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Aberdeen City Health & Social Care Partnership
A caring partnership

To: Members of the Integration Joint Board

Town House,
ABERDEEN 19 March 2019

INTEGRATION JOINT BOARD

The Members of the **INTEGRATION JOINT BOARD** are requested to meet in **Meeting Room 5, Health Village on TUESDAY, 26 MARCH 2019 at 10.00 am.**

FRASER BELL
CHIEF OFFICER - GOVERNANCE

B U S I N E S S

1 Welcome from the Chair

DECLARATIONS OF INTEREST

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

4.1 Minute of Board Meeting of 22 January 2019 (Pages 5 - 12)

4.2 Minute of Board Budget Meeting of 12 March 2019 - DRAFT (Pages 13 - 18)

4.3 Matters Arising

5 Draft Minute of Clinical and Care Governance Committee of 19 February 2019 (Pages 19 - 26)

6 Draft Minute of Audit and Performance Systems Committee of 12 February 2019 (Pages 27 - 36)

7 Business Statement (Pages 37 - 40)

GOVERNANCE

8 Appointments (Pages 41 - 46)

9 Strategic Risk Register (Pages 47 - 80)

PERFORMANCE AND FINANCE

10 Improvement of Re-admissions Performance (Pages 81 - 86)

11 Health Improvement Fund (Pages 87 - 102)

STRATEGY

12 Locality Model (Pages 103 - 120)

13 Final Strategic Plan (Pages 121 - 178)

14 Strategic Commissioning Update (Pages 179 - 186)

15 Franks Law (Pages 187 - 224)

16 Granite City Good Food (Pages 225 - 264)

TRANSFORMATION

17 Workforce Plan (Pages 265 - 290)

18 Transformation Decisions Required (Pages 291 - 404)

CAPITAL

19 Denburn/Aurora (Pages 405 - 440)

ITEMS THE BOARD MAY WISH TO CONSIDER IN PRIVATE

20 Horizons (Pages 441 - 448)

21 Update from the Chief Officer

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

Should you require any further information about this agenda, please contact Derek Jamieson, tel 01224 523057 or email derjamieson@aberdeencity.gov.uk

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Aberdeen City Health & Social Care Partnership
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ABERDEEN, 22 January 2019. Minute of Meeting of the INTEGRATION JOINT BOARD.

Present:- Councillor Sarah Duncan (Chairperson) and Jonathan Passmore MBE (vice Chairperson); Councillors Laing, Samarai and Dunbar (as substitute for Councillor Imrie); Rhona Atkinson and Dr Luan Grugeon (NHS Grampian Board member); and Mike Adams (NHS Staff Rep), Jim Currie (Trade Union Representative, ACC), Gill Moffat and Faith-Jason Robertson- Foy (Carer Representative), Dr Stephen Lynch (Clinical Director, (ACHSCP)), Sandra Ross (Chief Officer, ACHSCP), Jess Anderson (Legal, ACC) and Alex Stephen (Chief Finance Officer, ACHSCP).

Also in attendance: Frank McGhee (Director of Commissioning, ACC), Martin Allan (Business Manager, ACHSCP – for Item 7) Alison MacLeod (Lead Strategy and Performance Manager, ACHSCP - for items 8 and 10),

In attendance for workshop session: *

Apologies: Graeme Simpson (Chief Social Work Officer, ACC) Malcolm Metcalf (Carer Representative),

WELCOME FROM THE CHAIR

1. The Chair opened the meeting and welcomed all attendees. The Chair intimated that that as there would be changes to the NHS membership, this would impact on the IJB particularly as the Vice Chair would be leaving his post in April. There was further impact to the IJB structure as the Chair of the APS Committee was also leaving which will result in a restructure for this committee too.

The Chair expressed appreciation for the positive work and commitment of Jonathan Passmore (IJB Vice Chair) and Rhona Atkinson (APS Chair) and wished them every success in their new roles.

MEMBERS ARE REQUESTED TO INTIMATE ANY DECLARATIONS OF INTEREST

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

The Board resolved:-
To note that no declarations of interest were intimated by members for items on today's agenda.

INTEGRATION JOINT BOARD
22 January 2019

MEMBERS ARE REQUESTED TO DETERMINE THAT ANY EXEMPT BUSINESS BE CONSIDERED WITH THE PRESS AND PUBLIC EXCLUDED

3. The Chair proposed that agenda items 10 and 11 be considered with the press and public excluded and that item 9 be taken in public session.

The Board resolved:
In terms of Section 50(A)(4) of the Local Government (Scotland) Act 1973, to exclude the press and public from the meeting during consideration of the aforementioned items of business so as to avoid disclosure of exempt information of the classes described in paragraph 9 of Part 1 of Schedule 7(A) of the Act; and to agree to move item 9 into public session.

(i) to move the report at Item 9 into public session and
(ii) consider Items 10 and 11 with the press and public excluded

MINUTE OF SPECIAL MEETING OF THE INTEGRATION JOINT BOARD OF 13 NOVEMBER 2018

4. The Board had before it the minute of its Special Meeting of 13 November 2018

The Board resolved:
to approve the Minute as a correct record subject to amending the funding approval date for the Northern Corridor Project to January 2019.

MINUTE OF BOARD MEETING OF 11 DECEMBER 2018

5. The Board had before it the minute of its meeting of 11 December 2018.

The Board resolved:

to approve the minute as a correct record subject to noting that the Alcohol and Drug Partnership Annual Reports would reflect the wider ADP and not only the Investment Plan.

MATTERS ARISING

INTEGRATION JOINT BOARD
22 January 2019

6. The Chair asked if there were any matters arising, there being none the Chair advised that all matters arising were covered elsewhere in the business statement and later on the agenda.

BUSINESS STATEMENT

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

The Board resolved to:

(i) in respect of Item 1 (Aberdeen City Residential Nursing Home Provision) to note that a report would be presented to the Board in April 2020 following one year implementation

(ii) in respect of Item 5 (Diet, Activity and Healthy Weight) to note that a report will be presented in March 2019

(iii) to otherwise note the business statement

STRATEGIC RISK REGISTER

8. The Board heard from Martin Allan who presented the report 'Brexit Risk'.
This paper supplied additional detail to the existing mitigation contained within the Strategic Risk Register. Martin updated that the Partnership had been invited to attend the EU Health and Social Care Exit Planning event in Stirling which assisted influence the report.

The Chair expressed appreciation for the report and highlighted that the document remained fluid as the developing Brexit position modified and changed. The Chair then sought input from the members who actively participated with questions and comments.

Concerns were expressed that the report did not fully detail the impact of staff and staff numbers especially in areas of speciality which were particularly at risk. Whilst it was accepted that greater detail would be of benefit, the developing position and continuing volume of unknown impacts did not allow for this inclusion at this time. It was agreed that those staff at risk of impact had been the subject of much discussion by the official and staff sides with appropriate recognition of their value in all forums. It was confirmed that the Unions were satisfied at the level and volume of inclusions within such discussions.

As such, there was an agreement that whilst further detail would be of benefit, at this time, the report was satisfactory.

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22 January 2019

The report recommended that the Board:

a) Note the risk associated with the Brexit transition process (as contained within the strategic risk register), as attached at appendix A; and
b) Consider the following wording as a Policy Statement for issue:

The Board resolved:

(i) to note the risk associated with the Brexit transition process (as contained within the strategic risk register), as attached at appendix A; and

(ii) Agreed to issue the Policy Statement subject to amending the last sentence to read 'The IJB will continue to work closely with Aberdeen City Council and NHS Grampian to mitigate the risks *as far as is possible* to patients, clients and staff.'

Note that the Risk Register was to be reported to the Audit and Performance Systems Committee for discussion and that a further report would be reported to the IJB in March 2019

2019/2020 OBJECTIVES FOR MSG INDICATORS

9. The Board heard from the Alison MacLeod who presented her report based around the performance against the Ministerial Steering Group national indicators for the previous two financial years and program for this coming financial year, which all helped develop targets for the next financial year.

The Board members entered into discussion of the report and it was highlighted that the report did not particularly allow review against Board's Strategic Plan. It was strongly felt that the report focussed on numbers rather than consideration of benefit including value of performance or improvement. The Board did express concerns that the indicators and format of the report would allow for setting easily achieved or soft targets rather than the broader benefits achieved.

The Board resolved:

(i) Approve the local objectives for the six MSG Integration Indicators contained within Appendix A, and

(ii) Instructs the Chief Officer to submit the local objectives to the Ministerial Strategic Group for Health and Community Care by the deadline of 28th February 2019. And

(iii) Include this Board's observations and concerns in respect of the MSG indicators and the lack of evidenced outcome versus figures

(iv) the lack of evidenced outcome versus figures

INTEGRATION JOINT BOARD
22 January 2019

FINANCE SETTLEMENT UPDATE - PLEASE NOTE THIS IS NOW AN EXEMPT REPORT

10. The Board heard from Chief Officer Alex Stephen who highlighted the national discussions and position affecting all IJBs particularly in the area of reserve funding. Following further explanation around the report, the Chair expressed appreciation for the report and input and encouraged Board members participation in discussion.

Alex Stephen was able to explain the inclusion of education areas within the funding and it was highlighted that specialist recruitment was challenging in these areas.

The Board resolved to:

(i) note the content of this report, and

(ii) agree to cancel the budget meeting on 5 February 2019.

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

SKILLS DEVELOPMENT, TRAINING AND EMPLOYABILITY SERVICES - UPDATE

11. The Board heard from Alison MacLeod who provided an update on the contracts for skill development, training and employability services.

During Board members discussions on the report, it was apparent that this process is continuous having covered the previous 18 months and focusing on those renewals within the next 18 months. Board members heard that the duplications in services had been reduced as a result of the review.

The Chair expressed her appreciation for the volume of input to the document and expressed pleasure at the positive status of the contracts' status and the inclusion of service providers in understanding requirements before tendering.

The Board resolved:
(i) to note the content of the report

INTEGRATION JOINT BOARD
22 January 2019

UPDATE FROM THE CHIEF OFFICER

12. The Board heard verbal updates from Sandra Ross, the Chief Officer on the following items:

- North East Partnership
- Section 75 Progress
- Banks o' Dee
- Kingswells
- Cornerstone and
- BAC Contract Review

The Board resolved to

(i) Note the verbal update

FINANCE SETTLEMENT UPDATE

13. This was included at Item 10

INTEGRATION JOINT BOARD
22 January 2019

Aberdeen City Health & Social Care Partnership
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ABERDEEN, 12 March 2019. Minute of Meeting of the INTEGRATION JOINT BOARD.

Present:- Councillor Sarah Duncan (Chairperson) and Jonathan Passmore MBE (vice Chairperson); Councillors Al-Samarai, Bell and Laing, (as substitute for Councillor Lesley Dunbar); Dr Luan Grugeon (NHS Grampian Board member), Sandra Ross (Chief Officer, ACHSCP) and Alex Stephen (Chief Finance Officer, ACHSCP) and Claire Duncan (Lead Social Worker, ACC) for Graeme Simpson (Chief Social Worker, ACC).

Also in attendance: Martin Murchie (Chief Officer, ACC – as substitute for Frank McGee (Director, ACC), Alan Thomson and Jess Anderson (Legal, ACC),

Apologies: Councillor Lesley Dunbar, Graeme Simpson (ACC), Kim Cruttenden and Prof Steve Hays (NHS Grampian Board members), Mike Adams (NHS Staff Rep), Jim Currie (Trade Union Representative, ACC), Gill Moffat and Faith-Jason Robertson- Foy (Carer Representative), Dr Stephen Lynch (Clinical Director, (ACHSCP)),

WELCOME FROM THE CHAIR

1. The Chair welcomed all to the Budget Meeting of the Integration Joint Board and intimated the apologies.

MEMBERS ARE REQUESTED TO INTIMATE ANY DECLARATIONS OF INTEREST

2. There were no declarations of interest.

MEMBERS ARE REQUESTED TO DETERMINE THAT ANY EXEMPT BUSINESS BE CONSIDERED WITH THE PRESS AND PUBLIC EXCLUDED

3. There was no exempt business.

MEDIUM TERM FINANCIAL FRAMEWORK

4. The Board had before it the report by Alex Stephen, Chief Finance Officer.

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12 March 2019

The report recommended that the Board:

(i) Note the financial allocations proposed to be allocated by the partner organisations;

(ii) Approve the Bon Accord Contract level for 2019/20 of £27,233,000 and budget assumptions noted in section 3.8;

(iii) Formally approve the 2019/20 budget and the Aberdeen City IJB Medium Term Financial Strategy included as appendix 1 of this report;

(iv) Note that the IJB previously agreed to earmark £2.5 million in a risk fund and that this is included in the Medium Term Financial Framework;

(v) Instruct the Chief Officer to uplift the direct payments for clients with a staffing element included in their payment by 2.8% from the 1 May 2019 to cover the increase in the Scottish Living Wage;

(vi) Instruct the Chief Officer to negotiate uplifts for those Social Care providers not covered by the National Care Home Contract; and

The Board heard that the report indicated that this was an extremely tight budget forecast particularly against the backdrop of a revised funding formula by NHS Grampian by utilising the NHSScotland Resource Allocation Committee NRAC formulas. This has resulted in a £150K reduction.

Final Grant Settlement

The Board were reminded that this formula of funding was not the basis upon which the original funding and budget frameworks were based and that the budget had been set against a background of reduced funding from both partnerships.

The Board agreed that following the previous more positive financial contributions, the Board had been able to deliver positive outcomes against the strategy. It was disappointing that the current position would place additional pressures on the Board and its ability to deliver core services.

The Board conceded that whilst the reduction of Council funding had been predicted, the reduction from NHS Grampian against its revised formula was not. The Board were concerned that should NRAC formulas be applied to the basis of funding in future years, funding would continue to reduce and this would introduce additional risks.

Medium Term Financial Framework

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The Board heard that this indicated the challenging financial position to deliver savings year on year against the reductions received. Together with additional funding requirements in several areas, this clearly introduced additional risk.

The Board heard that mitigation of the risks included: zero-based budgeting exercises; an enhanced drive to deliver efficiencies throughout and that industry wide business toolkits were being applied to assist that delivery which introduced a confidence on the probability of delivering savings.

The Board were reminded that the risk fund remained in a healthy position should those funds be required.

Discussion included concerns around the Scottish Living Wage (SLW) and whilst Scottish Government funding presently assisted that delivery, removal or reduction of funds in that area would introduce an additional risk. The Board agreed that as the workforce were key to the delivery of services and efficiencies, it was important that a close watch be maintained on SLW.

The Board heard that the current reduction in prescription costs would hopefully continue and that projections had been made over the next 5/10 years.

This saving was very much linked upon the prevention and care at home strategy projects delivering their anticipated benefits and efficiencies also.

The Board heard that the revised strategy would see greater emphasis on prevention which albeit carrying an element of risk is very much the way forward. The revised strategy was intended to assist better provision of services and assist greater focus on benefit and efficiency together with digital enhancement to assist.

The Board commended the volume and quality of work carried out in preparing and presenting the Budget Report and extended their appreciation to the Chief Finance Officer.

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12 March 2019

The Board resolved to :-

(i) Note the financial allocations from the partner organisations and that the Chair write to the respective organisations to convey the Board's concern about the change in basis for funding and potential risks to the IJB's future financial position should this basis of allocation continue in the future;

(ii) Approve the Bon Accord Contract level for 2019/20 of £27,233,000 and budget assumptions noted in section 3.8;

(iii) Formally approve the 2019/20 budget and the Aberdeen City IJB Medium Term Financial Strategy included as appendix 1 of this report;

(iv) Note that the IJB previously agreed to earmark £2.5 million in a risk fund and that this is included in the Medium-Term Financial Framework;

(v) Instruct the Chief Officer to uplift the direct payments for clients with a staffing element included in their payment by 2.8% from the 1 May 2019 to cover the increase in the Scottish Living Wage;

(vi) Instruct the Chief Officer to negotiate uplifts for those Social Care providers not covered by the National Care Home Contract; and

(vii) Make the budget directions contained in appendix 2 of this report and instruct the Chief Officer to issue these directions to the constituent authorities.

- **COUNCILLOR SARAH DUNCAN, Chairperson**

INTEGRATION JOINT BOARD
12 March 2019

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

Minute of Meeting

19th of February 2019
Health Village, Aberdeen

Present:		
	Cllr. Sarah Duncan	Chairperson
	Luan Grugeon	IJB Voting Member
	Prof. Steven Heys	IJB Voting Member
Also in attendance:		
	Dr. Howard Gemmell	IJB Member (Service User Representative)
	Dr. Malcolm Metcalfe	IJB Member (Secondary Care Advisor)
	Kenneth Simpson	IJB Member (Third Sector Representative)
	Caroline Howarth	Clinical Director (GP)
	Lynn Morrison	Allied Health Professions Lead
	Heather Macrae	Nursing Lead
	Sarah Gibbon	Executive Assistant
	Linda Leaver	Risk Management Advisor (Patient Safety)
	Emma Ross	Service Manager (Older People & Physical Disability)
For Item 3	John Donaghey	Lead Nurse (Mental Health & Learning Disability)
Apologies:		
	Laura MacDonald	Health & Safety Representative
	Claire Duncan	Lead Social Work Officer
	Cllr. Claire Imrie	IJB Voting Member
	Graeme Simpson	Chief Social Work Officer

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

0. The Chair opened the meeting and welcomed the new attendees to the meeting. Introductions were given.

The Committee resolved: -

i) To welcome the new attendees to the committee meeting.
ii) To reorganise the agenda to consider item 6 (Clinical & Care Governance Framework Review) first.

CLINICAL & CARE GOVERNANCE REVIEW UPDATE REPORT

1. The Committee had before it a report which provided an update to the Committee on the review of the clinical and care governance arrangements for the Partnership.

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

a) Note the progress with the ongoing review of Clinical & Care Governance (CCG) within ACHSCP;
b) Approve the proposed model as attached at Appendix A;
c) Note the draft terms of reference for the Clinical & Care Governance Group, as attached at Appendix B;
d) Approve the terms of reference for the Clinical & Care Governance Committee, as attached at Appendix C;
e) Agree that the next annual joint development session of the CCG Group & CCG Committee in 2019 (date tbc) considers the strategic objectives (to be agreed by the IJB in March 2019 as part of the revised strategic plan) to ensure that the governance processes and data being reviewed are fully aligned.

Lynn Morrison provided an overview of the paper, outlining the key changes which have been made in the review so far:

- Increased frequency of meetings for CCG Group, which will use revised reporting mechanisms for its next meeting;
- Proposal for joint development sessions between group and committee;
- Establishing clinical and care risk management meetings;
- Reviewing the CCG Group and CCG Committee Terms of Reference;
- Reviewing data available to support the CCG processes in real time and establishing how to provide context around the data; and
- A proposed model for clinical and care governance (appendix A)

Committee Terms of Reference

The Committee discussed the terms of reference and noted:

- Lead Social Work Officer should be a member of the Clinical & Care Governance Committee.
- Joint Workshops between the Group and Committee would be useful.

- There is a potential need to expand the membership of the Committee to consider acute services and commissioned services. Following further discussion, the Committee suggested considering representation from a pathway approach.
- Duties,point 5 - may be too operationally focused. This committee is looking for assurance of progress against our strategic performance indicators.
- Duties, point 4 – should also note that we will escalate to ACC/NHSG as appropriate.
- Terms of Reference should refer to the Fairer Scotland Duty.

Group Terms of Reference

- There was a discussion on the Chair of the Group, and whether this needs to be the Clinical Director (GP). The Committee felt that overall this should be the decision of the group. The Group's Terms of Reference should be amended to reflect that it is the responsibility of the group to elect a consistent chair. The Committee should then be informed of the Chair of the Group and the Chair should attend the Committee meeting.
- The Committee discussed whether there is a need to consider staff-side/partnership representation on the Group. Councillor Duncan noted an interest given her Unison role. Members of the Task and Finish group will liaise with staffside/partnership reps in order to establish the best way to involve them in the CCG processes.

The Committee resolved: -

(i) To note the progress with the ongoing review of Clinical & Care Governance (CCG) within ACHSCP and to thank the members of the Task and Finish Group for the work to-date;
a) To approve the proposed model as attached at Appendix A;
b) To note the draft terms of reference for the Clinical & Care Governance Group, as attached at Appendix B and to provide the above noted comments to the group for consideration;
c) To approve the terms of reference for the Clinical & Care Governance Committee, as attached at Appendix C, pending the amendments outlined above;
d) To agree that the next annual joint development session of the CCG Group & CCG Committee in 2019 (date tbc) considers the strategic objectives (to be agreed by the IJB in March 2019 as part of the revised strategic plan) to ensure that the governance processes and data being reviewed are fully aligned and to instruct the Executive Assistant to set dates for these development sessions.
e) To request a further update at the next meeting of the Committee in May 2019.

MINUTE OF CCG COMMITTEE MEETING – 27 November 2019

2. The Committee had before it the minute of the Clinical & Care Governance committee meeting of 27 November 2018

The Committee resolved: -
To approve the minute as a correct record, pending the following amendment to page 4 (item 5, business statement):

"A review will be undertaken in the new year, looking at the service and possibilities for commissioning such a service".

MATTERS ARISING

3. The Chair asked if there were any matters arising from the meeting of 27 November 2018.

There was an extensive discussion on the representation of acute sector services (such as geriatrics and mental health) on the agenda of both the Clinical & Care Governance Committee

and the Clinical & Care Governance Group, and the escalation processes for issues within acute care services.

Specific examples relating to duty of candour, winter pressures and realistic medicine were raised. Members of the Committee felt that it was essential to have full oversight of the acute services for which the IJB is responsible, in order to achieve truly integrated health & social care. There was general agreement with this statement, however other Committee members felt that it would be more useful to consider pathways, as opposed to individual services and the distinction between acute/community.

It was noted that work is ongoing, at a strategic level, to deliver a framework for acute services delegated to the IJBs for strategic planning.

The Committee resolved that the most appropriate route for acute services to report through was first to the Clinical & Care Governance Group, before being escalated (if necessary) to the Committee. It was also suggested that the terms of reference for the Clinical & Care Governance Group could be expanded to include appropriate representation from acute, and other areas such as those involved in the Local Outcome Improvement Plan.

The Committee resolved: -

(i) To request that the Clinical Director (GP), Lead AHP and the Secondary Care Advisor to the IJB meet to further discuss the arrangements for ensuring appropriate representation of Acute Sector Services in the Clinical & Care Governance framework.

(ii) To escalate this issue to the IJB and to recommend that the IJB requests a workshop session focusing on integration within the wider system (including, for example acute and community planning).

BUSINESS STATEMENT

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

The Committeeresolved: -

(i) To note that item 2 i. (GP Practices - Torry) would be considered in by the IJB in March 2019 and agree to its removal from the CCG business statement.

(ii) To note that item 2 ii. (GP Practices – Rosemount) would be deferred to the CCG Committee meeting in May, after the formal project closure and associated report has been completed.

(iii) To note that item 3. (Care Opinion) would be considered by the Enabling Systems Programme Board on 21.02.2019 and to therefore remove it from the business statement.

(iv) To otherwise note the business statement.

REPORTS FOR THE COMMITTEE'S CONSIDERATION

UPDATE ON MENTAL HEALTH AND LEARNING DISABILITIES SERVICES.

5. The Committee had before it a report by John Donaghey which provided an update on Acute Mental Health service closures. He summarised the main points contained within the report and highlighted that though a previous report to committee had said that the reduction in bed-base had not impacted the Adult Community Mental Health Teams (as historically there is a reduction in referral activity from primary care following closure decisions) there may be more pressure which becomes significant through the first quarter of this year, based on last year's figures. He highlighted that community teams are usually involved in multi-disciplinary discharge meetings, however that these meetings are

happening less often and this results in the community staff members being informed of a discharge rather than included in the discussions.

He emphasised that a sustainability plan for mental health services will be developed using a whole systems approach over the next few months, with workshops planned for March, April and May. The sustainability review was welcomed by the Committee and it was noted that that adult social work services in the community would have useful data to support this review (such as an increase in 1-1 support requests) and that a full report on the review would be presented to the IJB in due course.

Thereafter, there were questions and comments relating to how the service operationally manages to contain patients in light of the loss of beds; the need to ensure connections between community and inpatients services in a whole-systems approach; what work is ongoing to address these significant challenges (such as skill mix and service re-design)

It was noted that the service was experiencing pressures on its administration staff, who input the data received from clinicians – data which would have been useful to help establish cause/effect. Alison Macleod offered to have a follow-up discussion out with the Committee meeting to establish if her team could provide any support.

The Committee resolved:-

i. To request that the Clinical & Care Governance Group monitor the situation through their reporting processes and escalate back to the Committee if required.

OCCUPATIONAL HEALTH & SAFETY REPORT

6. The Committee had before it a report with an update relating to delays in occupational health screening.

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

a) Note the content of the report.

Noting that it may be too early for the data to confirm any improvements as a result of the changes, Heather MacRae advised that anecdotally she had not heard any issues with recruitment recently.

The Committee resolved:-

i. To note the content of the report.

PERFORMANCE MONITORING

7. The Committee had before it a report by Alison Macleod which advised the Committee of the latest developments in relation to Performance Monitoring

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

A) Notes the mapping of the strategic performance indicators to the strategic aims and the strategic risk register.
B) Approves the proposed reporting arrangements of the strategic aims to both the Clinical and Care Governance and Audit and Performance Systems Committee.

Alison Macleod highlighted that versions of the report have already been submitted to both the IJB and APS committees. The appendix maps our performance indicators against the priorities and aims as outlined in the strategic plan and she emphasised that we are now attempting to map the strategic risks against our performance indicators. Reports which are presented to the committee will set the context and look at benchmarking/trends where possible.

The Committee noted that the report was helpful.

The Committee resolved:-

i. To note the mapping of the strategic performance indicators to thestrategic aims and the strategic risk register.

ii. To approve the proposed reporting arrangements of the strategic aimstothe Clinical and Care Governance Committee.

CLINICAL & CARE GOVERNANCE MATTERS

CLINICAL & CARE GOVERNANCE GROUP MINUTES

8. The committee had before it the minute of the Clinical & Care Governance Group from February 2019.

Emma Ross provided an update on the Banks O' Dee Care Home and outlined what actions are currently being undertaken.

Other items raised by the CCG Group included:

- Health Visiting – Heather MacRae advised that she is drafting an SBAR for some suggestions for solutions. This will also be reported via Child Protection Committee. It was agreed that any recommendations for the service should be reported back to the Clinical & Care Governance Committee.

The Committee resolved:-

i. To note the content of the minutes of the Clinical & Care Governance Group

ii. To request that any recommendations for the Health Visiting service following the Child Protection Committee are reported back to the Clinical & Care Governance Committee.

CARE GOVERNANCE DATA

SUMMARY REPORT – NHS ADVERSE EVENTS

9. The committee had before it a report from Sarah Gibbon (Executive Assistant) which provided an overview of the NHS adverse event report.

It was noted that the 'harm' data conflates two issues (clinical harm and financial harm). The Committee agreed we need to ensure that trends and lessons learned are identified for a more meaningful context.

The committee noted downward trends in falls and adverse events.

The Committee resolved: -

(i) To note the report and to note that further improvements to the reporting and data will be made as the task & finish group progresses.

SUMMARY REPORT – NHS FEEDBACK

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

The Committee resolved: -

i. To note the report and to note that further improvements to the reporting and data will be made as the task & finish group progresses.

ITEMS TO ESCALATE TO THE INTEGRATION JOINT BOARD

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

The Committee resolved: -

To request that the IJB considers a development session on integration in the wider context and the interface with acute services and community planning (for example), to ensure a whole-systems approach and understanding

COUNCILLOR Sarah Duncan, Chairperson.

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Aberdeen City Health & Social Care Partnership
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Audit and Performance Systems Committee

Minute of Meeting

Tuesday, 12 February 2019
10.00 am RmTHeCR2, Marischal College

Present:	Rhona Atkinson(Chairperson); and Jonathan Passmore MBE, Cllr Gill Al-Samarai and Councillor Sarah Duncan (as substitute for Councillor Jenny Laing)
Also in attendance;	Alex Stephen (Chief Finance Officer), John Forsyth (Legal)
Apologies:	Councillor Jenny Laing

MEMBERS ARE REQUESTED TO INTIMATE ANY DECLARATIONS OF INTEREST

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

Councillor Duncan declared an interest in Item 12 on the agenda (Ethical Care & Living Wage Update Report) by virtue of her position as a paid official of Unison. Councillor Duncan intimated her intention to absent herself during that discussion.

The Committee resolved:-
To note Councillor Duncan's intimation and intention

MEMBERS ARE REQUESTED TO DETERMINE THAT ANY EXEMPT BUSINESS BE CONSIDERED WITH THE PRESS AND PUBLIC EXCLUDED

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

The Committee resolved:-
To note that there was no exempt business to be considered.

WELCOME AND APOLOGIES

3. The Chairperson welcomed all members and attendees and extended a warm welcome to Andy Shaw (External Auditor) and David Hughes (Internal Auditor).

Apologies were noted from Councillor Laing.

The Chairperson advised that Item 8 (Transformation Programme Monitoring) would follow after Item 5 (Forward Report Planner).

AUDIT AND PERFORMANCE SYSTEMS COMMITTEE
12 February 2019

MINUTE OF PREVIOUS MEETING OF 13 NOVEMBER 2018

4. The Committee had before it the minute of the previous meeting of 13 November 2018.

The Committee resolved:-
To approve that the minute was an accurate reflection of the meeting.

FORWARD REPORT PLANNER

5. The Committee had before it the Forward Report Planner.

The Committee resolved:-
To note its content and timelines.

TRANSFORMATION PROGRAMME MONITORING (INCLUDING PCIP)

6. The Committee had before it a report by Gail Woodcock. The report also contained an update on the PCIP.

The report recommended that the Committee:-

a) Note the information provided in this report.

The Committee heard that the report provided information on the pace of delivery together with highlights, in depth analysis and key project updates. The report had captured Lessons Learned and was broadly aligned to the developing strategic plan.

Considerable discussion continued due to the depth and quality of the report and the information it contained.

The Committee were then delivered a presentation on the PCIP by Dr Leask. This drew equal particpative discussion from the Committee.

Both authors were commended on providing a great deal of the information and assurance that the Committee sought.

AUDIT AND PERFORMANCE SYSTEMS COMMITTEE
12 February 2019

The Committee resolved:-

(i) To note the information provided in this report within the context of the discussion held and the specific requests for further reports as noted
(ii) to commend officers for the quality of the process followed and the evaluation reports provided.
(iii) That officers Circulate a list of projects that were to be reallocated from the Transformation Programme
(iv) Submit the requested report(s) to the Committee Meeting of 20 August 2019

STRATEGIC RISK REGISTER REVIEW

7. The Committee had before it a report by Martin Allan (Business Manager, ACHSCP).

The report recommended that the Committee:-

a) Approve and provide comment on the revised risk register, as at Appendix A.
b) Undertake an in-depth review of 1, 2 & 3 within the strategic risk register at appendix A.
c) Approve and provide comment on the revised risk appetite statement, as at Appendix B.

The Committee heard from Sandy Reid on behalf of Martin Allan and thereafter engaged in the review sought.

The Committee resolved:-

(i) To approve and provide comment on the revised risk register, as at Appendix A
(ii) Undertake an in-depth review of 1, 2 & 3 within the strategic risk register at appendix
(iii) To provide comment on the revised risk appetite statement, as at Appendix B, and
(iv) To require the report be revised to include consideration of the comments made.

BOARD ASSURANCE & ESCALATION REVIEW

8. The Committee had before it a report by Martin Allan (Business Manager, ACHSCP).

The Committee commented that the report served as a map of governance and was a guide as to who needed to look at what and when.

The Committee resolved:-
To approve and provide comment on the Board Assurance and Escalation Framework, as at Appendix A.

PERFORMANCE MONITORING

9. The Committee had before it the report by Alison MacLeod (Lead Strategy and Performance Manager, ACHSCP).

The Committee were appreciative of the style and content of the report which assisted provide direction on reporting. The Committee commented that the report identified the distinctions between the APS and CCG Committees though clearly linked their interdependency.

The Committee resolved:-

(i) To notes the mapping of the strategic performance indicators to the strategic aims and the strategic risk register.

(ii) To approve the proposed reporting arrangements of the strategic aims to both the Clinical and Care Governance and Audit and Performance Systems Committee.

DELAYED DISCHARGES

10. The Committee had before it the report by Kenneth O'Brien (Service Manager, ACHSCP) which provided an update on current delayed discharge performance information regarding the Aberdeen City Partnership.

The Committee were appreciative of the volume and quality of the report, together with the honesty and passion presented during discussions all of which assisted the Committee provide the assurances they are required to discharge.

The Committee resolved:-
To note the performance information contained within the report

AUDIT AND PERFORMANCE SYSTEMS COMMITTEE
12 February 2019

REVIEW ON PROGRESS WITH LOCALITY PLANNING

11. The Committee had before it the report by Anne McKenzie (Aligned Senior Manager – North Locality) which discussed the transition from 4 to 3 localilites.

The Committee commented that the report provided the position statement they were looking for.

The Committee resolved:-
To note the contents of the report

STRATEGIC COMMISSIONING IMPLEMENTATION PLAN REVIEW

12. The Committee had before it the report by Anne McKenzie (Aligned Senior Manager – North Locality).

The Committee were satisfied that the report provided confirmation that the realignment is the best way forward.

The Committee resolved:-
To note the content of the report

ETHICAL CARE CHARTER & LIVING WAGE UPDATE REPORT

13. In accordance with Item 1 – Declarations of Interest, Councillor Duncan withdrew from the meeting at this point.

The Committee had before it the report by Claire Duncan (Lead Social Work Officer, ACC).

The report recommended that the Committee:-

d) Note the implementation of the Scottish Living Wage.
e) Note the progress across the stages of the Charter
f) Note that the Charter will be included in the workstream for Care at Home commissioning.

The Committee heard that this was the first report to Committee on the topic which was aligned to Scottish Government Charter on the Living Wage for all care workers. Whilst all care providers are aware of the requirements, this cannot be mandated on all

providers albeit most have agreed. How to introduce this within ACHSCP contracts is being considered but this may also bring financial impact.

The Committee resolved:-
(i) To note the implementation of the Scottish Living Wage.
(ii) To note the progress across the stages of the Charter.
(iii) To note that the Charter will be included in the workstream for Care at Home commissioning.
(iv) To encourage that service delivery partners strive to achieve all aspects of the Charter.
(v) To re-emphasise that the Charter was endorsed and not signed.

Councillor Duncan re-joined the meeting at conclusion of this item.

FINANCIAL MONITORING

14. The Committee had before it the report By Alex Stephen (Chief Financial Officer, ACHSCP).

A minor typo at 3.2 saw a change to the date of 31.12.2018. The Committee entered into discussions regarding the report and commented on the continuing financial challenges which would require strategy in some areas to assist. The report also highlighted some areas worthy of future development and consideration.

1.1. The report recommended that the Audit & Performance Systems Committee:
g) Notes this report in relation to the IJB budget and the information on areas of risk and management action that are contained herein.
h) Notes the budget virements indicated in Appendix E.

The Committee resolved:-
(i) To note this report in relation to the IJB budget and the information on areas of risk and management action that are contained herein.
(ii) To note the budget virements indicated in Appendix E.
(iii) To recognise the astute financial management exercised.

AUDIT AND PERFORMANCE SYSTEMS COMMITTEE
12 February 2019

EXTERNAL AUDIT PLAN

15. The Committee had before it the report by Andy Shaw, Director (Assurance, KPMG), the external auditor to the IJB.

The Committee heard an overview of the document which included the methodology used. This included reference to Audit Scotland requirements in respect of risk.

The Committee resolved:-
To approves the approach to external audit, as outlined in Appendix A.

INTERNAL AUDIT - BUDGET SETTING, MONITORING AND FINANCIAL PERFORMANCE

16. The Committee had before it the report by David Hughes, (Chief Internal Auditor, Aberdeenshire Council).

The Committee were assured by the report and discussion.

The Committee resolved:-
To review, discuss and comment on the issues raised within the report

LOCAL GOVERNMENT FINANCE - AUDIT SCOTLAND

17. The Committee had before it the report by Alex Stephen, Chief Finance Officer.

The report provided additional information what

The Committee resolved:-

(i) To reviews, discuss and comment on the report as attached at Appendix A.

(ii) To instructs the Chief Finance Officer to bring the report, *Local government in Scotland: Challenges and performance*, to be published by the Accounts Commission in March 2019, which comments on the wider challenges and performance of councils, to the Committee at its meeting in May 2019.

AUDIT AND PERFORMANCE SYSTEMS COMMITTEE
12 February 2019

CONFIRMATION OF ASSURANCE

18. 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.

The Committee resolved:-
That they were satisfied that they had been able to discharge their duties of assurance.

AUDIT AND PERFORMANCE SYSTEMS COMMITTEE
12 February 2019

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INTEGRATION JOINT BOARD
BUSINESS STATEMENT

26 MARCH 2019

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 is overdue.

No.	Minute Reference	IJB Decision	Update	Lead Officer(s)	Expected
1.	IJB 30.01.18 Article 10 22.01.19 Article 8	**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. In December 2018, the Board requested that an update report be provided to the January 2019 meeting which could include recent information which had been presented to the NHSG Board. On 22 January 2019, the Board noted the paper submitted then and requested a further report be presented to the APS Committee for discussion then presented to the IJB meeting of 26.03.	Business Manager, Aberdeen City Health and Social Care Partnership	26.03.2019
2.	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 was deferred to the meeting of 22 January 2019, however as the implementation plan is still under development, this will now be reported in March 2019.	Public Health Lead, Aberdeen City Health & Social Care Partnership	26.03.19
3.	IJB 09.10.18 Article 15	**Localities** The Board instructed the Chief Officer to		Lead Transformation Manager,	26.03.19

No.	Minute Reference	IJB Decision	Update	Lead Officer(s)	Expected
		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 26 March 2019 with the results of this review and consultation along with the new Strategic Plan once finalised.		Aberdeen City Health and Social Care Partnership	
4.	IJB 11.12.18 Article 12	**Draft Strategic Plan 2019-2022** The Board instructed that the revised ACHSCP Strategic Plan be presented to the IJB at its meeting of 26 March 2019 for final agreement, and noted that the IJB would be advised when the accompanying Implementation Plan would be presented to the Audit & Performance Systems Committee.		Planning and Development Manager, Aberdeen City Health and Social Care Partnership	26.03.19
5.	IJB 11.12.18 Article 20	**Commissioning and Procurement Workplan** The Board noted that service reviews were about to commence and that should any commissioning decisions be required as a result of the service reviews, these would be reported to the Board in March 2019.		Lead Strategy and Performance Manager, Aberdeen City Health and Social Care Partnership	26.03.19
6.	IJB 11.12.18 Article 15	**Strategic Planning Framework for Delegated Services (Acute)** The Board agreed to approve the approach set out in the report as a working draft proposal, and instructed that		Chief Officer, Aberdeen City Health and Care Partnership	June 2019

No.	Minute Reference	IJB Decision	Update	Lead Officer(s)	Expected
		the Chief Officer report back to the IJB for formal endorsement of the approach within six months, following review of the draft process and subject to receiving clarification on the North East Partnership Steering Group and its role and remit.			
7.	IJB 11.12.18 Article 16	**Alcohol and Drug Partnership Investment Plan** The Board requested that an annual report be submitted to the IJB in respect of the Investment Plan.		Alcohol and Drug Partnership Team Lead	December 2019
8.	IJB 11.12.18 Article 13	**Autism Strategy and Action Plan** The Board noted that progress reports on the implementation of the above would be provided annually, with updates to the Clinical Care and Governance Committee in the interim.		Strategic Development Officer, Aberdeen City Health and Social Care Partnership	April 2020

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INTEGRATION JOINT BOARD

Date of Meeting	26.03.2019
Report Title	Appointment of IJB Members
Report Number	HSCP.18.144
Lead Officer	Chief Officer, Aberdeen City Health and Social Care Partnership
Report Author Details	Derek Jamieson, Clerk to IJB (ACC Governance)
Consultation Checklist Completed	*Yes*
Directions Required	No
Appendices	A) IJB Meeting Schedule 2019/20

1. Purpose of the Report

1.1. Following changes to appointments within NHS Grampian and Aberdeen City Council which has impacted on the membership of the Integration Joint Board, the Board needs to appoint from within:

a. Vice Chairperson to the Integration Joint Board.

b. Members to the Audit & Performance Systems Committee and the Clinical & Care Governance Committee.

c. Chair of the Audit & Performance Systems Committee and the Clinical & Care Governance Committee.

INTEGRATION JOINT BOARD

2. Recommendations

2.1. It is recommended that the Integration Joint Board (IJB):

1. Note that NHSG has appointed Kim Cruttenden, as a voting member to the IJB, and is to shortly appoint a further two voting members;

2. Note that Aberdeen City Council has appointed Councillor Lesley Dunbar and Councillor Philip Bell as a voting members to the IJB;

3. Appoint an NHSG voting member as Vice Chair to the IJB;

4. Review the membership for the Audit & Performance (APS) Committee and appoint four voting members to the committee (two from each representative organisation)

5. Review the membership for the Clinical & Care Governance (CCG) Committee and appoint four voting members to the committee (two from each representative organisation)

6. Appoint a Chairperson from both the APS and CCG Committees, ensuring that this follows the principles of equal representation.

7. Reaffirm the IJB meeting schedule for 2019-20 attached as **Appendix A**.

3. Summary of Key Information

3.1. The IJB Standing Orders and its Committees' Terms of Reference identify the governance to be applied for appointment of membership and includes the principles of equal representation.

3.2. Rhona Atkinson and and Professor Steve Heys have now left the Aberdeen City IJB and Jonathan Passmore shall leave by the end of March 2019.

3.3. Kim Cruttenden has joined NHS Grampian and been appointed to the IJB. At the time of writing this report, two further NHSG Board members are to be confirmed

INTEGRATION JOINT BOARD

3.4. Councillor Jenny Laing has been replaced by Councillor Lesley Dunbar as ACC voting member to the IJB. Councillor Claire Imrie has been replaced by Councillor Philip Bell as ACC voting member to the IJB.

Vice Chair

3.5. The IJB needs to appoint a voting member to Vice Chair for the IJB. As required by 3(1) of the IJB Standing orders, as the current chair of the IJB is an Aberdeen City Council voting member, the vice chair should be appointed from the NHS Grampian voting members.

Voting Members to Committees

3.6. Standing Order 23 of the IJB Standing Orders and paragraph 2.1 of the APS Committee's terms of reference note that the power to appoint committee members rests with the IJB.

3.7. Following recent changes in the Integration Joint Board, there are now two vacancies on both the APS and CCG Committees.

3.8. As per IJB standing order 2(1) the composition of IJB committees have been based on the principle of equal representation between Aberdeen City Council (ACC) and NHG Grampian (NHSG) in terms of voting membership.

3.9. In order to meeting the principle of equal representation between ACC and NHSG for this committee, the IJB should appoint two NHSG members and two ACC members to each committee.

Chair of the Audit & Performance Systems (APS) Committee/Clinical & Care Governance Committee

3.10. The Board is required to appoint a Chairperson to both the APS and CCG Committees as per standing order 23(2). In order to adhere to the Board's equal representation principles, it is recommended the Chairs should be voting members from different organisations (NHSG/ACC).

4. Implications for IJB

4.1. **Equalities:** there are no equalities implications.

4.2. **Fairer Scotland Duty**: there are no implications relating to the Fairer Scotland Duty

INTEGRATION JOINT BOARD

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: NA

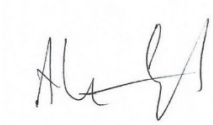
5. Links to ACHSCP Strategic Plan: NA

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	
	Sandra Ross (Chief Officer)
	Alex Stephen (Chief Finance Officer)

MEETING SCHEDULE 2019-20

INTEGRATION JOINT BOARD

All meetings commence at 10am in the Health Village:-

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;
10:00am, 24 March 2020 - Health Village.

Workshops

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
10:00am, 3 December 2019 - Lewis Room, Royal Cornhill Hospital

AUDIT AND PERFORMANCE SYSTEMS COMMITTEE

All meetings commence at 10am in the Health Village:-

10:00am, 28 May 2019 - Health Village;
10:00am, 20 August 2019 - Health Village: **closed meeting with auditors;**
10:00am, 29 October 2019 - Health Village;
10:00am, 25 February 2020 - Health Village; and
10:00am, 28 April 2020 - Health Village: **closed meeting with auditors.**

CLINICAL AND CARE GOVERNANCE COMMITTEE

All meetings commence at 10am in the Health Village:-

10:00am, 14 May 2019 – Health Village;
10:00am, 13 August 2019 – Health Village;
10:00am, 5 November 2019 – Health Village
10:00am, 4 February 2020 – Health Village

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INTEGRATION JOINT BOARD

Date of Meeting	26.03.2019
Report Title	Strategic Risk Register
Report Number	HSCP.18.143
Lead Officer	Sandra Ross, Chief Officer
Report Author Details	Name: Martin Allan Job Title: Business Manager Email Address: martin.allan3@nhs.net
Consultation Checklist Completed	*Yes*
Appendices	a. Strategic Risk Register

1. Purpose of the Report

1.1. To present the Integration Joint Board (IJB) with the latest version of the Aberdeen City Health & Social Care Partnership's (ACHSCP) strategic risk register.

2. Recommendations

2.1. It is recommended that the Integration Joint Board:

a) Approve the revised risk register, as shown in Appendix A.

3. Summary of Key Information

At its meeting in January 2019, the IJB considered a report on strategic risk, with particular reference to Brexit, and noted that the Risk Register was to be reported to the Audit and Performance Systems Committee for discussion and that a further report would be reported to the IJB in March 2019.

Revised Strategic Risk Register

3.1. The strategic risk register has been reviewed by the risk owners and updates provided on each risk contained within it.

3.2. Key changes to the strategic risk register in this version are:

a) Including the IJB risk assessment matrices as an appendix to the strategic risk register for ease of reference. This is the NHS Scotland Core Risk Assessment Matrix, as outlined in appendix 6 of the Board Assurance and Escalation Framework.

b) Re-combining risk 1a and 1b and revising the description of the risk to read: *"There is a risk that if there is not sufficient capacity in the market, that we fail to deliver on our duty to provide the services outlined in the integration scheme"*

c) Adding an additional risk (Risk 10): "There is a risk that ACHSCP is not sufficiently prepared to deal with the impacts of Brexit on areas of our business, including affecting the available workforce and supply chain". This new risk was approved by the Integration Joint Board at its meeting on 22 January 2019.

In-Depth Review of Risks 1, 2 & 3

3.3. At the meeting of the APS Committee on 11 September 2018, the Committee agreed "*to monitor three risks within the strategic risk register at each Committee meeting up until the next review period, and to treat the register as a living document".*

3.4. The APS Committee received additional updates on risks 1, 2 & 3 at its meeting in February 2019 and undertook an in-depth discussion on each of these risks. These changes are reflected in the current version of the strategic risk register (appendix A)

4. Implications for IJB

4.1. **Equalities –** while there are no direct implications arising directly as a result of this report, equalities implications will be taken into account when implementing certain mitigations.

4.2. **Fairer Scotland Duty –** while there are no direct implications arising directly as a result of this report, the Fairer Scotland duty will be taken into account, where appropriate, where implementing certain mitigations.

INTEGRATION JOINT BOARD

4.3. **Financial** – while there are no direct implications arising directly as a result of this report financial implications will be taken into account when implementing certain mitigations.

4.4. **Workforce -** there are no direct implications arising directly as a result of this report.

4.5. **Legal -** there are no direct implications arising directly as a result of this report.

4.6. **Other -** there are no direct implications arising directly as a result of this report.

5. Links to ACHSCP Strategic Plan

5.1. Ensuring a robust and effective risk management process will help the ACHSCP achieve the strategic priorities as outlined it its strategic plan, as it will monitor, control and mitigate the potential risks to achieving these.

6. Management of Risk

6.1. **Identified risks(s):** all known risks

6.2. **Link to risks on strategic or operational risk register:** all risks as captured on the strategic risk register.

6.3. **How might the content of this report impact or mitigate these risks:** Ensuring a robust and effective risk management process will help to mitigate all risks.

Approvals	
	Sandra Ross (Chief Officer)
	Alex Stephen (Chief Finance Officer)

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Aberdeen City Health & Social Care Partnership

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Strategic Risk Register 2018/19

Revision	Date
1.	March 2018
2.	September 2018
3.	October 2018 (IJB & APS)
4	February 2019 (APS)
5.	March 2019 (IJB)

Aberdeen City Health & Social Care Partnership

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Introduction & Background

This document is made publicly available on our website, in order to help stakeholders (including members of the public) understand the challenges currently facing health and social care in Aberdeen.

This is the strategic risk register for the Aberdeen City Integration Joint Board, which lays the foundation for the development of work to prevent, mitigate, respond to and recover from the recorded risks against the delivery of its strategic plan.

Just because a risk is included in the Strategic Risk Register does not mean that it will happen, or that the impact would necessarily be as serious as the description provided.

More information can be found in the Board Assurance and Escalation Framework and the Risk Appetite Statement.

Appendices

- Risk Tolerances
- Risk Assessment Tables

Colour – Key

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

Risk Summary:

1	There is a risk that there is insufficient capacity in the market (or appropriate infrastructure in-house) to fulfil the IJB's duties as outlined in the integration scheme. This includes commissioned services and general medical services.	**High**
2	There is a risk of financial failure, that demand outstrips budget and IJB cannot deliver on priorities, statutory work, and projects an overspend.	**High**
3	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.	**High**
4	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.	**Medium**
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.	**Medium**
6	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	**Medium**
7	Failure to deliver transformation at a pace or scale required by the demographic and financial pressures in the system	**High**
8	There is a risk that the IJB does not maximise the opportunities offered by locality working	**High**
9	There is a risk of failure to recruit and that workforce planning across the Partnership is not sophisticated enough to maintain future service deliver	**High**
10	There is a risk that ACHSCP is not sufficiently prepared to deal with the impacts of Brexit on areas of our business, including affecting the available workforce and supply chain.	**High**

- 1 -	
Description of Risk: There is a risk that there is insufficient capacity in the market (or appropriate infrastructure in-house) to fulfil the IJB's duties as outlined in the integration scheme. This includes commissioned services and general medical services.	
Strategic Priority: Outcomes, safety and transformation	**Leadership Team Owner:** Lead Commissioner
Risk Rating: low/medium/high/very high **HIGH** **Risk Movement:** increase/decrease/no change **NO CHANGE 11.03.2019**	**Rationale for Risk Rating:** • While there has previous provider failure in City (and across Scotland), this has provided valuable experience and an opportunity for learning). • Discussion with current providers and understanding of market conditions across the UK and in Aberdeen locally. • Impact of Living Wage on profitability depending on some provider models. **Rationale for Risk Appetite:** • As 3rd and independent sectors are key strategic partners in delivering transformation and improved care experience, we have a low tolerance of this risk.
Controls: • Robust market and relationship management with the 3rd and independent sector and their representative groups. • Market facilitation programme and robust contract monitoring process • GP Contracts and Contractual Review and GP Sustainability Risk Review - workforce and role review in primary care.	**Mitigating Actions:** • The IJB's commissioning model has an influence on creating capacity and capability to manage and facilitate the market • Development of provider forum and peer mentorship to support relationship and market management • Risk fund set aside with transformation funding • Additional Scottish Government funding toward the Living Wage and Fair Working Practices have been agreed and applied by the IJB • Lessons learned during a recent experience of managing a residential home; GP practice closure and care provider should market failure occur, and the transition of a significant number

	of care packages, and continued strengthening relationships and partnership working • Strategic Commissioning Implementation & Market Facilitation Plan will be reviewed in March 2019 • Approved Reimaging Primary Care Vision and currently implementing the Primary Care Improvement Plan • Implementation of the new GMS Contract
Assurances: • Market management and facilitation • Inspection reports from the Care Inspectorate • Contract monitoring process, including GP contract review visit outputs.	**Gaps in assurance:** • Market or provider failure can happen quickly despite good assurances being in place. For example, even with the best monitoring system, the closure of a practice can happen very quickly, with (in some cases) one partner retiring or becoming ill being the catalyst. • We are currently undertaking service mapping which will help to identify any potential gaps in market provision
Current performance: • We received notification on Monday 11th February 2019 from Four Seasons Health Care (the private provider of care at the Banks O' Dee Care Home) of their intention to withdraw service following a contractual notice period. If no provider is found a thirteen-week notice period of closure will commence thereafter. It is envisaged that formal notice will be given on 20th March, with closure date of 21st June 2019. • Sleepovers – the uplift to accommodate the living wage for sleepover staff was implemented in October 2018. • A 'Lessons Learnt' exercise was undertaken in February 2019 with the contracts team relating to the recent situation with Allied Healthcare – this will provide useful information should other providers fail.	**Comments:** • National Care Home Contract uplift for 2016/17 was 6.4% and 2.8% 2017/18. Negotiations with individual providers are currently taking place for uplifts specific to their needs of up to 3.8%. • IJB agreed payment of living wage to Care at Home providers for 2016/17, 2017/18 and 2018/19

• Several GP practices have required support from ACHSCP over the past 2 years, most recently Torry Medical Practice and Rosemount Medical Group.	

-2-	
Description of Risk: There is a risk of IJB financial failure and projecting an overspend, due to demand outstripping available budget, which would impact on the IJB's ability to deliver on its strategic plan (including statutory work).	
Strategic Priority: Outcomes and transformation	**Leadership Team Owner:** Chief Finance Officer
Risk Rating: low/medium/high/very high **HIGH** **Risk Movement:** increase/decrease/no change*:* **NO CHANGE 11.03.2019**	**Rationale for Risk Rating:** • If the partnership fails financially then decisions will be required to stop services. In a health and social care environment this is difficult to do given the reliance service users place on these services. It could also impact on the delivery of the strategy plan as officer's time would be diverted from transformational activities to balance the budget. • If the levels of funding identified in the Medium Term Financial Framework are not made available to the IJB in future years, then tough choices would need to be made about what the IJB wants to deliver. It will be extremely difficult for the IJB to continue to generate the level of savings year on year to balance its budget. **Rationale for Risk Appetite:** The IJB has a low-moderate risk appetite to financial loss and understands its requirement to achieve a balanced budget. The IJB recognises the impacts of failing to achieve a balanced budget on Aberdeen City Council & its bond – an unmanaged overspend may have an impact on funding levels. However the IJB also recognises the significant range of statutory services it is required to meet within that finite budget and has a lower appetite for risk of harm to people (low or minimal).

Controls: Budgets delegated to cost centre level and being managed by budget holders.	**Mitigating Actions:** • Financial information is reported regularly to the Audit & Performance Systems Committee, the Integration Joint Board and the Leadership Team. • Approved reserves strategy, including risk fund. • Robust financial monitoring and budget setting procedures including regular budget monitoring & budget meeting with budget holders. • Medium-Term Financial Strategy was reviewed and approved at the IJB on 12th March 2019. This includes a predicted outlook for 10 years • Audit & Performance Systems receives regular updates on transformation programme & spend. • The Leadership Team are committed to driving out efficiencies, encouraging self management and moving forward the prevention agenda to help manage future demand for services. Lean Six Sigma methodology is being applied to carry out process improvements.
Assurances: • Audit and Performance Systems Committee oversight and scrutiny of budget under the Chief Finance Officer. • Board Assurance and Escalation Framework. • Quarterly budget monitoring reports. • Regular budget monitoring meetings between finance and budget holders.	**Gaps in assurance:** • The financial environment is challenging and requires regular monitoring. The scale of the challenge to make the IJB financially sustainable should not be underestimated. • Financial failure of hosted services may impact on ability to deliver strategic ambitions.
Current performance: • Year-end position for 2017/18	**Comments:** • Regular and ongoing budget reporting and management scrutiny in place.

• Forecasted year end position 2018/19 overspend on mainstream position • Projected overspend on mainstream budgets can be accommodated from within the total resources available to the IJB.	• Budget monitoring procedure now well established. • Budget holders understand their responsibility in relation to financial management. • Scottish Government Medium Term H&SC Financial Framework – released and considered by APS Committee. • The recent Audit Scotland report 'Progress with Integration' recommended that HSCPs should aspire to develop a long-term financial strategy.

- 3 –	
Description of Risk: There is a risk that hosted services do not deliver the expected outcomes, fail to deliver transformation of services, or face service failure and that the IJB fails to identify such non-performance through its own systems and pan-Grampian governance arrangements. This risk relates to services that Aberdeen IJB hosts on behalf of Moray and Aberdeenshire, and those hosted by those IJBs and delivered on behalf of Aberdeen City.	
Strategic Priority: Outcomes and transformation	**Leadership Team Owner:** Chief Officer
Risk Rating: low/medium/high/very high **HIGH** **Risk Movement:** (increase/decrease/no change): **NO CHANGE 11.03.2019**	**Rationale for Risk Rating:** • Considered high risk due to the projected overspend in hosted services • Hosted services are a risk of the set-up of Integration Joint Boards. **Rationale for Risk Appetite:** • The IJB has some tolerance of risk in relation to testing change.
Controls: • Integration scheme agreement on cross-reporting • North East Strategic Partnership Group • Operational risk register	**Mitigating Actions:** • This is discussed regularly by the three North East Chief Officers • Regular discussion regarding budget with relevant finance colleagues. • Chief Officers should begin to consider the disaggregation of hosted services.
Assurances: • These largely come from the systems, process and procedures put in place by NHS Grampian, which are still being operated, along with any new processes which are put in place by the lead IJB.	**Gaps in assurance:** • There is a need to develop comprehensive governance framework for hosted services, including the roles of the IJB's sub-committees.

	• A framework for strategic planning for delegated (hosted) services has been developed and is in the process of being approved by the 3 IJBs. The Aberdeen City IJB did not approve this framework as they had concerns regarding the governance processes relating to the meetings of the North East Partnership Steering Group • Pan-Grampian meetings between IJBs are not happening with sufficient regularity to resolve hosted services issues. There is a desire to increase the frequency of the meeting of the North East Partnership Steering Group and to refine its role and remit to clarify its decision making powers.
Current performance: • The projected overspend on hosted services is a factor in the IJB's overspend position. This may in future impact on the outcomes expected by the hosted services.	**Comments:** • It is noted that NHS Grampian are currently undertaking an internal audit on the governance of hosted services.

- 4 –	
Description of Risk: There is a risk that relationship arrangements between the IJB and its partner organisations (Aberdeen City Council & NHS Grampian) are not managed in order to maximise the full potential of integrated & collaborative working to deliver the strategic plan. This risk covers the arrangements between partner organisations in areas such as governance arrangements, human resources; and performance.	
Strategic Priority: Outcomes and service transformation	**Leadership Team Owner:** Chief Officer
Risk Rating: low/medium/high/very high **MEDIUM** **Risk Movement:** (*increase/decrease/no change)* **NO CHANGE 11.03.2019**	**Rationale for Risk Rating:** • Considered medium given the experience of nearly three years' operations since 'go-live' in April 2016. • However, given the wide range and variety of services that support the IJB from NHS Grampian and Aberdeen City Council there is a possibility of services not performing to the required level. **Rationale for Risk Appetite:** There is a zero tolerance in relation to not meeting legal and statutory requirements.
Controls: • IJB Strategic Plan • IJB Integration Scheme • IJB Governance Scheme including 'Scheme of Governance: Roles & Responsibilities'. • Agreed risk appetite statement • Role and remit of the North East Strategic Partnership Group in relation to shared services • Current governance committees within IJB & NHS.	**Mitigating Actions:** • Regular consultation & engagement between bodies. • Regular and ongoing Chief Officer membership of Aberdeen City Council's Corporate Management Team and NHS Grampian's Senior Leadership Team • Regular performance meetings between ACHSCP Chief Officer, Aberdeen City Council and NHS Grampian Chief Executives. • Additional mitigating actions which could be undertake are including this area within the audit programme and doing bench-marking activity with other IJBs.

	• In relation to capital projects, Joint Programme Boards established to co-produce business cases, strategic case approved by IJB and economic, financial, commercial, management case approved by NHSG Board and ACC Committees
Assurances: • Regular review of governance documents by IJB and where necessary Aberdeen City Council & NHS Grampian. The next review of the Scheme of Governance is due in June 2019.	**Gaps in assurance:** • None currently significant though note consideration relating to possible future Service Level Agreements.
Current performance: • Most of the major processes and arrangements between the partner organisations have been tested for over two years of operation and no major issues have been identified. • A review of the Integration Scheme has been undertaken and the revised scheme has been approved by NHSG, Aberdeen City Council & Scottish Government. • However this does not remove the risk as processes within the IJB and partner organisations will continue to evolve and improve.	**Comments:** • Nothing to update on this risk.

- 5 –	
Description of Risk: 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 national and 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.	
Strategic Priority: Outcomes, safety, transformation of services	**Leadership Team Owner:** Lead Strategy & Performance Manager
Risk Rating: low/medium/high/very high **MEDIUM** **Risk Movement:** (*increase/decrease/no change)* **NO CHANGE 11.03.2019**	**Rationale for Risk Rating:** Service delivery is broad ranging and undertaken by both in-house and external providers. There are a variety of performance standards set both by national and regulatory bodies as well as those determined locally and there are a range of factors which may impact on service performance against these. Poor performance will in turn impact both on the outcomes for service users and on the reputation of the IJB/partnership. **Rationale for Risk Appetite:** The IJB has no to minimal tolerance of harm happening to people as a result of its actions, recognising that in some cases there may be a balance between the risk of doing nothing and the risk of action or intervention.
Controls: • Clinical and Care Governance Committee and Group • Audit and Performance Systems Committee • Performance Management and Evaluation Group • Performance Framework • Risk-assessed plans with actions and performance measures • Linkage with ACC and NHSG performance reporting • Annual Report • Chief Social Work Officer's Report	**Mitigating Actions:** • Fundamental review of key performance indicators reported • Review of systems used to record, extract and report data • Review of and where and how often performance information is reported on and how learning is fed back into processes and procedures. • On-going work developing a culture of performance management and evaluation throughout the transformation programme

• Internal Audit Reports Complaints Contract management framework	
Assurances: • Joint meeting of IJB Chief Officer with two Partner Body Chief Executives. • Reports to Clinical and Care Governance Committee and Audit & Performance Committee. • Care Inspectorate Inspection reports • Contract review meetings. • External reviews of performance. • Benchmarking with other IJBs.	**Gaps in assurance:** • Formal performance reporting process is evolving.
Current performance: • Performance reports submitted to IJB and Audit and Performance Systems Committee. • Performance Management and Evaluation Group meeting regularly. • Various Steering Groups for strategy implementation established and reviewing performance regularly. • Performance data discussed at team meetings. • Close links with social care commissioning, procurement and contracts team have been established	**Comments:** • Clinical and Care Governance Committee and Group have been established and are meeting regularly, reporting arrangements are being developed. . •

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Description of Risk: There is a risk of reputational damage to the IJB and its partner organisations resulting from complexity of function, decision making, delegation and delivery of services across health and social care.	
Strategic Priority: All	**Leadership Team Owner:** Communications Lead
Risk Rating: low/medium/high/very high **Medium**	**Rationale for Risk Rating:** • Governance processes are in place and have been tested since go live in April 2017. • Budget processes tested during approval of 3rd budget, which was approved. **Rationale for Risk Appetite:** Willing to risk certain reputational damage if rationale for decision is sound.
Risk Movement: (*increase/decrease/no change)* **No Change 11.03.2019**	
Controls: • Leadership Team • IJB and its Committees • Operational management processes and reporting • Board escalation process	**Mitigating Actions:** • Clarity of roles • Staff and customer engagement – recent results from iMatter survey alongside a well-establish Joint Staff Forum indicate high levels of staff engagement. • Effective performance and risk management • To ensure that ACHSCP have a clear communication & engagement strategy, and a clear policy for social media use, in order to mitigate the risk of reputational damage. • Communications lead membership of Leadership Team facilities smooth flow of information from all sections of the organisation

	• Robust relationships with all local media are maintained to ensure media coverage is well-informed and accurate
Assurances: • Role of the Chief Officer and Leadership Team • Role of the Chief Finance Officer • Performance relationship with NHS and ACC Chief Executives • Communications plan / communications manager	**Gaps in assurance:** None known at this time
Current performance: • Communications officer in place to lead reputation management	**Comments:** • Communications strategy and action plan in place and being led by the HSCP's Communications Manager • Communication and Engagement Group being strengthened by selection of 'Communications' Champions' across ACHSCP comprising of staff across the partnership to support us in getting the messages timely and appropriate • Locality leadership groups being established to build our relationship with communities and stakeholders • Regular Chief Officer (CO) and Chief Executives (Ces) meeting supports good communication flow across partners as does CO's membership of the Corporate Management Teams of both ACC and NHSG

- 7 –	
Description of Risk: Failure of the transformation to delivery sustainable systems change, which helps the IJB deliver its strategic priorities, in the face of demographic & financial pressures.	
Strategic Priority: All	**Leadership Team Owner:** Transformation Lead
Risk Rating: low/medium/high/very high **HIGH** **Risk Movement:** (*increase/decrease/no change)* **NO CHANGE 11.03.2019**	**Rationale for Risk Rating:** • Recognition of the known demographic curve & financial challenges, which mean existing capacity may struggle • This is the overall risk – each of our transformation programme work streams are also risk assessed with some programmes being a higher risk than others. **Rationale for Risk Appetite:** • The IJB has some appetite for risk relating to testing change and being innovative. • The IJB has no to minimal appetite for harm happening to people – however this is balanced with a recognition of the risk of harm happening to people in the future if no action or transformation is taken.
Controls: • Transformation Governance Structure and Process • Audit and Performance Systems Committee – quarterly reports to provide assurance of progress • Programme Board structure: Executive Programme board and portfolio programme boards are in place.	**Mitigating Actions:** • Programme management approach being taken across whole of the transformation programme • Transformation team in place and all trained in Managing Successful Programmes methodology

	• Regular reporting to Executive Programme Board and Portfolio Programme Boards • Regular reporting to Audit and Performance Systems Committee and Integration Joint Board • Six Sigma methodology being used to support delivery of strategic plan, medium term financial plan and to ensure sustainability. Evaluation process in place to track delivery of change and efficiencies • A number of plans and frameworks have been developed to underpin our transformation activity across our wider system including: Reimagining Primary and Community Care Vision, Transformation Plan, Primary Care Improvement Plan, Action 15 Plan.
Assurances: • Executive Management and Committee Reporting • Robust Programme Management approach supporting by an evaluation framework • IJB oversight • Board escalation process • Internal Audit has undertaken a detailed audit of our transformation programme. All recommendations from this audit have now been actioned.	**Gaps in assurance:** • There is a gap in terms of the impact of transformation on our budgets. Many of the benefits of our project relate to early intervention and reducing hospital admissions, neither of which provide earlier cashable savings. A range of financial workstreams have been established to deliver tangible cashable savings, however these are at an early stage and have yet to deliver, and there is therefore a gap in assurance in this area
Current performance: • Demographic financial pressure is starting to materialise in some of the IJB budgets. • Many projects are now in Delivery phase with a couple of projects achieving Close stage.	**Comments:** • The transformation team and organisational development team have been brought together (November 2018) to maximise the potential for successful and sustainable system change. • The wider transformation team is being supported to utilise Lean Six Sigma to drive out efficiencies and

• A number of evaluation reports are now available including West Visiting Service and INCA and the learning from these projects is in planning stages to be embedded across the wider organisation as appropriate.	improve processes across the organisation, this will be supported via a wider cultural change process across the whole organisation. • Improvements in process across the organisation will provide opportunities for implementing digital solutions. A digital strategy to support this will be developed

- 8 –	
Description of Risk There is a risk that the IJB does not maximise the opportunities offered by locality working	
Strategic Priority: All	**Leadership Owner:** Chief Officer
Risk Rating: low/medium/high/very high **HIGH** **Risk Movement:** (*increase/decrease/no change)* **NO CHANGE 11.03.2019**	**Rationale for Risk Rating:** • Localities are in an early, developmental stage and currently require strategic oversight so are included in this risk register. Once they are operational, they will be removed from the strategic risk register as a stand-alone item and will be included in the wider risk relating to transformation (risk 7). **Rationale for Risk Appetite:** The IJB has some appetite to risk in relation to testing innovation and change. There is zero risk of financial failure or working out with statutory requirements of a public body.
Controls: • Audit and Performance Systems Committee • Action plans as derived from the locality plans. • Locality Leadership Groups • Strategic Planning Group • Previous professional management structure maintaining safe delivery of services.	**Mitigating Actions:** • Continued broad engagement on locality working and requested development of comprehensive communication plan
Assurances: • Strategic Planning Group • Locality plans performance monitoring and review.	**Gaps in assurance** • Progress of delivering locality plans.

Current performance:	Comments:
• A period of consultation has recently considering proposed changes to the locality model and whether ACHSCP should move from a 4 to a 3-locality model, to align more strongly with community planning partners. Following this a three-locality model has been included in the draft revised strategic plan which will be consulted on in early 2019. • Heads of Locality are not currently reflected in the interim leadership team structure; however each Locality Leadership Group has an aligned senior manager from the Leadership Team and the future leadership arrangements for the localities will be confirmed in March/April 2019 as part of the wider review of the leadership team.	• Locality Leadership Groups continue to meet • Locality plans & profiles have been created for each of the 4 localities, approved by the IJB & published on the website. • All 4 localities have implementation action plans in place which provide evidence of progress being made towards the agreed priorities • The locality plans and supporting action plans will be reviewed as part of the review of the locality model to ensure they remain fit for purpose and aligned to the revised strategic plan

- 9 –	
Description of Risk: There is a risk of failing to recruit and retain staff, and that workforce planning across the Partnership is not sophisticated enough to maintain future service delivery.	
Strategic Priority: All	**Leadership Team Owner:** People & Organisation
Risk Rating: low/medium/high/very high **HIGH** **Risk Movement:** (*increase/decrease/no change)* **NO CHANGE 11.03.2019**	**Rationale for Risk Rating:** • The current staffing complement profile changes on an incremental basis over time. • However the number of over 50s employed within the partnership (by NHSG and ACC) is increasing (i.e. 1 in 3 nurses are over 50). • Current vacancy levels and delays in recruitment across ACHSCP services. **Rationale for Risk Appetite:** • Risk should be able to be managed with the adoption of workforce planning structures and processes
Controls: • Clinical & Care Governance committee reviews operational risk around staffing numbers	**Mitigating Actions:** • Active engagement with schools commenced to raise ACHSCP profile. • Use commissioning to encourage training of staff • Development of a workforce plan – due to be approved at IJB March 2019. • Agreed to establish a working group to lead on further development on workforce planning.

	• Increased emphasis on health/wellbeing of staff and communication with staff + greater promotion of flexible working
Assurances: • Workforce plan once developed for the whole Partnership.	**Gaps in assurance** • Need more information on social care staffing • Information on social care providers would be useful to determine trends in wider sector
Current performance: • Workforce planned developed for health and social care staff. Information expected from Scottish Government during over the next few months which should help improve workforce planning across all partnerships. • High levels of locum use and nursing vacancies in the psychiatry service, • Three secondary schools were visited by members of the Leadership Team during February and March 2019 • ACHSCP sickness absence rates lower in December 2018, compared to October/November. +	**Comments:** • The Leadership Team has considered several work-force initiatives including 'Career Ready' and 'Developing the Young Workforce' initiatives. The business manager will be developing these further before bringing a proposal to the IJB for approval. • Consultation responses provided to the Scottish Government relating to the Health & Care (Staffing) (Scotland) Bill.

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Description of Risk: There is a risk that ACHSCP is not sufficiently prepared to deal with the impacts of Brexit on areas of our business, including affecting the available workforce and supply chain. Whilst the impact on health and social care services of leaving the EU is impossible to forecast, it is clear that a number of issues will need to be resolved. Key areas for health and social care organisations to consider include: staffing; medical supplies; accessing treatment; regulation (such as working time directive and procurement/competition law, for example); and cross border issues.	
Strategic Priority: Outcomes, safety and transformation	**Executive Team Owner:** Business Manager
Risk Rating: low/medium/high/very high **HIGH**	**Rationale for Risk Rating:** • There is still a high level of uncertainty around 'Brexit' as impacts are difficult to forecast.
Risk Movement: (*increase/decrease/no change)* **NO CHANGE 11.03.2019**	
Controls: • NHSG have held a voluntary survey of EU nationals. ACC currently undertaking a survey of all staff to gather similar information. • NHSG - An initial operational assessment has been undertaken. A BREXIT co-ordinating group established with executive leadership. Engagement with staff who may be impacted by withdrawal of UK from the EU. Co-ordination with professional leads across Scotland and at SG - procurement, medicines, staff and resilience	**Mitigating Actions:** • Mitigating actions have been developed on a national and local level through Scottish Government guidance and the ACC and NHSG EU exit steering groups respectively. These actions are linked to the Scottish Planning Assumptions (based on the reasonable worst case scenario-no deal). The assumptions are: • Travel, Freight and Borders • Disruption of Services

• ACC- A Brexit Steering Group has been established and is meeting every 2 weeks. The Partnership is now a member of this Group. • Attendance at EU Exit - Planning on health and social care in Scotland Workshop, Stirling, 5th February, 2019. Outcomes fed into the Brexit Steering Group and reflected in this risk. • National Procurement of NHS National Services Scotland has been working for over 6 months with Scottish Government, NHS Scotland Health Boards, DHSC and suppliers to try to minimise the impact of EU Exit on the supply of Medical Devices & Clinical Consumables. Activities range from increased stock holding in items supplied from our own National Distribution Centre to UK wide participation in centralised stock building and supplier preparedness. • Scottish Government and NHS are participating in national exercises planned to test response structures. • Mutual Recognition of Professional Qualifications (MRPQ) will continue for health professionals already working in the UK before EU Exit, and for those whose application process began before the EU Exit date.	• Information and Data Sharing • Demonstrations and Disorder • Remote and Rural Scotland • Scottish Workforce • As the Partnership does not directly employ staff, The Chief Officer will work closely with partners to ensure that as implications become clear the Partnership are able to best represent and meet the needs of all staff. • The Partnership's Business Continuity Planning process is established which will identify key services to prioritise in any contingency event. •Review ALEO contingency plans. Request evidence of risk assessment and mitigation from ALEOS for assurance of ability to deliver against contract. •Survey of providers asking key questions on preparedness.
Assurances: • Understanding that current legislation will remain in effect immediate post Brexit	**Gaps in assurance:** • Whilst ACC/NHSG are gathering some data, the Partnership is unable to scrutinise accurate data on status of **all** staff across broader partnership (and other data sets relating to people performance). Resource being identified to help with collation and analysis of data. Chief Officer and Leadership Team have met with

	officers in NHSG and ACC to progress the data requirements of the Partnership. • Clarification regarding position for EU staff both current and future. • Uncertainty of final political decision on EU exit.
Current performance:	**Comments:** • ACHSCP colleagues will need to ensure continued engagement with ACC and NHSG working groups.

Appendix 1 – Risk Tolerance

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

Very High	Unacceptable level of risk exposure that requires urgent and potentially immediate corrective action to be taken. Relevant Chief Officer/Managers/Directors/Executive and Assurance Committees should be informed explicitly by the relevant Managers/Risk Owners. Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective. The IJB's will seek assurance that risks of this level are being effectively managed. However the IJB's may wish to accept opportunities that have an inherent very high risk that may result in reputation damage, financial loss or exposure, major breakdown in information system or information integrity, significant incidents(s) of regulatory non-compliance, potential risk of injury to staff and public

Appendix 2 – Risk Assessment Matrices (from Board Assurance & Escalation Framework)

Table 1 - Impact/Consequence Definitions

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

Table 2 - Likelihood Definitions

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

Table 3 - Risk Matrix

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

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

Table 4 - NHSG Response to Risk

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

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

Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Date of Meeting	26th March 2019
Report Title	Readmissions after 28 Days
Report Number	HSCP.18.150
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. Readmissions Report

1. Purpose of the Report

1.1. The purpose of this report is to provide an update on an analysis of readmissions data that took place in response to performance against this indicator being highlighted in the 2017/18 Annual Report.

2. Recommendations

2.1. It is recommended that the IJB:

a) Notes the finding of the analysis exercise.

b) Instructs the Chief Officer to investigate how the ACHSCP performance compares to the Grampian wide performance by referring the data to the Unscheduled Care Group.

c) Refers the report to the Clinical and Care Governance Group proposing that they could potentially use some of the data – particularly that in relation to Respiratory Medicine, Cardiology and

Infectious Diseases – as baseline indicators to measure the success of the Acute Care @ Home project.

3. Summary of Key Information

3.1. There are 23 national indicators that we report against. One of these is national indicator 14 "Readmissions to hospital within 28 days (per 1,000 population).

3.2. The IJB approved the Annual Report for 2017/18 at its August 2018 meeting. In this, it was reported that readmissions to hospital within 28 days had increased from 94 (per 1,000 population) the previous year to 103. The figures for Scotland, for the same period, were reported as having fallen from 100 (per 1,000 population) to 97. So, not only had the Aberdeen position worsened but it was going against the national trend.

3.3. The IJB requested that the reasons for this be investigated and a report brought back.

3.4. Appendix A is an analysis of the data on readmissions for the calendar year January to December 2018. The report shows analysis of readmissions data by Specialty, Hospital, Main Diagnosis and GP Practice. The data has been aligned to Aberdeen City HSCP based on patient postcode, except for data by GP practice which has been aligned based on patients current registered GP practice.

3.5. The following are the key findings of the analysis: -

- The readmission rate was 11.1%
- 28% of readmissions were for the same reason as the original admission.
- 87% of the readmissions were to ARI and, of these, 92% had originally been discharged from ARI.
- The top 3 areas where patients were readmitted were General Medicine, General Surgery (excluding Vascular) and Geriatric Medicine. These accounted for 48% of all readmissions.
- Excluding those areas where the total readmissions were less than 10, Paediatrics, Palliative and Clinical Oncology, the areas with the highest readmission rates where the readmission code was the same as the original admission code are: -
    - Haematology (54%)

- Oral and Maxillofacial Surgery (47%)
- General Surgery (excluding Vascular) (39%)
- Neurosurgery (38%)
- Ear, Nose and Throat (36%)
- Neurology (36%)

- Other than for Marywell, where the high readmissions rate is thought to be due to that practice's focus on homelessness, readmissions rates per GP practice were around the overall average.

3.6. It is suggested that the data does not indicate any particular areas of concern. It is proposed that the report be passed to the Unscheduled Care Group to allow for a comparison with the Grampian wide performance, and to the Clinical and Care Governance Group proposing that they could potentially use some of the data – particularly that in relation to Respiratory Medicine, Cardiology and Infectious Diseases – as baseline indicators to measure the success of the Acute Care @ Home project.

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.

4.5. Legal – there are no legal implications arising from this report.

4.6. Other – none.

5. Links to ACHSCP Strategic Plan

5.1. This report is providing analysis on performance against one of the national indicators which demonstrates progress or otherwise on the strategic priorities and national health and wellbeing outcomes as outlined in the strategic plan identifying areas for improvement activity.

INTEGRATION JOINT BOARD

6. Management of Risk

6.1. Identified risks(s)

If we do not analyse areas that are underperforming we will not fulfil our ambition to be a high performing partnership.

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 analysing areas that are underperforming the IJB can determine appropriate action, if required, to address this and drive performance standards up to an acceptable level.

Approvals	
	Sandra Ross (Chief Officer)
	Alex Stephen (Chief Finance Officer)

Aberdeen City Readmissions within 28 days, *based on data for January to December 2018*

The Aberdeen City Readmission Rate for the reporting period January 2018 to December 2018 is 11.1%
This is based on the number of readmissions as a percentage of total admissions, data source; Discovery.

1) Top 10 specialties with the highest Readmissions within 28 days for Aberdeen City patients

Readmission National Specialty Code	Readmission National Specialty Description	Total Readmissions Jan-Dec 2018	Percentage of readmissions with the same main diagnosis code for the original admission as for the readmission
A1	General Medicine	961	19%
C11	General Surgery (excl Vascular)	704	39%
AB	Geriatric Medicine	556	15%
AF	Paediatrics	385	38%
C2	Accident & Emergency	253	26%
A9	Gastroenterology	211	31%
CB	Urology	181	20%
AQ	Respiratory Medicine	178	30%
AD	Medical Oncology	147	31%
AG	Renal Medicine	130	22%

The 3 specialties General Medicine, General Surgery and Geriatric Medicine accounted for 48% or all readmissions within 28 days for 2018.

Of Aberdeen City's readmissions with 28 days…..

- 87% were readmitted to ARI
- Of the 87% (4,007 readmissions) readmitted to ARI within 28 days
  - 92% had originally been discharged from ARI
  - 4% had originally been discharged from Woodend
  - 4% had originally been discharged from other hospitals

- 28% of Aberdeen City readmissions within 28 days were for the same diagnosis code as the original admission.

2) Readmissions within 28 days by Readmission main Diagnosis code ICD10 Chapter

Readmission Main Diagnosis Code ICD10 Chapter	Percentage of Readmissions by ICD10 Chapter
1 Certain infectious and parasitic diseases	5%
2 Neoplasms	9%
3 Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	*<5%*
4 Endocrine, nutritional and metabolic diseases	*<5%*
5 Mental and behavioural disorders	*<5%*
6 Diseases of the nervous system	*<5%*
7 Diseases of the eye and adnexa	*<5%*
8 Diseases of the ear and mastoid process	*<5%*
9 Diseases of the circulatory system	7%
10 Diseases of the respiratory system	11%
11 Diseases of the digestive system	10%
12 Diseases of the skin and subcutaneous tissue	*<5%*
13 Diseases of the musculoskeletal system and connective tissue	*<5%*
14 Diseases of the genitourinary system	6%
15 Pregnancy, childbirth and the puerperium	*<5%*
16 Certain conditions originating in the perinatal period	*<5%*
17 Congenital malformations, deformations and chromosomal abnormalities	*<5%*
18 Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	20%
19 Injury, poisoning and certain other consequences of external causes	15%
21 Factors influencing health status and contact with health services	*<5%*
No Readmission Main_Diagnosis_Code Recorded	*<5%*

ICD10 Codes are the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO). It contains codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases that are grouped into Chapters.

3) Readmissions within 28 days by GP Practice

Readmission rates across City GP Practices vary from 9% to 15% for the period January to December 2018

Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Date of Meeting	26.03.2019
Report Title	Aberdeen City Health &Social Care Partnership's Health Improvement Fund
Report Number	HSCP.18.145
Lead Officer	Sandra Ross, Chief Officer (ACHSCP)
Report Author Details	Name: Katie Cunningham Job Title: Public Health Coordinator Email Address: katie.cunningham@nhs.net
Consultation Checklist Completed	Yes
Directions Required	No
Appendices	A. Health Improvement Fund, 2016-19 Report B. Health Improvement Fund Infographic 2017-18

1. Purpose of the Report

The purpose of the report is to:

a) Provide an update on the use of the Health Improvement Fund and developments from 2016-19.

b) Present the 2016-19 report on the Health Improvement Fund before it is circulated widely to partners, colleagues and members of the public.

c) Make recommendations regarding the annual reporting arrangements for the Fund from financial year 2019/20 onwards.

INTEGRATION JOINT BOARD

2. Recommendations

2.1. It is recommended that the Integration Joint Board:

a) Note the content of the report contained in appendix A, including the contribution of the Fund towards achieving the principles of the Christie Commission[1] and Community Empowerment Act[2]

b) Instruct the Chief Officer to bring an annual report relating to the Health Improvement Fund to the IJB in April 2020 and annually thereafter.

c) Instruct the Chief Officer to further develop the HIF core and Neighbourhood Health: HIF to be directed through localities with the ambition to allocate funds through Participatory Budgeting in the future

3. Summary of Key Information

3.1. The Health Improvement Fund (HIF) was established by the Scottish Executive in 2000 to focus on tackling priority health topics and addressing the broader determinants underlying health inequalities.

3.2. The fund remains an annually occurring allocation administered through the Aberdeen City Health & Social Care Partnership (ACHSCP) budget by public health and wellbeing. Since 2016, a proportion of HIF (£123,638) has remained available to commission or procure initiatives using evidence based rationales which address identified public health priorities. In recent years this has been used to fund City wide health improvement projects or pieces of work such a series of co-production training workshops during 2017/18 and to fund temporary health improvement posts in Aberdeen.

3.3. The remainder of the fund (£68,000) is available to kick-start community level initiatives to improve health and wellbeing, with the term 'community' encompassing both geographical areas and communities of interest (eg. carers). Advertised under the brand 'Neighbourhood Health: HIF,' grants of up to £2500 are available to anyone living or working in Aberdeen, as long as the work takes place within Aberdeen. Applications must meet the following funding principles:

1. Inspire members of the community to get involved
2. Meet local needs and reflect local circumstances
3. Are innovative and creative
4. Join people together
5. Help make Aberdeen a healthy and happy place for all

3.4. The fund is managed and overseen by staff from Aberdeen City H&SCP public health and wellbeing team. Allocations are decided upon by local decision making groups involving a range of frontline staff and community representatives, guided by a scoring process based on the funding principles stated above. There is one decision making group per locality with applications for city-wide projects being distributed amongst the groups.

3.5. Since its inception 2016, Neighbourhood Health: HIF has been subject to ongoing review and refinement. Quality improvement methodology was utilised to ensure the fund was in keeping with a number of principles and priorities described in the report of the Christie Commission[1] and Community Empowerment (Scotland) Act 2015[2]. These include:

- A focus on prevention and reducing inequalities
- Empowering people and communities
- Collaboration and engagement

3.6. A number of changes have been made including steps to improve visibility and ownership of the fund amongst staff and communities; streamlining of the administrative and financial processes involved; and development of a more robust evaluation method, in partnership with NHSG Health Intelligence. In 2018, an options appraisal was undertaken to inform the future direction of the fund. The approved option going forward is that HIF core and Neighbourhood Health: HIF are further developed and directed through localities with the ambition to allocate funds through Participatory Budgeting in the future.

[1]https://www.gov.scot/publications/commission-future-delivery-public-services/
[2]http://www.legislation.gov.uk/asp/2015/6/contents/enacted

3.7. Since 2016, over £280,000 has been allocated to 211 projects through the Neighbourhood Health process, supporting beneficiaries across all areas of Aberdeen City. Projects funded have sought to address a range of issues including physical activity, mental health, early years and community cohesion. Two celebration events have also been held as an opportunity to network and share practice.

3.8. The fund has enabled discussions and engagement about health improvement priorities and prevention at locality level. More frontline staff and community members have a broader understanding of the funding principles and have been involved in the decision-making process. It has therefore been concluded the fund and the processes adopted are meeting the funding principles and are contributing to an increased preventative spend at community level.

3.9. There is an opportunity to share transferrable learning from the fund, its principles, and the process of refinement. It is recommended that from April 2020, an annual reporting format is adopted which is easy read and accessible to the public building upon the 2016-19 report (appendix A) and infographics currently compiled for the fund (appendix B). The report would demonstrate how the funding was spent, outcomes achieved, and profile project case studies.

4. Implications for IJB

4.1. Equalities

The principles of the Health Improvement Fund focus on 'making Aberdeen a healthy and happy place for all.' This inherently seeks to promote social inclusion and cohesion across the City. Specific groups protected by The Equality Act 2010 who have engaged with the fund since 2016 include people with physical disabilities; ethnic groups including Afro-Caribbean and Nepalese; lesbian, gay and bisexual people; and pre-natal groups.

4.2. Fairer Scotland Duty

The allocation of current funding is weighted to enable more support to be given to projects in areas of socio-economic disadvantage.

4.3. Financial

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

4.4. Workforce

The fund provides an opportunity to engage our staff in promoting a preventative approach to health with both clients and colleagues. Endorsement of the fund and approval of the recommendations described in the report will provide an opportunity to raise the profile of the fund with a broader range of H&SCP colleagues, increasing the range of staff who understand the funding principles and supporting the development of a health promoting culture across the organisation.

4.5. Legal

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

4.6. Other

No other implications have been identified.

5. Links to ACHSCP Strategic Plan

The principles of the Health Improvement Fund are in keeping with vision of the Aberdeen City H&SCP in that both seek to work with communities to enable people to achieve fulfilling, healthier lives and wellbeing. The fund has contributed to the following priorities in the H&SCP's Strategic Plan, 2016-19:

- "*Support and improve the health, wellbeing and quality of life of our local population"*
- *"Promote and support self-management and independence for individuals for as long as reasonably possible"*
- *"Contribute to a reduction in health inequalities and the inequalities in the wider social conditions that affect our health and wellbeing".*

INTEGRATION JOINT BOARD

6. Management of Risk

6.1. Identified risks(s)

Risks due to a lack of IJB endorsement of the fund, its principles, and the recommendations described include:

- Lost opportunity to share learning from, and increase ownership of, the Health Improvement Fund, including opportunities to realise the outcomes described in the Christie Commission[1] and Community Empowerment Act[2]

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

None

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

This report provides the opportunity for the IJB to endorse the fund and share learning from the Health Improvement fund.

Approvals	
	Sandra Ross (Chief Officer)
	Alex Stephen (Chief Finance Officer)

References

1. The Christie Commission (2011). Commission on the Future Delivery of Public Services. Available from: https://www.gov.scot/publications/commission-future-delivery-public-services/
2. Scottish Government (2015). Community Empowerment (Scotland) Act 2015. Available from: http://www.legislation.gov.uk/asp/2015/6/contents/enacted

Aberdeen City Health and Social Care Partnership

Health Improvement Fund

The Journey from 2016-19

Aberdeen City Health & Social Care Partnership
A caring partnership

ABERDEEN CITY COUNCIL

NHS Grampian

Background

The Health Improvement Fund seeks to improve health and wellbeing in communities across Aberdeen. The Fund is allocated in two ways:

Neighbourhood Health: used for awarding community grants of up to £2500

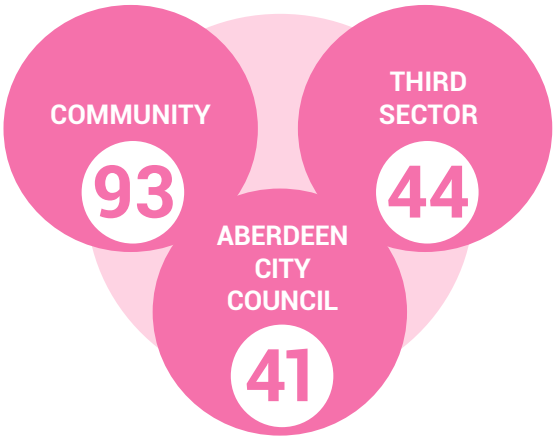
Core Health Improvement Funding: used for commissioning larger, City wide programmes of work

Neighbourhood Health

Principles

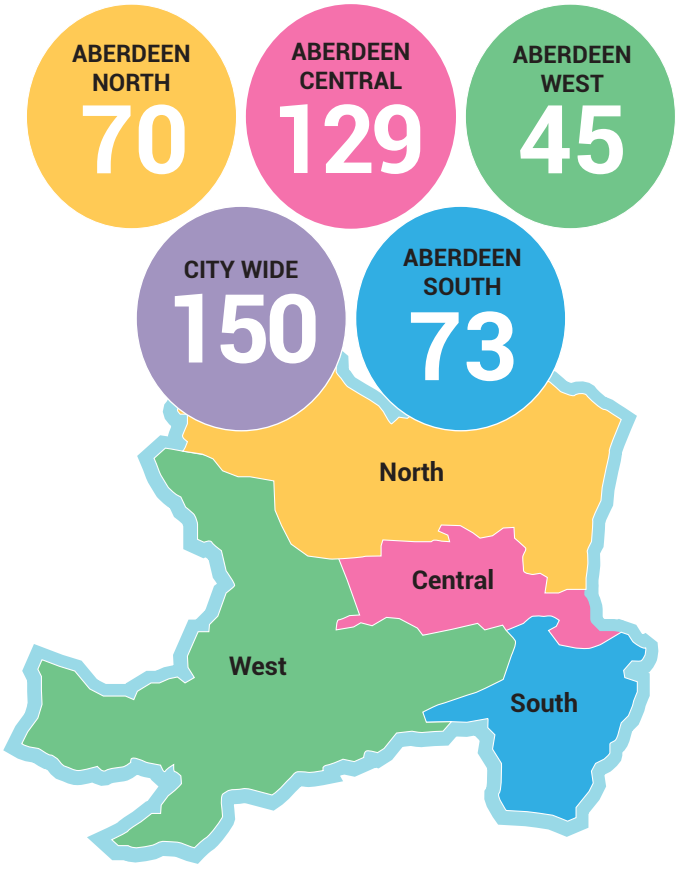
- Inspire members of your community to get involved
- Meet local needs and reflect local circumstances
- Are innovative and creative
- Join people together
- Help to make Aberdeen a healthy and happy place for all

Of the 211 funded projects since 2016, the top 3 sources of applications were from:



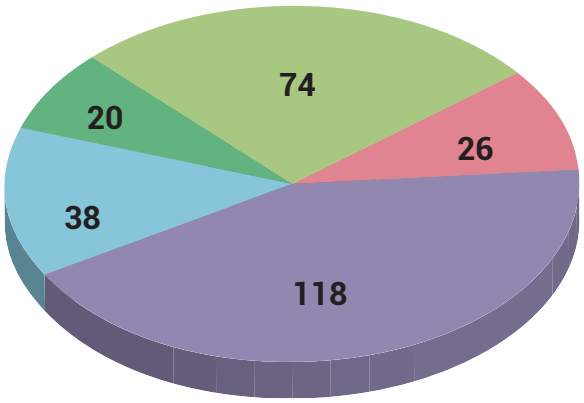
Since 2016

Applications Received



Funded Projects

Just under ½ of projects were funded. The focus of funded applications are illustrated here:



- Primary Prevention
- Self Help/Self Management
- Promoting Social Inclusion/Reducing Social Isolation
- Environmental Improvements
- Other

The Journey since **2016**

Why Change?

- Simplify the process, making it easier for local people and staff to get involved
- Ensure the Fund is in line with new & current legislation[1,2,3]

What has Changed?

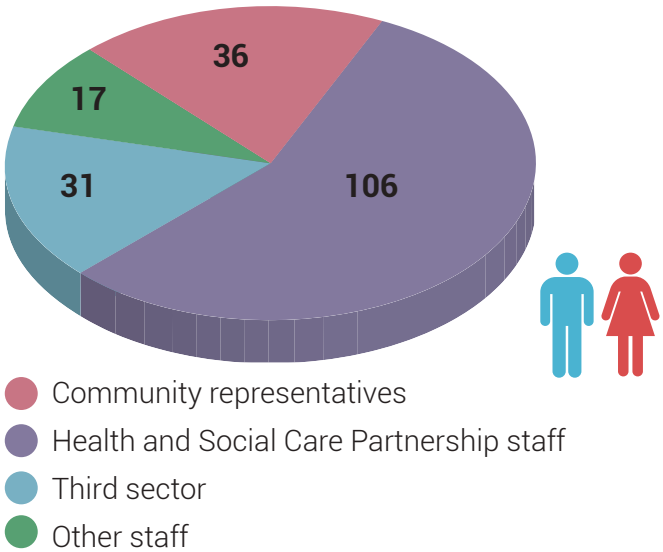
- Funding re-branded as 'Neighbourhood Health'
- Grants of up to £2500 available to kick-start initiatives to improve health and wellbeing locally
- Simplified application form
- New website, www.neighbourhoodhealth.org.uk
- Communication plan to reach staff and local communities including use of social media and local radio
- Decisions about funding made by frontline staff and community representatives

What have the changes taught us?

- Enabled more conversations within communities about how money could be spent to prevent ill health.
- Allowed those that understand the need within the area they work and/or live to have their voices heard
- Provided an opportunity to network and share practice beyond traditional partnerships.
- Harnessed the knowledge and expertise of staff and community members to ensure resources are used efficiently.

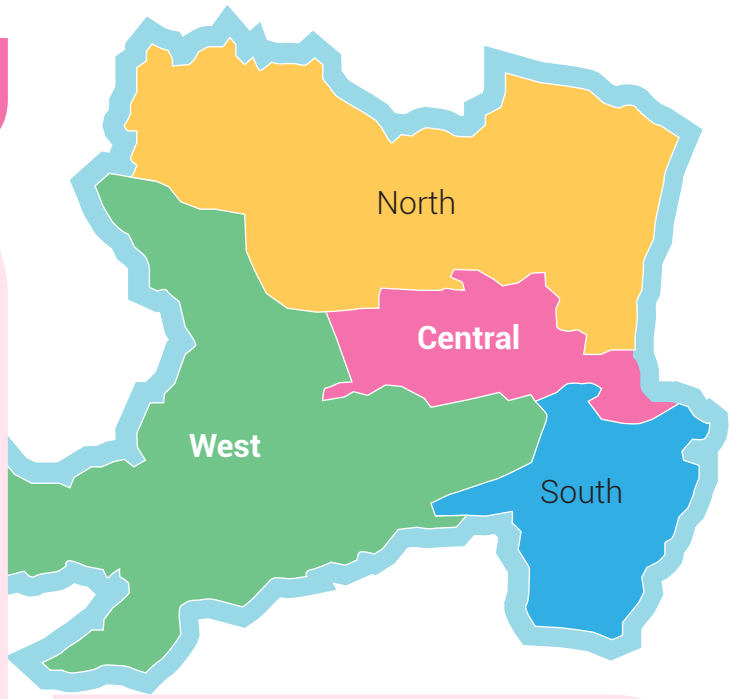
Allocations are decided upon by local decision making groups involving a range of frontline staff and community representatives, guided by a scoring process based on the funding principles.

Here is a breakdown of group members since 2016



[1]Public Bodies (Joint Working)(Scotland) Act 2014
[2]Community Empowerment (Scotland) Act 2015
[3]Commission on the Future Delivery of Public Services, 2011 (Christie Commission)

Case Studies – **Central**



Printfield Community Project – 'Inside Out'

Printfield Community Project applied for funding to deliver yoga classes for a group of women experiencing anxiety and panic attacks. The classes ran for 26 weeks and sought to provide them with skills to manage their stress more effectively and improve their overall wellbeing.

Participants also improved their social connections, and the group hope to continue meeting together to practice the relaxation techniques they've learned.

"I have more control over my anxiety and (will) hopefully reduce (my) medication."

"I have learned to relax when I am under stress"

Northfield Academy – 'Living Life to the Full'

Living Life to the Full is an initiative which aims to integrate Cognitive Behavioural Therapy (CBT) self-help skills into the curriculum in order to improve pupils resilience and wellbeing. It can also be used for one to one support and with small groups for pupils experiencing life difficulties.

Following Health Iimprovement Funding (HIF), 40 staff from Northfield Associated School Group have been trained alongside staff from Primary Care, Community Learning & Development and Police Scotland. Staff found the training to be highly valuable and relevant to their roles.

Kingswood Day Centre – 'Boccia'

Boccia is a bowls-like game which can be played by those of all ages, including those with physical disabilities. Kingswood Day Centre applied for a small amount of HIF money to buy a Boccia set for service users and their families. By playing the game together, residents were encouraged to build social connections, as well maintaining their physical abilities.

"When Boccia is being played there is always lots of laughter heard, therefore the Boccia set has been very successful"

"Thank you very much for the funding that has helped make this successful"
Day Centre Manager

Case Studies – **West**

Mindful Libraries at Airyhall

The aim of this project was to remove barriers for people accessing activities that can help reduce stress. Members of the public were given the opportunity to explore and learn more about what can make a difference to their mental and physical wellbeing. HIF supported a number of sessions that introduced the underlying philosophy/science behind mindfulness and then a series of taster sessions. The project highlighted the need for providing reading materials in different languages. It connected individuals with organisations, activities and opportunities within the community that they were not previously aware of and successfully removed barriers of fear, knowledge, finance and logistics. The project successfully showed a new method of delivery of health information[4] which can be built on going forward.

"I really enjoyed the mindfulness event last night. There seemed to be a lot of people there. Unfortunately, I can't get to the other ones on Wednesdays, but I just wanted to say I hope the library continues to do these events. It shows real innovation and community engagement."
Customer feedback about Spring Clean Your Mind Talks

"The library staff convinced me to come along to the talks – I'm really glad I did it has been so interesting and I've enjoyed the surprise element."
Customer feedback from Spring Clean Your Mind Talks

"I enjoyed the Challenge and would take part again if you ran it next year."
Customer feedback from Six Minute Reading

Hen House – Tor-na-dee Care Home

A new hen house was purchased with funding from HIF. With the help of relatives they laid foundations and landscaped the outside run. One resident gave advice on caring for the hens and supervised the introduction of the new pair of hens. For a new resident to the home this project has helped him feel at home and he feels that his opinion matters. The two new hens were donated by a local hen breeder, a relative of one of the residents. The grandchildren of one of the residents named the hens. This venture has given children access to the care home, in a non-threatening manner, where they were unsure about visiting before. This has ultimately benefited their Grandmother who may not have seen so much of them prior to the project.

A large number of residents, relatives and visitors visit the hens frequently, where they might have stayed indoors otherwise.

Mannofield Church - Thursday Fly Cup

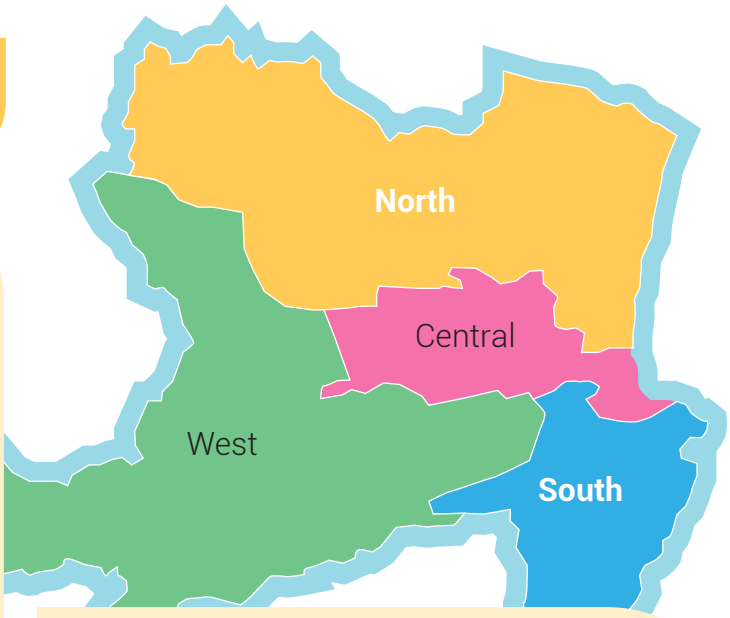
Funding was given to Mannofield church to provide activity/games monthly for members of the wider community who are socially isolated or at risk of becoming isolated. It is open to all ages. The group has up to 18 regulars and 42 turned up for their Christmas sing along. Volunteers are from within the congregation and wider community. They also provide transport if required. Over the last year they have had a magician (twice he was so popular), craft afternoon, memory afternoon (looking at old photos and books of Aberdeen) and Owls!

"We were quite overwhelmed by the positive reaction to the owls".

"There was lots of chat, lots of laughter and a good buzz at every meeting which would indicate that people were enjoying the sessions"

[4]**www.aberdeencity.gov.uk/mindful-libraries**

Case Studies – **North**



Toe Tapping Tea Parties

Danestone Community Centre applied for funding to kick-start Toe Tapping Tea Parties primarily to target loneliness and social isolation in older people. It was identified that there was a lack of groups running locally on a Sunday which has been found to be the loneliest day of the week for many.

The funding was used to pay for live music, refreshments and decorations. Sessions so far have been a success with over 20 people of mixed ages in attendance. The sessions will continue as part of the Centre's programme.

EncourAGE

The EncourAGE project in Dyce aims to provide opportunities for older people to be more active within the community, reduce social isolation and loneliness and provide activities within sheltered housing complexes in the area. HIF has supported this area of work in numerous ways by supporting the establishment of a lunch club, social outings for people who are experiencing loneliness, the development of a programme of activities in sheltered housing and equipment to support the men's shed. The lunch club has now managed to become sustainable and is supported by 18 volunteer drivers and 28 volunteer helpers, this provides the only opportunity for many attendees to leave their house and meet other people.

The project has also run successful 'Have a Go' weeks to encourage people in the community to get involved in new activities and outings which has now led to over 10 activities forming part of the weekly programme at Dyce Community Centre all run by volunteers.

The programme of activities in sheltered housing has not only enabled residents to be more active socially and physically but are open to members of the local community therefore enabling residents to connect with other people.

MISS

The MISS (Miscarriage Information Support Service) started in March 2017 after Chairperson/Founder Abi Clarke suffered a miscarriage in 2015 at 7 weeks pregnant. At the time, Abi felt there was not enough support in the area and decided to start a group to support others. The Health Improvement Fund provided invaluable support to cover set up and promotion costs of the group.

The peer support group has attracted people from all over Aberdeen due to the invaluable support it provides those who have experienced a loss. The sessions also comprise guest speakers and activities aimed at supporting attendees including; mindfulness, yoga or reiki master. Local businesses have also attended to take part in activities which can be as simple as painting chairs or making cards. There are up to 10 individuals attending each of the support groups, some of whom are regular and some new. MISS has now expanded and is run by a committee who aim to raise awareness of miscarriage in Aberdeen and provide invaluable support. The MISS group meets monthly at Danestone Community Centre and is open to anyone who has experienced miscarriage, stillbirth or fertility issues.

"*The Health Improvement Fund* really helped the support group, and without it I probably wouldn't have been able to start. Thanks all who believed in us."
Abi Clarke, Chairperson/Founder of MISS

Case Studies – **South**

Tuk In Project

The Tuk In Project was launched in December 2017 and since then, it has distributed roughly 1700 meals across priority areas through its weekly café. Alongside this it has been catering to local community events including the Participatory Budgeting events, Sunnybank Open Day, Marischal College community Christmas village, 6 different Fersands and Fountain outreach events, the Launch of the Tullos Community garden event, Grampian Pride, Play on the Longest Day (Play Forum), National Playday (Play Forum), Shared Futures event (New Scots), and the George Street Farmers Market and Sustainability Festival.

While the Tuk Tuk is out at any of these events it hands out recipes, promotes CFine Service and looks to engage with other organisations. It has engaged approximately 20 volunteers with various support needs, several of whom have now gone on to full time employment.

Cove and Altens Woodland Walk

The project funded was to improve the existing woodland path and especially to make it accessible year round. Today, the whole path is now being used daily by dog walkers, parents with children in buggies, walkers and joggers (including people from the nearby Industrial Site at lunchtimes). The work was undertaken in partnership with Aberdeen City Council. A section of path that was almost unusable has been improved and now much safer for people to use. The path is well advertised in the local community newsletter called "the Cove Chronicle" which is distributed to every household every two months.

Torry Tots

The Torry Tots project created a welcoming environment for parents/carers and young children to come along, play, chat and learn. There was no other group in the area that caters for families.

"Me and my little girl loved it. She had a ball and met lots of new children and I also got to speak to new parents. Will definitely be coming back as everyone was so welcoming."

Activities and information from Childsmile also lent more support to families who were accessing this group.

Garage Community Bakery

A former social worker and trained baker delivers 'fun', easy and basic bread-making and baking sessions from a converted garage to community members . The Garage Community Bakery applied for funding to work with adults at risk of isolation and to improve on emotional health and wellbeing.

The project has also engaged with community groups of all ages.

"The general feedback from individuals was very positive and many of those who attended courses at the Garage Bakery expressed interest in further courses – evidence from participants suggested a positive impact on confidence, learning new skills, social engagement and not forgetting fun! Equally an increased awareness of the technicalities of bread making."

Case Studies – **Core**

In 2017, Governance International were commissioned through HIF to run a series of workshops using the Co-production Star toolkit[5].

"Co-production is about professionals and citizens making better use of each other's assets, resources and contributions to achieve better outcomes or improved efficiency."

As a result of these workshops the co-production toolkit was used to test out a number of projects.

Stepping Forward

The aim of this project was 'to raise awareness of falls prevention by provision of easily accessed information and self management options'. The first step was to listen to stories from service users of their experiences. Listening to their stories was a powerful experience in thinking how things could be done differently. As a result of these conversations the idea to develop 'falls ambassadors' came about. Why not enable people to visit groups of people at risk of a fall and talk to them about ways to prevent people falling or where that is not possible help them access the correct support as soon as possible.

The ambassadors working with Occupational Therapy tested out this approach on a number of groups and following positive feedback applied for Health Improvement Funding to develop a model that would become sustainable. This enabled them some resource to work with students from a local university to develop a video[6] and promotional materials to recruit more ambassadors and to develop a teaching video that can be used at groups across the City.

The ambassadors have great ambitions of developing a website that will help keep people well for longer and access the right services when needed quicker. Using a co-production approach has enabled the powerful messages and ideas from service users to be used to make improvements to keep others well for longer.

stepping forward **together**

Living Well with Diabetes

The aim of this project was 'to encourage patients and partners to mutually identify various opportunities where newly diagnosed patients are able to self manage Type 2 Diabetes within a community setting'. Using the co-production approach the project is continually co-developing Peer Supporters (with support from Diabetes Scotland) who are people living with the condition; has enhanced existing peer support group with an improved communication plan in accessing regular speakers at the Health Village as well as co-designed a second Peer Support group at RGU beginning in March 2019.

All of the above has pulled together a collective recognition for a programme called Living Well with Diabetes. The programme is being co-produced based on experience, skills and knowledge from patients, staff and partners.

"Seems like we are gaining confidence that we have something to offer the newly diagnosed person, it was a good session with all round input from everyone."
Peer Supporter

"I now have some real understanding for me, of what we are trying to achieve."
Carer

If you would like to find out more information, visit www.neighbourhoodhealth.org.uk, search for 'Health Improvement Fund' on Facebook or find us on Twitter – twitter.com/IFforHealth'

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NHS Grampian

[5]www.govint.org/our-services/co-production/
[6]www.youtube.com/watch?v=2pVaJhWRW7M

Media Services: IT Services, University of Aberdeen
WL 0219

Neighbourhood Health 2017/18

The Health Improvement Fund

Cash to Create Healthier Communities

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NHS Grampian

The Health Improvement Fund is to kick start local initiatives to improve health and wellbeing in communities across Aberdeen. The funding has also been extended to include Food In Focus monies to support local community food work.

Key Principles

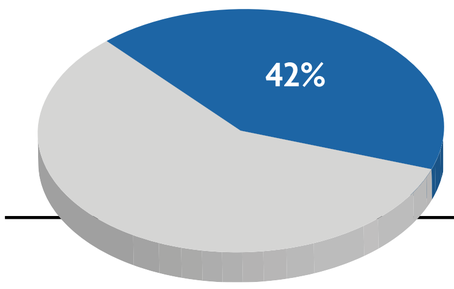
- Inspire members of the community to get involved
- Meet local needs and reflect local circumstances
- Are innovative and creative
- Join people together
- Help to make Aberdeen a healthy and happy place for all

Highlights of 2017/18

- Increased number of funded applications due to 2 rounds of funding.
- Continued to involve local people in the decision making.
- Increased use of social media and local radio to promote fund.
- First showcase event took place highlighting the good work of 2016/17 funded projects.
- A number of drop-in sessions were held across the City to support applicants.

Food in Focus (FIF) applications made up 18% of all applications.

11 out of 26 (42%) Food in Focus applications were funded.



Applications Received

ABERDEEN NORTH	ABERDEEN CENTRAL	ABERDEEN WEST
29	45	15

CITY	ABERDEEN SOUTH
47	27

Of the 87 funded projects, the top 3 sources of where the applications were from:

COMMUNITY	THIRD SECTOR	ABERDEEN CITY COUNCIL
54	16	11

What people are saying about The Health Improvement Fund...

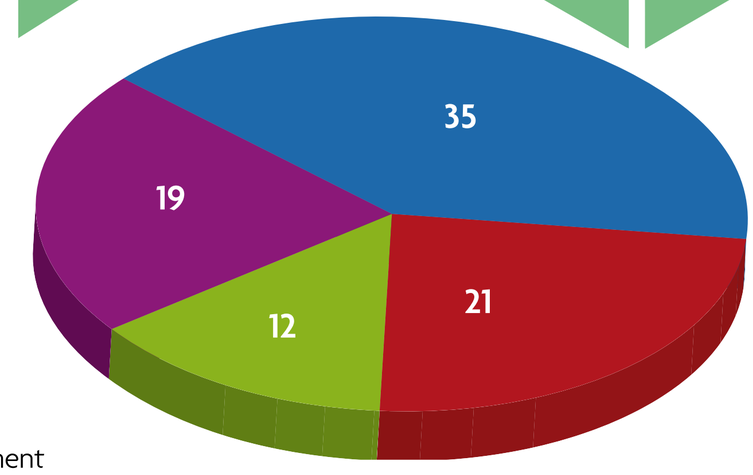
Building a Hen Hoose – Tor-Na-Dee Care Home
"It is very important for our residents to be able to go outside and get fresh air. The chickens are a great attraction. It is a focal point for interaction and we have residents here who don't speak or interact much and they'll talk to people and the chickens"

Middlefield Hub Cooking Group
"I really enjoyed the six weeks and learned a lot about cooking with less fat and sugar. My child enjoyed the food I made and this has encouraged me to start cooking from scratch at home. I liked the course so much that I have signed up to go on the volunteer's C2C course. It will help when I visit the Career's Office."

The Creators Club - Kincorth /Leggart Community Council
"A lego club has been launched for children in an Aberdeen community called the Creators Club at Kincorth Library for 8-11 year olds. A community council member has said 'It is the community council's hope that the club funded through HIF will encourage more people into the library. Play has shown to improve creativity, problem solving skills, memory and the attention span of children. It is open to all children of all abilities, irrespective of any health issue. The club will create displays in the library showing the young people's creation"

Funded Projects

Just over ½ of projects were funded. The focus of funded applications are illustrated here:



- Primary Prevention
- Self Help/Self Management
- Promoting Social Inclusion/Reducing Social Isolation
- Environmental Improvements

Next steps

- **Continue with the new process**
- **Make changes based on learning from experience**
- **Learn and share on what's working well through Showcase events**

More information:
www.neighbourhoodhealth.org.uk/
Email: nhsg.neighbourhoodhif@nhs.net
or call 01224 558716
Facebook: Health Improvement Fund
Twitter: twitter.com/IFforhealth

This infographic is also avialble in large print and other formats and languages, upon request. Please call NHS Grampian Corporate Communications on 01224 551116 or 01224 552245

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Aberdeen City Health & Social Care Partnership
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INTEGRATION JOINT BOARD

Date of Meeting	26 March 2019
Report Title	Locality Model
Report Number	HSCP.18.153
Lead Officer	Sandra Ross, Chief Officer
Report Author Details	Gail Woodcock Lead Transformation Manager gwoodcock@aberdeencity.gov.uk
Consultation Checklist Completed	Yes
Directions Required	Yes
Appendices	a. Map of proposed three city localities b. Review of City Localities – what you said and our response and summary of responses

1. Purpose of the Report

1.1. At its meeting on 9 October 2018, the Integration Joint 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 three locality model and report back to IJB on the 26th March with the results of this review and consultation along with the new Strategic Plan once finalised.

1.2. This report provides the results of the review and consultation as well as a proposed plan for how we might ensure greater impact of locality working, aligned with the aims set out in the refreshed strategic plan.

1.3. The report recommends that the partnership moves to a three-locality model, moving to greater alignment with locality boundaries of our partners including children's services, early intervention and housing services.

2. Recommendations

2.1. It is recommended that the Integration Joint Board (IJB):

INTEGRATION JOINT BOARD

a) Agree to recognise three localities in the city, as per Appendix A.

b) Note the planned approach to strengthen and maximise benefits available through locality working.

c) Instruct the Chief Officer to report back to a future IJB with a further update on the implementation of the revised localities.

d) Instruct the Chief Officer to discuss opportunities for developing clear, distinct terminology for Health and Social Care Partnership localities and Community Planning Partnership localities and report back with a recommendation to the IJB.

3. Summary of Key Information

Background – Health and Social Care Localities

3.1. Locality planning is a key element of the Public Bodies (Joint Working) (Scotland) Act 2014 in relation to the planning and delivery of our integrated services. Under this legislation, the partnership must have two or more localities to support the planning and delivery of health and social care services across the city.

3.2. A locality is defined with the Act as a smaller area within the borders of an Integration Authority. The purpose of creating localities is not to draw lines on a map, but to provide an organisational mechanism for local leadership of service planning, to be fed upwards into the Integration Authority's strategic commissioning plan. In the Scottish Government guidance note on localities, localities refer to the group of people in these areas who must play an active role in service planning for the local population, to improve outcomes.

3.3. Localities are intended to be the engine room of integration, bringing together service users, carers, and health and care professionals to plan and help redesign services.

3.4. If this approach is to be successful, localities and their leadership teams must have the information they need about the nature of the communities they serve and must be empowered by the Health and Social Care Partnership to allow for local decision making on delivering outcomes against identified need. This requires engagement with all stakeholders within the locality, housing, children services, education and emergency services.

3.5. During the year preceding the launch of the ACHSCP the shadow IJB identified four localities. These were based on alignment with GP structures at that time. Given the early stage of the organisation at that time, an option was identified for this to be reviewed at the appropriate time.

3.6. At the meeting on 9 October 2019, the IJB considered a report which sought approval for the intent to move to a three locality model (covering the whole of the city) for the partnership, that is in alignment with the Community Planning Aberdeen priority localities (covering parts of the city.)

3.7. This report highlighted key benefits that this realignment would bring:

i. Provide greater joined up focus to areas where people experience poorer outcomes
ii. Alignment with key partners which would enable closer alignment across operational service delivery
iii. Simplify locality arrangements to make it easier for members of the public to understand what locality their community falls under and therefore how to engage with services.

<u>Background – Community Planning and neighbourhoods</u>

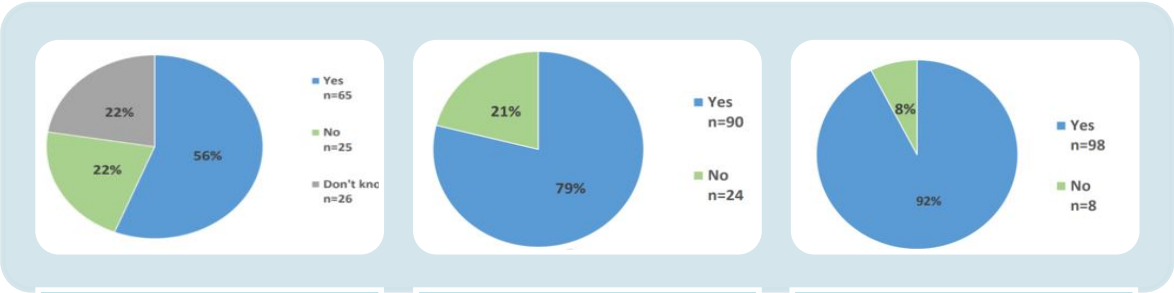
3.8. Aberdeen has 37 neighbourhoods – these neighbourhoods were identified and defined by those living in Aberdeen and as such can also be described as natural communities. When considering options for locality boundaries, these natural neighbourhood boundaries have been recognised and proposals align with these boundaries.

3.9. Community Planning Aberdeen has identified three "priority localities" in Aberdeen. These areas represent communities which experience poorer outcomes than other areas of Aberdeen. These "priority localities" are:

i. Tillydrone/ Woodside/ Seaton neighbourhoods
ii. Torry neighbourhood
iii. Heathryfold/ Middlefield/ Northfield/ Cummings park/ Mastrick neighbourhoods

Review of Localities – Consultation & Engagement

3.10. During December 2018, a consultation on the proposal to move from four to three localities took place. This consultation included an online survey, a number of drop-in sessions and discussions at each of the existing Locality Leadership Groups.



56% of respondents thought that moving to three localities was a good idea

79% of respondents agreed with the rationale of moving to three localities

92% of respondents thought that there would be benefits in having more joined up locality planning arrangements.

3.11. A summary of the responses to the survey along with a "you said and our response" communication is attached at Appendix B. This information is also available on the partnership website: https://www.aberdeencityhscp.scot/our-delivery/locality-consultation/

3.12. Following the initial consultation, members of locality leadership groups, locality partnership groups, staff, partners and community members were invited to a locality event on 25 February 2019, with the title "Our Localities Journey". Over 80 people attended this event, including a mix of staff (Aberdeen City Health and Social Care Partnership, Aberdeen City Council & NHS Grampian), third sector organisations, and community members.

3.13. The event consisted of several presentations and workshops, considering our journey so far and seeking input about how we build on the work to date in the next stages of our localities journey.

3.14. A summary of the workshop feedback is set out in the table below:

What have been our biggest successes so far?

- Empowerment and confidence – for staff and community members
- Consistency across localities
- Implementing Link Workers
- Opportunities for staff to work together in the community
- Meaningful and inclusive strategies in place

What hasn't worked as well as anticipated?

- Opportunities for general public to get involved
- Too much consultation
- Capacity and resources – having ideas on the group and being able to make it happen
- Systems not speaking to each other/ gaps between systems
- Lack of consistency
- Confusion between CPA localities (3 specific areas) and HSCP localities (4 covering whole city)

What do we need to retain going forwards

- Information sharing and effective communication
- Keep momentum building
- Continue involvement with communities
- Co-production approach
- Communities should have a say in the terminology of localities – what it means to them

How can we dovetail the Strategic Plan with the Local Outcome Improvement Plan?

- Use the same language (plain English)
- Show direct links between the plans
- Develop a process to allow dovetailing to happen
- Avoid duplication of networking and consultation
- Ensure clear alignment with Engagement, Participation and Empowerment strategy

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How can we support the LLGs going forward?

- Common structure, layout, aims
- Coherence across all LLGs with a shared Terms of Reference
- Consistent and informed membership
- Communication channels/ effective networks in each area – with community councils, community networks, CPA locality partnerships
- Empower LLGs to take decisions within an agreed framework
- Way of sharing learning across LLGs
- LLGs influencing delivery of LOIP and Strategic Plan

Who else needs to be involved in LLGs

- Child/ young people representation
- Those with lived experience

Note:
HSCP = Health and Social Care Partnership
LLG = Locality Leadership Group: HSCP locality governance group
LOIP = Local Outcome Improvement Plan: led by Community Planning Aberdeen
Locality Partnership = CPA priority locality governance group
Strategic Plan = HSCP strategic document

Additional Considerations in relation to the proposal to move to three localities

3.15. A number of discussions have taken place with officers responsible for health and social care services; children's services; and communities and early intervention services (in Aberdeen City Council.) There is agreement across all of these services to explore further opportunities for integrated working and delivery.

3.16. It is highlighted that there is an Aberdeen City Council priority to have three locality plans covering the whole of the city. While these may have different areas of focus to the HSCP locality plans, there will be some areas of overlap, and it is therefore logical to align the locality areas for both of these.

3.17. These discussions have identified a number of benefits of working towards dovetailing the geographies of our citywide localities. These include:

i. Opportunities for greater efficiencies in terms of data sharing and delivery planning etc.
ii. Greater opportunities for collaboration and realising benefits for people in communities as a result of increased collaborative working.
iii. Opportunities to ensure greater alignment between wider locality plans and smaller area plans.
iv. Opportunities to enable and empower multi-agency teams of people, to look at what's important to people in our communities as part of their journey through life – on a cross-system basis.
v. Opportunities to support a cross-system response to "wicked" issues such as obesity and whole population wide public health priorities.
vi. Opportunities for teams to be based together, guiding what is planned and progressing from a cross sectoral perspective.

3.18. Proposals for where the boundaries of localities are, have been guided by the boundaries of our natural citizen-identified communities (neighbourhoods), and solid and tangible boundaries that exist in the city (for example the two rivers and major roads.) Proposed boundaries have also taken into consideration existing and potential service delivery boundaries, for example associated school group (ASG) areas and service delivery boundaries. (Note that in some instances it has not been possible to adhere to both neighbourhood and ASG boundaries, and in such instances, neighbourhood boundaries (as person led boundaries) have taken precedence.

3.19. A repeating concern that has been highlighted during all of the consultation and engagement activity around localities has been the confusion in relation to the terminology used around localities: The Community Empowerment (Scotland) Act 2015 and the Public Bodies (Joint Working) (Scotland) Act 2014 both identify the need for "localities" to be identified. This has led to the position, whereby the Health and Social Care Partnership, identify localities covering the whole of the city, and the Community Planning Aberdeen Partnership identifies three smaller localities. It is suggested that it would be helpful to resolve this confusion by referring to these different geographical areas by different titles.

3.20. There has also been discussion about what the Health and Social Care Partnership localities, if agreement is reached to move to three, should

individually be called. Working titles for the three localities are "North", "Central" and "South". It is suggested that Locality Leadership Groups be tasked to identify proposed titles for these localities with a final decision being made by IJB (to ensure an element of consistency across the localities.)

Implementing Three Localities

3.21. In order to move from four to three localities, taking cognisance of feedback from the consultation and engagement events, and learning from elsewhere, a number of key steps have been identified.

3.22. It is stressed that the approach to achieving effective locality working will be one based on a co-production approach and doing things with our stakeholders and partners.

3.23. The table below set out some of the steps that will be undertaken along with some indicative timescales.

What	Why	When
Develop standard (easy read) locality profile framework & action plan format	To ensure consistency across city and minimise opportunity for confusion.	May 2019
Populate locality framework & action plan with information from existing 4 localities	To ensure that the good work already carried out is not lost – the importance of this was relayed in the consultation.	May 2019
Align each locality framework & action plan with relevant CPA locality plans.	Consultation identified a potential benefit of improving alignment and reducing confusion.	Summer 2019
Form revised locality leadership groups (LLGs). Forming workshop with each LLG.	To minimise any potential gap in locality leadership during transition period.	May 2019
LLGs to review and finalise populated locality framework and action plans, and Terms of Reference	To ensure continuation of good partnership working, engagement and communication. To ensure that LLGs are supported in the best possible way to be as effective as possible in delivering their purpose.	As part of forming workshops.
Leadership Team to be aligned to support LLGs	Strong leadership and support will help empower and enable the success of locality working. Alignment will	ongoing

	also ensure regular, direct reporting on progress and barriers in localities to IJB, raising the profile and providing greater weight to what is happening in localities.	
LLGs to develop community engagement plans aligned with Participation, Engagement & Empowerment Strategy	This was identified in the consultation as an area of good practice and also something that could be improved on.	Summer 2019
Opportunities to be identified for co-location for housing; health & social care; and childrens services (and any other services as required.)	Recent evaluation of transformation projects has identified key benefits of co-location to support integrated working.	Summer 2019 and ongoing
Process to be implemented whereby LLGs can identify proposed titles for each locality (to be determined by IJB)	To ensure that titles for localities are meaningful to those in localities. Consultation identified that coherence across all LLGs with a shared Terms of Reference is important.	Summer 2019
Develop and implement strong governance structure to support the right culture to ensure the success of locality working.	To ensure locality leadership groups are empowered and effective at achieving their objectives and driving improvement. Consultation identified that it was important that LLGs be empowered to take decisions within an agreed framework.	Summer 2019
Continue to engage with key stakeholders including communities to maximise the buy in and likelihood of benefits being delivered.	Consultation identified that a co-production approach and effective engagement was important to continue.	ongoing
Discuss with Community Planning Partnership opportunities to develop clear, distinct terms to describe localities (CPP and HSCP localities.)	Confusion over terminology has consistently been identified as something that could be improved.	May 2019

4. Implications for IJB

4.1. Equalities

It is anticipated that the implementation of aligned localities will positively impact on the protected characteristics as protected by the Equality Act 2010.

4.2. Fairer Scotland Duty

It is anticipated that the implementation of aligned localities will positively impact on people affected by socio-economic disadvantage.

4.3. Financial

There are no specific financial implications arising from this report, however, it would be anticipated that a move to three localities could result in a more efficient use of our resources.

4.4 Workforce

There are no specific workforce implications arising from this report, however a move to three localities would be a key driver when developing workforce plans.

4.5 Legal

This report is relevant to the requirement to define two or more localities in the city, arising through the Public Bodies (Joint Working) (Scotland) Act 2014.

4.6 Other - NA

5. Links to ACHSCP Strategic Plan

5.1. The recommendations in this report are directly linked to our refreshed strategic plan.

6. Management of Risk

6.1. Identified risks(s)

There is a risk that the improvements and benefits sought through a move to three localities, as set out in this report will not be achieved.

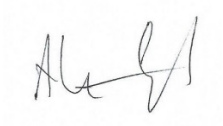
INTEGRATION JOINT BOARD

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

(8) There is a risk that the IJB does not maximise the opportunities offered by locality working – risk rating is currently HIGH

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

This risk is identified as high as localities are currently in an early, developmental stage and required strategic oversight. The engagement undertaken as part of the consultation about potentially moving to 3 localities has identified areas of good practice that should be continued and mechanisms that should be put in place to strengthen locality working. It is anticipated that a move to three localities will reduce confusion that exists currently around the differences between CPA localities and HSCP localities and provide opportunities for greater integrated working and therefore greater benefits to be achieved.

Approvals	
	Sandra Ross (Chief Officer)
	Alex Stephen (Chief Finance Officer)

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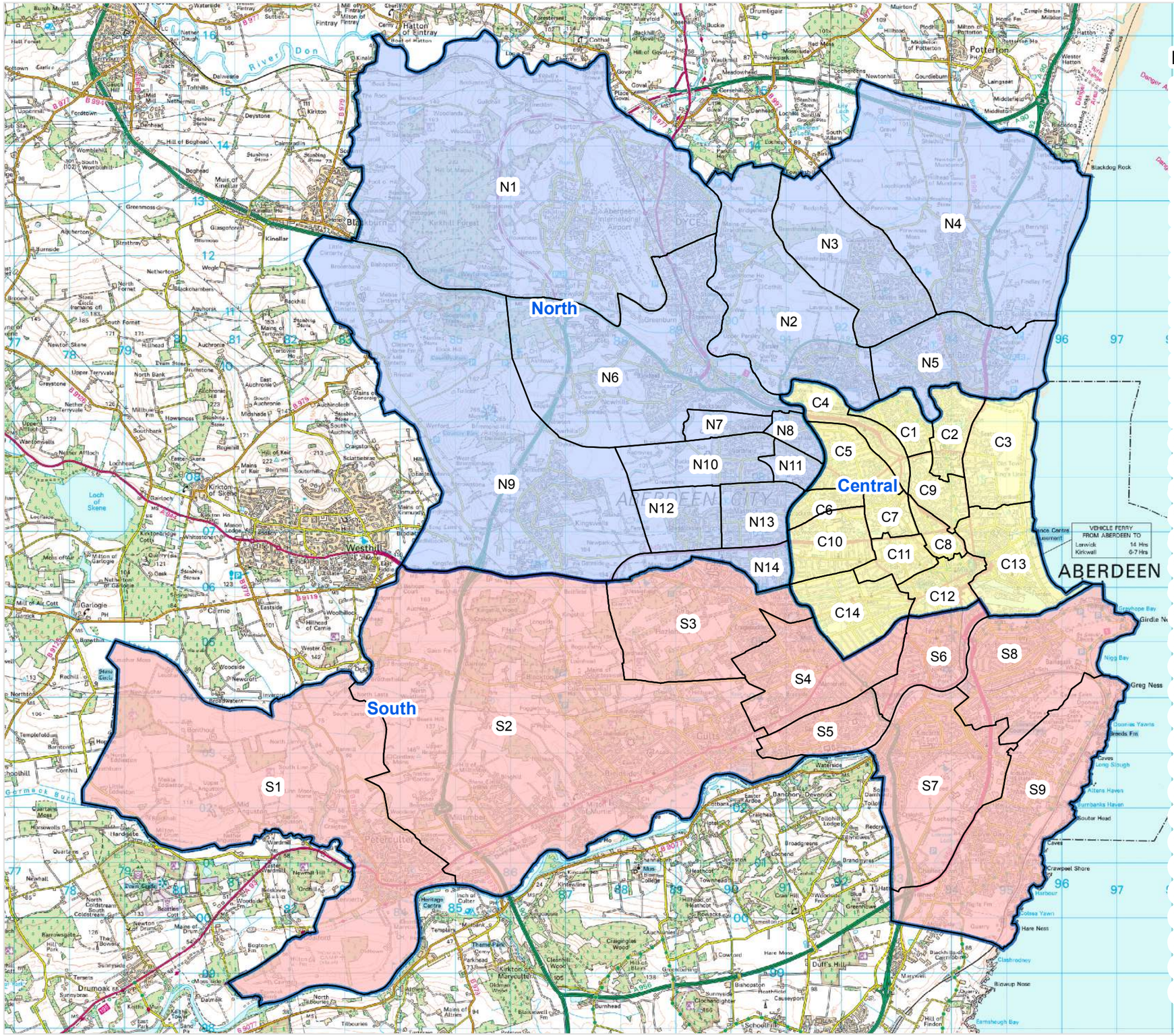
Proposed HSCP Localities (NSC) and Neighbourhoods



Neighbourhood

- N1 Dyce
- N2 Danestone
- N3 Oldmachar
- N4 Denmore
- N5 Balgownie & Donmouth
- N6 Bucksburn
- N7 Heathryold
- N8 Middlefield
- N9 Kingswells
- N10 Northfield
- N11 Cummings Park
- N12 Sheddocksley
- N13 Mastrick
- N14 Summerhill
- S1 Culter
- S2 Cults, Bieldside & Milltimber
- S3 Hazlehead
- S4 Braeside, Mannofield, Broomhill & Seafield
- S5 Garthdee
- S6 Ferryhill
- S7 Kincorth, Leggart & Nigg
- S8 Torry
- S9 Cove
- C1 Tillydrone
- C2 Old Aberdeen
- C3 Seaton
- C4 Woodside
- C5 Hilton
- C6 Stockethill
- C7 Ashgrove
- C8 George Street
- C9 Froghall, Powis & Sunnybank
- C10 Midstocket
- C11 Rosemount
- C12 City Centre
- C13 Hanover
- C14 West End

Scale: 1:75,000

Date: March 2019

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Review of City localities – what you said and our response

More than half of you said that moving to three localities is desirable.

56% of you said that this would be a good idea, (of the remainder, approximately half said they didn't think it was desirable and half said they weren't sure). However, 79% of people agree with the rationale for moving to three localities. The reasons for this difference may be about people needing more information before taking a view of whether this is a good idea in practice. The numbers are different when people are aware of the reasons, so we would conclude that people need to be made clear about the rationale for moving to a three-locality model. We will ensure that our rationale is as clear as possible in our Revised Strategic Plan.

There was a recurring theme around efficiencies and inefficiencies.

Some of you feel that working in localities which are aligned with those of our partners – including children's services, housing and community planning – would help to create a more efficient and joined-up system. There were concerns expressed about the amount of work that has already gone into developing locality profiles based on four localities and that this effort could have been wasted. These four profiles were built up from smaller areas within each locality called Scottish Index of Multiple Deprivation data zones and neighbourhoods, so it is relatively easy to restructure this information to reflect the profiles of the proposed three localities.

Action plans have been drawn up for our existing four localities using this data, and the actions in these plans can relatively easily be mapped against the proposed three localities. The priority will be on maintaining our collective focus on ensuring that the action plans are delivered.

There were questions raised about whether a three-locality model would require fewer staff to deliver services.

Care will still have to be provided across the whole city and so there is no intention to reduce the number of HSCP posts as a result of the proposed move to three localities. It may be appropriate to redesign services, and staff involved will be fully consulted. Our resources in terms of both finance and staff are limited, and the needs of our aging population are increasing – so we do need to implement solutions that ensure that are as efficient as possible and that our available staff have as much capacity as possible to provide the

required health and social care services in line with the aims and priorities of our Strategic Plan.

There were concerns raised about potential damage to the reputation of the partnership as a result of moving from four to three localities.

It is important that the partnership stays agile, recognising the ever-changing environment in which we operate. Our consultation has shown that the majority of respondents say that they want to, and can see advantages in, changing our locality model and we are responding to that. Our ambition remains to improve outcomes for people in Aberdeen. In line with our draft strategic plan, close partnership working is identified as essential to achieve this.

There were comments that a move to three localities would mean larger localities, each containing communities with many differences (for example levels of poverty/ affluence).

We know that our current and proposed localities are of a significant size and diversity. Our collective opportunity is to work in partnership to develop and implement plans to improve outcomes for people living in the city. This will be an ongoing process and will require good engagement with our communities. Delivery and ongoing review of our evidenced-based action plans, which include prioritised geographical areas, will be key to this. The proposed change to three localities is not about going back to the drawing board, but about realigning our work to date in the new locality areas and creating an environment which will allow the pace of change to increase.

You said that while you recognise that there is already good community engagement in place, you felt that this could also be improved.

We also recognise this and this is an area that we want to improve on. We will work collaboratively with partners and Aberdeen citizens to help to achieve this.

You raised queries about how Locality Leadership Groups would work with three localities and some people raised concerns that the membership of the LLGs may become too big to be effective.

The existing Terms of Reference for LLGs, which were recently reviewed, set out a clear purpose and decision-making remit. There will be a further engagement exercise in due course to ensure that LLGs are supported in the best possible way to be as effective as possible in delivering their purpose.

Next Steps

The feedback from this locality specific consultation has and will continue to influence our draft strategic plan, which will commence its formal consultation process shortly. During the consultation period for the strategic plan, there will be further opportunity to hear from a wide range of stakeholders.

Feedback will inform reports on the Strategic Plan and Locality Working which will be considered by the Integration Joint Board in March 2019.

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Aberdeen City Health & Social Care Partnership
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INTEGRATION JOINT BOARD

Date of Meeting	26th March 2019
Report Title	Strategic Plan 2019-22
Report Number	HSCP.18.154
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. Strategic Plan Review and Refresh Engagement Record B. Delivery, Enabling and Partner Plans C. Strategic Implementation Dashboard D. Strategic Plan 2019-22

1. Purpose of the Report

1.1. The purpose of this report is to seek the IJB's approval for the finalised Strategic Plan 2019-22.

INTEGRATION JOINT BOARD

2. Recommendations

2.1. It is recommended that the IJB:

a) Notes the process undertaken to develop the Strategic Plan 2019-22 from the consultation draft they approved in December 2018.

b) Approves the final draft of the Strategic Plan 2019-22.

c) Instructs the Chief Officer to publish the Strategic Plan 2019-22 on the ACHSCP website.

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. The 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 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.

INTEGRATION JOINT BOARD

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

3.6. The first strategic plan for Aberdeen City Health and Social Care Partnership covered the period April 2016 to March 2019. A programme of work to refresh the current strategic plan began with stakeholder engagement sessions in April 2018. A record of the review and refresh engagement sessions is attached at Appendix A.

3.7. The IJB held a workshop in September 2018 and an initial draft of the strategic plan was considered at the IJB meeting in October 2018. At its meeting in December 2018 the IJB approved a draft of the strategic plan for consultation although they were advised that a design company would be commissioned to make the plan more visually engaging.

3.8. The graphically designed version of the strategic plan went out for consultation mid-January with a closing date for comments set as 28th February. A total of 22 individuals and/or organisations submitted comments. These were mainly suggestions for additions to text, improvement to layout and presentation, improvement of linkage to other plans and services areas, and readability. Most comments were incorporated into the final version. An Equality and Diversity Impact Assessment was undertaken on the plan by the Equality and Diversity Manager of NHS Grampian. His comments were incorporated into the final version and he has confirmed that this meets requirements.

3.9. The main changes in the finalised version from the consultation draft are: -

- The title of Aim 3 has been changed from “Enabling” to “Personalisation”. Comments were received that having “Enabling” as an Aim and “Enablers” which had no bearing on the aim was confusing.
- What were previously quoted as “Priorities” are now known as the “Commitments” and some have been reworded.
- A new commitment has been added to the Resilience aim in relation to complex physical disabilities.
- The previously duplicated commitment that appeared in both the Connections and Communities aims remains linked to the Connections aim but has been replace in the Communities aim by wording that has been taken from Community Planning Aberdeen’s Community Engagement, Participation and Empowerment Plan.
- The new Priorities have been reworded and although many of these are ongoing over the life of the plan, where possible a timescale has been assigned in terms of the year of the plan it will be completed in.

- A new section has been added to the Enablers section entitled "Modern and adaptable infrastructure".

3.10. During the consultation period, work was also undertaken on determining a Strategic Planning Framework for ACHSCP. The basic premise of this was that we are 3 years along our integration journey, more mature as a Partnership and there already exist, or are in development, a number of strategic planning documents that articulate our strategic intentions in relation to various areas of service delivery. In addition, we have commitments and contributions in various partner strategic documents to deliver, most notably NHS Grampian's Clinical Strategy and the Local Outcome Improvement Plan but there are a number of others.

3.11. It was established that ACHSCP plans fall into two categories. The first category is those plans which are service, service area or condition specific. Under the Strategic Planning Framework these will be known as **Delivery Plans**, examples of these are the Carers, Learning Disabilities, and Autism strategies. The second category is those plans that are cross partnership and which support service delivery, such as the Strategic Commissioning Implementation Plan, the Medium-Term Financial Framework, and the Workforce Plan. These will be known as **Enabling Plans**. A third category is those plans which are owned and developed by our partner organisations but within which we have a commitment or a contribution to make. These will be known as **Partner Plans**.

3.12. A list of these plans showing whether they already exist or are well developed, or have still to be developed is attached at Appendix B. Each of these plans will have a lead or senior manager nominated as having overall responsibility for ensuring that the commitments or contributions are delivered. Some of the plans which are already developed will be refreshed to align with the revised Strategic Plan. A Strategic Planning Framework guide and templates will be developed along with a timeline for developing those delivery and enabling plans not yet in place. The requirement for some plans will be identified as a result of a gap being acknowledged, for example, the Social Work Criminal Justice service is already developing their delivery plan. Others will be developed as a local response to national strategies e.g. Mental Health and Dementia.

3.13. The Strategic Plan is the high-level, overarching plan that sits above the delivery and enabling plans and alongside the partner plans. It sets out our overall strategic direction which references the strategic intent of all of the other plans but does not duplicate the detailed information contained in them.

The format and layout of the revised strategic plan reflects this new approach.

3.14. All activity, whether it is operational service delivery or decision making in relation to committing expenditure, should be aligned to the Strategic Plan. Our own managers and staff and those working with our partners should be able to recognise their contribution to the Strategic Plan. The Interim Leadership Team are currently in the process of setting their individual objectives for 2019/20. These are all based on the Strategic Plan. Objectives for staff will also be framed within the Strategic Plan.

3.15. It is recognised that the Strategic Planning Framework is new and not yet widely understood. It is also accepted that the links between the Strategic Plan and the various other plans are not always immediately obvious. A Strategic Implementation Dashboard has been compiled and this is contained in Appendix C. The dashboard lists the deliverables in the various plans, notes the lead manager, the measure, the timescale and the progress status and links the deliverable to a relevant aim and commitment in the Strategic Plan. The dashboard is in excel format so the information can be sorted using any of the fields and there is a separate sheet relevant to each of the 3 years of the strategic plan.

3.16. Not all the existing plans have timescales and measures noted so there is still some work to be done in completing the dashboard. It is hoped that the progress status from this dashboard can be used to produce performance dashboards. It is intended that the dashboard, once finalised, will be published alongside the strategic plan to provide the link to the finer detail in relation to specific service delivery areas. It will also be used as a management tool to monitor progress on delivery.

3.17. The work in developing the dashboard helped to cross reference the information contained in the strategic plan and to refine the commitments and priorities identified. It also helped to refine and align relevant performance indicators.

3.18. A finalised version of the strategic plan for 2019-22 is attached at Appendix D. This version has been updated using the consultation feedback and the work undertaken in developing the strategic implementation dashboard.

4. Implications for IJB

4.1. Equalities – this report has no direct implications in relation to equalities. The strategic plan has been equality impact assessed by the Equality and Diversity Manager of NHS Grampian.

4.2. Fairer Scotland Duty – this report takes cognisance of the IJB's responsibilities in relation to the Fairer Scotland Duty.

4.3. Financial – There are no direct financial implications arising from the recommendations of this report. The 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. The strategic plan articulates the workforce implications of implementing the proposed strategy.

4.5. Legal – publication of a strategic plan is required under the terms of the Public Bodies (Joint Working) (Scotland) Act 2014.

4.6. Other – none.

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:

The strategic plan links directly to the risks noted in the strategic risk register.

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	
	Sandra Ross (Chief Officer)
	Alex Stephen (Chief Finance Officer)

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Review & Refresh Engagement Record

	Name/Agency	Date
1	Scottish Health Council Representatives	05/04/2018
2	ACVO	
3	NHSG Public Involvement Officer	
4	Partnership Manage, ACVO	
5	Health, Wellbeing & Housing (Netralt)	
6	Netralt AGM	17/05/18
7	Cairns Counselling	21/05/18
8	Autism Strategy Engagement Event, Rosemount CC.	24/05/18
9	Senior Community Projects Officer, AFCCFT	29/05/18
10	CEO and Head of Cancer Support Services (CLAN)	04/06/18
11	Community Planning Manager, Community Planning Aberdeen	05/06/18
12	CEO Osprey, Business Development Manager, Grampian Housing Association, Director of Housing & Social Justice (Langstane Housing Association), CEO (Langstane Housing)	08/06/18
13	Operations Director – Enhanced Services (BAC)	11/06/18
14	(Consultant) & (Head of Social Inclusions) – NHSG Public Health	12/06/18
15	Representative from Community Council Forum & Civic Forum	12/06/18
16	Public Health Dietician (ACHSCP Public Health Team)	13/06/18
17	City Home Helpers/ Wellbeing at Work Manager (BAC)	18/06/18
18	Customer Service Manager (DWP)	20/06/18
19	Chief Executive (AFCCT)	26/06/18
20	Civic Forum	26/06/18
21	Danestone Patient Participation Group	29/06/18
22	Community Council Forum	02/07/18
23	Interim Enhanced Services Director & Care at Home Manager (BAC)	03/07/18
24	Learning Development Manager and Team, BAC	16/07/18
25	Service Manager - Sacro	17/07/18
26	Service Co-Ordinator/Team Leader Momentum	18/07/18
27	Our Positive Voice	19/07/18
28	CEO Alcohol and Drugs Action	02/08/18
29	Head of Service, Aberdeen Foyer	07/08/18
30	Inspire	14/08/18
31	Director – Children and Families & Carers Resource Service Manager, VSA	14/08/18
32	Triple A	21/08/18
33	ACVO mental health & wellbeing group	28/08/18
34	Whinhill Public Patient Involvement Group	29/08/18
35	Barnados	03/09/19
36	Manager, Advocacy Service Aberdeen	06/09/18
37	IJB Strategic Plan Workshop	18/09/18
38	Senior Leadership Team Strategic Plan Workshop	21/09/18
39	Ethnic Minority Forum	25/09/18

40	Scottish Care Workshop	26/09/18
41	West Locality Workshop	01/10/18
42	North Locality Workshop	03/10/18
43	Central Locality Workshop	04/10/18
44	South Locality Workshop	05/10/18
45	ACHSCP Pharmacy Leads	08/10/18
46	IJB	09/10/18
47	Autism Forum	11/10/18
48	General Manager, GREC	24/10/18
49	South LLG	24/10/18
50	Aberdeen Advocacy Team Meeting	25/10/18
51	CPA Management Group	29/10/18
52	NHSG Non-Exec Board Member	06/11/18
53	ACHSCP Communication & Engagement Group	12/11/18
54	Strategic Planning Group	13/11/18
55	West LLG	20/11/18
56	MH/LD Ops Management Group	21/11/18
57	Civic Forum	27/11/18
58	Community Council Forum	03/12/18
59	Joint Staff Forum	03/12/18
60	AHP Leads	04/12/18
61	North LLG	05/12/18
62	City Multi-Agency Partnership Group (MH)	05/12/18
63	District Nurse TLs	12/12/18
64	City Staff Partnership Forum	15/01/19
65	Senior OTs	17/01/19
66	Community Nursing Steering Group	30/01/19
67	Central LLG	07/02/19
68	CASPA/Care at Home providers	13/02/19
69	Public Health team	14/02/19
70	ACHSCP Integration Workshop	14/02/19
71	Aberdeen Voice of Experience (AVOX)	26/02/19
72	Bon Accord Care	28/02/19

Existing or Well Developed	To be Developed
ACHSCP Delivery Plans	
Locality Plans	Rehabilitation
Ageing wi Opportunity	Dementia
Mental Health	Social Isolation
Alcohol	Pharmacy
Drugs	Dental
Action 15	Optometry
Primary Care Improvement	Adult Support and Protection
Learning Disabilities	Criminal Justice
Autism	Transitions
Carers	Health Inequality Framework
Winter Plan	Co-Production and Community Asset Approaches
Disabled Adaptations	Public Health & Wellbeing
ACHSCP Enabling Plans	
Workforce Plan	Digital Plan (inc TEC Framework)
Medium Term Financial Strategy	Risk (inc. H&S and Contingency)
Commissioning	Communications
	Transformation/Improvement
	Infrastructure
	Organisational Development
Partner Plans	
Local Outcome Improvement	Immunisation Transformation Plan
Engagement, Participation and Empowerment	GMS Premises Plan
NHSG Clinical Strategy	NHSG Regional Asset Management Plan
Health and Social Care Delivery Plan	Palliative Care
Public Health Priorities for Scotland	Cancer
Nursing 2030 Vision	Updated Local Suicide Prevention Action Plan
National AHP – Active and Independent Living Programme (AILP)	
NHSG Nursing, Midwifery and Allied Health Professions (NMAHP) Strategy	
Unscheduled Care (6 Essential Actions)	
Integrated Children's Services	
Child Healthy Weight	
Pregnancy & Parenthood in Young People	
Child Poverty Action Plan	
Grampian Independent Advocacy	
SeeHear	
British Sign Language	
Type 2 Diabetes Framework	
Strategy for Healthy Weight and Diet	
A Healthier and More Active Future	
Sustainable Food Charter	
Active Aberdeen	
Tobacco	
Local Housing Strategy	
Aberdeen Adapts	

Existing or Well Developed	To be Developed
Dental Plan	
Towards a Fairer Aberdeen that Prospers	
Sexual Health & Blood Borne Viruses (MCN)	
Every Life Matters	

	Aim	Commitment	Deliverable	From Delivery Plan	Lead Officer	Measure of Success	Timescale	RAG Status
1	Prevention	Address the factors that cause inequality in outcomes in and across our communities	increase the availability of accurate and relevant health and social care information and work with BSL users to identify this;	British Sign Language	Alison MacLeod	a survey to assess how well all health and social care information has been accessible to BSL users in the format they require (first survey 2021, to be repeated 2024);		
1	Prevention	Address the factors that cause inequality in outcomes in and across our communities	increase the availability of accurate and relevant health and social care information and work with BSL users to identify this;	British Sign Language	Alison MacLeod	use of local BSL / English Interpreters and BSL users to provide information in BSL on the Partnership website		
1	Prevention	Address the factors that cause inequality in outcomes in and across our communities	raise employees' awareness across the partnership of BSL and Deaf culture by rolling out the national learning resource when this becomes available;	British Sign Language	Alison MacLeod	increased percentage of employees who have made use of the national resource;		
1	Prevention	Address the factors that cause inequality in outcomes in and across our communities	raise employees' awareness across the partnership of BSL and Deaf culture by rolling out the national learning resource when this becomes available;	British Sign Language	Alison MacLeod	work with BSL users to increase employee skills in basic BSL.		
1	Prevention	Address the factors that cause inequality in outcomes in and across our communities	ensure that BSL users are offered psychological therapies on a fair and equal basis	British Sign Language	Alison MacLeod			
1	Prevention	Address the factors that cause inequality in outcomes in and across our communities	consult with NESS and BSL users on our Draft Mental Health Strategy	British Sign Language	Alison MacLeod	involvement of BSL users in consultation around the following strategies: Mental Health Strategy – September/October 2018; Strategic Plan – JanuaryFebruary 2019; Dementia Strategy - Autumn 2019; Carers Strategy – January/February 2021; Learning and Development Strategy – January/February 2021; Others – as required.		
1	Prevention	Address the factors that cause inequality in outcomes in and across our communities	Ease the additional financial burden that disability can bring	Disabled Adaptations	Alison MacLeod	Number of Private Sector Grant Applications agreed.		
1	Prevention	Address the factors that cause inequality in outcomes in and across our communities	Independent advocacy in Grampian continues to be need and user led and is based on stakeholder involvement through direct involvement;	Grampian Independent Advocacy	Alison MacLeod	Satisfaction rates of Advocacy services provided		
1	Prevention	Address the factors that cause inequality in outcomes in and across our communities	Individuals, who need it, have fair and equitable access for the long term;	Grampian Independent Advocacy	Alison MacLeod	Level of Advocacy provided		
1	Prevention	Address the factors that cause inequality in outcomes in and across our communities	There is a proper balance between individual and collective advocacy;	Grampian Independent Advocacy	Alison MacLeod	Balance between individual and collective Advocacy		
1	Prevention	Address the factors that cause inequality in outcomes in and across our communities	Independent advocacy in Grampian is evaluated and reported, through monitoring tools and service level agreements;	Grampian Independent Advocacy	Alison MacLeod			
1	Prevention	Address the factors that cause inequality in outcomes in and across our communities	An effective planning tool is developed to ensure that advocacy is considered by all planning groups in Grampian;	Grampian Independent Advocacy	Alison MacLeod			
1	Prevention	Address the factors that cause inequality in outcomes in and across our communities	All strategic planning documents and change projects address advocacy need;	Grampian Independent Advocacy	Alison MacLeod			
1	Prevention	Address the factors that cause inequality in outcomes in and across our communities	A three year rolling action plan is developed and implemented that defines collective themes at Grampian level, which are converted into detailed plans by each IAO at local authority level.	Grampian Independent Advocacy	Alison MacLeod	Refreshed Advocacy Plan		
1	Prevention	Address the factors that cause inequality in outcomes in and across our communities	Undertake a review of specialist housing requirements for people with mental health, learning disabilities and substance misuse.	Local Housing Strategy	Alison MacLeod	Review completed		

1	Prevention	Address the factors that cause inequality in outcomes in and across our communities	Local partnerships should consider options for the introduction of basic sensory checks for example for people of a certain age, and at agreed times in their care pathway.	SeeHear	Alison MacLeod			
1	Prevention	Address the factors that cause inequality in outcomes in and across our communities	Local partnerships should audit their skills base in relation to awareness of sensory impairment in the workforce and take steps to address any deficits identified, targeted in the first instance at older people's services.	SeeHear	Alison MacLeod	Training on sensory impairment for staff		
1	Prevention	Address the factors that cause inequality in outcomes in and across our communities	Local partnerships (in this instance local statutory and third sector agencies) should be able to evidence that their service planning reflects the need in their area, and reflects appropriate responses to the hierarchy of need outlined earlier.	SeeHear	Alison MacLeod	Service planning identifies need in relation to sensory impairment and reflects response to this		
1	Prevention	Address the factors that cause inequality in outcomes in and across our communities	They should audit current spend and service patterns on sensory impairment, including for carers, in relation to specialist provision and also to those elements of other service provision that impact on people with a sensory impairment. In the light of the findings, consideration should be given to options for service redesign as appropriate;	SeeHear	Alison MacLeod	Spend and usage of NESS service		
1	Prevention	Address the factors that cause inequality in outcomes in and across our communities	They should develop care pathways for people with a sensory impairment, which confirm the component parts of the individual's journey. In so doing they should assess performance against the care pathway and the key factors for effective pathways outlined earlier, and use this as the basis for service improvement, and identify the relevant responsibilities across agencies for the delivery of this;	SeeHear	Alison MacLeod	Sensory Impairment pathway developed with individual agency's responsibilities identified. Service improvement identified and Pathway performanced managed.		
1	Prevention	Address the factors that cause inequality in outcomes in and across our communities	Accessible local information strategies should be developed to include preventative measures and good self-care in retaining sensory health, but also providing information on how to access services.	SeeHear	Alison MacLeod			
1	Prevention	Address the factors that cause inequality in outcomes in and across our communities	There should be robust systems for maintaining information locally, and sharing this between agencies, in relation to people who have received a diagnosis of a sensory impairment at any time from birth onwards.	SeeHear	Alison MacLeod	Rocbust Information systems in place		
1	Prevention	Address the factors that cause inequality in outcomes in and across our communities	Agencies should review their compliance with the Equalities Act 2010 and the UNCRPD Article 9 in relation to sensory impairment, particularly in relation to communication, and give consideration to whether any future action may be required.	SeeHear	Alison MacLeod	Compliance reviewed		
1	Prevention	Promote positive health and wellbeing	Healthy life expectancy (time lived in good health) is five years longer by 2026.	LOIP	Gail Woodcock	Increase the number of distress brief intervention opportunities for people with mental health issues by 10% by 2021		
1	Prevention	Promote positive health and wellbeing	Healthy life expectancy (time lived in good health) is five years longer by 2026.	LOIP	Gail Woodcock	Reduce suicide rates amongst men in Aberdeen to below 2016 levels (20) by 2021.		
1	Prevention	Promote positive health and wellbeing	Healthy life expectancy (time lived in good health) is five years longer by 2026.	LOIP	Gail Woodcock	Reduce % of men and women who are obese to 20% by 2021.		
1	Prevention	Promote positive health and wellbeing	Healthy life expectancy (time lived in good health) is five years longer by 2026.	LOIP	Gail Woodcock	Reduce tobacco smoking by 5% overall by 2021.		
1	Prevention	Promote positive health and wellbeing	Healthy life expectancy (time lived in good health) is five years longer by 2026.	LOIP	Gail Woodcock	Increase health literacy		

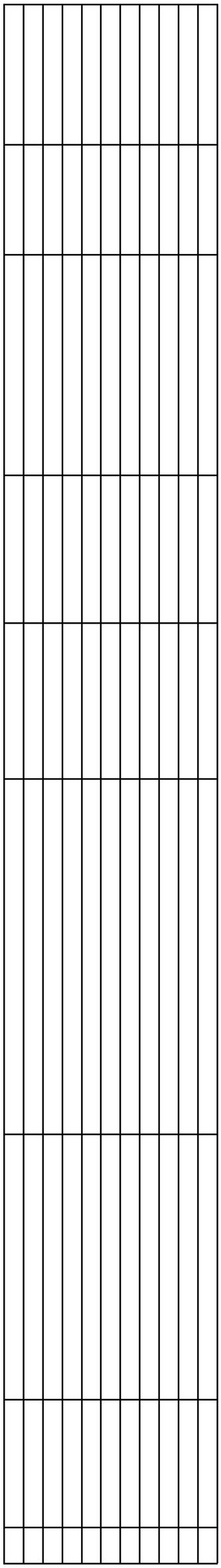
1	Prevention	Reduce harmful impact of alcohol, drugs, tobacco, obesity and poor	Rate of harmful levels of alcohol consumption reduced by 4% and drug related deaths lower than	LOIP	Gail Woodcock	Increase by 10% the percentage of adults in Aberdeen City who are non drinkers or		
1	Prevention	Reduce harmful impact of alcohol, drugs, tobacco, obesity and poor oral health	Rate of harmful levels of alcohol consumption reduced by 4% and drug related deaths lower than Scotland by 2026.	LOIP	Gail Woodcock	Increase % of the population who feel informed about using alcohol responsibly by 2021.		
1	Prevention	Reduce harmful impact of alcohol, drugs, tobacco, obesity and poor oral health	Rate of harmful levels of alcohol consumption reduced by 4% and drug related deaths lower than Scotland by 2026.	LOIP	Gail Woodcock	Increase number of alcohol brief interventions delivered by Primary Care providers and other professionals by 100% by 2021.		
1	Prevention	Reduce harmful impact of alcohol, drugs, tobacco, obesity and poor oral health	Rate of harmful levels of alcohol consumption reduced by 4% and drug related deaths lower than Scotland by 2026.	LOIP	Gail Woodcock	Increase the uptake of alcohol treatment by improving access to alcohol services and ensuring they are local, integrated and targets areas of greatest need by 10% year on year by 2021.		
1	Prevention	Reduce harmful impact of alcohol, drugs, tobacco, obesity and poor oral health	Rate of harmful levels of alcohol consumption reduced by 4% and drug related deaths lower than Scotland by 2026.	LOIP	Gail Woodcock	Reduce the incidence of fatal drug overdose through innovative developments and by increasing the distribution of naloxone by 10% year on year by 2021.		
1	Prevention	Reduce harmful impact of alcohol, drugs, tobacco, obesity and poor oral health	Rate of harmful levels of alcohol consumption reduced by 4% and drug related deaths lower than Scotland by 2026.	LOIP	Gail Woodcock	Increase opportunities for individuals who have been at risk of Blood Borne Viruses, being tested and accessing treatment by 2021.		
1	Prevention	Reduce harmful impact of alcohol, drugs, tobacco, obesity and poor oral health	Rate of harmful levels of alcohol consumption reduced by 4% and drug related deaths lower than Scotland by 2026.	LOIP	Gail Woodcock	Increase uptake of drug treatment and specifically within Locality Areas by 10% each year by 2021.		
1	Prevention	Reduce harmful impact of alcohol, drugs, tobacco, obesity and poor oral health	Rate of harmful levels of alcohol consumption reduced by 4% and drug related deaths lower than Scotland by 2026.	LOIP	Gail Woodcock	Increase number of people undertaking recovery from drug and alcohol issues who are being supported to maintain drug / alcohol free lives in their community by 2021.		
1	Prevention	Promote positive health and wellbeing	Deliver the Vaccination Transformation Programme	PCIP	Gail Woodcock	Increase vaccination uptake		
1	Prevention	Promote positive health and wellbeing	Promoting health and wellbeing and tackling inequalities	Nursing	Heather MacRae			
1	Prevention	Address the factors that cause inequality in outcomes in and across our communities	Promoting health and wellbeing and tackling inequalities	Nursing	Heather MacRae			
1	Prevention	Promote positive mental health and wellbeing	Scale up the Beating the Blues project	Action 15	Karen Gunn			
1	Prevention	Reduce the harmful health impact of alcohol, drugs, tobacco, obesity and poor oral health	More young people and families at risk are supported to stay together	Alcohol	Karen Gunn			
1	Prevention	Reduce the harmful health impact of alcohol, drugs, tobacco, obesity and poor oral health	More children and young people at risk as a result of parental alcohol misuse are safer	Alcohol	Karen Gunn			
1	Prevention	Reduce the harmful health impact of alcohol, drugs, tobacco, obesity and poor oral health	Reduce alcohol related crime, antisocial behaviour, preventable accidents and harms	Alcohol	Karen Gunn	Alcohol related crime is reduced		

Year 2

	Aim	Commitment	Deliverable	From Delivery Plan	Lead Officer	Measure of Success	Timescale	RAG Status
1	Prevention	Address the factors that cause inequality in outcomes in and across our communities	Provide training on creation of accessible information & effective communication methods such as talking mats, social stories, videos	Learning Disability	Kevin Dawson	Training will be available	Mar-21	Green
1	Prevention	Address the factors that cause inequality in outcomes in and across our communities	Work with Universities and Colleges to explore learning opportunities to increase knowledge and understanding of Autism for a range of stakeholders	Autism	Kevin Dawson	Learning opportunities will be mapped and attendance statistics will be used to create baselines for improvement	Mar-21	Green
1	Prevention	Address the factors that cause inequality in outcomes in and across our communities	Develop and launch good practice checklists for 'autism appropriate' environments	Autism	Kevin Dawson	Checklist will be developed and launched; evaluation of its use; anecdotal evidence of improvements	Mar-21	Green
1	Prevention	Address the factors that cause inequality in outcomes in and across our communities	Raise awareness of the Appropriate Adult (AA) Scheme	Autism	Kevin Dawson	Analysis of data regarding requests and usage of AAs	Mar-21	Green
1	Prevention	Promote positive health and wellbeing	Provide information on suitable counselling type supports with knowledge of Autism interlinked to Mental Health	Autism	Kevin Dawson	Information will be available; services will be listed on relevant databases	Mar-21	Green
2	Resilience	Promote and support self management and independent living for individuals	Promotion of events & networks that have people with Learning Disabilities at the centre	Learning Disability	Kevin Dawson	People being actively involved	Mar-21	Green
2	Resilience	Value and Support unpaid Carers	Promote awareness of anticipatory/life planning, including Carers Support Plans	Learning Disability	Kevin Dawson	Awareness is raised	Mar-21	Green
2	Resilience	Promote and support self management and independent living for individuals	Review internal assessment & review documents to ensure they capture information on how services are promoting/utilising people's skills & abilities	Learning Disability	Kevin Dawson	Review will be completed & documentation amended to best capture information	Mar-21	Green
2	Resilience	Promote and support self management and independent living for individuals	Promote use of the 'Healthy Hoose' Model for people with Learning Disabilities	Learning Disability	Kevin Dawson	Awareness will be raised	Mar-21	Green
2	Resilience	Promote and support self management and independent living for individuals	Promote Health Passports as model of best practice	Learning Disability	Kevin Dawson	Increasing numbers of Health Passports in place	Mar-21	Green
2	Resilience	Promote and support self management and independent living for individuals	Commence dialogue with staff in General Practice, including Community Link Workers regarding the needs of people with a Learning Disability, resource/supports available & discuss how data can be best captured	Learning Disability	Kevin Dawson	Awareness will be enhanced	Mar-21	Green
2	Resilience	Promote and support self management and independent living for individuals	Promotion of Annual Health Checks & preventative screening to individuals, families and providers	Learning Disability	Kevin Dawson	Numbers of health checks/screenings will increase	Mar-21	Green
2	Resilence	Promote and support self management and independent living for individuals	Raise awareness of the 'Keep Safe' approach	Learning Disability	Kevin Dawson	'Keep Safe' approach will be in operation & supporting people with Learning Disabilities	Mar-21	Green
2	Resilence	Promote and support self management and independent living for individuals	Explore the 'Quality Checkers' model	LD	Kevin Dawson	Scoping will be complete	Mar-21	Green

2	Resilence	Promote and support self management and independent living for individuals	Scope information available regarding Long Term Conditions and promote use of such information to people with Learning Disabilities (considering accessibility)	LD	Kevin Dawson	Information will be widely available to people and accessible versions provided as required	Mar-21	Green
2	Resilence	Promote and support self management and independent living for individuals	Promote the 'Making Every Opportunity Count' model for people with Learning Disabilities	LD	Kevin Dawson	Model will be explored and in use	Mar-21	Green
2	Resilence	Promote and support self management and independent living for individuals	Provide enhanced clarity on the assessment pathway for Children and Young People (as informed by national development work)	Autism	Kevin Dawson	Information on the Pathway will be readily available; reduction in complaints; linkage to children's plan; assessment and diagnosis trends will be measurable	Mar-21	Green
3	Personalisation	Right Care, Right Place, Right Time	Integrated working practices in the Adult Learning Disability Service will be enhanced	Learning Disability	Kevin Dawson	Health & Social Work practices, where possible, will have greater alignment	Mar-21	Green
3	Personalisation	Right Care, Right Place, Right Time	Explore & expand use of Technology Enabled Care (TEC)	Learning Disability	Kevin Dawson	Awareness will be raised, and TEC will have greater usage	Mar-21	Green
3	Personalisation	Right Care, Right Place, Right Time	Develop a 'Transitions Pathway' where changes in practice will be trialled	Learning Disability	Kevin Dawson	Pathway will be developed & in operation/changes will be trialled	Mar-21	Green
3	Personalisation	Right Care, Right Place, Right Time	Raise awareness of the Liaison Nurse Service	Learning Disability	Kevin Dawson	Use of Service will be extended where possible/Awareness will be enhanced	Mar-21	Green
3	Personalisation	? -support to staff	Develop/Cascade Training focussed on what is a Learning Disability, including specific information on the interaction with Mental Health & Communication methods	LD	Kevin Dawson	Training will be developed and launched	Mar-21	Green
3	Personalisation	Right Care, Right Place, Right Time	Provision of flexible and appropriate learning pathways and environments which meet the needs of autistic children	Autism	Kevin Dawson	Analysis of local and national statistics detailing attendance, exclusion and positive educational and wellbeing outcomes; anecdotal evidence of improvements from children and families	Mar-21	Green
3	Personalisation	Right Care, Right Place, Right Time	Develop mechanisms to track unmet need and analyse gaps in provision (from signposting to direct support), to inform future development	Autism	Kevin Dawson	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	Mar-22	Green
4	Connections	Enable our citizens to have opportunities to maintain their wellbeing and take a full and active role in their local community	Promote Peer Support	Learning Disability	Kevin Dawson	People are aware of & actively involved in peer support	Mar-21	Green
4	Connections	Enable our citizens to have opportunities to maintain their wellbeing and take a full and active role in their local community	Explore ACHSCP signing up to the 'Charter for Involvement' & promotion of the charter to other organisations (wider than Learning Disability Services/Organisations	Learning Disability	Kevin Dawson	ACHSCP/National Involvement Network/Local Organisations already signed up to the Charter	Mar-21	Green

4	Connections	Enable our citizens to have opportunities to maintain their wellbeing and take a full and active role in their local community	Facilitate an event with interested Leisure/Activity providers and groups to discuss and promote the autism and establish mechanisms to increase widening access	Autism	Kevin Dawson	Event will have taken place; baseline of knowledge will be measured, and improvement methods identified	Mar-21	Green
4	Connections	Enable our citizens to have opportunities to maintain their wellbeing and take a full and active role in their local community	Scope viability of 'Travel Buddy'/transport scheme	Learning Disability	Kevin Dawson	More people can independently travel	Mar-21	Green
4	Connections	Enable our citizens to have opportunities to maintain their wellbeing and take a full and active role in their local community	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	Autism	Kevin Dawson	Event will have taken place; baseline of knowledge will be measured, and improvement methods identified; increase in employment of autistic people	Mar-21	Green
5	Communities	Enable our communities to utilise their energy, strengths, people and assets to self organise and exercise autonomy	Establish what user engagement work is taking place locally & how feedback is being captured and used to improve services/quality	LD	Kevin Dawson	Greater knowledge of User Engagement will exist	Mar-21	Green
5	Communities	Enable our communities to utilise their energy, strengths, people and assets to self organise and exercise autonomy	Awareness Raising of people with Learning Disabilities in the wider community	Learning Disability	Kevin Dawson	More positive & welcoming experiences	Mar-21	Green
5	Communities	Enable our communities to utilise their energy, strengths, people and assets to self organise and exercise autonomy	Awareness of Community Resources which promote & support wellbeing	Learning Disability	Kevin Dawson	Information on resources will be widely available/accessed	Mar-21	Green
5	Communities	Develop a diverse and sustainable care provision	Continue to raise awareness of Asset Based approaches in Learning Disabilities	Learning Disability	Kevin Dawson	Awareness will be raised	Mar-21	Green
5	Communities	Deveop a diverse a sustainable care provision	Facilitate an event with the housing sector to promote the housing needs of Autistic people and their families	Autism	Kevin Dawson	Event will have taken place; baseline of knowledge will be measured, and improvement methods identified	Mar-21	Green
5	Communities	Develop a diverse and sustainable care provision	Conduct & maintain mapping of ACHSCP provided/commissioned services/housing	Learning Disability	Kevin Dawson	Mapping will be completed & held centrally/maintained	Mar-21	Green
5	Communities	Deveop a diverse a sustainable care provision	Scope future presenting needs and develop commissioning intentions, including the development of a Learning Disability Commissioning Plan	Learning Disability	Kevin Dawson	Greater knowledge of future need will be established/Commissioning intentions will be identified	Mar-21	Green



Year 3

	Aim	Commitment	Deliverable	From Delivery Plan	Lead Officer	Measure of Success	Timescale	RAG Status
1	Prevention	Reduce harmful impact of alcohol, drugs, tobacco, obesity and poor oral health	Ensure access to alcohol services is local, integrated and targets areas of greatest need	ADP Transformation & Delivery Plan	Karen Gunn	Continue the development of Community Alcohol Hubs targeting communities where deprivation is greatest as a whole system / whole population approach to alcohol	Aug-21	Amber
1	Prevention	Reduce harmful impact of alcohol, drugs, tobacco, obesity and poor oral health	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	SMS Transformation & Delivery Plan	Karen Gunn	Measurable and reportable quality assurance measures	Aug-21	Amber
1	Prevention	Reduce harmful impact of alcohol, drugs, tobacco, obesity and poor oral health	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	LOIP / Community Justice Partnership / ADP	Karen Gunn	Increase the uptake and retention of people in the Justice System with drug and alcohol problems in specialist services by 100% by 2021	Aug-21	Amber
1	Prevention	Reduce harmful impact of alcohol, drugs, tobacco, obesity and poor oral health	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;	ADP Transformation & Delivery Plan	Simon Rayner / Tam Walker	Ensure joint working and robust quality assurance processes are in place that meet best interests of the child and their family are met.	Aug-21	Amber
1	Prevention	Reduce harmful impact of alcohol, drugs, tobacco, obesity and poor oral health	Reduce the adverse and harmful impact of parental drug / alcohol use on children	ADP Transformation & Delivery Plan	Simon Rayner	Ensure family members, partners and carers receive a proactive offer of support and advice in relation to drug and alcohol misuse	Aug-21	Amber
1	Prevention	Reduce harmful impact of alcohol, drugs, tobacco, obesity and poor oral health	Reduce the adverse and harmful impact of parental drug / alcohol use on children	ADP Transformation & Delivery Plan	Karen Gunn	Reduction in number of live births experiencing neonatal abstinence syndrome	Aug-21	Amber
1	Prevention	Address the factors that cause inequality in outcomes in and across our communities	Develop innovative ways to engage those most at risk to drug or alcohol related problems	SMS Transformation & Delivery Plan	Karen Gunn	Increase number of service users from target cohorts engaging services	Aug-21	Amber
1	Prevention	Reduce harmful impact of alcohol, drugs, tobacco, obesity and poor oral health	Take forward recommendations in relation to “The Delivery of Psychological Interventions in Substance Misuse Services in Scotland Report”	SMS Transformation & Delivery Plan	Karen Gunn	Services are trauma informed	Aug-21	Amber
1	Prevention	Reduce harmful impact of alcohol, drugs, tobacco, obesity and poor oral health	Maintain links with local recovery groups, support groups and mutual aid fellowships	ADP Transformation & Delivery Plan	Karen Gunn	Ensure that a range of support mechanisms in place and available to groups who support those in recovery	Aug-21	Amber
2	Resilience	Value and Support Unpaid Carers	Review Eligibility Criteria for Adult Carers after three years.	Carers	Alison MacLeod	Revised Eligibility Criteria approved, published and utilised	Jun-21	Green
2	Resilience	Value and Support Unpaid Carers	Review the Integrated Children’s Services Operational Guidance.	Carers	Alison MacLeod	Revised Operational Guidance approved, published and utilised	Jun-21	Green

2	Resilience	Value and Support Unpaid Carers	Review strategy after 3 years	Carers	Alison MacLeod	Strategy revised, approved, published and implemented	Mar-21	Green
2	Resilence	Promote and support self management and independent living for individuals	Promotion of 'Transitions across the Lifespan' national toolkit	Autism	Kevin Dawson	Awareness and use of toolkit will be raised; reduction in unsuccessful transitions; anecdotal evidence of improvements in relation to life transitions	Mar-22	Green
2	Resilence	Promote and support self management and independent living for individuals	Increased use of Care Opinion by Autistic People and their families	Autism	Kevin Dawson	Increased usage evidence through available data	Mar-22	Green
2	Resilience	Value and Support unpaid Carers	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	Autism	Kevin Dawson	Increased awareness of rights will exist; data of carers support plans completed	Mar-22	Green
3	Personalisation	Right Care, Right Place, Right Time	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	Autism	Kevin Dawson	Working group will review supports and analyse gaps and put necessary	Mar-22	Green
3	Personalisation	Right Care, Right Place, Right Time	Creation of 'autism appropriate' integrated assessment pathway for Adults	Autism	Kevin Dawson	Assessment data will be recorded and analysed	Mar-22	Amber
3	Personalisation	Right Care, Right Place, Right Time	Development and implementation of a Transitions Pathway (children to adults)	Autism	Kevin Dawson	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	Mar-22	Amber
3	Personalisation	Right Care, Right Place, Right Time	Ensure that our workforce is appropriately supported and valued in our quality processes to ensure best possible care, recruitment and retention	SMS Transformation & Delivery Plan	Simon Rayner	Staff service feedback and job satisfaction	Aug-21	Amber
3	Personalisation	Right Care, Right Place, Right Time	Build capacity of our specialist services to improve access, waiting times and retention in treatment	SMS Transformation & Delivery Plan	Simon Rayner	We exceed waiting times standard	Aug-21	Amber
3	Personalisation	Right Care, Right Place, Right Time	Ensure access to alcohol services is local, integrated and targets areas of greatest need	SMS Transformation & Delivery Plan	Simon Rayner	Continue the development of Community Alcohol Hubs targeted to communities where deprivation is greatest as a whole system / whole population approach to alcohol	Aug-21	Amber

4	Connections	Enable our citizens to have opportunities to maintain their wellbeing and take a full and active role in their local community OR Counter the experience of loniness and isolation experienced by all age groups	Increased use of Individual Plans (IEPs/Child's Plans) to monitor progress	Autism	Kevin Dawson	Analysis of plans to be undertaken and progress tracked	Mar-22	Green
4	Connections	Enable our citizens to have opportunities to maintain their wellbeing and take a full and active role in their local community OR Counter the experience of loniness and isolation experienced by all age groups	Develop and launch promotional work to raise community knowledge and understanding of the strengths of autistic people	Autism	Kevin Dawson	Increased knowledge, understanding and acceptance; promotional events or materials will be launched	Mar-22	Green
5	Communities	Deveop a diverse a sustainable care provision	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	Autism	Kevin Dawson	Training Framework will be in place; attendance and evaluation data will be available	Mar-22	Green

NHS Grampian

ABERDEEN CITY COUNCIL

Aberdeen City Health & Social Care Partnership

A caring partnership

Strategic Plan 2019-2022

Aberdeen City
Health & Social Care
Partnership
A caring partnership

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

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Aberdeen City
Health & Social Care
Partnership

A caring partnership

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

Please contact Aberdeen City Health and Social Care Partnership on 01224 523237 or ACHSCPEnquiries@aberdeencity.gov.uk

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

ভাষা/ইন্টারপ্রেটিং এবং অন্যান্য ফরমেটের যোগাযোগ সাহায্যের জন্য দয়া করে :01224 523 542 নম্বরে যোগাযোগ করবেন।

如果需要語言/傳譯及其他形式的傳訊支援服務，請聯絡:01224 523 542。

Если требуется помощь при выборе языка /переводчика или других способов общения, звоните по телефону : 01224 523 542

للحصول على مساعدة بخصوص اللغة/الترجمة و وسائط الاتصال الأخرى، الرجاء الاتصال بالرقم التالي:01224 523 542

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Strategic Plan on a Page

OUR VISION:

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

OUR VALUES:

- Caring
- Person Centred
- Enabling

OUR AIMS

Prevention	Resilience	Personalisation	Connections	Communities
Working with our partners to achieve positive health out-comes for people and address the preventable causes of ill-health in our population	Working with our partners to support people so that they can cope with, and where possible, overcome the health and wellbeing challenges they may face	Ensuring that the right care is provided in the right place and at the right time when people are in need. Ensuring that our systems are as simple and efficient as possible.	Develop meaningful community connections and relationships with people to promote better inclusion, health and wellbeing and reduce social isolation.	Working with our communities, recognising the valuable role that people have in supporting themselves to stay well and supporting each other when care is needed

OUR DELIVERY PLANS

Mental Health | Action 15 | Suicide Prevention | Learning Disabilities | Autism | Tobacco | Oral Health | Carers | Primary Care Improvement Plan | Locality Plans | Alcohol | Drugs | Criminal Justice

OUR ENABLING PLANS

Medium Term Financial Strategy | Workforce | Commissioning | Infrastructure

HOW WILL WE KNOW WE HAVE BEEN SUCCESSFUL

- Reduced Attendances at A&E
- Lower Premature Mortality Rate
- Reduction in emergency admission rate
- Increase % of people living independently in the community
- Improved Health Literacy
- Improved Healthy Life Expectancy
- Improved Vaccination Uptake
- Reduced levels of social isolation reported
- Increase in % of adults who report they are in housing most suitable for their needs
- Increase in % of carers who report they are supported to have a life alongside caring
- Increase in % of adults able to look after their health very well or quite well
- Increase in physical activity and healthy weight
- Increase in % of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life
- Increase in % of adults supported at home who agreed that their health and social care services seemed to be well coordinated
- Increase in % of adults receiving any care or support who rated it as excellent or good
- Increase in number of people with positive experience of care provided by their GP practice,

Foreword

Aberdeen City Health & Social Care Partnership and its governance body, the Integration Joint Board, have now been operating for almost three years – and during this time, real progress has been made to integrate the health and social care services delegated from our partners, Aberdeen City Council and NHS Grampian.

This vital work will now continue over the period of our new Strategic Plan 2019–22.

This is a time of challenge and change. Demand for our services is rising as people live longer but often with complex needs. We also face rising costs, reduced finances, and recruitment challenges.

But we must not diminish the quality of service we provide. To rise to the challenges ahead, we must transform the landscape of this complex and sensitive sector of public service to bring about an ever-deeper integration of our health and social care services.

Sarah Duncan
IJB Chair Councillor

Our new Strategic Plan sets out the aims, commitments and priorities, which underpin this process of change – importantly, in alignment with Community Planning Aberdeen's Local Outcome Improvement Plan, NHS Grampian's Clinical Strategy and Aberdeen City Council's Local Housing Strategy.

We must change at pace and we must transform in step with all of our partners because none of us alone can deliver improvement.

Sandra Ross
ACHSCP Chief Officer

Our Strategic Plan shows how we will help to build more resilient and better-connected communities. It demonstrates how we will encourage and enable supported self-management and our prevention agenda to help manage future demand for services. And it sets out how must modernise how we do things, building in collaboration and co-operation within our own workforce and the public – to support our citizens to take more control over and responsibility for their own health and wellbeing.

We must do things better and smarter so that our funding delivers ever-more joined-up, locality-based models of health and social care – models which fully involve our citizens in planning and delivery, in a culture of transparency and trust.

Our new Strategic Plan maps out what we will do to achieve all this and how we will measure our success.
This is our plan – but it is also your plan. Because only by working as partners can we transform to thrive.

1. Introduction

Aberdeen City Council (ACC) and NHS Grampian (NHSG) delegate a wide range of adult health and social care services to Aberdeen City Health & Social Care Partnership (ACHSCP). The Partnership's first Strategic Plan was published in April 2016 and had a lifespan of 3 years. This latest version of the Strategic Plan covers the next 3 years.

Our Strategic Plan outlines how we plan to deliver improvements to our existing services which will have a positive impact on the health and wellbeing outcomes for people living and working in Aberdeen City. This plan is mainly for them, but it is also for our staff and partners without whom we could not deliver. The services we deliver aim to meet a wide variety of needs. In developing the Strategic Plan, we reviewed our performance against our existing priorities, considered the emerging risks (mainly in terms of increasing demographics, reduced finances, and difficulties in recruiting and retaining staff) and consulted with our customers, our partners and our staff. This helped us to clarify our strategic aims, commitments and priority areas that are detailed in this plan.

The overarching aim of ACHSCP is to provide integrated services which improve people's health and wellbeing. In considering our strategic direction for the next 3 years, we have taken into account the national integration principles so we will ensure our services will be provided in ways which:

- ✔ Are joined up and easy for people to access
- ✔ Take account of people's individual needs
- ✔ Take account of the particular characteristics and circumstances of different service users in different parts of the city
- ✔ Respect the rights and dignity of service users
- ✔ Take account of the participation by service users in the community in which service users live
- ✔ Protect and improve the safety of service users
- ✔ Improves the quality of the service
- ✔ Are planned and led locally for the benefit of service users, people who look after service users and the people who provide health or social care services
- ✔ Anticipate people's needs and prevent them arising
- ✔ Make the best use of facilities, people and resources

A key challenge is for these principles to be part and parcel of our day-to-day practice.
It is important to us as a partnership that our actions meet the expectations that are placed on us.

Our Vision

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

Our Values

- Caring
- Person centred
- Enabling

> *Our vision and values underpin all of our activities and define who we are and what is important to us.*

Our Strategic Intent

We face demographic and financial challenges now and in the future. Doing more of the same is not a sustainable option for us. We need to have honest conversations with our customers, our staff and our partners about their expectations and their contributions. We will work together to enable people to keep as well as they can in a way that suits them. We accept that we will have to reshape and transform how and where we deliver services as well as focus our effort on addressing preventable factors. We remain ambitious to be recognised as an innovative and high performing partnership.

With the support of the people of Aberdeen and our many valued partners we are confident we will achieve this.

IN 2030 ABERDEEN WILL BE ONE OF THE HEALTHIEST PLACES TO LIVE IN EUROPE BECAUSE .....

Everyone is as healthy as can be, has the knowledge, understanding and skills to look after themselves, their families and their communities

Businesses work closely with communities and volunteers

Positive mental health and wellbeing is shared by all

The healthiest choice is the easiest and preferred option

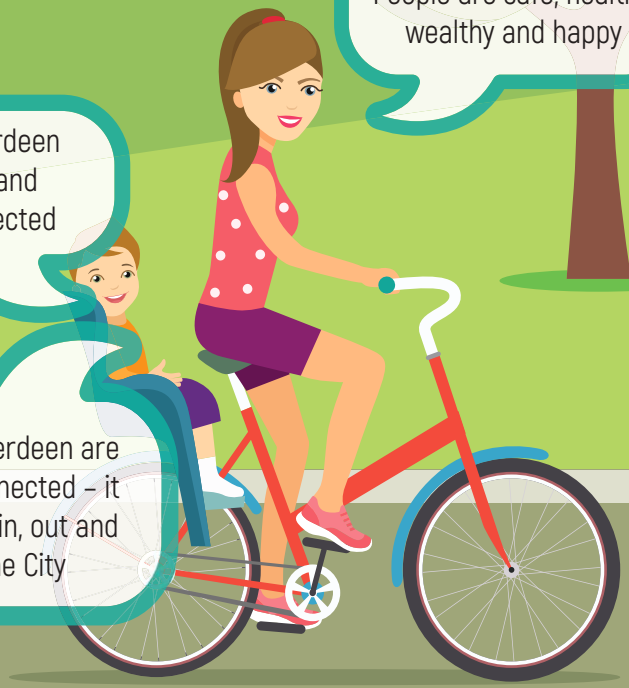
People know who to turn to by being able to easily access health information

Health status is shared across the City – health inequalities are uncommon

People are safe, healthy, wealthy and happy

People of Aberdeen are socially and digitally connected

The City is safe to live, work and play



Citizens of Aberdeen are physically connected – it is easy to get in, out and around the City

There is a strong sense of independence, resilience, confidence, self-esteem and aspiration within our communities

Equal opportunities are enjoyed by all

There is a sense of pride and passion in Aberdeen

People take responsibility for their own health and participate in preventative and anticipatory care

We will deliver on our Strategic Plan under five broad strategic aims:

	Strategic aim	What does this mean?
1.	Prevention	Working with our partners to achieve positive health outcomes for people and address the preventable causes of ill-health in our population.
2.	Resilience	Supporting people and organisations so they can cope with, and where possible overcome, the health and wellbeing challenges they might face.
3.	Personalisation	Ensuring that the right care is provided in the right place and at the right time when people are in need.
4.	Connections	Develop meaningful community connections and relationships with people to promote better inclusion, health and wellbeing and to reduce social isolation.
5.	Communities	Working with our communities, recognising the valuable role that people have in supporting themselves to stay well and supporting each other when care is needed.

We will make specific commitments against each of these aims and identify priorities.

As a Partnership we already have a number of delivery plans in place and in development for example for Carers, people with Learning Disabilities, Autism and Mental Health. In addition, we have a role to play in helping our partners deliver on their plans and as such, where relevant, we have identified a commitment we have made in particular partner plans for example the Local Outcome Improvement Plan and NHS Grampian's Clinical Strategy.

Not all delivery plans are service or condition specific. Some are "enabling" plans i.e. they support us to deliver our services. Examples of enabling plans are our Medium-Term Financial Strategy and our Workforce Plan.

Our Strategic Plan is the high level, overarching plan that sits above all of these plans and we do not intend to duplicate the detail that is contained in these plans here. The aims, commitments and priorities are all pitched at a strategic level. Whilst some of our existing plans will need to be refreshed in light of the new aims, commitments and priorities in this new Strategic Plan, we hope our staff and our partners recognise their contributions to our Strategic Plan and likewise the role we have to play in helping them deliver on their plans.

We have also identified the performance measures that will help us identify whether we are achieving what we set out to do. Our Performance Framework is mapped to the aims, commitments and priorities and we will collect and share data that helps us to have the conversations around what is working well and what needs to change.

Our strategy will play an important role in ensuring that people's experiences match or exceed their expectations when they use our services. When designing and delivering our services it is fundamental that local community voices are heard.

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

We recognise that working with our partners is a positive and productive thing to do and we will seek to co-ordinate our activities so that we work seamlessly together.

Scotland's **Public Health Priorities** have strongly influenced the development of this plan.

These are: -

- **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 wellbeing**
- **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**

Their stated aim is for people to be as healthy as they can be, and this is set within a broader desire to reshape our attitudes towards health and wellbeing.

In its **Health and Social Care Delivery Plan 2016**[3] , the Scottish Government encourages us to focus on:

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

Effective **community planning** arrangements will help us to deliver better services and achieve better outcomes for our citizens and communities. The Community Planning Aberdeen (CPA) **Local Outcome Improvement Plan (LOIP)**[4] sets out a multi-agency approach to make Aberdeen a better place to live and work in. ACHSCP is a member of the CPA and recognises the value of all partners working together 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.

The **Community Empowerment (Scotland) Act 2015** empowered community organisations by strengthening their voices in decisions about public services. Community Planning Aberdeen's **Engagement, Participation and Empowerment Strategy** sets out a vision of collaboration & empowerment and offers a positive way of working with communities. Its objectives are ones which ACHSCP has adopted i.e.

- **communities' inherent strengths and assets – their people, their energy, their connections, sense of purpose and resources, and their abilities to self-organise and exercise autonomy – will be valued as a fundamental building block of a healthy society**
- **every community will be equally heard and listened to**
- **participation will be the norm rather than the exception**
- **staff will be empowered to work in collaborative and empowering ways**
- **people will be able to see the difference that involvement has made**

A close alignment with the priorities (Prevention, Self-Management, Planned Care, Unscheduled Care) set out in **NHS Grampian's Clinical Strategy (2016-2021)** will ensure improved experiences and outcomes for the people who use our services and their carers. This is related to the NHS Scotland Clinical Strategy and the principles of realistic medicine in the related reports from the Chief Medical officer *(Realistic Medicine and Realising Realistic medicine).* People often want to be more involved in decisions about their care, but they may not know what questions to ask. We need to support shared decision making and empower people to be confident to ask questions about their care and to help us manage demand in the most appropriate way, including supporting self-management.

The Aberdeen City Council **Local Housing Strategy (LHS) 2018-2023** sets out how local housing need and demand will be addressed and how this contributes to the national housing priorities. The LHS 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.**

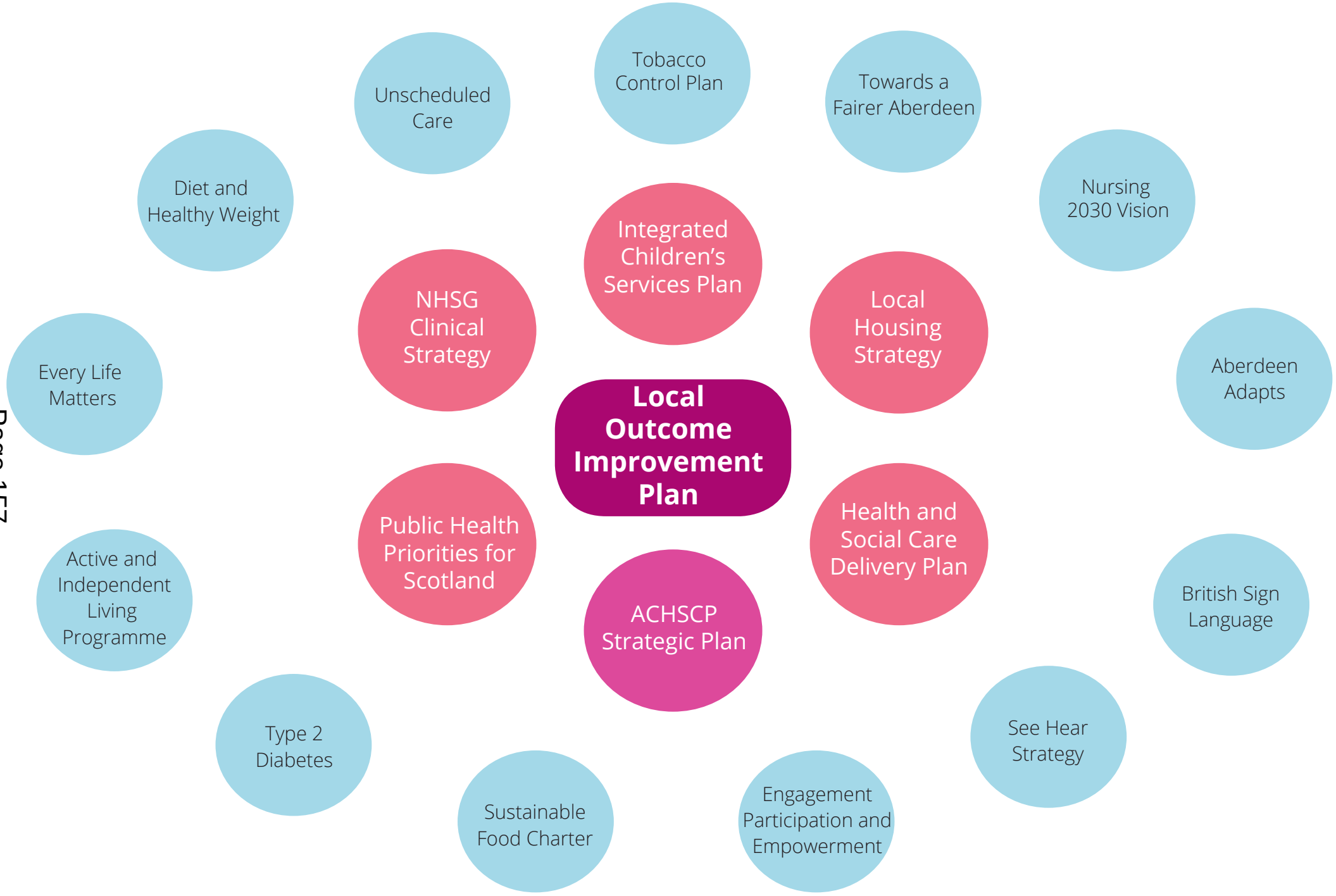
Aberdeen City Health & Social Care Partnership
A caring partnership

ACHSCP will work closely with ACC Housing colleagues to deliver the positive outcomes identified in the LHS Joint Delivery Action Plan.

Local Development Plan - Future Demand and Growth" - the Aberdeen City and Aberdeenshire Strategic Development Plan (SDP) 2014 sets out a target of building 31,500 new houses by 2035, achieving an annual house building rate of 3,000 per year by 2020. Over 50% of these will be built in Aberdeen City. The greatest demand for services over the next seven years will be in the North and South Localities. There are additional housing units being developed which will require a 'rebalance' of existing General Medical Services (GMS) and the delivery of new ways of working and new professional roles to ensure patients get access to the right person, at the right place at the right time. ACHSCP will continue to work with ACC and NHSG to ensure priorities are identified for the investment in infrastructure to modernise primary and community care services. The Strategic Housing Investment Plan (SHIP) sets out the local priorities for the delivery of affordable housing, this includes a 15% target for wheelchair accessible housing.

One of the key drivers for **Aberdeen City Integrated Children's Services Plan "Children Are Our Future" 2017/20** is that children have the best start in life. We acknowledge the need to build stronger connections between children and adult services. Investment in early years/family support will enable current and future generations to enjoy improved health and wellbeing and have better life outcomes. In particular children and young people who are looked after or care experienced are at greater risk of having poorer life chances and we need to ensure we deliver on our corporate parenting responsibilities. Better outcomes for the children and young people in Aberdeen will be achieved by working more collaboratively with children's services and aligning our respective activities more fully. Working together with our wider partners, we aim to ensure that transitions between children's and adult services are as smooth as possible for those who require care and their carers.

Not least because Aberdeen City commissions almost all of its adult social care services from external organisations, these **third and independent sector providers** and their representative bodies – Aberdeen Council for Voluntary Organisations (ACVO) and Scottish Care - are key partners in our service delivery. Bon Accord Care (BAC), the Arm's Length External Organisation (ALEO) wholly owned by Aberdeen City Council and the delivery arm for older people's social care services, is also a key partner. ACHSCP will work with these partners to deliver on its strategic commissioning intentions as detailed in the Strategic Commissioning Implementation Plan. We need to foster and build good working relationships with these service providers as we cannot deliver our services without them. They are the experts in their field and we value that expertise and will work with them to co-design and co-produce the highest quality, efficient and effective services that we can within the finances available, ensuring that we deliver the best possible outcomes for the people in Aberdeen who use these services.


Local Outcome Improvement Plan
Tobacco Control Plan
Towards a Fairer Aberdeen
Unscheduled Care
Diet and Healthy Weight
Nursing 2030 Vision
Integrated Children's Services Plan
NHSG Clinical Strategy
Local Housing Strategy
Every Life Matters
Aberdeen Adapts
Public Health Priorities for Scotland
Health and Social Care Delivery Plan
Active and Independent Living Programme
British Sign Language
ACHSCP Strategic Plan
Type 2 Diabetes
See Hear Strategy
Sustainable Food Charter
Engagement Participation and Empowerment

In addition to universal health services which are available to the general public, the services provided by ACHSCP include adult social care and health services for older people and people with learning disabilities and mental health and substance misuse problems, as well as Disabled Adaptations and support for those in the criminal justice system. They also include primary and community healthcare services including Allied Health Professionals (AHPs), General Practitioners (GPs), District Nurses, community dental, ophthalmic and pharmacy services, Public Health, Health Visiting and School Nursing.

In addition to our core services, the Partnership also has a strategic planning responsibility for some specific services which cover the whole Grampian area and some services which are delivered in acute hospital settings.

Our Strategic Plan applies to these services too, as we need to make sure that the ways in which they are delivered, match our aims, commitments and priorities.

Grampian-wide service we are responsible for	Hospital services we have strategic planning responsibility for

• 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

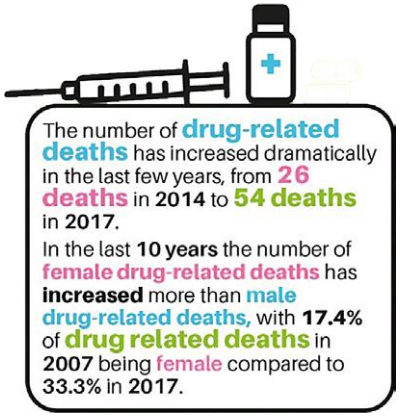
Table 2 ACHSCP Strategic Planning (Hosted/Acute) Responsibilities.

Aims	Commitments	Priorities (timescale across the lifetime of the plan unless otherwise identified)
Prevention	• Promote positive health and wellbeing • Reduce harmful impact of alcohol, drugs, tobacco, obesity and poor oral health • Address the factors that cause inequality in outcomes in and across our communities	• Develop Mental Health Strategy (Year 1) and deliver on this in future years • Deliver Action 15 Plan • Refresh our local Suicide Prevention Plan • Develop a local Dementia Plan (Year 1) • Deliver on Scotland's Public Health Priorities • Work with the Active Aberdeen Partnership to improve levels of physical activity • Deliver health improvement actions for early years, children and young people • Work with partners to address environmental factors – place planning and Aberdeen Adapts (in relation to climate change) • Work with Alcohol and Drug Partnership (ADP) to deliver Drug Strategy • Work with Alcohol and Drug Partnership (ADP) to refresh Alcohol Strategy (Year 1) • Refresh Tobacco Strategy (Year 1), • Develop local action plans on healthy diet and weight and Type 2 diabetes (Year 1) • Develop local plan for delivery of dental services (Year 1) • Develop a framework for addressing health inequality (year1) • Work with the Integrated Children's Services to identify ways to give children the best start on life • Work with the Grampian Independent Advocacy Group to review advocacy provision • Work with NESS to review delivery of the national SeeHear Strategy and with ACC to implement the British Sign Language Plan • Deliver the Action Plan for Learning Disabilities • Deliver the Action Plan for Autism • Improve levels of Health Literacy
Resilience	• Promote and support self-management and independent living for individuals • Value and Support Unpaid Carers • Develop coordinated arrangements which enable people of	• Deliver self-management transformation projects • Work closely with Housing colleagues to deliver the positive outcomes identified in the LHS Joint Delivery Action Plan. • Deliver disabled adaptions where appropriate • Develop a local plan for the delivery of rehabilitation services (Year 1) • Deliver on our Action Plan for Carers

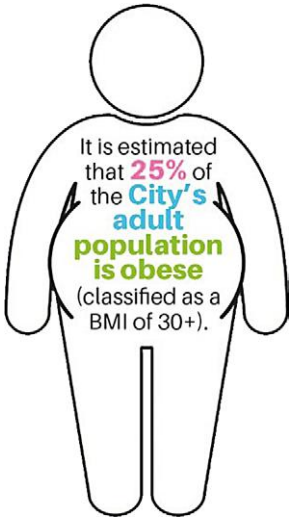
Aims	Commitments	Priorities (timescale across the lifetime of the plan unless otherwise identified)
Resilience	all ages with complex physical disabilities to maintain their health and avoid unnecessary complications	
Personalisation	• Provide the right care, in the right place, at the right time • Reshape our community and primary care Sectors • Develop our palliative and end of life care provision	• Deliver on the Unscheduled Care 6 Essential Actions • Continue to improve delayed discharge experience • Develop a plan for transitions at all stages starting with children with disabilities transitioning to Adult Learning Disability Services in Year 1 • Deliver on our Primary Care Improvement Plan • Modernise infrastructure to support the delivery of primary and community care services • Continue to deliver initiatives related to Shifting the Balance of Care to the community • Continue to deliver initiatives related to preventing admission to hospital • Work with regional colleagues to develop strategies related to cancer and palliative care
Connections	• Enable our citizens to have opportunities to maintain their well-being and take a full and active role in their local community • Reduce the level to which people of all ages feel lonely and isolated	• Continue to deliver the Link Worker Project • Develop the Silver City Surfers project • Develop a local Dementia Plan (Year 1) • Deliver on our Action Plan for Carers • Develop a plan to reduce social isolation (Year 2)
Communities	• Enable our communities to utilise their energy, strengths, people and assets to self-organise and exercise autonomy • Develop a diverse and sustainable care provision	• Promote community engagement, participation and empowerment • Implement the new locality model • Promote an asset- based approach • Encourage co-design and co-production of services • Work with our partners in Community Planning to deliver on the LOIP • Work on delivering our Medium-Term Financial Framework • Review our Commissioning Plan (Year 1) • Develop a Market Facilitation Plan (Year 2) • Develop a Risk Management and Business Continuity Plan • Work with the Sustainable Food City Partnership Aberdeen to deliver the Sustainable Food Charter

6.1 Prevention

We recognise that if we want to improve the health and wellbeing of our citizens, we must identify and over-come any barriers to change. We strongly believe that compassionate and inclusive leadership can help to unlock the potential to transform services and we will work with citizens, communities and partners to promote change. 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.

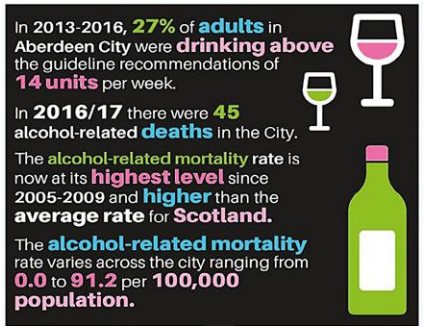


This includes working with our partners in Children's Services to ensure current and future generations live well. If we can keep people as healthy and as well as possible, we can keep them out of hospital and away from GP practices unless and until it is appropriate for them to be there. We will work with our partners to ensure we "make every opportunity count". Colleagues who are already visiting clients' homes for other reasons (fire safety, crime detection or prevention) can alert us to health and social care needs that could benefit from early intervention.



There is no shortage of health improvement messages, including keeping physically active, eating healthily, minimising our alcohol intake, avoiding non-prescription drugs, quitting smoking and good oral health. What is also needed is an approach that recognises our experiences of the complexity and cumulative impact of health conditions, and an understanding of what may work for each individual and their desired personal outcomes. We need to make healthy choices the easy choices. Most people remain relatively healthy and active without the need for formal supports and services. Although health problems generally increase with age, ill health and disability should not be seen as a predictable consequence of growing older in Aberdeen.

Tobacco use, obesity and oral ill-health can all have harmful impacts on health. Obesity is one of the contributing factors to the development of type 2 diabetes which can lead to other negative impacts on a person's health. Promoting a healthy diet and weight and increasing opportunities for physical activity will go some way to off-setting these effects. We also need to understand the impact food poverty and household food insecurity have on families' ability to make healthy food choices. The right kind of support that can help address this. As well as raising the awareness of the effects, we need to provide information and opportunities so people can understand the impact of the choices they make on their health and wellbeing.



If people are to become more active, then they need access to open/green space. We will work with our partners to influence the provision of these. We also need to better understand the impact climate change will have on the future health of the population and include this within our awareness-raising and education.

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.**

Poor mental health is a significant public health challenge which many of us, our friends and our families will experience. Such issues can have an impact on a person's ability to function and live independently. We want our citizens to enjoy the best possible mental health and wellbeing. When anyone begins to experience poor mental health, appropriate supports should be available in their communities for them to access. The national Mental Health Strategy 2017-2027 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.

No death by suicide should be regarded as either acceptable or inevitable. Suicide is preventable. We want to ensure that help and support is available to anyone contemplating suicide and to those who have lost loved ones to suicide.

Health inequalities across the city are unfair and avoidable. Reducing and overcoming such inequalities are part of our Fairer Scotland Duty and will be our focus. Alcohol and drug use significantly contribute to poorer health and wellbeing across all parts of our city. 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 need more intensive support and treatment. We will support our local Alcohol and Drugs Partnership to deliver the national strategy "Rights, respect and recovery: alcohol and drug treatment strategy".

We want all members of our communities to have the same opportunities and experiences. Our citizens with learning difficulties, autism, a sensory impairment or those that have been through the criminal justice system, can all experience inequality in outcomes. We have developed plans to try to redress the balance and delivery of these will be an area of focus over the next three years. We will identify and work closely with those undertaking caring roles who can speak on behalf of cared-for people and ensure that appropriate advocacy services are in place for those who have difficulty making their own voice heard.

Health literacy, i.e. the degree to which people have the capacity to understand the information they need to make appropriate health decisions is not equal across all of our communities. We will ensure that health information is provided in an easy-read format and that the use of techniques such as "Teachback" are used as widely as possible to improve the levels of health literacy.

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).

6.2 Resilience

Resilience can be understood to be the ways in which people and organisations adapt 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 in response to life's day-to-day challenges.

Supported self-management means moving away from a model where people are passive recipients of care and treatment towards a more collaborative relationship where they are active partners, taking greater ownership of their own health and wellbeing. Many people with long-term conditions already make appropriate decisions and manage many factors that contribute to their health and wellbeing on a day-to-day basis. For this shift to be effective, people 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. We have implemented a number of transformation projects such as the introduction of Community Link Practitioners in all GP practices, the implementation of a "House of Care" model which involves the individual in planning conversations with their healthcare professional(s), and the development of a services directory which people can use to find support that best suits their needs. We will continue to embed these initiatives over the lifetime of the Strategic Plan to build resilience in the community.

Good quality housing and related services such as the use of the community alarm or telecare equipment play a key role in enabling people to live independently and safely at home for as long as is reasonably practicable. We will work with our colleagues in Aberdeen City Council Housing and Registered Social Landlords to ensure that people have housing that is right for their needs including arranging adaptations to their existing homes, if relevant, rather than compounding a disabling condition by having to move to a new house. The approach to adaptations should be tenure-neutral i.e. there should be equivalency regardless of the type of property an individual lives in. In addition to this we plan to map review specialist housing provision across all client groups, mapping the existing stock and developing a strategic approach to delivery of new accommodation models.

Stable, sustainable employment is an important foundation for people's health and wellbeing. Employers play a critical role in supporting positive health and wellbeing outcomes by promoting active physical and mental health initiatives and sustaining people with health conditions in work. ACHSCP will look to be a public health partner with the city's employers.

Many people of all ages live with complex physical disabilities that can often bring unnecessary complications such as additional injuries as a result of falling in the home. We will develop coordinated arrangements through rehabilitation and reablement which enable them to better manage their conditions and maintain their best health.

Unpaid carers are significant partners and our health and social care services could not function as well as they do were it not for their contribution. We will ensure that the support offered to all carers is targeted both at their individual outcomes and the personal outcomes of those being cared for. Our Carers Strategy 2018-2021 Action Plan sets out key actions that will support unpaid carers in Aberdeen to overcome the impact their caring role may have on their life and enable them to have a life alongside caring if they so choose.

6.3 Personalisation

This approach is where services are tailored to the needs of individual people, so that they have access to the right care, in the right place at the right time. It means that there are no in-built assumptions of what someone needs or a uniform 'one size fits all' provision but instead there is appropriate signposting to other resources and services as and when appropriate for each individual. This identification of the right care needs to start early and follow through with the individual as they transition through the various stages in their life. We are developing a Transitions Plan that will identify actions to help ensure this happens.

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 types of care. We continue to shift the balance of care away from residential and hospital settings into the community and are actively seeking to prevent hospital attendance and admission so that conditions can be treated and supported in the community. Our service provision has a significant emphasis on prevention and supported self-management.

Primary care is a crucial area of operation, 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 many other health services. Our Primary Care Improvement Plan outlines our proposed initiatives to address this sector's significant operating challenges. Our community care services can also benefit from review.

We are embarking on a programme of improvement projects that will support the reshaping of both the primary and community care sectors. This includes a modernisation programme of the infrastructure that supports the service delivery. Most of our social care services are provided by our partners in the third and independent sectors. We know that we all have workforce recruitment challenges to overcome but even so, all partners have shown a continuing ability to introduce new ways of delivering health and social care.

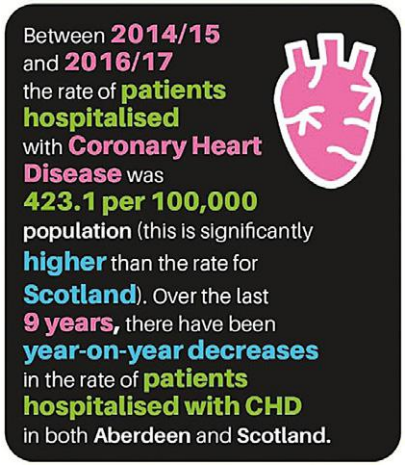
Palliative care seeks to improve the quality of life of people who have a terminal illness or life-limiting conditions including cancer. End-of-life care is that part of palliative care which seeks to ensure that a person dies as peacefully and with as much dignity as possible. We recognise the need to be responsive to the changing preferences and priorities of people with advanced illness and those of their carers. Although the choices that are expressed after diagnosis may well change later, sensitive anticipatory planning will help ensure that care meets the needs and wishes of the individual and, where appropriate, their carer.

People are healthier when they feel connected to things that matter to them. We want our citizens to feel connected to their community and have opportunities to make connections across their community, depending on their need. Some may be living with dementia or undertaking a caring role and may wish to seek support from individuals or groups of people in a similar situation. Others may need help getting to grips with technology and could benefit from others with expertise in that area.

There is a wealth of knowledge, expertise, and willingness in the community and we want to help connect those who need with those who can support. Some people may not even realise they can help or believe that they have anything to offer. We want to foster the environment which creates the ability for everyone to make the connection they need.

ACHSCP 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 not be realised if transport challenges are not addressed. ACSHSCP has a specific transformation project around community transport and will work with partners to ensure this is delivered with improved transport outcomes for our communities.

Perceptions of loneliness and isolation can differ across client groups and age groups. 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 and in some instances, early death. Offering different opportunities, depending on who we are and where we are, can help address these challenges. We will develop a plan to address social isolation and help promote the positive power of connections.



6.4 Connections

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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.

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We will develop a plan to address social isolation and help promote the positive power of connections.

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%).

6.5 Communities

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. We will ensure communities are involve in the planning, design and delivery of our services.

Localities are intended to be the engine room of integration, bringing together our citizens, unpaid carers and professionals from the public, third, independent and housing sectors to reshape our services based on informed practice and local insights. The decision to implement a four-locality model in Aberdeen was taken in the pre-integration shadow year. Our proposed three-locality model (Figure 3.1) will result in a closer alignment with community planning structures and activities, better partner collaborations, more public clarity and a better focus on areas where people experience poorer outcomes. These three localities (North, Central, and South) again cover the whole city as the legislation obliges and, crucially, the three community planning localities would be wholly within their respective ACHSCP localities.

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 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. This is why the IJB has previously endorsed Community Planning Aberdeen's 'Engagement, Participation and Empowerment' Strategy. Working with our citizens to co-produce the outcomes that matter to them is an important principle for us.

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:

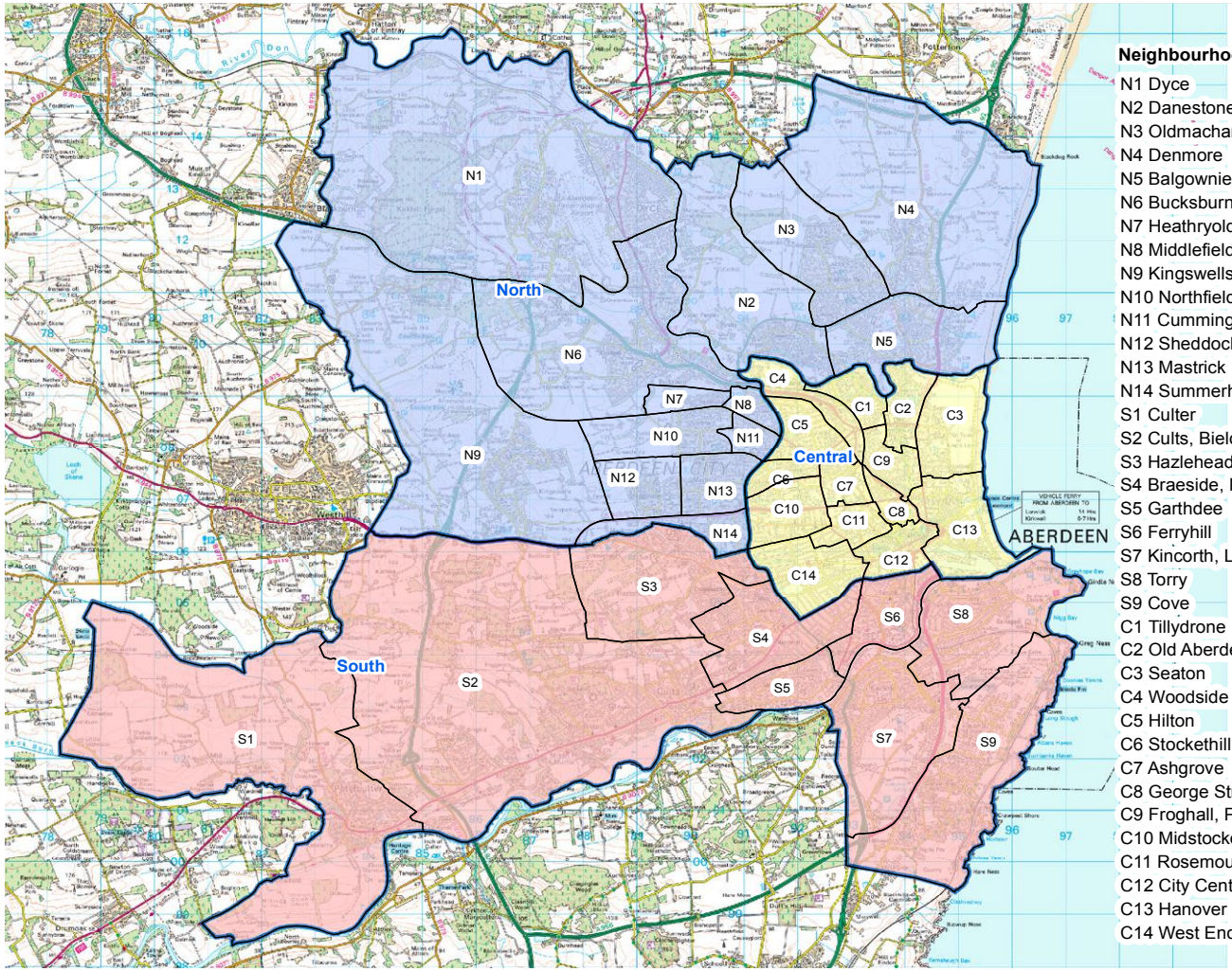
- start with the assets and resources in our communities and identify opportunities and strengths;
- see people as having something valuable to contribute and support them to develop their potential in adding social value to their communities;
- focus on community organisations, encouraging and adding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

Our service delivery can only be successful if we have sufficient finances and workforce both in-house and with our partners. There are many challenges to our service delivery, and we need to ensure we are aware of the risks and have mitigations and contingencies in place to enable us to develop a diverse and sustainable care provision. This includes a commitment to sustainable food provision. We will refresh our commissioning plan and develop a market facilitation plan which puts our partners at the centre of designing and delivering services both now and in the future.

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**.

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%).



Neighbourhood

- N1 Dyce
- N2 Danestone
- N3 Oldmachar
- N4 Denmore
- N5 Balgownie & Donmouth
- N6 Bucksburn
- N7 Heathryold
- N8 Middlefield
- N9 Kingswells
- N10 Northfield
- N11 Cummings Park
- N12 Sheddocksley
- N13 Mastrick
- N14 Summerhill
- S1 Culter
- S2 Cults, Bieldside & Milltimber
- S3 Hazlehead
- S4 Braeside, Mannofield, Broomhill & Seafield
- S5 Garthdee
- S6 Ferryhill
- S7 Kincorth, Leggart & Nigg
- S8 Torry
- S9 Cove
- C1 Tillydrone
- C2 Old Aberdeen
- C3 Seaton
- C4 Woodside
- C5 Hilton
- C6 Stockethill
- C7 Ashgrove
- C8 George Street
- C9 Froghall, Powis & Sunnybank
- C10 Midstocket
- C11 Rosemount
- C12 City Centre
- C13 Hanover
- C14 West End

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.**

36

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

Our enablers are those fundamental elements which we need to develop further in order to meet our strategic objectives:

- empowered staff
- principled commissioning
- digital transformation
- sustainable finance
- modern and adaptable infrastructure

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 activities.

Commitment

- Value and empower all staff, both our own and our partners to work as positively and collaboratively as possible in the delivery of health and social care services
- Positively engage with professional and regulatory bodies and trade union representatives

Priorities

- Develop our Workforce Plan (Year 1)
- Work towards adopting the principles of Unison's Ethical Care Charter
- Work towards ACC and NHSG achieving the Carer Positive Award

7.1 Empowered staff

Our staff groups across the public, third, independent and housing sectors are pivotal to our aspirations – and there is a strong relationship between the morale of staff and people's experiences of using our health and social care services. Our staff are key to delivering positive outcomes to our patients and clients. Taking care of our staff will maximise the impact of these outcomes.

Valuing our staff and empowering them all to work as positively and collaboratively as possible is crucial to delivering 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 need to 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 with our local and 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 apply the learning to other sectors and care settings. Positive engagement with professional and regulatory bodies and trade union representatives is essential to our workforce ambitions.We strongly believe that fair work is work that offers our staff an effective voice, opportunities, security, fulfilment and respect. 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 Partnership has endorsed the Ethical Care Charter 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.

Our Carers Strategy identifies an action for businesses to achieve the Carer Positive Award and we will seek to achieve that and encourage others in Aberdeen to do likewise to help meet the Scottish Government's target of 30% of all businesses with this award. We need to offer similar supports to other elements of our workforce.

7.2 Principled Commissioning

Our approach to commissioning is collaborative and generates an innovative range of options to achieve shared outcomes, social value and social cohesion.

The commissioning of services will be one of the Partnership's most important functions as it seeks to ensure that all services enhance the quality of life for the people and their carers now and in the future. We recognise that it will be most effective if it is done in partnership with individuals, families, groups, communities and other agencies that have an interest in the continued wellbeing of the people of Aberdeen.

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 individual budgets or direct payments will need consistent and accurate information that clearly explains the options and opportunities available.

All our commissioning will be respectful of the appropriate legislation, mindful of best practice such as the Ethical Care Charter, and sensitive to the needs of our local care provision. We will not adopt a uniform one-size-fits-all commissioning approach but instead we will be sensitive to age, wellbeing and complexity of need.

Commitment

- Ensure that all commissioned services enhance the quality of life for people and their carers now and in the future
- We will give people more informed choice and flexibility over their care and support

Priorities

- Review Commissioning Plan (Year 1)
- Develop a Market Facilitation Plan (Year 2)
- Embed Self Directed Support into social care delivery. (Year 1)

- ✔ **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-system 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**

Commitment

- Aspire to reach a point 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 continue to engage with us.

Priorities

- Develop and deliver our Digital Transformation Plan in conjunction with our partners.

7.3 Digital Transformation

Digital technology is key to transforming our health and social care services across ACHSCP 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 part in our lives in so many other ways. There are significant opportunities to introduce digital solutions across all sectors and services. We aspire to reach a point 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 continue to engage with us. In developing our digital transformation, we are linking closely with the work that both NHS Grampian and Aberdeen City Council are undertaking to reduce duplication of effort, achieve better value for money and join up systems where appropriate.

7.4 Sustainable Finance

Over the next few years we will have to address the significant challenge of health and social care budgets reducing in real terms while demand for services increases. To achieve our objective of improving the health, wellbeing and independence of people to live at home for as long as is reasonably practicable, we need to look at how we manage our resources to deliver the best value for the people who use our services, their carers and their communities.

A Medium-Term Financial Framework (MTFF) 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 establishes the estimated level of resources required by the partnership to operate its services over the next five financial years, given the demand pressures and funding constraints that we are likely to experience.

Table 3 below shows the level of budget pressure the Partnership will face after assumptions have been made about the level of income likely to be received from partners. The budget pressures include provision for pay awards, Scottish Living Wage uplifts, demographic projections and prescribing inflation and represent just over 2% of the total budget. To offset these anticipated pressures, key 'financial saving' workstreams have been identified and provisional targets (in brackets) have been set to be delivered from these. The total savings are equivalent to approximately 1.5% of the overall budget.

	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

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 many partner agencies who deliver commissioned services.

We will always seek to invest in those functions and services which can demonstrate a positive impact on people's health and wellbeing, and are aligned with the aims, commitments and priorities of our Strategic Plan. There will be times, however, when disinvestment options will be considered, particularly when the impact, alignment or value for money delivered by a service is not as strong as it could be.

Our investment/disinvestment decisions 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 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. There is a national and a local desire to see the evidence of the impact of our transformation and our evaluation framework will provide that assurance.

Commitment

- Address the significant challenge of health and social care budgets reducing in real terms while demand for services increases

Priorities

- Deliver our Medium-Term Financial Framework

Commitment

Support service redesign and provide modern buildings, equipment, new technologies and effective transport links essential to delivering successful integrated, community-based health and social care services fit for the future

Priorities

Develop and deliver an Infrastructure Plan

7.5 Modern and Adaptable Infrastructure

In these times of changing needs and service redesign, modern buildings, equipment, new technologies and effective transport links are essential to delivering successful integrated, community-based health and social care services fit for the future. The Capital and Services team support both the redesign of services and the development of robust business cases to secure the necessary investment for the related infrastructure required to support the delivery of identified new service models.

This requires collaborative working across primary and community care services to identify the priorities for ACHSCP and to feed these into the planning of our partners (ACC and NHSG) who retain ownership of buildings and lead all funding submissions to the Scottish Government Capital Programmes.

This work is undertaken in line with the NHS Grampian Asset Management Plan, the General Medical Services (GMS) Premises Plan, and the ACC Asset Management Plan. Work has recently commenced to develop an Infrastructure Plan which will support this activity.

6. How will we know we are making a difference

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.

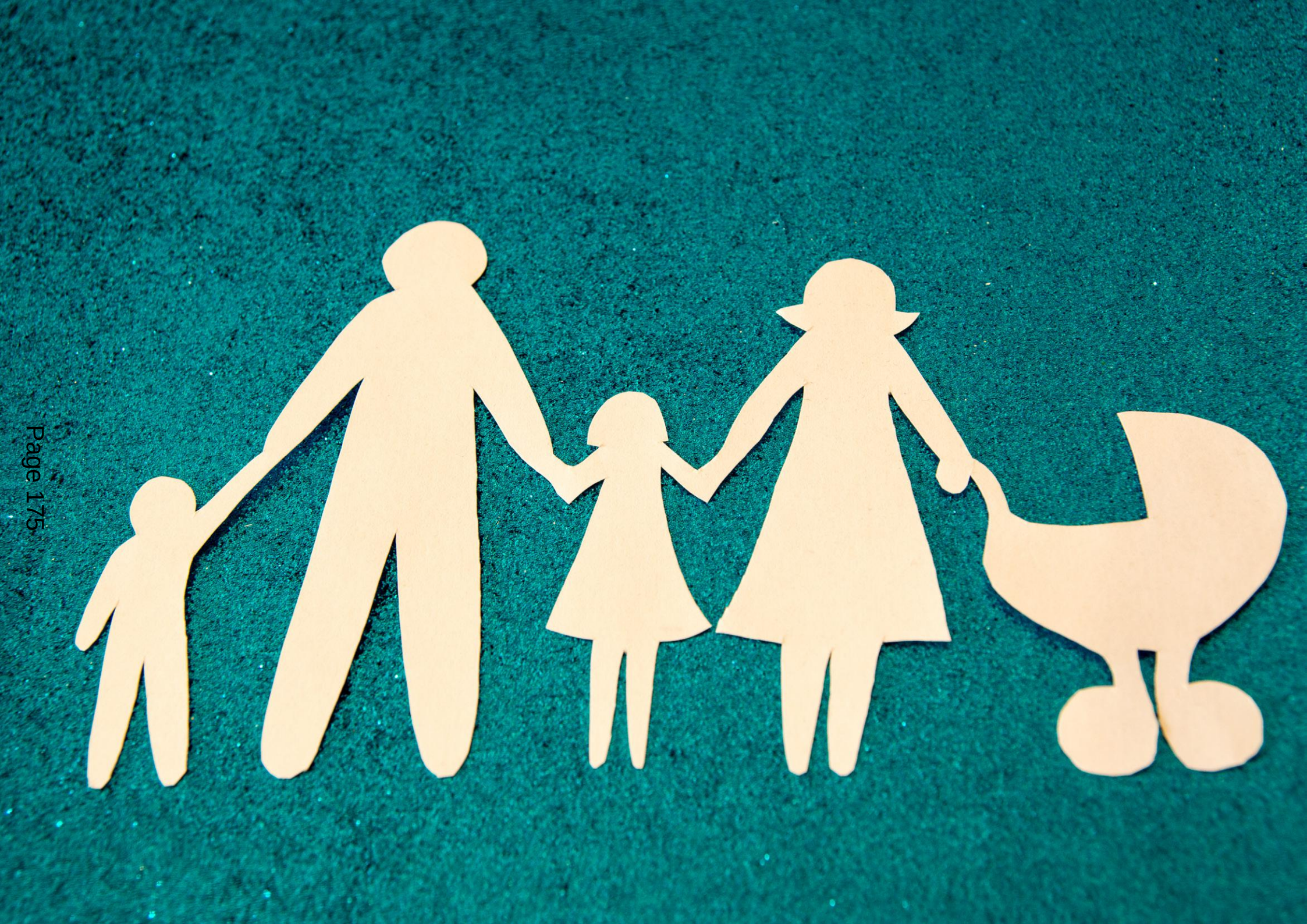
Our emphasis will always be on fulfilling outcomes. Ensuring that personal, organisational and national outcomes are linked in a coherent manner will be central to the successful implementation of a Partnership-wide, outcomes-focused approach.

The National Performance Framework 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 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.

There are six Ministerial Steering Group (MSG) indicators which are reported on a quarterly basis. These are a subset of the national indicators and have been identified as being the key ones that demonstrate progress on integration. In addition, we have a number of measures that are collecting and reporting for partner plans such as the Local Outcome Improvement Plan and a number of measures which are identified in our own delivery plans. Relevant measures have been aligned to the aims, commitments and priorities in this Strategic Plan and these will be reported over the year to relevant operational forums and to our Audit and Performance Systems and Clinical and Care Governance Committees.

Our aim is not to duplicate effort but to arrange existing performance reporting in such a way that it demonstrates achievement of our Strategic Plan.

Our Annual Performance Report is a statutory requirement. It is published on our website and shows how well we have performed as a Partnership in achieving what we set out to do. Future annual reports will be organised in line with the aims, commitments and priorities of this Strategic Plan.



PREVENTION	RESILIENCE	PERSONALISATION	CONNECTIONS	COMMUNITY
Reduction in number of A&E attendances	Reduction in Emergency Admission Rate (per 100,000 population)	Increase in % of population aged 75+ living in a community setting (including a care home)	Increase % of Community Links Practitioners in post	Increase in total of home care hours delivered
Reduction in number of alcohol-related hospital admissions	Reduction in readmission to hospital within 28 days (per 100,000 population)	Reduction in total number of delayed discharges	Increase number of clients supported by Community Links Practitioners	Reduction in social care unmet need
Reduction in number of alcohol-related deaths	Decrease in falls rate (per 100,000 population|	Increase in the proportion of the last six months on life spent at home or in a community setting	Reduce level of social isolation reported	Increase in residential care occupancy rate
Reduction in number of drug-related hospital admissions	Decrease in premature mortality rate for people aged under 75 (per 100,000 population)	Reduction in number of adverse events	Increased uptake of Silver City project	Increase in proportion of care services graded "Good" (4) or better in Care Inspectorate inspection
Reduction in number of drug-related deaths	Increase in % adults supported at home who agree they felt safe	Increase in % of population registered with a GP	Increase use of Chaplaincy listening service	Decrease in proportion of care service contractually non-compliant
Reduce % of men and women who are obese to 20% by 2021	Increase in % of adults supported at home who agree that they are supported to live as independently as possible	75% of adults should be registered with an NHS dentist by the end of 2020, 78% by the end of 2022 NB: include % participation (i.e. visited within last 2 years)	Increased uptake of Dementia Scholarship	Increase in % of adults supported at home who agreed that their health and social care services seemed to be well coordinated
Reduce suicide rates amongst men in Aberdeen to below 2016 levels (20) by 2021.	Increase in % of adults who report they are in housing most suitable for their needs	Increase in number and percentage of new-build properties developed and fully accessible for people with particular needs	Achievement of Dementia Friendly City status	Increase in total % of adults receiving any care or support who rated it as excellent or good
Reduce tobacco smoking by 5% overall by 2021.	Increase in % of home care where two or more members of staff are required	Increase in number of older people or people with a disability given housing options prior to hospital discharge or whilst in interim accommodation		Decrease in number of complaints received
Increase the number of successful 12 week quits	Increase in % of adults with intensive care needs receiving care at home	Increase in % uptake of Self-Directed Support Options		Increase in number of complaints responded to within 20 working days
Increased physical activity	Increase in number of people using a community alarm service	% of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life		Increase in number of community groups convened and meeting regularly

PREVENTION	RESILIENCE	PERSONALISATION	CONNECTIONS	COMMUNITY
Increase levels of Health Literacy	Increase in number of people using telecare	Reduce offender re-conviction rate		Increase in number of community training sessions delivered
Increased uptake in vaccinations offered	Increase in number of adaptations delivered per tenure	Number of new referrals to initial investigation under Adult Support and Protection		Increase in % of staff who say they would recommend their workplace as a good place to work
Improved breastfeeding targets	Reduction in number of adaptation reinstatements agreed	Increase in % of people with positive experience of care provided by their GP practice		Decrease in total FTE posts vacant
Reduce number of deaths related to cancer	Increase in number of people provided with 12 months post-diagnostic support			Decrease in total FTE agency staff employed
Reduce number of deaths related to circulatory disease	Increase in % of adults able to look after their health very well or quite well			Decrease in sickness absence rate
Improved child dental health	Increase in number of unpaid carers supported			Decrease in staff turnover rate
Less than 5% of adults in Grampian should have no teeth remaining by 2022	Increase in % of carers who report they are supported to have a life alongside caring			
Reverse the rising incidence of oral cancer in Grampian by 2022	Increase in % of adults able to look after their health very well or quite well			
Reduce the life expectancy gap between most and least deprived areas				
Reduction in drug prescriptions for type 2 diabetes care				
Incidence of type 2 diabetes				
Reduce heart attack admission rate gap between most and least deprived areas				
Reduce cancer rate gap between most and least deprived areas				

Aberdeen City
Health & Social Care
Partnership
A caring partnership

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

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Aberdeen City Health & Social Care Partnership
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INTEGRATION JOINT BOARD

Date of Meeting	26.03.2019
Report Title	Progress Report – Aberdeen HSCP Strategic Commissioning Implementation Plan (2018)
Report Number	HSCP.18.146
Lead Officer	Sandra Ross, Chief Officer
Report Author Details	Name: Anne McKenzie Job Title: Lead Commissioner (Interim) Email Address: anne.mckenzie@nhs.net
Consultation Checklist Completed	*Yes*
Appendices	No

1. Purpose of the Report

1.1. This report provides an update on progress made against the Aberdeen City Health & Social Care Partnership's (ACHSCP) Strategic Commissioning plan 2018 - 2022

2. Recommendations

2.1. It is recommended that the Integration Joint Board:

a) Note the content of the report

3. Summary of Key Information

3.1. The ACHSCP Strategic Commissioning Plan was approved by the Integration Joint Board (IJB) in 2018. This plan set out the ACHSCP's commissioning intention over the next four to five years, to help to reshape services in the face of financial and demographic challenges.

3.2. The plan was to be considered amongst other key strategic documents –

- the Carers Strategy,
- the Learning Disability strategy,
- the Mental Health Strategy,
- the Strategic Plan and the four locality plans.

The plan also set out the partnership's ambition to stabilise and grow the available market to support the implementation of its strategic ambition

3.3. In 2018, the IJB approved all of the above strategies and plans with the exception of the Mental Health strategy. The actions plans associated with these other key strategic documents are created and are being implemented. Locality plans are formed and associated action plans are currently being implemented.

3.4. The strategic commissioning plan identified not only the principles which would underpin commissioning for the future, but also key areas of focus, with associated timescales for completion.

3.5. It should be acknowledged that during the course of 2018 there was a period of significant change within the organisation, both with a change in leadership, and a delay in the move to operational delivery through a locality model. This has undoubtedly reduced the productivity against the recommendations made in the plan

3.6. 2019 offers a better opportunity for achievement of the recommendations. The leadership within the organisation is stable; the locality structure is under review with a sound ambition to maximise the opportunity for partnership working, and improved outcomes for the population of the City and the strategic plan is being refreshed. The overall ambitions of the organisation remain constant – to improve the outcomes for people who require Health and Care.

3.7. The Strategic Commissioning Plan identifies key priority areas (listed below) and the remainder of the report will provide an update against each priority

- Care at home
- Reablement
- Residential care for older people and people with a physical disability
- Residential care for people with a learning disability

- Residential care for people with mental health needs
- Intermediate care
- Out of hours and responder capacity
- Joint equipment store

3.8. **Care at home –** the ambition to move to an outcomes focussed model of delivery, shifting away from time and task remains constant. Our ambition to work in partnership with local providers was evident recently with local providers absorbing the care packages previously provided by Allied healthcare. One further example of progress has been our reduction in the number of hours of unmet need – achieved to a great extent through improved relationships and communication between service managers and care providers. Work has commenced on preparation to recommission the Care at Home provision within the City. The anticipated date for completion is the 31st March 2020.

3.9. **Reablement** – We await the evaluation of the reablement approach adopted by Bon Accord Care. Our ambition is for this approach to be adopted by all providers, and will feature in the revised Care at Home contract.

3.10. **Residential care for all people -** We await the revised National Care Home contract, currently under review. We have had an opportunity to shape this contract through local representation at the negotiations. As part of our medium term financial strategy, we have established working groups to review our current bed base, and our out of area placements. It is anticipated that the output from these groups will advise and inform our decision making for the number and function of our bed base for the future, and how we fund these beds. There has been a recent example of redesigning nursing home provision at Kingswells.

3.11. **Intermediate care -** We continue to block purchase a number of beds within our nursing homes – predominantly but not exclusively for interim placements for people who no longer require hospital care. These beds are well utilised.

3.12. **Out of hours -** A working group has been established to progress how we respond to unscheduled requirements for health and care services. It is anticipated that this group will consider the demand for services outwith normal working hours.

3.13. **Joint equipment store -** The partnership is committed to the provision of one equipment store within the City, and a working group has been established to progress this work

3.14. Transformation Programme 'Big ticket items' - Strategic Commissioning is considered as one of the six "big ticket" items. Progress against some other identified workstreams is as follows:

- Acute care at home – work to refine this model of care continues, with tests of change and associated learning. This model has incorporated early supported discharge. Further work will continue to explore this model, under the wider banner of unscheduled care.
- Supporting self-management of long-term conditions – building community capacity – the first tranche of Primary Care Link Workers are recruited and operational within GP practices across the City. Recruitment to the remaining capacity is imminent. Three GP practices signed up to the House of Care model with differing degrees of success. Work is underway to create a National service directory which will allow people to access information about local services to support them to manage their long-term condition
- Modernising primary and community care – our Primary Care Implementation plan is approved and actions are being implemented.

3.15. Market facilitation - We have established "provider of last resort" through Bon Accord Care. There is no change to our values with respect to market facilitation, nor in our ambition to work in partnership with our providers within the context of our strategic ambitions. Appreciation of our available market, understanding our future needs and developing a market to provide for those needs will underpin our strategic commissioning plan for the future. Plans are in place to meet regularly, in partnership with providers on a 6-8 weekly basis in order to further develop our relationship and mutual respect and work jointly to address some of the key issues which we face – we see this as key to market facilitation. The first meeting will take place on the 26th March, Key principles will underpin this relationship – outcomes focussed, person led care, incorporating technology as usual business, financially achievable and sustainable, collaborative working. We will explore the feasibility of creating a training passport within the City with Leaders of Health and Care professions and regulatory bodies on the 4th April. We regard this as a key contributing factor to market stability in the future,

3.16. Strategic commissioning – The revision of the strategic plan affords us with the opportunity to consider our approach to strategic commissioning, We will use our knowledge of the needs of our local population, our knowledge of the evidence base and best practice example triangulated with involvement of our communities and staff to determine how best to meet people's needs and

fulfil the aims of the strategic plan. Fundamental to this process is our developing relationship with our providers, We foresee a shift away from a traditional procurement based relationship to one which reflects a partnership approach, working with partners and the public to co produce outcome focussed services for the future. We recognise that this method may require longer negotiation and consequently a requirement for extension to current contracts. Assuming that time well spent in designing the service will allow us to enter in to longer term contracts with more confidence of the outcome which allows both parties the opportunity to plan for the longer term. Our expectation is that innovation is central to provision. We will revise our strategic commissioning plan and this will reflect our priorities over the next three years.

4. Implications for IJB

4.1. **Equalities -** There are no equalities implications arising from the recommendations of this report.

4.2. **Financial -** There are no financial implications arising from the recommendations of this report.

4.3. **Workforce -** There are no implications for our workforce arising from the recommendations of this report.

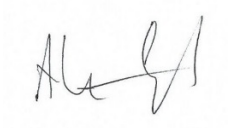
4.4. **Legal -** There are no direct legal implications arising from the recommendations of this report.

5. Management of Risk

5.1. Identified risks(s)

This report provides an update against the recommendations made in the Strategic Commissioning Plan. There are no identified risks within this update.

INTEGRATION JOINT BOARD

Approvals	
	Sandra Ross (Chief Officer)
	Alex Stephen (Chief Finance Officer)

INTEGRATION JOINT BOARD

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Aberdeen City Health & Social Care Partnership
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INTEGRATION JOINT BOARD

Date of Meeting	26th March 2019
Report Title	Free Personal Care for under 65s (Frank's Law)
Report Number	HSCP.18.149
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. Free Personal Care Guidance B. Action Plan

1. Purpose of the Report

1.1. The purpose of this report is to provide an update on ACHSCP's preparations for the introduction of Free Personal Care for under 65s (also known as Frank's Law) on 1st April 2019.

2. Recommendations

2.1. It is recommended that the IJB:

a) Notes the introduction of Free Personal Care for under 65s on 1st April 2019 and the preparations ACHSCP have made for this.

b) Endorses the Action Plan developed.

INTEGRATION JOINT BOARD

3. Summary of Key Information

3.1. Free Personal Care for those aged 65 or over was introduced in Scotland in 2002, following the passing of the Community Care and Health (Scotland) Act 2002 ("the 2002 Act"). The Free Personal and Nursing Care payment rates for people who are self-funders residing in care homes have been uprated periodically in line with inflation.

3.2. A feasibility study into extending free personal care to people under the age of 65 was conducted and the findings were published in September 2017. The study showed that extending free personal care was an option which could have important benefits for many of those who are currently charged for this support. The benefits included increased uptake of services and fairness in terms of charging arrangements. Many individuals under 65 who have, in the past, been assessed as requiring personal care, have declined to receive it due to the cost. The care has been provided by family, increasing the pressure on them as unpaid and informal carers. Extending free personal care would mean that everyone who required this support would have access to it equally, regardless of age, condition or means.

3.3. As a result of the study, the existing arrangements for free personal care are being extended to those under 65 as of 1st April 2019. This extension has become known as Frank's Law, after Frank Kopel, a footballer who was diagnosed with, and later died from, early onset dementia and whose family campaigned for a change in the arrangements. It extends free personal care to those aged under 65 who are assessed as needing this service, regardless of age, condition or means.

3.4. A significant number of adults under the age of 65 already receive their personal care free of charge because the level of their income and assets takes them out of the charging threshold as per the charging policy. The new arrangements, however, ensure that we are required to provide free personal care to all eligible adults by 1 April 2019.

3.5. The Scottish Government established an Implementation Advisory Group who prepared guidance on the extension of free personal care to under 65s and also established a Finance Sub Group who were tasked with estimating the costs. The financial estimates were based on the approach taken for predicting demand when free personal care was introduced for the over 65s.

3.6. Guidance was produced in December 2018 and this is attached at Appendix A. Additional funding was built into the local government settlements for

2019/10. It is estimated that ACHSCP should have approximately £1.3 million available to implement Frank's Law.

3.7. Following receipt of the guidance and indication of funding available, a small working group was set up to ensure ACHSCP was prepared for the introduction of Frank's Law. Appendix B details the main issues for the IJB and the Action Plan that was devised in response, which also contains the progress made to date. The group has met a number of times and is in the final stages of implementation. Although some of the changes cannot be implemented until 1st April, preparations are well in hand for the changeover and the working group will continue to monitor progress up to and beyond 1st April .

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 positive implications in relation to the Fairer Scotland duty.

4.3. Financial – additional finance has been provided for the extension of free personal care to the under 65s and initial estimates indicate that this will be sufficient in the short term.

4.4. Workforce – all staff will need to be informed of the introduction of the new arrangements and key staff will require specific training. This is all in hand as per the Action Plan.

4.5. Legal – the report details our preparations for the implementation of the new arrangements in relation to free personal care.

4.6. Other – none.

5. Links to ACHSCP Strategic Plan

5.1. By extending free personal care to under 65s we are ensuring we are providing the right care at the right time and also removing the inequality of those under 65 having to pay for this. This is in line with the aims in our Strategic Plan.

INTEGRATION JOINT BOARD

6. Management of Risk

6.1. Identified risks(s)

There is a risk of legal challenge if we do not make the necessary arrangements for the introduction of free personal care to under 65s and inadvertently charge for this care when we are not entitled to.

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 making sufficient preparations for the introduction of the extension to free personal care we are ensuring that we are meeting the outcomes set by Scottish Government.

Approvals	
	Sandra Ross (Chief Officer)
	Alex Stephen (Chief Finance Officer)

Free Personal Care (FPC) for Under 65s (Frank's Law) – Implemented from 1st April 2019

Key elements of guidance: -

- From 1st April 2019 charging arrangements for personal care apply equally regardless of age, condition or means.
- It is the supported person's responsibility to approach the Local Authority if they want to seek public sector support for their care costs.
- Eligibility Criteria applies
- For those under 65 already receiving personal care and being charged for it, the Partnership will arrange to cease making these charges - effective from 1st April 2019.
- Young people are entitled to FPC anytime between their 16th and 18th birthday
- For Care at Home, a decision on eligibility for FPC is made irrespective of income, capital assets, marital status or the care contribution currently provided by an unpaid carer.
- For Residential Care, FPC is separate from the living/accommodation costs – the former is paid by ACHSCP, the latter by the individual.
- Current rules in relation to Ordinary Residence still apply i.e. the cost of providing FPC to a supported person who is ordinarily resident in another local authority area can be recovered from that local authority.
- Current rules in relation to Cross Border Placements apply i.e. if an individual is placed by a Scottish Authority personal care is free, if they are placed by an English, Welsh or Northern Irish Authority personal care is chargeable.
- Individual's personal care payment is payable for 2 weeks after hospital admission.
- If an individual is temporarily absent, payments for personal care continue for 14 days.
- Individuals can "top-up" their care if they wish.
- Payments for personal care start from when the service is provided (not the date of assessment).
- Timescales for assessments will be the same as for over 65s currently
- Where a supported person receives funding towards the cost of their care in a care home from a public source, payment of Attendance Allowance, and the care components of Disability Living Allowance and Universal Credit, must cease 4 weeks after the funding starts. It is the responsibility of the person or person's family who has moved to a care home to report receipt of personal care payments to the Department for Work and Pensions as soon as they start to receive FPC.

Action Plan

	Action	Person Responsible	Timescale	Progress Update
1	All policy, procedures and practice notes need to be reviewed and if necessary updated to reflect the new legislation relating to free personal care.	MA/TM	31st March 2019	Policies, procedures and practice notes have been reviewed and other than the Charging Policy there are no specific references to charging for personal care for the under 65s. (See item 12 for Charging Policy action). The existing leaflets are outdated and need to be redesigned anyway. TM will link with KF. JM has been tasked with checking website and Intranet content. TM will discuss with the BAC Information and Training Officers whether any material they have needs to be revised.
2	Link to charging for personal care for under 65s in CareFirst needs to be removed	AW	31st March 2019	A simple process has been identified that will break the link and this will be done on or just before 1st April. NB: The 1st is a Monday so AW will probably do it on the Sunday.
3	Care Plans to be reviewed to ensure no reference to charging for personal care for under 65s is made	TM KP LO	31st March 2019	The current Care Plan template does not refer to FPC. A new outcomes focused template is being introduced across all adult services soon. Individual Care Plans will refer to chargeable personal care where relevant however that reference is accurate as of now. Care Plans will be updated as and when the packages are reviewed.
4	Accurate estimate of current and future demand and cost pressure in each client group needs to be made including early identification of children transitioning to adult services.	AW (report) Service Mangers and AM	4th March 2019 (deadline for IJB Pre-Agenda papers)	Approx. £1.3 million has been allocated to Aberdeen City for the introduction of free personal care to under 65s. A "Care Search" Report can be run to identify how many under 65 packages are currently being delivered. 327 non-residential clients have been identified and one self-funder in residential. The breakdown across client groups is - 158 (LD), 32

	Action	Person Responsible	Timescale	Progress Update
				(MH), 1 (SM) & 137 (PD) The initial estimated "cost" to Aberdeen City to introduce free personal care to under 65s is currently £182,000 which is the difference between the income we currently get and what we would "lose" post April 2019. NB: the data is not 100% accurate (see action 8 below).
5	Communication – general and to staff	AM/GL	31st March 2019	AM to link with GL to ensure comms goes out prior to 1st April. Out with the partnership and ACC, comms can be distributed via Scottish Care, ACVO, Carers Centre, CAH Providers, Care Home Providers, Financial Inclusion Team, CAB, Cash in Your Pocket, Link Workers, Advocacy Services etc. Although it is an individual's responsibility to come forward and request a funded service, we feel we have a moral responsibility to let people know about it.
6	Communication with Commissioned Services including preparation for additional demand and discussion on market capacity to meet this	AM	31st March 2019	CAH Providers have been asking how this will affect them. They are keen to understand anticipated demand and whether any additional training will be required to deal with the younger client group. It is not thought additional training would be required. From 1st April we can monitor demand through the Care Search report and analyse any spike in terms of the age of the client to give us an indication of increased demand which we can share with providers. There needs to be specific communication relevant to CAH providers and Care Homes. This will be distributed via the Contracts Team and Scottish Care.

	Action	Person Responsible	Timescale	Progress Update
7	Revision of contracts with Commissioned Services	JS-C	31st March 2019	MR will liaise with the Contracts Team in relation to current contract wording and identification of any amendments required.
8	Ensure accurate differentiation between care and non-care elements of Housing Support.	KP	31st March 2019	The figures are not accurate as, on Care First, care packages have a notional split of 60% Housing Support, 40% Personal Care. Only the personal care element is free. If this notional split is not accurate there is a risk that we may still be charging for a proportion of the personal care element when it should be free. The only way to get an accurate split is to reassess the packages. Most cases are in LD but there are capacity issues in terms of getting reviews done. We can consider sampling to check how far out the notional split. LO will discuss with KP – need to consider a risk-based approach.
9	Staff Training – specific sessions/comms for existing staff but also core training needs to be revised.	TM	31st March 2019	An information session will be delivered in advance of 1st April for the Duty Team and Response Team in preparation for queries from the public. The Old Age Psychiatry Team at Cornhill will also be involved. TM & LO will deal with this. TM will also revise core training.
10	Consider implications for Finance Team	SC	31st March 2019	There are minimal implications initially. Information for charging is taken from CareFirst so if the update goes through this will be OK. Invoices are sent 3 months in arrears, so the team have time to prepare. The main impact will be capacity to undertake Finance Assessments for re-assessments. AW also met with PH to discuss changing the report they receive that informs invoicing.

	Action	Person Responsible	Timescale	Progress Update
11	Ensure SG Monitoring and Analysis requirements are met	AW		Amendments to CareFirst will ensure this is done.
12	Ensure revised Charging Policy takes cognisance of new legislation	AM	31st March 2019	Complete
13	Prepare report to IJB on implementation	AM	4th March 2019	Added to tracker

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Care, Support and Rights Division

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Circular No. CCD3/2018

COSLA
Health and Social Care Partnership, Chief Officers
Health and Social Care Partnership, Chief Finance Officers
Local Authority Chief Finance Officers
Local Authority, Chief Executives
Local Authority Chief Social Work Offices
Social Work Scotland Self-directed Support Practice Forum
Social Work Scotland Adult Social Care Committee

21 December 2018

Dear Colleagues

Free Personal Care Guidance

Background

The Cabinet Secretary for Health and Sport, Ms Jeane Freeman, and the COSLA Health and Wellbeing Spokesman, Councillor Peter Johnston, wrote a joint letter to you in July 2018 regarding The Community Care (Personal Care and Nursing Care) (Scotland) Amendment (No. 2) Regulations 2018 which come into force on 1 April 2019 and which extends free personal care to those under the age of 65.

The Scottish Government has been working with an Implementation Advisory Group which consists of members from Scottish Government, COSLA, local authorities, Integration Authorities and service providers. The Group has helped to draft statutory guidance to local authorities that outlines the provision of free personal care to those both over and under the age of 65.

Additionally, in his Budget statement on 12 December, the Cabinet Secretary for Finance, Economy and Fair Work announced that the Scottish Government would provide £30 million in 2019-20 to implement our commitment to extend Free Personal Care to Under 65s.

Action

Local Authorities should replace existing Free Personal and Nursing Care in Scotland with the updated Guidance, which is attached.

Free Personal Care

Free Personal Care is available to all adults who are assessed by their local authority as needing this service by **1 April 2019.** Local Authorities will be required to continue to measure the eligibility of those applying for personal care and those who are assessed as needing this service who will receive this service free of charge regardless of their age, condition, socio-economic status or marital status.

Definition of Personal Care

Schedule 1 of the 2002 Act in conjunction with section 20 of Schedule 12 of the Public Service Reform (Scotland) Act 2010 provides the definition of personal care which is shown at Annexes B and C in the guidance.

Funding

There will be two elements of funding for social care in the year 2019/20:

- £120 million will be transferred from the health portfolio to the Local Authorities in-year for investment in integration, including delivery of the Living Wage and uprating free personal care, and school counselling services; and

- £40 million has been included directly in the Local Government settlement to support the continued implementation of the Carers (Scotland) Act 2016 and to extend free personal care for those under the age of 65.

Enquiries

All enquiries relating to this circular should be emailed to adultsocialcare@gov.scot or by telephone on 0131 244 5403.

This circular is also available on the SHOW website at https://www.sehd.scot.nhs.uk/publications/CC2018_03.pdf.

Yours faithfully

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GUIDANCE ON FREE PERSONAL AND NURSING CARE IN SCOTLAND FOR ADULTS

GUIDANCE FOR LOCAL AUTHORITIES, THE NHS BOARDS AND HEALTH AND SOCIAL CARE PARTNERSHIPS (HSCPs) AND OTHER SERVICE PROVIDERS

December 2018
(Electronic version https://www.sehd.scot.nhs.uk/publications/CC2018_03.pdf)

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1. INTRODUCTION

1. This guidance is an update of the Free Personal and Nursing Care in Scotland guidance and details action required for the extension of Free Personal Care to all adults under the age of 65. This replaces the guidance in circular No. CCD5/2003. This policy is to be implemented nationally by 1 April 2019.

Background

2. Free Personal Care for those aged 65 or over was introduced in Scotland in 2002, following the passing of the Community Care and Health (Scotland) Act 2002 ("the 2002 Act"). The policy was reviewed by Lord Sutherland in 2008, and as a result, additional funding was provided to local authorities by the Scottish Government. The Free Personal and Nursing Care payment rates for people who are self-funders residing in care homes have been uprated periodically in line with inflation.

3. The Scottish Government conducted a feasibility study into extending free personal care to people under the age of 65 which was published in September 2017. The study showed that extending free personal care was an option which could have important benefits for many of those who are charged for this support, including increased uptake of services, and would ensure that charging arrangements for personal care apply equally regardless of age, condition or means. In addition, other people who may in the past have declined support due to concerns about the cost would be able to receive that care, if eligible.

4. The First Minister during her Programme for Government announcement on 5 September 2017 declared that the Scottish Government would over the next year begin work to fully implement what had now become known as Frank's Law, by extending free personal care to those aged under 65 who are assessed as needing this service, regardless of age, condition or means. The Programme for Government stated that the Scottish Government would work with the Convention of Scottish Local Authorities (COSLA) and a range of stakeholders to shape the implementation of this policy.

5. Scottish Government officials established an Implementation Advisory Group (IAG) to advise on the delivery of the extended policy.

6. A significant number of adults under the age of 65 already receive their personal care free of charge because of their income and assets in line with local charging policies, however the government's aim was to ensure that local authorities would be required to provide free personal care to all eligible adults by 1 April 2019.

7. This guidance has been prepared by the Scottish Government with input from the IAG which includes representatives from the Scottish Government, COSLA, HSCPs, local authorities, service providers and supported people.

Legislative Framework

8. The Social Work (Scotland) Act 1968 ("the 1968 Act") sets out the legislative framework stating *"It shall be the duty of every local authority to promote social welfare by making available advice, guidance and assistance as may be appropriate for their area."* The 2002 Act provides the legislative backing to provide personal care free of charge. However The Community Care (Personal Care and Nursing Care) (Scotland) Regulations 2002 ("the 2002 Regulations") qualifies this by providing that local authorities only require to not charge for personal care for those persons aged 65 years or over. The Community Care (Personal Care and Nursing Care) (Scotland) Amendment (No. 2) Regulations 2018 revokes regulation 3 of the 2002 Regulations, removing this qualification, thereby extending personal care entitlement to all adults who are assessed by the local authority as needing this service, free of charge.

9. Schedule 1 of the 2002 Act in conjunction with section 20 of Schedule 12 of the Public Service Reform (Scotland) Act 2010 ("the 2010 Act") provides the definition of personal care which is shown at Annex B and C. The Acts and explanatory notes are available through HMSO or on www.scotland-legislation.hmso.gov.uk

10. The Social Care (Self-directed Support) (Scotland) Act 2013 ("the 2013 Act") places a duty on local authorities to adhere to the general principles of the 2013 Act:

    a. A supported person must have as much involvement as they wish, in relation to their assessment of needs for support or services and the provision of support or services.

    b. A supported person must be provided with any assistance that is reasonably required to enable them to express any views they may have about their options for self-directed support and to make an informed choice when choosing an option for self-directed support.

    c. Local authorities must collaborate with a supported person in relation to the assessment of their needs for support or services and the provision of support or services for the supported person.

11. After the local authority has identified the supported person's needs in collaboration with the adult, the local authority must offer four options in relation to any relevant support identified at the assessment stage. The four options provided under the 2013 Act are:

    Option 1 The making of a direct payment by the local authority to the supported person for the provision of support.

    Option 2 The selection of support by the supported person, the making of arrangements for the provision of it by the local authority on behalf of the supported person and, where it is provided by someone other than the local authority, the payment by the local authority of the relevant amount in respect of the cost of that provision.

    Option 3 The selection of support for the supported person by the local authority, the making of arrangements for the provision of it by the authority and, where it is provided by someone other than the authority, the payment by the authority of the relevant amount in respect of the cost of that provision.

Option 4 The selection by the supported person of Option 1, 2 or 3 for each type of support and, where it is provided by someone other than the authority, the payment by the local authority of the relevant amount in respect of the cost of the support.

Key Aspects of the Policy

Transition from Child to Adult Services

12. Currently children are not charged for any social care (either personal or non-personal) up to the point that they transition from children's social work services to adult social work services, which can be at any point between their 16th and 18th birthdays for children not looked after by local authorities, depending on the service provided by the local authority.

13. Young people who have been looked after until their 16th birthday are entitled to support in order to smooth the transition to adulthood, in terms of duties in the Children (Scotland) Act 1995, as extended by the Children and Young People (Scotland) Act 2014. This assists such young people to access appropriate support, including personal care. Specifically, "continuing care" is the right to the same accommodation and assistance that the young person was being provided with immediately before ceasing to be looked after. This applies until age 20 (though this age limit will from April 2019 be raised to age 21) unless the young person chooses to leave the accommodation before then.

14. If a young person is not being provided with "continuing care", then, up to age 19, the young person is entitled to "aftercare" which is advice, guidance and assistance. From age 19 until age 26, some elements of aftercare can be provided by a local authority on a discretionary basis.

15. The extension of Free Personal Care to under 65s will mean that all children and young adults between 16 and 18 years of age will, from 1st April 2019, be eligible to receive their personal care without charge.

Implementation

16. Implementation can be put into 2 broad categories:

    a. **Care at home** - arrangements for adjusting local authority systems to take into account the personal care for those receiving care in their home.

    b. **Care Home Provision** - arrangements for flat rate payments for personal care and/or nursing care for those in receipt of care home services who currently meet their own care costs.

17. The key aspects of the extended policy are:

    For those living in their own home

18. All eligibility for free personal care is subject to an assessment by the local authority. No local authority charge will be made for such personal care services after 1 April 2019. Eligibility for free personal care is made irrespective of income, capital assets, marital status or the care contribution currently provided by an unpaid carer. Non

personal care services will continue to be subject to charges at the discretion of the local authority as set out in the current guidance for non-residential charges as issued by COSLA.

For those living in a care home

19. The provision of payments towards personal care will apply to those who pay their own care costs (self-funders). Arrangements for those already resident in care homes on 1 April 2019 are set out in paragraphs 22 and 23 of Section 2 of this guidance. For those assessed as eligible for personal care payments, these will be paid directly to the care home by the local authority.

20. For those people who are self-funders entering a care home after 1 April 2019, an assessment will be required to be carried out before they become eligible for personal and/or nursing care payments. People who are self-funders will continue to pay the remainder of their own costs, often described as living or accommodation costs.

Attendance Allowance, Disability Living Allowance and Universal Credit (care components) when residing in a care home

21. It is important to clarify that social security benefits legislation provides that where a supported person receives funding towards the cost of their place in a care home from a public source, payment of Attendance Allowance and the care components of Disability Living Allowance and Universal Credit must cease 4 weeks after the funding starts. It is the responsibility of the person or person's family who has moved to a care home to report receipt of personal care payments to the Department for Work and Pensions as soon as they start to receive free personal care. If they fail to do so, and continue to receive payments to which they are no longer entitled, they are likely to be required to repay them.

Action required by local authorities/HSCPs

22. This guidance sets out the key actions required by local authorities/HSCP's to ensure measured, consistent and effective implementation across Scotland. Local authorities will need to work closely with a number of agencies including the voluntary and independent sector as well as the NHS and housing providers so they can provide appropriate information and support to their clients.

2. ELIGIBILITY

Assessment

1. Eligibility for free personal and nursing care will be subject to an assessment arranged by the local authority except where the supported person is already in a care home on 1 April 2019 and has already been assessed by the local authority as requiring personal care. For these supported people, arrangements are set out at paragraphs 22 and 23 below.

2. This section focuses on the assessment arrangements local authorities have in place for assessing the care of supported people. This guidance should also be read in conjunction with the 1968 Act and the 2013 Act. Any reference to an assessment should be understood in the context of the implementation of multi-agency assessment, which aims to ensure the care requirements of the supported person are identified as quickly and effectively as possible and that they are focussed on personal outcomes. Supported people's assessments should be distinct from any financial assessment, which is addressed separately in section 3 of this guidance.

3. The underpinning principle for identifying the supported person's specified care needs is to put in place a personalised support plan. Authorities should therefore foster this approach when responding to referrals and applications for funding. In other words in order to receive a payment for personal care the supported person must have received an assessment in order to ascertain whether the care in place, including personal care, is the most appropriate. As determined by the 2013 Act, the person will be fully involved in this process and supported to make informed choices. Authorities will need to be clear in their local policies and protocols that funding for personal care will only be available for supported people whose needs have been assessed. Local authorities must take carers' views into account so far as it is reasonable and practicable to do so in assessing the needs of the supported person and in deciding whether and how to provide services for the supported person.

Care at Home

4. By 1 April 2019, local authorities will be responsible for making payments, or no longer charging for the personal care element of a support package. Local authorities will already have in place mechanisms for the assessment of need and provision of care services based on that need. The implementation of free personal care should build on these mechanisms.

5. Local authorities will already know the identified support in place for existing supported people over the age of 65 in their areas. There will be systems in place for monitoring and reviewing supported people's care requirements and there is no reason why the implementation of the extension of free personal care policy should require re-assessments for existing supported people over the age of 65, unless a supported person requires or requests a review. However action will be required to determine the personal care element of a supported person's needs under the age of 65, to ensure those who are eligible for free personal care do not pay for this component. Guidance on payment mechanisms is set out in section 5.

6. Local authorities should therefore provide clear guidance for staff relating to what constitutes personal and non-personal care. This guidance should also include timescales for assessments as well as guidance on service provision and service payments.

7. HSCPs, local authorities and NHS Boards will have agreements in place on how personal care services are provided locally and by whom. The implementation of the

extension of free personal care to those under the age of 65 may necessitate a review of existing provisions and strategic plans.

Definition of Personal Care

8. Section 1 and Schedule 1 of the 2002 Act provide that local authorities are not to charge for personal care provided by them.

9. In legal terms, the definition of personal care covers both personal care and personal support (as defined in the 2010 Act). The 2002 Act requires that neither personal care nor personal support shall be charged for. In addition, it specifies that no charge should be made for the specific types of care listed in Schedule 1 to the 2002 Act as shown in **Annex B**.

10. The following guidelines offer further explanation of the components of personal care and should be read in conjunction with the relevant legislative provisions.

Personal Hygiene

11. Assistance with washing as well as bathing and showering is included.

Continence Management

12. Help with the use of continence equipment is included.

Problems of Immobility

13. Only care provided to deal with the effects of immobility which directly meets a supported person's care needs as defined in the 2002 Act is included (ie personal hygiene, continence management, eating, simple treatments and personal assistance tasks).

Food and Diet

14. The 2002 Act provides that charges may not be applied to the preparation of, or the provision of any assistance with the preparation of, a person's food including (without prejudice to that generality) –
    - defrosting, washing, peeling, cutting, chopping, pureeing, mixing or combining, cooking, heating or re-heating, or otherwise preparing food or ingredients;
    - cooking, heating or re-heating pre-prepared fresh or frozen food;
    - portioning or serving food;
    - cutting up, pureeing or otherwise processing food to assist with eating it;
    - advising on food preparation; and
    - assisting in the fulfilment of special dietary needs, but not the supply of food (whether in the form of a pre-prepared meal or ingredients for a meal) to, or the obtaining of food for, the person, or the preparation of food prior to the point of supply to the person.

Simple Medical Treatments

15. The 2002 Act provides that charges may not be applied for assisting with simple medical treatment or medication, for example -.

- applying creams or lotions;
- administering eye drops;
- applying dressings in cases where this can be done without the physical involvement of a registered nurse or of a medical practitioner;
- assisting with the administration of oxygen as part of a course of therapy.

Equipment & Adaptations

16. This policy is related to the provision of social and nursing care not the provision of equipment and adaptations. For the purposes of this policy only memory and safety devices which help supported people to manage their own personal care are included[1] (eg the use of personal reminder systems to allow supported people to manage their medicines or the use of sound/movement alarms linked to light controls to guide people with dementia to the toilet and minimise the risks related to wandering at night). Community alarms and other associated devices are not included in this policy.

Personal Support

17. Personal support, is defined at paragraph 20 of schedule 12 of the 2010 Act as shown at **Annex C** and means counselling, or other help, provided as part of a planned programme of care.

Housing Support Services

18. Housing Support Services help people to manage their home and can include help with issues such as claiming welfare benefits, completing forms, managing a household budget, keeping safe and secure and getting help from other specialist services. This support is non-personal care.

19. In practice housing support is often provided as part of a package of care which may include some services which are personal care. From a local authority perspective, housing support services which focus on helping a supported person to manage their home, should be clearly distinguishable from personal care services. In those situations where a single provider is delivering both housing support and personal care it may be harder to distinguish between personal and non-personal elements. Care should be taken to avoid additional administration which could become burdensome for the local authority or support provider.

20. Some local authorities may already separately record details of personal and non-personal care and may be able to use existing arrangements to manage and adjust charges. All local authorities should ensure that they can differentiate the various elements within a care package in terms of chargeable and non-chargeable items. Local authorities can then calculate the revised charge using their charging regime. It is recognised that this process will vary from authority to authority and local authorities will need to decide how best to undertake this task.

Care Home Care

[1] Guidance on the Provision of Equipment and Adaptations (CCD5/2009)

21. From 1 April 2002, supported people who apply for payment towards their care home provision, are required to have a comprehensive needs assessment carried out, to ascertain how best their care needs may be met, and whether a care home is the most appropriate setting. In some cases the outcome of the assessment may determine that the supported person's needs could be met in their own home. To ensure supported people and their families have complete clarity, local authorities should ensure there are clear protocols and guidance for staff as well as encouraging care home owners and managers to ensure prospective self-funding residents are aware of the parameters for public funding.

Arrangements for those already in a care home

22. Those aged 65 and over who pay their own care home provision (self-funders) may wish to have their support plan assessed by the local authority to potentially access free personal care. From 1 April 2019 those under the age of 65 will be required to be assessed by their local authority in order to potentially access free personal care. Supported people who wish to seek the flat rate payments towards their care costs will have to notify the local authority in which they are resident. The rates for these payments are identified in The Community Care (Personal Care and Nursing Care) (Scotland) Regulations 2002, as amended from time to time.

23. The extension of free personal care will not change the existing charging arrangements for care home provision under the National Assistance Act 1948 and the National Assistance (Assessment of Resources) Regulations 1992 (as amended for Scotland). These are set out in more detail in Section 3.

Local eligibility criteria and priorities

24. Local authorities will need to have in place agreed eligibility criteria for assessments of need and priorities for the provision of and access to services based on need, which adhere to the National Standard Eligibility Criteria and Waiting Times for the Personal and Nursing Care of Older People Guidance from 2009, which now applies to supported adults of any age. Many authorities will have these in place already and there is no requirement on authorities to change these arrangements. Local authorities are expected to ensure that their available resources are used in the most effective way to meet supported people's personal outcomes. Where local authorities have problems providing appropriate support they should have arrangements ready to meet, manage, or review personal care needs.

Supported People currently receiving care at home services via their local authority

25. In preparation for the implementation of the extension of this policy, local authorities will need to inform supported people currently receiving care at home services about the level of personal care and non-personal care they receive. While a reassessment of care may be necessary in some cases, according to individual circumstances, it is envisaged that a review of the person's financial contribution using existing mechanisms may be sufficient. Local authorities will then have to calculate whether there needs to be an adjustment to any charges the supported person is currently paying for their care package. Guidance on charging is set out in Section 3.

Supported People currently arranging their own care home provision

26. Supported people who currently arrange their own services and who wish to access free personal care will only be able to do so following a care assessment arranged by the local authority. Delivery of care must be based on local protocols and when the local authority is in a position to provide for the required services. Access to assessment for supported people should also be prioritised in line with local criteria.

27. In some cases an assessment arranged by the local authority may find the supported person receives services over and above their level of need according to the assessment. (The supported person may have made private arrangements for these services). The local authority will provide a contribution towards the cost of care up to the level of assessed need only and in line with local criteria for range, level and frequency of service provision.

28. Guidance on payment mechanisms for those who are currently arranging their own care and who are subsequently assessed as needing personal care services and wish to continue with the same providers is set out in Section 5.

Monitoring and Reviewing Care Needs

29. Local Authorities will have formal monitoring and review systems and time-scales in place to respond to the changing care needs of supported people. These systems should reflect the Health and Social Care Standards and the Quality Framework for Care Homes for Older People, the latter of which the Care Inspectorate introduced on 30 July 2018. Protocols should be clear to staff who are responsible for responding to individual circumstances where a supported person's care requirements may have suddenly changed due to a crisis in their situation, for example because of the onset of an acute illness, or the death of a main carer.

Training

30. Local authorities and other organisations should ensure that staff training and development is given a high priority on joint training agendas for those staff involved in the assessment and planning process.

Clarity of information

31. Local authorities will need to be clear in their local policies and priorities. As part of their on-going public information strategies, local authorities should make explicit that a contribution towards a supported person's care costs will be set according to the requirements that are identified at the time of the practitioner's assessment and will be in line with local protocols.

32. Local authorities will also need to provide clear information on what constitutes personal care, on criteria for eligibility for services and on the range, level and frequency of service provision.

33. Local authorities should also consider how a supported person who currently privately arranges their care can be provided with information about how to request an assessment which may act as a passport to receiving free personal care.

3. CHARGING AND INCOME MAXIMISATION

This section of the guidance covers all non-residential care and support services where personal care is offered

Care at Home Services

1. Under the provisions of the 2002 Act, and the 2002 Regulations local authorities will no longer be able to charge adults for the personal care element of care at home services.

2. Other, non-personal care such as personal alarms, remains chargeable and local authorities will need to provide clear information to supported people and their carers on their charges for care at home services.

3. Although the 2002 Act provides powers for the Scottish Government to regulate charging for non-residential care services, the Scottish Government has not exercised this power. This enables local authorities to set charges taking into account local circumstances, and supporting local accountability. COSLA's National Strategy & Guidance, Charges Applying to Non-residential Social Care Services, is published on its website at www.cosla.gov.uk.

Financial Assessment for those receiving Care at Home

4. Prior to the implementation of the extension of free personal care, local authorities will put in place a process which identifies personal and non-personal care.

5. Local authorities must ensure they do not take for granted the care contribution currently being made by an unpaid carer, and that any reassessment takes account of the amount of care an unpaid carer is willing and able to provide.[2]

6. Once the level of non-personal care has been identified, local authorities should calculate the revised charge by applying this to their charging regime. It is recognised that the scale of this process will vary between local authorities and decisions may need to be taken by each local authority on how best to undertake this task. However, it must be stressed that all charges for personal care will cease from 1 April 2019.

Providing Information on Charging Policies

7. All local authorities must provide clear information on their charging policies. This will help supported people, their carers and their families understand how their charges are calculated and how the local authority will collect the charges.

8. Information on their policies for waiving and abating charges, how to apply for these and the method used to consider such requests and review the decisions of the local authority should also be included in the material. Information on the local authority complaints process should also be provided and details of how to contact the Scottish Public Services Ombudsman (SPSO) if unsatisfied with a decision made by the local authority.

Income Maximisation

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

9. Local authorities are recommended to continue to operate income maximisation services and to continue investing in staffing resources, publicity material, IT systems and training.

This section of the guidance covers care home services where personal care is offered.

Financial Assessment for those in Care Homes

10. The existing care home charging and financial assessment arrangements under the National Assistance Act 1948 and the National Assistance (Assessment of Resources) Regulations 1992 (as amended for Scotland) will remain in place with the exception of free personal and nursing care. Guidance on charges for those residing in Care Homes can be found at Charging for Residential Accommodation Guidance.

11. The local authority contribution to the supported person's total care home costs will continue to take account of the provisions of the 2002 Act and the regulations made under that Act. In practice there will be 3 main cases as follows:

    a) *People who currently receive care funded by the local authority and contribute only their state pension and benefit income;*

    b) *People who currently receive care supported by the local authority but who contribute a greater amount, from sources in excess and out with their income which may include their state pension, tariff income, income from capital between the lower and upper capital limits or other income such as occupational pension;*

    c) *People who currently fund their care home fees in full because they have capital over the upper capital limit.*

12. Where following the financial assessment, the local authority contribution to the total care home costs of people **without** nursing care is less than the sum specified in the 2002 Regulations, as amended from time to time , it will need to be increased to the amount provided for in the regulations.

13. Similarly, where the local authority contribution to the total care home costs of those needing personal **and** nursing care is less than the sum specified in the 2002 Regulations, it will need to be increased to the sum specified in the 2002 Regulations.

14. Those who fund their care home fees in full may receive free personal and nursing care payments however they will need to request an assessment to be carried out. If the assessment finds the person eligible for personal care and/or nursing care, this will be provided directly to the care home.

4. CONTRACTS

1. This Guidance cannot cover all the potential issues that may arise around contractual arrangements or provide information on the ongoing work around contracts. In practice, there will be a number of contractual matters that will require clarity. As a general rule, these issues should be resolved locally.

Care at Home

2. The 2013 Act puts a duty on the local authority to provide 4 options to all adults eligible for support or provided with services at home.

3. The options are intended to provide a framework in which a local authority can meet its social welfare and wellbeing duties relating to adults in a flexible and creative way.

4. The 2013 Act provides 4 options for contractual arrangements for supported people, local authorities and provider agencies in relation to payments for personal care at home. Supported people must be able to choose which option they wish to take. This will require flexibility in approach from local authorities and voluntary and independent care providers.

5. These options should also be open to the supported person for their personal care requirements. For more detail on these options please refer to the Statutory guidance which accompanies the 2013 Act.

Care Homes

6. The extension of free personal and nursing care to adults under age 65 will require local authorities to put in place contractual arrangements for those who under current financial assessment arrangements would not qualify for public sector support towards their care home services. Supported people under the age of 65 would not have previously been included in the existing arrangements between local authorities and the voluntary and independent care sectors. People who are self-funders may also decide at any time to apply to local authorities for an assessment of eligibility for free personal care.

7. Current contractual arrangements between local authorities and provider agencies are complex and varied, particularly those providing care home services. For further information relating to contracts please refer to Competition and Marketing Authority's (CMA) Guidance on unfair contract terms at Unfair contract terms: CMA37. Other information on the CMA's consumer protection powers can be found in Consumer protection enforcement guidance: CMA58.

8. The CMA carried out a market study into care homes for the elderly, to review how well the market works and if people are treated fairly. The CMA has published consumer law advice for care home providers which has been produced with the involvement of the care sector, COSLA and the Scottish Government to help care homes to meet their obligations under consumer law.

Routes for contractual arrangements

9. Supported people must be able to choose how their care home services are arranged, whether by arranging directly themselves, or with the assistance of their local authority. This will require flexibility in approach from local authorities and voluntary and independent care providers. Please refer to the current Guidance on Charging for Residential Accommodation issued by the Scottish Government as an annual circular.

Information for supported people

10. Section 9 of the Social Care (Self-directed Support) (Scotland) Act 2013 provides that, where a local authority has given a supported person an opportunity to choose one of the options for self-directed support it must give the supported person an explanation of the different options along with information about how to manage support. In addition, the local authority must provide information about organisations who can help the supported person understand what care and support is available, help them make decisions about the options and provide information on how to manage support. Such organisations include those providing voluntary sector independent support.

11. Local independent support organisations can be found through the "Get help" button on Self Directed Support Scotland's website: https://www.sdsscotland.org.uk/. Scottish Government has funded 30 independent support services until 2021, and others are funded by local authorities or run on a voluntary basis by supported people.

12. Many voluntary sector organisations for disabled people and older people can also offer advice through websites or phone lines. The following websites provide this information and further signposts:

    - Care Information Scotland
    - Age Scotland
    - Alzheimer Scotland
    - Scottish Government

5. PAYMENT MECHANISMS

1. All local authorities have in place payment mechanisms for both care at home and care home care and these should be indicative of self-directed support payment mechanisms, which can be found in the 2013 Act guidance.

2. Each payment mechanism will involve a range of systems including:

    - a contract or agreement with the supported person, or private and voluntary sector agency about the use of money;
    - billing systems/invoices; and
    - payment of the money into relevant bank accounts, either personal or agency.

Ordinary Residence

3. Where a supported person has been assessed as needing personal and/or nursing care by a local authority under section 12A of the 1968 Act, and the care is provided under this Act, the supported person cannot be charged for the care covered by section 1 of the 2002 Act.

4. The costs of providing free personal and nursing care services to a supported person who is ordinarily resident in another local authority area can be recovered from that other local authority.

Cross-border placements

5. Scottish local authorities will occasionally make arrangements for supported people who are ordinarily resident in their area to be placed in care homes in England, Wales or Northern Ireland. In such circumstances the supported person will be eligible for personal and nursing care payments from the Scottish placing local authority. Placements in Scotland of people ordinarily resident in local authority areas in England, Wales and Northern Ireland will not be eligible for personal and nursing care payments. Funding responsibility for such placements rests with the English, Welsh or Northern Ireland placing local authority. It is important to note that there are established UK wide principles determining "ordinary residence" and these continue to apply in respect of funding responsibility for personal and nursing care payments. Further information on this is provided in the published guidance CCD3/2015.

Hospital admission

6. When a supported person is admitted to hospital from a care home, the local authority will continue to make personal and nursing care payments at full rate for 2 weeks after admission. When a supported person is admitted to hospital from their own home and is receiving direct payments for their personal care, the local authority will continue to make payments for personal care for 2 weeks after admission.

Supported people who have privately contracted to pay for more service than they have been assessed as needing

7. Staff in local authorities, particularly those involved in care and finance assessments, should understand clearly that payments for nursing care and/or personal care can only

be made on the basis of the assessment which sets out the services that the supported person needs.

8. If the supported person has already agreed or in future agrees to a more comprehensive or a greater package of care than the assessor decides is required, either in their own home or in a care home, the supported person can pay for that service from their own resources, in a separate financial arrangement with the independent sector provider. This applies both to care home and care at home arrangements.

9. Supported people living in their own homes in the community are not eligible for nursing care payments**.**

Start date of payments and retrospective payments

10. Payments will commence once the personal and/or nursing care service is being provided or when the supported person moves into a care home and is provided with personal and/or nursing care. It does not start before and will not be backdated for example, to the date of referral or assessment.

11. People who fully fund their own personal care services will be required to contact their local authority to arrange an assessment to confirm whether they are eligible for free personal care, if they wish to receive the benefit of free personal care.

Free home care for up to 4 weeks after discharge from hospital

12. Under existing arrangements, supported people are entitled to up to 4 weeks free home care (covering personal and non-personal care) after discharge from hospital. The extension of free personal and/or nursing care will make no difference to these arrangements.

Opting in/out of the payment system for personal care and/or nursing care

13. It is the supported person's responsibility to approach the local authority if they want to seek public sector support for their care costs. If a supported person is resident in a care home and is in receipt of Attendance Allowance or receives the care components of Disability Living Allowance, Universal Credit or Personal Independence Payment, they must notify the Department for Work and Pensions accordingly so these can be stopped in accordance with the rules.

14. It is the responsibility of the local authority to make payments to provider agencies and supported people. Service providers can notify the local authority on behalf of existing people who are self-funders provided the person agrees. With new applications for payments, it is the responsibility of the supported person or someone acting on their behalf and with their consent to ask for an assessment. This can be a carer, advocate or provider.

Payments for short-term nursing care and personal care

15. There may be occasions where a supported person needs to have personal and/or nursing care on a short-term basis:

    • for respite care;

- in an emergency or crisis, for instance if a carer or relative is suddenly taken ill and is unable to look after the supported person; and
- for a trial period - to explore whether they would prefer to move into a care home on a permanent basis.

16. For these short-term requirements, local authorities should satisfy themselves that the supported person's care is being properly met. Payments for personal and/or nursing care should be paid on the basis of the records kept either by the local authority or the care home which should indicate the level of need. A guiding principle here should be that the supported person should not be treated any less generously under these arrangements than they would otherwise have been.

Temporary absence from free personal and/or nursing care

17. There may be occasions when a supported person requires to be hospitalised or is placed in another form of care and therefore receives care financed from other public funds.

18. On these occasions the care provider has a duty, as soon as reasonably practicable (but in any event no later than the next working day) inform the local authority.

19. The local authority will continue to pay the contract of care for a period of 14 days from the commencement of the supported person's absence, with day 1 being counted as the day the supported person is moved to another form of care.

6. Monitoring and Analysis

1. Monitoring and analysis of the extension of free personal care will be carried out by the Scottish Government. Monitoring of the extended policy of free personal care to adults will commence from 1 April 2019. Arrangements by local authorities will require to be put into place to carry out this monitoring and analysis. The monitoring and analysis will not cover issues such as contract compliance as this should continue to be undertaken according to locally agreed practice.

2. This monitoring and analysis will help to identify the impact of the extension of free personal care, which will inform future budgets and development of the policy.

Community Care and Health (Scotland) Act 2002

[ANNOTATED EXTRACT]

Part 1 Community Care

1 Regulations as respects charging and not charging for social care

(1) Subject to subsection (2)(a) below, a local authority are not to charge for social care provided by them (or the provision of which is secured by them) if that social care is—

(a) personal care as defined in schedule 12 paragraph 20 of the Public Services Reform (Scotland) Act 2010 *["personal care" means care which relates to the day to day physical tasks and needs of the person cared for (as for example, but without prejudice to that generality, to eating and washing) and to mental processes related to those tasks and needs (as for example, but without prejudice to that generality, to remembering to eat and wash)]*;

(b) personal support as also defined in Schedule 12 paragraph 20 of the 2010 Act *["personal support" means counselling, or other help, provided as part of a planned programme of care]*;

(c) whether or not such personal care or personal support, care of a kind for the time being mentioned in schedule 1 to this Act; or

(d) whether or not from a registered nurse, nursing care.

2 Accommodation provided under 1968 Act etc.

For the purposes of the definition of "social care" in section 22(1) and (2) of the 2002 Act, of sections 22 (charges to be made for accommodation), 26 (provision of accommodation in premises maintained by voluntary organisations) and 65 (general provisions as to application to Scotland) of the 1948 Act and of sections 86 and 87(2) and (3) (charges that may be made for accommodation) of the 1968 Act, the Scottish Ministers may by regulations determine what is and what is not to be regarded as accommodation provided under the 1968 Act or under section 25 of the 2003 Act (provision of care and support services etc for persons who are or have been suffering from mental disorder).

Part 4 General

22. Interpretation

(1) In this Act

(A) "the 1948 Act" means the National Assistance Act 1948 (c.29); "the 1968 Act" means the Social Work (Scotland) Act 1968 (c.49); "the 2003 Act" means the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13); and

(B) "social care" means, subject to subsection (2) below, a service provided (a) under the 1968 Act; or

(b) under section 25 (care and support services for persons who have or have had a mental disorder) or 26 (services designed to promote well-being and social development of such persons) or 27 (assistance with travel in connection with such services) of the 2003 Act.

to an individual by a local authority or a service the provision of which to an individual, under the 1968 Act or any of those sections, is secured by a local authority.

(2) In this Act, “social care” does not include a service which (or so much of a service as) consists of the provision of accommodation; but in the definition of the expression in subsection (1) above, the references to a service being provided are to the provision of any other form of assistance (including, without prejudice to that generality, the provision of advice, guidance or a material thing).

THE COMMUNITY CARE AND HEALTH (SCOTLAND) ACT 2002

Schedule 1

Social Care Not Ordinarily Charged For

[Whether or not personal care (see section 1(1)(a) or personal support (see 1(1)(b)]

1 As regards the personal hygiene of the person cared for -
(a) shaving;
(b) cleaning teeth (whether or not they are artificial) by means of a brush or dental floss and (in the case of artificial teeth) by means of soaking;
(c) providing assistance in rinsing the mouth;
(d) keeping finger nails and toe nails trimmed;
(e) assisting the person with going to the toilet or with using a bedpan or other receptacle;
(f) where the person is fitted with a catheter or stoma, providing such assistance as is requisite to ensure cleanliness and that the skin is kept in a favourable hygienic condition;
(g) where the person is incontinent -
(i) the consequential making of the person's bed and consequential and changing and laundering of the person's bedding and clothing; and
(ii) caring for the person's skin to ensure that it is not adversely affected.

2 As regards eating requirements, the preparation of, or the provision of any assistance with the preparation of, the person's food including (without prejudice to that generality) -
(a) defrosting, washing, peeling, cutting, chopping, pureeing, mixing or combining, cooking, heating or re-heating, or otherwise preparing food or ingredients;
(b) cooking, heating or re-heating pre-prepared fresh or frozen food;
(c) portioning or serving food;
(d) cutting up, pureeing or otherwise processing food to assist with eating it;
(e) advising on food preparation; and
(f) assisting in the fulfilment of special dietary needs.

But not the supply of food (whether in the form of a pre-prepared meal or ingredients for a meal) to, or the obtaining of food for, the person, or the preparation of food prior to the point of supply to the person.

3 If the person is immobile or substantially immobile, dealing with the problems of that immobility.

4 If the person requires medical treatment, assisting with medication, as for example by
(a) applying creams or lotions;
(b) administering eye drops;
(c) applying dressings in cases where this can be done without the physical involvement of a registered nurse or of a medical practitioner;
(d) assisting with the administration of oxygen as part of a course of therapy.

5 With regard to the person's general well-being -
(a) assisting with getting dressed;

(b) assisting with surgical appliances, prosthesis and mechanical and manual equipment;
(c) assisting with getting up and with going to bed;
(d) the provision of devices to help memory and of safety devices;
(e) behaviour management and psychological support.

[Counselling, or other help, provided as part of a planned programme of care is explicitly included within the definition of personal support (see 1(1)(b)]

THE PUBLIC SERVICES REFORM (SCOTLAND) ACT 2010

Schedule 12, Section 20

Care Services: Definitions

In this schedule, unless the context otherwise requires –

"someone who cares for" (or "a person who cares for") a person, means someone who, being an individual, provides on a regular basis a substantial amount of care for that person, not having contracted to do so and not doing so for payment or in the course of providing a care service;

"vulnerability or need", in relation to a person, means vulnerability or need arising by reason of that person –

(a) being affected by infirmity or ageing;
(b) being, or having been, affected by disability, illness or mental disorder;
(c) being, or having been, dependent on alcohol or drugs; or
(d) being of a young age;

"personal care" means care which relates to the day to day physical tasks and needs of the person cared for (as for example, but without prejudice to that generality, to eating and washing) and to mental processes related to those tasks and needs (as for example, but without prejudice to that generality, to remembering to eat and wash); and

"personal support" means counselling, or other help, provided as part of a planned programme of care.

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Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Date of Meeting	26.03.2019
Report Title	Granite City Good Food Update (formerly Sustainable Food City Partnership Aberdeen)
Report Number	HSCP.18.011
Lead Officer	Sandra Ross, Chief Officer
Report Author Details	Name: Jenny Gordon Job Title: Public Health Dietician Email Address: jenny.gordon1@nhs.net
Consultation Checklist Completed	Yes
Directions Required	No
Appendices	*a.* GCGF Sustainable Food Charter *b.* GCGF Annual Report 17/18 *c.* 'A Healthier Future' Consultation Reponses (IJB Jan 18)

1. Purpose of the Report

The purpose of the report is to:

a) Ask the Chair of the Integration Joint Board to sign of the Granite City Good Food (GCGF) charter on behalf of the Aberdeen City Health and Social Care Partnership (ACHSCP)

b) Support the principles and promote the GCGF to staff and partners by encouraging involvement in the 6 priority areas.

2. Recommendations

2.1. It is recommended that the Integration Joint Board (IJB):

1. Note the update report on the 'Granite City Good Food (GCGF)

2. Support the principles of the GCGF and its Charter though the Aberdeen City Health and Social Care Partnership (ACHSCP) action plan (in development)

3. Instruct the Chair of the Integration Joint Board to sign of the (GCGF) charter on behalf of the Aberdeen City Health and Social Care Partnership (ACHSCP)

4. Request that an annual update on ACHSCP GCGF is presented to the IJB.

5. Request that the Grampian consultation strategies for Tobacco and Diet, Activity and Healthy Weight are presented to the Board

3. Summary of Key Information

3.1. Good food is vital to the quality of people's life and every person in Aberdeen should have the opportunity to access healthy, tasty and affordable food. Too much or too little food or general poor nutrition is well documented to severely affect health and wellbeing (1). The most vulnerable or deprived in Aberdeen city are most at risk. Food Poverty Action Aberdeen is a partnership of 61 public, private, faith and community groups/organisations which continues to report a growing number of individuals and families accessing food banks across the city. The level of overweight and obesity is also one of the biggest public health challenges, with 65% (2/3) of adults in Scotland and 61% in Aberdeen now being overweight(2). Much of that harm is from over eating high energy dense food and drinks and generally poor diets

The Sustainable Food Cities (SFC) model

3.2. The Sustainable Food Cities (SFC) model has been developed and led nationally by the Soil Association, Sustain and Food Matters. The SFC aims to transform food culture by:

- Establishing a cross sector food partnership
- Developing and delivering a food strategy and action plan
- Embedding healthy and sustainable food policy

3.3. The GCGF (formerly Sustainable Food City Partnership Aberdeen) held its inaugural meeting in March 2017 and is utilising the recognised national

SFC model. GCGF was announced as the 48th member of SFC network and the 3rd in Scotland.

3.4. Since June 2017 a dedicated GCGF Co-ordinator has been funded from several sources including; Esmée Fairbairn Foundation, NHS Grampian (Public Health Directorate) and Aberdeen City Council's 'Common Good Fund' and ACHSCP 'Food in Focus' funding.

3.5. The focus of the GCGF movement is to reduce food poverty and support local sustainable food.

3.6. The Sustainable Food Cities Partnership Aberdeen (SFCPA) is the steering group that leads the GCGF movement. The group is chaired by Councillor Lesley Dunbar and members are: Aberdeen City Council, CFINE, NHS Grampian (Public Health Directorate), The Allotment Market Stall, Tillydrone Community Project, Enscape Ltd, Robert Gordon University and ACHSCP (Public Health and Well Being Team). The SFCPA reports to the 'Sustainable City outcome improvement group within Community Planning Aberdeen (CPA).

The SFC Six Key Priority Areas

3.7. The SFC model suggests six key theme areas, and these will be used to focus work across Aberdeen. The SFCPA steering group leads on positive food change by:

- implementing strategy and policy commitment
- sourcing funding and resource allocation
- co-ordinating existing food projects and services by bringing together key stakeholders and encouraging a coordinated strategic partnership approach.

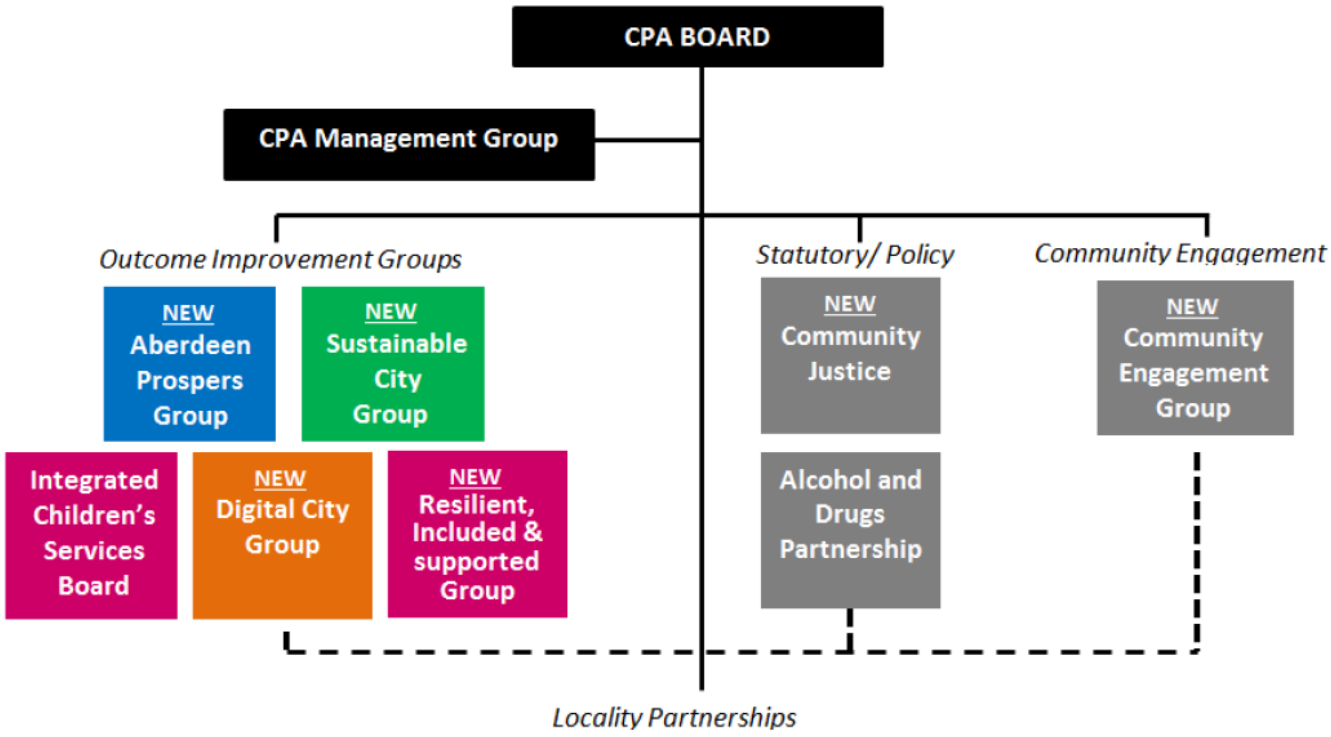
3.8. One of the anticipated benefits is that information will be shared among these 6 key theme areas largely by the GCGF co-ordinator attending relevant meetings and updating activity on the action plan. This sharing of knowledge and information will promote partnership working at different levels and help us to deliver better outcomes for the people of Aberdeen.

INTEGRATION JOINT BOARD

3.9. Appendix B contains the GCGF 2017/18 Annual Report which shows examples of partners work supporting the 6 key priority areas, reflecting a range of volunteering opportunities.

GCGF Governance

3.10. The GCGF will report to the 'Sustainable City outcome improvement group in Aberdeen's community planning structure (as below) with crossover into other groups.



GCGF IN ACHSCP

In response to the feedback from the Executive Team (September 2018) regarding progressing GCGF in ACHSCP, the following is being implemented to drive the GCGF movement with ACHSCP and its partners:

- ACHSCP GCGF steering group has been formed (Dec 2018)
- ACHSCP GCGF action plan being developed (March 2019) including communication plan

INTEGRATION JOINT BOARD

Scottish Government: 'A Healthier Future'

After a consultation process in 2017/2018 where the IJB agreed a proposed response to "A Healthier Future – Scotland's Diet and Health Weight Delivery Plan" (Appendix B) the final strategy was published in July 2018. By advocating positive change to food culture in Scotland, their vision is to "create a Scotland where everyone eats well, and has a healthy weight". The delivery of this strategy focuses on 5 key outcomes:

- Outcome 1: Children have the best start in life – they eat well and have a healthy diet
- Outcome 2: The food environment supports healthier choices
- Outcome 3: People have access to effective weight management services
- Outcome 4: Leaders across all sectors promote healthy diet and weight
- Outcome 5: Diet-related health inequalities are reduced

In response to the national strategy, NHS Grampian Corporate public health system convened and led a Healthier Futures Strategy Group to develop a local strategy. The draft local strategy 'A healthier future and more active future for the North East of Scotland' contains 17 local recommendations for action. This will be released for wider consultation in combination with the NHSG Tobacco Strategy in April 2019 and provides the IJB with an opportunity to comment on both strategies via a short Snap survey.

3.11. In summary, supporting people to make changes to their diet and weight will require a range of innovative ideas/solutions to truly make the transformational change to our existing food culture. Both the national and local healthy diet and weight strategies and the GCGF have commons aims in addressing positive change to food culture. Supporting the GCGF and signing the GCGF Food Charter is one initiative that will help establish the partnership working required to promote healthier foods and diets to the people of Aberdeen.

4. Implications for IJB

4.1. Equalities

INTEGRATION JOINT BOARD

The proposals outlined in this report are expected to have a positive impact on individuals who share characteristics protected by The Equality Act 2010. For example community growing opportunities are commonly intergenerational - multicultural and inclusive of people with physical and learning disabilities and can be used to promote equalities opportunities, social inclusion and community cohesion.

4.2. Fairer Scotland Duty

Granite City Good Food seeks to reduce the inequalities of outcome which result from socio-economic disadvantage. The numbers of people who are overweight, obese and/or with poorer nutrition are greater in areas of multiple deprivations. This results in health inequalities, for women and children in particular.

The proposals of the GCGF movement aim to reduce these health inequalities, as related to socio-economic disadvantage.

4.3. Financial

There are no direct financial implications arising from the recommendations of this report.' In the future our annual reporting to the IJB will identify any costs for work we wish to undertake should these not be able to be contained within mainstream budgets or be of a level that requires Board approval.

4.4. Workforce

Our workforce needs to be fit for purpose and understand their contribution to addressing the issue of people being overweight and obese, which includes promoting staff health and wellbeing as an organisation.

4.5. Legal

Implications relating to the Fairer Scotland Duty are outlined above. There are no further legal risks identified.

4.6. Other

No other implications have been identified.

5. Links to ACHSCP Strategic Plan

The principles of the GCGF link closely with several of the priorities as identified in the ACHSCP, including:

- "*Support and improve the health, wellbeing and quality of life of our local population"*
- *"Promote and support self-management and independence for individuals for as long as reasonably possible"*
- *"Contribute to a reduction in health inequalities and the inequalities in the wider social conditions that affect our health and wellbeing".*

6. Management of Risk

6.1. Identified risks(s)

There are several specific risks relating to not endorsing the content of this report:

- Continued rise in chronic conditions arising from obesity and type 2 diabetes are linked to poor diets, and impact on primary and community health care services
- Environmental effects of sustained use of processed foods i.e. packaging, food miles/transport and food waste
- Not engaging with the GCGF would be a missed opportunity to adopt a partnership approach in supporting the wider food agenda in Aberdeen and supporting the Scottish Government's Healthier Futures Strategy

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

Strategic Risk Register: There is a risk of financial failure, that demand outstrips budget and the IJB cannot deliver on priorities, statutory work, and projects an overspend.

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

The proposals outlined in this report help to mitigate the risk of demand outstripping budget, as they have a preventative focus on aiming to reduce the health consequences of poor diets and improving access to affordable, healthy

foods. The CGGF with its wide range of partners could provide a range of innovative projects and work that could support and address significant and complex health issues like obesity.

Approvals	
	Sally Shaw (Interim Chief Officer)
	Alex Stephen (Chief Finance Officer)

References

1. Scottish Government (2018). *A Healthier Future –Scotland's Diet & Healthy Weight Delivery Plan*. from: http://www.gov.scot/Publications/2018/

2. Scottish Government (2017). The Scottish Health Survey. (online) Available from: http:/www.gov.scot/resources/0052/00525472.pdf

3. Aberdeen City Health and Social Care Partnership 2016. ACHSCP Strategic plan 2016-2019. Available from: www.aberdeencityhscp.scot

Sustainable Food City Partnership Aberdeen

Food Charter

Nourishing an interest in healthy and sustainable food

Our Mission:

The Sustainable Food City Partnership Aberdeen believe that every person in Aberdeen should have access to healthy, tasty, affordable food and that this food should also be good for the environment and our local economy.

Our Charter:

Good food is vital to the quality of people's lives and plays an essential role in improving individual and population health and well-being. We can achieve our sustainable food mission by working together and committing to the SFCPA's six Charter goals.

1 Promote healthy and sustainable food to the public.

- Communicate the importance of healthy and sustainable food to every audience using clear, consistent messages.
- Celebrate culinary and cultural diversity while promoting a positive and inclusive food culture by engaging the public with healthy, sustainable, ethical and local food.

2 Tackle food poverty and diet-related ill health.

- Support new, and expand existing, services and support to tackle poverty, build resilience, promote inclusion, improve health and well-being and employability in communities.
- Support food businesses to reduce the fat, sugar and salt content of food and increase the availability and accessibility of healthier options.

3 Build community food knowledge, skills and resources.

- Increase accessibility and provide more opportunities to grow, cook and eat good food.
- Promote a positive food culture and food education across our community settings and create a space for information and resources to be shared

4 Promote a diverse and vibrant food economy.

- Celebrate, promote, and support local food producers and land resources to keep value within our local economy and to raise employer awareness of the importance of the National Living Wage.
- Engage consumers and food suppliers at local and regional levels to shorten the sustainable food supply chain.

5 Transform catering and food procurement.

- Inspire and enable all food settings to source and supply healthy, seasonal, locally and ethically produced food.
- Support and enable small scale local producers and other sustainable food businesses to access large scale procurement markets via cooperative marketing and supply initiatives.

6 Reduce waste and the ecological footprint of the food system.

- Reduce food waste, food miles and unnecessary packaging and create opportunities to redistribute surplus food and increase recycling from the whole supply chain across Aberdeen.
- Promote food systems that protect wildlife and support food produced with high animal welfare standards.

Individuals and organisations are making a pledge to make a difference.

JOIN US TODAY!

Here's what you can do to ensure that the food you eat is good for you, the planet and your pocket:

Individuals:

- Eat a healthy diet. Try to eat 5 + portions of seasonal fruit & vegetable per day, and limit your sugar intake;
- Buy more local and seasonal produce;
- Grow your own food, in an allotment or community garden;
- Cook your own meals from scratch using fresh, local, sustainably sourced ingredients;
- Reduce your food waste at home;
- Compost food waste and recycle packaging;
- Look out for and buy responsibly sourced food.

Organisations:

- Procure sustainable, local and responsibly sourced food;
- Provide opportunities to grow food at work and within the community;
- Increase access to healthy food and drinks in canteens and vending machines and encourage staff to eat healthy diets including reducing sugar consumption.

Sign the Charter today and pledge your commitment to making Aberdeen a Sustainable Food City.

Name: _____

Organisation/ Individual: _____

Date: _____

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2018

GRANITE CITY GOOD FOOD

2017-2018 Annual Report

Sustainable Food City Partnership Aberdeen (SFCPA)

October 2018

Table of Contents

List of Acronyms:

ACC	Aberdeen City Council
ACFN	Aberdeen Community Food Network
CFO	Community Food Outlet
CFINE	Community Food Initiatives North East
CFM	Community Food Member
FPAA	Food Poverty Action Aberdeen
FS	FareShare
NHSG PHD	NHS Grampian Public Health Directorate
SFC	Sustainable Food Cities
SFCPA	Sustainable Food City Partnership Aberdeen

Sustainable Food City Partnership Aberdeen (SFCPA)

Introduction

Good food is vital to the quality of people's lives. At Granite City Good Food, we believe that every person in Aberdeen should have access to healthy, tasty, affordable food and that this food should also be good for the environment and our local economy.

We recognise that food is at the heart of some of our cities most pressing social, economic and environmental problems; however, we also see good food as a key part of the solution.

Granite City Good Food is a citywide movement, aiming to raise awareness and drive positive food change whilst making healthy and sustainable food a defining characteristic of Aberdeen as a city.

Partners

Granite City Good Food is driven by a steering group of key stakeholders, who focus on leading strategic policy change and resource allocation which is essential to the SFC movement. The steering group is call the Sustainable Food City Partnership Aberdeen (SFCPA). This cross-sector partnership is made up of:

- Aberdeen City Council
- Public Health and Wellbeing Team, Aberdeen Health & Social Care Partnership
- Community Food Initiatives North East (CFINE) / Food Poverty Action Aberdeen
- Enscape Consulting Ltd.
- NHS Grampian's Public Health Directorate (NHSG PHD)
- The Allotment Market Stall
- Robert Gordon University
- Tillydrone Community Flat

Funding

In 2017-18 Granite City Good Food was jointly funded by:

- Aberdeen Health & Social Care Partnership (Food in Focus)
- Esmée Fairbairn foundation (via Soil Association)
- NHS Grampian Public Health Directorate

We thank them for their contribution and for ongoing commitment to the Sustainable Food Cities approach in Aberdeen.

Background

An initial event entitled 'EAT Aberdeen' was held in May 2016 to gauge interest in Aberdeen taking forward the Sustainable Food Cities approach. The event was well attended and confirmed a positive commitment. The Sustainable Food City Partnership Aberdeen was then formed, holding its inaugural meeting on 29th March 2017 and has been growing from strength to strength ever since.

The SFCPA was officially announced as the 48th member of the Sustainable Food Cities Network in the U.K, and 3rd in Scotland.

Granite City Good Food

Summary 2017-18 Achievements

- Achieved Sustainable Food Cities Bronze Award. Aberdeen first city in Scotland, only a handful across the U.K to achieve this!
- Developed 2017-18 Action Plan;
- Developed SFCPA Food Charter: ~70 signatures;
- Created SFCPA website & Social Media (Facebook, Twitter), posting regular content;
- Hosted Launch Event: ~80 attendees;
- Assisted the establishment of Aberdeen Procurement Partnership, Community Café Network and Grampian Food Heritage Group;
- Secured commitment for groups to lead SFC priorities:
  Priority 1: (All subgroups to play part. ACFN (~30+ partners) and Child Healthy Weight Working Group (~20 partners) and agreed to specific actions.)
  Priority 2: Food Poverty Action Aberdeen (63+ partners)
  Priority 3: Aberdeen Community Food Network (ACFN) (40+ partners)
  Priority 4: Grampian Food Heritage (20+ partners)
  Priority 5: Aberdeen Procurement Partnership (10+ partners)
- Attended and presented at SFC Annual Conference;
- Presence at 30 Aberdeen events including health & wellbeing fairs and food festivals with information and materials promoting sustainable food;
- Member of Food Growing Strategy Steering Group – inputting into upcoming Food Growing Strategy and distribution of £145k funding to community growing;
- Reporting into ACC Community Planning structure via 'Sustainable City' Outcome Improvement Group;
- Ran successful Sugar Smart campaign – engaged with a variety of sectors. Piloted 5-week programme for primary school engagement;
- Supported 'Menu for Change' event;
- Input into Aberdeen Food Poverty Action Plan;
- Supported new Sustainable Food Eco-City Award 2018.
- Supported first George Street Farmer's Market and Sustainability Festival

Aberdeen wins National Good Food Award!

Aberdeen has become the first city in Scotland to win a prestigious Sustainable Food Cities award!

The award recognises work to promote healthy, sustainable and local food and to tackle some of today's greatest social challenges, from food poverty, diet-related ill-health and lack of food skills and more!

Thanks to all partners involved!
This award represents the hard work being done citywide to promote good food, and is a first step in our Sustainable Food Cities journey.

Case Studies

- **Aberdeen City Council – Pop-up Fruit and Vegetable Market**

  The SFCPA Coordinator met with Health & Wellbeing Officers at Aberdeen City Council to discuss actions to fulfil commitments to the Sustainable Food Cities approach. It was agreed that a trial 'pop-up fruit and veg shop' would be held at Marischal College for ACC staff.

  The stall sells locally sourced (where possible) produce from CFINE, a Wholesale Fruit and Veg Supplier, is run by volunteers and promoted widely to staff by council officers. ACC staff are offered the opportunity to send 'pre-orders' of veg boxes to be collected on site.

  The stand began running on 27th March and has been running on the last Tuesday of every month since then. In total we estimate the stall has made £600 profit, all of which is reinvested into projects which support vulnerable individuals/ families in Aberdeen.

Two volunteers run the Pop-up stall every month.

ACC staff queue up every month to purchase produce.

The staff have been really happy with the provision of this stall and it has been agreed to continue for the foreseeable future.

Rebekah Walker, Health & Wellbeing Adviser says:

"'The pop-up stall at Marischal has been great! Employees have commented on the quality of the produce and the good prices. It's something people look forward to every month and its helped create a feel-good factor amongst staff.''

All packaging at this stall is fully compostable/recyclable. The stand serves not only as a purchasing opportunity, but also raises awareness of wider food poverty, sustainable food and environmental issues. For one of the sessions we partnered with ACC's Waste & Recycling team who hosted a stand beside the shop to engage with staff on recycling issues (including food waste).

ACC Waste & Recycling Team host a stand alongside the Marischal College 'Pop-up Market'

- **Aberdeen Community Café Network**

Community Food & Health Scotland were interested in developing a Community Café Network in Aberdeen, (similar to the Edinburgh Community Café Network). After the first meeting, CFHS did not have capacity to continue coordinating/ facilitating this network therefore sought a local group to take on this responsibility. The SFCPA Coordinator took on this role and has developed a successful network, with key actions being focus organising and running training session for the network, on topics such as; Starting a Community Café, Environmental Health, Volunteering, Cooking Skills Qualifications, Sustainability, Social Media and more. The sessions are held in varying locations, moving between community café's in the area and are well-attended. For the development of this network, it has been proposed that they form part of the larger Aberdeen Community Food Network.

Members of the Aberdeen Community Café Network meet with ACVO to discuss Volunteering

Partnership Developments

- **SFC Annual Conference**
  We attended and presented at the Sustainable Food Cities Annual Conference in Cardiff; sharing information on Aberdeen's approach to developing a Food Growing Strategy; an overview of Community Food projects in the city and the importance of driving policy change. Connecting with other SFC representatives from across the UK helps us to learn what's happening across the UK, allowing us to learn from cities who are further along their SFC journey.

- **Funding**
  Funding for 2018-19 has been confirmed (via ACC Common Good Fund, Esme Fairbairn via Soil Association and NHS Grampian Public Health Directorate). This funding will extend the Granite City Good Food Co-ordinator position for 12 months.

- **Branding**
  The Steering Group agreed the need for a catchy branding/identity which captured the ethos of what we're trying to achieve, as well as standing out to people across the city, encouraging them to join in the Sustainable Food movement. **Granite City Good Food** was agreed, with a fantastic new logo commissioned for free by a local graphic designer. This launched to our wider network alongside the first edition of the Granite City Good Food Newsletter. The branding aligns with ACC's Food Growing Strategy's branding 'Granite City Growing'.

- **Governance**
  The Steering Group have been regularly reporting into ACC Community Planning structure via the 'Sustainable City' Outcome Improvement Group.

- **Memorandum of Understanding**
  The MoU was written and agreed by all partners. The key statement being: *'Good food is vital to the quality of people's lives. Granite City Good Food believe that every person in Aberdeen should have access to healthy, tasty, affordable food and that this food should be good for the environment and our local economy'*

- **2017-18 Action Plan**

The SFCPA Action Plan 2017-18 was created in August 2017 and shared at the SFCPA launch event in September 2017, and by email/online for onward consultation. It contains an action plan summary, as well as detailed actions for 'partnership development' and each of the 6 priority areas for 2017-18. It was agreed that this will be a 'living' document ongoing so that it can change to reflect the transformation of the partnership as we progress. The Action Plan is available online on the Granite City Good Food webpage.

- **Launch Event**

We hosted a launch event (01.09.17) - the civic reception event gathered various stakeholders and members of the public across Aberdeen to celebrate and discuss how to progress the SFC approach. The event attracted 90+ attendees and included pop-up stands from local partners (TAMS, Soil Association, Aberdeen for a Fairer World, NHS Grampian). At this event, the Food Charter was launched, and key partners were invited to sign the Charter on behalf of their organisations.

Promoting Healthy & Sustainable Food to the Public

- **Marketing and Promotion**

  Promotion of the partnership, and the wider Sustainable Food Cities approach, has been achieved over the past 12 months by the creation of Social Media pages (see below), a Granite City Good Food e-Newsletter (which can be viewed here.), webpage as well as information shared via local community newsletters, radio stations and bulletins. Our aim is to promote the approach widely to the public and across community partners. The new branding 'Granite City Good Food' encompasses the citywide approach.

@GraniteCityGoodFood (301 Likes)

@GC_GoodFood (344 Followers)

- **Food Charter**

The SFCPA Food Charter was created and shared widely. It encapsulates the SFCPA goals and includes practical sustainability actions for individuals and organisations to commit to. This is a core visioning document of the SFCPA and is being used to promote the SFC approach citywide as well as encouraging actions of commitment from partner organisations.

The charter was launched at a cross-sector networking/celebration event and sent to attendees by email and shared on the SFCPA Facebook and Twitter pages. In January 2018, an online form version of the Charter was created and shared with our wider network to encourage the signing of the charter.

The current number of signatories to the Food Charter is: 61, including 17 organisations and 44 individuals

SFCPA partners, led by City Council leader, sign the Food Charter.

- **Community Events**
  Over 2017-18 Granite City Good Food have attended ~30 community events across Aberdeen including health and wellbeing fairs, Open Days, Farmer's Markets and food festivals with information and materials promoting food sustainability and the SFC approach.

- **Sustainable Food Eco-City Award 2018**
  The Aberdeen EcoCity Awards recognise and reward local people for their efforts to make Aberdeen a more sustainable city. The Awards invite submissions from individuals, community groups, schools, businesses, charities and other organisations. This year for the first time a 'Sustainable Food' category has been sponsored by Granite City Good Food. Any local business working to promote sustainability can nominate themselves. The winner receives a £200 cash prize and award at a presentation event. More information online at:
  www.aberdeencity.gov.uk/services/environment/aberdeen-ecocity-awards

2017-18 Campaign – Sugar Smart

The Sugar Smart Aberdeen campaign engaged primarily with Primary Schools, Workplaces, Community Groups, and Sports and Leisure Facilities.
Our aim was to ensure that any person who engaged with the SUGAR SMART Aberdeen campaign: consumed more fruit and vegetables, less sugary snacks and drinks and increased their daily activity levels based on the information and opportunities gained through the campaign.

Sugar Smart Aberdeen achieved the following outputs:

- Civic Reception launch event, Aberdeen Town House, 1st September 2017 (~90 Attendees)
- Survey/Questionnaire of pupils at Heathryburn School. (~150 pupils)
- Online survey shared with parents of pupils. (~10 responses)
- Sugar Smart Assembly at Heathryburn Primary, 22nd February 2018. Councillors & Press in attendance. Sugar Smart quiz and information shared. Health Group Pupils presented work on Eat Well Guide. (~200 pupils, 20 teachers)
- Heathryburn 'Ditch the Fizz' Challenge to give up fizzy juice for 18 days. Health Group Pupils voted on the name and the whole school was encouraged to take part.
- Ditch the Fizz launch assembly (8th March) - free bottles of water handed out. (~200 pupils, 20 teachers attended) Pupils completed fizzy juice diaries as part of the Challenge, to show how much fizzy juice they drank.
- Sport Aberdeen revised food menu in Beach Leisure Centre canteen, sourcing healthier options where possible.
- CFINE volunteers incorporated Sugar Smart messages into 'Cooking on a budget' and 'Confidence to Cook' training sessions in the kitchen. 4-week programme with approx. 6 participants per programme. Total ~40 individuals received Sugar Smart messages and tips through cooking demonstrations.
- Aberdeen City Council shared Sugar Smart messages in their staff Health and Wellbeing Newsletter.
- NHS Grampian shared Sugar Smart articles in their Healthy Working Lives Newsletter.

Sugar Smart Aberdeen Case Study: Heathryburn School

Heathryburn School pupils held a Sugar Smart Assembly to launch their 5-Week Sugar Smart programme which ran from 22nd February - 29th March 2018.

Heathryburn was the Sugar Smart pilot school in Aberdeen, with the programme being designed by the pupils themselves. The programme included a range of activities to help transform the school's food environment and raise awareness of the impacts of consuming too much sugar.

Kelly Milne, Heathryburn's Head Teacher, said: "It's great that we are the pilot school for this amazing Sugar Smart project and everyone really enjoyed taking part. There were lots of activities scheduled in for both pupils and parents and we are hoping to see some really positive outcomes because of the programme."

The Sugar Smart Pilot 5-Week Programme, led by Granite City Good Food, included:

- Pupil and parent surveys on sugar consumption
- 'Ditch the Fizz' challenge to give up drinking fizzy juice for 18 days
- Poster and video making
- Sugar Smart quizzes, display boards and pop-up information stands
- Parental engagement and peer education lessons
- Healthy snacks and water delivered by CFINE's electric Tuk-Tuk
- A pupil-led assembly delivered to parents

Tackling Food Poverty, Diet-Related Ill Health & Access to Healthy Food

Lead group: **Food Poverty Action Aberdeen**

- **Action Plan for Tackling Food Poverty/Insecurity in Aberdeen**
  In June 2018 FPAA drafted, in consultation with partners, an 'Action Plan for Tackling Food Poverty/Insecurity' in Aberdeen. The statement of intent from this Action Plan states:

  Food poverty/insecurity is not acceptable in Aberdeen and we call on Aberdeen City Council, Community Planning Aberdeen, Aberdeen Welfare Reform Board, NHS organisations and the Sustainable Food City Partnership Aberdeen (SFCPA) to make tackling food poverty/insecurity a priority and for acceleration on the commitments that have been made, and working in partnership with Food Poverty Action Aberdeen (FPAA), to reduce, and work towards ultimately eradicating, food poverty/insecurity.

  FPAA's Action Plan has the following aims:

  Aim 1: Tackle the underlying causes of food poverty/insecurity in the city;

  Aim 2: Ensure that every child and vulnerable adult can eat one nutritious meal a day;

  Aim 3: Promote Aberdeen as a city that cooks, eats and grows together;

  Aim 4: Ensure, when prevention is not enough, that there is crisis and emergency support so that people do not go hungry;

  Aim 5: Commit to measuring levels of food poverty/insecurity so we know the scale of the issue and if we are being effective.

- **Moving Beyond Emergency Food Aid Event**

This Network event, jointly hosted by Menu for Change and Food Poverty Action Aberdeen, was titled: *'Moving beyond emergency food aid in North East Scotland: What are the next steps?'.*

It brought together key organisations that are responding to growing food poverty and insecurity to discuss how, as a city and a country, we can move beyond people having to rely on emergency crisis food provision to make ends meet. The event was held on Friday 23rd March 2018 in the Aberdeen Town House Civic Rooms.
The event consisted of:

- Welcome and introduction to A Menu for Change – project overview and review of good practice from across Scotland;
- Action Plan for Tackling Food Insecurity in Aberdeen – an overview of the Food Poverty Action Aberdeen action plan
- Panel Presentations:
  Lynsey Allan, Aberdeen Cyrenians, Service Manager
  Dave Kilgour, Community Food Initiatives North East
  Andrew Martin, Aberdeenshire Council, Strategic Policy Leader (Community Engagement and Equality)
  3 members of Aberdeen Community: short presentations about their experience of facing food poverty and what they think the next steps need to be to ensure emergency food aid is not a permanent fixture in the North East of Scotland
- Group Work: Mapping, discussion around what we can do collectively to tackle the issue, draw on experience to consider action focused ideas.

Actions/Outcomes captured from the Group Work at this event were collated and added to the Action Plan for Tackling Food Poverty/Insecurity in Aberdeen.

- **Child Healthy Weight Working Group**

This multi-agency group is made up of public and third sector organisations who work together to share resources and services across the city. The Vision of CHW is: *'We will work together to enable our children and young people to be healthy and active'*

Progress over the last year:

- Group agreed action plan;
- Further development of child healthy messages with marketing colleagues;
- Group agreed to 'recruit' co-ordinator for Northfield ASG community action project;
- Conversations with key partners in the Northfield ASG area regarding taking forward actions within the plan;
- Multi-agency child healthy weight partners supported summer holiday fun and food provision;
- Survey sent to partners re. child healthy weight training needs.

- **Food and Fun Holiday Hunger Programme**

The Aberdeen City Council project saw the local authority work in partnership with Community Food Initiatives North East (CFINE), Aberdeen Football Club Community Trust, Sport Aberdeen, Transition Extreme and the Denis Law Legacy Trust to deliver the Food and Fun programme. Along with food, youngsters in the city's regeneration areas got to take part in sports and other activities.

CFINE looked after the food side of the project, which saw more than 10,000 meals prepared for children. Organisers plan to continue the programme over the other school holidays throughout the year, including in October and at Easter.

- **Community Food Outlets**

Aberdeen hosts approximately 50 Community Food Outlets (CFOs) – set up by CFINE, staffed and run by volunteers. These are 'pop-up' fruit and vegetable stalls in locations lacking provision/ with limited access to local shops, as well as areas of 'Multiple Deprivation' - where individuals often face barriers to purchasing fresh produce due to financial restraints. CFO's sell 'loose' items so that healthy, fresh fruit and vegetables can be purchased at favourable rates in smaller quantities. The addition of CFO's to areas (such as Sheltered Housing Complex') helps tackle a variety of health inequalities, barriers to accessing food and works to build confidence and skills (volunteers) and alleviate social isolation. These are supported citywide by the key public and third sector organisations - CFINE supports the CFO's (providing volunteers, sourcing and delivering food), with other key organisations agreeing to host CFO's onsite (e.g. ACC, Community Centres, Sheltered Housing, NHS Hospitals) etc.

- **Tuk-In Community Café**

- CFINE's 'Tuk-In' Community Café is an electric Tuk-Tuk - a quirky, innovative way of working against food poverty and food waste. The mobile cafe travels to areas with limited access to fresh fruit and vegetables selling freshly made soup and fruit pots at affordable prices. Tuk-In was crowdfunded, with match-funding from the Health Improvement Fund. Members of the public took part in the crowdfunder, showing huge support for the project. The tuk-tuk is available for corporate events (recently attending ACC and Aberdeen H& SCP events) distributing ~600 portions. All profits from corporate events are reinvested, keeping community costs low.
  Tuk-In operates every Wednesday, visiting: Tillydrone, Woodside and Printfield to sell soup, fruit pots and bread for £1.50.

  2017-18 Outputs:
  ~ 8194 meals distributed to priority communities;
  ~16 volunteers involved, 4 have progressed onto full time employment.

Building Community Food, Knowledge, Resources & Projects

Lead group: **Aberdeen Community Food Network**

Other groups: Granite City Growing

- **NHS Grampian Food Skills Training Programmes**

  Aberdeen City Public Health Team Foodskills Training programme is open to anyone using skills gained to improve health and well-being in their local community. Courses offered include: Elementary Food Hygiene, Food and Health (basic nutrition), C2C 'Training 4 Trainers' and REHIS nutrition training. They are free to attend and held at community venues throughout the city, hosted in partnership with ACFN partners.
  In 2017-18, the following figures were recorded:

  30 participants completed the 'Confidence 2 Cook' 2-day training
  9 participants attended the REHIS food and health course
  2 participants attended the REHIS Food and health for carers of adults with learning disabilities.

- ACFN promote Confidence to Cook Training for Trainers (T4T) encouraging volunteers to gain qualifications to deliver cooking sessions, developing a pool of trained volunteers delivering classes across many kitchens in Aberdeen. Classes include information on hygiene, budgeting and nutrition. In 2017 NHS Grampian developed a C2C Resource Pack, promoted by ACFN with a launch event.
  Numbers of T4T trained individuals across 2017-18: 51.

  ACFN Classes run in 2017 (including NHS Grampian and other partners) include:
  - C2C Kincorth Academy (May 2017) - 106 S2 pupils
  - C2C Kincorth Academy (June 2017) - 100 S5 pupils,
  - C2C Torry, 1-to-1 sessions (June 2017) - 1 x S3 and 1 x P7 pupil
  - Sessions delivered for P7 Transition groups in the Torry and Kincorth ASG
  - 2 x 'Cook and play' sessions at Williamson
  - Bramble Brae Bakes (BBB);
  - Homestart Recipe for Life

- **Community Cooking Classes**

ACFN partner CFINE deliver a range of cooking skills classes at their 'Cook at the 'Nook' kitchen to vulnerable individuals of all ages on low income. Classes run for 4 weeks and include 'Cooking on a Budget' and 'Confidence to Cook'. These are free of charge to priority individuals, and CFINE accept referrals from partners.

Across 2017-18 Cook at the Nook had the following outputs:

- Beneficiaries trained in kitchen: 859 from priority communities;
- >20 volunteers involved in various initiatives and events in kitchen;
- 2 volunteers supported to become voluntary trainers in the kitchen;
- ~ 8194 meals created (to be distributed via 'Tuk In')

- **Granite City Growing – a Food Growing Strategy for Aberdeen**

  Aberdeen City Council are developing a food growing strategy for Aberdeen with support from national charity Greenspace Scotland and local stakeholders.

  The Community Empowerment (Scotland) Act 2015 requires every local authority to prepare a food growing strategy for its area to identify land that could be used to grow food and describe how provision for community growing, in particular in areas which experience socio-economic disadvantage, can be increased.

  Aberdeen's strategy will meet the requirements set out in the Scottish Government guidance. ACC are also currently working to gather information about how people are already growing food in the city, through public surveys and consultation.

  This strategy supports the work of the Sustainable Food City Partnership Aberdeen and is part of an exciting movement encouraging a healthy relationship to local food which is accessible to all and which is good for both people and the planet.

  Stakeholders involved in developing the strategy include:

  - Aberdeen City Health and Social Care Partnership
  - Community Food Initiative North East
  - Garthdee allotments
  - Go Green at Robert Gordon University
  - James Hutton Institute
  - Local Development Plan team
  - Locality managers
  - NHS Grampian
  - Powis Residents Association
  - Sustainable Food City Partnership Aberdeen
  - The Allotment Market Stall
  - The Civic Forum
  - The Environmental Policy Team, ACC
  - The Recycling Team, ACC
  - Environmental Services, ACC
  - The Communities Team, ACC

Greenspace Scotland facilitated 3 stakeholder engagement workshops across 2017-18 with the above groups to collect views and input, ensuring the finalised strategy reflects local priorities and issues.

The finished Food Growing Strategy will be in place during 2019.

As well as overseeing the drafting of the statutory strategy, the Food Growing Strategy Steering Group identified the need to improve current food growing provision in Aberdeen.

Agreements/Actions over the last 12 months include:

- Aberdeen should aim to lead the way, not just 'tick the box';
- Strategy alone will not tackle barriers to food growing;
- Funding is needed to promote community growing and improve access to growing spaces, particularly in regeneration areas;
- A Committee Report was drafted and approved (Spring 2017);
- A 'Community Food-growing Programme' was researched, developed and approved by ACC Communities, Housing and Infrastructure Committee (August 2017);
- £145k was awarded to support community growing initiatives, as part of Aberdeen's commitment to Sustainable Food Cities;
- A branding or identity was developed/agreed - 'Granite City Growing – Aberdeen Growing Together', linking to the Granite City Good Food branding. This is to be used for promotional/engagement purposes with community members.
- A student from the University of Aberdeen has created an online map of Aberdeen growing spaces. This will be used as an engagement tool showing existing food-growing sites and connecting local groups to them. It will also map potential food-growing sites for future use.

The above ACC funding was used to improve and create new community growing spaces across Aberdeen. The Community Food Growing Programme has funded the following:

1. **A Community Food-growing Officer** employed by CFINE who has proved vital to the success and growth of the funded food-growing projects;
2. **Deeside Family Centre**: Baskets, planters, tools for children's growing classes targeting children of nursery age;
3. **Redmoss Allotments:** Drainage repair to bring 3 allotments back into use. Seven new mini allotments and five micro allotments have been created and taken up by people in the Torry area;
4. **Torry Food Growing Initiative:** Several community growing projects are being developed and funding will be released soon once the projects are defined and agreed by the steering group;
5. **Cummings Park Community Centre:** There are plans for fencing, planters, raised beds, tools, storage, fruit trees and funding will be released soon once the project is defined and agreed by the steering group;
6. **Sheddocksley Bowling Green:** There are plans for the creation of growing space, polytunnel and community events. Funds will be released soon once the project has received planning consent;
7. **Seaton Community Centre:** Planters, tools, seeds and community fridge-freezer;
8. **Tillydrone Community Flat:** Container gardening and polytunnel for residents to grow their own fruit and vegetables;
9. **Seaton Community Gardening:** The residents of a sheltered housing facility have been given funds to create their own food-growing space;
10. **Greening Donside:** Creation of a Community growing spaces and Wild Orchard with a polytunnel;
11. **School Garden Project:** A pilot project with One Seed Forward and the University of Aberdeen. Raised beds were installed in 3 regeneration area primary schools to teach children about growing. Over 600 hours of 'gardening time' was delivered each month during the growing season targeting two classes in each school. Educational material was developed to enable other schools to embed food-growing within their curriculum;
12. **Edible Walls:** Four primary schools in the regeneration areas were supported to, create 'edible walls' by growing in repurposed plastic bottles, a toolkit was developed and engagement with school pupils on growing was delivered through the growing season;
13. **Food Growing Bags:** 100 bags distributed to public through Facebook engagement within the regeneration areas. Participants were given four food plants to take away and plant;
14. **Grove Nursery:** The erection of a polytunnel to support new growing initiatives in coming years;

15. **BID Bee hive project:** Six bee hives have been set up in the city centre. Funding also paid for the monitoring technology and training in bee-keeping skills;
16. **Plant It, Grow It, Taste It:** A project aimed at indoor food-growing in all of Aberdeen's primary schools delivered by the Royal Northern Countryside Initiative;
17. **Bonnymuir Green Community Trust:** A project to provide community food-growing on a disused bowling green.

The aim is for communities to create, maintain and share these spaces. The projects target 'regeneration areas' of Aberdeen - Tillydrone, Mastrick, Northfield, Middlefield, Torry and Seaton - with the aim to increase interest, knowledge/skills and access to growing opportunities in these areas.

Unpaid Work Team Helped Create the Spaces

Woodside Primary School

Oldmachar Community Pre-School

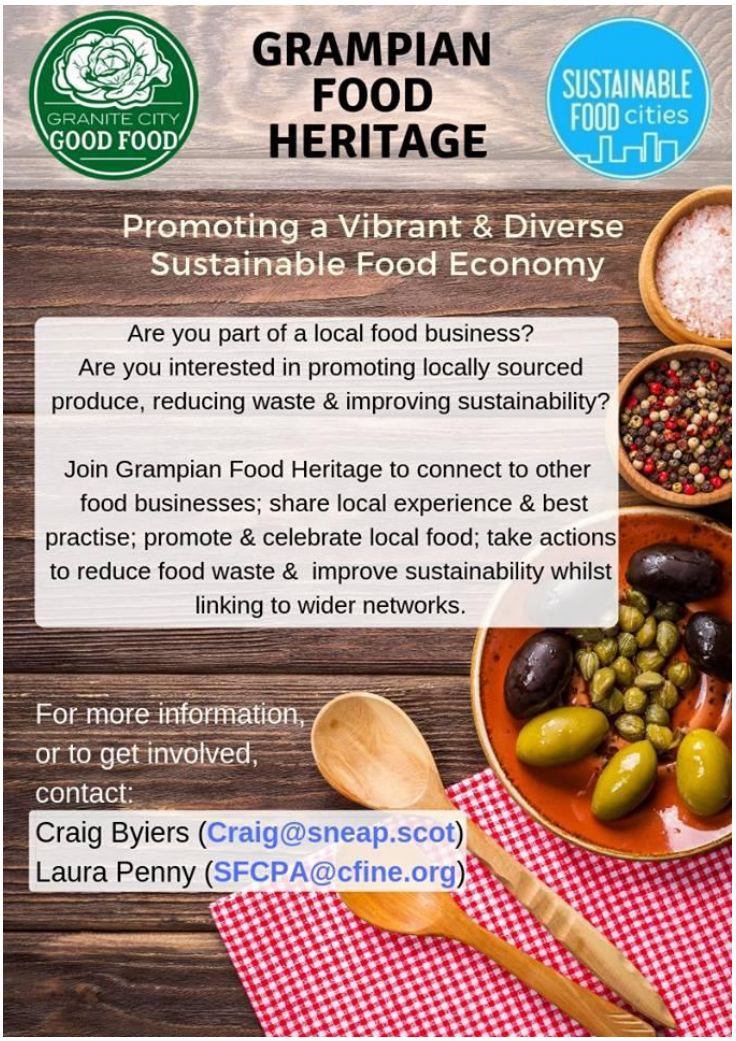



Edible Walls were created and used for engagement lessons with local school groups

Building a Vibrant & Diverse Sustainable Food Economy

Lead group: **Grampian Food Heritage**

The key achievement of 2017-18 under this priority was the formation of the Grampian Food Heritage Group. It is a network of local chefs, food business owners and other food business with an interest in sustainability. In July 2018 the group held its inaugural meeting and agreed the following purpose:



1. **Giving a voice to the local food and drink sector;** raising collective issues, ideas and actions to progress on the ground, whilst having them recognised in citywide policies and strategy at a higher level;

2. **Working together as a collective;** identify to be carried out in partnership which will help and promote businesses involved, whilst raising awareness of the importance of sustainability in the food and drink sector.

3. **A Forum for ideas and innovation;** this group aims to be creative and think outside the box when looking at collective actions;

4. **Promotion and Education;** sharing information about the importance of local, seasonal, sustainable produce via campaigns, information events, pop-up markets, chef demonstrations etc.

5. **Building a vibrant and diverse sustainable food economy;** by promoting local businesses, food and events which promote the food and drink sector in Aberdeen, the group aims to draw a focus on this sector. This group aims to improve the food culture in Aberdeen and will do so by highlighting 'the best food in Aberdeen'.

- **George Street Farmer's Market & Sustainability Festival**

  This was run in partnership between Aberdeen Inspired, Aberdeen Climate Action, the Greater George Street Trader's Association and Granite City Good Food, with funding coming through ACC's Participatory Budgeting and matched by Aberdeen Inspired.

  The first ever George Street Farmer's Market & Sustainability Festival was held on Saturday 7th July, bringing families and individuals to George Street with the opportunity to purchase local produce and learn about sustainability.

  The event included 15 local food and drink producers selling top quality fresh and locally produced food, 14 local 3rd sector groups and featured stalls such as; an electric tuk-tuk vehicle, locally grown fruit and veg, information on energy reduction and sustainable transport and community growing initiatives.

  Due to its popularity, the George Street Farmers Market has become a regular event running on the first Saturday of each month, with a quarterly Sustainability Festival tied in.

- **The Allotment Market Stall (TAMS)**

TAMS is a social enterprise that works with the Aberdeen City Allotment sites and community gardens to collect excess produce and sell it on stalls in city parks and community events during the growing season. The profits are given

back to the allotments and community gardens to be spent on them.

The stalls are run by volunteers who have an interest in growing and cooking food. The idea is to share knowledge and encourage people to give it a go. They also offer sessions on cooking and preparing locally grown food at primary schools and community events. This makes the link between growing, preparing and cooking food and eating more healthily.

The aims of TAMS are in line with Sustainable Food City initiatives and include; encouraging people to eat and grow food locally, reducing the carbon footprint of food by selling food grown in Aberdeen, contribute to improving diets in Aberdeen City, reduce food waste from allotments and community gardens and to make the links between food production, preparation and healthier eating. Any produce not sold is offered to local food banks (via Food Poverty Action Aberdeen).

TAMS won the 'Growing Smarter' Organisation **EcoCity Award** for 2017.

www.theallotmentmarketstall.org.uk

Transforming Catering & Food Procurement

Lead group: **Aberdeen Procurement Partnership**

- The key achievement of 2017-18 under this priority was the formation of the Aberdeen Procurement Partnership. APP is a cross-sector sustainable food procurement working group supported by the Food for Life team at The Soil Association. Current buy-in includes members of local business, local authority and sports & leisure facilities. The working group brings together senior decision makers to develop strategic drivers for sustainable food procurement.

In 2017-18 APP developed the following Vision/Aim for their group:

- Advocating for change at national level;
- Sharing best practice across Aberdeen Procurement professionals;
- Implementing actions identified by the group;
- Work towards sustainable food procurement/ SFCPA's aims in the City of Aberdeen[1]
- Work in line with Scottish Government statutory procurement policy, best practice and Good Food Nation ambitions[2]

Other key activities over 2017-18 include:

- Identifying key barriers across partners to sourcing locally/ more sustainably;
- Supply chain mapping: collecting and collating data on suppliers, processers, producers in Aberdeen and surrounding area.
- Capturing timelines for upcoming public-sector procurement frameworks.

[1] https://www.cfine.org/Granite-City-Good-Food

[2] In 2014 the Scottish Government made a commitment to making Scotland a Good Food Nation; a Land of Food and drink, not only in what we as a nation produce but in what we buy, serve and eat. Public expenditure on food has the potential to unlock benefits for community health, well-being and social justice through access to good nutrition including access to fresh and seasonal produce.

Reducing Waste & the Ecological Impact of the Food System

Lead group: **FareShare Grampian**

FareShare Grampian, run by CFINE, collects and distributes consumable surplus food, diverted from landfill to 170 charities, churches, public sector staff and community organisations locally, with 125 based in Aberdeen city. The focus for food distribution is primarily concerned with reaching:

1. People experiencing food poverty/insecurity either directly through e.g. food banks or through partner organisations e.g. HomeStart supporting vulnerable families and, as an addition to the support they provide, food and other products are made available;
2. Organisations which cook food and serve to beneficiaries on site.

In 2017-18, CFINE sourced 403 tonnes of food via FareShare Grampian, the equivalent of 959,000 meals, with a conservative value (based on £3.50/Kg) of £1,410,500. 90% of this was distributed within Aberdeen city, with 10% going to Aberdeenshire. In 2018-19, CFINE expects to source up to 500 tonnes of food via FareShare Grampian.

Key charitable organisations receiving FareShare produce in Aberdeen include: Aberdeen Cyrenians, The Salvation Army, Integrate Scotland, Barnardos, Instant Neighbour, Fersands & Fountain Community Project, YMCA and more.

- FareShare won the 'Waste and Recycling Business' Category **EcoCity Award' for** 2017.

Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Date of Meeting	26th March 2019
Report Title	Aberdeen City Health and Social Care Partnership Workforce Plan 2019-21
Report Number	HSCP.18.146
Lead Officer	Sandra Ross, Chief Officer
Report Author Details	Name: Susie Downie Job Title: Transformation Programme Manager Email Address: sdownie@aberdeencity.gov.uk
Consultation Checklist Completed	Yes
Directions Required	No
Appendices	a. ACHSCP Empowered Workforce Plan 2019-21

1. Purpose of the Report

1.1. This report seeks approval from the IJB for the ACHSCP Empowered Workforce Plan and its subsequent publication.

2. Recommendations

2.1. It is recommended that the Integration Joint Board:

a) Approve the ACHSCP Empowered Workforce Plan (2019-21)
b) To publish the ACHSCP Empowered Workforce Plan (2019-21)

3. Summary of Key Information

3.1. The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) requires that a strategic plan is produced and presented to the Integration Joint Board (IJB).

INTEGRATION JOINT BOARD

3.2. The workforce plan supports the ACHSCP in delivering its strategic priorities and ensures appropriate staffing arrangements are in place across the ACHSCP. It has been co-produced with a wide variety of stakeholders and staff groups.

3.3. There are detailed workforce plans for each statutory partner organisation (Aberdeen City Council and NHS Grampian) and who will continue to contribute to and be part of these discussions and processes. This workforce plan looks to ensure a sustainable workforce with the right skills and behaviours that is sustainable. The aim is to enhance the work which is currently in place and to specify workforce priorities for the health and social care partnership.

3.4. The plan acknowledges that in order to achieve the identified objectives, there is a need to:

- Fundamentally change what is done, the way it is done and with whom to fully integrate services
- Increase engagement of the workforce, in its widest sense, by making them feel more valued
- Support staff's well-being (physical & mental)
- Make work a joyful thing and increase trust with colleagues and partners

These enablers are required in order to ensure change is achieved that positively impacts both colleagues and customers.

3.5. It considers some of the key challenges that have been reported to the IJB in other contexts (such as ageing population; ageing workforce and increasing complexity; lack of digitalisation). These challenges point to a need to engage in the potential of younger people, in order to have appropriate succession planning in place. The need to retain and train people to support the transformation of the way support is delivered is also required.

3.6. There is a strategic intent for staff to see themselves as one coherent group working together to achieve better outcomes for the people who use health and social care services. It is recognised that this will require to be in tandem with both partners operating models (including respective terms and conditions).

3.7. There is a need to maximise resources by service redesign to eliminate duplication of effort, and to focus on the types of support that will deliver better outcomes for the people who rely on support. This needs to be done

by focusing on the voice of the customer and ensuring streamlined pathways for those who use the services.

3.8. Ensuring the workforce is digitally enabled and mobilised using new technologies is a priority for the partnership. The workforce plan looks to ensure staff, processes and systems are appropriately trained and supported in order to maximise use of resources and ensure efficient ways of working.

Delivery

3.9. Underpinning the delivery of the workforce plan is an action plan based upon four themes; Right People, Right Skills, Right Roles, and Sustainability. Each theme has a supporting action plan which is set against timescales as follows;

- Short Term: 1 year
- Medium Term: up to 2 years
- Long Term: 3 years

3.10. Those responsible for each action or set of actions will set out more specific timescales and tasks within these timeframes and will report on a regular basis within the current governance framework of the partnership. The Enabling Systems Programme Board will oversee progress.

4. Implications for IJB

4.1. **Equalities** -. Both partners are committed to equalities of opportunities both in recruitment and progression as well as non-discrimination within the workforce.

4.2. **Fairer Scotland Duty** – Part of our workforce strategy will be to ensure we recruit the right people and to increase exposure across all socio-economic groups with a particular focus on developing young people, modern apprenticeships and overall succession planning. By doing this we are paying due regard to the Fairer Scotland duty. We look to recruit the right staff who are able to support those in need no matter their situation.

4.3. By reviewing our workforce arrangements and making improvements we look to ensure socio-economic implications are taken into account of Fairer Duty Scotland.

4.4. **Financial** - there are no direct financial implications arising from the recommendations of this report. However there may be projects contained within the action plan e,g. IT / training which will have an impact on resources.

4.5. **Workforce -** the report reflects the plan to ensure a workforce that is able to deliver the strategic vision and plan of the ACHSCP.

4.6. **Legal –** approval of the workforce plan will help ACHSCP ensure that it fully meets its duties as set out in the Public Bodies (Joint Working) (Scotland) Act 2014. Powers under the Act which would permit the Board to employ its own staff have not yet been invoked.

5. Links to ACHSCP Strategic Plan

5.1. The workforce plan seeks to support delivery of all five themes within the strategic plan. The plan includes key enablers and actions which are aligned to its priorities.

6. Management of Risk

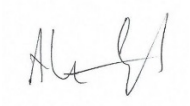
6.1. **Identified risks(s):**. Whilst the partnership has a vision of a truly integrated workforce, the partnership does not directly recruit to posts. Therefore we will work with partners to ensure that processes do not hinder progress e.g. recruitment, annual appraisals, and that we are in alignment

6.2. **Link to risks on strategic or operational risk register:** Strategic Risk Register (Risk 9: High risk)

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

The workforce plan objectives are to ensure that the right staff are in the right roles at the right time. There is specific work with Career Ready and Developing the Young Workforce to ensure that there is appropriate succession planning and encouraging young people into either arm of the partnership. There is a focus on retraining of staff and engaging with teams around soft skills to encourage further integration and joint working to ensure seamless care for the individuals who use health and social care services.

INTEGRATION JOINT BOARD

Approvals	
	Sandra Ross (Chief Officer)
	Alex Stephen (Chief Finance Officer)

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Aberdeen City
Health & Social Care
Partnership
A caring partnership
NHS
Grampian
ABERDEEN
CITY COUNCIL
ACHSCP
Empowered Workforce Planning
2019 – 2021

Aberdeen City
Health & Social Care
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AB10 1AB

Contents

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Vision

Our ACHSCP strategic plan will determine our workforce plan and vision. Our organisational values underpin all our activities, initiatives and developments. As part of the strategic plan refresh and wide consultation process we have revised these, 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".

Our Values:

"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 we remain committed to integrating our services for health and social care.

We remain committed as an organisation 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

Strategic Plan Priorities

Prevention

Resilience

Enabling

Connections

Communities

Workforce Plan Purpose

The workforce plan supports the HSCP to deliver priorities in the strategic plan and ensure appropriate staffing arrangements are in place across the ACHSCP. In terms of this plan we aim to achieve several key objectives. These are ;

- To integrate we need to fundamentally change what we do, the way we do it and with whom
- To increase engagement of our workforce by making them feel more valued
- To communicate with staff to show the difference they are making
- To support our staff's well-being (physical and mental)
- To make work a joyful thing and increase trust with colleagues and partners
- To become a 'learning organisation' in its culture and ways of working.

Collaborative Approach to Workforce Planning

Currently there are detailed workforce plans for each of our partners organisations *(Aberdeen City Council and NHS Grampian)* and we will continue to contribute to and be part of these discussions and processes. Our plan looks to set out our vision for health and social care services, and thus the workforce required to deliver this, as well as identify specific challenges.

The aim of this report is to enhance what we have and to give workforce priorities for the health and social care partnership.

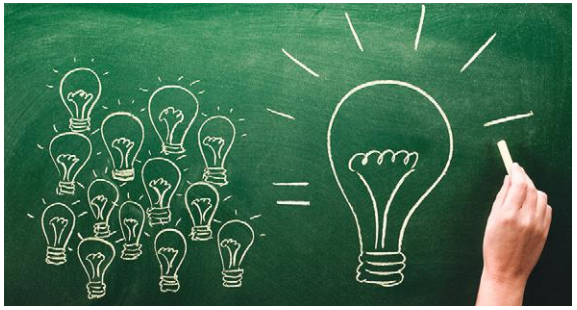


Fig. 1: Workforce Plans

Our partners from NHS Grampian, Aberdeen City Council (ACC), Third and Independent sectors are an integral part of ensuring our vision is realised and meaningful engagement and participation in development of the plan and its actions is vital. Together we will take the right steps to plan for and deploy our future workforce effectively against this complex, shifting background.

Context

There are many factors which impact our workforce supply, demographic trends, recruitment/retention and technological advancement (please see underpinning workforce plans). Therefore within this plan we need to be agile and flexible in our thinking in order to be able to adapt our initiatives and actions appropriately and quickly.

National drivers

From the original publication of the national outcomes for health and social care (2014) which stated an intention to increase empowerment of staff in decision-making, the Scottish Government has supported this intent with publishing published its first joint health and social care workforce plan over 2017/18. Published in 3 parts its purpose is to better enable local and national workforce planning to support improvements in service delivery and redesign (Scottish Government, 2019).
This links inherently to other legislative changes including tools to ensure safer workforce, the new GP contract and implementation and widening of the multi-disciplinary team.

Audit Scotland published a report in 2017 recommending the better need to understand future demand and how to meet that demand. Last year this was followed up with a progress toward integration in 2018. The report notes areas such as collaborative leadership and digitalisation as key areas of focus for integrated authorities (Audit Scotland, 2018).
All of these reports, amongst others, have informed this plan.

Delivering Safe and Effective Services Through Our Workforce

We are committed to developing a flexible, adaptable and supported workforce. It is essential that we continuously monitor and review our workforce requirements. In doing so, we are committed to working in partnership with Trade Unions, in line with staff governance standards already established within NHS Grampian and Aberdeen City Council. In doing so it is the intention to deliver an integrated workforce plan supporting the delivery of **"Safer, Healthier, Independent Lives"**.

This sits within the context of national work including the Health and Care (Staffing) (Scotland) Bill which places a legal requirement to ensure appropriate numbers of suitably trained staff are in place, irrespective of where care is received. As part of this, each delegated NHS service produces an annual workforce plan that underpins the NHS Grampian overarching plan and the Primary Care strategy for the city.

Impact of Brexit

With 3.5% of the current Aberdeen City Council workforce from the EU, and with the government stating that there are no plans to repatriate current employees, the short-term effect on the workforce is still estimated to be minimal. In the medium to long term there may be some return to EU countries of origin. As such consideration will be given to workforce planning in service areas with high ratios of EU nationals.

Our greatest resource is YOU...

We know that our staff are dedicated and hard working and there is a need to maximise the use of this scarce and reducing resource more effectively. This will ensure that staff feel supported and listened to and are able and empowered to make change.

People working together to actively share, learn and apply to ultimately achieve best practice

Sustainable improvements will only be achieved by a strong and continued focus on innovation, improvement and accountability across the whole health and social care workforce.

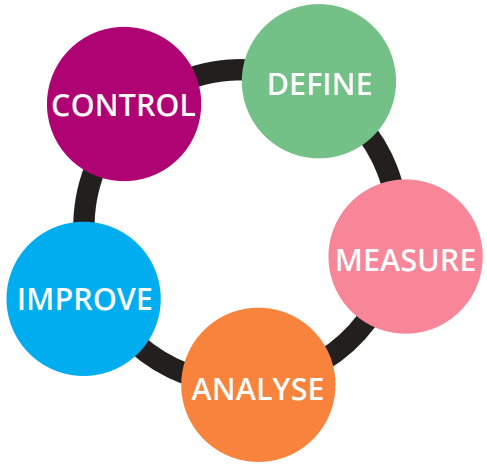
As an organisation we are looking to examine what we do and how we do it, to be more effective and efficient.

We want staff to have knowledge of improvement methods and how to use them at all levels. Staff may already be working on ideas and by giving training and support then this can be progressed to its potential as well as staff being felt listened to and able to take action.

Using well established improvement tools and techniques staff are empowered to make changes to improve frontline services.

Quality improvement...

- ...Creates time and opportunity
- ...reduces staff frustration and allows ideas to be voiced
- ...Supports understanding of what and how work is delivered by those doing it
- ...Improves quality
- ...Supports action and tests ideas and good practice



Who are we?

Our workforce provides services to adults and children. This plan covers staff within the NHS, Council and Third & Independent Sectors. The services we provide aim to help those who are unwell, those most in need and maximise the number of people in Aberdeen to be healthy, well and independent.

Prevention is better than cure and much of our work looks to ensure we prevent illness and connect with our local communities and resources to support them to maintain their health and wellbeing and build positive, collaborative relationships.

We support a wide range of people including those ;

- With long term conditions or disabilities ;
- Who have caring responsibilities ;
- Who have a degree of vulnerability or are in need of protection ;
- Who are well and want to maintain or improve their current level of health and wellbeing ;
- Who need an intensive or acute level of service ;
- We also see and support children within our services, for example as part of health visiting, speech and language therapy & community nursing

> *"The partnership is more than who we are. It is how we collaborate. It's about having the right people, with the right skills, in the right roles, at the right time, at the right cost"*
>
> Sandra Ross, Chief Officer

At a Glance: Who we are

We have **2013** staff

76% Female / 24% Male

270 new starts (on avg) each year which equates to **23** new people every month

We are a complex organisation delivering multiple services

18

Annual Turnover of staff

10.6%*

£80m of the budget is spent directly on staffing costs

Age profile of workforce being over **40** **62.8%**

Age profile below 25 **5%**

1 in 3 nurses are aged over 50

Overall budget 2018/19

£313,000,000

£90m of which is with 3rd & independent partners

Recruiting to Vacancies (on average) at any one time

160

Our staff operate out of approx.

40 locations across the city

Staff Absence

5.13%

Costing £3.1million

(5.4% Scottish average, 2017/18)

Full time/Part-time split

52% part-time

48% full time

Challenges & Risks

Workforce planning is a moving feast with multiple dependencies and complexities. In order to secure the workforce required to deliver our organisational priorities we need to consider these on a regular basis. These include skill shortages in specific fields and occupations, ensuring we are attracting, retaining and retraining our staff. We are integrating as we will never have enough resource to meet the demands of population.

Some of our biggest challenges currently are:

- By 2037, Aberdeen's over 65s population will increase by almost 56%. With projection that the over 75s population is projected to grow by around 70%. This likely means a huge increase in the demand on services but also a decrease in available workforce. However Aberdeen does have the highest proportion of working age population than the rest of Scotland.

- There is a national shortage of social workers with a drop of nearly 32% over the past five years of students completing the course, additionally there has been a drop in the number of students applying to join the profession

- Reducing the levels of turnover within services with high rates. As people leave, the organisation loses critical experience and expertise and invokes costs. The average costs of a leaver is £30,000 **(*incl. lost output, recruitment cost, management time, ref. Oxford Economies Report 2014).** We want to have those who work here to want to stay. In addition, we have anecdotal evidence about staff leaving for instance, due to work pressures, or lack of flexibility. More work should be under taken to monitor and record exit interviews with staff to ensure that we understand the reasons why staff are leaving us and address these.

- Within the medical workforce there have been decreases of GPs in recent years and again this is impacting on our current workforce supply. This causes large costs in terms of locum cover. Better cross service and integrated working to support individuals better and meet the demands appropriately in Primary Care and reduce the workload on GPs
(Ref: ACHSCP Primary Care Improvement Plan, 2018)

- High level of vacancies in particular in nursing and mental health. We need to improve pathways from our schools and Higher Education Institutions for our young people to easily access work and work experience opportunities.

- Locality working looks to deliver more integrated health and social care services (less silos) and to improve access by delivering more locally based services. Recent studies also note the impact of social isolation and the importance of connecting communities and to help build real and lasting relationships to address this.

- Care worker recruitment is a huge challenge. The health and social care system depends on care to deliver services to those most vulnerable in society. This is a huge challenge with a budget of £90million.

- We have lengthy recruitment processes and the longer that we take to recruit staff the more likely that these people will take up employment elsewhere.

What do we want to achieve?

A workshop with key stakeholders including the senior leadership team, exam-aged school children and their teacher from Harlaw Academy took place in November 2018. This wordle represents the outputs of discussion regarding what the organisation should seek to achieve and will be used as priority areas for our action plan to focus our work on:

Collaborative Working

To facilitate and enable integrated working and development of equal partnership with communities.
By leaders at all levels being compassionate, supportive and thoughtful in responding to staff and situations this will ensure everyone feels valued, equal and empowered. This is an essential ingredient for the partnership's success and sustainability.

Development of new training & Skills and sharing of current

We will require new skills and knowledge to deliver services in the future. By becoming more flexible and better use of mobile technology staff can have better work/life balance. We need to share cross-system training, coaching and development opportunities to ensure all colleagues have equal opportunity and diverse training.

Living healthy for longer

Whilst we expect out population and staff to live longer there is a projection that the number of ill health years will also increase. We recognise there are health inequalities in our workforce which we will need to address in different and engaging ways.

Better use of space to ensure effective use of resources

North East Economy

The north east economy fluctuations with the oil economy in the area which impacts on health and social care recruitment of staff.

Independent & Third Sector

The value and contribution of the third and independent sector needs to be recognised for the difference it makes to the communities across Aberdeen.

Opportunities of greater collaboration and coproduction of services would greatly improve effectiveness.

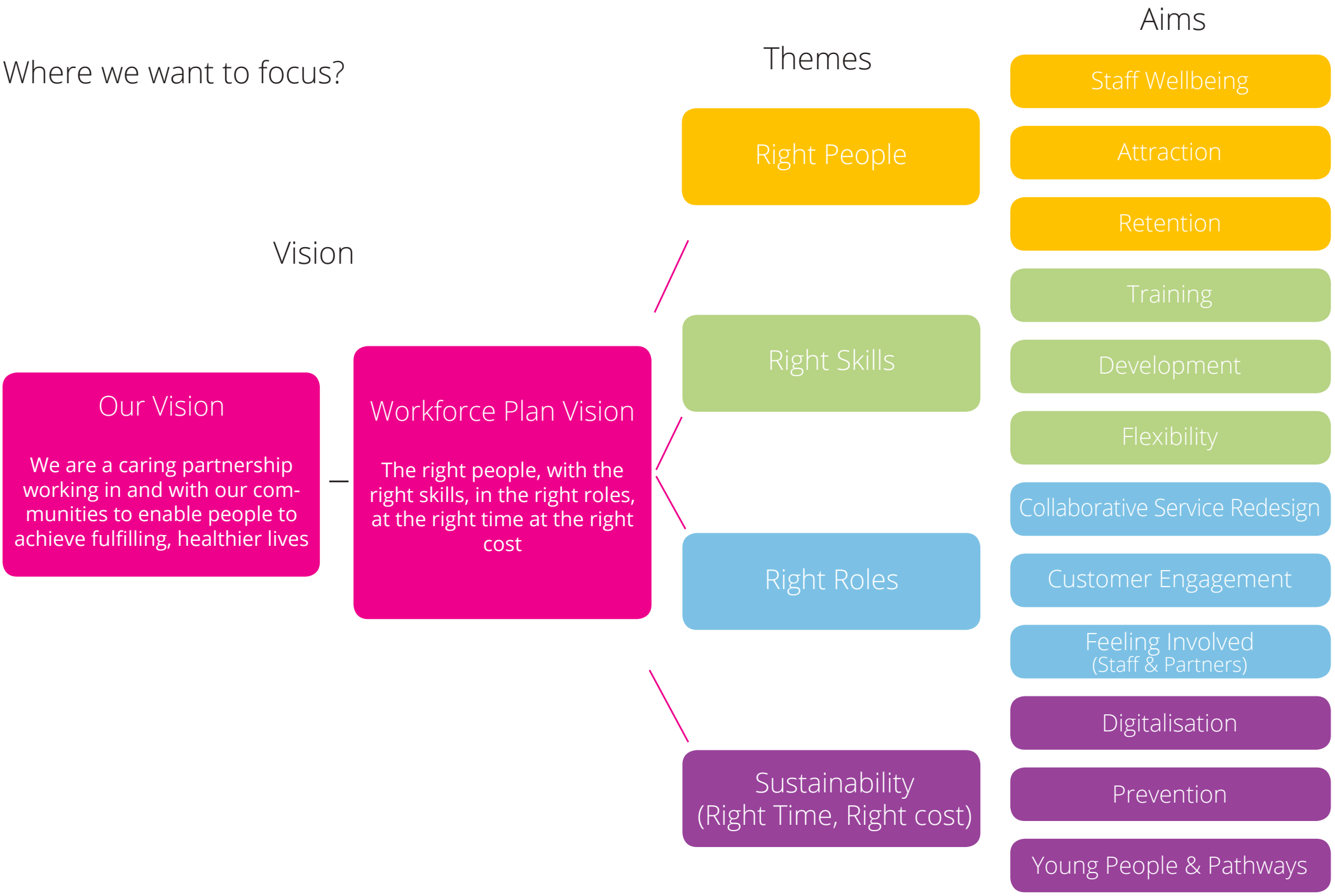
Releasing Capacity

We are committed to making the best use of our resources to deliver best value in improving outcomes for people.

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.

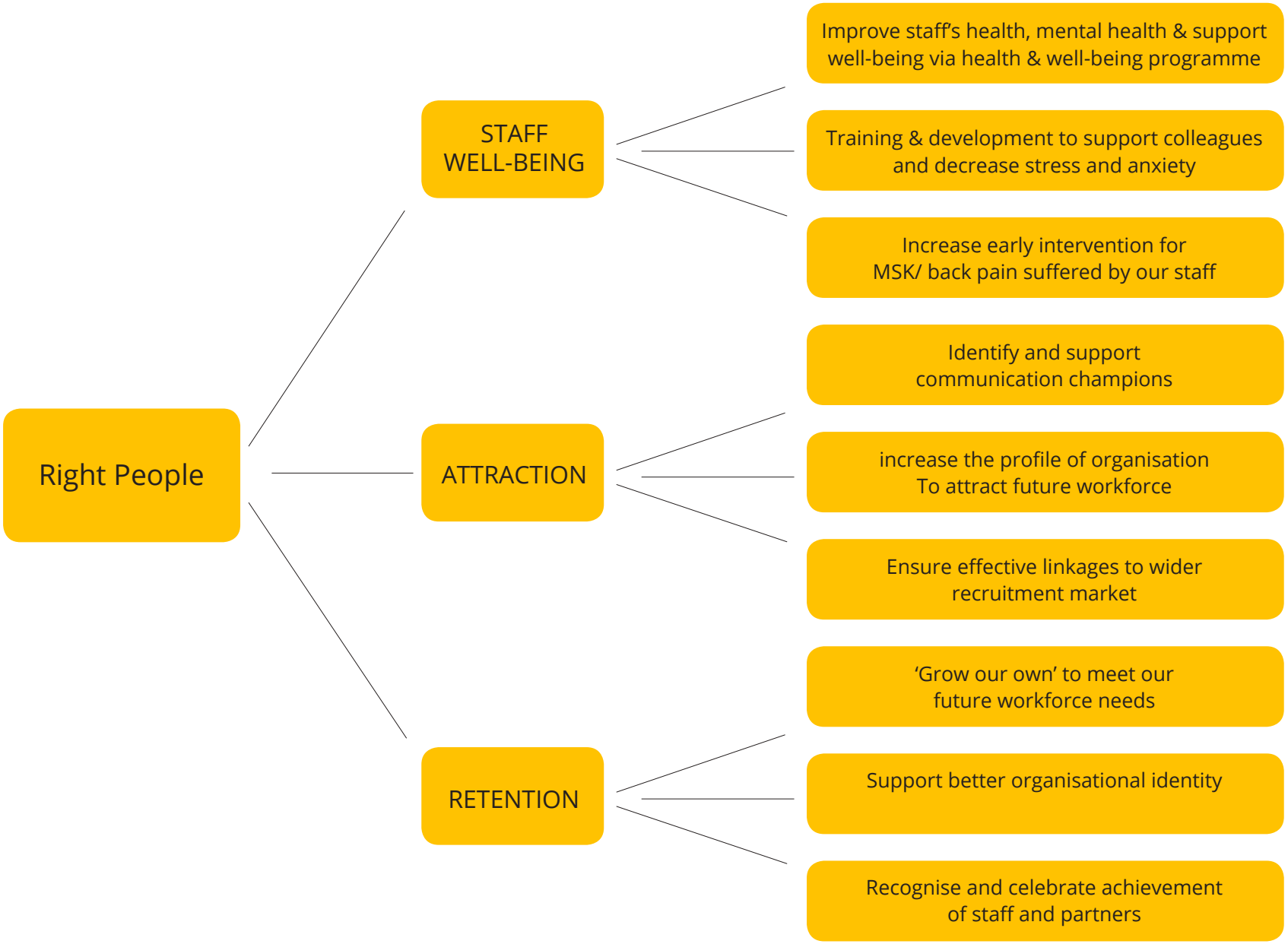
We have inherent challenges in implementation and ensuring staff have the necessary skills and support to take advantage of new technology.

Where we want to focus?

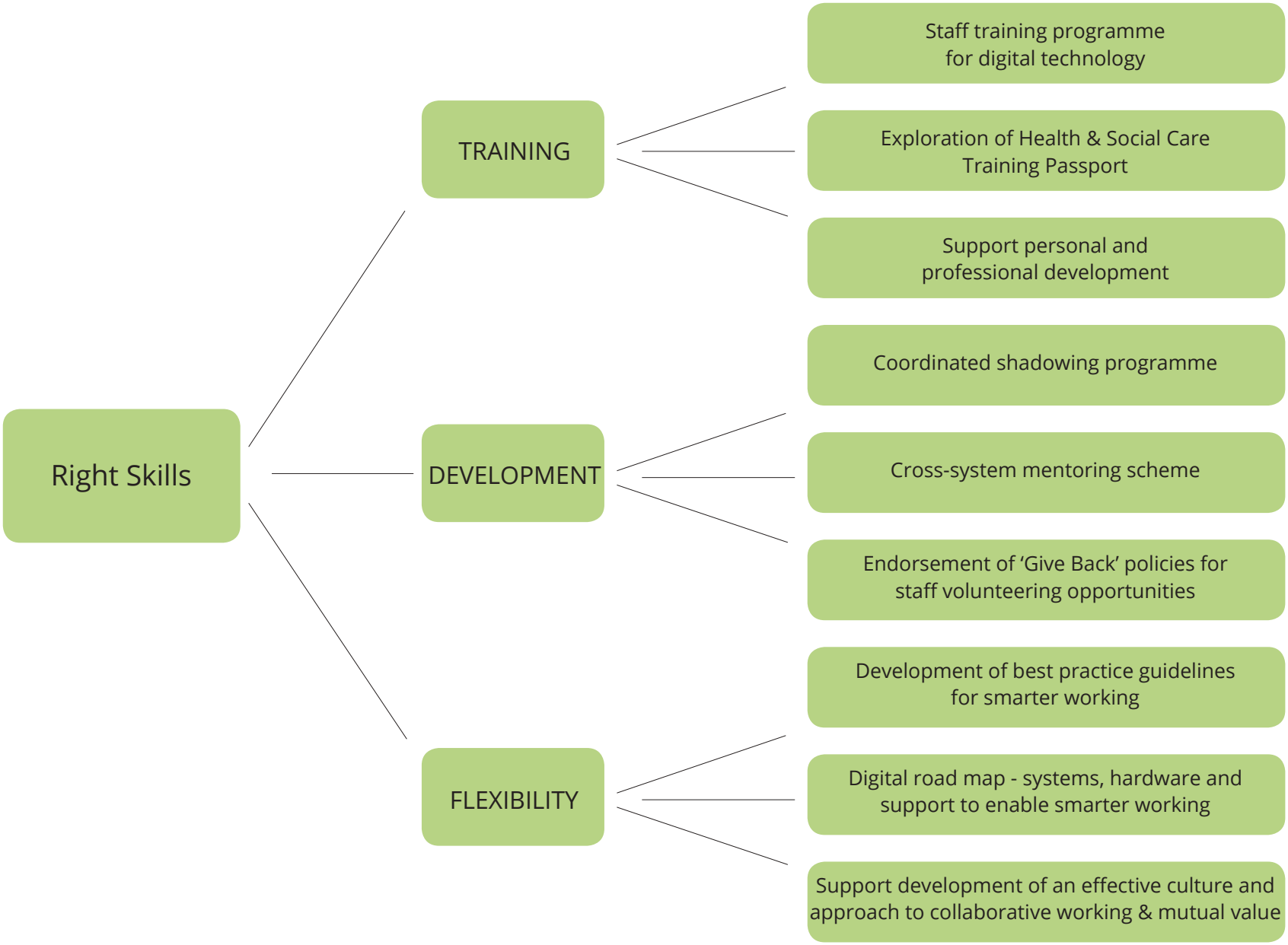


Action Plan Overview: In four parts

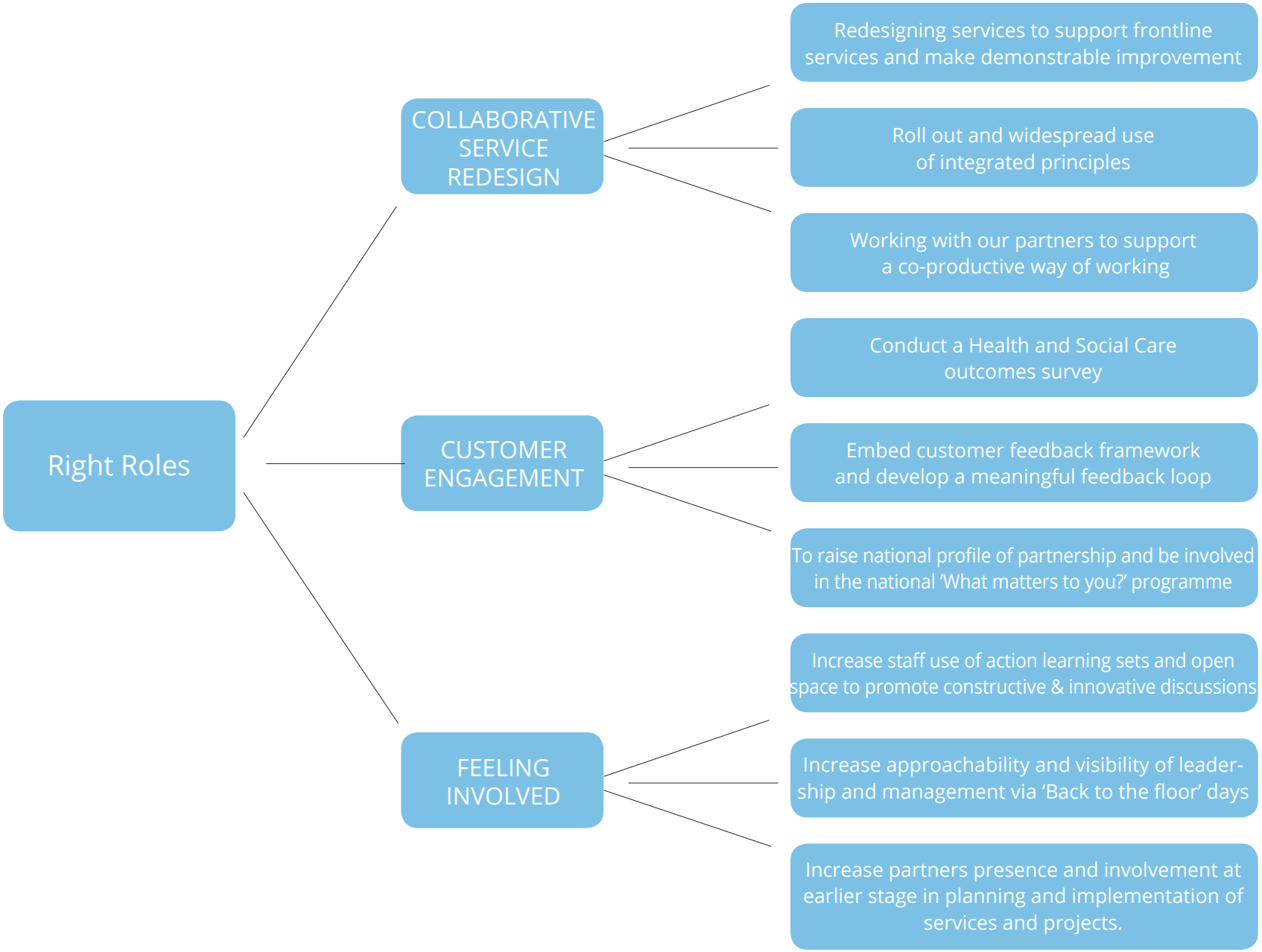
Theme 1



Theme 2


Right Skills
TRAINING
DEVELOPMENT
FLEXIBILITY
Staff training programme for digital technology
Exploration of Health & Social Care Training Passport
Support personal and professional development
Coordinated shadowing programme
Cross-system mentoring scheme
Endorsement of 'Give Back' policies for staff volunteering opportunities
Development of best practice guidelines for smarter working
Digital road map - systems, hardware and support to enable smarter working
Support development of an effective culture and approach to collaborative working & mutual value

Theme 3


Right Roles
COLLABORATIVE SERVICE REDESIGN
CUSTOMER ENGAGEMENT
FEELING INVOLVED
Redesigning services to support frontline services and make demonstrable improvement
Roll out and widespread use of integrated principles
Working with our partners to support a co-productive way of working
Conduct a Health and Social Care outcomes survey
Embed customer feedback framework and develop a meaningful feedback loop
To raise national profile of partnership and be involved in the national 'What matters to you?' programme
Increase staff use of action learning sets and open space to promote constructive & innovative discussions
Increase approachability and visibility of leader-ship and management via 'Back to the floor' days
Increase partners presence and involvement at earlier stage in planning and implementation of services and projects.

Theme 4


Sustainability
DIGITALISATION
To develop a digitally enabled workforce
Development of I.T. Infrastructure and systems for to support the workforce working in the community
Increased use of TEC by identification of TEC champions within the partnership to spread new ways of working
PREVENTION
Ensure staff promote self-management to individuals that they work with
Health literacy – teach back training for all ACHSCP staff to support customers understanding & ability to self-manage
Community connections and referrals to wider community resources
YOUNG PEOPLE & PATHWAYS
Focus on engaging with young people via Career Ready and Developing Young People programmes
Development of a modern apprenticeship approach for ACHSCP
Approach and consider opportunities from the Higher Education Institutions to develop pathways

Next Steps

Monitoring of progress with the actions and intentions set out in the 2019-21 Workforce Plan will be carried out within the governance framework of the partnership. It is accountable and reporting to the Enabling Systems Programme Board. The Organisational Development and Culture Change (ODCC) working group will continue to support the monitoring and delivery of the plan and the projects which it is founded on.

Across the health and care system much of the workforce are already currently engaged in re-thinking pathways of care to create a more integrated and joined-up system in order to improve services for individuals across Aberdeen city. This includes earlier intervention, better preventive and supportive care in community settings, better links between mental health and physical health, and ensuring choice and person led care and support whatever form that may take.

The models of care are clearly still evolving however this plan looks to be adaptive and aims to think through what staff is needed, as well as how continuing professional development and re-training can allow greater flexibility and experience once people are trained. Indeed recognising that much of our future workforce is already currently employed and is indeed our greatest resource and force for change for the better.

"The partnership is more than who we are. It is how we collaborate. It's about having the right people, with the right skills, in the right roles, at the right time, at the right cost"

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INTEGRATION JOINT BOARD

Date of Meeting	26 March 2019
Report Title	Transformation – Decisions Required
Report Number	HSCP.18.151
Lead Officer	Sandra Ross, Chief Officer
Report Author Details	Gail Woodcock Lead Transformation Manager gwoodcock@aberdeencity.gov.uk
Consultation Checklist Completed	Yes
Directions Required	Yes
Appendices	a. Care First Replacement Business Case (CONFIDENTIAL) b. Link Working Change Control c. Link Working in Custody Suite Business Case d. Link Working Direction to ACC e. Community Listening Service Business Case f. Community Listening Service Direction to NHSG g. Unscheduled Care Project development summary h. Interim Housing Direction i. List of projects closed/ moved j. Financial Summary (CONFIDENTIAL)

1. Purpose of the Report

1.1. The purpose of this report is to request approval from the IJB to incur expenditure, and for the Board to make Directions to NHS Grampian and Aberdeen City Council, in relation to projects that sit within the Partnership's Transformation Programme. The report also requests formal approval of a financial change relating to one of the projects within the transformation

programme, and to incur expenditure in relation to the procurement of a new social care system.

1.2. The projects relate to strategic intentions, as set out in the overall Transformation Plan, the Primary Care Improvement Plan (PCIP) and the Action 15 Plan which have been previously approved by the IJB, as key areas of change for delivering on the Strategic Plan.

1.3. The report also brings to the attention of the IJB a refresh of the transformation programme in line with the refreshed strategic plan.

2. Recommendations

2.1. It is recommended that the Integration Joint Board (IJB):

a) Approve the expenditure, as set out in Appendix i, relating to the following projects:

   a. Link Working in Custody Suite
   b. Community Listening Service

b) Approve the expenditure, as set out in Appendix A, for a replacement case management system for Adult Social Work, and instruct the Chief Officer to procure the replacement integrated case management system jointly with Aberdeen City Council Integrated Children's Services, subject to approval by Aberdeen City Council's relevant committee for their share of the project expenditure.

c) Note the progress towards developing integrated Unscheduled Care working in the City.

d) Approve the proposed project change relating to Community Link Working – Links Approach as set out in Appendix C, which would result in the continuation of the existing contract until 2022.

e) Make the Directions relating to the above projects as specified in Appendices D and F and instruct the Chief Officer to issue the Directions to NHS Grampian and Aberdeen City Council as appropriate.

INTEGRATION JOINT BOARD

3. Summary of Key Information

Background

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

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

3.3. In order to allow this report to be considered in a transparent manner, details relating to finances and the procurement of a replacement system for Care First have been attached as confidential appendices.

Review and refresh of Transformation Programme

3.4. Work has been ongoing to review and refresh the transformation programme priorities, in line with the refreshed strategic plan and recognising the progress to date with the implementation of several projects and the resultant opportunities that these changes now bring. The refresh will take a whole systems approach and will use Lean Six Sigma as a tool to support collaborative team work to improve performance by systematically reducing waste and reducing variation across the whole organisation.

3.5. The Transformation Programme for the Aberdeen City Health and Social Care Partnership (ACHSCP), agreed by the IJB in April 2016, included the following priority areas for strategic investment:

- Acute Care at Home;

- Supporting Management of Long-Term Conditions – Building Community Capacity;
- Modernising Primary and Community Care;
- Culture and Organisational Change;
- Strategic Commissioning and Development of Social Care; and
- Information and Communication Technology and Technology Enabled Care (included within a wider work programme also including infrastructure and data sharing)

3.6. The Primary Care Improvement Plan (PCIP), identifies priorities for releasing GP capacity in the city across six pre-identified areas. These are:

1. The Vaccination Transformation Programme
2. Pharmacotherapy Services
3. Community Treatment and Care Services
4. Urgent Care (advanced practitioners)
5. Additional Professional Roles
6. Community Links Practitioners

3.7. The Action 15 Plan, identifies, at a high level, the intentions of the partnership to contribute to supporting the employment of 800 mental health workers across Scotland over the next five years to improve access in key settings. These key settings are A&Es, all GP practices, every police station custody suite, and prisons.

3.8. The draft revised strategic plan includes the following five strategic aims: Prevention, Resilience, Personalisation; Communities; and Connections. It also identifies four key enables for delivery: Empowered Staff; Principled Commissioning; Digital Transformation; Modern & Adaptable Infrastructure; and Sustainable Finance.

3.9. Our learning from the implementation of our transformation programme so far is informing our journey as it progresses, including ensuring that as we move from test of change status to scale up status, we integrate new ways of working with existing business as usual so that our transformation is achieved in an efficient and sustainable manner that maximises our available resources, and in line with our review of localities.

INTEGRATION JOINT BOARD

3.10. A review of the transformation programme has identified a number of projects/ activities that have now concluded or have been moved to a more appropriate operational area.

3.11. The remaining projects and change activities have been restructured into the following programmes, to reflect the funding sources and align to strategic aims and enablers within our revised strategic plan:

Transformation Programme of Work	Links to Strategic Aims & Enablers	Links to Strategic Risk Register*	Links to Medium Term Financial Framework	Comments
Primary Care Improvement Plan	Resilience Personalisation Communities	1, 2, 5, 7, 9	Transformation	Agreed by IJB in July 2018 Specific Funding Source.
Action 15 Plan	Prevention Resilience Personalisation Communities	2, 3, 5, 7, 9	Medicines Management Transformation	Agreed by IJB in July 2018 Specific Funding Source.
Alcohol and Drugs Partnership Plan	Prevention Resilience Personalisation Communities	2, 4, 5, 7, 9	Transformation Medicines Management	Agreed by IJB in December 2018 Part of Community Planning Aberdeen's Local Outcome Improvement Plan. Specific funding source.
Locality Development Transformation Programme	Prevention Resilience Personalisation Communities Connections	1, 2, 4, 7, 8, 9	Transformation Medicines Management Efficiency Savings Service Redesign	Will capture change actions identified in Locality plans. Will also include significant cross-cutting projects such as Unscheduled Care and Social Transport.
Digital Transformation Programme	Prevention Resilience Personalisation Communities	1, 2, 7, 9	Efficiency Savings Transformation	Will support the delivery of the Digital Strategy.

INTEGRATION JOINT BOARD

	Connections Digital Transformation Modern & Adaptable Infrastructure		Medicines Management Service Redesign	
Organisational Development Transformation Programme	Prevention Resilience Personalisation Empowered Staff	6, 7, 8, 9	Service Redesign Transformation	Will support the delivery of the Workforce Plan.
Efficient Resources Transformation Programme	Prevention Resilience Sustainable Finance	1, 2, 7, 9	Efficiency Savings Transformation Service Redesign	Will utilised Lean Six Sigma methodology, working deep within teams delivering services to reduce variation and increase efficiency.
Resilient, Included and Supported Outcome Improvement Plan	Prevention Resilience Communities Connections	4, 7, 8	Medicine Management Transformation	Part of Community Planning Aberdeen's Local Outcome Improvement Plan. No specific funding source.

*Summary of Strategic Risk Register:

1	There is a risk that there is insufficient capacity in the market (or appropriate infrastructure in-house) to fulfil the IJB's duties as outlined in the integration scheme. This includes commissioned services and general medical services.	**High**
2	There is a risk of financial failure, that demand outstrips budget and IJB cannot deliver on priorities, statutory work, and projects an overspend.	**High**
3	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.	**High**
4	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.	**Medium**
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.	**Medium**
6	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	**Medium**
7	Failure to deliver transformation at a pace or scale required by the demographic and financial pressures in the system	**High**
8	There is a risk that the IJB does not maximise the opportunities offered by locality working	**High**
9	There is a risk of failure to recruit and that workforce planning across the Partnership is not sophisticated enough to maintain future service deliver	**High**

INTEGRATION JOINT BOARD

CareFirst Replacement – Background and Business Case Summary

3.12. CareFirst is an IT platform, used by Aberdeen City Council Children's Services and Aberdeen City Health and Social Care Partnership Social Care services. The existing contract is due to expire in March 2020.

3.13. The system hosts highly sensitive and critical data about social care clients and deals with significant values of payments for commissioned care. The system is an essential support for front line social workers (Children's and Adults) when dealing with some of the most vulnerable service users in Aberdeen.

3.14. The business case attached at Appendix A sets out the need and an options appraisal for the procurement of a replacement system. The current system is an older system which has been through many upgrades, and as a result is not always user friendly. Effective caseload management is essential in helping ensure that statutory requirements are met.

3.15. There is an opportunity, through this procurement, to ensure that the replacement system has the future capability to support integrated services such as nursing and allied health professions, along with partner integrated services such as link working.

3.16. It is anticipated that the benefits of a new modern system will include efficiencies in staff time required to support the system, and efficiencies which enable social workers to be able to spend more time directly supporting people and families.

3.17. The preferred option is to procure a new replacement system. As the system supports both adults and children's services, permission to incur expenditure for the replacement of this system is being sought through both the IJB and the appropriate Aberdeen City Council committees.

3.18. The indicative cost for this project is as set out in the business case. (Note this information is commercially sensitive as a procurement process will take place to identify the preferred provider.)

3.19. It is planned that the procurement process will start in April 2019, with a view to commencing implementation of the system in January 2020. It is anticipated that the implementation of the new system will take eighteen months to complete.

Link Workers – change control and extension to Custody Suite

3.20. Link Workers, a key deliverable as part of our Primary Care Improvement Plan, are now operating out of eighteen GP practices, and a recent recruitment exercise has brought the total number of Link Practitioners to 18.35 FTE (20 individuals). This will enable referrals to be received from all GP practices in the city by April 2019.

3.21. When the IJB first provided approval to incur the financial expenditure relating to Link Workers in January 2017, this decision was supported by a business case covering 3 years. A contract for two years with the option to extend for a further two years was entered into with the supplier identified through a robust procurement exercise on the 8th January 2018. We are now approaching the end of the first year of this contract.

3.22. The contract is monitored on a regular basis complying with Following The Public Pound guidance. Fortnightly operational meetings take place as well as quarterly performance review meetings.

3.23. In order to allow full focus to be on the delivery of an effective service, without the distractions that would be result as a requirement to plan for the end of a contractual period, it is recommended that the opportunity to extend the contract for a further two years (to a total of 4 years) is taken up.

3.24. This is in line with the Primary Care Improvement Plan which includes provision for the funding of this service for the remaining 3 years of the extended contract.

3.25. A further opportunity for an extension to the Link Practitioner service has been identified through the Alcohol and Drugs Partnership, which has recommended that a Link Practitioner be based in the Custody Suite at Kittybrewster for an initial 2-year duration.

3.26. This duration would allow for the testing of the Links Approach in this specific location, working with a specific cohort of service users.

3.27. The business case for this custody suite test of change is attached at Appendix C.

3.28. The resultant financial implications for the change control and the Custody Suite test of change is inserted in Appendix I (financial summary). The change control would be funded through Primary Care Improvement Funding and the Custody Suite test of change from the Alcohol and Drugs Partnership for Government 2018-19: additional investment in services to reduce problem drug and alcohol use funding.

Community Listening Service

3.29. The Listening Service is identified in both the Primary Care Improvement Plan and the Action 15 Plan. The Listening service seeks to scale up an existing volunteer service which provides an opportunity for people to talk through anxieties and concerns relating to life with a trained and clinically supervised volunteers.

3.30. The service supports the development of positive health behaviours in terms of supporting people to take ownership of their own lives (early intervention/ prevention), as well as providing opportunities for volunteers to contribute to the wellbeing of others.

3.31. The service has been operating on a small scale for 7 years and evidence shows that it supports those who are isolated. The model provides a complementary form of support to people, including those are may feel more

isolated in their preferred place of care, as carers as friends and family die or move away. This service is complementary to our Link Practitioner service.

3.32. The listener volunteers are supported via a Coordinator role and receive clinical support.

3.33. Please refer to Appendix I for the financial breakdown for the project

Unscheduled Care

3.34. This project seeks to establish an approach to delivering unscheduled care within Aberdeen that builds on learning taken from INCA, West Visits and Acute Care at Home projects. Through the project, integrated community teams will work together to provide joined up care to those with unscheduled care needs.

3.35. It includes the implementation of enabling operational structures on a cross city and locality basis. Key elements of the overall project include: a single point of contact for receiving and processing of referrals; a multi-disciplinary team approach to the identification and management of appropriate cases for early preventative intervention; and a multi-disciplinary team approach to case management and the delivery of treatment and care.

3.36. Currently unscheduled care in Aberdeen is uncoordinated, often characterised by services working in isolation from each other. This can lead to poorer outcomes for people requiring care; and the inefficient use of resources (including those providing care.)

3.37. It is hoped that an integrated stepped care approach, particularly around the provision of acute care at home and enhanced community support, will lead to better outcomes and reduced levels of hospital admissions.

3.38. It is intended to implement this integrated way of working at scale, as far as possible utilising existing resources (noting that some initial additional resource will be required over the first two years to support the transition into this way of working.

3.39. Work is ongoing to develop a business case for this project and this business case along with further detail about the project will be brought back to a future IJB. A project development summary is attached at Appendix G.

INTEGRATION JOINT BOARD

Interim Housing Project

Over the past twelve months, the Partnership has worked jointly with Aberdeen City Council Housing, NHS Acute Occupational Therapy and Bon Accord Care to address the issue of delayed discharges where re-housing or housing adaptations are the main reason for a person remaining in hospital. A pilot project has resulted in two level access properties (one in the north and one in the south of the city) being fully adapted to meet a broad variety of disability and accessibility needs. These two properties were put at the disposal of the multidisciplinary teams responsible for discharge from both Aberdeen Royal Infirmary and Woodend Hospital, who were able to place individuals (who would otherwise be delayed in hospital) into these homely settings whilst awaiting rehousing or significant home adaptations.

The results of this pilot have been very positive with indicative savings of over £90,000 already, part way through the project (based on bed days saved) from a full year spending commitment of only £46,000. Given the success of the pilot to date, both the Transforming Communities and Service Delivery Programme Board and the Executive Programme Board of the Partnership have endorsed its continuation and ongoing funding. The project is therefore presented to the IJB for funding of the two properties on an ongoing basis. The financial commitment for 2019/20 will be significantly less than the pilot's initial costs as all one-off adaptations/capital works to the two properties have already been completed. Financial commitment for 2019/20 will be £25,440.07 with future years being uplifted as per Aberdeen City Council rent and council tax budget decisions.

4. Implications for IJB

4.1. Equalities

It is anticipated that the implementation of these plans will have a neutral to positive impact on the protected characteristics as protected by the Equality Act 2010. Equality and Human Rights Impact Assessments are being completed.

4.2. Fairer Scotland Duty

It is anticipated that the implementation of these plans, will have a neutral to positive impact on people affected by socio-economic disadvantage.

4.3. Financial

The recommendations in this report will result in financial expenditure from the Integration and Change budgets (which include Action 15 Funding and Primary Care Improvement Fund). Full details of the financial implications are attached at Appendix I.

4.4 Workforce

The anticipated benefits of the projects include the release of capacity within our General Practitioner workforce (aligning with the PCIP), as well as efficiencies in other areas of general practice.

The Scottish Government has included projections for funding for future years and has advised that it should be assumed that the funding will be recurring and that workforce recruitment to deliver the plans can be progressed as permanent posts where appropriate.

Due to the anticipated magnitude on service delivery, consultation and engagement with staff and trade unions will be key throughout all aspects of transformation. The success of our ambitions will depend on our staff, and hence organisational development and staff training will be a key aspect of delivering transformation.

4.5 Legal

The changes to the Link Practitioner contract will be progressed in line with legal advice. The Care First replacement project will be procured using agreed processes/ frameworks as appropriate. At this time, there are no anticipated legal implications for the other projects referred to in this report.

4.6 Other - NA

5. Links to ACHSCP Strategic Plan

5.1. The recommendations in this report seek to deliver aspects of the Primary Care Improvement Plan, and there are clear links to the wider strategic plan including supporting and improving the health, wellbeing and quality of life of our local population, and supporting our staff to deliver high quality services that have a positive impact on personal experiences on outcomes.

INTEGRATION JOINT BOARD

6. Management of Risk

6.1. Identified risks(s)

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

In respect of the projects included with this report, risks relate to implications for primary care if capacity is not created within General Practitioner workload to allow the new GMS contract to be implemented.

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

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

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

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

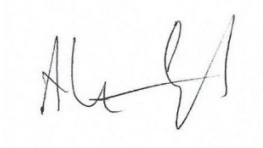
1.B – Risk of Market Failure (General Practice Services)

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

The report seeks approval to progress a number of projects which will directly positively contribute to mitigating these risks.

Approvals	
Sandra Ross	Sandra Ross (Chief Officer)

INTEGRATION JOINT BOARD

	Alex Stephen (Chief Finance Officer)

Exempt information as described in paragraph(s) 8 of Schedule 7A
of the Local Government (Scotland) Act 1973.

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Aberdeen City Health & Social Care Partnership
A caring partnership

Programme/ Project Change Request

Project Stage

Implement

Project Name & Reference No.	**Community Link Working SM201**	**Associated Programme**	**Transforming Communities and Service Delivery**
Programme Manager	**Jo Hall**	**Date of Change request**	**23/1/2019**
Approved By		**Date of Approval**	

1. Change Request Information	
Change Request Name	**Community Link Working – additional link practitioner for custody suite**
Change Control Number	17
Priority/ Urgency	Medium
Requested By	Jo Hall
Request Date	04/03/19

2. Change Description
To extend the contract arrangements currently in place with the Scottish Association of Mental Health who provide link practitioner within primary care settings to include an additional link practitioner for the custody suite for a two-year period. This extension will provide support to introduce a link practitioner into the custody suite at Kittybrewster.

3. Assessment of Impact to Programme	
Benefits	In Aberdeen, both the Alcohol and Drugs Partnership (ADP) and Police Scotland have identified a need to adopt new approaches and take additional steps to support the health and wellbeing of those in custody. This project will support the following ADP workstreams: • Workstream 2: Reducing Harm, Morbidity and Mortality • Workstream 3: Service Quality Improvement • Workstream 5: Intelligence Led Delivery
Scope	By implementing a linking working approach within the custody suite at Kittybrewster, similar to that which is currently being rolled out across GP

	practices in Aberdeen City, it is anticipated that the resource, will help address socioeconomic inequalities and social determinants of health. The programme is envisaged to reduce pressures on mainstream primary and community care services by meeting a need for joined up support across the Health and Social Care Partnership. This will be achieved by embedding a Link Practitioner into the Kittybrewster custody suite and supporting them to appropriately with link community, local GP practices and ACHSCP locality teams.
Cost	The budget for this element of the project is £78,905. This will enable a test of change to take place and provide a link practitioner in the custody suite for a 2-year period.
Spend	The change will result in an additional spend of £78,905.52. This expenditure was approved by the Alcohol and Drugs Partnership subject to integrated Joint Board ratification.
Time	The time scale for this change is two years from the start date of the link practitioner being deployed into the custody suite.
Blueprint	Work is ongoing to develop the blue print for sustainable provision. This work also contributes to the work being carried out within the custody suite as part of Action 15.
Other	

	Business Case	Project Stage **Define**

Project Name	Link Practitioner (Custody Suite)	**Date**	16.11.18
Author	Jenny McCann Community Links Development Manager	**Version**	V1.2

Contents

1. Business Need

Evidence tells us that those within a custody setting have poorer health and wellbeing outcomes, with people experiencing high levels of mental health problems, trauma, learning difficulties (sometimes undiagnosed) and challenges with problem alcohol and substance use.

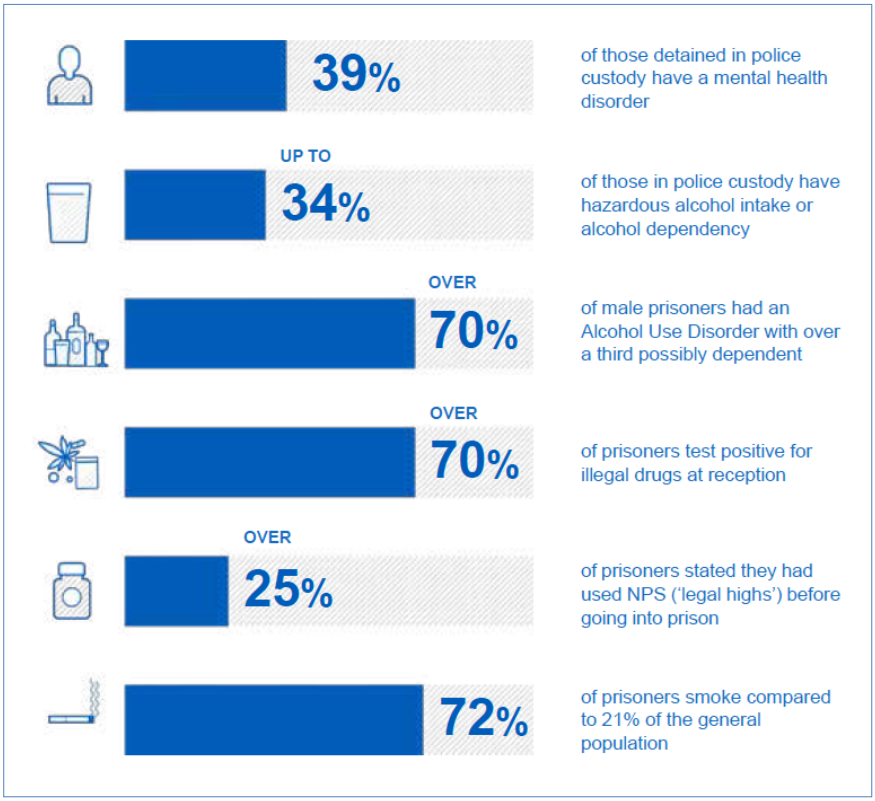


Fig 1 Recent data on the health and wellbeing of those in custody in Scotland[1]

These health and wellbeing challenges will often co-exist with long term social disadvantages and are directly linked to the wider determinants of people's health. Nationally there has been a commitment to work with others to improve health and wellbeing in justice settings, focusing on mental health and substance use and to adopt approaches with a focus of prevention and early intervention to both contribute to reducing health inequalities and improving wellbeing and life chances[1].

Reduced resources and growing demand across Health and Social Care means that there is a need to shift the focus from managing symptoms to prevention and resolving underlying causes. The development of a link working approach takes a step towards holistic management of individuals by introducing a complimentary non-medical skill set to primary care as well as supporting existing staff to adopt the links approach

[1] **Justice in Scotland: Vision and Priorities (2017) https://www.gov.scot/publications/justice-scotland-vision-priorities/**

In Aberdeen, both the Alcohol and Drugs Partnership (ADP) and Police Scotland have identified a need to adopt new approaches and take additional steps to support the health and wellbeing of those in custody.

This project will support the following ADP workstreams:

- Workstream 2: Reducing Harm, Morbidity and Mortality
- Workstream 3: Service Quality Improvement
- Workstream 5: Intelligence Led Delivery

By ensuring that drug and alcohol strategies are responsive to the developing community justice agenda we aim to increase the uptake and retention of people in the justice system with drug and alcohol problems in specialist services over the next 2 years through improved data gathering, intelligence and joint working, specifically

- Ensure that when those in community based drug / alcohol treatment or mental health treatment enter and leave the community justice system that their treatment programme is continued
- Ensure those entering the community justice system who are not currently in community based treatment for drug / alcohol issues or primary health care are afforded opportunities to engage
- Ensure that other underlying issues relating to an individuals' health, wellbeing and offending are identified and supported, such as housing issues, benefits

This project will identify unmet needs in terms of physical health as well as mental health and contribute the Action 15 developments that are also planned for Kittybrewster Custody Suite.

The project will also contribute data and intelligence to help inform a health needs analysis being undertaken by Public Health in relation to health and wellbeing and will also inform the work of the MCN for BBVs and Sexual Health.

Outcomes from the project will contribute to discussions about a pan Grampian response to health and wellbing and police custody.

By implementing a linking working approach within the custody suite at Kittybrewster, similar to that which is currently being rolled out across GP practices in Aberdeen City, it is anticipated that the resource, will help address socioeconomic inequalities and social determinants of health (depending on an individual's motivation and desire to engage). The programme is envisaged to reduce pressures on mainstream primary and community care services by meeting a need for joined up support across the Health and Social Care Partnership. This will be achieved by embedding a Link Practitioner into the Kittybrewster custody suite and supporting them to appropriately with link community, local GP practices and ACHSCP locality teams.

The Kittybrewster Custody Suite has a throughput/ footfall of 10,000 people a year (approximately 80% men, and 20% women). Through the provision of a link practitioner within the custody suite we will be able to support and enable change for those ready to take the next step to addressing health and wellbeing challenges within their lives. It is anticipated that by providing a service within the custody suite (as opposed to be referred to an external service) we will be able to provide a more motivating point to engage with support. This has been shown to be the be case with the delivery of recovery services, and we plan to apply the same approach to a different setting.

The partnership recognises the current (and future) challenges posed by an ageing population with long-term health conditions (both within the justice system and wider community) and the prevalence of Health inequalities combined with fiscal challenges. Whilst the 2014 health and wellbeing profile of the residents of Aberdeen City[2] show statistically significant scores above national average for several indicators (e.g. life expectancy (males), patients hospitalised with cerebrovascular disease and patients prescribed drugs for anxiety/depression/psychosis) there are areas where Aberdeen scores statistically significantly worse than the national average (e.g. drug related deaths, alcohol and drug related hospital admissions; patients hospitalised with coronary heart disease; people (65+) with intensive needs cared for at home).

The ACHSCP is committed to carefully considering approaches to reduce health and social inequalities and in particular, to balance provision of universal or more targeted service delivery with identified needs in and across localities. The Link Working Programme reflects this commitment and will be an important development to achieve this.

The project will provide an opportunity to scope and more deeply understand the demand locally for a link practitioner within the custody suite. It seeks to build on the initial successes and intelligence gained from the implementation of the link working approach within Aberdeen City, by utilising the community link working approach as a framework to facilitate transformational change within primary and community care. The programme will provide an opportunity to add intelligence about ways to prevent and reduce health inequalities and support an improved focus on person centre care planning and self-management.

The underpinning goal of the Link Working Programme is to assist primary care teams (and the wider health and social care system) to develop new capacities to become more effective in enabling patient self-management and supporting people to live more interconnected lives, which support their general wellbeing and sense of belonging.

The project aligns strongly with the aspirations as set out in Aberdeen City Health and Social Care Partnership's Strategic Plan and aims to support delivery of the strategic priorities.

2. Objectives

List the project's objectives. Make these tangible and clear as they will influence which option is recommended and will be used to monitor project progress and success.

To test a new way of person-centred working in a new setting – the approach has been tested in GP Practices, this would see it tested in the custody suite

Promote person centred care - provide support and advice that is responsive to individual personal preferences, needs and value at a time when they most need it

Improved service effectiveness and efficiency - achieve more effective use of resources across the partnership and Police Scotland. These resources include staff, buildings, information, and technology.

[2] **ScotPHO (2014)** ***Health and Wellbeing Profiles 2014 (Aberdeen City).*** **Available from: https://scotpho.nhsnss.scot.nhs.uk/scotpho/profileSelectAction.do**

Improved staff satisfaction – staff morale and cohesion will be improved
Improve health and wellbeing of community – people will have improved opportunities to access support to live well at a point when they are in.
Support transformational change to the way we deliver health and social care through a model that focuses on community resources and prevention – increase number and quality of connections between the custody suite and other sectors in the community.

3. Options Appraisal

3.1 Option 1 – Do Nothing (Status Quo)	
Description	*Describe the option and show to what extent it fulfils the project's stated objectives and any other benefits.* This option involves continuation of status quo
Expected Costs	*Detail the estimated costs involved with implementing this option, including whole life costing where appropriate.* As per current costs
Risks Specific to this Option	*Describe any significant risks which are specific to this option and any mitigating action.* Risks are managed as per existing arrangements
Advantages & Disadvantages	*Weigh up the main pros and cons of this option.* **Advantages:** No change required No additional activity required. No additional costs. **Disadvantages:** Missed opportunity to test evidenced new way of working in a new environment Potential advantages may be missed. Possibility of low staff morale due to difficulty of caring for people in a holistic way. Clinical staff may end up undertaking inappropriate tasks No improvements in outcomes for citizens from existing system
Other Points	Any other relevant information.

3.2 Option 2 – Appoint a Link Practitioner within the Custody Suite for one year	
Description	*Describe the option and show to what extent it fulfils the project's stated objectives and any other benefits.* This option involves employing a link practitioner for one year to work alongside the Custody Health Care Team in the Kittybrewster Custody Suite.
Expected Costs	*Detail the estimated costs involved with implementing this option, including whole life costing where appropriate.* Costs relate to the provision of a link practitioner/ 1WTE equivalent link worker and associated training and IT requirements for one year
Risks Specific to this Option	*Describe any significant risks which are specific to this option and any mitigating action.* There is a risk that we may not be able to recruit a link practitioner for one year One year is insufficient time to and would be unable to demonstrate impact of programme.
Advantages & Disadvantages	*Weigh up the main pros and cons of this option.* **Advantages:** Limited Costs Small scale test over a short time period requires less resource and support; Opportunity to test the design of systems to manage two-way communication/feedback between local agencies/third sector and custody care team within the custody suite; **Disadvantages:** There is already evidence available about the impact of link practitioners. It is suggested that it may be challenging to recruit and retain a (quality) candidate to a post for only one year. If recruitment was possible, such a short time period for the role would limit the potential to effectively test the impact of the project (high risk that a Link Practitioner would leave post prior to the end of the contract) or support the significant transformational shift that is desired;
Other Points	

3.3 Option 3 – Appoint a Link Practitioner within the Custody Suite for two years in line with the current contract commissioned through the Health and Social Care Partnership

Description	*Describe the option and show to what extent it fulfils the project's stated objectives and any other benefits.* This option involves employing a link practitioner for two years to work alongside the Custody Health Care Team in the Kittybrewster Custody Suite.
Expected Costs	*Detail the estimated costs involved with implementing this option, including whole life costing where appropriate.* Costs relate to the provision of 1WTE link worker and associated training and IT requirements for two years
Risks Specific to this Option	*Describe any significant risks which are specific to this option and any mitigating action.* There is a risk that the Custody Health Care Team may not buy into this project and resist its implementation. This is being mitigated through: the cocreation of the project with relevant stakeholders within both the custody suite and the Custody Health Care Team; sharing examples of best practice and the production of clear guidelines and appropriate documentation. There is a risk that the NHS and Police Scotland IT systems are incompatible with those of SAMH. This is being mitigated by working closely with both stakeholders and Alcohol and Drugs Action (who already a service out of the custody suite) to understand what actions can be taken to ensure appropriate IT access.
Advantages & Disadvantages	*Weigh up the main pros and cons of this option.* **Advantages:** Supports testing of a completely new person-centred way of a working within the custody suite; Increased understanding and partnership working and improved relationships across the statutory and voluntary sectors; Opportunity to design systems to manage two-way communication/ feedback between local agencies/third sector and the custody suite; Needs of individual can be assessed holistically and team has an opportunity to work out how best to meet the person's needs; Supports the continued shift to a more person-centred culture; May realise financial efficiencies; Possibility of improved staff and patient experiences; Potential to reduce flow of people through the custody suite (Re-)Connect some of the most vulnerable into Primary Care Services **Disadvantages:**

	Will require funding to support
Other Points	*Any other relevant information.*

3.4 Scoring of Options Against Objectives

Objectives	Options Scoring Against Objectives							
	1	2	3	4	5	6	7	8
To test a new way of person-centred working within the custody suite	0	1	3					
Promote person centred care	1	1	2					
Improved service effectiveness and efficiency	0	1	2					
Improved staff satisfaction	0	1	2					
Improve health and wellbeing of community	0	1	2					
Support transformational change to the way we deliver health and social care through a model that focuses on community resources and prevention	0	1	2					
Total	1	6	13					
Ranking	3	2	1					

Scoring
Fully Delivers = 3
Mostly Delivers = 2
Delivers to a Limited Extent = 1
Does not Deliver = 0
Will have a negative impact on objective = -1

3.5 Recommendation

Based on the options appraisal above, it is recommended that option 3 is delivered

4. Scope

What will the project produce? What are its outputs?

Consider what business services, processes, people and environments will be delivered, affected or changed by the project.

Also define the work the project will carry out to make the transition from the project to 'business as usual'.

Project and Programme Aims:

The community link working programme aims to explore how by embedding link practitioners into primary care teams we can support people to live well in their community. This project will see the extension of the programme to include a link practitioner based within the custody suite at Kittybrewster, working alongside the Custody Health Care team

Community link working is:

- An approach (or range of approaches) for connecting people to non-medical sources of support or resources in the community which are likely to help with the health problems they are experiencing
- Used interchangeably with other terms, such as social prescribing, signposting, and community referral
- Used primarily in primary care and enables staff to draw on non-medical options to support their patients
- Used with a number of different client groups and draws on a wide range of local, city-wide and national support services
- Person-centred and tailored to the individual's needs irrespective of where it is delivered.

This project will be made up of two interrelated interventions; the provision of a custody attached link practitioner, and the development of a broader links approach within the custody suite.

The Link Practitioner – A link practitioner worker is a community orientated role, in this case attached to the custody suite at Kittybrewster, whose primary purpose is to work with individuals who find themselves in custody on a one-to-one basis to help identify and address issues that negatively impact their health. Central to the approach is identifying and supporting individuals to access suitable resources within the community that can benefit their health and increase health competence. They also network with these local community resources to support the development of their own capacity and identify any gaps in local service provision.

Key Elements of model:

- A Link Practitioner will be attached/ embedded into the custody suite as Kittybrewster as an extension to the existing Aberdeen Links Service (which is deploying/will see link practitioners

(employed by Scottish Association of Mental Health [SAMH]) attached to every GP practice in Aberdeen City)

- The custody link practitioner will become part of the existing Aberdeen Links team and will be able to draw upon the existing skill mix within the team, depending on needs and priorities
- Link Practitioners must have the 'right' skills, including excellent listening, communicating and people skills and the ability to develop trusting relationships and have 'good' conversations.
- Initially no specific referral criteria but a focus on 'vulnerable' people
- Person centred approach using common assessment & goal setting tools / outcome focussed
- Custody Health and Police Scotland engagement and support established from the outset and with a commitment to use signposting when appropriate
- Focus on prevention and reducing health inequalities
- Clear referral pathways established to citywide and local third sector service and organisations
- Non-dependency relationship
- Identifies gaps in local / citywide service provision to refer people onto
- Custody and city-wide governance structures in place
- Sustainable funding for third sector service provision
- Community Links Development Manager to oversee and support implementation of the model
- Improvement methodology to be used to evaluate the model

Custody Suite Link Working Outputs:

Custody Suite Goals

- Reduction in the flow of people through the custody suite
- Improved and sustained engagement with most appropriate health and social care services
- Added value to Custody Suite interactions by providing staff with a range of options, including signposting when appropriate, to complement medical care using a more holistic approach
- Custody Health Care staff and referrers confident in and engaged with the link working approach (linking with community assets)
- Enhanced inter-service relationships within wider locality e.g. better communication, exchange of knowledge and ideas

Patient Goals

- Improved links into wider services (Community, Mental health and Primary Care)
- Sustained relationship with services (as appropriate) past initial engagement
- Increases in self-esteem and confidence, sense of control and empowerment
- Reduction in symptoms of anxiety and/or depression, and negative mood
- Improvements in physical health and a healthier lifestyle
- Reduction in isolation (social isolation and loneliness/ isolation from services/ isolation from communities)
- Improvements in motivation and meaning in life, provided hope and optimism about the future
- Acquisition of learning new interests and skills

4.1 Out of Scope

List any notable exclusion, those areas that may be viewed as associated with the project or the affected business area but which are excluded from the scope of the project.

This project will link into a number of transformation projects most significantly with Aberdeen Links Service, as well as the development of Scotland's Services Directory. However, other projects are outwith the scope of this project.

Benefits

Citizen Benefits

Benefit	Measure	Source	Baseline	Expected benefit	Measure frequency
Social connectedness	Loneliness	Outcome Questionnaire	On initial assessment	Reduced loneliness	Baseline @ 6 &12 months
	Participation in groups	Outcome Questionnaire	On initial assessment	Increased connectedness	Baseline @ 6 &12 months
	Social Support	Outcome Questionnaire	On initial assessment	Increased social networks	Baseline @ 6 &12 months
Wellbeing	Resilience	Outcome Questionnaire	On initial assessment	Improved citizen resilience	Baseline @ 6 &12 months
	Quality of life	Outcome Questionnaire	On initial assessment	Improved quality of life	Baseline @ 6 &12 months
	Happiness	Outcome Questionnaire	On initial assessment	Increased happiness	Baseline @ 6 &12 months
Satisfaction	Perception of Link Workers project	Service Questionnaire & Interviews	n/a	Standard and satisfaction with care is no worse than usual care	@ 6 months

Staff Benefit					
Benefit	Measure	Source	Baseline	Expected benefit	Measure frequency
Professional development (Link Practitioner)	Staff development	Staff supervision	Goal setting & job aspiration session during training & induction	New skill development and training opportunities identified & met	Baseline (1 month) @ 6, 12 & 18 months
	Job satisfaction	Service questionnaire	n/a	Staff feel they are empowered to make a difference to people's lives	@ 6 months
	Perceived multi-disciplinary working	Staff feedback	Current perceptions of multi-disciplinary working	Improved multi-disciplinary working	Baseline @ 9 months
Embracing the Link approach (Custody Team)	Understanding of the links approach	Service Questionnaire & Interviews	Current perceptions of the links approach	Improved/ increased engagement with the links approach	Baseline @ 6 months
	Knowledge of community assets	Service Questionnaire & Interviews	Current knowledge levels of community assets	Increased knowledge of and therefore engagement with community assets and services	Baseline @ 6 months
	Confidence of social prescribing	Service Questionnaire & Interviews	Current confidence in social prescribing	Increased linkages with and referrals to community assets	Baseline @ 6 months
	Satisfaction with the Links Approach	Service Questionnaire & Interviews	n/a	Staff feel satisfied with see the value of the links approach	@ 6 months

5. Costs

5.1 Project Capital Expenditure & Income

(£'000)	2017/18	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Total
Sub-Total											

5.2 Project Revenue Expenditure

(£'000)	2018/19	2019/20	2020/21	2021/22	Total
Payroll cost for 1WTE Link Practitioner		£34,812	£34,812		**£69,624.92**
Supplies & Services		£520	£520		£1,010.44
Admin costs		£4,120	£4,120		£8,240.16
Sub - Total		**£39,453**	**£39,453**		**£78,905.52**
Total (Revenue and Capital)		**£39,453**	**£39,453**		**£78,905.52**

6. Procurement Approach

If this project will involve the procurement of products or services, describe the approach that will be taken based upon the recommended option.

The Scottish Association of Mental Health were awarded the contract to deliver the Aberdeen Links Service in January 2018. The provision of a Custody Suite Link Worker will therefore be delivered through an amendment of the existing Aberdeen Links contract.

7. State Aid Implications

Indicate whether this project will have any state aid implications.

There are no anticipated state aid implications.

8. Equalities Impact Assessment

What equalities impacts (including health impacts) with the project have. Indicate whether an equalities impact assessment and/or health impact assessment has or will be undertaken.

The Community Link Working Programme will actively promote the engagement of people from diverse and marginalised groups by:

- Engaging with communities through asset member and spreading approaches in community capacity building to identify and respond to small gaps in services
- Support the engagement of small, local groups from diverse backgrounds
- Encourage processes to make it easy to find, understand and use information

9. Key Risks

Description	**Mitigation**
Fully explain any significant risks to the project, especially those which could affect the decision on whether and in what form the project goes ahead.	*Details of any mitigating action already taken or suggested*
Lack of buy in from the Custody Health Care Team, who therefore resist its implementation.	Cocreation of the project with relevant stakeholders within both the custody suite and the custody health care team; sharing examples of best practice and the production of clear guidelines and appropriate documentation. Custody or ADP representative invited on to Community Link Working Project team to ensure communication and to champion project
Lack of time in programme to achieve clear outcomes	Resource identified to support evaluation and other sources of funding/models may be looked at to extend the programme past 2 years
Lack of capacity in third sector to respond to local need	ACVO Third Sector Interface sit on project team to ensure that any issues are raised and to support the third sector
Lack of information system to support signposting and link practitioner process	Link Practitioner trained to access and input into the new Scotland's Services Directory (a digital platform for health and wellbeing information)

For the proposed new model of service delivery to be effective and to maximise the benefits, full commitment and "buy in" to the new service model and the project from all partners and stakeholders is essential.	Communication and Engagement Strategy to be in place
Difficulty in sharing patient information between Custody Health Care Team and link practitioner	Ongoing dialogues with information governance and data sharing teams to ensure process in place.
NHS and Police Scotland IT systems are incompatible with those of SAMH.	Ongoing close working with both stakeholders and Alcohol and Drugs Action (who already deliver a service within the custody suite) to understand what actions can be taken to ensure appropriate IT access
Project Delay	Project Plan to be in place and monitored at project team meetings

10. Time

10.1 Time Constraints & Aspirations

Detail any planned or agreed dates, any time constraints on the project or the affected business areas and any other known timescales.

This link practitioner resource will be provided by SAMH, following an amendment to the current contract. The link practitioner resource will commence in late June 2019 and will run for an initial 2 year duration.

10.2 Key Milestones

Description	Target Date
ADP Board approval of Business Case and to incur expenditure	07.12.18
IJB approval	26.03.19
Amendment of Contract	April 2019
Recruitment of Link Practitioner	April/May 2019
Go live date	June 2019

11. Governance

Include any plans around the ownership and governance of the project and identify the people in the key project roles in the table below.

This project will sit within the Programme Management Structure of the Aberdeen City Health and Social Care Partnership.

A project team is in place for the Community Link Working Project, this project team reports through the Self-Management and Building Community Capacity working group to the Transforming Communities and Service Delivery Programme Board, and ultimately the Executive Programme Board and IJB.

The project will also report back to the Alcohol and Drugs Partnership Board through project highlight reports on a quarterly basis.

Role	Name
Project Sponsor	Gail Woodcock, Lead Transformation Manager
Project Manager	Jo Hall – Transformation Programme Manager
Implementation Lead	Jenny McCann - Community Links Development Manager
Other Project Roles	ADP representative and/or Custody Suite Representative Shona Alexander – Practice Manager Dr Robert Caslake – ACHSCO Community Geriatrics Service Donna Dickson – Practice Manager Dr Raj Gupta – General Practice Clinical Lead Susan Morrison – Partnership Officer, ACVO Jane Russell – Partnership Manager, ACVO Calum Leask – Research Manager Cliff Watt – Community Business Manager, SAMH Cat Anderson – Project Implementation Manager, SAMH Graeme Henderson – Director, SAMH Jenny Wooley – Senior Primary Care Link Practitioner

12. Resources

Task	Responsible Service/Team	Start Date	End Date
Legal Advice - Contract (ACC)	Alison Watson – ACC Solicitor Lorna McColl – Central Legal Office	November 2018	ongoing
Data Sharing/ Information Governance Advice	Roohi Bains	November 2018	ongoing
ICT			

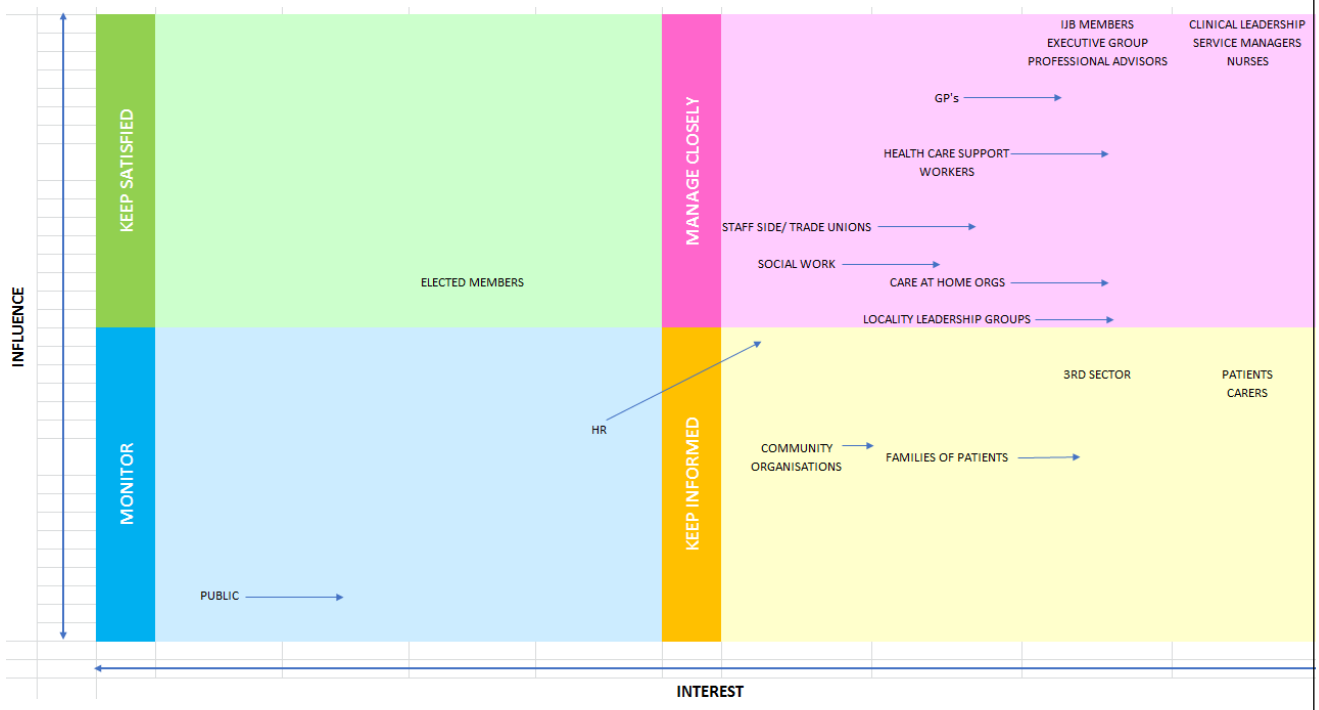
13. Environmental Management

Fully explain any impacts the project will have on the environment (this could include, for example: carbon dioxide emissions, waste, water, natural environment, air quality and adaptation). Include both positive and negative effects and how these will be managed. Include details on how this has been assessed; giving an idea of the cost implication if this exists.

The project should have a neutral impact on the environment as the team will be locally based.

14. Stakeholders

List the key interested individuals, teams, groups or parties that may be affected by the project or have an interest in it, including those external to the organisation. Show what their interest would be and their level of responsibility. Also discuss any plans for how they will be engaged including the use of any existing communication channels, forums or mechanisms already in place.



A stakeholder matrix has been developed by the Project Team as above. Due to the significant number of stakeholders affected by the project it is imperative that a communication strategy is developed which will consider appropriate ways to ensure communication throughout the duration of the project.

15. Assumptions

Document the high level assumptions that have been made during the development of the business case and any other unanswered questions that may be significant.

The following assumptions have been made:

- We will be able to amend the existing Community Link Working Contract with SAMH
- That we are able to recruit an appropriate link practitioner
- People in custody will engage with the process

16. Dependencies

Document any projects, initiatives, policies, key decisions or other activities outside the control of the project that need to be taken into account or which may present a risk to the project's success.

This project is part of a wider transformational programme across Aberdeen City intended to radically change the system of health and social care. Whilst this project will have great value on its own, when it is taken together with the other elements of implementing the integration strategies and plans it will provide essential and fundamental support for service change across the city.

Whilst this project is dependent upon the partner organisations successfully dealing with the challenges in a positive and proactive way, it is also a significantly contributing action that is part of the overall approach to dealing with these issues through:

- Promoting people's shared responsibility for prevention, anticipation and self-management
- Improved integration across the ACHSCP and other public and third sector bodies
- Recognition, promotion and development of the link worker roles
- Engagement and buy in from Custody Health Suite staff and Police Scotland staff based at Kittybrewster

17. Constraints

Document any known pressures, limits or restrictions associated with the project.

Constraints are being defined and managed as the project progresses

18. ICT Hardware, Software or Network infrastructure		
Description of change to Hardware, Software or Network Infrastructure	**Approval Required?**	**Date Approval Received**
Mobile device and ICT equipment to be provided by SAMH for Link Practitioner	No	
Network infrastructure to provide ICT access for link practitioner	Ongoing – Police Scotland to lead	

19. Support Services Consulted

Service	Name	Sections Checked / Contributed	Their Comments	Date
Legal	Alan Thomson/ Alison Watson	Legal		
SAMH	Andy McGregor	Finance	Provided budget for business case	November 2018
Custody Health Care Team	Lindsay Ross/ Dr Jennifer Low	Relevant Sections	Information is accurate and happy with content	December 2018

20. Document Revision History

Version	Reason	By	Date
1.1	Draft Business Case	Jenny McCann	16.11.18
1.2	Comments received from Dr Jennifer Low	Jennifer Low	05.12.18
1.3	Updates/amendments	Jo Hall	04.03.19

INTEGRATION JOINT BOARD

DIRECTION

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

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

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

Related Report Number:- HSCP.18.151

Approval from IJB received on:- 26th March 2019

Description of services/functions:-

1. **Links Contract Extension:**

Extend the provision of Link Practitioners in GP practices to a total of 4 years.

2. **Link Practitioner in Custody Suite:**

Provision of a Link Practitioner within the Kittybrewster Custody Suite for period of two years.

Reference to the integration scheme:- Annex 1 Part 2: 12. Primary medical services provided under a general medical services contract, and arrangements for the provision of services made under section 17C of the National Health Service (Scotland) Act 1978, or an arrangement made in pursuance of section 2C(2) of the National Health Service (Scotland) Act 1978(26)

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

The link working approach ties closely with all 5 strategic aims for ACHSCP: prevention; resilience; enabling; connections; and communities.

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

Timescales involved:-

Start date:- 26.03.2019

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

End date:-

- Link Practitioners in GP Practices: 07.01.2022
- Link Practitioners in Kittybrewster Custody Suite: approximately July 2021 (dependent on successful recruitment to post)

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

Associated Budget:-

(£'000)	2018/19	2019/20	2020/21	2021/22	Total
Payroll cost for 1WTE Link Practitioner		£34,812	£34,812		£69,624.92
Supplies & Services		£520	£520		£1,010.44
Admin costs		£4,120	£4,120		£8,240.16
Sub - Total		£39,453	£39,453		£78,905.52
Total (Revenue and Capital)		£39,453	£39,453		£78,905.52

Details of funding source:- TBC

- Link Practitioners in GP Practice: funding attached to Primary Care Improvement Plan
- Link Practitioners in Kittybrewster: Alcohol & Drugs Partnership Funding

Availability:- Confirmed

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

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	Business Case	Project Stage **Define**

Project Name	Community Listening Service	**Date**	02.07.18
Project ID	SM212	**Programme Board**	Transforming Communities and Service Delivery
Author	Jo Hall Transformation Programme Manager Katrina Blackwood, Healthcare Chaplain	**Version**	V1.4

Contents

1. Business Need

Reduced resources and growing demand across Health and Social Care means that there is a need to shift the focus from managing symptoms to prevention and resolving underlying causes.

Since 2011 the NHS Grampian Spiritual Care Department has been developing the listening service in eleven GP surgeries and other healthcare settings. The service is provided in the main by carefully selected, trained and supervised volunteers, supported by experienced chaplains.

Currently the service is co-ordinated by a Band 6 Chaplain, alongside other aspects of the Chaplain's role. With the service expanding it now requires a funded co-ordinator post to continue to deliver the high standard service within Aberdeen City and to expand the service further by growing the volunteer workforce.

The service offers fifty-minute sessions to patients to talk through anxieties and concerns relating to life rather than medical conditions. Most patients return for further appointments until they become more confident in their own coping mechanisms and more resilient. Community Chaplaincy Listening (CCL) helps people explore their deepest hurts and draw strength from their own inner resources and those of the communities of support around them. CCL is a national programme, to be delivered regionally. Evidence shows that it is supportive of patients and professionals releasing time for professionals to deal with issues directly relating to their profession and supporting patients to take ownership of their own concerns, becoming more confident within themselves and building resilience.

It is important to differentiate 'spiritual listening' from other talking therapies offered by health and social care professionals. CCL Listeners do *not* offer counselling or cognitive behavioural therapy or any kind of psychological intervention. Rather they walk alongside the person telling the story, ask the right questions and offer support and encouragement. The role of the CCL Listener is not to fix the problem or issue being described, but to create a safe space for the speaker to verbalise whatever gets in the way of their wellbeing and resilience. It should also be noted that this is a service for Wellbeing and not a faith based or religious service.

The project aligns strongly with the aspirations as set out in Aberdeen City Health and Social Care Partnership's Strategic Plan and aims to support delivery of the strategic priorities:

- Person centred care and support – Spiritual wellbeing is synonymous with Person Centred Care as it supports people in having a voice and confidence to use this.
- Support and improves the health, wellbeing and quality of life in the local population – CCL is delivered within the local community, training volunteers from the local community and

connecting with resources within the local community. Patient Reported Outcome Measures (PROM) research evidences an improvement in health, wellbeing and quality of life.

- Early intervention/prevention – This service supports the development of positive health behaviours in supporting people in taking ownership of their own lives.
- Value and support unpaid carers – unpaid carers often do not recognise the value of the care they provide. It is also recognised that they often do not give time to care for themselves, affecting their own wellbeing. By offering them time to talk they may build their own resilience and therefore be able to continue longer in their caring role benefitting both themselves and the person/people they care for. CCL was referred to in Professor John Swinton's report 'Living Well with Dementia in Aberdeen City: Creating Communities that Care'.
- Health Inequalities – People living with a high level of deprivation often feel isolated with no one to talk to. They may also feel that no one is listening to them. CCL, placed within the community and used by social care and other third sector agencies, could redress this.
- Local community asset – over the seven years of the development of the Listening Service (CCL) evidence shows that it supports those who are isolated. With an aging population people may well feel more isolated in their preferred place of care, as carers, as friends and family die or move away. This model provides a complimentary form of support to people and is essential as part of the pathway of care providing physical, emotional, spiritual and mental wellbeing. Once the Link Workers become established this would be a complimentary service.
- Delivery of a high-quality service – Because of the well-established use of the particular gifts of volunteers in CCL, this is a good model of capacity building without high levels of expenditure. Because of the effective use of volunteers, supported by skilled and experienced chaplains, this service reflects an efficient and effective use of resources of both health and social care. This service now requires a dedicated post to continue to provide a high level of service and expansion.
- Linkage to other self-management projects – The CCL project has strong links to both the community link working project and the House of Care specifically the spiritual pillar of the project.

The approach through this project is also a key deliverable of the partnerships Primary care improvement and action 15 plan.

2. Objectives

List the project's objectives. Make these tangible and clear as they will influence which option is recommended and will be used to monitor project progress and success.

Promote person centred care - provide support and advice that is responsive to individual personal preferences, needs and values.

Improved service effectiveness and efficiency - achieve more effective use of resources across the partnership. These resources include staff, buildings, information, and technology.

Improved staff satisfaction – staff morale and cohesion will be improved

Improve health and wellbeing of staff and community – people will have improved opportunities to access support to live well.

Support transformational change to the way we deliver health and social care through a model that focuses on community resources – increase number and quality of connections between general practices and other sectors in the community that they serve.

3. Options Appraisal

3.1 Option 1 – Do Nothing (Status Quo)	
Description	*Describe the option and show to what extent it fulfils the project's stated objectives and any other benefits.* This option involves continuation of status quo
Expected Costs	*Detail the estimated costs involved with implementing this option, including whole life costing where appropriate.* As per current costs £2,700 per financial year for clinical supervision (£300 per volunteer)
Risks Specific to this Option	*Describe any significant risks which are specific to this option and any mitigating action.* Risks are managed as per existing arrangements Recruitment and retention of volunteers
Advantages & Disadvantages	*Weigh up the main pros and cons of this option.* **Advantages:** No change required No additional activity required. No additional costs. **Disadvantages:** Missed opportunity to expand service and use volunteer workforce Potential advantages may be missed. Possibility of low staff morale due to difficulty of caring for people in a holistic way. Clinical staff may end up undertaking inappropriate tasks No improvements in outcomes for citizens from existing system Missed opportunity to transform the ways in which services have to be delivered in the future.
Other Points	Any other relevant information.

3.2 Option 2 – Part time Chaplaincy Listening Service coordinator for 18.75 hours	
Description	*Describe the option and show to what extent it fulfils the project's stated objectives and any other benefits.* This option involves employing a part time coordinator (18.75 hours) who would: • deliver 2/3 sessions of CCL Listening per week • oversee and support chaplains and volunteers who deliver the service • liaise with GP Practices and Practice Managers • organise Supervision and Value Based Reflective Practice (VBRP) for volunteer listeners and liaise with VBRP facilitator • investigate and prioritise areas where the service would be most supportive • raise awareness of the service and the existing evidence of the difference the service makes • influence colleagues in accepting this service as part of their available tool box of support • promote the service at different health and wellbeing and third sector events • identify future CCL locations • select, train and supervise volunteers deployed into identified areas.
Expected Costs	*Detail the estimated costs involved with implementing this option, including whole life costing where appropriate.* Costs relate to salary costs for the provision of the 0.5 WTE coordinator and associated training and IT requirement. The cost across 4 years would be £128k
Risks Specific to this Option	*Describe any significant risks which are specific to this option and any mitigating action.* There is a risk that we may not be able to recruit to this post We will be unable to meet the demand on the service and increase number of volunteers
Advantages & Disadvantages	*Weigh up the main pros and cons of this option.* **Advantages:** • CCL would be able to develop from a service which is presently placed primarily in primary health care to support social care services and third sector partners. • CCL supports the ACHSCP Strategic Priorities and with its use of volunteers the service would be sustainable. • Needs of individual can be assessed holistically and team has an opportunity to work out how best to meet the person's needs; • Supports the continued shift to a more person-centred culture;

	• May realise financial efficiencies; • Possibility of improved staff and patient experiences; • Quick impact city wide. **Disadvantages:** • Will require funding to support • Will be unable to meet demand of the increase in volunteers across the 4-year period.
Other Points	

3.3 Option 3 – Chaplaincy Listening Service coordinator (0.5WTE) in year 1 and 2 increasing to 1 WTE in year 3 and 4 to support growth in programme.	
Description	*Describe the option and show to what extent it fulfils the project's stated objectives and any other benefits.* This option involves employing 0.5 WTE for 2 years and increasing to one WTE coordinator (37.5 hours) in year 3 and 4 who would: • deliver 4/5 sessions of CCL Listening per week • oversee and support chaplains and volunteers who deliver the service • liaise with GP Practices and Practice Managers organise Supervision and VBRP for volunteer listeners • investigate and prioritise areas where the service would be most supportive • raise awareness of the service and the existing evidence of the difference the service makes • influence colleagues in accepting this service as part of their available tool box of support • promote the service at different health and wellbeing and third sector events • identify future CCL locations • Support increased number of volunteers • select, train and supervise volunteers deployed into identified areas including succession planning • Sustainability of project
Expected Costs	*Detail the estimated costs involved with implementing this option, including whole life costing where appropriate.* Costs relate to salary costs for the provision of the coordinator and associated training and IT requirements. See section 5
Risks Specific to this Option	*Describe any significant risks which are specific to this option and any mitigating action.* There is a risk that we may not be able to recruit to this post

Advantages & Disadvantages	*Weigh up the main pros and cons of this option.* **Advantages:** • CCL in every GP practice in the city when we have full time capacity in post • CCL would be able to develop from a service which is presently placed primarily in primary health care to support social care services and third sector partners. • CCL supports the ACHSCP Strategic Priorities and with its use of volunteers the service would be sustainable. • Needs of individual can be assessed holistically and team has an opportunity to work out how best to meet the person's needs; • Supports the continued shift to a more person-centred culture; • May realise financial efficiencies; • Possibility of improved staff and patient experiences; • Quick impact city wide. • This option would enable the service to accommodate increase in provision provided in other health and social care context e.g. custody suite • The service would be able to plan for the growth in number of volunteers and individuals that it supports. **Disadvantages:** • Will require funding to support
Other Points	

3.4 Scoring of Options Against Objectives

Objectives	Options Scoring Against Objectives							
	1	2	3	4	5	6	7	8
Promote person centred care	1	3	3					
Improved service effectiveness and efficiency	1	2	3					
Improved staff satisfaction	1	2	3					
Improve health and wellbeing of staff and community	1	2	3					
Support transformational change to the way we deliver health and social care through a model that focuses on community resources	0	2	3					
Total	4	11	12					
Ranking	3	2	1					

Scoring
Fully Delivers = 3
Mostly Delivers = 2
Delivers to a Limited Extent = 1
Does not Deliver = 0
Will have a negative impact on objective = -1

3.5 Recommendation
Based on the options appraisal above, it is recommended that option 3 is delivered

4. Scope

What will the project produce? What are its outputs?

Consider what business services, processes, people and environments will be delivered, affected or changed by the project.

Also define the work the project will carry out to make the transition from the project to 'business as usual'.

Programme Aims:

Key Aims:

- To support people and through communities to build resilience
- To compliment the work of other professionals

Outcomes:

- People taking ownership for their own wellbeing
- People being more resilient in facing challenges in their life journey
- Building up resilient communities who can support each other
- Professionals time being freed to use specific skills – specifically GP time
- Professionals knowing, they have a variety of tools to support those in their care and therefore reducing frustration and low morale

The patient journey through the CCL is a simple one. Patients are referred to the service most commonly by their GP; alternatively, they can be referred by another healthcare professional or they can request an appointment themselves. They meet with the Chaplaincy listener who introduces them to the service and what to expect. They then meet with the listener for as many sessions as are needed for them to tell their story, consider the existential issues they are facing and feel some sense of resolution or peace with what is currently happening in their life. The patients decide on the number of sessions they need. Once they feel the burden of their spiritual distress has lightened in some way they discharge themselves from the listening service. Sessions last 50 minutes and patients are free to discharge themselves from the listening service at any time, without explanation.

Current Programme:

The Chaplaincy Listening Service currently has 10 active volunteers who provide on average 2 hours of voluntary support per week. This equates to 1040 hours per annum. In September 2018 there will be a further 6 – 7 volunteers recruited bring total number of volunteers to 16.

In relation to scale up our planned increased in volunteers is as follows:

2018 – 16 volunteers
2019 – 25 volunteers

2020 – 37 volunteers
2021 – 48 volunteers

Rules/ Framework:

RECRUITMENT: Adhere to organisational processes
Interviews/ recruitment by reps of Implementation working group

REFERRALS: Need to build into Communications Strategy

FINANCE: Devolved budget for team

TRAINING: Required training for team members:
Training Plan required

CLINICAL SUPERVISION: Chaplain

HR POLICIES: Comply with corporate policies re sickness absence etc.
Managed by team (discuss with HR)

SERVICE PROVISION: 0.5 WTE increasing to 1 WTE

4.1 Out of Scope

List any notable exclusion, those areas that may be viewed as associated with the project or the affected business area but which are excluded from the scope of the project.

This project will link into several transformation projects; however, other projects are out with the scope of this project.

	Business Case	Project Stage **Define**

Benefits (anticipated benefits are agile and will adapt to complex system in which service operates)

Citizen Benefits

Benefit	Measure	Source	Baseline	Expected benefit	Measure frequency
Improved wellbeing	Perceived resilience Social support	Questionnaire (eg. adapted CARE Measure tool) + Case studies	n/a	Improved citizen wellbeing over duration of service	3 months post implementation
Service satisfaction	Perceived compassion of listeners Perceived quality of listeners			Service acceptable to citizens	

Staff Benefit

Benefit	Measure	Source	Baseline	Expected benefit	Measure frequency
Listeners -Professional Development	Training provided to listeners	CPD log	n/a	Increased professional development through training provision	3 months post implementation
-Improved wellbeing	Sense of belonging Perceived value Overall wellbeing	Questionnaire + Case studies		Improved wellbeing of listeners through volunteering	
General Practice -Satisfaction	Ease of referral process	Questionnaire			

With service	Value of listeners			Listening service acceptable to General Practice staff	

Resource Benefits					
Benefit	**Measure**	**Source**	**baseline**	**Expected benefit**	**Measure frequency**
Reduced pressure on primary care	Number of free hours of care delivered	Service descriptive data	n/a	Free care delivered by listeners will reduce pressure on primary care	3 months post implementation
Reducing health inequalities	Employment	Service Data		Access to listeners provided to users across employment spectrum	
	SIMD	Service Data		Increase in users from deprived areas using CL service	
	Ethnicity	Service Data		Increase in users from ethnic minorities using CL service	

5. Costs

5.1 Project Capital Expenditure & Income

(£'000)	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Total
Mobile Phone	£300										£300
Laptop	£898.75										£899
Sub-Total	£1198.75										**£1199**

(£'000)	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Listening Service Coordinator (Band 6 + oncosts)	£21,820	£22,667	£46,748	£50,276	Recurring	£141,511
Travel Costs (based on 100miles per month @ 40p) + travel to national events	£750	£750	£1,000	£1,000	Recurring	£3,500
ICT Equipment (mobile contract)	£240	£240	£240	£240	Recurring	£960
CCL training	INKIND from chaplaincy care service					
Clinical Supervision	£4,800	£4,800	£4,800	£4,800	Recurring	£19,200
Volunteer Support budget	£2,000	£2,000	£2,000	£2,000	Recurring	£8,000

Marketing and Promotion	£2,000	£1,000	£500	£500		£4,000
Sub - Total	**£31,610**	**£31,457**	**£55,288**	**£58,816**		**£171,171**
Total (Revenue and Capital)	**£32,808**	**£31,457**	**£55,288**	**£58,816**		**£178,369 (4 years)**

6. Procurement Approach

If this project will involve the procurement of products or services, describe the approach that will be taken based upon the recommended option.

7. State Aid Implications

Indicate whether this project will have any state aid implications.

There are no anticipated state aid implications.

8. Equalities Impact Assessment

What equalities impacts (including health impacts) with the project have. Indicate whether an equalities impact assessment and/or health impact assessment has or will be undertaken.

The Listening Service actively promotes the engagement of people from diverse and marginalised groups by:

- Encouraging processes to make it easy to find, understand and use information
- Encouraging people to take ownership for their own wellbeing
- Encouraging people to be more resilient in facing challenges in their life journey
- Building up resilient communities who can support each other

9. Key Risks

Description	Mitigation
Fully explain any significant risks to the project, especially those which could affect the decision on whether and in what form the project goes ahead.	*Details of any mitigating action already taken or suggested*
Difficulty in recruiting coordinator to position	Discussion will be ongoing in relation to advertising and promoting post

Difficulty in recruiting busy practices to participate.	Locality Quality Lead to ensure communication with general practices and to champion programme
For the proposed new model of service delivery to be effective and to maximise the benefits, full commitment and "buy in" to the new service model and the project from all partners and stakeholders is essential.	Communication and Engagement Strategy to be in place
Consulting space within GP practices is limited	Investigate community space and potential hub approach across city

10. Time

10.1 Time Constraints & Aspirations

Detail any planned or agreed dates, any time constraints on the project or the affected business areas and any other known timescales.

It is anticipated that the funding for this post will come through the contribution from Scottish Government for delivering the primary care improvement plan and action 15. It is therefore important that this project is progressed as quickly as possible to ensure no underspend is clawed back.

10.2 Key Milestones

Description	Target Date
Project Team Established	August 2018
Business Care presented to TCSD Programme Board	04.08.18
Draft Business Case to be presented to Executive Programme Board	12.08.18
Chaplaincy Listening Service Coordinator Recruitment commence (develop job profile, job evaluation,	October '18 - January '19
Business Case to go to Executive Programme Board	27.02.19
Business Case to go to Integrated Joint Board for approval	26.03.19
Subject to approval post to be progress through recruitment panel	April - May 2019
Chaplaincy Listening Service Coordinator in post	June 2019

11. Governance

Include any plans around the ownership and governance of the project and identify the people in the key project roles in the table below.

This project sits within the Programme Management Structure of the Aberdeen City Health and Social Care Partnership.

A project team has been established which reports through the Self-Management and Building Community Capacity working group to the Transforming Communities and Service Delivery Programme Board, and ultimately the Executive Programme Board and IJB.

Role	Name
Project Sponsor	Lorraine McKenna (TBC)
Project Manager	Jo Hall – Transformation Programme Manager
Implementation Lead	Katrina Blackwood - Healthcare Chaplain
Other Project Roles	Mark Rodgers - Head of the Spiritual Care Department Dr Calum Leask – Research and Evaluation Team Jane Russell – Partnership Manager, ACVO Anne MacKenzie , Commissioning Lead

12. Resources

Task	Responsible Service/Team	Start Date	End Date
Support with Recruitment	Recruitment Team	September '18	May '19

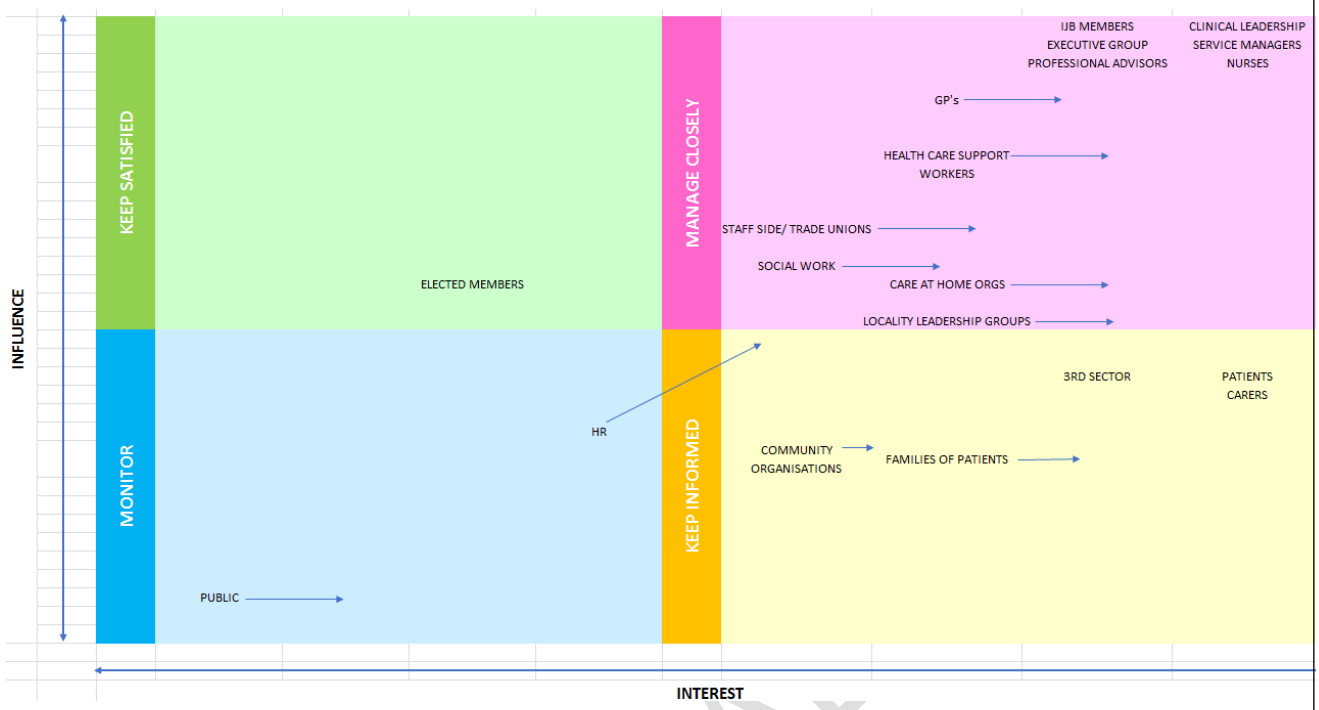
13. Environmental Management

Fully explain any impacts the project will have on the environment (this could include, for example: carbon dioxide emissions, waste, water, natural environment, air quality and adaptation). Include both positive and negative effects and how these will be managed. Include details on how this has been assessed; giving an idea of the cost implication if this exists.

The project should have a neutral impact on the environment as the team will be locally based.

14. Stakeholders

List the key interested individuals, teams, groups or parties that may be affected by the project or have an interest in it, including those external to the organisation. Show what their interest would be and their level of responsibility. Also discuss any plans for how they will be engaged including the use of any existing communication channels, forums or mechanisms already in place.



A stakeholder matrix has been developed by the Project Team as above. Due to the significant number of stakeholders affected by the project it is imperative that a communication strategy is developed which will consider appropriate ways to ensure communication throughout the duration of the project.

15. Assumptions

Document the high level assumptions that have been made during the development of the business case and any other unanswered questions that may be significant.

The following assumptions have been made:

- We will be able to recruit to the coordinator roles
- That there will be support and buy in from GP practices across the city
- Patients will engage with the process

16. Dependencies

Document any projects, initiatives, policies, key decisions or other activities outside the control of the project that need to be taken into account or which may present a risk to the project's success.

This project is part of a wider transformational programme across Aberdeen City intended to radically change the system of health and social care. Whilst this project will have great value on its own, when it is taken together with the other elements of implementing the

integration strategies and plans it will provide essential and fundamental support for service change across the city.

17. Constraints

Document any known pressures, limits or restrictions associated with the project.

Constraints are being defined and managed as the project progresses

18. ICT Hardware, Software or Network infrastructure

Description of change to Hardware, Software or Network Infrastructure	Approval Required?	Date Approval Received
Not required – will be utilising NHS System and office365		

19. Support Services Consulted

Service	Name	Sections Checked / Contributed	Their Comments	Date
Finance	S Thomson / G Parkin	Finance	Ok with financial section	31.08.18
Human Resources	HR Team			

20. Document Revision History

Version	Reason	By	Date
1.1	First draft business case	Jo Hall	02.07.18
1.2	Business Case reviewed by project team	Jo Hall	29.08.18
1.3	Business Case updated	Jo Hall	22.02.19
1.4	Financial updated with new agenda for change salary costs	Jo Hall	15.03.19

INTEGRATION JOINT BOARD

DIRECTION

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

NHS GRAMPIAN is hereby directed to deliver for the Board, the services noted below in pursuance of the functions noted below and within the associated budget noted below.

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

Related Report Number:- HSCP.18.151

Approval from IJB received on:- 26th March 2019

Description of services/functions:-

Chaplaincy Listening Service coordinator (0.5WTE) in year 1 and 2 increasing to 1 WTE in year 3 and 4 to support growth in programme.

Reference to the integration scheme:-

Annex 1, Part 2:

- Primary medical services provided under a general medical services contract, and arrangements for the provision of services made under section 17C of the National Health Service (Scotland) Act 1978, or an arrangement made in pursuance of section 2C(2) of the National Health Service (Scotland) Act 1978(26).
- Mental health services provided outwith a hospital.

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

The project aligns strongly with the aspirations as set out in Aberdeen City Health and Social Care Partnership's Strategic Plan and aims to support delivery of the strategic priorities:

- Person centred care and support
- Support and improves the health, wellbeing and quality of life in the local population
- Early intervention/prevention

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

- Value and support unpaid carers
- Health Inequalities and used by social care and other third sector agencies, could redress this.
- Local community asset
- Delivery of a high-quality service
- Linkage to other self-management projects.

Costs involved:- £178,369 (4 years)

Associated Budget:- Action 15 funding

Availability:- confirmed

Timescales involved:-

Start date:- 26.03.2019

End date:- ongoing (in line with Action 15 Plan)

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

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

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	Unscheduled Care Model Development Update Report	Project Stage **Define**

Project Name	Unscheduled Care	**Date**	11/02/2019
Project Reference No.	TBC – joining Acute Care at Home and West Visits Business Cases	**Governance Programme Board(s)/ IJB**	TCPB EPB IJB
Project Manager/ Author	S McNamee	**Date of Programme Boards/ IJB**	

1. Summary of Project

This project seeks to establish an approach to delivering Unscheduled Care within Aberdeen City which builds on learning taken from the INCA, West Visits project and the Acute Care at Home (AC@H) project. This project requires re-allocation of existing resource including alignment of existing Business as Usual (BAU) teams, AC@H and West Visiting teams, to deliver a coordinated response to Unscheduled Care needs. In the main, these unscheduled needs will be identified by GP / practice who will refer for further assessment / diagnostics and/or the delivery of a treatment and/or care plan. Who completes this assessment will develop and expand as MDTs develop in localities.

The project will include the implementation of enabling operational structures such as:

- A single point of contact / referral / triage (SPOC) for receiving and tasking of referrals (whether this is a city-wide SPOC or smaller locality SPOCs is to be determined)
- A Multi-Disciplinary Team (MDT) approach to the identification and management of appropriate cases for early preventative intervention (proactive case finding using the

electronic frailty index[1] and High Health Gains predictor – via SPIRE (Scottish Primary Care Information Resource – aligns with Silver City approach)

- An MDT approach to case management[2][3] and delivery of treatment and/or care (MDT working in localities / Enhanced Community Support / including the use of the Living Well in Communities (LWiC) MDT framework for good practice.)

2. Business Need

[1] https://ihub.scot/media/1370/20180222-efrailty-care-coordination-poster.pdf
[2] https://www.kingsfund.org.uk/publications/case-management
[3] https://www.kingsfund.org.uk/publications/montefiore-health-system-summary

	Unscheduled Care Model Development Update Report	Project Stage **Define**

Why is this project needed?

Unscheduled Care is usually undertaken in response to the onset of an acute illness or the rapid decline in function of someone living with an existing condition(s). Responses to need for different levels of treatment or care can be broadly categorised in terms of a stepped care approach described in the diagram below.

Unscheduled care across Aberdeen City is currently un-coordinated, often characterised by services working in isolation from each other. This leads to poorer outcomes for those requiring care and inefficient use of resources. The existence of many separate teams with different referral systems and multiple handovers is evidence of the lack of coordination and in-built inefficiency within the system. There are currently higher levels of hospital admissions than could be achieved through a more coordinated approach. A more synchronised approach across 7 days where care could be stepped up and down in response to the needs of an individual would allow for more people to be treated / supported in the community thus avoiding hospital admission.

Initial approaches to resolving these issues (Acute Care at Home - ACH) have been challenging to deliver due to workforce challenges. The completion of assessment and diagnostics through a home visit on behalf of GPs (West Visits) has proven to be of value to GPs and a more effective use of resource and is similar to the initial assessment at home that ACH patients would get. The model articulated in this update report builds on learning from 'pathfinder' projects:

- Acute Care at Home
- West Visits
- Integrated Neighbourhood Care Aberdeen (INCA)

The model of care articulated in this report sees existing community teams using the skills they already possess, or could be supported relatively quickly to develop, to adopt the best bits of the transformative approaches already tested. By embedding them as approaches within a stepped care approach delivered by existing community teams we connect all activity in a pathway that sees all citizens get the right level of support at the right time by the right person.

This project aligns with Partnership strategy as it both enables and relies on connected partnership working. This project also aligns with national strategic direction in shifting the balance of care from hospital to community settings.

What problem does the project seek to resolve? (Admission data)

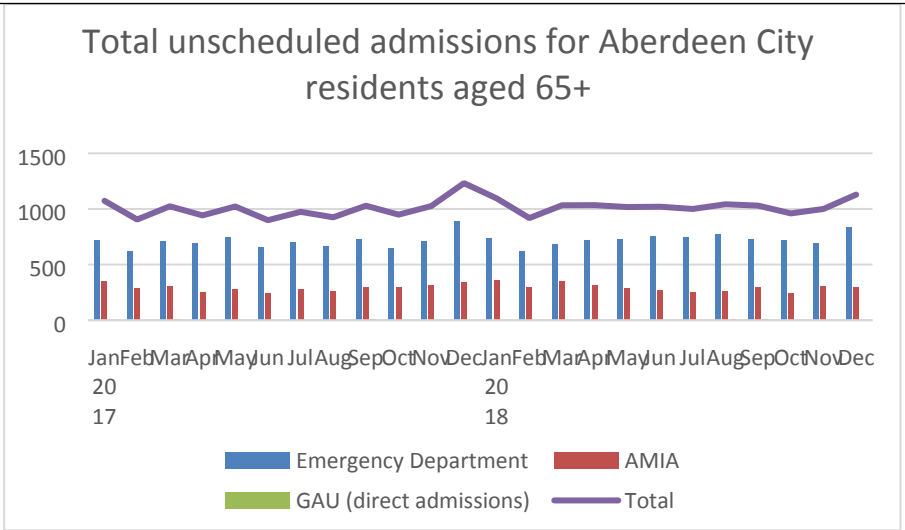
[*In this update report a focus has been placed on Older Adults, however in the final Business Case there will be a wider look at all admissions to give assurance that we are focussing our resource at the segment of our patient base that will make most impact***]**

Predicted demand is modelled on previous demand. Reliable admissions data is taken from discharges recorded on acute systems.

The table and graph below chart all unplanned admissions for Aberdeen City residents aged 65+ for 2017 and 2018. The data shows two things of interest:

- ✓ Generally Unscheduled admissions sit around 1000 per month through Emergency Department (ED) or Acute Medical Initial Assessment area (AMIA)with a very small number admitted through Geriatric Assessment Unit (GAU);
- ✓ Unscheduled admissions generally spike in December

Discharge from	2017											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Emergency Department	719	619	712	687	742	655	697	663	731	648	711	892
AMIA	351	284	308	252	279	242	274	262	294	298	314	337
GAU (direct admission)	3	2	4	3	1	2	3	0	4	3	1	3
Total	1073	905	1024	942	1022	899	974	925	1029	949	1026	1232
Discharge from	**2018**											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Emergency Department	733	615	680	716	727	752	745	773	731	721	694	834
AMIA	361	300	350	317	289	268	254	263	294	238	304	293
GAU (direct admission)	1	3	3	1	1	0	1	6	5	1	2	2
Total	1095	918	1033	1034	1017	1020	1000	1042	1030	960	1000	1129



Impact of admissions from Care Homes

The data above can be further broken down to identify of those admissions how many came from care homes, i.e. known to have a higher need for care and thus more predictable. The table and graph below detail the numbers of admissions form care homes and the percentage of overall admissions to either Emergency Department (ED) or Acute Medical Initial Assessment area (AMIA).

<u>Emergency Department</u>

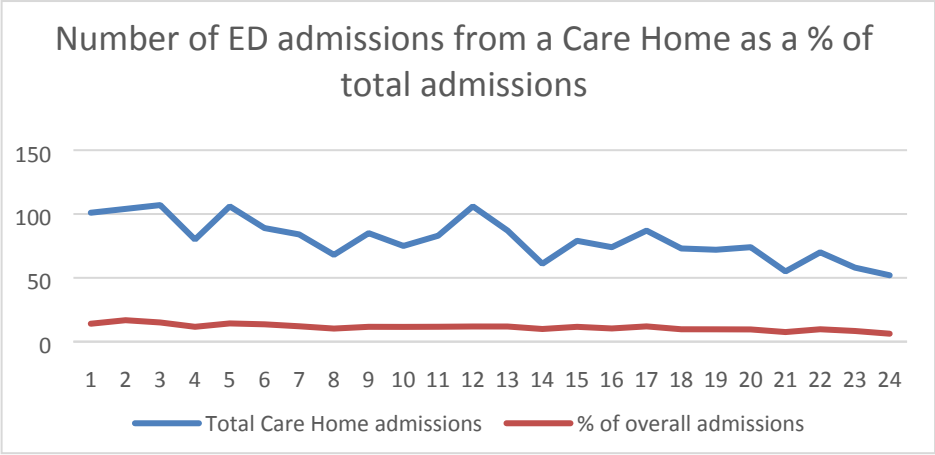
Admissions data to the Emergency Department suggests that:

- ✓ As a percentage of overall admissions to ED the number of admissions from Care Homes has been continually reducing over the last two years.

We know from above that the overall admission figures are relatively stable year on year so there is definitely something different happening in care homes – an improvement. This may be caused by

a number of factors but points to **successful preventative activity having an impact.** If similar strategies are employed for those other patients (Care at Home recipients, people identified at higher risk of admission, those living with multiple morbidities, etc.) then it is fair to assume we can expect to have a similar improvement on admission rates.

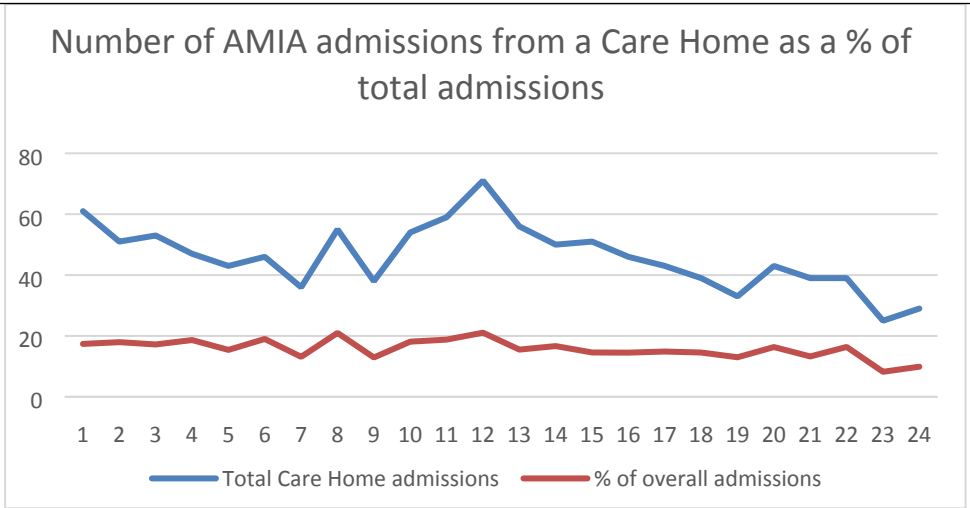
Discharge from	2017											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Emergency Department	719	619	712	687	742	655	697	663	731	648	711	892
Total Care Home admissions	101	104	107	80	106	89	84	68	85	75	83	106
% of overall admissions	14	16.8	15	11.6	14.3	13.6	12.1	10.3	11.6	11.6	11.7	11.9
Discharge from	**2018**											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Emergency Department	733	615	680	716	727	752	745	773	731	721	694	834
Total Care Home admissions	87	61	79	74	87	73	72	74	55	70	58	52
% of overall admissions	11.9	9.92	11.6	10.3	12	9.71	9.66	9.57	7.52	9.71	8.36	6.24



AMIA

If a GP wishes to admit a patient to hospital (in-hours during GP working hours) the admission route will generally be to AMIA rafter than ED. The table and graph below shows, similar to the ED admission data, AMIA has also experiences a downward trend in admissions from Care Homes though this improvement trend is less stable. This supports the hypothesis that system is getting better at reducing unplanned admissions from Care Homes – most likely through the work of GPs, Link Geriatricians, Community Geriatric Nurses, Community Nursing and AHP Teams and Care Home staff.

Discharge from	2017											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
AMIA	351	284	308	252	279	242	274	262	294	298	314	337
Total Care Home admissions	61	51	53	47	43	46	36	55	38	54	59	71
% of overall admissions	17.4	18	17.2	18.7	15.4	19	13.1	21	12.9	18.1	18.8	21.1
Discharge from	**2018**											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
AMIA	361	300	350	317	289	268	254	263	294	238	304	293
Total Care Home admissions	56	50	51	46	43	39	33	43	39	39	25	29
% of overall admissions	15.5	16.7	14.6	14.5	14.9	14.6	13	16.3	13.3	16.4	8.22	9.9



Summary of Problem

We don't have a coordinated approach across services to Unscheduled Care. If we did, we would have the potential to impact on admissions numbers to both ED and AMIA. Two clear areas where improvement can be targeted is admissions of people aged 65+ and also admissions from care homes. In order to do this, we need to have a joined-up approach across community teams to both planned and unscheduled care which will become preventative when successful.

Unscheduled Care

Unscheduled Care is usually undertaken in response to the onset of an acute illness or the rapid decline in function of someone living with an existing condition(s). Responses to need for different levels of treatment or care can be broadly categorised in terms of a stepped care approach described in the diagram below.

This project aligns with the Partnership's strategy as it both enables and relies on connected partnership working. This project also aligns with national strategic direction in shifting the balance

of care from hospital to community settings.

There is a difference in service level available in-hours on Weekdays and Out-of-Hours (evenings and weekends). In general, there is a much-reduced availability of workforce to continue care in evenings and weekends and this is often covered through an out-of-hours rota system staffed by those working in-hours in community teams. There is also the Grampian GMED service which covers out-of-hours for urgent cases.

To have any hope of moving to a much more preventative and planned-care approach we need to have service provision that covers 7 days. It is also clear from the INCA, West Visits and Acute Care at Home projects thus far that stand-alone or 'double-run' services are not sustainable or scalable. In order to have good chances of success we need to ensure that **existing community teams** deliver care which can be rapidly stepped up or down in line with the needs of the individual.

This will require some changes to how the current system operates to implement a stepped care approach which is:

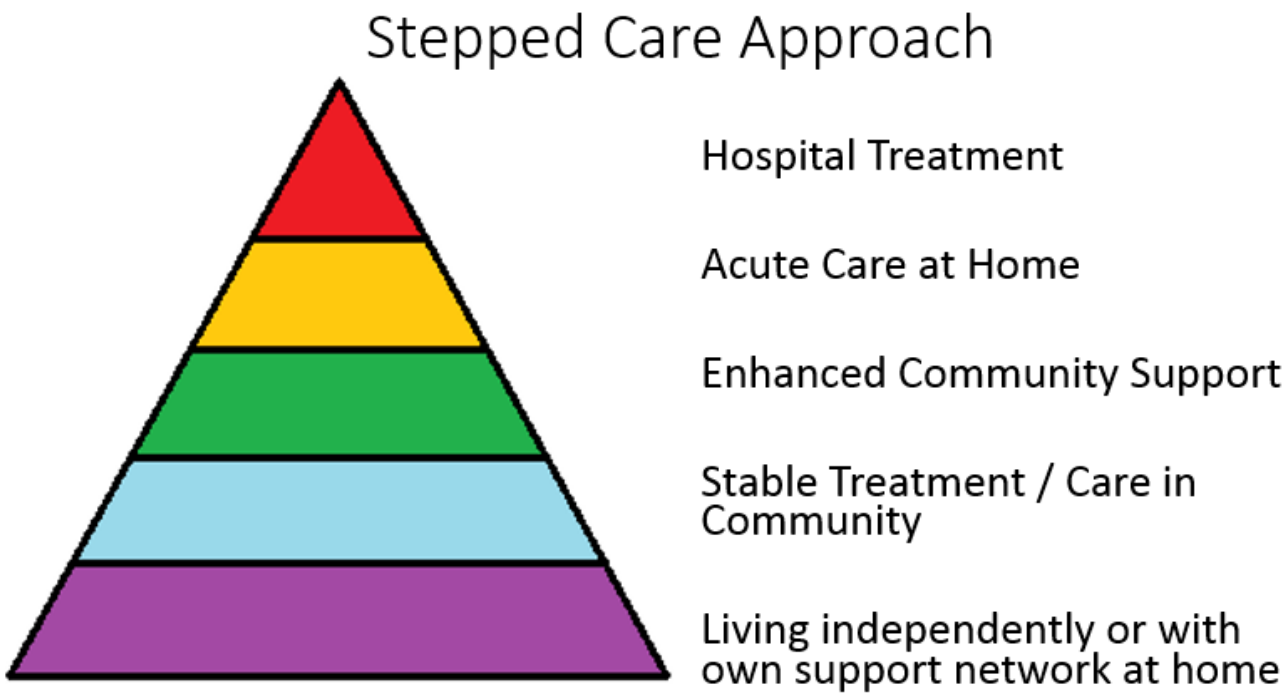
- ✓ Led and run by MDTs made up of **existing skilled and experienced staff** in localities / sub-localities (geography / practice aligned);
- ✓ seamless for the patient – **same staff group providing Urgent / Acute Care at Home, Enhanced Community Support and stable / planned treatment / rehab / support** thus ensuring continuity of care.

Stepped Care Approach

This project will establish a coordinated unscheduled care response serving all localities and GP practices in the city. The service will primarily aim to reduce hospital admissions by providing rapid assessment and diagnostics within the community enabling a decision to be made whether treatment and care can be delivered at home or whether hospital admission is most appropriate for the individual. This project will also enable the earlier discharge of patients from hospital for a short period of 'Active Recovery' post-discharge. There are two different approaches that will enable us

to maintain the person in their own home rather than admission to and treatment in hospital:

- Acute Care at Home
- Enhanced Community Support



In cases where treatment and care at home is deemed suitable (pre- or post-admission) then this care will be delivered by a multi-disciplinary community team comprising members as required by the treatment / care plan. The MDT shall include (but not limited to):

- GPs

- Trainee GPs
- Physician's Associates
- Social Workers
- Advanced Practitioners (e.g. Nurses, AHPs)
- Pharmacists / Pharmacy Technicians
- Community Nurses
- Community Physiotherapists
- Community OTs
- Health Care Support Workers
- Care at Home Workers

Acute Care at Home

This model provides rapid assessment and access to diagnostics to enable decision making on whether the person would be better treated in a hospital setting or in their own homely setting. A range of factors will influence this decision such as:

- Acuity of illness of person being assessed
- Level of required medical / therapeutic support available for delivery of treatment plan
- Suitability / safety of homely environment for delivery of treatment plan

If the person is suitable for treatment, then a treatment plan will be developed and delivered by the acute care at home team in partnership with existing community teams. This will facilitate the stepping down and continuation of care by community teams as the individual returns to baseline levels of function / wellness. In this manner all treatment and care will be delivered as part of a seamless patient focused pathway.

It is true to say that these patients would previously have been treated in hospital by medical, nursing and AHP teams and now they will be treated and supported in the community – this will be an additional workload. It is envisaged that by reducing / eradicating the need for referrals and in some cases duplicated assessments between MDT colleagues that we can release capacity to service this increased demand.

In addition to this, some of our community teams currently do not have basic equipment required to complete observations when out in people's homes in the community. Part of this costings of this project would ensure that community-based staff have the required equipment needed to assess patients and allow them to escalate any deterioration professionally (NEWS equipment – pulse oximeters, tympanic thermometers, etc.). This will also strengthen trusting professional relationships within the community MDT and facilitate the fast, accurate passing of information required to diagnose or manage treatment / support plans.

Workforce

Difficulties have been experienced in the current delivery of the Acute Care at Home Project. This was due to an inability to recruit to Consultant Geriatrician posts on which we relied on for medical input. General Practitioners were a possible alternative for medical input but GPs are also experiencing demand pressure. The positive experience in the West Visits project which utilised Advanced Nurse Practitioners to conduct home visit assessments on behalf of GPs pointed to a possible solution.

There are also however limited numbers of ANPs available, and a lack of a framework for consolidation of learning. Current community nursing teams have DNs qualified to and working at Advancing Practice level. There is scope to develop some of those community nurses to Advanced Nurse Practitioner / Advanced District Nurse Practitioner level which would give additional qualified diagnostic capacity within localities. The training and consolidation of skills and competencies of the current advancing practitioners within existing community nursing teams would take a period of 9-18 months to see them become competent Advanced District Nurse Practitioners in line with our

Partnership need and further embed the stepped care approach within those teams.

The challenges experienced by the Acute Care at Home project in obtaining medical input and competent advanced practitioners has led to a wider exploration of how we could obtain these inputs for assessment, diagnostic and treatment planning which would not further pressurise GP or Geriatrician workloads.

A potential solution has been found to allow the Unscheduled Care project to 'go-live' whilst at the same time bringing required numbers of community nurses and therapists up to advanced practitioner level. Proposals are currently being worked up to access three types of roles:

- Career Start GPs
- Clinical Development Fellows (CDF)
- Trainee GPs
- Physician's Assistants

Career Start GPs are newly qualified GPs and therefore able to undertake all the assessments, diagnostics and come to a diagnosis as a qualified medic. Clinical Development Fellows (CDF's) are doctors after their foundation 2 years who aren't quite ready to commit to a specialty. They are not GPs but they are doctors who we could encourage/enthuse to become GPs. They have to do a certain amount of GMED plus some Acute plus some element of project work. We are currently working up a specification for a primary care CDF to be included in / enhance our service. An appropriate support and supervision structure would need to be agreed and implemented.

Enhanced Community Support (ECS)

This model provides a same day or rapid response to escalation of identified need to medically-fit patients, determined by a General Practitioner / Advanced Practitioner. Older people may be

identified for Enhanced Community Support (ECS) at any time by a range of community practitioners, members of the MDT or by house call or other GP contact.

Older people can also be discharged home to ECS and managed by the team for a short focused period of time. ECS is intended to be a short 7-day (approx.) escalation of care during which time the patients care is coordinated by a Case Management role (e.g. locality District Nurse / Nursing Team Leader / Community Geriatric Nurse / Care Manager) who has access to dedicated social care hours but would not be delayed by having to undergo a SW assessment.

We are working on a solution where by the hours being 'saved' for people in hospital can be used – it won't allow for specific times but will give access to already available and paid for care at home hours across a range of providers. This is a key element to be tested and implemented in the new Bon Accord Care SLA from 1 April 2019 and it is envisaged this approach will be rolled out to all other providers in 2020.

To be 'admitted to' ECS older people are referred through a Single Point of Contact / Referral (SPOC).

The key difference between the normal workings of the MDT model and ECS are:

- Patients are discussed daily by GP & key professionals involved in the older person's assessment (this builds on learning from 'Virtual Ward' approach in Aberdeenshire and elsewhere)
- Assessments are escalated
- Patients are reviewed at a **weekly** ECS MDT meeting

The same MfE Link Geriatrician Consultant will be available to localities and team for advice and support including access to diagnostics, clinic or admission. Consultants will input to weekly ECS MDT meetings.

During an 'admission to' ECS every older person will be offered:

- A Comprehensive MDT Geriatric Assessment, as indicated
- A review or completion of an ACP
- A review or reconciliation of medicines

On 'discharge' any ongoing assessment will be continued through mainstream services and existing community teams.

Preventative work in Care Homes
In analysing data for the Acute Care at Home project admissions to hospital from care homes were identified as an area for improvement. Testing of a version of an ECS-type model has taken place through the current Acute Care at Home project and alignment of Community Geriatric Nurses to localities. CGNs and the ACH team have been reviewing patients on a weekly basis, refreshing / developing Anticipatory Care Plans (ACPs) and intervening early to prevent decline in residents identified as at risk.

Preventative Work in GP Practices
Building on the already successful "Silver City" model of Geriatrician and GP supported MDT reviews in practices, an 'enhanced model' of preventative care is currently in development. Currently, primary care MDT members can bring any patients for whom they have early concerns for a full MDT discussion/review as part of a regular structured meeting – tasks/interventions are then put in place to support the patient in question. In addition to this, the Partnership is currently working with iHub to utilise data from GP systems to flag up cohorts of patients for discussion/review who are **not yet** presenting to MDT members, but are at risk of transitioning to higher levels of frailty etc. This will further expand the early intervention possibilities in primary care, and will allow for work to be undertaken with 'at risk' patients before they present in a crisis scenario.

Out-of-hours and Weekend Cover

Existing Out-of-Hours teams would continue in their role but would have added support over weekends from the 7-day rota staff under this model. Further work needs to be completed to scope

need and impact of this.

INTEGRATION JOINT BOARD

DIRECTION

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

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

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

Previous Reports:- HSCP.17.042

See Annex 1 attached to this report

Previous Direction:- HSCP.17.042 (superseded by this Direction)

See Annex 2 attached to this report

Related Report Number:- HSCP.17.151

Approval from IJB received on:- 26th March 2019

Description of services/functions:-

In June 2017, the IJB approved a project for Interim Step-Down Housing – a new model of service delivery designed to reduce housing related delayed discharge.

Reference to the integration scheme:-

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

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

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

- Develop a consistent person centred approach that promotes and protects the human rights of every individual and which enable our citizens to have opportunities to maintain their wellbeing and take a full and active role in their local community.
- Support and improve the health, wellbeing and quality of life of our local population.
- Promote and support self-management and independence for individuals for as long as reasonably possible.
- Value and support those who are unpaid carers to become equal partners in the planning and delivery of services, to look after their own health and to have a quality of life outside the caring role if so desired.
- Contribute to a reduction in health inequalities and the inequalities in the wider social conditions that affect our health and wellbeing.

Timescales involved:-

Start date:- 1st December 2017

End date:- until otherwise specified

Associated Budget:- Financial commitment for 2019/20 will be £25,440.07 with future years being uplifted as per Aberdeen City Council rent and council tax budget decisions.

Details of funding source:- Delayed Discharge Budget/Funding

Availability:- CONFIRMED

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

INTEGRATION JOINT BOARD

Report Title	Interim Step Down Housing – Delayed Discharge
Lead Officer	Judith Proctor, Chief Officer
Report Author (Job Title, Organisation)	Dorothy Askew, Planning and Development Manager
Report Number	HSCP/17/042
Date of Report	21/04/17
Date of Meeting	06/06/17

1: Purpose of the Report

The purpose of this report is to seek approval to develop an interim housing option for people who have low level support needs and are delayed in hospital awaiting housing adaptation or rehousing.

Based on current trends for those who are delayed due to housing needs we estimate that two properties will alleviate system pressures and have an impact on the current number of bed days lost.

The report seeks agreement to proceed with proposal to develop two fully furnished, fully serviced properties that are adapted to meet a range of needs.

2: Summary of Key Information

Historically, housing related delays have had a significant impact on delayed discharge figures. Whilst not high in numbers, the length of delay and the bed days lost can be significant. We have been working on a number of initiatives aimed at reducing the number and length of delays.

The delayed discharge housing liaison group was established to monitor and actively case manage housing related delays. The group meets monthly and has multi-disciplinary membership that includes housing, social work and acute sector representation. Joint working has fostered good relationships and resulted in an improvement in the numbers delayed. When first established, the group routinely dealt with more than 20 people with a housing related delay. Due to a number of initiatives this dipped to an average of 3-5 people delayed awaiting housing solutions.

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This project relates closely with work being done as part of our role in the Adapting for Change National Demonstrator project. Aberdeen City was one of the five demonstrator site projects looking to test the implementation of the recommendations of the Scottish Governments 'Adapting for Change' Report.

In December 2015, members of the demonstrator site project team published the results of a survey relating of housing related delays. The survey supported the anecdotal evidence provided by staff and highlighted the need for step-down housing options.

Project proposal:

The project will deliver two accessible housing properties. These will be adapted to meet a wide range of needs and will be available on a temporary basis whilst the patient/service user is waiting for alternative housing or adaptation.

The properties will be fully furnished and will provide temporary accommodation for a defined period of time, expected to be in the region of 8 – 20 weeks (based on adaptation timescales). Allocations will be made on the basis of an agreed eligibility criteria and monitored via the Housing Delayed Discharge Liaison Group, who has representation from housing, NHS acute sector, social care, occupational therapy and Disabled Person Housing Service (DPHS).

It is proposed that the properties are let as 'temporary' accommodation and that an occupancy/service agreement is developed to avoid potential misuse of the accommodation offer, for example someone choosing unrealistic options or restricting their areas of choice being allowed to live rent-free indefinitely.

Aberdeen City Council's legal services have confirmed that if we apply a rental charge this would be deemed to constitute a tenancy arrangement and would give the individual security of tenure. It is therefore proposed that no rental charge will be applied, this will mean that the person will have no legal rights to remain and will be able to move on when their adaptation is completed or suitable alternative accommodation is identified. This is similar to the way we manage other intermediate care facilities such as Clashieknowe.

A service charge could be applied to cover the cost of utilities and services. This would require an amendment to the charging policy applied by Aberdeen City Council in relation to the provision of services. This income would offset some of the revenue costs associated with the project, however in applying the charge we would need to be mindful that some service users may already have financial commitments such as rent or mortgage to maintain their current own property.

INTEGRATION JOINT BOARD

This would be particularly relevant for those awaiting private sector adaptations. It should be noted that housing benefit is normally only paid for the main/sole accommodation, there are certain exclusions but for the majority of patients/service users would be unable to claim benefit and would be financially disadvantaged.

Communities, Housing and Infrastructure have indicated that they are willing to support the proposal and will identify appropriate properties. Two options have been identified: properties located at a variety of locations across the city or access to Smithfield Court. Smithfield Court was identified as key-worker housing, however the level of interest has been low and the properties may be available. The properties are located in the central area of the City with easy access to hospital facilities, particularly important for those who have ongoing rehabilitation needs.

Alternatively, housing colleagues have agreed to look for two 'amenity-style' properties, one base in the north and one in the south of the City. These are one bedroom, cottage style properties base on one level. As stand-alone properties there is likely to be less issues in relation to housing management, client mix, etc. This would be the preferred option and costings have been based on this model.

It is proposed that we operate a 'serviced housing' model, similar to the scheme operated by the Private Sector Leasing (PSL) scheme. This PSL team would take responsibility for processing the allocation, cleaning, maintenance, and turnaround of the accommodation.

The Aberdeen City Integration Joint Board would be responsible for covering the full rental and management charge for the properties. The cost to tenants currently accessing the PSL scheme is rent £75 per week/£325 per calendar month (pcm). The cost of council tax will be dependent on the house type but is likely to be band A/band B (£1107.30/£1291.85 annually, includes water/sewage charges).

A service agreement between HSCP and the patient/service user will set out acceptable conduct, engagement with rehabilitation and support packages and a specific clause that the individual(s) engage with the housing allocation and services such as Disabled Persons Housing Service (DPHS) to progress their housing application.

The estimated costs of the project are based on the one amenity style properties and based on maximum budget costs. Charges will relate only to actual cost incurred.

INTEGRATION JOINT BOARD

The level of adaptation required will depend upon the properties that are identified. We aim to provide as flexible a design as we can within the limitation of the property type available. As a minimum, each property will be wheelchair accessible, have a level access shower and appropriate installation of hand rails.

The specification for the level of adaptation will be made in consultation with housing professionals and specialist occupational therapists. We will consult with specialist housing Occupational Therapists and acute sector Occupational Therapists who are involved in the delayed discharge housing liaison group.

The installation of a level access shower will cost approximately £4k per flat. This cost estimate is dependent on the property type, design and approvals but estimated to be in the region of 6 – 8 weeks.

If dispersed properties are the preferred option the approximate cost of a furniture package is estimated to be approximately £400 per property. This is based on the local authority framework contract costs. Rental costs based on a standard 1 bedroom property would equate to £3,500 annually exclusive of Council Tax, heating, etc.

The eligibility criteria will be developed in the line with the criteria already in use at other interim housing-type projects (i.e. Clashieknowe). Work is ongoing to revise the Choice Policy; this will now include housing related delays and will apply in the case of these interim properties. The average length of stay is expected to be in the region of 8 – 20 weeks. This is based on the current time taken for completion or adaptation/re-housing may be variable dependent on requirements. The charging policy should reflect an option to apply an ‘extended-stay' charge that should act as a disincentive to avoid mis-use of the properties and ensure flow.

The Interim Housing project is only one part of a wider programme of activities intended to support the Partnership’s delayed discharge position. The revised choice policy currently under development, (alongside more integrated social work staffing in the hospital sites), will support flow out of wards and into these properties in a ‘joined-up‘ manner. The intention is to ensure that those individuals who cannot safely and timeously return to their own homes, have an appropriate resource in which to wait, that is not a hospital bed. The Interim Housing properties are another component of a wider ‘spread’ of resources that already include interim care home beds.”

INTEGRATION JOINT BOARD

	Equalities, Financial, Workforce and Other Implications

The project will require capital funding for set up and ongoing running costs. These include rental, furnishings, utilities, maintenance and on-going management. There is the potential to apply a charge and the income could offset some of the ongoing costs. This has the potential to have a detrimental impact on the project as people may refuse the accommodation offer on the basis of cost.

Cost profiles are dependent on the availability of accommodation, timescales for the delivery of adaptions, development of eligibility criteria and operational procedures.

Capital Costs (based on dispersed model):
Adaptation works to provide a level access shower, ramp (where required) and kitchen modification per flat, estimated to be c£12,000
Furnishing cost for the dispersed model is c£450 per flat

Revenue Costs (based on dispersed model):
Rental value £75 x 52 weeks (£3,900 annual) per flat
Management costs £60 x 52 weeks (£3,120 annual) per flat*
Council tax based on band B c£105 x 52 weeks (£1,291 annual) per flat
Estimated utilities costs £50 per week (£2,600 annual) per flat
*Includes turn-around costs, may be reduced following negotiation. This is based on current PSL scheme values.

Revenue Cost per flat:	**Based on 2 properties**
Rental -April 2017- March 2018 £3,900 each	£7,800.00
Managements Cost £3,120	£6,240.00
Council Tax £1291.85	£2,583.00
Utilities £2,600	£5,200.00
	Total: £21,823.00
Capital Cost Adaptation costs £12,000	**Based on 2 properties** £24,000.00
Furnishing costs for dispersed properties £450 (if required	£900.00
	Total: £24,900.00
Total funding requested in year 1 (includes capital expenditure)	**£46,723.00**

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[Please note: all costs given above are maximum budget costs, for example utilities charges will be re-charged on actual usage figures]

The aim of the proposal is to deliver a reduction housing related delays. The project requires capital investment relating to the one-off set-up costs including the cost of adaptation, furnishing. Rental costs, council tax or business rates and management costs will be required on an ongoing basis.

A service charge of £20 per week, in line with temporary accommodation costs in other areas could be applied but would be subject to discretion and the persons ability to pay.

The budget to sustain the revenue costs will need to be identified from operational budgets.

4:	Management of Risk

Identified risk(s):

The key risks identified are that the proposal does not deliver the expected outcome or the properties become a further source of delay and services users an unable to move on due to lack of suitable housing, or non-engagement of service user.

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

The project will be subject to evaluation. If the impact does not meet the expected outcomes and deliver reduction in through-put and delays the properties can be returned to housing stock. A period of notice, still to be agreed will be required.

A robust eligibility criteria and occupancy agreement will be in place to mitigate the risk of non-compliance with the conditions of occupation, which include engagement with housing services and moving on arrangements. This will be in line with NHS Grampian's Choice Policy, which is currently in draft format and will reduce the risk of people refusing to move on.

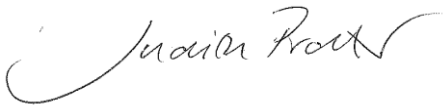
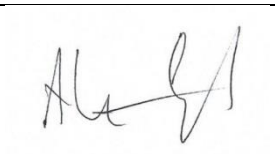
INTEGRATION JOINT BOARD

5:	Recommendations

It is recommended that the Integration Joint Board:

1. Approve the proposal to develop an interim housing option as detailed within this report.

2. Approve the direction (appendix 1) to Aberdeen City Council in relation to the expenditure required to deliver this project.

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

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Integration Joint Board

APPENDIX 1

DIRECTION

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

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

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

Approval from IJB received on:- 6th June 2017

Description of services/functions:- Interim Step-Down Housing – a new model of service delivery designed to reduce housing related delayed discharge. A high level description of this project is set out in the attached Project Summary.

Reference to integration scheme:-

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

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

- Develop a consistent person centred approach that promotes and protects the human rights of every individual and which enable our citizens to have opportunities to maintain their wellbeing and take a full and active role in their local community.
- Support and improve the health, wellbeing and quality of life of our local population.
- Promote and support self-management and independence for individuals for as long as reasonably possible.

- Value and support those who are unpaid carers to become equal partners in the planning and delivery of services, to look after their own health and to have a quality of life outside the caring role if so desired.
- Contribute to a reduction in health inequalities and the inequalities in the wider social conditions that affect our health and wellbeing.

Timescales involved:-

Start date:- 1st July 2017

End date:- until specified otherwise

Associated Budget:-

Details of funding source:- Integrated and Change Fund and will be overseen by the Delayed Discharge Group

- Interim Housing Proposal: £46,723.00.

Note: Costs provided for one-year test of change and include capital adaptation costs.

Availability:- Confirmed

Integration Joint Board

Supporting Documents

1. Draft Minute of the IJB Meeting

060617 IJB minute DRAFT.doc

2. Original Report (HSCP/17/042)

6. HSCP.17.042 -Interim Housing Prop

3. Completed Consultation Checklist

Checklist - Interim Housing Proposal - HS

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Project Name	Project Description	Project Status
Silver City	A MDT approach to supporting older people to reduce their risk of medical admission	Subsumed into new Unscheduled Care Project
Dementia Scholarship	Training for GPs on dementia. No expression of interest from GPs to undertake this training for last 2 years.	Closed
Asset Based Community Development Promotion and Mentoring	Engaging and developing our community building approach in a co-production manner with key stakeholders during early stages of locality development.	Closed as activity concluded
Torry Community Renewal	Community engagement activity in Torry funded through former Modernising Primary Care Fund.	Closed as project concluded.
Integrated working in Localities	Support to develop integrated work in Torry and Kincorth and organisational development across leadership team and wider partners.	Closed as project concluded.
Locality Based Ward (Woodend) Test of Change	Alignment of one of four elderly rehabilitation wards to one locality, to test benefits of such alignment and develop integrated working between hospital and community staff groups.	Closed as project activity ceased.
Fob Access	Enable fob access to buildings used by partnership for appropriate partnership staff.	Project did not start.
Wifi in GP Practices	Rolling out additional secure access wifi points across the city to support integrated working.	Project Complete
TEC National Development Programme	Raising awareness of telecare. Funded by Scottish Government. Funding ceased.	Project Complete
INCA Test of Change	Testing integrated self managing nursing and care at home teams. Evaluation complete and learning is being used across a range of transformational activity	Project Complete
Integrated Triage ways of working	Testing and evaluating a range of triage processes.	Project did not move from define stage. Now part of wider unscheduled care project.

Nursing Workforce Succession Planning	Supporting training and development within nursing workforce	Moved to business as usual.
Middlefield Community Hub	Integrated community care treatment hub within a community facility. Will inform future city model for community treatment hubs.	Project Complete
Pharmacists in practices	Additional pharmacy support in practices - initial phase.	Project complete
Cornerstone Buurtzorg Support	Testing of self managing teams model with shared learning.	Project Complete
Community Falls Clinic and Pathway	Development of falls pathway.	Project complete
Learning Disabilty Support Group	Grant funding to provide support to group	Move to commissioning
Dementia Post Diagnostic Support	Contract funding	Move to commissioning
Airyhall Dementia Support	Contract funding	Move to commissioning
Living Well Dementia Café	Contract funding	Move to commissioning
Parish Nursing	Contract funding	Move to commissioning
Golden Games	Grant funding	Move to commissioning
New Dyce Practice - new ways of working	Contract funding	Move to commissioning
New Northfield Practice - new ways of working	Contract funding	Move to commissioning
Mental Health Strategy Development	Funding to support development of strategy	Move to commissioning
Third Sector engagement	Funding to support engagement and participation of third sector.	Move to commissioning
Independent Sector engagement	Funding to support engagement and participation of independent sector.	Move to commissioning

Exempt information as described in paragraph(s) 8 of Schedule 7A
of the Local Government (Scotland) Act 1973.

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Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Date of Meeting	26th March 2019
Report Title	Denburn/Aurora Project Investment in Facilities to Support the Redesign and Modernisation of Primary and Community Care Services in Aberdeen City.
Report Number	HSCP.18.148
Lead Officer	Sandra Ross, Chief Officer
Report Author Details	Name: Teresa Waugh Job Title: Project Manager Email Address: twaugh@nhs.net
Consultation Checklist Completed	Yes
Directions Required	No
Appendices	a. Summary of Key Information for the Outline Business Case b. Stakeholder and Communications Engagement Plan c. Stakeholder Engagement Final Report

1. Purpose of the Report

1.1. The purpose of the report is to provide the IJB with a summary of the Outline Business Case (OBC) for the Investment in Facilities to Support the Redesign and Modernisation of Primary and Community Care Services in Aberdeen City.

INTEGRATION JOINT BOARD

2. Recommendations

2.1. It is recommended that the Integration Joint Board:

a) Approve the strategic direction for the delivery of Primary and Community Care Services (PCCS) set out within the summary of the Outline Business Case for the Denburn/Aurora Project (Appendix A).

b) Agree that the Outline Business Case be submitted to the NHS Grampian (NHSG) Board on 4th of April 2019, with a recommendation to approve and submit to the Scottish Government Capital Investment Group (CIG) on 15th of May 2019.

3. Summary of Key Information

3.1. NHS Grampian (NHSG) and Aberdeen City Integration Joint Board (IJB) have worked together to identify the investment in infrastructure required to support the transformation of Primary and Community Care Services (PCCS). This will deliver on the commitments set out in the NHS Grampian Capital Investment Plan to develop new facilities for communities in the Denburn, Mastrick and Northfield area.

3.2. The joint IJB and NHSG Project Team follow the model set out in the Scottish Capital Investment Manual (SCIM) for the submission of Capital Projects to the Scottish Government Capital Investment Group (SG-CIG):

- Stage 1 - Initial Agreement (IA), which was approved by the (SG-CIG) in March 2018.
- Stage 2 - Outline Business Case (OBC – which this report presents) and;
- Stage 3 - Full Business Case (FBC).

While the work is being undertaken within the Aberdeen City Health and Social Care Partnership (ACHSCP) and supports the IJB's strategic direction, new capital infrastructure remain the responsibility of NHSG and, as such the project team are working towards the following approval timelines for submission of the Stage 2 – OBC:

- NHSG Asset Management Group (AMG) – 27th March 2019,
- NHSG Board – 4th April 2019,

- Scottish Government Capital Investment Group (CIG) – 15th May 2019.

3.3. The role of the IJB is to approve the strategic direction set out in the OBC to ensure the future service delivery model will deliver on key commitments set out in the ACHSCP Strategic Plan, Vision for Primary Care and delivery of respective Transformation and Primary Care Improvement Plans.

3.4. The purpose of the OBC is to identify the preferred option for implementing the strategic/service solution confirmed at IA stage. The Preferred Way Forward (PWF) confirmed at IA stage is the recommended Preferred Option (PO) at OBC stage, to build a single new integrated centre for the delivery of health and care services within close proximity to the existing services in the communities of Northfield and Mastrick, currently delivered by the Denburn/Aurora Medical Practice Grouping.

3.5. A site options appraisal was completed and concluded in June 2018, this process included a feasibility study of available sites. The scoring methodology applied by the Project Group included assessment against a defined set of scoring criteria, weighting was applied and a scoring matrix completed, including an assessment against project tolerances. The long list of available sites was assessed and a short list defined following the above methodology. The site which scored the highest was Greenferns Area, D1 (Bucksburn Farm) Site A, and it was recommended that the Property and Asset Development team were instructed to begin dialogue with those relevant to secure the site.

3.6. In addition to the new facility, a city centre General Medical Services (GMS) satellite site will also be established at the Health Village, Frederick Street. This is following the completion and approval of an options appraisal presented to the Aberdeen City Capital Programme Board in October 2018. This business case outlined the need to take into account the lack of growth to the Aurora Medical Practice List, the distribution of Rosemount Medical Group patient list as well as sustainability of wider GMS across the city. The Primary Care Team have developed a 7 year plan to rebalance city centre patients while increasing capacity for the currently dispersed Northfield, Mastrick and Cornhill patients to receive their GMS closer to their communities at the new facility. The need to retain GMS provision for the city centre/student population in the longer term will be reviewed following implementation of the 7 year rebalancing plan.

3.7. In order to ensure a planned approach from January 2019 the Denburn/Aurora Working Group will refocus to support the detailed

planning and transition of services to the new accommodation at both Health Village and Greenferns sites.

3.8. Dental services will not be provided from the new facility, this is confirmed at OBC stage following an options appraisal presented to the Aberdeen City Capital Programme Board[1] in October 2018. The approved recommendation sets out a reduction of 2 current dental seats at Northfield when the new facility opens, whilst retaining 2 current dental seats at Mastrick for a transitional period of up to 2 years. As with all Public Dental Services (PDS) practices in the city, rebalancing work will continue where patients who require routine NHS dental care will be encouraged to transfer registration to a high street NHS dental practice. Where patients require the more specialised support of the PDS, their care will be transferred to another PDS practice within the city. This presents an opportunity to further integrate services from the Mastrick area to ensure an ongoing presence in the community; in addition there are plans within the Community Planning Partnership to develop this area too. During the longer term a clear defined exit strategy from the Mastrick Clinic within the 5 year period would be developed, along with an overall dental strategy for the city, linking to the North Corridor project and other strategies and projects across the Aberdeen City Health and Social Care Partnership, NHS Grampian and Aberdeen City Community Planning Partnership.

3.9. The National Framework Scotland approach involved a mini competition to appoint a Principal Supply Chain Partner (PSCP). This process is now complete and a preferred contractor has been identified as a PSCP and approved at the NHSG Board on 6th December 2018. Further details can be found in Appendix A.

3.10. The OBC sets out the following key drivers for change to develop new infrastructure for the identified communities:-

- the delivery of integrated PCCS focused on the needs of the local community,

- continued growth in the population in the Green Belt areas away from the City Centre,

- poor condition of the current Denburn Health Centre premises in the City Centre of the Central Locality means the building is unfit for purpose, with a limited period of operational use, and limited life of the Northfield and Mastrick premises with no further expansion space,

[1] Joint NHS Grampian/Aberdeen City Health & Social Care Partnership Programme Board

INTEGRATION JOINT BOARD

- decant of all other services from the Denburn Health Centre to the Health and Care Village, Frederick Street, City Centre in the Central Locality,

- destabilisation of the practice as current facilities do not enable the service to progress the transformational change required to further modernise and enhance service delivery, and

- securing the provision of GMS for existing communities, specifically Northfield and Mastrick in the Central Locality.

3.11. Due to the increasing demand, demographic changes and workforce challenges, it is important that Aberdeen City Health and Social Care Partnership redesign a future service delivery model for PCCS to ensure improved access and sustainability, The key aspects of the service delivery model remain unchanged at OBC stage, however due to the implementation of the new GMS contract these have been reshaped and enhanced to align with the opportunities this now presents. This future service model also supports the delivery of the Aberdeen City IJB Strategic Plan, Transformation Plan and Primary Care Improvement Plan.

3.12. This stage 2 OBC Preferred Option (PO) was developed following a significant programme of communication with Key Stakeholders including GP providers, extended PCCS (including Allied Health Professionals, Community Nursing, Public Health and Social Care). Further engagement with wider Community Planning Partners was undertaken at the Aberdeen City Capital Programme Board.

3.13. The Denburn/Aurora Communications and Engagement Sub Group will continue to progress communications and engagement activities including developing a further set of materials and information to be issued advising of the next steps and timeline to ensure key stakeholders are fully informed. The current live version of the Stakeholder and Communications Engagement Plan is attached as appendix B.

3.14. The following stakeholder engagement sessions have been held as part of the OBC stage 2 development:

- Local Councillor Engagement Sessions, including 1-1 sessions – 26th November 2018 – 11th December 2018.
- MSP Briefing – 30th November 2018

- Patient, Carer, Public and Staff Engagement Drop in sessions held in a number of community centres and GP surgeries – 27th November 2018 to 5th December 2018.
- Attendance at Community Council Meetings – 11th November/18th December 2018 and 16th January 2019.

3.15. A stakeholder engagement report has been produced and is attached as Appendix C. Further engagement on the Preferred Option (PO) design, construction and commissioning phases will commence at FBC stage 3.

4. Implications for IJB

4.1. Equalities - A full EHRIA will be completed prior to submission to the SG-CIG.

4.2. Fairer Scotland Duty - Demographics, including socio-economic disadvantage, are considered throughout the IA. The proposed future service delivery model will be designed to meet the future demographics requirements of the area.

4.3. Financial - There are no direct financial implications arising from the recommendations of this report. Further information in relation to costs can be found at Appendix A.

4.4. Workforce - There are no direct workforce implications arising from the recommendations of this report. The identified workforce affected by the proposed changes have had the opportunity to attend engagement sessions and are also represented at the Project Group level by both Service Managers and Staff Side Representation. The process for further workforce engagement will be set out at Full Business Case Stage and will take place in advance of further public engagement.

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

5. Links to ACHSCP Strategic Plan

5.1. The Outline Business Case will support the following elements of the ACHSCP Strategic Plan:

- Develop a consistent person centred approach,
- Support and improve the health, wellbeing and quality of life of our local population,

- Promote & support self-management.

6. Management of Risk

6.1. Identified risks(s)

The Risk Register developed at IA stage has been further developed at OBC stage to also include the identified PSCP risks. This overall Risk Register will continue to be a live document and will be reviewed on a continuous basis, this sets out more detail around the consequence, likelihood and specific action taken to manage or mitigate the risks.

Specific risks for the IJB at OBC stage have been identified as follows, with plans for mitigating these:

Risk	Impact	Likelihood	Risk score	Mitigation
The practice does not sign up to the preferred option/service solution (letter of intent)	Major	Low	Moderate	Relevant financial information to be available in advance of key reporting deadlines for consideration by the practice.

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

There is a risk that the IJB does not maximise the opportunities offered by Locality working.

Approvals	
	Sandra Ross (Chief Officer)
	Alex Stephen (Chief Finance Officer)

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APPENDIX A

DENBURN/AURORA PROJECT - SUMMARY OF KEY INFORMATION
OUTLINE BUSINESS CASE

1. Business Planning Process

The Outline Business Case (OBC) is the second phase in the business planning process for the project. The first phase Initial Agreement (IA) was approved by the IJB in January 2018, NHSG Board in February 2018 and the Scottish Government Capital Investment Group (CIG) in March 2018. The Scottish Government accepted the recommendations within the IA and invited NHS Grampian to proceed with an Outline Business Case (OBC).

Following approval of the OBC the final phase of the business planning process will involve the development and approval of a Full Business Case (FBC).

The Outline Business Case aims to:

- Identify the preferred option for implementing the strategic/service solution confirmed at IA stage
- Demonstrate that the preferred option optimises value for money and is affordable
- Set out the supporting commercial and management arrangements to be put in place to successfully implement that option.

In accordance with the Scottish Capital Investment Manual (SCIM) guidance, each of the “five case models” have been reviewed and refreshed accordingly, Strategic, Economic, Commercial, Financial and Management.

2. Strategic Direction

National and Local Strategic Synergy

This outline proposal will contribute to the delivery of key national and local strategic policies, providing national and local strategic synergy.

- Strategic Investment Priorities of NHS Scotland
- North of Scotland Regional Clinical Strategy
- 2020 Vision for Health and Social Care
- NHSG Clinical Strategy Strategic Priorities
- New GMS Contract
- NHSG Healthfit 2020 Vision
- NHS Grampian Workforce Strategy
- Aberdeen City and Shire Strategic Development Plan (2014)
- Community Planning - Aberdeen
- Primary and Community Care Strategic Plan
- Primary and Community Care Transformation Programmes
- A Digital Strategy for Scotland

- Primary Care Improvement Plans
- North Region of Scotland (Regional Asset Plan)
- Infrastructure Plans

Drivers for Change

The need for change is being driven by the following key drivers as highlighted within the Initial Agreement (IA) and this continues to be the case when reviewing the Outline Business Case (OBC):

- the delivery of integrated PCCS focused on the needs of the local community,

- continued growth in the population in the Green Belt areas away from the City Centre,

- poor condition of the current Denburn Health Centre premises in the City Centre of the Central Locality means the building is unfit for purpose, with a limited period of operational use, and limited life of the Northfield and Mastrick premises with no further expansion space,

- decant of all other services from the Denburn Health Centre to the Health and Care Village, Frederick Street, City Centre in the Central Locality,

- destabilisation of the practice as current facilities do not enable the service to progress the transformational change required to further modernise and enhance service delivery, and

- securing the provision of GMS for existing communities, specifically Northfield and Mastrick in the Central Locality.

Investment Objectives

The following Investment Objectives set out specifically what needs to be achieved to overcome the local challenges and need.

- provide a safe working environment and support improvements to the physical quality and age of the healthcare estate in line with the NHSG AMP,
- support the development of a service model to meet future service demand and demographic challenges,
- allow the development of service arrangements that support the delivery of an enhanced model of integrated PCCS leading to improved patient experience,
- achieve equitable access to service provision across the locality,
- support an efficient business model that promotes viability and sustainability and
- create attractive employment opportunities.

Revisiting the Strategic Case

The IA Strategic Case has been revisited and refreshed to respond to specific questions regarding the proposals strategic/service solution(s) and the OBC will focus on these key changes in line with guidance set out in the Scottish Capital Investment Manual (SCIM).

The key areas of change are identified throughout the OBC as follows:

City Centre Presence (GMS Provision)

Whilst developing the OBC strategic case there was a need to take into account a number of changes to the local operating environment impacting on the sustainability of GMS including the establishment of the Torry Medical Practice as a 2C Practice, the re-distribution of the Rosemount Medical Practice and that there is currently limited space for the Aurora Medical Practice to grow its patient list at the Northfield Surgery and Mastrick Clinic. To respond to the need to ensure a managed transition, in addition to the new facility a city centre GMS presence will also be established on a permanent basis at the Health Village, Frederick Street. The Primary Care Team have developed a 7 year transitional plan, which will include the retention of up to 5,000 of a population in the city centre/student population and will manage the process of patient moves during this period on a voluntary basis.

Final Service Delivery Model (Dental Provision/Mastrick)

Within the IA details were provided in relation to the Public Dental Service Provision which is provided from the Northfield Surgery and Mastrick Clinic, both with two dental seats currently. Although there will be no public dental service in the new facility, it is important that these communities are provided with a Public Dental Service when required. An approved options appraisal presented to the Aberdeen City Capital Programme Board in October 2018 set out a reduction of 2 current dental seats at Northfield when the new facility opens, whilst retaining 2 current dental seats at Mastrick for a transitional period. A clear defined exit strategy from the Mastrick Clinic within the 5 years transition period would be developed. As with all PDS practices in the city, rebalancing work will continue where patients who require routine NHS dental care will be encouraged to transfer registration to a high street NHS dental practice. Where patients require the more specialised support of the PDS, their care will be transferred to another PDS practice within the city. This also presents an opportunity to further integrate services from the Mastrick area by retaining the Mastrick Clinic for Dental Services and other purposes to ensure an ongoing presence in the community; in conjunction with Aberdeen City Council Community Planning Partnership. Redevelopment plans will be aligned to the Council's timeline to develop Mastrick Town Centre.

3. Option Appraisal

Service Model

Key aspects of the proposed service delivery model remain unchanged at OBC stage; this future service model supports the delivery of the Aberdeen City IJB

Strategic Plan, Transformation Plan and Primary Care Improvement Plan. Due to the implementation of the 2018 GMS contract in Scotland, these have been reshaped and enhanced to align with the opportunities this now presents, and therefore they are confirmed as follows:

- A triage and video consultation Hub to ensure a no appointment backlog service for patients and incorporating facilities to support training.
- Enhanced use of technology and diagnostic services to build on the Dr First model, diagnostic pods, attend anywhere, telemedicine, telephone consultation and screening.
- An asynchronous care model making full use of email consultation.
- Co-location of all practice and aligned staff e.g. community nursing, AHP's and Social Services professionals.
- Clinicians and professionals share flexible and adaptive clinical space and bookable multi-purpose rooms with facilities for visiting services. There will be a single integrated reception area, shared administration space and staff facilities, a waiting area that is flexible and can be used by the community in the evenings and weekends.
- Support for clinicians to use the Clinical Guidance Internet for PCCS.
- Electronic record storage
- Improved integrated working between health and community care teams to impact on reducing unplanned admissions to hospital through a greater anticipation of need and increasing the ability to provide specialist planned care closer to home.
- Redesign of care pathways to improve access to PCCS and a more integrated and community based approach to supporting those with Long Term Conditions.
- The roles of Primary Care Mental Health Workers, Link Workers, Physician Associates and an integrated model of working with Social Work Care Management will be extended and embedded in the new service delivery model.
- Integrated care management (e.g. Virtual Ward Rounds) to provide support in the community to people with the most complex medical and social needs to reduce unplanned admissions and delayed hospital discharge for the +75s.
- Joint working with local Pharmacies delivering the Extended Pharmacy Role.

The project also provides an opportunity to focus on the delivery of a new service model that will include;

- primary prevention activities to meet the specific needs of a population within an area of deprivation (e.g. immunisations),
- secondary prevention activities that begin to reduce health inequalities (e.g. screening programmes, alcohol reduction programmes and mental health support),
- capital investment in new facilities will enable the Aberdeen City HSCP to seize the opportunity to design and organise facilities to create the right environment for change (e.g. investing in new technology, targeting

information to address the health profile of the population, creating community space and supporting health choices for staff, patients and the community accessing the space),

- people with Long Term Conditions account for 50% of all GP appointments so the project provides an opportunity to embed programmes to promote self-management, person centred care and shared decision making, and
- further develop Link Workers and this will ensure that the wider resources in the community will be maximised as part of an integrated health and care system.

Physical Infrastructure to support the service model

The preferred way forward identified at IA stage, remains the preferred option at OBC stage, to build a single new integrated centre for the delivery of health and care services at a suitable site in the Central Locality, within close proximity to the existing services in the communities of Northfield and Mastrick, currently delivered by the Denburn/Aurora Medical Practice Grouping.

During the site options appraisal key meetings took place between 4 May 2018 to 21 June 2018 with key stakeholders involved in the project including the Denburn/Aurora Practice Management Team, members of the Property Asset Development Team, Capital and Services Team as well as the relevant programme board for governance.

This process included:

- Site Assessment Report
- Site Appraisal Criteria
- Site Selection Scoring Methodology
- Scoring Criteria/Weighting/Matrix/Tolerances

Taking all the above scoring methodology and assessments into account, a long list to short list of site options was determined. This provided the project with a recommended site option of Greenferns Area D1, Bucksburn Farm (Site A), which scored highest throughout the comprehensive and robust site scoring process. This site is currently being secured for the project by NHS Grampian Property and Asset Development Team.

4. Economic Case

The purpose of the Economic Case is to undertake a detailed analysis of the costs, benefits and risks of a short list of options, including a do nothing and/or do minimum option, for implementing the preferred strategic /service solution identified within the Initial Agreement.

A full economic assessment has been completed at OBC stage; the objective is to demonstrate the relative value for money of the chosen option in delivering the required outcomes and services.

5. Financial Case

The total planned capital investment is £8.1m. NHS Grampian has provided for a total of £5M of capital funding within its infrastructure programme over the financial years 2018/19-2020/21 and it is anticipated that a further £3.1M will be required to be provided by the Scottish Government Health and Social Care Directorate in financial year 2020/21. This is in line with the values indicated in the Initial Agreement and it is anticipated that the project will be deliverable within the £8.1 m funding envelope.

The operating costs of the new building are forecast to be delivered within the existing Revenue Budgets, as the floor area is significantly less than the buildings that will be closed (Denburn & Northfield). This will be confirmed at Full Business Case (FBC) stage.

There are not anticipated to be any additional costs of staffing or any other additional service delivery costs as a direct result of the proposals in this OBC, rather the focus, initially will be on maximising the benefit available from re organising and redesigning service delivery using the existing team.

6. Commercial Case

This section outlines the commercial arrangement and implications for the Project. This is done by responding to the following questions:

- The procurement strategy and appropriate procurement route for the Project;
- The scope and content of the proposed commercial arrangement;
- Risk allocation and apportionment between public and private sector;
- The payment structure and how this will be made over the lifetime of the Project;
- The commercial arrangements of the offer, and
- The contractual arrangements for the Project

Procurement

The planned procurement route identified in the Initial Agreement was to contract with Hub North of Scotland Ltd, as part of the national exclusivity arrangements covering construction contracts for physical alterations or new build community premises. In subsequent dialogue with Hub North of Scotland Ltd and Scottish Futures Trust, NHS Grampian has exercised the right to suspend the exclusivity agreement and seek to progress the scheme using the National Framework Scotland 2 procurement route.

The Framework approach involved a mini competition to appoint a Principal Supply Chain Partner (PSCP) from a list of organisations previously appointed to the National Framework following a full EEC tendering process led by Health Facilities Scotland. This process is now complete and a preferred contractor has been identified as a PSCP.

On the 6th December 2018 the NHSG Board approved the appointments of the PSCP and independent cost advisors for the project, following recommendations from the Aberdeen City Capital Programme Board.

7. Management Case

The purpose of the Management Case is to demonstrate that those responsible are ready and capable of successfully delivering the Project. This section provides updates on the project management arrangements indicated in the Initial Agreement (IA), with the focus now shifting to the detailed arrangements.

Project Management Arrangements, Governance and Timescales

A project governance structure has been established for this project using a programme and project management approach (PPM).

The governance and reporting structure for the project is consistent with the Scottish Capital Investment Guidance (SCIM) and seeks to ensure that the Scottish Government Capital Investment Group (CIG), Scottish Futures Trust (SFT), the Aberdeen City Integration Joint Board, as well as the NHSG Board are appropriately involved in the Project as it progresses through its key milestones.

The following table provides indicative timescales for completion of key milestones for delivery of the project

Initial Agreement Approval	March 2018
Outline Business Case approval	May 2019
Final Business Case approval	December 2019
Land Purchase Concluded	TBC
Commence construction	Early 2020
Completion of new facility	Spring 2021

Risk Management

Effective management of the project risks is essential for the successful delivery of any infrastructure project. A robust risk management process has been put in place and will be actively managed through the whole programme to reduce the likelihood of unmanaged risk affecting any aspect of the Project.

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Denburn/Aurora Project: Stakeholder & Communications Engagement Plan	
Lead Officer	**Kay Dunn, Lead Planning Manager (Capital and Services), Aberdeen City HSCP**
Project Manager	**Teresa Waugh, Project Manager (Capital and Services), Aberdeen City HSCP**
Date	**06.07.18**
Version	**V4 Final LIVE**

Stakeholder and Communications Engagement Plan

Stakeholder	Stake in Project	Type of Engagement	Purpose of Communication	What do we need from them?	Method	When do they need to know and how often?	Key Messages	Costs Incurred	Responsibility	Outcome
Denburn/Aurora Practice Partners	To shape the future delivery of Primary Health and Care Services. HIGH	Collaborate	They will deliver the future service.	Clinical expertise	Workshops Meetings Project Group 121 Sessions	Monthly/ As required	Transformation of Service Modernise infrastructure Innovative Schedule Of Accommodation Design Achieve best value.	Workshop budget – Transforma-tion Fund	Lead Planning Manager Project Managers	Approval of Future Service Delivery Model, Schedule of Accommodation and sign off IA (Initial Agreement), OBC (Outline Business Case) and FBC (Full Business Case). Agreement of Interim Transitional Period Arrangements.
Denburn/Aurora Practice Management Team	To shape the management model for future Primary Health and Care Services. MEDIUM	Collaborate	They will manage the future service.	Operational expertise	121 Sessions Team Meetings	Weekly/ Monthly/ As Required	Lead Roles Key Tasks Actions Timelines	Not applicable	Programme Director and Lead Planning Manager/ Project Managers	Task delivered on timescale to meet CIG (Capital Investment Group) deadlines.
Denburn/Aurora Practice Support Staff	To shape the support and administra-tion model for the future delivery of Primary Health and Care Services. MEDIUM	Consult	They will support the future service.	Operational expertise	Workshops Project Group 121 Sessions	Monthly	Transformation of Service Modernise infrastructure Innovative Schedule Of Accommodation Design Achieve best value	Workshop budget/ Transform-ation Fund	Lead Planning Manager Project Managers	Approval of Future Service Delivery Model, Schedule of Accommodation and sign off IA (Initial Agreement), OBC (Outline Business Case) and FBC (Full Business Case)

GMS (General Medical Services) Indirect Practices	To be involved in shaping the services to patients city wide HIGH	Collaborate	They will deliver a part of the future service	Clinical and Operational expertise	121 Sessions	As required	Transitional Period Business as Usual Seamless Transition	TBC	Lead Planning Manager/ Project Managers	Approval of Interim Transitional Period Arrangements. Approved boundaries throughout the city
Community and Patient Representatives	To influence the decision making process playing a key role as advisor/ Influencer HIGH	Collaborate	To influence decisions bringing valuable user experience	User and Community perspective	Events Communica-tions Sub Group Project Group National Standards for Community Engagement	Fortnightly Monthly As required at specific events	New Delivery Model Site Location Future access to GMS (General Medical Services/GP)	Expenses Workshop Budget Events	Project Manager/Public Involvement Officer/ Development Officer	Fully involved in process and design meets the needs of public/community. Opportunities to influence are maximised
Denburn, Northfield, Mastrick Communities	To shape future service delivery model and impact this has on the community MEDIUM	Collaborate	They live in the communities which will be directly affected by the proposals	User and Community perspective, Feedback on Community Concerns	Community Council Meetings Newsletter Social Media Briefings Consultation Events Letters Questionnaires National Standards for Community Engagement	Monthly Regular Basis/ As Required	New delivery model Site location Future access to GMS (General Medical Services/GP) Transitional Period	Workshop Budget/Events	Lead Planning Manager Project Managers Public Involvement Officer Development Officer	Fully involved in process and design meets the needs of the community.
GMS (General Medical Services/GP) Patients	To improve access to services and shape future service delivery model. MEDIUM	Collaborate	They will be recipients of the future service and interim city centre solution	User perspective.	Workshops Project Group 121 Sessions Website Newsletter Social Media Briefings Consultation Events Letters Questionnaires National Standards for Community Engagement	Monthly Regular Basis/ As Required	New delivery model Site location Future access to GMS (General Medical Services/GP) Transitional Period	Workshop budget Transformatio-n Fund	Lead Planning Manager Project Managers Public Involvement Officer Development Officer	Patient, Community and Public engagement in design. Patient Focussed Services with an interim solution agreed

Dental Patients	To ensure provision remains within the community MEDIUM	Collaborate	They will be recipients of a different model for the community, ease of access	User perspective	Website Newsletter Social Media Briefings Consultation Events Letters Questionnaires National Standards for Community Engagement	Monthly Regular Basis/ As Required	New delivery model Future access to dental services	Workshop/ Event Budget	Lead Planning Manager Project Managers Public Involvement Officer Development Officer Dental Team	Provision in the community maintained with transitional/ decommissioning period agreed
GMS (General Medical Services/GP) Patients – Students • University of Aberdeen RGU (Robert Gordon University) • NESCOL (North East Scotland College)	To improve access to services and shape future service delivery model. MEDIUM	Collaborate	They will be recipients of the future service and interim city centre solution	User perspective specifically students who access services in the area	Workshops Project Group 121 Sessions Website Student Newsletters (The GAUDIE & RADAR) Social Media Briefings Consultation Events Letters Questionnaires Engagement Standards Aberdeen Student Radio & RGU radio	Monthly Regular Basis/ As Required	New delivery model Site location Future access to GMS (General Medical Services/GP) Transitional Period	Workshop budget Transform-ation Fund	Lead Planning Manager Project Managers Public Involvement Officer Development Officer	Patient, Community and Public engagement in design. Patient Focussed Services with an interim solution agreed
Dental Management Team	To shape the delivery of Dental Provision in the identified community MEDIUM	Collaborate	They will deliver and manage the future service	Clinical and Operational expertise	Meetings Project Group Impact Assessments	Monthly/ As Required	Service Review Modernise infrastructure Achieve Best Value	Decommiss-ioning	Dental Management Team Programme Director and Lead Planning Manager/ Project Managers	Approval of revised provision in the community maintained with transitional/ decommissioning period agreed
Extended Services • Allied Health Professionals • Pharmacy • Link Workers • Social Work • Community Nursing • Mental Health • Substance	To maximise opportunities for Integrated working HIGH	Collaborate	To contribute to the new delivery model, enhancing the range of services available to patients	Operational Clinical and Non Clinical extended service expertise Locality/Community Expertise	Workshops 121 Sessions Project Group	Regular Basis/As Required	New Delivery Model Integrated Working Schedule of Accommodation Design	Workshop/ Event Budget	Lead Planning Manager Project Managers	Approval of Future Service Delivery Model, maximise shared Schedule of Accommodation and signed Service Level Agreements/Operational Implementation Plans

Misuse										
IJB Partners (Integration Joint Board)	To explore the opportunities to deliver new model of care e.g. AHP (Allied Health Profession-als), Pharmacy, Acute Service Planning. HIGH	Collaborate	They may contribute to the delivery of the future service.	Strategic/ Operational expertise.	Reporting to IJB (Integration Joint Board)	Briefing Workshop (Capital Programmes) IA (Initial Agreement), OBC (Outline Business Case), FBC (Full Business Case) Stages. IJB Meetings	Authority Governance Strategic Intent	Not applicable	Lead Planning Manager Project Managers	Approval of Strategic Case.
NHS Grampian (NHSG) Partners	To ensure efficient use of NHS Grampian resources and develop infrastructure in line with NHSG Asset Management Plan. HIGH	Collaborate	They will manage the capital planning and Hubco Project Management.	Planning expertise (capital, assets and Hubco).	Reporting to AMG. (Asset Management Group)	Bi-monthly to AMG. (Asset Management Group)	Modernise infrastructure Achieve best value Workforce	Workshop budget – Transforma-tion Fund	Lead Planning Manager Project Managers	Approval of Future Service Delivery Model, Schedule of Accommodation and sign off IA (Initial Agreement), OBC (Outline Business Case) and FBC (Full Business Case).
Aberdeen City Council (ACC) Partners	To explore the opportunities to integrate wider services in the future service delivery model. MEDIUM	Involve	They may deliver other services from the new building.	Operational expertise and input at planning stage.	Reporting to Committee.	As required.	Housing, Welfare Services and Children's Services/ Schools/ Chief Social Work Officer	Not applicable	Councillor Officers and Lead Planning Manager.	Approval of Strategic Case.
Locality Leadership Groups (LLG)	To ensure Integrated and locality based opportunities are maximised	Collaborate	Locality Perspective on the future service delivery model	Locality Perspective and expertise	Meetings Workshops	Quarterly	Locality Working Transformation of Services	Not applicable	Lead Planning Manager/ Project Manager	Approval of Future Service Delivery Model, Schedule of Accommodation and sign off IA (Initial Agreement), OBC (Outline Business

	MEDIUM									Case) and FBC (Full Business Case).
Scottish Health Council	To advise in relation to matters relating to Major Service Change/ National Standards for Community Engagement HIGH	Collaborate	Patient and Public Perspective	Professional Expertise/Advice	Meetings as required	As required	Advice & Guidance	Not applicable	Lead Planning Manager Project Managers Public Involvement Officer Service Change Advisor	Decision on Major Service Change/Engagement Activities/Evaluations
Community Planning Partnerships	To ensure Community Planning opportunities are maximised MEDIUM	Collaborate	Partner Agencies	Community Planning perspective/ expertise	Meetings as required	As required	Working with and alongside communities to develop the services that they need	Not applicable	Lead Planning Manager Project Managers	Approval of Future Service Delivery Model, Schedule of Accommodation and required Infrastructure
Grampian NHS Board	To fully consider all options and make decisions in line with priorities in the Asset Management Plan. HIGH	Empower	Approval of plan and associated capital spending.	Approvals and Capital Funding.	Reporting NHSG Board.	IA (Initial Agreement), OBC (Outline Business Case) and FBC (Full Business Case) stage to Board.	Governance Capital Programme Capital Budget Links to acute services	Not applicable	Programme Director and Lead Planning Manager	Approval of Strategic Case, Economic Case, Commercial Case, Financial Case and Management Case, at IA (Initial Agreement), OBC (Outline Business Case) and Full Business Case (FBC) stages
Aberdeen City Council (ACC) Councillors/MP's/ MSP's	To ensure the concerns and needs of their constituents are understood and considered. HIGH	Involve	Testing the plan with the public.	Feedback on community concerns and assistance to share information.	Elected Member briefings and Reporting to IJB. (Integration Joint Board)	IA (Initial Agreement), OBC (Outline Business Case) and FBC (Full Business Case) stages.	Service change affecting constituents.	Not applicable	Lead Planning Manager/ Project Manager	Supportive of the proposals and approve the relevant Business Case

Third/Independent Sector	To explore the opportunities to deliver a mixed model of health and care services. MEDIUM	Collaborate	They may be partner in future service delivery model.	Operational expertise and input at planning stage.	Project Group.	Monthly	Transformation of Service Commissioning Achieve best value Workforce	Not applicable	Lead Planning Manager/ Project Manager	Third/Independent sector engagement in design and delivery of new model.
SHMU – Station House Media Unit	To provide a platform to communicate with the wider community and public groups MEDIUM	Involve/ Inform	Communicating aspects of the Project with the wider public and community/ groups	Community Expertise Feedback on Community concerns and assistance to share information	Radio Shows Community Newsletters – Regeneration Area's	As required	Transformation of services New Delivery Model Site Location Integrated Working Schedule of Accommodation	Publication Materials/ Budget Events	Lead Planning Manager Project Manager Patient Community Reps Public Involvement Officer Development Officer	Utilise varying methods of communication with those affected by the changes to reach as large an audience as possible
Grampian Regional Equality Council Protected Characteristic Groups • Age. • Disability. • Gender reassignment. • Marriage and civil partnership • Pregnancy and maternity. • Race. • Religion or belief. • Sex. • Sexual orientation	To ensure needs and concerns are understood and considered under the Equality Act 2010 MEDIUM	Collaborate	To ensure those identified as Protected Characteristics are identified and communicated with, using appropriate methods. Extra/varied communication consideration	User Perspective, specific to particular user groups. Pay particular attention to those for example without digital access/ethnic minorities, hearing or sight impairments etc.	Workshops 121 Website Newsletter Social Media Briefings Consultation Events Letters Questionnaires Internal Reports National Standards for Community Engagement Patient Demographics	Monthly Regular Basis/ As Required	New delivery model Site location Future access to GMS (General Medical Services/GP) services. Transitional Period	Workshop budget – Transform-ation Fund. Translating Information Communicati-on Methods	Equality and Diversity Manager Lead Planning Manager Project Managers Public Involvement Officer Development Officer	To ensure protected groups are not discriminated against under the obligations of the Equality Act 2010
Scottish Government	To ensure full compliance with SCIM, (Scottish Capital Investment Manual) Major Service Change and secure funding.	Empower	Approval of plan and associated capital spending.	Approvals and Capital Funding.	Reporting to Capital Investment Group.	IA (Initial Agreement), OBC (Outline Business Case) and FBC (Full Business Case) stages.	Authority Governance Capital Programme and funding	Not applicable	Chief Officer, Programme Director and Lead Planning Manager	Approval of IA (Initial Agreement), OBC (Outline Business Case) and FBC (Full Business Case).

	HIGH									

General Guide to Type of Engagement :		
Inform	:	To provide balanced, accurate and consistent information to assist stakeholders in understanding the issue, alternatives, opportunities, solutions.
Consult	:	To obtain feedback from stakeholders on issues, alternatives, outcomes, solutions.
Involve	:	To work directly with the stakeholder to ensure their concerns and needs are understood and considered.
Collaborate	:	To work together with the stakeholder in looking at the development of alternatives, decision-making, and identifying preferred solutions.
Empower	:	To give the stakeholder decision-making powers. Stakeholders are enabled/equipped to actively contribute to the outcome.

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DENBURN/AURORA PROJECT – OBC (Outline Business Case) Stage

Engagement Sessions Briefing Report

Findings from the range of Engagement Sessions carried out from 27th November 2018 to 16th January 2019 with key stakeholders including staff, patients, members of the public, MSP's and Elected Members.

1. Background

The Scottish Government has approved an Initial Agreement to invest £8.1 million in a new Integrated Community facility to deliver health and care services for the patients of the Denburn/Aurora Medical Practice Grouping. They key driver for change was the ongoing deterioration of the Denburn Health Centre at the Rosemount Viaduct in the Central Locality. In 2017, the Denburn Medical Practice successfully tendered to provide General Medical Services (GMS) to the populations of Northfield and Mastrick, now referred to as the Denburn/Aurora Medical Practice. The Northfield Surgery and Mastrick Clinic are also a priority for replacement in the next 5-10 years. The Outline Business Case sets out the service solution for the patient population at the Denburn/Aurora Medical Practice and ensures investment in facilities to further integrate health and care services.

This single new facility will incorporate the General Medical Services currently being delivered from the Denburn Medical Centre, Northfield Surgery and Mastrick Clinic, alongside Aberdeen City Health & Social Care Partnership (ACHSCP) services including community nursing, community midwifery, health visitors, and other AHP services. The Initial Agreement – which was the first phase in the planning process was approved by the Scottish Government in April 2018. The next two phases are the Outline Business Case (OBC) and the Full Business Case (FBC), these will be considered by the Scottish Government in April 2019 and December 2019 respectively.

The Greenferns area has been confirmed as the site location of the new facility, following an assessment of available sites and a period of engagement with key stakeholders, which is located to the west of Northfield next to Orchard Brae and Heathryburn Schools. When the new building is complete in spring 2021, services currently operating from Denburn, Mastrick and Northfield sites will move into the new building in the Greenferns area. When the new building opens an additional City Centre GMS service will also open and operate from the Health Village on Frederick Street, Aberdeen on a permanent basis to provide local access for City Centre patients and also the practices student population. This will ensure that the city centre patients accessing their current service from the Denburn Health Centre will continue to have access to a GP service in the city centre as well as having access to the new facility in the Greenferns area.

2. Methodology

A5 flyers and A4 posters signposting the public to the consultation were placed and displayed (where accepted) in businesses, public notice boards and community centres. The flyers and posters were also displayed at Denburn Health Centre, Northfield Surgery, Mastrick Clinic, Rosemount Community Centre, Northfield Community Centre and Mastrick Community Centre. Public social media accounts (Facebook, twitter) in the local area were mapped and sent details of the consultation. They were also distributed to the Rosemount and Mile End Community Council, Northfield Community Council and Mastrick, Sheddocksley and Summerhill Community Council. MSPs and Elected members were also briefed during specific engagement sessions and one to one meetings were also held.

Details of the consultation were made available in an information sheet and hard copies of these at the events were distributed to those in attendance – see appendix 1. An evaluation form was distributed at the events to capture key questions about the changes (see appendix 2) and individuals were asked to complete and return the form. People were also asked to provide their contact details if they are "Interested in Getting Involved" – see appendix 3.

3. Summary of findings

In total, information sheets were handed out to 85 people in all sessions, 50 people completed the evaluation form and 7 people were interested in getting involved. Out of the 50 responses received from all sessions 16 of them were patients, 8 of them work in the area, 6 of them were staff and 2 people said they live in the area. 18 people did not respond to this question.

3.1 Responses received by Location

The breakdown of overall responses received by location is shown in Table 1.

Table 1: Response received by location

Location	Number of responses	Percentage of responses
Northfield Surgery	19	38%
Denburn Health Centre	16	32%
Mastrick Clinic	5	10%
Northfield Community Council and Community Mental Health	4	8%
Mastrick, Sheddocksley and Summerhill Community Council	2	4%
Rosemount Community Centre	1	2%
Rosemount and Mile End Community Council	1	2%
Northfield Community Centre	1	2%
Mastrick Community Centre	1	2%
Total	**50**	**100%**

The highest rate of response was received from Northfield Clinic at 38%, followed by Denburn Health Centre at 32% and Mastrick Clinic at 10%.

3.2 Responses by Categories

When asked the questions to capture the feelings of receiving information about the project and the changes that are taking place, various responses were received. Figure 1 shows out of all 50 responses 48% agreed and 36% strongly agreed that they felt informed about the project while 10% disagreed and 4% strongly disagreed. Only 2% neither agreed nor disagreed.

Figure 1: People feel informed about the project

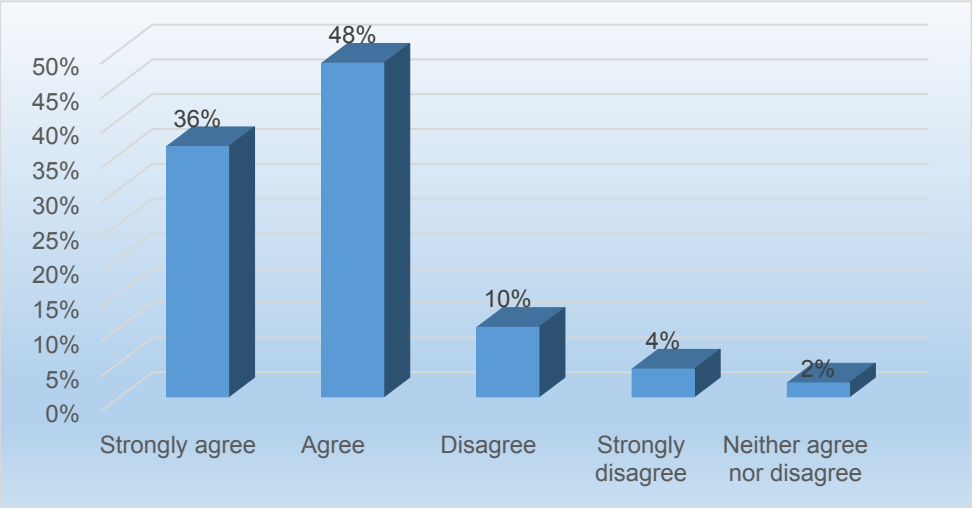
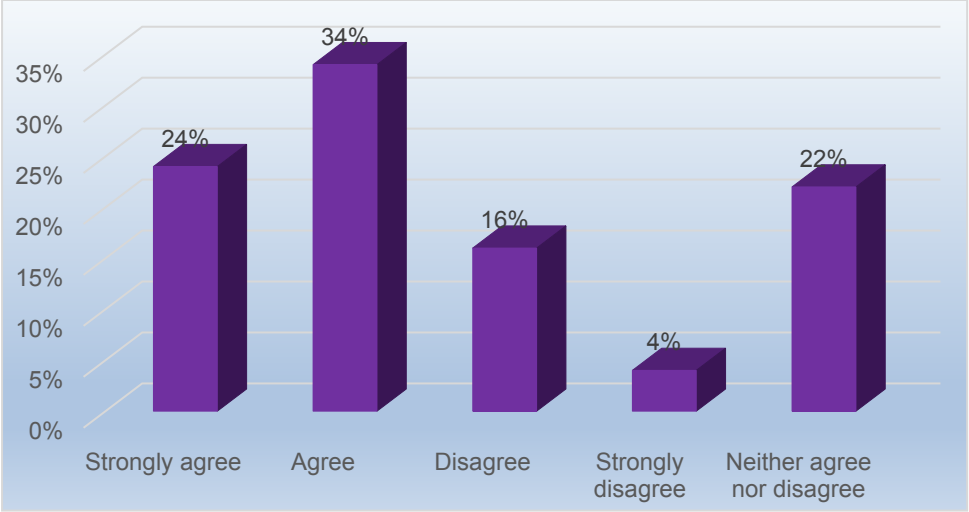


Figure 2 shows how people feel involved in the changes that are taking place. 34% agreed that they felt involved and 24% strongly agreed that they felt involved. In contrast 16% disagreed and 4% strongly disagreed. 22% neither agreed nor disagreed.

Figure 2: People feel involved in the changes that are taking place



Responses received for the question about people feel at ease about the changes that are taking place, 70% agreed or strongly agreed that they felt at ease, 14% disagreed or strongly disagreed, 12% neither agreed nor disagreed and 4% did not respond to this question – shown in Figure 3.

Figure 3: People feel at ease about the changes that are taking place

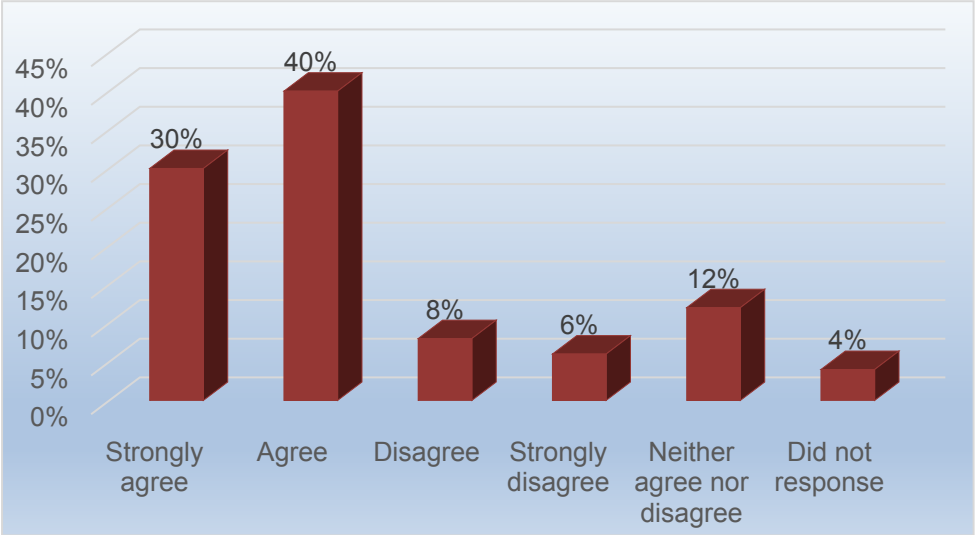
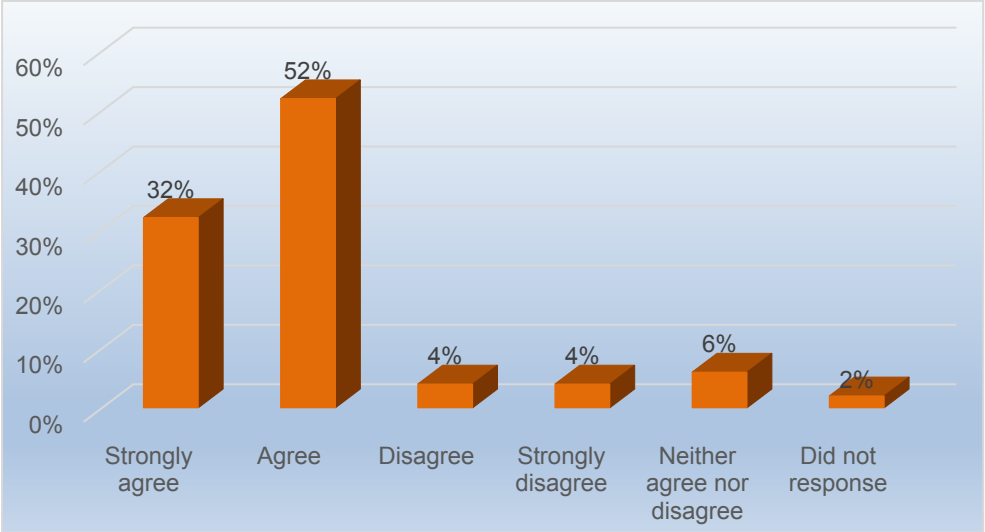


Figure 4 shows 52% respondents agreed and 32% strongly agreed that they were clear about getting more information about the project. Whereas 4% disagreed and 4% strongly disagreed. 6% of respondents neither agreed nor disagreed and 2% did not respond.

Figure 4: People are clear about getting more information about the project



3.3 Comments and suggestions

In total, 38 Comments and suggestions were received. Responses received for Building/Practice requirements are grouped into mainly four categories; building, accessibility, service requirements and parking. Table 2 shows responses received for by categories.

Table 2: Comments and suggestions by categories

	Responses	% of Responses
Building/Practice Requirements	12	32%
Receiving information	6	16%
Facilities	5	13%
Triage system	5	13%
Positive	5	13%
Negative	3	8%
Transport	2	5%
Total	**38**	**100%**

The most common responses received in category 'Building/Practice requirements', out of 38 respondents 12 (32%) were comments or suggestions that the building should be easily accessible, future proofed and adequate parking including disabled parking provision. For service requirement the responses included pharmacy service and full range of support for patients.

Receiving or getting information about the project and changes that are taking place was the second highest category with the response rate of 16%. Followed by Facilities (13%) which included suggestion for café, vending machine, Wi-Fi for patients and staff and space for wellbeing classes.

13% were not happy with the triage system. 13% gave positive comments such as "The session was very helpful and informative" and "Opportunities for people with health inequality". In contrast, 8% gave negative comments such as "This change won't work for me" and "It's very annoying to hear my surgery will now be changed".

3.4 Voting poll to decide the name of the new building

Attendees in all sessions were asked to vote for the new building name with the two name suggestions put forward following stakeholder consultation: 'Greenferns Health and Care Centre' and 'Greenburn Health and Care Centre'. A voting poll was also open on the Project Facebook page from 27th November 2018 to 5th December 2018. 116 responses were received. 61 responses were in favour of 'Greenferns Health and Care Centre' and 55 responses were in favour of 'Greenburn Health and Care Centre'. The breakdown of the voting poll is shown in Table 3.

Table 3: Voting Poll

	Greenferns Health and Care Centre	Greenburn Health and Care Centre	Total Number of Votes
Facebook Poll	13	19	32
Northfield Clinic	14	9	23
Denburn Health Centre	9	8	17
Northfield Community Council and Community Mental Health	10	6	16
Rosemount Community Centre	8	3	11
Mastrick, Sheddocksley & Summerhill Community Council	2	6	8
Mastrick Clinic	3	2	5
Northfield Community Centre	1	2	3
Mastrick Community Centre	1	0	1
Rosemount and Mile End Community Council	0	0	0
Total	**61**	**55**	**116**

If you require further analysis or more information about this briefing report please contact:

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Got an idea? Let's hear it - https://ahscp.hunchbuzz.com

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Appendix 1 – Information Sheet

What's the background to the project?

The Scottish Government has approved an Initial Agreement to invest £8.1 million in a new facility to deliver health and care services for the patients of the Denburn/ Aurora Medical Practice Grouping. In 2017, the Denburn Medical Practice were chosen to provide General Medical Services (the services you associate with receiving from your GP practice) to the populations of Northfield and Mastrick, now referred to as the Denburn/Aurora Medical Practice.

The three current buildings at Denburn, Mastrick and Northfield will be replaced by this exciting, built for purpose facility. You can see an artist's impression of the main entrance to the right.

View of Main Entrance

What services will be provided?

The new facility will incorporate the GP services being delivered from Denburn Medical Centre, Northfield Surgery and Mastrick clinic alongside a range of services provided by the Aberdeen City Health and Social Care Partnership. These include community nursing, community midwifery, health visitors and allied health professional services (speech and language therapy and podiatry).

Where will the facility be?

The Greenferns area has been confirmed as the site location of the new facility. This is to the west of Northfield not far from Orchard Brae and Heathryburn Schools.

What about city centre patients?

When the new building opens, an additional satellite service of the Denburn/Aurora Medical Practice Grouping will also open and operate from the Health Village on Frederick Street, Aberdeen, on a permanent basis to provide local access for city centre patients and also the practice's student population.

This will ensure that the city centre patients accessing their current service from the Denburn Health Centre will continue to have access to a GP service in the city centre, as well as having access to the new facility in the Greenferns area.

Transport links

There will be good parking available on site and the area currently has a range of bus routes that service the surrounding area. Please check the sites of First Bus Aberdeen and Stagecoach for details.

Public dental provision

It is really important that although there will be no public dental service in the new facility in the Greenferns area, we continue to provide these communities with a Public Dental Service when required. However, dental provision will continue at both the Mastrick clinic and Northfield surgery until at least 2021. The Public Dental Service more generally is going to be focussing its support to people with complex medical and social needs – the Aberdeen City Health and Social Care Partnership will be engaging with the public on these changes over the next 5 years or so.

Timeline for the new facility

Construction is set to begin in early 2020 and is due to complete in spring 2021.

Naming the new facility

The new facility is going to be named by a public vote at our 6 engagement sessions and also through our Facebook page. Keep an eye on our website and Facebook page below for the big announcement of the winner!

Facebook page

We have launched a Facebook page for the project. Please visit, comment and give us a like!

www.facebook.com/DenburnAuroraDevelopmentProject/

Further information

If you would like further information, visit our Facebook page or our NHS Grampian website page – www.nhsgrampian.org/dmndp

Also, feel free to contact the Project Manager Teresa Waugh on achscp.capital@nhs.net if you would like to find out more or give us your views.

Thank you!

Appendix 2

Session evaluation form

We'd be grateful if you could take a minute to answer the questions below. Please tick one box for each of the four questions. Thank you!

1. I feel better informed about this project

Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree

2. I feel more involved in the changes that are taking place

Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree

3. I feel more at ease about the changes that are taking place

Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree

4. I am clear what to do if I want more information about the project

Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree

Any other comments

Information about you

1. Please tick one box below to identify the capacity in which you attended this session

Someone who attend this practice as a patient or lives in the area	
Member of staff of the Denburn/Aurora practice	
Someone who works in the area (non-Denburn/Aurora staff)	

2. Would you consider yourself to be covered by any of the 9 protected characteristics which protect people from discrimination, harassment and victimisation? Please tick all that apply

Age	
Disability	
Gender reassignment	
Marriage and civil partnership	
Pregnancy and maternity leave	
Race	
Religion or belief	
Sex	
Sexual orientation	

3. Do you consider yourself to be a carer? A carer is anyone who, unpaid, looks after a friend or family member who can't cope alone due to illness, disability, a mental health problem or an addiction. Please tick one box below

Yes	
No	
Don’t know	

Appendix 3

Interested in getting involved?

This project to reshape community health and care provision in the Northfield/Mastrick area and the city centre is a long-term one. The timeline for completion of the new facility in the Greenferns area is spring 2021.

We are keen to represent the views of our communities in the development of this project. For example, part of our visions is to create a community orchard and outdoor gym. If you are interested in playing a part, please give us your contact details below. We will only contact you regarding this specific project.

At this stage there is no commitment involved. We'd simply like to contact interested people in due course to tell them more about the opportunities for becoming involved. This will range from being given information about the project's development to more actively giving your views and influencing the development. Thank you for your interest!

Name
Address
Email address
Phone number

Personal Information

Please note the personal information provided in this form will be held securely and processed in line with the Data Protection Act 1998. The information within the form will be held by the Capital Team within the Aberdeen Health and Social Care Partnership for the purposes of contacting you regarding the Denburn and Aurora project. This information will be retained for internal purposes only. This information will not be shared with any third parties without your consent. As an individual you have a right under the Data Protection Act 1998 to obtain information from us.

Appendix 4

What would you like the new building to be called?

Please put a cross against one of the names below and put your slip in the box. The name with the most votes wins. Thank you!

Greenferns health and care centre	
Greenburn health and care centre	

Exempt information as described in paragraph(s) 8 of Schedule 7A
of the Local Government (Scotland) Act 1973.

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