Aberdeenshire Health & Social Care Partnership

REPORT TO ABERDEENSHIRE INTEGRATION JOINT BOARD – 28th AUGUST 2019

UPDATE FROM THE ENABLING HEALTH AND WELLBEING PROGRAMME BOARD

1 Recommendations

It is recommended that the Integration Joint Board (IJB):

1.1 Consider progress to date of the Enabling Health & Wellbeing Programme Board;
1.2 Acknowledge progress towards meeting the associated strategic priorities;
1.3 Acknowledge implementation of a number of projects are in the early stages; and
1.4 Agree to receive future reports, including further analysis of performance information.

2 Risk

2.1 IJB Risk 1: Sufficiency of Resources – There is a risk the resources available to the Integration Joint Board (IJB) are not sufficient to meet the ongoing health and wellbeing needs of the Aberdeenshire population.

2.2 IJB Risk 6 – Working effectively with partner organisations.

2.3 IJB Risk 4: Service Capacity/Business Transformation – The Enabling Health and Wellbeing programme aims to develop services which are fit for the future, both in terms of financial resources and available workforce. Without this programme of work there is a risk resources will not be sufficient to meet the increasing demand.

3 Background

3.1 The Enabling Health and wellbeing programme group was formed in 2019. The strategic aim of the programme board is to achieve the best health and wellbeing outcomes for the people of Aberdeenshire with a specific focus on Early Intervention, Prevention and Primary care. These priorities are directly linked to the existing and future Strategic plan for Aberdeenshire Health & Social Care Partnership (H&SCP) as well as the Aberdeenshire HSCP Medium term financial strategy. Realistic medicine is considered an ethos underpinning all practice within the programme.[1]

3.2 The programme board brings together the leads for specific projects which are working towards this overall aim in order to share knowledge and skills, manage interdependencies and provide assurance of the progress and

[1] https://www.nhsinform.scot/care-support-and-rights/nhs-services/using-the-nhs/realistic-medicine

governance of these projects. The purpose of the programme board approach will be to ensure that each project has a set of defined outcomes (examples provided under each project) and that the progress towards these outcomes is reviewed and monitored. Additional to this the aim is to develop outcomes for the overall plan to which each project will play its part in delivering.

The current projects are:

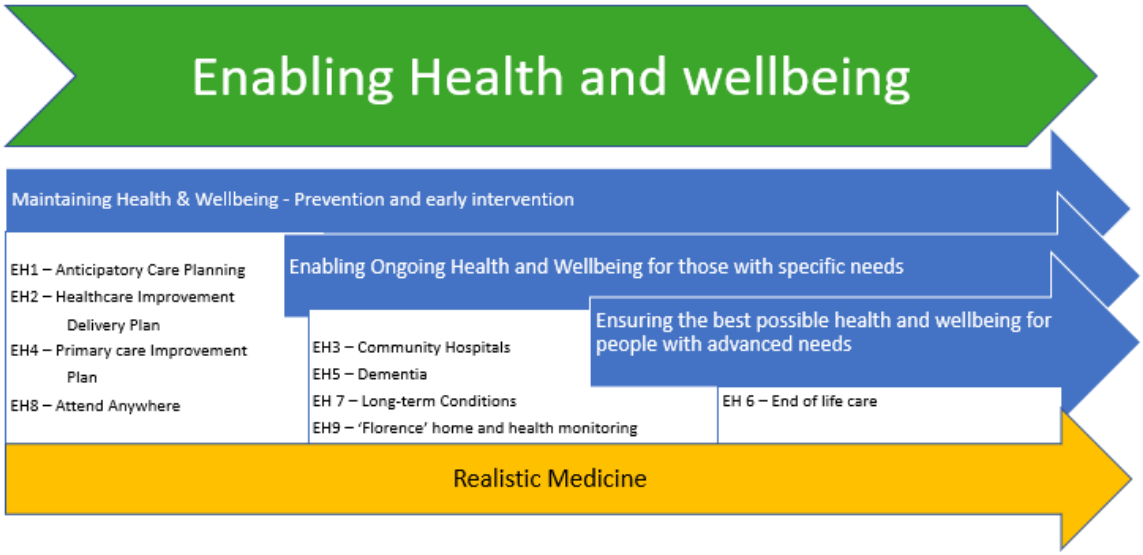

Diagram 1 – Projects currently underpinning the programme board

4 Anticipatory Care Planning (EH1)

4.1 Anticipatory Care Planning (ACP) is a person-centred, proactive, "thinking ahead" approach. It is a dynamic record, developed over time through evolving conversation, collaborative working, and shared decision-making. An individual's ACP is developed with them and their carers with input from health and social care services. It sets out exactly what is to happen in the event of a 'crisis,' in and out of hours.

4.2 It is estimated that 5-6% of the population have the complexity of need where their care outcomes could potentially benefit from an ACP. It is recognised that it is important that individuals should be identified or self-identify to enable their wishes re future care are captured, identifying resources within their families and friends, in addition to health and care services to enable this.

4.3 There is increasing evidence that appropriate access to community services and good anticipatory care, supported by the development of a Key Information Summary (KIS) that contains the right information, can reduce the risk of hospital admission by 30-50%.

4.4 Work has been ongoing for several years to encourage the use of ACPs, but this has been slow and the effectiveness of plans inconsistent. This has led to difficulties for other services accessing the information out of hours, as information is often incomplete, difficult to access, or out of date.

4.5 In June 2019, Cluster Leads for Formartine and Garioch were identified to take part in a new piece of work aimed at refining the ACP process with the use of KIS. This work is in its infancy at present, but the hope would be to work alongside Moray and City where possible to create a universal approach across Grampian. As part of this work, the group applied to join Healthcare Improvement Scotland's (ihub) Living and Dying Well with Frailty Collaborative; groups will be advised on the 16th August 2019 if they have been successful in their application. The aim of the collaborative is to improve earlier identification, anticipatory care planning, and shared decision-making, and support a multidisciplinary approach so that people living with frailty get the support they need, at the right time, at the right place. It is recognised that the aims of the collaborative fits well with our own priorities.

Example of outcomes –

- **Demonstrate an increase in the number of completed ACPs and KIS.**
- **Relaunch with reviewed process.**

5 Health Improvement Delivery Plan (EH2)

5.1 The Health Improvement Delivery Plan for 2019-20 sets out actions for a healthier Aberdeenshire. Our ambition is that local people are able to look after and improve their own health and wellbeing and live in good health for longer.

5.2 Aberdeenshire has the 5th highest life expectancy for men and 10th highest life expectancy for women compared to all 32 local authorities in Scotland[2]. Scotland's overall health however is poor when considered in the UK and European context. In addition to this, Scotland's life expectancy has in recent years shown signs of stalling. This is most acute in deprived areas. This acts as a 'warning light' and indicates the public's health is no longer improving. A main cause for concern is that socio-economic factors play a bigger role in how long you live than it did before.

5.3 People's lifestyles affect their health and quality of life. People often choose more than one unhealthy behaviour simultaneously. This matters because co-occurrence makes a difference in terms of life expectancy and quality of life. [3]

[2] https://www.nrscotland.gov.uk/files//statistics/life-expectancy-areas-in-scotland/15-17/life-expectancy-15-17-publication.pdf
[3] https://www.kingsfund.org.uk/sites/default/files/2018-03/Tackling%20multiple%20unhealthy%20risk%20factors%20-%20full%20report.pdf

5.4 71% of Scottish adults reported at least one unhealthy behaviour and 31% had multiple unhealthy behaviours. People living in the most deprived areas were twice as likely to have two or more unhealthy behaviours as those living in the least deprived areas. Men and women who reported two or more unhealthy behaviours were more likely to have a long-term condition.[4]

5.5 Some of the most common long-term conditions are preventable, their onset delayed or progression slowed down through healthy lifestyle and self-management. Treatment and care for people with long-term conditions is estimated to take up around £7 in every £10 of total health and social care expenditure.[5]

5.6 The Health Improvement delivery plan aims to tackle these issues by taking a whole-system approach to improving health and wellbeing with a targeted focus on;

- ensuring every child has a good start in life
- encouraging healthy weight, diet and activity
- reducing smoking
- reducing harm from drugs and alcohol
- improving mental health and wellbeing
- minimising the impact of poverty and inequality
- making health improvement everyone's business
- Our communities are inclusive and support people to live well

Example of outcomes –

- **Agreed discrete set of indicators to be developed against the nationally agreed public health priorities.**

6 Community Hospital (EH3)

6.1 The Community Hospitals project is newly established with the purpose of developing a consistent strategy for community hospitals. This is required to ensure a clear direction for the future model of Community hospitals. The project and subsequent strategy will have a specific focus on:

- Ensuring resources are utilised effectively and to their maximum potential.
- Providing appropriate governance and accountability for each of the Community Hospitals.

[4] https://www.gov.scot/publications/scottish-health-survey-2016-volume-1-main-report/pages/54/
[5] https://www.gov.uk/government/publications/long-term-conditions-compendium-of-information-third-edition

- Ensuring appropriate budgets are in place for each Community Hospital and that there is effective use of budgets.
- Ensuring sustainability by modernising the GP contract for medical input to the Community Hospitals.
- Ensuring there are clear linkages between this project and other projects that relate to Community Hospitals so that there is no duplication of effort.

Examples of outcomes –

- **To ensure all Community Hospitals are delivering high quality, safe and sustainable services that are fit for the future needs of our residents of Aberdeenshire. For this to be achieved, a Community Hospital strategy will need to be developed and implemented to provide clear direction for all the Aberdeenshire Community Hospitals.**
- **To ensure there is appropriate governance and accountability for each of Community Hospitals within Aberdeenshire that they are achieving what is set out in the strategy.**

7 Primary Care (EH4)

7.1 The primary care improvement plan for Aberdeenshire has been established to implement Scotland's new GP contract. This will move responsibility for some services to the Health and Social Care Partnership and away from Independent Contractors. The Scottish Government have negotiated and are implementing the changes.

7.2 For years there has been increasing problems across Scotland with GP recruitment and sustainability. Increasing numbers of General Practice Independent Contractors and struggling to sustain services and the number of Practices and whole-time equivalent GPs are falling. NHSG is responsible for providing Primary Care services with the responsibility devolved to the HSCP/IJB.

7.3 The six key workstreams that the HSCP must deliver on are:

1) Vaccination Service
2) Pharmacotherapy
3) Community Treatment Centres
4) Urgent Care
5) Additional Professionals
6) Link Workers

7.4 In some streams, the whole of a service should move to the HSCP (vaccination, pharmacotherapy, community treatment, link workers) and in others the HSCP is required to employ staff to support work (4 and 5). The

GPs will continue to provide clinical leadership for the services. Short Life working groups have been established for each workstream, with Clinical Leads involved in each group.

7.5 The Aberdeenshire HSCP are now instructed to deliver the contract within a three-year period, the first year being 2018/2019. Funding in support of the contract sits with the HSCP to deliver the primary care improvement plan.

Example of outcomes-

- **Delivery of the outcomes of the Primary Care Improvement Plan and deliver a more sustainable multi-disciplinary Primary Care Service by developing the six workstreams.**
- **Ensuring sustainable future services for patients where Practices are identified using the Primary Care sustainability tool.**

8 Dementia (EH5)

8.1 In March 2019 the IJB considered a report on the delivery of Post-Diagnostic support in Aberdeenshire and the development of the next Aberdeenshire dementia strategy. These two elements have been incorporated as projects within the programme board.

8.2 The development of a preferred pathway for dementia post-diagnostic support in Aberdeenshire is underway. At present this support is delivered by mental health nurses and link workers employed by Alzheimer Scotland on a grant basis. The current grant agreement goes up to end of March 2020. An initial stakeholder workshop took place in June and further workshops are planned. The IJB will be updated further on this in Autumn 2019. The target for having the pathway agreed and implemented is March 2020.

8.3 The engagement period for the development of the next Aberdeenshire dementia strategy is currently in progress. Phase one of this engagement was with people living with dementia and carers. A series of events and engagement sessions have taken place with people living with dementia, carers and some professionals using the 'village storytelling' model. These have been well received and provided valuable insights. In addition, a survey ran to 9th August. Analysis of this feedback is underway.

8.4 The second phase of engagement is with professionals from health and social care and the third sector. This will involve several targeted workshops incorporating the feedback from the initial events and survey as well as a visit from Tommy Whitelaw, Dementia Campaigner.

8.5 The aim is to have the draft strategy available for consultation in winter 2019 with a view to this being completed March 2020.

Examples of outcomes-

- **Development of Aberdeenshire dementia strategy and preferred pathway for dementia post-diagnostic support in Aberdeenshire.**

9 End of Life Care (EH6)

9.1 Moray IJB have recently led on the strategic review process for palliative and end of life care on behalf of the three IJBs/Acute Sector. Grampian's approach has been to take a cross-system, whole pathway focus to maximise opportunities and ensure best possible outcomes for the population now and in the future whilst ensuring effective and efficient use of available resources. This has taken the format of three workshops with wide engagement from various stakeholders and teams involved in the delivery of palliative and end of life care, the last of which was undertaken in at the start of July 2019.

9.2 The draft strategic plan is out for consultation until the 23rd September 2019, with a final plan due by end of October 2019.[6] It is envisaged that the Grampian Strategic Plan will then guide the work of the partnership going forward.

9.3 A review of the Marie Curie service is in the early stages following a workshop held with relevant stakeholders, including representatives from Marie Curie, in May 2019. At the workshop it was acknowledged that there is a need to consider the wider out of hours service provision, including Aberdeenshire Responders for Care at Home (ARCH) and GMEDS in order to understand how a future service may look to meet the identified demand.

Examples of outcomes -

- **All relevant staff trained in palliative and end of life care.**
- **More individuals being supported to die in their preferred place of death.**
- **Reduction in the number of avoidable hospital admissions.**

10 Supported Self-Management for Long Term Conditions (EH7)

10.1 "Self-Management refers to a way of living and working that means people living with long term conditions feel more in control of their own health and wellbeing".[7] It is one of four key operational themes in the HSCP Medium

6 http://www.nhsgrampian.org/nhsgrampian/InvolvingYou.jsp;jsessionid=CFB0287A550527906D62B7D31580228B?pContentID=10241&p_applic=CCC&p_service=Content.show&

7 HSC Alliance Scotland - Self Management).

Term Financial Strategy and one of four priority themes in NHS Grampian Clinical Strategy 2016 -2021.

10.2 A Grampian-wide group (Grampian Supported Self-Management Transformational Programme Board) has been established to promote access to equitable supported self-management across Grampian. It brings together partners from NHS Grampian, the three Health & Social Care Partnerships, and the Third Sector.

10.3 A range of activities have been undertaken to date to support self-management In Aberdeenshire. These include:

- House of care
- Making every opportunity count
- Good conversations: Personal outcomes approach
- Physical activity
- Development of peer support

Diagram 2 - The House of Care[8]

10.4 The 'House of Care' is a framework which enables people living with long term conditions to have a conversation with practitioners which focuses on their needs and priorities and facilitates joint decision making, goal setting and care planning. Grampian is one of six partners in Scotland's House of Care programme in collaboration with the Health and Care Alliance Scotland. The Programme advocates implementation of House of Care to facilitate transition in Primary Care from the Quality Outcomes Framework approach to the more personalised care and support of realistic medicine.

10.5 House of Care has been implemented by Huntly, Macduff, and Cruden & Hatton GP Practices, with Banchory Practice scheduled to go live this year. Applications for a third cohort of practices for 2019/20 are being considered.

[8] https://www.alliance-scotland.org.uk/health-and-social-care-integration/house-of-care/#expanded

10.6 'Making every opportunity count' is an approach which encourages practitioners to engage in conversations with those they support about behaviours which may impact their health and to provide brief advice and signposting to promote behaviour change.[9] This might include: smoking, healthy eating, healthy weight, being physically active, and alcohol intake, money and housing issues.

10.7 Approximately 800 practitioners in Aberdeenshire (including Health, Social Care and Third Sector) have participated in face to face Making Every Opportunity Count training. E-learning modules are available on employee development platforms and supporting information hosted on hi-net Grampian.[10]

10.8 Physical activity includes Health Walks, Mapping, Chair-based exercises and phase IV Cardiac Rehabilitation Classes.

10.9 As part of this work 'Paths for All' have developed a network of health walks across Aberdeenshire.[11] Grant funding from the Smarter Choices Smarter Places Open Fund and the Walking for Health Fund has been secured by Paths for All to improve short everyday journeys and increase new walkers respectively. This work will be overseen by Live Life Aberdeenshire.

10.10 In addition to the above a network of conversation cafes have developed across Aberdeenshire to develop a culture of peer support and this continues to grow.

10.11 It is evident that real progress has been made in developing supported self-management in Aberdeenshire. There is now a need to evaluate what has been achieved to date and identify opportunities and priorities for further development. The Supported Self-Management for Long Term Conditions project will undertake this evaluation, recommend priority actions and develop an action plan for the period 2019 – 2021. The intended outcomes of the project are:

- People will have equitable access to support for self-management.
- People will be confident in their ability to manage their long term conditions.
- Support and services will maximise opportunities to build confidence and ability for self-management.
- Our systems will support and build opportunities for self-management.

10.12 The Grampian Supported Self-Management Transformational Programme Board has developed a draft action plan for 2019/20 and local actions which contribute to the Grampian-wide outcomes will be incorporated into the Aberdeenshire Plan.

[9] https://www.hphsgrampian.scot.nhs.uk/view/meoc
[10] https://www.hi-netgrampian.org/people-networks/public-health-directorate/health-inequalities/making-every-opportunity-count/
[11] https://www.pathsforall.org.uk/

Examples of outcomes –

- **Continued implementation of House of Care across Aberdeenshire Practices.**
- **Continued roll out of Making Every Opportunity Count training.**
- **Continued development of conversation cafes across Aberdeenshire to develop a culture of peer support.**

11 Attend Anywhere (NHS Near me) Video Consultation (EH8)

11.1 The Attend Anywhere video consulting platform supports the Scottish Government's commitment in the national Digital Health and Care Strategy 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 and specialist support". NHS Grampian is supporting and promoting the adoption of patient-facing video consultation using Attend Anywhere, under the branding of *NHS Near Me,* which has been made available to Scottish Health Boards to use. Aberdeenshire H&SCP successfully bid for £115,076 in Scottish Government funding to scale up the adoption of Attend Anywhere, with a principal focus on general practice, as well as some targeted testing in multi-disciplinary core teams, and to support HMP Grampian healthcare appointments.

11.2 The Aberdeenshire Attend Anywhere project aims to:

- Increase the use of Attend Anywhere video consultations by services, practitioner, and patients for suitable circumstances.
- Reduce the need to travel to healthcare appointments by patients and staff.
- Increase choice and flexibility in how and where consultations can be delivered.

11.3 Key objectives for the use of Attend Anywhere within general practice are to:

- Raise public awareness of the availability and applicability of video consultations for GP appointments.
- Generate public appetite and requests for GP appointments using video consulting.
- Secure adoption and use of video consulting by GPs for patient consults – a target of adoption by 50% of GP practices has been set, however it is hoped

that the vast majority of GP practices will agree to adopt and offer the video consultation option to their patients.

- Use the project learnings to identify those general practice service pathways and consult types most suited to video consultation.

Examples of outcomes -

- **Delivered the roll out of IT kit (webcams etc) to GP practices.**
- **The development of guidance and training for GP practice staff.**
- **The development of a public promotional and communication campaign scheduled to commence in autumn 2019.**

12 BP Monitoring in General Practice using Florence Home & Mobile Health Monitoring (EH10)

12.1 Under the stewardship of Aberdeenshire HSCP, funding of £138,674 has been secured from the Scottish Government to scale up blood pressure (BP) monitoring using the Florence text messaging system in general practices in Grampian, as part of a national scale up programme.

12.2 Implementation of the Florence system in Grampian for home BP monitoring was originally approved with Scottish Government funding for implementation during 2018-2019, however the project was postponed pending resolution of information governance concerns raised by NHS Grampian and which have been progressed by the Scottish Government under a 'once for Scotland' approach. NHS Grampian is currently one of only two Scottish Health Boards not using Florence. With the release of a final version of national information government guidance promised in the near future, implementation of the Grampian project is now planned across financial years 2019-2020 and 2020-2021.

12.3 The project aims (pan Grampian) as set out in the funding bid were to:

- Increase the use of Florence HMHM for BP monitoring to 50% of GP practices in Grampian by March 2021.
- Benefit 3,250 patients.
- Release 3,250 face to face general practice appointments.
- Release 1,147 hours of clinical staff time.

12.4 Given the delay in commencement of implementation, these targets will be reviewed and adjusted as necessary in due course. In participating practices, Florence will be offered in suitable circumstances to patients as an additional and alternative option to existing BP monitoring. The project will be evaluated on conclusion to inform any longer-term commitment in Grampian to this form of home monitoring.

Examples of outcomes –

- **Increase the use of Florence HMHM for BP monitoring to 50% of GP practices in Grampian by March 2021.**
- **Benefit 3,250 patients.**
- **Release 3,250 face to face general practice appointments.**
- **Release 1,147 hours of clinical staff time.**

13 Performance

13.1 In relation to the various projects under the Enabling Health and wellbeing Programme, performance indicators have been identified, or are in the process of being identified, as a way to track and report progress with each area of work. The intention of this approach is to enable the programme group to monitor progress across all individual projects with the intention of measuring the progress of the overall programme of work and identifying and responding to any unintended consequences.

13.2 The measures for each project will link directly to the priorities identified with Aberdeenshire's Strategic Plan and within the Aberdeenshire Commissioning plan.

14 Equalities, Staffing and Financial Implications

14.1 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.

14.2 Work is ongoing to align the aims of the projects with the medium-term finance strategy.

14.3 An equalities impact assessment is not required as there are no policy changes being recommended as part of this report, which is for information only on progress made to date with the Enabling Health and Wellbeing programme of work.

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Strategic Development Officers

Appendix 1 – Project leads

ID	Project	Project Leads
EH1	Anticipatory Care Planning	Linda Bonner
EH2	Health Improvement Delivery Plan	Kim Penman
EH3	Community Hospital	Ali McGruther / Jill Matthew
EH4	Primary Care	Angie Wood / Chris Allan
EH5	Dementia	Amy Richert
EH6	End of Life Care	Linda Bonner & Jill Matthew
EH7	Long Term Conditions	Kim Penman / Shona Strachan
EH8	Attend Anywhere	Erika Skinner
EH9	Florence Home and health monitoring	Erika Skinner