REPORT TO ABERDEENSHIRE INTEGRATION JOINT BOARD – 20 DECEMBER 2017

COMMISSIONING (IMPLEMENTATION AND CHANGE) PLAN 2017-2019

1   Recommendation

It is recommended that the IJB:-

1.1   **Approve the Commissioning (Implementation and Change) Plan 2017-2019.**

2   Risk

2.1   IJB 4 – Service Capacity/Business Transformation

2.2   The Commissioning Plan meets the statutory requirement to detail the commissioning intentions of the Health and Social Care Partnership in line with the Strategic Plan. The Commissioning Plan leads the strategic direction of the Partnership through identifying areas of transformational change which will enable the Partnership to achieve the identified ten local priorities.

3   Background

3.1   This commissioning plan builds on the direction provided by the IJB following three development sessions associated with the strategic refresh and the programme planning for the medium term financial strategy. The plan follows the two new themes and ten local priorities and is organised using the 4 programme plans which will each be led by one of the partnership managers.

3.2   The plan has been produced in line with consultation with the Senior Management Team and with comments from the Integration Joint Board on draft documents circulated in October and November 2017.

3.3   The Chief Officer, along with the Chief Finance Officer and the Legal Monitoring Officer within Business Services of the Council have been consulted in the preparation of this report and their comments have been incorporated within the report.

4   Equalities, Staffing and Financial Implications

4.1   An equality impact assessment is not required because any equalities impact as a result of the commissioning plan will be carried out in relation to each specific piece of work and not on the plan as a whole.

4.2   The financial implications arising from activity contained within the commissioning plan will be reported back to the IJB within separate and specific reports.

Mike Ogg
Partnership Manager
Aberdeenshire Health and Social Care Partnership

Report prepared by Laura Buchan, Strategic Development Officer
Date 7 December 2017

Aberdeenshire
Health & Social Care
Partnership

Aberdeenshire Health and Social Care Partnership

Commissioning (Implementation and Change) Plan 2017 – 2019

Content

INTRODUCTION

Background

Aberdeenshire Health and Social Care Partnership (AHSCP) produced its first 3 year strategic plan in 2016, setting out how to improve the health and wellbeing of adults and older people in Aberdeenshire and deliver the 9 National Health and Wellbeing core indicators set out by the Scottish Government.

The Strategic Plan identified 4 themes and 15 priorities to be progressed on a local level. A Commissioning (Change and Implementation) Plan was developed for 2016-17 outlining the work required to meet the priorities. The plan did not cover all the work of the Partnership but focused on areas where it was recognised that transformational change could be achieved. Progress on the 15 priorities was reported to the Integration Joint Board (IJB) on a 6 monthly basis.

The IJB held a development session in July 2017 with the aim of reflecting and evaluating the 4 themes and 15 priorities within the Strategic Plan. The IJB wanted to consider whether the local themes and priorities were still relevant as the Partnership makes plans for improvement over the next 18 months, and, whether there was an opportunity to streamline some of the themes and priorities.

From this session and further work undertaken by the Partnership's Senior Management Team (SMT), revised themes and priorities were agreed by the IJB in August 2017. There are now 2 themes and 10 priorities to be progressed through this Commissioning Plan. These are detailed on pages 5 and 6.

2017 – 2019 Intentions

The Commissioning (Implementation and Change) Plan details the Partnership's commissioning intentions based on achieving the 9 national outcomes, and progressing the 2 local themes and 10 priorities.

In order to ensure progress on achieving these priorities, 4 programme plans have been developed. These identify specific programmes of work which will deliver the 10 priorities. The 4 Programmes are listed below and each of the 4 Partnership Managers has responsibility for one of the programmes:

1. Enabling Health and Wellbeing
2. Facilitating Shared Ownership and Engagement
3. Reshaping Care At Home
4. Safe, Effective and Sustainable

The links between the programme plans and the strategic priorities are detailed in the table on page 5.

This Commissioning Plan must be considered alongside the programme plans as they provide the detail of the operational delivery of each priority. Each

programme plan provides specific information on the financial implications of the programme and the short, medium and long term goals for each to deliver quality services which are affordable and sustainable. The actions within each programme plan describe specific pieces of work which will drive change on a strategic level.

The driver diagram on page 6 of this plan clearly shows the relationship between the individual programmes which are to be delivered within the programme of work plans, and the AHSCP strategic priorities.

In all the work carried out by the AHSCP, due regard is given to equalities, alongside consideration of the affordability, sustainability, and the risk associated with each piece of work. Equalities Impact Assessments (EIA's) are carried out regularly in order to assess and then mitigate potential negative impacts on people with protected characteristics before any piece of work is taken forward.

The table below provides a summary of the financial position within the Partnership.

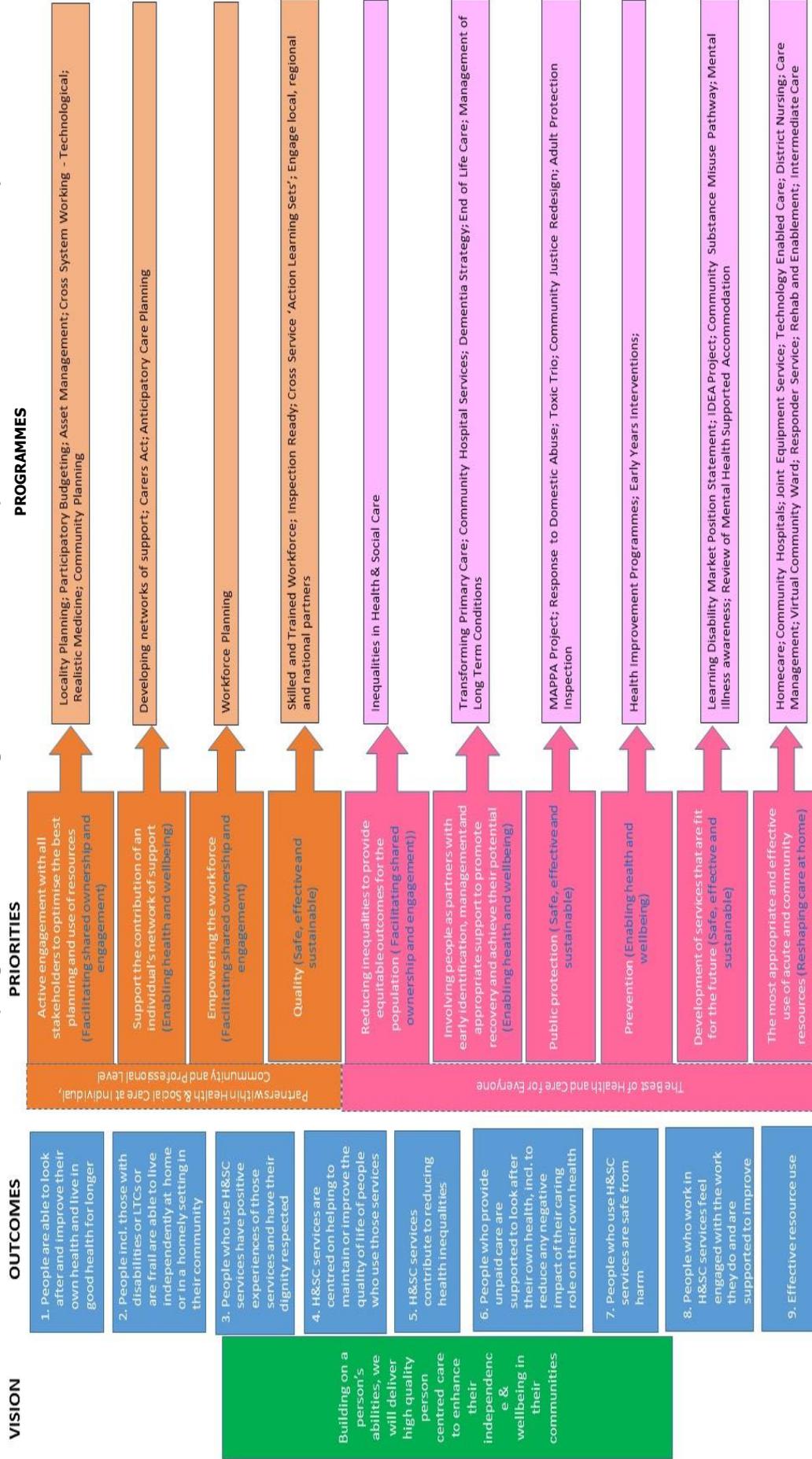**Summary Financial Forecast 2017/18** (as of October 2017)

	Revised Budget 2017/18 £000's	Actual to 31 October 2017 £000's	%	Forecast to 31 March 2018 £000's	Variance £000's
Section 1					
Health & Social Care	229,536	126,850	55.3	234,113	4,577
Funds	3,499	1,092	31.2	2,109	(1,390)
SG Resources	709	0	0	479	(230)
Set aside budget	26,665	0	0	26,665	0
2017/18 Position	**260,409**	**127,942**	**49.1**	**263,366**	**2,957**
Section 2					
Prescribing	**43,649**	**26,485**	**60.7**	**45,460**	**1,811**
B/f from 2016/17	9	0	0	0	(9)
Total IJB Resources	**304,067**	**154,427**	**50.8**	**308,826**	**4,759**

Aberdeenshire Health and Social Care Partnership Programmes of Work and Links to 10 Local Priorities

	PROGRAMMES OF WORK			
	Enabling Health and Wellbeing	Facilitating Shared Ownership and Engagement	Reshaping Care At Home	Safe, Effective and Sustainable
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.		X		
Priority 2: Developing the support mechanisms that enable people to have improved health and wellbeing.	X			
Priority 3: Empowering the workforce.		X		
Priority 4: Ensuring quality through safe, effective and sustainable service provision.				X
Priority 5: Reducing inequalities to provide equitable outcomes for our communities.		X		
Theme 2: The best of health and care for everyone				
Priority 6: Involving people as partners with early identification, management and appropriate support to promote recovery and achieve their potential.	X			X
Priority 7: Public Protection.				X
Priority 8: Prevention and early intervention to promote healthy lifestyles and resilient communities.	X			
Priority 9: Development of services that are fit for the future.	X		X	
Priority 10: The most appropriate and effective use of acute and community resources.			X	

Aberdeenshire Health and Social Care Partnership Driver Diagram

The diagram below details the specific programmes of work which are covered by the 4 programmes and links them to the 10 local priorities and 9 National Outcomes. The programmes in the diagram are delivered at operational level as directed by the IJB.

VISION

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

OUTCOMES

1. People are able to look after and improve their own health and live in good health for longer
2. People incl. those with disabilities or LTCs or are frail are able to live independently at home or in a homely setting in their community
3. People who use H&SC services have positive experiences of those services and have their dignity respected
4. H&SC services are centred on helping to maintain or improve the quality of life of people who use those services
5. H&SC services contribute to reducing health inequalities
6. People who provide unpaid care are supported to look after their own health, incl. to reduce any negative impact of their caring role on their own health
7. People who use H&SC services are safe from harm
8. People who work in H&SC services feel engaged with the work they do and are supported to improve
9. Effective resource use

PRIORITIES

Partners within Health & Social Care at Individual, Community and Professional Level

- Active engagement with all stakeholders to optimise the best planning and use of resources (Facilitating shared ownership and engagement)
- Support the contribution of an individual's network of support (Enabling health and wellbeing)
- Empowering the workforce (Facilitating shared ownership and engagement)
- Quality (Safe, effective and sustainable)

The Best of Health and Care for Everyone

- Reducing inequalities to provide equitable outcomes for the population (Facilitating shared ownership and engagement))
- Involving people as partners with early identification, management and appropriate support to promote recovery and achieve their potential (Enabling health and wellbeing)
- Public protection (Safe, effective and sustainable)
- Prevention (Enabling health and wellbeing)
- Development of services that are fit for the future (Safe, effective and sustainable)
- The most appropriate and effective use of acute and community resources (Reshaping care at home)

PROGRAMMES

- Locality Planning; Participatory Budgeting; Asset Management; Cross System Working – Technological; Realistic Medicine; Community Planning
- Developing networks of support; Carers Act; Anticipatory Care Planning
- Workforce Planning
- Skilled and Trained Workforce; Inspection Ready; Cross Service 'Action Learning Sets'; Engage local, regional and national partners
- Inequalities in Health & Social Care
- Transforming Primary Care; Community Hospital Services; Dementia Strategy; End of Life Care; Management of Long Term Conditions
- MAPPA Project; Response to Domestic Abuse; Toxic Trio; Community Justice Redesign; Adult Protection Inspection
- Health Improvement Programmes; Early Years Interventions;
- Learning Disability Market Position Statement; IDEA Project; Community Substance Misuse Pathway; Mental Illness awareness; Review of Mental Health Supported Accommodation
- Homecare; Community Hospitals; Joint Equipment Service; Technology Enabled Care; District Nursing; Care Management; Virtual Community Ward; Responder Service; Rehab and Enablement; Intermediate Care

6

FACILITATING SHARED OWNERSHIP AND ENGAGEMENT
Links to Strategic Priorities 1, 3 & 5

Introduction

We need to work closely with communities in order to support individuals to take ownership of their health and wellbeing and engage in identifying and meeting local needs. The approach taken will ensure that people's skills, abilities and knowledge within communities are recognised and valued, developing community capacity which will deliver sustainable communities.

Health and Social Care teams working closely with partners in the community require easily accessible shared information, and a flexible workforce to ensure the services and support provided are fit for purpose.

Individual programmes within this 'programmes of work' will aid focus on engagement and ensure robust relationships are developed, and the workforce is capable of adjusting to changing demands which will ultimately improve outcomes for all.

Locality Planning

Aberdeenshire's first Locality Plans are being developed and work has been undertaken in each partnership area to meet and consult with stakeholders. Various engagement activities have been organised to consult with a range of people including health and social care partnership staff, service user forums, third sector groups and organisations and Aberdeenshire Council's Area Committees. The information gathered will aid identification of the local priorities around Health and Social Care services within each area, and moving forward help to inform future strategic direction. An action plan is being developed for each area to identify the work required to ensure the ongoing delivery of the local priorities.

Health and Social Care Locality Plans will be published in April 2018, and link with existing work carried out to support communities in line with the Community Empowerment (Scotland) Act 2015, and Aberdeenshire's Local Outcomes Improvement Plan LOIP (2017 – 2027).Implementation of the locality plans seek to address the specific needs and issues of each local area, and drive strategic change regarding investment, service delivery and community empowerment. .

Participatory budgeting

Participatory budgeting gives local people increased control over how budgets are spent to meet local needs. Communities are encouraged to put forward proposals for projects which will improve the health and wellbeing of the community. Allowing the public to be involved in deliberation and decision

making will ensure services are shaped by local people, and they take ownership of their community's wellbeing.

Learning from the participatory budgeting pilots in 2016/17 is been considered to ensure new methods for evaluation of projects is implemented. This will guarantee that efficient and appropriate processes are in place, and maximum benefit is achieved from investment. Robust evaluation of project fit and outcome success are being developed. The Integration Joint Board are considering outcomes from the process at their December 2017 meeting; this will allow transparent decisions about how the IJB wish to proceed with participatory budgeting in light of the findings.

Participatory Budgeting shows a commitment to working with people in our community, so they have a direct say in how and where a proportion of the AHSCP budget is used to address local requirements within a democratic framework, ensuring local resources are targeted to address identified local needs.

Asset Management

Across Aberdeenshire, co-located health and social care teams are working closely together to deliver services. Engagement will continue between team managers and the Partnership's Asset Management group, in order to link with colleagues in property services, ICT, and the Worksmart Team enabling further progress.

The outcome of this work will ensure that current property resources are maximised, and plans for future resource needs are developed. This will allow the integrated teams to concentrate on working together to provide person centred services.

Cross System Working

 For integrated care teams to work together effectively, they require more than just integrated team structures and sharing offices. Teams require accessible shared systems to facilitate efficient productivity. Additionally access to communication systems for all stakeholders (including members of the public) requires development.

Easily accessible shared information will ensure people receive a continuous and consistent service, following a smooth pathway in a timely manner, and receive the appropriate resources and support when required.

Phase one involves setting up a working group which will initially identify electronic systems within the partnership that require improvement to achieve effective cross system working. This will outline the work and resources required to deliver systems fit for purpose. This work is linked to asset management (as above) and will therefore also consider identification of further opportunities to

promote Worksmart and consider appropriate accommodation to deliver this. Phase one of both of these pieces of work will continue into 2018/2019.

Realistic Medicine

Realistic Medicine proposes a move from a culture of 'doctor knows best' to one where health and wellbeing is co-produced with patients/clients. If people are supported to better understand their health they are more likely to positively contribute to their wellbeing.

Currently within social work and health, the patient/client is involved where possible in decision making and planning relating to their health and care. Promotion with staff and the public of the approach which Realistic Medicine takes will educate and inform people about opportunities for them to be involved in decisions made around their care, help people to recognise the benefits and thus provide and promote an improved and efficient service.

Workforce planning

Development of workforce planning is key to delivering the strategic priorities, and the workforce plan has been formed against a backdrop of three major work streams;

- Health and Community Care,
- Improving Public Health and Reducing Inequalities,
- Clinical Service Redesign, incorporating developing locally accessible diagnostic and treatment services, and Primary Care.

Recruiting and retaining staff in particular professions within health and social care is a challenge, and it is paramount that a well-trained and respected workforce is developed. In order to achieve this some roles may be redesigned to create a robust workforce that is fit for purpose, and one that can respond flexibly to new demands and developments in health and social care in the future.

Recognising the challenges in recruitment it is beneficial to work in partnership with Human Resources to organise positive, proactive recruitment activities such as targeted recruitment fairs in order to attract the right staff. It is also important to work with the Education service to identify opportunities to promote careers in health and social care to school pupils and University and College graduates.

Workforce planning will ensure that workforce size is correct with the optimal skill mix to support sustainable services, and manage redesign of services where needed, whilst reflecting on local issues and delivering this within the available budget. Linking to the programmes of work there are measureable targets on a short, medium and long term basis which will be regularly monitored to ensure this is effective. Adapting the workforce to the needs of the community will ensure services are fit for purpose, and reflect changing demands

Inequalities in Health & Social Care

It is recognised there are many challenges in reducing health and social care inequalities. Targeting resources on programmes delivering anticipatory and early intervention will increase support to people in our communities who may experience the greatest inequalities. Closer links and an enhanced role for the Public Health team with the Community Planning Partnership will improve access to the health and social care services for those in need.

Individuals have the right to equality from their health and social care services and the HSCP is legally required to 'mainstream equalities'. To support this an action plan was approved by the IJB in April 2016. As required under the Equalities legislation, the partnership will publish a report every two years setting out progress made. The first report will be published within the required timeframe of end of March 2018.

ENABLING HEALTH AND WELLBEING

Links to Strategic Priorities 2, 6, 8, 9

Introduction

It is recognised that individually we all have a responsibility for our own health and wellbeing. We can enable individuals to lead a more healthy lifestyle and access sustainable services which are fit for purpose if and when needed. We will do this through:

- raising awareness of the causes of serious health conditions and what can be done to prevent them;
- developing support networks in the community; and
- ensuring existing services are sustainable and redesigned if required,

The programmes of work focus on areas of work that will deliver high quality, person-centred, locally based support to allow individuals to be as independent as possible.

Developing networks of support

We need to ensure people can gain access to support from community services in order to become more self-reliant, and feel empowered to take ownership of their own wellbeing. An increase in community capacity, growing community services and maintaining strong links with them, will ensure people are supported to remain in their own homes for longer in line with national drivers.

Integration has brought about close collaboration between secondary, primary, and community partners to plan services for localities. Services need to improve the outcomes and wellbeing of people with care and support needs, and their carers as identified in the 9 National Outcomes. There is a need to focus resources on prevention and increase capacity within the communities to better meet demand, improve equity of access to services, and make services sustainable into the future.

Working to maintain the relationships between the AHSCP and the third sector is evident through successful projects, for example the Community Health in Partnership (CHiP) Project where CHiP Officers provide support to the wider third sector so they can be involved and influential in the design and delivery of health and social care services.

Clear communication with all partners including, Community Planning Partnership, Education Service, Housing, and Community Education is key to ensuring we meet the shared objective of increasing resilience and empowerment within the community.

Unpaid Carers

Progress on implementation of the Carers (Scotland) Act 2016 continues in preparation for the legislation coming into force in April 2018. A clear implementation plan has been developed, which lays out the steps required to ensure the new duties and responsibilities of the AHSCP, and Education and Children's Services are met.

Progress has been made on the development of local carers' strategies for adult and young carers which will be published in April 2018. Over the coming months work will continue including:
- Development of a new Adult Carer Support Plan (ACSP) & Young Carer Statement,
- Development of a local eligibility criteria for carers,
- Publication of a short breaks services statement, and
- Development of a pathway to involve carers in the discharge from hospital of the people they care for.

The model for delivery needs to be agreed so that adult support plans can be prepared from 1st April 2018.This may involve procurement of services from the third sector. Additional funding is to be made available from the Scottish Government for implementation of the requirements in the legislation. As some of the requirements relate to young carers, the funding will be shared between the Partnership, and Education and Children's Services.

Implementation of the Act will result in a clearer pathway for all carers to follow, to access advice and support within the community. Additionally carers who are eligible will have access to further support to assist them to continue in their caring role, and support the person they care for at home.

Anticipatory Care

The Partnership has launched an updated Anticipatory Care Strategy aimed to empower people to take more responsibility for their own health and care. A substantial element of Anticipatory Care Planning is the Anticipatory Care Plan (ACP) however the ACP also incorporates other elements including Power of Attorney, Emergency Care Planning for Carers, Advanced Directives and, where appropriate, Advanced Statements. These documents are ways in which people can identify how they wish to be cared for should their needs increase or circumstances change in the future.

Aberdeenshire's model focuses on people who are living at home and supports them to stay within their own community for longer. It has been designed to support a vision of informed and involved patients and carers working with flexible and responsive health and social care teams. As we look to the future existing practice will be built upon and we will work towards aligning our local model with the national one.

Raising awareness across the Partnership and with stakeholders is currently underway, further work will be carried out to align the local strategy with the national work that has been developed, and implementation of the ACP toolkit "Let's think Ahead".

Prevention

Reducing pressure on services and ensuring resources are used in the most appropriate way can be addressed via informed changes in many different areas. Improving the health of the population is key to this, and this preventative approach can be moved forward by targeting particular behaviours to reduce avoidable harm and illness.

The 'Making Every Opportunity Count' (MeOC) currently encourages staff to engage with people in conversations relating to lifestyles and life circumstances. Existing health improvement programmes also support people in relation to specific health issues, including: smoking, substance misuse, obesity, mental wellbeing, etc. A merger of NHS Grampian's Smoking Advice Service and Health Point Service will provide a dedicated health coaching service and is to be rolled out in 2018.

Focus will be given to the specific needs within the community, and how sufficient funds are then allocated to meet this need. This will allow the Partnership to deliver evidence based interventions, which need to be sustainable, and will make a difference to people. This more robust system will support people within the community in the most appropriate way, and facilitate a further shift towards education and prevention.

Early years Intervention

Significant transformation is underway within AHSCP Child Health Teams with implementation of the National Health Visiting Pathway; and introduction of Immunisation teams. The health visitor pathway should ensure improved health and wellbeing outcomes for children and their families through increased home contact particularly in the ante natal phase and standardised assessment. Substantial investment over 4 years in the Health Visitors Masters' degree programme will provide, in the medium term, a sustainable health visitor workforce. The new Immunisation teams will deliver immunisations for all ages including the pre-school immunisation programme. This will allow the School Nurse role to be developed in line with national guidance, to provide specialist support to children and young people on issues such as mental wellbeing, sexual health etc.

Early years priorities are to enable every child to have the best start in life and this is being taken forward working with partners. These include the implementation of evidenced based parenting support to ensure that the right level of support is available at the right time to families. Positive Parenting Programme Group Work, PEEP (Peers Early Education Partnership) and infant massage are all being rolled out across Aberdeenshire. 'Developing early communication skills' and 'supporting play' will also be the focus for multi-agency action.

Health improvement programmes for early years include UNICEF Baby Friendly (breastfeeding), child healthy weight, smoking in pregnancy / smoke free homes and Childsmile (oral health).

Transformation of Primary Care

Transformation of primary care services is focused on two main areas; developing the primary care team to deliver more complex care within communities, which will help to reduce hospital admissions; and looking at the resources and services within primary care services to ensure they provide the right care at the right time for people who do require to be admitted to hospital.

This work links with the 6 essential actions to improve unscheduled care which are;

1. Clinically Focussed and Empowered Hospital Management
2. Hospital Capacity and Patient Flow (Emergency and Elective) Realignment
3. Patient Rather Than Bed Management – Operational Performance Management of Patient Flow.
4. Medical and Surgical Processes Arranged to Improve Patient Flow through the Unscheduled Care Pathway
5. Seven Day Services Appropriately Targeted to Reduce Variation in Weekend and Out of Hours Working
6. Ensuring Patients are Optimally Cared for in their Own Homes or Homely Setting

The initial stages of this work are focused on agreeing a sustainable model for current service provision.

Community Hospitals

Work is ongoing to review community hospital strategy in line with the shift in the balance of care. The introduction of the virtual community ward is helping people to stay at home whilst receiving appropriate support from the local multi-disciplinary team in a coordinated approach which wraps support around the person and their individual needs. In addition to this, development of the responder care at home service is able to provide support to people to enable them to return home sooner or even avoid a hospital admission completely. These strategies should see a reduction in the demand for in-patient community hospital provision.

Dementia

The 3 year dementia strategy (2015 - 2018), outlines Aberdeenshire's implementation plan and priorities from Scotland's National Dementia Strategy.

The publication of Scotland's 3rd National Dementia Strategy (2017-2020) in June 2017 is a key driver for local priorities for action, and the Aberdeenshire Dementia Strategy and Action Plan is consequently under review, with a revised action plan and strategy to be published in 2018.

Progress has been achieved through many successful projects carried out to deliver the actions identified in the local dementia strategy. Key priorities moving forward, have been identified to address gaps. Included in these are:

- Developing and reviewing the role of the dementia link workers who will continue to provide support beyond the one year post diagnosis. (Commissioned Service)
- Developing and expanding the Dementia Local Enhanced Service (LES)
- Sustaining the development of dementia friendly communities (Commissioned Service)
- Developing the use of the 8 Pillars model in the context of integrated core teams
- Developing a wide range of community based supports for people with dementia. (Some Commissioned Services)
- Promoting good quality palliative and end of life care
- Implement national plans to improve services for people with dementia in acute and specialist NHS care
- Promoting the use of technology to enable people to live safely and independently

This detailed scope of work involves future investment to meet the objectives outlined in the Dementia Strategy, and it will build on existing successful

14

services whilst also enhancing the community's capacity for supporting people with dementia and their families.

Improving experience of end of life care

End of life care is an integral aspect of the care delivered by any health or social care professional to those living with, and dying from, any advanced, progressive or incurable condition. The care focuses on the person, not the disease, and applies a holistic approach to meeting the physical, practical, functional, social, emotional and spiritual needs of patients and carers facing progressive illness and bereavement.

Aberdeenshire's out of hour's provision from Marie Curie ensures people receive sensitive end of life support in the setting they prefer. A review of this provision is to be carried out with Marie Curie to ensure that care is consistent across a 24 hour period.

Management of long term conditions

A programme to develop a whole system approach to self-management of long term conditions is underway. Over the past 18 months 'Good Conversations' training has been rolled out across the health and social care teams. The 'House of Care' approach enabling staff to support people to articulate their own needs, and decide on their own priorities, is to be rolled out in general practice/ primary care starting with 2 Aberdeenshire early adopter practices in 2017/18.

Evidence shows that encouraging people with long term conditions to be physically active contributes to preventing poor health and supporting rehabilitation. Work is progressing with the third sector and leisure services to develop a range of physical activity opportunities and services to enable people with long term conditions to begin and continue being physically active. The MacMillan Move More programme is supporting people with cancer and their families to be more active, and the charity GCRA (Grampian Cardiac Rehabilitation Association) provides Exercise for Life classes which provide a network of exercise groups across Aberdeenshire.

SAFE, EFFECTIVE AND SUSTAINABLE
Links to Strategic Priorities 4, 6 & 7

Introduction

Within this programme of work there are a number of projects which ensure the future provision of services keeps people safe, delivers effective use of resources and ensures services are sustainable for the future.

Projects such as the IDEA Project for people with learning disabilities and the Community Substance Misuse Detox and Rehabilitation pathway look to move services away from a more traditional buildings based model and improve community capacity so that more people can access services locally which are more tailored to their individual support needs.

Learning Disability 'Market Position Statement'

People with learning disabilities are living longer and this is increasing the demand for housing which can be adapted for people with more complex care needs. Younger people with disabilities are less interested in older more traditional residential options and are instead looking to be more independent and explore options where they are able to maintain their own tenancy. The intention is to reduce provision of more traditional residential accommodation and improve availability of a more community based models through provision of additional extra care housing. The purpose of extra care housing is to provide flexible accommodation in the community for people with a range of different additional support needs that gives people the support they need to live independently and be part of their local community.

The Local Housing Strategy reflects the work being done in partnership to identify opportunities for development of new housing that will meet the needs of people with a learning disability.

Production of the market position statement will help to clarify our intentions to private and third sector providers who may have an interest in providing more flexible accommodation options and will provide strategic direction to the management and further development of accommodation for people with learning disabilities

Continued Roll out of IDEA

The focus of the IDEA project is to support people with learning disabilities to be more involved and valued in their communities. The project aims to shift the balance from more traditional buildings based day care services, to activities which support people to become more active and receive support in their local community. This model helps people to be more independent and helps build resilient and supportive communities. This then reduces the reliance on statutory day care services which are expensive to provide, and difficult to tailor to the needs and preferences of individuals compared to more community based alternatives.

Community Substance Misuse Detox and Rehabilitation pathway

As with many other services, the substance misuse service is looking to move away from a residential and in-patient model for rehabilitation and instead focus on more community based provision. Shifting the balance of spend from

16

residential options, which may in fact be out of area, to more community based models will provide increased opportunities to support more people at home. This work will link closely with the Alcohol and Drugs Partnership (ADP), and other third sector supports to help build community resilience.

Reducing stigma associated with Mental Health

There is a continuous need to improve public perception and awareness of support for people with mental ill health which will promote inclusion, and improve community and peer support as well as promoting self-care and self-management. As it is becoming more socially accepted to talk about mental health issues more people are coming forward for support. There is work to be done around building supportive communities that can provide lower level support for people that don't require a medical intervention. Working with the voluntary sector will be important in achieving this – particularly working with the Scottish Association for Mental Health (SAMH).

Mental Health 'Supported Accommodation'

There is currently a limited range of supported accommodation in Aberdeenshire for people with mental ill health who require a high level of support, and consequently there is a reliance on provision in neighbouring partnership areas. The need for further supported accommodation resources needs to be addressed. The Partnership will explore opportunities to make better use of community based supports for people with lower levels of need, and together this will help to improve the availability of higher level support for those who need it within Aberdeenshire.

Multi Agency Public Protection Arrangements (MAPPA)

MAPPA provides a framework within which agencies can share information in order to jointly assess risk; and apply resources proportionately. This enables the multi-disciplinary team to jointly manage the risk of serious harm posed to the public by high risk offenders therefore improving public protection and reducing the likelihood of serious harm. This arrangement is being rolled out across Aberdeenshire, initially this was around high risk offenders but lower categories of offenders are now being assessed in this way. This joined up approach will help professionals to ascertain the wider picture around the risks posed by offenders and use this information to improve public safety.

Response to Domestic Abuse

The Caledonian System is an integrated approach to addressing men's domestic abuse. In Aberdeenshire around 96% of reported domestic abuse is mal on female. The approach combines a court-ordered programme for men, aimed at changing their behaviour, whilst providing support services for women and children. Implementing this approach to tackling domestic abuse helps to tackle the cause of the behaviour whilst providing support to those who have been negatively affected by the abuse. In order to measure the success of

current provision for people effected by domestic abuse the Gender Based Abuse Partnership carried out a piece of research, including focus groups, to gather the experience of people who have experience of domestic abuse and identify where improvements can be made. An action plan has been drawn up as a result of this and work is ongoing to meet the identified actions. Achievement of the action plan will help to improve support for people who are affected by domestic abuse, and will include work around raising awareness within partnership staff including help to signpost people to appropriate support services. We will specifically be working with the voluntary sector to support this.

Supporting children affected by parental mental illness, substance misuse and domestic violence

It has been identified that children living in households where there is parental mental illness, substance misuse and domestic abuse are at a higher risk of harm. The Partnership works closely with children's services to ensure we can effectively identify and support children who are at risk. Recent improvement work has focused on looking how adult and children's services, including education, will work together to identify where children are potentially at risk, and take a holistic approach and provide a proactive rather than reactive response.

Community Justice

The new model for community justice has been designed to deliver a community solution to achieving improved outcomes for community justice; to prevent and reduce further offending. Within the new model, there is an emphasis on collective responsibility through a partnership approach, which covers a wide range of interests, including housing, employability, health and wellbeing.

To support this approach in Aberdeenshire, a Community Justice Partnership (CJP) has been established, with representation from all of the statutory community justice partners, Aberdeenshire Voluntary Action, the Department of Work and Pensions and the Northern Community Justice Authority (until disestablishment on 31st March 2017).

The 4 priorities of the CJP have been identified as:

1. Improving Community Understanding and Participation in Community Justice
2. Strategic Planning and Partnership Working
3. Effective Use of Evidence Based Interventions
4. Equitable Access to Services

Adult Protection

The Partnership has been selected to participate in a thematic scrutiny of the Adult Support and Protection services. This has been led by the Care

Inspectorate (CI) alongside Health Improvement Scotland (HIS) and Her Majesty's Inspectorate of Constabulary Scotland (HMICS). This thematic inspection is the first ever independent scrutiny of adult support and protection in Scotland. The joint inspection will scrutinise and evaluate three key areas of adult support and protection work:

- Outcomes for adults at risk of harm and their unpaid carers.
- Key adult support and protection processes.
- Leadership for adult support and protection.

The Inspection report will highlight key strengths and, if appropriate, recommendations for improvement which will lead the further development of adult protection service in Aberdeenshire.

RESHAPING CARE AT HOME
Links to Strategic Priorities 9 & 10

Introduction

Enabling people to stay at home is a local priority for the Partnership. To eanble this to happen,it is essential that the right community supports are in place. It is recognised that there are many important and interrelated elements of service delivery that will enable us to achieve this including ensuring the availability of care at home, rehabilitation and enablement, providing appropriate access to health professionals, enabling people to receive support at home and taking advantage of new technology which can support people to remain more independent.

Home Care Service

Currently a significant proportion of home care provision is delivered by the Partnership's internal home care service. This service has developed significantly over the last few years and currently there are approximately 740 home carers employed in the service. The service has the unique ability to provide a high quality person centred service on the following 4 areas;

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

There is a desire to change the current balance to increase externally commissioned home care services from private and voluntary providers. The internal service is more expensive to provide given the commitment to induction

and ongoing training, and shadowing opportunities before each home carer takes on their work. Savings may be made by rebalancing the provision. Forecast change in in-house provision and private provision is detailed in the programme plan.

Through concentrating the internal service on these areas there will be opportunities for external providers to grow their services in other areas and hence create a more diverse and sustainable market place.

Joint Equipment Service

Demand for specialist equipment which is purchased through the Joint Equipment Service (JES) has grown considerably but the budget has remained the same suggesting the service is working well. This is mainly due to a commitment to recycling equipment and some changes to the staffing structure. The JES has a role to play in supporting timely discharge from hospital and in ensuring equipment is standardised and appropriately maintained across Aberdeenshire. The service is also responsible for delivering equipment in line with our digital health and care aspirations. Continued effective operation of the JES will ensure the right equipment is available to people when they need it, and thus enabling people to remain at home for as long as possible.

Digital Health and Care

For Health and Social Care integration to truly succeed requires transformational change of how we respond to demand for services. Digital transformation is increasingly a key building block at the heart of successfully meeting this challenge. Digital technology has the potential to empower people to more actively manage their own health, close to home, and be a core driver of efficiencies in how we use our available financial and staff resources.

Technology should not be seen as a series of services or projects in their own right – although we will clearly identify particular technology projects to pursue as priorities – but rather as a golden thread, a strategic enabler, running through all our service redesign and transformational work.

The Evolving Multi-Disciplinary Team

Through integration and the shift in the balance of care there is an opportunity to look at staff teams and develop the workforce in line with local need. District Nurses, Care Managers, Home Carers and Allied Health Professionals such as Physiotherapists and Occupational Therapists have a key role to play in building the support networks that will enable people to remain at home. This work is linked to national strategy around the changing role of district nurses and the shift to a rehabilitation and enablement approach which is currently being rolled out across the partnership.

Virtual Community Ward

The Virtual Community Ward (VCW) has a vital role in enabling people to remain at home with support from the multidisciplinary team. Twenty seven separate VCW teams were operational by June 2017. A further two VCWs have commenced since then, bringing the total to twenty nine out of the thirty two GP practices across Aberdeenshire. The intention is to develop the VCW in order to support more people without the need for admission to a hospital or a care home. The success of each VCW in part relates to having ready access to services such as responder carers and occupational therapy equipment.

Responder Service

The responder service is provided by home care staff based in the community and ready to respond in both planned and unplanned situations. This service is relatively new and demand is growing rapidly. The service has recently expanded to include support for people in the community who fall, and this service is helping to reduce demand on the Scottish Ambulance Service. This service has support from the Fire and Rescue service in situations where there is an urgent need to gain entry to a property or in situations where a fall has occurred and assistance is required to move the person safely. The responder service has a key role to play in moving the demand away from emergency services and supported accommodation to flexible, appropriate support which is provided in people's own homes.

Rehabilitation and Enablement

Staff across the Partnership are being trained in rehabilitation and enablement including care managers and homecare staff – ensuring that every person is assessed regarding their ability to improve or maintain their skills and independence. This training needs to be rolled out to a wider group of staff in order to ensure that all staff are looking at an individual's suitability for rehabilitation and enablement. As a Partnership we need to ensure we embed this thinking into staff culture and maximise the opportunities for people to be enabled to regain skills, and maintain their independence.

Intermediate Care resources

Intermediate Care resources in Care Homes have a key role to play in the reduction of delayed discharge and inappropriate admissions to hospital. Intermediate Care plays an important role in supporting rehabilitation and enablement of people who are not able to stay at home but do not need medical input, and therefore do not require a hospital stay. The new national care home contract is investigating support for new models of care which will encourage the growth of this service. Growing the availability of intermediate care

resources can have a significant impact on shifting the balance of care through reducing the time people spend in hospital, reducing the reliance on home care services, and therefore enabling more people to live more independently in the community.

Unscheduled Care

The Partnership is planning to reduce the demand for unscheduled or emergency care through a number of initiatives aimed at improving public knowledge in areas of; knowing who to turn to, and improving self-care and self-management. If we can ensure that people are given the skills and knowledge they need to manage their own health where possible and reduce the occurrence of avoidable health conditions; as well as ensuring people know who to turn to; then we can ensure more appropriate use of health and social care services and therefore reduce avoidable demand.

Housing

In order to enable more people to stay at home there has to be a sufficient supply of suitable housing. Aberdeenshire Housing service are involved at a strategic level in partnership decision making to ensure services can work together to provide the right accommodation for people to be able to remain at home. The strategic priorities will also inform the development of the Aberdeenshire Local Housing Strategy and associated delivery plan.

COMMISSIONING AND PROCUREMENT

Health and Social Care commissioning and procurement is a complex area and as such, it requires special consideration within a public body's overall approach to the delivery of services. The Partnership currently has contracts in place with 157 providers of services that include care home provision, care at home, supported living and training and skills development. The annual spend on commissioned social care services is approximately £67M.

Social care procurement is undertaken by the Social Care Commissioning, Procurement and Contracts Team (SCCPC) which is a joint Aberdeen City and Aberdeenshire Council service.

Procurement of non- social care services and goods e.g. community meals and equipment is undertaken with the relevant Category Manager in the commercial and procurement service.

Procurement activity must carefully balance the purchasing of services within a set of principles which acknowledges a balance between human rights, outcomes for the individual, best value and statutory procurement regulations.

There is specific procurement activity linked to many of the projects in the 4 programmes including e.g.

1. Rebalancing the split between internal and external home care services
2. Procurement of private and third sector care home places and supported accommodation
3. Purchase of specific pieces of technology in line with Digital Health & Care
4. Purchase of specialist equipment

Working together, the Partnership and the commercial and procurement service is able to identify where there is scope for review of existing service provision, retendering and opportunities to procure services and goods jointly with Aberdeen City.