Aberdeenshire Health & Social Care Partnership

REPORT TO ABERDEENSHIRE INTEGRATION JOINT BOARD
01 JUNE 2022

STRATEGIC PLANNING GROUP UPDATE

1 Recommendation

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

1.1 Acknowledge the report from the Strategic Planning Group following its meeting on 21st April 2022.

1.2 Provide comment on and approve the draft response to the Scottish Government Consultation on the Health and Social Care Strategy for Older People.

1.3 Provide comment on the performance report for the Health Improvement Delivery Plan.

2 Directions

2.1 No direction requires to be issued to Aberdeenshire Council or NHS Grampian as a result of this report.

3 Risk

3.1 IJB Risk 1 - Sufficiency and affordability of resource - transformational change is required to ensure service and financial efficiencies.

3.2 IJB Risk 6 - Service/business alignment with current and future needs - transformational change will determine and deliver priorities to meet needs.

3.3 IJB Risk 8 - Risk of failure to deliver standards of care expected by the people of Aberdeenshire in the right time and place - transformational change and service improvement will support the delivery of this outcome.

4 Background

4.1 A key responsibility of the Strategic Planning Group (SPG) is to have oversight of the transformational workstreams arising from the Health and Social Care Partnership (HSCP)'s Strategic Delivery Plan, monitoring and reporting on progress to the IJB as part of its performance reporting framework.

4.2 This update report provides a summary of the main items of discussion at the SPG's most recent formal meeting on 21st April 2022.

5 Summary

Health and Social Care Strategy for Older People – Consultation

5.1 This Scottish Government consultation paper has been produced following a process of engagement and consultation with older people in 2021, the outcomes of which have informed the content for this next stage of consultation. The consultation centres on four themes of: Place and Wellbeing; Preventative and Proactive Care; Integrated Planned Care; and Integrated Unscheduled Care. The consultation document indicates that it will continue to be informed by and align with recommendations from the Independent Review of Adult Social Care and the National Care Service consultation. Following input by members of the SPG, a draft response is attached at Appendix 1, for consideration and approval by the IJB before submission by the deadline of 19th June 2022.

HSCP Commissioning and Procurement Plan

5.2 The Aberdeenshire HSCP Commissioning and Procurement Group was established to develop and monitor implementation of the HSCP's commissioning and procurement plan with the aim of ensuring work on specific contracts is completed within required timescales and aligned with the priority workstreams within the strategic delivery plan. The group has reported to the Senior Management Team (SMT) on a regular basis and, moving forward, it has been agreed that the group should also have a separate reporting line to the SPG. The aim of this is to further develop strategic oversight around the interlinkages between the HSCP's strategic plan and our commissioning and procurement planning processes, reflecting a key responsibility of the SPG.

5.3 The SPG was provided with an overview of the range of projects implemented as part of the Commissioning and Procurement Plan, to ensure these services remain fit for purpose in terms of meeting service user outcomes, affordability, sustainability, and alignment with the HSCP's strategic plan and service specific strategies. In the past year (as approved by the IJB as part of the annual procurement plan) this has included the completion of significant and complex projects such as the new single contractual framework for Support at Home services.

5.4 Such projects are illustrative of the increasing emphasis on an outcomes-focussed and collaborative approach to commissioning, reflecting key recommendations from the Independent Review of Adult Social Care. In the review and commissioning of any services a key aim is also to support wide stakeholder involvement and engagement. It was acknowledged that whilst progress has been made in supporting the contribution of those with lived experience to local commissioning and procurement planning processes, this remains a key area for continued improvement locally. Reports from the Commissioning and Procurement Group will continue to be provided to the SPG and SMT on a quarterly basis moving forward.

Aberdeenshire HSCP Workforce Plan

5.5 The SPG were provided with an update on progress with development of the HSCP's 3-year integrated workforce plan. This is a significant piece of work informed by the National Workforce Strategy for Health and Social Care and overseen by the HSCP's Workforce and Training Group. The engagement process has aimed to ensure representation and input from all staff groups and stakeholders including Trade Union/Staff Side partners, primary care and the third and independent sectors. A cross-Grampian collaborative approach has also been in place via regular meetings between the workforce planning leads from across the 3 HSCPs and NHS Grampian. The workforce plan is recognised as critical to delivery of the HSCP's strategic priorities, ensuring staff health and wellbeing remains central, and will be brought to the IJB for approval prior to publication of the final version by October 2022.

Health Improvement Delivery Plan Workstream Performance Report

5.6 The report presented to SPG members on progress against the HSCP's Health Improvement Delivery Plan is attached at Appendix 2. Whilst acknowledging progress has been impacted at points by the Public Health Team being redeployed to support activity related to the pandemic, the report describes how activity has been prioritised with a particular focus on how health improvement action in Aberdeenshire can be delivered effectively to address health inequalities.

Other items of business

5.7 NHS Grampian Plan for the Future - The SPG continues to receive regular updates on the development of the NHS Grampian strategy with the aim of supporting an integrated approach and alignment with the HSCP's own strategic plan.

5.8 Shaping Places for Wellbeing Programme - Members noted progress in the early stages of implementation of this mentoring partnership involving Aberdeenshire Council and NHS Grampian working with the Improvement Service and Public Health Scotland. As previously reported to the IJB this 3-year programme, focusing on Fraserburgh as a mentor project town, will seek to address the role of place in creating the conditions for better wellbeing and reduced inequality and enabling a system-wide partnership action on the social determinants of health.

5.9 Quality Framework for Community Engagement and Participation – The HSCP will be participating in a self-evaluation process supported by Health Improvement Scotland to assess the effectiveness of our community engagement and participation approaches, how we are delivering against our statutory duty in relation to community engagement, and identify areas for improvement. This will be key to delivery of the HSCP's strategic priority on Engagement and will inform the development of the HSCP's engagement and

participation strategy. SPG members have been invited to participate to ensure a breadth of representation from the HSCP and its partners.

6 Equalities, Staffing and Financial Implications

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

6.2 A high level Equalities Impact Assessment was completed for the Strategic Plan 2020-2025. Potential impacts of this high level multi-faceted strategic plan have been considered. Implementation of aspects of the strategic plan could result in unintended negative impacts on certain population groups.

6.3 To provide assurance each individual project delivering the priorities within the Strategic Plan will be required to complete an Integrated Impact Assessment. This will mitigate against potential negative impacts when designing the service improvements.

6.4 An integrated impact assessment is not required for the IJB's response to the Older People's Strategy for Health and Social Care because this is a response to a consultation and does not have a differential impact on any of the protected characteristics or on those facing socio-economic disadvantage.

6.5 Financial and staffing outcomes and measurements will be determined on an individual project basis and scrutiny will be provided through the agreed governance structure.

Pamela Milliken, Chief Officer, Aberdeenshire HSCP

Report prepared by Angela MacLeod, Programme Manager
05 May 2022

References:

Scottish Government (March 2022) 'Health and social care strategy for older people: consultation'. Source: https://consult.gov.scot/healthcare-quality-and-improvement/health-and-social-care-strategy/

Scottish Government (March 2022) 'National Workforce Strategy for Health and Social Care in Scotland'. Source: https://www.gov.scot/publications/national-workforce-strategy-health-social-care/

Healthcare Improvement Scotland (March 2022) 'DRAFT: The Quality Framework for Community Engagement and Participation: Supporting the delivery of effective engagement, developing practice and sharing learning'. Source: https://www.hisengage.scot/quality-framework

APPENDIX 1

Draft Aberdeenshire Integration Joint Board (IJB) Response to the 'Health and Social Care Strategy for Older People' (Scottish Government, March 2022)

Notes:

For ease of reference an extract from each section of the consultation document has been included (in italics) at the start followed by questions which can be responded to from an organisational perspective. Questions directed at individuals and their experience of care/services have been excluded. Each question is then followed by the proposed draft response from the IJB.

The full consultation document is available at the following link:
https://consult.gov.scot/healthcare-quality-and-improvement/health-and-social-care-strategy/)

The consultation paper is split into four sections which relate to the key themes from the engagement previously undertaken:

- Place and Wellbeing
- Preventative and Proactive Care
- Integrated Planned Care
- Integrated Unscheduled Care

This response has been compiled with input from members of the Aberdeenshire HSCP Strategic Planning Group, including representation from NHS, Council, Third Sector, Further Education, and other officers from the HSCP.

PLACE AND WELLBEING

Extract:

'Our health is determined by the conditions in which we are born, grow, age, live and work. Supporting partnership working between communities, third sector and public sector and to align policy across government is vital to improve health and wellbeing and reduce health inequalities of older people.

The focus is on supporting local level actions and aligning national policy behind these; accepting that further large-scale change will also be needed if we are to eliminate some social determinants of health inequalities. The social determinants of health include housing, education, employment, social support, family income, our communities, childhood experiences and access to health services.

In this section we want to concentrate on the range of organisations which provide support to older people, ranging from health services to support provided by the third sector and how these work together to provide the care and support needed in their local community. Place and Wellbeing also considers the aspects in our lives which impact on our health, including inequalities.

There are some excellent examples of support being provided by third sector organisations across all areas of Scotland. In most circumstances these support mechanisms may be vital to an older person's wellbeing and increasing their social circle. This can help reduce social isolation and frailty, which can lead to a higher risk of falls and dementia.'

Question:

Do you have examples of communities, voluntary/third sector and public sector organisations working together to improve older people's health and wellbeing and reduce any health inequalities which they experience?

Draft response:

Aberdeenshire HSCP works closely with its Third Sector Interface, Aberdeenshire Voluntary Action (AVA), as part of its shared objective to join up and activate parts of the third sector and volunteers to support health and social care outcomes, and to actively explore all opportunities where community groups and third sector organisations can play a role in improving older people's health and wellbeing and reducing inequalities. Most recently in response to the very challenging winter period the HSCP commissioned AVA to undertake additional activity to recruit and support volunteers for a six-month period to be deployed across our Care Homes and Very Sheltered Housing, undertaking such tasks as befriending and social contact/activities and support with mealtimes.

A pilot is also being undertaken by AVA, alongside its counterparts in Moray and Aberdeen City, to support the reduction of delayed discharges by identifying and matching volunteers with patients in hospital who need some help to get and stay at home (other than health and social care input). This may be for a range of reasons but can be when there is no family network to support them.

Through its grant funding budget the Aberdeenshire HSCP has contributed funding to a variety of third sector organisations over several years with the aim of supporting local services and projects which help people to live well and independently within their own communities, complementing the services being delivered by health and social care staff. Many of these services have a focus on care and supports for older people.

Place and Wellbeing is a strategic priority of the work of our Council partners within Live Life Aberdeenshire (LLA) and links to the "hub and spoke" model for the delivery of services which focuses on communities in populated settlements and rural locations as well. As LLA fully reactivate their wellbeing programmes and activities across the service areas (Cultural Engagement, Physical Engagement including long term health conditions) plans are being introduced to support pre pandemic levels of uptake/engagement in services and the introduction of new activities to support key outcomes. Older People and associated activities have been delivered through a variety of methods during restrictions (hybrid of online and in-person) and will move to more physical attendance where demand is evident.

Services such as the library door stop vans will continue to grow where "Place" and accessibility can be a challenge for our older population. Work delivered through the LLA's long-term health conditions teams is being expanded and plans are being introduced to support further activities in care homes in partnership with the HSCP.

Other examples of local initiatives in existence across Aberdeenshire include:

- Conversation Cafes which are supported across sectors to enable older people to feel less socially isolated and be more connected.

- During the pandemic community resilience groups in various communities supported older people who were shielding at home and to help reduce isolation.

- Local Health and Wellbeing forums have worked with partners to identify older people's health and wellbeing needs.

- In Central Aberdeenshire the Community Planning Partnership worked with the Bothy in Kintore to provide 'buddy benches' in identified areas to provide outdoor, communal seating areas with the aim to reduce social isolation. The Men's Shed in Westhill are working on a similar initiative.

- The Aberdeenshire-wide Live Life Well Exercise Referral programme includes a high proportion of older adults, and the Live Life Aberdeenshire 'Fit to Walk' service supports a range of older people throughout Aberdeenshire.

- Good nutrition is vital to older people to maintain health but also helps to maintain independence. The Mearns and Coastal Healthy Living Network provide a range of supports to older people including social event, lunch clubs but also home shopping services. Garioch Kitchen is offering a course 'More Taste, Less Waste' which is aimed at older people and those living alone, highlighting the importance of nutrition for older people.

- There are various third sector groups providing physical exercise opportunities for individuals such as Grampian Cardiac Rehab Association – this presents the opportunity for additional social benefits such as reducing isolation.

- The Aberdeenshire Wellbeing Festival has been effective in providing activities across organisations/sectors and communities to support mental wellbeing of the Aberdeenshire population, including older people.

We would also note the importance of the positive impact on wellbeing from the provision of good quality, affordable and suitable homes for older people which is fundamental to our Council's Local Housing Strategy and Housing services. Working in partnership across the HSCP and Council and with Residential Supported Living partners is key to identifying the appropriate models of Housing to support the care provision for older people.

Mental Health and Wellbeing

Extract:

'We know that older people are more likely to experience circumstances which contribute to poorer mental health, such as poverty, isolation, loneliness and poor physical health. The impacts of the current pandemic may exacerbate these circumstances. We also know that the mental health and wellbeing of people on the Shielding or Highest Risk was impacted negatively and disproportionately compared to the rest of the population.

A person's home has a huge impact on our health and wellbeing, and even more so when we grow older and we must ensure that our homes support older people in being able to live independently at home for as long as possible.'

Question:

Is there anything else you would like to add about mental health services for older people?

Draft response:

Aberdeenshire HSCP has committed to an ambitious programme for action for Mental Health services locally as part of its Mental Health Strategy 2019-2024 (to be reviewed and refreshed this year), bringing organisations, groups and individuals together to ensure action is taken collaboratively. This includes an understanding of the specific factors that affect the mental health and wellbeing of older people (discrimination; participation in meaningful activities; relationships; physical health; poverty), and a focus on the need to ensure older adults are able to access support and have good experiences of transition from mental health services.

A key part of our Mental Health Strategy is a commitment to improve access to mental health professionals across a range of settings as part of the national Action 15 programme. The HSCP has been developing an in-house Community Link Worker Service to be based in primary care and supporting people with their mental wellbeing. Support will be provided to connect patients with community resources and services so they can take action on the wider social and /or lifestyle factors that are impacting on their mental health and wellbeing and will include support for older adults. Separately the HSCP has targeted funding to increase the provision of Distress Brief Intervention (DBI) services and suicide prevention awareness.

The consultation rightly highlights the disproportionate impact of the Covid-19 pandemic on many protected groups and in particular older people. Social isolation was present prior to the pandemic and in many circumstances this has been exacerbated. Whilst throughout Covid-19 our teams have worked hard to minimise any detrimental impact to people who require health and social care services, we would note the very particular challenges presented by the rurality of our geography coupled with the hugely significant increase in demand for mental health services overall. Access and availability of mental health services for older people is essential including our care homes and very sheltered housing. By addressing the

causes of loneliness and isolation for the ageing population, the impact on physical and mental health could be hugely significant with the concomitant impact of reducing pressure across mental health and other care services.

Aligned to this, activities to address Mental Health and Wellbeing remain a key feature of the work of our Council partners in Live Life Aberdeenshire with service teams aligning activities and programmes to support those most in need in the communities of Aberdeenshire. Work to support key areas - poverty, isolation, loneliness and poor physical health as a result of the pandemic is undertaken in partnership with internal and external partners and agencies to maximise our resources and efforts. Service Teams are fully aware of the barriers to participation and is a key consideration when introducing new activities.

Question: ***Is there anything else you would like to add about Place and Wellbeing for older people?***

Draft response:

Aberdeenshire covers a significant geographical area with a large number of remote and rural communities. Access to services and reducing inequality of access is therefore a fundamental concern.

Ensuring accessible and affordable transport has been rightly highlighted as critical to supporting people to access not just health and social care services, but to also enable them to engage in activities which can improve their overall wellbeing, help maintain social contact and reduce isolation. It is the unique challenges presented by living in a remote and rural area which require a range of flexible and adequately resourced transport options (such as community volunteering schemes and third sector supported initiatives alongside public transport provision) to meet need and reduce barriers to accessing services particularly for older people living in rural areas.

PREVENTATIVE AND PROACTIVE CARE

Extract:

‘Early identification and prevention of issues as they arise is critical in delivering improved outcomes for people. A “Getting it Right for Everyone” approach to community health and social care brings individual and family needs into sharp focus. The approach should be anticipatory and preventative, avoiding crisis wherever possible and services should cluster around individuals and families to support them.

In this section we want you to think about things which might help all older people and also things which might help older people who have more health conditions or vulnerabilities. Preventative work can be wide-ranging and might include work

to address mental wellbeing or interventions aiming to reduce the likelihood falls or frailty in later life.

Most people see prevention as being able to continue to use the ordinary services and activities in the community, which are not always described as health and social care services but are a very important part of peoples physical and mental wellbeing. These include:

• Places where people meet and are a reason to go out, such as libraries, cafes, etc.;
• Publicly accessible toilets and benches/seating that make public places more accessible;
• Transport, including community-run transport; and
• Enough money, including help with keeping fuel costs down.'

Question:

When thinking about health and social care services for older people in Scotland, what do you feel has worked well in the past?

What is currently working well?

Draft response:

From its inception, the Aberdeenshire HSCP has focused on developing a locality-based multi-disciplinary team model of service delivery in a location to the benefit of patients and service users. This now well-established model was crucial in our response to the unprecedented challenges faced during the COVID-19 pandemic. It is also important to recognise the very positive relationships we have with our partner organisations of NHS Grampian and Aberdeenshire Council which have again proved crucial in supporting the delivery of health and social care services for older people.

As a key priority within our strategic plan, Aberdeenshire HSCP's Reshaping Care programme of redesign has included a range of early intervention and prevention work and the development of a variety of interlinked support packages to enable people, including those with disabilities or long-term conditions, or who are frail, to live as independently as possible at home or in a homely environment. Collaborative working across sectors is fundamental to establishing models of care for older people which are fit for the future, examples of which are provided below. These have been strengthened as a result of health and social care, Local Government and community responses to COVID-19.

Collaborative working across primary and secondary care has also been critical to the development of the Aberdeenshire Frailty Pathway / Hospital at Home model. The HSCP is developing a phased implementation of the model with an initial focus on creating an 'Early Supported Discharge (Hospital at Home) Pathway' (see further detail below), with the aim of creating capacity within the system whilst also allowing

for ongoing learning and evaluation to determine what a full Hospital at Home service could look like for Aberdeenshire.

As our Reshaping Care programme continues it will be important to ensure sustainable model of care for care homes and homely settings recognising the very key role this plays in supporting the health and wellbeing of older people. Again strong partnership working between the local authority and the HSCP is critical to ensure that suitable and appropriate housing stock is planned for within communities, including through the provision of suitable housing, appropriate design, adaptations to suit individual needs, and information and advice to inform choice. The Housing Solutions Change Programme allows discussion at an early stage on the appropriateness of an individual's home and planning for the future to avoid a crisis situation.

Other areas which have worked well include:

- Development of digital technologies, particularly the advances made during the Covid-19 pandemic such as the roll out of 'Near Me', are transforming the way people live their lives, interact socially and stay connected, work, shop and access healthcare and other services. The Supported Home Self-monitoring for people living in the community is an example of this approach. Aberdeenshire HSCP has participated in work around a small number of simple digital self-management technologies to help people better manage their own health at home such as remote self-monitoring of blood pressure.

- Support for care homes and very sheltered housing has been increased during the pandemic which has improved understanding of the complexities around care homes, including the diverse range of complex medical needs. The formation of the HSCP Care Homes oversight group with the operational front facing assurance team has supported the care homes to work on areas for development and improvement and enhance and enrich the delivery of person-centred care.

- Rehabilitation to improve/maintain an individual's ability to live independently and participate in community activities, whilst ensuring availability of community activities and public transport to facilitate participation, is essential. Alongside this the development of 'upstream' initiatives with a focus on prevention, increasing physical activity and education on long term conditions through partnership approaches, is also a key priority.

Question: ***How do you think services could be improved?***

Draft response:

The impact of demographic change with a rising population of older people, and the need to ensure this is robustly factored into future planning for adult social care, is a critical issue, as acknowledged within the Independent Review of Adult Social Care (IRASC). The current national challenges in recruitment and retention of health and social care staff must be addressed to ensure we can provide safe, sustainable models of care and support for older people. The IRASC made clear the need to ensure the social care workforce is valued, nurtured and rewarded for the very important work that they do, which must remain central to the delivery of any future reforms whilst ensuring there are sufficient resources underpinning this (recognising where remote and rural geography adds an additional layer of complexity).

Other areas and opportunities for improvement are noted below:

- Research has been undertaken in Aberdeenshire exploring malnutrition in older people and how Community Planning partners might address this. This is particularly important to addressing issues experienced by rural areas with more limited services and increased costs of food and fuel. Part of this was not just focusing on the community malnutrition tools but also linking in a range of supports like food projects, food banks services and practical food skills activities. Older people require a full range of local supports depending on their needs and the area they live in, with the potential to focus on social supports or link in physical activity opportunities like walking groups, as well as inclusion of a range of practitioners already working with older people (for example sheltered housing wardens, and Fire and Rescue Service carrying out fire safety checks).

- There is an opportunity to further strengthen the links between mental health and wellbeing, physical activity and healthy eating in older people. Increased mental health support for older people and their families/care givers available and accessible at the point of need will be essential.

- There is potential to improve frailty pathways (as previously noted work is already being implemented in Aberdeenshire) through prioritisation of frailty as a clinical specialty working across primary and secondary care.

- Maximising the use of community spaces and places is important, supporting collaboration in the use of publicly owned space and enabling connections to be made. For example sharing of spaces has been proven to work well where there are older people's settings in the same space as nurseries and community groups.

- There is potential to improve the connectedness of day care services and activity provision for older people with the community and providing opportunities for older and younger people to come together to share spaces, ensuring this aligns with what the current population of older adults and their families need. This may include opportunities to develop and learn to support

a more resilience-based approach. There is an opportunity within Sheltered Housing to further strengthen the provision of activities such as weekly sessions like crafts, music, coffee mornings etc in line with provision in Very Sheltered Housing.

- Intergenerational projects provide opportunities to support learning for older and younger people and there is significant potential for this to be expanded to include not just care homes and nurseries but to all other generations including colleges, academies and other community-based groups. Many opportunities exist for a variety of students to have work placements in care homes (for example, the University of Highlands and Islands has sport science students working in care homes as part of their course to promote physical activity in the older population).

Anticipatory Care Planning

Extract:

'Anticipatory Care Planning is a 'thinking-ahead' approach to care, whereby people are supported to discuss and consider how they would like to be treated and cared for, should there be a future change or deterioration in their health. Anticipatory Care Plans are a way of documenting what would be important to the individual in the context of their health and care, with some specific information about what type of treatment or care would or would not be acceptable to them. These can be shared in advance with the appropriate people and services who may be able to help.'

Question: ***What do you think about this Anticipatory Care Planning aspect of care?***

Draft response:

Within Aberdeenshire HSCP the Oversight Care Assurance team has been supporting care homes and very sheltered housing complexes with their Anticipatory Care Plan (ACP) documentation to ensure they are as robust and person-centred as possible and supporting staff with education where needed to improve this process. We would suggest that the spiritual care aspects of this process require further input and development to support staff to have those conversations with the person regarding their beliefs.

ACPs are also an important aspect of general practice care for patients who have long term conditions to manage their health when attending for their reviews. Overall we would suggest culture and practice in promoting and completing ACPs has improved. We are also fortunate in Aberdeenshire to have the established Virtual Community Ward model which a large number of GP practices utilise as part of the multi-disciplinary team approach. This helps to support the process of putting plans in place for people who need health and social care services at an earlier

stage, to prevent unnecessary hospital admission. Work is also underway to support and enhance the community hospital ward multi-disciplinary teams to support early discharge planning.

INTEGRATED PLANNED CARE

Extract:

> 'Everyone in Scotland should get the right care, at the right time, in the right place based on their individual circumstances and need. Planned care is care and treatment that is scheduled in advance with health and care professionals. This includes planned surgery for routine and elective treatments, planned social care at home and planned hypertension reviews in general practice, for example. Many of the issues on social care we heard about were around staffing. When older people have a carer supporting them in their own homes, experiences were mixed and again people want to see the good practice being the standard everyone can expect.'

Question: ***What could be done to improve joint working between health and social care services?***

Draft response:

The Aberdeenshire health and social care model has been built around integrated local teams and this is a model we would see as essential to delivering person-centred care for older people. The increasing complexity of patients managed within the community also needs to be considered and ensuring sufficient resources and capacity are invested in primary and community care to deal with increased demand.

The consultation quite rightly highlights the importance of effective planned care, and in particular the value and importance to older people of receiving high standards of care in their own homes. As previously noted the current significant challenges in recruitment and retention within the social care workforce are well documented, and indeed across the majority of health and social care services. As a HSCP we are striving to be creative in our approach to addressing some of our current gaps in staffing, for example, offering different types of staff contract and flexible working to accommodate individual staff circumstances and enhance staff retention. We are working with our partners across Grampian on a recruitment campaign to target people that may not have worked in the social care sector previously, initially focusing on social care staff, especially homecare staff, as well as some of the roles in social care that are traditionally harder to recruit to. The campaign seeks to highlight the very real positives of working with people in need of care and support, and we would also stress the importance of valuing the role of those who work in the social care sector. The need to address social care sustainability, including how we align this with commissioning and procurement strategy, will be a key area of focus locally over the short to medium term.

Extract:

‘In July 2020 the Scottish Government launched Right Care Right Place, highlighting the way in which access urgent care had changed. This included the use of minor injuries units and pharmacies in providing healthcare advice and support to treat minor illnesses and common conditions in local communities.

The most frequent single improvement that people said was needed was around patient transport. Aspects and examples that often came up were:

• Getting times of transport and times of clinics etc. to match up
• Improving awareness of staff making appointments and at clinics and on wards of how the system there worked
• Taking account of the needs of people with dementia or other reasons why they need someone they know with them
• Making the telephone contact a Freephone number ‑ calls of an hour or longer happening when people are left on hold, all at the person’s or their relative’s /friend’s expense
• Again, there are places where it works well.’

Question:

What is currently working well to support planned health care and treatment?

What needs to be improved?

Is there anything else you would like to add?

Draft response:

The Covid-19 pandemic saw a rapid and unprecedented reconfiguration of primary and community care services. Within Aberdeenshire this has seen healthcare professionals working together across acute and primary care and in partnership with NHS 24’s 111 service. The need for new ways of delivering services during COVID-19 demonstrated what can be achieved to keep people safe and also reduce overcrowding and long waits. The development of the Flow Navigation Hub model in Aberdeenshire has meant that we are better able to schedule our minor injury service locally, direct people to the most appropriate site and reduce patient waiting times.

As we remobilise services, we are reflecting on the changes that have been brought about as a result of the pandemic to review and redesign our service to ensure we are making the best use of what we can locally to benefit the local communities. Within Aberdeenshire a further key area of redesign since the Covid-19 pandemic has been our work to develop a Hospital at Home model. The HSCP has been developing a phased implementation of the model with an initial focus on creating an ‘Early Supported Discharge (Hospital at Home) Pathway’. Good progress has been made in recruitment to the first multi-disciplinary team, and the development of the pathway and supporting processes based on an integrated model between

health and social care staff focused on improving the flow of patients through the Frailty Pathway.

The role and input of Consultant Geriatricians is critical but presently significantly impacted by staffing shortages which leads to them being very stretched across community and acute services. This risks our ability to be a fully functioning Hospital at Home model based on the national definition. Specialist GP support is being considered in Aberdeenshire and a review of the national definition of Hospital at Home would be helpful to allow different models to be considered. The consultation on the national older people's strategy highlights the very positive feedback on Hospital at Home models where they have been implemented. As previously highlighted this reinforces the importance of ensuring sufficient resources and workforce capacity are made available in primary and community care to deal with the increased complexity and demands of care required for an increasing older population.

Extract:

> 'As people become older, they are often more aware of their mortality and will often live with health conditions which cannot be cured. Palliative care can be defined as 'good care' for people whose health is in irreversible decline and whose lives are coming to an inevitable close. Palliative care includes, but is not exclusively about care at the very end of life. Holistic palliative care interventions can sit alongside planned treatments which are aimed at controlling the underlying disease process. Palliative care can also be provided in an urgent or emergency setting. People thought that getting better awareness and confidence around end-of life conversations and support among health and social care staff is as much a priority as getting awareness among the public. The Scottish Government has committed to producing a new palliative and end of life care strategy in 2022. It is envisioned that the new national strategy for palliative and end of life care will take a whole system, public health approach.'

Question:

When thinking about palliative and end of life care in Scotland, what is working well?

What could be improved?

Draft response:

The delivery of person-centred care through integrated community teams and with quick access to equipment are key features of what is working well, supported by well informed, trained and skilled staff. The importance of continued and increased education and training in relation to palliative and end of life care would also be noted.

Within Aberdeenshire care homes and very sheltered housing, staff are highly skilled at supporting people at the end of life and ensuring the person has a calm and peaceful passing. Our Care homes have been supporting staff following the death of a resident with the use of a debrief tool. This tool can also be used for any challenging events to support the staff.

INTEGRATED UNSCHEDULED CARE

Extract:

> 'Unscheduled care is care and treatment which cannot be reasonably foreseen or planned in advance. Unscheduled care and treatment can be required at any time of the day. Unscheduled care includes emergency GP appointments or A&E treatment.
>
> Post operative is the time period after surgery. Post operative support varies – even in the same health and social care partnership area. Older people need extra assistance post operative – whether it be with dressings or just a general chat on how they are feeling.'

Question:

What is currently working well to support older people who require urgent or emergency care?

What could be improved?

Is there anything else you would like to add about integrated unscheduled care for older people?

Draft response:

Within Aberdeenshire, the multi-disciplinary Virtual Community Ward model has been embedded across Aberdeenshire for several years. It is key to allowing integrated multi-disciplinary teams to identify, 'wrap around' and support individuals who need health and social care services at an earlier stage, with the aim of avoiding unnecessary hospital admission and improving patient outcomes and experience. We also utilise the Aberdeenshire Responders Care at Home (ARCH) to support urgent and unplanned care needs.

We would suggest that the new strategy, as well as taking account of the Independent Review of Adult Social Care, should also be cognisant of the Scottish Mental Health Law Review. This is in particular reference to issues around decision making and capacity, supported decision making, advocacy and the ability to be able to have appropriate care provided when this is needed, avoiding where possible any delays in awaiting Guardianship for those who lack capacity.

Access to integrated, up to date records across health and social care services including out of hours is another essential component to delivering the right care in the right place and at the right time as part of a person-centred, holistic approach to care.

Question:

Please use this space to highlight or raise any other areas you feel should be included in the new health and social care strategy for older people.

Draft response:

With evidence that the burden of Covid-19 has disproportionately affected specific population groups including older people, there will be a need to focus efforts to mitigate the risk of long-term inequalities. Digital technology/telecare has a significant role in addressing some aspects of loneliness and isolation and connectivity more widely and this has been a key feature of the HSCP's response to maintaining contact with patients and service users. At the same time, it is recognised that this has the potential to create further inequity where sections of the population may be disadvantaged in terms of access to and use of services, impacted by issues such as rural inaccessibility, costs associated with IT connectivity, equipment, confidence in use of technology, or where a digital option is simply not viable or appropriate for certain client groups. The HSCP is exploring what action we can co-produce with our partners, communities and the third sector to facilitate digital inclusion.

We would reiterate the fundamental importance of ensuring safe and appropriate models of Housing, including adaptations where required, to be able to support older people to remain independent and to support good health and wellbeing.

Intergenerational shared spaces with older and younger people using the same space to live and work together is an opportunity to change how we support intergenerational practice and could be explored further with many examples of these types of projects working successfully across the UK and other countries.

The importance of ensuring consistent application and promotion of the health and social care standards across all settings including care homes for older people is noted, to ensure all people, no matter their age, know what they should expect from any health and social care provider.

One of our most clear and critical challenges is how we ensure we have the health and social care workforce capacity needed to provide safe, sustainable models of care and support for older people for the future, and therefore it is essential that there is a clear alignment between this strategy with workforce planning actions over the short, medium and long-term.

APPENDIX 2: PROJECT UPDATE REPORT – HEALTH IMPROVEMENT DELIVERY PLAN

Submitted by: George Howie, Principal Health Improvement Officer		**Date of Report: 13/04/22**	
Project title: Aberdeenshire Health Improvement Delivery Plan, 2021 – 2023	**Priority workstream (if applicable):** Transformational	**RAG status for current phase***	Amber

Project phase
The Aberdeenshire Health Improvement Delivery Plan covers the period 2021 - 2023.
The RAG status reflects progress in delivery of the plan to the end of 2021 – 2022.
March 2023 is the planned completion date for the Aberdeenshire Health Improvement Delivery Plan.

Initiation **	**Planning****	**Implementation****	**Close****
Oct 2019 - March 2020	Oct 2019 - March 2020	March 2023	September 2023

Which strategic priority does the project align to?
The strategic priorities the Health Improvement Delivery Plan aligns to are indicated below with an *.

Prevention and early intervention *	Reshaping care *	Engagement *	Effective use of resources *	Tackling inequalities and public protection *

Brief description of the project
The Aberdeenshire Health Improvement Delivery Plan, 2021 - 2023 highlights 4 priorities which are in line with national and Grampian Public Health priorities. These priorities are as follows:

- Improving mental health and wellbeing.
- Healthy eating, being active and healthy weight.
- Reducing the impact of poverty and inequalities.
- Building community capacity for health improvement.

The Aberdeenshire Health Improvement Delivery Plan, 2021 - 2023 outlines the principal actions that will take place at an Aberdeenshire level in relation to each of the above priorities, as well as highlighting activity that will take place within specific localities. Key action will be progressed in collaboration with our communities and partners across health and social care, local government and the third sector.

Project update as of 14/04/22

Progress in delivering actions within the plan have been delayed in some cases due to the Public Health Team being redeployed to support activity related to the COVID-19 pandemic in 2021 - 2022.

In light of the adverse impact the COVID-19 pandemic has had on health and wellbeing, including the potential to further widen the health inequalities gap, and limited capacity within the Public Health Team due to staff redeployment the Public Health Team have prioritised activity under 3 of the key priorities within the Aberdeenshire Health Improvement Delivery Plan in 2021 - 2022 – Improving mental health and wellbeing, Healthy eating, being active and healthy weight and reducing the impact of poverty and inequalities.

Key achievements

Improving mental health and wellbeing

- The Public Health Team facilitated the delivery of the annual Aberdeenshire Wellbeing Festival in support of Mental Health Week. A week-long programme of community-based activities were developed which support people to be active, to connect, to learn, to volunteer and take notice of the opportunities in their communities and recognise the important role they play in supporting individual and community wellbeing. Local services and organisations were encouraged to participate/host community events.
- Commissioned and other digital supports, including Kooth, Togetherall, Daylight and Sleepio were promoted with Community Planning Partners, CMHT's to further build mental health and wellbeing community resilience and self-help.
- A marketing company were commissioned to devise and deliver the online Mind Yer Mind campaign based on the 5 themes of mental wellbeing. The campaign aimed to ensure people will be supported to look after their health and wellbeing and live well by accessing advice and support that is relevant to their needs. Lived Experience feedback on initial campaign to the end of March 2021 is currently being compiled, this will be used to inform the key focus for future campaigning. Resources created during the campaign included e-books and the recruitment of Mental Health and Wellbeing Ambassadors.

Healthy eating, being active and healthy weight

- The Public Health Team have led the development and implementation of a system wide Community Planning Partnership plan focusing on healthy eating active living (HEAL). A series of facilitated workshops were held with the HEAL Strategic Planning Group, a series of resources were developed to support these workshops and the strategic planning process e.g. a Network Analysis, a Causal Map and Asset Mapping tool. In collaboration with Community Learning and Development a public engagement programme commenced late 2021 to co-produce a series of HEAL actions for Aberdeenshire, an Engagement Toolkit was developed to support this process. The public engagement programme was also able to identify local assets that may support the implementation of these actions and barriers that may hinder implementation of actions. The public engagement programme to date has consisted of 8 pop up stalls in

streets/community venues in Banff, Mintlaw, Udny, Alford, Stonehaven, Banchory and Garioch locations; 8 groups were engaged face to face or online to include carers, people in recovery from alcohol/drug issues, older people, parents of young children, young people, people with disabilities/mental health problems, ESOL learners. 147 people have contributed to the public engagement process to date. The project Strategic Planning Group will identify a range of HEAL actions to address gaps identified in existing HEAL activity in 2022/23.

- A funding bid to Scottish Government was successful to deliver at scale the HENRY Healthy Families programme, an early years healthy living programme that supports and enables families to make healthy lifestyle choices. Online delivery of training to an anticipated 220 families to commence May 2022.
- To continue to build community food skills capacity and support those living on a low income and/or who are vulnerable a review was conducted of the provision of food skills training in Aberdeenshire. Virtual food skills opportunities were offered to connect people as we live with COVID-19. A thematic Halloween inspired event took place in Tarland in 2021 for children, families and those identified as affected by low income, food insecurity benefited from an educational session, people will be encouraged to consider healthy eating recipes with a healthy root vegetable as a main ingredient and consider reducing food waste.
- Mapping of support for food insecurity in Aberdeenshire. Support the development of approaches to prevent and alleviate food insecurity, reduce stigma associated with seeking support and building communities' resilience to combat food insecurity. A Food Plan and Virtual Food Network have been established in South Aberdeenshire, with an emphasis on supporting more vulnerable groups. Within Garioch a survey tool has been developed to help identify Food Skills training/support.
- Work commenced with Live Life Aberdeenshire to develop a funding proposal to develop and sustain an Aberdeenshire wide support pathway for people with Long Term Conditions to help them look after their own health and wellbeing. The service will provide individuals with access to Live Life Aberdeenshire services via Primary Care, with a target of supporting 500 individual per annum. Funding approved for an initial 18 months.

Reducing the impact of poverty and inequalities

- The Public Health Team supported Aberdeenshire Council Education and Children's Services to improve the availability of Free Period Products in schools and community settings within the context of The Period Products (Free Provision) (Scotland) Act 2021. This work is designed to improve the health and wellbeing of families living in/at risk of poverty by ensuring access to appropriate products/services while preserving dignity. An online service was established in response to the COVID-19 pandemic. 4 Pharmacy pilots are currently ongoing; engagement with Grampian Women's Aid has taken place to raise awareness of the project and a consultation in development through Engagement HQ. Aberdeenshire collection points now detailed on the Hey Girls app which is accessible via android and iOS. Publicity on social media resulted in a large increase for free, this may not be sustainable and a review required due to budget restrictions. Evaluation of online service is chiefly by asking questions at end of the application form. Data from schools on the numbers of products ordered is also collected via the online order form.

- To improve access to local information and advice services for those experiencing a range of challenges relating to money the Just in Time leaflet was developed and distributed to a wide range of settings and audiences throughout Buchan, the leaflet was also promoted on the Public Health Team's North Facebook page. Just in Time leaflet signposts individuals/families to local help and support. In 2021/22 COVID restrictions have impacted on where the leaflet can be placed for easy public access, a wider range of outlets is planned for 2022/23. A briefing/awareness session was held for 12 local partners in Buchan. In Huntly and Kincardine and Mearns a Worrying About Money leaflet was distributed to local partners and promoted through the Public Health Team's South Facebook page.

Case Study / Testimonials

Feedback/learning from the key actions in the Aberdeenshire Health Improvement Delivery plan is collected in a range of ways and data gathered is routinely reviewed to ascertain the impact of individual projects and to inform future planning.

A Performance Monitoring Framework has been devised by the Public Health Team to gather quantitative and qualitative data and learning from the programmes of work/projects outlined in the Health Improvement Delivery Plan.

Deliverables

The Aberdeenshire Health Improvement Delivery Plan 2021 - 2022 is focused on 4 key priorities, the plan outlines the principal actions and anticipated deliverables for each of the priorities, these include service redesign and the development of strategic plans, new training programmes and resources.

Benefits

Through the development and implementation of the Aberdeenshire Health Improvement Delivery Plan the Public Health Team seeks to improve ownership among partners of health improvement priorities and increase awareness in the Aberdeenshire public of health and wellbeing issues and their role in supporting their own health and wellbeing.

The key high-level changes that the Public Health Team and our partners are looking to achieve for each of the 4 priorities in the Aberdeenshire Health Improvement Delivery Plan are as follows:

Improving mental health and wellbeing

Working with partners the AHSCP Public Health Team aim to:

- Further improve public and practitioner awareness of mental health and how to improve it.
- Further improve public and practitioner awareness of mental health services and how to access them.

Healthy eating, being active and healthy weight

Working with partners the AHSCP Public Health Team aim to:

- Create a positive relationship with food and physical activity from birth to adulthood.
- Enable families, young people, older people, those living alone and carers to develop Food Skills for health and wellbeing.
- Create and promote opportunities that promote healthy living.
- Enable children and adults to achieve a healthy weight and to be able to make positive food and physical activity choices.
- Create and promote opportunities for children and adults in Aberdeenshire be more active.

Reducing the Impact of poverty and inequalities

Working with partners the AHSCP Public Health Team aim to:

- Prevent and minimise the impact of poverty and inequality on health and wellbeing.
- Create the circumstances for vulnerable people and those living in poverty, or at risk of *poverty*, to live in better health.
- Support action to ensure children have the best start in life by maximising parental income; improving employability prospects; improving housing options, reducing fuel poverty and reduce digital exclusion.

Building community capacity for health improvement

Working with partners the AHSCP Public Health Team aim to:

- Create vibrant and resilient communities which value diversity and support those in need.
- Build capacity for health improvement within communities.
- Create and promote the use of greenspace, leisure activities and opportunities that enhance health and wellbeing.

Additional comments	**Equalities**
The COVID-19 pandemic has provided an opportunity to consider how key health improvement action in Aberdeenshire can be delivered effectively in alternative ways without further widening health inequalities.	***Equalities outcomes agreed for 2020-2024*** A key ambition of the Aberdeenshire Health Improvement Delivery Plan is to:

<table>
<tr>
<td>The COVID-19 pandemic necessitated an increased reliance on digital communication, this has the potential to be effective in reaching some sections of our communities in Aberdeenshire and will have a role in complementing face to face delivery of health improvement action moving forward.</td>
<td>

Ensure that the Aberdeenshire public have improved health and wellbeing through access to information and support appropriate to their needs.
Opportunities to further develop knowledge and skills.
Access to person centred holistic services.

Engagement with partners and key target audiences ensure that the priorities within the Health Improvement Delivery Plan and the way in which key actions are delivered reflects the needs of communities across Aberdeenshire.</td>
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<td>Challenges and support

The COVID pandemic is likely to have an adverse impact on health and wellbeing and has the potential to further widen the health inequalities gap in Aberdeenshire. The achievements in relation to improvements in some measures of health and wellbeing seen in recent years have the potential to plateau or regress. A key priority as we live with COVID will be to ensure that the health inequalities gap does not widen further.</td>
<td>Engagement

The Aberdeenshire Health Improvement Delivery Plan seeks to engage with our communities in Aberdeenshire at a locality level in the planning, where relevant the delivery and in the evaluation of the key actions in the Plan. A range of online and where appropriate face to face engagement methods have been utilised by the Public Health Team e.g. surveys, individual interviews, focus group discussions and through engagement events such as Mini-Publics.</td>
</tr>
</table>

***RAG status explanations**

Green	**On track - no forecast issues with achieving project aims and milestones**
Amber	**Some issues but manageable by project team**
Red	**Significant issues requiring escalation to the SPG/SMT**