Aberdeenshire
Health & Social Care
Partnership

Integrated Aberdeenshire

A Partnership with People and Communities

Annual Report 2016-17




Aberdeenshire COUNCIL

NHS Grampian

Welcome

Aberdeenshire Health and Social Care Partnership (AHSCP) was formed in February 2016 bringing together the full range of community health and social care services for adults.

A challenging programme of work was set out in our Strategic Plan for 2016-19 and this has been our baseline year to build upon the strong foundations that were in place in Aberdeenshire.

Within the report you will find a number of extremely positive achievements from this inaugural year, demonstrating our performance is amongst the best in Scotland.

We are particularly pleased with progress that has been made to reduce the number of people who are delayed in hospital. Through a commitment to increasing care at home, Intermediate care, falls prevention and a rehabilitation and enablement approach, we have enabled people to be discharged home much earlier and avoided readmission to hospital.

Implementation of the Virtual Community Ward (VCW) has brought about greater collaborative working between staff locally and this has meant that the health and care needs of vulnerable people can be monitored regularly and an appropriate level of treatment and care provided to avoid hospital admission or admission to respite care on an emergency basis. More than 600 people have been supported at home this year, by the VCW, when previously they would have been admitted to hospital.

Participatory budgeting has been introduced across Aberdeenshire. This innovative approach brings communities together to decide the priorities in terms of new developments or projects and gives people a real sense of being involved in how money is spent in their towns and villages.

The Health and Social Care management structure is in place with Locality Managers taking responsibility for managing the resources in their geographical area. Progress is now being made to take forward locality planning with a greater emphasis on working with communities, community councils and community planning partners.

Financially, 2016-2017 has been a challenging year. In this report we detail the achievement of our breakeven financial goal and show how we have delivered the wide range of health and social care services. We have also made progress with service transformation which will allow more sustainable delivery of services within available budget. Staff at all levels have worked hard to achieve the priorities and work towards realisation of the 9 National Health and Wellbeing Outcomes.

From this first year as one organisation, it has been beneficial to review what we have done, celebrate success and look forward to continued progress in 2017-18

Councillor Anne Stirling	**Dr Lynda Lynch**	**Adam Coldwells**
Chair of IJB	**Vice Chair**	**Chief Officer**

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Introduction

Our Partnership

The Aberdeenshire Health and Social Care Partnership formed in April 2016 as a result of the Public Bodies (Joint Working) (Scotland) Act 2014. The purpose of the Act is to integrate planning and delivery of certain adult health and social care services. The Partnership is governed by an Integration Joint Board (IJB) who have responsibility for governance, strategy and scrutiny. Membership of the IJB is detailed in the section on Audit and Governance on Page 32.

Policy and Strategic Context

The main purpose of integration is to enable local authorities and NHS boards to work together to use available resources to improve the wellbeing of people who use health and social care services, in particular those whose needs are complex and who require support from health and social care at the same time.

In the Aberdeenshire Health and Social Care Partnership Strategic Plan 2016-2019, we set out a number of priorities under four themes:

1. Involving and engaging our communities
2. Partners in health and social care
3. Best of health and care for everyone
4. Effective treatment and care

These themes demonstrate our commitment to working together with local communities to provide health and social care services. In practice this means providing people with access to information and support to enable them to keep healthy, manage their health conditions and avoid preventable illness. This enables people to live longer healthy lives, be able to contribute to their local community and receive the best of health and care services when they require it.

We want to encourage people to feel a sense of ownership of local services and by working together identify the services and resources that can best meet the needs of people.

Working with Local Communities

Crucial to health and social care integration is a commitment to listening to and working with local communities. Membership of the IJB includes key representatives from the third sector (voluntary and community groups) as well as carer and service user representation to ensure communities are represented at the highest level of decision making within the Partnership.

Service user feedback is an important element in developing services which are user led so we have ensured there are various opportunities for service users to input into the design of future service development. Surveys such as the service user and unpaid carers' survey carried out by the market research company IBP will provide an insight into service user and carers' experience, what we are doing well and what we need to improve.

Strategic Commissioning: Implementation & Change Plan 2016-17

The Implementation and Change Plan (2016-17) details the projects to be delivered and commissioned in order to achieve the Partnership's Strategic Plan 2016-2019.

The table below details the four themes in the Strategic Plan and outlines the 15 strategic priorities aligned to the four themes. Each priority is then mapped to the 9 National Outcomes for Integration.

Theme		Strategic Priority	Mapped to National Outcomes
1.Involving and engaging our communities	1	Pro-active, responsive & consistent community engagement and involvement in integration and service planning	1, 2, 4, 5, 6, 9
	2	Informed, equitable, and equality sensitive, locality involvement in use of community resources	1, 2, 4, 5, 6, 9
2.Partners in health and social care	3	Involving people as partners in their care, listening and responding to them	3, 4, 5, 6, 7, 9
	4	Self-management of long term conditions,	2, 4, 5, 9
	5	Improving the way unpaid carers are recognised and supported	2, 6, 9
	6	Empowering the workforce to influence service decisions	5, 8, 9
3.Best of health and care for everyone	7	Reducing health inequalities	1, 2, 3, 5, 9
	8	Improving health: (Smoking, diet, alcohol)	1, 4, 5, 6, 9
	9	Supporting people who use health and social care services to achieve their potential and contribute to the life of their community	1, 2, 4, 5, 6, 8
	10	Primary Care: better access, continuity of care, making best use of practitioners' skills	1, 6, 8, 9
	11	Early diagnosis, treatment and care of people with dementia	1, 2, 3, 4, 5, 7, 9
	12	Reducing avoidable admissions to hospital	3, 7, 9
4.Effective Treatment and Care	13	Timely, well-managed discharge from hospital to home or homely surroundings	3, 7, 9
	14	Identifying, treating and promoting recovery from mental ill health	5, 6, 9
	15	Identifying and taking steps to protect vulnerable adults	1, 2, 3, 4, 7, 8

Outcome 1. People are able to look after and improve their own health and wellbeing and live in good health for longer

Outcome 2. People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community

Outcome 3. People who use health and social care services have positive experiences of those services, and have their dignity respected

Outcome 4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services

Outcome 5. Health and social care services contribute to reducing health inequalities

Outcome 6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing

Outcome 7. People using health and social care services are safe from harm

Outcome 8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide

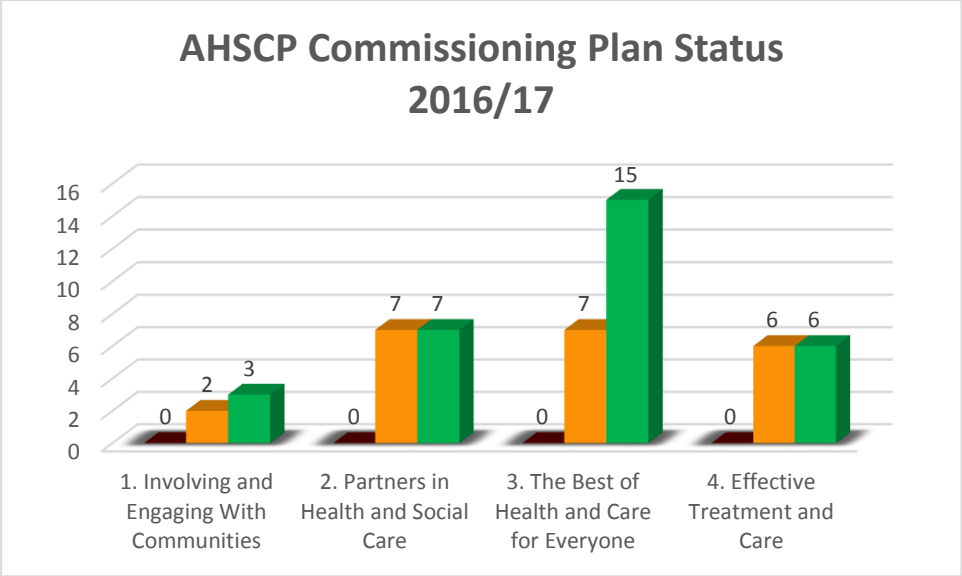
Outcome 9. Resources are used effectively and efficiently in the provision of health and social care services

The Strategic Plan details how the Health and Social Care Partnership will start to bring about transformational change that will lead to a different approach in how we engage with people, empower and support them to maintain their health and wellbeing and involve them in decisions at every stage about their health and care.

Our Commissioning Plan emphasises a shift in focus to services being identified and commissioned locally to build long-lasting relationships with communities in order to do the above effectively.

Strategic Plan Review 2016-17

At the end of year one, a review was undertaken of the Strategic Plan and progress made towards achieving the national outcomes through the Implementation and Change Plan. A total of 53 new projects were identified at the beginning of 2016 and by year end, there were no projects at Red status (no progress) 22 Amber (some progress) and 31 Green (good progress). Regarding the 22 projects highlighted as Amber, it is worth noting that with many of these, Aberdeenshire is performing above the national average. Historically the Partnership has set high standards for achievement and the amber status is a reflection of our progress towards achieving the high standards.



This demonstrates that good and consistent progress has been made during year one to achieve change.

We have detailed each of the Strategic Themes in turn and provided some examples where success has been achieved.

Strategic Theme 1: Involving and Engaging with Communities

There are already a number of ways in which people can be involved in their communities, through Community Councils, volunteering opportunities and taking an interest in the main issues that are important for the people in towns and villages. Through the Health and Social Care Partnership and locality planning, there will be increased opportunities for people to be involved in planning and development of services that will better meet their needs. There are benefits to people from involvement – strong social networks are consistently and positively associated with improved health and wellbeing, reduced illness and death rates.

The strategic priorities aligned to theme 1 are:

- Pro-active, responsive & consistent community engagement and involvement in integration and service planning
- Informed, equitable, and equality sensitive locality involvement in use of community resources

Many people who require health and social care are not able or enabled to play their full part in local decisions. In order to improve on this, a number of projects were identified to be taken forward in the first year to produce and implement a participation and engagement strategy and to develop locality plans.

Thrive and the Foyer

The Partnership commissioned Thrive and The Foyer to develop and inform its approach to community capacity building. The project engaged with people in Inverurie, to build capacity and help develop the relationship between local people and staff

providing health and social care services. Using a range of methods such as social media, community calendar of events, insight gathering and real life stories, the project demonstrated that creating new connections can help build shared purpose, grow social capital and motivate people to take action together.

What Works Scotland

What Works Scotland (WWS) a consortium of University of Edinburgh, University of Glasgow, The Economic and Social Research Council and the Scottish Government, have worked closely with the Health and Social Care Partnership over the last year to support development of our strategic approach to community participation and empowerment.

Community Forums

There are a number of Forums in place across Aberdeenshire enabling people to have the opportunity to give their views and be involved in planning and development of services. A Community Justice Forum and a Health and Social Care Third Sector Providers Forum are being progressed. These themed forums will be used for consultation purposes. Additionally, there are Independent Provider Forums where participants are a mix of Third & Private Sector providers.

Participatory Budgeting

Participatory Budgeting (PB) is where communities are encouraged to put forward proposals for change that will improve the health and wellbeing of the community. Representatives from each community then consider the proposals and vote for the ones that will be bring most benefit. Successful proposals are awarded funding to undertake the project.

Photograph shows groups involved at a Participatory Budgeting Event in Peterhead

Scottish Government Community Choices Funding has been secured to extend the reach of PB to all 6 administrative areas in Aberdeenshire. There are locally led steering groups in all areas leading the planning and engagement with local communities. Over a further £100k has been added to the PB pot from partners over and above the HSCP contribution of £200k and we have agreement to test a variety of PB approaches including introducing digital voting and a mini-public model in Upper Marr.

Strategic Theme 2: Partners in Health and Social Care

The Health and Social Care Partnership works with a wide range of partners. To ensure that treatment, care and support are delivered to people in an effective and efficient way, care managers, GPs, district nurses and home care staff are co-located in

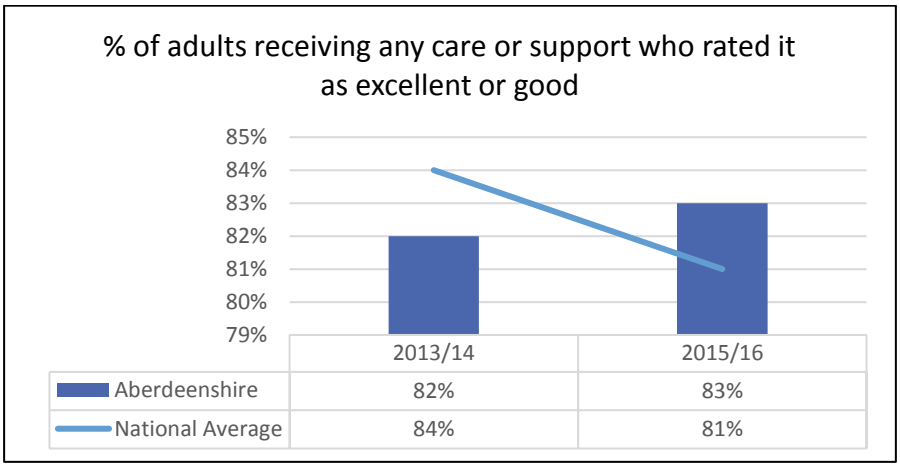
many areas and work closely together on a daily basis. People that we provide services to and their family carers are also our partners.

There are 4 priorities under this theme:

- Involving people as partners in their care, listening and responding to them
- Self-management of long term conditions
- Improving the way unpaid carers are recognised and supported
- Empowering the workforce to influence service decisions

Service Satisfaction

It is important to know what satisfaction there is with services being provided so we can understand where we are doing well and where we need to improve and then act accordingly.



Source, ISD June 2017

As the chart above demonstrates, Aberdeenshire has moved from performing at 2% below the national average to 2% above the national average, improving performance through a time of significant change.

This person-centred approach supports people to develop the knowledge, skills and confidence they need to more effectively manage and make informed decisions about their own health and health care. Self-care and self-management of health conditions is promoted by staff in the Partnership.

Involving people as partners in their care; listening and responding to them

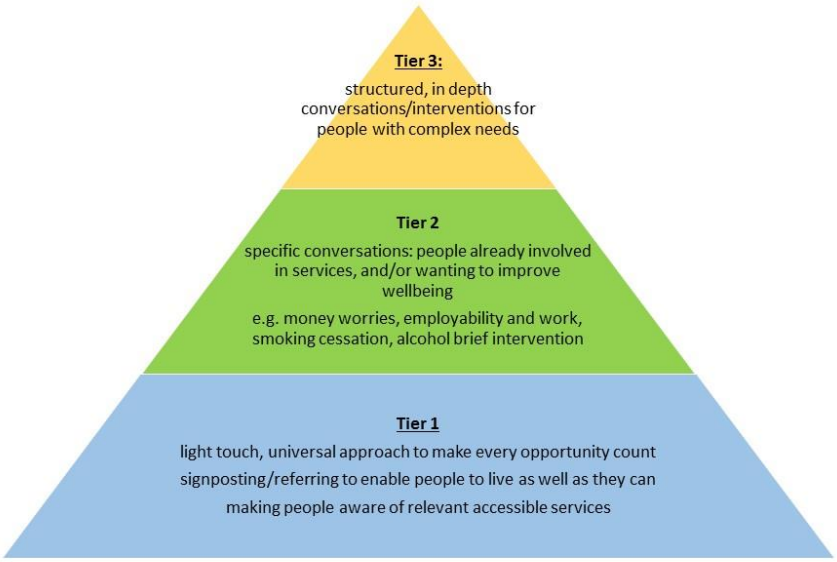
Thistle Foundation (a charitable organisation) was commissioned to deliver training to the health and social care teams using 'making it personal' and 'expert patient' approaches. Feedback on the training from staff indicated it was well received, in particular the sharing and building of relationships that this early integrated opportunity brought. The training was a step change for staff as it was the start of coming together as one team and bringing all the different elements of a multi-disciplinary team together.

Making Every Opportunity Count (MeOC)

MeOC encourages staff to engage with people in conversations relating to lifestyle and life circumstances. This could include, smoking, healthy eating, healthy weight, being physically active, alcohol intake, money and housing issues.

The brief and focused conversations (taking 30 seconds to 3 minutes) makes best use of staff time and can provide a positive influence on health by providing information and being able to signpost people to appropriate services for further advice or support.

The pyramid diagram below identifies a tiered approach to MeOC. For the general population Tier 1 or the 'light touch' approach will be appropriate but for a smaller group of the population, perhaps those with more complex health conditions, a more structured and in-depth conversation (Tier 3) would be more appropriate.



Rehabilitation and Enablement

The aim of this has been to embed the principles of rehabilitation & enablement within health & social care teams, particularly care at home and care management teams.

Following a pilot project, the rehabilitation and enablement pathway has been developed whereby all new referrals to home care will be considered for this approach. Enablement is an intensive short term intervention of up to 6 weeks which helps people to regain the confidence and ability to carry out everyday tasks for themselves. Following the enablement period, the need for ongoing longer term support may be reduced or removed altogether. A review takes place at three to four weeks, at which point any request for continuing care at home will have been identified.

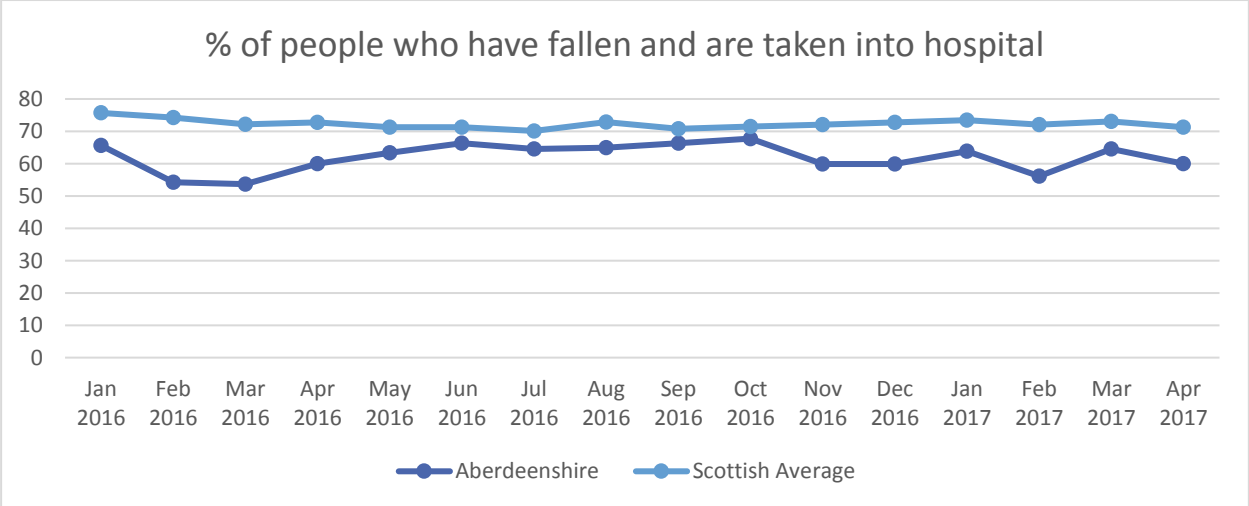
Over 500 home care staff have been trained in using rehabilitation and enablement approaches. The programme is now being extended to include community hospital and very sheltered housing staff with the intention to have all members of the health & social care teams trained in rehabilitation and enablement. Successful implementation of the rehabilitation and enablement approach will help people to regain some of their skills

and abilities thus reducing the need for ongoing care and support. By reducing demand on this service, we are in a better position to have care available, for example, when someone is being discharged from hospital and requires support to return home.

Falls prevention and management of uninjured fallers.

The Falls Steering Group is an Aberdeenshire wide group whose remit is to reduce falls in the community and provide support to people should they fall at home. The group has focused on providing support to people who fall at home and are uninjured. The Scottish Ambulance Service would not normally respond to someone who is uninjured and so the group has set up a pathway which enables people to get support to get up. The pathway utilises the care at home responder service which can react to an urgent call for assistance. Scottish Fire and Rescue Service will provide support to assist uninjured individuals to get up off the floor if the responder service are unable to assist or reach within an hour. This will provide increased support for people who have fallen at home and are uninjured and by reducing the time someone lies on the floor waiting for help their chance of further health complications as a result of the fall area is greatly reduced.

A short life working group called Scottish Ambulance Service Falls and Frailty Pathway Group reports into the Aberdeenshire Falls Steering Group. This group is part of a National Project to provide alternative support options for people who fall at home and sustain an injury but do not require admission to hospital. Aberdeenshire already has one of the lowest rates in Scotland for people who have to be taken into hospital as a result of a fall and is below the national average (see table below). The group is focusing on supporting people to access rehabilitation services such as support from an occupational therapist or physiotherapist. By supporting people who have fallen to access further services it is possible to reduce the likelihood of a further fall in the future.



Supporting Unpaid Carers

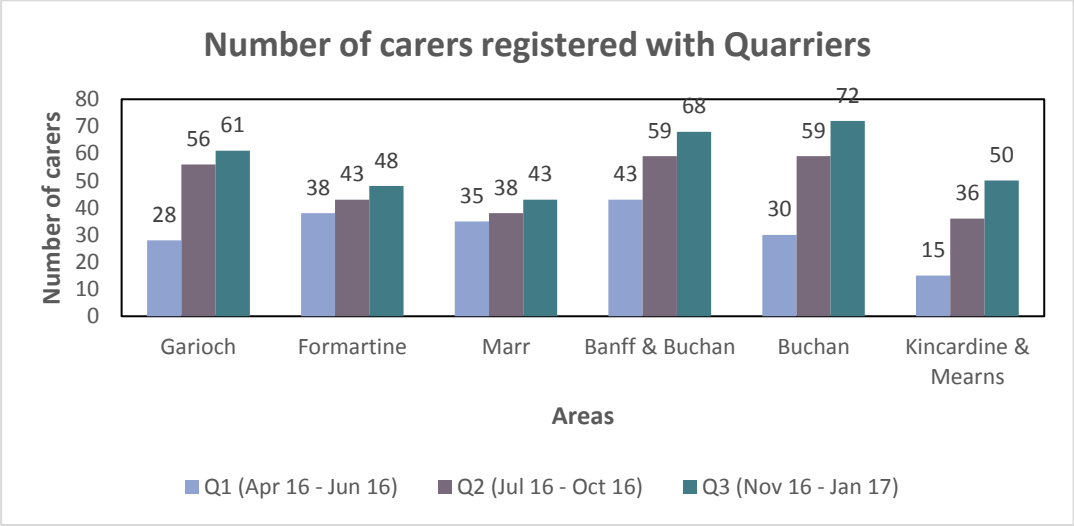
The Health and Social Care Partnership has a strong commitment to engaging and working with unpaid carers. Many carers are well-supported but others are not. Caring responsibilities can affect carers' physical and mental health with many carers having

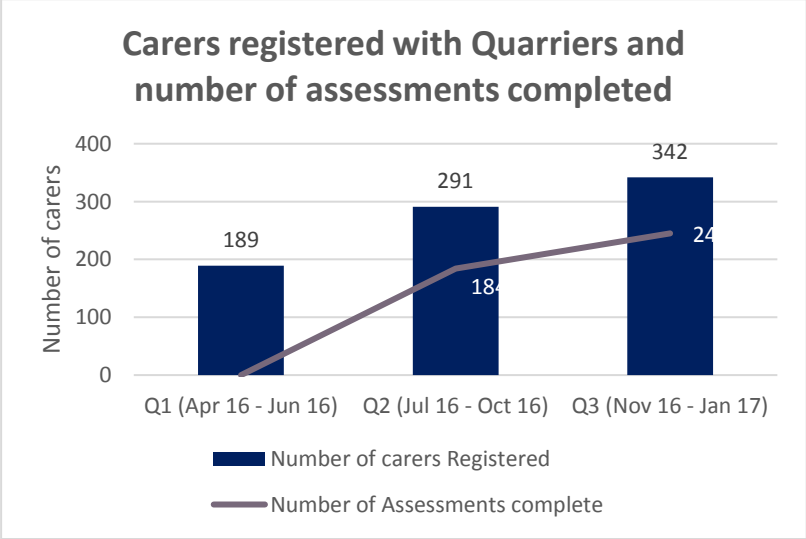
long-term health conditions. Some carers are looking after people with complex needs and carers are aging. Carers are recognised and valued more than ever before. The imperative is to better support carers on a more consistent basis so that they can continue to care, if they so wish, in good health and to have a life alongside caring.

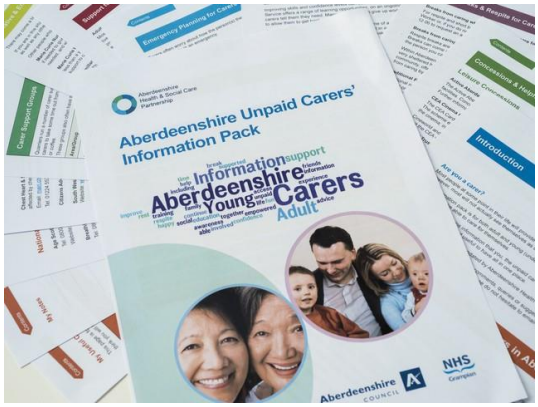
The Partnership commissions a carers support service from Quarriers which provides support to young and adult carers. In addition to this service, other organisations also provide support to carers e.g. PAMIS provides a specialist service for families of people with profound and multiple disabilities.

Carers can be offered an assessment to determine what information, training and assistance would enable them to continue in their caring role.

The graphs below show the number of carers registered with Quarriers across Aberdeenshire and the number of assessments that have been carried out by Quarriers during 2016/17.







Achievements during this year have included the publication of an Information Pack for carers which is widely available in electronic or paper version.

Included in the pack is information on carers' support services, helpful hints for carers and community services that promote carer involvement.

The Partnership continues to support carers to access training and development opportunities. There is an ongoing programme of support for carers to complete an SVQ level 2 – Social Services and Healthcare.

> *"I am a carer to my son who has SPD (Sensory Processing Disorder) and I knew I wanted to go back to work in the future but needed to go in a different direction in a career. I needed something that would fit around my son and a job that I would enjoy. At my Carer ś Support Group I was told about the opportunity for carers to do the SVQ qualification. It ś quite scary being a 43 year old and taking up a new qualification, but I took the plunge and made enquiries. Sandra (SVQ assessor) came to my house and explained the course to me and more importantly how much 1-1 support I would get if I needed it. After talking to her I felt at ease and confident that I could do this.*
>
> *When I got my certificate through, I was beaming with pride. My children were proud of me as they knew how hard I had worked. After a few applications, I got offered a part time job working with children with additional needs. Now I am out there working and still caring for my son as I get all the school holidays, no childminders needed :-) Happy days for us all as a family!!*
>
> Excerpt from story of Carer who has completed the SVQ

Since the start of this project in February 2014, over 40 carers have registered for the qualification and to date 20 have completed the qualification.

During this year, we have made good progress towards implementation of the Carers (Scotland) Act 2016. This new legislation comes into force in April 2018 and brings new duties and responsibilities for the Health and Social Care Partnership. The intention is to support carers in a flexible, person-centred way with an emphasis on supporting carers on a preventative basis.

The Partnership is developing a Carers Strategy and a recent carers' survey has provided us with valuable information on how carers view their role and what needs to be done to bring about improvement. Events have been planned to engage with carers regarding the draft strategy prior to a final version being agreed by the Integration Joint Board and published.

Empowering the workforce

We recognise that integration of health and social care has brought many changes however staff have risen to the challenge in an exceptional way. Partnership and Location Managers are in place and settling in well to the new experience of managing both health and social care resources in their geographical areas. Budgets are being devolved to areas giving managers more responsibility for services and opening up greater possibilities for service redesign so that greater efficiency and effectiveness can be achieved.

Through a programme designed to improve opportunities for teams to be co-located, communication and decision making by front line staff has been improved significantly. Improving ICT infrastructure has been challenging as we are joining together the ICT and support systems of two large organisations. The progress we have made to date has contributed to ensuring communication across services is unimpeded by legal, technical or organisational barriers.

A Joint Staff Forum was set up to allow open and transparent discussion across the staff groups, organisations, Human Resources and trades unions in order to support staff through this period of change.

Strategic Theme 3: The Best of Health and Social Care for Everyone

This theme is about closing the 'health gap' between those living in the most advantaged and most disadvantaged communities; ensuring that people have the best opportunity to improve their health and making sure people can access the treatment they require, when they need it. There are six priorities within this theme;

- Reducing health inequalities
- Improving health (smoking, alcohol, diet)
- Supporting people who use health and social care services to achieve their potential and contribute to the life of their community
- Primary care: better access, continuity of care, making best use of practitioners' skills
- Early diagnosis, treatment and care of people with dementia
- Reducing avoidable admissions to hospital

Over the last year the Partnership has been working on a number of projects and initiatives to support these priorities.

Keep Well Wellbeing Check

The Keep Well Wellbeing Check and Making Every Opportunity Counts programmes have offered brief advice and support to people who would like to improve their lifestyle and wellbeing. Brief lifestyle advice has been provided through General Practices, health and social care teams and third sector partners focusing on people who may be experiencing health inequalities including carers, unemployed people, older people on low income and offenders.

Smoking Advice Service at HMP Grampian

The Smoking Advice Service is available in Her Majesty's Prison (HMP) Grampian providing support to prisoners to stop smoking. Smoking Advisors have worked

alongside Scottish Prison Service and NHS staff to provide 1:1, group support and access to stop smoking medications on prescription. 34 prisoners were supported in the past 12 months to set a date for when they aim to stop smoking. 24 stopped within 4 weeks and 18 at 12 weeks. This gives a quit rate of 70.5% at 4 weeks and 52.9% at 12 weeks. These rates are the highest in Scotland. This service is supporting HMP Grampian become a smoke-free prison.

Signposting Project

The Signposting Project has been in place for a number of years and provides a service throughout Aberdeenshire working with statutory and third sector organisations to build support for those referred helping to maximise participation in local and community networks, services and activities. Staff work with each individual to provide tailored solutions based upon individual need. The project provides options for people however people are encouraged to make their own decisions and take the steps they feel will help most.

The project has 4 distinct strands of work.

- **The Signposting Service.** Working with anyone over the age of 16 who is experiencing or is at risk of developing mild to moderate health issues or reduced wellbeing due to circumstances in their lives for which they need help, advice or support.
- **The Signposting Service for Older People.** Working with people in Aberdeenshire over the age of 65 who are isolated, socially or geographically and are experiencing or are at risk of developing mild to moderate health issues or reduced wellbeing due to circumstances in their lives for which they need more in-depth help advice and support.
- **The Out and About Project.** The Out and About Project provides an opportunity for older people who have little or no social contact and are experiencing loneliness to meet with other like-minded individuals with a view to forming natural friendships and encouraging participation in activities, events, groups and organisations in their communities.
- **The Signposting Carers Information Project.** The Carers Information Project was a project piloted in 2 areas- Buchan and Garioch with the aim of increasing the number of carers identified at early stages. Early identification of carers can help to ensure that they are signposted to the appropriate community supports, organisations and agencies best placed to support them in their carer role.

Anticipatory Care Plans

The purpose of Anticipatory Care Plans (ACPs) are to ensure better quality care and person centred focus and choice. Anticipatory Care Planning involves forward planning regarding further support an individual would require from family, friends/neighbours, to stay as well as possible and manage their long-term conditions at home. It identifies what short term additional healthcare and/or social care can be provided to prevent an avoidable admission to hospital. Where an admission is unavoidable, planning will ensure admission to the right place (care home or hospital), for the right treatment with an agreed discharge plan already in place. There is an ongoing programme of work to promote and improve the quality of ACPs across Aberdeenshire. Aberdeenshire's Anticipatory Care Strategy was introduced in June 2017 and along with recent national

guidance on ACPs, work will be progressed to promote good practice and encourage staff to support people to create ACPs.

Services and Support for People with Dementia

We aim to improve support for people with dementia, not just within health and social care but also in the wider community. A combination of Best Practice in Dementia Care Training and the Promoting Excellence Framework is being rolled out across the Partnership to ensure staff at all levels are appropriately trained in order to best support people with dementia. This can include helping staff to understand the importance of being 'in the moment' with someone with dementia which can help to reduce stress and anxiety and also how to signpost people to other services which can provide further support for them and their families.

Dementia Friendly Aberdeenshire, hosted by Aberdeenshire Voluntary Action, is working to raise awareness and develop dementia friendly initiatives responding to the distinct needs of different communities.

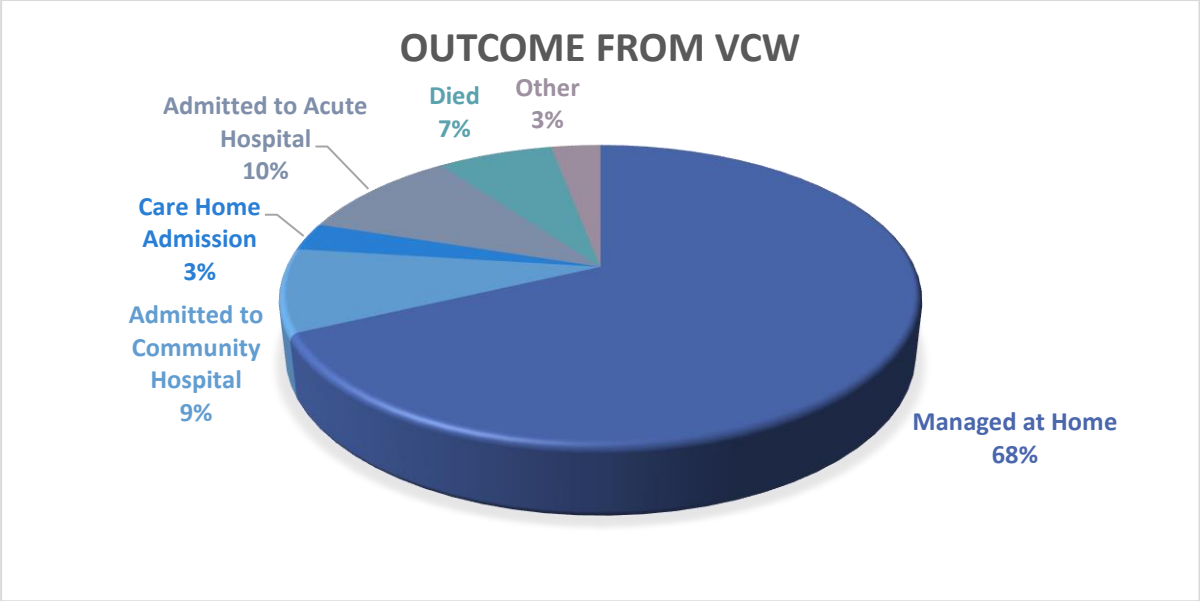
An example of this is the formation of Dementia Friendly Aberdeenshire: Portlethen (DFA: P). This has been a grassroots initiative which began with a public meeting in September 2016. Since then, DFA: P has gone from strength to strength and has recently become a constituted group. Its achievements to date include working with partners to establish designated dementia friendly walking routes and a number of awareness raising events, including a very successful 'Vintage Tea Party' at the local library.

As well as continuing to raise awareness of dementia in the local community, DFA: P is working with Aberdeen Football Club Community Trust to develop dementia friendly walking football, and with the Lethen Arms to put on 'Boogie in the Bar' – dementia friendly informal dancing sessions.

Although every community across Aberdeenshire is different, DFA: P has served as a model for development of initiatives elsewhere, with different elements of this initiative being adapted to the needs of other communities.

Virtual Community Ward

The Aberdeenshire Health and Social Care Partnership has implemented the Virtual Community Ward (VCW) model which provides a methodology for managing a group within the population who require regular or urgent intervention. The aim of the VCW is to put a robust process around the care and management of individuals by the right person giving the right support. This support is provided to individuals by multi-disciplinary integrated health and social care teams. The VCW is very effective in identifying individuals earlier in their disease progression thereby allowing earlier intervention which can significantly improve patient outcome and experience. Over the last year, 842 people who were assessed through the VCW were maintained at home and 259 were either admitted to hospital or a care home (see chart on next page).



This is a tremendous outcome for the people who have been able to stay in their own home and receive additional help and support from different members of the health and care team whilst they regain their health.

Strategic Theme 4: Effective Treatment and Care

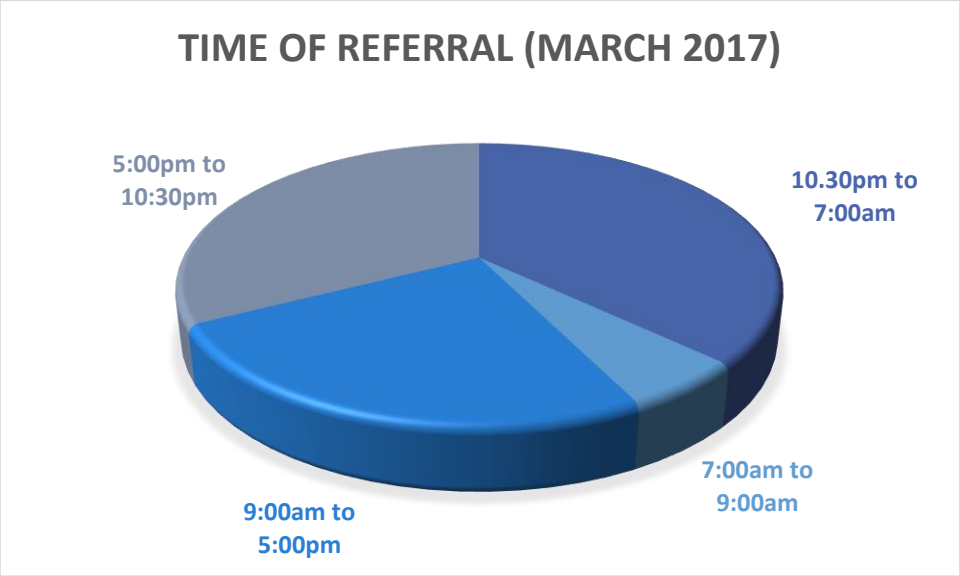
This theme is about ensuring that people are able to receive the right care to meet their needs. Availability of appropriate community services will enable more people to be cared for at home and ensure that people are safe in their communities.

The three priorities within this theme are;

- Timely, well managed discharge from hospital to home or homely surroundings
- Identifying, treating and promoting recovery from mental ill health
- Identifying and taking steps to protect vulnerable adults

Aberdeenshire Responder Care at Home (ARCH) Service

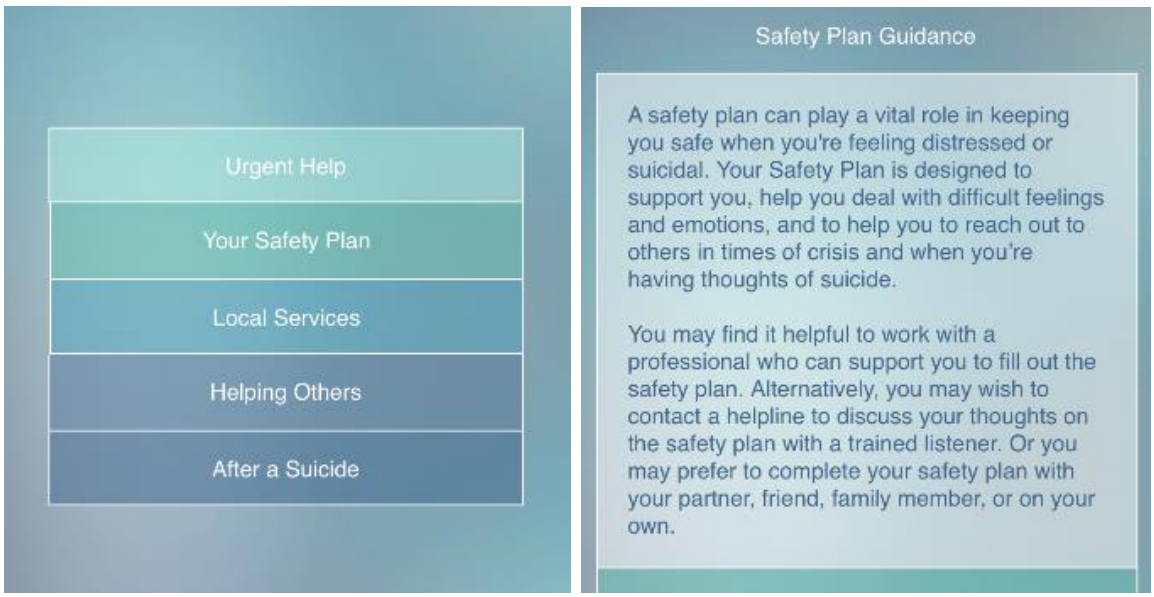
ARCH is an enhancement to the mainstream care at home service. Teams of home care responders are based throughout Aberdeenshire and are available 24 hours a day for planned, unplanned and urgent care. Development of this service has been well received by health & social care teams. Historically, there has been a significant number of people admitted to hospital and care homes with an acute health episode because their need arose outside of usual service operating hours and therefore there was no support available within the community to enable people to stay at home. The ARCH service is able to respond to these unplanned events and in addition, practitioners can plan overnight visits that can support more people to return home from hospital earlier than would previously have been possible. The chart below presents information on the time of referrals to the ARCH service and clearly shows that a large proportion of those are out with normal operating hours.



Grampian Suicide Prevention App

The Grampian Suicide Prevention App was launched a year ago and has a high take up rate and very positive responses. It has been used more than 18,000 times since its launch in March 2016. The app, which is available on all platforms, is a way of allowing people to gain knowledge of suicide prevention without having to directly engage with mental health services.

The app provides a wealth of information for people who require support and for people who have been affected by suicide. The app provides practical information to help people cope if they may be feeling suicidal and also information for people who want to support family members and friends. Launch of the app, along with the introduction of Google and Facebook adverts, coincided with a 29% reduction in suicides in Aberdeen and Aberdeenshire during 2016.



Screen grabs showing part of the suicide prevention app

Commissioning of Mental Health Services

In 2016, following a strategic event involving stakeholders, it was identified that there was an opportunity to modernise and improve commissioned mental health services through a retendering exercise. In line with nationally agreed good practice and local need the specification focussed on; a shift from a buildings based service to a more inclusive and sustainable community model; an increased focus on recovery; ensuring people get services when they need them; improved links to services which can support the achievement of positive outcomes (e.g. employability and education services); equal access to services in all localities; working with communities and making best use of community resources; use of technology where this is appropriate and equal access to services; ensuring that people who use services have a say in the design and delivery of those services. The 'Mental Health Pathways to Recovery' tender resulted in Scottish Association for Mental Health (SAMH) being awarded the contract to deliver services.

Innovative Approaches in Learning Disability

Over the last year, we have been progressing a more innovative approach that will enable us to provide specialist accommodation and appropriate levels of care for people with complex care needs, such as behaviour that challenges. This is with the aim of reducing the need to accommodate people out with their local authority area. The Partnership is currently exploring the development of modular housing that can be built off-site to a range of specifications and then transported and established on any site. With appropriate planning, modular housing can be tailored to individual requirements and built around the needs of the individual, rather than adapting existing housing.

There continues to be considerable challenges with regard to provision of extra care housing for adults with a learning disability. We need to build on the success that we have achieved through re-provision of accommodation that no longer meets the needs and aspirations of a younger generation. Research suggests that traditional group living residential models of care are becoming increasingly unpopular with younger people. The established St James's Court extra care housing in Inverurie was the first of its kind in Central Aberdeenshire. It provides adults with learning disabilities their own self-contained flat, with onsite support available 24 hours a day. This has been an extremely effective model of provision for the residents who stay there, allowing greater opportunity for people to be more independent. We will continue to look at opportunities for new build extra care housing through our Asset Management Plan over the coming years.

Aberdeenshire Health and Social Care Partnership's IDEA project aims for people with a learning disability to be more involved and valued in their communities through the transformation of Day Services. In line with the project's philosophy and after much planning and consideration, the Harlaw Day Centre building in Inverurie was officially closed in August 2016. As an alternative to attending a building-based service, new opportunities were established across Central Aberdeenshire which are integrated more fully into local communities. People now have the opportunity to participate in various activities that meet their outcomes in the local community centre, a community church and a community flat. For those people who do still require a buildings based service provision continues to be made available at Port Road, Inverurie. Following these changes the day service is thriving and continues to meet the ever evolving needs of its service users. As part of this project, an approved fully-accessible changing place was

developed in the centre of Inverurie, the first of its kind for the town. The lack of suitable changing facilities in the community can be one of most restrictive practical problems preventing people with participating in everyday activities. Having this resource allows for greater access to community activities, particularly for adults with profound and multiple disability.

Changing Place, Port Road Day Centre, Inverurie.

Adult Support and Protection

Aberdeenshire Health and Social Care Partnership has undertaken a considerable amount of work around raising awareness of the importance of adult protection among staff within the Partnership and the wider community. There are a number of training courses available for staff that will help them to identify where someone could be at risk of harm and the steps that need to be taken.

A leaflet has been produced which is available online and in print form through various outlets which provides information on identifying harm and how to report suspected adult protection concerns.

Adult protection is everyone's responsibility and the Partnership is working hard to support and encourage staff to work together to identify when people may be at risk. Where harm is a risk factor, a multi-disciplinary approach involving relevant staff involved in an individual's care as well as their family and/or carers can ensure the best outcome for the person affected and support them to remain safe in the future.

The following example highlights how working together has resulted in a positive outcome for this individual.

Case Example

Referral made by Care Manager regarding a 71 year old man with dementia who resides in a residential care home. The Adult had been found with pressure sore on left cheekbone following missed 2 hourly turning visit by night staff. Following inquiries further concerns regarding the care home were noted. An investigation occurred including a council officer visit to a relative of the adult and examination of care record. The adult was not interviewed as he lacked capacity and was unable to communicate due to his dementia. As a result a meeting was convened, attended by the managing director from the service provider, the care manager, contracts officer, care inspector and an adult protection senior practitioner. This meeting not only focused on the AP incident but looked holistically at care being provided to other residents. As a result of the meeting the managing director undertook to put an action plan together. This was fully supported and monitored by other agencies. The situation improved for the adult and his relative and reduced risk to other residents in the care home.

Excerpt from Aberdeenshire Adult Protection Committee Biennial Report 2014-2016

Community Justice Redesign

Community Justice is a method of crime reduction and prevention, which includes the community in the process. The aim is to prevent, control and reduce crime and make amends to the community for any harm that has been caused.

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; and to support desistance. The new model, underpinned by the Community Justice (Scotland) Act 2016, (http://www.legislation.gov.uk/asp/2016/10/contents/enacted) places planning at a local level, bringing a local perspective to community justice and enabling decisions to be made by the people who know their area best.

A legal duty has been placed on a set of statutory community justice partners to engage in this Local Planning process. In line with the requirements of the Act, the statutory community justice partners involved in community justice locally include: Aberdeenshire Council, NHS Grampian, Police Scotland North East Division, Scottish Fire and Rescue Service, Skills Development Scotland, Aberdeenshire Integration Joint Board, Scottish Courts and Tribunals Service, the Scottish Prison Service and the Crown Office Procurators Fiscal Service.

To support its vision, the Scottish Government has also developed a National Strategy for Community Justice and an Outcomes Performance and Improvement Framework, both of which are referenced at various points within the Aberdeenshire Community Justice Outcomes Improvement Plan for 2017/18. The Outcomes, Performance and Improvement Framework includes a set of common outcomes for Community Justice, containing both structural outcomes (the things we do as partners) and person-centred outcomes (the changes that these activities bring about for the people using these services).

Statutory partners have also been required to prepare a Participation Statement that sets out what has been done to achieve the involvement of third sector and community bodies with an interest in community justice in the preparation of the Local Plan. The Aberdeenshire Community Justice Partnership continues to work closely with Aberdeenshire Voluntary Action to develop a new theme forum to consult with third sector bodies – not only to fulfil the requirements of the legislation, but also to develop a mechanism for ongoing engagement and to identify and maximise future opportunities to increase communities' awareness and understanding of community justice.

Informing local communities about community justice issues and involving them in the decisions that affect them will support reintegration, reduce stigma and lead to the delivery of better, more responsive services and improved community justice outcomes. The National Strategy specifies that when consulting with communities, victims of crime and their families, people with convictions and their families, people who live in the community, local businesses and community bodies must all be included. To meet these requirements, a range of consultation and engagement activities were carried out by the Community Justice Partnership over the year, including, but not limited to:

- Consultation with communities via the November Citizen's Panel Survey;
- Consultation with service users, both within the community and within a custodial setting;

- Online consultation for members of the public, facilitated through Survey Monkey and promoted via partner websites and social media;

- Consultation with a range of community justice stakeholders via a series of briefing sessions delivered at 5 locations across Aberdeenshire.

In addition, briefing sessions designed to raise awareness of the new model for community justice were also delivered to all Aberdeenshire Area Committees during early 2016, with feedback obtained from local Elected Members.

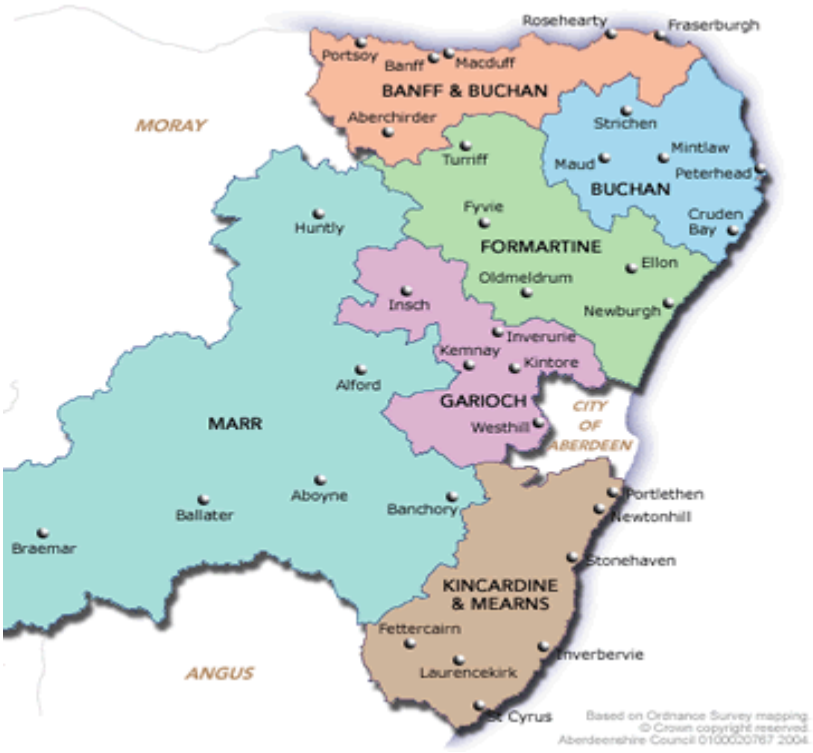
Informed by a local Needs Assessment together with the outcomes of stakeholder, service user and community consultation exercises, the first Community Justice Outcomes Improvement Plan for Aberdeenshire was published in April 2017. An annual report on the progress of the Community Justice partners in working together towards fulfilling the priorities identified in the Local Plan will be complied for submission to the Aberdeenshire Community Planning Board and the national body Community Justice Scotland at the end of March 2018.

Localities

The Health and Social Care Partnership is committed to developing and delivering services that meet the needs of people in their own communities. The Integration legislation determined that we identify two or more localities within our Partnership area.

The map below identifies the 6 areas that the Partnership has agreed to align service development and provision to, as it fits well with NHS Grampian and Aberdeenshire Council's current planning arrangements.

Map of Aberdeenshire HSCP Localities



Structures

Management arrangements for the Health and Social Care Partnership are now in place. Four Partnership Managers are in post – North, Central, South and Strategy & Business Services. This was followed by appointment of the Location Managers in January 2017. Location Managers manage the health and social care services in their area. Twenty locations were identified across the Shire based around core teams delivering services for natural communities in the Partnership. Smaller locations have been grouped together within the management structure enabling the Partnership area to be managed by 12 Location Managers. There are also management arrangements in place for mental health/learning disability, community justice, and strategy and business services.

The operational management structure is supported by a professional structure including Lead Nurse, Clinical Lead, Allied Health Professionals Lead and Lead Social Worker.

Locality Planning

Aberdeenshire Health and Social Care Partnership aims to encourage local decision making within natural communities. Local arrangements for planning, service management and operational delivery are being established. Locality Planning groups are being set up within each of the six local authority areas: Banff & Buchan; Buchan; Garioch; Formartine; Kincardine & Mearns and Marr.

The Locality Planning groups will play an important role in engaging with communities and those groups and organisations who support local communities. By working together and involving people in decisions about health and social care services we aim to improve both the experience and personal outcomes for individuals.

It is recognised that this process will mature over the coming years and be able to provide the opportunity for services to be planned, delivered and managed locally.

Partnership Engagement Workshops

Locality Planning Workshops were held from October 2016 to January 2017. Working collaboratively with all partners including health and social care staff, third sector, housing, patient/carer representatives, the workshops included discussion on terms of reference, attendees at meetings, current improvement initiatives and areas for development in line with the 15 strategic priorities. Outputs from all the workshops were collated and fed back to all attendees. These were then taken forward by the 3 Partnership Teams (North, Central and South) to identify how this will best work within their areas and how links with already established groups and structures such as community planning partners and community councils can further develop opportunities for people to become involved in their communities.

Information and Data

A Strategic Needs Assessment was undertaken at the end of 2015 across the 3 Partnership areas (North, Central and South) to support the development of the locality planning process. The Partnership has worked with the ISD ‘LIST’ (Local Intelligence Support Team) in order to develop locality profiles. The profiles will provide the locality planning groups with a wide range of information that will help to identify the priorities for each of the 6 geographical areas.

Next Steps

Locality planning workshops for each of the areas are to be held to ensure consistency and sharing of good practice. The workshops will involve a wide range of health and social care staff, representatives from local groups and organisations along with local people who use health and social care services. Locality Plans will be drafted by January 2018 and will outline the priorities for each locality for 2018/19 along with an action plan as to how these priorities will be progressed.

Performance

Financial Performance

2016/17 has been the first full year of service delivery and financial responsibility and as such has brought some challenges as expected for an organisation of this scale. However, a partnership approach between officers, the IJB and funding partners has ensured that clear communication and sharing of information has resulted in a consistent and positive financial position. Building on this, work is well underway to achieve the priorities and begin to complete milestones towards the realisation of the 9 national outcomes.

The foundations have been established to enable health and social care services to work together by empowering staff to make decisions at a local level and build a long lasting relationship with their communities. Employees have been involved from an early stage, using their knowledge and insight to identify where there are real communities around which services can be organised.

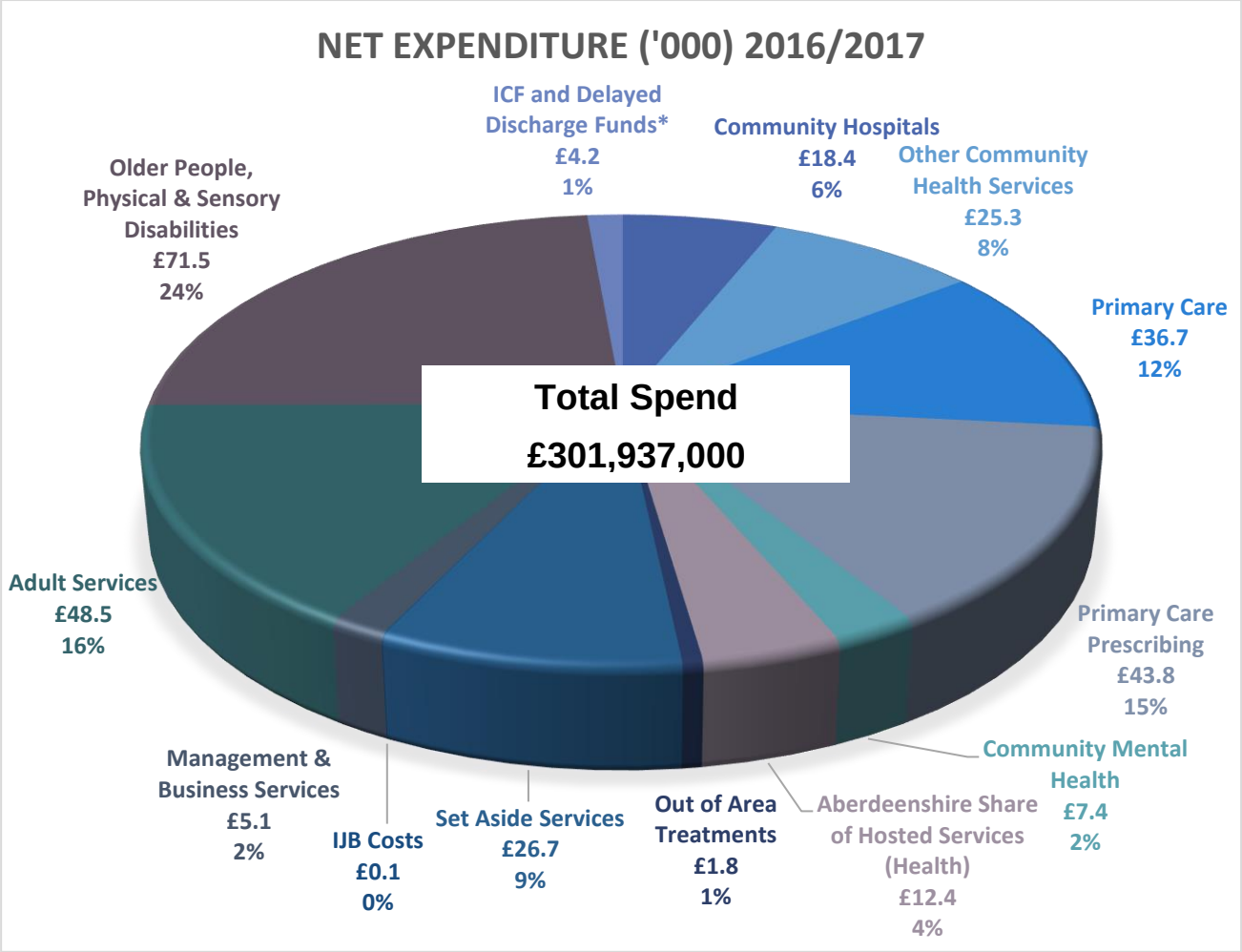
Position at 31 March 2017

In overall terms, the IJB has maintained its forecast position reported to the Board during the year, albeit being within budget by £9,000. To achieve this, all available resources including new funds and balances carried forward from last year have been utilised. Core budgets across Health and Social Care services continue to experience cost and demographic pressures. These points have been consistently reported to the IJB during the financial year.

The financial resources available to both partners has resulted in a number of positive discussions where information and knowledge has been shared with all partners which proved essential when considering the increasing demands on services from the demographic challenges of a growing population.

Analysis of the Financial Statements

The accounts show an end of year position of £301,937,000 which is within budget by £9,000 compared to a total budget of £301,946,000. This included the use of balances carried forward from previous years and the use of funds made available from the Scottish Government.



The main areas of overspend occurred within Community Hospitals, Prescribing, Adult Services and Older People. These were offset with resources from other budgeted areas. A series of actions are in place to review areas of overspend in 2017/18 with particular focus being placed on eligibility criteria for social care packages and a review of prescribing.

In order to continue the strategic approach for future years, it is proposed to establish a Medium Term Financial Strategy. This will look across years 1-5 and consider all of the financial resources available to the IJB.

Performance against National Core Indicators

For the first year as a Partnership, we are delighted to see that Aberdeenshire has excellent overall performance across the national suite of core indicators. Performance against each indicator is gathered using a variety of survey feedback and national data sources which emphasise the importance of a personal outcomes approach and enable comparison of performance across partnerships. The table on the following pages shows how Aberdeenshire has performed against these core indicators.

Annual Performance (published May 2017 from Source, ISD)

	Indicator	Title	Current score	Scotland
Outcome indicators	NI - 1	Percentage of adults able to look after their health very well or quite well	96%	94%
	NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	88%	84%
	NI - 3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	80%	79%
	NI - 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	82%	75%
	NI - 5	Total % of adults receiving any care or support who rated it as excellent or good	83%	81%
	NI - 6	Percentage of people with positive experience of the care provided by their GP practice	84%	87%
	NI - 7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	89%	84%
	NI - 8	Total combined % carers who feel supported to continue in their caring role	39%	41%
	NI - 9	Percentage of adults supported at home who agreed they felt safe	84%	84%
	NI - 10	Percentage of staff who say they would recommend their workplace as a good place to work	NA	NA

Data indicators	NI - 11	Premature mortality rate per 100,000 persons	349	441
	NI - 12	Emergency admission rate (per 100,000 population)	8,140	12,037
	NI - 13	Emergency bed day rate (per 100,000 population)	83,634	119,649
	NI - 14	Readmission to hospital within 28 days (per 1,000 population)	73	95
	NI - 15	Proportion of last 6 months of life spent at home or in a community setting	89%	87%
	NI - 16	Falls rate per 1,000 population aged 65+	15	21
	NI - 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	78%	83%
	NI - 18	Percentage of adults with intensive care needs receiving care at home	53%	62%
	NI - 19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	677	842
	NI - 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	19%	23%
	NI - 21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home	NA	NA
	NI - 22	Percentage of people who are discharged from hospital within 72 hours of being ready	NA	NA
	NI - 23	Expenditure on end of life care, cost in last 6 months per death	NA	NA

6 Outcomes for Integration

In addition to the National Core Indicators performance can also be measured against the 6 Outcomes for Integration as identified by the Ministerial Review. The 6 Outcomes are:

1. Unplanned admissions;
2. Occupied bed days for unscheduled care;
3. A&E performance;
4. Delayed discharges;
5. End of life care; and
6. The balance of spend across institutional and community services.

Some exceptional performance against these outcomes is detailed below:

Delayed Discharges decreasing trends

Delayed Discharge is when someone is medically ready to be discharged from hospital but is unable to be discharged due to a lack of available alternative care in the community. Several streams of work have been focusing on reducing both numbers and bed days which continue to come to fruition. This is a delicate balance across the system to ensure quality care. Delayed Discharge Occupied Bed Days has been on a decreasing trend since November 2014 this has been made possible by cross-partner working team approach of the Priority Discharge Group with both acute and community representatives. In November 2014, 3,325 bed days were lost to delayed discharge. In December 2016 this reduced to 1,520 which is a 54.3% reduction. This means that less people are being kept in hospital after they are ready to be discharged or that people spend less time waiting for alternative care provision once they are ready to be discharged. It also means that beds are made available quicker for those who require a hospital admission.

Emergency Bed Days

Emergency Bed Days relate to the number of days beds are occupied by someone who is in hospital as a result of an emergency as opposed to a planned admission. Within our community hospitals we are currently performing 25% lower than the Scottish average (676 in Aberdeenshire versus 841 national average). We believe that our community and planned care initiatives such as rehabilitation and enablement (p10), falls prevention (p11), anticipatory care plans (p15), virtual community ward (p16) and suicide prevention initiatives (p18) all contribute to Aberdeenshire's low level of emergency bed days compared with the Scottish average.

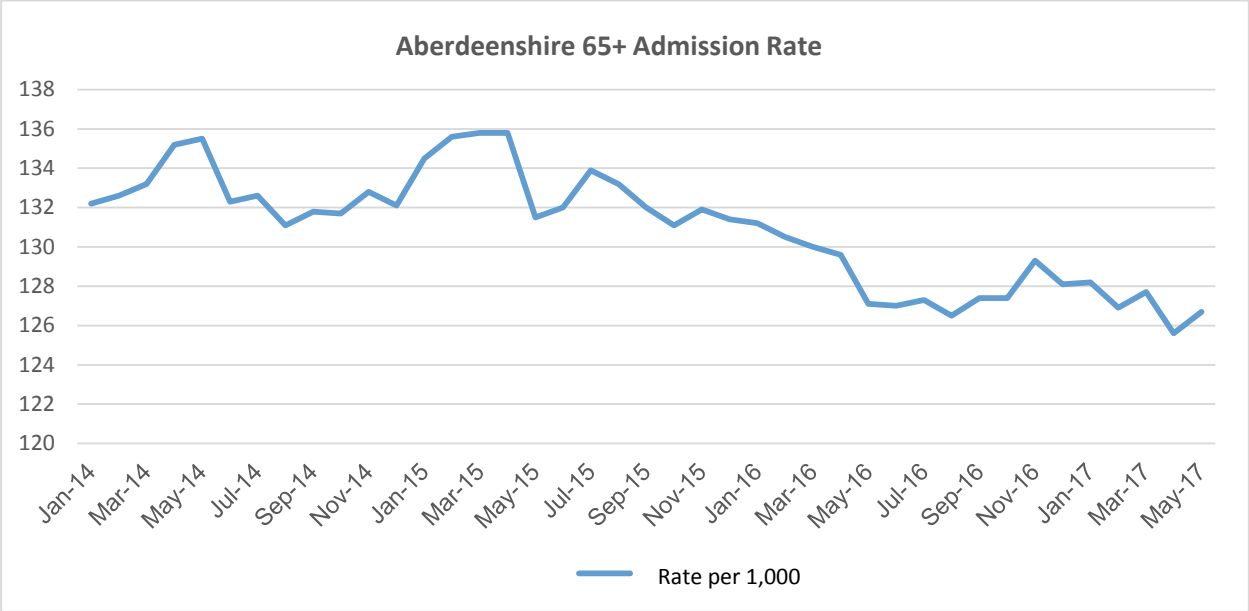
End of Life Care: Education and Support:

Roll out of NHS Grampian Palliative and Supportive Care Plan to increase the understanding and education of staff in end of life care. Crucial to the success of this were the relationships developed with the senior staff in the Care Homes, Community Hospitals and Community Nursing teams. The trust and enthusiasm which developed helped embed the principles within the plan into the units and ultimately improve the planning and organisation around end of life care. Staff at Roxburghe House provided a

considerable amount of training within other hospital settings. Last year, several events were held in hospitals across Aberdeenshire and more than 300 staff attended.

Emergency Admission Rates

The table below shows the decreasing trend in emergency admission rates for over 65; s per 1,000 of the population. This downward trend is positive because it shows that we are getting better at keeping people at home however, due to the increasing numbers of older people the actual numbers of admissions remains fairly constant.



Audit and Governance

IJB and decision making

The Integration Joint Board (IJB) is a joint board of Aberdeenshire Council and NHS Grampian. It oversees the Aberdeenshire Health and Social Care Partnership (AHSCP). The IJB has responsibility for adult health and social care services in Aberdeenshire

The IJB consists of five Aberdeenshire Councillors and five NHS Grampian Board members. There are also non-voting members of the board which include council and NHS officers as well as representatives from users of adult health and social care services, carers groups, trades union and the third sector.

The voting members of the IJB for the year ahead (2017/2018) are:

Aberdeenshire Councillors	NHS Grampian Board members
Councillor Anne Stirling (Chair)	Dr Lynda Lynch (Vice Chair)
Councillor Anne Allan	Amy Anderson
Councillor Bill Howatson	Sharon Duncan
Councillor Dennis Robertson	Alan Gray
Councillor Ann Ross	Eric Sinclair

Voting members for 2016/2017 were:

Aberdeenshire Councillors	NHS Grampian Board members
Councillor Anne Stirling	Dr Lynda Lynch (Vice Chair from 29th September 2016)
Councillor Anne Allan (Vice Chair then Chair from 1st September 2016)	Raymond Bisset (Chair to 1st September 2016)
Councillor Raymond Christie	Terry Mackie
Councillor Alison Grant	Alan Gray
Councillor Bill Howatson	Eric Sinclair

Details of all IJB members including non-voting members are available at https://www.aberdeenshire.gov.uk/social-care-and-health/health-and-social-care-integration/integration-joint-board/ and this includes the register of interests for both voting and non-voting members.

Audit Committee

The audit committee is a joint Committee with representation from Aberdeenshire Councillors and NHS Board members. The purpose of the Committee is to assist the IJB to deliver its responsibilities for the conduct of public business, and the supervision of funds under its control. In particular, the Committee will seek to provide assurance to

the IJB that appropriate systems of internal control are in place to ensure that: business is conducted in accordance with the law and proper standards; public money is safeguarded and properly accounted for; Financial Statements are prepared timeously, and give a true and fair view of the financial position of the IJB for the period in question; and reasonable steps are taken to prevent and detect fraud and other irregularities.

Clinical and Adult Social Work Governance

The Clinical and Adult Social Work Governance Committee comprises members of the IJB and other lead professionals from the health and social care partnership. The purpose of the committee is to provide assurance to the IJB on the delivery of safe, effective, person-centred services in line with the IJB's statutory duty for the quality of health and social care services.

This committee links with operational managers who will provide information on service performance and delivery including highlighting any challenges which have the potential to impact on effective service provision. The committee will seek assurance on topics such as;

- Professional Registration and Revalidation e.g. Registration of care workers with the Scottish Social Services Council and Nurses with the NMC
- Significant legislative or regulatory changes which may impact service delivery
- Inspections by external bodies including Care Inspectorate and Health Improvement Scotland

Inspection of Services

Healthcare Improvement Scotland (HIS)

The aim of Healthcare Improvement Scotland is to drive improvements that support the highest possible quality of care for the people of Scotland. They oversee a broad work programme which supports health and social care services to improve. This includes the regulation of independent hospitals and clinics.

Announced inspections in Peterhead Community Hospital, Fraserburgh Hospital and Ugie Hospital took place in March 2017. They found cleanliness standards to be "very good" with patients describing ward cleanliness as "very good", "extremely impressive" and "exceptional". This is testament to the team work and professional focus of all the staff who work there.

What the hospitals did well

- A good percentage of staff across all three hospital sites have completed their mandatory infection prevention and control training.
- HIS saw generally good hand hygiene across all three hospital sites.
- All three hospital sites were clean and well maintained.

What the hospitals could do better

- Changes in the use of personal protective equipment must include advice from the infection prevention and control team and be approved through the appropriate NHS board governance structures.
- All patient chair cushions and pressure-relieving cushions in Fraserburgh Hospital must be clean.

Care Inspectorate

The Care Inspectorate undertakes inspections of regulated care services on an unannounced basis for all care service types. Inspections will take place at any time of the day or night and these inspections provide members of the public with reassurance that the services are delivering quality care and support in appropriate accommodation for the people that require this. The Care Inspectorate uses a six point grading scale to assess the quality of registered services:

6 – Excellent	5 – Very Good
4 - Good	3 - Adequate
2 - Weak	1 - Unsatisfactory

Services are assessed by four quality themes:

Quality of Care and Support	Quality of Environment
Quality of Staffing	Quality of Management and Leadership

Overall, the services in Aberdeenshire are achieving a high standard with many services being rated as good or excellent. Across all services, staff were motivated and dedicated to provide the best care and support for individuals. Staff told the inspectors that they had ready access to high quality training and people using services were encouraged to participate in service planning and delivery.

Table: Care Inspectorate Average Grades 2016/17

	Quality of Care & Support	Quality of Environment	Quality of Staffing	Quality of Management & Leadership
Average Grades	4.7	4.9	4.8	4.4

In 2016/17 **78%** of services were rated as good or better.

If a services does not achieve the expected grades, improvement action plans are put in place and staff will work directly with the Care Inspectorate to ensure issues are addressed quickly and professionally. Full details of all inspections of Aberdeenshire services can be by using the following link to the Care Inspectorate website

http://www.careinspectorate.com/

Conclusion

This Annual Report has identified progress with a wide range of transformational programmes designed to integrate health and social care and improve the lives of people in Aberdeenshire.

Key to enabling progress to be made has been success in redesigning and integrating our management structure to better reflect our localities and the needs of people within them, manage the health and social care services under one umbrella and begin the process of identifying where services can be provided more effectively and efficiently. In this next year, we anticipate that significant progress can be made to build on the foundations for locality planning involving local people, their families and the range of groups and organisations who provide valuable services.

A number of the main areas for investment are showing real benefit to people. The number of people being delayed in hospital has reduced due to more innovative provision of home care services and the use of intermediate care services.

Introduction of the Virtual Community Ward has enabled daily multi-disciplinary discussions to take place to ensure that treatment, care and support for the most vulnerable people can be planned in a more preventative way so reducing the need for hospital admission or emergency respite.

Development of a rehabilitation and enablement approach to the provision of care at home, along with specific work around falls prevention and increased use of telecare has all resulted in people being able to remain at home safely while regaining their health and ability.

We are pleased that our performance against many of the national indicators is very positive and our programmes for change show that we are starting to make a difference locally.

We are aware that the report does not cover the day to day delivery of core services through health and social care and has only highlighted some of the key achievements over the last year. We are immensely proud of the commitment given by health and social care staff over the last year to continue to provide excellent care and support to people whether at home, in hospital or in one of our many residential and day care settings while also being part of the new challenging environment of integration.

The Partnership has a very good relationship with organisations in the Private and Third sector and we continue to be dependent on them for provision of many of the services that meet the needs of people in our towns and villages. We will continue to work with partners to build on the success of this year and bring about continued improvement next year.

The Integration Joint Board and the Health and Social Care Partnership will continue to work together to deliver high quality person centred care that builds on the abilities of people and enhances their independence and wellbeing in their own communities.

Further statistical analysis of the performance of the Health and Social Care Partnership is available online at https://www.aberdeenshire.gov.uk/social-care-and-health/health-and-social-care-integration/

Glossary

Virtual Community Ward (WCV) – a means by which people are assessed by a team of professionals in order to identify community supports that can meet their health and social care needs, thus avoiding being admitted to hospital

Participatory Budgeting – this is where local communities are given a budget and decide on how the money is to be used, rather than the Health and Social Care Partnership deciding.

Self-Management – where people take responsibility for managing their own health conditions

Unpaid Carers – a person, of any age, who provides unpaid help and support to a relative, friend or neighbour who cannot manage to live independently without the carer's help

Person-centred – person centred is when services are tailored to meet the needs of the individual rather than people having to accept a standardised service which may not meet their needs

Multi-disciplinary Team – this is a team of professionals with different knowledge, skills and experience who along with the individual can work out what is required to meet their health and social care needs

Rehabilitation and Enablement – this is an approach that focuses on rebuilding people's skills and abilities so that, in time, they may be able to do more for themselves and become less reliant on services

Health Gap – this is the difference between the health of people who live in deprived communities and those who live in more affluent areas

Primary Care – the first point of contact for health care, for most people this will likely be their GP but also includes services such as a community pharmacy

Anticipatory Care Plans – identifies what support people might need in the future from friends/family to help them manage their condition at home. It can also look at how other people can help them in an emergency situation For example if the main carer is unwell, having these plans in place can help to prevent someone having to go into hospital

Asset Management Plan – is a plan that looks at what assets a community already has, for example housing, hospitals and care homes and looks to see what may be required in the future in order to meet demand

IDEA Project – a project which aims to find ways for people with learning disabilities to be supported in their community and access community activities rather than attending building-based day care services

Strategic Needs Assessment – looks at the future health and social care needs of a community in order to plan what services will be required in the future

NB. Data explanatory note: Information included in this report is taken from both locally and nationally published information sources. The decision to utilise either is based on the purposes of the collection, to have the most recent data and accuracy. Therefore there are some minor discrepancies between the ISD published and non-ISD published health information. All non-published information should, therefore, be treated with caution. In addition, as with any performance information, there will be a margin of data anomalies and quality issues. These are addressed on an ongoing basis to ensure quality performance information as far as possible.