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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 Luan Grugeon (NHS Grampian Board Members); and Mike Adams (Partnership Representative, NHS Grampian), Caroline Hiscox (Professional Nursing Adviser, NHS Grampian), Jim Currie (Trade Union Representative, Aberdeen City Council (ACC)), Bernadette Oxley (Chief Social Work Officer, ACC), Liv Cockburn (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, 23 January 2018

INTEGRATION JOINT BOARD

The Members of the **INTEGRATION JOINT BOARD** are requested to meet in **Meeting Room 5, Health Village on TUESDAY, 30 JANUARY 2018 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

4a Minute of Previous Board Meeting - 12 December 2017 (Pages 7 - 16)

4b Matters Arising

5 Draft Minute of Clinical and Care Governance Committee - 9 January 2018 for noting (Pages 17 - 24)

6 Business Statement (Pages 25 - 30)

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ITEMS THE BOARD MAY WISH TO CONSIDER IN PRIVATE

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19 Exempt Appendices - Transformation Decisions Required (Pages 293 - 322)

WORKSHOP

20 Regional Delivery Plan

To access the Service Updates for this Committee please use the following link: https://committees.aberdeencity.gov.uk/ecCatDisplayClassic.aspx?sch=doc&cat=13450&path=0

Website Address: http://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
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INTEGRATION JOINT BOARD

Minute of Meeting

12 December 2017
Health Village, Aberdeen

Present: Jonathan Passmore MBE (Chairperson); Councillor Sarah Duncan (Vice Chairperson); and Councillors Cooke and Donnelly; and Rhona Atkinson (for items 1-14) Dr Nick Fluck and Luan Grugeon (NHS Grampian Board members); and Laura MacDonald (as substitute for Mike Adams (Partnership Representative, NHS Grampian), Jim Currie Trade (Union Representative, Aberdeen City Council (ACC)), Caroline Hiscox (Professional Nursing Adviser, NHS Grampian), Faith-Jason Robertson-Foy and Gill Moffat (Carer Representatives), Kenneth Simpson (Third Sector Representative)(for items 1-14)), 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)(for items 1-14)), Judith Proctor (Chief Officer, ACHSCP) and Alex Stephen (Chief Finance Officer, ACHSCP).

Also in attendance: Tom Cowan, Head of Operations, ACHSCP), Iain Robertson (Democratic Services, ACC), Jess Anderson (Legal Services, ACC) (for items 1-14)), Alan Thomson (Legal Services, ACC) (for item 15)), Sally Shaw (Head of Strategy and Transformation, ACHSCP), Jennifer Rae (Planning Officer, ACHSCP)(for item 10)), Jennifer Laing (Bon Accord Care)(for item 11)), Susie Downie and Lorraine McKenna (ACHSCP)(for item 12)) and Alison MacLeod (Lead Strategy and Performance Manager, ACHSCP) (for item 13)).

Apologies: Councillor Samarai, Mike Adams and Angela Scott.

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.

WELCOME FROM THE CHAIR

1. The Chair opened the meeting and welcomed Caroline Hiscox onto the Board as Professional Nursing Adviser and thanked her predecessor Jenny Gibb for her work on the Board. The Chair also advised that Kenneth Simpson would also be standing down from the Board as the Third Sector Representative following today's meeting and thanked Mr Simpson for being a stalwart of health and social care integration in Aberdeen City during the past few years. The Chair added that Mr Simpson's successor would be nominated by the Aberdeen Council of Voluntary Organisations (ACVO) in due course.

Thereafter the Chair thanked all members and officers who had attended the two day workshop sessions on 21 and 22 November which he had found to be very useful. He also advised that today's meeting would be the first meeting with the Board's revised standing orders in effect; and noted that the Strategic Commissioning Plan had been deferred from today's meeting in order to ensure alignment with the Transformation Plan and would be presented to the Board on 30 January 2018 for consideration.

The Board resolved:-

(i) to welcome Caroline Hiscox onto the Board as the Professional Nursing Adviser;

(ii) to thank Jenny Gibb and Kenneth Simpson for their contributions towards the integration of health and social care in Aberdeen City; and

(iii) otherwise note the information provided.

DECLARATION OF INTERESTS

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

The Board resolved:-

To note that no declarations of interest were intimated by members for items on today's agenda.

DETERMINATION OF URGENT BUSINESS

3. The Chair advised that he had accepted item 10 (Scheme of Assistance Private Sector Grants Budget 2017-18) and item 14 (Care Home Provision) onto today's agenda as matters of urgency.

The Board resolved:-

To agree that items 10 and 14 be considered as matters of urgency in terms of Section 50(B)(4)(b) of the Local Government (Scotland) Act 1973.

DETERMINATION OF EXEMPT BUSINESS

4. The Chair proposed that item 14 (Care Home Provision) 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 and 9 of Schedule 7(A) of the Act.

MINUTE OF IJB MEETING – 31 OCTOBER 2017

5. The Board had before it the minute of the Board meeting of 31 October 2017.

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

MATTERS ARISING

6. The Chair asked if there were any matters arising from the meeting of 31 October 2017.

In reference to item 7 (Draft Minute of Clinical and Care Governance Committee), the Chief Officer advised that the Lead Social Worker would provide an update on fire safety to members in due course following engagement with colleagues from Aberdeen City Council; and

In reference to item 16 (Board Development Work), the Chief Officer explained that a consultation document had been circulated to members on 4 December 2017 and responses would provide the basis for a report to be presented to the Board at its meeting on 30 January 2018.

The Board resolved:-
To note the information provided.

DRAFT MINUTE OF AUDIT AND PERFORMANCE SYSTEMS COMMITTEE MEETING – 21 NOVEMBER 2017

7. The Board had before it the draft minute of the Audit and Performance Systems Committee of 21 November 2017 for information.

The Board resolved:-
(i) to accept the APS Committee's recommendation for the Board to review the Statement of Risk Appetite on an annual basis and request that this review be added to the Board's report tracker;
(ii) to note that the Board Assurance and Escalation Framework would be presented to the Board in January 2018; and
(iii) otherwise note the draft minute.

BUSINESS STATEMENT

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

The Board resolved:-
(i) to remove item 2 (Winter Planning) from the Statement;
(ii) to revise item 11 (Transformation Decisions) to note that Aberdeen City Council rather than the Partnership would be engaging with the Digital Partner; and
(iii) otherwise note the Statement.

CHIEF SOCIAL WORK OFFICER ANNUAL REPORT

9. The Board had before it a report by Bernadette Oxley (Chief Social Work Officer (CSWO), ACC)) which informed members of the role of the CSWO to provide information on statutory decision making in the period and to report on progress in key areas of social work and social care provision within Aberdeen City.

The report recommended:-
That the Board –
(a) Note the content of the Annual Report; and
(b) Offer comment and observations on the content.

Bernadette Oxley advised that the report included information on both children's and adult social work which covered a wide range of areas and she drew members attention to challenges in staffing and workforce planning. Ms Oxley explained that a new commissioning framework was being developed and the Board should pay particular attention to the management of risk section within the report as the IJB was accountable for adult social work services within Aberdeen City including the provision of statutory services such as criminal justice and adult support and protection.

Thereafter there were questions and comments on (1) the processes put in place following the disbandment of the Criminal Justice Board; (2) the learning disability strategy, with particular emphasis on young people transitioning between children's and adult social care; (3) pressures on Mental Health Officers and what steps the Partnership had taken to support these officers; (4) the provision and viability of social work courses at local universities; (5) the harmonisation of workforce planning within the Partnership; (6) the process for delegating powers from the CSWO to senior social workers; (7) the level of uptake in Self Directed Support; (8) the level of risk to the Partnership due to reductions in core funding; (9) Social Work's role in the provision of palliative care services; and (10) recent trends in positive destinations for looked after children within Aberdeen City.

The Board resolved:-
(i) to instruct the Chief Officer to provide information on how the Partnership could provide development opportunities and support to Mental Health Officers and to integrate this into the wider workforce planning work stream which would also include detail on engagement with external partners such as the universities;
(ii) to commend the Chief Social Work Officer for the detail provided within the report; and

(iii) otherwise note the report.

LEARNING DISABILITY COMMISSIONING

10. The Board had before it a report by Jenny Rae (Planning Officer, Strategy and Transformation Team, ACHSCP) which sought approval for the award of contracts for the tendered Framework for Supported Living Services.

The report recommended:-
That the Board –
(a) Approve the award of contracts for the Framework for Supported Living to the successful providers; and
(b) Direct the Chief Officer to issue a Direction to Aberdeen City Council to enable the completion of the contractual process.

Jenny Rae advised that following a successful tendering exercise, providers for Supported Living and Enhanced Supported Living contracts had been identified and she requested Board approval to issue these contracts.

The Board resolved
(i) to approve the award of contracts for the Framework for Supported Living to the successful providers; and
(ii) to direct the Chief Officer to issue a Direction on its behalf to Aberdeen City Council to enable the completion of the contractual process.

SCHEME OF ASSISTANCE PRIVATE SECTOR GRANTS BUDGET 2017-18

11. The Board had before it a report by Jenny Laing (Occupational Therapy Manager, Bon Accord Care) which provided information on the Scheme of Assistance budget and advised that the 2017-18 budget of £770,000 had been fully committed and that there would now be delays in progressing new applications for this fund.

The report recommended:-
That the Board –
(a) Agree additional funding of £250,000 in 2017-18 from the Integration and Change Fund to prevent delays in processing requests for adaptations;
(b) Instruct the Head of Strategy and Transformation to form a short-life working group, including representatives from Bon Accord Care, Aberdeen City Council and the ACHSCP, to undertake a review of the Scheme of Assistance policy and full working practices in order to ensure demand and budget are managed as efficiently and effectively as possible. This work needs to be completed and should be brought back to the IJB on 27 March 2018; and
(c) Instruct the Chief Officer to issue a direction to Aberdeen City Council allocating an additional £250,000 to the private adaptations budget.

Jennifer Laing advised that the Scheme of Assistance provided financial support to private households to adapt their properties based on assessed need. She requested that the Board agree to allocate an additional £250,000 to support the Scheme up to

the end of the 2017-18 financial year and recommended that a concurrent review of the Scheme take place to assess it future impact on IJB strategic planning.

Thereafter there were questions and comments on (1) the projected cost effectiveness of the Scheme for the wider health and social care system; (2) recent trends in the costs of administering the Scheme; (3) the proposed terms of reference for the Scheme's review and the importance of taking a holistic view on allocation of discretionary grants; and (4) the timescales for the review of the scheme and when recommendations would be reported to the Board.

The Board resolved:-

(i) to agree additional funding of £250,000 in 2017-18 from the Integration and Change Fund to prevent delays in processing requests for adaptations;

(ii) to instruct the Head of Strategy and Transformation to form a short-life working group, including representatives from Bon Accord Care, Aberdeen City Council and the ACHSCP, to undertake a review of the Scheme of Assistance policy and full working practices in order to ensure demand and budget are managed as efficiently and effectively as possible. This work needs to be completed and should be brought back to the IJB on 27 March 2018;

(iii) to instruct the Chief Officer to issue a direction to Aberdeen City Council allocating an additional £250,000 to the private adaptations budget; and

(iv) to instruct the Chief Finance Officer to ensure that the terms of reference for the Scheme of Assistance policy align with the Board's Strategic Plan, and further instruct him to circulate the review's terms of reference to members.

LOCALITY PLANS

12. The Board had before it a report by Susie Downie (Transformation Programme Manager, ACHSCP) which sought approval for the publication of the four Locality Plans which was a requirement of the Public Bodies (Joint Working) (Scotland) Act 2014.

The report recommended:-

That the Board –

(a) Approve the four proposed Locality Plans; and

(b) Note the ongoing development programme of work within the localities.

Susie Downie advised that the production of Locality Plans was a statutory requirement and explained that the plans provided a demographic snapshot for each of the four localities, including an assessment of local priorities and need. Lorraine McKenna (Head of Central Locality, ACHSCP) added that the Locality Leadership Group had led on the development of the plans and had engaged with a wide range of stakeholders. Ms McKenna also provided the Board with an overview of identified risks in relation to locality planning.

Thereafter there were questions and comments on (1) the use of inclusive language within the plans in relation to stakeholder and equalities groups; (2) the consultation process, with particular reference to expanding the breadth of the consultation to capture the views of individuals and groups who were not regular respondents; (3) the importance of integrating primary care and social care at locality level; and (4) the

administration of localities , with particular focus on locality boundaries, the centralised location of Partnership staff and opportunities for collaborative working.

The Board resolved:-

(i) to approve the proposed four locality plans;
(ii) to note the ongoing development programme of work within localities;
(iii) to note that Locality Plans were living documents and officers would continue to monitor narratives on engagement with stakeholders and equalities groups to ensure this language was both inclusive and compliant with the Board's statutory duty;
(iv) to note that progress with regards to implementing Locality plans would be presented to the Board on 22 May 2018; and
(v) to commend officers for their work in preparing articulate and easy to read plans.

CARERS STRATEGY

13. The Board had before it a report by Alison MacLeod (Lead Strategy and Performance Manager, ACHSCP) which presented a revised draft strategy which included additional content on Young Carers as requested by the Board at its previous meeting on 31 October 2017.

The report recommended:-

That the Board –

(a) Instruct the Chief Officer to issue the draft Carers Strategy – A Life Alongside Caring for wider public consultation; and
(b) Instruct the Chief Officer to bring the final version of the Carers Strategy to the IJB on 27 March 2018 for approval.

Alison Macleod advised that since the last Board meeting further detail on young carers had been added to the draft Carers Strategy and she requested Board approval to consult on the draft Strategy for a period of six weeks beginning on 8 January 2018 before the final plan was presented to the Board for approval on 27 March 2018. Ms Macleod explained that the publication of a Carers Strategy was a statutory requirement and highlighted that an action plan would also be prepared that would set out implementation timescales, ownership, resource and dedicated funding.

Thereafter there were questions and comments on (1) monitoring arrangements for the implementation of the Strategy and the need for carer involvement in this process; (2) the length of the Strategy's consultation period; (3) financial implications on the Partnership in relation to the Strategy's implementation; and (4) the need for key IJB strategies to be reviewed prior to the next review of the IJB Strategic Plan to inform its future development and ensure alignment.

The Board resolved:-

(i) to instruct the Chief Officer to issue the draft Carers Strategy – A Life Alongside Caring for wider public consultation;
(ii) to instruct the Chief Officer to bring the final version of the Strategy to the IJB meeting on 27 March 2018 for approval;

(iii) to note that responsibility for monitoring the implementation of the Carers Strategy rested with the Clinical and Care Governance Committee; and
(iv) to instruct the Strategic Planning Group to review all IJB strategies and report back to the IJB for approval in order to inform the development of the next Strategic Plan.

UNDERSTANDING PROGRESS UNDER INTEGRATION

14. The Board had before it a report by Sally Shaw (Head of Strategy and Transformation, ACHSCP) which provided an update on the work of the Ministerial Strategic Group for Health and Community Care (MSG) and sought agreement to revise ACHSCP's objectives for the year 2017-18.

The report recommended:-
That the Board –
(a) Note the change in collection of the data by MSG, including the proposed framework for sharing regular updates and request for revised objectives;
(b) Instruct officers to develop new objectives for agreement by the IJB at its meeting on 30 January 2018 prior to submission to MSG; and
(c) Instruct officers to look at how the Partnership could enhance data with locally determined measures in order to maximise the usefulness of such data collection.

Sally Shaw provided an update on a recent request made by the Ministerial Strategic Group (MSG) for the Partnership to submit revised performance indicators. The Chair added that reporting these indicators to the MSG was not a statutory requirement but it may be in the Board's interest to provide this information in order to steer the MSG on performance and reporting priorities moving forward.

Thereafter there were questions and comments on (1) the Partnership's engagement with ACC's Commercial and Procurement Service, NHSG's Health Intelligence Unit and Scotland Excel; and (2) Partnership plans to review outcomes and indicators within its performance management framework.

At the conclusion of this item, the Chair wished all Board members, officers and members of the public a Merry Christmas and Happy New Year prior to the Board moving into private session.

The Board resolved:-
(i) to note the change in collection of the data by MSG, including the proposed framework for sharing regular updates and request for revised objectives;
(ii) to instruct the Chief Officer to develop new objectives for agreement by the IJB at its meeting on 30 January 2018, prior to submission to MSG; and
(iii) to instruct the Chief Officer to look at how the Partnership could enhance data with locally determined measures in order to maximise the usefulness of such data collection.

In accordance with the decision recorded under article 4 of this minute, the following items were considered with the press and public excluded.

CARE HOME PROVISION

15. The Board had before it a report by Alex Stephen (Chief Finance Officer, ACHSCP) and Sally Shaw which provided an update on care home provision within Aberdeen City.

The Board resolved:-
To agree the recommendations within the exempt report, together with two additional resolutions.

WORKSHOP

16. The Board broke out for a workshop session and received a presentation from Alex Stephen on the IJB Budget Protocol.

The Board resolved:-
To thank Mr Stephen for their informative presentation.
JONATHAN PASSMORE MBE, Chairperson.

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

Minute of Meeting

09 January 2018
Health Village, Aberdeen

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

Also in attendance:
Heather MacRae (Professional Lead for Nursing and Quality Assurance)
Ashleigh Allan (Clinical Governance Facilitator)
Dr. Stephen Lynch (Clinical Lead)
Dr Howard Gemmell, (Patient/Service User Representative)
Tom Cowan (Head of Operations, ACHSCP)
Sally Shaw (Head of Strategy & Transformation, ACHSCP)
Sarah Gibbon (Executive Assistant)
Bernadette Oxley (Chief Social Work Officer)
Judith Proctor (Chief Officer)
Trevor Gillespie (Team Manager, Performance Management)
Claire Duncan (Lead Social Work Officer)
Kenneth O'Brien (Service Manager)

Apologies:

Laura MacDonald (ACHSCP UNISON rep/Health and Safety rep)

OPENING REMARKS

MINUTE OF THE CCG MEETING – 03 October 2017

1. The Committee had before it the minute of the previous Committee meeting of the 3rd of October 2017

Matters Arising

- There was a request for clarification on Item 2B of the previous minute.

- The Committee requested to reflect on the winter plan and discuss current pressures, particularly in relation to the particular challenges this year associated with the flu 'outbreak', which has received considerable media and political attention.

  Kenneth O'Brien (present for a later agenda item) gave an update outlining the key pressures from a community and hospital perspective. He explained the winter plan is in place for the Partnership and has been implemented. He also outlined the benefits of the hospital social work public holiday working hours. He described the measures in place to monitor the position. Questions were raised including whether the demand has changed; whether the flu vaccination was a good match for the types of flu being seen; whether the levels of social work were felt (anecdotally) to be enough'.

  Assurances were given that with the resources available, the system had coped with the demand appropriately. There was no indication of a large surge of primary care demand, but an acknowledgement that we are still relatively early in the period to fully judge the relative demand and understand the underlying trend.

  The Committee noted that the full winter debrief, which will be prepared by NHSG Public Health, will give a greater understanding of the number alongside a detailed nation-wide report on the flu vaccine.

The Committee resolved:-

i. To approve the minute as a correct record, pending the revision .

BUSINESS STATEMENT

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

The Committee resolved:-

i. To note the statement.
ii. To remove the item 1 'Workforce planning' from the business statement. This matter is to be referred to the IJB for consideration of a report in due course.
iii. To refocus item 3 'Mental Health & Learning Disability staffing' to reflect the potential patient harm element of this wider workforce issue.

iv. To request a detailed report on fire safety to be presented to the next committee meeting, highlighting what the outstanding landlord actions are, how ACHSCP can help support them to complete these and how assurance relating to registrations and contracts

REPORTS FOR THE COMMITTEE'S CONSIDERATION

LEARNING FROM EXAMINING LEVEL 2 REVIEWS INTO FALLS

3. The Committee had before it a report by Heather MacRae, providing an overview on the learning gained from examining level 2 reviews relating to falls. A number of learning points from the critical review of 12 cases are now being acted on.

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

a) Note the work undertaken and lessons learned from the review
b) Request regular updates on falls in light of the increase in RIDDOR reports
c) Request an update from the Aberdeen City HSCP Patient Falls lead.

Thereafter, there were questions and comments relating to falls on the wards during Christmas; capacity of staff to undertake toolbox talks relating to falls; managing the balance between risks of falls and the longer term impacts of immobilising an individual; and the different contexts of falls in hospitals and at home.

The Committee resolved:-

i. Note the work undertaken and lessons learned from the review
ii. Request regular updates on falls in light of the increase in RIDDOR reports
iii. Request an update from the Aberdeen City HSCP Patient Falls lead, to include exploring the possibility of doing a similar piece of work focusing on the community and falls at home.

CARE HOME REVIEW REPORT

The committee had before it a report by Kenneth O'Brien which presented the results of a review following notification by the Care Inspectorate about concerns at a Care Home in Aberdeen City. Kenneth O'Brien outlined the circumstances in which the need for the review had arisen. The report gave several key findings including that the care home was not found to be an 'outlier' in regards to the particular area of concern investigated.

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

a) Note the content of this report and its appendix.
b) Consider the suggestion within the appendix relating to a need for more joined up working, support, and scrutiny relating to the care home sector going forward.

The conclusion of the enquiry group was that this was a recording error caused by the CI systems not adequately capturing all instances of deaths within services. The CI had accepted this was an issue for them. Moreover, the local CareFirst system which records all changes within care and nursing homes supported the conclusion that data-wise there was no issue with this home in terms of the numbers of deaths.

However the multidisciplinary team undertaking the review did note an increasing complexity of need within the wider care home population and the report recommended a further exploration of what can be done to support the care home sector going forward. It also noted there remained work to do to improve the 'joined up' nature of support and scrutiny to the Care Home sector.

Tom advised that there was currently work being undertaken in conjunction with the CI in relation to establishing some 'early alert' indicators and that the Partnership was looking at the networks of support that can be established across the sector, some of which also relates to formal business support mechanisms, as was the recent case involving BAC and another home.

Thereafter there were questions and comments relating to: whether the care home was an outlier in terms of needing more support that other homes; the nation-wide nature of the recording issue and the need to put pressure on care homes to record correctly; the mechanisms available to allow care home issues to be identified early and current escalation processes within ACHSCP; how to ensure a robust clinical and care governance systems for contracted services; and developing a support network for improving quality within care homes.

The Committee resolved to:-

i. Note the content of this report and its appendix.
ii. Consider the suggestion within the appendix relating to a need for more joined up working, support, and scrutiny relating to the care home sector going forward.
iii. To pass their acknowledgement and thanks to the people involved in the investigation & the report.

VERBAL UPDATE – DELAYED DISCHARGE

5. Kenneth O'Brien provided a verbal update the Committee's previous request to consider what data may be available to try to measure outcomes from the Partnership's delayed discharge performance. Previous committee meeting had requested further information how the improvements made in delayed discharges were impacting on individuals. Kenneth O'Brien has collaborated with Health Intelligence colleagues and Care First colleagues to examine what this could look like and presented three new possible areas for consideration: readmissions; discharge destination; and time between discharges to death. Following discussion, the Committee did not feel that this data should be measured and presented at this time.

Thereafter, there were questions and comments relating to: aligning the delayed discharge information presented to the IJB's strategic direction and looking at broader measures that would give an idea of improvement (example: length of stay; readmission rates etc)

The Committee resolved to:-

i. Note the verbal update as requested

CLINICAL & CARE GOVERNANCE MATTERS

CLINICAL & CARE GOVERNANCE REPORT

6. The committee had before it a report by Dr. Stephen Lynch, (Clinical Lead for ACHSCP) which provides assurance to the Committee that there are robust mechanisms in place for reporting clinical and care governance issues.

The report was accompanied by the following appendices:-

- **Agenda Item 6a:** Clinical and Care Governance Group – Approved Minute September 2017
- **Agenda Item 6b:** Clinical and Care Governance Group – Unapproved Minute December 2017
- **Agenda Item 6c:** Clinical and Care Governance Group - Report December 2017

The report recommended:-

That the Clinical & Care Governance Committee -

a) Note the content of the report

The Committee requested that either the Chief Officer or the Head of Operations ensure that they attend the Clinical & Care Governance Group meeting.

Dr. Stephen Lynch invited any questions and highlighted a couple of items that the Clinical & Care Governance Group wished to be brought to the Committee's attention relating to workforce:

1. **Domestic Abuse Support Worker Role –** delays in ability to recruit have led to reduction in service able to offer. Mitigated by working with Cyrenians and with help from other support workers. Lower risk categories may have experienced a wait.

2. **Court Admin –** role is up for redeployment with the current Aberdeen City Council restructure, so not allowed to recruit. Requires a specialist team with specific training and accreditation.

3. **Nursing Cover** - for nightshifts at Woodend General Hospital

The Committee discussed the causes of the recruitment difficulties and outlined that one of the challenges is how we understand, more globally, the impact of changing staffing level to monitor any potential negative effects (on the organisation and those receiving services). The Committee additionally discussed general practitioner

recruitment, outlining how many are not going into partnership due to capital costs (which may change with new GP contract).

The Committee resolved:-

i. To note the content of the report.

CARE GOVERNANCE DATA

SUMMARY REPORT – NHS ADVERSE EVENTS

7. The committee had before it a report from Heather MacRae and Ashleigh Allan which provided an overview on the NHS adverse event report for 1st of July to 30th September 2017

The report was accompanied by the following appendix:

- **Agenda Item 7a –** Incident Report (NHS)

The report recommended:-

That the Clinical & Care Governance Committee –

a) Acknowledge that the report provides the assurance required.

Heather MacRae spoke to the report and highlighted several items for note including tissue viability nursing.

The Committee resolved to:-

i. Acknowledge that the report provides the assurance required.

SUMMARY REPORT – NHS FEEDBACK

8. 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 July to the 30th of September 2017.

The report was accompanied by the following appendix:

- **Agenda Item 8b –** Feedback Report (NHS).

The report recommended:-

That the Clinical & Care Governance Committee -

a) Acknowledge that the report provides the assurance required.

Committee members acknowledged that this report represents a small subset of services for which ACHSCP is responsible: outlined desire to understand complaints within GP practices and care homes.

The Committee resolved:-

i. To acknowledge that the report provides the assurance required.

ii. Request that officers consider how complaints from areas such as GP practices and care homes can be considered.

ITEMS TO REPORT TO THE INTEGRATION JOINT BOARD

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

AOCB

10. There were no additional items of competent business for discussion.

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BUSINESS STATEMENT

30 January 2018

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. The ACC Scheme of Delegation is due to be presented to Full Council on 5 March 2018 in line with the development of the Target Operating Model.	Chief Officer, Aberdeen City Health and Social Care Partnership	27.03.18
2.	sIJB 27.10.15 Article 7	**Performance Assurance Framework** The Shadow Board requested a report on the development of a performance assurance framework.	At the Board's meeting on 31 October 2017, the IJB tasked the Head of Strategy and Transformation with reporting performance quarterly over the year; bi-annually to the IJB and bi-annually to the Audit and Performance Systems Committee. The Framework will next be submitted to the next Audit and Performance Systems Committee and thereafter to the IJB on	Head of Strategy and Transformation , Aberdeen City Health and Social Care Partnership	22.05.18

No.	Minute Reference	IJB Decision	Update	Lead Officer(s)	Due
			22 May 2018. **Recommended for removal**		
3.	sIJB 23.02.16 Article 5	**Locality Planning** The Shadow Board requested a timetable which outlined the development of locality planning.	The Board approved the Locality Plans at its meeting on 12 December 2017 and requested an update on implementation on 22 May 2018. **Recommended for removal**	Integrated Localities Programme Manager, Aberdeen City Health and Social Care Partnership	22.05.18
4.	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 draft minute of the Clinical and Care Governance Committee will be circulated following today's meeting. **Recommended for removal**	Chief Officer, Aberdeen City Health and Social Care Partnership	30.01.18
5.	IJB 30.08.16 Article 5	**Standing Orders** The Board requested that officers review standing order 23 and report back to the Board.	Standing orders were reviewed and agreed on 31 October 2017. The Board requested that a review of committee terms of reference, membership and structure be scheduled for 22 May 2018.	Legal and Democratic Services, ACC	22.05.18
6.	IJB 15.08.17 Article 14	**Strategic Commissioning Plan** The Board requested that following	The Strategic Commissioning Plan is on today's agenda.	Head of Strategy and Transformation	12.12.17

No.	Minute Reference	IJB Decision	Update	Lead Officer(s)	Due
		consultation, an updated Strategic Commissioning Implementation Plan be presented to the IJB for approval at its December meeting.		Aberdeen City Health and Social Care Partnership	
7.	IJB 15.08.17 Article 17	**Aberdeen City Residential Nursing Home Provision** The Board requested a review of the Partnership's strategic intentions towards intervention in the event of future market failure.		Chief Officer, Aberdeen City Health and Social Care Partnership	27.03.18
8.	IJB 15.08.17 Article 19	**IJB Meetings** The Board instructed officers to develop proposals to extend the length of Board meetings to ensure that all items of business and workshop sessions could be appropriately considered.	The IJB Meeting Schedule was agreed on 31 October 2017. The Board requested that a review of meeting arrangements take place at its meeting on 27 March 2018.	Chief Finance Officer, Aberdeen City Health and Social Care Partnership	27.03.18
9.	IJB 31.10.17 Article 14	**Draft Carers Strategy** Approval of the draft strategy was deferred on 31 October 2017 to allow the incorporation of further detail on young carers.	At its meeting on 12 December 2017, the Board agreed that the draft plan could be circulated for consultation and instructed the Chief Officer to present the final strategy for approval on 27 March 2018.	Lead Strategy and Performance Manager, Aberdeen City Health and Social Care Partnership	27.03.18
10.	IJB 31.10.17 Article 15	**Transformation Decisions** The Board requested an options appraisal on the Partnership's use of ACC and NHSG estates and the development of	Transformation reports are on today's agenda.	Chief Officer, Aberdeen City Health and Social Care Partnership	30.01.18

No.	Minute Reference	IJB Decision	Update	Lead Officer(s)	Due
		digital solutions; and instructed the Chief Officer to provide an update on implementation timescales.			
11.	IJB 31.10.17 Article 16	**Board Development Work** The Board requested a report on Board Development which would be shaped following consultation with members on their developmental priorities and needs.	A report on Board Development is on today's agenda.	Chief Officer, Aberdeen City Health and Social Care Partnership	30.01.18
12.	IJB 12.12.17 Article 11	**Scheme of Assistance Private Sector Grants Budget 2017-18** The Board instructed the Head of Strategy and Transformation to form a short-life working group, including representatives from Bon Accord Care, Aberdeen City Council and the ACHSCP, to undertake a review of the Scheme of Assistance policy and full working practices in order to ensure demand and budget are managed as efficiently and effectively as possible.		Head of Strategy and Transformation , Aberdeen City Health and Social Care Partnership	27.03.18
13.	IJB 12.12.17 Article 14	**Understanding Progress Under Integration** The Board instructed the Chief Officer to develop new objectives for agreement by the IJB at its meeting on 30 January 2018 prior to submission to the MSG; and instructed the Chief Officer to look at how the Partnership could enhance data with locally determined measures in order to maximise the usefulness of such data	A report on MSG Objectives is on today's agenda.	Head of Strategy and Transformation , Aberdeen City Health and Social Care Partnership	30.01.18

No.	Minute Reference	IJB Decision	Update	Lead Officer(s)	Due
		collection.			
14.	IJB 12.12.17 Article 15	**Care Home Provision** The Board noted that a report would be brought back in the New Year to update the Board and provide more information on the future model of care and instructed the Chief Finance Officer to prepare financial modelling and present this information to the Board at the earliest possible opportunity.		Chief Finance Officer, Aberdeen City Health and Social Care Partnership	27.03.18

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Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Report Title	A response to the Scottish Government's 2017 consultation document for diet, activity and healthy weight.
Lead Officer	Tom Cowan, Head of Operations, ACHSCP
Report Author(s)	Jenny Gordon, Public Health Dietitian, ACHSCP & Linda Smith, Public Health & Wellbeing Lead, ACHSCP
Report Number	HSCP.17.111
Date of Report	17th January 2018
Date of Meeting	30th January 2018

1: Purpose of the Report

The purpose of this report is to:

1. Ask the IJB to endorse the enclosed response to the Scottish Government's consultation document for diet, activity and healthy weight.

2. Provide opportunity for the IJB to contribute further comment to the final consultation responses to the Scottish Government's consultation document for diet, activity and healthy weight.

3. Invite the IJB to consider its role in providing leadership and advocating for a range of measures to prevent, reduce and support the numbers of people who are overweight and obese in our population.

2: Summary of Key Information

In October, 2017 the Scottish Government opened a consultation on a range of proposals for improving diet and weight in Scotland in its document 'A healthier future – Action and ambitions on diet, activity and healthy weight' (1). Responses will be used to inform the development of a final national strategy.

The minister for Public Health and Sport states that "our diet, activity and weight are among the biggest public health challenges we face, with very significant preventable impacts on our health, public services and the Scottish Economy" (1)

INTEGRATION JOINT BOARD

Scottish Health Survey (2016) data indicates that 65% (2/3) of adults in Scotland are overweight with local data for Aberdeen indicating this to be slightly lower at 61% (2). In 2016/17, 21.9% of primary 1 children in Aberdeen were at risk of being overweight or obese (3). Poor diet is connected to significant harms to people's health as well as wider socio-economic performance. Much of that harm is from overconsumption leading to people becoming overweight and obese. A good diet and healthy weight significantly reduces the risks of developing type 2 diabetes, 13 types of cancer, and other disease including cardiovascular disease and depression (1).

Ten years ago it was estimated that the total cost of obesity to Scottish society was in excess of £457 million (4). The effect of obesity is much wider than the costs directly relating to health conditions and healthcare costs have been estimated to be a minority of the costs to society of obesity. Obesity has been shown to adversely affect employment, production levels (via increased sickness absence from work or school and premature death) and mental wellbeing. Additionally, it is increasingly being cited as a cost burden in infrastructure planning. People with extreme obesity (e.g. BMI > 50) are increasing in numbers and present much greater costs to housing, transport, social support as well as healthcare.

The ambition of Scottish Government is to change our food culture to help address Scotland's obesity rates and poor diet (3). Achieving this ambition will require leadership and sustained action across all sectors of society with intended action in three broad areas:

- Transforming the food environment,
- Living healthier and more active lives,
- Leadership and exemplary practice.

The actions outlined in the consultation document for diet, activity and healthy weight are developed from Scottish Government's previous experience of implementing the 'Obesity Route map' (5) and learning from the range of actions in strategies to address alcohol use and smoking. This has shown that a broad range of interventions is needed as the factors that contribute to becoming overweight and obese are complex.

Interventions that focus more on the wider environment, rather than individual choice, are essential in making the healthier choices easier when we eat at home, eat out or eat on the go. Consumer education and personal responsibility are important, along with physical activity, but will not be enough on their own to make the desired changes across the population as a whole nor for people who are already overweight and obese.

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Promoting healthy weight and activity is complex and relies on a number of different factors at individual, community, environment and societal levels which also relates to other lifestyle factors and the strategies to address them such as alcohol and tobacco. Good mental wellbeing is vitally important to enable a person to have control over their life and contribute meaningfully in society. Whilst we are aware of wider issues relating to food in Aberdeen, such as food poverty, food access, knowledge and skills, wider factors such as poor education, literacy, housing, employment and poverty also need to be addressed. To improve the publics' health we need everyone to work together effectively in a new way such as the example provided by Sustainable Food Cities to improve local outcomes; this includes the public, front line staff and community planning partners.

In order to collate a response on behalf of the IJB to the consultation document for diet, activity and healthy weight we invited a range of professionals from both the health and social care partnership and the local authority to a workshop in December. The 14 consultation questions were discussed and common themes to the range of responses highlighted. Seventeen professionals contributed to this process and their job titles are listed at the end of the proposed consultation response. The proposed response from the IJB to Scottish Government is in appendix one.

The responses endorse the view of Scottish Government that a wide range of approaches and interventions are required and should include the following key elements to address the complex issue of becoming overweight and of obesity:

Communities - including health literacy, engagement and insight, develop health champions, whole family approach and identifying and sharing good practice (do more of what works)

Leadership – including advocacy, making sure it's everyone's priority, i.e. councillors, non-executive board members, managers, head teachers - anyone that has the authority to make change**.** Key to this is influencing the partners we work with through, for example, community planning.

Legislation – including national and local quality assurance (evidence based, measuring/monitoring/evaluation) and raising awareness of implications of legislation (example- proximity of food vans)

Early intervention, promotion and prevention – need a range of approaches starting with children and their families, need a focus on food skills and everyone giving out the same consistent messages and information

INTEGRATION JOINT BOARD

Services – need to include the views of service users, their families and their networks to develop a person centred weight management service. All services/organisations need the time and the skills to include these conversations in their work.

Intelligence shows that the situation in relation to people being overweight and obese is not improving in Aberdeen and across Scotland. This consultation gives an opportunity to reflect on how the IJB can work with partners and stakeholders to influence changes to our food culture. As the IJB will be aware of wider issues relating to food and health we would welcome further discussion about creating conditions and transformational ways to enable the people of Aberdeen to have healthy and happy lives and grow and live well. In addition, we will bring a future paper to the IJB requesting they sign the food charter for the SFCPA (Sustainable Food City Partnership Aberdeen). Meantime, this paper is seeking endorsement from the IJB of a proposed consultation response to the SG's draft strategy for diet, activity and healthy weight.

Appendix:

1. Proposed consultation response from the IJB.

References

1. Scottish Government (2017). *A Healthier Future – Action and Ambitions on Diet, Activity and Healthy Weight*. Available from: http://www.gov.scot/Publications/2017/10/1050

2. Scottish Government (2016) The Scottish Health Survey

3. ISD Scotland (2016/17) Primary 1 BMI Statistics: Epidemiological Categories.

4. Foster, K. (June 2015) Business case to support the prevention and treatment of overweight and obesity in the Grampian population. NHS Grampian.

5. Scottish Government (2011) Obesity Route Map - Action Plan. Available from: http://www.gov.scot/Publications/2011/03/17104457/2

Definition: Obesity and BMI
Body Mass Index (BMI) is the most commonly accepted measure of general obesity. BMI is calculated by dividing weight (measured in kilograms) by height

squared (measured in metres). Adults are classed as overweight if their BMI is 25 to less than 30, obese if their BMI is 30 to less than 40 and morbidly obese if their BMI is 40 or more.

3:	Equalities, Financial, Workforce and Other Implications

- The number of people who are overweight and obese, as well as have poorer nutrition, is higher in areas of deprivation with significant and consequent health inequalities for women and children (3) in particular.
- Food Poverty Action Aberdeen (FPAA) continues to report a growing number of individuals and families accessing food banks across the city
- Our workforce needs to be fit for purpose and understand their contribution to addressing the issue of people being overweight and obese, which includes promoting staff health and wellbeing as an organisation.
- Leadership to achieve actions across the three broad areas will be needed at all levels, across our community planning partnership as well as from Scottish Government.

There are no financial, equality or workforce implications arising directly from this report.

4:	Management of Risk

Identified risk(s):

- There will be an ongoing cost implication of not doing anything;
- There is a risk of more people being morbidly obese that will impact significantly on our health and social care and infrastructure as well as the quality of life of Aberdeen citizens.
- The significant rise in type 2 diabetes will continue to impact on primary and community health care services.

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

This consultation will be the basis for a future strategy for Scotland in 2018 and for Grampian. The public health directorate established a Grampian wide obesity strategy group in 2017. The H&SCP also has representation on the Sustainable Food City Partnership Aberdeen (SFCPA) and the IJB will be asked to support the

INTEGRATION JOINT BOARD

Sustainable Food City Food Charter in 2018. The food charter describes pledges that contribute to addressing our food culture.

In addition there is an established multi-agency food network in Aberdeen that has strong representation from the third sector. The H&SCP's self management programme will also make a contribution to supporting people with health conditions such as diabetes. More concerted and collective effort is, however, needed to prevent and mitigate against the consequences of being overweight and of obesity across our community planning partnership.

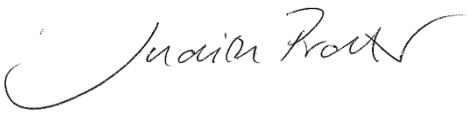
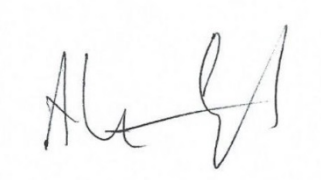
5:	Recommendations

It is recommended that the Integration Joint Board:

1. Agrees the consultation response, as at Appendix 1 and instructs the Chief Officer to submit the response to the Scottish Government by the deadline of 31/1/18

2. Instruct the Chief Officer to prepare an additional paper to be presented to the Integration Joint Board in early 2018 to consider the Food Charter for the SFCPA.

3. Commit to the leadership that is required to achieve the range of actions to address overweight and obesity.

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

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Appendix 1 – Proposed consultation response from the IJB to the Scottish Government

Question 1
Are there any other types of price promotion that should be considered in addition to those listed above? Please explain your answer.

We would agree with Scottish Government's (SG) intention to take forward measures to restrict the promotion of food and drink high in fat, sugar and salt. In addition, we suggest consideration to promotions that promote extra food for no /minimal extra cost, for example, 'buy one get one free'; meal deals, increase portion size for minimal extra cost.

We would like to see more evidence of what works to change consumer purchases and behaviour towards promoting a healthier diet by restricting these price promotions. Numerous different price promotions are likely to be confusing for the consumer, especially those on a low budget and with poor literacy. A scoping exercise on the various types of price promotion (in-store and out-of store, e.g. online) would help with an overview of the evidence on what would work to promote the healthier food options.

Question 2
How do we most efficiently and effectively define the types of food and drink that we will target with these measures? Please explain your answers.

We agree that foods high in fat, sugar and low in nutrition value should be targeted first. In general we would wish for a straight forward and easily understandable system for the consumer, taking into consideration equality principles. It would be an advantage to focus initially on children's food items, energy drinks and juice.

We would also recommend information that is easy to understand for the consumer on portion sizes as people don't eat one food in isolation.

Question 3
To what extent do you agree with the actions we propose on non-broadcast advertising of products high in fat, salt and sugar?

√	Strongly agree
	Agree

INTEGRATION JOINT BOARD

☐	Neutral
☐	Disagree
☐	Strongly disagree

Please explain your answer?
Whilst we strongly agree to extend current restrictions on the advertising of food and drink high in fat, sugar and salt to before the 9pm. We questioned the effectiveness of just focusing on TV advertising. We acknowledge advertising is a strong influence on choice but this is now done through numerous ways, including social media. We would particularly endorse restricting advertising to children, at sporting events and promotion products within TV programmes and films.

Question 4
Do you think any further or different action is required for the out of home sector?

√	Yes
☐	No
☐	Don't know

Please explain your answer
We agree to building on the work that has been happening nationally and locally such as promoting the Healthy Living Award. In addition, developing and extending the commitment to working with retailers, Food Standards Agency, NHS Health Scotland and the industry to become a Good Food Nation. Whilst we recognise the importance of local partnership arrangements and the need to promote the local economy through local enterprise, industry and tourism, there appears to have been a rapid growth in out of home section provision. From the information provided it is clear that this out of home provision is a staple part of people's lifestyle/diet. Local networks such as Sustainable Food Networks, food growing strategies provide a basis for this local working and changing the food culture. More positive actions to encourage large and small businesses to follow / promote "Good Food Nation Policy", such as tax subsidies and incentives, could help.

Environmental health and trading standards officers work regularly with food businesses and could have a role in assisting businesses to comply with new laws or guidelines, although they may need additional resources so they have capacity and appropriate training to provide this support to businesses.

A specific strategy for out of home providers will be tricky to implement at local level – need to engage the industry and public at start. There is a need to involve the public and educate them on what is being planned so that we can fully understand the rise in out of home sector.

The healthy living award should be extended or further developed to support small and medium enterprises (SME's) in deprived areas, working with local corner shops and support with provision of fresh food and veg and encourage sign up to award scheme. It would be helpful to do more profiling of healthier options and work with communities to identify what they would like to see in store. This will also need an increased food sampling and analysis regimen to ensure compliance.

Share good practice and evidence, both locally and nationally, for example, licensing, public engagement, social marketing, ways to promote the healthy option as the easy option, such as from the third sector and social enterprises.

Question 5
Do you think current labelling arrangements could be strengthened?

[√] Yes

[ ] No

[ ] Don't know

Please explain your answer
We agree that current labelling arrangements should be further explored and strengthened and would endorse the view of a more simplified, easier to understand system. This should then be communicated to families and the public and fully evaluated. Consideration should be given to effectiveness of food labelling for people with poor health literacy and language barriers. We therefore would recommend a health impact assessment be undertaken on new proposals.

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Question 6

What specific support do Scottish food and drink SME's {small and medium enterprises} need most to reformulate and innovate to make their products healthier?

Need to support the SME retailers to ensure they survive as we recognise their importance in the local economy. This is very important in remote and rural areas, but also in urban areas to ensure local access for a range of population groups, especially where transport to larger retailers is a barrier to food access. This is particularly evident at local levels in the Health and Social Care Partnership.

Sustainable Food Cities is about changing food culture and one of the 6 indicators is about building a food economy and another is about food procurement, this process could identify examples of good practice that could be shared. Additional capacity and resource at a local level would help strengthen and scale up ways of working at a faster pace. Funding needs to be ring fenced and sustained over longer periods of time to support change. Economic and business development would have a role to play in supporting this; small businesses could get support from environmental health backed up by public analyst services but again this requires to be resourced.

Supporting SMEs with grant agreements and contracts that encourage healthier choices could also be piloted. Minimise loss of profit for businesses through social marketing and promotion of access to local options.

Providing healthier food and drink choices should not be more expensive and challenging but used to promote their businesses in contributing to a healthier population through, for example, awards schemes.

Question 7

Do you think any further or different action is required to support a healthy weight from birth to adulthood?

☑ Yes

☐ No

☐ Don't know

Please explain your answer.

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We endorse the proposals to build on existing work from the past decade to work with local staff such midwives, health visitors and school nurses as well as in education, 3rd sector and community settings. We would further recommend an increased focus on healthy school and healthy community settings and promotion of health equity. We would agree with a consistent preventative approach for this important life stage and suggest connection to local actions, such Healthy Cities, UNICEFs Child Friendly City and Sustainable Food Cities. Strategies to increase promotion of food skills in communities and the school curriculum would help.
A clear and sustained commitment to the areas of work that has been progressed is required in order to scale up and create change. This needs to be supported by sustained financial commitment.

Question 8
How do you think a supported weight management service should be implemented for people, with, or at risk of developing, type 2 diabetes – in particular the referral route to treatment?

Better understanding of best practice with better investment on longer term evaluations; recognise that a range of options may be necessary at a local level for weight management; optimum would be to co-produce and have holistic interventions that include psychological and practical elements e.g. cooking, support in order to promote self-management and empowerment. Use of inclusive and non-medical language would assist in promoting community based and non-NHS based programmes that could be co-produced with people living with diabetes, wider partners and professionals.

Question 9
Do you think any further or different action on healthy living interventions is required?

√	Yes
	No
	Don't know

Please explain your answer.
Opportunity, support and resource to widen out good practice in this area is to be welcomed and encouraged in non-NHS settings within a social prescribing model. More emphasis on living well rather than single interventions, building citizenship and asset based approaches with sustained funding over time.

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Question 10
How can our work to encourage physical activity contribute most effectively to tackling obesity?

We recognise the importance of infrastructure, environment, planning and usefulness of the Place Standard to increasing physical activity. But we would recommend an inclusive and co-produced approach with people experiencing long term conditions, mental health difficulties, overweight and obesity to improve local outcomes. Stigma needs to be reduced and language may be a barrier to engaging families and people. Undertaking health impact screening and assessment at planning stages would help identify potential negative impacts. Local work between local people with, for example, schools, Living Streets could help shape local planning and infrastructure.

Question 11
What do you think about the action we propose for making obesity a priority for everyone?

Agree with the actions but needs to be non-stigmatising with a culture change to enable leadership at all levels across all our systems rather than being seen as an issue for the NHS to address. The emphasis on transforming the food environment, physical activity and early years is welcomed and important for prevention. However, need to scale-up healthy living programmes to enable people to self manage and live fulfilling lives. Achieving the ambitions and actions at a local level will need leadership at all levels and across local partnerships and systems.

We support the need for numerous actions at different levels and it is good to see learning has been taken from other strategies such as alcohol and tobacco, however, the complexity of preventing a further increase in numbers of people who are overweight or obese should not be underestimated.

Question 12
How can we build a whole nation movement?

Build the momentum, take pride, celebrate our success and do more of what works and build best practice. Social marketing, include the public, local and national politics, communication and consistent messages, partnerships and shared accountability. Resource preventive actions better and provide support to better evidence the benefits of prevention over time. Promote health equity to reduce inequalities and be more proactive with doing health impact screening or assessment during planning stages (health in all policies approach).

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Align with the other strategies and policies e.g. alcohol and drugs; mental health; community justice, community empowerment (Scotland) act, and the proposed new socio-economic duty. Move from a topic based approach to a social environmental approach.

Involve all stakeholders at political, organisational and community levels and start a movement with people, families, employers, employees, communities. Work in and with key settings pre and postnatally, early years, children and young people, adults and elderly (across the life span).

Question 13
What steps, if any, should be taken to monitor change?

To support collaborative working and shared accountability by having access to monitoring systems across community planning. This would support and change the way local information can be used to help monitor change.
Consider setting targets and establish performance indicators or look at how we incorporate existing measures to monitor progress in tackling overweight obesity
Evaluate the effectiveness of actions with lower socio-economic status.
Increase local capacity to enable support and use of improvement methodology and scaling up of projects.

Question 14
Do you have any other comments about any of the issues raised in this consultation?

The document appears to be more NHS focused and the language needs to change to be more reflective of a strength based and inclusive approach, enable wider leadership and collaborative working that will promote a healthy food culture. The focus on the food environment is welcome, however, support for this area will require legislation rather than rely on voluntary agreements.

Behaviour change and seeing the connections with the environment at local levels in design stages e.g. planning decisions, greenspace, walking and cycling infrastructure is important.

The above responses endorse the view of Scottish Government that a wide range of approaches and interventions are required and should include the following key elements to address the complex issue of becoming overweight and of obesity:

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Communities - including health literacy, engagement and insight, develop health champions, whole family approach and identifying and sharing good practice (do more of what works)

Leadership – including advocacy, making sure it's everyone's priority, i.e. councillors, non-executive board members, managers, head teachers - anyone that has the authority to make change**.** Key to this is influencing the partners we work with through, for example, community planning.

Legislation – including national and local quality assurance (evidence based, measuring/monitoring/evaluation) and raising awareness of implications of legislation (example- proximity of food vans)

Early intervention, promotion and prevention – need a range of approaches starting with children and their families, need a focus on food skills and everyone giving out the same consistent messages and information

Services – need to include the views of service users, their families and their networks to develop a person-centred weight management service. All services/organisations need the time and the skills to include these conversations in their work.

The above IJB response to the Scottish Government's draft strategy for diet, activity and healthy weight was collated from comments received from the following staff in Aberdeen City H&SCP and Aberdeen City Council and endorsed by Aberdeen City's Integration Joint Board on 30.01.18:

Senior wellbeing coordinator, AC H&SCP
Health improvement officer – Neighbourhoods x 2, AC H&SCP
Health improvement officer – Schools, ACC
GP clinical lead/paediatrician, AC H&SCP
Lead dietitian, AC H&SCP
Community health worker, AC H&SCP
Public health dietitian, AC H&SCP
Protective services manager-Communities, Housing and Infrastructure, ACC
Planning and development manager, ACH&SCP
Head of locality, AC H&SCP
Service manager, AC H&SCP
Public health co-ordinator, AC H&SCP
Childsmile co-ordinator, AC H&SCP
Senior health improvement officer, AC H&SCP
Health improvement officer – children & young people, AC H&SCP

INTEGRATION JOINT BOARD

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Aberdeen City Health & Social Care Partnership
A caring partnership

Integration Joint Board

Report Title	Revised Board Assurance and Escalation Framework
Lead Officer	Alex Stephen, Chief Finance Officer, ACHSCP
Report Author (Job Title, Organisation)	Alex Stephen, Chief Finance Officer, ACHSCP
Report Number	HSCP/17/100
Date of Report	21/11/2017
Date of Meeting	30/01/2018

1: Purpose of the Report

1.1. To present the Integration Joint Board with the revised Board Assurance and Escalation Framework for approval.

2: Summary of Key Information

The Board Assurance and Escalation Framework (BAEF).

2.1. In order to fulfil its remit, the Integration Joint Board (IJB) needs to be able to demonstrate an effective governance process whereby it can be assured that key risks to the achievement of integration objectives are appropriately identified, communicated and addressed.

2.2. The BAEF describes the regulatory framework of the IJB to support its vision, values and principles. Fundamental to the framework are the IJB's strategic priorities and the appetite for risk that the board has across these priorities.

2.3. It presents and populates a model where individuals, groups and committees, plans, reports, and reporting processes are mapped at different organisational levels, against two broad assurance requirements: compliance and transformation.

2.4. A key element of the assurance framework is the risk management system, whose outputs (i.e. strategic and operational risk registers, and other reports) contribute significantly to board assurance on key risks to objectives.

2.5. The appendices illustrate the landscape in which the IJB will operate:

- The committee structure and terms of reference.
- The risk assessment system.
- The risk escalation process.
- The clinical and care governance framework.
- The IJB's cycle of business.

2.6. The A&PS committee performs the key role of reviewing and reporting on the effectiveness of the governance structures in place and on the quality of the assurances the Board receives.

Introduction and Revision of the BAEF.

2.7. The BAEF was formally approved by the shadow IJB at its meeting in March 2016. The A&PS committee assumed responsibility for the regular review and any necessary escalation of the BAEF at its meeting in May 2016. The Executive Team and the Good Governance Institute have undertaken further work to review the BAEF.

2.8. Key changes in this revision include:

- Standardisation of references to board level (strategic) and corporate level (operational) risk registers,
- Additional detail regarding the risk appetite,
- Explanation of the risk assessment methodology, and;
- Further information on the strategic & operational risk registers

2.9. This revised version of the BAEF was presented to the A&PS committee at its meeting on the 21st of November. The A&PS committee requested a number of further amendments, which are included in this version of the BAEF:

- to request that narrative be provided on page 12 to explain the diagram;
- to request that reporting links between the A&PS Committee and the Executive Team be inserted into the diagram on page 71;
- to recommend to the IJB that the Statement of Risk Appetite be

reviewed by the Board on an annual basis;
- to request that version control and authorisation be added to future versions of the BAEF;

2.10. The committee also requested that further detail on the risk escalation process for locality planning. This has been raised with the Heads of Locality, who will ensure risk escalation processes are thoroughly considered ahead of the locality 'go-live'. Following this, the amendment will be included in the BAEF.

3:	Equalities, Financial, Workforce and Other Implications

Equalities – there are no equalities implications

Financial – there are no financial implications

Workforce – there are no workforce implications

Other – there are no other implications

4:	Management of Risk

Identified risk(s):

- There is a risk that responsibilities, processes and route of reporting may be unclear in some parts of the system, which could impact on the ability to escalate risks of significance to the IJB's operations.

- There is a risk that the framework may not be updated in line with the pace of change experienced across the partnership.

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

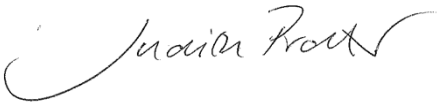
How might the content of this report impact or mitigate the known risks: This report helps to mitigate the risks as it commits to an annual review of the BAEF to ensure it is updated appropriately. Further, the information provided in the BAEF (appendix A) helps to mitigate the impact of a number of risks in the strategic risk register, by providing the necessary assurance and escalation processes.

Integration Joint Board

5:	Recommendations

It is recommended that the Integration Joint Board:

1. Approves the revised BAEF, as presented at appendix A.

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

Aberdeen City Health & Social Care Partnership

A caring partnership

Board Assurance and Escalation Framework

Revised 22.01.2017

Content

Part 1: Introduction

1.1 Background

The partner organisations of Aberdeen City Health and Social Care Partnership (ACHSP), Aberdeen City Council and NHS Grampian (the "Parties"), are committed to successfully integrating health and social care services, to achieve the partnership's vision of:

"A caring partnership, working together with our communities to enable people to achieve healthier, fulfilling lives and wellbeing."

ACHSP has established an Integration Joint Board (IJB) through the Public Bodies (Joint Working) (Scotland) Act 2014. The remit of the IJB is to prepare and implement a Strategic Plan in relation to the provision of health and social care services to adults in its area in accordance with sections 29-39 of the Public Bodies Act. The arrangements for governance of the IJB itself, including rules of membership, are set out in the Integration Scheme and Standing Orders.

While the Parties are responsible for implementing governance arrangements of services the IJB instructs them to deliver, and for the assurance of quality and safety of services commissioned from the third and independent sectors, the Parties and the IJB are accountable for ensuring appropriate clinical and professional governance arrangements for their duties under the Act. The IJB therefore needs to have clear structures and systems in place to assure itself that services are planned and delivered in line with the principles of good governance and in alignment with its strategic priorities.

The IJB must have in place a robust framework to support appropriate and transparent management and decision-making processes. This framework will enable the board to be assured of the quality of its services, the probity of its operations and of the effectiveness with which the board is alerted to risks to the achievement of its overall purpose and priorities.

1.2 Regulatory framework

The Aberdeen City Health and Social Care Integration Scheme describes the regulatory framework governing the IJB, its members and duties. In particular, the IJB is organised in line with the guidance set out in the Roles, Responsibilities and Membership of the Integration Joint Board - Guidance and advice to supplement the Public Bodies (Joint Working) (Integration Joint Board) (Scotland) Order 2014. The principles of and codes of conduct for corporate governance in Scotland are set out in "On Board: A Guide for Members of Public Bodies in Scotland", published by the Scottish Government in July 2006. Detailed arrangements for the board's operation are set out in "Roles, Responsibilities and Membership of the Integration Joint Board" Guidance and advice to supplement the Public Bodies (Joint Working) (Integration Joint Board) (Scotland) Order 2014. There are also Standing Orders of the IJB.

The IJB will make recommendations, or give directions where appropriate (i.e. where funding for employment is required) to the decision-making arms of the two Parties as required.

1.3 Purpose of the framework

This governance framework describes the means by which the board secures assurance on its activities. It sets out the governance structure, systems and performance and outcome indicators through which the IJB receives assurance. It also describes the process for the escalation of concerns or risks which could threaten delivery of the IJB's priorities, including risks to the quality and safety of services to service users.

It is underpinned by the principles of good governance[1] [2] [3] and by awareness that ACHSP is committed to being a leading edge organisation in the business of transforming health and social care.

This commitment requires governance systems which will encourage and enable innovation, community engagement and participation, and joint working. Systems for assurance and escalation of concerns are based on an understanding of the nature of

[1] Good Governance Institute (GGI) and Healthcare Quality Improvement Partnership (HQIP), *Good Governance Handbook,* January 2015,. http://www.good-governance.org.uk/good-governance-handbook-publication/

[2] The Scottish Government, Risk Management – public sector guidance, 2009. http://www.gov.scot/Topics/Government/Finance/spfm/risk

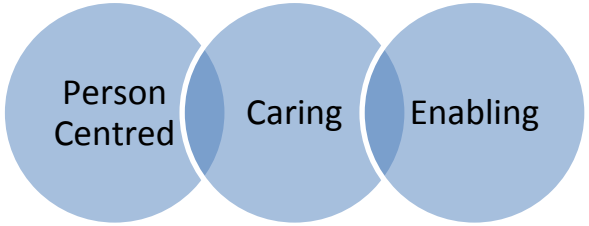
[3] Chartered Institute of Public Finance and Accountancy (CIPFA) and the International Federation of Accountants® (IFAC®). *International Framework: Good Governance in the Public Sector*, (2014) - http://www.cipfa.org/policy-and-guidance/standards/international-framework-good-governance-in-the-public-sector

risk to an organisation's goals, and to the appetite for risk-taking. The development of a mature understanding of risk is thus fundamental to the development of governance systems. The innovative nature of Health and Social Care Integration Schemes also requires governance systems which support complex arrangements, such as hosting of services on behalf of other IJBs, planning only of services delivered by other entities, accountability for assurance without delivery responsibility, and other models of care delivery and planning. This framework has been constructed in the light of these complexities and the likelihood that it may be important to amend and revise the systems as our understanding of the integration environment develops.

The structures and systems described are those in place from June 2017. In order to ensure that the framework can best support the IJB in its ambitions going forward, it will be reviewed annually.

1.4 An integrated approach to governance for health and social care

In working towards the vision stated above, the IJB is committed to ensuring that delegated services are:



The integration principles identified by The Scottish Government [4] also underpin decision-making within the IJB.

In 2013, the principles of good governance for both healthcare quality and for quality social care in Scotland were described.[5] These stressed the importance of:

- Embedding continuous improvement
- Providing robust assurance of high quality, effective and safe clinical and care services

[4] Integration Planning and Delivery Principles, The Scottish Government. http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Principles

[5] Governance for Quality Healthcare, The Scottish Government, 2013. http://www.gov.scot/Topics/Health/Policy/Quality-Strategy/GovernanceQualityHealthcareAgreement

- The identification and management of risks to and failure in services and systems
- Involvement of service users/carers and the wider public in the development of services
- Ensuring appropriate staff support and training
- Ensuring clear accountability

The rest of this document and its appendices sets out the structures and systems currently in place to support both assurance of compliance and of transformation of services within the scope of ACHSP business. This framework can be represented graphically as follows in Table 1:

Table 1: Assurance and Compliance Framework

<table>
<tr><th></th><th>ASSURANCE of COMPLIANCE</th><th>ASSURANCE of IMPROVEMENT, INNOVATION and TRANSFORMATION</th></tr>
<tr><td>FOCUS</td><td>Compliance with standards and regulation, communication and escalation of concerns and risks</td><td>Improving services, measuring and sustaining improvement
Challenging work patterns, innovation, redesign and transformation</td></tr>
<tr><td>KEY COMPONENTS</td><td colspan="2">People and Groups: partners; roles; committee structures
Plans and Activities: engagement plan; risk management policy and system; audit system
Feedback and Reporting processes: concerns and escalation process</td></tr>
<tr><td rowspan="4"></td><td colspan="2">Board Level</td></tr>
<tr><td colspan="2">Corporate Level</td></tr>
<tr><td colspan="2">Service Level</td></tr>
<tr><td colspan="2">Individual Level</td></tr>
<tr><td>OUTCOMES</td><td>IJB measures of success for stakeholders and assurances from internal and external sources</td><td>IJB measures of success for stakeholders and assurances from internal and external sources</td></tr>
</table>

Part 2: The Framework

2.1 Strategic priorities

From the nine strategic outcomes identified nationally as desired outcomes form integration, the ACHSP has, in its Strategic Plan[6], articulated seven strategic priorities, which form the basis of its governance framework.

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

These priorities underpin:

- Decision-making criteria for service development, planning and delivery; resource allocation etc.
- The Board Assurance Framework of key strategic risks
- Strategic risk register
- Risk registers across all departments and areas of operation
- Individual performance and appraisals
- Evaluation of achievement against objectives

[6] Aberdeen City Health and Social Care Partnership Strategic Plan 2016-19.

2.2 Risk Management

a) Risk appetite

Risk appetite can be defined as:

The amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time'.
(HM Treasury - 'Orange Book' 2006)

The ACHSP recognises that achievement of its priorities may involve balancing different types of risk and that there may be a complex relationship between different risks and opportunities. The IJB has debated its appetite for risk in pursuit of the goals of integration so that its decision-making process protects against unacceptable risk and enables those opportunities which will benefit the communities it serves.

B) Risk Appetite Statement

The IJB has consequently agreed a statement of its risk appetite.[7] The IJB will review and agree the risk appetite statement on an annual basis.

This statement is intended to be helpful to the board in decision-making and to enable members to consider the risks to organisational goals of not taking decisions as well as of taking them. As a newly established organisation, the ACHSP's appetite for risk will change over time, reflecting a longer-term aspiration to develop innovation in local service provision. The IJB regularly debates its appetite for risks and opportunities in the pursuit of its objectives and will ensure that the statement on risk appetite reflects these discussions
The full risk appetite statement is outlined below:

Aberdeen City Health and Social Care Integration Joint Board (the IJB) recognises that it is both operating in, and directly shaping, a collaborative health and social care economy where safety, quality and sustainability of services are of mutual benefit to local citizens, to stakeholders and to organisational stakeholders. It also recognises, as a newly-established organisation, that its appetite for risk will change over time, reflecting a longer-term aspiration to develop innovation in local service provision based on

[7] Aberdeen City Health and Social Care Partnership Risk Appetite Statement – contained within ACHSP Strategic Plan 2016-19.

evidence of benefits and on a culture of continuing, planned engagement with the public and other stakeholders, including those involved in service delivery. As a result the IJB is working towards a mature risk appetite over time.

It recognises that achievement of its priorities will involve balancing different types of risk and that there will be a complex relationship between different risks and opportunities. The risk appetite approach is intended to be helpful to the board in decision-making and to enable members to consider the risks to organisational goals of not taking decisions as well as of taking them. The board has identified several broad dimensions of risk which will affect the achievement of its strategic priorities. These are: financial risk; regulatory compliance risks; risks to quality and innovation outcomes; risk of harm to clients and staff; reputational risk.

The IJB will set a level of appetite ranging from "none" up to "significant" for these different dimensions. It will have zero tolerance of instances of fraud. It will accept no or minimal risk in relation to breaches of regulatory and statutory compliance. Similarly, it will accept no or minimal risks of harm to service users or to staff. It will accept low to moderate risk in relation to financial loss and to quality and innovation outcomes which predict clearly identifiable benefits and can be managed within statutory safeguards. It will accept moderate to high risks to reputation where the decision being proposed has significant benefits for the organisation's strategic priorities. Higher levels of all risk types may be accepted if specific and effective controls are demonstrably in place and there are clear advantages for integration objectives.

The IJB has an appetite from its inception to take decisions which may expose the organisation to additional scrutiny and interest where there is evidence of confidence by key stakeholders, especially the public that difficult decisions are being made for the right reasons. This is most likely to be evident in relation to innovation where there is a perceived need to challenge relationships, standards and working practices and/or where the IJB considers there are identifiable, longer-term benefits of greater integration of systems and technology.

This risk appetite statement will be reviewed annually.

c) Risk Management policy and system

The Risk Appetite statement, risk management policy, strategic and corporate risk registers form the risk management framework.

The framework sets out the arrangements for the management and reporting of risks to IJB strategic priorities, across services, corporate departments and IJB partners. In line with the principles set out in the Australia/New Zealand Risk Management Standard

4360 [8], it describes how risk is contextualised, identified, analysed for likelihood and impact, prioritised, and managed. This process is framed by the requirement for consultation and communication, and for monitoring and review.

Identified risks are measured according to the IJB risk assessment methodology described below and recorded onto risk registers. The detailed methodology for assessment of risk appears at Appendix 6. They are escalated according to the flowchart shown at Appendix 7.

d) Risk Assessment methodology

Risks are measured against two variables: the likelihood (or probability) of any particular risk occurring and the consequence or severity (impact) of that risk should it occur.

For example, there may be a risk of fire in a particular office building. If it happens, this would cause harm or damage to people, property, resources and reputation.

The ***likelihood*** of this occurring will be affected by the strength of fire safety precautions (prevention). The ***consequence*** or ***severity*** of the incident if it does occur will be affected by contingency management (containment, firefighting, evacuation procedures, emergency help, communications etc. by fire safety response).

Risk measurement tables are widely used by organisations and set out levels of both likelihood and consequence, in order to reach an overall risk assessment score. It is rare in the type of services the IJB is concerned with that this is a scientific process but it provides a practical way of comparing different types of risk issues and helping organisations to prioritise between issues so that they can be managed and the risk reduced. This measurement system is also used to decide when to escalate issues that cannot be managed locally or that are of such significance that the members of the senior team or of the IJB need to be aware of them.

The IJB's risk measurement table is shown below:

[8] Standards New Zealand, AS/NZS ISO 31000:2009 Risk Management – Principles and guidelines is a joint Australia/New Zealand adoption of ISO 31000:2009

DESCRIPTOR	Rare	Unlikely	Possible	Likely	Almost Certain
Probability	Can't believe this event would happen - will only happen in exceptional circumstances.	Not expected to happen, but definite potential exists - unlikely to occur.	May occur occasionally, has happened before on occasions - reasonable chance of occuring.	Strong possibility that this could occure - likely to occur.	This is expected to occur frequently / in most circumstances - more likely to occur than not.

Risk Matrix

Impact / Likelihood	Negligible	Minor	Moderate	Major	Extreme
Almost Certain	Medium	High	High	Very High	Very High
Likely	Medium	Medium	High	High	Very High
Possible	Low	Medium	Medium	High	High
Unlikely	Low	Medium	Medium	Medium	High
Rare	Low	Low	Low	Medium	Medium

The outputs from risk assessment are as follows:

IJB board level: The Board Strategic Risk Register (SRR)

The fundamental purpose of the SRR is to provide the organisation's Governing Body - i.e. the IJB - with assurance that it is able to deliver the organisation's ***strategic objectives and goals.*** This involves setting out those issues or risks which may threaten delivery of objectives and assure the IJB that they are being managed effectively and that opportunity to achieve goals can be taken: it is the lens through which the IJB examines the assurances it requires to discharge its duties. The IJB uses this document to monitor its progress, demonstrate its attention to key accountability issues, ensure that it debates the right issue, and that it takes remedial actions to reduce risk to integration. Importantly, it identifies the assurances and assurance routes against each risk and the associated mitigating actions.

The IJB's SRR format is shown here with a real example of the kind of issue included in the document (Appendix 1). While many of the issues may be termed strategic, the key thing to remember is that these are issues which may affect the ability to deliver on strategy. It is quite possible that significant operational issues will also be incorporated, therefore. The Senior Operational Management team reviews the Operational Risk Register (ORR) (see next section), and escalates risks classified as 'very high' to

the Executive Team, for consideration of inclusion in the SRR (see Appendix 7 – risk escalation process). The Executive Team reviews the SRR in light of their experiences and insight into key issues, including commissioning risk, and recommends the updated version to the Audit & Performance Systems Committee (APSC) for approval and review by the IJB.

The issues identified are measured according to the IJB risk appetite and risk assessment methodology.

The risks are identified by:

- Discussions at Executive Team
- Review of Performance data and dashboards
- Reports from Project Management Board on review of Performance Management Office (PMO) dashboards
- Review of the Operational Risk Register (see below)
- Review of Chief Officer reports and reports from IJB sub committees

The Executive Team agrees issues for inclusion on (and removal from) the SRR, and submits to the IJB or APSC quarterly for formal review

The Audit and Performance Systems Committee reviews the SRR for the effectiveness of the process annually.

Corporate Level: Operational Risk Register

While the SRR is a *top-down* record of risks to objectives, the Operational Risk Register (ORR) is a *bottom-up* operational document which reflects the top risks that are escalated through the IJB's delegated services, and gives detail on how they are being managed.

It may well contain risks that have a strategic angle, as well as those which are operational in nature, and will definitely contain risks that affect strategic objectives.

Risks from service risk registers and locality risk registers and (once developed) are escalated to the ORR according to their risk assessment scores.

The IJB has a standardised risk register format which is used for the ORR and all other risk registers. It is shown below with a real risk included as an example.

The Operational Risk Register comprises high scoring risks or those which cannot be managed locally from a range of sources. This document is routinely reviewed by both IJB sub committees to ensure:

- the right risks are being reported and escalated
- actions are being taken to mitigate risk
- these actions have been effective in reducing the risk level
- the IJB is aware of high level risks affecting services and of those where actions are not being taken in a timely manner or have not been successful in reducing the risk

The issues identified are measured according to the risk assessment methodology. They are recorded using the following format:

Table 2: Risk Recording Format

Strategic Priority	Description of Risk	Context	Impact	Date Last Assessed	Controls	Gaps in controls	Likelihood	Consequences	Risk Assessment	Assurances	Risk Owner/Handler	Comments

The risks are identified, using the risk assessment matrix for high scoring risks, from:

- Review of Performance Management Office (PMO) dashboards
- Operational department risk registers
- Service and locality risk registers and review of reports from service governance groups
- Review of reports from IJB sub committees
- IJB Occupational Health and Safety committee reports

The Head of Operations owns the Operational Risk Register, and the Audit and Performance Systems Committee moderates risks escalated to ensure consistency and appropriateness of issues identified for inclusion and removal.

The Senior Operational Management Team reviews the Operational Risk Register and it will be reported to the Clinical and Care Governance Committee bi-monthly demonstrating the changes in the risk profile of the IJB.

The risk register is shared with the NHS Grampian and Aberdeen City Council through the report consultation process.

Service and locality level: Risk registers and reports from governance groups

Service and locality risk registers use the same format as the ORR and are compiled at local level and discussed at local management and governance meetings.

Where risks cannot be satisfactorily managed locally, or where they are above scores as set out in the escalation flowchart, they will be escalated for possible entry onto the ORR. It is critical to emphasise that the risk management system cannot rely on escalation through the risk register process alone. Senior management, through the operational group management structure, has a key role in helping to manage and find solutions to risk issues at all levels of the organisation.

Arrangements have developed over the first year of operations across services, taking into account existing systems. Operational risks managed at the service and department level are monitored by the Chief Officer and Executive Team. The Clinical and Care Governance Group (see Appendix 3) has a key role in identifying risk across services which may affect the safety and quality of services to users. The aims in developing risk communication between services and the IJB will be to achieve consistency in reporting the nature and scale of risks and to clarify how these are reported, escalated and actions monitored. The risk escalation flowchart at Appendix 7 shows the basis for this process.

2.3 Roles and Responsibilities for governance

a) Committee structure

This section describes the key committees and groups in relation to the IJB governance framework.

The board has established two sub-committees, as follows: **Audit and Performance Systems**, and **Clinical and Care Governance**. These sub committees have powers conferred upon them by the IJB.

In relation to governance and assurance, the **Audit and Performance Systems Committee (APSC)** performs the key role of reviewing and reporting on the effectiveness of the governance structures in place and on the quality of the assurances the Board

receives. It has a moderation role in relation to the consistency of risk assessment. It also has oversight of information governance issues.

The **Clinical and Care Governance Committee (CCGC)** provides assurance to the IJB in relation to the quality and safety of services planned and/or delivered by the IJB. Its key role is to ensure that there are effective structures, processes and systems of control for the achievement of the IJB's priorities, where these relate to regulatory compliance, service user experience, safety and the quality of service outcomes. To support this role, the CCGC is informed by the clinical and care governance arrangements in place across NHS Grampian and Aberdeen City Council (see Appendix 4 - Clinical and care governance diagram).

It also assures the IJB that services respond to requirements arising from regulation, accreditation and other inspections' recommendations. The Committee will consider and approve high value clinical and care risks, consider the adequacy of mitigation, the assurance provided for that mitigation and refer residual high risks to the Board. It has a key role in assuring the board that learning from governance systems across services, including learning arising from incidents, complaints and identified risks, is shared and embedded as widely as possible.

The IJB's **Executive Team** is an executive group with oversight of the implementation of IJB decisions. It oversees risk registers, financial and operational delivery, the innovation and transformation programmes and assures the Audit and Performance Systems Committee of transformation progress. The group also assures the board on progress towards the achievement of its strategic priorities through the Performance Management Framework.

There are existing **governance arrangements within the providers of services delegated to the IJB**. Arrangements to standardise reporting systems through the IJB's governance structures are being progressed and will be reported in due course.

A diagram illustrating the structure appears at Appendix 2. A summary of the purpose, membership and reporting arrangements for these groups appears at Appendix 3.

b) Individual responsibilities

1. Board and corporate level:

The Chief Officer provides a single point of accountability for integrated health and social care services.

The Board and all its members must as a corporate body ensure good governance through the structures and systems described in this document. To ensure that the IJB is well-led and that all members are supported in this responsibility, a board development programme will be constructed to transfer knowledge and skills. To provide assurance that the Board has the capability and competence required, an annual self-assessment and periodic (minimum 3 yearly) independent assessment will be undertaken.

2. Professional level:

There are existing clinical and professional leadership structures in place to support clinical and care governance. These are:

- Lead Nurse
- Chief Social Work Officer
- Lead Allied Health Professional (AHP)
- Primary Care Clinical Leads (GPs)
- Public Health Lead
- Clinical Lead

3. Locality level:

The IJB is consulting on the key requirements for a management structure to lead on the delivery of services. This will require that there is a direct line of sight to the appropriate clinical and professional lead roles, and must take into account the location of services: some are locality based and others not. The development plan is that each of the six delivery points will have a single leader responsible for the good clinical and care governance of services within their remit.

2.4 Reporting of information to provide assurance and escalate concerns (internal & external)

The framework shown in Table 1 in section 1.4 can be populated as shown in Table 3 below. Locality managers will work with their partners in local services to develop systems for reporting from their various governance forums through to the IJB, as indicated in Table 3 below. In addressing the nature of assurance, it is important to note that the IJB, the APSC, and the CCGC operate assurance mechanisms to review *process* as well as *performance*, and in this regard the work of the APSC is the key governance mechanism for auditing *process*. The Committee-level Good Governance Matrices and effectiveness' audits also inform assurance around process.

Table 3: Reporting of information to provide assurance and escalate concerns

FOCUS	Assurance of compliance, performance, improvement and transformation						
	Individuals	Plans / activities	Groups / Partners	Reporting and feedback processes			
				Compliance with standards	Risk escalation and review	Performance monitoring	Improvement and Transformation reporting
Board level	Chair Chief Officer Board members Chairs / CEOs of the Partners	Strategic plan RM strategy Strategic Risk Assurance Register Corporate Risk register Performance framework Audit plan Standing Orders Integration Scheme	Board Executive group Audit and Performance Systems Committee Clinical and Care Governance Committee Other IJBs Scrutiny / governance arms of Parties	Review of BAEF Review of risk scoring Review of Performance dashboard PMO report Audit reports to Board Exception and action plan review Bi-annual review of integration scheme Bi-annual review of strategic plan			
Corporate level	Directors Senior Managers PMO	Strategic and Operational risk registers Performance dashboard Business planning Budget monitoring Joint Complaints Procedure	Executive Group Senior Management Teams Cluster Management Group Strategic Planning Group Clinical and Care Governance Group	Financial monitoring Corporate risk register review Risk moderation and review			

Service level	Clinical leads and Social work leads Professional leads Locality managers Service managers Service users	Communication and Engagement plan Clinical and care governance policies Risk registers and assessments	Community partners Service governance forums 'Deep Dive' activity	Risk register system Governance reports Real time feedback Response to complaints Service level dashboards
Individual level	Staff members Service users Carers	Communication and Engagement plan Raising concerns policy Safeguarding alerts Risk assessment Incident reporting	Staff forums IJB engagement activity	Objective setting and review Supervision and line management Staff surveys Feedback mechanisms (see assurance source section)

Table 4: Reporting of information to provide assurance and escalate concerns with partner organisations

FOCUS	Assurance of compliance, performance, improvement and transformation						
	Individuals	Activities	Groups / Partners	Reporting and feedback processes			
				Compliance with standards	Risk escalation and review	Performance monitoring	Improvement and Transformation reporting
NHSG Board	NHSG Board Chair ACHSCP Chief Officer	Regular Report	NHS Board Executive Group	Oversight of IJB activity & minutes			
ACC Full Council	ACC Chief Executive	Regular Report	ACC Full Council ACC Chief Executive Executive Group	Oversight of IJB activity & minutes Information on financial governance, risk management, clinical & care governance etc			
Pan-Grampian IJBs	Chief Officer, Aberdeen City Chief Officer, Aberdeenshire Chief Officer Moray Chair Aberdeen City, Chair Aberdeenshire IJB Chair Moray IJB	Regular meetings	North East Partnership Steering Group	In the process of being established regionally			
ACC & NHSG CEs	CE NHSG CE ACC CO ACHSCP	Quarterly Performance Meetings	ACC NHSG ACHSCP	Performance Finance Risk Governance Directions Transformation Programme			

2.5 Sources of assurance

a) Quality of services

Current providers have a range of clinical and care governance arrangements in place. Through these, the IJB has access to assurances which support the delivery of high quality care and ensure good governance. These assurances include:

- Quality Strategies
- Policies on raising concerns
- HR Policies
- Safeguarding Policy (Vulnerable Adults)
- Incident reporting and investigation policies and procedures
- Information Governance policies and processes
- Board member visits to service areas ('Deep Dive' activity)
- Staff Surveys
- Joint Staff Forum
- Staff Induction Programmes
- Leadership Programmes
- Performance and Appraisal Development Process
- Compliance reports – health and social care
- Learning lessons systems

b) Engagement

The IJB regards the engagement of its partners and stakeholders in the planning and delivery of services as essential to achieving the goals of integration. The nature and level of engagement varies from group to group and the range of stakeholder with whom the IJB engages is broad, including:

- Service users
- Carers and families
- Staff
- The 'Our Ideas' Partnership suggestions website and system
- Commissioners
- Other providers in the acute and primary care health and social care sectors
- The independent and voluntary sector
- Housing, education providers, North East Partnership (IJBs)

Engagement will include consultation; communication of information; involvement in decision-making around planning and transforming services; feedback on services and other issues of concern or interest.

The ACHSP Communication and Engagement plan is in place in order to support engagement across these groups, and to provide a source of assurance that appropriate activities have been identified and implemented. It includes consideration of how to engage with hard to reach communities. The plan will include measures to assess its effectiveness over time. These will be reported through the IJB's Executive Group.

Newsletters	Groups
• Health Village newsletter • NHSG Team Brief • Scottish Care newsletter/ e-bulletin • SHMU community newsletters • Aberdeen Partnership Newsletter • ACVO e-bulletin • VSA Carers News	• Care at Home Providers Group Forum • Individual Independent providers • Care and Support Providers Aberdeen • Individual Third sector providers • Housing providers / associations • NHS Grampian Public Forum • City Voice • Civic Forum • Sheltered Housing Network • Joint Strategy groups • GP Cluster Management Groups • Cluster Operational Groups (COGs) • Implementation Group (CIGs) • Public Health Co-ordinators Network • Local Community councils • Mental Health and Learning Disability forums • Joint Staff Forum • Learning Partnerships

c) Other internal and external sources of assurance

In addition to the assurances emanating from the IJB's clinical and care governance framework, and its engagement with partners and stakeholders, there are numerous internal and external sources which relate to the delegated services. These include:

- Internal Audit
- External Audit
- External inspection agencies (Care Inspectorate and Healthcare Improvement Scotland)
- Health and Safety Executive
- Mental Welfare Commission
- Externally commissioned independent investigations e.g. Ombudsman and homicide investigations
- Clinical Audit
- Audit Scotland
- Scottish Council for Voluntary Organisations (SCVO)
- Royal College reviews
- Accreditation
- Information Services Division (ISD) Scotland
- Benchmarking with other health and social care providers
- Involvement in and learning from case reviews
- Voluntary Health Scotland
- Coroner's Inquests

The IJB will also commission external reviews of specific services where the need for additional independent assessments and assurance are identified.

Appendices

1 Strategic Risk Register format

2 Committee diagram

3 Transformation Programme Structure and Senior Management Structure

4 Role of the Committees

5 Clinical and care governance diagram

6 Risk assessment tables

7 Risk escalation process

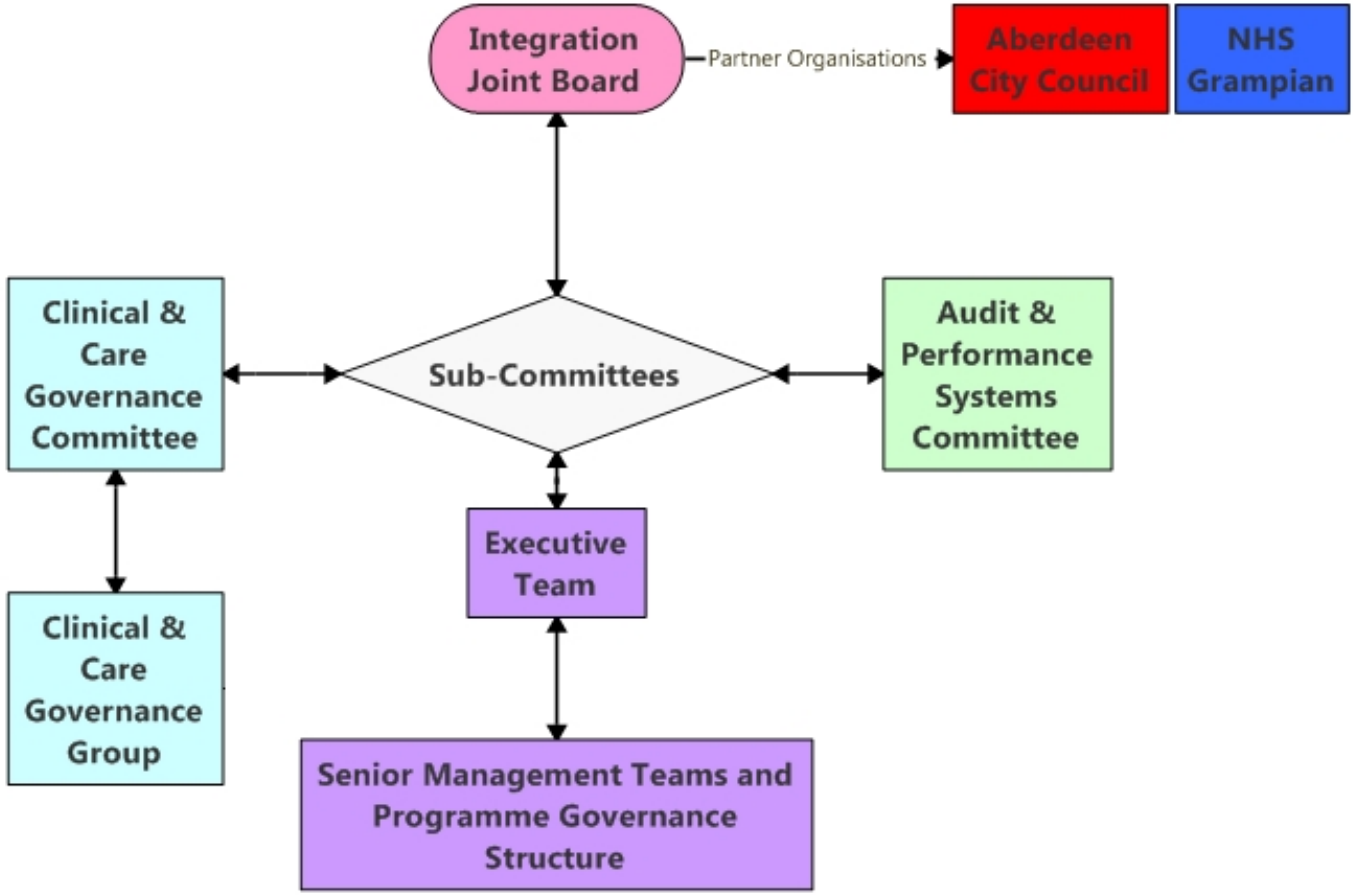
8 Cycle of business (continually developed)

9 Ownership and Version Control for the Board Assurance and Escalation Framework

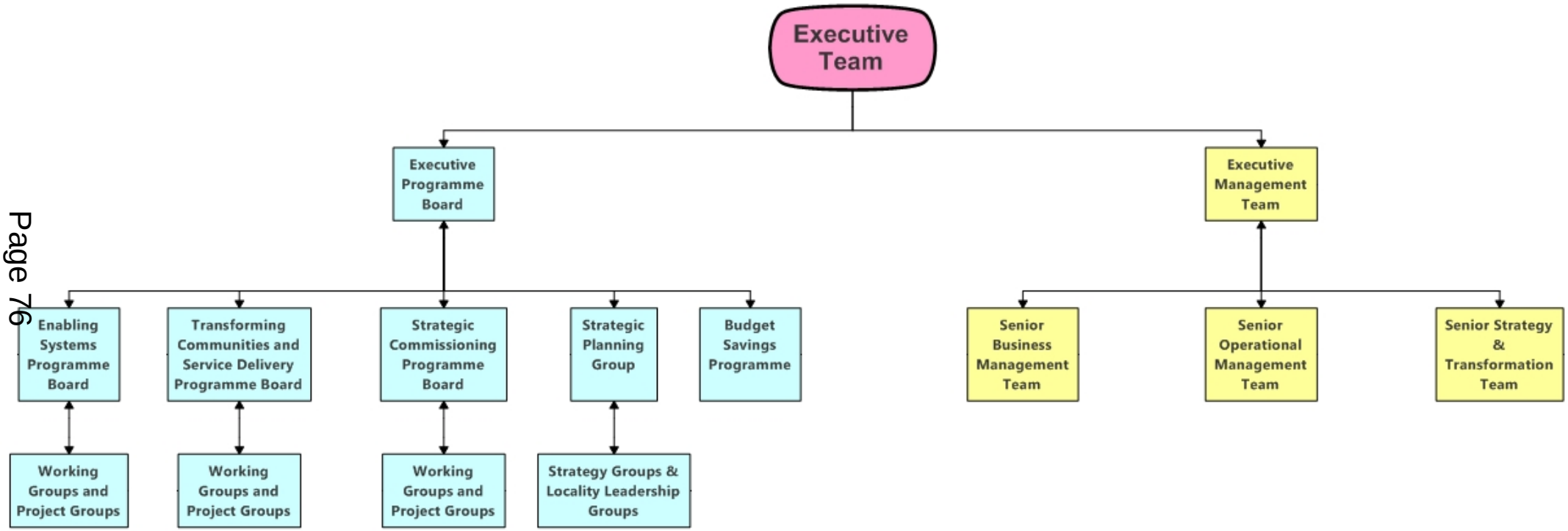
Appendix 1 – Strategic risk register format

- 1 -	
Description of Risk:	
Strategic Priority:	**Lead Director:**
Risk Rating: low/medium/high/very high **Medium**	**Rationale for Risk Rating:** **Rationale for Risk Appetite:**
Risk Movement: increase/decrease/no change **NO CHANGE**	
Controls:	**Mitigating Actions:**
Assurances:	**Gaps in assurance:**
Current performance:	**Comments:**

Appendix 2 - Board committee diagram



Appendix 3 – Transformation Programme Structure and Senior Management Structure



Appendix 4 – Roles of the Committees

Principal function/s	Membership	Reports to	Reports received / reviewed
Executive Team			
Robust and effective management processes are required to ensure management oversight of: • Care and Clinical Governance • Risk Management and oversight of Service and Corporate Risk Registers • Financial governance and performance oversight • Service performance • Staff governance • Health and Safety • Executive oversight of change programmes • Ensuring IJB's strategic plans are operationalised • Good decision making and development of business cases	The core membership is as follows: • Chief Officer – chair • Executive Assistant – co-ordinates papers, provides analysis and follows up actions, minutes meeting • Chief Finance Officer – financial reporting • Clinical Lead – Clinical Governance reporting • Head of Operations – Operational performance • Head of Strategy and Transformation - performance	IJB	The following will report as required to the Executive Group: • Lead Service Managers - Social Work • Lead Service Managers – Nursing, AHPs, Public Health, Primary Care Development and Intermediate Care and Rehab • Integration Programme Manager • Chief Officers – Moray and Aberdeenshire in relation to performance of 'hosted services' • General Manager Mental Health and Learning Disabilities (NHS) • Designated service health and safety leads • Partnership representatives / trade union representatives • Service Improvement and Quality • Chief Social Work Officer • Health Intelligence • Business Managers
Strategic Planning Group			

Principal function/s	Membership	Reports to	Reports received / reviewed
The role of the Strategic Planning Group is overseeing the development of the strategic commissioning plan and in continuing to review progress, measured against the statutory outcomes for health and wellbeing, and associated indicators. The strategic commissioning plan should be revised as necessary (and at least every three years), with the involvement of the Strategic Planning Group.	Prescribed groups of persons to be represented in strategic planning group: • health professionals; • users of health care; • carers of users of health care; • commercial providers of health care; • non-commercial providers of health care; • social care professionals; • users of social care; • carers of users of social care; • commercial providers of social care; • non-commercial providers of social care; • non-commercial providers of social housing; and third sector bodies carrying out activities related to health care or social care.	Executive Group	Locality Leadership Group
Audit & Performance Systems Committee			
To review and report on the relevance and rigour of the governance structures in place and the assurances the Board receives. These will include a risk management system and a performance management system underpinned by an Assurance Framework.	The Committee will be chaired by a non-office bearing voting member of the IJB and will rotate between NHS and ACC. The Committee will consist of not less than 4 members of the IJB, excluding Professional Advisors. The Committee will include at least two voting members, one from Health and one from the Council. The Board Chair, Chief Officer, Chief Finance Officer, Chief Internal Auditor and other Professional Advisors and senior officers as required as a matter of course, external audit or other persons shall attend meetings at the invitation of the Committee. The Chief Internal Auditor should normally attend meetings and the external auditor will attend at least one meeting per annum.	IJB	Annual audit plan

Principal function/s	Membership	Reports to	Reports received / reviewed
Clinical & Care Governance Committee			
To provide assurance to the IJB on the systems for delivery of safe, effective, person-centred care in line with the IJB's statutory duty for the quality of health and care services.	The Committee shall be established by the IJB and will be chaired by a voting member of the IJB. The Committee shall comprise of: • 4 voting members of the IJB • Chief Officer • Chief Social Work Officer • Chair of the Clinical and Care Governance Group/ Clinical Lead (GP) • Chair of the Joint Staff Forum • Professional Lead – Nurse/AHP • Public Representative • Third sector Sector representatives	IJB	CCG Group report Feedback/Incidents Reporting Escalations from CCG Group
Clinical & Care Governance Group			
To oversee and provide a coordinated approach to clinical and care governance issues within the Aberdeen City Health and Social Care Partnership.	• Clinical Lead (Chair) • Clinical and Care Governance Lead • Head of Operations • Lead Social Work Manager • Lead Nurse • Public Health Lead • Clinical Governance Coordinator/Facilitator • Patient/Public Representative • Lead Allied Health Professional • GP Representative • Dental Clinical Lead or Dental Service Representative • Lead Optometrist • Representative from Sexual Health Service • General Practice Patient Safety Lead	Clinical and Care Governance Committee	Reports from services: AHP Dentistry Optometry Pharmacy Nursing General Practice Social Work/Care Woodend Hospital and Links @ Woodend Biannual Reports Falls Pharmacy/medication Patient Safety in Primary Care

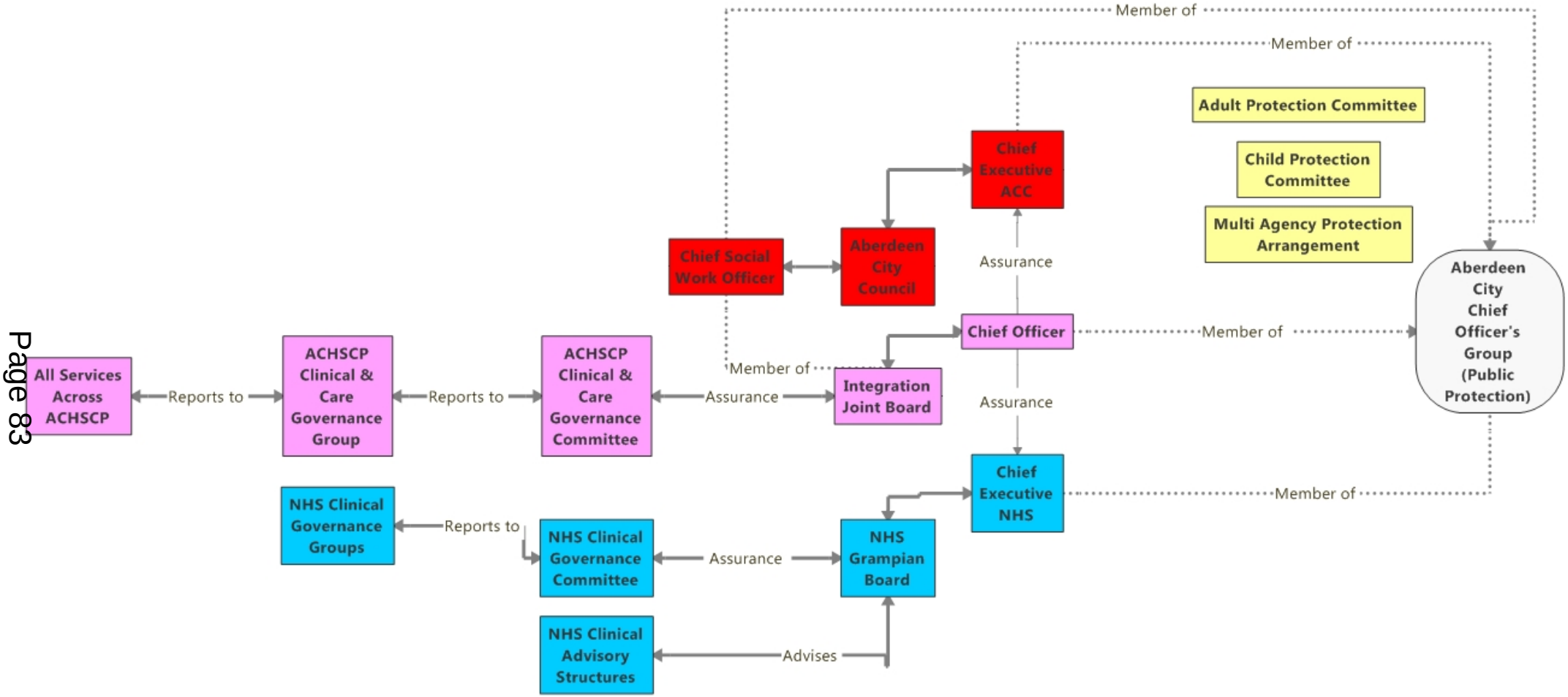
Principal function/s	Membership	Reports to	Reports received / reviewed
	• Woodend Hospital and Link@ Woodend Representative • Representative from Commissioned Service • Partnership Representative • Representative from Community Mental Health and Learning Disability Services • Representative from Acute Sector • Public Partner		
Locality Leadership Group			
To deliver the locality planning requirements of the Public Bodies (Joint Working) (Scotland) Act 2014, in respect of the Aberdeen City Health and Social Care Partnership. The Locality Leadership Group will play a key role in ensuring the delivery of the Aberdeen City Health and Social Care Strategic Plan, including contributing to the delivery of its associated strategic outcomes. The role of the Locality Leadership Group will include developing and ensuring appropriate connections and partnerships across the Locality to improve the health and wellbeing of the locality population and reduce the health inequalities that we know impact poorly on people's lives. The locality leadership group will influence, and be influenced by, the city's Strategic	Chair and Vice Chair to be agreed by Group and appointed for a fixed 2-year period. ▪ Health and Social Care Partnership Locality Manager ▪ GP Locality Lead ▪ Other GPs (TBC) ▪ Representative of Acute Sector (Unit Operational Manager) ▪ AHP Representative ▪ Nursing Representative ▪ Community Mental Health/ LD/ Rehab representation ▪ Unscheduled care representative (Out of hours/ A&E) ▪ Geriatric Medicine representative ▪ Social Care Representative (Bon Accord Care & Adult Social Care) ▪ Housing sector representative ▪ Third sector representative ▪ Independent Sector Representative ▪ Carer representative ▪ Patient representative ▪ Community representatives ▪ People managing services in the locality area	Strategic Planning Group	Reports from Heads of Locality & Services (see box above)

Principal function/s	Membership	Reports to	Reports received / reviewed
Planning Group and ultimately the Integration Joint Board. The locality leadership group will also influence and be influenced by Community Planning Partnership processes.	Other locality stakeholders as determined by the group Further to the above membership, the group may arrange reports/ attendance at meetings from non-members as required, such as; ▪ Primary Care Dentistry Locality Representative ▪ Primary Care Optometry Locality Representative ▪ Primary Care Pharmacy Locality Representative		
Executive Programme Board			
♦ Provide direction to programme board and working groups ♦ Identify prioritised projects ♦ Approve Business Cases ♦ Ensure programme progress including ensuring that progress is supported to continue at pace ♦ Approve significant changes to programmes	♦ Executive Team ♦ Lead Transformation Manager	Seek IJB approval to incur expenditure for projects where required under standing orders (full life costs) Report on progress and performance to IJB	Papers from Enabling Systems/Strategic Commissioning/Transforming Communities and Service Delivery Programme Boards
Programme Boards (Enabling Systems; Strategic Commissioning; and Transforming Communities)			
♦ Support and enable progress at pace across transformation portfolio ♦ Review and approve Project Proposal Documents ♦ Consider “deep dives” into working group programmes to be assured of progress	♦ Chair (ET Member) ♦ Lead Transformation Manager (lead officer & vice chair) ♦ Operational Managers ♦ Lead Professional Managers ♦ Independent Sector ♦ Third Sector	Executive Programme Board	Workstreams and project groups

Principal function/s	Membership	Reports to	Reports received / reviewed
Ensure delivery of anticipated benefits and where these are no longer deliverable, redirect projects/ programmes accordingly	• ACC Communities and Housing • Acute Sector Finance		

Appendix 5 – Clinical and care governance diagram

The diagram on the following page provides an overview of the clinical & care governance processes within ACHSCP. The processes draw upon the existing clinical & care governance within Aberdeen City Council and the NHS. Clinical & care governance matters relating to the ACHSCP are considered by it's Clinical & Care Governance Group. The Clinical & Care Governance group has representation from all services across ACHSCP and report to the ACHSCP Clinical & Care Governance Committee.


Member of
Member of
Adult Protection Committee
Child Protection Committee
Multi Agency Protection Arrangement
Chief Executive ACC
Chief Social Work Officer
Aberdeen City Council
Assurance
Aberdeen City Chief Officer's Group (Public Protection)
Chief Officer
Member of
All Services Across ACHSCP
Reports to
ACHSCP Clinical & Care Governance Group
Reports to
ACHSCP Clinical & Care Governance Committee
Member of
Assurance
Integration Joint Board
Assurance
Chief Executive NHS
Member of
NHS Clinical Governance Groups
Reports to
NHS Clinical Governance Committee
Assurance
NHS Grampian Board
NHS Clinical Advisory Structures
Advises

Appendix 6 – Risk assessment tables

NHS Scotland Core Risk Assessment Matrices

Table 1 - Impact/Consequence Definitions

Descriptor	Negligible	Minor	Moderate	Major	Extreme
Patient Experience	Reduced quality of patient experience/ clinical outcome not directly related to delivery of clinical care.	Unsatisfactory patient experience/clinical outcome directly related to care provision – readily resolvable.	Unsatisfactory patient experience/clinical outcome, short term effects – expect recovery <1wk.	Unsatisfactory patient experience/ clinical outcome; long term effects –expect recovery >1wk.	Unsatisfactory patient experience/clinical outcome, continued ongoing long term effects.
Objectives/ Project	Barely noticeable reduction in scope, quality or schedule.	Minor reduction in scope, quality or schedule.	Reduction in scope or quality of project; project objectives or schedule.	Significnt project over-run.	Inability to meet project objectives; reputation of the organisation seriously damaged.
Injury (physical and psychological) to patient/ visitor/staff.	Adverse event leading to s minor injury not requiring first aid.	Minor injury or illness, first aid treatment required.	Agency reportable, e.g. Police (violent and aggressive acts). Significnt injury requiring medical treatment and/or counselling.	Major injuries/long term incapacity or disability (loss of limb) requiring medical treatment and/or counselling.	Incident leading to death or major permanent incapacity.
Complaints/ Claims	Locally resolved verbal complaint.	Justifie written complaint peripheral to clinical care.	Below excess claim. Justifie complaint involving lack of appropriate care.	Claim above excess level. Multiple justifie complaints	Multiple claims or single major claim. Complex justifie complaint.
Service/ Business Interruption	Interruption in a service which does not impact on the delivery of patient care or the ability to continue to provide service.	Short term disruption to service with minor impact on patient care.	Some disruption in service with unacceptable impact on patient care. Temporary loss of ability to provide service.	Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked.	Permanent loss of core service or facility. Disruption to facility leading to significant "knock on" effect.
Staffing and Competence	Short term low staffing level temporarily reduces service quality (< 1 day). Short term low staffing level (>1 day), where there is no disruption to patient care.	Ongoing low staffing level reduces service quality **Minor error** due to ineffective training/implementation of training.	Late delivery of key objective/ service due to lack of staff. **Moderate error** due to ineffective training/ implementation of training. Ongoing problems with staffing levels	Uncertain delivery of key objective /service due to lack of staff. **Major error** due to ineffective training/implementation of training.	Non-delivery of key objective/ service due to lack of staff. Loss of key staff. **Critical error** due to ineffective training / implementation of training.
Financial (including damage/loss/ fraud)	Negligible organisational/ personal financial loss (£<1k).	Minor organisational/ personal financial loss (£1-10k).	Significnt organisational / personal financial loss (£10-100k).	Major organisational/personal financial loss (£100k-1m).	Severe organisational/ personal financial loss (£>1m).
Inspection/Audit	Small number of recommendations which focus on minor quality improvement issues.	Recommendations made which can be addressed by low level of management action.	Challenging recommendations that can be addressed with appropriate action plan.	Enforcement action. Low rating. Critical report.	Prosecution. Zero rating. Severely critical report.
Adverse Publicity/ Reputation	Rumours, no media coverage. Little effect on staff morale.	Local media coverage – short term. Some public embarrassment. Minor effect on staff morale/ public attitudes.	Local media – long-term adverse publicity. Significnt effect on staff morale and public perception of the organisation.	National media/adverse publicity, less than 3 days. Public confidnce in the organisation undermined. Use of services affected.	National/International media/ adverse publicity, more than 3 days. MSP/MP concern (Questions in Parliament). Court Enforcement. Public Enquiry/FAI.

Table 2 - Likelihood Definitions

Descriptor	Rare	Unlikely	Possible	Likely	Almost Certain
Probability	• Can't believe this event would happen • Will only happen in exceptional circumstances.	• Not expected to happen, but definite potential exists • Unlikely to occur.	• May occur occasionally • Has happened before on occasions • Reasonable chance of occurring.	• Strong possibility that this could occur • Likely to occur.	This is expected to occur frequently/in most circumstances more likely to occur than not.

Version March 2013

Table 3 - Risk Matrix

Likelihood	Consequences/Impact				
	Negligible	**Minor**	**Moderate**	**Major**	**Extreme**
Almost Certain	Medium	High	High	V High	V High
Likely	Medium	Medium	High	High	V High
Possible	Low	Medium	Medium	High	High
Unlikely	Low	Medium	Medium	Medium	High
Rare	Low	Low	Low	Medium	Medium

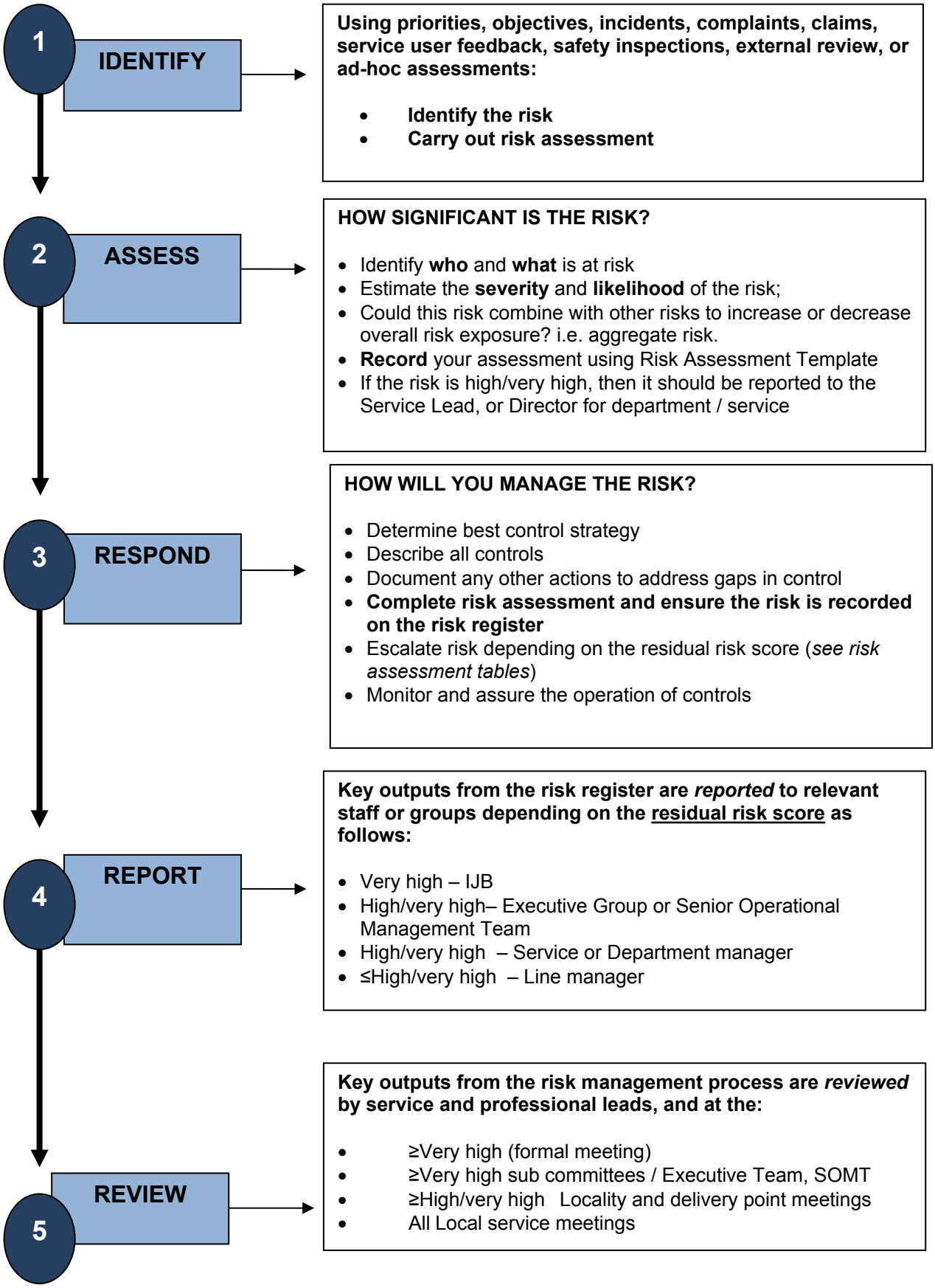
References: AS/NZS 4360:2004 'Making It Work' (2004)

Table 4 - NHSG Response to Risk

Describes what NHSG considers each level of risk to represent and spells out the extent of response expected for each.

Level of Risk	Response to Risk
Low	Acceptable level of risk. No additional controls are required but any existing risk controls or contingency plans should be documented. 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. 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 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 significnt resources. 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 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 Board may wish to seek assurance that risks of this level are being effectively managed. However NHSG may wish to accept high risks that may result in reputation damage, financial loss or exposure, major breakdown in information system or information integrity, significnt 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 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 Board will seek assurance that risks of this level are being effectively managed. However NHSG 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, significnt incidents(s) of regulatory non-compliance, potential risk of injury to staff and public.

Appendix 7 – Risk escalation process



Appendix 8 – Cycles of business

Business Type	Report Title	Lead Officer	Committee	Frequency	Last Reported	Reporting Date(s) for 2017/18
Audit	Annual Internal Audit Plan	D. Hughes	APS	Annual	Apr-17	Apr-18
Audit	Statement of Internal Financial Controls from Internal Auditors	D. Hughes	APS	Annual	Jun-17	Jun-18
Audit	Internal Audit Annual Report	D. Hughes	APS	Annual	Jun-17	Jun-18
Audit	External Auditor Plan	KPMG	APS	Annual	Feb-17	Feb-18
Audit	External Auditor Report	KPMG	APS	Annual	Aug-17	Sep-18
Audit	Internal and External Auditors Private Meeting	NA	APS	Annual	Apr-17	Feb-18, Nov-18
Finance	Financial Monitoring Report	A. Stephen	IJB & APS	Quarterly	Oct-17 (IJB)	Feb-18 (APS), May-18 (IJB), Sep-18 (APS), Dec-18 (IJB)
Finance	Unaudited Annual Accounts	A. Stephen	APS	Annual	Jun-17	Apr-18
Finance	Audited Annual Accounts	A. Stephen	IJB	Annual	Aug-17	May-18

Finance	Annual Budget	A. Stephen	IJB	Annual	Mar-17	Mar-18
Finance	Review of Financial Regulations	A. Stephen	APS	Annual	Sep-17	Sep-18
Governance	Chief Social Worker Annual Update	B. Oxley	IJB	Annual	Dec-17	Dec-18
Governance	Board Assurance Framework Review	A. Stephen	APS	Annual	Jan-18	Jan-19
Governance	Governance Statement	A. Stephen	APS	Annual	Apr-17	Apr-18
Governance	Review of Committee Members	J. Proctor	IJB	Annual	Jun-17	May-18
Governance	Report on Directions	J. Proctor	IJB	Annual	NA	Mar-18
Governance	Review of Scheme of Delegations	J. Anderson	IJB	Annual	NA	TBC - expected March
Governance	Review of Standing Orders	J. Anderson	IJB	Annual	Dec-17	Dec-18
Performance	Annual Performance Report	J. Proctor	IJB	Annual	Jun-17	Jun-18
Performance	Review of Performance Management Framework	S. Shaw	APS	Annual	NA	TBC

Performance	Performance Management Framework	S. Shaw	IJB & APS	Quarterly	Oct-17 (IJB)	Feb-18 (APS), May-18 (IJB), Sep-18 (APS), Dec-18 (IJB)
Risk	Strategic Risk Register	J. Proctor	IJB & APS	Quarterly	Nov-17 (APS)	Mar 18 (IJB), Aug 18 (APS), Oct 18 (IJB), Jan 18 (APS)
Risk	Operational risk register	Tom Cowan	CCG	Bi-monthly	Feb-17	Every meeting
Strategic	Strategic Plan - Review and Update	S. Shaw	IJB	Every 3 years	NA	Mar-19
Transformation	Transformation Programme Monitoring	G. Woodcock	APS	Quarterly	Nov-17 (APS)	Feb-18 (APS), Apr-18 (APS), Aug-18 (APS), Nov-18 (APS)
Transformation	Review of Transformation Process	G. Woodcock	APS	Annually	NA	TBC
Transformation	IJB Annual Update	G. Woodcock	IJB	Annual	NA	Jan-18
Performance	Delayed Discharge	Kenny O'Brien	IJB	Bi-Annual	Jun-17	Jan-18, Aug-18
Performance	Delayed Discharge	Kenny O'Brien	CCG	Quarterly	Oct-17	Mar-18
Performance	Ethical Care Charter Update	C. Duncan	IJB	6 Monthly	Aug-17	Feb-18
Authorisation	Interim Bed Funding	K' O'Brien	IJB	Every 2 Years	Aug-17	Aug-19

Performance	Annual Review of Themes from GP Contract Review Visits	S. Lynch	CCG	Annual	Jun-17	Jun-18
Governance	Annual Clinical and Care Governance Action Plan	T. Cowan	CCG	Annual	NA	TBC
Governance	Review of Integration Scheme	J. Proctor	IJB	Every 2 years	TBC	Apr-18
Governance	Review of the risk appetite statement	A. Stephen	IJB	Annual	NA	Apr-18
Strategic	Update report on progress with Carers Strategy	A. Macleod	CCG	TBC	TBC	TBC
Governance	Refresh of Member's Register of Interest	I. Robertson	IJB	Annual	Jun-17	Jun-18

Appendix 9: Ownership & Version Control

Ownership:

The BAEF Framework is owned by the Executive Team and is regularly reviewed by the team.

Version Control

1. Version Control/Document Revision History (begun 24.11.2017)			
Version	Reason	By	Date
1.	**Revisions to the BAEF requested by the Audit & Performance Committee at its meeting on the 21st of November 2017**	**Sarah Gibbon, Executive Assistant**	**24.11.2017**
2.	**Additional revisions to BAEF pending submission to IJB**	**Sarah Gibbon, Executive Assistant**	**22.01.2018**

Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Report Title	Delayed Discharge Performance and Improvement Programme – Update
Lead Officer	Judith Proctor, Chief Officer – Aberdeen City Health and Social Care Partnership
Report Author (Job Title, Organisation)	Kenneth O'Brien, Service Manager – Aberdeen City Health and Social Care Partnership
Report Number	HSCP.17.122
Date of Report	12th January 2018
Date of Meeting	30th January 2018

1: Purpose of the Report

This report is presented to the Integration Joint Board (IJB) for the purposes of provision of information, supporting scrutiny of the Partnership's performance, and to facilitate further discussion.

This paper follows on from the previous update provided to the Integration Joint Board at its meeting in June 2017, and the interim update provided to the Clinical and Care Governance Committee in October 2017.

Two key areas are discussed:

- Current delayed discharge performance information in regards to the Aberdeen City Partnership;

  AND

- The current status of the Aberdeen City Delayed Discharge Action Plan – with information on progress and recent developments.

2: Summary of Key Information

Current Performance Information

For the purposes of clarity, the IJB should be aware that the Delayed Discharge figures classify patients/clients into THREE types of delay:

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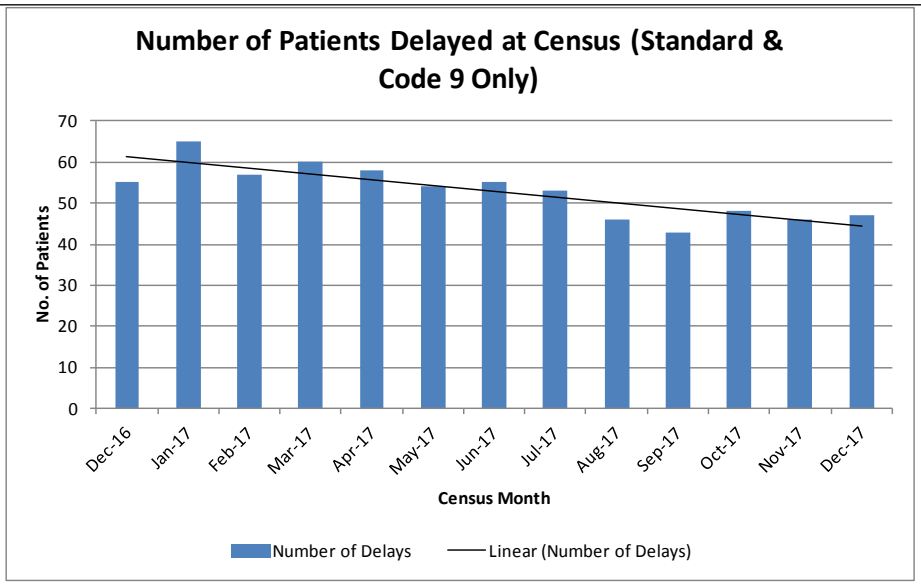
1. "Standard" Delays – which are individuals who are medically fit for discharge and yet remain in a hospital bed.

2. "Code 9" Complex Delays – which are individuals who have particularly complex needs (such as requiring legal intervention in the courts) that would indicate a longer timescale for a safe and appropriate discharge.

3. "Code 100" Commissioning/Reprovisioning Delays – which are individuals who have exceptional complex needs relating to previously being long-term hospital inpatients or other such prolonged circumstances. It is recognised by the Government that the normal timescales for discharge would be unable to be adhered to for such patients/clients.

"Code 100" delays are reported to the Government however are not included in nationally published data.

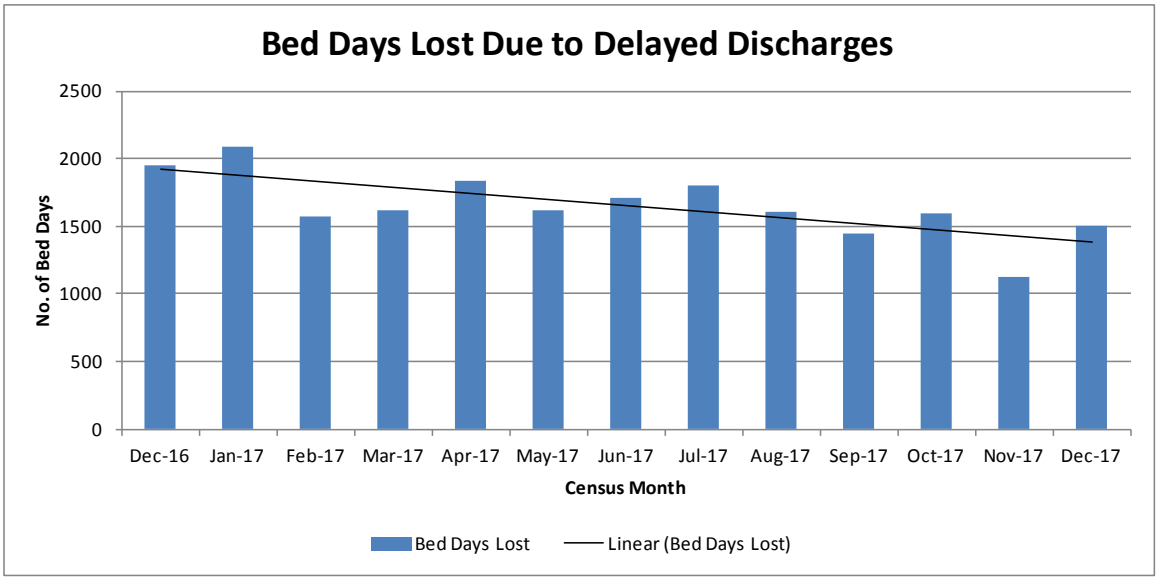
The IJB may also wish to note that the Scottish Government changed the criteria, definitions and data recording requirements for Delayed Discharges starting from the July 2016 census point onwards. This has had a particular impact on the counting of the number of clients/patients delayed at each census point as individuals who were not previously counted are now included in the definition of a 'delayed discharge'. Where 'trend' information is presented in this report that incorporates 'pre' and 'post' July 2016 figures, the post July 2016 figures have been adjusted to allow for trend comparison. This does not affect the count of "bed days lost" due to delayed discharges, as this data was not significantly affected by the changes in counting methodology. As more delayed discharge data accrues under the new data definitions, this adjustment will be phased out of general delayed discharge reporting.



[FIGURE 1] – Numbers of Patients/Clients Delayed at Census

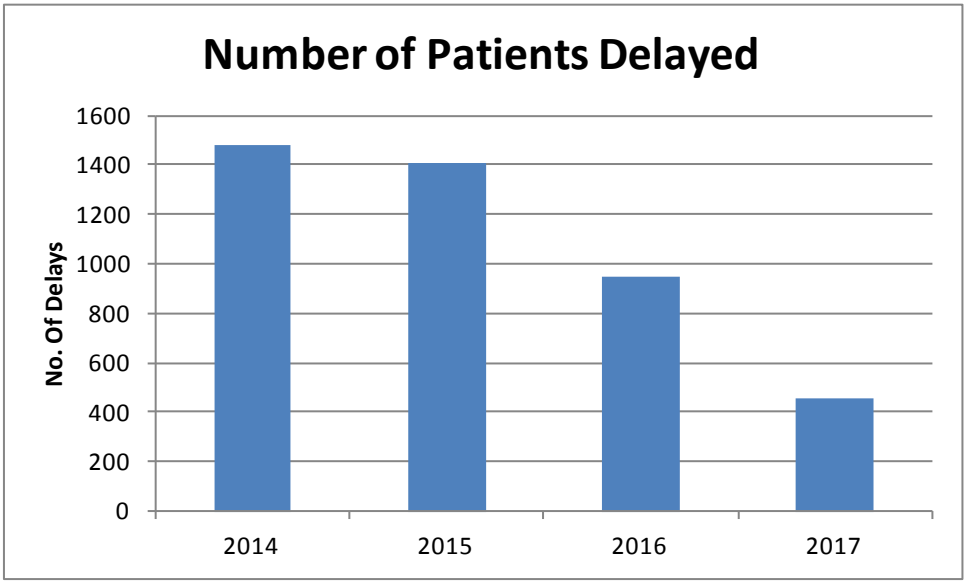
Figure 1 shows the overall count of those patients/clients classified as a 'delayed discharge' as at the monthly census point, (reflecting the fact that the Government captures Delayed Discharge performance on a monthly basis). This includes both "standard" delays and "code 9 delays".

As can be seen, the previously identified downward trend has continued over the last six months, with a further 18.5% drop in overall numbers delayed since the May 2017 census (the last data reported to the IJB).



[FIGURE 2] – Bed Days Lost Due to Delayed Discharges

Figure 2 shows the number of bed days occupied by patients/clients classified as a delayed discharge, also presented at monthly intervals. This also shows the continued trend downwards in the period since progress was last reported to the IJB, (with an additional 7% decrease in bed days lost).



[FIGURE 3] – Number of Patients/Clients Delayed – Annual Trend

Figure 3 shows progress, year on year, in reducing the number of individuals classified as delayed discharges at point of census. The overall volume of delayed discharged individuals has decreased 69% between 2014 and 2017. Between 2016 and 2017, the drop in numbers was 52%.

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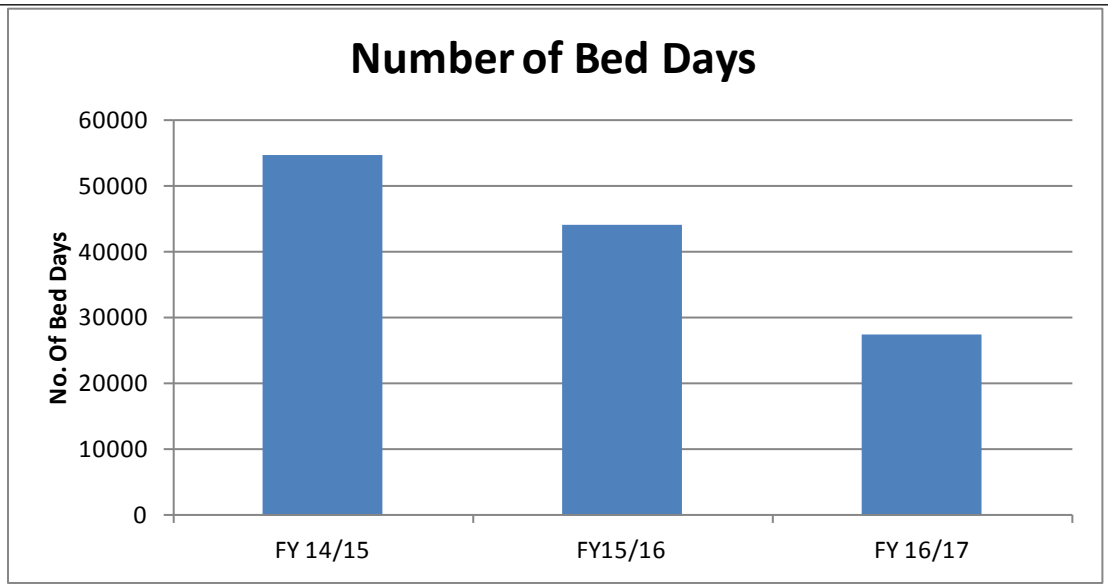
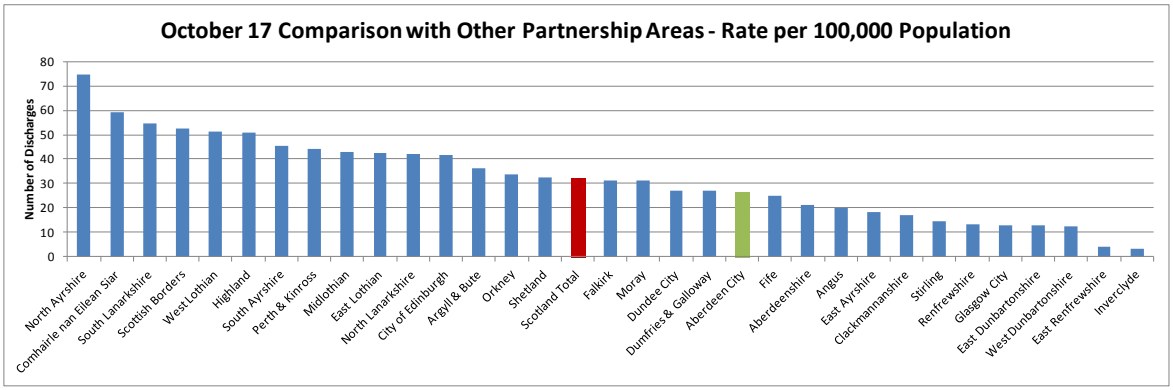


[FIGURE 4] – Number of Bed Days Occupied by Delayed Discharges – Annual Financial Year Trend

Figure 4 shows progress, year on year, in reducing the number of bed days occupied by delayed discharges. The overall volume of bed days 'lost' to delayed discharges has decreased 49% between 2014/15 and 2016/2017. At the next report to the IJB, full bed day performance will be refreshed to include the latest available data.



[FIGURE 5 – Comparison with Other Partnership Areas – Rate per 100,000 Population]

Figure 5 shows Aberdeen City's position against other Partnership areas when the most recently published cross-partnership census figures (October 2017) are adjusted to reflect population figures. The total of delayed discharges at census in

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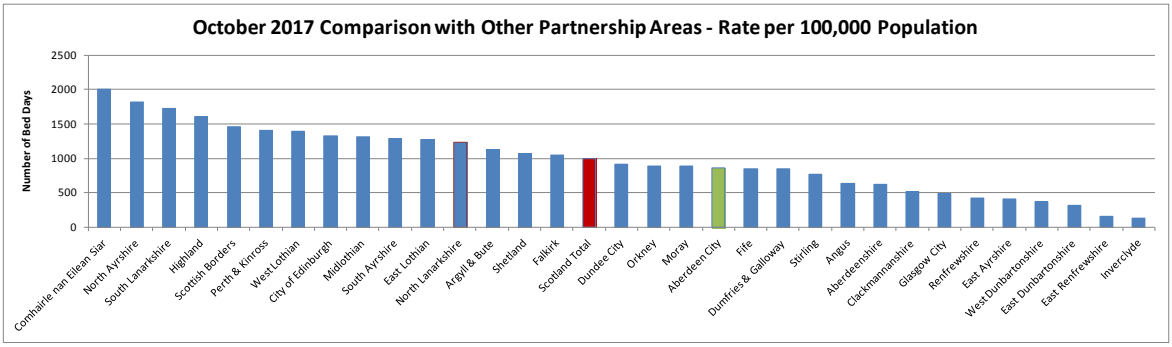
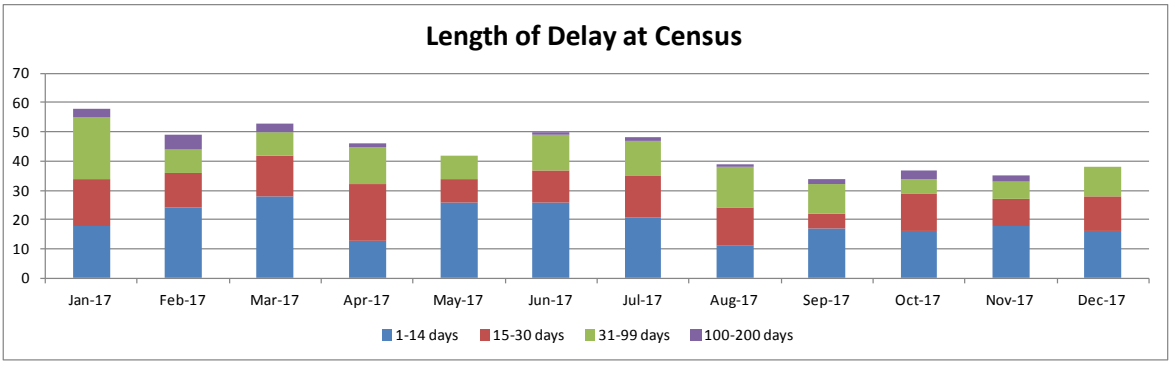
Aberdeen City in October 2017 equated to a rate of 26.1 delayed discharges per 100,000 population. This was below the Scotland wide rate of 32.1 per 100,000 population and 19 Partnerships recorded a higher rate than Aberdeen City. Aberdeen City now ranks well below the Scottish average for discharge census numbers, having previously been performing well above the Scottish average for an extended period.



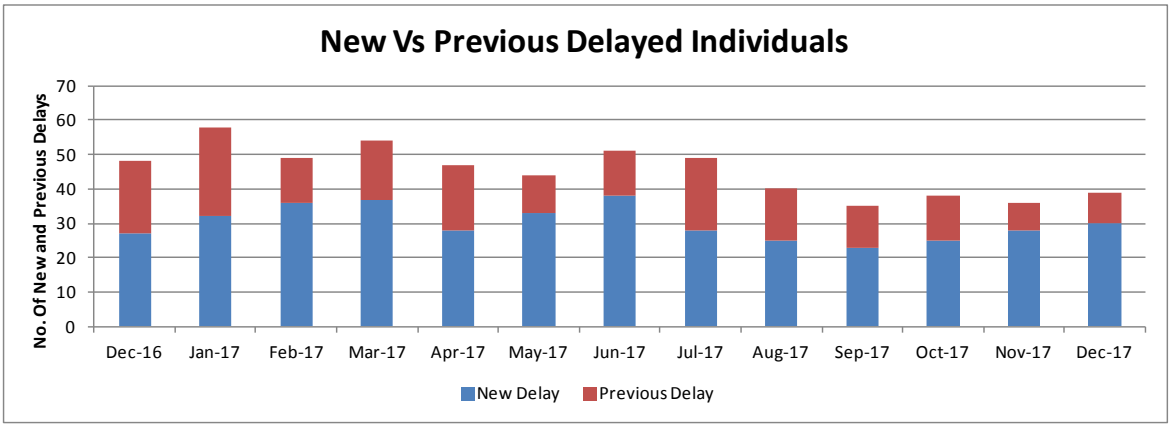
[FIGURE 6 – Comparison with Other Partnership Areas (Bed Days) – Rate per 100,000 Population]

Figure 6 shows Aberdeen City's position against other Partnership areas when the most recently published cross-partnership bed day figures (October 2017) are adjusted to reflect population figures. The total of delayed discharges in Aberdeen City in October 2017 equated to a rate of 861.7 bed days per 100,000 population. This was below the Scotland wide rate of 991.7 per 100,000 population and 18 Partnerships recorded a higher rate of bed days lost than Aberdeen City. Aberdeen City now ranks well below the Scottish average for bed days lost, having previously been well above the Scottish average for an extended period.



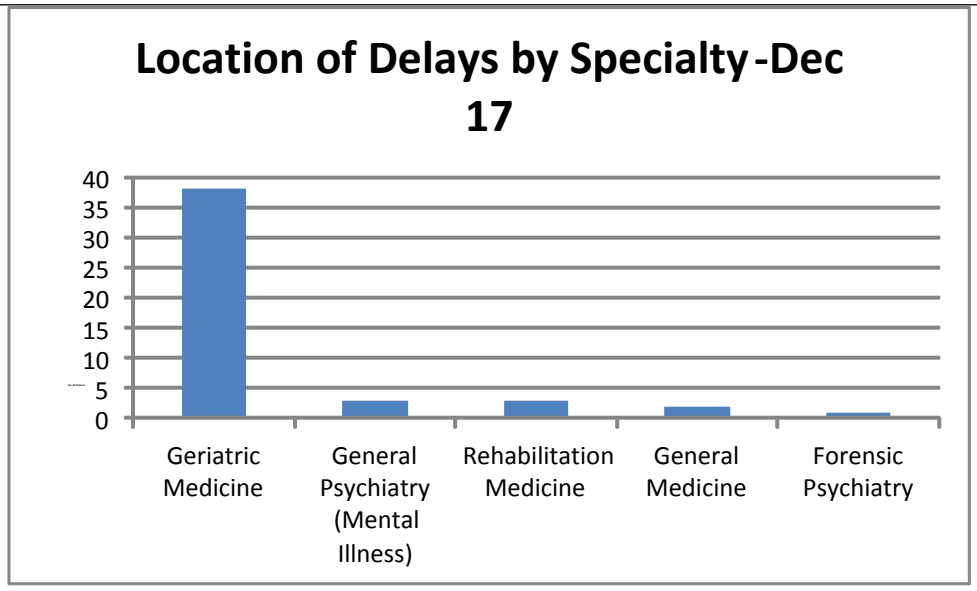
[FIGURE 7] – Length of Delay at Census

Figure 7 provides information on the **length of delay** for delayed discharge patients/clients at monthly census points. The longer delay periods (100-200 days and 200+ delays) tend to only be complex cases. What is notable is the contraction of the number of individuals facing long delays (which is also reflected in the more general reduction in bed days lost).



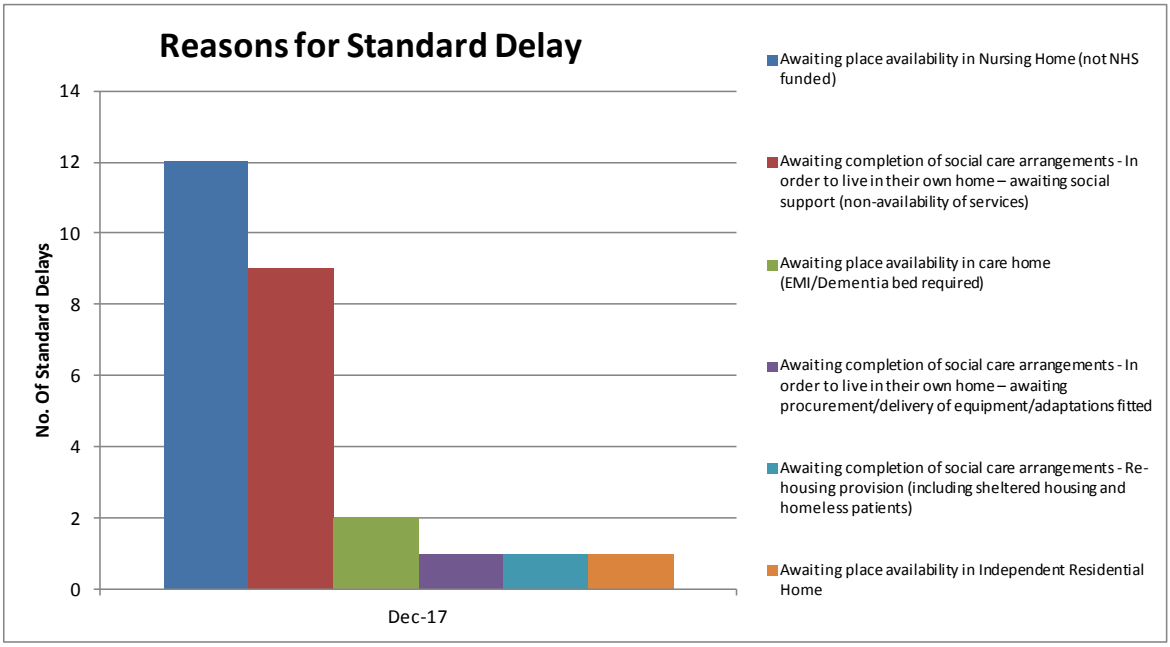
[FIGURE 8] – Proportion of "New vs Previous" Delayed Individuals at Census

Figure 8 shows (over the past 12 months) the proportion of individuals at each census who were 'new' delays that month vs those who had been 'carried forward' from the previous census period. The shift from 'previous' delays to 'new' delays evidences the speed at which discharges are being facilitated following an individual being deemed 'ready for discharge'.

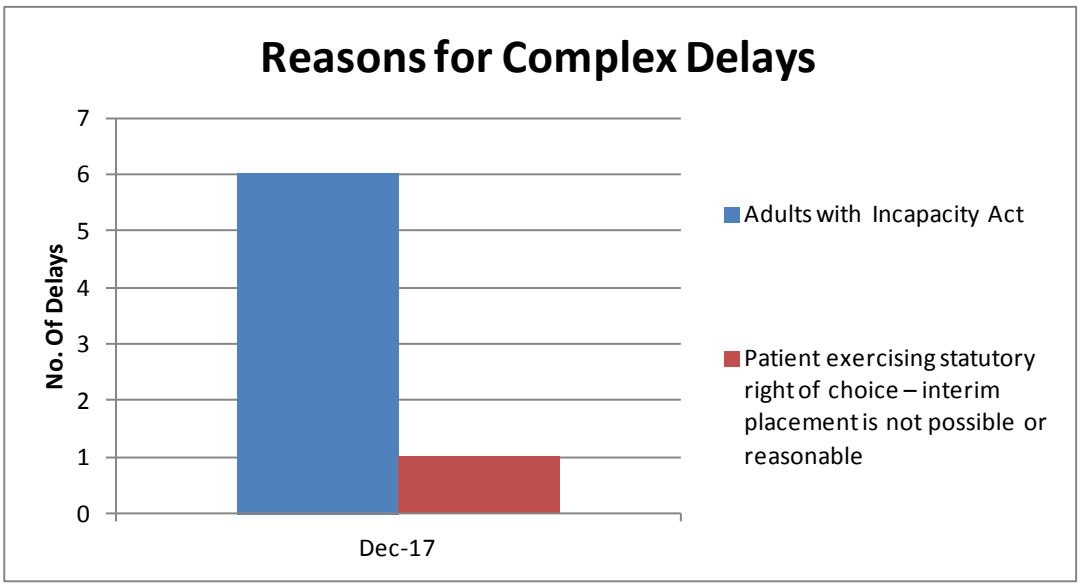


[FIGURE 9] Location of Delays by Specialty

Figure 9 breaks down where within hospital specialisms delays are occurring. This is the latest information available based on the December 2017 census information. Geriatric Medicine remains, by far, the largest speciality for delayed discharge patients, followed by General Psychiatry and Rehabilitation Medicine.



[FIGURE 10 – Reasons for Standard Delay]



[FIGURE 11 – Reasons for Complex Delays]

Figures 10 and 11 shows the **reasons** why patients/clients are a delayed discharge. The vast majority of standard delays are accounted for due to lack of an appropriate resource – care at home provision and care home needs. The majority of current "Code 9" complex delays are due to the need to seek legal orders for patients/clients under the auspices of the Adults with Incapacity (Scotland) Act 2000, along with a small number of individuals with a need for specialised care services.

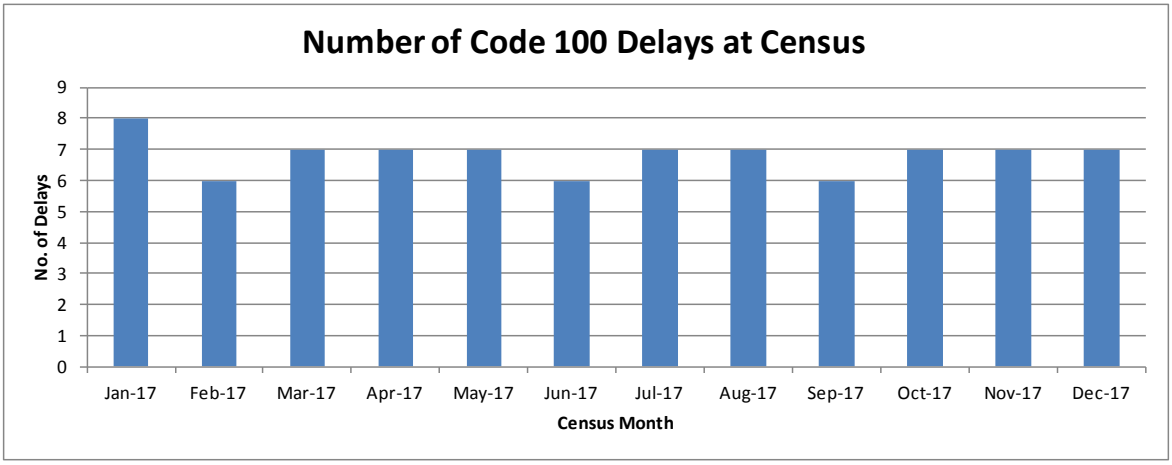


FIGURE 12 – Code 100 Delays, Trend

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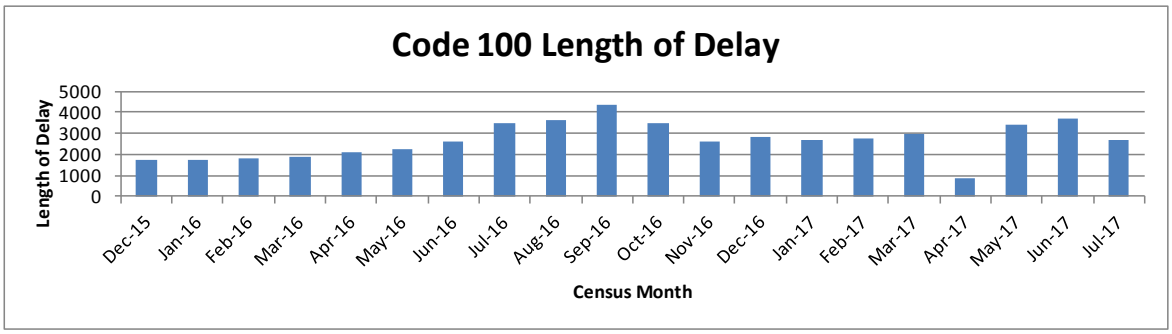
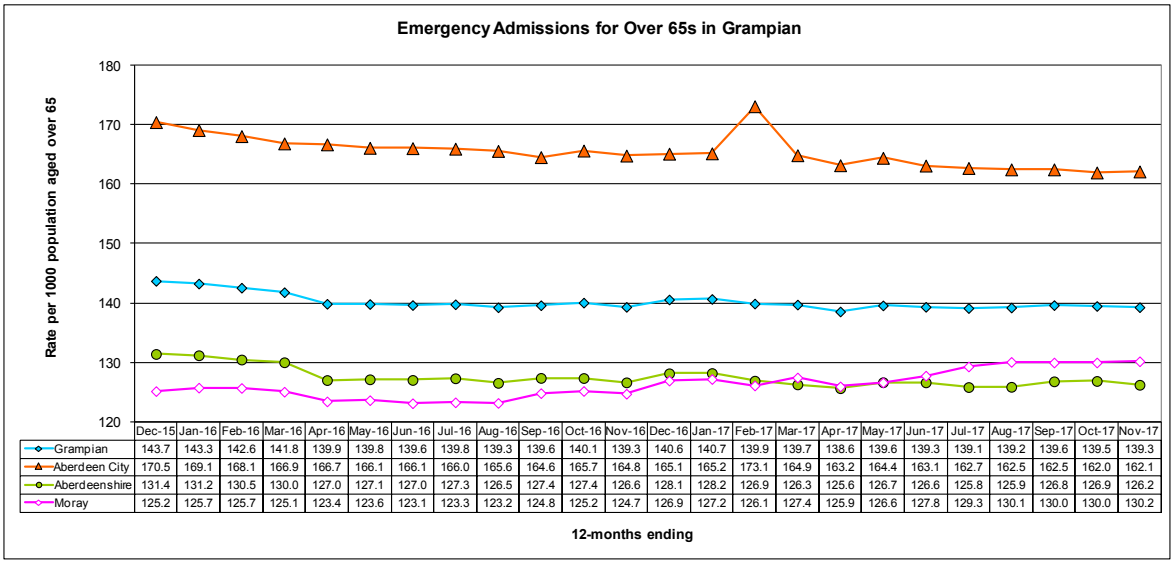


FIGURE 13 – Code 100 Delays, Length of Delay

Figures 12 and 13 shows the number of individuals who have been classed as a 'Code 100' Delayed Discharge over the past 12 months, and the accumulated bed days attributed to these complex cases. It should be noted, that whilst the overall volume of individuals who are classified as Code 100 remains small overall, the lengths of delay recorded are very significant – reflecting the ongoing difficulties in commissioning bespoke support services for these complex client groups.



	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
Grampian	143.7	143.3	142.6	141.8	139.9	139.8	139.6	139.8	139.3	139.6	140.1	139.3	140.6	140.7	139.9	139.7	138.6	139.6	139.3	139.1	139.2	139.6	139.5	139.3
Aberdeen City	170.5	169.1	168.1	166.9	166.7	166.1	166.1	166.0	165.6	164.6	165.7	164.8	165.1	165.2	173.1	164.9	163.2	164.4	163.1	162.7	162.5	162.5	162.0	162.1
Aberdeenshire	131.4	131.2	130.5	130.0	127.0	127.1	127.0	127.3	126.5	127.4	127.4	126.6	128.1	128.2	126.9	126.3	125.6	126.7	126.6	125.8	125.9	126.8	126.9	126.2
Moray	125.2	125.7	125.7	125.1	123.4	123.6	123.1	123.3	123.2	124.8	125.2	124.7	126.9	127.2	126.1	127.4	125.9	126.6	127.8	129.3	130.1	130.0	130.0	130.2

FIGURE 14 – Emergency Bed Days, Aberdeen City, Recent Trend

Figure 14 evidences a small trend of declining emergency bed days for the over 65's within Aberdeen City over the past 12 months, thereby reducing the 'flow/demand' into hospital of patients who will then subsequently require

discharge arrangements. Whilst it is still early to draw overall conclusions, the work of the Partnership in regards to its development of community focused and preventative interventions may be beginning to show its impact. This would be the beginning of an indication that 'demand' for hospital beds is being curtailed alongside speedier 'throughput' within the system itself.

Indicative Costs/Savings

When attempting to calculate the indicative costs/savings achieved through the reduction in delayed discharge bed days, NHSG Management Accounting introduced a new "lowest bed day cost" in November 2017 as part of their work portfolio for "Shifting the Balance of Care". This generated a bed day figure of **£279 per day per bed**. This figure was applied to the 38% reduction in bed days lost to delayed discharges from 2015/2016 to 2016/2017. This would indicate an indicative saving of **£4,628,889** comparing the two financial years. Including bed day reductions from 2014/15 in the overall calculation, the indicative savings rise to **£7,591,590**.

	2014/15	2015/2016	2016/2017	+ / - (cumulative, 2014-17)
Indicative Cost of Bed Days Lost to Delayed Discharge	£15,223,077	£12,260,376	£7,631,487	- £7,591,590

Summary of Key Data

- There has been a continued downward trend in both numbers delayed and bed days 'lost' due to delayed discharges since the last report to the IJB in June 2017.

- Aberdeen City has seen a 52% reduction in numbers of people delayed at census, comparing full calendar years 2016 and 2017.

- Aberdeen City has seen a 38% reduction in 'bed days lost' due to delayed

discharges, comparing financial years 2015/16 and 2016/17. The reduction in bed days lost has continued later into 2017, but at a notably slower rate.

- There has been a reduction in the proportion of individuals who are delayed for a longer period in hospital. Throughput and flow continues to improve.

- Code 100 delays, whilst relatively small in regards to volume, remain significant in regards to their combined 'lengths of delay'.

Aberdeen City Delayed Discharge Action Plan

As has been previously reported to the IJB, an Aberdeen City Delayed Discharge Group has been operating since 2015, bringing together primary care, secondary care and social work/social care staff to monitor performance and implement improvements in delayed discharge performance.

To that end, the Aberdeen City Delayed Discharge Group has a regularly updated action plan which documents current initiatives and future plans. This action plan is provided in Appendix 1 for the IJB's review.

Key aspects of the action plan that the IJB may wish to note:

- The renewal and 'go live' of the next phase of interim beds to support discharge following the IJB's approval of an additional 24 months funding.

- The 'go live' of the National Power of Attorney awareness campaign to which the Aberdeen City Health and Social Care Partnership has contributed.

- The transition work currently being undertaken to move from the ageing EDISON delayed discharge recording infrastructure to a fully integrated system within the TrakCare system.

- The co-location of Flow Coordination, Care Management and Liaison Nursing at Woodend Hospital to support further integration and joint working

INTEGRATION JOINT BOARD

3:	Equalities, Financial, Workforce and Other Implications

The issue of Delayed Discharge disproportionately impacts upon 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 the continued improvement in the timeliness of discharges.

The implementation of the 'action plan' (see Appendix One), involves expenditure from the dedicated delayed discharge funding stream. Specific projects within the action plan that require funding authorisation will have appropriate permissions sought from the relevant authorities depending on the level of expenditure incurred.

There are no direct workforce implications relating to this report.

4:	Management of Risk

Identified risk(s):

From the Partnership's Strategic Risk Register

"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."

Link to risk number on strategic or operational risk register:

Risk #7 (strategic)

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 delayed discharge action plan will help to address the overall volume of delays within the hospital estate – thereby mitigating some of this risk.

INTEGRATION JOINT BOARD

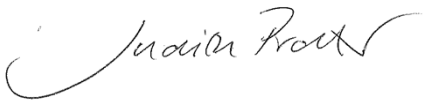
5:	Recommendations

It is recommended that the Integration Joint Board:

1. Note the Partnership's current performance in relation to delayed discharges;

2. Note the current status and progress in relation to the Aberdeen City delayed discharge action plan;

3. Instruct the Chief Officer to provide a further update on delayed discharge performance and actions taken to further improve performance in six months.

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

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Delayed Discharge Action Plan

Key Milestone/ Actions	Summary of Activity	Status (RAG)	Latest Update	Date of Last Update
Performance Data Recording				
Develop DD Performance Dashboard	New Dashboard presented to DD Group on 19-05-2017 - agreed core data presentation on dashboard + 'cycling' of 'themed' information over different months.	G	New Dashboard presented to DD Group on 19-05-2017 - agreed core data presentation on dashboard + 'cycling' of 'themed' information over different months.	19/05/2017
EDISON Replacement Project	City Partnership participation in project lead by eHealth to shutdown and migrate DD recording from EDISON to the Trakcare system.	A	Initial meetings held with eHealth + screens being 'built' into Trakcare. Still awaits final deadline for migration + formal testing of system. (Initial concept testing of screens has taken place).	22/12/2017
Discharge Pathway [Process of Discharge & Resources to Support Discharge]				
Choice Policy to be Redrafted and Refreshed	To ensure that an up-to-date, competent 'Choice' policy to support discharge is in place and operational on a local level.	G	Clinical Governance have now collated all feedback and the working group is currently engaging with stakeholders and redrafting to address issues flagged and raised. Will likely also need to go out to IJB's specifically for consultation prior to finalising. Other Grampian Partnership concerns being addressed as part of final redraft.	22/12/2017
Enhanced Hospital Social Work Capacity	Injecting additional social work capacity into three key roles: coordination of ARI discharges at discharge hub; Coordination of Woodend discharges; flow and managemnet of interim bed base. Names of postholders: M. Reid; J. Gaffney; N. Sorrie	G	Chief Officer has signed off and approved business case making all 3 posts permanent following evaluation. This is now an ongoing commitment for the DD fund in future years.	19/05/2017
Creation of Woodend Flow/Discharge Team	Create an integrated team, based at Woodend Hospital, that will manage flow into and out of the hospital.	G	Staff now co-located at Woodend + majority of ICT infrastructure in place. Allowing team a period of time to 'form and storm', will then begin process of quantifying shared tasks and new ways of improving flow and patient experience. Still issues r.e. ACC staff accessing NHS clincial info - attempting to address.	22/12/2017
Service Manager (Delayed Discharge) Role	Provision of a role that coordinates all DD activity across the Partnership.	G	Postholder secondment extended until 31st March 2018. DD funds cover this role. Future of role beyond 31st March 2018 currently being considered.	22/12/2017
Housing Pathway Coordination	Housing have approached DD Group with a potential proposal to provide an enhanced support service to all housing related delays within hospital and interim/intermediate care. Likely to involve increased staff availability to support discharge hubs + high priority individual wards, alongside some 'man marking' of individual problematic delays.	A	Housing have decided (after further consideration) they want to utilise existing resources at the DPHS first of all, before they build further capacity in the system. Will monitor in the coming months via the Housing DD Group + proposal will be looked at again if existing capacity not felt to be meeting needs.	22/12/2017
Rosewell Pathway Review	Review of flow into and out of Rosewell Rehab (20 beds). Aim is to streamline and maximise use.	G	Review group has held a successful meeting with revised criteria and pathway agreed. To now be written up and circulated amongst key partners as part of initial consultation. Further engagement required with primary care given increasing complexity of Rosewell cohort.	22/12/2017
DD Health Intelligence Post Shortfall	Ongoing funding to support dedicated DD analyst time.	G	Recurring payment made from DD funds to cover shortfall in health intelligence budget for dedicated DD analyst.	21/09/2017
Complex Delays - Code 9 and Code 100				
Power of Attorney Project	Project to encourage Power of Attorney prior to admission to hospital - thereby minimising long-term delays awaiting court orders.	G	KOB has been approached by a conglomerate of H&SCP's who are running a much broader POA campaign. DD group has given approval to join this initiative. Liaised with ACVO and third sector partners now agreed and forwarded to campaign. Campaign is now live and is running over the course of the year. KOB has met with campaign organisers in December 2017 to discuss evaluation data - expecting first metrics from campaign early 2018.	22/12/2017

Review Guardianship Pathway	Review of current practice in regards to Guardiansjip applications - spot delays and structural difficulties and then resolve.	G	Review work completed and findings have been fed back to DD Group. Multiple reasons noted for delay - however potentially two key elements that might reduce delays. Costed proposal taken to September DD meeting - agreed to fund both MHO time and admin time for 1 year to evaluate if it has an impact. TC&SD Programme Board has now endorsed DD group decision. Claire Wilkie to now lead on creating post + recruiting.	22/12/2017
Complex Patient - Bed Capacity	Initially conceived as whether Interim Bed spaces could be created for very complex patients - now looking much more as to whether ringfenced capacity could be created in resources to support discharge.	R	Meeting of Partnership executive group in September 2017 has requested that this proposal be frozen. This is to allow strategy and transformation colleagues time and space to do a much more substantive review of strategy relating to LD bed base.	21/09/2017
Participate in National Project on Complex Delays	National project currently looking at Scotland wide structural issues in progressing complex delayed discharges.	G	Aberdeen City has participated in a national project focusing on the most complex delays. Will examine in a detailed way the structural elements of delay + seek solutions. KOB presented at national conference r.e. progress so far + also presented at Partnership Exec Group. Year 2 funding approved for national project. KOB met with project team in December 2017 to determine how this will link in with Aberdeen City work. Further meeting focusing on LD complex delay work in January 2018.	22/12/2017
Interim and Intermediate Bed Base Provision				
Bed Base Review	Comprehensive review of Partnership bed requirements for older adults and adults with physical disabilities.	A	Some of this work already implemented via contribution to partnership's strategic commissioning strategy (primarily commisioned social care bed base). Now to begin work in 2018 on Partnership hospital based bed requirements + then join up.	22/12/2017
Identify and Commission Interim Beds to Support Discharge	Set up of interim beds in care home sector - ensuring faster discharges + additional capacity in the sector.	G	Group has agreed to endorse maintaining the same number of beds for 2017/18, but with amended eligibility criteria. Multiple notes of interest from care home providers for next 'round' - IJB approved funding on 15/08/2017. Contracts + GP cover secured for all beds - revised protocol issued to all care homes and staff, live as of 1st December 2017.	21/08/2017
Identify and Commission Interim Housing Provision	Set up interim housing properties patients can move from hospital to await re-housing and/or adaptations being conducted.	A	IJB has approved funding. Housing has identified one of the two properties and are beginning work on OT adaptations to the property. 2nd flat still being sought. Also working to pull together protocol/procedure for use of beds. Housing have been unable to commit to further development fo project until January 2018 due to other workload demands. Implementation meeting scheduled for end fo January 2018.	22/12/2017
Services & Other Resources to Support Discharge				
Aligning Care At Home Supply and Demand	Initiative to support matching much more robustly the demand for care at home (and the supply of care) to match Partnership priorities.	G	Tom Cowan has approved secondment of experienced staff member for up to 51 weeks to support coordinating unmet needs list + develop liasion with care providers. Worker started beginning of November 2016. Tom Cowan also approved secondment of care at home providers staff member to liaise r.e. care at home - costs now confirmed and this worker has completed their work as well.	01/12/2017
Establish a Joint Equipment Store for Aberdeen City	Project to evaluate options and then progress with a Joint Equipment Store .	G	Salary costs related to Joint Equipment Store work - anticipated to be spending for 2016/17 and part of 2017/18 only.	28/07/2017
Anticipatory Care Planning	Review of ACP work to improve impact + minimise admissions, re-admissions and failed discharges	G	BT participating in Short Life Working Group. BT stating that work of group is progressing, with potential for a project to enhance ACP being brought to the DD group - potentially on a Grampian wide basis. No costs at present.	22/12/2017
Capital Projects Supporting Discharge				
Planning and Development Manager Post	Salary costs for DD Capital Projects Staff Member	G	Funding for staff member 2016/17 + part 2017/18	01/08/2017
Saving Bed Days - Use of Technology	Use of new ICT equipment to trial new ways of working to support discharge.	G	DD group have approved pilot proposal to use tablet devices at Woodend Hospital to conduct pre-amputation assessments and fall management programmes. Money allocated to procure small volume of tablets to support this. Now awaiting delivery of the equipment which has been ordered. Tablets now in place and implementation now beginning.	21/04/2017
Pilot implementation of NEWS System	Approval for pilot purchase of NEWS equipment to support early intervention and prevention of admission via primary care.	G	Approval given to purchase - buying of equipment imminent.	22/12/2017

TEC - Upgrades To Equipment		G	TEC 200k one off spend - on DD dashboard for finance tracking [Requires update to finalise and confirm amount required + which TEC activity is being paid for.	12/12/2017

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Aberdeen City Health & Social Care Partnership
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INTEGRATION JOINT BOARD

Report Title	MSG: Understanding Progress Under Integration
Lead Officer	Sally Shaw, Head of Strategy and Transformation, ACHSCP
Report Author (Job Title, Organisation)	Alison MacLeod, Lead Strategy and Performance Manager, ACHSCP
Report Number	HSCP/17/113
Date of Report	20th December 2017
Date of Meeting	30th January 2018

1: Purpose of the Report

At its meeting on 12th December 2017, the Board considered a report on the Ministerial Strategic Group (MSG) Integration Indicators and the request from MSG to share updated objectives for 2018/19 by 31st January 2018. One of the decisions of the Board was to instruct the Chief Officer to develop these new objectives for agreement by the IJB at its meeting on 30 January 2018, prior to submission to MSG. The other decisions relevant to that report are being progressed separately.

Attached as an appendix to this report is the completed prescribed template that details the following for all 6 of the indicators: -

- The baseline data (2015/16 where available)
- The stated improvement objective for 2018/19 (described both as the expected change from baseline data and as the actual expected figure)
- A description of how the improvement is expected to be achieved
- Any relevant notes.

Also on the template is space for progress update, which is blank on the baseline report but will be used for quarterly reporting purposes throughout 2018/19.

The purpose of this report is to seek IJB approval of the objectives stated in the baseline report and agree that the report can be submitted to MSG immediately to meet their requested deadline of 31st January 2018

INTEGRATION JOINT BOARD

2:	Summary of Key Information

The Ministerial Strategic Group (MSG) for Health and Community Care was established at a National level and is being chaired by the Cabinet Secretary for Health, Wellbeing and Sport. Membership of the Group comprises representatives from agencies and professions involved in the delivery of integration.

The Integration Joint Board (IJB) previously considered a report at its meeting on the 28 March 2017, seeking agreement for the Aberdeen City Health & Social Care Partnership (ACHSCP) to participate in a national measurement of improvement under integration. The IJB agreed to allow publically available performance data to be used to support the MSG to measure performance under integration and instructed the Chief Officer to reply formally to the request, setting out the IJB's position.

The MSG wrote to Chief Officers on the 22 November 2017 (letter attached to previous report considered at the Board meeting on 12 December 2017). The letter provided an update on the work relating to understanding progress under integration, including:

- Thanking integration authorities for their contributions to date
- Detailing a suggested potential framework for providing future updates to the MSG
- An invitation to share updated objectives for 2018/19 by 31 January 2018
- Draft guidance on preparing and sharing local objectives around six indicators for MSG

The format and narrative as specified in the draft guidance, indicated that the work the IJB had undertaken to date provides a good basis from which to build. Revising the objectives for 2018/19 provides the IJB an opportunity to enhance the determined measures with more locally defined measures. This will support the ability to make more of a specific link between the objectives and ongoing transformation activity, e.g. the impact of Acute Care at Home project will have on admissions to hospital, or delayed discharge and correlation to unmet need.

Integration authorities are asked to share their updated 2018/19 local objectives with the MSG by 31 of January 2018, however there is the recognition that this may be dependent on governance timescales and meetings of the Integration Joint

INTEGRATION JOINT BOARD

Board. Given this, MSG are happy to accept interim objectives if necessary. Should the IJB be minded to approve the attached report the intention would be to submit it electronically immediately following the decision therefore allowing fully approved revised objectives to be submitted by the deadline.

Appendices

A) MSG Improvement Indicators

3:	Equalities, Financial, Workforce and Other Implications

None relevant to this report.

4:	Management of Risk

Identified risk(s):

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

Link to risk number on strategic or operational risk register: 6 (strategic)

How might the content of this report impact or mitigate the known risks: Submitting revised objectives in line with the proposed framework from MSG to measure performance under integration nationally, will provide assurance that the IJB is performing well in these areas, but also allow an opportunity for further benchmarking for performance under integration with other integration authorities. Also by enhancing the data collected for MSG with locally determined data collection we can evidence much better links and impacts of our transformational activity.

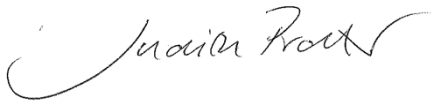
INTEGRATION JOINT BOARD

5:	Recommendations

It is recommended that the Integration Joint Board:

1. Approve the revised MSG Integration Indicator objectives contained within the attached MSG Integration Indicator Baseline Report (Appendix A).

2. Instruct the Chief Officer to submit the MSG Integration Indicator Baseline Report to MSG immediately to meet the deadline of 31st January 2018.

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

Aberdeen City Health and Social Care Partnership – MSG Improvement Indicators 2018/19

Aberdeen City HSCP	Unplanned Admissions	Unplanned Bed Days	A&E Attendances & seen within 4 hours	Delayed Discharge Bed Days	Last 6 months of life spent in community	Balance of Care (resident in non-hospital setting)
Baseline	Number of emergency admissions (Acute Specialties) Baseline 2015/16 21,777, 2016/ 21,269, 2017/18 (to Sep 17) 10,519 ▪ 2% reduction in emergency admission from 2015/16 to 2016/17 ▪ 4% reduction in A&E attendances admitted as an emergency from 2015/16 to 2016/17. ▪ 23% of A&E attendances were subsequently admitted as an emergency in 2015/16 (based on12 monthly average) and 22% in 2016/17. ▪ In 2015/16 49% of emergency admissions were from A&E, this reduced to 48% in 2016/17 and 46% in 2017/18 (to Sep 17).	Number of unscheduled hospital bed days for Acute Specialties, excluding Geriatric Long Stay and Mental Health, Baseline 2015/16 158,323, 2016/17 147,719, 2017/18 (to Sep 17) 58,060. ▪ 7% decrease in number of unscheduled hospital bed days from 2015/16 to 2016/17. Number of Mental Health unscheduled hospital bed days Baseline 2015/16 63,936, 2016/17 60,154, 2017/18 (to Sep 17) 29,637 ▪ 6% reduction in number of unscheduled bed days from 2015/16 to 2016/17 Number of Geriatric Long Stay unscheduled hospital bed days Baseline 2015/16 7,525,	Number of A&E attendances Baseline 2015/16 46,435, 2016/17 45,459, 2017/18 (to Sep 17) 23,447. ▪ 2% reduction in number of A&E attendances from 2015/16 to 2016/17 ▪ Percentage of attendances seen within 4 hours has remained constant at 95% in 2015/16, 94% in 2016/17 & 94% in 2017/18 (to Sep 17).	Number of Delayed Discharge bed days (all delays standard and code 9's) Baseline 2015/16 43,944, 2016/17 27,353, 2017/18 (to Sep 17) 10,046. ▪ 61% reduction in number of bed days occupied by delayed discharges 2015/16 to 2016/17. ▪ 83% reduction in number of bed days occupied by Code 9 delayed discharges from 2015/16 to 2016/17. ▪ In 2015/16 16% of bed days occupied by delayed discharges were occupied by code 9's, this decreased to 14% in 2016/17 and increased again to 16% in 2017/18 (to Sep 17).	Percentage of last 6 months of life spent in the community Baseline 2015/16 88%, 2016/17 89%. ▪ A higher percentage of individuals spend their last 6 months of life in a community setting, with 88% in 2013/14, 2014/15 and 2015/16, and 89% in 2016/17.	Balance of care – Percentage of population in community or institutional settings. Percentage of population aged 75+ in community setting (including care home) Baseline 2013/14 98.2%, 2014/15 98.1%, 2015/16 98.3%. In 2015/16 83.3% aged 75+ were at Home (Unsupported), 8.2% at Home (Supported), 6.8% in a Care Home, 0.03% in a Hospice/Palliative Care Unit, 0.02% in a Community Hospital and 1.65% in a Large Hospital. This compares to 2013/14 where 83.5% were at Home (Unsupported), 8.4% at Home (Supported), 6.4% in a

Aberdeen City Health and Social Care Partnership – MSG Improvement Indicators 2018/19

Aberdeen City HSCP	Unplanned Admissions	Unplanned Bed Days	A&E Attendances & seen within 4 hours	Delayed Discharge Bed Days	Last 6 months of life spent in community	Balance of Care (resident in non-hospital setting)
		2016/17 7,321, 2017/18 (to Sep 17) 1,530 ▪ 3% reduction in number of unscheduled bed days from 2015/16 to 2016/17				Care Home, 0.04% in a Hospice/Palliative Care Unit, 0.1% in a Community Hospital and 1.64% in a Large Hospital.
Objective	Projecting that 2017/18 will outturn at a 0.8% decrease on 2016/17 figure i.e. to 21,099, the objective will be to return to achieving a reduction on the 2017/18 figure closer to that of the reduction achieved from 2015/16 to 2016/17 i.e. 2%, achieving an annual figure of 20,677 by the end of 2018/19.	Projecting that 2017/18 will outturn at almost a 30% decrease on the 2016/17 figure i.e. to 104,142 the objective would be to maintain a steadier rate of decline in 2018/19 to a level of 5% below the 2017/18 figure i.e. an annual total of 98,921	Projecting that 2017/18 will outturn at a 0.08% increase on 2016/17 figures i.e. to 45,495 the objective would be to achieve a reduction on the 2017/18 figure closer to that achieved from 2015/16 to 2016/17 i.e. 2% achieving an annual total of 44.585. Additionally, the objective will be to improve the attendances seen within 4 hours to the 2016/17 rate of 95%.	Projecting that 2017/18 will outturn at a 35% decrease on 2016/17 figures i.e. to 17,780 and given that we feel much of the quick win improvements have already been achieved , the objective would be to maintain this reduction at a more stable rate of 5% on the 2017/18 rate i.e. to an annual total of 16,891.	The objective will be to achieve a 1% increase on the 2016/17 figure to achieve 90% by the end of 2018/19	The objective will be to achieve a 0.2% increase on the 2016/17 figure to achieve 98.5% by the end of 2018/19.

· Note :- Most of the initiatives listed below are at the early stages of implementation. Whilst we anticipate that the impact they will have on people's health and wellbeing will ultimately be significant, our approach is to achieve a steady, sustainable step change. The objectives listed above will be continuously reviewed as the initiatives become embedded and evidence becomes available as to the level of impact on each of the improvement indicators.

Aberdeen City Health and Social Care Partnership – MSG Improvement Indicators 2018/19

Aberdeen City HSCP	Unplanned Admissions	Unplanned Bed Days	A&E Attendances & seen within 4 hours	Delayed Discharge Bed Days	Last 6 months of life spent in community	Balance of Care (resident in non-hospital setting)
How will it be achieved	· Focus on locality needs and solutions · Implementing the Acute Care at Home model · Implementing the Integrated Neighbourhood Care in Aberdeen (INCA) model · Increasing availability of care through strategic commissioning (particularly intermediate care and creative use of SDS options) · Continued geriatric support to the ED at ARI achieving diagnosis-treatment-home where clinically safe to do so. · Modernisation of Primary Care	· Focus on locality needs and solutions · Implementing the Acute Care at Home model · Implementing the Integrated Neighbourhood Care in Aberdeen (INCA) model · Increasing availability of care through strategic commissioning (particularly intermediate care and creative use of SDS options) · Continued geriatric support to the ED at ARI achieving diagnosis-treatment-home where clinically safe to do so. · Modernisation of Primary Care · Increased use of Technology Enabled	· Focus on locality needs and solutions · Implementing the Acute Care at Home model · Implementing the Integrated Neighbourhood Care in Aberdeen (INCA) model · Increasing availability of care through strategic commissioning (particularly intermediate care and creative use of SDS options) · Modernisation of Primary Care · Increased use of Technology Enabled Care and Responder Services · Implementing Link Workers · Increased Pharmacy Support in GP practices	· Focus on locality needs and solutions · Implementing the Acute Care at Home model · Implementing the Integrated Neighbourhood Care in Aberdeen (INCA) model · Increasing availability of care through strategic commissioning (particularly intermediate care and creative use of SDS options) · Continued geriatric support to the ED at ARI achieving diagnosis-treatment-home where clinically safe to do so. · Modernisation of Primary Care · Increased use of Technology Enabled	· Focus on locality needs and solutions · Implementing the Acute Care at Home model · Implementing the Integrated Neighbourhood Care in Aberdeen (INCA) model · Increasing availability of care through strategic commissioning (particularly palliative and end of life care) · Modernisation of Primary Care · Increased use of Technology Enabled Care and Responder Services · Targeted Support for Carers · Increased adoption and roll	· Focus on locality needs and solutions · Implementing the Acute Care at Home model · Implementing the Integrated Neighbourhood Care in Aberdeen (INCA) model · Increasing availability of care through strategic commissioning (particularly intermediate care and creative use of SDS options) · Focus on enablement models of care. · Modernisation of Primary Care · Increased use of Technology Enabled Care and Responder Services

Aberdeen City Health and Social Care Partnership – MSG Improvement Indicators 2018/19

Aberdeen City HSCP	Unplanned Admissions	Unplanned Bed Days	A&E Attendances & seen within 4 hours	Delayed Discharge Bed Days	Last 6 months of life spent in community	Balance of Care (resident in non-hospital setting)
	· Increased use of Technology Enabled Care and Responder Services · Implementation of Link Workers · Increased Pharmacy Support to GP practices · Targeted Support for carers	Care and Responder Services · Implementation of Link Workers · Increased Pharmacy Support to GP practices · Targeted support for carers	· Increased GP locality collaboration – widening access to primary care	Care and Responder Services · Implementation of Link Workers · Increased Pharmacy Support to GP practices · Targeted Support for Carers · Implementation of the Delayed Discharge Action Plan	out of Anticipatory Care Plans in respect of end of life care as soon as possible in the pathway · Continued, active participation in the Palliative Care Strategy Group	· Implementation of Link Workers · Increased Pharmacy Support to GPs · Targeted Support for Carers · Increased GP locality collaboration – widening access to primary care
Progress (updated by ISD)						
Notes	ACH&SCP are 12% below the Scottish average for Emergency Admissions and very close to the 25th percentile rate (per 100,000 population).	ACH&SCP are 9% below the Scottish average for Unplanned Bed Days. We will seek to undertake further detailed analysis of unplanned bed days in relation to Geriatric Long Stay and Mental Health.	ACH&SCP has one of the lowest rates of A&E attendance of any partnership in Scotland however we are still committed to improving on this.	ACH&SCP have already achieved a 68% (3,034) reduction in DD Bed Days between Feb 15 and Sep 17 as a result of a rigorous action plan. We have moved from being the 2nd worst partnership to the 12th best.	ACH&SCP are above the Scottish average in this indicator (87%) and the highest placed City based partnership. Dying at home is a personal choice and rural partnerships have the highest percentages this indicator.	Most partnerships have a similarly high percentage for the overall number of those resident in a non-hospital setting the variance tends to be between supported and unsupported and this will be given further analysis during 2018/19.

Aberdeen City Health & Social Care Partnership
A caring partnership

Integration Joint Board

Report Title	Transformation: Transformation Plan
Lead Officer	Sally Shaw, Head of Strategy & Transformation
Report Author	Gail Woodcock, Lead Transformation Manager (ACHSCP)
Report Number	HSCP.17.114
Date of Report	16th January 2018
Date of Meeting	30th January 2018

1: Purpose of the Report

The purpose of this report is to bring to the attention of the IJB an update in relation to the Transformation Plan. This details the transformation journey to date and highlights the IJB's priority deliverables.

The Transformation Plan provides an overarching narrative that supports all of the IJB's transformation activities. This includes matters covered by other related papers on today's agenda including:

- Primary Care Transformation;
- Decisions on Transformation Projects; and
- The Strategic Commissioning Implementation Plan.

2: Summary of Key Information

2.1 Transformation Plan

The Aberdeen City Health and Social Care Transformation Plan (Appendix A) presents a narrative which explains the key drivers and ambitions of the transformation programme, and its progress to date. This includes the background to the development of this plan and a consideration of why its ambitions and priorities remain relevant and appropriate to realising the delivery of our Strategic Plan.

The plan highlights the need for change, and the lessons learned from previous approaches to change in relation to health and social care. Transformation is

happening in the context of significant increases in demand and financial challenges, which creates tension both within the partnership and across the wider system.

The plan highlights the progress to date, both in terms of the development and delivery of the programme, and in delivering improvements. All of what has been done since the inception of the IJB in 2016, has been achieved at the same time as forging new ways of working in respect of our brand new organisation.

The delivery of our transformation plan is supported through a number of specific funding streams. The plan highlights that while all of this funding is badged under the term transformation and change, an element of the funding has been provided to support the integration agenda.

Related to the plan is the development of an emerging outcomes framework which provides a framework for the evaluation of the delivery of anticipated benefits including citizen, staff and resources benefits, and captures the inter-relationship of the wide range of projects within the plan. Further detail on this framework will be shared with the IJB at a later date.

Appendices

A) Transformation Plan

3:	Equalities, Financial, Workforce and Other Implications

Financial Implications

The activities within the transformation plan are funded through a range of specific transformation and change budgets. These budgets provide capacity for developing new models and testing new ways of working at the same time as continuing to delivery business as usual, therefore reducing any risks that may be associated with reduced capacity due to change processes.

The overall transformation plan affects all services provided through the partnership, and therefore is considered in the context of the overall funds allocated to the partnership of approximately £265 million.

The plan provides an illustration in appendix 1 of the level of financial challenges facing the IJB. This information will be refined and updated in the IJB financial

strategy, to be discussed at the next board.

Equalities Implications

The transformation plan will have neutral to positive equalities implications.

Workforce Implications

Implementation of projects within the plan will impact on workforce in a number of ways, including delivering new models and new ways of working which seek to address the challenges of our changing workforce, for example by helping to create attractive working opportunities.

4:	Management of Risk

Identified risk(s):

There are no specific risks as a result of this report.

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.

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.

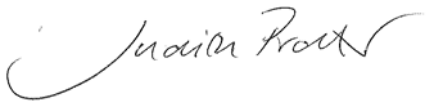
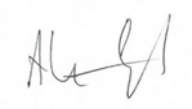
9. Failure to deliver transformation at a pace or scale required by the demographic and financial pressures in the system

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

Integration Joint Board

How might the content of this report impact or mitigate the known risks:
This paper provides an overview of our overall plan which is in place to provide a context and support to mitigating against these risks.

5:	**Recommendations for Action**
It is recommended that the Integration Joint Board: 1. Notes the Transformation Plan, as at appendix A; and 2. Endorses the progress made to date.	

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

CITY HEALTH AND SOCIAL CARE PARTNERSHIP – TRANSFORMATION AND CHANGE PLAN

Foreword

The Aberdeen City Integration Joint (IJB) and Health & Social Care Partnership (HSCP) have been operational since 2016 and we are, at the time of writing, 17 months into the formal operations of these new organisations. Since April 2016 a number of changes have taken place which makes this a good time to reflect on the agreed strategic direction of the IJB, its transformation and change programme and the approach being taken to this. Changes have included the Local Government Election and changes in NHS Board membership which has changed significantly membership of the IJB. Inevitably in a new and dynamic organisation not all current members were involved in previous discussion and decision making. This is therefore a useful point to review decisions made by the Board and assess progress toward its agreed ambitions.

The Aberdeen IJB has set out an ambitious transformation programme within a deliberate and agreed approach and against a growing appetite to take the risks necessary to truly transform and change the way that health and care is delivered in the City. This approach was developed and agreed over a 2 year timeframe and over the period from the work of the initial Transformational Leadership Group (TLG), the Shadow IJB and finally culminating with agreement to the overall programme and framework at the IJB's first live meeting, on the 29th of April 2016. This paper describes some of these decisions in order to demonstrate cohesion and continuity of decision making and progress being made against ambitions.

Background

The Aberdeen City Integration Joint Board which oversees the Health and Social Care Partnership came into formal existence in April 2016 when it agreed and published its Strategic Plan. The Board's role and function is set out in the underpinning legislation – the *Public Bodies (Joint Working) (Scotland) Act 2014*[i]. The purpose for the integration policy has been set out elsewhere in more detail but can be summarised as being necessary in order to reshape our whole health and care system in Scotland to enable us collectively to sustain good quality services at a time of unprecedented change and challenge – budgets are reducing, our population is ageing and we are contending with a reducing working age population and a reducing workforce supply – more than in any other time in recent memory. The system must change and adapt to the new pressures it faces and health and social care integration is seen as a key mechanism toward that.

Integration Joint Boards (IJBs) were set up in order to change the patterns of behaviour, planning and delivery across health and social care and, in large part, to achieve change through a more

disruptive approach; deliberately setting strategy, planning and then, utilising delegated budgets directing and commissioning the NHS and Local Authority Partner organisations to delivering more joined up, community based models and in doing so, utilising resources 'locked' in traditional silos.

Key to these changes is a different approach to working with people, communities and the professionals within our organisation. We need to focus on reducing and reshaping demand, improving people's health, wellbeing and independence and in supporting professionals and teams to work in a far more joined up and integrated approach than we have ever achieved before. Audit Scotland in its report *Health and Social Care Integration*[ii] emphasises the significant shift in the delivery of services required of Integration Authorities toward wellbeing and preventative approaches and shifting care from being hospital based toward the community-based services.

Need for Change

The case for integration has been set out in detail in the range of guidance and the economic case which accompany the legislation. The national challenge is also clear:

- 1 in 4 adults has a long-term illness or disability;
- Around 2 million people in Scotland have at least one long-term condition;
- People in Scotland are living longer, but more of those people over the age of 75 are living with a long-term condition and/or significant frailty; and
- Overall the population of people over the age of 75 is expected to increase by 63% over the next 20 years[iii].

The Scottish Government estimates that the need for health and care services will rise by between 18% and 29% between 2010 and 2030. Coupled with a shrinking working age population and the known workforce supply challenges, it is clear that the current model of health and care cannot be sustained and that it must change. The emphasis of change is toward more preventative and anticipatory approaches and those that are community-based with acute services being used only when there is no alternative.

Audit Scotland undertook an early review into the changes being brought about through the integration of health and social care in its paper of March 2016. The report; *Changing Models of Health and Social Care*[iv] set out the challenge of increasing demand for services and growth over the next 15 years in Scotland. Among the pressures identified in this were:

- 12% increase expected in GP consultations;

- 33% increase in the number of people needing homecare and a 31% increase in those requiring 'intensive' homecare;
- 35% increase in demand for long-stay care home places; and
- 28% increase in acute emergency bed days and a 16% increase in acute emergency admissions.

These are all areas that we recognise in Aberdeen and our strategic plan and the transformation and change programme take into account our need to address these pressures. But we do so against a context of local challenge:

- Increasing levels of GP vacancies with every practice in the City having at least 1 GP vacancy, and 2 practice failures in the past 2 years;
- Increasing demand for home care as we shift the model, but workforce supply issues in relation to recruitment and retention in the care market;
- Increasing demand for care home places but more beds closing and care homes reporting significant fragility in their operating models;
- Challenge of realising efficiencies achieved in reducing bed day use and changing patterns of delivery and behaviour.

The Audit Scotland report went on to say that on the basis of these estimated increases in demand, the Scottish Government would need an increased annual investment of between £422 and £625 million in health and social care services in order to keep pace. That level of increased investment is simply not available. However it is against this backdrop of increasing demand and decreasing budgets that the Aberdeen City Health and Social Care Partnership (ACHSCP) has had to develop its Strategic Plan and its transformation and change programme. Transformation and change is necessary to make an impact in a number of directions:

- Absorbing these expected increased demands in the short to medium term with no corresponding increase in base budgets;
- Creating a significant shift in the balance of care and shift in the way people access advice, support and services in order to continue to deliver within a reducing budget and with recognised workforce supply challenges;
- Activities and change to reduce demand, increase preventative approaches and promoting resilience and wellbeing in the medium to long term;
- Improving people's experience of health and social care and their health and wellbeing outcomes;

- Changing and developing a new culture within a brand new organisation and in doing so create new roles, teams and functions to enable us to meet the challenge;
- Improving the partnership's performance against local and national outcome measures; and
- Development and delivery of savings and efficiency programmes that ensure duty to balance the overall budget at year end.

In making the decision to take forward the approach and plan, the Integration Joint Board (IJB) recognised that *'the complex projects set out….will take some time to plan, test and realise outcomes from. It is therefore anticipated that the delivery of these priorities will require a three year investment programme in the first instance with a rolling evaluation and programme thereafter'.*

Aberdeen Position and Financial Challenge

The total Aberdeen HSCP budget is around £265 million per annum. It is estimated in the case of the Aberdeen City IJB that if nothing else changes, it will cost an additional £12 million a year in order just to standstill. Even within this figure there will still be a certain amount of managing or absorbing the increased demand, particularly on the health element of the budget where it is more difficult to put a financial cost on increased service provision. The £12 million gap is made up of the requirement to meet rising pay awards, increases in prescribing and social care costs – particularly for the growing population of people with very complex, life-long conditions.

It is therefore likely that Aberdeen City IJB will need to identify £36 million of budget savings over the next three years and at the same time transform service delivery. Transformation does not necessarily deliver savings at this level within this timeframe and savings toward the gap in the budget will need to be identified and delivered through a wide range of measures to be agreed by the IJB. The aim of the financial element of this plan is to use the transformation activities to absorb costs and where possible create capacity in mainstream budgets\services. This capacity will be used

- to help support services moving from the large hospital setting to a local community setting; and
- to enable people to be taken care of for longer in their own home, reducing the reliance on the traditional residential care setting.

As this capacity is used the level of savings from the large hospital (set aside)\residential care budgets increases. Over the same time period the level of general budget efficiencies reduces as these savings will become more difficult to identify due to the recent transformation and redesign of

mainstream service delivery. **Appendix 1 -** provides an illustration of how these savings might be provisionally distributed across the IJB's activities.

Funding of almost £20 million has been identified and transferred over from the Scottish Government to support the transformation and change programme. However, a large proportion of this has been required to support social care providers with the implementation of Scottish Living Wage commitments.

Further new funding may be released in order to implement the new GP contract to be announced in November 2017 but it is neither prudent nor good practice to plan on the basis of uncertain allocations and this has not been factored in to any of our assumptions.

Audit Scotland Reviews

The Scottish Government has recognised that this change is complex and will require funding to achieve in order to manage effectively. Funding has been made available to IJBs to support development of the infrastructure to deliver integration as well as support double running costs and transformation/change investment.[v] There was recognition that there would be a cost to delivering this reform but it was anticipated that IJBs would be able to make more efficient use of resources across health and social care and as a result generate annual savings of between £138 and £157 million. Audit Scotland however stated that is was '*unclear whether these anticipated savings will release money that IJBs can invest in more community-based and preventative care*'[i] the inference here being in terms of whether cash release is possible (see below), or whether IJBs will be managing to absorb increasing demand and pressure within a reducing financial settlement. Even if these savings were cashable, they still fall short of the annual uplift requirements identified in the same report of an additional £422 million a year required each year to deal with increased financial pressure and demand.

Aberdeen City Health and Social Care Partnership Strategic Plan

Our Strategic Plan[vi] sets the direction of travel for this change and sets the local case for transformational change against these challenges. It recognises that this is the kind of transformation that cannot happen overnight, regardless of how challenging and immediate the pressures are. It recognises that this is a 10 year change process that requires the right building blocks to be put in place to effect longer term, more sustainable change. And it recognises that underpinning structural change and changing models, is a longer term change in the culture of our organisation.

The Strategic Plan built on the momentum of work started prior to the 'go live' and driven by the Transitional Leadership Group (TLG) and Shadow IJB (SIJB). Over a period between December 2014 and the IJB go live in April 2016 the TLG and SIJB undertook a series of workshops and meetings in order to inform the eventual Strategic Plan and the approach it wished to oversee in terms of the longer term transformation of health and social care in Aberdeen. This work set the direction for the Chief Officer and Executive Team and remains the agreed framework. The planning in relation to the Change Fund at that time was based on it being for one year only and it was late in the process where it was confirmed as mainstreamed.

The following principles were agreed by the TLG/SIJB:

- Learning from the use of the previous Change Fund would be applied – a strategic commissioning approach to change would be undertaken;
- It was agreed that it was unlikely that multiple, small projects could deliver the magnitude of change required;
- Strategic Commissioning would mainstream new ways of working and the change fund would allow for double running costs as new models are embedded;
- The evidence base would inform commissioning and the programme would have an evaluation programme underpinning it;
- We would do things with a proper approach to quality and involvement of key partners, professionals and communities and it was recognised that this would take time;
- Localities as an engine room for change – we have always seen these as vitally important and as such we had to protect a significant portion of funding to realise the vision for these;
- A clear assumption was made that there would be no expectation of any additional funding and that the IJB and Partnership would manage within the financial parameters set, only making a case to partner organisations in the event of significant new, unexpected pressures or demographic change. There was also an assumption that there was no expectation that double running costs and additionality could be maintained.

Initially the IJB was clear that it wanted to protect and ring-fence the transformation funding specifically and only for transformation and change projects. This was a clear demonstration of the Board's ambitions and intent to deliver sustainable change over the medium and longer term. While this remains the Board's ambition, its thinking has matured to reflect the mainstreaming of all funds and the primary requirement to balance the budget. A useful and creative tension arises from this and informs ongoing discussion on the allocation of IJB funds.

Transformation and Change Programme

While the Strategic Plan sets direction, the Transformation and Change Programme, building on the framework and principles set out above, describes the activities toward that destination. This paper has set out a review on how we reached the decisions on these actions, the approach taken and updates on the progress being made, and it builds on the paper agreed at the IJB on the 29th of April 2016. That paper; '*Strategic Commissioning and Transformation – Principles and Strategic Process*'[vii] set out the approach the Board agreed in relation to delivering to its change, and the methodology by which it agreed its strategic investment. It provided more detail on the timeline, outcomes expected, investment and impact against national outcomes.

As set out elsewhere in this paper, it built on the work of the TLG and SIJB and in doing so made a number of points which are worth reiterating here:

- The Integrated Care Fund and other transformational budgets were now mainstreamed (and require to be considered in the context of the wider financial challenges of the sector);
- This mainstreaming means that we were able to plan in the medium term – enabling an opportunity to focus on big shifts and complex processes – without the need for immediate payoff;
- It was recognised that the complex projects within the programme would take some time to plan, test and realise outcomes from. It was therefore anticipated that the delivery of these priorities would require a three year investment programme in the first instance with a rolling evaluation and programme thereafter; and
- It was not anticipated that these activities would utilise all our transformation funding and the remaining funding would be utilised for supporting locality based innovation tests as well as smaller scale change.

The transformation and change programme identifies the prioritised projects which are considered to potentially have the biggest effect on the whole system. These are also initiatives that will support fully our aspirations of shifting towards a more person centred and community focussed health and social care economy. **It is important to highlight that while all the funding has been badged under the term transformation and change, an element of the funding has been provided to support the integration agenda.**

The Approach

The proposals for transformation and change agreed by the IJB in April 2016 were set out against a framework of best evidence of what works in changing health and social care and within principles

for best practice in the planning and implementation of new care models. The principles were based upon the model set out in the Audit Scotland report '*Changing Models of Health and Social Care'* - Learning from the use of the previous *Reshaping Care for Older People* Change Fund was useful here and the model agreed by the Aberdeen IJB particularly focusses on:

- Development of a clear business plan detailing timescales, resources, costs and estimated savings/efficiencies.
- Focus on a small number of models in priority areas and do these well, rather than trying to change too many things at once;
- Allow sufficient time to test new ways of working and to gather the evidence of what works; and
- Basing models around small, local areas or clusters with groups of staff that know the local population

The 6 'big ticket items' proposed were presented as such on the basis of a number of hypotheses of what we believe will work to address the challenges facing health and care in Aberdeen. Things we believe will have the greatest chance of success in addressing the demands outlined elsewhere in this paper.

We now have in place an evaluation work stream that will support understanding of what is working and the progress we are making – enabling change and adjustment in projects and activities as we go. The Programme Team are working with relevant national bodies to support us in the use of the best available evidence on what works including the iHub, LIST analysts and with local expertise in the Universities in Aberdeen through our colleagues in Public Health and Health Intelligence. Recent mapping work was undertaken against the programme and the Nuffield Institute report *Shifting the Balance of Care: Great Expectations*[viii] and the programme reflects well those areas where there has been found to be best evidence of what works in shifting the balance of care.

Put another way, the Aberdeen IJB has made appropriate decisions on the basis of what's most likely to work and there is growing evidence to support this. And – there are few, if any, other activities that will deliver this change any faster or improve measures any further, than what we're engaged in now.

Future Vision – 2020

The Strategic Plan will be reviewed within the first 3 years of the IJB's operation and the Transformation and Change Programme will be subject to ongoing review and evaluation. However, we have an agreed direction of travel and a programme that will grow in momentum toward a vision

for 2020 and beyond. The vision builds on the solid good work and foundations laid to date in the first year of operation (see performance below) and builds on the Strategic Commissioning approach set out in our plan;

- Through this we will continue to focus on improved **outcomes and experience** for people and we will strive to continue our **performance improvement**;
- We will focus on the **cultural change** required in line with our integrated approach and building on shift toward **community-based services;**
- This will be delivered through our **Locality Based Approach** and our **INCA teams** will test approaches to truly integrated working with care workers embedded in teams;
- Our **Locality Leadership** will be working in a co-productive way with communities and neighbourhoods, supporting approaches to building **community capacity and resilience** that will support us in increasing community based solutions to increasing demand, social isolation and availability or alternative supports;
- Recognition that services will be supporting a very different population at home with increasing levels of complexity and frailty – as such our community services – especially our **Acute Care at Home** team – will be tested, rolled out and adapted to enable this at scale across the City;
- Related to this and our ongoing and significant improvement in use of Acute Services we will continue to make more **efficient use of the Acute Sector** and only those with acute medical needs that cannot be cared for in a community setting occupying an acute bed. We will continue to work to prevent admission, divert referrals and ensure speedy discharge for those admitted for treatment and who are ready to go home. In doing so we will be able to **realise the efficiencies we have created and utilise the large set aside budget** toward investing in and sustaining community-based health and care capacity;
- Our **Community Links Worker** programme will be rolled out and be making a difference in supporting people who may otherwise utilise GP or other healthcare services. We anticipate this impacting loneliness and isolation; supporting our ambitions to signpost people to community services or other forms of community and self-support; and supporting greater family and personal resilience as well as reducing reliance on public services. This will be of particular benefit in our most **deprived communities**;
- We will accelerate our approach to **Technology Enabled Care (TEC)** in conjunction with our partners ensuring that more people can access this preventative support and stay at home safely. Coupled with this we will continue in our work to identify safe and effective approaches as an alternative to sleepovers;

- There will be a continuing relationship with housing colleagues both within Aberdeen City Council and with our Registered Social Landlords and we'll develop **housing approaches** to meet the needs of people with complex needs in our communities. This will continue the work we've started on **repatriating those with complex needs** who are cared for out of region and support us in managing a good transition across Children's Services and into Adult Services for young people;
- Our **Integrated Neighbourhood Teams** will have matured and developed within our Localities and we'll be realising the benefits of single teams, reduced duplication and streamlining of effort. Teams will be better able to predict need, prevent crises and manage people with more complex needs within the skill mix and resources available in the locality;
- Our **Strategic Commissioning Plan** and our work with **3rd and Independent Sector Providers** will recalibrate our relationship with providers of care across the City. We will be working in a more co-productive way with them and through this maximising **re-enablement approaches, locality commissioning opportunities and self-directed support;**
- We will continue to develop new approaches to **Primary Care** and deliver the IJB's vision for a long term programme of change, delivering a modern, resilient model with a multi-professional, integrated approach, underpinned by greater collaboration and delivery at locality level and underpinned by **technological solutions, predictive and anticipatory approaches and prevention.**

While doing all of this we will continue to build the IJB's confidence, capability and risk appetite to ensure good, robust governance, strategic direction, performance management and scrutiny.

Progress to Date

The IJB has been fully operational for 17 months and the Transformation and Change programme was agreed 16 months ago. We are effectively in year 2 of the investment programme set out in the 2016 paper and as anticipated, the first year of the programme focussed on developing the building blocks to deliver this scale of complex change.

Some areas have been slower to achieve than others. The governance and decision making within the context of the new IJB and in its relationships with partner organisations was new and inevitably officers were required to navigate 3 organisational processes across a number of areas:

- Standing orders and legal basis for decision making and entering into new contracts;
- Agreement, scrutiny, decision making and establishment of new posts on partner organisations' payroll;

- Decision making and governance of change plans, business cases and spending allocations for change projects required discussion at a series of IJB Committee meetings, consistent with the Board's intent around balancing good governance with officer delegations.

A clear demonstration of these challenges is the longer than expected timeline to recruit to the full complement of staff across the Executive Team, Strategy and Transformation Team and all four of the Heads of Localities.

It's important to reflect that this was all being done at a point in time when the capability and processes of a brand new organisation were also being built and that this was a singular and unique process. There may be reflection on this but as an IJB we will never undergo a similar phase of development and growth. We have learnt from these processes and we have in place clearer parameters within which to work with partner organisations in these areas and we keep in regular review our standing orders, commissioning approaches and the processes and authority for setting Directions for NHS Grampian and Aberdeen City Council.

A significant outcome of this is the impact on the budget and our need to re-profile the budgets targeted at transformation and change and manage this in a way the will derive the originally intended outcome while preserving the IJB's principle of spending its transformational funding impactfully and well. Within this there has been the opportunity to use unspent monies in-year opportunistically and also to support a prudent policy of developing a reserve, as allowed under the legislation, against unexpected pressures and enable the IJB to manage within its own budget, and not seek balances from its partner organisations.

This creates tension in the system at a time when there remain ongoing pressures to use any underspends to balance mainstream or traditional approaches and the IJB remains of the view that such reserves should be preserved against transformation and change and supporting the IJB shift the wider system toward change.

Performance Improvement

While some projects will deliver improvement in time, some of the work undertaken prior to and over the 'go live' is delivering measurable improvement for the IJB and the wider health and care system already:

- 22% reduction in DDs in year 1 and further reductions ongoing into the 2nd year of operation;
- Reduced emergency admissions;
- Reduced bed days lost to delays;

- Reducing emergency admissions;
- Improving staff engagement;
- Better management across winter pressures; and
- Decreased waits for homecare.

It is estimated that the work undertaken in relation to the improved position on Delayed Discharges has saved 3,210 bed days in the last financial year, which is equivalent to an 8 bed ward at an annual cost of £2.3m If we continue to shift the balance of care in this direction through delivery of our programme we will seek to realise this funding and the wider total set aside budget, in order to meet the identified funding gap, and sustain/invest further in community based models.

Financial Challenges and Benefits

Achieving transformation in culture, service delivery, changing the attitudes and expectations of a changing population and challenging the models of delivery in the NHS and Local Authority is difficult. Doing this against the context of reducing budgets makes it even more so. However that is the task given to IJBs and the wider Public Sector leadership in Aberdeen and the North East.

In parallel to this, there's no blueprint, or tested methodology for achieving this and, as recognised by the TLG, SIJB and IJB, our Transformation and Change Programme is about testing the capacity for these projects to save money and make the changes necessary.

Other challenges have been recognised in delivery of this programme of work across Scotland (v)

- Investment in community based services in the NHS has not increased at the same rate as investment in hospital-based services. Between 2010/11 and 2013/14, spending on community-based services increased by 4.9% in cash terms but reduced by 0.5% in real terms. In contrast, spending on hospital-based services increased by 8.4% in cash terms and 2.8% in real terms;
- Community-based services do not always save money but can increase costs. Similarly (and as we have found to be the case in Aberdeen City) new models of care which prevent admissions or reduce bed days lost to delayed discharges may relieve pressure in Acute Services however the savings are not realised or transferred;
- The impact of above may be dissipated across a range of wards and settings in the Acute Hospital and as a result no savings can be released. This is largely through an inability to disaggregate overhead costs from e.g. slight reductions in beds across a number of wards, reduction in use of theatres, portering, cleaning, heat and light costs; and

- Financial benefits may relate as much to absorbing increasing demand and cost pressures as realising cash.

The IJB has an agreed Reserves Policy[ix] . This was agreed on the basis of the IJB recognising the ability to carry forward funds and, as set out in the paper agreed on the 25th of October 2016:

'The ability to carry funds from one year to the next will help support the transformation agenda which the Health & Social Care Partnership is currently working towards. In particular there will be an underspend on the transformation funds which will require to be carried forward. The underspend of the transformation funds is not unexpected, as it takes time to develop the proposals and programmes to deliver the objectives of the funding.'

Transformation and Change Programme Update

An update on the Transformation and Change programme is provided in **Appendix 2**. This provides detail of activity progress under the 6 big ticket items agreed by the Board.

Conclusion

This paper has sought to provide useful context to the changes being put in place across Aberdeen's Health and Social Care Partnership and provide background in relation to the process for agreeing this ambitious programme. The IJB has demonstrated clear leadership, with its partners in Aberdeen City Council and NHS Grampian in its efforts to deliver the benefits of integration and will require to maintain a keen focus on balancing transformation and continuing to improve performance, with the financial challenges across our system, in the coming years.

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[i] *Public Bodies (Joint Working)(Scotland) Act 2014*, Scottish Parliament
[ii] *Health and Social Care Integration*, Audit Scotland, December 2015
[iii] Finance Committee. 2nd Report, 2013: *Demographic Change and an ageing population.* Scottish Parliament 2013
[iv] *Changing Models of Health and Social Care,* Audit Scotland, March 2016
[v] *Public Bodies (Joint Working)(Scotland) Bill, Financial Memorandum* 2013
[vi] *Aberdeen City Health and Social Care Strategic Plan 2016-2019*
[vii] *Strategic Commissioning and Transformation – Principles and Strategic Process*, IJB Paper, 29th April 2016
[viii] *Shifting the Balance of Care: Great Expectations* Nuffield Trust, March 2017
[ix] *Reserves Policy,* IJB Paper 25th October 2016

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Appendix 1

Estimated Funding Gap 2018-2021 (For illustrative purposes only)

Gap	Year 1	Year 2	Year 3	total
Estimated funding Gap:	**£12m**	**£12m**	**£12m**	**£36m**
Potentially funded by:				
Benefits Realisation– Transformation and Change\Absorbing growth	**£4m**	**£4m**	**£4m**	**£12m**
Potential Activity Shift	**£3m**	**£5m**	**£6m**	**£14m**
General Savings\Efficiencies	**£5m**	**£3m**	**£2m**	**£10m**
				£36m

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Appendix 2 – Transformation Plan Summary Update

The table set out over the following pages details the 6 Big Ticket priority items in the Transformation and Change Programme. It provides an update in activity being undertaken to deliver the priority, anticipated benefits and spend.

Each programme and project is supported by more detailed project management information and the following is provided as a narrative update only. Further updates and project overview is undertaken within the agreed programme governance.

Where there is a view that a programme may release cash, this is set out in **bold type** in the table.

Strategic Commission (big Ticket)	Project Activity	Project Summary	Anticipated Benefit(s)
Self-Management of Long Term Conditions and Building Community Capacity	Supporting adoption of Link Working Approach	Commissioning of Link Worker Role - Supporting practices to become Link Worker practices - Development of Link App - Rolling out Making Every Opportunity Count - Supporting Roll out of Silver City Approach **Update** Link Worker contract to be undertaken by SAMH and programme launched in the media on the 22nd of January	• Increasing capacity within primary care • Reducing pressure on GP/primary care workforce • Absorbing increasing demand • Diverting toward community based and 3rd sector resources • **Potential reduction in prescribing costs built into evaluation** • **May be in part offset by additional funding in Primary Care supporting the new GP contract**

Strategic Commission (big Ticket)	Project Activity	Project Summary	Anticipated Benefit(s)
	Connecting Communities	Supporting the development of connected communities through - enabling Social Transport - Supporting Befriending Service - Enabling self-managing groups	• Reducing demand on care services • Absorbing increasing demand • Building self-care and resilience • Promoting wellbeing
	Care Navigation	Creation of Care Navigator Role	• Improving experience of care • **Reducing duplication** • Promoting self-care and self-access
	Supporting Self-Management of Long Term Conditions	- Enabling faith based and dementia activities - Dementia Link Workers - Training for GPs in dementia - Developing Mental Health Strategy - Beating the Blues Online Support	• Absorbing increasing demand • Improving people and carer experience • **Early intervention and crisis reduction** (against increasing levels of dementia)
	House of Care	Modelling Care in new ways	• Absorb demand • Promote self-care • **Reduce duplication**
	Golden Games	A festival to raise the profile of active aging in Aberdeen.	• Promotes wellbeing and positive ageing

Strategic Commission (big Ticket)	Project Activity	Project Summary	Anticipated Benefit(s)
	Carers Support Service	A test of change to increase referral rate for carers to receive carer support.	• Absorb increasing demand and requirement under Carers' Act • **Reduce demand and crises** • **Early identification and reduction in formal service requirement**
	Locality Development	Supporting the development of Localities - Designing integrated community teams - Locality based Ward test of change (Woodend)	• Significant shift toward single Locality Teams • **Reduced duplication of effort** • **Shift in ways people access services** • **TEC** • Absorb/manage increasing demand
Modernising Primary and Community Care	GP Practice New Ways of Working	Range of activities including testing new models of primary care - New Dyce and New Northfield - new ways of working - Testing new models of Triage and access	• Reduce pressure on Primary Care • Absorb/Manage increasing demand • Manage challenge of workforce supply • **Reduce unplanned admissions to ARI** • **Realise Efficiencies in Acute Spend (Set Aside budget)** • **Reduce Delayed Discharge numbers and bed days lost (Set Aside)**
	Pharmacy and Prescribing	Additional pharmacy support to enable review of long term medication and address risks around prescribing budgets	• Mitigate anticipated increase in cost and volume of medicines • Reduced falls

Strategic Commission (big Ticket)	Project Activity	Project Summary	Anticipated Benefit(s)
		- Allocation of pharmacists in GP practices to address polypharmacy and medicines review	• Reduction in waste of medication • Patients stabilised on fewer medications will potentially require less contact with health professionals, freeing up capacity • Fewer unscheduled hospital admissions due to adverse drug reactions. • **Potential efficiencies through best practice with caveat on global cost increases**
	Buurtzorg/ INCA* (*Integrated Neighbourhood Care Aberdeen)	Person Centred, self-managing community nursing and care teams **Update** First teams are now in place and undergoing initial training and induction.	• **Reduce Duplication** • Absorb /manage increasing demand • **Reduce admissions (realise efficiencies from set aside)**
	Nursing Succession Planning	Addressing challenges in workforce planning for District Nurses.	• Improve workforce supply • Half the workforce over 50
	Community Falls Clinic and Pathway	Develop Falls pathway.	• **Reduce Admissions and realise efficiencies from set aside**

Strategic Commission (big Ticket)	Project Activity	Project Summary	Anticipated Benefit(s)
	Develop GP led beds test in a locality		• **Reduce Admissions and realise efficiencies from set aside**
	Advanced Nurse Practitioners	Support to further expand ANP workforce in Aberdeen City	• Workforce Supply • New Models of care • Relieving pressure on Primary Care • Improving unscheduled care pathway • **Reducing admissions and realising efficiencies from set aside**
	Community Mental Health Hub	Primary Care Clinical roles to work alongside existing Mental Health Workers to support community based mental health support	• Absorbing pressures • Improving response • Reducing 'revolving door' admissions • **Reducing prescribing costs**
	Community phlebotomy service	Implementation of a Citywide Phlebotomy Service in order to provide more efficiency within our nursing system.	• Managing workforce supply • Reducing demand on highly skilled professionals • Absorbing/managing increasing demand • **May be offset from additional primary care funding** • **Potential ability to reconfigure workforce**

Strategic Commission (big Ticket)	Project Activity	Project Summary	Anticipated Benefit(s)
	Clinical Guidance Intranet	Intranet to support clinical governance	• **Reduced admissions** •
	Transforming Urgent Care - early evening	Development of new models to transform urgent care: - early evening service - west visiting service	• **Relieving pressure in Primary Care** • **Reducing / diverting demand** • **Reducing admissions**
	Alcohol Hub	A test of change to improve the care and treatment for people with alcohol related problems with the aim of reducing the impact on Primary and Secondary Care.	• Reducing demand • Reducing harm and the burden of alcohol related disease
IT, Infrastructure & Data Sharing	Planning for capital development	Development of asset plan Henry Rae community Hub	• Range of prevention and LTC management, relieving pressure on primary care
	Kingsmead		• Increase care home capacity • Increased respite provision • Decrease reliance on primary care services
	Integrated Working	Fob Access - Smarter working and co-location - Joint equipment store - Integrated health and safety	• Development of a positive partnership culture • Streamlined access to equipment in order to support people at home

Strategic Commission (big Ticket)	Project Activity	Project Summary	Anticipated Benefit(s)
		- integrated accommodation for teams	• **Reduced duplication**
	ICT - systems and equipment	Integrated ICT Solutions - Office 365 - ICT hardware - Mobile access to systems - Website - Community Vision - Trackcare - Shared Desktop	• Reduced carbon footprint • Increased information sharing • Efficiencies in working
	Technology Enabled Care	Development of framework - Home and mobile health monitoring - telecare - wifi/ broadband - Surgery Pod test of change	• Supporting self-management of LTC / reducing reliance on primary care • Providing the right support in the most appropriate place
	DATA SHARING	Mapping of data and systems used - ISP for data sharing - Development of document register - Review of management systems	* Better safe sharing of information. * Ability to widely share ACP's * Effective and seamless 24 hour care and support

Strategic Commission (big Ticket)	Project Activity	Project Summary	Anticipated Benefit(s)
OD and Cultural Change	Wider Leadership Development Support	To ensure all new and existing managers acquire the necessary tools in order to do their jobs at each turn of their career path	• Ensuring an enabled workforce • Maximising workforce retention • Providing career pathways
	Ensure a fit and healthy workforce.	Review and put together sustainable plan for Healthy Working Lives activities	• Reduction in absence figures • Supporting appropriate continued recovery at work
	Implementation of "Ideas Hub"	Online innovation platform	• Maximises opportunity to identify and implement efficiencies • Maximises staff engagement and recognition
	Heart Awards	Programme and event to support and reward our staff and wider colleagues.	• Employee recognition and engagement • Increased motivation
	Conference	Annual Event to bring wider partnership together around our Transformation Programme	• Good two way communication • Increased visibility of ET • Reaffirming the partnerships vision and aspirations
	Develop plan of annual engagement activities		

Strategic Commission (big Ticket)	Project Activity	Project Summary	Anticipated Benefit(s)
	Board Development, systems and governance testing	Development of effective IJB and committee systems, processes and operating culture.	• Robust governance • Supporting the Board to understand the complexities of H&SC landscape • Supporting decision making
Strategic Commissioning	Implementation of commissioning strategy		• All partnership activity is aligned to strategic plan and commissioning strategy • Maximising better outcomes and individual experience • Improved health and wellbeing and reduced reliance on services
	Supporting Resources	Capacity to support progress of work stream	
Acute Care at Home	Acute Care @ Home	- Recruitment to Team Leader and Consultant posts near completion - Set up costs including supplies, services & accommodation	• **Reduced delayed discharges.** • **Reduced hospital admission** • **Reduced risk of acquired infection and other complications.** • Better quality of care for same or reduced cost to more traditional approaches. • Reduced length of hospital stay • Improved experiences and outcomes for people

Strategic Commission (big Ticket)	Project Activity	Project Summary	Anticipated Benefit(s)
			• Improved staff experience
Transformation – Supporting Infrastructure	Evaluation/ Benefits Realisation	Resource to develop and deliver evaluation framework	• Support effective roll out • Clear articulation of what is working and why • **Easier identification of financial efficiencies**
	Transformation Programme and Change Management	Capacity to support delivery of strategy, transformation, project management and business analysis.	• Underpins the ability to achieve efficiencies, absorption and adoption of new ways of working. • Allows the 'day job' to be undertaken whilst innovation and efficiency is identified, planned and undertaken
	Transformation Stakeholder Engagement	Capacity to support third and independent engagement and participation	• Developing lower cost models of community support • Stimulating a different shape market • Maximising partnership working
	Other	Capacity to support integration - including capital project management, organisational development facilitation, performance management,	

Strategic Commission (big Ticket)	Project Activity	Project Summary	Anticipated Benefit(s)
		communications, legal	

Aberdeen City Health & Social Care Partnership
A caring partnership

Integration Joint Board

Report Title	Transformation: Transformation Plan and Decisions Required
Lead Officer	Judith Proctor, Chief Officer Sally Shaw, Head of Strategy & Transformation
Report Author	Gail Woodcock, Lead Transformation Manager (ACHSCP)
Report Number	HSCP/17/115
Date of Report	22nd December 2017
Date of Meeting	30th January 2018

1: Purpose of the Report

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

The projects relate to strategic decisions, set out in the overall transformation programme that has previously been agreed in principle by the IJB as key areas of change for 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 in April 2016, 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;

- Strategic Commissioning and Development of Social Care; and
- 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 make 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.

2.2 Authority to progress with specific projects

This report seeks authorisation from the Integration Joint Board for approval to incur expenditure in respect of the following items which have been considered and recommended for approval in principle by the Executive Programme Board and discussed and developed through Working Groups where appropriate.

2.2.1 Extension to Contracts:

There are a number of contracts which sit within the Transformation and Change Programme which are historical activities that have been continued until such time as an agreed transformation plan is developed and agreed which will meet the business needs that these projects are currently supporting. These are:

- THInC Social Transport;
- Living Well Dementia Cafés;
- Dementia Post Diagnostic Support (Alzheimer's Scotland); and
- Befriending Service (Sheddocksley Baptist Church)

Due to the nature of these projects being extensions to previous contracts, which seek to ensure no detriment to existing service users during the review and establishment of new models (where appropriate), outline businesses cases rather than full businesses cases have been completed. This lighter touch approach has been put in place in order to free up capacity for developing and delivering more substantive transformation activity.

Integration Joint Board

2.2.2 THInC Social Transport

Social transport and accessibility is often cited as a key enabler or blocker for people being able to access the right services at the right time. Work is underway to develop a range of options for social transport, taking into consideration inter-relationships with our wider plans to transform existing service models into more local models embedded in communities.

THInC: Transport in the City operates in the city in order to assist older residents with mobility difficulties to access transport to attend health related appointments. Originally funded through the previous, national 'Rehaping Care for Older People' programme's Change Fund, the service operates during week days and is operated by Buchan Dial-a-Community Bus social enterprise.

In March 2017, the IJB agreed to provide funding for this service to continue to operate in Aberdeen City during 2017/18 while a review and full options appraisal for sustainable social transport was progressed. A consultancy was appointed by NESTRANS and the final report from this work is now complete. This report has highlighted that further work is required prior to coming up with a robust proposal for approval, and a rapid improvement event is planned for the beginning March 2018 to progress this. This additional work will also ensure coherence with the developing Carers Strategy.

Given the potential impact of ceasing this service in advance of a new sustainable solution being put in place, it is recommended that the current service be extended for a further financial year.

Further key milestones during 2018 to ensure that a robust proposal is developed and considered by IJB in early course include:

- **March 2018:** Rapid Improvement Event to focus on recommended improvements highlighted within consultant's report
- **May 2018:** Wider consultation on planned improvements to transport system supporting access to health and social care
- **August 2018:** Report to IJB
- **September:** Process testing of new model(s)
- **November 2018:** Review and/or further improvement of model(s)
- **January 2019:** Final model(s) operational

The Outline Business Case for this project extension is attached at Appendix A and the associated Direction at Appendix B.

2.2.3 Living Well Cafés/ Befriending Service/ Dementia Post Diagnostic Support

These services all contribute to keeping people well and/or better able to manage their long term conditions, including those with dementia and their carers:

- The **Living Well Café** in Bridge of Don, is run by Newhills Church and offers a friendly and hospitable space to support people with memory loss and their families and carers. A number of activities are provided including crafts, singing, light exercises and a space for reminiscing with opportunities to look over old photographs and chat about past events which is beneficial to people with memory loss.

- The **Befriending Service** run by Sheddocksley Baptist Church employs a parish nurse to augment the care provided by community and district nurses, including providing health and advice with personal health, life issues and befriending.

- **Dementia Post Diagnostic Support Service** (Dementia Link Workers) is provided by Alzheimer's Scotland and provides advice, information and support to people recently diagnosed with dementia and their families and carers, this was originally funded through the Change Fund. In March 2017, IJB approved funding for this service to continue in 17/18. It is planned that the establishment of Link Workers throughout the City in conjunction with community organisations and supports throughout the city (including the Living Well Cafes and Befriending Service mentioned in this report) will provide joined up post diagnostic support for people with dementia and their families/ carers in the longer term. It is therefore recommended that a further nine months of funding to this service be provided during the transition to these new arrangements.

A comprehensive review has been undertaken by an academic expert in this field (Professor Swinton) and this was considered at a recent event "Living and Aging Well in Aberdeen" in December 2017. Following on from this comprehensive review, work will now be focussed in on identifying sustainable models for supporting our citizens in an inclusive, participative Aberdeen community, including early support networks, more complex support needs and carers. This developmental work will be used to inform our strategic commissioning requirements into the future.

In the interim, it is important to ensure that those who require support continue to receive the support that is currently in place and to this end, this report

recommends that funding is provided to allow the above services to continue for a further 12 months, (9 months in the case of the Dementia Post Diagnostic Support Service).

Outline Business Cases and associated directions for each of the above four services are attached.

Appendices

A. Social Transport Outline Business Case
B. Direction to ACC: Social Transport

C. Living Well Cafes Outline Business Case
D. Direction to ACC: Living Well Cafes

E. Befriending Service Outline Business Case
F. Direction to ACC: Befriending Service

G. Post Diagnostic Support Outline Business Case
H. Direction to ACC: Post Diagnostic Support

3:	Equalities, Financial, Workforce and Other Implications

Financial Implications

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

Project	Total to 31/3/18	Year 1	Year 2	Total
THInC Social Transport	£79,426	£87,203	£0	£166,629
Living Well Dementia Café (Newhills)	£58,164	£30,000	£0	£88,164
Dementia Link Workers	£290,755	£78,000 (9 months)	£0	£368,755
Befriending Service (Sheddocksley Baptist Church)	£48,000	£16,000	£0	£64,000

Note –

- The above costs do not take into consideration anticipated savings/ efficiencies to business as usual budgets which may results.
- These costs are planned for in the current Integration and Transformation Programme financial plan, and are within the available budget.

Equalities Implications

The recommendations in this report are anticipated to have positive implications in relation to age characteristics as protected by the Equalities Act 2010, as the extensions to contracts will support services that positively contribute to older people receiving services and interacting with communities.

Workforce Implications

There are no implications for workforce employed by NHS Grampian or Aberdeen City Council. The recommended decisions in relation to continuing contracts for a further 9 and 12 months will have implications for staff employed by the organisations receiving funding.

4:	Management of Risk

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 projects included with this report, risks relate to implications for service users and their families if the services do not continue (for the service extensions), which could result in increased strain on the overall health and social care system. In respect of the preschool immunisation project risks around not proceeding relate to increased numbers of children and adults not having sufficient protection which could result in increased reportable infectious diseases.

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

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

This paper seeks approval to incur expenditure in order to continue a number of services which will provide the space and time to develop effective transformation plans while continuing to support those with long term conditions.

5:	Recommendations for Action

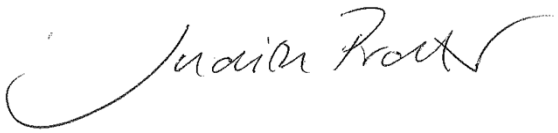
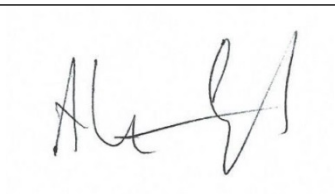
It is recommended that the Integration Joint Board:

1. Agree to incur the expenditure relating to extending the contractual/ grant arrangements in relation to the following projects:

    a. Thinc Social Transport
    b. Living Well Cafés
    c. Befriending Service (Sheddocksley Baptist Church)
    d. Dementa Post Diagnostic Support

2. Make the Directions relating to the above projects as specified in Appendices B, D, F & H and instruct the Chief Officer to issue the Directions to Aberdeen City Council, appending the relevant Business Case to each Direction.

Integration Joint Board

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

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:- 30 January 2018

Description of services/functions:- The award of contractual agreements required for the provision of funding for the delivery of Social Transport Extension project as described in the document: Social Transport Outline Business Case.

Reference to the integration scheme:- These projects will contribute to the evidence that the Partnership will be obliged to demonstrate how well the nine National Health and Wellbeing outcomes are being met (section 2). Annex 1, Part 2 identifies a range of services, some of which will be relevant to the THInC Extension project.

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.
- 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.

.....

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

Timescales involved:-

Start date: 01 April 2018

End date: 31 March 2019

Associated Budget:-

Details of funding source:- Access Fund, Integrated Care Fund

THInC Transport Extension - £87,203 (Buchan Dial-a-bus £62,920; Aberdeenshire Council £24,283)

Availability:- Confirmed

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

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:- 30 January 2018

Description of services/functions:- The award of contractual agreements required for the provision of funding for the delivery of The Living Well Café Extension Project as described in the document: Living Well Café Business Case.

Reference to the integration scheme:- This project will contribute to the evidence that the Partnership will be obliged to demonstrate how well the nine National Health and Wellbeing outcomes are being met (section 2). Annex 2, Part 2 identifies a range of services, some of which will be relevant to the Living Well Café Project.

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

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Timescales involved:-

Start date:- 1 April 2018

End date:- 31 March 2019

Associated Budget:-

Details of funding source:- Integrated Care Fund.

- A contribution of £30k This will provide a contribution to support the Newhills Church to covers the salaries of the three staff members (1 x 30 hours, 1 x 15 hours and 1 x 10 hours) plus half of the Project Administrator (1 x 7.5)

Availability:- Confirmed

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

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:- 30 January 2018

Description of services/functions:- The award of contractual agreements required for the provision of funding for the delivery of The Befriending Service extension project as described in the document: Sheddocksley Baptist Church Befriending Service (Parish Nursing) Business Case.

Reference to the integration scheme:- This project will contribute to the evidence that the Partnership will be obliged to demonstrate how well the nine National Health and Wellbeing outcomes are being met (section 2). Annex 2, Part 2 identifies a range of services, some of which will be relevant to the Befriending Service.

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

Timescales involved:-

Start date:- 1 April 2018

End date:- 31 March 2019

Associated Budget:-

Details of funding source:- Integrated Care Fund.

- £16,000 – Contribution towards delivery of Sheddocksley Baptist Church Befriending Project.

Availability:- Confirmed

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

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:- 30 January 2018

Description of services/functions:- The award of contractual agreements required for the provision of funding for the delivery of The Post Diagnostic Support service as described in business case: Alzheimer's Scotland Post Diagnostic Support Worker Service

Reference to the integration scheme:- This project will contribute to the evidence that the Partnership will be obliged to demonstrate how well the nine National Health and Wellbeing outcomes are being met (section 2). Annex 2, Part 2 identifies a range of services some of which will be relevant to the post diagnostic support worker service

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

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Timescales involved:-

Start date:- 1 April 2018

End date:- 31st December 2018 (Continuation of Post Diagnostic Support project).

Associated Budget:-

Details of funding source:- Integrated Care Fund.

- Continuation of Post Diagnostic Support Project for 9 months- £78,000

Availability:- Confirmed

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

Aberdeen City Health & Social Care Partnership
A caring partnership

Integration Joint Board

Report Title	Strategic Commissioning Implementation Plan
Lead Officer	Sally Shaw, Head of Strategy and Transformation
Report Author	Kevin Toshney, Planning and Development Manager
Report Number	HSCP.17.107
Date of Report	18th December 2017
Date of Meeting	30th January 2018

1: Purpose of the Report

1.1 Following on from the articulation of our strategic ambitions and priorities as set out in the Partnership's Strategic Plan[1], this paper outlines additional information in respect of our commissioning intentions and market facilitation activity which are set out in the attached Strategic Commissioning Implementation Plan.

1.2 A draft Strategic Commissioning Implementation Plan was presented to the IJB in August 2017 and approval was given for there to be a period of consultation on this document and the revised Plan to be presented to the IJB at its meeting on 12th December 2017. This revised Strategic Commissioning Implementation Plan can be found at Appendix A to this report.

1.3 The revised plan reflects contributions and comments received during the consultation.

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. Its policy ambition has been to:

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

Integration Joint Board

"…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 our Strategic Plan 2016-19 marking the full delegation of the agreed health and social care functions and services from Aberdeen City Council and NHS Grampian to the Integration Joint Board.

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 was also acknowledged that the purpose of the plan is to provide high level narrative of our vision and ambitions rather than specific detail about how those intentions will be delivered.

2.4 The need to provide that detail was recognised and additional work undertaken to deliver 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 these to the IJB in 2017/18.

2.5 With respect to our commissioning intentions work was facilitated to help identify our desired areas of focus. The criteria that we applied to this initial scoping exercise were:

- What was the sector's market resilience/fragility?
- What would the likely impact be from reshaping the sector?
- What were the opportunities to develop a more fully integrated service?

2.6 Work streams were set up around the identified areas with third and independent sector representation in these groups channelled through Aberdeen Council for Voluntary Organisations (ACVO) and Scottish Care respectively. Participants were asked to consider, 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?

The combined outputs from these work streams form the basis of our commissioning intentions outlined in the plan.

2.7 In addition to our proposed commissioning intentions, the plan also incorporates a Market Facilitation Statement suggesting how best to support the resilience, sustainability and quality of our commissioned provision across the city.

2.8 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 all been facilitating ongoing discussions with our partners in the third, independent and housing sectors with respect to many different developmental activities.

2.9 A market facilitation steering group involving colleagues from ACVO and Scottish Care was established to oversee the development of the key principles that underpin commissioner/provider relationships and activities that will support the reshaping of existing care models.

2.10 Consultation on the draft Plan was undertaken during the period 15th August-20th November 2017. The draft Plan was placed on the Partnership's website and circulated to our partner organisations Aberdeen City Council and NHS Grampian for them to promote through their respective communication channels.

2.11 '*Commissioning conversations'* were held with colleagues from across the health, social care, third, independent and housing sectors who either wanted clarification of particular elements of the draft Plan or to suggest possible amendments.

2.12 Both ACVO and Scottish Care facilitated workshops to enable members of the Care and Support Providers Aberdeen (CASPA) and both the Care at Home and Care Home forums to discuss our proposals.

2.13 In addition, ACVO and Scottish Care also provided specific feedback themselves.

2.14 The underpinning values and principles outlined in the Market Facilitation Statement were welcomed as being an explicit statement of how the Partnership should conduct its business. The need for sectors and services to be reshaped was broadly acknowledged but there was a sense that the Partnership needed to first address some basics in order for subsequent innovative activities to flourish. These basics included better communication, especially at times of transition or crisis and the timely agreement and payment of funding/invoices.

2.15 Given that the partnership places a strong emphasis on positive, collaborative relationships it was felt that outlining the different participation and engagement opportunities that are available to interested colleagues would be beneficial. Re-establishing the Market Facilitation Steering Group and continuing to have appropriate 'Strategy & Transformation' participation in the provider forums were seen as being good and desirable statements of intent.

2.16 It was felt that additional information in relation to the partnership's governance, how it procures services and how it manages contracts would provide a very useful baseline against which providers could compare their experiences.

2.17 The revised Plan is a more coherent document in terms of both language and content because of the feedback received during the consultation period.

2.18 It is envisaged that following IJB approval a number of project teams will be set up within the Strategic Commissioning Programme Board to develop more fully specifications and implementation timelines for our new models of care.

2.19 Responsibility for overseeing the implementation of this plan will sit with, in the first instance, the Head of Strategy and Transformation and the Strategic Commissioning Programme Board.

2.20 The appendices attached to this plan give some high level, baseline information in respect of current commissioned activity and associated financial expenditure.

2.21 Intensive work is currently being undertaken to identify the necessary metrics and timescale to enable robust evaluation of new activity in the Transformation Plan. We recognise that we need to develop very transparent means of showing how this activity is impacting and influencing current commissioning activity shown in Appendix 1 of the Strategic Commissioning Implementation Plan.

This will be necessary if we are going to be successful in delivering new and innovative new models of service which offer a greater person centred approach and improved outcomes alongside maximum efficiency and sustainability.

2.22 Regular updates of progress to date will be provided to the Chief Officer, the Executive Team Programme Board and the IJB as appropriate.

Appendices

A) Strategic Commissioning Implementation Plan:

1. Current commissioned/Procurement Activity
2. Current and planned transformation activity

3:	Equalities, Financial, Workforce and Other Implications

Financial Implications

Further discussions need to be undertaken in respect of these commissioning intentions to develop appropriate, costed option appraisals and business cases. It is not envisaged that there will be an increase in expenditure but that instead the ongoing transformation of our sectors and services will release funds for next phase implementation of our desired models of care.

Equalities Implications

This Plan does not discriminate against any equality or diversity group but instead

seeks to advance equality of opportunity between those who share a protected characteristic and those who do not.

It is suggested however that the evaluation of this intended programme of activity includes significant opportunities for those who use services to confirm that they are not experiencing unintended consequences and that there is a tangible improvement in their personal experiences and outcomes as expressed throughout the document.

Workforce Implications

Increased recruitment and retention levels and improved employee satisfaction across all sectors in the Partnership are integral to the success of our developmental activities. It is envisaged that our commissioning intentions together with our market facilitation activities will have a positive impact on our workforce and in turn deliver improved personal experiences and outcomes for the people who use our services.

4:	Management of Risk

Identified risk(s):

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 development potential and then seeking to actively co-produce desirable solutions will contribute to the mitigation of the identified risks.

Integration Joint Board

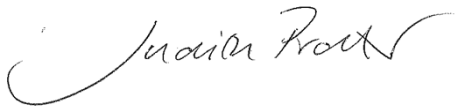
5:	Recommendations for Action

It is recommended that the Integration Joint Board:

1. Approve the revised Strategic Commissioning Implementation Plan;

2. Instruct the Chief Officer to put in place the required structures and resources to implement this plan; and

3. Request an annual update on the implementation of the Strategic Commissioning Implementation Plan to both the IJB and the Audit & Performance Systems Committee.

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

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Aberdeen Health & Social Care Partnership

Strategic Commissioning Implementation Plan 2018-2022

ABERDEEN CITY COUNCIL

NHS Grampian

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Foreword

I am delighted to welcome the publication of this Strategic Commissioning Implementation Plan which sets out our commissioning priorities for the next few years. The plan also maps out, in the Market Facilitation Statement, how we intend to support our valued partners in the third and independent sectors to realise our ambitions together.

This plan supplements the partnership's Strategic Plan 2016-19 and is aligned to the Transformation Plan, both being central to our ongoing commitment to reshape significant areas of service delivery and introduce new, enhanced models of care.

The document is wholly consistent with our strategic ambitions and priorities and is integral to our aspiration to be a high-performing partnership that delivers improved experiences and outcomes for the people who use our services and their carers.

The plan should also be seen in its wider context – as one of a suite of strategic documents that we are producing to show how we will deliver good quality, person-centred services across all our areas of work. The others include a Carers Strategy, a Learning Disability Strategy, a Mental Health Strategy and our four Locality Plans. We are ensuring that there is a strong strategic coherence between all of these documents and we will co-ordinate their implementation smoothly.

The third and independent sectors are integral to our ambition to provide integrated services to the people who need them. I look forward to continuing to develop positive relationships with our many partner organisations as we seek to address common challenges and develop truly transformative supports and services that will be of value to the people who use them and their carers.

Judith Proctor

Chief Officer

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If you require further information about any aspect of this Plan please contact:

ACHSCPEnquiries@aberdeencity.gov.uk

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Community Health and Care Village
50 Frederick Street
Aberdeen
AB24 5HY

Website: https://aberdeencityhscp.scot

Twitter: https://twitter.com/HSCAberdeen

1.0 Executive Summary.

This Strategic Commissioning Implementation Plan reflects the many conversations we have had with valued partners and stakeholders over the past year or so about the partnership's commissioning intentions and market development activities.

Our Strategic Plan 2016-19 was published on 1st April 2016 ('Go Live' day) with the delegation of health and care functions and services to our Integration Joint Board. The ambitions that we set out to improve the health and wellbeing of the population of Aberdeen and reduce the health inequalities that we know impact poorly on people's lives were broadly well received. There has since been a continued interest in our chosen areas of focus and what we propose to do differently to deliver improved experiences and outcomes for the people who use our services.

This Strategic Commissioning Implementation Plan provides the required clarification and detail about the ongoing transformation of our health and care services and the continuing support and development of our market provision.

We recognise the value of developing effective and sustainable models of care but we also accept that most people remain healthy and active into old age without the need for services. Although health problems generally increase with age, ill health and disability should not be inevitable as we grow older. A strong aspiration of the partnership is for our personalised approach to be evident in all our activities and for individuals and their carers to truly believe that they have choice and control, as far as is reasonably practicable, over the care and treatment that is offered to them.

We are seeking a significant shift in how we commission services. We want to promote health and wellbeing and strengthen early intervention and prevention. We also want to make sure that people have access to the right treatment, care and support services when they need them, in ways which are effective, personalised and empowering. We need to enable people to be more in control of their health and wellbeing and managing any health problems they may have.

This Plan has a strong evidence base. It is important that we are able to show the difference that these intentions will make to people's lives. We accept that we will be judged on the difference that we make to the health and wellbeing of the people of Aberdeen and the effectiveness of the services that we have put in place.

The depth and resilience of the relationships that we have with our commissioned providers is important to us. Market fragility can cause uncertainty and unexpected change to the detriment of the people who are using services and those staff members who are providing them.

We strongly believe that a well-resourced and well supported market will be better placed to make a significant contribution towards the development of enhanced models of care and a more stable health and care environment.

These ambitions and activities will not be without their challenges. In the next few years it is likely that health and social care budgets will reduce in real terms while the demand for services will increase. We will need to be realistic and responsible in how we manage our resources to deliver the desired outcomes for those who use our services and their carers.

The integration of health and social care services has offered us many opportunities to reflect on what we currently do and to agree about what we could and should be doing to benefit the local population. We are very clear about the pivotal role that our communities and localities can play in shaping the health and care services of the future.

We are committed to improving the health and wellbeing of the local population, delivering quality services and becoming one of the highest performing partnerships in Scotland. This Strategic Commissioning Implementation Plan is an integral driver towards the fulfilment of these ambitions.

2.0 Introduction.

Following on from the publication of the Partnership's Strategic Plan[1], this Strategic Commissioning Implementation Plan seeks to outline our commissioning intentions over the next four to five years to help reshape our services in the face of anticipated demographic, financial and workforce challenges.

Our proposals have focussed on particular service areas which the partnership feels are ripe for change and development or have the potential for significant, positive impact on improving outcomes for the individuals who use our services and their families.

These areas include:

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

We recognise that our intentions will be of interest to many stakeholders including those from the independent, third and housing sectors that we presently commission particular services from or those who we may do so in the future.

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

With this in mind, a Market Facilitation Statement is incorporated into this plan. This offers additional information that will hopefully be of value by helping to enhance awareness and understanding of our local health and social care marketplace. We hope to sustain relationships and align our respective organisational aims and ambitions going forward.

2.1 Vision, values and priorities

Given the diversity and complexity of the partnership's delegated functions and the interdependency with its partner organisations (ACC and NHSG), it is crucial that all our developments and activities are strategically coherent and co-ordinated and that there is a strong, clear alignment with our vision, values and priorities.

Our Strategic Plan outlined our vision as a partnership and our defining purpose by stating explicitly that we are:

"A caring partnership working together with our city communities, to enable people to achieve fulfilling, healthier lives and wellbeing".

Our values are the pillars that shape our identity and help explain why we do the things we do; they underpin all our intentions and should be evident in all our activities. They are:

- caring
- person-centred
- enabling

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.

Our vision, values and priorities will be expressed in each and every one of our strategic policies or plans and we will seek to evidence these in all of our current activities and future developments.

2.2 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:

"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 will work towards embedding 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

We are very aware that an individual's needs may and will vary over the course of time and so we will not adopt a uniform, one-size-fits-all commissioning approach but instead strive to be sensitive to age, wellbeing and complexity of need.

2.3 Strategic coherence.

There is currently an ambitious and wide-ranging legislation and policy agenda for the provision of health and social care that varies from the choice and control we can

[2]Scottish Government, Health and Social Care Integration: Strategic Commissioning Plans Guidance 2015

[3] Strategic Commissioning Steering Group, Joint Strategic Commissioning: a definition, 2012

exercise at an individual level[4] through a broader population health and inequality perspective to the development and implementation of stronger collaborative approaches to strategic commissioning and service delivery.

A key emphasis of our reform and transformation is the anticipated positive impact on individual experiences and outcomes. Through an appropriate and consistent focus on prevention and early intervention alongside an integral enablement approach, we will seek to support individuals to self-manage their health and wellbeing and independence as much as is possible.

Supporting our unpaid carers is a key thread that runs through all of our developmental and operational activities. We will publish our Carers Strategy early spring 2018 showing how we will fulfil the requirements of the Carers (Scotland) Act 2016[5] (Adult Carers Support Plans/Young Carers Statements, Information and Advice services, Short Breaks statement) and our wider ambitions to support carers to have a meaningful life alongside that caring role if they so choose.

It is difficult to say with certainty how many unpaid carers there are but they are an integral element of our wider workforce which works across the health, social care, third, independent and housing sectors. It is our intention to support and develop a skilled and valued workforce that makes a significant contribution to the wellbeing of others so that individuals are able to live longer, healthier lives at home, or in a homely setting.

Delivering a seamless experience to those who use our health and care services will require us to be as strategically coherent and co-ordinated in practice as possible. This will require the involvement of many different partner organisations and stakeholders as we wish to say with confidence that we have co-designed and co-produced the solutions to the challenges that we face now and that we will face in the future.

2.4 Our localities.

In line with the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014[6] we have identified four localities (North, South, West, Central), roughly aligned with the existing four GP cluster areas.

We have said from the outset that the purpose of creating localities is not to draw lines on a map and run the risk of creating a postcode lottery in respect of service delivery but instead to provide an organisational mechanism for local leadership of service planning, to be fed upwards into our strategic commissioning intentions and activities.

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[4] Social Care (Self-Directed Support)(Scotland) Act 2013

[5] http://www.legislation.gov.uk/asp/2016/9/contents/enacted

[6] http://www.legislation.gov.uk/asp/2014/9/contents/enacted

The respective Locality Leadership Groups are all up and running and have a pivotal role in bringing together individuals and organisations to discuss the needs of the local population(s) and how these might be best served.

The Locality Plans will reflect the overarching ambition and direction previously detailed in the Strategic Plan and in addition show where they hope to develop other activities and supports that will minimise the isolation and loneliness experienced by a great many individuals, strengthen community bonds and improve the health and wellbeing of the local population.

All of our Locality Managers are now in post and we are progressing with our plans to develop locality based multi-disciplinary teams that will engage with the third and independent sectors to support vibrant community activities and seamless person-centred care across our areas of work.

2.6 Quality

The quality of the services that we commission and what this means for the personal experiences and outcomes of the individuals who use our services and their carers is very important to us.

It is important for the partnership to know and understand how well it is doing in relation to the nine national health and wellbeing outcomes but it is also crucial that we know and understand what positive difference we are making to people's health and wellbeing and their experiences of the services that we provide.

Our ambition is to be recognised as a high performing partnership and for that to happen, all our services across the health, social care, third and independent sectors must aspire to deliver effective, good quality services themselves.

Our own improvement activities and quality assurance processes as well as positive, supportive relationships with the Care Inspectorate, Health Improvement Scotland and other regulatory bodies will all help us to deliver safe, responsive and effective activities and services.

3.0 Our commissioning intentions.

3.1 Key intentions.

Consistent with our understanding and analysis of the existing provision and the outcomes we wish to achieve, we intend to shift the balance of care to enhanced, community based models. This will require us to reshape our overall provision across many different areas but our initial areas of focus will be as outlined in figure 3.1 below.

In doing this we continue with our ambition to encourage individuals to take increased control over their support by considering and using the options of Self-Directed Support. Reshaping our overall provision increases real opportunity for individuals to have an increased suite of options of which they can purchase or direct.

Table 3.1 Commissioning Intentions

3.2 Care at Home – support provided in a person's own home and may include personal care.
3.3 Re-ablement model – this is a model that aims to increase confidence and ability of the individual to be able to undertake task independently again.
3.4 Residential care for older people and people with physical disabilities. • Standard care home provision for older adults and others with a range of conditions that are appropriately met within that form of setting. • Advanced Dementia Care in a Care Home Setting. • Care Home services for individuals with very complex physical presentations • Brain Injury Care Home Provision. • Palliative and End of life Care
3.5 Residential care for people with a learning disability • Standard Care Home provision for Learning Disability clients (under 65) • Learning Disability Specific Nursing Care Home Provision • "Core and Cluster" 24/7 staffed service for individuals with particularly challenging behaviour. • Intensive short-medium term residential provision.
3.6 Residential care for people with mental health needs • Standard Care Home provision for Mental Health clients (under 65) • Rehabilitation Residential Service • Longer Stay Mental Health Residential Home provision • Short Stay/Break Residential Service
3.7 Intermediate care • Locality based Intermediate Care • Centralised Comprehensive Intermediate Care – Care Home Model: • Centralised comprehensive intermediate care for both 'step up' and 'step down' – via a ''housing' type model:
3.8 Out of Hours & Responder Capability
3.9 Joint Equipment Service.

As we develop these services we will be mindful of people's likely experience of using them and how these relate to other health and care services that might require to be accessed.

Developing effective services and supports that will promote improved health and wellbeing and provide flexible and responsive care through periods of transition or times of crisis will be of significant value in preventing unscheduled admission to hospital and minimising discharge delays.

This will require a change in the way resources are deployed and in what services are developed and commissioned.

3.2 Care at home

Good and effective care at home helps people with eligible care needs to live in their own home when they might otherwise likely require residential care. It should support people with care needs to live independently in the community and to maintain greater independence for longer.

It also acts as a key support, in conjunction with other health and care services in supporting people where there needs change and in recognising when more intensive support or other forms of care might be appropriate. A key ambition is that we are able, in Aberdeen, to have care at home services as part of the wider team approach we are developing and be able to adapt it to people's changing needs. In doing so, we will have a positive impact on preventing unnecessary admissions to hospital and helping people home earlier after a period of hospital treatment.

An interim procurement of care at home services for older people and adults with physical disabilities and/or learning disabilities will be completed before the end of 2017/18 This will address some operating challenges experienced by providers pending a more thorough reshaping of our provision.

3.2.1 What will we commission?

We are going to develop a locality based, outcomes focused care at home model that will be more responsive to the needs and circumstances of the individuals who receive this service and provide positive opportunities for providers who will have greater flexibility to decide how best to meet needs and fulfil outcomes.

Our care at home framework will continue to be city wide to ensure that there is equitable access and consistency of quality however within that we will be looking at ways in which we can be pragmatic and flexible about our delivery of service across the different localities. We will need a range of providers, some of them specialist to work across different client groups and complexity of need.

We will encourage 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. This approach will move away from "time and task" to a less prescriptive way of working that offers individuals greater choice in the way in which their allocated hours of care are used.

This approach will benefit from our INCA ("Buurtzorg") learning of how self-organising, integrated health and care teams can best provide seamless care by adopting a 'what needs to be done' approach rather than constant referral on or signposting elsewhere.

We also recognise the value of trusting our providers and offering them greater choice and control over the way that care is administered and delivered so that the fundamental agreement is between them and the individuals who are receiving the service. We envisage that this approach will result in packages of care that can flex easily to accommodate variations in demand and/or emergencies.

We will also examine our funding models to determine how we can best support the sustainability of our care at home provision and at the same time incentivise providers to be more responsive to our unmet need challenges and complex referrals.

We wish to develop 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 sector, faith organisations and ourselves as caring and compassionate citizens and neighbours to counter the detrimental effects of isolation and loneliness.

We will develop our care at home model in the two year time period 2018-2020 in time for the next procurement of this provision.

3.3 Reablement Model

Allied to our emerging care at home approach will be the development of a Reablement service to support individuals to learn or relearn skills necessary for daily living.

Reablement encourages individuals to develop the confidence and skills to carry out daily living activities such as personal care, and other practical tasks themselves so that they can continue to live at home. It tends to be provided to those individuals who have just been discharged from hospital or who are experiencing a change in their circumstances and needs.

'Reablement' is 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.

3.3.1 What will we commission?

Our intention is to develop a time limited reablement programme (up to six weeks) that would essentially form an integral element of the care at home pathway with a view to enabling more people to remain safely at home.

The aims of this would be to assess an individual's functional ability within their own home or a homely setting. The programme will work with the individual and their

carers, and other staff where appropriate to maximise their independence with activities of daily living, and determining any on-going care at home requirements.

Other elements will include:

- Single access and referral point.
- Aligned staff comprising care management/coordinators, occupational therapists and support 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 connections – facilitating links to community/ third sector and other informal supports to counter isolation and loneliness.
- 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.

It is anticipated that having participated in the support that this service offers, two exit options will be available for individuals.

1 Where there are no on-going social care needs and the individual returns to pre-enablement level of functioning, signposting to informal community supports will be offered to maintain that functional status.

2 Alternatively, where there is a continued need for care at home support, the appropriate levels will be determined and arrangements put in place with the care provider. Integral to this process will be a smooth handover/ transition from the reablement service to the provider(s).

For both exit routes, communication with appropriate colleagues from primary and community care services will be a routine part of the discharge process.

The developmental timeline for this programme will mirror that of the care at home model above, 2018-2020.

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

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 suggested a growing older population coupled at the same time 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, our Older Adult and Physical Disability residential services will focus on supporting those individuals with a greater complexity of need and will continue to be a significant element of our wider service provision.

3.4.1 What will we commission?

Given that the partnership has set a clear strategic direction in 'shifting the balance of care' there is no envisaged increase in the overall volumes of standard care home places procured over the next four year period.

The partnership will instead, manage demand within the existing volume of beds, with a greater diversion of individuals to other available options such as reablement, care at home, intermediate care and the Acute Care at Home Service which will be available in the earlier part of 2018 .

In supporting our current provision, we are mindful of business sensitivity around occupancy rates but conscious that we need a level of capacity within the care home system to support client/patient 'flow' and appropriate management of any business continuity risks.

The continued development of our 'bed based' resource will include the following:

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

We will continue to require relatively large volumes of standard care home places which are equipped to manage the increasing complexity of needs/demands relating to older adult care and younger adults with physical disabilities.

The development of our locality model will offer our providers opportunities to link into a wider range of local resources and activities that may benefit the individuals that they care for. We are also keen to explore different intergenerational models and activities that may be appropriately and safely introduced.

We are open to discussions about the current residential care/nursing care distinction and its continuing relevance given the increasing complexity of individuals who are being cared for in all of these establishments. It may be that one categorisation with the consistent use of dependency tools to determine safe staffing levels is an option worth pursuing given the broad similarities that currently exist. We recognise that further discussions in respect of this development would involve our regulatory partners from the Care Inspectorate and the SSSC.

We have yet to determine what percentage of this standard provision should, if any, be block booked/funded. We are mindful that perhaps a better balance needs to be struck between the flexibility that comes with spot purchasing beds and the continuity and stability that block funding arrangements offers our providers. Whatever the

basis of the contracting, it will be done around a specification that is outcome based and consistent with the principles of personalisation.

B) Advanced Dementia Care in a Care Home Setting:

We envisage needing 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.

The increase in dementia prevalence (number of people, aged 65+ with dementia is projected to increase by 13% by 2022)[7] over the coming years leads us to believe that we will need to at least match our existing Elderly Mentally Infirm (EMI) bed base with the new type of service.

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

A key commissioning intention over the next five years will also be to trial different models of dementia care from the current 'care home' structures /staffing /delivery. This will be an opportunity for the partnership to look at national and international developments such as Hogeway Dementia Village[8] and Butterfly[9] models with a view to appraising their suitability for our purposes.

C) Care Home services for individuals with very complex physical presentations

We would wish to develop 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.

We would envisage funding of such residential services to be a mix between both block funding of some resource and 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.

It is hoped that the combination of placing 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.

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

[8] https://hogeweyk.dementiavillage.com/en/

[9] http://www.dementiacarematters.com/carehomedevelopment.html

D) Acquired Brain Injury Care Home Provision.

We envisage a small volume of care home beds to support individuals with brain injuries and other neurological conditions particularly those for whom more general services have already proven unable to meet their needs.

We are aware of the extent of current out of area placements for those with specialised brain injury residential provision and known unmet need within the City. 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. We envisage that there will be still be sufficient numbers remaining for us to develop our provision further.

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 recognise that individuals with an acquired brain Injury have differing complexities and needs from those with alcohol related brain damage and would therefore wish to develop a more detailed options appraisal in regards to the configuration of any new service(s).

E) Palliative and End of Life Care.

Commissioning appropriate care and support arrangements for individuals with palliative and end of life care needs are in order to response to changes in their wellbeing or circumstances, typically at times of crisis.

It can be the case that in the absence of other available options, individuals are admitted to hospital at the end of their life, although this may not be their or their carers chosen place to die.

We will give further thought to the development of a suite of palliative and end of life options that have appropriate levels of trained staff and other resources to continue to be able to provide person centred care and support at this critical time. We will explore the possibility of these arrangements being available across each of our localities.

The complexities of all of these different establishment based models are such that we envisage the life span of this Implementation plan 2018-2022 being needed to support our providers and reshape our provision to support our aspirations set out on our Strategic and Transformation Plans.

3.4 Residential care for people with a learning disability (LD)

The current discussion about the provision and purpose of residential services for individuals with learning disabilities must be seen within the wider context of national legislation and policy.

The Mental Health (Care and Treatment) (Scotland) Act 2003[10] puts a legal duty on local authorities to ensure provision of appropriate care and support services. The Keys to Life (2013)[11] is the current 10 year National Learning Disability Strategy which states that residential models of care should be viewed as a relatively small but very important element of overall provision primarily for the most complex individuals with the greatest need within a wider portfolio of supports and services.

Locally, there has already been a significant drive to rebalance our LD provision by shifting resources away from a predominance of residential care settings to supported living arrangements where individuals receive housing support or care at home services. This was part of wider efforts to support individuals who have a LD to have greater opportunity to become more active and be seen as valued members within their communities across the city.

The partnership is currently in the early stages of developing a Learning Disability Strategy. This will be published in 2018/19 and its particular ambitions, priorities and developmental activities will dovetail with the commissioning principles and intentions set out in this plan.

3.4.1 What will we commission?

The projected demographics for LD individuals suggest a future need for residential accommodation for those individuals that have significant needs, both in regards to their LD and other aspects of their of support, e.g. health, physical disability, communication and behaviour.

The residential models described in this section forms part of a much wider continuum of health and social care services that are intrinsically interrelated. We wish to develop our LD provision along the lines of the 'right support in the right place at the right time' that is, as their needs change, individuals can access different models of care in different services.

A) Care Home provision for Learning Disability clients (under 65)

Some adults with a Learning Disability will have care and support needs that relate to their physical health or increasing frailty/dementia with age. These individuals benefit not from specialist LD specific services but from the expertise and care in standard care home or EMI provision.

[10] http://www.legislation.gov.uk/asp/2003/13/contents
[11] http://www.gov.scot/resource/0042/00424389.pdf

The intention will be to negotiate on a partnership wide basis with our residential and nursing care home providers to ensure that they are able to register with the regulator to deliver services to such individuals. We recognise that this may necessitate support from the partnership to engage with the regulator as a Body Corporate. Thereafter, these beds would be accessed from within the general care home estate governed by the National Care Home Contract. Beds would likely be purchased on a spot purchase basis.

B) Learning Disability Specific Nursing Care Home Provision

There is a need for a small volume of Nursing Care Home provision that focuses specifically on, and is configured for, the specialist needs of individuals with LD who also have other health/disability presentations.

This service is not restricted to any one age group as it is the complexity of need and disability which is the defining referral criteria for this model of care.

We would like to explore different staffing models for these services. Staffing levels could, for example, be nurse led with a mixed nursing/social care staff team depending on the needs and dependencies of the individuals receiving the care and support.

It is envisaged that this model would be specifically commissioned in small units (4-6 individuals) from the third and independent sectors with funding likely to be on a block contract basis.

Further discussions with other stakeholders in respect of possible accommodation options for this model of care will be necessary in advance of any other dialogue and development.

C) "Core and Cluster" 24/7 staffed service for individuals whose behaviour can challenge services.

This service will deliver care and support to people with complex care and behavioural management needs over a close geographical area, with some individuals residing in the 'core' resource and others in the surrounding area.

This model of care is not new but we envisage further developments along these lines given the advantages of single occupancy, available peer support and accessible staff support offered in a community setting.

Services would need to be small in design to support individually delivered care and support, and yet support enough individuals within the wider service to give a staff team of sufficient size to deliver the required flexibility and continuity of support.

The availability of suitable accommodation in suitable areas is a significant consideration for the size and location of these services and their developmental timeline(s).

We would envisage that we would work with our third and independent sector partners to stimulate such services.

D) Intensive short-medium term residential provision.

This model of care will provide intermediate support to those individuals with the most complex and highest level needs/behaviours who are either in a crisis situation or transition.

More specifically, we envisage that such a resource will be helpful to those individuals who are experiencing deterioration in their health, wellbeing and behaviours and whose current support(s) are unable at this time to continue to meet their needs. It may also include those individuals who have recently been in hospital and this service is part of their 'step down' to other accommodation and support models.

The inherent advantages offered by such a service are primarily because it offers intensive support for a time limited period, the exact length of which will vary for different individuals. It is not a long stay solution to accommodation or provider issues.

We envisage that this service will be relatively small but with a high staff/individual ratio. Its specialised nature would necessitate that it be delivered by providers with long standing experience, knowledge, and proven capability in supporting individuals through such periods of heighten need. In addition, sourcing safe and appropriate accommodation will be a key factor in the development and implementation of this model of care.

We envisage that these service models that will support individuals with a LD will require the time period 2018-2022 to be fully developed and implemented.

3.5 Residential care for people with mental health needs

The current thinking 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[12] 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.

[12] http://www.legislation.gov.uk/asp/2003/13/contents

The new national strategy for mental health (Mental Health in Scotland - a 10 year vision) was published in 2017 and has a focus on early intervention, self-management and improving both access and efficiency of mental health services. There is also a local Strategy (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 individuals who experience mental illness.

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 who experience mental illness to have greater opportunity to become 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.

3.5.1 What will we commission?

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

It is important that these services are easily accessible and responsive to individual needs and that they genuinely deliver person centred and recovery focused provision to maximise improved outcomes.

A) Standard Care Home provision for Individuals with Mental Health needs (under 65 years)

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 deliver services to these individuals assessed as needing this type of support.

B) Rehabilitation Residential Service

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

It is envisaged that this service would primarily be met through procuring the services of specialist providers within the third and independent sectors. It is likely that this service would be 'block funded' to support market stability and allow greater control in regards to placement flow.

C) Longer Stay Mental Health Residential Home provision

Longer Stay Mental Health Residential Home provision which primarily focuses on meeting ongoing complex mental health needs with the intention that a proportion of individuals 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 third and independent sectors with block funding arrangements.

D) Short Stay/Break Residential Service

This service will offer Short Stay/Break residential type care support for individuals who are either in crisis or requiring planned support at a residential level for a relatively brief period.

It is likely that such a service would be block funded to ensure the sustainability of the provision and the availability of this resource as and when it is required by individuals.

These models of care will be developed and implemented in a similar timescale to those of the other client group residential models, 2018-2022.

3.6 Intermediate care

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

The primary client group to whom the partnership will be directing its bed based intermediate care resources will be older adults, although we envisage that younger adults with complex physical and neurological conditions would also benefit from the development of such models and services.

If the partnership wishes to achieve a reduction in hospital admissions and 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.

3.6.1 What will we commission?

"Maximising Recovery, Promoting Independence: An Intermediate Care Framework for Scotland"[13] identifies 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.

Similarly, there may also be some potential for block funding/booking a small cohort of standard care home beds to expedite discharge from hospital following on from the initial success of our interim beds however this taken forward as part of our will be evaluated in conjunction with developments in the partnership's intermediate care bed base.

A) Locality Based Intermediate Care:

It is envisaged that this service would primarily be met through linking in with the local third 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 individuals assessed as requiring this type of support. It is likely that this would be under the auspices of the National Care Home Contract as the needs of those individuals needing this support 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.

B) 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 partnership directly, or a third/independent sector provider – however any potential provider would have to evidence significant robustness of service delivery given the critical nature of this model to partnership priorities.

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

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

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 partnership directly, or a third/independent sector provider – however any potential 'non-statutory' provider would have to evidence significant robustness of service delivery given the critical nature of this model to partnership priorities.

This provision will be developed over the two year period 2018-2020.

3.7 Out of Hours & Responder Capability

The purpose of out of hours (OoH) and community response services is to provide both scheduled and unscheduled 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 and support during unsocial hours and through the night. This involves caring for individuals who may be seriously unwell, often working in isolation from colleagues.

Some of the matters that OoH services can typically be required to respond to include:

- Medication management; 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; individuals present with a requirement for equipment due to a deterioration of their health and wellbeing or with equipment that is not functioning properly thereby posing potential risk to the individual and others.
- Acute ill health; individuals present with acute episodes of ill health or significant exacerbations of existing conditions either of which may be predictable or unpredictable.
- Palliative care; an exacerbation of condition(s) resulting in a deterioration in health and wellbeing or responding to the needs of carers and other family members who may feel unable or unsupported to deal with the developing circumstances.
- The frail elderly; may require support due to falls, confusion, deterioration of co morbidities, or UTI's.
- Mental health; interventions may be required to deal with distressed individuals who are needing additional supports until such time as other scheduled services are available for them to access.

Given the range and complexity of existing Out of Hours services it can be difficult for individuals, their carers and some staff from the many different organisations who are working in the evenings, nights and weekends to know what service best meets their immediate needs and how to access it.

Our ambition to deliver improved experiences and outcomes should apply across all of our scheduled and unscheduled activities and interventions. Providing an effective out of hours service that co-ordinates our responses to different individuals in different circumstances and communicates with other professionals, services and agencies as appropriate will be hugely valued by those individuals and their carers.

This will sit alongside planning already underway in relation to Acute Care at Home and End of Life Care.

3.7.1 What will we commission?

The Scottish Government's Review of Primary Care Out of Hours Services[14] recommends that partnerships should look for opportunities for integrated OoH service provision with clearly understood and delivered care pathways.

We recognise that there is a need to have a more integrated blended approach where services can work together to maintain the individual, where possible, in their own home or homely environment until other services can assist the next day.

We will seek to develop 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.

We will co-ordinate our responses to reduce the number of services who become involved by "default" so that our interventions are always by the appropriate professionals and agencies that can be of greatest value to the individuals who need our support.

We will develop a multi-disciplinary resource that has the capacity to respond to different situations some of which will be resolved shortly after intervening and some which will have a longer, more involved duration.

Development of this service will be undertaken during the period 2018-2021.

3.8 Joint Equipment Service.

The provision of required aids, adaptations and other OT equipment is currently managed and distributed separately by two different organisations depending on whether there is an assessed social care or health need for the equipment or aids.

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

These resources have developed separately from different origins and have different process strengths in terms of ease of ordering, timely delivery, stock control and equipment recall.

Increasingly, individuals with a complexity of needs require a combination of equipment and it is perhaps not as straightforward as it might be for them, their carers and other colleagues to navigate their way around the current service delivery models. This can lead to a less than seamless experience of health and social care services working together.

3.8.1 What will we commission?

The partnership intends to develop a single, integrated equipment service maximising available technology to enable individuals to live and function as independently as possible in their home or homely environment.

It is envisaged that this would be a 7 day, timely and responsive service from prescription through to delivery and installation with the anticipated benefit of releasing time and resource to care.

Some of the other expected benefits from developing such a service include;

- Unified stock – resulting in savings around procurement
- Improved procurement across all areas allowing improved value and standardisation of equipment.
- Reduced waiting times – better outcomes for individuals
- One unified IT system – resulting in a high standard of stock control.
- Direct access to equipment from a wider group of community based assessing staff
- Clear accountability for the repair, servicing and maintenance of all equipment.

We are open to the possibility that this service serves not just the city, but is developed on a pan Grampian basis to ensure a consistency of response and provision across the regions geography and population.

Development of this new service would be undertaken in 2018-2020.

4.0 Our Transformation Plan.

Whilst the Strategic Plan sets direction the Transformation and Change Plan describes the activities we will engage in to create sustainable health and social care

provision across Aberdeen City. The Transformation and Change Plan should be read in conjunction with this document as it clearly articulates how we have reached the decisions on our 6 ‘big ticket’ items.

Strategic commissioning is one of the partnership’s six ‘big ticket’ items that were approved by the IJB last year. The others were:

- acute care at home
- supporting self-management of long term conditions – building community capacity
- modernising primary and community care
- Transformation – supporting infrastructure
- IT, infrastructure and data sharing

Within these areas, a significant volume of transformational activity is being led and supported by colleagues to test new ideas and support sustainable change. There is a strong coherence between these activities and our overarching strategic narrative outlined in our Strategic Plan, the Transformation Plan and this Commissioning Implementation Plan.

Appendix 2 shows the current investment allocated to the six big ticket items listed above to date.

5.0 Evaluating impact.

The theme of improved personal experiences and outcomes for the individuals who use our services and their families runs through this plan however we would wish to say more about the particular benefits that will follow on from the implementation of our intentions.

For each project we have highlighted the expected benefits and impact, within the Transformation and Change Plan. Further work is being carried out to identify the necessary metrics that will help us fully evaluate the impact of these projects.

6.0 Next steps.

To fulfil the commissioning intentions outlined in this plan and to continue to dove tail this in entirety with our Transformation and Change Plan, we will establish a number of work streams that will develop more detailed specifications including project milestones and timelines and oversee their implementation. The Head of Strategy and Transformation will have overall responsibility to ensure this work is actioned and proper governance is followed.

What Will We Commission?	When Will This Be Delivered?
Care at Home	2018-2020
Reablement	2018-2020
Residential Care for older People/Physical Disabilities	2018-2022
Residential Care for Learning Disabilities	2018-2022
Residential Care for Mental Health	2018-2022
Intermediate care	2018-2020
Out of Hours/Responder service.	2018-2021
Joint Equipment Store	2018-2020

Table 6.1 Commissioning Implementation Plan

The financial resources that are to be aligned with these activities will also have to be worked through and agreed. In some areas, this will require exit strategies from how we currently commission particular models to be developed so that the monies can be realigned to our desirable future models. It may also be possible that accessing available transformation funding is appropriate for some aspects of this programme of activity.

Reports on our progress in respect of these developmental activities will be in the first instance to the Strategic Commissioning Board and from there to the Chief Officer and IJB as appropriate.

7.0. Market Facilitation Statement.

7.1 Introduction.

Our ethos to working in partnership with other stakeholders has been consistent from our integration 'Go Live' in that we believe that working closely across the health, social care, third, independent and housing sectors will help us realise our vision more fully and achieve all of our strategic ambitions and priorities in a coherent and co-ordinated timeline.

We are very aware that improving the personal experiences and outcomes of the individuals who use our services and their carers will require many varied contributions from many different individuals and organisations.

We are committed to developing and sustaining positive relationships across the third, independent and housing sectors and working together to develop and provide the high quality services that are wanted and needed by our citizens.

7.2 Why do we need a market facilitation statement?

This document is aimed at existing and potential providers of adult health and social care services and hopes to build on the work already done through the development and publication of our Strategic Plan 2016-19.

There is a rich diversity of organisations in Aberdeen committed to improving the lives of its citizens through better health and wellbeing, better relationships and/or better opportunities. Working in the health and social care sector provides great opportunities for personal and professional development but we recognise that there are different financial challenges that impact on the workforce and the wider sectors.

We wish to continue our dialogue with the individuals who use our services, their carers, providers and other stakeholders about the vision of the future of local health and social care markets in Aberdeen City, and how we can all work in partnership to develop a market that delivers improved experiences and outcomes for the citizens of our city who use our services now or who will do so in the future.

7.3 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 to enable us to understand the local market structure, key players, 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 we intend to influence the market through 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 we will make to deliver the required market structure, capacity and capability necessary to achieve desired outcomes.

The collection and analysis of data and the publication of a market facilitation 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 its practice in all three elements.

7.4 Current commissioned provision.

Most of our current provision is procured externally from many different partner organisations across the following areas

- Residential
- Care at Home
- Housing Support and Supported Living
- Employability/Training and Skills Development
- Day Care
- Advice, Advocacy, Counselling and Support
- Carer Support
- Substance Misuse
- Sensory Impairment

The majority of these contracts were established before integration 'Go Live'. All of our future commissioning will reflect the partnership's ambitions and priorities and at the same time, hopefully be sufficiently robust enough to withstand changing market circumstances.

7.5 Expectations and opportunities.

7.5.1 Our ideal marketplace

We want our relationships with each and every organisation, agency or association to be characterised by the values of:

- ✓ Respect
- ✓ Trust
- ✓ Collaboration
- ✓ Transparency

We wish to develop a diverse, active, and sustainable market that is able to support individuals in their ability to manage their own long term health needs, and to enjoy living as independently as possible for as long as possible in their own homes. Our commissioned services will offer individuals 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.

To safeguard our commissioned service delivery from any future market upheaval we will commission a “service of last resort” 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 will 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 e.g. divestment or change of registration.

7.5.2 What principles and behaviours can providers expect from the Partnership?

We have bold and ambitious plans to transform how we deliver our integrated health and social care services and are very mindful that positive relationships with our providers will be a necessary condition of our future successes together.

Our evident principles and behaviours will include

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

Should any provider believe that for some reason, the Partnership has fallen short of these standards that it has set itself then we would welcome a conversation about those circumstances and a dialogue about how we can best ensure that our practice always matches our rhetoric.

7.5.3 Our expectations of providers.

The providers we want to work with are those who want to help us realise the ambitions and priorities outlined in our Strategic Plan.

These providers:

- ✓ are committed to an enablement approach that is focussed on keeping individuals well, promoting independence and preventing the need for higher level care.
- ✓ 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.

We are keen to have meetings with different representatives from different organisations so they can tell us of the positive impacts they are having on the individuals who access their services and their own organisational development plans.

7.5.4 What providers can do to prepare

There are a number of different ways in which providers can begin to reshape their activities and priorities in order to align themselves with the partnership's own ambitions and priorities and future commissioning intentions.

The improved health and wellbeing of the individuals who use their services is of paramount importance.

- ✓ Develop models of care that focus on the holistic wellbeing of the person and on helping the individual to achieve personal and social outcomes.
- ✓ Consider how their services are, or can be made, preventative in their focus and how they support people to be as independent as possible

Providers are well placed to develop positive meaningful relationships with the individuals who use their services, their families and the communities in which they operate.

- ✓ Ensure they have mechanisms in place to engage, and, preferably, co-produce with service users and their families
- ✓ Consider how their services work within local communities and how they support the building of capacity within those communities
- ✓ Consider how their services and staff can form part of, or wrap around, the multi-disciplinary locality teams

The quality and effectiveness of the partnership's activities is based on the quality and effectiveness of individual services and organisations.

- ✓ 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

Collaboration and co-production across all activities is expected as a standard, not optional behaviour.

- ✓ Recognise that increasingly the purchasing partner will no longer be the Partnership but will be the service user or groups of service users via Self Directed Support
- ✓ Explore new forms of collaborative partnerships with other providers.

The Partnership is always keen to meet with different providers to discuss their ongoing development and what organisational supports can be put in place to facilitate this.

7.5.5 Getting the basics right

We are very aware that in order to create and support a more resilient environment where high quality of care is delivered and innovation flourishes we need to ensure firstly that we have got the basics right.

Better communication across all sectors and services is an essential element of a partnership that wants to improve its behaviours and activities. The need for timely and effective exchange of assessments and other up to date information becomes more crucial at times of transition or crisis.

We also recognise that what providers want is clear and unambiguous information about our expectations and future intentions. We will seek to keep providers up to date with significant changes in our organisational structure and workforce so that they know who to contact and how to escalate issues. We will then seek to respond to all queries and concerns as quickly as possible.

The prompt and accurate payment of invoices will always help ease any financial concerns that organisations may have. Delays can be frustrating especially when providers have already put in place the required levels of care and support for individuals.

Where spot purchasing is the agreed funding arrangement it would be beneficial for all partners if the parameters and criteria for agreeing any variation from the 'flat fee' were more widely known and understood especially if commissioning for complexity is going to become commonplace.

Consistent dialogue and support from all health and social care professionals to the providers will ultimately always be of value to the individuals who are receiving services. Increased interventions at times of transition or crisis and regular participation in other planned activities such as reviews are recognised as contributing to positive relationships and improved outcomes.

An integral element of all of our commissioning will be the involvement of providers to help frame our future solutions based on what we know is currently working and what are the challenges that are being experienced. We will use this intelligence to inform our procurement processes which will be flexible and proportionate to the scale and significance of the service(s) being commissioned.

We will design contract size around end need and purpose e.g. relevant to service being commissioned, the local market and its geography.

We will be consistent in our decisions regarding contract lengths recognising that longer contracts support greater stability in the marketplace but that shorter contracts can also be of value as an interim measure pending other discussions and decisions.

Similarly, we recognise the respective merits of block funding and spot purchase arrangements and will put in place appropriate funding mechanisms for each particular procurement exercise. We will operate on the principle of full cost recovery; we do not expect providers to subsidise the service that is being commissioned by the partnership.

7.5.6 Encouraging innovation

Innovation has been a key building block of our Transformation programme and we are keen to continue this exciting journey of exploration and discovery. We want to be recognised as a high performing partnership that supports innovation across all sectors to deliver improved experiences and outcomes.

Some of the things we may do to support greater innovation include:

- ✓ Directly fund innovation through seed or start-up funding; recognise that not every innovation will be successful.
- ✓ Design potential for innovation into contracts. 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.
- ✓ 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 other funding; signpost to alternative sources, assist with applications, endorse applications.
- ✓ Advocacy; speak on behalf of providers in discussions with Care Inspectorate, SSSC etc.

Contact us to discuss these and other ways of supporting your ambitions and innovations.

7.6 Participation and Engagement.

We recognise that creative, flexible and sustained participation and engagement across our localities and service delivery areas are essential elements in understanding the concerns and priorities of our citizens and communicating our ambitions and intentions.

The partnership, in association with other community planning partners has developed an Empowerment, Engagement and Participation strategy but we recognise that we need to be more consistent in how we engage with our stakeholders and maintain a meaningful dialogue with them.

We would welcome further comment and dialogue of where and how we could improve our approach to engagement and participation at an individual and broader organisational level.

7.6.1 Market Facilitation Steering Group.

The Market Facilitation Steering Group comprises representatives from the Partnership's Strategy and Transformation team, the Commissioning, Procurement & Contracts (Social Care) team, ACVO, CASPA (Care and Support Providers Aberdeen) and Scottish Care.

The group meets every two months and its primary role is to support the ongoing facilitation of our local health and social care market by asking the questions 'what is needed' and 'what will work'.

Sharing of information and developmental opportunities is recognised as being an important factor in strengthening the resilience and stability of individual organisations and the wider third and independent sectors. The group will also enable a strong providers' perspective to inform and influence proposed activities related to the roll out of this statement.

The credibility of this statement relies on the contribution of providers. The ongoing review and refresh must reflect their expertise and experiences.

7.6.2 Provider Forums.

These forums are an invaluable resource for strengthening our relationships with providers and facilitating discussions about the current challenges that the sectors are experiencing and the latest partnership developments that are to be communicated to a wider audience.

ACVO facilitates CASPA (Care And Support Providers Aberdeen) meetings and Scottish Care facilitates a Care Home forum and a Care at Home forum.

The partnership is committed to consistent attendance and active participation in these forums.

7.6.3 Locality Leadership Groups.

We have established Leadership Groups in our four localities to connect our operational service delivery with our communities and provide opportunities for the area's residents and other stakeholders to discuss and agree their respective challenges and priorities.

The membership of these groups reflects the diversity of the partnership's activities across the city. They have overseen the development of profiles showing the health and wellbeing of the local population, the evident health inequalities and the assets available for communities to use to their advantage. These profiles will in turn, inform the development of the Locality Plans which will outline our locality specific actions and developments.

7.6.4 Strategic Planning Group and Strategic Steering Groups

The integration legislation sets out the requirement to establish a Strategic Planning Group and also prescribes its core membership including representation from the third and independent sectors.

7.6.5 Communication and Engagement Group and Newsletter.

Our newsletter 'Partnership Matters', edited and produced by our Communications Lead is a great read and ideal for keeping up to date with our latest news and developments. With an increasing circulation, it is also an excellent opportunity to promote what is happening in your own service, organisation or sector.

7.6.6 ACHSCP Conference & Heart Awards.

The partnership is committed to holding an annual conference to showcase its achievements and developments and to enable participants to contribute

Similarly, the Hearts awards are an opportunity to celebrate our achievements and the commitment of our workforce in providing good quality services

> For further information about any of our engagement activities please email ACHSCPenquiries@aberdeencity.gov.uk in the first instance and we will forward your query to the appropriate colleague who will provide you with a timely and appropriate response.

7.7 Structure and Governance

The Public Bodies (Joint Working) (Scotland) Act 2014 has introduced significant change to the governance and operation of health and social care delivery.

7.7.1 The Integration Joint Board

The Integration Joint Board (IJB) is the key governance body with a responsibility for the planning and commissioning of the health and social care services which are delegated to it by its partner local authority and health board.

A Scheme of Integration[15] sets out what functions and services are delegated to the IJB.

The Chief Officer is accountable to the IJB and the Chief Executives of the local authority and the health board for the performance and quality of the Partnership's delegated functions. The Chief Officer is supported in this responsibility by her Executive team of:

- Head of Operations
- Head of Strategy and Transformation

[15] http://aberdeencityhscp.scot/contentassets/472f1da29a8f40729b99f404721f1658/aberdeen-city--ijb-integration-scheme.pdf

- Clinical Director
- Chief Finance Officer.

IJB meetings are public meetings. The schedule of dates and official reports (available one week in advance of the relevant meeting) can be found on our website. https://aberdeencityhscp.scot .

7.7.2 Strategic 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 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

7.7.3 How the partnership procures services.

Buying and contracting health and social care services is a complex activity that is clearly different from the procurement of other goods, works and services because of the considerable impact they will have on the health and wellbeing of individuals who will use these services.

The procurement and contract management of these services is undertaken by the **Social Care Commissioning, Procurement and Contracts Team (SCCPC)**. The SCCPC also undertakes this role for the Aberdeenshire Health and Social Care Partnership as well as Aberdeen City and Aberdeenshire Councils' Children's Services.

As a guiding principle, the SCCPC team place the procurement of services within the wider context of strategic commissioning, taking account of procurement and social work legislation and the Partnership's policy direction set out in its Strategic Plan, this Strategic Commissioning Implementation Plan and other relevant policies and plans.

The Scottish Government has, with other partner agencies, implemented **Public Contracts Scotland –Tender**, an online electronic platform, to help public sector organisations adopt standard procurement processes for goods, services and works for a wide variety of contracts. All our Partnership contracts are tendered via Public Contracts Scotland – Tender.

Collaboration and co-production are key behaviours that we endorse throughout the Partnership however we recognise that there is a commercial sensitivity and confidentiality to the procurement process that must be adhered to.

We will always seek to ensure that the procurement of services reflects the co-designed solutions that have been developed by our colleagues and partners.

7.11.4 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 the 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.

The relationship between the different elements of the Partnership is crucial to achieving the desired outcomes for the individuals who use our services. This will be so much more difficult where relationships are poor.

For further information about how the Partnership procures services from the third and independent sectors or how it manages existing contractual relationships please contact CommissioningandContracts@aberdeencity.gov.uk .

For help with **language / interpreting** and other formats of communication support, please contact 01224 522856/522047

ভাষা/ইন্টারপ্রেটিং এবং অন্যান্য ফরমেটের যোগাযোগ সাহায্যের জন্য দয়া করে :01224 523 542 নম্বরে যোগাযোগ করবেন।

如果需要語言/傳譯及其他形式的傳訊支援服務，請聯絡:01224 523 542。

Если требуется помощь при выборе языка /переводчика или других способов общения, звоните по телефону : 01224 523 542

للحصول على مساعدة بخصوص اللغة/الترجمة و وسائط الاتصال الأخرى، الرجاء الاتصال بالرقم التالي:01224 523 542

Lai saņemtu palīdzību sakarā ar valodu/tulkošanu un citiem iespējamiem komunikāciju atbalsta formātiem, lūdzu zvanīt 01224 523 542

Jei jus turite sunkumu su kalba/ vertimu ar kitomis bendravimo formomis, skambinkite 01224 523 542.

Jeśli potrzebujesz pomocy **językowej / tłumacza** lub innej pomocy w porozumiewaniu się, proszę zadzwonić pod numer: 01224 523 542

Appendix 1 - CURRENT COMMISSIONED/PROCUREMENT ACTIVITY CURRENTLY (2017/18)

TYPE OF COMMISSIONED SERVICE	AMOUT OF PROJECTS/CONTRACTS	TOTAL COMMISSIONING SPEND
Employability	6	547,385.37
Adult Carers Support		231,883.90
Day Care Services	2	202,326.85
Advocacy / Befriending	13	728,337.05
Sensory Impairment		465,899.00
Housing Support (younger people)	3	1,012,450.00
OP/PD Care/Nursing Home	26	28,969,589.74
OP/PD Care at Home	13	8,041,388.12
OP/PD all residential	8	3,411,924.96
MH care Homes	16	5,018,160.14
LD Supported Living	25	9,767,396.50
Other		26,289,000.00
TOTAL		£84, 685, 741.63

APPENDIX 2 – CURRENT AND PLANNED TRANSFORMATION ACTIVITY 2017 – 2019

STRATEGIC COMMISSIONING AREA	PROJECT	CURRENT YEAR	2018/19
Self-Management of Long Term conditions and Building Community Capacity	**Link Workers**	**£808,030.88**	**£1,561,445**
	Connecting Communities		
	Care Navigation		
	Supporting Self-Management of Long Term Conditions.		
	House of Care		
	Golden Games		
	Carers Support Services		
	Locality Development		
Modernising Primary and Community Care	**GP Practices new Ways of Working**	**£1,796,872**	**£2,103,670**
	Pharmacy and Prescribing		
	INCA		
	Nursing Succession Planning		
	Community Falls Clinic and Pathway		
	Develop GP led beds		
	Advanced Nurse Practitioners		
	Community Mental Health Hub		
	Community Phlebotomy Service		
	Clinical Guidance Intranet		
	Transforming Urgent Care – early evening		
	Alcohol Hub		
IT, Infrastructure & Data Sharing	**Planning for Capital Development**	**£814,464**	**£1,115,554**
	Kingsmead		
	Integrated Working		
	ICT Systems and Equipment		
	Technology Enabled Care		
	DATA Sharing		
OD and Cultural Engagement	**Wider Leadership and Development Support**		

	Ensure a Fit and Healthy Workforce	**£153,600**	**£95,600**
	Implementation of the 'ideas Hub'		
	Heart Awards		
	Conference		
	Develop Plan of Annual Engagement		
	Board development, systems and governance testing		
Strategic Commissioning	**Implementation of Commissioning Strategy**	**£3,685**	**£750,000.00**
	Supporting Resources		
Acute Care at Home	**Acute Care at Home**	**£245,804.00**	**£724,272.00**

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Aberdeen City Health & Social Care Partnership
A caring partnership

Integration Joint Board

Report Title	Re-Imagining Primary and Community Care
Lead Officer	Judith Proctor – Chief Officer
Report Author	Sally Shaw – Head of Strategy and Transformation
Report Number	HSCP.17.123
Date of Report	10 January 2018
Date of Meeting	31 January 2018

1: Purpose of the Report

The purpose of this report is to bring to the attention of the IJB the developed vision of how we seek to 'reimagine primary and community care' in Aberdeen.

The paper has been developed following on from the workshops held with the IJB in November 2017.

The activity in this plan will be driven by the principles and aspirations of the Strategic Plan and is one of a developing suite of papers that sits under and is fully aligned to the Transformation Plan. In time we will see clear commissioning intentions developing from this vision being articulated in the Commissioning Implementation Plan. These later two plans also being before the IJB today.

Primary care is an essential element of good modelling in order to continue to shift the balance of care to community based provision. This paper focusses on primary care but this has to be seen as one element of that community modelling

2: Summary of Key Information

2.1 Re – Imagining Primary & Community Care

The articulated vision is seen as being long term, spanning the next ten years and beyond. This means that the plan needs to be both dynamic in its development and incremental in its implementation.

Integration Joint Board

Whilst the national and local challenges facing health and social care have been well articulated elsewhere, the vision highlights some very specific issues relating to primary and community care.

Primary and community care are critical in supporting our health and care system. The vast majority of healthcare interventions actually happen in primary care. They are also key in supporting good prevention and early intervention.

These are services that support an individual the entire span of their lifetime, supporting both physical and mental health. They provide long term continuity as well as single interventions.

The paper identifies what we believe the evidence and data directs us to focus on, via a long term programme, and that we need to consider transformational change in;

(1) **Workforce** – primary and community care is provided by a range of health and non-health professionals working together across disciplines, agencies and localities.

The paper explores some of the changing demographics, the supply issues and how we might develop a primary care that supports a model of fewer GP's in the future.

(2) **Changing relationships with people and communities –** the paper sets out within the Blue Print (Appendix A of the Re-Imagining Primary & Community Care paper, attached at Appendix 1) the need for honest conversations with individuals and communities about the challenges now and into the future if we fail to take appropriate action. These honest and open conversations will be necessary to achieve the ongoing, generational culture change required.

(3) **New practice models –** we need to be open to thinking about how we shape the future services. We need to explore the possible, e.g. single triage, hub and spoke model development etc.

(4) **Estates and premises –** describing a move from traditional 'practice based' & building based care to in the most appropriate place by the most appropriate practitioner. There is an absolute need to develop a clear plan about what will be required across the localities of Aberdeen in respect of functional buildings and spaces that are conducive for good quality primary and community care.

(5) **IT and technology –** setting out the need to support the growth of ability and confidence in staff, individuals and communities in the use of technological enabled care and support systems.

The vision is not a step by step guide but a suggested pathway to shaping the model(s) of health and social care in Aberdeen with a specific focus on primary care in our localities. Developments will be informed by and fully aligned to our 4 Locality Plans, supporting local development and determination of services.

We recognise that doing more of the same is not an option and is not sustainable. What we do have is the opportunity to change. Although the paper does not offer a complete blueprint for the change, we are clear we want to see change deliver such things as;

- People being able to access the right advice and act on it when they need.
- A different first point of contact which will be widened to other more appropriate services, to include for example, community pharmacists.
- People will experiencing appropriate triage and guided by the most appropriate professional.
- GP's increasingly becoming 'specialists generalists'.
- A primary and community care workforce that has an increased skill set.
- A shift, through our localities toward further focus on preventative approaches to addressing health improvement and tackling health inequalities.

The paper endeavours to set out in the table on page 7 and 8 of Appendix A a description of the possible future state in respect of patients, primary care professionals and estates and premises.

3:	**Equalities, Financial, Workforce and Other Implications**

Financial Implications

Further discussions need to be undertaken in respect of any future commissioning intentions to develop appropriate, costed option appraisals and business cases.

Equalities Implications

This Plan does not discriminate against any equality or diversity group but instead

seeks to advance equality of opportunity between those who share a protected characteristic and those who do not.

It is suggested however that the evaluation of future activity includes significant opportunities for those who use services to confirm that they are not experiencing unintended negative consequences and that there is a tangible improvement in their personal experiences and outcomes.

Workforce Implications

It is envisaged that this vision will have a positive impact on our workforce providing increased job satisfaction, varied career paths and further training opportunities.

Appendices:

1. Re-Imagining Primary & Community Care in Aberdeen
    a. Appendix A: The Blue Print

4:	Management of Risk

Identified risk(s):

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 and financial pressures in the system

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

By the continued move towards a sustainable vision of primary and community care, we are flexing our approach and working with communities to co design services and respond to challenges.

Integration Joint Board

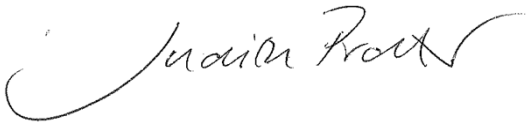
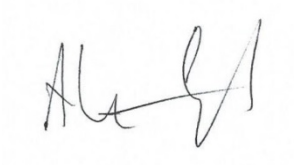
5:	Recommendations for Action

It is recommended that the Integration Joint Board:

1. Consider the Reimaging Primary and Community Care Paper, as attached at Appendix A.

2. Instructs the Chief Officer to develop a detailed Communication plan; and

3. Instructs the Chief Officer to develop an Engagement Strategy to develop this vision further with all stakeholders and to bring this back to the IJB in May 2018.

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

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Re-imagining Primary and Community Care in Aberdeen

Introduction

This paper sets out a direction of travel for the future of primary and community care in Aberdeen City. It aims to provide the Integration Joint Board (IJB) with a vision and the overarching concepts for change that will support current developments in primary and community care (in the context of the current Transformation plan). It supports the longer term changes required to sustain good quality services for the people in Aberdeen.

The case for the wider transformation of health and social care has been driven by legislation and is set out in a number of related documents plans and papers; including the Aberdeen City Health and Social Care Partnership Strategic Plan and the Transformation Plan which should be read as a companion piece to this paper. All aspects of the partnerships Commissioning Implementation Plan have a direct or indirect impact on our ability to achieve our aspirations in respect of primary care. This document focusses on a specific part of our wider services – that of Primary and Community Care and in the context of our Locality Working and developments in the new (pending) GMS contract.

This paper builds on the work undertaken by the IJB membership at a workshop session which took place in November 2017. It signals the IJB's commitment to supporting longer term planning, innovation and new ways of working and in setting a clear articulation of future investment and resourcing aims toward that vision. It also signals the IJB's understanding of the complexity of tackling these specific challenges and an awareness of the partnerships need to be innovative in our thinking and bold in our actions.

We anticipate this being a 10 year + vision – and that many of the changes started under this plan will be completed or further developed over the course of that time. Within the complexity of the change required we know and understand that we need to make a start and set a direction – this paper sets out what we see as the main challenges and opportunities in order for us to be able to make that start.

Why Focus on Primary and Community Care?

While the national and local challenges to health and social care have been well articulated elsewhere there are specific issues that relate to primary and community care.

Overall the population of people over the age of 75 is expected to increase by 63% over the next 20 years. The case for integration has been set out in detail in the range of guidance and the economic case which accompany the Integration legislation. The national challenge is clear:

- 1 in 4 adults has a long-term illness or disability;
- Around 2 million people in Scotland have at least one long-term condition;
- People in Scotland are living longer, but more of those people over the age of 75 are living with a long-term condition and/or significant frailty;

- Overall the population of people over the age of 75 is expected to increase by 63% over the next 20 years;
- Over the next 15 years, alongside other pressures, we expect an increase of 12% in GP consultations – if nothing changes; and
- At the same time as we predict an increase in demand for consultations there will be a decrease in the number of GPs working – we anticipate vacancies in the city increasing.

The Scottish Government estimates that the need for health and care services will rise by between 18% and 29% between 2010 and 2030. Coupled with a shrinking working age population and the known workforce supply challenges, it is clear that the current model of health and social care cannot be sustained and that it must change. The emphasis of change is toward more preventative and anticipatory approaches and those that are community-based with acute services being used only when there is no alternative.

These pressures of demography and workforce are replicated across the UK, and we are not unique in seeking to ensure that we can continue to support people in our communities to stay well and receive the appropriate support in the right place and at the right time when required.

Primary and Community Care are crucial to our health and care system. The vast majority of healthcare interventions take place in Primary Care. It is seen as the first point of contact with NHS services – 90% of all patient interaction across the health care system is with primary care practitioners. Primary and Community Care are key services in relation to prevention and wellbeing and in maintaining people's independence at home and in the community. These are universal services that provide care across the lifespan and across physical and mental health, they are the first point of contact that many in our city have with formal health and care services. They provide long term continuity as well as single interventions. As such and given the expected increases in demand and ongoing challenges in workforce supply we must continue to think and act differently in our planning and delivery of these services – and hence the single focus of this work on this area of our health and care partnership. We also need to ensure that planning and delivery is designed alongside individuals and localities in order that we support them to act and think differently in their expectations of primary care services. This is not to suggest any lowering of quality, indeed to develop quality of experience and ability to manage health more independently.

Who is the Primary and Community Care Workforce?

Primary care is provided by a range of health and non-health professionals, working together in multidisciplinary and multiagency networks across localities, with access to the expertise of specialist colleagues. All primary care practitioners have developed working practices, using local knowledge, clinical expertise and an evolving supportive and enabling relationship with the person to make shared decisions about their care and help them to manage their own health and wellbeing.

It is this ethos that supports our ability to develop a future vision and to start creating concepts that we know we will be able to implement.

This is a broad and diverse workforce and is provided under different contractual mechanisms. For the purposes of this paper it includes:

- General Medical Services – under an independent contractor model for the most part in Aberdeen
- Staff working in GMS services include – General Practitioners, Practice Nursing staff, ANPs, Pharmacists, General Dental Practitioners and Community Optometrist.
- Services working alongside but under contract to the HSCP – District Nursing, Community AHPs, Community Pharmacists, Mental Healthcare Workers, Health Visitors. LD Nursing etc.

There are a number of challenges within this workforce. A survey undertaken by ISD in 2015 and reported in 2016 concluded the following main points (Survey covers 2013 -2015):

- The estimated whole time equivalent (WTE) of GPs declined by 2% between 2013 and 2015 (from 3,735 to 3,645).
- The estimated WTE of registered nurses and Health Care Support Workers employed by general practice however increased by 2%.
- There was a decrease in the proportion of GPs working 8 or more sessions from 51% of GPs in 2013 to 43% in 2015.
- Nearly 9 out of 10 practices reported using GP locums. The estimated GP locum input was 350 WTE for the year ending 31 August 2015. This was an increase from an estimate of 290 WTE GP locum input reported by the survey in 2013.
- The majority of practices also reported difficulties in recruiting locums, with 60% of practices regularly unable to recruit locums for unplanned absences.
- One in five (22%) responding GP practices reported current GP vacancies at 31 August 2015. This is an increase from 9% of practices reporting current vacancies in 2013.
- In 2015, half of the vacancies reported had been vacant for over 6 months. In contrast, a much smaller percentage of practices reported vacancies amongst nurses, with 1% reporting vacancies for nurse practitioners/advanced nurse practitioners, and 4% reported vacancies for general practice/treatment room nurses.
- Over a third of GPs working in Scottish general practice are aged 50 years old or over. Among male GPs this proportion is higher, with nearly half (47%) aged 50 years old or over,
- Among registered nurses in Scottish general practice over half (53%) are aged 50 years or over.

Our experience and data is telling us this is not merely a recruitment issue but one about supply. Our aging population is playing out in our workforce as well as in increased demand on services. The majority of our nursing workforce being 50 years plus.

We have had clear changes to the demographics of our GP population – a huge shift in to a predominantly female workforce, with the majority of GPs now working part time.

So it is not about merely a financial solution, it's about being intelligent with what we have got – in thinking differently about how to maintain a level of GP availability for those that need the range of skills of a GP, and how we support the role by developing a range of allied health professionals working side by side with General Practitioners and their teams. Some of this work is already underway within our Transformation programme where we are already investing in Community Nursing succession planning, and putting resource into the development of a range of practitioners

to support our future primary care services such as Link workers and an increase in Pharmacy support in General Practice.

The Case for Change

Our Transformation Plan clearly articulates the wide range of pressures facing health and social care. Developing a resilient primary care service will be critical in ensuring safe, appropriate and sustainable services being able to meet the needs of future generations of people working and living in Aberdeen City. Building such resilience will take time. We need to start with our known pressure points and take the opportunity to think differently and not burden ourselves with trying to create more of the same – we can't. The current system isn't working in respect of being able to absorb the current increase in demand; it is not working well for GPs either. The BMA surveyed one thousand, eight hundred GPs in Scotland (2015) and from this survey; a quarter of GPs stated that their workload was unmanageable. Sixty-nine per cent also advised that their workload was having a negative impact on their personal commitment to their career.

Workforce issues

As stated there is a need to change the relationship with the public in their expectations of all health and social care services. Audit Scotland in their recent report, NHS in Scotland 2017 recommends that;

> ***"The Scottish Government, NHS boards and integration authorities, should continue to work with the public, local communities and staff to develop a shared understanding and agreement on ways to provide and access services differently…."***

And:

> ***" continue to develop a comprehensive approach to workforce planning that: reflects forecast of future staffing and skills requirements to deliver changing models of healthcare provision at regional, local and community level."***

ACHSCP recognises it needs significant change and this vision sets out some of the things we **could and should** be doing and building now to help achieve the resilient primary care that we aspire to.

What this Vision is and what it is not

This is not a step by step plan but a vision towards a changing model of health and social care in Aberdeen City with a specific focus on Primary Care in our localities. It should be read alongside our Transformation Plan and Commissioning Implementation plan and is one of our big ticket change items.

We aim to set out a broad framework for these work streams that will help us focus on what we believe are the main platforms for change.

The plan has been developed with the IJB following a 2 day workshop - the ideas and proposals set out here have been checked against the aspirations and ambitions of our Strategic Plan and will

inform the work that we will undertake to deliver our Primary Care Transformation plan as required by the new GMS contract (**pending this being agreed).**

What are we seeking to achieve

As an IJB we want to ensure the sustainability and development of good health and wellbeing for the population of the City. We want people to be well and do well and we want them to be able to access the right advice and service at the right time, from the right person. Doing more of the same isn't sustainable – as set out above – and we have an opportunity to change. While we acknowledge we do not have a complete blueprint for change we want to see change deliver the following:

- People in Aberdeen can access the right advice and act on it when they need. We will change the relationship with people and more people will seek advice and treatment from the wider healthcare system;
- The first point of contact for many will be widened to include Community Pharmacists, online or phone advice;
- People will have appropriate triage and be guided to the most appropriate professional – in time we will shift thinking from 'going to see the GP' to 'going to get advice to support me to manage this myself'
- GPs will increasingly become 'specialist generalists' and we will support them in undertaking this role – focusing their skills and training on areas of complexity and continuity for those patients with most need for their skills;
- We will broaden further the skill set in primary and community care.

Main Areas for Change

In order to achieve our ambitions we believe that the evidence and data supports a focussed, long term programme that supports transformation in:

- **Our Relationships with people and communities**
- **The Workforce**
- **New Practice Models**
- **Estate and Premises**
- **Technology**
- **Prevention and Public Health (a future vision)**

Our IJB Commitment to a Long Term Plan

The Aberdeen IJB has recognised since it came into being, that given the scale of the challenge facing health and social care that the work to transform our system would involve us working across a long term vision. That is not to say that we will **only** see change in the longer term, but it recognises that there is a need to work actively to a longer term aim over a number of years. Our plan will set out that vision acknowledging that some of the work won't potentially be completed within a 5 year programme but will go beyond this. We will set out short and medium term concrete plans, but our vision is one that allows for a longer term view and the art of the possible. We also recognise our approach needs to be agile as some of the complexities of challenge are not easily in our gift to

change, e.g. the complexity around GPs owning their buildings and this being part of their pension planning.

An **example** of this might include the following in relation to accessing information:

Vision

We aim to transform the way the people access information, self-care and health and care services. We can envisage moving toward a hub and spoke model with a transformed estate and modernisation of assets, including premises, equipment, ICT and a transport structure. This might include larger, multi-functional buildings in which a wide range of professionals work flexibly over the day and week. People will access these buildings for health and care information, by phone and VC/Skype and will access both partnership and 3rd sector services in one place but accessible to the wider community. General practice will remain the gateway to primary care, with individuals still being registered to practices. However, we aim to shift expectation and behaviour toward people thinking about *going to the health and wellbeing service* rather than *going to see their GP.* People will get the right information or be directed to the right person to meet their needs and our professionals will be utilising the full extent of their skills where they are most needed at the earliest opportunity.

This is a long term vision because:

Shifting toward a hub and spoke model will mean big changes to the way that we use buildings we have and those that are owned by others. We will need to make strategic investments of IJB/Public Sector Budget to achieve this and the formal planning for new premises can take 5-10 years to complete. This will also involve us working with universities and other education providers to develop new roles and prepare the professionals of the future in new approaches. This can take time. Training a GP can take up to 10 years, training District Nurses 5-7years and Physician Associates 2 years following a first degree and 2 years preparation in work. This shouldn't daunt us but we do recognise that what we initiate now we may not see the fruits of for 5-10 years.

Elements we'll begin to deliver in the short term are:

We will begin working with premises that we have across the city and look for immediate opportunities to work differently where we are now. We will look at technology and opportunities to develop new forms of triage and access that uses such technology. We are already investing in new ways of delivering new roles – Link Workers, INCA, West Visiting and Acute Care at Home, Pharmacists, Mental Health workers in Primary Care. Our plans will continue to be tested and evaluated and we will create the building blocks from these toward the longer term vision.

Elements we'll begin to deliver in the medium terms are:
We will begin conversations with the Universities and workforce regulatory bodies on how we development the necessary academic support and meet ongoing registration requirements for the new roles we envisage for future workforce. We will also consider how we offer transitional support for practitioners working in these new service delivery models. We are looking at what investment is required to mainstream further the role of Physician Associate, achieve robust nursing succession planning and revisit our ideas on how we develop a care centre of excellence in one of our care facilities.

Elements we'll deliver in the longer term are:

We need to support individuals, communities and our workforce in being confident in the use of technology, using it as the norm in supporting people in managing their long term health conditions, accessing mainstream support and in feeling safe within their own homes. Our Tech Enabled Care work stream and like-minded partners will work to develop the most up to date health and care navigation system. Technology is a fast moving industry and we will need to ascertain good advice on how we ensure we are always using and investing in the safest and effective technology solutions.

Describing the possible future state

There are a number of future scenarios and the following section tries to set out the potential future for a number of elements of the system – for different types of patients, for members of the Primary Care Team and for the future of our premises across the city. These are given for illustrative purposes only.

Who /What?	Current	Future
Patient with short term, self-limiting condition	• Appointment to see GP • Sees GP in practice premises • Face to face appointment with GP	• Central Triage and signposted to right advice or professional • Registered with a practice but can access advice and services in a range of access points across the city • Increasing use of phone /VC advice and contact
Patient with Long Term Condition(s) / Complex Needs	• Sees GP or range of GPs depending on availability • May require frequent, short appointments • Care largely led by GP • Limited access to self-monitoring	• Increased continuity of practitioner with more practitioner time freed up to support 'expert generalist' role • Less frequent but longer appointments • Care co-ordinated by GP with more input from wider range of expert practitioners depending on need • Greater availability of self-monitoring supported by single point of access = greater self-management and independence in the community
Primary Care Professionals	• Practice based • IT challenges	• Increased potential to be agile and work across a range of high quality hubs • Increasing connectivity and

Who /What?	Current	Future
	• Referral to secondary care for testing/imagining • Individual/isolated practice • Fairly rigid career pathway for GPs • Limited access to wider roles in team	ability to access patient information across the estate • Increased access to imaging and testing in primary care • Increasing multi-disciplinary team approach to complex patient care • Diverse career pathways that enable wider range of employment opportunities without need to 'buy in' to premises • Increased range of extended practice roles in wider team – Advanced Nurse Practitioner, Physician Associates, Link Worker, Mental Health Worker
Estate and Premises	• Range of buildings and premises not all fit for future purpose • 30 separate practice buildings and teams across the city • Patient access largely limited to own practice premises	• Clear estate / premises plan that reflects wider primary care vision • Vision rationalises this without loss of income to GPs • Patients can access range of services to meet needs across the city
Prevention and Public Health	• Range of prevention and wellbeing initiatives across the Partnership	• IJB has an agreed vision and plan to address its preventative and public health ambitions. • Plan is linked to delivery at a locality and community level and this is set out in the context with the Community Planning Aberdeen agenda and the Local Outcome Improvement Plan

Conclusion

At the workshop help in November 2017 we considered our 'pathway' to the future primary care services. A pathway starts with thinking about the long term vision which this paper has endeavoured to articulate. It also considers some of the short, medium and long terms goals which

are beginning to be fleshed out in the Blue Print – Appendix A. These as stated will be agile, as we learn from our own and others experience

Another consideration was thinking about - who do we need to enrol? This isn't just about thinking about who is going to help us achieve our aspirations – it's about identifying who might be challenging of our aspirations. The challenge is welcomed and necessary to provide the friction for action and for stimulating thinking that there might be other solutions etc. It is essential for us to engage in our work going forward with;

- Public – there was an element of fear of backlash discussed. As already said in this paper we need to be having very honest conversation with the public and indeed all stakeholders.
- Community pharmacist.
- Dentist
- Optometrists
- GP Practices
- All other primary care and community based staff
- Scottish Government
- NHS Board – in patient/ elective and acute care
- IT departments
- Local Leaders
- Different patient groups – LTC's

This is a complex and long term piece of work, which will continually provide us with challenges and opportunities. By starting to plan for achieving our vision we need to look at what strengths will help us initiate and continue developing the vision and achieving the steps on the way. Some important strengths have been identified as;

- Involving the public – it was felt essential that this was a continual piece of collaborative work to support proper design, achieve 'buy in' and shared ownership.
- To continue to develop the positive culture of the partnership to ensure resilience and good management of risk enablement.
- We have already done some really good early work with localities and this is a good foundation for future work.
- Showing our innovation and our ability to roll things out when they work and having the confidence to stop doing stuff that doesn't work.

This work is not just being driven by resource constraints and rising demand it is about what we think will be better for those who live and work in Aberdeen City over the next generations.

It will clearly need a shift in focus in respect of the culture of both how services are design and delivered and a change in expectations. We want individuals to stop thinking, 'I need to see my GP' but instead for them to think, 'I need to access primary care/the right service'. In order to do this we need to rebuild this primary care service and make it easy to access and navigate.

It is about less primary care services being provided in buildings but more being delivered at home, closer to home and being more affordable.

Our future model will have aspects of co-location where there is a clear rationale for this but will also see an increased remote workforce that is trained and supported to fully undertake this type of working and new roles. Our models will attract the workforce of our future primary care.

It will have IT and tech enable care as a main resource in providing the primary and community care of the future. This is to support staff, data sharing and bringing diagnostics into the community.

In conclusion, this paper is about the necessity for us to do all of this and setting that into the current context. If we are to do this we all need to prepared to;

- Do – we need to keep a momentum going, in building a resilient Primary Care fit for our future generations we need continual drive. We expect and welcome challenge.
- Unpick – what we are doing now, to work around sensitivities and release our imaginations.
- Lobby for – this might be locally and nationally, but we will certainly need this support.
- Investment – in staff in new buildings and of people's time.
- Disinvestment – in all that isn't going to help us achieve in achieving our aspirations.
- Be bold – let's do the right thing for the people of Aberdeen City and our future generations.

We will design an incremental programme plan which will give full consideration to;

- What feasibility studies we may undertake in order to establish our preferred options going forward.
  - This may also mean looking at success achieved elsewhere and analysing how this may be used in some or all of our localities in Aberdeen.
  - Looking at what initiatives could be planned in localities or city wide. E.g. triage
  - How we may develop better use and closer availability of such things as diagnostics
  - Developing and sustaining roles such as Physician Associates, Advanced Nurse Practitioners and practice based Pharmacists.
  - Identify current practices and the model they operate and forecast the end date of that provision.
  - Maximising the use of shared space and work environment that promotes multidisciplinary working.
- Identifying what's in our gift.
  - Looking at opportunities of change being offered by current practices undergoing change.
  - Rollout of West Visiting service (after evaluation)
  - Developing link Workers
- Expansion
  - Describing how we will plan, prepare and implement roll out of those projects that have proven successful in delivering measureable benefits.

Appendix A - Blue Print

Change Theme	Vision	Short Term	Medium Term	Long Term
Our Relationships with people and communities	The relationship we have with people and communities will be built on trust and honesty. It will increasingly support self-management and self-determination. It will put individuals and the localities they live in at the heart of designing and delivering our future primary care services.	We will host a series of city wide and locality based workshops to explore the suite of challenges we face and the inability to sustain current models. We need to be very clear about the risk of not moving and not moving quickly. We will share what is working locally across localities and also success stories external to Aberdeen City – we will develop thinking of the possible for individual localities on a short, medium and long term basis. Locality leadership will support wider primary and community care planning in alignment with Locality Plans and this vision	Continue to introduce individuals and communities to alternative models support implementation locally.	Community members in our localities will be identified as contributing and participating assets of our primary care system.
The Workforce	ACHSCP will be a partnership of choice, attracting future	Conduct a full workforce survey to highlight current gaps and risk in respect of	Examine the need and practical issues of impact on further and higher education	Development of a suite of formalised training that continues to support and

Change Theme	Vision	Short Term	Medium Term	Long Term
	practitioners with varied and interchangeable skills. We will offer good career and progression opportunities affording our staff varied portfolios and ability to work across health and social care.	building our new models. Feasibility study into what a mixed economy of GP (independent and salaried) looks like and any contract implementation issues. Revisit and develop further our aspiration of creating a Centre of Excellence.	with colleges and universities. Representation from workforce registration bodies need to be included. Develop ACHSCP Workforce Plan in alignment with new GMS contract and National requirements.	further develops our primary and community care workforce.
New Practice Models	The structure of our specialist primary care services will be informed by evidence and responsive to the assessed population. It will be shaped by those living within localities. Primary care will be designed individually to these localities and will not be a one size fits all.	Evaluate the impact of; • Link Workers • INCA • Acute Care at Home • Visiting Service Evaluation will be about improved outcomes for individuals but also about whole system impacts. Consider what is working well – triage models etc. and develop across the localities.	Evaluated and roll out of all intiatives City wide Further develop the 'Healthy Hoose' model. Develop further the collaborative working across practices. Wider MDT as first contact Have options appraisals identified and developed with localities and wider	Developed hub and spoke model. Extended and integrated teams. Single locality triage. Extend availability of testing and imaging in primary care Maximise potential in new developments for mixed models and increasing use of technology

Change Theme	Vision	Short Term	Medium Term	Long Term
		Look at opportunities and barriers to working in GP clusters. Identify with current practices what their future intent is, in respect of retirement etc. and establish timelines for this.	stakeholders to maximise the best practice outcomes from these opportunities. Develop model for remote health monitoring in certain conditions – e.g. Respiratory Illness	Following evaluation roll out wider access to remote monitoring for self-management and prevention
Estate and Premises	By using a locality asset based approach to evolving our primary care services we will become less reliant on specific buildings. Our future primary care should not be about buildings – it should be about a collective use of skills to prevent, maintain and improve the health and well-being of our citizens, in the most appropriate place for them by the most appropriate practitioner.	Review the full estate and premises, looking at identifying maintenance cost and capacity issues. Identify what capacity for 'space' we have in existing buildings within our localities.	Develop a disinvestment strategy in to potentially costly and non-fit for purpose buildings. Have a clear plan of what will be required across our localities in terms of functional buildings or spaces.	Have developed one-stop, multi-functional buildings
IT & Technology	To support the increased confidence of staff, people and communities in the use of technological enabled care and support systems. For those with long term health conditions to use	Identify IT and tech issues that need to be addressed to support our increased provision of service in peoples own homes and community based buildings.	Develop a clear IT and Tech policy Develop training plans for both practitioners and individuals in use of technological solutions.	Practitioners and individuals will be confident in using technology as a safe and effective means of supporting the self-management of long term conditions.

Change Theme	Vision	Short Term	Medium Term	Long Term
	technology to support both the management of their condition and ability to respond confidently to fluctuations in their conditions, hence seeking specialist primary care when absolutely required.	Review the ability of or gaps in the ability of current IT and tech systems for supporting our current transformation initiatives – INCA, Care @ Home etc. Consider the range of data protection issues currently encountered within our integrated teams.	Review our data protection policy and ensure we are maximising currently legislation in terms of supporting us to share information safely, not restricting are ability to do so. Identify on-going issues that are causing real barriers and seek to develop a plan of lobbying for any necessary legislative change. Would be more effective if we gathered this information across all IJB partnerships.	Increased and developed diagnostics within the community. Effect legislative change.
Prevention and Public Health (a future vision)	Primary care is about the use of both clinical and social approaches in supporting individuals and localities providing a whole range of preventative support to achieve their individual and collective	We will develop a Prevention and Public Health Strategy which the principles of will thread through all of our redesign and transformation Identify community		Good health is achieved through a holistic/ social/ community based approach.

Change Theme	Vision	Short Term	Medium Term	Long Term
	outcomes. Primary care will be designed and resourced taking into recognition the needs of those people who are negatively affected by inequalities, social isolation or other wider social determinants of health.	resources to enable effective social prescribing		

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Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Report Title	Initial Agreement for the Investment in Facilities to Support the Redesign and Modernisation of Primary and Community Care Services in Aberdeen City.
Lead Officer	Judith Proctor, Chief Officer, ACHSCP
Report Author (Job Title, Organisation)	Kay Dunn, Lead Planning Manager, ACHSCP
Report Number	HSCP/17/102
Date of Report	12.01.2018
Date of Meeting	30.01.2018

1: Purpose of the Report

The purpose of the report is to update the IJB on the development of the Business Case for the Investment in Facilities to Modernise Primary and Community Care Services (PCCS) in Aberdeen City.

The Initial Agreement (IA) to replace the Denburn Health Centre in the Central Locality with a newbuild on a Greenfield site was approved by the Scottish Government Health and Social Care Directorate SGHSCD Capital Investment Group (CIG) in early 2014.

NHS Grampian agreed with the Scottish Government Capital Investment Group (CIG) to refresh the IA to take account of a number of changes in the strategic drivers locally and nationally, including ensuring the refreshed IA is compliant with the refreshed Scottish Capital Investment Manual (SCIM) Guidance published in early 2015.

While the work is being undertaken within the Health and Social Care Partnership and supports the IJB's strategic direction, issues of Capital remain the responsibility of NHS Grampian and, as such, approval by the NHS Board will be sought at its next meeting.

2: Summary of Key Information

Appendix A provides a summary of key information contained within the initial agreement. The initial agreement will be considered for approved for submission to the Scottish Government by the NHS Grampian Board at its meeting of the 1st of February 2018. The approved Initial Agreement will then be considered by the

INTEGRATION JOINT BOARD

Scottish Government Health and Social Care Directorate (SGHSCD) Capital Investment Group (CIG) meeting to be held on 27th of February 2018 (the Initial Agreement will be made public following formal notification of the decision by SGHSCD CIG).

In 2014, the key strategic drivers were the ongoing deterioration of the Denburn Health Centre which was also deemed functionally unsuitable for the provision of modern PCCS and the urgent need to respond to the growth in new communities.

Since that time, a number of key drivers have changed including; the establishment of IJBs and the publication of the Strategic Plan in 2016, the slowdown in the build out rates of emerging communities and the need to ensure the ongoing provision of General Medical Services (GMS) to the communities of Northfield and Mastrick.

The IJBs Strategic Plan (2016-2019) sets out the vision for the future delivery of services, whilst building on the work undertaken to redesign PCCS. The refreshed IA sets out a proposed service delivery model that will support the delivery of the IJBs strategic priorities:-

- Ensure a person centred approach;
- 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;
- Contribute to a reduction in health inequalities and the inequalities in the wider social conditions that affect our health and wellbeing (specifically in the communities of Northfield and Mastrick); and
- Support our staff to deliver high quality services that have a positive impact on personal experiences and outcomes.

The new service delivery model will also contribute to the delivery of the following big ticket items included within the IJB Transformation Plan;

- Acute care at home, by increasing the number of people supported to be cared for in their own communities;
- Management of Long Term Conditions, by ensuring the future service delivery model includes a Multi Disciplinary Team to support self management and management of Long Term Conditions;
- Modernisation of primary health and community care services, by delivery new roles in Primary Care, integrated health and care at Locality level and

ensuring the modernisation of the infrastructure to support the delivery of that vision;

- Organisational culture change, by ensuring new ways of working and shared used of buildings and clinical space; and
- Transformation of ICT, by investing in new technologies support triage models, paperlite offices, electronic records and innovative ways of consulting with patients at home and in their own communities as well as consulting with colleagues in the acute sector

Between May 2016 and October 2017, the Project Team worked with Clinical Leads, Practice Partners, Practice Managers, NHSG Planners, NHS Finance, clinical and professional colleagues across PCCS including Public Health, Community Nursing, Allied Health Professionals, Adult Social Work Managers and Patient representatives from the Denburn Health Centre to refresh the Strategic Case for Change and develop a proposed future service delivery model. In January 2017, the Denburn Medical Practice secured the commission to deliver GMS to the communities of Northfield and Mastrick. A key condition of the offer of contract was that the provider commits to the ongoing delivery of services within the communities of Mastrick and Northfield. The Northfield and Mastrick Practice is now an independent practice under the new name of the Aurora Medical Practice.

The proposed option, is to build a single new integrated Community Hub for the delivery of health and care services at a Greenfield Site in the Central locality in close proximity to the existing services in the communities of Northfield and Mastrick. This will be a purpose built facility with a Schedule of Accommodation designed to maximise utilisation of space and encourage increased community access through flexible use of the buildings. This will ensure the sustainability of the future service model from a 3 site to a 1 site model with patients getting access to equitable GMS provision within close proximity to the existing Denburn Health Centre (from wider Central Locality Practices, Northfield Surgery and Mastrick Clinic (from a new purpose built facility within close proximity to the existing Practices).

All newbuild options on a Greenfield site will be identified within close proximity to the communities of Northfield / Mastrick. The Initial Agreement sets out the investment for improved facilities to provide GMS to these communities. The aim moving forward will be to ensure patients are aware this is not the removal or reduction of service but an investment in purpose built facilities to extend the service delivery model to better meet the needs of the population, ensure the

sustainability of GMS in those communities and increase access to GMS for people in these communities who are currently registered with other GPs across the City (most of which are registered with City Centre Practices).

It is anticipated that the capital costs will be financed partly from NHS Grampian's formula capital allocation (£5m) supplemented by additional capital funding of £3.1m allocated specifically to support the project by the Scottish Government Health Finance Directorate. This is a significant investment in facilities to improve the wellbeing of the population and reduce health inequalities.

During the period of review the Project Team were unable to undertake consultation of communication with the Denburn / Aurora Medical Grouping patients and point of care staff to allow for the formal staff transfer and TUPE process to conclude and the new service to bed in. Following consultation with the new Aurora/Denburn Medical Group and the NHSG Public Engagement Officers, it was agreed to run additional 'drop in sessions' at the Denburn Health Centre and the first in a series of 'drop in sessions' at the Northfield Surgery and Mastrick clinic in early January 2018. In addition, 'drop in sessions' and 1-2-1 briefings were offered to Ward Councillors and MSPs to brief them on the submission of a refreshed Initial Agreement in February 2018.

A detailed programme of consultation will commence from February 2018 to engage the Denburn, Northfield and Mastrick patients and wider community on the following aspects to be further developed in the Outline Business Case and Full Business Case:

- Proposed service delivery model
- Benefit realisation for the community
- Design quality statement
- Site options
- Site design options

The programme of consultation will include emails, newsletters, social media communications, public events and invitations to workshops. A Community Engagement Group was established in November 2017 to develop the programme of work and the NHSG Public Engagement Officers are seeking to secure wider representation on that group from patients and public representatives from the Denburn Health Centre, Northfield Surgery and Mastrick Clinic. A briefing is being developed for circulation following the NHSG Board on the 1st of February 2018 to advise the public how they can engage in future public consultations. Community feedback will be included in the ongoing development of the Outline Business Case (OBC) and Full Business Case (FBC) up to the final submission to CIG in

INTEGRATION JOINT BOARD

September 2019.

Appendices

- NHS Grampian Infrastructure Investment Initial Agreement for the Investment in Facilities to Support the Redesign and Modernisation of Primary and Community Care Services in Aberdeen City (embargoed until the NHS Grampian Board on the 7th of December 2017).

3:	Equalities, Financial, Workforce and Other Implications

Equalities, financial, workforce and other implications are considered robustly throughout the report and the full initial agreement.

4:	Management of Risk

Identified risk(s):

The Risk Register (RR) will be finalised at the OBC stage and will set out more detail around the consequence, likelihood and specific action taken to manage or mitigate the risks. Risks for the IJB at IA stage have been identified in the following:-

- Securing a Greenfield site within close proximity to the existing services in the communities of Northfield and Mastrick
- Patient support for the proposed new service delivery model during OBC and FBC consultation
- Reviewing Practice boundaries and managing the redistribution of patients to GMS closer to their own communities
- Scottish Government Health and Social Care Directorate approval of additional £3.1m funding to ensure the case is deemed affordable at OBC and FBC stage and that the investment in infrastructure enables the IJB vision for the future delivery of Primary and Community Care Services

Link to risk number on strategic or operational risk register:

9: There is a risk that the IJB does not maximise the opportunities offered by locality working.

INTEGRATION JOINT BOARD

10: Workforce planning across the Partnership is not sophisticated enough to maintain future service delivery. **How might the content of this report impact or mitigate the known risks:** The project has a detailed Risk Register in place in line with SCIM Guidance which is reported to the North Corridor Programme Board.

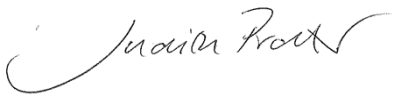
5:	**Recommendations**

It is recommended that the Integration Joint Board:

1. Note the initial agreement as outlined in appendix A and that it aligns with the IJB's strategic vision for primary care, prior to submission to the Scottish Government Health & Social Care directorate Capital Investment Group in January 2018;

2. Note that the Initial Agreement will be presented to the NHS Board on the 7th of December and that a consultation process will now commence; and

3. Note that the Chief Officer chairs the programme board and that under Government requirements that the NHS Grampian Board is the decision maker for capital projects.

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

NHS GRAMPIAN

INFRASTRUCTURE INVESTMENT

Initial Agreement for the Investment in Facilities to Support the Redesign and Modernisation of Primary and Community Care Services in Aberdeen City

1. Actions Recommended

The Board is asked to approve, for submission to the Scottish Government Capital Investment Group (CIG), the revised Initial Agreement for the Investment in Facilities to Support the Redesign and Modernisation of Primary and Community Care Services in Aberdeen City.

2. Strategic Context

The Asset Management Plan, approved by the Board in June 2017, sets out a programme of investment in our infrastructure linked to NHS Grampian's Clinical Strategy and supporting the strategic theme of delivering high quality care in the right place through providing safer, effective and sustainable services.

The matters outlined for Board approval in this paper relate to planned investment in infrastructure, consistent with our strategic themes that will deliver:

- improvements in patient experience and environment (person centred) and
- negate backlog risks (safe).

3. Key matters relevant to recommendation

The Initial Agreement is the first phase in the business planning process for the project. The Initial Agreement describes the strategic context within which the proposed investment will take place and to establish the position of the project in relation to NHS Grampian's overall organisation and service strategies. Following approval of the Initial Agreement the two subsequent phases of the business planning process will involve the development and approval of Outline and Full Business Cases.

The Initial Agreement aims to:

- Establish the case for change and strategic fit with NHS Grampian's corporate/service strategies and with national policies and priorities

- Clearly identify the desired outcomes from the proposed project

- Provide stakeholders with an early indication of the preferred way forward for the project

3.1 Previous approval

An Initial Agreement for this project was previously approved by the Board and the Scottish Government CIG in December 2014. This identified the following key drivers for change:

- the poor condition and inadequacies in the current facilities at Denburn Health Centre which severely limits the future opportunities for the development and change needed to ensure modern services can be delivered effectively and efficiently, and

- the continued growth of the City population, predominantly in new housing schemes planned for the green belt surrounding the City, which will require a redistribution of healthcare premises throughout the City to meet NHS Grampian's ambition to ensure primary health care services are delivered locally and are an integral part of the community.

3.2 Changes in underlying assumptions

Subsequent to the approval granted by the Board, in December 2014, the following assumptions underlying the initial case were revisited:

3.2.1 Economic landscape and impact on spread of housing development

While the rest of the UK economy is recovering from the 2008 Economic Downturn, Aberdeen is now experiencing a decline of its own due to the drop in price of oil[1]. The movement of oil and gas workers out with the City is also having an impact on new housing developments. A number of proposed developments, including two of the largest developments in the West Locality (Maidencraig and Countesswells) have reduced the size and number of units to be built in the coming years. There has also been a notable slow down in the completion of each phase of live housing developments as completed units are selling at a significantly slower rate than initial projections. Planning assumptions have been updated in line with the revised targets set out in the Aberdeen City and Shire Strategic Development Plan (SDP).

3.2.2 Succession and Service Sustainability

The Northfield and Mastrick Medical Practice has historically experienced significant pressures with the recruitment and retention of staff. Further turnover in General Practitioner (GP) staffing at the practice, towards the end of 2016, prompted a full review of the service. This concluded with the Denburn Medical Practice being awarded a contract to provide General Medical Services within the Northfield and Mastrick area, in addition to their existing practice responsibilities. The Northfield and Mastrick medical practice was renamed the Aurora Medical Practice which, together with the Denburn Medical Practice now forms a new general practice grouping that co-ordinates its services across three sites, Denburn Health Centre, Northfield Surgery and Mastrick Clinic.

[1] Community Planning Aberdeen 'Local Outcome Improvement Plan' (2016)

This arrangement will ensure the ongoing delivery of services to the immediate and wider Locality communities and, moving forward, will provide a platform for the development of capacity to service new and growing communities in the adjacent West Locality.

3.2.3 Population Demographic and impact on health and social care

Changes in the population demographic include a population that is living longer, low birth rates, changing family structures and high levels of inward migration. There is an increasing rate of people presenting with multiple morbidities in the general population and the ageing population with more complex and Long Term Conditions. The most significant changes in the disease incidence profile will be an increase in the prevalence of the following complex and Long Term Conditions; palliative care, learning disabilities, mental health, asthma, coronary heart disease, chronic obstructive pulmonary disease (COPD), cardiovascular disease, diabetes, epilepsy, stroke, transient ischemic attack (TIA), peripheral arterial disease, obesity and osteoporosis. The disease incidence profile also shows that people living in the most deprived communities continue to experience greater health inequalities; this includes the Northfield and Mastrick areas.

3.3 Other factors affecting the case for change

3.3.1 Clinical Service Provision

The Aurora/Denburn Medical Practice grouping currently provides General Medical Services and works closely with aligned community health and social care services to provide integrated care for their practice population of 16,337 across the three locations, Denburn Health Centre, Northfield Clinic and Mastrick Clinic.

From April 2017, a Triage Model of Care, initially developed within the Denburn Medical Practice, was in place serving all three locations. There are arrangements in place to help manage clinical demand between the three sites using remote telephonic working but the geographical separation, poor state of repair and functional limitations on building design, significantly impede the practice's plans to improve range, quality and access to services, through the introduction of innovative models of service delivery and more efficient working practices. These restrictions also inhibit the ability to involve other healthcare professional disciplines in the model of care.

3.3.2 State of Physical Premises

All three buildings are not considered functionally suitable to support modern primary health care provision and require significant investment to deal with essential backlog maintenance and statutory compliance issues. The backlog maintenance risk assessed at Denburn Health Centre, and included in NHS Grampians Asset Management Plan, is quantified as £6.4m. This figure however, is quoted before fees, VAT and other project related costs, and recent experience of delivering large backlog maintenance projects would suggest a more realistic estimate of the investment required to extend the useful life of the existing building for a further 10 to 15 years would be £20m. There is also no expansion space at the Northfield

Surgery and Mastrick Clinic to meet the demand from the current population, many of which are seeking GMS services from elsewhere in the City.

All three locations are identified as a priority for replacement in the NHS Grampian (NHSG) Asset Management Plan (AMP).

3.3.3 Spread of Population and General Practice Boundaries

Historically there have been no defined general practice boundaries within Aberdeen City and many natural communities are serviced by multiple practices. The Aurora/Denburn Practice grouping is no exception with a widely disparate practice population serviced across three geographically dispersed centres.

One of the key aims set out in the Aberdeen City HSCP Strategic Plan (2016-19) is to ensure services are provided at a community or locality level where it is more effective or efficient to do so. In order to achieve this there is a need to match capacity to the growing demand for services across the City by “rebalancing” the current distribution of service provision, which is heavily weighted towards the City Centre.

3.3.4 Case for Change

Recognising the key issues outlined above, the revised strategic assessment for the project now includes the following drivers for change:

(i) the delivery of integrated Primary and Community Care Services focused on the needs of the local community,

(ii) continued growth in the population in the Green Belt areas away from the City Centre,

(iii) poor condition of the current Denburn Health Centre premises in the City Centre of the Central Locality means that the building is unfit for purpose, with a limited period of operational use and no expansion space, and limited life of the Northfield and Mastrick premises,

(iv) decant of all other services from the Denburn Health Centre to the Health and Care Village, Frederick Street, City Centre in the Central Locality, and

(v) destabilisation of the practice as current facilities do not enable the service to progress the transformational change required to further modernise and enhance service delivery, and

(vi) Securing the provision of GMS Services for existing communities, specifically Northfield and Mastrick in the Central Locality.

3.4 Option appraisal

3.4.1 Service Model

The Project Group engaged in an extensive review and option appraisal process, involving consultation with all key stakeholders.

The first step in this process was to agree the model of service necessary to meet the health needs of the patient populations registered with the Aurora/Denburn Medical Practice grouping.

The analysis of health needs was informed by the demographic composition of the patient lists, practice deprivation profile, distribution of the practice population, population health trends and disease prevalence and a review of the number of displaced patients living in the communities of Northfield, Mastrick and Cornhill who access General Medical Services elsewhere in the City.

The outcome was agreement on an innovative model of primary care service delivery, building on the Triage model already in place. The key aspects of the proposed service model to be taken to the Denburn/Aurora Practice grouping patients and the communities of greater Northfield and Mastrick are summarised as follows:

- A triage and video consultation Hub to ensure a no appointment backlog service for patients and incorporating facilities to support training.

- Enhanced use of technology and diagnostic services to build on the Triage model, diagnostic pods, attend anywhere, telemedicine, telephone consultation and screening.

- An asynchronous care model making full use of email consultation.

- Co-location of all practice and aligned staff e.g. community nursing, AHPs and Social services professionals.

- Clinicians and professionals share flexible and adaptive clinical space and bookable multi-purpose rooms with facilities for visiting services. There will be a single integrated reception area, shared administration space and staff facilities, a waiting area that is flexible and can be used by the community in the evenings and weekends.

- Support for clinicians to use the Clinical Guidance Internet for PCCS.

- Electronic record storage.

- Improved integrated working between health and community care teams to impact on reducing unplanned admissions to hospital through a greater anticipation of need and increasing the ability to provide specialist planned care closer to home.

- Redesign of care pathways to improve access to PCCS and a more integrated and community based approach to supporting those with Long Term Conditions.

- The roles of Primary Care Mental Health Workers, Link Workers, Physician Associates and an integrated model of working with Social Work Care Management will be extended and embedded in the new service delivery model.

- Integrated care management to provide support in the community to people with the most complex medical and social needs to reduce unplanned admissions and delayed hospital discharge for the +75s.

- Joint working with local Pharmacies delivering the Extended Pharmacy Role.

In early January 2018, additional briefings took place with Ward Councillors and 'drop in sessions' held in the Denburn Health Centre, Northfield Surgery and Mastrick Clinic to consult patients on 'what matters'. A more in depth period of consultation and engagement will commenced from February 2018 up to the final submission of the Full Business Base in September 2019.

3.4.2 Physical Infrastructure to support the service model

An initial 'Long List' of options for the associated physical infrastructure required to support this service model was then developed. Each option was scored against the investment objectives and refined down to a 'Short List' of 3 options to be taken forward to the next stage for detailed consideration.

The Short listed Options are summarised below:

Option	Description	Score
1	New build on Greenfield site close Northfield and reconfigure Mastrick.	57.14%
2	Newbuild at Greenfield site general maintenance at Mastrick and close Northfield.	57.14%
3	Newbuild Greenfield (extended service model) and close Denburn, Northfield and Mastrick.	100%

Note: All newbuild options on a Greenfield site will be identified within close proximity to the communities of Northfield / Mastrick. The Initial Agreement sets out the investment for improved facilities to provide GMS to these communities. There will be a programme of communication with those communities from January 2018 to ensure they are aware this is not the removal or reduction of service but an investment in purpose built facilities to extend the service delivery model to better meet the needs of the population, ensure the sustainability of GMS in those communities and increase access to GMS for people in these communities who are currently registered with other GPs across the City (most of which are registered with City Centre Practices).

The Preferred Way Forward Option 3 is to build a single new integrated Community Hub for the delivery of health and care services at a Greenfield Site in the Central

locality in close proximity to the current services in Northfield / Mastrick. This will be a purpose built facility with a Schedule of Accommodation designed to maximise utilisation of space and encourage increased community access through flexible use of the buildings.

The proposed innovative design will include a custom built triage and video consultation Hub, shared clinical space, multipurpose bookable rooms, hot desking facilities for other Partner Organisations including Third Sector, electronic records, additional sessional clinics and targeted public health programmes and shared service areas (e.g. waiting rooms, receptions and joint staff facilities). This will create the basic infrastructure platform to enable the practice to further develop extended delivery models including the triage Hub and introduce new ways of working by extending the use of technology enabled care, improving efficiency to ensure no appointment backlog and a same day service for patients. A programme of consultation with the patients and communities on the detail of the proposed service delivery model will commence from February 2018. The feedback from patients and communities will be incorporated in the Outline Business Case and Final Business Case to be submitted in September 2019.

In addition, the new facility will allow the service delivery model to be enhanced to include access to additional support sessions from a range of professionals in health, care and welfare support services to enable will better support patients to direct their own care and self-manage their health and wellbeing, where appropriate e.g. supported by the Link Worker to self-refer to other support services.

3.5 Financial Case

3.5.1 Capital Costs

The indicative capital costs for the programme of works for the Preferred Way Forward is £8.1m (inclusive of VAT and fees), including land purchase, enabling works and a provision for moveable equipment. This investment will deliver a facility to support the preferred service solution based on the current practice list size. The intention is to design the building to allow future expansion of up to 50% of the current capacity to be built on at a later stage.

The practice has an aspiration to grow the list size significantly, based on current population projections. An option was considered to build this capacity for growth, including room for enhanced acute service provision in the community e.g. diagnostic radiology, in to the design at the outset. The capital cost of this option was £12.2m but recognising the conflicting priorities for the use of scarce capital resource and the 5 to10 year timescale to achieve this level of growth in population, it was agreed to limit the size of the development to reflect the current practice population with some capacity to absorb limited growth through new and innovative ways of working.

The capital costs will be financed partly from NHS Grampian's formula capital allocation (£5m) supplemented by additional capital funding of £3.1m allocated specifically to support the project by the Scottish Government Health Finance Directorate.

3.5.2 Indicative Revenue Costs

The innovative approach to be adopted in the use of the accommodation will result in a net reduction in the overall footprint and it is anticipated that revenue running costs of the buildings will be managed within existing resources.

It is assumed that any development in services for patients arising as a consequence of the development will be met within existing resources.

3.6 Procurement

The Board is committed, through a process mandated by the Scottish Government, to an exclusivity agreement that guarantees Hub North Scotland Limited, first refusal on all construction contracts for physical alteration or new build of community premises if the capital value is in excess of £750,000.

All investment in hub projects complies with relevant Scottish Government and European Union procurement regulations.

External advisors for Technical and Legal services will be procured by NHSG to scrutinise design stage submissions, and to assist the Project Team in the administration of the project.

3.7 Project Management Arrangements and Timescales

This project has followed the Scottish Government, Health and Social Care Directorate (SGHSCD) Scottish Capital Investment Manual (SCIM) Guidance 2016. This ensured a robust Programme and Project Management (PPM) approach to the development of Strategic Assessment (approved in early 2014), the submission of an Initial Agreement (approved in 2014), the submission of a revised Initial Agreement (January 2018) to the SGHSCD Capital Investment Group (CIG). The revised Initial Agreement complies with the new standards set out in the 2016 SCIM Guidance.

The next stage will be more in depth engagement with key stakeholders, including Councillors, patients and the wider communities to submit the Outline Business Base and Final Business Case.

The following table provides indicative timescales for completion of key milestones for delivery of the project:

Outline Business Case approval	December 2018
Full Business Case approval	September 2019
Land Purchase Concluded	September 2019
Commence construction	October 2019
Completion of new centre	December 2020

4. Risk Mitigation

Approval of the recommendations as outlined will assist in mitigating Strategic Risk 855 *by ensuring that we implement an asset investment, disposal and backlog maintenance programme or redesign of service provision to reduce dependence on physical buildings.*

5. Responsible Executive Director and contact for further information

If you require any further information in advance of the meeting please contact:

Responsible Executive Director
Alan Gray
Director of Finance
alangray@nhs.net

Judith Proctor
Chief Officer
Aberdeen City Health & Social Care Partnership
JProctor@aberdeencity.gov.uk

Contact for further information
Garry Kidd
Assistant Director or Finance
garry.kidd@nhs.net

Kay Dunn
Lead Planning Manager
Aberdeen City Health & Social Care Partnership
kay.dunn1@nhs.net

1 February 2018

Additional supporting information:

Initial Agreement for the Investment in Facilities to Support the Redesign and Modernisation of Primary and Community Care Services in Aberdeen City.

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