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Aberdeen City Health & Social Care Partnership
A caring partnership

To: Jonathan Passmore MBE (Chairperson); Councillor Duncan (Vice Chairperson); and Councillors Cooke, Donnelly and Samarai; and Rhona Atkinson, Dr Nick Fluck and Professor Mike Greaves (NHS Grampian Board Members); and Mike Adams (Partnership Representative, NHS Grampian), Jenny Gibb (Professional Nursing Adviser, NHS Grampian), Jim Currie (Trade Union Representative, Aberdeen City Council (ACC)), Bernadette Oxley (Chief Social Work Officer, ACC), Kenneth Simpson (Third Sector Representative), Dr Howard Gemmell (Patient and Service User Representative), Gill Moffat and Faith-Jason Robertson-Foy (Carer Representatives), Dr Stephen Lynch (Clinical Director, Aberdeen City Health and Social Care Partnership (ACHSCP)), Dr Satchi Swami (Secondary Care Adviser, NHS Grampian),Judith Proctor (Chief Officer, ACHSCP) and Alex Stephen (Chief Finance Officer, ACHSCP).

Town House,
ABERDEEN, 8 August 2017

INTEGRATION JOINT BOARD

The Members of the **INTEGRATION JOINT BOARD** are requested to meet in **Meeting Room 5, Health Village** on **TUESDAY, 15 AUGUST 2017 at 10.00 am**.

FRASER BELL
HEAD OF LEGAL AND DEMOCRATIC SERVICES

B U S I N E S S

1 Welcome From the Chair

DECLARATION OF INTERESTS

2 Members are requested to intimate any declarations of interest (Pages 5 - 6)

DETERMINATION OF EXEMPT BUSINESS

3 Members are requested to determine that any exempt business be considered with the press and public excluded

STANDING ITEMS

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5 Draft Minute of Audit and Performance Systems Committee - 20 June 2017 (Pages 17 - 22)

6 Draft Minute of Clinical and Care Governance Committee - 28 June 2017 (Pages 23 - 30)

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WORKSHOP

18 Role of Chief Social Work Officer

19 Adult Support and Protection

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Website Address: www.aberdeencityhscp.scot/

Should you require any further information about this agenda, please contact Iain Robertson, 01224 522869 or iairobertson@aberdeencity.gov.uk

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You must consider at the earliest stage possible whether you have an interest to declare in relation to any matter which is to be considered. You should consider whether reports for meetings raise any issue of declaration of interest. Your declaration of interest must be made under the standing item on the agenda, however if you do identify the need for a declaration of interest only when a particular matter is being discussed then you must declare the interest as soon as you realise it is necessary. The following wording may be helpful for you in making your declaration.

I declare an interest in item (x) for the following reasons ……
For example, I know the applicant / I am a member of the Board of X / I am employed by… and I will therefore withdraw from the meeting room during any discussion and voting on that item.

OR

I have considered whether I require to declare an interest in item (x) for the following reasons …… however, having applied the objective test, I consider that my interest is so remote / insignificant that it does not require me to remove myself from consideration of the item.

OR

I declare an interest in item (x) for the following reasons …… however I consider that a specific exclusion applies as my interest is as a member of xxxx, which is

(a) a devolved public body as defined in Schedule 3 to the Act;

(b) a public body established by enactment or in pursuance of statutory powers or by the authority of statute or a statutory scheme;

(c) a body with whom there is in force an agreement which has been made in pursuance of Section 19 of the Enterprise and New Towns (Scotland) Act 1990 by Scottish Enterprise or Highlands and Islands Enterprise for the discharge by that body of any of the functions of Scottish Enterprise or, as the case may be, Highlands and Islands Enterprise; or

(d) a body being a company:-

i. established wholly or mainly for the purpose of providing services to the Councillor's local authority; and

ii. which has entered into a contractual arrangement with that local authority for the supply of goods and/or services to that local authority.

OR

I declare an interest in item (x) for the following reasons……and although the body is covered by a specific exclusion, the matter before the Committee is one that is quasi-judicial / regulatory in nature where the body I am a member of:

- is applying for a licence, a consent or an approval
- is making an objection or representation
- has a material interest concerning a licence consent or approval
- is the subject of a statutory order of a regulatory nature made or proposed to be made by the local authority…. and I will therefore withdraw from the meeting room during any discussion and voting on that item.

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Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Minute of Meeting

6 June 2017
Health Village, Aberdeen

Present: Jonathan Passmore MBE (Chairperson); Councillor Sarah Duncan (Vice Chairperson); and Councillors Cooke, Donnelly and Samarai; and Rhona Atkinson, Dr Nick Fluck and Professor Mike Greaves (NHS Grampian Board members); and Mike Adams (Partnership Representative, NHS Grampian), Jim Currie (Trade Union Representative, Aberdeen City Council (ACC)), Heather Macrae (NHS Grampian, as substitute for Jenny Gibb), Kenneth Simpson (Third Sector Representative), Faith-Jason Robertson-Foy (Carer Representative), Dr Howard Gemmell (Patient/Service User Representative), Dr Stephen Lynch (Clinical Director, Aberdeen City Health and Social Care Partnership (ACHSCP)), Bernadette Oxley (Chief Social Work Officer, ACC), Dr Satchi Swami (Secondary Care Adviser, ACHSCP), Judith Proctor (Chief Officer, ACHSCP) and Alex Stephen (Chief Finance Officer, ACHSCP).

Also in attendance: Angela Scott (Chief Executive, ACC), Kevin Toshney (Acting Head of Strategy and Transformation, ACHSCP, for agenda items 8 and 13), Kenneth O'Brien (Service Manager, ACHSCP, for agenda item 9), Gail Woodcock (Integrated Localities Programme Manager, ACHSCP, for agenda item 10), Dorothy Askew (Planning and Development Manager, ACHSCP, for agenda item 11), Shona Smith (Lead Officer – Primary Care Modernisation, ACHSCP, for agenda item 14) and Iain Robertson (Clerk, ACC).

Apologies: Jenny Gibb, Gill Moffat and Tom Cowan.

The agenda and reports associated with this minute can be located at the following link:-
http://committees.aberdeencity.gov.uk/ieListMeetings.aspx?CommitteeId=516

Please note that if any changes are made to this minute at the point of approval, these will be outlined in the subsequent minute and this document will not be retrospectively altered.

OPENING REMARKS FROM THE CHAIR

1. Following the Board's observation of a minute's silence in remembrance of those who lost their lives and all others affected by the attacks in London on 3 June 2017, the Chair opened the meeting and welcomed Councillor Sarah Duncan onto the Board as the Vice Chairperson and also welcomed Councillors Cooke, Donnelly and Samarai onto the Board. The Chair announced that the Partnership had recently made a number of appointments and highlighted the appointment of Sally Shaw as Head of Strategy and Transformation and the appointments of Lynn Morrison and Lorraine McKenna as Heads of Localities. He noted that a recruitment process was ongoing to make appointments to the two remaining Head of Locality posts.

The Board resolved:-

(i) to welcome Councillor Duncan onto the Board as the IJB's Vice Chairperson;
(ii) to welcome Councillors Cooke, Donnelly and Samarai onto the Board as voting members;
(iii) to congratulate Sally Shaw on her appointment as the Head of Strategy and Transformation;
(iv) to congratulate Lynn Morrison and Lorraine McKenna on their appointments as Heads of Localities; and
(v) otherwise note the information provided.

DECLARATION OF INTERESTS

2. Professor Greaves declared an interest for agenda item 13 (Care at Home Commissioning) due to his membership of the Quarriers Board. Kenneth Simpson declared an interest for agenda items 10 (Transformation Programme) and 13 (Care at Home Commissioning) as he was the Chairperson of the Aberdeen Council of Voluntary Organisations (ACVO).

The Board resolved:-

To note the declarations of interest intimated by Professor Greaves for agenda item 13 and by Kenneth Simpson for agenda items 10 and 13.

DETERMINATION OF EXEMPT BUSINESS

3. The Chair proposed that item 13 (Care at Home Commissioning) and item 14 (Northfield/Mastrick Locality) on today's agenda be considered with the press and public excluded.

The Board resolved:-

In terms of Section 50(A)(4) of the Local Government (Scotland) Act 1973, to exclude the press and public from the meeting during consideration of the aforementioned items of business so as to avoid disclosure of exempt information of the classes described in paragraphs 8 (Commissioning of Care at Home Services) and 7 (Northfield/Mastrick Locality) of Schedule 7(A) of the Act.

MINUTE OF IJB MEETING – 28 MARCH 2017

4. The Board had before it the minute of the Board meeting of 28 March 2017.

The Board resolved:-
To approve the minute as a correct record.

DRAFT MINUTE OF AUDIT AND PERFORMANCE SYSTEMS COMMITTEE MEETING – 11 APRIL 2017

5. The Board had before it the draft minute of the Audit and Performance Systems Committee of 11 April 2017 for information.

The Board resolved:-
To note the draft minute.

DRAFT MINUTE OF CLINICAL AND CARE GOVERNANCE COMMITTEE MEETING – 14 MARCH 2017

6. The Board had before it the draft minute of the Clinical and Care Governance Committee of 14 March 2017 for information.

The Board resolved:-
To note the draft minute.

BUSINESS STATEMENT

7. The Board had before it a statement of pending business for information.

With reference to item 10 (Living Wage Monitoring Arrangements) the Board discussed whether this should remain on the Statement and took the view that it was appropriate to remove it as additional monitoring arrangements would be put in place through reporting to the Audit and Performance Systems Committee and an implementation update would be included within the Ethical Care Charter annual performance report.

The Board resolved:-
(i) to remove item 8 (Good Governance Institute Implementation Plan) from the Statement;
(ii) to remove item 10 (Living Wage Monitoring Arrangements) from the Statement but to note that monitoring arrangements would be put in place which would include reporting to the Audit and Performance Systems Committee and an update on living wage implementation would be included within the Ethical Care Charter annual performance report; and
(iii) otherwise note the Statement.

APPOINTMENT TO COMMITTEES

8. The Board had before it a report by the Clerk which advised the Board on the requirement to appoint committee members and to appoint a Chairperson to the Clinical and Care Governance Committee.

The report recommended:-
That the Board –
(a) Appoint two ACC voting members to the Audit and Performance Systems Committee;
(b) Appoint two ACC voting members to the Clinical and Care Governance Committee;
(c) Appoint an ACC voting member as Chairperson of the Clinical and Care Governance Committee; and
(d) Note the IJB meeting schedule for 2017-18.

The Vice Chair moved, seconded by Rhona Atkinson that the following nominations be agreed by the Board:-

a) To nominate Councillors Cooke and Duncan as voting members of the Audit and Performance Systems Committee;
b) To nominate Councillors Donnelly and Samarai as voting members of the Clinical and Care Governance Committee;
c) To nominate Councillor Donnelly as Chairperson of the Clinical and Care Governance Committee; and
d) To reaffirm Professor Greaves' Chairmanship of the Audit and Performance Systems Committee.

The Board resolved:-
(i) to appoint Councillors Cooke and Duncan as voting members of the Audit and Performance Systems Committee;
(ii) to appoint Councillors Donnelly and Samarai as voting members of the Clinical and Care Governance Committee;
(iii) to appoint Councillor Donnelly as Chairperson of the Clinical and Care Governance Committee;
(iv) to reaffirm Professor Greaves' Chairmanship of the Audit and Performance Systems Committee; and
(v) to note the IJB meeting schedule for 2017-18.

ANNUAL PERFORMANCE REPORT

9. The Board had before it a report by Kevin Toshney (Acting Head of Strategy and Transformation, ACHSCP) that presented the draft content of the Partnership's Annual Performance Report of its first year of operation to the Board for approval.

The report recommended:-
that the Board –
(a) Approve the annual performance report;
(b) Agree that the report be distributed widely, as according to the communications plan outlined in Appendix A;

(c) Instruct the Chief Officer to provide copies of the report to the IJB's partner organisations, Aberdeen City Council and NHS Grampian.

The Chief Officer advised that the report provided information on the Partnership's performance against priorities set out in the Strategic Plan as well as the nine National Health and Wellbeing Outcomes during its first year of operation. She highlighted that an improvement plan had been included to track progress made thus far and to outline areas in need of further improvement. She explained that an executive summary was planned and members still had an opportunity to shape its development as it was in draft form. She added that the report's formatting would be adjusted to make it as easy to read and accessible to the public as possible and a communication plan was being drafted to support this objective.

The Chair highlighted that the report was ambitious and captured the Partnership's achievements over the course of its first year but also outlined the scale of the challenges it would encounter during the integration process.

Thereafter there were questions on community mental health funding and the proportion delegated to the IJB; the level of Self-Directed Support uptake; and Partnership performance with regards to the number of sickness days lost per employee.

The Board resolved:-
(i) to approve the annual performance report;
(ii) to agree that the report be distributed widely, as according to the communications plan outlined in Appendix A;
(iii) to delegate authority to the Chief Officer to make minor revisions to the report in consultation with the Chair and Vice Chair of the IJB; and
(iv) to instruct the Chief Officer to provide copies of the report to the IJB's partner organisations, Aberdeen City Council and NHS Grampian.

DELAYED DISCHARGE PERFORMANCE REPORT

10. The Board had before it a report by Kenneth O'Brien (Service Manager, ACHSCP) which provided an update on delayed discharge performance to support scrutiny and facilitate further discussion.

The report recommended:-
That the Board –
(a) Note the Partnership's current performance in relation to delayed discharge;
(b) Note the current status and progress in relation to the Aberdeen City delayed discharge action plan; and
(c) Consider the frequency and detail they require of future delayed discharge reporting, given the progress to date.

Kenneth O'Brien advised that the Partnership's delayed discharge performance continued to improve with a 38% reduction in the number of individuals delayed and a 42% decrease in the number of bed days lost in comparison to the same period last year. Following this, Mr O'Brien cautioned members that performance may be steadier this year in comparison to the rapid improvements recorded during 2016.

With regards to Aberdeen City's performance in comparison to other Partnership areas per 100,000 population, he noted that Aberdeen City was very close to the national average. And in terms of Code 100 delays which cover more complex client groups, he explained that the volume of individuals delayed may increase in the short term due to an ongoing review at Royal Cornhill Hospital and an NHS statutory review of DL-2015 which refers to hospital based complex clinical care.

Mr O'Brien also highlighted the Delayed Discharge Action Plan and in particular the development of the draft Grampian-wide Choice Policy which was currently out for consultation and aimed to standardise care home, interim and intermediate discharge flow out of hospital sites across Grampian.

Thereafter there were questions on Partnership projections for a slower rate of delayed discharge improvement during 2017/18 in comparison to the previous year; the challenges of undertaking transformational change and the development of new paradigms such as locality planning; steps taken by the Partnership to learn from best practice; initiatives developed by the Partnership which could be rolled out in the short term to improve delayed discharge performance; the role and remit of the Delayed Discharge Group; the involvement of unpaid carers in tackling delays and how awareness could be raised amongst health and social care professionals in addition to the wider public; and the development of the draft Grampian-wide Choice Policy.

The Board resolved:-

(i) to commend officers for the recent improvement in delayed discharge performance and to reaffirm the Board's aspiration to better the Scottish national average in terms of delayed discharge performance;

(ii) to note the current status and progress in relation to the Aberdeen City delayed discharge action plan; and

(iii) to note that regular updates on delayed discharge performance would be presented to the Clinical and Care Governance Committee and to request progress updates to the IJB on a bi-annual basis.

DECLARATION OF INTEREST

Kenneth Simpson declared an interest in the following item as outlined in item 2 of this minute and chose to remain in the meeting during consideration of this item.

TRANSFORMATION PROGRAMME

11. The Board had before it a report by Gail Woodcock (Integrated Localities Programme Manager, ACHSCP) which requested approval for projects which sit within the Partnership's Transformation Programme.

The report recommended:-

That the Board –

(a) Approve expenditure of £2,219,000 in relation to the establishment of a Hospital at Home Service;

(b) Approve expenditure of up to £243,130 (total for two years) relating to enhancing the Third Sector Contribution to Integrated Services Project through the provision of a grant to ACVO, subject to State Aid assessments;
(c) Approve expenditure of £284,700 (over four years) required for the District Nurse Training project;
(d) Approve expenditure of £296,000 (over two years) for the Enhanced Pharmacy Support project;
(e) Approve expenditure of £1,121,378 (over two years) in support of the Testing Buurtzorg Principles in Neighbourhood Teams project;
(f) Note that a robust business case process is in place and that each project will have a clear business case which sets out key milestones for delivery benefits realisation and performance metrics; and
(g) Instruct the Chief Officer to issue Directions attached at Appendix F-K to Aberdeen City Council and NHS Grampian as appropriate once the full business case for each project has been approved by the Executive Programme Board and append the business cases with each Direction.

The Chief Officer explained that the individual projects outlined in the report would support the Board's strategic ambitions and if so agreed, the Board would be required to set Directions to partner organisations to deliver these projects.

The Chair reminded members that the strategic objectives had been agreed in principle and the Board was being asked to approve the use of resource for individual projects which would support these strategic objectives.

Gail Woodcock summarised the five projects set out within the report and advised that if the Board agreed to incur expenditure, detailed business cases would be developed and these would be submitted to the Executive Programme Board for scrutiny and approval. She noted that the Programme Board had been established to support the development and delivery of the Partnership's Transformation Programme.

Thereafter there were questions on district nursing succession planning; the Buurtzorg Model; affordable housing for key workers; the development of indicators during the business planning process to monitor performance and delivery; the impact on funding levels for acute services as a result of systemic change; the involvement of service users during the consultation process; the use of Integrated Care and Transformation Funding to support the delivery of the projects; and the role of the Audit and Performance Systems Committee to provide assurance to the Board on project governance and implementation.

The Board resolved:-
(i) to approve expenditure of £2,219,000 in relation to the establishment of a Hospital at Home Service;
(ii) to approve expenditure of up to £243,130 (total for two years) relating to enhancing the Third Sector Contribution to Integrated Services Project through the provision of a grant to ACVO, subject to State Aid assessments;
(iii) to approve expenditure of £284,700 (over four years) required for the District Nurse Training project;
(iv) to approve expenditure of £296,000 (over two years) for the Enhanced Pharmacy Support project;

(v) to approve expenditure of £1,121,378 (over two years) in support of the Testing Buurtzorg Principles in Neighbourhood Teams project;
(vi) to task the Audit and Performance Systems Committee with providing ongoing assurance to the Board that the aforementioned business cases were being developed through a thorough and robust process; and
(vii) to instruct the Chief Officer to issue Directions attached at Appendix F-K to Aberdeen City Council and NHS Grampian as appropriate once the full business case for each project has been approved by the Executive Programme Board and append the business cases with each Direction.

INTERIM HOUSING PROPOSAL

12. The Board had before it a report by Dorothy Askew (Planning and Development Manager, ACHSCP) which sought approval to develop an interim housing option for people who have low level support needs and are delayed in hospital awaiting housing adaptation or rehousing.

The report recommended:-
that the Board –
(a) Approve the proposal to develop an interim housing option as detailed within the report; and
(b) Approve the Direction attached as Appendix A to Aberdeen City Council in relation to expenditure required to deliver this project.

Dorothy Askew advised members that the report proposed the adaptation of two fully furnished, fully serviced properties to meet a range of needs and alleviate system pressures. She noted that the properties would be let as temporary accommodation for between 12-20 weeks and clients would be asked to enter into an occupancy agreement. Mrs Askew explained that the volume of housing delays had been historically low but noted that the length of delays had been significantly longer at times. She confirmed that the Council's Communities, Housing and Infrastructure Directorate would manage these properties and performance information in relation to delayed discharges would be reported to the Partnership's Delayed Discharge Group.

Thereafter there were questions on the number of payment methods open to clients to enable them to access these properties; the role of occupational therapists in identifying the two properties; and the existing arrangements in place at intermediate care facilities such as Clashieknowe.

The Board resolved:-
(i) to approve the proposal to develop an interim housing option as detailed within the report; and
(ii) to approve the Direction attached as Appendix A to Aberdeen City Council in relation to expenditure required to deliver this project.

SELF-DIRECTED SUPPORT UPLIFT

13. The Board had before it a report by Carol Simmers (Planning and Development Manager, ACHSCP) which sought approval apply the 2.8% uplift of

funding to contracted providers of social care services in relation to adult care staff extends to existing Direct Payment recipients of all Adult Social Care client groups who commission services from Personal Assistants, contracted providers and off-framework providers through Self-directed Support Options 1 and 2. The report also sought approval to proceed with applying the 2.8% rate increase from 1st April 2017 across all Option 1 and 2 packages across adult service areas.

The report recommended:-
that the Board –
(a) Note the 2017-18 cost of the Scottish Living Wage implementation is an estimated £120,000 in respect of Self-Directed Support options 1 and 2;
(b) Approve the 2.8% uplift to Adult Social Care SDS packages awarded under options 1 and 2 where a personal assistant is employed from 1 April 2017 at a cost of £120,000 to allow personal assistants to receive the Scottish Living Wage of £8.45 per hour;
(c) Approve that if the additional uplift payments should they be applied and not passed onto personal assistants, the ACHSCP reserve the right to retract the offer of the uplift to the supported person. This will be formally recorded in written communication provided to the supported person when informing them of agreed uplift in rates; and
(d) Approve the Direction to Aberdeen City Council contained in appendix 1.

Alex Stephen (Chief Finance Officer, ACHSCP) referred members to the Board's decision on 28 March 2017 to approve a 2.8% living wage uplift for contracted providers of social care services and explained that on reflection the report should have explicitly referenced Self-Directed Support (SDS) Personal Assistants and today's report had been prepared to ensure these colleagues received the living wage. Mr Stephen outlined the steps the Partnership would take to communicate this decision to clients and social care agencies and the process for monitoring if clients had been using the additional funds for its stated purpose, including bi-annual financial checks to monitor compliance.

Thereafter the Board expressed concern that clients may not pass on additional SDS funding to pay their personal assistants the living wage and discussed options available to the Partnership to challenge non-compliance as well as risks to the Partnership and clients if this practice were to take place.

The Board resolved:-
(i) to note the 2017-18 cost of the Scottish Living Wage implementation is an estimated £120,000 in respect of Self-Directed Support options 1 and 2;
(ii) to approve the 2.8% uplift to Adult Social Care SDS packages awarded under options 1 and 2 where a personal assistant is employed from 1 April 2017 at a cost of £120,000 to allow personal assistants to receive the Scottish Living Wage of £8.45 per hour;
(iii) to approve that if the additional uplift payments should they be applied and not passed onto personal assistants, the ACHSCP reserve the right to retract the offer of the uplift to the supported person. This will be formally recorded in written communication provided to the supported person when informing them of agreed uplift in rates; and
(iv) to approve the Direction to Aberdeen City Council contained in appendix 1.

In accordance with the decision recorded under article 3 of this minute, the following items were considered with the press and public excluded.

DECLARATIONS OF INTEREST

Professor Mike Greaves and Kenneth Simpson declared an interest in the following item as outlined in item 2 of this minute and chose to remain in the meeting during consideration of this item.

CARE AT HOME COMMISSIONING

14. The Board had before it a report by Kevin Toshney which outlined a business case for developing a Care at Home framework across different client groups by, in the first instance, retendering the provision of care at home services for older people.

The Board resolved:-
To approve the recommendation contained in the exempt report together with one additional resolution.

NORTHFIELD/MASTRICK LOCALITY

15. The Board had before it a report by Shona Smith (Lead Officer – Primary Care Modernisation, ACHSCP) which provided an update to the Board on the negotiation process with Denburn Medical Practice and to note the package of financial support to ensure practice viability.

The Board resolved:-
To note the proposed package of financial support for Aurora Medical Practice in relation to Northfield Practice.

VERBAL UPDATE ON KINGSMEAD CARE HOME

16. The Chief Officer provided a verbal update to the Board on recent developments and proposed future steps with regards to the Kingsmead Care Home.

The Board resolved:-
To note the verbal update.

WORKSHOP

17. The Board then broke out for a workshop session on Transformation Programme and Priorities presented by the Chief Officer

The Board resolved:-
To thank the Chief Officer for the informative presentation.
JONATHAN PASSMORE MBE, Chairperson.

Aberdeen City Health & Social Care Partnership
A caring partnership

AUDIT AND PERFORMANCE SYSTEMS COMMITTEE

Minute of Meeting

20 June 2017
Town House, Aberdeen

Present: Professor Mike Greaves (NHS Grampian (NHSG)) Chairperson; Rhona Atkinson (NHSG); and Councillors Cooke and Duncan.

Also in attendance: Councillor Samarai and Jonathan Passmore MBE (IJB members), Alex Stephen (Chief Finance Officer, Aberdeen City Health and Social Care Partnership (ACHSCP)), Tom Cowan (Head of Operations, ACHSCP), David Hughes (Internal Audit), Lorraine McKenna (Business Manager, ACHSCP), Jimmie Dickie (Finance, Aberdeen City Council (ACC)), Gillian Parkin (Finance, NHSG) and Iain Robertson (Clerk, ACC).

Apologies: Judith Proctor (Chief Officer, ACHSCP).

OPENING REMARKS

1. The Chair opened the meeting and welcomed Councillors Cooke and Duncan onto the Committee and advised he looked forward to receiving their expertise to support the work of the Committee.

The Committee resolved:-
To welcome Councillors Cooke and Duncan onto the Committee.

DECLARATIONS OF INTEREST

2. Members were requested to intimate any declarations of interest.

The Committee resolved:-
To note that no declarations of interest were intimated at this time for items on today's agenda.

DETERMINATION OF EXEMPT BUSINESS

3. The Chair proposed that all Committee business on today's agenda be considered with the public and press in attendance.

The Committee resolved:-
To agree that all Committee business on today's agenda be open to the public and press.

MINUTE OF PREVIOUS MEETING – 11 April 2017

4. The Committee had before it the minute of the previous meeting of 11 April 2017.

The Committee resolved:-
To approve the minute as a correct record.

IJB COMPLAINTS HANDLING PROCEDURE

5. The Committee had before it a report by Lorraine McKenna (Business Manager, ACHSCP) which outlined a joint complaints handling procedure (CHP) for the Aberdeen City IJB. The procedure introduced a standardised procedure to handling complaints which complied with Scottish Public Services Ombudsman's (SPSO) guidance on a model complaints handling procedure.

The report recommended:-
That the Committee –

a) Approve the Aberdeen City Integration Board's Complaints Handling Procedure as outlined in appendix A; and
b) Instruct officers to submit the compliance statement and self-assessment in appendix B to SPSO before the 3rd of July.

Lorraine McKenna advised that IJBs were required to produce a CHP that complied with the SPSO's guidance on a model complaints handling procedure. She explained that the CHP had set out governance arrangements, administration, timescales and decision making processes and noted that the IJB was required to submit a Compliance Statement and Self-Assessment to the SPSO by 3 July 2017, following which the SPSO would advise on whether further amendments would be needed. Ms McKenna confirmed that the final CHP would be uploaded onto the Partnership's website for public inspection.

Thereafter there were questions on the scope of the CHP and guidance to service users who may want to complain about services provided by one of the IJB's partner organisations; how complaints about senior Partnership staff would be handled; the complaints procedure for on the spot resolutions, the responsibility for signing off IJB complaints; and arrangements for the complaints process and performance to be monitored by the Committee.

DRAFT

The Committee resolved:-

(i) to request further clarity to enable service users to use the appropriate route when complaining about services provided on behalf of the IJB by Aberdeen City Council and NHS Grampian;
(ii) to request further information on how complaints about senior Partnership officers would be handled;
(iii) to request that a performance report on IJB complaint handling be presented to the Committee on a bi-annual basis;
(iv) to instruct officers to seek guidance from the SPSO on protocols for signing off IJB complaints; and
(v) to instruct the Partnership's Business Manager to circulate a revised version to Committee members for comment and approval ahead of submission to the SPSO by 3 July 2017.

REVISED BOARD ASSURANCE AND ESCALATION FRAMEWORK

6. The Committee had before it a report by Alex Stephen (Chief Finance Officer, ACHSCP) that presented the revised Board Assurance and Escalation Framework (BAEF) for approval.

The report recommended:-

That the Committee -

a) Comment on the revised BAEF, as in appendix A; and
b) Recommend the revised BAEF be approved by the Integration Joint Board.

Alex Stephen advised that the Executive Team had recently reviewed the BAEF following the Committee's first year of operation and noted that the Framework had been updated to compliment the IJB's Local Code of Governance which had been agreed at the Committee's previous meeting. Mr Stephen explained that the BAEF set out reporting arrangements for the Corporate Risk Register and the formal cycle of business in relation to performance, risk and financial management. He added that a key aim of the BAEF was to reduce the duplication of reporting between the IJB and its committees and highlighted that committees had remits which aimed to strengthen the IJB's governance arrangements to enable the Board to focus on effecting transformational change.

Thereafter the Committee highlighted the importance of preparing a framework that was contextual and easy to read to make the IJB more transparent in order to increase public engagement. Members suggested a number of changes that could be made to support this aim and requested that a revised version be presented to the Committee's next meeting.

The Committee resolved:-

(i) to request that references to the Corporate and Operational Risk Registers be standardised or differentiated where appropriate within IJB reports and governance documents;
(ii) to request that the Chief Finance Officer liaise with Councillor Cooke to receive feedback on the BAEF; and
(iii) to instruct the Chief Finance Officer to present a revised version of the BAEF to the Committee's next meeting on 21 August 2017.

DRAFT

INTERNAL AUDIT ANNUAL REPORT AND INTERNAL FINANCIAL CONTROL STATEMENT 2016-17

7. The Committee had before it a report by David Hughes (Chief Internal Auditor) which provided Internal Audit's Annual Report and Internal Financial Control Statement for 2016/17.

The report recommended:-
That the Committee –
a) Note the Internal Financial Control Statement for 2016/17;
b) Note that the Chief Internal Auditor has confirmed the organisational independence of Internal Audit;
c) Note that there has been limitation to the scope of Internal Audit work during 2016/17; and
d) Note that no self-assessment has been undertaken as required by the Public Sector Internal Audit Standards as an external assessment is being completed by KPMG which will be reported to Aberdeen City Council's Audit, Risk and Scrutiny Committee.

David Hughes advised Internal Audit could provide reasonable assurance on the IJB's internal control system. He explained that he was obliged to confirm the independence of the IJB's internal auditors and as Chief Internal Auditor he took the opportunity to do so. Mr Hughes highlighted the limitations on Internal Audit and this largely centred on the lack of access to ACC's Care First System but informed the Committee that Internal Audit had recently reached an agreement with the Council on this issue and he was now sufficiently satisfied to advise that this limitation would no longer be included in future reports. He also noted that internal auditors were required to undertake an annual self-assessment with a periodic external assessment carried out. This would be conducted by KPMG in relation to 2016-17 and their findings were due to be reported to the Council's Audit, Risk and Scrutiny Committee on 26 September 2017.

Thereafter there were questions on Internal Audit's access to the Care First System; and the scope of Internal Audit's remit, with a particular focus on its access to NHSG data. The Committee also discussed how audit committee meetings of the IJB and its partner organisations could be streamlined to better co-ordinate Internal Audit's reporting arrangements.

The Committee resolved:-
(i) to note the Internal Financial Control Statement for 2016/17;
(ii) to note that the Chief Internal Auditor has confirmed the organisational independence of Internal Audit;
(iii) to note that there had been limitation to the scope of Internal Audit work during 2016/17;
(iv) to note that no self-assessment had been undertaken as required by the Public Sector Internal Audit Standards as an external assessment was being completed by KPMG which would be reported to Aberdeen City Council's Audit, Risk and Scrutiny Committee; and
(v) to request that Partnership officers liaise with colleagues from ACC and NHSG to co-ordinate the scheduling of their respective audit committees to support a more streamlined reporting process.

FINANCE UPDATE

8. The Committee had before it a report by Alex Stephen which: (1) summarised the current year revenue budget performance for the services within the remit of the Integrated Joint Board for the period to end March 2017; (2) advised on any areas of risk and management action relating to the revenue budget performance of the Integrated Joint Board (IJB) services; and (3) requested approval of budget virements so that budgets are more closely aligned to anticipated income and expenditure.

The report recommended:-
That the Committee –
(a) Note this report in relation to the IJB budget and the information on areas of risk and management action that are contained herein;
(b) Note that the Executive Team are reviewing this position in conjunction with the 2017/18 budget to determine any shortfalls or additional funds available as a result of the outturn position; and
(c) Note the virements identified in Appendix E.

Alex Stephen advised that the Board was in a more favourable financial position than anticipated due to a receipt of additional income and a reduction in primary care and prescribing costs. Mr Stephen provided assurance on the robustness of the Partnership's financial system and explained that the Executive Team had been challenging budget holders within the Partnership to learn lessons from the previous year to identify additional areas where efficiencies could be made. He added that the format of the financial report was currently being reviewed by the Executive Team to provide clearer links with IJB Directions and this would be presented to the Committee in due course.

Thereafter there were questions on historical issues relating to unmet budget reductions; budget lines and movements relating to Locums; the level of in-house client contributions; the anticipated overspend on prescribing due to factors such as Sterling's exchange rate; the level of underspend due to staff vacancies; the likelihood of further budgetary clawbacks; the use of Transformation Funding to achieve efficiency savings; the expected number of recurring virements; and the Board's accumulation of reserves and strategy to utilise these funds.

The Committee resolved:-
(i) to note the report in relation to the IJB budget and the information on areas of risk and management action that are contained therein;
(ii) to note that the Executive Team are reviewing this position in conjunction with the 2017/18 budget to determine any shortfalls or additional funds available as a result of the outturn position;
(iii) to note the virements identified in Appendix E and to further note that the virements would be presented to the IJB meeting on 15 August 2017 for approval; and
(iv) to instruct the Clerk to circulate slides to Councillors Cooke and Duncan from the IJB's Prescribing Workshop session held on 7 March 2017.

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UNAUDITED FINAL ACCOUNTS

9. The Committee had before it a report by Alex Stephen which provided the Committee with an opportunity to review and comment on the unaudited final accounts for 2016/17.

The report recommended:-
That Committee -

a) Consider and comment of the Integration Joint Board's Unaudited Accounts for 2016/17;
b) Note the revised Annual Governance Statement and assurances provided from NHS Grampian, Aberdeen City Council and the internal auditors; and
c) Agree to bring forward the Committee's meeting date on 12 September 2017 to 21 August to ensure that the IJB annual accounts can be agreed and submitted in a timely manner to partner organisations.

Alex Stephen advised that in drafting the accounts he had closely followed the CIPFA template, and outlined his hope that auditors across Scotland could liaise on a standard way to audit IJB accounts particularly as these were the first set of annual accounts to be audited. He advised that changes to the Annual Governance Statement may have to made as new information became available and he highlighted the Partnership's responsibility for operating Kingsmead Nursing Home as an example of a recent addition to the Statement.

Thereafter there was discussion on whether the Management Commentary could be interpreted from a political perspective; and questions on the parameters of significant market failure within the social care market; and the Partnership's source for demographic information contained within the Management Commentary.

The Committee resolved:-

(i) to revise Jonathan Passmore's term as Vice Chairperson on page 127 to read *April 2016 to December 2016;*
(ii) to request that officers in consultation with the Chairperson of the IJB, review references to potential risks to the IJB if additional funding from the Scottish Government was not made available in future years on page 121;
(iii) to note the revised Annual Governance Statement and assurances provided from NHS Grampian, Aberdeen City Council and the internal auditors; and
(iv) to agree to bring forward the Committee's meeting date on 12 September 2017 to 21 August to ensure that the IJB annual accounts can be agreed and submitted in a timely manner to partner organisations.

PROFESSOR MIKE GREAVES, Chairperson.

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Aberdeen City Health & Social Care Partnership
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CLINICAL AND CARE GOVERNANCE COMMITTEE
Minute of Meeting

10am, 28th of June 2017
Health Village, Aberdeen

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Present: Councillor Alan Donnelly (Chairperson), Jonathan Passmore MBE (Chair Person, IJB), Councillor Gill Samarai, Dr Nick Fluck (NHSG Board Member)

Also in attendance: Dr Stephen Lynch (Clinical Director, Aberdeen City Health & Social Care Partnership), Dr Howard Gemmell (Patient/Service User Representative), Tom Cowan (Head of Operations, Aberdeen City Health & Social Care Partnership), Ashleigh Allan (Clinical Governance Facilitator), Heather Macrae (Professional Lead for Nursing & Quality Assurance), Laura Mcdonald (Trade Union/Staffside Rep), Claire Duncan (Lead Social Worker), Trevor Gillespie (Team Manager, Performance Management),

Apologies: Judith Proctor (Chief Officer)

OPENING REMARKS FROM THE CHAIR

Cllr Donnelly opened the meeting.

MINUTE OF PREVIOUS MEETING – 14 MARCH 2017

1. The Committee had before it the minute of the previous Committee meeting of the 14th of March 2017.

The Committee resolved to:-
Approve the minute as a correct record.

BUSINESS STATEMENT

2. The Committee had before it a statement of pending business for information.

With reference to No. 4 Heather Macrae informed the Committee that she is taking this forward and has contacted Rosie Cooper, Falls Lead.

The Committee resolved to:-

i. Note the statement.

REPORTS FOR THE COMMITTEE'S CONSIDERATION

ADVERSE EVENT (SIGNIFICANT EVENT ANALYSIS) AND COMPLAINT REVIEWS IN GENERAL PRACTICE.

3. The committee had before it a report by Dr Stephen Lynch (Clinical Director, ACHSCP) which provided information on the themes from the 2016/17 contract review visits to general practice. It additionally provided an analysis of adverse and significant events in practices that don't use Datix and provided more information on the checks and balances around peer reviews.

The report recommended:-
That the Clinical & Care Governance Committee -

a) Request and review an annual report on the themes from practice contract visits;
b) Instruct the Clinical Director, in conjunction with the locality GP leads, to facilitate cluster based SEA review and shared learning, and to explore opportunities for cross sector SEA work; and
c) Instruct Health and Social Care Partnership officers to engage with NHS Grampian on future versions of Datix and encourage its use in primary care settings.

Referring to the first recommendation Mr Passmore asked for assurance; stated the Committee encourages 100% participation; and we ensure it is absolutely comprehensive. Referring to the second recommendation he felt it important the

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Partnership supports this work and particularly emphasised the learning element be broadened and we **must find opportunities,** instead of explore opportunities.

The Committee resolved to:-

Amend the recommendations, and to add a fourth, to read:

i. Request and review an annual report on the themes from practice contract visits and to encourage full participation in the process;
ii. Instruct the Clinical Director, in conjunction with the locality GP leads, to facilitate cluster based SEA review and shared learning, and to ensure opportunities for cross sector SEA work are maximised; and
iii. Instruct Health and Social Care Partnership officers to engage with NHS Grampian on future versions of Datix and encourage its use in primary care settings.
iv. Instruct the Clinical Director to engage with the NHS process in relation to the Duty of Candour

MENTAL HEALTH AND LEARNING DISABILITY STAFFING

4. The committee had before it a report by Tom Cowan (Director of Operations, ACHSCP) which provided an update on issues in the Mental Health and Learning Disabilities (MH&LD) services relating to the current staffing position across both delegated services within ACHSCP and within those Acute services under the direct management of NHS Grampian.

The report recommended:-
That the Clinical & Care Governance Committee -

a) Request the development of a detailed action plan to be presented at the next Clinical & Care Governance Committee; and
b) Request quarterly updates on progress at committee.

Cllr Samarai asked for assurance that there is sufficient time for the detailed action plan to be presented to the next Committee meeting, considering its going to encompass a collaborative whole system approach. Mr Cowan said he would go back to the author of the report and check the timelines.

Dr Fluck provided a national overview of the current staffing situation. For doctors in training there is a 68% overall fill rate into training positions, at every single stage of training there are more posts than there are even people who could fill them. In GP training the position is slightly better in the north, in terms of schemes for the national average, it is into the 70s. The government created a hundred new GP training posts which lead to an overall recruitment of 25 more GP trainees across the country, however it has skewed the distribution of where they have taken up positions with remote and rural areas being most hit, for example there is a 50% vacancy rate in Elgin and people have chosen to go more to the conurbations. Dr Fluck added the picture is unlikely to change. The additional factors are part-time working; only 11% intend to work full-time. In terms of retirement age for doctors this has gone down.

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With regard to the EU we know the numbers of EU doctors wanting to come to the UK has almost vanished in the last year.

Mr Passmore acknowledged the current situation and said it isn't just about recruitment it is also about the impact on the staff we have got, it is extremely critical. There might be little we can do in the short term to alleviate the pressures they are under but we must ensure we communicate what we are trying to do, even if it is just to acknowledge their problems and reassure them we are working on them. Referring to having a balanced approach to this Mr Passmore said it must be fully balanced.

It was recommended a piece of work be commissioned very quickly, for the Chairs Group, to look at what national activity is going on and where we are in a) influencing it; and b) implementing any of the work that is taking place locally. When we have the opportunity this would be escalated to the IJB. Furthermore Mr Passmore would have the opportunity, at the national group to bring what leverage he can, as well as be well informed.

The Committee resolved to:

i. Request the development of a detailed action plan; and
ii. Request updates on progress at every Clinical & Care Governance committee on progress of that plan.
iii. Request national activities, including our compliance, in order to inform the IJB on progress.

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CLINICAL & CARE GOVERNANCE MATTERS

CLINICAL & CARE GOVERNANCE GROUP – SUMMARY REPORT

5. The committee had before it a report by Dr Stephen Lynch (Clinical Director, ACHSCP) which provided the details of any governance issues or concerns that the Clinical & Care Governance Group agreed should be escalated to the committee.

The report was accompanied by the following appendices:

- **Agenda Item 5a -** Approved minute of the Clinical & Care Governance Group meeting (8th February 2017)

- **Agenda Item 5b -** Draft minute of the Clinical & Care Governance Group meeting (31st May 2017)

- **Agenda Item 5c -** Clinical & Care Governance Group report

The report recommended:-

That the Clinical & Care Governance Committee -

a) Note the content of the report

The Committee resolved to:-

i. Note the content of the report.

GOVERNANCE DATA

SUMMARY REPORT – NHS ADVERSE EVENTS

6 The committee had before it a report from Ashleigh Allan (insert job title) which provided an overview on the NHS adverse event report for 1st January – 31st March 2017.

The report was accompanied by the following appendix:

- **Agenda Item 6a –** Incident Report (NHS)

The report recommended:-
That the Clinical & Care Governance Committee -

a) Acknowledge that the report provides the assurance required.

The Committee resolved to:-

i. Acknowledge that the report provides the assurance required.

SUMMARY REPORT – NHS FEEDBACK

7 The committee had before it a report from Ashleigh Allan (Clinical Governance Facilitator) which provided an overview of the NHS feedback report for 1st of January – 31st of March 2017.

The report was accompanied by the following appendix:

- **Agenda Item 7b –** Feedback Report (NHS).

The report recommended:-
That the Clinical & Care Governance Committee -

a) Acknowledge that the report provides the assurance required.

The Committee resolved to:-

i. Acknowledge that the report provides the assurance required.

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SUMMARY REPORT - SOCIAL WORK DATA

8 The committee had before it a report from Trevor Gillespie, Team Manager, which sought to provide an analysis to support the performance information presented to the committee.

The report was accompanied by the following appendix:

- **Agenda Item 8a –** Adult Social Care Health & Safety Report

The report recommended:-
That the Clinical & Care Governance Committee -
a) Note the content of the report

Claire Duncan referred to the report and highlighted a couple of concerns in terms of social work. With regards to Health & Safety, and the number of actions outstanding, 19 work place inspections have been completed but only 12 returns.

In terms of the outstanding tasks, from the ones that were completed, they include fire and safety risk assessments. Mrs Duncan informed the committee that she will be taking these forward for resolving, but posed the question did the committee want updates on particular outstanding issues? Mr Cowan responded and said the committee do want assurances, around the non returns, this is not optional. It was noted that Fire safety certificates, checks, availability of protocols are in place, this includes commissioned services. Assurance is sought urgently as a matter of priority, as compliance with fire safety check was of considerable concern to the committee.

The second concern Mrs Duncan drew attention to was that of social work staff absence and the significant rise in short term absences, particularly within the learning disability service. 1800 days over a 3 month period have been lost. Mr Cowan advised he has brought in, short term, an experienced NHS manager to take over the temporary leadership of learning disability services to provide some support to the Head of LD services.

The Committee resolved to:-
i. Note the content of the report
ii. Express concern around the increasing absence for psychological reasons, across the board, and request a report back on actions being taken across the whole partnership.
iii. Bring, out of committee, reassurance in compliance of health and safety responsibilities of both in-house services and to commission services. Officers to be tasked to deliver this assurance to the committee.

ITEMS TO REPORT TO THE INTEGRATION JOINT BOARD

9 The Chair of the Committee invited any escalations to the IJB.

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There was one escalation:

1. Mr Gillespie referred to the social work complaints process and pointed out changes from the 1st of April this year. He wished to make the committee aware this has been signed off and is compliant. The committee suggested a presentation on the changes be taken to the Clinical Care Governance Group, and any recommendations be brought here.

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1. Mr Passmore raised data virus attacks and asked for assurance on the ability of services to continue in the event there is an attack. Dr Fluck spoke of a business continuity solution and of its effectiveness in using web based access to Vision 360. Dr Fluck also said there is likely to be a full debrief report. Dr Lynch advised that practices also manually print off a list of patient appointments at the end of each day. Mr Cowan pointed out the Board have signed off a significant sum of money to be invested in technology and IT in relation to future business continuity.

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BUSINESS STATEMENT

15 AUGUST 2017

Please note that this statement contains a note of items which have been instructed for submission to, or further consideration by, the Integration Joint Board (IJB). All other actions which have been instructed are not included, as they are deemed to be operational matters after the point of decision. Items which have been actioned are shaded.

No.	Minute Reference	IJB Decision	Update	Lead Officer(s)	Due
1.	TLG 17.11.14 Article 3	**Delegated Functions and Services** The TLG agreed that the starting position in terms of delegated functions and services would be those set out in set one of the regulations and orders as set out in tables 2 and 3 appended to the report, and within that starting point, agreed that further work on the handling of NHS services delivered across the north east and in relation to hosted services within scope would be carried out by the Strategic Change Management Group and recommendations brought back to the Shadow Board.	The Scheme of Delegation was deferred by the Board at its meeting on 28 June 2016 and will be aligned to the development of Aberdeen City Council's revised Scheme of Delegation.	Chief Officer, Aberdeen City Health and Social Care Partnership	31.10.17
2.	sIJB 27.01.15 Article 5	**Delayed Discharges** The Shadow Board agreed in principle to the proposals attached and for officers to develop these further. The Shadow Board also agreed to additional funding support from the Scottish Government and to receive regular updates on progress in developing this work and in relation to Delayed Discharge performance.	The Board resolved at its meeting on 6 June 2017 to receive bi-annual updates. **Recommended for removal**	Service Manager, Aberdeen City Health and Social Care Partnership	12.12.17

No.	Minute Reference	IJB Decision	Update	Lead Officer(s)	Due
3.	sIJB 31.03.15 Article 5	**Winter Planning** The Shadow Board requested a report that would provide an early update on winter planning and the roles of both parent organisations be added to the schedule and for said report to be submitted no later than the August meeting.	A report on Winter Planning is on today's agenda.	Chief Officer, Aberdeen City Health and Social Care Partnership	15.08.17
4.	sIJB 27.10.15 Article 6	**Document Management** The Shadow Board requested a report on document management and storage.	The IJB's Complaints Handling Procedure was approved by the Audit and Performance Systems Committee on 20 June 2017. Thereafter a Compliance Statement and Self-Assessment were submitted to the Scottish Public Services Ombudsman ahead of the 3 July 2017 deadline. **Recommended for removal**	Chief Officer, Aberdeen City Health and Social Care Partnership	15.08.17
5.	sIJB 27.10.15 Article 7	**Performance Assurance Framework** The Shadow Board requested a report on the development of a performance assurance framework.	A report on the Performance Management Framework is due to be presented to the Board's next meeting on 31 October 2017.	Chief Officer, Aberdeen City Health and Social Care Partnership	31.10.17
6.	sIJB 23.02.16 Article 5	**Locality Planning** The Shadow Board requested a timetable which outlined the development of locality planning.	A Locality workshop session was held on 20 June 2017.	Integrated Localities Programme Manager, Aberdeen City Health and Social Care	12.12.17

No.	Minute Reference	IJB Decision	Update	Lead Officer(s)	Due
				Partnership	
7.	sIJB 23.02.16 Article 6	**Clinical and Care Governance Framework** The Board resolved to defer decision making on the Clinical and Care Governance Framework on 23 February 2016 to the Board's next meeting on 29 March 2016.	The 28 June 2017 minute of the Clinical and Care Governance Committee is on today's agenda.	Chief Officer, Aberdeen City Health and Social Care Partnership	15.08.17
8.	IJB 30.08.16 Article 5	**Standing Orders** The Board requested that officers review standing order 23 and report back to the Board.	A report on Standing Orders shall be submitted to the Board's next meeting on 31 October 2017.	Legal Services, ACC	15.08.17
9.	IJB 30.08.16 Article 12	**Ethical Care Charter** The Board requested an update on the work of the Ethical Care Charter Working Group	An update report on the Ethical Care Charter is on today's agenda.	Chief Officer, Aberdeen City Health and Social Care Partnership	15.08.17

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Aberdeen City Health & Social Care Partnership
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INTEGRATION JOINT BOARD

Report Title	Unison Ethical Care Charter
Lead Officer	Judith Proctor, Chief Officer
Report Author (Job Title, Organisation)	Claire Duncan, Lead Social Work Officer
Report Number	HSCP/17/067
Date of Report	5 July 2017
Date of Meeting	15 August 2017

1: Purpose of the Report

1.1. The purpose of this report is to update on progress with the scoping and planning for the implementation of UNISON's Ethical Care Charter.

1.2. The Charter was presented to the Integrated Joint Board and endorsed in July 2016 and the recommendation to sign up to the Charter was endorsed at a meeting of Aberdeen City Council in October 16. The Chief Officer was tasked with drafting an action plan with timescales for implementation.

2: Summary of Key Information

2.1 In October 2012 UNISON launched its Ethical Care Charter, and invited all Public Sector Commissioners for Care at Home to sign up to the Charter.

2.2 UNISON conducted a survey of homecare workers in summer of 2012 and received over 400 responses. The findings led them to describe homecare staff as a committed but poorly paid and treated workforce. The findings highlighted that poor terms and conditions could contribute towards lower standards of care for people in receipt of homecare services.

2.3 In light of UNSION's findings, they called for councils to commit to becoming Ethical Care Councils by commissioning homecare services which adhere to the Charter. The objective is to establish a minimum baseline for the safety,

quality and dignity of care by ensuring employment conditions which a) do not routinely short-change clients and b) ensure the recruitment and retention of a more stable workforce through more sustainable pay, conditions and training levels.

2.4 Aberdeen City Council signed up to the Charter in conjunction with its primary care at home provider, Bon Accord Care after the recommendation in October 16 at full council.

2.5 Given the role of the IJB is as a commissioning body which contracts its services through procurement led by ACC, it has no requirement to sign up to the Charter, but can, through its commissioning role, support implementation of its recommendations.

2.6 An Ethical Care Charter working group has now been established led by the Lead Social Work Officer. The role of the group is to develop the action plan, scope the potential impacts of implementing the Charter and establish clear timescales for implementation of the Charter. The group consists of representation from across the Partnership including operational colleagues, providers, contracts and commissioning, finance, and UNISON.

2.7 The Charter sets out requirements of each stage of implementation. These are set out below with (in italics) a brief description of existing arrangements within Aberdeen City:

Stage 1:

- The starting point for commissioning of visits will be client need and not minutes or tasks. Workers will have the freedom to provide appropriate care and will be given time to talk to their clients. *(Assessments are already carried out based on need)*
- The time allocated to visits will match the needs of the clients. In general, 15-minute visits will not be used as they undermine the dignity of the clients (*Care is currently not commissioned in time slots but the way we pay for care is in 15 minutes blocks. Work has been undertaken around these bandings and how we pay for care)*
- Homecare workers will be paid for their travel time, their travel costs and other necessary expenses such as mobile phones. (*Initial scoping has determined that a large majority are already paid travel time. Ensuring the others are*

also paid travel time will potentially have financial implications for future however the plan of locality based working will help reduce the impact of any additional costs)

- Visits will be scheduled so that homecare workers are not forced to rush their time with clients or leave their clients early to get to the next one on time (*The partnerships commissioning intentions and model of locality based working should ensure that carers have more autonomy to provide care relevant to individual need which will in turn improve job satisfaction, recruitment, retention and quality of care*)
- Those homecare workers who are eligible must be paid statutory sick pay (*Initial scoping has determined that the majority of staff are already paid sick leave.)*

Stage 2:

- Clients will be allocated the same homecare worker(s) wherever possible (*The partnerships commissioning intentions and model of locality based working should deliver this along with improving care delivery as an attractive career option which will improve the recruitment, and retention of staff.*)
- Zero hour contracts will not be used in place of permanent contracts. (*Initial scoping has determined that some providers use zero hours contracts, not in place of permanent contracts but for bank staff. Further research will be undertaken to ascertain the overall position amongst Providers and seek a solution.*
- Providers will have a clear and accountable procedure for following up staff concerns about their clients' wellbeing. (*Investigations will be made into what providers are currently doing in regards to this.)*
- All homecare workers will be regularly trained to the necessary standard to provide a good service at no cost to them and in work time. (*The current situation is varied across Providers.* It is likely this *may have potential financial implications to the partnership)*
- Homecare workers will be given the opportunity to regularly meet co-workers to share best practice and limit their isolation. (*Again this is not common across Providers and requires further analysis)*

Stage 3:

- All homecare workers will be paid at least the Living Wage. (*Since October 2016, providers of adult social care have been funded to pay the Scottish Living Wage. Monitoring is ongoing to ensure this is happening.)*
- If Council employed homecare workers paid above this rate are outsourced it should be on the basis that the provider is required, and is funded, to maintain these pay levels throughout the contract. (*Externally commissioned providers of adult social care will be funded to pay at least the Scottish Living Wage. This will be a requirement of their contract and will be in place for the duration of the contract.)*
- All homecare workers will be covered by an occupational sick pay scheme to ensure that staff do not feel pressurised to work when they are ill in order to protect the welfare of their vulnerable clients**.** (*Initial scoping has determined*

that the majority of providers have an occupational sick pay scheme).

Current Care at Home Provision

2.8 Aberdeen City Council commissions 80% of its care at home services externally, with the remaining 20% delivered through Bon Accord Care. Changes made in relation to some aspects of implementing the Charter will have a financial impact and these will be scoped as part of the work being undertaken by the working group. Where these have a significant impact, a decision will be required by the IJB.

2.9 Weekly figures in regard to homecare service commissioning is set out in table 1 below:

Table 1 Weekly figures:

	All Home Care (including direct payments (DPs))	Home Care- Commissioned
Clients	**1,869**	**1,757**
Providers	**44**	**42**
Hours	**23,691.21**	**19,710.96**
Estimated weekly Cost	**£362,235**	**£302,803**

2.10 The table demonstrates both the extent of hours of care provided each week, as well as the number of providers engaged by ACC under contract or framework agreements.

2.11 A significant amount of work has already been undertaken which supports the delivery of the requirements in the Ethical Care Charter and how we commission care at home services in the future.

2.12 The allocation of a 6.4% increase in rates in October 2016 followed by a further 2.8% in April 2017 has allowed commissioned providers to pay their staff the Scottish Living Wage which is £8.45 per hour.

2.13 The production of the Strategic Plan sets a clear direction for the Partnership and for our commissioned providers.

2.14 The co-production of the Strategic Commissioning Implementation Plan and its Market Facilitation Statement allows commissioned providers to identify concerns around ethical care and help shape flexible service re-

design to address these.

2.15 It was agreed at the last IJB that a design of a revised service specification for care at home would be undertaken which would inform an interim retendering process with new contracts being established initially from 1st January 2018. A 'Care at Home' work stream has also been established to inform and influence the development of future commissioning arrangements beyond January 2020. The aspiration of the work stream is for our care at home provision to be aligned with our emergent locality model and for existing individual client group arrangements to be aligned into a single cross client group care at home framework with a more straightforward pricing structure.

2.16 It is therefore an ideal time to ensure that all aspects of the Ethical Care Charter are firmly embedded within our commissioning plan. It is clear that the current model of care at home provision could be improved. We aim to move away from a time and task approach towards a service provision that focuses on a person centred approach meeting individual outcomes. This aligns with the ethos of the Charter.

2.17 Further work is required to finalise the scoping and potential impact of implementing the Ethical Care Charter commitments hence the reason the working group has been set up. Delivery of the Charter requires collaborative working with our commissioned providers and partners and not only are they represented on the group and on the commissioning work-streams, but they will also take the lead in delivering some of the actions. There is also a requirement to assess the impact the Charter will have in Aberdeen and how this shapes a new model of home care delivery as we move into locality working.

2.18 The Draft Action Plan attached at Appendix A is the beginning of the identification of this work. The plan will be further developed over time as we move through stage one actions and on to the later stages. Further reports will be submitted to the Integration Joint Board on the progress being made and any decisions that are required by the IJB.

INTEGRATION JOINT BOARD

3:	Equalities, Financial, Workforce and Other Implications

Equalities Implications

3.1 100% of our care at home is commissioned from external providers. Implementation of the recommendations will improve working conditions and have a positive impact on the external workforce which provides our services. The recommendations are also expected to have positive implications in relation to our service users across the Partnership as required services will be more readily available, more consistent, more sustainable and of a higher quality.

Financial Implications

3.2 Some elements of the Charter will undoubtedly require consideration of the existing funding conditions and will require a review of existing contracts. The Health and Social Care Partnership will be required to financially support changes required for the Charter and the funding implications for this would need to be explored. In addition new increased hourly rates will mean that delivering the same volume of activity will cost more but it is also envisaged that a more coherent framework will help to address unmet care need. Further consideration will need to be given as to how minimise this risk.

Workforce Implications

3.3 The care at home sector has significant recruitment and retention challenges. Payment of the living wage to staff will help address some of this as will the retendering exercise that aims to make the market more sustainable. The majority of the workforce is female, so this will have greater impact on them rather than men. There will be no workforce implications for the Partnership.

4:	Management of Risk

4.1 Identified risk(s) and link to risk number on strategic risk register:

Strategic Risk 1 – There is a risk of significant market failure.

Strategic Risk 7 – There is a risk that the IJB and the services it directs and has operational oversight of, fail to meet performance standards or outcomes as set by

regulatory bodies and that, as a result, harm or risk to people occurs.

4.2 How might the content of this report impact or mitigate the known risks:

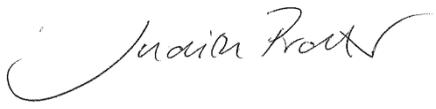
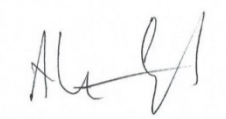
Implementation of the Ethical Care Charter should help mitigate these risks. The Aberdeen City Health and Social Care Partnership is heavily reliant on externally commissioned services. By supporting the improvement of working conditions of care staff there is a greater chance that the market will be more sustainable and that the quality of care will be improved.

5:	Recommendations

It is recommended that the Integration Joint Board:

1. Notes the ongoing and planned work in relation to the implementation of the Ethical Care Charter; and

2. Requests the Chief Officer arrange for further reports to be presented to the Integration Joint Board detailing the progress made in implementing the Ethical Care Charter on a six monthly basis.

6:	Signatures
	Judith Proctor (Chief Officer)
	Alex Stephen (Chief Finance Officer)

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Appendix A

Aberdeen City Health & Social Care Partnership
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Draft Ethical Care Charter Action Plan

Stage 1					
	Action	**Responsible**	**Tasks**	**Timescales**	**Update**
1.1	Scope issues relating to 15 minute visits and these not being used in future	Lead Social Worker	Review all 15 minute packages with a view to these being discontinued when appropriate	To be established once numbers are obtained.	Requested CareFirst report showing volume of 15 minute slots in care management
1.2	Scope cost and impact of homecare working being paid travel, travel costs and other expenses, within financial parameters of the HSCP	CASPA rep	Work to be undertaken to scope potential cost of paying travel time/mobile phones.	31st December 2017	Obtain comparison samples from different client groups. To be considered at next CASPA meeting in August.
1.3	Scope Homecare workers who are eligible being paid statutory sick pay	ACVO	Conduct survey to establish position re payment of statutory sick pay (where eligible)	To be determined once scale of task is identified	
1.4	Guidance on Adopting the Charter to be given to all providers for their consideration in groups with request they identify any issues re implementing Charter content.	Emma Watt Nick Price Joyce Duncan	Request provider groups/forum to identify any issues re implementing Charter and feed up to group	30th September 2017	

Appendix A

Aberdeen City Health & Social Care Partnership
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Stage 2					
	Action	**Responsible**	**Tasks**	**Timescales**	**Update**
2.1	Scope issue of Zero hour contracts and these not be used in place of permanent contracts	ACVO	Conduct survey to establish which providers use zero hours contracts	31st December 2018	
2.2	Scope issue of workers are trained to necessary standard at no cost to themselves and in work time	Provider reps and contracts	Conduct survey to establish current arrangements for training and assess scope of work to meet action.	31st December 2018	

Stage 3					
	Action	**Responsible**	**Tasks**	**Timescales**	**Update**
3.1	All homecare workers to be paid the living wage	Head of Strategy and Transformation	Conduct survey to confirm funding provided is being used to pay workers the Scottish Living Wage	31st December 2018	Initial survey undertaken in relation to Oct 2016 uplift. This to be revisited. April 2017 uplift is not being processed until contract variation is signed. Further assessment required to confirm all providers have signed, are in receipt of uplift and are paying the new rate of SLW.

Aberdeen City Health & Social Care Partnership
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INTEGRATION JOINT BOARD

Report Title	Learning Disability Services Commissioning Framework
Lead Officer	Judith Proctor, Chief Officer
Report Author (Job Title, Organisation)	Katharine Paton, Service Manager (Learning Disabilities)
Report Number	HSCP/17/068
Date of Report	13th July 2017
Date of Meeting	15th August 2017

1: Purpose of the Report

This report seeks approval to recommission the Framework for Learning Disability services by replacing the existing framework with a :

1. Framework for Supported Living Services and

2. Framework for Training and Skills Development Services which will be commissioned in partnership with Aberdeenshire Health & Social Care Partnership

These commissioning arrangements will support the delivery of improved, person centred services to people with a Learning Disability whilst delivering greater choice and better utilising the skills and expertise of Social Care Providers.

2: Summary of Key Information

2.1 Background

Support for people with a Learning Disability was commissioned via a Framework in 2015. The Framework was divided into 2 Lots:

Lot 1: Support with personal care and housing.

Lot 2: 'Lifestyle Support' was previously referred to as Day Supports.

This current contractual arrangement was for 2 years with the option of two 1 year extension periods. The Framework is currently within the 1st year of extension which

ends on 31st March 2018. It is proposed that the contractual arrangement is not extended for a further year that it ceases by a target date of potentially on 31st December 2017, but no later than 31st March 2018 (see paragraph 2.3) and is replaced with the arrangements detailed in this report.

Existing Framework Arrangement

At the time of commissioning the current framework a benchmark rate was set by Aberdeen City Council. However, providers on the framework who supplied these services previously did so under a wide spectrum of rates, with no direct relationship between differential rates and complexity of the care. There was no differentiation on more complex care being rewarded with a higher rate to recognise, for example, the additional training and skills required.

Commissioning complex care provision has been difficult as providers struggle to support complex care at the stated framework hourly rate. As such services have had to purchase care out with the Framework often at a higher rate. This is not an efficient use of scarce resources and the improvements proposed in this report mean the use of suppliers out with the Framework will be minimal, if not non-existent.

2.2 Proposed Frameworks

Three frameworks are proposed to be used to provide to support to learning disability clients.

2.2.1 Framework for Supported Living Services

This new Framework will provide 'Supported Living' services to a person or group of individuals who have a variety of support needs to live successfully in their own home. These methods of support are distinct from those classified as Care at Home (visiting support).

Currently in Aberdeen care delivered under Supported Living can take the form, for example, of 5 people sharing a house of multiple occupancy and being support by on site care staff to manage everyday life tasks, such as personal care, household tasks including cooking and cleaning, budgeting, engaging community life, support with health conditions as well as an overnight staff member being located within the building. These are typically referred to as a 'service' and support provided to all of the tenants by one provider.

2.2.2 Framework for Training and Skills Development Services

This replacement Framework will provide Training and Skills Development Services.

INTEGRATION JOINT BOARD

A dialogue is ongoing with Aberdeenshire Health & Social Care Partnership around the joint commissioning of this Framework. Aberdeen City and Aberdeenshire populations use a number of same services, lending weight to a joint commissioning process.

Currently in Aberdeen support delivered under Training & Skills Development can take the form of a workshop environment where a person goes once or more per week and completes an activity such as cooking, music, gardening, or crafts. Other supports may focus on people completing a vocational qualification or undertaking training to prepare them for employment. These supports are generally provided by organisations which do not support people with direct care, due, in part, to Care Inspectorate registration requirements.

There are separate providers delivering support with Training and Skills Development. Support in this area of life is different from support within a person's own home and will be delivered by providers with different skills and expertise.

2.2.3 Framework for Care at Home

On the 6 June 2017 the Integration Joint Board approved the commissioning of a Framework for Care at Home which includes Care at Home for Learning Disability Services. This Framework will take effect from January 2018 and rates using the Charted Institute of Public Finance & Accountancy (CIPFA) guidance for commissioners in conjunction with the cost calculator provided by the UK Home Care Association (UKHCA) are being established. These are visiting support hours and as set out in 2.2.1 these are complementary to Supported Living services and therefore similar hourly rates would enable greater market stability.

2.3 Timeline

To align the commissioning work to be undertaken and support market stability the Framework for Supported Living follows the timeline of the Framework for Care at Home. Each framework arrangement will run until 31st December 2019 as interim while commissioning strategies are developed in line with locality based commissioning. The current framework arrangements cease on 31st March 2018 and it is proposed to commence the new contractual arrangements for Supported Living from 1st April 2018 at the latest, although ideally from 1st January 2018 to fully align with the Care at Home Framework. Engagement has already taken place with existing providers and they are aware of the proposed changes. The current contracts could only be terminated early by mutual agreement with providers. Should a provider choose to not terminate, their contract would run until 31st March and then transition to the new Framework contact from 1st April. There is a strong sense that providers will be agreeable to mutual termination on 31st December should this

timeline be progressed.

The joint arrangements for Training & Skills Development Services with Aberdeenshire Health & Social Care Partnership will take effect from 1st April 2018, with existing contracts continuing until 31st March 2018.

2.4 Current Rates and the Living Wage

Providers set their hourly rates in 2015 with no uplift during the life of the contract. Living Wage uplifts have been approved by the Integration Joint Board for providers within the current contractual arrangements, an initial 6.4% from 1st October 2016 and a further 2.8% uplift from 1st April 2017. These uplifts were funding from additional monies received as part of the financial settlement.

A total of 17 providers are on Lot 1 of the Framework 'Support with personal care and housing' with rates per hour ranging from £14.76 to £20.93, two of these providers no longer operate in Aberdeen City and a further two do not provide any learning disability support in Aberdeen.

A total of 11 providers are on Lot 2 of the Framework 'Lifestyle Support' with rates per day ranging from £38.28 to £54.69, only 4 are actively providing support.

The range of rates for these two Lots is broad given that support to be commissioned is the same regardless of provider. There is no crossover between the providers supplying 'Support with personal care and housing' and those actively supplying 'Lifestyle Support'.

Within Aberdeen City the Provider Market remains fragile. Challenges in recruitment and retention as well as ability to make service arrangements financially viable for organisations contribute to this.

The Framework for Supported Living will identify a 'standard' and an 'enhanced' rate. Criteria will be established to ensure fairness in the application of an enhanced rate, and rates would be set through the use of a cost of care calculator. Cost of Care Calculators have been developed by a number of different national organisations, with support from Government, in order to provide support to commissioners in securing care which is affordable, provides value for money and offers market sustainability. These calculators enable commissioners to model the cost of care on an hourly basis based on the Scottish Living Wage, other statutory employment requirements and aspects which fulfil the recommendations of the Ethical Care Charter. CIPFA have published guidance for commissioners in the setting of cost rates and in conjunction with the UKHCA cost calculator the following maximum prices have been established for Supported Living, with exact pricing subject to further refinement:

Standard Care - £17.50

This is care which is composed of direct support to individuals with a Learning Disability and associated conditions. The support requires knowledge of Learning Disabilities and general methods of care and support for individuals. There may be aspects of staff training which is specific to the person they support however this will not be excessive. Line management support for staff will be at a general level comparable with many other care and support services.

Enhanced Care - £19.50

This is care which is composed of direct support to individuals with a Learning Disability and associated complex conditions, such as physical or mental health and or challenging behaviour. This support is more complex in nature with staff requiring to be specially trained in care and support methods which are more intensive as well as specific training pertaining to the individual. Typically enhanced care and support will be delivered by more robust staff teams with enhanced management support. Many individuals will have bespoke support timetables and structures to deliver high quality safe care. Multi-disciplinary Teams will be involved on a more regular basis, with the person sometimes subject to particular legislation or guidelines in terms of their day-to-day support.

Benefits of undertaking a full commissioning exercise

2.8 Introduction of new providers who have capacity to provide supports

The current Framework is closed to new providers and is somewhat limited in capacity. There are some providers who do not provide support to people with a Learning Disability in Aberdeen (3 providers). There are other providers who although on the Framework have now withdrawn support from Aberdeen (2 providers). The remaining providers are at capacity and cannot provide any additional support to people. This is why support gets commissioned out with the framework. It is hoped that the providers we have commissioned in this manner will be part of the new Framework. The new Framework will be openly published to enable additional providers to submit a tender and potentially be accepted onto the framework.

2.9 Chance for providers to review rates

The fragility of the local market is the first entry on the Integration Joint Board's Risk Register. Adopting the recommendations in this paper will mitigate this risk as providers will align their business strategic plan to the Framework they bid for. Providers will submit rates which are reflective of the cost of providing such care and

support up to a maximum price per hour of care, £17.50 for Standard or £19.50 for Enhanced. Services will continue to be delivered within the overall budget envelope for Learning Disabilities. It is anticipated savings achieved from a more targeted and person centred approach will fund any increase in individual rates charged.

2.10 Greater focus on Training and Skills Development Services

Support for people to engage with training and skills development opportunities is a key priority for the Partnership as this enables people to fully explore and develop their skills and abilities whilst feeling valued as citizens, accepted and integrated into their local communities. This approach may ultimately achieve a reduction in longer term demand for services.

There are a number of organisations which provide supports to both Aberdeen City and Aberdeenshire, joint commissioning activity will prevent duplication by submitting separate tender bids, and it will provide consistency in relation to service delivery, cost and monitoring. Some providers delivering this support are not part of the framework. It is hoped that these providers will be part of the new Framework moving forward.

2.11 Use of Separate Frameworks

Splitting the commissioning of different service types for people with Learning Disabilities into different frameworks will enhance choice of service provision as an individual can access any of the frameworks (Care at Home, Supported Living, Training & Skills Development). They are not restricted to one Framework if they have assessed needs which can be met by another. This enables providers to deliver person centred support by providing a service which they have skill and expertise in.

A separate Framework for Supported Living and Training and Skills Development will allow providers to apply for the Framework which best suit their abilities. Supported individuals will receive more suitable person centred support from skilled providers to achieve their outcomes.

Appendices

1. Direction to Aberdeen City Council

2. Summary Risk Report (supporting information)

INTEGRATION JOINT BOARD

3:	Equalities, Financial, Workforce and Other Implications

Equalities Implications

It is believed that this report will have a neutral impact.

Financial Implications

In purchasing services, the Council and NHS Grampian must comply with the requirements of the Public Contracts (Scotland) Regulations 2015 ("the Regulations"), as well as Aberdeen City Council's and Aberdeenshire Council's Procurement Regulations ("Procurement Regulations 2016"). The Procurement Regulations relating to Contracts and Procurement have been drafted in such a way as to ensure compliance with "the Regulations."

The Services which form the basis of this report are classified as "light touch" regime (Regulations 74-76) services. This means that the full requirements of the Regulations do not apply. However, in relation to "light touch" regime (Regulations 74-76) Services, the Council and NHS Grampian must undertake a degree of advertising and follow a procedure leading to the award of a contract which is sufficient to enable competition in accordance with the principles of openness, fairness and non-discrimination. This requirement is founded in the Council's European Treaty obligations.

The Care at Home Framework project team has begun to identify a standard rate for an hour of Care at Home support, it is important that the rate for Supported Living services is complementary to ensure there is fairness in the procurement approach of the Partnership.

The current predicted spend for services classified as both Care at Home and Supporting Living amounts to £13.78 million per year. The supports to be purchased under the Care at Home Framework will amount to £1.2 million per year, with a proposed spend for Supported Living services on a new framework being £12.58 million per year. Of this figure Older People's services currently fund just under £1 million for people 65 and over with a Learning Disability in Learning Disability specific services (services which would be contracted under a new Supported Living Framework). It should be noted that these figures are not inclusive of any changes to Sleepover payments, as finalised figures have not been agreed.

It is viewed that payment of fair market rates as highlighted for Standard and

Enhanced Care are feasible within the current budget. Support arrangements for individuals are to be reviewed on at least a yearly basis, with promotion of creative support arrangements, including of the use of technology as a high priority for the service.

Workforce Implications

It is acknowledged that it is the decision of provider organisations whether they choose to bid for any of the Frameworks. Should a provider choose not to submit a bid for any of the Frameworks, any services they provide may need to be provided by another organisation, and TUPE (Transfer of Undertaking (Protection of Employment) Regulations 2006) may be applicable in this situation.

The Care Sector continues to experience significant challenges with regard to recruitment and retention of skilled and knowledgeable staff. The development of new contractual arrangements will enable providers to consolidate the issues facing the sector and submit rates which are accurate and reflective to the true cost of providing care and support.

Strategic Plan

The recommendations in this report complement the strategic priorities outlined in the Partnership's Strategic Plan primarily by supporting the development of person centred approaches to care and support and by enabling supported individuals to strengthen their connection and contribution to their local community.

4:	Management of Risk

Identified risk(s) and link to risk number on strategic or operational risk register:

- (1) There is a risk of significant market failure in Aberdeen City.

How might the content of this report impact or mitigate the known risks:

The content of this report seeks to mitigate the known risks by recommending a decision which supports the development and implementation of new commissioning arrangements for Learning Disability services which will provide market stability helping to achieve the future sustainability of services, and promote person centred care and support.

INTEGRATION JOINT BOARD

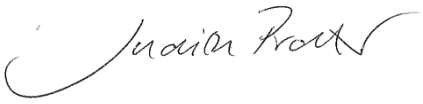
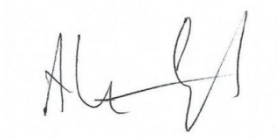
5:	Recommendations

It is recommended that the Integration Joint Board:

1. Agrees to retender the provision of Supported Living for people with a Learning Disability in the form of a Framework for Supported Living with a separate Lot for Enhanced Care provision (to the timelines as detailed within this report).

2. Agrees to retender the provision of 'lifestyle support' for people with a Learning Disability in the form of a Framework for Training & Skills Development Services through joint commissioning with Aberdeenshire

3. Notes that another paper will be presented to the Board in early 2018 detailing the result of the tender process and seeking approval to issue contracts

6:	Signatures
	Judith Proctor (Chief Officer)
	Alex Stephen (Chief Finance Officer)

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INTEGRATION JOINT BOARD

DIRECTION

ISSUED UNDER S26-28 OF THE PUBLIC BODIES (JOINT WORKING) (SCOTLAND) ACT 2014

The **ABERDEEN CITY COUNCIL/NHS GRAMPIAN** is hereby directed to deliver for the Board, the services noted below in pursuance of the functions noted below and within the associated budget noted below.

Services will be provided in line with the Board's Strategic Plan and existing operational arrangements pending future directions from the Board.

Related Report Number: - HSCP/17/068

Approval from IJB received on:-

Description of services/functions: - The commissioning of Supported Living services (inclusive of separate Lot for enhanced/complex care) and Training & Skills Development services (in partnership with Aberdeenshire HSCP) through the commissioning of 2 separate Framework arrangements for people with a Learning Disability.

Reference to the integration scheme:-

Services: - services listed in Annex 2, Part 2 of the Aberdeen City Health and Social Care Integration Scheme.

Functions: - functions listed in Annex 2, Part 1 of the Aberdeen City Health and Social Care Integration Scheme.

Link to strategic priorities (with reference to strategic plan and commissioning plan):-

- Develop a consistent person centred approach that promotes and protects the human rights of every individual and which enable our citizens to have opportunities to maintain their wellbeing and take a full and active role in their local community.
- Promote and support self-management and independence for individuals for as long as reasonably possible.
- Contribute to a reduction in health inequalities and the inequalities in the wider social conditions that affect our health and wellbeing.

Prior to sending this direction, please attach a copy of the draft IJB minutes, original report and the completed consultation checklist.

.....

- Strengthen existing community assets and resources that can help local people with their needs as they perceive them and make it easier for people to contribute to helping others in their communities.

Timescales involved:-

Start date: - no later than 1st April 2018

End date: - 31st December 2019

Associated Budget:-

Details of funding source: - Current Learning Disability Budget

Availability: - Current Budget of £12.58 million is to be utilised for commissioning care described as Supported Living, which falls under the scope of the report

Prior to sending this direction, please attach a copy of the draft IJB minutes, original report and the completed consultation checklist.

Summary Report

This appendix summarises the key risks should the Integration Joint Board choose not to approve the recommendations as sought in report number HSCP/17/068 on the Learning Disability Framework.

Identified risk(s):

As there is already approval to commission a Framework for Care at Home support there is a potentially high risk of market instability should there not be the same approval to commission the Frameworks detailed in this report. Many of the Learning Disability providers supply Care at Home and Supported Living; there is a significant risk of a two-tiered cost structure in organisations if the Framework for Supported Living is not commissioned in tandem with the Framework for Care at Home.

There is a risk that Providers may choose to remove themselves from the current Learning Disability Framework and concentrate on Care at Home services. This would leave a critical gap in service provision and compound the current difficulties we face in relation to delayed discharge. There would also be a lack of cohesion in the approach taken by Adult Social Care should the current Framework not be recommissioned as the Care at Home Framework will be.

Providers will continue to face challenges in relation to recruitment & retention. Organisations are stating they do not have the capacity or organisational viability to undertake work. As the current Framework Providers have been unable to fully meet the demands of the Learning Disability Service there has been no other choice but to commission care from out with the Framework. Alternative providers have been commissioned where they have evidenced available capacity in addition to the skills, knowledge and ability to support people with a Learning Disability. If the Framework is not recommissioned the service will still require to commission care out with the current Framework in these situations. These providers will become part of a recommissoned Framework.

Providers are already at restricted capacity; this issue will heighten unless more organisations are given an opportunity to join the Framework.

Some Providers have already made the decision to cease offering support in Aberdeen and it has proved difficult to secure replacement care.

The current Framework does not allow new providers to join without making substantial changes to the initial invitation to tender and contract, recommissioning of the Framework is only option to address these issues.

People with Learning Disabilities and complex health care needs are challenging the current providers due to the complexity of needs and the requirement for more enhanced support.

Over the past 3 years we have experienced the increased occurrence of unstable community placements which have resulted in emergency situations, including hospital admissions which are now classified as Delayed Discharge due to the difficulty in securing suitable service provision. Without the appropriate support there will continue to be a very high risk of unstable placements and increased crisis intervention (including out of area or hospital admissions). As there is already a critical gap in essential care for this group the development of a separate Lot (Rate and Service Specification) for complex care will be required to address this issue.

Link to risk number on strategic or operational risk register:

- (1) There is a risk of significant market failure in Aberdeen City.

How might the content of this report impact or mitigate the known risks:

The content of this report seeks to mitigate the known risks by recommending a decision which supports the development and implementation of new commissioning arrangements for Learning Disability services which will provide market stability.

Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Report Title	Winter Planning Debrief – 2016/17
Lead Officer	Judith Proctor, Chief Officer – Aberdeen City Health and Social Care Partnership
Report Author (Job Title, Organisation)	Kenneth O'Brien, Service Manager – ACHSCP Kate Livock, Project Manager (Unscheduled Care) – NHS Grampian
Report Number	HSCP.17.038
Date of Report	26th July 2017
Date of Meeting	15th August 2017

1: Purpose of the Report

1.1 The Aberdeen City Integration Joint Board (IJB) made a specific request that a report on the winter planning debriefs for the year 2016/17 (detailing the learning across Grampian) be presented to them by August 2017.

1.2 Resultantly, this report to the IJB:

- Gives a brief background as to the context and process of winter planning for period 2016/17.
- Sets out the learning established from National, Grampian, and Aberdeen City specific debrief sessions relating to winter 2016/17.
- Describes how this learning is being incorporated into winter/surge planning for the 2017/18 period.

2: Summary of Key Information

Introduction/Background to Winter Planning in 2016/17

2.1 In Grampian there is an established process for winter planning, which is undertaken as a year-round planning cycle and incorporates an integrated approach with business continuity principles. Health and Social Care Partnerships and other partners such as NHS 24 and the Scottish Ambulance service are key to the process and participate in joint planning and debrief

exercises.

2.2 The winter planning cycle for 2016/17 commenced in the June of 2016 with a Grampian Cross Sector Winter (Surge) Plan event aimed at identifying initiatives that would ensure strong performing services that deliver quality care for patients and positive experiences for carers and staff during periods of surge.

2.3 The key lessons from winter 2015/16 were discussed and agreement reached on the priorities for Winter (Surge) planning for 2016/17. Aberdeen City and other sectors were encouraged to test their draft Winter (Surge) plans using desk top testing exercises and this process culminated in a Cross Sector Desk Top Exercise held in advance of a review of the draft Grampian Winter (Surge) Plan by the Senior Leadership Team and submission to the Scottish Government in late August 2016.

2.4 Following feedback and further review of the plan the final draft was submitted for approval to the Grampian Senior Leadership team in September 2016 prior to submission of the approved Grampian Winter (Surge) Plan to the Scottish Government in October 2016. The Grampian Winter (Surge) plan was implemented in October 2016 and ongoing review was undertaken via the Cross Sector System Huddles.

2.5 Following the winter 2016/17 period, debrief events took place at National, Grampian and Aberdeen City levels. The Cross Sector Winter debrief event held in Aberdeen was well attended and a number of key priorities for winter 2017/18 were identified from this integrated approach.

National Debrief Information

2.6 Representatives from both Aberdeen City Health and Social Care Partnership and NHS Grampian participated in national events relating to winter and surge preparedness. These events gave a national perspective related to the 2016/17 winter period. Of particular note (based on national data):

- Public Health reported a relatively mild year for influenza and norovirus – often key drivers of winter pressures.

- Admission and Discharge statistics showed a national drop in discharges from hospital of 30% over the Christmas and New Year Period. Hospitals filled up over Christmas and then faced capacity challenges as of 4th January 2017 onwards.

- Public Holiday working is very much on the agenda to remove the 'cliff edge' of discharge on Christmas Eve. A national review of this area is planned to report to the Cabinet Secretary in September 2017.

Grampian Wide Debrief Information

2.7 A number of key priorities/learning for Grampian Winter (Surge) Planning 2017/18 were identified through the debrief / review process some of which are:

- A key priority for winter 2017- 18 will be to build on the excellent planning undertaken by team in all sectors and services and to continue to improve upon the overall winter (surge) planning process. The overall process includes recording activity and measuring performance against agreed indicators as well as supporting colleagues through the provision of opportunities for joint planning events such as table top exercises and the facilitation of such events. Accurate data will be important as part of the planning process and for ongoing monitoring.

- The cross system huddle is now an established practice, ensuring safe, effective discharge/admission. The increased frequency of the huddles over the 2016/17 winter period, (in response to increased activity), was key to delivering a shared approach to risk. It was noted that there are benefits to be gained from consistency of cross system representation at the huddles and this will feature in 2017/18 planning.

- Robust communication and engagement of all staff was key to effective implementation of the Grampian Winter (Surge) plan in 2016/17. Further improvement of this communication will be addressed through the early winter planning process that has already commenced and the planned table top exercises.

- Workforce planning across the Health and Social Care sector in Grampian was one of the key challenges due to the limited availability of staff for planning into rotas. With many teams working at full capacity it was difficult to arrange "additional" capacity without "additional" staff. Despite this many areas benefited from hardworking and conscientious teams who would work in ways that offered flexibility. Uncertainty about the availability of funding for additional capacity over the winter period in 2016/17 led to delays in decision making and reduced the ability to utilise resource and deliver it effectively and efficiently.

- The testing of the winter plans was seen as important and valuable in 2016/17 - it allowed teams to come together to work as a single system and to test winter plans against scenarios that were designed to prove their resilience.

- The challenges of 2 four day public holiday periods created immense pressure across the system and resulted in a surge in activity from the 4th January onwards. Work towards delivery of 7 day services e.g. pharmacy and diagnostics would lessen the impact upon patient flow.

- The operation of the integrated discharge hub during the public holidays supported patient flow significantly but it was noted that future plans should include other discharge hub disciplines (including social work).

Aberdeen City Debrief Information

2.8 Looking specifically at Aberdeen City, further local priorities/learning for Winter (Surge) Planning in 2017/18 were identified through the local debrief / review, highlights of which were:

- Discharges and transfers were key to ensuring optimal flow across the whole system. Fortnightly meetings of the Delayed Discharge Group supported improved flow across the whole system and contributed to the significantly improved position in Aberdeen city over previous years, r.e. delayed discharges over the December/January period.

- It was noted that whilst, from a national perspective, Public Health colleagues had fed back that it had not been a significant year for influenza and norovirus, the local picture had felt somewhat different. Rosewell House had been shut to admissions (affecting flow out of hospital) + there has been quite a significant amount of short term staff sickness.

- Additionally, a care at home provider withdrew from providing services on the 6th January – putting Care Management colleagues (and the general care at home supply) under additional strain at a challenging time.

- It was noted that in non-hospital services there was a distinct ‘surge’ in activity upon the return in January 2017, post Public Holidays.

- Multiple managers noted that there were challenges with the scheduling by the Partnership of ‘non-operational’ tasks during January 2017.

- The interim care home beds to support flow out of hospital were felt to be very successful – providing useful surge capacity in January 2017.

Summary

2.9 In summary, whilst winter 2016/17 was challenging with increased pressures across the system; the general consensus was that the health and social care system responded more effectively than in previous years. There was evidence of greater communication, flow, risk sharing and integrated planning. However, all elements of the system recognise there is a need to develop further to both embed and enhance the existing good practice. It is also recognised that whilst winter 2016/17 was challenging there were not major environmental or public health issues compared to previous years.

2.10 As a result, winter planning for 2017/18 is already underway taking full account of the above learning from last year's debriefs. This includes workshop sessions across the City partnership focussing on key additions to winter/surge planning for 2017/18 and how they might be implemented. Drafts of the City winter/surge plan for 2017/18 are now being considered by leads across professions/disciplines within the Partnership and their input will be incorporated into the final document.

2.11 Both City specific plans and the full NHS Grampian winter/surge plan will be subject to table-top testing prior to being finalised. Such testing will allow for issues or concerns regarding the drafts of the plans to be resolved prior to them being finalised and implemented.

Assurance

2.12 Locally, the Aberdeen City component of winter planning will be fully reviewed by the Senior Operational Management Team of the Partnership prior to the draft being finalised. Additionally, the Partnership's Clinical and Care Governance Committee will have full sight of the plan prior to it being formally signed off and submitted to NHS Grampian for incorporation into the NHSG comprehensive winter/surge plan.

2.13 NHS Grampian's Senior Leadership Team, (including the Aberdeen City Partnership's Chief Officer), will fully review the Grampian wide 2017/18 winter plan. This 'Grampian wide' plan will also be signed off by the NHSG board prior to submission to the Scottish Government. The full Grampian winter plan will also be presented to the Aberdeen City IJB for noting at its 31st October 2017 meeting.

INTEGRATION JOINT BOARD

3:	Equalities, Financial, Workforce and Other Implications

Equalities

3.1 The patients/clients of the services of the City H&SCP are disproportionately older adults and adults with chronic illness and/or long term disabilities. Whilst 'age' and 'disability' are protected equality characteristics, it is not anticipated that there will be anything other than a positive impact for both groups via improved preparedness over the winter period as a result of appropriate debrief and learning from winter 2016/17

Financial

3.2 There are no new financial implications within this paper.

Workforce

3.3 There are no direct workforce implications relating to this report.

Other

3.4 There are no other implications relating to this report.

4:	Management of Risk

There are significant risks, both operational and reputational, for NHS Grampian and the City Partnership if it does not have an accurate, comprehensive, and realistic winter plan. This includes:

- Delay/failure of service provision and inability to meet organisational and statutory responsibilities.
- Increased costs due to last minute spending to mitigate system failures and capacity issues.

An appropriate winter plan offers the opportunity to mitigate and manage predictable risk in a considered manner. This would therefore improve service delivery in difficult periods and minimise unexpected and/or unplanned costs. Appropriate debrief, learning and revision of winter planning arrangements (as set out in this report) supports the creation of a high quality winter plan for 2017/18.

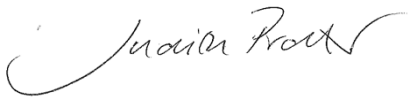
INTEGRATION JOINT BOARD

5:	Recommendations

It is recommended that the Integration Joint Board:

1. Note the information contained in this report relating to learning from the 2016/17 winter period.

2. Note the arrangements put in place to incorporate such learning as part of the 2017/18 winter planning process.

6:	Signatures
	Judith Proctor (Chief Officer)
	Alex Stephen (Chief Finance Officer)

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Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Report Title	Renewal of Interim Care Home Bed Funding
Lead Officer	Tom Cowan (Head of Operations, ACHSCP)
Report Author (Job Title, Organisation)	Kenneth O'Brien (Service Manager, ACHSCP)
Report Number	HSCP.17.069
Date of Report	26th July 2017
Date of Meeting	15th August 2017

1: Purpose of the Report

1.1 This report is presented to the Integration Joint Board (IJB) for the purposes of requesting funding to continue the provision of thirteen care home beds dedicated to supporting discharge out of hospital.

1.2 Resultantly, this report provides to the IJB:

- Background information relating to the use of the interim care home beds.
- A summary of recent performance information relating to delayed discharges associated with a need for care home admission.
- A financial breakdown summarising the costs of renewing the interim beds.
- An indication of 'next steps' if the IJB approves funding as requested.

2: Summary of Key Information

Background

2.1 Since October 2015, with the agreement of the Chief Officer of the City Health and Social Care Partnership and the Aberdeen City Delayed Discharge Group – 6 beds had been booked in advance in a local nursing home under the auspices of the National Care Home Contract (NCHC). The purpose of those beds was to provide dedicated interim placements for those individuals who were in hospital care, but were:

1. Fit for discharge;

2. Assessed as requiring permanent nursing home admission;

3. Did not have a place immediately available in their care homes of choice.

2.2 The intention was to provide some flexibility in nursing home placement arrangements to allow for speedier discharges – this was particularly important as "awaiting nursing home admission" had consistently been recorded in delayed discharge statistics as being the highest single contributor to the overall volume of 'standard' delayed discharges recorded.

2.3 Given the success of the original tranche of six nursing care home beds in reducing nursing care home related delays in hospital, it was agreed by both the City Delayed Discharge Group and the Aberdeen City IJB to expand the initiative. As a result, following request for 'notes of interest', three care homes offered THIRTEEN additional beds for use as interim placements. The IJB formally approved funding for the thirteen additional beds (via the dedicated delayed discharge funding stream) at its 30th August 2016 meeting.

2.4 Subsequently, letters of agreement were issued to the care homes in question, and the beds came on stream 'piece meal' as providers had vacancies to offer. However all of the 13 'expansion' beds now have the same 'end date' – namely 30th November 2017. At the same time, as agreements were signed with care home providers, Primary Care Development colleagues negotiated agreements with GP practices to deliver primary care medical services to the interim beds in the care homes. This was also funded through delayed discharge monies (again authorised by the IJB at its 30th August 2016 meeting).

2.5 Given that the funding approved by the IJB expires at the end of November 2017, consideration is required as to the future of the interim beds. The Partnership's Delayed Discharge Group explicitly considered this issue at its May 2017 meeting by evaluating the impact the expansion of the interim care home beds had on care home related delays.

Evaluation

2.6 Fortunately, via the monthly delayed discharge census returns to the Scottish Government, it is possible to explicitly identify the delays in discharge which relate specifically to care home supply/flow issues. Health Intelligence

colleagues undertook an analysis looking at both the **volume of individuals delayed** and the **number of bed days lost** that could be linked to a need for nursing care home provision.

2.7 It was agreed that, to allow for a fair comparison, the period October 2016 - March 2017 (when the additional interim beds were on stream), would be compared with the same period in the previous year, October 2015 – March 2016 (when only the 6 original nursing interim beds were in place).

2.8 The patient volumes and 'bed days delayed' labelled using the following delayed discharge codes were counted and collated for both time periods:

- Place Availability 24C Awaiting Place Availability in Nursing Home
- Care Arrangements 25A Awaiting completion of arrangements for Care Home placement

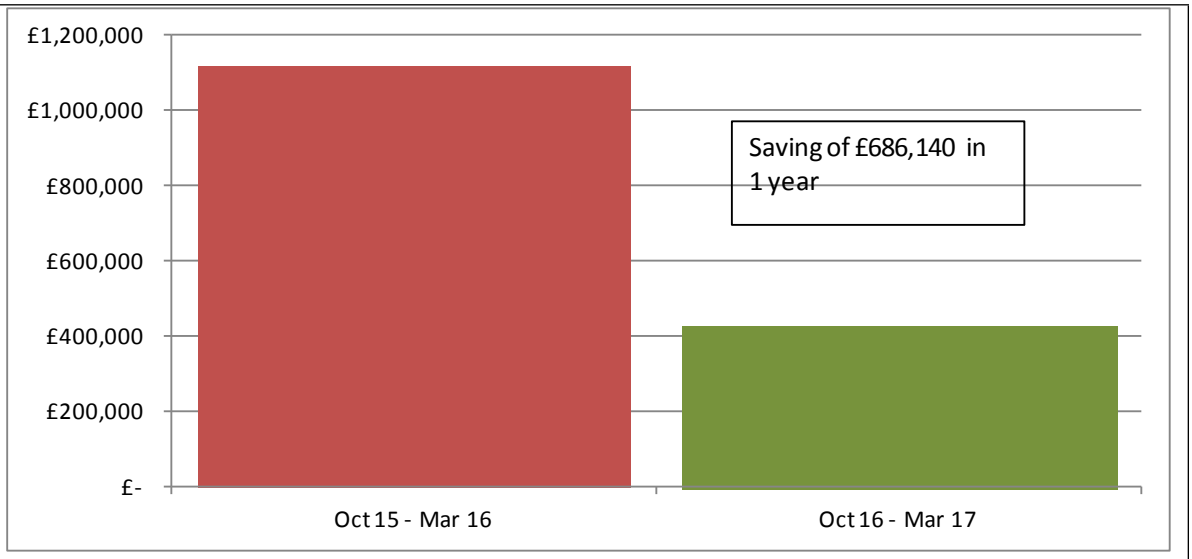
2.9 For the 2015/16 data (prior to the introduction of the additional interim beds), delays related to nursing home placement/provision remained notable components of the Partnership's overall delayed discharge position [5220 bed days lost].

2.10 Conversely, the 2016/17 data (post introduction of additional interim bed capacity) shows a decrease in both volumes of individuals delayed and bed days due to nursing home placement/provision [2010 bed days lost purely due to care home placement reasons].

2.11 The quantitative data can be summarised as follows:

	2015/16	2016/17	+ or -	% change
Volume of Patients Delayed	147	82	-65	-44%
Number of Bed Days Lost	5220	2010	-3210	-61%

2.12 In monetary terms, applying the NHS National Services Scotland ISD national average delayed discharge 'bed day' cost figure (£214 per day) to the volume of bed days saved, it can be seen that there have been indicative savings of £686,140 due to the reduction of 3210 delayed bed days over the two periods.



2.13 It should be noted that operational staff identified that the additional interim beds were exceptionally useful as 'surge' capacity during January/February 2017 when there was a large 'winter pressures' influx of additional delayed discharges.

2.14 After examining various potential options it was **agreed that it should recommend that the IJB approve funding for the full thirteen beds for an additional 24 month period.** However, the Delayed Discharge Group also agreed that the eligibility criteria for the beds should be varied to allow (in non-surge/winter periods) for the beds to be accessed from the community to prevent hospital admissions when they are void. It was also felt that although funding should be for a 24 month period, the beds should be booked on a 12 month rolling programme.

Costs/Funding Breakdown

2.15 In the scenario where the IJB approves a 12 month rolling programme with funding from the dedicated delayed discharge budget, this would result in full year costs of **£417,944.04.**

2.16 This cost projection has been calculated on the basis of the weekly National Care Home Rate for 2017/18 of £667.09, alongside minimum client contributions of £133.15 for 50% of the beds (long term care), and client contributions of £73.50 for 25% of the beds (respite admissions). On the assumption of surge capacity being 'built into' the beds, 25% of the beds have no client contribution factored into them – reflecting potential voids at

'non surge' periods [resulting in a total 'bed' cost of **£397,944.04]**.

2.17 Primary Care Medical Costs for the beds would also still need to be met by the Delayed Discharge Fund, for the additional medical cover required to support these beds. As the beds are now to be used slightly more flexibly (including use to support admissions from the community in non-peak periods) an increase in GP usage may also incur an increase on overall budget [primary care medical cover now set at **£20,000** per year].

Next Steps

2.18 The option to potentially continue funding the thirteen interim beds post November 2017 was announced via an informal 'notice' that was sent to all registered care home providers in Aberdeen. The 'notice' asked all of Aberdeen City's nursing home providers to indicate if they had an interest in providing interim beds from 1st December 2017 onwards. It was apparent from the replies to this notice that there is sufficient interest amongst the care home providers to support a further year of interim bed provision.

2.19 If the IJB approves the spending to renew the thirteen interim beds on a 12 month rolling programme for an additional 24 months, those care home providers who expressed an interest in providing interim beds will be approached to discuss/agree provision in the first instance.

2.20 There will be no requirement to carry out a formal procurement exercise because the expansion of the interim beds relates only to the numbers of beds to be booked in advance - there has been no change to the service to be provided under the National Care Home Contract. Aberdeen City Council Commercial and Procurement Services have (and will continue to) provide advice, guidance and supported contact with the care home providers throughout this process.

2.21 The wider commissioning work which the City Partnership is currently undertaking will incorporate the needs and demands for interim care home beds in the longer term, post the 24 month period.

INTEGRATION JOINT BOARD

3:	Equalities, Financial, Workforce and Other Implications

Equalities

3.1 The issue of Delayed Discharge disproportionately impacts upon older adults and adults with chronic illness and/or long term disabilities. If continued use of interim beds is approved, it is not anticipated that there will be anything other than a positive impact for both groups via the already noted improvement in the timeliness of discharges.

Financial

3.2 Factoring in funding from the Delayed Discharge monies, the following total costs (including beds and medical costs) would be incurred.

Costs in 2017/18 Financial Year (Dec '17 – March '18):	**£139,314.68**
Costs in 2018/19 (until end of Nov 2018):	**£278,629.36**

Similar costs would be incurred in the following 12 months, December 2018 through November 2019, but there may be a degree of adjustment depending on the outcome of National Care Home Contract negotiations for the financial years 2018/19 and 2019/20.

Workforce

3.3 There are no direct workforce implications related to this report.

4:	Management of Risk

Identified risk(s):

- *There is a risk that the IJB and the services that it directs and has operational oversight of fail to meet performance standards or outcomes as set by regulatory bodies and that, as a result, harm or risk of harm to people occurs.*

INTEGRATION JOINT BOARD

Link to risk number on strategic or operational risk register: SEVEN

How might the content of this report impact or mitigate the known risks:

One of the most high profile performance standards the Partnership is held to account for is that of the numbers of people delayed in hospital unnecessarily. Significant volumes of delays will always have tangible consequences for patient flow and care – particularly in times of peak demand. The interim bed project helps to address the overall volume (and length) of delays within the hospital estate – thereby mitigating some of this risk.

5:	Recommendations

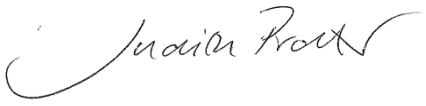
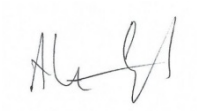
It is recommended that the Integration Joint Board:

1. Approves the project to renew the funding of the thirteen interim beds for a further twenty-four month period, commencing 1st December 2017.

2. Instructs the Chief Officer to provide an update on the interim bed base project by the end of the twenty-four month period unless by exception.

3. Instructs the Chief Officer to issue the Direction to Aberdeen City Council to purchase the 13 interim beds for twenty-four months.

6:	Signatures

	Judith Proctor (Chief Officer)
	Alex Stephen (Chief Finance Officer)

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INTEGRATION JOINT BOARD

DIRECTION

ISSUED UNDER S26-28 OF THE PUBLIC BODIES (JOINT WORKING) (SCOTLAND) ACT 2014

The **ABERDEEN CITY COUNCIL** is hereby directed to deliver for the Board, the services noted below in pursuance of the functions noted below and within the associated budget noted below.

Services will be provided in line with the Board's Strategic Plan and existing operational arrangements pending future directions from the Board.

Related Report Number:- HSCP.17.069

Approval from IJB received on:- 15th August 2017

Description of services/functions:-

Provision of Nursing Care Home beds (13) specifically reserved to support the flow of patients/clients out of hospital in-patient care, and/or prevent admission to hospital.

Reference to the integration scheme:-

The direction will support the evidencing of the Partnerships commitment to the following Health and Wellbeing Outcomes (referenced in the Integration Scheme):

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

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

Link to strategic priorities (with reference to strategic plan and commissioning plan):-

This direction seeks to support delivery of the following strategic priorities:

- Develop a consistent person centred approach that promotes and protects the human rights of every individual and which enable our citizens to have

Prior to sending this direction, please attach a copy of the draft IJB minutes, original report and the completed consultation checklist.

opportunities to maintain their wellbeing and take a full and active role in their local community.

- Support our staff to deliver high quality services that have a positive impact on personal experiences and outcomes.

Timescales involved:-

Start date:- 1st December 2017

End date:- 30th November 2019

Associated Budget:-

Details of funding source:- Dedicated Delayed Discharge Budget/Funding

- Year 1 - £397, 944.04
- Year 2 - £397, 944,04 *(noting there may be a degree of adjustment required depending on the outcome of National Care Home Contract negotiations)*

Availability:- YES

Prior to sending this direction, please attach a copy of the draft IJB minutes, original report and the completed consultation checklist.

Aberdeen City Health & Social Care Partnership

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Strategic Risk Register 2017/18

Risk Rating	Low	Medium	High	Very High
Risk Movement	Decrease	No Change	Increase	

Level of Risk	*Risk Tolerance*
Low	Acceptable level of risk. No additional controls are required but any existing risk controls or contingency plans should be documented. Chief Officers/Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective.
Medium	Acceptable level of risk exposure subject to regular active monitoring measures by Managers/Risk Owners. Where appropriate further action shall be taken to reduce the risk but the cost of control will probably be modest. Managers/Risk Owners shall document that the risk controls or contingency plans are effective. Chief Officers/Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective. Relevant Chief Officers/Managers/Directors/Assurance Committees will periodically seek assurance that these continue to be effective.
High	Further action should be taken to mitigate/reduce/control the risk, possibly urgently and possibly requiring significant resources. Chief Officers/Managers/Risk Owners must document that the risk controls or contingency plans are effective. Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective. Relevant Chief Officers/Managers/Directors/Executive and Assurance Committees will periodically seek assurance that these continue to be effective and confirm that it is not reasonably practicable to do more. The IJB's may wish to seek assurance that risks of this level are being effectively managed. However the IJB's may wish to accept high risks that may result in reputation damage, financial loss or exposure, major breakdown in information system or information integrity, significant incidents(s) of regulatory non-compliance, potential risk of injury to staff and public
Very High	Unacceptable level of risk exposure that requires urgent and potentially immediate corrective action to be taken. Relevant Chief Officer/Managers/Directors/Executive and Assurance Committees should be informed explicitly by the relevant Managers/Risk Owners. Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective. The IJB's will seek assurance that risks of this level are being effectively managed. However the IJB's may wish to accept opportunities that have an inherent very high risk that may result in reputation damage, financial loss or exposure, major breakdown in information system or information integrity, significant incidents(s) of regulatory non-compliance, potential risk of injury to staff and public

Risk Summary:

1. There is a risk of significant market failure in Aberdeen City
2. There is a risk of financial failure , that demand outstrips budget and IJB cannot deliver on priorities, statutory work, and project an overspend
3. Failure of the IJB to function, make decisions in a timely manner etc
4. There is a risk that the outcomes expected from hosted services are not delivered and that the IJB does not identify non-performance in through its systems. This risk relates to services that Aberdeen IJB hosts on behalf of Moray and Aberdeenshire, and those hosted by those IJBs and delivered on behalf of Aberdeen City.
5. There is a risk that the governance arrangements between the IJB and its partner organisations (ACC and NHSG) are not robust enough to provide necessary assurance within the current assessment framework – leading to duplication of effort and poor relationships
6. There is a risk that services provided by ACC and NHS corporate services on behalf of the IJB do not have the capacity, are not able to work at the pace of the IJB's ambitions, or do not perform their function as required by the IJB to enable it to fulfil its functions
7. There is a risk that the IJB and the services that it directs and has operational oversight of fail to meet performance standards or outcomes as set by regulatory bodies
8. There is a risk of reputational damage to the IJB and its partner organisations resulting from complexity of function, delegation and delivery of services across health and social care.
9. Failure to deliver transformation at a pace or scale required by the demographic and financial pressures in the system
10. There is a risk that the IJB does not maximise the opportunities offered by locality working
11. Workforce planning across the Partnership is not sophisticated enough to maintain future service delivery

- 1 -	
Description of Risk: There is a risk of significant market failure in Aberdeen City	
Strategic Priority: Outcomes, safety and transformation	**Lead Director:** Acting Head of Strategy and Transformation
Risk Rating: low/medium/high/very high **HIGH** **Risk Movement:** increase/decrease/no change **NO CHANGE 27.07.17**	**Rationale for Risk Rating:** • Previous experience of provider failure in City and wider across Scotland • Discussion with current providers and understanding of market conditions across the UK • Impact of Living Wage on profitability depending on some provider models **Rationale for Risk Appetite:** • 3rd and independent sectors key strategic partners in delivering transformation and improved care experience and we have a low tolerance of risk of market failure.
Controls: Robust market and relationship management with the 3rd and independent sector and their representative groups. Market facilitation programme and robust contract monitoring process	**Mitigating Actions:** • Creation of capacity and capability to manage and facilitate the market • Development of provider forum to support relationship and market management • Risk fund set aside with transformation funding • Additional SG funding toward the Living Wage and Fair Working Practices have been agreed and applied by the IJB • Recent experience of managing a residential home should

	market failure occur.
Assurances: Market management and facilitation Audit and Performance Systems Committee overview **Contract monitoring process**	**Gaps in assurance:** Market or provider failure can happen quickly despite good assurances being in place
Current performance: The Partnership/ACC had to step in and take control of a nursing home in Kingswells on 1st of April 2017. This has provded the Partnership with experience of how to take control and run a residential home should a provider fail. However, capacity only exists to deal with one residential home at a time and if two homes failed a the same time the resources would be stretched. There is an indication through recent court cases that staff who are providing overnight care (sleepovers) will need to be paid at HMRC rates and this could be back-dated for 6 years. Should this financial liability materialise then this could have a large impact on the financial viability of some of the care providers.	**Comments:** • NCHC uplift for 2016/17 was 6.4% and 2.8% 2017/18 • IJB agreed payment of living wage to Care at Home providers for 2016/17 and 2017/18 • Development of a commissioning plan with a draft presented to the IJB on the 15th of August 2017.Market Facilitation steering group established September 2016; membership includes ACVO, CASPA and Scottish Care. •

-2-
Description of Risk: There is a risk of IJB financial failure with demand outstripping available budget. There is a risk that the IJB cannot deliver on priorities and statutory work, and that it projects an overspend.

Strategic Priority: Outcomes and transformation	**Lead Director:** Chief Finance Officer
Risk Rating: low/medium/high/very high **HIGH**	**Rationale for Risk Rating:** • Analysis of demographic change and growth in demand year on year • Analysis of current budget pressures known and expected in the Public Sector in Scotland and the UK • Understanding of financial pressures on both partner organisations (ACC and NHS Grampian) **Rationale for Risk Appetite:** The IJB has a low risk appetite to financial failure and understands its requirement to achieve a balanced budget. However the IJB also recognises the significant range of statutory services it is required to meet within that finite budget and has a lower appetite for risk of harm to people.
Risk Movement: increase/decrease/no change*:* **INCREASE 27.07.17**	
Controls: Budgets delegated to cost centre level and being managed by budget holders.	**Mitigating Actions:** • **Financial information is reported regularly to both the Audit & Performance Systems Committee, the Integration Joint Board and the Executive Team.** • **Reserves strategy, including risk fund** • **Robust financial monitoring and budget setting procedures**
Assurances: • Audit and Performance Systems Committee oversight and scrutiny of budget under the CFO • Board Assurance Framework.	**Gaps in assurance:** • None known

Current performance: Pressure forecast on budget at June 2017, recovery plans are being developed to bring this back into balance. Therefore, risk rating moved to high until recovery plans are implemented.	**Comments:** • Regular and ongoing budget reporting and tight management control in place • Budget monitoring procedure now well established • Budget holders understand their responsibility in relation to financial management.

- 3 -	
Description of Risk: There is a risk that the IJB fails to function properly within its Integration Scheme, Strategic Plan and Schemes of delegation in particular reference to being able to make appropriate decisions in a timely manner and meet its required functions.	
Strategic Priority: Outcomes, safety and transformation	**Lead Director:** Chief Officer

Risk Rating: low/medium/high/very high **MEDIUM**	**Rationale for Risk Rating:** Failure of the IJB to function is a fundamental risk which would impact on all strategic priorities. Capacity of Executive Group while recruitment to full complement in structure, a potential risk
Risk Movement: increase/decrease/no change **NO CHANGE 27.07.17**	**Rationale for Risk Appetite:** Zero appetite.

Controls: • Experience of operating in shadow form • Agreed etiquette of the board and risk appetite statement allowing for balance of timely decision taking with effective challenge and scrutiny • Performance reporting mechanisms	**Mitigating Actions:** • Recruiting to further senior posts in the structure. • Operation of Executive team focussing on priorities • **A review of the standing orders has been commissioned**
Assurances: • Board Assurance Framework • Audit & Performance Systems Committee	**Gaps in assurance:** • None known
Current performance: • Meeting requirements • Increasing workload experienced following 'go live' and in relation to need to support IJB's committees – being mitigated by further recruitment to senior posts The Partnership will soon be able to advertise to fill Head of Locality Vacancies • Steering group has been established to recruit officers to the Strategy and Transformation Team. Senior posts within this	**Comments:** • The process for agreeing and then recruiting into senior posts in the structure has, by necessity, to go at the pace of the partner organisations. This has extended the process and has meant that key posts are either just now being recruited to, or yet to be advertised; • Given governance to agree certain senior posts within ACC has to be reported to Finance Policy and Resources Committee

team have now been recruited too.	there is a risk of disagreement to establish and the impact of this on the IJB and its decision making is untested.

- 4 –
Description of Risk: There is a risk that the outcomes expected to be delivered by hosted services are not realised and that the IJB fails to identify non-performance through its own systems. This risk relates to services that Aberdeen IJB hosts on behalf of Moray and Aberdeenshire, and those hosted by those IJBs and delivered on behalf of Aberdeen City.

Strategic Priority: Outcomes and transformation	**Lead Director:** Chief Officer
Risk Rating: low/medium/high/very high **MEDIUM** **Risk Movement:** (increase/decrease/no change): **NO CHANGE 27.07.17**	**Rationale for Risk Rating:** • Considered medium risk due to the reporting arrangements being relatively new and needing testing in the first full year of operation **Rationale for Risk Appetite:** • The IJB has some tolerance of risk in relation to testing change.
Controls: • Integration scheme agreement on cross-reporting • NE Strategic Partnership Group • Operational risk register	**Mitigating Actions:** • This is discussed regularly by the three North East Chief Officers • Regular discussion regarding budget with relevant finance colleagues
Assurances: These largely come from the systems, process and procedures put in place by NHS Grampian, which are still being operated, along with any new processes which are put in place by the lead IJB	**Gaps in assurance:** None currently known
Current performance: No issues to report Governance arrangements are being ??? on across the three IJBs, so	**Comments:** • A meeting of the senior management teams of the three North East Scotland Health and Social Care Partnerships took place in

that budget management, setting and strategic planning are aligned. This work will be presented to the three North East Scotland HSCPs when completed. Work is taking place at an officer level to move this forward.	December 2016 in order to establish the operating principles and processes for reporting outcomes from hosted services and governance to IJBs • Further meetings are planned across the year to ensure flow of communication and establish practice of reporting on hosted services

- 5 –	
Description of Risk: There is a risk that the governance arrangements between the IJB and its partner organisations (ACC and NHSG) are not robust enough to provide necessary assurance within current assurance framework – leading to duplication of effort and poor relationships.	
Strategic Priority: Outcomes, safety and transformation	**Lead Director:** Chief Officer

Risk Rating: low/medium/high/very high **MEDIUM**	**Rationale for Risk Rating:** Considered medium as arrangements are complex and mitigations untested in the 'go live' environments
Risk Movement: (*increase/decrease/no change)* **NO CHANGE 27.07.17**	**Rationale for Risk Appetite:** The IJB has zero appetite for failure to meet its statutory requirements.

Controls: • Scheme of delegation • Integration Scheme • Current governance committees within IJB and NHS • North East Strategic Partnership Group	**Mitigating Actions:** • Consultation and engagement between bodies • Consideration being given by Chief Officers regarding development of Service Level Agreements or other mechanism
Assurances: • Agreement on regular reporting on hosting at each IJB • Regular Chief Officer meetings across Grampian area • Chief Officer a member of both NHS Grampian Senior Leadership Team and Aberdeen City Council's Corporate Management Team	**Gaps in assurance:** • Potential gaps around standard interpretation of schemes
Current performance: • Most of the major governance processes have been tested over the last year. However, this does not remove the risk as governance processes in the IJB and the partner organisations will continue to evolve and improve.	**Comments:** • Regular performance meetings between the Chief Officer and the Chief Executives of NHS Grampian and Aberdeen City Council take place • Reporting template has been agreed to ensure a consistency of reporting and clear 'line of sight' to Accountable Officers • A Protocol for budget setting has been developed to assist in

	this complex process and was tested for the first time for the 17/18 budget

- 6 –	
Description of Risk: There is a risk that the services provided by ACC and NHS Corporate Services on behalf of the IJB do not have the capacity or are unable to work at the pace of the IJB's ambitions. There is a further risk that they are unable to perform their function as required by the IJB to enable it to fulfil its functions.	
Strategic Priority: Outcomes and service transformation	**Lead Director:** Chief Officer

Risk Rating: low/medium/high/very high **MEDIUM** **Risk Movement:** (*increase/decrease/no change)* **DECREASE 27.07.17**	**Rationale for Risk Rating:** • Given the wide range and variety of services that support the IJB from NHS Grampian and ACC there is a possibility of under or non-performance • Depending on which area this is in (e.g. corporate finance, legal services) the consequences are considered significant • **There is the potential for budget reductions to impact on services** **Rationale for Risk Appetite:** There is a zero tolerance in relation to not meeting legal and statutory requirements.
Controls: • IJB Strategic Plan • IJB Integration Scheme • Agreed risk appetite statement • Role and remit of the North East Strategic Partnership Group in relation to shared services	**Mitigating Actions:** • Regular reporting at both Executive Management Team and Senior Operational Management team • Regular and ongoing Chief Officer membership of ACC Corporate Management Team and NHS Grampian Senior Leadership Team • Consideration in relation to Service Level Agreements being undertaken by the 3 North East Chief Officer. • Creation of Business Management Team with the partnership with representatives from all corporate services.
Assurances: • Executive Group reviews performance of corporate services' support regularly • Chief Finance officer role ensure liaison in relation to financial services • Chief Officer regularly discusses these service provisions with Corporate Directors	**Gaps in assurance:** • None currently significant though note consideration relating to possible future Service Level Agreements

Current performance:	Comments:
• No issues have been identified over the last year of operations, therefore, the Executive Team feel this risk can be reduced to medium. However, risk will be kept under review as partner organisations change their structures and systems	• Nothing to update on this report.

- 7 –	
Description of Risk: There is a risk that the IJB and the services that it directs and has operational oversight of fail to meet performance standards or outcomes as set by regulatory bodies and that, as a result, harm or risk of harm to people occurs.	
Strategic Priority: Outcomes, safety, transformation of services	**Lead Director:** Chief Officer

Risk Rating: low/medium/high/very high **MEDIUM**	**Rationale for Risk Rating:** Risk felt to be moderate, given controls with potential risks in need of mitigation due to go-live implications
Risk Movement: (*increase/decrease/no change)* **NO CHANGE 27.07.2017**	**Rationale for Risk Appetite:** The IJB has zero tolerance of harm happening to people as a result of its actions or inaction.

Controls: • Clinical and Care Governance Committee and Group Audit and Performance Systems Committee • Risk-assessed performance plans and actions • Development of KPIs reported	**Mitigating Actions:** System re-design and transformation
Assurances: • Executive Group reviews processes and performance regularly • Joint meeting of IJB Chief Officer with two Partner Body Chief Executives • Audit & Performance Systems Committee • Clinical and Care Governance Committee	**Gaps in assurance:** • Formal performance systems not yet developed. • Audit & Performance Systems Committee meets regularly and is establishing reporting mechanisms Intelligent Board performance model has been agreed and is being populated

Current performance: Council and NHS performance systems remain in place with single reporting in development.	**Comments:** • Clinical and Care Governance Committee and Group have been established and are meeting regularly • Further work with the Good Governance Institute is supporting us in testing our processes robustly as a live organisation to ensure they are fit for purpose • Action plan following last year's formal Inspection of Services for Older People has been agreed and approved by both the IJB and Inspection agencies • Establishing reporting and assurance mechanisms for hosted and commissioned services

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Description of Risk: There is a risk of reputational damage to the IJB and its partner organisations resulting from complexity of function, delegation and delivery of services across health and social care.	
Strategic Priority: All	**Lead Director:** Chief Officer
Risk Rating: low/medium/high/very high **HIGH**	**Rationale for Risk Rating:** Newness of the organisation and agenda for system transformation pose risk of reputational damage **Rationale for Risk Appetite:**

Risk Movement: (*increase/decrease/no change)* **NO CHANGE 27.07.17**	Willing to risk certain reputational damage if rationale for decision is sound.

Controls: • Executive Management Team • IJB and its Committees • Operational management processes and reporting • Board escalation process	**Mitigating Actions:** • Clarity of roles • Staff and customer engagement • Effective performance and risk management
Assurances: • Role of the Chief Officer and Executive Team • Role of the Chief Finance Officer • Performance relationship with NHS and ACC Chief Executives • Communications plan / communications officer	**Gaps in assurance:** None known at this time
Current performance: • Chief Finance Officer appointed on a permanent basis • Communications officer in place to lead reputation management	**Comments:** • Communications strategy and action plan in place and being led by the HSCP's Communications Manager • Communications Group in place comprising of staff across the partnership supporting us in getting the message right and appropriate • Locality leadership groups being established to build our relationship with communities and stakeholders • Regular CO/CEOs meeting supports good communication flow across partners as does CO's membership of the Corporate Management Teams of both ACC and NHSG

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Description of Risk: Failure to deliver transformation at a pace or scale required by the demographic and financial pressures in the system	
Strategic Priority: All	**Lead Director:** Chief Officer
Risk Rating: low/medium/high/very high **HIGH**	**Rationale for Risk Rating:** This is the overall risk – each of our transformation programme work streams will also be risk assessed with some programmes being a higher risk than others

Risk Movement: (*increase/decrease/no change)* **NO CHANGE 27.07.17**	**Rationale for Risk Appetite:** The IJB has some appetite for risk relating to testing change and being innovative. The IJB has zero appetite for harm happening to people.
Controls: • Strategic Transformation and Commissioning programme management and governance • Audit and Performance Systems Committee • Transformation programme board in place • Recruitment to key senior posts	**Mitigating Actions:** • Programme approach being taken in terms of the transformation programme • Recruitment has taken place into senior and key project and programme management posts • Regular reporting to Executive Management Group • Regular reporting to Audit and Performance Systems Committee
Assurances: • Executive Management and Committee Reporting • Programme Management approach • IJB oversight • Board escalation process •	**Gaps in assurance:** • Executive Management team developing financial model for transformation programme to track delivery of change and efficiencies – this is in developing and as such, a gap.
Current performance: Demographic financial pressure is starting to materialise in some of the IJB budgets.	**Comments:** • Challenge of pace of recruitment to key posts given complexity of working across two systems has had an impact on pace • A review of the transformation programme and governance arrangements is being undertaken.

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Description of Risk There is a risk that the IJB does not maximise the opportunities offered by locality working	
Strategic Priority: All	**Lead Director:** Chief Officer
Risk Rating: low/medium/high/very high **MEDIUM**	**Rationale for Risk Rating:** Considered medium in relation to ability to work at the pace required until all senior and locality posts recruited to in the new structure

Risk Movement: (*increase/decrease/no change)* **NO CHANGE 27.07.17**	**Rationale for Risk Appetite:** The IJB has some appetite to risk in relation to testing innovation and change. There is zero risk of financial failure or working out with statutory requirements of a public body.
Controls: • Transformation programme and programme board • Audit and Performance Systems Committee	**Mitigating Actions:** • There is a localities development programme manager in place supporting this work • Agreed operational structure that reflects the importance of localities and roles which support transformational potential of working at this level
Assurances: • Regular Transformational Programme Board reports to Executive Management Team and to Audit and Performance Systems Committee • Programme Management approach • Recruitment of new Head of Strategy and Transformation role which will lead on the transformation at Executive level	**Gaps in assurance** • None currently known
Current performance: • Two Heads of Locality now in post •	**Comments:** •

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Description of Risk **Workforce planning across the Partnership is not sophisticated enough to maintain future service delivery**	
Strategic Priority: All	**Lead Director:** Chief Officer
Risk Rating: low/medium/high/very high **MEDIUM 27.07.17** **Risk Movement:** (*increase/decrease/no change)* NEW 27.07.17	**Rationale for Risk Rating:** • The current staffing complement profile changes on an incremental basis over time • However the number of over 50s employed by the partnership is increasing **Rationale for Risk Appetite:**

	• Risk should be able to be managed with the adoption of workforce planning structures and processes
Controls: • **Clinical & Care Governance committee reviews operational risk around staffing numbers**	**Mitigating Actions:** • **Development of a workforce plan** • **Career development scheme for nurses**
Assurances: • **Workforce plan once developed for the whole Partnership.**	**Gaps in assurance** • Need more information on social care staffing • Information on social care provideers would be useful to determine trends in wider sector
Current performance: •	**Comments:**

Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Report Title	Finance Update as at end June 2017
Lead Officer	Alex Stephen, Chief Finance Officer
Report Author	Gillian Parkin (Finance Manager)\Jimmie Dickie (Finance Business Partner)
Report Number	HSCP.17.065
Date of Report	26 July 2017
Date of Meeting	15 August 2017

1: Purpose of the Report

i) To summarise the current year revenue budget performance for the services within the remit of the Integration Joint Board as at Period 3 (end of June 2017); and

ii) To advise on any areas of risk and management action relating to the revenue budget performance of the Integration Joint Board (IJB) services.

iii) To request approval of budget virements so that budgets are more closely aligned to anticipated income and expenditure (see Appendix E).

2: Summary of Key Information

Reported position for period to end June 2017

2.1 An adverse position of £1,228,000 is reported for the three month period to the end of June 2017 as shown in Appendix A. A forecasted year-end position has been prepared based on month 3 results. This has resulted in a projected overspend of £4,518,000 on mainstream budgets. Work is progressing with the budget holders to confirm the forecast position and seek solutions to recover the position. Given the timing of this report the forecast is presented as originally calculated and an appendix F has been added which identifies the actions being considered to help recover the financial position.

2.2 A review has been undertaken of the spend and commitments against the Integration and Change Fund budget and the forecast has been adjusted accordingly. As can be seen from the forecast identified in Appendix A it is currently anticipated that the £4,518,000 can be accommodated from within this budget for 2017/18. This would protect the partners from incurring any additional financial pressure on their own budgets. However, it is important

that recovery plans are developed and implemented quickly, in order to protect the IJB's Integration and Change Funding so it can be used for transformation. The Executive Team and Senior Managers are committed to resolving this overspend in 2017/18, although are mindful there will be some transitional spend while the recovery plans are implemented.

2.3 An analysis of variances is detailed below:

Community Health Services (Year to date variance - £81,000 overspend)

Major Movements:

£20,000	across non pay budgets
£52,000	Under recovery on income.

Within this expenditure category there is an overspend on non pay costs due to unmet 2017/18 budget reduction targets. An under recovery on income mainly relating to education service level agreement for speech and language therapy (£20,000) due to renegotiation of contract and salaried dental service income being lower than anticipated due to lower patient numbers meeting the eligibility criteria for payment.

Hosted Services (Year to date variance £173,000 overspend)

There are overspends on Police Forensic Service due to unfunded posts and unmet efficiency targets. Along with an overspend on medical locum costs due to the inability to recruit within Intermediate Care. (which covers Care of the Elderly, Orthopaedics and the Mobility and Rehabilitation Service). Hosted services are led by one IJB, however, the costs are split according to the projected usage of the service across the three IJBs. Decisions required to bring this budget back into balance may need to be discussed with the three IJBs, due to the impact on service delivery.

Learning Disabilities (Year to date variance - £371,000 overspend)

Major Movements:

£334,000	Commissioned services
£81,000	Under-recovery customer and client receipts
(£59,000)	Underspend direct payments

Staffing budgets for allied health professional underspending due to staff vacancies. The overspend on commissioned services reflects additional commitments against the needs led spot purchase care budget of £316,000 and block funded services budget of £18,000 as a result of an increase in the

number of clients.

The under-recovery in client and customer receipts is mainly on residential and nursing care which is where the under recovery occurred last year. The underspend on direct payments includes recovery of £111,000 of income refunded from financial audits and reviews.

This Learning Disabilities budget will be closely monitored to determine if future growth due to packages transitioning from childrens' services will continue to be offset by recovery of underspends and reducing the direct payment contingency from eight to four weeks.

Mental Health & Addictions (Year to date variance - £135,000 overspend).

£59,000	Additional expenditure on locums
£50,000	Additional expenditure on commissioned services
£14,000	Direct payments

The overspend on medical locum costs is due to the inability to recruit. Mental Health currently have 4 whole time equivalent consultant vacancies and 1 whole time equivalent speciality doctor, which are currently all being filled by locums.

The commissioned services overspend reflects overspends against mental health block funded care £26,000, mental health needs led spot purchased care £12,000 and addictions block funded care £14,000; partially offset by an underspend on addictions spot purchased care £2,000. Direct payments is a needs led service which depends on client achieving the eligibility criteria and picking a direct payment rather than a traditional care package. The overspend might reduce in future months as underspends are recovered and the direct payment contingency in existing budgets is reduced from eight weeks to four weeks as agreed during the budget process.

Older People & Physical and Sensory Disabilities (Year to date variance - £149,000 overspend)

Major Movements:

£261,000	Commissioned services
£124,000	Direct payments
(£125,000)	Recoveries client board
(£53,000)	Contributions from other local authorities
(£50,000)	Staffing vacancies

There is an overspend of £261,000 on commissioned services. This consists mainly of an overspend of £223,000 in additional payments to Bon Accord care for running Kingsmead Nursing Home. There is an overspend of £124,000 on needs led direct payments, mainly on older people home care due to additional clients. The overspend may reduce in future months as underspends are recovered and the direct payments contingency in existing budgets is reduced from eight weeks to four weeks.

There is a £125,000 over-recovery of client contributions towards the costs of in-house residential care. There is a £53,000 over-recovery of income for contributions from other councils towards the cost of residential care packages. The £50,000 underspend on staffing is mainly due to staffing vacancies. An exercise will be undertaken during the budget process to ensure that staffing budgets reflect the new management structure.

Central Living Wage/Inflation Provision etc (Year to date variance - £172,000 overspend)

Major Movements:

£115,000	Additional running expenses Kingsmead
£70,000	Staff vacancy savings

On the 1st April 2017 Aberdeen City Council took over the running of Kingsmead Nursing Home. The additional spend for the year to date of £115,000 is mainly due to ongoing running costs of the occupancy agreement £90,000.

A budget of staff vacancy savings across the partnership is held against the adult social care directorate. As these savings may be delivered across the partnership there is an additional expense against this budget of £70,000 for the first three months.

Primary Care Prescribing (Year to date variance – £113,000 overspend)

As actual information is received two months in arrears from the Information Services Division this position is based on actuals for April 2017 with an estimation of spend for May and June. The budget to June includes the additional budget added during the budget process of £559,000. The average cost per item varied throughout 2016/17 and averages at £11.28 over the year. The actual average cost per item in April was £11.32 and this price is used for estimating May and June spend. The volume of items estimated to June has decreased by 0.4% compared to quarter 1 2016/17.

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Primary Care Services (Year to date variance - £16,000 overspend)

The position within Primary Care Services represents the impact of the revision of the Global Sum (based on practice registered patient numbers) payments for 2017/18 anticipated to be matched by revised annual grant allocations. Cost pressures still exists for Enhanced Services continuing, which includes diabetic care, extended hours and immunisations. A new cost pressure is emerging in 2017/18 for premises in relation to Business Rates.

Out of Area Treatments (Year to date variance - £70,000 overspend)

The projected overspend reflects that the number of patients receiving care outside of the Grampian area has increased over the last few months. A review is being undertaken to determine how best to manage this budget and financial pressure in future.

List of Appendices:

a) Finance Update as at end June 2017
b) Summary of risks and mitigating action
c) Sources of Transformational funding
d) Progress in implementation of savings - June 2017
e) Virements
f) Recovery Plans (to follow)

3:	Equalities, Financial, Workforce and Other Implications

3.1 Every organisation has to manage the risks inherent in the operation of large and complex budgets. These risks are minimised by the regular review of financial information by budget holders and corporately by the Board. This report is part of that framework and has been produced to provide an overview of the current financial operating position.

3.2 Key underlying assumptions and risks concerning the forecast outturn figures are set out within Appendix B. Appendix D monitors the savings agreed by Aberdeen City Council.

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4:	Management of Risk

Identified risk(s): There is a risk of financial failure , that demand outstrips budget and IJB cannot deliver on priorities, statutory work, and project an overspend.

Link to risk number on strategic or operational risk register: 2

How might the content of this report impact or mitigate the known risks: Good quality financial monitoring will help budget holders manage their budgets. By having timely and reliable budget monitoring any issues are identified quickly, allowing mitigating actions to be implemented where possible.

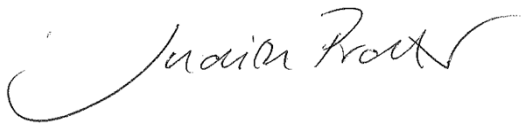
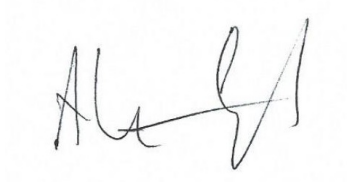
Should there be a number of staffing vacancies then this may impact on the level of care provided to clients. This issue is monitored closely by all managers and any concerns re clinical and care governance reported to the executive and if necessary the clinical and care governance committee.

5:	Recommendations for Action

It is recommended that the Integration Joint Board:

1. Notes this report in relation to the IJB budget and the information on areas of risk and management action that are contained herein.

2. Instructs Officers to review the financial position and identify savings to bring the mainstream budget back to a break even position.

6:	Signatures
	Judith Proctor (Chief Officer)
	Alex Stephen (Chief Finance Officer)

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Appendix A: Finance Update as at end June 2017

Accounting Period 3	Full Year Revised Budget Budget £'000	End June Budget Budget £'000	YTD Actual £'000	YTD Variance £'000	Variance Percent %	Year-End Forecast £'000
Community Health Services	31,631	7,881	7,962	81	0.3%	140
Aberdeen City share of Hosted Services (health)	20,290	5,119	5,292	173	0.9%	693
Learning Disabilities	30,358	7,587	7,958	371	1.2%	1,561
Mental Health & Addictions	19,718	4,927	5,062	135	0.7%	500
Older People & Physical and Sensory Disabilities	72,949	18,237	18,386	149	0.2%	808
Central Living Wage/inflation provision etc	(1,339)	(351)	(179)	172	(12.8%)	(40)
Criminal Justice	46	7	(44)	(51)	(110.9%)	(1)
Housing	1,861	465	465	(0)	(0.0%)	0
Primary Care Prescribing	39,865	9,874	9,987	113	0.3%	302
Primary Care	36,985	9,366	9,382	16	0.0%	64
Out of Area Treatments	1,005	249	319	70	7.0%	491
Sub Total: Mainstream position	**253,368**	**63,362**	**64,590**	**1,228**	**1.93%**	**4,518**
Integration and Change Funds	20,360					
Total funding available						(20,360)
Projected expenditure to end March 2018						15,262
Contribution to mainstream position (as above)						4,518
Total position including Integration and Change Fund	**273,728**	**63,362**	**64,590**	**1,228**		**(580)**

Appendix B: Summary of risks and mitigating action

	Risks	Mitigating Actions
Community Health Services	Balanced financial position is dependent on vacancy levels.	• Monitor levels of staffing in post compared to full budget establishment. • A vacancy management process is in the process has been created which will highlight recurring staffing issues to senior staff.
Hosted Services	Potential increased activity in the activity led Forensic Service. The use of locums for intermediate care	• Work is being undertaken at a senior level to consider future service provision and how the costs of this can be minimised. • Substantive posts have recently been advertised which might reduce some of this additional spend.
Learning Disabilities	Fluctuations due to expensive support packages being implemented. Increase in provider rates for specialist services. Underspend is dependent on vacancy levels continuing at present levels.	• Review packages to consider whether they are still meeting the needs of the clients. • To review increased costs of packages transitioning from Childrens' services to see if there is a spike in demand or if the increased costs are a trend.
Mental Health and Addictions	Increase in activity in needs led service. Potential complex needs packages being discharged from hospital. Increase in consultant vacancies resulting in inability to recruit which	• Work has been undertaken to review levels through using Carefirst. • Review potential delayed discharge complex needs and develop tailored services. • A review of locum spend is being undertaken across NHS Grampian.

	Risks	Mitigating Actions
	would increase the locum usage. Average consultant costs £12,000 per month average locum £30,000 per month.	
Older people services incl. physical disability	Balanced financial position is dependent on staffing levels. Increase in activity in needs led service.	• Monitor levels of staffing in post compared to full budget establishment. • A vacancy management process has been created which will highlight recurring staffing issues to senior staff. • Review packages to consider whether they are still meeting the needs of the clients.
Prescribing	Primary Care prescribing is impacted by volume and price factors both of which are forecast on basis of available date and evidence at start of each year by the Grampian Medicines Management Group	• Monitoring of price and volume variances from forecast. • Review of prescribing patterns across General Practices and follow up on outliers. • Implementation of support tools – Scriptswitch, Scottish Therapeutic Utility. • Poly pharmacy and repeat prescription reviews to reduce wastage and monitor patient outcomes. •
Out of Area Treatments	Increase in number of Aberdeen City patients requiring complex care from providers located out with the Grampian Area.	• Review process for approving this spend.

Appendix C: Sources of Transformational funding

	2017/18 (£m)	**2016/17 c/fwd** (£m)	**Total** (£m)
Integrated Care Fund	3.750	2.684	6.434
Delayed Discharge Fund	1.125	1.420	2.545
Winter resilience		0.190	0.190
Mental Health Access		0.054	0.054
Primary Care Pharmacy	0.318	0.215	0.533
Social Care transformation funding	9.504	4.773	14.277
Tranche 2 Social Care Funding	3.860		3.860
Primary Care Transformation		0.267	0.267
Mental Health Fund		0.147	0.147
Transforming Urgent Care		0.286	0.286
Keep Well/Public Health (Tobacco, CHW)		0.381	0.381
	18.557	**10.417**	**28.974**
Adjust for social care budget transfer	-8.614		-8.614
Funding available for IJB commitment	**9.943**	**10.417**	**20.360**

Appendix D: Progress in implementation of savings - June 2017

Area	Agreed Target	Status	Action	Responsible Officer
Vacancy Management	1,100	Amber	Once a post becomes vacant grades and hours are reviewed before the vacancy process begins. *All vacancies are authorised by finance and senior management. Where possible posts are held until it is essential to be filled for the running of a service.*	Judith Proctor
City Core Community Health	103	Green	Only essential training is being permitted. Overtime is being monitored on a monthly basis and will only be used if this is essential to the running of a service and should be the last resort.	Tom Cowan
City Core Community Health	100	Green	There is currently an administration review being undertaken – reviewing all workload and grades of admin staff required. When a vacancy arises the grade and hours are reviewed and posts only being filled if essential. Bank usage is being monitored on a monthly basis and is the last resort of filling holiday or sick leave cover.	Alex Stephen
Various on-costs on commissioned services	315	Green	Care providers will receive no increase in funding other than any increases agreed for sleepovers, living wage and through the NCHC if applicable.	Tom Cowan

Area	Agreed Target	Status	Action	Responsible Officer
Review and reduce commissioning in association with other Councils to reduce rates.	575	Amber	Review placements provided by Aberdeen City that should be funded by other councils. Some packages are expensive and by working with other Councils it should be possible to negotiate better rates. Review care packages to determine whether they are still fit for purpose and meet the eligibility criteria. *Additional social workers have been recruited to review packages and a process has been set-up where expensive packages are required to be signed off by a resource allocation panel.*	Tom Cowan
Direct payment - reduce contingency levels	200	Green	Direct payment clients receive a contingency payment amounting to 8 weeks and this it to be changed to 4 weeks.	Tom Cowan
Speed up financial assessment process	100	Amber	By improving this process clients will know quicker how much contribution, if any, they require to make to their care package. Speeding up this process will give clients more certainty and reduce potential arrears.	Alex Stephen
Income Generation	350	Green	Review charging levels across the Partnership and look for ways to generate more income to support core services - making best use of our assets etc.	Sally Shaw
Self-Directed Support	59	Green	Remove budget for organisation providing support to SDS clients. Contract has come to an end and has not been renewed (support now being provided in-house)	Alex Stephen

Area	Agreed Target	Status	Action	Responsible Officer
Remove historic underspends	260	Green	Complete	Alex Stephen
Outreach team not filled	280	Green	Funding and posts are no longer required re strategic plan.	Alex Stephen
Review of the Training/Overtime & Parking	163	Amber	Managers to consider ways to reduce overtime & training and pay travel as incurred not issuing parking passes.	Judith Proctor
Management Model	710	Green	Review and assessment of the Partnership overall management model. Where staff are employed in transformational roles then they should be charged against the integration and change fund. Where it is possible to reduce the number of posts without making someone redundant then this will be considered and actioned.	Tom Cowan
Total	**4, 315**			

Appendix E: Virements

Period 1-3 Health	
Budget Virements/Additional Funding	
Amputee Ward Funding	£18,560
Public Health Fund (MIN)	£24,000
School Immunisation Programme	£158,525
Primary Care Pharmacy	£318,401
Junior Health Visiting Funding	£40,740
Total Virements	**£560,226**

Period 3 – Adult Social Care		
Budget Virements/Additional Funding		
Learning disability	living wage	£ 1,100,407.00
	sleepovers	£ 767,848.00
Mental Health	living wage	£ 388,408.00
	sleepovers	£ 256,901.00
Physical Disability	living wage	£ 265,858.00
	sleepovers	£ 105,261.00
Older People	living wage	£ 574,317.00
Central living wage budget		**-£ 3,459,000.00**

Appendix F: Recovery Plans 17/18 (draft)

1. Adult Social Care Recovery Plan

Area	Action	Responsible Officer/s
Learning Disability Commissioned Services	1. An exercise is to be undertaken to determine if the increase in learning disability clients is the start of a new trend/profile. 2. 2) A senior officer is to review the process of children transitioning from Children's services to Adult Social Care so that a protocol might be agreed.	CareFirst/Service Managers/ Finance
All Commissioned Care	Desktop review of CareFirst packages to remove duplicates and incorrect packages. Maximise use of existing care estate. Are care packages the right size for client's needs? 1. Desktop review to provide initial list of care packages to be reviewed based on practitioners knowledge to check if the care packages are the right size for the client's needs. 2. A review group to commence reviewing high cost packages to check if care packages are the right size for client needs 3. Peer review to check that all new high cost packages are the right size for client needs. 4. Out of authority placements to be reviewed to see if they are the right size for client's needs. 5. Additional staff may be required to carry out reviews. A business case will be developed if the pace of progress determines that additional resources are required.	CareFirst/Service Managers/ Finance

Area	Action	Responsible Officer/s
All Commissioned Care	Voids. 1. Clients to be matched to voids in block funded services wherever possible. 2. Any voids that cannot be filled should be de-commissioned. 3.	CareFirst/Service Managers/ Finance
All Commissioned Care	Adult Social Care as Registered Landlord 1. Ask housing services to take over looking after social care tenancies to free up staff time. 2. Review tenancies to see if they can be of a more short term nature so that clients can be moved onto more appropriate resources. 3. Consider moving back to residential care model.	CareFirst/Service Managers/ Finance
All Commissioned Care	Standalone Packages 1. Review high cost stand-alone packages to see if more appropriate funding/care models can be established.	CareFirst/Service Managers/ Finance
All Commissioned Care	Equipment 1. Ensure services are provided in the most cost effective way by the partnership.	CareFirst/Service Managers/ Finance

Area	Action	Responsible Officer/s
All Commissioned Care	Kingsmead 1. To put steps in place so that Kingsmead can accept new clients. 2. To move to a frail elderly only model of care. 3. To increase the number of frail elderly clients nearer to capacity as this is a block funded service.	CareFirst/Service Managers/ Finance
All Commissioned Care	SDS 1. All SDS packages being reviewed to ensure that they have the right size of package. 2. A resource allocation panel has been established to monitor and review High value Self Directed Support packages. 3. Review SDS contingency being reduced from 8 to 4 weeks to see how much might be kept as a saving. 4. Develop equivalency model of support and consider introducing financial caps on services eligible for direct payment.	CareFirst/Service Managers/ Finance
All Commissioned Care	Sleepovers/waking nights 1. Review provision to ensure that care models are the right size for client's needs.	CareFirst/Service Managers/ Finance
Older People & Physical Disability Homecare	1. Review CM2000 banding model to see if savings can be generated by altering payments to providers without disrupting the market.	CareFirst/Service Managers/ Finance

Area	Action	Responsible Officer/s
Maximising Income	1. Get external help to review charging strategy. 2. Review charging policy for transport. 3. Speed up financial assessment process including review of how best to apply delegated powers within the partnership.	CareFirst/Service Managers/ Finance
Total target to be achieved = £2.4 million. Individual project targets to be confirmed.		

2. Health Recovery Plan

Area	Action	Responsible Officer/s
Specialist Older Adults and Rehab	<u>Forecast position: £550k overspend</u> The main factors for this forecasted overspend is due to unfunded pay award £200k and £300k circa for locums to provide out of hours medical services (one doctor per 200 patients). If the City element of these unavoidable costs was funded then this would improve the year-end forecast. To reduce spend at a scale of this order would require the closure of a ward or planned significant reduction in activity level in other elements of the hosted service, such as a increase in waiting times for wheelchairs, prosthetics and orthotics. All of these changes would have an impact on a cross Grampian basis, such changes would need to be considered by other IJBs and in the case of a ward closure the acute sector.	Jason Nicol

Area	Action	Responsible Officer/s
	Removing beds with no mitigation would have significant impact on our delayed discharge performance. Further work would be required with professional leads for nursing, medical and AHPs as well as other IJBs/Acute Sector colleagues if this option were to be developed.	
City H&SCP Nursing	Forecasted position: £391k overspend With potentially 4 locality managers being in post by end of November 2017. This should help drive the implementation of the Buurtzorg model which will have a positive impact on the overall nursing position. Work has been undertaken re vacancy management with support from the Finance team. This will be ongoing throughout the year.	Heather MacRae
Mental Health	Forecasted position: £400k overspend Due to a retirement of a key member of the ADP support team. A review will be undertaken of the management structure. Expensive medical locums is the cause of the forecasted overspend. A review of the process around authorisation and payment of these locums and analysis of the services that the locum support is under way.	Karen Gunn

Aberdeen City Health & Social Care Partnership
A caring partnership

Integration Joint Board

Report Title	Strategic Commissioning Implementation Plan
Lead Officer	Judith Proctor, Chief Officer.
Report Author	Kevin Toshney, Planning and Development Manager
Report Number	HSCP.17.077
Date of Report	14th July 2017
Date of Meeting	15th August 2017

1: Purpose of the Report

Following on from the articulation of the Integration Joint Board's (IJB's) strategic ambitions and priorities in the partnership's Strategic Plan 2016-19, this paper outlines additional information in respect of the IJB's commissioning intentions which are set out in the attached draft Strategic Commissioning Implementation Plan.

Following IJB approval, this draft Strategic Commissioning Implementation Plan will be the subject of public consultation across Aberdeen City Health & Social Care Partnership's (ACHSCP's) sectors, localities and stakeholders.

If agreed by the IJB a final Plan will be brought to the December Board meeting for approval.

2: Summary of Key Information

2.1 The Public Bodies (Joint Working) (Scotland) Act 2014 provides a framework for the effective integration of adult health and social care services and to:

"…improve the quality and consistency of services for patients, carers, service users and their families; to provide seamless, joined up quality health and social care services in order to care for people in their own homes or a homely setting

where it is safe to do so; and to ensure resources are used effectively and efficiently to deliver services that meet the increasing number of people with longer term and often complex needs, many of whom are older."

2.2 One of the key milestones set out in the legislation was the publication of the IJB's Strategic Plan 2016-19 (http://aberdeencityhscp.scot/en/progress/news/achscp-strategic-plan-2016-19/) marking the full delegation of the appropriate and agreed health and social care functions and services to the IJB

2.3 The significant volume of 'integration conversations' that were undertaken to inform and influence the development of the strategic plan was recognised by the IJB. The Plan was relatively well received by different stakeholders but it has been acknowledged that while it provides a high level narrative of our vision and ambitions it perhaps lacks clarity of detail about the commissioning intentions.

2.4 The need to provide that additional detail was recognised and additional external capacity was sourced to lead this. A paper titled 'Indicative Strategic Planning Timetable' was presented to the IJB at its meeting on 15th November 2016 confirming the intention to develop a Commissioning Plan and Market Facilitation Plan/Statement and to bring this to the IJB in 2017.

2.5 Strategic commissioning is the term used for all the activities involved in assessing and forecasting needs, planning the nature, range and quality of future services, considering options, linking investment to agreed outcomes and working in partnership to put these in place.

2.6 Effective commissioning requires the development of a comprehensive commissioning plan that outlines in more detail the models of care that we wish to develop across the city. It will be a statement of intent and will be used as the basis for participation by the third, independent and housing sectors to participate in the collaborative development and implementation of the overall strategy.

2.7 The areas of focus have been identified because of the opportunities to develop a more integrated service and the significance of their market fragility or likely impact.

2.8 It is recognised that, as was the case in the development of the Strategic Plan, the process needs to be equitable and transparent and open to influence from stakeholders: such as via an ongoing dialogue with individuals, carers and providers and work undertaken with third and independent sector representation, channelled through the Aberdeen Council of Voluntary Organisations (ACVO) and Scottish Care respectively.

2.9 Participants considered, in respect of their particular focus, the following questions:

- What are the outcomes we wish to see?
- What models of care do we intend to commission?
- What are our priority areas?
    - for development/growth
    - for remodelling
    - for disinvestment/decommissioning
- What will be different?

Their reflections form the basis of the accompanying draft Plan.

2.9 In addition to the proposed commissioning intentions, the draft Plan incorporates a Market Facilitation Statement suggesting how best to support the resilience, sustainability and quality of the commissioned provision.

2.10 Market facilitation is not a new activity for the partnership. It is an integral element of the commissioning cycle and as such, operational, planning and procurement colleagues have been facilitating ongoing discussions with partners in the third, independent and housing sectors with respect to many developmental activities including the partnership's Strategic Plan.

2.11 There is a keen intention to build on that dialogue and incorporate the key principles that will underpin commissioner/ provider relationships and activities that will support the reshaping of existing care models across all of the sectors. A market facilitation steering group involving colleagues from ACVO and Scottish Care has been established to oversee the development of these key principles and activities.

2.12 This Statement will be an invitation to the third, independent and housing sectors to collaborate in the realisation of the IJB's strategic ambitions and priorities.

2.13 There will be consultation across the health, social care, third and independent sectors as outlined in the accompanying consultation plan.

2.14 Responsibility for overseeing the implementation of this Plan will be with, in the first instance, the Head of Strategy and Transformation and the Strategic Commissioning Programme Board. Regular updates of progress will be provided to the Executive Team Programme Board and the IJB as appropriate.

3:	Equalities, Financial, Workforce and Other Implications

Financial Implications

Further discussions and consideration need to be undertaken to develop appropriate, costed option appraisals and business cases.

Equalities Implications

An Equalities Impact Assessment will be completed in respect of the revised Plan.

Workforce Implications

Increased recruitment and retention levels and improved employee satisfaction across all sectors are integral to the success of our developmental activities. Setting out coherent and co-ordinated commissioning intentions will stimulate interest and motivation to develop innovative models of care that will seek to improve personal experiences and outcomes.

Integration Joint Board

4:	Management of Risk

Identified risk(s) and link to risk number on strategic or operational risk register:

1) There is a risk of significant market failure in Aberdeen City'

9) Failure to deliver transformation at a pace or scale required by the demographic or financial pressures in the system'

How might the content of this report impact or mitigate the known risks:

Focussing on areas of service delivery that have been identified because of their market fragility and seeking to co-produce desirable solutions will contribute to the mitigation of the identified risks.

The Partnership's Risk Appetite Statement is intended to support innovation and different ways of working and seeks to be risk enabling. There is a significant opportunity, supported by the IJB's approach to risk to drive further innovation through this commissioning plan. These opportunities include; commissioning for outcomes, enabling better flexibility for providers, commissioning an approach that increases opportunities for self-directed budgets, and approaches with providers to highly localised micro provision.

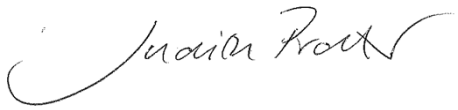
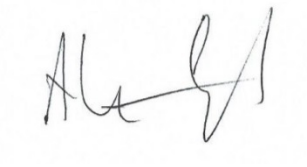
5:	Recommendations for Action

It is recommended that the Integration Joint Board:

1. Agree that consultations on the draft Strategic Commissioning Implementation Plan be undertaken, as outline in the accompanying consultation plan.

2. Instruct, that following consultation, an updated Strategic Commissioning Implementation Plan is presented to the IJB at its December meeting for approval.

Integration Joint Board

6:	Signatures
	Judith Proctor (Chief Officer)
	Alex Stephen (Chief Finance Officer)

Draft Strategic Commissioning Implementation Plan

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1. INTRODUCTION.

Following on from the publication of the partnership's Strategic Plan[1], this Plan seeks to outline our commissioning intentions over the next over the next four to five years to reshape our services to improve individual experiences and outcomes in the face of future demographic and financial challenges.

The work to develop our commissioning intentions has focussed on particular service areas which the Partnership feels are ripe for change and have potential for significant impact on improving outcomes for service users and on improving efficiency.

These areas include:

- Care at home
- Residential care (older people & physical disability, learning disability, mental health)
- Intermediate care
- Re-ablement services
- Out of hours and responder services

Our intentions will be of interest to many stakeholders including those from the independent, third and housing sectors who we will commission particular services from. With this in mind, a Market Facilitation Statement is incorporated into this Plan giving guidance on our commissioning intentions, translating them into specific information to help providers prepare for forthcoming opportunities.

1.1 Vision, values and priorities

Our Strategic Plan outlines our vision, values and strategic priorities. Our vision is: "A caring partnership working together with our city communities to enable people to achieve fulfilling, healthier lives and wellbeing". Our values, which underpin everything we do, are to be caring, person-centred, empowering, enabling, and cooperative.

Our strategic priorities are to:

- Improve the health and wellbeing of our local population
- Contribute to a reduction in health inequalities and wider social inequalities that impact on health and wellbeing
- Strengthen existing community assets and resources
- Promote and support self-management and independence
- Develop personalised services
- Support those who are unpaid carers
- Work in partnership with our residents, communities and organisations
- Deliver high quality services that have a positive impact on personal experiences and outcomes.

[1] http://aberdeencityhscp.scot/en/progress/news/achscp-strategic-plan-2016-19/

1.2 Our approach to commissioning.

Our approach to commissioning is shaped by the Scottish Government's guidance on strategic commissioning plans[2] which defines strategic commissioning as: "the term used for all the activities involved in assessing and forecasting needs, linking investment to agreed outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place"[3].

We see commissioning as collaborative decision-making about how to achieve defined, agreed and jointly owned outcomes, generating a broader and more innovative range of options. To achieve our vision of effective strategic commissioning, we aim to embed the following principles into our practice:

- Commissioning is undertaken for outcomes (rather than for services)
- Commissioning decisions are based on evidence and insight and consider sustainability from the outset
- Commissioning adopts a whole systems approach
- Commissioning actively promotes solutions that enable prevention and early intervention
- Commissioning activities balance innovation and risk
- Commissioning decisions are based on a sound methodology and appraisal of options
- Commissioning practice includes solutions co-designed and co-produced with partners and communities
- Commissioning is evaluated on outcomes and social and economic return on investment

1.3 LEGISLATIVE and POLICY DRIVERS.

In Scotland there is currently an ambitious and wide-ranging policy agenda for health and social care. Key areas of reform and transformation include:

- Integration of adult health and social care introduced through the Public Bodies (Joint Working) (Scotland) Act 2014
- Greater personalisation of services and implementation of self-directed support, specifically through the Social Care (Self-Directed Support)(Scotland) Act 2013
- Reshaping Care of Older People is focussed on shifting care towards anticipatory care and prevention approaches in order to improve care of older people
- Carers' Act (Scotland) 2016
- Development and implementation of joint strategic commissioning and stronger partnership approaches to service delivery.

In line with the requirements of legislation, Aberdeen City Health and Social Care Partnership has identified four localities, roughly aligned with the existing four GP cluster areas. The purpose of creating localities is not to draw lines on a map, but to provide an organisational mechanism for local leadership of service planning, to be fed upwards into the Integration Authority's strategic commissioning plan. The intention is to develop single integrated community teams that will include staff that are employed by the NHS and Aberdeen City Council and working for the Aberdeen City

[2]Scottish Government, Health and Social Care Integration: Strategic Commissioning Plans Guidance 2015
[3] Strategic Commissioning Steering Group, Joint Strategic Commissioning: a definition, 2012

Health and Social Care Partnership. The team may also include staff employed by other agencies including the third and independent sector. Appropriate linkages will be developed with other providers within these communities to support seamless person centred care, including, where appropriate, effective community supports to enable self management of long term conditions and maintaining long term health and wellbeing.

We are also exploring opportunities for adopting “Buurtzorg” principles, especially those of self managing and self organising teams within an Aberdeen context. This is anticipated to include the development of local community teams initially in two communities in Aberdeen, with these principles embedded throughout the development and delivery of these teams. Public World is working with Aberdeen City to develop a shared understanding of Buurtzorg including co-designing a test and learn site.

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3. OUR COMMISSIONING INTENTIONS.

3.1 Key intentions.

Consistent with the outcomes we wish to achieve, and our analysis of existing provision, we intend to shift the balance of care from institutional models to enhanced, community based models of care. This will increase the need for community based services providing support to stay at home and effective services at times of transition. It will require a change in the way resources are deployed and in what services are commissioned and facilitated.

In order to deliver this change, we will over the next four years re-shape services with the aim of ensuring flexible, personalised, and cost-effective support to stay at home.

3.2 Care at home

3.2.1 Purpose.

Good care at home helps people with care needs to live in their own home when otherwise they would need to be in residential care. It should:

- help people with care needs look after themselves in, and participate in all aspects of, the community
- encourage people with care needs to live independently in the community and to maintain greater independence for longer, while recognising that, for some older people in particular, there will be an inevitable deterioration in their condition
- prevent people with significant health or care needs from having to use emergency services or from being admitted to hospital inappropriately.

Where possible, assistance should include helping the supported person to become empowered and skilled to undertake tasks for themselves. Where this is not possible then the provision may include but will not be limited to the following activities:

- assisting with individuals' personal care
- recognising and assisting with health needs
- assisting with nutritional needs
- supporting a person to identify and attain personal goals and quality of life outcomes
- helping a person live with or manage having memory loss or dementia
- helping a person through end of life care
- supporting a carer who is helping any of the above.

3.2.2 What will we commission?

- Encourage a move away from a range of services aiming to maintain somebody in the community into a single integrated health and social care community service for older Integrated framework for care at home across all types of service user
- Equitable access to and quality of provision across the city (no postcode lottery)
- Designed around a single point of entry

- Allow for planning and development of care on a locality basis
- Sufficient capacity in the system to accommodate variations in demand and/or emergencies
- A focus on developing collaborative relationships between providers eg in determining which geographical areas particular providers would cover, in shared recruitment and training
- An approach to commissioning based on developing long term relationships with trusted providers who have greater flexibility to decide how best to meet need and deliver outcomes.
- Give providers choice and control over time, people and process ie way that care is administered and delivered
- Providers are paid an appropriate and sustainable rate for what they do
- Providers to are incentivised to improve their efficiency (ie how they use time and resource; how they review their own use of care workers)
- Workers are paid the Scottish Living Wage and providers subscribe to Fairer Work Practices
- Easy to understand and manage contract payment mechanism and contract arrangements
- Simple to administer ie as few rates as possible
- Support and care delivered in users' own homes and that gives them choice in the way in which their allocated hours of care are used, including time for social and other activities. This may include as appropriate but is not not limited to:
- Personal Hygiene - Bathing, showering, hair washing, shaving, oral hygiene, nail care
- Continence Management - Toileting, catheter/stoma care, skin care, incontinence laundry, bed changing
- Food and Diet - Assistance with the preparation of food and assistance with the fulfilment of special dietary needs
- Problems with Immobility - Dealing with the consequences of being immobile or substantially immobile
- Simple Treatments - Assistance with medication (including eye drops), application of creams and lotions, simple dressings, oxygen therapy
- Personal Assistance - Assistance with dressing, surgical appliances, prostheses, mechanical and manual aids. Assistance to get up and go to bed. Transfers including the use of a hoist.
- Domestic tasks - support to deal with money, undertake shopping, and other domestic tasks
- Social life - enabling a full and rewarding social life and the opportunity to maintain or build personal relationships
- Employment and training - Providing support to access training, development and employment opportunities
- A move away from a range of services aiming to maintain somebody in the community into a single integrated health and social care community service for older people
- A 'what needs to be done' approach by lead care workers rather than constant referral on or signposting elsewhere
- ability to work across different budgets to create seamless services

- How, when and which services are provided to be agreed between the service user and the provider
- A whole-needs approach, where attention is paid to the needs of the whole person rather than treating them as a series of discrete problems, embedded in service delivery ie "Do we have the right help for this person and is it being delivered in a way that will maximise their opportunities for greater independence?"
- A move away from "time and task" to a less prescriptive way of working that offers service users greater choice in the way in which their allocated hours of care are used, including time for social and other activities;
- A more collaborative approach to addressing the needs of individuals that would see fewer workers engaging with any one service user but fulfilling a wider range of activities and tasks
- A more holistic approach to addressing needs that would bring in a much wider and innovative range of assets and supports, including those available through the voluntary and community sector, volunteers, and good neighbours
- Care packages that flex easily to meet changing needs (both escalating and reducing needs)
- Models that wrap around existing carers
- Models that allow individuals to have a relationship with their carer

3.3 Residential care for older people and people with physical disabilities.

3.3.1 Purpose

The current discussion about the purpose of residential services for older adults and adults with a physical disability comes at a time when 'bed based' care is subject to greater scrutiny across the health and social care continuum. Demographic projections have put forward a future in Scotland where there is a growing older population coupled with a shrinking working age population - so the national policy focus has been on either reducing the volume of bed based care, or at the very least constraining growth below the baseline that would be expected given the shift in demographics.

Locally, the Aberdeen City Health and Social Care Partnership's strategic plan indicates a more general desire to shift the balance of care away, for all adult social care client groups, from institutional settings. This is further developed in the Partnership's current overarching commissioning strategy for older people[4] which argues for further efforts to "…establish a trend towards care at home, particularly to reduce reliance on residential care".

Therefore, the role of Older Adult and Physical Disability residential services going forward should be seen as being a relatively small BUT very important element of the wider service provision offered. Residential care will focus on supporting the more complex individuals with the greatest need.

[4] Ageing wi' Opportunity in Aberdeen City: A Joint Commissioning Strategy for Older People 2013 – 2023: http://www.aberdeencity.gov.uk/nmsruntime/saveasdialog.asp?lID=50024&sID=23017

3.3.2 What will we commission?

It should be noted that demographic projections would indicate that, all other things being equal, a need for additional residential care home beds would be expected. Aberdeen City 'standard care homes' currently operate at an occupancy rate of approximately 83% (based on current contract information). NHS Grampian Health Intelligence have taken the current care home bed base and have extrapolated potential occupancy to 2020 based on future demographic projections. This indicates a shift upwards in occupancy rates for the care home estate to 89-91% by the year 2020.

Normally such a projected occupancy range (in excess of the current Scottish average of 86%) would trigger consideration of expansion of service provision. However, the Partnership has staked a clear strategic direction in 'shifting the balance of care' away from residential/institutional settings. As a result, it is planned that there will not be an increase in overall volumes of standard care home places procured over the next five year period.

Rather, the Partnership will manage demand within the existing volume of beds, with a greater 'diversion' of individuals from institutional care via the expansion of services such as enablement, intermediate care, hospital at home and care at home services. This should allow for the growth in residential bed based care to be curtailed and the remaining demand to be managed within current bed volumes. The Partnership is mindful that a balance needs to be struck between high occupancy rates (for the viability of providers) and reasonable 'spare' capacity remaining within the care home system to support client/patient 'flow' and appropriate management of any business continuity risks.

Particular aspects include:

1) Standard care home provision for older adults and others with a range of conditions that are appropriately met within that form of setting.

Relatively large volumes of standard care home places which are equipped to manage the broad range of needs/demands relating to older adult care alongside some younger adults with a physical disability. Small numbers of LD and Mental Health clients will also access this resource.

It is envisaged that this service would primarily be met through linking in with the local voluntary and independent care home sector. Beds would primarily be spot purchased. It is likely that this would be under the auspices of the National Care Home Contract(NCHC) as the client/patient cohort would not be expected to exceed the demands of what is currently considered standard care home provision – i.e. the current residential/nursing models.

We have yet to decide our view on models of provision elsewhere where %'s of standard care home beds are block booked/funded on the basis of supporting the supplier market and providing greater control of placements. A commissioning aspiration over the next five years would be to trial/pilot such a model to examine/evaluate it on its merits.

An exception to our focus on spot purchasing in this area may be for a smaller dedicated cohort of beds that serve younger adults. [It would be hoped that the upcoming iteration of the NCHC may incorporate under-65's within it more explicitly, making the arranging of such a service less onerous.] There may also be some potential for block funding/booking a small cohort of standard care home beds to expedite discharge from hospital – however this will be evaluated in conjunction with developments in the Partnership's intermediate care bed base.

2) Advanced Dementia Care in a Care Home Setting:

A moderate volume of more specialised care home places that are specifically equipped to provide Advanced Dementia Care for particularly complex dementia related needs and presentations.

Again, it is envisaged that this service would primarily be met through linking in with the local voluntary and independent care sector.

Given the more specialised provision envisaged by this model of care, we are more convinced that at least a partial switch from the existing spot purchasing arrangement to block funding may yield dividends in regards to quality and continuity of such a service.

A commissioning intention over the next five years will also be to trial at least one very different model of acute dementia care which moves away from traditional 'care home' structures /staffing /delivery.

This will be an attempt for the Partnership to begin to consider its longer term model of delivery following the next round of commissioning. The Partnership will look both nationally and internationally at new developments in dementia care – ranging from Hogeway Dementia Village models through Butterfly models and ABLE methodologies – amongst others.

3) Specialised Care Home services for individuals with very complex physical presentations

Given the complex and specialised nature of this residential care delivery, we envisage these services only being provided via very particular, and specialist, independent and voluntary sector services.

We would envisage funding of such residential services to be a mix between both block funding of some resource + the ability to top up supply via spot purchase arrangements. This would strike a balance between the need to support and give security to relatively small volume suppliers whilst also allowing some flexibility in regards to numbers of beds purchased.

4) Advanced Dementia Care Home: Whilst we anticipate Advanced Dementia Care dealing with more complex presentations than the existing EMI places – the increase in dementia prevalence over the coming years leads us to believe that we will need to at least match our existing EMI bed base with the new type of service. (The number of people with dementia is projected to increase in those 65 years and over by 13% by 2022)[5]. The rising prevalence over time likely reflects the increase in the older age groups within the population and also potentially the increase in risk factors within the population[6]. Therefore, a reasonable estimate for volume of beds for this model would be in the range of **300-320 beds**.

[5] Aberdeen City's Partnership Statement of Intent and Action Plan in relation to People with Dementia 2013 - 2023

[6] Aberdeen City Joint Strategic Needs Assessment 2012: http://www.aberdeencity.gov.uk/nmsruntime/saveasdialog.asp?lID=50032&sID=23017

5) Specialised Care Home Services for individuals with very complex physical presentations.

A small volume of more specialised care home services that are equipped specifically to manage non-age related physical disabilities that are particularly complex or intensive, (e.g. high need neurological presentations etc)

It is hoped that the combination of cohorting some of our younger clients in more age appropriate standard care home settings; coupled with planned improvements in care at home provision and responder services, will allow us to meet complex demand within the existing bed base numbers.

Therefore, a reasonable estimate for volume of beds for this model would remain the existing **37 beds**. This takes account of potential Partnership progress with its various efforts to "shift the balance of care" alongside the general consistent level on unmet need within the system.

6) Specialised Brain Injury Care Home Provision.

A small volume of very specialised care home beds that work specifically to support individuals with brain injuries (of various aetiologies) – particularly individuals for whom more general services have already proven unable to meet their needs.

Given the complex and specialised nature of the proposed residential care delivery, we envisage these services only being provided via very particular, and specialist, independent and voluntary services.

We would envisage funding of such a residential service to be primarily a spot purchase arrangement. However, some guarantees of volumes could be provided to support supplier security and confidence. There would also be an option to link in and 'pool' a client cohort across a Grampian wide basis to increase the size and viability of any such service.

We requested information on all out of area placements for those with specialised brain injury residential provision + known unmet need within the City. This provided a gross figure of 30. We have to be mindful that a small number of those individuals will require such complex care that an out of area specialised provider would always have been the only viable option for their care.

Making a degree of adjustment, we could realistically expect the service to require at least 15 beds when commissioned. This would be based on Aberdeen City needs only. The service could be sized differently if negotiations were held with other Partnership areas to accommodate and provide services on a grouped basis.

These figures currently cohort together Alcohol Related Brain Damage clients and those adults with an Acquired Brain Injury. We recognise that these client cohorts have differing complexities and needs, and would therefore encourage a more detailed options appraisal in regards to configuration of any new service at the point of commissioning arrangements commencing.

3.4 Residential care for people with a learning disability

3.4.1 Purpose

The current discussion about residential services for individuals with learning disabilities (and their purpose) must be seen within the wider context of national and local policy. As a starting point, the Mental Health (Care and Treatment) (Scotland) Act 2003[7] puts a legal duty on local authorities to ensure provision of care and support services, including residential and support services. Therefore any commissioning intentions must ensure that this statutory duty continues to be met.

Additionally, The Keys to Life[8] (2013) which is the current 10 year National Learning Disability Strategy reinforces this point, stating that residential models of care should be viewed as a minority element of overall provision, working with the most complex individuals, whilst retaining as many elements of a homely environment as possible. This followed on from "The Same as You"[9] (2000). The direction of travel within national policy has been for the residential elements of LD services to be directed at those with the most significant and complex needs – with alternate models of support utilised for the majority of individuals with support needs.
Locally, the Aberdeen City Partnership's strategic plan indicates a more general desire to shift the balance of care away (for all adult social care client groups) from institutional settings. It should also be acknowledged that, locally, there has already been a significant drive to shift LD resources away from a residential model through the *reregistration process* where services historically recognised as residential care settings have shifted their focus to providing housing support and care at home services. This was part of a wider drive to support LD individuals to become more active and valued citizens within their communities.

It should, therefore, be recognised that the residential LD services and care models described in this report form part of a much wider continuum of health and social care services that are intrinsically interrelated. Readers must recognise that this document does not provide the "full picture" of support to individuals with an LD.

Also of note is that projected demographics for LD individuals suggest a future cohort for residential bed based care that have *proportionally greater needs* – both in regards to their LD and other aspects of their presentation. This is currently evidenced by the increased acceptance of referrals to the Transitions team.

In summary, the purpose of LD residential services going forward should be seen as a small BUT very important element of the wider LD service provision. Residential care will focus on supporting the most complex individuals with the greatest need. It is on this foundation that the Partnership's commissioning of services will be built.

[7] http://www.legislation.gov.uk/asp/2003/13/contents
[8] http://www.gov.scot/resource/0042/00424389.pdf
[9] http://www.gov.scot/resource/doc/1095/0001661.pdf

*NOTE: The Partnership is currently in the early stages of developing an overarching **Learning Disability Strategy** – it is anticipated that the commissioning intentions set out in this paper will dovetail with the priorities and aims/objectives of that document*

3.4.2 What will we commission?

1) Standard Care Home provision for LD clients (under 65)

This would be registered care home provision for individuals with a Learning Disability but who do not have care and support needs that are LD specific. Rather, the standard care home provision currently offered to older adults and adults with a physical disability would best meet their needs.

The intention will be to negotiate on a Partnership wide basis with our standard residential and nursing care home providers to ensure that they are able and willing to register with the regulator to deliver services to this client cohort. This may necessitate Partnership support to engage with the regulator as a body corporate. Thereafter, once achieved, beds would likely be purchased on a spot purchase basis. These beds would be accessed from within the general care home estate governed by the National Care Home Contract (independent/voluntary sector).

Negotiation on a global basis with City Residential/Nursing care home providers to agree under 65 registration and spot purchase access to standard care home services. [Will require liaison and support from the Care Inspectorate].

2) LD Specific Nursing Care Home Provision

Small volume of Nursing Care Home provision that focuses specifically on, (and is configured for), LD related needs. Potentially via external provider on a block contract (unless larger volumes can be established via Grampian wide 'pooling' of LD individuals and related service).

This would be dedicated nursing level care home provision that is configured specifically for the specialist needs of individuals with LD who may also have specific dementia or wider health/disability presentations.

It is envisaged that this would be specifically commissioned in small units (4-6 individuals). Given the clinical complexities of such care provision, it is anticipated that this would be sought from the specialist provider arms of the independent/voluntary sector.

3) 24/7 staffed "Small Cohort" Properties.

Continually staffed, small volume services which are generally mainstream housing 'type' accommodation. Primarily standard 'homely' properties but with full-time staff teams meeting both high physical and LD specific needs.

This would be 24/7 staffed care provision (but not at a clinical nursing level) that supports a small cohort of individuals within one setting/property. It is anticipated that each 'service' would support between 4-6 individuals of a roughly comparable need presentation.

We would intend to commission such services from the independent/voluntary sector. We are not yet decided in regards to whether services should be tendered individually or in bulk – this would be dependent on market conditions and appetite.

4) "Core and Cluster" 24/7 staffed service for individuals with particularly challenging behaviour.

Single Occupancy settings with consistent and relatively large staff teams delivering very complex care provision and behavioural management. [Some staff resource sharing across multiple individuals within a close geographic area – i.e. "core and cluster"].

It is envisaged that this service would be primarily delivered by specialised services within the independent and voluntary sector given the complex nature of the support needs of the individuals involved.

Services would need to be configured to be small enough to support individually delivered care and support, and yet 'pool' enough individuals within the wider service to ensure service continuity amongst the staff teams.

5) Intensive short-medium term residential provision.

Very high staff ratio service provision on a time limited basis to those individuals with the most complex and highest level needs/behaviours who are either in crisis or in transition.

It is envisaged that, much like core and cluster, the specialised nature of the service would necessitate that it be delivered by independent/voluntary providers with long standing experience, knowledge, and proven capability in this area.

3.5 Residential care for people with mental health needs

3.5.1 Purpose

The current discussion about the purpose of residential services for people with mental illness must be seen within the wider context of national and local legislation and policy. The Mental Health (Care and Treatment) (Scotland) Act 2003[10] puts a legal duty on local authorities to ensure provision of care and support services, including residential and support services. Therefore any commissioning intentions must ensure that this statutory duty continues to be met.

A new National Strategy for Mental Health is currently being finalised for publication this year (Mental Health in Scotland - a 10 year vision). The draft material[11] currently released relating to this

[10] http://www.legislation.gov.uk/asp/2003/13/contents
[11] https://consult.scotland.gov.uk/mental-health-unit/mental-health-in-scotland-a-10-year-vision/supporting_documents/mentalhealthstrategy.pdf

strategy indicates a desire to focus on early intervention, self-management and improving both access and efficiency of mental health services.

Locally, the Aberdeen City Partnership's strategic plan[12] indicates a more general desire to shift the balance of care away (for all adult social care client groups) from institutional settings. It should also be acknowledged that, locally, there has already been a significant drive to shift mental health resources away from a residential model through the *reregistration process* where services historically recognised as residential care settings have shifted their focus to providing housing support and care at home services. This was part of a wider drive to support people with mental illness to become more active and valued citizens within their communities.

It should, therefore, be recognised that the residential mental health services and care models described in this report form part of a much wider continuum of health and social care services that are intrinsically interrelated. Readers must recognise that this document does not provide the "full picture" of support to individuals with a mental health diagnosis.

Additionally, Aberdeen City has a Mental Health Strategy in place (The Joint Mental Health and Well-Being Strategy for Aberdeen City 2012–22), which places an emphasis on early intervention and the enhancing of existing services to best meet the needs of those with mental illness.

Therefore, our commissioning of residential services will, primarily, be focussed, on those individuals with severe and enduring mental illness with associated issues (such as physical health problems, behavioural or other such concerns). This ensures that mental health residential services are targeted efficiently, and on those with the greatest level of need. The mental health residential bed base will remain a small BUT very important element of the wider service provision made available.

What is essential is that all residential services will be *'recovery focused'* – i.e. there is ongoing encouragement to meet particular outcomes and any residential placement remains under review with the aim to achieve greater independence and meet an individual's full potential.

Mental Health residential services are easily accessible and responsive to local needs and demands.

- Mental Health residential services genuinely deliver person centred and recovery focused provision with improved outcomes.
- Mental Health residential services are able to link in and cooperate fully with the full suite of health and social care services available to adults with a mental illness.

3.5.2 What will we commission?

1) Standard Care Home provision for Mental Health clients (under 65)

This would be registered care home provision for individuals with a mental health diagnosis but who do not have care and support needs that are mental health specific. Rather, the standard care home provision currently offered to older adults and adults with a physical disability would best meet their needs.

The intention will be to negotiate on a Partnership wide basis with our standard residential and nursing care home providers to ensure that they are able and willing to register with the regulator to

[12] http://ihub.scot/media/1110/aberdeen-city.pdf

deliver services to this client cohort. This may necessitate Partnership support to engage with the regulator as a body corporate. Thereafter, once achieved, beds would likely be purchased on a spot purchase basis. These beds would be accessed from within the general care home estate governed by the National Care Home Contract (independent/voluntary sector).

2) Rehabilitation Residential Service

Short stay (2-3 year) Rehabilitation Residential Service with a focus on building independent living skills for those adults with complex needs but identified potential to move to community based living.

It is envisaged that this service would primarily be met through procuring the services of specialist providers within the independent and voluntary sector. This service would primarily be 'block funded' to support market stability and allow greater control in regards to placement flow. There may be capability to allow a small proportion of spot-purchase beds on top of the main block funding arrangements.

As will be indicated below, (in the infrastructure section), there will be a need to ensure that the physical environments of such a service are setup to allow for both physical and mental health needs.

3) Longer Stay Mental Health Residential Home provision

Longer Stay Mental Health Residential Home provision which primarily focuses on meeting ongoing complex mental health needs. However, this model will still retain a 'recovery and outcomes' focused delivery of service – with an intention that a proportion of residents would move to other forms of less intensive supported living over time.

Again, it is envisaged that this service would primarily be met through engaging the services of specialist providers within the independent and voluntary sector. This service would primarily be 'block funded' to support market stability and allow greater control in regards to placement flow. There may be capability to allow a small proportion of spot-purchase beds on top of the main block funding arrangements.

As will be indicated below, (in the infrastructure section), there will be a need to ensure that the physical environment of such a service are setup to allow for both physical and mental health needs.

4) Short Stay/Break Residential Service

Short term (1 week) provision of Short Stay/Break residential type care support for individuals who are either in crisis or requiring planned support at a residential level for a short term period. [NOTE: this is not informal carer respite provision, rather short stay provision for the benefit of mental health service users themselves].

Again, it is envisaged that this service would primarily be met through engaging the services of specialist providers within the independent and voluntary sector. This service would primarily be 'block funded' to support market stability + allow greater control in regards to placement flow. There may be capability to allow a small proportion of spot-purchase beds on top of the main block funding arrangements.

As will be indicated below, (in the infrastructure section), there will be a need to ensure that the physical environments of such a service are setup to allow for both physical and mental health needs.

3.6 Intermediate care

3.6.1 Purpose

The purpose of Intermediate Care is to provide a short term intervention to preserve the independence of people who might otherwise face unnecessary, prolonged, hospital stays or inappropriate admission to hospital. The care is person centred, focused on rehabilitation and delivered by a combination of professional groups.

"Maximising Recovery, Promoting Independence: An Intermediate Care Framework for Scotland"[13] locates *bed based* intermediate care as part of a wider continuum of services both on a 'step up' basis during periods of acute need, and a 'step down' basis during recovery. Any intermediate bed base is therefore a constituent part of a much wider network of care and support to which the Partnership will be investing.

The primary client group to whom the Partnership will be directing its bed based intermediate care resources will be *older adults*, although *younger adults with a physical disability* and a small cohort of *adults with mental health issues* will also benefit from such a resource. The resources described should be configured in such a way that they can deliver intermediate care to individuals who, *as a secondary issue*, have drug and alcohol dependency alongside their main physical/mental health presentation.

The models of intermediate care the Partnership utilises will vary depending on patient/client cohort and the cost/benefit analysis of locality working vs economies of scale. It is clear that if the Partnership wishes to achieve a reduction in hospital admissions, delayed discharges, and a general shift in the balance of care away from institutional resources – high quality intermediate care will be a key driver of these objectives.

3.6.2 What will we commission?

1) Locality based Intermediate Care:

It is envisaged that this service would primarily be met through linking in with the local voluntary and independent care home sector. Beds would be reserved and 'block booked' with care homes in each locality to deliver 'care' and 'hotel' services to patients/clients. It is likely that this would be under the auspices of the National Care Home Contract as the client/patient cohort would not be expected to exceed the demands of standard nursing/residential care.

Assessment, care planning and rehabilitation delivery would be the responsibility of local integrated health and social care teams, who would 'outreach' to the beds within their locality area.

[13] Maximising Recovery, Promoting Independence: An Intermediate Care Framework for Scotland (2012): http://www.gov.scot/resource/0039/00396826.pdf

2) Centralised Comprehensive Intermediate Care – Care Home Model:

Larger volumes of centralised intermediate care that provides intensive step-up and step-down for individuals with a need profile at point of admission up to and including nursing home level care.

It is envisaged that the 'care' elements of the service would be met by one provider – to allow for economies of scale and ease of coordination. We are not yet decided as to whether this provider would be the Council/NHS directly, or a third/independent sector provider – however any potential 'non-state' provider would have to evidence significant robustness of service delivery given the critical nature of this model to Partnership priorities.

3) Centralised comprehensive intermediate care for both 'step up' and 'step down' – via a ''housing' type model:

It is envisaged that the 'care' elements of the service would be met by one provider – to allow for economies of scale and ease of coordination. Again, we are not yet decided as to whether this provider would be the Council/NHS directly, or a third/independent sector provider – however any potential 'non-state' provider would have to evidence significant robustness of service delivery given the critical nature of this model to Partnership priorities.

3.7 Out of Hours & Responder Service

3.7.1 Purpose

The purpose of out of hours and community response services is to provide both scheduled and unscheduled or emergency care to those in need. The current out of hours service provision appears to have areas of duplication and a large volume of responses tend to be handled in isolation by services and often in a way which can result in inappropriate and unnecessary admissions to the acute sector. Staff working in OOH services deal with many difficult pressures particularly delivering care during unsocial hours and through the night. This involves caring for patients who may be seriously unwell, often working in isolation from colleagues. OOH services and the pathway for the patient, is complex therefore it is difficult for the public and professionals to know where to refer their patient/client to. This can result in people finding it difficult to know where to seek advice or to go with their care requirements. There has previously been work done through NHSG and NHS 24, to inform the public, for example the know who to turn to campaign.

OOH services are required in response to a number of needs that present or are referred to:

- Medication management; typically, individuals have run out of medication, taken medication at the wrong time, taken the wrong amount of medication in error, are experiencing side effects of medication, have queries or anxiety about medication. These are often non-complex issues to resolve but time consuming for those involved.
- Equipment; users typically present with a requirement for equipment due to deterioration of condition or with equipment that is not functioning properly thereby posing potential risk to both patient and carer.

- Acute care; patients present with acute episodes or exacerbations of existing conditions either of which may be predictable or unpredictable.

- Palliative care; in general, this is the result of an exacerbation of condition resulting in call out of services. This is due to a number of factors eg fear of carer or family/relatives who feel unable or unsupported to deal with the situation, work/family demands, lack of care staff to support family and provide respite for family carers etc.

- The frail elderly; they may require an OOH service due to falls, confusion, deterioration of co morbidities, or UTI's.

- Mental health; OOH services may be required to deal with dementia, psychosis, emotional crisis, alcohol induced crisis, rescue medications or personality disorders

The Scottish Government's Review of Primary Care Out of Hours Services[14] recommended that:

- Health and social care partnerships should look for opportunities for integrated OOH service provision from Local Authorities and the NHS, including co-location opportunities
- Future models of care should meet local need and focus on early intervention and prevention
- A multidisciplinary OOH workforce be developed
- The use of video-conference technology, telehealth and telecare be enhanced including the use of mobile 'apps', to promote self care and to assist best use and access to urgent care services.
- Local care pathways need to be developed, clearly understood and delivered

3.7.1 What will we commission?

There is a need to have a more integrated blended approach where services can work together to maintain the patient, where possible, in their own home until contact with required services for assessment etc. can be undertaken the next day.

An integrated response service combining a single point of access for unscheduled support, capable of triaging the needs that are presented, supported by multi-disciplinary responders and enabled through the innovative use of assisted technology.

Pathway to reduce the number of services who become involved by "default" i.e. Police are called if there is no response to Community Alarms etc. they are often then expected to pick up patients who have fallen etc.

Care worker bank - access to "bank" of Care Provision so that short term support can be put in to avoid admission to the acute sector; able to be called on to provide support to the patient overnight until full assessment by the appropriate person can take place the following day. practically, this would not be feasible at this time due to the current fragility of the Care Worker market. There is a national Care Worker recruitment crisis and it was agreed that the role of the Care Worker needs to be enhanced with a clear career pathway to encourage people to take up this role.

[14] Pulling Together: transforming urgent care for the people of Scotland, November 2015

A more cohesive relationship with the Third Sector needs to be considered so that a full range of support services is available to support patients in Aberdeen City. Communication is pivotal across all services and there needs to be "good practice" in relation to data sharing i.e. promotion of multi disciplinary ACP's. Encourage Multi-Disciplinary ACP's so that all information including provision of specialist equipment and who to contact in the event of breakdown / malfunction etc.

3.8 Reablement service

3.8.1 Purpose

In this context, we see reablement as specific interventions provided to support people to learn or relearn skills necessary for daily living distinct from a wider concept approach to enablement which we endorse as a fundamental underpinning way of working across all of our health and social care services. Our intention is to develop a time limited reablement programme that would essentially form the gateway into continuing care with a view to enabling more people to remain safely at home and to reducing the costs of care. Providing personal care, help with daily living activities and other practical tasks, usually for up to six weeks, reablement encourages service users to develop the confidence and skills to carry out these activities themselves and to continue to live at home. It tends to be provided to people who have just been discharged from hospital or are otherwise entering the care system following a crisis.

Adults in Hospital or Community settings identified as having a new care need or a changed care need would be referred to the service. The requirement to be assessed for an identified care at home need is the primary reason for referral to this service.

3.8.2 What will we commission?

A service that is an integral part of the care at home pathway and that forms the gateway into care at home services, with the aims of:

- assessing service users' functional ability within their own homes (or homely setting), working with the service user and their family and/ or carers over a time-limited period to maximise their independence with activities of daily living, and determining any on-going care at home service requirements required
- supporting individuals to lead full and independent lives while ensuring most cost-effective use of available care at home resources.

A single-access point into assessment for care at home and a reablement programme for adults where a new care need or a change to their care support requirements has been identified

- Time limited reablement programme (up to 6 weeks)
- Care at home reablement Service comprising care management/coordinators, occupational therapy and aligned care workers/ health care support workers
- Clear pathways to other key services during the programme, such as physiotherapy, to ensure timely access
- A person-centred approach – focussing on personal goals/outcomes using an agreed approach e.g. Talking Points
- Client-held support plans
- Social connectedness – facilitating links to community/ third sector support would be a key feature. Link workers may have a role in supporting this.

- A focus on ensuring support for unpaid/family carers to enable them to be able to continue in their caring role
- Optimising the use of telecare to support independence

1) Single access point and referral vetting process

- Referrals will come from a wide range of sources i.e. Medical, Nursing, AHP, Social Care, Care workers, self-referral and referrals from carers
- All referrals will be made through a Single Access Point
- An agreed referral format would be used e.g. Single Shared Assessment (SSA). For self-referral and referral from other non-statutory service routes, a suitable method of referral would need to be agreed
- All referrals would be vetted to ensure suitability for this pathway or redirected if inappropriate and a Key Worker identified

2) Assessment process

- An holistic assessment of the individual's physical, cognitive and functional abilities and social circumstances would be carried out by the care manager/coordinator or occupational therapist to assess reablement potential, including motivation to engage with this approach
- Baseline measures will be established and reassessed post-intervention
- Personal goals will be agreed with the client – SMART goals
- An intervention plan will be agreed with the client/family

3) Interventions

- 6 week programme- expected date for end of the programme agreed at the outset
- Reablement plan agreed with the client/patient
- Programme delivered by Care workers/OTs as appropriate
- Where there is a pre-existing care at home arrangement, the programme would be delivered in conjunction with the current care at home provider's care workers
- Continuous monitoring of improvement towards achieving personal goals
- Weekly review meetings of progress
- Links made to any other relevant services to support a successful outcome from the programme e.g. timely access to Physiotherapy
- TEC solutions considered as part of the reablement programme – short and long term solutions
- Links made to community solutions/groups that will help support transition from the programme/achievement of the agreed goals

4) Review

- Expected date of discharge from the programme identified at the outset
- Continuous monitoring of improvement towards achieving personal goals
- Weekly review meetings of progress against the personal goals with the assigned Care Manager/OT
- Close working with any pre-existing care at home provider

- By week 4, a formal assessment of progress towards goals by the Key Worker and determination of on-going care needs and plans made with care at home provider to support continuing care at home needs

5) Discharge/exit routes from the reablement service

- **No on-going social care needs** – return to pre-enablement level of functioning – exit route would include signposting to community support to maintain functional status and feedback to referrer
- **Continued need for care at home support** – level would have been determined and arrangements would be in place with care provider, including a robust handover/ transition from the reablement service to the longer-term provider.

For both exit routes, links to primary care and community services including updating Anticipatory Care Plans would be a routine part of the discharge process.

4. MARKET FACILITATION STATEMENT

4.1 OUR APPROACH TO MARKET FACILITATION

There are three commonly understood elements of market facilitation: market intelligence or analysis, market structuring, and market intervention, as described below.

Intelligence/analysis: the development of a common and shared perspective of supply and demand. Market intelligence should help the commissioner to understand the structure of market, key players, current market offerings, market drivers, the scope for innovation, market capacity and capability, and barriers to entry. It is critical to assessing market readiness, supporting provider resilience, and preventing or managing supplier and market failure.

Structuring: making explicit to providers how the commissioner intends to perform and behave in influencing the market. For example, this might include communications with providers and service users, ongoing planning, quality assurance or performance management arrangements designed to encourage desired services and discourage those that are not needed.

Intervention: the interventions commissioners make in order to deliver the kind of market believed to be necessary to achieve desired outcomes and impact. For example, this might include financial incentives, offering specialist training, support to providers with business planning, setting up not for profit ventures, grants, or other forms of support for providers to encourage the development of particular services.

The collection and analysis of data and the publication of a market facilitation plan, or market position statement, constitute the major part of market intelligence activity. Market structuring and market intervention have some overlap and involve a wide range of tasks and activities. For example, an activity that works with providers to change the shape of purchasing from cost and volume to outcomes would be market structuring activity: the actual contract would be a market intervention.

The partnership recognises that it is at an early stage in developing its capability in market facilitation and is committed to improving practice in all three elements.

4.2 Our ideal marketplace

Our ideal is a diverse, active, and sustainable market that matches people's individual needs and preferences to an appropriate range of high quality services and support, and offers them real choice and control over how their needs are met.

As well as a range of established independent and third sector providers, we wish to see small-scale providers and micro-enterprises able to form a vibrant and valuable part of the markets through the close local connections they often have and by their ability to provide very bespoke support in response to individual requirements.

Our view of the ideal market also encompasses social action initiatives such as time banking, befriending and meal sharing.

4.2.1 The providers we want to work with

The providers we want to work with are those who:

- have explicit quality standards and carry out independent monitoring
- are committed to active engagement with service users and communities and are willing to work towards a co-production approach
- are able to show the impact of their activities in terms of the outcomes they achieve rather than in terms of the number of people for whom they provide a service or the number of hours delivered
- wish to innovate and are willing to try new models of care, delivery and contracting
- have a collaborative approach to working with the Partnership and with other providers

4.3 Supply

Concerns about the stability of the UK care market, particularly given the growing dependence on the private sector market, are well documented. As we have seen, in Aberdeen all care at home and residential care is purchased externally with independent and third sector providers facing many of the same challenges as those faced nationally and across the UK. There have additionally been some high profile care home failures within the city in recent years. In recognition of the risks posed, we will commission a "service of last resort" in order to ensure continuity of care to service users of "failing" or "failed" services until such time as alternative arrangements for the running or delivery of the service are in place. This element of service provision should, in future, be clearly defined and understood as contingency for provider failure or serious service interruption brought about by financial or business failure such as insolvency; quality failure such as major safeguarding concerns or Care Inspectorate intervention; force majeure such as fire or flood; management or workforce failure such as inability to recruit a manager; and strategic exit eg divestment or change of registration.

4.2 What providers can do to prepare

- Develop models of care that focus on the holistic wellbeing of the person and on helping the individual to achieve personal and social outcomes as opposed to simply delivering personal care tasks

- Ensure they have in place means of evaluation that show the impact of their activities in terms of the outcomes they achieve rather than in terms of the number of people for whom they provide a service or the number of hours delivered
- Ensure they have mechanisms in place to engage, and, preferably, co-produce with service users and their families
- Consider how their services are, or can be made, preventative in their focus and how they support people to be as independent as possible
- Consider how their services work within local communities and how they support the building of capacity within those communities
- Recognise that increasingly the purchasing partner will no longer be the Partnership but will be the service user or groups of service users via SDS
- Consider how their services and staff can form part of, or wrap around, the multi-disciplinary locality teams
- Explore new forms of collaborative partnerships with other providers (eg alliancing, consortia, prime providers, joint ventures)

5 STRUCTURE AND GOVERNANCE

6.1 Commissioning Board

Whilst the ultimate body responsible for approving this Plan and its intentions is the IJB, the Commissioning Board, chaired by the Head of Strategy and Transformation, will be responsible for oversight and review of the strategy on an annual basis.

The role of the Board is to

- Ensure the partnership's approach to commissioning remains fit for purpose
- Maintain oversight of commissioning activity across the partnership, especially where this involves sourcing from third parties
- Ensure the effectiveness and efficiency of commissioning across the partnership

6.2 Market facilitation steering group

The primary role of the Market Facilitation Steering Group is to represent the perspective of providers in the ongoing development and monitoring of the Partnership's market facilitation plan and activity. It comprises representatives from the partnership, the Commercial and Procurement Service, and from provider groups ACVO, CASPA and Scottish Care.

In order to fulfil this role, the group has responsibility to ensure that:

- the plan meets the needs of providers in terms of giving them meaningful information that helps them to prepare for forthcoming business opportunities
- the views of providers inform the plan
- the plan is consistent with Scottish Government requirements and with best practice
- the plan benefits from the expertise and experience of providers
- the plan is reviewed and refreshed annually.

it is envisaged that this group would continue to operate and hopefully flourish as we endeavour to deliver our shared ambitions of improved experiences and outcomes for the individuals who use our services and their families.

6.3 HOW THE PARTNERSHIP PROCURES SERVICES

Buying health and social care services is a complex area which requires particular consideration within the overall approach to the procurement of goods, works and services. This is because these services have a considerable impact on the quality of life and health of service users. As a result of this complexity, procurement and contract management of these services is undertaken by a dedicated team – the Social Care Commissioning, Procurement and Contracts Team (SCCPC). The team also supports both the Aberdeen City and Aberdeenshire's Health and Social Care Partnerships and both Councils' Children's Services with strategic commissioning activity.

As a guiding principle, the team place the procurement of services within the wider context of strategic commissioning, taking account of procurement and social work legislation and policy direction, such as human rights, personalisation and the integration of health and social care.

Within that context, compliance with the following is required:

- Procurement Reform (Scotland) Act 2014, particularly Sections 12 and 13
- The Public Contracts (Scotland) Regulations 2015, particularly Chapter 3 Section 7
- The Procurement (Scotland) Regulations 2016.
- Aberdeen City Procurement Regulations and Aberdeenshire Financial Regulations including the values and thresholds set out in these documents and the specific sections on the exceptional procedure for Health or Social Care Services
- Statutory guidance on the procurement of care and support services
- Best Practice guidance on the procurement of care and support services
- guidance given in the Procurement Journey

All Partnership contracts are tendered via Public Contracts Scotland – Tender, an online electronic service commonly known to professional buyers as an e-Sourcing platform. The Scottish Government has implemented PCS-Tender along with various partners to help Scottish public sector organisations adopt standard processes for goods, services and works for a wide variety of contracts. PCS-Tender provides a more consistent tendering experience for suppliers, enabling them to store answers to standard questions. Registration is quick and easy to carry out on-line.

6.4 HOW CONTRACTS ARE MANAGED

Contract management is about active management of the relationship between the Partnership and the provider over the life of the contract for the delivery of services to the agreed standard. There are three aspects to effective contract management, all of which must be actively managed: performance management, relationship management and contract administration.

The Contract Management Framework sets out a proportionate approach to risk to determine frequency of monitoring activity. Contracts are monitored for compliance with terms and conditions, and for quality and value for money. The Framework also describes the process to be followed in non-compliance situations. Guidance is available for Providers on our Contract Management Framework, so that they know what to expect from the process.

Three key factors for successful provider relationship management are:

- Mutual trust and understanding
- Openness and excellent communications

- Dealing with problems early

All contract information is recorded and managed using an electronic database system developed specifically for use by the team (Capita Support). The system enables a range of reports to be produced, including team performance, monitoring reports on performance of contracts to assist with strategic commissioning decisions, and data to be uploaded to the Corporate Contracts Register.

6.5 SUPPORT FOR THE MARKET

6.5.1 Principles/behaviours – what providers can expect from the Partnership

- mutual honesty and respect
- acknowledge and value the contribution that each provider makes
- openness and transparency
- consult with and inform providers about our plans for the future
- open and fair in all aspects of our procurement and tendering
- proactive in identifying and supporting potential partnership working between providers

6.5.2 Getting the basics right

- ensure information is clear, consistent and timely
- respond to queries and concerns as quickly as possible
- flexible and proportionate procurement processes appropriate to size and scale of service being commissioned
- structure payment mechanisms in a way that helps providers manage cash flow
- 'simplest by default' payment mechanisms eg might a grant/funding agreement be more appropriate in some circumstances?
- Pay providers on time and accurately
- design contract size around end need and purpose eg smaller lots relevant to service being commissioned, market and geography
- allow sufficient time for bids to be developed and submitted, partnerships/consortia to be formed etc
- longer term contracts/funding arrangements
- make sure providers know how to escalate issues and to whom
- keep providers up to date with changes in personnel /structure etc
- full cost recovery - do not expect providers to subsidise the service
- Supplier Incentive Service (SIS). When suppliers sign up to the service they will become eligible for benefits including improved cash flow through early ayment; increased process efficiency via e-invoicing, dedicated processing and query resolution; enhanced channels of communication due to an improved P2P process; enhanced client satisfaction and visibility as a SIS member within the council.

6.5.3 Encouraging innovation

- Directly fund innovation through seed or start up 'innovation' funding. Recognise that not every innovation will be successful.
- Design potential for innovation into contracts eg ensure terms and conditions are flexible enough to allow for changes in technology or service approach during the life of the contract.

- Talk to providers about what is reasonable. Increased risk for the provider means an increased risk of provider failure.
- Create space for innovation eg innovation workshops with providers
- Support the development of community micro enterprises – invest in support, provide a point of contact and effective help for local people with a good idea who are keen to set up an enterprise
- Grants/funding agreements for small voluntary/community organisations
- Facilitate access to funding eg signpost to alternative sources, assist with applications, endorse applications
- Advocacy, speaking on behalf of providers eg in discussions with Care Inspectorate, SSSC
- Rewarding/recognising engagement in contracts and in contract prices

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Aberdeen City Health & Social Care Partnership
A caring partnership

Integration Joint Board

Report Title	Transformation Programme – Decisions Required
Lead Officer	Judith Proctor, Chief Officer
Report Author	Gail Woodcock, Integrated Localities Programme Manager (ACHSCP)
Report Number	HSCP.17.063
Date of Report	7/7/17
Date of Meeting	15/8/17

1: Purpose of the Report

1.1. The purpose of this report is to request approval from the Integration Joint Board to incur expenditure, and instruction to issue Directions to NHS Grampian and Aberdeen City Council, in relation to projects that sit within the Partnership's Transformation Programme.

1.2. The projects relate to strategic decisions, set out in the overall transformation programme that have previously been agreed in principle by the IJB as key areas of change in delivering on the direction set out in the Strategic Plan.

2: Summary of Key Information

2.1 Background

The Transformation Programme for the Aberdeen City Health and Social Care Partnership, agreed by the IJB, includes the following priority areas for strategic investment:

- Acute Care at Home
- Supporting Management of Long Term Conditions – Building Community Capacity
- Modernising Primary and Community Care
- Culture Change/ Organisational Change

Integration Joint Board

- Strategic Commissioning and Development of Social Care
- Information and Communication Technology and Technology Enabled Care (included within a wider work programme also including infrastructure and data sharing)

As set out above, these programmes, consisting of a range of individual and linked projects, seek to support the delivery of the objectives and aspirations as set out in our Strategic Plan.

Good governance and delegation levels require the IJB to approve the level of expenditure on these projects and directions to both NHS Grampian and Aberdeen City Council that will enable funding to be released to deliver the projects. The governance structure in place has ensured effective operational and executive oversight:

- A programme management approach has been adopted across our transformation portfolio. This approach seeks to ensure progress while managing the natural tensions that will exist between corporate strategy, change processes, and business as usual operations.

- The programme governance structure has been established to support the development and delivery of transformation at pace and at scale. This includes the Executive Programme Board which is tasked with providing overall direction to the complex programme of activities, in line with agreed strategy and policy. Three further Programme Boards, including a broad range of stakeholders, are in place to support progression at pace. Working Groups ensure progress on agreed portfolio projects, including supporting the development of business cases and specific projects which are delivered by Project Teams.

- There is a good cross section of involvement from across the wider partnership throughout our programme management structure, including executive, operational, strategic, business functions, and including representation from our partners, NHS Grampian, Aberdeen City Council, 3rd Sector and Independent sector.

- Work is ongoing to support all aspects of this complex programme of activity to comply with best practice in relation to programme management and good governance. This includes the adoption of an iterative project development process including the development of robust business cases which clearly identify the anticipated benefits, inputs required, and risks of any project.

2.2 Authority to progress with specific procurements and grants

This report seeks authorisation from the Integration Joint Board for approval to:

- Incur expenditure in respect of the following item which have already been considered and recommended for approval in principle by the Executive Programme Board and discussed and developed through Working Groups where appropriate.

A Project Summary report for for this item is attached as an appendix to this report. The full business case is available for review by IJB Board members by contacting the report author.

2.2.1 Enhanced Carers Support Service

This project will test the implications of identifying and supporting carers at an earlier stage, including streamlining processes and ensuring that more unpaid carers have appropriate access and supports to assist them in their caring role.

A project summary is attached at Appendix A. A full business case was approved by the Executive Programme Board on 26 July 2017. The IJB is requested to approve the expenditure relating to this project and instruct the Chief Officer to issue directions.

2.3 Change Control: THInC Project

At its meeting on 28 March 2017, the IJB approved: *"the expenditure of £73,775 required to continue the THInC project through to 31 March 2018, through the provision of a grant to Aberdeenshire Council, subject to State Aid assessments*".

Subsequent to this decision, further information has become available which means that of the total project amount of £73,775, £12,064 will be incurred by Aberdeenshire Council and £61,711 will be incurred by Buchan Dial A Community Bus (BDACB) (the transport operator). Aberdeenshire Council has confirmed that they are unable to accept the full grant and pass part of that grant to BCACB.

A change control is therefore required to allow officers to process the grant in two parts, to Aberdeenshire Council (£12,064) and to BDACB (£61,711).

Note: the total funding required remains the same.

Integration Joint Board

IJB members will recall that the extension of the THInC project was to allow additional time for a review of social transport options for Aberdeen, and an external specialist (funded by HTAP) has now been identified to undertake this review with a report with recommendations expected in January 2018.

3: Equalities, Financial, Workforce and Other Implications

3.1 Financial Implications

The recommendations in this report will result in financial expenditure from the Integration and Change budgets as follows:

Project	Year 1	Year 2	Total
Enhanced Carer Support Service	£94,766	£94,766	£189,532

These costs are planned for in the current Integration and Transformation Programme financial plan, and are within the available budget.

The projected Integration and Change Fund financial position for 2017/18 at the time of writing this report is as follows (assuming the recommendations in this report are approved):

	£'000
Balance (17/18)	10,172
Income Received (17/18)	18,509
Expenditure Budget (17/18)	14,719
Agreed on programme (17/18)	8,864
Remaining funds (17/18)	**5,098**

3.2 Equalities Implications

The recommendations are expected to have positive implications in relation to the following protected characteristics: age and disability.

3.3 Workforce Implications

There are no partnership workforce implications as a result of this report.

Integration Joint Board

4:	Management of Risk

4.1 Identified risk(s):

Risks relating to the Transformation Programme are managed throughout the transformation development and implementation processes. The Executive Programme Board and portfolio Programme Boards have a key role to ensure that these risks are identified and appropriately managed.

The business case for each project clearly identifies the risks and mitigations that will be put in place.

In respect of the Carers Support Service, risks include a risk of legal challenge as no full procurement process is proposed for this test, along with risks that expectation is increased and project does not deliver desired benefits.

4.2 Link to risk number on strategic or operational risk register:

The main risk relates to not achieving the transformation that we aspire to, and the resultant risk around the delivery of our strategic plan, and therefore our ability to sustain the delivery of our statutory services within the funding available.

9. Failure to deliver transformation at a pace or scale required by the demographic and financial pressures in the system

2. There is a risk of financial failure , that demand outstrips budget and IJB cannot deliver on priorities, statutory work, and project an overspend

4.3 How might the content of this report impact or mitigate the known risks:

This paper seeks approval to incur expenditure in order to progress a number of projects related to the transformation programme. Progress in these activities will positively contribute to the pace of transformation.

Integration Joint Board

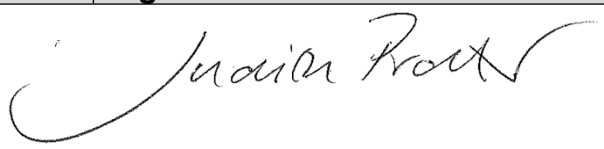
5:	Recommendations for Action

It is recommended that the Integration Joint Board:

1. Approves expenditure of up to £189,532 (total for two years) in relation to the Enhanced Carers Support project, subject to State Aid assessments.

2. Approves the project change in relation to the grant funding for the THInC project as per section 2.3

3. Issues the Direction attached at Appendix B, and instructs the Chief Officer to issue to Aberdeen City Council, appending the Business Cases to the Direction.

6:	Signatures	
		Judith Proctor (Chief Officer)
		Alex Stephen (Chief Finance Officer)

Appendix A: Project Summary: Enhanced Carer Support Service

Appendix B: IJB Direction to Aberdeen City Council – Enhanced Carer Support Service

Project Summary

Date: 7/7/17

Project Name	Enhanced Carer Support	Author	Gail Woodcock

1 Summary of Project

This project will test the implications of identifying and supporting carers at an earlier stage, including streamlining processes and ensuring that more unpaid carers have appropriate access and supports to assist them in their caring role.

The project will support the recommendations of the Joint Inspection of Services for Older People and will contribute to the Partnerships developing Carers Strategy which is being developed in response to the Carers' (Scotland) Act 2016.

2 Anticipated Benefits

Customer/ Client Benefits

- Earlier access to carers' support for unpaid carers
- Improved carer satisfaction
- Improved health and wellbeing of unpaid carers
- Increased uptake of appropriate benefits/ income maximisation by unpaid carers

Staff Benefits

- Staff providing social work services are more satisfied as a result of reduced unmet demand
- Improved multi-disciplinary working resulting in more efficient hospital discharges and greater staff morale

Resources Benefits (financial)

- Increased capacity within older people, physical disability and rehab services as a result of reduced quantity of unmet demand, including reduced acute hospital admissions and reduced delayed discharge (whether this benefit may be cashable will seek to be established during the test period)
- Carers supported to continue in their caring role for longer, delaying the point at which statutory service are required (this is likely to be a long term financial benefit and with changing demographics may ensure sustainability of existing resource rather than cashable benefits.)
- Faster referral process, unpaid carers given support sooner, reducing the likelihood of carers being unable to continue their carer role, and therefore the reducing the need for statutory care for those being cared for.

3 Options Considered

A: Do nothing

This option would see carers support continued to be offered via existing arrangements. While there would be no impact on current costs, this option would not allow a new model to be tested, and the impacts of the test would be unknown. Failure to transform may result in increased long-term costs as a result of increasing demands.

B: Deliver new service through a full tendering and procurement process

This option would ensure full market testing, however the timelines involved would mean that lessons learned from the test would not be available in a timely fashion in order to inform commissioning planned for 2018/19.

C: Test impact of enhanced service through variation of existing contract to incorporate a two year test of change

This option will be quick to implement and lessons learned will be available in a timely manner to inform future procurements. This approach does not ensure best value during the test period and may create a potential for legal challenge

Further to scoring against the project objectives, **Option C** is the preferred option and has been developed into a full business case.

4 Financial Implications

Expenditure	Year 1	Year 2
Staffing Resources	£76,400	£76,400
Non-staffing resources	£18,366	£18,366
Sub-Total	**£94,766**	**£94,766**

Note: It would be intended to fund this from the Integrated Care Fund.

5 Exit Strategy

This is a test of change and will be evaluated during the project duration. If the desired benefits are being achieved, a business case will be developed to support the longer term implementation of this service as part of future commissioning plans.

INTEGRATION JOINT BOARD

DIRECTION

ISSUED UNDER S26-28 OF THE PUBLIC BODIES (JOINT WORKING) (SCOTLAND) ACT 2014

The **Aberdeen City Council** is hereby directed to deliver for the Board, the services noted below in pursuance of the functions noted below and within the associated budget noted below.

Services will be provided in line with the Board's Strategic Plan and existing operational arrangements pending future directions from the Board.

Approval from IJB received on:- 15 August 2017

Description of services/functions:- Enhanced Carer Support Service. A high level description of this project is set out in the attached Project Summary and a detailed Business Case is also attached.

Reference to the integration scheme:- This project will contribute to the delivery of functions delegated by the Local Authority to the Integration Joint Board: Duty of local authority to provide information to carer, duty of local authority to take into account abilities of carer; support for adult carers (in relation to Social Care Self Directed Support).

Link to strategic priorities (with reference to strategic plan and commissioning plan):- This direction seeks to support delivery of the following strategic priorities:

- Develop a consistent person centred approach that promotes and protects the human rights of every individual and which enable our citizens to have opportunities to maintain their wellbeing and take a full and active role in their local community.
- Support and improve the health, wellbeing and quality of life of our local population.
- Promote and support self-management and independence for individuals for as long as reasonably possible.
- Value and support those who are unpaid carers to become equal partners in the planning and delivery of services, to look after their own health and to have a quality of life outside the caring role is so desired.
- Contribute to a reduction in health inequalities and the inequalities in the wider social conditions that affect our health and wellbeing.
- Strengthen existing community assets and resources that can help local people with their needs as they perceive them and make it easier for people to contribute to helping others in their communities.

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Timescales involved:-

Start date:- 1 October 2017

End date:- 31 March 2019

Associated Budget:-

Details of funding source:- Integration and Change Fund.

- Up to £191, 528 (total for two years)

Availability:- Confirmed

Prior to sending this direction, please attach a copy of the original report and the completed consultation checklist, the Project Summary report and the Business Case

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of the Local Government (Scotland) Act 1973.

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