NHS Grampian

Annual Operational Plan 2019/20
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Section 1: NHS Grampian Priorities

This Annual Operational Plan sets out how the Board will respond to the national priorities for NHS Scotland. The Plan is set within the context of the Board’s own clinical strategy.

The Board’s clinical strategy:

- Confirms the direction for clinical services for the five year years and beyond;
- Identifies the objectives across the health system to improve outcomes for patients; and
- Identifies the changes required to make the health system work more effectively.

In terms of delivery of the plan, the Board has the appropriate governance systems in place, with responsibility for implementation of the actions allocated to the System Leadership Team. We also recognise the increasing importance of collaborative working and investing both time and resources building relationships at all levels and across services and communities.
Section 2: Unscheduled Care (Including Delayed Discharge)

Context

Previous NHS Grampian Local Delivery Plans stated that our ambition was to seek to provide clinical treatment or advice in the right setting, at the right time, delivered by the right clinician/person. This aim was reinforced within the NHS Grampian Clinical Strategy, approved by the NHS Board in October 2016.

NHS Grampian has demonstrated resilience in unscheduled care, including over the winter period when services can be under greater pressure and performs positively against the national average. Much of the resilience is due to the efforts and hard work of committed and conscientious staff in our hospitals and communities as well as comprehensive cross-system planning and delivery. There has been considerable development of community based activity to minimise unplanned admissions to hospital and to facilitate supported discharge when admission does take place.

Working collaboratively across teams in NHS and Health and Social Care Partnership settings, multi-skilled staff work closely to focus on people’s needs. In hospitals we have seen the further evolution of safety brief models including a daily conference across all sectors, we have developed integrated discharge pathways that cross sectors, we have developed close working relationships in partnership with other agencies to streamline processes and colleagues continue to develop more new ideas. We have been particularly successful at reducing the number of bed days spent in hospital by those awaiting discharge.

We have established an overview of unscheduled care that is provided by Chief Officers and the General Manager of Acute Services to provide leadership and direction. This overview includes strategic direction as well as a clear line of sight through the programme of work that delivers transformational change required in line with local and national strategies, as well as high level approval of operational planning such as the Winter Plan.

We participate fully in the national Unscheduled Care Programme focusing on delivery of the six essential actions. We operate a full staffing cohort to deliver the national Programme and are focused around the two acute sites, including a dedicated site based Improvement Manager embedded in the local team for Moray.

We also participate fully in the national Ministerial Steering Group and its supporting working groups.
**Action Plans – 2019/20**

Health and Social Care Partnerships have developed performance plans for the following indicators:

- Unplanned admissions
- Unplanned bed days
- A&E attendances
- Delayed discharge bed days
- Last six months of life at home
- Balance of care

These plans set out how the partnerships, with their wider communities and the Board will deliver optimum performance within resources available. Each partnership has developed Strategic Commissioning Plans. These provide more detailed information as well as the demographic and workforce challenges which are faced and which could detrimentally impact on delivery of planned targets for the future.

The Strategic Commissioning Plans are embedded below.

moray_strategic_plan_010416.pdf
Health and Social Care Strategic Plan March 2016 Final.pdf

In terms of our performance in relation to delayed discharges and the 4 hour A&E standard we have included further details below.

**Current and Planned Performance – Delayed Discharges and 4 Hour Standard**

In terms of current performance, we would highlight the improvement activity that has been taken forward between the health and social care partnerships, the acute sector, local authorities and other partners to change how we improve access to health and social care. In the paragraphs below we set out how these actions have reduced the number and time patients have waited for discharge and the reduction in requirement for emergency admissions.

**Delayed Discharge/Bed Days**

There has been a concerted effort in Grampian to reduce the number of people delayed in hospital awaiting discharge and the length of time they are delayed. Whilst there are fluctuations from month to month and seasonally an overall downward trend can be demonstrated.
In Moray and across Grampian as a whole, the principal reason for delay is due to awaiting completion of care arrangements whereas in Aberdeen City and Aberdeenshire, the principal reason is due to waiting for place availability.
Emergency bed days for over 75s have been on a downward trend since April 2015. The latest figure, for the year ending January 2018, was 4218 bed days per 100,000 population which was 5.0% lower than for the year ending January 2017. The reduction was greatest in Moray, at 7.0% compared to 4.4% in Aberdeen City and 4.5% in Aberdeenshire.

Accident & Emergency Attendance Access Times and Patient Flow

Overall Grampian’s attendance rate at A&E is one of the lowest in Scotland. We continue to promote our ‘Know Who to Turn To’ campaign to encourage people to access the service provider most appropriate to their needs.

Action Plans

Action planning and reporting for the Six Essential Actions (6EA) Programme are reported monthly via the Programme Managers Monthly Meetings with the National Improvement Team.

The three main areas of focus for action in 2019-20 are:

- Escalation Planning
- Discharge Planning
- Admission Avoidance

As an integrated system we will seek to improve unscheduled care services and performance by the following actions:

- Continue to take work forward by local 6EA groups with cross system membership.
- Daily cross system /sector flow huddles continue to support patient flow and there are three patient safety flow huddles per day.
- Refreshed re-launch of daily dynamic discharge supported by the Service Improvement Managers.
- Implementation of work planned through use of driver diagrams which have been produced with specialty senior clinical decision support.
- Ongoing development, support and evaluation of virtual community ward model and acute hospital at home models.
- Support patient flow through increased Site and Capacity Team operational hours to 24/7.
- Support discharge planning through additional pharmacy support in acute assessment ward and short stay medical ward.
- Support discharge planning through introducing discharge screening at weekends.
- Support discharge planning through flow coordination in acute assessment ward.
- Site based Discharge Co-ordinator to support a multidisciplinary approach to discharge planning in Dr Gray’s wards.
• Support admission avoidance by investing in self-management for people with long term conditions via remote assessment and alerts.

• Continuing to develop the acute care at home model.

• Support Admission Avoidance through use of Frailty Assessment at the front door in Aberdeen.

• Support Admission Avoidance through introduction of Social Work input at the front door in Aberdeen.

• Focusing on locality needs and solutions.

• Implementing integrated neighbourhood care in Aberdeen model.

• Continuation of the Silver City project – a self-management approach to tackling social isolation for the older population at risk of hospital admission.

• Support Admission Avoidance by continued delivery of the Virtual Community Ward bringing greater collaborative working locally and supporting over 600 people to stay at home.

Unscheduled Care Services Delegated to Integration Joint Boards for Strategic Planning

The Integration Schemes for the Integration Joint Boards (IJBs) sets out the services which are delegated in terms of service delivery and strategic planning. Within the legislation there is a specific requirement relating to six acute hospital based services which are delegated to the IJBs for strategic planning.

<table>
<thead>
<tr>
<th>Service Delegated for Strategic Planning</th>
<th>Agreed Host IJB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident and Emergency services within hospitals</td>
<td>Moray IJB</td>
</tr>
<tr>
<td>General Medicine hospital services</td>
<td>Aberdeenshire IJB</td>
</tr>
<tr>
<td>Geriatric Medicine hospital services</td>
<td>Aberdeen City IJB</td>
</tr>
<tr>
<td>Rehabilitation Medicine hospital services</td>
<td>Aberdeen City IJB</td>
</tr>
<tr>
<td>Respiratory Medicine hospital services</td>
<td>Aberdeenshire IJB</td>
</tr>
<tr>
<td>Palliative Care services provided within hospitals</td>
<td>Moray IJB</td>
</tr>
</tbody>
</table>

The three IJBs and NHS Grampian have agreed a collaborative approach and underpinning framework to optimise the benefits and opportunities around this work focusing on population outcomes across the whole pathway and system. This is based on the below agreed high level principles.

• Strategic planning leadership provided by an IJB.

• Development of a strategic vision and strategic plan focussed on whole patient pathway for the population of Grampian – this is done in partnership with all IJBs, acute services and other agencies.

• Resources and operational management/delivery of acute service retained by acute management team.

A phased plan has been agreed to take forward the strategic planning of the six delegated services. Initial focus has been on geriatric medicine services in the context of the wider model of care and a process is being put in place to take forward strategic planning for palliative care.
Section 3: Planned Care

Context

Our ambition for planned care as set out in our Clinical Strategy is to:

- Provide care close to people’s homes, including diagnostics, treatments and wellbeing support.
- Tailor specialist treatment based on the realistic needs and goals of each patient.
- Improve the efficiency and productivity of services whilst safeguarding quality of care and working conditions for staff.
- Sustain planned care services as part of a North East and North of Scotland network, being sensitive to our dispersed population and securing sufficient capacity to improve faster access to care.

The National Waiting Times Improvement Plan was published in October 2019. The Plan reconfirmed that the overall approach to health and social care is rooted in the right of people to have safe, effective and person-centred healthcare.

The Waiting Times Improvement Plan focuses on reducing the length of time people are waiting for key areas of healthcare. The plan also takes account of the wider context of national, regional and local planning, health and social care integration, workforce planning, primary care development and the overall reform agenda. This includes the recognition of the relationship and impact unscheduled care demand will have on the capacity to deliver its objectives and the need to ensure a balanced approach to ensure patients’ needs are met.

This Waiting Times Improvement Plan outlines the steps and timescales that will be taken, alongside significant and focussed additional investment to support this work. It sets out the clear deliverables over the next 30 months and how these will lead to improvements throughout this period.

Elective Care

Current Performance – TTG, OP and Diagnostics

At present we are predicting we will overachieve against the commitment given for our outturn position in Outpatients and TTG for 31st March 2019. In relation to the TTG position, the main variation from the plan has been the number of patients waiting over 52 weeks which has increased above the forecast trajectory. This has been mainly due to these patients being unsuitable to benefit from the additional independent sector that has been established to address our priority and longest waiting patients. The plan for 2019/20 will specifically seek to address these longest waiting patients.
Proposed Plan

We have assessed demand for our elective (planned) services. This takes account of the volume of patients treated the year before; changes in the numbers of patients waiting for both outpatient and inpatient treatment and the existing / growing backlog.

As part of the Elective Care Programme, individual specialities are developing service plans which take account of the realisation of productive opportunities (the Target Operating Model).

A key focus for 2018/19 was on realising our productive opportunities, as well as planning the service redesign to transform care in the medium to long term. Key areas that we focused on were pre-operative length of stay (day of surgery admission) and theatre utilisation. We will continue to monitor the effective utilisation of core capacity at our three main sites – Aberdeen Royal Infirmary, Dr Gray’s and Woodend (Orthopaedics).

In addition to the Target Operating Model, during 2019/20 we will continue to develop theatre workforce to address the challenges we are facing in recruiting registered nurses. We have agreed to establish a Theatre Academy in order that we can develop the trained staffed required to support the new theatre staffing model that we are proposing to implement within the new elective care facilities and all our main theatres. This will enable us to increase the operating capacity within ARI by 25% by 31 March 2021 and provide sustainable models for all theatres across Grampian.

In terms of addressing demand through realistic medicine, we are planning to establish a Psychology and AHP Hub – focusing on return patients and patients where there are alternatives to surgery. We have confidence in recruiting to such posts and we know from initial experience this approach has the potential to reduce demand on a number of services.

As a result of the workforce challenges and level of backlog of patients waiting, we will continue to rely on sourcing additional capacity to continue to improve our performance during 2019/20.

Whilst the level of Scottish Government Access Support funding to be allocated to NHS Grampian is still to be formally confirmed, the Board has committed, based on discussions with Scottish Government, to support the continuation of the actions implemented during 2018/19 to increase capacity in the following areas:

- Additional independent sector capacity.
- Investment in recurring posts where there was an identified demand and capacity gap.
- Additional agency staffing to increase theatre availability locally.

These actions are being taken on the understanding that funding will be made available from Scottish Government for this additional capacity on formal agreement of our plan.
In addition to the continuation of the 2018/19 capacity, we are aiming to increase capacity in the following key areas subject to additional funding being confirmed.

1. Additional Capacity at Stracathro

We have agreement from a number of surgical services to utilise additional capacity at Stracathro that could be provided through the establishment of a mobile theatre and increasing the NHS Grampian share of capacity on the Stracathro site. Our initial priority services to allocate this capacity to General Surgery and Urology. The present assumption is that this would be utilised five days a week and 100% of the available time by NHS Grampian.

Discussions are ongoing with NHS Tayside in relation to the ability to increase the NHS Grampian share of the regional capacity to 50%. The financial consequences of this proposal are being developed and not reflected in our plan at this stage.

2. Addressing Long Waiting Patients (>78 weeks)

As requested we have undertaken a detailed analysis of the patients waiting over 78 weeks, which are mainly in the specialties of general surgery, urology and plastic surgery. In order to increase capacity we are proposing to reallocate capacity at Dr Gray’s Hospital, utilise available capacity at Albyn Hospital and to take forward discussions with NHS Shetland regarding utilising capacity that they have available. The other category of waits waiting longest is within plastic surgery. We believe that this could be addressed through a redesign of current capacity and discussions are ongoing with the clinical team to agree an improvement plan.

3. Colonoscopy

In support of improving cancer performance, we have been able source additional colonoscopy capacity at Albyn Hospital. This will be directed to reducing the waits for suspected colorectal cancer patients.

4. Orthopaedics

In line with the significant service redesign undertaken within the service, we are in the process of finalising plans to reduce the backlog and increase recurring capacity. The investment is largely in community based staff to focus on foot and ankle referrals and hand referrals where we have a significant gap in capacity to address.
The funding requirement for 2019/20 is set out below and detailed in the waiting times improvement plan.

<table>
<thead>
<tr>
<th>Funding Request</th>
<th>£/k</th>
</tr>
</thead>
<tbody>
<tr>
<td>OP &amp; TTG Projects</td>
<td>7,703</td>
</tr>
<tr>
<td>Nationally Provided Contracts1</td>
<td>2,000</td>
</tr>
<tr>
<td>Vanguard @ Stracathro</td>
<td>1,940</td>
</tr>
<tr>
<td><strong>OP &amp; TTG Subtotal</strong></td>
<td><strong>11,643</strong></td>
</tr>
<tr>
<td>Diagnostics</td>
<td>1,532</td>
</tr>
<tr>
<td>Cancer</td>
<td>1,158</td>
</tr>
<tr>
<td><strong>Cancer &amp; Diagnostics Subtotal</strong></td>
<td><strong>2,690</strong></td>
</tr>
<tr>
<td><strong>Total Funding</strong></td>
<td><strong>14,333</strong></td>
</tr>
</tbody>
</table>

**Cancer**

NHS Grampian is committed to ensuring that all those who require treatment for cancer should receive that treatment as soon as clinically appropriate. Improving cancer performance remains a Board priority as outlined within the Annual Operational Plan 2019/20 and we have established a robust cancer improvement action plan which seeks to deliver the recommendations of the Scottish Government’s Effective Cancer Management Framework. The NHS Grampian Cancer Local Improvement plan sets out our ambitions to fully explore, and implement where clinically appropriate, the Effective Cancer Management Framework peer review recommendations to improve cancer management. To enhance our capacity to improve performance we have:

- Appointed a Medical Lead for Cancer Performance and a Head of Cancer (Pathways and Access) to provide the leadership and capacity to support the implementation if improvements across all cancer pathways; and
- Increased multi-disciplinary team (MDT) co-ordinator capacity to ensure appropriate monitoring of patients and implementation of clinical management plans for all patients with a cancer diagnosis. Each cancer pathway has an action plan which is reviewed regularly and variance escalated

NHS Grampian acknowledges that improvement against both 31 and 62-day standards is required and our focus for 2019/20 is to improve performance for all cancer pathways. Particular focus is on colorectal and urology pathways which accounted for 85% of NHS Grampian’s 62-day breaches in the first quarter of 2019. We will focus on addressing ongoing capacity issues within endoscopy, which particularly impact on the colorectal screening pathway, and access to theatre capacity to ensure maximum utilisation of available staffed capacity.

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1 Dermatology, Ophthalmology & Orthopaedics
Recognising the significant staffing challenges which have impacted on capacity across NHS Grampian, a number of actions have been taken to effectively manage available resources whilst mitigating risk and ensuring appropriate governance. In order to achieve this, a clinically-led risk management system of clinical prioritisation was introduced from June 2017 to enhance our ability to prioritise patient clinical need, as determined by the treating clinician. The system is underpinned by robust monitoring and escalation processes which were developed in partnership with Primary Care and includes ongoing assessment of clinical risk to ensure highest risk patient groups are identified. NHS Grampian is committed to ensuring all available staffed theatre resource is targeted at patients with the highest clinical need.

In order to achieve this we are progressing a number of short-term actions to address the existing backlog, and medium and long-term initiatives which are focused on sustainable performance improvement:

- Breach analysis to focus on areas of consistent failure and patients waiting over 100 days;
- Systems of governance and assurance to monitor performance across all pathways;
- Weekly cancer pathway tracking meetings to identify and ensure early escalation of patients deviating from expected timed pathways and actions taken to prevent breaches where possible;
- Implementation of enhanced monitoring of available staffed theatre capacity across NHS Grampian with a view to identifying additional sessions for Colorectal, Urology and Breast.

These actions are underpinned by the following principles:

- As far as reasonably possible, patients requiring a procedure will be booked in turn;
- Available staffed theatre capacity will be allocated to cancer cases a matter of priority; and
- All available staffed theatre capacity will be allocated to the next highest priority patients.

A short-term plan has been developed to address the existing backlog of patients waiting longer than 62 days for treatment. As we treat patients waiting longer than the 62 day pathway target, we recognise that our cancer performance in 2019/20 is likely to deteriorate further. Agreed short-term actions are:

- Currently, urology and colon cancers account for 85% of patients waiting beyond 62 days for treatment. It is anticipated that the urology & colorectal backlog will be cleared in Q3 2019 as three whole day sessions of staffed theatre capacity will be reallocated as capacity to treat urology and colorectal patients who have waited more than 62 days for treatment.
- Increase capacity for scoping through use of the private sector at Albyn Hospital, Aberdeen Health Village and Dr Gray’s.

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2This system is currently under evaluation.
• Appointment of additional Urology consultant, colorectal nurse specialist
• Through enacting this short-term plan, we will significantly reduce the number of patients waiting more than 62 days for treatment across urology & colorectal cancer pathways to approximately 12 by end of Q3 2019.

Recognising finite critical care capacity, and to minimise unintended consequences through creating bottlenecks in the system, this short term plan will be in place throughout the summer theatre timetable from June to September 2019. Enhanced monitoring of the 6-4-2 theatre session allocation process will continue beyond this timescale and support the actions within the medium-term plan.

A high-level plan has been developed to ensure sustainable achievement of both the 31 and 62-day standards beyond Q3 2019/20. This seeks to maximise utilisation of core capacity across all elective sites within NHS Grampian and sets out our commitment to realising the productivity and efficiency opportunities outlined within the NHS Grampian Waiting Times Improvement Plan.

We anticipate that our short-term plan will address the existing backlog by Q2/Q3 2019 through a number of key actions, one of which seeks to reallocate existing staffed theatre capacity. As the backlog is cleared in the short-term, we will utilise reallocated staffed theatre capacity in the medium-term to maintain our cancer performance, with a specific focus on colorectal, urology and breast cancer pathways.

In order to sustainably improve cancer performance a number of work streams and developments will be undertaken in the medium-term. These are:

• Specialty-level service reviews;
• Consultant job plan template reviews;
• Theatre timetable redesign;
• Theatre capacity re-alignment across NHS elective sites;
• Development of a regional ovarian cancer service for the North of Scotland; and
• Increase capacity in endoscopy, radiology, PET and theatres as per 30 month waiting times improvement cancer plan.

These workstreams and developments have a number of interdependent improvement and sustainability initiatives. These initiatives have been outlined within the waiting times template.

**Diagnostics**

Our draft Waiting Times Improvement Plan sets out the diagnostic trajectories and improvements for 2019/20.
Regional Working

In line with the North of Scotland Health and Social Care Delivery Plan Discussion Document, NHS Grampian continues to work with Boards across the North of Scotland (NoS) in the development of a unified elective care system. This involves the harmonisation of our access policies and referral pathways, and integration of eHealth solutions and health intelligence.

More importantly, this also includes the development of sustainable clinical pathways across the region, underpinned by a clinical prioritisation framework. At present, the following clinical areas are progressing regional developments:

- **Oral Maxillofacial Service** - regional clinically led collaborative model being progressed.
- **Dermatology** - exploration of the potential for a long term regional network arrangement for NHS Tayside and Grampian being progressed. Two clinically led, regional workshops have taken place, setting out the challenges, opportunities, and preferred way forward.
- **Radiology** - part of the national shared services agenda, supported by a regional working group.
- **Laboratories** - part of the national shared services agenda, supported by a regional working group.
- **Urology** - exploration of pathways of care between NHS Tayside and Grampian for prostate cancer patients. One clinically led regional workshop has taken place, setting out the challenges, opportunities, and possible way forward. A further clinically led workshop is being planned for May 2019.
- **Vascular** - exploration of pathways of care between the north Boards. One clinically led discussion has taken place, setting out the challenges, opportunities, and possible way forward. A further clinically led discussion is currently being planned.
- **Cardiac** - Three key priority areas have been agreed and are being progressed by the NoS Cardiac Services Group.
  - Approval of a NoS TAVI Business Case by the NoS CEO Group in November 2018. The NoS TAVI Service hosted in ARI is expected to go operational from April 2019.
  - A NoS Catheter Laboratory Workstream has been established to review equity of access to current catheter laboratory facilities. This will inform future capacity requirements across the NoS whilst ensuring optimal utilisation of current capacity, workforce and skills. This workstream has representation from NHS Grampian, NHS Highland and NHS Tayside and will also consider requirements for replacement or additional catheter laboratory capacity across the NoS.
  - NoS Cardiothoracic Surgery Sustainability Plan – a high level Cardiothoracic Surgery Action Plan was developed in 2018 and work remains ongoing with clinical and operational service leads to deliver on actions during 2019.
In addition to the above clinical areas, there is agreement by the North Chief Executives to:

- Review the priorities of all regional workstreams with a view to address and support short-term initiatives aimed at achievement of the Waiting Times Improvement Plan; and
- Set out a clear Acute Hospital Plan / Strategy for the north region, allowing short-term actions to be identified and addressed as part of a longer-term plan.

**Overall Waiting Times Improvement Plan**

The draft NHS Grampian Waiting Times Improvement Plan for 2019/20 is embedded below.

Further work will be carried out to progress our plans and trajectories for the period to 31 March 2021.
Section 4: Mental Health and Learning Disability

Context

Following discussions with Scottish Government in November 2018 on integration and NHS Mental Health and Learning Disability Services we submitted a detailed plan setting out the:

- Changes made within the operational arrangements at Royal Cornhill Hospital to maintain access to inpatient services; and
- Strategic review that was commissioned to consider the options for the future provision on pan-Grampian Mental Health and Learning Disability Services.

This section draws on that report, in addition to the plans that have been developed to improve access to Child and Adolescent Mental Health Services.

Operational Arrangements within Royal Cornhill Hospital

The revised operational arrangements implemented in November within Royal Cornhill Hospital continue. The consolidation of inpatient services into five wards was undertaken in close partnership with staff and patients. Steps taken included:

- All staff affected by temporary service closures had 1:1 meetings with Human Resources and nurse management to identify preferences for moves to alternative ward areas.
- Close working relationship with corporate communications and public involvement colleagues to ensure regular and appropriate communication.
- Regular email briefings to staff and other stakeholders including GPs.
- Press releases as required by NHS Grampian Corporate Communications Department.
- Meetings with staff in the staff lounge - lunchtimes and evenings (for night staff).
- Development of plans for reallocation of medical catchment areas.
- Briefing to Psychiatric Medical Advisory Committee.

As a result of the changes, staff to patient ratios have improved and there has been no impact on access to inpatient facilities for patients requiring admission. Permanent staffing complement has increased by 35 registered nursing staff following the recruitment of new graduates, however this is set against retirements and staff movement resulting in the continued use of bank and agency nursing staff to increase capacity, where appropriate.
The integration of acute and community mental health is well established across Grampian. Multi-disciplinary, multi-agency mental health teams are aligned to specific general practices in each IJB (Moray, Aberdeen and Aberdeenshire) with care pathways established to specific wards at Royal Cornhill Hospital and Dr Gray’s Hospital (Elgin) should an acute episode require admission for a patient. The pathway is designed to support individuals in the community and to ensure wherever possible that the requisite resources are in place close to home.

The effectiveness of this model is reflected in the comparatively lower bed base, low cost specialist service in Grampian and, for example, the low Emergency Detention Certificates rates. The implementation of these arrangements is being overseen by the cross-Grampian Mental Health and Learning Disability Clinical and Care Leadership Group.

**Strategic Review**

The action plan submitted to Scottish Government set out how NHS Grampian would deliver the following:

- An integrated strategic plan for the provision of mental health services which optimises outcomes to meet population need and implement the appropriate reporting and governance processes; and

- Transition of the inpatient services to be formally hosted for strategic planning and operational delivery within an IJB of which there are three in Grampian.

The high level framework and process for the development and governance of an integrated system wide strategic plan has been agreed with the three IJB’s and dedicated senior leadership and strategic planning capacity has been put in place to facilitate the implementation of the action plan. Underpinning this will be a robust stakeholder engagement and communication plan which sets out the key stakeholders, along with the various mechanisms to support wide ranging and meaningful engagement and communication in relation to patients, families, the public, staff and partners. In the interim whilst the strategic review is undertaken we have confirmed the following transitional arrangements:

- Joint executive leadership will be provided by Chief Officer and Director of Finance (current NHS Grampian executive lead for Mental Health and Learning Disability). The NHS Board will retain responsibility for delivery of the MH Waiting Times Standards during this period.

- The leadership management triumvirate based at Royal Cornhill Hospital will integrate with the Aberdeen City Health and Social Care Partnership senior management structure.

- Existing professional and governance links will be retained within NHS Grampian.

- No formal structural or organisational change processes will be implemented during the shadow period.
We have taken steps to ensure that we listen to the voice of those with lived experience of accessing services in Grampian and this work is ongoing. There is a commitment to ensuring that our strategy development is reflective of what we are told matters most to those accessing our services. To this end we have engaged the Health and Social Care Alliance Scotland to lead a local process of engagement with service users, carers and their advocates. Sessions have been held in Aberdeen City, Aberdeenshire and in Moray and have been attended by around 120 people comprised of those with experience of accessing services and those who support people to access services. There is also a parallel online survey seeking views of those with lived experience, feedback from which will be incorporated into the formal report that the Alliance will produce in due course.

Staff engagement is central to our strategy development - a staff survey has been responded to by 325 colleagues working across the sectors within Grampian. The results will inform the development of the Grampian-wide sustainability plan for MHLD, taking account of staff views in regard to many aspects of service delivery and opportunities for improvement with regard to future stability, redesign and sustainability.

In addition to the engagement activities outlined above, there have been other parallel engagement activities within some professional groups.

This review process and related engagement activity will culminate in the generation of a draft future sustainability plan for consultation between June and September.

Main stakeholder workshops have been undertaken in March, April and a furthermore workshop scheduled in May – to include broad representation from stakeholders including: inpatient services, community services, social care, third sector and staff partnership.

We remain on target to complete the following key tasks by the due date:

- Approval of a co-produced robust integrated strategic plan which includes a redesigned workforce model by the three IJB’s in partnership with relevant parties (By 30 September 2019).
- Formal agreement of the revised delegation arrangements by 1 October 2019 with full implementation from 1 April 2020.
ISD Data

We note that in the latest ISD publication that the total (net) expenditure for general psychiatry services for 2017/18 was £73.4m for NHS Grampian. This was equivalent to £125 per head of population which compared to £178 across Scotland and as much as £245 in Greater Glasgow & Clyde.

Similar to all services the per capita funding NHS Grampian receives means that most of our services will highlight a lower level of funding per head. This would explain c50% of the above variation in cost per head of population.

In terms of the remainder of the cost differential this is due to the model of integration of acute and community mental health that is well established across Grampian. Multi-disciplinary, multiagency mental health teams are aligned to specific general practices in each IJB sector (Moray, Aberdeen and Aberdeenshire) with care pathways established to specific wards at Royal Cornhill Hospital and Dr Gray’s Hospital (Elgin) should an acute episode require admission for a patient. The pathway is designed to support individuals in the community and to ensure wherever possible that the requisite resources are in place close to home. The effectiveness of this model is reflected in the comparatively lower bed base, low cost specialist service in Grampian and, for example, the low Emergency Detention Certificates rates.

Child and Adolescent Mental Health Services (CAMHS)

A CAMHS whole system redesign has been implemented in Grampian and is now nearing conclusion. After an extensive organisational change and engagement process (involving key partners, staff, patients and carers), the CAMHS services have now been redesigned for all children and young people aged between 0-18 years including learning disabilities. This will enable the service to provide safe, effective, equitable and efficient care regardless of age or location of the patient requiring to access services.

The redesign has supported the following key changes:

- NHS Grampian uses the Choice and Partnership Approach (CAPA). The CAMHS service has fully implemented the CAPA model which enables the service to flex capacity to meet demand. CAPA also enables the CAMHS service to provide a more responsive and equitable service with no internal waits. This model maximises efficiency within the workforce by transparent and clear job planning for all grades of staff. The CAMHS national referral criteria was implemented across the service in early 2017 and the service now accepts referrals from a wider range of professionals such as health visitors and school staff. The referrals will therefore now all be screened by the same five clinical staff from our new Unscheduled Care Team for a six month pilot to assure consistent decision making.
• We now have a standard referrals process which follows the national CAMHS referral guidance as produced by the Scottish Government. Revised referrals guidance document has been produced and is being utilised. CAMHS now receives referrals from a wider range of professionals such as School Nurses, Head Teachers and Health Visitors.

• We have expanded the multi-disciplinary team employing a speech and language therapist, a physiotherapist, dietician and occupational therapists. We have appointed to all posts across the service and we do not have any problems currently recruiting to vacant posts. There can be a lag in employing some newly qualified staff due to course completion dates and recruitment processes.

• A new strategic multi-agency meeting has been commissioned focused on supporting mental wellbeing in order to prevent mental ill health. The main areas of focus are to deliver standardised training for the parenting programmes, adverse childhood events (ACEs) and anxiety reduction across the region.

In terms of further steps, £1m has been granted from the Scottish Government Health and Care Directorate to facilitate the co-location of the CAHMS services for Aberdeen and Aberdeenshire on a single site. CAMHS has been delivered care from four separate sites, by three separate teams all operating different age ranges and different models of delivery of care. It has been estimated that approximately 23% of the workforce capacity is being lost due to travel between CAMHS sites which is not efficient or effective. Building works is estimated to conclude in Spring 2019. This new facility will have many new benefits to patients, and staff, and in addition it will provide increased capacity and space to house new staff to ensure the workforce has enough clinical space to see patients. Support is also being provided by the Archie Foundation and there has been extensive ongoing input from the Patient Involvement Team, stakeholders and staff to ensure that the new site is fit for purpose.

The service aims to be a regional ‘CAMHS Centre of Excellence’ which can ensure equitable and efficient healthcare. CAMHS NHS Grampian strives to be a source of locally accessible expertise to families and the wider services around the child, and to offer targeted specialist care.

**Improving Performance**

Within this section we set out how we will achieve the following performance standards:

• Set out the Trajectory showing how the CAMHS Standard (90%) will be delivered by end 2020.

• Set out the Trajectory showing how the PT Standard (90%) will be delivered by end 2020

• Set out the Trajectory showing how the ED – Mental Health Standard (95%) will be delivered by end 2020.
CAHMS

The service has welcomed and has been working closely with the Mental Health Access Improvement Team (MHAIST) to review current arrangements and identify opportunities to improve access and reduce waiting times. The report arising from the MHAIST review has been agreed and an action plan developed.

There has been an overall improvement in waiting times by 27% in the last year from September 2017 to September 2018. Children who have been referred are prioritised and all emergency cases are seen within 48 hours; all urgent cases are seen within 7 days. Additional clinics have also been offered to all staff in CAMHS for this quarter to help reduce longest waits (which are mainly for neurodevelopmental conditions). The funding to support this has come from the Taskforce.

It is of note that the CAMHS service currently counts the second appointment (Partnership) as start of treatment despite the fact that the initial appointment (Choice) includes a treatment plan and clear formulation, or self-help advice. The waits in Aberdeen City and Aberdeenshire for Choice appointment are all now all currently less than 8 weeks. The wait to second appointment (Partnership) is 6-8 weeks. There are however a number of vacancies due to staff recently leaving posts at present so waits may change slightly.

The table below summarises the waiting times position under the CAPA model.

<table>
<thead>
<tr>
<th></th>
<th>Wait to CHOICE (assessment)</th>
<th>Wait to Partnership (Generic Treatment)</th>
<th>Wait to URGENT CHOICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aberdeen City</td>
<td>5 weeks</td>
<td>8 weeks</td>
<td>2 days</td>
</tr>
<tr>
<td>Aberdeenshire</td>
<td>6 weeks</td>
<td>8 weeks</td>
<td>2 days</td>
</tr>
<tr>
<td>Moray</td>
<td>21 weeks</td>
<td>5 weeks</td>
<td>15 days</td>
</tr>
</tbody>
</table>

We can now confirm that all patients in Aberdeen City and Aberdeenshire are meeting the 90% target - first appointment within 8 weeks and second appointment by 16 weeks. The move to the new City Hospital facility should increase capacity by approx. 20% increase efficiency.

In relation to the CAHMS service in Moray, a detailed action plan has been discussed and developed with the MHAIST team. In Moray all patients now seen for first appointment with 21 weeks (was 29, last quarter 25 weeks and this quarter 21 weeks). By next quarter it will be reduced further. The time to second appointment is 6 week. We continue to work with MHAIST and there is approval for the Moray service to run additional evening or weekend choice clinics to reduce waits

With the support of MHAIST and the local team we anticipate a more HUB type role to support the Moray service and new staff are being recruited

Patients with a neurodevelopmental problem such as ADHD and ASD are waiting the longest and we have collaborated with MHAIST to develop a plan to reduce the waiting times. Extensive demand and capacity modelling based on CAPA has been undertaken to streamline the service capacity.
Additional core clinic capacity has also been introduced over the next three to six months to address the backlog of patients waiting.

‘Attend Anywhere’ virtual appointments system has been implemented to ensure patient and staff travel to appointments or multi-agency meetings is reduced. Recent outcome data about Attend Anywhere from other services is positive and we expect this to be fully operational in CAHMS following the move to the new Centre of Excellence.

The CAMHS team have a workforce plan, DCAQ analysis, and CAPA planning that enables the service to detail the impact of work undertaken and to be taken going forward.

With regards to PT there has been no Director of Psychology post in Grampian for 18 months. Although the lead psychologists from each area (Learning Disabilities, Adult, Specialisms, Acute, Old Age, and CAMHS) have been covering these roles there has been no consistent oversight or leadership for PT. This post is due to be advertised shortly and the post holder will be able to support the details of developing the AOP for PT.

**Psychological services**

As indicated due to issues with the data for the service we are not at this stage able to provide an accurate trajectory to improve performance. We have prioritised this work and we advise of progress. Irrespective we remain committed to the following actions to improve performance in the interim:

1. The appointment of a Director of Psychology

2. In terms of staffing our current position is as follows:
   - Aberdeen City - there are no vacancies in the secondary care service and we are looking to appoint to the one vacancy in primary care which if filled would significantly reduce waiting times across that service.
   - Aberdeenshire - there is one 0.6 whole time equivalent (wte) 8B vacancy and one 0.7 wte 7/8A vacancy in secondary care. In Primary care there is one 1.0wte Band 6 post out to advert and all other vacancies are filled
   - Moray has one current vacancy in secondary care and one in primary care.

3. Using Action 15 monies in both City and Aberdeenshire we are developing posts (4 in City, 9 in Shire) for Band 5 mental wellbeing workers who will support the Tier 1 patients and also reducing waiting times at tier 2 by providing interventions at an early stage, preventing deterioration for many patients.
Emergency Department

As a Board we are generally compliant with the ED standard – in 2018/19 this was 94.4% and 95.1% in the previous year. One of the breach reasons is 'Wait for Specialist - Psychiatry' which we monitor. However this does not take into account all the MH presentations to the ED we are looking at whether our systems could capture a wider set of data in relation to MH patients. This will provide further assurance as to our performance against the 95% standard.

A copy of the draft Improvement Plan for CAHMS and Psychological Therapies is embedded below.

Investment in Additional Capacity

In terms of overall workforce, Grampian has less staff than the Scottish average. The NHS Grampian Board has agreed to provide an additional £1m over the next five years to increase capacity within the service. This is in addition to funding that will be made available by the Scottish Government. The service is developing a workforce plan to support the implementation of this investment.

Despite the differential in workforce\(^3\), the number of patients waiting over 18 weeks is less than the Scottish average. Furthermore, national staffing vacancy rates are 4.8% whereas Grampian’s staffing vacancy rate is 2.6% which is nearly half the national average.

<table>
<thead>
<tr>
<th>NHS Board of Treatment</th>
<th>Data</th>
<th>Total</th>
<th>WTE per 100,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Grampian</td>
<td>% patients waiting more than 18 weeks</td>
<td>16%</td>
<td>60.4 WTE</td>
</tr>
<tr>
<td>Scottish Average</td>
<td>% patients waiting more than 18 weeks</td>
<td>23%</td>
<td>92.8 WTE</td>
</tr>
</tbody>
</table>

In addition to this, the service has been working closely with National Education Board for Scotland (NES) and has secured increased funding for training posts in both the masters and doctoral training programmes. The service also has secured NES funding for Tier 1 and training to skill up education staff to manage anxiety and this funding will continue until March 2020.

The service has also submitted an early plan to access a share of the £5m investment being made available by the Scottish Government to support the implementation of the recommendations made by the national taskforce.

\(^3\)Our board’s WTE per 100,000 total population for CAMHS is still low at 10.0wte (Scottish average is 16.8wte).
This should result in an additional £0.5m in local resources. The main focus for increasing capacity for CAMHS is a bid relating to a new nurse led unscheduled care team and increased support for Early Intervention Services in Tier 1 and 2.

Whilst noting the welcome additional investment in services, the three local authorities have discontinued their funding of the CAHMS services hosted by NHS Grampian through Changing Children’s Services.
Section 5: Prevention and Self-Management

Context

Primary prevention activities can stop people becoming ill and reduce the need to use clinical services. Secondary prevention interventions help to identify disease at the earliest stage to begin prompt treatment and minimise future health problems. Individuals, families and communities play a significant role in managing their own health conditions. A partnership of care contributes to better outcomes and more effective use of health services. Both prevention and self-management are key themes in the Grampian Clinical Strategy which will be supported through implementation of this plan.

NHS Grampian will provide direct input to strategic needs assessment and strategic planning and commissioning undertaken by the Health and Social Care Partnerships, Community Planning Partnerships, Alcohol and Drug Partnerships, Community Justice Partnerships, and Children’s Services Partnerships. We will use direct involvement to lead and influence preventive and protective actions and interventions to improve population health through the range of partnership delivery plans, which are responsive to local need and local priorities.

Current Performance

Performance is measured by a variety of metrics, previously contained in Local Delivery Plans and other key documents. Performance continues to be monitored and managed by the Board and its partners.

Alcohol Brief Intervention

NHS Grampian achieved 125% against the Alcohol Brief Intervention standard in 2017/18 (8,343 ABI delivered against a standard of 6,658).
Smoking Cessation

NHS Grampian achieved 80% (916 against a standard of 1,149 12-week quits from the 40% most deprived population) against the smoking cessation standard in 2017/18. NHS Grampian is a high performing Board against the LDP standard given that it is set significantly higher than any other Board area in Scotland. Community Pharmacies had a 25% success rate (against a national average of 20%), the second highest amongst mainland Boards; the specialist smoking cessation team had the highest success rate of mainland Boards at 73% (compared to the national average of 38%); the team also support smoking cessation in HMP Grampian, which had the highest success rate within prisons at 49%.

Breastfeeding

The national standard is that 46% of new-born children should be exclusively breastfed at 6-8 weeks by March 2021.
Dental Registrations

The national target is that 80% of 3-5 year olds should be registered with an NHS dentist. This has been delivered since the quarter ending March 2013.

![3-5 year old dental registration rate - snapshot at September 2018](image)

Alcohol and Drug Service Waiting Times

90% of clients should wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery. It should be noted that the services monitored against this target are wider than NHS and include local authority and voluntary organisation partners involved in tier 3 and 4 alcohol and drug services.

![Drug & Alcohol Service Waiting Times: Referral to Treatment (3 week target)](image)
Prevention

Alcohol and Other Drugs
- NHS Grampian will continue to participate in Grampian’s Alcohol and Drug Partnerships to ensure our investment is focussed on evidence based policies, prevention and treatment interventions.
- We will continue our efforts to increase delivery of Alcohol Brief Interventions through primary care and wider settings.
- As a statutory consultee, NHS Grampian will participate in all alcohol licensing applications to the alcohol licensing boards in Grampian to reduce overprovision in our communities.

Child Health
- NHS Grampian Children’s Transformation Board will lead strategic planning for children’s services across Grampian, which will include prevention and health improvement actions.
- We will support maternal and infant nutrition (including breast-feeding support) across maternity, health visiting and community settings.
- We will provide universal childhood screening.
- We will oversee the Vaccination Transformation Programme.
- We will deliver and report against our Child Poverty Action Plans developed with our three Local Authorities under the terms of the Child Poverty (Scotland) Act 2017.

Health Promoting Prison
- NHS Grampian will directly participate in Grampian’s Community Justice Partnerships and ensure prevention and health improvement actions are included in strategic planning and implementation.
- We will support HMP Grampian become a smoke-free prison, and will provide a holistic health coaching service to support prisoner health.

Health Inequalities
- NHS Grampian will directly participate in Grampian’s Community Planning Partnerships’ and ensure prevention and health improvement actions are included in their LOIPs and Locality Plans.
- We will implement and monitor the actions identified by the Board Health Inequalities Working Group.
Mental Health

- We will provide mental health services and will ensure mental health promotion is addressed by strategic planning across the partnership planning landscape.
- We recognise that mental health is important to growth, development, learning and resilience. Working with our partners we will review our approach to supporting young people to be resilient and agree a plan to ensure the necessary support and services for young people as they grow up.

Nutrition, Physical Activity and Healthy Weight

- We will implement our Healthier Future action plan to tackle obesity, improve nutrition and physical activity.
- We will implement the Diabetes Framework Action Plan.

Oral and Dental Health

- We will improve access to high quality dental services through focused efforts at those populations who are less likely to be registered with a dentist.
- We will increase participation in our NHS oral health improvement programmes – Childsmile, Caring for Smiles, Mouth Matters and Smile for life.

Tobacco

- We will implement our renewed Tobacco Control Action Plan.
- We will continue efforts to extend smoking cessation support, with a particular focus on populations living in areas our most deprived areas, patients of Royal Cornhill Hospital and prisoners at HMP Grampian.

Sexual Health and Blood-Borne Viruses

- The Managed Care Network for Sexual Health and Blood Borne Viruses will continue to implement its priority action plan to reduce stigma, increase awareness of and support for individuals to reduce their risk taking behaviour and to ensure the provision of services for those who need. In particular we will raise awareness of liver health and actions to tackle liver disease and to increase those at risk of blood borne viruses to be tested.

Staff Health and Wellbeing

- The link between health and work is increasingly well understood: good quality work promotes better health, and a healthier workforce is a more productive one. We will implement our staff health and wellbeing plan to support NHS staff to stay fit and healthy.
Supported Self-Management

Chronic disease and multi-morbidity is projected to continue increasing in Grampian as elsewhere. NHS Grampian’s Supported Self-Management Transformation Programme Board will oversee the supported self-management agenda. The Transformation Programme Board has adopted the house of care model, which empowers patients with chronic disease and multi-morbidity to be equal partners in their care, and supports patient autonomy in maintaining and improving health, while attending to the necessary social and environmental surroundings that need to be in place to allow self-determination to be meaningfully expressed. The latter aspect will help inform Health and Social Care Partnerships and Community Planning Partnerships with planning and commissioning decisions.

The programme is also fully consistent with the ambitions inherent in realistic medicine.

- Of the eleven practices across Grampian who have received house of care training and practice mapping, seven are live (Kincorth & Cove, Huntly, Fochabers, Macduff, Cruden & Hatton, Aberlour) or soon to go live (Banchory); the remaining four have had implementation delayed. Seven further applications for cohort three are being processed for 2019/20.
- We will continue to support the practices that are live, and will aim to support implementation in cohort three and cohort four practices during 2019/20.
- We will explore the potential for expert patient programmes to support self-management for patients in Grampian.
- We will explore the implications of the self-management agenda for Acute settings.

NHS Grampian’s ambition is to embed person-centred care and support planning across primary care in Grampian, and integrate this work with strategic planning for community capacity building and community asset development.
Section 6: Finance

1. 2019/20 Revenue Budget

NHS Grampian’s draft revenue budget was agreed by our Budget Steering Group on 25th February 2019.

Operating within Statutory Financial Limits

NHS Grampian expects to operate within the Revenue Resource Limit and Capital Resource Limit over the three year financial planning cycle to 31 March 2022. On the revenue side, underspends of £3.0m are planned for the 2019/20 and 2020/21 financial years balanced by a planned overspend of £6.0m in 2021/22. The pattern of these variances is based on the need to provide revenue funding to support two major capital projects which will come into operation in 2021/22.

A high level summary of the 2019/20 finance plan is embedded below.

Finance narrative - AOP (updated 26 03 19) (002).docx

In the following three financial years the key matters that the Board Finance Plan will be focused on addressing will include:

- Reviewing the service models operating within Dr Gray’s Hospital (Elgin) and Mental Health where the current levels of temporary medical and nursing staff are presenting challenges to the sustainability of services. Redesign of services within these areas will be necessary to secure provision of a sustainable service model.
- Developing the plans for achieving national waiting times standards for elective and cancer care linked to the investment in diagnostic and treatment facilities.
- Identifying funding sources to meet the £10m costs of the new Baird Family Hospital and ANCHOR centre due to open in 2021/22.
- Working collaboratively with the three Health and Social Care Partnerships to deliver their strategic plans within available resources.

Anticipated Level of Savings

The predicted levels of savings required over the three period of the plan are noted below (NHS Grampian directly managed services only):

<table>
<thead>
<tr>
<th></th>
<th>2019/20</th>
<th>2020/21</th>
<th>2021/22</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial gap</td>
<td>£10.2m</td>
<td>£10.2m</td>
<td>£10.2m</td>
</tr>
</tbody>
</table>
The draft finance plan sets out the actions that will be taken in 2019/20. The Board will be progressing its plans to achieve the required level of savings over the remaining two years and address the issues noted above.

**Commitment to Deliver National Priorities Requirements**

a. Mental Health

Mental Health Services are managed by NHS Grampian for inpatient services and by the three Health and Social Care Partnerships for community based services.

Our financial plans include commitments to increase investment in Mental Health Services by:

- £1.0m investment in the CAMHS service in addition to separate funding stream for new posts being provided through NES.
- NHS Grampian’s share of the further funding announced by the Scottish Government to increase the mental health workforce and support the transformation of CAMHS.

b. Primary Care

In line with the requirements of the MOU of the new GP Contract, a Grampian GP oversight Group has been established to provide collective surveillance over the implementation of the contract. This grouping has in its membership the Chief Officers of the IJBs, LMC/GP Sub, NHS Grampian Property Lead, eHealth Lead, workforce lead, Pharmacy Director, Public Health lead as well as the Contract Manager. The purpose is also to maximise appropriate cross-system working and good communication, ensuring all key elements of the MOU are represented and all parties are suitably informed, supporting decision making.

At a local partnership level all three partnerships have PCIPs in place. These are currently under review in line with the new guidance. There is good cross partnership collaboration in place to ensure shared learning and objectives as appropriate. Action 15 monies have also been deployed in accordance with the ambitions of our PCIPs maximising the opportunity to strengthen outcomes for people.

NHS Grampian has historically had well established mechanisms in place to ensure good system working across all primary care contractors. Leadership is provided for Primary Care on behalf of NHS Grampian and the IJBs by one Chief Officer hosting the functions of the contract. Work has also been underway to strengthen support for the advisory and negotiating functions of the LMC and GP Sub with the funds available directly as required.

In line with the Public Bodies (Joint Working) Act 2014 Primary Care Services in Grampian are delegated to the three Health and Social Care Partnerships. NHS Grampian will pass on the share of the funding for primary care announced in the 2019/20 Scottish Government budget in full to the Health and Social Care Partnerships for investment in Primary Care Services.
c. Health and Social Care

NHS Grampian is continuing to pass our share of the £350 million national pot to the Health and Social Care Partnerships. An uplift of 2.6% has also been applied to this funding transfer for 2019/20.

We have also updated the calculation of the set aside budgets for the three Health and Social Care Partnerships based on 2017/18 data and will share these with the Chief Officers and Chief Financial Officers.

Financial Templates

Financial templates were requested from Boards by the Health Finance Department. These have been submitted with this Annual Operational Plan.

Infrastructure

The Board’s Asset Management Plan sets out the priorities for managing the infrastructure that supports the delivery of patient care and associated services across NHS Grampian and is a key enabler to the delivery of the Grampian Clinical Strategy.

The plan includes a “balanced” five year investment programme which outlines how we intend to use the various sources of funding available to the Board in support of our priorities. It also includes a “long list” of other priorities for investment in infrastructure, delivery of which will be dependent on the availability of additional funding in the coming years.

The Asset Management Plan is reviewed annually and the updated version will be presented to the Board for approval at a future meeting. We have highlighted below the current commitments in our five year investment programme for the period to 31 March 2024. The following balanced approach will ensure that we are able to obtain maximum benefit from the available funding:

- Progress the Clinical Strategy by responding to new and improved ways of delivering services that require fewer assets, services will increasingly be delivered in people’s homes, on an outpatient basis, on a mobile basis and through the use of new technologies such as the Electronic Patient Record and video conferencing.
- Improve estate and asset performance on all key indicators, including a targeted reduction in significant and high risk backlog maintenance and a continued programme of essential equipment replacement.
- Disinvest from buildings with high operating costs, backlog maintenance requirements, or short remaining life where these do not meet future service requirements; and
- Invest and develop in new technology that achieves simplification of the existing information technology infrastructure, whilst simultaneously allowing additional investment and improved resilience.
A summary of the immediate investment priorities for the next five years is presented in the five year plan included below.

In terms of taking forward our plans for the future we welcome and recognise the support and close working relationships we have with colleagues in the Scottish Government, Scottish Futures Trust (SFT) and Health Facilities Scotland (HFS).
Section 7: Healthcare Associated Infection

Context

The prevention and control of Healthcare Associated Infection (HAI) is a fundamental part of providing safe, effective and patient centred care to all patients on a daily basis across NHS Grampian. This includes supporting healthcare providers locally to maintain a clean and safe environment, and deliver care which is person centred, recognising the impact HAIs can have on patients, families and carers. Measures to prevent and control antimicrobial resistance are also a key priority.

To meet the expected performance within the HAI standards, and to prevent HAI, NHS Grampian undertakes an extensive surveillance programme, implements a yearly HAI Work Programme (which incorporates Antimicrobial Resistance) and a yearly HAI Education Programme.

Standards

To prevent HAI, NHS Grampian works to agreed local and national delivery standards as described below:

- Healthcare Associated Infection Standards (HIS 2015)
- AMR/HAI 5 year Strategic Framework (SARHAI 2016-2021)
- National Hospital Antimicrobial Prescribing Quality Indicators for 2017-18
- Local Delivery Plan Standards for 2016/17
  - *Clostridioides* (formerly *Clostridium*) *difficile* infections (CDI) in patients aged 15 and over is 32 cases or less per 100,000 total occupied bed days (TOBD)
  - *Staphylococcus aureus* bacteraemia (SAB) cases are 0.24 or less per 1,000 acute occupied bed days (AOBD)
- National Key Performance Indicators for MRSA screening
- National Key Performance Indicators for CPE screening
- National Health Facilities Scotland (HFS) Environmental Cleaning Target
- National Health Facilities Scotland (HFS) Estates Monitoring Target
- National Hand Hygiene Compliance Target

To support this work, NHS Grampian’s annual HAI Work Programme reflects the delivery areas from the HAI Standards and the Vale of Leven report. The HAI work programme is a programme of works currently ongoing and is ratified by the Infection Prevention & Control Committee and HAI Executive Committee at year end. Work areas are added to the programme as required. Additionally the HAI work programme is complemented by the HAI Education Programme which focuses on the education component of HAI related work across the organisation.
<table>
<thead>
<tr>
<th>Issue</th>
<th>Group</th>
<th>Target</th>
<th>Period &amp; source</th>
<th>NHS Scot</th>
<th>NHS Gramp</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDIs</td>
<td>Healthcare Associated Infection</td>
<td>Local Delivery Plan Standards</td>
<td>Jul – Sep 2018, HPS</td>
<td>14.8</td>
<td>19.4</td>
<td>Amber</td>
</tr>
<tr>
<td></td>
<td>Community Associated Infection</td>
<td>32 cases per 100,000 TOBD</td>
<td></td>
<td>9.1</td>
<td>12.9</td>
<td>Amber</td>
</tr>
<tr>
<td><em>E coli</em> Bacteraemia</td>
<td>Healthcare Associated Infection</td>
<td>No target (rate per 100,000 bed days)</td>
<td>Jul – Sep 2018, HPS</td>
<td>40.2</td>
<td>28.3</td>
<td>Green</td>
</tr>
<tr>
<td></td>
<td>Community Associated Infection</td>
<td>No target (annualised rate per 100,000 population)</td>
<td></td>
<td>48.8</td>
<td>38.6</td>
<td>Green</td>
</tr>
<tr>
<td>SABs</td>
<td>Healthcare &amp; Community Associated Infection</td>
<td>Local Delivery Plan Standards</td>
<td>Jul – Sep 2018, HPS</td>
<td>0.33</td>
<td>0.37</td>
<td>Amber</td>
</tr>
<tr>
<td>Surgical Site Infections (SSIs)</td>
<td>Caesarean Section</td>
<td>n/a</td>
<td>Jul – Sep 2018, HPS</td>
<td>1.5</td>
<td>0.6</td>
<td>Green</td>
</tr>
<tr>
<td></td>
<td>Hip Arthroplasty</td>
<td>n/a</td>
<td>Jul – Sep 2018, HPS</td>
<td>0.6</td>
<td>0.4</td>
<td>Green</td>
</tr>
<tr>
<td>MRSA (CRA) screening</td>
<td>HPS</td>
<td>90%</td>
<td>Jul – Sep 2018, HPS</td>
<td>84</td>
<td>84</td>
<td>Amber</td>
</tr>
<tr>
<td>Issue</td>
<td>Group</td>
<td>Target</td>
<td>Period &amp; source</td>
<td>NHS Scot</td>
<td>NHS Gramp</td>
<td>RAG</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------------------------</td>
<td>--------</td>
<td>-----------------</td>
<td>----------</td>
<td>-----------</td>
<td>-----</td>
</tr>
<tr>
<td>CPE (CRA) screening</td>
<td>HPS</td>
<td>90%</td>
<td>Jul – Sep 2018, HPS</td>
<td>79</td>
<td>93</td>
<td>Green</td>
</tr>
<tr>
<td>Cleaning</td>
<td>HFS</td>
<td>90%</td>
<td>Oct – Dec 2018, NHSG</td>
<td>N/A</td>
<td>94</td>
<td>Green</td>
</tr>
<tr>
<td>Estates</td>
<td>All clinical areas</td>
<td>HFS</td>
<td>Oct – Dec 2018, NHSG</td>
<td>N/A</td>
<td>95</td>
<td>Green</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>SGHD</td>
<td>90%</td>
<td>Oct – Dec 2018, NHSG</td>
<td>N/A</td>
<td>98</td>
<td>Green</td>
</tr>
</tbody>
</table>

**RAG Status Ready Reckoner**

- Above upper control limit  
  - **Red**
- Below upper control limit but above National average  
  - **Amber**
- Below National average  
  - **Green**
- Below lower control limit  
  - **Green**

**Governance**

Governance structures exist to ensure escalation of issues or concerns are timely and efficient. These include Infection Prevention and Control Team governance structures as described in HDL 2005 (8) as well as reporting structures aligning communication from the ward level to Board. The Infection Control Manager (ICM) has direct accountability to the HAI Executive and can contact the Chief Executive as required.

The HAIRT (HAI Reporting Template) is submitted every two months detailing NHS Grampian’s performance against relevant standards and the rest of NHS Scotland. The HAIRT is escalated via the IPC committee, HAI Executive Committee and Clinical Governance Committee before being submitted to the Board for ratification. At each stage of this process, the relevant committee has an opportunity to ask questions, make suggestions or raise concerns.
Ongoing surveillance allows the monitoring of infection rates in real time. This enables increased incidence to be actioned and managed. Problem Assessment Groups (PAGs) are convened at short notice to manage outbreak situations or other HAI related incidents within the organisation. PAGs and Incident Management Team (IMTs) meetings are well attended, facilitating support for the outbreak area as well as developing an action plan to help manage and control the situation. Health Protection Scotland is available to support NHS Grampian, upon request, with ongoing outbreak or incidents.

**Actions**

Current performance against standards continues to be monitored.

- Surveillance meetings are held weekly and are attended by the IPC team including doctors. Antimicrobial pharmacists provide input. Each case of *Clostridioides* (formerly *Clostridium*) *Difficile* and *Staphylococcus aureus* bacteraemias (SABs) is reviewed in all aspects of the case. All information is shared with responsible clinical teams for shared learning. Extensive work has been undertaken to address the increased incidence of CDI rates seen within NHS Grampian during April to June 2018. Trends continue to be monitored.

- Standard Infection Prevention and Control Education Pathway (SIPCEP) introduced in June 2018 which addresses the Vale of Leven Recommendation 42 that all those working in a healthcare setting have mandatory IPC training which includes CDI.

- National mandatory surveillance continues to be reported to Health Protection Scotland for E coli bacteraemia, surgical site infection (SSIs) Caesarean Section, Hip Arthroplasty, elective large bowel and elective vascular procedures.

- IPC nurses support HAI audits at ward level on a routine basis. Audits include hand hygiene, invasive devices, facilities management tool and SICPs management of care equipment.

- Hand hygiene compliance is reported and monitored.

- Divisional management walkabouts continue with HAI issues considered.

- The IPC team works collaboratively with Estates and Facilities colleagues such as Decontamination Lead, Head of Domestic services, Projects, Maintenance and Technical Service, with joint attendance at many Committees. The joint working relationship facilitates innovative solutions to varying issues which is required for the multi-faceted challenges presented to the teams. This makes for a good working relationship.

- The IPC team has a strong work relationship with the IPC doctors, again working to resolve ongoing threats, issues and concerns.

- The Antimicrobial Team (AMT) Reports to both the HAI Executive and the Grampian Medicines management group. The AMT provides guidelines and support in all aspects of antimicrobial prescribing and antibiotic stewardship to all primary and secondary care providers in NHS Grampian. It meets monthly with representation from Microbiology, Infection Prevention and Control,
Infectious Diseases, Acute Medical and Surgical Specialties. There is a programme of work in place to ensure timely review of antimicrobial guidelines and contingency planning and risk assessment for any guidelines which are overdue review. The AMT ensures all guidelines are available to all staff in including supporting documents from national organisations such as HPS and SAPG relating to the management of infection on the NHS Grampian intranet and Antimicrobial Companion App.

- The AMT actively participates at the request of the Infection Prevention and Control team in the investigation or management of any raised incidences of HAI.

- Audit of prescribing of antibiotics against the national prescribing indicators are undertaken and results feedback to clinical teams by members of the AMT. Antibiotic consumption is monitored by the AMT using HMUD data to identify trends in increases in overall prescribing and that of alert or high risk for C.diff antimicrobials. Action is taken to address any increasing trends in antibiotic consumption where possible.

- The AMT participates in a programme of educational events for NHS Grampian staff at all levels and the public including supporting EAAD (European Antibiotic Awareness Day) and WAAW (World Antibiotic Awareness Week).
Health and Social Care Integration
November 2019
Section 1: Introduction

1.1 The purpose of this briefing is to provide an overview of the arrangements across Grampian in relation to health and social care integration and the approach that we are taking to the co-ordination of strategic planning and service delivery to meet the requirements of the population. There are three health and social care partnerships within Grampian aligned to the three local authority areas – Moray, Aberdeenshire and Aberdeen City. The area and population for each is noted below for information:

<table>
<thead>
<tr>
<th></th>
<th>Aberdeen City</th>
<th>Aberdeenshire</th>
<th>Moray</th>
</tr>
</thead>
<tbody>
<tr>
<td>Area (sq km)</td>
<td>65</td>
<td>6,313</td>
<td>2,239</td>
</tr>
<tr>
<td>Population</td>
<td>222,800</td>
<td>261,800</td>
<td>96,150</td>
</tr>
</tbody>
</table>

1.2 The briefing has been developed to cover the following key areas:

- **Partnership Working**
  - Setting out the arrangements established within Grampian to support cross-system working
  - See Section 2

- **Strategic Planning**
  - The direction and focus for the health and social care partnerships for the next three to five years
  - See Section 3

- **Strategic Commissioning**
  - The approach taken within Grampian to undertake joint strategic commissions across the delegated services to inform future redesign and resource requirements
  - See Section 4

- **Improvement**
  - Examples of the improvements that have been realised since the inception of the health and social care partnerships
  - See Section 5
Section 2: Partnership working

2.1 Within Grampian, there have been well established partnership working which pre-dates the formal establishment of the health and social care partnerships. The significant changes over the last 20 years in establishing community based case and the transfer of resources following closure of long stay facilities has brought many benefits to the population and improved care provision closer to home or at home as a result. In the transition period leading up to the establishment of the health and social care partnerships, there was agreement amongst the statutory partners that we would wish to build on our approach to partnership working, maximising all that could be developed and planned locally whilst also retaining the benefits of planning across the Grampian area, where appropriate.

2.2 To enable the continuity of cross-Grampian system working we have established a number of key groups where statutory partners and the health and social care partnerships are able to come together. The key groups that we would highlight are:

- **North East Partnership Forum** – the forum was established to bring the members of the three Integrated Joint Boards (IJBs) together to (1) develop understanding of the delegated services across the three areas; (2) focus on areas where services were provided by one health and social care partnership on behalf of the others (hosted services for example, GMED out of hours service and health and social care services within HMP Grampian) and (3) share best practice. The forum has met regularly and has been well attended by the members of the IJBs. Whilst the forum does not have any decision making authority in relation to delegated services, it has been helpful in building effective relationships with the three IJBs, promoting the benefits of a cross system leadership and enabling a joint approach to the planning of a number of shared services.

- **North East System Wide Transformation Group** – the Group comprises the three local authority Chief Executives, NHS Grampian Chief Executive and the three health and social care partnership Chief Officers. The Group has been established to implement system-wide leadership focusing on a collaborative approach to planning of the acute hospital services and delegated services for the benefit of the North East. The immediate focus of the group is overseeing the following strategic commissions - Palliative Care, Care of the Elderly, Respiratory Medicine, General Medicine, Emergency Department and Out of Hours provision and Rehabilitation Medicine. Details of these commissions and the approach is set out in Section 4.

2.3 In addition to the above there is also a separate Chief Officers Groups focused on community partnership and planning and public protection which includes the local authority Chief Executives, NHS Grampian Chief Executives and the local senior officers from Police Scotland and Scottish Fire and Rescue Service.

2.4 We welcomed the opportunity during the current year, to undertake the self-evaluation of the health and social care partnerships within Grampian against the key areas identified for consideration by the Ministerial Steering Group. The feedback and responses from this evaluation will further inform the development of the health and social care partnerships and the wider partnership arrangements developed in Grampian and noted above. The Board received a paper (October 2019) with key recommendations to build on the strong base to further enable and support integrated services.
Section 3: Strategic Planning

3.1 The three health and social care partnerships have been progressing the development of their next strategic plans. A summary of the key areas of focus for these plans and their stage of development is noted below:

Aberdeen City

The Aberdeen City Health & Social Care Partnership (ACHSCP) published a strategic plan for the years 2019-2022, after it was approved by the IJB on the 26th of March 2019.
Aberdeenshire

Status
The IJB consulted on its Strategic Plan 2020-2025 during August to October 2019 and is due to present the final plan for approval in December 2019. The draft plan was developed after extensive engagement, over a six month period, with many people, communities and organisations within Aberdeenshire.

Priorities
The strategic priorities and key areas of focus for the plan are as follows:

- **Prevention and early intervention** - through redesign of primary care the IJB will ensure that people get the right advice and support to maintain their independence and avoiding, where possible, people waiting until a point of crisis in their life before seeking support. The 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. For example - individuals will be empowered to selfcare/ self-manage, reducing avoidable hospital admissions through supporting people to improve lifestyle and address health inequalities, more people with dementia are enabled to live well and safely at home or in a homely setting for as long as they and their family wish and enabling people with an identified particular need to have access to appropriate affordable housing.

- **Reshaping care** – the partnership has made great progress to date and over the life of this next strategic plan it will continue to explore how they 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 example - increased use of digital technology to enable people to access specialist support and advice without the need to travel, increased use of the Virtual Community Ward to further reduce the number of avoidable admissions to hospital and to tailor packages of care, all new referrals to care management to be directed first through the rehabilitation and enablement pathway.

- **Engagement** - the Partnership will strengthen its relationships with the public, 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. For example - the strategy will support and embed a culture of ongoing engagement which ensures service planning, decision-making and delivery are informed and shaped by involvement of the people who access our services, our staff, local communities and partners and a strong and sustainable relationship between Third Sector and Partnership staff.
Priorities (continued)

- **Effective use of resources** - will ensure that the Partnership use the resources 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. For example - Using the funding from Scottish Government the Partnership will improve availability of preventative, ongoing and crisis support for people with mental health conditions, we are reviewing our accommodation with support for people with learning disabilities and other additional needs, all carers are offered an Adult Carer Support Plan or a Young Carers Statement. These assessments identify the impact of someone’s caring role and the IDEA project which is looking at providing day services in a different way for people with learning disabilities and other additional support needs.

- **Tackling inequalities** - ensuring the people of Aberdeenshire are protected and have equitable access to health and social care services and housing support. For example - 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, by reducing stigma and breaking barriers to accessing services we can improve the health and wellbeing of people in the criminal justice system, in line with the Local Housing Strategy and the Rapid Rehousing Transition Plans Aberdeenshire is part of a consortium which will build 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.
Moray

Status
The IJB consulted on its Strategic Plan 2019-2029 during August to October 2019 and is due to present the final plan for approval in (date). The Strategic Plan for 2019-2029 is the overarching umbrella plan under which many existing programmes of work, client group strategies and delivery plans sit. These include strategies to improve services and responses for unpaid carers; older people; physical and sensory disabilities; mental health; learning disability; the Moray Alcohol and Drug Partnership.

Strategic Themes
The strategic themes and key areas of focus for the plan are as follows:

- **Taking greater responsibility for our health and wellbeing** – encouraging people to take charge of their own health and wellbeing and that of their families and communities. We want people to be able to draw on their own personal resources and those of their community not only when they experience health and care challenges but to prevent problems happening. For example supporting people, including members of the workforce, to take their physical and mental health seriously throughout their lives, building skills and confidence to long-term health conditions and build resilience through making most of community assets and promoting prevention, early intervention and harm reduction programmes, including around mental health and loneliness.

- **Being supported at home or in a homely setting** - developing services in partnership with the Third Sector and Independent Care Sector, to deliver better and more joined-up care. For example - enhancing locality-based care delivered by health and social care professionals from different disciplines working together as multi-disciplinary teams (MDT) to provide more co-ordinated care to help patients prevent avoidable hospital admissions, continuing to work with people to provide them with the services and support they need, in the most appropriate setting and by the most appropriately skilled staff group, to regain and maintain their health, wellbeing and independent living skills and continuing to develop rapid responses for people at home who have an urgent care and support need. This will include access to equipment and care at home to prevent avoidable hospital admission where possible and to help people return home from hospital quickly.
Strategic Themes (continued)

- **Taking control and making choices over decisions affecting our care and support** - we are committed to working with people not as passive recipients but as partners in their own care, support and treatment. For example - involving people and their families in all processes from assessing their own health and wellbeing needs through to the planning and commissioning of the support to meet their needs, build on the implementation of self-directed support (SDS) to support people to identify and achieve their personal outcomes and uphold the rights of carers to be involved in the care and support planning of the person they care for or intend to care for, continue to encourage health and care workers to find out what matters to the person so that the care of their condition fits their needs and situation, explore the opportunities presented by the House of Care programme to help people with long term conditions be more involved in their care and self-management and support people to exercise their preference in relation to palliative and end of life care in the setting of their choice.
Section 3: Strategic Commissioning

3.1 As noted earlier in Section 2, the statutory partners agreed to support the health and social care partnerships undertake strategic reviews of all the six delegated services, with an IJB Chief Officer appointed to lead each review. These reviews are timed to be undertaken over a 18-24 year period with the reviews of Mental Health, Care of the Elderly and Palliative Care underway. The reviews will also inform any changes in the allocation of resources and the associated redesign required to enable this to occur.

Mental Health – strategic commissioning review

3.2 The review of mental health is the furthest advanced of the reviews and for information we have summarised below the status of the work that has been undertaken:

3.3 In January 2019, the three Integration Joint Boards and the System Leadership Team of NHS Grampian, jointly made a commitment to carry out a strategic review to place the system-wide Mental Health and Learning Disability (MHLD) services on a more sustainable footing. The specific aims of the review were to:

- Articulate a sustainable, future-proofed delivery of person-centred Mental Health and Learning Disability (MHLD) care, incorporating local and regional delivery requirements.
- Develop a robust co-produced integrated sustainability plan for the provision of MHLD services which optimises outcomes and meets population needs

3.4 This review has been a front-runner project in road-testing a strategic planning process which has been developed by the Grampian Joint Chief Officers’ Group and NHS Grampian System Leadership Team. The agreed planning framework for this strategic review included a staff survey and four staff engagement workshops to ensure input from a broad range of stakeholders. Between 60 and 70 people attended the workshops which covered:

- Workshop One – current challenges and opportunities for transforming services
- Workshop Two – moving from business as usual to the envisioned future state
- Workshop Three – reviewing feedback from the consultation with people with lived experience of services, conducted by the Health and Social Care Alliance
- Workshop Four – consolidation event to consider the emerging views for the future shape of services.

3.5 The Health and Social Care Alliance (the Alliance) undertook a Grampian wide consultation process to engage local people, communities and third (voluntary) sector organisations in informing the Grampian strategic review of MHLD services. The Alliance held six afternoon and evening engagement events in five geographical areas across Grampian.
3.6 In total 124 people participated in the events and in excess of 650 responses, comments and statements were given. The outcome of this process was a comprehensive report from the Alliance: Hearing the Voices and Contribution of People. The feedback has been welcomed and is been actively used to inform the future strategy, as well as highlight opportunities to build on existing good practice and improve services for people across Grampian.

3.7 The outcome of the strategic commission process has been a Grampian-wide strategic framework for consultation. The consultation process commenced in June and concluded on 31 August 2019.

Following conclusion of this process, the Grampian-wide strategic framework will be presented to the North East Partnership Forum (the three Health and Social Care Partnerships) prior to the final plan being considered by the three Integration Joint Boards and NHS Grampian Board. The plan will then provide the framework to inform the future direction and planning of the Grampian wide mental health and learning disability services.
4.1 In addition to improving the integration of health and social care services, there is also evidence that the changes that are occurring are making a difference to the flow of patients. In terms of unscheduled care, we have undertaken a detailed analysis of the data over recent years and would highlight the following:

Emergency bed days

4.2 Emergency bed days, for over 75s have been on a downward trend since April 2015.
Overall bed days occupied

4.3 The reduction from a peak of 385,640 for the 12 months ending July 2018 to 359,390 in 12 months ending August 2019, represented a 7% reduction, equivalent to approximately 72 beds.
Attendance at Emergency departments

National publications from ISD shows an increase of 4.7% from autumn 2017 to current date in the number of unscheduled care attendances for A&E and Minor Injury Units for Scotland. The trend is mirrored in Grampian but with a smaller increase of 3.2%. Grampian rates of attendance are continuously and systematically lower than Scotland. Minor attendances remain stable, whilst the increase in major attendances is approximately eleven per day at ARI and five at Dr Gray's. In terms of other observations regarding ED attendances, our data would highlight the following:

- Attendances are increasing in complexity, with more classified as 'major'
- 11% of attendances are inappropriate and redirected.
- There is a downward trend in the number of attendances whose conditions are not true accidents or emergencies and we have had good support from the public around utilising alternative and more appropriate services.
- High intensity use is strongly associated with proximity to A&E and people from less affluent areas
ANNUAL REVIEW 2017/18

SELF ASSESSMENT REPORT

Produced November 2018
ANNUAL REVIEW
SELF ASSESSMENT CONTENTS

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Better Care

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Additional Reports

Appendix 1: Performance against Local Delivery Plan Standards

Appendix 2: Report from Grampian Area Partnership Forum

Appendix 3: Report from Area Clinical Forum

Appendix 4: Staff Achievements
Chapter 1: Introduction

This self assessment report is produced for the public of Grampian and will be placed on the NHS Grampian website in advance of the Annual Review on 21st January 2019 www.nhsgrampian.org. The Annual Review will consist of a number of Cabinet Secretary meetings with staff, patient representatives and a visit to the Inverurie Health and Social Care Hub. There will be no open public meeting on this occasion but it is planned to have one later in the year.

Scottish Government guidance requests a self assessment of 15 pages in length however, even limiting the information provided, this document is longer. It cannot however be taken as a comprehensive picture of the work of NHS Grampian in 2017/18 and readers are referred to the Board website where further corporate documents can be accessed.

Grampian Health Board is responsible for leading efforts to improve the health of the people in Grampian, and for providing the health care services that people need. We also provide some specialist clinical and support services to other NHS Boards within the North of Scotland.

14,500 directly employed staff and a range of independent primary care practices (74 General Medical, 132 Pharmacy, 90 Dental and 57 Opticians) provide the full range of primary, community and specialist health services to the half million people who live in Grampian.

Services are provided at over 100 locations and where possible in people’s own homes across an area covering 3,000 square miles of city, town and village and rural communities.

In 2016/17 we treated 97,000 individual inpatient cases, 46,000 day cases, 50,000 day patients, 436,000 patients attended our specialist out-patient clinics and our accident and emergency departments treated 152,000 people.

In 2017/18 we worked with neighbouring and Island Boards across the North of Scotland to produce a draft discussion document which sets out the challenges faced by health and social care partners across the north, with initial thoughts for closer partnership working across organisations to improve efficiency and quality and progress towards sustainability. Future plans will be developed in this context. Five key propositions for collaboration across the North have been identified:

- Changing demand and improving efficiency
- Developing effective alliances
- Transforming care through digital technology
- Developing world class health intelligence
- Making the north the best place to work
Chapter 2: Progress against 2016/17 Annual Review Action Points

NHS Grampian’s 2016/17 Annual Review took place on 6th October 2017. Following the meeting the Cabinet Secretary for Health, Wellbeing and Sport, Shona Robison, wrote to the Board Chairman setting out the outcome from the review and the actions she wished the Board to take forward.

Information on the current position with the matters discussed at the last Annual Review is detailed below and throughout the report.

<table>
<thead>
<tr>
<th>Agreed Action</th>
<th>Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Deliver key responsibilities in terms of clinical governance, risk management, quality of care and patient safety.</td>
<td>We have reviewed our approaches to clinical governance, risk management and quality and safety and are implementing a strengthened and integrated approach. The changes have been supported by the Board Clinical Governance and Audit Committees.</td>
</tr>
<tr>
<td>• Continue to review, update and maintain robust arrangements for preventing and controlling Healthcare Associated Infection, with particular emphasis on SABs</td>
<td>We continue to implement strategies for preventing healthcare associated infections. All cases are reviewed on an individual basis. There is regular reporting on performance to the NHS Board.</td>
</tr>
<tr>
<td>• Keep the Health and Social Care Directorates informed on progress towards achieving all access targets and standards, in particular for child and adolescent mental health services and psychological therapies.</td>
<td>Throughout the year we worked with Mental Health Access Improvement Support Team and Healthcare Improvement Scotland to deliver improvements within the resources available to us and to meet agreed trajectories.</td>
</tr>
<tr>
<td>• Achieve the same elective waiting times performance at 31 March 2018 as delivered on 31 March 2017.</td>
<td>This target was not delivered, however the Board worked closely with the Access Support Team of Scottish Government throughout the year to demonstrate best endeavours.</td>
</tr>
<tr>
<td>• Work with planning partners on health and social care integration and significantly reduce patients experiencing a delayed discharge</td>
<td>Partnerships continued to implement initiatives to minimise hospital admission and facilitate supported discharge. Bed days occupied by those delayed continued to fall.</td>
</tr>
<tr>
<td>• Continue to make progress against the staff sickness absence standard</td>
<td>The sickness absence rate for the year was 5.13%. Whilst this is above the national standard it continues to compare favourably to the Scottish average of 5.39%</td>
</tr>
<tr>
<td>• Continue to achieve financial in year and recurring financial balance, and keep the Health and Social Care Directorates informed of progress in implementing the local efficiency savings programme</td>
<td>NHS Grampian successfully achieved its three financial targets in 2017/18. Throughout the year there was regular and proactive dialogue with the Health and Social Care Directorates.</td>
</tr>
</tbody>
</table>
Better Health

Chapter 3 Health Improvement, Disease Prevention and Self Care

Our Achievements

- Working across multiple agencies and partners to deliver strategies
- We have one of the most effective smoking cessation services in Scotland
- Coronary heart disease and lung cancer have both reduced in Grampian
- Dental health continues to improve

Our Challenges

- Ongoing social and economic inequalities in our population
- Rising mortality rates in some population groups seen nationally
- The requirement to dedicate resources to front-line services, reducing scope for upstream work on the fundamental determinants of health
- The complexity of multi-agency partnership working and an accelerating pace of change
- We have higher than average social and health harm from alcohol and drug misuse
- Achieving healthy weight in children

It is recognised that there is a need to strengthen prevention efforts if we are to maintain increases seen in healthy life expectancy, stop the widening of health inequalities and reduce spend on preventable ill health which would help to fund new treatments and meet increasing demands on the health service. A Short Life Working Group consisting of Executive and Non-Executive Board Members reviewed the role of the NHS Board in tackling inequalities. Its recommendations were subsequently endorsed by the Board.

Health is improving for everyone. But while life expectancy rates are increasing overall, they are rising faster for the affluent than the most deprived so the gap is getting wider – for men in Grampian this is almost ten years.

Primary prevention activities can stop people becoming ill and reduce the need to use clinical services. Secondary prevention interventions help to identify disease at the earliest stage to begin prompt treatment and minimise future health problems. Individuals, families and communities play a significant role in managing their own health conditions. Both prevention and self management are key themes in the NHS Grampian Clinical Strategy.

NHS Grampian provides direct input to strategic needs assessment and strategic planning and commissioning undertaken by Grampian’s Health and Social Care Partnerships, Community Planning Partnerships, Alcohol and Drug Partnerships, Community Justice Partnerships, and Integrated children’s Services Partnerships. We use direct involvement to lead and influence preventive and protective actions.
and interventions to improve population health through the range of partnership delivery plans, which are responsive to local need and local priorities.

Performance is measured by a variety of metrics, previously contained in Local Delivery Plans and other key documents. Performance continues to be monitored and managed by the Board and its partners. Further detail is given in Appendix 1, with more detailed information on a wider range of measures included in the NHS Grampian Health Improvement Team Annual Outcomes Report and the Health and Social Care Partnerships’ Annual Reports included in Chapter 7.

Of particular note during 2017/18:

- We are in the process of transforming chronic disease management in primary care, helping people to look after their health while living with long-term health conditions, by investing in organisational development for an initial cohort of nine GP practices to implement House of Care
- We anticipated the national public health priorities, including work to increase access to healthy food, physical activity and support to maintain a healthy weight, and work to renew the Grampian tobacco control strategy, including helping prepare for the requirements of new legislation for smoke free hospital grounds
- We ensured continuing access to free smoking cessation advice and support through community pharmacies, and provided targeted smoking cessation support within Royal Cornhill Hospital and HMP Grampian
- We worked to improve uptake of the national healthy start programme, and widened the provision of free healthy start vitamins to all pregnant women
- We delivered a “Breastfeeding Welcome” programme, supported the Grampian breastfeeding peer support scheme, and supported the successful reaccreditation of all UNICEF Baby Friendly services across Grampian
- We delivered the national Healthy Working Lives programme, supporting over eighty organisations to maintain their healthy working lives award, provided occupational health and safety services to SME organisations, and provided targeted health information to our agricultural sector
- We developed and implemented a cross-cutting NHS Grampian staff health and wellbeing plan
- We are implementing the Fairer Scotland Duty and agreed improved NHS Grampian Board reporting and actions on health inequalities. We have committed to developing an inequalities strategy and performance dashboard.
## Chapter 4 Mental Health

### Our Achievements

- The Board approved additional capital and revenue investment in mental health services over the next 5 years, including commitment to a Child and Adolescent Service Centre of Excellence and improvements to inpatient accommodation at Royal Cornhill
- Review of bed capacity to support patient safety and safer staffing levels
- Patient flow was redesigned within Royal Cornhill Hospital with clinical and patient support which has improved opportunities for therapeutic engagement with patients and facilitate better discharge planning to the community.

### Our Challenges

- Registered nurse and medical staffing vacancies resulting in a high dependence on use of agency and bank nurse staff and high medical locum costs
- Continuing to improve access to Child and Adolescent Mental Health Services (CAMHS) and reducing the waiting list size.
- Strengthening efforts to improve mental health and wellbeing particularly with children and young people

At the end of March 2017, the Mental Health in Scotland – 10 year vision was published setting a commitment over the 10 years of the Strategy to achieve parity between mental and physical health. This is the first national strategy in health and social care since the establishment of Integration Joint Boards and provides new opportunities for local areas to develop their own approaches, to innovate and to work across service boundaries to meet the needs of the local population. This strategy aims to make clear the scale of the ambition over 10 years, to focus national actions to support local delivery, to remove barriers to change, and to make sure that change happens.

At its meeting in June 2017 NHS Grampian re-iterated its commitment to parity between mental and physical health and to supporting the Mental Health and Learning Disability service implement the necessary changes to address known challenges.

Within Grampian we have an excellent track record of integrated multi-agency working in relation to promoting mental health and wellbeing, and the delivery of mental health services across the pathway of care. We continue to build on the excellent cross-agency working to strive to deliver the best possible outcomes, however, we recognise there are a wide range of challenges to address in order to achieve our shared aspirations and meet those ambitions set out in the National Mental Health Strategy. We are committed to designing contemporary services which meet the future needs of the population and recognise that delivery of care may require to be fundamentally different to the current approach and that they will be enhanced by fully embracing and implementing integration locally. A draft Mental Health Services Action Plan has been produced by the Board.
This builds on the considerable improvement activity which has already taken place.

Of particular note during 2017/18:

a. A Delayed Transfer of Care Group was established in June 2017 focussing on patients in adult mental health wards whose discharge or transfer to another clinical area had been delayed. During this time the number of delayed transfers has reduced by 50% and made a significant impact on patient flow within the four adult mental health wards.

b. The implementation of enhanced arrangements for daily site and capacity assessment. As a result of these enhanced arrangements, there has been demonstrable improvement in patient flow across the RCH site.

c. A review of the patient observation policy and practice on the Adult Mental Health wards was undertaken in line with national guidelines developed by Health Improvement Scotland. Our aim has been to move towards therapeutic engagement with patients who require enhanced support rather than simply "observe" patients who present with heightened risk profiles.

As a result of this improvement activity the following outcomes were delivered:

- 50% reduction in delayed transfers in Adult Mental Health (AMH) wards since June 2017
- Significant reduction in number of patient observations required in AMH wards
- Whilst admission rates have increased length of stay and occupancy levels have reduced and there is less boarding of patients
- Nurses reporting more time to offer therapeutic activities to patients

**Child and Adolescent Mental Health Services**

NHS Grampian provides a service for children and young people, from birth to 18 years and follows the national guidance as produced by the Scottish Government in September 2009. Availability of staffing is the key challenge facing the service. As a consequence we do not meet access time standards for this service.

During 2017/18 we have taken a number of steps to improve access to the CAHMS service:

- Increased capacity - nine new posts have been appointed to (Psychotherapist, Assistant Psychologist, Physiotherapist, Systemic Practitioner and Dietician) with all staff now in post. The Board has committed to invest a further £1m in increasing staffing and plans are underway to commit this funding in line with the service plan.

- We continue to work with the Mental Health Access Improvement Support Team (MHAIST). MHAIST fully recognises that lack of staffing resource is the major contributor to us not achieving the targets.

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1 Not all Boards provide access to the CAHMS service to the age of 18.
We have been praised by MHAIST for the use of the Choice and Partnership Approach (CAPA) as we are one of only 2 NHS Boards in Scotland currently implementing this approach. In the CAPA model, patients and families are seen at a Choice Appointment first at least once and for at least an hour. All urgent and emergency referrals are prioritised and seen within the agreed clinical timescales.

- We have continued to implement a redesigned model of care which makes best use of available staffing and the Board has agreed to enhance staffing levels.
- Funding has been agreed to co-locate all CAMHS staff in an upgraded building to create a centre for excellence.
- We continue to work with our three local authority partners to support development of tier 1 and tier 2 services.
Chapter 5 Maternity and Child Health

Our Achievements

- Progressing plans to restore a safe, sustainable and comprehensive maternity service at Dr Gray’s Hospital
- Significant progress with planning for the new Baird Family Hospital
- Establishment of Outcomes for Children Transformation Board

Our Challenges

- Availability of staffing to maintain a sustainable and safe paediatric and obstetric services at Dr Gray’s Hospital
- Responding to the full requirements of Best Start
- Ensuring uptake in child immunisation, particularly in Aberdeen City

NHS Grampian has established an Improving Outcomes for Children Transformation Board which oversees the strategic direction and development of maternity and child health services across NHS Grampian. It provides assurance to the NHS Board on all aspects of this wide agenda.

Maternity Services

In January 2017 the Scottish Government published its strategic plan for the reconfiguration of maternity and neonatal services across Scotland - 'The Best Start: A Five-Year Forward Plan for Maternity and Neonatal care in Scotland'.

The plan was the result of an extensive 18 month review of maternity and neonatal care services in Scotland, which included high levels of engagement with staff and service users. The plan set out 76 recommendations for the future delivery of the services. The Best Start plan signals a very significant change in the way in which maternity and neonatal services will be organised, and in which midwives, obstetricians and neonatal teams will provide care to women, families and neonates.

The NHS Grampian Board approved the key themes proposed for the refresh of the NHS Grampian Maternity Strategy 2016-2020 at its meeting on 7 April 2016. These themes supported the direction set out within the NHS Grampian Maternity Strategy 2010-2015 and had been aligned to take into consideration the likely recommendations of the Best Start national review. A short life working group and forum has been established to take this agenda forward.

NHS Grampian has invested in planning to deliver significant improvements to its maternity facilities. The improvements planned for the Baird Family Hospital, alongside the new Community Maternity Unit in Inverurie, the newly refurbished Peterhead Community Maternity Unit, and facilities in Dr Gray’s, Elgin leave the service well placed to deliver a range of services from community based hubs across Grampian which will greatly benefit women and families, and meet the Best Start recommendations.
Of particular note in 2017/18:

- Relatively high levels of breastfeeding with an increasing trend
- Achievement of early access to antenatal care and IVF Local Delivery Plan standards
- Baby Steps in Moray – a midwife led interactive programme supporting women to take small steps to improve their health during pregnancy

**Obstetric Services at Dr Gray’s Hospital Elgin**

NHS Grampian remains committed to the re-establishment of services at Dr Gray’s and is working hard to make this happen. A [short to medium term plan](#) was submitted to Scottish Government in November 2018 and has been made available widely to staff and the population of Moray. The plan outlines the first phase of efforts to increase choice for pregnant women and to maximise the local provision of treatment. The plan incorporates the recommendations made in the Chief Medical Officer’s expert advisory group report and addresses issues raised by the KeepMum campaign group.

**Children’s Health**

In October 2017, we produced our ‘The State of Child Health: a Grampian perspective’ report, which was well received by NHS Grampian’s ‘Improving Outcomes for Children Transformation Board’. This provides an overview of child health status within Grampian, is written to be accessible by readers requiring different levels of detail, and is based on the report of a similar name produced by the Royal College of Paediatrics and Child Health.

Of particular note in 2017/18:

- We had the lowest teenage pregnancy rate in Scotland
- Talk Boost was taken forward, a literacy, language and communication initiative for Primary 1 pupils which is already showing a narrowing of the literacy attainment gap
- Maintenance of Unicef Baby Friendly Accreditation Programme
- Continuous improvement in oral health with child dental registration above 90%
- Low Intensity Anxiety Management (LIAM) scheme in Aberdeenshire for low level anxiety in children and young people.
Immunisation

Uptake rates of vaccine amongst infants in Aberdeen City are well below the level of 95% (recommended by the World Health Organisation as being necessary to maintain a high level of immunity in the population and avoid outbreaks of vaccine preventable diseases). This low level of uptake creates a vulnerable group of children who could contract a serious, potentially fatal vaccine preventable infection. Uptake rates in Aberdeenshire and Moray, whilst less than ideal are acceptable. Across the system, greater efforts are required to actively and assertively follow up infants who fail to attend their scheduled appointments where there has been no active refusal of parental consent for vaccination.

School based vaccine programmes such as influenza show good uptake rates throughout Grampian in comparison to Scotland.

Our strong collaboration with local authority, Health and Social Care Partnerships and health have enabled conversations and agreement to address this risk collectively to maximise the opportunity for improved uptake.
Better Value

Chapter 6 Financial Performance and Efficiency

Our Achievements

- Continued delivery of our 3 financial targets
- Ongoing delivery of efficiency improvements
- Impressive capital programme of new builds and backlog maintenance

Our Challenges

- Delivery of access targets within resource availability
- Recruitment and retention of staff to meet population needs

In 2017/18 we met the three financial targets set for us:

- Operated successfully within revenue resource limit
- Operated successfully within capital resource limit
- Operated successfully within cash requirement

The efficiency savings target of £27.7 million for the year was achieved in full through the continued implementation of a range of initiatives including reduced energy costs from investment in more efficient infrastructure, property rationalisation, focused procurement activity to reduce the unit costs of consumables, introduction of biosimilar drugs as alternative treatment regimes and productivity improvements through investment in technology and redesign of services to enable reduced staffing levels in back office functions and redeployment of clinical staff to areas of greatest need. Recurring savings amounted to £18.25 million and non-recurring of £9.45 million.

As part of the Board's ambitious five year capital programme, infrastructure investment of £57.6m was made during 2017/18. Major investments included:

- the redesigned Community Maternity Unit at Peterhead opened in March 2018,
- the new Health Centre at Foresterhill opened in May 2018,
- the Inverurie Health and Care Hub opened in August 2018
- design work is well advanced for the new Baird Family Hospital and the ANCHOR Centre, with construction of enabling works starting on site in October 2018.
- The new multi storey car park at Aberdeen Royal infirmary, funded by a charitable donation from the Wood Foundation, opened in December 2017.
- Investment of £12.9m to reduce high and significant backlog maintenance
- Investment of £12.3m for replacement of essential IT and medical equipment
Chapter 7 Integration of Health and Social Care

**Our Achievements**

- Reduction in delayed discharges and bed days occupied by those awaiting discharge
- Good performance against national indicators when compared to elsewhere
- Good and effective joint working between agencies

**Our Challenges**

- Achieving financial balance with growing demand for health and social care
- Key workforce shortages and recruitment challenges
- Transforming care whilst maintaining service provision

Three Integration Joint Boards (Aberdeen City, Aberdeenshire and Moray) were established on 6 February 2016 under the terms of the Public Bodies (Joint Working) (Scotland) Act 2014 with full delegation of functions and resources to enable integration of primary and community health and social care services effective from 1 April 2016. Each IJB is a separate legal organisation and acts as principal in its own right.

Much has been achieved in each of the IJBs during 2017/18 with systems and processes put in place and strategic plans produced. There is a history of good, effective joint working in Grampian between agencies and the IJBs have consolidated and built on this foundation.

Each IJB was asked to produce an annual performance report for 2017/178. These are included below and provide greater detail than is included in this self assessment. Achievements include:

**Aberdeen City**

- Continued progress in tackling whole-systems challenges of emergency admissions and delayed discharge.
- Implementation of pilots and projects, including but not limited to: INCA (Integrated Neighbourhood Care Aberdeen); a West Unscheduled Care service; Primary Care Psychological Therapies service (across the city); Alcohol Hub Test of Change; Link Work Practitioners; the Golden Games Festival; Interim Housing pilot project; and Acute Care @ Home.

**Aberdeenshire**

- Continued evolution of locality organisational structure and integrated health and social care teams to deliver joined-up, person centred care to communities.
- Continued progress against both local indicators and national core integration indicators, with good performance compared nationally.
• Implementation of pilots and projects (including, but not limited to): the review of Minor Injury Units; the Virtual Community Ward Model; development of Local Carer Strategies; Participatory Budgeting; development of a Workforce Plan; Health Visiting Service; Wellbeing Festival; and Inclusive Day Services projects

Moray

• Delivery of successful community-based activity programmes, including but not limited to: Boogie in the Bar; Be Active Life Long (BALL) groups; Singing Exercise and Tea (SET) Groups; Men’s Sheds; Health & Wellbeing Vintage Tea Parties.
• Development of housing-based models of care across several different settings working with older people and younger adults with specific conditions.
• Notable progress in the outcomes of wellbeing such as reducing emergency bed days; increasing numbers of anticipatory care plans; and increasing number of clients receiving more than 10 hours of care.

Aberdeen City IJB Annual Performance Report 2016-17
Aberdeenshire IJB Annual Performance Report 2016-17
Moray IJB Annual Performance Report 2017-18
Better Care

Chapter 8 Unscheduled Care

Our Achievements

- Continued cross system focus on reducing delayed discharges and length of delay
- Year round process for winter planning
- Comprehensive approach to demand and capacity management
- Establishment of North of Scotland Trauma Network
- International recognition of ECMO service
- Cross sector leadership across health and Social Care Partnerships and NHS Board

Our Challenges

- Cross system workforce challenges in recruitment and retention
- Consistent maintenance of good performance against the 4 hour Accident and Emergency standard

NHS Grampian has stated that its ambition is to seek to provide clinical treatment or advice in the right setting, at the right time, delivered by the right clinician. This aim was reinforced within the NHS Grampian Clinical Strategy, approved by the NHS Board in October 2016.

Over the last few years we have demonstrated resilience in unscheduled care, including over the winter period, when services can be under greater pressure. Much of the resilience is due to the efforts and hard work of committed and conscientious staff in our hospitals and communities as well as comprehensive cross-system planning and delivery. There has been considerable development of community based activity to minimise unplanned admissions to hospital and to facilitate supported discharge when admission does take place.

Since the early stages of integration of health and social care, working relationships have developed positively; we now have genuinely integrated working practices with multi-skilled staff working closely in teams focused around people’s needs. In hospitals we have seen the development of safety brief models that are held up as exemplars to other Boards, we model integrated working for planning and implementing discharge pathways that cross sectors, we have developed roles in partnership with other agencies to streamline processes and colleagues continue to develop more new ideas. This cross system working is emphasised in the daily cross system huddle allowing the resolution of ‘day to day’ challenges between the various sectors. We have been particularly successful at reducing the number of bed days spent in hospital by those awaiting discharge.
The 4 hour A&E standard is one measure used to assess unscheduled care performance and, in common with elsewhere, NHS Grampian has faced challenges in delivering this in full in recent times. Performance in Grampian is however consistently above the Scottish average.

**North of Scotland Trauma Network**

The North of Scotland trauma Network went live on 1\textsuperscript{st} October 2018 after extensive planning with partners over the last few years. Each region of the trauma network will be capable of providing a tiered response that ensures the timely provision of sufficient pre hospital care to maximise survival, prevent disability and distress. The network will:

- Through a new major trauma triage tool, assist paramedics and technicians in getting trauma patients to the most appropriate level of care
- Facilitate transfer arrangements from rural settings
- Provide 24 hour consultant led multi disciplinary care
- Ensure a rehabilitation plan for every patient
- Support a quality improvement approach

**ECMO**

ARI has been delivering this specialist service since 2001 and is one of six centres as part of a UK network that provide Extracorporeal Membrane Oxygenation (ECMO) services to adult patients who have severe respiratory failure. ECMO treats severely ill patients whose lungs and heart cannot manage unsupported. Special equipment is used to pump blood out of the body to remove carbon dioxide and restore oxygen levels. ECMO is used to treat conditions including swine flu (H1N1), severe pneumonia and heart failure and in the treatment of avalanche victims. As part of the UK network, Aberdeen provides care to patients from across Scotland when extra capacity is required in the Network. The team have over the years been recognised a number of times for their dedication and excellent care to patients and their families. In 2016 an external Peer Review reported the team met or exceeded every standard of care and acknowledged their dedication and commitment to patients. Their exceptional practice has been shared across the UK network.

**Planning for Winter**

For 2017/18 NHS Grampian produced a consolidated plan across acute services and the health and social care partnerships. The overall aim of the plan was to ensure that Grampian was as prepared as possible for the winter period.

The winter plan was developed in the context of the national 6 essential actions framework as well as sound principles of planning for resilience and preparedness. Following final approval by Scottish Government, the Grampian Winter (Surge) Plan is now published on the web and its effectiveness will be monitored on an ongoing basis through review of weekly data on key performance metrics. Leadership throughout the winter will be provided by the Medical and Nursing Directors and festive debriefs are scheduled for early January.
Chapter 9 Elective Care

Our Achievements

- 18 month programme of intensive engagement with 21 stakeholder pathway groups
- Enhanced and documented understanding of key elective specialties
- Approved Initial Agreement for capital investment in elective care capacity
- Agreed cross system process for developing strategic sustainability plans
- Prioritisation of waiting lists based on clinical need of patients, including clinical escalation process

Our Challenges

- Performance against Cancer standards
- Performance against TTG
- Workforce challenges in recruitment and retention, notably among theatre nurses

Treatment Time Guarantee (TTG) and Outpatient Standard

Throughout 2017/18 NHS Grampian reported breaches of the 12 week treatment time guarantee. However, we worked closely with the Scottish Government Access Support Team to maximise delivery of improved access times within the resource available and in accordance with agreed performance trajectories.

During the year, elective care capacity has been impacted by a number of factors, including critical care capacity and theatre nurse availability. Key to future improvement is ensuring capacity, both in terms of staff and facilities are maximised.

Elective Care Programme

The Elective Care Programme in Grampian was originally stimulated by the Scottish Government’s elective care centres programme. Key elements of the Grampian programme which were progressed during the year included:

- Intensive engagement process with 21 services involving a broad range of acute and primary care staff – this commenced in March 2017 and was completed in September 2018.
- Cross system workstreams to identify not only the service specific redesign initiatives but also the common themes that need to be progressed across patient pathways.

The output of this process has informed a comprehensive redesign programme and a specification for the use for the capital funding available for elective care centre development.
Planning of elective care will also include regional working with partner Boards. A Regional Programme Board has been established, overseeing the joint working between the northern Boards and the preparation of regional strategic assessment to explore population and demographic changes, drawing conclusions about future demand for certain high volume specialties.

**Clinical prioritisation**

In order to mitigate the clinical risk associated with the recurring demand and capacity gap, a clinical elective surgery categorisation system has been developed and deployed to ensure that those patients who require surgical intervention within a clinically defined time period receive it. In essence this process introduces prioritisation across three categories, with priorities assessed by clinicians on the basis of clinical need.

In addition, a process of clinical escalation has been developed and implemented. This process allows clinicians to escalate specific patients where compliance with the revised classification is challenging. This then allows resolution at three levels (a) within the speciality, (b) across surgical specialities, and (c) at sector / external capacity level. To date, all escalations have been resolved at individual speciality level.

From a research perspective we will robustly evaluate the impacts across the healthcare system and patient experience. This is being taken forwards with Public Health colleagues in terms of scope and commission.

**Optimisation of use of resources**

Redesign and optimisation initiatives are a key feature of the overall strategy that will result from (a) the Elective Care Programme, and (b) the various improvement strands progressing within the Acute Sector. Examples include:

- Institute for Healthcare Optimisation (IHO) Option 1 – The ‘right-sizing’ of emergency theatres based on demand, reducing variation through standardised emergency surgical urgency classification and booking processes.

- Establishment of a Day of Surgery Admissions (DOSA) unit – This project has established a DOSA unit adjacent to the main theatre suite in ARI in order to improve experience, and optimise available time and resource for patients prior to surgery. This will reduce cancellations, delays and reliance on ward based staff capacity to prepare patients.

- Theatre booking – Significant progress has been made in implementing more robust theatre booking processes, marrying leave planning and substantive staff availability to ensure published theatre lists are planned at least 6 weeks ahead. Booking of cases is monitored at key points thereafter, with automated reports generated to support the process.
• Managing demand - For some specialties, conversion rates post new outpatient appointment is as low as 50% of patients requiring any further input from that specialty. A range of actions require to be taken to drive up the appropriateness of referrals including making primary into secondary care referral pathways clear through the revised Clinical Guidance Intranet (CGI), and with systems in place that facilitate prompt and easy decision support.

Recruitment and retention

As with all NHS Boards in Scotland, and indeed as seen across the UK as a whole, there is a significant and increasing gap in the supply of trained professional health care staff. This has a clear impact on our ability to deliver operational and strategic success.

There is continuing exploration of the development of new workforce models, including growth of existing and new roles, such as Advanced Nurse Practitioners, Clinical Development Fellows, Physicians’ Associates and Assistant Perioperative Practitioners. New roles create the advantage of utilising a broader spectrum of the population to recruit from. This is particularly important in NHS Grampian to address the historical challenges relating to workforce supply. For these roles to be attractive, whole life career pathways (incorporating accredited education) will require to be further developed and offer real opportunities which will place NHS Grampian at the centre of ground breaking initiatives for the rest of NHS Scotland. Development of these new roles will go some way to reducing the impacts of continuing vacancies, but these roles take considerable time to train, and have inherent vulnerability in themselves.

A ‘Supply, Recruitment and Retention’ task and finish group to identify key opportunities and strategies has been established to build on the existing work in relation to creating a resilient and sustainable workforce.

Collaborative working with the local Higher Educational Institute’s, North of Scotland Boards, Scottish Government Directorates and NES is continually being strengthened to address the workforce supply challenges in the North

The strategic approach being taken to address workforce supply, recruitment and retention in NHS Grampian recognises the importance of organisational context and culture to deliver an empowered and engaged workforce who are skilled, competent and enabled to deliver high quality care is fundamental to the sustainability of services
Cancer Access Times

We are committed to improvement and are working closely with the Scottish Government Cancer Access Team focusing on implementing redesigned pathways for those tumour types where we continue to have challenges.

In terms of improvement activity there are ongoing tumour group specific action plans including colorectal, urology, lung, breast and oncology, which are regularly monitored and challenged to help improve any bottlenecks identified with the patient pathways. Improvements that have been achieved to date include:

- GP direct access to CT for patients with suspected cancer,
- Reduction in wait to outpatient appointment,
- Use of standard MDT proformas, which are automatically generated to the GP system within Grampian.

A full pathway review project has been initiated. This will ensure that all pathways reflect current clinical practice, and that appropriate timescales are set for each step in the pathway with monitoring steps embedded to identify any divergence from the plan.

With regard to our governance arrangements we would highlight the following:

- Twice weekly meetings to discuss all individual patients on a cancer pathway, allowing appropriate escalations to be taken forward by the relevant service, and any indications of performance issues which may impact any of the tumour specific pathways.
- Service specific performance improvement plans in place, addressing particular bottleneck areas identified within the given pathway, with a meeting in place on a regular basis to monitor these and work collaboratively with services, MCN and primary care colleagues to address any performance / process issues.
- Breach patients are circulated to services on a weekly basis, with discussion at divisional level, helping promote shared learning across services.
- Regular meetings with the Scottish Government to discuss all aspects of cancer waiting time performance, and thus any potential support they may be in a position to offer in this regard.
- Whilst the standards are not yet being met on a sustainable basis, overall the length of pathways have reduced and NHS Grampian performs well in terms of cancer outcomes.
Chapter 10 Quality and Person Centred Care, including Staff Experience

Our Achievements

- We have agreed 4 Quality ambitions and are developing a range of metrics to provide intelligence to the Board and others on our progress and performance
- Development of a professional practice model for nursing, midwives and Allied Health Professions
- Responding and Learning from feedback

Our Challenges

- Progressing the improvement in health and safety
- Implementing quality reporting to the Board
- Differentiating NHS Grampian as an employer of choice

Quality and Safety

NHS Grampian is committed to ensuring that quality and quality improvement is at the centre of everything that we do. The NHS Board has overall responsibility for assurance of the quality of care. During 2017/18 we have worked with the NHS Board, clinical staff and senior teams across the system to develop new quality assurance processes. This has included defining our ambitions for quality and the management of risk. The quality ambitions agreed by the NHS Board in August 2017 are:

- No preventable deaths
- Continuously seek out and reduce harm
- Achieve the highest level of reliability for clinical care
- Deliver what matters most

A progress report was provided to the NHS Board in October 2018 and is embedded below.

Quality Indicators (2).docx

Professional Practice

We have developed a Professional Practice model for nursing, midwifery and allied health professionals. This depicts values and defines the structures and processes that support staff to control their own practice and to deliver quality care.
This will enable us to

- Measure and articulate the professional contribution of nurses, midwives and allied health professionals.
- Demonstrate the contribution nurses and midwives make to the Quality Strategy ambitions of person-centred, safe and effective care.
- Embed staff and care experience/engagement at its core.
- Recognise the culture and conditions required to enable good-quality care

Of particular note in 2017/18:

- We are the first Health Board in Scotland to have implemented a person centred Welcome Wards approach across Grampian. This change means friends, relatives and carers are able to visit hospital at times matching the needs and wishes of each patient.
- We are the first Health Board in Scotland to develop and implement a new one page hospital nursing admission document. The new documentation looks at the whole person, not just the condition or illness that has brought them into hospital. This then allow nurses to spend time with patients building better relationships.
- We have seen a 41% reduction in our Cardiac Arrest rate in General Wards in Acute Adult Hospitals. This is supported by the implementation of the National Early Warning Score 2.

Health and Safety

NHS Grampian is committed to effective and efficient health and safety for patients, staff and those who visit our premises. We work together with the Health and Safety Executive and other bodies to ensure compliance and to make improvements where these are required. The overall agenda is overseen by a Health and Safety Committee that reports to the Senior Leadership Team and Staff Governance Committee.

Of particular note in 2017/18:

- Demonstration of a robust system for health surveillance and screening related to Hepatitis B vaccine provision.
- Work progressing to respond to manual handling improvement notice in acute wards at ARI.
- Significant reduction in ligature points at Huntly Ward as the first stage in a three year programme across all inpatient areas in Royal Cornhill Hospital.

Encouraging Feedback and Handling Complaints

NHS Grampian encourages and values all forms of feedback and is committed to ensuring that the information and learning gathered from all our feedback systems informs the aspiration of continuous improvement and the continued development of a person-centred approach to service delivery.
NHS Grampian’s 2017/18 Handling and Learning from Feedback Annual Report demonstrates how feedback and complaints are encouraged, responded to and learned from.

Staff Experience

NHS Grampian recognises that staff are its most valuable asset. Our Clinical Strategy recognises that good staff wellbeing, both physical and mental, is crucial to delivering organisational goals. We are now in the fourth year of utilising the iMatter staff engagement tool, rolling out the process to all staff.

Absence levels are one of a number of indicators which can be used to understand staff wellbeing, however it should not be considered in isolation, as absence figures only represent a percentage of staff who are not able to attend their workplace. Over the last year NHS Grampian has consistently reported sickness absence rates below the Scottish average.

We have concentrated, over recent years, on developing an approach to Staff Governance that is built from the bottom up, through engagement with operational sectors, but also reflects the overall Board priorities. This continued through 2017/18, with the fourth annual workshop, held in May 2017, post the publication of the national Staff Experience Report in February 2018. This work has continued over the course of 2018 through engagement with Local Partnership Forums to support staff governance action planning and monitoring as fundamental to the structure and reporting of these forums.

Since fully implementing iMatter in 2017 the focus of the NHS Grampian Staff Experience Steering Group has been working to improve our strategic response to improvement of staff health and wellbeing. Examples of work undertaken include the development of a single brand for staff health and wellbeing alongside a website where all information relevant to staff health and wellbeing, including aspects of their employment. This will support information on wellbeing being accessible to staff, including those who are working away from NHS Grampian sites, allowing staff to be signposted to support, services and policies available to them. To support accessible data for services, exit questionnaires are now electronic and sit alongside face to face exit interviews.

Some specific examples of initiatives include

- Smoke free NHS sites
- Cycle to work scheme
- Healthy Working Lives activities
- Health and Safety audits
- Flexible working
- Mindfulness training
- Lone working policies and practices
- Occupational Health Services support
- Bullying and Harassment policy
- People Management policies
- Attendance management policy
- 6 step workforce planning tool
### Appendix 1

**Summary of performance against Local Delivery Plan Standards**

<table>
<thead>
<tr>
<th>LDP Standard</th>
<th>Current Published Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>People diagnosed and treated in 1st stage of breast, colorectal and lung cancer (25% increase)</td>
<td>2016 &amp; 2017</td>
</tr>
<tr>
<td></td>
<td>22.7% Grampian</td>
</tr>
<tr>
<td></td>
<td>25.3% Scotland</td>
</tr>
<tr>
<td>31 days from decision to treat (95%) and 62 days from urgent referral with suspicion of cancer (95%)</td>
<td>Quarter to June 2018</td>
</tr>
<tr>
<td></td>
<td>• 92.7% Grampian (31)</td>
</tr>
<tr>
<td></td>
<td>• 95% Scotland (31)</td>
</tr>
<tr>
<td></td>
<td>• 81.9% Grampian (62)</td>
</tr>
<tr>
<td></td>
<td>• 84.6% Scotland (62)</td>
</tr>
<tr>
<td>12 weeks Treatment Time Guarantee (TTG 100%)</td>
<td>Quarter to September 2018</td>
</tr>
<tr>
<td></td>
<td>55.3% Grampian</td>
</tr>
<tr>
<td></td>
<td>74.6% Scotland</td>
</tr>
<tr>
<td>12 weeks for first outpatient appointment (95% with stretch 100%)</td>
<td>At end September 2018</td>
</tr>
<tr>
<td></td>
<td>57.9% Grampian</td>
</tr>
<tr>
<td></td>
<td>70.5% Scotland</td>
</tr>
<tr>
<td>18 weeks Referral to Treatment RTT</td>
<td>September 2018</td>
</tr>
<tr>
<td></td>
<td>64.4% Grampian</td>
</tr>
<tr>
<td></td>
<td>81.4% Scotland</td>
</tr>
<tr>
<td>People newly diagnosed with dementia will have a minimum of 1 year’s post-diagnostic support</td>
<td>2015/16</td>
</tr>
<tr>
<td></td>
<td>21% Grampian</td>
</tr>
<tr>
<td></td>
<td>42% Scotland</td>
</tr>
<tr>
<td>At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation</td>
<td>2017/18</td>
</tr>
<tr>
<td></td>
<td>86.9% Grampian</td>
</tr>
<tr>
<td></td>
<td>86% Scotland</td>
</tr>
<tr>
<td>Eligible patients commence IVF treatment within 12 months (90%)</td>
<td>Quarter to June 2018</td>
</tr>
<tr>
<td></td>
<td>100% Grampian</td>
</tr>
<tr>
<td></td>
<td>100% Scotland</td>
</tr>
<tr>
<td>Sickness absence (4%)</td>
<td>2017/18</td>
</tr>
<tr>
<td></td>
<td>5.13% Grampian</td>
</tr>
<tr>
<td></td>
<td>5.39% Scotland</td>
</tr>
<tr>
<td>18 weeks referral to treatment for Psychological Therapies (90%)</td>
<td>Quarter to June 2018</td>
</tr>
<tr>
<td></td>
<td>72.1% Grampian</td>
</tr>
<tr>
<td></td>
<td>76.3% Scotland</td>
</tr>
<tr>
<td>LDP Standard</td>
<td>Current Published Performance</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------</td>
</tr>
<tr>
<td>Clostridium difficile infections per 1000 occupied bed days (0.32)</td>
<td>Year to June 2018</td>
</tr>
<tr>
<td>SAB infections per 1000 acute occupied bed days (0.24)</td>
<td>0.44 Grampian (Cdiff)</td>
</tr>
<tr>
<td>SAB infections per 1000 acute occupied bed days (0.24)</td>
<td>0.28 Scotland (Cdiff)</td>
</tr>
<tr>
<td>NHS Grampian has not been identified as an outlier</td>
<td>0.35 Grampian (SAB)</td>
</tr>
<tr>
<td>Clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery (90%)</td>
<td>Quarter to June 2018</td>
</tr>
<tr>
<td>Clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery (90%)</td>
<td>94.9% Grampian</td>
</tr>
<tr>
<td>Clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery (90%)</td>
<td>94% Scotland</td>
</tr>
<tr>
<td>Sustain and embed alcohol brief interventions in 3 priority settings (primary care, sexual health, antenatal) and broaden delivery in wider settings</td>
<td>2017/18</td>
</tr>
<tr>
<td>Sustain and embed alcohol brief interventions in 3 priority settings (primary care, sexual health, antenatal) and broaden delivery in wider settings</td>
<td>8343 Grampian actual</td>
</tr>
<tr>
<td>Sustain and embed alcohol brief interventions in 3 priority settings (primary care, sexual health, antenatal) and broaden delivery in wider settings</td>
<td>6658 Grampian standard</td>
</tr>
<tr>
<td>Sustain and embed alcohol brief interventions in 3 priority settings (primary care, sexual health, antenatal) and broaden delivery in wider settings</td>
<td>81177 Scotland actual</td>
</tr>
<tr>
<td>Sustain and embed alcohol brief interventions in 3 priority settings (primary care, sexual health, antenatal) and broaden delivery in wider settings</td>
<td>61081 Scotland standard</td>
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<td>Sustain and embed successful smoking quits, at 12 weeks post quit, in the 40% SIMD areas</td>
<td>7/18 Year</td>
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<td>Sustain and embed successful smoking quits, at 12 weeks post quit, in the 40% SIMD areas</td>
<td>1149 Grampian standard</td>
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<td>Sustain and embed successful smoking quits, at 12 weeks post quit, in the 40% SIMD areas</td>
<td>916 delivered</td>
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<td>Sustain and embed successful smoking quits, at 12 weeks post quit, in the 40% SIMD areas</td>
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<td>Sustain and embed successful smoking quits, at 12 weeks post quit, in the 40% SIMD areas</td>
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<td>GP Access</td>
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<td>GP Access</td>
<td>91% Grampian</td>
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<td>GP Access</td>
<td>93% Scotland</td>
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Caring. Listening. Improving

Members of the NHS Grampian Area Partnership Forum (GAPF) have been spent this year listening, and supporting our staff on issues which matter to them and on the changing environments of healthcare. Significant effort has been made to follow through on these discussions and remedying where possible the issues raised. GAPF has been particularly active around the review and development of staff policies and also dealing with the many issues around the integration agenda that affect our staff working in health and social care.

GAPF Away Days

GAPF has held successful away days, aligned to different sectors, including the Acute Sector November 2017, Aberdeen City Health & Social Care Partnership December 2017, Aberdeenshire Health & Social Care Partnership March 2018 and Facilities & Estates August 2018. Each away day concentrates on themes relevant to that area and the GAPF has been supportive in making these ideas reality, whether through policy development, dealing with cross Grampian issues or facilitating cross Grampian solutions.

In addition to the sector away days, GAPF hosts an away day, involving representatives from all sectors. The theme for 2018 was Big Rocks, based on the thinking of Steven Covey on identifying priorities and undertaking the biggest pieces of work first. GAPF has continued work around Big Rocks and has identified 5 themes which will be incorporated in to future GAPF meetings.

The 5 themes include:

- Communication, information and dissemination, recent examples include Endowments, Turas Learn and Finance.
- Views, feedback and discussion (airing), recent examples include Occupeye and Car Parking.
- Consultation and negotiation, recent examples include the proposed Brexit questionnaire.
- Decision making to develop GAPF advice info to support the Board, this is currently a regular written report to the Board, however, this would be agreed at the end of the meeting when items for communication were discussed, items for Board would also be agreed.
- Approval, this would include the approval and sign off of policies.
Integrating Health & Social Care

NHS Grampian, together with partners in Aberdeenshire, Moray and Aberdeen City, has continued to work together in developing the new culture for staff working within the Health & Social Care Partnerships. Work continues, to develop effective working relationships. An example of this would be the work stream regarding the Health & Safety Gap Analysis involving NHS Grampian and all 3 Health & Social Care Partnerships.

Priority Actions 2018-19

We aim to continue to build on our successful foundation and have developed our priorities, in partnership, in line with the Staff Governance Standards.

Well Informed

Continue to promote the importance and commitment to the partnership model of working through two way communication between Grampian Area Partnership Forum and the Sector Partnership Forums representing local areas to listen and promote increased local involvement of staff in the partnership processes. Extend and embed partnership working further across Grampian, ensuring involvement in all areas of the change agenda, developing staff participation and improving staff experience.

Involved in Decisions

2018/19 will continue to be a period of significant change in NHS Grampian, for NHS staff working within the 3 HSCPs; and for NHS staff across the North region. Progression of the shared services agenda for corporate services and for estates and facilities will see changes to working arrangements for some staff. The regional agenda is also likely to extend to some clinical services and staff involvement in how these changes will be progressed continues to be a key priority.

 Appropriately trained and developed

Continue to extend accessible, blended approach to learning, including extending an e-learning approach through Turas Learn. Review of learning opportunities to improve accessibility, mindful of the difficulties of releasing staff from the workplace, by increasing access to information technology resources. The Grampian Area Partnership Forum Endowments Sub Group receives an annual allocation from the Endowment Committee to consider applications for staff training & development.

Treated fairly, consistently, with dignity and respect in an environment where diversity is valued.

Creating strong links and communication channels within NHS Grampian through the Once for Scotland Policy work stream.

Following approval, the implementation of the Health and Safety Strategy and policy across NHS Grampian.
Continue to promote local partnership structures to resolve issues at the most relevant level in the organisation.

**Provided with a safe and continuously improving and safe working environment, promoting health & well being of staff, patients and the wider community.**

Supporting initiatives which seek to develop and embed a model that supports health and wellbeing of staff.

We have continued the process to embed health and safety as a key component of safe patient care as part of the normal business of NHS Grampian.

We continue to seek to improve recruitment of health and safety representatives and nurture the partnership approach to health and safety including the involvement of staff side colleagues in development of policies relating to health and safety and in the workplace inspection regimes. The Grampian Area Partnership Forum Endowments Sub Group also receives an annual allocation from the Endowments Committee to consider applications from staff which address one or more of the Staff Governance Standard and can link to patient benefit.
Appendix 3

Report from Area Clinical Forum

Clinical Engagement

ACF members recognise the importance of their role and the links which they provide between clinical services and the Senior Leadership Team (SLT) and the NHS Grampian Board. It has been noted that communication between the ACF and senior level could be improved and this has been welcomed from all of those involved. The ACF has regular representation from members of the SLT and the Board and it is essential that this continues. There has been ongoing work to improve links and to improve the information flow from and to the ACF committee. The ACF members are very keen to be involved in helping to shape strategy and key developments by providing clinical perspective and access to the wider professional group. The ACF would like to have the opportunity to consult on key pieces of work at an early stage and are committed to involving their individual committees and wider clinical membership as an integral part of this. There are now regular agenda setting meetings with the Chair and Vice Chair of the ACF and the SLT which should help ensure this engagement continues.

Information Sharing

There are a number of large projects at varying stages of development and over the past year the ACF has welcomed presentations and engagement from those leading projects and also welcomed the opportunity to discuss and provide multidisciplinary clinical opinion. Examples of these are the Elective Care Programme, NHS Grampian Clinical Strategy, Regional Delivery Plan, Baird Family Hospital and ANCHOR Centre plan and the Beating Cancer Ambition and Action Plan. The ACF will continue to engage with these and other key developments to ensure that the wider membership have access to relevant information and a route to communicate ideas via the ACF.

Staff Experience and Wellbeing

In 2017 the ACF committee compiled a paper on staff health and wellbeing. This was shared with the Staff Experience Group in December 2017 where it was well received and promoted further discussion. The NHS Grampian Director of Workforce wrote a formal response to the report which was welcomed by the committee and in addition she also attended the March 2017 ACF meeting to continue discussion on this topic. This engagement was a useful forum to continue a positive and constructive discussion on staff experience, stress and in particular wellbeing. Staff experience and wellbeing will continue to be an area which the ACF would like to reflect on a regular basis as we continue to work in challenging workforce times.
Recruitment and Retention

Closely related to staff experience and wellbeing is recruitment and retention, the interconnectedness of the two is regularly highlighted in committee discussion. There are significant recruitment and workload challenges in the NHS and not unique to NHS Grampian and the ACF view this as a particular concern across the clinical specialities. Many relevant factors have been discussed and fed back to the Board including recruitment/ screening issues, financial issues, promoting research and innovation, enhancing academic links etc. The ACF has welcomed discussion from nursing and midwifery on new approaches to recruitment on a more ‘global’ scale and would like to engage more in plans to attract school leavers into a career in healthcare, recognising that most school leavers will be unaware of the vast array of opportunities in the NHS. In addition the ACF has increasing concern that new developments such as the General Medical Services (GMS) contract which provides a range of new opportunities will also cause significant challenges in workforce supply which has a large potential to adversely impact other areas.

Improving communication

As a Grampian-wide, multi-professional forum for all clinical groups, the ACF continues to seek to establish effective links with all three Integration Joint Boards (IJBs) i.e. Aberdeen City, Aberdeenshire and Moray. This is essential to enable clinical advice, questions and concerns to be readily shared and to facilitate collaboration and mutual understanding across patient pathways that span community and secondary care. Members are keen to understand the new structures and processes within the health and social care partnerships, including hosted services, however it is still felt that knowledge gaps exist and these continue to have a negative impact on communication between professionals across the whole health and social care system. It is recognised that health and social care partnerships are complex organisations that continue to evolve over time and ACF members would certainly like to improve relationships and communication to ensure that the IJBs can access the ACF for multi-professional clinical advice.
Appendix 4

Staff Achievements 2018

January
- Ally Lister district nurse from Huntly was among a group of 20 to have been awarded the title of Queen’s Nurse, marking the first time the honour had been made in Scotland for almost 50 years. Ally was selected earlier 2017 to take part in a nine-month development programme run by the Queen’s Nursing Institute Scotland (QNIS). Each of the community nurses were nominated by their managers for providing high quality, compassionate care.

February
- A specialist team from RACH visited Bangladesh to support the ‘Walk for Life’ charity programme. Ros Baker, Andy Shipley, Leanora Mills and myself (Simon Barker) delivered instructional lectures alongside practical support and guidance in the Ponseti casting technique. This has been used to treat 21,000 children in the WfL programme and is the standard of care in Aberdeen and around the world. Without this life-changing resource-appropriate treatment, clubfoot ostracises and limits the life-opportunities for children in Bangladesh.

March
- Staff show their dedication after ARI flood. Teams throughout ARI rose to the occasion when a flood in the main concourse took pharmacy robots out of commission. The incident took place on the evening of Monday 12th February and led to disruption for much of that week. Staff volunteered for weekend shifts to restock the pharmacy and ensure we were able to return to a normal service.

April
- Dr Roger Staff, Head of Imaging Physics, has been awarded The Normal Veall Medal. This prestigious national award is handed out each year by the BNMS Council to a scientist who has made an outstanding contribution to the science and/or practice of nuclear medicine in the United Kingdom. In addition to leading the NHS Grampian imaging physics team, an internationally recognized centre of excellence, Dr Staff is a globally recognised research scientist, publishing over 100 peer review publications, multiple book chapters and generating more than £2m of grant income.

May
- Awards shortlist for neonatal innovation: Nicole Bauwens – Nurse Manager at the neonatal unit in AMH - has been announced as a finalist in the 2018 RCNi Nurse Awards, the UK’s most prestigious nursing accolade. The RCNi Nurse Awards identify and celebrate nurses who, every day, go above and beyond to save lives, provide outstanding care for patients and transform nursing practice for the better. Nicole has been shortlisted for the Child Health Award for introducing ‘Family Integrated Care’ to the unit, empowering parents and staff to work together.
• Twà’ well kent faces from NHS Grampian were special guests of HRH The Prince of Wales at a Buckingham Palace event in March that celebrated nursing in the UK. The Countess of Wessex was also in attendance and met two frontline NHS Grampian staff, Nurse Manager Jean Quirie and Healthcare Support Worker Helen Collinson. Jean was nominated following her work as a nurse for 50 years and was described as an inspirational and supportive colleague. Helen was nominated due to her humour, hard work and dedication in every shift and described as "treasured, loved and fondly thought of by patients, families and the team".

• Dr Kirsty MacLennan, clinical psychologist, was delighted to be invited to present at an All Party Parliamentary Group at the House of Commons on Psychological Support for People with Diabetes.

June

• ITU nurse – and budding photographer - Carrie-Ann Goodbrand has won the Scottish round of nationwide photography competition run by UK heart valve disease charity Heart Valve Voice and The Royal Photographic Society. The contest aims to raise awareness of heart valve disease; a growing health concern with approximately 1.5 million people over the age of 65 currently affected by the condition in the UK.

• Energy project wins national award. A project linking the Foresterhill Health Campus and Royal Cornhill complexes to the existing energy centre, in addition to delivering energy conservation measures recently picked up a prestigious industry award. The project was delivered jointly by NHS Grampian and Vital Energi and won Retrofit Project of the Year at the annual Heating and Ventilation News awards in London. In 2012 we installed a CHP, Biomass and conventional Dual Fuel boiler powered energy centre at Foresterhill to provide electricity in addition to low-carbon heat and hot water. In 2017 infrastructure was installed which allowed Royal Cornhill Hospital to share this energy centre via a district heating and HV “Energy link”.

July

• Dr Richard Coleman collected the ‘Outstanding Role Model’ award at the recent NHS Education for Scotland (NES) Medical Awards. The awards were presented as part of the 2018 NES Medical Conference, the largest of its kind, which brought together 1,500 delegates over two days to Edinburgh. Richard is currently Associate Medical Director with responsibility for Education, Workforce and Training.

• ARI nurses scoop dermatology award. Sobia Regi and Mary Fergus have been jointly named dermatology nurses of the year by the Scottish Dermatological Nursing Society. They are part of the phototherapy team based in Ward 406 at ARI. They have been crucial to the delivery of this service, which underwent a redesign in 2015/2016 to address a nine month waiting list. The hard work and dedication of Sobia, Mary and their colleagues has reduced this to 6 weeks.
• The inaugural ‘Valuing Our Healthcare Support Workers’ Event took place. This pilot event was initiated by Kerry Jane Lyon, a maternity HCSW and Associate Practice Educator, based in Aberdeen Maternity Hospital. Kerry was inspired by the recent International Day of the Midwife and International Nurses’ Day and felt that Healthcare Support Workers also deserved the same recognition and appreciation. Kerry said “I wanted to hold an event specifically dedicated to the wonderful Healthcare Support Workers in AMH. I was overwhelmed with the enthusiasm others showed for the day and hopefully we’ll be able to do something bigger and better, across NHS Grampian, next year”.

• Pharmacy technicians represented NHS Grampian at the Association of Pharmacy Technicians (APTUK) national conference and exhibition held in Glasgow. At the awards ceremony, Aberdeen branch won branch of the year, a huge achievement just after their 1st birthday. In addition, branch member Kay Morgan won 2nd place in Technician of the Year Award, but was overwhelmed when it was announced she was to be endorsed as a fellow of the Association.

August

• Congratulations to Sandra Wilson, a Senior Diabetes Specialist Nurse, who has been named a Diabetes UK Clinical Champion. A total of twenty healthcare professionals have been appointed by the charity; Sandra is one of only two working in Scotland. Sandra plans to establish high quality standards of care for people with diabetes. She wants to improve how education is delivered by working with health and social care staff and also the third sector.

• Queen’s Nursing Institute Long Service Awards. Almost 50 nurses from across the north-east have been recognised for their dedication to community care. The group came together for an event in Inverurie, where they were presented with the Queen’s Nursing Institute Scotland (QNIS) award for long service. They all work in roles within the community, including district nursing, health visiting and practice nursing, and have an outstanding total of 1,249 years of service between them. They were presented with the prize, which consists of a badge and certificate, by Linda Harper, one of our Associate Directors of Nursing.

• Staff at Muick Ward Royal Cornhill walked from Loch Muick to Muick Ward in 24hrs raising over £6000 which funded an internet cafe on the ward for their patients.

September

• Suzanne Livingston, Community Rehabilitation Nurse Specialist, who has just passed the national Headway charity Certificate in Brain Injury, affiliated to the University of Northampton

• The Scottish Research Nurse & Coordinators Network present the Gail Woodburn Nurse of the Year Award at their annual conference each year and nominations are now open. The award recognises and rewards excellence in the research nurse profession and hopes to increase the wider understanding of clinical research nursing.
October

- The District Nursing Team at Great Western Medical Practice, and their supportive Direct Delivery Team from Airyhall Clinic, have won the Royal College of General Practitioners Palliative Care Award. The team were nominated for their continued excellent service to all patients, but particularly palliative patients.

November

- Scottish Health Awards – Shona McCann, won the Care for Mental Health Award at the Scottish Health Awards 2018. She was nominated by some of the ladies she cared for which made it even more special. She is Specialist Midwife in Perinatal Mental Health - the first in this role in Scotland. Ann Ovall, Public Dental Service Dentist at the Health Village won Dentist of the Year. She and her colleagues treat priority group patients including those with learning difficulties, complex medical issues, physical impairment, anxiety and psychiatric conditions. They also carry out domiciliary visits to housebound and hospital patients and care home residents, many of whom have dementia.
24th June 2019

Dr Lynda Lynch
Chair
NHS Grampian
Summerfield House
2 Eday Road
Aberdeen
AB15 6RE

NHS GRAMPIAN: 2017/18 ANNUAL REVIEW

1. This letter summarises the main points discussed and actions arising from the Annual Review and associated meetings at Curl Aberdeen on 29 April 2019. I would like to record my thanks to everyone who was involved in the preparations for the Review and to those who attended the various meetings.

Meeting with the Area Clinical Forum

2. I had a constructive discussion with the Area Clinical Forum (ACF) and I was pleased to note that the ACF is a well-attended committee and it was clear the Forum feels that links with the Board are improving. It is important that the ACF is fully engaged with the Board’s work and that there are effective links with the senior management team. This improved position is therefore welcome and work should continue to ensure that moving forward, the Forum’s contribution to the work of the Board is strengthened further. The ACF should be the main source of clinical advice and meaningful engagement of local clinicians will be essential in taking forward both the critical health and social care integration agenda and other service redesign programmes. I also heard that it can be difficult to attract members to Professional Advisory Committees and that structures need to be developed to encourage participation and that you and the Board Chief Executive are keen to see this happen. Later on in the private session you made clear your commitment to continue to support the improving relationship and ensure engagement of the ACF at the earliest opportunity.
3. I heard that the Forum is supporting work on practising Realistic Medicine but that this can be difficult for a number of reasons, including workforce challenges. We had a discussion about the staffing challenges being faced by the Board, particularly in relation to difficulties with staff recruitment across a number of professions. I heard about some of the approaches being taken locally to attract staff, such as the work with local schools to promote the wide variety of opportunities available within the NHS and to encourage pupils to consider a career with NHS Grampian. There was also discussion about the impact the location of training has on attracting staff, with many trainees opting to work where they train. In this regard I noted the concern raised about the impact the location of specialist services, such as national major trauma centres and neonatal intensive care units, could have on recruitment locally, if training for associated staff is concentrated in the location of specialist services. We also discussed the challenges in recruiting to professions not on the national Shortage Occupation List and I advised that the Scottish Government continues to work with the UK Government, particularly on how the rules are applied for Scotland.

Meeting with the Area Partnership Forum

4. My meeting with the Area Partnership Forum (APF) was equally constructive and I heard from the attending members that local relationships are sound with good partnership working and that there is generally a good attendance at meetings. Similar to the ACF, I was pleased to hear of the improved links with the Board and that there is progress in engaging with the APF at the earliest opportunity in areas of work including local service re-design. I heard from the Forum about the successful away days and that this is a good opportunity to share good practice across NHS Grampian and the Health and Social Care Partnerships. The Forum will consider if there are any opportunities for wider sharing of good practice across other NHS Boards. I also heard that the Forum is engaged in other areas of work including: working to build a safe environment to report bullying and harassment concerns; the critical health and social integration agenda; and of the work to address, where possible, the recruitment and retention challenges faced by the Board, including the work to develop local young people e.g. through the modern apprenticeship scheme.

Patients/Carers Meeting

5. I would like to extend my sincere thanks to all those who took the time to come and meet with me. I greatly appreciated the openness and willingness of the patients and carers present to share their experiences. I heard that overall, patients appreciate the high quality of services and the excellent care provided by medical and nursing staff in NHS Grampian. There was a good discussion on: public involvement and I heard positive feedback from many of the attendees about the Board’s engagement and partnership working with local people; work to bring about improvements in cleaning standards in hospitals and infection control; and the benefit of mindfulness services, both to NHS staff and members of the public who would benefit from lower level interventions. I heard concerns about social isolation, particularly in light of well used community groups closing. Many areas spoken about were supported by a number of attendees and were raised with the Board leadership in the private session.
Annual Review – Public Session

6. I was pleased to hear during the Chair’s presentation you reiterate the Board’s clear focus on patient safety, effective governance and performance management and on the delivery of significant improvements in local health outcomes.

7. A detailed account of the specific progress the Board has made in a number of other areas is available to members of the public in the self-assessment paper which the Board prepared for the Annual Review. This has been posted on NHS Grampian’s website. We then took a number of questions from the floor. I am grateful to you and the Board team for their efforts in this respect, and to the audience members for their attendance and questions.

Annual Review – Private Session

Health Improvement and Improving Inequalities

8. NHS Grampian is to be commended for exceeding its target in delivering alcohol brief interventions, exceeding the target by 25%. A brief intervention is a short motivational interview, in which the costs of drinking and benefits of cutting down are discussed, along with information about health risks. These have been proven to be effective in reducing alcohol consumption in harmful and hazardous drinkers. The target for NHS Grampian in 2017/18 was 6,658 interventions with 8,343 being achieved. The Board is also to be commended for its performance against the drug and alcohol treatment waiting times standard in 2017/18, achieving 93.6% against the 90% standard. For the challenging 2017/18 smoking cessation standard, the Board recorded 916 successful post-3 month quits in the most deprived areas, against the standard of 1,149.

9. In respect of the Board’s performance in the priority area of access to psychological therapies and child and adolescent mental health services (CAMHS), the Board’s performance is below the standard and the national average - significantly below for CAMHS with 41.1% of patients seen within 18 weeks for the quarter ending December 2018 against the national standard of 90%. You advise that this is largely due to an increase in demand and staffing challenges. You assured me that in collaboration with your health and social care partnerships, there is work underway to improve access. This includes new CAMHS posts, all now in place, and a commitment to increase the workforce further and the creation of a CAMHS Centre of Excellence due to open in June. There has been additional Government investment of £8,292,959 from 2018/19 to 2021/22 for Grampian to recruit additional staff in key settings. While progress is being made, the Board acknowledge that there is more work to be done and that you are working to meet the CAMHS and psychological therapies standard.

Patient Safety and Infection Control

10. Rigorous clinical governance and robust risk management are fundamental activities for any NHS Board, whilst the quality of care and patient safety are of paramount concern. I know there has been a lot of time and effort invested locally in effectively tackling infection control; this is reflected in the Board delivering an 91% reduction in cases of C Difficile infection in those aged 65 and over since 2007 and a 82% reduction in cases of MRSA.
11. The Health Environment Inspectorate carried out an unannounced inspection at Dr Gray’s Hospital in November 2017. This resulted in five requirements and one recommendation; an improvement plan was developed by the Board to address the requirements and the recommendation.

**Improving Access: Waiting Times Performance**

12. NHS Grampian have continued to experience a range of whole system challenges which have had an impact on performance against the elective waiting times standards during 2017/18. The Board has experienced challenges recruiting to fill nursing posts, with vacancy levels remaining high. A high level of theatre nurse vacancies have led to significant levels of elective theatre sessions being cancelled. The Board has a large number of patients waiting over 12 weeks for treatment and I note that the Board are working to stabilise and recover performance, retaining an absolute focus on patient-centred care at all times.

13. The Scottish Government’s Access Support Team have provided significant funding to NHS Grampian to support the recovery of waiting times and a detailed recovery plan has been received from the Board, noting the interventions currently underway to support recovery of the position. The Access Support Team will continue to work closely with NHS Grampian.

14. While NHS Grampian have had a year of variable performance against the 4-hour unscheduled care target, I note that performance has improved lately with a level averaging between 90% - 95%. Performance for the year to February was 94.4%.

15. The Board’s performance against the 31 day cancer standard has been below the 95% standard for all of the last five quarters, with the last quarter of 2018 sitting at 90.1%. Performance against the 62 day standard has been well below the 95% standard in all of the previous five quarters, with the latest quarterly performance of 80.1%. The main areas of pressure are in colorectal and urology pathways. Peer review and scrutiny across Boards is continuing to ensure the Effective Cancer Management Framework is implemented with robust tracking, oversight, escalation and scrutiny embedded across Scotland. As part of this, NHS Grampian has received four peer review visits to review systems and process for both pathways. The Board is continuing to review every patient who has already breached to ensure a management plan is in place for each patient and I welcomed your assurance that work is ongoing to improve performance. It is essential that progress continues until the backlog is cleared, and to ensure no new patients breach the standards.

**Health and Social Care Integration**

16. There are three Integrated Joint Boards (IJBs) in the Grampian area: Aberdeen City; Aberdeenshire; and Moray. There is a history of good, effective joint working in Grampian between agencies and the IJBs have consolidated and built on this foundation. There is work being taken forward across Grampian to deliver joined-up, person-centred care to communities.

Scottish Ministers, special advisers and the Permanent Secretary are covered by the terms of the Lobbying (Scotland) Act 2016. See www.lobbying.scot

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17. In terms of delayed discharge, Aberdeen City is the most consistent performing partnership, with almost continual downward trends. The Partnership has put in place a range of measures to make a sustainable improvements, including the development of intermediate care beds in two care homes to provide step-down rehabilitative care. Aberdeenshire have operated a Virtual Community Ward (VCW) since early 2016, which is a multidisciplinary health and social care team providing care for patients who need regular of urgent attention in their own home, avoiding unnecessary hospital admissions. In Moray, the Partnership makes innovative use of housing provision, including the development of eight bungalows for people with autism and challenging behaviour.

Finance

18. It is vital that NHS Boards achieve both financial stability and best value for the considerable taxpayer investment made in the NHS. I am therefore pleased to note that NHS Grampian met its financial targets for 2017/18. The need for strong financial performance is essential as the demands on health and care services continues to grow. Nonetheless, you confirmed that the Board continues to actively monitor the achievement of all local efficiency programmes and, whilst the position is challenging, NHS Grampian remains fully committed to meeting its financial responsibilities in 2018/19 and beyond.

Conclusion

19. I want to record my thanks to the Board and local staff for their generally strong performance in 2017/18. NHS Grampian is making progress in taking forward a challenging agenda on a number of fronts. I have been assured that the Board understands the need to improve performance in some key areas, whilst maintaining the quality of frontline services and demonstrating best value for taxpayers’ investment. We will continue to keep progress under close review and I have included a list of the main performance action points in the attached annex.

Regards,

Joe FitzPatrick

Scottish Ministers, special advisers and the Permanent Secretary are covered by the terms of the Lobbying (Scotland) Act 2016. See www.lobbying.scot

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NHS GRAMPIAN ANNUAL REVIEW 2017/18

MAIN ACTION POINTS

The Board must:

- Continue to deliver on its key responsibilities in terms of clinical governance, risk management, quality of care and patient safety

- Keep the Health & Social Care Directorates informed on progress towards achieving all access targets in line with agreed improvement trajectories.

- Make progress in the priority area of mental health by ensuring that Board meets and maintains the national access standards for both CAMHS and Psychological Therapies.

- Continue to review, update and maintain robust arrangements for controlling Healthcare Associated Infection

- Continue to achieve financial management targets

- Continue to work with planning partners on the critical health and social integration agenda

- Keep the Health & Social Care Directorates informed of progress with its significant local health improvement activity

- Keep the Health & Social Care Directorates informed of progress with local service redesign plans, in line with the national policy

- Provide a written update to the Scottish Government on progress against the above actions by 30 October 2019.
Mid-year review – briefing note
October 2019
Section 1: Introduction

1.1 The purpose of this briefing is to summarise key matters in relation to the Board’s performance, finance and progress against the Annual Operational Plan as at 30 September 2019.

1.2 The briefing is set out in a number of sections as follows:

- **Section 2: Performance** – summary of actions and performance against key metrics – elective care, cancer, mental health and unscheduled care
- **Section 3: Finance** – summary of the position at end of month 5 – revenue and capital
- **Appendices 1 and 2**: Actions arising from feedback on the Annual Operational Plan (2018/19) and arising from the Annual Review (2018/19)

1.3 In terms of highlights in the year to date we would note the following:

- Celebration of the first anniversary of the Major Trauma service based at Aberdeen Royal Infirmary (the first centre established in Scotland).
- NHS Grampian has been selected as the preferred Board to provide the first national ECMO service for NHS Scotland (we established this service as part of the UK national network and it has gained national and international accreditation for the outcomes it achieves).
- In June we opened the CAHMS Centre of Excellence in Aberdeen, which brings together all the 0-18yrs services for children in one purpose designed facility.
- NHS Grampian services have featured prominently in national media through the commissioned TV series in relation to the Royal Aberdeen Children’s Hospital and community midwifery services in North Aberdeenshire.
- Celebrated the 250th anniversary of the opening of Dr Gray’s Hospital, Elgin.
- Development of the partnership with Western Australia to recruit graduate nurses. Western Australia have a surplus of graduate nurses looking for posts and we have established a formal partnership which will enable us to recruit c100 nurses per annum to Grampian to fill vacant posts.
- Positive evaluations of health and care social integration using the framework provided by the Ministerial Steering Group.
- Active leadership, participation and contribution to the Global Citizenship agenda with further development of ongoing partnership with the Ethiopian health system, and decision to establish an ‘International Office’ approach within the Board.
- Regional leadership across a number of speciality workstreams (regional collaboratives) aimed at re-shaping and transforming regional access, sustainability and performance.
Section 2: Key performance metrics

a. Unscheduled Care

High level overview

At the October 2019 meeting, the NHS Grampian Board reviewed unscheduled care and the preparations for winter. We would highlight the following in relation to our overall arrangements:

- The NHS Grampian Unscheduled Care Programme Board (Chief Officers from Acute and the three Health and Social Care Partnerships) ensures there is a co-ordinated approach to cross sector, high level leadership and governance. The work of the Unscheduled Care Programme Board is informed by the Grampian Clinical Strategy; Integration Joint Board Strategic Plans; and through discussion with the System Leadership Team.

- We participate fully in the national Unscheduled Care Programme focusing on delivery of the six essential actions. We operate a fully staffed small team to deliver the National Programme and are focused around the two acute sites, including dedicated site based Improvement Managers embedded in the local teams for Aberdeen City, Aberdeenshire & Moray.

- Health and Social Care Partnerships, as part of the National requirements, have developed plans for the following indicators, which are monitored by their respective IJBs: unplanned admissions and bed days, A&E attendances, delayed discharge bed days, last six months of life at home and balance of care.

- Joined up system planning for unscheduled care improvement is delivered by the Grampian Unscheduled Care Delivery Group. Its membership is drawn from all sectors and wider partners (e.g. Scottish Ambulance Service) and it has oversight of system performance and improvement planning.

The success of cross system working is based in the effective “Building and Bridging” of networks across all sectors within the whole system. This was the theme of the 2019 Annual Unscheduled Care Conference held on the 27th August. It provided an opportunity to share learning through short presentations from staff and colleagues leading on a number of unscheduled care improvement initiatives across Grampian as well as facilitating the opportunity for delegates, (77 staff from Acute, HSCP’s and Third Sector) to create and expand networks through a number of interactive workshop sessions.

1 Six Essential Actions 1. Clinically focused and empowered hospital management team; 2. Hospital Capacity Patient Flow (emergency and elective) re-aligned; 3. Patient rather than bed management; 4. Medical and Surgical processes aligned; 5. Seven day services appropriately targeted; 6. Patients are cared for in their own homes or a homely setting
Winter Planning

In Grampian there is an established process for winter planning which is undertaken as a year-round planning cycle and incorporates an integrated approach with the application of business continuity principles. Partners, including NHS24, Scottish Ambulance Service, the three Health and Social Care Partnerships and Local Authorities, are key to the process and participate in joint planning workshops and debrief exercises.

In terms of actions that are being taken to increase capacity during peak periods we would highlight the following:

- All frontline staffing rotas will be complete by the end of October 2019 for those areas that are required to respond immediately to increases in demand, for example the Emergency Department and Acute Medical Initial Assessment Unit.

- Plans to provide surge capacity & resource over the winter period for the predicted increase in medical admissions are being finalised. The plan will ensure priority access for cancer and urgent patients whilst endeavouring to maintain the balance between elective and unplanned surgery; all of this is cognisant of the requirement to also deliver elective waiting time trajectories.

- The Grampian Influenza (Flu) Immunisation programme is run in conjunction with the National Programme and commenced on the 1st October 2019. The programme will continue to focus on target groups (full detail can be seen in the Grampian Winter (Surge) Plan 2019/20). A publicity campaign to encourage NHS Grampian staff as well as social care staff, including those working in care homes; providing care at home; and in the voluntary sector was conducted during September. A local initiative to increase access to flu immunisation for staff will see “Peer to Peer” vaccination tested in some wards at ARI before being rolled out to other areas.

The Winter (Surge) Plan 2019/20 will be considered for approval by the Board on 7 November.
a. Unscheduled Care – performance summary

The percentage spending 4 hours or less in an A&E department was 93.7% - down from 94.7% for the year ending August 2018. However this was still well above the Scotland wide rate of 90.5%. The total number of attendances was 139,738 which represented a 0.2% increase from the same period one year previously (139,488). A greater increase of 2.4% was recorded across Scotland. Performance during September is noted below:

<table>
<thead>
<tr>
<th></th>
<th>8 Sept</th>
<th>15 Sept</th>
<th>22 Sept</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>93.4%</td>
<td>91.4%</td>
<td>89.4%</td>
</tr>
<tr>
<td>ARI</td>
<td>89.9%</td>
<td>87.6%</td>
<td>85.2%</td>
</tr>
<tr>
<td>Scotland</td>
<td>89.3%</td>
<td>88.2%</td>
<td>86.9%</td>
</tr>
<tr>
<td>Greater - 8 hrs</td>
<td>10</td>
<td>6</td>
<td>5</td>
</tr>
</tbody>
</table>

Delayed discharges

In terms of our performance in relation to delayed discharges, there has been a concerted effort in Grampian to reduce the number of people delayed in hospital awaiting discharge and the length of time they are delayed. Whilst there are fluctuations from month to month an overall downward trend has been delivered since the inception of the Integration Joint Boards.

Delayed Discharges at August 2019 Census Point

There were 105 patients delayed – down 8.7% from 115 in July. A smaller reduction of 2.8% was recorded across Scotland. 23 (21.9%) of these delays were for patients with specific complex care needs. Of the remaining 82 patients delayed at the census, 79 were due to health and social care reasons and three due to patient and family related reasons. Comparison with prior three months (delayed discharges).

<table>
<thead>
<tr>
<th></th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aberdeen</td>
<td>41</td>
<td>32</td>
<td>38</td>
<td>33</td>
<td>36</td>
</tr>
<tr>
<td>Aberdeenshire</td>
<td>49</td>
<td>40</td>
<td>37</td>
<td>55</td>
<td>44</td>
</tr>
<tr>
<td>Moray</td>
<td>20</td>
<td>32</td>
<td>27</td>
<td>24</td>
<td>22</td>
</tr>
</tbody>
</table>

Bed Days in August 2019

Patients spent 3,194 days in hospital due to delays in discharge in Grampian. This represented a 7.8% decrease from July when the total was 3,464 bed days. By contrast an increase of 3.3% was recorded across Scotland. Comparison with prior three months (bed days)

<table>
<thead>
<tr>
<th></th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aberdeen</td>
<td>1,126</td>
<td>1,156</td>
<td>1,066</td>
<td>1,115</td>
<td>1,039</td>
</tr>
<tr>
<td>Aberdeenshire</td>
<td>1,306</td>
<td>1,512</td>
<td>1,078</td>
<td>1,523</td>
<td>1,350</td>
</tr>
<tr>
<td>Moray</td>
<td>926</td>
<td>810</td>
<td>768</td>
<td>698</td>
<td>680</td>
</tr>
</tbody>
</table>
b. Elective Care

The performance in terms of the number of patients waiting longer than 12 weeks for a first outpatient appointment or treatment (inpatients /day cases) is shown below.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatients</td>
<td>15,830</td>
<td>11,958</td>
<td>10,173</td>
<td>11,800</td>
<td>9,825</td>
<td>9,960</td>
<td>7,050</td>
<td>5,810</td>
<td>3,730</td>
</tr>
<tr>
<td>Over 26 weeks</td>
<td>5,236</td>
<td>3,954</td>
<td>2,949</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment</td>
<td>5,654</td>
<td>4,231</td>
<td>3,913</td>
<td>4,100</td>
<td>3,725</td>
<td>4,050</td>
<td>4,000</td>
<td>2,540</td>
<td>2,880</td>
</tr>
<tr>
<td>Over 26 weeks</td>
<td>3,194</td>
<td>2,154</td>
<td>1,937</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Key points we would highlight are:

- The number of patients waiting (in total and over 26 weeks) for both a first outpatient appointment and treatment has improved since the start of the calendar year. We have only had a very small number of outpatients who have waited over 78 weeks and this position is expected to continue to improve. The number of TTG patients waiting over 78 weeks was on an increasing trajectory from early 2018 and peaked in April 2019 at about 450 patients. Since April this number is on a steady downwards trajectory which we expect to continue.

- The trajectories for both number of patients waiting for an outpatient appointment and treatment was revised from the AOP due to – ability of independent sector to fulfil planned capacity requirement; impact of pension and income tax on willingness of medical staff to pick up waiting list initiatives; and a later start in commencement of additional activity at Stracathro along with a reduced throughput capacity model shared with NHS Tayside versus the AOP model.

- In terms of improving position between now and end of March the additional activity that will be available in the period October to March 2020 will be: Vanguard Stracathro (to reduce long waiting patients – urology and general surgery) and ‘See and Treat’ contracts with the independent sector for Dermatology, OMFS, Gynaecology and ENT.

- We believe that the trajectory for outpatients is deliverable but are more cautious regarding TTG performance as a result of challenges in sourcing the additional capacity either internally or externally. We will however retain our focus on reducing long waiting patients and prioritising our highest risk patients (Category 1 and 2, including cancer). We are undertaking further detailed work, specialty by specialty, to review the deliverability of the proposed actions in relation to improving the TTG position in 2020/21.
In terms of diagnostic performance we have had some staffing related issues around Ultrasound which have now been resolved and the waits for this should be compliant by the end of this year. A private contractor is scheduled to start in November which will provide additional MRI capacity and address this long waiting backlog of patients. Within Endoscopy the expansion of the specialist nurse cohort within Urology should lead to a sustainable deliver of the Cystoscopy standard while private sector capacity is leading to an overall improvement in the Upper, Lowers and Flexis performance.

**Projected trajectories included in indicative plan submitted to Scottish Government on 7 October:**

NHS Grampian committed to significantly reducing waiting times over 2019/20. The overall suggested trajectories for 20/21 by quarter are:

<table>
<thead>
<tr>
<th>Standard</th>
<th>March 2020</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatients</td>
<td>7,050</td>
<td>6,150</td>
<td>5,250</td>
<td>4,140</td>
<td>3,730</td>
</tr>
<tr>
<td>TTG</td>
<td>4,000</td>
<td>3,580</td>
<td>3,350</td>
<td>2,950</td>
<td>2,880</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>988</td>
<td>586</td>
<td>377</td>
<td>248</td>
<td></td>
</tr>
</tbody>
</table>
Cancer

NHS Grampian is committed to ensuring that all those who require treatment for cancer should receive that treatment as soon as clinically appropriate. We have established a robust cancer improvement action plan which seeks to deliver the recommendations of the Scottish Government’s Effective Cancer Management Framework. The NHS Grampian Cancer Local Improvement Plan sets out our ambitions to fully explore, and implement where clinically appropriate, the Effective Cancer Management Framework peer review recommendations to improve cancer management. To enhance our capacity to improve performance we have:

- Appointed a Medical Lead for Cancer Performance and a Head of Cancer (Pathways and Access) to provide the leadership and capacity to support the implementation of improvements across all cancer pathways; and

- Increased multi-disciplinary team (MDT) co-ordinator capacity to ensure appropriate monitoring of patients and implementation of clinical management plans for all patients with a cancer diagnosis. Each cancer pathway has an action plan which is reviewed regularly and variance escalated

Recognising the significant staffing challenges which have impacted on capacity across NHS Grampian, a number of actions have been taken to effectively manage available resources whilst mitigating risk and ensuring appropriate governance. In order to achieve this, a clinically-led risk management system of clinical prioritisation was introduced from June 2017 to enhance our ability to prioritise patient clinical need, as determined by the treating clinician. The system is underpinned by robust monitoring and escalation processes which were developed in partnership with Primary Care and includes ongoing assessment of clinical risk to ensure highest risk patient groups are identified. NHS Grampian is committed to ensuring all available staffed theatre resource is targeted at patients with the highest clinical need.

In order to achieve this we are progressing a number of short-term actions to address the existing backlog, and medium and long-term initiatives which are focused on sustainable performance improvement:

- Breach analysis to focus on areas of consistent failure and patients waiting over 100 days;
- Systems of governance and assurance to monitor performance across all pathways;
- Weekly cancer pathway tracking meetings to identify and ensure early escalation of patients deviating from expected timed pathways and actions taken to prevent breaches where possible;
- Implementation of enhanced monitoring of available staffed theatre capacity across NHS Grampian with a view to identifying additional sessions for Colorectal, Urology and Breast.

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2This system is currently under evaluation.
These actions are underpinned by the following principles:

- As far as reasonably possible, patients requiring a procedure will be booked in turn;
- Available staffed theatre capacity will be allocated to cancer cases as a matter of priority; and
- All available staffed theatre capacity will be allocated to the next highest priority patients.

A short-term plan has been developed to address the existing backlog of patients waiting longer than 62 days for treatment. Agreed short-term actions are:

- Currently, urology and colon cancers account for 85% of patients waiting beyond 62 days for treatment. It is anticipated that the urology & colorectal backlog will be cleared in Q3 2019 as three whole day sessions of staffed theatre capacity will be reallocated as capacity to treat urology and colorectal patients who have waited more than 62 days for treatment.

- Increase capacity for scoping through use of the private sector the following locations - Albyn Hospital, Aberdeen Health Village and Dr Gray’s.

- Appointment of additional Urology consultant, colorectal nurse specialist

- Through enacting this short-term plan, we will significantly reduce the number of patients waiting more than 62 days for treatment across urology & colorectal cancer pathways to approximately 12 by end of Q3 2019.

Recognising finite critical care capacity, and to minimise unintended consequences through creating bottlenecks in the system, this short term plan has taken place throughout the summer theatre timetable from June to September 2019. Enhanced monitoring of the 6-4-2 theatre session allocation process continues and supports the actions within the medium-term plan.

A high-level plan has been developed to ensure sustainable achievement of both the 31 and 62 day standards beyond Q3 2019/20. This seeks to maximise utilisation of core capacity across all elective sites within NHS Grampian and sets out our commitment to realising the productivity and efficiency opportunities outlined within the NHS Grampian Waiting Times Improvement Plan. We anticipate that our short-term plan will address the existing backlog by Q2/Q3 2019 through a number of key actions, one of which seeks to reallocate existing staffed theatre capacity. As the backlog is cleared in the short-term, we will utilise reallocated staffed theatre capacity in the medium-term to maintain our cancer performance, with a specific focus on colorectal, urology and breast cancer pathways. In order to sustainably improve cancer performance a number of work streams and developments will be undertaken in the medium-term. These are likely to include: Specialty-level service reviews; Consultant job plan template reviews; Theatre timetable redesign; Theatre capacity re-alignment across NHS elective sites; and increased capacity in endoscopy, radiology, PET and theatres as per 30 month waiting times improvement cancer plan.
Cancer – performance summary

In terms of the performance to the quarter ended 30 June 2019 we would highlight that the following key points relate to Grampian:

62 Day Standard

- 86.8% of patients in Grampian started treatment within the 62 days, a considerable improvement of more than 10% from the previous quarter (76.4%). It was the highest compliance rate achieved since the quarter ending March 2016. Across the whole of Scotland the compliance rate was 82.4%.

- Breast with 96.8% and Ovarian and Upper GI, both with 100%, all met the 95% target. Cervical recorded the lowest compliance rate of 25.0%.

31 Day Standard

- 93.8% of patients in Grampian started treatment within 31 days up from 92.8% during the previous quarter. This was the highest compliance rate since the quarter ending June 2016. Across Scotland the compliance rate was 89.3%.

- Three cancer types failed to meet the 95% target: Urological with 84.8%, Cervical with 85.7% and Lung with 92.7%.

Projected trajectories included in indicative plan submitted to Scottish Government on 7 October:

NHS Grampian trajectories for 20/21 by quarter are projected to be as follows:

<table>
<thead>
<tr>
<th>Standard</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer 31-day</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>Cancer 62-day</td>
<td>90%</td>
<td>91%</td>
<td>91%</td>
<td>92%</td>
</tr>
</tbody>
</table>

Although Cancer normal works on calendar quarters for consistency within this plan these figures represent financial quarters.
Diagnostics

Key actions that we plan to progress in 2019/20:

- **Endoscopy** - The year two plan starts to build sustainability by adding a substantive consultant and Clinical Fellow as recurring posts with a view to adding a second of both within the year three plan. In addition, specific non-consultant expansion is supported around the sustained increase in bowel screening demand that has been seen across Scotland. A further IS contract to reduce the backlog of routine patients is anticipated, along with an increased anaesthetic service delivery to support a reduction of the longest waiting patients.

- **Radiology (CT)** - Our performance and recovery of our CT position is entirely reliant on staff doing significant volumes of additional work. This is not a sustainable solution. The investment in additional HCSWs will allow this work to be transferred to a sustainable team. This will maintain the current position and improve it for all general CT patients. Should staff stop doing additional work, we anticipate a negative impact of 225 patients per month leading to an alternative end of year position of 2,700. The remaining tail of patients are Cardiac CT patients which we will seek to address in our year 3 plan.

- **Radiology (MRI)** - There is going to be a significant reduction in our MRI waits in Year 1 Q3 and Q4 due to the introduction of an additional mobile MRI van adding to our core capacity. We anticipate we will continue to require this IS support at a reduced rate to maintain this position through Year 2 pending capacity expansion via the Elective Care Programme. The remaining tail of long waiting MRI patients are Cardiac MRI patients which we will seek to address in the year 3 plan.

Projected trajectories included in indicative plan submitted to Scottish Government on 7 October:

<table>
<thead>
<tr>
<th>Standard</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRI</td>
<td>140</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>CT</td>
<td>90</td>
<td>80</td>
<td>80</td>
<td>80</td>
</tr>
<tr>
<td>Ultrasound</td>
<td>79</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Barium Studies</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Radiology Total Over 6 Weeks</td>
<td>309</td>
<td>180</td>
<td>180</td>
<td>180</td>
</tr>
<tr>
<td>Uppers, Lowers, Colons</td>
<td>466</td>
<td>193</td>
<td>80</td>
<td>50</td>
</tr>
<tr>
<td>Cystoscopy</td>
<td>213</td>
<td>213</td>
<td>117</td>
<td>18</td>
</tr>
<tr>
<td>Endoscopy Total Over 6 Weeks</td>
<td>309</td>
<td>180</td>
<td>180</td>
<td>180</td>
</tr>
<tr>
<td>Diagnostic Total Over 6 Weeks</td>
<td>988</td>
<td>586</td>
<td>377</td>
<td>248</td>
</tr>
</tbody>
</table>
c. Mental Health

Since the annual operational plan was agreed by the Board, a number of further key actions have been progressed:

- Relocation of the CAHMS services for Aberdeen and Aberdeen City into a single purpose designed centre of excellence. This has been a significant undertaking and the service was opened to users from July.

- Appointment of Dr Lynne Taylor as the Clinical Director for Psychology for NHS Grampian.

- Review of the application of the updated advice on new waiting times standards for CAHMS and psychological therapies. We have established a local Project Board to oversee this work and establishment of the required supporting data capture and performance monitoring systems.

- Agreement by the three Integration Joint Boards to enhance available resources within primary care using the Action 15 funding allocated by Scottish Government to enable implementation of key priorities within the NHS Scotland Mental Health Strategy.
Mental Health – performance summary

In terms of performance we have noted below the current position:

CAHMS

In terms of measurement against the NHS Scotland standard for CAHMS our performance for quarter ended June 2019 (the latest publication date) was:

- 326 children and young people started treatment at CAMHS services in Grampian, an increase of 6% from the previous quarter when 307 were seen.
- 51.2% were seen within 18 weeks, up from 43.3% during the previous quarter.

As reported previously to the Board and Performance Governance Committee, the current waiting times guidance does not record activity when we undertake the first CHOICE appointment for referrals to the service. Our current waiting time for a first CHOICE appointment is 6 weeks for Aberdeen City and Aberdeenshire and 12 weeks for Moray. Our reported performance at the end of August was 59%. The agreed AOP trajectories to 31 December 2020 are noted below:

<table>
<thead>
<tr>
<th>Actual (August)</th>
<th>By December 2019</th>
<th>By March 2020</th>
<th>By June 2020</th>
<th>By September 2020</th>
<th>By December 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>59%</td>
<td>65%</td>
<td>80%</td>
<td>85%</td>
<td>90%</td>
<td>90%</td>
</tr>
</tbody>
</table>

Psychological Therapies

In terms of measurement against the NHS Scotland standard our performance for quarter ended June 2019 (the latest publication date) was:

- 1057 people started treatment for Psychological Therapies in Grampian—10.56% more than during the previous quarter (956).
- The proportion of patients waiting less than 18 weeks was 72.9%—up from the previous quarter’s figure of 68.1%.

<table>
<thead>
<tr>
<th>Actual (August)</th>
<th>By December 2019</th>
<th>By March 2020</th>
<th>By June 2020</th>
<th>By September 2020</th>
<th>By December 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>61.5%</td>
<td>75%</td>
<td>75%</td>
<td>80%</td>
<td>85%</td>
<td>90%</td>
</tr>
</tbody>
</table>
Section 3: Finance

Key points we would highlight in relation to revenue and capital position.

Revenue

- NHS Grampian submitted the Quarter 1 Financial Update to Scottish Government in July.
- At the end of August, a revenue overspend of £1.95 million was reported. We have undertaken a full year forecast and have reported to Scottish Government that we will achieve the end of year position reflected in the AOP. NHS Grampian have planned to underspend against the RRL by £3m in current year and 2020/21 and to use this to contribute towards the forecast additional revenue expenditure required in 2021/22 to support the opening of the Baird and ANCHOR centre.
- In terms of current year, the main pressures leading to the overspend position at Month 5 are continued high usage of locum medical staffing and agency nursing in order to cover vacancies, maternity leave and other gaps in staffing rotas. An element of the locum medical and agency nursing staffing is funded through the elective care programme in order to enhance internal local capacity to address backlog and demand/capacity gaps.
- We are on target to deliver the Board savings plan of £10.2m, which in percentage terms is the lowest of any of the large territorial boards. Audit Scotland have consistently reported positively on the good financial planning, management and budgetary controls arrangements that have been implemented by the senior finance team.
- The forecast position is that this overspend will be recovered over the remainder of the year and revenue break even will be achieved for 2019/20. This includes achieving a surplus of £3.0 million for the year itself which will be returned to the Scottish Government in line with the three year financial trajectory contained within the Annual Operational Plan.
- There are a number of risks around the revenue position which will be monitored and managed during the second half of the financial year. These include the continued high use of supplementary staffing, new drug approvals through SMC and any financial impact of Brexit.
Capital

NHS Grampian's Capital Resource Limit is on target to be achieved.

The Board has an approved five year capital programme of £305m committed to supporting investment in its infrastructure. Key projects include:

- Baird Family Hospital and ANCHOR project (see separate briefing)
- Elective Care Project – investment in new facilities in Aberdeen, diagnostic investment in Elgin (MRI) and development of a number of community hubs
- Primary care developments in Northfield / Mastrick and North of Aberdeen City are being progressed, with planning commencing on other priority primary and community care needs in Aberdeen (Danestone), Aberdeenshire (Banchory and Ellon) and Moray (Keith).
- We are investing nearly £20m in upgrading inpatient mental health adult admission wards at Royal Cornhill Hospital (two of the six wards in the programme have been completed) and have developed the CAMHS Centre of Excellence.
- We are investing £52m in replacing and upgrading medical equipment across NHS Grampian. This will include replacing the Cyclotron (first Board in Scotland to replace this equipment which produces the materials essential to support PET scans), replacing our two cath labs, developing a hybrid Interventional Radiology theatre and potential expansion of our robotically assisted surgical capacity (we established the first service in Scotland).
- We will continue to invest in reducing backlog maintenance. As set out in the NHS Scotland State of the Estate report, the backlog maintenance on Aberdeen Royal Infirmary remains amongst the highest in Scotland, given its size and the age of the buildings (60% of NHSG premises are over 30 years old). The Board approved the Acute Reconfiguration Project (ARP) in 2012 to reduce high and significant backlog maintenance in inpatient areas. At this time the risk reassessed backlog maintenance was £193m at 1st April 2012. This included backlog maintenance and compliance with statutory standards but excluded functional suitability. The ARP which is now completed has reduced the overall backlog to £143m. The high and very high backlog risks have reduced from £76.5m at 1st April 2012 to £28.5m at 1st March 2018 (£48m reduction).
- We are developing a business case for consideration by the Board in December on an option to co-locate our Board administration functions at Woodhill House (main base for Aberdeenshire Council).
- NHS Grampian will host the North of Scotland HEPMA project which will see hospital electronic prescribing being rolled out across all secondary care sites in the North of Scotland over the next 3-4 years.
- We are developing our Digital Health and Care Strategy and are significantly progressing our move to establishment of electronic paper records (EPR programme)
Section 4: Health Improvement

Our aim is to improve the health of the population and to reduce the avoidable differences in health outcomes. In order to deliver our aim, action and participation is required from all those with responsibilities for improving health and reducing inequalities at every level. The local authority Chief Executives, the Health and Social Care Partnership Chief Officers, NHS Grampian Chief Executive and the Director of Public Health have begun work to map out our public health system and shared priorities, with the aim of identifying areas where there is added value of working together to support our local communities. The specialist public health workforce from across the agencies in the North East have also come together to consider our response to the Public Health Priorities in Scotland.

A public health performance framework is currently under development with the aim of providing transparency and accountability across the system. It is intended to sit alongside the other outcomes frameworks in operation. Whilst this is under development, for the purposes of the mid-year review we will highlight performance under the national Public Health Priorities.

Priority 1: A Scotland where we live in vibrant, healthy and safe places and communities

Community Planning Partnerships produce locality plans which cover smaller areas within the CPP area, usually focusing on areas that will benefit most from improvement. NHS Grampian has actively participated in these local discussions providing data on need, evidence of what might work, sharing practice from elsewhere in addition to participating in the discussions with communities.

Supporting and enabling sustainable communities is a key philosophy within Aberdeen’s LOIP. Our work involves leading collaborative efforts in environmental sustainability, encouraging active travel and reducing food poverty.

We are working with HMP & YOI Grampian and Community Justice colleagues to embed efforts to improve offender health within their plans. The 2018 DPH Annual Report provided an overview of the health needs of those involved in the Community Justice system and suggested areas for improvement.

Priority 2: A Scotland where we flourish in our early years

NHS Grampian has actively participated in inspections for children and young people in need of care and protection in Moray and Aberdeen City. Both reports identified areas of strength in particular staff were able to recognise neglect and plan support, effective response to immediate risk of significant harm, and a range of universal and targeted support was available for children, young people and their families. The Inspectors also confirmed that joint working was effectively promoted by leaders. The Inspectors identified areas for improvement for example being able to demonstrate improving trends for children and young people who are looked after. Work is underway in collaboration with academic and public sector colleagues to define and measure child neglect. NHS Grampian has commenced a revision of our Child Health 2020 Strategy.

Performance Targets:
Access to maternity services: We continue to deliver the standard in full with 92.8% booked for antenatal care by 12th week of gestation which is higher than the Scottish average.

Breastfeeding: We have seen a slight reduction with 37.6% of new-born children exclusively breastfed at 6-8 weeks. Improvement actions include increasing peer support to reduce drop off between birth and 6-8 weeks, in collaboration with partners promote e-learning courses for breastfeeding and weaning and enhance Breastfeeding Friendly schemes. NHS Grampian is working towards UNICEF Baby Friendly Gold Award.

**Priority 3: A Scotland where we have good mental wellbeing**

The three Grampian Health and Social Care partnerships have developed or in the process of developing a strategy to promote mental health and wellbeing including actions across the life stages, dealing with stigma and discrimination, suicide prevention and mental health improvement.

Examples of involving children, young people and families in the development of services which may affect their care includes the extensive consultation on the development of the CAMHS Link Centre, Aberdeen Imagineers and the Champions Boards.

**Performance Targets:**

There are no health improvement targets set for mental health and wellbeing. The focus of the improvement actions include:

A pan Grampian multiagency group has been convened to review support available across Tiers 1-4. A stakeholder event considered the mapping exercise and identified three areas for further development:

1. **Adverse Childhood Experiences:** each area has raised awareness of the impact of ACEs and are collaborating on a position statement to support staff to take appropriate action.
2. **Place Based:** There are currently a number of investment streams to support mental health of children and young people. A group has been established to consider best practice and produce a framework to support Integrated Children’s Services partnerships to take appropriate evidence based action.
3. **Parenting Programmes:** A number of examples of good practice but we are considering what and how we scale up this provision.

We are participating in a number of national pilots/programmes including Low Intensity Anxiety Management (LIAM), NES subgroup progressing action 3 of the Scottish Mental Health Strategy. Our training programme continues to raise awareness and skills of managers to address mental health issues in the workplace.

**Priority 4: A Scotland where we reduce the use of and harm from alcohol, tobacco and other drugs**
Strategy Development

NHS Grampian continues to work closely with the Alcohol and Drugs Partnerships in Grampian. The Public Health directorate supports sharing of good practice, evidence reviews and supports ADPs to ensure investment is based on evidence based policies, prevention and treatment interventions.

Examples of work include support for Aberdeen City to implement two LOIP priorities aimed at reducing drug related deaths (DRD) and harms from high risk alcohol consumption. In Aberdeenshire, the ADP strategy has been reviewed and work undertaken to ensure resource allocation supports delivery of outcomes. We are leading a human factors approach to understand and prevent drug related deaths involving multiple partners (SMS services, Social Work, Housing, Police, Fire Service etc). This has led to new models of care which public health colleagues are supporting evaluation and further service improvements. An evidence guide has been produced on ABI and DRD to guide action in Moray.

Performance Targets

Alcohol Brief Interventions: There has been an improvement in the total number of ABIs delivered in the health board area since 2015, mainly due to delivery in wider settings. In 2019/20 Q1, there were 1706 Alcohol Brief Interventions (ABI) carried out in Grampian - 25.6% of the annual target of 6,658. At least 80% are required to be delivered in priority settings with Grampian achieving 78.7% (1343).

Improvement actions in 19/20 for priority settings include: raising awareness of benefits of connecting ABI into chronic disease management clinics in general practice, training and implementation of ABI in MIUs, tests of change in ARI with a referral pathway into the alcohol liaison service and maternity services through further training of midwives. In wider settings we are working to embed alcohol screening and brief interventions into the wellbeing service, housing assessments/support projects and justice settings including police custody suites.

Treatment within 3 weeks of referral to alcohol and drugs services:

Alcohol: 93.8% in August 2019 compared to 93.0% in July.
Drugs: 96.9% in August 2019 compared to 96.0% in July.
Overall: 95.3% in August 2019 compared to 94.4% in July.
**Tobacco Control**

*Strategy Development:*

In collaboration with our partners we have reviewed our Tobacco Control strategic plan. This has been out to consultation and will be revised in light of comments.

*Performance Targets:*

NHS Grampian support for smoking cessation performed well in 2017/18 against the Scottish average:

- Pharmacy quits: 3rd highest success rate of getting people to a 12 week quit: 25% compared to the Scottish average 18%
- Non Pharmacy quits: highest success rate: 73%. The Scottish average is 33%
- Prison quits: highest success rate: 49%. The Scottish average is 22%

Between April 2018 and March 2019, 881 successful quits were achieved in the 40% most deprived area against a target of 919. This was a better position than anticipated, but still fell short of the target by 4%. The quit rate after 12 weeks was consistently higher than Scotland overall and within more deprived areas. Full published annual report due 22.10.19.

**Sexual Health and Blood Borne Virus:**

We continue to implement our Sexual Health and BBV strategy. Work includes free condom provision in over 100 outlets across the region, easily accessible digital information, increasing testing for blood borne viruses through Dry Blood Spot Testing, adopting a realistic medicine approach to support patients with their choice of care and treatment, widening access with 60% of new referrals for abortion are self-referrals and we continue to engage in wider partnerships to raise awareness of, prevention, testing and treatment options and reduction of stigma.

*Performance Targets:*

Across a range of metrics NHS Grampian is performing well. Pregnancies in young people are at the lowest rate for a decade and the lowest rate of any mainland Board.

We are committed to eradication of Hepatitis C achieving our treatment targets year on year.

New HIV infections has almost halved (12 in 2018 compared to 22 the previous year). Our Get Tested, Get Treated, Get Cured campaign has been adopted by other Boards. Our Positive Voice Grampian have championed ‘Fast Track Cities’ which is a global initiative to end HIV infections and stigma. Aberdeen City Council has pledged to sign the declaration of Paris later in 2019 with long term goals by 2030 to reduce to zero new HIV transmissions, zero HIV-related deaths and zero HIV-related stigma.

**Priority 5 A Scotland where we have a sustainable, inclusive economy with equality of outcomes for all**

*Strategy Development:*
NHS Grampian has worked very closely with Community Planning Partnerships within the North East in the development of the LOIPs, Locality Plans, Child Poverty Action Plans.

In addition, NHS Grampian has established a Health Inequalities working group to ensure equality is at the forefront of what we do. Actions arising from this group include the development of an inequalities dashboard for Board members, briefings for Governance Committee chairs, review of NHS Grampian procurement policy and tests of change within some of our priority areas for example utilising national funding to address Cancer Screening Equity. Work has commenced, target group identified, community champions are being recruited and community pharmacies engaged to deliver Making Every Opportunity Count.

Child Poverty Action Plans: NHS Grampian has actively participated in the development of Community Planning Partnership plans. However to ensure NHS Grampian plays an active role in the agenda the System Leadership Team has agreed actions for NHS Grampian to deliver.

Performance data indicates that 3905 Best Start Grant claims since December 2018 with total payments of £816,500. We receive data from Scottish Government which allows us to focus our improvement efforts. The new digital system for Health Visiting currently under development will allow us to monitor the number of families signposted to financial support services. The Family Nurse Partnership, launched in May 2015 in Grampian has demonstrated two clear outcomes; a reduced amount of time spent with input from social services and a reduced amount of time spent with housing services as clients move through the programme. We are working with our local authority colleagues to increase the uptake of free school meals which is currently estimated at 50%. Work is underway to put in place a midwifery and early years practitioners pathway to financial support services across Grampian.

Priority 6 A Scotland where we eat well, have a healthy weight and are physically active.

In collaboration with our partners we have translated the Healthier Future action plan to tackle obesity, improve nutrition and physical activity in Grampian. Consultation has concluded and plan is being finalised. The DPH annual report this year will focus on Obesity and encourage discussion across the partnerships as to action we can take as individuals, communities and/or organisations. In addition we have robust mechanisms in place to implement the Diabetes Framework.
**Performance Targets:** The DPH Annual Report 2019 will focus on tackling Obesity. It sets out the challenge; almost a quarter of children by the time they reach primary school are at risk of being overweight with 13% at risk of obesity. Two thirds of adults are obese or overweight in the North East. We aim to half the number of children who are obese by 2030 in the North East.

Dental registration rates in Grampian show steady growth. There is no longer significant differences in registration rates between children living in least and most deprived however this is not replicated in adults (79.7% in most deprived compared to 91.5% least deprived). There is no timely data for participation in our oral health improvement programmes – Childsmile, Caring for Smiles, Mouth Matters etc. however our oral health outcomes measures for children continue to improve.

P1 76% no obvious decay experience in 2018 compare to 70% in 2016

P7 78.8% no obvious decay experience in 2017 compared to 73.2% in 2015.

**Supported Self Management**

Strategy Development: Supported self management is a key pillar in the Clinical Strategy for Grampian. Action is co-ordinated through the Supported Self Management Transformation Board, convened in 2017 under the auspices of the Senior Management Team.

Performance Targets:

There are no nationally set targets. A supported self-management/Realistic Medicine conference was held on 10/10/19 and highlighted the range of good practice underway across the region. An example of good practice is the House of Care model which is being supported in 18 practices across Grampian with support from Alliance Scotland. The feedback from the initial practices has been extremely positive with patients, staff and practices reporting improvements in interactions, better job satisfaction, greater efficiencies in how the practice operates.
Appendix 1: Actions arising from the Annual Review

**Action 1:** Continue to deliver on its key responsibilities in terms of clinical governance, risk management, quality of care and patient safety.

**Response**

- To develop our Quality Management System the System Leadership Team (SLT) reviewed the processes for clinical governance, risk management and performance governance ensuring that these are fit for purpose, consistent with good practice, and support NHSG to apply intelligent board principles to the work of SLT, the Board and its sub-committees.
- The key areas identified by SLT for effective quality management to evidence that we are caring, listening and improving are: Performance, Assurance, Improvement and Risk. To facilitate the PAIR framework SLT has established subgroups with the purpose of providing clear cross system linkages giving SLT an oversight of all processes and emergent strategic issues.
- The **Clinical Quality and Safety Subgroup** is chaired by the Director of Nursing and provides a focus for learning, mitigation of clinical quality and safety of care risks and identification of areas for improvement.
- The Subgroup has cross-system representation and meets six weekly and reports to SLT after every meeting using the PAIR template report. Every second meeting (quarterly) a more formal report is provided. Following agreement at SLT this report is then submitted to the NHSG Clinical Governance Committee. This report includes:
  - Discussion items, actions and recommendations from the Subgroup.
  - Summary reports from each of the Sector Clinical Governance Groups.
  - The Clinical Quality and Safety of Care risk position.
  - Key quality and safety indicators from the Sector and overarching Clinical Risk Management Group (e.g. Adverse Events, Feedback and Complaints, Duty of Candour, HEI, Falls, Pressure Ulcers etc).
- The Head of Health Intelligence is a member of the Subgroup and through the Performance Intelligence Network (PIN) has undertaken a considerable amount of work progressing the Grampian Health Systems Outcomes Framework.
- Continuous improvement is one of the key enablers to deliver our agreed Clinical Strategy and to provide co-ordination and to maximise our impact we have an established Quality Improvement Hub with the focus of:
  - **Improvement Priorities:** A number of work areas support our local delivery of national improvement programmes e.g. SPSP and Excellence in Care. In addition we have supported system-wide improvement work e.g. Anticipatory Care Planning, Frailty, Diabetes. We are now giving improvement focus to the emerging Access QI programme with HIS, as one of the three Boards along with Tayside and Lothian working on this.
o **Building QI Capacity:** We offer a range of development opportunities from ½ day as part of the Career Aspirations programme up to a 9 day Lead Level programme. We are the first Board to have delivered the Scottish Coaching, Leading and Improvement (SCLIP) Programme locally and a geographical Scottish Improvement Leader (ScIL) programme in conjunction with Tayside. This has been possible because our Associate Director for Quality Improvement & Assurance is one of the Lead Faculty supporting national delivery with NES.

o **Collaborations:** Led by our Clinical Lead (ScIL) the North East of Scotland Quality Improvement Network NESQIN #inspiredbyQI has 100 + members and connects with neighbouring Boards and HSCPs. It meets 4 times a year to share learning, continue professional development and work collectively on improvements. Along with our local Universities our quality and safety work is showcased as part of our annual Quality and Safety in Healthcare event and Celebrating Excellence Events.

**NHSG Level 1 adverse event reviews 01.10.2018 – 30.09.2019**
- Our policy and process directly aligns with the National Framework, all terminology is consistent.
- **38 Level 1 reviews** commissioned in the last calendar year.
- 20 of the reviews have final reports uploaded, the rest are awaiting completion.
- In addition we use the reporting system to collate:
  - M&M discussions - most discussions relate to the death of patients and are not in themselves an adverse event
  - data on 2222 calls for review by resuscitation team
  - All substance misuse service deaths are recorded on the system
  - All deaths where individuals have been in contact with mental health services
  - We do not consider these to be category 1 events so do not routinely conduct Level 1 reviews for them unless an adverse event is identified.
- Suicides are considered on an individual basis by the adverse events group in Mental Health. They may be reviewed as a level 1 or 2 depending on the extent that the individual was in contact with services. A rationale is recorded on Datix to evidence decision making.

**NHSG complaints and SPSO summary 01.10.2018 – 30.09.2019**
- Our policy and process directly aligns with the Complaints Handling Procedure.
- **2005 complaints** were entered onto the system during this timeframe.
- **21 (i.e. 1.0%)** of the complaints during this time period have been identified by SPSO for their consideration. The SPSO did not follow up to full investigation in 5 cases. 14 cases are still being investigated and 2 have been investigated and were not upheld.
- This sounds at odds because we have had published reports, however, the SPSO can and do take many years to reach a conclusion. The SPSO has closed 56 complaints and 16 were upheld.
Governance

- All new major and extreme severity adverse events, all new major and moderate severity complaints, SPSO findings and new SPSO complaints are discussed at a weekly meeting attended by the Director of Nursing and the Medical Director. All overdue Level 1 events and SPSO responses are discussed and any concerns are escalated to the SLT meeting which occurs directly after. Each of the sectors/partnerships convenes a similar meeting and adverse events and reviews are on the agenda of them all.
- Data on Level 1 reviews and complaints and SPSO are discussed at each Clinical Governance Committee quarterly meeting. In addition, services present the learning from a Level 1 review and SPSO complaint at the NHSG Clinical Governance Committee. A development session is planned for the committee and board members in November on these areas of work.
- Current challenges include timely completion of reviews and complaints, and sharing of learning that we can evidence cross system.
- Current developments include use of snap survey to gather feedback from people who have been involved in a complaint. This data has been collected since the beginning of the year and enables us to gather thematic picture of where we can improve our complaints handling. This is being extended to include Level 1 review, from both staff and the public. It is anticipated this will be in use by the end of the year. It was on our action plan following the HIS baseline assessment.

Action 2: Keep the Health and Social Care Directorates informed of progress towards achieving all access targets and standards in line with agreed improvement trajectories, including the suite of elective care standards and mental health access standards.

Response

There are regular review meetings with Scottish Government Health and Social Care Directorates in relation to monitoring progress regarding access targets for elective care and mental health. A summary position is presented in our performance briefing above.

Action 3: Make progress in the priority area of Mental Health by ensuring that Board meets and maintains the National Access Standards for both CAMHS and Psychological Therapies.

Response

We are making progress towards the National Access Standards for both CAMHS and Psychological Therapies in line with the trajectories agreed within the Annual Operational Plan. A summary position is presented in our performance briefing above.
Action 4: Continue to review, update and maintain robust arrangements for controlling Healthcare Associated Infection.

Response

- Overall NHS Grampian has coped well in the first two quarters of 2019 that relate to HAI.
- Performance in relation to SABs have remained below the national average. CDI rates have continuously improved with the most recent local data (for the first time) demonstrating a position which will likely indicate we are now below the national average for Q2.
- This is represented by a reduction in confirmed CDI cases within NHSG of 37.5% percentage in comparison to Q1.
- The E-Coli bacteraemia figures for Q2 have also demonstrated a 9.8% reduction.
- A recent HAI inspection across 9 community hospitals in Moray and Aberdeenshire went well with 6 requirements and 2 recommendations which have been incorporated into an action plan.
- There has been an increased demand on staff in particular IPC and facilities and estates staff. These pressures have included a higher than average number of concurrent PAGs and IMTs; assurance required following the learning identified at the Queen Elizabeth Hospital and more recently Edinburgh Children’s hospital; new builds and upgrading of current facilities across Grampian. All demands have been met and managed due to the good working relationships with these teams and with service.

Action 5: Continue to achieve financial management targets.

Response

We continue to forecast achievement of the year end position in relation to RRL and CRL targets as reflected within the Annual Operational Plan.

Action 6: Continue to work with planning partners on the critical health and social care agenda.

Response

We assessed the status of health and social care integration using the framework provided by the Ministerial Steering Group. These assessments were undertaken jointly with the HSCPs, our Board and respective Local Authority Partners. The assessments demonstrated the good progress that we have made to progress the integration of health and social care and realise the benefits that this brings to providing care closer to home and prevents unnecessary admissions to hospital.
Performance Report to the Board

September 2019
Introduction

This report summarises

- current performance against the Board’s annual operational plan trajectories and progress against the actions in the annual operational plan letter from Scottish Government; and
- relevant information published by the NHS Information Services Division (ISD) regarding aspects of the Board’s performance.

The overall approach adopted is that performance management is integral to the delivery of quality and effective management, governance and accountability. The need for transparent and explicit links of performance management and reporting within the organisational structure at all levels is important.

The indicators noted below are a high level set of performance standards which are supported by a comprehensive framework of measures at directorate and service level. These are reported to and monitored by the relevant senior officers and their clinical and senior professional support staff.
Responsive

Unscheduled Care

<table>
<thead>
<tr>
<th>Annual Operational Plan</th>
<th>Performance</th>
</tr>
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<tbody>
<tr>
<td>95% of patients should wait no more than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment.</td>
<td>The percentage spending 4 hours or less in an A&amp;E department for the year ending 31 July 2019 was 93.8%, above the Scotland wide rate of 90.6%.</td>
</tr>
</tbody>
</table>

In common with elsewhere in Scotland, delivery of the 4 hour standard has been challenging. However, performance within NHS Grampian remains above the Scottish average in terms of performance against the national standard.

In terms of the latest published data for the year ending July 2019:

- The total number of attendances was 139,606 which represented a 0.2% increase from the same period one year previously (139,320). An increase of 0.3% was recorded across Scotland.
- The percentage spending 4 hours or less in an A&E department was 93.8% - down from 94.0% for the year ending June 2018. This was still well above the Scotland wide rate of 90.6%.

The weekly published performance during August has been:

<table>
<thead>
<tr>
<th>Week ending</th>
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<th>Week ending</th>
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<tbody>
<tr>
<td>4 Aug</td>
<td>11 Aug</td>
<td>18 Aug</td>
<td>25 Aug</td>
</tr>
<tr>
<td>Grampian</td>
<td>91.8%</td>
<td>82.2%</td>
<td>89.5%</td>
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<tr>
<td>Scotland</td>
<td>89.0%</td>
<td>88.4%</td>
<td>89.4%</td>
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As set out in recent performance reports to the Performance Governance Committee and the Board, pressures on our unscheduled care services continue. There is a separate paper on the Board agenda (October 2019) regarding unscheduled care, with the winter plan due to come to the Board for approval in November.

Delayed discharges

In terms of our performance in relation to delayed discharges, there has been a concerted effort in Grampian to reduce the number of people delayed in hospital awaiting discharge and the length of time they are delayed. Whilst there are fluctuations from month to month an overall downward trend has been delivered since the inception of the Integration Joint Boards.

Number of patients whose discharges was delayed as at July 2019:

- There were 115 patients delayed – up 11.6% from 103 in June. A smaller increase of 4.8% was recorded across Scotland.
- The number of delayed discharges in each Integrated Joint Board (IJB) was as follows: Aberdeen City: 33 (down 13.2% from June), Aberdeenshire: 55 (up 48.6% from June) and Moray: 24 (down 11.1% from June)
Comparison with prior three months (delayed discharges)

<table>
<thead>
<tr>
<th></th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
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<tbody>
<tr>
<td>Aberdeen</td>
<td>41</td>
<td>32</td>
<td>38</td>
<td>33</td>
</tr>
<tr>
<td>Aberdeenshire</td>
<td>49</td>
<td>40</td>
<td>37</td>
<td>55</td>
</tr>
<tr>
<td>Moray</td>
<td>20</td>
<td>32</td>
<td>27</td>
<td>24</td>
</tr>
</tbody>
</table>

- 18 (15.7%) of these delays were for patients with specific complex care needs. This compared to 19.4% across Scotland. Of the remaining 97 patients delayed at the census, 92 were due to health and social care reasons and five due to patient and family related reasons.

**Bed Days – July 2019:**

- Patients spent 3,464 days in hospital due to delays in discharge in Grampian. This represented a 17.2% increase from June when the total was 2,955 bed days. A smaller increase of 7.4% was recorded across Scotland.

- The number of bed days due to delayed discharges in each IJB was as follows: Aberdeen City: 1,115 (4.6% increase from June), Aberdeenshire: 1,523 (41.3% increase from June) and Moray: 698 (9.1% decrease from June)

Comparison with prior three months (bed days)

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<thead>
<tr>
<th></th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
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</thead>
<tbody>
<tr>
<td>Aberdeen</td>
<td>1,126</td>
<td>1,156</td>
<td>1,066</td>
<td>1,115</td>
</tr>
<tr>
<td>Aberdeenshire</td>
<td>1,306</td>
<td>1,512</td>
<td>1,078</td>
<td>1,523</td>
</tr>
<tr>
<td>Moray</td>
<td>926</td>
<td>810</td>
<td>768</td>
<td>698</td>
</tr>
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The Health and Social Care Partnerships are introducing additional efforts to reduce patients being delayed in hospital. These include extending staffing capacity and introducing new processes to improve timely and safe flow out of hospital. In some areas the establishment of interim and very sheltered housing flats will provide additional care outside of hospital.

**Annual Operational Plan - actions for 2019/20**

Health and Social Care Partnerships have developed performance plans for the following indicators:

- Unplanned admissions
- Unplanned bed days
- A&E attendances
- Delayed discharge bed days
- Last 6 months of life at home
- Balance of care

These plans set out how the partnerships, with their wider communities and the Board will deliver optimum performance within resources available. Each partnership has developed Strategic Commissioning Plans. The Aberdeen City Health & Social Care Partnership (ACHSCP) has published a new strategic plan for the years 2019-2022, with the Aberdeenshire (2020-2025) and Moray (2019-2022) Strategic Commissioning Plans under review at present.
These provide more detailed information as well as the demographic and workforce challenges which are faced and which could detrimentally impact on delivery of planned targets for the future. The Heath Board with its partners will continue to implement appropriate surge plans in line with the Scottish Government six essential actions focusing on areas such as:

- Cross system safety huddles (daily)
- Co-ordinated and supported patient flow co-ordination (including weekend activity)
- Reducing delays in transfer of patients to home or a community setting
- Supporting the public to access services where care and advice can be sought through planned pathways rather than using emergency or unscheduled capacity.

The Scottish Government have confirmed that an additional £465,000 will be made available to increase capacity across the Board and Integration Joint Boards to meet winter pressures.
Mental Health and Learning Disability Services

In terms of national standards for mental health and learning disabilities, the key targets relate to access to Child and Adolescent Mental Health Services (CAMHS) and Psychological Therapy services.

Current performance

Since the annual operational plan was agreed by the Board, a number of further key actions have been progressed:

- Relocation of the CAMHS services for Aberdeen and Aberdeen City into a single purpose designed centre of excellence. This has been a significant undertaking and the service was opened to users from July.

- Appointment of Dr Lynne Taylor as the Clinical Director for Psychology for NHS Grampian.

- Review of the application of the updated advice on new waiting times standards for CAMHS and psychological therapies. We have established a local Project Board to oversee this work and establishment of the required supporting data capture and performance monitoring systems.

- Agreement by the three Integration Joint Boards to enhance available resources within primary care using the Action 15 funding allocated by Scottish Government to enable implementation of key priorities within the NHS Scotland Mental Health Strategy.

In terms of performance we have noted below the current position:

a. CAMHS

In terms of measurement against the NHS Scotland standard for CAMHS our performance for quarter ended June 2019 (the latest publication date) was:

- 326 children and young people started treatment at CAMHS in Grampian, an increase of 6% from the previous quarter when 307 were seen.

- 51.2% were seen within 18 weeks, up from 43.3% during the previous quarter.

As reported to the Board and Performance Governance Committee previously the current waiting times guidance does not record activity when we undertake the first CHOICE appointment for referrals to the service. Our current waiting time for a first CHOICE appointment is 8 weeks for Aberdeen City and Aberdeenshire and 12 weeks for Moray.
b. Psychological Therapies

In terms of measurement against the NHS Scotland standard for psychological therapies our performance for quarter ended June 2019 (the latest publication date) was:

- 1057 people started treatment for Psychological Therapies in Grampian – 10.56% more than during the previous quarter (956).
- The proportion of patients waiting less than 18 weeks was 72.9% – up from the previous quarter’s figure of 68.1%.

**Annual Operational Plan – actions 2019/20**

As reflected in the Annual Operational Plan we have a comprehensive programme of actions to enhance access to mental health and learning disabilities across NHS Grampian. The Board will consider an update on the strategic commissioning review that is being undertaken at the October Board meeting.

Following submission of the Annual Operational Plan, we have now confirmed with Scottish Government the improvement trajectories to the end of 2020 as set out below:

**Access to CAMHS services**

<table>
<thead>
<tr>
<th>By December 2019</th>
<th>By March 2020</th>
<th>By June 2020</th>
<th>By September 2020</th>
<th>By December 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>65%</td>
<td>80%</td>
<td>85%</td>
<td>90%</td>
<td>90%</td>
</tr>
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</table>

**Access to Psychological Therapies**

<table>
<thead>
<tr>
<th>By December 2019</th>
<th>By March 2020</th>
<th>By June 2020</th>
<th>By September 2020</th>
<th>By December 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>75%</td>
<td>75%</td>
<td>80%</td>
<td>85%</td>
<td>90%</td>
</tr>
</tbody>
</table>
Elective Care

Treatment Time Guarantee and Outpatients

The performance in terms of the number of patients waiting longer than 12 weeks for a first outpatient appointments or treatment (inpatients/daycases) is shown below.

<table>
<thead>
<tr>
<th></th>
<th>6 Jan 2019</th>
<th>1 April 2019</th>
<th>30 June 2019</th>
<th>1 Sept 2019</th>
<th>Trajectory (Sep 2019)</th>
<th>Change since Jan 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatients</td>
<td>15,830</td>
<td>12,243</td>
<td>12,544</td>
<td>13,304</td>
<td>11,800</td>
<td>(2,526)</td>
</tr>
<tr>
<td>Treatment</td>
<td>5,654</td>
<td>4,752</td>
<td>4,325</td>
<td>4,200</td>
<td>3,925</td>
<td>(1,454)</td>
</tr>
</tbody>
</table>

The number of patients waiting for both a first outpatient appointment and treatment has improved since the start of the calendar year. The number of patients waiting for an outpatient appointment has however slightly increased since April due to available capacity both internally and externally being lower than projected. Capacity will be higher during the remainder of the financial year, including additional resources in Aberdeen, Elgin and at the Regional Treatment Centre, Stracathro.

Over the next 30 months, the Improvement Plan will make a phased, decisive improvement in the experience of patients waiting to be seen or treated measured at October 2019, October 2020 and Spring 2021.

Similar action is being taken in parallel with mental health waiting times through the recent Programme for Government as noted above.

Actions for 2019/20

The waiting time position is monitored weekly by members of the Board’s executive Leadership. Specialty teams review their performance, particularly when unexpected increases occur. This includes close scrutiny of elective classification status. There has been extensive modelling of demand and capacity at specialty level and a range of improvement options and their cost have been identified. Target operating plans are being produced at specialty level to ensure maximum efficiency is delivered.

The Board’s Annual Operational Plan for 2019/20 confirms the funding from Scottish Government to support the retention of the additional capacity sourced in 2018/19 whilst we progress plans for the new diagnostic and treatment centre and sourcing additional permanent workforce to reduce our current dependency on temporary staffing and use of the independent sector. We have also submitted a separate plan to significantly reduce the number of patients who have waited more than 78 weeks for treatment.

Longer term sustainability is dependent on new models of care being taken forward through the Board’s Elective Care programme and the wider population focus on prevention and self-management consistent with the Board’s clinical strategy.
Cancer

The statistics for cancer for the quarter to 30th June will be published on 24 September. The latest published results are as at 31st March 2019.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>31 days from decision to treat (95%)</td>
<td>Quarter to March 2019 – compliance rate with standard</td>
</tr>
<tr>
<td>62 days from urgent referral with suspicion of cancer (95%)</td>
<td>• 92.8% Grampian (31 day standard)</td>
</tr>
<tr>
<td></td>
<td>• 94.8% Scotland (31 day standard)</td>
</tr>
<tr>
<td></td>
<td>• 76.4% Grampian (62 day standard)</td>
</tr>
<tr>
<td></td>
<td>• 81.4% Scotland (62 day standard)</td>
</tr>
</tbody>
</table>

During the quarter ending 31 March 2019:

- 92.8% of patients in Grampian started treatment within 31 days, up from 90.1% in the previous quarter.

- 76.4% of patients in Grampian started treatment within the 62 days, down from 80.1% in the previous quarter and the lowest compliance achieved since the 95% standard came into effect in 2011.

The published performance highlights the continued challenges we face in meeting the 31 and 62 day access standards.

**Actions for 2019/20**

NHS Grampian is committed to ensuring that all those who require treatment for cancer should receive that treatment as soon as clinically appropriate. Improving cancer performance remains a Board priority as outlined within the Annual Operational Plan 2019/20 and we have established a robust cancer improvement action plan which seeks to deliver the recommendations of the Scottish Government’s Effective Cancer Management Framework. The NHS Grampian Cancer Local Improvement plan sets out our ambitions to fully explore, and implement where clinically appropriate, the Effective Cancer Management Framework peer review recommendations to improve cancer management.

To enhance our capacity to improve performance we have:

- Appointed a Medical Lead for Cancer Performance and a Head of Cancer (Pathways and Access) to provide the leadership and capacity to support the implementation of improvements across all cancer pathways and

- Increased multi-disciplinary team (MDT) coordinator capacity to ensure appropriate monitoring of patients and implementation of clinical management plans for all patients with a cancer diagnosis. Each cancer pathway has an action plan which is reviewed regularly and variance escalated.

NHS Grampian acknowledges that improvement against both 31 and 62 day standards is required and our focus for 2019/20 is to improve performance for all cancer pathways. Particular focus is on colorectal and urology pathways which accounted for 85% of NHS Grampian’s 62 day breaches in the first quarter of 2019.
We will focus on addressing ongoing capacity issues within endoscopy, which particularly impact on the colorectal screening pathway, and access to theatre capacity to ensure maximum utilization of available staffed capacity.

Recognising the significant staffing challenges which have impacted on capacity across NHS Grampian, a number of actions have been taken to effectively manage available resources whilst mitigating risk and ensuring appropriate governance. In order to achieve this, a clinically-led risk management system of clinical prioritization was introduced from June 2017 to enhance our ability to prioritise patient clinical need, as determined by the treating clinician. The system is underpinned by robust monitoring and escalation processes which were developed in partnership with Primary Care and includes ongoing assessment of clinical risk to ensure highest risk patient groups are identified. NHS Grampian is committed to ensuring all available staffed theatre resource is targeted at patients with the highest clinical need.

In order to achieve this we are progressing a number of short term actions to address the existing backlog, and medium and long term initiatives which are focused on sustainable performance improvement.

- Breach analysis to focus on areas of consistent failure and patients waiting over 100 days
- Systems of governance and assurance to monitor performance across all pathways
- Weekly cancer pathway tracking meetings to identify and ensure early escalation of patients deviating from expected timed pathways and actions taken to prevent breaches where possible
- Implementation of enhanced monitoring of available staffed theatre capacity across NHS Grampian with a view to identifying additional sessions for Colorectal, Urology and Breast.

These actions are underpinned by the following principles:

- As far as reasonably possible, patients requiring a procedure will be booked in turn
- Available staffed theatre capacity will be allocated to cancer cases as a matter of priority and
- All available staffed theatre capacity will be allocated to the next highest priority patients

A short term plan has been developed to address the existing backlog of patients waiting longer than 62 days for treatment. As we treat patients waiting longer than the 62 day pathway target, we recognize that our cancer performance in 2019/20 is likely to deteriorate further. Agreed short term actions are:

- Currently, urology and colon cancers account for 85% of patients waiting beyond 62 days for treatment. It is anticipated that the urology and colorectal backlog will be cleared in quarter three 2019 as three whole day sessions of staffed theatre capacity will be reallocated as capacity to treat urology and colorectal patients who have waited more than 62 days for treatment.
• Increase capacity for scoping through use of the private sector at Albyn Hospital, Aberdeen Health Village and Dr Gray’s Hospital.

• Appointment of an additional Urology consultant, colorectal nurse specialist

• Through enacting this short term plan, we will significantly reduce the number of patients waiting more than 62 days for treatment across urology and colorectal cancer pathways to approximately 12 by the end of quarter three 2019.

Recognising finite critical care capacity, and to minimize unintended consequences through creating bottlenecks in the system, this short term plan will be in place throughout the summer theatre timetable from June to September 2019. Enhanced monitoring of the 6-4-2 theatre session allocation process will continue beyond this timescale and support the actions within the medium term plan.

A high level plan has been developed to ensure sustainable achievement of both the 31 and 62 day standards beyond quarter three 2019/20. This seeks to maximize the utilization of core capacity across all elective sites within NHS Grampian and sets out our commitment to realizing the productivity and efficiency opportunities outlined within the NHS Grampian Waiting Times Improvement Plan.

We anticipate that our short term plan will address the existing backlog by quarter two/three 2019 through a number of key actions, one of which seeks to reallocate existing staffed theatre capacity. As the backlog is cleared in the short term, we will utilize reallocated staffed theatre capacity in the medium term to maintain our cancer performance, with a specific focus on colorectal, urology and breast cancer pathways.

In order to sustainably improve cancer performance a number of work streams and developments will be undertaken in the medium term. These are:

• Specialty level service reviews
• Consultant plan job template reviews
• Theatre timetable redesign
• Theatre capacity re-alignment across NHS elective sites
• Development of a regional ovarian cancer service for the North of Scotland and
• Increase capacity in endoscopy, radiology, PET and theatres as per 30 month waiting times improvement cancer plan.

These workstreams and developments have a number of interdependent improvement and sustainability initiatives.
Well Led

Financial performance – four months ending 31 July 2019

As at the end of July 2019, the Board has reported an overspend of £2.17 million on NHS directly controlled services. The July position had a net overspend of £0.236m, largely due to:

- Pay being overspent due to continued high usage of locum medics and agency nursing. Locum costs now 29% up on same period last year.

- Non pay was overspent due to medical supplies and hospital drugs being higher than forecast. These overspends were offset by higher than expected recoveries from provision of specialist treatment to patients outwith Grampian.

As reported previously, the level of overspend recorded at the end of the first quarter is higher than at the end of the first quarter in 2018/19 - £1.93 million in 2019/20 compared to £0.6 million in 2018/19. We are still forecasting a position of financial breakeven at the end of the year (31 March 2020).

None of the IJBs has yet produced results for the new financial year. The financial performance of the IJBs will be monitored each quarter at meetings between the Director of Finance, Chief Officers and Chief Financial Officers to assess any potential risks to the NHS Grampian position from overspends against IJB budgets.
Appendix 1: Information Services Division (ISD) published data

ISD of NHS National Services Scotland publishes regular data on aspects of Board performance and key indicators.

Below we have highlighted recent publications of interest:

- Scottish Stroke Improvement Programme
- Emergency admissions arising from falls
- Detecting cancer early
- Prescribing items and costs

Scottish Stroke Improvement Programme

The ISD publication on the Scottish Stroke Improvement Programme 2019 includes data from the Scottish Stroke Care audit describing the quality of care in each acute hospital in 2018. The following key points relate to Grampian:

- There were 820 confirmed strokes in Grampian during 2018. This was equivalent to a rate of 140 per 100,000 population and below the rate of 178 per 100,000 population across Scotland.

- 87% of stroke patients were admitted to a stroke unit within one day of admission at ARI (based on final diagnosis) up from 79% in 2017 and above the Scotland wide rate of 82%. ARI was one of only two hospitals to show a statistically significant improvement between 2017 and 2018. Dr Gray’s also recorded improvement but compliance remained below the Scotland rate at 76% compared to 68% in 2017.

- 80% of stroke patients had a swallow screening within 4 hours of admission at ARI in 2018, up from 79% in 2017 and 84% at Dr Gray’s. (Scotland - 80%).

- 96% of stroke patients had a brain scan within 24 hours of admission at ARI in 2018, up from 95% in 2017 and 95% at Dr Gray’s. (Scotland – 95%)

- 93% of acute ischaemic stroke patients were given aspirin in hospital within 1 day of admission at ARI in 2018, up from 92% in 2017, and 92% at Dr Gray’s. (Scotland – 92%)

Commenting on these results, Dr Mary Joan MacLeod, Consultant in stroke medicine explained the positive effect of the new ward area, flexibility of our nursing staff to cope with more patients than their complement, flexibility of the ward layout to allow us to have additional beds when demand is high. Our thrombolysis rates compare favorably to the rest of Scotland.

Following discussion at SLT we intend to look at how changes and developments in rehabilitation care are improving patient care and the way care is managed in hospital and community services.
Emergency admissions arising from falls

ISD has updated the annual publication of emergency admissions arising from falls during 2018/19. The following key points relate to Grampian:

- The admission rate due to falls was 5.6 per 1000 population (a total of 3282 admissions). This represented an increase of 7.2% from 2017/18 (5.2 per 1000 population) but was well below the Scotland wide rate of 6.9 per 1000 population.

- The admission rate was below the Scotland wide rate in each of the three local authorities with Aberdeenshire recording the lowest rate of 5.0 per 1000 population, Moray recording 5.3 and Aberdeen City, 6.4.

- There is a strong relationship between a person’s age and the likelihood of being admitted to hospital as a result of a fall. Those aged 65 and over are over six times more likely to have an emergency admission compared to those aged under 65 with an admission rate of 17.6 per 1000 population in 2018/19. This compared to 22.4 per 1000 population across Scotland.

- The admission rate amongst over 65s was markedly higher in Aberdeen City at 23.4 per 1000. This was the only local authority to record above the Scotland rate with Aberdeenshire recording 14.7 per 1000 population and Moray, 15.1 (see graph)

We have begun to assess where there is greatest potential for avoiding emergency admissions from falls. This work combines demographics and patient characteristics with evidence of effective interventions.
Detecting cancer early

This ISD publication is based on patients diagnosed with cancer during the two-year period during 2017 and 2018, with the following points relating to Grampian:

- 22.2% of people were diagnosed with breast, colorectal and lung cancer at the earliest stage (stage 1) in Grampian. This is below the rate of 25.5% across Scotland and a drop from 22.6% for 2016 and 2017. It represented an improvement of 2.8% from the baseline years of 2010 and 2011 but this was a much lower rate of improvement than across Scotland (9.4%).

- For individual cancers the proportion diagnosed at stage 1 were as follows:
  - Breast: 42.6% compared to 40.4% across Scotland
  - Colorectal: 14.0% compared to 16.4% across Scotland
  - Lung: 10.0% compared to 17.9% across Scotland

- 13.2% of patients were recorded with a ‘not known’ stage of disease compared to only 6.0% across Scotland. 23.8% of lung cancer patients were diagnosed at an unknown stage compared to 7.2% across Scotland. This was due to moving to using the updated staging classification TNM8 a year early.

The NHS Grampian/University of Aberdeen cancer research partnership has focused on the early diagnosis of cancer, patient and service factors which predict early versus late stage disease, and whether diagnostic route can influence outcomes. The following highlights have been drawn from our research:

- Patient factors such as age, gender, socioeconomic status, and presence of comorbidities can influence cancer stage at diagnosis and cancer survival, but the relationship varies with cancer type.
- Cancer biology including histological subtype and grade are poorly accounted for in published epidemiological studies and not considered at all in national DCE reports.
- Within NHS Grampian, there is evidence that rural patients have poorer one-year survival after a cancer diagnosis, but no evidence that they face diagnostic delays or have later stage cancers at diagnosis.
- Patients diagnosed via screening are three times more likely to have early stage disease than those referred via the urgent suspected cancer route
- No prior GP contact increases the odds of emergency cancer presentation
- Patients diagnosed via emergency admission are twice as likely to have late stage disease than those referred via the USC route, and twice as likely to die from cancer within one year of diagnosis.

Future research priorities include building datasets that include pathology data and datasets that capture processes and outcomes after diagnosis, and innovative interventions to improve outcomes in those at high risk of adverse cancer outcomes.
Prescribing items and costs

The ISD publication on prescribing items and costs in 2018/19 highlighted the following points in relation to Grampian:

• The total number of prescription items dispensed in Grampian in 2018/19 was 9.3 million items, representing a decrease of 0.1% compared to 2017/18. Across Scotland there has been very little variation in prescribing volume in the last year – a slight increase of 0.03%.

• The Gross Ingredient Cost per prescription item dispensed in Grampian decreased by 5.2% between 2017/18 and 2018/19, from £12.23 to £11.60. Across Scotland the decrease was 2.0%, with the cost per item reducing from an average of £11.27 to £11.05.

• 16.0 prescription items were dispensed per head of population in Grampian in 2018/19 compared to 19.0 items per head of population across Scotland. Only Lothian dispensed fewer items per head of population (14.3).

1 This system is currently under evaluation
Strategic Plan
2019-2022

Aberdeen City Health & Social Care Partnership
A caring partnership
Strategic Plan 2019-2022
If you require further information about any aspect of this document, please contact:

Aberdeen City Health & Social Care Partnership
Community Health and Care Village
50 Frederick Street
Aberdeen
AB24 5HY
Contents

1  Strategy on a page
2  Introduction
3  Our Services
4  Our Strategic Aims
5  Our Enablers
6  How will we know we are making a difference
7  Summary Aims, Priorities and Commitments

Appendices
1. Housing Contribution Statement (tbc)
2. Equality Impact Assessment (tbc)
This document is also available in large print, other formats and other languages, on request.

Please contact the Aberdeen City Health & Social Care Partnership on 01224 625729

For help with language / interpreting and other formats of communication support, please contact 01224 522856 / 522047
Strategic Plan on a Page

OUR VALUES:
- Caring
- Person Centred
- Enabling

OUR VISION:
“We are a caring partnership, working in and with our communities to enable people to achieve fulfilling, healthier lives.”

Prevention
- Working with our partners to achieve positive outcomes for people and lessen the need for formal support

Resilience
- Working with our partners to support people so that they can cope with, and where possible, overcome the health and wellbeing challenges they may face.

Enabling
- Ensuring that the right care is provided in the right place and at the right time when people are in need. Ensuring that our systems are as simple and efficient as possible.

Connections
- Develop meaningful community connections and relationships with people to promote better inclusion, health and wellbeing and combat social isolation

Communities
- Working with our communities, recognising the valuable role that people have in supporting themselves to stay well and supporting each other when care is needed.

Mental Health Strategy Implementation Plan
Action 15 Plan
Primary Care Improvement Plan
Learning Disability Implementation Plan
Carers Strategy Implementation Plan
Resilient, Supported and Included Plan
Autism Implementation Plan
Workforce Plan
TEC Framework
Digital Strategy
Locality Plans
Transformation Plan
Reimagining Primary & Community Care
Medium Term Financial Plan
Engagement, Empowerment & Partition Strategy

More adults able to look after their health
More adults supported to live at home independently
Greater use of community alarm and telecare service
More unpaid carers supported
Primary Care Improvement Plan actions completed
Secondary delayed discharges
Greater proportion of adults aged 75+ living in a community setting
Coordinated Engagement Plan produced
Reduced levels of social isolation

HOW WILL WE KNOW WE HAVE BEEN SUCCESSFUL?
IJB Chair Foreword
To be inserted

Chief Officer Foreword
To be inserted
2. Introduction

Aberdeen City Council (ACC) and NHS Grampian (NHSG) delegate a wide range of adult health and social care services to Aberdeen City Health & Social Care Partnership (ACHSCP).

Our Strategic Plan outlines how we plan to deliver these. This plan belongs to everyone living and working in Aberdeen. In developing it, we met with many people – individuals and professional bodies - across the city to help us understand how they want services to look and feel, what is important to them, and what we should focus on.

This gave us lots of information about what is going well, what needs to be improved and what we need to concentrate on. It also highlighted that there are many and varied needs in relation to health and social care services and we have worked to shape our strategic plan to meet these.

Principles of the Strategic Plan

Our Strategic Plan will set the focus and direction for the next three years, based on clear principles and priorities. The partnership also has to take into account the national integration principles when preparing our plan.

Our guiding principles is to provide integrated services which improve people's health and wellbeing. These services will be provided in ways which:

- Are joined up and easy for people to access
- Take account of people's individual needs
- Take account of the particular characteristics and circumstances of different service users in different parts of the city
- Respect the rights and dignity of service users
- Take account of the participation by service users in the community in which service users live
- Protect and improve the safety of service users
- Improves the quality of the service
- Are planned and led locally for the benefit of service users, people who look after service users and the people who provide health or social care services
- Anticipate people's needs and prevent them arising
- Make the best use of facilities, people and resources

A key challenge is for these principles to be part and parcel of our day-to-day practice. It is important to us as a partnership that our actions meet the expectations that are placed on us.
Our principles are underpinned by our vision:

“We are a caring partnership working in and with our communities to enable people to achieve fulfilling, healthier lives.”

We will achieve this by being:

- Caring
- Person centred
- Enabling

Our Strategic Plan is based on

- conversations with people
- integration principles
- consideration of local and national strategies
- our vision
- our values

Our Strategic Plan seeks to establish a shared understanding of our challenges and priorities.

We face demographic and financial challenges now and in the future. Satisfying the increasing demand for our services will be a significant challenge with fewer resources available.

Doing more of the same is not a sustainable option for us and so we will need to have honest conversations with the local population about their expectations and how we can enable people to keep well and, where appropriate, support them to manage their conditions.
We will deliver on our Strategic Plan under five broad strategic aims:

<table>
<thead>
<tr>
<th>Strategic aim</th>
<th>What does this mean?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Prevention</td>
<td>We will work with our partners to achieve positive individual outcomes and lessen the need for formal support.</td>
</tr>
<tr>
<td>2. Resilience</td>
<td>Supporting people and organisations so they can cope with, and where possible overcome, the health and wellbeing challenges they might face.</td>
</tr>
<tr>
<td>3. Enabling</td>
<td>Ensuring that the right care is provided in the right place and at the right time when people are in need.</td>
</tr>
<tr>
<td>4. Connections</td>
<td>Develop meaningful community connections and relationships with people to promote better inclusion, health and wellbeing and to combat social isolation.</td>
</tr>
<tr>
<td>5. Communities</td>
<td>Working with our communities, recognising the valuable role that people have in supporting themselves to stay well and supporting each other when care is needed.</td>
</tr>
</tbody>
</table>

We accept that we will have to reshape and transform how and where we deliver our services.

We remain ambitious to be recognised as an innovative and high-performing partnership.

With the support of the people of Aberdeen and our many valued partners we are confident that we will achieve this.
Our Strategic Plan is about working in partnership

Our strategy will play an important role in ensuring that people's experiences match or exceed their expectations when they use our services.

The scope of our partnership's activities has been formally outlined in our Integration Scheme¹ and consists of services from the health, social care, third, independent and housing sectors, which are all committed to providing high-quality integrated services to our citizens.

We recognise that working collaboratively with all our community planning partners is a positive and productive thing to do and we will seek to co-ordinate our activities so that they work seamlessly together.

Our plan has been strongly influenced by

1. Scotland's public health priorities² have strongly influenced the development of this plan. Their stated aim for people to thrive and be as healthy as possible is set within a broader desire to reshape our attitudes towards health and well-being:

   • a Scotland where we live in vibrant, healthy and safe places and communities
   • a Scotland where we flourish in our early years
   • a Scotland where we have good mental wellbeing
   • a Scotland where we reduce the use of and harm from alcohol, tobacco and other drugs
   • a Scotland where we have a sustainable, inclusive economy with equality of outcomes for all
   • a Scotland where we eat well, have a healthy weight and are physically active

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¹ http://www.aberdeencityhscp.scot/contentassets/47a823b88e3c4f26f2630d112000cb644a1/aberdeen-city--integration-scheme.pdf
2. The Scottish Government’s Health and Social Care Delivery Plan 2016³ and its focus on:
   - better care
   - better health
   - better value

3. Effective community planning arrangements will help us to deliver better services and achieve better outcomes for our citizens and communities. The Community Planning Aberdeen (CPA) Local Outcome Improvement Plan (LOIP)⁴ sets out a multi-agency approach to make Aberdeen a better place to live and work in. The partnership is a member of the CPA and recognises the value of all partners working together to address our common challenges. The actions set out in this Strategic Plan will make a significant contribution towards fulfilling the LOIP’s ‘Place’ and ‘People’ objectives.

4. Similarly, a close alignment with the priorities (Prevention, Self-Management, Planned Care, Unscheduled Care) set out in NHS Grampian’s Clinical Strategy (2016-2021)⁵ will ensure improved experiences and outcomes for the people who use our services and their carers.

We have been working hard since we started as a partnership in spring 2016 to lay out our ambitions and directions in documents which can help guide and shape how we deliver all of our different health and social care services.

Following the publication of this new Strategic Plan, we will take the opportunity to take a fresh look at our delivery plans to ensure they continue to reflect the ambitions and priorities set out in this overarching plan.

⁴ https://communityplanningaberdeen.org.uk/aberdeen-city-local-outcome-improvement-plan-2016-26/
⁵ http://foi.nhsgroup.nhs.uk/globalassets/foi/staticfiles/medical/foi/clinicalstrategy_public.pdf
3. our services

Local Outcome Improvement Plan (LOIP)

Strategic Plan

Locality Plans

Strategic Commissioning Implementation Plan

Transformation Plan

Re-imagining Primary & Community Care
Carers Strategy
Learning Disability Strategy
Mental Health Strategy
Autism Strategy

Figure 2 ACHSCP Strategic Portfolio
The IJB also has a strategic planning responsibility for some specific services which cover the whole Grampian area and some services which are delivered in acute hospital settings. (Table 2).

Our Strategic Plan applies to these services too, as we need to make sure that the ways in which they are delivered, match our objectives and priorities.

### Table 2 ACHSCP Strategic Planning (Hosted/Acute) Responsibilities.

<table>
<thead>
<tr>
<th>Grampian-wide service we are responsible for</th>
<th>Hospital services we are responsible for</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Intermediate Care of the Elderly and Specialist Rehabilitation</td>
<td>• Accident and Emergency</td>
</tr>
<tr>
<td>• Sexual Health</td>
<td>• Inpatient hospital services</td>
</tr>
<tr>
<td>• Acute Mental Health and Learning Disability (decision pending)</td>
<td>• General medicine</td>
</tr>
<tr>
<td></td>
<td>• Geriatric medicine</td>
</tr>
<tr>
<td></td>
<td>• Rehabilitation medicine</td>
</tr>
<tr>
<td></td>
<td>• Respiratory medicine</td>
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<tr>
<td></td>
<td>• Palliative care</td>
</tr>
<tr>
<td></td>
<td>• Mental health</td>
</tr>
<tr>
<td></td>
<td>• Learning disability</td>
</tr>
</tbody>
</table>
The partnership’s Chief Officer also has operational responsibility for School Nursing and Health Visiting. Better outcomes for the children and young people in Aberdeen will be achieved by working more collaboratively with children’s services and aligning our respective activities more fully. Working together with our wider partners, we aim to ensure that transitions between children’s and adult services are as smooth as possible for those who require care and their carers.

We know that many adults in poor physical and mental health – who may have housing difficulties, substance misuse challenges and challenging family relationships – can trace their current experiences back to adverse events in childhood. We recognise that the first few years are critical to a child’s development and that positive interventions at this stage can be crucially important.

Transition from childhood through adolescence to adulthood can be unsettling for many people. We recognise that early engagement with young adults and their families can ease anxieties and reduce the likelihood of harmful consequences to health and wellbeing.

Good quality housing and related services also play a key role in enabling people to be able to live independently at home for as long as is reasonably practicable.

The Aberdeen City Council Local Housing Strategy (LHS) 2018-2023 sets out how local need and demand will be addressed and how this contributes to the national housing priorities. The strategy aims to deliver six strategic outcomes:

1. There is an adequate supply of housing across all tenures and homes are the right size, type and location that people want to live in with access to suitable services and facilities.
2. Homelessness is prevented and alleviated.
3. People are supported to live, as far as is reasonably practicable, independently at home or in a homely setting in their community.
4. Consumer knowledge, management standards and property condition are improved in the private rented sector.
5. Fuel poverty is reduced which contributes to meeting climate change targets.
6. The quality of housing of all tenures is improved across the city.

We are committed to working with our housing colleagues to support the fulfilment of these outcomes. The Housing Contribution Statement at Appendix X sets out how we will work with housing colleagues to deliver the aims of this strategy.

We recognise, too, that working with all our community planning partners is a good and positive thing to do and we have actively sought to align our activities as best we can.
In 2030 Aberdeen will be one of the healthiest places to live in Europe because...........

Everyone is as healthy as can be, has the knowledge, understanding and skills to look after themselves, their families and their communities.

Positive mental health and wellbeing is shared by all.

The healthiest choice is the easiest and preferred option.

People know who to turn to by being able to easily access health information.

Health status is shared across the City – health inequalities are uncommon.

People are safe, healthy, wealthy and happy.

The City is safe to live, work and play.

People are safe, healthy, wealthy and happy.

Businesses work closely with communities and volunteers.

People take responsibility for their own health and participate in preventative and anticipatory care.

There is a sense of pride and passion in Aberdeen.

Equal opportunities are enjoyed by all.

Citizens of Aberdeen are physically connected – it is easy to get in, out and around the City.

There is a strong sense of independence, resilience, confidence, self-esteem and aspiration within our communities.

People of Aberdeen are socially and digitally connected.
4.1 Prevention

We recognise that if we want to improve the health and wellbeing of our local people, we must identify and overcome any barriers to change.

We strongly believe that compassionate and inclusive leadership can help to break down ingrained attitudes and unlock the partnership's potential to transform services and we will work with our partners to enable the necessary changes to happen.

We also recognise that we need to engage with people about their experiences and focus on improved outcomes.

Most people remain relatively healthy and active without the need for formal supports and services. Although health problems generally increase with age, ill health and disability should not be an inevitable consequence of growing older in Aberdeen.

We want to strengthen our early, preventative interventions and focus on the promotion of good, positive physical and mental health and wellbeing for all people across all age-groups and client groups.

Mental health issues are a significant public health challenge which many of us, our friends and our families will experience. Such issues can have an impact on a person's ability to function and live independently and can affect other people in their network of family and friends.

We aim to provide help from the right person, in the right place and at the right time. This means developing appropriate services which are more quickly accessible and available locally for all levels of mental health problems. We continue to move away from hospital-based services as the main mental health provision to develop community-based care and treatment resources where there is a significant emphasis on prevention and supported self-management.

We will seek to ensure that our citizens enjoy the best possible mental health and wellbeing and that when anyone begins to experience poor mental health, appropriate supports are available in their communities for them to access.

We are very aware that each person's recovery journey is unique to them. We are keen to work with and alongside them by delivering services that promote a “rights” based model which is focused on their personal recovery and enduring quality of life.
The national Mental Health Strategy 2017-2027\(^7\) has prevention and early intervention as one of its five themes and outlines key action points associated with this. This national strategy will inform and influence the development of the partnership's own mental health strategy.

**Health inequalities** across the city are unfair and avoidable. Reducing and overcoming such inequalities underpins everything that we understand about the health and wellbeing of our local population and the activities and interventions which we propose to implement to improve this.

Deprivation is a key driver of poor health and inequalities across our communities and we welcome Aberdeen City Council's anti-poverty strategy ‘Towards a Fairer Aberdeen That Prospers For All 2017-2020’ as a significant statement of intent to remedy such matters.

Health and social care partnerships have a duty, under the Fairer Scotland Duty, to contribute to reducing health inequalities. We will always seek to understand better the health and wellbeing of our local population and the factors which contribute to unequal health outcomes.

We will, with our community planning partners, use this information to take appropriate actions to reduce the health inequalities in our city.

**Alcohol and drug use** significantly contribute to poorer health and wellbeing across all parts of our city. Much of the harm caused by substance use can be prevented through joined-up health and social care services undertaking evidence-based early intervention. There can be many personal challenges to overcome but we need to make a person's recovery journey easier by removing the stigma associated with seeking help.

We will seek innovative ways of tackling substance use in all its forms and we will provide accessible, high-quality services for people who need more intensive support and treatment.

We will support our local Alcohol and Drugs Partnership to deliver the national strategy “Rights, respect and recovery: alcohol and drug treatment strategy” \(^8\)

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\(^7\)https://www.gov.scot/publications/mental-health-strategy-2017-2027/
\(^8\)https://www.gov.scot/publications/rights-respect-recovery/
4.2 Resilience

Resilience can be understood to be the ways in which people and organisations adapt to circumstances that may be less than stable or positive. It is not a new concept, but it is one that can significantly influence our attitudes and behaviours in response to life’s day-to-day challenges.

Supported self-management means moving away from a model where people are passive recipients of care and treatment towards a more collaborative relationship where they are active partners taking greater responsibility for their own health and wellbeing. Many people with long-term conditions already make appropriate decisions and manage many factors that contribute to their health and wellbeing on a day-to-day basis. For this shift to be effective, people need to have opportunities to develop their knowledge, skills and confidence to make informed decisions and adapt their health-related behaviours. They also need to have access to the necessary expertise to support them in overcoming barriers and achieving their goals.

There is no shortage of health improvement messages, including keeping physically active, minimising our alcohol intake and eating five portions of fruit and vegetables a day; what is also needed is an approach that recognises our experiences of the complexity and cumulative impact of our health condition(s), and an understanding of what may work for each individual and our desired personal outcomes.

Unpaid carers are significant partners and our health and social care services could not function as well as they do were it not for their contribution. We will ensure that the support offered to all carers, is targeted both at their individual outcomes and the personal outcomes of those being cared for.

Our Carers Strategy 2018-2020 sets out key actions that will support our many unpaid carers with the challenges that they experience regularly to enable them to have a life outwith caring if they so choose.

Priorities

Promote and support self-management and independent living for individuals
Value and support unpaid carers

Commitments

We will continue to invest in our ‘Promoting self-management and building community capacity’ transformation portfolio
We will our unpaid carers to identify as carers, to manage their caring role, to be involved in the planning of services for the cared for person and to have a life alongside caring if they so choose

Evidence

% of adults able to look after their health
% adults supported to live at home independently
Use of community alarm and telecare services
Number of unpaid carers supported
Feedback from unpaid carers in relation to support, involvement and having a life alongside caring

9https://www2.gov.scot/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey
4.3 Enabling

This approach means services are tailored to the needs of individual people, so that they have access to the right care, in the right place at the right time. It means that there are no in-built assumptions of what someone needs or a uniform ‘one size fits all’ provision but there are instead appropriate directions to other resources and services as and when appropriate for each individual.

Primary care is a crucial area of operation within the partnership, providing appropriate advice and treatment for physical and mental health illnesses and conditions across all ages. It is the first point of healthcare contact for many people and the gateway to many other health services.

We know that we have workforce recruitment challenges to overcome but even so, this sector has shown a continuing ability to introduce new ways of delivering healthcare. It has a key role to play in promoting people’s health and wellbeing and maintaining their independence at home in the community.

Our Primary Care Improvement Plan outlines our proposed initiatives to address this sector’s significant operating challenges.

We are mindful, though, of those who are ‘furthest from the point of care’ – not in a geographical sense but because of their substance use, poor mental health, complexity of ill-health, disability or vulnerability.
Their numbers may be small compared to some other population groups but the impact of getting it right for them may well be proportionately greater. This aim is not just about better and more effective use of what we currently have but actively redesigning to deliver improved experiences and outcomes.

Palliative care seeks to improve the quality of life of people who have a terminal illness or life-limiting conditions. End-of-life care is that part of palliative care which seeks to ensure that a person dies as peacefully and with as much dignity as possible.

We recognise the need to be responsive to the changing preferences and priorities of people with advanced illness and those of their carers. The choices that are expressed after diagnosis may well change later; for example, most people, when asked, initially express a preference for dying at home but in fact most die in hospital.

There are different reasons that explain this, but conversations about sensitive anticipatory planning will help ensure that the holistic care that is put in place meets the needs and wishes of the individual and, where appropriate, their carer.

The national Strategic Framework for Action on Palliative and End-of-Life Care says that by 2021 everyone who needs palliative care will have access to it.

Evidence

<table>
<thead>
<tr>
<th>Primary Care Improvement Plan actions completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of adults aged 75+ living in a community setting</td>
</tr>
<tr>
<td>Number of delayed discharges</td>
</tr>
<tr>
<td>Proportion of last 6 months of life spent at home or in a community setting</td>
</tr>
</tbody>
</table>

4.4 Connections

We strongly believe that those living, working and volunteering locally are best placed to identify local issues and needs; to suggest how these needs might be addressed; to prioritise the needs based on what is most important to the local community; and reflect all of these within an agreed action plan for the community.

We will seek to make open and ongoing engagement with our local population a defining feature of who we are as a partnership. We will continue to engage with our localities, develop better relationships with their residents and work together to support a quality of life that is as good, positive and active as possible.

People are healthier when they feel connected to things that matter to them. This is why the IJB has previously endorsed Community Planning Aberdeen’s ‘Engagement, Participation and Empowerment’ Strategy\(^\text{12}\). Working with our citizens to co-produce the outcomes that matter to them is an important principle for us.

We want to promote and develop the wellbeing of our communities by increasing opportunities for the people who live in these areas to shape their own lives and take part in local decision-making. This means that we:

- start with the assets and resources in our communities and identify opportunities and strengths;
- see people as having something valuable to contribute and support them to develop their potential in adding social value to their communities;
- focus on communities, encouraging and adding social value at every opportunity.

The IJB does not have a formal responsibility for transport connections and resources but we recognise that for many people an ambition of feeling ‘better connected’ will be not be realised if transport challenges are not addressed.

Perceptions of loneliness and isolation can differ across client groups and age groups. People’s perception of how lonely they are and the impact of this can be associated with an increased risk of poor health, increased attendance at GP surgeries and A&E Depts and in some instances, early death.

Offering different opportunities, depending on who we are and where we are, can help address these challenges. See for example, the partnership’s Learning Disability Strategy ‘A’thegether in Aberdeen 2018-2023\(^\text{13}\) which has as its first outcome “people feel connected to their communities”.

\(^\text{13}\)https://www.aberdeencityhscp.scot/globalassets/atthegether-in-aberdeen-strategy.pdf
4.5 Communities

We recognise the value of an asset-based approach to developing effective and sustainable models of care that focus on the health and wellbeing of our local population. We will seek to build on the existing assets and strengths within our communities and strive to ensure that our citizens and communities are fully involved in the design and delivery of services.

Localities are intended to be the engine room of integration, bringing together our citizens, unpaid carers and professionals from the health, social care, third, independent and housing sectors to reshape our services based on informed practice and local insights.

The decision to implement a four-locality model was taken in the pre-integration shadow year.

Our proposed three-locality model (Figure 3.1) will result in a closer alignment with community planning structures and activities, better partner collaborations, more public clarity and a better focus on areas where people experience poorer outcomes. These three localities (North, Central and South) again cover the whole city as the legislation14 obliges and, crucially, the three community planning localities would be wholly within their respective ACHSCP localities.

Many of our services are delivered by our partners in the third, independent and housing sectors. Many organisations in these sectors have positive relationships with the people who use their services and their carers and have wider connections with our local communities.

The depth of the relationships that we have with these many different organisations is important to us. Market fragility can cause uncertainty and unexpected change to the detriment of the organisations who are delivering services, their staff members and those people who use and often depend on these services.

We strongly believe that well-supported and well-resourced care makes a significant contribution towards a more stable health and care environment and the development of enhanced models of care. Our Market Facilitation Statement15 shows how we will seek to develop the sustainability of our valued providers.

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A recent consultation on this proposed three-locality model produced a favourable response.
5. Our Enablers

Our enablers are those fundamental elements which we need to develop further in order to meet our strategic objectives.

- empowered staff
- principled commissioning
- digital transformation
- sustainable finance

It is a good and positive thing to develop these in their own right as well as because of the positive contribution that they make to our activities.

5.1 Empowered staff

Our staff groups across the health, social care, third, independent and housing sectors are pivotal to our aspirations – and there is a strong relationship between the morale of staff and people’s experiences of using our health and social care services.

Valuing our staff and empowering them all to work as positively and collaboratively as possible will be crucial to delivering safe, caring, responsive and effective health and social care services. Collaborative leadership will provide the supports that our staff need to flourish but for this to be evident we will need to increase opportunities for integrated leadership development to help our leaders work more collaboratively.

Recruitment and retention of staff is a real challenge in different parts of the partnership and it is likely that new roles and new working practices will be needed as we move towards more anticipatory and preventative approaches. We have significant opportunities to work with our local regional college and universities to be truly innovative in how we recruit, develop and retain our staff across all sectors and job roles.

We are mindful that organisational cultures can be a barrier to change and are keen to reconcile these so that different professions and staff groups understand each other’s roles, responsibilities and perspectives more fully.
We have many partner organisations in the city who are very effective in training and developing their workforce. We will consider how best to support those activities and apply the learning to other sectors and care settings. Positive engagement with professional and regulatory bodies and trade union representatives will be of value to our workforce ambitions.

We strongly believe that fair work is work that offers our staff an effective voice, opportunities, security, fulfilment and respect. Balancing the rights and responsibilities of our employer organisations and workers will generate benefits at an individual and organisational level and also more widely across our communities. The IJB has endorsed the Ethical Care Charter and incorporating this charter in the commissioning of our care at home services will make a significant contribution to addressing particular challenges in the delivery of care experienced by that workforce. We need to offer similar supports to other elements of our workforce.

5.2 Principled Commissioning
Our approach to commissioning is collaborative and generates an innovative range of options to achieve shared outcomes.

The commissioning of services will be one of the partnership’s most important functions as it seeks to ensure that all services enhance the quality of life for the people and their carers now and in the future. We recognise that it will be most effective if it is done in partnership with users, families, communities and other agencies that have an interest in the continued wellbeing of our local population.

- Commissioning is undertaken for outcomes (rather than for services)
- Commissioning decisions are based on evidence and insight and consider sustainability from the outset
- Commissioning adopts a whole-system approach
- Commissioning actively promotes solutions that enable prevention and early intervention
- Commissioning activities balance innovation and risk
- Commissioning decisions are based on a sound methodology and appraisal of options
- Commissioning practice includes solutions co-designed and co-produced with partners and communities
- Commissioning is evaluated on outcomes and social and economic return on investment

Figure 3.2 Commissioning Principles
Self-directed support (SDS) options will continue to be a key element of our personalised approach given that it enables people to have more informed choice and flexibility over their care and support. We are very aware that having more people commissioning and controlling their own care through individual budgets or direct payments will need consistent and accurate information that clearly, without jargon, explains the options and opportunities available.

All our commissioning will be respectful of the appropriate legislation, mindful of best practice such as the Ethical Care Charter\(^\text{17}\), and sensitive to the needs of our local care provision. We will not adopt a uniform one-size-fits-all commissioning approach but instead strive to be sensitive to age, wellbeing and complexity of need.

5.3 Digital Transformation

Digital technology is key to transforming our health and social care services across the partnership so that we can be truly person-centred, enabling and effective.

We appreciate that it is easy to get frustrated at what appears to be a lack of progress in introducing digital solutions, especially when technology plays such a central part in our lives in so many other ways. There are significant opportunities to introduce digital solutions across all sectors and services. We aspire to reach a point when digital services are an integral part of everything we do and have become not only the first point of contact with health and care services for many people but also how they will choose to continue to engage with us.

\(^{17}\text{http://www.unison-scotland.org/unisons-ethical-care-charter/}\)
5.4 Sustainable Finance

Over the next few years we will have to address the significant challenge of health and social care budgets reducing in real terms while demand for services increases. To achieve our objective of improving the health, wellbeing and independence of people to live at home for as long as is reasonably practicable, we need to look at how we manage our resources to deliver the best value for the people who use our services, their carers and their communities.

A Medium-Term Financial Strategy (MTFS) has been developed to pull together into one document all the known factors affecting the financial sustainability of the partnership over the medium term. This strategy establishes the estimated level of resources required by the partnership to operate its services over the next five financial years, given the demand pressures and funding constraints that we are likely to experience.

Implementing this strategy will help us to deliver the ambitions and priorities of the partnership’s Strategic Plan, maximise our resources and improve our financial planning across the medium term.

Table 3 below shows the level of budget pressure the IJB will face after assumptions have been made about the level of income likely to be received from partners. The budget pressures include provision for pay awards, Scottish Living Wage uplifts, demographic projections and prescribing inflation. To offset these anticipated pressures, the IJB has identified key ‘financial saving’ workstreams and has set provisional targets (in brackets) to be delivered from these.

<table>
<thead>
<tr>
<th>Year</th>
<th>2019-20 £’000</th>
<th>2020-21 £’000</th>
<th>2021-22 £’000</th>
<th>2022-23 £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Budget Pressures (year on year)</td>
<td>6,452</td>
<td>6,749</td>
<td>6,304</td>
<td>6,623</td>
</tr>
<tr>
<td>Workstreams to reduce financial pressure:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Efficiency Savings</td>
<td>(1,150)</td>
<td>(1,650)</td>
<td>(1,650)</td>
<td>(1,650)</td>
</tr>
<tr>
<td>Transformation</td>
<td>(1,458)</td>
<td>(1,487)</td>
<td>(1,517)</td>
<td>(1,547)</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>(1,000)</td>
<td>(1,000)</td>
<td>(1,000)</td>
<td>(1,000)</td>
</tr>
<tr>
<td>Service Redesign</td>
<td>(2,844)</td>
<td>(2,612)</td>
<td>(2,137)</td>
<td>(2,426)</td>
</tr>
<tr>
<td>Shortfall</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 3 ACHSCP MTFS Budget Pressures and Workstreams
We are committed to making the best use of our resources to deliver best value in improving outcomes for people. Careful consideration is given to the allocation of financial resources to our local authority and health board partners and also to our many partner agencies who deliver commissioned services.

We will always seek to invest in those functions and services which can demonstrate a positive impact on people’s health and wellbeing and which are aligned with the ambitions and priorities of our Strategic Plan. There will be times, however, when disinvestment options will be considered because of ineffective impact, weak alignment and poor value for money.

Our investment/disinvestment decisions will always be rooted in the sustainability of our local market and the delivery of our Strategic Plan. We hope that any changes can be as a result of planned service reviews or known commissioning cycles, but we accept that there will be times when circumstances arise that present us with an opportunity to reconsider the allocation of resources.

Our focus on transformation will continue. We recognise the very real challenge of asking our staff to contribute to the transformation of our services whilst at the same time asking them to ensure an ongoing consistency of the day-to-day operation. We recognise that there is a national and a local desire to see the evidence of the impact of our innovative activities and services. Our evaluation framework provides that assurance.
6.1 We remain committed to our ambition of being recognised as one of the highest performing partnerships in Scotland for our effective performance across all sectors and services. Our service delivery will, without exception, be safe, effective, responsive, caring and well-led.

Our emphasis will always be on fulfilling outcomes. Ensuring that personal, organisational and national outcomes are linked in a coherent manner will be central to the successful implementation of a partnership-wide outcomes-focused approach.

The National Performance Framework is a single framework to which all public services are aligned. It sets out a vision of national wellbeing across a range of economic, health, social and environmental factors. The nine National Health and Wellbeing Outcomes are high-level statements of what we are trying to achieve as a partnership. A core set of indicators are aligned with the different outcomes to show us the progress we are making in delivering person-centred, high-quality, integrated services and fulfilling the ambitions and priorities set out in our Strategic Plan.

6.2 Our Annual Performance Report shows how well we have performed as a partnership in working towards and fulfilling our operational objectives and the national outcomes. Future annual reports will also comment on how well we have fulfilled the objectives and priorities set out in this plan.

We are determined to be recognised as a partnership that works closely with our citizens, staff, unpaid carers and our partner agencies in the third, independent and housing sectors to fulfil the vision and ambitions of this Strategic Plan.

http://nationalperformance.gov.scot/
https://www.gov.scot/Topics/Health/Policy/Health-Social-Care-Integration/National-Health-WellbeingOutcomes
<table>
<thead>
<tr>
<th>Strategic Aims</th>
<th>Priorities</th>
<th>Commitments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention</td>
<td>Promote positive mental health and wellbeing.</td>
<td>We will produce a Mental Health Strategy and Action Plan showing how we will promote positive mental health and wellbeing and support those who are on a recovery journey.</td>
</tr>
<tr>
<td></td>
<td>Address the factors that cause inequality in outcomes in and across our communities.</td>
<td>We will actively contribute to reducing known health inequalities in the health and wellbeing of our local population.</td>
</tr>
<tr>
<td></td>
<td>Reduce alcohol and drug-related harm.</td>
<td>We will support the Alcohol and Drug Partnership in delivering actions to reduce substance related harm.</td>
</tr>
<tr>
<td>Resilience</td>
<td>Promote and support self-management and independent living for individuals.</td>
<td>We will continue to invest in our ‘Promoting self-management and building community capacity’ transformation portfolio.</td>
</tr>
<tr>
<td></td>
<td>Value and support unpaid carers.</td>
<td>We will support our unpaid carers to identify as carers, to manage their caring role, to be involved in the planning of services for the cared-for person and to have a life alongside</td>
</tr>
<tr>
<td>Enabling</td>
<td>Reshape our primary care sector.</td>
<td>We will implement fully our Primary Care Improvement Plan.</td>
</tr>
<tr>
<td></td>
<td>Shift the balance of care from the acute health sector</td>
<td>We will support and implement as appropriate the local Unscheduled Care Essential Actions Plan developed with our partner agencies.</td>
</tr>
<tr>
<td></td>
<td>Develop our palliative and end of life care provision</td>
<td>We will review our current palliative and end of life care provision and develop an action plan to fulfil the strategic framework vision.</td>
</tr>
<tr>
<td>Connections</td>
<td>Enable our citizens to have opportunities to maintain their wellbeing and take a full and active role in their local community.</td>
<td>We will develop a co-ordinated engagement plan for all of the partnership’s activities and initiatives with our client and patient groups, communities and localities.</td>
</tr>
<tr>
<td></td>
<td>Counter the perception of loneliness and isolation experienced by all age groups.</td>
<td>We will develop the social capital of our partnership across all sectors and services.</td>
</tr>
<tr>
<td>Community</td>
<td>Enable our citizens to have opportunities to maintain their wellbeing and take a full and active role in their local community.</td>
<td>We will implement a three-locality model and in doing so, align our activities more fully with those of the Community Planning Aberdeen locality model.</td>
</tr>
<tr>
<td></td>
<td>Develop a diverse and sustainable care provision.</td>
<td>We will refresh our Market Facilitation Statement and develop an Action Plan showing how we will support our local care provision.</td>
</tr>
</tbody>
</table>
If you require further information about any aspect of this document, please contact:

Aberdeen City Health & Social Care Partnership
Community Health and Care Village
50 Frederick Street
Aberdeen
AB24 5HY

or email achscpenquiries@aberdeencity.gov.uk
Aberdeenshire Health and Social Care Partnership Strategic Plan 2016 – 2019
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Housing contribution statement

A Health and Equality Impact Assessment has been carried out and is available on the Aberdeenshire Council website

An accessible version is available at: www.aberdeenshire.gov.uk/social/healthsocialcareintegration.asp This document is also available in large print and other formats and languages on request. Please email communicatebetter@aberdeenshire.gov.uk or telephone 01224 664601
**Introduction**

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

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

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

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

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

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

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

**Vision**

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

**Philosophy**

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

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

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

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

**How we will work**

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

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

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

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

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

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

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

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

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

Health and Social Care Integration

The Scottish Government has agreed a piece of legislation called The Public Bodies (Joint Working) (Scotland) Act 2014. The legislation requires each Health Board and Local Authority to publish an integration scheme. The scheme sets out how they will work together to improve the health and wellbeing of people who use health and social care services, particularly those whose needs are complex and involve support from health and social care at the same time. Aberdeenshire’s integration scheme can be found at http://committees.aberdeenshire.gov.uk/FunctionsPage.aspx?dsid=81013&action=GetFileFromDB

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

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

The Housing Contribution

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

Further details can be found in the Housing Contribution Statement at the end of this document.
Aberdeenshire

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

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

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

**Cause of death in Aberdeenshire (2013)**

<table>
<thead>
<tr>
<th>Female</th>
<th>Male</th>
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</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>Cancer</td>
</tr>
<tr>
<td>Circulatory Diseases</td>
<td>Circulatory Diseases</td>
</tr>
<tr>
<td>Respiratory Diseases</td>
<td>Respiratory Diseases</td>
</tr>
<tr>
<td>Digestive Diseases</td>
<td>Digestive Diseases</td>
</tr>
<tr>
<td>External Causes</td>
<td>External Causes</td>
</tr>
<tr>
<td>Other</td>
<td>Other</td>
</tr>
</tbody>
</table>

3.8%  4.6%  10.9%  31.9%  25.8%  17.1%  6.3%  10.3%  31.9%  30.2%
Our Localities

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

Banff and Buchan – Population 35,500

The economy of Banff and Buchan is mainly based on the traditional industries of fishing and agriculture. The area is largely rural, with fewer employment and service connections to the city of Aberdeen than other parts of Aberdeenshire. People from Eastern Europe have been attracted to work in the area, particularly in the fish processing and service industries. 3% of the population identify themselves as Polish. Hospital services are provided at Chalmers Hospital, Banff and Fraserburgh Hospital. Parts of Fraserburgh have significantly lower life expectancy for both males and females and increased mortality rates although as a whole people living in the area have a life expectancy that is higher than the Scottish average. Rates of emergency admission to hospital remain high. There are pockets of deprivation associated with difficulties in accessing public services. The area also continues to face deep-seated issues due to problematic use of alcohol and other drugs that directly and indirectly threaten the wellbeing and economic prospects of the area. Community Planning partners, however, are committed to supporting and building confident, skilled, influential and active communities and have carried out a programme of local engagement events, conversations and focus groups in order to encourage a debate about boosting community capacity. One of the ways in which this can be achieved is through encouraging people, particularly older people, to volunteer. This benefits both the volunteer and the community alike. Service developments include improving community transport to offer better access to hospital and health appointments for rural areas.
Buchan – Population 39,400

The area has a contrasting mix of farms, villages and industrial areas. Peterhead is the largest town in Aberdeenshire, the principal white fish landing port in Europe, and a major oil industry service centre. Despite this affluence, there is considerable demand for affordable housing. There are relatively deprived areas where rates of most cancers and heart disease are higher. Although across Buchan the life expectancy of the majority of communities is above the Scottish average, parts of Peterhead have significantly lower life expectancy for both men and women and increased mortality rates. 0.6% of the population identify with ethnic groups other than Scottish or British. People over 65 years in Buchan are more likely to experience emergency hospital admissions than the general population and have higher rates of admissions for this age group than elsewhere in Aberdeenshire. However, the rate of emergency admissions for this age group is reducing yearly.

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

Formartine – Population 39,400

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

Garioch – Population 50,500

The area experienced rapid population growth in recent years and the population is expected to grow further by nearly 12% over the next decade, which is the fastest projected growth rate in Aberdeenshire. The life expectancy of people living in Garioch is above the Scottish average. Inverurie and Insch Hospitals provide inpatient and outpatient services. Asthma, which is one of the most prevalent health conditions in Aberdeenshire, is particularly a concern in Garioch. Garioch’s age profile has a higher representation of younger age groups than Aberdeenshire generally and an increasing proportion of older people. Unemployment levels are low and Garioch is seen...
as thriving and prosperous. As an indicator of affluence, the percentage of the over 60 years population in receipt of pension credit is the lowest of all the six local authority areas. Greater social inclusion, which has a significant impact on people’s health and life expectancy, is a priority for this area. Service providers from all sectors are responding to the needs of older people and people with learning disabilities by offering more choice and control in how they access services, and by supporting unpaid carers and family members to look after their own health.

**Marr – Population 37,000**

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

**Kincardine and Mearns – Population 42,000**

The area reflects the Aberdeenshire age profile, with, overall, an ageing population and a decreasing number of children. Within this there are some rapidly developing commuter-belt communities with much higher numbers of young families than in more rural areas. Each requires a different approach to community inclusion. Across Kincardine & Mearns, the life expectancy is better than the Scottish average, as are the rates of mortality for all ages. Data from community pharmacists suggest that the area has the lowest prevalence of potential harmful drug use across all of Aberdeenshire. The percentage of the over 60 years population in receipt of pension credit is consistently below the Aberdeenshire average. The area is served by Kincardine Community Hospital in Stonehaven. Issues relating to social inclusion have been specifically highlighted for those towns that have rapidly expanded and where the lack of any central focus or community facilities is becoming apparent. However, across the area, more residents are being encouraged to take part in social, leisure and support activities that promote positive health and wellbeing, and helping older people to plan better for their future needs is a priority.
The Views of Aberdeenshire Communities: Community Engagement

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

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

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

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

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

Members of the Aberdeenshire Youth Council provided their views at a consultation event, helping to ensure that young people, for whom the long term strategic aims will have a very real impact, were included.
An online survey available between late August and early November 2015 attracted 39 responses, 84% of which were from people in the age range 17 – 64 years.

The Aberdeenshire Citizens’ Panel was consulted in November 2015, attracting 694 responses.

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

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

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

Why must health and social care change in Aberdeenshire?

Our population is ageing, as it is across the whole of Scotland. This is one of the great success stories of better health care and treatment. By the year 2035, the number of people aged over 65 will have increased by 65%. Many older people are living long, healthy lives and are fit and active well into old age. Life expectancy in Aberdeenshire is better than the rest of Scotland.
Life expectancy at birth in Aberdeenshire and Scotland, 2011-2013

However, increasing age can often be accompanied by increasing disability due to health conditions such as stroke or dementia, and simply the frailty that comes with the aging process. Older people and people with disabilities who experience these kinds of health problems need high levels of health care as well as personal and practical help if they are to continue to live in their own homes or in homely surroundings in their community. Adults of all ages who need access to urgent hospital treatment should be confident that they will be treated and discharged home without delay. These are some of our challenges for the next 20 years.

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

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

1 National Records of Scotland
2 Aberdeenshire health Profile 2015
to expect, we need to seek sustainable solutions. Some of this builds on work we have already started, but some demands that we take a different approach.

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

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

**Projected population and hypothetical service costs – Aberdeenshire 2035**

**POPULATION (2035)**

<table>
<thead>
<tr>
<th>AGE</th>
<th>297,255</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 64 years</td>
<td>224,028 (75%)</td>
</tr>
<tr>
<td>65 + years</td>
<td>73,227 (25%)</td>
</tr>
</tbody>
</table>

**HEALTH & SOCIAL CARE COSTS (£m) BY AGE**

- **Social Care**
  - 0 – 64 years: 95m
  - 65 + years: 61m

- **NHS**
  - 0 – 64 years
  - 65 + years

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

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

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

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

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3 Improving the Public’s Health, King’s Fund 2013
Strategic Aims

1. to achieve sustainable, positive health and social care outcomes for people living in Aberdeenshire through working in partnership with communities and people who use services and their unpaid carers

2. to improve the health of the Aberdeenshire population

3. to provide high quality treatments and care

Strategic Priorities

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

These principles and the priorities set out below apply to all settings and sectors, be they community-based or provided in a hospital

<table>
<thead>
<tr>
<th>Theme</th>
<th>Priority</th>
<th>Historical situation</th>
<th>Mid term</th>
<th>Longer term</th>
<th>Contributes to National Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>The best of health and care for everyone</td>
<td>Reducing health inequalities</td>
<td>There is an unacceptable gap between health outcomes for people in the most deprived areas and those for people in the most affluent areas</td>
<td>Health and social work intelligence underpins decisions aimed at reducing health inequalities</td>
<td>Health and social care outcomes for people are improving in areas with the highest levels of deprivation</td>
<td>1,2,3,4,5,9</td>
</tr>
<tr>
<td></td>
<td>Improving health; smoking cessation, reducing harm from alcohol, tackling obesity</td>
<td>Aberdeenshire residents have good health relative to the rest of Scotland but there is considerable scope for improvement</td>
<td>More people make healthy choices, change their health–related behaviour and seek help to make these changes</td>
<td>Fewer people have the most common preventable health conditions</td>
<td>1,3,4,5,9</td>
</tr>
<tr>
<td>Theme</td>
<td>Priority</td>
<td>Historical situation</td>
<td>Mid term</td>
<td>Longer term</td>
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<tr>
<td>Partners in health and social care</td>
<td>Involving and engaging with communities</td>
<td>Information and decisions about service development are made largely by services, with occasional opportunities for community involvement</td>
<td>Community leaders are aware of the important matters that face health and social care services. Locally responsive service development is the norm</td>
<td>Local people say they can influence health and social care planning. They actively participate in the creation and improvement of services.</td>
<td>All</td>
</tr>
<tr>
<td>Partners in health and social care</td>
<td>Improving the way unpaid carers are recognised and supported</td>
<td>A small proportion of carers are known and receive support and can plan ahead with confidence</td>
<td>Carers, including young carers, have access to personalised assessment and support plans</td>
<td>Individuals providing unpaid care and those thinking about it for the future are effectively supported</td>
<td>1,2,3,4,6,9</td>
</tr>
<tr>
<td>Partners in health and social care</td>
<td>Involving people as partners in their care; listening and responding to them</td>
<td>Passive recipient of treatment, care and services</td>
<td>Consistent recognition of each individual as a partner in planning their care and treatment</td>
<td>Support and treatment plans are based on people's abilities and personal outcomes, with an effective balance of formal health and social care services, Third Sector and community assets</td>
<td>1,2,3,4,7,9</td>
</tr>
<tr>
<td>Partners in health and social care</td>
<td>Self-management of long term conditions such as heart or breathing problems</td>
<td>A lack of foresight, often reactive, vulnerable to crises, with insufficient planning to meet housing needs</td>
<td>People can access the information, advice and technology they require to help them access suitable housing and manage their health condition</td>
<td>People are consciously in control of their health condition and helped to manage it well</td>
<td>1,2,4,5,9</td>
</tr>
<tr>
<td>Partners in health and social care</td>
<td>Empowering the workforce to influence service decisions</td>
<td>Employees contribute to service development occasionally; local knowledge and experience is an underutilised resource</td>
<td>Employees in public and Third Sector services contribute to service development</td>
<td>Employees contribute to service development as an fundamental part of their role in an integrated locality team</td>
<td>3,4,5,8,9</td>
</tr>
<tr>
<td>Theme</td>
<td>Priority</td>
<td>Historical situation</td>
<td>Mid term</td>
<td>Longer term</td>
<td>Contributes to National Outcomes</td>
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<tr>
<td>Effective treatment and care</td>
<td>Primary Care: better access, continuity of care, making best use of practitioners’ skills</td>
<td>Many health services are centralised and hospital-based. People often wait to see a GP when access to another practitioner could be a better use of resources and would offer a high quality but more accessible service</td>
<td>There is increased capacity to offer local diagnosis and treatment, with strong local leadership and consistently effective community engagement</td>
<td>People know the formal and informal services and supports that are available and use them appropriately</td>
<td>1, 2, 5, 8, 9</td>
</tr>
<tr>
<td>Early diagnosis, treatment and care of people with dementia</td>
<td>The strategic intentions to improve outcomes for people with dementia is set out in the Aberdeenshire Dementia Strategy 2015-2018</td>
<td>Local support is increasing, through professional intervention and developments such as dementia friendly communities</td>
<td>People with dementia and their carers feel included and can participate in the life of their community</td>
<td></td>
<td>1, 2, 3, 4, 6, 7, 9</td>
</tr>
<tr>
<td>Reducing avoidable admissions to hospital</td>
<td>Many acute hospital services are coping with rising levels of unplanned need and demand</td>
<td>People work with health and social care practitioners to anticipate and plan their care needs</td>
<td>Community-orientated specialised, planned treatment</td>
<td></td>
<td>1, 2, 7, 9</td>
</tr>
<tr>
<td>Timely well-managed discharge from hospital to home or homely surroundings</td>
<td>Some people, particularly very dependent older people, have not been able to go home when medically fit because care is not available</td>
<td>Service demand and capacity is known, processes and procedures are agreed and followed and inter-agency working is effective</td>
<td>Suitable accommodation and care at home is available when people are ready to leave hospital</td>
<td></td>
<td>1, 2, 3, 6, 7, 9</td>
</tr>
<tr>
<td>Theme</td>
<td>Priority</td>
<td>Historical situation</td>
<td>Mid term</td>
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<tr>
<td><strong>Effective treatment and care con’t</strong></td>
<td>Identifying, treating and promoting recovery from mental ill health</td>
<td>Mental illness retains a stigma in some areas that make it difficult for people to seek help at an early stage</td>
<td>There is a smooth transition between services for people with ongoing needs and easy access to community resources as part of their recovery plan</td>
<td>People understand what affects their mental health and wellbeing and take steps to improve it</td>
<td>1, 2, 3, 4, 5, 6, 7, 9</td>
</tr>
<tr>
<td>Identifying and taking steps to protect vulnerable adults</td>
<td>Awareness of adult support and protection procedures and how to identify an adult at risk of harm has been limited to professionals who work with people</td>
<td>Service providers and Aberdeenshire residents recognise their role and responsibility to help protect vulnerable people and uphold their human rights</td>
<td>People who are unable to protect themselves are kept safe in their homes, when they use our services and in their community</td>
<td>1, 2, 4, 7, 8</td>
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**Health and Social Care Services**

**Public health**

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

**Clinical services**

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

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

Integrated locality teams

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

Hosted Services

Some health services are provided on a Grampian-wide basis. These cannot be planned and delivered by each partnership separately but require a different approach called ‘hosting’. One partnership will take the lead responsibility on behalf of the other two for planning, or for planning and service delivery. Decisions about hosting will require to be made for hospital-based acute services, GMED out of hours service, hospital-based mental health and learning disability services, and community health services that had previously been hosted.
Multi-disciplinary locality teams: model structure. An extended team will be aligned to more than one core team.
Strategic Planning with Acute Hospital Services

Health and social care practitioners and managers have identified some cross-cutting themes that, if consistently applied to practice, will offer a high quality service to people and improve job satisfaction for staff. These themes include:

- Making primary and secondary prevention of ill health everyone’s business
- Removing unhelpful variation in practice
- Helping people to cope better with their natural anxiety about ill health
- Arranging care to enable people to remain at home for as long as possible
- Offering unpaid carers practical and emotional support

For Accident and Emergency, in addition to the above, it is important to educate and inform the public so they ‘know who to turn to’, and to provide consistent, 24/7, support for professional decision-making.
Outcomes

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

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

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

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

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

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

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

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

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

The conversation café in Maud Resource Centre is organised monthly and is run by volunteers and staff members from statutory and voluntary organisations. Meetings involve cups of tea, coffee and cakes, and lively conversation. At some conversation cafes there are taster sessions, e.g. making cards or jewellery or exercise classes using the Maud Centre gym. People have made connections with others in their community, helping to reduce the experience of isolation.

MACBI, a company limited by guarantee and with charitable status, was set up by local people in the Central Buchan area with the aim of improving community leisure facilities in Mintlaw and Central Buchan. The centre has a multi-purpose hall that is two badminton court size with temporary staging that can be assembled for events ie: Fitness room; Soft play area; Meeting rooms /Lounge/ viewing area; Café; Reception/foyer; Changing rooms. It offers yoga, aerobics, martial arts, badminton, keep fit, dance, drama, singing and music making, youth groups, mums and toddlers, interest groups. Centre users range from individuals to community groups, organisations and businesses.
Outcome 2: People including those with disabilities or long term conditions or who are frail are able to live independently at home or in a homely setting in their community

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

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

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

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

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

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4 Self-management – lived experience, Alliance
We have created a Priority Discharge Team whose role is to enable people to leave hospital when they are medically fit thus avoiding a delayed discharge. This team is working across health and social care, involving ward staff, occupational therapists from the joint health and social work team, care managers and a team of carers who are working to an enablement plan with these individuals. It takes on average 43 days from referral to assessment and between six to seven months for the adaptation to be finished. There is considerable variation in time because of the wide range of adaptations that are made.

Locally-based Third Sector mental health services work with people to support improvements in both mental health and physical health – diet, exercise and social activities. People are encouraged to join mental health support groups where they gain confidence and develop social skills, and then move onto mainstream community activities. Group work includes teaching resilience and self-management. This complements the work of psychiatrists, community psychiatric nurses, psychologists, occupational therapists and support workers.

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

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

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

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

It takes on average 43 days from referral to assessment and between six to seven months for the adaptation to be finished. There is considerable variation in time because of the wide range of adaptations that are made. (2012 – 2015)
**Outcome 3:** People who use health and social care services have positive experiences of those services and have their dignity respected

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

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

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

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

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

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

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5 Aberdeenshire Community Engagement Report May 2015
We are proud of the quality of care provided in our care homes and very sheltered housing. Our newest care homes, in Stonehaven and one planned on the same ‘care village’ model for Inverurie, provide new opportunities for the local community to be invited into the home and for residents to be involved in the life of the area in which they live. In our open door policy, we are balancing our duty to protect vulnerable people in our care with their human rights.

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

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

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

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

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

NHS Grampian Stakeholder Engagement Framework

We have very good quality end of life services and aim to support individuals at the end of their lives to die in the place of their choosing.
Outcome 4: Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services

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

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

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

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

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

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

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

Our staff can and do have a considerable impact on the quality of people’s lives. All staff are expected to offer a service that is sensitive to characteristics such as race, religion and sexual orientation and to be aware that an unpaid carer may be a same-sex partner.
We are using technology to help people to understand their diagnosis and treatment. During a consultation a patient may miss information; the explanation of the diagnosis may involve quite technical medical information and language, the diagnosis may be a shock and the patient may be stressed and unable to take it in. No Delays allows the GP or the specialist to prescribe a digital postcard by email to the patient. This is a personalised package of short videos that explains their condition in detail and informs them about local services.

A robotic pharmacy kiosk has been installed in a shop in Inverallochy. The kiosk, which is linked to a pharmacy in Fraserburgh enables people to talk to a pharmacist remotely and have their prescriptions dispensed. People can order medicine and collect their prescription next day. The new service is designed to improve access to residents who may not have easy access to a pharmacy.
Outcome 5: Health and social care services contribute to reducing health inequalities

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

- The community planning partnership has an overarching role and interest in reducing health inequalities. As a health and social care partnership, we should help and encourage colleagues to assess the health impact of decisions to ensure that these are positive where possible, and any negative impact is mitigated.

- Communities that we know have higher levels of deprivation need our support most, to help build motivation and optimism, especially amongst young people. Working with community planning partners, we can help young people to develop the skills and knowledge to transform health and wellbeing in their localities.

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

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

Across Aberdeenshire, residents should expect to get a high quality service, with easy access to self-help information and health and social care. However, there is no one size fits all; some communities will find it easier, and will wish, to do more with less formal support.

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

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

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6 Director of Public Health Report 2013-2014
Alcohol-related hospital stays (2013/14)

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

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

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

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7 ScotPho 2015

Aberdeenshire Health and Social Care Partnership Strategic Plan 2016–2019
Outcome 6: People who provide unpaid care are supported to look after their own health, including to reduce any negative impact of their caring role on their own health

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

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

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

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

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

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

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

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

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

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

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

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

Aberdeenshire carers’ strategic outcome group

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

Health & Care Experience Survey 2013-14: Aberdeenshire

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

VSA Carers’ Support
Outcome 7: People who use health and social care services are safe from harm

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

• Employees, volunteers, families and unpaid carers all share a professional and personal responsibility to help identify people who might be at risk of harm, and to report their concerns. Early identification of vulnerable people can help to develop a safety network or circle of family, friends, neighbours and professionals.

• Employees must have ready access to sound professional guidance and advice.

• Strong resilient communities are best prepared to help create a culture where avoidable harm is minimised but people of all ages who have disabilities are not prevented from taking the sort of risks that others would accept for themselves.

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

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

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

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

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

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8 Adult Support and Protection (Scotland) Act 2007
9 NHS Grampian Policy for the Management and Learning from Adverse Events and Feedback
10 Aberdeenshire Community Engagement Report May 2015
11 Health and Social Care Integration Clinical and Care Governance Framework
98% of people said they had enough information about how and when to take their medicines

Health and care experience survey 2013-2014: Aberdeenshire

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

Supporting and Protecting Adults from Harm
Advice on who to contact if you have concerns about the wellbeing of an adult at risk

www.aberdeenshire.gov.uk/care/help/protection/adult_support_protection.asp
Outcome 8: People who work in health and care services feel engaged with the work they do and are supported to improve

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

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

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

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

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

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

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12 Petch, A, An evidence base for the delivery of adult services 2011
“Speaking as an Occupational Therapist, joint location has thus far been helpful - I am able to pop through to my social work occupational therapy colleagues to find out about progress with aids and equipment for individuals. This is a bonus after working pretty much on my own previously. I have done joint training with a social work OT for carers about involving residents in activities at a nearby care home. As I choose to sit in the main office with the care managers/social workers there is more communication about people, and I have a better understanding of the care manager’s role and they of mine. An interesting observation is that since co-location our monthly joint clinical meeting has become much shorter in duration – information is not being saved up but communicated more frequently”

Occupational therapist, Portlethen

“42% of Health and Social Care respondents agree/strongly agree that their services recognise and consult diverse local communities about levels, range, quality and effectiveness of services.

53% of Health and Social Care respondents agree/strongly agree that there is strong positive engagement between the partners and local community and voluntary groups.”

Aberdeenshire Staff Survey, Care Inspectorate 2012

My team has excellent working relationships with other professionals
There is sufficient capacity in my team to undertake preventative work
I have good opportunities for professional development
My workload is managed to enable me to deliver effective outcomes to meet individual’s needs
I receive effective support and challenge from my line manager
I have an annual appraisal/performance review with my line manager
I have received appropriate training to do my job

Strongly Agree ▶ Agree ▼ Disagree ▲ Strongly Disagree ■ N/A ▭
Outcome 9: Resources are used effectively and efficiently in the provision of health and social care services

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

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

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

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

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

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

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

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

We expect that this better use of resources will be pivotal in reducing health inequalities, an aim that runs through this entire strategic plan. However, community representatives will also make an important contribution to decisions that affect their area. We will improve the information and guidance that we offer them so that we can have confidence in informed, evidence-based decisions.
“Building on existing links with local communities, integrated health, social care teams and third sector organisations, Community Hospitals will become resource centres, supporting people to fulfil their desire to stay at home longer, receive diagnosis and treatment closer to home, receive inpatient care in their local community and when specialist care is required, facilitate the earliest possible return to their community”

Community Hospital Strategy June 2015

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

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

North Aberdeenshire tends to have the highest caseloads

Numbers exclude Criminal Justice Social Work

Performance

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

Appendix 1

The proposed location of integrated health and social care teams (July 2015)
## Appendix 2

### Current organisation of health and social work services.

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

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

- Accident and emergency services
- General medicine; geriatric medicine; rehabilitation medicine; respiratory medicine; psychiatry of learning disability
- Palliative care services
- Inpatient hospital services provided by GPs
- Alcohol and drugs addiction services
- Mental health services except secure forensic mental health services
Appendix 3

NHS Grampian and Aberdeenshire Social care spending on services for people aged 65+years Aberdeenshire

Allocation of budget for services for people aged 65+years.

13 Integrated resource framework 2015
14 Integrated resource framework 2015
## Appendix 4

### Aberdeenshire Health and Social Care Partnership Revenue Budget 2016-2017

<table>
<thead>
<tr>
<th>Partner</th>
<th>Annual Budget £’000</th>
<th>Whole Time Equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core Services</td>
<td>NHSG 58,501</td>
<td>967</td>
</tr>
<tr>
<td>Hosted Services</td>
<td>NHSG 7,129</td>
<td>76</td>
</tr>
<tr>
<td>Primary Care</td>
<td>NHSG 33,702</td>
<td>0</td>
</tr>
<tr>
<td>Prescribing</td>
<td>NHSG 41,881</td>
<td>0</td>
</tr>
<tr>
<td>Community Mental Health</td>
<td>NHSG 6,547</td>
<td>122</td>
</tr>
<tr>
<td>Social Care Funding via NHS Grampian</td>
<td></td>
<td>9,500</td>
</tr>
<tr>
<td>Integrated Care Fund</td>
<td></td>
<td>3,780</td>
</tr>
<tr>
<td>Delayed Discharge monies</td>
<td></td>
<td>1,134</td>
</tr>
<tr>
<td>Criminal Justice</td>
<td>Council 33</td>
<td>72</td>
</tr>
<tr>
<td>Learning Disabilities</td>
<td>Council 30,865</td>
<td>261</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Council 4,088</td>
<td>49</td>
</tr>
<tr>
<td>Substance Misuse</td>
<td>Council 1,581</td>
<td>23</td>
</tr>
<tr>
<td>Care Management</td>
<td>Council 34,001</td>
<td>73</td>
</tr>
<tr>
<td>Other Older People Services</td>
<td>Council 30,492</td>
<td>1,036</td>
</tr>
</tbody>
</table>

**TOTAL** | **£263,234** | **2,679**

### Set Aside’ Hospital Budget

<table>
<thead>
<tr>
<th></th>
<th>£'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicative budget at March 2016</td>
<td>26,700</td>
</tr>
</tbody>
</table>
Appendix 5

Aberdeenshire Health And Social Care Partnership

Health And Social Care Strategic Plan 2016 - 2019

Housing Contribution Statement

This Housing Contribution Statement sets out the role of social housing providers to deliver the outcomes in the Aberdeenshire Health and Social Care Strategic Plan.

1. Role Of The Housing Sector In The Aberdeenshire Health And Social Care Partnership

The Integrated Joint Board will become responsible for adaptations that the local authority provides including those it funds for the private sector. The Integrated Joint Board will not be responsible for adaptations provided by registered social landlords. No other housing functions will move to become part of the Integrated Joint Board’s remit. However, the Integrated Joint Board and housing providers will work closely in the joint strategic planning on housing and housing-related services to ensure the delivery of the national outcomes for health and wellbeing. Much of this work will take place through the Strategic Planning Group that supports the Board. There are two housing representatives on the Strategic Planning Group representing the local authority and the registered social landlords.

These representatives are part of the Aberdeenshire Housing Strategy Group that oversees the Aberdeenshire Local Housing Strategy 2012-2017. There are nine priorities in the strategy and these can be seen in section six. Each priority is taken forward by a strategic group and each group has a role to play to build on existing good practice to support the integration of health and social care. The Particular Needs Strategic Outcome Group is the overarching strategic planning group that identifies the priorities for those with a particular need to access appropriate, affordable housing and support to allow them to sustain and improve their health and live as independently as possible.

Housing will be part of the local arrangements of the Aberdeenshire Health and Social Care Partnership. Housing should form part of the extended team to provide support at a local level. As these are formed in the months ahead, it is key that housing engages in the local delivery of health and social care.
2. Overview of the Shared Evidence Base and Key Issues

There are important sources of evidence that help to set out the needs, influence and connections between housing, health and social care. Alongside these local and national sources, there is a wide body of research that helps to inform the role of social housing providers. There is a number of key issues that housing providers will need to consider when planning the delivery of services. These include:

<table>
<thead>
<tr>
<th>Issue</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of affordable housing in Aberdeenshire with particular pressure on the Aberdeen Housing Market Area</td>
<td>Aberdeen City and Shire Housing Need and Demand Assessment (2011)</td>
</tr>
<tr>
<td>Large proportion of the existing private sector stock in disrepair</td>
<td>Scottish House Condition Survey (2015)</td>
</tr>
<tr>
<td>Demand will rise for housing support services</td>
<td>Aberdeenshire Joint Strategic Needs Assessment (2012)</td>
</tr>
<tr>
<td>Demand will rise for aids and adaptations to enable people to live independently at home</td>
<td></td>
</tr>
<tr>
<td>Demand will rise for very sheltered housing</td>
<td>Aberdeenshire Council and CHP: Market Position Statement (2014)</td>
</tr>
<tr>
<td>Higher than average prevalence of people with long-term conditions such as dementia</td>
<td>Aberdeenshire Health Profile (2015)</td>
</tr>
<tr>
<td>High levels of fuel poverty</td>
<td>Scottish House Condition Survey (2015)</td>
</tr>
<tr>
<td>Number of people presenting as homeless to Aberdeenshire Council has fallen in the last three years</td>
<td>Aberdeenshire Council Local Housing Strategy Newsletter (2015)</td>
</tr>
<tr>
<td>Lower proportion of over 75s moving into residential care</td>
<td>Aberdeenshire Council and CHP: Market Position Statement (2014)</td>
</tr>
<tr>
<td>Local variations in health conditions, need and demand for housing</td>
<td>Aberdeenshire Health Profile (2015) Local Strategic Assessments (2013)</td>
</tr>
</tbody>
</table>

The Aberdeen City and Shire Housing Need and Demand Assessment for 2016 will further inform the role that housing will play in supporting the integration of health and social care.
3. Overview of the Housing-Related Challenges going forward and the Improvements Required

The challenges and improvements are grouped into four areas:

**Housing Support**

The role of housing support services is changing. There are new demands placed on support services as a result of welfare reform, the lack of supply of affordable housing, the advent of self-directed support and the need for independent living. At the same time, it is recognised that all providers of social housing have a role in supporting their tenants. The Christie Commission and the Community Empowerment Act set a clear direction for social housing providers to target their support services to the most vulnerable tenants to prevent future demand from arising. We will work locally with health and social care partners to ensure that, where relevant, we are part of the local teams providing local support. Where possible we will provide housing support services to those who do not receive social work services.

**Housing Supply**

The Aberdeenshire Housing Need and Demand Assessment sets out a need for 540 new affordable homes each year. Aberdeenshire has the fastest growing population in Scotland and is projected to increase by 22% over the next 25 years. The supply of new housing falls short of the level of need. Pressure on the waiting list for social housing remains high. The allocations policies of Aberdeenshire Council and registered social landlords will continue to take account of health-related conditions and care needs. People at risk of homelessness will receive timely and clear information and support. All unintentional homeless will have access to good quality settled accommodation. We will identify, address and remove any barriers to access health and wellbeing services.

Aberdeenshire Council is working with Aberdeen City Council, registered social landlords and the private sector to increase the supply of affordable housing in the North East of Scotland. In doing so it will aim to ensure there is sufficient diversity in all housing, all sizes and tenure to meet the changing needs of Aberdeenshire residents. In particular, 15% of new build affordable homes will be developed each year for those with particular needs. We will develop, where possible, affordable new build properties suitable for older people that incorporate dementia design principles. Where appropriate, existing stock will continue to be reconfigured for those with particular needs.

**Housing Adaptations**

The preventative role of housing adaptations in enabling independence for older people, those with a disability and for people with dementia is well established. Housing adaptations along with other preventative measures such as assistive technology have the potential to reduce the need for more expensive and intensive services in the long term. We will develop a tenure-neutral and person-centred approach to ensure equity of service and delivery of adaptations. This responds to the recommendations of the Scottish Government’s Working Group for Adaptations and places Aberdeenshire in a proactive position to tackle the demands on adaptations budgets from an ageing population. Aberdeenshire forms part of the National Adaptations Network and will continue to review and take forward best practice from other areas.
We will continue to provide a Care and Repair service to older people and or people with disabilities. We will provide information, advice and help with repairs, maintenance and adaptations to Aberdeenshire owner occupiers and private landlords' tenants. We will work with partner agencies as part of the Care and Repair service. This will include the Scottish Fire and Rescue Service to provide home fire safety visits.

**Community**

All social housing providers in Aberdeenshire are committed to the engagement of their tenants. The Scottish Social Housing Charter commits landlords to ensure that tenants and other customers find it easy to participate in and influence their landlord's decisions at a level they feel comfortable with. North East Tenants, Residents and Landlords Together (NETRALT) coordinate tenant engagement at a regional level. Social landlords and health and social care partners will commit to working with tenants on the future of health and social care.

**4. Resources**

The supply of new affordable housing will be funded through a range of sources including the Scottish Government, Aberdeenshire Council, Registered Social Landlords and private house builders. The Aberdeen City Region Deal is aiming to increase the funding available for affordable housing.

The Integrated Joint Board will be responsible for the monitoring of funding of adaptations to local authority and private sector stock. Local authority adaptations are and will continue to be funded through the Housing Revenue Account. Private sector stock adaptations are funded through Aberdeenshire Council's Capital Plan. Social housing providers will continue to provide housing support services where funding is available.

**5. The relationship Between the Health and Social Care Strategic Plan and the Local Housing Strategy**

The table below links the Aberdeenshire Health and Social Care Strategic Plan to the Aberdeenshire Local Housing Strategy 2012-2017. It sets out the contribution of housing providers and housing-related services to the priorities in the strategic plan.
<table>
<thead>
<tr>
<th>Priorities in the Health and Social Care Strategic Plan</th>
<th>National Outcomes</th>
<th>Priorities in the Local Housing Strategy</th>
<th>Housing’s Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early diagnosis, treatment and care of people with dementia</td>
<td>1-5, 7, 9</td>
<td>Particular needs Affordable housing Private sector</td>
<td>Adaptations; Care and Repair dementia project; Frontline housing staff and craft workers; Dementia design</td>
</tr>
<tr>
<td>Timely, well managed discharge from hospital to home or to homely surroundings</td>
<td>3, 7, 9</td>
<td>Particular needs Private sector Fuel poverty Homelessness Asset management</td>
<td>Adaptations; Specialist provision role in anticipatory planning to be developed; Step-up/step-down facilities for hospital discharge to be explored; Housing options – holistic approach and consideration of overall support options; Housing support</td>
</tr>
<tr>
<td>Reducing avoidable admissions to hospital</td>
<td>3, 7, 9</td>
<td>Private sector; Particular needs Affordable housing Asset management</td>
<td>Adaptations; Care and Repair dementia project; specialist provision; dementia design; housing support; housing frontline staff and craft workers</td>
</tr>
<tr>
<td>Involving and engaging communities</td>
<td>1, 5, 6, 9</td>
<td>Tenant participation Particular needs</td>
<td>Tenant participation frameworks; Locality planning and capacity building to be further developed</td>
</tr>
<tr>
<td>Reducing health inequalities</td>
<td>1, 2, 3, 5, 9</td>
<td>Homelessness</td>
<td>Housing support for vulnerable individuals; Quality housing stock; Affordable and appropriate housing; Specialist provision</td>
</tr>
<tr>
<td>Better support for unpaid carers</td>
<td>2, 6, 9</td>
<td>Particular needs</td>
<td>Community use of specialist provision</td>
</tr>
<tr>
<td>Self-management of long-term conditions</td>
<td>2, 4, 5, 9</td>
<td>Private sector Affordable housing Particular needs</td>
<td>Adaptations; Specialist Provision; Early intervention and prevention; Housing support; Housing options; Signposting for frontline staff</td>
</tr>
</tbody>
</table>
6. **Structure Chart**

The diagram below shows how housing partners work together through the Local Housing Strategy and contribute to the Health and Social Care Partnership.

[Diagram showing the structure chart]

The Aberdeenshire Housing Strategy Group is represented on the Health and Social Care Strategic Planning Group. All nine strategic outcome groups will support health and social care. At a local level there will be support teams in place and housing will play a role in liaison with social work services:
Appendix 6

Health and Equality Impact Assessment Summary

A Health and Equality Impact Assessment (H&EIA) assessment of the strategic plan was carried out, the results of which are summarised below. The full H&EIA is available on Aberdeenshire Council’s website in the pages about health and social care integration.


Older People

There will be a positive impact in that maintaining an active and healthy lifestyle into the later years of life increases health and wellbeing. For those people who need practical help to continue to live in their own homes, greater community support will complement formal services and reduce social isolation. It was recognised that expecting communities to offer more support for older people may increase the perception that older people are a ‘burden’, but this will be mitigated by work to promote the value that older people bring to society and support for intergenerational work.

Improving access to local information, care and treatment will particularly benefit older people who have mobility problems. Some older people are also unpaid carers and the plan strongly supports the role and value of unpaid carers of all ages.

Developing more sheltered/very sheltered housing will promote health and wellbeing for those older people living in fuel poverty.

Younger people

The increased emphasis on preventing common diseases and modifying health-related behaviour such as smoking, will improve the health of young people.

Ethnic minority groups

About 2,000 people in Aberdeenshire identify themselves as Asian. Pakistani and Bangladeshi people have poorer health than the White Scottish population. Person-centred work, which takes into account a person’s beliefs, values and culture, is likely to benefit these groups. However, people who are not fluent in English may have difficulty comprehending and following advice and guidance. The H&SACP has committed to offering documents in different formats and languages as well as access to Language Line and translation services.
Gypsy travellers
There is a commitment to ensure that people are listened to and their personal circumstances taken into account, which is intended to improve the experiences of Gypsy/traveller communities in using services. Outreach programmes will continue, and local actions plans will be sensitive to the needs of the travelling community in their area.

Employees
The strategic plan sets out actions that are designed to increase skills, knowledge and improve morale and job satisfaction. Those employees who have caring responsibilities will be supported by HR policies that effectively balance service requirements with recognising and supporting the needs of staff. Managers will be familiar with these policies and will apply them fairly.

Looked After Young People
This group of people have some of the poorest health outcomes. Focussing on reducing health inequalities will especially benefit them. It is recognised that some young people who are or have been looked after may not have strong connections to their local area. Health and social care staff and Third Sector organisations will continue to support them to develop a sense of place and belonging.

People with disabilities or long term health problems
Developing community-based ways of working will make it easier for people to access services. The strategy intends to support the 27% of residents who report having one or more long term health conditions to live well with these conditions. Bringing rehabilitation and enablement into mainstream practice will benefit this group. The strategy promotes the development of social networks that act as a buffer against mental ill health.

People with Learning Disabilities including Autism
The strategy is entirely consistent with the local strategy for people with learning disabilities which is being implemented successfully across Aberdeenshire. Work to strengthen community capacity, to offer treatment and care locally where possible and to reduce physical and communication barriers are seen as positives.
Lesbian, gay, bisexual, heterosexual people

There is a commitment to ensure that people are listened to and their personal circumstances taken into account. This will improve the experiences of people who are LGBT. The H&SCP will develop equalities outcomes and an action plan which will include a requirement for diversity training for employees.

People in the criminal justice system

Community-based commissioning of health and social care services means that the Courts can have wider sentencing options that have better health and offending outcomes.

People misusing substances

People with substance misuse issues may find it easier to be aware of and access local support. The existing policy to retain and expand local services should continue since it is associated with positive results. However, although stigma will continue to be challenged, it is recognised that some people will still prefer to access services outwith their local area, and this option will continue to be available.
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<td>11</td>
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<td>Meaningful engagement with all stakeholders to optimise effective planning and use of resources</td>
<td>13</td>
</tr>
<tr>
<td>Empowering the workforce</td>
<td>16</td>
</tr>
<tr>
<td>Developing the support mechanisms that enable people to have improved health and wellbeing</td>
<td>19</td>
</tr>
<tr>
<td>Ensuring quality through safe, effective and sustainable service provision</td>
<td>21</td>
</tr>
<tr>
<td>Reducing inequalities to provide equitable outcomes for our communities</td>
<td>25</td>
</tr>
<tr>
<td>recovery and achieve their potential</td>
<td>26</td>
</tr>
<tr>
<td>Public Protection</td>
<td>28</td>
</tr>
<tr>
<td>Prevention and early intervention to promote healthy lifestyles and resilient communities</td>
<td>32</td>
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<td>The most appropriate and effective use of acute and community resources</td>
<td>36</td>
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</tr>
<tr>
<td>References</td>
<td>46</td>
</tr>
</tbody>
</table>
Foreword

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

Aberdeen Health and Social Care Partnership Vision

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

We have sought to present these in a balanced and informative way, recognising that the HSCP is still a young organisation and continuing to learn and evolve.

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

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

Finally, we wish to acknowledge the contribution of the people of Aberdeenshire to helping us learn and improve engagement undertaken by us to date, indeed the scale of public involvement was unprecedented. We know high regard for their local health and care services. We are committed to continuing to listen and respond to the views of the people of Aberdeenshire as we move forward with our transformational change programme to ensure we provide safe, effective, responsive and sustainable local services for the future.

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

Dr Lynda Lynch
Chair,
Aberdeenshire IJB

Councillor Anne Stirling
Vice-Chair,
Aberdeenshire IJB

Adam Coldwells
Aberdeen Health and Social Care Partnership
Executive Summary

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

The report is structured around our ten strategic priorities:

i. Meaningful engagement with all stakeholders to optimize effective planning and use of resources
ii. Empowering the workforce
iii. Developing the support mechanisms that enable people to have improved health and wellbeing
iv. Ensuring quality through safe, effective and sustainable service provision
v. Reducing inequalities to provide equitable outcomes for our communities
vi. Recovery and achieve their potential
vii. Public protection
viii. Prevention and early intervention to promote healthy lifestyles and resilient communities
ix.

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

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

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

In addition the Virtual Community Ward model has continued to be implemented locally, bringing together multidisciplinary health and social care teams who provide care for people who need regular or urgent attention, of people have avoided unnecessary admission to hospital as a result of this approach.

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

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

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

With a proactive approach we are taking to address this over the next 5 years through our Medium Term Financial Strategy.
We know that continuing to deliver services in the same way will not be sustainable nor meet the needs of our communities in the future. This report describes the four programme plans developed in 2017-18 which will cover Care; Enabling Health and Wellbeing; Facilitating Shared Ownership and Engagement; and Safe, Effective and Sustainable.

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

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

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

All Integration Joint Boards are required to publish an annual report. This annual report documents our performance over our second year of operation. Throughout this report, performance information for our – 2016-17 and 2017-18 – has been provided, to report on progress through 1

Organisational Overview

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

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

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

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

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

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

• Describe the key areas of work and achievements for Aberdeenshire Health and Social Care Partnership (HSCP) from April 2017 to March 2018.

• Acknowledge the various challenges we have faced in the last year, what we have learned, and how we have responded to these challenges.

• Describe the progress of the HSCP in delivering our strategic priorities, and the work we must still undertake.

• Explain what this has meant for individuals, carers and families at the heart of our local communities.

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

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

• Commitment and leadership

• Sound governance at a strategic and operational level

• Accountability

• Sound management of resources

• Responsiveness and consultation

• Use of review and options appraisal

• A contribution to sustainable development

• Equal Opportunities arrangements

• Joint working.

have demonstrated these characteristics.
Policy and Strategic Context

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

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

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

- **Our changing demography** – By the year 2035, it is forecast that the population of people aged over 65 in Aberdeenshire will have increased by 65%. Whilst a great success story, it also means that people will be living longer with potentially more complex health or care needs.

- **Increasing financial constraints within the public sector** – The increase in demand on health and social care services will place an increasingly unsustainable pressure on resources and current models of service delivery. Put in context, we expect a year on year increase in costs of at least 1.7%, or around £5 million per annum.

- **Workforce pressures** – Our recruitment challenges in Aberdeenshire mirror many of those being reported nationally, for example there have been well documented challenges in the GP workforce across Scotland. But we also see similar challenges in nursing, home care, and a variety of other health and social care professions.

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

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

The following diagram attempts to set out the relationship between the national outcomes and our own strategic priorities and vision.
In the last year we have produced our new Commissioning Plan (Implementation and Change Plan) 2017 – 2019. This document sets out our intentions in terms of service planning and priorities to deliver the Strategic Plan within available resource. In this updated Commissioning Plan, we have streamlined our strategic themes and priorities to ensure they remain locally relevant whilst continuing to support the delivery of the National Health and Wellbeing outcomes.
In addition, the HSCP has developed four programme plans which will drive forward the operational service resource. Each of the Programme Plans has a particular focus but encompasses a range of diverse and inter-dependent projects, as described below.

**Reshaping Care:**
The strategic aim of this programme is to ensure the most appropriate and effective use of resources both within the community and in the acute hospital sector. It is centred around the 4 key themes of rehabilitation and enablement; responder services; end of life care; and care in remote and rural communities.

**Enabling Health and Wellbeing:**
This programme will oversee the Primary Care Transformation project, including implementation of the new GP Contract, and ensuring the future. Our linkages with third sector partner providers are also critical to successful delivery of this programme.

**Safe, Effective and Sustainable:**
The development of services and future and meet the needs of our communities form the basis of this programme focusing on learning disabilities services, community mental health services, care homes, substance misuse services, community justice and adult protection.

**Facilitating Shared Ownership and Engagement:**
This programme covers the range of ‘enablers’ underpinning successful delivery of all the programme plans. This includes: supporting meaningful public engagement; targeting of resources; planning; development of infrastructure; locality planning; and mainstreaming equalities.

The four programme plans will be crucial to ensuring we can deliver against our strategic priorities and within available budgets. We are aware of the huge challenges facing us and consequently during 2017-18 we developed a Medium Term Financial Strategy to help us take a more planned and pragmatic approach to our
Performance Measurement

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

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

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

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

In addition, we have 40 local performance indicators which further help us measure and understand how we are performing in key areas across health and social care (see Appendix 3 for a summary of our 2017-18 performance). Our local indicators have been given challenging targets to meet. Where our performance for purpose. This will support the IJB in decision-making, governance and scrutiny, and will inform local service planning and delivery. Our key aim is to understand and demonstrate what outcomes we are achieving for the people of Aberdeenshire, in line with the National Health and Wellbeing Outcomes.

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

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

<table>
<thead>
<tr>
<th>Priority</th>
<th>Achievements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meaningful engagement with all stakeholders to optimise effective planning and use of resources</td>
<td>• Locality Planning, Minor Injuries Unit Review, Participatory Budgeting</td>
</tr>
<tr>
<td>Empowering the workforce</td>
<td>• Locality team development, Workforce plan, iMatter</td>
</tr>
<tr>
<td>Developing the support mechanisms that enable people to have improved health and wellbeing</td>
<td>• Implementation of Carers (Scotland) Act, Development of Carers Strategies for adults and young people</td>
</tr>
<tr>
<td>Ensuring quality through safe, effective and sustainable service provision</td>
<td>• Mental Health Services, Suicide prevention, Quality Improvement projects</td>
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<tr>
<td>Reducing inequalities to provide equitable outcomes for our communities</td>
<td>• Mainstreaming equalities, Ethnic minority involvement and consultation</td>
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<tr>
<td>Involving people as partners with appropriate support to promote recovery and achieve their potential</td>
<td>• Primary Care Transformation, Dementia Strategy</td>
</tr>
<tr>
<td>Public Protection</td>
<td>• Multi Agency Public Protection Arrangements, Community Justice, Adult Support and Protection, Inspection of services</td>
</tr>
<tr>
<td>Prevention and early intervention to promote healthy lifestyles and resilient communities</td>
<td>• Children and young people’s health, Making Every Opportunity Count, Alcohol Brief Interventions, Health Inequalities</td>
</tr>
<tr>
<td>Learning Disability Services, Inclusive day services, Older people’s accommodation</td>
<td>• Joint Equipment Service, Technology Enabled Care, Virtual Community Ward, Rehabilitation and Enablement, Responder service, Mainstream homecare</td>
</tr>
</tbody>
</table>
Theme 1: Partners within health and social care at individual, community and professional level

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

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

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

Locality Planning

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

![Map of Aberdeenshire](image)

Previously, we reported that we had established locality planning groups within each of the six local authority areas: Banff & Buchan, Buchan; Garioch, Formartine, Kincardine & Mearns, and Marr. The groups are made up of a range of stakeholders, including health and social care staff, third sector representatives, staff from housing services, community planning, patients, and carers. The core purpose of the groups was to ensure wide representation and involvement in the process of developing Aberdeenshire HSCP’s 2018-21, which were produced during 2017-18.
Continuous stakeholder engagement was central to the development of the locality plans. Members of each locality planning group had a responsibility to involve their internal and external networks in reviewing the proposed areas of focus for each plan and in providing comments and feedback as the plans were developed.

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

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

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

and March 2018. The consultation was promoted widely through social media, HSCP and third sector organisation staff members, community groups, and networks. Location Managers and other staff from Aberdeenshire HSCP also presented the plans at events across Aberdeenshire, including area committees, plans.

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

during 2017-18 will be used to inform the new Aberdeenshire HSCP Strategic Plan for 2019-22.

A Performance section below.

**Reviewing Aberdeenshire’s Minor Injury Units**

As explained above, we are committed to planning and delivering health and social care services in a more ef person-centred way. Part of that commitment means ensuring that people can access the right treatment at the right time in the right place.

In line with this aim, during March 2018 we carried out our most extensive piece of public engagement to date, to review the Minor Injury Units (MIUs) across Aberdeenshire.

The purpose of the MIU review was to seek assurance regarding the current MIU provision across the nine units in Aberdeenshire, taking into consideration location, demand and activity, practitioner competency and ongoing sustainability.

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

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

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

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

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

**Participatory budgeting**

Supporting individuals and communities to take greater responsibility for their own health and wellbeing, and introduced in Aberdeenshire in 2016. The aim of this was to:

- Increase community participation in decision making processes about HSCP funding;
- Stimulate positive action for health and wellbeing in communities experiencing deprivation / health inequalities and build community capacity / social capital.

In 2017-18 over 3,000 people voted in six PB activities to determine the allocation of a total funding allocation of £326,000 for small grants.
Empowering and enabling communities: Your Voice Your Choice

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

23 applications went forward to the voting stage and groups ranged from a local primary school pupil to the organisers of a local fish festival. The ‘Big Event’ was held at Bervie Primary School on Saturday 24th June 2017. Following all presentations, votes were cast and then winners were announced.

One of the successful applicants was Kincardine & Deeside Befriending. Their project was about befriending in the South Mearns Coastal Strip, with the aim of reducing loneliness and isolation for older people by matching them on a one-to-one basis with a volunteer befriender. A regular visit from a befriender can provide companionship, practical and emotional support, welcome respite provided.

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

Priority 2: Empowering the Workforce

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

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

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

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

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

The Workforce Plan and iMatter staff engagement process.
iMatter

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

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

- 71% of staff feel appropriately trained and developed;
- 81% of staff would be happy for a friend or relative to access services within the Aberdeenshire Health and Social Care Partnership.

They agreed action plans for improvement and to date, 205 out of 247 teams have created and added these plans to the iMatter story board. This demonstrates the strong commitment from staff and managers throughout the Partnership to the iMatter process.

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

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### iMatter – A Team’s Experience

**Team Manager**

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

The conversation could be a little uncomfortable at times, but the team had the opportunity to speak openly and directly about what was working well for them and what could be better.

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

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

**Team Member**

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

and to build from there as well as discuss what wasn’t going so well. The team developed an action plan together rather than having one imposed upon us and I feel we have ownership of the plan and collective responsibility for it.

W
was originally intended. The actions taken have reduced isolation, caseload management has improved and time delays have been reduced to name just a few.

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

The 2018 Workforce Plan sets development of the workforce within the context of the Health and Social Care Partnership Strategic Plan and the Commissioning (Implementation and Change) Plan 2017-19. Its purpose is to ensure that we have the correct size of workforce with the right skill mix to support the ongoing redesign of services across Aberdeenshire that can be delivered and sustained within the available budget. The plan's vision.

It covers all staff employed by NHS Grampian and Aberdeenshire Council working within the integrated framework.

The Workforce Plan aims to integrate:

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

An action plan is incorporated into the Workforce Plan, the overall success of which will be measured against achievement of the outcomes above.

Identifying training and development needs

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

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

Support and guidance has also been provided to teams across the HSCP in process improvement and effective team working. The aim is to support and enable a culture of continuous improvement throughout the whilst maintaining high quality of services.
Priority 3: Developing the support mechanisms that enable people to have improved health and wellbeing

Engaging and working with unpaid carers continued to be a priority during 2017-18. During this year, our main area of focus was on preparing for introduction of the Carers (Scotland) Act 2016. This new legislation came into force on 1st April 2018 and brings new duties and responsibilities for the Health and Social Care Partnerships.

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

The HSCP commissions a carers support service from Quarriers, which provides support to young and adult carers. In addition to this service, other organisations also provide support to carers; for example, the organisation Promoting A More Inclusive Society (PAMIS), provides a specialist service for families of people with profound and multiple disabilities.
Looking ahead to 2018-19, from 1 April 2018, carers will be offered an Adult Carer Support Plan (ACSP) or Young Carer Statement (YCS), which for this reporting period will be described as a carer’s assessment. This assessment determines what information, training and assistance will enable the carer to continue in their caring role.

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

The number of carer assessments was higher at the start of Quarter 1, due to Quarriers working through a backlog of referrals since starting the service. The reason for this being that data was not transferred from the previous commissioned carer support service and so they had to start from the beginning. The number of carer assessments then gradually decreased over the year as Quarriers caught up with their referrals.
Achievements during 2017-18 have included the production of draft Local Carer Strategies.

The Partnership and Aberdeenshire Council developed separate Local Carer Strategies for both adult and young carers which were consulted on in draft form in early 2018.

These strategies outline the plans of what we will to do over the next few years to best support carers in Aberdeenshire. Consultation on both strategies was in the form of a survey and face-to-face consultation with all relevant stakeholders.

We also prepared and consulted on separate draft Eligibility Criteria for adult and young carers, based on a national framework provided by the Scottish Government. This framework detailed areas, or quality of life indicators, which are used to assess a carer’s eligibility for social care services. After full consultation with stakeholders, these were ready to be approved by the IJB and Children’s Services and Education Committee in April 2018.

In December 2017, a carer representative was appointed to the IJB. The representative will communicate the views of carers to the IJB on all issues discussed at monthly meetings.

Carers Act. From the 1st of April 2018, the ACSP and YCS will gather the mandatory data required. We are also providing regular updates to the IJB on the impact of the Carers (Scotland) Act 2016 for our local carers.

The Partnership continues to support carers to access training and development opportunities. There is an ongoing programme of support for carers to complete a Scottish Vocational Qualification in Social Services and Healthcare, if the cared-for is an adult, or Social Services (Children and Young People) if the cared-for is a baby, child, or young person. Since the start of this project in 2014, almost 70 carers have

Looking forward into 2018-2019, we will be monitoring the impact of the Carers (Scotland) Act 2016, including our support for carers following the implementation of the Act.

**Priority 4: Ensuring quality through safe, effective and sustainable service provision**

W and to remain at home or in a homely setting with appropriate care and support. The following section describes some key areas of progress during 2017-18 in delivering against this priority.

**Mental Health Services**

The Aberdeenshire Mental Health Strategic Outcomes Group is the main forum for bringing together key stakeholders in community mental health and autism services. The group is made up of members from across the Partnership and the third sector with representation from the Community Mental Health Team (CMHT), Public Health, Aberdeenshire Voluntary Action (AVA) and Scottish Association for Mental Health (SAMH). The group meet every two months, to discuss, review, and determine key priorities and to ensure these are clearly aligned to our four programmes of work. We continue to support individuals who have found the change of .

The integrated management structure introduced in January 2017 established three Managers for Mental Health and Learning Disability, covering North, Central, and South Aberdeenshire. These posts manage both NHS Grampian and local authority staff. This new structure has undoubtedly enabled stronger partnership working to achieve a joined-up approach to holistic service provision and allocation of resources.
Community Mental Health Teams

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

Primary Care Psychological Service

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

Direct Access Community Supports

In our last report we highlighted work undertaken to commission a more inclusive and sustainable model of community support for people with mental health problems with an increased focus on recovery, achievement of personal outcomes, and equitable access. SAMH are currently commissioned to provide a range of recovery focused community services, branded My Life Dynamic. My Life Dynamic comprises six elements which people can access based on their individual needs and what would be most helpful to them in building self-resilience and achieving their recovery goals. These are Supporting Wellness through Employment and Learning (SWEL), The Listening Project, AyeConnect, Know-where-to-go, Cultivate, and hearME. A dedicated website provides further information on what is available and how to make contact. The most recent contract monitoring report indicates that 236 people currently access these services across Aberdeenshire with 15-20 new referrals being received each week. The ‘hearME’ initiative has proved and developments.

A pilot 1st Response service is currently provided by Penumbra and allows immediate and direct access to people feeling overwhelmed or in crisis. There is no application form and no waiting list. The service supported

Public Health

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

Autism

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

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

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

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

Suicide Prevention

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

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

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

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

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

Local Suicide Statistics

across Aberdeenshire in 2017 following a 16% decrease seen the previous year. This emphasises the importance of continuing our work through the Local Suicide Prevention Action Plan to try to effect a consistent positive change on suicide rates.

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

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

Physiotherapy Quality Improvement Projects

Last year our physiotherapy team undertook a project to evaluate the use of telephone consultations for those accessing the musculoskeletal (MSK) pathway. The pilot involved four members of staff and was carried out over a three-month period, during which time 137 people were offered telephone consultation. Of those, nine the option to opt back in should they subsequently require an appointment. Of the 86, only 16 people opted back in and 70 people were discharged with no further treatment. This represents just over 50% of the pilot group.
consultation. We worked in collaboration with the Robert Gordon University (RGU) to review the literature and undertake research with the patients and staff who were involved in the pilot to identify what makes a good telephone consultation, with the aim of producing a training package for staff. This is currently being written up by RGU.

A further development during 2017-2018 has been a test of change in one GP Practice to establish physiotherapy as first contact for those requesting an appointment with their GP. Kemnay GP Practice applied for funding to enable patients to be directed, following screening by reception staff at the time of contact, to a physiotherapist for telephone consultation. Ongoing evaluation suggests that this is working very successfully and has proved popular with patients who now have immediate access to a physiotherapist for assessment and advice. If follow up is required, this can be booked at the time. To date 221 people have been directed telephone advice.
Mainstreaming equalities means ensuring that equality, diversity and inclusion are integrated into both strategic to mainstream equality across their functions. Mainstreaming is an effective way to ensure that we are considering equalities matters in relation to the work of the whole HSCP.

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

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

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

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

- Availability of trained interpreters for face-to-face interpreting services;
- Availability of ‘language line’ telephone interpretation services;
- Key health and social care information available in translation;
- On request published material translated into other language / other formats;
- Information on sources of help /support for people experiencing domestic abuse available;
- Inclusion of a statement on AHSCP publications explaining how members of the public can request the document in another format or language; and
- The public can request the document in another format or language.

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

Ethnic minority involvement and consultation

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

The Grampian Regional Equality Group was commissioned by NHS Grampian to manage and facilitate a number of involvement and consultation events, including two events in Fraserburgh during November 2017.
These events have been taking place on an annual basis since 2008. They have yielded a great deal of useful health care related information and are a very effective way of identifying areas where further improvement is needed.

Lithuanian, Latvian, Brazilian, Scottish and British. Participants completed questionnaires and took part in group discussions about experiences and accessibility of a range of services, including GP services, community services, dental services, pharmacy services, and alcohol and substance misuse.

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

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**Dental care for Syrian new Scots**

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

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

Full preventive measures.

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**support to promote recovery and achieve their potential**

**Primary Care Transformation**

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

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

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

We are, for example, seeing the development of other practitioners with enhanced skills such as nurses, allied health professionals and pharmacists, who can take on more of the care within GP practices which traditionally may have been seen as exclusively part of the GP’s role. The pharmacy service has been developing a model using both pharmacists and pharmacist technicians, supported by dedicated funding, to ensure availability across each area. This model will continue to be developed through the new contract for General Practice in Scotland.
In November 2017, the Scottish Government published the draft 2018 General Medical Services (or GP) Contract in Scotland. In January 2018, this contract was accepted by General Practitioners across Scotland. Within Aberdeenshire we are now planning for implementation of this contract over the next three years. It is hoped that the new contract will bring a number of benefits for patients through

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

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

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

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

The survey asks about people’s experiences of:

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

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

A key indicator where our performance declined slightly was the percentage of people with a positive experience of care provided by their GP Practice, moving from 83% in 2015-16 to 81% in 2017-18 (lower than the Scottish average of 83%).

Aberdeenshire Dementia Strategy

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

Presently, we monitor the percentage of new dementia diagnoses who receive one-year post-diagnostic support as a local indicator within our performance framework. The data for this indicator is provided by ISD. It is Aberdeenshire achieved 89.5%

2017/18 is not yet available as complete data is not collected until 12 months after diagnosis.
As noted, they are integrated within the local Community Mental Health Teams through which a range of post-diagnostic support is provided by all members of the multi-disciplinary team, including Community Psychiatric Nurses, Occupational Therapy, and Social Work colleagues. Evaluation is underway of how Post Diagnostic has access to this vital support.

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

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

Priority 7: Public Protection

Multi Agency Public Protection Arrangements (MAPPA)

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

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

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

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

A revised MAPPA awareness package has been developed within Aberdeenshire and is now widely available.

Domestic Abuse

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

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

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

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

Over the past year we have worked with the Aberdeenshire Employability Partnership to improve access to employability services for people at all stages within the justice system. An employability group has also been established and meets weekly with a programme led by participants. We have also set up a running group.

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

Operation Hotspur, which is a joint initiative with Police Scotland and Community Substance Misuse Service, runs in North Aberdeenshire and of factor during contact with the police.

The Community Justice Resource Centre in Peterhead now offers a full programme of services and activities, including a Women’s Drop in and Women’s Group, Harm Reduction Clinics, and Caledonian Group. A rolling job skills and employability, community safety, and consequential thinking, has recently commenced at the centre. W once complete, we will replicate the programme there as well as providing a base for the Integrated Community Substance Misuse Service.

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

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

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

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

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

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

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

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

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

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

In November 2017 a Joint Thematic Inspection of Adult Support and Protection in Aberdeenshire was carried out, led by the Care Inspectorate with support from Her Majesty’s Inspectorate of Constabulary and Health Improvement Scotland. The Inspection involved submission of a position statement and supporting evidence, 12 scrutiny sessions.

The full inspection report is awaited and will be considered at the Adult Protection Committee following publication. Recommendations from the report will be included in the Adult Protection Committee 2018-20 Action Plan.
Inspection of Services – Care Inspectorate

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

<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
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<tbody>
<tr>
<td>6</td>
<td>Excellent</td>
</tr>
<tr>
<td>5</td>
<td>Very Good</td>
</tr>
<tr>
<td>4</td>
<td>Good</td>
</tr>
<tr>
<td>3</td>
<td>Adequate</td>
</tr>
<tr>
<td>2</td>
<td>Weak</td>
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<tr>
<td>1</td>
<td>Unsatisfactory</td>
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Services are assessed by four quality themes:

<table>
<thead>
<tr>
<th>Quality Theme</th>
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</thead>
<tbody>
<tr>
<td>Quality of Care and Support</td>
</tr>
<tr>
<td>Quality of Environment</td>
</tr>
<tr>
<td>Quality of Management and Leadership</td>
</tr>
</tbody>
</table>

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

Table: Care Inspectorate Average Grades

<table>
<thead>
<tr>
<th>Reporting Year</th>
<th>Quality of Care &amp; Support</th>
<th>Quality of Environment</th>
<th>Quality of Management &amp; Leadership</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016/17 Average Grades</td>
<td>4.7</td>
<td>4.9</td>
<td>4.8</td>
</tr>
<tr>
<td>2017/18</td>
<td>4.6</td>
<td>4.5</td>
<td>4.6</td>
</tr>
</tbody>
</table>

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

If a service does not achieve the expected grades, improvement action plans are put in place and staff will work directly with the Care Inspectorate to ensure issues are addressed quickly and professionally. Full details of all inspections of Aberdeenshire services can be found on the Care Inspectorate website: www.careinspectorate.com
Priority 8: Prevention and early intervention to promote healthy lifestyles and resilient communities

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

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

Children and young people’s health

A population approach from pre-birth to later life is needed to improve health and wellbeing in Aberdeenshire. Early interventions to improve children and young people’s health are an important part of this. Health Visitors Pathway has been rolled out in an incremental way, with more universal home visits undertaken, and increased use of the Pathway materials and guidance.

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

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

Mental wellbeing is also an important factor.
Childsmile has been instrumental in improving oral health outcomes for Aberdeenshire's children.

The Childsmile teams also worked with 87 nurseries and primaries in the 20% most deprived areas of Aberdeenshire to support Aberdeenshire schools to adopt a whole school approach to health and wellbeing with a specific focus on child healthy weight, healthy eating and active living. Initiatives taken forward included adoption of the Daily Mile, the Food For Life programme and Grow Well Choices - a locally developed resource for Early Years establishments and Primary Schools, to support children to adopt healthy lifestyles and a healthy weight. The latest available data shows that 77% of Aberdeenshire children in Primary 1 had a healthy weight.

Upper Marr Health Visiting Service

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

The Trainee Health Visitor raised the issue for discussion at the Early Years Forum to look at income streams that would enable the group to continue. The Early Years Forum includes partner agencies from statutory services and third sector, including Home Start which has a national agreement for supported Early Years establishments.

As a result of this intervention and with the support of Home Start, the group was able to continue to fund the hire of their premises at a reduced rate. In addition, three of the parents have become Home Start volunteers which has raised the profile of this service within a small rural community with minimal public transport links.

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

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

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

Across Aberdeenshire this has included the following activities.

- 15 active Health Walk groups offering 20 weekly and one monthly walking opportunities
- 28 volunteers have been trained to lead health walks, of which 18
- Two Aberdeenshire Health Walk groups working through a 12 months Dementia Friendly accreditation process.
- One Disability Inclusion training course has been delivered in partnership with Paths for All

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

Making Every Opportunity Count

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

More focussed support was provided to services working with people experiencing disadvantage to embed MEOC into everyday practice. For example, Victim Support reported that using MEOC routinely has helped provide ‘a more rounded service’ with MEOC conversations covering a range of issues including housing, This approach is now being explored with Health and Social Care Teams teams, for example the Diabetes and Heart Failure Team and North Aberdeenshire Physiotherapy Team, to mainstream health and wellbeing conversations.

In 2017 over 500 staff across Aberdeenshire participated in a MEOC awareness session, including 20 Department of Work and Pensions Work Coaches
Alcohol Brief Interventions

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

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

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

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

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

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Aberdeenshire Wellbeing Festival

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

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

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

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

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

Priority 9:

Learning Disability Market Position Statement

Last year we told you about the successful development of extra care housing at St James’ Court, Inverurie. An evaluation of this development has provided us with insights which will inform our approach to the provision of extra care housing for those with learning disability in future. We intend to reduce the number of people with learning disabilities inappropriately placed or placed out of area because of the lack of availability of suitable local accommodation. An increase in the provision of extra care housing will be required to support this objective. We are in the process of developing a Market Position Statement which makes our strategic intentions clear to potential third and independent sector partners. We hope that when published this will stimulate future development of extra care housing. We will work with our housing colleagues to ensure the Market Position Statement reaches potential developers.

Inclusive Day Services – Enabling Aberdeenshire (IDEA) project

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

It included the development of a fully accessible changing place with the aim of improving access to the community for those with profound and multiple disability. This project also made it possible to close costly to maintain and for those who still required a building base for some of the time, to move into much improved facilities in Port Road. Use of the innovative Pitscurry Project was also increased.

The Pitscurry Project provides craft and work activities including gardening, horticulture, wood kindling, wood work, arts, crafts and pottery for up to 25 adults with learning disabilities each day. The gardens produce soft fruit and vegetables which supply the on-site training café. The Buzzard Café provides up to six people the opportunity to work both in the kitchen and serving meals to members of the public each day with support from two staff members.
An evaluation of the IDEA project was undertaken one year in, taking account of the views of service users, family carers, day service staff and Health and Social Care professionals. This highlighted that we have been particularly successful in enabling those with low to moderate learning disabilities without multiple and complex physical disability to access community activities and to feel more integrated with the community.

However, these outcomes for those with profound and multiple disability, those who present behaviour which challenges and those with severe autism. The changing place is well used by those who attend Inverurie DAYS but has not been accessed this year by other members of the Community yet. The IDEA approach is now mainstreamed and being applied across all other adult day services sites across Aberdeenshire.

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

Community detoxification and rehabilitative pathway

Health and Social Care Integration in Aberdeenshire has brought together the two statutory services which deliver assessment, treatment and intervention to people and their families who are affected by problematic drug and alcohol use. The practice is a working model in North Aberdeenshire where use of both “home detox” and community hospitals is established. In South and Central Aberdeenshire, the clinical lead nurse for alcohol has delivered training and support to health and social care staff. Working links are also being established with relevant Location Managers and community hospitals. The model is now ready to be rolled out.

Clearer links have also been established around pathways out of substance misuse mental health nurses and community substance misuse social workers and support workers. The period of such a short detox is most effectively enhanced through the continuation of the detoxification process through community support intervention and treatment.

Older People’s Accommodation

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

Deer and Rose Innes, Aberchirder – have now closed and two new build in-house care homes have opened in Stonehaven and Inverurie. A third, North Aberdeenshire Care and Support Village in Peterhead, is at the planning stage. We have also started looking at sheltered housing, very sheltered housing and care home capacity to help us ensure there is sufficient capacity in the right places enabling people to continue to live in their own communities as their needs change.

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

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

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

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

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

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

Aberdeenshire Joint Equipment Service

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

The Service employs a range of staff performing a variety of functions including arranging delivery, installation, training (supported by occupational therapists) and return collections, and a full maintenance and repair service for equipment provided. The number of deliveries made over the 7 years of operation and value of orders provided has more than doubled homes each month alone.
During 2017-18 the service has been working towards taking on the delivery, servicing, decontamination and maintenance of children’s equipment, which will facilitate more effective provision of equipment across Health, Community and Education settings. A range of specialist equipment has also been incorporated including communication aids.

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

**Technology Enabled Care**

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

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

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

**Virtual Community Ward**

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

Every quarter, the VCW team provide a report on the actual VCW discharge outcome as well as what the presumed outcome might have been if the VCW were not in operation. While the presumed outcomes are arguably speculative, they are based on the views of experienced clinicians. Based on their opinions, the table below shows the number of VCWs in operation over the last two years, the number of patients who have been admitted, and the number of hospital admissions we believe have been avoided.

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of VCWs</th>
<th>Number of admissions to VCWs</th>
<th>Number of hospital admissions avoided</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016-17</td>
<td>26</td>
<td>1,674</td>
<td>627</td>
</tr>
<tr>
<td>2017-18</td>
<td>27 (84% of Aberdeenshire practices)</td>
<td>1,619</td>
<td>592</td>
</tr>
</tbody>
</table>

Based on these figures some hospital admissions may have been avoided over which can be broken down into 411 acute and 808 community hospital admissions over the two reporting years.

There has, as yet, been no formal evaluation of patient satisfaction and experience with the VCW model. In part this is because many may not be aware that their care is being organised behind the scenes in a different manner. Anecdotal evidence, where patients are aware of the VCW structure and have heard of its success, shows that in some areas patients are actively asking for admission to the VCW model as a preferred pathway.
During summer 2017, VCW teams were asked to provide feedback on their experiences of the VCW. VCW model had made to their local services and patient outcomes.

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

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

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

**Rehabilitation and Enablement**

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

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

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

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

**Ugie Hospital Peterhead review**

We are currently undertaking a review of the provision of services on the Ugie Hospital site with a view to ensuring that our buildings are used most ef

Over the last year we established a short life working group to produce an options appraisal for alternative patient pathways at Ugie Hospital and six options are currently under consideration. A public consultation exercise and community engagement event were held in Peterhead with the approach informed by the National
Standards for Community Engagement. A questionnaire was developed and published on the Health and Social Care Partnership Facebook page and provided in paper format at local healthcare premises. The questionnaire was also available for completion at the engagement event. 577 responses were received, and these are currently being analysed. 159 people attended the engagement event. Results of the questionnaire will be used to inform the next stage of the report.

Responders Service (ARCH)

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

Mainstream Homecare

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

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

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

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

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

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

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

Our performance is also measured against the number of delayed discharge bed days. This indicator is important because it tells us about the number of days that patients in hospital, having been assessed as available.

Our performance against the national target of number of Delayed Discharge bed days again based on most delayed discharges between 2015-16 (28,293) and 2016-17 (18,176). Provisional data for 2017-18 suggests
We also monitor our performance against a locally set indicator (Local Indicator 11, see Appendix 3) which provides a census snapshot of the number of delayed discharges. In comparing our performance against this target between quarter 4 of 2016-17 and quarter 4 of 2017-18, we can see a slight downward trend from 42 to 39, albeit this has fluctuated during the year.

Winter months as activity and pressures on the system increase. There are further complexities for example intervention, or people with mental health illness who require very specialised supported accommodation.

The overall trend for people waiting for a care home place or home care continues to decrease. The overall priority for Aberdeenshire HSCP and managed carefully to ensure it remains person-centred and does not promote poor outcomes.

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

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

\(^2\)ISD data for 2017/18 are provisional and may be revised in future.
Financial Performance

We are determined to meet through integrated partnership working as well as prioritised resource management. To put in context, our current planning assumptions are to expect a year on year increase in costs of at least 1.7% or around £5 million per annum.

services, prescribing and community hospital services. A range of actions were implemented to monitor and effect positive changes on our position of £3.483 million over budget.

represents 1.1% of a £303 million revenue budget.

The complex range of services and funding which the HSCP is responsible for is illustrated in the following two diagrams providing a breakdown of our expenditure in 2017-18 by service area and by localities.

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

Within our last years. This strategy has now been developed, constructed around our 4 programme plans, and agreed by the IJB.

can continue to meet the needs of our communities in the provision of high quality, safe and affordable local of health and social care services.
Audit and Governance

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

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

**Members**

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

3In line with the Integration Scheme Cllr Anne Stirling stepped down as Chair of the IJB on 31/03/18 and was replaced by Dr Lynda Lynch.
The IJB has a responsibility to ensure that its business is conducted in accordance with the law and proper standards, that public money is safeguarded and properly accounted for and used economically effectively. The IJB has continued to meet monthly during 2017-18 including receiving regular reports on the HSCP’s advance.

Audit Committee

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

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

An area of focus for the Committee during 2017-18 was the Post Integration Review, which reported against how the HSCP was meeting the requirement of Scottish Government Integration Financial Assurance Guidance. This provided assurance over whether integration objectives were in line to be achieved, including evaluation of Assurance was obtained over each of these areas.

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

Clinical and Social Work Governance Committee

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

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

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

Grampian and North of Scotland Context

is accountable to the IJB for the management of integrated services. At a Aberdeen City and Moray HSCPs, and has regular performance reviews with the Chief Executives of NHS Grampian and Aberdeenshire Council.

opportunities for joint working on a North of Scotland basis.
Appendices

Appendix 1: National Health and Wellbeing Outcomes

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

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

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

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

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

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

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

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

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

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

Data Source: ISD  
Last updated: July 2018

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

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Title</th>
<th>Aberdeenshire</th>
<th>Scotland</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>NI - 1</td>
<td>Percentage of adults able to look after their health very well or quite well</td>
<td>96% (3979) 95% (4821)</td>
<td>93%</td>
<td>A</td>
</tr>
<tr>
<td>NI - 2</td>
<td>Percentage of adults supported at home who agreed that they are supported to live as independently as possible</td>
<td>84% (213) 85% (151)</td>
<td>81%</td>
<td>G</td>
</tr>
<tr>
<td>NI - 3</td>
<td>Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided</td>
<td>79% (203) 84% (150)</td>
<td>76%</td>
<td>G</td>
</tr>
<tr>
<td>NI - 4</td>
<td>Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated</td>
<td>75% (203) 70% (126)</td>
<td>74%</td>
<td>A</td>
</tr>
<tr>
<td>NI - 5</td>
<td>Total % of adults receiving any care or support who rated it as excellent or good</td>
<td>81% (222) 83% (160)</td>
<td>80%</td>
<td>G</td>
</tr>
<tr>
<td>NI - 6</td>
<td>Percentage of people with positive experience of the care provided by their GP practice</td>
<td>83% (3227) 81% (3531)</td>
<td>83%</td>
<td>A</td>
</tr>
<tr>
<td>NI - 7</td>
<td>Percentage of adults supported at home who agreed that their services and support had an impact on improving or maintaining their quality of life</td>
<td>85% (216) 83% (148)</td>
<td>80%</td>
<td>A</td>
</tr>
<tr>
<td>NI - 8</td>
<td>Total combined % carers who feel supported to continue in their caring role</td>
<td>40% (185) 37% (125)</td>
<td>37%</td>
<td>A</td>
</tr>
<tr>
<td>NI - 9</td>
<td>Percentage of adults supported at home who agreed they felt safe</td>
<td>82% (206) 87% (152)</td>
<td>83%</td>
<td>G</td>
</tr>
<tr>
<td>NI - 10</td>
<td>Percentage of staff who say they would recommend their workplace as a good place to work</td>
<td>NA NA NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>NI - 11</td>
<td>Premature mortality rate per 100,000 persons (European age-standardised mortality rate per 100,000 for people aged under 75)</td>
<td>349 2015 331 2016</td>
<td>440</td>
<td>G</td>
</tr>
<tr>
<td>NI - 12</td>
<td>Emergency admission rate (per 100,000 population)</td>
<td>8,441 2016/17 8,395 2017/18</td>
<td>11,959</td>
<td>G</td>
</tr>
<tr>
<td>NI - 13</td>
<td>Emergency bed day rate (per 100,000 population)</td>
<td>90,234 2016/17 82,753 2017/18</td>
<td>115,518</td>
<td>G</td>
</tr>
<tr>
<td>NI - 14</td>
<td>Readmission to hospital within 28 days (per 1,000 population)</td>
<td>79 2016/17 83 2017/18</td>
<td>98</td>
<td>A</td>
</tr>
<tr>
<td>NI - 15</td>
<td>Proportion of last 6 months of life spent at home or in a community setting</td>
<td>89% 2016/17 90% 2017/18</td>
<td>88%</td>
<td>G</td>
</tr>
<tr>
<td>NI - 16</td>
<td>Falls rate per 1,000 population aged 65+</td>
<td>16 2016/17 13 2017/18</td>
<td>22</td>
<td>G</td>
</tr>
<tr>
<td>NI - 17</td>
<td>Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections</td>
<td>90% 2016/17 87% 2017/18</td>
<td>85%</td>
<td>A</td>
</tr>
<tr>
<td>NI - 18</td>
<td>Percentage of adults with intensive care needs receiving care at home</td>
<td>53% 2016/17 55% 2017/18</td>
<td>61%</td>
<td>A</td>
</tr>
<tr>
<td>NI - 19</td>
<td>Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population)</td>
<td>677 2016/17 609 2017/18</td>
<td>772</td>
<td>G</td>
</tr>
<tr>
<td>NI - 20</td>
<td>Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency</td>
<td>22% 2016/17 21% 2017/18</td>
<td>23%</td>
<td>G</td>
</tr>
<tr>
<td>NI - 21</td>
<td>Percentage of people admitted to hospital from home during the year, who are discharged to a care home</td>
<td>NA NA NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>NI - 22</td>
<td>Percentage of people who are discharged from hospital within 72 hours of being ready</td>
<td>NA NA NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>NI - 23</td>
<td>Expenditure on end of life care, cost in last 6 months per death</td>
<td>NA NA NA</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

**RAG scoring based on the following criteria**

If current Aberdeenshire position is better than current Scotland position and Aberdeenshire value has improved or stayed the same then "Green"

If current Aberdeenshire position is worse than current Scotland position and Aberdeenshire value has improved or stayed the same then "Amber"

If current Aberdeenshire position is worse than current Scotland position and Aberdeenshire value has worsened by 5% or less of previous Aberdeenshire value then "Amber"

If current Aberdeenshire position is worse than current Scotland position and Aberdeenshire value has worsened by more than 5% of previous Aberdeenshire value then "Red"
## Appendix 3: Aberdeenshire HSCP Local Indicators – Annual Performance Summary

<table>
<thead>
<tr>
<th>ID.</th>
<th>Indicator Description</th>
<th>2016/17</th>
<th>2017/18</th>
<th>RAG Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>L01</td>
<td>Percentage of Adult Protection Cases screened within 24 hours of notification</td>
<td>78%</td>
<td>84%</td>
<td>R</td>
</tr>
<tr>
<td>L02</td>
<td>Percentage of Adult Protection enquiries that proceed to Investigation</td>
<td>22%</td>
<td>36%</td>
<td>G</td>
</tr>
<tr>
<td>L03</td>
<td>Rapid response service, Home Care Responders Referrals (median minutes between referral and visit)</td>
<td>16</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>L04</td>
<td>Percentage of all clients on SDS pathway</td>
<td>83.5%</td>
<td>92%</td>
<td>G</td>
</tr>
<tr>
<td>L05</td>
<td>OT Assessments completed within timescales</td>
<td>89%</td>
<td>88%</td>
<td>R</td>
</tr>
<tr>
<td>L06</td>
<td>Number of people receiving community alarm and/or telecare</td>
<td>3336</td>
<td>3342</td>
<td>G</td>
</tr>
<tr>
<td>L07</td>
<td>Rate of emergency occupied bed days for over 65s per 1000 population, average over 12 months</td>
<td>2393</td>
<td>2334</td>
<td>G</td>
</tr>
<tr>
<td>L08</td>
<td>Emergency Admissions rate per 1000 population for over 65s, average over 12 months</td>
<td>195</td>
<td>189</td>
<td>G</td>
</tr>
<tr>
<td>L09</td>
<td>Number of people over 65 years admitted as an emergency in the previous 12 months per 1000 population, average over 12 months</td>
<td>127</td>
<td>125</td>
<td>G</td>
</tr>
<tr>
<td>L10</td>
<td>Number of Bed Days Occupied by Delayed Discharges (inc code 9) per 1000 18+ population</td>
<td>88</td>
<td>79</td>
<td>G</td>
</tr>
<tr>
<td>L11</td>
<td>Number of delayed discharges inc code 9 (Census snapshot, NO=monthly=average=for=annual=figure)</td>
<td>47</td>
<td>43</td>
<td>G</td>
</tr>
<tr>
<td>L12</td>
<td>A&amp;E Attendance rates per 1000 population (All Ages)</td>
<td>88</td>
<td>87</td>
<td>G</td>
</tr>
<tr>
<td>L13</td>
<td>A&amp;E Percentage of people seen within 4 hours, within community hospitals</td>
<td>99.6%</td>
<td>99.7%</td>
<td>G</td>
</tr>
<tr>
<td>L14</td>
<td>Percentage of new dementia diagnoses who receive 1-year diagnostic support</td>
<td>89.5%</td>
<td>not yet available</td>
<td></td>
</tr>
<tr>
<td>L15</td>
<td>Smoking cessation in 40% most deprived after 12 weeks</td>
<td>431</td>
<td>not yet available</td>
<td></td>
</tr>
<tr>
<td>L16</td>
<td>Percentage of clients receiving alcohol treatment within 3 weeks of referral</td>
<td>90%</td>
<td>88%</td>
<td>A</td>
</tr>
<tr>
<td>L17</td>
<td>Percentage of clients receiving drug treatment within 3 weeks of referral</td>
<td>90%</td>
<td>84%</td>
<td>R</td>
</tr>
<tr>
<td>L18</td>
<td>Number of Alcohol Brief Interventions being delivered</td>
<td>1112</td>
<td>962</td>
<td>R</td>
</tr>
<tr>
<td>L19A</td>
<td>Number of complaints received and % responded to within 20 working days - NHS</td>
<td>56%</td>
<td>53.6%</td>
<td>A</td>
</tr>
<tr>
<td>L19B</td>
<td>Number of complaints received and % responded to within 20 working days - Council</td>
<td>86.5%</td>
<td>93.8%</td>
<td>G</td>
</tr>
<tr>
<td>L20</td>
<td>NHS Sickness Absence % of Hours Lost, quarterly average over 12 months</td>
<td>4.7%</td>
<td>5.0%</td>
<td>A</td>
</tr>
<tr>
<td>L21</td>
<td>Council Sickness Absence (% of Calendar Days Lost)</td>
<td>5.2%</td>
<td>5.1%</td>
<td>A</td>
</tr>
</tbody>
</table>

**Notes:**
Indicators L22 – L40 are based on the results of our local bi-annual survey of service users and carers. This was not repeated in 2017-18 and therefore these indicators have been omitted to prevent inconsistency in presentation of data.
Appendix 4: Aberdeenshire HSCP iMatter Results

Staff governance standards

Well Informed 82%
Appropriately Trained & Developed 78%
Involved in Discussions 75%
Treated Fairly & Consistently, with Dignity & Respect in an Environment where Diversity is Valued 80%
Provided with a Continuously Improving & Safe Working Environment, Promoting the Health & Wellbeing of Staff, Patients & the Wider Community 80%

Experience as an individual

I am clear about my duties and responsibilities 88%
I get the information I need to do my job well 82%
I am given the time and resources to support my learning growth 75%
I feel involved in decisions relating to my job 75%
I am treated with dignity and respect as an individual 85%
I am treated fairly and consistently 84%
I get enough helpful feedback on how well I do my work 77%
I feel appreciated for the work I do 77%
My work gives me a sense of achievement 84%
My team/my direct line manager

I feel my line manager cares about my health & well-being
- 87%

I feel involved in decisions relating to my team
- 79%

My team works well together
- 83%

I would recommend my team as a good one to be a part of
- 85%

My Organisation References

I understand how my role contributes to the goals of my organisation
- 84%

I feel my organisation cares about my health and wellbeing
- 75%

I feel senior managers responsible for the wider organisation are wide
- 68%

wider organisation

I feel involved in decisions relating to my organisation
- 69%

I get the help and support I need from other teams and services within the organisation to do my job
- 75%

I would recommend my organisation as a good place to work
- 78%

I would be happy for a friend or relative to access services within my organisation
- 81%
References


6. www.quarriers.org.uk/


NHS Grampian

Finance Plan Submission for Annual Operational Plan – 2019/20

Section 1: Executive Summary

1.1 The estimated financial gap for 2019/20 is £10.2m for the NHS Board directed services. Further details of how the financial gap has been estimated is included in Section 2. This represents a 1.7% savings target for the Board with the apportionment of the savings across the key service units noted below:

<table>
<thead>
<tr>
<th>Service Unit</th>
<th>2019/20 £m</th>
<th>2018/19 £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS – directed services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Services</td>
<td>£9.4m</td>
<td>£10.6m</td>
</tr>
<tr>
<td>Mental Health and Learning Disability services</td>
<td>£0.4m</td>
<td>£0.6m</td>
</tr>
<tr>
<td>Corporate Services and Facilities</td>
<td>£0.4m</td>
<td>£1.5m</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£10.2m</strong></td>
<td><strong>£12.7m</strong></td>
</tr>
</tbody>
</table>

This does not include savings which will need to be achieved by the three Grampian Health & Social Care Partnerships to break even in 2019/20. We are currently working with the three Health & Social Care Partnerships to estimate the savings that will need to be in 2019/20 and the agree the associated improvement actions.

1.2 In terms of closing the gap the key areas of focus will be as follows:

<table>
<thead>
<tr>
<th>Service Area</th>
<th>2019/20 £m</th>
<th>2018/19 £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locum and agency staffing</td>
<td>£4.0m</td>
<td>£4.4m</td>
</tr>
<tr>
<td>Medicines</td>
<td>£3.0m</td>
<td>£4.5m</td>
</tr>
<tr>
<td>Service efficiencies (including Procurement)</td>
<td>£2.7m</td>
<td>£3.8m</td>
</tr>
<tr>
<td>Non Clinical Areas</td>
<td>£0.5m</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£10.2m</strong></td>
<td><strong>£12.7m</strong></td>
</tr>
</tbody>
</table>
Section 2: Budget for 2019/20

2.1 The draft Scottish Government budget for 2019/20 was announced in December. Based on the budget the following position was confirmed for 2018/19:

<table>
<thead>
<tr>
<th></th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline funding (2.6% uplift)</td>
<td>23.9</td>
</tr>
<tr>
<td>NRAC Parity Funding</td>
<td>4.2</td>
</tr>
<tr>
<td></td>
<td><strong>28.1</strong></td>
</tr>
</tbody>
</table>

2.2 Similar to all territorial Boards the baseline funding will be uplifted by 2.6% to all NHS Boards. The budget also allocated further funding to move all Boards to at least within 0.8% of the NRAC parity target. NHS Grampian received an allocation of £4.2m in recognition of this commitment.

2.3 The Scottish Government budget also included provision for the following, with the allocation of funding to Board yet to be confirmed: Additional funding not yet allocated to Boards includes:

<table>
<thead>
<tr>
<th></th>
<th>2019/20</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>155</td>
<td>120</td>
</tr>
<tr>
<td>Waiting Times Improvement</td>
<td>146</td>
<td>56</td>
</tr>
<tr>
<td>Mental Health &amp; CAMHS</td>
<td>61</td>
<td>47</td>
</tr>
</tbody>
</table>

There is also an additional £8 million for Trauma Centres and £2 million for Cancer.

Estimated financial gap

2.4 Based on the above new allocations and the assumptions noted below the estimated financial gap for 2019/20 is as follows:

<table>
<thead>
<tr>
<th></th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline funding – uplift</td>
<td>23.9</td>
</tr>
<tr>
<td>Less: proposed allocation to IJBs</td>
<td>(8.8)</td>
</tr>
<tr>
<td>New resources – NHS Board Directed Services</td>
<td><strong>15.1</strong></td>
</tr>
<tr>
<td>Less: projected increase in expenditure</td>
<td>(17.8)</td>
</tr>
<tr>
<td>Less: new commitments approved</td>
<td>(7.5)</td>
</tr>
<tr>
<td>Net cash savings target (exc IJBs)</td>
<td><strong>(10.2)</strong></td>
</tr>
</tbody>
</table>
Projected increase in expenditure

2.6 The increase in expenditure takes into account the following

<table>
<thead>
<tr>
<th></th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay Uplift</td>
<td>14.2</td>
</tr>
<tr>
<td>Non Pay Uplift</td>
<td>3.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>17.8</strong></td>
</tr>
</tbody>
</table>

Pay

Pay uplift has been estimated in line with the Scottish Government’s public sector pay policy. A three year pay deal has been agreed for staff covered by Agenda for Change. 2019/20 is the second year of the deal. Staff at the top of their AfC pay scale will receive an increase of 2.8%. The pay deal also includes changes to the number of scale points within each pay band which means those staff towards the bottom of a pay scale will receive higher increases in 2019/20 ranging from 4.0 to 13.0%. NHS Grampian has modelled the overall impact of the pay deal in 2019/20 which suggests an average increase of 2.9% on the total Agenda for Change pay bill. The pay award for Medical and Dental staff in 2019/20 has not yet been confirmed but has been assumed at 2.0% for planning purposes.

Provision has also been made in the budget for:

- The ongoing impact of Paid As If At Work for regular overtime and additional hours.
- The impact of the pension auto-enrolment exercise which will take place in May 2019.
- Zero basing of medical staffing budgets.
- The payment of Discretionary Points to medical staff.

No provision has been made in the budget for the impact of incremental drift.

Non-pay

Drug cost inflation is a combination of cost increases and demand increases for existing drugs and new drugs, with some offset for off patent savings. An exercise is carried out each year by Pharmacy staff, Finance staff, Clinicians and Managers to estimate actual drug pressures for secondary care. The exercise focuses on new drugs and increased usage of existing drugs. As part of this process, those drugs meeting the Orphan, Ultra Orphan and End of Life categories have been quantified as part of the New Medicines Fund along with Individual Patient Treatment Requests (IPTRs) likely to be funded. Scottish Government has asked NHS Boards to plan on a share of £80 million of PPRS funding next year to meet the costs of drugs approved under the New Medicines Fund. This equates to circa £7.5 million for NHS Grampian. NHS Grampian’s costs for these drugs are estimated at £16.7 million.
The exercise to forecast pressures on secondary care drug budgets has now been completed for 2019/20. The GMMG paper suggests that total drugs expenditure for secondary care will be £69.3 million in 2019/20 compared to £64.3 million forecast for 2018/19. This is an increase of £5.0 million in expenditure, which will require to be met from a combination of savings already being delivered by the Acute Sector on drug budgets (mainly through the use of cheaper biologics) together with some new investment to meet the cost of new drug approvals by the Scottish Medicines Consortium. A similar exercise was undertaken for GP prescribing costs to support the development of the IJB budgets.

In addition to pay and drug inflationary costs, uplifts are also required for patient service agreements with other health boards, energy costs and rates costs.

New commitments

As in recent years, there is no resource identified in the Revenue Budget to fund service developments or ongoing cost pressures. It is assumed that these will be managed by operational areas. There is provision within the Revenue Budget to address a number of previous commitments and unavoidable issues facing the Board, together with a number of investment proposals agreed by the Senior Leadership Team. These total £7.5 million and are summarised below.

The Budget includes a small contingency of £0.5 million for non-specific unfunded cost pressures and emerging issues. This will provide for any new unexpected cost pressures arising during the financial year as well as a number of recognised risks that have not been provided for in the base budget (e.g. new policy announcements etc.).

It should be noted that the Budget does not include any funding provision in 2019/20 for additional costs of any service developments or cost pressures (it is assumed that these will be managed by operational areas).

<table>
<thead>
<tr>
<th>National Service Division Uplift</th>
<th>£1.1m</th>
<th>Dr Gray’s Obstetric costs</th>
<th>£0.5m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Waste Contingency costs</td>
<td>£0.6m</td>
<td>Acute Sector redesign fund</td>
<td>£1.6m</td>
</tr>
<tr>
<td>PACS system national refresh</td>
<td>£0.2m</td>
<td>Mental Health agency nursing</td>
<td>£0.2m</td>
</tr>
<tr>
<td>PET / CT scan national programme</td>
<td>£0.1m</td>
<td>Junior Medical staffing</td>
<td>£0.7m</td>
</tr>
<tr>
<td>Forensic Medical examination service</td>
<td>£0.3m</td>
<td>Recruitment and Workforce support</td>
<td>£0.3m</td>
</tr>
<tr>
<td>CAHMS investment (year 1 - £1m investment over 5 yrs)</td>
<td>£0.2m</td>
<td>Other</td>
<td>£0.4m</td>
</tr>
<tr>
<td>CAHMS (loss of local authority funding)</td>
<td>£0.6m</td>
<td>Contingency</td>
<td>£0.5m</td>
</tr>
<tr>
<td>Electronic Patient Record training team</td>
<td>£0.2m</td>
<td><strong>Total</strong></td>
<td><strong>£7.5m</strong></td>
</tr>
</tbody>
</table>
Section 3: Closing the gap and delivery of savings

3.1 A high level indicative plan to deliver the required savings for the core operational unit is noted below. In terms of closing the gap the key areas of focus will be as follows:

<table>
<thead>
<tr>
<th></th>
<th>2019/20 £m</th>
<th>2018/19 £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locum and agency staffing</td>
<td>£4.0m</td>
<td>£4.4m</td>
</tr>
<tr>
<td>Medicines</td>
<td>£3.0m</td>
<td>£4.5m</td>
</tr>
<tr>
<td>Service efficiencies (including Procurement)</td>
<td>£2.7m</td>
<td>£3.8m</td>
</tr>
<tr>
<td>Non Clinical Areas</td>
<td>£0.5m</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£10.2m</strong></td>
<td><strong>£12.7m</strong></td>
</tr>
</tbody>
</table>

3.2 Further information in relation to the potential options is noted below.

**Workforce**

We will maintain a continued focus on reducing the dependence on supplementary staffing, in particular medical locum and agency nursing costs. The challenges to service delivery across Grampian will require to be carefully balanced against the costs associated with securing the necessary workforce to meet the current and future patient demand. Based on our analysis of expenditure across the North of Scotland there may be opportunities to work together on solutions in the short and medium term.

**Agency Spend (10 months to January 2019)**

<table>
<thead>
<tr>
<th></th>
<th>Grampian</th>
<th>Tayside</th>
<th>Highland</th>
<th>Orkney</th>
<th>Shetland</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Agency Medical Locums</strong></td>
<td>£13.1m</td>
<td>£2.5m</td>
<td>£10.1m</td>
<td>£1.2m</td>
<td>£2.7m</td>
<td>£29.6m</td>
</tr>
<tr>
<td><strong>Agency Nursing</strong></td>
<td>£6.2m</td>
<td>£2.6m</td>
<td>£1.1m</td>
<td>-</td>
<td>£0.1m</td>
<td>£10.0m</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>£19.3m</td>
<td>£5.1m</td>
<td>£11.2m</td>
<td>£1.2m</td>
<td>£2.8m</td>
<td>£39.6m</td>
</tr>
</tbody>
</table>
Medicines

Medicines saving derived from applying “Realistic Medicine” principles in secondary care, including continued switch to generic drugs, maximising national contract savings, avoiding wastage and robustly assessing the cost effectiveness of new drugs. A summary position based on advice from the Grampian Medicines Management Group is noted below:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Secondary Care</th>
<th>Primary Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base budget – current year</td>
<td>69.1</td>
<td>104.2</td>
</tr>
<tr>
<td>Over / underspend</td>
<td>4.8</td>
<td>0.6</td>
</tr>
<tr>
<td>Projected expenditure</td>
<td>64.3</td>
<td>103.6</td>
</tr>
<tr>
<td>Anticipated growth</td>
<td>7.1</td>
<td>0.3</td>
</tr>
<tr>
<td>Target savings</td>
<td>-(3.0)</td>
<td>-</td>
</tr>
<tr>
<td>Net uplift</td>
<td>4.1</td>
<td>-(0.3)</td>
</tr>
</tbody>
</table>

Service efficiencies

As in prior year we will continue to drive service efficiencies through a range of measures, which going forward will include identifying opportunities across the North of Scotland. An analysis of the potential productive opportunities has been undertaken and these can be summarised in the table below:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Opportunity</th>
<th>Potential Efficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Care</td>
<td>Treat suitable emergency admissions as day cases or outpatients</td>
<td>£0.9m</td>
</tr>
<tr>
<td>BADS procedures</td>
<td>Increase day case rates for suitable procedures</td>
<td>£0.7m</td>
</tr>
<tr>
<td>Low Clinical Value Procedures</td>
<td>Standardise admission rates for as range of low value clinical procedures</td>
<td>£0.4m</td>
</tr>
<tr>
<td>Inpatient Cost Per Case</td>
<td>Move to Scottish average</td>
<td>£46.5m</td>
</tr>
<tr>
<td>Theatre Efficiency</td>
<td>Eliminate cancellations due to capacity issues</td>
<td>£3.5m</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td><strong>£52.0m</strong></td>
</tr>
</tbody>
</table>

In terms of cash releasing savings, our approach in 2019/20 will be to address the productive opportunities through a focused approach to optimising the resources that we have available and to seeking to recruit to vacant posts within theatre nursing and critical care in particular.
Appendix 1: Trend in medical locum expenditure during 2018/19

Overall spend is down by £0.01m compared to similar period last financial year. This includes a reduction of £0.7m within Acute offset by increases within the three IJBs.

<table>
<thead>
<tr>
<th></th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Spend 2016/17</td>
<td>1,501</td>
<td>1,501</td>
<td>1,664</td>
<td>1,603</td>
<td>1,570</td>
<td>1,731</td>
<td>1,640</td>
<td>1,696</td>
<td>1,330</td>
<td>1,667</td>
<td>1,345</td>
<td>1,605</td>
</tr>
<tr>
<td>Total Spend 2017/18</td>
<td>1,717</td>
<td>1,470</td>
<td>1,451</td>
<td>1,388</td>
<td>1,417</td>
<td>1,420</td>
<td>1,350</td>
<td>1,120</td>
<td>1,190</td>
<td>1,037</td>
<td>1,004</td>
<td>1,077</td>
</tr>
<tr>
<td>Total Spend 2018/19</td>
<td>1,261</td>
<td>1,261</td>
<td>1,286</td>
<td>1,231</td>
<td>1,021</td>
<td>1,653</td>
<td>1,127</td>
<td>1,375</td>
<td>1,568</td>
<td>1,278</td>
<td>1,438</td>
<td></td>
</tr>
<tr>
<td>TARGET 25% REDUCTION</td>
<td>977</td>
<td>977</td>
<td>977</td>
<td>977</td>
<td>977</td>
<td>977</td>
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**Monthly Spend £’000**

- Total Spend 2016/17
- Total Spend 2017/18
- Total Spend 2018/19
- TARGET 25% REDUCTION
IMPROVEMENT PLAN TEMPLATE

The aim of the Mental Health Access Improvement Support visit is for Healthcare Improvement Scotland to work with you and your colleagues to facilitate the development of improvement plans relating to waiting times for CAMHS and Psychological Therapies (PT). The Scottish Government Programmed for Government (PfG) Delivery Plan, has requested that these plans be in place by April 2019 with clear milestones over 2 years for all CAMHS and PT services. Part of the commission for Healthcare Improvement Scotland is to support development of these plan as well as discuss how national improvement resource can support their implementation.

Plans for improvement should include:

- Clarity of the purpose of the service
- Data used to inform the improvement
- Prioritisation of identified improvement
- Timescale for improvements - short term (within 12 months), medium term (12 – 24 months) and long term (more than 24 months)
- Resources required and identified to support delivery of plans
- Clearly defined improvement methodology to deliver improvements
- Clearly defined governance structure to support improvement
- Clearly defined improvement resource to support delivery of improvement
<table>
<thead>
<tr>
<th>Priority</th>
<th>Topic</th>
<th>Aim/Intended Improvement</th>
<th>Data Supporting Identification</th>
<th>Timetable to Achieve</th>
<th>Resource Required to Deliver</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Data Collection: CAMHS and Psychological Therapies</td>
<td>Improve eHealth systems to support the current standalone psychological therapy data sets, which are not fit for purpose.</td>
<td>There is significant variation in the amount of data being recorded and what is recorded across different systems currently.</td>
<td>Pilot of TracCare working for 8 weeks in CAMHS, scheduled for May 2019 for 10 weeks.</td>
<td>A pilot is about to start. Module to better fit to TracCare to enable mental health and learning disability services to manage waiting times. This module has been successfully implemented in NHS Luton. The CAMHS service will pilot the waiting times module.</td>
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<tr>
<td></td>
<td></td>
<td>There are limitations to this database as it does not have the capacity to stop and start the clock adequately in all areas of service delivery with regards to waiting times.</td>
<td>Data from primary care is not recorded on the standalone system and does not reflect the large amount of work in this area which is having a significant positive impact on access to psychological therapies in primary care.</td>
<td>The CAMHS waiting times module will be planned following the CAMHS pilot, subject to the OHAD resource approval.</td>
<td>Require to adapt minimum data set from NHS or other board (hypothetical) and implement.</td>
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<td></td>
<td></td>
<td>Agree and implement standardized improvement outcomes measures as a minimum data set.</td>
<td>CAMHS cannot provide accurate data and cannot robustly record rejected referrals and T2A and T2A data accurately reflect significant manual entering of counting of data.</td>
<td>Approximately one year timescale from start date of 1st December 2020.</td>
<td>Have data system that will record timely recording of outcome data and analysis.</td>
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<td>To be able to measure an agreed minimum data set for outcomes of psychological therapies and CAMHS interventions which inform service delivery.</td>
<td>Currently no standardized outcome measures to demonstrate positive clinical improvements in CAMHS or psychological therapies.</td>
<td>6 months from 1st April 2019 to implement minimum outcome data set in CAMHS.</td>
<td>Work closely with the data analyst to ensure adequate data recording.</td>
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<td></td>
<td>Have an adequate system that records data in a timely and robust way to accurately inform service planning and delivery.</td>
<td>&quot;(Zones) are to roll out TracCare in wider NHS&quot;</td>
<td>Have done talk with national data workforce groups via the Director of Psychology (January 2019).</td>
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<tr>
<td><strong>2. Coordination and Leadership of Psychological Therapies across all Trusts</strong></td>
<td><strong>2. Champion</strong></td>
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<tr>
<td>Goal: Champion does not have a lead psychologist &amp; Director of Psychology currently in post to help ensure governance or leadership across services. This is required to ensure there is a lead to coordinate psych services at frontline, governance, commissioning and delivery of care.</td>
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<tr>
<td>Action: Appoint a Director of Psychology for Champion to lead the delivery of psychological services across services.</td>
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<td>Objectives:</td>
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<tr>
<td>- Have clear governance and line management structures for psychologists working in Champion across all areas of care.</td>
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<td>- Clear data, improved service delivery, and the ability to evidence funded posts.</td>
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<td>- To demonstrate improvements in waiting times, quality and quantity of care.</td>
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<td>Notes: This is a particular gap when coordinating requests from patients to access services. NDIS where Champion responses are required. No formal agreements between the different services with regards to the delivery of Pys and currently there is, high reliance on informal link.</td>
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<td>Data coming in from all Pts is different and not always consistent with NS and NES requirements so there is a need for these to be coordinated. Currently this is impacting on service delivery and allocation of funding.</td>
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<td>- Updated data for CAMHS post from 1st April 2019</td>
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**3. Improved waiting times in CAMHS and PT**

- Waiting times for CAMHS in Aberdeen City and Aberdeenshire have significantly improved but

- To measure capacity and demand in Moray CAMHS to ensure that access to this area of the service improves for

- Current data shows that NHS Grampian is not currently meeting waiting times at all areas of the CAMHS CAPP modelling for longest waits starting 1st April 2019 for 4 weeks

- Continued work with the NHSBT team in CAMHS
| Across Grampian | Assessment and treatment waiting times | Service. Data is patchy and not standardised (see no 3 
4, 5, 6) |
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<td></td>
<td>Clear data to manage service improvements in Grampian with director of psychology in post to drive forward required change (see no 2)</td>
<td>There is significant variation across services with waiting times, capacity and demand modelling especially in PT.</td>
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<td></td>
<td>Continued improvements to meet the future ideal standard of 4 weeks to assessment and 8 weeks to treatment across the service in CAMHS and PT</td>
<td>Data from primary care is currently not being recorded on the standalone system and therefore does not reflect the large amount of work in this area which is having a significant positive impact on access to psychological therapies in primary care.</td>
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<td></td>
<td>Standardised management of PT in line with national targets, goals and standards set by SHG</td>
<td>There is significant variation in service delivery across Grampian for PT, recording of data and delivery of care. This is not the case in CAMHS due to recent service redesign and work with MENTAL Health.</td>
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<td>NMS-Grampian CAMHS: stopping clock at second appointment which is not consistent across Scotland.</td>
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<td>NRT standards are difficult to compare as not measuring like with like nationally, or within Grampian CAMHS across second appointment, PT current first appointment or stop the clock.</td>
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<td>6-9 months from 1st April 2019 for improved waiting times in Moray CAMHS.</td>
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<td>9-12 months from 1st April 2019 to find a solution for collection of primary care data.</td>
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<td>12 months from 1st July 2019 for standardised data collection to measure waiting times (see no 1).</td>
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<p>| Work with wider PT work streams after Director of Psychology in post (see no 2) |
| Improved clear data systems that are fit for purpose and work more closely with data analyst (see no 1). |
| Support from Senior leads to implement changes required in service delivery |
| Increased administrative and support assistant support to ensure adequate resources to input data and support clinical management support. |
| Increase staffing levels in line with national staffing to meet demand (see no 1). |
| Closer liaison and working with NHS via the Director of Psychology (see no 2). |
| Acquire advice from NHS and SHG on the standard definitions for recording data to ensure all boards recording the same stop the clock criteria. |</p>
<table>
<thead>
<tr>
<th>4. Grow staffing levels and capacity in CAMHS and PF to meet national average standard</th>
<th>To have sufficient staffing levels to meet demand and be in line with national standard. CAMHS (NHS) CAMHS &amp; PF staff per 100,000 population is 1 and national average is 1.5. To fill funded posts in PF and grow the service to meet increasing demand for PF.</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAMHS demand and capacity modelling will show that capacity can meet increasing demand on service. CAMHS and PF can meet waiting times targets along with improved outcomes for patients. Staff satisfaction will increase as some services currently working at unsustainable levels now meet demands. Increase psychological skills set for other clinicians (e.g. nursing, OT) within the service with psychologists providing supervision.</td>
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<tr>
<td>5. Improve CAMHS Neurodevelopmental work stream</td>
<td>To improve the flow, capacity and management of referral in the neurodevelopmental assessment and treatment pathway in CAMHS. To change how the current Neurodevelopmental assessment pathway is delivered, understand how this contributes to the waiting list backlog and to identify resource implications of the current service make up.</td>
</tr>
<tr>
<td>Current data from working with the NMAHST neurodevelopmental pathway indicates that the service cannot currently meet demand by using the current framework. The data shows: 1. 5 weeks from 1st April to increase staffing levels for unspecialised care pathways CAMHS with high demand. 2. Half the posts already appointed to these roles have not yet been released. 3. 6 months from 1st July 2019 to plan further increase in staffing levels in CAMHS with new funding from 1st July 2019. 4. 9-12 months to start delivering staffing in PF once Director of Psychology is in place from 1st July 2019 (NHS funding). 5. 12-18 months to grow both CAMHS and PF by recruiting trainees currently within the service from 1st October 2019.</td>
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<tr>
<td>Work with NHS to increase research funding to ensure growth can occur and increase local training number to attract staff. Have better PF capacity. CAMHS modelling in services to demonstrate gaps to demand for services. Co-ordinate increased service across CAMHS teams across service to increase capacity and team functioning. Support NES training of nursing and AHPs to increase access to psychological therapies. Increase the number of Band 5 and 7 CAMHS posts in Primary care and PF. Develop areas for development such as the ASAP process for NES and primary care.</td>
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<tr>
<td>Workforce</td>
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</table>
| Recruit and Retain Staff in PT CAMHS (currently have no significant issues with recruitment and retention) | The aim is to deliver a more accessible and seamless service where families do not have to see less professionals in different services to gain a diagnosis.

- Aim is for Diagnosis to be made by MDT approach within 4 months.
- Inappropriate referrals to CAMHS.
- Duplication of roles and assessments with community child health.
- Families require to access multiple services before receiving diagnosis.
- CAMHS capacity cannot meet demand.

| To increase staffing levels in NHS-Grampian more in line with national levels. To recruit and retain staff when new roles become available and ensure posts can be filled to manage waiting times and service demands. |
| To attract more staff to NHS-Grampian to work in areas of PT. |
| To be able to retain staff once in post for PT services. |
| To ensure PT services are not lost. To add more staff to another local service who do not have the same service pressures. |
| To be able to be innovative and have the capacity in services to ensure staff to feel job satisfaction. | Staff in PT (and CAMHS) moving between services in NHS-Grampian. Due to geography of Grampian, can struggle to recruit staff from outside area, and staff can leave one local PT or CAMHS team to join another leaving gaps in staff.

Staffing supply does not meet demand and waiting times cannot be met.

- New roles/jobs (e.g. from NHS-Grampian) have been withdrawn or posts have remained unfilled.
- Use of short-term funded posts and due to geography.

| 32 week to undertake process mapping from 1st April 2013 |
| 4-6 months to start new models of working with community child health to manage demand following meeting in April 2013 with CCG. |
| 6 months to finalise MINI-HFST to develop and implement pathway options from June 2013. |
| 12-18 months to fully implement and implement recommended changes from July 2013. |

| to support whole systems change. |
| Support from CAMHS management team to help drive forward required service changes. |
| Further support from Analyst to support understanding of the output data and improvement support for development of action plan. |
| Work and liaise with national CAMHS taskforce teams. |
| Director of Psychology to support and attract staff to services (see Q2) |
| Developers and encourage psychology training staff into local posts. |
| Support staff interests such as teaching or research to retain staff in the service. |
| Support flexibility in job planning and service modeling for innovation. |
| Support from IT and DHS teams to... |
Welcome from Chair and Chief Officer, Moray Integration Joint Board

Welcome to the Moray Integration Joint Board’s 2nd Annual Performance Report. This has been another exciting and challenging year with a huge amount of ongoing effort and activity as we endeavour to make sure we have the right services across Moray helping and supporting people to stay well. We have taken some bold steps in our approach to how we deliver services. We are particularly proud of the housing based models of care developed across a number of different settings working with both older people and younger adults with specific conditions. We have ensured people can remain independent in their own tenancies with the right care, whilst maintaining the right to privacy and family life.

We have had great success in the community based activity programmes we have delivered, working with communities to ensure good social connections and promoting active living. The wide variety of approaches adopted have been well received by communities, the number of people taking part in activities are testimony to the public interest and engagement with what’s on offer.

We have also had our fair share of challenges, recruitment and retention of key personnel and finance resources in particular. However, we have not lost our focus on change and improvement, continuing to reshape our services and always keeping people and families at the centre of what we do.

Whilst the challenges will always be there and may often be very difficult, we continue to strive to deliver on our agreed priorities and support our enthusiastic teams and wider support network in making a difference for the people of Moray.

We have worked with particular communities around some of their local issues and we thank all of those communities and community councils for working with us to help us better understand what is needed and how we can work better with them.

Shona Morrison
Chair, Moray Integration Joint Board

Pam Gowans
Chief Officer, Moray Integration Joint Board
Introduction

The Public Bodies (Joint Working) (Scotland) Act 2014 is the legal framework supporting health and social care integration in Scotland and requires that Integration Joint Boards (IJB’s) produce annual performance reports that assess their performance in planning and carrying out their functions.

The IJB for this area came into existence on 1 April 2016 and the Moray Integration Joint Board was established. Moray Integration Joint Board (MIJB) has the responsibility for the planning and delivery of the majority of adult health and social care services in Moray.

The 2017/18 Report is the second Annual Performance Report of the MIJB and provides an overview of the progress made during the year.

In-line with the expectations explicit in the legislation and Scottish Government guidance, the report considers our performance from several different perspectives:

• The progress we have made in achieving the nine National Health and Wellbeing Outcomes and the related key priorities of the MIJB;

• Making our Strategic Plan a reality;

• The views of other people based on service user feedback, carers and external organisations who inspect and regulate our services;

• The way in which we have managed our finances and delivered best value
Strategic Context

Scottish Government’s strategic vision is ‘by 2020 everyone is able to live longer healthier lives at home, or in a homely setting’.

The Moray Integration Joint Board (MIJB) was formally established on 1st April 2016. The Moray Integration Joint Board is responsible for prioritisation and oversight for delivery of a wide range of Health and Social care services based in the community. The integrated delivery of health and care is now known as Health and Social Care Moray and is made up of the services traditionally delivered independently by NHS Grampian and Moray Council.

Staff remain employed by these public bodies but are deployed as directed by the MIJB. The key aim is to improve quality and efficiency by working together with wider key care partners. The challenge for the MIJB is to transform and modernise services ensuring they are fit for the future and sustainable in the longer term.

A key strategic responsibility for the MIJB, like others, is to continue to develop ways of working that shift the balance of care from institutional care to care in the community. The legislation has identified specific emergency admission pathways to the acute hospital, for Moray this tends to be Dr Grays, the assumptions are that a proportion of these admissions could be prevented particularly in the case of older people. It is the task of the MIJB to understand the trends, patterns of admission and to identify improvement or redesign to ensure we are maximising the opportunities for avoidable admissions being prevented. It is however acknowledged that this happens in the context of many appropriate admissions. It should be noted that in the last 10 years Moray has reduced the number of beds in use by circa 20% against an increase in the over 65yrs population of 10%. This demonstrates an efficiency and significant shift in the location of care delivery towards community having already taken place to date.

In addition, the MIJB has responsibility for hosted services of Primary Care Out of Hours Service (GMED) and Primary Care Contracts (General Medical Services, pharmacy, dentistry and optometry), these national contracts are managed on a Grampian wide basis. The hosting IJB is responsible for leading the strategic planning of these services again to ensure future resilience and sustainability. Hosting arrangements means that one IJB within the Grampian Health Board area hosts the service on behalf of all 3 IJB’s. These services at a local level are important elements of ensuring we can improve on care delivery in the community and maximise the range of skills available across the multi-disciplinary teams 24/7.

The Strategic Plan of the MIJB directly responds, in a local context, to the national requirements of the Integration of Health and Social Care set out in the legislation, and the 9 national health and wellbeing outcomes identified. These outcomes are underpinned by performance measures by which the success of the local strategy is measured. The MIJB is a statutory partner of the Moray Community Planning Partnership and a key contributor to the Local Outcomes Improvement Plan (LOIP) that looks to ensure wider partners across the public, third and private sector are working for and with the community to support the people of Moray to thrive in their communities.

What do we know about the Moray population in relation to health and wellbeing?

Historically Moray tends to have a health profile that is better than the Scottish national average. Overall Moray has:

- above average educational attainment at S4 level, smoking rates, fuel poverty
- average levels of employment, alcohol-related mortality,
- below average income, crime, homelessness, alcohol-related hospital admissions,
- significantly better health condition prevalence rates than the average across Scotland regarding – emergency admissions, over 65s multiple emergency admissions, new cancer registrations and admissions for Chronic Obstructive Airways Disease (COPD), Chronic Heart Disease (CHD) and asthma.
- above average, traffic accident casualties, and potential geographical challenges to equal access to services
The Strategic Plan 2016-19 was approved in April 2016 to allow the MUB to become fully established was developed by the Strategic Planning and Commissioning Group. This group consisted of stakeholders from across the wider health and social care system, including representatives of all sectors and the public to ensure engagement in the preparation, publication and review of the Plan. This process supported the development and agreement of the strategic priorities in Moray as follows:

**Our Vision**

‘To enable the people of Moray to lead independent healthy and fulfilling lives in active and inclusive communities where everyone is valued, respected and supported to achieve their own goals’

We will achieve our objectives by adopting the principles of:

- Working together with all partners including patients, unpaid carers, service users and their families, promote choice, independence, quality and consistency of services by providing seamless, joined up, high quality health and social care services.

- Supporting people to live independently at home or in a homely setting for as long as possible will always be our default position.

- We will strive to ensure resources are used effectively and efficiently to deliver services that meet the needs of an increasing number of people with longer term and often complex care needs.
• We will always work to support people to achieve their own quality outcomes and goals that improve their quality of life.

• Developing our integrated teams so that clinical, professional and non-clinical staff can work together to provide seamless, joined up, high quality health and social care services.

• These principles will be underpinned by a focus on building relationships with all parties involved based on respect and trust and supporting communities to be caring and resilient.
What have we achieved so far?

The Strategic Plan 2016-19 outlines the key strategic outcomes to achieve the shared vision for change.

This report is a summary of progress during 2017/18 in achieving the principles outlined above. It also reviews and analyses performance in relation to the 9 National Outcomes for health and social care whilst highlighting some of the specific project work undertaken.

Key areas of focus during 2017/18

Transforming Primary Care and Out of Hours Care

Transformation Programme in Learning Disabilities Services.

Developing Acute Care for the elderly in the context of our wider older peoples pathways of care.

Preparing for the implementation of the new Carers Act 2018.

Continue to build on our housing based initiatives supporting people to live independently with a range of personal challenges or health and care needs.

Continued focus on Health Improvement and active communities.

Implementing key aspects of our Good Mental Health for All strategy.

Start to engage more proactively on the possibilities of Digital transformation and how Technology Enabled Care (TEC) solutions can further support independence.

Continue to implement enabling approaches such as Self Directed Support (SDS) and Shared Lives.

Progress

Across the outcomes of wellbeing there are areas of notable progress:

• Reducing emergency inpatient day rates for people aged 75+.

• Increases in the proportion of people 75+ living at home with an anticipatory care plan shared with the out of hours service.

• Increase in number of clients receiving more than ten hours of care with a corresponding reduction of clients moving to long term residential care.

• An encouraging improvement in the proportion of care services graded ‘good’ or above.

Challenges

Where we have more challenging areas of performance these relate to:

• Whilst there is a shift in the balance of care of older people into community settings, demand for services is increasing related to the ageing population and people living longer with complex conditions.

• The number of total emergency acute hospital admissions has increased.

• The number of delayed discharges from hospital remains a challenge, however there has been progress in reducing the number of days delayed over the past year and it is anticipated that this trend will continue.

• There is increase in the readmission to hospital within 28 days rate which needs careful monitoring.

• Finances continue to be challenging with a picture of increasing pressures against a decreasing budget.

• Workforce supply, recruitment and retention continue to be a challenge with a reducing number in the working age population.
National Outcomes

The National Health and Wellbeing Outcomes are the Scottish Government’s high-level statements of what health and social care partners are attempting to achieve through integration and ultimately through the pursuit of quality improvement across health and social care. These outcomes provide a strategic framework for the planning and delivery of health and social care services and they focus on the experiences and quality of services for people using these services, carers and their families. We have used this framework as the basis for our performance report and further detail is provided in pages 10-49.

Health and Wellbeing Outcomes

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

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.

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

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

5. Health and social care services contribute to reducing health inequalities.

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

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

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.

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

National Indicators have been developed to underpin the outcomes and performance is highlighted in the pages that follow.

National Indicators are identified for each of the National Outcomes

- Green performance is better than Scottish average,

- Amber performance is worse than Scottish average but within 5% tolerance,

- Red performance is worse than Scottish average by 5%. Arrows indicate the direction of the current trend.

** HACE survey is undertaken every two years therefore information for 2014/15 and 2016/17 is not available.
People are able to look after and improve their own health and wellbeing and live in good health for longer.

This national outcome is truly incorporated in our vision ‘to enable the people of Moray to lead independent healthy and fulfilling lives...’

We are working together with partners to facilitate people being independent and leading the lives they choose, maintaining good health and wellbeing.

During 2017/18 in addition to normal service delivery, there were a number of initiatives undertaken to encourage people to develop their sense of participation in the community. With the recognition of the effects of loneliness, connecting people was as focussed an objective as the emphasis on good physical health.

<table>
<thead>
<tr>
<th>National Indicator</th>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/18</th>
<th>Scotland</th>
<th>RAG*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of adults able to look after their health very well or quite well **</td>
<td>96%</td>
<td>N/A</td>
<td>93%</td>
<td>93%</td>
<td></td>
</tr>
<tr>
<td>Premature mortality rate</td>
<td>399</td>
<td>360</td>
<td>372</td>
<td>425</td>
<td></td>
</tr>
</tbody>
</table>

How did we do?

93% of adults surveyed in Moray believe they are well able to look after themselves, which is in line with the Scottish average. The premature mortality rates are reducing and they are already significantly lower than the Scottish average.

The emergency admission rate is among the lowest rates for Scotland and is well below the Scottish average. This performance has been sustained over the last few years.

NHS Grampian set their target for 2017/18 as 792 twelve week quits from our 40% most deprived areas based on the national average Local Delivery Plan of achieving 1.5% quits of the smoking population. The table below illustrates performance of the 3 partnerships in Grampian, against the Government target in 2017/18, and shows that a total of 670 quits were delivered during the first three quarters of 2017/18 – 78% of the target of 861. 285 were delivered in Aberdeen City, 314 in Aberdeenshire and 71 in Moray.

Smoking cessation success after 12 weeks has dropped slightly during 2017, so staff resource has been targeted to this for the current year.
What did we do?

Residents of Moray are provided with a wide range of support options to enable them to look after their own wellbeing with a number of projects and initiatives undertaken during 2017/18.

**TSiMoray Health and Wellbeing Forum**

This Forum brings together many organisations from the third sector and communities. The forum provides the opportunity for Moray’s local third sector and partners to present and raise awareness of new developments. The forum has served to connect forum members to each other, to funding opportunities and to strategic and operational partnerships such as Moray Alcohol and Drug Partnership, Making Recovery Real Partnership (supporting merger between that and Mental Health and Wellbeing Partnership). 94% members feel more connected as a result of participating. All these activities are focussed in improving choice and opportunity to achieve wellbeing across Moray with a range of supporting organisations and activities.

**Good Mental Health for All**

Penumbra have successfully opened the Mental Health and Wellness Centre in Batchen Street in Elgin, April 2017. The service acts as a single access point for a range of adult services designed to promote positive mental health and support people to recover from mental ill health, concentrating on prevention, early intervention and education whilst also supporting people to access a range of advice and information in other areas, such as finances, benefits, housing, healthcare, and employment and educational services.

Penumbra have developed programmes and held events in communities across Moray and have plans in 2018/19 to roll out the Mental Health and Wellness Centre model and activities to Keith, Forres and Buckie.

In the first year, 1,646 instances of support have been provided. 21% short term, 1% medium term and 16% group sessions. 59% of contacts have been sign posted by GP or other health professionals, with the remainder self referring.

It has now been a year since 6 Mental Health GP Link Workers were recruited across Moray to signpost to a range of alternative community and non-medical resources, services and opportunities that can contribute to people’s mental health and wellbeing. Contract monitoring of these commissioned services show that significant numbers of people are being supported with issues such as self-help, signposting to mental health information and services where issues relating to employment, benefits, housing, debt, advocacy support, legal advice or parenting can be addressed. The GP Link Workers are based in GP surgeries and provide direct support to the primary care team and are on hand taking referrals for people with mental health distress. They provide a holistic assessment, early intervention and connect people to ongoing support.

To support and promote independence, positive health and wellbeing for older people in Moray, a range of community initiatives and programmes have been developed with the aim of promoting independence, choice and reducing social isolation by increasing community connections and promoting the use of local assets.
Boogie in the Bar

Boogie in the Bar has supported the older people in Moray to increase their physical activity whilst enjoying a ‘boogie’ on the dance floor. Each of the two events to date have been linked to a health and wellbeing campaign, encouraging Self Care; by promoting how to reduce the risk of falls, heart health and increasing the awareness of the role of the unpaid carer – over 250 people have attended each of the events.

Boogie in the Bar has been supported by community volunteers and Joanna’s staff supporting the venue. Funds raised at the events have been gifted back to support local community groups.

Those attending have had the opportunity to renew and make new friendships.

Be Active Life Long (BALL) Groups

Throughout Moray there are 22 BALL groups, with over 750 older people accessing their local group each week; keeping them connected to their communities and encouraging new friendships.

Outcomes highlighted in The Institute for Research and Innovation in Social Services (IRISS) report on the Moray BALL groups demonstrates:

Individuals can experience life-changing improvements in wellbeing through shared physical and mental activities.

The benefits of the groups extend beyond the individual to wider community and by easing pressure on formal support services.

In order to support and maintain community BALL groups, POW WOW workshops have been developed to build on the strengths of BALL Groups through the provision of tailored training and support. At the first workshop the strengths and weakness of the groups were discussed and solutions were identified; 35 members attended.

Singing Exercise & Tea (SET) Groups

SET groups are aimed at the over 60s who suffer from long term health conditions, dementia, reduced mobility, learning and physical disability. The groups offer gentle chair based exercises (supporting NHS physiotherapy programmes) whilst reminiscing to well-known tunes from the past. The skills and talents of the group members have been put to full use, this year with 2 of the 3 SET groups working with a local song writer and producer; writing, recording and performing their own songs; including ‘Porridge and Berries’ which can be viewed on: www.youtube.com/watch?v=snKsHw-EN2E

“I can enjoy myself in my wheelchair and now I know where my granddaughter goes.”

“We are still young enough to enjoy ourselves.”

“Everything was great, music, meeting friends, lots of dancing and smiling faces”

“People are so welcoming, I would be a recluse, days would go by without speaking to anyone”

“It has made me pick my life back up again”
Men’s Sheds

The Men’s Shed movement is progressing throughout Moray; supported by Health & Social Care Moray and TSi. Men’s Sheds provide men with the opportunity to meet new people, have fun, share skills and knowledge with like-minded people, whilst; reducing social isolation, promoting mental and wellbeing and maintaining independence. Men’s Sheds are available throughout Moray in, Fochabers, Forres, Keith and Elgin.

The ‘shedders’ are supported to develop their knowledge and skills to increase their capacity in relation to governance, committee skills, funding applications, opportunities and business plans through training and support, for example;

Members of the Keith Men’s Shed under took training to drive the Outreach Mobile Information Bus; enabling them to be out and about raising awareness of the benefits of Men’s Sheds and to increase membership; 5 new members were recruited in Keith.

A learning day supported 35 members to visit Inverurie and Westhill Men’s Sheds; with 100% agreeing the learning visit was valuable.

Health & Wellbeing Vintage Tea Parties

A further 4 Vintage tea parties were delivered across Moray. The vintage tea model was adapted to include 3 dementia friendly events, a community hospital, sheltered housing and also a primary school parent engagement event. Over 1000 over 60’s attended the locality based events with different priorities being progressed in each locality. Outcomes included the development of men’s sheds, increased use of community transport, increased membership of BALL groups and the development of new SET Groups. The Vintage Tea methodology won awards in the NHS Scotland Conference, was runner up at the Self-Management Week Alliance Scotland event and showcased at the Public Health Conference in 2017.
Healthpoint

Healthpoint and healthline offer free and confidential health advice on a wide range of topics. Healthpoint in Moray is based within Dr Gray’s, Hospital, Monday to Friday, and provides an additional outreach service, supporting community access to information on health and wellbeing and deliver sessions throughout Moray using the Outreach Mobile Information Bus and community venues.

The information and advice on offer includes:

- Practical ways to improve your health
- Your health concerns
- Support groups and organisations
- How to access NHS services
- Long term conditions e.g. Diabetes, Asthma
- Access to free condoms
- Access to smoking cessation services

During 2017 the healthpoint outreach service was delivered across Moray; 50% of those attending were of the working age population, 35 % older people and the rest were split between young people, school aged children and the early years.

The top 2 enquiries within the healthpoint were weight management and physical activity.

The figures tell part of the story for clients who access the healthpoint, weight management support disclose other issues in their lives, including; immobility, stress, depression, suicidal thoughts, relationship problems, wanting to stop smoking, financial worries, loneliness and having a health condition which can impact on them losing weight e.g. someone with COPD having difficulty in exercising are some of the things the staff have been able to support clients with.

The healthpoint advisors are trained in Health Behaviour Change and are skilled in motivational techniques; with 42% of those attending healthpoint reaching a weight loss target of between five and thirty percent during 2017/18.
Case Study 1

Mary had been suffering from knee pain and had been referred for a knee operation; prior to her operation attended the pre-assessment service. Due to Mary’s weight her operation was deferred and she was referred to healthpoint. Supported by the healthpoint advisors, Mary followed the healthy eating advice and made many changes to her diet and then increased her physical activity. She went on to lose 3½ stone, no longer required her operation and has maintained her weight loss.

Case Study 2

Bob an extremely shy, quiet gentleman who was referred via the Department of Working Pensions; since attending healthpoint, during his weekly weigh in, the healthpoint advisors have noticed a change in his confidence levels. Bob now engages in conversation and is confident enough to travel by bus for his weekly weigh in (previously he used to rely on a lift). Bob has lost six stone in weight and to further support his weight loss journey he has incorporated a home exercise routine.

Case Study 3

This year as part of the health point outreach service, we have visited various men’s groups throughout Moray; which has resulted in an increase in the number of men accessing health point for further information and support, as well as an increase in the numbers of requests to provide health and wellbeing support and advice to groups such as ‘Men’s Sheds’.

As part of the outreach service, we met Simon, who is a carer for his wife; both Simon and his wife suffer from multiple health and wellbeing issues. Through discussions with a health point advisor, Simon talked about how he was feeling emotionally weighed down. The health point advisors were able to signpost him to local services available to support the health and wellbeing of his wife, but as important for Simon too. Simon felt the advice and support he received was really beneficial for them both and he felt valued by the time the health point advisor spent with him stating that “it was good to be able to talk and the information provided was of value.”
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.

One of our strategic outcomes is ‘Supporting people to live independently at home or in a homely setting for as long as possible will always be our default position’ and the work that has been carried out with partners under Strategic Housing Implementation Plan (SHIP) for Moray demonstrates that commitment.

The SHIP has been developed from an assessment of forecasts of future needs for Moray in terms of accommodation requirements, and Moray Council, HSCM and partners are working to build appropriately to meet these requirements. We have also established a strong partnership with a housing association and this has enabled the delivery of extra care facilities that allow people to live independently in their own tenancy with the care on site. More detail of these initiatives are in the examples further on in this report.

In the event of people finding themselves in hospital our aim is to get you back home as soon as you are medically fit, particularly in the older population. The evidence is clear that extended hospital stays often lead to people losing their confidence, mobility and as such their independence. Preventing delays in discharge remains a focus in Moray and new initiatives are showing encouraging signs of positive impact for future.

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</tr>
</thead>
<tbody>
<tr>
<td>Percentage of adults supported at home who agreed that they are supported to live as independently as possible**</td>
<td>74%</td>
<td>N/A</td>
<td>83%</td>
<td>81%</td>
<td>1</td>
</tr>
<tr>
<td>Emergency admission rate (per 100,000 population)</td>
<td>8,673</td>
<td>8,734</td>
<td>9,037</td>
<td>11,959</td>
<td>2</td>
</tr>
<tr>
<td>Readmission to hospital within 28 days (per 1,000 population)</td>
<td>76</td>
<td>74</td>
<td>81</td>
<td>97</td>
<td>2</td>
</tr>
<tr>
<td>Proportion of last 6 months of life spent at home or in a community setting</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
<td>88%</td>
<td>3</td>
</tr>
<tr>
<td>Delayed discharge bed days</td>
<td>764</td>
<td>1,095</td>
<td>955</td>
<td>722</td>
<td>4</td>
</tr>
</tbody>
</table>

How did we do?

Moray continues to perform well in terms of low emergency admissions.

Emergency Admission to hospital rates are well below the national average and the average across Grampian. Although there has been a slight increase in 2017/18.

This is an area of work that is closely monitored by the IJB and Health & Social Care Moray.

In relation to occupied bed days, it is encouraging to see that the rate of emergency occupied bed days for over 65’s per 1000 population has also reduced during 2017/18, as can be seen below:

- Apr–Jun – 2558
- Jul–Sept – 2531
- Oct–Dec – 2495
- Jan–Mar – 2444
What did we do to make a difference?

There have been a number of initiatives undertaken in the past year to make a positive change to where people are cared for and providing different options.

**Acute Care of the Elderly (ACE) in Dr Gray’s**

There have been major shifts in the provision of elderly medicine in Moray with the commissioning of a community-based model with hospital in-reach. An additional Geriatrician was appointed and started in August 2017 after a period with no Geriatrician in place in Moray, we now have 2 Geriatricians equating to 1.6 whole-time equivalent. In Dr Gray’s Hospital, ward 7, a 10 bedded unit has been created as Acute Care for the Elderly Unit (ACE). This new approach seeks to actively identify frail elderly people admitted to the hospital who would benefit from enhanced specialist care involving the family all the way. It is resulting in shorter spells in hospital and increasing the chances that people will get back home, retaining their independence with support if required.

Clear plans are created with the person and their family having discussions with the team. This leads to timely discharge to return home or to a homely setting.

For those people identified to require longer input in rehabilitation there are other options such as community hospital placement or Jubilee Cottages. This approach has resulted in significant reductions in people’s hospital stays.

The Geriatricians are now working closely with all community-based staff and community hospital teams to bring about further improvement, seeking to optimise the potential of our community settings with this specialist support in place. Good joint working is also being taken forward with our Older Adult Mental Health Teams alongside the more general teams supporting older people. By working more closely, in line with integration principles, the right knowledge and experience will be available to facilitate improved decisions, making the pathway of care and recovery better and improving people’s experience.
Daily Dynamic Discharge in Moray Community Hospitals

As part of the national quality improvement programme, 6 Essential Actions to improve Unscheduled Care, staff from Health & Social Care Moray, The Moray Council, and Dr Gray’s are working together to implement Daily Dynamic Discharge in Moray Community Hospitals. The intended outcomes are that this focused piece of work will impact positively on patient experience, ensuring people are treated accordingly and moved seamlessly through the health and care system to a positive discharge. This approach further enhances our ability to prevent delays in hospital.

The Daily Dynamic Discharge is now established practice for the Seafield Hospital team, where communication has improved and evidence of positive impacts for people is emerging. The next step is to introduce Daily Dynamic Discharge at Fleming Hospital, Aberlour and share the learning with peers at Dr Gray’s and other Community Hospitals through out Moray Senior Charge Nurse meeting forum.

Early indications are promising where performance over the year has improved with a reduction of 24% against this indicator as shown below. As this is a complex area, the situation will continue to be monitored closely.

People will be supported in their communities by a variety of services including the Care at home services.

Care at Home

During 2017 there was a restructure of Care at Home services to ensure a more local community-based approach to try to provide sustainability in an environment where demand is outstripping capacity. This is a particular issue during summer holiday period and winter.

Brokerage services have been further developed and realigned with a reablement manager overseeing progress on a weekly basis, to streamline the process of securing appropriate service for people in the community.

- HSCM provide 51% of care at home with the remaining 49% provided by external providers. This is managed through a partnership working group that meets weekly to review the care provided to clients. This group ensures co-ordination of care amongst the various agencies to deliver the required care using available resources in the most efficient and effective way.

- There are currently 919 people receiving support from Care at home services, an increase of 26 clients on previous years, which is forecast to increase significantly over the next couple of years.

- Moray has a rate of 18.6 per 1,000 population (aged 65+) receiving care which is significantly higher in comparison to the national average rate of 16.9 per 1,000 population.

One of our key aims is to support people to live independently at home, or in a homely setting for as long as possible. When clients are supported at home it increases the potential for client satisfaction and reduces the use of care home places, thereby saving associated costs.
To accomplish this, for some clients with specific needs, there has been an increase in the amount of double up care provided (where two carers are required to attend at the same time). This has resulted in the average number of hours received per client increasing to 13.2hrs over the year.

A local customer satisfaction survey issued to service users of care at home had a 38% response rate and has shown positive results:

- 93% feel they had an Overall positive experience
- 96% feel positive about Quality of Care provided (increased from 94%)
- 100% of service users view the service helps to improve their quality of life

It continues to be the case that in Moray we have areas where care is less available and we continue to seek to identify ways in which we can attract people into this vital area of service.

**Transforming Accommodation Options: Woodview**

In last year’s annual performance report, we highlighted that the construction of a £2.5m new build of 8 bungalows for people with autism and challenging behaviour was nearing completion at Urquhart Place, Lhanbryde. This project is a ‘first’ because HSCM provide the landlord function for these properties which allows us to ensure co-ordination of actions round the premises are carried out with the tenants specific needs in mind. In addition we are able to tailor the accommodation to the needs of the tenant whilst ensuring the accommodation is sustainable for future use.

The first 4 tenants from Maybank, Forres successfully made the transition to the new development in August 2017.

The project immediately achieved some outstanding results. This includes:

- All 25 WTE support worker posts being filled. This had never previously been achieved at Maybank and the Manager was always engaged in a continuous process of recruitment;
- A 75% reduction in medication based on a survey of the same period in 2016;
- A 91% reduction in number of incidents per month from 12.6 to 3 since the same period in 2016;
- The overall recorded incident severity is 90% less than the historic monthly average;
- A 100% reduction in staff injuries from an average of 6.6 in the same period 2016 to nil; and
- A 97.4% reduction in use of BSS (restraint techniques) and 100% reduction in use of supine since the same period in 2016.

These benefits continue to be sustained and a further 4 tenants will have moved into Woodview Urquhart Place by June 2018.
Transforming Accommodation Options: Varis Court

In partnership with Hanover (Scotland) Housing Ltd, we also reported on a substantial extra care development at Varis Court, Forres. The new build provided housing with care for older people; including people with care.

The strength of our partnership approach was demonstrated in an agreement with Hanover Housing, to lease 5 of the 33 units with the purpose of testing new models of delivering health care with the purpose of informing how health and social care services could be redesigned in the future for the Forres locality area. The 12 month test site was based on a nursing team providing 24 hours of care, 7 days a week at Varis Court with a strong reablement and recovery focus. The nursing team also provided support for people in their own homes in the community.

Although the benefits of the test site are in the process of being fully evaluated, it is clear that important insights and learning can be gained from this project that will inform the future design of health and social care services in the Forres Area.

This site also has designated dementia flats that help support clients to live independently for longer when they have been unable to stay at home due to the associated risks.

Linkwood View Development is Social Housing Development of the year

The benefits of Health & Social Care Moray’s partnership were further demonstrated last year with the opening of the Linkwood View Development at Glassgreen, Elgin.

Commissioned by Health & Social Care Moray, with the landlord and care functions provided by Hanover Housing for the 30 unit facility, Hanover Scotland won the Premier Guarantee Award, with local construction firm, Springfield Properties, for ‘Best Social Housing Development of the Year!’

Following its opening in 2017, all units are filled and the development is making an important contribution to the delivery of extra care housing for a wide mix of tenancy groups in the Moray area. The age range is more diverse than other developments with older people, learning disabilities, mental health and dementia tenancies being accommodated and supported.

During the final quarter of 2017/18, we worked to deliver the aims and aspirations in the Scottish Government’s 6 Essential Actions to Improving Unscheduled Care Programme (Winter Plan). This plan set out the need for Health and Social Care Moray to provide safe and effective care, ensuring flow through additional surge capacity and ensuring continuity of social care access for people.

Our staff demonstrated the highest levels of commitment and endeavour in supporting people to remain at home.
Making Recovery Real

The Making Recovery Real (MRR) in Moray programme via the Moray Recovery Partnership consisting of the Scottish Recovery Network, local partners and those with lived experience of mental health problems has embedded well and outcomes were celebrated with a Ministerial Visit in November 2017. Making Recovery Real in Moray has been a key driver in the delivery of the Moray and the National strategies underpinning recovery focused priorities and objectives. Making Recovery Real in Moray ensures that recovery focused principles and values, and the experience of those with mental health problems are at the centre of delivering upon our shared vision for good mental health for all in Moray.

Self-Directed Care (SDS)

171 people received a direct payment in 2015-16, this figure increased to 199 in 2016/17 and there were 31 new referrals in 2017/18. It is anticipated this increase in demand will be sustained during 2018/19 and beyond.

Moray Council have been part of a Scottish Government project alongside East Renfrewshire taking part in a two year project in relation to SDS in a Residential Care Home. We explored the use of all four options of SDS, with an emphasis on Option 1 (Direct Payments). The Social Care (Self-Directed Support) (Scotland) Act 2013 stipulates that you cannot use a Direct Payment (DP) in a residential care home, therefore the project was to explore if the use of a DP would allow for better outcomes for individuals in a residential setting. Over the course of the two years we worked alongside residents and their families, and two care homes in Moray (Andersons and Parklands Group) to explore the use of SDS with an emphasis on a DP. Online training was offered to all staff within the care homes, with those who took this up reporting the benefits of this and the positive impact that this will make in their working practice. The final report was submitted to the Scottish Government in June 2017, highlighting the positive impact that a Direct Payment can have on an individual’s social support which can be individualised to them. Scottish Government are currently holding a series of meetings to discuss the outcomes of the project from both Moray and East Renfrewshire to determine if there will be a change in legislation. Taking part in the project has allowed us to reflect on our own working practice and the conversations which we have with individuals in a residential setting.

A project was also undertaken to look at Individual Service Funds (ISF’s) which forms part of Option 2 of SDS. An ISF aims to afford greater choice and control to an individual which would normally be afforded to a DP. The processes were co-produced in conjunction with partner providers who wished to explore the use of ISF’s within their organisation. Through the use of an ISF, individuals would work in collaboration with their chosen ISF provider to ascertain how they would wish for their agreed outcomes to be met and the provider would arrange the agreed support. Whilst it is acknowledged that an ISF has delivered positive outcomes for some individuals, it has also been less positive for others, however, this has allowed areas of improvement to be identified.
We work in partnership with service users, carers, providers and a wide range of other stakeholders to develop and improve the services we provide. We listen to the feedback from community engagement, surveys and planning groups when planning our services and the following table highlights what people think about our services.

<table>
<thead>
<tr>
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<th>2017/18</th>
<th>Scotland</th>
<th>RAG*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated</td>
<td>96%</td>
<td>N/A</td>
<td>93%</td>
<td>93%</td>
<td></td>
</tr>
<tr>
<td>Percentage of people with positive experience of accessing their GP practice</td>
<td>74%</td>
<td>N/A</td>
<td>83%</td>
<td>81%</td>
<td></td>
</tr>
<tr>
<td>End of Life Care</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
<td>88%</td>
<td></td>
</tr>
<tr>
<td>Proportion of care services graded ‘good’ or above in Care inspectorate inspections</td>
<td>78%</td>
<td>78%</td>
<td>85%</td>
<td>85%</td>
<td></td>
</tr>
</tbody>
</table>

How did we do?

93% of people surveyed considered their health and care services were well co-ordinated, which is in line with the Scottish average.

There was a slight reduction from previous years, however there was an increase to 83% of those who had a positive experience of access to their GP.

What did we do to make a difference?

We regularly undertake surveys and run community engagement on a variety of issues. We are also committed to training our staff to provide them with the skills required to deliver a quality service that people value.

**Dementia Skilled Practice Level of the Promoting Excellence Framework.**

This framework defines the skill level required by all staff involved with direct contact with people with dementia, their families and carers. Approximately 350 carers provide a service to 950 adults across Moray.

An innovative method of engaging and providing training was delivered to Homecare staff during 2017. Staff were provided access to LearnPro (Moray Council’s learning platform) or were issued with hard copies of the training packages and peer or telephone support was made available during office hours. Upon completion of all five modules and assessments a certificate of achievement was presented.
Mental Health Services, Moray

An outpatient survey was carried out in October 2017. It was concerned with the patient’s experience of our outpatient department. It covers aspects relating to the process of receiving an outpatient appointment, waiting times, the environment and care and treatment. 41% of completed questionnaires were returned for analysis, which is 99 out of the 242 sent.

The survey included questions under the following headings.

Out patient appointment process

- 99% of patients were happy with the method used to communicate their appointment date and time.
- 98% of patients ‘strongly agreed’ or ‘agreed’ that their appointment was issued in sufficient time to be able to make arrangements to attend.
- 77.8 felt that the length of time to wait for their first appointment was ‘just right’
- 20.2% of patients felt the wait was ‘too long’

Attendance

- 43.4% of patients were ‘seen on time’ by the clinician
- 27.3% were seen in ‘less than 15 minutes’
- 19.2% were seen in ‘more than 15 minutes’

Environment

The majority of patients were ‘very satisfied’ or ‘satisfied’ with the:

- Cleanliness of the waiting area
- Temperature of the waiting area
- Seating suitability of the waiting area

However, comments for seating suitability ranged from ‘little privacy’, ‘lack of seating’, ‘layout used as a through corridor’, ‘dingy and cramped’.

Care and Treatment

- 94.9% patients felt that the Reception staff were ‘very helpful’ or ‘helpful’
- 95% patients ‘strongly agreed’ or ‘agreed’ that they felt supported and listened to; 4% ‘disagreed strongly’ or ‘disagreed’
- 97% patients ‘strongly agreed’ or ‘agreed’ that they were treated with dignity and respect
- 94.9% patients ‘strongly agreed’ or ‘agreed’ they felt involved in decisions about their care and treatment.

Overall

93% patients rated their level of experience with the service provided as either ‘excellent’, ‘very good’ or ‘good’. 3% patients rated their experience as ‘poor’.

The survey will be repeated in December 2018.
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

Improving people’s quality of life by reducing social isolation and connecting people to their communities is an area of focus. Supporting those with long term conditions by developing self-management programmes can have a benefit of reducing unplanned admissions to hospital.

A key project underway has a focus to deliver transformational change in Learning Disabilities, in relation to increasing levels of independence in the community with the intention to further improve their quality of life.

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</tr>
</thead>
<tbody>
<tr>
<td>Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life</td>
<td>86%</td>
<td>N/A**</td>
<td>79%</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Percentage of people with positive experience of the care provided by their GP practice</td>
<td>87%</td>
<td>N/A**</td>
<td>80%</td>
<td>83%</td>
<td></td>
</tr>
<tr>
<td>Emergency admission rate (per 100,000 population)</td>
<td>8,673</td>
<td>8,734</td>
<td>9,037</td>
<td>11,959</td>
<td></td>
</tr>
<tr>
<td>Readmission to hospital within 28 days (per 1,000 population)</td>
<td>76</td>
<td>74</td>
<td>81</td>
<td>97</td>
<td></td>
</tr>
<tr>
<td>Delayed discharge bed days</td>
<td>764</td>
<td>1,095</td>
<td>955</td>
<td>722</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Local Indicator</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client feedback: ‘I feel satisfied with my level of involved in the design of the support plan’</td>
<td>99.5%</td>
<td>99.8%</td>
<td>99.6%</td>
</tr>
</tbody>
</table>

**How did we do?**

National survey results for people’s feelings of a positive experience in relation to services provided have shown decreases on previous years’ results and are below the Scottish average.

Clients who have support plans are requested to provide feedback on their experience. 1,463 clients were asked and of 59% responses received in 2017, 99.6% agree they feel satisfied with their level of involvement.

**What did we do to make a difference?**

Improving unscheduled care across Scotland is a key priority for the Scottish Government. The aim of the 6 Essential Actions for Improving Unscheduled Care (6EA USC), is for safe, person centred, effective care, delivered to every patient, every time without unnecessary waits, delays and duplication. This includes improving the timeliness and quality of patient care from arrival to discharge from hospital; aiming to ensure that ultimately 98% of patients attending Emergency Departments anywhere in Scotland are seen, treated and discharged or admitted within 4 hours.

There was no dedicated Occupational Therapy (OT) provision to the Emergency Department (ED) at Dr Gray’s Hospital (DGH) prior to 2016.
A report by the Royal College of Occupational Therapists November 2016, made a number of recommendations including ‘all rapid response and acute emergency care services must have occupational therapists embedded within the Multidisciplinary team’. In 2015, there had been 5 referrals to OT from the ED.

Following a successful bid (Nov 2016) to the 6 Essential Actions For Improving Unscheduled Care initiative, time limited resource was secured to fund OT staff to be based in the ED at DGH.

The project supported Essential Actions: EA6 – Ensuring patients are Cared for in their Own Homes EA2 – Capacity and Patient Flow Realignment EA5 – 7 Day Services The key aims were:

- Prevent unnecessary admissions
- Provide multi factorial assessment in the Emergency Department and Clinical Decision Unit over 7 days (extended to include Acute Medical Assessment Unit and Surgical Assessment Unit March 2017)
- Establish an OT integrated falls pathway to prevent falls-related hospital admissions
- Maximise the OT contribution to achieving delayed discharge targets and reducing overall length of stay

November 2016 to November 2017

- 560 new referrals were made to OT
- 86 of the 560 patients were treated in ED ‘Out of Hours’ & were referred to OT for follow up telephone assessment
- 324 follow up contacts made by OT staff after initial assessment
- 884 total patient contacts with OT
- 225 of the 560 patients referred to OT were discharged directly home (40%)
- 207 of the 560 referrals were falls

Occupational Therapists played a critical role in the:

- contribution to the ED 4-hour performance
- discharge of patients from hospital at multiple contact points
- reduction of admissions, positively impacting on bed availability
- absolute value of getting patients back to their own homes and staying mobile and independent

The aims of the project were achieved.

**Transformational Change in Learning Disabilities**

Our learning disabilities accommodation review team was created and funded through the Integrated Care Fund. In late summer 2016 we established, through a commissioned study by Alder Advice, that there is significant scope to improve the quality of life of people with a learning disability in Moray. We were missing opportunities to help people achieve greater levels of independence whether in terms of living arrangements or work/leisure. There are strategic and operational initiatives in hand to address this; we recognise that there is also significant scope to improve the economic impact, efficiency and effectiveness of the services being provided.
There is therefore a strong business case for service transformation which is in summary:

- A higher quality of life occurs when services deliver better outcomes for people with a learning disability.
- Better outcomes and higher quality of life reduce need.
- Need is a driver of services, and therefore cost.
- By focussing on improved outcomes, and so reducing need, we have the opportunity to reduce the level of expenditure and develop a more sustainable financial model.

We have introduced the ‘Progression’ model as part of a transformational change of services in Moray. The ‘Progression’ model is a person-centred developmental approach that has been tried and tested in England and Wales, and seeks to help each adult with a learning disability to achieve their aspirations for independence. It is a relational change from traditional care management approaches by focussing on the individuals’ hopes and choices, using these as the basis to co-develop care and support plans that enable each person to reach their potential.

The model calls for changes to systems and processes that will have implications for professional practice:

- The way in which assessments are carried out.
- Support plans are prepared.
- Risks are managed.
- Reviews are undertaken.

There are also implications for the way in which care and support services are commissioned.

Services such as residential care, supported living and day opportunities must introduce new models that offer greater flexibility and provide a strong focus on enablement of individuals.

Our introduction of the ‘Progression’ model has linked to the opportunity created through Integration moves to develop more effective working between NHS Grampian and Moray Council. This has required significant changes to establish practices. By simultaneously introducing the ‘Progression’ model we have ensured alignment between integrated working arrangements and our goals for the transformational change of our ways of working with people with a learning disability.

We recognised the scale of the change required. We have learnt from the English and Welsh experiences of adopting the ‘Progression’ model and aspired to create a Scottish model of ‘Progression’ that suits our national context. We have introduced a whole system change that has profoundly affected the culture and delivery of our learning disability services. It has included:
• New ways of professional practice and the way in which professionals relate to people with a learning disability and their families.

• Revision to the framework within which health and social services operates.

• Changes to the role and models of our in-house provider services.

• The introduction of improved systems for commissioning supporting a more effective operation of the commissioning cycle.

The following diagram shows what is in scope for the project.

We recognise the significant overlap and inter-relationship between the work that has taken place across the three work streams of the project.

Work continues through 2018/19 to achieve this transformational change, now focussing on the benefits realisation.

**Jubilee Cottages**

In May 2017, 6 vacant houses were opened, transformed into halfway homes for people ready to leave hospital. The £120,000 project provides a homely environment where people can work on regaining their independence. During their short stay in the cottages, they are supported by a team of staff to manage everyday living tasks such as getting in and out of bed and preparing meals. The specific rehabilitation aimed at the Jubilee Cottages differs from standard rehabilitation in the way that the service is provided in a low risk, controlled home environment through high intensity and collaborative rehabilitation to foster an encouraged independence to return home in a maximum of 6 weeks. The rehabilitation service is provided free of charge by the Community Care Department and cottages are equipped with a telecare service to provide a 24-hour on call response. The project has accommodated 12 residents throughout the year.

“My expectations of Jubilee Cottages was that it was a half-way house; giving me the opportunity of experiencing being on my own before heading home which, for me, has given me the insight into realising that I can tire easily following my stroke and time in a hospital setting.”

---

“Jubilee Occupant

“This has helped me be a bit more realistic that things may have to be thought about and planned more when I go home.”

---

“Jubilee Occupant

“I found the experience ideal and perfectly situated for me. It was not for the physical side that I was here but confidence; to allow me a flavour of what life would be like at home following my stroke.”

---

“Jubilee Occupant
Access to key services, public spaces and retail centres is much poorer in Moray than Scotland generally, possibly due to poorer public transport connections across a very rural area. The difficulties recruiting GP to the area has resulted in some merging of practices which has increased the transport time for patients to attend appointments. Innovative solutions are actively being sought through the use of technology to ensure clients have access to the services they require when they require it.

<table>
<thead>
<tr>
<th>National Indicator</th>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/18</th>
<th>Scotland</th>
<th>RAG*</th>
</tr>
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</table>
| Premature mortality rate | 399 | 360 | Not yet available | 440 | |}

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<tr>
<th>Local Indicators</th>
<th>2016/17 Q4</th>
<th>2017/18 Qtr 1</th>
<th>2017/18 Qtr 2</th>
<th>2017/18 Qtr 3</th>
<th>2017/18 Qtr 4</th>
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<tbody>
<tr>
<td>Percentage of clients receiving alcohol treatment within 3 weeks of referral</td>
<td>96.3%</td>
<td>100%</td>
<td>98.6%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Percentage of clients receiving drug treatment within 3 weeks of referral</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

**How did we do?**

Access to Psychological Therapies: Moray Mental Health team have a 100% achievement rate for the 18 week Referral to Treatment Time Standard.

The target of 90% for treatment within 3 weeks following referrals for Drug and for Alcohol patients is being exceeded consistently. We continue to drive to embed Alcohol Brief Interventions (ABI) into routine practice, within the priority settings; primary care, accident and emergency and antenatal care.

**What did we do to make a difference?**

We recognise the challenges of service delivery in rural locations and are taking forward projects to allow clients to receive services in their local areas.

**Making every Opportunity Count (MeOC) in Moray**

MeOC principles and practice are embedded within Health and Social Care as part of core business. This transformative 3-tiered approach is designed to support a common way of preventative working suitable for all public and third sector services by providing a simple approach to the ‘how’.

MeOC provides practitioners with a range of flexible tools; including a DIY MOT self-check, which provides a framework for practitioners to support clients to identify any health and wellbeing concerns they may have.

Once, identified practitioners can signpost clients to the most appropriate supporting service; to date the types of enquiries and signposting opportunities have focused on:

- Lifestyle concerns which include access to; healthy eating/weight management, smoking cessation, substance misuse and alcohol and physical support services
- Mental health and wellbeing concerns
• Access to Health & Social Care services (Moray Council Access Team, Healthpoint)

• Financial concerns

• Fuel poverty

• Carers information

• Essential skills and literacy

• Access to support groups (Men’s Sheds and Be Active Life Long groups)

• Transport

• Volunteering

Working in partnership we aim to build on our success to date and further embed and sustain the MeOC approach within Health and Social, care and partner organisations.

The Department of Work and Pensions (DWP) have fully embraced the DIY MOT self-check and subsequently embedded MeOC within their system of work; which builds on and compliments the role of the DWP Work Coaches. The MeOC approach has now been rolled out across DWP in Grampian.

Moray Council Home Carers are implementing MeOC with their service users; by signposting to services whilst having conversations with the service users in their own homes.

What it’s meant to clients

• Increased awareness and access to services that support self-care, self-management; including lifestyle advice and information.

• Reduced isolation; access to transport which has enabled clients to attend groups, appointments and visit relatives in hospital.

• The MeOC approach has supported clients to address underlying concerns, which previously they have been reluctant to do.

• Condition specific concerns have been raised e.g. mental health.

• Through access to help and support employment has been secured.

“It’s such an easy approach and makes such sense.”

staff feedback

“The DIY MOT breaks down barriers to questions we may feel unconformable asking.”

staff feedback

“People feel that we actual DO care by providing information to services that can support them”

staff feedback

“The sign posting booklet is great”

staff feedback
Baby Steps

Research shows that there are many risks associated with having a body mass index of 30 or above (BMI >30) during pregnancy; which includes risks to the pregnant women, her unborn baby and an increased risk of interventions in labour.

Health intelligence demonstrates a rise in a number of women presenting at their booking appointment with a BMI > 30 in Moray; higher than the Scottish average.

Baby Step is a Health and Wellbeing programme for pregnant women with a BMI >30, which aims to inform women of these risks and empower, motivate and support them to take small steps towards a healthier pregnancy; leading to longer term improvement in the health and wellbeing of those attending, their children and their families. The 8 week programme is fully supported by a midwife and is fun, free and interactive. The development of a Baby Steps toolkit has enabled the scale and spread of the Baby Steps programme across the Grampian region and received interest from other Health Boards in Scotland.

Outreach Mobile Information Buses (OMIB)

Over the past year we have built on and developed new collaborations to work in and with communities utilising our Outreach Mobile Information Bus to address health inequalities and promote social inclusion.

We have built relationships, trust and capacity with communities, maximising opportunities for health gain, with partner organisations such as the Men’s Sheds and Street Pastors; who have now become volunteer drivers. This has enabled the ‘shedders’ to promote the benefits of Men’s Sheds and increase their membership. The street pastors, now have a safe space to engage with those more vulnerable in our communities encouraging and signposting them to other supporting agencies.

We have increased access to approved information, advice and support to enhance community resilience through the outreach work with the Department for Work and Pensions, Quarriers and REAP Scotland; taking services to local communities.

Targeted interventions, that address health protection have been delivered both within and out with Moray such as dry blood spot testing and immunisation clinics for young people.

The OMIB has supported community events and promoted National, Regional and Local campaigns that address priorities area such as Mental Health and Wellbeing; working in partnership to improve ‘wellbeing on wheels’.
Digital Transformation

Moray Digital Transformation Oversight Group has been formed with the remit to assess needs and find assistive technologies for implementation to streamline and support delivery of clinical services.

A pilot of ‘Attend Anywhere’ was carried out at Maryhill GP practice. This provided the facility for clients to have an appointment ‘virtually’ by use of an app on their phone, to take them to their appointment in the virtual waiting room. A doctor would then be able to ‘meet’ them and using a video call carry-out a consultation.

The pilot has proved a success from patient and doctor perspectives and so the technology will be rolled out to other practices across Moray. It is also intended to trial use by District Nursing teams and practice based Advanced Nurse Practitioners on home visits to be able to consult with colleagues at the practice.
People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and well-being.

A key strategic objective for Health and Social Care Moray (HSCM) is to have people cared for at home, if they wish, for as long as possible. HSCM and Moray Council recognise the significant input that families and carers contribute in supporting people to live at home. Engagement with carers to establish what they need to support them in their caring role has been a key focus during 2017 and the learning will inform actions taken forward.

How did we do?

Despite a slight reduction from 67% to 65%, Moray continues to perform above the Scottish average (61%) in the measure relating to adult with intensive care needs receiving care at home. In the survey conducted nationally the percentage of carers who feel supported has dropped in the last two years, although the rate at 39% is above the national average.

An annual survey was sent to all carers registered with Quarriers Carer Support Service in Moray (approximately 1,400 people). The response rate was lower than hoped, at 3.6%, however 97% of responses received rated overall support as good/excellent. The service was recognised as responsive, providing relevant information and having staff who were knowledgeable, supportive, helpful and respectful.

What did we do to make a difference?

Ensuring Carers feel supported and able to cope with their role is a priority. Moray’s estimated 8,000 unpaid carers gained new rights when the Carers (Scotland) Act 2016 came into force at the end of March.

The Act recognises the value of the unpaid care provided nationally and the impact caring can have on individual carers. It furthers the rights of unpaid carers with the intention of ensuring that they are better supported, able to continue to care if they wish to, have a life out with their caring role and are recognised as equal partners in care.

In preparation for the introduction of the Act, Health and Social Care Moray co-ordinated the work required to support implementation, including delegation of certain local authority functions to the Integration Joint Board which required amending the Integration Scheme between Moray Council and NHS Grampian.

The views of carers were invited on proposed local eligibility criteria which are now being used to determine whether a carer has the right to an enhanced level of support over and above the general carer information and advice service. All carers in Moray continue to be able to access information, advice and support through the commissioned Quarriors Carer Support Service whether they have an Adult Carer Support Plan or not.

Training sessions were held for staff working in health and social care settings.
and partner agencies that may come into contact people who provide or intend to provide care for another person. Information on the Carers Scotland Act and the local eligibility criteria have been produced and are widely available to carers.

**Carer Aware**

Moray’s unpaid carers also have a way to be better prepared for a crisis now that a local information and identity card is available.

Many people looking after someone who needs care and support do so with little or no outside help. They often worry what would happen if they found themselves in an emergency situation, unable to alert anyone that they are a carer with someone relying on them.

In response to this concern, the Moray Carer Services Provider Network created the Moray Carer Aware Card which was launched on national Carers’ Rights Day in November.

Carers can fill out the free card with their details and those of an emergency contact. Should the unexpected happen, for example an accident or being taken ill, the information provided on the card can be used to alert the carer’s named contacts that the person who is cared for may need assistance.

Health & Social Care led multi agency staff training sessions to raise awareness of the Carer Aware Card and promote the use of the carers’ emergency planning toolkit.

Any carer can get help and support about emergency planning, including the carer aware card, from Quarriers.

**Adult Carer Support**

On 22 November 2017 the Council approved a plan for public consultation on draft eligibility criteria for adult carer support. Following the current review of the Health and Social Care Integration Scheme, eligibility criteria will be the responsibility of the Moray Integration Joint Board.

Public consultation took place for six weeks from 4 December 2017-19 January 2018. 500 hard copies of the consultation were made available, as well as electronic access online on the Moray Council website.

This included printed consultation packs issued to Quarriers carer centre, all libraries, Council Access Points, Moray Resource Centre, all community care teams. It was also issued to partner organisations, including Alzheimer Scotland, Crossroads, Cornerstone and Enable Scotland. Information and links were also sent to a range of local patient/service user groups. The Moray Integration Joint Board was included as consultees. Media releases and social media information were also included, as well as information in two partner organisation’s newsletters.

Three face to face public information sessions were arranged in December – two public drop-in sessions and an information and discussion session at the Quarry’s Carers Café in Elgin. Partner carer organisations (Quarriers, Alzheimer Scotland, Crossroads, Cornerstone and Enable Scotland) were also offered face to face sessions for their carer groups.

A total of 10 responses were received. 7 of the 10 respondents indicated they were carers.

The local eligibility criterion for support to unpaid adult carers was approved by the Moray Council on 28 February 2018. Carers who meet the eligibility threshold for enhanced support will be offered a personal Self-directed Support (SDS) budget of £300 per annum.
People using health and social care services are safe from harm.

We aim to ensure that our patients and clients feel safe and secure in which ever environment they are, be it at home, hospital or other care accommodation and we develop and carry out our working practices support this aim.

<table>
<thead>
<tr>
<th>National Indicator</th>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/18</th>
<th>Scotland</th>
<th>RAG*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of adults supported at home who agree they felt safe</td>
<td>81%</td>
<td>N/A</td>
<td>84%</td>
<td>83%</td>
<td></td>
</tr>
<tr>
<td>Premature mortality rate per 100,000 persons (people aged under 75)</td>
<td>399</td>
<td>360</td>
<td>Not yet available</td>
<td>2016/17 440</td>
<td></td>
</tr>
<tr>
<td>Readmission to hospital within 28 days (per 1,000 population)</td>
<td>76</td>
<td>74</td>
<td>81</td>
<td>97</td>
<td></td>
</tr>
<tr>
<td>Falls (rate per 1,000 population aged 65+)</td>
<td>17</td>
<td>16</td>
<td>15</td>
<td>22</td>
<td></td>
</tr>
</tbody>
</table>

How did we do?

The national survey records 84% adults agreeing they felt safe, an increase from 2015/16. According to locally collated information 98% of people with support plans feel safety needs are completely or partially met which is in line with previous year’s performance.

Patient results of 100% positive were received in an audit looking at A&E staff’s perceptions of those who self-harm and in turn the patient’s experience of being treated in the department.

What did we do to make a difference?

We address this outcome through our governance arrangements, which highlight areas where additional attention is required to help people remain safe from harm.

Clinical care and governance committee

The Clinical and Care Governance Committee of the MJIB is responsible for quality assurance demonstrating compliance with statutory requirements in relation to clinical governance, authorising an accurate and honest annual clinical governance statement and responding to scrutiny and improvement reports by external bodies such as Healthcare Improvement Scotland (or any successor). To achieve this, the Committee oversees a governance framework including a strategy, annual work programme, infrastructure of governance groups and an annual report.

During the financial year 2017/18 the Clinical and Care Governance Committee have considered:

- and approved a Falls Action Plan for Moray;
- the consultation on new National Health and Social Care Standards;
- examining adverse events and feedback from Health and Social Care – reviewed every meeting and is scrutinised by the Committee;
- scrutinising Health and Safety workstreams
analysing self-assessments on clinical governance arrangements by all delegated services within Health and Social Care Moray

**Falls**

The Active Independent Living Programme was launched for Allied Health Professionals in June 2017.

Developing on the work undertaken by the pilot of a Falls Response Team last year learning from Occupational therapy (OT) in the Emergency Department at Dr Gray’s Hospital has informed the development of the falls pathway. This pathway was piloted August 2017 and implemented in October 2017 at one of the GP practices. This pathway is now planned for implementation across Moray.

This work has demonstrated effective integrated working where Therapy Support works supported by Third Sector Services establish local community connections for people. Through the use of an integrated falls pathway identifying and ensuring timely multi-factorial fall assessment and early intervention for people who have experienced a fall helps to reduce falls related admissions to hospital.

Health & Social Care Moray in collaboration with the Scottish Ambulance Service (SAS) have redesigned the current falls referral pathway to create a single point of entry for referrals to The Moray Council Adult Social Care Access Team. The SAS attend the person and where non injury is identified, the referral form is completed by the SAS crew and emailed to the Adult Social Care Access Team who respond, engaging with the person and/or their family to identify what support, onward referral, information or help is required. Use of the referral pathway commenced March 2018.

The aims include: access for people who have fallen to the right support, by the right person(s); reducing the need for a SAS intervention where non injury from a fall is identified; maximising an integrated approach by a range of services to mitigate possible attendance at the Emergency Department.

This process was presented to the Big BRAG event 10 May 2018 and will now be taken forward as a case study for NHS under the 6 Essential Actions for Improving Unscheduled Care.

**Muirton Garden, Seafield Hospital**

Muirton garden is now a dementia friendly area for the use of patients, their families and staff. The staff group were aware of the importance of patients having time out with the ward area to manage a wide range of symptoms and also to provide therapeutic and meaningful activity.

The work to create the garden was completed by the nursing staff group and their relatives/spouses. Donations made to the ward were used to fund the project and Friends of Seafield (neighbour community hospital charity) donated the potting shed.

The garden was officially opened on 6th September 2017 and was welcomed by the families of previous patients, current patients and their carers. The official opening was featured in the local papers.
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.

Health and Social care services are continually developing in line with the strategic vision of the IJB. Staff are required to maintain existing services whilst implementing significant changes, which presents real challenges that need to be recognised and resolved. We aim for our staff to feel confident, competent and be professional whilst performing the job they care about.

**How did we do?**

NHS Grampian conducted two staff surveys, iMatter in 2016 and Dignity at Work in 2017, which were issued to NHS staff in Health and Social Care Moray to complete.

From analysis of iMatter, staff felt clear about duties and responsibilities, felt line managers were approachable and would be happy to recommend their team as a good one to be part of. Areas that had least positive feedback related to involvement in decisions relating to the organisation, visibility of senior management and confidence that performance was managed well.

Of the 371 staff that responded to the Dignity at work survey, 12% felt there was bullying or harassment from colleagues in the workplace but that they did not report it because they did not think action would be taken. Emotional or verbal abuse from patients or service users has been experienced by 33% of staff responding with 60% of these instances being reported and there was a greater feeling of confidence that something would be done.

Whilst results for these surveys were in line with the results for NHS Grampian there are areas for improvement in confidence of staff that their concerns will be acted on and addressed. Local indicators for sickness absence follows the national trends of peaks in % over the winter period however the rate has remained above the target of 4% for the last 3 quarters and further analysis will be undertaken to understand the issues.

**What did we do to make a difference?**

Recognising a need to engage with the wider workforce and address key issues relating to visibility of strategic direction including opportunities to contribute to developments, the following outlines some of the approaches undertaken.
Organisational Development Plan

An Organisational Development Plan has been approved by the MIJB. This plan describes the partnerships approach to developing a positive organisational culture that will help the MIJB deliver on its strategic priorities and aims to ensure the people of Moray get the best services possible. For that to be achieved, our staff need to be supported to be able to do the best they can do. This plan seeks to build on the strengths already in place across the workforce and ensure that we create an environment where staff learn and thrive. Although the current environment is challenging we recognise the need to invest in our staff to help them through the challenges and the changes. The plan sets out our ambition and how we are implementing key actions to ensure they are given every opportunity to be their best and feel valued in doing so.

Supporting staff to lead and embrace changing roles in the establishment of Multi-disciplinary Teams (MDT’s)

One of the highlighted areas for extended MDT’s was additional practice based Pharmacy support. We have identified funding for extra support for pharmacy assistants, technicians, including pharmacist prescribers. These posts are apportioned to practices and play a significant part in the delivery of health care at the frontline supporting the wider multi-disciplinary team to reshape how they work.

Community nursing has been supported to look at the future of this profession in the changing environment undergoing a review process which is promoting a redesign incorporating coordinated service delivery and care through practices/localities as integrated teams. We are aiming for coherence across Moray as we seek to implement change.

Prof Amanda Croft, Acting Chief Executive for NHSG, has developed an Advanced Clinical Academy which is being tested in Moray. The Academy assists in assessing, training and mentoring MDT members to work at the top of their professional license. An initial project will be a training needs assessment of DN staff. It is envisaged that this opportunity will be offered to GP practice nursing teams in due course. The academy will, in time, support other professions seeking to achieve advanced practice providing a clear and recognised framework for staff to engage with in their development of advanced clinical skills.

The concept of Bite Sized Leadership for GP’s emerged over the past year. Funding was secured for additional GP sessions in Cancer and Palliative Care, Dementia, Medicines Management and Child Health. Working together with the Clinical Leads and the Cluster Quality Lead (both GP leadership roles supporting IJB and HSCP)this grouping meets regularly and incorporates developments in these key areas by building on the foundations set within the GP Strategic Plan. Through the Moray Quality Forum, each of the Leads will host an evening meeting for discussion around their proposed remits. This provides an opportunity for further collaborative working, learning and agreements on ways of working based on good practice for both with GP’s and hospital colleagues.
Healthy Working Lives – keeping staff well

We celebrated maintaining the Gold Healthy Working Lives (HWL) award for the 7th consecutive year; having achieved gold plus status since 2013. Moray was the first sector within NHS Grampian to achieve Gold status.

The accolade from Health Scotland recognises the organisation as an employer who strives to improve the health, wellbeing and safety of employees and the wider community.

Many activities and initiatives were undertaken in 2017. These included the successful ‘52 weeks of Kindness campaign’ to encourage little acts of kindness between staff and also with the wider community. Positive relationships and kindness are at the heart of wellbeing and happy workplaces.

A range of activities to encourage staff to try new opportunities and increase health and wellbeing have been promoted and supported within Moray. Staff can also access health and wellbeing checks via healthpoint, where healthpoint advisors can personalise information and advice to support healthier lifestyle choices.

Sharing Good Practice Forum – promoting learning and development

This is a multi-disciplinary forum, promoting learning and development, which is held each quarter. It is used to share learning from Adverse Event reviews and has now also had sessions on the following:

- Confidentiality
- Supervision
- Results of local audits
- STEPPS (Systems Training for Emotional Predictability and Problem Solving)
- Individual Placement Support (Employment Support Service)
- MBT (mentalisation based therapy) and its application in clinical practice

Future sessions have been arranged to include:

- Feedback from the recent Patient Safety Climate Tool and any associated planned actions.
- Progressing the application of Rights in Mind: A Pathway to Patient’s Rights in Mental Health Services

“The activities, information and support that healthy working lives provides, means that I am healthier not just in the workplace, but have a healthier lifestyle which benefits both me and my family”

HWL group member.
Investing in Leadership Development

We are investing in our health and care system leaders, providing opportunities to learn with other public sector partners, challenging norms and considering collaborations for the good of the people of Moray and Grampian. Working in uncertain times and developing personal resilience are current themes for leaders. We have engaged and run the first programme with 6 health and social care managers working with colleagues across the Grampian system of care, providing leadership development fit for the future and recognising the changing environment in which they are expected to operate. We have access through North East Public Sector Collaborative arrangements to a range of programmes and training to develop our system leaders.

Case Study 4

Self-Harm Packs

Patient results of 100% positive were received in a recent audit of the experience of self-harming patients in A&E. Additional feedback identified a need for more information and resources and this idea was developed and taken forward by the Nurse practitioner. She worked with a service user to research and identify items for inclusion in a pack. These self-help materials include a relaxation CD, stress booklet, distraction items and written information for this specific purpose and is distributed by the nurse practitioner team. This work has built up the confidence and knowledge base for staff and assists with ensuring the right response at the right time.
Given the financial pressures that are being experienced in the public sector it is imperative that every effort is made to ensure that within HSCM resources are targeted appropriately. There are huge costs associated with hospital stays so it is essential that they are allocated appropriately.

In addition technology is required to support staff in delivering an increasing demand for services. Many of our buildings are old and are not fit for the methods of service delivery now used.

<table>
<thead>
<tr>
<th>National Indicator</th>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/18</th>
<th>Scotland</th>
<th>RAG*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmission to hospital within 28 days (per 1,000 population)</td>
<td>76</td>
<td>74</td>
<td>81</td>
<td>97</td>
<td>![Green]</td>
</tr>
<tr>
<td>Delayed discharge bed days</td>
<td>764</td>
<td>1,095</td>
<td>955</td>
<td>772</td>
<td>![Red]</td>
</tr>
<tr>
<td>Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency</td>
<td>22%</td>
<td>21%</td>
<td>20%</td>
<td>23%</td>
<td>![Green]</td>
</tr>
</tbody>
</table>

**How did we do?**

The number of people waiting to be discharged from hospital when they are ready (Delayed Discharges) peaked within 2016/17 and although the figure has reduced in 2017/18 we are still well above the Scottish average. The peak was due to recording timeframes of 72 hours being implemented, and as a result the incidents appear to increase however there is a considerable amount of effort focused into projects to reduce this figure for 2018/19 and beyond.

**What did we do to make a difference?**

MIJB were allocated £416k from the Primary Care Fund which has been used to test out new approaches in the delivery of primary care, including Link Workers, Wellbeing Practitioners, Out of Hours service and pharmacy input. These tests will inform future service delivery and identify efficiencies in working practices.

**Accommodation**

Office requirements are being reviewed in relation to development of localities, multi-disciplinary teams and their future requirements. In addition work will be undertaken to expand the introduction of SMART working and flexible working to facilitate reduction in desk and office space requirements across all locations.

Work was undertaken during 2017 to facilitate the co-location of the OT's, Social Workers and Homecare into the Forres Health Centre, promoting more collaborative working and supporting the Multi-Disciplinary Team process, which is recognised in the new GP contract as the way forward.

A review of accommodation for respite services identified there was an under-utilisation of capacity. An opportunity to rationalise buildings was taken and resulted in the closure of Doocot View, Buckie and Taigh Farris, Forres thereby achieving savings in building and operation costs. Clients were supported to access alternative options.
Point of Initial Contact

Over the past year, the Moray Practice Managers group has increasingly worked collaboratively and cooperatively to address issues of sustainability. HSCM has provided funding for significant development training in communication, negotiation and accountability skills, to develop the capability to respond to Tier 1 presentations by signposting appropriately, thus releasing capacity for Tier 2 and 3 care within practices.

Moray Practice Managers group is represented at the HSCM Operational Management Team meeting which brings together all health and social care managers to a forum for discussing changes that impact on point of initial contact and service delivery for patients.

Practices are establishing a database of commonly used resources to facilitate sharing and sustainability along many themes. These can be used across Moray and will reduce unhelpful variation in practice.
Finance Planning and Performance

Financial Governance

The Moray Integration Joint Board (MIJB) has a responsibility under the Public Bodies (Joint Working) (Scotland) Act 2014 to set a revenue budget each financial year. The funding of the MIJB revenue budget in support of the delivery of the Strategic Plan is delegated from NHS Grampian and Moray Council. The total level of funding delegated to the MIJB for the 2017/18 financial year was £117.1 million.

NHS Grampian  ●
Moray Council  ●
Scottish Government  ●
MIJB General Reserves  ●

The Scottish Government element of funding has been provided in order to facilitate transformation and support the principles of integration. This funding is mainstreamed and recurring and supports the delivery of the Strategic Plan.

The table below summarises the financial movement during the year

<table>
<thead>
<tr>
<th>Total Funding inc Reserves 17/18</th>
<th>Actual Expenditure 17/18</th>
<th>Balance of Reserves at 31.3.18</th>
</tr>
</thead>
<tbody>
<tr>
<td>£ 000</td>
<td>£ 000</td>
<td>£ 000</td>
</tr>
<tr>
<td>117,074</td>
<td>116,227</td>
<td>847</td>
</tr>
</tbody>
</table>

Audit Scotland provided MIJB with an unqualified option on its annual accounts for 2016/17 and will report on financial accounts for 2017/18 in September 2018.

Financial Performance and Best Value

Financial performance forms part of the regular reporting cycle to the MIJB. Throughout the year the Board, through the reports it receives is asked to consider the financial position at a given point and any management action deemed as necessary to ensure delivery of services within the designated financial framework. From the mid-point in the financial year, the Board are presented with financial information that includes a forecast on the likely financial outturn at the end of the financial year.
### Revenue Summary 2017/18

The financial performance for the MIJB in 2017/18 was:

<table>
<thead>
<tr>
<th>Service Area</th>
<th>2017/18 Budget £'000</th>
<th>2017/18 Actual £'000</th>
<th>Variance Fav / (Adverse) £'000</th>
<th>2016/17 Actual £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Hospitals</td>
<td>5,428</td>
<td>5,475</td>
<td>(47)</td>
<td>5,520</td>
</tr>
<tr>
<td>Community Health</td>
<td>3,612</td>
<td>3,555</td>
<td>57</td>
<td>3,654</td>
</tr>
<tr>
<td>Learning Disabilities</td>
<td>5,870</td>
<td>6,025</td>
<td>(155)</td>
<td>5,288</td>
</tr>
<tr>
<td>Mental Health</td>
<td>7,139</td>
<td>7,447</td>
<td>(308)</td>
<td>7,405</td>
</tr>
<tr>
<td>Addictions</td>
<td>965</td>
<td>1,003</td>
<td>(38)</td>
<td>823</td>
</tr>
<tr>
<td>Adult Protection &amp; Health Improvement</td>
<td>153</td>
<td>144</td>
<td>9</td>
<td>165</td>
</tr>
<tr>
<td>Care Services Provided In-House</td>
<td>13,460</td>
<td>13,427</td>
<td>33</td>
<td>13,047</td>
</tr>
<tr>
<td>Older People &amp; Physical and Sensory Disability</td>
<td>16,066</td>
<td>16,945</td>
<td>(879)</td>
<td>16,267</td>
</tr>
<tr>
<td>Intermediate Care &amp; Occupational Therapy</td>
<td>1,382</td>
<td>1,508</td>
<td>(126)</td>
<td>1,629</td>
</tr>
<tr>
<td>Care Services Provided by External Contractors</td>
<td>10,961</td>
<td>11,024</td>
<td>(63)</td>
<td>9,946</td>
</tr>
<tr>
<td>Other Community Services</td>
<td>7,149</td>
<td>7,143</td>
<td>6</td>
<td>7,169</td>
</tr>
<tr>
<td>Administration &amp; Management</td>
<td>2,687</td>
<td>2,569</td>
<td>118</td>
<td>2,703</td>
</tr>
<tr>
<td>Primary Care Prescribing</td>
<td>16,798</td>
<td>17,844</td>
<td>(1,046)</td>
<td>17,304</td>
</tr>
<tr>
<td>Primary Care Services</td>
<td>15,252</td>
<td>15,085</td>
<td>167</td>
<td>14,890</td>
</tr>
<tr>
<td>Hosted Services</td>
<td>3,885</td>
<td>4,061</td>
<td>(176)</td>
<td>3,681</td>
</tr>
<tr>
<td>Out of Area Placements</td>
<td>669</td>
<td>658</td>
<td>11</td>
<td>525</td>
</tr>
<tr>
<td>Improvement Grants</td>
<td>980</td>
<td>787</td>
<td>193</td>
<td>930</td>
</tr>
<tr>
<td><strong>Total Core Services</strong></td>
<td><strong>112,456</strong></td>
<td><strong>114,700</strong></td>
<td><strong>(2,244)</strong></td>
<td><strong>110,946</strong></td>
</tr>
<tr>
<td>Strategic Funds (inc Reserves)</td>
<td>4,618</td>
<td>1,527</td>
<td>3,091</td>
<td>875</td>
</tr>
<tr>
<td><strong>Total Net Expenditure</strong></td>
<td><strong>117,074</strong></td>
<td><strong>116,227</strong></td>
<td><strong>847</strong></td>
<td><strong>111,821</strong></td>
</tr>
</tbody>
</table>

### Main Reasons for Variances Against Budget in 2017/18

Overall, the MIJB core services resulted in an overspend of £2.2m. This position has been improved considerably when the slippage on strategic funds are taken into consideration resulting in an overall underspend of £0.847m.

**Learning Disabilities** – the Learning Disability service was overspent by £0.155m at the year-end. The overspend is primarily due to the purchase of care for people with complex needs, including young people transferring from Children’s services. This is offset by underspends on staffing (£0.129m) that has existed throughout this financial year, mainly relating to physiotherapy, speech and language and psychology services. The Learning Disability Transformation Programme is in its implementation phase which will enable the system to be confident that people are being supported in the best way to ensure they have the right kind of support to become as independent as possible. Demographics suggest that the number of people with a learning disability will continue to increase, and whilst these people will live longer with more complex needs this creates additional financial pressure in the system.
Mental Health – services were overspent at the end of the year by £0.308m. In the main this was due to senior medical staff costs including locums (£0.181m), nursing and other staff (£0.073m). There are clear obligations that exist in relation to mental health consultants and the responsibility for ensuring the clinical needs are met fall to NHS Grampian whilst the financial impact directly affects the MIJB. This continues to be closely monitored.

Older People and Physical and Sensory Disability Services – services were overspent by £0.879 million as at 31 March 2018. This primarily is due to external purchasing of care with a continuing increase in demand on services. Primarily, this was attributable to growth through increased care packages which have risen by 30% on the level at March 2017. Additionally, there have been increases to hourly rates that have highlighted further this adverse variance.

Primary Care Prescribing – remains the most significant financial pressure facing the MIJB which gave rise to an overspend in year of £1 million. Prescribing is the largest budget within the services delegated to the MIJB at £16.8 million and is extremely difficult to predict due to the number of external factors influencing costs and control. Medicines management practices are in place to promote cost effective treatment options, identifying and responding to prescriber variation, reviewing patients’ treatment regimens ensuring waste is minimised, however, external influences remain the predominant factor in cost control of the prescribing budget.

Hosted Services – are operated and managed on a Grampian wide basis. Hosting arrangements means that one IJB within the Grampian Health Board area hosts the service on behalf of all 3 IJB’s. Strategic planning for the use of hosted services is undertaken by the 3 IJB’s for their respective populations. MIJB has responsibility for hosting the Primary Care Out of Hours Services (GMED) and Primary Care Contracts. The reported overspend for the year was £0.176m; this is representative of Moray’s share of all hosted services within Grampian. The overall recharge includes overspends on sexual health, Marie Curie nursing, Police forensic examiners and GMED, which is reduced by underspends in other areas of the hosted budgets namely - Intermediate care, Diabetes & Retinal screening and HMP Grampian.
Financial Outlook

One of the major risks facing the MIJB and its ability to deliver the services delegated to it within the context of the Strategic Plan is the uncertainty around the funding being made available from the partners and the Scottish Government.

The Scottish Government 2018/19 funding settlements, for both health boards and local authorities, announced in December 2017 were challenging resulting in an adverse impact from the local authority on the onward negotiation of funding to the MIJB. Whilst the strategic outcomes and intent remain unchanged, the challenge is to ensure that the economic impact of decisions are highlighted as there is insufficient funding to maintain current levels of service in 2018/19 and beyond.

The reduced funding levels, combined with the demographic challenges we are facing in a period of ambitious reform present defined risks and uncertainties that require monitoring and managing on an ongoing basis. The ageing population and increasing numbers of people living with long term conditions and complex needs will generate demands which cannot be met unless alternative service delivery models are generated. There is an on-going commitment to provide care to those in the greatest need while providing those services within the resource available.

Best Value

NHS Grampian and Moray Council have delegated functions and associated budgets of these functions to the MIJB. It is the responsibility of the MIJB to decide how to use these resources to achieve the objectives of the Strategic Plan.

The governance framework comprises the systems of internal control and the processes, culture and values, by which the MIJB is directed and controlled. It demonstrates how the MIJB conducts its affairs and enables the MIJB to monitor progress towards the achievement of its strategic priorities and to consider whether those priorities have led to the delivery of cost-effective services.

The MIJB ensures proper administration of its financial affairs through the appointment to the Board of a Chief Financial Officer, in line with Section 95 of the Local Government (Scotland) Act 1973.

Financial Reporting on Localities

The financial reporting for 2017/18 is not currently reported at locality level. This continues to be a work in progress and remains a priority for development.
Reporting on the Integrated Care Fund

MUIB received a total of £1.59m from the Scottish Government’s Integrated Care Fund (ICF) in 2015/16 to support delivery of improved outcomes from health and social care integration, help drive the shift towards prevention and early intervention and further strengthen our approach to tackling inequalities. This amount has remained static but is now part of core funding to assist the continuation of programme delivery and in line with the overarching strategic policy drivers outlined in the Strategic Plan.

Allocation to date of the ICF resources can be summarised as follows:

<table>
<thead>
<tr>
<th>Theme</th>
<th>2017/18 Allocation £000</th>
<th>2017/18 Actual Expenditure £000</th>
<th>Underspend in Year £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promoting Community Wellbeing</td>
<td>111</td>
<td>89</td>
<td>22</td>
</tr>
<tr>
<td>Staying Independent, Self-Management of Long Term Conditions</td>
<td>466</td>
<td>390</td>
<td>76</td>
</tr>
<tr>
<td>Recovery, Rehabilitation &amp; Enablement</td>
<td>191</td>
<td>202</td>
<td>-11</td>
</tr>
<tr>
<td>Intensive Support</td>
<td>86</td>
<td>61</td>
<td>25</td>
</tr>
<tr>
<td>Related Enablers</td>
<td>726</td>
<td>714</td>
<td>12</td>
</tr>
<tr>
<td>Unallocated Balance</td>
<td>10</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Total ICF 2017/18</td>
<td>1,590</td>
<td>1,456</td>
<td>134</td>
</tr>
</tbody>
</table>

Inspections

Our services are subject to independent scrutiny by external agencies. These inspections are against national standards and check that the services that are being delivered meet the standards, the needs of those receiving the service and they provide value for money. The score is from 1 (lowest) to 5 (highest).

During 2016/17 we operated 26 services that scored 3 or below by the Care Inspectorate. There were no enforcement actions received but there were recommendations for improvements.

Working in partnership with providers, both internal and external, action plans were established to improve performance and progress was monitored by the commissioning team. Examples of actions identified were to ensure reviews are completed on time and support plans updated.

Inspection scores for 2017/18 show that 13 of those original 26 are now scoring 4 or more, 9 remain on 3 and there are two that have dropped below 3. Monitoring of the action plans continues to ensure that recommendations are actioned appropriately and timeously.

It is important to note that there has been a recent change to grading requirements and criteria so it will not be possible to carry out direct comparisons in the next year.
Localities and working with communities

Moray has two localities agreed by the IJB, an East and West Locality.

We have tested out a number of approaches in community engagement and participation in the future design and delivery of services and this year in particular we have focused predominantly on Forres as an area where there was an opportunity to increase the pace of change and integration of services. We have used this approach based on our experience of an earlier piece of work the Speyside Area when we worked closely with a very rural community, Glenlivet in early 2017 to secure General Medical Services in collaboration with the community. After a challenging start where the community felt we had not sufficiently engaged we worked with them towards a mutually positive outcome. The learning in the ‘how’ we engage was significant and has influenced the ongoing approach in Forres.

“Very good start and look forward to expanding it at next meeting.”

Community Councillor

“Useful discussion. Need feedback.”

Attendee feedback

“A lot to discuss in a short time. More ongoing discussion required. Information gained was interesting due to mix of people on table.”

Attendee feedback

“Very good. This is groundbreaking. Keep on sharing. Keep the momentum going?”

Attendee feedback
Forres

Community conversations in the Forres area are further paving the way for the transformation of services fit for the future as we learn how to work well with communities.

Working with communities is at the heart of integrated health and care. It enables people who understand the area, the issues, the needs and strengths of the people who live there, to get involved in making decisions about local services.

Three engagement events – in June, August and November 2017 – provided an opportunity for the community to learn more about the MIJB, Health and Social Care Moray and the challenges of delivering high quality, safe, effective and sustainable services now and in the future.

Facilitated table discussions at each event provided opportunities to consider how existing resources could be utilised to better meet local needs and improve outcomes.

Attendance at the events ranged from 40-70 people and along with the residents included board members, ward councillors and health and social care practitioners.

In February 2018 Health and Social Care Moray launched an ambitious change programme to develop a new model of joined-up care for the frail elderly in the Forres locality.

It is bringing together staff, GPs, the third and independent sectors, voluntary groups and the local community including the community council to identify improved ways of caring for patients which supports them to manage their health conditions, helps them recover their independence after illness or injury and enables them to remain within their own home by preventing hospital admission.

A series of co-production workshops for all stakeholders will be held in 2018 to inform the development of a business case for the proposed new model which will be presented to the MIJB in November 2018.

Keith and Speyside

We have already in recent years conducted a similar process in Keith and Speyside in relation to the strategic needs assessment required to request a replacement health centre in Keith. This was also run in workshop form and gathered significant views from that local area. This process is now about to enter a formal process of establishing a business case and this will again require further input from the community, workforce locally, key partners including the community council, seeking to co-produce the future ambitions.
What next?

We have some significant pieces of planning in the next 5-10 years for Elgin and Lossiemouth and Buckie and Cullen. We believe we have started to apply a framework in practice that is well received and will seek to replicate this across Moray in any strategic planning underway.

Review of Strategic Plan

In April 2017 a workshop was held by the Strategic Planning and Commissioning group to review the Strategic Plan and ensure that the intentions remained relevant to the vision of the MIJB, whilst the Strategic Planning and Commissioning Group drive forward the development of the Plan by overseeing planning and commissioning on behalf of the MIJB. The review of the Strategic Plan considered:

The outcome of the session confirmed that a light-touch review of the Strategic Plan was appropriate in the interim with consideration for a complete refresh in a year’s time and a full needs analysis with progress against the Plan to be visible.

A programme of workshops and engagement sessions with stakeholders has been arranged during 2017/18 with a revised draft Strategic Plan to be presented to MIJB for consideration in early 2019.
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If you require further information about any aspect of this Annual Report please contact:

Aberdeen City Health and Social Care Partnership
Community Health and Care Village
50 Frederick Street
Aberdeen AB24 5HY

Email: ACHSCPEnquiries@aberdeencity.gov.uk
Website: https://aberdeencityhscp.scot
Twitter: https://twitter.com/HSCAberdeen
1. Exciting and Dynamic Times

Welcome from the IJB Chair

I warmly welcome the publication of this, our first Annual Report which sets out how we have performed in establishing both the Integration Joint Board and the Health and Social Care Partnership and how we are working towards fulfilling the ambitions and priorities outlined in our Strategic Plan.

I am delighted to have taken over the Chair of the IJB following the baton being passed to me from the IJB’s first Chair, Cllr Len Ironside CBE. Cllr Ironside steered the IJB during its first 10 months of live operation and was a champion for integration and improving outcomes for people. My aim now as Chair is to continue to build upon the strong foundations we have made and to drive our ambitions of delivering significant transformation improved outcomes for people in Aberdeen. I will be supporting our new IJB members who have joined us since the Local Government elections in May 2017 in fulfilling their important roles as members of the IJB in setting the direction and ensuring sound governance for our endeavours.

We aim to be one of the top performing IJBs in Scotland – one which attracts the best people and professionals to work with us and which strives to reduce inequalities in health and improve the wellbeing of our communities.

We have made a start and I look forward to leading a Board and supporting an Executive Team in making even greater progress in across this year and into the next.

Jonathan Passmore, MBE, Chair

Chief Officer Foreword

We can be proud of what we have achieved in our first 12 months of operation. We have lived within our means during this challenging financial year and delivered a balanced budget for 2017/18, accommodating payment of the Scottish Living Wage to our external care providers. We have also maintained a continuity of service for the people who depend upon us during this time of significant change.

We have made significant strides towards establishing the necessary senior management structure to give us the leadership capacity to deliver on our strategic priorities – and we have established our own strong ‘Team Aberdeen’ identity as a Partnership by holding our first Transformation Conference and HEART Awards celebration.

We have opened our new £4.3million Len Ironside Centre to cater for some of Aberdeen’s most vulnerable adults – and we have driven our priority of reducing delayed discharge to a point where we are seeing real results in reducing both the numbers of people delayed as well as the length of time people are delayed.

We have laid the groundwork to establish Link Workers in every GP practice and to pilot the Buurtzorg care-at-home model in our emerging Localities, while at the same time creating the foundations for our Carers Strategy and our Commissioning Plan.

These are exciting and dynamic times for health and social care in Aberdeen as we forge ahead on our journey of change, transformation and improvement – and I want to thank every colleague for their help, their support and their great ideas over the past year.

There are demographic and financial challenges ahead but, strongly supported by our Integration Joint Board, we will meet them together as a team and develop sustainable solutions which meet the needs of all who rely upon our services.

Judith Proctor, Chief Officer.
2. Executive Summary

The population of Aberdeen City is ageing with a projected 70% increase in people over the age of 75 by 2037. This is likely to place enormous pressure on health and social care services and forces us all to think differently about how we achieve and maintain good health and wellbeing.

Our ambitious transformation programme is developing new models of care to support people with long term health conditions and provide traditional hospital (acute) care in communities or even at home. The development of an adaptable and sustainable workforce is key to this, and we aim to develop our assets across primary, community, social care and the third sector. Underpinning all of this is a positive can-do organisational climate with staff and communities being fully engaged and supported to do their very best for the people of Aberdeen.

The drive for effective performance and high quality of care is at the heart of everything we do. Working within a framework adapted from the Care Quality Commission, we monitor measures that are most important to us as a quality organisation. These are based on those where we have the greatest level of accountability and leverage to improve. In some cases the data may be limited and the measures may be imperfect, but we can still use it to understand where we are, and where we want to be.

Safe:
Developing systems and approaches to keep people and communities safe from harm is a priority of the Community Planning Partnership. Our role in this is to raise awareness of risk and to ensure referrals are made for adult support and protection when appropriate. This is an area where referrals are inconsistent – a situation we wish to understand better and improve.

Effective:
Co-ordination of care between professionals is a key ingredient in improving health and well-being outcomes for people in Aberdeen. In the first year of Partnership, we have maintained a downward trend in the rate of emergency admissions to hospital each month, and in the number of bed days used for unscheduled care – a trend which we believe will place us in the top quartile of all Scottish Partnerships next year.

Alcohol consumption and related harm is a significant public health issue in Scotland and particularly so in Aberdeen. Our focus in this first Partnership year has been to increase the number of alcohol brief interventions that are delivered in settings outside of GP surgeries, reaching more people in need of support.

Responsive:
Increasing the uptake of self-directed support and reducing unmet need for social care are all indicators of independent living. There has been little change in performance of services in the past year – a situation we aim to improve in 2017/18.

Reducing the number of people affected by delays in hospital discharge has been a key priority for us this year and one where improvement has been considerable. Improved operational processes, effective service commissioning and the combined ‘one team’ ethos has improved the experience of care for many older people and their families.

Against the context of an ageing and growing population, our focused efforts have meant that fewer people are delayed in hospital when they are ready to be discharged. At the end of our first full Partnership year, the number of people in hospital each month with standard delays reduced by 22% and the total number of avoidable hospital bed days reduced by 47%.

Caring:
88% of care for people in the last six months of their lives takes place at home or in a homely setting. This is comparable to other places in Scotland, but our aim in 2017/18 is to drive improvement in palliative and end of life care which reflects best practice and accords as much as possible with the needs and wishes of patients and their families.

Well-led:
The driving ethos of the Partnership is that staff engagement, participation and delegated authority promotes trust and autonomy – an important factor in a modern, adaptive organisation. The use of ‘i-Matter’ as a feedback and participation tool will be extended into our second year, aiming to work with staff to enhance team working and address difficult issues such as staff sickness. Our transformation programme to develop staff and culture includes effective communication, co-location of teams, information sharing and leadership development. We have placed particular importance on Partnership identity and awarding staff for efforts that have made a notable difference in the job that they do.
3. Our Partnership

“We are a caring partnership working together with our communities to enable people to achieve fulfilling, healthier lives and wellbeing”

The Aberdeen City Health and Social Care Partnership (ACHSCP) formally came into existence in February 2016 with the approval of its Integration Scheme by Scottish Ministers. The Integration Joint Board (IJB) – the Partnership’s board of governance, strategy and scrutiny – became responsible for its delegated health and social care functions on the 1st of April 2016.

Integration ‘go live’ was a hugely significant event, given the many different arrangements that we were obliged to have in place as well as the obvious requirement to ensure continuity of care and support for the many individuals who use our health and social care services across the city.

We believe that our integration transition was successful and gave us a positive platform to begin the transformation of our services and deliver the vision and ambitions of our Strategic Plan.

The IJB is growing in its leadership role and relationships within it are positive and supportive of good decision-making. We have navigated significant governance challenges arising from the legislation with a focus on enabling the IJB’s decision-making authority and siting this appropriately within delegations from partner organisations.

At its first meeting last year, the IJB agreed our strategic ambitions and priorities, and set out its expectations about the scale and pace of our transformation programme. The IJB is clear that they now expect the Chief Officer and her Executive Team to deliver the anticipated benefits from the many different change activities and initiatives that are being progressed by staff across the Partnership.

Did you know...

That one of the ways that we ensure that the voice of people who use our services and carers in the city is heard is through the participation of their representatives on our Integration Joint Board?

They fulfil a crucial role in articulating the user and carer experience and we will develop support networks for them and the many different organisations that operate in the city to support them.

- Held seven public meetings over the last year, establishing the relationships and procedures required to effectively deliver the strategic plan
- Prepared and agreed its first joint budget
- Established and operated two sub committees (Audit and Performance System Committee and Clinical and Care Governance Committee)
- Hosted its first annual conference and an awards ceremony
- Agreed spend for several significant transformation projects
- Established performance management and risk frameworks
- Held several workshops to inform IJB members of the services for which the IJB has strategic responsibility
- In conjunction with Aberdeen City Council opened a new day care centre called the ‘Len Ironside Centre’
- Approved and is in the process of implementing a new management structure

The Chief Officer’s Executive Team is now firmly established and is supporting the IJB with its discussions and decision-making, leading the organisation and improving our service delivery. The senior management structure below the Executive Team has also been established and the final posts are anticipated to be filled in the first few months of the new financial year. Providing this enhanced leadership capacity will significantly help with the scale and pace of our transformational change activity.
The commitment and motivation of our staff underpins our ambitions and priorities and their involvement is at the heart of everything we do and hope to achieve. Some of the many initiatives that we have put in place to support improved relationships and engagement include:

• Establishing a Joint Staff Forum with trade union and staff side representation.
• Supporting trade union and staff side representation on the IJB.
• Developing our Organisational Development (OD) Plan.
• Developing a Workforce Plan.
• Promoting the Aston Team tool
• Rolling out the ‘iMatter’ engagement tool across the partnership
• Developing an ‘ACHSCP specific’ Induction for new staff.
• Publishing a bi-monthly ‘Partnership Matters’ newsletter
• Developing a programme of Executive Team job shadowing sessions/workshops

Our Strategic Plan:

Our Strategic Plan outlines the demographic and financial challenges that the partnership must address as it sets out its strategic ambitions and priorities for the delegated health and social care services.

Our priorities are:

• Develop a consistent person-centred approach that promotes and protects the human rights of every individual and which enable our citizens to have opportunities to maintain their wellbeing and take a full and active role in their local community.
• Support and improve the health, wellbeing and quality of life of our local population.
• Promote and support self-management and independence for individuals for as long as reasonably possible.
• Value and support those who are unpaid carers to become equal partners in the planning and delivery of services, to look after their own health and to have a quality of life outside the caring role if so desired.
• Contribute to a reduction in health inequalities and the inequalities in the wider social conditions that affect our health and wellbeing.
• Strengthen existing community assets and resources that can help local people with their needs as they perceive them and make it easier for people to contribute to helping others in their communities.
• Support our staff to deliver high quality services that have a positive impact on personal experiences and outcomes.

During the first full year of operation, our focus has been on establishing the building blocks to enable the transformation of service delivery in future years. Pivotal to our ambitions is having a locality model that connects us to our communities and which underpins the delivery of our integrated health and social care services.

• We have established Leadership Groups in our four localities. The membership of these groups includes residents, community activists and locality based colleagues from across the health, social care, third and independent sectors.
• These groups are reaching out into their communities and initiating conversations about what matters to local residents. This is informing and influencing the development of our locality profiles and plans.
• The Chairs of the Leadership Groups also sit on our Strategic Planning Group to ensure a stronger strategic, locality based coherence across all our planning activities.

Did you know...

That profiles for each of our four localities highlighting the area’s assets as well as the health and wellbeing of the local population are being developed.

Each Locality Leadership Group will use their own profiles as the basis for their engagement activities with their local communities so that appropriate priorities can be agreed, with a key focus on building on existing community strengths and assets.

Another key activity where significant progress has been made is in our good, positive and improving relationships with our partner organisations in the third and independent sectors. Aberdeen Council for Voluntary Organisations (ACVO) and Scottish Care (the umbrella group for many of our care home and care at home provider organisations) have both played a prominent role in the constructive discussions that have taken place about how we ensure that improved personal experiences and outcomes for the many different people who use, and rely on, our services are delivered.
4. The Case for Change

Our Strategic Plan has made it clear that because of the impending demographic and financial challenges we can’t continue to deliver services as we have traditionally done. We need more than just incremental change to ensure our solutions are fit for the 21st century: we need transformation. Our IJB expects us to deliver significant transformational change at pace, to improve the personal experiences and outcomes for individuals who use our services now and for those who will do so in the future. It has outlined in its Transformation Plan, the six ‘big ticket’ items that it wishes to see progressed and completed and has set up the Integration Transformation Programme Board to oversee an ambitious programme of work that will fulfil our strategic priorities and deliver our strategic vision.

Our ‘Big Ticket’ Items are:

- Organisational Development and Cultural Change
- Modernising Primary and Community Care
- IT, Infrastructure and Data Sharing
- Strategic Commissioning
- Supporting Self-Management of Long Term Conditions and Building Community Capacity
- Acute Care @ Home

Organisational Development & Cultural Change

In its broadest sense, our partnership includes colleagues who work for our partner agencies (Aberdeen City Council and NHS Grampian) as well as those colleagues who work in the third and independent sectors, our carers and volunteers. Reshaping our services in order to deliver them differently will require the partnership to invest in its workforce across all these sectors.

This enabler work-stream recognises that people are key to delivering our integration and transformation ambitions. Activities in this work-stream will support this new “Team Aberdeen” culture to be developed and will support the development of people in the right places and with the right skills and attributes to support people in communities. The work-stream also recognises the anxiety many of our staff will feel as we transition into our new partnership and integrate at every point of delivery, aligning with our values of caring, person-centred and enabling.

During 2016/17 we have:

- Firmly established the ACHSCP brand identity.
- Delivered the Partnership’s first Conference: Taking Care of Transformation #TCOT16.
- Delivered the Partnership’s first Staff and Partner Celebration Event: “Having Exceptional Achievement Recognised Together – HEART Awards.
- Established multi-partner and community Locality Leadership Groups, tasked to develop and delivery locality plans for each locality.
- Launched an online innovation platform called ‘OurIDEAS’ for colleagues across the partnership to share and develop their ideas.
- Designed a series of shadowing opportunities for the Executive Team along with a programme of workshops for 3rd and 4th tier managers.
- Developed a series of engagement opportunities via social media, including locality-based Facebook pages and a unique Twitter handle for ACHSCP.

Did you know...

That the Partnership’s first conference, Taking Care of Transformation: TCOT 2016 was held in November 2016 and brought together around 300 staff and partners, with a shared agenda of innovation, transformation and integration.
IT, Infrastructure and Data Sharing
Effective and linked ICT systems will be an essential, enabling component of the various integration and transformation themes. Our ambitions to innovate and transform will be hampered if there is a continued reliance on current, single service systems.

We are developing an integrated IT system, associated equipment and infrastructure that reflect and support the alignment of our multi-disciplinary teams with our localities. The effective use of ICT will also assist in the bringing together of our new organisation and help to ensure that our staff and wider partnership community have opportunities to participate and engage with our planning and service delivery processes, including being able to influence and identify innovation opportunities.

During 2016/17 we have:
- Relocated the Healthy Hoose into the new Middlefield Community Hub
- Completed the new Len Ironside Centre
- Agreed additional ICT and Business Development capacity to support delivery of our ICT work stream
- Commenced testing of a data-sharing and video-conferencing virtual hub to support better care to be delivered more efficiently
- Supported the roll-out of public wifi in health and social care facilities in the South Locality
- Developed a service agreement for data-sharing across HSCP services including performance monitoring
- Developed a single shared file for the Executive Team
- Begun work towards trialling Microsoft Office 365 across the partnership

Acute Care @ Home
We are seeking to develop a Hospital at Home service that will provide, for a limited time period, active treatment by appropriate professionals, in the individual’s home, of a condition that would otherwise require acute hospital in-patient care.

The development of such a service fits with our ambition for our strategic intentions to have a greater preventative impact especially since we know that prolonged length of stay for the frail elderly and those with long-term conditions can lead to a higher risk of acquired infection and other complications such as loss of confidence, function and social networks.

During 2016/17 we have:
- Engaged with a range of stakeholders to develop an options appraisal of different Hospital at Home Models
- Developed a project proposal for a phased ‘roll out’ of a hospital @ home model, which was approved by the Executive Programme Board for progression to full business case
- Developed a draft specification for a new Hospital at Home service

Did you know...
That, in conjunction with our partner, Aberdeen City Council, in spring 2017 we opened a brand new community asset: the Len Ironside Centre? This valuable resource provides support and activities, helping some 50 adults with severe learning and physical disabilities. The expansive facilities including an extensive outdoor sensory garden, a hi-tech computer room, a specially adapted kitchen and café area, a special sensory room and a large dining room/lounge which can double up as a theatre, and will provide an opportunity to explore and develop community-centred relationships.
Supporting Self-Management of Long-Term Conditions and Building Community Capacity

This work stream recognises that pressures on mainstream primary and community care services cannot be reduced through a “more of the same” approach. The work stream seeks to shift our relationship with communities to enable a more co-productive approach and to nudge the culture towards being more empowered and responsible in relation to ourselves and each other.

There is a strong consensus across the Partnership in support of developing new ‘lower level’ support and link posts embedded in our communities and in our locality teams. There is clear alignment with what our statement of intent says in relation to improving health and wellbeing, reducing health inequalities, taking greater responsibility for our health and wellbeing and letting innovation flourish in our localities.

During 2016/17 we have:

• Developed a case for rolling out Link Workers in every practice in the City
• Continued to support a range of dementia-related services
• Supported the early roll-out of ‘Making Every Opportunity Count’
• Facilitated the Silver City project - a self-management approach to tackling social isolation for the older population at high risk of hospital admission
• Continued to deliver the Golden Games
• Worked in communities in the South Locality, adopting a co-production approach to develop innovative solutions to local challenges

Modernising Primary & Community Care

This proposed investment recognises that there are a range of elements that will help modernise and develop primary care. An approach that offers a menu of change for primary care to test, will give the widest spread of change activity, enable practices to step in at a level they can manage and will grow new models appropriate for their context.

Collaborative working, in locality hubs, with increased pharmacist provision, social work links and GP-led beds will help to reduce admissions to hospital, prescribing costs and provide more sustainable primary and social care services. These hubs will be supported by the design of integrated health and care teams, local communities and a ‘Team Aberdeen’ and person-centred culture and ethos throughout our wider organisation. Different approaches may include models such as the ‘Buurtzorg’ model and Advanced Nursing and Allied Health Professional (AHP) roles in the community.

During 2016/17 we have:

• Developed a business case and received approval to roll-out Community Mental Health Hubs across the city
• Established a Project Team to design and implement an integrated care model in Aberdeen’s communities using the Buurtzorg Principles
• Progressed a project proposal relating to a multi-skilled pharmacy team to business case stage
• Developed new ways of working at Dyce Medical Practice

Did you know...

A co-production developed, locality based Falls Clinic involving Occupational Therapists, Physiotherapists, District Nurses and Clinical Support Workers now takes place monthly in Kincorth.

This clinic benefits people who have had a fall, have lost confidence due to slips and trips or who are unsteady on their feet. During their clinic appointment service users develop their own, individualised “Falls Action Plan” with support from staff. Service users are encouraged to self-manage some areas of their falls risk with guidance from clinic staff. Referral on to other specialist services, provision or review of walking aids, home assessments for provision of equipment and adaptations to the home environment are all common outcomes following clinic appointments.

At Denburn Medical Practice, the traditional model for accessing services has been turned on its head, and a new approach adopted which uses a range of techniques including proactive GP-led triage, increased use of telephone consultations, and removing barriers to patient contact by increasing the number of practice telephone lines and changing the reception culture.

This logical, person-centred approach has increased productivity by 50%:

• Clinical contacts for each GP have increased from 110 per week to 220 per week.
• The non-attendance for booked appointments (Did Not Attend or DNA) rate has practically been eliminated resulting in savings of £20,000 per year.
• Out of Hours contacts have reduced by approximately 20%.
• There are no backlog appointments.
Strategic Commissioning

This proposal is fundamental to our ambition to work with our partners across all sectors in reshaping the services that we deliver to address the common challenges that we face. A coherent commissioning approach will be pivotal to the people who use our services having improved personal experiences and outcomes.

Other anticipated benefits include a more resilient, local marketplace, innovative and effective care models and contractual arrangements that are fit for purpose.

During 2016/17 we have:

- Established a Market Facilitation Steering Group to oversee the development of our agreed facilitation principles and activities
- Provided additional funding to Scottish Care to enhance their developmental capacity for working with the care at home/care home sectors
- Established a range of work streams to develop service specifications for key commissioning activities

5. How Are We Doing?

Our Performance Framework

Achieving our aims and objectives depends on having an effective performance framework to measure progress. There are hundreds of indicators used to monitor the services we deliver, the quality of care we offer and the outcomes we achieve. Our approach has been to develop a structured framework for managing information to ensure the right information reaches the right people at the right time. This helps prevent information overload and ensures that important information is not missed.

We are operating in a constantly changing environment and what we measure now to assess performance is likely to develop as we pool data between health and social care, particularly at locality and community level. During our first year we have drawn on indicators that help to assure performance of current practice and support continuous improvement. They are based on aspects of care and management where we have the greatest level of accountability and leverage to improve. In some cases the data may be limited and the measures may be imperfect, but we can still use it to understand where we are, and where we want to be.

The national and local indicators we use are contextualised around a balanced performance framework adapted from the Care Quality Commission.

Table 5.1 summarises our current situation and the progress we have made in our first year. This draws from measures which have been set nationally or ones we have chosen locally to align with our strategic goals and ambitions. Each indicator shows the most recent performance position and the proportional change from the baseline position of April 2016 when the Partnership became ‘live’. A trend line is also shown based on historical data, enabling change and improvement to be viewed in a longer term context.
Safe

As a Community Planning Partner, we have a responsibility to keep people and communities safe from harm and our collective aim is to develop systems and approaches that raise awareness and identify risk. Supporting all Partners and agencies to refer vulnerable adults for support and protection is a key objective and we have set improvement outcomes to do this collectively. These involve increasing the number of referrals from the HSCP (and other agencies) and identifying a sensitive way to measure appropriateness. There were 1203 referrals during 2016/17 of which 410 required further adult protection action, 522 required further non adult protection action and 271 required no further action.

Effective

Supporting people to live fulfilling and healthy lives is at the heart of what we do. During our first year our ‘award winning’ Silver City Team helped older people take up new hobbies and build confidence in looking after their health and well-being. A new Advanced Nurse Practitioner in Knocrh focuses specifically on supporting older people and helping to co-ordinate care. These are just two examples where new efforts are helping to build individual resilience in health and well-being for people in our communities.

Confident individuals, supported communities and effective co-ordination of care between professionals are key ingredients in improving health and well-being outcomes for people in Aberdeen. One measure of progress is the number of emergency hospital admissions. In the first year of Partnership, we have maintained a steady downward trend in the rate of emergency admissions to hospital each month, and in the number of bed days used for unscheduled care – a trend which we believe will place us in the top quartile of all Scottish Partnerships next year.

Figure 5.1 illustrates the reduction in patient admissions each month from November 2014 to December 2016.

Emergency Hospital Admissions

<table>
<thead>
<tr>
<th>Month</th>
<th>Admissions</th>
<th>Bed days</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15</td>
<td>60,000</td>
<td>10,000</td>
</tr>
<tr>
<td>2015/16</td>
<td>50,000</td>
<td>9,000</td>
</tr>
<tr>
<td>2016/17</td>
<td>40,000</td>
<td>8,000</td>
</tr>
<tr>
<td>2017/18</td>
<td>30,000</td>
<td>7,000</td>
</tr>
<tr>
<td>2018/19</td>
<td>20,000</td>
<td>6,000</td>
</tr>
<tr>
<td>2019/20</td>
<td>10,000</td>
<td>5,000</td>
</tr>
</tbody>
</table>

Figure 5.1 illustrates the reduction in patient admissions as an emergency each quarter from June 2013 to March 2017

Alcohol consumption and related harm is a significant public health issue in Scotland and the rate of alcohol related hospital admissions in Aberdeen City is statistically higher than Scotland overall. Whilst there are many universal prevention interventions (such as alcohol pricing), the HSCP aims to widen access to individual support and behaviour change through alcohol brief interventions (ABIs). For the past number of years this intervention has relied heavily on GPs, and Aberdeen City Practices conduct almost two thirds of all ABIs in Grampian.

Table 5.1: Headline Performance National & Local Indicators

<table>
<thead>
<tr>
<th>Category</th>
<th>Title</th>
<th>LB Baseline</th>
<th>Current Period</th>
<th>% Change Scotland</th>
<th>Latest Period</th>
<th>YOY Trend</th>
<th>Long Term Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe</td>
<td>Falls rate per 1,000 population aged 65+ (Annualised)</td>
<td>16.1</td>
<td>18.9</td>
<td>-1.3%</td>
<td>21</td>
<td>2016/17</td>
<td>1 Annual</td>
</tr>
<tr>
<td></td>
<td>Percentage of adults supported at home who agreed they felt safe</td>
<td>83%</td>
<td>84%</td>
<td>NA</td>
<td>84</td>
<td>2015/16</td>
<td>2 Biennial</td>
</tr>
<tr>
<td></td>
<td>Number of new referrals to initial investigation under adult protection</td>
<td>98</td>
<td>106</td>
<td>+8.2%</td>
<td>2016/17</td>
<td>Q4</td>
<td>8 Quarters</td>
</tr>
<tr>
<td></td>
<td>Percentage of social care complaints responded to in time*</td>
<td>62%</td>
<td>84%</td>
<td>+35.5%</td>
<td>2016/17</td>
<td>Q2</td>
<td>6 Quarters</td>
</tr>
<tr>
<td></td>
<td>Number of health complaints and % responded to in time*</td>
<td>104 (76.0%)</td>
<td>106 (76.8%)</td>
<td>-0.0%</td>
<td>2016/17</td>
<td>4 Annual</td>
<td></td>
</tr>
<tr>
<td>Well Led</td>
<td>Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated</td>
<td>77%</td>
<td>77%</td>
<td>NA</td>
<td>79%</td>
<td>2015/16</td>
<td>2 Biennial</td>
</tr>
<tr>
<td></td>
<td>Average number of days to sickness lost per employee in social care</td>
<td>11.6</td>
<td>13.0</td>
<td>+21.2%</td>
<td>-</td>
<td>Jan 17</td>
<td>Monthly, Rising</td>
</tr>
<tr>
<td></td>
<td>Average percentage of work hours per month lost to sickness absence - NHS staff</td>
<td>5.0%</td>
<td>4.9%</td>
<td>-2.0%</td>
<td>5%</td>
<td>Q4</td>
<td>8 Quarters</td>
</tr>
<tr>
<td>Effective</td>
<td>Premature mortality rate per 100,000 population*</td>
<td>464</td>
<td>464</td>
<td>NA</td>
<td>441</td>
<td>2015</td>
<td>6 Annual</td>
</tr>
<tr>
<td></td>
<td>Emergency admission rate (per 100,000 population, Annualised)</td>
<td>9.077</td>
<td>9.620</td>
<td>-5.6%</td>
<td>11.874</td>
<td>2016/17</td>
<td>7 Annual</td>
</tr>
<tr>
<td></td>
<td>Emergency bed day rate (per 100,000 population Annualised)</td>
<td>100,979</td>
<td>102,266</td>
<td>+1.3%</td>
<td>106,531</td>
<td>2016/17</td>
<td>6 Annual</td>
</tr>
<tr>
<td></td>
<td>Readmission to hospital within 28 days (per 1,000 population Annualised)</td>
<td>88.4</td>
<td>86.9</td>
<td>-1.7%</td>
<td>96</td>
<td>2016/17</td>
<td>4 Annual</td>
</tr>
<tr>
<td></td>
<td>Total % of people visiting any care or support who rated it as excellent or good</td>
<td>82%</td>
<td>82%</td>
<td>NA</td>
<td>81%</td>
<td>2016/17</td>
<td>2 Biennial</td>
</tr>
<tr>
<td></td>
<td>Percentage of health and care resource spent on hospital days where the patient was admitted in an emergency</td>
<td>23.5%</td>
<td>23.1%</td>
<td>+0.4%</td>
<td>21%</td>
<td>2016/17</td>
<td>6 Annual</td>
</tr>
<tr>
<td></td>
<td>Proportion of care services graded ‘good’ (4) or better in Care Inspectorate inspections*</td>
<td>79%</td>
<td>79%</td>
<td>NA</td>
<td>83%</td>
<td>2015/16</td>
<td>3 Annual</td>
</tr>
<tr>
<td></td>
<td>Number alcohol brief interventions</td>
<td>1047</td>
<td>1030</td>
<td>-1.6%</td>
<td>-</td>
<td>Q4</td>
<td>8 Quarters</td>
</tr>
<tr>
<td>Responsive</td>
<td>Percentage of adults supported at home who agreed that they are supported to live as independently as possible</td>
<td>82%</td>
<td>82%</td>
<td>NA</td>
<td>84%</td>
<td>2015/16</td>
<td>2 Biennial</td>
</tr>
<tr>
<td></td>
<td>Total combined is carers who feel supported to continue in their caring role</td>
<td>42%</td>
<td>42%</td>
<td>NA</td>
<td>41%</td>
<td>2015/16</td>
<td>2 Biennial</td>
</tr>
<tr>
<td></td>
<td>Percentage of adults with intensive care needs receiving care at home</td>
<td>55%</td>
<td>55%</td>
<td>NA</td>
<td>62%</td>
<td>2015/17</td>
<td>5 Annual</td>
</tr>
<tr>
<td></td>
<td>Number of days people spend in hospital when they are ready to be discharged (per 1,000 population) 75+ only</td>
<td>1,765</td>
<td>1,156</td>
<td>-35.4%</td>
<td>916</td>
<td>2016/17</td>
<td>5 Annual</td>
</tr>
<tr>
<td></td>
<td>Number of delayed discharges per month at census. Standard and Code’s 5</td>
<td>86</td>
<td>58</td>
<td>-38.9%</td>
<td>-</td>
<td>Mar-17</td>
<td>12 Monthly</td>
</tr>
<tr>
<td></td>
<td>Number and proportion of eligible people taking up self directed support</td>
<td>227 (6.9%)</td>
<td>233 (7%)</td>
<td>+1.4%</td>
<td>-</td>
<td>Mar-17</td>
<td>2 Half Year</td>
</tr>
<tr>
<td></td>
<td>Number of unmet social care hours</td>
<td>1878</td>
<td>1462</td>
<td>-22.2%</td>
<td>-</td>
<td>2016/17</td>
<td>4 Quarterly</td>
</tr>
<tr>
<td>Caring</td>
<td>Percentage of adults able to look after their health very well or quite well</td>
<td>96%</td>
<td>96%</td>
<td>NA</td>
<td>94%</td>
<td>2015/16</td>
<td>2 Biennial</td>
</tr>
<tr>
<td></td>
<td>Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided</td>
<td>78%</td>
<td>78%</td>
<td>NA</td>
<td>79%</td>
<td>2015/16</td>
<td>2 Biennial</td>
</tr>
<tr>
<td></td>
<td>Percentage of people with positive experience of the care provided by their GP practice</td>
<td>86%</td>
<td>86%</td>
<td>NA</td>
<td>87%</td>
<td>2016/17</td>
<td>2 Biennial</td>
</tr>
<tr>
<td></td>
<td>Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life</td>
<td>80%</td>
<td>80%</td>
<td>NA</td>
<td>84%</td>
<td>2015/16</td>
<td>2 Biennial</td>
</tr>
<tr>
<td></td>
<td>Proportion of last 6 months of life spent at home or in a community setting</td>
<td>88.2%</td>
<td>88%</td>
<td>-0.1%</td>
<td>87%</td>
<td>2016/17</td>
<td>5 Annual</td>
</tr>
</tbody>
</table>

* latest information available as of current period.
Our focus in this first Partnership year has been to increase the number of ABIs offered in wider settings, aiming to reach even more people in need of support. So whilst the number of ABIs has not increased between 2015/16 and 2016/17 overall, the balance between those delivered by GPs and wider settings has changed. This is as a result of increased staff training within the Alcohol and Drug Partnership and the identification of new opportunities to deliver ABIs – a more sustainable model for the future.

Responsive

For some people, support and care is needed to help people lead an independent life. ‘Self-directed support’ (SDS) is an arrangement that allows people to choose how their support is provided and gives them as much control as they want of their individual budget. It can include support for daily living, to go to college, to be employed or to enjoy leisure pursuits more. Having greater control of your life leads to improved health and well-being and the HSCP is working hard to encourage people to take advantage of SDS. In the past year there has been little change in the proportion of people who take up SDS (options 1 and 2) at just 7% of all eligible people, this is a situation we wish to improve upon in 2017/18.

With a growing number of older people living with high and complex care needs, the need for social care services is increasing, alongside workforce recruitment and retention challenges. This situation can lead to ‘unmet need’, affecting individuals who are struggling to cope and putting strain on carers and family members. In some cases it can lead to hospital admission and the risk of delayed discharge. Unmet need can be difficult to define and harder still to measure. The data we capture may be incomplete or imperfect, but it gives us an initial indication of progress as we improve data quality. Over the past year, there has been a downward trend in both the number of clients awaiting care and the number of hours required. This reflects the collaborative approach to commissioning services between HSCP staff and care providers.

Delays in being discharged from hospital affect mainly older people and usually occur because of the time needed to secure care home accommodation or to arrange social support for returning home. Figure 5.2 shows the number of ‘standard’ patients delayed each month and the number of hospital bed days used per month from July 2012 until March 2017. This improving situation, of reducing care home capacity and a loss of some 160 beds since 2012.

The steady improvement from early 2015 is the result of Partnership efforts during the shadow period and the first live year of operation. These endeavours were initially focused on improving operational processes which have since matured, and we are now seeing the impact of specific initiatives. Over the past year, our health and social care staff have worked particularly hard to co-ordinate services for patients and to secure appropriate follow-on care. Increasing the number of ‘intermediate care’ beds has allowed patients and their families more time in an appropriate environment to consider their care home options.

Caring

Person centred care and positive experiences of services are features of the caring organisation to which we aspire. Humanising health and social care is the way we will achieve this, where success is based on the way care is delivered as well as health outcomes. Measuring our progress so far has been based on large scale surveys of service satisfaction and we aim to do more here in the coming years. Nonetheless this information has highlighted aspects of care where improved experience of care may be needed, particularly in primary care and in home care.

88% of care for people in the last six months of their life takes place at home or in a homely setting. This is comparable to Scotland overall, but our aim is to drive improvement in palliative and end of life care which reflects best practice and accords as much as possible with the needs and wishes of patients and their families. Invasive, painful and costly treatment in acute hospital is not always the best course of action. Through our transformation programme, we will be aiming to find sensitive and person-centred ways to improve this and to combine facts and values in our measurement to ensure we keep in touch with the human factors of quality.

Well-led

The driving ethos of the Partnership is that staff engagement, participation and delegated authority promotes trust and autonomy – an important factor in a modern, adaptive organisation. Our transformation programme to develop staff and culture includes effective communication, co-location of teams, information sharing and leadership development. We have placed particular importance on Partnership identity and awarding staff for efforts that have made a notable difference in the job that they do.

An indication of an engaged, supported and motivated workforce is absenteeism. Over the past year, sickness absence in social care (headcount 560) has increased and the average number of sickness days per employee in a year is currently thirteen. This is measured differently for health care staff (headcount 1381), where the average percentage of work hours lost per month due to sick leave is just under 5% and similar to the national average for Scotland.

During the past year we introduced ‘i-Matter’, a feedback tool for staff which provides a measure of engagement, communication and motivation. Our plan for 2017/18 is to use the tool pro-actively to engage with staff and teams on ways to address and improve sickness absence. This is a key area of improvement work affecting culture and productivity.
Driving improvement 2017/18

We believe our Partnership efforts and focus over the past year have impacted positively towards many national and local outcomes as demonstrated by the progress shown against our baseline position.

In addition to our ambitious transformation plans we have identified a number of key areas which will be a focus for our improvement activities during 2017/18. These include:

- **Emergency Admission**: To reduce the number and rate of avoidable unplanned admissions for older people. We aim to be in the top percentile when benchmarked against all other local authorities in Scotland.
- **End of Life/Palliative Care**: To maintain support for people at home or in a homely setting in their last six months of life and to establish new ways to monitor and report the preferences of people.
- **Staff Engagement**: To establish and develop a 'fully engaged' workforce across all of the partnership.
- **Self Directed Support**: To increase the uptake of SDS options 1 and 2.
- **Unmet Care Needs**: To reduce the number of people whose social care needs have been identified but care has not been established.
- **Delayed Discharge**: To reduce delayed discharge and shorten the length of delays. We aim to be in the top 25th percentile when benchmarked against all other local authorities in Scotland.

Our performance in these areas will be reported to the IJB and its Audit and Performance Systems Committee throughout the year and highlighted in next year’s annual performance report.

Our Financial Stewardship

The Integration Joint Board (IJB) has a responsibility under the Public Bodies (Joint Working) (Scotland) Act 2014 to set a balanced budget. The funds for the Integration Joint Board are delegated from Aberdeen City Council and NHS Grampian with the purpose of delivering the IJB’s Strategic Plan. The level of funding available to the IJB is heavily influenced by these organisations' grant settlements from the Scottish Government.

The level of funding delegated to the IJB at the start of the 2016/17 financial year was (Figure 5.4):

- £14m
- £111m
- £139m

Our performance in these areas will be reported to the IJB and its Audit and Performance Systems Committee throughout the year and highlighted in next year’s annual performance report.

The IJB’s Position at 31st March 2017

The Integration Joint Board has an ambitious strategic plan which seeks to transform the health and social care services under its remit within Aberdeen City.

In order to facilitate this, additional funding has been provided by the Scottish Government which can be used to help transform services, support integration and reduce delayed discharges. This additional funding is now all mainstreamed and recurring.

It is important to note that whilst the allocation of this funding is extremely useful in terms of delivery of the strategic plan, other services are being transformed from within mainstream budgets on a continuous basis. A good example of this is our public health and wellbeing team who are now undertaking new duties linked to the delivery of the strategic plan.

In reality the whole budget is available to integrate, change and transform.
## 2017/18 Financial Year

A proposed budget for 2017/18 which outlined budget pressures, budget reductions and an indicative budget position for the next five financial years was presented to a special meeting of the IJB on 7th March.

The proposed balanced budget was approved.

## Did you know...

In February 2017, 230 colleagues came together to celebrate at the partnership’s first ceremony to celebrate the exceptional work of our extended workforce across the partnership. The HEART Awards – ‘Having Exceptional Achievement Recognised Together’ – aimed to celebrate the exceptional work of colleagues in ACHSCP and its partner organisations.

At the event, as well as showcasing some exceptional talent and achievements of staff within the partnership, 5 awards were presented under different categories:

- Hearing Others: The Communication and Inclusion Award
- Empowering People: The Enablement Award
- The Respect and Equality Award
- #Team Aberdeen: The Integration Award
- Our Pick: The Staff Choice Award.

---

### Table 5.2 Service Expenditure

<table>
<thead>
<tr>
<th>Service</th>
<th>Gross Expenditure (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health Services</td>
<td>31,649,313</td>
</tr>
<tr>
<td>Learning Disabilities</td>
<td>29,264,461</td>
</tr>
<tr>
<td>Mental Health &amp; Addictions</td>
<td>18,304,741</td>
</tr>
<tr>
<td>Older People, Physical &amp; Sensory Impairments</td>
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<tr>
<td>Criminal Justice</td>
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</tr>
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<td>Primary Care Prescribing</td>
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</tr>
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<td>Hosted services</td>
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<tr>
<td>Out-of-Area Treatments</td>
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<tr>
<td>Set-Aside Treatments</td>
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</tr>
<tr>
<td>Head Office/Admin</td>
<td>1,007,021</td>
</tr>
<tr>
<td>Transformation</td>
<td>2,856,283</td>
</tr>
<tr>
<td></td>
<td><strong>305,544,132</strong></td>
</tr>
</tbody>
</table>

Table 5.2 Service Expenditure (* these relate to the services delivered in the Acute Sector for which the IJB is responsible for Strategic Planning but not Operational Delivery. This is a notional budget)

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### Figure 5.5 Service Expenditure

- Community Health Services: 13.1%
- Learning Disabilities: 10.4%
- Mental Health & Addictions: 9.6%
- Older People, Physical & Sensory Impairments: 6.0%
- Criminal Justice: 12.1%
- Housing: 0.9%
- Hosted services: 0.3%
- Out of Area Treatments: 0.4%
- Head Office/Admin: 0.7%
- Transformation: 22.8%
- Set Aside Services: 6.9%
- Primary Care: 1.4%
- Primary Care Prescribing: 0.9%
6. Looking Forward

In addition to everything that we have highlighted thus far there are also a key number of activities that are already underway and we are going to highlight because of their importance to the partnership’s ambitions and priorities. We look forward to reporting on the completion of all these in next year’s annual performance report. These include:

Buurtzorg:
The Buurtzorg model of community care is a consistent person-centred approach that seeks to enable our citizens and their friends, family and neighbours to have opportunities to take a full and active role in their wellbeing. The integrated nurse and care worker teams will be supported to self-manage, taking the appropriate decisions in the right place at the right time.

Link Workers:
Appropriate person-centred wellbeing support is organised through a dedicated community orientated member of staff in each practice, called the Link Worker. Such Link Workers aim to improve people’s resilience where people see themselves as part of an interconnected whole, by supporting them to link more closely with their communities and opportunities in the community. The implementation of Link Workers will directly support the strategic priorities for the ACHSCP. A project team has been set up to drive this high profile innovative intervention forward. Work is ongoing to procure a partner provider to deliver the Link Worker resource, in partnership with our GP practices, and embedded in local communities.

Carers Strategy:
This strategy is being developed in a co-productive manner with carers, recognising the very important role that many thousands of unpaid carers undertake and the supports that we need to provide in order for them to feel able to continue in this role.

We are developing our Carers Strategy in line with the Carers (Scotland) Act 2016 and this will outline how we hope to develop our understanding of the carer role, be able to identify more readily who are carers are and what informal and formal supports can be offered to them.

Locality Teams:
The operationalisation of our locality model has commenced with the recruitment of our Heads of Localities and an initial alignment of service functions within our senior leadership team.

With assistance from a design support organisation we will be working with our staff across the four localities to develop our vision of integrated, multi-disciplinary, locality based teams working in and with our local communities.

7. Conclusion

When the IJB published its Strategic Plan on 1st April last year it emphasized the need to ensure that the day to day delivery of services was not compromised by our integration transition or the commencement of our transformation programme.

On integration ‘go live’ day we gave ourselves a very positive platform for our next steps. Our performance over the past year, on the whole, has been good. It will be better next year.
Aberdeen City
Health & Social Care
Partnership
A caring partnership
NHS Grampian
Infrastructure Investment Plan – period ending 31 March 2024
Draft

April 2019
Contents

Introduction
Section 1: Overview of the five year plan
Section 2: Strategic planning and priorities
Section 3: Maintaining our infrastructure
Introduction

1.1 The purpose of this paper is to set out the following:

- Section 1: overview of the five year infrastructure investment plan;
- Section 2: the basis for strategic planning and identifying investment priorities, and
- Section 3: the actions that will be taken to maintain the Board’s property and equipment.

1.2 The five year Infrastructure Investment Plan supports the Board’s Asset Management Plan, which is summarised within the North of Scotland Regional Asset Management Plan.

1.3 The development of the Infrastructure Investment Plan is overseen by the Board’s Asset Management Group, chaired by the Director of Finance. The Asset Management Group has representation from all the main senior personnel responsible for managing the Board’s infrastructure, members of the System Leadership Team, the three Integration Joint Boards, the clinical advisory structure and staff partnership.

1.4 The Infrastructure Investment Plan will be kept under review to ensure that it addresses the key priorities for the Board and the ambitions as set out within the Board’s clinical strategy. In support of the plan we ensure that:

- Appropriate governance and management structures are in place to effectively manage the Board’s assets;
- The Board’s assets are utilised effectively and efficiently through maintaining, enhancing, replacing and disposing of those assets deemed surplus to requirements;
- Effective prioritisation of backlog maintenance and essential equipment replacement where there is a high or significant risk to the ability of the assets to deliver current and future services; and
- Availability of an appropriate number of quality and affordable assets to meet the population health needs and which are financially sustainable over the longer term.
Section 1: Overview of the Infrastructure Investment Plan

1.1 The summary five year plan sets out the key areas where investment will be targeted over the next five years. The following balanced approach will ensure that we are able to obtain maximum benefit from the available funding to:

- Responding to new and improved ways of delivering services,
- Improve estate and asset performance on all key indicators, including a targeted reduction in significant and high risk backlog maintenance and a continued programme of essential equipment replacement.
- Disinvest from buildings with high operating costs, backlog maintenance requirements, or short remaining life where these do not meet future service requirements; and
- Invest and develop in new technology that achieves simplification of the existing information technology infrastructure, whilst simultaneously allowing additional investment and improved resilience.

<table>
<thead>
<tr>
<th></th>
<th>2019/20</th>
<th>2020/21</th>
<th>2021/22</th>
<th>2022/23</th>
<th>2023/24</th>
<th>Total</th>
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<tbody>
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<td>16.5</td>
<td>74.8</td>
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<td>Elective Care</td>
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<td>Primary and Community Care</td>
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<td>Equipment</td>
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<td>104.4</td>
<td>37.2</td>
<td>17.4</td>
<td>314</td>
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</table>
Section 2: Strategic Planning and key priorities for investment

Strategic Planning

2.1 In terms of strategic planning, it is important that the Board’s infrastructure is able to support the ambitions set out within the Clinical Strategy and the NHS Scotland National Delivery Plan. The Asset Management Group continuously reviews the status of the Board’s infrastructure plans with a focus on the following key elements:

- **Major site development plans** - establishment of development plans for each of our main sites. We have a well-established development framework for the Foresterhill Campus and are currently undertaking site appraisals at Dr Gray’s Hospital, Woodend Hospital and Cornhill Hospital. These are in addition to ongoing assessments undertaken of our community hospital infrastructure in line with future service and investment requirements.

- **Primary Care Premises strategy** – the Board has a primary care premises strategy which is kept under review with the latest strategy having been recently considered by the three IJBs and the Board’s Asset Management Group. This enables the identification of the priorities for future investment in new infrastructure and to inform Board decisions regarding the case for investment in new premises to support the delivery of local primary and community care services.

- **Digital Strategy** – the importance of the Board’s digital infrastructure is acknowledged and work is progressing to assess the priorities for investment over the next five years. The Digital Strategy will presented to the Asset Management Group later this year before being considered for Board approval.

- **Strategic Risk Assessments** – the Asset Management Group has undertaken a comprehensive risk assessment of the Board’s infrastructure in relation to backlog maintenance and essential equipment replacement. These risk assessments are used to target investment in a prioritised and risk assessed basis.

- **Office accommodation** – following Board approval in December we have established a project board to oversee the implementation of agile working across our services and to develop the business case for co-location of our corporate and administrative functions.
Strategic priorities

2.2 In terms of those projects which have already been identified as a strategic priority the following are being progressed, with the associated funding having been confirmed.

<table>
<thead>
<tr>
<th>Project</th>
<th>2019/20</th>
<th>2020/21</th>
<th>2021/22</th>
<th>2022/23</th>
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<td>5.4</td>
<td>13.9</td>
<td>4.7</td>
<td>0.2</td>
<td>24.8</td>
</tr>
</tbody>
</table>

- The Baird Family Hospital and ANCHOR Centre is the largest single project that we have undertaken as a Board and will result in a significant redesign of the services we provide to the population of Grampian. The Final Business Case is due to be considered by the Board in late summer with the enabling works already commenced.

- The Elective Care Centre will be one of six to be established in Scotland to support the National Waiting Times Improvement Programme. This represents a major investment in facilities which will improve the Board’s capacity to meet future demand for elective care.

- The replacement of the Denburn Health Centre with new facilities in Northfield/Mastriick and new facilities for the population of North Aberdeen and the surrounding Aberdeenshire hinterland will be the two key projects which we will deliver in the next five years. As previously agreed with the Board we are also developing initial agreements to make a case for further investment in service redesigns at Banchory, Ellon, Danestone and Keith. These have been confirmed within the primary care premises strategy as the areas of highest priority for investment.

- The Board has also approved a plan to invest significantly in the improvement of mental health ward accommodation at Royal Cornhill Hospital to meet legislative requirements and to establish a centre of excellence for Child and Adult Mental Health Services at the City Hospital.
Section 3: Maintaining our infrastructure

3.1 As set out in the NHS Scotland State of the Estate report, the backlog maintenance on the Aberdeen Royal Infirmary remains amongst the highest in Scotland, given its size and the age of the buildings (60% of NHS Grampian premises are over 30 years old). The Board approved the Acute Reconfiguration Project (ARP) in 2012 to reduce high and significant backlog maintenance in inpatient areas. At this time the risk reassessed backlog maintenance was £193m (1st April 2012). This included backlog maintenance and compliance with statutory standards but excluded functional suitability. Our infrastructure investment programme completed to 31st March 2018 has reduced the overall backlog to £143m. The high and very high backlog risks have reduced from £76.5m to £28.5m during this period.

3.2 In addition, the NHS Scotland State of the Estate report also highlights the need for and importance of a robust and risk assessed essential equipment replacement programme. Over the next five years we will invest £55m in essential equipment replacement.

3.3 The Board has reconfirmed that core capital funding will be prioritised for use in backlog maintenance and essential equipment replacement. The summary below sets out the proposed allocations of funding for 2019/20 and future years.

<table>
<thead>
<tr>
<th></th>
<th>2019/20</th>
<th>2020/21</th>
<th>2021/22</th>
<th>2022/23</th>
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<td>4.1</td>
<td>6.1</td>
<td>28.3</td>
</tr>
<tr>
<td>Other</td>
<td>0.7</td>
<td>0.6</td>
<td>0.7</td>
<td>0.7</td>
<td>0.7</td>
<td>3.4</td>
</tr>
</tbody>
</table>

3.4 The Board also has an asset disposal programme progress against which is monitored by the Asset Management Group and Performance Governance Committee. It has been previously agreed that all asset disposal proceeds will be re-invested in the infrastructure programme and will not be used to support the Board’s revenue position.
A Strategic Commissioning Plan for the adult population of Moray developed and agreed in partnership with Health, Social, Voluntary, Independent sectors, and the public. It describes how the new integrated partnership intends to improve the health and wellbeing of adults in Moray through the design and delivery of integrated services.
This document is also available in large print and other formats and languages upon request. Please call corporate communications on 01343 563601
“The landscape for the future delivery of health and social care for adults in Moray is changing. The new legislation progressed through the Scottish Parliament in April 2014; The Public Bodies (Joint Working) Scotland Act 2014 set a new legal framework for the future of these services. For Moray this means that the Health and Social Care Partnership known to people will continue but under the direction and operation of the Moray Integrated Joint Board (IJB).

The IJB is a new public organisation that from the 1st of April 2016 will be responsible for the planning and delivery of services. The board is a partnership arrangement in the broadest sense in that it is expected to work with voluntary and private sector partners alongside communities to improve the quality and effectiveness of services as well as supporting people in our communities to keep well and live independent and fulfilling lives in their own right.

It is important to say that this new organisation will continue to work in sync with the Moray Council and NHS Grampian, as well as being a partner in the Community Planning Partnership arrangements for Moray. It is also important to say that children’s services will continue to work together with adult services in the interests of families and building our future generations.

The current situation in Moray is a very positive one, with the majority of people living well and already caring well for themselves and their families. We need to build on this together. The future of services and our ability to future proof Moray in a way that means there is a strong emphasis in helping people to help themselves will determine our ability to have the right services available to meet your needs when you really do need help of a more complex nature. So when I say together I mean together, the people of Moray whether you are a professional working in public, voluntary or private sector service, a paid or unpaid carer or a member of the community.

The new arrangements have brought the need for the development of a strategic plan for Moray which will set the direction of travel and hopefully convey the spirit in which we want to move forward. Extensive consultation and engagement has informed this plan, people from all walks of life have been involved in a variety of discussions over the past year in relation to pulling this strategy together.

This Strategy sets out our ambitions for Moray in terms of achieving good health for us all and responsive, supportive services when you need them. Where ever you sit in Moray we have a
great opportunity to improve on how we all work together and share our knowledge and experiences to improve. We want to gather the talent and enthusiasm which in the end will benefit us all. We do have a challenging time ahead with financial constraints but the level of challenge will be less if we work through things together and maximise our potential by drawing on the strengths and assets of our communities. “

Pam Gowans, Chief Officer, Moray Health and Social Care Partnership
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PART ONE: INTRODUCTION          What’s the strategy about and how did we develop it?

1.0 Introduction
This is the first Moray Integration Joint Board (MIJB) Strategic Plan to be developed since the evolved Partnership was established in accordance with the provisions of the Public Bodies (Joint Working) (Scotland) Act, 2014.

In Moray, the Partnership has been established as a Body Corporate – i.e. a separate legal entity from either the Council or the Health Board, with responsibility for its governance resting with the Integration Joint Board (IJB).

It has responsibility, primarily, for a range of health and social care functions relating to adults and is responsible for the strategic planning of integrated services, together with monitoring of the corresponding service delivery. The Act places a duty on IJB’s to develop a “strategic Commissioning Plan” for all adults in the area.

This Strategic Plan describes how the MIJB intends to improve the health and wellbeing of adults in Moray through the design and delivery of integrated services and achieve the national outcomes.

- It will describe how the integrated partnership will make changes and improvements to develop health and social services for adults over the coming three years.

- It will explain what our priorities are, why and how we decided them and how we intend to make a difference by working closely with partners in Moray.

- The Plan is underpinned by a number of national and local policies, strategies and action plans. It will provide the strategic direction for how health and social care services will be shaped in Moray in the coming years and describe the transformation that will be required to achieve our vision.

1.1 Purpose

The main purpose of Integration is to improve the wellbeing of people who use health and social care services, particularly those whose needs are complex and involve support from health and social care at the same time. Its core aims are:
• To improve the quality and consistency of services for patients, carers, service users and their families;

• To provide seamless, integrated, quality health and social care services in order to care for people in their homes, or a homely setting, where it is safe to do so; and

• To ensure resources are used effectively and efficiently to deliver services that meet the needs of the increasing number of people with long term conditions and often complex needs, many of whom are older.

1.2 Scope of the Strategy
This strategy covers all adults18+ who use our health and social care services which are agreed as in scope of integrated services (Appendix 1). This includes existing service user client groups - older people, physical and sensory disabled, learning disability, autism, mental health, drug and alcohol and unpaid carers.

1.3 A Shared Approach
Moray Health and Social Care Partnership is a mature partnership with a proven record of partnership working with other agencies such as the third sector and independent sector. Communication and engagement with patients, service users and the wider public is embedded in our shared approach to strategic commissioning in the development of a suite of joint strategies which link directly to the Moray Single Outcome Agreement.

Strategic commissioning is the term used for all the activities involved in assessing and forecasting needs, linking investment to agreed outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place. The output of the strategic commissioning process is the strategic plan.

Building on the strong partnership relationships, we established a Strategic Planning Group (SPG) made up of a broad range of people, professionals and partners. This includes local clinicians and professionals from across health and social care, including GPs. Patients, service users and unpaid carers along with staff from the third sector and the independent sector are also on the group. The group co-produced the plan using their combined knowledge, expertise and experience.
A range of commissioning activities was carried out to inform this plan. This included a health needs analysis, service mapping of what is in scope, review of existing strategic priorities, review of finance, review of national and local policy/guidance, a robust staff and public consultation and engagement plan, a series of workshops at key points in the development of the plan. These are detailed in the accompanying appendices.

1.4 Stakeholder Engagement and Communication
The partnership acknowledges that supporting the health and wellbeing of adults needs to involve more than health and social care sectors e.g. the population itself, housing, transport, leisure, community support groups and the independent sector and third sector all have a role to play if we are to achieve the national outcomes and redesign our services.

A wide range of communication and engagement activities have taken place in the development of this plan. This includes staff and public newsletters, website updates, a series of locality events, a series of staff workshops and draft plan questionnaire. Working Together (Appendix 2) details the findings which have informed the plan.

1.5 Equalities and Diversity Impact Assessment
The Strategic Plan has been Equality and Diversity Impact assessed to ensure that consideration of the needs of our local equality and diversity communities are an integral part of the way we operate. The 9 “protected characteristics” of equality as defined by the Equality Act 2010 are: Race, Disability, Age, Sex (male or female) Sexual orientation, Gender reassignment, Pregnancy and maternity, Marriage and civil partnership, Religion or belief. The assessment is detailed in Appendix 7.

1.6 Housing Contribution Statement
Housing are fully engaged in the strategic planning process, the housing contribution statement describes the role of the Council as Strategic Housing Authority, as a social landlord and the role of local social housing providers in achieving the outcomes required by the Moray Strategic Plan. The full statement is available in Appendix 8.

1.7 Timescale and Review
This Strategic Plan sets the direction of travel for future commissioning decisions and service redesign and development over the next three years (2016-19) and will be subject to monitoring and review on an annual basis in line with government policy around the Act. This will ensure it
continues to respond to emerging needs and expectations of adults through future locality planning arrangements, local and national policy and emerging priorities.

This is not a static document. It is a live strategic plan and as such we look forward to engaging with all those with an interest in health and social care to deliver on our plan between now and 2019.
PART TWO: BACKGROUND TO THE PLAN

Why do we need to change?

2.0 Introduction

‘Separate - and sometimes disjointed - systems of health and social care can no longer adequately meet the needs and expectations of increasing numbers of people who are living into older age, often with multiple, complex, long-term conditions, and who need joined up, integrated services.” (Scottish Government 2012 analysis report integration of health and social care)

Over the last decade there has been growing recognition that services for the population in Scotland will need to change. Demographics, economics, increasing care complexity and people’s expectations are driving a rethink about what kind of health, wellbeing and social care services are needed, and about the way in which services are planned and coordinated to be effective in securing the best possible outcomes for the population.

2.1 Policy Context

Two main National documents have influenced this strategy:

**The Christie Commission on the Future Delivery of Public Services (2011)** recommended radical changes to the way public services are designed and delivered if they are to be sustainable and capable of meeting the needs and expectations of individuals and communities. It sets out four objectives which must shape a programme of reform;

- Public services are built around people and communities, their needs, aspirations, capabilities and skills and work to build up their autonomy and resilience;

- Public service organisations work together effectively to achieve outcomes;

- Public service organisations prioritise prevention, reduce inequalities and promoting equality; and

- All public services constantly seek to improve performance and reduce costs and are open, transparent and accountable.

**The 2020 Vision (Healthcare) and The Healthcare Quality Standards Strategy NHS Scotland (2010)** identified quality ambitions to support the delivery of person centred, safe and effective
care and emphasises the need to support people to manage their own conditions as far as possible. The strategy detailed 3 quality ambitions:

- Beneficial partnerships between patients, families and those delivering care which respects individual needs and values, demonstrates compassion, continuity, clear communication and shared decision-making.
- There will be no avoidable injury or harm to people from healthcare they receive and an appropriate clean and safe environment will be provided.
- The most appropriate treatments, interventions, support and services will be provided at the right time for everyone who will benefit and wasteful or harmful variations will be eradicated.

The 2020 Vision augmented this and sets out the Scottish Government’s strategic vision, and specifies 12 area of improvement (one of which is integrated care) for achieving sustainable quality in the delivery of healthcare services:

**By 2020 everyone is able to live longer healthier lives at home, or in a homely setting.**

“We will have a care system where we have integrated health and social care, a focus on prevention, anticipation and supported self-management. When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm. Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions. There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.”

From a local perspective this document overarches our existing suite of joint commissioning strategies for older people, mental health, learning disabilities, physical and sensory disabilities, drug and alcohol, carers and dementia. Recurring themes within these strategies are community capacity building, prevention and early intervention, co-production, rehabilitation, reablement and recovery, person centred and outcomes focused care, care at home, use of technology to enable care and workforce development. **Appendix 3** further details the national and local policy context

### 2.2 Moray Health Profile and Changing Demand

Moray tends to have an overall health profile that is better than the Scottish national average. However behind this lies evidence of variation in health status, with some communities reporting
greater levels of health problems than others (Appendix 5 Health Needs Analysis). Overall Moray has:

- high life expectancy
- above average educational attainment, employment, income
- below average crime, homelessness, alcohol-related mortality and hospital admissions
- average smoking rates
- health condition prevalence rates that are similar to, and often lower than, the national average; some emergency hospital admission rates that are higher than elsewhere in Grampian, lower multiple admission rates nationally
- above average fuel poverty, traffic accident casualties, and potential geographical challenges to equal access to services

Within and across Moray, not all communities are exposed to the underlying causes of health equally, and health condition prevalence and emergency hospital admission rates show observable variation by geography.

Predicted growth in older adult population over next twenty years, suggests expectation for increasing service demands, reduced working population, increase in multiple long term conditions

Moray tends to score well for the social and economic factors that underpin good health, when compared to the Scottish national average. However, its rurality is a known issue that can cause people difficulty in accessing services, and despite high average employment and low overall income deprivation, moray has a higher proportion than average of households reported to be living in fuel poverty. Moray also has an above average level of road traffic accident casualties in Scotland. Moray’s population is ageing, consistent with national trends. Increasing life expectancy is to be celebrated. Population projections show a 45% increase in the over 65 population and a reduction
of 15% in the under 65’s in the next twenty years. Not only does this suggest an increase in service demands, it may also impact on the available workforce.

![Graph showing Moray population by age group, estimate for 2013 and projection for 2035](image)

With increasing age there is also a rise in the number of people living with long term conditions which includes people with enduring mental health problems who are likely to have increased care and support needs. The mental health needs of people can generate significant problems for them, their families and carers. Addressing these needs can make significant demands on services. Mental health is a crucial part of our health and wellbeing.

The prevalence of long term conditions will increase with the ageing population, and increase the burden on health and social care services in the community setting and the use of emergency beds if not managed well in the community. There are clear links between long term conditions, deprivation, lifestyle factors and the wider determinants of health. The chart below shows the number of long term conditions which can be accrued as people age.

![Graph showing the number of long term conditions as people age](image)
2.3 Current Service Structures

Services in Moray are primarily delivered through the NHS and Local Authority in partnership with communities and the voluntary and independent sectors.

There are many community and voluntary organisations and groups in Moray that also contribute to people’s health and wellbeing, this type of work is hugely varied.

Moray has a population of approximately 88,560 (ISD General Practice Populations data) and stretches across approximately 860 square miles of predominantly rural landscape.

Most people live in the natural communities/main towns of Elgin, Lossiemouth, Buckie, Forres and Keith. Other smaller communities are also scattered throughout Moray e.g. Hopeman, Burghead, Cullen and Aberlour, Dufftown, Fochabers, and Tomintoul in remote and rural locations.

The town of Elgin hosts the acute services at Dr Grays hospital; a 129 (122 acute assessment beds and 7 assessment beds) bedded District General Hospital which provides acute services to the greatest density of the Moray population.

Five community hospitals exist in Moray in the towns of Forres, Buckie, Aberlour, Dufftown and Keith providing 79 inpatient beds in total delivering a range of acute and intermediate care services for local areas.

Community health and social care services are built around the community hospitals with community based teams co-located where possible. 14 GP services are arranged in practice clusters around the natural communities. Teams in Elgin are aligned to GP practices.

Mental Health services in Moray are delivered primarily through the NHS and local authority in partnership with communities and the voluntary and independent sectors. Responsibility and resources for planning and delivering these services will move to the IJB.

Interim management arrangements around these services have been in place since September 2015, Work is underway to refine and understanding the requirements of the ongoing management structure to take us forward.

2.4 Key Service Developments in terms of integration and national outcomes,

Our developing relationship with tsIMORAY will support us to continue the development of a moray based third sector forum focused on health and wellbeing in our communities; enabling and empowering smaller groups and organisations in the delivery of priorities identified; facilitating and
connecting to make and improve relationships and engaging with partners; further developing their participative role in the process of integration as the culture of collaborative and co-productive practice continue to be developed.

This strategy recognises the enormous and valuable contribution that communities and volunteers can make in the areas of promoting health and wellbeing.

The Reshaping Care for Older People programme and associated Change Fund enabled the partnership to accelerate local progress and to develop plans to drive sustainable improvements in the national outcomes that relate to the care of older people. It enabled us not only to shift the location of care (from institution to community) but also to transform the culture and philosophy of care from reactive services provided to people towards preventative, anticipatory and co-ordinated care and support at home delivered with people.

Housing as Partners - Housing has become a key partner in our joint commissioning process. The partnership acknowledges the vital contribution that housing can make to improving health and wellbeing outcomes.

The Community Care Redesign programme aims to meet future demand. A single point of access to community care is established. The access service provides an early intervention and preventative approach to care with greater choice and control over the support people need.

Moray Partners in Care – Community care has developed a new model of care and support in the community which promotes independence and supports greater choice and control and improved outcomes. It is based on three offers – Help to help yourself, help when you need it and ongoing support for those that need it.

Improvement Programmes currently underway in Moray include: Modernisation of Primary Care, Focus on Dementia, Self-Directed Support, Unscheduled Care, Older People in Acute Care, Patient Safety Programme, Long Term Condition Action Plan.

All of these components co-exist and as we move forward we will seek to continue to build on this good work, evolving through the identification of local needs with the aim of building community resilience in Moray.
2.5 Current Performance

MHSCP can demonstrate sustained and improving performance in relation to a range of key national and local measures that form the “basket of measures” for older people.

This includes; reducing emergency inpatient days rates for people aged 75+, increases in the proportion of people 75+ living at home with an anticipatory care plan shared with the out of hours service, an increase in the number of clients receiving more than ten hours of care with a corresponding reduction of clients moving to long term residential care.

The Partnership is also recognised as being in the top quartile in terms of the number people experiencing delayed discharge. We can also demonstrate an increase in both the delivery and flexibility of respite provision based on local demand.

These improvements have been instrumental in reshaping care for older people and shifting the balance of care from institutional settings to community settings. However, as demand continues to increase the following issues are emerging:

- The number of total emergency acute hospital admissions is not reducing
- The number of delayed discharges from hospital remains a challenge
- The number of people from Moray who readmitted to hospital within 30-days of discharge has been increasing, with the exception of Dr Gray’s Hospital where the rate is reducing
- The availability of home carers in some areas is cause for concern

2.6 Financial Framework

One of the principles underlying The Public Bodies (Joint Working) (Scotland) Act 2014 is that the Integration Joint Board will, through the Strategic Plan, be able to allocate resources within the integrated budget and to prioritise and agree transfers in order to meet the goals as specified in the Strategic Plan. The ability to plan within the overall resource for a defined population and user groups and to use budgets flexibly is one of the advantages of integrated care.

This Strategic Plan incorporates a 3 year financial plan for the resources within the scope. These resources comprise:

- The payment made to the Integration Joint Board by The Moray Council for the adult social care services that have been delegated;
• The payment made to the Integration Joint Board by NHS Grampian for the delegated healthcare services; and
• The amount set aside by NHS Grampian for large hospital services used by the population of the Integration Joint Board.

The 3 year Financial Plan outlines the indicative resources available for the years 2016/17 to 2018/19 and is detailed at Appendix 4. The Integration Joint Board assumes responsibility for these resources as of 1 April 2016.

Strong leadership, effective planning and performance management are essential elements for successful integration. Accordingly, an effective assurance framework is required to identify and minimise the associated risks. Financial governance is an essential element to the assurance process and has been embedded into the process thus far through the Integration Scheme and will continue to be monitored through a range of documents underpinning this Strategic Plan.

In 2014/15 the total spend for The Moray Health and Social Care Partnership amounted to £86m. The top 5 cost areas were primary care prescribing (£17m; 20% of total costs), the older peoples physical and sensory disability services (£16m; 18%), care services provided in-house by Moray Council (£13m; 15%), care services provided by external contractors and commissioned by The Moray Council (£9m; 10%) and community health services (£9m; 10%). Of the £86m, the split of health to social care was split equally with £43m on each arm of the budget.
The following chart shows the consolidated expenditure for 2014/15 across Health & Social Care:

### % Share of Expenditure

- **Primary Care Prescribing** - 20%
- **Older Peoples Physical & Sensory Disability Services** - 18%
- **Care Services Provided In-House** - 15%
- **Care Services Provided by External Contractors** - 10%
- **Community Health** - 10%
- **Mental Health & Addictions** - 8%
- **Other Moray Wide Services** - 5%
- **Admin & Management** - 5%
- **Learning Disabilities** - 5%
- **Moray Wide Allied Health Professionals** - 4%

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**2.7 Estimating Future Demand on Resources**

When population projections are applied to the current financial position, it confirms that current ways of working are not sustainable. There is a shared understanding across the IJB that increasing demand on health and social care services will have financial implications if services continue in their current form. The IJB is committed to ensuring the fullest use of all the available resources in order to improve the health and wellbeing of the community. There is a need for efficiencies, smart solutions and new ways of working in this new integrated environment.

**2.8 Conclusion**

We believe that the Case for Change is unassailable. It highlights the pressures currently faced by our health and social care system and the demands that will be placed upon it in the future. If we
continue to deliver services as we currently do they will not meet the needs of our population and will not be sustainable for the years to come. Changes are needed to meet future health and social care needs.

Consequently Moray cannot insulate itself from the need for change and this Strategic Plan presents an opportunity to consider a more integrated model for the health and social care system that allows us to deliver an excellent and equitable service to the population.

We must ensure that the Strategic Plan for Health and Social Care builds on the achievements to date and seeks to challenge the system further towards building community resilience and community engagement that has the community and services working together to maximise the opportunities for all.

The partnership acknowledges that supporting the health and wellbeing of adults needs to involve more than health and social care sectors: the population itself housing, transport, leisure, community support groups and the independent sector and third sector all have a role to play if we are to achieve the national outcomes and redesign our services.

Sustainable change requires the longer term transformation and integrated working that will be enabled by joint strategic commissioning and integrated resourcing.
PART THREE: OUR STRATEGY

3.0 Introduction

This section sets out our three year vision statement, our values and principles, and our strategic outcomes. These are all designed to deliver progress and continuous improvement against the national and local outcomes, which are set out later in section 4.

3.2 Our Shared Vision

“To enable the people of Moray to lead independent, healthy and fulfilling lives in active and inclusive communities where everyone is valued, respected and supported to achieve their own goals.”

A vision developed by listening to the views of people who use health and social care services, unpaid carers and those who deliver services in Moray and the wider community.

3.3 Our Values and Principles

Through “Working Together“ with all partners including patients, unpaid carers, service users and their families, we will promote choice, independence, quality and consistency of services by providing a seamless, joined up, high quality health and social care service.

Supporting people to live independently at home or in a homely setting for as long as possible will always be our default position.

We will strive to ensure resources are used effectively and efficiently to deliver services that meet the needs of an increasing number of people with longer term and often complex care needs; many of whom are older.

We will always work to support people to achieve their own quality outcomes and goals that improve their quality of life.

We will always listen and treat people with respect and value the support and contribution provided by unpaid carers.
We will respect our workforce and give them the support and trust they need to help them achieve positive outcomes for the people of Moray

3.4 Our Strategic Outcomes

Our shared vision for change will be achieved through the delivery of **6 key strategic outcomes** and a wide range of related improvement actions. They were informed by a process of community consultation and analysis of available data about health (including mental health) and social care needs of the population. This included best practice and national evidence of ‘what works’ in delivering integrated care and addressing positive health and wellbeing. The priorities were agreed and developed at a series of workshops with the Strategic Planning Group and reflect the areas that people felt important.

- More people will live well in their communities - the population will be responsible for their own health and wellbeing – the community will respond to individual outcomes
- Carers can continue their caring role whilst maintaining their own health and wellbeing
- Relationships will be transformed to be honest, fair and equal
- Investment in a seamless workforce to ensure that skills, competencies and confidence match the needs to enable people to maintain their wellbeing
- Technology enabled care considered at every intervention

3.4 Our Commissioning Framework

Commissioners will be important across the health, wellbeing and social care sectors over the next few years. Working with their colleagues across the public, independent and third sectors they will be reconfiguring services to ensure that they meet the needs of the population. They will be change agents working with managers, professionals, service users, patients and carers to ensure that services are increasingly outcome focused, self-directed and effective in helping people live as long as possible in a homely setting.
Strategic commissioning will demand new skills and new practices, and a new level of maturity in the partnership as we try to ensure that every penny spent from the public purse (and by individual service users) is used wisely and effectively, and that services are cost-effective, of good quality and sustainable into the future.

The following table describes the key elements of integrated approaches to commissioning within the practice matrix which we aspire to in the future (extract from IPC and JIT learning development framework, joint commissioning practice matrix).

<table>
<thead>
<tr>
<th>Areas</th>
<th>Integrated Approaches</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Commissioning plans, decisions and actions are arrived at through a single organisation or network</td>
</tr>
<tr>
<td>Purpose and Strategy</td>
<td>• Inclusive planning and decision process as an integral partner</td>
</tr>
<tr>
<td></td>
<td>• A transparent relationship between integrated bodies</td>
</tr>
<tr>
<td></td>
<td>• Single agency with one commissioning function</td>
</tr>
<tr>
<td>Needs and Market</td>
<td>• Single projects undertaking needs and market analysis and using these to inform commissioning and contracting priorities</td>
</tr>
<tr>
<td>Intelligence</td>
<td>• Single research analysis, public health teams</td>
</tr>
<tr>
<td>Partner Engagement</td>
<td>• A single team is responsible for systematic engagement to inform a single strategy</td>
</tr>
<tr>
<td></td>
<td>• Partners are closely involved in sharing intelligence</td>
</tr>
</tbody>
</table>

We will commission outcomes focused services that deliver high quality care and support and can evidence a positive quality of experience for the individual and their carer. We will develop a quality driven approach that promotes and protects human rights and which seeks the appropriate involvement of people and their carers in the commissioning process.

3.5 Commissioning Intentions

Our commissioning intentions are outlined in the following pages within our strategic outcomes.
1. More people will live well in their communities – the population will be responsible for their own health and wellbeing – the community will respond to individual outcomes

Moray has a clear intention to **build community capacity** in order, amongst other things, to facilitate earlier intervention and a preventative approach and to achieve a real shift in the balance of care.

The recognition of the resource and assets already in localities and building community resilience is key to working in partnership with people in their communities. Together we will build, healthier resilient communities – community in the widest sense.

Co-production and community capacity building will involve working with people who use our services, their carers and the Third Sector to build an approach to providing care, based on co-production principles, develop new community driven models of care provision, and to help people maintain their independence wherever possible.

We aim to have supportive local communities which have the capacity to provide care and support with and for people. Growing community capacity that focuses on early intervention and a preventative approach will reduce isolation and loneliness, enable participation, improve independence and wellbeing and delay escalation of dependency and need for more complex care and support.

Our developing relationship with the Third Sector will support us to continue the development of a moray based third sector network focused on health and wellbeing in our communities.

It should be recognised that people living with multiple conditions can benefit greatly from peer support, either in person or online, and that this can help them to self-manage and build their personal resilience.

**Examples of activities (next 1-3 years)**

- Strengthen health improvement and preventative approaches
- Develop locally provided community based services
- Reduce stigma of mental health
- Invest in activities that promote positive mental health and wellbeing
- Raise awareness of contribution that housing services and adaptations can make
- Develop a consistent approach to “working together” (co production)
- Increase the capacity of the Third Sector
- Signposting people to access “help to help yourself” services and information
- Support label free accessible wellbeing led by communities
- Support people to make connections that will maintain their wellbeing
- Rights based approach to define responsibilities
- Develop Dementia Friendly Communities
- Increase access to peer support to promote recovery
- Support people to self-manage long term conditions
- Improve information about what is available in the community
- Develop seamless service across the system
- Focus on recovery in mental health
- Develop networks to facilitate peer support locally in partnership with the third sector
- Embed Self Directed Support

**What does it mean for you?**

- I am offered emotional and psychological support from my peers, local community or professionals
- I am given information and advice on opportunities to stay well and be physically active
- I'm supported to do the things that matter most to me
- My local community gets the support and information it needs to be a safe and healthy place to be
## 2. Carers can continue their caring role whilst maintaining their own health and wellbeing

Supporting carers to continue in their caring role will be key to providing care and support for the people in Moray. We must work with carers as partners and encourage and support families to provide a caring role.

Providing unpaid care for someone with multiple conditions can also have a significant impact on the lives of those caring, who are often elderly. Carers and their families should be consistently recognised as partners, valued and receive practical support and flexible respite.

### Examples of activities (next 1-3 years) development areas

- Provide carers with choices that enables them to maintain their health and wellbeing and continue in their caring role
- Refresh and Develop Moray Carers Strategic Plan fit for the future
- Unpaid Carers must be considered in locality plans i.e. rurality factor
- Early identification of carers to support early intervention and prevention approaches
- Flexible respite options

### What does it mean for you?

- I feel I get the support I need to keep on with my caring role for as long as I want to do it
- I am happy with the quality of my life and the life of the person I care for
- I can look after my own health and wellbeing
- Staff knows if I have a carer and my carer feels supported
3. Relationships will be transformed to be honest, fair and equal

Developing more equal and reciprocal relationships between health and social care professionals, people currently receiving help, and their families, neighbours and communities will not happen without specific commitment from both the individuals concerned and those professional working to support them.

We will build on and improve our existing engagement with service users, patients, families, carers and the public in general to actively work with communities in localities to ensure their needs and expectations are understood and responded to. This will include working with localities to co-design future services.

People in Moray should expect, for themselves and those they care for, to be listened to, to be involved not just in deciding upon the packages of care they receive, but as an active participant in how it will be delivered: and to enjoy better health and wellbeing within their homes and communities as a result.

We will work together acknowledging the challenges and identifying solutions with all partners to deliver sustainable services and to promote positive health and wellbeing acknowledging each other's contributions to promoting independent living and where possible despite the challenges together make it happen.

Examples of activities (next 1-3 years) development areas

- A clear commitment to engage with localities
- A new relationship where goals and boundaries are shared and understood
- Managing expectations
- Communication process need to be open and person centred
- Mutual respect shall prevail which breeds confidence
- Invest in a language of recovery
- Communication and engagement with communities in localities opportunity to deliver a new message will be responsive to local need, more effective delivery more effective use of resources, will acknowledge local differences and culture
- Transform relationships to be open, honest, fair, equal – all sectors
- People experience choice and are recognised as partners in every contact
- Provide choice and increase personal responsibility to
- Build on engagement with general practitioners and acute hospital doctors
- Clear communication structures across the partnership
- Develop and embed “Moray Partners in Care” approach and framework with teams across localities as a tool of empowerment with individuals

What does it mean for you?
I have a single agreed point of contact for my community health and care team

Services and support help me to reduce the symptoms that I am concerned about

I develop my own “thinking ahead” Anticipatory care plan

My choices are respected in making decisions about keeping me safe from harm

I am offered emotional and psychological support from my peers, local community or

Services and support help me to reduce the symptoms that I am concerned about

I develop my own “thinking ahead” Anticipatory care plan

My choices are respected in making decisions about keeping me safe from harm

I am offered emotional and psychological support from my peers, local community or
4. **Invest in a seamless workforce to ensure that skills, competencies and confidence match the needs to enable people to maintain their wellbeing**

People who manage a range of conditions are commonly affected by a range of emotional and psychological issues which include pain, fatigue, depression, anxiety, low self esteem and distress. Wider issues which can have an impact include employment, caring responsibilities, family relationship and social life.

Within our new plan success has as much to do with shifting our attitudes, expectations and aspirations in the community of Moray as it has about shifting resources, care institutions, providers and workforce.

Achieving these aims will require all of us to **work together**, to resolve our differences and transcend traditional boundaries; to recognise our shared aspirations and responsibilities; to share our skills, talents and resources; and to familiarise ourselves with an exciting new dynamic where we are all both contributors and beneficiaries alike. A **unified ethos** and philosophy of care will be required which takes a holistic approach to individuals. **Culture change** will be supported by the development of a positive ethos and working environment.

**Examples of activities (next 1-3 years) development areas**

- Improved focus on local issues from a needs and delivery perspective
- Build the right workforce for quality care, co-location where possible
- Build and improve positive leadership and accountability
- Create shared processes across sectors and professions
- Workforce development planning
- A holistic approach should be taken when supporting people to address issues - **Conversation at the heart of everything we do**
- Transform the cultures and philosophy of care from reactive services provided to people towards preventative, anticipatory and coordinated care and support people at home with people
- “Right thing easy to do” If not me who, if not now when
- Develop an assessment mechanism that reduces duplication where possible
- Embed three R’s Reablement, Rehabilitation and Recovery in practice
- Give respect and autonomy to professionals to do their job properly
- Set up mechanism for sharing good integrated practice
- Improve information sharing e.g. between GP’s, secondary care, community pharmacies, optometry and social care
- Develop easy access to service information across Moray
- Improve multidisciplinary team working by supporting the establishment of locality implementation groups across the five communities identified within our locality plans
What does it mean for you?

I feel that the outcomes that matter to me are taken account of at my work.

I feel that the services I am using are continuously improving.

Engaged and motivated workforce that have the confidence to match the requirements to enable the population to maintain their wellbeing.

I feel that I get the support and resources I need to do my job well.

I feel my views are taken into account in decisions.
5. Technology enabled care considered at every intervention

We acknowledge that technology enabled care is vital to the delivery of the 20:20 vision for health and social care and will contribute to achieving the national outcomes. It should be seen as a mainstream and integrated part of care planning at a strategic and operational level.

Technology has the power to radically transform the way we deliver healthcare by enabling all patients to take a more active role in their own health and increase prevention through supported self-care. We believe that by embracing rapidly emerging mobile and health care we can empower people to own their own care and transform the way we plan and deliver services.

By capitalising on new and emerging technology we have the opportunity to provide a modern model of continuous, coordinated care centred on the individual, with professionals acting in partnership with the person to improve their health and wellbeing.

Telehealth and telecare is here and already working, supporting people in or close to their home. It can reduce the hospitalisation rate of older people with multiple conditions significantly, and improve outcomes for patients who can find it difficult to travel or those who can self-manage their condition.

There is a wide range of potential benefits of technology in relation to health and wellbeing from community alarm, medication prompt, bed sensors to video conferencing to a consultant clinic. Technology is ever changing; home self-monitoring is now available to support people managing conditions at home.

Proactively managing a patient's health in this way can lead to much better outcomes for them, reducing the risk of being hospitalised, and thereby also reducing the pressure on our acute care sectors.

Keeping people connected using technologies i.e. mobile phone, tablet, access to libraries also have a role to play in reducing social isolation and loneliness.

Examples of activities (next 1-3 years) development areas

- Prepare application for Technology Enabled Care Fund
- Increase the use of NHS video conferencing facilities to other partners, increasing the numbers and range of users and the level of clinical consultations
- Increase use of home monitoring
- Scale up use of digital information, remote monitoring and consultation
- Develop and implement information sharing standard protocol
- Develop shared information systems
- Explore “one patient record” concept
- Use of technology to improve communication, free up time
- Use of technology e.g. home monitoring
- Explore the use of Apps
What does it mean for you?

I can look after my own health and wellbeing

My GP shares my Key Information Summary and Emergency Care Summary with the emergency teams

I am able to stay safe and monitor my conditions at home using everyday technology

My GP, local pharmacist and I receive a summary within 48 hours of my discharge from hospital

I can look after my own health and wellbeing

My GP shares my Key Information Summary and Emergency Care Summary with the emergency teams

I am able to stay safe and monitor my conditions at home using everyday technology

My GP, local pharmacist and I receive a summary within 48 hours of my discharge from hospital
6. Infrastructure and redesign

We need to challenge ourselves to seek to ensure we are properly equipped to take health and social care into the future conducive with a modern system. This redesign is a necessity not an opportunity.

Examples of activities (next 1-3 years) development areas
- Review current community hospital model in terms of delivering intermediate care
- Agree the definition of intermediate care in an integrated environment
- Community medicines management – working in partnership
- Develop a consistent approach to assessment across all settings
- Invest in preventative mental health community services
- Improved access to services
- Scope joint estate to maximize team working
- Develop implementation plan to improve information sharing protocols
- Clear route map of implementation to ensure success

What does it mean for you?

<table>
<thead>
<tr>
<th>Services and support are available to when I need them</th>
<th>The right care for me is delivered at the right time</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel resources are used appropriately</td>
<td>I feel that I get the support and resources to do my job (staff)</td>
</tr>
</tbody>
</table>
PART FOUR: DELIVERING OUR STRATEGY How are we going to know we are achieving?

4.0 Introduction
Achieving our long term vision for this strategy requires that people, communities, unpaid carers, staff from a range of different public services, the third and independent sectors will need to come together to design and deliver future services that achieve the best possible outcomes we possible can for adults in Moray. It is acknowledged that this requires a whole systems approach, partnership working and involvement of the whole community.

The integration planning and delivery principles are the lens through which all integration activity should be focused to achieve the national health and wellbeing outcomes. They set the ethos for delivering a radically reformed way of working and inform how services should be planned and delivered in the future.

The main purpose of the integration planning and delivery principles is to improve the wellbeing of service-users and to ensure that those services are provided in a way which:

- Are integrated from the point of view of service-users.
- Take account of the particular needs of different service-users.
- Takes account of the particular needs of service-users in different parts of the area in which the service is being provided.
- Take account of the particular characteristics and circumstances of different service-users.
- Respects the rights of service-users.
- Take account of the dignity of service-users.
- Take account of the participation by service-users in the community in which service-users live.
- Protects and improves the safety of service-users.
- Improves the quality of the service.
• Are planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care).

• Best anticipates needs and prevents them arising.

• Makes the best use of the available facilities, people and other resources.

4.1 Governance
The IJB will be a statutory partner in the Community Planning Partnership and as such a member of the community planning board and will therefore report with the other partners to the community planning board, although the relationship is not hierarchal.

As part of their remit to prepare and implement a Strategic Plan the IJB established a Strategic Planning Group April 2015. To date the group has focused on developing and consulting on the Strategic Plan and gaining a shared understanding of strategic commissioning. Moving forward it will:

• Oversee the implementation plans for each work stream of the Strategic Plan through a focus on each of the strategic priorities;
• Support the development of locality planning and engagement; and
• Ensure alignment between the Strategic Plan and the plans of the three health and social care partnerships within the Grampian area.

Membership of the Strategic Planning Group is in line with the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014. A complete list of the Strategic Planning Group membership is included in Appendix 2.

The IJB will create such Committees that it requires to assist with the planning and delivery of integrated services such as a “Clinical and Care Governance Group”. The role of the Clinical and Care Governance Group will be to consider matters relating to Strategic Plan development, governance, risk management, service user feedback and complaints, standards, education, learning, continuous improvement and inspection. It will:

• Provide assurance to the IJB, the Council and NHS, via the Chief Officer, that the professional standards of staff working in Integrated Services are maintained and that appropriate professional leadership is in place.
- Review significant and adverse events and ensure learning is applied.
- Support staff in continuously improving the quality and safety of care.
- Ensure that service user/patient views on their health and care experiences are actively sought and listened to by services.

### 4.2 National Health and Wellbeing Outcomes

<table>
<thead>
<tr>
<th>National Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Healthier living</strong></td>
</tr>
<tr>
<td>People are able to look after and improve their own health and wellbeing, and live in good health for longer.</td>
</tr>
<tr>
<td><strong>2. Independent living</strong></td>
</tr>
<tr>
<td>People, including those with disabilities, long-term conditions, or who are frail, are able to live as far as reasonably practicable, independently at home, or in a homely setting, in their community. <em>This outcome aims to ensure delivery of community based services, with a focus on prevention and anticipatory care, reducing emergency admissions to hospital. It recognises that independent living is vital to improving health and well-being.</em></td>
</tr>
<tr>
<td><strong>3. Positive experiences and outcomes</strong></td>
</tr>
<tr>
<td>People who use health and social care services have positive experiences of those services, and have their dignity respected. <em>It is important that health and social care services take full account of the needs and aspirations of the people who use services. Person centred planning and delivery of services will ensure that people receive the right service at the right time, in the right place, and services are planned for and delivered for the benefit of people who use the service.</em></td>
</tr>
<tr>
<td><strong>4. Quality of life</strong></td>
</tr>
<tr>
<td>Health and social care services are centred on helping to maintain or improve the quality of life of service users. <em>Everyone should receive the same quality of service no matter where they live.</em></td>
</tr>
<tr>
<td><strong>5. Reduce health inequality</strong></td>
</tr>
<tr>
<td>Health and social care services contribute to reducing health inequalities. <em>This outcome is focusing upon the role of services in seeking to reduce the gap in health inequalities.</em></td>
</tr>
<tr>
<td><strong>6. Carers are supported</strong></td>
</tr>
<tr>
<td>People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and well-being.</td>
</tr>
<tr>
<td><strong>7. People are safe</strong></td>
</tr>
<tr>
<td>People who use health and social care services are safe from harm. <em>In carrying out our responsibilities, we must ensure that the planning and provision of health and social services supports protects individuals from harm.</em></td>
</tr>
<tr>
<td><strong>8. Engaged workforce</strong></td>
</tr>
<tr>
<td>People who work in health and social care services are supported to continuously improve the information, support, care and treatment they provide, and feel engaged with the work they do.</td>
</tr>
<tr>
<td><strong>9. Resources are used effectively and efficiently</strong></td>
</tr>
<tr>
<td>To deliver Best Value and ensure scarce resources are used effectively and efficiently in the provision of health and social care services.</td>
</tr>
</tbody>
</table>
The main purpose of integration is to improve the wellbeing of people who use health and social care services, particularly those whose needs are complex and involve support from health and social care at the same time. This Strategic Plan is intended to achieve the National Health and Wellbeing Outcomes prescribed by Scottish Ministers.

In order to record progress against the new Health and Wellbeing Outcomes, the Scottish Government has developed a core suite of integration indicators for Partnerships to report on.

The first set of national indicators is based on survey feedback from existing surveys, to reflect the importance of personal outcomes and user feedback.

The second set of indicators are derived from organisational/system data most of which are already collected for other reasons.

4.2 Performance Management and Monitoring

Performance monitoring and evaluation is a key component of the commissioning cycle, it drives improvement and the future development of services. Monitoring impact of services and analysing the extent to which they have achieved the purpose will be key in achieving the national outcomes.

Joint Performance is already in place within the Moray HSCP in the form of the Joint Performance Management Group. The suite of core indicators has been adopted and the group is currently revising the previous reporting against the future reporting to inform an Integrated Performance Framework. All performance, targets and improvement measures will be produced and in place for IJB come April16 with regular reporting in place.

The Integration Joint Board will publish an annual performance report which will set out progress towards the National Health and Wellbeing Outcomes. The report will include information about the core suite of indicators, supported by local measures and contextualising data to provide a broader picture of local performance.

Appendix 9 Cycles and flow in the performance framework illustrates the complexities of monitoring the performance of the whole system. It maps potential pressure points and the range of points that we measure.
It is acknowledged that there needs to be more outcome focused measures particularly around service user/patient experience, there may also be some local measures specific to Moray localities to be developed.

4.3 Workforce Development

Moray, like many areas, faces major challenges in recruiting and retaining staff and there is a continuing need to train and develop skills as the nature and demands of jobs change. Staff are our most valuable resource. Without staff, at all levels, the changes required across health and social care will not happen. Supporting informal carers and volunteers and ensuring a flexible, well-trained, motivated and highly-valued workforce will be pivotal in the delivery of this strategy. This strategy will enable new roles and new ways of working to be explored.

We will be working with staff to develop further opportunities to engage, equip and inspire our workforce. Workforce development will focus on the whole health and social care workforce exploring cross-sector opportunities for learning and development.

Our Older People’s Strategy summarised our long term goal for the workforce.

“A health and social care workforce that reflects demography and need, increasingly community-based and less focused than at present on acute and unscheduled care: with changes delivered via training, education and career paths: knowledge, skills and attitudes: with more people working in teams and away from hospitals: and making maximum use of emergent IT and other technology for example Telecare.”

This long term goal still stands however within our new plan success has as much to do with shifting our attitudes, expectations and aspirations in the community of Moray as it has about shifting resources, care institutions, providers and workforce. Achieving these aims will require all of us to work together, to resolve our differences and transcend traditional boundaries; to recognise our shared aspirations and responsibilities; to share our skills, talents and resources and to familiarise ourselves with an exciting new dynamic where we are all both contributors and beneficiaries alike.

We are working towards a joint approach to developing our future workforce and will continue to invest in support for cultural change in Moray, with organisational development activities to support the transformation of the whole system within our partnership organisations.
A series of Workforce Engagements in Moray highlighted several positive messages:

- There is enthusiasm to progress the integration agenda
- Good examples exist of coordinated, multi-agency working and multi-disciplinary care
- Several examples were given of already integrated teams, with some co-location.
- Staff are “signed up” to putting the person/service user/patient at the centre of their care
- High levels of staff skill exists
- Our smaller size is an advantage – there are often strong personal and professional relationships which help “get the job done”

The workshop break out groups focused on how we build strong integrated locality teams and the responses fall broadly into 3 strategic themes:

1. Build the right workforce for quality care
2. Ensure positive leadership and accountability
3. Create shared processes across sectors and professions

The IJB will develop an Integrated Workforce Plan which will be aligned to develop and support the workforce to achieve this major reform.

4.4 Locality Planning

The Act requires each authority to subdivide in to a minimum of two localities; the purpose is to provide an organisational mechanism for local leadership of service planning, and to feed upwards into the IJB Strategic Plan – localities must have real influence on how resources are spent in their area.

Localities refer to the group of people in these areas who must play an active role in service planning for the local population, in order to improve outcomes.

**Localities must:**

a) Support the principles that underpin collaborative working to ensure a strong vision for service delivery is achieved. Robust communication and engagement methods will be required to assure the effectiveness of locality arrangements.

b) Support GPs to play a central role in providing and co-ordinating care to local communities, and, by working more closely with a range of others – including the wider primary care team,
secondary care and social care colleagues, and third sector providers – to help improve outcomes for local people.

c) Support a proactive approach to capacity building in communities, by forging the connections necessary for participation, and help to foster better integrated working between primary and secondary care.

After extensive engagement and consultation two locality areas were identified in the partnership Moray East and Moray West using area data zones. These will be used for organisational purposes. Locality Planning will operate within these localities in five natural communities.

<table>
<thead>
<tr>
<th>Moray East</th>
<th>Moray West</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buckie/Cullen</td>
<td>Elgin/ Lossiemouth</td>
</tr>
<tr>
<td>Keith</td>
<td>Forres</td>
</tr>
<tr>
<td>Speyside</td>
<td></td>
</tr>
</tbody>
</table>
There is however acknowledgement that there is a requirement to work with natural communities at as local a level as possible. In addition there may be occasions when “communities of interest” are considered on particular issues which means the configuration of a community may differ from groups of people to geographical areas, when it comes to service design and community resilience.

Strategic and locality level planning must work together to create the best possible working arrangements and to enable them to take account of local, and often deep rooted, issues, such as inequalities and poverty.

Localities exist to help ensure that the benefits of better integration improve health and wellbeing outcomes by providing a forum for professionals, communities and individuals to inform service redesign and improvement.
Appendix 1 NHS Grampian Quality Indicators

Delivering what matters most

Employee engagement index (EEI) from iMatter

Dignity at work survey

Datix complaints and complements

Care Opinion

No Preventable Deaths

Hospital Standardised Mortality Ratio (HSMR)

Cardiac arrests in hospital

Suicides

Incidence of lung cancer

Life expectancy

Continuously seek out and reduce harm

Patient falls in hospital

Hospital acquired pressure ulcers

Hospital acquired infections

Achieving the highest reliability for clinical care

Emergency admissions after 7 and 30 days

Potentially preventable admissions (PPA)

Immunisation uptake

Waiting times for diagnosis and treatment

Length of stay

Use of supplementary staff
a. Executive Summary

Background

This indicative plan outlines NHS Grampian’s contribution to the National Waiting Times plan building on the impact achieved in year one. Within this second year our focus is on building sustainable capacity to match our demand and allow significant transfer of investment in year three, from non-recurring private sector or additional hours working by core staff, to recurring capacity.

The national plan outlines phased improvements to ensure delivery of waiting times standards and within the scope of this plan highlights that:

- By October 2020:
  - 85% of outpatients will wait less than 12 weeks to be seen; and
  - 85% of inpatient/day cases will wait less than 12 weeks to be treated.

- By Spring 2021:
  - 95% of outpatients will wait less than 12 weeks to be seen;
  - 100% of inpatient/day cases will wait less than 12 weeks to be treated;
  - and
  - 95% of patients for cancer treatment will be treated within the 62-day waiting time standard.

In presenting the indicative plan at this stage we have set out our optimum position based on being able to significantly increase our investment in recurring capacity, whilst maintaining the level of independent sector support at levels consistent with year one of the plan. Over the coming weeks, we will risk assess these actions and refine the plan and trajectories accordingly.

The plan is structured in four key sections:

- Treatment Time Guarantee and Outpatients – Section 1
- Diagnostics – Section 2
- Cancer – Section 3
- Mental Health – Section 4
**Project performance improvement**

**a. Elective Care**

NHS Grampian committed to significantly reducing waiting times over 2019/20. The overall suggested trajectories for 20/21 by quarter are:

<table>
<thead>
<tr>
<th>Standard</th>
<th>March 2020</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatients</td>
<td>7,050</td>
<td>6490</td>
<td>4890</td>
<td>4040</td>
<td>3580</td>
</tr>
<tr>
<td>TTG</td>
<td>4,000</td>
<td>3510</td>
<td>3030</td>
<td>2590</td>
<td>2210</td>
</tr>
<tr>
<td>Diagnostics</td>
<td></td>
<td>988</td>
<td>586</td>
<td>377</td>
<td>248</td>
</tr>
</tbody>
</table>

This year 2 plan assumes a starting point of our current projections, though efforts will continue to mitigate all slippage to date. The impact of winter during 2019/20 is uncertain; if this has a greater than anticipated impact on elective capacity the starting point of this plan will shift to a higher baseline.

**b. Cancer**

NHS Grampian trajectories for 20/21 by quarter are projected to be as follows:

<table>
<thead>
<tr>
<th>Standard</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer 31-day</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>Cancer 62-day</td>
<td>90%</td>
<td>91%</td>
<td>91%</td>
<td>92%</td>
</tr>
</tbody>
</table>

Although Cancer normal works on calendar quarters for consistency within this plan these figures represent financial quarters.

**c. Mental Health**

Our trajectories for 2020/21 remain consistent with those set out in the 2019/20 AOP; namely:

<table>
<thead>
<tr>
<th></th>
<th>By December 2019</th>
<th>By March 2020</th>
<th>By June 2020</th>
<th>By September 2020</th>
<th>By December 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAHMS</td>
<td>65%</td>
<td>80%</td>
<td>85%</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Psychological Therapies</td>
<td>75%</td>
<td>75%</td>
<td>80%</td>
<td>85%</td>
<td>90%</td>
</tr>
</tbody>
</table>

---

1 Summarised by specialty in Appendix 1
Resources

The funding requirement for 2020/21 is set out below and detailed in the waiting times improvement plan.

<table>
<thead>
<tr>
<th>Funding Request</th>
<th>Recurring £k</th>
<th>Non-recurring £k</th>
<th>Totals £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>OP &amp; TTG Specialty Projects*</td>
<td>6,904</td>
<td>4,804</td>
<td>11,708</td>
</tr>
<tr>
<td>Core support</td>
<td>1,229</td>
<td>2,943</td>
<td>4,172</td>
</tr>
<tr>
<td>Redesign &amp; Capacity building</td>
<td>1,193</td>
<td>0</td>
<td>1,193</td>
</tr>
<tr>
<td><strong>OP &amp; TTG Subtotal</strong></td>
<td><strong>9,326</strong></td>
<td><strong>7,47</strong></td>
<td><strong>17,073</strong></td>
</tr>
<tr>
<td>Diagnostics</td>
<td>858</td>
<td>1,225</td>
<td>2,083</td>
</tr>
<tr>
<td>Cancer*</td>
<td>303</td>
<td>0</td>
<td>303</td>
</tr>
<tr>
<td><strong>Total Funding</strong></td>
<td><strong>10,487</strong></td>
<td><strong>8,972</strong></td>
<td><strong>19,459</strong></td>
</tr>
</tbody>
</table>

* Please note that significant proportions of spend which will impact positively on cancer performance is included in the OP/TTG spend counts. The identifiable posts are listed in the cancer section.

Key Risks

The Waiting Times Improvement Plan Oversight Group has identified a number of risks associated with the service delivery of this plan:

- Sub-specialty pressures for specialist interventions for which there are recruitment challenges and independent sector provision is unavailable;
- Increasing demand as a result of national screening programmes, improvements to clinical pathways which require changing, or additional interventions, and supra-regional service developments;
- Availability of skilled workforce and associated recruitment timescales;
- Limitations of existing infrastructure to increase capacity (theatres, diagnostics, outpatient clinic space) in advance of the delivery of the Elective Care Centre;
- Limitations of existing clinical and support services including laboratories, decontamination facilities, pharmacy services, physiologists and allied health professionals.

Additionally, there are a number of risks due to external factors. These present a significant challenge to the delivery of expected performance against the trajectories set out within this plan:

- Uncertainty over timing and impact of Brexit on workforce availability, and supply of instrumentation and clinical supplies;

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2 We have assumed that there is no further funding for Mental Health beyond those already reflected in planned earmarked allocations.
• Likelihood of insufficient capacity within independent sector providers to deliver required trajectories; and
• Surges in unscheduled care activity throughout the year that impact on both available and planned elective capacity
Section 1: Treatment Time Guarantee and Outpatients

The plan for TTG and outpatient improvement in Year 2 reflects the move towards building recurring sustainable capacity and the need to optimise additional capacity to address existing backlog and demand and capacity gaps.

The plan is based on the following key action areas:

- Sustainability through Redesign and Capacity Building
- Specialty Specific Funding and Trajectories
- Core support capacity
- Productivity and best practice

a. Sustainability through Redesign and Capacity Building

Our commitment to transformational change is demonstrated through our programme of redesign and transformation activities designed to increase core capacity, reduce demand, and sustainably deliver waiting times. The programme will be undertaken using a whole systems approach, recognising the importance of co-production and collaboration with the three Integration Joint Boards.

The two main areas where the Year 2 plan will seek to develop sustainable capacity through redesign are in relation to development of:

- An NHS Grampian Theatre Academy and
- A Psychology Hub

NHS Grampian Theatre Academy

NHS Grampian has experienced shortages within the peri-operative workforce across all theatres for some years which is set within the context of a national shortage of experienced peri-operative staff. This significantly impacts on available staffed theatre capacity which has resulted in deteriorating waiting times performance over a number of years. This has been compounded due to the existing and ongoing chronic shortage of registered nurses available across NHS Grampian. Recognising the scale of this challenge, NHS Grampian has agreed a number of key actions to address our workforce challenges. These deliverables are designed to provide long-term capacity improvements whilst recognising the requirement to take action to address short and medium-term challenges.

In January 2019, both NHS Scotland and Scottish Government colleagues undertook a critical friend support visit to provide assistance to NHS Grampian to support sustainable performance improvement across elective theatres.

The workforce challenges which exist within NHS Grampian were recognised by the visiting team and a number of recommendations were made to support improvements in productivity and efficiency, workforce development and sustainability, and performance monitoring. A key recommendation was to undertake shared learning visits to Golden Jubilee National Hospital and NHS Lanarkshire to explore their established Theatre Academy model.
To support the implementation of the recommendations, an action plan was developed which detailed timescales, accountable leads and progress against each recommendation. The action plan sets out a number of deliverables which support short, medium and long-term improvements in performance and sustainability.

Significant shared learning and experience from across NHS Scotland has demonstrated increased rates of peri-operative workforce retention through a structured programme of development and support.

As a result, in 2019, NHS Grampian committed to establishing a Theatre Academy to secure sufficient and sustainable workforce capacity to improve faster access to care. This is in keeping with the principle of sustaining planned care within the North of Scotland network.

The Theatre Academy promotes the development of a ‘grow and develop our own’ model and sees active participation in the Operating Department Practitioner (ODP) programme through committing to the largest number of student places. The programme was developed by the University of the West of Scotland and commences in Winter 2019.

The Theatre Academy encompasses all theatres across NHS Grampian with the appropriate educator skill mix to support the development of new graduate nurses, assistant scrub practitioners and trainee ODPs – a model similar to the Golden Jubilee Theatre Academy.

The development of an NHS Grampian Theatre Academy seeks to achieve the following outcomes:

- Skill mix and staffing levels will be in line with the nationally approved workforce model;
- AFPP standards will be met;
- Registered nurses and ODPs will be trained and become competent in scrub, recovery and anaesthetics thus improving the flexibility of the workforce. The ODP programme takes trainees from a training role to registered practitioners over a two year period; and
- Training will be completed in a timely manner with staff feeling supported throughout the training period.

In addition to these outcomes, we aim to establish an appropriately trained and skilled workforce to support the theatre staffing model which is proposed for the new Elective Care Centre facility and within the Main Theatre Suite, ARI. This will provide sustainable capacity across all NHS Grampian elective sites.

Summary

<table>
<thead>
<tr>
<th>Funding Allocation</th>
<th>£000's</th>
<th>Recurring?</th>
<th>If recurring, full year cost £000's</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theatre Academy</td>
<td>587</td>
<td>Yes</td>
<td>587</td>
<td>Requires recurring funding to sustain capacity</td>
</tr>
</tbody>
</table>
Psychology Hub

Many people waiting for their first and especially return appointments are not best seen by medical or surgical consultants. This can be because:

- Peoples’ somatic symptoms are not amenable to medical or surgical interventions, for example, in the case of medically unexplained or functional symptoms
- Potential side-effects of treatments closely match or outweigh any potential benefits, such as in level 3 surgical procedures
- Advice, information, education and reassurance is insufficient to change the complex behaviours driving onset or exacerbation of conditions, symptoms and increased risk of poor outcomes, for example, in the case of non-alcoholic fatty liver disease
- Significant psychological factors are at least maintaining disease burden or symptoms to the extent that they need treated in their own right, which can be the case where stress drives clawing behaviours in dermatology for example.

This development in Acute Sector Psychology is focused on the creation of alternative care pathways, which will reroute people who fall in to the above categories and would ordinarily return to see medical staff for further routine appointments, investigations, and treatments. New pathways will consist of psychological assessments followed by brief, often manualised psychological therapies (5-10 appointments) followed by discharge back to primary care. Much of this high-volume work will be delivered by junior psychology staff, with senior staff support. A range of innovative material will be designed and developed, including the pathways themselves, associated therapist manuals and digital self-help material.

In addition to novel implementation of psychological therapies, we will disrupt standard pathways for ESCatS Category 3 surgery\(^3\), using behavioural science techniques (or “nudges”). For example, we will introduce decisional aids at key decision points that maintain freedom of choice whilst helping people use their values to balance options, risks, and benefits in order to make the best decision and reduce post-surgery regret. In so far as possible, procedures and pathways will be automated using digital technology. We anticipate that once our first pathways and processes are designed and implemented, capacity will be available to roll out elsewhere.

Resource will be focused on the following services in order to release medical and surgical capacity and increase new outpatient capacity:

- Dermatology
- Gastroenterology
- Liver
- Urology
- Oral and Maxillofacial Surgery
- Level 3 Surgery

Enabling work to support this new model of care began in 2019/20 and will continue into 2020/21. We anticipate that approximately 9 WTE staff members will be

\(^3\) ESCatS Category 3 surgery is that which is considered clinically non-time critical in its delivery
recruited within 2020-21 to support the design and embedding of all new pathways, and development of manuals and digital materials.

**Potential Impact**

<table>
<thead>
<tr>
<th></th>
<th>Recurring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Return Slots freed from consultants</td>
<td>855</td>
</tr>
<tr>
<td>Conversion to freed new slots</td>
<td>540</td>
</tr>
<tr>
<td>Decision support for alternatives to surgery</td>
<td>433</td>
</tr>
</tbody>
</table>

Within year 3 and onwards we would anticipate that the main capacity gains will be achieved by avoiding patients entering medical acute sector system in the first place. We believe that this is an exciting opportunity to implement the precepts of realistic medicine at scale but it is important to note that the assumptions of improvement is based on an evidence base.

**Summary:**

<table>
<thead>
<tr>
<th>Funding Allocation</th>
<th>£000’s</th>
<th>Recurring?</th>
<th>If recurring, full year cost £000’s</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychology Hub</td>
<td>606</td>
<td>Yes</td>
<td>606</td>
<td>Plan to commence in Q4 2019, as in 19/20 AOP; recurring funding confirmed available from April 2020 will allow progression to full recruitment</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liver</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dermatology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urology &amp; OMFS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery Choice</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Gastroenterology**

A 2014 meta-analysis concluded that cognitive behavioural therapy (CBT) is an effective treatment for functional gut disorders.

**Liver**

We will use at scale an intervention called ACT Now! to treat people with non-alcoholic fatty liver disease at high risk of developing cirrhosis. The Scottish Health Technologies Group conducted an independent clinical and economic evaluation of this treatment. It was more effective than medicine and had substantially greater cost-effectiveness (£130 / QALY v > £10,000 / QALY).

**Dermatology**

Stress and anxiety are recognised drivers of scratching / clawing behaviours that exacerbate skin lesions. Systematic reviews have highlighted behavioural therapy and CBT are effective in reducing both the emotional difficulties and the aforementioned illness behaviours.

**Urology & OMFS**

A 2014 Cochrane Review concluded that CBT is an effective treatment for medically unexplained symptoms and many meta-analysis have concluded this treatment is effective in treating various types of pain.

**Surgery Choice**

A Cochrane Review published in JAMA in 2017 as a systematic review of over 31,000 patients indicated decisional aids are associated with a reduction of 7.2% in elective surgeries, improved decision quality and decision-making processes without worse patient or health system outcomes.
b. Specialty Specific Funding and Trajectories

Below we set out specific actions against each of the key clinical specialties.

Dermatology

The focus of the year two for Dermatology involves expanding the non-consultant workforce to relieve the pressure on what is understood to be a national shortage of Dermatologists.

Whilst this workforce is recruited and trained there will be a continued requirement for independent sector support to maintain the performance improvements made within Year 1 to the new outpatient position whilst recovering the substantial return patient backlog

Trajectory and Funding

<table>
<thead>
<tr>
<th></th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>OP</td>
<td>70</td>
<td>70</td>
<td>70</td>
<td>70</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Funding Allocation</th>
<th>£000's</th>
<th>Recurring?</th>
<th>If recurring, full year cost £000’s</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phototherapy Nursing</td>
<td>80</td>
<td>Yes</td>
<td>80</td>
<td></td>
</tr>
<tr>
<td>Pharmacy Clinics</td>
<td>63</td>
<td>Yes</td>
<td>63</td>
<td></td>
</tr>
<tr>
<td>Non Consultant Clinics</td>
<td>131</td>
<td>Yes</td>
<td>131</td>
<td></td>
</tr>
<tr>
<td>Capital dependencies for expansion</td>
<td>70</td>
<td>No</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>IS Sector Support</td>
<td>452</td>
<td>No</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>796</td>
<td></td>
<td>274</td>
<td></td>
</tr>
</tbody>
</table>

Cardiology

The focus of the Cardiology plan this financial year is to complete the service expansion commenced in the year 1 plan and reduce the IS support required as this capacity and service redesign is achieved. With the recurring commitments in place we would anticipate no further requirement for IS support into Year 3 to maintain the New Outpatient target. The mobile Cath Lab will remain a requirement for the foreseeable future.

The TTG patients waiting in Cardiology is mainly related to complex pacing and devices and one of the key rate limiting steps is anaesthetic support for these lists which will be supported by this additional post which will also support Cardiac Surgery and TAVI procedures.

Trajectory and Funding

<table>
<thead>
<tr>
<th></th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
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<tbody>
<tr>
<td>OP</td>
<td>106</td>
<td>70</td>
<td>70</td>
<td>70</td>
</tr>
<tr>
<td>TTG</td>
<td>29</td>
<td>16</td>
<td>4</td>
<td>0</td>
</tr>
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<td>£000’s</td>
<td>Recurring?</td>
<td>If recurring, full year cost £000’s</td>
<td>Comments</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>--------</td>
<td>------------</td>
<td>-------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Cardiology Consultant (Imaging)</td>
<td>140</td>
<td>Yes</td>
<td>140</td>
<td>Recurring costs from Year 1 commitment</td>
</tr>
<tr>
<td>WTIP 2018/19</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiology Consultant (Heart Failure/Devices)</td>
<td>140</td>
<td>Yes</td>
<td>140</td>
<td></td>
</tr>
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<td>IS Clinic Support</td>
<td>65</td>
<td>No</td>
<td></td>
<td>Half of current rate</td>
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<tr>
<td>Mobile Cath Lab</td>
<td>450</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiologist</td>
<td>135</td>
<td>Yes</td>
<td>135</td>
<td></td>
</tr>
<tr>
<td>Anaesthetic Assistant</td>
<td>19</td>
<td>Yes</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Physiologists x2</td>
<td>104</td>
<td>Yes</td>
<td>104</td>
<td>Recurring costs from Year 1 commitment</td>
</tr>
<tr>
<td>Total</td>
<td>1,053</td>
<td></td>
<td>538</td>
<td></td>
</tr>
</tbody>
</table>

**ENT**

The ENT service is being supported during Q3 and Q4 2019/20 with IS support due to staff vacancies. We anticipate a continued requirement for IS support for approx. 6 months to maintain service until these vacancies are filled.

**Trajectory and Funding**

<table>
<thead>
<tr>
<th></th>
<th>Quarter 1</th>
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<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>OP</td>
<td>90</td>
<td>30</td>
<td>30</td>
<td>0</td>
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<tr>
<td>TTG</td>
<td>452</td>
<td>338</td>
<td>212</td>
<td>81</td>
</tr>
</tbody>
</table>

**Gastroenterology**

Significant improvements have been made during Year 1. Maintaining these improvements are dependent on mainstreaming an active clinical triage system that has proved successful in demand management. It is also dependent on the medical staff posts listed in the Endoscopy section which will have a contribution to General Gastroenterology as well.

The active clinical triage system described will allow:

- Clinical vetting and streaming to optimal outpatient clinics
- OP key information gathering to inform requirement for type of and optimised use of clinic time
- Ability to increase patient numbers per clinic by maximising the use of consultant time for consultant only tasks.
In addition there is one-off non-recurring funding identified within this proposal to add a search functionality of the patients EPR accessible via the electronic vetting screen. This is considered a proof of concept pilot which is envisaged to significantly reduce the time required to rapidly search through a patients medical record to enable efficient operationalisation of the ACRT principles. This would apply to all specialties and the concept is transferable to other health boards if proved in practice.

Trajectory and Funding

<table>
<thead>
<tr>
<th></th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
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<tr>
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<td>20</td>
<td>15</td>
<td>10</td>
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<th>If recurring, full year cost £000’s</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>Active Clinical Triage Team</td>
<td>200</td>
<td>Yes</td>
<td>158</td>
<td>Successful pilot completed</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>200</td>
<td></td>
<td>158</td>
<td></td>
</tr>
</tbody>
</table>

General Surgery

The year 2 general surgery plan continues the expansion commenced within the year 1 plan with a particular emphasis on colorectal capacity which has a significant impact on cancer performance. A matched expansion of pathology and radiology resources is included to accommodate this increased capacity.

In addition there is an expansion of the non-consultant workforce in terms of Colorectal Nurse specialists and Physicians Associates to improve the efficiency of the consultant team.

We continue to require the additional operating capacity provided each weekend by the IS in Dr Gray’s Hospital. We are using this capacity flexibly between Urology and General Surgery at present and would anticipate continuing to flexibly use this capacity as; but all costs are presented below against General Surgery.

Please note that there is an assumption that the activity delivered via the Vanguard Theatre at Stracathro will continue to be delivered on a recurring basis via the Stracathro Site whether this be via the Vanguard theatre on site or not.

Trajectory and Funding

<table>
<thead>
<tr>
<th></th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OP</strong></td>
<td>840</td>
<td>783</td>
<td>435</td>
<td>87</td>
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<tr>
<td><strong>TTG</strong></td>
<td>441</td>
<td>328</td>
<td>202</td>
<td>72</td>
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<table>
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<th>If recurring, full year cost £000’s</th>
<th>Comments</th>
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<tbody>
<tr>
<td>GS Consultant</td>
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<td>Yes</td>
<td>140</td>
<td>Continuation of previous years commitments</td>
</tr>
<tr>
<td>GS Consultant (Vanguard)</td>
<td>150</td>
<td>Yes</td>
<td>150</td>
<td>Continuation of previous years commitments</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>Colorectal Consultant (plus Radiology, pathology tail)</td>
<td>358</td>
<td>Yes</td>
<td>358</td>
<td>Includes 174k recurring and 10k non-recurring for matched radiology and pathology expansion</td>
</tr>
<tr>
<td>0.5wte Colorectal Consultant</td>
<td>70</td>
<td>Yes</td>
<td>70</td>
<td>Part University Post</td>
</tr>
<tr>
<td>Colorectal Nurse Specialist x2</td>
<td>110</td>
<td>Yes</td>
<td>105</td>
<td>In year costs include one off capacity costs</td>
</tr>
<tr>
<td>Physicians Associates</td>
<td>105</td>
<td>Yes</td>
<td>105</td>
<td></td>
</tr>
<tr>
<td>IS Weekend Operating Team Capacity</td>
<td>802</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,855</td>
<td></td>
<td>1038</td>
<td></td>
</tr>
</tbody>
</table>

**Gynaecology**

The year two Gynaecology plan includes expanding the consultant workforce but significantly also expanding the non-consultant workforce to concentrate the impact. It is anticipated that IS support will be required during year 2 whilst these posts are recruited to and becomes fully effective with an anticipation that this support can be removed from the beginning of Year 3.

**Trajectory and Funding**

<table>
<thead>
<tr>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>OP</td>
<td>400</td>
<td>160</td>
<td>0</td>
</tr>
<tr>
<td>TTG</td>
<td>123</td>
<td>83</td>
<td>43</td>
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**Funding Allocation**

<table>
<thead>
<tr>
<th></th>
<th>£000’s</th>
<th>Recurring?</th>
<th>If recurring, full year cost £000’s</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gynaecology Consultant</td>
<td>140</td>
<td>Yes</td>
<td>140</td>
<td>Continuation of previous years commitment</td>
</tr>
<tr>
<td>Gynaecologist</td>
<td>140</td>
<td>Yes</td>
<td>140</td>
<td></td>
</tr>
<tr>
<td>IS S&amp;T Contract</td>
<td>200</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse Led Clinics (2x Band 5)</td>
<td>90</td>
<td>Yes</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>Specialist Nurse and support (band 6)</td>
<td>165</td>
<td>Yes</td>
<td>165</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>735</td>
<td></td>
<td>535</td>
<td></td>
</tr>
</tbody>
</table>

**Neurology**

The Neurology Service has been assisted by an external IS support for over two years. The year 2 plan focussed on maintaining this support whilst expanding the substantive service by one consultant and a specialist nurse to allow the IS contract to be removed from the requirement list in year 3.

**Trajectory and Funding**

<table>
<thead>
<tr>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>OP</td>
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<td>71</td>
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</tr>
<tr>
<td>Funding Allocation</td>
<td>£000’s</td>
<td>Recurring?</td>
<td>If recurring, full year cost £000’s</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>--------</td>
<td>------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>Neurology Consultant</td>
<td>150</td>
<td>Yes</td>
<td>150</td>
</tr>
<tr>
<td>Dystonia Headache Nurse</td>
<td>52</td>
<td>Yes</td>
<td>52</td>
</tr>
<tr>
<td>Continued IS</td>
<td>60</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>262</td>
<td></td>
<td>202</td>
</tr>
</tbody>
</table>

**Ophthalmology**

The focus of the year 2 plan for Ophthalmology is to build service resilience and sustainability to allow the removal of IS support in Year 3 which has been in place for a number of years. The areas of focus are additional capacity for Cornea clinics which represent our longest waiting outpatient tail and substantively staffing the cataract procedure room five days a week with NHS nursing and medical staff.

The longest waiting TTG patients are primarily GA cataracts and an in year backlog recovery via IS support is requested. Continued in year use of the IS for ambulatory cataracts is anticipated as the service transitions to a permanent staffing model.

In addition, it is crucial that the Injection service is expanded; although this activity is counted as return outpatient activity it is a clinical priority and non-expansion of this service will result in capacity being pulled from cataract operating lists as a lesser clinical priority.

**Trajectory and Funding**

<table>
<thead>
<tr>
<th></th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>OP</td>
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<td>79</td>
<td>0</td>
<td>0</td>
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<tr>
<td>TTG</td>
<td>140</td>
<td>110</td>
<td>80</td>
<td>50</td>
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**Funding Allocation**

<table>
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<th>Recurring?</th>
<th>If recurring, full year cost £000’s</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cataract Room- Existing Staffing Costs</td>
<td>114</td>
<td>Yes</td>
<td>114</td>
<td>Continuation of existing commitment</td>
</tr>
<tr>
<td>Expansion of virtual glaucoma clinic</td>
<td>20</td>
<td>Yes</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Expansion of Ophthalmic Imaging Support</td>
<td>73</td>
<td>Yes</td>
<td>73</td>
<td></td>
</tr>
<tr>
<td>Expansion of Intravitreal Injection Service</td>
<td>270</td>
<td>Yes</td>
<td>270</td>
<td></td>
</tr>
<tr>
<td>Increased Optometry Support for Cornea Clinics</td>
<td>9</td>
<td>Yes</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Medical and Nursing capacity for full use of Cataract Procedure Room</td>
<td>481</td>
<td>Yes</td>
<td>481</td>
<td></td>
</tr>
</tbody>
</table>
Indicative Waiting Times Improvement Plan – 2020/21

OMFS

A joint collaboration with the UoA was recurring supported at the quarter 2 point of 2019. No further requirement is anticipated

<table>
<thead>
<tr>
<th>Trajectory and Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>OP</td>
</tr>
<tr>
<td>TTG</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Funding Allocation</th>
<th>£000’s</th>
<th>Recurring?</th>
<th>If recurring, full year cost £000’s</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>UoA Oral Surgery Posts</td>
<td>195</td>
<td>Yes</td>
<td>195</td>
<td>Continuation from year one additional resource</td>
</tr>
<tr>
<td>Total</td>
<td>195</td>
<td></td>
<td>195</td>
<td></td>
</tr>
</tbody>
</table>

Pain Management

To improve the chronic pain performance a recurring funded service redesign was supported in the Year 1 WTIP plan and this requires to be continued. In addition we have supported a second MTI post from slippage funding, on a fixed term basis, and we would request support to maintain this on a permanent footing. This would give the service two MTI posts which would have staggered timing to allow for a consistency of service delivery.

<table>
<thead>
<tr>
<th>Trajectory and Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>OP</td>
</tr>
<tr>
<td>TTG</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Funding Allocation</th>
<th>£000’s</th>
<th>Recurring?</th>
<th>If recurring, full year cost £000’s</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Pain Redesign</td>
<td>261</td>
<td>Yes</td>
<td>261</td>
<td>Continuation of Year 1 commitment</td>
</tr>
<tr>
<td>MTI Post</td>
<td>42</td>
<td>Yes</td>
<td>84</td>
<td>Part of year 2 funded from slippage</td>
</tr>
<tr>
<td>Total</td>
<td>303</td>
<td></td>
<td>345</td>
<td></td>
</tr>
</tbody>
</table>
**Plastic Surgery**

The focus of the year 2 plan is to add sustainability to the cancer pathway via the recruitment of specialist nurses for Melanoma. These posts will work across Plastics and Dermatology.

In addition the longest waiting TTG patients are complex breast reconstructions and a service expansion via an additional consultant with associated diagnostic expansion is requested.

**Trajectory and Funding**

<table>
<thead>
<tr>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OP</strong></td>
<td>24</td>
<td>5</td>
<td>5</td>
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<tr>
<td><strong>TTG</strong></td>
<td>114</td>
<td>38</td>
<td>20</td>
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<table>
<thead>
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<th>Recurring?</th>
<th>If recurring, full year cost £000’s</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2x Melanoma Nurses (Band 7)</td>
<td>110</td>
<td>Yes</td>
<td>104</td>
<td>In year costs include one off capital</td>
</tr>
<tr>
<td>Consultant for Breast and Skin</td>
<td>239</td>
<td>Yes</td>
<td>234</td>
<td>Includes 87k recurring and 5k non-recurring for matched radiology and pathology expansion</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>349</td>
<td></td>
<td>338</td>
<td></td>
</tr>
</tbody>
</table>

**Respiratory**

The focus in respiratory is to assist with the cancer pathway by reducing the time to bronchoscopy which will be supported by an expansion of the nursing workforce.

**Trajectory and Funding**

<table>
<thead>
<tr>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OP</strong></td>
<td>0</td>
<td>0</td>
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<table>
<thead>
<tr>
<th>Funding Allocation</th>
<th>£000’s</th>
<th>Recurring?</th>
<th>If recurring, full year cost £000’s</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronchoscopy Nurse</td>
<td>40</td>
<td>Yes</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>40</td>
<td></td>
<td>40</td>
<td></td>
</tr>
</tbody>
</table>
Trauma and Orthopaedics

The Orthopaedic Service has seen a steady reduction in its waiting times over time via a number of recurring actions agreed via the Orthopaedic National Improvement programme. We require these actions to continue along with the additional trauma activity to avoid elective impact.

To improve our TTG position from January 2020 we are extended the trauma IS nursing team support to a five day service with the additional two days a week being elective operating at Woodend. We would wish to continue this for the duration of year two as our main TTG barrier is theatre access due to fragility of the nursing resource.

In addition:
- We have 6PAs of funding from the Major Trauma Centre development which are currently not being used. We would be supportive of sourcing a further recurring 6PAs of funding to facilitate an expansion of the consultant workforce by a further consultant to add core capacity into this service. We believe a fulltime consultant post would be attractive and recruitable.
- The main operating constraint for Orthopaedics is our theatre and ward nursing fragility. There are sustainable plans to address this but in the short-term we are supporting of seeking a private provider to provide a theatre nursing team, associated recovery staffing and ward nursing to open one theatre and a 12-15 bedded area 5 days a week. We would have sufficient surgeons to utilise this capacity and our preference would be to extend our anaesthetic team by a locum appointment rather than including this in the contract for full clinical governance integration. The cost included in this plan is indicative from an extrapolation of current contracts but will be informed by a full competitive tender process.

Trajectory and Funding

<table>
<thead>
<tr>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>OP</td>
<td>976</td>
<td>829</td>
<td>778</td>
</tr>
<tr>
<td>TTG</td>
<td>1120</td>
<td>988</td>
<td>856</td>
</tr>
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</table>

<table>
<thead>
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<th>Funding Allocation</th>
<th>£000’s</th>
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<th>If recurring, full year cost £000’s</th>
<th>Comments</th>
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</thead>
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<tr>
<td>Senior Clinical Fellows x3</td>
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<td>207</td>
<td>Continuation of previous commitment</td>
</tr>
<tr>
<td>PROMS Post</td>
<td>35</td>
<td>Yes</td>
<td>35</td>
<td>Continuation of previous commitment</td>
</tr>
<tr>
<td>F&amp;A Post</td>
<td>144</td>
<td>Yes</td>
<td>144</td>
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</tr>
<tr>
<td>GPwSI</td>
<td>88</td>
<td>Yes</td>
<td>88</td>
<td>Continuation of previous commitment</td>
</tr>
<tr>
<td>ERAS</td>
<td>52</td>
<td>Yes</td>
<td>52</td>
<td>Continuation of previous commitment</td>
</tr>
<tr>
<td>Physiotherapy Posts</td>
<td>55</td>
<td>Yes</td>
<td>55</td>
<td>Continuation of previous commitment</td>
</tr>
<tr>
<td>IJB Podiatry Posts</td>
<td>244</td>
<td>Yes</td>
<td>244</td>
<td>Continuation of previous commitment</td>
</tr>
<tr>
<td>Hand therapy posts</td>
<td>52</td>
<td>Yes</td>
<td>52</td>
<td>Continuation of previous commitment</td>
</tr>
</tbody>
</table>
### Urology

The Urology service year two plan involves continuing the expansion commenced in year 1 by adding a further consultant post with matched expansion into pathology and radiology. In addition we wish to expand the specialist nursing establishment by three posts which will have a significant impact on cancer performance, sustainability and Cystoscopy performance.

Please note that there is an assumption that the activity delivered via the Vanguard Theatre at Stracathro will continue to be delivered on a recurring basis via the Stracathro Site whether this be via the Vanguard theatre or not.

#### Trajectory and Funding

<table>
<thead>
<tr>
<th></th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>OP</td>
<td>308</td>
<td>85</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>TTG</td>
<td>30</td>
<td>30</td>
<td>30</td>
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#### Funding Allocation

<table>
<thead>
<tr>
<th>Funding Allocation</th>
<th>£000's</th>
<th>Recurring?</th>
<th>If recurring, full year cost £000's</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant Post (Vanguard)</td>
<td>150</td>
<td>Yes</td>
<td>150</td>
<td>Continuation of previous years commitment</td>
</tr>
<tr>
<td>Specialist Nurses x3</td>
<td>159</td>
<td>Yes</td>
<td>159</td>
<td></td>
</tr>
<tr>
<td>Additional Consultant</td>
<td>239</td>
<td>Yes</td>
<td>234</td>
<td>Includes 87k recurring and 5k non-recurring for matched radiology and pathology expansion</td>
</tr>
<tr>
<td>Total</td>
<td>548</td>
<td></td>
<td>543</td>
<td></td>
</tr>
</tbody>
</table>

### Restorative Dentistry

Restorative Dentistry was supported by a hygienist and associated nursing support in last year’s plan on a recurring basis. No further support requirement is anticipated.

#### Trajectory and Funding

<table>
<thead>
<tr>
<th></th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>OP</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Haematology

Historically Haematology has not had a significant outpatient waiting list issue but it has seen an increasing demand in terms of numbers, complexity, and treatment options that is adding strain to the service. The current performance is only being maintained by systematic and significant overbooking of clinic capacity based on staff good will. This is not a sustainable service and is at risk of significant deterioration if the service booked as per recommended templates. In a year approximately 184 new patients and 1,860 return appointments were overbooked in the malignant haematology service.

The two consultant posts suggested will allow the service to maintain its trajectory within core capacity.

Trajectory and Funding

<table>
<thead>
<tr>
<th>Quarter</th>
<th>OP</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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</tr>
<tr>
<td>2</td>
<td>0</td>
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<tr>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>4</td>
<td>0</td>
</tr>
</tbody>
</table>

Paediatric Anaesthetic Expansion

There is currently a national shortage of paediatric anaesthetics and this presents a growing challenge within Grampian. A SLWG has examined the options and recommended increasing the establishment of the paediatric anaesthetic service to:

- Create service sustainability
- Increase capacity
- Increase recruitment changes by reducing the on call commitment

Failure to recruit to these vacancies, which is considered unlikely without the expanded capacity, is likely to have significant impact on paediatric TTG flow as emergency and urgent work will be prioritised.
### c. Core supporting capacity

A number of underlying support projects are also requested for continued support

<table>
<thead>
<tr>
<th>Funding Allocation</th>
<th>£000’s</th>
<th>Recurring?</th>
<th>If recurring, full year cost £000’s</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preassessment Nursing Capacity</td>
<td>16</td>
<td>Yes</td>
<td>16</td>
<td>To cope with the additional pre-assessment workload associated with both increasing activity and increasing complexity with multiple sites. This will also reduce reliance on WLI workload</td>
</tr>
<tr>
<td>Anaesthetic and Pharmacy Preassessment Capacity</td>
<td>170</td>
<td>Yes</td>
<td>170</td>
<td></td>
</tr>
<tr>
<td>Waiting Times Team</td>
<td>71</td>
<td>No</td>
<td></td>
<td>To cope with the additional out of area workload and private sector referrals this would add sustainability. We expect this to also be required in the year 3 plan</td>
</tr>
<tr>
<td>Private Sector Contract Manager (0.5 b6)</td>
<td>22</td>
<td>No</td>
<td></td>
<td>We have multiple private sector contracts which carry a significant workload to setup and successfully monitor. This post will smooth this process</td>
</tr>
<tr>
<td>WLI Budget</td>
<td>1,100</td>
<td>No</td>
<td></td>
<td>The flexible use of this budget has proved useful and successful over multiple years</td>
</tr>
<tr>
<td>Agency Nurse Staffing</td>
<td>1,750</td>
<td>No</td>
<td>Only into year 3</td>
<td>Year 2 will continue to require the use of agency nurses to support both general and specialist surgical elective activity.</td>
</tr>
<tr>
<td>Elective Resources Manager</td>
<td>75</td>
<td>Yes</td>
<td>75</td>
<td>This is a continuation of previous commitment</td>
</tr>
<tr>
<td>Pathology Redesign</td>
<td>400</td>
<td>Yes</td>
<td>400</td>
<td>This is a continuation of previous commitment</td>
</tr>
<tr>
<td>Outpatient Nurses</td>
<td>158</td>
<td>Yes</td>
<td>158</td>
<td>Matched expansion of the workforce around additional core clinical capacity</td>
</tr>
<tr>
<td>Anaesthetics (2)</td>
<td>270</td>
<td>Yes</td>
<td>270</td>
<td>This is a continuation of previous commitment</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4,032</strong></td>
<td></td>
<td><strong>1,089</strong></td>
<td></td>
</tr>
</tbody>
</table>
d. Best practice and efficiency

In addition to the above actions we are committed to achieving optimum use of our resources through the following:

Access QI

As a key component of the delivery of a sustainable Waiting Times Improvement Plan, NHS Grampian has committed to a new programme of work focused on building quality improvement expertise. The programme will sustainably improve waiting times performance across three key specialties: gynaecology, urology, and dermatology. Building QI methodology knowledge and DCAQ management capacity within our teams and across pathways will facilitate the sharing of learning and good practice across the organisation.

The programme is supported by the newly launched Scottish Flow Academy and will bring together existing national programmes to ensure consistency of approach and promotion of best practice across a number of work streams to maximise outputs.

The programme formally launches on 30th October 2019.

Scottish Access Collaborative

NHS Grampian has fully participated in each of the six agreed specialty pathways and contributed towards identification of best practice, understanding and addressing variation, and agreeing key challenges and opportunities.

Each specialty group has agreed a number of key recommendations to support sustainable improvements to the agreed pathways. NHS Grampian is committed to reviewing and implementing appropriately the recommendations from each of the specialty reports. This work will be undertaken as part of the wider Acute Redesign and Transformation programme. This will maximise the impact on waiting times performance through consolidating learning across the organisation, prioritising key areas for improvement and aligning a number of work streams seeking to address similar challenges. This includes the nine ‘Endorsed Challenges’ agreed by the Scottish Access Collaborative.

Productivity and Efficiency

NHS Grampian is under ever-increasing pressure from rising demand for elective surgery, the availability of beds and workforce challenges against the backdrop of continuing financial challenges. More than ever we need to use our existing resources as effectively and efficiently as possible to meet the needs of the population of NHS Grampian.

In response, we set out our commitment in 2019/20 to realising opportunities that exist through productive and efficiency improvements and the additional capacity this can provide. This will continue in years 2 and 3.

NHS Grampian is committed to increasing the percentage of BADS procedures carried out as day cases or outpatients and is 1 of 4 Health Boards piloting the use of Variability Methodology to support this commitment. This programme embraces
the principle of a whole system approach and is working with both medical and surgical specialties across NHS Grampian. Day case rates have increased by over 4% since 2018, saving almost 800 bed days.

Since April 2017, 2,500 bed days have been saved through the redesign of day of surgery admission across over two thirds of surgical specialties. Continued rollout to the remaining specialties to achieve 90% admission on day of surgery will release up to an additional 1,740 bed days in 2020/21.

**Improvements to theatre productivity and efficiency across all acute sites over the last 24 months** has reduced late starts and early finishes by over 700 hours. This work has been supported by the Acute Sector Improvement Team which has been funded via non-recurring financial support which we require to make recurring. This is separate and distinct from the SAC funding package.

<table>
<thead>
<tr>
<th>Funding Allocation</th>
<th>£000’s</th>
<th>Recurring?</th>
<th>If recurring, full year cost £000’s</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Sector Improvement Team (1 wte 8A and 1 wte 8B)</td>
<td>140</td>
<td>Yes</td>
<td>140</td>
<td></td>
</tr>
</tbody>
</table>
Section 2: Diagnostics

Access to diagnostics is pivotal to the delivery of waiting times. In March 2019, the National Endoscopy Action Plan was published to set out key deliverables for the next 24 months:

- **By Spring 2021**
  - 90% of new patients will wait no more than 6 weeks for one of the four key endoscopic tests:
    - Upper Endoscopy;
    - Lower Endoscopy (including colonoscopy);
    - Colonoscopy; and
    - Cystoscopy.
  - The most urgent patients (including ‘urgent suspicion of cancer’ and from the national bowel screening programme) are prioritised referral pathways.
- **By Spring 2022**
  - 100% patients will wait no more than 6 weeks.

NHS Grampian is committed to sustainably delivering waiting times for all diagnostic, therapeutic and surveillance endoscopy by 2022. In seeking to achieve this, the Endoscopy Sustainability and Recovery Plan (January 2019) outlines three phases which are detailed within the diagnostics section of this plan:

- Clearing the existing backlog and factor in demand growth as waiting times reduce;
- Sustaining waiting times adjusting for changes in demographics; and
- Withdrawal from independent sector provision.

Endoscopy

The year two plan starts to build sustainability by adding a substantive consultant and Clinical Fellow as recurring posts with a view to adding a second of both within the year three plan. In addition specific non-consultant expansion is supported around the sustained increase in bowel screening demand that has been seen across Scotland.

A further IS contract to reduce the backlog of routine patients is anticipated, along with an increased anaesthetic service delivery to support a reduction of the longest waiting patients.
<table>
<thead>
<tr>
<th>Funding Allocation</th>
<th>£000’s</th>
<th>Recurring?</th>
<th>If recurring, full year cost £000’s</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recurring Posts</td>
<td>138</td>
<td>Yes</td>
<td>138</td>
<td>Continuation of previous commitment</td>
</tr>
<tr>
<td>Matched expansion of decontamination unit</td>
<td>92</td>
<td>Yes</td>
<td>92</td>
<td></td>
</tr>
<tr>
<td>Surveillance revalidation and pre-assessment nurse</td>
<td>43</td>
<td>Yes</td>
<td>43</td>
<td>Continuation of previous commitment</td>
</tr>
<tr>
<td>Bowel Screening – Band 5 Nurse and admin support</td>
<td>71</td>
<td>Yes</td>
<td>71</td>
<td></td>
</tr>
<tr>
<td>Endoscopy Consultant and clinical fellow</td>
<td>220</td>
<td>Yes</td>
<td>220</td>
<td></td>
</tr>
<tr>
<td>Anaesthetic Cover for GA lists</td>
<td>19</td>
<td>Yes</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>IS Weekend Lists</td>
<td>497</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1,080</td>
<td></td>
<td>583</td>
<td></td>
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</tbody>
</table>

**Radiology**

**CT**

Our performance and recovery of our CT position is entirely reliant on staff doing significant volumes of additional work. This is not a sustainable solution. The investment in additional HCSWs will allow this work to be transferred to a sustainable team. This will maintain the current position and improve it for all general CT patients. Should staff stop doing additional work we anticipate a negative impact of 225 patients per month leading to an alternative end of year position of 2,700.

The remaining tail of patients are Cardiac CT patients which we will seek to address in our year 3 plan.

<table>
<thead>
<tr>
<th>Funding Allocation</th>
<th>£000’s</th>
<th>Recurring?</th>
<th>If recurring, full year cost £000’s</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>6 HCSW</td>
<td>180</td>
<td>Yes</td>
<td>180</td>
<td></td>
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<tr>
<td>Total</td>
<td>180</td>
<td></td>
<td>180</td>
<td></td>
</tr>
</tbody>
</table>
MRI

There is going to be a significant reduction in our MRI waits in Year 1 Q3 and Q4 due to the introduction of an additional mobile MRI van adding to our core capacity. We anticipate we will continue to require this IS support at a reduced rate to maintain this position through Year 2 pending capacity expansion via the Elective Care Programme.

The remaining tail of long waiting MRI patients are Cardiac MRI patients which we will seek to address in the year 3 plan.

<table>
<thead>
<tr>
<th>Funding Allocation</th>
<th>£000’s</th>
<th>Recurring?</th>
<th>If recurring, full year cost £000’s</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>Mobile MRI</td>
<td>675</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>675</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Imaging Diagnostics In General

For multiple years a band 3 post has been supported via WTIP funding to ensure cancer patients are prioritised. This post has been very successful and we are keen to transfer this to a permanent, recurring funded post.

We would like to introduce an 8A consultant Radiographer Post which will expand our reporting skills, training (of additional radiographers in advanced skills including reporting) and capability across the service. This post will impact on the turnaround of reporting which will have a direct impact on cancer pathways.

In addition we would like to pilot a Band 7 post which will focus on demand management, in line with the principles of realistic medicine. A recent piece of work successfully identified outliers in terms of referral numbers and successfully reduced this demand. We would like to support a one year fixed term post to identify if recurring efficiency savings can be generated by such a post. Should this be evaluated positively we would submit a recurring funding request within the Year 3 plan.

<table>
<thead>
<tr>
<th>Funding Allocation</th>
<th>£000’s</th>
<th>Recurring?</th>
<th>If recurring, full year cost £000’s</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer Tracker</td>
<td>30</td>
<td>Yes</td>
<td>30</td>
<td>Recurring from previous plans</td>
</tr>
<tr>
<td>Realistic Medicine Post - Test</td>
<td>53</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultant Radiographer Post – 8A</td>
<td>65</td>
<td>Yes</td>
<td>65</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>148</td>
<td></td>
<td>95</td>
<td></td>
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</table>
## Diagnostic Trajectory 2020/21: Patients Waiting More Than 6 Weeks

<table>
<thead>
<tr>
<th>Standard</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
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</thead>
<tbody>
<tr>
<td>MRI</td>
<td>140</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>CT</td>
<td>90</td>
<td>80</td>
<td>80</td>
<td>80</td>
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<tr>
<td>Ultrasound</td>
<td>79</td>
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</tr>
<tr>
<td>Barium Studies</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Radiology Total Over 6 Weeks</strong></td>
<td><strong>309</strong></td>
<td><strong>180</strong></td>
<td><strong>180</strong></td>
<td><strong>180</strong></td>
</tr>
<tr>
<td>Uppers, Lowers, Colons</td>
<td>466</td>
<td>193</td>
<td>80</td>
<td>50</td>
</tr>
<tr>
<td>Cystoscopy</td>
<td>213</td>
<td>213</td>
<td>117</td>
<td>18</td>
</tr>
<tr>
<td><strong>Endoscopy Total Over 6 Weeks</strong></td>
<td><strong>309</strong></td>
<td><strong>180</strong></td>
<td><strong>180</strong></td>
<td><strong>180</strong></td>
</tr>
<tr>
<td>Diagnostic Total Over 6 Weeks</td>
<td>988</td>
<td>586</td>
<td>377</td>
<td>248</td>
</tr>
</tbody>
</table>
Section 3: Cancer

NHS Grampian is committed to ensuring that all those who require treatment for cancer should receive that treatment as soon as clinically appropriate. Improving cancer performance remains a Board priority as outlined within the Annual Operational Plan 2019/20.

NHS Grampian acknowledges that improvement against both 31 and 62 day standards is required. (Year 1 Quarter 2 results 62 day = 82% and 31 day= 96%) The funding and recruitment of the personnel below will allow us to continue to stabilise our position and make improvements during 2020/21. Some of these posts were part of our Year 1 request for funding that were not successful. Not having the key clinical and support staff in post have caused a delay in our current improvement.

Particular focus remains on colorectal and urology pathways which combined account for 66% of the 31-day fails and 66% of the 62-day fails in the second quarter of 2019.

The additional independent sector capacity in Endoscopy will ensure that all USC patients will only wait 10/12 days for a scope. This will also help with reducing the wait for Screening Colonoscopies that currently sits at 5/6 weeks down from a high of 12 weeks in Dec 2018.

In order to address short-term capacity challenges and develop sustainable cancer performance improvement over the next 12 months the following bids are required. Funding is only identified where this has not been included in the relevant speciality (TTG & NOP) section of the plan.

<table>
<thead>
<tr>
<th>Bid</th>
<th>2020/21 Recurring Funding Requirement (£000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 WTE Urology Specialist Nurses Band 7</td>
<td></td>
</tr>
<tr>
<td>2 WTE Colorectal Specialist Nurse Band 7 Training - Non recurring</td>
<td></td>
</tr>
<tr>
<td>1 WTE Plastic Specialist Nurse Band 7</td>
<td></td>
</tr>
<tr>
<td>1 WTE Bronchoscopy/Clinic Nurse Band 6</td>
<td></td>
</tr>
<tr>
<td>Additional Cancer diagnostic clinics</td>
<td></td>
</tr>
<tr>
<td>1 WTE Gynaecology Specialist Nurse Band 7</td>
<td></td>
</tr>
<tr>
<td>0.5 WTE Band 5 Nurse</td>
<td></td>
</tr>
<tr>
<td>0.5 WTE Band 2 Nurse</td>
<td></td>
</tr>
<tr>
<td>0.5 WTE Band 3 Secretary.</td>
<td></td>
</tr>
<tr>
<td>1.0 WTE Cancer Tracker Band 3 (Dr Grays)</td>
<td>15</td>
</tr>
<tr>
<td>1.0 WTE Cancer Tracker Band 3 (ARI) – continuation of commitment from current year</td>
<td>30</td>
</tr>
<tr>
<td>1 WTE Consultant Plastic Surgeon with associated costs including secretary, radiology and pathology</td>
<td></td>
</tr>
<tr>
<td>1 WTE Colorectal Surgeon with associated costs including secretary, radiology, OP admin and pathology</td>
<td></td>
</tr>
<tr>
<td>1 WTE consultant Urologist with associated costs including secretary, OP admin support, radiology and pathology.</td>
<td></td>
</tr>
<tr>
<td>Physician Associate for Breast Service</td>
<td>48</td>
</tr>
<tr>
<td>Breast – Weekend Clinics (non-recurring) (included in WLI Budget)</td>
<td></td>
</tr>
<tr>
<td>2 WTE Consultant Haematologists</td>
<td></td>
</tr>
<tr>
<td>Head of Cancer</td>
<td>107</td>
</tr>
</tbody>
</table>
The matched expansion of Radiology and Pathology to support the consultant expansion in Colorectal (two posts), Urology and Plastics comprises:

- **Radiology**
  - Consultant Radiologist
  - Secretarial Support
  - Radiographer
  - Nurse Support
  - Admin Booking
  - Soliton VC Revenue

- **Pathology**
  - Consultant Pathologist (0.8wte)
  - Band 6 Scientist (0.8wte)
  - Admin 0.4wte
  - Secretary 2.8wte

### Section 4: Mental Health

Within this section we set out how we will achieve the following performance standards:

- Set out the Trajectory showing how the CAMHS Standard (90%) will be delivered by end 2020.
- Set out the Trajectory showing how the PT Standard (90%) will be delivered by end 2020.
- Set out the Trajectory showing how the ED – Mental Health Standard (95%) will be delivered by end 2020.

### Child and Adolescent Mental Health Services (CAMHS)

A CAMHS whole system redesign has been implemented in Grampian and is now nearing conclusion. After an extensive organisational change and engagement process (involving key partners, staff, patients and carers), the CAMHS services have now been redesigned for all children and young people aged between 0-18 years including learning disabilities. This will enable the service to provide safe, effective, equitable and efficient care regardless of age or location of the patient requiring to access services.

The redesign has supported the following key changes:

- NHS Grampian uses the Choice and Partnership Approach (CAPA). The CAMHS service has fully implemented the CAPA model which enables the service to flex capacity to meet demand. CAPA also enables the CAMHS service to provide a more responsive and equitable service with no internal waits. This model maximises efficiency within the workforce by transparent and clear job planning for all grades of staff. The CAMHS national referral
criteria was implemented across the service in early 2017 and the service now accepts referrals from a wider range of professionals such as health visitors and school staff. The referrals will therefore now all be screened by the same five clinical staff from our new Unscheduled Care Team for a six month pilot to assure consistent decision making.

- We now have a standard referrals process which follows the national CAMHS referral guidance as produced by the Scottish Government. Revised referrals guidance document has been produced and is being utilised. CAMHS now receives referrals from a wider range of professionals such as School Nurses, Head Teachers and Health Visitors.
- We have expanded the multi-disciplinary team employing a speech and language therapist, a physiotherapist, dietician and occupational therapists. We have appointed to all posts across the service and we do not have any problems currently recruiting to vacant posts. There can be a lag in employing some newly qualified staff due to course completion dates and recruitment processes.
- A new strategic multi-agency meeting has been commissioned focused on supporting mental wellbeing in order to prevent mental ill health. The main areas of focus are to deliver standardised training for the parenting programmes, adverse childhood events (ACEs) and anxiety reduction across the region.

In terms of further steps, £1m was granted from the Scottish Government Health and Care Directorate to facilitate the co-location of the CAHMS services for Aberdeen and Aberdeenshire on a single site. The new facility opened in June 2019 and is already providing many new benefits to patients, and staff. In addition provides increased capacity and space to house new staff to ensure the workforce has enough clinical space to see patients.

The service aims to be a regional ‘CAMHS Centre of Excellence’ which can ensure equitable and efficient healthcare. CAMHS NHS Grampian strives to be a source of locally accessible expertise to families and the wider services around the child, and to offer targeted specialist care.

There has been an overall improvement in waiting times over the last year. Children who have been referred are prioritised and all emergency cases are seen within 48 hours; all urgent cases are seen within 7 days. Additional clinics have also been offered to all staff in CAMHS for this quarter to help reduce longest waits (which are mainly for neurodevelopmental conditions). The funding to support this has come from the Taskforce.

It is of note that the CAMHS service currently counts the second appointment (Partnership) as start of treatment despite the fact that the initial appointment (Choice) includes a treatment plan and clear formulation, or self help advice. The waits in Aberdeen City and Aberdeenshire for Choice appointment are all now all currently less than 8 weeks. The wait to second appointment (Partnership) is 6-8 weeks. There are however a number of vacancies due to staff recently leaving posts at present so waits may change slightly.

The table below summarises the waiting times position under the CAPA model.

<table>
<thead>
<tr>
<th></th>
<th>Wait to CHOICE (assessment)</th>
<th>Wait to Partnership (Generic Treatment)</th>
<th>Wait to URGENT CHOICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aberdeen City</td>
<td>5 weeks</td>
<td>8 weeks</td>
<td>2 days</td>
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<tr>
<td>Aberdeenshire</td>
<td>6 weeks</td>
<td>8 weeks</td>
<td>2 days</td>
</tr>
<tr>
<td>Moray</td>
<td>21 weeks</td>
<td>5 weeks</td>
<td>15 days</td>
</tr>
</tbody>
</table>

We can now confirm that all patients in Aberdeen City and Aberdeenshire are meeting the 90% target - first appointment within 8 weeks and second appointment by 16 weeks.
In relation to the CAHMS service in Moray, a detailed action plan has been discussed and developed with the MHAIST team. In Moray all patients now seen for first appointment with 21 weeks (was 29, last quarter 25 weeks and this quarter 21 weeks). By next quarter it will be reduced further. The time to second appointment is 6 week. We continue to work with MHAIST and there is approval for the Moray service to run additional evening or weekend choice clinics to reduce waits

With the support of MHAIST and the local team we anticipate a more HUB type role to support the Moray service and new staff are being recruited

Patients with a neurodevelopmental problem such as ADHD and ASD are waiting the longest and we have collaborated with MHAIST to develop a plan to reduce the waiting times. Extensive demand and capacity modelling based on CAPA has been undertaken to streamline the service capacity.

Additional core clinic capacity has also been introduced over the next three to six months to address the backlog of patients waiting.

‘Attend Anywhere’ virtual appointments system has been implemented to ensure patient and staff travel to appointments or multi-agency meetings is reduced. Recent outcome data about Attend Anywhere from other services is positive and we expect this to be fully operational in CAHMS following the move to the new Centre of Excellence.

The CAMHS team have a workforce plan, DCAQ analysis, and CAPA planning that enables the service to detail the impact of work undertaken and to be taken going forward.

With regards to PT there has been no Director of Psychology post in Grampian for 18 months. Although the lead psychologists from each area (Learning Disabilities, Adult, Specialisms, Acute, Old Age, and CAMHS) have been covering these roles there has been no consistent oversight or leadership for PT. This post is due to be advertised shortly and the post holder will be able to support the details of developing the AOP for PT.

**Psychological services**

As indicated due to issues with the data for the service we are not at this stage able to provide an accurate trajectory to improve performance. We have prioritised this work and we advise of progress. Irrespective we remain committed to the following actions to improve performance in the interim:

1. The appointment of a Director of Clinical Psychology

2. In terms of staffing our current position is as follows:

   - Aberdeen City - there are no vacancies in the secondary care service and we are looking to appoint to the one vacancy in primary care which if filled would significantly reduce waiting times across that service.
Bereenshire - there is one 0.6 whole time equivalent (wte) 8B vacancy and one 0.7 wte 7/8A vacancy in secondary care. In Primary care there is one 1.0wte Band 6 post out to advert and all other vacancies are filled.

Moray has one current vacancy in secondary care and one in primary care.

3. Using Action 15 monies in both City and Aberdeenshire we are developing posts (4 in City, 9 in Shire) for Band 5 mental wellbeing workers who will support the Tier 1 patients and also reducing waiting times at tier 2 by providing interventions at an early stage, preventing deterioration for many patients.

Emergency Department

As a Board we are generally compliant with the ED standard – in 2018/19 this was 94.4% and 95.1% in the previous year. One of the breach reasons is 'Wait for Specialist - Psychiatry' which we monitor. However this does not take into account all the MH presentations to the ED we are looking at whether our systems could capture a wider set of data in relation to MH patients. This will provide further assurance as to our performance against the 95% standard.
## Appendix 1: TTG and outpatient trajectories

### Outpatients

<table>
<thead>
<tr>
<th>Speciality</th>
<th>June</th>
<th>September</th>
<th>December</th>
<th>March</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENT (Adult)</td>
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</tr>
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</tbody>
</table>
*Note 1: We have applied an optimism bias of 2,000 patients. Every service trajectory has been supplied by each service but we are aware from experience that these will reflect a range of risk profiles in terms of deliverability. We are also aware that as the overall waiting list is built down sub-speciality issues will become more important and pressing and these get progressively harder to model and to mitigate for in terms of delay or change.

Note 2: The overall total figures have been rounded up to the nearest 10.

### TTG

<table>
<thead>
<tr>
<th>Speciality</th>
<th>June</th>
<th>September</th>
<th>December</th>
<th>March</th>
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Total: 3510 3030 2590 2210

*Note 1: There has been an optimism bias of 750 applied as per the rational in OP
Note 2: The overall totals have been rounded up to the nearest ten.
Handling and Learning
From Feedback Annual Report

2017 - 2018

NHS Grampian
Caring – Listening – Improving
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**Section 1 - Encouraging and Gathering Feedback**

1.1 - Methods used to encourage feedback:
NHS Grampian values all feedback and is committed to ensuring that the information and learning gathered from all our feedback systems informs the aspiration of continuous improvement and the further development of a person centred approach to service planning. NHS Grampian encourages and receives feedback through a variety of sources:

- Feedback Cards – with a prepaid, addressed envelope (available in all clinical areas).
- Letters (received in clinical areas, addressed to the Feedback Service or the Chief Executive).
- E-mails (received through the Feedback Service’s email address - available on NHS Grampian’s website, information leaflets and feedback cards, through the Chief Executive’s email address, through the general NHS Grampian contact address on the website or directly to senior officers)
- Phone calls (received directly by the Feedback Service or redirected from anywhere in the organisation).
- Letters and email correspondence from MSPs and MPs on behalf of members of the public.
- Letters from the Patient Advice and Support Service on behalf of members of the public.
- Letters from the Advocacy Services in the Grampian area on behalf of members of the public.
- NHS Grampian’s email address.
- NHS Grampian’s Website.
- Facebook.
- Twitter.
- Care Opinion Website.

**Care Opinion (Previously called Patient Opinion):**
A valuable mechanism through which patients and members of the public can give feedback on their experiences is by posting comments on the Care Opinion Website. Patient Opinion was launched in 2013, and changed its name to Care Opinion in 2017. It is a great addition to NHS Grampian’s other feedback mechanisms.

Work is continuing to encourage services to promote Care Opinion as a way of listening to patients relatives, friends, carers, advocates, volunteers and even staff who would like share their stories to help make a difference.

Corporate Communications also help raise awareness of Care Opinion through social media, and have recently won an award for their work promoting this – please click on the link to see the poster: [http://www.nhsgrampian.org/nhsgrampian/files/SocialMediaQualityEventPoster.pdf](http://www.nhsgrampian.org/nhsgrampian/files/SocialMediaQualityEventPoster.pdf)

Care Opinion reports are presented quarterly at the Engagement and Participation Committee. Between 1 April 2017 and 31 March 2018, 330 stories were posted on Care Opinion about NHS Grampian. These stories have already been viewed 679,300 times; this is a considerable increase from the 281 stories posted in 2016/17, which were viewed 321,215 times.
Please see graphs below for more information about Care Opinion posts about NHS Grampian:

**Number of Complaints, Compliments and Care Opinion Posts Received**

- Complaints
- Compliments
- Care Opinion Posts

**Care Opinion Stories Posted**

- Care Opinion Posts

**Care Opinion Story Views**

- Care Opinion Views

**Percentage of Positive Care Opinion Stories**

- Care Opinion Percentage Views Positive
Real Time Experience:
Person-centred care is an integral part of the Quality Ambition for NHS Scotland and is described within the Quality Strategy as: ‘care which delivers mutually beneficial partnerships between patients, families and those delivering health care services.’ This care needs to reflect individual needs and values and demonstrate compassion, continuity, clear communication and shared decision making.

We involve the public and ask for views and feedback in a number of ways before, during and after care:

- Involved in decisions.
- Family and carer involvement.
- Involved in ward rounds.
- Real time feedback.
- Discharge portfolio and ticket home.
- Patient diaries.
- Viewpoint – electronic questionnaire units.
- Getting to know me/Must dos with me.
- Patient Admission/Assessment Document.
- Care planning.
- Care Assurance Tool.
- Verbal feedback
- Care Opinion
- Telephone follow up
- Patient postcards
- Survey/audit work
- National surveys
- Public involvement – Participation Standard.
- Patient Action Co-ordination Team (PACT).

A huge range of activity is underway to embed person-centeredness in the care delivered in NHS Grampian. The above mentioned activity is not exhaustive and there are many other person-centred activities being undertaken independently by various staff groups.

1.2 - Making people feel their feedback is welcomed:
Local processes and procedures have been developed to ensure they are efficient and fully comply with the principles and policy intentions of the Patient Rights (Scotland) Act 2011, which means we ensure that they:

- Encourage, welcome and view feedback, comments, suggestions, concerns and complaints as opportunities for ensuring we provide person centred care.
- Promote learning and improvements from all forms of feedback.
- Are effective, fair and consistently applied.
- Are easily accessible to all and that information is available in other formats where this is required.

Everyone who provides feedback should be thanked verbally or through an acknowledgement letter or email. NHS Grampian appreciates all learning opportunities that service users provide us with, and would like everyone who gives feedback to know that we value the time it has taken for them to tell us about their experience.
1.3 - Engaging with equalities groups:
The Patient Advice and Support Service (PASS) provides free, confidential information, advice and support for anyone wishing to give feedback about the treatment and care provided by the NHS in Scotland. NHS Grampian and representatives of the PASS work collaboratively to ensure that patients and equalities groups are aware of this service and are appropriately supported to give feedback. PASS activity, performance reports and case studies are shared and discussed to demonstrate how patients’ needs are being met in Grampian.

Local support is also available to people who wish to give feedback through local Advocacy Services. PASS and Advocacy services are publicised on NHS Grampian’s website and information and contact details are given to members of the public over the phone by the Feedback Team. PASS leaflets are available in health points and our complaint acknowledgment letters also give information about the support PASS can offer.

Involvement and consultation with our local equality and diversity communities:

Meeting the health care needs of our equality and diversity communities is an integral part of our comprehensive healthcare service. In addition, we also carry out specific targeted healthcare work and campaigns to benefit these communities.

When developing equality objectives, we meet our legal duty to involve people with a relevant protected characteristic and their representative organisations. We also consider other evidence relating to people with a protected characteristic.

To help us take this work forward, NHS Grampian has three Groups and one Committee with wide community representation. The Racial Equality Working Group drives forward the racial equality agenda. The Disability Discrimination Act Review Group address disability and age related issues. The Diversity Working Group addresses issues relating to sex (male or female), sexual orientation, gender reassignment, pregnancy and maternity and marriage and civil partnership. The Spiritual Care Committee addresses religious and faith issues. We also carry out regular involvement and consultation events.

Foreign language communication:
When healthcare is provided, it is important to ensure that effective two way communication arrangements are in place. Our local ethnic communities now make up 13.5% of the population of Grampian. Our annual involvement events and other research carried out jointly with the Grampian Regional Equality Council have shown that over 90% of recent migrant workers and their families are non-English speaking when they first arrive in Grampian. This barrier to communication is overcome in a number of ways:

“Language Line” telephone interpretation:
This gives staff access to expert interpreters, on the telephone in 60-90 seconds for over 170 different languages. It is live in over 1,000 locations across NHS Grampian and was used on 7,084 occasions in 2017. Every clinic, Hospital and GP Practice in Grampian is equipped and over 4,500 staff have been trained in its use.
“Face to face” interpreters:
NHS Grampian has funded the training of 154 “face to face” qualified interpreters who were used on 2,684 occasions in 2016/17.

Materials in translation:
All requests for materials in translation are met. In addition, a wide range of local healthcare information is available pre-translated. On average, we translate 5 pieces of personal healthcare information per week, mostly from Eastern European languages into English, to help staff understand the previous treatments and health issues of patients.

Communication disability:
The 2011 Census showed that one in five of the population of Grampian have a communication disability. The measures NHS Grampian has put in place help people with a communication disability include:

- For people who are deaf, all four qualified British Sign Language (BSL) interpreters in Grampian are under contract to NHS Grampian. All requests for BSL interpretation are met.
- NHS Grampian is currently expanding the availability of BSL by the introduction of Video BSL to supplement our “face to face” BSL service.
- For people who use a hearing aid, over the last four years, NHS Grampian has purchased and issued over 250 Portable Induction Loops. We also provide more specialist equipment for in-patients.
- For people with a Learning Disability or Aphasia (the partial or total loss of the ability to communicate verbally or using written words) accessible/pictorial is provided. All requests for accessible/pictorial material are met.
- For people with a sight problem, all NHS Grampian published material complies with the Royal National Institute for the Blind “Good Practice Guidelines on making information accessible for people with a sight problem. All requests for information in large print, audio and Braille formats are met.

All NHS Grampian published material includes the offer at the front to make the information available in any other language or format, upon request and also give details of who to contact to obtain this.

1.4 - Publicising our feedback methods and ensuring people know what to expect:

Feedback methods are publicised on posters, feedback cards and on NHS Grampian’s public facing website. Other communication tools are used to promote opportunities to provide feedback.

These include Facebook, Twitter, articles in NHS News, a public facing news paper published twice a year. People can find out what to expect when they give feedback by the information given on the website, the information provided in acknowledgement letters and also through the advice offered over the phone.
1.5 - Streamlining the way feedback is recorded across the board:
The Feedback Service, Acute Sector, Mental Health Sector and other sectors throughout Grampian are continuously looking at ways to improve our feedback working practices, processes and procedures. This has occurred most recently with the introduction of the new Complaints Handling Procedure (CHP) April 2017.

The Feedback Team hold monthly meetings to discuss and improve the way we handle our complaints and how we can share learning that has been highlighted following the investigation of the complaint. Our Datix Complaints Module (electronic complaints recording system) has also been changed to assist the new processes and make it easier to extract the information and ensure the feedback and the issues raised are passed to the most appropriate member of staff. Meetings are also held with managers to ensure that the recording process is appropriate.

A ‘Complaints Lead’ protocol, which was written in 2016, is updated each year to include any changes and circulated to all managers who lead on investigations. A Scottish Public Services Ombudsman protocol, is also updated yearly, and helps to ensure we all work in an efficient and timely manner.

1.6 - Using feedback to identify improvement opportunities:
NHS Grampian encourages feedback and passes all forms of feedback to the relevant staff, to encourage sharing of patient experiences and providing valuable learning opportunities. To ensure learning occurs from feedback, service managers must demonstrate what the feedback tells them about their services; identify their learning opportunities for service improvement, and record actions taken as a result. Learning outcomes are documented on Datix and are included in Clinical Governance reports to demonstrate the learning and actions taken across NHS Grampian as a result of feedback.

Meetings are encouraged with staff and patients, relatives and carers, so that staff can learn firsthand how the care delivered has affected the people involved and what improvements can be introduced as a result.

The number of meetings with staff has increased over the last year, and staff are meeting complainants earlier in the complaints process, sometimes at first point of contact, as well as once the investigation has been completed. We are now recording on Datix how often meetings are offered and held to allow us to report on this going forward.

Section 2 - Encouraging and Handling Complaints
2.1 - Involving complainants to the level they wish:

When complaints are received over the phone, the Feedback Team ask if they would be happy for someone to contact them and if they would find a meeting helpful. The key issues are clarified during the call and the complainant is asked what they would like to happen as a result of their complaint.
Clinical treatment, sensitive and complex complaints are managed by a Complaints Officer, who will make contact with the complainant to clarify issues, explain the process and to ask if they would like a meeting. To help set expectations the timeline is explained and the complainant advised that complex or cross service complaints can take longer than 20 working days to complete due to a thorough investigation with all the appropriate staff involved.

Complaint Leads are increasingly making direct contact with complainants to provide a more person-centred approach to complaint handling, which helps to establish what the key issues are for the complainant. As outlined above, meetings are being offered at this stage to allow further discussion of the concerns raised, if desired by the complainant, and this would be followed by sending a written response to confirm the complaint outcome and any agreed actions to be undertaken by the service.

NHS Grampian has not received any requests for Alternative Dispute Resolution (ADR) to be provided during 2017/18, but the Complaints Officers attend complaint meetings to support complainants and staff as required. A Family Liaison role has recently been introduced, and is being developed as a single point of contact, independent to the Service Manager and Feedback Team to support families, if required.

2.2 - Encourage early resolution and ownership of complaints:
The Feedback Service continues to triage feedback as it is received to allow identification of non-clinical complaints that are suitable for early resolution. Email communication takes place with the relevant Complaint Lead on the day these complaints are received, to encourage quick investigation and resolution of the complaint by telephone.

2.3 - Measuring complainant satisfaction with the process:

Following the introduction of the new CPH in April 2017, NHS Grampian designed a questionnaire to gain feedback from complainants about their experience of raising a complaint. The questions asked allow us to produce a report on the new Key Performance Indicators (KPIs) that are described in the CHP.

We have a paper questionnaire to send out with responses, but also have an electronic questionnaire that is sent to complainants who have provided their feedback by email. Benefits of the electronic survey are that no postage is needed and it is easier to extract the data and reports.

NHS Grampian Complainant Experience Report

The Feedback Team sent an electronic survey link to 127 complainants asking them to give feedback about how satisfied they were with the handling of their complaint. We received 30 completed survey entries meaning a participation rate of 24%. The results of the survey were quite mixed but some areas showing large agreement from respondents on how they felt.
The results of the feedback received for question are shown below. This will be a good benchmark for going forward and we hope to have more views over the coming year and see improvements in satisfaction as we continue to improve our approach.

For each question people were asked to select either between four options (agree, disagree, neither agree or disagree or don’t know), or three options (yes, no, no answer).

**Q1, It was easy finding information on how to make a complaint to NHS Grampian:**

- Agree: 60%
- Disagree: 20%
- Neither agree or disagree: 10%
- Don’t know: 10%

**Q2, Submitting a complaint to NHS Grampian was easy:**

- Agree: 80%
- Disagree: 10%
- Neither agree or disagree: 10%
- Don’t know: 0%

**Q3, NHS Grampian staff dealing with my complaints were helpful, courteous and professional:**

- Agree: 50%
- Disagree: 30%
- Neither agree or disagree: 20%
- Don’t know: 0%
Q4, NHS Grampian staff listened and understood my complaint, showed empathy and apologised:

Q5, NHS Grampian staff checked what outcome I wanted:

Q6, I was given the information including timescales for responses etc, which explained the complaints process:

Q7, My complaints was handled in a timely manner and I was kept informed of any delays:
Q8, All my complaint issues were answered:

Q9, complaint response was easy to read and understand:

Q10, Overall I was happy with how my complaint was handled:

Q11, I raised concerns about how my complaint was handled:
Q12, Were your concerns addressed:

![Bar chart showing the responses to Q12.](chart.png)

2.4 - Learning from complaints relating to each area of the board:

Sector Leads are responsible for ensuring that their Complaint Leads record the learning identified and action taken in the appropriate fields in the Datix Complaints Module. The learning and actions fields are audited by the Feedback Service to ensure actions have been recorded, implemented, sustained and shared across the Organisation, as appropriate. Where there is limited information or a field is blank the Leads are contacted and asked to provide the relevant information.

Below is a summary of action taken as a result of complaints received 2017/18:

<table>
<thead>
<tr>
<th>Action taken as a result of complaints received 1 Apr 2017 - 31 Mar 2018</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access - Improvements made to service access</td>
<td>186</td>
</tr>
<tr>
<td>Action plan(s) created and instigated</td>
<td>121</td>
</tr>
<tr>
<td>Communication - Improvements in communication staff-staff or staff-patient</td>
<td>435</td>
</tr>
<tr>
<td>Conduct issues addressed</td>
<td>35</td>
</tr>
<tr>
<td>Education/Training of staff</td>
<td>99</td>
</tr>
<tr>
<td>No action required</td>
<td>368</td>
</tr>
<tr>
<td>Policy reviewed</td>
<td>18</td>
</tr>
<tr>
<td>Risk issues identified and passed on</td>
<td>39</td>
</tr>
<tr>
<td>System - Changes to systems</td>
<td>40</td>
</tr>
<tr>
<td>Share lessons with staff/patient/public</td>
<td>120</td>
</tr>
<tr>
<td>Waiting - Review of waiting times</td>
<td>104</td>
</tr>
<tr>
<td>Total</td>
<td>1565</td>
</tr>
</tbody>
</table>

NHS Grampian Complaints Response Times and Outcomes:

As of the 1 April 2017, the new CHP required that complaints are responded to within 5 working days to achieve Early Resolution, called ‘Stage 1’, and for ‘Stage 2’ complaints, are acknowledged within 3 working days and responded to in 20 working days.

Complaint Leads found adopting the new proactive way of resolving complaints quite challenging, in particular developing the confidence and skills to phone complainants and try and achieve resolution over the phone.

We are encouraged to learn that the amount achieved by Early Resolution has increased over the past few months. It has taken slightly longer than anticipated for the new process to be embedded into the working day of our staff.
The chart below illustrates the percentage of complaints closed at each stage, between April 2017 and March 2018. Most closed at stage 2 but between 17 and 41% were closed at stage 1. In addition between 3 and 29% of complaints were escalated.

The chart below illustrates response times by stage between April 2017 and March 2018. 84% of Stage 1 complaints were closed within five working days in April but this dropped to 27% by November before increasing to 70% in March.

Response rates were much lower for non-escalated Stage 2 complaints with well under a half of all complaints closed off within 20 working days in each month except March which reported significant improvement to 62%.

Response times were more variable for escalated complaints with two thirds closed off within 20 working days in April but only 22% in October.
Average response times, in working days, are illustrated in the chart below. For stage 1 the average is generally between five and eight working days but reached over 11 days in September.

The chart below illustrates outcomes for complaints closed at Stage 1. Over half of complaints were upheld in April, August and December but only 24% in February, when a higher proportion were partially upheld.
The chart below shows that a lower proportion of non-escalated Stage 2 complaints are upheld, under 40% each month.

The chart below shows that outcomes are more variable for escalated Stage 2 complaints. 67% were upheld in April and 69% in March compared to none at all in May. The majority are, however, either partially or fully upheld.
the total number of all feedback received by NHS Grampian over the last 5 financial years:

The Patient Experience complaint severity rating 1 Apr 2017-31 Mar 2018:

The types of issue complained about 1 Apr 2017-31 Mar 2018:

How complaints were resolved 1 Apr 2017 - 31 Mar 2018:
2.5 - The links between the management of selected complaints to the management of serious and adverse events:

The Feedback Manager attends a weekly Grampian wide Clinical Risk Meeting (CRM). This meeting is usually chaired by the Nursing Director or the Medical Director. Attendees include organisation leads for performance and governance, quality informatics, quality governance and risk, health and safety, infection control, organisational development, mental health and acute services.

The CRM allows for an overview and connections to be made for complaints and adverse events and for the Feedback Manager to raise concerns or seek support from the Directors if required.

When feedback or a complaint identifies a major or extreme event, or events, it is usual practice for the service involved to initiate a Significant Event Analysis (SEA). An SEA is an in-depth investigation into any event thought to be significant in the care of patients. Once the investigation is complete, a meeting is usually offered to the complainant and their family to discuss the findings, identifying any learning opportunities and actions to be taken, as required.

Appropriate investigation and follow-up of adverse events, near misses and complaints increases our knowledge of why these events happen and improves our ability to prevent them recurring. The opportunity to share transferable lessons from the outcomes of investigations is vital in the prevention of reoccurrence of similar events.

2.6 - Working with local independent contractors to monitor how feedback is used to drive improvements:

In line with the new CHP, we have amended the electronic questionnaire that we send to allow the collection of Independent Contractors (GPs, Dentists, Pharmacists and Opticians) so that the information gathered complies with the new KPIs provided.

The Feedback Service sends a group email, which has the contact details of all the independent contractors throughout NHS Grampian. The questionnaire is available for one month to allow Contractors to enter their complaints data.

As mentioned below in our Training Section, the Complaints Officers have completed complaints training and awareness sessions to various staff groups in Primary Care, including GPs, Practice Managers, Dental Consultants and Dental staff, and other various staff members throughout the Primary Care sector.
Section 3 - The culture, including staff training and development

3.1 - Challenges encountered in embedding a culture that actively encourages feedback:

To overcome challenges and to embed a culture that encourages all types of feedback, NHS Grampian appreciates the importance of:

- Local ownership and accountability, in terms of governance, in dealing with and learning from complaints.
- Adhering to national guidelines.
- A central team managing the feedback system, to ensure an overview of activity and for this team to be properly resourced.
- Managers and staff within services being clear of their roles and responsibilities in dealing with complaints - both formal and informal.
- The Feedback Team and the DATIX Team working collaboratively to ensure the effective use of the information management system, and to provide advice and support to the services.
- Continuing to develop how we learn from complaints and monitor success.
- Further enhancing the monitoring and reporting systems.

3.2 - Supporting staff and the public enabling openness and confidence:

The Complaints Officers offer bespoke training and support staff involved in complaints. Assistance is given with arranging and attending meetings and to ensure that all staff understand the complaints process.

3.3 - Staff training plans:

The Complaints Officers also attend various staff meetings to ensure all staff are fully aware of the complaints process. Support and advice is given with regards to adopting a person centred approach when dealing with patients, relatives and carers.

Training has been carried out in the following locations:-

- GP Surgeries in Aberdeenshire and Aberdeen City
- Mental Health Services
- Drop in Centres
- Suttie Centre
- Feedback Team Office

Training sessions have also been carried out with Registrars, Support Managers, Divisional General Managers and Gynaecology Consultants. The Complaints Officers also attended a training session at Aberdeen University to discuss the complaints procedure to Dental Consultants, Dentists and Dental Nurses.
These training sessions ensure that all staff are aware of the complaints process and the work of the Scottish Public Services Ombudsman.

The Complaints Officers also work closely with Divisional General Managers to ensure a standardised approach to investigating and responding to complaints. Complaints Officers, investigators and front line staff are encouraged to contact patients by telephone to discuss their concerns and achieve early resolution. The Complaint Officers also offer support and training to assist front line staff to become proficient in speaking to complainants by telephone.

Section 4 - Improvements to services as a result of complaints and feedback

4.2 - Steps taken to ensure the focus on learning and improvement are recognised as the main outcome from feedback:

- Feedback and complaints are discussed at weekly multi-disciplinary clinical governance/quality meetings and appropriate actions are taken to improve on identified areas of concern.
- Clinical treatment complaints are discussed through peer review and shared learning events.
- Learning points are identified from patient feedback by service managers and these are shared with their teams.
- Action points from patient feedback are implemented to ensure that the same things don't happen again.
- Analysis of complaints and feedback is a part of service reviews to ensure any themes or significant events that require more significant service improvement or resource to improve are identified.

NHS Grampian will continue to embed a more robust system to maximise the learning from complaints by providing the appropriate training and practical support to services.

4.3 - Learning being brought together with learning from other sources, e.g. adverse events, to provide an integrated approach to improvement planning:

Both complaints and adverse events are discussed during the weekly Clinical Risk Meeting to allow linking of incidents, investigations and their outcomes. There is a focus on the learning that has occurred and the actions taken as a result, and these can be shared through learning notices distributed across the organisation, as required.

Section 5 - Accountability and Governance

5.1 - The reporting processes for complaints and feedback:

As previously mentioned the Feedback Service prepares a report every week and shares it with the attendees mentioned above in Paragraph 4.3.
The Feedback Service report includes:

- New complaint descriptions and patient experience severity scoring.
- Complaints which are still open/in progress after 20 working days.
- Recently closed serious, sensitive or complex complaints to ensure full learning and action has been taken and discuss shared learning opportunities.
- Ombudsman complaints which have recently been reported on to allow discussion of recommendations made and ensure learning and action is taken and shared.

Complaint Handling Performance, including response target achievement, how many complaints are open and overdue.

Early Resolution report, highlighting which services have achieved the 5 working day early resolution since the introduction of the New Complaints Handling Procedure on 1 April 2017.

A ‘Learning from Complaints and Scottish Public Services Ombudsman Cases (SPSO) Report’ is prepared four times a year by the Feedback Manager. This report is usually presented to the Clinical Governance Committee and at every Engagement and Participation Committee. The report includes information on feedback, complaints and SPSO cases closed over the previous three months. Some feedback information includes; feedback types (compliments, comments, suggestions, concerns and complaints), numbers received, locations and themes of feedback and complaints. The severity and outcomes of complaints and SPSO findings, and the learning identified and action taken as a result of feedback and complaints.

The ‘Handling and Learning from Feedback’ annual reports are available on NHS Grampian’s website and are also shared with and presented to the Engagement and Participation Committee.

5.2 - Supporting NHS Board non-executive Directors to seek assurance that improvements can be systematically and reliably demonstrated:

NHS Grampian Board is assured that:

- Feedback and complaints are administered in line with national guidance, including managing the flow of information, issuing the responses in a timely manner and responding to SPSO investigations.
- The necessary advice and training is provided across the organisation, to enable long term sustainability.
- The Feedback Service enables liaison between service teams and the central services (DATIX and Feedback Officers) to facilitate greater levels of collaboration, which ensures that NHS Grampian has the information necessary to use the learning identified and make service improvements as a result of the feedback received.

NHS Grampian is fully compliant with complaint handling arrangements, in line with the Patient Rights (Scotland) Act 2011, and in particular ensures that action is taken, as necessary, following the outcome of any feedback.

The feedback system is constantly being developed to ensure mechanisms are in place to support fast, effective and efficient responses across NHS Grampian.
Specialist advice and support continues to be given to patients and staff on the management of this process, and there is a commitment to deliver local training and awareness-raising to ensure high quality, effective feedback and complaints handling is the norm across the organisation.

NHS Grampian has a strong organisational commitment to stakeholder engagement, through our core values of “Caring, Listening, Improving” and the strategic themes of “involving our patients, public staff and partners” and “developing and empowering our staff”.

To ensure NHS Grampian lives by its core values, the organisation will continue to listen carefully to patients, families, carers, the public and staff, on an ongoing basis and at every stage of their health care interaction. NHS Grampian will continue to make it easier for people to share their experiences, ideas and opinions and to remain genuinely engaged in decision making at all levels, and will continue to demonstrate a consistent and system-wide culture of learning from and taking action as a result of feedback received.

*This report was produced by:*

*Mary Marshall, Complaints Officer*

*Carol Clark, Complaints Officer*

*Louise Ballantyne, Feedback Manager*
Introduction

This is the annual outcomes report for the NHS Grampian health improvement team for the financial year 2017 / 2018. The health improvement team is part of the Public Health Directorate, located at Summerfield House, Aberdeen.

The report is deliberately concise, and focuses on outcomes. It is important to highlight that a large amount of process work lies behind each outcome achieved.

As well as colleagues working in the health improvement team, I would like to make a special mention of our colleagues in the health and wellbeing teams of the health and social care partnerships. We share the overarching ambition to improve health and wellbeing, and we do a great deal of our work together.

And let me also acknowledge the dedicated efforts of our wider colleagues, partners and allies who take forward and deliver health improvement in their work every day.

Christopher Littlejohn
Interim Deputy Director of Public Health & Head of Health Improvement
NHS Grampian

01224 558640
chris.littlejohn@nhs.net

Health is more than the absence of disease. It is a prerequisite for living, working and participating in society.\(^1\) Health is as much mental and social as it is physical, and includes the human need for connection, meaning and purpose.

To be healthy is to be able to self-manage one’s health and adapt to changing circumstances to maintain functional ability.\(^2\)

Health Improvement is conventionally taken to include health promotion and disease prevention.

Health promotion includes health promoting public policy, environments, community action, health services, and skills development for individuals to support healthy behaviours.\(^3\)

Disease prevention includes secondary prevention through early detection and treatment of disease.

\(^1\)https://doi.org/10.3399/bjgp14X682381
\(^2\)https://doi.org/10.1136/bmj.d4163
\(^3\)www.who.int/healthpromotion
Health can be measured at a population level, where it becomes evident that health is not equally distributed. Some people live much longer, healthier lives than others, and find it easier to obtain, access and benefit from healthcare. Improving health includes taking actions to reduce avoidable variation in health and healthcare outcomes. Priority developments during 2017/18 included work to support NHS Grampian board with inequalities-informed reporting and decision-making.

**Key messages**
- Health inequalities are unfair and avoidable.
- To reduce health inequalities we need to act across a range of public policy areas, with policies to tackle economic and social inequalities alongside actions with a specific focus on disadvantaged groups and deprived areas.
- We need to shift the focus from meeting the cost of dealing with health or social problems after they have developed to prevention and early intervention.

**Key actions**
- Drive a fairer share of income, power and wealth through policy, legislation, regulation and taxation.
- Ensure fair and equitable access to good quality housing, education, health and other public services.
- Ensure all public services are planned and delivered in proportion to need.

**Health Promoting Health Board**

We said we would...

- clarify and improve NHS Grampian Board’s understanding of its role in relation to health inequalities

As a result we have...

- worked with non-executive Board members and developed a clear set of actions, which we presented to the Board in January
Health Promoting **Health Service**

The national health promoting health service programme supports the promotion of health by healthcare services. By making every opportunity for health promotion count, our healthcare system becomes more person-centred and holistic. Priority developments during 2017/18 included development of a comprehensive strategic plan to support health and social care staff health and wellbeing, to continue the implementation of making every opportunity count (MEOC), and the inclusion of health improvement activities in the two managed clinical networks led by the public health directorate.

**We said we would…**
- develop a staff health and wellbeing plan

**As a result we have…**
- aligned our delivery resources around health promoting health service and developed a staff health and wellbeing plan for implementation by the HPHS group

**Making every Opportunity Count**

**We said we would…**
- develop digital resources to support the continued implementation of MEOC

**As a result we have…**
- published resources at www.hi-netgrampian.org

**We said we would…**
- enhance health visitors’ oral health improvement role through the Dental and Oral Health MCN and improve referrals of newborns to the Childsmile programme

**As a result we have…**
- worked with health visitors to develop posters and aide memoires to promote referrals into Childsmile. This is being developed as a national Childsmile resource.
We said we would…

• develop a local Managed Care Network (MCN) strategy which covers the remainder of the national Sexual Health and Blood Born Virus Framework

• work locally to implement the Pregnancy and Parenthood in Young People (PPYP) Strategy

As a result we have…

• completed our MCN strategy and will publish this in the Summer of 2018.

• gathered, analysed and shared data to make an assessment of local needs of young people in relation to the actions within the PPYP strategy.

We said we would…

• work with HIV Scotland to establish a local support group

As a result we have…

• established in partnership, the Our Positive Voice Group which supports people in Grampian to live well with HIV.
Health Promoting Prison

There is a strong association between a life of hardship and experience of the criminal justice system, and both of these are associated with poorer health. We have strong partnership relations with Scottish Prison Service and together we are taking actions to improve the health of prisoners at HMP Grampian. Priority developments during 2017/18 included preparation for the national smoke free prisons programme.

We said we would…

• support HMP Grampian to be a health promoting prison

As a result we have…

• set up a healthpoint in the prison library so that prisoners can easily obtain reliable health information, advice and coaching
• put robust smoking cessation support in place in advance of smoke free prisons
Health Promoting Workplaces

Work and the work environment is an important determinant of health. We deliver the national healthy working lives programme to employers across all sectors in Grampian. Priority developments during 2017/18 included the provision of occupational health and health and safety services to small and medium enterprises in Grampian, especially those in the low-pay sector.

We said we would…

- deliver the national Healthy Working Lives programme

As a result we have…

- supported 81 organisations to maintain their healthy working lives award
- provided occupational health and safety services to SME organisations

We said we would…

- find ways to support the health of those in lower paid sectors

As a result we have…

- run a know who to turn to campaign for the agricultural sector
- published Fit for Farming targeting those in the agricultural sector
- secured a monthly public health column in the Press and Journal Farming Section
- surveyed the health needs of the fish processing sector
Priority developments during 2017/18 included preparation for Scotland’s healthier future strategy on diet, physical activity and healthy weight; and preparation for Scotland’s renewed tobacco control strategy. As with all areas of health improvement, attention is required on the social and built environment within which people live their lives, as well as on helping people with lifestyle change and maintenance.

Health Promoting Environments & Lifestyles

We said we would…

• do the groundwork in advance of the national healthier future strategy

As a result we have…

• developed a strategic framework that identifies priorities for Grampian to coincide with the national launch of a healthier future and
• put in place an agreed governance structure to oversee implementation of the strategic framework

We said we would…

• work to create a world without tobacco

As a result we have…

• done the groundwork to develop a new strategic framework to coincide with the launch of the renewed national tobacco control strategy
• helped Royal Cornhill Hospital to be a smoke free hospital ground
• helped develop a new NHS Grampian policy to meet the requirements of new legislation for smoke free hospital grounds
Health Promotion
Across the Lifecourse

Our health trajectory is influenced not just by our adult environments, lifestyles and behaviours, but by our childhood, infancy and even antenatal exposures. Improving health requires attention across the lifecourse, from parental health preconception, through pregnancy, birth and beyond. Priority developments during 2017/18 included widening provision of antenatal and postnatal vitamins through the national healthy start programme, and promoting and supporting breastfeeding.

We said we would…

• widen the provision of free vitamins to all pregnant women and improve access to free vitamins to all eligible children

As a result we have…

• put in place a system that provides all pregnant women in Grampian free healthy start vitamins via their community midwife

and

• put in place a system this provides all eligible children free healthy start vitamins via their health visitor

We said we would…

• encourage breastfeeding as a norm across Grampian

As a result we have…

• delivered the Breastfeeding Welcome programme
• supported the breastfeeding peer support scheme with staff time
• funded reaccreditation for all UNICEF Baby Friendly services across Grampian
Health Promoting Lifestyles

Lifestyles – such as choices around smoking, alcohol and drug consumption, what we eat, how much exercise we take, sexual behaviour, toothbrushing, adherence to medical treatment, how we spend our leisure time, our social connectedness, our sense of meaning and purpose in life – are an important determinant of health. Priority developments for 2017/17 included achieving our local delivery plan target for smoking cessation, and developing a person-centred health coaching workforce.

We said we would…

• support 792 smokers* in Grampian to quit and remain stopped for at least twelve weeks

As a result we have…

• By the end of December 2017 we helped 727 smokers to quit and stay stopped for at least twelve weeks and are on track to surpass our target for the year **

*targeting those who live in postcode areas included in SIMD quintiles one and two
**the twelve-week follow-up data for smokers who quit January through March won’t be available until after publication of this report

We said we would…

• develop a generic health coaching resource by merging our smoking cessation and healthpoint teams

As a result we have…

• produced discrete options for organisational change and service reconfiguration
Health Promotion

Chronic Disease Programmes

Most demand on the NHS is due to chronic disease, which includes long-term conditions such as arthritis, asthma, chronic obstructive pulmonary disease, chronic kidney disease, diabetes, heart disease and stroke amongst others. An increasing number of people are living with two or more long-term conditions. Regular medical reviews, pharmacological treatments, and monitoring of biometrics such as blood pressure and blood sugar are important. But people also have an important role to play in their own health and it is important that health systems support people with long-term conditions to keep themselves as healthy as possible. Priority developments for 2017/18 included the implementation of the house of care programme to support self-management in Grampian, and to facilitate the Grampian self-management network as a source of information and support for all those with an interest in living with and supporting people long-term conditions.

**We said we would...**

- support self-management for people living with a long-term condition in Grampian

**As a result we have...**

- convened a programme board and subgroups to oversee implementation
- secured the active involvement of people from across the whole health system
- invested funds and staff time in training and organisational development for an initial cohort of nine GP practices (two in Moray, four in Aberdeenshire, and three in Aberdeen City) to implement house of care

**We said we would...**

- facilitate the Grampian self-management network

**As a result we have...**

- found a local partner to host the network and lead the agenda for four meetings this year
- hosted papers and video recordings from the network meetings on our website
Health Promoting Partnerships

Improving the health of the population fundamentally requires collaborative action across organisations and sectors. Grampian’s strategic landscape includes a range of partnership arrangements which directly or indirectly have huge potential to improve population health and wellbeing.

We said we would work in support of...

- our alcohol and drug partnerships
- our community justice groups
- our community planning partnerships
- our health and transport partnerships
- our integrated children’s services groups

As a result we have...

- worked to support the work of the public health directorate leads for alcohol and drugs, community planning and child health
- directly represented public health in Aberdeen City’s community justice group
- directly represented public health on the Grampian health and transport action group