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Aberdeen City Health & Social Care Partnership
A caring partnership

To: Members of the Integration Joint Board

Town House,
ABERDEEN, 4 December 2018

INTEGRATION JOINT BOARD

The Members of the **INTEGRATION JOINT BOARD** are requested to meet in **Meeting Room 5, Health Village on TUESDAY, 11 DECEMBER 2018 at 10.00 am**.

FRASER BELL
CHIEF OFFICER - GOVERNANCE

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

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 Board Meeting of 9 October 2018 (Pages 5 - 16)

4b Matters Arising

5 Draft Minute of Audit and Performance Systems Committee of 13 November 2018 (Pages 17 - 24)

6 Draft Minute of Clinical and Care Governance Committee of 27 November 2018 (Pages 25 - 32)

7 Business Statement (Pages 33 - 38)

STEWARDSHIP

8 IJB Budget Meeting - Date Change (Pages 39 - 42)

PERFORMANCE AND FINANCE

9 Chief Social Work Officer Annual Report (Pages 43 - 84)

10 Performance Monitoring (Pages 85 - 102)

STRATEGY

11 Draft Strategic Plan (Pages 103 - 144)

12 Autism Strategy (Pages 145 - 188)

13 Carers Short Break Statement (Pages 189 - 216)

14 Draft Commissioning Brief for Strategic Planning Process for Care of the Elderly (Pages 217 - 238)

15 Alcohol and Drugs Partnership Investment Plan (Pages 239 - 258)

Members, please note that the appendix is unsigned due to the file size of the signed document

AUDIT

16 Audit Scotland Report (Pages 259 - 310)

ITEMS THE BOARD MAY WISH TO CONSIDER IN PRIVATE

17 Chief Officer's Update

TRANSFORMATION

18 Transformation Decisions Required (Pages 311 - 330)

STRATEGY

19 Commissioning and Procurement Workplan (Pages 331 - 370)

20 Countesswells - to follow

WORKSHOP

21 Finance Workshop

This workshop will provide a refresher on funding and reporting routes; a review on the financial performance for the year 2018/19 to date; and will begin some preparatory work relating to the budget setting for 2019/20. Time will also be given for discussion on social care charging.

Website Address: https://www.aberdeencityhscp.scot/

Should you require any further information about this agenda, please contact Steph Dunsmuir, tel 01224 522503 or email sdunsmuir@aberdeencity.gov.uk

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INTEGRATION JOINT BOARD

Minute of Meeting

09 October 2018
Health Village, Aberdeen

Present: Jonathan Passmore MBE (Chairperson); Councillor Sarah Duncan (Vice Chairperson); and Councillors Lesley Dunbar (as substitute for Councillor Laing, for agenda items 10-17), Avril MacKenzie (as substitute for Councillor Imrie) and Samarai; and Rhona Atkinson, Professor Steve Heys and Luan Grugeon (NHS Grampian Board members); Mike Adams, Partnership Representative, NHS Grampian), Jim Currie (Trade Union Representative, Aberdeen City Council (ACC), for agenda items 1-16), Kenneth Simpson (Third Sector Representative, for agenda items 1-16), Howard Gemmell (Patient and Service User Representative), Faith-Jason Robertson-Foy and Gill Moffat (Carer Representatives), Heather MacRae, (Professional Nursing Adviser, NHS Grampian), Graeme Simpson (Chief Social Work Officer, for agenda items 1-15), Claire Duncan (as substitute for Graeme Simpson, for agenda items 16-17), Sandra Ross (Chief Officer, Aberdeen City Health and Social Care Partnership (ACHSCP)), Dr Caroline Howarth (as substitute for the Clinical Director, ACHSCP) and Alex Stephen (Chief Finance Officer, ACHSCP).

Also in attendance: Iain Robertson and Jess Anderson (Governance, ACC), Martin Allan (Business Manager, ACHSCP for agenda item 9), Kenneth O'Brien (Service Manager, ACHSCP or agenda item 11), Alison MacLeod (Lead Strategy and Performance Manager, ACHSCP for agenda item 12), Kevin Toshney (Planning and Development Manager, ACHSCP for agenda item 13), Lorraine McKenna (Head of Central Locality, ACHSCP for agenda item 14), Claire Wilkie (Service Manager, Mental Health and Substance Misuse, ACHSCP, for agenda item 16) and Alan Thomson (Governance, ACC, for agenda item 17).

Apologies: Councillor Laing, Councillor Imrie, Dr Malcolm Metcalfe 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 Sandra Ross to her first Board meeting as Chief Officer of the Partnership. He advised that he had found both the Strategic Planning workshop and the Partnership's annual conference to be very informative and noted that he received a good deal of assurance that the Board had sound governance arrangements in place following the Standards Commission's IJB workshop on 24 September 2018. He explained that one of the key issues which had arisen from the Standards Commission workshop was the role of service user and carer representatives on IJBs and whether they felt valued. Gill Moffat confirmed that she and her colleagues had always felt valued on the Aberdeen City IJB.

The Chair also highlighted that Jenny Laing (Occupational Therapy, Bon Accord Care) had represented the Partnership during a roundtable meeting on housing adaptations held by the Scottish Parliament's Local Government and Communities Committee on 3 October 2018 and recommended that Members watch the meeting as it was now available online Here.

The Board resolved:-
(i) to welcome Sandra Ross to her first Board meeting as Chief Officer of the Partnership;
(ii) to thank all those involved with the organisation and delivery of the annual conference and Strategic Planning workshop;
(iii) to thank Jenny Laing for representing the Partnership at the Local Government and Communities Committee on 3 October 2018.; and
(iv) otherwise note the information provided.

DECLARATION OF INTERESTS

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

Howard Gemmell declared an interest in agenda item 12 (Disabled Adaptations) as he may possibly be a user of this service in the near future but advised that he would remain in the meeting during consideration of this item.

Kenneth Simpson declared an interest in agenda item 16 (Mental Health Commissioning) as he was a member of the Aberdeen Council of Voluntary organisations (ACVO) Board but advised that he would remain in the meeting during consideration of this item.

The Board resolved:-
To note the declarations of interest intimated.

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DETERMINATION OF EXEMPT BUSINESS

3. The Chair proposed that agenda item 17 be considered with the press and public excluded.

<u>The Board resolved</u>:-
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 paragraph 8 of Schedule 7(A) of the Act.

MINUTE OF IJB MEETING – 28 AUGUST 2018

4. The Board had before it the minute of the IJB meeting of 28 August 2018.

<u>The Board resolved</u>:-
To approve the minute as a correct record.

MATTERS ARISING

5. The Chair asked if there were any matters arising from the meeting of 28 August 2018.

<u>The Board resolved</u>:-
(i) to request that the Chairs of the Audit and Performance Systems Committee and Clinical and Care Governance Committee discuss areas where the remits of their committees overlap to ensure alignment and reduce duplication; and
(ii) otherwise note the information provided.

DRAFT MINUTE OF CLINICAL AND CARE GOVERNANCE COMMITTEE MEETING – 4 SEPTEMBER 2018

6. The Board had before it the draft minute of the Clinical and Care Governance Committee of 4 September 2018 for information.

<u>The Board resolved</u>:-
To note the draft minute.

DRAFT MINUTE OF AUDIT AND PERFORMANCE SYSTEMS COMMITTEE MEETING – 11 SEPTEMBER 2018

7. The Board had before it the draft minute of the Audit and Performance Systems Committee of 11 September 2018 for information.

<u>The Board resolved</u>:-
To note the draft minute.

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BUSINESS STATEMENT

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

The Board resolved:-
(i) to remove item 4 (Board Development Work), item 7 (Primary Care) and item 12 (Prescribing) from the Statement;
(ii) to agree that a dedicated update on prescribing would be provided to the Board within the regular Finance Report; and
(iii) otherwise note the Statement.

IJB MEETING DATES 2019-2020

9. The Board had before it a report by Iain Robertson (Committee Services Officer, ACC) which proposed meeting and developmental workshop schedules for the Board for 2019-20.

The report recommended:-
That the Board-
(a) Approve the IJB meeting schedule for 2019-20;
(b) Approve the stand-alone developmental workshop schedule for 2019-20; and
(c) Instruct the Chief Officer to publish the IJB meeting schedule on the Partnership's website.

Iain Robertson proposed the following dates for IJB business meetings and developmental workshop sessions:-

IJB Business Meetings:

10:00am,11 June 2019 - Health Village;
10:00am, 3 September 2019 - Health Village;
10:00am, 19 November 2019 - Health Village;
10:00am, 21 January 2020 - Health Village;
10:00am, 11 February 2020 (Budget Meeting) - Health Village;
10:00am, 10 March 2020 **(Provisional 2nd Budget Meeting)** - Health Village; and
10:00am, 24 March 2020 - Health Village.

Developmental Workshop Sessions:

10:00am, 16 April 2019 - Foresterhill Health Centre;
10:00am, 13 August 2019 - Seminar Room, Woodend Hospital;
10:00am, 8 October 2019 - 4 – W – 01 Marischal College; and
10:00am, 3 December 2019 - Lewis Room, Royal Cornhill Hospital.

Thereafter there was discussion on the best way of ensuring that workshop venues across the city were accessible to all IJB members and officers, particularly those with mobility issues.

The Board resolved:-
(i) to approve the recommendations; and

(ii) to instruct the Chief Officer to make appropriate arrangements for Members with mobility issues to ensure they can attend Developmental Workshop sessions out with the Health Village.

STRATEGIC RISK REGISTER REVIEW

10. The Board had before it a report by Martin Allan (Business Manager, ACHSCP) which presented the revised version of the ACHSCP strategic risk register and risk appetite statement.

The report recommended:-
That the Board-
(a) Note the revised risk appetite statement; and
(b) Note the revised risk register.

Martin Allan advised that the risk register and risk appetite statement had been reviewed following the risk workshop on 24 April 2018 and added that the Audit and Performance Systems Committee would treat the risk register as a living document by conducting deep dives of three separate risks at each Committee meeting. Mr Allan also asked the Board to provide a steer on its appetite for risks relating to commissioned and hosted services.

Thereafter there were questions and comments on (1) how frequently the register would be reported to the Board; (2) the importance of capturing risks relating to the Brexit transition process; (3) the need to develop a communication plan which would set out the Board's approach towards risk management; and (4) Members discussed the risks associated with commissioned and hosted services and noted that this was a complex area and requested that a draft proposal be presented to the next meeting of the Audit and Performance Systems Committee for further discussion and development.

The Board resolved
(i) to endorse the revised risk appetite statement;
(ii) to endorse the revised risk register;
(iii) to instruct the Chief Officer to capture risks relating to the Brexit transition process within the Risk Register and to report this update to the Board's next meeting;
(iv) to instruct the Business Manager to populate gaps within the Risk Appetite Statement relating to Commissioned and Hosted Services and report this to the next meeting of the Audit and Performance Systems Committee;
(v) to agree that the Audit and Performance Systems Committee would escalate a risk to the IJB if the Committee agreed that any risk rating within the Strategic Risk Register should be increased;
(vi) to instruct the Chief Officer to develop a communication plan which would inform service users and stakeholders of the Board's approach towards risk management; and
(vii) to agree to review the Risk Register on an annual basis.

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MEDIUM-TERM FINANCIAL STRATEGY NARRATIVE REVIEW

11. The Board had before it a report by Alex Stephen (Chief Finance Officer, ACHSCP) which updated the narrative and figures contained in the Medium-Term Financial Strategy (MTFS) approved by the Board on 27 March 2018.

The report recommended:-
That the Board -
(a) Note the updated elements of the Medium-Term Financial Strategy; and
(b) Note that a further report on the_Medium-Term Financial Strategy would be brought back to the IJB in February 2019.

Alex Stephen advised that a high level review of the MTFS had been conducted which found that current assumptions remained in line with projections reported to the Board on 27 March 2018, with the exception of pay award assumptions. He added that a report on charging for the use of health and social care services and equipment would be presented to the Board's next meeting on 11 December 2018.

Thereafter there were questions and comments on (1) how the MTFS linked in with the risk appetite statement; (2) the process in place for reporting outcomes of service reviews to the Board and its committees; (3) the financial and governance challenges of managing hosted services, with particular discussion on the role and output of the North East Partnership; and (4) the Chief Finance Officer confirmed that NHS Grampian used the mid-point of salary grades as the basis for its assumptions on the financial impact of staff pay awards.

The Board resolved:-
To approve the recommendations.

WINTER PLAN SIGN OFF

12. The Board had before it a report by Kenneth O'Brien (Service Manager, ACHSCP) which (1) provided a brief description of the context and process behind the creation of the current Winter Plan for the Partnership; (2) documented the testing arrangements put in place regarding the 2018-19 Winter Plan; and (3) set out monitoring arrangements for the Winter Plan.

The report recommended:-
That the Board –
(a) Review and approve the 2018-19 Winter Plan ACHSCP and instruct the Chief Officer to send the Plan to NHS Grampian for inclusion in the Grampian-wide Winter Plan; and
(b) Endorse the review arrangements for the ACHSCP Winter Plan for over the 2018-19 winter period.

Kenneth O'Brien advised that the Partnership was required to produce a winter plan which covered the scope of its services and included plans for surge demand and difficulty in delivering services over the winter period. Mr O'Brien explained that planning for winter 2018-19 began with a de-brief of the previous plan during February and March 2018, and following this de-brief the Partnership and NHS

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Grampian's senior management teams had been developing and testing the new winter plan. He noted that if the Partnership's winter plan was approved at today's meeting it would then be incorporated into the wider NHS Grampian winter plan.

Thereafter there were questions and comments on (1) what lessons had been learned from last year's plan; (2) the importance of focussing on prevention as well as statutory activity, and the Board noted that it would be beneficial if the Third and Independent Sectors were consulted on this section ahead of next year's winter plan; and (3) Mr O'Brien provided the Board with an update on the Partnership's efforts to improve the uptake of flu jabs.

The Board resolved:-
(i) to approve the recommendations; and
(ii) to note that regular updates on the implementation of the Winter Plan would be provided to the Clinical and Care Governance Committee.

DECLARATION OF INTEREST

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

DISABLED ADAPTATIONS

13. The Board had before it a report by Alison MacLeod (Lead Strategy and Performance Manager, ACHSCP) which advised of the various arrangements that currently exist in relation to Disabled Adaptations and sought approval for the development of new arrangements going forward which would provide the IJB with greater assurance in relation to its role in managing this delegated function.

The report recommended:-
That the Board –
(a) Note the current situation with regards to managing Disabled Adaptations in the various tenures and their responsibilities for this delegated function; and
(b) Establish a Task and Finish Group to negotiate new arrangements that provide the IJB with greater assurance in relation to the management of Disabled Adaptations enabling these to continue to be delivered utilising the necessary expertise and meeting desired outcomes. The Task and Finish Group would also oversee the transition from the current arrangements to the new ones, reviewing processes and procedures and identifying options for efficiencies.

Alison MacLeod advised that responsibility for disabled adaptations formerly rested with Aberdeen City Council but this area had now been delegated to the Partnership. She explained that the report proposed new arrangements for managing this delegated function.

Thereafter there were questions and comments on (1) the roles and remits of the Task and Finish Group and Disabled Adaptations Group; (2) the procurement

process that would be required prior to the adaptation of a property; (3) the role of the Council's Private Sector Housing Team in the administration of adaptation grants; (4) the benefits of having service user representation on the Disabled Adaptations Group; (5) the importance of engaging with private housing developers to encourage the design and development of more adaptable housing units; and (6) Members discussed the importance of establishing good relationships with owners, landlords and tenants to receive assurance on the standard of properties prior to adaptation.

The Board resolved:-

(i) to note the current situation with regards to managing Disabled Adaptations in the various tenures and their responsibilities for this delegated function;

(ii) to instruct the Chief Officer to explore the possibility of having service user representation on the Disabled Adaptations Group; and

(iii) to note that progress updates and assurance on disabled adaptations would be reported to the Clinical and Care Governance Committee on a regular basis.

STRATEGIC PLAN REVIEW

14. The Board had before it a report by Kevin Toshney which presented an initial working draft of the Strategic Plan 2019-2022 for consideration.

The report recommended:-

That the Board –

(a) Note the draft Strategic Plan; and

(b) Agree for a draft consultation version of the Strategic Plan 2019-2022 to be presented to the next IJB meeting.

Kevin Toshney advised that the Board was statutorily required to produce a Strategic Plan to replace the existing three-year plan which was due to expire in March 2019. Mr Toshney provided an overview of the governance milestones and the engagement activity the Partnership had undertaken to inform the refreshed three year plan and advised that a new suite of indicators would be developed to monitor the achievement of priority areas. He added that following the refresh of the Strategic Plan, the Partnership would review its portfolio of strategic documents.

Thereafter there were questions and comments on (1) ensuring that future commissioning practice would include solutions co-designed and co-produced with partners and communities; (2) including more information within the Plan on staff development and the Board's endorsement of the Ethical Care Charter; (3) making the Plan as easy to read and user-friendly as possible; (4) re-emphasising the priority that patients and service users are empowered to manage their own health care; (5) ensuring that the Plan aligned with the Primary Care Improvement Plan; (6) making greater reference to tackling inequalities and the role of unpaid carers in this regard; (7) making reference to the Council's Anti-Poverty Strategy as a way to tackle health inequalities and to achieve strategic coherence with key partners; and (8) the importance of engaging with people who did not regularly use health and social care services before the age of 65.

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The Board resolved:-
(i) to approve the recommendations; and
(ii) to request that Members submit any editorial issues to Kevin Toshney ahead of publication of the Consultation Draft;
(iii) to request that more emphasis on prevention and empowering patients/service users be included within the Consultation Draft;
(iv) to request that more detail on staff development and the Ethical Care Charter be included within the Consultation Draft;
(v) to review the table on p155 with a view to making it easier to understand for all readers; and
(vi) to request that greater references are made to health inequalities and Aberdeen City Council's Anti-Poverty Strategy within the Consultation Draft.

LOCALITIES UPDATE

15. The Board had before it a report by Sandra Ross (Chief Officer, ACHSCP) which sought approval for the intent to move to a three-locality model for the Partnership that would be in alignment with Community Planning Aberdeen locality partnerships.

The report recommended:-
That the Board instruct the Chief Officer to review the locality structure and consult with relevant stakeholders and staff on the proposal to move from a four to a three-locality model and report back to the IJB on 26th of March 2019 with the results of this review and consultation along with the new Strategic Plan once finalised.

Sandra Ross advised that options on future locality working would be reviewed during the refresh of the three-year Strategic Plan and explained that as part of this process, the Partnership would look at the option of moving to a three locality model to align with the locality model put in place by Community Planning Aberdeen.

Thereafter there were questions and comments on (1) the potential workforce and financial implications of moving to a three-locality model; and (2) the Chief Officer confirmed that it would be business as usual for existing localities whilst the review was ongoing.

The Board resolved:-
(i) to approve the recommendation; and
(ii) to request the Chief Officer to provide further information to Jim Currie on the potential implications for staff if the Board agreed to adopt a three-locality model.

ROSEMOUNT MEDICAL GROUP UPDATE

16. The Board had before it a report by Lorraine McKenna (Head of Central Locality, ACHSCP) which presented a follow up report as requested by the Board on 28 August 2018, on the preferred option to transfer patients to other practices as a result of the closure of the Rosemount Medical Group.

That the Board –

(a) Note the actions as outlined in this report for the transfer of patients from Rosemount Medical Group (RMG) to other practices and instruct the Chief Officer to implement the changes;

(b) Agree to incur expenditure of up to £144,026, to be funded from the Primary Care Reserve Fund; and

(c) Make the Direction, as attached at appendix A, and instructs the Chief Officer to issue the Direction to NHS Grampian.

Lorraine McKenna advised that the Partnership had informed patients registered at RMG of the closure of RMG and the Board's preferred option for managing this closure by letter and through holding drop-in sessions to provide further information and assurance to patients and stakeholders on the process. She explained that a project group had been established and to date, GP practices in the city had indicated that they could absorb 80% of RMG patients into their practice lists and noted she was hopeful the remaining 20% of patients would be re-allocated before RMG closed in January 2019. Ms McKenna added that the project team continued to engage with First Bus to address transportation issues identified during the consultation and engagement process; as well as pharmacy colleagues to help them prepare for the closure and ensure that patients with repeat prescriptions had enough medication over the transition period.

Thereafter there were questions and comments on (1) the transportation and accessibility issues identified by service users following their re-allocation to new GP surgeries; (2) the challenges of engaging with hard to reach groups or those with complex health needs to ensure they were informed and could cope with re-allocation to a new surgery; (3) Ms McKenna explained that the Partnership had a statutory obligation to ensure that the remaining 20% of RMG patients were assigned to a GP practice by the end of January 2019; and (4) the Chief Finance Officer confirmed that the Partnership had not committed to covering any recurring costs following the re-allocation of RMG patients.

<u>**The Board resolved:-**</u>

(i) to agree the recommendations;

(ii) to instruct the Rosemount Project Team to consider accessibility issues for patients being transferred to new GP practices; and

(iii) to thank GP practices, First Bus and public sector partners for supporting the Partnership during this challenging time.

DECLARATION OF INTEREST

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

MENTAL HEALTH COMMISSIONING

17. The Board had before it a report by Claire Wilkie (Service Manager, Mental Health and Substance Misuse, ACHSCP) which outlined the challenges related to the

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re-provision of care, with particular focus on the housing element, and to provide options for approval.

That the Board –

(a) Approve the re-provisioning of the balance of accommodation for people with mental health and substance misuse issues from residential care to support living services; and
(b) Approve the ongoing exploration of all identified options in para 3.4.

Alex Stephen advised that the Strategic Planning Group had oversight of mental health commissioning but the development of options for re-provision of care may depend on areas out with the Partnership's control such as the availability of land and facilities; and engagement with external providers.

Thereafter there were questions and comments on (1) the cost implications of providing out of area placements; (2) the wider use of housing tenures such as sheltered housing to enhance supportive living; (3) the extent of consultation with carers and the family network when taking decisions on the care and housing needs of patients with complex mental health issues; (4) the level of assurances offered by the Partnership to external providers to ensure they built or operated a health and social care facility in line with the Board's strategic commissioning intentions; and (5) the importance of having appropriate placement programmes in place for vulnerable patients.

The Board resolved:-

(i) to approve the recommendations; and
(ii) to wish Claire Wilkie well on her retirement.

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

BON ACCORD CARE REVIEW

18. The Board received a verbal update from the Chief Officer on progress with regards to Bon Accord Care's contractual review.

The Board resolved:-

(i) to note the verbal update from the Chief Officer; and
(ii) to agree that updates from the Chief Officer would become a standing item on future IJB agendas.

JONATHAN PASSMORE MBE, Chairperson.

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Aberdeen City Health & Social Care Partnership
A caring partnership

Audit and Performance Systems Committee

Minute of Meeting

Tuesday, 13 November 2018
10.00 am Meeting Room 5, Health Village

Present:	Rhona Atkinson (NHS Grampian) Chairperson; Councillors Cooke and Duncan; and Jonathan Passmore MBE (NHS Grampian).
Also in attendance:	Sandra Ross, Chief Officer (AHSCP), Alex Stephen, Chief Finance Officer (AHSCP), Martin Allan, Business Manager (ACHSCP), Claire Duncan, Lead Social Worker (ACHSCP), Sarah Gibbons (Execute Assistant, ACHSPC), and Alan Thomson and Karen Finch (Governance, ACC).
Apologies:	Councillors Laing and Samarai.

DECLARATIONS OF INTEREST

1. Members were asked to intimate any declarations of interest.

The Committee resolved:-
to note that there were no declarations of interest for items on the agenda.

DETERMINATION OF EXEMPT BUSINESS

2. The Committee were asked to determine any exempt or confidential business.

The Committee resolved:-
to note that there were no items of exempt or confidential business on the agenda.

MINUTE OF PREVIOUS MEETING OF 11 SEPTEMBER 2018

3. The Committee had before it the minute of their previous meeting of 11 September 2018.

In relation to article 6, resolution (iii) Martin Allan advised that he was working with colleagues from Aberdeen City Council on risk management to ensure consistency on the reporting and that an update on the Strategic Risk Register would be provided at the next meeting.

<u>The Committee resolved</u>:-
(i) to approve the minute as a correct record: and
(ii) to note the information provided.

BUSINESS PLANNER

4. The Committee had before it the latest version of the Business Planner.

<u>The Committee resolved</u>:-
(i) to delete items 5 (Contracts Register), 6 (Audited Annual Accounts), 7 (Internal Audit Report – Care Management), 8 (Confirmation of Assurance), 10 (Performance Monitoring) and 13 (IJB Complaints Handling Procedure); and
(ii) to otherwise note the content of the planner.

COMMITTEE MEETING SCHEDULE

5. The Committee had before it a report by Iain Robertson (Committee Services Officer – ACC) which proposed meeting dates for the Audit and Performance Systems Committee for 2019-20.

The report recommended:
That the Committee -
(a) Approve the meeting schedule for 2019-20;
(b) Instruct the Chief Officer to publish the meeting schedule on the Partnership's website; and
(c) Agree to re-schedule the Committee's meeting from 26 February 2019 to 12 February 2019.

<u>The Committee resolved</u>:-
to approve the recommendations contained in the report.

FINANCIAL MONITORING

6. The Committee had before it a report by Alex Stephen (Chief Finance Officer, ACHSCP) which provided a summary of the current year revenue budget performance for the services within the remit of the Integration Joint Board as at Period 6 (end of September 2018) and advised on any areas of risk and management action relating to the revenue budget performance of the Integration Joint Board (IJB) services.

The report recommended:
That the Committee –

(a) notes the report in relation to the IJB budget and the information on areas of risk and management action; and
(b) notes the budget virements as indicated in Appendix E.

Alex Stephen advised that a working group to look at a Learning Disability Grampian solution had been commissioned however there hadn't been a timeline identified to progress the work.

Councillor Duncan sought guidance on whether anything was being done to identify clients with learning disabilities that may require care packages if their guardian became unable to care for them, wherein Claire Duncan advised that where the guardian was in recent of a care package for themselves that information could be built into the package for the person they look after.

Councillor Duncan sought guidance as to whether there had been any progress with the three IJB's discussing the GMED service, wherein Jonathan Passmore advised that a meeting would be scheduled to have a discussion around the strategic overview of hosted services to ensure that there was robust operational management and financial control arrangements in place.

The Committee resolved:-
(i) to request the Chief Finance Officer to provide an update in relation to the Grampian solution for Learning Disability Client care;
(ii) to note that a mapping exercise across the city had commenced to locate all services, where they were based and what was available and that a report on the outcome of the exercise would be submitted to the meeting in February 2019;
(iii) to note the additional information provided; and
(iv) to otherwise approve the recommendations contained in the report.

FINANCIAL REGULATIONS

7. The Committee had before it a report by Alex Stephen (Chief Finance Officer, ACHSCP) which presented a revised version of the IJB's Financial Regulations for approval.

The report recommended:
That the Committee approve the revised Financial Regulations, as set out in Appendix A.

Alex Stephen advised that there were two major changes to the financial regulations those being a change to reflect that the IJB had a reserves strategy which was reviewed annually and in relation to grants that officers could use delegated powers to apply for grants quickly without requiring IJB approval each time.

He further advised that in relation to reporting on amounts set aside for hospital services that at present the information was supplied once per year and not quarterly as required and that this was due to the requirement for a suitable system to be in place nationally.

The Committee resolved:-
(i) to approve the recommendation contained in the report; and
(ii) to note the information provided.

SCOTTISH MEDIUM-TERM FINANCIAL FRAMEWORK

8. The Committee had before it a report by Alex Stephen (Chief Finance Officer, ACHSCP) which (1) presented the Committee with the Scottish Government's Medium-Term Health & Social Care Financial Framework; and (2) explained that the Framework explored Health and Social Care expenditure and reform analysis which underlined the imperative of using total resources across the whole system to drive best value, reform and long-term financial sustainability of the Health and Social Care system.

The report recommended:
That the Committee note the Scottish Government's Medium-Term Health & Social Care Financial Framework, as attached at appendix A.

Jonathan Passmore shared his thoughts on the Scottish Government Medium Term Health & Social Care Financial Framework specifically relating to efficiency savings, the need to look at productivity changes rather than efficiency savings, the challenges that the IJB would face and how those would be mitigated against.

The Committee resolved:-
(i) in the short term, to request the Chief Finance Officer to discuss with officers how the report impacts on services during financial workshops scheduled for later in the month;
(ii) to request the Chief Finance Officer to produce a detailed action plan to address the longer term impact on services and submit a report to the Committee on 12 February 2019;
(iii) to otherwise approve the recommendation contained in the report.

JOINT INSPECTION OF SERVICES FOR OLDER PEOPLE

9. The Committee had before it a report by Alex Stephen (Chief Finance Officer, ACHSCP) which provided the Committee with the opportunity to discuss and comment on the Care Inspectorate's report 'Progress Review Following a Joint Inspection'.

The report recommended:
That the Committee reviews, discusses and comments on the report as attached at Appendix A.

Claire Duncan (Lead Social Worker, ACHSCP) advised that the initial inspection was undertaken in 2015/16 which produced eight recommendations. The outcome of the review is that the ACHSCP had made good progress in relation to five of the recommendations, reasonable progress in relation to two, and limited progress in relation to one (locality management teams).

Jonathan Passmore and the Chairperson intimated their congratulations to those involved in this area.

The Committee resolved:-
(i) to note the thanks offered to those involved within this sector;
(ii) to otherwise note the content of the report.

NHS AUDIT SCOTLAND REPORT

10. The Committee had before it a report by Alex Stephen (Chief Finance Officer, ACHSCP) which provided the Committee with an opportunity to discuss and comment on Audit Scotland's Report 'NHS in Scotland 2018' which was published on 25 October 2018.

The report recommended:
That the Committee reviews, discusses and comments on the report as attached at Appendix A.

The Committee resolved:-
(i) in relation to a question regarding whether the brokerage arrangement in place for IJB's would be written off, to request the Chief Finance Officer to discuss with his counterparts from other IJB's the potential for the brokerage with IJB's being written off similar to that of the arrangements with the NHS;
(ii) in relation to effective leadership, to request the Chief Finance Officer to prepare a report in relation to leadership development and the support model in place for the leadership group and submit it to this Committee within six months;
(ii) to otherwise note the recommendation in the report.

CONFIRMATION OF ASSURANCE

11. The Chairperson provided Members with an opportunity to request additional sources of assurance for items on today's agenda or other areas of business, and thereafter asked the Committee to confirm it had received reasonable assurance to fulfil its duties as outlined within its Terms of Reference.

Jonathan Passmore sought additional assurance in relation to delayed discharges to enable the Committee to view the performance information to inform them of any areas of concern.

The Committee resolved:-
(i) to request the Chief Officer to prepare a performance report on Delayed Discharges and present the report to the Committee's next meeting on 12 February 2019; and
(ii) to otherwise confirm the receipt of reasonable assurance for items on the agenda.

- RHONA ATKINSON, Chairperson.

AUDIT AND PERFORMANCE SYSTEMS COMMITTEE
13 November 2018

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CLINICAL & CARE GOVERNANCE COMMITTEE

Minute of Meeting

27th November 2018 – 1000
Health Village, Aberdeen

Present:	Cllr. Sarah Duncan	Chairperson
	Luan Grugeon	IJB Member
Also in attendance:	Lynn Morrison	Allied Health Profession Lead
	Heather Macrae	Nursing Lead
	Claire Duncan	Adult Social Work Lead
	Graeme Simpson	Chief Social Work Officer
	Dr. Howard Gemmell	IJB Member
	Sarah Gibbon	Executive Assistant
	Lorraine McKenna	Primary Care Lead
	Lesley Simpson	Criminal Justice Service Manager
	Linda Leaver	Risk Management Advisor (Patient Safety)
	Caroline Howarth	Clinical Lead
Apologies	Cllr. Claire Imrie	IJB Member
	Prof. Steven Heys	IJB Member
	Kenneth Simpson	IJB Member
	Dr. Malcolm Metcalfe	IJB Member

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 the new attendees to the meeting. Introductions were given.

The Committee resolved: -
To welcome the new attendees to the committee meeting.

2. VERBAL UPDATES

MINUTE OF CCG COMMITTEE MEETING – 04 September 2018

3. The Committee had before it the minute of the Clinical & Care Governance committee meeting of 04 September 2018

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

MATTERS ARISING

4. The Chair asked if there were any matters arising from the meeting of 04 September 2018.

The Committee resolved: -
To note there were no matters arising.

BUSINESS STATEMENT

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

Heather MacRae spoke to an update provided by Karen Gunn relating to the mental health & learning disability services. Karen Gunn had been unable to attend the meeting. The update outlined the timeline of events to date and an early indication of any impacts on the adults and older adults community mental health teams.

The Committee discussed the Airyhall Day Centre/Living Well Café which had previously been funded through transitions money. The Committee felt this was a very valuable service, particularly from a prevention/early intervention perspective. A review will be undertaken in the new year, looking at the service and possibilities for ACHSCP to commission it.

The Committee noted the intention to undertake a pan-Grampian, whole systems review of mental health service pathway in January, which will consider elements such as workforce. A paper which will be presented to the IJB in December outlines the strategic framework for the planning processes for services delegated by NHSG Grampian for strategic planning. ACHSCP needs to ensure that it has appropriate representation and participation in these processes.

Thereafter there were questions and comments relating to 1) prevention and early intervention; 2) community supports such as Link Work Practitioners 3) assuring that community teams are sufficient supported

The Committee resolved: -
(i) To note the Business Statement.

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(ii) To note the verbal update provided relating to the Mental Health & Learning Disability Services.
(iii) To request additional information on the support being provided to mitigate any potential impact on community teams is circulated via email after the meeting.
(iv) To request that a further update on Mental Health & Learning Disability Services is provided to the Committee in February 2019.

REPORTS FOR THE COMMITTEE'S CONSIDERATION

COMMITTEE DATES 2019-20

6. The Committee had before it a report by Sarah Gibbon, Executive Assistant, which proposed a series of meeting dates for the Clinical & Care Governance Committee for the financial year 2019/20.

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

a) Approve the meeting schedule for 2019-20.
b) Instruct the Chief Officer to publish the meeting schedule on the Partnership's website.

Sarah Gibbon spoke to the report and highlighted that the August 2019 date is the same day as an IJB development session. The IJB development session will start later in the afternoon to accommodate this.

The Committee resolved:-

i. To approve the meeting schedule for 2019-20, pending correct of the February date.
ii. To instruct the Chief Officer to publish the meeting schedule on the Partnership's website.

JOINT INSPECTION OF SERVICES FOR OLDER PEOPLE – PROGRESS REVIEW

7. The Committee had before it a report which provided the Committee with the opportunity to discuss and comment on the Care Inspectorate's report 'Progress Review Following a Joint Inspection'.

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

a) Reviews, discusses and comments on the report as attached at Appendix A

Claire Duncan (Lead Social Work Officer) spoke to the report. She highlighted that the report was expected one-year post inspection, however due to capacity issues at the Care Inspectorate it was received after 2 years. She emphasised that improvement has been made in 7/8 of the recommendations and that there are no further follow ups planned.

The Committee discussed the recommendation relating to locality working and the reasons that progress hadn't been made. It was noted that in the recent Audit Scotland report, most IJBs required further work to full implement an integrated locality management model. There needs to be clarity what successful locality working will look like in reality to develop a shared vision and milestones for achieving this. It was suggested that ACHSCP should focus on certain areas first to make the biggest impact. The Committee felt that this should be articulated within the ACHSCP Strategic Plan and agreed to escalate as a discussion item for the IJB in December.

The Committee also discussed the recommendation around adult support and protection, specifically in relation to diligent leadership. Claire Duncan stated an intention to bring both the Adult Protection Unit quarterly report and the Adult Protection Biannual Report to the Clinical & Care Governance Committee for further assurance on actions being taken around this recommendation.

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Thereafter there were comments and questions relating to 1) recruitment to the Chairs of the Adult Protection and Child Protection Committees; 2) when another inspection might be expected; and 3) the need to make best use of the Care Inspectorates Quality Indicators and opportunities for self-evaluation in-between inspections.

COMMUNITY PAYBACK ORDER – ANNUAL REPORT

8. The Committee had before it a report which presented the Community Payback Order Annual Report for the financial year 2017/18.

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

a) Note the Community Payback Order Annual Report 2017/18 as attached at appendix A.

Lesley Simpson spoke to the report and provided an overview of the paper. She provided further information about the programmes, including Caledonian and Moving Forward, Making Changes. This information will also be circulated to the Committee with the minute.

The Committee noted that the feedback from the community is incredibly positive and that the CPO team receive a high-number of requests for support with projects.

Thereafter there were questions and comments related to 1) whether there were clear pathways for what happens for clients after the placement and the possibility to strengthen links with volunteering in the city; and 2) potential roles for the Link Work Practitioners.

<u>The Committee resolved:-</u>

i. Note the Community Payback Order Annual Report 2017/18 as attached at appendix A.
ii. To acknowledge their thanks to Lesley Simpson and the team for a very impressive report.

GENERAL PRACTICE – UPDATE REPORT

9. The Committee had before it a report which provided an update on progress with projects relating to both Rosemount Medical Group and Torry Medical Practice.

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

a) Note the content of this report
b) Consider the requirement for any additional assurance or further work

Lorraine McKenna provided an overview of the report and some background context to the paper.

The Committee discussed the wider work required to ensure that other practices are as sustainable as possible and learning from the lessons we've gather to date. It was noted that this is under the remit of the Primary Care Lead (GPs) and will be taken forward. The Committee discussed a number of factors relating to GP practice sustainability including: 1) how sustainability is very dynamic and can change quickly; 2) how the fluid movement of staff in 2C practices can help practices to support each other and 3) the commitment to share the learning from both the Rosemount and Torry projects.

<u>The Committee resolved:-</u>

i. Note the content of this report
ii. Acknowledge thanks to the both project teams & the support received from GP practices across the city
iii. To request that a further update on Torry is provided to the Committee at its February meeting, with a particular focus on existing support to the practice team

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iv. To request that a further update on Rosemount is provided to the Committee at its February meeting, with a particular focus on the project close and lessons learned

CLINICAL & CARE GOVERNANCE FRAMEWORK REVIEW

10. The Committee had before it a report which provided an update on work ongoing to review the Clinical & Care Governance Framework within ACHSCP.

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

a) Note the update and request that a further update will be presented to the Clinical & Care Governance Committee at its meeting on 19 February 2019.

Lynn Morrison spoke to the report and provided a short presentation on the work to date. She discussed the current arrangements as outlined in the 'Board Assurance & Escalation Framework' and how the task and finish group as exploring possibilities for establishing a clinical and care risk meeting. She gave an overview of the type of data that would be used to build a live data-dashboard from Datix (and subsequently Tableau).

The Committee reaffirmed that there is a need to clarify the roles between not only the Clinical & Care Governance Group and Committee, but also between the Clinical & Care Governance Committee and the Audit & Performance Systems Committee. There is also potential for overlap between clinical and care governance processes and health and safety arrangements.

The Committee discussed the reporting and data requirements and emphasised that it is critical to include reporting on commissioned services and GP practices. They also restated that data needs to be analysed and benchmarked to provide context and meaning.

The Committee resolved to:-

i. Note the update and request that a further update will be presented to the Clinical & Care Governance Committee at its meeting on 19 February 2019.

CLINICAL & CARE GOVERNANCE MATTERS

CLINICAL & CARE GOVERNANCE REPORT

6. The committee had before it a report by Heather MacRae (Lead Nurse, ACHSCP) which provided assurance to Committee on the robust mechanisms in place for reporting clinical and care governance issues.

The report recommended: -

That the Committee note the content of the report.

The report was accompanied by the following appendices: -

- **Agenda Item 3a:** Clinical and Care Governance Group - Report June 2018

Heather MacRae provided an overview to the report, noting that the expectation is that this report will look different in the futures as a result of the clinical and care governance framework. She noted a number of the risks with a high or very high rating were related to workforce.

Claire Duncan raised a concern that mental health and learning disability services (MH&LD – Karen Gunn), and specialist older adults and rehabilitation services (SOAARS – Jason Nicol) do not current report into the Clinical & Care Governance Group. She felt that this is a risk as adult social work in these services are not being reported appropriately, for example the current high case-loads for social workers in Learning Disabilities. The Committee agreed that there is a need to ensure that all sectors are represented at the Clinical & Care Governance Group

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meeting and this should be address in the review of the terms of reference and membership of the group.

Caroline Howarth further raised an issue with delays to Occupational Health Screenings, which are delaying recruitment processes and could be de-incentivising people to take up roles when they are offered them. There is a lot of work ongoing to improve this currently and the Clinical & Care Governance Committee requested further clarity on what is being done.

Thereafter there were questions and comments relating to recruitment and training within the Health Visiting services and it was noted that a business case relating to immunisations will be presented to the IJB in December.

The Committee resolved:-

- i. To note the content of the report and appendices.
- ii. To note areas of achievement and good practice
- iii. To request that a report is brought back to the CCG Committee in February on Occupational Health Service. This report should detail the current processes, issues with delays, impact on recruitment and actions being taken for improvement.

CARE GOVERNANCE DATA

SUMMARY REPORT – NHS ADVERSE EVENTS

7. The committee had before it a report from Heather MacRae (Lead Nurse) which provided an overview of the NHS adverse event report.

The report recommended: -
That the Clinical & Care Governance Committee acknowledge that the report provides the assurance required.

The report was accompanied by the following appendix:

- **Agenda Item 4a –** Incident Report (NHS)

Heather MacRae spoke to the report and again highlighted it is in the historical format and will be revised through the CCG Framework review. She highlighted the work ongoing in Tissue Viability services. Major adverse event related to optometry, however on reviewing the Datix is was noted as good practice with a good chronology and regard to the Duty of Candor.

Lynn Morrison further provided an update on a dashboard for falls in the community, by locality level, which is being developed by Rosie Cooper. Looking at how this dashboard would then fit in with the broader CCG dashboard. She is also looking at how we can include information from our providers.

The Committee resolved: -

(i) To acknowledge that this report provides the assurance required, however that further improvements to the reporting will be made.

SUMMARY REPORT – NHS FEEDBACK

8. The committee had before it a report from Heather MacRae which provided an overview of the NHS feedback report.

The report recommended: -

a) That the Committee acknowledge that the report provides the assurance required, however that further improvements to the reporting will be made.

The report was accompanied by the following appendix:

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

Heather MacRae spoke to the report and again highlighted it is in the historical format and will be revised through the CCG Framework review. She noted that it is a fairly low level of complaints coming into the partnership and the number of complaints which were resolved at frontline resolution stage.

The Committee resolved: -

i. To acknowledge that this report provides the assurance required, however that further improvements could be made.

ITEMS TO ESCALATE TO THE INTEGRATION JOINT BOARD

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

The Committee resolved: -

- To discuss progress with implementing localities and ensuring a clear vision and measures of what is successful locality working, during the strategic plan agenda item.

COUNCILLOR Sarah Duncan, Chairperson.

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INTEGRATION JOINT BOARD
BUSINESS STATEMENT

11 December 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. If a date is highlighted in red this means that an item has been delivered at a previous meeting or is overdue.

No.	Minute Reference	IJB Decision	Update	Lead Officer(s)	Expected
1.	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.	The Board instructed the interim Chief Officer to discuss how the proposed model could be delivered incrementally and at a lower cost with Bon Accord Care, and to report back to the IJB on 28 August 2018 with an update. The Board requested that an update report on Kingswells Care Home be presented to its December meeting. **A verbal update is on the agenda (during the Chief Officer's update).** The Board further requested that a performance monitoring report be presented to a future Board meeting on achievement of outcomes.	Chief Officer, Aberdeen City Health and Social Care Partnership	11.12.18
2.	IJB 31.10.17 Article 14	**Carers Strategy** Approval of the draft strategy was deferred on 31 October 2017 to allow the incorporation of further detail on young carers.	The Carers Strategy was agreed at the Board meeting on 27 March 2018. Thereafter the Board requested the Chief Officer to submit the Aberdeen City Short Breaks Services Statement to the Board meeting in October 2018.	Lead Strategy and Performance Manager, Aberdeen City Health and Social Care	11.12.18

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Agenda Item 7

No.	Minute Reference	IJB Decision	Update	Lead Officer(s)	Expected
			This report was deferred to December due to the publication of the template and guidance from the Scottish Government. **This report is on the agenda.**	Partnership	
3.	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 digital solutions; and instructed the Chief Officer to provide an update on implementation timescales.	This report will be presented to the Board on 11 December 2018. **Recommended for removal as being considered by APS Committee.**	Chief Finance Officer	11.12.18
4.	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.	The Disabled Adaptations report was presented to the Board on 19 October 2018. It was noted that progress updates and assurance on disabled adaptations would be reported to the Clinical and Care Governance Committee on a regular basis. **Recommended for removal**	Lead for Strategy, Aberdeen City Health & Social Care Partnership	Received on 09.10.18
5.	IJB 30.01.18 Article 7	**Diet, Activity and Healthy Weight** The Board instructed the Chief Officer to prepare an additional paper to be presented to the IJB in early 2018 to consider the Food Charter for the SFCPA.	**This report has been deferred to the meeting of 22 January 2019.**	Public Health Lead, Aberdeen City Health & Social Care Partnership	11.12.18

No.	Minute Reference	IJB Decision	Update	Lead Officer(s)	Expected
6.	IJB 30.01.18 Article 19	**Mental Health Commissioning** The Board instructed the Chief Officer to ensure that the Strategic Commissioning Board presents a report to the Board which would outline challenges related to the re-provision of care, with particular focus on the housing element and to provide options for the Board's consideration.	The Board agreed at its meeting on 9 October 2018 to approve the re-provisioning of the balance of accommodation for people with mental health and substance misuse issues from residential care to support living services. **Recommended for removal**	Lead for Strategy, Aberdeen City Health & Social Care Partnership	Received on 09.10.18
7.	IJB 30.01.18 Article 10	**Risk Management** The Board requested that the updated strategic risk register be presented to the Board at its next meeting on 22 May 2018	The Strategic Risk Register and Risk Appetite Statement were endorsed by the Board on 9 October 2018. The Audit and Performance Committee will monitor risk on an ongoing basis and escalate any change in risk rating to the Board. The Board instructed the Chief Officer to capture risks relating to the Brexit transition process within the Risk Register and to report this update to the Board's next meeting;	Business Manager, Aberdeen City Health and Social Care Partnership	11.12.18
8.	IJB 27.03.18 Article 13	**Ethical Care Charter Implementation** The Board requested that reports on the Scottish Living Wage and Ethical Care Charter implementation be consolidated and reported to the Board in due course.	An update on the implementation of the Ethical Care Charter will be presented to the next meeting of the Audit and Performance Systems Committee in February 2019. **Recommended for removal**	Lead Social Work Officer, Aberdeen City Health & Social Care Partnership	26.03.19
9.	IJB 27.03.18 Article 13	**Medium Term Financial Strategy** The Board agreed to review the narrative	The Medium-Term Financial Strategy was reviewed by the Board on 9 October 2018.	Chief Finance Officer, Aberdeen City	Received on 09.10.18

No.	Minute Reference	IJB Decision	Update	Lead Officer(s)	Expected
		of the Medium Term Financial Strategy at its meeting on 9 October 2018.	**Recommended for removal**	Health and Social Care Partnership	
10.	IJB 27.03.18 Article 20	**GMS Contract** The Board asked the Chief Officer to bring a final Primary Care Improvement Plan to the IJB for agreement prior to its submission to Scottish Government in July 2018.	An update report on the provision of GMS services for Torry was requested by the Board on 22 May 2018. **Recommended for removal**	Lead Transformation Manager, Aberdeen City Health and Social Care Partnership	26.03.19
11.	IJB 22.05.18 Article 20	**Skills Framework** The Board instructed the Chief Officer to report back with the outcome of the local negotiations and a proposed way forward beyond the interim period to take account of the Strategic Commissioning Plan and the need to commission on the basis of outcome delivery.	Significant progress in relation to local negotiations have been made and officers expect these to be finalised within the next month. Once that work is completed, a full picture report will be presented to the IJB. An indicative date of 22 January 2019 has been set.	Lead Strategy and Performance Manager, Aberdeen City Health and Social Care Partnership	22.01.19
12.	IJB 22.05.18 Article 23	**Bon Accord Care Contract Review** The Board instructed the Chief Officer to issue the Direction to Aberdeen City Council and make the necessary arrangements and then update the Board in August 2018.	A verbal update was provided on 9 October 2018. **Recommended for removal – a standing verbal update will be provided during the Chief Officer's Updates until the contract is signed**	Chief Officer, Aberdeen City Health and Social Care Partnership	Received on 09.10.18
13.	IJB 28.08.18 Article 11	**Technology Enabled Care Framework** The Board requested officers to develop proposals on how the Partnership's digital programme would align with Aberdeen City Council and NHS Grampian's digital	**Recommended for removal as this matter will be reported via the Audit and Performance Systems Committee**	Lead Transformation Manager, Aberdeen City Health and Social Care	22.01.19

No.	Minute Reference	IJB Decision	Update	Lead Officer(s)	Expected
		agendas and present this to a future meeting of the Board.		Partnership	
14.	IJB 28.08.18 Article 16	**Rosemount Medical Group – Options Appraisal** The Board requested that a follow up to August's report be presented to the Board's next meeting on 9 October 2018.	At its meeting on 9 October 2018, the Board noted the actions for the transfer of patients from Rosemount Medical Group (RMG) to other practices and instructed the Chief Officer to implement the changes. **Recommended for removal**	Primary Care Lead, Aberdeen City Health & Social Care Partnership	Received on 09.10.18
15.	IJB 09.10.18 Article 15	**Localities** The Board instructed the Chief Officer to review the locality structure and consult with relevant stakeholders and staff on the proposal to move from a four to a three-locality model and report back to the IJB on 26th of March 2019 with the results of this review and consultation along with the new Strategic Plan once finalised.		Lead Transformation Manager, Aberdeen City Health & Social Care Partnership	26.03.19

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Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Date of Meeting	11 December 2018
Report Title	IJB Budget Meeting
Report Number	HSCP/18/120
Lead Officer	Sandra Ross, Chief Officer
Report Author Details	Name: Alex Stephen Job Title: Chief Finance Officer
Consultation Checklist Completed	N/A
Directions Required	N/A
Appendices	N/A

1. Purpose of the Report

1.1. To revise the date of the Integration Joint Board's Budget meeting.

2. Recommendations

2.1. It is recommended that the Integration Joint Board:

a) Agree to move the planned IJB budget meeting on the 5th March 2018 to the 12th March 2018.

3. Summary of Key Information

3.1. The IJB has scheduled its budget meetings for the 5th of February and the 5th March 2019.

3.2. Aberdeen City Council's (ACC) budget meeting is also scheduled for the 5th of March 2019.

3.3. In order to avoid a clash and ensure that the Chief Finance Officer and colleagues have enough time to provide accurate and analysed information on the implications of the ACC budget setting to the IJB Budget meeting, it is proposed that the IJB defer their budget setting meeting.

3.4. It is suggested that the IJB agree to hold their March budget setting meeting on the 12th March 2019.

3.5. The initial budget setting meeting on the 5th of February will remain the same.

4. Implications for IJB

4.1. **Equalities –** there are no equalities implications arising from the recommendations of this report.

4.2. **Fairer Scotland Duty –** there are no implications for the Fairer Scotland Duty as the recommendations of this report related to an operational, stewardship matter.

4.3. **Financial-** Deferring the IJB will allow for the Council budget setting meeting to take place and for the implications of their decisions to be worked through and included in the IJB papers.

4.4. **Workforce**- there are no workforce implications arising from the recommendations of this report.

4.5. **Legal-** there are no legal implications arising from the recommendations of this report.

5. Links to ACHSCP Strategic Plan

5.1. Governance documents such as the Integration Scheme; the Board’s standing orders and an annual meeting schedule underpin the Board’s governance arrangements and help ensure that outcomes within the Partnership’s Strategic Plan can be effectively and legally delivered.

6. Management of Risk

6.1 **Identified risk(s):** If the IJB does not defer the budget meeting date, there is a risk that not all the information would be available to provide IJB budget papers in a timely manner.

6.2 Link to risk number on strategic or operational risk register: Strategic Risk Register (3) Failure of the IJB to function, make decisions in a timely manner etc

6.3 How might the content of this report impact or mitigate the known risks: Agreeing to defer the IJB budget setting meeting would mitigate this risk.

Approvals	
[signature]	Sandra Ross (Chief Officer)
[signature]	Alex Stephen (Chief Finance Officer)

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Aberdeen City Health & Social Care Partnership
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INTEGRATION JOINT BOARD

Date of Meeting	11.12.2018
Report Title	Chief Social Work Officer Annual Report
Report Number	HSCP.18.101
Lead Officer	Graeme Simpson, Chief Social Work Officer
Report Author Details	Graeme Simpson, Chief Social Work Officer
Consultation Checklist Completed	Yes
Directions Required	No
Appendices	*a.* Chief Social Work Officer Annual Report

1. Purpose of the Report

1.1. This report presents the Chief Social Work Officer's Annual Report for 2017/18 financial year to the Integration Joint Board. The purpose of the report is to inform Board Members of the role and responsibilities exercised by the Chief Social Work Officer; to provide information on statutory decision making in the period; and to give a progress report on key areas of social work provision within Aberdeen City.

2. Recommendations

2.1. It is recommended that the Integration Joint Board:

a) note the content of the Annual Report, as attached at Appendix A.

3. Summary of Key Information

3.1. The role of the Chief Social Work Officer is a statutory post in accordance with the Social Work (Scotland) Act 1968, as amended by the Local Government (Scotland) Act 1994. This requires Local Authorities to appoint a single CSWO for the purposes of listed social work functions.

3.2. The required qualifications of the Chief Social Work Officer are set out in regulations and the post holder must be able to demonstrate senior strategic and operational experience. National Guidance on the role was published by the Scottish Government in 2009 and was revised in May 2017. It provides an overview of position, outlining the responsibility for values and standards, complex decision making, particularly in relation to deprivation of liberty decisions and professional leadership. The guidance also covers accountability and reporting arrangements.

3.3. The Chief Social Work Officer provides advice to the Council and ACHSCP on social work matters; undertakes decision making in respect of statutory functions and provides professional governance, leadership and accountability for the delivery of social work and social care services, whether they are provided by the Council/ACHSCP or on behalf of the Council by another agency. Social Work in Scotland, an Audit Scotland Report published in September 2016, outlined the increased complexity of the role as follows: "With integration and other changes over recent years, the key role of the Chief Social Work Officer (CSWO) has become more complex and challenging. Councils need to ensure that CSWOs have the status and capacity to enable them to fulfil their statutory responsibilities effectively".

3.4. This report is consistent with the content and format guidance laid down by the Chief Social Work Adviser for Scottish Government. The annual report does not provide a complete account of social work activity over the year. Rather it is an opportunity to provide an overview of the range of services and initiatives in social care and to highlight key achievements and challenges.

4. Implications for IJB

4.1. Equalities – there are no equalities implications

4.2. Fairer Scotland Duty – there are no implications for the Fairer Scotland Duty

4.3. Financial – there are no financial implications

4.4. Workforce – there are no workforce implications

4.5. Legal – there are no legal implications

4.6. Other – there are no other implications

INTEGRATION JOINT BOARD

5. Links to ACHSCP Strategic Plan

5.1. This report presents an overview of the activity within Adult Social Care, which works towards achieving the strategic plan.

6. Management of Risk

6.1. Identified risks(s) – NA

6.2. Link to risks on strategic or operational risk register: NA

6.3. How might the content of this report impact or mitigate these risks: NA

Approvals	
[signature]	Sandra Ross (Chief Officer)
[signature]	Alex Stephen (Chief Finance Officer)

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Chief Social Work Officer

ANNUAL REPORT 2017/18

Foreword

Foreword

I am pleased to present the Chief Social Work Officer's Annual Report for Aberdeen City for 2017/18. This provides an overview of the social work services provided, information on statutory decisions made by the Chief Social Work Officer on behalf of the Council and some of the key challenges facing the service in 2017-18 and beyond.

Every local authority is required to have a professionally qualified Chief Social Work Officer (CSWO), as set out in Section 45 of the Local Government etc. (Scotland) Act 1994. The qualifications are set down in regulations that state that the CSWO must be registered as a Social Worker with the Scottish Social Services Council (SSSC). The overall aim of the CSWO role is to ensure that the Council and the Aberdeen Health and Social Care Partnership receive effective, professional advice and guidance in the provision of all social work services, whether these are provided directly, in partnership with other agencies, or purchased on behalf of the local authority.

The CSWO has a responsibility for overall performance improvement and the identification, management and reporting of corporate risks as these relate to social work services. To fulfil these responsibilities, the CSWO has direct access to elected members, reporting through various Committees, the Chief Officer of the AHSCP and has direct links to the Chief Executive of the Council. The CSWO provides professional leadership and promotes values and standards of professional practice, ensuring that only Registered Social Workers undertake those functions reserved in legislation and meet the requirements of their regulatory body and the SSSC Codes of Practice. Any social worker or social care professional may approach the CSWO for advice.

A number of specific statutory responsibilities are discharged by the CSWO. These relate primarily to decisions about the curtailment of individual freedom and the protection of individuals and the public. These decisions must be made by the CSWO or by a senior, professionally qualified social worker to whom the responsibility has been delegated by the CSWO and for which the CSWO remains accountable. There must be CSWO cover 24 hours a day, every day of the year. The Chief Officer – Integrated Child & Family Services is the Chief Social Work Officer.

To ensure that CSWO cover is in place at all times, the Council has in place a scheme of delegation of the statutory responsibilities Lead Service Managers in Children's Social Work and Lead Social Worker, Aberdeen Health and Social Care Partnership. Over the past year the Service has undergone significant change in leadership across Children's Social Work and the Aberdeen City Health and Social Care Partnership. It has been important for services to increasingly evidence the impact they are having on the lives of they are intervening in. The challenge is to do so against a challenging economic and financial backdrop.

In this context, the CSWO has a crucial role in ensuring that any financial decisions made do not compromise the safety and wellbeing of people who use social work services. These pressures are felt not just by ourselves, but also by our colleagues across the third and public sector. The City Council commissions high volumes of adult social care and the difficulty of securing this provision has continued over the past year. These are challenges that the Health and Social Care partnership are addressing through innovative commissioning approaches, which are outlined later in this report. In addition, the City Council, the Health and Social Care

Partnership, our stakeholders and partners face recruitment challenges, with difficulty in filling key posts.

In its 2016 report on Social Work in Scotland, Audit Scotland noted that the role of the CSWO has become increasingly complex with the introduction of Health and Social Care Partnerships. In Aberdeen, Children's Social Work is located within the City Council, and is attached to the role of Chief Officer – Integrated Children & Family Services, whilst Adult and Criminal Justice social work resides within the Health and Social Care Partnership. This provides two challenges. Firstly, the CSWO has to retain oversight, professional leadership and provide assurance of safety and quality of all social work services across two large and complex organisations. Secondly, the CSWO has to step back from the role of Chief Officer to provide independent, professional oversight and challenge of Children's Social Work. This is not unique to Aberdeen and is an issue facing a number of CSWOs across the country.

This report recognises the excellent work delivered day in day out by staff in Children's Social Work and Aberdeen Health and Social Care Partnership. These staff deliver high quality support and services to vulnerable adults and children and to discharge statutory responsibilities to ensure their safety, wellbeing and protection. This report attempts to reflect their work.

Graeme Simpson
Chief Social Work Officer

Children's Social Work

Children's Social Work is a statutory, targeted service working with those families who are among the most vulnerable and disadvantaged in the city. Many of the children of these families are required to work with us on a compulsory basis. In 2015 Aberdeen City Council adopted a systemic model of practice known as "Reclaiming Social Work". This was a whole system redesign of social work services for families in need in Aberdeen. The model recognises the important role social workers play in helping and supporting families in need, and we have redesigned our structure to ensure they are free to focus on this work. While the service model has evolved over the course of the past three years in response to challenges in respect of recruitment and the changing financial environment, the model continues to enable social workers to work more collaboratively within newly formed systemic units and concentrate on social work, not unnecessary bureaucracy.

Initial advice was that it would take up to three years to recruit sufficient appropriately trained and experienced Consultant Social Workers, and this is proving true. It has not slowed progress, however, as whilst remaining true to the systems based theoretical model, we have developed alternative solutions such as systemic teams, rather than units, introduced a mentoring scheme to support staff develop the skills necessary to apply for Consultant Social Worker posts. Whilst recruitment remains a challenge across much of the public sector. In the North East we are confident that the posts will be filled and that the service model will be fully operational within the coming months. The positive experience of those units already in place will roll out across the service. The impact of the model on service users is being independently evaluated. This will also draw upon the evidence from staff and partners and, more importantly, service users.

The wider restructure of the Council and the establishment of an Integrated Children & Family Service will require Children's Social Work in collaboration with Education colleagues to further consider how services can be integrated to benefit the needs of children, young people and their families. While acknowledging the scale of the change across the Council, staff throughout Children's Social Work have worked with a professionalism and dedication to improve the lives of children and their families.

The Aberdeen City Health & Social Care Partnership

The Aberdeen City Health and Social Care Partnership has continued in its second year of operation to embed the integration of the delegated health and social care functions, the ongoing transformation of our services and to work towards fulfilling the ambitions and priorities outlined in our Strategic Plan.

The partnership is required to show on an annual basis how effective it has been in attaining or working towards the national health and wellbeing outcomes. Core indicators are aligned to all these outcomes and over the past year (2017-18) 14 of the 19 reported indicators have improved or stayed the same. Most notable improvements are evident in the rate of emergency bed-days for adults reducing by 9% and the number of days people spend in hospital when they are ready to be discharged reducing by 27%. Of the 5 indicators that had performed worse than the previous period, 4 indicators were within 3% of the previous period's performance except readmission to hospital within 28 days at 10%.

For the same period, the partnership performed better than Scotland for 12 of the 19 indicators with particularly good comparative performance in the rate of emergency admissions at 16% better than the average, the rate of emergency bed-days for adults at 12% and the falls rate per 1,000 population in over 65s at 11%. We performed worse in 7 of the indicators with readmissions to hospital within 28 days of discharge worse than average by 7%, the percentage of all adults with intensive needs receiving care at home worse by 7% lower and the number of days people spend in hospital when they are ready to be discharged worse by 9%.

We have identified that some of the sources of our performance data are not as robust as we would like, and we have committed to undertaking a full review of our indicators and of how the information is gathered. In addition, we are about to embark on refreshing our Strategic Plan as the lifespan of the current one ends on 31st March 2019.

There is a strong expectation to deliver significant transformational change at pace to improve the personal experiences and outcomes for individuals who use our services. We have increased the capacity of our transformation team to drive an ambitious programme of change activity that will deliver the desired improvements and required efficiencies. This programme includes the introduction of INCA (Integrated Neighbourhood Care Aberdeen) in the South Locality, Acute Care @ Home in the Central Locality, and a new approach to home visiting for all GP practices in the West Locality as well as the roll out of our primary care Psychological Therapies service and Links Practitioners. These have all been small tests of change, the learning from which will inform the future rollout of these initiatives across the whole partnership.

During the year, both our Chief Officer and our Head of Operations moved on to other roles which was unsettling for the staff but they have continued to fulfil their roles and deliver services with a high degree of professionalism. Despite these changes our aim remains to be one of the top performing partnerships in Scotland across all sectors and one which attracts the best people to work with us and I look forward to working with the new Chief Officer towards achieving this goal.

Partnership Working - Governance and Accountability Arrangements

Integrated Children's Services

In line with the Children and Young People (Scotland) Act 2014, Statutory Guidance, Section 3, our Integrated Children's Services Partnership began the development of the new Aberdeen City ICS Plan 2017 - 2020. The plan was published on the 1st April 2017 and formally launched at our annual ICS Conference on 12th June 2017. Key themes identified in the plan were:

- Closing the outcome gap for our disadvantaged children and young people
- Improving health and wellbeing, particularly in areas such as mental health and physical activity
- Improving community safety and the environment to make safe spaces for children and young people of all ages
- Ensuring that we engage and include children and young people in the ongoing progress and development of our work.

The first annual update report on progress to deliver these objectives was completed and submitted to the Scottish Government. It is the intention to refresh the Local Outcome Improvement Plan in the coming year and this review will influence and inform the areas of continuing priority for the IBS Board. The Chief Social Work Officer and senior Children's Social Work leaders are represented in each of the ICS Partnership senior governance groups ensuring that the Corporate Parenting, and Child Protection agendas will be delivered and supported within a multi-agency approach over the coming three years.

This work will be driven by our ICS Board who will be provided with reports on the progress and improvement. This will ensure timely performance updates and recommendations for the Outcome Groups to drive forward.

The Health and Social Care Partnership

Aberdeen City Council has delegated a range of statutory functions in respect of social care services to the Integrated Joint Board (IJB). Legal responsibility for these functions still sits with the City Council, under the direction of the IJB.

The Chief Social Work Officer is a member of the Integration Joint Board as the responsibilities of this role in relation to local authority social work provision continue to apply to functions which have been delegated under the integration arrangements. The Lead Social Work Officer continues to link with the Chief Social Work Officer with regards to the governance arrangements, continuous improvement, quality assurance and management of adult social care services.

Through an interim Clinical and Care Governance Framework, arrangements have been put in place by the IJB to comply with the National Framework for Clinical and Care Governance. A Clinical and Care Governance Committee (C&CGC) and a Clinical and Care Governance Group (C&CG) have been established to oversee the implementation of this framework. The C&CG Committee 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 in place.

The role of the Clinical and Care Governance Group is to oversee and ensure provision of a coordinated approach to clinical and care governance issues within the partnership. The Group reports to and provides assurance to the C&CG Committee that there are robust mechanisms in place for reporting clinical and care governance issues. The Lead Social Work Officer is a member of the Clinical Governance Group (C&CGG) and the Chief Social Work Officer has a freestanding invite to attend this group.

H&SCP Commissioning

Strategic Commissioning is fundamental to our ambition to work with partners across all sectors in reshaping the services that we deliver to address the common challenges that we face. A coherent commissioning approach is pivotal to the people who use our services having improved personal experiences and outcomes. Other anticipated benefits include a more resilient, local marketplace, innovative and effective care models and contractual arrangements that are fit for purpose.

During 2017/18 the ACHSCP has:

- published its Strategic Commissioning Implementation Plan which details our key commissioning intentions and incorporates a market Facilitation Statement;
- established a Strategic Commissioning Programme board to support progress across the priority commissioning programmes. It provides leadership, direction, challenge, permission, and control to commissioning projects as well as removing blockages;
- published its Carers and Learning Disability strategies as well as its Primary Care and Transformation Plans and
- further developed and enhanced its relationship arrangements with provider umbrella organisations such as Scottish Care and ACVO involving them in key groups such as the Strategic Commissioning Programme Board.

Social Services Delivery Landscape

About Aberdeen

Place: Aberdeen City covers an area of 186 square kilometres and in terms of population size, it is the 8th largest local authority in Scotland. The City is made up of 37 neighbourhoods – 8 of which have been recognised as deprived based on SIMD.

Population: In June 2017, the estimated population of Aberdeen City was 228,800, with slightly more than half of the population being female (50.2%). This estimated population was 0.5% lower than the previous year's population of 229,840. The main contributor to this decrease was negative net-migration to the City between mid-2016 and mid-2017. In the period up to 2041, the population of Aberdeen is forecast to increase to 243,056 (5.8%) with the number of children (aged 0-15) increasing by 0.9% and the number of those aged 65+ by 12.5%. (Figure 1)

Age structure: Compared to Scotland, Aberdeen City has a lower proportion of people in the older age groups, 55+ years and a higher proportion of its population in the young adult age groups, 15-24 years and, particularly 25-34 years (Figure 2)

Life expectancy: In 2014-2016 estimated life expectancy at birth was 80.8 years for females and 76.4 years for males. Both male and female life expectancy have decreased in each of the last three years and are now lower than average life expectancy for Scotland. Consistent with longer-term trends in Scotland, both male and female life expectancy have increased since 2001-2003, with the rate of increase being higher in males than females, thus narrowing the gap between male and female life expectancy. However, the rates of increase in this period were lower in Aberdeen City than for all other local authorities.

Estimated life expectancy by deprivation: Estimated life expectancy is strongly associated with deprivation. Males in the most deprived quintile (SIMD 2016) in Aberdeen have a life expectancy of 72.0 years compared to 81.0 years for those in the least deprived quintile – a difference of 9 years. Females in the most deprived quintile have a life expectancy of 77.1 years compared to 84.1 years for those in the least deprived quintile – a difference of 6.4 years.

Deprivation (SIMD 2016): Based on overall rankings of deprivation (i.e. All Domains), Aberdeen performs relatively well in the SIMD with 113 (40%) of its data zones being in the 20% least deprived areas of Scotland. However, there are 22 (8%) data zones in the 20% most deprived areas of Scotland – equivalent to a population of 18,171.

Resources

Finance

The current Council 5 Year Business Plan lays out the net budget for social work services until 2022-23, showing a decrease of 0.3% from 2017-18. However, within this figure, adult social work services will reduce by 6.8%. This is based on current assumptions of future government funding.

SOCIAL WORK SERVICES	**2017-18 (£'000)**	2018-19 (£'000)	2019-20 (£'000)	2020-21 (£'000)	2021-22 (£'000)	2022-23 (£'000)
Total Budget	**121,541**	128,384	126,045	123,608	121,993	121,182
Adults	**83,308**	84,995	82,483	80,046	78,431	77,620
Children	**38,233**	43,389	43,562	43,562	43,562	43,562

Please note that these figures may change during the current budgeting process and the adult social care budget does not reflect how the Partnership might use additional capacity/transformational funding to pay for some adult social care services.

Children's Social Work

Social Work Services meet commitments within budget. However, Children's Services in 2017-18 were overcommitted through increase in demand, particularly against the joint budget with Education for specialist residential placements through the Children's Hearing and additional requirements for foster placements. The budget has now been re-profiled to effectively meet the demographic changes facing the City and the year on year increase in residential care charges.

As demand projections indicate an ongoing budget pressure, a sustainable solution is being developed through a range of initiatives. Investment is being made in service transformation to improve outcomes and constrain demand pressures, in particular the adoption of the Reclaiming Social Work Model, gives the opportunity for an outcome-based approach to setting the Children's Services budget. The Inclusion Review in Education enables joint approaches to managing demand and meeting the needs of looked after children within City resources.

The integration of Children's Social Work services and universal services for children will offer further opportunities to strengthen and develop prevention and early intervention strategies to constrain growth in demand for more costly interventions.

Particular consideration needs to be given to changes in relation to commissioned services and the impact of market forces.

H&SCP

The Scottish Government Local Government Finance Settlement (Circular 7/2015 version 4) imposed a range of conditions on Councils, which were reflected in the creation of the consolidated budget. £250 million, for Scotland as a whole, will be transferred from the Health Budget to integration authorities in 2016/17, whereby £125 million is to support additional spend on expanding social care to support the objectives of integration; and £125 million is provided to help meet a range of existing costs faced by local authorities in the delivery of effective and high-quality health and social care services.

The Aberdeen City Integrated Joint board (IJB) share of the £250 million is £9.5 million. £4.75m to fund additional capacity and £4.75m to meet local authority budget pressures. This includes a requirement that all social care workers including those in the independent and third sectors are paid the Living Wage. There is also additional capacity/transformational funding available of £9.625m. This consists of additional social care capacity £4.75m, Integrated Care Fund £3.75m and Delayed Discharge Funding £1.125m. The Chief Officer will consider an investment strategy for this funding.

In 2017/18 a third tranche of additional funding of £3.86m was made available so that social care workers providing care to adults could be paid the Scottish Living Wage. Councils could reduce the funding passed over to the Integration Joint Board by their share of £80 million. In Aberdeen City this reduction amounted to £3.090 million. This gives a total delegated budget of £264.323m for 2017/18 for the Aberdeen City and Social Care Partnership budget.

Service Quality and Performance including delivery of statutory functions Performance Frameworks

HSCP Performance Framework

For the IJB to function effectively as a governance body it requires the right information at the right time to ensure it is focused on the right issues. The information needs of the organisation are increasing as it operates in a constantly developing environment. For intelligence to have an impact on improving health and care, it is important to work together at all levels of the system to co-produce intelligence, aiming to improve ownership, responsibility and collective leadership. This Framework and the proposed approach to performance and governance are not just about change at IJB level but must permeate the organisation at locality level and in multidisciplinary teams. Achieving our aims and objectives depends on having an effective performance framework to measure progress. There are hundreds of indicators used to monitor the services we deliver, the quality of care we offer and the outcomes we achieve. Our approach has been to develop a structured framework for managing information to ensure the right information reaches the right people at the right time. We are operating in a constantly changing environment and what we measure now to assess performance is likely to develop as we pool data between health and social care, particularly at locality and community level. We draw on indicators that help to assure performance of current practice and support continuous improvement. They are based on aspects of care and management where we have the greatest level of accountability and leverage to improve. In some cases, the data may be limited, and the measures may be imperfect, but we can still use it to understand where we are, and where we want to be, and we are working to improve the quality and range of data available and our ability to analyse it. The national and local indicators we use are contextualised around a balanced performance framework adapted from the Care Quality Commission

Risk

The Integration Joint Board has in place a Board Assurance Framework to provide the necessary assurance associated with good governance that the partnership has put in place the structures, behaviours and processes necessary for setting risk appetite, for delegating the identification of both significant events and trends, for assessment and mitigation of risk, and for putting in place effective controls and assurances, properly owned and actioned.

A key element of the assurance framework is the risk management system, whose outputs (i.e. strategic and corporate risk registers, and other reports) contribute significantly to board assurance on key risks to our strategic ambitions and priorities. The IJB Risk Management policy sets out the arrangements for the management and reporting of risks to IJB strategic priorities, across services, corporate departments and IJB partners. 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.

The Strategic Risk register is owned primarily by the Chief Officer with individually identified risks assigned to different members of the Executive Team as appropriate. It sets out those

risks which may threaten achievement of the IJB's strategic priorities, in order for the board 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 these. Importantly, it identifies the assurances and assurance routes against each risk and the associated mitigating actions.

The Strategic Risk Register is presented to the Executive Team for discussion every month. It is also submitted to the Audit and Performance Systems Committee (APS) on a quarterly basis and then presented, with appropriate APS comments included, to the following IJB meeting thus ensuring regular and robust scrutiny of the assessed risks and the mitigating activities and interventions.

Child Protection

The Aberdeen City Child Protection Committee (CPC) is chaired by the Aberdeen City's Lead Nurse and has a membership across the full range of agencies and services with child protection responsibility including Aberdeen City Council (including social work, education and housing), Police Scotland, NHS Grampian, the Reporter to the Children's Hearing, Aberdeen Violence against Women Partnership and the third sector. All members aim to consistently improve upon the delivery of robust child protection practices across the public, private and wider third sectors.

The Local Police Commander and the Chief Executives of NHS Grampian and Aberdeen City Council are the Chief Officers responsible for the leadership, direction and scrutiny of the local child protection services and the Child Protection Committee. They have strategic responsibility for the CPC.

The CPC has three sub committees. The CPC's Operational sub-committee is responsible for driving forward the work of the child protection programme. It works alongside the Significant Case Review sub-committee and the Learning & Development sub-committee. The child protection programme encompassing the period 2016 – 2019 is in course of delivery and on-going development.

A child sexual exploitation (CSE) sub group has been established for three years and its remit has been extended to incorporate child trafficking. Short Life Working Groups are established to work on identified priorities; neglect, child protection and domestic abuse, missing children, vulnerable 16/17year olds and Strength-based practice

A Child Protection Partnership with Aberdeenshire and Moray CPC areas collaborates over the child protection register (CPR), joint investigative interview arrangements and bespoke training events. Aberdeen City holds and administers the CPR, co-ordinates the training programme and leads the organisation of the Partnership.

The Child Protection Landscape in Aberdeen

A significant source of information about categories of concerns and emerging trends comes from the management information compiled by the CPR. This enables the CPC to consider issues in its own geographical area and to compare trends across the Grampian area. The

annual figures are taken at 31 July each year and reported to the Scottish Government. The statistics used in this report are therefore consistent with the return to the Scottish Government.

The number of children on the CPR is variable with need. Throughout the period, the number of children on the CPR remained comparable with the Scottish average of around 3 children per 1000 population of 0 -16-year olds.

No. of children on the Aberdeen City CPR from 31st July - 31st July

2011	2012	2013	2014	2015	2016	2017	**2018**
96	86	92	73	98	118	80	**68**

Children remain on the CPR for as long as necessary, 88% were de-registered within 12 months and 60% within 6 months, a total of 162 children in 2017 – 2018. 33 children (22%) who were registered over the year from 1 August 2017 to 31 July 2018 had previous registration history, with a range of time intervals between individual registrations. Aberdeen City's rate of re-registrations has fluctuated between 16% and 25% over the course of the year.

Most children on the CPR (66%) are under 5 years old, including pre-birth registrations which indicates that we respond at an early stage to children in need of protection. Short periods of registration indicate that the supports put in place and intervention made reduces the risks to the child within a shorter time-frame. 21% are in the 5-10 age group whilst 13% of children on the CPR are aged 11-15 years which reflects an awareness of and response to the risks to that age group, in particular of child sexual exploitation.

The main risk factors for children on the CPR are emotional abuse 37%, neglect 32% and domestic abuse 31% (as at 31.07.18). Parental drug misuse is recorded as a risk factor in 25% of cases, parent mental health in 23.5% and non-engaging family in 19% of cases.

A suite of performance management information is considered at each meeting of the Operational Sub-Committee and reported upon, in accordance with a data framework, to the CPC. The strategic focus on the range of performance information enables the CPC, through its child protection programme, to concentrate on the predominant areas of risk to children.

Key themes of Child Protection Programme 2016 - 2019

The Child Protection Programme (CP Programme) has been developed and continues to evolve to ensure that the CPC functions are fulfilled; namely continuous improvement, strategic planning, public information and communication. Those functions have been incorporated into the multi-agency CP Programme.

Three key themes of the CP Programme are linked to the Quality Indicators as outlined in the Care Inspectorate document "How Well Are We Improving the Lives of Children and Young People?". These are

- How well are the lives of children and young people improving?
- How well are partners working together to improve the lives of children, young people and families?

- How good is the leadership and direction of services for children and young people?

The CP Programme is informed by ongoing self-evaluation and there are a number of strands to this. As well as performance information, the CPC considers national developments, case file auditing, significant case reviews, inspection findings, statistics and practitioners' knowledge. It has an annual development day to which all members of the Chief Officers Group, CPC, Sub Committees and any other relevant groups are invited.

Child Protection Programme delivery 2017 – 2018

- Making best use of child protection data in order to review performance, benchmark with other authorities, identify trends and areas for improvement.
- Recent figures from the CPR indicate that the predominant risk factors across Aberdeen City remain domestic abuse, parental drug and alcohol misuse, emotional abuse and neglect, with increasing evidence of concerns around parental mental health
- There has been much emphasis on ensuring practitioners have relevant, consistent up-to date information and guidance at their disposal. This is through multi agency guidance, web site information, and learning events
- Bespoke learning events to respond to local practitioners' needs have been held. These have related to Initial & Significant Case Reviews (March 2017), CSE national event (March 2017), Child Protection and Disability Conference (June 2017), Awareness Raising month (Oct 2017), Internet Safety (Nov 2017), Child Protection and Domestic Abuse Conference (Nov 2017), CSE and child trafficking Conference (Jan 2018), and Inter-Agency Referral Discussions in Aberdeen City (April 2018)
- Live Facebook events to inform the public about child sexual exploitation, child trafficking and online safety have been held in conjunction with Police Scotland
- Significant and Initial Case reviews have been high on the agenda. The SCR sub-committee has been formed to develop local procedures, to ensure we learn lessons from SCRs conducted locally and in other parts of the country and to make sure learning is disseminated to the Aberdeen City workforce
- Neglect remains a persistent risk factor and has featured in an in-depth ICR.

Child Protection Programme delivery 2018 onwards

In the year ahead, the following areas will be our focus:

- Dissemination of learning from ICRs and SCRs
- Addressing and responding to cumulative neglect
- Developing multi agency guidance and awareness raising of child trafficking
- Addressing child protection and disability
- Improving children's and families experience of and participation in the child protection process
- Responding to Scottish Government's national Child Protection Improvement Programme
- Responding to other national priorities as identified by the Scottish Government or to local need as identified through performance data and other self-evaluation activity, such as multi agency case file audits

- Improving awareness of Child Protection and Culture such as FGM, Honour Violence and Forced Marriage
- Alignment with strategic improvement programmes of Aberdeen Violence Against Women Partnership, Adult Protection Committee, Alcohol & Drugs Partnership
- Continuing our work on CSE/CT/Online safety, neglect, child protection and domestic abuse, missing children, and vulnerable 16 & 17-year olds
- Exploring how to implement Strength based practice across all agencies and services in Aberdeen City.

Looked After Children

The total number of Looked After Children has in the past year reduced slightly from 594 to 576. This represents 1.6% of children aged 1-17 compared to a National figure of 1.4%. Aberdeen City has undertaken significant work to ensure the numbers of Looked After Children sit within the National average and this figure reflects this.

The overwhelming majority of Looked After Children continue to be placed in a 'family' home. As at 31st March 2018, 508 children were cared for within a family setting; 108 (18%) were cared for by parents; 112 (19%) by friends/relatives; and 288 (49%) by foster carers/adopters. 68 (11%) of Looked After Children were accommodated in a residential setting. This latter figure compares to a national picture of 10% of Looked after Children being in residential care.

Our strategic aim is to further shift the balance of care, increasing the proportion of children safely looked after at home with their parent(s) or with friends/relatives. At present Aberdeen City in these areas sits below the national average. It is a service priority that we support children to remain within their families where it is safe to do so. We are further developing our approach to ensuring kinship carers are supported to care for their family members when their parents are unable to do so. Given the continuing financial pressures, particular emphasis will be placed on out of city placements both fostering and residential.

Over the past year we have recommissioned our "Early Help" and "Intensive Support" services. The aspiration of these new services will be to provide tailored support to young people and their families who are in crisis and where there is a risk to the child being accommodated and/or being placed in an out of authority residential setting. These new services will compliment the support provided by our in-house services.

Supporting staff to understand and delivering on our new and extensive duties as set out in the Children & Young People (Scotland) Act 2014 has been a major focus over the past year - in particular Continuing Care and supporting Looked After Children to remain in their care placement beyond their 16th birthday possibly up to the age of 21.

There are five Children's Homes maintained by the local authority, each accommodating five or six young people. In addition, there are two 'satellite' homes each with two places within the city. Separately there is one Children's Home managed by Barnardo's and one for young people transitioning to independence managed by Action for Children. Due to significant challenges in recruitment, one of our homes has been non-operational for the past year. While recruitment activity remains a key priority to build up the capacity of the residential staff, over the past year there has been a strong focus embedding our philosophy of care. In

partnership with Scottish Attachment in Action we have rolled out DDP training for staff. This has seen a very positive shift and evidenced positive outcomes for our young people.

Over the coming year it is our intention to develop a multi-agency approach to Throughcare. This will aim to bring together a number of key agencies into a co-located setting to support young people as they transition from care to an independent setting. It recognises the need for a responsive and flexible support offer to care experienced young people is critical and that social work staff are not always the best placed profession to support them.

The educational attainment of Looked After Children in Aberdeen has been considerably lower than that of Looked After Children throughout Scotland and as a result, is a local priority. The appointment of the Virtual Head Teacher has provided a clearer focus on how schools and services are supporting Looked After Children to achieve their full potential. Over the past year there has been a slight improvement but how schools and wider council services support the attainment needs of our looked after young people remains a high priority.

Youth Justice

The Whole System Approach (WSA) for youth justice in Aberdeen has been embedded within the GIRFEC framework. Youth offending has fallen continually over recent years, showing a 20% reduction over the past year. While there is no room for complacency and recognition that the partnership needs to continue to support the WSA the figures noted below are to be welcomed.

	2015	2016	2017	**2018**
No. of young people who were accused in relation to multiple CrimeFiles per year	262	198	170	**136**
No. of young people who were accused in relation to a single CrimeFile per year	602	559	587	**522**

Through collaborative working and shared decision making, the WSA offers early intervention for low level offences, diversion from statutory measures, prosecution and custody, and community alternatives. WSA processes are continually reviewed and the approach strengthened and over the past year the Responsible Group which takes a Youth Justice lead has held a number of development events to ensure a focus and collective understanding of the needs of young people is at the forefront of practice and strategic planning.

Effective and enhanced links between Youth Justice and Adult Criminal Justice are in place. The Youth Team has ensured a coherent approach to youth justice and a strengthening joint approach where necessary. This has helped shift practice to ensure that young people are not being "up tariffed" in terms of recommendations. In addition, skills and knowledge of staff working with young offenders has been enhanced by a number of learning and development events held over the past year. This has included:

- A refocus of our Care & Risk Management Meeting Policy
- Continued input from Christine McCarllie in relation to Young People who exhibit sexually harmful behaviour
- AIM2 and ASSET Assessment training

The Family and Community Support Service IFIT (Intensive Family Intervention Team) respond to the needs of young people who present high risk behaviours to de-escalate the level of risk and avoid the need for secure/custodial intervention. The IFIT Service works collaboratively with our third sector provider of intensive support services.

Corporate Parenting

In 2015 Aberdeen was successful in its application to the Life Changes Trust (LCT) for funding to help to develop its Champions Board and the associated three-year Development Plan provides the basis for Aberdeen City Council's initial corporate parenting plan. The LCT award provided renewed enthusiasm, momentum and commitment. Whilst improvements have been made, there is more work to ensure that all corporate parents fully understanding their responsibilities to Looked After Children. This remains a key priority for Aberdeen. We are currently working with LCT to explore extending the life of their support beyond the three years.

The Champions Board has recognised that while there has been undoubted value in senior leaders coming together to consider the challenges facing CEYP there is a need to challenge and embed a practice across all agencies that recognises the unique needs of CEYP. This remains a priority for the Council and its key partners. Capturing the views of CEYP is a challenge and the Service is exploring how young people can more easily give their views both in terms of their own planning but also in relation to wider service planning.

To ensure the continuing priority of Corporate Parenting at both a strategic and operational basis a revised Corporate Parenting Improvement Plan will be developed in the coming year which will fall within the remit of the Integrated Children's Services Board to provide appropriate support and governance.

The Champions Board, which meets quarterly, provides an opportunity for care experienced young people to talk directly to decision makers about how best to remove complex barriers to multi-agency working so that innovative solutions can be agreed and implemented in a timely manner. An essential element of this is the development of participation in the city to help empower our CEYP and provide them with opportunities to develop their confidence, leadership and teamwork skills.

ACE (Aberdeen's Care Experienced) group is supported by a Development Officer funded by LCT and recruited in partnership with Who Cares? Scotland. A range of activities have been arranged throughout the year including an annual residential week. The group provides the platform to present the issues and areas for improvement to the Board's subsequent meetings. While our young people continue to inspire and impress us with their commitment and enthusiasm we will review and improve our engagement and participation activities for young people over the coming year.

Children's Social Work employs two full time Children's Rights Officers who as well as providing support to Looked After Children to attend reviews and statutory hearings, have a broader Corporate Parenting development role. This has included managing and coaching five Children's Rights Development Assistants (CRDAs). CRDAs are care experienced young people employed by the council for up to a year and for six hours per week. The success of this has been recognised and we will look to adapt this model on a sustainable basis.

An individual grants scheme for care experienced young people, launched in September 2016, continues to provide the opportunity for CEYP aged 14 - 25 to apply for a grant of up to £500. The scheme is managed by ACVO, the local Third Sector Interface, who are responsible for the launch, administration and management of the grants. A decision panel consisting of young people from ACE; Who Cares? Scotland and representatives from Education, Children's Social Work and ACVO, assess and decide on the applications. This model of support has been positively received and evaluated.

The latest data set shows a slight improvement in Looked After Children's attainment and school leaver destinations. Whilst the data shows that 71% of Looked After Children achieved positive follow up destinations compared to 91% of other all children – a 20% difference. This means that considerable work is still required to ensure Looked After Children have the same educational opportunities and life chances as others. The Virtual School Head Teacher for Looked After Children post was established in December 2015 to address high exclusion rates disparities in achievement. Whilst each Looked After Child remains the responsibility of the school at which they are enrolled, the Virtual School Head Teacher provides additional co-ordination of support at a strategic and operational level. The role of the Virtual School Head Teacher is to advocate for the right to education for every one of these children, to reduce the exclusion rate and to address the use of part time timetables, which disadvantages this group.

Our Family Firm approach is being reviewed and developed in collaboration with our HR service as part the Councils approach to developing a young workforce strategy. Our Opportunities for all Manager works in close partnership with the service to identify employability opportunities.

Secure Applications for Children

A very small number of young people present a significant danger to themselves or others and for these few; a placement in secure care may be warranted. These placements can be instigated through Court proceedings, or by the CSWO. The CSWO decides whether to implement a secure authorisation by a Children's Hearing and whether to remove a child from secure accommodation – and provides rigorous oversight to the process. The CSWO must be satisfied that the strict criteria for secure placements are met and that such is in the best interest of the child. Such placements are used for the minimum possible time, though this will vary according to the needs of the child.

PLACEMENTS	2013-14	2014-15	2015-16	2016-17	**2017-18**
Total New Placements	3	10 (9 children)	7	6 (4 children)	**6**
Placed by Court	1	1	0	0	**1**
Placed by Hearing & CSWO	0	2	0	1	**1**
Placed by CSWO	2	7	7	5	**4**
Hearing request - Declined	2	2	1	1	**0**

While it is encouraging that there is a fairly stable trend, the use of secure care will continue to be required where circumstances merit. Where the potential for secure is identified, the CSWO must be assured that every effort has made to avoid this option given it results in the ultimate, non-custodial, deprivation of liberty for a young person. The CSWO in Aberdeen takes this role very seriously, and has, on occasion, involved the City Council's legal team to ensure Human Rights Legislation is not being breached, and to provide external challenge to decision making. The importance with which this is regarded is reflected in newly commissioned services for those most at risk of secure and specialist residential provision and redesigned in-house provision to ensure that Secure Accommodation is truly the last resort.

Emergency Transfer of Children

The CSWO will, on occasion, be asked to consider moving a child on a Compulsory Supervision Order to a more suitable placement before the child's circumstances can be presented to a Children's Hearing. There can be a range of circumstances which can trigger the need for such a move including where the carer/s or establishment is unable to meet the child's needs or where the child's behaviour is posing a risk to themselves or others. Research tells us that children do best when there is careful planning in the lead up to a move of placement. The use of emergency moves should consequently be kept to a minimum, reflective of the emergency nature of the child circumstances. It is therefore encouraging that the data reflects the low use of emergency transfers.

	2013-14	2014-15	2015-16	2016-17	**2017-18**
No. of emergency transfers	16	17	10	10	**6 (5 children)**

Adoption; Fostering and Kinship Care

The Chief Officer – Integrated Children & Family Services/CSWO is the Agency Decision Maker. This is a statutory role to consider the approval of plans presented to the Adoption & Permanence Panel and the Alternative Family Care Panel. While the Court determines whether an Adoption Order is granted, the CSWO is the ultimate local authority decision maker on matters pertaining to adoption. It is the role of the CSWO to thoroughly review the information and be assured the recommendations from the Panel are the right ones for the child. As such, some recommendations will not be agreed, or further information sought.

	2013-14	2014-15	2015-16	2016-17	**2017-18**
Adopters Approved	14	34	29	14	**12**
Adoption Plans Approved	19	32	24	23	**29**
Children Adopted	21	19	28	25	**17**
Foster Carers Approved	6	7	9	4	**2**

In March 2014 Aberdeen City was a pilot authority for the PACE, (Permanence & Care Excellence) programme. The PACE programme recognised that delay and drift occurred in the planning for children at every stage of the permanence process and across all agencies. For some this drift and delay can make it difficult for their permanence plan to realised resulting in children remaining within the "care system" for the duration of their childhood.

The service has begun to see a reduction in the length of time it is taking for children's plans to be agreed. The restructure of Children's Social Work recognises the importance of plans being timeously progressed, as the structure embeds, further improvements are anticipated. The success of the PACE programme was recognised in November 2016 when Aberdeen City won a prestigious Herald Society, national award.

The need to have an increased supply of foster carers and adopters is critical to meeting the needs of children who cannot be cared for by their family, perhaps of greater significance locally, is how we identify and support suitable kinship carers. Kinship care enables the child to remain within their family and positive sense of identity. Research also suggests that the outcomes for children living in appropriate kinship placements can often be better than other settings. Accordingly, the service is further developing its support offer to kinship carers to respond to this need.

It is estimated there is a need for 800 foster carers across Scotland. The service operates in a very competitive environment with several Independent Fostering and Adoption agencies operating in the area. The service re-design saw the establishment of a team dedicated to the recruitment, assessment and preparation of new adopters and foster carers. This team will be critical to minimising the need for children to be placed outside of Aberdeen and the associated dislocation from family and community this brings.

The work of the Fostering and Adoption Team was recognised in a highly positive Care Inspectorate inspection this year.

Adult Protection

The Adult Protection Committee (APC) is chaired by an independent convener who is also the convener of Aberdeenshire Council APC. Over the past year there has been significant work undertaken with the committee to both strengthen and improve to provide robust governance of adult protection practices across public, private and wider third sectors. Following an APC development day in November 2017, a decision was made to revise the membership of the committee with new members identified for each agency who are at a senior level within their organisation. Representation on the APC includes Council, NHS Grampian, Aberdeen City Health & Social Care Partnership, Police Scotland, Advocacy

Services, Aberdeen Council for Voluntary Organisations, Scottish Ambulance Service and Scottish Fire and Rescue Service.

The Local Police Commander and the Chief Executives of NHS Grampian and Aberdeen City Council make up the Executive Group for Public Protection and provide leadership, direction and scrutiny of local adult protection services. The group provide oversight and a line of accountability to the Adult Protection Committee. The minutes of each APC are submitted to the group along with exception reporting.

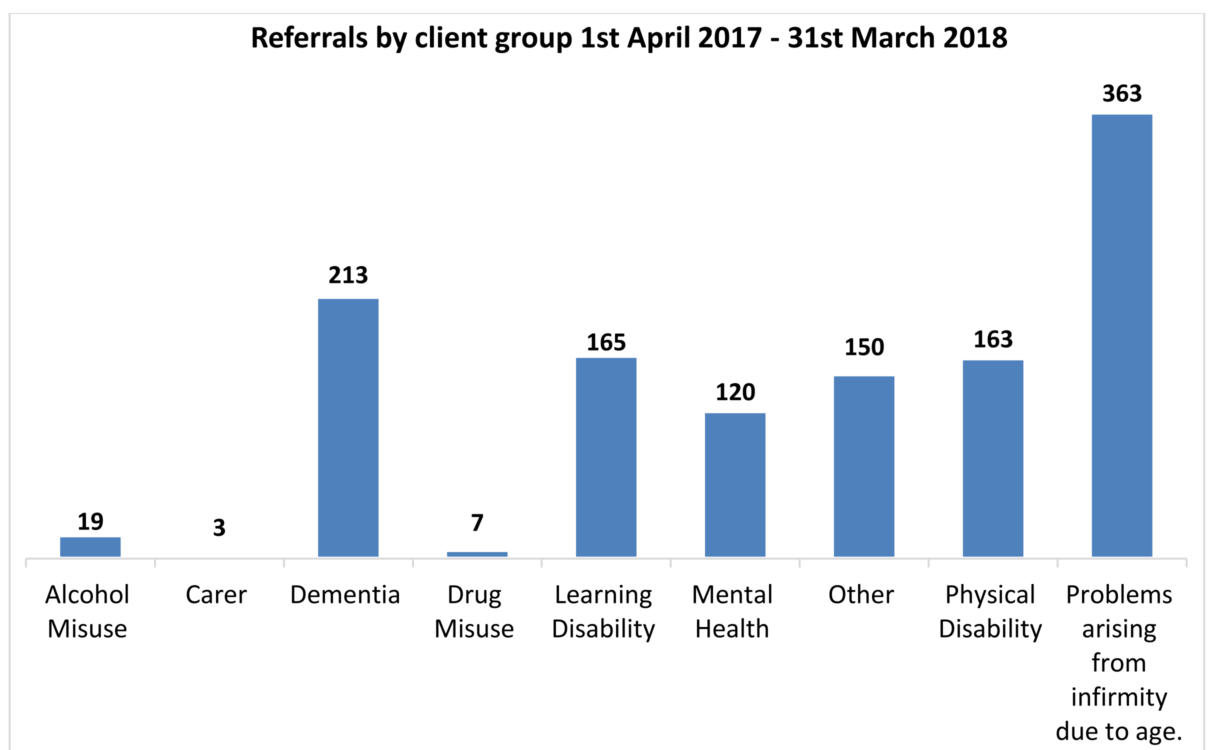
An Operational sub-group has now been established for adult protection and is chaired by the Lead Social Worker who has, as part of her role, lead responsibility for adult protection in the Health & Social Care Partnership. The group is an inter-agency forum and will be responsible for delivering the identified priorities of the APC as detailed in the Adult Protection (AP) Action Plan. The group will have a strong operational basis and will:

- Carry out tasks identified in the AP Action Plan
- Keep a tracker of national and local case learning reviews and Serious Case Reviews (SCR)
- Be responsible for the learning and dissemination of information highlighted in reviews/SCRs
- Highlight ASP operational issues and address them
- Ensure a performance management framework is in place and information is presented to the APC
- Undertake a comprehensive programme of self-evaluation based on quality assurance drivers which demonstrates continuous improvement in service delivery and outcomes.
- Produce quarterly Adult Protection Bulletins
- Establish a communication strategy to enable the effective awareness raising of adult protection across agencies and communities.

The Adult Protection Committee and Child Protection Committee work collaboratively on cross cutting areas of improvement work, such as in relation to the development of consistent case review procedures and multi-agency guidance for professionals working with vulnerable 16 -17 year olds. The CPC and APC each have representatives on the other group and minutes are shared to ensure relevant information and initiatives are shared. There are established procedures in place to guide professionals where there are both child and protection concerns.

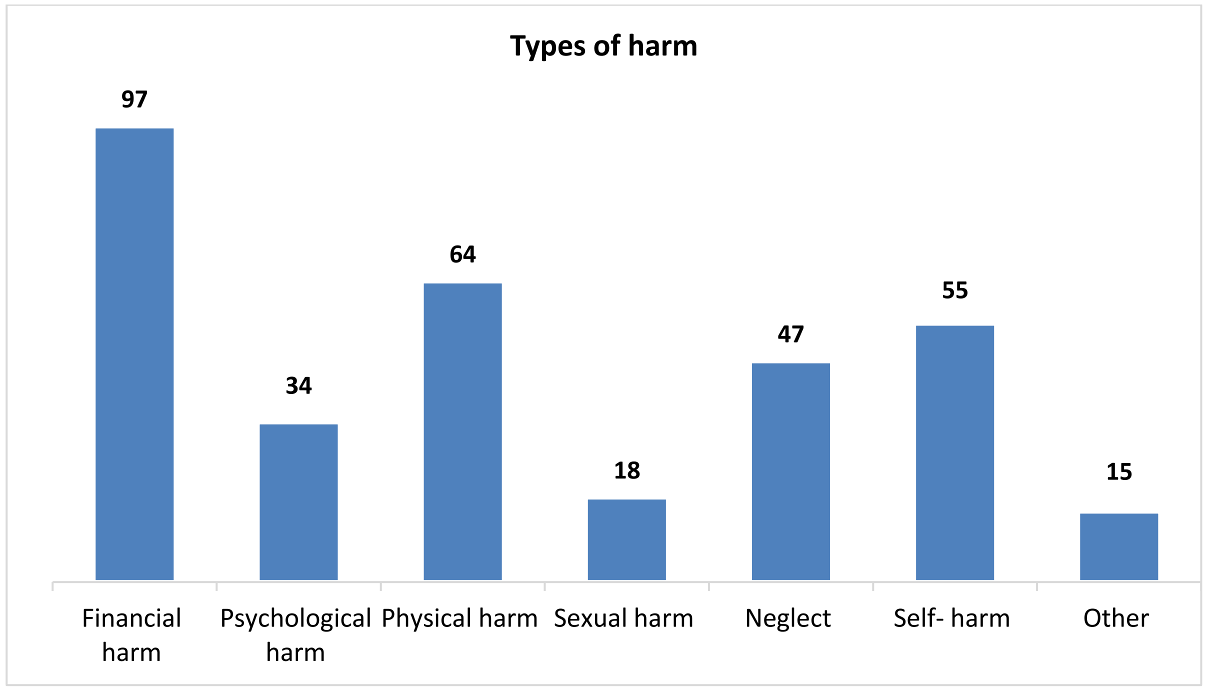
Adult Protection Referrals

1125 referrals were submitted to the adult protection unit over the last year. This is a decrease of 6.5% on the previous year when 1203 referrals were received. The largest number of referrals received per client group continued to be for problems arising from infirmity due to age (32%), followed by Dementia (19%) with 213 reports received.



No further action was taken in 42% of cases with either no risk being identified, inappropriate referral, no support required or support already in place. A further 22% of cases resulted in further action out with the ASP process which could for example be a service/support package being put in place.

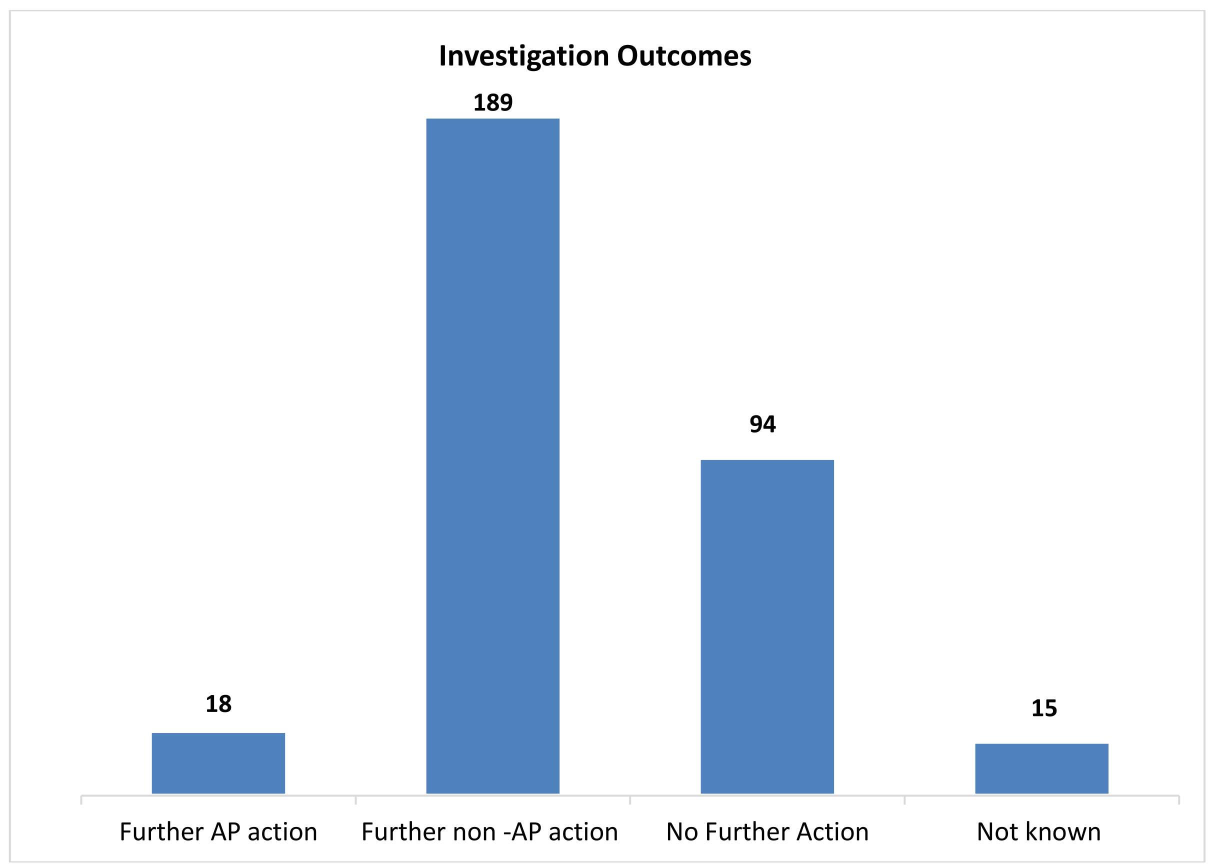
From the all referrals received, 36% of those resulted in investigations completed under the Adult Support and Protection (Scotland) Act 2007. The over 65 age group accounted for 150 out of the 316 investigations.



The main risk factors for adults is financial harm 31%, physical harm 20%, self-harm 17% and neglect 15%.

A suite of performance management information is considered at each meeting of the Operational Sub-group and reported upon, in accordance with a data framework, to the APC. The strategic focus on the range of performance information enables the APC, through its action plan to concentrate on the predominant areas of risk to adults.

Financial harm has continued to increase over several years. The Financial Harm sub group continues to work closely with banks and Trading Standards as well as statutory partners to try to minimise the risk of financial harm and raise awareness. June 2018 was Scams Awareness month which was organised by Citizens Advice who worked closely with the Consumer Protection Partnership to prioritise areas that cause most harm.



There were no protection orders used during the period of this report. Three Large Scale Investigations were conducted which involved multi agency work and cooperation. The commitment from all involved resulted in improving outcomes for the service users and an increased understanding of others' roles and remits. Within the Health & Social Care Partnership we have continued to build relationships with providers and work collaboratively with them to upskill their staff in ASP ensuring our service users are safe and well cared for. Grampian Threshold Guidance was introduced several years ago for care providers and it is our intention to refresh this guidance and ensure this is embedded in practice across all our providers.

Developments in Adult Protection

Following the Joint Inspection of Older Adults in 2016 and the commission of an internal review of adult protection practice within the Health & Social Care Partnership, a short life

working group was established and has continued to drive forward improvements across the partnership based on the improvement plan that was developed.

Significant work has been undertaken, not only in the partnership but with other statutory partners and agencies across Aberdeen. Over the past year we have developed a culture of learning and development for staff ensuring that effective support, good direction and strong leadership are in place.

Vision

"Aberdeen City Health and Social Care Partnership is committed to ensuring an effective, responsive and inclusive approach to the support and protection of adults at risk of harm"

Key themes of adult protection improvement work 2017-2018

A risk register has been developed for the Adult Protection Committee identifying areas of risk, the controls and mitigations. From this, an APC Action Plan for the newly refreshed committee has been written with identified timescales and measures. As previously advised, the new operational sub group will have the responsibility for driving the work forward. Work is around continuous improvement, strategic planning, public information and communication. Work will be informed by ongoing self-evaluation using performance information, case file auditing, significant case reviews, inspection findings, statistics and practitioner's knowledge.

A Champions network has been established across health services within the partnership. Several healthcare staff have been trained in adult protection with more staff training arranged. The role of the Champion has been designed and agreed and once rolled out across the partnership, the aim will be to introduce this across all partners.

A GP event, "Overcoming Barriers in Adult Support and Protection and the Care of Vulnerable Adults" was held at Curl Aberdeen on 22nd November 2017. The event was attended by GPs, Nursing staff, Police, SFRS, Advocacy, solicitors and social work staff. Scenarios of ASP cases were looked at using the Action Learning Framework and this highlighted that while we have made progress in raising awareness in ASP, there is still a way to go with upskilling professionals.

The Care Inspectorate and Health Improvement Scotland returned to Aberdeen for a follow up review inspection at the beginning of June 2018. They considered progress on the 8 recommendations made in their inspection report in 2016. The review consisted of a week of file reading, focus groups, meetings with senior managers and some members of the APC. The inspectors also met with a carers group. At the time of writing, the inspection report has not been received but initial feedback has confirmed that progress has been made in all areas apart from the progression of localities within the Health & Social Care Partnership.

Following the publication of the Joint Inspection of ASP across 6 authorities, a Grampian Workshop has been held to consider the findings from the report and key actions have been identified and will be undertaken by Grampian Working Group.

Adult Protection work identified over next year:

- Continued training with an emphasis on joint training across all partners.
- Increased use of and better quality of chronologies and multi-agency chronologies
- Ensuing staff receive specific training in risk assessment and risk management planning
- Champions to be identified in all partnership agencies to raise awareness and a better understanding of the ASP process.
- Communication and Engagement Strategy developed
- To improve the process for individuals and their families/carers by gathering qualitative data about the experience of the ASP process
- To build upon the work done regarding financial harm
- Adult Support and Protection to be integrated in Locality Plans
- Robust performance framework to be developed
- Improving adult and unpaid carers experience of and participation in the adult protection process

Criminal Justice

Criminal Justice Social Work

The Criminal Justice Social Work (CJSW) service sits within the Health and Social Care Partnership, although further work still requires to be done to increase our profile. Aberdeen continues to follow the national and international trend in that offending is on a downward trajectory. This, and several changes to legislation, guidance and practice across the justice system, have impacted on the Criminal Justice Social Work Service and we need to be responsive to the challenges these bring. Whilst a high-level Community Justice Group is working to deliver on the improvements set out in the Local Outcome Improvement Plan, we still need to improve joint working at operational level to be proactive, rather than reactive to change.

In terms of trends, we can report a slight decrease in the number of Criminal Justice Social Work Reports to courts, a decrease in Community Payback Orders (CPO) imposed, but an increase in the number of CPOs with stand-alone Supervision Requirements. In relation to Unpaid Work we are seeing an increase in the number of people who, due to mental/physical health problems, mobility issues, alcohol/drug use and other issues, require indoor placements. There has also been an increase in the number of sex offenders requiring men-only placements. These have proved challenging for the Unpaid Work Team. We continue to provide a range of outdoor placements and, unsurprisingly, did a lot of snow clearing last winter.

Staffing has been a major issue during the past year for a variety of reasons. Local economic issues tend to deter external candidates, so we often recruit newly qualified workers who have undertaken social work placements with us. This does however mean that lack of experience impacts on ability to be trained to use more enhanced risk assessment tools; a high level of training is required and, several years later, they move on to further their horizons or take maternity leave – or both.

Community Justice

The Community Justice priorities for improvement are embedded in the Local Outcome Improvement Plan (LOIP) and CJSW is involved in several of the projects associated with this. These include:

- Project aimed at increasing the number of people referred to relevant services at the Police Custody Suite. Small scale testing was started in relation to engaging individuals with relevant housing/accommodation supports. This project is on hold pending the development of Police Scotland-led multi agency 'Hub' pilots at custody suites
- Project aimed at increasing the number of individuals aged 16 – 25 appropriately diverted from prosecution. The first part of the project has been around improving information sharing arrangements and raising awareness of the benefits of 'diversion' and processes involved, with staff from the relevant organisations. Future efforts will focus on increasing the numbers;
- Employability pilot, aimed at supporting a small number of individuals on a custodial sentence, Community Payback Order with Supervision, or Diversion from Prosecution to progress on the Employability Pipeline. This project is at the early stages of engaging with potential participants prior to close partnership working to support them going forward. This will enable partners to learn from individual 'journeys' to inform potential future service planning aimed at improving outcomes. (A range of evidence is available which shows that being employed can contribute to reducing the likelihood of someone reoffending.);
- Project to improve the quality of Community Payback Orders by increasing the number of Supervision and Unpaid Work exit questionnaires completed by individuals at the end of their Order, and using the feedback to inform service development;
- Project to increase the number of CPO Unpaid Work individual placement providers in within locality. For 11 out of 12 crime categories, the locality was one of the top three home postcode areas of people against whom charges were made (2013-2016). In some cases, it is desirable for an individual to undertake Unpaid Work in their own locality area. However, there are only a very small number of placement providers, which this project aims to address.

An additional emerging project aims to improve collaborative working to support young people in Polmont.

Pre-Disposal

There has been an increase in the number of individuals given Bail Supervision as an alternative to remand. Arrest Referral and Diversion from Prosecution have both been identified as Community Justice areas for improvement. We are looking at the possibility of working with Police Scotland colleagues to deliver an arrest referral service from Kittybrewster Custody Hub. We have already made improvements in relation to Diversion for young people aged 16-25, specifically data collection and a roadshow and practitioner's forum facilitated by the Centre for Youth and Criminal Justice (CYCJ). There is still work to be done to increase referrals from the Procurator Fiscal, but this will be taken forward nationally. It is anticipated that this "down tariffing" approach which addresses issues at the lower end of the criminal

justice system will prevent people from going to court, having convictions and ultimately from going to prison.

Court

The Problem Solving Court has now been independently evaluated and acknowledged as a model for best practice. The referral criteria for the Problem Solving approach have now been reviewed to be more flexible to ideally include more young people as an alternative to both CPOs and custody.

Young People

On the positive side, earlier intervention has meant that the number of young people entering the adult criminal justice system has declined but that those who do so are at the higher end of the needs/risk continuum. The Youth Team has responsibility for Criminal Justice (CJ) work for those aged 16/17 who are care experienced, while the CJSW service has reassumed responsibility for those who are not. It will be obvious from the information above that we consider young people to be a high priority, so we are committed to training CJ staff to work with this age group. Training in the Smart AV Risk Assessment is being rolled out as further training in working with young people was requested.

Accredited Programmes

The Caledonian System is delivered by ACC to both City and Shire. Aberdeen CJSW was actively involved in the national reaccreditation of the Men's Programme and the accreditation of the Women's Support Service. Aberdeen staff have also been involved in the development and delivery of training. The SARA 3 enhanced domestic abuse risk assessment has been rolled out. The Moving Forward Making Changes (MFMC) is delivered by Aberdeenshire CJSW to both City and Shire. There were issues in relation to changes in funding arrangements and how they may impact on the service, but these have now been resolved. Aberdeen City now has two workers fully trained to deliver the pre-group and groupwork component of the programme. This allows for greater flexibility across both Authorities in the delivery of the programme.

MAPPA

MAPPA continues to function well in relation to both sex offenders and those who are Category 3 (MAPPA extension) offenders, i.e. those who by reason of their conviction are subject to supervision in the community and are assessed as posing a high or very high risk of serious harm to the public. New MAPPA Level 1 and Environmental Risk Assessment (ERA) processes have been recently introduced and, although labour intensive, are gradually bedding in.

Women's Services

The Connections Women's Centre has now been operational in Spring Garden for three years. Outcomes for women are generally good and feedback is positive. We have however, identified a cohort of high needs/risk women with whom we need to work differently if we want to reduce their risk of going to prison on a regular basis or for longer sentences. This

project will be taken forward by staff at the Women's Centre over the next year in collaboration with partner agencies.

Learning Disability

The Learning Disability Service continues to respond to the complex and varied needs of the individuals with Learning Disabilities across Aberdeen City. In July 2017 our new Day Service provision opened, marking a new era for the way in which people with more complex needs can be supported in a building-based service. Since its opening the service and staff have continued to develop their links with the local community and plans are being pursued to create a sensory garden for all the community to enjoy. There are a range of local community groups who use the building for their own group activities and our aim is to continue to develop this over the next year. The Centre, known as the Len Ironside Centre has a Business Hub attached to it and this has enabled the integration of our Community Learning Disability Health and Social Work teams. Working from the same office space promotes joint working and supports the integration of systems and processes, enabling a more holistic service provision to those who require support.

On-going awareness raising of the Learning Disability population within the geographic localities identified within the Health & Social Care Partnership continues to be a focus. Links have been made with Locality Managers and Leadership groups and the service continues to raise awareness through events and information sessions.

One of our achievements during 2017-18 was the development of the service's first Learning Disability Strategy, known as A'thegither in Aberdeen. This whole life strategy was commended for its accessibility and engagement by the Integration Joint Board and will be formally launched alongside development of an Action Plan & Commissioning Plan in 2018. We are proud to say that the development of the strategy fully embraced the principles of engagement and meaningful consultation right from its conception and ensured that people with Learning Disabilities, their families, professionals and organisations were instrumental in its development and the finalised strategy was developed in a co-productive manner. The 3 strategic outcomes identified correlate very much with other policy and strategic documents within both the Partnership and the wider Council, focusing on community connections; promoting people's skills and abilities; and improving health & wellbeing. Work is ongoing in established sub-groups to explore the key issues of Transitions, Housing and Complex Care.

Commissioning activity has also been a key focus for us this past year with revised Frameworks for Care at Home and Supported Living now launched. These new agreements have brought new providers into the city whilst also maintaining many of our existing relationships. The Frameworks have clarified the commissioning requirements the service has for certain models of support, with the addition of an Enhanced Supported Living lot ensuring that the provision of care and support of our most complex individuals can be achieved in a transparent and consistent manner. The implementation of the Frameworks has enabled the monitoring procedures to be aligned to the wider monitoring framework used within the centralised procurement service. Commissioning activity for Skills Development, Training and Employability Services was undertaken in conjunction with City based Mental Health Services and Learning Disability Services in Aberdeenshire. This work sought to bring cohesion to the commissioning of such services and to deliver greater choice of provision to the populations of Aberdeen City and Aberdeenshire.

We continue to work closely with providers of services in the City, exploring joint opportunities and offering support where required. The revision of Frameworks has supported an increased benchmark hourly rate with further Scottish Living Wage uplifts continuing to be given subject to funding settlements. Some providers however still find Aberdeen a tough environment to deliver care & support within, with one care home service requiring to be re-provisioned. Support for individuals with more intensive needs will continue to be met through the re-tender of the existing Intensive Support Service Contract; work will take place in 2018 to redefine the service specification and undertake the necessary procurement activity.

Learning Disability Strategy

Work to develop and implement a Learning Disability Strategy for Aberdeen culminated in the IJB approving this on 27th March 2018 to much acclaim. A strategic steering group composed of wider partnership organisations and a number of sub-groups worked over the course of the latter half of the year to produce a succinct, user friendly strategy. A key part of the strategy development was the promotion of wider engagement with the local community and people with a Learning Disability. The launch of the strategy was planned for Learning Disability Week in May 2018 and featured an event where people with Learning Disabilities could showcase their talents. It was a very sociable and enjoyable affair. Work is now in progress on developing an Action Plan and the Steering Group will continue to drive progress on delivery of the strategy's aims.

Mental Health Legislation

The Mental Health (Scotland) Act 2015 which was enacted on 30th June 2017 increases further still the role of the Mental Health Officer (MHO). This Act is essentially an amendment Act and has been introduced to tackle some of the problems with The Mental Health (Care and Treatment) (Scotland) Act 2003. For example, the provision of mandatory MHO reports in certain circumstances when Compulsory Treatment Orders and Compulsion Orders are extended, significant changes to the Named Person provisions, the introduction of a role for MHOs in the transfer of prisoners for treatment and a brand-new provision relating to Victim's Rights. This enactment is thought to be part of the evolution of mental health legislation reflecting a greater emphasis on the rights of people who use services. MHOs are a key component of this movement.

The figures given below suggests an overall decrease in the use of compulsory measures. Such data is difficult to interpret but the increasing duties for MHOs outlined above means we have not seen a corresponding decrease in workload demands on our MHO Service.

Detention in Hospital Intervention

	2011 - 2012	2012 - 2013	2013 - 2014	2014 - 2015	2015 - 2016	2016 - 2017	**2017 - 2018**
Compulsory Treatment Order	49	65	56	52	62	82	**53**
Emergency Detention in Hospital	20	30	36	36	28	40	**50**
Short-Term	156	186	180	157	170	241	**203**

The Mental Health (Care and Treatment) (Scotland) Act 2003 (the 2003 Act) Section 32, places a responsibility on Local Authorities to appoint sufficient MHOs for their local area to undertake statutory duties. With the integration of Health and Social Care Services this duty remains the responsibility of the Local Authority.

The 2003 Act stipulates that MHOs must be Registered Social Workers working for the local authority who are experienced and who have completed specialist training. Aberdeen City Council (ACC) secures accredited MHO training in partnership with The Robert Gordon University, with the University hosting the academic elements of the course. The Council provides the practice setting and the Practice Assessors who are qualified, practicing MHOs who oversee and assess the knowledge and practice of MHOs in training. In 2016-17, four social workers completed their training and were appointed by the CSWO. A further four are currently undertaking training. Numbers of suitably experienced social workers coming forward for training vary and the demands of the course and on the service in which the worker is based are significant. Practice Assessing is also a demanding role. Recruitment, retention and training of MHOs is an ongoing challenge.

	2013	2014	2015	2016	2017	**2018**
No. of MHOs	34	32	30	34	34	**39**
No. of Trainees	No course	4	4	4	4	**3**

The above figures are intended to provide an overall picture and do not take into account MHOs on Maternity Leave, Sick Leave and those who have moved to promoted, seconded posts. The actual numbers of MHOs providing a service are less than those given above.

There are 32 MHOs located across adult services and 7 in the Out of Hours team. There are 14.7 FTE core MHOs who are paid at a higher grade; these posts are MHO/SW posts and all but one are aligned to multi-disciplinary teams in Adult and Older Adult Mental Health at Royal Cornhill Hospital (RCH). The nonaligned MHO is peripatetic covering where needed. There is one higher graded MHO in the Learning Disability Service. All five Senior Social Worker Posts at RCH are also MHOs. Delayed Discharge monies have been used to create a further temporary half time Grade 14 MHO post to focus on cases where welfare guardianship applications for people in hospital are required. The efficacy of this post is being monitored and will be reviewed. The other MHOs are a mixture of Senior Social Workers, a Service Manager and G13 social workers across adult services.

Mental Health Strategy

The Health and Social Care Partnership is in the process of refreshing the Aberdeen City Mental Health Strategy taking into account the refreshed national strategy which was published in March 2017. Some consultation activity took place towards the end of 2017 with a couple of multi-agency workshops that examined the 40 actions from the national strategy and prioritised them in relation to local needs, identifying the key themes for our local strategy. The long established Mental Health Partnership Group which is a multi-agency group is leading on developing these themes into a strategic document and the aim is to have a first draft of the strategy ready for wider public consultation by the summer of 2018. Following the consultation period, it is hoped that the final strategy will have achieved the necessary approvals and be published by the end of 2018. An action plan will also be developed, and the Mental Health Partnership Group will monitor the delivery of this.

Autism Strategy

Work has commenced to deliver a refresh of the local Autism Strategy & Action Plan for Aberdeen City. This follows the launch of the new National Outcomes & Priorities for Autism by Scottish Government in March 2018. A multi-agency steering group has been established and engagement work planned to establish key priorities and actions for the updated Strategy & Plan.

Adults with Incapacity – Guardianship

Currently for those adults who lack capacity to make decisions or act to safeguard their own welfare, their property or their financial affairs, the Sheriff Court can appoint a guardian under the Adults with Incapacity (Scotland) Act 2000 (the 2000 Act). The local authority has many duties under the 2000 Act including the duty to make application to the Sheriff Court to have the CSWO appointed as Welfare Guardian where this is necessary and no one else is doing so. This duty applies also to financial and property matters, and application must be made to appoint a private solicitor as Financial Guardian. Private individuals can also apply to be appointed as welfare and/or financial guardians. In all cases where welfare powers are sought a report from an MHO is required.

People on Guardianship tend to be diagnosed with dementia, a learning disability or some other condition which affects cognitive abilities such as Huntington's disease, stroke or alcohol related brain damage. In cases where a private individual has been appointed, the local authority has a duty to supervise the guardian at least once a year. Numbers of Guardianships have been increasing year on year. The use of this piece of legislation is also influenced by judgements made in Sheriff and European Courts around deprivation of liberty as it applies to the provision of care and this, alongside the introduction of Self Directed Support is partly responsible for the increase in the use of Guardianship.

- The CSWO is Welfare Guardian for 98 people – down from 110 last year
- Private individuals are welfare guardian for 335 people – up from 312 last year

The overall increase in the use of Guardianship places a growing demand on social work services across the board. There are more Guardianships in place for people with a learning disability than for any other client group. Judgements made in the European Courts around

Deprivation of Liberty have impacted on views about the authority of the 2000 Act. There has been a major consultation by the Scottish Government around the Adults with Incapacity (Scotland) Act 2000 which looks at ways to address the deprivation of liberty issues as well as making the legislation more flexible and quicker to implement. Moves towards supported rather than substitute decision making was also a key aspect of the consultation. There is no doubt that these proposals will have an impact on resources. There will be Short Life Working Groups over the Autumn and tests of the proposals are likely to begin in early January 2019. There is also a review underway to consider how the provisions of the 2003 Act fulfil the needs of people with learning disability and autism.

Older People

2017/18 has seen the Older People/Physical Disability/Rehabilitation Community Care Management service consolidate the four locality-based area teams, working alongside the city-wide Care Management Response Team. There have been increased opportunities to collaborate with our colleagues in the NHS and the wider Partnership with the introduction of initiatives such as the INCA teams in the South and West localities, and the roll out of Acute Care at Home, in the Central locality. Frontline practitioners and managers have been actively participating in the Locality Leadership Groups, as well as various sub groups that have evolved from these, exploring issues such as challenges around care at home provision, and how to reach unpaid carers.

In addition, the Hospital Social Work team based at Aberdeen Royal Infirmary has continued its ongoing integration into the Partnership's Specialist Older Adults and Rehabilitation Service (SOARS). Management of Hospital Social Work is now fully integrated into the wider arrangements in place across SOARS – with appropriate links to the Lead Social Worker for the Partnership.

Practice Improvement/Supporting the Workforce

Practitioners from the Care Management Response Team have been engaged in a test of change alongside NHS colleagues in the Community Adult Assessment and Rehabilitation Service (CAARS) aiming to increase collaborative working and to provide a more targeted and streamlined service to individuals who require access to both these areas of service, ultimately improving the service user experience. This process has involved joint meetings, interagency shadowing, and the establishment of a joint screening tool used by both teams. This is to improve the prioritisation of referrals and ensure individuals are seen timeously and by the most appropriate professional, dependent on need.

There has been a further pilot of new Assessment, Support Plan and Review tools, which has been well received by staff and are now in development by colleagues in Carefirst. With the implementation of the Carers (Scotland) Act 2016, we have now developed the Adult Carer Support Plan tool, and have rolled out information sessions across Adult Services, ensuring staff are fully apprised of new statutory requirements therein. Our commissioned service for adult carers is also now providing an enhanced service, with whom we are working closely to identify and reach unpaid carers to facilitate access to supports and signposting where appropriate.

The SDS core skills training programme has been successfully rolled out and well received by practitioners. Alongside this, we have introduced a Resource Allocation Panel, to support parity of decision making across all areas of service and ensure consistent application of eligibility criteria.

In July the first meeting of our Staff Liaison Group was held. This was introduced to improve the opportunity for meaningful engagement of frontline practitioners in decision making around service transformation, development, and delivery. It is also anticipated that involvement in this forum will afford staff the opportunity for professional development, and a means to enhance their resilience and leadership skills.

Hospital Social Work has now embedded two Care Managers into Woodend Hospital as part of an “Integrated Transitions Team”. Working alongside liaison nursing and an NHS flow coordinator, these staff are offering integrated pathways of support and assistance both into and out of specialist rehabilitation services.

Partnership Working to Address Capacity Issues

As has been the case in previous years, there are continued challenges around the ability of Care at Home providers to fully meet assessed need for care. The new Care at Home framework went live as of January 2017, and alongside this the roll out of the commissioner portal. This is an additional interface within the CM2000 operating system, which enables the electronic matching of care requirements to the available resource from the care providers. Our two Resource Co-Ordinators are now fully embedded into their new role, and this innovative approach has seen a subsequent significant reduction in the recorded hours of unmet need, which has demonstrated overall a downward trajectory throughout 2018. Improvements in our ability to provide care at home enables delivery of the Partnership’s strategic outcomes, in terms of supporting older people to live at home or in a homely setting for as long as possible, and is further underpinned by the Technology Enabled Care workstream, which frontline staff and managers have been engaged in.

The new Care at Home framework will run until January 2019, and as such we are working with providers going forward to explore models of delivery of care at home that move away from time and task to an outcomes focused delivery model. This is currently being developed alongside our ALEO: Bon Accord Care, whose contract expires at the end of July.

Throughout 2017-18 there has been one Large Scale Investigation undertaken into practice in a care home. A targeted multi-agency approach was effective in supporting the care home to make required improvements, and it has been further supported by collaborative working with the new management and provision of care home drop in sessions by Care Management staff.

A small test of change was undertaken by the Partnership to support diversion from acute hospitals. Predicated on managing winter pressure, 2 ‘admission-avoidance’ care home beds were ‘reserved’ in a local nursing home for a three-month period for individuals with a combination of increased physical dependency and medical needs that were clinically safe to be managed by primary care. The beds provided wrap around care and support alongside dedicated GP medical cover as an alternative to hospital admission. The three-month pilot

proved to be very successful with over 95% occupancy over the course of the project and qualitative positive feedback from service users and families and other professionals.

A follow up Progress Review to the 2016 Joint Inspection of Older People's Services took place in June 2018, looking specifically at the recommendations from the previous inspection. This involved file reading of Adult Support and Protection cases, and focus groups with service users, unpaid carers, frontline staff, managers, and lead officers within the Health & Social Care Partnership. The written feedback from this has not yet been received, but initial feedback from the Inspectors recognised improvements and progress in respect of delayed discharge; SDS conversations; Adult Support and Protection processes; and staff morale.

Hospital Social Work has continued to drive forward capacity and process improvements in 2017/18 to further reduce the occurrence of delayed discharges across the hospital estate. A further reduction of 30% in bed days lost was recorded in 2017/18 (primarily related to social work and care activity).

Further Development and Improvement in 2017/18

- New assessment, review and support planning tools to be operational.
- Further collaborative working with commissioned service to improve access to supports for unpaid carers.
- Preparation for the implementation of the Carers (Scotland) Act 2016 in April 2018.
- Regular surgeries to be held in all care homes to enable residents, families and staff to discuss standards of care and any concerns.
- Expand the volume of admission-avoidance beds to 4 and these will be operational for a full year.
- Dedicated Mental Health Officer capacity in place to support complex discharges out of hospital in a safe and timely fashion.

Complaints About Social Work / Social Care Services

The CSWO is made aware of the volume and nature of social work complaints received and will be required to occasionally sign off complaints, where the circumstances of the case require it. An excel spreadsheet register and CareFirst version 6 is used to record data on complaints and allows for analysis and ensures that complaint information is available for services and committees as well as informing service improvements. Complaint information and analysis is reported on a quarterly basis, with trend information provided when possible to help aid understanding of the reasons for the complaints.

Since 1st April 2017, social work complaints are handled under the Complaint Handling Procedure (CHP), which was drawn up by the Scottish Public Services Ombudsman (SPSO). Within the CHP, Stage one complaints can be made, which should be responded to within 5 working days, with the ability to extend to 15 in exceptional circumstances. Stage two complaints are intended for investigation of more complex issues where more time is needed – these should be completed within 20 working days. Where an individual is dissatisfied with the response received, they can take the matter forward to the SPSO and a decision will be made on whether further investigation is needed.

In the period April 2017 to March 2018, there were 250 total complaints recorded, 13 Stage one and 237 Stage two complaints. In 2016/17 there were 237 total complaints. These 250 complaints contained a total of 754 separate complaint points. Of these 754 complaint points, 111 points were upheld, 58 were partially upheld, 507 were not upheld, there were 32 where no decision could be made and 49 were withdrawn.

Children’s services received 149 complaints, which contained 522 separate complaint points, 60 of which were upheld, 36 partially upheld, 377 were not upheld, 19 where no decision could be made and 30 were withdrawn.

Adult services received 101 complaints, which contained 232 complaint points, 51 of which were upheld, 22 partially upheld, 127 not upheld, 13 where no decision could be made, and 19 were withdrawn.

In 2017/18, 87% of complaints that required acknowledgement within 3 working days, were completed on time. This is in comparison to 97% in 2016/17. This reduction is likely attributable to the fact that less time is now permitted to provide acknowledgements.

In total, 85% of complaints were responded to within the 20-working day deadline, compared to 73% in 2016/17. Children’s services responded in time to 85%, compared to 74% in 2016/17 and adult services responded in time to 84% of their complaints compared to 88% in 2016/17.

A total of 7 individuals approached the SPSO for a decision. Only 4 cases were taken on by the SPSO and in two cases, we were asked to reaffirm our apology for errors made and the remaining 2 are still outstanding.

Many factors can influence the number of complaints received and it is difficult to quantify the exact reasons. This can be partly due to the volume of complaints from specific complainants, as well as policy changes and amendments to eligibility criteria for example. The team must react to variations on the volume and complexity of complaints, whilst juggling the other statutory responsibilities, which can at times be challenging and have an effect on compliance.

The Complaints, Rights and Enquiries (CRE) team continue to be actively involved in the investigation of complaints to aid social work staff, which is welcomed by the teams. The CRE team will continue to build on their steady good level of compliance, always with a view to making improvements where possible.

User and Carer Empowerment

Self-Directed Support

The Self-Directed Support (SDS) Team lead by the SDS Coordinator continues to be the hub which gathers and coordinates all feedback in relation to SDS activity and they ensure that action is taken to address new and emerging issues as and when they arise. The implementation of SDS continues to be overseen by the SDS Programme Board which meets monthly and has representation from senior staff from Adult and Children’s Social Care,

Finance, the SDS Team and CareFirst. It receives updates on progress, considers any issues or innovations, and directs the appropriate staff to resolve or implement these.

We are now in the final phase of implementation whereby we are mainly monitoring the effectiveness of, and making minor improvements to, the information, processes and procedures already in place. Significant progress has been made in the last 12 months towards the implementation of the Self-directed Support legislation to the point where it is fully embedded in our operational practice and all of our supported young people, adults and where appropriate their guardians or carers have choice and control over the care received.

This has been achieved in 4 main ways: -

1. Training, advice and guidance for staff
2. Improving access to information for supported young people, adults and their guardians or carers.
3. Revised and improved processes, procedures and documentation.
4. Continual feedback and review

Bespoke training for staff has been delivered and staff make good use of the dedicated helpline to access advice and guidance. The main tool for accessing information is the MyLife portal which is a dedicated web portal where everyone can find out all about Self Directed Support and what it means for them whether they are a member of staff, an individual or an organisation. It contains information on legislation and options and on help available for getting financial support. There is also a Resource Directory for services available from Aberdeen City Council, from the Health and Social Care Partnership and from local third and independent sector providers as well as a Frequently Asked Question section and a range of personal testimonies of individual experiences of self-directed support designed to inspire others.

Information leaflets have been developed (including an Easy Read version) and these are available in public places including GP surgeries. The forms that are used to record packages on our electronic case management system CareFirst, have been revised and these facilitate the gathering and reporting on the progress, of the implementation of SDS and the uptake of each of the 4 options.

A review of all Option 1 packages in Adult Services has been completed and this has led to a number of improved care arrangements for service users. We are hoping to extend the review process to option 2 packages.

The Resource Allocation Panels continue to work well and the remit and process has been refined. We are making progress with identifying individual budgets and are looking to improve the reports that the panel provides to senior management.

We are currently reviewing the process for undertaking audits of Direct Payments to ensure this is as streamlined and as simple as possible for both service users and staff. We are in the final stages of implementing a Pre-Paid Card which will greatly improve access to Direct Payment monies and further simplify the financial audit process and requirements.

Workforce

Planning and Development

Employees in Children's Social Work and Council employees working in the Health & Social Care Partnership are eligible to access the full range of corporate learning and development whether online, through qualifications or workshops.

Over the last year, staff have accessed a wide range of opportunities from this corporate menu – including personal and professional development such as Facilitation Skills, customer service skills through workshops such as Behaviour Breeds Behaviour, digital skills through Microsoft Office courses and management development including Improvement Methodology.

Children's Social Work

We are now at the end of the third year of the implementation of the Reclaiming Social Work Model within Children's Social Work and systemic practice has now been adopted as mainstream practice. Filling Consultant Social Work posts has remained a challenge. The Unit model has been adapted to mitigate this by having fewer units than originally intended with larger units with more Social Work posts.

Recruitment in the social care sector remains a challenge in the Northeast and "growing our own" is a key priority within our workforce planning.

Workforce

There continues to be significant difficulties in recruiting Social Workers (especially experienced Social Workers) and Consultant Social Workers / Team Managers across Children's Fieldwork and the service has utilised agency workers to supplement the core workforce. While this has ensured safe practices, it has resulted in higher than wanted changes in Social Worker for children and their families. Over the year our use of agency staff has reduced as we have built up our workforce. The position is similar in the Children's Residential Service where the vacancy rate remains high.

Learning and Development

As our use of systemic practice beds in the need for First Year System Training has diminished.

It is hoped that Clinical Practitioners will be able to attend a Train the Trainers in Systemic Practice course. This will allow them to deliver the First Year Systemic Training to other staff at Aberdeen City Council at no cost.

More recently the review of residential child care has seen a similar commitment to providing training in Dyadic Developmental Psychotherapy (DDP) for staff working in Children's Homes as well as a number of those working in Family & Community Support roles. This training continues to be rolled out.

The Children's Social Work Learning and Development Team Leader is working on the Training

and Development plan. New Courses such as Parenting Assessments and finance for social works are already running. Workshops to improve Professional writing are being rolled out. A Newly Qualified Social Worker (NQSW) Training program now offers 144 hours face to face training per annum. All NQSWs are also offered mentoring one to one or within a group. Social Work staff are signposted to Leadership and management training offered by corporate training, NELC, and online via OIL or External Providers.

Our Practice Placement Program has undergone rationalization. Our Practice Improvement programme remains a key part of our development. This includes a series of half day training events for all staff throughout the year, as well as an annual full day conference. The theme of this year's conference which was held in May, was the health and wellbeing of our service and its staff and included inputs from national speakers as well as Health and wellbeing activities for staff.

In addition to this service specific learning and development, employees within Children's Social Work have access to the corporate learning and development menu outlined above.

Conclusion

Aberdeen City Council and its partners, like most areas, continue to face demand management and financial challenges. Having a strong social work vision and effective leadership is critical to ensuring that our approach to meeting these challenges utilises that services focus on up to date evidence-based models, research informed practice and a strength-based approaches. This will ensure that children's, adult's and criminal justice is making a difference – and that the impact effectively measured.

Graeme Simpson
Chief Social Work Officer
September 2018

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Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Date of Meeting	11th December 2018
Report Title	Performance Monitoring
Report Number	HSCP.18.114
Lead Officer	Sandra Ross, Chief Officer
Report Author Details	Name: Alison MacLeod Job Title: Lead Strategy and Performance Manager Email Address: alimacleod@aberdeencity.gov.uk
Consultation Checklist Completed	Yes
Directions Required	No
Appendices	A. Priorities, Outcomes and Indicators Map B. Strategic Performance Indicators

1. Purpose of the Report

1.1. The purpose of this report is to advise the Integration Joint Board (IJB) of current developments and future proposals in relation to Performance Monitoring.

2. Recommendations

2.1. It is recommended that the Integration Joint Board:

a) Approves the proposals in relation to performance monitoring approach and timescales as described in paragraphs 3.11 to 3.14 of this report.

b) Notes the commentary in relation to the red indicators from the Annual Report reported to the IJB on 28th August 2018 in paragraph 3.14 of this report.

c) Instructs the Lead Strategy and Performance Manager to develop a local survey to provide robust and relevant feedback from those who use our services

3. Summary of Key Information

3.1. The IJB approves the Annual Performance Report in early summer each year. In addition to the annual reports, in October 2017 the IJB agreed that performance reports would be submitted quarterly to both the Audit and Performance Systems Committee and the IJB alternatively. These reports have been based on both national and local indicators. The IJB received a quarterly report in May 2018, and the Audit and Performance Systems Committee received a quarterly report in September 2018. This means that the IJB are due to receive a quarterly performance report at this meeting however there is so much development on performance management and related strategy at the current time that it was felt it would be useful for this report to detail this and seek approval on a way forward.

3.2. The 23 national indicators are taken from national systems, historical data is available, and we can benchmark nationally. National Indicators 1 to 9 are taken from a bi-annual survey using random sample patients from GP practice lists and as reported previously the response rate to these surveys is typically poor and not reflective of the population using health and social care services. Discussions are underway at a national level as to how this could be improved however the development of a local survey to provide robust and relevant feedback from those who use our services is also being investigated.

3.3. The local indicators were agreed at an early stage in the partnership's development. There are 16 local indicators under the headings of Responsive, Effective, Safe and Well Led. These are collated from a variety of local systems. Indicators such as complaints and absence rates are recorded and reported differently in both NHSG and Aberdeen City Council therefore it is difficult to provide a partnership wide picture.

3.4. In January 2018, the Ministerial Steering Group (MSG) identified 6 performance indicators that they felt demonstrated progress on integration and data is collected nationally on these across all partnerships on a quarterly basis.

3.5. Statutory performance information is collated and reported to the Scottish Government on an annual basis. Some of this information is useful at an operational level and some at a strategic level.

3.6. Whilst the national, statutory and MSG indicators will continue to be reported as required, it was proposed that we review our local indicators and from the range of national, statutory, MSG, local and any other available performance information, identify a bespoke set of strategic performance indicators that give us as a partnership the assurance that we are performing well.

3.7. Good performance means that we are meeting our strategic priorities. These are set out in our strategic plan. We also have the nine national health and wellbeing outcomes that the Scottish Government has indicated partnerships must work towards achieving and the health and social care related commitments in Aberdeen City Council's Local Outcome Improvement Plan (LOIP). The LOIP indicators are also currently being reviewed. The outcome of this review is expected by March 2019.

3.8. A review of all of the performance information currently reported has been undertaken and those that were deemed to demonstrate progress under the priorities and outcomes identified. Appendix A attempts to group the health and wellbeing outcomes, local indicator categories and LOIP priorities under the seven strategic priorities in the current Strategic Plan and to map the linkage of the various performance indicators to each of these.

3.9. From that mapping exercise a range of strategic performance indicators have been identified. These have been grouped into themes under each strategic priority and are listed in appendix B. Also indicated is the source of the data, how often it is captured and whether there is any trend or benchmarking data available. Not all of the performance indicators are currently available however this should not mean that we cannot work towards ensuring the necessary systems and procedures are in place to enable the capture and reporting of this data in future. The mapping spreadsheet and Strategic Performance Indicators were reported to Audit and Performance Systems Committee at their September meeting.

3.10. Since then, following an IJB Workshop on 18th September five new strategic priorities have been identified as part of the strategic plan refresh. In addition, a review of the Strategic Risk Register is underway, and this is another strategic document that performance should be linked to.

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3.11. It is proposed that the mapping exercise is updated to make the links to the refreshed strategic priorities and the strategic risk register. It is further proposed that these strategic priorities form the basis of the Annual Report.

3.12. It is proposed that a tiered approach is taken to performance reporting. The IJB will receive reports on the National and the MSG Indicators as soon as these are available after the end of the financial year, probably at their June meeting. These will be reported nationally, and it is only right that the IJB have sight of this and are advised of the context of the current performance.

3.13. The IJB will also receive the Annual Report for approval at their September meeting. Again this will be published nationally so the IJB is the appropriate level for approval.

3.14. The Audit and Performance Systems Committee and/or the Clinical and Care Governance Committee will receive regular performance reports throughout the year focusing on each of the strategic priorities in turn. These committees will have the opportunity to escalate any areas of concern to the IJB at any time.

3.15. At it's meeting on 28th August the IJB requested that the Partnership circulated a progress update on performance against identified areas of improvement to all IJB members. There were two areas of improvement. The first was in relation to carers not feeling supported to continue in their caring role or feeling that they have a say in the services provided for the person they look after, and the second in relation to the number of readmissions to hospital within 28 days.

3.16. With regards to the carers indicators, as the data gathered was from 2017/18 prior to the implementation of the Carers (Scotland) Act 2016 and the launch of the Aberdeen City Carers Strategy (both in April 2018) it is felt that the relatively negative response from carers was to be expected. It is anticipated that with the delivery of the Carers Strategy Action Plan carers will begin to feel more supported and have more of a say in the care provided to the people they care for. This will be tested at the second of the Carers Conversations Events in January 2019 and reported to IJB as part of the annual report on the implementation of the Carers Strategy in June 2019.

3.17. In relation to readmissions, work is ongoing to ascertain the causes of these. A review was previously undertaken in relation to readmissions for 2011/12 and the approach is to mirror that methodology to determine whether integration has had a positive or negative effect. We are comparing the

source of the referral, the condition of the patient, the existence and effectiveness of Anticipatory Care Plans and the availability of appropriate care in the community. Our initial findings are that readmissions are generally older, more frail, susceptible to falls and suffering from some form of dementia. We are also aware that our unmet needs list for community care is greatly improving and was it lowest ever in late November 2018. A lot of work has gone into reducing the level of unmet need and we will continue to look at options to improve this further. Further detail will be provided when the review is complete.

4. Implications for IJB

4.1. Equalities – this report has no negative implications for people with protected characteristics.

4.2. Fairer Scotland Duty – this report has no implication in relation to the Fairer Scotland duty.

4.3. Financial – this report has no direct implication on finance.

4.4. Workforce – there are no implications for the workforce arising from this report. Performance data will continue to be collected and reported by existing staff as happens currently.

4.5. Legal – there are no legal implications arising from this report. The strategic performance indicators will be used to inform the production of the Annual Report which we are statutorily obliged to publish.

4.6. Other – none.

5. Links to ACHSCP Strategic Plan

5.1. This report aims to develop a set of strategic performance indicators which will demonstrate progress on the strategic priorities and national health and wellbeing outcomes as outlined in the strategic plan.

6. Management of Risk

6.1. Identified risks(s)

If we do not agree relevant and meaningful strategic performance indicators we will be unable to demonstrate our progress on our strategic priorities, the national

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health and wellbeing outcomes and our commitments in the Local Outcome Improvement Plan.

6.2. Link to risks on strategic or operational risk register:

This report links to Strategic Risk 5: -

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

6.3. How might the content of this report impact or mitigate these risks:

By agreeing a set of relevant and meaningful strategic performance indicators and putting in place arrangements for regular reporting and review the partnership can provide assurance of it progress towards achieving it's strategic priorities and meeting the national health and wellbeing outcomes and commitments in the Local Outcome Improvement Plan.

Approvals	
[signature]	Sandra Ross (Chief Officer)
[signature]	Alex Stephen (Chief Finance Officer)

Priorities, Outcomes and Indicators

Priorities	Person Centred Approach	Support and Improve Health, Wellbeing and Quality of Life	Promote and Support Self Management and Independence	Value and Support Unpaid Carers	Contribute to a reduction in Health and Wellbeing Inequalities	Strengthen existing community assets and resources	Support Staff to deliver high quality services
Wellbeing Outcomes	People who use health and social care services have positive experiences of those services and have their dignity respected	Health and Social Care Services are centred on helping to maintain or improve the quality of life of service users	People are able to look after and improve their own health and wellbeing and live in good health for longer	People who provide unpaid care are supported to reduce the potential impact of their caring role on their own health and wellbeing	Health and Social Care services contribute to reducing health inequalities	Resources are used effectively in the provision of health and social care services without wast.	People who work in health and social care services are supported to continuously improve the information, support, care and treatment they provide and feel engaged with the work they do
		People who use health and social care services are safe from harm	People are able to live as far as is reasonably practicable independantly and at home or in a homely setting in their community				
Local Indicator Category	Responsive, Effective	Effective, Safe	Effective	Responsive	Effective	Well Led	Well Led
LOIP	Included	Resilient, Supported	Resilient, Supported	Resilient, Supported	Resilient, Supported, Included	Resilient	Resilient, Supported
Indicators (MSG)	Delayed Discharge Bed Days	Unplanned Admissions					
	Last 6 months of life spent in the community	Unplanned Bed Days					
	Balance of Care (resident in non-hospital setting)	A&E Attendances					
National Indicators	Proportion of last 6 months of life spent at home or in a community setting	% of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	% of adults able to look after their health very well or quite well	Total combined % carers who feel supported to continue in their caring role		Proportion of care service graded 'Good' (4) or better in Care Inspectorate inspections	% of people with positive experience of the care provided by their GP Practice
	Expenditure on end of life care, cost in last 6 months per death	% of adults supported at home who agreed they felt safe	% of adults supported at home who agree that they are supported to live as independantly as possible			% of adults with intensive care needs receiving care at home	% of adults supported at home who agreed that their health and social care services seemed to be well coordinated
	Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,00 population)	Premature mortality rate per 100,000 persons (under 75)	Readmission to hospital within 28 days (per 1,000 population)				Total % of adults receiving any care or support who rated it as excellent or good
	% of people admitted to hospital from home during the year who are discharged to a Care Home	Emergency Admission Rate per 100,000 population	% of health and care resource spent on hospital stays where the patient was admitted in an emergency				% of staff who say they would recommend their workplace as a good place to work
	% of people who are discharged from hospital within 72 hours of being ready	Emergency Bed Day Rate (per 100,000 population)					
		Falls rate per 1,000 population aged 65+					
LOIP Indicators	Delayed Discharges	Number of new referrals to initial investigation under Adult Pro	Emergency hospital admissions - over 65		Alcohol related hospital admissions	Clients supported by Community Links Workers	
		Warwick Edinburgh Mental Wellbeing Scale	Home Care Hours - over 65		Alcohol related mortality		
					Average age seeking help for alcohol problem		
Local Indicators	Number of bed days occupied by delayed discharges per month (inc code 9) per 1,000 18+ population	Number of new referrals to initial investigation under adult support and protection	A&E attendance rates per 100,000 population		Social Care Unmet Need (hours)	% of adults with intensive care needs receiving care at home	Number of complaints received and responded to within 20 working days
	Number of delayed discharges inc code 9 (monthly census snapshot)	Number of community payback orders			Smoking cessation in 40% most deprived areas after 12 weeks		Adult Services posts vacant
	Uptake of self-directed support (% of eligible clients)	Number of Criminal Justice Social Work Reports to court			Number of Alcohol Brief Interventions delivered		Sickness Absence
Others		Life Expectency	% of home care wher two or more members of staff are required	Number of clients receiving support from an unpaid carer	Drug related hospital admission		Total Vacant Posts
		Offender Reconviction Rate	Number of clients using Community Alarm Service	Care Duration	Drug related mortality		Staff Turnover rate
			Number of clients using Telecare	Care Hours	Average age seeking help for drug problem		% of care services in Aberdeen graded good or better on the 4 quality themes
			% of people 65+ with intensive care needs receiving care at home	Number of ACSPs completed	Level of Unmet Need in Social Care		FTE Social Care Agency Staff employed
				Number of ACSPs declined	% of clients receiving alcohol treatment within 3 weeks of referral		
				Number of Short Breaks Provided	% of clients receiving drug treatment within 3 weeks of referral		
				Total Hours of Replacement Care provided	Number of people with a Learning Disability who are in Further Education		
				Total number of new carers identified	Number of people with a Learning Disability who are in Employment		
				% of carers who report they are able to access the information they need	Number of people with a Learning Disability who attends a Day Centre or has alternative opportunities		
				% of carers who report they are supported to manage their caring role	% of Adults registered with a dentist		
				% of carers who report they are involved in planning services for themselves			
				% of carers who report they are involved in planning services for the person they care for			
				% of carers who report they are respected and listened to			
				% of carers who report they are supported to have a life alongside their caring role			

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Strategic Performance Indicators

1. Person Centred Approach

	Measure	Source	Value	Comments
	Theme - Enabling people to have choice and control over their care			
1.1	% Uptake of Self-directed Support Options	SDS Team Stats	% of those eligible offered the 4 SDS options and the % uptake of each	Available monthly, can compare back to Feb 2017 and benchmark nationally. Legislative requirement and strategic intent to implement SDS. Audit Scotland requirement to have 100% uptake by 2020.
	Theme – Shifting the Balance of Care			
1.2	Percentage of population aged 75+ living in a community setting (including care home)	MSG	Percentage of population aged 75+ in community setting (including care home)	Available quarterly. Historical data available also able to benchmark nationally.
	Theme - Delivering care most appropriate for the individual			
1.3	Total Number of Delayed Discharges	Delayed Discharge Dashboard (from TrakCare)	Total number of new and recurring recorded Delayed Discharge	Available monthly. Historical data available also able to benchmark nationally.
	Theme – End of Life Care			
1.4	Proportion of last 6 months of life spent at home or in a community setting	MSG	Proportion of last 6 months of life spent at home or in a community setting	Available annually. Historical data available also able to benchmark nationally.

2. Support and Improve Health, Wellbeing, and Quality of Life

	Measure	Source	Value	Comments
	Theme – Keep people healthy with no need for emergency admission to hospital settings			
2.1	Emergency Admission Rate (per 100,000 population)	National Indicator (NI-12)	Number of admissions (per 100,000 population)	Available annually. Historical data available also able to benchmark nationally.
2.2	Emergency Bed Day Rate (per 100,000 population)	National Indicator (NI-13)	Number of bed days (per 100,000 population)	Available annually. Historical data available also able to benchmark nationally.
2.3	Number of A&E Attendances	MSG	Number of A&E Attendances	Available quarterly. Historical data available also able to benchmark nationally.
2.4	Readmission to hospital within 28 days (per 100,000 population)	National Indicator (NI-14)	Number of people readmitted to hospital within 28 days (per 100,000 population)	Available annually. Historical data available also able to benchmark nationally.
2.5	Falls Rate per 1,000 population aged 65+	National Indicator (NI-16)	Falls Rate per 1,000 population aged 65+	Available annually. Historical data available also able to benchmark nationally.
	Theme – People's perception of their health, wellbeing and quality of life			
2.6	% of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	National Indicator (NI– 2)	% of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	Available bi-annually NB: national survey not effective – propose local survey.
2.6	Warwick Edinburgh Mental Wellbeing Score	LOIP Indicator	Self-assessment score based on a14 item scale with 5 response categories, summed to provide a single score ranging from 14-70	Not currently recorded but it is a measure in the LOIP and would propose we investigate the possibility of implementing this.
	Theme – Indications of good health and quality of life			
2,8	Premature mortality rate per 100,000 persons for people aged under 75	National Indicator (NI-11)	Number of people under 75 recorded as dying prematurely	Available annually. Historical data available also able to benchmark nationally.

	Measure	Source	Value	Comments
2.9	Life Expectancy	Public Health	Average age both males and females are expected to live per area	Available annually. Historical data available and able to benchmark against other areas.
	Theme – Keeping people safe			
2.10	% of adults supported at home who agreed they felt safe	National Indicator (NI-9)	% of adults supported at home who agreed they felt safe	Available bi-annually NB: national survey not effective – propose local survey.
2.11	Number of new referrals to initial investigation under Adult Protection	APU Statistics	Number of new referrals to initial investigation under Adult Protection	Available monthly. Historical data available. Increase in new referrals can be a positive outcome due to better awareness and increased reporting.
2.12	Number of Community Payback Orders	CJSW Statistics	Number of Community Payback Orders	Available monthly. Historical data available. Measure indicates the number of offenders paying their debt to society which assist in their rehabilitation.
2.13	Number of Criminal Justice Social Work Reports to Court	CJSW Statistics	Number of Criminal Justice Social Work Reports to Court	Available monthly. Historical data available. Measure indicates the number of offenders being processed through the court system and Social work's contribution to that.
2.14	Offender Re-conviction Rate	CJSW Statistics	Offender Re-conviction Rate	Available monthly. Historical data available. Lower reconviction rate indicates improved rehabilitation and safer communities.

3. Promote and Support Self-Management and Independence

	Measure	Source	Value	Comments
	Theme – people's perception of their ability to look after their own health and live independently			
3.1	% of adults able to look after their health very well of quite well	National Indicator NI-1	% of adults able to look after their health very well of quite well	Available bi-annually NB: national survey not effective – propose local survey.
3.2	% of adults supported at home who agree that they are supported to live as independently as possible	National Indicator NI-2	% of adults supported at home who agree that they are supported to live as independently as possible	Available bi-annually NB: national survey not effective – propose local survey.
	Theme – Enabling people to live independently			
3.3	Total Home Care Hours Delivered	Source Social Care Data Set	Total Home Care Hours Delivered	Social Care Data will be uploaded to Source from August 2018 and will be reported using Tableau.
3.4	% of Home Care where two or more members of staff are required	Source Social Care Data Set	% of Home Care where two or more members of staff are required	Social Care Data will be uploaded to Source from August 2018 and will be reported using Tableau.
3.5	% of people aged 65+ with intensive care needs receiving care at home	National Indicator NI-18	% of people aged 65+ with intensive care needs receiving care at home	Available annually. Historical data available also able to benchmark nationally.
3.6	Number of people using a Community Alarm Service	Source Social Care Data Set	Number of people using a Community Alarm Service	Social Care Data will be uploaded to Source from August 2018 and will be reported using Tableau.
3.7	Number of people using Telecare	Source Social Care Data Set	Number of people using Telecare	Social Care Data will be uploaded to Source from August 2018 and will be reported using Tableau.

4. Value and Support Unpaid Carers

	Measure	Source	Value	Comments
	Theme – amount of unpaid care provided			
4.1	Number of clients receiving support from an unpaid carer	Source Social Care Dataset	Number of clients receiving support from an unpaid carer	Social Care Data will be uploaded to Source from August 2018 and will be reported using Tableau.
4.2	Care Duration	Carers Census	The length of time in years that a carer has been providing care	Census data available from 2019 onwards
4.3	Care Hours	Carers Census	The number of hours per week that the carer provides in a typical week.	Census data available from 2019 onwards
	Theme – Impact of Carer's Strategy			
4.4	Number of ACSPs completed	Carers Census	Number of ACSPs completed	Census data available from 2019 onwards
4.5	Number of ACSPs declined	Carers Census	Number of ACSPs declined	Census data available from 2019 onwards
4.6	Number of Short Breaks Provided	Carers Census	Number of Short Breaks Provided	Census data available from 2019 onwards
4.7	Total Hours of Replacement Care provided	Carers Census	Total Hours of Replacement Care provided	Census data available from 2019 onwards
4.8	Total number of new carers identified	Carers Census	Total number of new carers identified	Census data available from 2019 onwards
4.9	% of carers who report they are able to access the information they need	Carers Conversation Survey	% of carers who report they are able to access the information they need	Next Carers Conversation Survey scheduled for January 2019. Results available from March 2019 and biannually thereafter.
4.10	% of carers who report they are supported to manage their caring role	Carers Conversation Survey	% of carers who report they are supported to manage their caring role	Next Carers Conversation Survey scheduled for January 2019. Results available from March 2019 and biannually thereafter.
4.11	% of carers who report they are involved in planning services for themselves	Carers Conversation Survey	% of carers who report they are involved in planning services for themselves	Next Carers Conversation Survey scheduled for January 2019. Results available from March 2019 and biannually thereafter.

	Measure	Source	Value	Comments
4.12	% of carers who report they are involved in planning services for the person they care for	Carers Conversation Survey	% of carers who report they are involved in planning services for the person they care for	Next Carers Conversation Survey scheduled for January 2019. Results available from March 2019 and biannually thereafter.
4.13	% of carers who report they are respected and listened to	Carers Conversation Survey	% of carers who report they are respected and listened to	Next Carers Conversation Survey scheduled for January 2019. Results available from March 2019 and biannually thereafter.
4,14	% of carers who report they are supported to have a life alongside their caring role	Carers Conversation Survey	% of carers who report they are supported to have a life alongside their caring role	Next Carers Conversation Survey scheduled for January 2019. Results available from March 2019 and biannually thereafter.

5. Contribute to a reduction in Health Inequalities

	Measure	Source	Value	Comments
	Theme – Reduce substance misuse			
5.1	Alcohol related hospital admissions	LOIP	Alcohol related hospital admissions	To be developed
5.2	Alcohol related mortality	LOIP	Alcohol related mortality	
5.3	Average age seeking help for alcohol problem	LOIP	Average age seeking help for alcohol problem	
5.4	Number of Alcohol Brief Interventions delivered	Local Indicator	Number of Alcohol Brief Interventions delivered	
5.5	% of clients receiving alcohol treatment within 3 weeks of referral	ADP Dashboard	% of clients receiving alcohol treatment within 3 weeks of referral	
5.6	Drug related hospital admission	ADP Dashboard	Drug related hospital admission	
5.7	Drug related mortality	ADP Dashboard	Drug related mortality	
5.8	Average age seeking help for drug problem	ADP Dashboard	Average age seeking help for drug problem	
5.9	% of clients receiving drug treatment within 3 weeks of referral	ADP Dashboard	% of clients receiving drug treatment within 3 weeks of referral	
5.10	Smoking cessation in 40% most deprived areas after 12 weeks	Local Indicator	Smoking cessation in 40% most deprived areas after 12 weeks	
	Theme – access to services			
5.11	Social Care Unmet Need (hours)	Social Care	Number of hours or unmet need per week	
5.12	% of adults registered with a GP		% of adults registered with a GP	
5.13	% of adults registered with a dentist		% of adults registered with a dentist	
	Theme – helping those with a disability to			
5.14	Number of people with a Learning Disability who are in Further Education	LDSS Data Collection	Number of people with a Learning Disability who are in Further Education and the number of days per week they attend	Available annually, historical data available.
5.15	Number of people with a Learning Disability who are in Employment	LDSS Data Collection	Number of people with a Learning Disability who are in Employment and the type of employment.	Available annually, historical data available.
5.16	Number of people with a Learning Disability who attends a Day Centre or has alternative opportunities	LDSS Data Collection	Number of people with a Learning Disability who attends a Day Centre or has alternative opportunities and the number of hours per week.	Available annually, historical data available.

6. Strengthen existing community assets and resources

	Measure	Source	Value	Comments
	Theme – Quality of Care Home Provision			
6.1	Proportion of care service graded 'Good' (4) or better in Care Inspectorate inspections	Care Inspectorate	Proportion of care service graded 'Good' (4) or better in Care Inspectorate inspections	Available annually, historical data available for comparison
	Theme – Community assets and resources			
6.2	% of adults with intensive care needs receiving care at home	National Indictor NI-18	% of adults with intensive care needs receiving care at home	Available annually, historical data available for comparison and able to benchmark nationally
6.3	% of Community Links Workers in post	Commissioned Service	% of Community Links Workers in post	Will be available for 2019 onwards
6.4	Number of clients supported by Community Links Workers	Community Link Worker data	Number of clients supported by Community Links Workers	Will be available for 2019 onwards
6.5	Number of community groups convened and meeting regularly	Locality Leadership Groups	Number of community groups convened and meeting regularly	Will be available for 2019 onwards
6.6	Number of community training sessions delivered	Engagement Development Officer	Number of community training sessions delivered	Will be available for 2019 onwards

7. Support staff to deliver high quality services

	Measure	Source	Value	
	Theme – Service User Experience			
7.1	% of people with positive experience of the care provided by their GP Practice	National Indicator NI-6	% of people with positive experience of the care provided by their GP Practice	Available bi-annually NB: national survey not effective – propose local survey.
7.2	% of adults supported at home who agreed that their health and social care services seemed to be well coordinated	National Indicator NI-4	% of adults supported at home who agreed that their health and social care services seemed to be well coordinated	Available bi-annually NB: national survey not effective – propose local survey.
7.3	Total % of adults receiving any care or support who rated it as excellent or good	National Indicator NI-5	Total % of adults receiving any care or support who rated it as excellent or good	Available bi-annually NB: national survey not effective – propose local survey.
7.4	Number of complaints received and responded to within 20 working days	Local systems	Number of complaints received and responded to within 20 working days	Easily available for social care, harder to extract for partnership services from NHSG systems
	Theme – Staff Experience			
7.5	% of staff who say they would recommend their workplace as a good place to work	IMatters	% of staff who say they would recommend their workplace as a good place to work	Collected annually – can be compared with other NHSG and ACC areas
7.6	Total FTE posts vacant	HR Systems	Total FTE posts vacant broken down per service	Collection methodology to be explored
7.7	Total FTE Agency Staff employed	HR Systems	Total FTE Agency Staff employed broken down per service	
7.8	Sickness Absence Rate	HR Systems	Sickness Absence Rate	
7.9	Staff Turnover rate	HR Systems	Staff Turnover rate	

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Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Date of Meeting	11th December 2018
Report Title	Draft Strategic Plan 2019-2022
Report Number	HSCP.18.102
Lead Officer	Sandra Ross, Chief Officer.
Report Author Details	Kevin Toshney, Planning and Development Manager. KToshney@aberdeencity.gov.uk
Consultation Checklist Completed	Yes
Directions Required	No
Appendices	a) ACHSCP Draft Strategic Plan 2019- 2022

1. Purpose of the Report

1.1. The purpose of this report is to present the draft Strategic Plan 2019-2022 to the IJB and to get its approval for there to be a public consultation on this plan.

2. Recommendations

2.1. It is recommended that the Integration Joint Board:

a) Note the draft Strategic Plan 2019-2022.

b) Agree that there should be a public consultation on this plan during the period 7th January – 28th February 2019.

c) Agree that the most current version of the ACHSCP Strategic Plan should be presented to the IJB at its Budget Meeting.

NHS Grampian
ABERDEEN CITY COUNCIL

d) Agree that the revised ACHSCP Strategic Plan 2019-2022 should be presented to the IJB at its scheduled meeting on 26th March 2019 for final agreement and that the IJB are to be advised when the accompanying Implementation Plan will be presented to the Audit and Performance Systems Committee.

3. Summary of Key Information

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

3.2. Its policy ambition is to:

"…improve the quality and consistency of services for patients, carers, service users and their families; to provide seamless, joined up quality health and social care services in order to care for people in their own homes or a homely setting where it is safe to do so; and to ensure resources are used effectively and efficiently to deliver services that meet the increasing number of people with longer term and often complex needs, many of whom are older."

3.3. Integration authorities are required by the legislation to produce a Strategic Plan for the delegated functions and budgets that they have a responsibility for.

3.4. The strategic plan:

(a) sets out the arrangements for the carrying out of the integration functions for the area of the local authority over the period of the plan,

(b) sets out how those arrangements are intended to achieve, or contribute to achieving, the national health and wellbeing outcomes, and

(c) includes such other material as the integration authority thinks fit.

The strategic plan is required to be reviewed and, if required, replaced every three years

3.5. Integration authorities are required to have at least 2 localities whose views must be taken into account and the arrangements for each locality must be set out separately.

3.6. At its previous meeting of 9th October 2018, the IJB agreed to begin a consultation on the Partnership's locality model, which would include the possibility of moving from a 4 to a 3-locality model so that there was the opportunity for a better alignment with community planning structures and activities. The IJB also requested that this proposal be incorporated into the draft Strategic Plan so that there could be a public consultation with appropriate stakeholders. Feedback on the response to this specific proposal will be provided to the IJB when the revised strategic plan is presented to the IJB in March 2019.

3.7. A short-life working group has been set up to produce a 3-locality model that will offer better opportunities for aligning with community planning structures and activities. A map of the proposed locality model will be included in the consultation draft of the strategic plan.

3.8. The partnership is required to ensure that stakeholders are fully engaged in the preparation, publication and review of the strategic commissioning plan. There has been significant engagement with appropriate stakeholders in the development phase of this plan

3.9. Engagement with our stakeholders in respect of this plan will continue up to its final revision in March 2019. A statement showing the extent of our engagement activity will be provided along with the revised Strategic Plan at the IJB meeting scheduled for 26th March 2019.

3.10. The draft Strategic Plan 2019-2022 is set out in Appendix A.

4. Implications for IJB

4.1. **Equalities -** There are no direct equalities implications arising from the recommendations of this report. However, the draft Strategic Plan takes cognisance of the equality outcomes expected of the IJB.

4.2. **Fairer Scotland Duty** - There are no direct implications arising from the IJB's Fairer Scotland duty in respect of the recommendations of this report.

However, the draft Strategic Plan takes cognisance of the IJB's Fairer Scotland duty.

4.3. Financial - There are no direct financial implications arising from the recommendations of this report. However, the draft Strategic Plan articulates the financial implications of the implementing the proposed strategy.

4.4. Workforce - There are no direct workforce implications arising from the recommendations of this report. However, the draft Strategic Plan articulates the workforce implications of implementing the proposed strategy.

4.5. Legal - Non-publication of a strategic plan would be contrary to the Public Bodies (Joint Working)(Scotland) Act 2014.

5. Links to ACHSCP Strategic Plan

5.1. This is a revised and refreshed version of the partnership's Strategic Plan.

6. Management of Risk

6.1. Identified risks(s)

The identified risks in the partnership's Strategic Risk Register are explicitly linked to the ambitions and priorities outlined in the Strategic Plan and the arrangements that are put in place to meet these and fulfil the desired national outcomes.

6.2. Link to risks on strategic or operational risk register:

- There is a risk of significant market failure in Aberdeen City:
  - a. Adult Social Care High
  - b. General Practice Services

- There is a risk of financial failure, that demand outstrips budget and IJB cannot deliver on priorities, statutory work, and projects an overspend.
- There is a risk that the outcomes expected from hosted services are not delivered and that the IJB does not identify non-performance in through its systems. This risk relates to services that Aberdeen IJB hosts on behalf of Moray and Aberdeenshire, and those hosted by those IJBs and delivered on behalf of Aberdeen City.
- There is a risk that relationship arrangements between the IJB and its partner organisations (Aberdeen City Council & NHS Grampian) are not

managed to maximise the full potentials of integrated & collaborative working. This risk covers the arrangements between partner organisations in areas such as governance; corporate service; and performance.

- There is a risk that the IJB, and the services that it directs and has operational oversight of, fail to meet both performance standards/outcomes as set by regulatory bodies and those locally-determined performance standards as set by the board itself. This may result in harm or risk of harm to people.
- There is a risk of reputational damage to the IJB and its partner organisations resulting from complexity of function, delegation and delivery of services across health and social care
- There is a risk of failure to deliver transformation at a pace or scale required by the demographic and financial pressures in the system
- There is a risk that the IJB does not maximise the opportunities offered by locality working
- There is a risk of failure to recruit and that workforce planning across the Partnership is not sophisticated enough to maintain future service deliver

6.3. How might the content of this report impact or mitigate these risks:

This draft Strategic Plan proposes high level strategic objectives in order to address known challenges in the health and wellbeing of the local population and the capacity and capability of the partner agencies to deliver the desired integrated services.

Approvals	
[signature]	Sandra Ross (Chief Officer)
[signature]	Alex Stephen (Chief Finance Officer)

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Aberdeen City Health & Social Care Partnership

Strategic Plan 2019-2022

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Integration Principles.

The partnership is required to take into account the national integration principles when preparing the Strategic Plan.

These principles, stated below, clearly state that the main purpose of integrated services is to improve the wellbeing of our citizens and these services should be provided in a way in which, so far as possible:

- Is integrated from the point of view of recipients
- Takes account of the particular needs of different recipients
- Takes account of the particular needs of recipients from different parts of the area in which the service is being provided
- Takes account of the particular characteristics and circumstances of different service users
- Respects the rights of service users
- Takes account of the dignity of service users
- Takes account of the participation by service users in the community in which service users live
- Protects and improves the safety of service users
- Improves the quality of the service
- Is planned and led locally in a way which is engaged with the community (including in particular service users, those who look after service users and those who are involved in the provision of health or social care)
- Best anticipates needs and prevents them arising
- Makes the best use of the available facilities, people and other resources

A key challenge, which we accept unreservedly is for these principles to be part and parcel of our day-to-day professional practice across all sectors and services. It is important to us as a principled partnership that our actions meet, if not exceed the expectations that are placed on us.

Contents

1. Introduction

2. Some background information

3. Achieving healthier, fulfilling lives

4. Our Enablers

5. How will we know we are making a difference?

Appendices.

1. Housing Contribution Statement (tbc)
2. Equality Impact Assessment (tbc)

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

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Twitter: https://twitter.com/HSCAberdeen

This document is also available in large print, other formats and other languages, on request.

Please contact the Aberdeen City Health & Social Care Partnership on 01224 625729

For help with **language / interpreting** and other formats of communication support, please contact 01224 522856/522047

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IJB Chair Foreword

To be inserted…

Chief Officer Foreword

To be inserted…

1. Introduction

1.1 This Strategic Plan outlines our continuing ambitions in respect of the health and wellbeing of our local population and those adult health and social care functions and services which are delegated by Aberdeen City Council (ACC) and NHS Grampian (NHSG) to the Aberdeen City Health & Social Care Partnership (ACHSCP).

It reflects the many conversations we have had with the people of Aberdeen and our professional colleagues across the health, social care, third, independent and housing sectors across all adult age groups and client groups about what the partnership should be doing to promote and support everyone's health and well-being especially those with complex needs.

The ambitions and priorities of this plan are relevant across all these sectors. The challenge that we accept is to make this plan a credible and meaningful document for many different people in different situations and circumstances across the city: the young adult living with autism; the person receiving palliative and end-of-life care; the frail, elderly person; the middle-aged man trying to cope with a number of physical and mental illnesses and health conditions; the woman living with a mental health illness; the man on his substance misuse recovery journey; the person with a sensory impairment; the woman with complex physical and learning disabilities; the older person living with dementia and the unpaid carers.

1.2 Our strategic vision and values underpin all our activities, initiatives and developments. We have revised these given comments made during our many engagement conversations, but their essence remains the same.

"We are a caring partnership working in and with our communities to enable people to achieve fulfilling, healthier lives".

"Caring, Person centred, Enabling"

This vision and these values are relevant and applicable across the diversity and complexity of all the delegated functions across the health, social care, third, independent and housing sectors. They define who we are and what is important to us.

1.3 We remain committed to improving the:

- **the health and wellbeing of our local population across all localities**
- **the experiences and outcomes of the individuals who use our services**
- **the allocation of our staffing, financial and physical resources**

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It is heartening to know that our overall health profile is better than the Scottish national average however we know that within the city, there are significant differences in life expectancy, premature deaths, emergency hospital admissions and general health and wellbeing, with some communities reporting greater levels of health problems than others.

We have reduced unmet needs for social care, increased the proportion of people aged 65 years and above with intensive care needs who receive care at home, and increased the uptake of self-directed support. We have dramatically reduced the number of additional days that people spend in hospital due to their delayed discharge and the number of people whose A&E attendance results in emergency admission to hospital is markedly lower than the rest of Scotland.

People's experiences of using our services is a very useful indication of how caring and person-centred we actually are. We are committed to improving the personal experiences and outcomes of the people who use our services and their carers and, we want to hear of those examples and circumstances where expectations have not been met so we can learn from these and where necessary improve matters.

We are pleased that there has been an increase in the % of adults who said that they are supported to live as independently as possible; who say they have had a say in how their care is provided; who agree that their care is well co-ordinated and who rated their care or support as excellent or good. We are mindful though, that there has been a decrease in positive GP experiences and that our unpaid carers also feel less than satisfied but overall these local experiences reflect well against the national trend of reducing levels of satisfaction.

The safety and wellbeing of our citizens is important to us; we want to ensure that Aberdeen is a place where everyone feels safe, supported and included. We are committed to working with our public protection partners to keep people safe from any physical, sexual, psychological or financial harm or neglect. There has been significant work undertaken to both strengthen and improve the governance of adult protection services. We will continue delivering the improvements outlined in our Improvement programme 2018-2020.

1.4 We have reflected on our experiences since integration 'Go Live' in April 2016 and the impact of our current plan to shape our proposed strategic objectives for the next three years. We have also identified those key enablers that need to be in place to give our objectives and priorities the best possible chance of being fulfilled.

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Objective	What is this?	Priorities
Prevention	We will work with our partners to achieve positive individual outcomes and lessen the need for formal supports.	Promote positive mental health and wellbeing. Address the factors that cause inequality in outcomes in and across our communities. Reduce alcohol and drug related harm.
Resilience	Supporting people and organisations so that they are able to cope with and where possible overcome the adverse health and wellbeing challenges that they might face.	Promote and support self-management and independent living for individuals. Value and support unpaid carers.
Right Care, Right Place, Right Time	Ensuring a personalised response to individual needs and circumstances that can adapt to complexity and occasional or enduring use.	Reshape our primary care sector. Shift the balance of care from the acute health sector to community-based services. Develop our palliative and end of life care provision.
Connections	Develop meaningful connections and relationships to promote better inclusion, health and wellbeing.	Enable our citizens to have opportunities to maintain their wellbeing and take a full and active role in their local community. Counter the perception of loneliness and isolation experienced by all age groups.
Communities	We will work in and with our communities, recognising the valuable role that people have in supporting themselves to stay well and support each other when care is required.	Implement our three-locality model. Develop a diverse and sustainable care provision.
Empowered Workforce **Principled Commissioning** **Digital Transformation** **Sustainable Finance**		

Table 1 ACHSCP Objectives and Priorities.

1.5 This plan provides an overview of adult health and social care in Aberdeen and seeks to establish a shared understanding of our challenges and priorities. Given our future demographic and financial challenges it is unlikely that the partnership will be able to satisfy an increased demand for our services with fewer resources available. Doing more of the same is not a sustainable option for us and so we will need to have honest conversations with the local population about their expectations and how we can enable them to keep well and where appropriate, support them to manage their conditions. We accept that we will have to reshape and, in some cases, transform how and where we deliver our services.

We remain ambitious to be recognised as an innovative and high-performing partnership. With the support of the people of Aberdeen and our many valued partners we are confident that we will achieve this and other shared, desired outcomes.

2. Some background information

The **Aberdeen median** age is **36 years** compared to **42** across **Scotland**.

By **2026** the **population of Aberdeen** is projected to **increase** by **3.2%** to **237,169**, with the largest projected increase in the 75+ years age group (15.5%).

113 (40%) of the city's data zones are in the **20% least deprived** areas of Scotland. However, there are **22 (8%)** data zones in the **20% most deprived** areas of Scotland.

24% of the city's **population** was **born outside the UK** (**compared to 9.0% for Scotland**). Of those, it is estimated that **60%** are from **EU countries** and **40%** from **non-EU countries.**

The **population** of **Aberdeen** on **30th June 2017** was estimated to be **228,800** (**4.2% of the total population of Scotland**).

Aberdeen has a **higher proportion** of **working age people** and a **lower proportion** of **under 16 year-olds** and **people** of **pensionable age** than does **Scotland.**

In **2014-2016** estimated **life expectancy at birth** was **80.8 years** for **females** and **76.4 years** for **males.**

Both **male** and **female life expectancy** have **decreased** in each of the **last three years** and are now **lower** than average life expectancy for Scotland.

In **2017** the **mortality rate** remained **unchanged** at **10.6 per 1,000 population** (the national rate increased between **2016** and **2017** from **10.5** to **10.7** per **1,000 people**).

In **2016/17** there were **1,520 alcohol-related hospital stays** in Aberdeen City. While the rate of stays has **decreased** over the past 10 years, it is still higher than that for Scotland (705.4 compared to 680.8 per 100,000 population).

It is estimated that over a fifth (**21.1%**) **of adults** in **Aberdeen City smoke** - **lower than Scotland at 24.3%.** Those in the **most deprived areas** are **more likely** than those in the **least deprived areas to smoke** (32% compared to 12%).

Females in the **most deprived areas** have a life expectancy of **77.7 years** compared to **84.1 years** for those in the **least deprived** quintile – a difference of **6.4 years.**

Males in the **most deprived area** (SIMD 2016) in Aberdeen have a life expectancy of **72.0 years** compared to **81.0 years** for those in the **least deprived** quintile – a difference of **9 years.**

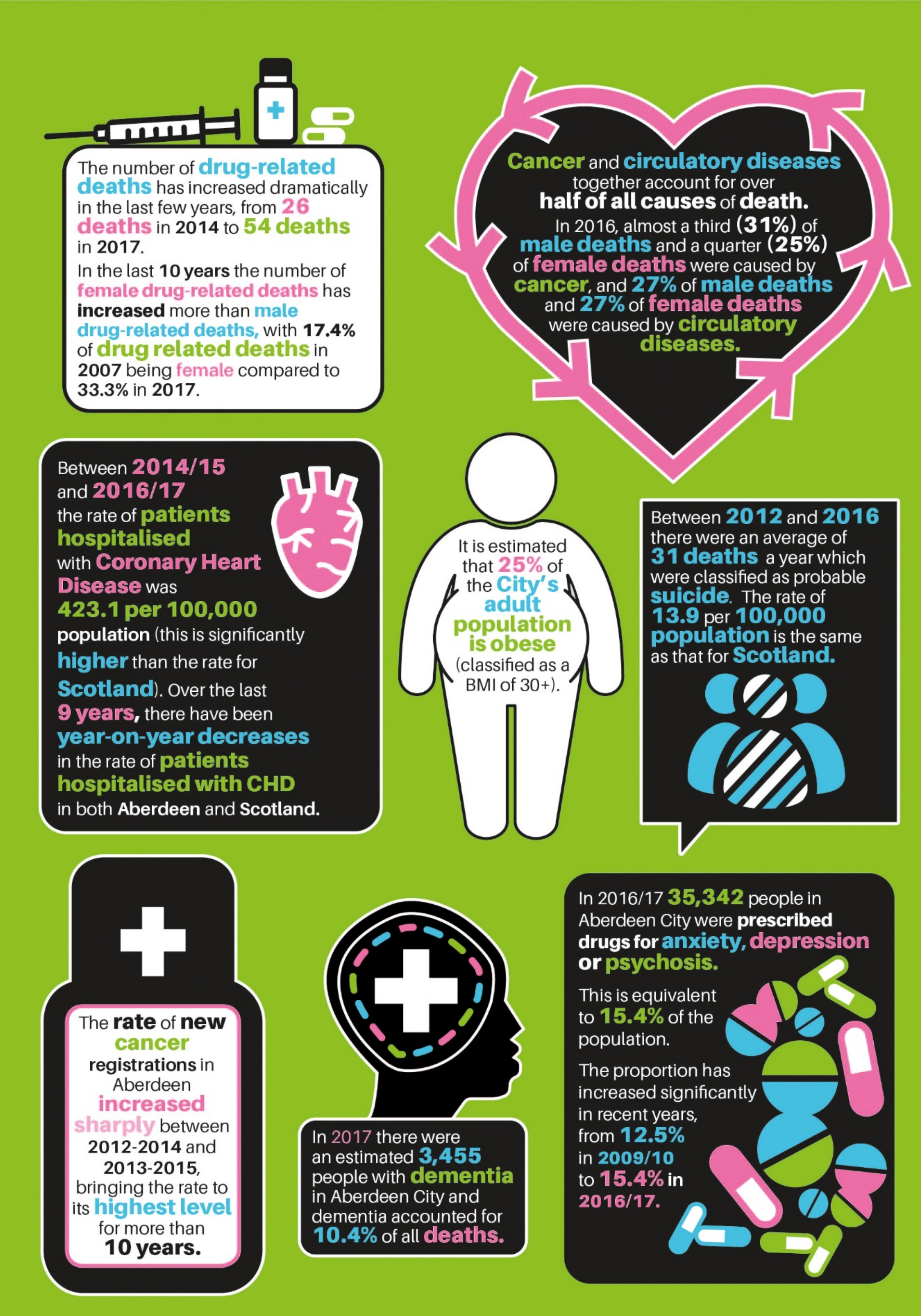
In **Aberdeen healthy life expectancy** is **65.0 years** for **males** and **67.4 years** for **females**, giving expected periods of **'not healthy'** health of **11.9 years** for **males** and **13.8 years** for **females.**

In **2013-2016**, **27%** of **adults** in **Aberdeen City** were **drinking above** the guideline recommendations of **14 units** per week.

In **2016/17** there were **45** alcohol-related **deaths** in the City.

The **alcohol-related mortality rate** is now at its **highest level** since **2005-2009** and **higher** than the **average rate** for **Scotland.**

The **alcohol-related mortality** rate varies across the city ranging from **0.0** to **91.2** per **100,000 population.**


The number of drug-related deaths has increased dramatically in the last few years, from 26 deaths in 2014 to 54 deaths in 2017.
In the last 10 years the number of female drug-related deaths has increased more than male drug-related deaths, with 17.4% of drug related deaths in 2007 being female compared to 33.3% in 2017.
Cancer and circulatory diseases together account for over half of all causes of death.
In 2016, almost a third (31%) of male deaths and a quarter (25%) of female deaths were caused by cancer, and 27% of male deaths and 27% of female deaths were caused by circulatory diseases.
Between 2014/15 and 2016/17 the rate of patients hospitalised with Coronary Heart Disease was 423.1 per 100,000 population (this is significantly higher than the rate for Scotland). Over the last 9 years, there have been year-on-year decreases in the rate of patients hospitalised with CHD in both Aberdeen and Scotland.
It is estimated that 25% of the City's adult population is obese (classified as a BMI of 30+).
Between 2012 and 2016 there were an average of 31 deaths a year which were classified as probable suicide. The rate of 13.9 per 100,000 population is the same as that for Scotland.
The rate of new cancer registrations in Aberdeen increased sharply between 2012-2014 and 2013-2015, bringing the rate to its highest level for more than 10 years.
In 2017 there were an estimated 3,455 people with dementia in Aberdeen City and dementia accounted for 10.4% of all deaths.
In 2016/17 35,342 people in Aberdeen City were prescribed drugs for anxiety, depression or psychosis.
This is equivalent to 15.4% of the population.
The proportion has increased significantly in recent years, from 12.5% in 2009/10 to 15.4% in 2016/17.

2.1 A coherent and co-ordinated strategy will play an important role in ensuring that people's experiences when they use our services match their expectations of compassionate, responsive and effective care, support or treatment.

The scope of our partnership's activities has been formally outlined in our **Integration Scheme**[1] and consists of services from the health, social care, third, independent and housing sectors which are all committed to providing high-quality integrated services to our citizens.

2.2. Scotland's **public health priorities**[2] have strongly influenced the development of this plan. Their stated aim for people to thrive and be as healthy as possible is set within a broader desire to reshape our attitudes towards health and well-being.

- **a Scotland where we live in vibrant, healthy and safe places and communities**
- **a Scotland where we flourish in our early years**
- **a Scotland where we have good mental well-being**
- **a Scotland where we reduce the use of and harm from alcohol, tobacco and other drugs**
- **a Scotland where we have a sustainable, inclusive economy with equality of outcomes for all**
- **a Scotland where we eat well, have a healthy weight and are physically active**

These priorities provide a substantial foundation for our own ambitions and priorities and a very useful reference for us to use when we reflect upon the impact of our activities and initiatives. Another key national document with which this plan has a strong alignment is the Scottish Government's **Health and Social Care Delivery Plan 2016**[3] and its focus on:

- **better care**
- **better health**
- **better value**

Working towards our own objectives will clearly be of positive value to these national priorities also.

[1] http://www.aberdeencityhscp.scot/contentassets/47a823b8be3c4f26830d11200cb644a1/aberdeen-city--integration-scheme.pdf
[2] https://www.gov.scot/publications/scotlands-public-health-priorities/
[3] https://www.gov.scot/Resource/0051/00511950.pdf

2.3 A critical factor in the success of our ambitions and priorities will be the positive, supportive relationships that we continue to develop with our key partner agencies, Aberdeen City Council and NHS Grampian.

Effective community planning arrangements will support us to deliver better services and achieve better outcomes for our citizens and communities. The **Community Planning Aberdeen (CPA) Local Outcome Improvement Plan**[4] sets out a coherent, multi-agency vision to make Aberdeen a better place to live and work in. The partnership is a member of the CPA and as such, recognises the value of positive collaborations and consensual decisions to address our common challenges. The actions set out in this Strategic Plan will make a significant contribution towards fulfilling the LOIP's **'Place'** and **'People'** objectives.

Similarly, a close alignment with the priority areas (Prevention, Self-Management, Planned Care, Unscheduled Care) set out in **NHS Grampian's Clinical Strategy (2016-2021)**[5] will ensure the delivery of improved experiences and outcomes to the people who use our services and their carers.

We recognise that working collaboratively with all our community planning partners is a good and positive thing to do and we will be actively seeking to align our activities as best we can.

2.4 We have developed a significant strategic portfolio (Figure 2) since integration 'Go Live' in 2016 to ensure that we have a consistent and coherent overview of the health and wellbeing of our local population and the needs of the different client groups.

All of these documents are important in their own way but the **Strategic Commissioning Implementation Plan**[6], our **Transformation Plan** and **Locality Plans**[7] have a particular significance because of what they say about our future commissioning intentions, our continuing transformation of what we do and how we do it and our locality-specific activities and initiatives to address evident differences in health and wellbeing across our city's communities.

Following the publication of this revised Strategic Plan we will take the opportunity to refresh this portfolio to ensure there is a continuing alignment with the ambitions and priorities set out in this overarching plan.

[4] https://communityplanningaberdeen.org.uk/aberdeen-city-local-outcome-improvement-plan-2016-26/
[5] http://foi.nhsgrampian.org/globalassets/foidocument/dispublicdocuments---all-documents/Grampian_Clinical_Strategy_2016-2021_Full_Version.pdf
[6] https://www.aberdeencityhscp.scot/globalassets/strategic-commissioning-implementation-plan.pdf
[7] https://www.aberdeencityhscp.scot/our-delivery/

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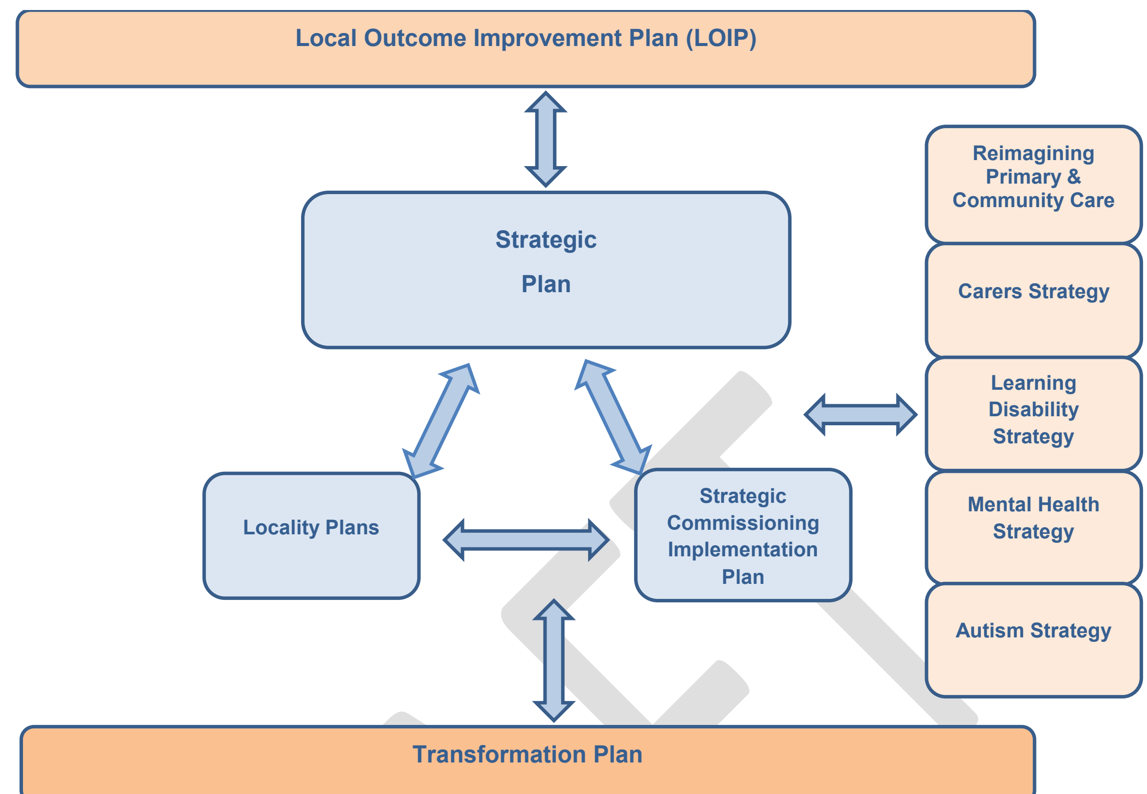

Figure 2 ACHSCP Strategic Portfolio

2.5 In addition to the fully delegated functions and services, the IJB also has a strategic planning responsibility for the city-specific hosted services and certain acute sector services (Table 2).

Hosted services are those health services which have a wider Grampian provision but are assigned to 'lead' IJBs for strategic planning and operational management purposes. This Strategic Plan applies to our hosted services as we need to ensure that their model of care contributes appropriately towards our city-specific objectives and priorities. We are mindful though that the other Grampian IJBs also need that reassurance from their perspective and so we will work with NHS Grampian and the other IJBs to develop a governance structure that is as robust as the governance for the fully delegated functions and services.

Our longer-term strategic intent is to limit the scope of hosted services to an absolute minimum and to only host those services where remaining hosted offers clear advantages to our local population and the partnership itself.

Similarly, strategic planning at an IJB level of those acute sector services is desirable because of the significant proportion of unscheduled care/emergency admissions that these services experience and the positive difference that partnerships can make towards this. It is fair to suggest that we have not undertaken as much of this planning to-date as we would have wished. We will do better.

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Hosted	Acute
• Intermediate Care of the Elderly and Specialist Rehabilitation • Sexual Health • Acute Mental Health and Learning Disability (decision pending)	• Accident and Emergency • Inpatient hospital Services ▪ General medicine ▪ Geriatric medicine ▪ Rehabilitation medicine ▪ Respiratory medicine ▪ Palliative Care ▪ Mental Health ▪ Learning Disability

Table 2 ACHSCP Strategic Planning (Hosted/Acute) Responsibilities.

2.6 Children's services are not formally within the scope of this Strategic Plan as they are not delegated by the local authority and health board to the Integration Joint Board however some children-specific health services (Health Visiting, School Nursing) are operationally devolved to the partnership's Chief Officer. Better outcomes for the children and young people of this city will be achieved by working more collaboratively with children's services and aligning our respective activities where possible, more fully.

We are mindful that there are many adults in poor physical and mental health, who may have housing difficulties, substance misuse challenges and impacted family relationships who can trace a line from their current experiences back to the adverse events they experienced as a child. We recognise that the first few years of pre-school life is critical to a child's later development and that appropriate interventions at this stage are crucially important in addressing inequalities. We will collaborate with other partner agencies to address enduring, inter-generational family challenges.

Transition from childhood through adolescence to becoming an adult can be unsettling for many individuals and their families. Our approach to supporting transitions gives us the opportunity to demonstrate our partnership values in our professional practice and to show our commitment to preventative and anticipatory models of care. We recognise that early, positive and consistent collaborations with young adults, their families and existing supports and services will ease any transition anxieties that may be apparent and reduce the likelihood of harmful consequences to health and wellbeing.

2.7 Adaptations and garden maintenance are the only housing functions which are formally delegated to the IJB. We acknowledge though, that the provision of good quality housing and housing related services plays a key role in enabling people to be able to live independently at home for as long as is reasonably practicable.

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The **Aberdeen City Council Local Housing Strategy (LHS) 2018-2023**[8] covers all types and tenures of housing including social rented, private rented and owner-occupied accommodation. It sets out how local need and demand will be addressed and how this contributes to the national housing priorities. The strategy aims to deliver six strategic outcomes:

1. There is an adequate supply of housing across all tenures and homes are the right size, type and location that people want to live in with access to suitable services and facilities.
2. Homelessness is prevented and alleviated.
3. People are supported to live, as far as is reasonably practicable, independently at home or in a homely setting in their community.
4. Consumer knowledge, management standards and property condition are improved in the private rented sector.
5. Fuel poverty is reduced which contributes to meeting climate change targets.
6. The quality of housing of all tenures is improved across the city.

We are committed to working with our housing colleagues to deliver the delegated housing functions as effectively as possible and support the fulfilment of the above outcomes.

The Housing Contribution Statement (see Appendix One) shows the contributions that this LHS and its Joint Delivery Action Plan makes to the wellbeing of our residents and the broader objectives and priorities set out in this plan.

2.8 The alignment of the partnership's objectives and priorities with all these other strategic points of reference will be a crucial factor in ensuring the effectiveness of our proposed actions and initiatives and the fulfilment of personal, organisational and national outcomes.

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[8] https://www.aberdeencity.gov.uk/sites/default/files/2018-09/Local%20Housing%20Strategy%202018-2023.pdf

3. Achieving healthier, fulfilling lives

Figure 3 Aberdeen in 2030 (Source: ACHSCP Public Health).

We recognise that if we want to be successful in the delivery of integrated health and social care services to improve the health and wellbeing of our local population we must actively identify and overcome any barriers to change that we come across.

Some of these barriers may include our own capacity to make the desired changes and a weariness or change fatigue on the part of some of our key stakeholders. We strongly believe that compassionate and collaborative leadership will be the key to breaking down engrained attitudes and entrenched working practices and unlocking the partnership's significant potential across all sectors to transform itself.

We believe that we are working from a good starting place given our successful integration 'Go Live' transition and the solid progress we have made since then. We recognise that we need to shift the change emphasis from top down to bottom up; engage routinely with our citizens about their lived experiences and have a relentless focus on improved outcomes.

3.1 Prevention. Most people remain relatively healthy and active without the need for formal supports and services in their lives. Although health problems generally increase with age, ill health and disability should not be an inevitable consequence of growing older in
Aberdeen City.

We will seek to improve our understanding of what preventative interventions will have the greatest impact on the health and wellbeing of different population groups within the city and support the effective implementation of these. We want to strengthen our early, preventative interventions and focus on the promotion of good, positive physical and mental health and wellbeing for all people across all age-groups and client groups.

Priorities:

3.1.1 Promote positive mental health and wellbeing.

3.1.2 Address the factors that cause inequality in outcomes in and across our communities.

3.1.3 Reduce alcohol and drug-related harm.

3.1.1 Poor mental health is a significant public health challenge which many of us will either personally experience or see a family member or friend cope with the challenges it brings or be a support to others in a professional capacity. Most of these are mild to moderate mental health problems but for some people it can be a more serious long-term illness and can impact on an individual's ability to function and live independently.

We aim to provide help from the right person, in the right place and at the right time. This means developing appropriate services which are more quickly accessible and available locally for all levels of mental health problems. We continue to move away from hospital-based services as the main mental health provision to develop community-based care and treatment resources where there is a significant emphasis on prevention and supported self-management.

We will seek to ensure that our citizens enjoy the best possible mental health and wellbeing and that when anyone begins to experience poor mental health, appropriate asset-based supports are available in their communities for them to access. We are very aware that each person's recovery journey is unique to them. We are keen to work with and alongside them by delivering services that promote a "rights" based model which is focused on their personal recovery and enduring quality of life.

The national **Mental Health strategy 2017-2027**[9] has prevention and early intervention as one of its five themes and outlines key action points associated with this. This national strategy will inform and influence the development of the partnership's own mental health strategy.

[9] https://www.gov.scot/publications/mental-health-strategy-2017-2027/

COMMITMENT: We will produce a Mental Health strategy and Action Plan showing how we will promote positive mental health and wellbeing and support those who are on a recovery journey.

3.1.2 Health inequalities are unfair and avoidable differences in health outcomes across the city's population. They are a key theme that underpins everything that we understand about the health and wellbeing of our local population and the activities and interventions which we propose to implement to improve this.

Deprivation is a key driver of poor health and embedded inequalities in and across our communities and we welcome the local authority's anti-poverty strategy **'Towards a Fairer Aberdeen That Prospers For All 2017-2020'** as a significant statement of intent to remedy such matters.

We recognise that we need to understand the health impact of our activities and interventions better. Tackling the underlying causes of health inequalities needs a whole system approach that seeks to change cultures and behaviours. A bucket list of singular interventions, no matter how well intentioned will not change matters sufficiently well enough.

Health and social care partnerships have a duty under the Fairer Scotland Duty to contribute to reducing health inequalities. We will always seek to understand better the health and wellbeing of our local population and what factors are contributing to different health outcomes. We will, with our community planning partners, use this information to identify and implement appropriate actions to reduce the health inequalities that exist in our city. We are mindful that our workforce will need appropriate support to recognise what works and to make this shift of emphasis succeed.

COMMITMENT: We will actively contribute to reducing known health inequalities in the health and wellbeing of our local population.

3.1.3 Alcohol and drug use significantly contribute to poorer health and wellbeing across all parts of our city. Much of the harm caused by substance use can be prevented through joined up health and social care services undertaking evidenced-based early intervention. There can be many personal challenges to overcome but we need to make a person's recovery journey easier by removing the stigma associated with seeking help.

We will seek innovative ways of tackling substance use in all its forms and we will provide accessible, high quality services for people who require more intensive support and treatment. We will support our local Alcohol and Drugs Partnership to

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deliver the national strategy ***"Rights, respect and recovery: alcohol and drug treatment strategy"***[10]

COMMITMENT: We will support the Alcohol and Drug Partnership in delivering actions to reduce substance related harm.

3.2 Resilience. Resilience can be understood to be the adaptability of individuals and organisations to circumstances that may be less than stable or positive. It is not a new concept, but it is one that can significantly influence our attitudes and behaviours to life's day-to-day challenges.

Priorities:
3.2.1 Promote and support self-management and independent living for individuals.
3.2.2 Value and support unpaid carers.

3.2.1 Supported self-management means moving away from a model where individuals are passive recipients of care and treatment to a more collaborative relationship where they are active partners. For this shift to be effective, individuals need to have opportunities to develop their knowledge, skills and confidence to make informed decisions and adapt their health-related behaviours. They also need to have access to the necessary expertise to support them in overcoming barriers and achieving their goals.

Supported self-management is not just about us taking greater responsibility for our own health and wellbeing. Many people with long term conditions already make appropriate decisions and manage a broad range of factors that contribute to their health and wellbeing on a day-to-day basis. Instead, we need to accept that there are wider considerations and explanations in relation to the lives that we lead and our current health and wellbeing.

There is no shortage of health improvement messages including keeping physically active, minimising our alcohol intake and eating five portions of vegetables a day for us to acknowledge and adopt; what is needed is an approach that recognises our experiences of the complexity and cumulative impact of our health condition(s), an understanding of what may work for each and every individual and our desired personal outcomes.

COMMITMENT: We will continue to invest in our 'Promoting self-management and building community capacity' transformation portfolio.

[10] https://www.gov.scot/publications/rights-respect-recovery/

3.2.2 It is a good thing to recognise and support the vital role that "unpaid" carers fulfil as they are, in many respects, the experts in relation to the health and wellbeing of the person they care for. The **Scottish Health and Care Experience Survey**[11] however shows that we can do so much better as only 40% of the respondents who identified as carers feel supported to continue in their caring role and only 49% feel they have a say in the services provided for the person they look after.

Being an unpaid carer is a very individual experience that depends on the needs of the cared for person. There are some common issues but the mother of a young adult daughter with mental health difficulties for example will have a different perspective of the carer role from the partner of an older person with dementia.

Carers are a significant partnership stakeholder and our health and social care services could not function as well as they do were it not for the contribution of our unpaid carers. We will ensure that the support offered to all carers, irrespective of who they are, is targeted at their particular individual outcomes and, of course, the personal outcomes of those being cared for.

Our **Carers Strategy 2018-2021**[12] sets out key actions that will support our many unpaid carers with the challenges that they experience regularly to enable them to have a life out with caring if they so choose.

COMMITMENT: We will support our unpaid carers to identify as carers, to manage their caring role, to be involved in the planning of services for the cared-for person and to have a life alongside caring if they so choose.

3.3 Right Care in the Right Place at the Right Time. This approach means services are tailored to the requirements of the individual so that people have access to the right care, support or treatment when they need them, in ways which are personalised, empowering and effective. It means that there are no in-built premature assumptions of what someone needs or a uniform 'one size fits all' provision but there are instead appropriate diversions to other resources and services as and when appropriate for each individual.

[11] https://www2.gov.scot/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey
[12] https://www.aberdeencityhscp.scot/globalassets/carers-strategy---march-2018.pdf

Priorities:

3.3.1 Reshape our primary care sector.

3.3.2 Shift the balance of care from the acute health sector to community-based services.

3.3.3 Develop our palliative and end of life care provision

3.3.1 Primary care is an important area of operation within the partnership providing appropriate advice and treatment for physical and mental health illnesses and conditions across all ages.

It is the first point of healthcare contact for many people and the gateway to other health services. It provides the reassurance of long-term continuity as well as more immediate, single episodes of advice and treatment when required.

There are known workforce recruitment challenges to overcome but even so, this sector has shown a continuing ability to introduce new practice models and adopt evidence-based interventions. It has a key role to play in promoting people's health and wellbeing and maintaining their independence at home in the community.

Our **Primary Care Improvement Plan**[13] outlines our proposed initiatives to address this sector's significant operating challenges.

COMMITMENT: We will implement fully our Primary Care Improvement Plan

3.3.2 We mostly expect to live longer and healthier lives and to have more choice and control over the support we might need to maintain our independence as we age. For that to happen, we must plan now for new ways of providing services that deliver the outcomes for health and wellbeing that people will need and expect. However, we know that there is going to be an increasing demand for our services, and our resources are unlikely to grow at the same rate, if at all.

Shifting the balance of care from the acute health sector to primary care and community care is seen as a good and desirable thing to do. Most adults are relatively healthy and have little or no contact with our health and social care services, but we are aware that there are a small number of individuals who have a disproportionately high usage of health services. It is envisaged that effective integrated service provision in our communities and localities will, over time, reduce this.

[13] https://www.aberdeencityhscp.scot/globalassets/primarycareimprovementplan.pdf

We are mindful though, of those who, for whatever reason are viewed as being 'furthest from the point of care' not in a geographical context but because of their substance misuse, poor mental health, complexity of ill-health, disability or vulnerability. Their numbers may be small compared to some other population groups but the impact of getting it right for them may well be proportionately greater. This objective is not just about better and more effective use of what we currently have but actively redesigning to deliver improved experiences and outcomes.

COMMITMENT: We will support and implement as appropriate the local Unscheduled Care Essential Actions Plan developed with our partner agencies.

3.3.3 Palliative care is an approach that seeks to improve the quality of life of individuals who have a terminal illness or life-limiting conditions. End of life care is that part of palliative care which seeks to ensure that an individual dies as peacefully and with as much dignity as possible.

Palliative and end of life care involves a variety of general and specialist services across primary care; care at home; residential/nursing care homes; acute hospitals and hospices. Good communication, collaboration and continuity of care across all sectors is essential to ensure our care and support at these times is recognised as being caring, compassionate and person-centred.

We recognise the need to be responsive to the changing preferences and priorities of people with advanced illness and their carers. The choices that are expressed after diagnosis may well change later, for example, most people when asked, initially express a preference for dying at home but in fact, most die in hospital. There are different reasons that explain this, but sensitive anticipatory planning conversations will help ensure that the holistic care that is put in place meets the needs and wishes of the individual and, where appropriate, their carer.

The national **Strategic Framework for Action on Palliative and End of Life Care** says that by 2021 everyone who needs palliative care will have access to it.

Commitment: We will review our current palliative and end of life care provision and develop an action plan to fulfil the strategic framework vision.

3.4 Connections. We will seek to make open and ongoing engagement with our local population a defining feature of who we are as a partnership. We will continue

Priorities:
3.4.1 Enable our citizens to have opportunities to maintain their wellbeing and take a full and active role in their local community.
3.4.2 Reduce the perception of loneliness and isolation experienced by individuals across age and client groups.

to engage with our localities, develop better relationships with their residents and work together to support a quality of life that is as good, positive and active as possible.

3.4.1 We want to promote and develop the wellbeing of our communities by increasing opportunities for the people who live in these areas to shape their own lives and take part in local decision making. This means that we:

- start with the assets and resources in our communities and identify opportunities and strengths
- see people as having something valuable to contribute and support them to develop their potential in adding social value to their communities
- focus on communities encouraging and adding social value at every opportunity

We strongly believe that those living, working and volunteering locally are best placed to identify local issues and needs; to suggest how these needs might be addressed; to prioritise the needs based on what is most important to the local community; and reflect all of these within an agreed action plan for the community.

It is because people are healthier when they feel connected to things that matter to them that the IJB has previously endorsed Community Planning Aberdeen's **'Engagement, Participation and Empowerment' Strategy[14].** Working with our citizens to co-produce the outcomes that matter to them is an important principle for us.

The IJB does not have a formal responsibility for transport connections and resources but we recognise that for many people an ambition of feeling 'better connected' will be unrealised if transport challenges are not addressed.

[14] https://communityplanningaberdeen.org.uk/wp-content/uploads/2017/08/Engagement-participation-empowerment-strategy.pdf

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COMMITMENT: We will develop a co-ordinated engagement plan for all the partnership's activities and initiatives with our client and patient groups, communities and localities.

3.4.2 Perceptions of loneliness and isolation can differ across client groups and age groups. Some experiences can include those of an older person whose only social contact is with those who are formally contracted to deliver homecare support; the younger adult with mental health difficulties who believes that they don't have anyone in their life that they can turn to and confide in about their wellbeing and the person on a substance misuse recovery journey who has been shunned by everyone he once knew: family, friends, former workmates and peers who are in a different part of their own journey.

People's perception of how lonely they are and the impact of this can be associated with an increased risk of poor health, increased attendance at GP surgeries and A&E Depts and in some instances, premature mortality. Offering different opportunities depending on who we are and where we are can help address these challenges. See for example, the partnership's **Learning Disability strategy 'A'thegither in Aberdeen 2018-2023**[15] which has as its first outcome "people feel connected to their communities".

We wish to develop those resources and connections, sometimes known as 'social capital' across all sectors of the partnership so that different individuals in different circumstances can experience the benefits of accessing them.

COMMITMENT: We will develop the social capital of our partnership across all sectors and services.

3.5 Communities. We recognise the value of an asset-based approach to developing effective and sustainable models of care that focus on the health and wellbeing of our local population and communities. We will seek to build on the existing assets and strengths within our communities and strive to ensure that our citizens and communities are fully involved in the design and delivery of services.

Priorities:
3.5.1 Implement our three-locality model.
3.5.2 Develop a diverse and sustainable care provision.

3.5.1 Localities are intended to be the engine room of integration, bringing together our citizens, unpaid carers and professionals from the health, social care, third, independent and housing sectors to reshape our services based on informed practice and local insights.

[15] https://www.aberdeencityhscp.scot/globalassets/athegither-in-aberdeen-strategy.pdf

The decision to implement a four-locality model was taken in the pre-integration shadow year and was reflective of the significant considerations that were taken into account at the time.

Our proposed three-locality model (Figure 3.1) will result in a closer alignment with community planning structures and activities, better partner collaborations, less public confusion and an enhanced focus on areas where people experience poorer outcomes. These three localities (North, Central and South) again cover the whole geography of the city as the legislation[16] obliges and, crucially, the three community planning localities can be wholly located within their respective integration localities.

Figure 3.1 Proposed 3-Locality Model.

A recent consultation on this proposed 3-locality model produced a favourable response.

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

COMMITMENT: We will implement a three-locality model and in doing so, align our activities more fully with those of the Community Planning Aberdeen locality model.

3.5.2 A significant proportion of our services are delivered by our partners in the third, independent and housing sectors. We recognise the positive relationships that many organisations in these sectors have with the people who use their services and their carers, and the wider connections that they have with our local communities.

The depth and resilience of the relationships that we have with these many different organisations is important to us. Market fragility can cause uncertainty and unexpected change to the detriment of the organisations who are delivering services, their staff members and those people who use services and, in some cases, depend on them.

We strongly believe that a well-supported and well-resourced care provision will be better placed to make a significant contribution towards a more stable health and care environment and the development of enhanced models of care. **Our Market Facilitation Statement**[17] shows how we will seek to develop the sustainability of our valued providers.

COMMITMENT: We will refresh our Market Facilitation Statement and develop an Action Plan showing how we will support our local care provision.

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[17] https://www.aberdeencityhscp.scot/globalassets/strategic-commissioning-implementation-plan.pdf

4. Our Enablers

Our enablers are those fundamental elements which we require to support the development of, in order to facilitate the attainment of our strategic objectives.

- **empowered staff**
- **principled commissioning**
- **digital transformation and**
- **sustainable finance**

It is a good and positive thing to develop these in their own right as well as because of the positive contribution that they make to our portfolio of activities.

4.1 Empowered staff. Our staff groups across the health, social care, third, independent and housing sectors are pivotal to our aspirations. We accept that there is a strong relationship between people's experiences of using our health and social care services and the morale of staff who deliver those services.

Valuing our staff and empowering them all to work as positively and collaboratively as possible will be crucial to our desire to deliver safe, caring, responsive and effective health and social care services. Collaborative leadership will provide the supports that our staff need to flourish but for this to be evident we will increase opportunities for integrated leadership development to help our leaders work more collaboratively

Recruitment and retention of staff is a real challenge in different parts of the partnership and it is likely that new roles and new working practices will be needed as we move towards more anticipatory and preventative approaches. We have significant opportunities to work collaboratively with our local regional college and universities to be truly innovative in how we recruit, develop and retain our staff across all sectors and job roles.

We are mindful that organisational cultures can be a barrier to change and are keen to reconcile these so that different professions and staff groups understand each other's roles, responsibilities and perspectives more fully. We have many partner organisations in the city who are very effective in training and developing their workforce. We will consider how best to support those activities and give some thought to how we can apply the learning outcomes to other sectors and care settings. Positive engagement with professional and regulatory bodies and trade union representatives will be of value to our workforce ambitions.

We strongly believe that fair work is work that offers effective voice, opportunity, security, fulfilment and respect to our workforce across all sectors. Balancing the rights and responsibilities of our employer organisations and workers will generate benefits at an individual and organisational level and also more widely across our communities. The IJB has previously endorsed the Ethical Care Charter[18] and incorporating this charter in the commissioning of our care at home services will make a significant contribution to addressing particular challenges in the delivery of care experienced by that workforce. We recognise that we need to offer similar supports to other elements of our workforce.

COMMITMENT: We will promote a culture of compassionate and collaborative leadership that seeks to encourage staff to flourish in their job role and to empower them to do the right thing from a person-centred perspective.

4.2 Principled Commissioning. Our approach to commissioning is one which views it as collaborative decision-making that generates a broader and more innovative range of options about how to achieve shared outcomes.

The commissioning of services will be one of the most important functions undertaken by the partnership as it seeks to ensure that all services enhance the quality of life for the individuals and their carers now and in the future. We recognise that it will be most effective if it is done in partnership with intended users, families, communities and other agencies that have an interest in the continued wellbeing of our local population.

- 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

Figure 3.2 Commissioning Principles.

[18] http://www.unison-scotland.org/unisons-ethical-care-charter/

Self-directed support (SDS) options will continue to be a key element of our personalised approach given that it enables people to have more informed choice and flexibility over their care and support. We are very aware that having more people commissioning and controlling their own care through the use of individual budgets or direct payments will require consistent and accurate information that clearly, without the use of jargon, explains the options and opportunities that are available to them.

All our commissioning will be done in a way that is respectful of the appropriate legislation, mindful of known best practice such as the **Ethical Care Charter**[19]**,** and sensitive to the needs of our local care provision. 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.

COMMITMENT: Each and every commissioning decision that we make will be capable of being explained in the context of the strategic objectives and priorities set out in this Strategic Plan.

4.3 Digital Transformation. Digital technology is key to transforming our health and social care services across the partnership so that we can be truly person-centred, enabling and effective.

We appreciate that it is easy to get frustrated at what appears to be a lack of progress in introducing digital solutions especially when technology plays such a central and important part of our lives in so many other ways.

There are significant opportunities to introduce digital solutions across all sectors and services. We look forward to that future date when digital services are an integral part of everything we do and have become not only the first point of contact with health and care services for many people but also how they will choose to engage with us on an ongoing basis.

COMMITMENT: We will work closely with our digital partners in the local authority, health board and Scottish Government as well as with our many other partners across the partnership to ensure a seamless, co-ordinated approach to this digital transformation of how we deliver our services.

4.4 Sustainable finance. In the next few years we will have to address the very real and significant challenge of health and social care budgets most likely reducing in real terms while the demand for services increases. To achieve our objective of optimising the health, wellbeing and independence of people to live at home for as

[19] http://www.unison-scotland.org/unisons-ethical-care-charter/

long as is reasonably practicable, we need to look at how we manage our resources to deliver the best value for the individuals who use our services, their carers and their communities.

A medium-term financial strategy (MTFS) has been developed to pull together into one document all the known factors affecting the financial sustainability of the partnership over the medium term. This strategy will establish the estimated level of resources required by the partnership to operate its services over the next five financial years given the possible demand pressures and funding constraints that we are likely to experience.

Implementing this strategy will assist in delivering the ambitions and priorities of the partnership's Strategic Plan, maximise the use of our available resources and improve our strategic financial planning across the medium term.

Included in Table 3 below is the level of budget pressure the IJB will face after assumptions have been made in terms of the level of income likely to be received from partners. The budget pressures identified include provision for pay awards, Scottish Living Wage uplifts, demographic projections and prescribing inflation. To offset these anticipated pressures, the IJB has identified key 'financial saving' workstreams and has set provisional targets (in brackets) to be delivered from these.

	2019-20 £'000	**2020-21 £'000**	**2021-22 £'000**	**2022-23 £'000**
Budget Pressures (year on year)	6,452	6,749	6,304	6,623
Workstreams to reduce financial pressure:				
Efficiency Savings	(1,150)	(1,650)	(1,650)	(1,650)
Transformation	(1,458)	(1,487)	(1,517)	(1,547)
Medicines Management	(1,000)	(1,000)	(1,000)	(1,000)
Service Redesign	(2,844)	(2,612)	(2,137)	(2,426)
Shortfall	**0**	**0**	**0**	**0**

Table 3 ACHSCP MTFS Budget Pressures and Workstreams

We are committed to making the best use of our resources to deliver best value in improving outcomes for people. Careful consideration is given to the allocation of financial resources to our local authority and health board partners and also to our many partner agencies who deliver commissioned services.

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We will always seek to invest in those functions and services which can demonstrate a positive impact on the health and wellbeing of the individuals who use their services and an alignment with the ambitions and priorities of our Strategic Plan. There will be times however when disinvestment options will be considered because of not-so-good impact, weak alignment and poor value for money. Our investment/disinvestment decisions whatever they are, will always be rooted in the sustainability of our local market and the delivery of our Strategic Plan. We hope that any changes can be as a result of planned service reviews or known commissioning cycles, but we accept that there will be times when circumstances arise that present us with an opportunity to reconsider the appropriate allocation of resources.

Our focus on transformation will continue. We recognise the very real challenge of asking our staff to contribute to the transformation of our services whilst at the same time asking them to ensure an ongoing consistency of the day-to-day operation. We recognise that there is a national and a local desire to see the evidence of the impact of our innovative activities and services. Our evaluation framework provides that assurance.

COMMITMENT: We will develop our performance reporting to show how effective our financial resource allocation has been in fulfilling desired health and wellbeing outcomes.

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5. How will we know we are making a difference

5.1 We remain committed to our ambition of being recognised as one of the highest performing partnerships in Scotland for our effective performance across all sectors and services. Our service delivery will, without exception, be safe, effective, responsive, caring and well-led.

Our emphasis will always be on fulfilling outcomes. Ensuring that personal, organisational and national outcomes are linked in a coherent manner will be central to the successful implementation of a partnership-wide outcomes-focused approach.

The **National Performance Framework**[20] is a single framework to which all public services are aligned. It sets out a vision of national wellbeing across a range of economic, health, social and environmental factors. The nine **National Health and Wellbeing Outcomes**[21] are high-level statements of what we are trying to achieve as a partnership. A core set of indicators are aligned with the different outcomes to show us the progress we are making in delivering person-centred, high-quality, integrated services and fulfilling the ambitions and priorities set out in our Strategic Plan.

5.2 Our Annual Performance Report shows how well we have performed as a partnership in working towards and fulfilling our operational objectives and the national outcomes. Future annual reports will also comment on how well we have fulfilled the objectives and priorities set out in this plan.

We are determined to be recognised as a partnership that works closely with our citizens, staff, unpaid carers and our partner agencies in the third, independent and housing sectors to fulfil the vision and ambitions of this strategic plan.

[20] http://nationalperformance.gov.scot/

[21] https://www.gov.scot/Topics/Health/Policy/Health-Social-Care-Integration/National-Health-WellbeingOutcomes

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Objectives	Priorities	Commitments	Health & Wellbeing Outcomes	National Performance Framework
Prevention	Promote positive mental health and wellbeing.	We will produce a Mental Health strategy and Action Plan showing how we will promote positive mental health and wellbeing and support those who are on a recovery journey.	• people are able to look after & improve their own health & wellbeing & live in good health for longer	
	Address the factors that cause inequality in outcomes in and across our communities.	We will actively contribute to reducing known health inequalities in the health and wellbeing of our local population.	• people are able to live, as far as reasonably practicable, independently & at home	• we live longer, healthier lives
	Reduce alcohol and drug-related harm.	We will support the Alcohol and Drug Partnership in delivering actions to reduce substance related harm.	• people who use health and social care services have positive experiences of those services & have their dignity respected	• we have tackled the significant inequalities in Scottish society.
Resilience	Promote and support self-management and independent living for individuals.	We will continue to invest in our 'Promoting self-management and building community capacity' transformation portfolio.	• health & social care services are centred on helping to maintain or improve the quality of lives of people who use those services	• we live in well-designed, sustainable places where we are able to access the amenities and services we need
	Value and support unpaid carers.	We will support our unpaid carers to identify as carers, to manage their caring role, to be involved in the planning of services for the cared-for person and to have a life alongside	• health & social care services	

<table>
<tr>
<td>Right Care, Right Place, Right Time</td>
<td>Reshape our primary care sector.

Shift the balance of care from the acute health sector

Develop our palliative and end of life care provision</td>
<td>We will implement fully our Primary Care Improvement Plan.

We will support and implement as appropriate the local Unscheduled Care Essential Actions Plan developed with our partner agencies.

We will review our current palliative and end of life care provision and develop an action plan to fulfil the strategic framework vision.</td>
<td rowspan="3">contribute to reducing health inequalities

• people who provide unpaid care are supported to look after their own health & wellbeing

• people using health and social care services are safe from harm

• people who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support care and treatment they provide

• resources are used effectively and efficiently in the provision of health and social care services</td>
<td rowspan="3">• we have strong, resilient and supportive communities where people take responsibility for their own actions and how they affect others

• our public services are high quality, continually improving, efficient and responsive to local people’s needs respectively

• our people are able to maintain their independence as they get older and are able to access appropriate support when they need it</td>
</tr>
<tr>
<td>Connections</td>
<td>Enable our citizens to have opportunities to maintain their wellbeing and take a full and active role in their local community.

Counter the perception of loneliness and isolation experienced by all age groups.</td>
<td>We will develop a co-ordinated engagement plan for all of the partnership’s activities and initiatives with our client and patient groups, communities and localities.

We will develop the social capital of our partnership across all sectors and services.</td>
</tr>
<tr>
<td>Community</td>
<td>Enable our citizens to have opportunities to maintain their wellbeing and take a full and active role in their local community.</td>
<td>We will implement a three-locality model and in doing so, align our activities more fully with those of the Community Planning Aberdeen locality model.</td>
</tr>
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	Develop a diverse and sustainable care provision.	We will refresh our Market Facilitation Statement and develop an Action Plan showing how we will support our local care provision.		
Safe, Effective, Responsive, Caring, Well-Led				

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Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Date of Meeting	11 December 2018
Report Title	Autism Strategy and Action Plan
Report Number	HSCP.18.085
Lead Officer	Sandra Ross, Chief Officer
Report Author Details	Jenny Rae Strategic Development Officer Jenrae@aberdeencity.gov.uk 01224 523994
Consultation Checklist Completed	Yes
Directions Required	No
Appendices	a. Autism Strategy – Final Draft b. Engagement and Consultation Overview Report

1. Purpose of the Report

1.1. This report seeks approval of the revised Autism strategy and action plan (appendix A) for Aberdeen City.

2. Recommendations

2.1. It is recommended that the Integration Joint Board:

a) Approve the Autism Strategy and Action Plan, which will take effect from 1 April 2019; and

b) Note the Autism Strategy and Action Plan will be presented to Aberdeen City Council Operational Delivery Committee for approval in January 2019; and

c) Note that progress reports on implementation will be provided to the Integration Joint Board annually.

NHS Grampian ABERDEEN CITY COUNCIL

INTEGRATION JOINT BOARD

3. Summary of Key Information

3.1. The decision to revise the current Autism strategy and action plan was taken to ensure its strategic alignment within the context of health and social care and educational developments locally; and to ensure the local strategy was cognisant of national changes.

3.2. The process of revision has been directed and led by the Aberdeen City Health and Social Care Partnership (ACHSCP) along with key partners including Aberdeen City Council, NHS Grampian, the Third Sector and autistic people and their families. A Strategic Steering Group has been established comprising representatives of these stakeholders. The group has undertaken a series of engagement and formal consultation activities (appendix b) which have strongly influenced and informed the revised strategy and action plan content.

3.3. Autism is neither a Learning Disability or a Mental Health condition which is one of the reasons why there was a lack of progress in the delivery of the previous Autism Strategy. Autism has now been defined as a service area within the ACHSCP structure by the Chief Officer. As it is clearly an area of interest for the ACHSCP given the needs of the autistic population in Aberdeen.

3.4. The lack of an integrated assessment and diagnostic pathway for adults in relation to Autism is a source of concern for many people in Aberdeen who feel they would benefit from such an approach being available to them. This issue is not unique to Aberdeen City, with other areas also facing this issue. Work has already commenced, supported by the Autism Policy Team at Scottish Government, to bring together Aberdeen City, Aberdeenshire and NHS Grampian in the development of a truly integrated assessment and diagnostic approach. Additionally, financial resources are expected from the Scottish Government to support such work to be developed and tested. This partnership approach to delivery of such a core service will result in improved health and wellbeing outcomes.

4. Implications for IJB

4.1. Equalities:

It is believed that this report will have a neutral impact however the Autism strategy and action plan acknowledges and promotes autistic people as equal partners in our local communities; valued for their strengths and abilities.

4.2. Fairer Scotland Duty:

The content of this report primarily seeks to improve the lives of autistic people in Aberdeen City. Staff of the organisation and its partners will also see the impacts as they deliver supports and services to this client group. This strategy and action plan will seek to align with other strategic documents and their vision, such as the ACHSCP Strategic Plan and the Community Planning Aberdeen Local Outcome Improvement Plan, to improve outcomes for autistic people in Aberdeen. Additionally, the vision and strategic outcomes and priorities of the Scottish Strategy for Autism will continue to be applied and have guided the development of local core focus areas (on which the action plan is based). The specific actions identified in the strategy and action plan presented for approval seek to reduce inequalities and strengthen meaningful involvement of people in this process by co-producing solutions and measuring success.

4.3. Financial:

The action plan associated with the Autism strategy identifies where and how resources are to be aligned.

The provision of an assessment and diagnostic service and any associated service requirements or packages following this will be the most relevant resource concern for ACHSCP.

Work has commenced with the Autism Policy Team at the Scottish Government to address the issue of lack of assessment and diagnosis pathway, in conjunction with Aberdeenshire HSCP. Some external financial resource will be provided by Scottish Government for this purpose (exact amount to be confirmed) on a match funding basis. Work to identify funding as part of the matching process has begun and will include existing resource that is being used

Currently as no pathway exists autistic adults are often aligned to either Learning Disability or Mental Health services, however for social care support the current operational eligibility criteria prevents them from being eligible for support because

they do not have an associated Learning Disability or Mental Health condition. There is evidence of resource being used within these services to prevent a person entering crisis which may include admission to hospital or use of other statutory services such as the Criminal Justice System. It is this type resource that we will seek to align under any match funding requirements.

The costs of Autism to Scotland as a whole have been identified through recently published research (https://www.gov.scot/publications/microsegmentation-autism-spectrum/). This research supports the ethos that providing supports at an earlier stage and at a lower cost can reduce ongoing costs and have positive impacts on the health and wellbeing of autistic people.

It is envisaged that to successfully operate an assessment and diagnostic service for Aberdeen City and Aberdeenshire a staff resource equivalent to 3 x WTE Care Manager at G13 would be required, equates to £142,300 per year. This funding would require to be in place for up to 3 years to develop, test, implement and evaluate the pathway. After such time funding levels would be reviewed and hopefully reduced as demand for assessments reduces.

Full scoping of the staffing requirements for an assessment and diagnostic service will be provided pending the match funding offer from Scottish Government. This will also clarify how existing resources will be used to provide the complement of this match funding. Also looking to examples of good practice to inform any local developments.

4.4. Workforce

There are no direct workforce implications arising from the recommendations of this report.

4.5. Legal

There are no direct legal implications arising from the recommendations of this report.

4.6. Other

There are reputational implications when considering the Autism strategy and action plan. The lack of implementation progress of the current strategy and action plan have left many autistic people, their families and interested professionals and organisations feeling that expectations were raised but minimal real change was delivered. Through the engagement and consultation processes there have been strong expressions of anger, frustration and disappointment;

which has impacted on the relationships which must be built to successfully develop and deliver a revised strategy and action plan. Work has taken place to re-build and strengthen relationships, with more positive comments and conversations now being evidenced, and reputation, to some extent, being restored. There is a significant risk that this hard work will be lost and there be a negative reputation once more if real change is not evidenced.

5. Links to ACHSCP Strategic Plan

5.1. The recommendations in this report align with the strategic priorities outlined in the ACHSCP Strategic Plan primarily by supporting the development of person-centred approaches to care and support and by enabling supported individuals to strengthen their connection and contribution to their local community. As the Strategic Plan is being refreshed any significant changes in vision or approach will be reflected in this autism strategy and action plan in due course.

6. Management of Risk

6.1. Identified risks(s)

The current strategy and action plan have not been successfully implemented, the revised strategy and action plan seeks to rectify this and ensure implementation is progressed and monitored. Failure to approve the revised strategy and action plan has the potential likelihood to end in complaints and challenge, with a strong risk of reputational damage.

Link to risks on strategic or operational risk register:

(8) There is a risk of reputational damage to the IJB and its partner organisations resulting from complexity of function, delegation and delivery of services across health and social care.

6.2. How might the content of this report impact or mitigate these risks:

The content of this report seeks to mitigate the known risks by recommending a decision which supports the reputation of the IJB & Partnership, the development of an Autism strategy and action plan promotes person centred approaches to care and support and the strengthening of community connections. The risk rating is viewed as Medium.

INTEGRATION JOINT BOARD

Approvals	
[signature]	Sandra Ross (Chief Officer)
[signature]	Alex Stephen (Chief Finance Officer)

Aberdeen City Health & Social Care Partnership
A caring partnership

Aberdeen City Autism Strategy and Action Plan

2019-2022

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

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1. Introduction

1.1 Our Autism Strategy

Aberdeen City's Autism Strategy is a whole life strategy, which has been co-produced by Aberdeen City Council (ACC), NHS Grampian, Aberdeen City Health and Social Care Partnership (ACHSCP) and other partners.

The current strategy and action plan is being revised following updated outcomes and priorities detailed by the Scottish Government in addition to the requirement to ensure our local strategy and action plan for autism delivers change and improved outcomes for the autistic population.

The autistic population face a number of challenges, many of which are based on societal views of what constitutes accepted social norms and behaviours. These social conventions can be exceptionally difficult for an autistic person to navigate, let alone challenge. Autistic people can therefore find it difficult to meet the expectations that are often set for others, finding relationship building and social situations challenging, at times, and often taking more time to find their place in the world because people's knowledge and understanding of autism remains limited. There are many ways in which we can all, collectively, make changes to the way we operate systems, processes and services, which can better take account of the needs of autistic people, and help to improve their outcomes.

This strategy and action plan will not seek to duplicate activity aligned to other strategic or operational plans either locally or nationally. There are other documents and plans which autistic people and their families may benefit from, such as The Carers (Scotland) Act 2016 and Aberdeen City's Carers, Learning Disability and Mental Health Strategies (currently under review).

The spectrum nature of autism means that some autistic people may require the support of multiple service areas due to the complex nature of their needs. This strategy and action plan is aimed at improving the lives of all autistic people in Aberdeen, however detailed actions on how this will be achieved may more appropriately sit within other service area plans (such

as Learning Disability or Mental Health where people have a dual diagnosis).

1.2 Our Language

Throughout this document we will use language which is commonly used within Aberdeen. Autism or Autism Spectrum Condition (ASC) will be used when discussing the overall condition. Autistic people will be used when discussing people with a diagnosis of autism, including children and adults. Where there is information specific to the autistic child or adult population this will be stated. The term carers will be used to describe people undertaking an informal caring role and families may also be used where appropriate.

1.3 What is autism?

Autism (also known as Autism Spectrum Condition - ASC, or Autism Spectrum Disorder - ASD) is a neurodevelopmental lifelong condition. It affects different autistic people in different ways, with some individuals able to live and work independently, and some requiring specialist support. Autistic people develop differently from non-autistic people (neurotypicals), sometimes faster than their peers, sometimes slower.

What everyone on the autism spectrum will have is sensory and social difficulties. These are not always obvious, as they can be masked, and people can develop coping strategies. Most have also held the assumption that others experience the world the same way, so it can make it difficult to recognise these differences.

Autistic people have issues with communication, both verbal and non-verbal, e.g., difficulties with interpretation, tone of voice, facial expressions.

Autistic people may engage in repetitive behaviours. While these may, at times, be restricting for their families (e.g. only eating a limited range of food), many autistic people love to engage in areas of special interest repeatedly. The ability many autistic people have to focus intently, spot small details and notice patterns can be of great value to businesses and society generally. While some autistic people may, at times, be frustrated with their need to obsess over a certain topic, they generally derive much pleasure from doing so.

Autistic people can experience sensory input in a different way from non-autistic people. Being autistic means that they are more likely to have issues filtering out sensory information which can lead to being overwhelmed and/or under sensitive. Some of the repetitive behaviours referred to above, may also be a coping strategy to manage and control this feeling of being either overwhelmed or under sensitive

This document does not seek to replace or redefine clinical perspectives on autism. Clinical guidance on autism is generally taken from SIGN (Scottish Intercollegiate Guidance Network) publication 145, which references both current versions of ICD-10 (International Classification of Diseases – 10 [World Health Organisation]) and DSM-5 (Diagnostic and Statistical Manual of Mental Disorders - fifth edition [American Psychiatric Association]) as source references for diagnosis.

1.4 Our Vision

ACHSCP current Strategic Plan outlines the vision for health and social care within Aberdeen as:

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

This vision, the associated values and priorities guide the development of all strategic documents produced by the Partnership (appendix 1).

The vision, as outlined in the Scottish Strategy for Autism, continues to underpin our local autism strategy:

"Our vision is that individuals on the autism spectrum are respected, accepted and valued by their communities and have confidence in services to treat them fairly so that they are able to have meaningful and satisfying lives."

The Scottish Strategy for Autism Scottish Government 2011

Through engagement activity local people told us that understanding, and acceptance, of autism is of key importance. This will lay the building blocks to ensure that services are relevant and appropriate for autistic people. Where needed there should be support offered to educate, inform and, if required, challenge practice to ensure this vision is fully promoted and embedded in practice.

It is recognised that the process of genuine and meaningful engagement, with any group including autistic people, takes time, commitment and a willingness to adapt communication styles. Whilst attempts have been made to meaningfully engage the entirety autistic population in the development of the revised strategy it has not been possible to reach all aspects of this population or to always reach consensus on centre viewpoints, in part this is due to the formal nature of the process and the lack of diagnostic services available (which empower autistic people to contribute to such processes). This is a learning point and an area for improvement which will be taken forward into the implementation phase of the strategy and action plan.

2. Our Wider Context

2.1 Developing our autism strategy

In 2011, The Scottish Government launched a Scottish Strategy for Autism, with the recommendation that each local area produce a strategy and action plan. In 2014 Aberdeen City produced its local 10-year autism strategy and action plan.

The Scottish Strategy for Autism was written to consolidate a number of initiatives for autism into a strategic document which aimed to address the entire autism spectrum and the whole lifespan of autistic people in Scotland. The strategy produced 26 recommendations. Subsequent documentation was also published to further define the outcomes and priorities for the strategy.

In early 2018 the Scottish Government consulted on and launched a revised set of outcomes and priorities for autism. Our Aberdeen City strategy and action plan is now also being revised. The local revised strategy and action plan considers changes nationally and locally, as well as acknowledging the challenges faced in implementing the original strategy and action plan. It is intended that by ensuring the revised documents are meaningful to and reflective of local people's views, that we can collectively produce a realistic, achievable and sustainable strategy and action plan for autism within Aberdeen City. The national strategy runs until 2021. The Aberdeen strategy will be in operation for 3 years, from 2019-2022. This allows for a period to review our local strategy and action plan in line within any national changes, which may include a new national strategy for Scotland in 2021.

Within this document we will summarise the engagement work undertaken to re-develop the strategy and action plan and how we will seek to ensure

autistic people and their families are at the centre of how the strategy and action plan will be implemented and monitored.

2.2 Why do we need a strategy?

A local strategy is a best practice indicator, as highlighted by Scottish Government within the national strategy for autism. There are other important factors which lend themselves to having a local strategy and action plan.

A report launched in 2018 titled 'The Microsegmentation of the Autism Spectrum' (as recommended by the national Strategy for Scotland), identified a new national prevalence rate of autism of 1.035%. Additionally, research also suggests that prevalence of autism with an intellectual disability is noted as 32.7%, which is less than previously evidenced.

According to this research in Aberdeen there is a population of autistic people equalling 2379 and of this number 778 have presence of an intellectual disability and 1601 do not.

Currently assessment and diagnostic services are provided to adults only where a co-morbidity exists, typically an associated mental health issue or an intellectual disability. Using the prevalence rates, we can see that one third of the autistic population in Aberdeen will have a co-morbidity of an intellectual disability. There is no equivalent research conducted to provide prevalence figures for any co-morbid Mental Health condition. Those autistic people without such a co-morbidity (up to two thirds of the autistic population) will unlikely have received an assessment or subsequent diagnosis of autism. This is echoed by anecdotal information regarding the lack of adult diagnosis within Aberdeen.

A sole diagnosis of autism does not necessitate the provision of formal services by the local authority or Partnership, unless the individual meets the eligibility criteria for funded services. Many autistic people do not have a formal diagnosis and are often prevented from accessing relevant health and social care supports, formal or unpaid. As such, there is limited information available as to the general health and wellbeing of this population. Formal commissioned social care services are provided where autistic people also have a co-morbid condition and meet the eligibility criteria. This population can be seen to have more complex or multi-faceted forms of need. Further information on complex needs can be found within the local Learning Disability Strategy: A'thegither in Aberdeen.

The Pupil Census carried out in 2017 details that in Aberdeen City there are 536 children and young people in education who have autism or ASC

recorded. This data comprises of children with diagnosed and reported conditions, therefore the actual numbers of children in Aberdeen City with autism are likely to be significantly higher.

The Microsegmentation report also provides a Scotland wide context to the previous estimates of the cost of autism, suggesting a cost of £2.2 billion a year. The recently revised prevalence rates, including the presence of intellectual disability, also enable a lifetime cost per person to be identified of between £900,000 and £1.6 million. Many of these costs are related to the loss of productivity, i.e. employment of autistic people or their carers, but are also related to the high cost of services for people with an associated intellectual disability including accommodation costs. Information from the local perspective can be seen to echo this, with formal social care services for autistic people with an intellectual disability being amongst the most complex due to the requirement for enhanced care provision.

Generally, there is greater knowledge and understanding of autism, with higher media focus on ‘autism friendly’ or ‘relaxed’ activities. It can be noted that whilst these may provide awareness or support for some autistic people they do not lend themselves to a greater understanding or acceptance of autism as a spectrum, additionally such activities can, at times, be seen as ways that organisations may avoid a wider consideration of providing welcoming atmospheres more generally.

There is still a requirement to ensure that awareness equates to knowledge, understanding and a welcoming of autistic people and their varied skills and abilities into all communities and walks of life. As autism is a spectrum condition it is important to recognise and celebrate the diversity of autism. The recent launch of ‘autistic pride’ as a celebratory event of the gifts and skills of autistic people provides an example of such work. The presence of autistic people in employment is still low, whilst there are high numbers of autistic people known to the Criminal Justice System. There is still a noted disadvantage which autistic people face when accessing universal services.

A local strategy and action plan for autism will enable challenges and potential solutions to be identified and acted upon, such as the lack of assessment and diagnostic services; the availability of formal commissioned services; and the need to enhance knowledge, understanding and acceptance of autism.

In 2018 the Scottish Government published a revised set of outcomes and priorities for autism. These have been considered when development the revised local action plan.

The outcomes are:

- A Healthy Life
- Choice and Control
- Independence
- Active Citizenship

The priorities identified nationally reflect the key issues raised by autistic people, carers/families and other professionals. Priorities are aligned with each of the outcomes identified and incorporate actions such as:

- development of a Post-Diagnostic Support Toolbox
- improve awareness of autism within Criminal Justice Systems
- extension of the Blue Badge Scheme
- enhanced support for autistic people in Modern Apprenticeships

Further detail on all priorities identified can be found within the outcomes and priorities document.

2.3 Aberdeen Context

There are a range of local policy and practice documents which are connected to, or should be considered alongside, this revised strategy. These are developed by Aberdeen City Council, Aberdeen City Health and Social Care Partnership and NHS Grampian (see examples in appendix 2)

Recognising that the autistic population have been overlooked in previous strategic developments it should be noted that local and national health and wellbeing outcomes apply to the whole population, including autistic people. It is important in meeting these collective outcomes that the personal experiences and outcomes of autistic people within Aberdeen are also promoted. This strategy seeks to provide a platform by which these experiences and outcomes can be highlighted and used to inform and influence practice. One method of achieving this is by actively engaging with organisations who aim to provide valuable advice and guidance for autistic people and their families. Such organisations are often trusted sources which will be crucial in collating experiences and reaching out to the widest possible audience of autistic people.

The recent development of the local Learning Disability strategy and the revision of the Mental Health strategy are of particular note given the prevalence of co-morbidities for autistic people. Greater details around the strategic outcomes and associated actions for these strategies, and the application of these to the autistic population will be considered through the implementation of these strategies, all of which are being facilitated by the Partnership. Joint working will be of key importance to ensure the Partnership vision of improved health and wellbeing for local people, including autistic people, is promoted.

Community Planning Aberdeen, which brings together Public Sector agencies, aims to deliver improved outcomes for the people of Aberdeen. The Local Outcome Improvement Plan (LOIP) seeks to ensure that Aberdeen is a '*place where all people can prosper'*, it is important to note this includes all autistic people.

The current LOIP sets out 2 key drivers in relation to *'people are resilient, included and supported when in need'*:

- **People and communities are protected from harm** – individuals and communities are made aware of the risk of harm and supported appropriately to reduce this risk.

- **People are supported to live as independently as possible** – people are able to sustain an independent quality of life for as long as possible and are enabled to take responsibility for their own health and wellbeing.

The current 2014-2024 autism strategy sits under this outcome as a supporting strategy. This revised strategy will replace any previous version and will ensure consistency between the LOIP as a strategic document and other local plans/policies.

Overarching strategic documents such as the LOIP and the HSCP Strategic Plan are being refreshed with new versions expected in 2019. Any significant changes in vision or approach of these guiding documents will be reflected in this autism strategy in due course.

3. Revising our strategy and action plan

3.1 Good Practice Indicators

The national strategy sets out ten Good Practice Indicators. These indicators are mapped out in appendix 3.

It is acknowledged that local progress in relation to these indicators is not as clear as would be expected. It is recognised that further work will be undertaken through implementation of the strategy and action plan to address and map local progress in relation to the indicators.

3.2 Strategy Development

The decision to review our local strategy and action plan was linked to the revised set of outcomes and priorities for autism release by the Scottish Government in 2018 (as detailed above).

To ensure the revision of the local strategy and action plan was meaningful to people we held 4 initial conversational events alongside Autism Network Scotland which sought to gather the views of people on the following national outcomes from an Aberdeen perspective:

- A Healthy life
- Choice and Control
- Independence
- Active Citizenship

It became clear from this engagement that although these outcomes are understood to be relevant they are not as meaningful locally. Feedback from the engagement produced 13 distinguishable focus areas:

- Assessment and Diagnosis
- Education
- Transitions
- Support for Carers
- Housing
- Training
- Information
- Criminal Justice
- Health
- Leisure and Activities
- Services
- Knowledge and Understanding

- Employment

Following this a further series of 3 development sessions were arranged, at which people were invited to comment on the 13 areas identified and to formulate actions which would address the issues identified. People were also asked to consider how they would prioritise the areas that were identified. This has assisted in the production of the action plan.

A draft strategy and action plan was produced, and a 6-week formal consultation period took place. Comments and views from the consultation were used to further refine and develop the strategy and action plan. An engagement and consultation overview report was produced to further capture the detailed activity which took place and played a key role in the development of the strategy and action plan (see appendix 4).

A Strategic Steering Group has been established to lead on the development and implementation of the strategy (comprised of Public and Third Sector representatives). From the initial engagement conversations and the developmental sessions, it is clear that this strategy and action plan, and the ongoing implementation, is of interest to autistic people and their families (as well as professionals and organisations). It is hoped that both autistic people and family representatives can join or contribute to the Strategic Steering Group as it enters an implementation focus.

3.3 Focus Areas

From the engagement activities with autistic people, families, carers, professionals and organisations the 13 focus areas were identified.

For each area an overview has been developed and associated action points to deliver change are defined within the action plan section of this document.

This document will now consider each of the 13 focus areas identified.

Assessment and Diagnosis
Assessment processes for adults and children differ in Aberdeen City. For adults, assessment and diagnostic services in Aberdeen may be provided

where a co-morbidity exists, such as Mental Health or Learning Disability in conjunction with autism but are not necessarily common place.

Assessment and subsequent diagnosis for autism only in adults is not provided at this time by NHS Grampian, and there appears to be a lack of supports in place to provide information/advice in lieu of a formal diagnosis. There is the need to understand the barriers to assessment, which in part are attributed to resource constraint and current/historic practice. A full assessment pathway delivered by trained and competent staff, with details around diagnosis and post diagnostic supports, is desired as this can provide adults within a sense of context and understanding of their neurodiversity. In turn this supports autistic people to develop coping strategies and understand sensory information better. This is identified as a key action to be delivered within the action plan.

Assessment and diagnostic services for children are provided, however the waiting times can be long and there is a lack of post-diagnostic support for families. This can be in part attributed to the lack of resources available for assessment and diagnosis but is also reflective of the challenging nature of a spectrum condition to fully assess. Support is crucial for children, parents and staff (such as within schools) to fully understand autism and the relevant support strategies that can be used effectively. Sometimes Educational supports can be in place with no formal clinical diagnosis, such as support through Educational Psychology and other Additional Support for Learning Services, including the provision of training to staff, but it is recognised that resource constraints may be a limiting factor in the application of such supports. Some specialist services exist, such as Autism Outreach which operates specific access criteria and procedures.

For both children and adults consideration should be made as to the availability of post-diagnostic support and relevant signposting and guidance services.

There are organisations in Aberdeen who aspire to provide valuable and trusted information, guidance and signposting on autism to autistic people, families and other organisations or professionals. These organisations are an asset and can have a wide reach into the autistic population of Aberdeen. It is important that such organisations are valued and are empowered to play their role in the implementation of the local strategy and action plan. This may include provision of formal signposting services or the availability of autism appropriate environments and activities.

Education
The move to mainstream schooling has resulted in specialist training, knowledge and understanding being required across all schools. Some children struggle with the class environment (size, sensory aspects) and/or the curriculum, more flexible approaches are required to ensure support is child-centred, including the consideration of changes in current practice to promote the educational potential of the child. This should include the consideration of flexible spaces within the school environment which support the provision of education to autistic children, for instance the use of sensory friendly spaces where individual and groups can experience the curriculum. It is also important to recognise that school also provides valuable opportunities for autistic children to socialise with other autistic children and non-autistic children, promoting social understanding. This enhances a sense of peer support for autistic children but will also support the greater acceptance of autism and neuro-diversity within society.

Tools such as communication logs and play based learning are positive examples to highlight within Schools but these are not universally in use. Resources and supports at Orchard Brae/Mile End/Bucksburn and Autism Outreach are having a positive impact, but these are limited resources. There is a gap in education for the school population about autism more generally.

Transitions
Transitions often refer to the process of someone leaving education and entering adulthood, which may include the provision of formal services. Some autistic children will be receiving formal commissioned services which cease upon entering adulthood, in part due to their availability to support adults and the eligibility of the young adult to receive social care services on an ongoing basis (linkage to Assessment and Diagnosis). It is important that supports for children approaching transition are being used effectively to smooth the transition from education and explore the options available to each person (such as further education, community activities or employment).

Within the current Learning Disability service there is a small transitions team, but not every young adult will experience this resource/support due to their level of need and eligibility. Many families find the process of transition challenging and it can prove difficult to gain clear information about the next steps for the young adult. This is in part because of the way services are operated spanning Aberdeen City Council and the Partnership, more could be done to ensure any barriers between the

services are removed. Transitions should be focused on the needs of the young person rather than applied because they reach a set age – meaning they should start as and when required (including earlier for some). More information and advice around transitions are required, even if the young person will receive no formal services when they leave education (post 16/18).

Transitions are a crucial time, not just from childhood to adulthood. Across the lifespan transitions also refer to small changes in relation to environment or people and can also refer to general life transitions such as moving home, finding work and building relationships. It is important to remember transitions beyond education and ensure autistic people are supported to develop their own relevant and effective coping strategies when faced with change. This aspect can be overlooked and there is an identified lack of support to address needs arising from these types of transition.

Support for Carers

Families (including parents and siblings) require more support to understand autism and its impact for their family member, including tools and techniques for supporting and communicating with their loved one. Families often have to source information themselves rather than being able to build their resilience through readily accessible information. Better communication about local supports and services is required (through signposting and guidance services), particularly regarding support when individual's behaviour may be difficult or disruptive and support for siblings. Where a family is taking on a caring role they can struggle to access suitable forms of respite which would enable them to continue in their caring role. Many families have strong concerns about future needs/services, particularly if they are no longer able to support/care for the person. Carers of autistic adults and children will be able to benefit from the recently launched Carers Act and local Carers Strategy, including the provision of assessment through a Carers Support Plan, and where eligible, formal services which support their caring role.

Housing

Autistic people may need support to live independently. It is important that the specific housing needs of autistic people and families with autistic children are considered and supported, including types of accommodation and location and communication methods. Consideration as to the appropriateness of shared accommodation for autistic people should be given, particularly where the level of need is such that the shared aspects

of living can be seen to pose communication and sensory difficulties. The availability of training on autism for housing staff would increase understanding which would then enable them to provide support which promotes a person's independence. Some people may require more intensive forms of supported accommodation, however currently this is only provided where a co-morbidity exists and where a person has eligible needs for such services. Specific housing supports for autistic people with more complex need and a co-morbidity of an intellectual disability are referenced further within the Learning Disability Strategy.

Training
Training for professional/organisations is required to ensure staff can offer appropriate and personalised support for people which takes into consideration the individual's needs e.g. sensory needs. Autistic-led training should be better supported and promoted. There are many people and organisations keen to offer this in Aberdeen. These offers of support must be better utilised by the Public, Third and Independent sectors. Training for autistic people is lacking – such as being able to understand your own autism, coping strategies and key life skills, including independent travel, social media awareness and building relationships.

Information
Navigating resources to find appropriate and relevant information is hard for people as there is so much information available but it can be difficult to know where to find this and what to trust. Having a centralised source of information or place to go would help. Information on dealing with practical everyday scenarios is often what people are looking for. There are organisations or projects currently providing information, signposting and guidance services, as well as some who provide elements of direct support at times. Organisations should be better connected enabling support and guidance to reach all autistic people who seek this. People are also looking for better ways to connect with peers and build support networks. There is a commitment to produce the strategy and action plan in a variety of formats to ensure that the information contained is accessible and understandable. Autistic people will play a key role in this.

Criminal Justice
Some autistic people may be more susceptible to becoming a victim or perpetrator of crime due to a lack of understanding around social cues, communication or the Criminal Justice System itself. Support and training around this would be useful for autistic people, communities and staff within the Criminal Justice System.

Health
Autistic people are entitled to equal access to all forms of health services. Some autistic people have negative experiences within health services relating to their autism, but these can also affect their health more broadly (such as not understanding protocols, feeling distrusted, not identifying illness or ill health). There is good practice in some health provision, for example in the explanation of procedures or flexibility in scheduling of procedures/appointments.

Sometimes there is a lack of understanding of autism by some health professionals, and there is the need to have greater consistency across the City. This includes the consideration of alternative settings when the clinical environment is not suitable. There is a lack of counselling support which is provided within the context of autism and given the prevalence of issues such as anxiety, self-harm and suicidal ideation more suitable counselling support could act as a preventative measure or provide coping strategies. Support at an earlier stage, such as with communication difficulties through Speech and Language Teams, can have a positive effect for children regardless of the presence of a formal diagnosis. Peer support is valuable in understanding and supporting good health outcomes, with particular reference to mental health and wellbeing.

Leisure/Activities
Having access to relevant groups and activities is important, as well as being able to access groups that are comprised of autistic people. There are many community activities taking place, offering a range of activities including more specialist support. There is better awareness of what is available. Generally, within community activities there is better knowledge and understanding of autism, although there are still improvements which could be made. Being part of groups, perhaps with support, does help autistic people by breaking down barriers and feeling more socially included. Some activities which are well suited to children can be expensive to access or can be difficult for families to attend (due to location or timing). It is important to recognise that social interactions/skills can take place in a variety of environments through things such as play (board games for example). Support for older autistic people is an identified gap, therefore supporting and promoting the development of peer support for this group would be beneficial.

Services

It is acknowledged that financial resources are limited in the public sector and there is a lack of services available. Offering early intervention supports is crucial and may result in minimal resources or services being required in the future. Supports should be available on the basis of need, however at times this does not always appear to be the case. There are clear priorities and ambitions within documents such as the Partnership Strategic Plan and Strategic Commissioning Implementation Plan which services/supports for autism require to be reflective of. Knowledge and understanding of autism should be considered by decision making groups, such as including autistic people in such groups. Systems and processes such as social care eligibility criteria are challenging. Whilst it is acknowledged that it is the system driving decision making rather than individual staff this remains an area of tension for all concerned.

The quality of support services is instrumental and there are organisations whose remit is to support autism however, at present, not all of those organisations provide services within Aberdeen. It is the aim of this strategy to redress this by considering supports required by the autistic population, identify where the current deficits are in relation to commissioned services within Aberdeen and propose to address this. It is envisaged this will have a resource implication however changes are required to ensure better outcomes for autistic people are achieved. An example of this related to the availability of trusted sources of information and signposting for autistic people and their families.

Knowledge and Understanding

Knowledge and true understanding of autism is a theme which is core to many other aspects discussed throughout this strategy. More knowledge does exist within communities, in part because of localised awareness raising but also national media coverage (e.g. TV programmes), however these often do not show the diversity or spectrum of autism. Greater knowledge and understanding can still be promoted by focusing on some of the myths or misunderstanding around autism. We are always learning more about autistic people’s life experiences and the diversity of the spectrum. Everyone is different, so it is important to look at the capabilities and skills not just the stereotype, which at times can include clinical definitions of what it means to be autistic. Peer support groups or groups of autistic people play a key role in helping to explore and value the different outlook that autism can bring to the world.

Employment

Many autistic people want to work. They possess valuable skills which may enhance team delivery and effectiveness however they often face barriers into employment which prevents them from being able to demonstrate their skills. Employability skills should be more readily taught or explored during education or within other formal supports. Supportive aspects such as work trials, getting the right support at the Job Centre, reasonable adjustments or the Project SEARCH programme can be positive for autistic people, but these are not always available or utilised options. Often the key is finding the right work environment or one member of staff who can offer support. Providing support to increase knowledge and understanding of autism in the context of employment may lead to further positive opportunities.

4. Action Plan

13 focus areas were identified through engagement activity. Following this a series of actions were attributed to most of these areas.

Each action has also been aligned to the national outcomes which supports the linkage of our local strategy and action plan to work taking place nationally.

Some of the actions identified will require extensive planning, consultation and assessment of resources required, this is recognised within the timescales identified.

There is the acknowledgement that resources must be aligned to each action and focus area in order to effect real change. It is important that actions are prioritised to ensure best use of any resources made available. The evaluation of the strategy and action plan will also be an area of key importance, ensuring that the delivery of actions is being undertaken but also that they are having the expected or desired impact for autistic people in Aberdeen. The Strategic Steering Group will define evaluation measures and reporting procedures.

It should also be noted that many action points are interlinked or cut across themes, for example, training. For ease of planning, where an action can be linked to another theme this will be highlighted.

The Strategic Steering Group will ensure regular and robust reporting procedures to document progress.

The Aberdeen City Health and Social Care Partnership have facilitated the revision of the strategy and action plan and therefore will be accountable for its progress and implementation. A Strategic Development Officer is assigned to this area of work and alongside the Lead Strategy Manager will be accountable to the Partnership's governance structures.

Lead Officers or services within individual services or organisations will be responsible for the delivery of action points within this plan and will be required to regularly report on progress, this includes Integrated Children's and Family Services; NHS Grampian and Third Sector organisations.

Autistic people, families and other interested parties involvement in the development, delivery and evaluation of the identified outcomes will be promoted, and opportunities to increase this involvement will be identified where possible.

Assessment and Diagnosis					
What will we do?	**When will we have it done by?**	**How will we know it is working?**	**Who will be involved?**	**Any Associated Focus Areas and Resources**	**Link to national outcomes**
1. Creation of 'autism appropriate' integrated assessment pathway for Adults	Year 3	Assessment data will be recorded and analysed	Aberdeen City Health and Social Care Partnership – Mental Health and Learning Disability Services/ NHS Grampian	Training Funding from Scottish Government requested	A Healthy Life
2. Provide enhanced clarity on the assessment pathway for Children and Young People (as informed by national development work)	Year 2	Information on the Pathway will be readily available; reduction in complaints; linkage to children's plan; assessment and diagnosis trends will be measurable	Integrated Children's and Family Services/NHS Grampian	Information Existing resources will provide support	A Healthy Life
3. Provision (and revision where necessary) of support at pre-assessment and post-diagnosis stages, including review of supports such as the Cygnet (parent support) programme	Year 3	Working group will review supports and analyse gaps and put necessary commissioning arrangements in place for support which promotes knowledge of autism and coping strategies etc.	Aberdeen City Health and Social Care Partnership/ NHS Grampian/ Integrated Children's and Family Services/Third Sector/Autistic people	Existing resources will provide support to review	A Healthy Life Independence

Education					
What will we do?	**When will we have it done by?**	**How will we know it is working?**	**Who will be involved?**	**Any Associated Focus Areas and Resources**	**Link to national outcomes**
4. Request that Education Services map Autism knowledge and understanding in Schools and where gaps exist put in place plans to address such gaps	Year 1	Plans in place to address gap/needs including will be reportable to the implementation group	Integrated Children's and Family Services/ Autistic People	Training Information Existing resources will provide support to develop process	Choice and Control
5. Provision of flexible and appropriate learning pathways and environments which meet the needs of autistic children	Year 2	Analysis of local and national statistics detailing attendance, exclusion and positive educational and wellbeing outcomes; anecdotal evidence of improvements from children and families	Integrated Children's and Family Services	Existing resources will be utilised in a flexible manner	Choice and Control
6. Increased use of Individual Plans (IEPs/Child's Plans) to monitor progress	Years 1-3 – continued activity	Analysis of plans to be undertaken and progress tracked	Integrated Children's and Family Services	Existing resources will track progress	Choice and Control Independence
7. Work with Universities and Colleges to explore learning opportunities to increase knowledge and understanding of Autism for a range of stakeholders	Year 2	Learning opportunities will be mapped and attendance statistics will be used to create baselines for improvement	Aberdeen City Health and Social Care Partnership/ Integrated Children's and Family Services/ Autistic People/Further and Higher Education establishments	Training Knowledge and Understanding Services Existing resources will be utilised to explore opportunities	Choice and Control

Transitions					
What will we do?	**When will we have it done by?**	**How will we know it is working?**	**Who will be involved?**	**Any Associated Focus Areas and Resources**	**Link to national outcomes**
8. Development and implementation of a Transitions Pathway (children to adults)	Year 3	Pathway will be developed and in operation; Transitions Planning Documents will be recorded and baselines created to measure improvement; relevant data will be analysed to monitor and evaluate; anecdotal evidence of improvements from young people and families	Transitions Sub Group – Learning Disability Strategy (multi-agency group)	Information Education Services Health Existing resources will be utilised to develop the pathway	Choice and Control Active Citizenship Independence
9. Promotion of 'Transitions across the Lifespan' national toolkit	Years 1-3 – continued activity	Awareness and use of toolkit will be raised; reduction in unsuccessful transitions; anecdotal evidence of improvements in relation to life transitions	Aberdeen City Health and Social Care Partnership/ NHS Grampian/ Integrated Children's and Family Services	Promotional activity which will require no dedicated resource	Choice and Control Active Citizenship

Support for Carers					
What will we do?	**When will we have it done by?**	**How will we know it is working?**	**Who will be involved?**	**Any Associated Focus Areas and Resources**	**Link to national outcomes**
10. Promote the rights of Carers within the Carers Act and local Carers Strategy, including the rights to receive a Carers Support Plan and availability of local support	Years 1-3 – continued activity	Increased awareness of rights will exist; data of carers support plans completed	Aberdeen City Health and Social Care Partnership - Carers Strategy Implementation Group/ NHS Grampian/ Integrated Children's and Family Services/ Third Sector	Information Resources are aligned under the Carers Strategy Implementation Group	Choice and Control

Housing					
What will we do?	**When will we have it done by?**	**How will we know it is working?**	**Who will be involved?**	**Any Associated Focus Areas and Resources**	**Link to national outcomes**
11. Facilitate an event with the housing sector to promote the housing needs of Autistic people and their families	Years 1 -2	Event will have taken place; baseline of knowledge will be measured, and improvement methods identified	Aberdeen City Health and Social Care Partnership/Aberdeen City Council – Strategic Place Planning/Housing Sector	Training Low level expenditure to host event – collaborative approaches will be used to share any costs	Independence

Training					
What will we do?	**When will we have it done by?**	**How will we know it is working?**	**Who will be involved?**	**Any Associated Focus Areas and Resources**	**Link to national outcomes**
12. Application of the principles of the NHS Education for Scotland (NES) training framework for Autism, which will be applied in a way which promotes where possible the genuine involvement of autistic people in the development, delivery and evaluation	Years 1-3 – continued activity	Training Framework will be in place; attendance and evaluation data will be available	Aberdeen City Health and Social Care Partnership/NHS Grampian/ Integrated Children's and Family Services/other national organisation/interested parties	All areas To be funded from existing training budgets	Choice and Control

Information

What will we do?	When will we have it done by?	How will we know it is working?	Who will be involved?	Any Associated Focus Areas and Resources	Link to national outcomes
13. Develop and launch good practice checklists for 'autism appropriate' environments	Year 2	Checklist will be developed and launched; evaluation of its use; anecdotal evidence of improvements	Aberdeen City Health and Social Care Partnership/NHS Grampian/Integrated Children's and Family Services/ Third Sector/ Autistic People	Education Health Services Leisure/ Activities Criminal Justice Existing resources will provide support to develop checklist	Choice and Control
14. Presentation of Strategy in alternative formats – in co-production with autistic people and families	Year 1	Alternative forms will exist	Strategic Steering Group/Communities of Interest	Collaborative approach will be used to share any costs	Active Citizenship Choice and Control

Criminal Justice

What will we do?	When will we have it done by?	How will we know it is working?	Who will be involved?	Any Associated Focus Areas and Resources	Link to national outcomes
15. Raise awareness of the Appropriate Adult (AA) Scheme	Year 2	Analysis of data regarding requests and usage of AAs	Aberdeen City Health and Social Care Partnership/ Criminal Justice Services/Police Scotland/other national organisations	Promotional activity which will require no dedicated resource, links will be made with relevant national groups	Choice and Control
16. Develop links to Supporting Offenders with Learning Disabilities network (relevant to autism) and local Criminal Justice Board	Year 1	Links will be made and any project specific work identified	Aberdeen City Health and Social Care Partnership/ Criminal Justice Services/ other national organisations	Existing resource will be utilised to make links	Choice and Control

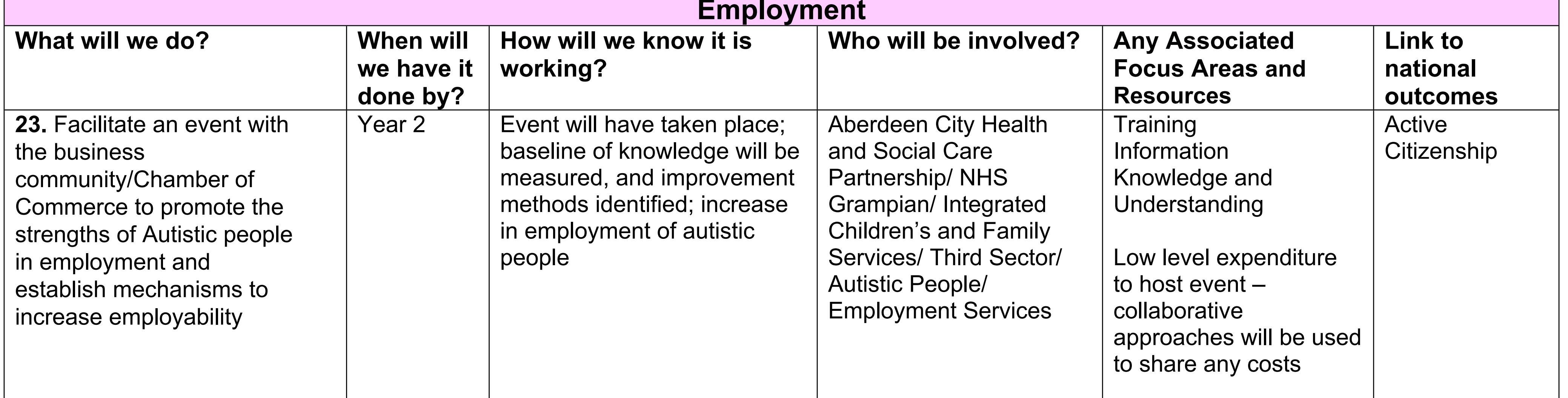
Health					
What will we do?	**When will we have it done by?**	**How will we know it is working?**	**Who will be involved?**	**Any Associated Focus Areas and Resources**	**Link to national outcomes**

Health					
What will we do?	**When will we have it done by?**	**How will we know it is working?**	**Who will be involved?**	**Any Associated Focus Areas and Resources**	**Link to national outcomes**
17. Increased use of Care Opinion by Autistic People and their families	Years 1-3 – continued	Increased usage evidence through available data	Aberdeen City Health and Social Care Partnership/ NHS Grampian	Promotional activity which will require no dedicated resource	A Healthy Life
18. Provide information on suitable counselling type supports with knowledge of Autism interlinked to Mental Health	Year 2	Information will be available; services will be listed on relevant databases	Aberdeen City Health and Social Care Partnership/ NHS Grampian	Existing resource will be utilised	A Healthy Life

Leisure/Activities					
What will we do?	**When will we have it done by?**	**How will we know it is working?**	**Who will be involved?**	**Any Associated Focus Areas and Resources**	**Link to national outcomes**
19. Facilitate an event with interested Leisure/Activity providers and groups to discuss and promote the autism and establish mechanisms to increase widening access	Years 1-2	Event will have taken place; baseline of knowledge will be measured, and improvement methods identified	Aberdeen City Health and Social Care Partnership/ NHS Grampian/ Integrated Children's and Family Services/ Third Sector/ Autistic People/ Leisure/Activity Services	Training Information Knowledge and Understanding Low level expenditure to host event – collaborative approaches will be used to share any costs	Active Citizenship

Services					
What will we do?	**When will we have it done by?**	**How will we know it is working?**	**Who will be involved?**	**Any Associated Focus Areas and Resources**	**Link to national outcomes**
20. Develop mechanisms to track unmet need and analyse gaps in provision (from signposting to direct support), to inform future development	Year 2-3	Tracking mechanisms will be identified and in operation; gaps will be mapped; areas for service developments will be identified; reduction in unmet need and complaints	Aberdeen City Health and Social Care Partnership/ Integrated Children's and Family Services	All Existing resource will be utilised to develop and maintain processes	Choice and Control Independence

Knowledge and Understanding					
What will we do?	**When will we have it done by?**	**How will we know it is working?**	**Who will be involved?**	**Any Associated Focus Areas and Resources**	**Link to national outcomes**
21. Develop and launch promotional work to raise community knowledge and understanding of the strengths of autistic people	Years 1-3 – continued activity	Increased knowledge, understanding and acceptance; promotional events or materials will be launched	Aberdeen City Health and Social Care Partnership/ NHS Grampian/ Integrated Children's and Family Services/ Third Sector/ Autistic People	All Promotional activity which will be carried out in collaboration, requiring no dedicated resource	Independence
22. Scope roll out of Autism Aware/ Alert Card	Year 1	Working group will conduct scoping and recommendations made/progressed	Aberdeen City Health and Social Care Partnership/ NHS Grampian/ Integrated Children's and Family Services/ Third Sector/ Community Resources/ Autistic People	Leisure and Activities Criminal Justice Health Education Existing resource will be utilised to conduct scoping	Independence



Employment					
What will we do?	**When will we have it done by?**	**How will we know it is working?**	**Who will be involved?**	**Any Associated Focus Areas and Resources**	**Link to national outcomes**
23. Facilitate an event with the business community/Chamber of Commerce to promote the strengths of Autistic people in employment and establish mechanisms to increase employability	Year 2	Event will have taken place; baseline of knowledge will be measured, and improvement methods identified; increase in employment of autistic people	Aberdeen City Health and Social Care Partnership/ NHS Grampian/ Integrated Children's and Family Services/ Third Sector/ Autistic People/ Employment Services	Training Information Knowledge and Understanding Low level expenditure to host event – collaborative approaches will be used to share any costs	Active Citizenship

5. Governance and Next Steps

The revised Strategy and Action Plan is a formal document which is approved by the Health and Social Care Partnership's Integration Joint Board and the Aberdeen City Council's Operational Delivery Committee. The Strategic Steering Group which is already established will take a focus on the implementation of the Strategy through the delivery of the content of the Action Plan and will be renamed the Autism Strategy Implementation Group.

A revised governance structure will be launched to implement the action plan. Each service area identified as holding responsibility for any actions will be required to align a Lead Officer to progress such work and report back to the Autism Strategy Implementation Group.

Regular reporting structures will be in place to ensure that progress is being made in a timely and satisfactory manner, and where issues or blockages arise, these are raised to relevant services, boards or committee for advice or resolution.

The Autism Strategy Implementation Group will hold itself to account, due to its varied membership, which will include representation from autistic people and Parents/Carers. Feedback from these representatives, members of the public and other organisations will be vital in ensuring the Strategy is being delivered in a meaningful way. Implementation reports, where possible, will be shared publicly and the Autism Strategy Implementation Group will continue to work with Autism Network Scotland and Scottish Government colleagues to support the benchmarking of progress and ensure better links regionally and nationally.

Autism Strategy Consultation Review

To support the revised Autism Strategy and Action development a variety of engagement and consultation activities were undertaken.

A summary of this activity follows:

Engagement Activity

A series of engagement and development activity with key groups and individuals took place to inform the draft Strategy and Action Plan for consultation.

- A Strategic Steering Group was established with membership initially from NHS Grampian, Aberdeen City Council and Aberdeen City Health & Social Care Partnership services. This group was expanded to include representatives from the Third Sector
- An Autism Forum, supported by ACVO, has nominated 3 representatives from Third Sector Organisations to join the Strategic Steering Group. The organisations within the forum aim to represent the views of Autistic People and their Families in both Aberdeen City and Aberdeenshire
- 4 initial engagement sessions were held with varied attendance, including Autistic People, Families/Carers, Professionals and Organisations. 1 of the sessions was solely for engagement with Autistic People
- In the region of 60 people attended these engagement sessions, with 3 of the sessions being supported by Autism Network Scotland (ANS is funded by Scottish Government to support the implementation of the national Autism Strategy)
- The engagement sessions focussed on the 4 outcomes identified in the refresh of the national Strategy outcome and priorities: A Healthy Life; Choice & Control; Independence; Active Citizenship. Feedback received identified that for our local Strategy refresh these outcomes although relevant were not the key aspects people would wish to be focussed on
- Following the engagement sessions feedback was collated and 13 key focus areas could be identified
- These were: Assessment and Diagnosis; Education; Transitions; Support for Carers; Housing; Training; Information; Criminal Justice; Health; Leisure and Activities; Services; Knowledge and Understanding; Employment
- A descriptor for each of these focus areas was created, through comments received at engagement and further developmental sessions were arranged
- 3 Development Sessions were conducted which focussed on the areas previously identified and sought to consider the actions needed to address any issues raised in relation to each specified area.
- 30 people attended these sessions, with mixed attendance including Autistic People, Families/Carers, Professionals and Organisation

Consultation Process

A 6-week formal consultation period was initiated to capture views on the draft Strategy and Action Plan. The draft was produced primarily from feedback obtained within the engagement and development sessions, in addition to a review of the existing Strategy & Action Plan, and discussions within Strategic Steering Group.

- A consultation survey was created to capture views via the Aberdeen City Council's consultation platform 'Citizen Space'
- The survey could be completed anonymously and as either an individual or group response – enabling group discussion of the questions and then 1 entry of electronic feedback.
- Face to Face sessions for consultation feedback were considered but due to staff capacity were not viable on this occasion
- Information on the consultation was provided widely within the Steering Group, Services/Teams and across other organisations and partners to encourage dissemination of information and completion of the survey
- Where data sharing allowed, information on the strategy consultation was disseminated widely through a mailing list comprising of Public, Third Sector and Independent sector organisations as well as other interested parties
- Consultation information was placed on Aberdeen City Council, NHS Grampian and Aberdeen City Health & Social Care Partnership Websites. Third Sector Organisations were also encouraged to share this information
- Information on the consultation was made available through internal and external e-bulletins

Consultation Overview

- 40 responses were received to the formal consultation
- Comprising of 28 individual and 12 group/collective responses. Group responses ranged from 2 people to upwards of 20 people's views being represented
- Respondents were asked to identify under which role they were completing the survey, with selection of more than 1 role possible. The highest response rates came from people identifying as a Professional or from an Organisation (20 responses), followed by Parent/Carer (16), Autistic Person (9) with the remaining classifying themselves as either Other Family Member (3) or Other (5)
- Respondents were asked whether they found the Strategy and Action Plan document easy to understand or had any views on the format. Around two thirds of respondents viewed it as being clear and understandable. The remaining third noted that some clarity was needed, and some responses indicated they did not like the format or did not find the structure easy to understand.

- We asked in what ways the format may be made more relevant to the audience, a range of comments were received with suggestions such as an easy read version, a video/audio version, summary document or leaflet, and a comic version.
- We specifically asked if people agreed with the vision identified, with 75% stating yes
- We also asked if people understood why the Strategy was being revised, with 90% stating yes
- We asked people for their views on which focus should be prioritised, and while some comments indicated that it was difficult to priorities one area over another the survey results generally indicate some higher priority areas: Assessment & Diagnosis; Education; Training; Transitions: Support for Carers; Health; and Services

Feedback

- Overall the feedback throughout the consultation could be related to the 13 key focus areas identified during the engagement and development activity
- Some increased clarity was requested in relation to concepts discussed in the document, this may be achieved via a glossary, further expansion of the concept or examples, a review of these aspects will be undertaken, and clarity provided
- The definition of Autism used whilst agreeable to many was not universally accepted, as such this will be reviewed and suggestions to provide an enhanced clinical view will be explored
- There were some comments on the language sued within the document such as terminology and what was generally viewed as 'jargon', every attempt will be made to provide a Plain English approach to this Strategy, with the acknowledgement that some terminology may require to remain but will be further explained (e.g. in a glossary section)
- Some data referenced within the draft was noted to have been more recently updated, changes will therefore be made to ensure any data references are relevant and up to date
- There were mixed comments received on the format and style of the document, and whilst many people found the style clear, there were suggestions made which could offer improved readership. The draft document was provided in one format with the expectation that an approved Strategy and Action Plan will be available in a range of formats, such as Easy Read. We will use the suggestions highlighted earlier in this report to ensure any alternative versions are appropriate.
- The areas of Assessment & Diagnosis; Education; and Training were the most commented on. Overall people expressed dissatisfaction with these areas are they are currently delivered, this echoes the views within the

engagement activities. Some suggestions for improvements in the draft were made in relation to these areas (amongst others) which will be reviewed and where appropriate will led to changes in the Strategy. Many of the comments can be viewed as being in relation to the achievement of the actions outlined, such as clarifying the outcome, timeline and responsible person/organisation further

- The Action Plan section was viewed to the most useful aspect of the document as respondents indicated that was where their main interest lay. Improvements were requested in relation to ensuring the actions were more specific (as detailed above). Additionally, some suggestions were received regarding formatting the Action Plan differently and even moving its location within the document. As the format of the document will more generally be reviewed and adjusted, these suggestions will be taken forward within that review

The main challenges noted through engagement and consultation were in relation to:

- Building trust and good relationships with stakeholders, many of whom feel they have been let down by either services or lack of progress under the current Strategy
- Ensuring the revised Strategy and Action Plan is deliverable, accountable and sustainable.
- Resource implications - with the acknowledgment that Autism does not attract specific funding and is not recognised as a service area, and that this must be rectified to ensure success
- How progress towards delivering on the outcomes will be measured and progress adequately reported on in a timely manner, and in a way which allows for public scrutiny

Overall the draft Strategy and Action Plan was welcomed, with some respondents recognising that although they had wished for the previous Strategy to have been more successfully implemented/progressed, that this revised version was a step in the right direction.

Many respondents echoed the view that we need to value Autism more, both in terms of Autistic people and their skills and abilities, but also in terms of the processes we have within organisations, such as ensuring good quality training is available and additional resources where appropriate.

There were mixed comments with reference to providing increased information and raising knowledge and understanding. Some responses favoured approaches which actively sought to raise the profile of Autism within Aberdeen, such as promotional campaigns but there were also responses which felt these approaches could be used as patronising and that being too focused on raising knowledge and understanding is still acting to promote segregation and distracts from the other more

prominent issues that people felt should be addressed given the limited resources available.

Most responses acknowledged the complexities of Autism, particularly given its nature as a spectrum condition. With many respondents indicating a will to be more involved in the ongoing engagement around Autism and the implementation of the Strategy and Action Plan once approved.

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Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Date of Meeting	11th December 2018
Report Title	Short Breaks Services Statement
Report Number	HSCP.18.103
Lead Officer	Sandra Ross, Chief Officer
Report Author Details	*Name:* Alison MacLeod *Job Title:* Lead Strategy and Performance Manager *Email Address:* alimacleod@aberdeencity.gov.uk
Consultation Checklist Completed	*Yes*
Directions Required	*No*
Appendices	*a.* Aberdeen City Short Breaks Services Statement

1. Recommendations

1.1. It is recommended that the Integration Joint Board approve the Aberdeen City Short Breaks Services Statement (SBSS).

2. Purpose of the Report

2.1. The purpose of this report is to seek the IJB's approval of the Aberdeen City Short Breaks Services Statement. Following IJB approval, the statement will be published as per the requirement in the Carers (Scotland) Act 2016.

3. Summary of Key Information

3.1. On 1st April 2018 The Carers (Scotland) Act 2016 (the "2016 Act") came into effect. The 2016 Act extends and enhances the rights of carers in Scotland to help improve their health and wellbeing so that they can continue to care, if they so wish, and have a life alongside caring.

NHS Grampian ABERDEEN CITY COUNCIL

3.2. On 27th March 2018 the IJB approved the Aberdeen City Carers Strategy and on 22nd May 2018 the IJB approved the Adult Carer Support Planning and Eligibility Criteria for Carers, both of which are a requirement of the 2016 Act.

3.3. A further requirement of the Act is that we publish a Short Breaks Services Statement by 31st December 2018. The purpose of the Short Breaks Services Statement is to outline what short breaks are, who can access them, provide information on what short breaks are available both locally and nationally, and detail Aberdeen City's approach to the provision of these.

3.4. As with the Carers Strategy, the Short Breaks Services Statement covers both Young and Adult Carers. A sub group of the Carers Strategy Implementation Group was constituted to drive the development of the statement. The group consisted of representatives from both adults and children's services, providers, and carers. Their work was informed by the work of a national "Think Tank" facilitated by Shared Care Scotland and comprising of representatives from 12 local authority/partnership areas including Aberdeen City. The Think Tank published a template and guidelines which the sub group used to produce the draft Aberdeen City Short Breaks Services Statement.

3.5. The draft SBSS underwent a 4-week consultation period focusing mainly on known carers, providers and members of the public. Feedback was very positive. People particularly liked the example short breaks scenarios. We propose to continue to develop a bank of example short breaks as more and more carers come forward and are more creative in personalising their support. These can be used during the support planning stage to help carers consider what type of short break might be useful for them.

3.6. A short break is very personal to the individual caring situation and it is difficult to provide a definitive list of what could be available as the possibilities are infinite. The statement aims to convey that what is currently available is not the limit of what could be available. Each and every carer will have the opportunity to discuss, as part of their support planning, what a short break means for them and they will be supported to find the service that meets their need.

3.7. As we have done for other Carer related documents, following approval of the SBSS, we will design and publish an easy read leaflet on short breaks.

3.8. The publication of the Short Breaks Services Statement completes the current outstanding requirements of the Carers (Scotland) Act 2016 although we are awaiting the publication of Terminal Illness Regulations which we anticipate will impose timescales within which an Adult Carer Support Plan or Young Carers Statement should be prepared. It is anticipated these regulations will be approved by December 2019 and come into effect at some point in 2020.

4. Implications for IJB

4.1. **Equalities** - the publication of the Short Breaks Services Statement is a requirement of the 2016 Act. The statement applies to all carers regardless of their equality status. An Equality and Human Rights Impact Assessment (EHRIA) was completed for the Carers Strategy which showed no negative impact. It is considered that an EHRIA is not required for the statement.

4.2. **Fairer Scotland –** the recommendations in this report have no direct implications on the Fairer Scotland Duty. All carers are treated equally dependant on need and eligibility.

4.3. **Financial –** charges for services to carers which meet their needs identified in either an Adult Carer Support Plan or Young Carers Statement should be waived. The financial impact of the Short Breaks Services Statement is not yet quantifiable. Additional funding of £725,000 was received for 2018/19 for the implementation of the 2016 Act. £150,000 was allocated to Aberdeen City Council Integrated Children's Services for supporting Young Carers leaving a balance of £575,000 for use in supporting Adult Carers. It is determined that this funding will accommodate the financial impact of the 2016 Act in the current year. Further funding is anticipated in the 2019/20 settlement.

4.4. **Workforce -** the Short Breaks Services Statement will assist the workforce support carers to identify sort breaks appropriate to their caring role.

4.5. **Legal -** were we not to publish a Short Breaks Services Statement we are at risk of not meeting our legal obligations under the 2016 Act which would disadvantage carers and cared for people.

4.6. **Other –** none.

INTEGRATION JOINT BOARD

5. Links to ACHSCP Strategic Plan

5.1 This report links to strategic priority 4 in the Strategic Plan i.e. "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."

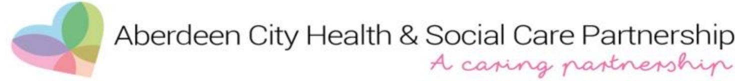
6. Management of Risk

6.1. **Identified risks(s):** There is a risk that if we do not publish a Short Breaks Services Statement, there is the opportunity that the IJB could be in breach of the 2016 Act, and that carers and cared for people could be disadvantaged.

6.2. **Link to risks on strategic or operational risk register:** The Short Breaks Services Statement is linked to Risk 5 on the 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."

6.3. **How might the content of this report impact or mitigate these risks:** Approval and publication of the Short Breaks Services Statement will ensure staff and carers have appropriate information which in turn will ensure our obligations under the 2016 Act are met.

Approvals	
[signature]	Sandra Ross (Chief Officer)
[signature]	Alex Stephen (Chief Finance Officer)



Aberdeen City

Short Breaks Services Statement

"A Life Alongside Caring"

December 2018

This document is also available in large print, other formats and other languages, on request.

Please contact the Aberdeen City Health & Social Care Partnership on 01224 625729

For help with language / interpreting and other formats of communication support, please contact 01224 522856/522047

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1. Background

On 1st April 2018 the Carers (Scotland) Act 2016 came into effect. The Act aims to give adult and young carers new rights, whilst bringing together all the rights carers currently have, under one piece of legislation.

The Carers (Scotland) 2016 Act defines a carer as an individual who provides or intends to provide care for another individual (the cared-for person). A Young Carer is someone who is under the age of 18 (or over 18 but still at school). An Adult Carer is someone who is 18 years old or over (and not a Young Carer).

For the purposes of this Short Break Services Statement the term carer is used to refer to both adult and young carers. Where relevant, specific reference will be made to either adult or young carers.

Anyone can be an adult or young carer and the care they provide can take a variety of forms and be for one or two hours a week up to a 24/7 role. In Aberdeen City it is estimated that there are up to 38,000 carers, 1,300 of which could be Young Carers, yet currently only a small percentage of those are known to carer services.

Of the total number of carers in Aberdeen it is estimated that: -

60% are female	**57%** are over 50	**51%** provide >35 hours of care per week	**25%** are retired

In April 2018 Aberdeen City published its first Carers Strategy, A Life Alongside Caring. The strategy sets out how the Aberdeen City Health and Social Care Partnership (ACH&SCP) and the Integrated Children's Services Partnership (ICSP) intend to deliver the requirements of the Act particularly in relation to:

- identifying both adult and young carers
- understanding the care that they provide and their support needs
- providing comprehensive and easily accessible information on the type of support available as well as how and where to get it.

The strategy is available on the partnership's website using the following link: -

https://www.aberdeencityhscp.scot/globalassets/carers-strategy---march-2018.pdf

During the development of the strategy we sought the views of carer and other relevant stakeholders across Aberdeen. The two things that adult carers said would have the most impact upon their caring role were: -

The provision of regular and appropriate respite

The cared-for person themselves receiving adequate services in their own right.

Our survey of carers indicated that: -

72% of carers felt that their mental health and wellbeing had suffered as a result of their caring role;

65% said they felt more lonely or isolated because of their caring role;

56% advised they have experienced difficulties in their relationship with the person they care for.

Aberdeen City Carers Strategy recognises these challenges for adult and young carers and values the support they provide. It seeks to respect carers, to listen to them and involve them in the care provided, not only to the cared for person but also to themselves. In addition, the strategy aims to support carers to identify themselves as carers, to manage their caring role and to be able to have a life alongside caring should they choose.

In line with the strategy and with the requirements of the Carers (Scotland) Act 2016, Aberdeen City is now publishing their Short Breaks Services Statement (SBSS). The Statement gives information about the short breaks services available locally and across Scotland for carers and the person or people they care for.

The aim of the Statement is to help carers and people with support needs understand:

- What short breaks are
- Who can access them
- What short breaks are available in their local area and in Scotland
- How they can access short breaks and find further information
- Whether there will be any charge for these

The content of this Short Breaks Service Statement has been informed by what carers have told us in our consultation around the Carers Strategy and other development work. It will continue to be reviewed in light of feedback.

The Short Breaks Service Statement will also signpost carers to information we expect to be available for them locally. This provides information on what services carers and the cared for person can expect from a range of local agencies, including education, health and social care. Knowing what is out there gives carers more informed choice and involvement in planning their own support.

2. Purpose

Section 25 of the Carers Act requires us to ‘consider in particular’ whether our duty to support carers ‘should take the form of or include a break from caring’ and to ‘have regard to the desirability of breaks from caring being provided on a planned basis.’

Based on what carers told us whilst we were developing the strategy, we know that offering breaks from caring will help both young and adult carers. The provision of regular and appropriate respite was one of the two top things carers identified as being something that would have a positive impact upon their caring role. The term “Respite” has now been replaced by “Short Break”. Personalised breaks from caring can help improve the mental wellbeing of the carer, the relationship they can have with their cared for person and, if the right break is planned, help minimise those feelings of loneliness and isolation that were reported to us.

The purpose of this Short Break Services Statement is to provide information to carers and cared for people so that they;

- know they can have a break in a range of ways.
- are informed about short breaks that are available.
- have choice in the support they access.
- can identify what a Short Break means both for them and for the cared for person
- supports them to plan to meet their needs and achieve their outcomes.

In line with the title of our strategy, we want the Aberdeen City Short Breaks Services Statement to give both adult and young carers ***a life alongside caring*** should they wish this. We are committed to valuing our carers, listening to them and providing them with tools to manage their caring role and to continue with this if that is what they want to do. We recognise that short breaks will be ***personal*** to each and every carer and their own individual caring experience. We are committed to ensuring that there is a ***range of choice*** of short breaks for carers and we will work with in-house staff and external service providers to ensure this is the case. We are also keen to work with carers themselves in sourcing their own personalised short break if that is not already available within existing provision.

We recognise that the primary concern of an adult or young carer is normally the person they care for and, with that in mind, when discussing or planning a short break for a carer we will also ensure there is detailed discussion of the ***impact*** that short break may have on the cared for person and what arrangements for replacement or additional care, if required, will be made.

3. Definition

Whilst the Carers Act requires us to publish a Short Breaks Services Statement, short breaks are not new, they are being provided currently albeit this tends to be in the form of traditional residential based “respite”. The Short Break Services Statement is a formal recognition of the importance Aberdeen City places on short breaks and their value to carers.

The Adult Carers Support Plan and Young Carers Statements provided under the Carers (Scotland) Act 2016 allow carers' personal outcomes to be identified, which in turn allows a decision to be made on whether a short break is appropriate to meet these outcomes and, if so, the most appropriate form that short break should take. In the case of young carers, the short break should allow the right of the young carer to be a child first. Short breaks can take any number of forms and can be for short or extended periods. They should be personalised to meet carer's needs and be planned around what matters to them. As such, short breaks can be very varied and will mean different things to different people.

Short Breaks are planned breaks that allow carers to have a break from their normal caring routine or role. We also recognise that adult and young carers can need access to support if they need alternative arrangements to be made for their cared for person to be looked after in an emergency at short notice. Emergency plans to deal with such situations are not Short Breaks. These should be considered at the point that the Adult Carer Support Plan or Young Carers Statement is prepared. This should minimise the stress that can be generated by emergencies and will be particularly important for any carers that are at increased risk due to their own health or caring circumstances.

The Carers (Scotland) Act 2016 states that all charges for services provided to carers to meet that their identified personal needs as detailed in their Adult Carer Support Plan or Young Carers Statement should be waived. Aberdeen City have also published Local Guidelines on the Waiving of Charges for Services to Carers which provides more detail on this.

Aberdeen City's definition of a short break: -

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

4. Types of Short Breaks

The following list gives examples of the different ways that breaks can be provided. There may be eligibility criteria attached to these. The Shared Care Scotland Directory provides some examples of these https://www.sharedcarescotland.org.uk/
.

Breaks in specialist/dedicated accommodation
The accommodation, which is only used for short breaks, might be guest houses, community flats, purpose-built or adapted accommodation. Depending on the group catered for, facilities may be able to offer specialist care.

Breaks in care homes (with or without nursing care)
Some care homes have a small number of places set aside specifically for short breaks. Rather than simply offering a 'spare bed' the home may provide activities for short-term guests to suit individual needs and interests.

Breaks in the home of another individual or family
These involve overnight breaks provided by paid or volunteer carers in their own home. These are sometimes referred to as shared care, family based or adult placement schemes. Families or individuals offering this support are carefully recruited and registered.

Breaks provided at home through a care attendant or sitting service
This includes individual support provided in the home of the cared-for person for periods of a few hours or overnight. The purpose may be to provide support while the carer is away, or to support the carer in other ways, e.g. by enabling the carer to have an undisturbed night's sleep.

Supported access to clubs, interest or activity groups
These opportunities might focus on a particular activity (e.g. sports clubs, leisure activities) and may be based in a community building. These generally take place over a few hours perhaps once or twice a week or, in the case of disabled children, they may be planned over the school holidays. The availability of adapted equipment or trained workers can help people with support needs to enjoy these activities.

Holiday breaks
These include opportunities for people to have a short break together, or independently. These breaks can be supported in different ways – through an agency specialising in breaks for people with particular needs; in adapted accommodation; or in ordinary hotels and guest houses, perhaps with additional support or equipment. More mainstream breaks may also be possible with the support of a paid carer or companion.

Befriending schemes where volunteers provide short breaks
Befriending normally involves a paid worker or volunteer assisting someone with care and support needs to have access to activities, for example going to the cinema, meeting friends, shopping, swimming and other such leisure pursuits. Befriending can be on a one-to-one basis or as part of a group.

Day care

Day care is typically based in a community building. The degree of flexibility varies; most are characterised by fixed opening hours on particular days; some offer a drop-in service whereby people can attend for part of the day only. Day care is not generally provided for short break or respite purposes but services which offer more flexible arrangements, designed around the needs of both the client and carer, can achieve this purpose.

Hospital/hospice-based break

This type of break is for people who need medical supervision because of complex or intense health care needs. Some facilities are designed in such a way to create a homelier environment with guest bedrooms, lounges and activity programmes. Some short-term hospital-based care provides a break for the carer.

Alternative breaks

Increasingly, with the development of Self-directed Support, more people are finding creative ways to take a break that don't necessarily involve external services. For example, they might use leisure equipment, computers, gardens or anything else that provides a break from routine.

5. Replacement care

Replacement care is a shorthand term to describe the care provided to the cared-for person, which replaces care normally given by the carer and which is provided as a form of support to the carer so that they can have a break from caring. Replacement care could be provided by family, friends or existing community support or, depending on need, it may be day or overnight attendance at a specialist care establishment. It is not necessary for the care provided to the cared-for person to be a like-for-like replacement for the care usually provided by the unpaid carer. There will be circumstances where the unpaid care usually provided by the carer cannot be exactly replicated by paid care.

Aberdeen City Health and Social Care Partnership commissions and provides care known as "Respite" which currently, mainly takes the form of residential stays in care homes or similar establishments typically for a number of weeks sometimes in blocks, and sometimes spread out over the course of the year. The definition of Respite is "a short period of rest or relief". It is thought that much of the Respite being commissioned or provided is, in fact, replacement care. This, however, cannot be definitively determined without a carer having their needs and personal outcomes identified through the adult carer support planning process and subsequently having those needs assessed as eligible.

Aberdeen City will seek to promote ***different ways*** that statutory services can help carers to access a break from caring. Sometimes replacement care will enable a carer to access a universal service, so no extra Short Break funding will be needed. Sometimes replacement care will be needed to enable access to a funded break from caring, and sometimes a formal, funded break for the carer won't be needed if the right care is given to the cared-for person. We believe that following the spirit and principles of the Carers (Scotland) Act 2016 will provide the best chance of getting it right.

6. Example Short Breaks

Below are some example short breaks that current carers told us about. We hope they will prompt other carers to determine the short break that is right for them.

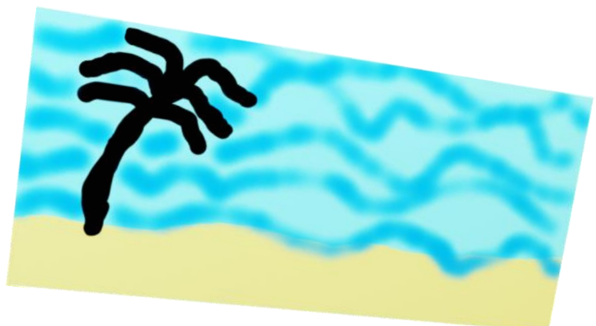
Tiffany's family

We are Kerri and Lee and we are parents of Tiffany who is 20 with a moderate/severe learning disability and autism. Her behaviour can be challenging when she gets anxious or her routines change. Tiffany lives at home with us and we are her main carers. She is an only child. Archway had supported Tiffany as a child and although they continued to offer respite as she got older they struggled to manage her needs and behaviours. Often stays were cancelled last minute due to staff not being available to provide the one to one support or we were called to collect her in the middle of the night as it was felt it was no longer safe for Tiffany or others. Overall the decision was taken that traditional respite of this form did not work for Tiffany leaving us to take solely responsible for supporting her. Over time this has taken its toll. We are exhausted, are both on medication prescribed by our GP, and our work and our finances have suffered as a result.

Tiffany's grandfather and his partner agreed to take Tiffany away to a hotel for 3 nights. The room cost was met through a direct payment. Not only did we get to have a much-needed break, but her grandad has got to know her better and has learned how best to manage her when she is anxious or displaying challenging behaviour. Without this break there was a high risk of us not being able to continue to care for Tiffany which would have had a devastating effect on the entire family. We are delighted that a regular break has been assessed as essential for us and that the cost of this will be funded.

Anne

My name is Anne and I care for Andrew who is 21 and has a learning disability in the mild/moderate range. He also has a diagnosis of Autism Spectrum Disorder and ADHD. I fostered Andrew when he was a child and I now support him in my home 24/7 and assist him with most aspects of his life, including finances, personal care, social support, medication and safety. Andrew can be a very intensive and loud individual who can also wake during the night and early hours of the morning. I used to get a break from caring for Andrew whilst he was a school but when he became an adult I lost this. The initial transition did not go well, mainly due to the change of workers. Initially, my son, Mark, was funded to provide support to Andrew each Tuesday and alternate weekends. This enabled me to have regular short breaks to do my own thing and have a rest from the intensity of supporting Andrew. Without these short breaks I would not have been able to carry on caring for Andrew. Subsequently, in addition, Andrew now gets 3 full days at a Day Centre. This gives me a slightly longer break, sometimes for a week or so to enable me to enjoy a holiday once in a while to help recharge my batteries. A friend of mine, who works in the social care sector and has previously supported Andrew, now receives one off funding to support Andrew at home while I go on holiday. I have taken Andrew on holiday; however, this is not a break for me as I still have to provide that intensive support while we are away. The short breaks enable me to continue my caring role which all parties are agreed is in Andrew’s best interest. Not only are the short breaks in Andrews best interest and more flexible than traditional respite but they also represent best value in the long term. Without them Andrew would have to go into residential care.



Jack's family

Our son Jack has a rare genetic brain disorder and as a result he requires total care and support with every aspect of his life. Jack can't speak or move by himself and is wheelchair bound. Jack is fed by a tube and has epilepsy. Despite all of this Jack is a happy young man.

Having Jack in the family means that sometimes plans need to be changed at the last minute. It is also very difficult to plan outings in advance. Even when we do go out, half the house – various medications, equipment and so on - has to come with us.

The respite provided by Archway has been an important part of our support over the last 10 years.   It's a lifeline for our family. Jack requires 24-hour care and we get anxious at the thought of putting him into someone else's care, so it's a huge relief to know there are specially trained staff, who we know and trust, on hand to help whenever we need. This gives us confidence to enjoy our break, knowing Jack is happy and well cared for. As time has gone on we have learned to enjoy our respite time more and more.

Life is usually very routine and unspontaneous for us and being able to have respite is amazing. We know that even if things have been very tiring and hard at home there is a break just around the corner. We can plan to go away for a few days on our own or on holiday and spend uninterrupted time with our other children. We can organise activities that would be impossible if we had Jack with us. It allows us to experience "normal" life for short periods of time, catch up on some sleep and gives us the ability to do spontaneous things every now and then. Although Jack can't tell us, I think he enjoys the break from us too!

Scott

I have cared for my wife for 20 years and had never thought of seeking assistance with that. Through discussions with the VSA Carers Service, I was told about the Short Breaks funding. I applied and was awarded some funding. I didn't really want a break away from caring for my wife, but my caring role has meant that I had not been paying attention to keeping my fitness levels up and I wanted to regain some of my former fitness, to make a positive change and to be able to run to fundraise in support of charities. I researched what support was available. I needed somewhere local where I could train early in the morning so that I could still be home to help my wife get up. I wanted the training to also positively stimulate my mental wellbeing and energy levels and provide the basis for future activity that I could continue on my own at home. I also wanted dietary advice. I joined a local fitness centre and was allocated a Personal Trainer who developed a training and nutrition programme for me. Not only am I following this and already seeing the positive benefits – I am actually enjoying it. My wife and my family have remarked on the difference it has made. I have successfully completed fundraising runs for Marie Curie and Clan Cancer Support. I got a Personal Best time in the Stroke Association Resolution Run!

Dylan

My name is Dylan. I am fifteen years old. I live with my mum and little sister. My mum has MS which means that some days she can't walk. At home I help look after my mum and my little sister. Sometimes I don't mind but sometimes I get pretty fed up and want my little sister to do more. I kind of know it's not her fault because she is nine years old, but I just feel like everything is on my shoulders.

In the house I do cleaning jobs but also personal tasks like helping mum to get up and get dressed. My mum's carer only comes for a little bit each day.
I don't really go out with my mates and I never invite them over to mine. I don't think anyone at school would understand. I find it difficult to find the time and energy to do my homework. I know I can be difficult at school, but I just get really frustrated with everything.

I met with guidance teacher at school and she asked me about how everything was at home because I didn't seem to be happy at school. I was able to explain my situation to her. She said it sounded like I needed a break from things and time to just be me. It was difficult to accept this at first, but I knew she was right. She told me about something called a Young Carers Statement. Together with my mum, my auntie and mum's carer we worked out a plan to help me.

Now my little sister goes to a summer club at Sport Aberdeen in the holidays, so I don't need to look after her all day. It means that I can go out with my mates for a few hours and my guidance teacher signed me up to football coaching once a week when mum's carer is in. I used to just play the Xbox on my own but at football coaching I have made a couple of mates. My guidance teacher planned some time during my school day to unwind and listen to my music and catch up on homework. I feel a lot less tense knowing I can escape to a quiet space in school when it gets too much. My Guidance teacher has also applied for me to go to Adventure Aberdeen to do some climbing as part of my timetable. Once a month my auntie visits my mum and my uncle takes me to the cinema now. It feels good knowing I have time planned to just do 'normal' stuff that my mates do. I have started to feel more like me again.

Sarah

My name is Sarah and I am 12 years old. Last year my mum lost her eye sight. I have been a carer for a year for my mum and it changed my life overnight. Before, I could go out with my friends most days but now I often can't go out because I have to help mum, make the dinner and tidy up. Most of my friends are going out lots and having sleepovers. I love my mum but caring for her has stopped us doing fun things together like we used to. When I was little we used to go on trips together all the time. It was fun, and I miss that.

When my guidance teacher met with me to discuss my Young Carers Statement I told him how I felt about missing doing fun stuff with my mum and not spending time with my friends. He spent time with me and my mum to plan to make things better. He applied for a small grant from the council, so mum and I could go for a weekend in Edinburgh like we used to. Mum and I laughed and giggled for the whole train journey.

Together we planned for me to go to my best friends sleep over. I really enjoyed it, so we planned to have a pyjama party once a month and my granny will stay with my mum, so I don't need to worry about her. Having these short breaks has helped my relationship with mum.

7. Outcomes

As part of the preparation of both Adult Carer Support Plans and Young Carers Statements the carers wellbeing needs, and outcomes will be identified. Any planned Short Break should be relevant and proportionate to the needs identified.

Short Breaks can make a huge difference not only to carers, but also to the people they care for and to others who can be affected by the caring role. They can provide a change of scene, an opportunity to relax and recharge batteries, the chance to socialise or simply time for the carer to attend to their own needs whether that is shopping, exercising, having a massage or a haircut. If the carer is a parent, a short break can offer the time to spend with other children or their partner. For young carers, a short break can allow them to be with their friends and be a child first. Short Breaks could include the cared for person but with additional help so that the carer is not required to undertake their normal caring duties and can enjoy the time they spend with the cared for person as a husband/wife, son/daughter, friend rather than as their carer.

Outcomes from short breaks should be improved health and wellbeing for the carer whilst the cared for person continues to receive the care they need. Short Breaks should ensure that the caring role can continue if that is what the carer wants. Whether Short Breaks are regularly planned events or a one-off occurrence the outcome is to support the carer's resilience in all aspect of their caring role.

Our Short Breaks Services Statement will ensure that, through outcome-focused conversations, carers will be supported to make informed choices about the need for and potential benefits of a Short Break. The outcomes of a break will be personal to each carer and cared-for person, but may include:

- Having more opportunities to enjoy a life outside/alongside the caring role
- Feeling better supported
- Improved confidence (for example, more confident as a carer)
- Increased ability to cope
- Reduced social isolation and loneliness, for example increasing social circles, connections and activities
- Increased ability to maintain the caring relationship - and sustain the caring role
- Improved health and wellbeing
- Improved quality of life
- Reduced likelihood of breakdown and crisis
- Improved educational attainment
- Reaching positive destinations post school leaving age

8. Support available

This chapter provides information on what support is already available however this is currently limited. Short Breaks should be personalised to the individual therefore it is impossible to list every permutation of a Short Break. As more and more carers design their own Short Break we will seek to add to the bank of examples and also to the list of support available.

Local short breaks services.

Currently Aberdeen City Health and Social Care Partnership commissions traditional residential based respite services. For Older People these are provided by existing commissioned Care Homes. Details can be obtained from Care Management. For Adults, Archway is the main provider and their website is www.archway.org.uk.

Integrated Children and Family Services is currently in the process of commissioning a Young Carers Support Service to support current universal and targeted provision. It is anticipated that this service will be operating in January 2019 to promote the rights of Young Carers through provision, protection and participation. The service will support Young Carers and in addition, help develop interests and activities out with the caring role and co-ordinate and develop a support network. The service will support assessment of needs and planned interventions, inclusive of Short Breaks which may take a variety of forms.

Integrated Children's Services is also in the process of establishing a small grants fund for Young Carers. Applications will be assessed on a needs basis for those Young Carers who have a Young Carers Statement. Small grants will support Young Carers in accessing Short Breaks, whether that be to support regular costs of an activity such as, fees or equipment or a family activity/trip, for example.

Links to local sources of information and directories,

An Adult Care Support Service is commissioned from Voluntary Services Aberdeen (VSA). The link to their website is provided below: -

https://www.vsa.org.uk/carers-and-support-people/

The Family Information Service (FIS) provides free, comprehensive and up-to-date information and advice about all services for children, young people and their families in Aberdeen. The directory of services is for parents, carers, young people and professionals. There is a specific area within FIS dedicated to Young carers, populated with relevant services including services which will support the planning of Short Breaks. These range from activities to childcare services. Details of what is available is on a dedicated page on the FIS website. The link to this is: -

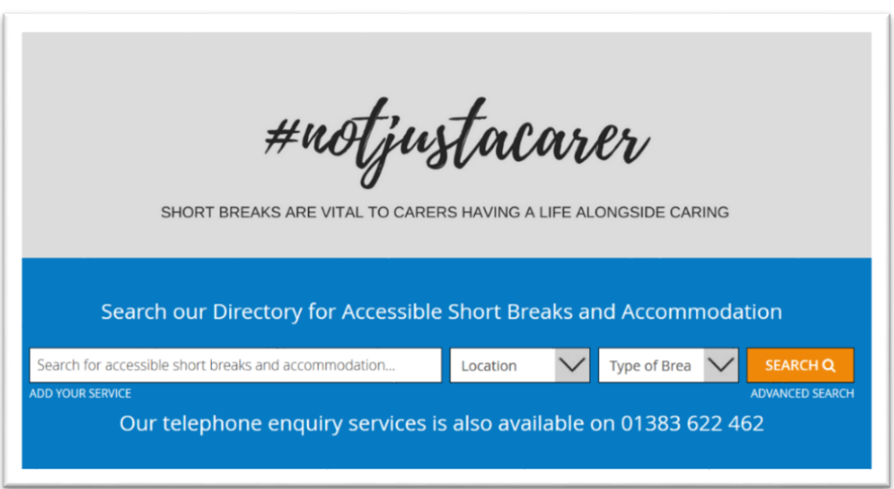
https://live.cloud.servelec-synergy.com/Aberdeen/PublicEnquiry_FS/SynergyEnglishHome.aspx

Links to national Short Break websites and databases

Shared Care Scotland https://www.sharedcarescotland.org.uk/

This website contains a searchable directory of short breaks. Anyone wishing to list a short break service can log in to do so.

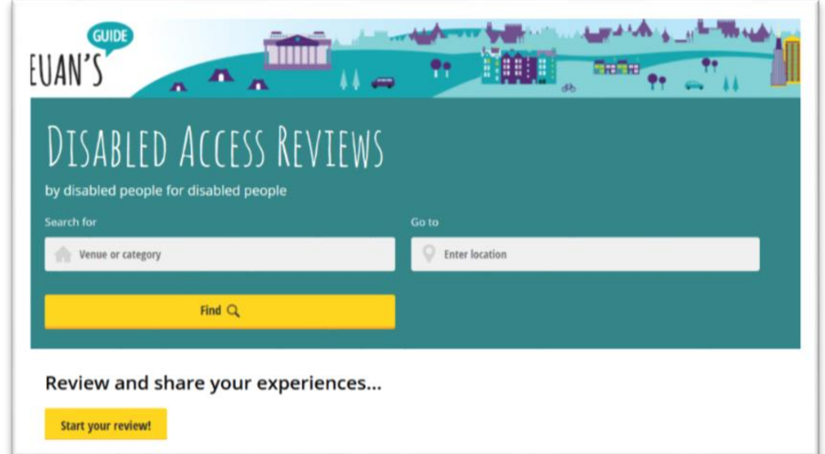
This website also provides information on 'Time to Live'[1], a set of small funds available in every Local Authority area, along with a database of funding sources[2] for short breaks.



The Take A Break website http://takeabreakscotland.org.uk/

Take a Break is Scotland's short breaks fund for carers of disabled children, young people and their families. Take a Break grants can be used for a break away, towards leisure activities or outings; sports equipment and more.

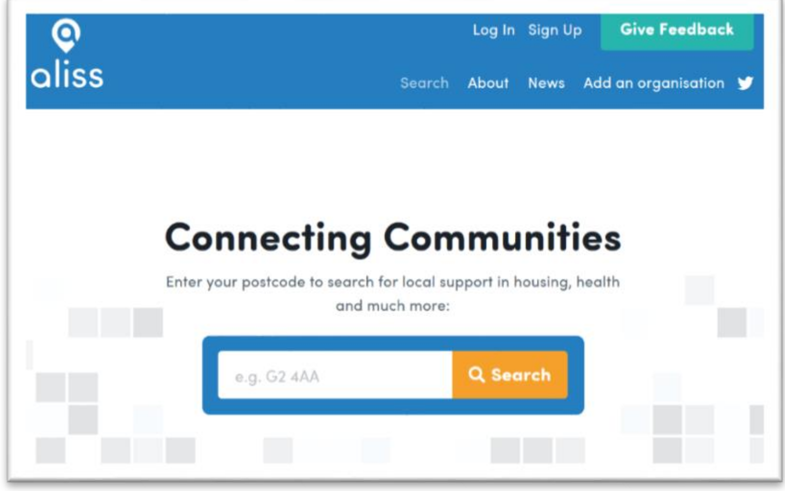
[1] https://www.sharedcarescotland.org.uk/shortbreaksfund/timetolive/
[2] https://www.sharedcarescotland.org.uk/funding-your-break/



Euan's Guide
https://www.euansguide.com/
Euan's Guide is the disabled access review website that aims to 'remove the fear of the unknown' and inspire people to try new places. The cornerstone of Euan's Guide is its community of independent reviewers, who share their photos and experiences of restaurants, hotels, train stations, attractions and anywhere else they may have visited.

ALISS https://www.aliss.org/

ALISS (A Local Information System for Scotland) aims to increase the availability of health and wellbeing information for people living with long term conditions, disabled people and unpaid carers. It supports people, communities, professionals and organisations that have information to share.



9. Eligibility

In April 2018 Aberdeen City published its local Carer's Strategy entitled A Life Alongside Caring and this is available on our website.
https://www.aberdeencityhscp.scot/globalassets/carers-strategy---march-2018.pdf

In May 2018 Aberdeen City published its Adult Carer Support Planning and Eligibility Criteria for Carers and this is available on our website:-
https://www.aberdeencityhscp.scot/globalassets/eligibility-criteria-for-carers-achscp-april-2018.pdf

These documents provide more detailed information on our general approach to providing support to carers, the process of undertaking adult carer support planning, what criteria is used for determining eligibility for funded services and guidance on what services will be chargeable.

As a result of our strategy we want carers in Aberdeen to be able to say that: -

- They are supported to identify as a carer and to access the information they need
- They are supported as a carer to manage their caring role
- They are respected, listened to, and involved in planning the services and support which both they and the person they care for receive.
- They are supported to have a life alongside caring if they choose to do so.

Short Breaks should be planned after an outcomes focused conversation, the identification of personal needs and outcomes and the development of an Adult Carers Support Plan or Young Carers Statement. The process for undertaking these is described in both flowchart and text form in the Adult Carer Support Planning document which also details the Eligibility Criteria and Thresholds that are used to determine eligibility.

There are 7 indicator areas used to assess impact and risk, these are: -

1. Health and Wellbeing
2. Relationships
3. Living Environment
4. Employment and Training
5. Finance
6. Life Balance
7. Future Planning (including planning for emergencies)

There are 5 thresholds of impact and risk: -

1. No impact – no risk
2. low impact – low risk
3. moderate impact – moderate risk
4. substantial impact – substantial risk
5. critical impact – critical risk

We will work with carers to assess the impact and risk on their caring role in relation to each of the 7 eligibility indicators. In addition we will take into account: -

- The amount of time spent caring each week
- How long it has been since they last had a break
- If they are the only person caring and if they care for more than one person
- Their ability to make arrangements for a Short Break with support.

Funded support will only be provided to carers where the caring role has substantial or critical impact. Some carer's outcomes may be achieved through accessing universal services. Universal services are those which are provided to the public generally (e.g. leisure and recreation facilities, support groups, neighbourhood networks). Where this is not possible or appropriate, Self-Directed Support (SDS) funding may be offered to provide access to short breaks and/or replacement care.

If a carer is eligible, an individual budget will be identified based on their individual needs. Carers will be supported to identify their own skills and resources and to look at different ways to improve their life, using the resources identified and the individual budget. Once all this is agreed, carers can choose from four options as to how much control and responsibility they want to take.

1. Direct Payment (a cash payment) where the carer chooses how the budget is used and they manage the money.
2. The carer directs how the budget is used, but the money is managed by someone else (sometimes called an Individual Service Fund).
3. The carer asks the Council to choose and arrange services for them.
4. The carer can choose a mix of these options for different types of support

Cross referencing with the cared for person's support plan and funding arrangements needs to be made. Providing additional or alternative support to the cared for person may meet, or partially meet the carers outcomes.

10. Charging policy

In September 2018, Aberdeen City published Local Guidelines on the Waiving of Charges for Support to Carers and this is available on our website.

Charges are waived if a Short Break directly benefits the carer's outcomes as identified in the Adult Carer Support Plan or Young Carer Statement. This is important because short breaks will often benefit carers and the cared-for person.

11. Feedback and further information

This Short Breaks Services Statement will be reviewed one year after it is implemented i.e. in January 2020. Not only will this be a refresh of the information and the links contained within the statement, but we will also review local and national case studies to ensure our statement is covering the most up to date practice and that carers are aware of this. We will involve carers and cared for people in the review.

You can feedback on this statement or obtain further information via ACHSCPEnquiries@aberdeencity.gov.uk

Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Date of Meeting	11th December 2018
Report Title	Strategic Planning Framework for Delegated Services (Acute)
Report Number	HSCP.18.116
Lead Officer	Sandra Ross, Chief Officer
Report Author Details	Sandra Ross, Chief Officer SanRoss@aberdeencity.gov.uk
Consultation Checklist Completed	Yes
Directions Required	No
Appendices	*a.* Proposed Planning Framework for Services Delegated for Strategic Planning. *b.* Draft Commissioning Brief for Strategic Planning Process (Care of the Elderly)

1. Purpose of the Report

1.1. This report presents the Integration Joint Board (IJB) with a proposed strategic planning framework for those services delegated by NHS Grampian to integration authorities for cross-system strategic planning across Grampian.

2. Recommendations

2.1. It is recommended that the Integration Joint Board:

a) Accept the proposed approach to planning for delegated services.

3. Summary of Key Information

3.1. The Integration Joint Board is tasked with strategic planning for a number of delegated services from the NHS. It is important to undertake this planning

NHS Grampian
ABERDEEN CITY COUNCIL

in a cohesive approach across the 3 Integration Joint Boards who are coterminous with NHS Grampian.

3.2. The attached self-explanatory paper (appendix A) proposes the approach to undertake this planning. The attached paper is being considered by all three Integration Joint Boards, within the Grampian area.

3.3. Appendix B contains the draft commissioning brief for the strategic planning process (Care of the Elderly).

4. Implications for IJB

4.1. **Equalities –** it is expected that endorsing the strategic planning framework will have a positive impact on people who share characteristics protected by the Equality Act 2010, for example age and disability, as the strategic planning framework provides a process for strategic planning for services on a pan-Grampian basis. As each speciality area undertakes the strategic planning, equalities will be considered, through formal evaluation, at that point.

4.2. **Fairer Scotland Duty –** The strategic planning framework outlined in the appendices.

4.3. **Financial –** There are significant financial implications to the successful implementation of strategic planning of services across the Grampian area.

4.4. **Workforce –** there are no direct workforce implications arising from the recommendations in this report.

4.5. **Legal –** Endorsing the strategic planning framework would help ensure that the Aberdeen City IJB is fully compliant in meeting its duties as set out in the Public Bodies (Joint Working) (Scotland) Act 2014. Specifically, the Aberdeen City Integration Joint Board's Integration Scheme sets out that *"for delegated Acute services that the IJB does not have operational oversight of, the IJB shall be responsible for the strategic planning of those services"*

4.6. **Other –** there are no other implication arising from the recommendations in this report.

INTEGRATION JOINT BOARD

5. Links to ACHSCP Strategic Plan

5.1. The current ACHSCP Strategic Plan outlines the responsibility of the IJB in relation to strategic planning for certain acute services, as outlined in the appendices. If the IJBs are to be successful in shifting the balance of care from acute services to community, then a co-ordinated focus on strategic planning for both acute and community services is required.

6. Management of Risk

6.1. **Identified risks(s):** There is a risk that the outcomes expected from hosted services are not delivered and that the IJB does not identify non-performance in through its systems. This risk relates to services that Aberdeen IJB hosts on behalf of Moray and Aberdeenshire, and those hosted by those IJBs and delivered on behalf of Aberdeen City.

6.2. **Link to risks on strategic or operational risk register:** Risk 3 (strategic):

6.3. **How might the content of this report impact or mitigate these risks:** This report provides a strategic planning framework which will help ensure that outcomes for hosted services are delivered.

Approvals	
[signature]	Sandra Ross (Chief Officer)
[signature]	Alex Stephen (Chief Finance Officer)

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Proposed Planning Framework for Services Delegated for Strategic Planning

Aim

To seek endorsement from the three Integration Joint Boards (IJBs) and NHS Grampian on the proposed strategic planning framework for those services delegated to the IJBs for cross-system strategic planning across Grampian.

Overall Ambition

In order to ensure as accountable services we are well positioned to deliver effective outcome focussed person-centred, sustainable care which responds to population need and is proactive in current and future challenges, it is essential that there is a clear understanding that delivery of care in many parts of the system will require to be fundamentally different to the current approach. This will require a significant change in thinking, engagement and ownership by the public, staff and organisations which is open to an ambitious approach to whole system thinking. The facilitation of this approach is to be owned, led and commissioned by the IJB.

Background

The Integration Schemes for the IJB sets out the services which are delegated in terms of service delivery and strategic planning. The service delivery and strategic planning arrangements for most of the services are straightforward as they are already provided in the IJB areas for the IJB populations. There are, however, some services that are provided on a cross IJB/Grampian wide basis resulting in a requirement to agree hosting arrangements. See appendix 1 which sets out the definition and principles of hosting.

There are two types of hosted services which are:

a. *services delegated for strategic planning*, which entails;

- strategic planning leadership provided by an IJB
- development of strategic vision and strategic plan focussed on whole patient pathway for the population of Grampian – this is done in partnership with all IJBs, acute services and other agencies
- resources and operational management/delivery retained by acute management team
- responsibility for delivery remains with NHS Grampian

As set out in the legislation, the acute hospital based services which are delegated for strategic planning are outlined in the Table 1 below, along with the IJB with the lead responsibility agreed back in 2015.

Service Delegated for Strategic Planning	Agreed Host IJB
Accident and Emergency services provided within hospitals	Moray IJB
General Medicine hospital services	Aberdeenshire IJB
Geriatric Medicine hospital services	Aberdeen City IJB
Rehabilitation Medicine hospital services	Aberdeen City IJB
Respiratory Medicine hospital services	Aberdeenshire IJB
Palliative Care services provided within hospitals	Moray IJB

Table 1: Outline of Delegated Services for Planning and Agreed Host IJB

b. *services delegated for planning and operational delivery* entails;

- full responsibility of the IJB for the planning and operational delivery of the service
- resources/operational budgets are agreed by IJBs
- agreed performance management arrangements by the IJBs for the hosted services

c. *services not yet delegated for planning*

NHS Grampian intends to delegate the planning of mental health services with immediate effect to ensure it is compliant with the Public Bodies (Joint Working) (Scotland) legislation. It is proposed to follow the same process which is set out within this paper. NHS Grampian will undertake discussions, with the IJBs, to establish who will take the lead responsibility for this planning.

This paper sets out the proposed framework underpinning *(a)* the development of strategic plans for the hosted services.

Proposed Framework

The Framework (contained within Appendix 2) has been developed by the Chief Officers Group in partnership with local strategic planning groups, the NHS Grampian Acute Sector and NHS Grampian Senior Leadership Team, facilitated by the Modernisation Directorate. Key features of the Framework are outlined below.

i. *Scope*

The Framework will be used to support strategic planning of those hosted services outlined in the background section. This will focus on a whole system pathway approach (through primary prevention, self management, planned/ unscheduled care to end of life) based on the needs of the people across Grampian, taking into consideration the unique aspects of the service itself, populations and local service delivery within individual geographical areas.

A key focus will be around sustainable delivery of population needs which ensures the best possible outcomes and experiences within the total resource envelope available across the pathway of care. In order to achieve this, it is anticipated that for many this will mean a radically different approach to the provision of care within specific parts of the system and also across the whole pathway of care.

i. *Commissioning*

The IJB who has delegated responsibility for strategic planning will have the leadership and responsibility to commission the development of a cross-system strategic plan which meets the needs of the local populations, achieves the national strategic outcomes and is deliverable within the available resource envelope. It will be important that this supports the different approaches required to ensure individual HSCPs have the appropriate level of buy-in and ownership of the strategic planning process and therefore the output and delivery of this.

In order to commence the process the IJB will agree a clear commissioning brief in collaboration with the partner IJBs and other statutory partners as appropriate. As a minimum, the commissioning brief will be agreed by the Strategic Planning Groups of each of the IJBs, NHS Grampian Acute Sector and NHS Grampian, prior to submission for approval to the North East Partnership Steering Group and the Joint Chief Officer Group. The host IJB will then formally endorse and sign this off.

The leadership for the commissioning process and overall process sits with the Chief Officer of the IJB delegated to host the service/pathway of care – this is outlined in Table 1.

The lead Chief Officer, along with other expert leads will be supported by a team which includes both local HSCP and NHS Grampian staff, including the acute sector, to take forward the process to develop a robust strategic plan. Details of the support are outlined in section *iv*. below.

Given the number of potential areas for development, there will be a phased programme to take these forward. The proposed phasing of this is summarised in Appendix 3.

ii. *Stakeholder Engagement*

Meaningful and robust engagement of service users, the public and staff across organisations is critical in order to ensure understanding, the active shaping and ownership in terms of delivery of the future model and the key priorities to be taken forward.

It is recognised that although we aspire to an approach which ensures meaningful engagement, collaboration and ownership by service users and the wider public, this is an aspect we will continue to enhance as part of this process and will require to continue to build on over time.

Key stakeholders for engagement will be set out in the commissioning brief agreed by the host IJB and will be reviewed again after the initial workshop.

The process for engagement will be flexible to reflect the differences in need and the approaches to delivery by individual HSCPs.

iii. *Governance*

The process outlined in Appendix 2, sets out the key stages for this;

- Setting of the parameters for delivery will be the focus of the Commissioning Brief which will be informed by the Joint Chief Officers Group.
- Approval of the Commissioning Brief will be sought via the HSCP and Acute Sector Strategic Planning Groups, Acute Sector, NHS Grampian Strategic Groups, NHS Grampian Senior Leadership Team and the North East Partnership Steering Group.
- Sign off of the Commissioning Brief will be via the Joint Chief Officers Group and then the Host IJBs.
- The Commissioning Brief will be rechecked after the first workshop by the Joint Chief Officers Group to ensure this remains valid. Any amendments would be re-submitted to the Host IJB for sign off.
- The HSCP Strategic Groups and Acute/NHS Grampian Strategic Group will approve the draft strategic plan for submission to the Chief Officers Group and host IJB prior to wider consultation
- Approval of the final draft of the strategic plan will be undertaken by each IJB/statutory organisation (as per their agreed governance structure) along with the North East Partnership Steering Group.

The overall governance for the development of the strategic plan sits with the commissioning IJB. As part of this they will require to provide assurance that prior to sign-off of the strategy,

each IJB and partner organisation has confirmed the strategic plan has gone through their relevant governance structure.

iv. *Support*

Key to the delivery of the process itself (and supporting the lead Chief Officer) a range of experts and support functions will be required. It is proposed that a dedicated team will facilitate the work and will include the following skills and capacity which will be commissioned from a range of both corporate and local teams across a range of organisations. This will support effective and efficient management of capacity across the system.

- Relevant clinical and non-clinical expertise relating to the subject area and whole pathway, spanning multi-agency organisations
- Leadership from each of the key organisations relating to the subject area
- Strategic and service planning
- Health intelligence
- Organisational development
- Service improvement
- Public health
- Communication and engagement
- Workforce
- Finance
- Staff side

It is recognised that based on the specific area, the range and level of expertise will require to be tailored as appropriate.

v. *Timescales*

It is anticipated that there will be a phased programme of delivery, initially focussing on those areas of highest priority as guided by the Joint Chief Officers Group and the NHS Grampian Senior Leadership Team.

It is hoped that for the full process, from initial commissioning to approval of the strategic plan by IJBs will take no more than six months. It is anticipated that due to the nature of the process that where there is unanimous agreement around areas for immediate improvement, these will be taken forward with adequate review and feedback mechanisms in place.

See Appendix 3 for the proposed timeline. This will be flexible and reviewed on a regular basis and will be informed by the evaluation of the process/framework as it is implemented.

vi. *Resources*

As highlighted in the scope section (i), an agreed principle is that the focus of the strategic plan is on the whole pathway, including secondary care and therefore includes the total

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resource envelope which can be attributed to this. This will also require clarity early in the process in terms of the specific funding linked to the "set aside" budgets for individual delegated large hospital services hosted where Integrated Joint Boards have strategic planning authority.

As part of the development of the strategic plan, this will include an underpinning resource framework which takes account of a number of factors. It is likely that these will focus on:

- whole resource envelope (includes funding, people, infrastructure etc)
- resource will follow agreed activity shifts - this is applicable for any part of the pathway
- maximised efficiency and productivity related to agreed outcomes
- resource shifts based on individual historic and projected IJB population use of acute or other cross-system wide services
- delivery remains with the operational service and any changes in cost base which are not linked to changes in activity (e.g. locum to cover staff vacancy or use of generic drugs in place of branded drugs) will sit with this service.
- resource variation due to agreements around forecasting predicted seasonal changes in activity
- clarity of impact, benefits and risks of such changes in resource flow/allocations
- later, mature discussions that will ensure no unintended consequences such as any impact on training/research/clinical trials

The draft principles outlined above will require further consideration, debate and development as part of a robust resource framework which will then be submitted to the IJB's, Acute Sector, NE Partnership Steering Group and NHS Grampian in the coming months for endorsement.

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vii. *Evaluation*

The Framework will be reviewed and further developed based on learning as we adopt, review and share learning. This will be flexible to ensure it delivers the ambition in the most effective and efficient way possible.

Risks

There are a number of risks which have been identified –these are summarised in the Table 2 overleaf, along with the proposed actions for mitigation/management of these.

Key Risks	Proposed Actions to Mitigate/Minimise Risk
Inadequate workforce capacity to take this work forward in order to ensure it develops and delivers robust strategic plans fit for the future.	Through a collaborative approach by key organisations to prioritising some existing capacity to the support team which will ensure

	delivery but maximise cross-system working, ownership and impact.
Those who are likely to be affected by changes or who are fundamental to making the agreed change have no/little ownership.	Deliver of a robust engagement plan which sets out key stakeholders and the various mechanisms to ensure a high a number of people are meaningfully engaged as possible.
Plans developed are not ambitious enough to ensure delivery of sustainable pathway of care which meets future needs.	Leadership by the Chief Officers and Acute Sector GM, along with the clear commissioning brief by host IJBs should challenge and reinforce this requirement.
Solutions and the ability to take forward whole system transformation may be constrained due to the inability to support the shift of resources across the pathway.	Framework requires to be agreed in how this can be achieved in a safe and transparent way.
Due to capacity and other priorities, the six services will require to be phased over a period of time.	Clear prioritisation of order based on risk.

Table 2: Summary of Key Risks and Potential Actions to Mitigate/Minimise Risk

Recommendations

The IJB is asked to:

- Endorse the recommended Framework which has been developed jointly by the Chief Officers and the Strategic Planning Groups within Aberdeenshire, Aberdeen City and Moray HSCP's;
- Note that the Framework requires those IJBs which have host responsibility to lead on the commissioning of strategic plans and this will be done in consultation with all IJBs; and
- Note that this Framework will be initially tested and revised as appropriate in the coming months with the development of the strategic framework for the provision of care to the elderly population linked to the service hosted by Aberdeen City.

Executive Lead

Adam Coldwells, Chief Officer with Interim Lead for Acute Delegated Services for Strategic Planning

Authors

- Adam Coldwells, Chief Officer with Interim Lead for Acute Delegated Services for Strategic Planning
- Lorraine Scott, Deputy Director for Modernisation
- Christina Cameron, Programme Manager, Modernisation

Date: 3rd October 2018

Appendix 1

Definition and Principles of Hosting

Definition

Hosting is where one IJB will take the lead responsibility on behalf of the other two IJBs for the planning and delivery of services. Through this arrangement the lead IJB which is hosting will be accountable for the delivery of the agreed outcomes which will be set out in the IJB Strategic Plans.

General Principles

The principles for hosting are proposed as follows;

- appropriate service consistency for the Grampian population
- there will be no resource fragmentation
- planning and delivery will be achieved through a cooperative approach
- there will be single point of leadership for the hosted service
- the work associated with hosting is appropriately distributed across the three IJBs
- the operational budgets for these services will be agreed by the parties prior to the implementation of the hosting arrangements.

Principles for Hosting of Acute Hospital Based Services for Strategic Planning

The IJBs and NHS Grampian will adhere to the following general principles in relation to the hosting of acute hospital based services;

- line management and resources are retained by the Director General Manager for Acute Services
- strategic planning for agreed outcomes in certain named specialties is led and coordinated by one IJB on behalf of all
- all three IJBs will report on outcomes for their populations
- financial transparency and reporting is at all three IJBs and the Acute Sector Board
- requires formal meetings between host and other IJBs.

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High Level Process for Development of Strategic Plans in Grampian

Engagement of:
- HSCP Strategic Planning Groups
- NHS/Acute Strategic Planning Groups
- NHS G Senior Leadership Team
- NE Partnership Steering Group

Confirm Leadership & Commissioning Brief for Development of Strategic/Sustainability Plan with Key Stakeholders

Agreement by the Joint Chief Officers Group

Commisioning brief shared with IJBs and Acute

Host Organisation signs off commission

Pre-Workshop Engagement & Preparation Work to Support Process
(approx 6-8 weeks prior to workshop 1)

WORKSHOP 1

Focus: *Clarify current position, issues/challenges, opportunities and form potential future model and the markers for success*

Update and Clarification on Commissioning Brief

WORKSHOP 2
(2-4 weeks after Workshop 1)
Focus: *Clarify future model and work-up key strategic and practical actions across pathway for short, medium & long term to deliver markers for success*

WORKSHOP 3
(2-4 weeks after Workshop 2)
Focus: *Prioritise actions in terms of impact/value and confirm timescales/leads and that these address key issues & deliver future model of care*

Host organisation signs off strategy for consultation

Prior to Each Workshop an information pack will be circulated with questions for discussion with teams prior to workshop.

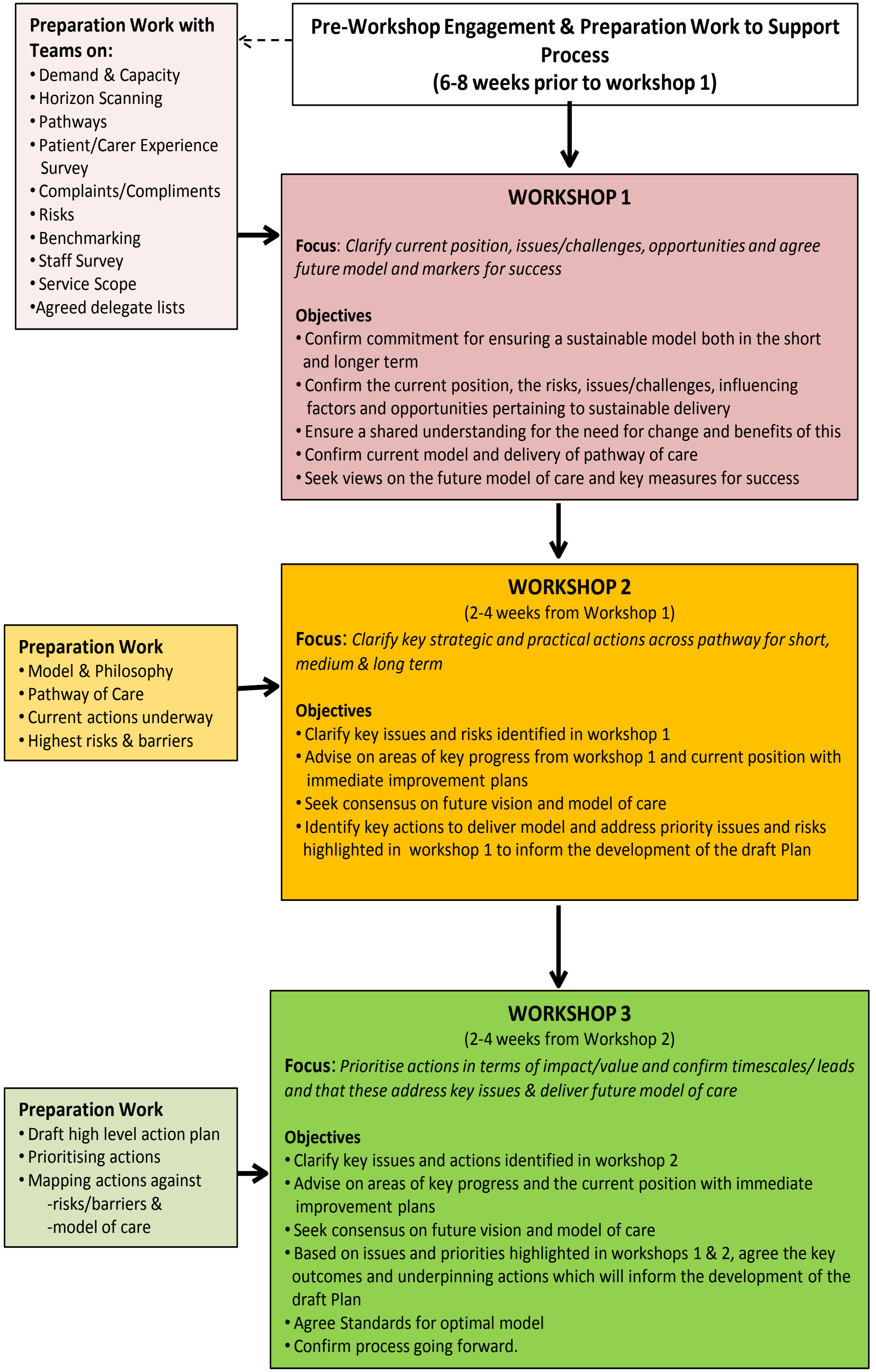
Post Workshop output will be written up and circulated for comment prior to next workshop to sense check agreements.

Draft Plan Out for Consultation
(within 4 weeks of Workshop 3)

Plan Revised & Finalised Based on Consultation
(approx 8 week consultation period)

Plan Approved by:
- H&SCP Strategic Planning Groups
- Acute Sector Strategic Group
- NHS Grampian Senior Leadership Team
- NE Partnership Steering Group

Approved by Chief Officers Group prior to submission to Host IJB for Endorsement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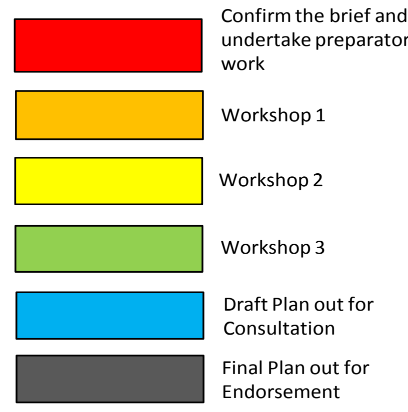
High Level Process to for Development of Strategic Plans
Preparation Work with Teams on:
• Demand & Capacity
• Horizon Scanning
• Pathways
• Patient/Carer Experience Survey
• Complaints/Compliments
• Risks
• Benchmarking
• Staff Survey
• Service Scope
•Agreed delegate lists
Pre-Workshop Engagement & Preparation Work to Support Process
(6-8 weeks prior to workshop 1)
WORKSHOP 1
Focus: Clarify current position, issues/challenges, opportunities and agree future model and markers for success
Objectives
• Confirm commitment for ensuring a sustainable model both in the short and longer term
• Confirm the current position, the risks, issues/challenges, influencing factors and opportunities pertaining to sustainable delivery
• Ensure a shared understanding for the need for change and benefits of this
• Confirm current model and delivery of pathway of care
• Seek views on the future model of care and key measures for success
Preparation Work
• Model & Philosophy
• Pathway of Care
• Current actions underway
• Highest risks & barriers
WORKSHOP 2
(2-4 weeks from Workshop 1)
Focus: Clarify key strategic and practical actions across pathway for short, medium & long term
Objectives
• Clarify key issues and risks identified in workshop 1
• Advise on areas of key progress from workshop 1 and current position with immediate improvement plans
• Seek consensus on future vision and model of care
• Identify key actions to deliver model and address priority issues and risks highlighted in workshop 1 to inform the development of the draft Plan
Preparation Work
• Draft high level action plan
• Prioritising actions
• Mapping actions against
-risks/barriers &
-model of care
WORKSHOP 3
(2-4 weeks from Workshop 2)
Focus: Prioritise actions in terms of impact/value and confirm timescales/ leads and that these address key issues & deliver future model of care
Objectives
• Clarify key issues and actions identified in workshop 2
• Advise on areas of key progress and the current position with immediate improvement plans
• Seek consensus on future vision and model of care
• Based on issues and priorities highlighted in workshops 1 & 2, agree the key outcomes and underpinning actions which will inform the development of the draft Plan
• Agree Standards for optimal model
• Confirm process going forward.

Appendix 3

Proposed Scheduling for Development of Strategic Plans

The following table shows a proposed scheduled for the process as described earlier. In respiratory, existing work to determine a target operating model in line with developing a plan for capital investment in elective services offers the opportunity of already diarised workshops. In General Medicine and Accident and Emergency, further work is required to finalise the scope of functions and services included within the strategic plans, therefore proposed dates are nominal.



2018-19	Care of the Elderly	Respiratory	Palliative Care	Rehabilitation	General Medicine	Accident and Emergency
Oct						
Nov						
Dec						
Jan						
Feb						
Mar						
Apr						
May						
June						
July						
August						
Sep						
Oct						
Nov						
Dec						

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Commissioning the Delivery of a Strategic Planning Framework for Delegated Services

Background

The Integration Schemes for the Integrated Joint Boards (IJBs) set out their accountable role in terms of strategic planning for delegated acute services. This incorporates strategic planning leadership and the development of a strategic vision and strategic plan which is focussed on the whole patient pathway for the population of Grampian. In Grampian these 6 services and the agreed Lead IJBs are:

Service Identified for Strategic Planning	Agreed Host IJB
Accident and Emergency services provided within hospitals	Moray IJB
Palliative Care services provided within hospitals	Moray IJB
General Medicine hospital services	Aberdeenshire IJB
Respiratory Medicine hospital services	Aberdeenshire IJB
Geriatric Medicine hospital services	Aberdeen City IJB
Rehabilitation Medicine hospital services	Aberdeen City IJB
Mental Health Services	Aberdeen City IJB (Interim)

Objectives of Commissioning

A framework has been developed by the Chief Officers Group in partnership with local strategic planning groups, the NHS Grampian Acute Sector and NHS Grampian Senior Leadership Team which will be used to support strategic planning of those hosted services outlined above.

To achieve the delivery of the framework, planning and facilitation resource requires to be agreed and briefed and will be accountable for the agreed outputs. This document is the brief that sets out the process, outputs and reporting arrangements for those commissioned to provide the resource, and should be read in conjunction with the paper – 'Proposed Planning Framework for Services Delegated for Strategic Planning'. An outline of the Strategic Planning Process is attached at **Appendix 1**.

It should also be noted that certain objectives may be agreed as part of the Strategic Planning Process itself; i.e. Workshop 1 is designed to identify and agree markers for success relative to the service. These can only be confirmed as objectives of commissioning at that stage.

Expected Outputs

Appendix 1 details key outputs at progressive stages of the planning process and includes but is not limited to:

Output / Deliverable	Detail
Pre-workshop Information Pack	This will provide sufficient detail to allow appropriate engagement with stakeholders prior to and during the workshops, examples of which are listed in the Strategic Planning Process at **Appendix 1**.
Post workshop reports	This will support stakeholders' engagement as part of the workshop process
Achievement of workshop objectives	As detailed for Workshops 1,2,3 in Appendix 1
Draft Plan	Following Workshop 3, this is an outline of the proposed end to end pathway

Consultation process for Draft Plan	Offering a wide range of stakeholders the opportunity to comment on the draft plan
Management of governance process for Draft Plan	Liaising with Host IJB process, as well as other organisational processes
Production of Final Plan	Incorporating any amendments following the consultation process
Scheduling and administration of Workshops	Including the preparation and distribution of information packs
Facilitation of Workshops	Direct facilitation or securing external facilitation

Timescale

The process is designed to be flexible to accommodate the unique aspects of the service itself, local populations and local service delivery as well as any unique drivers or context. In this way, the process for one service may differ from another; however the model process is designed to span a period of approximately 9-12 months from the point of commissioning to endorsement of a Final Plan.

Delivery

It is anticipated that the support necessary to undertake the planning processes can be commissioned from across the structures of the IJBs and NHS Grampian, e.g. the Modernisation Directorate in NHS Grampian or appropriate improvement and transformation staff in each of the organisations. Those inputs which are likely to be required are listed on page 4 of 'Proposed Planning Framework for Services Delegated for Strategic Planning' Where external support is necessary, this will be identified at the commissioning stage.

Stakeholders

The relevant stakeholders will form a group that is representative of key professions, viewpoints and structures and is conducive to meaningful discussion and ownership. Stakeholders will be agreed by the each of the four sectors advance of the workshops and are likely to be limited e.g. 10 delegates per sector.

Resources

Spending levels around the services themselves, including direct budgets should be ringfenced until the Final Plan is approved and any agreed resource allocation can be put in place around the end to end pathway.

Staff Policies

The process is designed to support transformational and system level thinking and offer a forum for radical redesign as appropriate however will be cognisant of relevant staff policies, noting that multiple policies may apply to different staff groups.

Reporting and Governance

Formal reporting will support the governance process as set out in the Strategic Planning Process **(Appendix 1).** Informal reporting arrangements may be agreed with relevant groups as appropriate; this is likely to include a minimum of reporting to the Lead Chief Officer and to the Chief Officers group on a regular basis, e.g. monthly.

Service Context

Geriatric Medicine as a delegated service is hosted by Aberdeen City Health and Social Care Partnership. The acute service operates across Aberdeen Royal Infirmary which has ringfenced medical beds as well as a Geriatric Assessment Unit and Woodend Hospital which has Elderly Rehabilitation beds. Specialist geriatricians are aligned to Aberdeenshire and Aberdeen City. In Moray the Older People's Pathway is delivered by specialist geriatrician and Dr Gray's Hospital acute beds. Demographic trends showing an increase in the amount of people living to older

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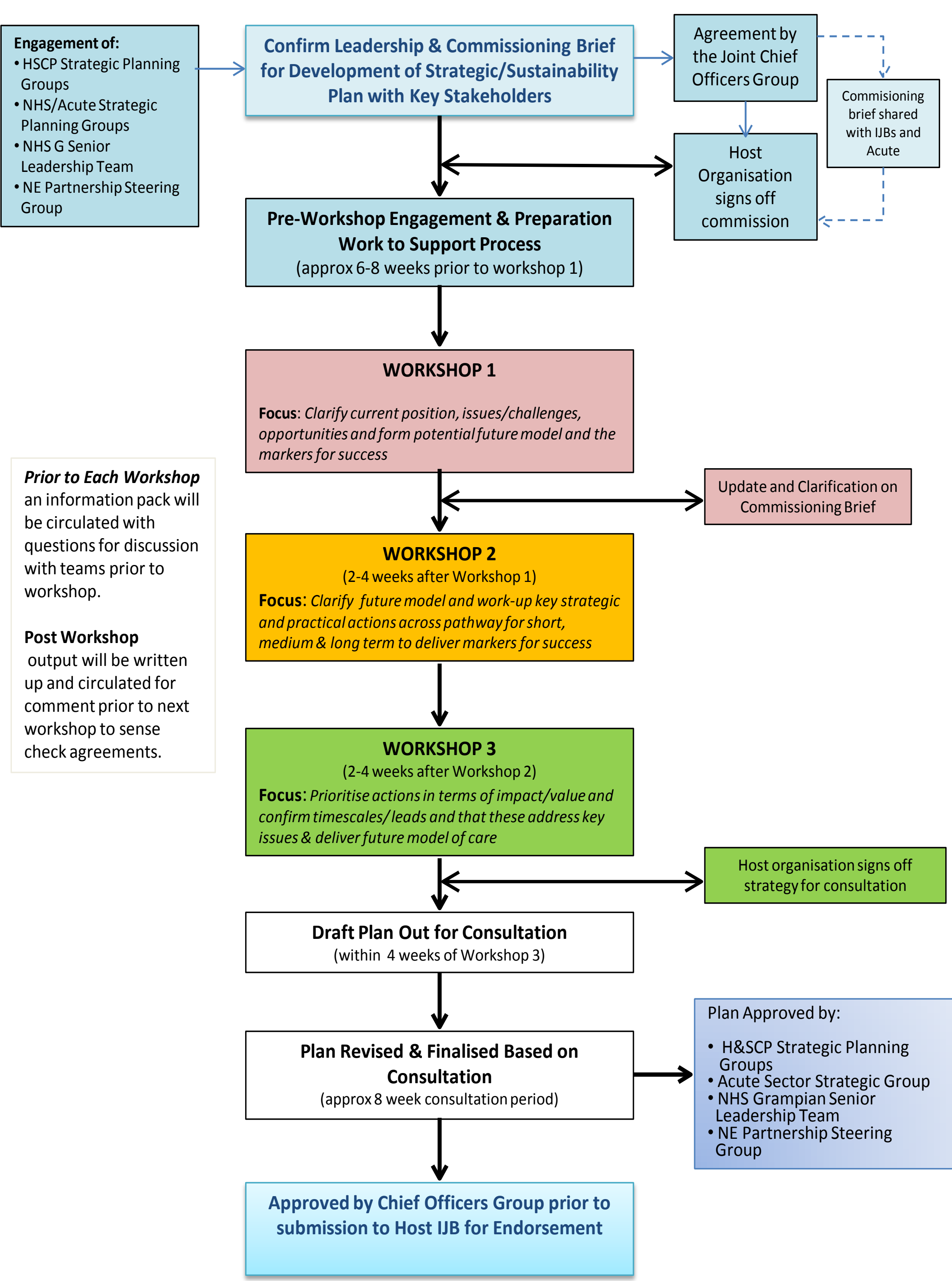
ages with increasingly multiple morbidiites are leading to increased demand for acute and community based services and redesign work in all settings has been undertaken. Additional pressures as a result of workforce challenges have added an urgency to the need to develop a strategic and sustainable plan for this service, considering the whole pathway within a single system.


DRAFT V6
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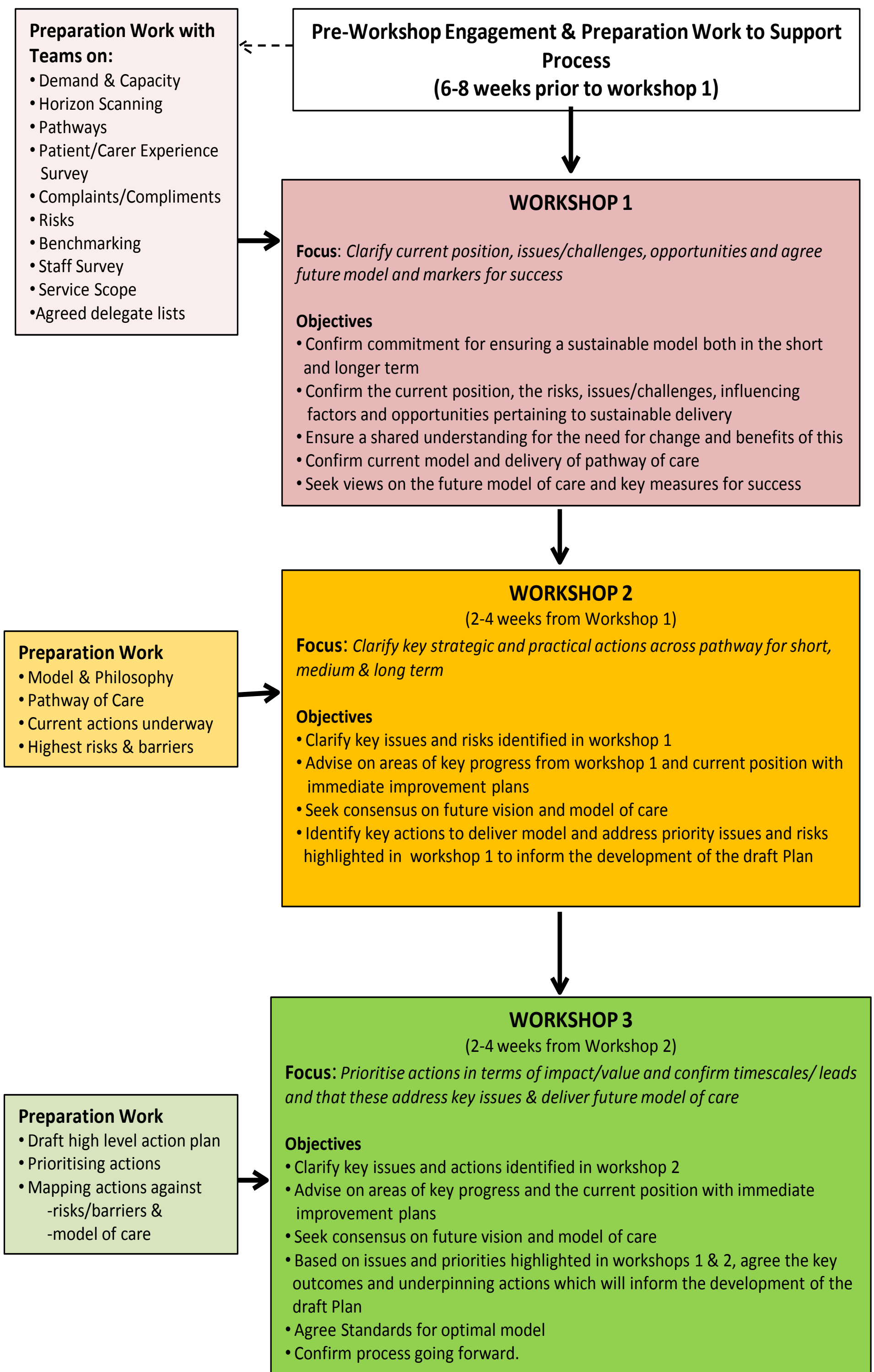
High Level Process to for Development of Strategic Plans



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Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Date of Meeting	11.12.2018
Report Title	Alcohol and Drug Partnership (ADP) Investment Plan: Programme for government 2018-19: additional investment in services to reduce problem drug and alcohol use
Report Number	HSCP.18.111
Lead Officer	Sandra Ross – Chief Finance Officer, ACHSCP
Report Author Details	Name: Simon Rayner Job Title: ADP Team Lead / SMS Operational and Planning Manager Email Address: simon.rayner@nhs.net
Consultation Checklist Completed	Yes
Directions Required	No
Appendices	a. ADP Framework for Investment

1. Purpose of the Report

1.1. The Scottish Government has given Alcohol and Drug Partnerships (ADPs) across Scotland additional recurring funding. For Aberdeen City this equates to £666,404 per year. The ADP has developed a framework for investment based on Scottish Government priorities and local performance. The IJB is accountable for the governance of this investment. This paper is going to the IJB from the ADP for ratification of the ADP proposal and to direct NHS Grampian and Aberdeen City Council accordingly.

2. Recommendations

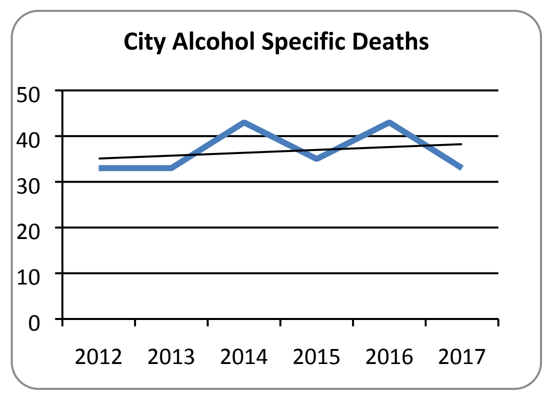
2.1. It is recommended that the Integration Joint Board:

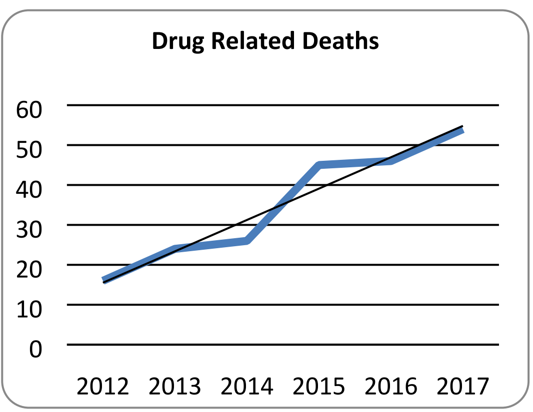
a) Agree the direct of travel as outlined in the ADP Investment Plan

INTEGRATION JOINT BOARD

3. Summary of Key Information

3.1. Alcohol and drugs continue to have a significant effect on the health and wellbeing of the population in Aberdeen City. In 2017 there were 57 drug related deaths and 33 deaths that can be directly attributed to alcohol. On a number of key measures Aberdeen is an outlier compared to the rest of Scotland. The negative impact of drugs and alcohol are city wide but have a disproportionately negative impact in areas of deprivation.





3.2. The increase in drug related deaths is comparable to other areas in Scotland and is related to the health consequences of long-term drug use resulting in increasingly complex presentations as the target population ages.

3.3. The estimated annual total cost of alcohol harm to Aberdeen (health, social care, crime and productive capacity) is £120.9m of which £22m per year is incurred within health and social care systems (AFS, 2012).

3.4. Alcohol and drug use are one of the top five public health priorities for Scotland and will be a central part of the HSCP Strategic Plan for 2019, in line with our aim to support and improve the health, wellbeing and quality of life of our local population; and to contribute to a reduction in health inequalities and the inequalities in wider social conditions that affect our health and wellbeing.

3.5. The Scottish Government have allocated £666,404 recurring funding to Aberdeen City ADP which is available from September 2018.

3.6. Investment intentions were agreed by the ADP Meeting of 27th Sept 2018 and jointly signed by the ADP Chair Supt Richard Craig (Police Scotland)

and Sandra Ross CO (AHSCP) on the 1st Nov and submitted to the Scottish Government Drug and Alcohol Policy Unit for information as per their requirement on 2nd Nov 2018.

3.7. The ADP membership has representatives of:

- Police Scotland
- Scottish Prison Service
- Aberdeen City Council (including Elected Members)
- NHS Grampian Public Health
- Aberdeen Health and Social Care Partnership
- Scottish Fire and Rescue Service
- ACVO
- Civic Forum
- Aberdeen In Recovery (people with lived experience of addictions)
- Drug, Alcohol and Blood Borne Virus Forum
- Active Aberdeen Partnership

3.8. ADPs, although required by the Scottish Government, are non-constituted bodies and as such governance and scrutiny are provided by the IJB. ADP officers are employed through the Aberdeen City Health & Social Care Partnership The scope of an APD is wider than adult health and social care and therefore the ADP also sits as group within the Community Planning Partnership. Adult alcohol and drug treatment services are the responsibility of the Health and Social Care partnership.

3.9. The current budget within the City for drugs and alcohol is £8,307,000. This is largely made up from funding directed by the Scottish Government and legacy funding for NHS Grampian and Aberdeen City Council.

3.10. The additional funding received represents Aberdeen City's share of an additional £20m as part of Programme for government 2018-19. The funding is in addition to the circa £8m invested locally in drug and alcohol services. Extant funding is a combination of NHS Grampian, Local Authority and Scottish Government investments channelled through ADPs (and their predecessor bodies).

3.11. In 2015 to 2017 the Scottish Government reduced funding to ADPs by circa £20m. Locally, pro rata savings were made on infrastructure with no detriment to direct service delivery. Due to the redesign work undertaken to reduce costs this additional funding is available for investment in frontline delivery.

3.12. The Scottish Government is currently refreshing its own National Strategy for Drugs and Alcohol. ADPs are also required to develop a new three year Delivery Plan for the period 2019 – 2022.

3.13. The criteria for the use of this funding are contained in:

- Letter dated 23rd August 2018 confirming additional funding: *Programme For Government 2018-19: Additional Investment In Services To Reduce Problem Drug And Alcohol Use*
- Letter dated 31 May 2018: *Supporting The Delivery Of Drug And Alcohol Services: 2018-19 Ministerial Priorities And Funding Allocations*
- Draft Scottish Government Strategy: *"All Together Now - Our Strategy to Address The Harms of Alcohol and Drugs in Scotland"*
- *As of 27th Nov 2018 new published Scottish Government Strategy:* *"Rights, Respect and Recovery Scotland's strategy to improve health by preventing and reducing alcohol and drug use, harm and related deaths"*

3.14. Based on the above five workstreams have been identified that incorporates the range of priorities from preventative, early intervention work through to treatment and recovery. These workstreams and the relevant indicative investments are:

	Yr 1	Yr2	Yr 3
Workstream 1: Whole Family Approach	£100,000	£100,000	£100,000
Workstream 2: Reducing Harm, Morbidity and Mortality	£100,000	£100,000	£100,000
Workstream 3: Service Quality Improvement	£400,000	£400,000	£400,000
Workstream 4: Supporting Recovery	£40,000	£40,000	£40,000
Workstream 5: Intelligence Led Delivery	£26,000	£26,000	£26,000
Total	£666,000	£666,000	£666,000

3.15. It should be noted that the investment amounts represent estimated costs not the relative priority of each workstream. The ADP Delivery Plan 2019 – 2022 will encapsulate the overall scope and priority for delivery.

3.16. Allocations to workstreams are indicative and once the projects are further developed then it may be necessary to come back to the IJB to formally direct ACC/NHSG to deliver the required services. This will be dependent on whether the costs are within officer delegations.

3.17. To ensure that investment meets local needs, innovative and, importantly, meets Scottish Government expectations the ADP will take a programmatic approach to investment. This will allow flexibility and engagement will allow engagement with partners to determine the best methods for implementation, delivery, monitoring and reporting.

3.18. There will be some overlap between workstreams. It is also recognised that there will be lead times required for implementation. Where feasible funds will be carried forward when an under spend is incurred. Non-recurring / unallocated under spend will be prioritised for use to support the workstreams within the framework

3.19. Progress on investment and performance will be via the ADP reported back to the IJB.

3.20. In determining the best methods for implementation we will seek to collaborate with:

- Public, localities, communities of interest and service users
- Professionals
- Community Planning Partnership; specifically Community Justice Board, Integrated Children's Services Board, Resilient, Included and Supported Group as well as Alcohol & Drugs Partnership
- Public Health and Managed Clinical Network for Sexual Health and Blood Borne Viruses
- Aberdeen Health and Social Care Partnership

3.21. This proposed investment of £666,404 will help improve our outcomes against a number of critical measures. Further detail for information can be found in Appendix A.

4. Implications for IJB

4.1. Equalities:

- This investment will have a *positive* impact on communities and service users through additional service capacity, improved access to support and improved service quality.
- This investment will have a *positive* impact on staff in relation to investment in training, professional development and increased staff numbers.
- This investment will have *no negative* impact on employees, service users or other people who share characteristics protected by The Equality Act 2010

4.2. Fairer Scotland Duty: This investment will have a *positive* impact on reducing *the inequalities of outcome which result from socio-economic disadvantage.*

4.3. Financial: as detailed throughout the report

4.4. Workforce: as detailed throughout the report

4.5. Legal: There are no direct legal implications arising from the recommendations of this report

5. Links to ACHSCP Strategic Plan

The Scottish Government expect to see alcohol and drugs as an identifiable section within the AHSCP Strategic Plan. This plan, the ADP Delivery Plan and priorities within the Community Planning Partnership should all be corporate and work is being undertaken to ensure this.

This report also aligns with the current ACHSCP Strategic Plan as the work of the APD also links particularly strongly to 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.
- Contribute to a reduction in health inequalities and the inequalities in the wider social conditions that affect our health and wellbeing.

6. Management of Risk

6.1. Identified risks(s)

Adult drug treatment services are currently graded “High Risk” on the risk register due to ongoing vacancies; service capacity and the ongoing negative impact on waiting times and patient safety.

6.2. Link to the ACHSCP Strategic Risk Register: Risk Number 5: “*There is a risk that the IJB, and the services that it directs and has operational oversight of, fail to meet both performance standards/outcomes as set by regulatory bodies and those locally-determined performance standards as set by the board itself. This may result in harm or risk of harm to people*”.

6.3. How might the content of this report impact or mitigate these risks:

This investment will bring additional service capacity, opportunity for redesign and partnership working which will help mitigate risks.

Approvals	
[signature]	Sandra Ross (Chief Officer)
[signature]	Alex Stephen (Chief Finance Officer)

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ADP 2018 Framework for investment

ANNEX C

PROGRAMME FOR GOVERNMENT 2018-19: ADDITIONAL INVESTMENT IN SERVICES TO REDUCE PROBLEM DRUG AND ALCOHOL USE

2018-19 INVESTMENT PLANS AND REPORTING TEMPLATE

ADP: ABERDEEN CITY

Our overall aim throughout this investment is *to reduce the number of drug and alcohol related deaths by 50% by 2026. Will achieve this by:*

Developing innovative ways to reduce alcohol and drug related deaths through increasing engagement in high quality, person centred services, reducing the adverse and harmful impact of parental drug / alcohol use on children, reducing the potential harm to young people caused by use of drugs / alcohol, reducing harm, morbidity and mortality, supporting recovery and development of increased business intelligence and analysis

Investment Area *	Key Challenge	Proposal & Intended Outcome	Anticipated Investment £	Anticipated Investment Measure - Progress
WORKSTREAM 1: WHOLE-FAMILY APPROACH				
Reduce the adverse and harmful impact of parental drug / alcohol use on children	*Support whole family approaches in tackling substance misuse by providing support, treatment and recovery through joint working and robust quality assurance processes to ensure that the best interests of the child and their family are met.*	Ensures effective joint working arrangements are in place between adult treatment services and children and family services;	*Year 1: £100,000* *Year 2: £100,000* *Year 3: £100,000*	- Demonstrable improved joint working, - Improved chronologies and joint case management - Holistic care for families affected by drugs and alcohol
	Enhance the support for kinship carers who have responsibility for vulnerable young people	Ensure family members, partners and carers receive a proactive offer of support and advice in relation to drug and alcohol misuse		- Feedback from Kinship carers
	Improve access to treatment services for parents and carers	Ensure that the most vulnerable and in particular those with children have access to appropriate services		- Increase in women represented in treatment stats - Increase in uptake of family planning and other harm reduction services
Reduce the potential harm to young people caused by use of drugs / alcohol through early intervention, education and prevention work and specifically targeting the most vulnerable young people	*Prioritise support for Looked After Children*	Ensure that prevention and early intervention work supports the most vulnerable young people in relation to drug and alcohol choices		- Increase in consistent programmes for at risk young people - Long term reduction of CEYP presenting with drug and alcohol related problems
	Develop a corporate educational approach in relation to drug / alcohol misuse with associated governance / assurance process	Increase the number of educational inputs by primary and secondary schools on alcohol / drugs and improve associated reporting		- Measurable activity and consistency in delivery across schools

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ADP 2018 Framework for investment

Investment Area *	Key Challenge	Proposal & Intended Outcome	Anticipated Investment £	Anticipated Investment Measure - Progress
WORKSTREAM 2 REDUCING HARM, MORTALITY AND MORBIDITY				
Reduce harm, morbidity and mortality	*Ensure action to reduce drug and alcohol deaths is innovative, planned, co-ordinated and reaches the most vulnerable*	*Increase the distribution and access to naloxone, particularly for people not engaged in specialist treatment services*	*Year 1: £100,000* *Year 2: £100,000* *Year 3: £100,000*	- Increase in distribution of naloxone to primary users and significant others
	Reduce risks associated with injecting behaviour and collaborate on the agenda to eradicate Hepatitis C	*Ensure the harm associated with Blood Borne Viruses is reduced for individuals and communities*		- Increase in BBV testing - Increase in BBV testing sites - Increase in case finding
	Ensure substance misuse treatment programme is in place for those within the criminal justice system and provide opportunities for those not engaged in specialist treatment to engage	*Ensure that those entering or leaving the community justice system have access to continued or opportunistic drug and alcohol treatment*		- Increase in uptake of treatment in justice settings - Decrease in breaks in continuity of care
	Continue the development of Community Alcohol Hubs targeting communities where deprivation is greatest as a whole system / whole population approach to alcohol	*Ensure access to alcohol services is local, integrated and targets areas of greatest need*		- Evaluation of the impact of alcohol hubs
	Reduce the harm caused by alcohol on local communities through intervention and prevention	*Increase number of alcohol brief interventions delivered by Primary Care providers and other professionals*		- Increased number o alcohol brief interventions delivered
	Develop a plan to improve understanding on how licensing could contribute to reducing the harm caused by alcohol	*Increase knowledge of the impact of alcohol within their local community*		- Increase delivery of community training sessions

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ADP 2018 Framework for investment

Investment Area *	Key Challenge	Proposal & Intended Outcome	Anticipated Investment £	Anticipated Investment Measure - Progress
Workstream 3: Service Quality Improvement				
Ensure services are high quality, person centred and reduce the adverse and harmful impact of parental drug / alcohol use and meet the needs of service users	*Continue to implement improvement activity and further develop our programme of quality assurance within our specialist services that will seek and involve service users views*	*Measurable and reportable quality assurance measures*	*Year 1:£400,000* *Year 2: £400,000* *Year 3: £400,000*	
	Ensure that our workforce is appropriately supported and valued in our quality processes to ensure best possible care, recruitment and retention	*Improved training and development for staff*		- *Staff service feedback and job satisfaction*
	Develop innovative ways to engage those most at risk to drug or alcohol related problems	*Improved low threshold access to treatment*		- *Increase number of service users from target cohorts engaging services*
	Build capacity of our specialist services to improve access, waiting times and retention in treatment	*Improved low threshold access to treatment*		- *We exceed waiting times standard*
	Evaluate and continue the development of Community Alcohol Hubs targeted to communities where deprivation is greatest as a whole system / whole population approach to alcohol	*Ensure access to alcohol services is local, integrated and targets areas of greatest need*		- *Evaluation of the impact of alcohol hubs*
	Take forward recommendations in relation to "The Delivery of Psychological Interventions in Substance Misuse Services in Scotland Report"	*Ensure service users have access to psychology and trauma informed services*		

DRAFT

ADP 2018 Framework for investment

Investment Area *	Key Challenge	Proposal & Intended Outcome	Anticipated Investment £	Anticipated Investment Measure - Progress
WORKSTREAM Supporting Recovery				
Ensure recovery is supported and visible in our communities	*Ensure that people undertaking recovery from drug and alcohol issues have opportunities and support to maintain drug / alcohol free lives*	*Develop a community service plan in the context of "people and place" and seek opportunities to provide those who are in recovery with appropriate support*	Year 1:£40,000 Year 2: £40,000 Year 3: £40,000	- *Locality plans include specific opportunities for people in recovery*
	Maintain links with local recovery groups, support groups and mutual aid fellowships	*Ensure that a range of support mechanisms in place and available to groups who support those in recovery*		- *Number and frequency of groups / meetings* - *Demographics of those attending groups / meetings*

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ADP 2018 Framework for investment

Investment Area *	Key Challenge	Proposal & Intended Outcome	Anticipated Investment £	Anticipated Investment Measure - Progress
WORKSTREAM Development of business intelligence and analysis				
Ensure delivery is development of business intelligence and analysis	*Develop ways of using business intelligence to improve our understanding of the causes and underlying issues which impact upon drug and alcohol related deaths*	*Improved information sharing and access to data which allows analysis to aide understanding and direct services*	*Year 1: £26,000* *Year 2: £26,000* *Year 3:£26,000*	TBD
	Build capacity of our specialist services to improve access, waiting times and retention in treatment	*Ensure Scottish Government performance reporting requirements are met*		TBD *Ensure Scottish Government performance reporting requirements are met*

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In submitting this completed Investment Plan, we are confirming that this has been signed off by both the ADP Chair and Integration Authority Chief Officer(s).

01/11/2018

Chair
Alcohol and Drugs Partnership

01/11/2018

Chief Officer
Aberdeen City Health & Social Care Partnership

Appendix – reconciliation with Scottish Government priorities

Background

The Scottish Government have allocated £666,404 recurring funding to Aberdeen City ADP which will be available from September 2018. Investment intentions have to be submitted to the Scottish Government by the 26th Oct.

The criteria for the use of this funding is contained in

Funding Allocation Letter August 2018	Funding Allocation Letter May 2018	Draft National Strategy
2018-19 - Programme for Gover	ADP - Funding - 2018-19 - Funding let	All Together Now - Our Strategy to Addr

The Scottish Government is currently refreshing its own National Strategy for Drugs and Alcohol. ADPs are also required to develop a new three year Delivery Plan for the period 2019 – 2022.

To maximise the opportunity for involvement and to ensure our funding is aligned to local delivery priorities that may not be evident until national and local plans are fully developed we will take a programmatic approach to investment. A separate paper outlines the approach to developing the Delivery Plan over the next six months. Taking a programmatic approach will also allow, as the ADP refreshes the Delivery Plan, the ADP to engage appropriately with other local partnerships, planning processes and ensure alignment of outcomes.

We have organised the criteria for investment into broad thematic workstreams:

Workstream 1: Whole Family Approach
Workstream 2: Reducing Harm, Morbidity and Mortality
Workstream 3: Service Quality Improvement
Workstream 4: Supporting Recovery
Workstream 5: Intelligence Led Delivery

It should be noted that the above workstreams do not represent the full scope of ADP activity. The full scope of ADP activity will be represented through the work undertaken to refresh the local Delivery Plan.

Directing funding in this way will allow engagement with partners to determine the best methods for implementation, delivery, monitoring and reporting.

The allocations for each workstream are:

	Yr 1	Yr2	Yr 3
Workstream 1: Whole Family Approach	£100k	£100k	£100k
Workstream 2: Reducing Harm, Morbidity and Mortality	£100k	£100k	£100k
Workstream 3: Service Quality Improvement	£400k	£400k	£400k
Workstream 4: Supporting Recovery	£40k	£40k	£40k
Workstream 5: Intelligence Led Delivery	£26k	£26k	£26k
Total	**£666k**	**£666k**	**£666k**

The high level actions for each workstream can be found in **Appendix 1.**

There will be some overlap between workstreams. It is also recognised that there will be lead times required for implementation. Where feasible funds will be carried forward when an under spend is incurred. Non-recurring / unallocated under spend will be prioritised for use to support the workstreams within the framework and aligned to:

- staff training
- secondments
- equipment and resources
- community resources and grants
- public information and engagement

ADP 2018 Framework for investment

Delivery methodologies

In determining the best methods for implementation we will seek to collaborate with:

- Public, localities communities of interest and service users
- Professionals
- Community Planning Partnership, and specifically Community Justice Board, Integrated Children's Services Board, Resilient, Included and Supported Group
- Aberdeen Health and Social Care Partnership

To maximise the impact of investment we will take a number to approaches to ensure resources have the appropriate impact. Broadly the framework will be:

		Example	Heading
1	Things we know work	Where we have service capacity issues, good evidence, existing requirement for continuous service improvement	Continuous Service Improvement
2	Things we don't know	Where we have ideas for innovation, ideas for new ways of working, some evidence but want to test these ideas with limited risk and build on learning	Improvement Project
3	Things we don't know that we don't know	Where we are unclear on how to improve and innovate, or the evidence is unclear we may fund someone to undertake some work to progress to the level of an Improvement Project	Action Research

By following this framework we will be able to use resources flexibly to invest in innovative new ways of working and maintain stability of service delivery, improve quality appropriately or to disinvest from areas where there is not significant improvement or change..

Governance, Accountability and Procurement

The ADP will use the governance and accountability structures of the AHSCP to manage, monitor and report on investments. Where the delivery method of any developments requires the purchase of services we will use Aberdeen City Procurement and Contracts and work within Public Contracts (Scotland) Regulations 2015.

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APPENDIX 1

WORKSTREAM 1: WHOLE-FAMILY APPROACH	
SCOTTISH GOVERNMENT CRITERIA	HIGH LEVEL LOCAL ACTION
Family members, partners and carers receive a proactive offer of help, advice and support;	With colleagues and through the Integrated Children's Service Board we will: • *Support whole family approaches tackling substance misuse, supporting recovery, joint working, providing quality assurance in assuring the best interests of the child and their family are met.* • *Collaborate with Managed Care Network for Sexual Health and BBVs to ensure vulnerable substance users have access to appropriate contraception planning support* • *Support Kinship carers* • *Prioritise support for Looked After Children* • *Seek to reduce stigma that inhibits people seeking help*
Treatment professionals with adult services have the skills to identify children who are being adversely affected by another's alcohol and/or drug use. This includes taking a key role within GIRFEC and child welfare and protection processes and ensuring ongoing professional development within supervision processes.	
Effective joint working arrangements are in place between treatment services and children and family services (including statutory child protection services) which ensure that services work together in the best interest of the child and their family;	
Services respond to the changing needs of people using them alongside children and other family members. This would be demonstrated in their care plans, programmes and activities;	
Families have access to support and help which addresses their collective needs as a family;	
Services recognise the impact that stigma plays in accessing and engaging in a range of services amongst parents with problematic alcohol or drug use.	

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WORKSTREAM 2 REDUCING HARM, MORTALITY AND MORBIDITY

SCOTTISH GOVERNMENT CRITERIA	HIGH LEVEL LOCAL ACTION
Improved planning and coordination of interventions to reduce and prevent drug and alcohol deaths;	In collaboration we will: • *Develop innovative way to develop prevention strategies to reduce drug and alcohol deaths particularly for people not engaged in specialist treatment services* • *Collaborate with the MCN for Sexual Health and BBVs to reduce risks associated with injecting behaviour and collaborate on the agenda to eradicate Hepatitis C as a means to improving all outcomes associated with Blood Borne Viruses* • *Develop innovative ways to distribute naloxone to communities not engaged in specialist treatment services* • *Work to ensure the continuity of substance misuse treatment of people moving through the justice system and ensure continuous opportunities for those not engaged in specialist treatment to engage* • *Evaluate and continue the development of Community Alcohol Hubs targeted to communities where deprivation is greatest as a whole system / whole population approach to alcohol* • *Actively support localities to reduce the impact of alcohol on hospital admission rates*
Broaden the delivery of key activities to reduce harm	
Work to support effective prisoner throughcare, particularly for locally identified vulnerable groups & whether this is referenced in local community justice improvement plans;	
Continuing support for the provision of naloxone in community, custodial and healthcare settings;	
Continued implementation of a Whole Population Approach for alcohol, targeting harder to reach groups, including those impacted most by the new minimum unit price for alcohol from 1 May 2018 and supporting a focus on communities where deprivation is greatest.	

<table>
<tr><th colspan="2">WORKSTREAM 3 SERVICE QUALITY IMPROVEMENT</th></tr>
<tr><th>SCOTTISH GOVERNMENT CRITERIA</th><th>HIGH LEVEL LOCAL ACTION</th></tr>
<tr><td>Continued implementation of improvement activity at a local level, based on the individualised recommendations within the Care Inspectorate Report, which examined local implementation of the Quality Principles.</td><td rowspan="8">In collaboration we will:

• Continue to implement improvement activity and further develop our programme of quality assurance within our specialist services that will seek and involve service users views

• Ensure that our workforce is appropriately supported and valued in our quality processes to ensure best possible care, recruitment and retention

• Develop innovative ways to engage those most at risk to drug or alcohol related problems

• Build capacity of our specialist services to improve access, waiting times and retention in treatment

• Evaluate and continue the development of Community Alcohol Hubs targeted to communities where deprivation is greatest as a whole system / whole population approach to alcohol

• Take forward recommendations in relation to “The Delivery of Psychological Interventions in Substance Misuse Services in Scotland Report”</td></tr>
<tr><td>Involve people with lived and living experience / Increased involvement of those with lived experience of addiction and recovery in the evaluation, design and delivery of services;</td></tr>
<tr><td>Ensure people have access to effective treatment - particularly those at most risk</td></tr>
<tr><td>Reduce waiting times for treatment and support services. Particularly waits for opioid substitution therapy (OST) including where these are reported as secondary waits under the LDP Standard;</td></tr>
<tr><td>Improved retention in treatment particularly those detoxed from alcohol and those accessing OST;</td></tr>
<tr><td>Improved access to drug/alcohol treatment services amongst those accessing inpatient hospital services;</td></tr>
<tr><td>Development of advocacy services;</td></tr>
<tr><td>Services and staff must deliver person-centred, trauma-informed care</td></tr>
</table>

WORKSTREAM 4 SUPPORTING RECOVERY	
SCOTTISH GOVERNMENT CRITERIA	HIGH LEVEL LOCAL ACTION
Ensure the recovery community thrives - to achieves its potential	In collaboration we will: • *Ensure that positive examples of recovery are visible in our communities* • *Ensure our specialist services continue to have opportunities to engage with communities of recovery* • *Work with partners to take forward recovery in the context of "people and place" and seek opportunities to take forward the recovery agenda* • *Maintain links with local recovery groups, support groups and mutual aid fellowships*
Continued development of recovery communities.	

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WORKSTREAM 5 DEVELOP AN INTELLIGENCE-LED APPROACH TO DELIVERY	
SCOTTISH GOVERNMENT CRITERIA	HIGH LEVEL LOCAL ACTION
Compliance with the Drug and Alcohol Treatment Waiting Times Local Delivery Plan (LDP) Standard, including, continuing action to increase the level of fully identifiable records submitted to the Drug and Alcohol Treatment Waiting Times Database;	In collaboration we will: • *Build capacity of our specialist services to improve access, waiting times and retention in treatment* • *Evaluate and continue the development of Community Alcohol Hubs targeted to communities where deprivation is greatest as a whole system / whole population approach to alcohol* • *Develop ways of using intelligence to improve performance and engagement in relation to drug and alcohol related problems*
Implementation planning for the Drug and Alcohol Information System (DAISY) including adaptations to local delivery systems and IT infrastructure, to ensure full compliance with data entry and national reporting requirements.	
Continuing work to increase compliance with the Scottish Drugs Misuse Database data entry requirements for the SMR25 (a) and (b) datasets, in preparation for DAISY;	
Compliance with the Alcohol Brief Interventions Local Delivery Plan (LDP) Standard.	

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Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Date of Meeting	11.12.2018
Report Title	Audit Scotland: Health & Social Care Integration – An Update on Progress.
Report Number	HSCP.18.119
Lead Officer	Sandra Ross, Chief Officer
Report Author Details	Alex Stephen, Chief Finance Officer
Consultation Checklist Completed	Yes
Directions Required	No
Appendices	*a.* Audit Scotland: Health & Social Care Integration – An Update on Progress.

1. Purpose of the Report

1.1. This report presents the Integration Joint Board with Audit Scotland's Report "*Health & Social Care Integration – An Update on Progress)*

2. Recommendations

2.1. It is recommended that the Integration Joint Board:

a) note the content of the Audit Scotland report as attached at Appendix A.

3. Summary of Key Information

3.1. Audit Scotland published their report 'Health & Social Care Integration – Update on Progress' on the 15 November 2018.

3.2. The report clearly states that integration is beginning to make a demonstrable improvement to the health and social care systems and that the Act can be used to advance change. However, they also found that more needs to be done to realise its full potential. With this in mind, the report has four key messages:

i. Integration authorities have started to introduce more collaborative ways of delivering services but there is much more to be done.

ii. Financial planning is not integrated, long term or focused on providing the best outcomes for people who need support. This is a fundamental issue which will limit the ability of Integration Authorities to improve the health and social care system. Financial pressures are making it difficult for Integration Authorities to achieve meaningful change.

iii. Strategic planning needs to improve, and key barriers that must be overcome include: a lack of collaborative leadership and strategic capacity; a high turnover in leadership teams; disagreement over governance arrangements; and an inability or unwillingness to safely share data with staff and the public.

iv. Significant changes are still required. Change cannot happen without meaningful engagement with staff, communities and politicians. At both a national and local level, all partners need to work together to be more honest and open about the changes that are needed to sustain health and care services in Scotland.

3.3. The report also makes a number of recommendations over six themes:

i. Commitment to collaborative leadership and building relationships

ii. Effective strategic planning for improvement

iii. Integrated finances and financial planning

iv. Agreed governance and accountability arrangements

v. Ability and willingness to share information

vi. Meaningful and sustained engagement

Reference to Aberdeen City Health & Social Care Partnership

3.4. Aberdeen City Health & Social Care Partnership were visited by Audit Scotland in April 2018. They met with a number of colleagues and members of the Integration Joint Board, as well as undertaking a service visit to Woodend Hospital. The report pinpoints leadership, information-sharing and governance as key strengths of the Partnership.

3.5. The report states: “We have seen examples of good collaborative and whole-system leadership, including in Aberdeen City, where relationships

have been built across the Partnership. Although differences of opinion still exist and there is healthy debate, Aberdeen City is now better placed to implement widespread changes to improve outcomes. We saw:

- the promotion of a clear and consistent message across the Partnership;
- a willingness to work with others to overcome differences;
- recruitment of staff to fit and contribute to a new culture;
- development of openness and appreciation of ideas;

Collaborative Leadership

3.6. A key element in the report focuses highlights that a lack of collaborative leadership and cultural differences are affecting the pace of change. As highlighted above, the report found examples of good collaborative and whole-system leadership.

3.7. Additionally, in Aberdeen City HSCP, both the Integration Joint Board and the Leadership Team have committed to undertake development programmes.

Integration Joint Board

3.8. At its meeting in August 2018, the IJB agreed to tender for external support to help with the continued development of the board. The Leadership Team will undertake a review of this report to include any key areas for development within the development programme for the IJB during the financial year 2019/20. The learning from this report will be included within the tender.

Leadership Team

3.9. Following a successful initial workshop led by Insights in October, the Leadership Team have committed to a series of development sessions, which are currently being finalised into a development plan for the team. The plan will include a focus on collaborative leadership throughout.

4. Implications for IJB

4.1. Equalities – there are no equalities implications

4.2. Fairer Scotland Duty – there are no implications for the Fairer Scotland Duty

4.3. Financial – there are no finance implications arising from the recommendations in this report. Further information on the financial position and pressures of IJBs is outlined in Appendix A.

4.4. Workforce – there are no workforce implications

4.5. Legal – there are no legal implications

4.6. Other – there are no other implications

5. Links to ACHSCP Strategic Plan

5.1. The Audit Scotland report provides a high-level review of progress with integrating health and social care. The recommendations and improvements identified in the report could help the IJB to deliver on all elements of its strategic plan.

6. Management of Risk

6.1. Identified risks(s) – NA

6.2. Link to risks on strategic or operational risk register: NA

6.3. How might the content of this report impact or mitigate these risks: NA

Approvals	
These will be added once your report has final approval for submission to committee.	Sandra Ross (Chief Officer)
These will be added once your report has final approval for submission to committee.	Alex Stephen (Chief Finance Officer)

Health and social care series

Health and social care integration

Update on progress

ACCOUNTS COMMISSION

Prepared by Audit Scotland
November 2018

The Accounts Commission

The Accounts Commission is the public spending watchdog for local government. We hold councils in Scotland to account and help them improve. We operate impartially and independently of councils and of the Scottish Government, and we meet and report in public.

We expect councils to achieve the highest standards of governance and financial stewardship, and value for money in how they use their resources and provide their services.

Our work includes:

- securing and acting upon the external audit of Scotland's councils and various joint boards and committees
- assessing the performance of councils in relation to Best Value and community planning
- carrying out national performance audits to help councils improve their services
- requiring councils to publish information to help the public assess their performance.

You can find out more about the work of the Accounts Commission on our website: www.audit-scotland.gov.uk/about-us/accounts-commission

Auditor General for Scotland

The Auditor General's role is to:

- appoint auditors to Scotland's central government and NHS bodies
- examine how public bodies spend public money
- help them to manage their finances to the highest standards
- check whether they achieve value for money.

The Auditor General is independent and reports to the Scottish Parliament on the performance of:

- directorates of the Scottish Government
- government agencies, eg the Scottish Prison Service, Historic Environment Scotland
- NHS bodies
- further education colleges
- Scottish Water
- NDPBs and others, eg Scottish Police Authority, Scottish Fire and Rescue Service.

You can find out more about the work of the Auditor General on our website: www.audit-scotland.gov.uk/about-us/auditor-general

Audit Scotland is a statutory body set up in April 2000 under the Public Finance and Accountability (Scotland) Act 2000. We help the Auditor General for Scotland and the Accounts Commission check that organisations spending public money use it properly, efficiently and effectively.

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Links

PDF download

Web link

Exhibit data

When viewing this report online, you can access background data by clicking on the graph icon. The data file will open in a new window.

Audit team

The core audit team consisted of Leigh Johnston, Neil Cartlidge, Christopher Lewis and Lucy Jones, under the direction of Claire Sweeney.

Key facts

£222.5 million

Savings Integration Authorities needed to achieve in 2017/18

Almost £9 billion

Health and social care resources directed by Integration Authorities

8.4 per cent

Increase in required savings from 2016/17

<70%

Integration Authority funding comes from the NHS

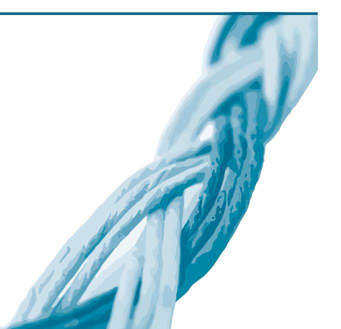
>30%

Funding comes from local authorities

31

Integration Authorities established through partnerships between the 14 NHS boards and 32 councils in Scotland

Summary



Key messages

1. Integration Authorities (IAs) have started to introduce more collaborative ways of delivering services and have made improvements in several areas, including reducing unplanned hospital activity and delays in discharging people from hospital. People at the end of their lives are also spending more time at home or in a homely setting, rather than in hospital. These improvements are welcome and show that integration can work within the current legislative framework, but IAs are operating in an extremely challenging environment and there is much more to be done.

2. Financial planning is not integrated, long term or focused on providing the best outcomes for people who need support. This is a fundamental issue which will limit the ability of IAs to improve the health and social care system. Financial pressures across health and care services make it difficult for IAs to achieve meaningful change. IAs were designed to control some services provided by acute hospitals and their related budgets. This key part of the legislation has not been enacted in most areas.

3. Strategic planning needs to improve and several significant barriers must be overcome to speed up change. These include: a lack of collaborative leadership and strategic capacity; a high turnover in IA leadership teams; disagreement over governance arrangements; and an inability or unwillingness to safely share data with staff and the public. Local areas that are effectively tackling these issues are making better progress.

4. Significant changes are required in the way that health and care services are delivered. Appropriate leadership capacity must be in place and all partners need to be signed up to, and engaged with, the reforms. Partners also need to improve how they share learning from successful integration approaches across Scotland. Change cannot happen without meaningful engagement with staff, communities and politicians. At both a national and local level, all partners need to work together to be more honest and open about the changes that are needed to sustain health and care services in Scotland.

several significant barriers must be overcome to speed up change

Recommendations

It is not possible for one organisation to address all the issues raised in this report. If integration is to make a meaningful difference to the people of Scotland, IAs, councils, NHS boards, the Scottish Government and COSLA need to work together to address six areas outlined below.

Commitment to collaborative leadership and building relationships

The Scottish Government and COSLA should:

- ensure that there is appropriate leadership capacity in place to support integration
- increase opportunities for joint leadership development across the health and care system to help leaders to work more collaboratively.

Effective strategic planning for improvement

Integration Authorities, councils and NHS boards should work together to:

- ensure operational plans, including workforce, IT and organisational change plans across the system, are clearly aligned to the strategic priorities of the IA
- monitor and report on Best Value in line with the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014.

The Scottish Government should:

- ensure that there is a consistent commitment to integration across government departments and in policy affecting health and social care integration.

Integrated finances and financial planning

The Scottish Government should:

- commit to continued additional pump-priming funds to facilitate local priorities and new ways of working which progress integration.

The Scottish Government and COSLA should:

- urgently resolve difficulties with the 'set-aside' aspect of the Act.

The Scottish Government, COSLA, councils, NHS boards and Integration Authorities should work together to:

- support integrated financial management by developing a longer-term and more integrated approach to financial planning at both a national and local level. All partners should have greater flexibility in planning and investing over the medium to longer term to achieve the aim of delivering more community-based care.

Integration Authorities, councils and NHS boards should work together to:

- view their finances as a collective resource for health and social care to provide the best possible outcomes for people who need support.

Agreed governance and accountability arrangements

The Scottish Government and COSLA should:

- support councillors and NHS board members who are also Integration Joint Board members to understand, manage and reduce potential conflicts with other roles.

The Scottish Government, COSLA, councils, NHS boards and Integration Authorities should work together to:

- agree local responsibility and accountability arrangements where there is disagreement over interpretation of the Public Bodies (Joint Working) (Scotland) Act 2014 and its underpinning principles. Scenarios or examples of how the Act should be implemented should be used which are specific to local concerns. There is sufficient scope within existing legislation to allow this to happen.

Ability and willingness to share information

The Scottish Government and COSLA should:

- monitor how effectively resources provided are being used and share data and performance information widely to promote new ways of working across Scotland.

The Scottish Government, COSLA, councils, NHS boards and Integration Authorities should work together to:

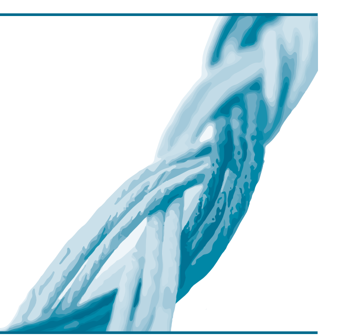
- share learning from successful integration approaches across Scotland
- address data and information sharing issues, recognising that in some cases national solutions may be needed
- review and improve the data and intelligence needed to inform integration and to demonstrate improved outcomes in the future. They should also ensure mechanisms are in place to collect and report on this data publicly.

Meaningful and sustained engagement

Integration Authorities, councils and NHS boards should work together to:

- continue to improve the way that local communities are involved in planning and implementing any changes to how health and care services are accessed and delivered.

Introduction



Policy background

1. The Public Bodies (Joint Working) (Scotland) Act, 2014 (the Act) is intended to ensure that health and social care services are well integrated, so that people receive the care they need at the right time and in the right setting, with a focus on community-based, preventative care. The reforms affect everyone who receives, delivers and plans health and care services in Scotland. The Act requires councils and NHS boards to work together to form new partnerships, known as Integration Authorities (IAs). There are 31 IAs, established through partnerships between the 14 NHS boards and 32 councils in Scotland.

2. As part of the Act, new bodies were created – Integration Joint Boards (IJBs) (Exhibit 1, page 9). The IJB is a separate legal entity, responsible for the strategic planning and commissioning of the wide range of health and social care services across a partnership area. Of the 31 IAs in Scotland, 30 are IJBs and one area, Highland, continues with a Lead Agency model which has operated for several years. In Highland, the NHS board and council each lead integrated services. Clackmannanshire and Stirling councils have created a single IA with NHS Forth Valley. You can find more information about integration arrangements in our short guide.

What is integration?
A short guide to the integration of health and social care services in Scotland

3. Each IA differs in terms of the services they are responsible for and local needs and pressures. At a minimum, IAs need to include governance, planning and resourcing of social care, primary and community healthcare and unscheduled hospital care for adults. In some areas, partners have also integrated children's services and social work criminal justice services. Highland Lead Agency, Dumfries and Galloway IJB, and Argyll and Bute IJB have also integrated planned acute health services. IAs became operational at different times but were all established by April 2016. The policy context for IAs is continually changing, and many policies have an impact on IAs, such as the new GP contract and changes to payments for social care services.

the reforms affect everyone who receives, delivers and plans health and social care services in Scotland

About this audit

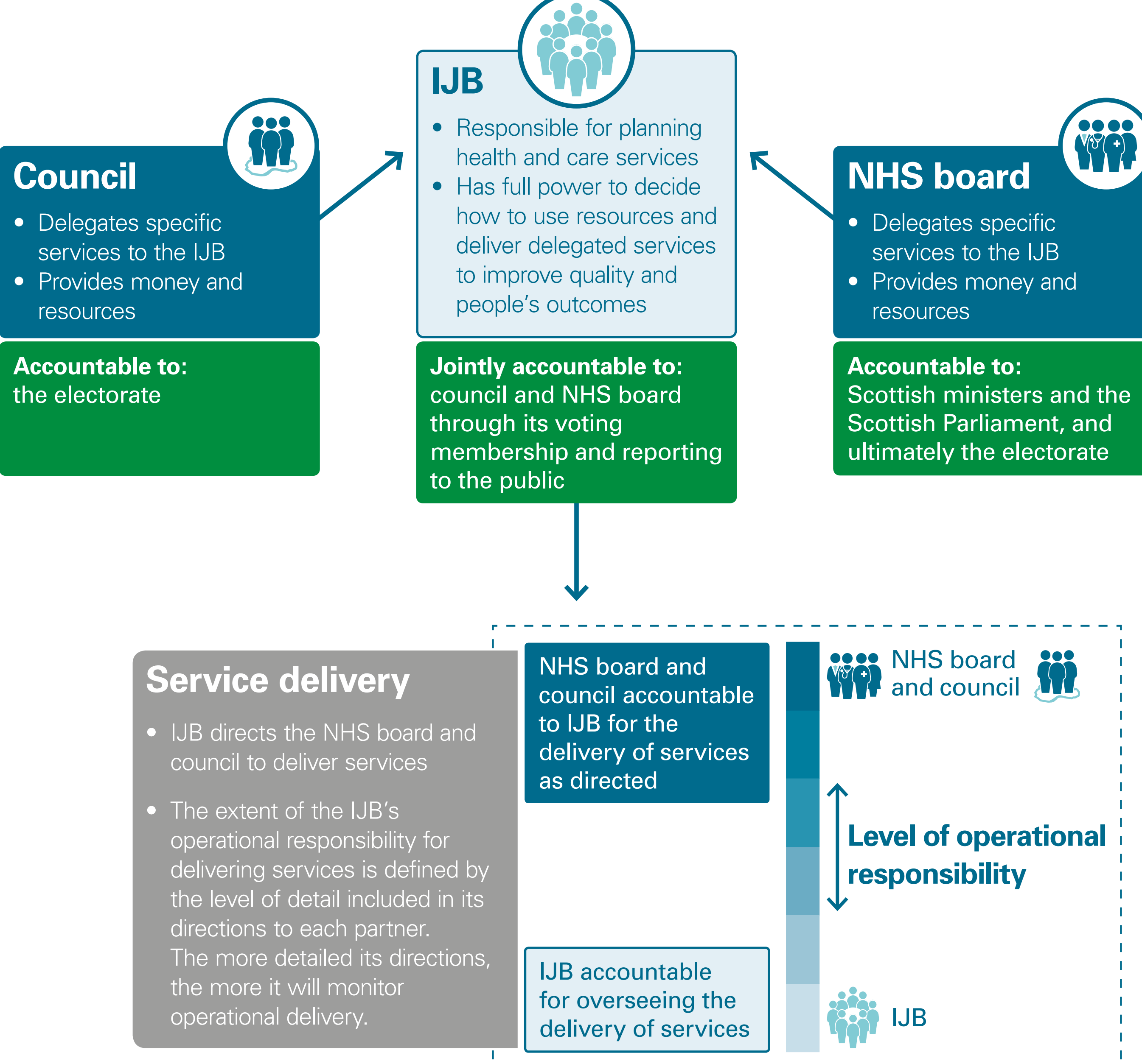
4. This is the second of three national performance audits of health and social care integration following the introduction of the Act. The aim of this audit is to examine the impact public bodies are having as they integrate health and social care services. The report sets out six areas which need to be addressed if integration is to make a meaningful difference to the people of Scotland. This audit does not focus in detail on local processes or arrangements and it complements the programme of strategic inspections by the Care Inspectorate and Healthcare Improvement Scotland.[1] Appendix 1 (page 41) has more details about our audit approach and Appendix 2 (page 42) lists the members of our advisory group who provided help and advice throughout the audit.

5. Appendix 3 (page 43) summarises progress against the recommendations in our first audit, which looked at transitional arrangements and highlighted several risks that needed to be addressed.[2] We will carry out a third audit in this series later in our work programme, which will report on the impact that integration has had and how health and social care resources are used.

Exhibit 1

Integration Joint Boards

There are 30 Integration Joint Boards across Scotland.



Source: Audit Scotland

Part 1

The current position

Integration Authorities oversee almost £9 billion of health and social care resources

6. Our findings show that integration can work and that the Act can be used to advance change. Although some initiatives to integrate services pre-date the Act, there is evidence that integration is enabling joined up and collaborative working. This is leading to improvements in performance, such as a reduction in unplanned hospital activity and delays in hospital discharges. But there is much more to be done.

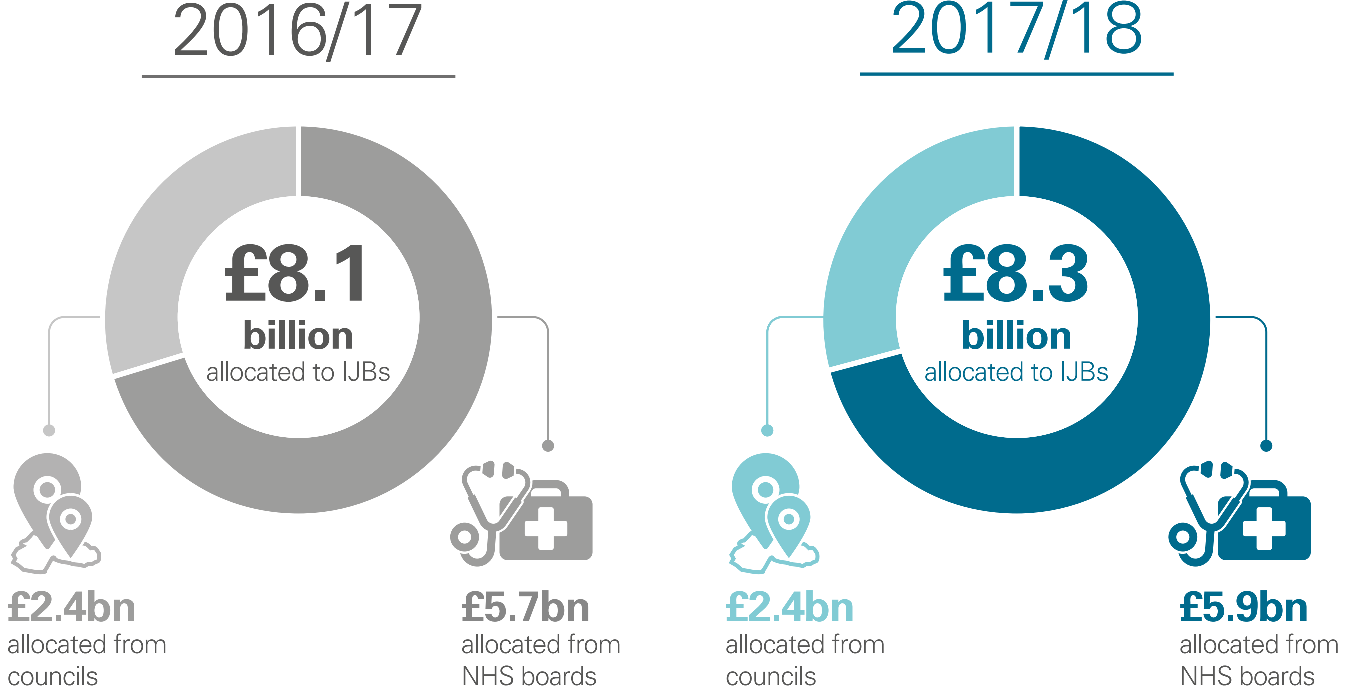
7. IAs are responsible for directing almost £9 billion of health and social care resources, money which was previously separately managed by NHS boards and councils (Exhibit 2, page 11). Over 70 per cent of this comes from the NHS, with the remainder coming from councils. As with councils and NHS boards, IAs are required to find efficiency savings from their annual budgets to maintain financial balance. Demands on services combined with financial pressures have led to many IJBs struggling to achieve this balance, with many needing additional financial contributions from partner organisations.

8. Each IA is underpinned by an integration scheme. This is the agreement between the council and the NHS board which shows how the IA will operate. For example, the scheme sets out arrangements for dealing with any budget overspends, which usually involves implementing a recovery plan. As local government bodies, IJBs can hold reserves if permitted by their integration schemes, although not all schemes allow this. Reserves are amounts of money that are built up from unspent budgets for use in future years. Generally, reserves are used for one of three purposes:

- as a working balance to help prevent the impact of uneven cash flows
- as a contingency to cushion the impact of unexpected events or emergencies
- held to fund known or predicted future requirements – often referred to as 'earmarked reserves'.[3]

there is evidence that integration is enabling joined up and collaborative working

Exhibit 2
Resources for integration
IAs are responsible for directing significant health and social care resources.



Lead Agency – the allocation for Highland Health and Social Care Services was:
£595 million in 2016/17 | £619 million in 2017/18

Note: Council allocations in 2016/17 and 2017/18 include criminal justice social work contribution.
Source: Audit Scotland, 2018

Financial pressures make it difficult for IAs to make sustainable changes to the way services are delivered

9. The Act was intended to help shift resources away from the acute hospital system towards preventative and community-based services. However, there is still a lack of agreement about whether this is achievable in practice – or whether rising demand for hospital care means that more resource is needed across the system. We have seen some examples of small-scale changes in the balance of care, which are explored further in Part 2 (page 23). These examples show that change can be achieved, but IAs now need to take the next steps to achieve wider-scale impact on outcomes over the coming years.

10. IAs needed to achieve savings of £222.5 million in 2017/18. This is an increase of 8.4 per cent on the previous year and is 2.5 per cent of the total allocation to IAs from NHS boards and councils. The level of savings, as a percentage of IA income, varied from 0.5 per cent in Moray, Orkney, Renfrewshire and South Lanarkshire, to 5.3 per cent in Shetland and 6.4 per cent in Highland Lead Agency. In several instances, budgets were agreed at the start of the financial year based on achieving savings which had yet to be identified.

Financial position

11. It is not easy to set out the overall financial position of IAs. This is due to several factors, including the use of additional money from partner organisations, planned and unplanned use of reserves, late allocations of money and delays in planned expenditure. This makes it difficult for the public and those working in the system to understand the underlying financial position.

12. In 2017/18, IJBs reported an overall underspend of £39.3 million. This represented 0.4 per cent of their total income allocation for the year.[4] However, this masks a much more complex picture of IJB finances. Appendix 4 (page 47) sets out more details about the financial position of IJBs in 2017/18. Many IAs have struggled to achieve financial balance at the year-end. The reasons for this vary but include rising demand for services, financial pressures and the quality of financial planning. In 2017/18, this resulted in several IJBs needing additional, unplanned allocations from their partners and adding to, or drawing on, reserves as follows:

- 17 needed additional money from NHS boards amounting to £33.3 million
- 11 needed additional money from councils amounting to £19.1 million
- eight drew on reserves amounting to £9.1 million
- 14 put money into reserves, amounting to £41.9 million.

13. Twenty-two IJBs are required by their integration schemes to produce a recovery plan if they forecast an overspend on their annual budget. Several IAs have had to produce recovery plans and are finding it harder to achieve the actions contained within them:

- In 2016/17, 11 IJBs needed to draw up a recovery plan. Of these, four IJBs achieved the actions set out in their recovery plans, but the remaining seven needed additional allocations from either their council or NHS board.
- In 2017/18, 12 IJBs needed to produce a recovery plan but only two achieved their recovery plans in full. In some cases, where additional allocations are required, the integration scheme allowed the NHS board or council to reduce the following year's allocation to the IJB by the same amount. In these circumstances there is a risk that IJBs will not have sufficient resources to deliver the services needed in future years.

14. An IA's integration scheme states how the IA will manage any year-end overspend and the responsibilities of the NHS board and council. For example, Fife IJB's integration scheme states that any overspend will be funded by partner bodies based on the proportion of their current year contributions to the IJB. In 2017/18, this meant that NHS Fife and Fife Council agreed to make additional contributions of 72 per cent and 28 per cent respectively.

15. The Highland Lead Agency model is also facing financial pressures. In 2017/18, NHS Highland overspent on adult social care services by £6 million. This was largely due to pressures on Highland Lead Agency adult social care services. This contributed to NHS Highland needing a loan of £15 million from the Scottish Government in 2017/18. Due to the way the Lead Agency model was established and the underlying agency agreement, the risks all rest with NHS Highland. Any increases in costs must be met by the NHS board.

16. Fourteen IJBs reported underspends in 2017/18 and these have arisen for a variety of reasons, for example: achieving savings earlier than expected; contingencies not being required; slippages in spending plans and projects; and staff vacancies.

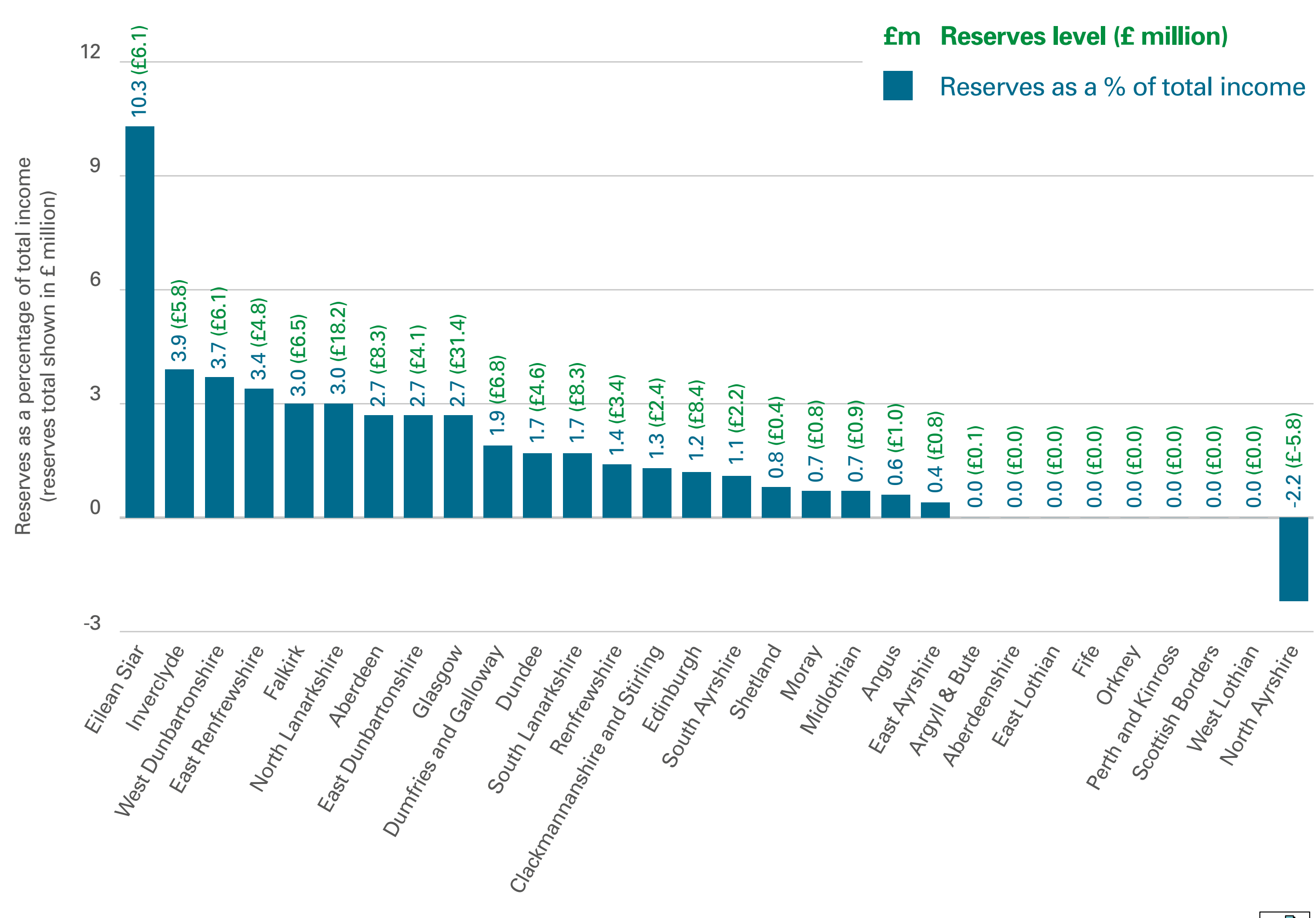
Reserves

17. The level of reserves held varies across IJBs, and not all integration schemes allow IJBs to hold reserves (Exhibit 3). In 2017/18, IJBs had built up reserves of £125.5 million, 1.5 per cent of their total income. This is not always a planned approach, and in some areas, reserves have arisen for several reasons including: the IJB receiving a late allocation of money; unspent strategic funding; staff vacancies; or year-end timing differences where money is received and allocated but unspent. Eilean Siar held the highest level of reserves as a percentage of its income at 10.3 per cent. The pressures on IJB budgets and the savings they need to achieve are significant, therefore the level of reserves in 2017/18 is not forecast to continue in future.

Exhibit 3

Reserves held by IJBs in 2017/18

There are significant differences in the levels of reserves held by IJBs.



Source: Integration Authority annual accounts, 2017/18

Hospital services have not been delegated to IAs in most areas

18. A key part of the reforms is that IJBs would direct some services provided directly within acute hospitals, to move care closer to people's homes and provide more joined-up care. Integration schemes, as approved by ministers, state that hospital services will be delegated to the IJB, as required under the Act. However, in practice, in most areas, the services have not been delegated. This has been a major source of debate and disagreement at a national and local level and is a fundamental issue which will hinder IJBs' ability to change the system.

19. The money for functions that are provided by large hospitals but are delegated to IJBs, such as unplanned care, is referred to as a 'set-aside' budget. Instead of paying this money to the IJBs along with payment for other delegated services, it is identified as a budget which should be directed by the IJB. The complexities around accurately preparing set-aside budgets has presented challenges to fulfilling this element of the Act. To date, the set-aside aspect of the Act is not being implemented. In line with Scottish Government guidance, NHS boards continue to manage the set-aside as part of their own resources.

20. In 2017/18, £809.3 million was included within IJBs' budgets for set-aside (where they were able to include a set-aside figure). This is 9.0 per cent of IJBs' income and is therefore a significant element of the health and social care budget that is not being directed by the IJBs. If IJBs are to use resources more strategically to prioritise prevention and care in a community setting, this issue needs to be resolved.

21. There are several reasons why all partners have struggled with this aspect of the Act, including fundamental issues in the data available to analyse set-aside-related activities. However, these technical issues do not appear to be the main issue. The main problem is a lack of common understanding and agreement on how to identify the set-aside budget and shared agreement on how to implement this aspect of the legislation.

Monitoring and public reporting on the impact of integration needs to improve

22. The context for integration is challenging, with many public bodies trying to work in partnership to achieve major changes while at the same time managing rising demand for services, financial pressures and continuing to deliver services and treat people. As we reported in *NHS in Scotland 2018*, the number of patients on waiting lists for treatment continues to rise while performance against targets is declining and an increasing number of NHS boards are struggling to deliver with the resources they have.[5] We have also reported that local government operates in an increasingly complex and changing environment with increasing levels of uncertainty.[6]

23. A significant number of measures are being used to monitor national and local progress which means IAs are reporting against a range of different measures to demonstrate progress (Exhibit 4, page 16). For the public to understand how the changes are working at a Scotland-wide level, these indicators need to be presented in a clear and transparent way.

24. It is important that the Scottish Government can demonstrate that resources provided have led to improvements in outcomes, in line with its national health and wellbeing outcomes. These outcomes are the Scottish Government's high-level statements of what health and social care partners are attempting to achieve through integration. These national outcomes are not being routinely reported at a national level, although IAs refer to them as part of their annual performance reports.

25. The Scottish Government introduced the National Performance Framework (NPF) in 2007 and launched a new framework in 2018. The NPF is made up of 11 national outcomes, each with indicators and aligned to the United Nations' sustainable development goals. There is a clear alignment between the aims of integration and several of the outcomes and indicators.[7]

26. The Ministerial Strategic Group for Health and Community Care brings together representatives from the Scottish Government, NHS, local government and IAs to monitor a set of six national indicators. These are used as indicators of the impact of IAs (Exhibit 5, page 18). These measures focus on the aim of integration helping to care for more people in the community or their own homes and reducing unnecessary stays in hospital. While these measures focus on health, performance can only improve with input from health and social care services. One of the six national indicators is supported by two measures: A&E attendances and achievement of the four-hour A&E waiting time target (3a and 3b at Exhibit 5, page 18).

27. Four of the indicators show improved performance, but there is significant local variation in performance between IAs. The performance measures do not themselves provide a direct indication of whether people's outcomes have improved, although they do represent key aspects of care which should ultimately improve people's lives.

Exhibit 4
Health and wellbeing outcomes and indicators
A significant number of measures are being used to monitor local and national progress.

National Performance Framework

Purpose

To focus on creating a more successful country, with opportunities for all of Scotland to flourish, through sustainable and inclusive economic growth

Values

We are a society which treats all our people with kindness, dignity and compassion, respects the rule of law, and acts in an open and transparent way

11 outcomes and 81 national indicators, for example:

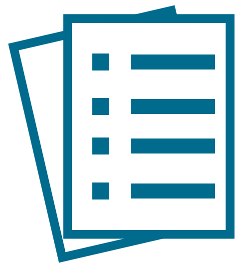
- **Outcome:** We are healthy and active
- **Indicators:** Healthy life expectancy, mental wellbeing, healthy weight, health risk behaviours, physical activity, journeys by active travel, quality of care experience, work-related ill health, premature mortality
- **Sustainable development goals:** gender equality, reduced inequalities, responsible consumption and production, good health and wellbeing

9 national health and wellbeing outcomes

- People are able to look after and improve their own health and wellbeing and live in good health for longer
- People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
- People who use health and social care services have positive experiences of those services, and have their dignity respected
- Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
- Health and social care services contribute to reducing health inequalities
- People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing
- People using health and social care services are safe from harm
- People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide
- Resources are used effectively and efficiently in the provision of health and social care services

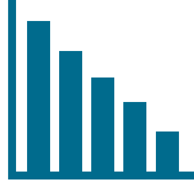
Cont.

Exhibit 4 (continued)



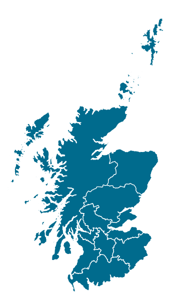
12 principles within the Act

- Be integrated from the point of view of the people who use services
- Take account of the particular needs of service users in different parts of the area in which the service is being provided
- Respect rights of service users
- Protect and improve the safety of service users
- Improve the quality of the service
- Best anticipate needs and prevent them arising
- Take account of the particular needs of different service users
- Take account of the particular characteristics and circumstances of different service users
- Take account of the dignity of service users
- Take account of the participation by service users in the community in which service users live
- Is planned and led locally in a way which is engaged with the community
- Make best use of the available facilities, people and other resources



6 national indicators

- Acute unplanned bed days
- Emergency admissions
- A&E performance (including four-hour A&E waiting time and A&E attendances)
- Delayed discharge bed days
- End of life spent at home or in the community
- Proportion of over-75s who are living in a community setting



Various local priorities, performance indicators and outcomes

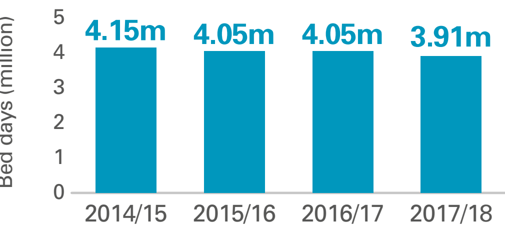
Source: Audit Scotland

Exhibit 5

National performance against six priority areas

National performance shows signs of improvement in some of the six key national indicators.

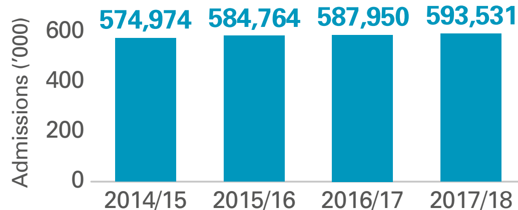
1. Acute unplanned bed days



Integration aims to reduce unplanned hospital activity

The number of acute unplanned bed days has reduced since 2014/15

2. Emergency admissions

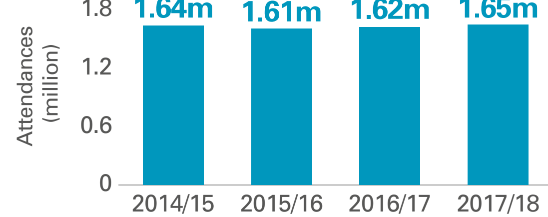


Integration aims to ensure that people's health and care needs are anticipated and planned appropriately, reducing unplanned hospital activity

The number of emergency admissions has risen each year since 2014/15

In 2017/18, local performance varied from 0.08 emergency admissions per head of population in NHS Orkney to 0.15 in NHS Ayrshire and Arran

3a. A&E attendances

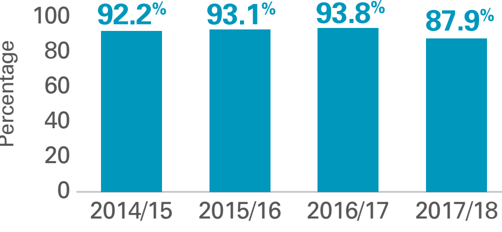


A&E attendances can be an indication of the degree to which community services are helping people receive care in the right place at the right time.

The number of A&E attendances has marginally increased since 2014/15

In 2017/18, local performance varied from 0.2 A&E attendances per head of population in NHS Grampian to 0.4 in NHS Greater Glasgow and Clyde

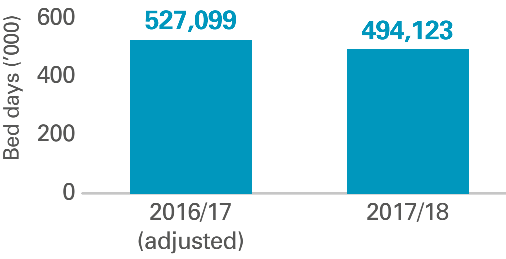
3b. Achievement of the four-hour A&E waiting time target



The achievement of the four-hour waiting time target has declined since 2014/15

Local performance varied in 2017/18 from 98.0% NHS Tayside to 75.4% NHS Lothian

4. Delayed discharge bed days (for population aged 18+)



Reducing delays in discharging people from hospital has been a long-standing aim for health and care services. With rising demand, some areas have struggled with this. Due to changes in data collection, comparable data is only available for two years.

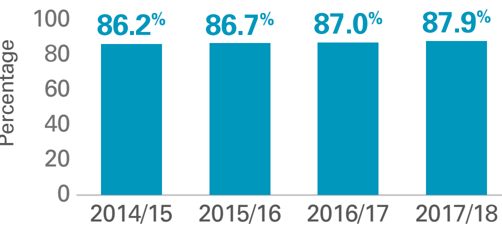
Delayed discharge rates have fallen since 2016/17

In 2017/18, local performance varied from 2.5% in Inverclyde to 26.5% in Eilean Siar delayed discharge bed days as a percentage of their population (18+)

Cont.

Exhibit 5 (continued)

5. End of life spent at home or in the community

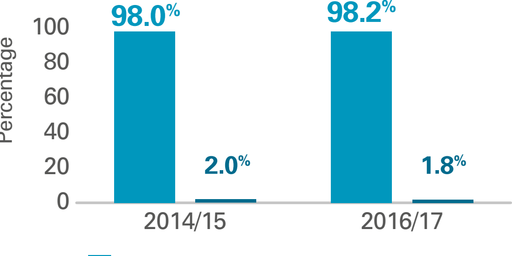


Integration aims to support people with health and care needs in their own home or in a community setting, especially at the end of life.

A gradual increase in the percentage of people's time spent at home or in a homely setting at the end of their life

In 2017/18, local performance varied from 95.1% of people's time spent at home or in a homely setting at the end of their life in Shetland to 85.2% in East Renfrewshire

6. Percentage of 75+ population in a community or institutional setting



Community setting (at home or care home)

Institutional setting (hospice or hospital)

Integration aims to shift the balance of care from an institutional setting to a community setting.

There has been a slight increase in the percentage of individuals aged over 75 who are living in a community setting. This is in line with the intentions of the Act.

Notes:

Indicator 1

1. These statistics are derived from data collected on discharges from non-obstetric and non-psychiatric hospitals in Scotland. Only patients treated as inpatients or day cases are included. The specialty of geriatric long stay is excluded.
2. Bed days for each year have been calculated based on the year in which the bed days were occupied. This differs from other analysis where length of stay or occupied bed days are reported by the year of discharge.
3. Unscheduled bed days relate to all occupied bed days within a continuous hospital stay following an emergency or urgent admission.
4. The Scotland total presented is the sum of all those resident in IA areas and excludes non-Scottish residents.
5. Approximately a quarter of IAs returned figures for people aged over 18 only. Where this is the case, bed days from 2016/17 for people aged under 18 in those partnerships have been applied to 2017/18 figures.
6. Based on data submitted to ISD in August 2018.

Indicator 2

1. ISD published data as at September 2018.

Indicator 3a

1. ISD published data as at August 2018.

Indicator 3b

1. ISD published data as at June 2018.
2. Performance for the month ending March for each year.

Indicator 4

1. ISD published data as at September 2018.
2. 2016/17 figures adjusted to reflect revised definitions across the whole year.

Indicator 5

1. ISD published data as at October 2018.

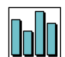
Indicator 6

1. Percentage of 75+ population in a community or institutional setting:
   - Community includes the following:
     - Home (unsupported) – refers to the percentage of the population not thought to be in any other setting, or receiving any homecare, on average throughout the year.
     - Home (supported) – refers to the percentage of the population estimated as receiving any level of homecare. Estimated from social care census carried out at the end of the reporting year (eg, Census carried out in March 2014 used to estimate home (supported) population during 2013/14).
     - Resident in a care home – based on care home census at the end of the reporting year (eg, Census at 31 March 2014 used to estimate 2013/14 care home population). The care home data is based on long-stay residents only. The proportion of incomplete long-stay residents aged 75+ cannot be calculated. Therefore, a scaling factor, based on the 65+ proportions, has been employed for the 75+ data. This assumes that there is the same degree of incompleteness in the census data returned for adults in each of the age bands.
   - Institutional includes the following:
     - Average population in hospital/hospice/palliative care unit throughout the year.
     - Hospital includes both community and large/acute hospitals.
     - Hospice activity is based on SMR records and will be incomplete as not all hospices submit this information.
2. Figures provided by ISD.

General

1. Population figures used taken from the National Records of Scotland mid-2017 estimates published in 2018.
2. Figures relate to all ages unless otherwise stated.

Source: Information Services Division (ISD) and Scottish Government



Integration Authorities' performance reports show local improvement

28. IAs are required to publish annual performance reports which contain information on local priorities and a range of local initiatives (Exhibit 6). These reports are an important way for IAs to inform the public about how well they have been performing against their stated priorities. The improvements that are set out in the performance reports are welcome and current pressures across the system have made them difficult to achieve. However, core indicators of performance are not improving in all areas of Scotland and nationally it is clear that there is much more to be done.

Exhibit 6

Examples of impact from integration

IAs have set out a number of local improvements in their performance reports.

Prevention and early intervention

Dumfries and Galloway

The D&G Handyvan provides information, advice and practical assistance with adaptations to people's homes. This is available to disabled people of any age and older people aged 60 and over. People are also supported to access financial assistance for major adaptations. This service helps people to feel more confident about continuing to live independently in their own home and to feel safe and secure in their home. People are less likely to have a fall, have improved health and wellbeing, and have a better quality of life. Often adaptations support people to be better connected with their friends and family and their wider community. 1,626 referrals were received during 2017/18. These resulted in 2,149 tasks being carried out by the service. 808 people were referred to prevent a fall, 577 people for home security, 16 people for minor adaptations and 225 people for small repairs.

Dundee

Social prescribing 'Sources of Support' (SOS) is one means of supporting people to better manage their health conditions. Link workers, working within designated GP practices, take referrals for people with poor mental health and wellbeing affected by their social circumstances and support them to access a wide range of non-medical services and activities that can help. In 2017/18, 256 patients were referred to three link workers and 220 people were supported. An external evaluation demonstrated that the service had a positive impact on both clients and on GPs themselves. 65 per cent of patient goals were met and 84 per cent had some positive outcome, including decreased social isolation, improved or new housing, financial and benefits issues being addressed, and increased confidence, awareness and self-esteem.

Outcomes from a GP perspective include reduced patient contact with medical services, providing more options for patients, raising awareness of non-clinical services, and increased GP productivity. 2017/18 saw a major scale-up of the SOS scheme through the Scottish Government Community Link Worker programme, extending the service from four GP practices to 16.

Delays in people leaving hospital

East Ayrshire

The Red Cross Home from Hospital Service supported about 1,700 people in 2017/18. The service is delivered across Ayrshire and Arran from University Hospitals Crosshouse and Ayr and supports people to be discharged as early as possible, reducing their length of stay and re-settling them in their home. Once home, the service helps to prevent falls and reduce social isolation, supporting people to regain their confidence, skills for living independently and organises telecare to support families to continue to care. A total of 1,730 bed days have been saved, equivalent to £302,750. 73 admissions to hospital have been avoided, and 625 bed days saved, equivalent to £109,375.

Perth and Kinross

There have been increases in staffing within social care discharge teams, Perth Royal Infirmary liaison services, and care home nursing. This, alongside improved funding procedures for care home placements, has supported speedier discharge to a care home setting or repatriation to such. There has been a reduction of 2,391 (12.5 per cent) delayed discharge bed days between 2016/17 and 2017/18 to 16,785.

Cont.

Exhibit 6 (continued)

Preventing admission to hospital

East Dunbartonshire

Rapid Response Service has established a different referral route for patients between A&E and the Community Rehabilitation Team to provide next-day response. During 2017/18, the service prevented approximately 33 per cent of people referred being admitted to hospital.

South Ayrshire

The Intermediate Care Team provide rapid multidisciplinary team support to people to support them to return home from acute hospital and to remain at home through GP referral. In particular, they have worked closely to establish pathways with the Combined Assessment Unit to prevent admission. The service provided by the Intermediate Care Team resulted in 674 hospital admissions being avoided and 301 early supported discharges during 2017/18. It is estimated locally that each avoided hospital admission saves five hospital bed days and each supported discharge saves three hospital bed days. Overall, it is estimated that the intervention provided by the Intermediate Care Team saved 3,370 bed days due to avoided admissions and 903 bed days due to early supported discharges.

Aberdeenshire

Set up in 2016, Aberdeenshire's Virtual Community Ward (VCW) aims to avoid unnecessary hospital admissions through bringing together multidisciplinary health and social care teams who provide care for patients who need regular or urgent attention. This GP-led approach involves the teams working closely together, generally meeting daily under a huddle structure. They identify and discuss vulnerable/at risk patients and clients, and coordinate, organise and deliver services required to support them. The VCW identifies individuals who need health and social care services at an earlier stage, which can improve patient outcomes and experience. Based on an evaluation carried out by the VCW team, 1,219 hospital admissions have been avoided because of the VCWs .

Referral/ care pathways

Aberdeenshire

During 2017/18 a test of change was carried out in one GP practice to trial people's first appointment with a physiotherapist rather than a GP. Ongoing evaluation suggests that this has been successful and has proved popular with patients who now have immediate access to a physiotherapist for assessment and advice. If follow up is required, this can be booked at the time. 221 people have been directed to the physiotherapist first; only 58 per cent required a face-to-face appointment and 26 per cent were discharged following telephone advice.

Renfrewshire

Over the past three years, the Primary Care Mental Health Team (Doing Well) has introduced a self-referral route to the service. This has led to a decrease in clients attending a GP to be referred to the mental health team. The number of self-referrals to the service has increased from 207 in 2013/14 to 1,237 in 2017/18. This self-referral route has successfully redirected work away from GP surgeries.

Midlothian

An advanced practitioner physiotherapist for Chronic Obstructive Pulmonary Disease (COPD) was appointed to support people attending hospital frequently because of their COPD to help them manage their symptoms at home and avoid admission to hospital. In the first year the service has worked with 65 patients and successfully avoided 30 hospital admissions. This delivered a potential reduction of 520 days spent in hospital by Midlothian residents and a much better patient experience. It was also a more cost-effective approach to delivering services for the partnership.

Cont.

Exhibit 6 (continued)

Reablement

Falkirk

A Reablement Project Team (RPT) was developed in Social Work Adult Services Assessment and Planning service in January 2017 to test out various reablement approaches and processes. The team consists of occupational therapists (with community care worker background) and social care officers. The reablement team support service users for up to six weeks. Individuals are reviewed on a weekly basis and care packages are adjusted as the person becomes more independent. Fewer people required intensive packages at the end of six weeks, which has freed up staff time and has reduced the use of external providers. Early indications suggest this work has led to a £200,000 reduction in purchasing care from external homecare providers.

Scottish Borders

The Transitional Care Facility based within Waverley Care Home is a 16-bed unit which allows older people to regain their confidence and independence so that they can return to their own homes following a stay in hospital. The facility is run by a multidisciplinary team of support workers, allied health professionals and social workers. 81 per cent of individuals discharged from Transitional Care return to their own homes and the hospital readmission rate for these individuals is six per cent.

Pharmacy

South Lanarkshire

The pharmacy plus homecare initiative has created an opportunity to amend consultant and GP prescribing practices. A reduction in prescribing can lead to less homecare visits. The IA estimates that savings could be in the region of £1,800 per patient (within the trial).

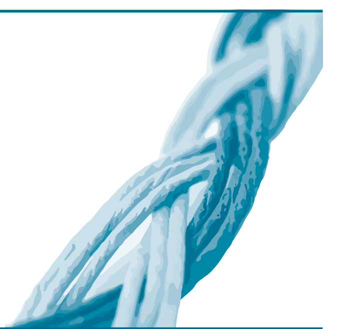
Angus

The Angus IA has improved how care homes manage medication. A new process developed by a Locality Care Home Improvement Group with GPs and pharmacy has led to zero medication waste in care homes.

Source: Audit Scotland review of Integration Authorities' Performance Reports, 2018

Part 2

Making integration a success

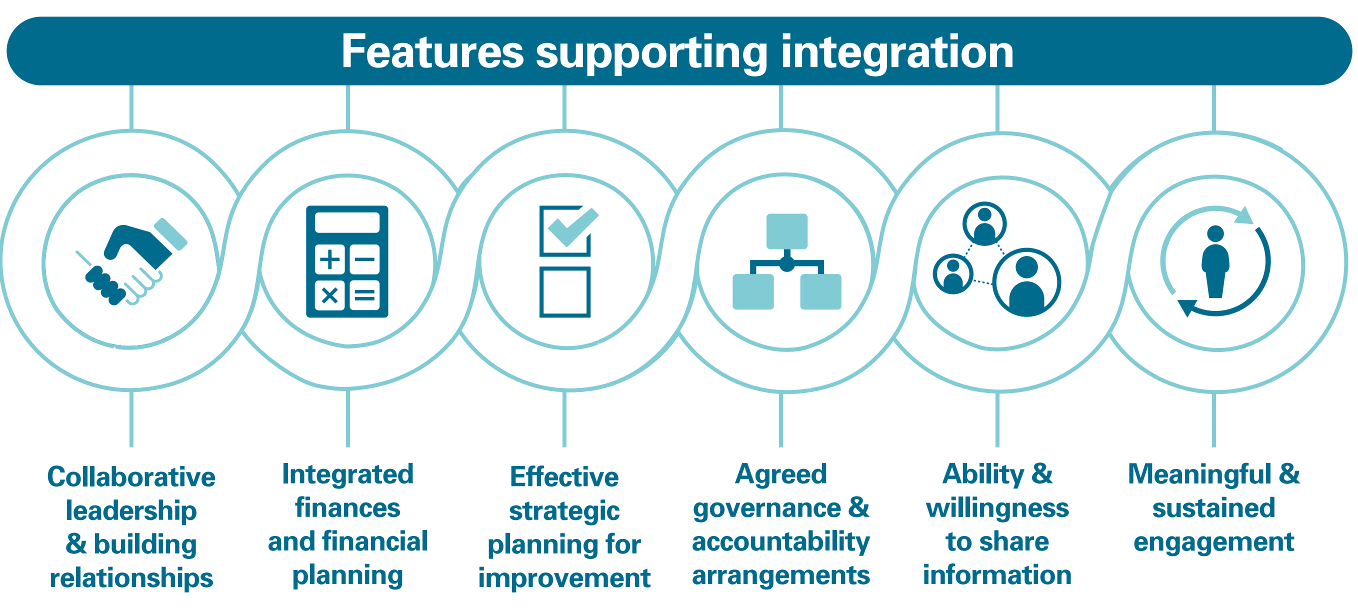


29. IAs are addressing some significant, long-standing, complex and inter-connected issues in health and social care. Our work has identified six key areas that, if addressed, should lead to broader improvements and help IAs to take positive steps toward making a systematic impact on health and care outcomes across their communities (Exhibit 7).

Exhibit 7

Features central to the success of integration

Six areas must be addressed if integration is to make a meaningful difference to the people of Scotland.



Source: Audit Scotland

A lack of collaborative leadership and cultural differences are affecting the pace of change

30. High-quality leadership is a critical part of the success of an organisation or programme of reform. Given the complexity of health and social care integration, it is important that leaders are highly competent, have capacity to deliver and are well supported. For transformation to succeed, the right leadership and strategic capacity need to be in place. Without this, the reforms will not succeed. We identified several risks in this area which need to be addressed:

- A significant number of IAs have had leadership changes with 57 per cent having had changes in their senior management team. As at October 2017, seven IJBs have a different Chief Officer (CO) in post than two years previously.
- There is significant variation in the role and remuneration of COs and Chief Financial Officers (CFO). Many have dual roles with positions held in partner organisations and there is a mix of full and part-time CFOs. This is a significant challenge, given the scale of the task facing IAs and the strategic role COs and CFOs have in directing change. In 2017/18, £3 million was spent on IJBs' CO remuneration and there are differences in salary levels, in part reflecting differences in roles and responsibilities.
- There is evidence of a lack of support services for IAs, in relation to HR, finances, legal advice, improvement, and strategic commissioning. This will limit the progress that they are able to make. It is important that the partner bodies support the IJB, including support services.

31. Top-down leadership which focuses on the goals of a single organisation does not work in the context of integration. NHS Education Scotland has described 'systems leaders' as having an ability to 'have a perspective from the wider system. They recognise that it is necessary to distribute leadership responsibilities to bring about change in a complex interdependent environment…They change the mind-set from competition to cooperation. They foster dialogue… which can result in new thinking… When leadership involves such a collective endeavour, the way people see their accountability matters.'[8] A lack of collaborative systems leadership and difficulties in overcoming cultural differences are proving to be significant barriers to change.

32. Leaders from all partners are operating in a complex and continually changing landscape and, without appropriate support in place, cannot fulfil their role effectively. Leaders need support if they are to deliver public services to improve wider outcomes and work collaboratively across organisational boundaries. This is hard to achieve, especially where there have been changes in key staff and local politicians, and in the context of the current financial and performance pressures. Accountability arrangements are important to encourage and incentivise the right kinds of leadership characteristics.

33. Cultural differences between partner organisations are proving to be a barrier to achieving collaborative working. Partner organisations work in very different ways and this can result in a lack of trust and lack of understanding of each other's working practices and business pressures. In better performing areas, partners can identify and manage differences and work constructively towards achieving the objectives of the IA. Overcoming cultural differences and improving understanding of each other's businesses will help partner organisations progress towards integration, particularly regarding integrated finances. Joint leadership development for people working in NHS boards, councils and IJBs can help with this. Exhibit 8 (page 25) provides an overview of the common leadership traits which are important in integrating health and social care services.

Exhibit 8
Traits of effective collaborative leaders
There are a number of leadership traits which are important in integrating health and social care services.

Influential leadership

- Clear and consistent message
- Presents a positive public image
- Ability to contribute towards local and national policy
- Shows an understanding of the value of services

Ability to empower others

- Encourages innovation from staff at all levels
- Non-hierarchical and open to working alongside others
- Respectful of other people's views and opinions
- Inspiring to others
- Creates trust
- Willing to work with others to overcome risks and challenges

Promotes awareness of IA's goals

- Confidence and belief in new technology to facilitate progress
- Facilitates planning of sustainable services
- Recruitment of staff to fit and contribute to a new culture
- Sets clear objectives and priorities for all
- Develops widespread belief in the aim of the integrated approach to health and social care

Engagement of service users

- People who use services feel able to contribute to change
- Ability to facilitate wide and meaningful engagement
- Open to and appreciative of ideas and innovation
- Ensures voices are heard at every level
- Transparent and inclusive

Continual development

- Encourage learning and development, including learning from mistakes
- Belief in training and understanding of who could benefit from it
- Encourage innovation, debate and discussion
- Driven to push for the highest quality possible

Source: Audit Scotland, 2018; from various publications by The Kings Fund; Our Voice; Scottish Government; Health and Sport Committee and the Scottish Social Services Council.

34. We have seen examples of good collaborative and whole-system leadership, including in Aberdeen City, where relationships have been built across the partnership. Although differences of opinion still exist and there is healthy debate, Aberdeen City is now better placed to implement widespread changes to improve outcomes. We saw:

- the promotion of a clear and consistent message across the partnership
- a willingness to work with others to overcome differences
- recruitment of staff to fit and contribute to a new culture
- development of openness and appreciation of ideas
- encouragement of innovation, learning and development, including learning from mistakes.

35. The Scottish Government and COSLA are co-chairing a group involving leaders from across councils and NHS boards. The aim of the group is to identify and overcome barriers to integration. The group has produced a joint statement on integration, confirming the shared responsibility of the Scottish Government, NHS Scotland and COSLA for ensuring the successful integration of Scotland's health and social care services. The statement acknowledges that the pace of integration needs to improve, and that the group needs to work together to achieve integration and to overcome challenges to better meet people's health and social care needs. The group is developing further support and training to support leadership for integration. The Scottish Government and COSLA are also co-chairing an Integration Review Reference Group. This group is reviewing progress on integration and will report its findings to the Ministerial Strategic Group for Health and Community Care. The group will conclude its work in January 2019. We will continue to monitor any actions resulting from the work of the group.

Integration Authorities have limited capacity to make change happen in some areas

36. IJBs are very small organisations, all of which have a CO and a CFO. Not all IJBs have the support they need, for example only half of IJBs have a full-time CFO and there have been difficulties in filling those posts in some areas. Each IJB has a chair and vice chair, but we have been told that many IJBs rely on its members working much more than contracted hours, and chairs and vice chairs have told us that they struggle to attend to IJB business during contracted time. Each IJB is made up of voting and non-voting members.

IJB membership (page 10)

37. Typically, an IJB meets about six times a year. The IJB also has one or more Strategic Planning Group, which are consulted and give feedback on strategic plans and significant changes to integrated functions. For this structure to work, the IJB needs to draw on, and be supported by, skills and capacity from its partner NHS board and council. This can lead to a reliance on information and advice being provided by the statutory partner organisations which influences the decisions made by the IJB. In areas where information is being shared across the partnership, we can see that more progress is being made with integration. We saw this happening in Aberdeen City IJB, where senior officer and finance officer groups bring together staff from across partner organisations to share information and skills which are essential for joint decision-making. If this does not happen, the IJB has less capacity to make change and address challenges.

38. We saw several barriers affecting the way that IJBs are operating, and more action is needed to increase knowledge and understanding of those involved in the decision-making process:

- Topics for discussion at IJB and committee meetings are affected by problems with both the lack of time available and with people's knowledge.
- IJB papers are often lengthy and issued to members within timescales that do not allow for proper consideration.
- Papers are often technical and contain complicated financial information that lay representatives and representatives from voluntary sector bodies may struggle to understand.
- Officers are limited in the time available to provide IJBs with information. Many officers of the IJB fulfil their role alongside roles held within statutory partner bodies.
- High turnover of people in key positions in IJBs has affected the skills available and has led to a lack of continuity and extra time being spent in building trust and relationships.

Good strategic planning is key to integrating and improving health and social care services

39. In the past, health and social care services have not linked the resources they have to their strategic priorities or longer-term plans. IAs still have work to do to ensure that priorities are linked to available resources, and to demonstrate that new ways of working will be sustainable over the longer term. IAs can only achieve this change with the support and commitment of NHS boards and councils.

40. IJBs, with the support of council and NHS board partner bodies, should be clear about **how** and **when** they intend to achieve their priorities and outcomes, in line with their available resources; and ultimately how they intend to progress to sustainable, preventative and community-based services. This includes working with NHS boards and councils to: agree which services will be stopped or decommissioned to prioritise spend; plan effective exit strategies from current ways of delivering services; and being clear how they will measure improvements in outcomes. Exit strategies are an important element in the ability to move from one service provision to another.

41. Scenario planning will help IAs build a picture of what they will need in the future. This involves looking at current trends, such as the effects of an ageing population, current lifestyles and future advances in health and social care. IAs should then use this analysis to anticipate potential changes in future demand for services and any related shortfalls in available finances. Strategic planning groups of the IJB have a role to play in ensuring the needs of the community are central to service decisions (Case study 1, page 28).

Case study 1

Shetland Scenario Planning

As part of its Strategic Commissioning Plan, the Shetland IA identified a growing gap between service demand and resources. To support strategic planning, NHS Shetland hosted a session with health and social care staff, IJB representatives, NHS board representatives, councillors, community planning partners, third-sector organisations and representatives of people using services. It considered several high-level scenarios:

1. the lowest level of local healthcare provision that it could ever safely and realistically imagine being delivered on Shetland 5-10 years from now
2. a lower level of local healthcare provision in 5-10 years than it has now on Shetland – a 'step down' from where it is now in terms of local service delivery
3. a higher level of local healthcare provision in 5-10 years than it has now on Shetland – a 'step up' from where it is now in terms of local service delivery
4. a future that describes the highest level of local healthcare provision that it could ever realistically imagine being delivered on Shetland 5-10 years from now.

The group then concentrated on scenarios 2 and 3 and explored them in more detail.

This systematic approach towards strategic planning, involving a wide variety of stakeholders, allowed them to build consensus on the main priorities of the IJB. The key outputs from the scenario planning exercise involved clear actions that were linked to a wide range of plans and policies. The key messages from the scenario planning formed discussion points within the IJB meetings. Actions identified were then incorporated into the business programme and an action tracker is a standing agenda item.

Source: Shetland IJB, 2018

42. Although strategic planning is the statutory responsibility of the IAs, councils and NHS boards should fully support the IJB and provide the resources needed to allow capacity for strategic thinking. In addition, the Scottish Government has an important role to play in leading and enabling change to take place. There must be a consistent message and understanding of integration, but this is not always the case. For example, the current move towards some aspects of health planning taking place at a regional level is causing uncertainty for IAs. Many IAs are unclear as to how this fits with the need for local strategic planning and decision-making. For IAs to think long term, they must have confidence that Scottish Government policy will support integrated thinking.

43. Strategic planning also helps to encourage and promote joined-up working and a commitment to scaling up new ways of working. Angus IJB has shown a strong long-term commitment to its enhanced community support model. This has now been implemented in three of its four locality areas and therefore has the potential for long-term impact on people’s outcomes (Case study 2, page 29).

Case study 2

Angus – Enhanced community support model

Angus IJB's Enhanced Community Support (ECS) workstream involves several multi-professional teams working together, including the third-sector. The teams provide care and support in people's own homes so that, where possible, hospital admission is avoided. As a result, staff can be more proactive, coordinate care and make referrals for additional support more quickly. The teams also hold weekly meetings to review the care that is being provided in a more coordinated way.

ECS has increased community and primary care capacity leading to an average of 37 empty hospital beds across Angus per day in 2017. This helped the IJB to close 21 of its 126 community hospital inpatient beds which are no longer needed. ECS has improved hospital readmission rates. It has also improved prevention and early intervention activity through an increase in the number of anticipatory care plans.

ECS has led to a more joined-up approach between the professional disciplines which has improved referral times and access to support. This has allowed people to be more independent, access local services and be supported to stay in their homes or a homely setting for longer.

The success of this approach has allowed the IJB to roll ECS out to three of its four localities, with plans to roll out to the final locality during 2018/19. The localities that have adopted this approach for the longest have seen improvements in the average length of stay and a reduction in the number of hospital admissions for people aged over 75.

Source: Angus IJB, 2018

44. A small number of IAs do not have detailed implementation/commissioning plans to inform their strategic plan. Of those which do, about half of these provide a link to resources. More needs to be done to show how the shift from the current ways of working to new models of care will happen and when positive changes to people's lives will be achieved.

45. Workforce pressures are a clear barrier to the implementation of integration plans and workforce planning is a particularly important element of strategic planning. Workforce planning remains the formal responsibly of councils and NHS boards. However, IJBs need to work closely with their partners to ensure that their plans for service redesign and improvement link with and influence workforce plans. IAs must be able to demonstrate what skills are required to ensure they can deliver services in the right place at the right time. IAs identify not being able to recruit and retain the workforce they need as a risk. The contribution of the third and independent sector should be part of workforce planning.

46. All three parts of the Health and Social Care National Workforce Plan have now been published, with the final part on the primary care workforce published in April 2018.[9] In our 2017 report, *NHS workforce planning*, we recommended that there is a need to better understand future demand and to provide a breakdown of the cost of meeting this demand.[10] We will publish a further report on workforce planning and primary care in 2019.

Housing needs to have a more central role in integration

47. Not enough links are being made between housing and health and social care which will improve outcomes and wellbeing. Housing services are an integral part of person-centred approaches and the wider delivery of health and social care integration. All IAs are required to include a housing contribution statement in their strategic plans and housing representation is mandatory on Strategic Planning Groups. Case study 3 illustrates strategic thinking within Glasgow City IJB which has used housing as a central aspect of health and social care. Three-quarters of IJBs reported some involvement of housing services in the planning of integrated health and social care services, although we found that the extent of this involvement varied greatly between partnerships.

Case study 3

The Glasgow Housing Options for Older People (HOOP) approach

The HOOP approach involves a small team working closely with social work, health and Registered Social Landlords (RSLs). The approach aims to: ensure a smooth transition for people from hospital to a homely setting; work closely with RSLs to prioritise people who are experiencing a delay in being discharged from hospital; develop knowledge of housing stock availability; and provide reciprocal information about RSLs tenants in hospital.

The team has worked on about 1,200 cases with surgeries in 19 sites across seven hospitals, six social work offices and six intermediate care units. The outcomes of the approach include helping:

- older people make informed choices along with their families, irrespective of tenure issues
- older people to return home or to community settings supported by a care package
- to reduce delayed discharge where there are housing issues
- prevent hospital admission and readmission, supporting older people with housing issues remain in the community
- secure appropriate accommodation for older people across the city suitable for their medical needs
- to increase knowledge of Glasgow's complex housing landscape among social workers and health professionals
- housing colleagues increase their knowledge about social work and health assistance to support older people returning home from hospital
- to future proof the city's new build investment by sharing information on customer needs and demand.

Source: Glasgow City IJB, 2018

Longer-term, integrated financial planning is needed to deliver sustainable service reform

48. Partners are finding it very difficult to balance the need for medium- to long-term planning, typically three to five years and five years plus, alongside annual settlements, current commitments and service pressures. We have called for longer-term financial planning in the health sector and local government for many years. While all IAs have short-term financial plans, only a third have medium-term plans and there were no longer-term plans in place at the time of our fieldwork. This is a critical gap as the changes under integration are only likely to be achieved in the longer term.

49. The Accounts Commission has previously reported that the 'Evidence from councils' annual audit reports generally demonstrates good medium-term (three to five years) financial planning, with some councils using scenario planning to provide a range of options'.[11] IAs should draw on the experience from councils to inform development of longer-term financial plans.

50. There is little evidence that councils and NHS boards are treating IJBs' finances as a shared resource for health and social care. This is despite the requirement to do this in the legislation, and budget processes set out in integration schemes describing budget-setting based on need. Partners must work with the IJBs to establish an approach to financial planning that considers the priorities of health and social care in the local community. Councils and NHS boards can be unwilling to give up financial control of budgets and IJBs can struggle to exert their own influence on the budget-setting process.

51. National data on the balance of spending between institutional care and care in the community is only available up to 2015/16. While this does not reflect any impact from IAs, it shows that the balance of spending changed little between 2012/13 to 2015/16 (Exhibit 9, page 32). Although this data is still collated, it is no longer published. This data should be publicly available and is a helpful indicator of whether IAs are influencing the shift of resources.

52. In October 2018, the Scottish Government published its *Medium Term Health and Social Care Financial Framework*.[12] The Framework is intended to help partners to improve strategic planning. It covers the period 2016/17 to 2023/24, and sets out trends in expenditure and activity, future demand and the future shape of health and social care expenditure.

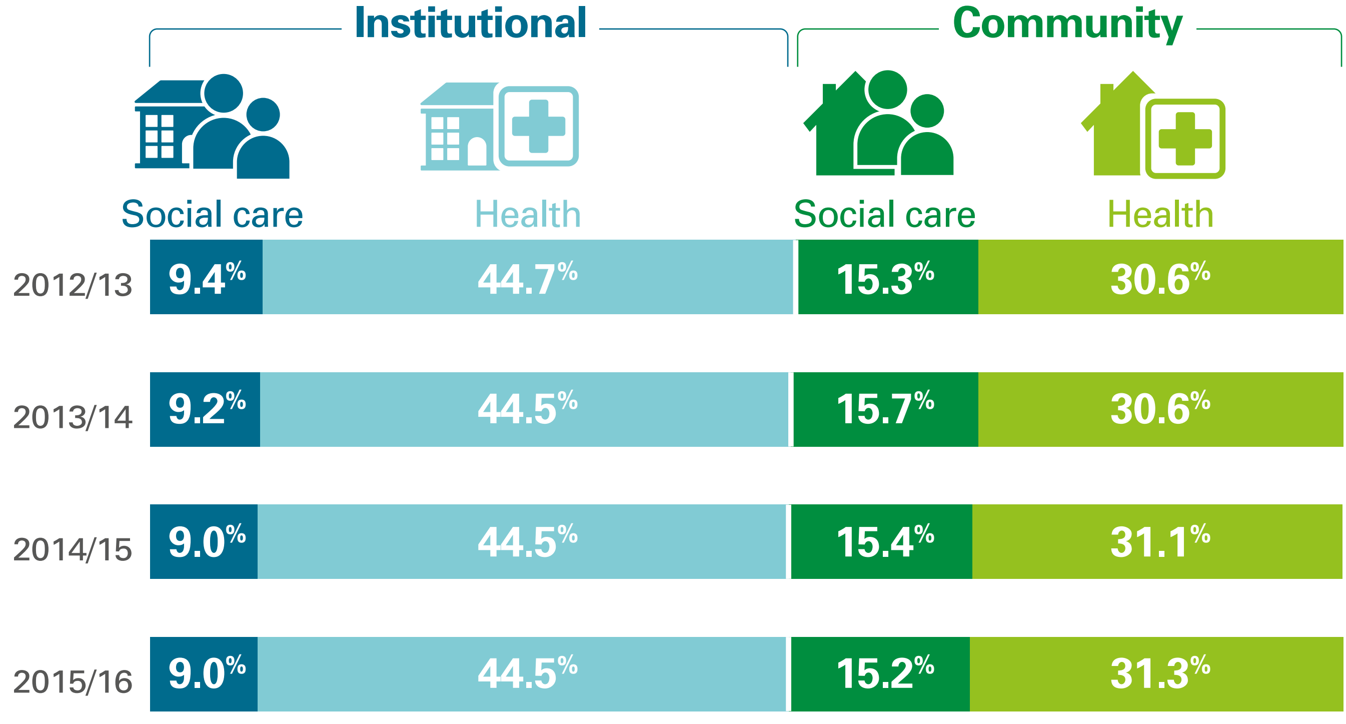
53. Attempts at integrating health and social care go back several years and it is not possible to identify the full cost of the reforms. This, in part, is due to the scale of the reforms and the interconnectedness with the rest of the health and social care system.

54. Due to ongoing financial pressures, most new service initiatives have been funded using additional financial support from the Scottish Government, rather than through the re-distribution of health and social care resources. Therefore, there should be an ongoing commitment from the Scottish Government to provide continued additional funding over coming years. This will provide financial stability to IAs while they implement new ways of working and plan how to redirect funding from current services.

Exhibit 9

The percentage of expenditure on institutional and community-based care

The percentage of expenditure on institutional and community-based care remained static between 2012/13 – 2015/16.



Source: Information Services Division, 2018

55. Major reforms have benefited from a degree of 'pump priming' money to help with change. In 2017/18, IAs total income included national funding which has been directed through NHS budgets, of:

- £100 million from the Integrated Care Fund to help shift the balance of care
- £30 million to help tackle delayed discharges
- £250 million to support payment of the living wage and help establish integration in its first year. This increased by £107 million in 2017/18.

56. The ring-fencing of funding intended to support delegated functions has not helped IAs' efforts to redirect resources, reducing their ability to use their resources flexibly. There are examples of small-scale transfers of resources and we appreciate that more time is needed for IAs to achieve this change (Case study 4, page 33). IAs need to demonstrate how they will sustain any improvements if specific dedicated funding is no longer available.

Case study 4

South Lanarkshire redirecting resources to provide more community-based care

In 2017, South Lanarkshire IJB decided to close 30 care of the elderly beds within Udston Hospital and invest in alternative community-based models of care. An assessment of need found that two-thirds of individuals on the ward could have been better cared for within a community setting. Recurring funding of about £1 million per annum was released as a result. The IJB planned for £702,000 of this to be redirected to community-based services, such as homecare and district nursing to build the area's capacity to support more people at home. To achieve this:

- engagement plans were developed to ensure people using care and their families, staff and elected members of the Udston area were involved in the changes
- financial modelling was undertaken to understand the profile of people on the ward and reallocate resources to more appropriate, alternative health and social services
- the IA worked in partnership with NHS Lanarkshire to ensure good governance.

The £702,000 provided a degree of financial flexibility to further develop intermediate care services and increase community-based rehabilitation services. The IJB plans to redesignate the Udston beds for use by step-down intermediate care patients to support a reduced reliance on the hospital and residential care.

Source: Bed Modelling in South Lanarkshire, IJB board paper, 30 October 2017

Agreeing budgets is still problematic

57. Fifteen IAs failed to agree a budget for the start of the 2017/18 financial year with their partners. This is partly down to differences in the timing of budget settlements between councils and NHS boards. It can also be due to a lack of understanding between councils and NHS boards of each other's financial reporting, accounting arrangements and the financial pressures faced by each. This lack of understanding can cause a lack of trust and reluctance to commit funds to an integrated health and social care budget.

58. There are difficulties with short-term and late budget settlements, but this should not preclude longer-term financial planning. IAs will only be able to plan and implement sustainable services if they are able to identify longer-term costs and funding shortfalls. This will also help to plan effective exit strategies from current services and larger-scale transfers of resources to community-based and preventative services.

It is critical that governance and accountability arrangements are made to work locally

59. Integrating services is a significant challenge, particularly when partners are dealing with current demand and constrained resources, while trying to better understand how services need to change. The Act should be a basis for all local partners to come together to implement changes. A perceived lack of clarity in the Act is adding to local disagreements and is delaying integration. This lack of clarity and misunderstanding is evident even among people working at senior levels and can impede good relationships.

60. Having a clear governance structure where all partners agree responsibility and accountability is vital. Disagreements can be particularly apparent when it is perceived that accountability for a decision rests with individuals who no longer have responsibility for taking them. Chief executives of councils and NHS boards are concerned that they will be held accountable for failures in how services are delivered when they are no longer responsible for directing those services. In practice, partners need to set out how local accountability arrangements will work. Integration was introduced to shift from a focus on what worked for organisations to what works for the person who needs a health and social care service. Applying this approach should help partners to implement the Act. In some areas partners are working through governance challenges as they implement the Act, and more should be done to share this experience.

61. Our first report on the integration of health and social care recommended that integration partners 'need to set out clearly how governance arrangements will work in practice…This is because there are potentially confusing lines of accountability...People may also be unclear who is ultimately responsible for the quality of care.' Clarity is still needed for local areas over who is ultimately responsible for service performance and the quality of care. In some instances, this uncertainty is hampering decision-making and redesign of services provision. Not enough has been done locally to address this.

62. IJBs have a commissioning role but most IJB COs also have delegated operational responsibility for those functions and services that are delegated to the IJB, with the exception of acute care. There are difficulties in understanding how the 'operational responsibility' aspect works in practice. Auditors report that members of IA leadership teams have differing views about governance, especially clinical governance, and roles and responsibilities. In some areas, councils and NHS boards are putting in place additional layers of reporting as if each were accountable for the actions of the IJB. The IJB approach was introduced in part to simplify arrangements, not to add complexity. There are also significant concerns about the impact of integration on the rest of the acute hospital system.

63. It is the IJB's role, through the CO, to issue directions to its partner council and NHS board about service delivery and allocation of resources. This can be made more difficult by disagreements about governance arrangements. It is complicated further by the reporting lines of the CO, who directly reports to both chief executives of the council and NHS board. COs have reported that it can be difficult to direct those who are effectively their line managers. This reinforces the need for strong relationship building and the establishment of a collective agreement over policy direction, funding arrangements and vision for integration.

Decision-making is not localised or transparent in some areas

64. The Act envisaged that decision-making would be devolved as locally as possible. In some areas, IAs, councils and NHS boards have not yet devolved decision-making in the spirit of the Act and locality plans and management structures are still in development. Officers, staff and local service providers have reported that this is because of a risk-averse response to integration that sees NHS boards and councils retain central control over decision-making. Decision-making by IAs is often influenced by statutory partners' priorities. Often, IJB members rely on their statutory partners for information, advice and policy formulation rather than taking the lead on planning and implementing new ways of providing services.

65. There are examples of IAs working hard to establish decision-making arrangements in their partnership. Aberdeen City has put in place governance systems to encourage and enable innovation, community engagement and participation, and joint working. This should leave it well placed for progressing integration and implementing new services in its community (Case study 5). We have also seen how IAs such as South Lanarkshire and Dundee City are beginning to develop locality-based approaches to service delivery (Case study 6, page 36).

Case study 5

Governance arrangements in Aberdeen City IA

Aberdeen City IJB worked with the Good Governance Institute to develop its risk appetite statement and risk appetite approach. The IJB wanted to consider which decisions and risks should, and importantly those which should not, be considered by the IJB. The idea was to ensure there was capacity for decisions to be made locally, so that staff could influence the outcomes of individuals by ensuring that care was tailored to individual needs. Staff and managers say they now feel trusted to make decisions and implement new ideas to benefit individuals in their communities.

The IJB considers that it has demonstrated an aspiration to develop and encourage innovation in local service provision, and local managers and staff understand that decision-making within localities and input of ideas is welcomed and encouraged within agreed risk parameters. Aberdeen City has worked hard to build relationships and trust throughout the partnership. It accepts that achieving its priorities will involve balancing different types of risk and that there will be a need to balance the relationship between different risks and opportunities. There is also an acceptance and tolerance that new ideas will not always be successful.

Source: Aberdeen City IJB, 2018

Case study 6

Locality approach in South Lanarkshire

In 2017, South Lanarkshire IJB realigned its management structure around its four localities. Each locality has a manager responsible for a range of multidisciplinary teams and a health and social care budget. Moving the management of services to a locality level has empowered local teams to review the models of care in their area to see what fits best for the local community. A public forum in each locality gives the local community a voice in shaping local services. Each locality has produced a local strategic needs assessment setting out local needs and priorities and directing attention towards more locally specific outcomes. A 'community first' model of care places the emphasis on developing more community capacity and support.

Staff report that multidisciplinary working and, where possible, co-location, has improved communication and learning across disciplines. They have better knowledge of skills within the wider integrated team, allowing the most appropriate professional to see people at the right time. Working with separate IT systems is a source of frustration and requires less efficient work arounds. Another challenge is balancing trying to change at pace with a need to maintain day-to-day workload. Teams have taken an incremental approach to change, starting with a small number of staff and people using the health and social care services, and, if the new model goes well, gradually increasing this until the change becomes normal practice.

Source: North Lanarkshire IJB, 2018

Best value arrangements are not well developed

66. As IJBs are local authority bodies, the statutory duty of Best Value applies to them. This means that IJBs, from the outset, must clearly demonstrate their approaches to delivering continuous improvement. In July 2017, IJBs submitted their first annual performance reports in accordance with statutory requirements. One of the reporting requirements is that they demonstrate Best Value in the delivery of services.

67. We found that some aspects of Best Value are widely covered within IJBs' annual performance reports and annual accounts, including financial planning, governance and use of resources. About half of all IJBs had a section in their annual performance reports setting out how they intended to demonstrate the delivery of Best Value. Overall the coverage varies between IJBs and is often not in enough detail to allow the public to judge the IJB's activity on continuous improvement.

IAs are using data to varying degrees to help plan and implement changes to services but there are still gaps in key areas

68. Information Services Division (ISD) is part of NHS National Services Scotland, a special NHS board. ISD provides Local Intelligence Support Team (LIST) analysts to each IA area, along with social care information known as SOURCE. Using a LIST analyst to tailor and interpret local data helps IAs to better understand local need and demand and to plan and target services. LIST also works with Community Planning Partnerships in several areas including care for prison leavers presenting to the Homeless Service and children affected by parental imprisonment.

69. Part of the work IAs are doing, supported by the LIST, is to better understand how to support the top two per cent of people using services who account for 50 per cent of hospital and GP prescribing expenditure. By doing this, they can better direct resources and take preventative steps to ensure these users receive more targeted care. This prevents unnecessary hospital admissions and improves personal outcomes through providing more appropriate care in a homely setting.

An inability or unwillingness to share information is slowing the pace of integration

70. There are several areas which need to further improve to help IAs and their council and NHS board partners make better use of data. These include:

- GP practices agreeing data-sharing arrangements with their IA
- IAs being proactive about sharing performance information, ideas and new practice with other IAs
- IAs and ISD agreeing data-sharing protocols for using data in national databases
- IAs identifying gaps in data about community, primary care and social care services and establishing how this information will be collected. This is something we have highlighted in several of our previous reports
- improving consistency in IAs' data, making comparisons easier.

71. Sharing of information, including both health and performance information, is a vital part of providing effective care that is integrated from the point of view of the people who use services. It is also vital in helping to anticipate or prevent need. Throughout our work we were told of examples where this was not happening in practice, because of local systems or behaviours. Examples include: GP practices being unwilling to share information from new service pilots with other IAs; IAs themselves being unwilling to share performance and good practice information with others; and difficulties in setting up data-sharing agreements between IAs and ISD. Different interpretations of data protection legislation are not helping with the ease with which information is being shared.

72. NHS and social care services are made up of many different specialties and localities, often with different IT systems, for example, systems to record X-ray results or record GP data. Many of these systems have been built up over years and commissioned separately for different purposes. Some services still rely on paper records.

73. This disjointedness has an impact on people who need care and on the ability of health and care professionals to provide the best support that they can. For example, people with multiple and complex health and care conditions can have to explain their circumstances to many different professionals within a short space of time. This can delay people getting the help they need, waste resources and gets in the way of care provision being more responsive to people's needs. Local data-sharing arrangements need to be in place so that professionals can appropriately share and protect the data they hold.

74. Time and money are being spent on fixing local IT problems when national solutions should be found. Local fixes are being put in place to help overcome data-sharing barriers. This includes bringing teams of staff together under one roof, so

they can discuss individual cases, rather than relying on electronic systems such as internal emails to communicate. Local areas are spending time and money implementing solutions which may continue to be incompatible in the future. There is a need for a coordinated approach to the solution, which includes the need to consider a national, single solution for Scotland.

75. New IT systems and technology are crucial to implementing new ways of working. For example, many areas are beginning to introduce virtual means of contacting people using care services, such as video links to people's homes so they do not have to visit a health or care centre. To do this successfully, a reliable communication infrastructure is needed, particularly in rural areas.

76. In April 2018, the Scottish Government published *Scotland's Digital Health & Care Strategy: Enabling, Connecting & Empowering*. As part of this, a new national digital platform is to be developed to enable the sharing of real-time data and information from health and care records as required, across the whole care system. We will monitor developments as part of our work programme.

Meaningful and sustained engagement will inform service planning and ensure impact can be measured

77. IAs were set up to have active public involvement, for example through the make-up of their boards and requirements that they publish and engage with communities about their plans. We found some good local examples of engagement. From our analysis of IA strategic plans, we saw evidence of community engagement that influenced the IA's priorities (Case study 7, page 39). Levels of ongoing engagement, and how much it shapes service redesign, are more difficult to judge, but several IAs explicitly mention the importance of engagement and see it as a priority.

78. Several third and independent sector organisations reported that they do not feel that IAs seek or value their input, although they have innovative ways to improve local services that will positively affect the lives of local people. Providers believe that service decisions are based on the funding available over the short term, rather than the needs of the community. Third-sector providers also report that there is often not time to attend engagement meetings, gather information for consultations or research lengthy committee papers. Therefore, IAs have a responsibility to help them become involved and to work with them earlier. IAs must discuss potential changes to services and funding with providers as early as possible.

79. Early engagement with staff, as with the public, has reduced since IAs published strategic plans. Staff want to know how they are contributing to the progress of integration. More communication and involvement will both help increase knowledge of the services available across partnerships and help overcome cultural differences and reluctance to accept change in ways of working.

80. Throughout this report we have recognised the challenging context IAs are operating in. This is inevitably having an impact on the extent to which they can meaningfully engage communities in discussions about improvements to services. IAs need to have in place wide-ranging and comprehensive arrangements for participation and engagement, including with local communities. Where local arrangements for engagement have been shown to work, these should continue. Engagement does not have to be managed and directed solely by the IA. If a local department or service has established relationships and means of engaging with third and independent sector providers which have proved successful, these should continue as before.

Case study 7

Edinburgh IJB: public engagement

The enhanced and proactive engagement approach adopted by Edinburgh IJB facilitated the involvement of the voluntary sector organisations in the co-production of strategic planning. Via the Edinburgh Voluntary Organisation Council, which sits on the IJB board as a non-voting member, the IJB invited the Lothian Community Health Initiatives' Forum (LCHIF) onto its Strategic Planning Groups (SPG). This allowed the LCHIF to get involved in developing the IJB's five strategic Commissioning Plans: Older People, Mental Health, Physical Disabilities, Learning Disabilities, and Primary Care.

LCHIF was subsequently invited to be part of the Older People's and Primary Care Reference Groups. Through involvement on the two reference groups, LCHIF and its members were able to contribute to the work that most reflected the services being delivered by them. The initial involvement of LCHIF on the SPG led to further engagement with other key influencing groups and networks which they felt ultimately benefited the sector, the forum and its members.

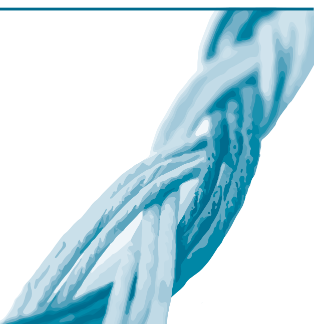
In addition to this involvement, the IJB has also embarked upon a review of its grants to the third-sector. This has been done in full collaboration and partnership with the third-sector. Through the SPG, a steering group was appointed, again with the involvement of LCHIF. This involvement contributed to a commitment being made to establish a grants forum in recognition of the ongoing dialogue that is required to ensure that prevention, early intervention and inequalities remains a priority for the IJB.

Source: Edinburgh IJB, 2018.

81. In September 2017, the Scottish Parliament's Health and Sport Committee published *Are they involving us? Integration Authorities' engagement with stakeholders*, an inquiry report on IAs' engagement with stakeholders.[13] The Committee also found a lack of consistency in stakeholder engagement across IAs. While some areas of good practice were cited, the Committee heard concerns over engagement being 'tokenistic', 'overly top down' and 'just communicating decisions that had already been made'. The Committee argued that a piecemeal approach to engagement with stakeholders cannot continue and that meaningful engagement is fundamental to the successful integration of health and social care services.

82. There is also a role for the Scottish Government in continuing to develop how learning from successful approaches to integration is shared across Scotland. IAs are not being proactive about sharing success stories and the principles behind the planning and implementation of new ways of working which have worked well. Much could be learnt from the work done to date in local areas and IAs should be encouraged to engage with each other and share knowledge and performance information.

Endnotes



1 More details about the joint inspections are available at the Care Inspectorate website.

2 *Health and social care integration*, Auditor General and Accounts Commission, December 2015.

3 *English local authority reserves,* Chartered Institute of Public Finance and Accountancy, June 2015.

4 This takes account of North Ayrshire IJB, which was the only IJB to have an accumulated negative reserve balance. This amounted to £5.8 million and was because of overspends in social care services that were not funded by additional allocations from the NHS board or council.

5 *NHS in Scotland 2018*, Auditor General, October 2018.

6 *Local government in Scotland: Challenges and performance 2018*, Accounts Commission, April 2018.

7 National Performance Framework, Scottish Government, June 2018.

8 *Systems thinking and systems leadership*, NHS Education for Scotland, 2016.

9 *National Health and Social Care Workforce Plan Part 3 – improving workforce planning for primary care in Scotland*, Scottish Government, April 2018.

10 *NHS workforce planning*, Auditor General, July 2017.

11 *Local government in Scotland: Challenges and performance 2018*, Accounts Commission, April 2018.

12 *Medium Term Health and Social Care Financial Framework*, Scottish Government, October 2018.

13 *Are they involving us? Integration Authorities' engagement with stakeholders*, Health and Sport Committee, Scottish Parliament, September 2017.

Appendix 1

Audit methodology

Our objective: To examine the impact public bodies are having as they work together to integrate health and social care services in line with the Public Bodies (Joint Working) (Scotland) Act 2014.

Our audit questions:

- What impact is integration having and what are the barriers and enablers to this change?
- How effectively are IAs planning sustainable, preventative and community-based services to improve outcomes for local people?
- How effectively are IAs, NHS boards and councils implementing the reform of health and social care integration?
- How effectively is the Scottish Government supporting the integration of health and social care and evaluating its impact?

Our methodology:

- Reviewed documents, such as integration schemes, IAs' strategic plans, IJBs' annual audit reports, annual performance reports, national performance data and other key documents including the Scottish Government's National Health and Social Care Financial Framework.
- Interviews, meetings and focus groups with a range of stakeholders including third-sector and independent sector providers. Our engagement involved hearing about experiences of engaging with IAs and how services had changed through integration.
- Interviews at four case study sites – Aberdeen City IJB, Dundee City IJB, Shetland Islands IJB and South Lanarkshire IJB. We met with:
  - Chief Officers and Chief Finance Officers
  - Chairs and vice-chairs of IJBs
  - NHS and council IJB members
  - Chief social work officers
  - IJB clinical representatives (GP, public health, acute, nursing)
  - IJB public representatives (public, carer and voluntary sector)
  - Heads of health and social care, nursing, housing and locality managers and staff
  - NHS and council chief executives and finance officers
  - IT, communications and organisational development officers.

Appendix 2

Advisory group members

Audit Scotland would like to thank members of the advisory group for their input and advice throughout the audit.

Member	Organisation
Alison Taylor	Scottish Government
Alistair Delaney	Healthcare Improvement Scotland
Allison Duncan	IJB Vice Chair
Eddie Fraser	IJB Chief Officer
Fidelma Eggo	Care Inspectorate
Gerry Power	Health and Social Care Alliance
Jeff Ace	NHS Chief Executive
John Wood	Convention of Scottish Local Authorities (COSLA)
Julie Murray	Society of Local Authority Chief Executives
Robin Creelman	IJB Vice Chair
Tracey Abdy	IJB Chief Finance Officer

Note: Members sat in an advisory capacity only. The content and conclusions of this report are the sole responsibility of Audit Scotland.

Appendix 3

Progress against previous recommendations

Recommendations	Progress
Scottish Government should:	
• work with IAs to help them develop performance monitoring to ensure that they can clearly demonstrate the impact they make as they develop integrated services. As part of this: – work with IAs to resolve tensions between the need for national and local reporting on outcomes so that it is clear what impact the new integration arrangements are having on outcomes and on the wider health and social care system.	IAs are reporting locally on outcomes but this is not being drawn together to give a national picture of outcomes for health and social care.
• monitor and publicly report on national progress on the impact of integration. This includes: – measuring progress in moving care from institutional to community settings, reducing local variation in costs and using anticipatory care plans – reporting on how resources are being used to improve outcomes and how this has changed over time – reporting on expected costs and savings resulting from integration.	We found there are a significant number of indicators and measures being used nationally and locally to understand whether integration is making a difference and to monitor changes. But, for the public to understand how the changes are working at a Scotland-wide level, these indicators need to be presented in a clear and transparent way. The Scottish Government has introduced a series of national outcomes for health and social care. The outcomes are not being routinely reported at a national level. The savings estimated to be made from integration were expected to derive from a reduction in unplanned bed days, fewer delayed discharges, improved anticipatory care and less variation in bed day rates across partnerships. The savings from these have not been specifically monitored by the Scottish Government, although actual and projected performance across these measures is reported to the Scottish Government's Ministerial Steering Group.
• continue to provide support to IAs as they become fully operational, including leadership development and sharing good practice, including sharing the lessons learned from the pilots of GP clusters.	Some leadership development has been commissioned from the Kings Fund by the Integration Division at Scottish Government but there is a lack of joint leadership development across the health and social care system to help to embed and prioritise collaborative leadership approaches. There is an appetite for examples of good practice from local partnerships but still a lack of good learning resources.

Cont.

Recommendations	Progress
Integration Authorities should:	
• provide clear and strategic leadership to take forward the integration agenda; this includes: – developing and communicating the purpose and vision of the IJB and its intended impact on local people – having high standards of conduct and effective governance, and establishing a culture of openness, support and respect.	We found that a lack of collaborative leadership and cultural differences are proving to be significant barriers to change in some areas.
• set out clearly how governance arrangements will work in practice, particularly when disagreements arise, to minimise the risk of confusing lines of accountability, potential conflicts of interests and any lack of clarity about who is ultimately responsible for the quality of care and scrutiny. This includes: – setting out a clear statement of the respective roles and responsibilities of the IJB (including individual members), NHS board and council, and the IJB's approach towards putting this into practice – ensuring that IJB members receive training and development to prepare them for their role, including managing conflicts of interest, understanding the organisational cultures of the NHS and councils and the roles of non-voting members of the IJB.	There is a lack of agreement over governance and a lack of understanding about integration which is acting as a significant barrier to progress in some areas. There are still circumstances where clarity is needed over who is ultimately responsible for service performance and the quality of care. In some instances, this uncertainty is hampering decision-making and redesigning how services are provided. Not enough has been done locally to address this.
• ensure that a constructive working relationship exists between IJB members and the chief officer and finance officer and the public. This includes: – setting out a schedule of matters reserved for collective decision-making by the IJB, taking account of relevant legislation and ensuring that this is monitored and updated when required – ensuring relationships between the IJB, its partners and the public are clear, so each knows what to expect of the other.	IAs have helped to improve engagement with the public and providers in the local area in some instances but there is more to do.
• be rigorous and transparent about how decisions are taken and listening and acting on the outcome of constructive scrutiny, including: – developing and maintaining open and effective mechanisms for documenting evidence for decisions – putting in place arrangements to safeguard members and employees against conflict of interest and put in place processes to ensure that they continue to operate in practice – developing and maintaining an effective audit committee – ensuring that effective, transparent and accessible arrangements are in place for dealing with complaints. – ensuring that an effective risk management system is in place.	We found that decision-making is not localised or transparent in some areas and risk management arrangements are not well developed.

Cont.

Recommendations	Progress
• develop strategic plans that do more than set out the local context for the reforms; this includes: – how the IA will contribute to delivering high-quality care in different ways that better meets people's needs and improves outcomes – setting out clearly what resources are required, what impact the IA wants to achieve, and how the IA will monitor and publicly report their progress – developing strategies covering the workforce, risk management, engagement with service users and data sharing, based on overall strategic priorities to allow the IA to operate successfully in line with the principles set out in the Act and ensure these strategies fit with those in the NHS and councils – making clear links between the work of the IA and the Community Empowerment (Scotland) Act and Children and Young People (Scotland) Act.	IAs are beginning to link their resources to strategic priorities but more needs to be done to show when their planned outcomes will be achieved. They also need to show how the shift from the current ways of working to new models of care will happen.
• develop financial plans that clearly show how IAs will use resources such as money and staff to provide more community-based and preventative services. This includes: – developing financial plans for each locality, showing how resources will be matched to local priorities – ensuring that the IJB makes the best use of resources, agreeing how Best Value will be measured and making sure that the IJB has the information needed to review value for money and performance effectively.	There is some evidence of small-scale transfers of resources, but most IAs have funded changes to services using ring-fenced funding, such as specific additional integrated care funding provided by the Scottish Government. This is instead of shifting resources from an acute setting, such as hospitals, to community settings such as local clinics and GP surgeries. While this may have achieved performance improvement in things such as delayed discharges, ring-fenced funding may not be available long term. Therefore, IAs need to ensure the financial sustainability of ongoing support for changes made. Financial planning is not integrated, or long term and financial pressures make meaningful change hard to achieve. Arrangements for understanding and measuring Best Value arrangements are not well developed.
• shift resources, including the workforce, towards a more preventative and community-based approach; it is important that the IA also has plans that set out how, in practical terms, they will achieve this shift over time.	We found there has been limited change in how resources are being used across the system at this stage – see above.

Cont.

Recommendations	**Progress**
Integration Authorities should work with councils and NHS boards to:	
• recognise and address the practical risks associated with the complex accountability arrangements by developing protocols to ensure that the chair of the IJB, the chief officer and the chief executives of the NHS board and council negotiate their roles in relation to the IJB early in the relationship and that a shared understanding of the roles and objectives is maintained.	We found a lack of agreement over governance and a lack of understanding about integration remain significant barriers in some areas. There are still circumstances where clarity is needed over who is ultimately responsible for service performance and the quality of care. In some instances, this uncertainty was hampering decision-making and redesigning how services are provided. In our opinion, not enough has been done locally to address this.
• review clinical and care governance arrangements to ensure a consistent approach for each integrated service and that they are aligned to existing clinical and care governance arrangements in the NHS and councils.	Auditors report that members of IA leadership have differing views about governance, especially clinical governance, and roles and responsibilities.
• urgently agree budgets for the IA; this is important both for their first year and for the next few years to provide IAs with the continuity and certainty they need to develop strategic plans; this includes aligning budget-setting arrangements between partners.	We found that at present, not all councils and NHS boards view their finances as a collective resource for health and social care. Some councils and NHS boards are still planning budgets around their own organisations rather than taking account of their IJBs local strategic priorities. The ambition for integration is that the health and social care resources in the local area would be brought together and used to deliver integrated services with improved outcomes for people. While this is happening in some areas, councils and NHS boards in other areas can be unwilling to give up financial control of budgets and IJBs can struggle to exert influence over their budgets. Some IAs have little or no involvement in the budget-setting process. At a very basic level IJBs struggle in some areas to agree budgets. Fourteen IJBs failed to agree a budget for the start of the 2017/18 financial year.
• establish effective scrutiny arrangements to ensure that councillors and NHS non-executives, who are not members of the IJB board, are kept fully informed of the impact of integration for people who use local health and social care services.	We have seen that IJB board papers are shared with council and NHS board partner organisations. In some areas though, rather than streamlining governance and scrutiny arrangements, councils and NHS boards are putting in place additional layers of reporting as if each were accountable for the actions of the IJB.
• put in place data-sharing agreements to allow them to access the new data provided by ISD Scotland.	IAs and ISD are have difficulties in agreeing data-sharing protocols for using national databases.

Appendix 4

Financial performance 2017/18

IJB	Position (pre-additional allocations) Overspend/ (underspend) (£million)	Additional allocation/ (reduction) Council (£million)	NHS board (£million)	Use of reserves (£million)	Year-end position Deficit/ (Surplus) (£million)
Aberdeen City	2.1	0	0	2.1	0
Aberdeenshire	3.5	1.5	2.0	0	0
Angus	(0.4)	0	0	0	(0.4)
Argyll and Bute	2.5	1.2	1.4	0	0
Clackmannanshire and Stirling	2.2	0.6	0.6	1.1	0
Dumfries and Galloway	(2.5)	0	0	0	(2.5)
Dundee City	2.5	0	2.1	0.4	0
East Ayrshire	3	2.2	1.3	0	(0.5)
East Dunbartonshire	1.1	0	0	1.1	0
East Lothian	0.7	0.6	0.1	0	0
East Renfrewshire	(0.4)	0	0	0	(0.4)
Edinburgh	7.4	7.2	4.9	0	(4.7)
Eilean Siar	(3.0)	0	0	0	(3.0)
Falkirk	1.3	0	1.4	0.2	(0.3)
Fife	8.8	2.5	6.4	0	0
Glasgow City	(12.0)	0	0	0	(12.0)
Inverclyde	(1.8)	0	0	0	(1.8)
Midlothian	(0.7)	0.2	0	0	(0.9)
Moray	1.9	0	0	1.9	0
North Ayrshire	3.5	0	1.0	0	2.6
North Lanarkshire	(11.7)	0	0.6	0	(12.3)
Orkney	0.7	0.2	0.5	0	0
Perth and Kinross	(1.4)	(2.6)	1.3	0	0
Renfrewshire	4.8	2.7	0	2.1	0
Scottish Borders	4.5	0.3	4.2	0	0
Shetland	2.4	(0.3)	2.9	0	(0.2)
South Ayrshire	0.3	0	0	0.3	0
South Lanarkshire	(1.2)	0	1.0	0	(2.2)
West Dunbartonshire	(0.6)	0	0	0	(0.6)
West Lothian	1.8	0	1.8	0	0

Note: Arithmetic differences arising from roundings.
Source: Audited Integration Authority annual accounts, 2017/18

Health and social care integration

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Agenda Item 19

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