Aberdeen City Health & Social Care Partnership

A caring partnership

ABERDEEN CITY COUNCIL

NHS Grampian

Annual Report 2019 -2020

Contents

Introduction

This annual performance report reflects the progress Aberdeen City Health and Social Care Partnership has made in the first year of our latest Strategic Plan i.e. 2019/20. Progress is measured using both local and national data as well as case studies and customer feedback.

Normally we would compare our performance on the National and MSG Indicators against the previous financial years and the Scottish national average. This year, however, due to data analysts being diverted onto Covid-19 work, the national data is not yet complete enough to allow this form of reporting or comparisons. We intend to publish an appendix to this report at a later date when the national average is available.

We continue to follow the principles of good governance which includes examining our governance structures to ensure they meet these requirements. Our governance structures provide a direct 'line of sight' for our IJB and our two partner organisations, Aberdeen City Council and NHS Grampian, delivering the assurances they need that Aberdeen City Health and Social Care Partnership is delivering on its commitments as they expect.

The delivery of transformation, service re-design and new ways of working does not come without risk. It is our task to manage those risks and our Strategic Risk Register identifies the risks to the achievement of our strategic aims and the accompanying controls and mitigating actions which helps us manage these risks whilst simultaneously maximising the opportunities they present.

We recognise, as a partnership, that our goals cannot be achieved without the involvement of the people using our services, as well as the unpaid carers who support many vulnerable people across the city. In September 2019, we reported the findings of our Local Survey, which asked people about their experiences of our services and to describe their own health and wellbeing. These findings are used to support our performance against nine of the national indicators. The national Health and Care Experience Survey is normally used to support benchmarking of these indicators but due to the Covid-19 pandemic, the results of this is not available for this report.

With Aberdeen City Health and Social Care Partnership in pandemic response mode since March 2020, this year's annual performance report (covering April 2019-March 2020) is subject to the impact of COVID19 and therefore is more concise than in previous years. Due to the pandemic, some members of staff who contribute to and are responsible for information illustrating our partnership's effectiveness, have been redeployed into different roles to support our response and meet the needs of our communities. Our next annual performance report, April 2020-March 2021, will outline the effect of the Covid-19 pandemic across our services and communities, and will highlight ways in which integrated partnership working has moved ahead at pace and scale, whilst keeping people safe and ensuring person-centred care.

Your Feedback

- In September 2019 ACHSCP undertook a local survey as a benchmark to provide data to measure the impact of the strategic plan.
- A total of 452 interviews were completed which equates to a response rate of 21%. Most respondents were retired and living in a care home or sheltered housing.
- To the right we have extracted some key indicators – some things to be proud of, and others where we need to improve.
- As well as the ratings, we got 53 pages worth of free text comments which we will use to celebrate success and improve service provision.
- We plan to repeat the survey in 2022 and directly compare results to demonstrate performance against our Strategic Plan.

91%

satisfaction with home care

86%

satisfaction with health and social care overall

90%

agree that support helps them live as independently as possible

We spoke to a number of our service users about their experiences of health and social care support. You can see their stories by scanning this code:

68%

say it is hard for them to get motivated to look after their own health

53%

don't take part in any community activities

6%

of care recipients also care for another - usually for more than 50 hours a week

Your Feedback

Positive

- This is a happy place.
- Staff are very caring.
- My doctor is very good and comes out to me.
- All the people who come in are excellent
- I go to care group twice a week.
- I have access to clubs etc. with transport available from the sheltered housing.
- There's bingo and afternoon teas and exercises etc. every week.

Negative

- It would be better if we had the same staff – there seem to be lots of changes
- There are not enough staff to cope so there are delays.
- I feel rather down sometimes.
- I would like to get out more.
- We need more activities
- Travel is a problem

Strategic Plan
How do we know we are progressing?

This year we developed a Performance Dashboard to demonstrate performance against our Strategic Aims. Whilst there has been significant development, work is still ongoing to make this fit for purpose. It is now updated monthly with live local data. Built on Tableau software, it is user friendly and very visual. Indicators continue to be developed and refined as priorities change. For 2020/21 we are considering measures that will demonstrate how we are delivering against the new ways of working introduced as a result of the COVID19 Pandemic.

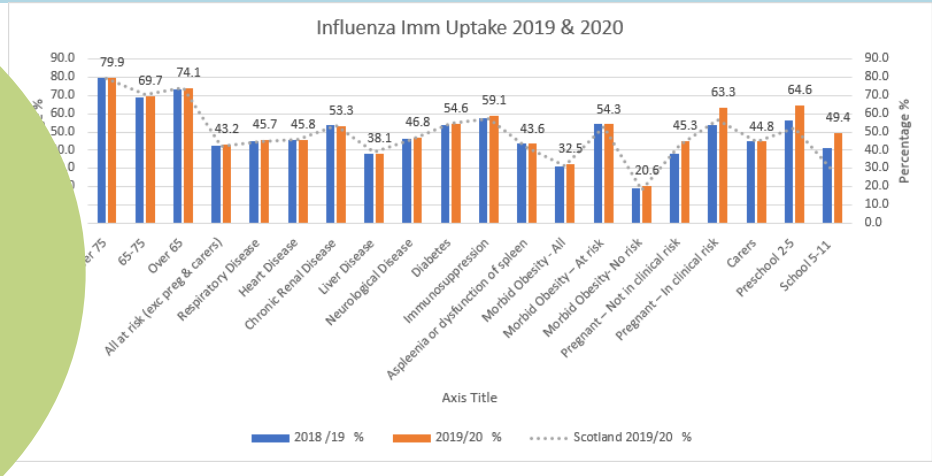
Prevention

Working with our partners to achieve positive health out-comes for people and address the preventable causes of ill-health in our population

The **Breastfeeding Friendly Scotland Scheme**, which aims to normalise breastfeeding and encourage mothers to breastfeed while out and about, is being implemented across Aberdeen city. There is an initial focus to sign up all businesses in Tillydrone and this is being supported by a peer support scheme with a number of peer supporters in Tillydrone already signed up.

Training and Awareness Raising has led to reduced incidents of malnutrition within Care Homes.

Influenza Immunisation uptake rates remain steadily comparable with the Scotland's Average, encouragingly there has been significant increase in uptake in pregnant and in clinical risk patients and childhood ranges in 19/20.



The **Fussy Eating Pack,** a resource to support health visitors and families and development of a fussy eating pathway was launched, with training for Health Visitors carried out in February 2020.

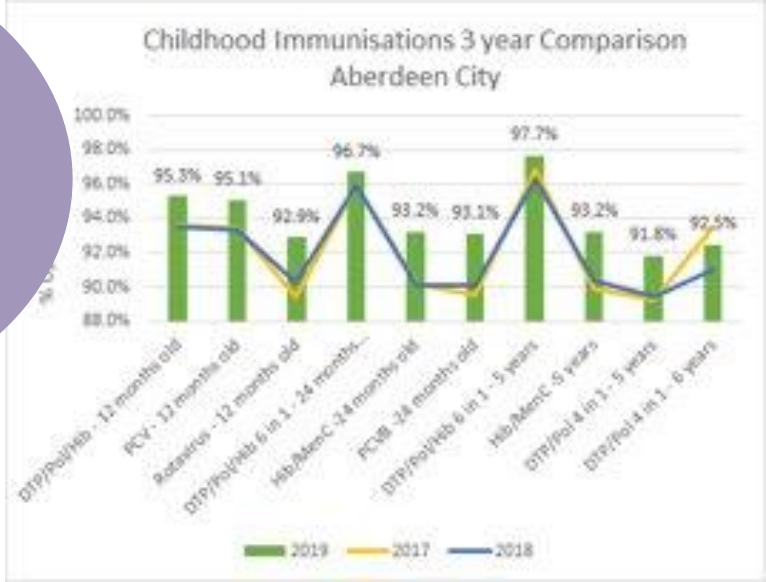
Adult Weight Management

Further development of the Adult Weight Management website, which includes self-management tools and resources as well as signposting to nationally approved information.

Hospital at Home

cover all City GP practices and now have a total of 15 virtual beds.

Childhood Immunisation uptake rate per cohort increased across all immunisations for 2019 as against previous year.



Prevention

Working with our partners to achieve positive health out-comes for people and address the preventable causes of ill-health in our population

Fast Track Cities
At a civic reception in February the Lord Provost signed a charter for Aberdeen City to become a Fast Track City joining a global partnership pledged to achieving progress on HIV prevention, diagnosis and treatment. A high-level action plan has been developed with partners and in conjunction with Our Positive Voice, a peer support group for people living with HIV, work to consult and implement the action plan is now underway.

Grampian Sexual Health is a pan Grampian, ACHSCP hosted service providing holistic and comprehensive sexual health care. The service provided 36,476 patient contacts in 2019/20, with 20,655 seen face to face (f2f) and 15,821 telephone/video contacts including telephone triage, representing 43% of activity. Overall activity increased 12% in 2019.

The Seaton Project
This is a set of individual projects which have been supported by the Public Health and Wellbeing Team with the aim of increasing health and wellbeing opportunities for the older residents of an area on the Scottish Index of Multiple Deprivation with significant health inequalities and life expectancy 5 years below the City average. Projects include a singing group, a Lunch Club and a Seated Exercise Group run in conjunction with Aberdeen Sports Village.

Ongoing work to support **Primary Care Alcohol Hubs** and reduce impact on acute hospital settings is taking place in two GP surgeries in Aberdeen. GPs refer directly to specialist services who offer to link in to practices and support people in their community, reducing time for GP and potential hospital admissions

Link workers have been trained to deliver **Alcohol Brief Interventions t**his provides city wide action to ensure discussions are taking place to help people understand safe drinking, the impact on mental health from consuming too much alcohol and offer of specialist support if needed.
A pathway to support direct referrals from ARI to specialist alcohol service has been established to allow people who have identified as requiring support, usually. for relatively acute alcohol dependence, The Integrated Alcohol service provides a smooth transition from hospital to support at home to reduce alcohol intake and prevent further admissions.

During 2019/20 the Community Mental Health Service undertook a series of consultation events with partners, staff, service providers, service users and carers to jointly look at developing our Community Mental Health Delivery Plan for Aberdeen City. This included collating a wide range of views on the existing community service provision and how we could enhance this further to meet the needs of our residents within their communities. Our **Strategic Vision** would echo the vision set out in the National Mental Health Strategy 2017-2027 "People can get the right help at the right time, expect recovery, and fully enjoy their rights, free from discrimination & Stigma".

As part of the Community Mental Health Delivery Plan, our aim around Prevention is to ensure People are supported to enjoy the best possible mental health & wellbeing. Our delivery plan actions to support this aim include:

- To explore the creation of Community Mental Health & Wellbeing Workers. This will link into the Primary Care improvement plan which focuses on releasing capacity for General Practitioners, as well promoting Action 15 objectives to divert services away from A&E and Custody.
- To improve & promote "Know who to turn to" information for Mental Health & Wellbeing, with a local leaflet which has been developed and distributed to all existing patients and promoted further within the ACHSCP Website. Further work will be developed in future to work with partners to showcase local supports.
- To promote the use of electronic tools to enhance wellbeing activities in Communities – This includes a project 'Enhancing Lives through Technology Project' first piloted by Occupational Therapists in the Older Adult Mental Health Service in Aberdeenshire which explores the benefits of combining the introduction of technology with specialised OT early intervention & prevention programmes and strategies. This work is now being developed further for the use in Aberdeen City.

Prevention

Working with our partners to achieve positive health out-comes for people and address the preventable causes of ill-health in our population

Prevention

Working with our partners to achieve positive health out-comes for people and address the preventable causes of ill-health in our population

Drug related death continues to a be a significant challenge for the City. Due to relaxation in laws for supplying Naloxone, we have supported some organisations who are not drug services to supply **Naloxone** and we will continue to expand this. The review and learning group has also increased partner representation to support a collaborative approach to addressing the number of deaths.

68% say that they can sometimes feel a bit down, which makes it harder for them to look after their own health and wellbeing

Substance Misuse
An assertive **Outreach Team** is being formed to support the most vulnerable and ensure they can have easy access the most appropriate support quickly. We anticipate this will reduce the number of deaths and burden on GP and hospital admissions as those most at risk will be identified through recent flags with partners, sought out and supported to access the relevant services.

"Know who to turn to" information on Mental Health & Wellbeing, via a local leaflet which has been developed and distributed to all existing patients and promoted further on the ACHSCP Website. Further work will be developed in future to work with partners to showcase local supports.

Community Mental Health & Wellbeing Workers
This will link into the Primary Care improvement plan which focuses on releasing capacity for General Practitioners, as well promoting Action 15 objectives to divert services away from ED and Custody.

Resilience

Working with our partners to support people so that they can cope with, and where possible, overcome the health and wellbeing challenges they may face.

The number of unpaid carers who report they feel supported has risen year on year from 37% in 2017/18, to 40% in 2018/19 to **58%** in 2019/20

38% say that their caring role has had a negative impact on their own health and wellbeing.

In 2019 the chair of the IJB signed a charter to pledge commitment for Aberdeen Health & Social Care Partnership to work with a number of other organisations in helping Aberdeen become a **Sustainable Food City** (now called Sustainable Food Places). Sustainable Food Places aims to help people and places share challenges, explore practical solutions and develop best practice on key food issues to drive positive food change. Granite City Good Food group have developed an action plan to support implementation of the charter goals.

82% of adults in Aberdeen City reported that they were able to look after their health well or quite well. This is an area of focus for future improvement

90% agreed that the health and social care services they received helped them to live as independently as possible

The **Disabled Adaptations Group** continues to meet to maximise the use of adapted properties across tenures in the City. The group is a partnership between ACC Housing, the Private Sector Grant team and a number of Registered Social Landlords operating in Aberdeen.

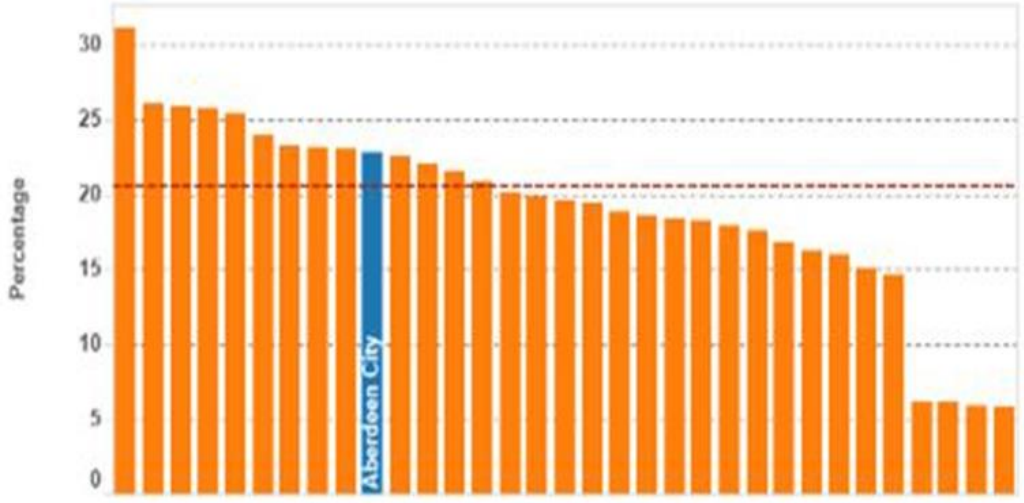
Resilience

Working with our partners to support people so that they can cope with, and where possible, overcome the health and wellbeing challenges they may face.

Falls rate per 1,000 population aged 65+.

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Aberdeen City	19	19	19	20	20	23	23
Scotland	21	21	21	21	22	23	20

Bar graph shows data for 2019/20:

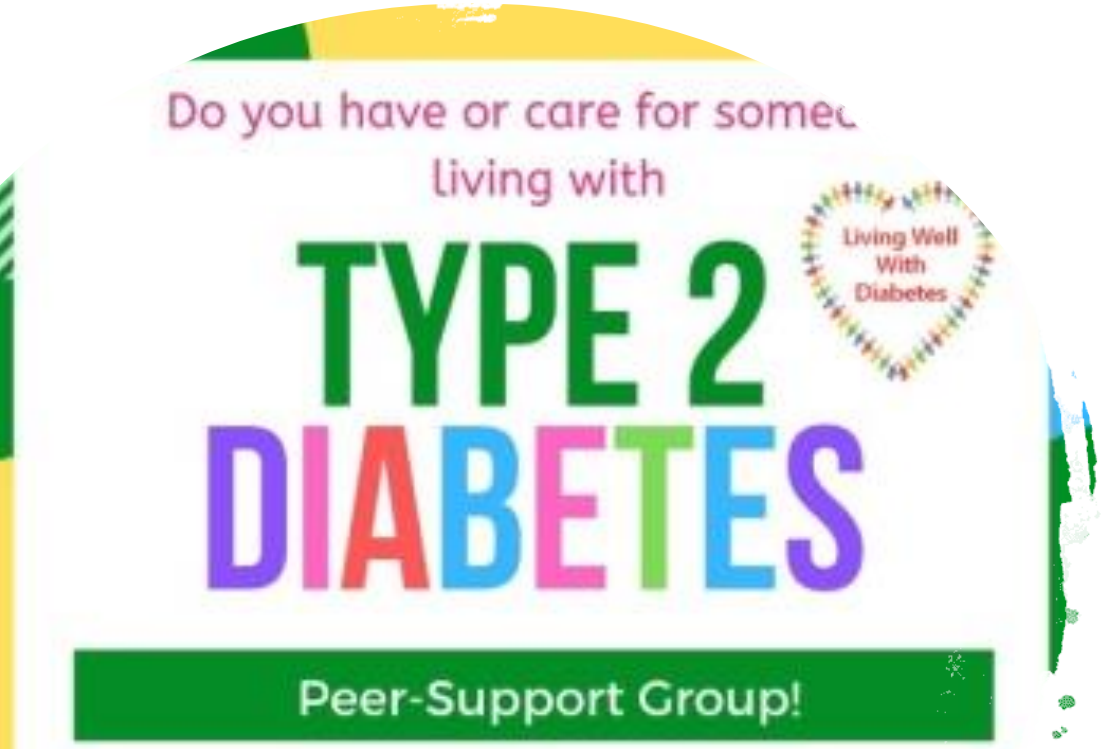


Additional Information for 2019/20:

Number of Falls	811
Population	35,532

Stepping Forward Together is a community-based group consisting of people living in the community with experience of/an interest in falls prevention, health and social care professionals and third sector partners. The group emerged from the co-production labs delivered to the partnership by Governance International and features as a case study on their website. http://www.govint.org/good-practice/case-studies/stepping-forward-together/ Our work continues to go from strength to strength. From February 2018 until March 2020 we had visited 16 groups in Aberdeen, speaking to over 260 individual people about falls prevention. SFT has 8 active, volunteer "falls Ambassadors" who go out to visit different groups and speak about their experience of having a fall, how they got the help they needed and what self management options are available in Aberdeen City. The project has been showcased in numerous different places (including our own AHSCP Conference last year) and we were due to speak about it at the "2020 International Forum on Quality and Safety in Healthcare" in April, which was sadly cancelled. SFT has remained active as a group throughout the COVID pandemic. The Falls Ambassador who volunteers with our Airyhall Library Group has kept in touch with group members on a weekly basis throughout Lockdown. SFT Ambassadors have continued sharing information on our Facebook page and have acted as a group of "critical friends" when we have needed some feedback from the people living in the community about ongoing work. They are currently helping us test the "LifeCurve App" which we hope will be a useful addition to a number of self management initiatives. We have kept in touch via virtual meetings and telephone conversations and look forward to a time when we can start

Resilience



Living Well with Diabetes

Tackling Scotland's health record and narrowing health inequalities are persistent challenges that require concerted, sustained, comprehensive approaches.

The Living well with Diabetes project applies the co-production principals which has led to development of peer supporters and 3 peer support groups. The Peer Supporters live and volunteer across different neighborhoods from Torry to Deeside, they manage diabetes ranging from 29 years to being newly diagnosed. They proactively offer IT skills and experiences for example being part of a research network as well as addressing health literacy supporting each other in this. They share all this with the Peer Support groups they facilitate with support from staff.

The Peer Support group meetings are held in an informal setting where new updates are exchanged and shared with support from staff and third sector partners. People are also empowered to confidently use a self-management online tool called My Diabetes, My Way; co-produce and pilot cooking sessions working with CFINE. The group have also influenced the review of the Diabetes MCN website and shared learnings at the Discover Digital event; The range of topics and concerns discussed allude to understanding of inequalities and self-management which individuals and staff work together to resolve or ensure support is addressed adequately.

Resilience

Working with our partners to support people so that they can cope with, and where possible, overcome the health and wellbeing challenges they may face.

Joint working between **ACC Housing** and ACHSCP led to the Supported Hospital Discharge project was launched in December 2019. The project introduced 13 rooms in 11 sheltered housing settings across the City and provides interim accommodation for people who are delayed in hospital awaiting a care package. Up to 31 March, 15 people have used the service. The total bed days saved by getting these people out of hospital to a more appropriate setting has been 445 days. Using the 'minimum bed day cost' of a hospital bed, which is £279 per day over £124,000 has already been saved

We have signed up to the **Housing and Dementia Framework** which highlights the partnership working between ACC Housing, ACHSCP and the third sector.

Exchange Street Clinic for men who have sex with men continued with record numbers of attendees in 2019, in collaboration with Alcohol and Drugs Action, increasing access to testing, treatment and prevention for HIV and STIs.

94% said that services help them to feel safe and secure

Our focus continues to be on a personalised approach to providing **post diagnostic support**. We have radically revised the way we deliver this, embedding it in practice across teams. We now have up to 400 staff across the partnership, as a whole, trained to a skilled level and able to deliver PDS at the point of need. All people who are newly diagnosed have access to a resource pack with information that has been co-produced with people living with dementia.

Healthier Seaton

In 2019, engagement with parents in Seaton was undertaken to understand what mattered to them in relation to health and wellbeing, 42 parents completed a survey or spoke with a community health worker. The main areas identified were healthy eating, cooking on a budget, mental health, finances and budgeting and having safe spaces to play outdoors. A project, 'Seaton Young Parents' then applied for Health Improvement Funding to deliver health promoting activities such as healthy cooking and First aid.


94% agree that they have their dignity respected
92% are satisfied with GP Services
89% agree that where they receive treatment and support suits their needs
90% agreed that the health and social care services they received helped them to improve or maintain their quality of life
97% agreed that community-based health and social care services are available to them

Personalisation

Stepped Care Approach to managing Unscheduled and Preventive Care in the City - we held a series of 3 key stakeholder workshops Jan-Mar 2020 to inform and support the Implementation of our Stepped Care Approach. We are now testing Locality based multi-disciplinary huddles which serve as a referral point, reducing hand-offs between services and ensuring a more responsive service to patients in a timely fashion

Diabetes- Adopting the "House of care" ethos to ensure the patient is in control of their appointments and able to direct the care planning

Trialled a **dietetic-led, remote, digital service for children and families with Cow's Milk Protein Allergy**. This evaluated positively, resulting in more patients being seen in a timely manner, by the right person, at a time and place which suited the patient. It also resulted in significant savings in the prescribing budget

2698 **Self Directed Support** assessments were completed in 2019/20

Connections

40-year-old male referred by GP, unemployed for a number of years as a result of severe anxiety and chronic suicidal ideation preventing him from being active in the community. He was quite heavily dependent on alcohol and felt unable to complete his benefits paperwork without support due to his anxiety. He was quite isolated, with very little social contact, and he identified himself that his physical health could be better particularly his oral health. Initial priority for him was support in completing ESA paperwork. Subsequently he was supported to register with a dentist, apply for an Access2Leisure membership, referred to the Foyer Impact Programme, Fair Start Scotland Project, Reach Out for additional activities, and ACIS for counselling. He has now started thinking about getting back into employment and is being proactive in finding courses to support his development in relation to this.

16% are lonely often or all of the time

Aberdeen Links Case Studies

Comments from Link Workers:
It is important to take the time to listen to people, get to know them, and hear what is really going on for them to be able to support them efficiently in a person-centred way.
There is much inequality in our communities and to even begin to address that we need to tackle the root causes - poor physical and mental health, poverty, poor education and employment opportunities etc.

49-year-old woman currently living in her family home with her husband and two grown up children. They had lived abroad for 10 years where she had built a stable life with various jobs, a crafting business and a good social group. Since returning to Aberdeen she has struggled to develop the same social network here and had been seeing the Psychological Therapist before starting with the link service. Her husband works away for up to six weeks at a time leaving her feeling lonely and isolated. The idea of getting back into work was daunting. A volunteering opportunity was arranged with Befriend A Child-and she was supported throughout the application and interview process. A personal development programme with Momentum was also arranged which will support with gaining employment, meeting new people and confidence building. She was supported to apply for a job online and given information on how to set up her own Etsy business.

Connections

74-year-old man referred by his GP as he has a diagnosis of Alzheimer's Dementia and his wife was struggling to support him alone. Referral made to 'Forget me not' – a group specific to those with dementia - and Bon Accord Care to receive support with home adaptions such as telecare and community alarms. He now attends day sessions three times a week which gives him activities tailored to his needs and which he enjoys. It also allows his wife to get time to herself to complete her own tasks. The sensors fitted to the home has given his wife peace of mind as she will be alerted if he leaves the property.

There are now 3 active diabetes peer support groups in Aberdeen City which are peer supported by the patients themselves. They have all had training on peer support and now help train other peers. The peer support groups are fully supported by the wider diabetes team and DM Consultants.

46-year-old woman referred by her GP unemployed for a number of years due to assuming a caring role for both her father, who is now deceased, and now her mother, who has recently been diagnosed with dementia. She feels that she has given up her own life to care for her parents and has therefore lost some of her own independence and identity. She has become quite isolated as a lot of her friendships were through work and other activities which she can no longer afford. She was referred to the Carers Service at VSA and was supported to apply for the Short Breaks fund which she used to purchase a gym membership and get a massage. She was also supported to contact care management who have now formally allocated a care manager to her mother whose care has now been increased to give her more of a break. Small tools have been introduced including a pictorial phone to make it easier for her to be contacted by her mother directly when she is not there. She is sleeping better and has one full day a week to herself.

73% of 60-69 age group took part in no activities

Community

Showcase Events

On the 12th June 2019 a showcase event was held at Hazlehead Park Cafe. The aim of the event was to celebrate the fantastic work going on across Aberdeen to improve health and wellbeing. Eleven projects that were supported by HIF attended to showcase how they have utilised the fund to develop gardening and outdoor projects. The event aimed to inspire people, to learn something new and establish new connections. Gardening and outdoor projects were chosen as evidenced health benefits such as being physically active; supporting mental wellbeing; providing a social opportunity as well as access to grow healthy produce.

Volunteering

Volunteering plays a significant part in creating a more sustainable approach to health and social care. Volunteers help build stronger relationships between services and communities supporting integrated care, improving public health and reducing health inequalities. The support volunteers provide can be of value especially to those who rely most heavily on services such as people with multiple long-term conditions. It provides benefits not just to service users and wider communities but also to volunteers themselves in terms of enhanced health and wellbeing. It is estimated that 70,500 people volunteer in Aberdeen

The **Health Improvement Fund** seeks to improve health and wellbeing in communities across Aberdeen. The Fund is awarded through community grants of up to £5000. In 2019/2020 77 projects were funded – here's a few examples

Grow Cook Connect

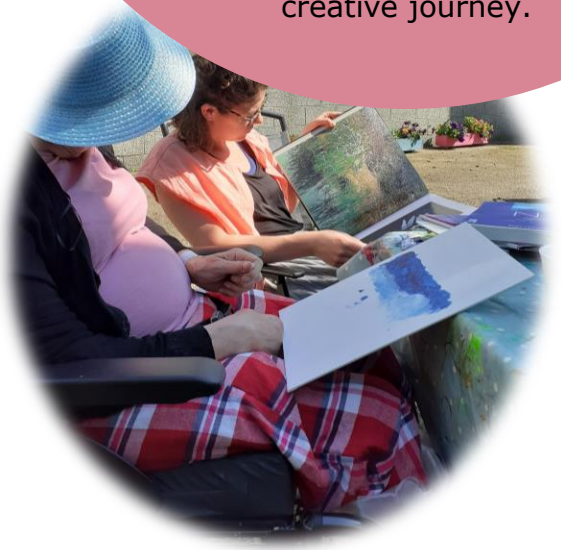
The Grow Cook Connect event was developed and delivered by the partnership work of 2 city food groups: Aberdeen Health and Social Care Partnership (AHSCP) Granite City Good Food Group and the executive group of the Aberdeen Community Food Network. The event aimed to inspire and celebrate food growing, cooking and community cafes across Aberdeen City. With 65 people in attendance the event resulted in an increased awareness of the vast array of food activities taking place alongside current challenges, these will now be considered by partners for future improvement

Local Empowerment Groups

Following the IJB's endorsement to move from 4 Locality Leadership Groups to 3 Locality Empowerment Groups (LEGs) in November 2019, a media campaign took place to recruit citizens, the response was very positive resulting in 75 people expressing an interest. Informal engagement sessions then took place across the City to start the process to co-design LEGs with an aim to improve population health and wellbeing. A report summarising feedback and next steps was shared with on-going engagement now reaching 135 people who have registered an interest.

Community

Artroom is an exciting arts project which works with patients who are undergoing intensive specialist stroke and neurological rehab. Taking part in art has been proven to improve the wellbeing of patients. This project aims to build independence and restore self confidence in a way that complements medical treatment. The group received HIF funding for art materials, including a starter pack for taking home after they leave the ward and for equipment. This was specialist equipment that could work around patients' limitations that would enhance their creative journey.



Greener Living @ the hub - after successfully running cooking classes with support from HIF, Middlefield Community Project decided to start growing their own fruit and vegetables to be used in the cooking classes. As well as the cooking classes the produce is used in the community café, for snacks in the nursery and to be given out to the local community. The funding was used to purchase a greenhouse, raised vegetable beds and grow tables. The group have 17 volunteers along with nursery children, children from the after school club and the youth club who all help out on a regular basis.

Stocket Grange Lunch Club - Staff at Stocket Grange sheltered housing complex applied for funding to enable them to expand their lunch club with a focus on healthy eating. The lunch club has grown from just 8 people attending to 25-30 people. Funding was used to purchase cooking equipment such as casserole dishes and serving spoons to ensure that more people could attend.

Lochside Academy received money from HIF to bring a board game to promote wellbeing to life. The game was created and designed by an S2 pupil at Lochside Academy to update an older, less interactive game. His idea was to create a game which requires those playing to travel from Marischal College to Lochside Academy via landmarks like Union Square and Aberdeen Beach. Throughout the game, players are able to pick up "choice cards" with positive wellbeing messages enabling them to move forward a number of squares. The choice cards can be made to suit any topic or theme that the young people would like to discuss, meaning the game is suitable for use across the Lochside Academy ASG, from primary to secondary school. The pupil had the idea for it to be printed on large, durable poster material so that those playing the game can complete the journey from Marischal College to Lochside Academy interactively.

Progress against our Enablers

Empowered Staff

In the past year, there have been two main areas of focus in implementing the workforce plan.

The first of these has been to continue to work towards reducing sickness absence in targeted areas and to reminding Managers of the various absence management protocols, and procedures that are in place in NHSG and ACC to support staff attendance.
We have also continued to create and promote a wide range of healthy working lives activities across the city, with a focus on stress and anxiety reduction. Towards the end of the year we submitted our portfolio for the gold healthy working lives award and the results of this external accreditation are awaited.

The second area of significant progress , has been in raising the profile, of health and social care as career of choice.

The partnership attended many careers events in Aberdeen and Aberdeenshire schools to proactively promote careers . This has been extended to close working with job centre plus to meet 'job ready' clients and hosting apprentices within the partnership.

CONNECT Conference took place 9th October 2019 at Pittodrie, which saw more staff and partners engaged with the event.

Principled Commissioning

In the past 12 months we have developed a shared strategic commissioning approach with ACC, with a framework based upon the seven principles and adopted these principles as we review current contracts. In particular, we have a focus on co production and co design with providers and service users. We have outcomes - macro (organisational / population) and micro (individual) - within our sights and a good example of this will be the care at home contract.

Our ambition for the future is to create strong links between the Strategic Plan and commissioning activity. We also aim to develop a Market Position Statement to try and strengthen engagement with the local market and in so doing improve market knowledge and market sustainability.

Digital Transformation

MORSE – Health Visitor Digitisation launched (Eve) A new mobile way of working for 100 Health Visitors has been rolled out in Aberdeen City. MORSE is a mobile caseload management tool and community digital record for children ages 0-5. Health Visitors have been issued with iPads to enable them to assess and support children in the community setting alongside their parents, accessing and recording records digitally.

The Partnerships digital journey with Microsoft O365 continued further with the roll out of Microsoft Teams. In collaboration with Aberdeen City Council, the teams roll out included the creation of new Team sites for Partnership services as well as adhoc Team sites to improve communication in projects. To assist in the roll out, staff volunteers were extensively trained as Digital Champions through Microsoft and Aberdeen City Council.

Scotlands Service Directory was embedded within the Aberdeen City Health and Social Care Partnerships website at the start of February 2020 and has received over 700 page views to date. The directory provides details of all NHS Health services alongside Health and Wellbeing services across Scotland.

Progress against our Enablers

Sustainable Finance

Total Budget	NHS	Council	Specific	Total
2019-20	236.4	90.9	4.7	332.0

The breakdown of spend across all of our activities in 2019-20 is shown below.

	2019-20	2018-19	2017-18
Older People, Physical	78.5	74.3	72.9
Set Aside Services	46.4	46.4	41.3
Primary Care Prescribing	40.8	40.3	41.4
Primary Care	41.1	38.9	37.2
Learning Disabilities	35.1	34.6	31.3
Community Health Services	34.8	31.6	31.4
ACHSCP share of Hosted Services	24.2	22.3	21.7
Mental Health and Substance Misuse	20.2	20	20
Transformation	3.9	5.6	5
Criminal Justice	4.7	5.1	4.7
Housing	1.5	1.9	1.9
Out of Area Placements	2.0	1.7	1.5
Head Office/Admin	1.8	0.2	-0.5
Cost of Services	335.0	322.9	309.8

The accounts for the year ended 31 March 2020 show a usable reserves position of £2,601,896. The reserves are being used for our transformation programme as agreed through our Medium Term Financial Framework.

	2019-20	2018-19	2017-18
Total Reserves	2.6m	5.6m	8.3m

The IJB has a notional budget representing the use of acute health services by the city's residents. It is envisaged that effective integrated service provision in our communities and localities will, over time, reduce the use of these acute health services. NHS Grampian has advised that for the past year, the partnership's use of these services had decreased as indicated below and that there had also been a budget increase due to movements in the price per bed days for the services.

Table 6.7

Set Aside	2019-20	2018-19	2017-18
Budget	46.4m	46.4m	41.3m
Days used	137,732	143,055	142,349

A proposed budget for 2020/2021 which outlined budget pressures, budget reductions and an indicative budget position for the next five financial years was presented to a special meeting of the IJB on 10 March 2020 by the Chief Finance Officer

Modern and Adaptable Infrastructure

Over 2019-20, ACHSCP continues to work collaboratively with our partners (ACC and NHSG) to identify the buildings; equipment; technologies and transport links which are essential to delivering successful, integrated, community-based health and social care services. Our work in this area is underpinned by the NHS Grampian Asset Management Plan; the General Medical Services Premises Plan, and the ACC Asset Management plan.

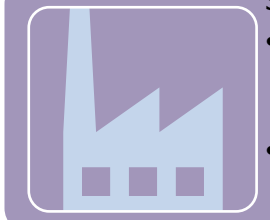
Importantly, we are working through updating our premises plan to reflect the requirements of the new GMS contract and the implementation of the Primary Care Improvement Plan. Whilst an intention of the Strategic Plan had been to create a stand-alone infrastructure plan, on reflection infrastructure requirements would be more thoroughly considered if included in each of the service delivery plans.

North

- The refreshed Initial Agreement for the north corridor was sent to SG CIG on 11th October 2019, which included a refresh of the Strategic, Economic, Financial, Commercial and Management Cases. Feedback is still awaited.
- Continued involvement in Elective Care Programme opportunities with colleagues, including Community Treatment and Care Services (CTAC's), which also includes city and shire boundaries work

Central

- Outline Business Case for Denburn was agreed by the NHSG Board under delegated powers in April 2019.
- Full Business Case is being developed .
- Design of new Greeferns facility at an advanced stage which is a blue print for future fully adaptable buildings.



South

- Approval received from IJB in March to progress with an innovative model of health and social care to provide interim services to the new community of Countesswells, in conjunction with independent pharmacy.
- Developing a strategic outline case for a community campus in conjunction with partners from Aberdeen City Council

Governance

Unannounced Care Inspection
ACHSCP Learning Disability Housing Support Service
July 2019

From the inspection the service was graded as;

Quality of care and support	**4 Good**
Quality of Staffing	not assessed
Quality of Management and Leadership	**4 Good**

People could be confident that their care plan would describe how their needs would be met and that it would reflect their wishes and choices. The sample of plans we looked at during the inspection contained lots of information about peoples health needs and how they were to be supported. At the time of the inspection the group manager was reviewing these to ensure they were more outcome focussed.

There was lots of very good evidence of staff working closely with multi disciplinary professionals to ensure peoples health and wellbeing needs were being met.

Recommendations

1. The provider should review the format of the support plans and review documents ensuring that these clearly demonstrate the input of service users, families and are outcome focussed.
2. The provider should review the training available to staff to ensure that staff have the skills to meet the individual needs of service users.
3. The provider should develop and put in place an improvement plan for the service, identifying key areas to be improved, this should involve service users, families, staff and key stakeholders.

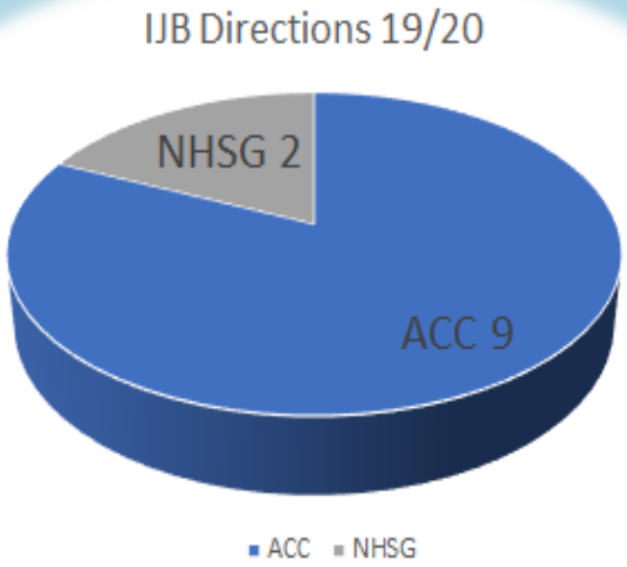
During the inspection they met with seven people who were using the service directly, met others when they were visiting places where people stayed and spoke with six relatives by telephone. Comments included:

"I am very happy, they are very good to X, they genuinely seem to care, they were very good at supporting X through his grief when his Mum died, more like family than staff, I feel content that X is there.“

"I am involved with recruiting staff, interviewing staff and I have given ideas such as scenarios for discussion as well as choosing questions to be asked. The support is ok, I am more independent now, they don't force me they help me along with it, I am quite happy with the way things are, the staff are respectful and treat me well, I have a say and I'm involved in my six monthly reviews."

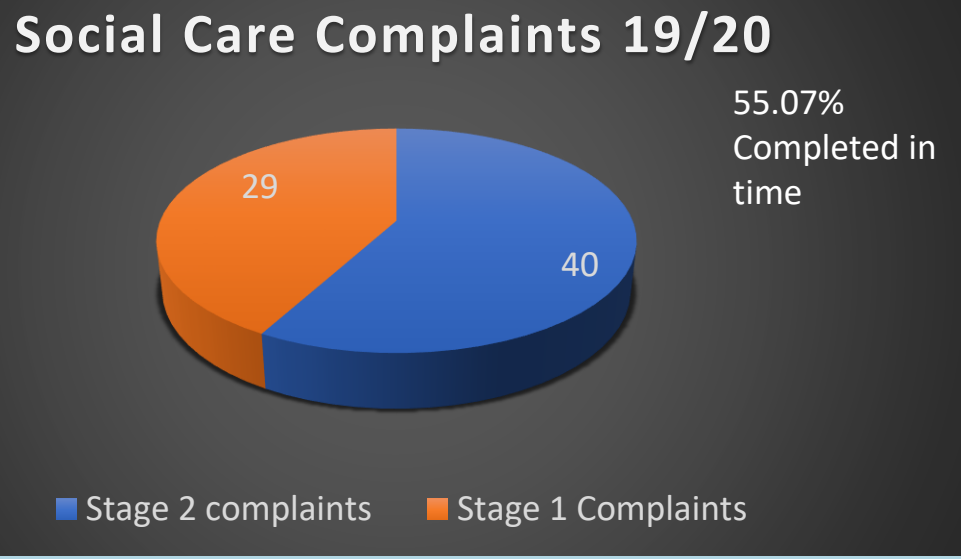
"I am very pleased, the staff are very compassionate, I am kept up-to-date, regular reviews, they do very well with the resources they have."

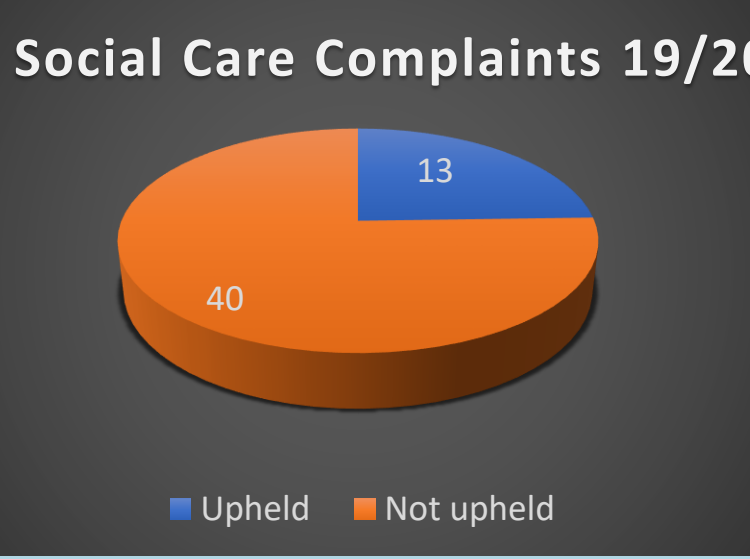
Governance



Our **Strategic Risk Register** is reviewed regularly. In August 2019 the Audit and Performance Systems Committee undertook one of its regular deep dives on four of the Strategic Risks - those in relation to performance standards, reputational damage, preparedness for Brexit and the relationship with partner organisations. In .January 2020 the IJB approved a revised Risk Appetite Statement and a Revised Risk Register. Towards the end of the year a specific risk in relation to Covid-19 was developed

In March 2019 the Ministerial Strategic Group (**MSG**) for Health and Social Care requested that every Health Board, Local Authority and IJB undertake a **Self-Evaluation** of their performance against a range of recommendations. This was submitted to MSG on 15th May 2019 and the submission was endorsed by the IJB at their meeting on 11th June 2019. Our performance was rated as 45% at Exemplary level, 41% at Established level and 14% at Part Established level. The IJB requested that the Chief Officer provide an update on progress on delivery of the actions in March 2020 and this indicated that of the 31 actions, 25 (80%) had been completed within the timescale. Of the 6 outstanding actions, two are related to our revised Scheme of Governance which is not due to be presented to IJB until December 2020. One is related to public consultation on our Annual Performance Report and the final three are related to the creation of Carer and Service User Focus Groups all of which were postponed due to Covid-19.


Social Care Complaints 19/20
55.07% Completed in time
29
40
Stage 2 complaints
Stage 1 Complaints


Social Care Complaints 19/20
13
40
Upheld
Not upheld

Governance


Health Complaints Escalated from Stage 1 to Stage 2
Percentage of complaints not upheld at this stage 32%
Percentage of complaints upheld at this stage 42%
Percentage of complaints partially upheld at this stage 26%


Health Complaints Managed at Stage 1 - Early Resolution
Percentage of complaints not upheld at this stage 14%
Percentage of complaints upheld at this stage 61%
Percentage of complaints partially upheld at this stage 25%


Health Complaints Managed at Stage 2 - To be Resolved within 20 Working Days
Percentage of complaints upheld at this stage 20%
Percentage of complaints not upheld at this stage 59%
Percentage of complaints partially upheld at this stage 21%

Priorities for Next Year

- Review of Covid19 response and lessons learned
- How Covid19 has accelerated service redesign and transformational change
- New Performance Measures for new service landscape
- Digital and Technology use
- Preparedness for Winter
- Delivery of Operation Home First
- Impact on staff and organisation

Appendix A

National Indicators benchmarked against previous years and Scottish Average with commentary to follow once available

Appendix B

MSG Indicators benchmarked against previous years and Scottish average with commentary to follow once available