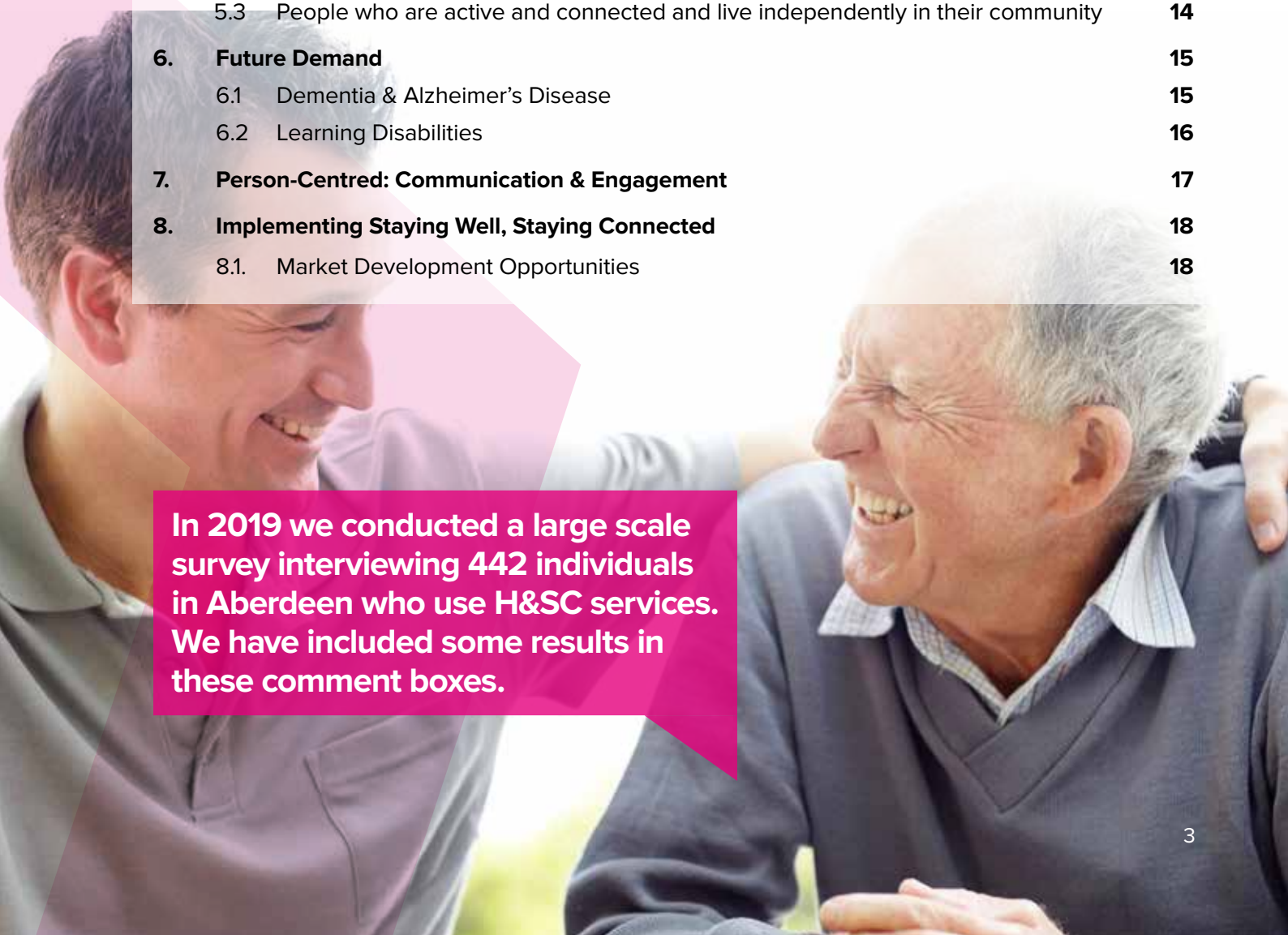
Aberdeen City
Health & Social Care
Partnership
A caring partnership

Stay Well
Stay Connected

Market Position Statement
December 2020 - December 2022

Contents



In 2019 we conducted a large scale survey interviewing 442 individuals in Aberdeen who use H&SC services. We have included some results in these comment boxes.

1. Executive Summary

We hope that this document sets the scene for the future vision of “Stay Well Stay Connected”. It marks the start of what we hope to be an exciting journey which focusses on meeting people’s outcomes, with a shift towards early intervention and prevention, designed in collaboration with providers, partners and service users.

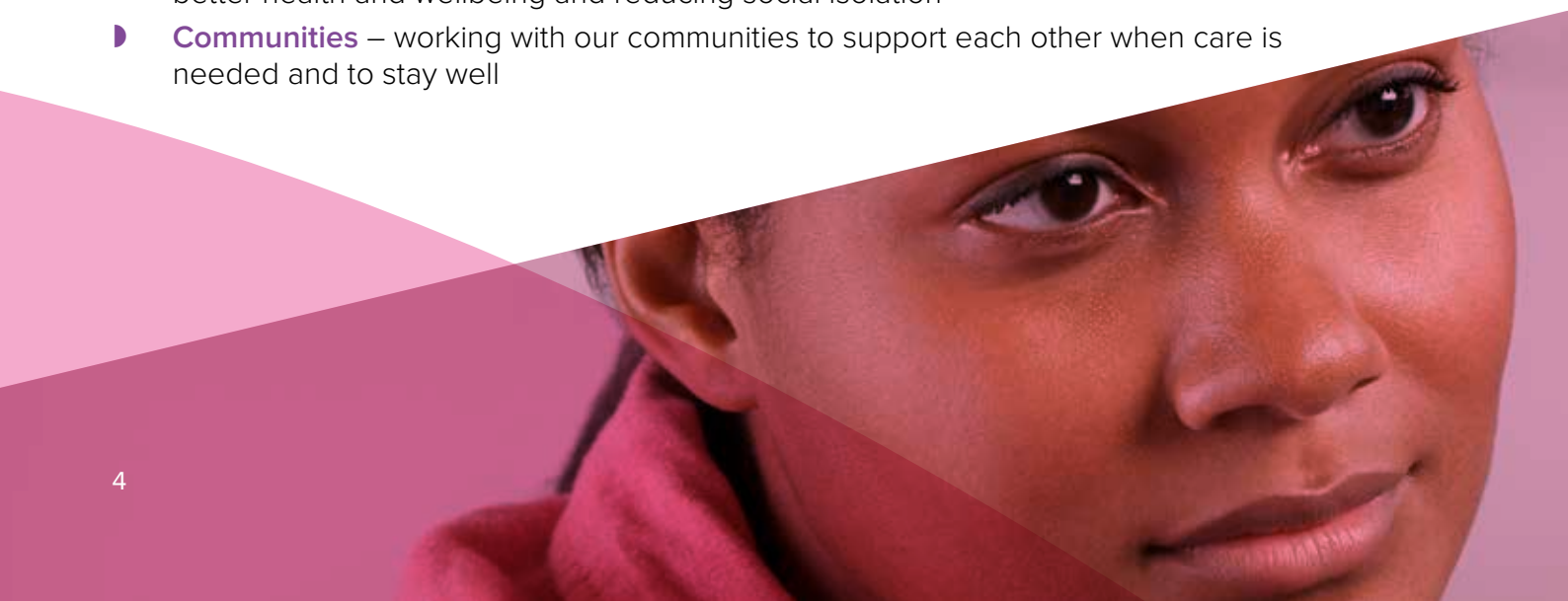
We hope that this document starts to describe our vision. It is aimed at our current and potential future partners and providers who are keen to work with us to achieve the shared ambition of “Stay Well, Stay Connected”, improving outcomes for people living within Aberdeen. We hope that having read the content, providers, partners and service users feel keen to shaire their ownideas on what they feel they are able to offer to fulfill out ambition for people living in Aberdeen.

2. Introduction

In 2018, Aberdeen City Health and Social Care Partnership (ACHSCP), working collaboratively with providers of commissioned day services, and other key partners, started a review of Day Care and Day Activities. This review followed on from a previous review in 2015, and the intent of the review was to ensure that the future provision was aligned to the the ACHSCP strategic plan. This plan sets out the key strategic ambitions which underpin all provision within the partnership and its commissioned services, with the overarching focus being on improving outcomes for the population of Aberdeen.

The key aims within the plan are as follows:

- **Prevention** - working with partners to achieve outcomes for people living within the City and in so doing, lessening the need for formal support
- **Resilience** – working with partners to support people tocope with and overcome the health and welbbeing challenges that they face
- **Enabling** – ensuring that the right care is delivered at the right time and in the right place and ensuring that systems are easy to navigate
- **Connected** – develop meaningful community connections, promoting better inclusion, better health and wellbeing and reducing social isolation
- **Communities** – working with our communities to support each other when care is needed and to stay well



Principles of Operation Home First (OHF)

The Operation Home First portfolio seeks to align the collective priorities of the three health and social partnerships and the acute sector within Grampian. There are three aims of this portfolio:

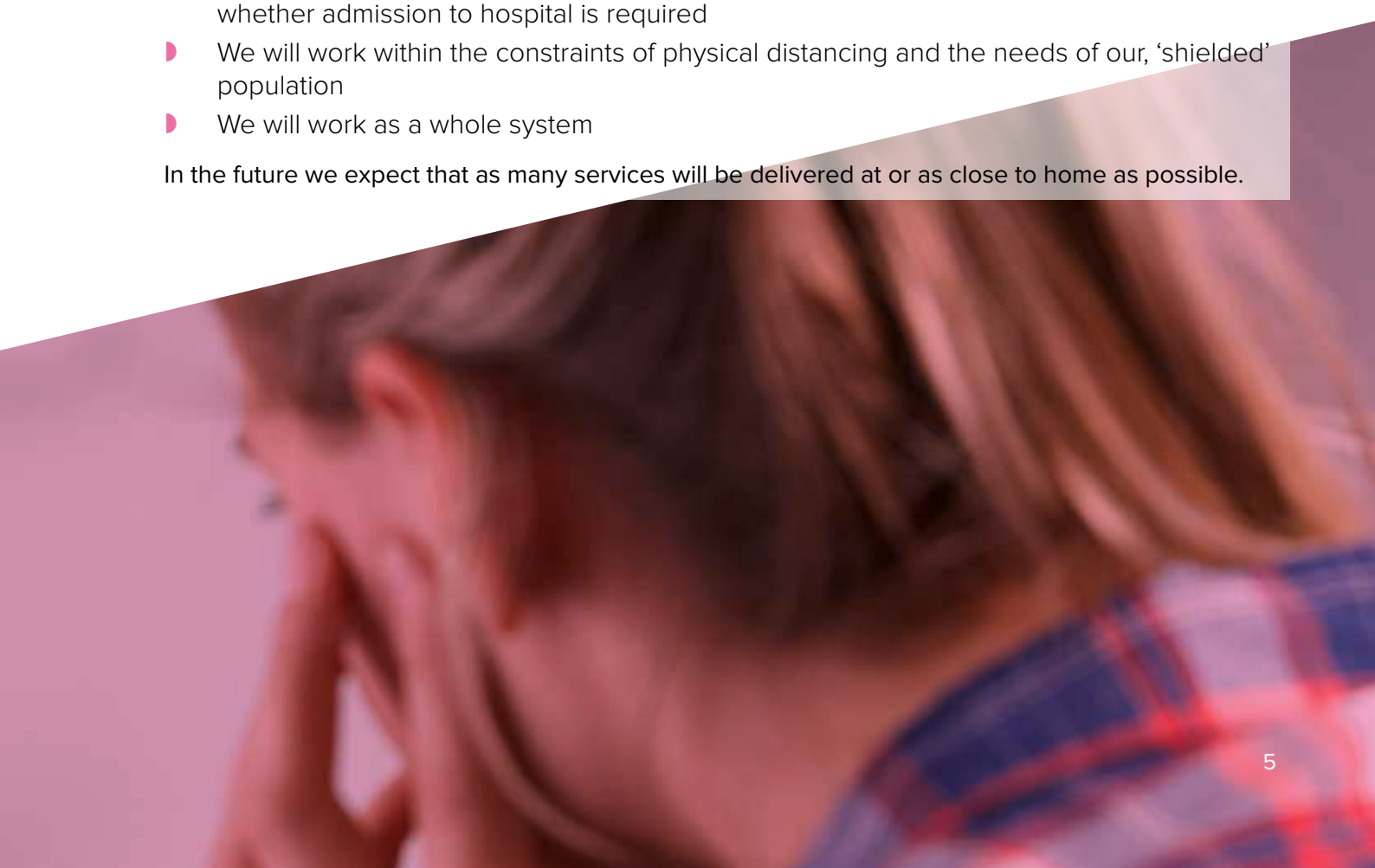
- Support early discharge back home
- Avoid unnecessary hospital attendance or admission
- Maintain people safely at home

This portfolio emerged as a consequence of the effective cross-system collaborations that occurred as a response to the COVID-19 pandemic. OHF emphasises the collective priorities that are evident as a cross-system agency but also recognises the local priorities that are the result of the unique local context. It is important to note the above as we are still in the midst of the pandemic and therefore agility and flexiblitity is critical in order to respond to local population needs within those strategic aims mentioned above.

Building on what we have learnt through COVID 19

- We will have a greater focus on better, evidence based, outcomes for our individuals
- We will remain flexible and agile so that should there be a surge in demand we are ready to respond
- We will maximise digital solutions wherever we can
- We will look at the whole person, their circumstances and supports when deciding on whether admission to hospital is required
- We will work within the constraints of physical distancing and the needs of our, 'shielded' population
- We will work as a whole system

In the future we expect that as many services will be delivered at or as close to home as possible.



3. The "Stay Well and Stay Connected" model

The overarching ambition Of "Stay Well, Stay Connected" can be described as follows:

"to work with you, your carers and our partners to ensure that there is sufficient choice of activity, local to your community (people or place) to support you and your carer to realise your outcomes."

The following diagram offers a figurative view of the model and its ambition.

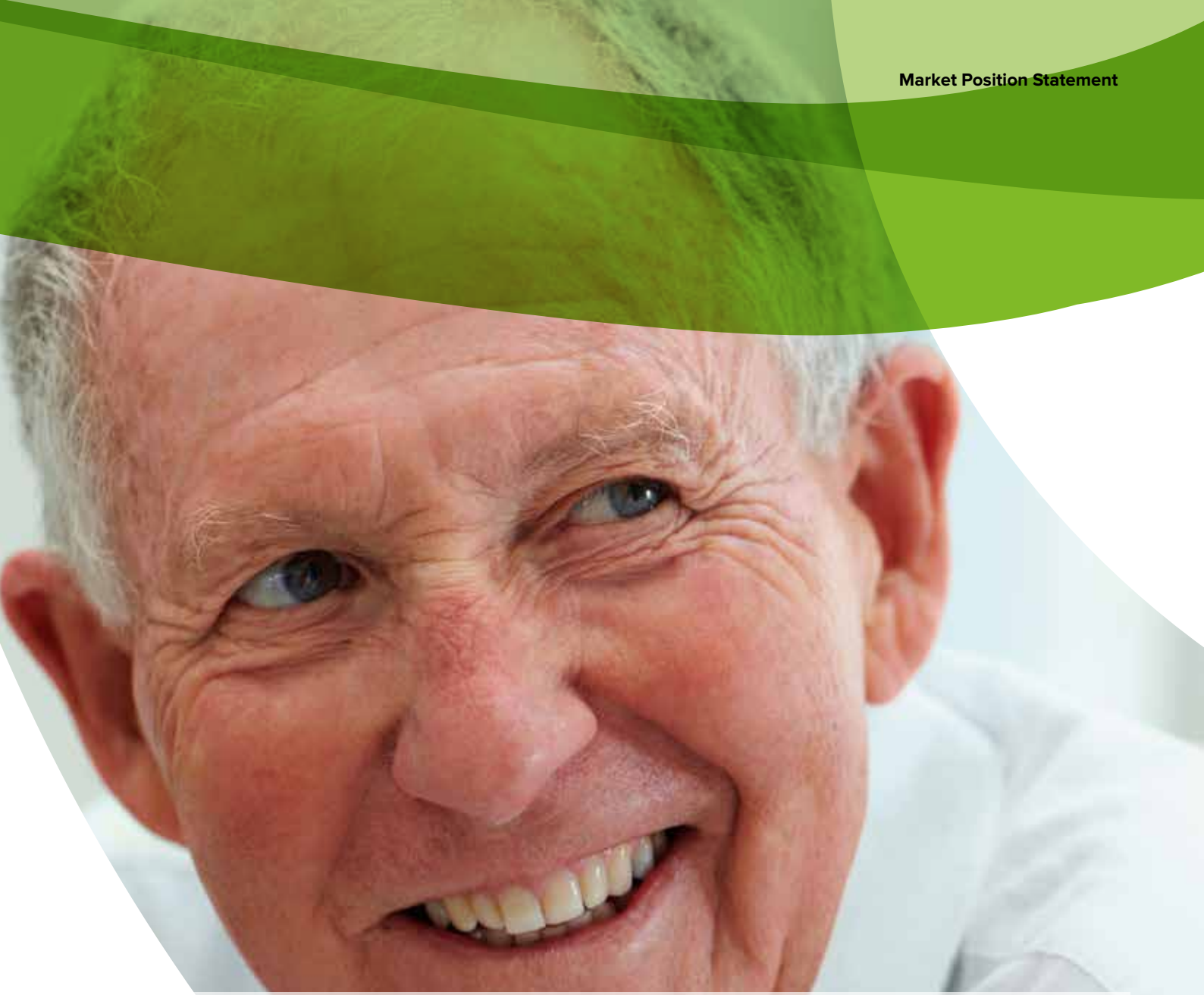
Day Care / Day Activity - the approved model

The model adopts a whole population approach, with a strong focus on outcomes, whilst at the same time, shifting to a model that embraces early intervention and prevention. The scope of the model is our adult population, but there is an enhanced focus on achieving outcomes for:

- People living with disabilities and enduring long term conditions
- People who for one reason or another have started to "lose their connection" to their community, which may be a community based on geography or interest
- Adult carers

90%

agree that support helps them live as independently as possible



3.1 Consultation with Service Users & Carers

There are the key themes from consultation with service users and carers about important considerations within this model.

- **Choice** - We are all very different and therefore it is important for us to be able to choose for ourselves the best way to ensure that we maintain our health and wellbeing, whether this is where we want to go, what we want to do or at what time we want to do it. This means that we do not necessarily want to go to a "buildings based" service.
- **Meeting Outcomes** - We all have different aspirations and therefore, it is important that we are listened to and our individual outcomes are met.
- **Accessibility** – travel can often pose significant challenges to people accessing services and therefore local access is preferrable
- **Keep it Simple** – accessing support should be kept as simple as possible
- **Communication and information** – people want clear and concise information on what is available and how to access it
- **Safety** – it is very important, particularly for unpaid carers, that loved ones will be safe.

4. Key considerations

We have developed a vaiety of strategies over the past couple of years, setting out our ambitions and the means with which people will access our health and care services. This document does not replace these strategies, but we hope will complement the way in which we deliver on them. There are other aspects of our health and care delivery that we need to take in to consideration. See below.

4.1 Our Carers need support

Our carers strategy is designed to ensure that carers are able to live their lives alongside caring. For this to happen, we need to work with carers to identify imaginative ways for them to maintain their resilience. We recognise that different people need different ways of maintaining their resilience – from taking time to have their hair cut, to knowing that they can have an opportunity for a complete break and a good night's sleep.

4.2 Our Short Breaks Statement

Short Breaks can take any number of forms in order to meet the carer's needs. The purpose is for carers to have a life outside of or alongside their caring role, supporting their health and wellbeing. This can also benefit the cared for person and others (e.g. family members) and should help to sustain the caring relationship.

4.3 Our Eligibility Criteria

The Aberdeen City Council Social Work team has a set amount of money for community care services and because of this uses guidelines known as eligibility criteria. These ensure:

- that everyone who asks for a service is dealt with according to his or her needs;
- that citizens in the greatest need or at most risk are prioritised, and
- that everyone understands what decisions are made about care.

The council has taken a policy decision, for the reasons explained above, that only those citizens with needs that have been assessed at Emergency/Urgent or High levels will be eligible for a service. The Eligibility Criteria will be used to assess the urgency or someones individual situation.

People assessed in the medium and low bands do not meet the eligibility criteria and so will not receive a service, but will be provided with information and advice on other sources of help where possible. The eligibility criteria apply to all citizens who currently receive a service; and anyone who may request or require an adult care service.

53%

don't take part in any community activities

4.4 Self Directed Support (SDS)

SDS is for anyone who has been assessed as eligible for support services from Aberdeen City Council. This includes adults, older people, children, families and carers. Individuals who have been assessed as eligible will then be given different choices to meet their care and support needs. Information and advice is given to help them choose the best option for them. There are 4 options or choices for self-directed support. A person can choose to have lots of control over their care and support or they can leave most of the decisions and work to the local council. Or they can have a mix. Link to Mylife.

4.5 COVID 19 Pandemic

At the time of writing, we are all living with the consequences of the global pandemic "COVID 19", and whilst there is the hope of a vaccine next year, there continues to be an absolute requirement to ensure that people using any commissioned services are safe. This has had an impact on the numbers of people currently able to use facilities, and any future provision needs to take safety and the risk of transmission of the virus into serious consideration.

Here is an overview of how people with dementia have been impacted by the pandemic (Draft Scottish Government Dementia Transition Plan November 2020). Key themes from this are below;

- People living with dementia and their carers often feel alone, vulnerable and anxious about COVID;
- Families are worried about what the future holds for their loved ones with dementia;

Moving forward its suggests that we need to learn from the experiences of people with dementia and their families have told us and others to respond to their needs during the pandemic; plan how we help across the whole journey of the illness and reinforce our shared human-rights based and person-centred approach to supporting people with dementia and their families and carers.

5. Our Current Model of Delivery

Currently everyone is assessed against eligibility criteria to ascertain need. What we currently know is that there are a range of SDS funding options that people choose and some decide upon a blended approach. Our ambition in the new model is to continue to support individuals' choice. This may see a shift to an increase in clients and their carers choosing options 1, 2 & 4.

For ease, we have divided the population into 3 different groups:

1. People with high level needs
2. People at the cusp of losing their physical and emotional resilience
3. People who are active and connected to their local community.

The availability of data available to us associated with these different groups is variable. However, based upon on available data we can describe the population currently using services, and who are currently connected to day services in the following way.

5.1 People with high level needs

5.1.1 Planned Residential Respite:

Older Adults

- Our average requirement for planned residential respite has been 15 places per week. Our model for provision has been within the residential sector within Rosewell. This provision has recently changed and an alternative is required.
- At the time of writing, there has been a temporary increase in the commissioned capacity within nursing homes within the City, to accommodate both the flow of clients out of hospital and also to provide respite where required. This does not provide for planned residential respite.

People with a Learning Disability

- In 2019 / 2020, the total provision for planned residential respite for people with a learning disability was 2902 nights. This was a reduction from the previous year where 3205 nights had been provided. Due to the restrictions associated with COVID, and the need to reduce the risk of transmission of the disease, it is anticipated that equivalent to 1600 nights will have been provided in 2020 / 2021.

Mental Health

- We have a commisioned residential service which offers 6 places for individuals experiencing severe and enduring mental illness which is usually booked in advance but can be utilised in an emergency if available space
- We have had successful use of SDS option 1 and 2 funding to create individual respite provision including short breaks to Edinburgh to attend a national autism conference, purchasing of a 'log cabin' in the garden to allow time out of the family home and short breaks in a caravan in Stonehaven.
- The specialist day assessment and treatment services for older people in Aberdeen located on RCH site have closed and been discontinued in the last 20 months. Kildrummy Day service (for people with severe mental health conditions) and Lochhead Day Hospital (for people with more complex dementia) both helped to keep these people living in their community settings, preventing avoidable hospital admissions and supporting earlier inpatient discharges. No alternative specialist provision or upstream services have yet been put in place to compensate for these services.

5.1.2 Buildings Based Day Support

Older Adults

- There is currently commissioned provision to accommodate the needs of 109 (82 Monday-Friday, 27 Saturday/Sunday) number of clients within a buildings based day service
- Some of the provision of this service is incorporated within our current service level agreement with our ALEO
- Some of the provision serves adults with a diagnosis of dementia, the majority of which are over the age of 65. A significant proportion of those whom attend have a diagnosis of dementia
- Within some services there is a flexibility to accommodate part days rather than full days. All services are delivered within the day time during "office hours"
- Transport is provided to and from some of our services but not all

People with a Learning disability

- A small proportion of this service is delivered by the partnerships "in house" learning disability services based at the Len Ironside Centre
- Many service users access day support through a blended care package. It is estimated however that there are approximately 95 clients receiving a form of Day Service which are funded with a mix of SDS Options. Of these people approximately 40-50 utilise our in house day care facilities

Mental Health (MH)

- MH has not traditionally used building based day support for people under 65.
- A weekend day care service is commissioned from MH for people over 55 with a diagnosis of dementia. This service is buildings based for full days and provides transport.
- Individuals over 65 with MH issues have also used the services detailed above which are available open to older people however this is not always suitable for people with Functional mental illness.

5.1.3 Community Support

Older Adults

- We know that some people would prefer to have 1:1 support and we know there has been a growth in care at home support in the absence of buildings based day support due to covid pandemic

People with a Learning Disability

- We recognise that there are approximately 950 adults living in Aberdeen with a learning disability who meet our eligibility criteria, a proportion of which receive suppport from our commissioned skills development programme. This programme is currently outwith the scope of our redesign
- It is estimated that there are in excess of 250 clients in receipt of 1:1 community support. The majority of this support is through a blended options approach

Mental Health (MH)

- There are instances of service users with mental illness using individual budgets via SDS options 1, 2 or a blended model, to create their own day care with use of music recording studio and commssioning of art classes being examples.
- MH service users have access to employment and skills development commissioned services if they meet eligibitly criteria. This service has the aim of enabling individuals to reenter the workplace or undertake vountary work hoever this is not always suitable and users can remain in the service longer due to lack of suitable options.
- MH commission an organised structured activity service which utilises community resources such as attending the cinema and visiting attractions,in groups but does not offer options for an individualised approach.

5.2 People presenting at the cusp of losing their physical and emotional resilience

We do not have data to describe the number of people who would fit into this category. There are several potential reasons for this lack of information;

1 the onset of people losing their resilience can often be insidious in nature and happens over a period of time.

2. people may not recognise when they are starting to lose their connection and therefore not present themselves in this way

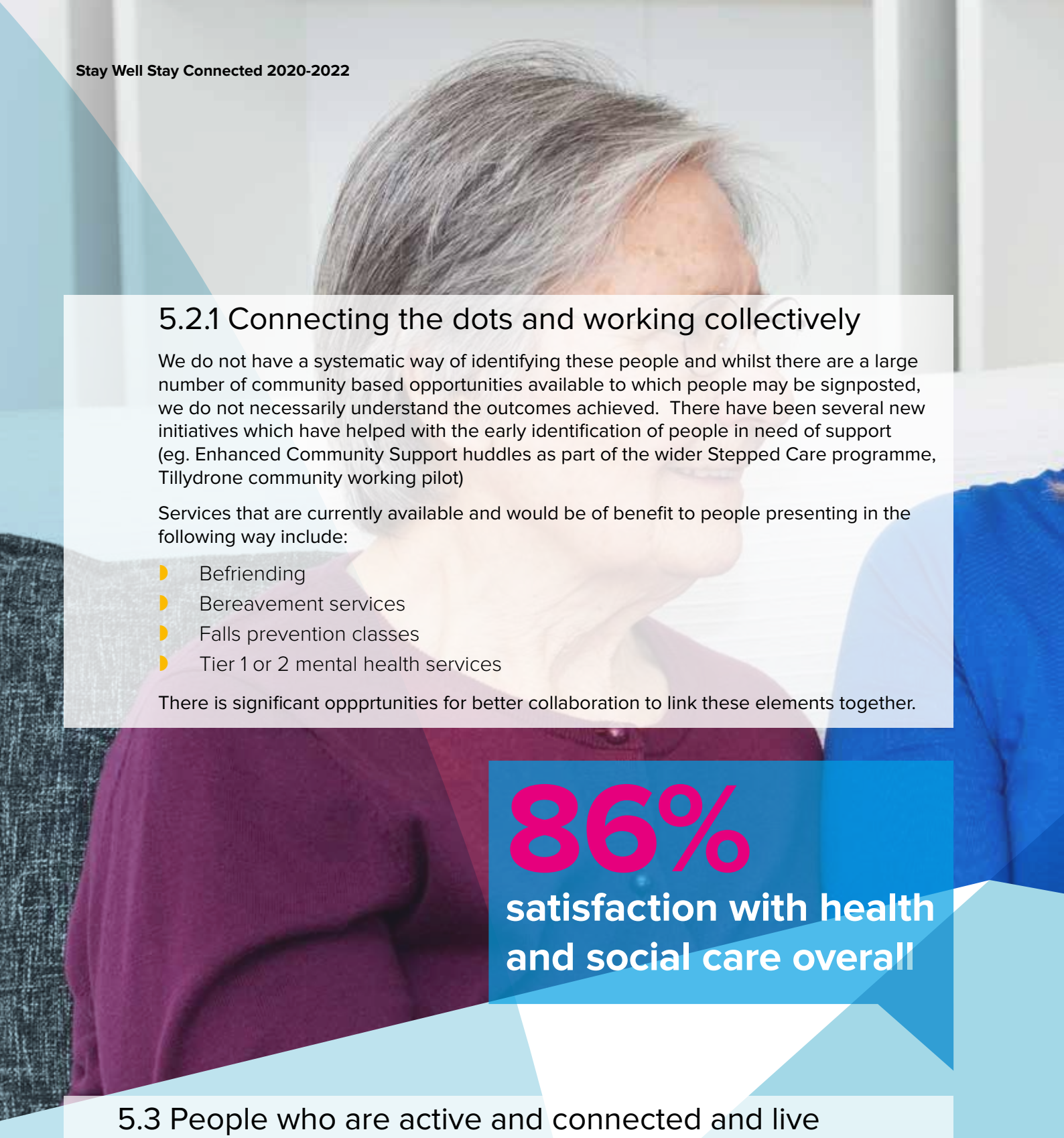
3. when people do present they may do so in a scattered way across several services

People who fit into this category may present in the following way or for the following reasons:

- **Recently bereaved**
- **Social Isolation for a variety of reasons**
- **Following a period of illness and subsequent loss of physical ability or confidence**
- **Following a fall**
- **Low level mental health condition**
- **People with a progressive long term condition eg dementia, Parkinson's disease, arthritis**
- **Financial hardship**
- **Domestic abuse**
- **Homelessness**

6%

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



5.2.1 Connecting the dots and working collectively

We do not have a systematic way of identifying these people and whilst there are a large number of community based opportunities available to which people may be signposted, we do not necessarily understand the outcomes achieved. There have been several new initiatives which have helped with the early identification of people in need of support (eg. Enhanced Community Support huddles as part of the wider Stepped Care programme, Tillydrone community working pilot)

Services that are currently available and would be of benefit to people presenting in the following way include:

- Befriending
- Bereavement services
- Falls prevention classes
- Tier 1 or 2 mental health services

There is significant oppprtunities for better collaboration to link these elements together.

86%

satisfaction with health and social care overall

5.3 People who are active and connected and live independently in their community

We have to acknowledge that there are a lot of adults living in Aberdeen who are fit and well and enjoy an independent life within their community.

What we know is that there is a significant amount of choice for people to access a wide variety of activity should they choose and if they have the necessary resilience. The impact of covid has meant reduced social opportunities for individuals and increased anxiety, functional decline and social isolation. Some of this, where possible, has shifted to virtual or alternative innovative means. We want to work with partners to know what that future looks like and how we post-covid restore what was of value and where we need to develop.

6. Future Demand

We face demographic and financial challenges now and in the future. Doing more of the same is not a sustainable option. By 2037, Aberdeen's over 65s population will increase by almost 56%. With projection that the over 75s population is projected to grow by around 70%. This likely means a huge increase in the demand on services but also a decrease in available workforce. However Aberdeen does have the highest proportion of working age population than the rest of Scotland. People are generally living longer and with long term condition and increased likelihood to have complexities such as, functional mental illness eg schizophrenia, bi-polar due to living longer.

Locality working looks to deliver more integrated health and social care services (less silos) and to improve access by delivering more locally based services. Recent studies also note the impact of social isolation and the importance of connecting communities and to help build real and lasting relationships to address this. Prevention is better than cure and much of our work looks to ensure we prevent illness and connect with our local communities and resources to support them to maintain their health and wellbeing and build positive, collaborative relationships.

We need to have honest conversations with our customers, our staff and our partners about their expectations and their contributions. We will work together to enable people to keep as well as they can in a way that suits them. We accept that we will have to reshape and transform how and where we deliver services as well as focus our effort on addressing preventable factors. We remain ambitious to be recognised as an innovative and high performing partnership organisation (ACHSCP Strategic plan 2019).

We need a blended holistic approach which considers both mental wellbeing and physical needs. We must do things better and smarter so that our funding delivers ever-more joined-up, locality-based models of health and social care – models which fully involve our citizens in planning and delivery, in a culture of transparency and trust.

6.1 Dementia & Alzheimer's Disease

It is anticipated that due to demographic change and due to the number of people living longer and with a variety of long term conditions that demand for services will grow. We expect that the number of those with dementia will increase.

From the Scottish Government's publication in 2016 'Estimated and projected diagnosis rates for dementia in Scotland 2014-2020', in 2014 there were an estimated 16,712 individuals newly diagnosed with dementia in Scotland. By 2020, this number is estimated to increase by 17% to 19,473. The age group with the most estimated diagnosis of dementia appears to be 80-84 year olds. Grampian's estimates are slightly under the national average at 15% increase over that time period.

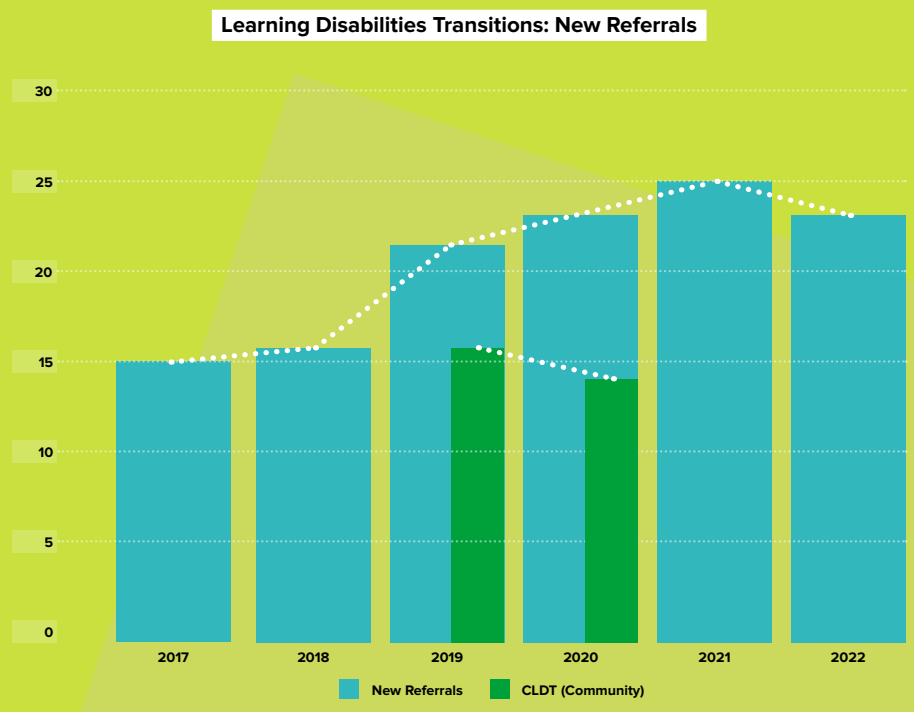
From the 2018 Community Planning Aberdeen Population Needs Assessment in 2017 there were an estimated 3,455 people (1.5% of the population) with dementia in Aberdeen City and dementia. Alzheimer's disease accounted for 10.4% of all deaths (221 deaths of which 150 were female and 71 were male). In Scotland it is the second most common cause of death. Most people with dementia are 65 years or over (approximately 96% at Scotland level).

6.2 Learning Disabilities

Scotland's Pupil Census reports of a steady increase regarding the number of children living with a Learning Disability, reasons for this can be attributed to improvements regarding recording data and improved practices rather than the actual prevalence of a Learning Disability diagnosis. However, the life expectancy of children, adults and older people with learning disabilities is increasing which means that more are living into older age. As a result, all care services will see an increase in the number of people with learning disabilities requiring access to education, health, social care and housing services in the future. See table below. There is therefore a need for strategic and local planning and investment to ensure that there is capacity within services and the workforce to meet their needs now and in the future.

New referrals

Transitions Cases (young people leaving children's services):



(*Unable to provide future referrals for Community Cases)

7. Person-Centred: Communication & Engagement

One of our main aspirations with the new model of day support is that it is as person-centred as possible. The Scottish Government define person-centred care as, 'Mutually beneficial partnerships between patients, their families and those delivering health and social care services which respect individual needs and values and which demonstrates compassion, continuity, clear communication and shared decision-making'.

As described in section 2, we have carried out a significant amount of engagement with people to inform the model and its implementation. Being as person-centred as possible will allow the dialogue started with our engagement process to continue into our delivery of day support in the future. In this sense, a person-centred approach can be thought of as 'continuous engagement'. It is vital, therefore, that we continually listen, learn and act to ensure that the range of services we offer meets the needs and wishes of people accessing the support.

8. Implementing Stay Well, Stay Connected

The outline implementation plan outlined several key markers:

- The provision of planned respite, including residential respite
- The testing of alternative models of support for individuals, reflecting personal choice and the achievement of outcomes
- Strengthening the opportunity for the early identification of people at the cusp of losing their physical and emotional resilience and making a shift to early intervention and prevention by growing community connection within our localities.

8.1. Market Development Opportunities

Develop opportunities for short breaks which focus on the achievement of individual outcomes for carers and cared for. Based upon a shared knowledge of demand, these short breaks will vary across the whole spectrum of population need and may include:

- **Planned support over a 24-hour period for an individual**
- **Shorter periods of support throughout the day or evening for individuals**
- **The use of technology to deliver support**
- **A socially integrated approach that supports people to reconnect with their communities**
- **An enabling approach which focuses on restoring and maintaining independence**

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