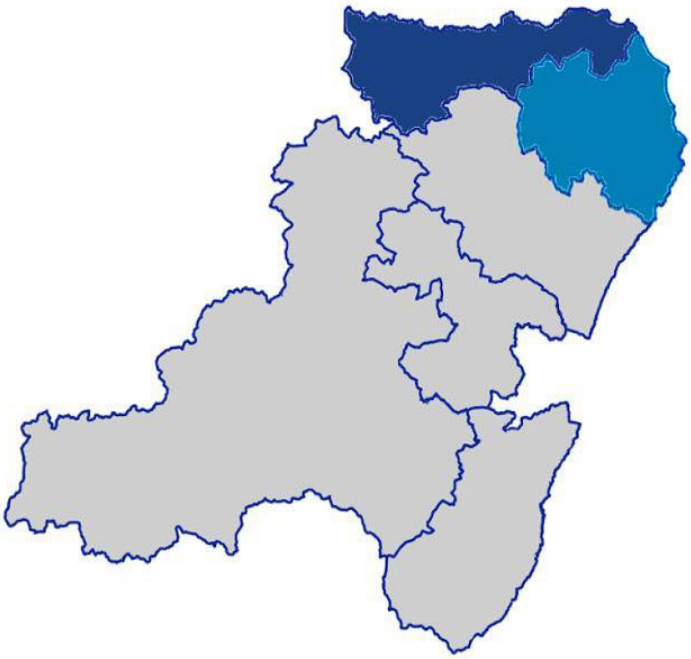
Aberdeenshire
Health & Social Care
Partnership

Health and Social Care Locality Plan North Aberdeenshire 2018 – 2021



Aberdeenshire COUNCIL

NHS Grampian

Contents

FOREWORD

Developing these initial Locality Plans for North Aberdeenshire has been a great opportunity for us to start to build new community networks and to strengthen existing partnerships, all of which is essential as we navigate the opportunities and challenges ahead of us in delivering Health and Social Care services into the future.

North Aberdeenshire is a great place to live and work and we would like to make it even better by supporting people to live healthier, active and safe lives through promoting greater personal independence, choice and control.

The changing demographics and increased demand on limited resources means that it is now more important than ever that we develop new ways of working that will give individuals and communities more control of their health and well-being.

The Locality Plan provides an overview of our early priorities for moving forward, and I would like to thank everyone who has helped contribute to this process. I very much look forward to working together to deliver on these outcomes.

Mark Simpson

North Partnership Manager

Aberdeenshire Health and Social Care Partnership

The locality plan provides an overview of what we will strive to achieve going forward, and in each area the Location Managers look forward to working together with everyone who has an interest in improving health and social care services at a local level.

Banff & Buchan Location Managers

Corinne Millar & Lesley Mackenzie

Buchan Location Managers

Alex Pirrie & Lorna Watt

1 INTRODUCTION

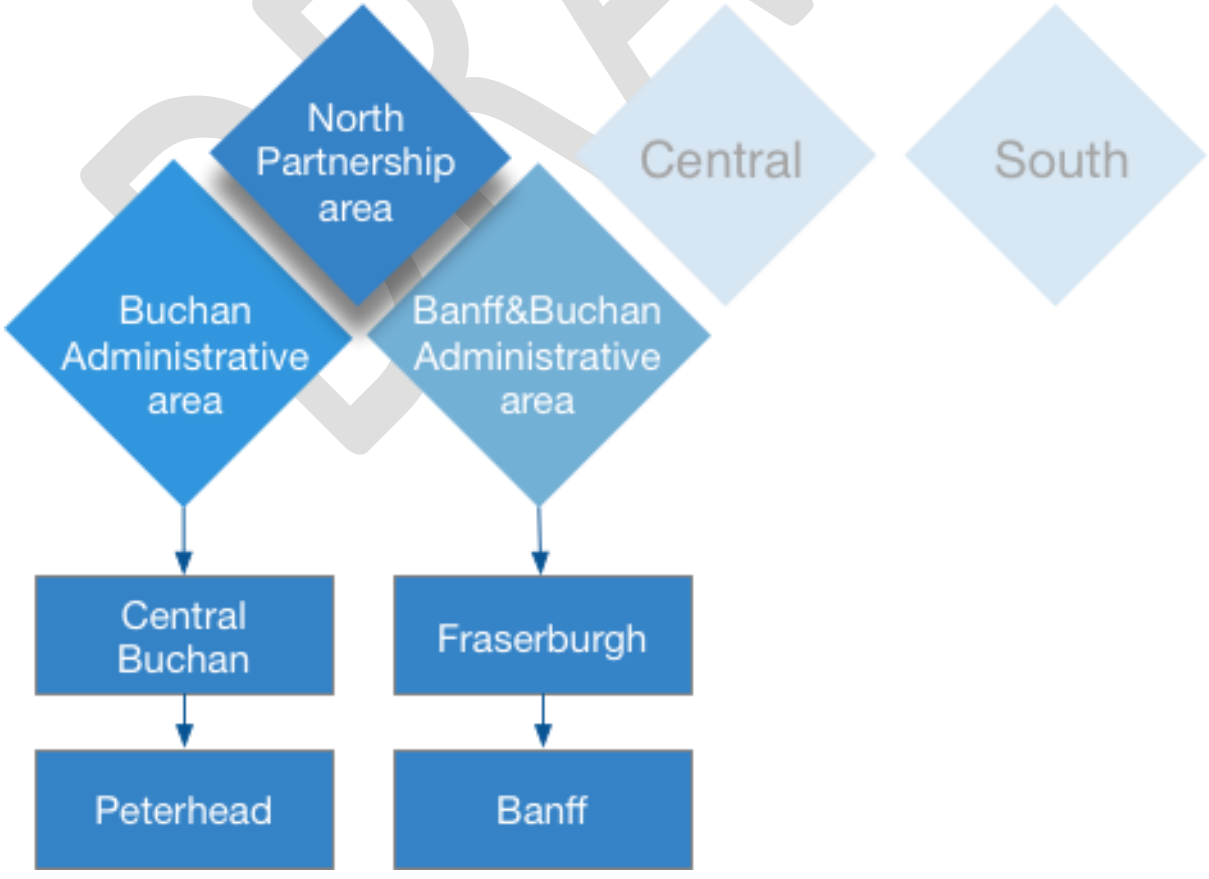
1.1 What is a Locality?

A locality is described as a small area within the Integration Authority borders. In Aberdeenshire our localities are organised so that health and social care teams and the people in the area they serve can have a clear influence on the resources that are available and the development of new services and supports.

Localities are defined by geography, the people that live and work in the area, the characteristics of the population and to some extent by existing services such as the location of community hospitals, health centres and social work offices.

Aberdeenshire Health and Social Care Partnership (AHSCP) has 4 Partnership managers, one for Strategy and Business Services and 3 Partnership Managers who cover Central, North and South Aberdeenshire. The Central, North and South Partnership Managers each have overall responsibility for two of the six administrative areas in Aberdeenshire. Within each administrative area lies Aberdeenshire's localities. There are 20 localities in Aberdeenshire which vary greatly in geography, size and characteristics.

The organigram below demonstrates the links between localities, administrative areas and partnership areas.



1.2 What is the Locality Plan?

Health and Social Care Partnerships (HSCP) are required by legislation to establish localities within their area. The forming of localities is seen as a way to lead health and social care service planning at a local level. The development of Locality Plans is a way for Aberdeenshire's localities to come together to look at and prioritise the needs of its people, and the priorities identified will feed into the larger strategic plan across Aberdeenshire. In the North 1 plan has been developed to cover the two administration areas, which are made up of 2 localities each:

- Banff & Buchan (Fraserburgh & Banff)
- Buchan (Central Buchan & Peterhead)

The forming of the localities and the development of a locality plan will help to ensure strong community, clinical and professional leadership and focus our joint responsibilities to improve outcomes for people. It will bringing together views from service users, carers, health and care professionals to plan and help redesign services enabling influence over resources within the area and ensuring at a local level we can support capacity building within north Aberdeenshire.

Our locality plan highlights the ongoing commitment of those who live and work within north Aberdeenshire, whilst also making reference to the challenges that we face.

1.3 The Benefits

- It gives the locality the opportunity to continue to play an active role in service design and improvement.
- The process of locality planning will raise awareness of current services and celebrate successful partnership working.
- It identifies local priorities, which ensures that the needs of the locality are being addressed by those who know it best.
- A culture is created where by these local relationships can lead to real change.
- It helps to put people at the centre of their own care, and enables them to stay in their own homes and communities, where possible.
- It supports collaborative working, allowing a seamless delivery of health and social care services which are easy to access.

1.4 What is the relationship between localities and community planning?

The Community Planning Partnership (CPP) *'work together for the best quality of life for everyone in Aberdeenshire'*. The CPP is responsible for delivering positive changes for the communities of Aberdeenshire, with a specific focus on reducing socio-economic inequality, primarily through the priorities identified in Aberdeenshire's Local Outcomes Improvement Plan (LOIP) 2017-2027.

Community Planning is about joining up the efforts and resources of the public, business, voluntary and community organisations to better plan, resource and deliver quality services that meet the needs of local people.

Each of the 6 administrative areas in Aberdeenshire has a Community Planning Group (CPG) on which the HSCP is represented. Strengthening links between the CPG and the HSCP will be vitally important to ensure people within the communities are at the heart of decision making.

Joint working with the CPG, will help to reduce duplication of work, and assist in providing a consistent pathway to share information widely with partners and gain input from all. Working in collaboration will allow us to develop new ways of allocating resources efficiently to ensure people are supported to live a healthy, active, and safe life.

1.5 Where does this plan fit in the wider picture?

The National Health and Wellbeing Outcomes provide a strategic framework for the planning and delivery of health and social care services. The suite of 9 national health and wellbeing outcomes focus on improving the experience and quality of services for the people using health and social care services, unpaid carers, and their families. These outcomes focus on improving how services are provided, as well as, the difference that integrated health and social care services should make, for individuals.

9 **National** Health and Wellbeing Outcomes

To deliver the 9 National Outcomes the Aberdeenshire Strategic Plan 2016 – 2019 was developed which provides direction for the Partnership. The priorities initially set were evaluated and streamlined in 2017 resulting in, 10 high level priorities under 2 themes. Additional to the Strategic Plan is our Commissioning Plan which ensures funding is aligned to the projects that are linked to the strategic priorities.

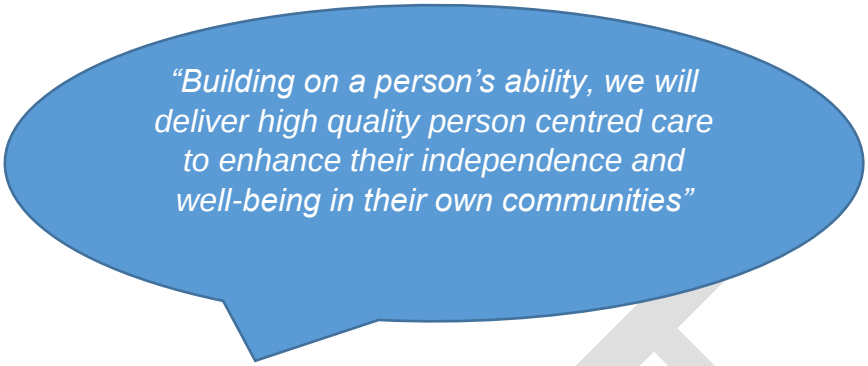
10 **Aberdeenshire** Priorities

This Locality Plan will be 1 of 5 plans for Aberdeenshire Health and Social Care Partnership. The plan fits into the bigger picture by aligning with the wider Aberdeenshire strategic priorities, and the nine national health and wellbeing outcomes.

Moving forward the Locality Plans will help to inform future strategic direction, and Locality Planning will continue to be closely linked to the Community Planning Group who engage with communities to prioritise local need.

1.6 What are we hoping to achieve?

The plan is centred on the Aberdeenshire Health and Social Care Partnership vision:



For the people in our community this means that treatment is designed around the needs of the person. People are entitled to expect the best possible advice, care and support from our staff in a timely manner and in the right place. Every individual is able to contribute to their own health and wellbeing, make their views known and participate in their own care. A person's family, their social network and their close community all have a part to play to achieve healthy lifestyles and to support those who need help to contribute to live in their own homes.

Within north Aberdeenshire we are committed to developing our services to meet local need. We plan to achieve this through ongoing local community consultations and engagement events, which will help us to better understand the local community resources, and to achieve better outcomes for individuals and the community as a whole.

1.7 Consultation and Development of plan

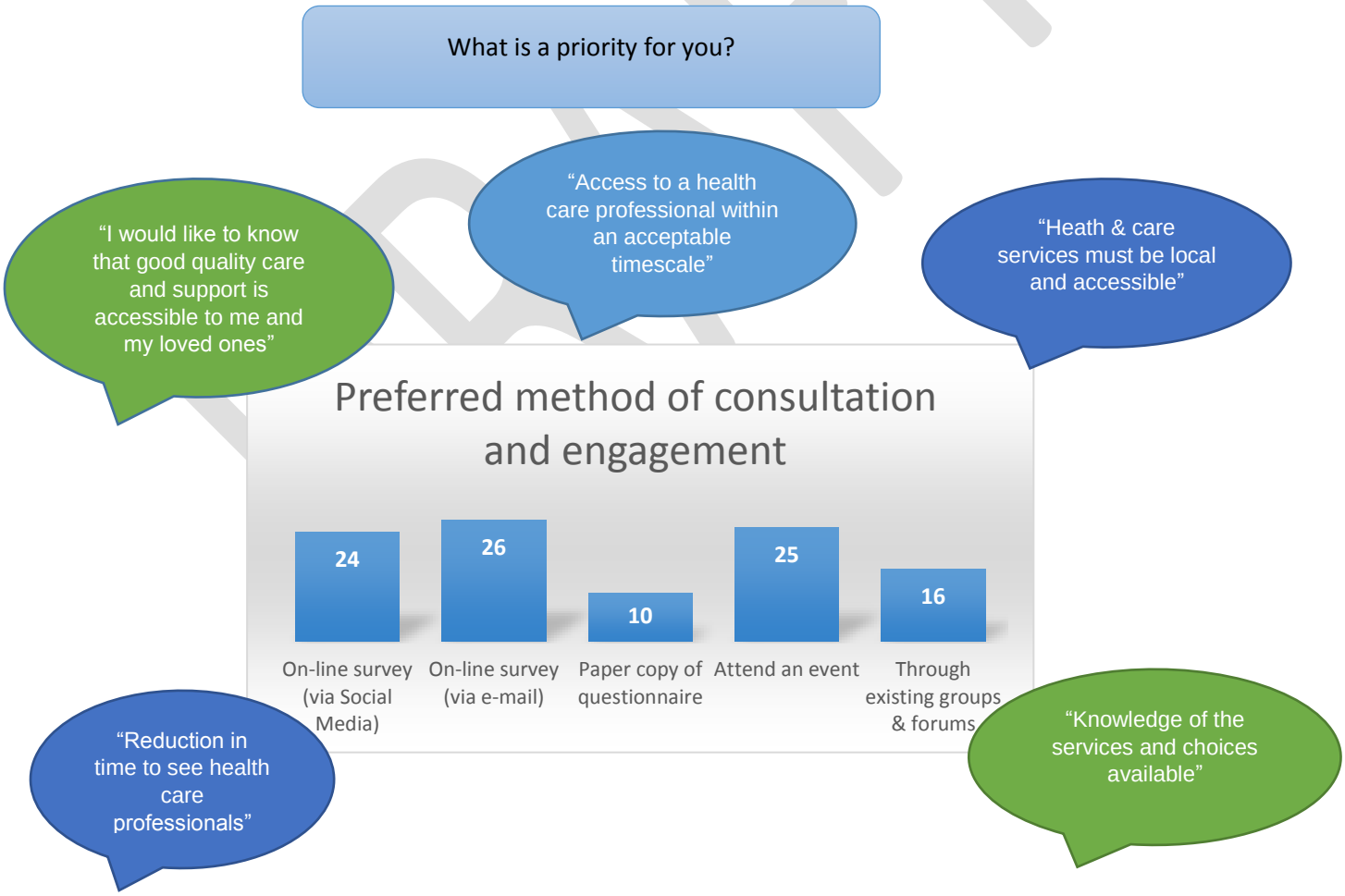
In North Aberdeenshire we carried out an initial engagement process in 2017; both with the communities and with professionals delivering health and social care in order to identify the local priorities. The engagement included:

- **Event for professionals** - held in Fraserburgh on the 7th November 2017, attended by a wide range of professional's from various sectors involved in delivering health and social care across north Aberdeenshire.
- **Public Survey** – accessible in October and November 2017, promoted on-line via social media, e-mail, Aberdeenshire Council's website, local press, third sector newsletters and mailing lists, and as a paper copy available in family resource centres, days centres, and posted out on request.
- **Community Planning Groups** – used for discussion, feedback and updating with a wide range of stakeholders.

At the engagement carried out in North Aberdeenshire in 2017, with both the public and professionals candid and open questions were asked to allow both the 'challenges', and the 'health and social care priorities' of people to be recorded. Further information was gained through this process to identify how people would like to be involved in the on-going engagement and consultations required to deliver Locality Plans.

Using the data collated from this engagement, a team comprising of; Location Managers, HCSP Team Managers, Clinical Lead, AHP Lead, and AVA (third sector representation) agreed the priorities for each of the 2 areas in North Aberdeenshire. From the more detailed data gathered from the engagement process and existing benchmarking data two action plans were produced which describe how the 4 priorities in Banff & Buchan, and the 4 priorities in Buchan will be taken forward.

Further consultation was then undertaken via an on-line survey collecting comments on the draft locality plans. This survey was open for 3 weeks in February 2018 and promoted widely through social media, local press, HSCP and third sector organisation staff members, and community groups and networks. Opinions and comments were collated and are reflected in the plan where appropriate.



This plan now lays out the priorities and action plan for each of the 2 administrative areas in north Aberdeenshire in two separate sections, the first covers Banff and Buchan, and the second Buchan.

2 ABOUT BANFF & BUCHAN

2.1 The Locality

Banff and Buchan is home to approximately 35,500 people, along with its key towns of Fraserburgh, Banff and Macduff it has many smaller villages ranging from the larger Portsoy in the northwest with a population around 1,700, to smaller villages such as Sandhaven just outside Fraserburgh with a population of 680.

The economy is mainly based on the traditional industries of fishing and agriculture. The area is largely rural with 72% of the working population employed locally, this is higher than other areas within Aberdeenshire and could be due to fewer employment and service connections to the city of Aberdeen than other parts of Aberdeenshire.

In addition, tourism plays a role in the economy of Banff and Buchan. This is largely concentrated around the area's 77km coastline of which the Banffshire stretch between Cullen in Moray and Pennan in Aberdeenshire has been voted as one of the top 20 most iconic coastlines in the world in a National Geographic survey.

The areas housing stock increased by 16.3% between 2005 and 2015, which is 7% lower than the highest increase within Aberdeenshire. The average house price is the lowest out of the 6 areas within Aberdeenshire at £132,263, compared to the Aberdeenshire average of £218,663.

Banff and Buchan suffers from pockets of deprivation, with the highest proportion of the most disadvantaged areas within Aberdeenshire – in particular around Fraserburgh. Also the Fraserburgh area has significantly lower life expectancy for both males and females and increased mortality rates although, as a whole, people living in the area have a life expectancy that is higher than the Scottish average.

The area also continues to face deep-seated issues due to problematic use of alcohol and other drugs that directly and indirectly threaten the wellbeing and economic prospects of the area. Community partners actively work together to reduce the impact of these issues, supporting Banff and Buchan in becoming a safer and stronger community.

2.2 Banff & Buchan area

Banff and Buchan

- **2** Community Hospitals
- **8** GP Practices
- **8** Community Pharmacies
- **6** Dental Practices
- **4** Opticians
- **2** Care Homes
- **12** Very Sheltered Housing Complexes
- **2** Sheltered Housing Complex
- **4** Day Services
- **9** Libraries
- **2** Leisure Facility
- **2** Community Centres

The assets listed above for Banff and Buchan are part of a suite of services, networks, and partnerships that provide support to our local communities. We recognise that people are our most valuable resource, however it is also important to make best use of the physical assets available in the community to help us deliver better outcomes for the people in Banff and Buchan.

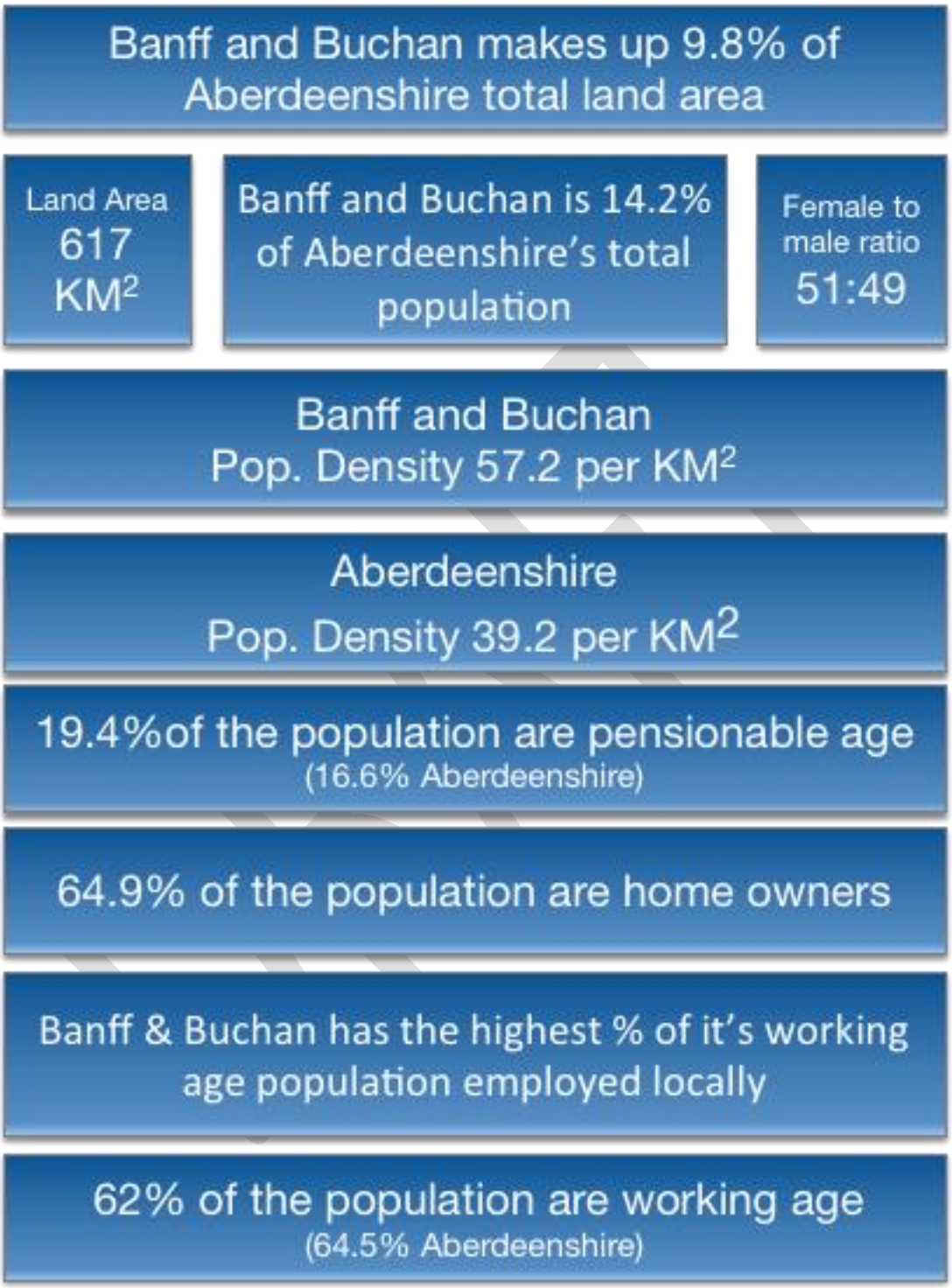
The Acute Hospital (Aberdeen Royal Infirmary) and Mental Health services (Royal Cornhill Hospital) are provided in Aberdeen City for the whole of Aberdeenshire.

Information regarding third and private sector resources can be found:

http://signpostingproject.org.uk/ https://www.aliss.org/

http://www.grampiancaredata.gov.uk/ http://avashire.org.uk/

2.3 Area profile Information



2.4 Health and Wellbeing of the locality

Banff and Buchan Health Profile

Banff and Buchan have the highest rates of emergency hospitalisation within Aberdeenshire.

82% of people receiving social care or social work services felt they were excellent or good. Aberdeenshire average 85%.

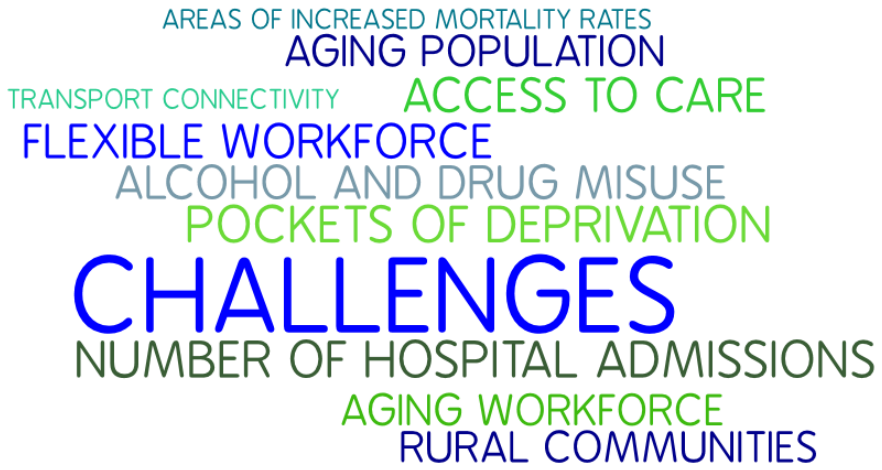
77% of people rated the care provided by there GPs as good or excellent, compared to 82% for Aberdeenshire as a whole.

79.9% of Banff & Buchan populations reported that their day-to-day activities were not limited by any health problems, this is below he Aberdeenshire figure of 84.5%

Multiple emergency admissions to hospital for people 65+ years is 20% higher than Aberdeenshire and is significantly higher than other localities.

Banff & Buchan is only marginally higher than the Aberdeenshire average rate for patients registered with cancer, but has the highest rate of patients hospitalised for COPD (Chronic Obstructive Pulmonary Disease), more than 20% above the Aberdeenshire rate.

2.5 What are the main challenges?



2.6 What are Banff and Buchan's priorities?

By analysing existing local data, and engaging and consulting widely as explained in section 1.7 and 2.5, we have identified the following as key priorities for 2018 to 2019:

1. Reduce the number of unplanned hospital admissions particularly among older people.

2. Develop the Workforce to meet the changing demands of health and social care provision within communities.

3. Manage the impact of long term alcohol and drug misuse on individuals, families, communities and resources.

4. Reduce the demand on unplanned care provided.

2.7 Banff and Buchan's Action Plan

Priority	Action	Impact	How	Measure	Time Frame	Lead
1: Reduce the number of unplanned hospital admissions particularly among older people. Linked to the Aberdeenshire HSCP Strategic Priorities: 1, 2, 4, 5, 6, 7, 8, 9 & 10	1. Review and improve the current rehabilitation and enablement pathway.	Promote independence in more people by increasing the number of people accessing the rehabilitation and enablement pathway.	Undertake a review of the pathway, and implement any recommendations which would improve the pathway. Additionally promote the advantages of rehabilitation and enablement to all, and embed this into the way we all work.	Number of people accessing rehabilitation and enablement pathway.	2018 - 2021 (Review 2019)	Location Managers.
	2. Ensure the Responder Service - *ARCH is accessed appropriately. (*ARCH – Aberdeenshire Responders for Care at Home)	Appropriate use of ARCH will enable more people to remain in their own home where possible.	Promote ARCH and ensure a clear message is given as to the support the responder service can provide, and when it is appropriate to use the service. Highlight the use of responders to work with patients to follow the enablement pathway.	Number of people accessing the service, and monitoring inappropriate use of the service.		Location Managers.
	3. Strengthen the understanding of how people can self-manage their own health and wellbeing.	Improved understanding of the importance of looking after your own health, will empower people to take responsibility.	Work closely with Public Health to promote: • awareness of self-management, • local groups, patient participation forum's and networks, and • health initiatives, all which could provide support, including involvement in Participatory Budgeting projects. Additionally, promote this culture with staff across all partners to encourage everybody to play an active role in promoting self-management.	Number of people signing up to health initiatives, and attending awareness raising sessions for the public and staff. Number of people who feel they can look after their own health well.		Location Manager, Public Health Team & CHiP (Community Health in Partnership) Officers.

Priority	Action	Impact	How	Measure	Time Frame	Lead
	4. Ensure communities are aware of the resources available to them, and promote the benefits to people of becoming engaged in their community.	Clear, consistent information on resources will ensure people know how to access the appropriate service to support them. Additionally people will feel less isolated and better able to cope, if they can access low level support from their community.	Conduct a survey to establish the community's current awareness and understanding of local services and community resources, and where results show lack of knowledge provide clear information. Work with all partners to promote and define services and resources available to people in their community.	Number of people engaged with resources in their community. Reduction in the number of inappropriate referrals.		Location Managers & CHiP Officers
	5. Development of the 'Virtual Ward', to assess which model will provide the most robust delivery.	An efficient and effective 'Virtual Ward' which will ensure a consistent service that uses its resources to the maximum.	Investigate the current and different models of delivery for the Virtual Ward, and evaluate findings, implementing any recommendations for improvement.	Number of patients using the VW which otherwise would have been admitted to hospital. **Overall number of unplanned hospital admissions.**		Location Managers.

Priority	Action	Impact	How	Measure	Time Frame	Lead
2: Develop the Workforce to meet the changing demands of health and social care provision within communities. Linked to the Aberdeenshire HSCP Strategic Priorities: 3, 4, 5, 9 & 10	1. Develop a flexible and well trained workforce equipped with the right skills and knowledge ensuring joint working and training with third sector colleagues.	By building on the existing strengths within integrated teams and partners, staff will be appropriately qualified to deliver person centred care helping to maintain or improve the quality of life for people within the community.	Support staff across the locality to have a shared vision and understanding of each other's roles and build on existing skills. Through joint training with partners develop a workforce which is fit for purpose.	Review of any innovative changes in how staff resources are allocated in teams. Staff responses on iMatter (staff experience survey).	2018 - 2021 (Review 2019)	Location Managers & CHiP Officer.
	2. Encourage staff to look at; how they can work differently; actively contribute to service development; and ensure all staff feel empowered to take responsibility for their own job.	Staff will be an integral part to the development of a robust workforce, and will take more ownership in the delivery of safe and sustainable high-quality services.	Assess and develop teams using an approved 'Improvement Performance' tool in line the partnerships workforce plan. Provide a team structure where staff feel empowered to take responsibility and use their own initiative to provide person centred care. Also consider sharing staff where possible across historic NHS and Social Care boundaries, to strengthen further integrated working and maximise the workforce's potential.	Number of staff undertaking the approved 'improvement performance' training. Staff responses on iMatter (staff experience survey). Review of any innovative changes in how staff resources are allocated in teams.		Location Manager & Continuous Improvement Officer.

Priority	Action	Impact	How	Measure	Time Frame	Lead
	3. Reduce the impact of any challenges faced due to difficulties in recruiting & retaining health and social care staff in the area.	Continuing to identify innovative ways to build and strengthen the existing workforce, will help ensure we can respond flexibly to new demands and future development in health and social care.	Promote working in Banff & Buchan as a positive career choice with current students in Aberdeenshire. Investigate increasing the number of student placements in the area. Ensure staff feel valued and their views respected. Provide a safe place where staff feel supported to take responsibility for their role, and are proud of the work they do.	Number of health and social care students who stay in the area after training is complete. Number of student placement available in Banff & Buchan. Staff responses on iMatter (staff experience survey).		Location Managers & Workforce Development Team
3: To manage the impact of long term alcohol and drug misuse on individuals, families, communities and resources.	1. Identify issues arising from long term alcohol and drug misuse on resources and services.	Identification of specific issues relating to long term use, will provide the information required to ensure resources and services are targeted in the most effective and useful way.	Establish a working group to look at impact from long term alcohol and drug misuse on resources and services. Identify areas of work to be taken forward which will begin to address issues.	Monitor Action Plan developed by new working group.	2018 - 2021 (Review 2019)	Social Work Manager & Location Managers

Priority	Action	Impact	How	Measure	Time Frame	Lead
Linked to the Aberdeenshire HSCP Strategic Priorities: 1, 2, 4, 5, 6, 7, 9 & 10	2. Work with the ADP and other third sector organisations and help to promote existing support available in the community for family members providing support to individuals.	Understanding and promotion of existing resources in the community for family members will help them to continue to provide support to some long term users with failing health.	Work closely with the CHiP officers to look at current availability of help within the community for those helping to support long term users. Promote resources available.	Number of people accessing support services available in the community.		Location Managers, Social Work Manager & CHiP Officer.
	3. Review use of ABI (Alcohol Brief Interventions) training programme for primary care staff, and identify any gaps in training needs and onward referrals.	Consistent training and monitoring of positive outcomes for individuals will help provide timely and continuous support by the appropriate service.	Carry out a review of ABI training delivered to primary care staff, and the impact of the training. Identify and address any gaps in the training and issues with the referral process.	Results of review on the ABI training. Number of primary care staff undertaking ABI training. Review of any changes made to referral process.		Location Managers
4: Reduce the demand on unplanned care provided.	1. Promote Anticipatory Care Plans which mitigate negative outcomes and maximise positive outcomes for people.	Higher number of people completing useful ACP's and planning ahead to better manage their own health and wellbeing.	Roll out the ACP strategy and the new 'Let's think ahead' tool across Buchan, beginning with a pilot in Fraserburgh (Feb 2018). Identify staff champions within the Fraserburgh area to lead/promote the implementation and development of this work.	Number of useful ACPs completed, and shared between partners. Number of emergency admissions.	2018 - 2021 (Review 2019)	NHS Programme Manager and Location Managers.

Priority	Action	Impact	How	Measure	Time Frame	Lead
Linked to the Aberdeenshire HSCP Strategic Priorities: 2, 4, 5, 6, 8, 9 & 10				Number of day's people spent in hospital when they are ready to be discharged.		
	2. Work with Public Health and communities to improve knowledge and understanding of what health and social care resources are available in their area, and when it is appropriate to use each resource.	Increased knowledge and understanding in the community, will result in a reduction in inappropriate use of the local services and resources.	Promote the National NHS Initiative 'Know who to turn to'. Also use the information from the survey being carried out for 'Priority 1', action 3(a) to establish the community's current awareness and understanding of local services and community resources, and where results show lack of knowledge provide clear information.	Reduction in the number of inappropriate referrals.		Location Managers and Public Health.
	3. Strengthen the understanding of how Mental Health services are delivered, what support they can provide, and how to access it.	Individuals will have a clear understanding of the type of support available, and know how to access services locally when they need them.	Work closely with public health and the third sector to communicate clearly how the service is provided. Ensure staff who deliver health and social care and the people who provide community services understand the referral system for people seeking support. Additionally continue to engage with service users and the people in their support network, to gain feedback for future service design and delivery.	Number of people accessing the service. Number of people able to stay in their own home and community due to support received.		Mental Health and Learning Disability Manager.

Priority	Action	Impact	How	Measure	Time Frame	Lead
	4. Improve the flow of patients, service users, information and resources within and between health and social care organisations in areas identified as having a high demand on urgent care services.	An improved understanding of services which will ensure 'urgent care services' are used appropriately in communities identified with a high demand.	Work with the iHub to develop a programme in Fraserburgh that aims to provide a regional approach to reducing inappropriate use of urgent care services. Work closely with iHub colleagues to engage, deliver and evaluate project.	Evaluation of project from the iHub Strategic Team. Number of inappropriate admission/referrals to A&E and out of hours services.		Location Managers & Improvement Hub Project Lead
	5. Expand our understanding and use of Digital Health Care.	Improved understanding of the advantages and different types of digital technology available to people, will empower people to more actively manage their own health close to home.	Ensure staff and public are aware of the types of digital health care available to them, and encourage and promote the use of these. Further embed the use of technology into how we support people day to day. Expand use of digital health care as technology advances occur. Promote 'Attend anywhere' where resource is available. Investigate innovative ways to delivering clinics in remote communities.	Use of existing and new digital health care technologies. Number of people accessing 'attend anywhere' appointments.		Location Mangers & Project Manager
	6. Work closely with both internal and external Care at Home providers to ensure a consistent high quality service.	A consistent high quality service will allow people to feel supported to stay in their own home for longer.	Continue to evaluate provision provided and review & improve when required, in line with Reshaping Care at Home work. Work with the Social Care Contract Manager (SCCM) to ensure external Home Care providers are providing a high quality service.	Number of people supported to stay in their own home.		Location Managers and SCCM.

3 ABOUT BUCHAN

3.1 The Locality

Buchan is home to approximately 39,400 people, with Peterhead been the largest town in Aberdeenshire. Buchan has many smaller towns and villages ranging from the larger Mintlaw in the centre of the Buchan area with a population around 2,590, to smaller villages such as New Deer to the west with a population of 570.

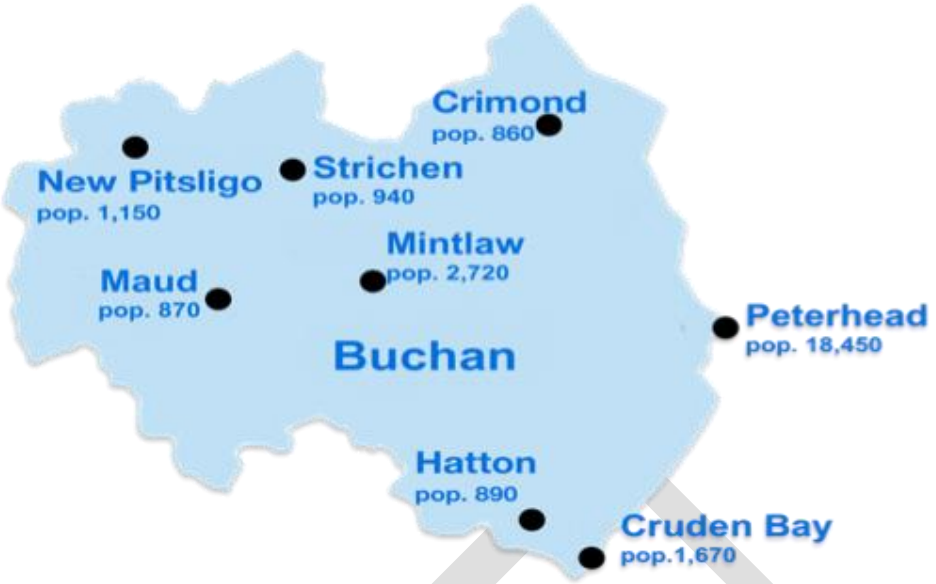
The area has a contrasting mix of farms, villages and industrial areas along with Peterhead which is the principle white fish landing port in Europe, and a major oil industry service centre. Peterhead is one of the UK's most versatile ports, serving a broad range of industries including oil and gas, renewables, fishing and leisure. Equally important are the nearby gas terminal at St Fergus and the Peterhead Power Station. Inland, the area is dependent upon agriculture. Whilst housing developments have continued, there has been a minor decline in rural services.

The areas housing stock increased by 19.2% between 2005 and 2015, which is the third highest increase within Aberdeenshire's six administrative areas. The average house price is £159,977, compared to the Aberdeenshire average of £218,663.

Although across Buchan the life expectancy of the majority of communities is above the Scottish average, parts of Peterhead have significantly lower life expectancy for both men and women and increased mortality rates. People over 65 years in Buchan are more likely to experience emergency hospital admissions than the general population, and have higher rates of admissions for this age group than elsewhere in Aberdeenshire. However, the rate of emergency admissions for this age group is reducing yearly.

For younger people, there are health concerns associated with alcohol and drug misuse, and for the older generation, priorities include combating fuel poverty and finding ways to employ enough carers to provide personal care. Buchan has the second highest rate within Aberdeenshire of Mental Health illness, however considerable work to improve individuals Mental Health is happening.

3.2 Buchan area



Buchan

- **2** Community Hospitals
- **5** GP Practices
- **11** Community Pharmacies
- **6** Dental Practices
- **3** Opticians
- **1** Care Home
- **10** Very Sheltered Housing Complexes
- **1** Sheltered Housing Complex
- **2** Day Services
- **6** Libraries
- **1** Leisure Facility
- **2** Community Centres

The assets listed above for Buchan are part of a suite of services, networks, and partnerships that provide support to our local communities. We recognise that people are our most valuable resource, however it is also important to make best use of the physical assets available in the community to help us deliver better outcomes for the people in Buchan.

The Acute Hospital (Aberdeen Royal Infirmary) and Mental Health services (Royal Cornhill Hospital) are provided in Aberdeen City for the whole of Aberdeenshire.

Information regarding third and private sector resources can be found:

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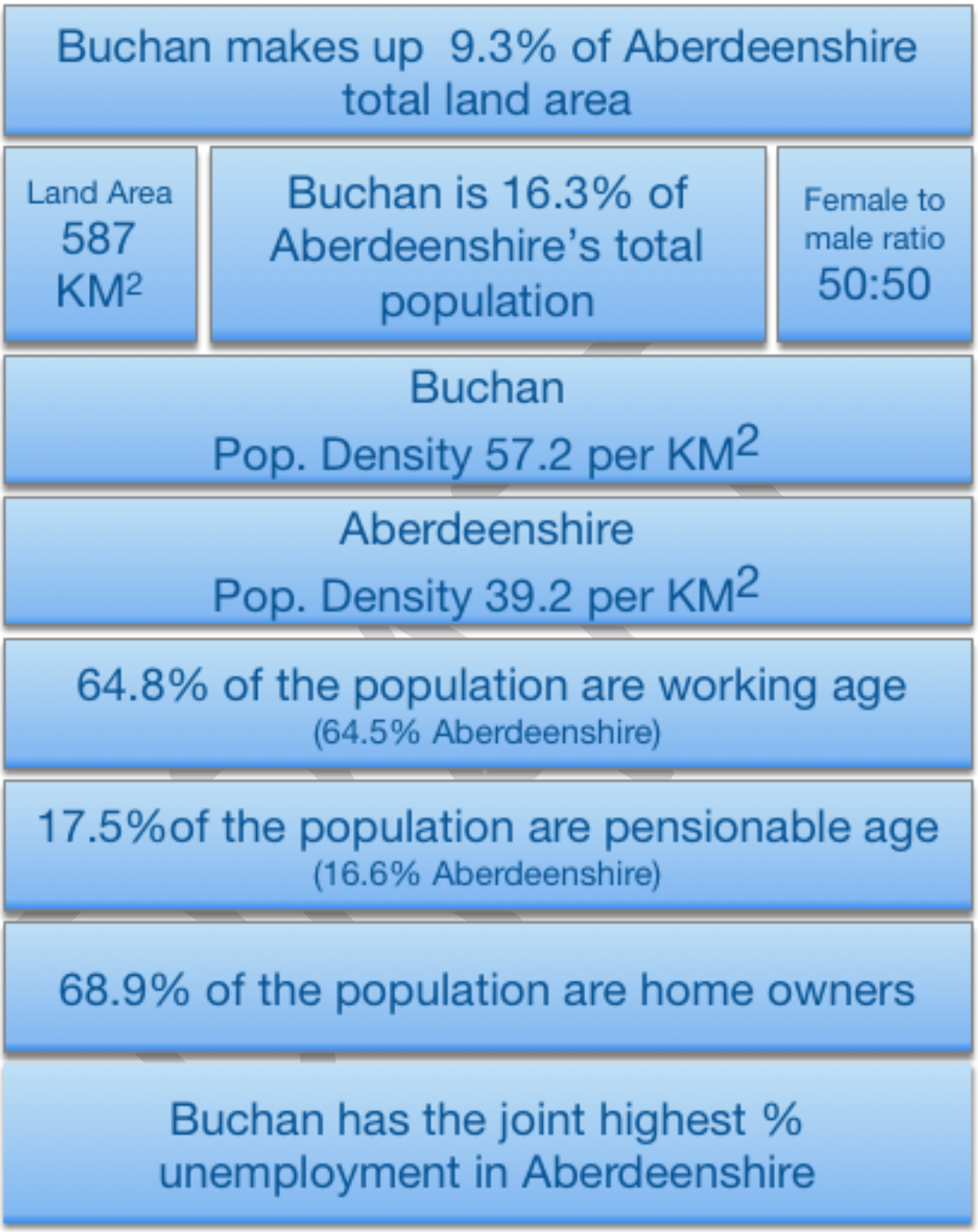
3.3 Area profile Information



3.4 Health and Wellbeing of the locality

Buchan Health Profile

Buchan has the second highest rates of emergency hospitalisation within Aberdeenshire.

Multiple emergency admissions to hospital for people 65+ is the second highest within Aberdeenshire.

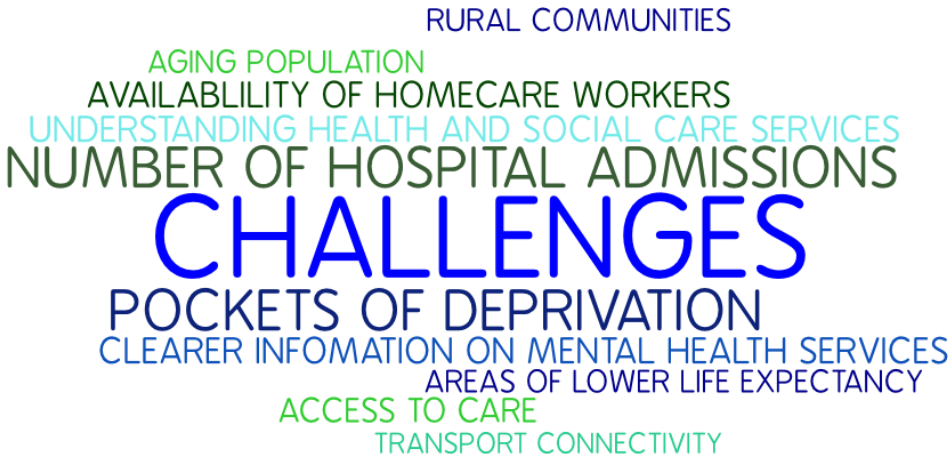
80% of people rated the care provided by there GPs as good or excellent, compared to 82% for Aberdeenshire as a whole.

85% of people receiving social care or social work services felt they were excellent or good, same as the Aberdeenshire average 85%.

81.6% of Buchan populations reported that their day-to-day activities were not limited by any health problems, this is below the Aberdeenshire figure of 84.5%

Buchan is below the Aberdeenshire average rate for patients registered with cancer, but is above the Aberdeenshire average for patients diagnosed with COPD (Chronic Obstructive Pulmonary Disease),

3.5 What are the main challenges?



3.6 What are Buchan's priorities?

By analysing existing local data, and engaging and consulting widely as explained in section 1.7 and 3.5, we have identified the following as key priorities for 2018 to 2019:

1. Reduce the number of unplanned hospital admissions particularly among older people, and increase the number of people planning ahead to meet their needs in old age.

2. Work with partners to improve the availability and quality of home care workers who provide care and support in rural areas.

3. Improve understanding that professionals with additional training can take on other tasks to reduce demand on GPs.

4. Develop signposting to services so they are more accessible, and the support they can provide is better understood.

3.7 Buchan's Action Plan

Priority	Action	Impact	How	Measure	Time Frame	Lead
1: Reduce the number of unplanned hospital admissions particularly among older people, and increase the number of people planning ahead to meet their needs in old age. Linked to the Aberdeenshire HSCP Strategic Priorities: 1, 2, 3, 4, 5, 6, 7, 8, 9 & 10	1. Review and improve the current rehabilitation and enablement pathway.	Promote independence in more people by increasing the number of people accessing the rehabilitation and enablement pathway.	Undertake a review of the pathway, and implement any recommendations which would improve the pathway.	Number of people accessing rehabilitation and enablement pathway.	2018 - 2021 (Review 2019)	Location Managers.
	2. Promote Anticipatory Care Plans which mitigate negative outcomes and maximise positive outcomes for people.	Higher number of people completing useful ACP's and planning ahead to better manage their own health and wellbeing.	Roll out the ACP strategy and the new 'Let's think ahead' tool across Buchan, beginning with a pilot in Fraserburgh (Feb 2018).	Number of useful ACPs completed, and shared between partners.		NHS Programme Manager and Location Managers.
	3. Strengthen an individuals and the communities understanding of how they can self-manage their own health and wellbeing.	Improved understanding (from an early age) of the benefits and importance of looking after your own health will empower people to take responsibility.	Work closely with Public Health to promote: • awareness of self-management, • local groups and networks, and • health initiatives, all which could provide support, including involvement in Participatory Budgeting projects. Additionally, promote this culture with staff across all partners to encourage everybody to play an active role in promoting self-management, and ensure staff undertake Making Every Opportunity Count awareness training as required.	Number of people signing up to health initiatives, and attending awareness raising sessions for the public and staff.		Location Manager, Public Health Team & CHiP (Community Health in Partnership) Officer.

Priority	Action	Impact	How	Measure	Time Frame	Lead
	4. Promote the benefits of the Virtual Wards across all GP practices in Buchan.	Increased awareness among GP's of the benefits of operating a Virtual Ward, especially in reducing unnecessary hospital admissions allowing people to be cared for in their own home or community.	Present evidence and information on the benefits of VW's to GP practices which do not currently operate one.	Number of VW's in Buchan, and number of patients treated in the VW which otherwise would have been admitted to hospital.		Location Managers.
	5. Promote and review where necessary respite provision.	Increased number of people aware of respite and how to access it, allowing the 'cared for' and any informal carers (if applicable) the chance of a break, which can help people feel able to cope in their own homes for longer.	Investigate current access to provision, and recommend a review if required. Additionally, promote current respite provision where it is working well.	Percentage of current provision used, and impact of any review carried out on respite provision. **Overall number of unplanned hospital admissions.**		Location Managers.
2: Work with partners to improve the availability and quality of home care workers who provide care and support in rural areas.	1. Explore new ways of working with commissioning to increase the number of care providers in central Buchan.	Increased number of care providers in central Buchan, providing an equitable service across north Aberdeenshire.	Work closely with the Social Care Contract Manager (SCCM) to investigate the options available, and implement changes where possible, in line with the Reshaping Care at Home work.	Number of home care workers providing care in central Buchan.	2018 - 2021 (Review 2019)	Location Managers and SCCM.

Priority	Action	Impact	How	Measure	Time Frame	Lead
Linked to the Aberdeenshire HSCP Strategic Priorities: 2, 3, 4, 5, 9 & 10	2. Improve the consistency of the care given from all home care providers.	Home care workers consistently providing quality care to people in their own homes.	Shared training for home care workers across all partners that includes information relating to: • Rehabilitation & enablement; • Procedure for reporting issues; and • Management of care network (i.e who to contact, when, where and how to record it).	Number of home care workers: • Undertaking training; • Referring people to the Rehabilitation & Enablement pathway, and other services/support; and, • Reporting issues.		Location Managers
3: Improve understanding that professionals with additional training can take on other tasks to reduce demand on GPs. Linked to the Aberdeenshire HSCP Strategic Priorities: 1, 2, 3, 4, 5, 6, 9 & 10	4. Work with Public Health, communities, and the Third Sector Interface (TSI) to improve knowledge and understanding of what health and social care resources are available in their area, and when it is appropriate to use each resource.	Increased knowledge and understanding in the community, will result in a reduction in inappropriate use of the local services and resources.	Promote the National NHS Initiative 'Know who to turn to'. Also, by conducting a survey to establish the community's current awareness and understanding of local services and community resources, and where results show lack of knowledge provide clear information. Additionally ensure staff undertake Making Every Opportunity Count awareness training as required.	Reduction in the number of inappropriate referrals.	2018 - 2021 (Review 2019)	Location Managers & Public Health Team

Priority	Action	Impact	How	Measure	Time Frame	Lead
	5. Encourage staff to look at how they can work differently, and actively contribute to service development. Also consider sharing staff where possible across historic NHS and Social Care boundaries, to strengthen further integrated working and maximise the workforce's potential.	Building on existing strengths within integrated teams, a more cohesive approach will be taken in order to deliver the best outcomes for people. This will be driven by the input from those involved in delivering health and social care, allowing them to be an integral part of service development.	Support teams across the locality to have a shared vision and understanding of each other's roles and build on existing skills.	Change in staff responses on iMatter (staff experience survey).		Location Managers & Team Leaders
	6. Provide clarity on the roles and responsibility of staff, and ensure all staff feel empowered to perform to the peak of their ability.	Staff will be appropriately qualified to provide the high-quality person centred care, and feel empowered to delivery better outcomes and experiences for individuals and communities. Additionally, resources are used effectively and efficiently to deliver services which centre on helping to maintain or improve the quality of life of the people using the services.	Work across the Buchan area to assess and develop teams using an approved 'Improvement Performance' tool in line with the partnerships workforce plan. Where appropriate include third sector, community and/or voluntary partners.	Number of staff undertaking the 'Improvement Performance' training.		Location Managers, Team Leaders & AVA

Priority	Action	Impact	How	Measure	Time Frame	Lead
4: Develop signposting to services so they are more accessible, and the support they can provide is better understood. Linked to the Aberdeenshire HSCP Strategic Priorities: 1, 2, 3, 4, 5, 8, 9 & 10.	1. Work with *AVA and the CHiP officers to engage with 3rd sector organisations in order to promote and define the services available in Buchan. (*AVA – Aberdeenshire Voluntary Action – provide the Third Sector Interface in Aberdeenshire)	Partnership working will ensure consistent information is widely shared, and people will receive relevant up to date information on services and how to access them.	Partners will continue to work closely, strengthening existing links and establishing new connections where required. Additionally, the results of the survey (see priority 3, action 1), to capture awareness and understanding of local services and community resources will be used to identify any gaps in information on services.	Number of people been referred to correct service.	2018 - 2021 (Review 2019)	Location Managers & CHiP Officers
	2. Ensure staff are aware of all the resources available (including voluntary and community), and have up to date information on hand in order to signpost people to the most appropriate service/support.	Staff will have the knowledge and feel confident to provide consistent information to ensure people quickly access the most appropriate service/support to meet their needs.	We will use existing events attended by the third sector to enable information sharing, between all partners, and investigate the most useful means to distribute and keep this information up to date.	Number of people attending events, and accessing information.		Location Managers & CHiP Officers

Priority	Action	Impact	How	Measure	Time Frame	Lead
	3. Review the merits of hosting a dedicated Liaison Officer Post as a first point of contact in other areas across Buchan.	A clear understanding as to whether a dedicated Liaison Officer has a positive impact on people accessing the correct services/support at the right time.	Evaluate the pros and cons of the post, and explore if this model would provide a benefit in other areas across Buchan.	Results of the review, and also of monitoring of any roll out of the model to other areas in Buchan.		Location Managers & CHiP Officers
	4. Strengthen the understanding of how Mental Health services are delivered, what support they can provide, and how to access it.	Individuals will have a clear understanding of the type of support available, and know how to access services locally when they need them.	Work closely with public health and the third sector to communicate clearly how the service is provided. Ensure staff who deliver health and social care and the people who provide community services understand the referral system for people seeking support. Additionally continue to engage with service users and the people in their support network, to gain feedback for future service design and delivery.	Number of people accessing the service. Number of people able to stay in their own home and community due to support received.		Mental Health and Learning Disability Manager.

4 PEOPLE AND FINANCES

4.1 Health and Social Care Teams

Health and Social Care Teams were developed in 20 locations across Aberdeenshire and the principles for each of the teams are:

- To be multi-disciplined.
- Meeting the needs of the “people” will be at the core of everything they do.
- Professionals acknowledge the skills and expertise of other professionals within the team.

The Health and Social Care Teams, will work closely with services, organisations and the community to make best use of available resources, and manage the ongoing work to deliver the strategic priorities within North Aberdeenshire.

4.2 Workforce Development

Aberdeenshire Health & Social Care Partnership continue to hold discussions with key partners and stakeholders across health and social care developing our workforce plans across our integrated teams. Evidence shows that staff who are valued, treated well and supported to give their best will deliver better outcomes for people.

We commit to value our workforce and develop the changes that need to be made to ensure a high quality of service is provided, ensuring a healthy organisational culture from a capable workforce who are then able to deliver integrated services supported through effective leadership and management.

4.3 Finance

The revised budget for Aberdeenshire Health and Social Care Partnership at the 31st October 2017 is £277,402,000. All the financial figures have not yet been broken down to a local level.

The proportion of the budget which is split at this point to a local level, shows 6.6% of the budget is allocated to Banff & Buchan, and 5.7% to Buchan, on top of 8.5% across all of North Aberdeenshire. The remainder of the budget is still calculated on an Aberdeenshire wide basis, and it is expected will be split out across the 6 areas as progress is made into the coming years.

It is the responsibility of the Partnership Manager to review our budget and ensure it is fit to meet the pressures which are faced. The resources must be managed to the best effect to ensure positive outcomes across the areas. With continuous rising demand and restricted resources efficient use of the budget must be made to meet challenging demand and current priorities. Current pressures are particularly high in areas of home care, care packages, prescribing and community hospitals.

5 HOW WILL WE KNOW WE ARE GETTING THERE?

5.1 Measuring performance

To ensure that we review the progress of this locality plan, we will develop a performance framework which will ensure there are defined links between the nine national health and wellbeing outcomes, the Aberdeenshire strategic priorities and the local priorities as set out in this plan. Measurement will also reference service related targets which Partnership currently feedback to the Integration Joint Board.

The Integration Joint Board will be responsible for checking the performance information, and the location manager along with the lead for each action will review the actions to ensure delivery of the locality plan. This information will allow the Integration Joint Board to see what effect the approach to integrating services is having for the people who use the services and support. A performance report will be developed each year as required by law.

Using the performance evidence we can measure the things that matter to the people using our services and ensure they are being achieved. This information will not only be used to evidence that we are achieving our targets, but also to identify what areas we need to improve.

Being clear about our progress and achievement is something that everyone needs to be aware of. The health and social care teams should have the information they need; to know how they are doing, when to seek help, and when to share best practice and successful approaches. Developing strong relationships and team-working based on a shared vision and values will support this and that is what this locality plan is all about.

6 OUR NEXT STEPS

Communication is an important part of our strategy and for this locality plan it is important to have a significant ongoing relationship between all partners and those who live in North Aberdeenshire.

We will develop a range of engagement mechanisms and tools, including; local events, publication of information via, social media, local press and existing groups/networks, and one-to-one opportunities for individual feedback.

Through the professionals working in health and social care, third sector organisations, and community planning groups we will ensure strong communication and engagement connections exist and are developed further. Our communication aim is to develop consistent staff and public messaging across all the agencies involved. It intends to provide reassurance and information to all and encourage input that will help to shape service delivery.

We will work with all community stakeholders within health and social care integration. This includes any person, organisation, company or group that shares a common interest in improving health and wellbeing outcomes in a particular locality. This will include people such as:

- Users of health and/or social care services.
- Unpaid carers.
- Communities of interest such as people with protected characteristics.
- Health and social care staff
- Third sector, including community bodies and groups, service providers, social enterprises and volunteers.

We will report our progress to professionals via existing communication pathways within, and between organisations. To ensure the community remain well informed we will provide effective timely updates via Community Planning Groups, Area Committee, the Third Sector Interface, Health and Social Care Forums, local press, and partners, networks and groups we work with in North Aberdeenshire.

We will carry out a comprehensive review after 18 months in October 2019 to ensure appropriate progress has been carried out on the actions, and ensure the direction of work on each priority still meets the local need.

We will strive to create open, two way communication across the community which is easy to access, and allows on-going feedback. This will ensure people are given the best opportunity to play an active role in service design and improvement, creating a culture where people are engaged leading to real change.

NB. Data Information 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.

Aberdeenshire
Health & Social Care
Partnership

If you require this document in another format, or if you require further information or would like to make comment on any aspect of this plan please contact:

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Aberdeenshire COUNCIL

NHS Grampian