



Aberdeen City
Health & Social Care
Partnership

A caring partnership

Transforming Care Through Integration
Aberdeen City Integration Joint Board

Annual Report 2016-17



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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 well-being.

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 life 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.

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.

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.

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 includes:

- 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**.

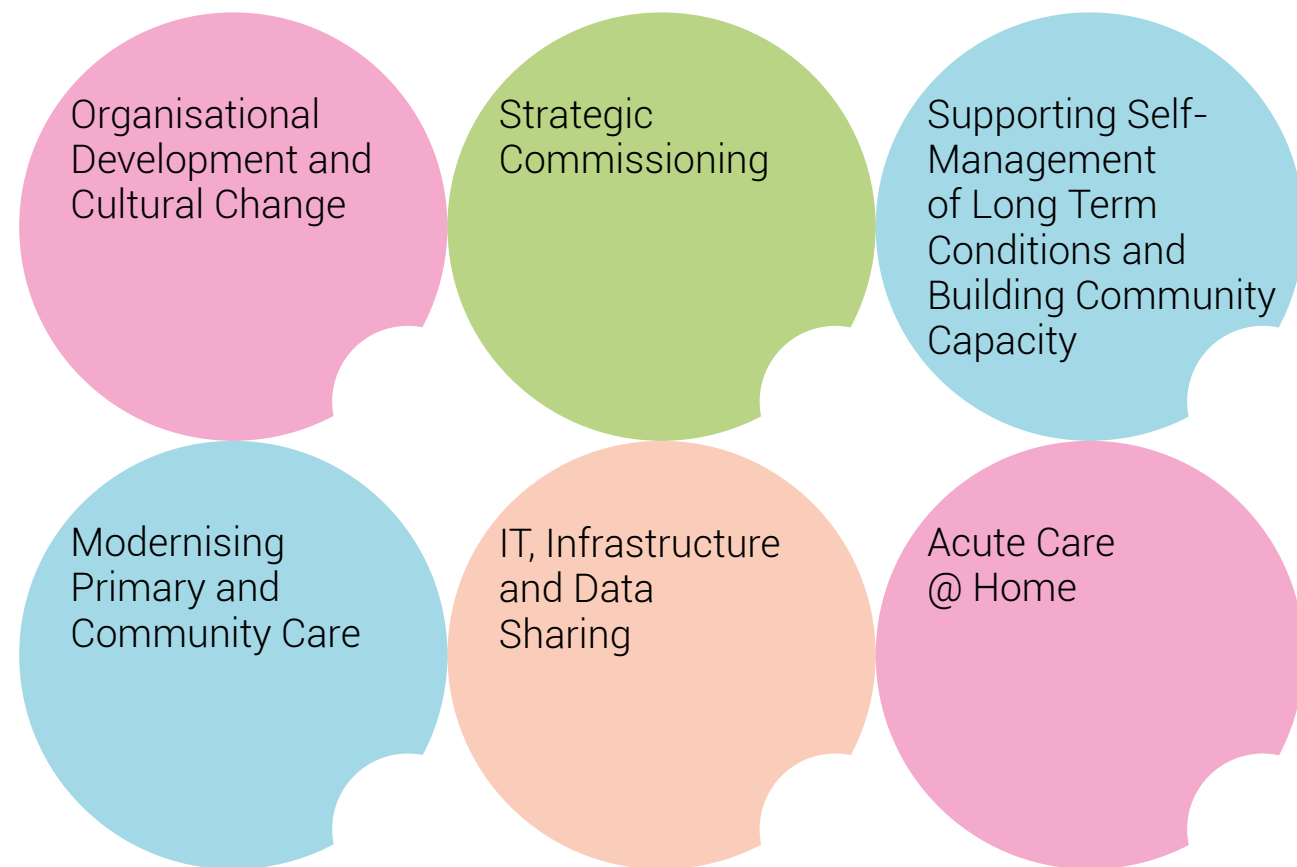
Another key activity where significant progress has been made is in our good, positive and improving relationships with our partner organisations in the third and independent sectors. Aberdeen Council for Voluntary Organisations (ACVO) and Scottish Care (the umbrella group for many of our care home and 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 & 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

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.

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



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

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.

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...

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.

5. How Are We Doing?



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

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.

| | |
|-------------------|--|
| Safe | How well do our services protect people from abuse and avoidable harm |
| Effective | How well does the care and treatment we provide and commission achieve good outcomes, help people maintain quality of life and is based on the best available evidence |
| Caring | How well do staff involve and treat people with compassion, kindness, dignity and respect |
| Responsive | how well are services organised to meet individual needs |
| Well-led | How well does leadership, management and governance of the organisation make sure it is providing high quality care, encouraging learning and innovation, and providing an open and fair culture |

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 ones we have chosen locally to align with our strategic goals and ambitions. Each indicator shows the most recent performance position and the proportionate 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.

Table 5.1. Headline Performance National & Local Indicators

| Category | Title | IJB Baseline | Current Position | % Change | Scotland | Latest Period | Trend Points | Long Term Trend | |
|--|--|--|------------------|----------|----------|---------------|--------------------|-----------------|--|
| Safe | Falls rate per 1,000 population aged 65+ (Annualised) | 19.1 | 18.9 | -1.3% | 21 | 2016/17 | 7 Annual | | |
| | Percentage of adults supported at home who agreed they felt safe | 83% | 83% | NA | 84% | 2015/16 | 2 Biennial | | |
| | Number of new referrals to initial investigation under adult protection | 98 | 106 | +8.2% | - | 2016/17 Q4 | 8 Quarters | | |
| | Percentage of social care complaints responded to in time* | 62% | 84% | +35.5% | - | 2016/17 Q2 | 6 Quarters | | |
| | Number of NHS complaints and % responded to in time | 104 (76.0%) | 106 (70.8%) | -6.9% | - | 2016/17 | 4 Annual | | |
| Well Led | Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated | 77% | 77% | NA | 75% | 2015/16 | 2 Biennial | | |
| | Average number of days to sickness lost per employee in social care | 11.6 | 13.0 | +12.1 % | - | Jan 17 | Monthly Rolling 12 | | |
| | Average percentage of work hours per month lost to sickness absence - NHS staff | 5.0% | 4.9% | -2.9% | 5% Q4 | 2016/17 | 8 Quarters | | |
| Effective | Premature mortality rate per 100,000 persons* | 464 | 464 | NA | 441 | 2015 | 6 Annual | | |
| | Emergency admission rate (per 100,000 population, Annualised) | 9,977 | 9,620 | -3.6% | 11,874 | 2016/17 | 7 Annual | | |
| | Emergency bed day rate (per 100,000 population Annualised) | 100,979 | 102,269 | +1.3% | 106,531 | 2016/17 | 6 Annual | | |
| | Readmission to hospital within 28 days (per 1,000 population Annualised) | 88.4 | 86.9 | -1.7% | 96 | 2016/17 | 6 Annual | | |
| | Total % of adults receiving any care or support who rated it as excellent or good | 82% | 82% | na | 81% | 2015/16 | 2 Biennial | | |
| | Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency | 23.5% | 23.1 % | -1.7% | 21% | 2016/17 | 6 Annual | | |
| | Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections* | 79% | 79% | NA | 83% | 2015/16 | 2 Annual | | |
| | Number alcohol brief interventions | 1047 | 1030 | -1.6% | - | 2016/17 Q4 | 8 Quarters | | |
| | Responsive | Percentage of adults supported at home who agreed that they are supported to live as independently as possible | 82% | 82% | NA | 84% | 2015/16 | 2 Biennial | |
| | | Total combined % carers who feel supported to continue in their caring role | 42% | 42% | NA | 41% | 2015/16 | 2 Biennial | |
| Percentage of adults with intensive care needs receiving care at home | | 55% | 55% | NA | 62% | 2016/17 | 5 Annual | | |
| Number of days people spend in hospital when they are ready to be discharged (per 1,000 population) 75+ only | | 1,765 | 1,156 | -34.5" | 915 | 2016/17 | 5 Annual | | |
| Number of delayed discharges per month at census. Standard and Code 9. | | 86 | 58 | -32.6" | - | Mar-17 | 12 Monthly | | |
| Number and proportion of eligible people taking up self directed support | | 227 (6.9%) | 233 (7%) | +1.4% | - | Mar-17 | 2 Half Yearly | | |
| Number of unmet social care hours | | 1878 | 1462 | -22.2% | - | 2016/17 Q4 | 4 Quarterly | | |
| Caring | Percentage of adults able to look after their health very well or quite well | 96% | 96% | NA | 94% | 2015/16 | 2 Biennial | | |
| | Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided | 78% | 78% | NA | 79% | 2015/16 | 2 Biennial | | |
| | Percentage of people with positive experience of the care provided by their GP practice | 86% | 86% | NA | 87% | 2015/16 | 2 Biennial | | |
| | Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life | 80% | 80% | NA | 84% | 2015/16 | 2 Biennial | | |
| | Proportion of last 6 months of life spent at home or in a community setting | 88.2" | 88.1 " | -0.1% | 87% | 2016/17 | 5 Annual | | |

* latest information available is before current period

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 Kincorth 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

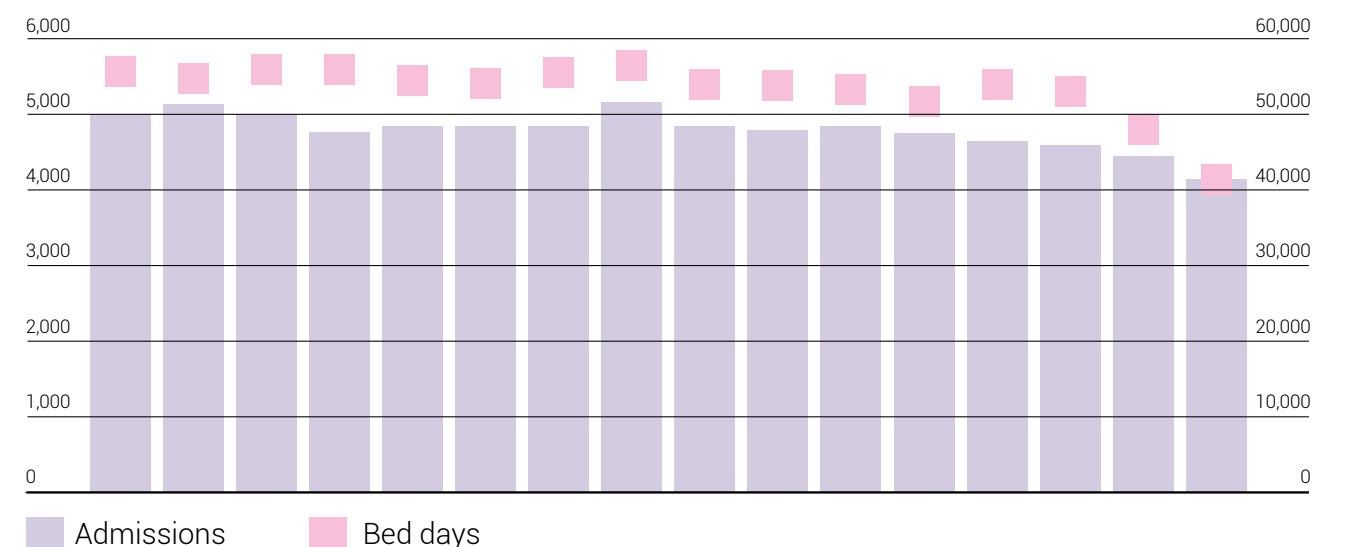


Figure 5.1 illustrates the reduction in patient admissions as an emergency each quarter from June 2013 to March 2017

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.

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, which at its peak culminated in 125 patients delayed in hospital in January 2015, is set in context of reducing care home capacity and a loss of some 160 beds since 2012.

Delayed Hospital Discharges

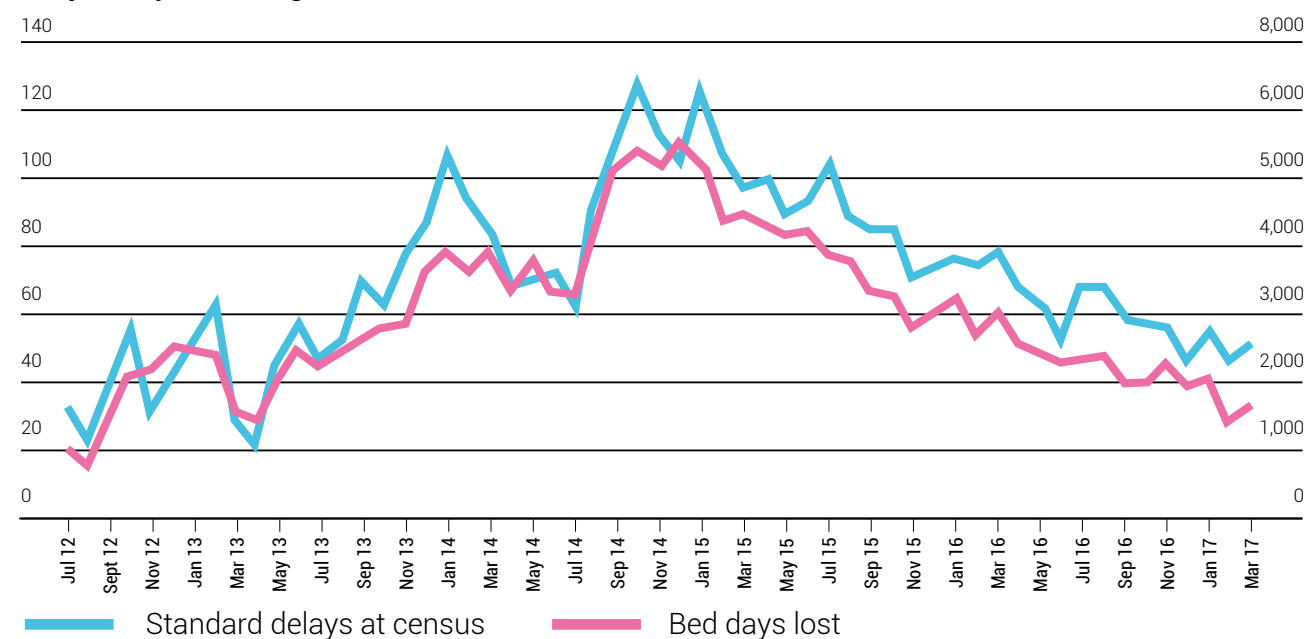


Figure 5.2. Delayed standard discharges and bed days used

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. |

Figure 5.3 ACHSCP Improvement Priorities.

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):

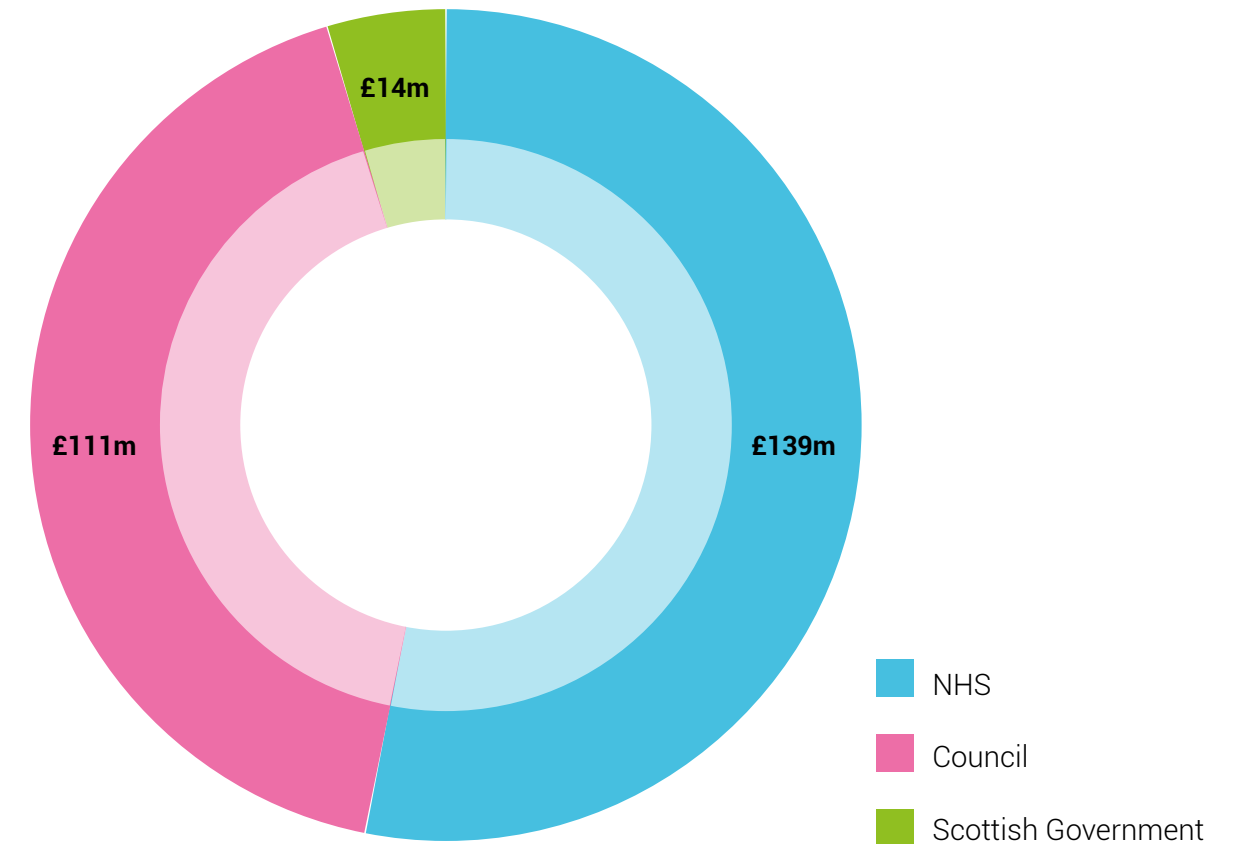


Figure 5.4 IJB Funding.

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.

| Service | Gross Expenditure (£) |
|--|-----------------------|
| Community Health Services | 31,649,313 |
| Learning Disabilities | 29,264,461 |
| Mental Health & Addictions | 18,304,741 |
| Older People, Physical & Sensory Impairments | 69,719,818 |
| Criminal Justice | 4,413,345 |
| Housing | 2,197,288 |
| Primary Care | 36,846,589 |
| Primary Care Prescribing | 40,125,916 |
| Hosted services | 21,207,851 |
| Out-of-Area Treatments | 1,219,506 |
| Set-Aside Treatments | 46,732,000 |
| Head Office/Admin | 1,007,021 |
| Transformation | 2,856,283 |
| | 305,544,132 |

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)

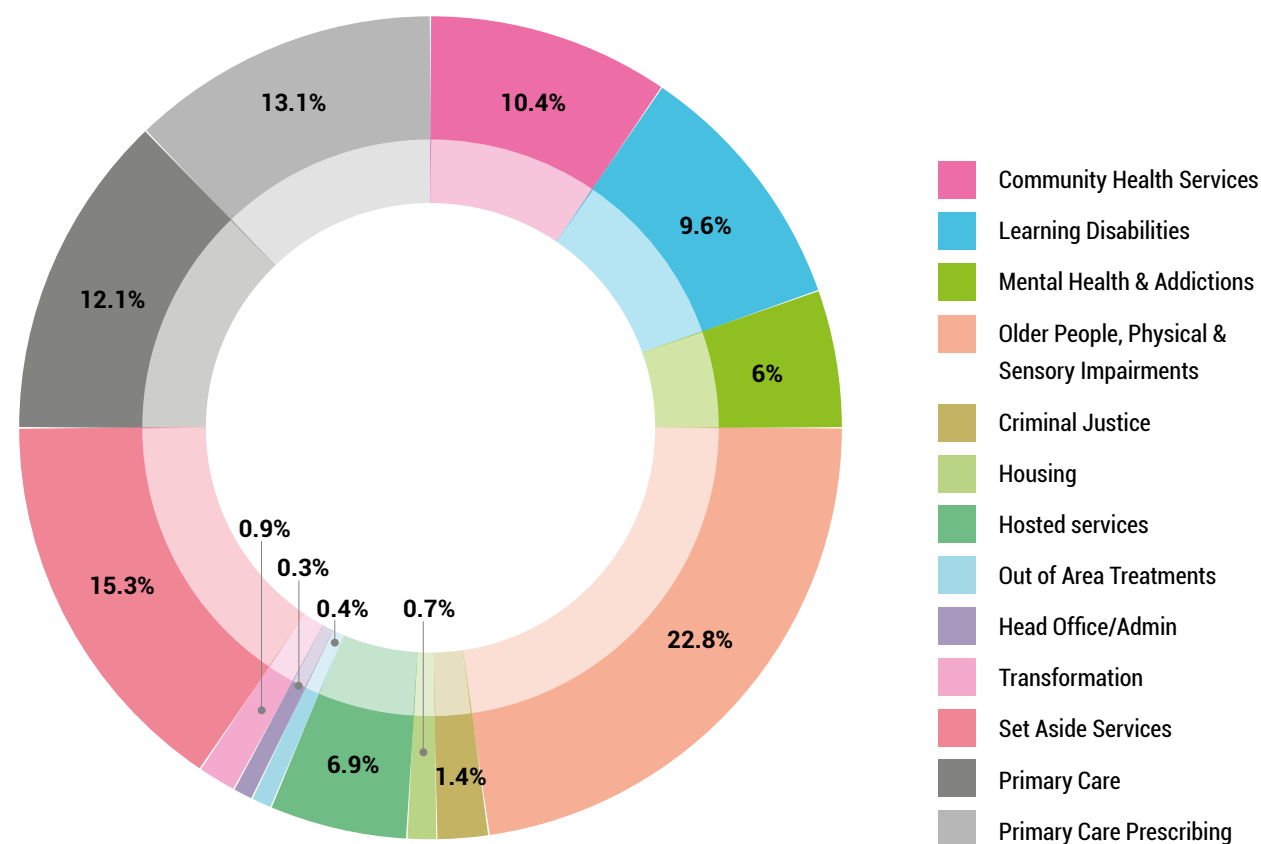


Figure 5.5 Service Expenditure

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.

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 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

