Public Document Pack

To: Members of the Audit and Performance Systems Committee

Town House,
ABERDEEN 6 February 2019

AUDIT AND PERFORMANCE SYSTEMS COMMITTEE

The Members of the **AUDIT AND PERFORMANCE SYSTEMS COMMITTEE** are requested to meet in **RmTHeCR2, Marischal College on TUESDAY, 12 FEBRUARY 2019 at 10.00 am**.

FRASER BELL
CHIEF OFFICER - GOVERNANCE

BUSINESS

TERMS OF REFERENCE

DECLARATION OF INTERESTS

1 Members are requested to intimate any declarations of interest

DETERMINATION OF EXEMPT BUSINESS

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

STANDING ITEMS

3 Welcome and Apologies

4 Minute of Previous Meeting of 13 November 2018 (Pages 9 - 16)

5 Forward Report Planner (Pages 17 - 22)

STEWARDSHIP & GOVERNANCE

6 Strategic Risk Register Review (Pages 23 - 58)

7 Board Assurance & Escalation Review (Pages 59 - 104)

PERFORMANCE

8 Transformation Programme Monitoring (including PCIP) (Pages 105 - 264)

9 Performance Monitoring (Pages 265 - 272)

10 Delayed Discharges (Pages 273 - 284)

STRATEGY

11 Review on Progress with Locality Planning (Pages 285 - 292)

12 Strategic Commissioning Implementation Plan Review (Pages 293 - 298)

13 Ethical Care Charter & Living Wage Update Report (Pages 299 - 304)

FINANCE

14 Financial Monitoring (Pages 305 - 322)

AUDIT

15 External Audit Plan (Pages 323 - 350)

16 Internal Audit - Budget Setting, Monitoring and Financial Performance (Pages 351 - 354)

17 Local Government Finance - Audit Scotland (Pages 355 - 396)

CONFIRMATION OF ASSURANCE

18 Confirmation of Assurance

PRIVATE MEETING WITH INTERNAL & EXTERNAL AUDIT

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 INTEGRATION JOINT BOARD

AUDIT AND PERFORMANCE SYSTEMS COMMITTEE TERMS OF REFERENCE

1. Introduction

(1) The Audit & Performance Systems Committee is identified as a Committee of the Integration Joint Board (IJB). The approved Terms of Reference and information on the composition and frequency of the Committee will be considered as an integral part of the Standing Orders.

(2) The Committee will be known as the Audit & Performance Systems Committee (APS) of the IJB and will be a Standing Committee of the Board.

(3) The purpose of the Committee is to provide assurance to the IJB on the robustness of the Partnership's risk management, financial management service performance and governance arrangements.

2. Constitution

(1) The IJB shall appoint the Committee members. The Committee will consist of four voting members of the IJB, with two members appointed from each partner.

3. Chairperson

(1) The Committee will be chaired by a non-office bearing voting member of the IJB and will rotate between NHS Grampian and Aberdeen City Council (ACC).

4. Quorum

(1) Three Members of the Committee will constitute a quorum.

5. Attendance at Meetings

(1) The Chief Officer, Chief Finance Officer, Chief Internal Auditor and other Professional Advisors and senior officers are required as a matter of course, external audit or other persons shall attend meetings at the invitation of the Committee.

(2) The Chief Internal Auditor will be invited to each meeting and the external auditor will attend at least one meeting per annum.

(3) The Committee may co-opt additional advisors as required.

6. Meeting Frequency

(1) The Committee will meet at least four times each financial year. There should be at least one meeting a year, or part thereof, where the Committee meets the external and Chief Internal Auditor without other seniors officers present. A further two developmental sessions will be planned over the course of the year to support the development of members.

7. Authority

(1) The Committee is authorised to instruct further investigation on any matters which fall within its Terms of Reference.

8. Duties

The Committee shall:-

(1) Review the overall Internal Control arrangements of the Board and make recommendations to the Board regarding signing of the Governance Statement, having received assurance from all relevant Committees.

(2) Prepare and implement the strategy for performance review and monitor the performance of the Partnership towards achieving its policy objectives and priorities in relation to all functions of the IJB.

(3) Ensure that the Chief Officer establishes and implements satisfactory arrangements for reviewing and appraising service performance against the national health and wellbeing outcomes, the associated core suite of indicators and other local objectives and outcomes and for reporting this appropriately to the Committee and Board.

The performance systems scrutiny role of the Committee is underpinned by an Assurance Framework which itself is based on the Board's understanding of the nature of risk to its desired priorities and outcomes and its appetite for risk-taking.

This role will be reviewed and revised within the context of the Board and Committee reviewing these Terms of Reference and the Assurance Framework to ensure effective oversight and governance of the partnership's activities.

(4) Act as a focus for value for money and service quality initiatives.

(5) Review and approve the annual audit plan on behalf of the IJB, receiving reports, overseeing and reviewing actions taken on audit recommendations and reporting to the Board.

(6) Monitor the annual work programme of Internal Audit, including ensuring IJB oversight of the clinical and care audit function and programme to ensure this is carried out strategically.

(7) Consider matters arising from Internal and External Audit reports.

(8) Review on a regular basis actions planned by management to remedy weaknesses or other criticisms made by Internal or External Audit.

(9) Support the IJB in ensuring that the strategic integrated assurance and performance framework is working effectively, and that escalation of notice and action is consistent with the risk tolerance set by the Board.

(10) Support the IJB in delivering and expecting cooperation in seeking assurance that hosted services run by partners are working effectively in order to allow Aberdeen City IJB to sign off on its accountabilities for its resident population.

(11) Review risk management arrangements, receive annual Risk Management updates and reports and annually review with the full Board the IJB's risk appetite document.

(12) Ensure the existence of and compliance with an appropriate Risk Management Strategy.

(13) Report to the IJB on the resources required to carry out Performance Reviews and related processes.

(14) Consider and approve annual financial accounts and related matters.

(15) Approve and understand the sources of assurance used in the Annual Governance Statement.

(16) Review the Annual Performance Report to assess progress toward implementation of the Strategic Plan.

(17) Be responsible for setting its own work programme which will include the right to undertake reviews following input from the IJB and any other IJB Committees.

(18) Promote the highest standards of conduct by Board Members.

(19) Monitor and keep under review the Codes of Conduct maintained by the IJB.

(20) Provide oversight of Information Governance arrangements and staffing arrangements as part of the Performance and Audit process.

(21) Be aware of, and act on, Audit Scotland, national and UK audit findings and inspections/regulatory advice, and to confirm that all compliance has been responded to in timely fashion.

(22) The Committee shall present the minute of its most recent meeting to the next meeting of the IJB for information.

9. Review

(1) The Terms of Reference will be reviewed annually to ensure their ongoing appropriateness in dealing with the business of the IJB.

(2) As a matter of good practice, the Committee should expose itself to periodic review utilising best practice guidelines.

Aberdeen City Health & Social Care Partnership
A caring partnership

Audit and Performance Systems Committee

Minute of Meeting

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

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

DECLARATIONS OF INTEREST

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

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

DETERMINATION OF EXEMPT BUSINESS

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

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

MINUTE OF PREVIOUS MEETING OF 11 SEPTEMBER 2018

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

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

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

BUSINESS PLANNER

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

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

COMMITTEE MEETING SCHEDULE

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

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

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

FINANCIAL MONITORING

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

The report recommended:
That the Committee –

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

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

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

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

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

FINANCIAL REGULATIONS

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

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

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

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

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

SCOTTISH MEDIUM-TERM FINANCIAL FRAMEWORK

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

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

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

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

AUDIT AND PERFORMANCE SYSTEMS COMMITTEE
13 November 2018

JOINT INSPECTION OF SERVICES FOR OLDER PEOPLE

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

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

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

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

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

NHS AUDIT SCOTLAND REPORT

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

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

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

CONFIRMATION OF ASSURANCE

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

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

The Committee resolved:-

(i) to request the Chief Officer to prepare a performance report on Delayed Discharges and present the report to the Committee's next meeting on 12 February 2019; and

(ii) to otherwise confirm the receipt of reasonable assurance for items on the agenda.

- RHONA ATKINSON, Chairperson.

AUDIT AND PERFORMANCE SYSTEMS COMMITTEE
13 November 2018

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AUDIT AND PERFORMANCE SYSTEMS COMMITTEE

BUSINESS PLANNER

12 February 2019

Please note that this planner contains a note of items which have been instructed for submission to, or further consideration by, the Audit and Performance Systems Committee (APS). 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	APS/IJB/CCG Decision	Update	Terms of Reference	Lead Officer(s)	Expected
1.	IJB 28.08.18 Article 9	**Primary Care Improvement Plan** To note that a PCIP implementation plan would be developed which would be configured around the practice of improvement and that performance would be monitored by the Audit and Performance Systems Committee.	This report will be presented to Committee in February 2019 (transformation report). On this agenda	Item 8(21)	G Woodcock	12.02.19
2.	IJB 28.08.18 Article 12	**Annual Performance Report** To note that performance monitoring of the Annual Report was within the remit of the APS Committee.	At its meeting on 11 September 2018, the Committee agreed to adopt a more creative approach for next year's Annual Report and instructed the Lead Strategy and Performance Manager to present options for consideration at the Committee's next meeting on 13 November 2018. The adoption of a more creative approach for next year's Annual Report will now be integrated into the broader refresh of the Strategic Plan and review of strategic	Item 8(16)	A MacLeod	12.02.19

No.	Minute Reference	APS/IJB/CCG Decision	Update	Terms of Reference	Lead Officer(s)	Expected
			performance indicators to ensure a cohesive approach is maintained. A report will be presented to Committee in February 2019. (performance report) On this agenda			
3.	IJB 28.08.18 Article 14	**Carers: Waiving of Charges and Replacement Care** To request that progress updates on implementation of the Local Guidelines be reported to the Audit and Performance Systems Committee.		Item 8(21)	A MacLeod	August 2019
4.	IJB 28.08.18 Article 18	**Transformation Decisions** To instruct officers to carry out *a lessons learned exercise* on the speed of the recruitment process and roll-out of the transformation programme and report these findings to the Audit and Performance Systems Committee.	This report will be presented to Committee in February 2019 and be aligned with the transformation progress report. On agenda	Item 8(16)	G Woodcock	12.02.19
5.	IJB 22.05.18 Article 1	**Strategic Risk Register Review** To refer the Strategic Risk Register to the Audit and Performance Systems Committee for further review.	The IJB agreed on 9 October 2018 that the APS Committee would escalate any risk which in the Committee's view, should to be increased. The IJB also instructed the Business Manager to populate gaps within the Risk Appetite Statement relating to	Item 8(11)	M Allan	12.02.19

No.	Minute Reference	APS/IJB/CCG Decision	Update	Terms of Reference	Lead Officer(s)	Expected
			Commissioned and Hosted Services and report this to the next meeting of the Audit and Performance Systems Committee. This Strategic Risk Register will be presented to Committee in February 2019. On agenda			
6.	APS 02.03.18 Article 8	**Internal Audit** To note that the Committee would receive an annual report from Internal Audit on any recommendations which had not been accepted or actioned by Management.		Item 8(6)	D Hughes	28.05.19
7.	IJB 30.01.18 Article 13	**Strategic Commissioning Plan** To request an annual update on the implementation of the Strategic Commissioning Implementation Plan to both the IJB and APS Committee.	On agenda	Item 8(4)	A McKenzie	12.02.19
8.	IJB 06.06.17 Article 7	**Living Wage/Ethical Care Charter Implementation** To note that monitoring arrangements would be put in place which would include reporting to the Audit and Performance Systems Committee and an update on living wage implementation would be included	This report will be presented to Committee in February 2019. On agenda	Item 8(21)	C Duncan	12.02.19

No.	Minute Reference	APS/IJB/CCG Decision	Update	Terms of Reference	Lead Officer(s)	Expected
		within the Ethical Care Charter annual performance report.				
9.	APS 11.09.18 Article 5	**APS Committee Duties** The Committee requested the Chief Finance Officer to present a report back to Committee at the end of the financial year confirming that these duties were met and outlining the anticipated schedule for meeting these duties in the financial year 2019-20.		Item 8(1-22)	A Stephen	28.05.19
10.	APS 11.09.18 Article 13	**Locality Planning** The Committee requested assurance on the progress of locality planning in terms of meeting strategic outcomes.	This report will be presented to Committee in February 2019. To follow	Item 8(16)	S Ross G Woodcock L McKenna	12.02.19
11.	APS 11.09.18 Article 13	**Future Financial Planning** The Committee requested assurance on the financial sustainability of core budgets, how the Partnership planned to reduce overspends and possible areas for disinvestment ahead of the IJB budget setting process.	This item was received on 13 November 2018 **Recommend for removal**	Item 8(4)	A Stephen	Item received 13 Nov 18
12.	APS 13.11.18 Article 8	**Scottish Medium Term Financial Framework** The Committee requested the Chief Finance Officer to produce a detailed action plan to address the longer term	This will be contained within the MTFS paper (due to be considered 12th March)	Item 8 (4)	A Stephen	12.02.19

No.	Minute Reference	APS/IJB/CCG Decision	Update	Terms of Reference	Lead Officer(s)	Expected
		financial impact on services and submit a report to the Committee on 12 February 2019.				
13.	APS 13.11.18 Article 6	**Financial Monitoring** The Committee requested the Chief Finance Officer to provide an update in relation to the Grampian solution for Learning Disability Client care; and The Committee noted that a mapping exercise across the city had commenced to locate all services, where they were based and what was available and that a report on the outcome of the exercise would be submitted to the meeting in February 2019.	Update on the service mapping exercise is provided within the transformation report.		A Stephen S Ross	12.02.19
14.	APS 13.11.18 Article 10	**NHS Audit Scotland Report – Effective Leadership** The Committee requested the Chief Finance Officer to prepare a report in relation to leadership development and the support model in place for the leadership group and submit it to this Committee within six months.			A Stephen	28.05.19
15.	APS 13.11.18 Article 11	**Delayed Discharges** The Committee requested the Chief Officer to prepare a performance report on Delayed Discharges and	On this agenda		K O'Brien	12.02.19

No.	Minute Reference	APS/IJB/CCG Decision	Update	Terms of Reference	Lead Officer(s)	Expected
		present the report to the Committee's next meeting on 12 February 2019.				

INTEGRATION JOINT BOARD

Date of Meeting	12.02.2019
Report Title	Strategic Risk Review
Report Number	HSCP.18.0129
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 b. Risk Appetite Statement

1. Purpose of the Report

1.1. To present the Audit & Performance Systems (APS) Committee with the latest version of the Aberdeen City Health & Social Care Partnership's (ACHSCP) strategic risk register for an in-depth review of items 1, 2 & 3.

2. Recommendations

2.1. It is recommended that the Audit & Performance Systems 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.

INTEGRATION JOINT BOARD

3. Summary of Key Information

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 include:

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 2019, 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. It is recommended that the APS Committee undertakes an in-depth review of risk 1, 2 & 3.

Review of Risk 1

3.5. A recent example of working in partnership with local care at home providers was during the transfer of care packages previously provided by Allied Healthcare with reasonably short notice. Most of the packages were absorbed by local providers within the Care at Home Framework, with only a small proportion being absorbed by Bon Accord Care as

provider of last resort. We recognise that in order to strengthen the market, and to ensure we achieve our ambitions within the strategic plan, we need to work in partnership with providers. We will start with bimonthly providers meetings, with all providers coming together in one room with us to discuss our collective current challenges and opportunities. This will allow us to consider challenges for the future and how we collectively equip ourselves to meet these needs - market facilitation. We will also be preparing to tender the care at home contract and will work with teams and providers to ensure that this is fit for purpose, and meets the needs of the population.

Review of Risk 2

3.6. There continues to be a risk of demand outstripping the available budget for Health and Social Care services within Aberdeen City. Some of this demand we only have limited control of and is dependant on the frailty and health of the adult population within Aberdeen. Previously, the IJB has shown good progress in managing the level of demand within the financial resources available to it. Prevention and self-management are recognised as priorities by the IJB. However, demand is starting to increase particularly for clients seeking support for complex disabilities. The next review of demand and finances will come in the update to the Medium Term Financial Strategy.

Review of Risk 3

3.7. Hosted services have been on the risk register since the inception of the IJB. Work continues at a chief officer level to further develop the assurances required that the hosted services are working effectively and to consider the strategic planning for these services collaboratively across the three areas.

Revised Risk Appetite Statement

3.8. Members of the Integration Joint Board considered the risk appetite statement during a development workshop on the 24th of April 2018. They recommended several revisions, which are included in the risk appetite statement at appendix A.

3.9. The review of the risk appetite statement included re-formatting the dimensions of risk and corresponding risk appetite into a table. When reformatted, it became apparent that there was not a corresponding risk appetite for “risks relating to commissioning and hosted services”.

3.10. This is now included and the IJB requested that this draft version is presented to the APS committee for approval.

Further Development Work

3.11. It is proposed that the format of the reporting of risk in the Partnership be looked at and reviewed. The Chief Officer has held discussions with the Risk Management Adviser in NHSG and it is proposed that the previously approved Risk Management Policy (agreed by the 3 IJB's, the 3 Local Authorities and NHSG) be reviewed. This review will help shape the future format of the Risk Register. It is also proposed that a revised process to reviewing all risks on the current Operational Risk Register be undertaken to be linked to the refreshed Strategic Objectives.

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

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.

INTEGRATION JOINT BOARD

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.

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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)

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

1. Risk Tolerances
2. 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.	

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- 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 17.01.2019**	**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 Contract Review visits and GP Sustainability Risk Review	**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 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 • Developing 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.
Current performance: • Currently there are concerns in relation to one care home (Banks O Dee). This is being managed in collaboration with the care Inspectorate in order to drive improvement. Additional vigilance is paid in circumstances where there is the potential for concern – for example, when the management of a care home changes hands. • Sleepovers – the uplift to accommodate the living wage for sleepover staff was implemented in October 2018. • • We were recently made aware of a national care provider closing services due to financial pressures. This affected 111 clients in receipt of care at home across the City. Working with local providers, all packages were successfully transferred with minimal disruption to clients	**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 2016/172017/18 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.	

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<table>
<tr><th colspan="3">-2-</th></tr>
<tr><td colspan="3">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).</td></tr>
<tr><td colspan="2">Strategic Priority: Outcomes and transformation</td><td>Leadership Team Owner: Chief Finance Officer</td></tr>
<tr><td>Risk Rating: low/medium/high/very high

HIGH

Risk Movement: increase/decrease/no change:

NO CHANGE 17.01.2019</td><td colspan="2">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.

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).</td></tr>
<tr><td>Controls:</td><td colspan="2">Mitigating Actions:</td></tr>
</table>

Budgets delegated to cost centre level and being managed by budget holders.	• Financial information is reported regularly to the Audit & Performance Systems Committee, the Integration Joint Board and the Executive Team. • Reserves strategy, including risk fund • Robust financial monitoring and budget setting procedures including regular budget monitoring & budget meeting with budget holders • Development of a Medium-Term Financial Strategy (approved by the IJB at its meeting on the 27th March 2018) • Audit & Performance Systems receives regular updates on transformation programme & spend.
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:** • None known – noting that the financial environment is challenging and requires regular monitoring. • Financial failure of hosted services may impact on ability to deliver strategic ambitions.
Current performance: • Year-end position for 2017/18 • 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.	**Comments:** • Regular and ongoing budget reporting and management scrutiny in place. • 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.

- 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**	**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.	
Risk Movement: (increase/decrease/no change): **NO CHANGE 17.01.2019**		
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
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. • 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

• A framework for strategic planning for delegated (hosted) services has been developed and is in the process of being approved by the 3 IJBs.	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 intend to undertake an internal audit on the governance of hosted services.

<table>
<tr><td colspan="3">- 4 –</td></tr>
<tr><td colspan="3">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.</td></tr>
<tr><td colspan="2">Strategic Priority: Outcomes and service transformation</td><td>Leadership Team Owner: Chief Officer</td></tr>
<tr><td>Risk Rating: low/medium/high/very high

MEDIUM

Risk Movement: (increase/decrease/no change)

NO CHANGE 17.01.2019</td><td colspan="2">Rationale for Risk Rating:
• Considered medium given the experience of two 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.</td></tr>
<tr><td colspan="2">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.</td><td>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.</td></tr>
</table>

	• 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.	**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.

<table>
<tr><td colspan="3">- 5 –</td></tr>
<tr><td colspan="3">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 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.</td></tr>
<tr><td colspan="2">Strategic Priority: Outcomes, safety, transformation of services</td><td>Leadership Team Owner: Strategy Lead</td></tr>
<tr><td>Risk Rating: low/medium/high/very high
MEDIUM
Risk Movement: (increase/decrease/no change)
NO CHANGE 17.01.2019</td><td colspan="2">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 regulatory bodies and 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.</td></tr>
<tr><td colspan="2">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</td><td>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 how learning is fed back into processes and procedures.
• On-going work developing a culture of performance management and evaluation throughout the transformation programme</td></tr>
</table>

• Internal Audit Reports Complaints	
Assurances: • Joint meeting of IJB Chief Officer with two Partner Body Chief Executives. • Reports to Clinical and Care Governance 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 have still to be established. • Establishing reporting and assurance mechanisms for hosted and commissioned services

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- 6 –	
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** **Risk Movement:** *(increase/decrease/no change)* **No Change 17.01.2019**	**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 2nd budget, which was approved. **Rationale for Risk Appetite:** Willing to risk certain reputational damage if rationale for decision is sound.
Controls: • Executive Management Team • IJB and its Committees • Operational management processes and reporting • Board escalation process	**Mitigating Actions:** • Clarity of roles • Staff and customer engagement – 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.

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Assurances:	**Gaps in assurance:**
• Role of the Chief Officer and Executive Team • Role of the Chief Finance Officer • Performance relationship with NHS and ACC Chief Executives • Communications plan / communications manager	None known at this time
Current performance:	**Comments:**
• Communications officer in place to lead reputation management	• Communications strategy and action plan in place and being led by the HSCP's Communications Manager • Communication and Engagement Group in place comprising of staff across the partnership supporting us in getting the message right and appropriate • Locality leadership groups being established to build our relationship with communities and stakeholders • Regular 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

<table>
<tr><th colspan="3">- 7 –</th></tr>
<tr><td colspan="3">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.</td></tr>
<tr><td colspan="2">Strategic Priority: All</td><td>Leadership Team Owner: Transformation Lead</td></tr>
<tr><td>Risk Rating: low/medium/high/very high
HIGH
Risk Movement: (increase/decrease/no change)
NO CHANGE 17.01.2019</td><td colspan="2">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.</td></tr>
<tr><td colspan="2">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.</td><td>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</td></tr>
</table>

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<table>
<tr><td></td><td>

- 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.

</td></tr>
<tr><td>

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.

</td><td>

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

</td></tr>
<tr><td>

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.

</td><td>

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

</td></tr>
</table>

• 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

<table>
<tr><th colspan="3">- 8 –</th></tr>
<tr><td colspan="3">Description of Risk
There is a risk that the IJB does not maximise the opportunities offered by locality working</td></tr>
<tr><td colspan="2">Strategic Priority: All</td><td>Leadership Owner: Chief Officer</td></tr>
<tr><td>Risk Rating: low/medium/high/very high
HIGH
Risk Movement: (increase/decrease/no change)
NO CHANGE 17.01.2019</td><td colspan="2">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.</td></tr>
<tr><td colspan="2">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.</td><td>Mitigating Actions:
Continued broad engagement on locality working and requested development of comprehensive communication plan</td></tr>
<tr><td colspan="2">Assurances:
Strategic Planning Group
Locality plans performance monitoring and review.</td><td>Gaps in assurance
Progress of delivering locality plans.</td></tr>
</table>

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.	• Locality Leadership Groups s continue to meet • Locality plans & profiles have been created for each of the 4 localities, approved by the IJB & published on the website.

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<table>
<tr><th colspan="3">- 9 –</th></tr>
<tr><td colspan="3">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.</td></tr>
<tr><td colspan="2">Strategic Priority: All</td><td>Leadership Team Owner: People & Organisation</td></tr>
<tr><td>Risk Rating: low/medium/high/very high

HIGH

Risk Movement: (increase/decrease/no change)

NO CHANGE 17.01.2019</td><td colspan="2">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.
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</td></tr>
<tr><td colspan="2">Controls:
Clinical & Care Governance committee reviews operational risk around staffing numbers</td><td>Mitigating Actions:
Requested reference to regional approaches
Consideration of engaging with schools/college/universities
Use commissioning to encourage training of staff
Development of a workforce plan
Agreed to establish a working group to lead on further development on workforce planning.</td></tr>
</table>

	• Increased emphasis on health/well being 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	**Comments:** • The Executive 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.

<table>
<tr><td colspan="2">-10-</td></tr>
<tr><td colspan="2">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 difficult 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.</td></tr>
<tr><td>Strategic Priority: Outcomes, safety and transformation</td><td>Executive Team Owner: Clinical Director</td></tr>
<tr><td>Risk Rating: low/medium/high/very high

HIGH</td><td>Rationale for Risk Rating:

• There is still a high level of uncertainty around ‘Brexit’ as impacts are difficult to forecast.</td></tr>
<tr><td colspan="2">Risk Movement: increase/decrease/no change

NEW RISK 22.01.2019</td></tr>
<tr><td>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
• ACC- A Brexit Steering Group has been established and met on 7/1/19 . The Partnership is now a member of this Group</td><td>Mitigating Actions:

• Engaged with both NHSG and ACC on working groups around Brexit (Chief Officer (NHSG) and Business Manager (ACC)).
• Stable workforce
• Medicines and medical devices being addressed at national level
• 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.</td></tr>
</table>

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	• The Partnership's Business Continuity Planning process is established which will identify key services to prioritise in any contingency event
Assurances: • Scottish Government considering policy for staff to remain post Brexit • Understanding that current legislation will remain in effect for a period of time 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). • Clarify the position regarding UK / Scotland planning to supply chain and medicine. • Clarification regarding position for EU staff both current and future. • Clarification regarding the contingency plans that will be implemented at local, regional and national level
Current performance:	**Comments:** • ACHSCP colleagues will need to ensure continued engagement with ACC and NHSG working groups.

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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

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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.	Significant 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 minor injury not requiring first aid	Minor injury or illness, first aid treatment required.	Agency reportable, e.g. Police (violent and aggressive acts). Significant 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	Justified written complaint peripheral to clinical care.	Below excess claim. Justified complaint involving lack of appropriate care.	Claim above excess level. Multiple justified complaints	Multiple claims or single major claim. Complex justified 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).	Significant 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. Significant effect on staff morale and public perception of the organisation.	National media/adverse publicity, less than 3 days. Public confidence in the organisation undermined. Use of services affected.	National/International media/ adverse publicity, more than 3 days. MSP/MP concern (Questions in Parliament). Court Enforcement. Public Enquiry/FAI.

Table 2 - Likelihood Definitions

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

Version March 2013

Table 3 - Risk Matrix

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

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

Table 4 - NHSG Response to Risk

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

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

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Risk Appetite Statement

Aberdeen City Health and Social Care Integration Joint Board (the IJB) recognises that it is both operating in, and directly shaping, a collaborative health and social care economy where safety, quality and sustainability of services are of mutual benefit to local citizens, to stakeholders and to organisational stakeholders. It also recognises that its appetite for risk will change over time, reflecting a longer-term aspiration to develop innovation in local service provision based on evidence of benefits and on a culture of continuing, planned engagement with the public and other stakeholders, including those involved in service delivery. As a result the IJB is working towards a mature risk appetite over time.

It recognises that achievement of its priorities will involve balancing different types of risk and that there will be a complex relationship between different risks and opportunities. The risk appetite approach is intended to be helpful to the board in decision-making and to enable members to consider the risks to organisational goals of *not* taking decisions as well as of taking them.

The board has identified several broad dimensions of risk which will affect the achievement of its strategic priorities. The IJB will set a level of appetite ranging from “none” up to “significant” for these different dimensions. Higher levels of all risk types may be accepted if specific and effective controls are demonstrably in place and there are clear advantages for integration objectives. The dimensions of risk and corresponding risk appetite are:

Dimension of Risk	Corresponding Risk Appetite
Financial risk	Low to moderate. It will have zero tolerance of instances of fraud.
Regulatory compliance risk	It will accept no or minimal risk in relation to breaches of regulatory and statutory compliance.
Risks to quality and innovation outcomes	Low to moderate (quality and innovation outcomes which predict clearly identifiable benefits and can be managed within statutory safeguards)
Risk of harm to clients and staff	Similarly, it will accept no or minimal risks of harm to service users or to staff. By minimal risks, the IJB means it will only accept minimal risk to services users or staff when the comparative risk of doing nothing is higher than the risk of intervention
Reputational risk	It will accept moderate to high risks to reputation where the decision being proposed has significant benefits for the organisation’s strategic priorities
Risks relating to commissioned and hosted services	The IJB recognises the complexity of planning and delivery of commissioned and hosted services. The IJB has no or minimal tolerance for risks relating to patient safety and service quality. It has low to moderate tolerance for risks relating to service redesign or improvement.

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

This risk appetite statement will be reviewed regularly, at least as often as the IJB's strategic plan is reviewed and more often when required.

Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Date of Meeting	12.02.2019
Report Title	Board Assurance & Escalation Framework
Report Number	HSCP.18.128
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. Board Assurance & Escalation Framework

1. Purpose of the Report

1.1. To present the Audit & Performance Systems (APS) Committee with the latest version of the Board Assurance and Escalation Framework (BAEF) for approval.

2. Recommendations

2.1. It is recommended that the Audit & Performance Systems Committee:

a) Approve and provide comment on the Board Assurance and Escalation Framework, as at Appendix A.

3. Summary of Key Information

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

3.2. The BAEF describes the regulatory framework of the IJB to support its vision, values and principles, within which the A&PS committee will work.

INTEGRATION JOINT BOARD

Fundamental to the framework are the IJB's strategic priorities and the appetite for risk that the board has across these priorities.

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

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

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

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

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

Introduction and Revision of the BAEF.

3.7. The BAEF was formally approved by the IJB at its meeting in March 2016. The A&PS committee assumed responsibility for the regular review and any necessary escalation of the BAEF at its meeting in May 2016.

Further Revision of the BAEF

3.8. Key changes to this version of the BAEF include:

- Updated risk appetite statement;
- Updated strategic priorities in anticipation of the revised strategic plan;
- Review of the terminology and structures to reflect the interim arrangements within senior management of ACHSCP
- Updated appendix 8 (Cycle of Business)

3.9. As the Committee will be aware, work is currently ongoing to take a full review of several processes including:

- Clinical & Care Governance processes
- Risk Management processes
- Health & Safety governance processes

3.10. The current revisions are presented to the APS committee to ensure that regular, annual review of the BAEF is undertaken. However, once these reviews have been concluded, the BAEF will be further revised to reflect the new arrangements. This will then be presented back to the APS committee.

4. Implications for IJB

4.1. **Equalities –** there are no direct implications arising directly as a result of this report

4.2. **Fairer Scotland Duty –** there are no direct implications arising directly as a result of this report

4.3. **Financial** – there are no direct implications arising directly as a result of this report

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 assurance and escalation framework will help the ACHSCP achieve the strategic priorities as outlined it its strategic plan, as it will provide assurance that key risks to the achievement of integration objectives are appropriately identified, communicated and addressed.

INTEGRATION JOINT BOARD

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, as captured in the BAEF will help to mitigate all risks.

Board Assurance and Escalation Framework

Revised 22.01.2019. Next review January 2020.

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Part 1: Introduction

1.1 Background

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

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

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

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

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

1.2 Regulatory framework

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

The IJB will make recommendations, or give directions where appropriate (i.e. where funding for employment is required) to the decision-making arms of Aberdeen City Council and NHS Grampian as required.

1.3 Purpose of the framework

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

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

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

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

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

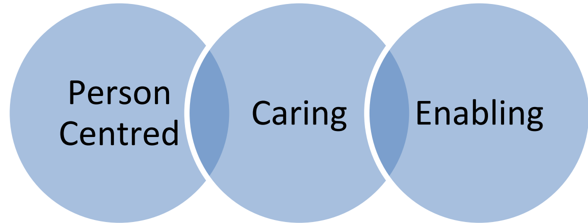
[3] Chartered Institute of Public Finance and Accountancy (CIPFA) and the International Federation of Accountants® (IFAC®). *International Framework: Good Governance in the Public Sector*, (2014) - http://www.cipfa.org/policy-and-guidance/standards/international-framework-good-governance-in-the-public-sector

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

The structures and systems described are those in place from January 2019. In order to ensure that the framework can best support the IJB in its ambitions going forward, it will be reviewed annually.

1.4 An integrated approach to governance for health and social care

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



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

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

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

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

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

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

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

Table 1: Assurance and Compliance Framework

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

Part 2: The Framework

2.1 Strategic priorities

From the nine strategic outcomes identified nationally as desired outcomes form integration, the ACHSCP has, in its revised Strategic Plan[6] (due to be approved at the IJB in March 2019), articulated five broad strategic aims, which form the basis of its governance framework.

Prevention	• We will work with our partners to achieve positive individual outcomes and lessen the need for formal support.
Resilience	• Supporting people and organisations so they can cope with, and where possible, overcome, the health and wellbeing challenges they might face.
Enabling	• Ensuring that the right care is provided in the right place and at the right time when people are in need.
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.
Connections	• Develop meaningful community connections and relationships with people to promote better inclusion, health and wellbeing, and to combat social Isolation.

These priorities underpin:

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

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

2.2 Risk Management

a) Risk appetite

Risk appetite can be defined as:

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

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

B) Risk Appetite Statement

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

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

The full risk appetite statement is outlined below:
Aberdeen City Health and Social Care Integration Joint Board (the IJB) recognises that it is both operating in, and directly shaping, a collaborative health and social care economy where safety, quality and sustainability of services are of mutual benefit to local citizens, to stakeholders and to organisational stakeholders. It also recognises that its appetite for risk will change over time,

reflecting a longer-term aspiration to develop innovation in local service provision based on evidence of benefits and on a culture of continuing, planned engagement with the public and other stakeholders, including those involved in service delivery. As a result the IJB is working towards a mature risk appetite over time.

It recognises that achievement of its priorities will involve balancing different types of risk and that there will be a complex relationship between different risks and opportunities. The risk appetite approach is intended to be helpful to the board in decision-making and to enable members to consider the risks to organisational goals of *not* taking decisions as well as of taking them.
The board has identified several broad dimensions of risk which will affect the achievement of its strategic priorities. The IJB will set a level of appetite ranging from "none" up to "significant" for these different dimensions. Higher levels of all risk types may be accepted if specific and effective controls are demonstrably in place and there are clear advantages for integration objectives. The dimensions of risk and corresponding risk appetite are:

Dimension of Risk	**Corresponding Risk Appetite**
Financial risk	Low to moderate. It will have zero tolerance of instances of fraud.
Regulatory compliance risk	It will accept no or minimal risk in relation to breaches of regulatory and statutory compliance.
Risks to quality and innovation outcomes	Low to moderate (quality and innovation outcomes which predict clearly identifiable benefits and can be managed within statutory safeguards)
Risk of harm to clients and staff	Similarly, it will accept no or minimal risks of harm to service users or to staff. By minimal risks, the IJB means it will only accept minimal risk to services users or staff when the comparative risk of doing nothing is higher than the risk of intervention
Reputational risk	It will accept moderate to high risks to reputation where the decision being proposed has significant benefits for the organisation's strategic priorities
Risks relating to commissioned and hosted services	The IJB recognises the complexity of planning and delivery of commissioned and hosted services. The IJB has no or minimal tolerance for risks relating to patient safety and service quality. It has low to moderate tolerance for risks relating to service redesign or improvement.

The IJB has an appetite to take decisions which may expose the organisation to additional scrutiny and interest where there is evidence of confidence by key stakeholders, especially the public, that difficult decisions are being made for the right reasons. This is most likely to be evident in relation to innovation where there is a perceived need to challenge relationships, standards and

working practices and/or where the IJB considers there are identifiable, longer-term benefits of greater integration of systems and technology.

This risk appetite statement will be reviewed regularly, at least as often as the IJB's strategic plan is reviewed and more often when required.

c) Risk Management policy and system

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

The framework sets out the arrangements for the management and reporting of risks to IJB strategic priorities, across services, corporate departments and IJB partners. In line with the principles set out in the Australia/New Zealand Risk Management Standard 4360 [7], it describes how risk is contextualised, identified, analysed for likelihood and impact, prioritised, and managed. This process is framed by the requirement for consultation and communication, and for monitoring and review.

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

d) Risk Assessment methodology

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

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

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

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

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

The IJB's risk measurement table is shown below:

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

Risk Matrix

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

The outputs from risk assessment are as follows:

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

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

The IJB's SRR format is shown here with a real example of the kind of issue included in the document (Appendix 1). While many of the issues may be termed strategic, the key thing to remember is that these are issues which may affect the ability to deliver on strategy. It is quite possible that significant operational issues will also be incorporated, therefore. The Leadership Team consider risks classified as 'very high' for inclusion in the SRR (see Appendix 7 – risk escalation process). The Leadership Team reviews the SRR in light of their experiences and insight into key issues, including commissioning risk, and recommends the updated version to the Audit & Performance Systems Committee (APSC) for approval and review by the IJB.

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

The risks are identified by:

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

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

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

Corporate Level: Operational Risk Register

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

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

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

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

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

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

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

Table 2: Risk Recording Format

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

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

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

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

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

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

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

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

Where risks cannot be satisfactorily managed locally, or where they are above scores as set out in the escalation flowchart, they will be escalated for possible entry onto the ORR. It is critical to emphasise that the risk management system cannot rely on

escalation through the risk register process alone. Senior management, through the operational group management structure, has a key role in helping to manage and find solutions to risk issues at all levels of the organisation.

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

2.3 Roles and Responsibilities for governance

a) Committee structure

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

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

In relation to governance and assurance, the **Audit and Performance Systems Committee (APSC)** performs the key role of reviewing and reporting on the effectiveness of the governance structures in place and on the quality of the assurances the Board receives. It has a moderation role in relation to the consistency of risk assessment. It also has oversight of information governance issues.

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

It also assures the IJB that services respond to requirements arising from regulation, accreditation and other inspections' recommendations. The Committee will consider and approve high value clinical and care risks, consider the adequacy of mitigation,

the assurance provided for that mitigation and refer residual high risks to the Board. It has a key role in assuring the board that learning from governance systems across services, including learning arising from incidents, complaints and identified risks, is shared and embedded as widely as possible.

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

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

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

b) Individual responsibilities

1. Board and corporate level:

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

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

2. Professional level:

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

- Lead Nurse
- Chief Social Work Officer
- Lead Allied Health Professional (AHP)

- Primary Care Clinical Leads (GPs)
- Public Health Lead
- Clinical Director (GP)

3. Locality level:

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

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

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

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

FOCUS	**Assurance of compliance, performance, improvement and transformation**						
				Reporting and feedback processes			
	Individuals	**Plans / activities**	**Groups / Partners**	**Compliance with standards**	**Risk escalation and review**	**Performance monitoring**	**Improvement and Transformation reporting**
Board level	Chair Chief Officer Board members	Strategic plan Strategic Risk Assurance Register	Board Leadership Team Audit and	Review of BAEF Review of risk scoring Review of Performance dashboard			

	Chairs / CEOs of the Partners	Operational Risk register Performance framework Audit plan Standing Orders Integration Scheme	Performance Systems Committee Clinical and Care Governance Committee Other IJBs Scrutiny / governance arms of Parties	PMO report Audit reports to Board Exception and action plan review Bi-annual review of integration scheme Bi-annual review of strategic plan
Corporate level	Directors Senior Managers PMO	Strategic and Operational risk registers Performance dashboard Business planning Budget monitoring Joint Complaints Procedure	Leadership Team Senior Management Teams Cluster Management Group Strategic Planning Group Clinical and Care Governance Group	Financial monitoring Corporate risk register review Risk moderation and review
Service level	Clinical leads and Social work leads Professional leads Service managers Service users	Communication and Engagement plan Clinical and care governance policies Risk registers and assessments	Community partners Service governance forums 'Deep Dive' activity	Risk register system Governance reports Real time feedback Response to complaints Service level dashboards
Individual level	Staff members Service users Carers	Communication and Engagement plan	Staff forums IJB engagement activity	Objective setting and review Supervision and line management Staff surveys

		Raising concerns policy Safeguarding alerts Risk assessment Incident reporting		Feedback mechanisms (see assurance source section)

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

FOCUS	**Assurance of compliance, performance, improvement and transformation**						
				Reporting and feedback processes			
	Individuals	**Activities**	**Groups / Partners**	**Compliance with standards**	**Risk escalation and review**	**Performance monitoring**	**Improvement and Transformation reporting**
NHSG Board	NHSG Board Chair ACHSCP Chief Officer	Regular Report	NHS Board Leadership Team	Oversight of IJB activity & minutes			
ACC Full Council	ACC Chief Executive	Regular Report	ACC Full Council ACC Chief Executive Leadership Team	Oversight of IJB activity & minutes Information on financial governance, risk management, clinical & care governance etc			
Pan-Grampian IJBs	Chief Officer, Aberdeen City Chief Officer, Aberdeenshire Chief Officer Moray Chair Aberdeen City,	Regular meetings	North East Partnership Steering Group	Established regionally			

	Chair Aberdeenshire IJB Chair Moray IJB			
ACC & NHSG CEs	CE NHSG CE ACC CO ACHSCP	Quarterly Performance Review Meetings Bi-monthly 2-1 meetings	ACC NHSG ACHSCP	Performance Finance Risk Governance Directions Transformation Programme

2.5 Sources of assurance

a) Quality of services

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

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

b) Engagement

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

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

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

ACHSCP endorsed and adopted the Community Planning Aberdeen 'Engagement, Participation and Empowerment Strategy' in order to support engagement across these groups, and to provide a source of assurance that appropriate activities have been identified and implemented. It includes consideration of how to engage with hard to reach communities.

Newsletters	Groups		Other
• Partnership Matters Newsletter • Health Village newsletter • NHSG Team Brief • Scottish Care newsletter/ e-bulletin • SHMU community newsletters	• Care at Home Providers Group Forum • Individual Independent providers • Care and Support Providers Aberdeen • Individual Third sector providers	• Sheltered Housing Network • Joint Strategy groups • GP Cluster Management Groups • Cluster Operational Groups (COGs) • Implementation Group (CIGs) • Public Health Co-ordinators	• The 'Our Ideas' Partnership suggestions website and system • 'Connect' – ACHSCP intranet • ACHSCP Website: https://www.aberdeencityhscp.scot/

• • ACVO e-bulletin • VSA Carers News	• Housing providers / associations • NHS Grampian Public Forum • City Voice • Civic Forum	Network • Local Community councils • Mental Health and Learning Disability forums • Joint Staff Forum • Learning Partnerships	

c) Other internal and external sources of assurance

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

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

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

Appendices

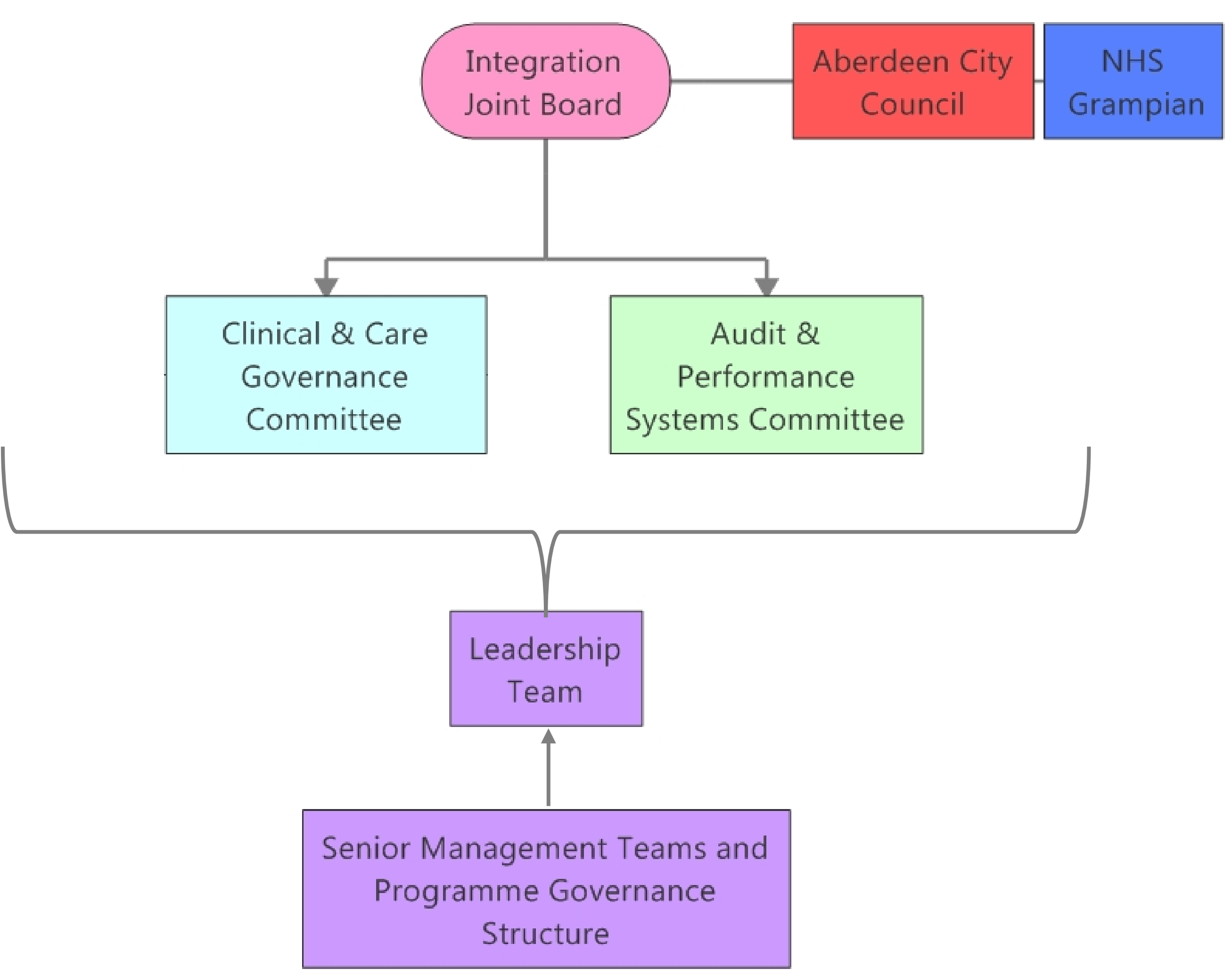
1	Strategic Risk Register format
2	Committee diagram
3	Transformation Programme Structure and Senior Management Structure
4	Role of the Committees
5	Clinical and care governance diagram
6	Risk assessment tables
7	Risk escalation process
8	Cycle of business (continually developed)
9	Ownership and Version Control for the Board Assurance and Escalation Framework

Appendix 1 – Strategic risk register format

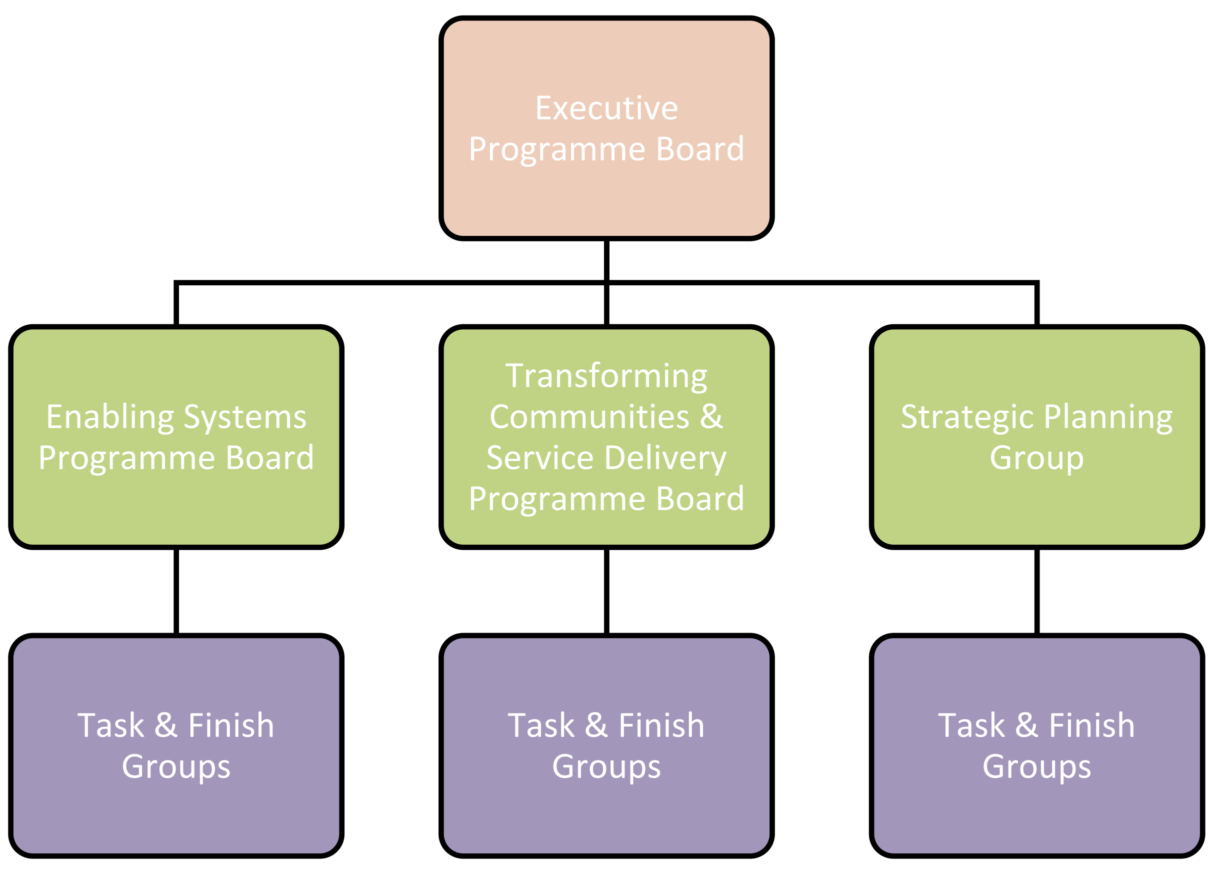
<table>
<tr><th colspan="2">- 1 -</th></tr>
<tr><td colspan="2">Description of Risk:</td></tr>
<tr><td>Strategic Priority:</td><td>Lead Director:</td></tr>
<tr><td>Risk Rating: low/medium/high/very high
Medium</td><td rowspan="2">Rationale for Risk Rating:

Rationale for Risk Appetite:</td></tr>
<tr><td>Risk Movement: increase/decrease/no change
NO CHANGE</td></tr>
<tr><td>Controls:</td><td>Mitigating Actions:</td></tr>
<tr><td>Assurances:</td><td>Gaps in assurance:</td></tr>
<tr><td>Current performance:</td><td>Comments:</td></tr>
<tr><td></td><td></td></tr>
</table>

Appendix 2 - Board committee diagram



Appendix 3 – Transformation Programme Structure



Appendix 4 – Roles of the Committees

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

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

Principal function/s	Membership	Reports to	Reports received / reviewed
	officers as required as a matter of course, external audit or other persons shall attend meetings at the invitation of the Committee. The Chief Internal Auditor should normally attend meetings and the external auditor will attend at least one meeting per annum.		
Clinical & Care Governance Committee			
To provide assurance to the IJB on the systems for delivery of safe, effective, person-centred care in line with the IJB's statutory duty for the quality of health and care services.	The Committee shall be established by the IJB and will be chaired by a voting member of the IJB. The Committee shall comprise of: • 4 voting members of the IJB • Chief Officer • Chief Social Work Officer • Chair of the Clinical and Care Governance Group/ ClinicalDirector (GP) • Chair of the Joint Staff Forum • Professional Lead – Nurse/AHP • Public Representative • Third sector Sector representatives	IJB	CCG Group report Feedback/Incidents Reporting Escalations from CCG Group
Clinical & Care Governance Group			
To oversee and provide a coordinated approach to clinical and care governance issues within the Aberdeen City Health and Social Care Partnership**.**	• Clinical Director (GP) (Chair) • Clinical and Care Governance Lead • Head of Operations • Lead Social Work Manager • Lead Nurse • Public Health Lead • Clinical Governance Coordinator/Facilitator • Patient/Public Representative • Lead Allied Health Professional	Clinical and Care Governance Committee	Reports from services: AHP Dentistry Optometry Pharmacy Nursing General Practice Social Work/Care Woodend Hospital and Links @ Woodend Biannual Reports Falls

Principal function/s	Membership	Reports to	Reports received / reviewed
	• GP Representative • Dental Clinical Lead or Dental Service Representative • Lead Optometrist • Representative from Sexual Health Service • General Practice Patient Safety Lead • Woodend Hospital and Link@ Woodend Representative • Representative from Commissioned Service • Partnership Representative • Representative from Community Mental Health and Learning Disability Services • Representative from Acute Sector • Public Partner		Pharmacy/medication Patient Safety in Primary Care
Locality Leadership Group			
To deliver the locality planning requirements of the Public Bodies (Joint Working) (Scotland) Act 2014, in respect of the Aberdeen City Health and Social Care Partnership. The Locality Leadership Group will play a key role in ensuring the delivery of the Aberdeen City Health and Social Care Strategic Plan, including contributing to the delivery of its associated strategic outcomes. The role of the Locality Leadership Group will include developing and ensuring appropriate connections and partnerships across the Locality to improve the health	Chair and Vice Chair to be agreed by Group and appointed for a fixed 2-year period. ▪ Health and Social Care Partnership Locality Manager ▪ GP Locality Lead ▪ Other GPs (TBC) ▪ Representative of Acute Sector (Unit Operational Manager) ▪ AHP Representative ▪ Nursing Representative ▪ Community Mental Health/ LD/ Rehab representation ▪ Unscheduled care representative (Out of hours/ A&E) ▪ Geriatric Medicine representative ▪ Social Care Representative (Bon Accord Care & Adult Social Care) ▪ Housing sector representative	Strategic Planning Group	Reports from Heads of Locality & Services (see box above)

Principal function/s	Membership	Reports to	Reports received / reviewed
and wellbeing of the locality population and reduce the health inequalities that we know impact poorly on people's lives. The locality leadership group will influence, and be influenced by, the city's Strategic Planning Group and ultimately the Integration Joint Board. The locality leadership group will also influence and be influenced by Community Planning Partnership processes.	▪ Third sector representative ▪ Independent Sector Representative ▪ Carer representative ▪ Patient representative ▪ Community representatives ▪ People managing services in the locality area Other locality stakeholders as determined by the group Further to the above membership, the group may arrange reports/ attendance at meetings from non-members as required, such as; ▪ Primary Care Dentistry Locality Representative ▪ Primary Care Optometry Locality Representative ▪ Primary Care Pharmacy Locality Representative		
Executive Programme Board			
• Provide direction to programme board and working groups • Identify prioritised projects • Approve Business Cases • Ensure programme progress including ensuring that progress is supported to continue at pace • Approve significant changes to programmes	• Leadership Team • Lead Transformation Manager	Seek IJB approval to incur expenditure for projects where required under standing orders (full life costs) Report on progress and performance to IJB	Papers from Enabling Systems/Strategic Commissioning/Transforming Communities and Service Delivery Programme Boards
Programme Boards (Enabling Systemsand Transforming Communities)			
• Support and enable progress at pace		Executive	Workstreams and project groups

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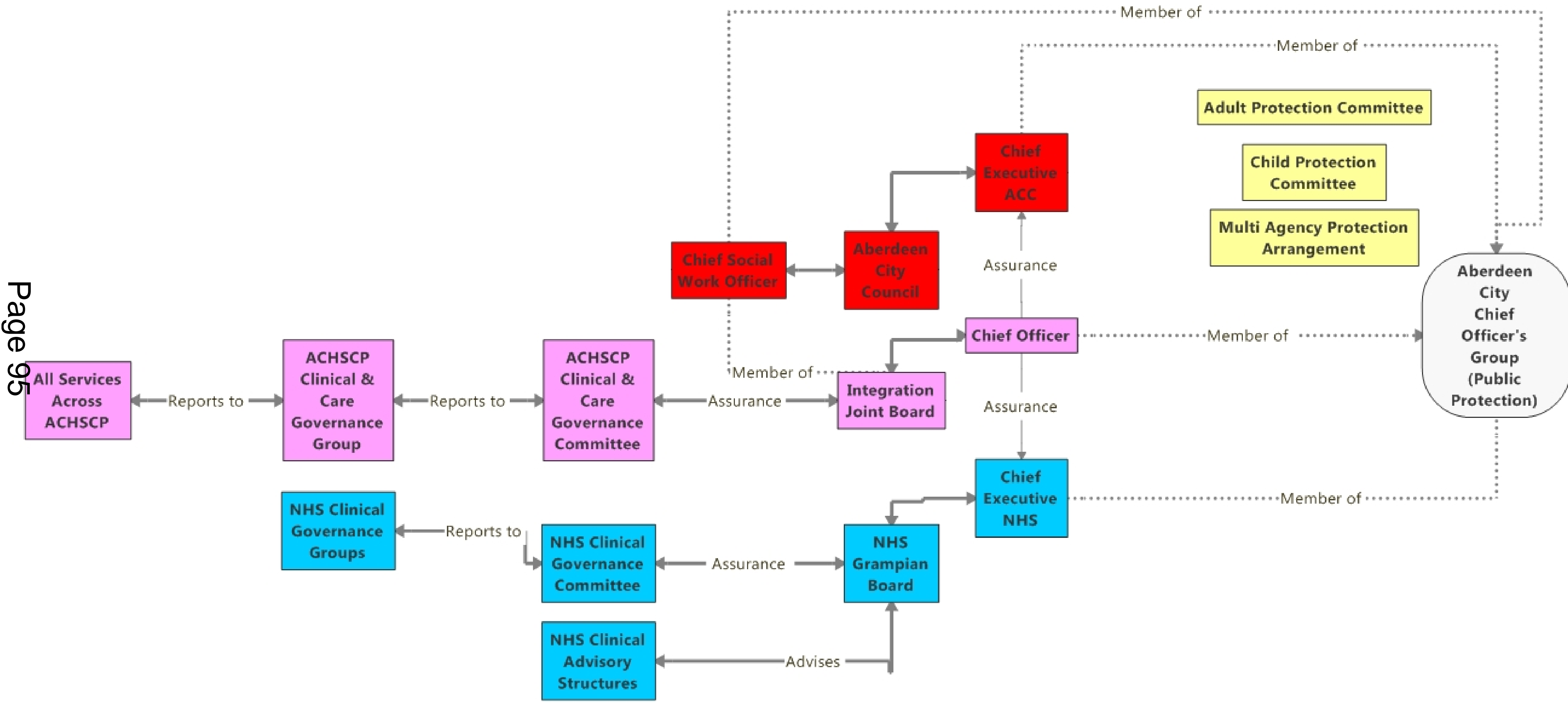
Principal function/s	Membership	Reports to	Reports received / reviewed
across transformation portfolio • Review and approve Project Proposal Documents • Consider "deep dives" into working group programmes to be assured of progress Ensure delivery of anticipated benefits and where these are no longer deliverable, redirect projects/ programmes accordingly	• Chair (ET Member) • Lead Transformation Manager (lead officer & vice chair) • Operational Managers • Lead Professional Managers • Independent Sector • Third Sector • ACC Communities and Housing • Acute Sector Finance	Programme Board	

Appendix 5 – Clinical and care governance diagram

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

Please note that this diagram will be revised following the review of Clinical & Care Governance.



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Appendix 6 – Risk assessment tables

NHS Scotland Core Risk Assessment Matrices

Table 1 - Impact/Consequence Defintions

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.	Significant 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 minor injury not requiring first aid	Minor injury or illness, first aid treatment required.	Agency reportable, e.g. Police (violent and aggressive acts). Significant 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	Justified written complaint peripheral to clinical care.	Below excess claim. Justified complaint involving lack of appropriate care.	Claim above excess level. Multiple justified complaints.	Multiple claims or single major claim. Complex justified 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).	Significant 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. Significant effect on staff morale and public perception of the organisation.	National media/adverse publicity, less than 3 days. Public confidence 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 Defintions

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	
	Ne
Almost Certain	M
Likely	M
Possible	
Unlikely	
Rare	

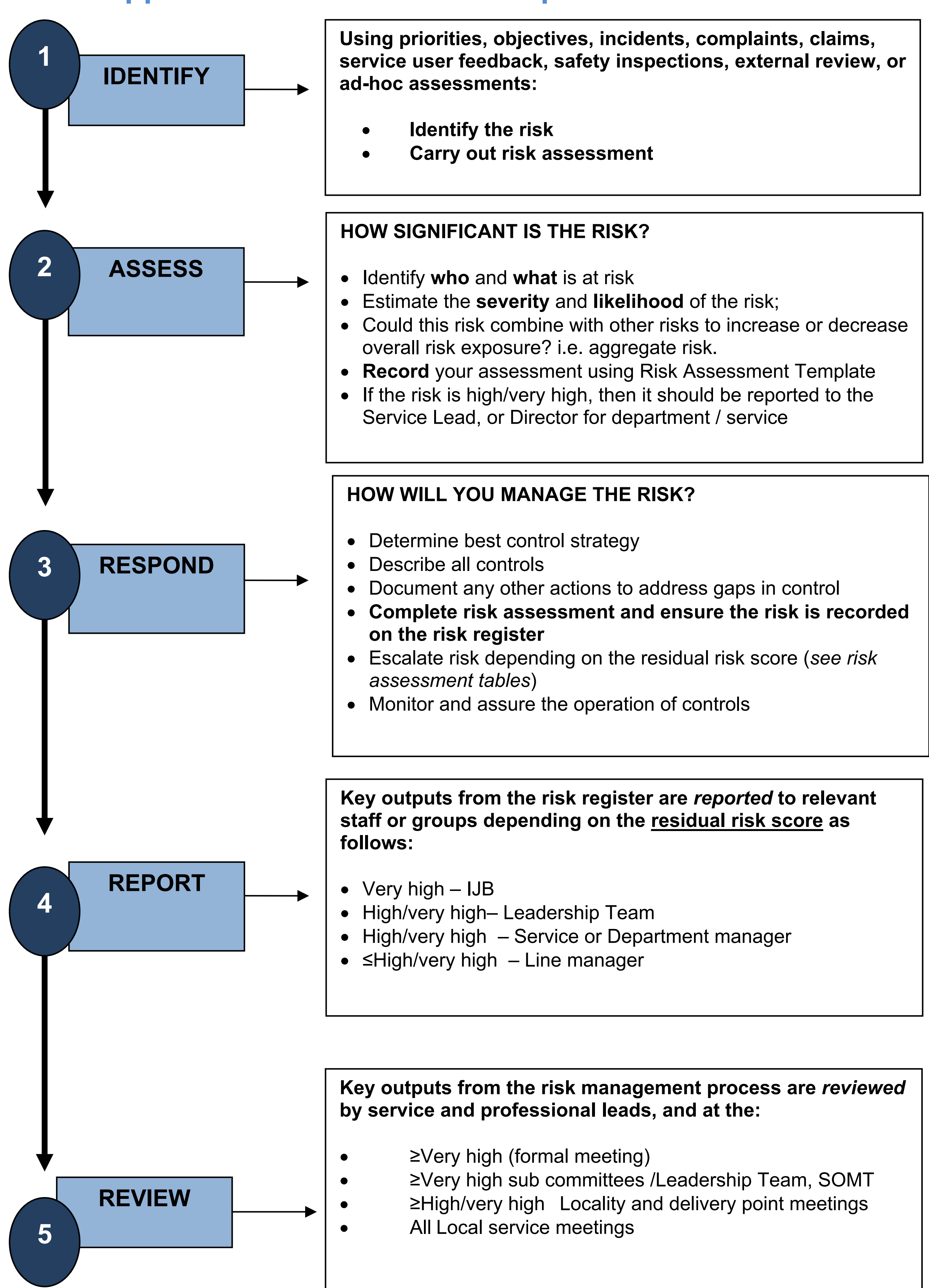
References: AS/NZS 4360:2

Table 4 - NHSG Resp

Describes what NHSG co
response expected for ea

Level of Risk	
Low	Acceptable lev or contingency Managers/Risk the risk registe
Medium	Acceptable le Managers/Risl but the cost of that the risk co Managers/Risk the risk registe Relevant Mana these continue
High	Further action possibly requir risk controls or risks applying t whether these Relevant Mana assurance that to do more. The managed. However NHS loss or exposu incidents(s) of
Very High	Unacceptable corrective acti Committees sh Managers/Risk the risk registe The Board will However NHS that may resu information sy compliance, po

Appendix 7 – Risk escalation process



Appendix 8 – Cycles of business (2019-20) – To be reviewed

Business Type	Report Title	Lead Officer	Committee	Frequency	Last Reported	Reporting Date (s) for 2019/20
Audit	Annual Internal Audit Plan	Internal Audit	APS	Annual	Apr-18	Apr-19
	Internal Financial Control Statement	Internal Audit	APS	Annual	Jun-18	Jun-19
	Internal Audit Annual Report	Internal Audit	APS	Annual	Apr-18	April019
	External Auditor Plan	External Audit	APS	Annual	Feb-19	Feb-20
	External Auditor Report	External Audit	APS	Annual	Jun-18 Sept-18	TBC (once plan received)
	Internal and External Auditors Private Meeting	NA	APS	Annual	Feb-19	Aug-19
Finance	Financial Monitoring Report	Chief Finance Officer	IJB & APS	Quarterly	Feb-19	Jun-19(IJB), Aug-19 (APS), Nov-19 (IJB), 25 Feb (APS)
	Unaudited Annual Accounts	Chief Finance Officer	IJB	Annual	May-18	May-19 (APS)
	Audited Annual Accounts	Chief Finance Officer	APS	Annual	Jun-18	June-19 (IJB)

Finance ctd.	Annual Budget	Chief Finance Officer	IJB	Annual	Mar-18	Mar-19
	Review of Financial Regulations	Chief Finance Officer	APS	Annual	Nov-18	Oct-19
	Annual Report on ADP (including Investment Plan)	ADP	IJB	Annual	Dec-18	Dec-19
	Reserves Policy	Chief Finance Officer	IJB	Annual	Apr-17	
Governance	Governance Review inc. TORs, SO, Committee Members Review, Roles & Responsibilities	Legal & Clerk	IJB	Annual	May-18	Jun-19
	Contact Register Annual Review	Commissioning Lead	APS	Annual	Sep-18	Aug-19
	Board Assurance Framework Review	Chief Finance Officer	APS	Annual	Feb-19	Sep-19
	Governance Statement	Chief Finance Officer	APS	Annual	Apr-18	Apr-19
	Review of APS TOR	Chief Finance Officer	APS	Annual	May-18	May-19
	Review of Financial Governance Arrangements	Chief Finance Officer	APS	Annual	Nov-18	Nov-19
	Local Code of Governance	Chief Finance Officer	APS	Annual	Apr-17	

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Governance continued	Review of the risk appetite statement	Chief Finance Officer	APS	Annual	Feb-19	Feb-20
	Chief Social Worker Annual Report	Chief Social Work Officer	IJB	Annual	Dec-18	Dec-19
	Review of CCG TOR	Clinical Director (GP)	CCG	Annual	Feb-19	Feb-20
	Annual Clinical and Care Governance Action Plan	Clinical Director (GP)	CCG	Annual	TBC	TBC
	Review of Committee Members	Chair	IJB	Annual	May-18	June-19
	Report on Directions	Chief Officer	IJB	Annual	TBC	TBC
	Review of Integration Scheme	Chief Officer	IJB	Every 2 years	Mar-18	Mar-20
	Refresh of Member's Register of Interest	Clerk	IJB	Annual	Jun-18	Jun-19
	Duty of Candor Annual Report	Business Manager	IJB	Annual	NA	Mar-19
	APS Duties Annual Review	Clerk	APS	Annual	Sep-18	May-19
Performance	Annual Performance Report (National & MSG Indicators)	Strategy Lead	IJB	Annual	NA	Aug-19

Performance continued	Annual Review of Performance Framework	Strategy Lead	APS	Annual	Jan-19	Jan-20
	Ethical Care Charter Update	Lead Social Work	IJB	6 Monthly	Feb-19	Feb-20
	Staff Absence Action Plan	Lead Social Work	CCG	Bi-Annual	NA	Jun-19, Nov-19
	Performance Management Framework	Strategy Lead	CCG & APS	Quarterly	Feb-19	As per below
	Prevention	Strategy Lead	CCG	Annually	NA	Aug-19
	Resilience	Strategy Lead	CCG	Annually	NA	Nov-19
	Enabling	Strategy Lead	APS	Annually	NA	Oct-19
	Connections	Strategy Lead	CCG	Annually	NA	Feb-20
	Communities	Strategy Lead	APS	Annually	NA	Feb-20
	Annual HIF Report	Public Health Lead	IJB	Annual	NA	Mar-20
	Annual Report	Chief Officer	IJB	Annual	Aug-18	Aug-19

Risk	Operational risk register	Head of Ops	CCG	Bi-monthly	Feb-17	May-19
	Strategic Risk Register	Chief Officer	IJB & APS	Quarterly	Feb-19	TBC
Strategic	Strategic Plan - Review and Update	Strategy Lead	IJB	Annual	Mar-19	Mar-20
	Strategic Commissioning Implementation Plan Update	Commissioning Lead	IJB	Annual	Feb-19	Feb-20 (APS), Mar-20 (IJB)
	Update report on progress with Carers Strategy	Strategy Lead	CCG	TBC	NA	Jun-19
	Annual Update on Carers Waiving of Charges & Replacement Care	Strategy Lead	APS	Annual	NA	Jun-19
	Annual Progress Reports on Autism Strategy	Strategy Lead	IJB	Annual	NA	Dec-19
	Annual Progress Reports on LD Strategy	Strategy Lead	IJB	Annual	NA	Dec-19
	Interim Progress Reports on LD Strategy	Strategy Lead	CCG	Annual	NA	Aug-19
	Interim Progress Reports on Autism Strategy	Strategy Lead	CCG	Annual	NA	Aug-19

Transformation	Transformation Programme Monitoring	Transformation Lead	APS	Quarterly	Feb-19	May-19, Aug-19, Feb-20, Apr-20
	Review of Transformation Process	Transformation Lead	APS	Annually	NA	TBC
	IJB Annual Update	Transformation Lead	IJB	Annual	NA	TBC
	Decisions Required	Transformation Lead	IJB	As required	Jan-19	As required

Appendix 9: Ownership & Version Control

Ownership:

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

Version Control

1. Version Control/Document Revision History (begun 24.11.2017)			
Version	Reason	By	Date
1.	Revisions to the BAEF requested by the Audit & Performance Committee at its meeting on the 21st of November 2017	Sarah Gibbon, Executive Assistant	24.11.2017
2.	Additional revisions to BAEF pending submission to IJB	Sarah Gibbon, Executive Assistant	22.01.2018
3.	Acceptance of changes	Sarah Gibbon, Executive Assistant	31.01.2018
4.	Annual Review	Sarah Gibbon Executive Assistant	18.01.2019

Aberdeen City Health & Social Care Partnership
A caring partnership

AUDIT & PERFORMANCE SYSTEMS COMMITTEE

Date of Meeting	12 February 2018
Report Title	Transformation Progress Report
Report Number	HSCP.18.130
Lead Officer	Sandra Ross, Chief Officer
Report Author Details	Gail Woodcock Lead Transformation Manager gwoodcock@aberdeencity.gov.ujk 01224 655748
Consultation Checklist Completed	Yes
Directions Required	No
Appendices	a. Transformation Programme: Acceleration and Pace Highlight Report b. INCA Evaluation Report c. INCA Briefing d. West Visiting Service Evaluation Report e. Primary Care Improvement Plan – Implementation Plan f. Aberdeen Links (Community Links Practitioner) – initial performance report

1. Purpose of the Report

The purpose of this report is to provide an update on the progress of the Transformation Programme.

This includes a high-level overview of the full transformation programme.

The report sets out our progress so far on the initial six transformation work priorities and how this work is informing the next stages of our transformation

journey. The report highlights specific progress and the initial evaluation of two significant projects within the programme.

The report also responds to the following decisions taken by the Integration Joint Board (August 2018):

- To note that a PCIP implementation plan would be developed which would be configured around the practice of improvement and that performance would be monitored by the Audit and Performance Systems Committee.
- To instruct officers to carry out a lessons learned exercise on the speed of the recruitment process and roll-out of the transformation programme and report these findings to the Audit and Performance Systems Committee.

Finally, the report brings to the attention of APS Committee the first performance report relating to the Community Links Practitioners project and shares the initial outputs of a service mapping exercise which commenced in November 2018.

2. Recommendations

2.1. It is recommended that the Audit & Performance Systems Committee:

a) Note the information provided in this report.

3. Summary of Key Information

3.1. Background

3.2. The Transformation Programme for the Aberdeen City Health and Social Care Partnership (ACHSCP), agreed by the IJB during its first year, includes the following priority areas for strategic investment:

- Acute Care at Home
- Supporting Management of Long Term Conditions and Building Community Capacity
- Modernising Primary and Community Care
- Culture Change/ Organisational Change
- Strategic Commissioning and Development of Social Care
- Information and Communication Technology, Infrastructure and Data Sharing

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

Revised Strategic Plan

3.4. With the development of the refreshed strategic plan, it is appropriate to consider the existing priorities within the Transformation Plan.

3.5. The draft revised strategic plan includes the following five strategic aims: Prevention; Resilience; Enabling; Communities; and Connections. It also identifies four key enablers for delivery: Empowered Staff; Principled Commissioning; Digital Transformation; and Sustainable Finance.

3.6. Much of the activity within the transformation programme remains relevant to these strategic aims, and the next stage for some of these projects is to move from test of change status to scale up status, integrating with existing business as usual and helping us transform in an efficient sustainable manner that maximises our available resources, and in line with our review of localities.

3.7. Our learning from the implementation of the transformation programme so far will inform the next stage of our journey. For example the INCA evaluation highlights "the need to move beyond signposting individuals to community assets, to actively establishing and maintaining those connections should the individual want to do so." The INCA evaluation highlights that "while colocation does not necessarily guarantee integrated working, it provides professionals with an opportunity for increased informal interactions that can enhance mutual decision making and practice".

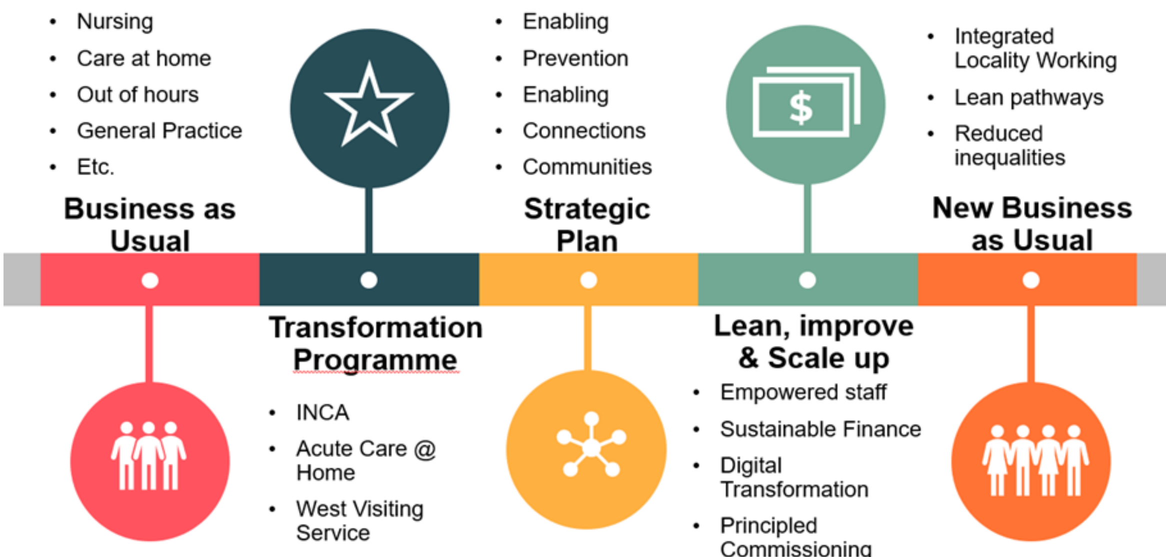
3.8. Creating an environment in communities within localities, whereby services are part of an integrated system, where co-location is encouraged, including traditionally thought of health and care services, including Link Practitioners, housing services, childrens services, and in partnership with community leaders and citizens, will be critical to achieving our strategic aims.

3.9. There are opportunities to join up existing business as usual activities along with projects such as the Acute Care @ Home project, to provide unscheduled care pathways, that otherwise would have been provided in a hospital setting, in a homely setting, at times of need. The West Visiting evaluation highlights opportunities to dove-tail this service with other

transformation projects in the City such as the Acute Care @ Home project. “Given that the average age of patients visited here was high (79 years), this could be a natural extension of the service and would allow for further integration of care.”

3.10. Work is ongoing to move towards this next stage of integration and transformation. Tools such as Lean Six Sigma will be utilised to improve business processes and ensure sustainability, and a workforce plan is being developed to ensure that our workforce is supported to provide the best possible care to meet the needs of people in Aberdeen. Our workforce will be supported to work as efficiently as possible using digital technologies, maximising the time that can be spent providing face to face care. All of this will be delivered within the context of our available financial resources.

3.11. The diagram below seeks to illustrate the journey that we are on.



Acceleration and Pace Highlight Report

3.12. The Acceleration and Pace Highlight report for the period October to December 2018 is attached at Appendix A. This report provides a high-level

overview of key milestones delivered during the reporting period, along with anticipated key milestones in the next reporting period and any significant issues, risks and changes.

3.13. Taking into consideration, where we are in implementing the transformation programme, our ongoing learning, and the refresh of the strategic plan, there have been a number of changes to how these priorities are shown on the dashboard and therefore in the Acceleration and Pace Highlight report. (Note that further changes may continue to be made in light of the refreshed strategic plan.) These changes are:

- Acute Care at Home has now been subsumed into the Modernising Primary and Community Care programme as it is a single project rather than a workstream. Further detail about how this project is evolving is included in that section of the report and will be highlighted at the APS committee.

- The Strategic Commissioning workstream has been reconfigured which has resulted in associated projects moving to a new Carers Strategy Implementation workstream – these projects are now funded through specific carers implementation funds and are not included in the Transformation Progress Report (as they are reported separately).

- The IT, Infrastructure and Data Sharing workstream has been renamed as the Digital Workstream. It was felt that Data Sharing activities were not projects in their own right, but more business as usual (i.e. requires ongoing oversight rather than having specific starts and finishes). Data sharing requirements are then considered and included on a project by project basis. Infrastructure projects remain on the Digital dashboard where appropriate. Some infrastructure projects relating to primary care premises have moved to Modernising Primary and Community Care and the Office Move project has been moved to Organisational Development and Cultural Change as the driver behind this project is to help create the environment for integrated teams.

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Integrated Neighbourhood Care Aberdeen (INCA) Evaluation

3.16. One of the significant projects within the Modernising Primary and Community Care transformation priority was the testing of integrated home care and nursing care teams in local communities.

3.17. This project sought to model some of the principles of the Dutch Buurtzorg model in Aberdeen. These principles include:

- Self-managing teams
- Person centred practice
- Empowered teams
- Relationship based practice

3.18. The service went live in two communities in Aberdeen (Cove and Peterculter) in February 2018. Each team included Care at Home Support Workers employed by Bon Accord Care and Nurses employed by NHS Grampian. Both teams had full autonomy over service operation including care planning, care delivery, referral management, assessment, team rostering and work commitments (within an agreed framework).

3.19. The detailed evaluation report is attached as Appendix B.

3.20. In summary, the evaluation found the following, which will be useful in planning further transformation of health and social care in Aberdeen:

  - For self-management to operate effectively, it should be situated within a clear operational framework and requires sufficient training and facilitation to succeed.
  - Reported high quality patient care and satisfaction was attributed to teams having autonomy to adjust frequency and duration of care, in addition to care continuity.
  - Co-located staff (within primary and community care teams) appeared to improve collaboration and job satisfaction.
  - Teams delivering new models of care need to establish and maintain communication links with existing teams to embed delivery into the wider system.

- Improving and implementing fit for purpose IT systems will enhance the quality of data that can be extracted and utilised to determine factors including capacity, patient facing time and cost effectiveness. The current IT caseload tool is not fit for purpose for data collection and extraction.
- Being located within traditionally hard to reach geographical areas and the team having responsibility for both assessment and delivery of care ensured rapid access to social care.

3.21. The INCA test of change period is now reaching its conclusion. What we have learned will be embedded into new ways of working such as unscheduled care, and our move towards our next stage of integrated locality working. A briefing about the INCA project which will be shared with stakeholders connected to the project is attached at Appendix C.

West Visiting Service Evaluation

3.22. Another significant project with the Modernising Primary and Community Care portfolio is the West Visiting Service. This project saw the establishment of a team consisting of an Advanced Nurse Practitioner and a Driver working with GP practices in the West Locality to undertake unscheduled home visits, thus releasing the capacity of practicing GPs in this locality.

3.23. The detailed evaluation report is attached at Appendix D.

3.24. In summary, the evaluation found the following:

- GPs reported high levels of satisfaction, identifying that the service reduces workload, and reduces stress levels of staff within practices.
- Patient satisfaction levels were high, and felt that they were sufficiently involved in decisions relating to their care.
- There would be benefits in extending the service operating hours to 1800 hours.
- During the period of evaluation, no significant differences were apparent between projected and actual emergency admissions, bed days and A&E attendances.
- The evaluation identified that the efficiency of the service realised over 40 hours of GP time (that otherwise would have been spend travelling), as well as over 106 hours of patient facing time, during the evaluation period.
- The service resulted in a reduced time that patients had to wait to be seen.

- The evaluation suggests that that there was capacity within the West model and the service would be suitable for scaling up

Primary Care Improvement Plan

3.25. The Integration Joint Board, at its meeting in August 2018 approved the partnership's Primary Care Improvement Plan (PCIP). At that meeting the IJB noted that "a PCIP implementation plan would be developed which would be configured around the practice of improvement and that performance would be monitored by the Audit and Performance Systems Committee."

3.26. The PCIP implementation plan is attached at Appendix E. It is highlighted that this is a live document and the various projects are at varying stages of design and implementation, therefore the detail of the plan will change over time.

3.27. The implementation plan shows that the areas of investment and improvement, as agreed by IJB, will be delivered on a phased basis to allow the development, testing and scaling-up of new roles within primary care settings, This activity seeks to release GP capacity to support them to undertake their roles as Expert Medical Generalists. (As articulated in the new GMS contract.)

3.28. Initial priority areas under the plan have been set and project teams have been established. GP practices have been engaged with in developing the priority areas through individual practice meetings and have been consulted on what their preferences are for the scale-up of key projects.

3.29. The progress of the PCIP is reported on regularly to the Grampian wide GP Sub Committee. In addition, regular progress communications are sent round GP practices and work is ongoing to communicate the changes to our wider stakeholders and citizens within Aberdeen through a varied range of channels.

Transformation – Lessons Learned about the speed of recruitment

3.30. A significant factor in the pace of implementation of the Transformation Programme to date has been the time take to recruit staff to both support

the delivery of the transformation programme and to deliver services relating to projects within the programme.

3.31. Since the creation of the Health and Social Care Partnership, which brings together staff employed by Aberdeen City Council and NHS Grampian, each time a new process was required (i.e. shared and joint recruitment/ job matching etc.), that new process required to be designed and developed in consultation with key stakeholders and then implemented. This is often a time consuming process. Thereafter once that process had been developed and agreed, further activities using the same process have been much faster.

3.32. During the time of partnership operation, it has also been the case that our partners, in particular Aberdeen City Council, have been undertaking their own transformation programmes, which have resulted in changes of process that affects the partnership. These changes of process have and continue to impact on the time required to progress recruitment.

3.33. The recruitment stages are set out in the diagram below, with some of the key processes/ milestones that contribute to its progression highlighted above each of the stages:

BUSINESS CASE PROGRAMME BOARD/ IJB APPROVAL	REVIEW OF AGENDA FOR CHANGE/ ACC POSTS FOR SIMILAR POSTS WRITE JOB PROFILE	ACC PROCESS (Establishment Control Panel) NHSG PROCESS (Vacancy Management Panel)	ACC/ NHS MATCHING PROCESSES (IF REQUIRED) APPROVAL TO ADVERTISE NHS/ ACC ALIGN ADVERTISING DATES	SINGLE PROCESS	NHS HEALTH SCREENING/ STATUTORY CHECKS/ REFERENCES
Post identified as required	**Design of Post**	**Job evaluation**	**Advertising**	**Shortleeting & Interview**	**Preferred Candidate Commence**

3.34. There are a number of processes where delays/ lags can and do happen, these include:

- Developing robust business case and achieving approval through programme board(s)/ IJB

- NHS – there needs to be a similar Agenda for Change post – sometimes this is difficult to find as the posts we might be creating may be different to traditional NHS posts
- Evaluation Analyst staff shortages in NHS – recent examples of this creating 2 month+ delay in process.
- NHS – evaluation panel meets periodically, if they run out of time, job matching process is not concluded. If there are questions about the post, the answers are collated after the panel meets and reported to next panel. Each panel includes different colleagues so there may be different questions arising from each panel
- Prior to advertising, NHS posts require to be signed off by one of a small number of posts, until recently these were all NHS operational managers.
- Prior to advertising, ACC posts require to be approved – the system for approval in ACC has changed. Currently posts require to be approved by the Establishment Control Board.
- For posts that could be filled by either NHS or ACC staff member, we need to wait until approval to advertise received by both and negotiate with recruitment teams so that advertising processes are concurrent.
- After the preferred candidate has been identified, until recently (Dec 2018), NHS required health screening to be undertaken for all posts – this could create a delay of around 3 months (this has now been changed for non-clinical staff.)

3.35. In terms of lessons learned, the primary lesson would be the time required to negotiate with our partners when undertaking a new process. It is therefore important to anticipate and build this additional time into the overall project timeline.

3.36. Other issues, as and when they have arisen have been resolved which has benefitted future repeating processes. For example, the requirement for a former Community Health Partnership (CHP) operational manager to approve NHS posts has now been resolved and most members of the partnership's leadership team can now approve vacancies.

3.37. Another key lesson would be the acknowledgement that changes are ongoing across our partners, which can lead to changes of processes at

short notice. These changes are outwith the control of the partnership, and are difficult to plan for.

Aberdeen Links – Initial Performance Report

3.38. Phase one of the community link working project has been live in 18 GP practices since summer 2018. In the first 4 months of delivery the project has received 464 referrals. The top four reasons for a referral to a Link Practitioner so far are: mental health, social isolation, finance and benefits, housing.

3.39. Implementation of phase two of the project is progressing and the second cohort of Link Practitioners are due to start the week commencing 4th March. This will enable us to work towards having a link practitioner attached to all GP Practices by April 2019.

3.40. A performance report containing a summary of referral information for quarter 3 (October – December) is available at Appendix F

Service Mapping

3.41. On the 27th November 2018, the partnership including ACVO and Scottish Care, hosted its first service mapping event in the city. The purpose of the event was to bring together the statutory, third and independent sectors to start to identify what health and social care services are delivered in Aberdeen. 152 individuals attended this event, representing 66 organisations. It is anticipated that this work will enable us to make the correct connections for our citizens, identify gaps in service provision and help to inform our commissioning decisions in the future.

3.42. Since the event in November we have been working closely with Healthcare Improvement Scotland (HIS) and the digital team at NHS24 to ensure that the valuable information gathered is captured and available to everyone to access.

3.43. Given the success of the event the structure used is now being delivered by colleagues in Aberdeenshire HSCP. A follow up event is planned in the city in March to coincide with the launch of the Scotland's Service Directory.

4. Implications for IJB

4.1. Equalities - Equalities implications are considered on a project by project as well as programme wide basis.

4.2. Fairer Scotland Duty - There are no implications as a direct result of this report.

4.3. Financial - The partnership receives around £20million per year from a range of sources to support its transformation programme. Transformation also impacts on the overall partnership budget of approx. £260million.

4.4. Workforce - Workforce implications are considered at project, programme and overall portfolio levels.

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

4.6. Other - NA

5. Links to ACHSCP Strategic Plan

5.1. The activities within the transformation programme seek to directly contribute to the delivery of the strategic plan. This report reports the early considerations of how our transformation programme needs to be adapted to support the refreshed strategic plan, which is currently out for consultation.

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. High level risks to programme delivery and mitigating actions are identified within progress reports reported on a regular basis to the Audit and Performance Systems Committee.

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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 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

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

This paper brings to the attention of the Audit and Performance Systems Committee information about our programme management governance and reporting processes and specifically detailed financial information about our transformation programme, in order to provide assurance of the scrutiny provided across our programme management governance structure in order to help mitigate against the above risks.

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Transformation Programme

Acceleration and Pace Highlight Report

Reporting Period: October 2018 – January 2019

DRAFT

- Organisational Development & Cultural Change
- Digital
- Modernising Primary & Community Care
- Supporting Self-Management of Long Term Conditions and Building Community Capacity
- Efficient Resources Workstream

Highlight Report 6.0

V1.0

Overall Transformation Programme

The Aberdeen City Health and Social Care Partnership's Transformation Programme seeks to deliver the change that is required for the partnership to deliver its strategic priorities.

Overall Programme Expenditure

Our transformation programme seeks to manage increasing demand, and where appropriate release savings, through the development of leaner and smarter systems, and most of our initial work and investment seeks to create the environment which will allow this to happen.

The table below sets out the current financial plan for our transformation programme. Note that there may be some delays in receiving information about the actual spend in the current year, due to a range of reasons including invoice processing, budget transfer schedules etc.

Programme Work stream	Investment/ Spend to 31/3/18	Projected Spend 2018/19	Actual Spend (to date) 2018/19
Digital	£1,178,678.39	£60,532.00	£25,038.24
Supporting Management of Long Term Conditions and Building Community Capacity	£374,675.59	£926,427.00	£188,239.16
Modernising Primary & Community Care	£1,184,683.07	£2,090,811.00	£872,697.44
Organisational Development & Cult	£727,936.56	£106,275.00	£14,483.00
Commissioning	£1,813,806.82	£1,041,731.50	£486,037.01
Delayed Discharge	£1,375,616.36	£739,472.00	£160,582.69
Carers Strategy	£87,146.72	£503,878.00	£242,517.80
Integration and Transformation Programme Delivery	£1,265,087.06	£1,286,412.00	£638,738.50

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Abbreviations used throughout the report:

ACHSCP: Aberdeen City Health and Social Care Partnership

EPB: Executive Programme Board

MPCC: Modernising Primary & Community Care

SMCC: Supporting Self-Management of Long Term Conditions & Building Community Capacity

ODCC: Organisational Development & Cultural Change

IIDS: IT, Infrastructure and Data Sharing

SC: Strategic Commissioning

Organisational Development and Cultural Change

1. Programme Summary and Anticipated Benefits

This **ENABLING** work stream recognises that people are key to delivering our integration and transformation ambitions. The appropriate organisational culture is an essential core building block and we will be unable to successfully embed the transformation we seek without changing the culture of our organisation and the people who make it.

The work will be aligned to the strategic priorities of the partnership and will work in a coordinated manner to ensure activities in this work stream support this our "Team Aberdeen" culture to be developed and support the development of people in the right places and with the right skills and attributes to support people in communities. The work stream also recognises the anxiety many of our staff will feel as we integrate at every point of delivery, aligning with our values of caring, person centred and enabling. To learn from both host organisations and enable and support colleagues to be able to work effectively and productively within an integrated environment. Identifying areas of good practice and sharing learning and impact.

2. Key Milestones during reporting period

Key milestones deliverables	Planned Date	Achieved Date	Update	Comments
Anticipated milestones from previous Programme Status Report:				
Annual Stakeholder Conference & Festival for ACHSCP	26-30 Oct 18	26-30 Oct 2018	A focus on staff working in localities and sharing good practice was taken for the conference this year. This included open events across the city over the course of week on back of feedback from staff around difficulty in releasing staff for just the one day. Event was delivered within budget and on time.	Evaluation of feedback has been good and will be used when planning next event.
Workforce Plan "Empowered Workforce"	March 2019	ongoing	Workshop took place 5/11/18 attended by leadership team and pupils from Harlaw Academy. From the workshop it was agree a workforce strategy and action plan would be drafted to state our intentions as a partnership in collaboration with our partners.	The plan will go to the IJB in March.
IMatter staff feedback	Dec 2018	Dec 2018	iMatter 2018 is complete and all teams are now working on their action plans. The ACHSCP will be in the Scottish Government 2018 Employee Engagement report as a good example of how to use and engage with iMatter. Strathclyde University have chosen the ACHSCP as the focus of their research on the iMatter process and will be holding 2 forums for ACHSCP staff on 29th January.	Complete

Training passport outline business case to be developed and agreed.	Feb 2019	Ongoing	Timelines have been pushed back due to a change in scope. Initial scope was too large and will now focus on a particular staff group. Project sponsors are identified, and a new business case is being collaboratively drafted.	
Senior Leadership OD development	March 2019	Ongoing	In line with the new interim structure, OD work has been engaged in by the leadership team to build on relationships and team effectiveness. This work has been well received and continues and a plan to have this ongoing is being drafted.	
Partnership OD plan	March 2019	Ongoing	Linked with the above an OD plan for roll out across the partnership is also being developed to identify priorities. The ODCC working group will further develop actions and monitor progress.	

3. Change Control

Change	Impact	
	Budget/Resource	Schedule
Programme Workstream Review and Amendments – the group undertook review of current projects and action in line with strategic direction. This change control covered projects and actions reviewed and amended under new outcome headings.	There were no cost changes to the overall programme - all projects are delivered within 'business as usual' resources.	Projects were updated immediately on approval of this change control - ESPB - 06/09/2018

4. Issues and Opportunities *New and Update*

The annual conference which took place over the course of a week received good and constructive feedback from staff and partners. Some felt this was an excellent way of including all partners and empowering staff to lead on workshops and events. However due to the large number of events – a demonstration of the engagement it received – there was also feedback that some areas had low attendance. This feedback has all been documented and will be considered for the approach for next year's events. The two measures of success for spread and engagement have both increased year on year.

The workforce planning development work has been instrumental in setting direction for both OD and workforce plans. This has meant a better linkage with both soft and 'hard' change management and ensuring that there is a better focus on succession planning and the uptake of younger people into the health and social care workplace. The plan requires some prioritisation due to its scope and breadth which will ensure focused resource to produce results.

5. Major Risks *New and Update*

- No major risks during current reporting period

6. Outlook and Next Period

Anticipated milestones for the coming period include:

- Delivery of the Heart Awards, 1st March 2019
- Workforce Plan to be finalised and submitted to the March IJB
- Training passport outline business case to be developed and agreed.
- Completion of Partnership iMatter's structures and reporting lines to national iMatter colleagues to be ready for questionnaires to go out by May 2019.

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Digital

1. Programme Summary and Anticipated Benefits

This programme considers a range of enablers including Infrastructure, ICT, Technology Enabled Care and Data Sharing, which are significant complex activities that are essential for realising our integration and transformation ambitions.

There are clear links between this enabler work stream and delivery programmes including: the Modernising Primary and Community Care programme, including the provider of smart devices to support our workforce directly caring for people in our communities; the Self-Management and Building Community Capacity programme, including the provision of technology enabled care to support people in communities to effectively self manage their long term conditions.

The workstream has been refined over recent months to reflect our developing refreshed strategic plan.

2. Key Milestones during reporting period

Key milestones deliverables	Planned Date	Achieved Date	Update	Comments
Anticipated milestones from previous Programme Status Report:				
Interim Partnership Intranet	Dec 2018	Jan 2019	Following the phase 1 roll out of the Partnership intranet in December 2018 to a selected group of staff for testing, the Intranet was successfully launched to the wider partnership audience on Monday 21st January. This also coincided with the partnership move to Marischal College. Both ACC and NHS staff have full access to the Intranet with no additional log in required as access is granted through IP Range exclusion.	Future developments to improve collaboration and inclusion on the Intranet will include a staff noticeboard for posting events etc.
AHSCP move to Marischal College	Phase 1: Winter 2018/2019	Phase 1: Jan 2019	This project included: Telephony phones for individual and PA phone routings for managers WIFI provision for NHS Staff. Printing solutions for NHS	Phase 1 Complete

Business Case developed for replacement for Care First.	March 2019	ongoing	The scope of the replacement for Carefirst has changed. This is now to include partnership health services to obtain the same caseload management tool. Investigation complete Business Case to allow a tender is due to be complete in Feb. Thereafter an investigation of different providers of that software will commence.	Planned to come to IJB in March 2019
Relay of 'City Connect' for Link Practitioners.	Dec 2018	Phase 1: Jan 2019	Following the phase 1 roll out of the Partnership intranet in December 2018 to a selected group of staff for testing, the Intranet was successfully launched to the wider partnership audience on Monday 21st January. This also coincided with the partnership move to Marischal College. Both ACC and NHS staff have full access to the Intranet with no additional log in required as access is granted through IP Range exclusion.	Feedback from the Link Practitioners has been very positive with very little issues following the implementation. Further roll out of City Connect across the remainder of Aberdeen City GP practices is due to be completed by March 2019.
Partnership devices advisory paper	Mar 2019	Ongoing	An option appraisal around mobile devices is being investigated and drafted.	
Digital collaboration with intranet diaries and file sharing etc.	Phase 1: April 2019	ongoing	Federation Partnering Agreement NHS mail for Business with NHS mail & skype possible. The agreement is with legal we expect to be rolling this out in February 2019.	
Implementation of GovRoam (a public sector wifi solution).	February 2019	ongoing	GovRoam is rolled within Council buildings for NHS staff and vice versa at NHS. There are some technical issues to resolve in order that the system is evadible for use. It is our expectation this will be resolved over the next month.	
Clinical Care and Governance review	March 2019	ongoing	Reviewing the processes for recording complaints and clinical governance across ACC and NHSG and how the can be effectively reported upon. Recommendation to be submitted March	

Other milestones delivered				
2nd Annual Grampian Digital Conference	Nov 2018	Nov 2018	Grampian collaboration with NHSG Acute, Aberdeen City HSCP, Aberdeenshire HSCP and Moray HSCP.	

3. Change Control

Change	Impact	
	Budget/Resource	Schedule
N/A		

4. Issues and Opportunities *News and Update*

New IT project manager now in post.
Vacant Business Analyst – awaiting potential redeployment of council staff.

5. Major Risks *New and Update*

1 FTE IT business analyst vacancy is impacting on pace of delivering projects. This is being partially mitigated through the re-prioritisation of projects and ongoing discussions with partners. Alternative options for providing capacity in this area are being explored.

6. Outlook and Next Period

Anticipated milestones for the coming period include:

- Update and feedback following Intranet launch
- Health & Social Care Case load Management (Carefirst replacement) business case complete and through governance
- Interim device solution for health visitors
- Phase 1 roll of Office 365 (Leadership Team)
- O365 Dashboards for Partnership services
- Gov Roam Implementation complete
- Mobile Device Strategy

Modernising Primary & Community Care Programme

1. Programme Summary and Anticipated Benefits

This work stream includes reviewing and developing strategies for:

• Collaborative working, in locality hubs, with increased pharmacist provision, social work links and GP led beds to help to reduce admissions to hospital
• Locality hubs supported by the design of integrated health and care teams, and investigating new models such as Buurtzorg and Advanced Nurse Practitioners
• New service delivery models for primary care and modernising of infrastructure

A long-term initial blueprint and vision for reimagining primary and community care has been developed and this long-term plan was approved by IJB in January 2018. A Primary Care Improvement Plan has subsequently been developed to resource and drive delivery of changes required.

2. Key milestones during reporting period

Key milestones deliverables	Planned Date	Achieved Date	Update	Comments
Anticipated milestones from previous Programme Status Report:				
Approval of Primary Care Improvement Plan and underpinning business cases	Sept 2018	Aug 2018	First Phase business cases approved August 2018.	Additional business cases approved / in development in line with phasing of PCIP
Recruitment process nearing conclusion for filling roles needed to implement year 1 across a number of projects in the Primary Care Improvement Plan	Jan 2019	Dec 2018	MSK First Contact Practitioner in post; Psychological Therapy roles fully recruited to, first tranche of additional Pharmacist resource recruited to.	Planning for Year 2 workforce recruitment underway.
Other milestones delivered				
Project Teams established for priority projects	Dec 2018	Dec 2018	MSK Project, Practice Aligned Pharmacy (Pharmacotherapy) Project, Chaplaincy Listening Project, Workflow Optimisation Project teams all established	
Workshops held to coordinate alignment of Acute Care at Home and the Unscheduled Visiting Service	Dec 2018	Dec 2018	Outputs from workshops informing the development of business case to deliver integrated unscheduled care.	Development of model and resourcing from within existing resource to continue in first quarter of 2019.
Approval of Action 15 Plan	Sept 2018	Sept 2018	Plan approved by IJB. Ongoing reporting to Scottish Government.	Project teams for projects in process of being established.

3. Change Control

Change	Impact	
	Budget/Resource	Schedule
Alignment of Acute Care at Home to Modernising Primary and Community Care Programme	No impact	No impact

4. Issues and Opportunities *New and Update*

Implementation of Acute Care at Home has had challenges around obtaining medical input into the model. This is being addressed through a more coordinated approach to Unscheduled Care which will see a wider range of advanced practice roles provide input rather than focus on Consultant Geriatrician input. This also provides an opportunity to link with existing teams to establish and embed a local stepped care model of treatment and care that responds quickly to citizen need.

INCA – A project review took place in September resulting in the consolidation of staff in the Peterculter area. This review also looked at elements of the model which have been problematic – such as the self-managing team element.

5. Major Risks *New and Update*

None in current reporting period

6. Outlook and Next Period

Anticipated milestones for next reporting period include:

- Unscheduled care: Development of operating model and business case covering Unscheduled Care (incorporating Acute Care at Home and Unscheduled Visiting Service); GP and public engagement session on development of Unscheduled Care approach
- Project Teams established for remaining PCIP and Action 15 projects

Supporting Self-Management of Long Term Conditions and Building Community Capacity

1. Programme Summary and Anticipated Benefits

This work stream recognises that pressures on mainstream primary and community care services cannot be reduced through a "more of the same" approach. The work stream seeks to shift our relationship with communities to enable a more co-produced approach and to nudge the culture towards being more empowered and responsible in relation to ourselves and each other. A number of referrals and appointments in primary care currently relate to social issues and low level anxiety/ depression, and evidence exists that this can be reduced through "non-clinical" support and link resources, embedded in the community and our locality teams.

To deliver population level impact and change we need to go beyond small tests of change and develop at scale activities.

2. Key milestones during reporting period

Key milestones deliverables	Planned Date	Achieved Date	Update	Comments
Anticipated milestones from previous Programme Status Report:				
Aberdeen Links Phase one link practitioner in post covering 18 GP practices and referrals being received from practice attached staff	September 2018	September 2018	4 Senior Link Practitioners and 7 Primary Link Practitioner commenced in post 23rd July. Referrals commenced in September 2018	Referral information available in appendix e of main report
Phase two Link Practitioner Recruitment ongoing and induction planning complete	December 2018	ongoing		Link practitioner posts for phase 2 were re-advertised in January 2019 due to being unable to meet number required
Community Chaplaincy Listening (CCL) Service Business Case Approved	September 2018	September 2018	Business Case approved at executive programme board in September 2018. Job profile has been developed to provide capacity to support planned growth of number of volunteer listeners in the city.	This project is linked to the Primary Care Improvement Plan
CCL coordinator job profile developed and being progressed through NHS recruitment process	December 2018	January 2019	Position is currently progressing through NHSG job evaluation with a view to commence recruitment in February 2019.	Job evaluation delayed due to capacity of evaluator within NHS Grampian

Social Transport demand responsive transport and booking office review completed with initial findings and recommendations which inform commissioning plan for next 3 years	Jan 2019	ongoing	Business Case approved by IJB in August 2018. Competitive tendering process for transport element to take place under new Aberdeen City Council transport providers framework	
Other milestones delivered				
Completing the Puzzle – Service Mapping Event planned and delivered	November 2018	November 2018	Service mapping event took place at Beach Ballroom on 27.11.18 66 organisations attended, Follow up event planned for March 2019	
Scotland's Service Directory (SSD) work progressing to city information live on digital platform live	December 2018	February 2019	Task and finish group continue to meet to progress city content. Project live date moved to Feb 2019 due to national delay in integration between ALISS and SSD information Discussion ongoing with NHSG/ACC to embed information onto website	We had hoped to have the system live in January 2019, however, there has been a delay nationally and we are working to revised timescale of end February 2019
Community Builder initial community engagement event taken place Implementation approach in place and further refinement taking place	October 2018 December 2018	October 2018 December 2018	Event took place on 30.10.18 in Froghall/Powis/George Street area. Attracted positive feedback in media.	See appendix 1 For press article

3. Change Control

Change	Impact	
	Budget/Resource	Schedule

4. Issues and Opportunities *New and Update*

Link practitioner recruitment continues to be a challenge, positions were re-advertised for phase 2. SAMH the organisation commissioned to deliver the service continue to look for opportunities to advertise and attract individuals to the role.

5. Major Risks *New and Update*

None at current time

6. Outlook and Next Period

Anticipated milestones for the coming period include:

- Phase 2 link practitioners recruited, and induction commenced
- Scotland's Service Directory 'live' in Aberdeen City
- Further 'completing the puzzle' event taken place
- Community Chaplaincy Listening Service coordinator recruitment complete
- House of Care cohort 3 practice recruitment complete
- Silver City Business Case developed for approval
- Social Transport provider appointed and in place by 1st April
- Care about Physical Activity engagement event taken place with care homes and care at home providers

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Efficient Resources Workstream

1. Programme Summary and Anticipated Benefits

In line with the Partnership's Medium-Term Financial Strategy (approved by IJB on 13 February 2018), a number of themed working groups have now been established with specific savings targets linked to each of these work streams.

These work streams would report on progress on a monthly basis through the Transformation Programme Management Governance Structure. A lead officer, responsible for reporting to the Programme Boards, has been identified for each work stream.

The anticipated benefits are cashable financial savings:

Work Stream	Savings Target				
	2018/19 £'000	2019/20 £'000	2020/21 £'000	2021/22 £'000	2022/23 £'000
Theme 1: review of pricing/ charging policies across the partnership	0	(300)	(300)	(300)	(300)
Theme 2: Review processes and ensure that these are streamlined and efficient: Direct Payments Cards; Financial Assessment Processes	(250)	(250)	(250)	(250)	(250)
Theme 3: Review of out of hours service	(400)	(100)	(100)	(100)	(100)
Theme 4: Review out of area placements	0	0	(500)	(500)	(500)
Theme 5: Bed Base Review	0	0	tbd	tbd	tbd
Theme 7: 3rd Party Spend	(250)	(500)	(500)	(500)	(500)
Theme 8: Prescribing/ Medicine Management	(200)	(1,000)	(1,000)	(1,000)	(1,000)
Theme 9: Service Review	0	(2,692)	(2,460)	(1,985)	(2,274)

In addition to these specific workstreams, in recognition of the learning achieved to date through our transformation programme and as we move forward to our next phase of transformation in line with our refreshed strategic plan, work is ongoing to utilise Lean Six Sigma methodology to improve business processes and sustainability – this will in turn positively contribute to our medium term financial plan.

2. Key milestones during reporting period

Key milestones deliverables	Planned Date	Achieved Date	Update	Comments
Lean Six Sigma Training delivered to initial cohort of 12 practitioners	Commenced January 2019	ongoing	Training currently ongoing	

Initial Lean Six Sigma projects selected	1/2/19	Feb 2019	Leadership team session held to identify possible projects – Dec 2018. Review of projects, their suitability to the process and alignment with strategic plan – Jan 2019. Projects aim to be largely complete by 30/4/19	5 projects identified for delivery: -nursing staff are not spending as much time with patients as they would like -LD clients receiving double benefits for transport for day care - Social Work financial assessment process is lengthy and paper heavy - Individuals are waiting too long for a wheelchair service - There are delays/ barriers in place for people accessing Sexual Health Services
Learning Disability Service Review Board	September 2019	September 2019	Review found a number of improvements that are required. Most of these are now being taken forward by Learning Disability Service Manager. One of these improvements has been identified as a project which would be suitable to use the Lean Six Sigma Methodology	Complete
Prepaid card			Pre-paid Financial Card service provider contracted.(Update required)	

3. Change Control

Change	Impact	
	Budget/Resource	Schedule
No changes in current reporting period.		

4. Issues and Opportunities *New and Update*

Additional resource will be required to deliver against some of the workstream activities (spend to save.)

5. Major Risks *New and Update*

No major risks during current reporting period.

6. Outlook and Next Period

Anticipated milestones for next reporting period include:

- First 5 projects using lean six sigma methodology mostly complete (with findings) by end of April 2019
- Next round of projects identified

Document Location

This document is only valid on the day it was printed and the electronic version is located with the document owner (Lead Transformation Manager)

Document Status

The current status for this document is ***Final***

Distribution

This document has been distributed as follows

Name	Responsibility	Date of issue	Version
APS consultation list	S Gibbon		V6.0

Purpose

The purpose of a Highlight Report is to provide the Integration Joint Board/ Audit and Performance Systems Committee/ Executive Programme Board with a summary of the stage status at intervals defined by the board. The board will use the report to monitor stage and project progress. The Lead Transformation Manager (who normally produces the report) also uses the report to advise the Project Board of any potential problems or areas where the Board could help.

Quality criteria

- Accurate reflection of checkpoint information
- Accurate summary of Risk & Issue Logs
- Accurate summary of plan status
- Highlighting any potential problem areas

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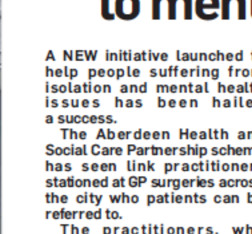
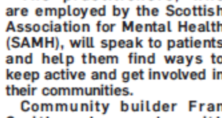
Appendix 1 (Community Builder – Evening Express, 3rd January 2019

Kat, top, and Colin, below, helping reduce people's stress levels

Project's 'grassroots approach' to mental health welcomed





Fran Smith says the link practitioner scheme is 'really positive'

A NEW initiative launched to help people suffering from isolation and mental health issues has been hailed a success.

The Aberdeen Health and Social Care Partnership scheme has seen link practitioners stationed at GP surgeries across the city who patients can be referred to.

The practitioners, who are employed by the Scottish Association for Mental Health (SAMH), will speak to patients and help them find ways to keep active and get involved in their communities.

Community builder Fran Smith, who works with groups and organisations to uncover what sort of activities are available to people, said the feedback on the scheme has been positive.

She said: "I think it's fundamental to speak to communities and speak to people about what impacts them, specifically around health and wellbeing.

"I think it's a really positive, grassroots approach.

"People have said 'that's really useful'. Sometimes you just need to speak.

"That link practitioner has the time to sit with someone and support them in a very person-centred way to really get to the bottom of what's impacting them.

"People have responded really positively to that. There's a few folk I've spoken to who had depression and they said that would be really, really useful. Having that resource in your doctor surgery, people have said it will be very welcome."

The link practitioners first began taking referrals around August and September.

They are currently stationed at around 18 practices, but all 29 city surgeries plan to have a link practitioner by the end of the financial year.

"The link practitioner is all about finding what support the person wants and then looking into the community to see what's there to support them," Fran said.

"It's not a traditional health professional approach in so far as it's not, 'this is what you need to do'.

"It's very much, 'what do you feel you're able to do to support your health and wellbeing?'.

"My role is basically to build relationships within communities and community groups.

"The link practitioners, they're going to be doing predominantly social prescribing.

"It's a fundamentally new approach from the Health and Social Care Partnership."

The initiative also utilises a national database called Aliss, run by the Health and Social Care Alliance, which Fran called a "community Google", adding: "You can just put in your post-code and it'll tell you everything that's happening in your area."

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Integrated Neighbourhood Care Aberdeen (INCA) Test of Change

Evaluation Report

October 2018

Dr Calum Leask

Research & Evaluation Manager

Aberdeen City Health & Social Care Partnership | NHS Grampian

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Executive summary

Background

Given increasing demographic and economic challenges, there is a need to develop and test new models of delivering health and social care. One model gaining international attention is the Dutch model Buurtzorg, characterised by self-managing nursing teams providing person-centred care and founded on principles of empowerment and relationship-based practice. The model has shown promise elsewhere, and locally the decision was taken to apply and adapt the principles of this model to test their congruence within the Scottish context.

This report evaluates a new model of integrated care delivered by community-based, self-managing teams in Aberdeen.

Methods

The Integrated Neighbourhood Care Aberdeen (INCA) service went live in February 2018. A key difference between the INCA model and the Buurtzorg model was the use of integrated teams locally, as opposed to purely nursing that exists within the latter. The INCA model consisted of two teams comprised of three support workers and three nurses in each, working in two sites across Aberdeen (one team co-located within a GP practice, the other located in a non-partnership building with no health and social care staff on site). Teams had full autonomy over service operation, such as: care planning; care delivery; referral management; assessment; team rostering and work commitments (within an agreed framework).

The evaluation framework for this project was co-created over two workshops with the INCA team. Service data collected included number of referrals, days on caseload, type of care provided and reasons for discharge. Patient outcome data collected included quality of life (QOL), self-rated health and mental wellbeing assessments. Patient experience and satisfaction was measured through semi-structured interviews. Staff outcomes, including feelings of autonomy, value and overall satisfaction were measured at baseline and three months, with staff experience being collected through semi-structured interviews. A variety of stakeholders were also interviewed to understand their experiences of working with the INCA teams.

Results

Due to challenges in staff retention, results were collated between go live (26/2/18) and the final day of operating of the Cove team (29/6/18). There were 43 referrals into the service with a discharge rate of 49%. District nursing (DN) teams (46.5%) were the highest referrers

into both sites and large palliative caseloads resulted in a majority (38.1%) of discharges being due to patients dying.

Patients were very satisfied with the support they received (mean satisfaction score 4.9/5). Interviews with nine patients highlighted high-quality staffing and a strong emphasis on collaboration in the design and delivery of support. Pre-post outcome data collected from eight patients demonstrated improved scores in QOL and self-rated health in half of the sample. The remaining patients had not been on the caseload long enough to administer follow-up questionnaires, or were inappropriate to collect data from (such as if they were palliative).

Staff acceptability was mixed, with the INCA teams decreasing from 12 to six staff members by the beginning of June 2018. Interview analysis highlighted challenges regarding self-management, resolving conflict and a predominantly social-care heavy caseload. However, staff felt autonomy over frequency and duration of service delivery led to improvements in patient-centred care. Co-located staff appeared to respond more positively about their experiences. Stakeholders working with the INCA teams (such as General Practitioners (GPs) and existing community teams) commented on the support the service provided by allowing rapid access to care provision, however also acknowledged communication challenges, particularly with accepting referrals.

Discussion and recommendations

This service appeared to provide high-quality support to patients, particularly due to staff having control over frequency and duration of visits according to individual needs. Self-management should be situated within a clear operational framework and requires sufficient training and facilitation to succeed. Teams delivering new models of care need to establish and maintain communication links with existing teams to embed delivery into the wider system. Improving and implementing fit for purpose IT systems will enhance the quality of data that can be extracted and utilised to determine factors including capacity, patient-facing time and cost effectiveness.

Key points

- The INCA service appears to be highly acceptable to patients receiving the service.
- Perceived high-quality patient care was attributed to teams having autonomy to adjust frequency and duration of care, in addition to care continuity.
- High staff turnover was associated with nurses feeling de-skilled, leading to an undesirable work/life balance.
- The INCA model provided rapid access to social care, facilitated by being located within traditionally hard-to-reach geographical areas and the team having responsibility for both assessment and delivery of care.
- Co-locating an INCA team with existing primary and community care teams appeared to improve collaboration and job satisfaction.
- Integrated teams are not necessarily a prerequisite for integrated working.
- The Caseload Management Tool is not fit for purpose regarding data collection and extraction.
- For self-management to operate effectively, it requires a clear framework outlining which elements of service operation staff are accountable for.

1. Introduction

Health and social care services are likely to face increasing demand, with a 59% predicted rise in the number of individuals aged over 65 years in next 20 years[1]. This demand is complicated by a probable decrease in financial resources. In 2016-2017, NHS boards had to make savings at unprecedented levels of £390m, despite the continual growth of operating costs[2]. Therefore, there is a need to reconfigure how services are delivered, with wide acknowledgement that doing more of the same will not be effective towards coping with this demand. At both local[3] and national[4] levels, it is hoped that these challenges can be met through the integration of health and social care and that this may also result in enhanced service delivery and promotion of population wellbeing. To achieve this, innovation is championed and testing new models of delivering integrated care is required.

One such model gaining international attention is the Dutch Buurtzorg model[5]. This model is characterised by, self-managing, community-based nursing teams, consisting of no more than 12 individuals with an approximate caseload of 50-60 patients. Coaches are utilised, as opposed to managers, to facilitate team cohesion and communication, as opposed to providing clinical input. The model is founded on the onion care model, which places the individual at the centre of their care and utilises an enablement ethos, in addition to harnessing informal networks as support structures[6]. The Buurtzorg team have characterising principles including autonomy (providing nurses with the ability to make decisions and act upon them to support professional and holistic nursing care); collaboration (developing strong links with community connections and professional partners to ensure well-coordinated cross-system support); trust (providing a basis for shared leadership and autonomy within teams) and creativity (joint decision-making processes between patients, their networks and professionals to develop novel solutions)[7]. Reported results are predominantly positive. For example, Buurtzorg has

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[1] Scottish Government (2016). A national clinical strategy for Scotland. Edinburgh: Scottish Government.
[2] Audit Scotland (2017). NHS in Scotland 2017. Edinburgh: Audit Scotland.
[3] Aberdeen City Health & Social Care Partnership. (2016). Aberdeen City Health and Social Care Partnership Strategic Plan 2016-19. Available from: https://www.aberdeencityhscp.scot/globalassets/strategic-plan.pdf [accessed 25/07/18].
[4] Scottish Government (2014). Public bodies (joint working) (Scotland) act 2014. Edinburgh: TSO.
[5] Kreitzer, M. et al. (2015). Buurtzorg Nederland: a global model of social innovation, change, and whole-systems healing. *Glob Adv Health Med*, 4(1), 40-44.
[6] Drennan, V. M. et al. (2017). The Guy's and St Thomas' NHS Foundation Trust Neighbourhood Nursing Team Test and Learn project of an adapted Buurtzorg model: an early view. Centre for Health & Social Care Research Joint Faculty of Kingston University & St. George's University of London
[7] Monsen, K. & de Blok, J. (2013). Buurtzorg: nurse-led community care. Creative Nursing, 19(3), 122-127.

the highest reported satisfaction rates of clients from all home-care organisations, in addition to reduced sickness absence rates (2.5%) compared with the Dutch average (6.3%)[8]. Therefore, aligning the key principles of self-managed, autonomous teams with the integration of health and social care has the potential to be a novel yet effective model to deliver efficient and effective person-centred care. However, this was untested in a Scottish context.

This report describes the evaluation of a new model of delivering integrated health and social care through self-managing, autonomous teams in Aberdeen City.

[8] Alders, P. (2015). Self-managed care teams to improve community care for frail older adults in the Netherlands. *Int J Care Coord*. 18(2-3), 57-61.

2. Context of implementation

In 2016, the Scottish Director of Health and Social Care Integration and Chief Nursing Officer invited Integration Joint Boards, health boards and local councils to engage in testing the principles of Buurtzorg in Scotland. In June 2016, representatives from Aberdeen City Health and Social Care Partnership (ACHSCP) attended a national event to learn about the principles, and were invited to become a test site to examine how these principles could work in the Scottish context.

Supported by Health Improvement Scotland's Living Well in Communities team and Public World, a series of local workshops were conducted in October 2016 which were attended by a number of stakeholders, including senior managers, community nurses, allied health professionals and commissioned care providers. It was agreed that change was necessary, with stakeholders agreeing that whilst the principles should be tested, they required adaptation to the local context.

A key difference identified was to test an integrated model (as opposed to a purely nursing model typical to Buurtzorg) and that care at home support workers should be core members of the team(s), working as equal partners with community nursing staff. The Buurtzorg "onion model"[9] closely aligned with ACHSCP's values, with staff striving to deliver person-centred care, drawing and building on informal as well as formal networks, and enabling service users to be as independent as possible. However, the way care was structured, with social care and nursing staff assessing and delivering care separately, as well as the nursing delivery model being made up of practice attached, direct delivery and out of hours teams, meant that there could be multiple different staff visiting each service user, and a coordinated, enabling approach difficult to achieve in reality. It was felt that testing the Buurtzorg principles in an integrated team would overcome these barriers and be congruent with the local agenda for change.

A project team was formed to begin planning implementation, and it was agreed that support workers would be employed through Bon Accord Care, Aberdeen City Council's local authority

[9] Drennan, V. M. et al. (2017). The Guy's and St Thomas' NHS Foundation Trust Neighbourhood Nursing Team Test and Learn project of an adapted Buurtzorg model: an early view. Centre for Health & Social Care Research Joint Faculty of Kingston University & St. George's University of London

trading company. Living Well in Communities and Public World supported a study visit to Almere in the Netherlands in June 2017 and by the end of October 2017, the 12 team members had been recruited.

3. Rapid scoping of the literature summary

A rapid scoping review was conducted to understand key findings from previous similar projects. The rationale of this exercise was not to provide a meticulous account of all published material, rather to provide a breadth of understanding from which to develop a bespoke evaluation framework for this project (described Section 3.2.1). Literature was identified using a combination of databases (e.g. PubMed and Medline), published reports and reference lists. The scoping process was limited by the majority of Buurtzorg literature being published in Dutch. Below, beneficial outcomes from Buurtzorg models are identified to provide examples of work undertaken previously, however this is not an exhaustive list. These are structured relative to locally-developed outcome groups of interest: patient outcomes; staff outcomes; resource/service outcomes; and unpaid carer outcomes.

3.1 Patient outcomes

A sample of identified patient outcomes are visible in Table 1. Buurtzorg models show high satisfaction rates amongst patients, particularly in staff quality. Some reports have also cited that due to enhanced patient outcomes, the average number of home care hours delivered are half of equivalent services.

Table 1. Example patient outcomes identified from scoping review

Outcome	Score	Source
Overall satisfaction	91%	Monsen & de Blok (2013)[10]
Perceived staff quality and participation	Ranked 3rd – 6th / 360 organisations	Alders (2015)[11]
Average number of home care hours delivered per patient year	50% reduction (due to patient improvement)	de Blok & Kimball (2013)[12]

3.2 Staff outcomes

A sample of identified staff outcomes are visible in Table 2. Overall staff satisfaction for this way of working is high, with other proxy measures (e.g. staff turnover and staff sickness) also comparing favourably to the industry average.

Table 2. Example staff outcomes identified from scoping review

Outcome	Score	Source
Satisfaction	95% for involvement 89% for overall satisfaction	Nandram (2015)[13]
Staff turnover	10% (15% industry average)	Gray et al. (2015)[14]
Staff sickness	3-4% (6-7% industry average)	de Blok (2013)[15]

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[10] Monsen, K. & de Blok, J. (2013a) Buurtzorg Nederland: A nurse-led model of care has revolutionized home care in the Netherlands. *J Am Nurse*, 113(8): 55–59

[11] Alders, P. (2015) Self-managed care teams to improve community care for frail older adults in the Netherlands. *Int J Care Coord*, 18(2–3): 57–61

[12] de Blok, J. & Kimball, M. (2013) Buurtzorg Nederland: Nurses Leading the Way! [online] AARP The Journal, Spring 2013 Available at: http://journal.aarpinternational.org/a/b/2013/06/buurtzorgnederland- nurses-leading-the-way [Accessed on 27 July 2017]

[13] Nandram, S. S. (2015) Organizational Innovation by Integrating Simplification: Learning from Buurtzorg Nederland. Cham: Springer

[14] Gray, B. H. et al. (2015) Home Care by Self-governing Nursing Teams. [online] The Commonwealth Fund. Available at: http://www.commonwealthfund.org/publications/casestudies/ 2015/may/home-care-nursing-teams-netherlands [Accessed 28 July 2017]

[15] de Blok, J. (2013). Buurtzorg: better care for lower cost. [online] Presentation at King's Fund. Available at: http://www.kingsfund.org.uk/sites/files/kf/media/jos-de-blokbuurtzorg-home-healthcare-nov13.pdf [Accessed 28 July 2017]

3.3 Resource / service outcomes

A sample of identified resource / service outcomes are visible in Table 3. Promisingly, Ministerial Strategic Group (MSG) Integration Indicators[16] such as emergency admissions have shown positive results through Buurtzorg models, in addition to demonstrating positive financial performance.

Table 3. Example resource/service outcomes identified from scoping review

Outcome	Score	Source
Emergency admissions	1/3 of similar organisations	Laloux (2014)[17]
Average hospital length of stay	Lower than similar organisations	Ernst & Young (2009)[18]
Average non-adjusted cost for home care per patient annually	1749 Euro less	Gray et al. (2015)[19]

3.4 Unpaid carer outcomes

A sample of identified unpaid carer outcomes are visible in Table 4. Family members are reported to be satisfied with the Buurtzorg model, particularly citing improvements in practice compared with previous experiences with traditional community nursing teams.

[16] Scottish Government. (2017). Measuring performance under integration. Available from: http://www.improvementservice.org.uk/documents/OEPB/board-papers-aug2017/oepb-31aug17-item4a-letter.pdf [accessed 26 July 2018]

[17] Laloux, F. (2014) Reinventing organisations: a guide to creating organisations inspired by the next stage of human consciousness. Brussels: Nelson Parker

[18] Ernst & Young (2009). Maatschappelijke Business Case Buurtzorg Nederland. Report by Ernest & Young. http://www.transitiepraktijk.nl/files/maatschappelijke%20business%20case%20buurt zorg.pdf [Accessed: 1 Aug 2018]

[19] Gray, B. H. et al. (2015) Home Care by Self-governing Nursing Teams. [online] The Commonwealth Fund. Available at: http://www.commonwealthfund.org/publications/casestudies/2015/may/home-care-nursing-teams-netherlands [Accessed 29 July 2017]

Table 4. Example unpaid carer outcomes identified from scoping review

Outcome	Score	Source
Acceptability	Reported positive change in nursing practice vs. community nursing teams	Drennan et al. (2017)[20]
Satisfaction	Not reported	Kreitzer et al. (2015)[21]

[20] Drennan, V. M. et al. (2017). The Guy's and St Thomas' NHS Foundation Trust Neighbourhood Nursing Team Test and Learn project of an adapted Buurtzorg model: an early view. Centre for Health & Social Care Research Joint Faculty of Kingston University & St. George's University of London

[21] Kreitzer, M. J. et al. (2015). Buurtzorg Nederland: A Global Model of Social Innovation, Change, and Whole-Systems Healing. *Glob Adv Health Med*, 4(1), 40-44.

4. Method

4.1 Design

The Integrated Neighbourhood Care Aberdeen (INCA) project began taking referrals in February 2018 as part of ACHSCP's transformation programme to redesign service delivery locally. Two teams consisting of three care at home support workers (SW) and three nurses each were recruited and based within two separate locations to inform implementation – one within a General Practice (Peterculter; West locality) and another in a corporate office (Cove; South locality). Similar to the Dutch Buurtzorg model, a coach was accessible to the teams, however they were sourced externally from another provider (Cornerstone) who were implementing Buurtzorg principles, rather than being employed in-house. The function of the coach was to support the team with anything they required, for example self-management and team working. Teams received both nursing and social care referrals and managed their own caseload, completing a full holistic assessment of both nursing and social care needs, in addition to planning care provision and rotas. The framework that guided service operation is available as Appendix 1. Inclusion criteria for patients were: living in the correct postcode area and not currently in receipt of nursing or social care. Exclusion criteria were patients living outside relevant postcode area and already in receipt of nursing or social care support. Pre-existing community nursing teams in Cove and Peterculter continued to provide nursing care to local residents who were already on their caseload before the project started, and referrals for nursing care were filtered by these teams to ensure that only those with a new need were picked up by the INCA teams. Similarly, social care referrals were sent to social work via pre-existing channels, and those that fitted the INCA criteria were forwarded onwards to the teams. Residents of Cove and Peterculter who were already receiving social care prior to the start of the INCA project continued to receive this from their existing provider. The full referral process is available in Appendix 2.

Whilst this was scheduled to be a two year pilot project, this evaluation presents findings over the first four months of implementation. This is due to staff retention challenges, meaning that the INCA team based in Cove ceased care provision as of 29/6/18.

4.2 Data collection and analysis

4.2.1 Evaluation framework development

This evaluation framework was developed through two co-creation workshops, based on theory described in detail elsewhere[22]. Workshops were facilitated by a Research & Evaluation Manager and a Public Health Researcher and held with the INCA team and lasted between 3-4 hours. In workshop 1, co-creators discussed what key outcomes they wanted the project to achieve and which components were crucial to measure in order to determine project success. The evaluation was split into two types: 1) process evaluation (thinking about the implementation of the project) and outcome evaluation (understanding the impact on citizens and patients; unpaid carers; staff; and resources and services). The scoping review (Tables 1-4) was used as a starting point for considering most appropriate measures. Co-creators were shown examples of the literature for each target population group to stimulate their thinking. In smaller groups, co-creators discussed which outcomes were most important to measure. Each smaller group then fed back their ideas to the wider group. Facilitators then supported the co-creators to collectively decide and prioritise what the key desired components to measure would be.

The purpose of workshop 2 was to confirm agreement of desired components to measure (decided in workshop 1) and to explore the practicalities of demonstrating the desired outcomes (e.g. when, how and who would collect the relevant data). Possible indicators and approaches to data collection (e.g. interviews, focus groups, and questionnaires) were discussed in three smaller groups, fed back to the larger group and collectively agreed with all co-creators. The two facilitators used the information collected in both workshops to develop the final evaluation framework.

The developed framework was utilised as a "best case scenario" guide, as given the complex system in which this service is being trialled, it would be necessary to ensure the framework was agile and adapted to changing circumstances and needs. Therefore, it was acknowledged and agreed by the group that the co-created framework developed initially may not be exactly reproduced after a period of service implementation.

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[22] Leask C F. et al. Principles and recommendations for utilising participatory methodologies in the co-creation and evaluation of public health interventions. *RIAE* (Submitted)

4.2.2 Service level data

A variety of service-level data were collected, including caseload characteristics, referral source, days on caseload, along with number and reasons for patient discharge. The Microsoft Excel based Caseload Management Tool (used by community nursing teams across Aberdeen City), was the system used to collate information. However, this system is not optimal for data extraction, with numerous challenges apparent when attempting to quantify certain elements of care, such as care duration.

4.2.3 Patient measures

4.2.3.1 Patient outcomes

Patient outcomes measured were QOL; self-rated health; emotional wellbeing; social support; physical activity; diet; alcohol consumption and smoking. Outcomes were measured using a co-created questionnaire that was administered to patients on initial assessment and again after three months. For pragmatic purposes, constructs were predominantly assessed using uniscales (i.e. single-item assessments)(Appendix 3).

4.2.3.2 Patient experience

Interviews were based on a semi-structured topic guide. Discussions were based on a series of exploratory questions regarding patients' experience of being supported by the INCA teams. Example questions included: *"Tell me about the support you get from the INCA team?"* and *"Have you noticed any changes to your health and wellbeing as a result of seeing the INCA team?"* (Appendix 4). Interviews lasted no more than 60 minutes and were audio recorded. Field notes were also taken during discussions and used as a reference point during analysis.

Audio recordings were transcribed verbatim and analysed thematically. Thematic analysis is useful towards understanding patterns occurring in the data in order to improve understanding on a particular topic[23], such as the experience of being cared for by a self-managing, integrated health and social care team. Analysis followed the six step framework previously described by Braun and Clarke[24], including: 1) familiarisation with the data; 2) developing initial codes; 3) searching for themes; 4) reviewing themes; 5) theme definition and 6) write up of results. The data were analysed independently by two researchers and then findings compared and adapted if required.

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[23] Maguire, M & Delahunt, B. (2017). Doing a thematic analysis: a practical, step-by-step guide for learning and teaching scholars. *AISHE-J*; 9(3).
[24] Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qual Res Psych*, 3(2), 77-101.

Satisfaction questionnaires were also distributed to patients, focusing on constructs of prevention, choice and overall satisfaction that were agreed during the co-creation workshops (Appendix 5).

4.2.4 INCA Staff measures

4.2.4.1 INCA Staff experience

Individual interviews were conducted with eight staff members once the Cove site completed operation. Interviews followed a semi-structured topic guide and discussions were based on a series of exploratory questions regarding their experience of working in this model. Example questions that were asked included: "*How did you find working in a self-managing way?*" and "*Was there anything that helped to make this new way of working successful?*" (Appendix 6). Interviews lasted approximately 60 minutes, with discussions being audio recorded. Field notes were taken during interviews to be used as a reference point when conducting analysis. These interviews were supplemented with exit interviews carried out with staff who decided to leave their post throughout the duration of the project (staff retention rates are visible in Figure 7).

Audio recordings from each interview were transcribed verbatim and analysed thematically (as described previously).

4.2.4.2 INCA Staff outcomes

The INCA team involved in the co-creation of this evaluation described three top outcomes they wanted from this job: 1) feeling valued for the work they do; 2) autonomy and 3) belonging (as part of a team). A questionnaire was co-created from which numerous detailed components were aggregated to ascertain to what extent the above were achieved (Appendix 7). Outcomes were assessed at baseline and at three months.

4.2.5 Partners' experience

Nine interviews were conducted with a variety of partners who engaged with the INCA team, including the project leads (PM) (n=3); GPs referring into the service (n=2); members of community nursing teams referring into the service (n=2) and social care referrers (n=2). Interviews lasted approximately 60 minutes and explored Partners' experience of working with the INCA team (Appendix 8). All discussions were audio recorded and transcribed verbatim. Analysis followed the same process described previously.

5. Results

5.1 Evaluation framework development

5.1.1 Evaluation framework co-creation workshops

The attendees of the co-creation workshops are described in Table 5.

Table 5. Co-creation workshop attendees

Workshop 1	Workshop 2
Research Manager x 1	Research Manager x 1
Public Health Researcher x 1	Public Health Researcher x 1
INCA Support Worker x 6	INCA Support Worker x 6
INCA Nurse x 6	INCA Nurse x 6
Nursing Service Manager x 1	Nursing Service Manager x 1
Strategic Advisor for Person Centred Care x 1	Transformation Programme Manager x 1
Transformation Programme Manager x 1	

5.1.2 Feedback on co-creation process

At the end of the process, feedback forms were distributed to the members. These included components around perceived skill / knowledge development, overall satisfaction and ownership in the process. Results are displayed in Table 6. Overall, the findings were predominantly positive, with constructs around organisation, enjoyment and knowledgeable facilitators scoring highest.

The following sections describe the data collected and analysed for this project.

Table 6. Responses from co-creation workshop 1 evaluation

Question	Dimension	Strongly disagree	Disagree	Neither	Agree	Strongly Agree	% agree
The purpose of the workshop was clearly described	Clear purpose	8%	8%	8%	23%	54%	77%
I gained new knowledge/skills from the workshop	Knowledge/skill development	8%	15%	15%	23%	38%	61%
I enjoyed participating in the workshop	Satisfaction	15%	0%	0%	38%	46%	84%
The facilitator was a good communicator	Facilitator good communicator	15%	0%	0%	15%	69%	84%
The material was presented in an organised manner	Organised workshop	15%	0%	0%	15%	69%	84%
The facilitator was knowledgeable on the topic	Knowledgeable facilitator	15%	0%	0%	8%	77%	85%
I made a valuable contribution towards the success of this workshop	Empowerment	8%	8%	8%	46%	31%	77%
I would be interested in attending similar workshops in the future, should they be relevant to me	Commitment	8%	8%	0%	31%	54%	85%
For this project, co-creating an evaluation framework is better than individually developing one.	Co-creation better?	15%	0%	0%	15%	69%	84%

To provide consistency, the results below are presented between the dates that both teams went live (26/2/18) and the final day of operating of the Cove team (29/6/18), unless otherwise stated.

5.2 Service overview

5.2.1 Caseload characteristics

The characteristics of the INCA caseloads are visible in Table 7. There were slightly more female patients, the majority of whom were an older cohort. However, large variability in the age and number of days on the caseload were apparent, with approximately half of the patients being discharged since the service's inception.

Table 7. Characteristics of INCA caseload (up until 29/6/18)

Characteristic	Overall	Cove	Peterculter
Caseload, N	43	19	24
Female, N (%)	23 (58)	11 (58)	12 (50)
Age, mean (range)	78 (26-95)	76 (26-95)	80 (52-93)
Caseload days, mean (range)	61 (5-123)	57 (5-109)	64 (11-123)
Discharged, N (%)	21 (49)	9 (47)	12 (50)

5.2.2 Referrals

Figure 1 shows referrals by month across teams and overall. March saw the highest number of referrals for both teams, with a subsequent decrease in referrals monthly thereafter.

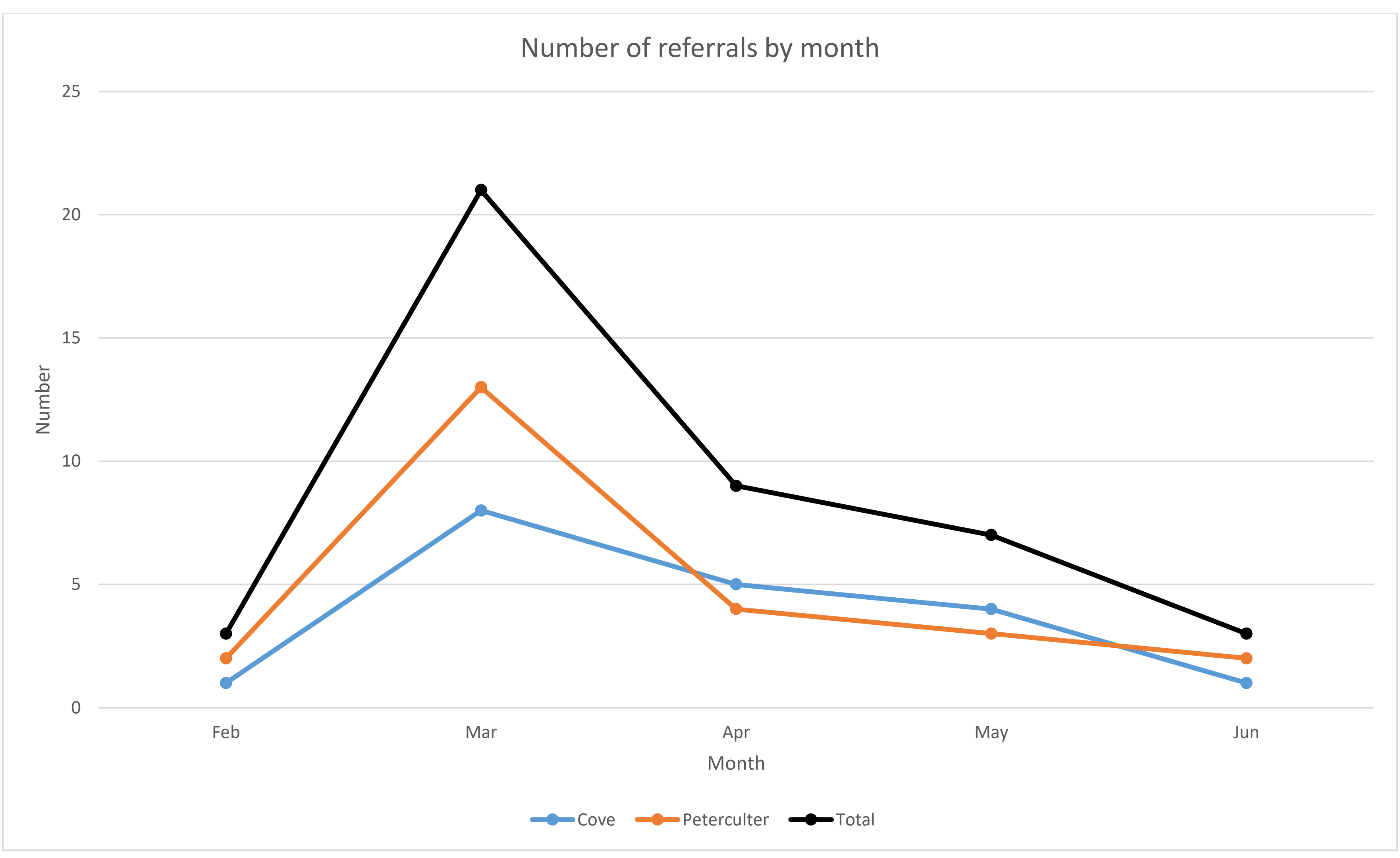

Figure 5. INCA monthly referral rates

Figure 2 shows the source of referrals overall and per team. Community nursing teams (46.5%) were the highest referrers both overall and for each team. The majority of the total remaining referrals came from Care Management (18.6%) and GP (16.3%) respectively. It was interesting to note, however, that there were also instances of self-referrals and family members referring into the service across teams.

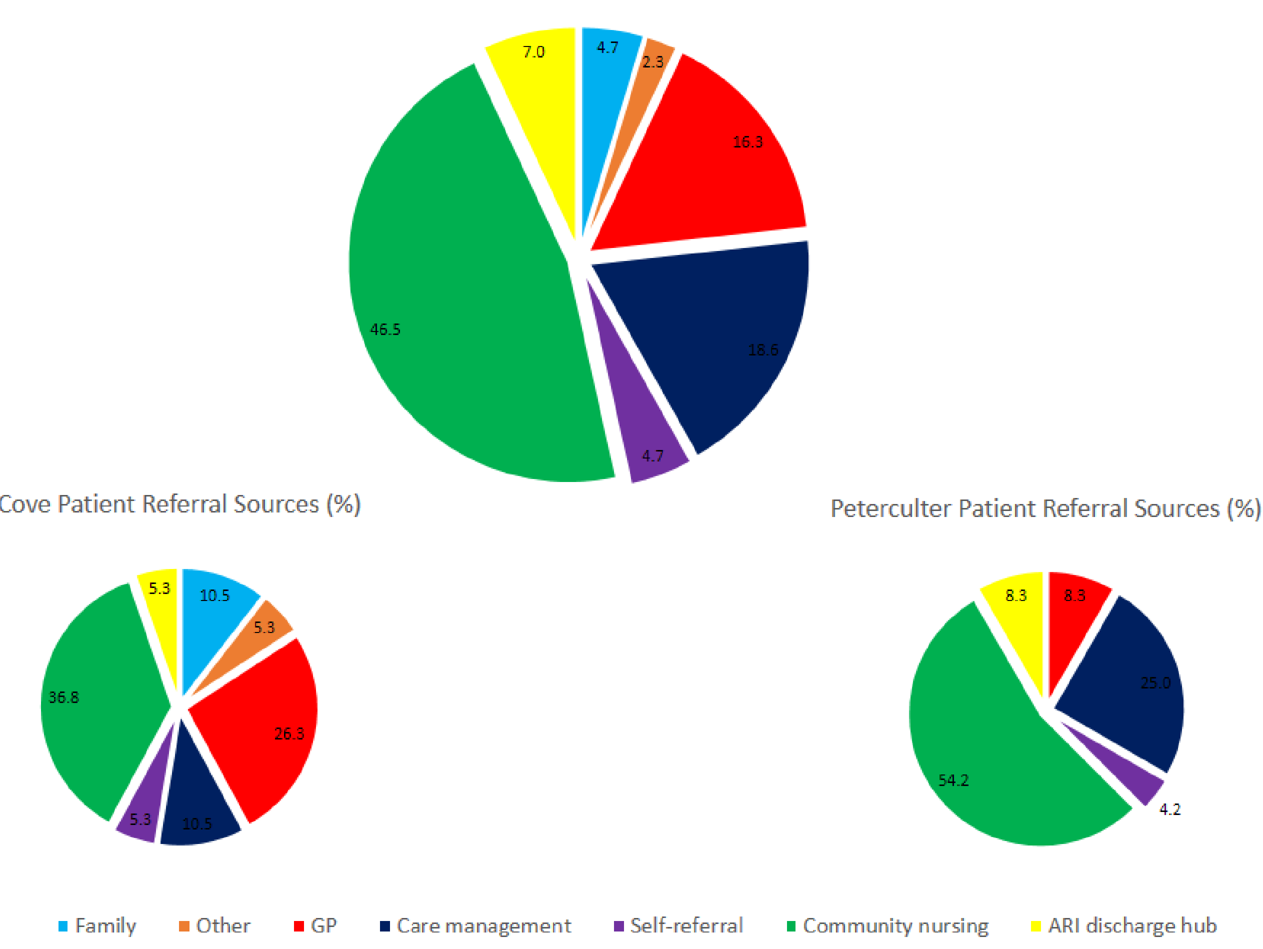

Figure 6. INCA referral sources

The primary diagnosis for patients being referred to INCA teams is presented as bar charts in Figure 3. Overall, there were a variety of primary diagnoses, with cancer (14%), Chronic Obstructive Pulmonary Disease (COPD; 11.6%) and Type 2 Diabetes (9.3%) the most commonly reported.

Total primary referral diagnosis (%)

Stroke
Mobility
Cystic fibrosis
Chronic Kidney Disease
Vascular dementia
Type 2 Diabetes
Prostate neoplasm
Pernicious anaemia
Not reported
Multiple sclerosis
Lung disease
Kidney stones
Joint replacement
Hypertension
Heart condition
Frailty
Dementia
Cystocele prolapse
COPD
Chronic back pain
Cancer

0.0 2.0 4.0 6.0 8.0 10.0 12.0 14.0 16.0

Cove primary referral diagnosis (%)

Stroke
Mobility
Not reported
Heart condition
Dementia
Cystic Fibrosis
COPD
Cancer
Chronic Kidney Disease
Type 2 Diabetes

0.0 5.0 10.0 15.0 20.0 25.0 30.0

Peterculter primary referral diagnosis (%)

Vascular dementia
Type 2 Diabetes
Prostate neoplasm
Pernicious anaemia
Not reported
Multiple sclerosis
Lung disease
Kidney stones
Joint replacement
Hypertension
Heart condition
Frailty
Dementia
Cystocele prolapse
COPD
Chronic back pain
Cancer

0.0 2.0 4.0 6.0 8.0 10.0 12.0 14.0

Figure 7. INCA primary referral diagnosis

5.2.3 Patient discharge

As aforementioned, Cove and Peterculter discharged 47% and 50% of patients respectively up until 29th June 2018. Figure 4 details the reasons that patients were discharged. Both sites had a caseload of numerous palliative patients, resulting in 38.1% of total discharges due to patients dying. Of all discharges, 23.8% were due to input no longer being required from the INCA team.

Total discharge reasons

Refused care 4.8%

Patient relocation 14.3%

Support no longer required 23.8%

Inappropriate admission 4.8%

Deceased 38.1%

Not reported 14.3%

0 1 2 3 4 5 6 7 8 9

Cove Peterculter

Figure 8. INCA discharge reasons

5.2.4 Interventions

Regarding data such as the number of visits and time spent with patients, the caseload management tool was not optimal for data extraction. Interventions are scheduled individually and may often be carried out at the same visit, but the Caseload Management Tool does not make this clear. Staff using the Caseload Management Tool have no ability to input the start and end time of visits. As such, to provide an indicative idea of the number and types of interventions, the month of May 2018 was selected to provide an overview of activity.

Table 8 shows the number of recorded interventions by time of day. Both teams totalled a similar number of total interventions, with the majority of interventions occurring in the morning. When accounting for the number of days for which data was available, the average number of interventions per day were 16.6 (Cove) and 21.6 (Peterculter).

Table 8. Number of interventions recorded in May 2018

Team	Number of Interventions			Total
	AM	PM	Unavailable data	
Cove	206	170	8	384
Peterculter	226	150	13	389
Grand Total	432	320	21	773

Figure 5 shows the number of interventions per day across both sites. The highest and lowest interventions per day for Peterculter were 23 and seven, with the same values from Cove being 17 and nine respectively.

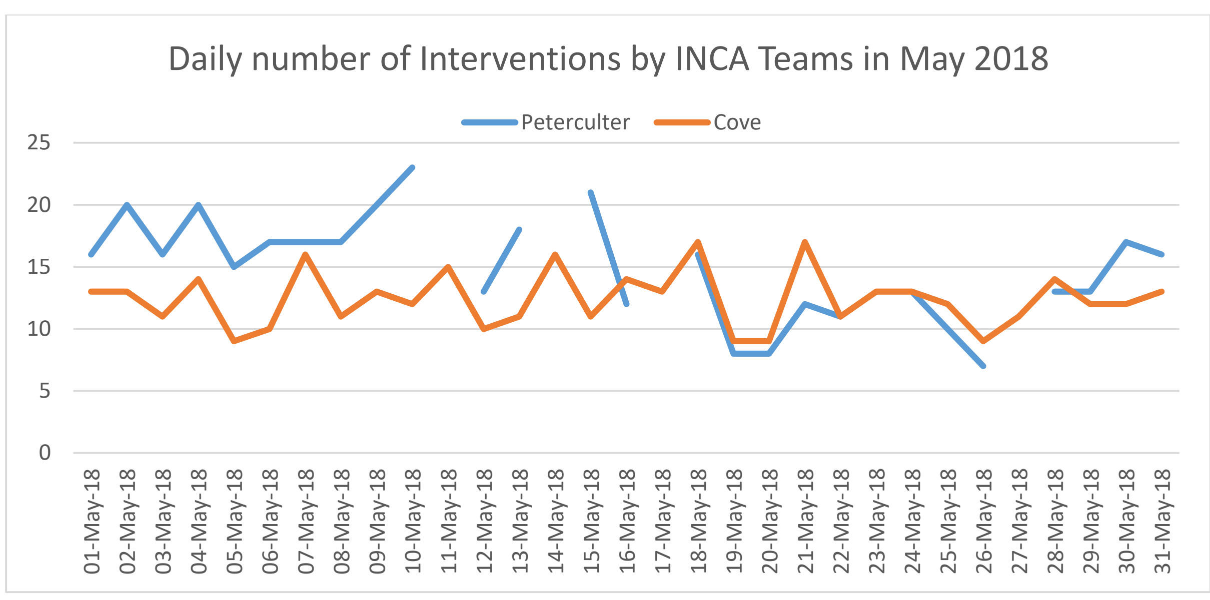

Figure 5. Daily number of interventions by INCA teams. NB: breaks in the Peterculter line indicate days where no daily plan was available to extract data from.

Figure 6 shows the type of interventions that both sites were delivering. The majority of interventions required social care input, for example personal care and meal support, whilst nursing activities were a smaller percentage of workload. As aforementioned, challenges with data entry using caseload management tool meant that, unless specifically stated, it was not possible to distinguish between phone calls and face-to-face visits.

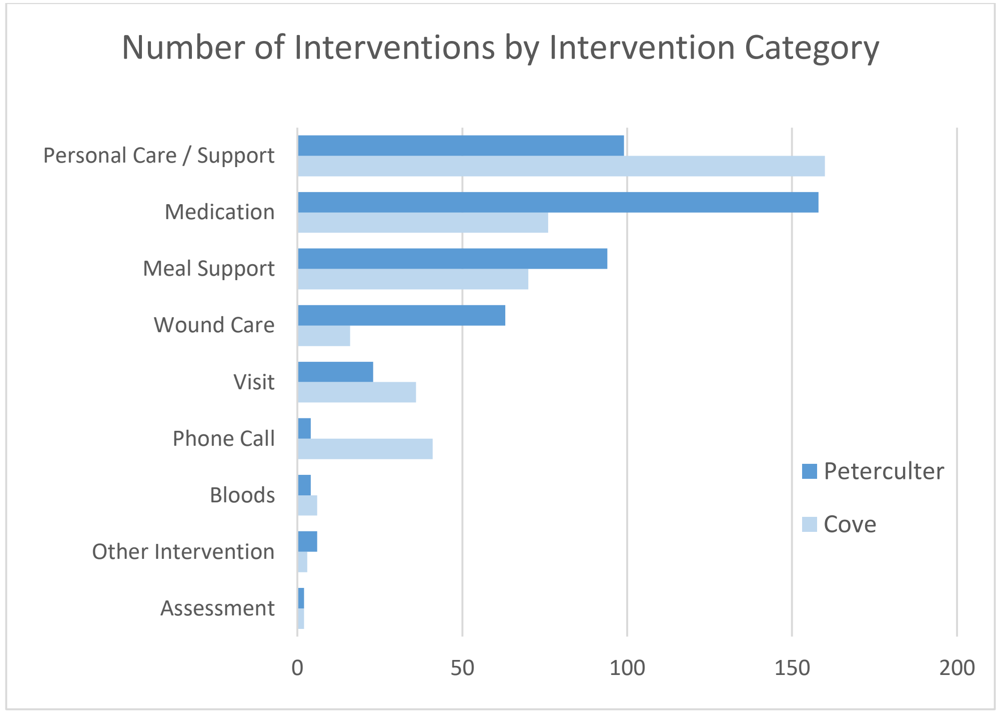

Figure 6. Number of interventions by intervention category

5.3 Patient results

5.3.1 Patient experience

Table 9 outlines the characteristics of patients who were interviewed in Cove (C) and Peterculter (P). The number and sex of interviewees was consistent across both sites, with one man and three women from each participating. The cohort were predominantly older (mean age = 83 years) and were referred onto the caseload with a variety of initial diagnoses associated with ageing.

Table 9. Interviewed patients demographic information

Participant ID	Age (yrs)	Sex (M/F)	Referral reason/diagnoses	Referral source
C1	95	F	Mobility	Social care management
C2	93	M	Mobility	Family
C3	91	F	Heart failure	GP
C4	84	F	T2D	Family
P1	86	F	Cancer	GP
P2	85	F	Frailty	Community nursing team
P3	64	F	Multiple sclerosis	Hospital discharge team
P4	66	M	Lung disease	Social care management

NB: GP = General Practitioner; T2D = Type 2 Diabetes

4.3.1.1 Themes

Table 10 outlines the four themes that emerged from thematic analysis: 1) Service Operation; 2) Staff Qualities; 3) Acceptability & Assets; 4) Confounding Factors. Each of these themes had a number of identified sub-themes that are described below. Due to the small sample of individuals interviewed, ascribing quotations to specific patients has been removed.

Table 10. Themes and sub-themes derived from patient interviews

Theme	Sub-theme
Service Operation	Care content
	Collaboration
	Delivery mechanisms
	External support
Staff Qualities	Caring

	Concern for safety
	Encouragement
	High quality staff
	Respectful
	Staff helpful
	Supportive
Acceptability & Assets	Patient characteristics
	Patient outcomes
Confounding Factors	Care discontinuation
	Consequences of ageing

4.3.1.1.1 Service Operation

Care content –There were numerous examples described by patients of the care that they received, unique to their individual needs. For example, the INCA teams were able to support patients with aspects of personal care: *"They come to help you with the showers and that"*, as well as providing clinical care to those who required it: *"The support I need at the moment is for my ears and eyes also my foot"*.

As the INCA model did not restrict patients to pre-designated times and days of care delivery, staff had the autonomy to arrange home visits at a time that was mutually beneficial: *"Initially it was first thing in the morning to get me up and then at bedtime to get me back into bed"*. Managing their own time also meant that staff could be flexible, with patients providing examples of longer or shorter periods of support as required: "*There has been one or two changes of course but there are four of them coming in here at different times"*. Over time, as patients became more independent, the number of visits they received reduced accordingly: "*In five months they got me from three times a day to be independent enough to have them just coming in once in a while, just a courtesy visit*".

Collaboration – Patients described forming a working partnership with staff and having active input regarding what care they received, for example: "*We talk about it and I have suggested about changing my going to bed time could be a bit earlier.... is an opportunity if there is something I want to say or something I need help with"*. Patients also commented how the

INCA team ensured their unpaid carers were involved in decisions around the support they received. This resulted in feelings of ownership in the care process and an associated open dialogue between families and staff: "*So say they came in and X (patient's daughter) phoned me then the Nurse would have a word with her and I will say 'do you want to tell X anything?' it gives X confidence because she'll say 'are you sure you are alright mum, you're not just saying that?'. No, I'm not. So they know and they try to involve people, but in a nice way*".

Good communication with staff was not only seen to encourage patients to take control of their own health, but led patients to express feelings of empowerment: "*I mean I like to do little things for myself and they will leave me to do it. You know, so I said 'don't fuss over me, if I need you I'll shout', so they have all just rallied round. That's about all I can say really. They respect your wishes*". Patients felt that the strong alliances that they had with staff directly contributed towards the re-ablement process: "*we agreed between us they would come in twice a day and then eventually as I was recovering and getting better through physiotherapy*".

Delivery mechanisms – Patients unanimously agreed that the care delivered to them was positively received. Aspects that they specifically commented on included the availability of the team: "*If I need them, I phone them and they will be down*", the stability of care provided: "*I don't feel abandoned, I feel supported*" and the overall reliability of staff: "*They are always here about the time they say they will be*".

Patients were conscious of staff having to attend others on their caseload with varying needs, signalling their appreciation for the amount of input they received: "*I am aware that there is certainly more than me around and I don't know how health conditions are for people without the area*". One patient did remark that they felt staff had excessive paperwork to complete and was unwieldy to store within their home: "*I have got stuff lying through there, on that dresser and they are writing in that writing books, I wonder if they are writing a book about me, it's taking up a lot of space and I have to keep that space for them, will just throw it in the bin because that's what's going to happen to it*".

External support - Patients described the INCA team working with their family/friends where possible to enhance external support structures that facilitated patient mobility out with their home. The assistance provided by family members in turn aided staff by contributing towards

patient re-ablement: "*I cannot get out by myself but then I don't need them to take me out because my son's .... I know if I phoned them, any of them, they would be here. I know they would"*. Family and friend involvement in patient care ensured that, where possible, patients continued with everyday activities and experienced social inclusion: *"I have my cousin who stays about 2 minutes from here and we go shopping on a Tuesday... Maureen and I meet every week and we do it together, she is very helpful".*

Regarding their network of support, patients reported being signposted to relevant community groups, such as tea dances or Men's Shed: "*Well they asked me if I would like to go [to a community group]"*. However, patients did identify barriers to attending these services, such as no wheelchair access: "*I am on 2 crutches and then when I do go out I need a wheelchair and getting into places, sometimes there is no access for wheelchairs".* Others did not perceive barriers to attending community assets, however felt them unnecessary given the strong family connections they had locally: "*Yes, they did [signpost], but I think meantime I've got my daughter and granddaughter"*.

Recognition was given to the INCA staffs' ability to engage with other professionals to provide additional support when required by patients. For example, the team were able to quickly gain patients access to further services that they otherwise had found challenging to receive: "*If we wanted to ask about some other service or something, they might be able to put in their outlines. I had said to the clinic that I hadn't seen a Physiotherapist since I had come home and then they saw about this for me ... if we are wondering about something, some other help or something, they would try and find out for you"*.

4.3.1.1.2 Staff Qualities

Patients reported positively of their experiences with all the staff members and several traits were frequently highlighted. Examples of these include: responsible staff; "*I think they do a good job. We are very fortunate here to have them and they never fail to come in so that's good"*, respectfulness; "*I mean there's nothing that she wouldn't do for you... she takes time to have a chat with you... you can speak to them. You know they would take time and listen to you"*, supportive; *"if I ask them to move anything, they would do it, just no hardship at all. They are very willing and a very nice group of people"* and caring: "*I don't remember much at the start, because I really wasn't well then..... then I came home and the ladies have been there since. I mean they were so helpful, even just speaking to them, you know and then it*

slowly got better and better and better". These qualities resulted in patients having strong feelings of trust: "*I can depend on somebody to do something about it ... I needn't feel I'm alone"* and that staff were providing a person-centred service: *"The girls have been helpful, they have come in and if I want anything done then they will do it"*.

Patients expressed a genuine concern from staff regarding their safety and wellbeing. For example, one individual described a recommendation from a staff member to have alarm systems installed in case of an emergency, for when team members may not be there to assist: "*They have been concerned about my safety since day one.... they will not let me get myself into any dangerous situation. If they felt it was not appropriate for me to do something, they wouldn't let me do it... INCA suggested that I get a panic button... and I thought brilliant"*. These feelings extended to ensuring disability aids in the home were used correctly and safely: *"we go upstairs on my ... I've got a lift, so they see that I am on my lift right and see that I am strapped in"*, in addition to staff providing supportive supervision when patients were trying new aids/equipment to support their recovery: " *When I got the walker for a start, I was able to go out, somebody took me sometimes.... so we just walked around the corner and back again which was very kind of them"*.

Although staff ensured that patients were not attempting to unsafely escalate the re-ablement process, it appeared that patients gained motivation from the team to aid their recovery, for example by discouraging sedentary behaviour: "*they were super in encouraging me to not just sit about. They got me going and encouraged me to get up to go to the bathroom and back and ... because they were encouraging me so much to get me going"*.

4.3.1.1.3 Acceptability & Assets

Patient characteristics – Patients described a desire not to become dependent on the care that they were being provided with and instead, discussed a shift towards self-managing elements of their health: *"I am trying to be self-sufficient as much as possible. I do what I can"*. Even though service provision was free and tailored to the individual, it was evident that patient's felt retention of control and continuing to complete tasks of everyday living they were capable of doing was important: "*there are a few things that I can do myself and I keep saying to them 'no, don't make me redundant all the time"*.

Patient outcomes – Interviewees were agreed in detailing the positive impact the INCA team had on their wellbeing. For some, simply receiving a telephone call to alert them of an up-coming visit had a positive effect on self-assurance: *"really helps my confidence as I know someone is coming and that is a big thing for me anyway knowing that someone will be along"*. This model of care and support appeared to build on patient's self-efficacy, with patients more likely to attempt to do more by themselves, knowing that support was at hand: *"As long as they are here when I am showering, I have no confidence to go in the shower myself, but they sit here and if I need them I shout"*. Furthermore, patients spoke of the learning experience that existed through detailed interactions and building relationships with the staff and provided examples whereby they had made positive changes to lifestyle behaviours over time: "*I am learning more and more as the time goes by and just watching my diet more than anything else"*.

For some patients who had reduced mobility and were socially isolated, the companionship that the staff provided resulted in improved mental wellbeing, such as reduced feelings of loneliness: *"I know they are coming and I am grateful for them to come in just to speak to because there is nobody else ... I like their company when they come in....I have made friends"*. In addition to personal outcomes however, patients described the relationships that they formed with staff over time that went beyond simply providing care, but into friendship: "*I just used to look forward to her visits and hear about her grandchildren and she heard about mine and that was just the highlight of my day"*.

4.3.1.1.4 Confounding Factors

During the time of interviewing, challenges with staff retention resulted in care being discontinued in one site. This had a direct impact on patients' experience, all of whom reported disappointment in their support coming to an end: "*I'm getting them moulded into my way and you are taking them away and putting them someplace else"*. There was reference from a number of patients who appreciated the low staffing numbers in each team and this was identified as a possible consequence to staff moving on: "*there is often one Carer on alone to do the whole thing. That is hard going for one person... but they are especially busy in the morning"*.

Despite the high-quality of support described, some patients acknowledged that simply the process of living into old age had a deleterious effect on their health: "*I could do a lot more*

before". However, these feelings of ill-health did not relate to the care received, but to patients' capabilities pre-referral to the team: *"I am not managing so well now"*.

5.3.2 Patient outcomes

Pre-post outcome measurements were available for eight patients across the two sites (Table 11). There were numerous reasons for this low number, but primarily because patients had not been on the caseload for a long enough duration to administer follow-up measurements. In addition, palliative patients and those who were inappropriate referrals also did not have these measurements taken. Half of patients noted positive changes in QOL, self-rated health and diet over 3 months. Four patients noted a two-point increase in self-rated health, the equivalent of moving from "poor" to "good", or "fair" to "excellent". Due to the small sample size, statistical analyses were not performed on this data.

Table 11. Patient characteristics and changes in pre-post patient outcome measures

Patient	Sex	Age (yrs)	QOL	SRH	Feelings	Alcohol frequency	Diet	Physical activity	Social support	Group membership
Cove										
1	M	94	-	2	-	-1	-1	-	-	-
2	M	72	1	-	-	-	1	1	-	-
3	F	95	2	2	-	-	1	-1	-	-
4	F	66	-	2	-1	-3	3	-1	-	-
Peterculter										
1	M	72	1	-	2	-	-1	-	-	-
2	F	84	-1	-2	-	1	-	-	-	-
3	M	80	2	-	-	-	1	-	-	-
4	F	85	-	2	1	3	-	-1	4	-
Average		*81*	*.6*	*.8*	*.3*	*0*	*.5*	*-.3*	*.5*	*0*

NB: M = male; F = female; QOL = quality of life; SRH = self-rated health; "-" indicates no change in score

5.3.3 Patient service satisfaction

Responses to the service satisfaction questionnaire are visible in Table 12. The questionnaire was comprised of three components: 1) Prevention (examining perceived support to live independently; reducing medical symptoms; information needed to treat; and care explained in an understandable way); 2) Choice (having a say in provided support; teams taking account of things that matter to the patient; being encouraged to have their say; and increasing choices available); and 3) Overall satisfaction (satisfied with support; recommend support to others; confidence in the INCA teams; well-coordinated care). Overall, satisfaction appeared to be very high, with all responders having confidence in the teams and feeling encouraged to input into the support they received. Two open-ended responders described the support and staff as “excellent”, with a third writing:

“I could never have made the progress I have without the help and encouragement of the INCA team.”

Table 12. Satisfaction questionnaire scores (N=13)

Questionnaire components	Cove Average Score	Peterculter Average Score	Total Average score
Prevention			
Independent living	4.8	4.6	4.7
Reduce symptoms	4.2	4.2	4.2
Well-informed	5	4.7	4.8
Care well-explained	5	4.5	4.8
Choice			
Input of support	4.8	4.7	4.8
Things that matter	4.8	4.4	4.6
Encouraged to input	5	4.7	4.8
Increase available choices	3.8	3.6	3.7
Overall satisfaction			
Satisfied with support	5	4.9	4.9
Recommend support	5	4.9	4.9
Confidence in teams	5	4.9	4.9
Well-coordinated care	4.7	4.6	4.6

NB: Scores based on Likert-scale responses, ranging from 1 (strongly disagree) to 5 (strongly agree). % agreement classed as responders who either responded “agree” or “strongly agree”

5.4 INCA staff results

It should be noted that main contributing factor towards the amalgamation of the two INCA teams was due to the high turnover of staff. The service began in February 2018 with a cohort of 12, however by June 2018 this has decreased to six. Figure 7 shows the turnover of staff in line with the timeline of the project.

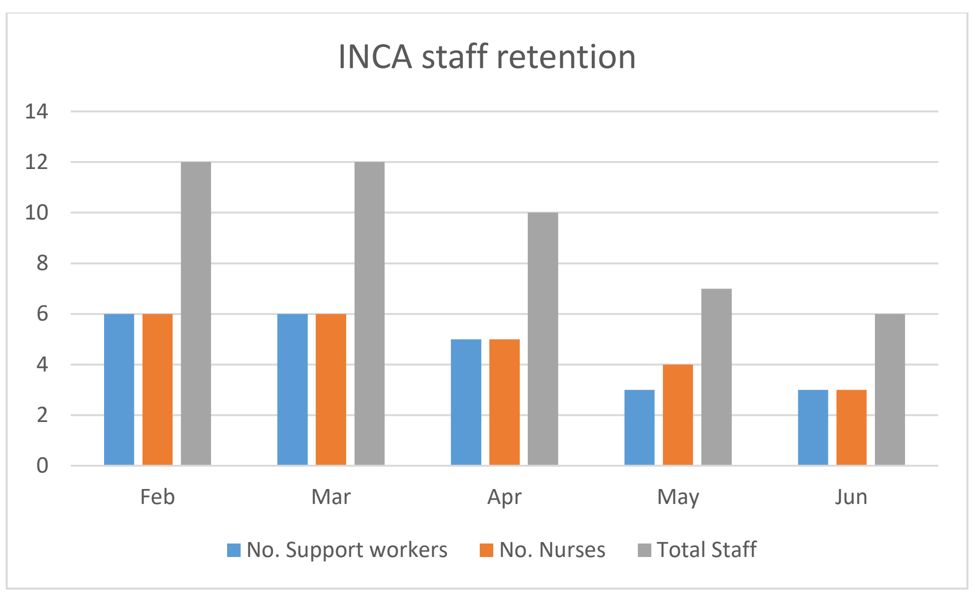

Figure 7. INCA staff retention rates

With the above in mind, the INCA staff outcome data are presented first to represent the feelings of staff three months into the project, whilst the interviews conducted with staff after the discontinuation of delivering care in Cove are described thereafter to highlight the changes that occurred over time.

5.4.1 INCA Staff outcomes

Twelve staff responded to baseline questionnaires, with nine providing responses at a three month follow up.

5.4.1.1 Staff value

Figure 8 shows the average change in score between constructs of feeling valued between baseline and three months. Aspects such as whether staff felt they made a difference and improved teamwork improved between assessments, however using relevant skills and developing their expertise appeared to decrease.

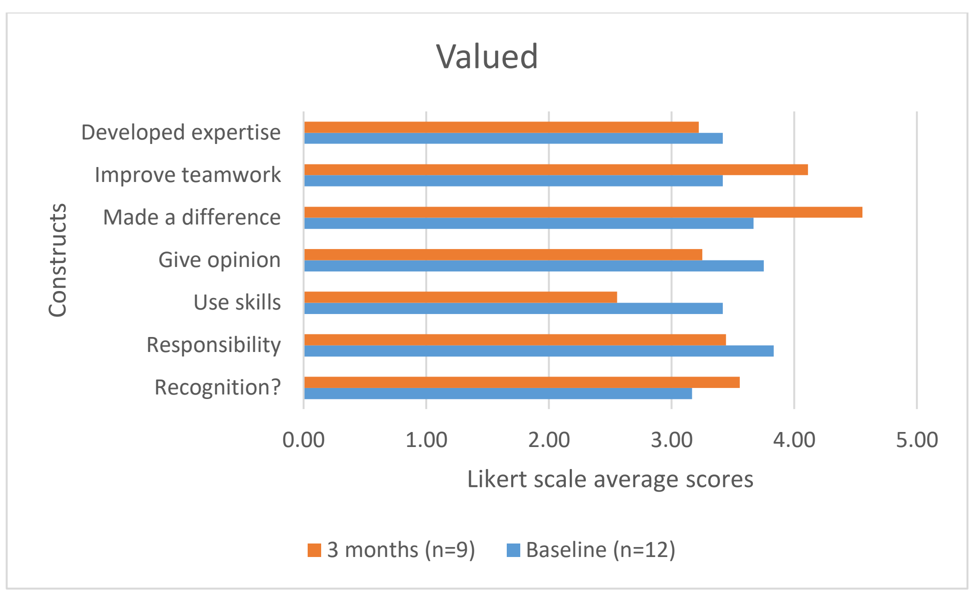

Figure 8. Pre-post changes in constructs of value

5.4.1.2 Staff autonomy

Figure 9 shows the average change in score between constructs of autonomy between base-line and three months. Staff reported a better work/life balance in their current role and reported more involvement in decisions around the rota. Staff marginally reported feeling less trusted in their current role.

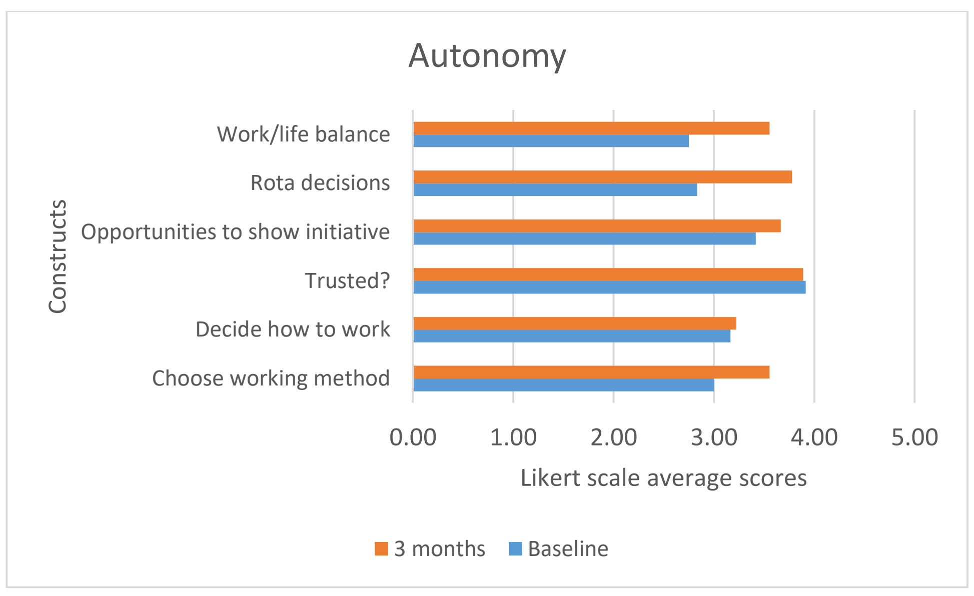

Figure 9. Pre-post changes in constructs of autonomy

5.4.1.3 Staff belonging

Figure 10 shows the average change in score between constructs of belonging between base-line and three months. Staff reported improvements in feeling respected and supported by

other colleagues, however there was a large decrease in knowledge of their work responsibilities.

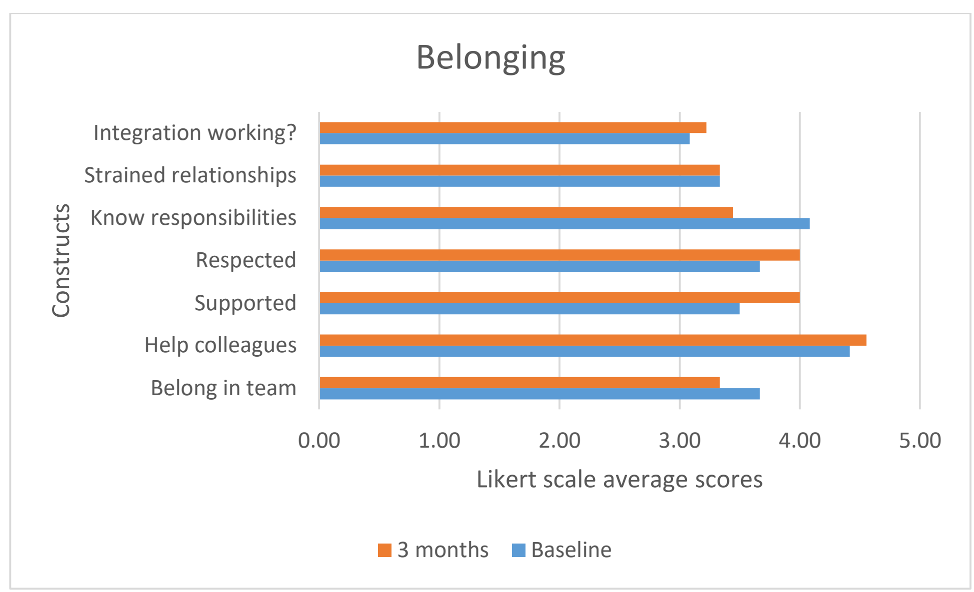

Figure 10. Pre-post changes in constructs of belonging

5.4.1.4 Overall staff satisfaction

Figure 11 shows the average change in score between constructs of overall satisfaction between baseline and three months. Overall, staff reported improved satisfaction in the care they provided to patients and more enthusiastic than previously about their job.

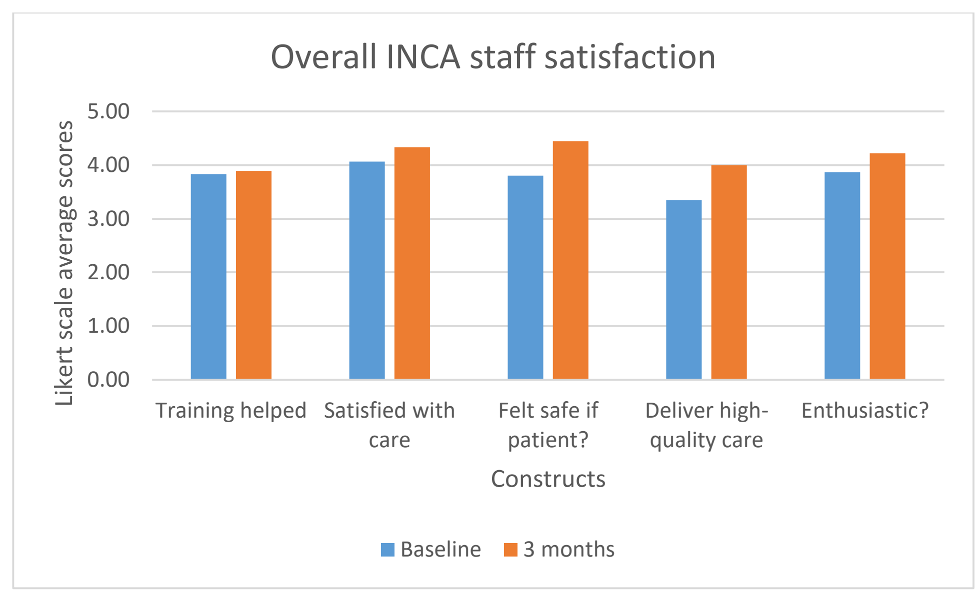

Figure 11. Pre-post changes in constructs of satisfaction

5.4.2 INCA staff experience

Nine team members were interviewed during the summer of 2018, four from Cove (C) and five from Peterculter (P). Their characteristics are shown in Table 13.

Table 13. Characteristics of interviewed INCA staff

Participant ID	Age (yrs)	Sex (M/F)	Experience (yrs.)	Role
C2	64	F	>10	Support worker
C4	34	F	6-10	Nurse
C5	30	F	>10	Nurse
C6	26	F	2-5	Nurse
P1	40	M	>10	Support worker
P2	-	F	6-10	Nurse
P3	43	F	>10	Nurse
P4	55	F	>10	Nurse
P6	54	F	>10	Support worker

5.4.2.1 Themes

Four key themes emerged from the analysis: 1) Service Development; 2) Service Operation; 3) Inter/intra Team Collaboration; and 4) Personal Attributes and Outcomes. These, along with the relevant sub-themes, are visible in Table 14. Again, attributing quotations directly to INCA staff has been removed for anonymity.

Table 14. Themes and sub-themes derived from INCA team interview analysis

Theme	Sub-theme
Service Development	Recruitment and retention
	Induction and training
Service Operation	Caseload
	Patient interactions
	Service characteristics
	Team structure and composition
	External barriers

Inter/intra Team Collaboration	Team relationships
	Team working
	Partnership working
Personal Attributes and Outcomes	Necessary personal qualities
	Positive job aspects

Service Development

Recruitment and retention - From the outset of the project, recruitment was a challenge. Participants raised concerns about the suitability of those recruited: *"I don't think we were experienced enough or had the right skills to go into these types of teams" "I wasn't the right person for that job, I don't have the experience, I don't have the knowledge".* There was some feeling that experienced nurses were reluctant to join the team "*because they couldn't see it working"* or because the local medical practice "*wanted to keep them".* One experienced community nurse resigned after two months, leaving the remaining nurses with limited community experience or training. Once staff started to leave, the same recruitment issues recurred: *"When we had no staff they were like well OK what are you going to do about it? Well we can't recruit, there's nobody wanting to recruit so that was a massive thing as well, nobody wanted to be a part of the team".*

There were a variety of reasons why it was difficult to retain staff. The most consistently reported issue for the nurses was feeling de-skilled with the suggestion they were being: *"paid an awful lot to heat up a meal or give someone a wash",* whilst others commented that: *"I didn't get to use any of my skills, I actually felt de-skilled hugely".* There was also a perception that one of the community nurse teams had a negative influence on the retention of staff: "*it was quite clear …when it came towards the end of people handing in their notices that it was heavily influenced by the existing community team".* Some staff described previous employers offering them their old jobs back, providing them with an alternative if they chose to take it: "*my previous manager, was a boss in [X organisation] before, so kept inviting me to resume my post full-time, but I told X I would continue here*".

Further challenges reported included an unsatisfactory work-life balance, with a need to come *"into work most days for meetings etc."* and *"even on our days off we were getting …phoned in to ask things about work. We were never getting away from it".* As a result, staff

morale was low, with several people reporting that the work was stressful, tiring and different to their expectations: *"I don't regret coming into the INCA team but overall it wasn't a good experience"*. Several mentioned having been attracted by the Buurtzorg ethos, but the experience deteriorated and became more unpredictable as more people left: "*because nobody knows who will leave next".*

Induction and training - Feedback on the induction process was mixed. A lot of information and orientation was covered, which was challenging, but did have benefits for some: *"It was useful at the time … some days were longer than others on the induction but …I'd be lying if I said I didn't come away …each day thinking '… I've learned something new today' so it was beneficial".* However, others felt that there was not enough input on aspects of the role that were fundamental to the project, such as self-management: *"I think the two weeks we had at the start would have been much better spent actually having a coach or somebody who does this kind of stuff to come in and …teach us how to be self-managing because we only got that very brief part from one of the Buurtzorg nurses"*. Once the work had started, ongoing training was not provided, with one noting there were: *"… no clear guidelines about when we were self-managing and when we weren't".*

Other areas where participants felt the induction had not met their needs included: *"input from care managers"* and *"dealing with bereavement (for support workers)".* There was one comment on the hurried nature of the process: "*I feel everything was really rushed at the start. You know we were kind of oh we don't have anywhere to put you so we're just going to chuck you here … even stuff like cabinets to put our paperwork in…it all felt like it was just being pushed through really quickly".*

Service Operation

Caseload – The caseload in both teams was characterised by heavy social care demand and limited need for nursing input (further to that provided by the community nursing team). It was generally acknowledged that this caseload weighting towards social care had been difficult for the nurses: "*I think the nurses, their self-worth went down which … ended up with a wee bit of friction … because their skills were not needed so much"; "I can only speak for myself and X just because we've spoken about it a lot but for us it was like we weren't even getting to do any nursing at all. It was all care and if I still wanted to be a carer I would have never done my nursing training".*

Workload was inconsistent and often at quite low levels: *"There was a lag to get the caseload … when you are in a care setting, you are always on the go, and so there was a time when we remained in the office and were not being with the clients. Yes, we are doing team working and study, but the main part is being here and being with the client."* There was a feeling that the community nursing teams hadn't always passed on clients to INCA: "*I think we would have got more but I think it was being filtered from the [X] DNs because if they were quiet they weren't going to give us the work that they were getting, they were going to take that".*

Patient interactions - Staff spoke about going beyond the traditional professional/patient relationship into something more meaningful: *"Last week when I went in, one girl was really upset, she just wasn't herself, but by the time I left we were laughing and joking. I asked: 'have I cheered you up?' 'Oh yes' she said, 'You certainly have, you always cheer me up', and to me that's a positive thing"; "we could only help their social and enhance their life and to a lot of them that was really really positive".*

The time that staff were able to have with patients meant there were success stories of enabling patients: *"One particular person we were told they wouldn't have long [to live], but 5½ months down the time this person is very happy. She was very fulfilled and really just took a new lease of life."*

There were also accounts of positive relationships with patients' families: "*If people have been unpaid carers they're so appreciative of us taking over some of their job to free up time with them but they totally get it because in the end we as a team and them as a relative or friend, whoever it is, only have one thing really in common and that is we're there for the patient, to keep them at home, that's what we want to achieve together".*

Service characteristics – Participants articulated that their service was able to reduce the waiting times for patients to receive care: "*If you got a referral we would see that person and do the assessment and if the person is eligible [they were] prescribed the right care from the next day … when the full team was on. Prescribing care from the next morning or evening, so fruitful and fantastic. With the conventional system it goes six to eight weeks and then a different level of Managers sanction what to pass on, so compared to that we are effective and benefiting for the community".* Although, there were exceptions to this, with one participant giving an example of a client waiting a fortnight for the INCA team to see her: *"we'd had*

a lady who'd waited, I've no idea how this happened, but had waited two weeks for us to come … and then we had to let her down and she was absolutely devastated".

Functioning in small and integrated teams meant that staff were able to provide continuity of care for patients accounting for changes in their needs: "*maybe their medical issues had moved on but they had social issues so we were carrying through".* Staff autonomy also allowed for this care continuity as staff felt they had been: "... *better able to enable patients in that model because [we] had more time, getting to know the patient better than when carers [are only] undertaking some elements of care.".*

The time staff were able to spend with patients was highly valued by staff and, as staff could choose the length of visits, they noted how they were less constrained than community colleagues working in traditional structures: "*The guys that are out in the community just now are brilliant but they are actually timed at how long they can spend and people are very aware of this that they have got 15 minutes … whereas with us, we went in sat down, we didn't make it feel as if we was clock watching and ... to me, that was as good a tonic as any tablet to them".* The team also had full control over the frequency and timing of patient visits, and for some participants this had been a very positive factor: *"It wasn't until I was working in this team and in this environment that I realised when you actually work in an environment that controls everything, what you're delivering isn't actually patient-centred, there's too many restraints on what you're doing. But, working in this environment, in their home, as a self-managed [team] with nobody on top of you saying 'you've got 15 minutes for that and 15 minutes for that bang, bang, bang' … you get so much more out of the individual you can give them more and you build up that relationship."*

Team structure and composition - There were conflicting opinions about whether nurses and support workers had been able to function effectively in the same team. Advantages highlighted were *"more concordance with care in this system"* and potential for greater continuity of care, whereas those who opposed the idea: *"disagreed with the recommendation which is nurses belong in the model … it was a social health care model."* Although it was acknowledged that this view had been influenced by caseload bias towards need for support rather than nursing care. One argument in favour of separate teams was: "*it's not so much the carers getting bogged down with our stuff because, you know, they can't do our job because they*

don't have that training but we can do their job and I feel that we'll get bogged down with them and that's why I think we both need to be in separate teams".

The small team numbers combined with working rotations meant that staff had often felt isolated from their colleagues: *"… quite a lot of shifts I have been on my own doing 8-8 because we do not have enough to have two on … the luxury of having three on, oh I'm … in my element!".* There was also conflict regarding the flat structure of the team, with even those who championed the concept commenting that some form of leadership role would be advantageous: *"… even saying that we are all equal, we need somebody to lead and sort of drive forward".*

External barriers - Many of the challenges the teams encountered had been out with their direct control. For example, it had taken a long time for the support workers to get access to a crucial caseload management tool: *"from day one the nurses were in control because they had access to all the log ins, they could get onto whatever so when we started getting clients the three nurses could go on and check what was happening with clients but if you were there yourself, … you couldn't go on to check nothing".*

Location had also proved to be an issue: "*The fact that we weren't in a health setting was a huge disadvantage to us...because we weren't part of a health setting we couldn't get our bloods picked up, we didn't have a label printer, everything was going back and forth to [X] which was fine in the start but as our caseload got busier it was so hard to find time to go and do the stuff you needed to do".* Problems had also arisen with the teams providing cover for each other, despite being located in opposite sides of the city.

Other challenges related to: not being involved in the decision to terminate the INCA service in one area: *"… self-managing took a whole new meaning that day they came and told us. That was quite a kick in the stomach so we are either all self-managing or we are not";* the perceived negative influence of the community nursing team from one of the areas and the coach not having a health background.

Inter/intra Team Collaboration

Team relationships – Tension had existed between and within teams from an early stage, with perception of roles and responsibilities being different: "*I think the damage had already been done and it was already too far gone and the fraughtness and the frustration, we were*

taking it out on each other and I think that would have been hard to come back from because you didn't want to fall out with anybody because you had to work with these people".

Communication seemed to have broken down within the team and between teams, potentially due to competition and defensiveness: *"In some ways it was really good, in terms of information/updates being cascaded to us, but communication between the INCA teams was really poor – there seemed to be a competitive element that shouldn't have been there"; "there was a divide between nurses and support workers but nae nothing that could not be mended with a wee bit of a sit down a conversation".* Among a small working team, personality clashes had arisen: *"I knew x was going to be a bit of a negative person because she was, and why have you even come to this job because "'I don't want to do this and I don't want to do that shift' and I thought ... Why even put yourself forward, you don't want to work weekends, why did you apply for the job really".* Whilst there had been tension in the team, it was also recognised that initial team building had been somewhat rushed and this may have contributed to working difficulties later.

Team working – Self-management of the team was one of the most frequently reported challenges of this way of working. In particular, understanding of what was meant by self-management and how it practically functioned seemed to be unclear: *"In the way we were self-managing – nobody made decisions – too scared to do so or it would be perceived that you've taken over."* Interviewees mentioned that they would have liked more time spent early in the project exploring the concept and clarity regarding which elements of their role should be autonomous. The role of the coach in supporting the team appeared to have insufficient prominence and as the project continued and staff number dwindled, the team had less time to get together for open discussion.

Conflicting opinions were evident, particularly around the care delivered to patients: *"I would say there was maybe a lot of… struggles with who want to be a leader, different opinions, things like that. Different opinions on what the whole project is, really, that caused a lot of conflict".* Whilst such decisions would have been a matter of professional opinion: *"it always felt like it was …us and them, … the nurses and the carers, it was like two sides and …we just felt like we couldn't be open and honest because we just felt like we would be kind of dismissed".*

It was also thought that greater openness in drawing on the experience and support of colleagues would have been beneficial "... *at the end of the day sometimes the carers were going into things that were totally outwith their depth and then it was well …, are you able to come back to me and say actually I don't know what I'm doing here and I felt that that wasn't always the case".*

Partnership working – There was a lot of tension highlighted, particularly with senior management across health and social care: *"I feel there were a great number of managers and other senior staff inputting into the INCA team frequently without communication with each other, leading to confusion and miscommunication within the team".* While meetings had been held and attendance expected, examining identified problems and finding solutions was less likely: *"... 'oh you're just being negative' but no we have legitimate issues that we need to address"* and there was a sense of frustration at not having been listened to.

The referral pathway had not always been followed and referral of patients on to the INCA team had been variable: *"We seemed to get ones they [existing teams] didn't want to go out and do".* However, this appeared to be less prevalent in the co-located team, who were able to provide examples of closer collaboration with colleagues: "*Occupational Therapists, very good, excellent communication, I work quite a lot with her, very collaborative, and very easy to approach and that is the outstanding person from my experience, the OT. We have had a lot of contact as we have to seek her advice and help sometimes with implementing equipment and providing wheelchairs or chairs or whatever".*

The majority of participants cited situations where they had signposted patients to local community assets as a mechanism to re-affirm their social networks. However, a further challenge was persuading patients to attend these, with issues highlighted including the logistics of attending such groups: *"I think in X we tried to … use those third sectors as much as possible but we were more restricted in X in terms of …transport … and persuading people to do it".*

Some staff members also acknowledged good practice existing elsewhere in the system and questioned whether service benefits were unique to this service: *"... the girls in the X team have really good relationships with their patients anyway so everything that was good wasn't anything new, I would say. It was stuff I'd done… in previous teams, … had good relationships, good palliative care, good holistic assessment, meeting families. That's all the stuff that I*

would have done in a normal team". However, staff did suggest that their own awareness of other (particularly 3rd sector) opportunities that they could signpost patients to had improved.

Personal Attributes and Outcomes

Necessary personal qualities – Several traits were consistently highlighted regarding the requirements to work in this model. Firstly, commitment was identified, with the majority of the remaining team members believing INCA was a good way to move forward and were determined to make it a success: *"I do not want INCA to fail and I think we have to make it work … we have all came through so much since we started and where we are now, we are in a better place with what we have got".*

Further qualities that were identified included patience, particularly due to the implementation issues of being a pilot project: *"You've got to have patience in this team, 100%*; and mutual respect with other professional colleagues: *"you are a very important part, I am a very important part too and as two important parts we can work together".*

Positive job aspects – Several participants discussed having enjoyed the experience of working in an INCA team, despite the difficulties encountered. Being 'patient focused' was seen as rewarding and in line with staff's own values. Another positive aspect highlighted was the potential to upskill staff in this model, particularly among support workers: *"I thought it was wonderful as I can learn or see and gain experience … I can see and learn more about catheter care; … clinical experience at an informal level, so that increases your care skills".* Others mentioned being able to see opportunities for training colleagues and improving the team's skills.

Working in this way was seen as a learning experience that enhanced their ability to perform a professional role in the future: *"I've learnt so much from being in the INCA team. I've come away from it with a total different outlook on my job … a totally different experience of how I will handle situations in the future".* One of the team felt very positively about the job *"in a sense being like a student nurse again"* in learning a new recording system used by a different practice.

5.5 Partners' experience of service

Three themes emerged from analysis: 1) Service Development; 2) Service Operation; 3) Collaboration. The themes and relevant sub-themes are visible in Table 15. Given the small sample interviewed, all responses are anonymised.

Table 15. Themes and sub-themes derived from INCA Partners' interview analysis

Theme	Sub-theme
Service development	Induction and training
	Referral considerations
	Learning experience
	Leadership
	Barriers
Service operation	Care need
	Service delivery
	Team workload
	Perceptions of team
Collaboration	Communication
	Relationships

Service development

Induction and training – There was a wide variety of content during the teams' induction, with both clinical and team-building activities incorporated into the programme: *"it was a mix of trying to help them come together as a team, but also get some of the stuff that they needed to know if they were coming into community new, so it was a bit of a mix". (PM)*. Although self-management was an underlying principle of service delivery, those designing / planning the induction found the concept challenging to define, making it even more difficult to teach: "*… it's so difficult to quantify what self-management is because what I consider self-management and maybe [PM] considers self-management is two different things*" *(PM).*

There was no on-going training provided, as the INCA teams were expected to self-manage and identify their training needs themselves. However, existing community teams interacting with them felt more could have been done to help, particularly as they were: *"Very experienced professionals in their own setting but new to community so I think there needed to be a lot more training and support available" (Nurse Referrer).*

Referral considerations – More clarity was required regarding the referral criteria, as Partners were unsure who to refer into the service: *"The other aspect I would say is that perhaps there wasn't total clarity of what would be most appropriate for the community nursing team and what would be most appropriate for the INCA team and within that maybe a bit of confusion"* (GP).

Interestingly, some interviewees felt that existing teams were potentially withholding referrals into the INCA team, although were unsure of the reasons why: "*I do think from the nursing side of it there has been a little bit of the other teams holding on to these patients and not actually referring in, for what …reason … I don't know*." *(PM)*. Whilst referrers indicated that they did not block referrals into the service, they did admit that this was being considered due to quality challenges: "*No, but we were nearly getting to that stage just because service provision from them was not as good as we'd hoped, but no I would have referred*" *(Social Referrer).*

Learning experience – From a project management perspective, there was a lot of knowledge gained from the development process. Primarily, the time required to implement a functioning, newly-formed, integrated health and social care team: *"I think it shows that integrated working can happen it just takes a lot longer than people are imagining to happen. It's not a quick fix and when you think we were out in Holland in June last year and there was an expectation this would be up and running in December and it wasn't as if anywhere else had actually brought support workers in I think we were somewhat unrealistic that this would go ahead with no issues. It shows it works but there's an awful lot of background stuff that's got to happen." (PM).* However, it was acknowledged that in applying broad principles from a different healthcare system and adapting it locally, educated approximations had to be taken on many factors, including team composition*: "Would I start with more than 6 people? If I was starting exactly the same, starting with zero caseload, I think it would be hard to justify, so maybe I would put in more additional Support Workers or something, but again I didn't envisage that it would always be so skewed towards social care. I think that was just where we started, but we haven't been able to get beyond that because of everything that has occurred" (PM).*

Despite the numerous challenges, learning was not just gained regarding the refinement of this model, but also used to inform other new models being trialled that were in their development phases: *"Although a lot of it is like 'oh no this hasn't worked and this hasn't worked', … we have learned a huge amount from the partnership, which has already been shared with other projects, lessons learned with Link Workers and Hospital at Home, so that has been invaluable and … it is very very early stages. We have only been live since March." (PM).*

Leadership – There was scepticism from partners whether a fully self-managed team could function optimally and consideration should be given to viewing self-management as a spectrum: "*I have my doubts whether that could be totally self-managed but what I do agree with is the principle of a lighter touch management than has been traditionally the case. The principle should be break down the barriers that stop you from being able to do things as much as possible within safety and governance*" *(GP)*. One consequence of implementing a self-managing team was a knock-on redefinition of the function of traditional service managers, something they also found challenging: "t*hey [INCA team] came to us at various times. They came to us about risk assessments and stuff that was going on, so we did all struggle with what they were meant to be managing, what they needed help with, what's the difference between being a Manager and being a heat shield and all that kind of stuff, which I think we are still probably working through to be honest." (PM).* Three managers performed various aspects of a project management role in developing and implementing this project and, with hindsight, it was agreed that a team leader style role would be beneficial to streamline the process: "*But to have somebody in that coordination role that was operational could have helped it, but then that wouldn't have been the ethos of self-management, but on moving forward and scaling up, would that be something that we would want to consider, yes I think so*" *(PM).*

Barriers – Some partners perceived cultural resistance to change for colleagues, potentially due to the publicity the project received: "I*t's been touted as … the answer to everybody's prayers and I don't think there was enough recognition that actually some of this has been going on under the radar and so therefore for those that have been working in a relatively integrated way it must have been an absolute kick in the teeth because they've been working but … this lot come in and they've been away to Holland and they're getting nice offices in the oil and they're getting iPads, they're getting everything thrown at them but what about us. There is that, you could see … resistance to that because actually we're working that way*"

(PM). Partners interacting with the team also felt that this collaboration resulted in increased workload for them: "*we have to rely on a phone call and them getting in touch, so that is a little bit of extra work and when you add that on to the number of referrals that come through to us, you know these extra 5 minutes per patient takes up quite a bit of time" (Nurse Referrer).* Respondents also described feelings of pressure to get the service operational quickly to its detriment: "*I think there was a tremendous amount of outside pressure looking in – 'get it started, get it started, get it started!'".*

Operationally, there were numerous challenges that were detrimental the project. For example, basic considerations including logging onto and accessing appropriate software were evident: "I *think there is a multitude of things. I think logistically and IT issues have been quite frustrating for them*" *(PM)*. Some partners felt that there were additional systems the team should have been able to access to improve efficiencies: "*They didn't have access to Docman which gives them all the information from hospitals or referrals from clinicians. There is a lot of information that they would need to have prior to assessing a patient." (Nurse Referrer)*. Additional barriers this individual highlighted were having staff employed through different parent organisations: "*having NHS employees and Aberdeen City Council or Bon Accord or whatever it is just having different managers, different ways of working, different policies, procedures*" *(Nurse Referrer).*

Service operation

Care need – It was widely remarked that there was a low nursing need that negatively impacted the nurses within the team: "*I know that some of the concerns from the nurses was they weren't doing an awful lot of nursing tasks*" *(PM).* Despite this, partners did provide examples where the team were able to assist existing teams by caring for palliative patients locally: "*they did actually take a patient from X [outside originally agreed postcode area] for us who had been diagnosed with a terminal illness and they kindly took him onto their caseload so that he could go home to spend his final days*" *(Nurse Referrer).*

Notwithstanding the lack of nursing need, a particular success of this model was the successful unblocking of social care delays through rapid care provision: "*when they first launched we definitely had quite a lot of unmet need that was sitting with my community colleagues, so I am aware that they filled a need there, so they took on the backlog of cases, and that*

included some of the X ones as well. So they absolutely, when they launched, took a certain amount of cases off of our backlog that had been sitting" *(Social Referrer).*

Service delivery – The majority of partners were in agreement that the team were providing high-quality care to patients: *"the patients stories that we hear back from the teams all the time are really inspiring and reminding you why you do your job" (PM)*. There were several reasons cited for this, particularly due to care continuity: *"they will come in when they say they are going to come in, they are working more flexibly than we could ever work here, (Social Referrer)*, and the autonomy to increase and decrease care input rapidly: *"you could hopefully be a lot more responsive to when people's needs fluctuate, whereas what happens is that they get an assessment, which is a snapshot in time, often when they are just home from hospital or something and their needs are quite high, a care package is put in and actually they do improve and they probably don't need it all," (PM).*

Service delivery appeared to be streamlined when teams were co-located with other professionals. For example, partners in one site admitted that: "*It was difficult in terms of interaction with the team because the team here was based in a remote centre rather than within the Medical Practice. That's never absolutely ideal within an integrated team. Whilst electronic communication is a good facilitator these days there's nothing that beats the corridor conversations at particular times of more intense need*" *(GP)*, whilst in the other, staff member suggested that: "*I think as well by having Carers onsite meant communication was improved … them being … co-located would have made a big difference*" *(Social Referrer).*

Despite the aforementioned benefits, partners did acknowledge that there are existing teams that are functioning in an integrated way already: "*What I do know is that we have a community nursing team that has been working very very well here and working in a very integrated way with other services where in other parts of the city my feedback is very different*" *(GP).* This led to the exploration of whether positive patient experience was unique to this model of delivery, or whether similar outcomes would be visible elsewhere: "*I suppose it's trying to think for me whether 'is that anything to do with INCA?', probably not really as a lot of it is about personalities and their knowledge and skills and what they bring to their job, which happens right across the board*" *(PM).*

Team workload – It was noted that the INCA team had a very small caseload, which appeared to disgruntle partners who regularly cited a heavy workload: "*Very few. I mean comparatively considering the amount of staff they have, whereas we've got what 90 odd*" *(Nurse Referrer).* However, this did result in referrals usually being accepted by the team: "*I think of everybody we referred, if they had the capacity, they did take on their care*." *(Social Referrer).*

The teams managed an on-call rota for a period of time and provided care seven days a week. It was felt that this delivery structure may deter future staff, particularly considering that community-based professionals do not typically work such hours: "*they are working a lot more weekends than the Community Nurses do currently and they are working into the evenings …. That will be a barrier …and honestly I don't know how that would pan out" (PM).*

Perceptions of team – It was unanimous across the board that the self-management component was challenging not just for the team, but any new professional who may have joined the service: "*I think we do need to keep going back and exploring the self-management component is (that) something that we keep or whether we take that away. It is quite hard for them. They will say that they want to self-manage, and they do, but there are other things that they don't want to self-manage around, and that's really hard for them to learn; hard for anybody, even if you have been working in the organisation for years and years*" *(PM).* The consequences of this were perceptions of disorganisation and last-minute decisions within the team: "*I have real doubts that any team can self-manage effectively, and I didn't see it in the INCA Team. I saw no evidence that they were managing themselves well. I saw evidence that they were trying to manage things, but it was very much at the 23rd hour, as I mentioned, and it seemed to be all very reactive rather than planning*" *(Nurse Referrer).*

It was noted that recruitment was particularly challenging, although not a new issue to the area. With this in mind, some partners were sceptical whether the service should have began:

"*I think that if they had appointed people well enough initially they could have foretold a lot of the problems that we had. (Nurse Referrer)*

But they didn't get the applicants (Nurse Referrer)

Well, if you don't get the applicants and they are not up to scratch you debate whether you start a service, especially a new service" (Nurse Referrer).

Even with these recruitment challenges, it was felt that the individuals remaining in the project had particularly enduring commitment qualities with a desire to make the service successful: "*I think they tried extremely hard here. It was quite clear how much initially they wanted to make this work. They gave it their all I think here*" *(GP).*

Collaboration

Communication – From the outset, the partners endeavoured to establish communication channels with the team to facilitate implementation: "*we tried to arrange regular meetings with the INCA team to discuss how things were going and if there was any way that we could support them further if they were having any problems and that seemed to be working okay*" *(Nurse Referrer)*. However, this seemed to break down over time, with the majority of partners reporting communication challenges with the team: "*This seemed to be one of the issues that we never knew if they had been in to the ward and done what they needed to do and then the person was discharged without feedback, certainly to the hospital team, of what package of care had been put in, so I suppose staff felt out of the loop once we handed over … from a referring point of view we never really knew what had then happened to allow us to update our systems*" *(Social Referrer).*

Indeed, it was felt that there were also difficulties communicating within the teams, meaning there was a lack of communication continuity: "*think what probably we could have been better with is the communication in teams; this wasn't that great. If you go and speak to one person and 2 days later they wouldn't pass it on and so you would be having the same conversation again with Person B, and that's frustrating not only for them but also for us*" *(PM).* Although, it was acknowledged that these challenges were in part due to wider IT and geographical issues the teams faced: "*And likewise when they are out on home visits they can't contact the practice and they are not able to contact anybody either because they are in a black spot and there is a lot of black spots*. *(Nurse Referrer).*

Relationships – At the beginning of the process, the teams did interact with other professionals, particularly those who were not co-located, in an attempt to establish relationships: "*… they came along to a PLT meeting to introduce themselves and give an update of how things were going*" *(GP).* However, it was felt that more should have been done to build this collaboration with partners as far back as the induction weeks: "*forgive me I could be wrong, at no*

point did we arrange for them to see the community nurses they were going to be working with nor did we invite… them to come in and explain what their role was and whether that may well have eased the process" *(PM).*

It was noted that there were personality clashes within the team that deterred from successful team working: "*I found that there was barriers with regards to that too because they didn't agree on an awful lot of things*" *(Nurse Referrer).* However, one commonly reported reason for this tension was staffing issues, from which relationship challenges derived as a consequence: "*As soon as people started to leave it became more of a challenge for them all, because all the stuff that you were trying to do and that needed to develop and evolve over time became more and more difficult because they were covering longer shifts, they were covering their own weekends and stuff*" *(PM).*

6. Discussion

The purpose of this report was to present process and outcome evaluation findings for the INCA project. Specifically, the impact on patients, staff and resources were explored. This paper is crucial to inform the future direction and development of this project by understanding what worked well and areas for improvement.

Patient perspective - Overall, this service appeared to be highly acceptable to patients, with overall satisfaction scoring an average of 98%.

Components within the choice element of the satisfaction questionnaire that patients strongly agreed with were their input into the support they received (average score 4.8/5), along with the team encouraging patients to have their say (average score 4.8/5). These quantitative findings are supplemented by the collaboration sub-theme that emerged from interview analysis, with patients often referring to the team-working that occurred between the two parties. This highlights the perceived benefit to patients of having equality in the relationship with those who support them. Indeed, the National institute for Health and Care Excellence have released specific guidelines stipulating the need to ensure that patients are active participants in the care and support that they receive[25]. These guidelines are reinforced by previous evidence demonstrating that joint decision-making leads to increased adherence to treatments[26] and improved knowledge of available options[27]. Given that the Buurtzorg principles, on which this model was founded, stress the importance of placing the patient in the centre of their care needs[28], it would appear that this component of the model worked well.

One reason that may have contributed to the high patient satisfaction was the ability of the team to be agile in their care delivery. For example, patients described circumstances where their health would fluctuate and would subsequently require more or less support. The au-

[25] National institute for health and care excellence (NICE) (2012). *Patient experience in adult NHS services.* London: NICE
[26] Nunes, V et al. (2009). *Clinical guidelines and evidence review for medicines adherence*. London: National collaborating centre for primary care and royal college of general practitioners.
[27] Stacey, D et al. (2017). Decision aids for people facing health treatment or screening decisions. *Cochrane database of syst rev.*
[28] Kreitzer, M. J et al. (2015). Buurtzorg nederland: A global model of social innovation, change, and whole-systems healing. *Glob Adv Health Med, 4*(1), 40-44.

tonomy the team possessed to adjust frequency and duration of support contrasts to traditional models, principally in social care, whereby care provision is fixed and requires reassessment to increase[29]. This appears to be a particularly beneficial component of care delivery in community settings, especially considering the predominantly older cohort who received care (mean age = 83 years), a population that report large variances in their health status from day-to-day[30]. Being able to tailor care delivery to compliment the needs of patients has been attributed as one of the key components of the Buurtzorg model in improving support for frail older adults[31].

Another important principle of the model incorporated within INCA was the mobilisation of community assets and social networks to support patients towards enablement[32]. Here, participants all provided examples of signposting they received towards other forms of support locally, such as community groups and activities. Community assets have previously been championed as offering the potential to enhance quality and longevity of life by improving coping abilities and self-esteem of individuals[33]. Despite this however, there was a reticence to attend community assets, with some patients citing logistical challenges and feelings of discomfort as barriers to attend new activities. It is possible that there are other factors influencing this opinion also, such as patients already feeling adequately supported by the INCA team. Indeed, the friendship that was commonly reported by patients, whilst having a direct positive impact on wellbeing, may lead to a reliance on the service and subsequent challenges discharging individuals from the caseload. Therefore, whilst strong relationships were formed between patients and staff, further work and resource is necessary to move beyond signposting individuals to community assets, to actively establishing and maintaining those connections should the individual want to do so.

Staff & Partners' perspective - One of the key challenges within this model was the composition of care need on the caseload. There was a dearth of nursing need (leading to nurses

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[29] Scottish Government. (2011). *Finding the care that is right for you*. Edinburgh: Scottish Government.
[30] Leask, C. F et al. (2016). Modifying older adults' daily sedentary behaviour using an asset-based solution: Views from older adults. *AIMS Public Health, 3*(3), 542-554.
[31] Alders, P. (2015). Self-managed care teams to improve community care for frail older adults in the Netherlands. *Int J Care Coord, 18*(2-3), 57-61.
[32] Monsen, K. A., & de Blok, J. (2013). Buurtzorg: Nurse-led community care. *Creat Nurs, 19*(3), 122-127.
[33] Glasgow centre for population health. (2011). *Asset based approaches for health improvement*. Briefing paper 9.

feeling de-skilled) and this is likely to have been heavily influenced by this service double-running in tandem with existing community nursing teams. Had this model been a redesign of traditional service delivery, it is probable that these issues would have been resolved and therefore, retention problems and subsequent challenges been, in part, avoided. However, this service did appear to fill a gap in providing rapid access to social care provision. Older adults and individuals with social care input often have complex needs that require varying degrees of input at different times[34,35]. It was therefore beneficial that the team had autonomy to vary the frequency and duration of care provided to react to the needs of patients. INCA differs from traditional social care delivery, where support is usually provided by prescribing set times and days that individuals will receive care. However, it has been acknowledged that the traditional model is not sustainable[36]. Providing front-line staff with the autonomy to decide when and how care is delivered may be one effective strategy towards delivering efficient and sustainable services.

Differences in acceptability were evident in the co-location (or lack thereof) of staff. Those based in corporate offices described feelings of isolation from other professionals, whereas staff based within the GP practice reported stronger partnership working with other colleagues. This finding is unsurprising; a recent European-wide study examining co-location in primary care reported a significant relationship between co-location of multiple professionals with inter-professional collaboration and improved secondary care coordination[37]. Whist co-location does not necessarily guarantee integrated working, it provides professionals with an opportunity for increased informal interactions that can enhance mutual decision-making and practice[38]. These networks were described clearly in Peterculter as participants were able to provide positive examples of collaborative working with other professionals, however were

[34] Audit Scotland. (2016). *Social work in Scotland*. Edinburgh: Audit Scotland.
[35] Leask, C. F et al. (2016). Modifying older adults' daily sedentary behaviour using an asset-based solution: Views from older adults. *AIMS Public Health, 3*(3), 542-554.
[36] Audit Scotland. (2016). *Social work in Scotland*. Edinburgh: Audit Scotland.
[37] Bonciani, M. et al. (2018). The benefits of co-location in primary care practices: The perspectives of general practitioners and patients in 34 countries. *BMC Health Serv Res, 18*(1), 132.
[38] Jong, J. D. (2008). *Explaining medical practice variation: Social organization and institutional mechanisms*. Utrecht: Utrecht University.

less prevalent in Cove. This is one clear distinction between the INCA model and the Buurtzorg model, whereby the latter are typically based in a stand-alone office within the neighbourhood they serve.

Despite numerous reported challenges, the participants felt they provided a high-quality service to patients and gave examples of enablement approaches they had seen prove fruitful, including for one patient deemed palliative when referred into the service. Care continuity was cited as one reason for this high-quality provision because it allowed staff to develop strong relationships with patients. Indeed, a paper by Freeman and Hughes[39] has highlighted the high value placed by both patient and clinician on continuity of care, with evidence suggesting that this may result in improved patient outcomes and staff satisfaction[40]. It appears that having a small team looking after a limited cohort of patients is a simple yet effective strategy to developing strong relationships, allowing for increased interaction and communication to occur.

The self-managing element of this model proved challenging to staff. Several reasons were cited for this, including personality clashes between team members, and a lack of clarity regarding team roles. Interestingly, the opposite has previously been reported as characteristics of successfully operating self-managing teams, for example clear task division and good team relationships[41]. However, a fundamental barrier to working in a self-managing way was the concept of operating as a self-managing team within a larger organisation, similar to previous findings[42]. Whilst these are issues that, in the Buurtzorg model, a coach would support teams to resolve[43], the team cited time and staffing challenges as barriers to accessing this resource. It appears that having these support structures embedded throughout implementation, in addition to providing a clear framework to outline tasks, are fundamental to facilitate effective manifestation of the principles of self-management within this model. This is reinforced by the input of senior managers who, although they were not directly involved in

[39] Freeman, G., & Hughes, J. (2010). Continuity of care and the patient experience. *The Kings Fund,* 1-64.
[40] Fairhurst, K., & May, C. (2006). What general practitioners find satisfying in their work: Implications for health care system reform. *Ann Fam Med, 4*(6), 500-505.
[41] Weerheim, W. et al. (2018). Successful implementation of self-managing teams. *Leadership in Health Services, [Epub ahead of print]*
[42] Drennan, V. M. et al. (2018). Tackling the workforce crisis in district nursing: Can the dutch buurtzorg model offer a solution and a better patient experience? A mixed methods case study. *BMJ Open, 8*(6), e021931.
[43] Kreitzer, M. J. et al. (2015). Buurtzorg nederland: A global model of social innovation, change, and whole-systems healing. *Glob Adv Health Med, 4*(1), 40-44.

service delivery, had power to change the structure of the model, causing conflict with the teams' perception of being self-managing.

Limiting factors - There are several limitations to consider. Firstly, due to retention issues of staff, this evaluation report has been produced several months earlier than scheduled. This has resulted in a variety of data either 1) scheduled to be gathered six months post implementation or 2) dependent on the scaling of the project, not being possible to report on. Whilst this evaluation has been agile to adapt to these challenges, it would have been more complete and robust had these retention issues not occurred.

From a patients perspective, the small sample size interviewed means these findings are not necessarily generalisable to all patients. However, data saturation did occur, whereby no new themes emerged from analysis. Further, patients stated that their health improved from seeing the INCA team, however this report has provided limited clinical evidence to reinforce that stance. Third, patients may have biased their findings in favour of staff due to being provided with free care, or for fear of reprisals if they voiced negative opinions, although they were reminded that all responses were anonymous and would not impact them in any way. It may also be considered that, whilst this model has a strong focus on re-ablement, it is possible that patients actually under-reported their levels of independence in case they got discharged from the caseload (a particularly pertinent point when considering the strong themes of relationship-building that emerged through interviews).

There was limited data gathered regarding unpaid carers' perceptions of the service and how it impacted them. This was due to logistical challenges contacting these individuals and future work should attempt to investigate this further.

There are additional limitations in the staff data collected. As stated, the staff outcome questionnaires were administered at the start of the project and at three month follow-up, whereas the majority of interviews were conducted after this point. As a result, the outcome data appears to suggest that this model of working had several benefits compared to the roles staff previously filled, however this is skewed when considering that only 75% of staff were still working in this model at follow-up. Given the cohort who remained employed in this model over time, it is reasonable to suggest that it was more acceptable to support workers than to nursing staff.

Also, factors such as patient-facing time and cost-effectiveness, although desirable, were not captured here. This was due to limitations within the electronic system used for data capture, in addition to being a test of change, therefore it was agreed that limited time and resources should be used to focus on whether the service *can* work, before determining aspects such as scale up and intricate financial testing[44].

[44] Bowen, DJ et al. (2009). How we design feasibility studies. *Am J Prev Med*. 36(5), 452-457.

7. Conclusion and recommendations

The INCA model appears to be highly acceptable to patients, who self-reported enhanced wellbeing (physically, mentally and socially) and described receiving person-centred care from trustworthy and high-quality staff. Future work should aim to ascertain whether these improvements are of clinical significance (and comparable to outcomes achieved in the traditional care model) and aim to capture the experience of unpaid carers to understand how this model impacts their wellbeing. Further, given the challenges in uptake of signposted community assets, exploring the mechanisms by which individuals can be supported to access and continue to attend these networks should be considered.

This model provided mixed acceptability to staff. Particular elements that proved successful include: 1) the autonomy to adjust care provision to the needs of the individual; 2) developing their own work roster to ensure care provision whilst also considering the preferences and circumstances of INCA staff; 3) continuity of care, allowing strong relationships to develop between staff and patients; 4) the rapid provision of social care; 5) co-location with other professionals to enhance cohesion of integrated working. However, other aspects of working, including a predominantly social care caseload, challenges resolving conflict and communication issues led to staff turnover and associated difficulties in work/life balance. Collectively therefore, the above may be considered when determining which components of self-management are likely to be positive to implement in traditional models. The self-management ethos requires a clear framework in which to operate, for example outlining the roles and responsibilities of staff, in addition to the appropriate support structures and mechanisms by which to overcome logistical, environmental and intrapersonal barriers. Future work may aim to incorporate the successful examples of self-managed working into existing service delivery to determine what improvements, if any, this makes.

The colleagues of INCA staff echoed the sentiments of high-quality care provision and rapid access to social care, however acknowledged communication challenges with the team. Future work should ensure that appropriate time is assigned to establishing and maintaining these relationships to improve the service. It is important to note that, whilst numerous challenges can be attributed to this service double-running with existing teams, this was operationalised for the purposes of testing the Buurtzorg principles locally and thus determining which aspects of working may be wider applicable across the system. Therefore, thought

should be given to how this service can be integrated with existing services, such as Acute Care @ Home and the West Visiting Service. Further, whilst it was acknowledged that not enough training and support was provided regarding the self-management element of the service, it cannot be concluded that self-managing teams are not feasible. Instead, it may be beneficial to view self-management as a spectrum, particularly when considering the above elements that proved successful. Finally, given the challenges extracting data from the IT system used, future work must ensure that systems utilised are fit for purpose.

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Appendix 1. INCA Framework

INCA FRAMEWORK

Principles

Person at the centre

Use of informal networks

Self-managing team

Relationships with formal networks

Enabling approach

Neighbourhood Based

EFFECTIVE USE OF RESOURCES

Anyone living in the Cove (postcode AB12 3??) or Peterculter (postcode AB14 ???) areas with a new need for nursing care, social care or both is eligible for assessment by the INCA teams.

The teams will cover 24 hours per day, 7 days per week including public holidays.

Out of hours periods where there are no scheduled visits should be covered on an on-call basis.

There will normally be no scheduled visits between 23:00 & 07:00.

We expect a minimum of one person (who could cover both teams) to be on call at all times. There will always be a qualified nurse on call.

The teams are expected to achieve 60% client related activity (either direct or indirect) within 6 months of go live date (22nd January 2018).

The remaining 40% of working hours covers annual leave, sickness, administration, training, team activities etc.

The teams have responsibility for managing their budget for stores and training.

The teams are expected to follow their host employer's personnel/HR policies and procedures & to discuss with the Project Team if there are any significant conflicts in terms of these policies.

The teams will manage absence but if a team member's absence level reaches the triggers within the host employer's Attendance Policy then this will be referred to the coach (once the ACHSCP has recruited coaching support. Until then, attendance will be managed by NHSG or BAC responsible managers)

Once the teams have reached their 60% client related activity target, if they are unable to provide the care hours required, they need to establish whether nursing or support worker hours need increased and seek support from the coach / HR regarding recruitment.

The teams should be knowledgeable about local/citywide community resources and be proactive in utilising those to achieve the best outcomes.

The teams will work out who should carry out required team tasks & whether / when to rotate them. For example:

- Rosters including accessing cover from bank/other INCA team if required
- Monitoring of hours worked & mileage
- Housekeeping
- Annual leave
- Stock orders
- Performance Monitor
- Management of student allocations and mentor issues (mentor registers, annual up-dates, triennial reviews)

SAFE, EFFECTIVE, PERSON-CENTRED CARE

Regular appraisal will be organised within the teams or with the coach.

Staff will identify their own training/learning needs with support from the coach but will also be asked to comply with some training requirements of either of the two host employers.

The teams will report incidents via relevant system.

Teams should respond to compliments and complaints through early resolution (and seek guidance from coach where this is not possible).

Teams should participate in audit / data collection to demonstrate the value of the project and influence plans for the future of service delivery across the city.

The teams should create holistic care/support plans with service users.

Team members should communicate openly and honestly with each other.

INTERACTION WITH HOST EMPLOYERS

Team members should keep themselves informed of what's going on in ACHSCP / BAC via email, communication channels (eg aligned District Nurse Team Leader), also Safety Action Notices & registering body updates.

Teams should assist with the evaluation of the project and be prepared to speak/present to other colleagues about how it's progressing.

HAVE FUN AT WORK

We believe that working in this way will be fun, but if this is not the case, support from the coach and/or the Project Team should be sought to explore and try to resolve any issues.

Appendix 2. INCA Referral Process

Referral pathway for INCA

Care at Home and Community Nursing Care

Social Work Process

Postcode identifies a resident of Cove (AB12 3..) or Peterculter (AB14...)

Nursing Process

Postcode identifies a resident of Cove (AB12 3..) or Peterculter (AB14...)

Is the patient in receipt of community nursing care?

NO

YES

Not eligible for INCA service. Progress referral as usual

Care at Home

Is the individual in receipt of Care at Home? (Check Care First or tel. 01224 264004)

YES

Not eligible for INCA service. Progress referral as usual

NO

Forward referral to INCA team

INCA Team

INCA team carries out a holistic assessment of persons needs and creates plan of care to be delivered by the team

If the person has social care needs or referral came via social work, the INCA team must provide detail back to Social Work email CMAdminGSX@aberdeencity.gcsx.gov.uk

INCA team records referral and plan of care on Vision Community Module

Individual is under 65

If there is a social care need they will require a financial assessment. This will be carried out by the INCA team and/or care manager

Individual has a need for overnight care

INCA team refers to Aberdeen City Community Nursing Out of Hours and (where appropriate) Marie Curie

20/03/2018 version 2.0

Appendix 3. Patient Outcome Questionnaire

Integrated Neighbourhood Care Aberdeen (INCA)
Patient OUTCOMES

ID: (Research Team use only) ☐

Q1 Thinking about the good and bad things that make up your quality of life, how would you rate your quality of life as a whole? *Please tick ONE box only*

Very good ☐ 5	Alright / neither good or bad ☐ 3	Bad ☐ 2
Good ☐ 4		Very bad ☐ 1

Q2 In general,would you say your health is....? *Please tick ONE box only*

Excellent ☐ 5	Good ☐ 3	Poor ☐ 1
Very good ☐ 4	Fair ☐ 2	

Q3 During the past 4 weeks how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable or downhearted and blue? *Please tick ONE box only*

Not at all ☐ 5	Moderately ☐ 3	Extremely ☐ 1
Slightly ☐ 4	Quite a bit ☐ 2	

Q4a How often do you have a drink containing alcohol? (if 'Never', go to Q5)
Please tick ONE box only

Never (go to Q5) ☐ 5	2 - 4 times a month ☐ 3	4 or more times a week ☐ 1
Monthly or less ☐ 4	2 - 3 times a week ☐ 2	

Q4b How many drinks containing alcohol do you have on a typical day when you are drinking? *Please tick ONE box only*

1 to 2 ☐ 5	5 to 6 ☐ 3	10 or more ☐ 1
3 to 4 ☐ 4	7 to 9 ☐ 2	

Q5 How many portions of different fruit and vegetables do you eat in a day? Remember that fruit juice only counts as 1 portion a day, regardless of how much you drink. The same applies to dried fruit. Potatoes count as starchy foods and not as vegetables. As a guide, a portion is about a handful.
Please tick ONE box only

0 ☐ 1	2 to 3 ☐ 3	5 or more ☐ 5
1 to 2 ☐ 2	3 to 4 ☐ 4	

Q6 In the past week, on how many days have you done a total of 30 minutes, or more, of physical activity, which was enough to raise your breathing rate? (This may include sport, exercise and brisk walking or cycling for recreation or to get to or from places BUT should not include housework or physical activity that may be part of your job)
Please tick ONE box only

0 ☐ 0	2 ☐ 2	4 ☐ 4	6 ☐ 6
1 ☐ 1	3 ☐ 3	5 ☐ 5	7 ☐ 7

Q7a Do you smoke cigarettes nowadays? *Please tick ONE box only*

Yes ☐ 1 No ☐ 2

Q7b If 'yes' to Q7a, approximately how many cigarettes do you smoke....?

i) on a weekday ☐ <number>

ii) on a day at the weekend ☐ <number>

Q8 During the past 4 weeks, was someone available to help you if you needed and wanted help? (For example, if you felt anxious, lonely or in a low mood, got sick and had to stay in bed, needed someone to talk to, needed help with daily chores, needed help just taking care of yourself) *Please tick ONE box only*

Yes, as much as I wanted ☐ 5
Yes, quite a bit ☐ 4
Yes, some ☐ 3
Yes, a little ☐ 2
No, not at all ☐ 1

Q9 Do you regularly participate in activities at different types of organisations?
Tick ALL that apply

a) Church, religious group or charitable organisations ☐ 1
b) Education (e.g. art groups, music groups or evening classes) ☐ 1
c) Social Clubs (e.g. rotary club, women's institute, working men's clubs or elderly lunch clubs ☐ 1
d) Sports Groups (e.g. sports club, gym or exercise classes) ☐ 1
e) No, I do not participate in any group activities ☐ 1

Q10 If so, how many different groups do you participate in? ☐ <number>

Q11 Please use the space provided below to describe any other experiences you would like to tell us about or to write any other comments you would like to make:

Thank you for taking the time to complete this questionnaire

Appendix 4. Patient Interview Topic Guide

Experience of care

-Tell me about the support you get from the INCA team

-How has that changed from when you first met them?

(Prompt: changes to how care is delivered or who is providing the care)

-What did you value the most about the support the INCA team provided?

-How involved are you in the decisions about your support?

(Prompt: are the things that matter to you taken into account?)

-What would make the support you received better?

-Were you receiving support before the INCA team? If so, how does this compare?

Impact on wellbeing

-Have you noticed any changes to your health and wellbeing as a result of seeing the INCA team?

[IF YES] describe how these have benefitted you?

(Prompt: change in mood?; changes in mobility?; changes in your social life?).

- Are you able to do things that you couldn't before?

Referral to other services?

-Did the INCA team refer / signpost you to any activities in the community? (eg. social groups or activities)

[IF YES], what was it? [potential coffee mornings / walking groups etc.]

-Describe your experience of [name service]? How did it impact you?

Impact on unpaid carers

-Do you have a friend / family member who helps you out?

[IF YES], has the INCA team made any difference to them?

Appendix 5. Patient Satisfaction Questionnaire

Integrated Neighbourhood Care Aberdeen (INCA)
Patient Experience

ID: (Research Team use only) ☐

We are hoping to gather as many views as possible on patients' experiences of care from our INCA Team. Please take a few minutes to complete this questionnaire. All information collected is anonymous, so please be honest. Once completed, place this questionnaire into the pre-paid (no stamp required) envelope provided and post it back to us.

Q1 PREVENTION: To what extent do you agree or disagree with the following statements....?

	Strongly agree	Agree	Neither agree/ disagree	Disagree	Strongly disagree
a) The INCA Team supported me to live as independently as possible	☐	☐	☐	☐	☐
b) The INCA Team helped to reduce any medical symptoms I have	☐	☐	☐	☐	☐
c) I felt the INCA Team had all the information needed to treat me	☐	☐	☐	☐	☐
d) My care was explained to me in a way I could understand	☐	☐	☐	☐	☐

Q2 CHOICE: To what extent do you agree or disagree with the following statements....?

	Strongly agree	Agree	Neither agree/ disagree	Disagree	Strongly disagree
a) I had a say in the help, care and support that was provided	☐	☐	☐	☐	☐
b) The nurse/support worker took into account things that matter to me	☐	☐	☐	☐	☐
c) I was encouraged to have my say	☐	☐	☐	☐	☐
d) The INCA Team helped to increase the choices available to me about how I want to live my life	☐	☐	☐	☐	☐

Q3 OVERALL EXPERIENCE: To what extent do you agree or disagree with the following statements ....?

	Strongly agree	Agree	Neither agree/ disagree	Disagree	Strongly disagree
a) I am satisfied with the INCA services I have received	☐	☐	☐	☐	☐
b) I would recommend the INCA service I received to others	☐	☐	☐	☐	☐
c) I have confidence in the INCA Team members supporting me	☐	☐	☐	☐	☐
d) My care through the INCA Team was well coordinated	☐	☐	☐	☐	☐

Q4 Please use the space provided below to describe any other experiences you would like to tell us about or to write any other comments you would like to make:

Thank you for taking the time to complete this questionnaire

Appendix 6. INCA Staff Interview Topic Guide

Introductory Questions

1. Tell me about your experience of working in an INCA team?
2. How did you find working in a self-managing way?
3. How did you find having nurses and support working in one team?
4. How did you get on interacting with other organisations or departments?

Positives of working in this way/Enablers

5. What has worked well in INCA?
6. Was there anything that helped to make this new way of working successful?
7. What have you enjoyed most about this way of working?
8. Were these positives common for the other nurses / support workers?

Negatives of working in this way/Barriers

9. What have been the (biggest) challenges to this new way of working?
10. How did you try and overcome these? Was this successful?
11. Were there any barriers that stopped you overcoming these challenges?
12. Did nurses and support workers face different types of challenges?

Considerations for future INCA teams

13. If a new INCA team member started, what advice would you give them coming into this new way of working?
14. What qualities do you think would make a successful INCA team member?
15. In what way do you think the INCA way of working could be improved in Aberdeen?
16. If you were to start a new INCA team, what would you do differently?
17. Is there anything else you would like to tell me about your experience working in a INCA team?

Appendix 7. INCA Staff Outcome Questionnaire

Integrated Neighbourhood Care Aberdeen (INCA)
Staff Experience

ID: *(Research Team use only)* ☐

Q1 **Job Title:** ☐ Support Worker ☐ Nurse

Q2 **INCA Team:** ☐ Peterculter ☐ Cove

Q3 **What is your year of birth? (yyyy)** ☐ *Leave blank if you prefer not to specify*

Q4 **How many years experience do you have working in either Health or Social Care?**

☐ <2 years ☐ 2-5 years ☐ 6-10 years ☐ >10 years

Q5 **How satisfied are you with the following aspects of your previous job?**

	Very satisfied	Satisfied	Neither satisfied/ dissatisfied	Dissatisfied	Very dissatisfied
a) The recognition I got for good work	☐	☐	☐	☐	☐
b) The amount of responsibility I was given	☐	☐	☐	☐	☐
c) The opportunities I had to use my skills	☐	☐	☐	☐	☐
d) The people I worked with sought out my opinions	☐	☐	☐	☐	☐

Q6 **To what extent do you agree or disagree with the following statements regarding your previous role?**

	Strongly agree	Agree	Neither agree/ disagree	Disagree	Strongly disagree
a) I feel my previous role made a difference to patients/service users	☐	☐	☐	☐	☐
b) I was able to make suggestions to improve the work of my team	☐	☐	☐	☐	☐
c) I was encouraged to develop my own expertise	☐	☐	☐	☐	☐

Q7 **To what extent do you agree or disagree with the following statements regarding your previous role?**

	Strongly agree	Agree	Neither agree/ disagree	Disagree	Strongly disagree
a) I had the freedom to choose my own method of working	☐	☐	☐	☐	☐
b) I could decide on my own how to go about doing my work	☐	☐	☐	☐	☐
c) I was trusted to do my job	☐	☐	☐	☐	☐
d) There were frequent opportunities for me to show my initiative within my role	☐	☐	☐	☐	☐
e) My team made their own decisions about rotas	☐	☐	☐	☐	☐
f) My previous role was committed to helping staff balance their work and home life	☐	☐	☐	☐	☐

Q8 **To what extent do you agree or disagree with the following statements regarding your previous role?**

	Strongly agree	Agree	Neither agree/ disagree	Disagree	Strongly disagree
a) I felt I belonged in the team	☐	☐	☐	☐	☐
b) I tried to help colleagues in my team whenever I could	☐	☐	☐	☐	☐
c) I got support from my work colleagues	☐	☐	☐	☐	☐
d) The people I worked with treated me with respect	☐	☐	☐	☐	☐
e) I always knew what my work responsibilities were	☐	☐	☐	☐	☐
f) Relationships at work were strained	☐	☐	☐	☐	☐
g) My team worked well together	☐	☐	☐	☐	☐

	Q9 In the last 6 months, have you taken part in any of the following types of training, learning or development paid for or provided by your previous employer?	Yes	No
	a) Taught courses (internal or external)	☐	☐
	b) Supervised on the job training	☐	☐
	c) Having a mentor	☐	☐
	d) Shadowing someone	☐	☐
	e) E-Learning / Online training	☐	☐
	f) Keeping up to date with developments within your type of work (e.g. by reading books or journals or by attending workshops or seminars)	☐	☐

Q10 To what extent do you agree or disagree with the following statements regarding your previous role?

	Strongly agree	Agree	Neither agree/ disagree	Disagree	Strongly disagree
a) My training, learning and development has helped me to do my job better	☐	☐	☐	☐	☐
b) I was satisfied with the quality of care I gave to patients/service users	☐	☐	☐	☐	☐
c) I would have felt safe being treated there as a patient	☐	☐	☐	☐	☐
d) I was able to deliver the patient care I aspired to	☐	☐	☐	☐	☐
e) I was enthusiastic about my job	☐	☐	☐	☐	☐

Q11 Please use the space provided below to describe any other experiences you would like to tell us about or to write any other comments you would like to make:

Thank you for taking the time to complete this questionnaire

Appendix 8. INCA Partner Interview Topic Guide

Introductory Questions

1. How were you introduced to this new way of working – did you have enough information?
2. Tell me about your experience of working with the INCA team? How were your interactions with the team?
3. How did you find having nurses and support working in one team?
4. What are your impressions of health & social care being integrated in a self-managing team
    a. *Did it affect you/patients? Are self-managing teams the way forward?*
5. [If a referrer] What were your criteria for referral to the team?
6. [If a referrer] Did you refer all patients who were eligible? If not, describe any barriers/facilitators.

Positives of working in this way/Enablers

7. Do you feel there have been any benefits from this project?
    a. *What has worked well*? *Any advantages to patients/referrers?*
8. Was there anything that helped to make this new way of working successful?

Negatives of working in this way/Barriers

9. Have you been aware of any challenges in this new way of working?
    a. *What have been the (biggest) challenges?*
    b. Prompt: Challenges of the INCA project and challenges of their role (referring) within INCA.
10. How did you try and overcome these challenges? Was this successful?
11. Were there any barriers that stopped you overcoming these challenges?
12. Were you aware of nurses and support workers facing different types of challenges?
13. Do you see any disadvantages to patients/referrers?

Considerations for future INCA teams

14. In what way do you think the INCA way of working could be improved in Aberdeen?
    a. *Any differences between your views about INCA in theory and in practice)*
15. Is there anything else you would like to tell me about your experience working with the INCA team?

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January 2019: Update Number 7

INCA

(Integrated Neighbourhood Care Aberdeen)

How did INCA come about?

Buurtzorg is a model of community nursing that was developed in the Netherlands and has gained a high level of international interest. In January 2018, two teams of community nursing and care at home staff were formed in Cove and Peterculter. They were asked to test the Buurtzorg principles, namely – keeping the person at the centre, drawing on and building informal networks (family, friends, neighbours, local voluntary organisations etc) to support them, working in small self-managing, neighbourhood-based teams, collaborating with formal networks (such as GPs, Occupational Therapists, Physiotherapists etc) as required, and using an enabling approach.

What's different about the Aberdeen approach?

In our integrated Health & Social Care Partnership we wanted to move our test beyond community nursing and include care at home as well. This was the first time we had formally brought together nurses employed by the NHS and support workers employed by Bon Accord Care to work so closely as one single team. In order to give the test teams time and space to develop the skills they needed to work in this new way, we chose to start small, building their caseload gradually from people with a new need for care, in tandem with existing community nursing and care at home services that were being delivered in those areas.

What's been happening in INCA?

After a year, we have learned a huge amount, but our test of change is coming to a close. We have evaluated what went on throughout, and have found that:

- people receiving their support from INCA greatly valued the service
- staff recruitment and retention was challenging. There are multiple reasons for this however, key ones were - difficulties around being a self-managing team and nurses concerned about their skills not being sufficiently utilised
- a real positive was the ability to rapidly provide, step up or step down support according to a person's individual and changing needs.

What’s next?

As we draw to a close, we will take forward and build on the learning from this project, to improve our provision of flexible, person-centred and enabling care provision in Aberdeen City.

Our learning will influence:

- the development of a multidisciplinary team approach to the rapid provision, stepping up and down of support in localities
- how we enhance continuity, build relationships and promote the ability to work in an enabling way
- how we support teams to self-organise, to allow flexibility of approach while still ensuring they have supportive leadership.

You can expect further opportunities to hear about, be involved in and influence the development of the stepped support approach.

How do I find out more information about the project?

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Please contact any of us to find out more about what is happening and to raise any questions or concerns.

West Unscheduled Care Test of Change

Evaluation report

June 2018

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Executive summary

Background

Given the increasing pressures on General Practice, there is a need to test new models of delivering healthcare. The recent general medical services contract highlighted unscheduled care models as a priority area to address. Utilising an advanced practitioner to deliver unscheduled afternoon visits has shown promise across Scotland, but has yet to be fully tested in Aberdeen City. This report evaluates a recently implemented unscheduled care model test of change.

Method

The West Unscheduled Care project was delivered as part of Aberdeen City Health and Social Care Partnership's programme to transform the delivery of health and social care in the city. This involved an Advanced Nurse Practitioner (ANP) conducting unscheduled home visits on behalf of GPs in the West Locality of Aberdeen. This evaluation reports on the first six months of implementation (November 2017 – May 2018).

Service-level data were collected per visit, including patient-facing time, visits by practice and outcome of visits. Practice staff and ANPs took part in mind-mapping sessions to explore perceived project benefits, barriers and implementation considerations. Patient questionnaires were distributed to determine overall satisfaction. Emergency admissions, bed days and A&E attendances were projected prior to implementation and compared to actual data to determine impact on hospital services.

Results

There were 241 referrals with only two rejected. Practices referred between seven and 68 times over six months, with a total visiting time of 106.55 hours. The most common outcomes for visits were "medication & worsening statement given (WSG)" (107 cases), "self-care advice" (47 cases) and "hospital admission" (28 cases).

GPs were very satisfied with the service (average score of 90%). They reported reduced workload, patients were provided with a high-quality service and it reduced stress of other practice staff. The biggest drawbacks identified were concerns whether the service had capacity to accept referrals and the financing of the service in the longer term. GPs felt the service could be improved by extending operating hours to 1800.

ANPs felt they provided holistic care to patients and were providing GPs with a good service. They reported that some days were quiet, meaning the service could handle more patients. ANPs also suggested that other professionals, such as paramedic practitioners and district nurses, could carry out the service if sufficiently trained.

Patients who returned questionnaires responded positively. For example, 100% of responders rated the ANP as "very good" for their compassion, respectfulness and overall satisfaction. All respondents felt sufficiently involved in decisions around their care and were provided information in an understandable way.

No significant differences were visible between projected and actual emergency admissions, bed days and A&E attendances.

Discussion and recommendations

Overall, this evaluation has reported a positive impact of the West Unscheduled Care project. Given the low rejection rate of referrals, it would appear this model can be delivered to more practices in its current form before capacity is reached. To scale up this project, consideration may also be given to recruit other advanced practitioners who may be qualified enough to deliver this service. In addition, the method of financing this service longer-term should be considered.

Background

Globally, there is an increasing ageing population, with the United Nations recently projecting a 56% growth in individuals over the age of 60 between 2015 – 2030[1]. In Scotland, more recent estimates have shown increases in the 45-64 and over 75 age groups (10% and 16% respectively) over the last decade[2]. The association between an ageing society and disease prevalence is well established, with 1 in 2 Scots having a minimum of one morbidity by the age of 50[3]. The result of this is increased pressure on primary care, particularly in General Practice, where these issues are escalated through challenges retaining General Practitioners (GPs). Indeed, the proportion of GPs between the ages of 55 – 64 leaving General Practice doubled from 2005 – 2014[4]. Therefore, there is a need to test new ways of delivering primary care to address these issues.

The recently published general medical services contract in Scotland outlined priorities to transform how services are delivered in primary care and highlighted urgent care services as an area of opportunity[5]. Unscheduled care models, that utilise an advanced practitioner resource as the initial response for home visiting, have shown promise in several pilot sites across Scotland. For example, a newly implemented paramedic support service in Inverclyde demonstrated a 60% reduction of home visits completed by GPs, therefore reducing the pressures on practice working[6]. As a result, it is important to test other approaches to delivering unscheduled care across Scotland to understand the impact these may have in a localised context.

This report describes the evaluation of a new model of delivering unscheduled primary care in Aberdeen City.

Method

Design

The "West Unscheduled Care" project was launched in November 2017 as part of Aberdeen City Health & Social Care Partnership's programme of activity to transform services in the city. Following a patient request for a home visit, their GP triaged the call to the Grampian Medical Emergency Department (G-MED), who would either accept or reject referrals. Patients would then be visited by an Advanced Nurse Practitioner (ANP), with a driver transporting the ANP to patients' homes. A recent systematic review found that ANPs demonstrate equal or better outcomes than physicians for outcomes including cost, patient satisfaction and physiological measures[7]. Following the home visit, the ANP would contact the GP if required and complete the appropriate documentation.

This project was tested within the West Locality of Aberdeen City. The rationale for this was twofold: 1) it contains a higher proportion of elderly patients compared to the other localities within the city; 2) it has a large geographical catchment area (approximately 140 square miles), meaning home visits

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[6] Scottish School of Primary Care. (2018). Evaluation of new models of primary care Inverclyde case study. Available from: http://www.sspc.ac.uk/media/media_573766_en.pdf [accessed 17/5/18]
[7] Swan, M. et al. (2015). Quality of primary care by advanced practice nurses: a systematic review. *International Journal for Quality in Health Care*, 27(5):396-404.

will require a considerable amount of travel time to complete. Inclusion criteria were: patient unable to attend the surgery; patient home-visit request was between 1300-1730 hours; patient's clinical condition was suitable to be managed by an advanced practitioner and the patient agreed to being seen by an advanced practitioner. Exclusion criteria included patients with illness related to pregnancy; psychiatric symptoms and other complex patients that may be more effectively handled by GPs.

Funding was obtained from the Aberdeen City Integration Joint Board to deliver the project.

Data collection and analysis

Service descriptive data

Following each patient visit, ANPs recorded a variety of data, including referral practice; reason for referral; time spent with patient and the outcome of the visit. These data were then uploaded to a database for the purposes of storage, confidentiality and analysis. Analysis included number of referrals per practice, average and total patient-facing time and financial savings associated with GP time. House call and home visit consultations were also compared for two case-based practices across the dates of implementation (Nov 17 – May 18) to the previous relative period (Nov 16 – May 17).

Patient experience of service

Patient experience was assessed using a questionnaire (formatted by the NHS Grampian Clinical Effectiveness team), based on a combination of previously validated tools (for example the GP Assessment Questionnaire) and adapted appropriately for the local context. Examples of questions included overall satisfaction with the ANP and time waited from phone call to visit. Questionnaires were administered to patients by the ANP following their consultation and were provided with pre-paid envelopes to return their responses. This method was chosen to avoid bias associated with handing responses directly to the ANP. However, logistical challenges associated with obtaining the pre-paid return envelopes meant that patients were only offered questionnaires as of March 2018. This significantly limited the potential response rate.

GP experience of service

GP experience was assessed using a mind-mapping process. Mind-maps are diagrams used to represent topics or several areas of focus around a central point of interest. Here, the central point of interest was the GPs' experience of this service, with topics explored including: perceived project benefits; perceived project drawbacks; implementation barriers and future recommendations. This method was chosen based on previous recommendations, whereby mind-mapping has been advocated as a valuable strategy to adopt to balance academic rigour and pragmatism required in healthcare service settings[8].

Mind-mapping exercises were conducted in March – May 2018. Practice Managers were contacted to arrange a one-hour slot where these could be carried out in their practice. Attendees from each practice were dependent on the time and availability of practice staff. Attendees were reminded of the purpose of the evaluation and that their responses would be anonymised so their involvement would not jeopardise them in any way. Mind-mapping sessions were led by the Research Manager, with a Programme Manager taking fieldnotes on a wall-mounted mind-map as a reference point during discussion. Once all the key themes were explored, these were member checked with attendees to ensure that a truthful version of events had been captured.

[8] Burgess-Allen, J & Owen-Smith, V. (2010). Using mind-mapping techniques for rapid qualitative data analysis in public participation processes. *Health Expectations*, 13, 406-415.

After all seven mind-mapping processes had been completed, findings were coded using NVivo software (Version 11; QSR International, Melbourne) and used as a basis to generate themes in relation to the key topics explored. This process also allowed for other important perspectives to be highlighted that were not initially considered prior to beginning data collection. Once completed, data were synthesised and restructured to provide a summary of key topics from across the attendees.

ANP experience of service

A similar process was used with the ANPs to understand their experience of the project. Here, the ANPs participated during their staff meeting and the mind-mapping process was conducted as a group activity. The same key topics were explored and these sessions were also led by both the Research and Programme Manager. Once the session was completed, the topics were refined and synthesised into key themes and restructured into a refined mind-map.

Ministerial Strategic Group (MSG) integration indicators

In line with the report on the MSG Integration Indicators published in December 2017[9], the project team considered which indicators this project may positively influence. Unplanned admissions, unscheduled hospital bed days and A&E attendances were identified as metrics to monitor over the course of implementation. These indicators were also retrospectively examined prior to project start in order to track changes. Data were examined over the course of 12 months, to allow for data capture six months prior to project implementation and then six months throughout the project duration. In addition, historical data were used to project the volume of the above over the first six months and then compared to actual data to determine impact.

As the data collection methods utilised fall under the categorisation of a service evaluation, ethical approval was not required.

Results

GP practice information

The GP practices, practice population and number of GPs attached to each practice are visible in Table 1. Both practice population (1694 – 10509) and number of GPs (4 – 12) vary widely across the seven practices.

Table 1. West locality GP practice characteristics *(data correct as of Feb 2018)*

Practice	Practice population	Number of GPs
Albyn	10509	9
Camphill	1694	4
Cults	7148	5
Great Western Road	10092	12
Hamilton	6830	6
Kingswells	5829	5
Peterculter	8020	6
Average	*7160*	*6.7*

[9] Scottish Government. (2017). Measuring performance under integration. Available from: http://www.improvementservice.org.uk/documents/OEPB/board-papers-aug2017/oepb-31aug17-item4a-letter.pdf [accessed 12/06/2018]

Visits overview

In the six-month period from 7th November 2017 – 7th May 2018, 241 visits were referred to the service, with 239 accepted. However, as rejections were only documented if GPs referred after discussion with the team leader who was receiving the call, these figures may be slightly higher than reported.

The characteristics of these patients visited are visible in Table 2. The reasons for being referred to the service varied, however those frequently reported were: vomiting; chest infections; abdominal pain; urinary tract infections and falls.

Table 2. Demographic characteristics of patients visited (N=239)

Characteristic	Number (N)
Age, mean (range)	79 years (24 – 97)
Female, N (%)	156 (65)
Albyn referrals, N	42
Camphill referrals, N	7
Cults referrals, N	35
Great Western Road referrals, N	68
Hamilton referrals, N	49
Kingswells referrals, N	13
Peterculter referrals, N	24

NB: 1 referral practice not reported

GP practice usage of service

Figure 1 shows the number of visits by GP practice each month, in addition to the total number of monthly visits. The total number of visits per month varied, with April 2018 seeing 52 referrals to the service, the largest across the duration. The most and least frequent practices referring to the service over the six-month period were Great Western Road (68 referrals) and Camphill (7 referrals) respectively. Adjusting for practice population, Hamilton had the largest number of referrals (7.2 per 1000 patients), whilst Peterculter had the smallest (0.3 per 1000 patients).

Visits per month by practice

No. of visits

60
50
40
30
20
10
0

Nov-17 Dec-17 Jan-18 Feb-18 Mar-18 Apr-18 May-18

Month

Albyn, Camphill, Cults, Great western Road, Hamilton, Kingswells, Peterculter, Total

Figure 1. Overview of visits per month by practice. NB: As analysis is of the first six months of implementation, only data up until 7th May is presented.

Time allocation of referrals and visits

Table 3 shows the time associated with referrals and visits. On average, the ANP would arrive with a patient 43 minutes after G-MED received the referral. The total patient-facing time was 106.55 hours, equating to £6259.81 saved of GP time when deriving an hourly cost of £58.75 from the recent Deloitte review of GP earnings[10]. Exploratory work conducted by ISD Scotland quantified the average derived journey time for GPs across the West Locality as 10 minutes per appointment, subsequently saving an additional 2390 minutes of GP time, or a monetary value of £2340.21.

Table 3. Time allocation of visits and referrals

Characteristic	Number (minutes)
Visit time	
Average	27
Median	24
Minimum	8
Maximum	113
Total visiting time (hours)	**106.55**
Time from G-MED referral to ANP arrival	
Average	43
Median	32
Minimum	8
Maximum	224

NB: 15 visits did not report the total duration of ANP visits, in which case the average visit duration was calculated and applied to these visits to derive a total visiting time

Outcome of visits

Figure 2 shows the outcome of ANP visits. The most common outcomes for visits was "medication & worsening statement given (WSG)" (107 cases). "Self-care advice" was the outcome for 47 cases, with 28 cases resulting in a hospital admission.

[10] Deloitte. (2017). A review of GP earnings and expenses. Available from: https://beta.gov.scot/publications/2018-gms-contract-scotland/documents/00527540.pdf [accessed 29/03/2018]

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Outcome of ANP visits (%)

3%
12%
45%
2%
9%
5%
2%
20%
2%

A&E attendance | Hospital admission | Medication & WSG | NA | Prescription & WSG | GP Referral & WSG | District Nursing Referral | Self-care advice | Not reported

Figure 2. Outcome of ANP visits

GP home visits data

Two practices were randomly selected to determine home visit workload over time. Table 4 demonstrates the number of home visit consultations and house call appointments by practices over two time periods: 1) November 2017 – May 2018, the six months of the project implementation and 2) November 2016 – May 2017, the corresponding period over the previous year. A reduction in both house calls and home visits were visible for both practices and, whilst it is not possible to solely attribute these reductions to this project, it is likely that it contributed significantly towards this reduced workload.

Table 4. Comparative GP home visits during project implementation and corresponding period 12 months prior

	Practice 1		Practice 2	
	House call appointments	Home visit consultation	House call appointments	Home visit consultation
Nov 16 – May 17	936	981	287	78
Nov 17 – May 18	904	849	285	60
Reduction	*32*	*132*	*2*	*18*

Patient experience

As mentioned previously, issues with the pre-paid return envelopes meant that participant feedback forms were only distributed from March 2018. During this period, six patients provided responses and their characteristics are described in Table 5.

Table 5. Patient responder demographic information

Patient no.	M/F	Age (years)	LTC? (Y/N)	Time from request to referral (hours)
1	F	75+	Y	1-2
2	M	75+	Y	0.5-1
3	F	65-74	-	-
4	F	75+	Y	1-2
5	F	75+	N	1-2
6	M	16-44	Y	<0 .5

NB: M = male; F = female; LTC = long-term condition

Responses to Likert-scale questions are visible in Table 6. Overall, the ANPs scored highly on all components assessed, such as listening to patients and treating them with respect.

Table 6. Patient Likert-scale responses (%)

Component	Very good	Good	Satisfactory	Poor	Very poor
Feeling at ease	100	-	-	-	-
Respectful?	100	-	-	-	-
Compassionate?	100	-	-	-	-
Good listener?	100	-	-	-	-
Overall experience	100				

Further patient views are shown in Table 7. ANPs were able to explain treatments in an understandable way to all patients and responders had confidence in the ANP whom visited them.

Table 7. Additional patient responses (%)

Component	Yes	No	Unsure
Enough time?	100	-	-
Involved in decision-making?	100	-	-
Advice if deteriorate?	100	-	-
Confidence in ANP?	100	-	-

Of the patients who used open-ended responses to provide additional information, two described the ANP they saw as "excellent". One wrote: *"the home visit was excellent – the nurse was very good and patient with me. I wish we could get someone like her all the time"* (Patient 3).

GP experience

To ensure anonymity, each GP practice was assigned a unique practice number. The attendees, service satisfaction scores and whether participants would recommend the service, are visible in Table 8. In total, 5/7 practices attended mind-mapping sessions, with one practice providing feedback electronically and one practice declining to participate. Overall, satisfaction was very high (average 9/10), with all attendees recommending this service to other practices across the city. The synthesised themes from the mind-mapping processes are shown in Figure 3.

Table 8. Attendees, usage and satisfaction scores during mind-mapping process

Practice number	Mind-mapping attendees	Satisfaction score	Recommend? (Y/N)
1	1 x GP	8	Y
2	1 x GP	10	Y
3	1 x GP 1 x Practice Manager	7.5	Y (with changes)
4	n/a	10	Y
5	1 x GP	9.5	Y
6	1 x GP	9	Y
7	-	-	-
Average		9	

Project benefits

GPs - There were a multitude of benefits identified from this project. For GPs, six practices reported time being saved, particularly through not having to leave the surgery and the associated travel time required for home visits:

"If we start our afternoon surgery and a request for a house call comes in, it's very disruptive either to leave what we're doing and leave the patient sitting for us to go and come back or leave the patient at home and delay the home visit 'til after surgery" (GP, Practice 1).

The service was also reported to reduce stress, particularly on the duty doctor, and also increase their capacity to complete other pressing tasks, for example emergency consultations and patient call-backs.

Patients - For visited patients, five practices specifically reference the high-quality of care provided by the ANP. One GP went as far to say that they would prefer to be visited by an ANP than a GP due to their skillset and conscientiousness:

"They're incredible [ANP]. So if I was unwell I might be looking to see an ANP rather than a GP … they're good all round practitioners and they're good at assessing things" (GP, Practice 5).

Having the ANP resource available also decreased the length of time patients had to wait to be seen and it was also suggested seeing a different health professional could provide a fresh perspective on how best to treat patients. Benefits were also highlighted for other patients too, for example getting faster access to care by having less disruption when visiting surgeries.

Practice working – in terms of the wider practice working, the main benefit was improving efficiencies, as practice staff did not have to wait until the duty doctor returned to the surgery to answer specific questions regarding other patients. This was also reported to reduce the pressure on practice staff:

"It's less stressful for the staff because they're not thinking 'oh god where's he? Where's she [duty doctor]? How long are they going to be before they come back? Can this message wait for them or not? Do I interrupt a doctor who's not duty doctor who's seeing a patient?' So these are potential stresses for the staff." (GP, Practice 2)

Project drawbacks

GPs – there were very limited drawbacks identified through this project and even fewer regarding the logistics of the service itself. Instead, drawbacks highlighted included that the service may not continue into the future, along with uncertainties of the capacity of the service (i.e. if all visits would be accepted).

"The difficulty is that I now need to go and phone someone else, I don't know if they're [G-MED] going to accept the visit, I don't know when the service is going to come. So I've got to go through all of this and the patient is then left hanging wondering: 'what's actually happening?'" (GP, Practice 3).

Patients – potential drawbacks identified to patients were all hypothetical, as no complaints had been received regarding the quality of care from the ANPs. These included: lack of care continuity (such as not seeing the same health professional) and length of appointments (it was generally felt that ANPs would spend longer with patients, however patients may not necessarily deem this as a positive).

"It depends on the patient. Others will think "why are you taking 20 minutes, it only takes you 2 minutes to do what you need to do?" So some patients will like it [longer appointments with the ANP], some will not" (GP, Practice 3).

Practice working – one practice reported that this project had a small increase in workload for receptionists and due to the project being a test of change, they were unable to plan other activities to do in practice time if referrals were not accepted:

"They [receptionists] take the call, request the house call and then it comes to the GP to deal with it, so if anything it might give them a bit more work to do because they have to do the emailing of the information … but it's one very small task they have to do as part of their workflow" (GP, Practice 1).

Figure 3. Synthesised mind-map of key practice themes

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Implementation barriers and facilitators

Practices were generally unanimous that implementation of the service was smooth. Practices spoke positively about the ease of referral to the service, in addition to receiving clear communication from the G-MED team and the ANPs when appropriate. The barriers highlighted to implementing this service in practices were all deemed to be minimal. For example, issues around remembering to contact the service and understanding of the ANPs' skillset, were all accepted to be inevitable and diminished over time. Initial IT difficulties in sending home visit summaries to the project team were alleviated by investing in new equipment. Additionally, two practices admitted to being sceptical whether the service would run successfully, however this also decreased over time:

"It was a culture change, you know? I've been in general practice for way too long now and that's always been the case. Years and years ago in another practice a nurse practitioner was out, and then gradually they came in and the GPs were like "okay, this works, this is great", so the role expanded … and gradually the confidence builds" (Practice Manager, Practice 3).

Future considerations

The most commonly requested revision of this service was to extend the hours of service up until 1800 hours. However, other requests were also provided around improving the service for the future, for example extending it to an all-day service. Interestingly, two practices highlighted the opportunity for a multi-disciplinary unscheduled visiting team that could include other Allied Health Professionals and Care Managers:

"Might the service in the future look like a team that had a selection of different professionals … the ability for a patient to be requesting directly rather than always having to go through the GP to get things going, that would be a huge advantage" (GP, Practice 6).

There were two large concerns that were consistently stressed across participants: 1) a feeling that scaling the service city-wide could dilute the effectiveness of the service that they receive; 2) anxieties around funding for the service would not continue in the future:

"My concern is more in terms of what happens in the future … and that's to do with my experience of over a couple of decades of fantastic sounding pilot projects that are pump-primed only to not recur … so I have to be allowed a certain about of cynicism about that" (GP, Practice 6).

ANP experience

Three ANPs participated in the mind-mapping session. A summary of their synthesised responses are visible in Figure 4.

Project benefits

Patients – The ANPs felt that patients were receiving a high-quality service. This, in part, may have been due to ANPs having more time to spend with patients than GPs, providing them the opportunity to gain important additional pieces of information:

"We have a quick swizz at the surroundings, so you maybe pick up other things when you're there, whereas a GP, time management wise, it's really difficult for them to do that. We can pick up other things that we can highlight to the GPs" (ANP 2).

ANPs also described the holistic care that they provided to patients. For example, they would not necessarily solely treat the specific problem that patients had, but instead provide additional support depending on need:

"If we went to see somebody and they couldn't get to the toilet we'd just take them to the toilet whilst we were there … yes we're Advanced Nurse Practitioners and when we're going in we're doing more of a GP role but at the end of the day, you still see yourself as a nurse" (ANP 1).

GPs and practice working – The ANPs were in agreement that completing home visits would reduce the GPs' workloads and therefore increase their capacity to "*concentrate on other things that they might not always have time to do*" (ANP 2). Furthermore, they would carry a range of supplementary equipment that a GP may not, therefore potentially providing a more efficient service to patients, in addition to reducing workload for other practice staff:

"We've got everything in the boot. If we think someone needs an ECG we can do it. We can do bloods as well, that's things that you'd need an appointment with a phlebotomist maybe 2/3 days down the line … so you're helping other services within the practice as well" (ANP 3).

Project drawbacks

Very few drawbacks were identified, with those highlighted being emphasised as minimal. The two that were identified were: 1) most of the patients were new to the practitioners, meaning they may not have had the same rapport as the GP, however, it was agreed that this did not negatively impact the quality of care patients received; 2) occasional postponements in receiving patient summaries from GPs, meaning that ANPs could visit patients with no prior knowledge:

"We do get the email beforehand that gives us their ECS and stuff, but sometimes there's been a delay in getting that email. So you've gone in, you've not got the email through and you've had to spend a wee bit of time saying to the patient 'what's your past medical history?' … things you wouldn't necessarily need to ask if you had that information in front of you" (ANP 2).

Implementation barriers and facilitators

Whilst there were limited barriers identified to implementing this test of change, the attendees did highlight three areas needing adapted that could jeopardise the scaling of this project should they not be addressed. Firstly, the ANPs typically worked out-of-hours (1800 hours onwards) at an enhanced hourly rate, whereas this project involved them working earlier in the day (1400-1800 hours). Whilst the majority of their hours were accumulated out-of-hours, meaning their pay enhancement still applied, they stressed that this was vital if they were to continue:

"The way we had to do our shift pattern was so we didn't lose our enhancements … if we just did the day time we would be losing quite a lot of money which, for us, you think well what's the benefit to us, because we're providing you [the GPs] with a really really good service but we're actually losing money" (ANP 2).

- **ANP Analysis**
  - **Project benefits**
    - GPs
      - *Increased capacity*
    - Patients
      - *High-quality care*
      - *Holistic care*
      - *Increased time*
      - *Reduced delays*
    - Practice working
      - *Improved efficiences*
  - **Implementation barriers**
    - Financial
    - Logistical
    - Workload
  - **Overcoming barriers**
    - Increase workload
    - Practice-based
  - **Project drawbacks**
    - Patients
      - *Initial assessment*
    - GPs
      - *Delayed patient summary*
  - **Recommendations**
    - Practitioner recruitment
    - Transportation

Figure 4. Synthesised mind-map of key ANP themes

ANPs suggested the possibility of being practice-based as a solution to increasing their workload, in addition to reducing pressure on practice staff.

Recommendations

Two clear recommendations were provided to move this project forward. Firstly, the ANPs noted how valuable the function of the driver was in this service, allowing them to review medical history and write up patient summary notes in between visits. Also, due to the volume of equipment they carried to home-visits, it was more practical to keep this within the G-MED cars, as opposed to using their own vehicles.

Further, the issue of practitioner recruitment was also highlighted. Whilst it was acknowledged that hiring ANPs could be challenging, the attendees suggested that other professionals, including paramedic practitioners and district nurses, could be trained up to deliver this service:

"I think some of them are frustrated [district nurses] that they don't get to utilise those skills … I think a lot of them would want to do something different" (ANP 1)

MSG objectives

Emergency admissions

Figure 5 shows the number of emergency admissions in the West Locality and Aberdeen City longitudinally compared with the projected numbers. Overall, the trend within the West Locality remains consistent with the projected numbers, with a slight spike visible during the winter months of 2017. Detailed projections per GP practice are available in Appendix 1.

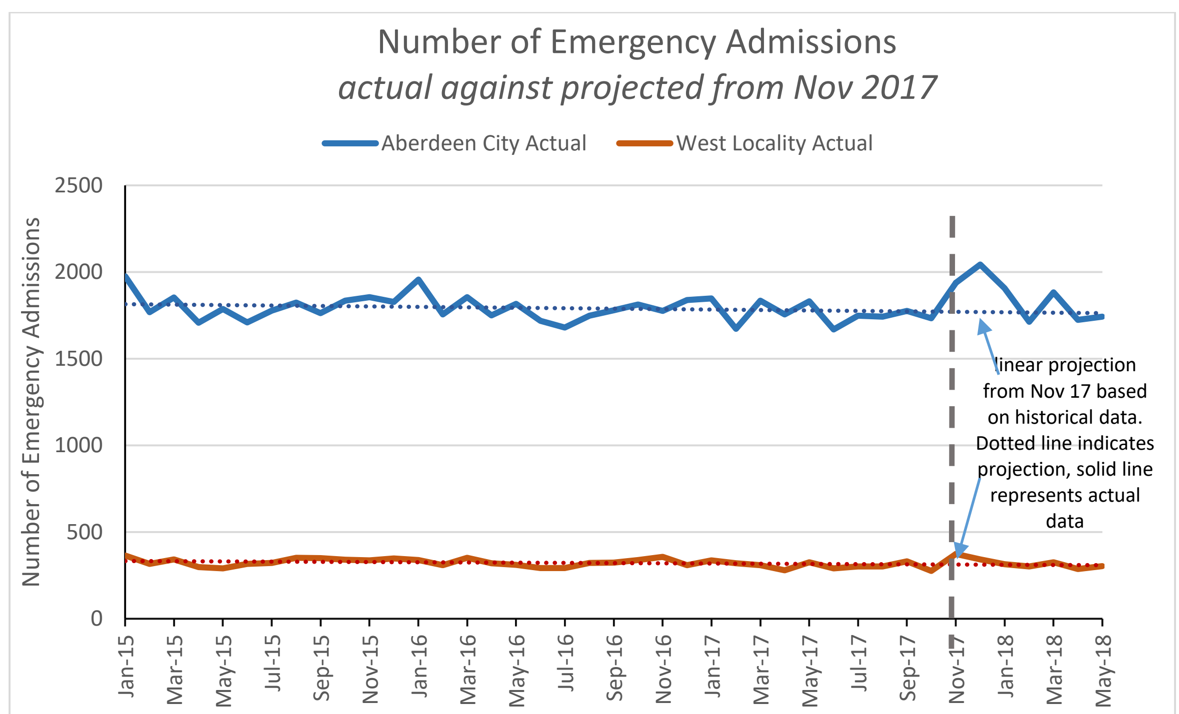

Figure 5. Number of emergency admissions actual vs. projected

Emergency bed days

Figure 6 shows the number of emergency bed days in the West Locality and Aberdeen City longitudinally compared with the projected numbers. The trend within the West Locality remains consistent with the projected numbers before marginally decreasing from January 2018 onwards. Detailed projections per GP practice are available in Appendix 2.

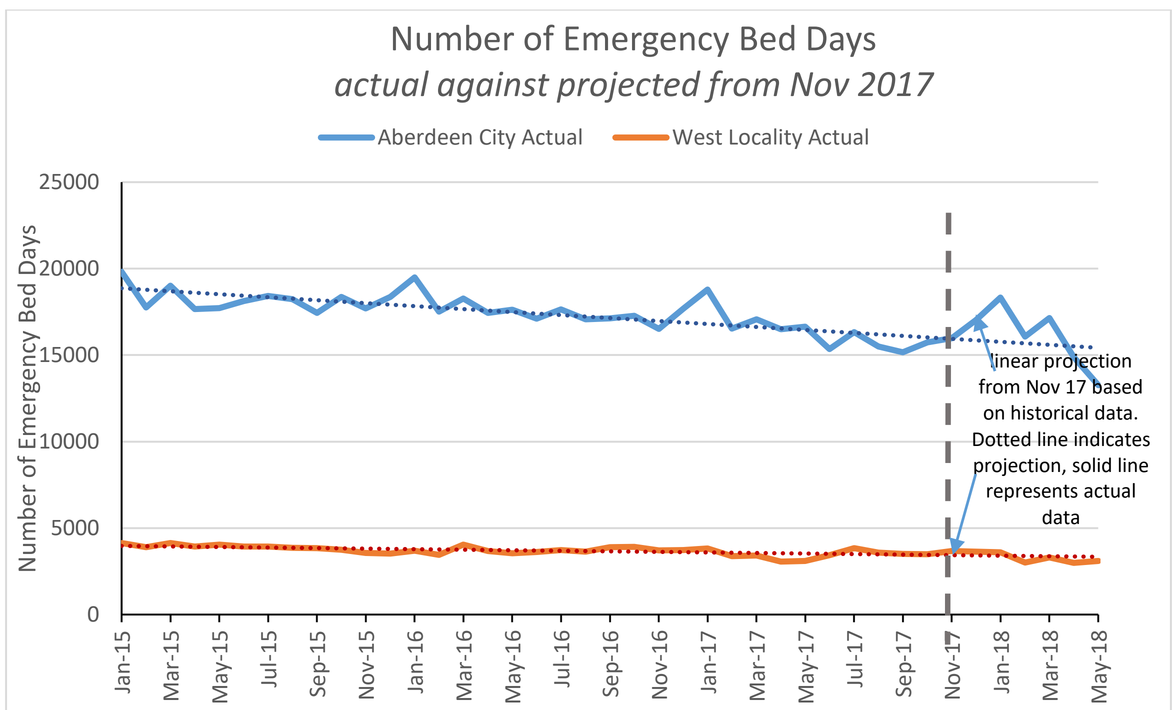

Figure 6. Number of emergency bed days actual vs. projected

A&E attendances

Figure 7. shows the number of A&E attendances in the West Locality and Aberdeen City longitudinally compared with the projected numbers. Again, the trend within the West Locality remains consistent with the projected numbers, with limited deviation from the hypothesised figures. Detailed projections per GP practice are available in Appendix 3.

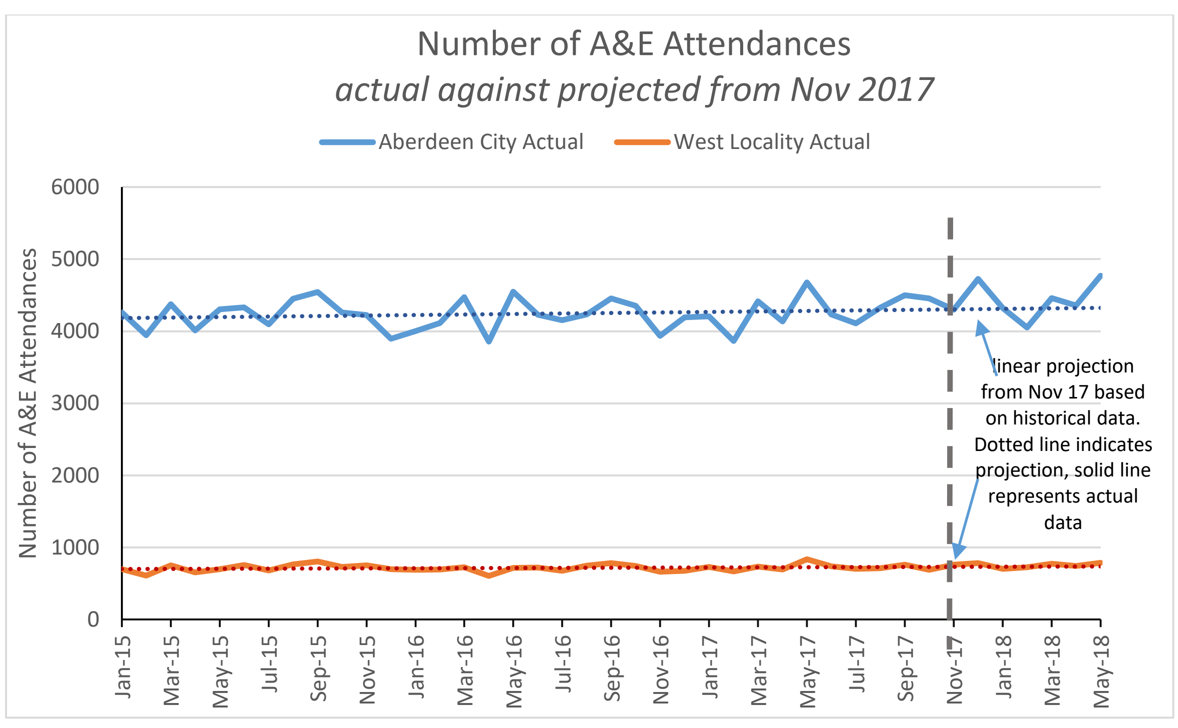

Figure 7. Number of emergency bed days actual vs. projected

Discussion and recommendations

This report describes the evaluation of a new unscheduled care service delivered through an ANP resource within the West Locality of Aberdeen City. Over a 6-month period, the ANPs completed a total of 239 visits, with a project cost during this time of £16,315. It has already been noted that the total visiting time of ANPs has saved GP time equivalent to the cost of £6259.81, with £2340.21 travel time also being saved, meaning a total saving of £8600.02. Considering that these costs do not include other factors such as reducing waiting time for other patients and potential admission avoidance, it is likely that, from a purely financial perspective, this project provides considerable value relative to actual spend.

The qualitative findings from both GP practices and ANPs about their experience of the service were predominantly positive. GPs were able to provide examples of additional tasks they had been able to complete due to ANPs carrying out home visits (such as patient call-backs and administrative tasks) and there was a self-reported reduction in stress of all practice staff. Given the problems previously highlighted regarding GP retention, in addition to considering that 37% of GPs do not pursue full-time clinical work due to work-related stress, this service may play an important role in reducing staff turnover (and the associated costs) in primary care[11].

From a practice perspective, the implementation of the project was well executed. In particular, mind-mapping participants commented on the ease of the referral process and clear communication with G-MED and ANPs when necessary. Initial implementation challenges of staff forgetting about the service were quickly overcome through increased familiarity, with one practice holding a briefing session with staff to alleviate this potential barrier. The most consistent improvement that was suggested across practices was to increase the service duration until 1800 hours, to provide additional

[11] Baird, B. et al. (2016). Understanding pressures in general practice. The King's Fund, London.

cover for the final proportion of the working day. This may help improve the sustainability of General Practice by alleviating pressures associated with late unscheduled calls, for example for practice staff with childcare needs. Additionally, the skillset and knowledge of the ANPs was regularly advocated by GPs, reinforced by previous systematic reviews showing that substituting physicians for nurse-led care may have positive effects on mortality, hospital admissions and patient satisfaction[12].

This evaluation attempted to demonstrate the impact of the service on emergency admissions, emergency bed days and A&E attendances. The actual activity data appears to follow the linear projection trend line applied, with no significant decreases being visible. However, these findings should not necessarily be deemed as an absence of effect. The project duration reported on (six months) is relatively small and implementation occurred over the winter months, where spikes in the above indicators are typically prevalent. It is likely that longitudinal monitoring of these data is required to understand the full impact.

Given the positive findings presented within this evaluation, thought should be given about how to scale this project to other parts of the city. With a low referral rejection rate of just 0.8%, this would suggest that the current level of capacity outweighs demand. Therefore, one pragmatic way to begin to roll out this model may be to increase the number of practices within this service's catchment area in order to determine what the probable capacity of this current model is. As a second observation, two of the practices suggested that a multi-disciplinary team may be a valuable model to explore to deliver unscheduled care. Indeed, it is not always necessary for a GP to deliver home visits; one rationale behind the increasing usage of advanced practitioners to deliver this service[13]. However, there are opportunities to dove-tail this service with other transformative projects within the city, for example the Acute Care @ Home project, that consists of a multi-disciplinary team to avoid hospital admission and accelerate discharge of acute geriatric patients[14,15]. Given that the average age of patients visited here was high (79 years), this could be a natural extension of the service and would allow for further integration of care. Noting that several practices voiced their reluctance to pay for this service, the source of funding to scale this test of change is crucial towards its continuance.

Acknowledgements

We would like to thank: the Aberdeen City Health & Social Care Partnership Integration Joint Board for funding this project; the West Unscheduled Care project team for developing and supporting this service; to G-MED colleagues who were pivotal in the implementation of the service; to Duncan Sage and colleagues from ISD Scotland for providing travel time data; to the practice staff and ANPs for participating in the data collection process; to the GMS Facilitators in NHS Grampian for deriving data on GP home visiting; and to Liane Cardno and colleagues (Health Intelligence department, NHS Grampian) for providing the projection data.

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Appendix 1. Emergency admissions by practice actual against projected

Note: Kingswells practice was formerly Victoria Street Medical Group, therefore data has been included for both practices.

Number of Emergency Admissions by selected GP Practice
actual against projected from Nov 2017

Number of Emergency Admissions

0 10 20 30 40 50 60 70 80 90

Jan-15 Feb-15 Mar-15 Apr-15 May-15 Jun-15 Jul-15 Aug-15 Sep-15 Oct-15 Nov-15 Dec-15 Jan-16 Feb-16 Mar-16 Apr-16 May-16 Jun-16 Jul-16 Aug-16 Sep-16 Oct-16 Nov-16 Dec-16 Jan-17 Feb-17 Mar-17 Apr-17 May-17 Jun-17 Jul-17 Aug-17 Sep-17 Oct-17 Nov-17 Dec-17 Jan-18 Feb-18 Mar-18 Apr-18 May-18

Albyn Medical Practice
Camphill Medical Practice
Cults Medical Group
Great Western Medical Practice
Hamilton Medical Practice
Peterculter Medical Practice
Kingswells Medical Practice
Victoria Street Medical Group

Appendix 2. Emergency bed days by practice actual against projected

Note: Kingswells practice was formerly Victoria Street Medical Group, therefore data has been included for both practices.

Number of Emergency Bed Days by selected GP Practice
actual against projected from Nov 2017

Linear projection from Nov 17 based on historical data. Dotted line indicates projection, solid line represents actual data

Number of Emergency Bed Days: 0, 100, 200, 300, 400, 500, 600, 700, 800

Jan-15, Feb-15, Mar-15, Apr-15, May-15, Jun-15, Jul-15, Aug-15, Sep-15, Oct-15, Nov-15, Dec-15, Jan-16, Feb-16, Mar-16, Apr-16, May-16, Jun-16, Jul-16, Aug-16, Sep-16, Oct-16, Nov-16, Dec-16, Jan-17, Feb-17, Mar-17, Apr-17, May-17, Jun-17, Jul-17, Aug-17, Sep-17, Oct-17, Nov-17, Dec-17, Jan-18, Feb-18, Mar-18, Apr-18, May-18

Albyn Medical Practice; Camphill Medical Practice; Cults Medical Group; Great Western Medical Practice; Hamilton Medical Practice; Peterculter Medical Practice; Kingswells Medical Practice; Victoria Street Medical Group

Appendix 3. A&E attendances by practice actual against projected

Note: Kingswells practice was formerly Victoria Street Medical Group, therefore data has been included for both practices.

Number of A&E Attendances
actual against projected from Nov 2017

Linear projection from Nov 17 based on historical data. Dotted line indicates projection, solid line represents actual data

Number of A&E Attendances

Albyn Medical Practice
Camphill Medical Practice
Cults Medical Group
Great Western Medical Practice
Hamilton Medical Group
Peterculter Medical Practice
Victoria Street / Kingswells

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ID	Task Name	Start	Finish
1	**MSK First Contact Practitioner**	**Wed 01/08/18**	**Sat 31/12/22**
2	Approval of Business Case by IJB	Wed 01/08/18	Wed 01/08/18
3	Torry Practice (Test of Change for model)	Mon 01/10/18	Sun 31/03/19
4	Limited Scale-up to test in 2 practices	Mon 01/04/19	Tue 31/03/20
5	Scale up to 1 cluster area	Wed 01/04/20	Wed 31/03/21
6	City-wide roll-out of model	Thu 01/04/21	Sat 31/12/22
7	**Chaplaincy Listening Service**	**Wed 01/08/18**	**Sat 31/12/22**
8	Approval of Business Case by IJB	Wed 01/08/18	Wed 01/08/18
9	Chaplaincy Listening service input in 11 practices	Sat 01/12/18	Tue 31/03/20
10	Appointment of Co-ordinator	Sat 01/12/18	Mon 01/04/19
11	Development and training of Volunteer base	Mon 01/04/19	Tue 31/03/20
12	City-wide offer of Chaplaincy Listening Service	Wed 01/04/20	Sat 31/12/22
13	**Practice Aligned Pharmacy**	**Sun 01/01/17**	**Sat 31/12/22**
14	Existing Pharmacy resource for Primary Care activity	Sun 01/01/17	Tue 31/03/20
15	Scoping of additional service requirements under new GP contract	Thu 01/11/18	Mon 01/04/19
16	Development of Workforce Plan to support delivery	Mon 01/04/19	Sun 30/06/19
17	Approval of Business Case by IJB	Thu 01/08/19	Thu 01/08/19
18	Recruitment of adidtional resource	Thu 01/08/19	Wed 01/04/20
19	City wide-team operational	Wed 01/04/20	Sat 31/12/22
20	**Community Phlebotomy**	**Tue 01/01/19**	**Mon 03/04/23**
21	Establishment of Project Team	Tue 01/01/19	Fri 08/02/19

Project: Project Phasing
Date: Mon 28/01/19

Task	External Milestone	Manual Summary Rollup
Split	Inactive Task	Manual Summary
Milestone	Inactive Milestone	Start-only
Summary	Inactive Summary	Finish-only
Project Summary	Manual Task	Deadline
External Tasks	Duration-only	Progress

ID	Task Name	Start	Finish
22	Scoping of requirement and development of delivery model	Mon 11/02/19	Fri 31/05/19
23	Approval of Business Case by IJB	Thu 01/08/19	Thu 01/08/19
24	Implementation of agreed delivery model city-wide	Thu 01/08/19	Fri 31/01/20
25	City-wide delivery model operational	Sat 01/02/20	Mon 03/04/23
26	**Integrated Triage**	**Mon 01/04/19**	**Thu 01/06/23**
27	Establishment of Project Team	Mon 01/04/19	Thu 09/05/19
28	Scoping of requirement and development of delivery model	Sat 01/06/19	Fri 19/07/19
29	Approval of Business Case	Wed 14/08/19	Wed 14/08/19
30	Implementation of agreed delivery model city-wide	Sun 01/09/19	Tue 31/03/20
31	City-wide delivery model operational	Wed 01/04/20	Thu 01/06/23
32	**Community Links Workers**	**Tue 01/08/17**	**Sat 31/12/22**
33	Approval of Business Case by IJB	Tue 01/08/17	Tue 01/08/17
34	Appointment of Commissioned provider	Fri 01/09/17	Mon 08/01/18
35	Development of model and Recruitment of Link Workers	Mon 08/01/18	Sun 22/07/18
36	Phase 1 Operational across 9 GP practices with 9 staff	Mon 10/09/18	Sun 07/04/19
37	Link Worker approach operational city-wide	Mon 08/04/19	Sat 31/12/22
38	**Unscheduled Visiting Service**	**Wed 01/11/17**	**Sat 31/12/22**
39	Test of Change introducing afternoon visiting service in West Locality	Wed 01/11/17	Wed 31/10/18

Timeline: 2019, 2020, 2021, 2022 — H2, H1, H2, H1, H2, H1, H2, H1, H2

01/08

14/08

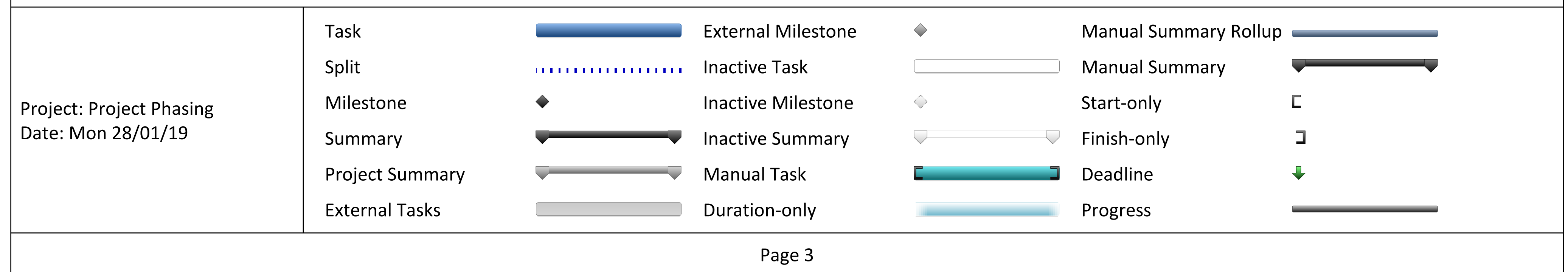
Project: Project Phasing
Date: Mon 28/01/19

Legend: Task; Split; Milestone; Summary; Project Summary; External Tasks; External Milestone; Inactive Task; Inactive Milestone; Inactive Summary; Manual Task; Duration-only; Manual Summary Rollup; Manual Summary; Start-only; Finish-only; Deadline; Progress

ID	Task Name	Start	Finish
40	Scale up to include expanded area in test	Thu 01/11/18	Sat 31/08/19
41	City-wide delivery of visiting service as part of coordinated approach to Unscheduled Care	Sun 01/09/19	Sat 31/12/22
42	**Vaccinations Transformation Programme**	**Fri 01/06/18**	**Sat 31/12/22**
43	Phase 1 Implementation (Schools Vaccinations)	Fri 01/06/18	Sun 31/03/19
44	Phase 2 Implementation (Childhood Immunisations)	Mon 01/04/19	Tue 31/03/20
45	Phase 3 Implementation (Adult and Travel Vaccinations)	Wed 01/04/20	Wed 31/03/21
46	Transformed Vaccinations Programme operationa	Thu 01/04/21	Sat 31/12/22
47	**Workflow Optimisation**	**Wed 01/08/1ٍ8**	**Sat 31/12/22**
48	Approval of Business Case by IJB	Fri 16/11/18	Fri 16/11/18
49	Define Project	Wed 01/08/18	Mon 31/12/18
50	Procurement Process	Sat 01/09/18	Sun 31/03/19
51	Project Implementation	Thu 01/11/18	Thu 12/12/19
52	System operational in Opt-in practices	Fri 13/12/19	Sat 31/12/22

2019 2020 2021 2022
H2 H1 H2 H1 H2 H1 H2 H1 H2

16/11



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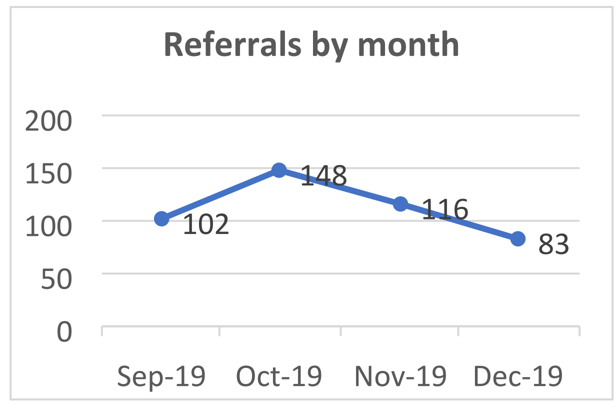
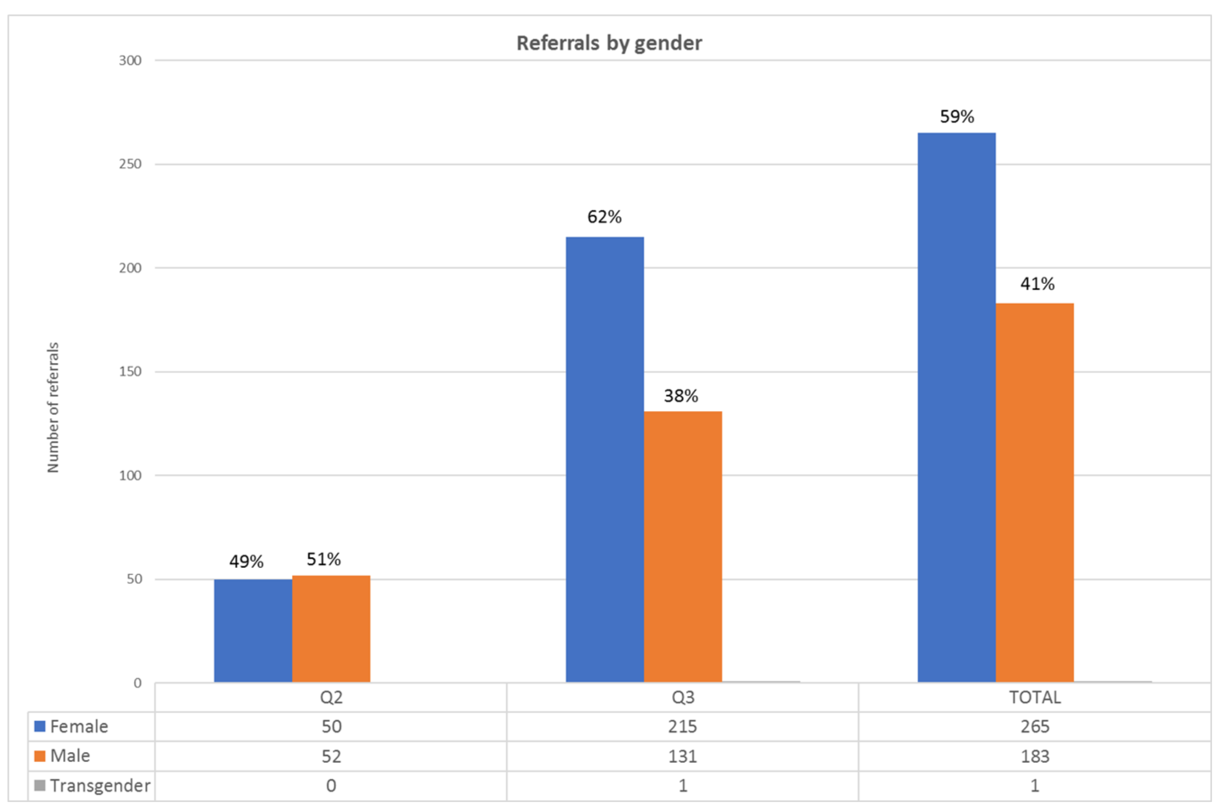
Appendix E: Aberdeen Links Quarter 3 2018/19 Report

Aberdeen Links Referral Numbers for Q2 and Q3



Referrals by quarter	
Q2	102
Q3	347
TOTAL	449

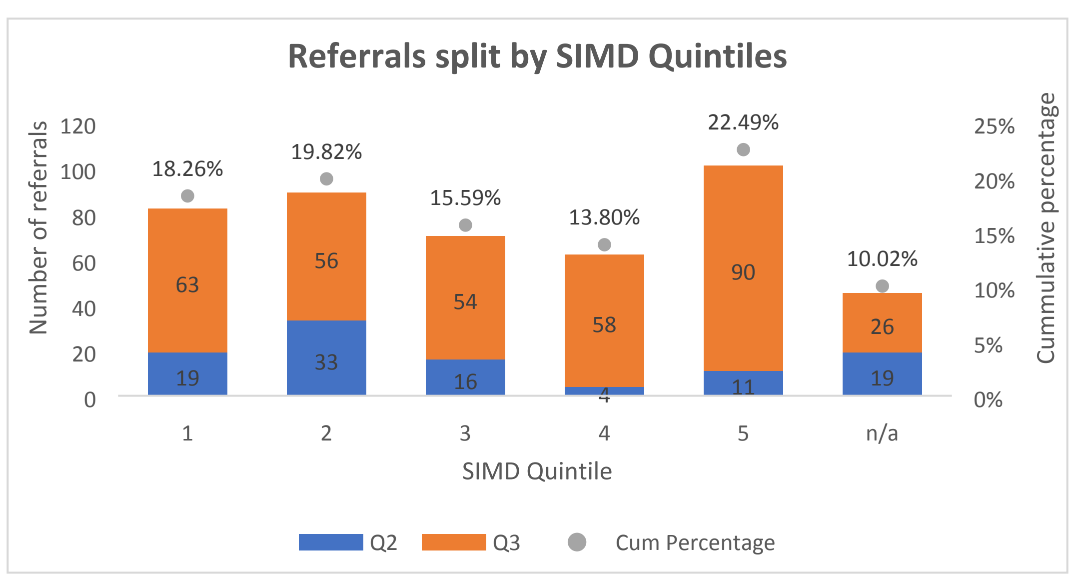
Referrals Split by Gender for Q2 and Q3



Referrals split by Age for Q2 and Q3

Age	Q2	Q3	TOTAL
<24	1	20	21
25-44	25	103	128
45-64	39	115	154
65+	40	109	146
Average	59	54	55
Min	19	18	17
Max	97	96	97

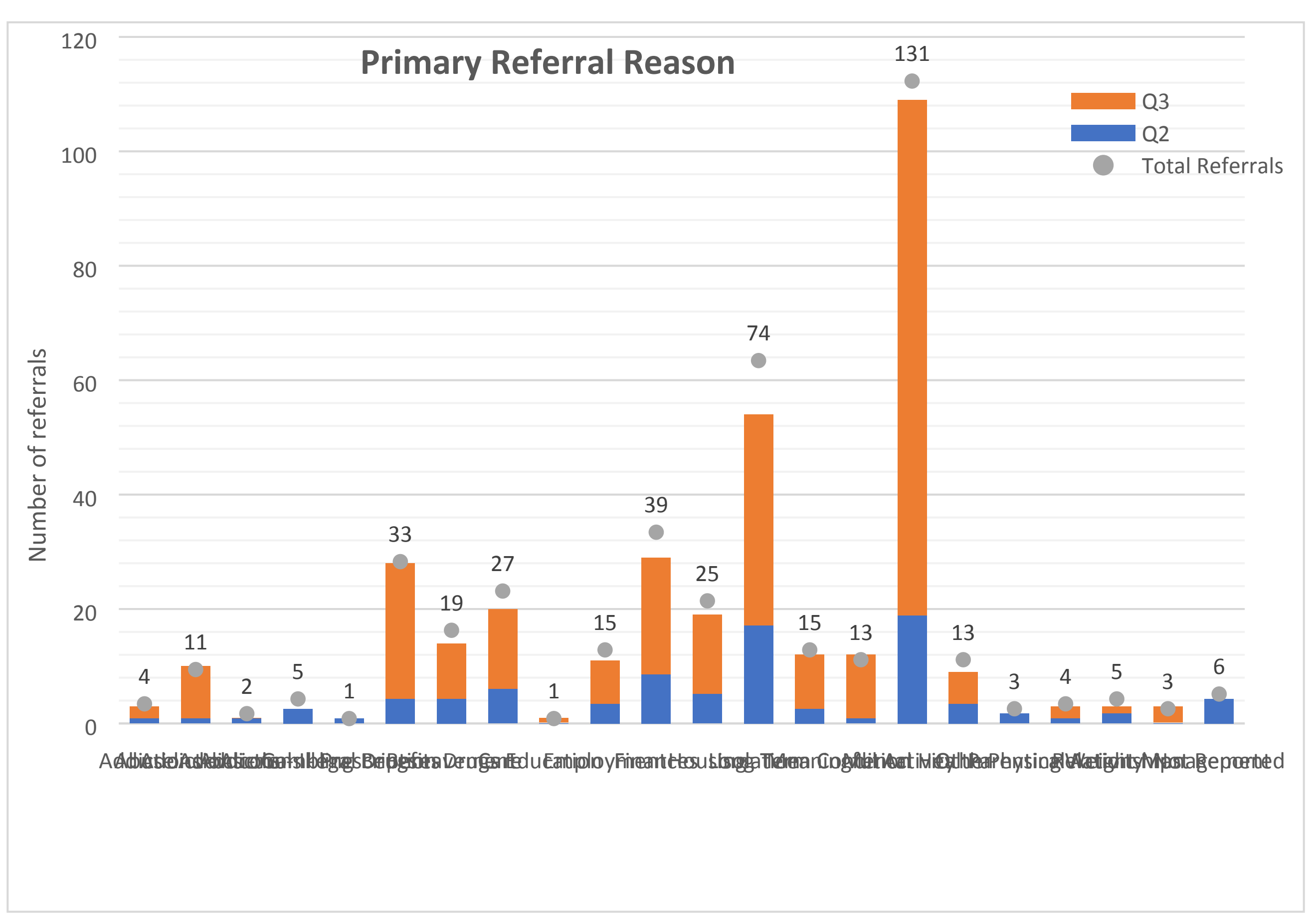
Referrals Split by SIMD* Quintiles for Q2 and Q3



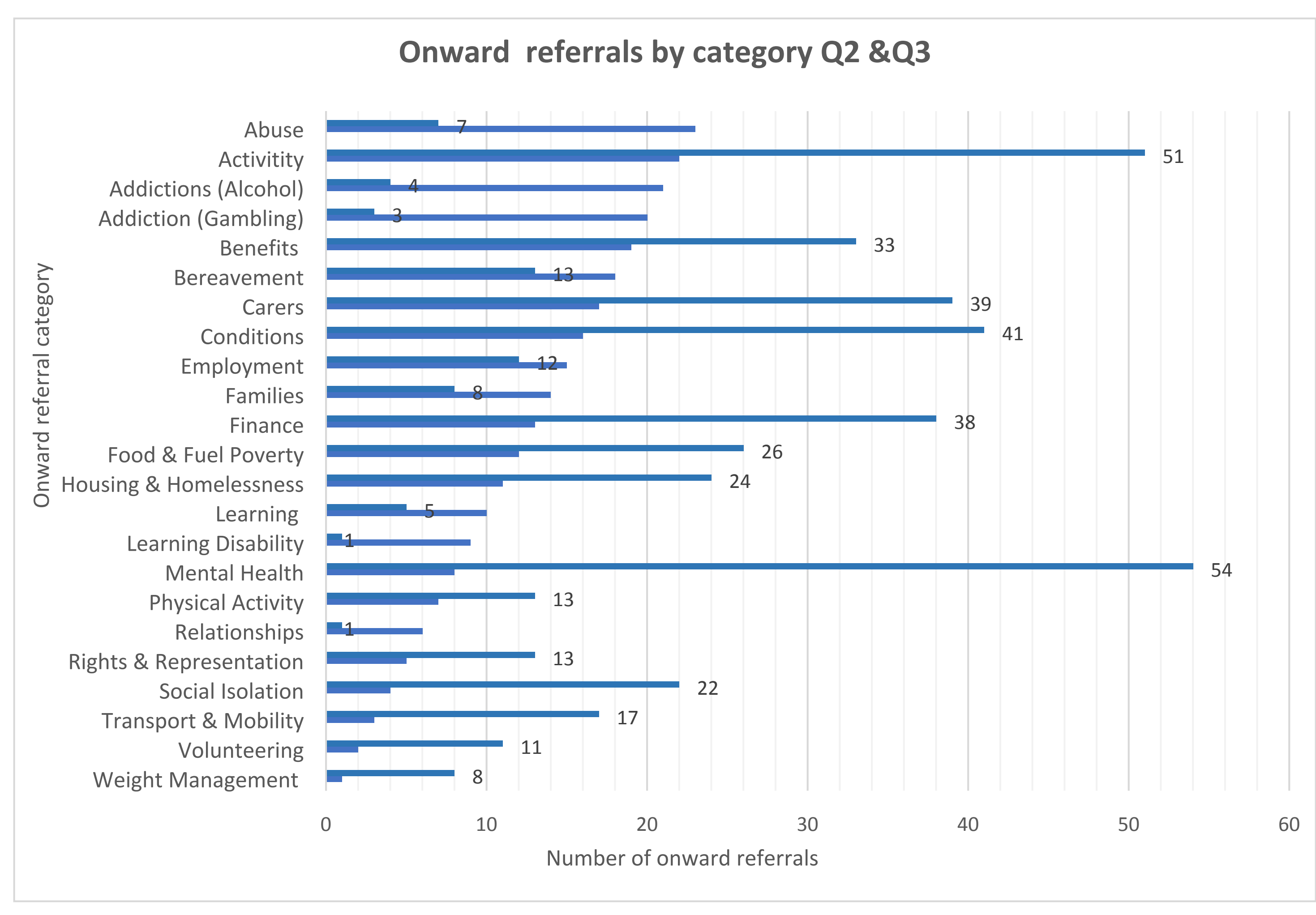
** SIMD (the Scottish Index of Multiple Deprivation) provides a deprivation rank for each of the 6,505 datazones in Scotland. SIMD Quintiles split up the dataset into 5 groups, each containing 20% of the data, with SIMD Q1 representing areas of greatest deprivation and SIMD Q5 areas of least deprivation*

n/a = those living in new build houses whose postcodes are not captured in the 2012 data used to determine which quintile a referral falls into.

Primary Reason for Referral Broken by Q2 and Q3



Onward Referrals by Category for Q2 and Q3



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Aberdeen City Health & Social Care Partnership
A caring partnership

AUDIT AND PERFORMANCE SYSTEMS COMMITTEE

Date of Meeting	12th February 2019
Report Title	Performance Monitoring
Report Number	HSCP.18.131
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. Aims, Priorities, Commitments, Outcomes, Risks and Indicators

1. Purpose of the Report

1.1. The purpose of this report is to advise the Audit and Performance Systems Committee of the latest developments in relation to Performance Monitoring.

2. Recommendations

2.1. It is recommended that the Audit and Performance Systems 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.

AUDIT AND PERFORMANCE SYSTEMS COMMITTEE

3. Summary of Key Information

3.1. In October 2017 the IJB agreed that performance reports would be submitted quarterly to both the Audit and Performance Systems Committee and the IJB alternately. These reports have been based on both national and local indicators.

3.2. In September 2018, the Audit and Performance Systems Committee approved a new set of Strategic Performance Indicators (SPIs) for Aberdeen City Health and Social Care Partnership which incorporated elements of the existing national and local indicators. These SPIs had been mapped to the priorities identified in the existing Strategic Plan, the 9 national Health and Wellbeing Outcomes and our commitments in relation to the Local Outcome Improvement Plan (LOIP).

3.3. In November 2018, a task and finish group was set up to review the structure and expected outcomes of the Clinical and Care Governance Committee. Part of this review was to ensure alignment of data that is provided to strategic objectives and the risk register. It is understood that data needs to be reported to the Clinical and Care Governance Committee, the Audit and Performance Systems Committee, the Integration Joint Board, the Ministerial Strategic Group (MSG) on Health and Community Care as well as to the Scottish Government generally.

3.4. In December 2018 the IJB approved two reports – one on the consultation draft of the refreshed Strategic Plan for 2019 – 2022 and one on Performance Monitoring. A graphic designed version of the consultation draft of the Strategic Plan has now been published. The consultation runs until 28th February 2019 and IJB will receive the final draft for approval at their meeting on 26th March 2019.

3.5. The consultation draft of the refreshed Strategic Plan revises the existing 7 Strategic Priorities down to 5 Strategic Aims. Each of these Aims has a number of related Priorities and Commitments along with the detailed evidence that will demonstrate whether we have achieved them or not. Although the plan is out for consultation it is not expected that the strategic aims, priorities and commitments will change significantly.

3.6. The December 2018 IJB report on Performance Monitoring identified that the mapping exercise undertaken to identify the Strategic Performance Indicators needed to be revisited in light of the revised Strategic Aims. It also proposed that Strategic Risks needed to be included in this mapping

exercise as the data would not only indicate where our risks are, but also confirm or otherwise whether we are successfully mitigating these risks.

3.7. Appendix A contains this latest mapping exercise and the Audit and Performance Systems Committee is asked to approve this mapping and the resultant suite of Strategic Performance Indicators. In the main these are the same as were reported in September 2018 although these have been re-distributed. There are a number of additional indicators that came to light during the development of the refreshed Strategic Plan. The total number of SPIs is now 60 and these are distributed amongst the Strategic Aims as follows: -

- Prevention (15)
- Resilience (14)
- Enabling (9)
- Connections (12)
- Communities (10)
- **TOTAL (60)**

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

3.9. The IJB agreed that it will receive the Annual Report at their September meeting. Again, this will be published nationally so the IJB is the appropriate level for approval. Future years Annual Reports will be based around the 5 Strategic Aims and our performance against these. It is intended to have these reports graphically designed in the same way as the Strategic Plan has been, to have an Annual Report on a page, which will be an "at a glance" view of our high level performance" and also that community conversations will be undertaken in relation to our performance and how social care clients and patients would wish to see our performance in future years.

3.10. It was further agreed at IJB in December 2018 that the Audit and Performance Systems Committee and/or the Clinical and Care Governance Committee will receive regular performance reports throughout the year focusing on each of the strategic priorities in turn. These committees have the opportunity to escalate any areas of concern to the IJB at any time. A proposal for which aims will be reported to which committee is also included

in the mapping spreadsheet. This is based on the Audit and Performance Systems responsibility for risk.

4. Implications for IJB

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

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

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

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

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

4.6. Other – none.

5. Links to ACHSCP Strategic Plan

5.1. This report aims to approve a performance management framework which will provide assurance and demonstrate progress on the strategic aims, priorities and commitments as well as the national health and wellbeing outcomes as outlined in the strategic plan.

6. Management of Risk

6.1. Identified risks(s)

If we do not agree relevant and meaningful strategic performance indicators we will be unable to demonstrate our progress on our strategic priorities, the national health and wellbeing outcomes and our commitments in the Local Outcome Improvement Plan.

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

This report links to Strategic Risk 5.: -

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

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

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

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Aims, Priorities, Outcomes, Risks and Indicators

Strategic Aims	Prevention	Resilience	Enabling	Connections	Communities
Priorities	Promote Positive Mental Health and Wellbeing	Support and promote self-management and independent living for individuals	Reshape our Primary Care sector	Enable our citizens to have opportunities to maintain their wellbeing, and take a full and active role in their local community	Implement our three locality model
	Address the factors that cause inequality in outcomes	Value and Support Unpaid Carers	Shift the balance of care from the acute sector to community based services	Reduce the perception of loneliness and isolation experienced by individuals across age and client group	Develop a diverse and sustainable care provision
	Reduce alcohol and drug related harm		Develop our palliative and end of life care provision		
Commitments	We will produce a Mental Health Strategy and Action Plan	We will continue to invest in our promoting self amangement and building community capacity transformation programme	We will implement fully our Primary Care Improvement Plan	We will develop a co-ordinated engagement plan for all the partnership's activities and initiatives with our client and patient groups	We will imprlement a three locality model and, in doing so, align our activities more fully with those of the Community Planning locality model
	We will actively contribute to known health inequalities	We will support our unpaid carers to identify as carers, to manage their caring role, to be involved in the planning of services for both the cared for person and to have a life alongside caring if they so choose	We will support and implement as appropriate, the local Unscheduled Care Essentials Action Plan, developed with our partenr agencies	We will develop the social capital of our partnership across all sectors and services	We will refresh our Market Facilitation Statement and develop and Action Plan showing how we will support our local care provision
	We will support the Alcohol and Drug Partnership in delivering actions to reduce substance related harm		We will review our palliative and end of life care provision and develop an action plan to fulfill the strategic framework vision		
Wellbeing Outcomes	Health and Social Care services contribute to reducing health inequalities	People are able to live as far as is reasonably practicable independantly and at home or in a homely setting in their community	Resources are used effectively in the provision of health and social care services without wast.	People are able to look after and improve their own health and wellbeing and live in good health for longer	People who use health and social care services have positive experiences of those services and have their dignity respected
	People who use health and social care services are safe from harm	People who provide unpaid care are supported to reduce the potential impact of their caring role on their own health and wellbeing	People who work in health and social care services are supported to continuously improve the information, support, care and treatment they provide and feel engaged with the work they do		Health and Social Care Services are centred on helping to maintain or improve the quality of life of service users
LOIP	Supported, Included	Resilient	Resilient, Supported	Resilient, Supported, Included	Resilient, Supported, Included
Strategic Risk			SR5. Performance standards not met		SR1. Insufficient capacity in the market
			SR6. Complexity of function		SR2. Risk of financial failure
			SR7. Failure to deliver sustainable system change		SR3. Risk of service failure
			SR9. Workforce Planning		SR4. Relationships with partner ofganisations
					SR8. Failure to maximise locality working
					SR10. Brexit
Strategic Performance Indicator	Number of A&E Attendances	Emergency Admission Rate (per 100,000 population)	% of population aged 75+ living in a community setting (including a Care Home	% Uptake of Self Directed Support Options	Number of new referrals to initial investigation under Adult Support and Protection
	Warwick Edinurgh Mental Health Wellbeing Score	Readmission to hospital within 28 days (per 100,000 population)	Total number of Delayed Discharges	% of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	Total of home care hours delivered
	Number of alcohol related hospital admissions	Falls rate (per 100,000 population|	Proportion of last 6 months on life spent at home or in a community Setting	% of adults able to look after their health very well or quite well	Social Care Unmet Need
	Number of Alcohol Brief Interventions delivered	Premature mortality rate for people aged under 75 (per 100,000 population)	% of staff who say they would recommend their workplace	Life Expectancy	Residential Care Occupancy Rate
	% of clients receiving alcohol treatment within 3 weeks of referral	% adults supported at home who agree they felt safe	Total FTE posts vacant	Offender re-conviction rate	Proportion of Care Services graded "Good" (4) or better in Care Inspectorate inspection
	Number of alcohol related deaths	% of adults supported at home who agree that they are supported to live as independantly as possible	Total FTE Agency Staff employed	Number of deaths related to cancer	Propotion of Care Service contractually non-compliant
	Drug related hospital admissions	% of home care where two or more members of staff are required	Sickness Absence Rate	Number of deaths related to circulatory disease	% of people with positive experience of care provided by their GP practice
	% of clients receiving drug treatment within 3 weeks of referral	% of adults with intensive care needs receiving care at home	Staff Turnover Rate	Level of social isolation reported	% of adults supported at home who agreed that their health and social care services seemed to be well coordinated
	Number of drug related deaths	Number of people using a Community Alarm Service	Adverse Events	% of Community Lnks Workers in post	Total % of adults receiving any care or support who rated it as excellent or good
	Obesity levels	Number of people using Telecare		Number of clients supported by Community Links Workers	Number of complaints received and responded to within 20 working days
	Suicide rate	% of adults registered with a GP		Number of community groups convened and meeting regularly	
	Smoking cessation in 40% most deprived areas after 12 weeks	% of adults registered with a dentist		Number of community training sessions delivered	
	Number of people with a learning disability who are in Further Education	Number of unpaid carers supported			
	Number of people with a learning disability who are in Employment	% of carers who report they are supported to have a life alongside caring			
	Number of people with a Learning Disability who attend a Day Centre or has alternative opportunities				
Committee	Clinical and Care Governance	Clinical and Care Governance	Audit and Performance Systems	Clinical and Care Governance	Audit and Performance Systems

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Aberdeen City Health & Social Care Partnership
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INTEGRATION JOINT BOARD

Date of Meeting	12th February 2019
Report Title	Delayed Discharge Performance Update
Report Number	HSCP.18.132
Lead Officer	Sandra Ross – Chief Officer
Report Author Details	Kenneth O'Brien Service Manager kobrien@aberdeencity.gov.uk
Consultation Checklist Completed	Yes
Appendices	None

1. Purpose of the Report

1.1. Following its meeting of 13th November 2018, the Audit and Performance Systems Committee requested that the Chief Officer prepare a performance report on delayed discharges and present the report to the Committee's next meeting.

1.2. Resultantly, this report provides an update on current delayed discharge performance information regarding the Aberdeen City Partnership.

2. Recommendations

2.1. It is recommended that the Audit & Performance Systems Committee:

a) Note the performance information contained within this report.

3. Summary of Key Information

Current Performance Information

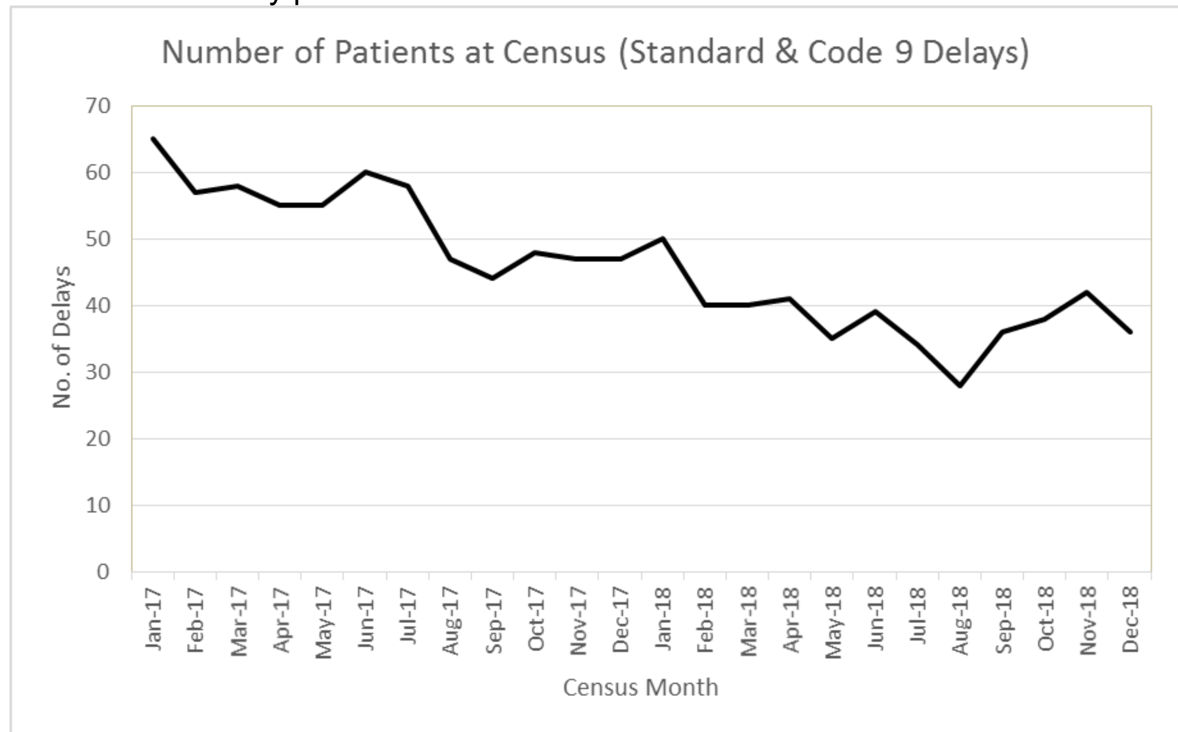
3.1. For the purposes of clarity, the Audit and Performance Systems Committee should be aware that the Delayed Discharge figures classify patients/clients into THREE types of delay:

- “Standard” Delays – which are individuals who are medically fit for discharge and yet remain in a hospital bed.

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

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

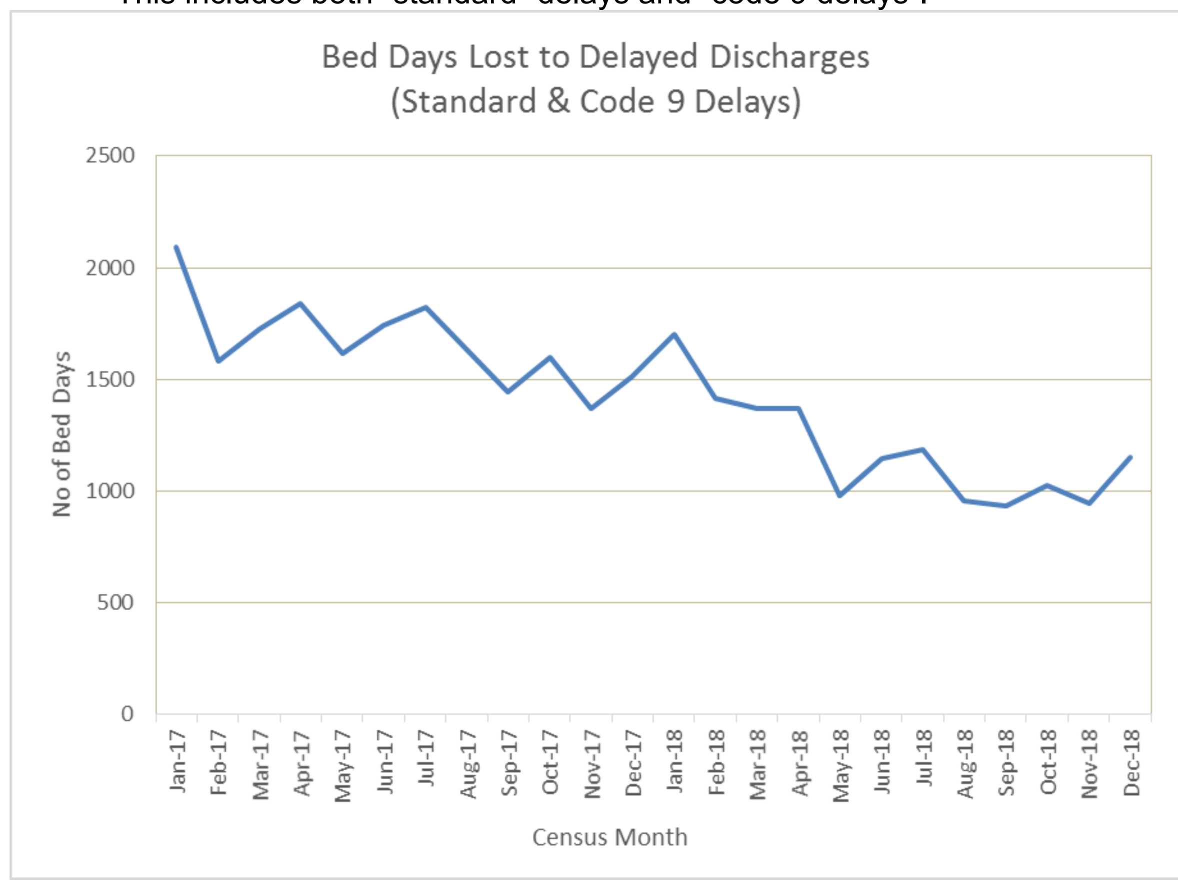
3.2. “Code 100” delays are reported to the Government however are not included in nationally published data.



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

3.3. **Figure 1** shows the overall count of those patients/clients classified as a ‘delayed discharge’ as at the end of month census point, (reflecting the fact

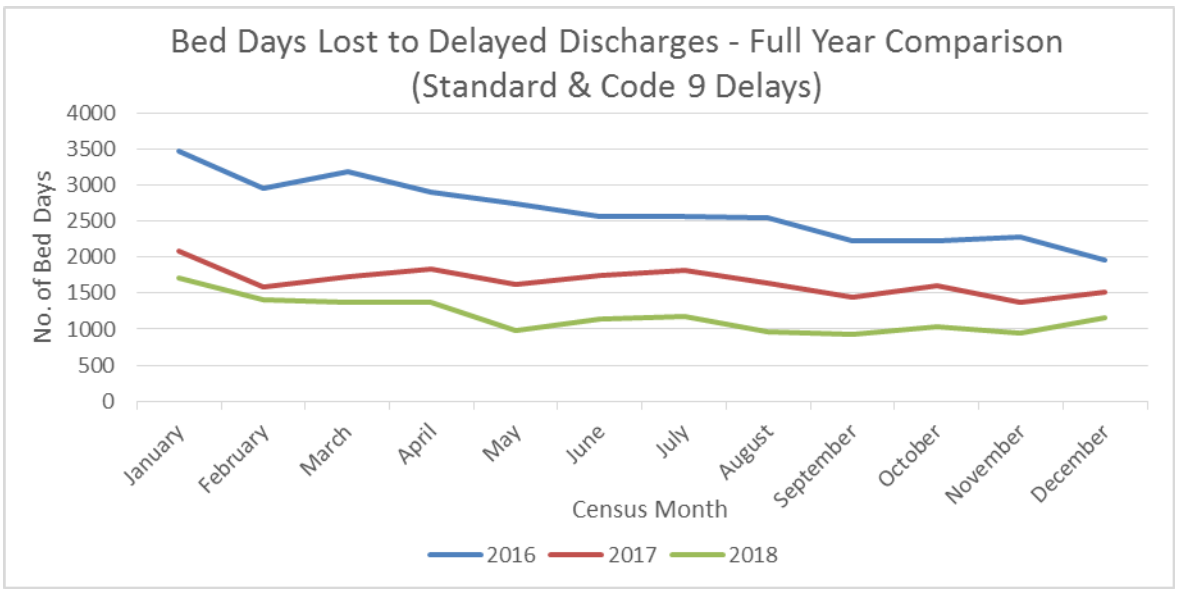
that the Government captures Delayed Discharge performance monthly). This includes both “standard” delays and “code 9 delays”.



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

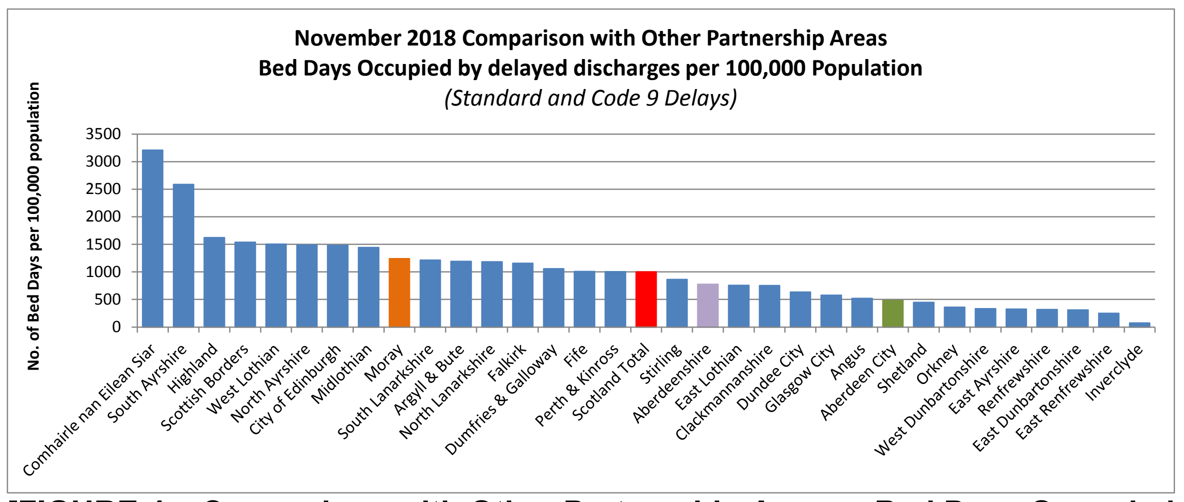
3.4. **Figure 2** shows the number of bed days occupied by patients/clients classified as a delayed discharge, also presented at monthly intervals. This has continued on a downward trend, although plateauing somewhat in recent months.

INTEGRATION JOINT BOARD



[FIGURE 3] – Bed Days Lost to Delayed Discharges – Full Calendar Year Comparisons

3.5. **Figure 3** shows the progress of the City Partnership in reducing bed days lost to delayed discharge over the course of the past three calendar years. Comparing calendar year 2017 with the most recent full year of data (2018), we can see that bed days lost to delayed discharges have reduced 28%. Comparing calendar year 2016 to 2018, bed days lost have reduced by 55%.



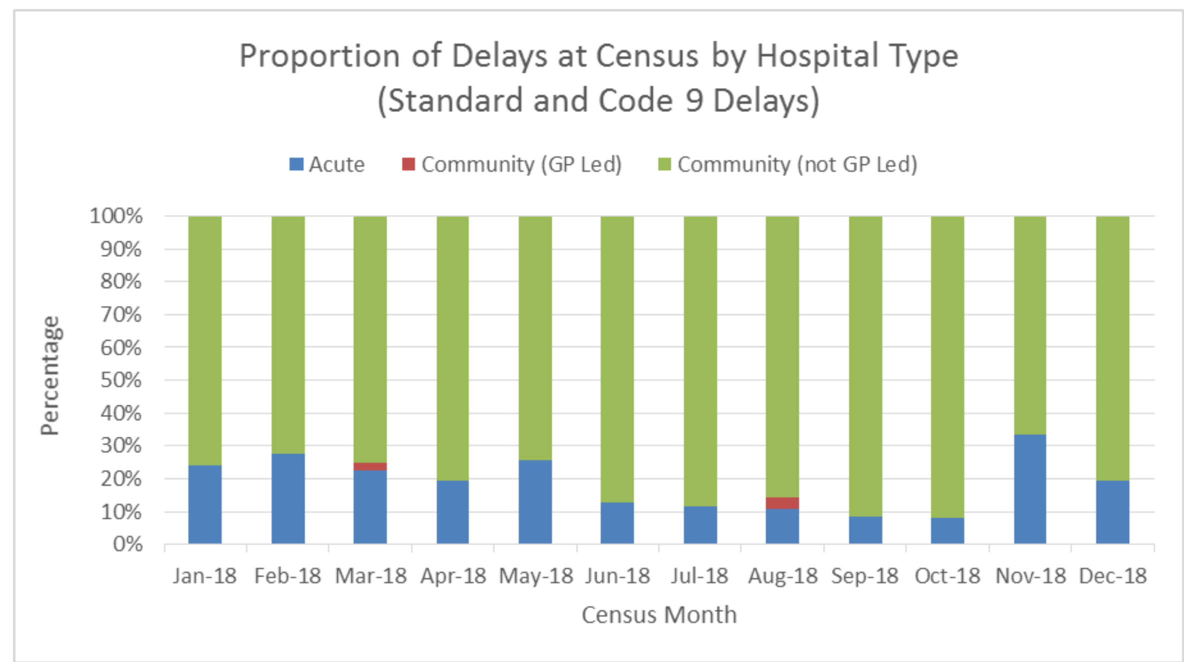
[FIGURE 4 – Comparison with Other Partnership Areas – Bed Days Occupied by delayed discharges]

INTEGRATION JOINT BOARD

3.6. Figure 4 shows Aberdeen City's number of bed days lost to delayed discharge in the context of other partnership areas. The data is adjusted to reflect population figures in the various areas. The most current cross-partnership data comes from the nationally published census information gathered for November 2018.

3.7. The total delayed discharge bed days in Aberdeen City in November 2018 equated to a rate of 482.7 bed days per 100,000 population. This was below the Scotland wide rate of 999.3 per 100,000 population and 23 Partnerships recorded a higher rate than Aberdeen City. This is an improvement on the October 2018 position when 21 partnerships reported a higher rate of delayed discharge bed days than Aberdeen City.

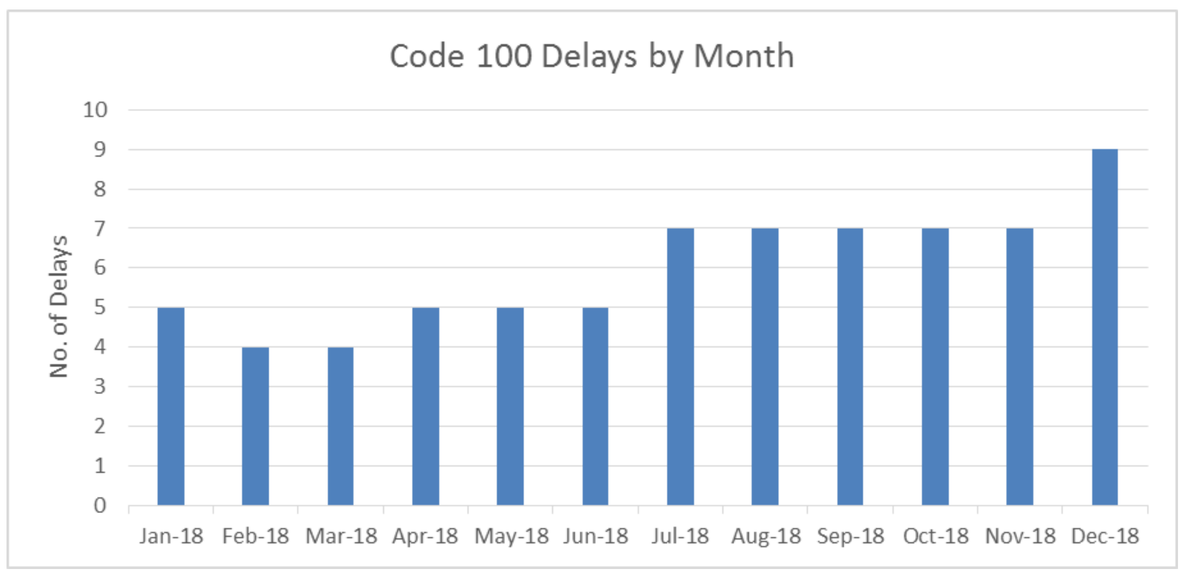
3.8. Based on data for November 2018 Aberdeen City is in the top 28% of Partnerships for delayed discharge bed days performance (adjusted for population). Aberdeen was the best performing city in Scotland for delayed discharge bed days (adjusted for population).



[FIGURE 5] – Location of Delays at Census by Hospital Type

3.9. **Figure 5** shows the location of delays by each hospital 'type'. Aberdeen City has continued over an extended period to record a relatively small percentage of its delayed discharges within the acute sector. In November 2018, 33% of the City Partnership's delays at census were in acute. For

comparison, the most recent Scotland wide breakdown of delayed discharges (November 2018) showed that 47% of all delays in Scotland were in the acute sector.



[FIGURE 6] – Code 100 Delays, Trend

3.10. Figure 6 shows the number of delayed discharges recorded as a Code 100 delay each month. [Please note that where a patients/clients delay has spanned more than one month this delay will be counted in each month that they were delayed]. Over the last 12 months 14 individuals were recorded as a Code 100 delay. It should be noted, that whilst the overall volume of individuals who are classified as Code 100 remains small overall, the lengths of delay recorded are very significant – reflecting the ongoing difficulties in commissioning bespoke support services for these complex client groups.

Summary of Key Data

3.11. To summarise:

- Aberdeen City has seen a 23% reduction in the number of people delayed at census comparing December 2017 to December 2018.

- Aberdeen City has seen a 28% reduction in 'bed days lost' due to delayed discharges, comparing full calendar years 2017 and 2018.

- From the latest 'cross-partnership' figures available, Aberdeen City's performance has improved slightly relative to other Health and Social Care Partnerships. As of November 2018, Aberdeen City is in the top 28% of all Partnerships for delayed discharge bed days performance when weighted for population. 8 of 32 Partnerships continue to perform better than Aberdeen City.

Aberdeen City Delayed Discharge Action Plan

3.12. The Aberdeen City Partnership has a regularly updated action plan which documents current and future initiatives related to delayed discharge.

3.13. Key aspects of the action plan that the Committee may wish to note:

- The success of the first-year pilot of interim housing provision for individuals delayed in hospital due to housing and adaptation needs. This is currently going through appropriate governance with a recommendation that it be continued for a further 12-month period.

- The impact of a dedicated Mental Health Officer (MHO) to support managing complex Code 9 delayed discharges. There has been a 61% reduction in delayed discharge bed days relating to such delays since the additional MHO capacity was put in place.

- The successful 'go live' of an embedded Social Worker/Care Manager in the Emergency Department at Aberdeen Royal Infirmary to 'turn around' patients/clients prior to becoming in-patients.

Sustainability of Current Improvements

3.14. Regarding sustaining the current level of improvement in delayed discharge performance – this will always be a potential challenge. Demographic change, accompanied by the ongoing pressure to discharge patients more quickly from a decreasing hospital bed base, does mean that the Partnership will have to "run to stand still" in relation to maintaining its performance.

3.15. It should also be recognised that some factors that impact upon maintaining delayed discharge performance are challenging for the Partnership to fully directly control. Capacity in the care at home market is directly influenced by the underlying labour market in the city and can have a knock-on effect on supporting discharge if there is a mismatch between supply of labour and demand for care. Similarly, closure or suspension of care homes operated in the private and voluntary sector can impact on the number of beds available to support flow out of hospital. Robust and active market management can mitigate the risks from these types of factors, but it can't eliminate them.

3.16. Positively, the Partnership does have access to £1.12 million of dedicated recurring annual funding from the Scottish Government specifically to support improvements in delayed discharge performance. This funding has been utilised by the Partnership to progress multiple initiatives to improve performance over the past 3 years.

3.17. The Partnership has taken a careful and evidence led and evaluation-based approach to the use of these funds. Even with the initiatives implemented to date using this funding to improve performance. The focus has been on testing new initiatives, evaluating them robustly, and then only continuing them if there is clear evidence of a positive impact.

3.18. As a result of this approach, the Partnership has been able to make permanent and 'lock in' some key initiatives that have delivered performance improvements – all within the budget envelope for dedicated delayed discharge initiatives/projects. The dedicated delayed discharge lead post, alongside interim care home beds, and dedicated social work liaison in the discharge hub, are all now established as ongoing commitments. This will help entrench existing performance gains.

Possibilities for Further Improvements in Performance

3.19. As mentioned above, even 'standing still' in the current environment is a challenge so, be definition, improving further will be an even greater challenge. From where it has previously been, the Partnership has improved dramatically regarding its delayed discharge performance. This has been to such an extent that the City Partnership was visited in December 2018 by the Scottish Government to get examples of good practice for sharing with other areas.

3.20. However, given there has been such significant improvements, it must be recognised that a lot of the relatively 'easy' wins to deliver improvements have already been exhausted.

3.21. Further improvements are possible, however they will, most likely, require higher amounts of spending to deliver smaller amounts of absolute performance gain. For example, it could be possible, to reduce significantly further the number of complex code 100 delayed discharges currently in hospital – however this would necessitate the Partnership committing to very large, high unit cost, ongoing packages of care and support on an ongoing basis.

3.22. Similarly, a further big improvement in delayed discharge performance could possibly be obtained by moving to a model of assessing and care planning for discharge outside of the hospital estate. However, this would require very significant investment in a large volume social care setting (or settings) that could 'cohort' and support enablement of most patients from the day they are clinically fit for discharge.

3.23. The above statements and examples notwithstanding, the Partnership continue to actively seek to gain further improvements in delayed discharge performance. The Partnership has led on the refresh of the "choice" policy and will seek to gain further efficiencies in the assessment and care planning elements of the discharge pathway. Additionally, further new initiatives are planned to hopefully deliver improvement in delayed discharge bed days lost. The delayed discharge lead for the Partnership will be visiting the highest performing Partnership within Scotland in March to learn from their projects/initiatives.

3.24. In summary, further improvement in delayed discharge performance is possible, and there is active work being undertaken to attempt to deliver this. However, such improvement is now much more of a challenge, and there may be a need to consider the financial costs of driving such improvement vs the performance gains achieved as a result.

4. Implications for IJB

4.1. Equalities

The issue of Delayed Discharge disproportionately impacts upon older adults and adults with chronic illness and/or long-term disabilities. Whilst 'age' and 'disability' are protected equality characteristics, it is not anticipated that there will be anything other than a positive impact for both groups via the continued improvement in the timeliness of discharges.

4.2. Fairer Scotland Duty

Given the nature of the work being undertaken in regards to improving delayed discharge performance, (including ensuring that all patients/clients are able to be safely and appropriately discharged from hospital regardless of their socioeconomic status) it is anticipated that continued progress in this area will only have a positive impact on inequalities.

4.3. Financial

The implementation of initiatives contained with the Delayed Discharge Action Plan involves expenditure from the Partnership's dedicated delayed discharge funding stream provided by the Scottish Government. Specific projects within the action plan that require funding authorisation have appropriate permissions sought from the relevant authorities depending on the level of expenditure incurred and the governance required. Resultantly, there are no direct financial implications arising from this report.

4.4. Workforce

There are no direct workforce implications relating to this report.

4.5. Legal

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

4.6. Other

None.

5. Links to ACHSCP Strategic Plan

5.1. The Partnership's Strategic Plan sets a very clear intention to shift the balance of care to community-based models. The focus on ensuring flow out into the community and homely settings from hospital, alongside sustaining individuals at home is congruent with this goal.

5.2. Additionally, given the strategic plan's focus on supporting staff to deliver high quality services, the focus on ensuring provision/support without delay is very relevant.

6. Management of Risk

6.1. Identified risks(s)

One of the most high-profile performance standards the Aberdeen City Partnership is held to account for is that of the numbers of people delayed in hospital unnecessarily. Significant volumes of delayed discharges will always have tangible consequences for patient flow and care – particularly in times of peak demand.

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

<u>From the Partnership's Strategic Risk Register</u>

Item Number 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 and that, as a result, harm or risk of harm to people occurs."

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

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

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Aberdeen City Health & Social Care Partnership
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AUDIT & PERFORMANCE SYSTEMS COMMITTEE

Date of Meeting	12.02.2019
Report Title	Localities – Update on Progress
Report Number	HSCP.18.139
Lead Officer	Sandra Ross, Chief Officer
Report Author Details	Anne McKenzie Aligned senior manager – North Locality
Consultation Checklist Completed	Yes
Appendices	NA

1. Purpose of the Report

1.1. This report provides the Audit & Performance System Committee with an update on progress with locality working to date. In particular, an update on achievements to date, barriers to achievement, and the rationale for change from a four to three locality model.

2. Recommendations

2.1. It is recommended that the Audit & Performance Systems Committee:

a) Note the contents of this report

3. Summary of Key Information

<u>What is a locality?</u>

3.1. A locality is defined with the Public Bodies (Joint Working) (Scotland) Act 2014 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. It recognises that this group of people will come from a range of different backgrounds, accustomed to different working styles, and that it will take time for them to find the best way to work together

Requirements from the Public Bodies (Joint Working) (Scotland) Act 2014

3.2. Requirements of Integration Authorities

- Define 2 or more localities.
- Ensure that localities are represented on the Strategic Planning group
- Involve and consult representatives of the locality where the integration authority is taking a decision which is likely to significantly affect service provision

3.3. Requirements of Localities

- Collaborative working using robust communication and engagement methods
- Supporting GPs to play a central role in providing coordinated care to local communities, working with the primary care, secondary/acute care, social care and the third/independent sector
- Community capacity building in order to forge connections

Locality Arrangements

3.4. 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.

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Localities Key Milestones

Date	Milestone
Pre-November 2017	Locality Engagement and formation of Locality Leadership Groups (LLGs). Health needs assessment per locality.
November 2017	All Heads of Locality in post. Draft locality plans written based on the public health and locality consultation.
December 2017	Draft locality plans submitted to and approved by the Integration Joint Board.
January 2018	Locality action plans are created.
February 2018	Terms of Reference for the LLGs are reviewed with LLG members.
March 2018	Localities 'Go Live' and consultation with staff. Plans to move to locality teams from April 2018.
April 2018	Plans to move to locality teams postponed to allow for reconsideration of the structure.
October 2018	Interim structure established. Heads of Locality assume different responsibilities, but remain as senior leadership team 'link' to LLGs
November 2018 onwards	Public consultation opens on "move from 4 to 3 localities".

Staff Consultation & Engagement

Action Plans Progressed

AUDIT & PERFORMANCE SYSTEMS COMMITTEE

3.5. While there has been a pause in the planned changes to organisational arrangements to align services across the localities, there has been a significant amount of work done in all 4 localities to build relationships across the LLGs and wider community networks and groups and we are beginning to see the benefits of this investment and some real traction in the actions being progressed within each of the locality plans.

3.6. The new Chief Officer implemented an interim leadership team due to vacancies in a number of posts at a senior level. This included a halt on the implementation of the previously agreed localities staffing structures whilst the leadership structure of the Partnership is reviewed. The Head of Operations is currently undertaking this review and it will include recommendations on how the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014 in regard to localities should be delivered in future.

3.7. Common achievements and barriers across all localities:

Achievements	**Barriers**
Creation and approval of the locality plans based upon local engagement events or surveys, consultation, and the available public health profile information.	Public Health data is available retrospectively Whilst the engagement process endeavoured to have a wide reach and reflect the views of the local population, the level of participation varied across different localities
Creation of locality action plans, with measurable outcomes.	Limitations of the available data and engagement with the local population at the time the initial plans were being developed
Establishment and development of Locality Leadership Groups. A diverse group of people coming together – some with very little prior knowledge of Health and Social Care – to take accountability of the delivery of the actions within the plan. Focus has been on relationship building and developing trust to underpin collaborative working	An element of confusion about the difference between HSCP Locality Leadership Groups and Aberdeen City Council Locality Partnerships. The difference in number and lack of configuration of plans. The exception to this being Torry, where the locality plans map across. In this case, to the exclusion of the rest of the South locality within the HSCP.
Further investigation of the evidence to identify particular opportunities for change for	Available data and capacity to support this engagement activity

example social isolation, access to support for unpaid carers.	
Establishment of sub groups to progress actions outwith the Locality Leadership Group Meetings	Capacity available to support local subgroups
All localities accessing training in Co production approach commissioned by IJB	Time to embed this approach to be at the stage genuinely co-producing solutions to shared challenges

3.8. Specific Examples of Progress

- Increased levels of unpaid carers accessing support – consultation with unpaid carers to determine why they currently do not access support.
- Better understanding of the health profile of each locality through further exploration of available data.
- Working in partnership with Aberdeen University to explore a means of improving the mental Health and Wellbeing of University students and subsequently reducing the demand for Primary Care interventions.
- Co – production approach – working with members of the community to establish a resource of "Falls Ambassadors", relaying key messages about preventing falls to their peers across the City. Working in conjunction with Robert Gordon's university students to create materials, including a video to promote key messages. Good example of work being carried out in one locality initially spreading across the whole city. South locality diabetes peer support project – Living Well With Diabetes.
- Establishing a West Wellbeing network which is exploring some of the key issues within the locality around social isolation and possible ways to build connections to mitigate some of these.
- Working with infrastructure colleagues to develop a model of delivery of Primary care e.g. across the North Corridor of the City, responding to public consultation within the design of the business case; exploring models of primary care for the new Countesswells development.
- Considering a means of improving access to care across an area of the City with a higher level of unmet need. Learning about locality level multi disciplinary working and the opportunities that shared systems offer to improving access to services.
- Locality asset mapping workshop to develop and share knowledge of what is available across the area to support health and wellbeing.

- West Locality community and staff engagement group established and have developed a framework and range of tools to support engagement work and developing a plan to promote key health and wellbeing activity across the year linked to the locality plan.
- Formed linkages with the Red Cross with regard to training and support of volunteers for our 'Alone Together' Co-production project to combat social isolation.
- Central Locality Carers and Health Equality sub group are looking at barriers to accessing services for carers e.g. language barriers, financial issues, knowledge and how easy it is/is not to access a GP.
- Coffee morning organised in St. Clements Episcopalian Church Mastrick to pull together the views of local people with regard to health & social care. A report is being compiled.

Rationale for Moving to Three Localities

The past year has offered an opportunity to explore the benefits of locality working within the Health and Social care partnership. It has also offered an opportunity to determine how locality working might be improved in the future in order to maximise the outcomes for the local population.

Three Locality Model

3.9. In a previous paper to its October meeting, the IJB agreed to Instruct the Chief Officer to review the locality structure and consult with relevant stakeholders and staff on the proposal to move from a four to a three-locality model and report back to the IJB on 26th of March 2019 with the results of this review and consultation along with the new Strategic Plan once finalised. Relevant stakeholders included staff, partner organisations, members of the locality leadership groups and public consultation sessions. Key findings included:

3.10. **More than half of those consulted said that moving to three localities is desirable.** 56% of people consulted 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).

3.11. **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.

3.12. Of those who felt a move to three localities would be helpful, the following reasons were given: better alignment; less confusion; more efficient working; and more effective change.

3.13. Of those who felt a move to three localities wouldn't be helpful, the following are reasons which were given: locality populations become too diverse; confusion of boundaries; loss of previous efforts; and impact on staff.

Next Steps

3.14. 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.

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

Further Information

3.16. Feedback and a presentation of the results of the public consultation are available on our website here: https://www.aberdeencityhscp.scot/our-delivery/locality-consultation/

4. Implications for IJB

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

4.2. Fairer Scotland Duty - there are no direct implications for the Fairer Scotland Duty arising from the recommendations of this report.

4.3. Financial–there are no direct financial implications arising from the recommendations of this report.

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4.4. Workforce–there are no direct workforce implications arising from the recommendations of this report

4.5. Legal - there are no direct workforce implications arising from the recommendations of this report.

4.6. Other - there are no other implications arising from the recommendations of this report.

5. Links to ACHSCP Strategic Plan

5.1. Localities underpin the majority of the components of the IJB Strategic Plan and will be reflected in the revised strategic plan due to be presented to the IJB in March 2019.

6. Management of Risk

6.1. **Identified risks(s)**There is a risk that the IJB does not maximise the opportunities offered by locality working.

6.2. **Link to risks on strategic or operational risk register:** Strategic Risk 8

6.3. **How might the content of this report impact or mitigate these risks:** This update on localities working and the process of consultation towards a move to three localities helps ensure the IJB & APS Committee are assured on progress.

INTEGRATION JOINT BOARD

Date of Meeting	Audit and Performance Committee (Jan)
Report Title	Progress Report – Aberdeen HSCP Strategic Commissioning Implementation Plan (2018)
Report Number	HSCP.18.124
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 Audit Performance Committee:

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. 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

3.2. 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.

3.3. (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.

3.4. 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

3.5. 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.

3.6. 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

3.7. **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. The current contract for Care at Home comes to an end in 2020 and work will start shortly on making preparations for a new contracts which reflects our ambitions.

3.8. **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.

3.9. **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, where there has been a provision of service to accommodate people with mental health as a ward in Cornhill closed.

3.10. **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.

3.11. **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.

3.12. **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

3.13. **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.

3.14. **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. We have plans 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. Key principles will underpin this relationship – outcomes focussed, person led care, incorporating technology as usual business, financially achievable and sustainable, collaborative working. We will also investigate a means of ensuring acceptance of learning for people in caring roles across different organisations.

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

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INTEGRATION JOINT BOARD

Date of Meeting	12.02.2019
Report Title	Ethical Care Charter
Report Number	HSCP.18.134
Lead Officer	Sandra Ross
Report Author Details	Claire Duncan Lead Social Work Officer claduncan@aberdeencity.gov.uk
Consultation Checklist Completed	Yes
Directions Required	No
Appendices	a) UNISONS Ethical Care Charter

1. Purpose of the Report

1.1. The purpose of this report is to update on the implementation of Unison's Ethical Care Charter.

1.2. The Charter was presented to the Integrated Joint Board and endorsed in July 2016. The recommendation to sign up to the principles of Charter was agreed at full council on 6 October 2016.

2. Recommendations

2.1. It is recommended that the Audit & Performance Systems Committee

a) Note the implementation of the Scottish Living Wage.

b) Note the progress across the stages of the Charter

c) Note that the Charter will be included in the workstream for Care at Home commissioning.

INTEGRATION JOINT BOARD

3. Summary of Key Information

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

3.2. In light of the findings, Unison produced their Ethical Care Charter and called for councils to commit to becoming Ethical Care Charter Councils by commissioning homecare services which adhere to the Charter. The Charter has 3 stages (see appendix for details) and although both the IJB and the Council agreed to the principles of the Charter, the impact of implementing all of the stages was to be considered.

3.3. A short life working group was established to consider all three stages of the Charter and to scope which principles were already adhered to and which would require to be considered further. It was also recognised that some would have cost implications for the Partnership.

3.4. The Partnership commissions 80% of its care at home services externally, with the remaining 20% delivered through Bon Accord Care. A revision of the service specification for care at home was undertaken and new contracts were put in place from January 2018. There was a Care at Home commissioning workstream that was working to influence future commissioning arrangements beyond 2020. This work will now be overseen by the lead for commissioning. The principles of the Charter are firmly embedded in our commissioning intentions.

3.5. Part of the work undertaken to date has been to consult with providers to establish which principles are currently not being met. The first stage was to send questionnaires to all providers asking for information on key aspects of their terms and conditions. Only five were returned out of a possible 17 care at home providers and these were largely from providers that already adhered to the key principles. The next stage was to attend the Provider Forum to present and discuss the Charter. As predicted there were some difficult discussions around key aspects and the financial implications this would have for providers. The message clearly from providers was that to implement the charter fully would have significant cost implications for the Partnership.

3.6. Key elements of the Charter which remain to be inconsistently applied across our provider framework are:

- Homecare workers will be paid for their travel time, their travel costs and other necessary expenses such as mobile phones (*Initial scoping has determined that a large majority are already paid travel time, and mileage between visits but most wouldn't pay bus travel and parking fees. Ensuring that all are also paid travel time will potentially have financial implications for future*

- Zero-hour contracts will not be used in place of permanent contracts (*Scoping has determined that some providers continue to use zero hours contracts. The position of providers is that they are not in a position to offer staff permanent contracts as cannot guarantee the hours and that some staff prefer it this way. We would be unable to make this a condition of the contract that Providers should not use zero hours contracts as this would be illegal. Even if it were a condition some providers may not agree or comply.)*

- All homecare workers will be regularly trained to the necessary standard to provide a good service at no cost to themselves and in work time *(This is varied across providers. Some start the training as part of a paid induction, some are not paid but receive the payment after 3 months employment and some not at all.* Imposing this *may have potential financial implications to the Partnership)*

- All home care workers will be covered by an occupational sick pay scheme to ensure staff do not feel pressurised to work when they are ill in order to protect the welfare of vulnerable clients *(It would appear that the majority of Providers do not provide occupational sick pay to staff. Few Providers have this in place after a standard term of employment. Providers at the forum were adamant that this was something they would not want to introduce as felt this would encourage sick leave. It is viewed that making this a condition of contract would have significant financial implications for the Partnership)*

3.7. Scottish Living Wage (SLW)

The Scottish Government made a commitment in February 2016 that front line workers employed in adult social care services should be paid the Scottish Living Wage. The SLW was originally set at £8.25 per hour, rising to £8.45 and subsequently £8.75. It rises again to £9.00 per hour

in 2019/20. The Scottish Government's commitment was supported by additional funding and has led to sums of public money being transferred to external providers through re-negotiation of contract prices, fees (including fees agreed under the National Care Home Contract) and hourly rates paid for service delivery.

Aberdeen City allocated a 6.4% increase in rates in October 2016 followed by a further 2.8% in April 2017 to allow commissioned providers to pay their staff the Scottish Living Wage. For the 2018/19 allocation, the Partnership agreed a process of negotiation with Providers on what they required rather than a straight uplift as it was viewed that they are now in a stronger position to implement the uplifts with minimal additional funding. It is proposed to repeat this approach for the 2019/20 uplift.

We cannot mandate the rate that employers pay their employees within contracts however there is reference to Fairer Working Practices (which includes payment of the SLW) under community benefits and it is part of the assessment for contract award. Following the allocation of additional funding to providers to pay the SLW, they are asked to confirm on a Contract Rates Response Form that the SLW is being paid and for 2018 97.5% of providers confirmed they were.

4. Implications for IJB

4.1. **Equalities:** Implementation of the recommendations will improve working conditions and have a positive impact on the external workforce who provide our services. The recommendations are also expected to have positive implications in relation to our service users across the Partnership as required services will be more readily available, more consistent, more sustainable and of a higher quality. The majority of the workforce is also female so this will have greater impact on them rather than males.

4.2. **Fairer Scotland Duty:** The Scottish Government believes that employers whose staff are treated fairly, who are well-rewarded, well-motivated, well-led, have access to appropriate opportunities for training and skills development, and who are a diverse workforce are likely to deliver a higher quality of service. Good relationships between employers and their workforce contribute to productivity and ultimately sustainable economic growth. It is therefore vital that we promote fair working practices through procurement activity to help drive an equal society. Part of the fair working practices includes the Scottish Living Wage which is a positive step towards

achieving a fair and sustainable market in Aberdeen. The allocation of recent funding for providers to pay the Scottish Living Wage is a positive step towards achieving a sustainable care market in Aberdeen and assist with socio economic growth.

4.3. **Financial:** Some elements of the Charter will undoubtedly require consideration of the existing funding conditions and will require a review of existing contracts. The significant risk is that the Health and Social Care Partnership will be asked to financially support the full extent of changes required for the Charter which would have a considerable impact on existing funding levels. In addition, new increased hourly rates will mean that delivering the same volume of activity will cost more but it is also envisaged that a more coherent framework will address the significant amount of unmet care need.

4.4. **Workforce:** The care at home sector has significant recruitment and retention challenges. Payment of the Scottish Living Wage to staff will help address some of this as will the retendering exercise that aims to make the market more sustainable. There will be no workforce implications for the Partnership.

4.5. **Legal:** The National Living Wage is set by statute, but employers can choose to pay the SLW. As an authority we cannot mandate the living wage however it is an expectation that we encourage providers to pay the SLW through our procurement processes.

5. Links to ACHSCP Strategic Plan

The current ACHSCP Strategic Plan outlines the responsibility of the IJB in relation to strategic commissioning of how care is delivered. If the IJB is to be successful in increasing market facilitation for care at home services, then a co-ordinated approach with providers to meet demand will be required.

6. Management of Risk

6.1. Identified risks(s)

Although there is an expectation we will encourage providers to pay the Scottish Living Wage from the funding settlement with the Scottish Government, as

advised we have no obligation to do this. The risk of not encouraging payment of the SLW is financial as it could jeopardise future funding settlements. There is a risk that commissioned services do not pass on the SLW to their workforce. The remaining principles of the Ethical Care Charter may also not be implemented by providers due to the perceived cost implications to them. If the Partnership cannot negotiate all the terms of the Charter within future commissioning arrangements it is doubtful all providers will adhere without an increased funding arrangement.

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

Strategic Risk 1 – risk of market failure.

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

Aberdeen Health and Social Care Partnership is heavily reliant on externally commissioned services. By supporting the improvement of working conditions of care staff there is a greater chance that the market will be more sustainable and that the quality of care will be improved. By taking action to pass on the required resource and ensuring providers sign up in principle to pass the SLW to their workforce this risk is mitigated.

AUDIT & PERFORMANCE SYSTEMS COMMITTEE

Date of Meeting	12th of February 2019
Report Title	Finance Update as at end December 2018
Report Number	HSCP.18.138
Lead Officer	Alex Stephen, Chief Finance Officer
Report Author Details	Gillian Parkin (Finance Manager) Lesley Fullerton (Finance Operations Manager)
Consultation Checklist Completed	Yes
Directions Required	No
Appendices	a) Finance Update as at end December 2018, b) Summary of risks and mitigating action, c) Sources of Transformational Funding d) Progress in implementation of savings - December 2018 e) Virements

1. Purpose of the Report

a) To summarise the current year revenue budget performance for the services within the remit of the Integration Joint Board as at Period 9 (end of December 2018);

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

c) To note the budget virements so that budgets are more closely aligned to anticipated income and expenditure (see Appendix E).

AUDIT & PERFORMANCE SYSTEMS COMMITTEE

2. Recommendations

2.1. It is recommended that the Audit & Performance Systems Committee:

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

b) Notes the budget virements indicated in Appendix E.

3. Summary of Key Information

Reported position for period to end December 2018

3.1. An adverse position of £217,000 is reported for the nine-month period to the end of December 2018 as shown in Appendix A. A forecasted year-end position has been prepared based on month 9 results. This has resulted in a projected overspend of £842,000 (£633,000 in September 2018) on mainstream budgets. The main areas of overspend are Learning disabilities, Aberdeen City share of hosted services (health), Mental Health and Addiction, and Out of Area Treatments.

3.2. At the last IJB meeting it was noted that a transfer from reserves would be required should it not be possible to reduce the overspend on mainstream budgets and in order to fund the spend forecast on the integration and change projects. The position is tracked below.

	01/04/18 £'000	**30/06/18 £'000**	**30/12/19 £'000**
Risk fund	2,500	2,500	2,500
Primary Care Reserve (previous unspent funding)	1,990	1,491	1,491
Integration and Change Funding	3,817	1,305	1,152
	8,307	**5,296**	**5,143**

The position highlighted above closely aligns with the Medium-Term Financial Strategy, where it was intended the level of reserves would be reduced in 2018/19 to fund the transformation programme. An analysis of variances is detailed below:

Community Health Services (Year to date variance - £454,000 underspend)

Major Movements:

(£58,682)	Across non-pay budgets
£215,283	Under recovery on income
(£610,527)	Staff Costs

Within this expenditure category there is an underspend on staff costs mainly relating to inability to recruit within dental services and ongoing management vacancies. This is currently being offset with an under recovery of income within the public dental service due to the partnership employing less dentists and also a reduction in staff car lease income as there is a reduced number of staff who have leased cars

Hosted Services (Year to date variance £391,606 overspend)

The main areas of overspend are as follows:

Intermediate Care: £103,009 relates to medical locum costs as a result of the requirement to provide consultant cover at night within Intermediate Care and higher than anticipated expenditure on the Wheelchair Service due to an increase in demand for this service.

Police Forensic Service: £132,658 overspend as there has been a legacy under funding issue with this budget. However, it has been assumed this overspend will be covered from a budget transfer from NHS Grampian.

Grampian Medical Emergency Department (GMED): £227,235 relates mainly to pay costs and the move to provide a safer more reliable service which has been a greater uptake of shifts across the service. Non-pay overspend due to repair costs not covered by insurance, increased costs on software and hardware support costs, increased usage of medical surgical supplies and an increase in drug costs. Additional funding has been received from the Scottish Government for out of hours and this has been allocated against this budget.

Hosted services are led by one IJB, however, the costs are split according to the projected usage of the service across the three IJBs. Decisions required to bring

this budget back into balance may need to be discussed with the three IJBs, due to the impact on service delivery.

Learning Disabilities (Year to date variance - £1,009,000 overspend)

Major Movements:

£1,300,000	Overspend of commissioned services
£400,000	Under-recovery customer and client receipts
£1,000,000	Adverse movement needs led homecare
(£300,000)	Favourable movement carers support
(£200,000)	Under spend on transfer payments
(£330,000)	Favourable movement needs led day care

Mainly due to overspend of commissioned services of £1,300,000. Under recovery of client contributions £400,000. Adverse movement in needs led homecare £1,000,000. Favourable movement in carers support £300,000. An underspend on transfer payments of £200,000 and needs led day care of £330,000. This budget projection has been updated as a result of the recent zero based budgeting exercise, the reason for the adverse movements being increasing demand and the complexity of clients' disabilities requiring support.

Mental Health & Addictions (Year to date variance - £634,000 overspend).

Major Movements:

£560,000	Needs led residential care overspent
£110,000	Homecare overspent

The overspend on commissioned services is mainly due to increased expenditure on residential services partly offset by increased client contribution.

Older People & Physical and Sensory Disabilities (Year to date variance - £450,000 underspend)

Major Movements:

(£186,000)	Over recovery of client contributions and board charges
(£286,000)	Favourable movement in Physical Disability Residential

Client contribution budgets remain closely monitored throughout the remainder of the financial year.

Directorate (£572,000 underspend)

(£220,000)	Staffing savings
(£100,000)	Over recovery of charging policy
(£180,000)	Decreased expenditure on commissioned services

The underspend on commissioned services is mainly on a provision set aside for increased funding for sleepovers which is now included in the relevant section.

Primary Care Prescribing (Year to date variance – £224,119 underspend)

As actual information is received two months in arrears from the Information Services Division, this position is based on actuals to October 2018 with an estimation of spend for November and December. At present it appears the budgeted level of spend will be close to the forecast at the end of the financial year, however, as has been shown previously spend on this budget line can move by material amounts between the months based on factors largely out with the control of the IJB.

Primary Care Services (Year to date variance - £80,245 overspend)

The position within Primary Care Services represents the impact of the revision of the Global Sum (based on practice registered patient numbers) payments for 2018/19 including protected element now being paid assumed to be offset by revised allocation yet to be received from Scottish Government as part of the new GMS contract.

The premises position continues with an overspend which will include any rental increases impacting on 2018/19 confirmed as a result of rent reviews. The

forecast to the end of the financial year is breakeven as it should be possible to reduce this overspend over the next few months.

Out of Area Treatments (Year to date variance - £14,000 overspend)

The main change this month is to include potential charges for keeping a space for a patient who has moved to a lower level of service provision and where the move was conditional on retaining this original bed. This situation is being investigated to determine whether it is compliant with the contract conditions. The overall forecast outturn is now showing as £183,000 overspend (of which £160,000 is attributable to this dispute).

Learning Disabilities

The learning disability budget is experiencing demand pressures, due to an increase in the number of clients requiring support with complex needs. Providers are seeking to pass these costs through to the IJB and given the lack of capacity in the system providers' rates are rising higher than had been anticipated. Also, a number of these clients require to be sent out of area due to the lack of capacity in the system locally. In Aberdeen City reviews are undertaken frequently of clients who are being cared for out of area. In terms of the review across Grampian and looking at commissioning the development of a new service locally, NHS Grampian are in the process of recruiting to a position which will take his work forward.

4. Implications for IJB

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

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

4.1. Equalities – none identified.

4.2. Fairer Scotland Duty – none identified.

4.3. Financial – contained throughout the report.

4.4. Workforce – none identified.

4.5. Legal – none identified.

4.6. Other.

5. Links to ACHSCP Strategic Plan

5.1. A balanced budget and the medium financial strategy are a key component of delivery of the strategic plan and the ambitions included in this document.

6. Management of Risk

6.1. Identified risks(s)

See directly below.

6.2. Link to risks on strategic or operational risk register: Strategic Risk #2

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

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

Good quality financial monitoring will help budget holders manage their budgets. By having timely and reliable budget monitoring any issues are identified quickly, allowing mitigating actions to be implemented where possible.

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

Appendix A: Finance Update as at end December 2018

Accounting Period 9	Full Year Revised Budget £'000	Period Budget £'000	Period Actual £'000	Period Variance £'000	Variance Percent %	Year end Forecast Month 9 £'000
Community Health Services	32,840	24,234	23,780	(454)	-1.9	(700)
Aberdeen City share of Hosted Services (health)	21,699	16,263	16,655	392	2.4	358
Learning Disabilities	31,739	23,806	24,815	1,009	4.2	1,279
Mental Health and Addictions	19,834	14,878	15,512	634	4.3	557
Older People & Physical and Sensory Disabilities	74,485	55,864	55,414	(450)	-0.8	(298)
Directorate	343	254	(319)	(572)	-225.6	(326)
Criminal Justice	93	74	69	(5)	-6.8	(22)
Housing	1,861	1,395	1,189	(207)	-14.8	0
Primary Care Prescribing	40,712	30,606	30,382	(224)	-0.7	(309)
Primary Care	38,578	28,989	29,069	80	0.3	121
Out of Area Treatments	1,517	1,137	1,151	14	1.2	183
Set Aside Budget	40,509	30,382	30,382	0	0.0	0
Integration and Change (Transformation)	4,296	2,960	2,960	0	0.0	2,322
Approved transfers from reserves						(3,164)
Reported position excl reserves	**308,505**	**230,843**	**231,059**	**217**		**0**

Appendix B: Summary of risks and mitigating action

	Risks	Mitigating Actions
Community Health Services	• Balanced financial position is dependent on vacancy levels.	• Monitor levels of staffing in post compared to full budget establishment. • A vacancy management process has been created which will highlight recurring staffing issues to senior staff.
Hosted Services	• There is the potential of increased activity in the activity-led Forensic Service. • There is the risk of high levels of use of expensive locums for intermediate care, which can put pressure on hosted service budgets.	• Work is being undertaken at a senior level to consider future service provision and how the costs of this can be minimised. • Substantive posts have recently been advertised which might reduce some of this additional spend.
Learning Disabilities	There is a risk of fluctuations in the learning disabilities budget as a result of: • expensive support packages may be implemented. • Any increase in provider rates for specialist services.	• Review packages to consider whether they are still meeting the needs of the clients. • All learning disability packages are going for peer review at the weekly resource allocation panel

NHS Grampian

	Risks	Mitigating Actions
	• Any change in vacancy levels (as the current underspend is dependent on these). • Dilapidation in properties that may need investment to restore. (2019/20)	
Mental Health and Addictions	• Increase in activity in needs led service. • Potential complex needs packages being discharged from hospital. • Increase in consultant vacancies resulting in inability to recruit which would increase the locum usage. Average consultant costs £12,000 per month average locum £30,000 per month.	• Work has been undertaken to review levels through using Carefirst. • Review potential delayed discharge complex needs and develop tailored services. • A review of locum spend has highlighted issues with process and been addressed, which has resulted in a much improved projected outturn.
Older people services incl. physical disability	• There is a risk that staffing levels change which would have an impact on the balanced financial position.	• Monitor levels of staffing in post compared to full budget establishment. • A vacancy management process has been created which will highlight recurring staffing issues to senior staff. • Review packages to consider whether they are still meeting the needs of the clients.

	Risks	Mitigating Actions
	• There is the risk of an increase in activity in needs led service, which would also impact the financial position.	• An audit of Carefirst residential packages established that £500,000 of packages should be closed. These findings were combined with a review of previous years accruals to determine how much the residential care spend should be reduced which also resulted in a favourable reduction in projected spend
Prescribing	• There is a risk of increased prescribing costs as this budget is impacted by • volume and price factors, such as the increase in drug prices due to short supply. As both of which are forecast on basis of available date and evidence at start of each year by the Grampian Medicines Management Group	• Monitoring of price and volume variances from forecast. • Review of prescribing patterns across General Practices and follow up on outliers. • Implementation of support tools – Scriptswitch, Scottish Therapeutic Utility. • Poly pharmacy and repeat prescription reviews to reduce wastage and monitor patient outcomes.
Out of Area Treatments	• There is a risk of an increase in number of Aberdeen City patients requiring complex care from providers located outwith the Grampian Area, which would impact this budget.	• Review process for approving this spend.

Appendix C: Sources of Transformational Funding	2018/19 £m	2017/18 c/fwd £m	Total £m
Integrated Care Fund	3.75	1.59	5.34
Delayed Discharge Fund	1.13	1.10	2.22
Mental Health Access		0.18	0.18
Mental Health Fund		0.28	0.28
Primary Care Pharmacy	0.30	0.39	0.69
Social Care Transformation Funding	13.36	3.13	16.49
Primary Care Transformation		0.30	0.30
Primary Care Improvement Fund	1.30		1.30
Action 15 Mental Health Strategy	0.43		0.43
OOH GMED funding	0.20		0.20
Transforming Urgent Care		0.54	0.54
Keep Well/Public Health		0.16	0.16
Carers Information Strategy		0.16	0.16
Mental Health Innovation		0.02	0.02
6EA Unscheduled Care		0.11	0.11
Winter funding		0.26	0.26
Health Visiting funding	0.09	0.09	0.19
ADP	0.67		0.67
6EA Unscheduled Care	0.04		0.04
Winter funding	0.19		0.19
Veterans Funding	0.18		0.18
	21.63	8.31	29.94
Adjust for social care and Health budget transfer	-17.14		-17.14
Adjust for GMED OOH Funding	-0.20		-0.20
Funding available for IJB commitment	4.29	8.31	12.60
Take off c/forward reserve			-8.31
REPORTED FULL YEAR BUDGET			**4.29**

Appendix D: Progress in implementation of savings – December 2018

Area	Agreed Target	Status	Responsible Officer
Review processes and ensure these are streamlined and efficient	(250)		M. Allan

- **Financial Processes** -Continuing to investigate the use of portal allowing the upload of required documents electronically (by staff or supported individuals) – now paused pending decisions around the future of Care First (or upgrade to Eclipse) or move to another supplier will impact on this. Information Leaflet is in final draft, awaiting printing
- **Pre-paid cards** – Small working group nearing completion of procurement pack. Aberdeen City Council IT Team have reviewed technical specification of identified preferred provider to ensure fit with current systems prior to moving forward with direct award under Surrey Framework. Initial screening completed and currently exploring Data Protection Impact of introduction of card. Data Protection Impact Assessment has been drafted and officers are liaising with Information Governance in Aberdeen City Council to finalise.
- Communications for staff and service users has been drafted based on similar work in other Local Authority areas, final wording awaiting elements to be taken from procurement pack. Awaiting agreement of competition dates to commence recruitment of Finance Officer role to support implementation of cards. Asked to consider individuals placed on ACC redeployment register in first instance (which may shorten recruitment timelines) – HR have identified individuals – this has been paused for now – awaiting appointment of card provider prior to appointment of finance officer role.

Area	Agreed Target	Status	Responsible Officer
Review of out of hours services	(400)		A Macleod

- At an initial meeting of the Shortlife Working Group it was agreed to split the work into two areas. The first was to review Sleepovers. Once this was completed we would have a clearer understanding of the requirements for the Responder Service and work on that could then begin. The review would need to begin asap. A saving target of £400,000 has been allocated for financial year 2018/19 and whilst some alternative arrangements have already been identified as part of the transfer of service provision at Donald Dewar Court further work needs to be undertaken as soon as possible.

Area	Agreed Target	Status	Responsible Officer
Review of Out of Area Commissioning	(250)		A Stephen

- **Workstream 1 - Streamlining of Processes and procedures for OOA Placements** *(updating of forms/guidance/flowcharts of processes*). The group have now met on 4 occasions with guidance flowcharts in final form. The group now have a clear spreadsheet of all out of area placements and associated costs. Review positions are now being sought for all Health Out of Area placements on a quarterly basis.
- **Workstream 2 - Learning Disabilities Cohort** – (*To check current information is correct; to benchmark with other models/areas; and review current placements and merging and existing local complex care packages with consideration of potential local alternatives)*. Identified and profiled all existing out of area placements and current /emerging locally delivered complex/intensive care packages. Aberdeenshire colleagues have undertaken same exercise. Now preparing case pen pictures with a view to determining potential cohorts of clients/needs.
- **Workstream 3 – Alcohol, Detox & Chronic/Long Term Alcoholism** – *to check current information is correct, to benchmark with other models/areas; and consider potential local alternatives*. This workstream group met in early June to review information around in-patient detox services. Group to undertake a case review of the last 10 admissions to identify whether their needs could be met elsewhere. Group reviewing Service Agreement arrangement and reporting outcomes.

Area	Agreed Target	Status	Responsible Officer
Medicines Management	(200)		A Stephen

- Community Pharmacy operationalising (Grampian Primary Care Prescribing Group) GPCPG report recommendations.
- Work commenced on tracking and reporting on impact of GPCPG recommendations.
- Development of an Oral Nutrition Supplements Business Case, which is projected to deliver savings and constrain future demand.
- Budget currently forecasting to underspend

Appendix D: Budget Reconciliation

	£	£
ACC per full council:		£86,855,213
NHS per letter from Director of Finance:		
Budget NHS per letter		£215,579,519
		£302,434,732
New Monies Received to Period 3:		
Scottish Government	£1,524,383	
NHS Adjustments	£832,722	£2,357,105
Reserves:		
Carry Forward Brought Down NHS	£1,229,063	
Carry Forward still to be brought down NHS	£3,952,649	
Carry Forward brought down ACC	£3,130,000	£8,306,965
		£313,098,802
Funding Assumptions:		
Less: Reserves		-£8,306,965
New Funding PCIP\Action 15 = 30%		£579,000
		£305,370,837
New Monies Received to Period 6		**£1,329,161**
Reported at month 6		**£306,699,998**

Additional allocations received during quarter 3 (as per Appendix E)

Item	Amount
FHHC Running Costs	£59,000
FHHC Unitary Charge	£548,428
Energy Budgets Uplift	£43,955
Physio Funding Acute to City	£9,721
Orthopaedic Project	£23,655
Shingles	£1,166
Rotavirus	£5,025
Men B	£17,250
Major Trauma	£10,221
AWM City Dietetics	£39,778
AFC Pay Award	£2,579
HNC Hosted Recharge	£2,784
NES Income Uplift Recharge	£-20,371
Plasma Products	£423
Hosted Budget Recharge	£75,105
Waiting Times	£181
N Care Allocation 1819	£1,366,390
Action 15 Balance of Funding	£129,000
Additional PCIP	£252,750
Total	**£2,567,040**

Less adjustment for pcip/action 15 allocation received above	£-762,879
Reported at Month 9	**£308,504,738**

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Appendix E: Virements

Health 7-9	£
FHHC Running Costs	59,000
FHHC Unitary Charge	548,428
Energy Budgets Uplift	43,955
Physio Funding Acute to City	9,721
ORTHOPAEDIC PROJECT	23,655
Shingles	1,166
Rotavirus	5,025
Men B	17,250
Major Trauma	10,221
AWM City Dietetics	39,778
AFC Pay Award	2,579
HNC Hosted Rech	2,784
NES Income Uplift Rech	-20,371
Plasma Products	423
Hosted Budget Recharge	75,105
Waiting Times	181
N Care Alloc 1819	1,366,390
Action 15 Balance of Funding	129,000
Additional PCIP	252,750
Total Virements	2,567,040

Social Care 7-9- to align budgets to spend	£
Adult Svcs Op & Physical Dis (Commissioning Services)	802,150
Adult Svcs Op & Physical Dis (Premises Costs)	-6,600
Adult Svcs Op & Physical Dis (Transfer Payments)	0
Adult Svcs Op & Physical Dis (Transport Costs)	6,600
Transformation Fund (Commissioning Services)	-40,000
Transformation Fund (Income)	-107,966
Transformation Fund (Staff Costs)	-274,184
Transformation Fund (Supplies & Services)	-380,000
Total Virements	0

NHS Grampian

Aberdeen City Health & Social Care Partnership
A caring partnership

AUDIT & PERFORMANCE SYSTEMS COMMITTEE

Date of Meeting	12.02.2019
Report Title	External Audit Strategy
Report Number	HSCP.18.136
Lead Officer	Andy Shaw, Director (Assurance, KPMG)
Report Author Details	Andy Shaw, Director (Assurance, KPMG)
Consultation Checklist Completed	*Yes*
Appendices	a) External Audit Strategy

1. Purpose of the Report

1.1. This report presents the draft external audit strategy to the Audit & Performance Systems committee for its consideration.

2. Recommendations

2.1. It is recommended that the Audit & Performance Systems Committee:

a) Approves the approach to external audit, as outlined in Appendix A.

3. Summary of Key Information

3.1. 2018-19 is the third year of KPMG's external audit appointment to Aberdeen City Integration Joint Board having been appointed by the Accounts Commission as auditor of the Board under the Local Government (Scotland) Act 1973.

3.2. The draft external audit strategy is attached in Appendix A and outlines KPMG's responsibilities as external auditor for the year ending 31 March 2019 and their intended approach to issues impacting on the Partnership's activities in the year.

AUDIT & PERFORMANCE SYSTEMS COMMITTEE

4. Implications for IJB

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

4.2. Fairer Scotland Duty - there are no direct implications for the Fairer Scotland Duty arising from the recommendations of this report.

4.3. Financial – as outlined in appendix A

4.4. Workforce – there are no direct workforce implications arising from the recommendations of this report.

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

4.6. Other - there are no other implications arising from the recommendations of this report.

5. Links to ACHSCP Strategic Plan

5.1. NA

6. Management of Risk

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

6.2. **Link to risks on strategic or operational risk register:** Strategic Risk 2

6.3. **How might the content of this report impact or mitigate these risks:** The approach to external audit as outlined in Appendix A will help mitigate this risk as it outlines work that KPMG will undertake on behalf of ACHSCP to ensure financial statements give a true and fair view and are prepared in accordance with relevant accounting standards and legislation. They will also review the governance statement and arrangements for preparing and publishing statutory performance information.

Aberdeen City Integration Joint Board

Audit strategy

Year ending 31 March 2019

23 January 2019

For Audit and Performance Systems Committee consideration on 12 February 2019

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About this report

This report has been prepared in accordance with the responsibilities set out within the Audit Scotland's *Code of Audit Practice* ("the *Code*").

This report is for the benefit of Aberdeen City Integration Joint Board and is made available to Audit Scotland and the Controller of Audit (together "the Beneficiaries"). This report has not been designed to be of benefit to anyone except the Beneficiaries. In preparing this report we have not taken into account the interests, needs or circumstances of anyone apart from the Beneficiaries, even though we may have been aware that others might read this report. We have prepared this report for the benefit of the Beneficiaries alone.

Nothing in this report constitutes an opinion on a valuation or legal advice.

We have not verified the reliability or accuracy of any information obtained in the course of our work, other than in the limited circumstances set out in the scoping and purpose section of this report.

This report is not suitable to be relied on by any party wishing to acquire rights against KPMG LLP (other than the Beneficiaries) for any purpose or in any context. Any party other than the Beneficiaries that obtains access to this report or a copy (under the Freedom of Information Act 2000, the Freedom of Information (Scotland) Act 2002, through a Beneficiary's Publication Scheme or otherwise) and chooses to rely on this report (or any part of it) does so at its own risk. To the fullest extent permitted by law, KPMG LLP does not assume any responsibility and will not accept any liability in respect of this report to any party other than the Beneficiaries.

Complaints

If at any time you would like to discuss with us how our services can be improved or if you have a complaint about them, you are invited to contact Andy Shaw, who is the engagement leader for our services to Aberdeen City Integration Joint Board, telephone 0131 527 6673 email: andrew.shaw@kpmg.co.uk who will try to resolve your complaint. If your problem is not resolved, you should contact Hugh Harvie, our Head of Audit in Scotland, either by writing to him at Saltire Court, 20 Castle Terrace, Edinburgh, EH1 2EG or by telephoning 0131 527 6682 or email to hugh.harvie@kpmg.co.uk. We will investigate any complaint promptly and do what we can to resolve the difficulties. After this, if you are still dissatisfied with how your complaint has been handled you can refer the matter to Fiona Kordiak, Audit Scotland, 4th Floor, 102 West Port, Edinburgh, EH3 9DN.

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Introduction

2018-19 is the third year of our external audit appointment to Aberdeen City Integration Joint Board (''the Board''), having been appointed by the Accounts Commission as auditor of the Board under the Local Government (Scotland) Act 1973 ("the Act"). The period of appointment is 2016-17 to 2020-21, inclusive.

Our planned work in 2018-19 will include:

— an audit of the financial statements and provision of an opinion on whether the financial statements:

- give a true and fair view in accordance with the applicable law and the Code of Practice on Local Authority Accounting in the United Kingdom ("the 2018-19 Code") of the state of the affairs of the Board as at 31 March 2019 and of the income and expenditure of the Board for the year then ended; and
- have been prepared in accordance with IFRS as adopted by the European Union, as interpreted and adapted by the 2018-19 Code, the requirements of the Local Government (Scotland) Act 1973, The Local Authority Accounts (Scotland) Regulations 2014 and the Local Government in Scotland Act 2003.

— completion of returns to Audit Scotland;

— a review and assessment of the Board's governance arrangements and review of the governance statement;

— a review of arrangements for preparing and publishing statutory performance information; and

— contributing to the audit of wider scope and Best Value through performance of risk assessed work.

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Adding value

Throughout the audit, we will consider opportunities to add value and will conclude on this in our annual audit report. We add value through:

— our experience, which brings insight and challenge;

— our tools and approach, which contribute to audit quality; and

— transparency and efficiency, which improves value for money.

Our team

The senior team involved in the external audit benefits from continuity in the engagement leader. The team has significant experience in the audit of local authorities and integration joint boards. It is supported by specialists, all of whom work with a variety of local government and public sector bodies. All members of the team are part of our wider local government and health network. Contact details for senior members of the audit team are provided on the back page of this report.

Our work will be completed in three phases from January 2019 to September 2019. Our key deliverables are this audit strategy document, an International Standards on Auditing (UK) ("ISA") 260 *Communication of audit matters with those charged with governance* report and an annual audit report.

Acknowledgements

We would like to take this opportunity to thank officers and members for their continuing help and co-operation throughout our audit work.

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Headlines

Materiality

Materiality for planning purposes has been based on 2017-18 gross expenditure and set at £3.1 million (1% of gross expenditure).

In line with the Code of Audit Practice, we are obliged to report uncorrected omissions or misstatements other than those which are 'clearly trivial' to those charged with governance and this threshold has been set at £0.155 million.

Page six

Audit risks

We have identified management override of controls as a default fraud risk which requires specific audit attention, in line with the International Standards on Auditing.

The risks with less likelihood of giving rise to a material error, but which are nevertheless worthy of audit understanding, relate to:

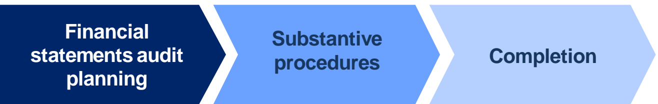
- completeness and accuracy of expenditure; and
- financial sustainability.

We will report on each of these areas in our ISA 260 report which we plan to issue in September 2019.

Pages seven and eight

Financial statement audit

Our financial statements audit work follows a three stage audit process which is identified below. Appendix three provides more detail on the activities that this includes. This report concentrates on the audit planning stage of the financial statements audit.



There are no significant changes to the 2018-19 Code, which means for this year there is consistency in terms of accounting standards the Board needs to apply.

Wider scope

Auditors are required to assess and provide conclusions in the annual audit report in respect of four wider scope dimensions:

- financial sustainability;
- financial management;
- governance and transparency; and
- value for money.

We test wider scope areas where there are identified risks. We consider that there are wider scope risks in respect of demand pressures and the transformation programme. We have identified financial sustainability as a wider scope financial statement level focus area as set out opposite.

In addition, due to ongoing uncertainty related to EU withdrawal, we will consider Brexit as part of our risk assessment procedures and wider scope responsibilities

Pages 10 to 15

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Headlines (continued)

Independence

In accordance with ISA 260 and the APB Ethical Standards, we are required to communicate to you all relationships between KPMG and the Board that may be reasonably thought to have bearing on our independence both:

— at the planning stage; and

— whenever significant judgements are made about threats to objectivity and independence and the appropriateness of safeguards put in place.

Appendix two contains our confirmation of independence and any other matters relevant to our independence.

Total fees charged by us for the period ended 31 March 2018 were communicated in our Annual Audit Report issued in September 2018. Total fees for 2018-19 will be presented in our ISA 260 report issued on completion of the audit. The proposed audit fee for 2018-19 is £29,400 as set out below:

Total fee	Pooled costs	Contribution to PABV (Audit Scotland)	Contribution to Audit Scotland	Auditor remuneration (including VAT)
£29,400	£1,670	£5,050	£1,080	£21,600

Quality

International Standard on Quality Control (UK and Ireland) 1 ("ISQC1") requires that a system of quality control is established, as part of financial audit procedures, to provide reasonable assurance that professional standards and regulatory and legal requirements are being complied with and that the independent auditor's report or opinion is appropriate in the circumstances.

Our Audit Quality Framework and KPMG Audit Manual comply with ISQC1. Our UK Senior Partner has ultimate responsibility for quality control. Operational responsibility is delegated to our Head of Quality & Risk who sets overall risk management and quality control policies. These are cascaded through our Head of Audit in Scotland and ultimately to Andy Shaw as the Director leading delivery of services to the Board.

The nature of our services is such that we are subject to internal and external quality reviews. KPMG's annual financial statements include our transparency report which summarises the results of various quality reviews conducted over the course of each year.

We also provide Audit Scotland with details of how we comply with ISQC1 and an annual summary of our achievement of KPIs and quality results.

We welcome your comments or feedback related to this strategy and our service overall.

Regularity

We consider the risk of fraud and error over income and expenditure recognition, in line with *Practice Note 10 Audit of financial statements of public sector bodies in the United Kingdom.* As the Board is a net spending body, we consider it appropriate to extend our consideration to cover expenditure as well as income. We do not consider there to be a significant risk over income or expenditure, see page seven. We have identified the completeness and accuracy of expenditure as an other focus area, see page eight.

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Financial statements audit planning

Materiality

We are required to plan our audit to determine with reasonable confidence whether or not the financial statements are free from material misstatement. An omission or misstatement is regarded as material if it would reasonably influence the user of financial statements. This therefore involves an assessment of the qualitative and quantitative nature of omissions and misstatements.

Generally, we would not consider differences in opinion in respect of areas of judgement to represent 'misstatements' unless the application of that judgement results in a financial amount falling outside of a range which we consider to be acceptable.

Materiality for planning purposes has been set at £3.1 million, which equates to 1% of 2017-18 gross expenditure. Materiality will be revised once draft financial statements for 2018-19 are received.

We design our procedures to detect errors in specific accounts at a lower level of precision, being £2.3 million (75% materiality).

Reporting to the Audit and Performance Systems committee

Whilst our audit procedures are designed to identify misstatements which are material to our opinion on the financial statements as a whole, we nevertheless report to the Audit and Performance Systems Committee any unadjusted misstatements of lesser amounts to the extent that these are identified by our audit work.

Under ISA 260, we are obliged to report uncorrected omissions or misstatements other than those which are 'clearly trivial' to those charged with governance. ISA 260 defines 'clearly trivial' as matters that are clearly inconsequential, whether taken individually or in aggregate and whether judged by any quantitative or qualitative criteria.

In the context of the Board, we propose that an individual difference could normally be considered to be clearly trivial if it is less than £0.155 million.

If management have corrected material misstatements identified during the course of the audit, we will consider whether those corrections should be communicated to the Audit and Performance Systems Committee to assist it in fulfilling its governance responsibilities.

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Financial statements audit planning (continued)

Significant risks and other focus areas

Risk assessment: Our planning work takes place during January 2019 and February 2019. This involves: risk assessment; determining the materiality level; and issuing this audit plan to communicate our audit strategy. We use our knowledge of the Board, discussions with management and review of Board papers to identify areas of risk and audit focus categorised into financial risks and wider dimension risks as set out in the Code.

Significant risk	Why	Audit approach
Financial statement risks		
Fraud risk from management override of controls	Professional standards require us to communicate the fraud risk from management override of controls as a significant risk; as management is typically in a unique position to perpetrate fraud because of its ability to manipulate accounting records and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively.	— Our audit methodology incorporates the risk of management override as a default significant risk. We have not identified any specific additional risks of management override relating to the audit of the Board. — Strong oversight of finances by management provides additional review of potential material errors caused by management override of controls. — In line with our methodology, we will carry out appropriate controls testing and substantive procedures, including over journal entries, accounting estimates and significant transactions that are outside the organisation's normal course of business, or are otherwise unusual.
Fraud risk from income revenue recognition and expenditure	Professional standards, as interpreted by Practice Note 10. require us to make a rebuttable presumption that the fraud risk from revenue recognition and expenditure are significant risks.	— The Board receives funding requisitions from Aberdeen City Council and NHS Grampian. These are agreed in advance of the financial year, with any changes arising from changes in need, requiring approval from each body. There is no estimation or judgement in recognising this stream of income and we do not regard the risk of fraud to be significant. — The Board issues directions to Aberdeen City Council and NHS Grampian in order to direct those bodies to deliver services delegated by the Board. The Board make these directions based on its budget agreed in advance of the financial year. There is no estimation or judgement in recognising expenditure to these bodies, and we do not regard the risk of fraud to be significant.

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Financial statements audit planning (continued)

Other focus area	Why	Audit approach
Financial statement focus area		
Completeness and accuracy of expenditure	The Board receives expenditure forecasts from Aberdeen City Council and NHS Grampian as part of the annual budgeting process. There is a risk that actual expenditure and resulting funding requisition income is not correctly captured.	— Our substantive audit will obtain support for gross expenditure included in Aberdeen City Council and NHS Grampian's accounting records. We will obtain confirmations of expenditure from each of these bodies.
Financial sustainability	Financial sustainability looks forward to the medium and longer term to consider whether the Board is planning effectively to continue to deliver its services or the way in which they should be delivered. This is inherently a risk to the Board given the challenging environment where funding is reduced and efficiency savings are required	— The Board receives funding from NHS Grampian and Aberdeen City Council, and as part of an Integration Scheme, has a risk sharing agreement with both bodies. This agreement stipulates overspends should be met through the use of reserves where possible, otherwise these bodies must make an additional one-off payment on the basis of each body's proportionate share of baseline contributions to the Board. This gives the Board comfort with regards to overspends, however, there is a risk going forward regarding ongoing budget balance, specifically in the context of challenging NHS and Council budgets. — We will consider the Board's financial planning, reserves strategy, and Board's use of reserves, concluding on the appropriateness of these in our annual audit report. — See page 13 for further information regarding the financial sustainability wider scope.

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Other matters

Accounting framework update

From 2018-19, IFRS 15 *Revenue from Contracts with Customers* replaces IAS 18 *Revenue* and IAS 11 *Construction contracts* and their associated interpretations. The core principle in IFRS 15 for local authorities is that they should recognise revenue to depict the transfer of promised goods or services to the service recipient or customer in an amount that reflects the consideration to which the authority expects to be entitled in exchange for those goods or services.

In addition, the adapted requirements for IFRS 9 *Financial Instruments,* which replaces IAS 39 *Financial instruments: recognition and measurement* have been introduced in 2018-19. The changes included:

- a single classification approach for financial assets driven by cash flow characteristics and how an instrument is managed;
- a forward looking 'expected loss' model for impairment rather than the 'incurred loss' model under IAS 39; and
- new provisions on hedge accounting.

Expected from 2019-20, IFRS 16 *Leases* supersedes IAS 17 *Leases*. IFRS 16 introduces a single lessee accounting model. Public body lessees will be more likely to account for operating leases in a similar way to the current IAS 17 treatment for finance leases.

Given the nature of the Board we do not consider that these changes will have a significant impact on the financial statements.

Controls testing

In respect of the financial statements, we identify the constituent account balances and significant classes of transactions and focus our work on identified risks. Determining the most effective balance of internal controls and substantive audit testing enables us to ensure the audit process runs smoothly and with the minimum disruption to the Board's finance team.

In 2017-18 we identified one minor recommendation in relation to value for money (workforce planning). We will follow-up progress in implementing this recommendation and report any new recommendations arising from our work in 2018-19 and report our view of progress. Appendix three summarises our approach across each phase of the audit.

Internal audit

ISA 610 *Considering the work of internal audit* requires us to:

- consider the activities of internal audit and their effect, if any, on external audit procedures;
- obtain an understanding of internal audit activities to assist in planning the audit and developing an effective audit approach;
- perform a preliminary assessment of the internal audit function when it appears that internal audit is relevant to our audit of the financial statements in specific audit areas; and
- evaluate and test the work of internal audit, where use is made of that work, in order to confirm its adequacy for our purposes.

We will continue liaising with internal audit and update our understanding of its approach and conclusions were relevant. The general programme of work will be reviewed for significant issues to support our work in assessing the statement of internal control.

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Wider scope and Best Value

Approach

We are required to assess and provide conclusions in the Annual Audit Report in respect of four wider scope dimensions: financial sustainability; financial management; governance and transparency; and value for money. We set out below an overview of our approach to wider scope and Best Value requirements of our annual audit. We provide on pages 13 to 15 our risk assessment in respect of these areas. We will provide narrative on these and other areas in the Annual Audit Report where relevant.

Risk assessment

We consider the relevance and significance of the potential business risks faced by Integration Joint Boards, and other risks that apply specifically to the Board. These are the significant operational and financial risks in achieving statutory functions and objectives, which are relevant to auditors' responsibilities under the *Code of Audit Practice.*

In doing so we consider:

- The Board's own assessment of the risks it faces, and its arrangements to manage and address its risks.
- Evidence gained from previous audit work, including the response to that work.
- The work of other inspectorates and review agencies, through the Local Area Network ('LAN') which is established for Aberdeen City Council.

The LAN brings together local scrutiny representatives in a systematic way to agree a shared risk assessment. Andy Shaw is the LAN lead for the shared risk assessment process for Aberdeen City Council. For 2018-19 there is no additional scrutiny required by external audit.

The shared risk assessment process across Scotland has changed for 2019-20 and no local scrutiny plans are prepared. We use the shared risk assessment process to consider if there are wider scope risks relevant to the Annual Audit Report.

Linkages with other audit work

There is a degree of overlap between the work we do as part of the wider scope/Best Value and our financial statements audit. For example, our financial statements audit includes an assessment and testing of the control environment, many aspects of which are relevant to our wider scope audit responsibilities.

We always seek to avoid duplication of audit effort by integrating our financial statements and wider scope/Best Value work, and this will continue. We consider information gathered through the shared risk assessment and the Audit Commission's five strategic priorities when planning and conducting our work.

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Wider scope and Best Value (continued)

Approach (continued)

Identification of significant risks

The Code identifies a matter as significant *'if, in the auditor's professional view, it is reasonable to conclude that the matter would be of interest to the audited body or the wider public. Significance has both qualitative and quantitative aspects.'*

If we identify significant wider scope risks, we will highlight the risk to the Board and consider the most appropriate audit response in each case, including:

- Considering the results of work by the Board, inspectorates and other review agencies.
- Carrying out local risk-based work to form a view on the adequacy of the Board's arrangements for securing economy, efficiency and effectiveness in its use of resources.

Concluding on wider scope and Best Value

At the conclusion of the wider scope/Best Value testing we will consider the results of the work undertaken and assess the assurance obtained against each of the wider scope audit dimensions, regarding the adequacy of the Board's arrangements for securing economy, efficiency and effectiveness in the use of resources.

If any issues are identified that may be significant to this assessment, and in particular if there are issues that indicate we may need to consider qualifying our wider scope conclusion, we will discuss these with management as soon as possible. Such issues will also be considered more widely as part of KPMG's quality control processes, to help ensure the consistency of auditors' decisions.

Reporting

We have completed our initial wider scope risk assessment and have not identified any significant risks, as noted on the pages 13-15. We will update our assessment throughout the year and should any issues present themselves we will report them in our Annual Audit Report.

We will report on the results of the wider scope and Best Value work through our Annual Audit Report. This will summarise any specific matters arising, and the basis for our overall conclusion.

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Wider scope and Best Value (continued)

Risk assessment

We have not identified any financial statement significant risks in relation to wider scope and Best Value. ★ relates to an identified Wider Scope focus areas to be specifically addressed through audit procedures, as further explained on the next page.

Financial management

- Budget setting and monitoring
- Changing landscape for public financial management
- "Telling the Story" in the financial statements
- Complying with the Code's disclosure requirements

Financial sustainability

- EU withdrawal
- Demand pressures ★
- Budgetary controls
- Medium and long term planning

Governance and transparency

- Performance indicators
- Authorisation and approvals
- Remuneration disclosures
- Openness and transparency
- Risk assessment review
- Decision making

Value for money

- Transformation programme ★
- Dependency on key suppliers
- Workforce planning
- Care income, financial assessments and financial guardianship
- Procurement arrangements
- Business planning

Potential risk type: Wider scope | Emerging | Best Value

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Wider scope and Best Value (continued)

Risk assessment (continued)

Wider scope area	Why	Audit approach
Financial sustainability and financial management	**Financial management** is concerned with financial capacity, sound budgetary processes and whether the control environment and internal controls are operating effectively. **Financial sustainability** looks forward to the medium and longer term to consider whether the Board is planning effectively to continue to deliver its services or the way in which they should be delivered. ***Specific identified focus areas:*** Demand pressures and the transformation programme This is inherently a risk to the Board given the challenging environment, where funding is unlikely to increase in real terms and efficiency savings are required to meet the demand pressures for services. These pressures include in respect of learning disabilities, GP prescribing and cost pressures such as the Scottish Living Wage and national drug costs.	— We will obtain an understanding of the Board's financial position and year end outturn position through review of board reports and other management information. We will assess management's progress with implementation of efficiency savings. Commentary and analysis on these areas will be provided within the annual audit report. — We will perform substantive procedures, including substantive analytical procedures, over income and expenditure comparing the final position to budget. — The Board receives funding requisitions from NHS Grampian and Aberdeen City Council, and has a risk sharing agreement in place with both bodies. This gives the Board comfort with regards to any overspends in 2018-19, however, there is a risk going forward regarding ongoing budget balance, specifically in the context of the challenging NHS Grampian and Aberdeen City Council budgets, see page eight. — We will consider the Board's financial planning and reserves strategy and conclude on the appropriateness of these in our annual audit report.

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Wider scope and Best Value (continued)

Risk assessment (continued)

Wider scope area	Why	Audit approach
Financial sustainability and financial management (continued)	***Specific identified focus areas (continued):*** Audit Scotland planning guidance requires us to consider the following matters which are potential risks to all Public Sector bodies. Changing landscape for public financial management Scottish public finances are fundamentally changing, with significant tax-raising powers, new powers over borrowing and reserves, and responsibility for 11 social security benefits. Scottish Government published an initial five-year Medium Term Financial Strategy in May 2018. The Board and its partners need to consider the impact of the new powers on its operations and future budgets. EU withdrawal The nature and impact of withdrawal from the EU continues to be uncertain and changing. There is a risk that the Board fails to prepare for, or is impacted by changes to employees, citizens, funding or regulations. The Board has identified the cost of drugs as an area of risk, arising from unfavourable exchange rates. Dependency on key suppliers This has brought into focus the risk of key supplier failure and the risk of underperformance in suppliers that are experiencing difficult trading conditions. The risk exists where individual public sector bodies are dependent on key suppliers; and the Scottish public sector as a whole is subject to significant systemic risk. There is a risk that entities are overly dependent on a small number of key suppliers to provide services. For the Board external social care providers are key suppliers.	— We will report on how the Board reports on its funding arrangements, responsibilities and performance through the audit of its management commentary and financial statements. — We will remain alert to the impact of the EU withdrawal on the Board’s operations and the environment within which it operates as part of our risk assessment procedures and wider scope responsibilities. We will consider the appropriateness of management’s risk assessment and planning for both matters with reference to guidance provided by Audit Scotland. — We will consider how the Board manages the risk of its partner bodies depending on key suppliers. This work will be primarily be informed by auditor’s analysis and reporting on the two partner bodies.

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Wider scope and Best Value (continued)

Risk assessment (continued)

Wider scope area	Why	Audit approach
Governance and transparency	**Governance and transparency** is concerned with the effectiveness of scrutiny and governance arrangements, leadership and decision making, and transparent reporting of financial and performance information. ***Specific identified focus area:*** Audit Scotland planning guidance requires us to consider the following matters which are potential risks to all Public Sector bodies. Openness and transparency There are signals of changing and more challenging expectations for openness and transparency in public business. This is an area the Board is expected to keep under review and consider where there is scope to enhance transparency.	— We will consider the effectiveness of scrutiny and governance arrangements, by evaluating the challenge and transparency of the reporting of financial and performance information. — We will discuss with officers the key changes in governance since the prior year audit, considering their appropriateness to the Board. There has been significant changes in senior management over the year, including in the chief operating officer post, and we will consider the refreshed structure. — We will update our understanding of the controls and processes around capturing officers' and Board members' interests. — We will obtain and review minutes of meetings of the various committees to assess the level of transparency, and consider the Board's plan for enhancing transparency.
Value for money	Value for money is concerned with how effectively resources are used to provide services. ***Specific identified focus area:*** Audit Scotland planning guidance requires us to consider the following matters which are potential risks to all Public Sector bodies. Care income, financial assessments and financial guardianship In some councils, responsibility for financial assessments on those receiving care has transferred from social care to finance, and this has revealed issues with backlogs of financial assessment and under-recovery of care charges over long periods (more than five years). Audit Scotland identified that officers within some councils may be operating as financial guardians for individuals with a lack of capacity to act in their own interests. This may give rise to a potential conflict of interest when finance officers are in a senior position and the council is issuing invoices to a person for their care.	— We will specifically consider statutory performance indicators, performance reporting and arrangements to provide for continuous improvement. — Across the audit of the Board and the audit of Aberdeen City Council, we will undertake a review of the arrangements for financial assessment of those requiring care and assess whether these are subject to delays, and how this is reported. — We will complete a questionnaire return to Audit Scotland providing intelligence on the extent to which officers undertake financial guardianship roles and the reasons for this. — We will feed into our Aberdeen City Council audit work on Best Value. In 2018-19 they will be focussing on Performance and Outcomes. We will provide narrative as appropriate in our Annual Audit Report.

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Appendices

Mandated communications with the Audit and Performance Systems Committee

Matters to be communicated	Link to audit and performance systems committee papers
Independence and our quality procedures ISA 260 (UK and Ireland).	— See page 18.
The general approach and overall scope of the audit, including levels of materiality, fraud and engagement letter ISA 260 (UK and Ireland).	— Main body of this paper
— Disagreement with management about matters that, individually or in aggregate, could be significant to the entity's financial statements or the auditor's report, and their resolution (AU 380).	— In the event of such matters of significance we would expect to communicate with the Audit and Performance Systems Committee throughout the year. — Formal reporting will be included in our ISA 260 report for the Audit and Performance Systems Committee meeting, which focuses on the financial statements.
— Significant difficulties we encountered during the audit. — Significant matters discussed, or subject to correspondence, with management (ISA 260).	
— Our views about the qualitative aspects of the entity's accounting and financial reporting. — The potential effect on the financial statements of any material risks and exposures, such as pending litigation, that are required to be disclosed in the financial statements (ISA 260 and ISA 540).	
— Audit adjustments, whether or not recorded by the entity, that have, or could have, a material effect on its financial statements. We will request you to correct uncorrected misstatements (including disclosure misstatements) (ISA 450).	
— The selection of, or changes in, significant accounting policies and practices that have, or could have, a material effect on the entity's financial statements (ISA 570).	
— Material uncertainties related to events and conditions that may cast significant doubt on the entity's ability to continue as a going concern (ISA 570).	
— Expected modifications to the auditor's report (ISA 705).	
— Related party transactions that are not appropriately disclosed (ISA 550)	

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Auditor Independence

Assessment of our objectivity and independence as auditor of the Aberdeen City Integration Joint Board (the Board)

Professional ethical standards require us to provide to you at the planning stage of the audit a written disclosure of relationships that bear on KPMG LLP's objectivity and independence, the threats to KPMG LLP's independence that these create, any safeguards that have been put in place and why they address such threats, together with any other information necessary to enable KPMG LLP's objectivity and independence to be assessed.

This letter is intended to comply with this requirement and facilitate a subsequent discussion with you on audit independence and addresses:

General procedures to safeguard independence and objectivity;

Independence and objectivity considerations relating to the provision of non-audit services; and

Independence and objectivity considerations relating to other matters.

General procedures to safeguard independence and objectivity

KPMG LLP is committed to being and being seen to be independent. As part of our ethics and independence policies, all KPMG LLP partners and staff annually confirm their compliance with our ethics and independence policies and procedures including in particular that they have no prohibited shareholdings. Our ethics and independence policies and procedures are fully consistent with the requirements of the FRC Ethical Standard. As a result we have underlying safeguards in place to maintain independence through:

– Instilling professional values
– Communications
– Internal accountability
– Risk management
– Independent reviews.

We are satisfied that our general procedures support our independence and objectivity.

Independence and objectivity considerations relating to other matters

There are no other matters that, in our professional judgment, bear on our independence which need to be disclosed to the Audit & Performance Systems Committee.

Confirmation of audit independence

We confirm that as of the date of this letter, in our professional judgment, KPMG LLP is independent within the meaning of regulatory and professional requirements and the objectivity of the partner and audit staff is not impaired.

This report is intended solely for the information of the Audit & Performance Systems Committee and should not be used for any other purposes.

We would be very happy to discuss the matters identified above (or any other matters relating to our objectivity and independence) should you wish to do so.

Yours faithfully

KPMG LLP

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Timeline

Communication

January
Audit planning meeting

February
Presentation of Audit Strategy

Statutory inspection period

June
Presentation of ISA 260 report

September
Presentation of Annual Audit Report

Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | Nov

2018

2019

May
Final audit fieldwork commences.

June
Financial statements signed by the Board and KPMG

Audit workflow

- Perform risk assessment procedures and identify risks
- Determine audit strategy
- Determine planned audit approach

- Understand accounting and reporting activities
- Evaluate design and implementation of selected controls
- Test operating effectiveness of selected controls
- Assess control risk and risk of the accounts being misstated
- Plan substantive procedures
- Perform substantive procedures
- Consider if audit evidence is sufficient and appropriate
- Form opinion

- Review wider scope objectives and areas
- Perform completion procedures

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Audit outputs

Output	Description	Report date
Audit strategy	Our strategy for the external audit of the Board, including significant risk and audit focus areas.	By 12 February 2019
Independent auditor's report	Our opinion on the Board's financial statements.	By 30 June 2019
ISA 260 report	Required communications with Those Charged With Governance	By 30 June 2019
Annual audit report	We summarise our findings from our work during the year.	By 30 September 2019
Audit reports on other returns	We will report on the following returns:	
	— Current issues return	January, March, July and October 2019
	— Technical database	6 July 2019
	— Fraud returns	November 2018, February, May and August 2019
Audit reports to support Audit Scotland's wider analysis	We will report on the following matters in conjunction with our Aberdeen City Council audit colleagues:	
	— National Fraud Initiative questionnaire	By 30 June 2019

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Audit Scotland code of audit practice – responsibility of auditors and management

Responsibilities of management

Financial statements

Audited bodies must prepare an annual report and accounts containing financial statements and other related reports. They have responsibility for:

— preparing financial statements which give a true and fair view of their financial position and their expenditure and income, in accordance with the applicable financial reporting framework and relevant legislation;

— maintaining accounting records and working papers that have been prepared to an acceptable professional standard and that support their financial statements and related reports disclosures;

— ensuring the regularity of transactions, by putting in place systems of internal control to ensure that they are in accordance with the appropriate Council;

— maintaining proper accounting records; and

— preparing and publishing, along with their financial statements, an annual governance statement, management commentary (or equivalent) and a remuneration report that are consistent with the disclosures made in the financial statements. Management commentary should be fair, balanced and understandable and also clearly address the longer- term financial sustainability of the body.

Further, it is the responsibility of management of an audited body, with the oversight of those charged with governance, to communicate relevant information to users about the entity and its financial performance, including providing adequate disclosures in accordance with the applicable financial reporting framework. The relevant information should be communicated clearly and concisely.

Audited bodies are responsible for developing and implementing effective systems of internal control as well as financial, operational and compliance controls. These systems should support the achievement of their objectives and safeguard and secure value for money from the public funds at their disposal. They are also responsible for establishing effective and appropriate internal audit and risk-management functions.

Prevention and detection of fraud and irregularities

Audited bodies are responsible for establishing arrangements for the prevention and detection of fraud, error and irregularities, bribery and corruption and also to ensure that their affairs are managed in accordance with proper standards of conduct by putting proper arrangements in place.

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Audit Scotland code of audit practice - responsibility of auditors and management

Responsibilities of management
Corporate governance arrangements
Each body, through its chief executive or accountable officer, is responsible for establishing arrangements to ensure the proper conduct of its affairs including the legality of activities and transactions, and for monitoring the adequacy and effectiveness of these arrangements. Audited bodies should involve those charged with governance (including Audit and Performance Systems Committees or equivalent) in monitoring these arrangements.
Financial position
Audited bodies are responsible for putting in place proper arrangements to ensure that their financial position is soundly based having regard to: — such financial monitoring and reporting arrangements as may be specified; — compliance with any statutory financial requirements and achievement of financial targets; — balances and reserves, including strategies about levels and their future use; — how they plan to deal with uncertainty in the medium and longer term; and — the impact of planned future policies and foreseeable developments on their financial position.
Best Value, use of resources and performance
The Scottish Public Finance Manual sets out that accountable officers appointed by the Principal Accountable Officer for the Scottish Administration have a specific responsibility to ensure that arrangements have been made to secure best value.

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Audit Scotland code of audit practice – responsibility of auditors and management

Responsibilities of auditors
Appointed auditor responsibilities
Auditor responsibilities are derived from statute, this Code, International Standards on Auditing (UK and Ireland), professional requirements and best practice and cover their responsibilities when auditing financial statements and when discharging their wider scope responsibilities. These are to: — undertake statutory duties, and comply with professional engagement and ethical standards; — provide an opinion on audited bodies' financial statements and, where appropriate, the regularity of transactions; — review and report on, as appropriate, other information such as annual governance statements, management commentaries, remuneration reports, grant claims and whole of government returns; — notify the Auditor General when circumstances indicate that a statutory report may be required; — participate in arrangements to cooperate and coordinate with other scrutiny bodies (local government sector only); — demonstrate compliance with the wider public audit scope by reviewing and providing judgements and conclusions on the audited bodies: – effectiveness of performance management arrangements in driving economy, efficiency and effectiveness in the use of public money and assets; – suitability and effectiveness of corporate governance arrangements; and – financial position and arrangements for securing financial sustainability. Weaknesses or risks identified by auditors are only those which have come to their attention during their normal audit work in accordance with the Code, and may not be all that exist. Communication by auditors of matters arising from the audit of the financial statements or of risks or weaknesses does not absolve management from its responsibility to address the issues raised and to maintain an adequate system of control.

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Audit Scotland code of audit practice – responsibility of auditors and management

Responsibilities of auditors
General principles
This Code is designed such that adherence to it will result in an audit that exhibits these principles.
Independent
When undertaking audit work all auditors should be, and should be seen to be, independent. This means auditors should be objective, impartial and comply fully with the Financial Reporting Council's (FRC) ethical standards and any relevant professional or statutory guidance. Auditors will report in public and make recommendations on what they find without being influenced by fear or favour.
Proportionate and risk based
Audit work should be proportionate and risk based. Auditors need to exercise professional scepticism and demonstrate that they understand the environment in which public policy and services operate. Work undertaken should be tailored to the circumstances of the audit and the audit risks identified. Audit findings and judgements made must be supported by appropriate levels of evidence and explanations. Auditors will draw on public bodies' self-assessment and self-evaluation evidence when assessing and identifying audit risk.
Quality focused
Auditors should ensure that audits are conducted in a manner that will demonstrate that the relevant ethical and professional standards are complied with and that there are appropriate quality-control arrangements in place as required by statute and professional standards.

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Audit Scotland code of audit practice – responsibility of auditors and management

Responsibilities of auditors
Coordinated and integrated
It is important that auditors coordinate their work with internal audit, Audit Scotland, other external auditors and relevant scrutiny bodies to recognise the increasing integration of service delivery and partnership working within the public sector. This would help secure value for money by removing unnecessary duplication and also provide a clear programme of scrutiny activity for audited bodies.
Public focused
The work undertaken by external audit is carried out for the public, including their elected representatives, and in its interest. The use of public money means that public audit must be planned and undertaken from a wider perspective than in the private sector and include aspects of public stewardship and best value. It will also recognise that public bodies may operate and deliver services through partnerships, arm's-length external organisations (ALEOs) or other forms of joint working with other public, private or third sector bodies.
Transparent
Auditors, when planning and reporting their work, should be clear about what, why and how they audit. To support transparency the main audit outputs should be of relevance to the public and focus on the significant issues arising from the audit.
Adds value
It is important that auditors recognise the implications of their audit work, including their wider scope responsibilities, and that they clearly demonstrate that they add value or have an impact in the work that they do. This means that public audit should provide clear judgements and conclusions on how well the audited body has discharged its responsibilities and how well they have demonstrated the effectiveness of their arrangements. Auditors should make appropriate and proportionate recommendations for improvement where significant risks are identified.

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Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Date of Meeting	12.02.2019
Report Title	Internal Audit Report – Budget Setting, Monitoring and Financial Reporting
Report Number	HSCP/18/133
Lead Officer	David Hughes, Chief Internal Auditor
Report Author Details	Name: David Hughes Job Title: Chief Internal Auditor Email Address: david.hughes@aberdeenshire.gov.uk
Consultation Checklist Completed	Yes
Directions Required	No
Appendices	None

1. Purpose of the Report

1.1. The purpose of this report is to present the outcome from the planned audit of Budget Setting, Monitoring and Financial Reporting that was included in the 2018/19 Internal Audit Plan for the Integration Joint Board.

2. Recommendations

2.1. It is recommended that the Audit & Performance Systems Committee:

a) review, discuss and comment on the issues raised within this report.

3. Summary of Key Information

3.1. Resources and budgets have been delegated by NHS Grampian and Aberdeen City Council (the Partners) to the Integration Joint Board (IJB). The IJB issues Directions to the Partners with instructions in terms of funding and service delivery to progress the strategic priorities within the Plan. The Aberdeen City Health and Social Care Partnership operationally delivers the services on behalf of the Partners.

INTEGRATION JOINT BOARD

3.2. Directions issued by the IJB on 27 March 2018 identified a budget of £97.367 million for Aberdeen City Council. NHS Grampian received an allocation of £153.484 million, which included £20.2 million relating to Aberdeen City's share for hosted services. An additional £40.6 million was set aside for large hospital services.

3.3. It is the responsibility of the Chief Officer to ensure services necessary to fulfil the Strategic Plan are delivered within the approved budget. The Chief Finance Officer is responsible for financial planning and providing financial advice to the Chief Officer and the IJB in order to do this, in addition to preparing the Partnership's annual accounts.

3.4. Budgets are currently monitored on a functional basis, however a timetable has been put in place for implementing locality budgets. This change to the budget structure will change the way the budget is monitored and reported to the IJB.

3.5. The Partnership faces the continuing and increasing challenge of an ageing population with complex care needs, coupled with limited funding and rising costs. Budget control and efficient use of resources is therefore one of the most important responsibilities the Partnership has in trying to deliver more integrated and effective health and social care services.

3.6. The objective of this audit was to provide assurance that appropriate arrangements are in place regarding IJB budget setting, monitoring and financial reporting. In general, this was demonstrated to be the case, however recommendations have been made and actions agreed with the Chief Finance Officer as follows.

3.7. It was not possible, without further explanation, to reconcile the original budget to the revised budget by reference to the virements applied. In order to provide greater assurance over this area it has been agreed that the audit trail will be improved by the start of the new financial year.

3.8. The IJB has been using Integration and Change Funding to cover funding gaps in the budget for mainstream services. This could mean a reduction in the delivery of the transformation programme, which is anticipated to

generate savings, and may not be sustainable. It has been agreed that the IJB funding and transformation strategies will be reviewed to demonstrate that plans are in place to deliver mainstream health and social care services within budget. This will be achieved through the annual refresh of the Medium Term Financial Strategy.

3.9. The Scheme of Integration and the IJB's Financial Regulations require that the Chief Finance Officer receives budget, actual and forecast figures from the partner organisations each month. Currently, only NHS Grampian figures are received by the Chief Finance Officer on a monthly basis. However, the Partnership is satisfied that the current reporting arrangements are adequate and will amend the Financial Regulations as appropriate.
.

3.10. Working papers are produced as part of the budget monitoring process. Whilst they were considered to be adequate, the assurance that they provide could be increased if they contained evidence of figures used from the ledger along with improved narrative and explanation where amendments have been made or estimates used. The Chief Finance Officer has agreed to ensure that working papers are enhanced as recommended.

3.11. There are delays in providing budget monitoring information to the Board, for example, the December 2017 data was presented to the Board on 2 March 2018. This provides little opportunity for the Board to take action if considered necessary to influence the year-end outturn. Management has stated that there are limited opportunities to report budget monitoring information due to the timing of the IJB and Audit & Performance Systems meetings. In order to close this gap, management has stated that they will send a bulletin item to Board members in early February highlighting the financial position to the end of quarter three. Whilst this will assist in providing information, it will not provide an opportunity for discussion and action in response to variances.

4. Implications for IJB

4.1. **Equalities –** An equality impact assessment is not required because the reason for this report is for Committee to discuss, review and comment on

the contents of an Internal Audit report and there will be no differential impact, as a result of this report, on people with protected characteristics.

4.2. **Fairer Scotland Duty –** there are no direct implications arising from this report.

4.3. **Financial –** there are no direct implications arising from this report.

4.4. **Workforce -** there are no direct implications arising from this report.

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

4.6. Other - NA

5. Links to ACHSCP Strategic Plan

5.1. Ensuring effective performance reporting and use of Key Performance Indicators will help the IJB deliver on all strategic priorities as identified in its strategic plan.

6. Management of Risk

6.1. **Identified risks(s):** The Internal Audit process considers risks involved in the areas subject to review. Any risk implications identified through the Internal Audit process are as detailed in the resultant report.

6.2. **Link to risks on strategic risk register:** There is a risk of financial failure, that demand outstrips budget and 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:** Where risks have been identified during the Internal Audit process, recommendations have been made to management in order to mitigate these risks.

Aberdeen City Health & Social Care Partnership
A caring partnership

AUDIT & PERFORMANCE SYSTEMS COMMITTEE

Date of Meeting	12.02.2019
Report Title	Local Government in Scotland – Financial Overview 2017/18 (Audit Scotland Report)
Report Number	HSCP.18.126
Lead Officer	Sandra Ross, Chief Officer
Report Author Details	Alex Stephen, Chief Finance Officer
Consultation Checklist Completed	*Yes*
Appendices	a) Local Government in Scotland – Financial Overview 2017/18 (Audit Scotland Report)

1. Purpose of the Report

1.1. This report provides the Audit & Performance System Committee with the opportunity to discuss and comment on Audit Scotland's Report 'Local government in Scotland – Financial overview 2017-18

2. Recommendations

2.1. It is recommended that the Audit & Performance Systems Committee:

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

b) 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 & PERFORMANCE SYSTEMS COMMITTEE

3. Summary of Key Information

3.1. The report at appendix A provides a high-level independent analysis of the financial performance of councils during 2017/18 and their financial position at the end of that year. It also looks ahead and comments on the financial outlook for councils.

3.2. The report also contains a section examining Integration Joint Boards financial performance for 2017/18. Key messages included:

- Funding to the IJBs increased in 2017/18 by three per cent in cash terms. Most of this additional funding came from the NHS and includes additional Scottish Government funding to the NHS for IJBs of £107 million.
- The majority of IJBs have underlying financial sustainability issues, with 11 out of 30 incurring deficits in 2017/18. A further eight would have incurred deficits without additional ('deficit') funding from their partners.
- Reserve positions vary enormously between IJBs.
- Medium-term financial planning is not used by most IJBs and further improvements to financial management should be introduced.

4. Implications for IJB

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

4.2. Fairer Scotland Duty - there are no direct implications for the Fairer Scotland Duty arising from the recommendations of this report.

4.3. Financial – the financial implications are outlined throughout the Audit Scotland Report. The IJB will need to be aware of these implications as Aberdeen City Council is one of its partner organisations and as such any financial difficulties relating to the local authority may impact on IJB budgets.

4.4. Workforce – there are no direct workforce implications arising from the recommendations of this report

4.5. Legal - there are no direct workforce implications arising from the recommendations of this report.

4.6. Other - there are no other implications arising from the recommendations of this report.

5. Links to ACHSCP Strategic Plan

5.1. Ensuring that the APS committee has full awareness of Audit Scotland recommendations which relate to both the IJB and ACHSCP will help to ensure the IJB successfully delivers on its strategic plan.

6. Management of Risk

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

6.2. **Link to risks on strategic or operational risk register:** Strategic Risk 2

6.3. **How might the content of this report impact or mitigate these risks:** Ensuring that the IJB has an oversight of Audit Scotland reports relating to its partners will provide the IJB on the scale of the challenges faced in transforming the healthcare system in Scotland.

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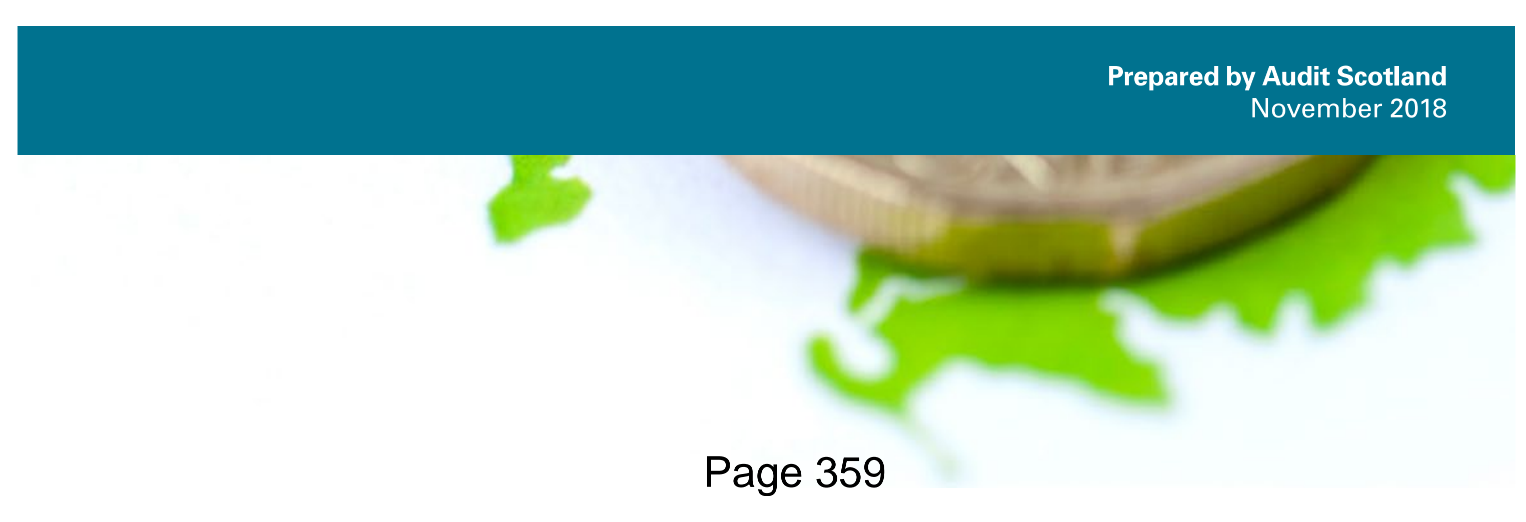
Local government in Scotland

Financial overview 2017/18

Prepared by Audit Scotland
November 2018



The Accounts Commission

The Accounts Commission is the public spending watchdog for local government. We hold councils in Scotland to account and help them improve. We operate impartially and independently of councils and of the Scottish Government, and we meet and report in public.

We expect councils to achieve the highest standards of governance and financial stewardship, and value for money in how they use their resources and provide their services.

Our work includes:

- securing and acting upon the external audit of Scotland's councils and various joint boards and committees
- assessing the performance of councils in relation to Best Value and community planning
- carrying out national performance audits to help councils improve their services
- requiring councils to publish information to help the public assess their performance.

You can find out more about the work of the Accounts Commission on our website: www.audit-scotland.gov.uk/about-us/accounts-commission

Audit Scotland is a statutory body set up in April 2000 under the Public Finance and Accountability (Scotland) Act 2000. We help the Auditor General for Scotland and the Accounts Commission check that organisations spending public money use it properly, efficiently and effectively.

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Links

PDF download

Web link

Information box

Exhibit data

When viewing this report online, you can access background data by clicking on the graph icon. The data file will open in a new window.

These question mark icons appear throughout this report and represent questions for councillors.

Audit team

The core team consisted of: Carol Calder, Kathrine Sibbald, Ashleigh Madjitey, Ruth Azzam and David Docherty, with support from other colleagues and under the direction of Brian Howarth.

Key facts

£8.3 billion IJBs' spending in 2017/18

6.9 per cent Real terms reduction in Scottish Government revenue funding since 2013/14

£17.4 billion Council income 2017/18

£12.2 billion Council net spending on day-to-day services in 2017/18

£2.7 billion Council capital spending in 2017/18

£1.9 billion Councils' usable reserves (excluding Orkney and Shetland) at 31 March 2018

£6.6 billion Councils' share of the Local Government Pension Scheme deficit at 31 March 2018

£15.1 billion Councils' net debt (excluding Orkney and Shetland) at 31 March 2018

£2.4 billion Council budgets delegated to IJBs in 2017/18

Chair's introduction

Welcome to the Accounts Commission's 2018 financial overview report for local government.

This report reflects a similar situation to last year as councils face an increasingly complex range of challenges and continuing pressure on finances. Challenges include increasing demand across many of the wide range of services councils deliver to local communities. Demand has to be met against tightening budgets in many service areas along with uncertainty stemming from external factors such as EU withdrawal.

One of the most significant issues for councils continues to be funding. In 2017/18, funding from the Scottish Government, councils' main source of funding, again reduced in real terms. The reduction was largely offset by increases in council tax and councils' fee income, with most councils applying the maximum three per cent increase to council tax. In total, the net effect of Scottish Government and council action was a reduction in funding of only 0.1 per cent in real terms although the impact on individual councils varied. In general, increased spending in education and social work was offset by reductions in other services. I would also note that the relationship of funding of individual councils to areas of deprivation remains unclear.

The forecast trend is for further reductions in funding from the Scottish Government in the medium term. Pressure therefore remains on councils to make further savings and find ways to meet service demand more efficiently and effectively. This will require difficult decisions and innovative thinking by councillors and senior management working together.

It is important that these decisions are taken in a planned and coordinated way. It is positive progress that almost all councils now have medium-term financial planning in place and some have made progress with long-term financial projections. I would encourage all councils to build on medium-term plans and develop suitable long-term financial planning. This supports consistency in financial decisions with corporate priorities and outcome aims, as well as supporting transformation initiatives. Councillors also need to be clear about the potential impact of planned savings or changes to fees and charges on the local community and economy as well as on achieving corporate objectives.

Last year, we highlighted the risk for some councils plans to use significant amounts of their reserves to manage funding gaps. I am pleased that this year, although overall reserves have continued to reduce, no council is using its reserves at a level that risks their financial sustainability in the next two to three years. We will continue to have an interest in how councils set their reserves policy and utilise reserves as funding pressures continue in the coming years.

The Commission recognises that one of the other most significant challenges for councils are financial issues associated with the Integration Joint Boards (IJBs). The majority of IJBs have underlying financial sustainability issues and without year-end support from the NHS and council partners, 20 out of the 30 IJBs would have reported deficits. In November 2018, we published a report on progress with *Health and social care integration*. This highlighted areas for improvement, including financial management and financial planning. The Commission will continue to keep a focus on IJBs and consider how best to monitor their progress in future.

Finally, we welcome that the audits of annual accounts from all 32 councils were signed off with no qualifications. This is testament to the hard work of council staff, especially those within the finance function, and of our auditors. We also note that again there has been some progress with the quality of reporting on financial matters. However, we encourage councils to continue to improve the transparency and clarity of financial information provided to councillors and the public.

I hope you find this overview useful and would welcome any feedback you may have.

Graham Sharp
Chair of Accounts Commission

Summary

Key messages

1 Councils depend on Scottish Government funding for a significant part of their income. Scottish Government revenue funding to councils reduced in 2017/18, in cash terms by 0.6 per cent (£0.06 billion) and in real terms, by 2.3 per cent (£0.22 billion). Council tax increases and increased fees and charges were used by councils to increase overall budgets by £0.3 billion (cash terms).

2 In 2017/18, councils managed funding gaps of four per cent in their net expenditure budgets of £12 billion, mainly through savings and planned use of reserves. Councils are under pressure to find different ways to fund and deliver services. In 2017/18, 24 councils increased council tax, whereas in 2018/19, all councils increased council tax.

3 Overall increases in spending in Education and Social Work were offset by reductions in other services.

4 Eighteen councils ended 2017/18 with lower levels of usable reserves than they had at the start of the year. Total usable reserves fell by £18 million, a relatively small amount.

5 Funding to the Integration Joint Boards (IJBs) increased in 2017/18 by three per cent in cash terms (1.4 per cent in real terms), including additional funding from the NHS. The majority of IJBs have underlying financial sustainability issues, with 20 incurring deficits or dependent on additional ('deficit') funding from their partners.

6 The financial outlook is for reductions in Scottish Government revenue funding to councils. This will mean continued and increasing financial pressures on council services, especially those that are not protected.

7 The impact of EU withdrawal is not yet clear, but councils need to identify the risks and develop contingency plans to manage these risks.

councils managed funding gaps of four per cent in their net expenditure budgets of £12 billion, mainly through savings and planned use of reserves

About this report

1. This report provides a high-level independent analysis of the financial performance of councils during 2017/18 and their financial position at the end of that year. It also looks ahead and comments on the financial outlook for councils. It is one of two overview reports that the Accounts Commission publishes each year. The second report comments on the wider challenges and performance of councils. It will be published at the end of the financial year, in March 2019.

2. Our primary sources of information for the financial overview are councils' 2017/18 audited accounts, including management commentaries and the 2017/18 external annual audit reports for each council. We have supplemented this with data submitted by councils to the Scottish Government through local finance returns (LFRs) and Provisional Outturn and Budget Estimates (POBE). LFRs present spending information on a different basis from the spending information that councils record in their annual accounts. We do not audit data contained in the LFRs.

3. We refer to 'real-terms' changes in this report. This means we are showing financial information from past and future years at 2017/18 prices (and 2018/19 prices where 2018/19 comparisons are made), adjusted for inflation so that they are comparable. We also refer to figures in 'cash terms'. This means we are showing the actual cash or money paid or received.

4. Throughout the report, we identify examples of questions that councillors may wish to consider, to help with understanding their council's financial position and to scrutinise financial performance. The Accounts Commission encourages councillors to use an appropriate level of scepticism in scrutiny and ensure they receive sufficient information to answer their questions fully. The example questions are also available on our website in ***Supplement 1: Scrutiny tool for councillors***.

5. Accompanying this report, and to facilitate insight and comparisons across the sector, we have provided additional financial information on our **website**. The information is based on councils' audited accounts. We hope this will be useful for senior council finance officers, their staff and other interested stakeholders. We will also publish a separate supplement on the Local Government Pensions Scheme (LGPS) in December 2018.

6. Orkney and Shetland have been excluded from some exhibits that show usable reserves and debt. This is because their values would make it difficult to see the relative positions of other councils. Most councils hold usable reserves of between seven and 36 per cent of their annual revenue, whereas Shetland's reserves were 260 per cent of its annual revenue and Orkney's 329 per cent of its annual revenue. These large reserves relate to oil, gas and harbour-related activities. Both Orkney and Shetland also have significant investments rather than borrowing, unlike other councils.

Part 1

Councils' budgets and spending in 2017/18

Key messages

1. Councils depend on Scottish Government funding for a significant part of their income. Scottish Government revenue funding to councils reduced by 2.3 per cent (£0.2 billion) in real terms in 2017/18, but council tax, grants to services and fees and charges increased, and overall budgets grew by £0.3 billion in cash terms.

2. Between 2013/14 and 2017/18, funding from the Scottish Government to local government decreased at a faster rate, 6.92 per cent, than the Scottish Government revenue budget at 1.65 per cent.

3. Distribution of funding from the Scottish Government is based mainly on population but could be more transparent to ensure clarity about how funding distribution reflects factors that drive demand and costs in councils.

4. In 2017/18, councils managed funding gaps of four per cent in their net expenditure budgets of £12 billion, mainly through savings and planned use of reserves. Their outturn at the year-end was better than budgeted.

5. Overall increases in spending in Education and Social Work were offset by reductions in other services

Scottish Government revenue funding to councils reduced by 2.3 per cent (£0.2 billion) in real terms in 2017/18

Council funding

The main source of councils' funding is the Scottish Government

7. Scottish councils get their annual funding and income from a range of sources (Exhibit 1, page 10). In 2017/18, these totalled £17.4 billion. The main source of funding is the Scottish Government, contributing 55 per cent. In 2017/18, the Scottish Government provided £9.65 billion (compared to £9.71 billion in 2016/17). Within this total, a relatively small element (two per cent, £211 million) is for specific policy areas, such as the Pupil Equity Fund, previously known as the Attainment Scotland Fund. This has increased from £91 million (one per cent) in 2016/17.

Although Scottish Government funding reduced, increases in council tax and charges increased the total amount available to councils to meet expenditure

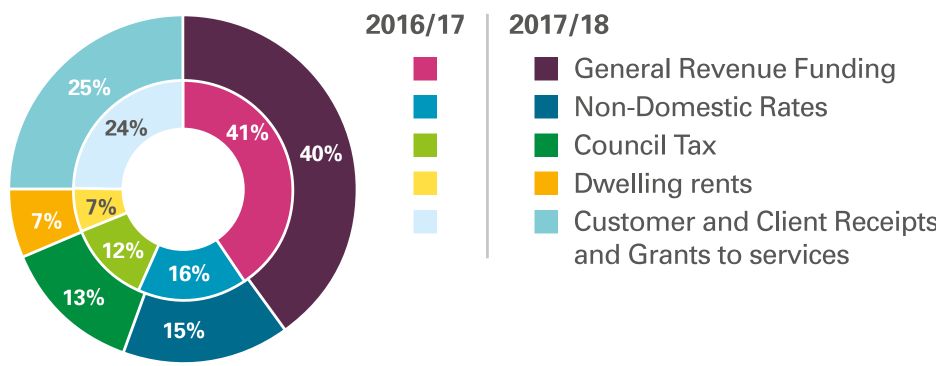
8. Total income and funding of £17.4 billion is an increase from £17.1 billion in 2016/17. Reductions in Scottish Government funding of £57 million have been

more than countered by increases in charges and grants to services, dwelling rents and council tax totalling £328 million. In total, this means that total income and funding is £271 million more in 2017/18 than 2016/17. Across Scotland in 2017/18, 13 per cent of income, £2.3 billion, was generated through council tax and 25 per cent, £4.3 billion, through fees, charges and grants credited to services.

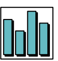
Exhibit 1

Sources of council revenue income, 2017/18

Total funding and income to councils in 2017/18 was £17.4 billion.



Source: Finance Circulars and Audited Financial Statements



An element of Scottish Government 2017/18 funding was agreed late, limiting councils' ability to properly plan and agree their budgets

9. Provisional funding allocations for 2017/18 were issued to councils on 15 December 2016 and further increases were agreed and communicated to councils in a letter from the Finance Minister, on 2 February. The financial circular of 9 March 2017 confirmed these changes. The amount to be distributed to councils as revenue funding increased by £182 million (1.9 per cent). Councils agree their budgets at meetings during February and March. One council noted in its budget papers that 'In the last few days, (the Finance Minister) announced …change(s) on 2nd February, the day before the administration's budget proposals were due to be signed off'. Another council noted that a 'very late and material revision was made to the revenue grant settlement… present(ing) challenges in terms of configuring a balanced budget at short notice and ensuring value for money spending proposals'. Receiving significant changes at a late stage in the budgeting process limits the time available to councils to plan, discuss and agree budgets.

Scottish Government Revenue funding fell by 2.3 per cent in real terms in 2017/18

10. Exhibit 2 (page 11) shows that in 2017/18 the **total revenue funding** from the Scottish Government reduced by 0.6 per cent in cash and 2.3 per cent in real terms. Including additional funding of £34.5 million and health and social care funding via the NHS, Scottish Government funding was reduced by 0.8 per cent in real terms in 2017/18, compared to the previous year.

Total revenue funding:

This consists of general resource grants, specific revenue grants (together known as revenue grants), and Non-Domestic Rates income (NDR).

Total revenue funding does not include the additional £34.5 million added at Stage 1 of the Budget Bill to be paid in 2017/18 in respect of 2018/19. It also does not include health and social care funding paid to local government via the NHS.

Exhibit 2

Changes in Scottish Government funding in 2017/18

Scottish Government Revenue funding fell by 2.3 per cent in real terms in 2017/18.

	2016/17 £m	2017/18 £m	Cash %	Real %
Revenue Grant	6,939	6,985	0.7 ▲	-1.0 ▼
NDR	2,769	2,666	-3.7 ▼	-5.3 ▼
Total revenue funding	**9,708**	**9,651**	**-0.6** ▼	**-2.3** ▼
Further funding		35[1]		
Health & social care funding via NHS	250	357		
	9,958	**10,043**	**+0.9** ▲	**-0.8** ▼

Note: £34.5 million was added at Stage 1 of the Budget Bill to be paid in 2017/18 and 2018/19. Accounting standards meant that this was correctly treated as 2017/18 income by councils.

Source: Finance Circulars 1/2017 and 4/2018

11. In 2017/18, the Scottish Government paid an additional £107 million to NHS boards to assist with health and social care. This was used mostly to offset new living wage and sleepover costs of care workers in local government.

Local government funding has reduced at a faster rate than other areas of the Scottish public sector

12. In May 2018, the Scottish Parliament Information Centre (SPICe) reported that between 2013/14 and 2017/18, funding from the Scottish Government to local government decreased at a faster rate than the Scottish Government revenue budget; 7.1 per cent and 1.8 per cent respectively. Using a similar approach, but with up-to-date inflators, the reductions have been 6.92 per cent and 1.65 per cent (Exhibit 3, page 12). This demonstrates a significantly higher impact on total local government funding compared to the total Scottish Government revenue budget. In cash terms, the funding from the Scottish Government to local government has fallen by 1.18 per cent while the Scottish Government revenue budget has grown by 4.41 per cent.

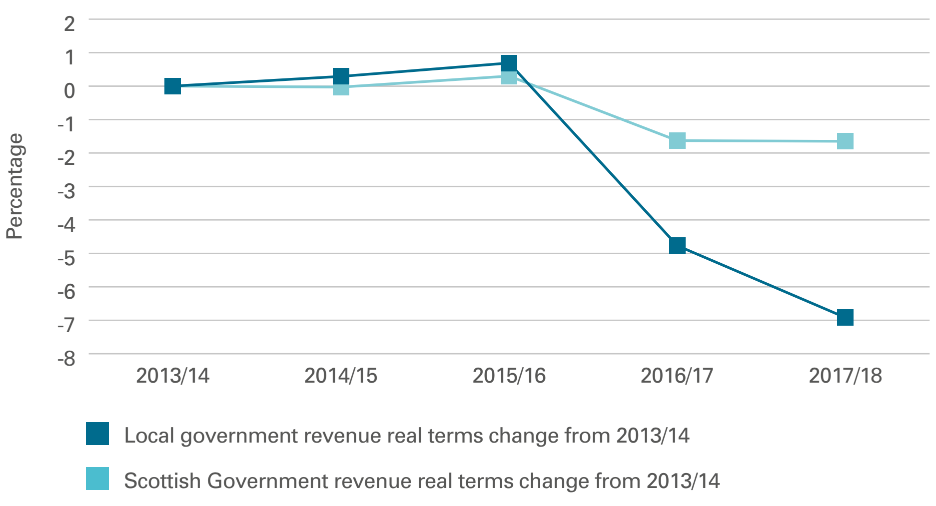
Distribution of funding from the Scottish Government could be clearer about how it reflects factors that drive costs in councils

13. As we reported last year, the Scottish Government and COSLA's mechanism for distributing funding to councils is the main determinant of a councils' overall funding. Grant-aided Expenditure, or GAE, is a needs-based methodology, used to allocate the Scottish Government's pre-determined spending review totals among councils. It is made up of 89 indicators such as 'services for people with disabilities' and 'road maintenance'. These indicators are weighted to reflect factors that impact on the demand for and cost of delivering services, for example, 'the size of the 16 to 64 year-old population' and 'length of roads to maintain'.

14. The weighting factors determine the proportion of GAE funding that goes to each council. It is important to note that GAE is purely a methodology to redistribute spending review totals: councils are not obligated to spend the specific amounts on each area identified in the methodology.

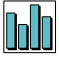
Exhibit 3
Real terms change in revenue funding for Scottish Government and councils since 2013/14

Scottish Government revenue budget has fallen by 1.65 per cent between 2013/14 and 2017/18, while revenue funding to councils has fallen by 6.92 per cent over the same period.



Note: Local government funding shown is General Revenue Grant funding, other ring-fenced funding, and NDR.

Source: Audit Scotland; and SPICe



15. Since 2008/09, the total amount of GAE has remained at £7.9 billion and the weighting allocated to each GAE indicator has stayed the same. Each year the councils' relative proportion of funding has been recalculated using the 89 indicators, which means that the amount each council receives may change as its 'population', 'number of teachers', or value of other indicators change. However, the methodology used, and relative importance of each indicator used in arriving at the overall distribution of GAE has not changed in ten years.

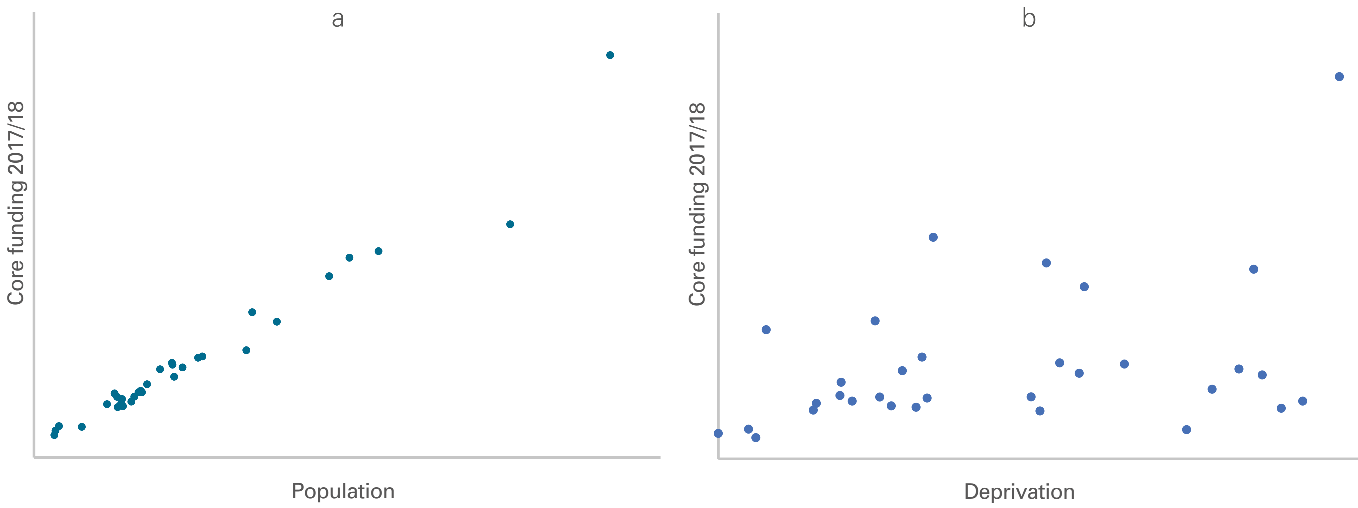
16. The majority of GAE is allocated according to population-based factors. Other factors are far less significant influences on total funding. For example, those which might be considered to link to deprivation, for example 'the number of current income deprived', are linked to a much smaller proportion of funding than population-based weighting factors.

17. This is demonstrated when we consider the relationship between how much funding a council receives and its population size and deprivation levels. The former is a very strong determinant of overall funding and the latter is only a moderate to weak factor (Exhibit 4, page 13). Given Scotland's demographic changes and the Scottish Government's commitment to tackling social and economic inequality, there is a risk that the GAE weightings no longer sufficiently represent need.

Exhibit 4

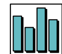
Scottish Government core funding compared to council population size and deprivation levels

The majority of core funding is allocated to councils according to population-based factors. A much smaller proportion of factors linked to deprivation influences funding levels.



Note: Deprivation has been calculated using the percentage of datazones in the council which are in the 30 per cent most deprived datazones in Scotland. Based on the Scottish index of multiple deprivation (SIMD).

Source: Scottish Government finance circulars; National Records for Scotland 2017 population estimates; and Scottish Index of Multiple Deprivation.



18. Scottish Government funding provided to councils on top of the GAE funding allocation, £3.7 billion in 2017/18, is either distributed using the same proportions as the GAE funding or through a separate methodology agreed by the Scottish Government and COSLA. The Scottish Government advises that in 2017/18, £0.2 billion was distributed using the GAE methodology and £3.5 billion through individual separate methodologies. The basis of the calculations for the separate methodologies are not publicly available and should be more transparent.

19. The £3.7 billion funding includes former ring-fenced grants, new policy commitments (since 2008/09), additional funding from the government spending reviews, special island needs allowance and loan charges. This funding, alongside the GAE, makes up the 'total estimated expenditure' which is then adjusted to take account of expected council tax and non-domestic rates income and specific ring-fenced grants such as the Pupil Equity Fund.

20. The Scottish Government and COSLA have two groups that consider the funding distribution allocations on a regular basis, the settlement and distribution group (SDG) which is supported by the data issues working group (DIWG). These groups work on understanding the strategic issues behind the distribution of funding and updating the data behind the indicators. Both groups include membership from Scottish Government, COSLA and several Directors of Finance. We recognise that a review of funding distribution is difficult in times of reducing budgets, as there will inevitably be some councils that end up with smaller allocations of funding, putting further strain on already tight budgets. But we continue to believe that it is important that the Scottish Government and COSLA assure themselves that the funding formula remains fit for purpose.

Council tax changes raised a further £189 million in 2017/18

21. Council tax is another important source of income for councils. In 2017/18, £2.3 billion, 13 per cent of council funding came from council tax, which is set by individual councils. Councils raised a further £189 million in 2017/18 through council tax, compared to 2016/17.

22. In 2017/18, the Scottish Government's council tax freeze was lifted but with a maximum increase of three per cent. Twenty-four councils chose to increase council tax, with twenty-one increasing rates by the maximum three per cent (Exhibit 5). This raised an estimated £49 million.

23. The national changes in 2017/18, also included increases to the council tax bands E to H and removal of second-home discounts. These changes raised the remaining £140 million and benefited councils with a relatively higher proportion of higher banded properties.

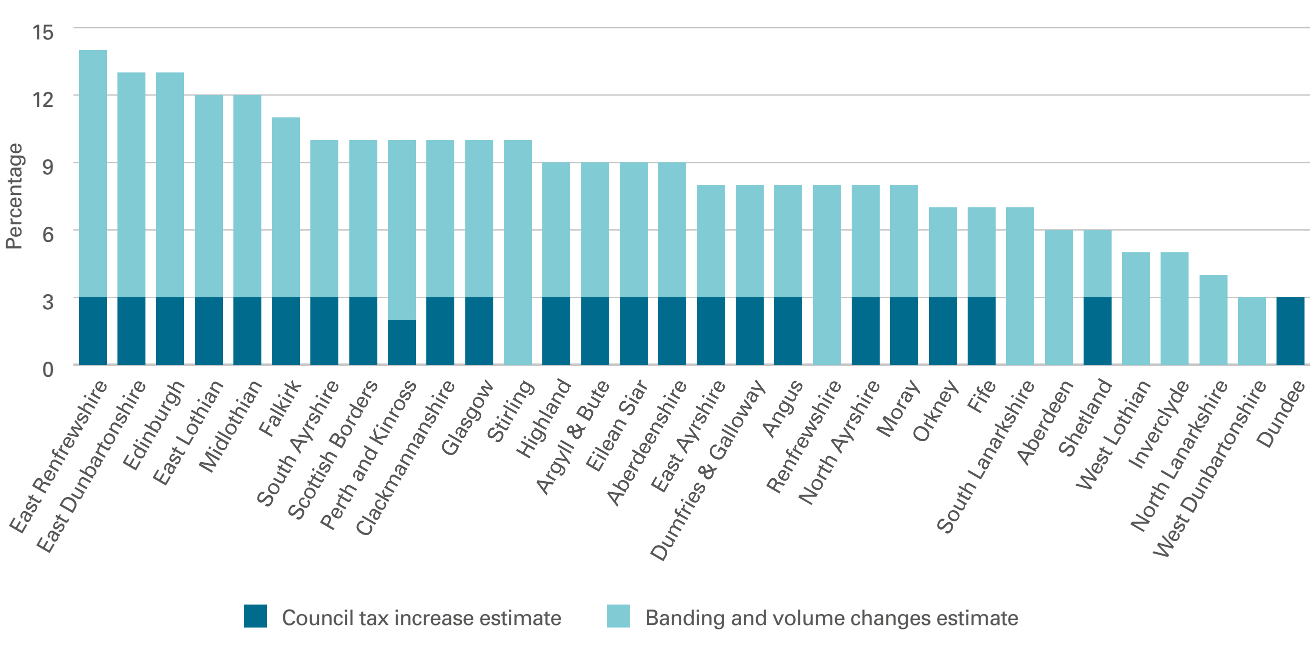
A significant element of income comes from fees, charges, house rent and grants taken directly to services

24. In 2017/18, 32 per cent (£5.4 billion) of councils' income was generated from fees, charges, rents and grants taken to services. The majority of this sum comes from two sources including house rents and grants from government and other bodies, such as the Department of Work and Pensions, which are credited to services. A smaller proportion of this money is raised from a wide range of charges for services including parking charges, music tuition in schools and fees for road closure consent. These are not easily distinguishable in the audited financial statements.

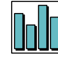
Exhibit 5

Increase in council tax income by council, 2017/18

Council tax changes raised a further £189 million in 2017/18.



Source: Audited financial statements 2017/18



There is significant variation between councils in charges for services

25. There is wide variation in what councils charge for and the level of charge made for services. In 2017/18 and 2018/19, there is variation in how councils are making increases to their income from fees and charges. Some councils are making incremental increases across the range of charges and fees they use. Some councils are making significant increases to groups of fees and charges, such as those related to commercial waste, harbour management or to burial and cremation. Some councils are introducing new fees and charges, these include, for example, charges for garden waste collection, use of residential centres, car parking charges, public toilets, and for pest control.

26. An analysis of a sample of 16 types of charges, from data provided by local audit teams in each council, indicates that from 2016/17 to 2018/19, 11 increased by more than the rate of inflation. Inflation over the two-year period has been calculated at 4.7 per cent. The service charges which showed the highest increases were:

- purchase of grave (lair), where of the 22 councils that had provided information on fees, the average increase was 20 per cent
- adult burial (interment), where 23 councils reported an average increase of 12 per cent
- junior swimming access, where 11 councils reported an average increase of 11 per cent.

Does your council have a charging policy?

Is it in line with corporate plans and objectives?

When was this last reviewed?

Do you receive sufficient information about the potential impact on the service and wider community when making decisions about changing fees and charges?

What information do you need to be able to explain increases in fees and charges to your constituents?

Councils' budgets 2017/18

Councils identified some consistent pressures in setting their 2017/18 budgets

27. Councils' 2017/18 budget papers identified some common themes in the pressures that councils were identifying. These include:

- Staff costs – as the single most significant expenditure for councils, changes to staff-related costs can generate significant pressure on budgets. Specific pressures included:
  - Pay inflation was a consistent pressure across councils. The Highland Council identified pay and pensions pressures of £4.2 million (0.7 per cent of its budget).
  - The introduction of the living wage and sleepover arrangements: this affected adult care services particularly. Renfrewshire Council's budget identified this pressure as £2.0 million (0.5 per cent of its budget)
- Other costs – inflationary pressures. Renfrewshire Council identified the ending of commissioned contracts and the renegotiation of new national care home contracts in adult care services as a budget pressure of £1.2 million (0.3 per cent of its budget).
- Financing costs – when a council borrows or invests in assets it can incur additional financing costs that become a new annual budget pressure. The Highland Council budgeted for additional pressures of £4.3 million (0.7 per cent of its budget) (including additional loans charges and unitary charges).

How do you engage with the budget-setting process and ensure you have the opportunity to influence the development and content of a strategic budget?

- Apprenticeship levy – this is a new levy on bodies of 0.5 per cent of pay bills above £3 million. The Highland Council identified this as a pressure of £1.2 million (0.2 per cent of its budget), East Ayrshire as £0.8 million (0.2 per cent of its budget) and Dundee City Council £1.0 million (0.3 per cent of its budget). Budgets tended not to assume receipt of funding or grants from the Scottish Government or Scottish Apprenticeship Advisory Board in respect of the levy.

- Demand costs – increasing demand for services was noted as a cost pressure. This was most distinct in adult care services. Renfrewshire Council identified this as £1.2 million (0.3 per cent of its budget). East Ayrshire Council agreed to fund demand pressures in adult social care of £2.0 million (0.6 per cent of its budget).

Budgeted net expenditure of £12.4 billion included 'funding gaps' of four per cent

28. Councils' 2017/18 budgets identified total final net expenditure budgets of £12.4 billion. This is after fees, charges and grants are credited to services as budgeted income. These total net expenditure budgets were not fully met by remaining income from core Scottish Government funding, including NDR, and council tax. The shortfall or 'funding gap' was £0.5 billion (four per cent).

Funding gaps were managed by planned savings and temporary use of reserves

29. Councils identified funding gaps of up to six per cent of total revenue, but still managed to present balanced budgets through:

- planned budget savings of £0.4 billion (three per cent of revenue funding). These included management and staff reductions and restructuring, service redesign and procurement

- planned use of £0.1 billion of unearmarked reserves.

Some councils reverted to a temporary planned use of reserves due to the uncertainty presented by the local government elections in May 2017

30. The local government elections in May 2017 had a bearing on some councils' approach to budget-setting. With outgoing administrations and the possibility of changed incoming administrations, officers did not feel able to agree transformational savings plans with outgoing administrations or have confidence that these could be sustained with new incoming administrations. This meant that reserves were used as a short-term contingency to manage funding gaps in 2017/18 until wider transformational plans could be agreed with new administrations. This demonstrates why medium and long-term financial planning is important.

Councils' outturn against their 2017/18 budget was more favourable than planned

31. 2017/18 net expenditure was £12.2 billion compared to the final budget of £12.4 billion. Common themes for this improved position were savings on staff costs and loan charges.

32. As we noted above the planned use of reserves was £105 million. The actual use of revenue reserves was much lower at £38 million and those that planned to use unearmarked General Fund reserves to balance the budget did not need to use reserves in line with their plan.

How does annual budget-setting link to medium and long-term financial planning in your council?

Does your council have a savings plan?

What are the options to close future funding gaps?

How well are you kept informed about progress in delivering those savings?

Overall increases in spending in education and social work were offset by reductions in other services

33. Scottish Government provisional outturn data identified expenditure grew by 1.1 per cent in cash terms, compared to 2016/17. In real terms it fell by 0.6 per cent. There were significant differences in expenditure between services:

- Education expenditure increased by 3.2 per cent (1.5 per cent in real terms). This reflects several national priorities including raising attainment.
- Social Work expenditure increased by 2.4 per cent (0.7 per cent in real terms). This included funding the living wage and demand pressures.
- Other 'non-protected' services fell by 2.6 per cent (4.3 per cent in real terms). This includes environmental services, culture and related services, planning and development services, and roads and transport.

Which service areas are under the most pressure to make savings?

What impact will savings have on the delivery of services and outcomes for service users, the wider community and the local economy?

What are the potential risks?

Part 2

Councils' financial position

Key messages

1. Eighteen councils drew on their usable reserves in 2017/18, overall by a relatively small amount.
2. Some councils have relatively higher levels of debt for their size.
3. Local policies vary on whether cash and investments are held to support reserves. This could increase the need for further future borrowing.
4. Capital expenditure in 2017/18 decreased by five per cent in real terms. Housing and education were the main areas of investment. Despite this the number of social houses provided by councils continues to fall.
5. Some councils have had significant increases in their debt positions.
6. There were delays with the valuation of pensions liabilities in councils across Scotland in 2017/18, but the net pension liability has reduced substantially in 2017/18.
7. Management commentaries in councils' accounts should do more to explain financial outturn against budget.

in 2017/18, councils drew on their usable reserves by £18 million, a relatively small element of usable reserves

Councils' financial position

In 2017/18, councils drew on their usable reserves by £18 million, a relatively small element of usable reserves

34. In last year's overview report we noted that more councils were drawing on their usable reserves. This trend continued in 2017/18, with 18 councils ending 2017/18 with lower levels of usable reserves than they had at the start of the year. In 2016/17, 20 councils were in this position.

35. Some councils added to their usable reserves including South Lanarkshire (increased by £15 million, 15 per cent), Stirling (increased by £6 million, 22 per cent) and Dundee (increased by £7 million, 35 per cent), due to significant in-year surpluses relative to the usable reserve balance. One council had a significant reduction in usable reserves: Aberdeen City reduced its usable reserve by £21 million (25 per cent), through a combination of a General Fund deficit and using part of its capital reserve.

What is the council's reserve policy?

What have reserves been used for in recent years?

Supporting services and bridging the funding gap or transforming services?

36. It is important that councillors are aware how usable reserves are being used each year, especially where the cumulative scale of this is potentially significant to financial sustainability. Northamptonshire County Council, in its 2017/18 financial statements, identifies that 'financial pressures ....have led to a position where the council has had to utilise almost all of its General Fund (£12 million) and earmarked reserves (£5.5 million) in order to deliver a balanced year-end outturn for 2017-18.' Our analysis based on 2018/19 budgets and levels of General Fund reserves indicates there are no short-term concerns in Scottish councils.

What are the different types of usable reserves your council holds?

Do you know what these can be spent on?

Is it clear that the reserves are needed for the purposes they are assigned?

Are the reserves sufficient for those purposes?

Could the reserves be better used for something else?

The overall total General Fund position is consistent with 2016/17 at £1.15 billion

37. Usable reserves held by councils totalled £2.4 billion. This includes General Fund balances and other statutory reserves. Within this total the General Fund balance remains relatively unchanged from 2016/17 at £1.15 billion. The nature and value of usable reserves are shown in Exhibit 6.

Exhibit 6

The relative size and nature of council's usable reserves

In 2017/18, usable reserves held by councils totalled £2.4 billion.

Source: Audited financial statements 2017/18

There is significant variation in the relative size and the nature of reserves held

38. Councils adopt different strategies for creating and managing their reserves, with some councils operating significant capital funds with associated investment plans. This provides a significant variation in the nature and extent of funds held (Exhibit 7). Councillors should scrutinise the nature, extent and timing of plans for using specific and committed funds to ensure that these remain valid, appropriate and reasonable.

Some councils have relatively higher debt than others

39. Councils' **net debt** varies by between 45 per cent of annual revenue in Shetland to 203 per cent in West Dunbartonshire (Exhibit 8, page 21). Higher levels of debt lead to higher annual costs of servicing this debt and councils need to ensure this is affordable. West Dunbartonshire has total debt of £535 million offset by cash assets of £22 million. This is a net external debt of £513 million compared to annual revenue of £253 million (from council tax, NDR, revenue support grant and dwelling rents).

Gross debt/net debt:

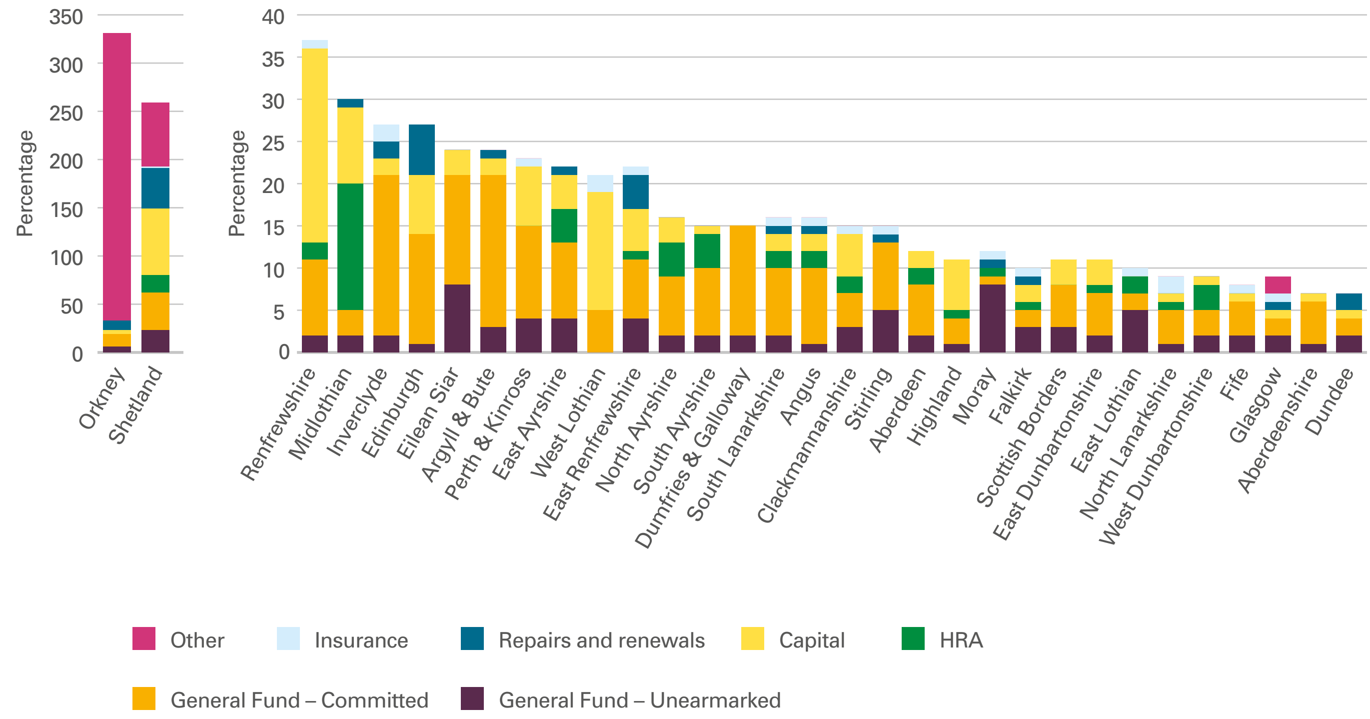
Gross debt is the total outstanding borrowing and the liabilities associated with PFI/PPP/NPDO and HuB schemes.[1] This includes both long and short-term balances.

Net debt is 'gross debt' less any cash or investments, which form part of the council's overall approach to treasury management.

Exhibit 7

Usable reserves as a percentage of council annual revenue

There is significant variation in the relative size and the nature of reserves held.



Source: Audited financial statements 2017/18 (Orkney and Shetland have reserves which are above 250 per cent of their annual revenue)

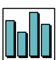
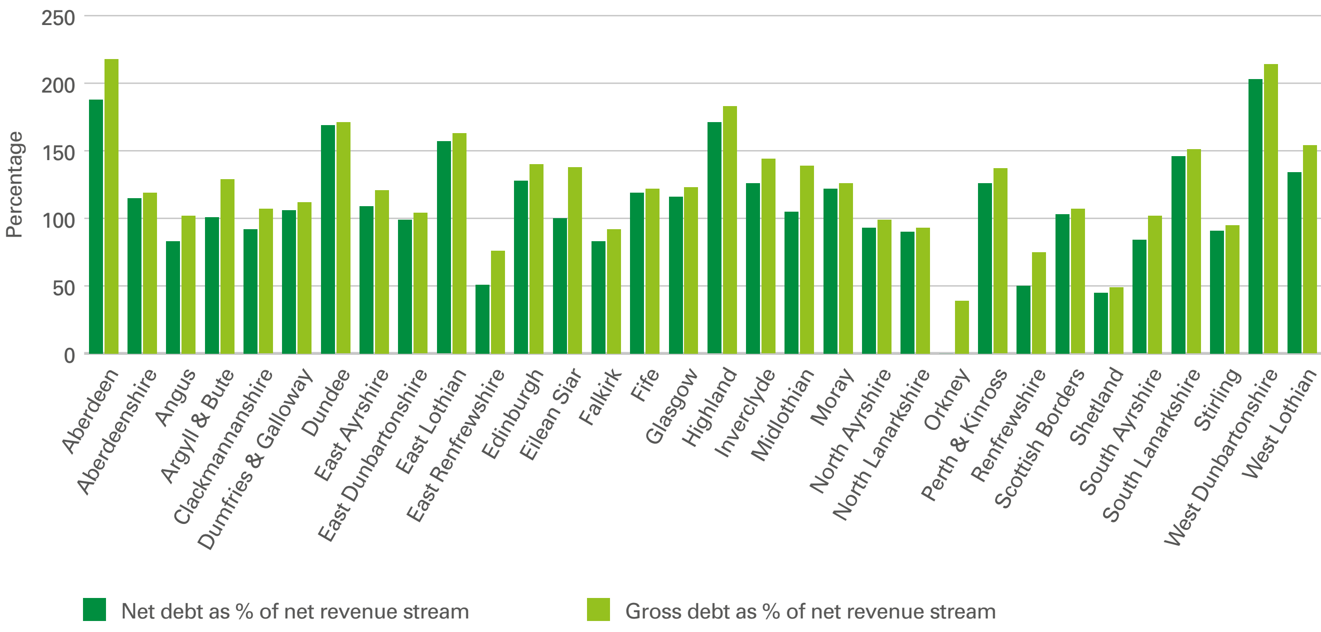


Exhibit 8

Council gross and net external debt compared to its annual revenue

Councils' net borrowing varies between 45 per cent of annual revenue in Shetland to 203 per cent in West Dunbartonshire.



Note: NRS is the net revenue stream, ie the net spending used for day-to-day delivery of council operations.
Source: Audited financial statements 2017/18 (Orkney is excluded as it has net investments)

Councils don't always have cash to support reserves and might need to borrow further

40. Thirteen councils have significant cash or investments that can be used to support the reserves position (Exhibit 9, page 22): spending reserves would reduce the cash or investments held. However, other councils have chosen in the past to use their cash or investments to fund capital spending rather than take on further borrowing. This means that some councils would need to borrow further over the longer term to provide the cash to spend on commitments identified in their reserves. This borrowing would increase their 'underlying' debt position from the position shown in Exhibit 9.

41. Councillors should be aware of the current borrowing position and the potential need for future borrowing when agreeing authorised borrowing limits as part of the prudential code .

Capital spending in real terms reduced by five per cent in 2017/18

42. In real terms, capital expenditure decreased by £138 million (five per cent) between 2016/17 and 2017/18 to £2,698 million. Exhibit 10 (page 22), illustrates the level of capital expenditure across the main services areas. The majority of investment is in schools' estate, new social housing and major refurbishment of social housing.

?

What is the council's current debt position?

Do you have clear information about the potential need for future borrowing when agreeing authorised borrowing limits?

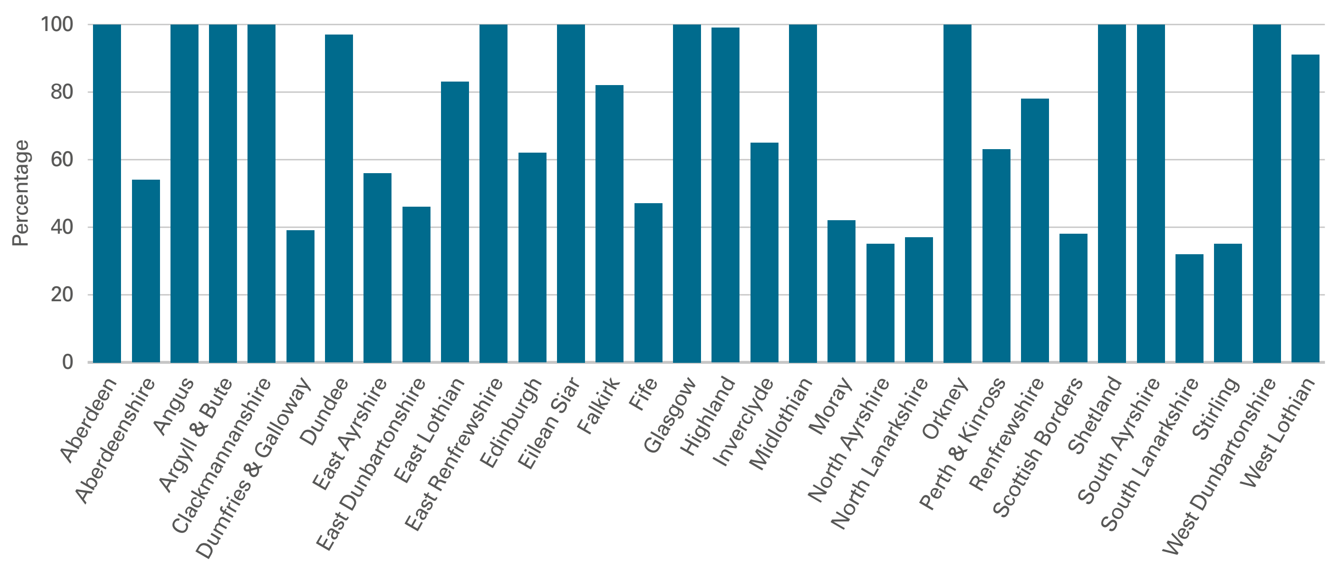
What share of the council's budget is taken up with interest payments and debt repayment?

What proportion of the council's debt is linked to inflation or at fixed rates? What does this mean for longer-term affordability?

Exhibit 9

Extent that usable reserves are represented by cash or investments

Thirteen councils have significant cash or investments that can be used to support the reserves position.



Source: Audited financial statements 2017/18 (100 per cent shown as max. amount, some councils exceed 100 per cent)

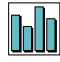
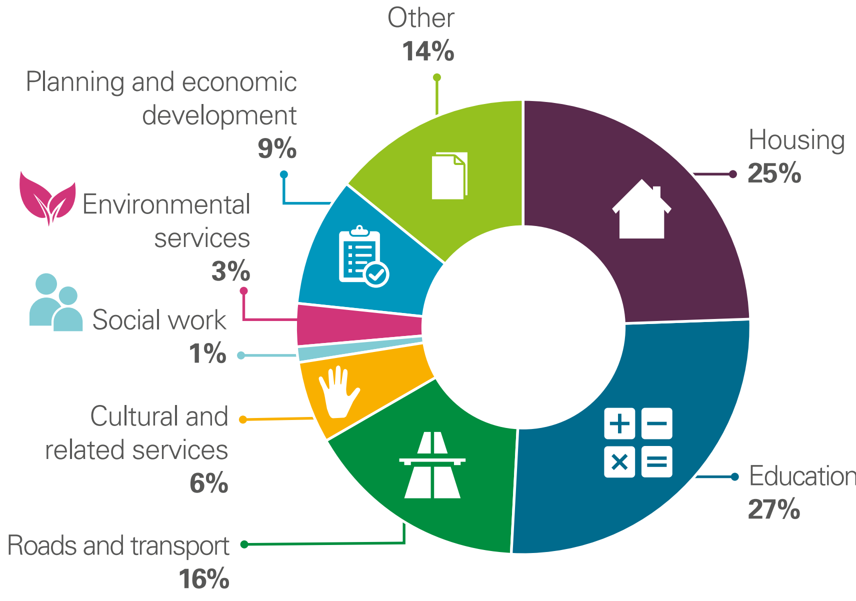


Exhibit 10

Capital expenditure by service area, 2017/18

The majority of investment is in schools' estate, new social housing and major refurbishment of social housing.



Source: Scottish Government POBE provisional outturn by service

Despite investment in social housing overall, numbers of council houses continue to fall

43. Across Scotland, social housing is provided by a mix of housing associations and by councils. In 24 areas, councils continue to be significant housing providers. The number of council houses in Scotland continued to fall slightly in 2017/18, down a further 334 houses (0.1 per cent of stock), although the rate of decrease has slowed. The right-to-buy council housing ended in Scotland on 31 July 2016, but applications submitted by that date are still being processed during 2017/18, with 1,640 sales in the first three quarters of 2017/18. Sales and other contributing factors, such as demolitions, continue to offset the number of new houses being completed by councils (with housing stock). This net movement varied between councils: 16 councils saw a decrease in house numbers and ten increased in 2017/18 (six councils no longer have housing stock following stock transfer).

Government grants and amounts from revenue continue to be the main sources of funding for capital expenditure

44. Sources of capital expenditure funding included (Exhibit 11, page 24):

- £1 billion of government grants (£138 million or 16 per cent higher than in 2016/17)
- £0.6 billion of internal charges to services (loans fund principal repayments) (£0.7 billion in 2016/17)
- £0.6 billion increase in the underlying need to borrow[2] (£0.7 billion in 2016/17) with £0.3 billion of this resulting in an increase in external borrowing.

Some councils had significant increases in their net debt position

45. Councils' net debt increased in 2017/18 by £0.6 billion to £15.1 billion. Twenty councils increased their net debt by a total of £0.8 billion, with another 11 councils reducing their net debt by £0.2 billion.

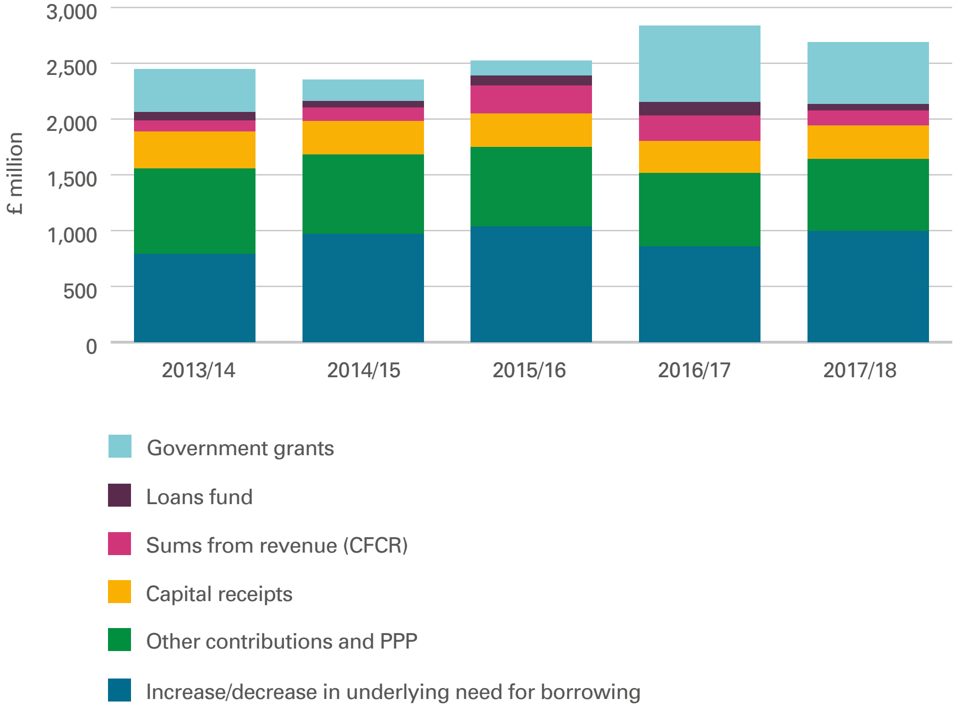
46. The councils with notable increases included:

- Argyll and Bute Council – a £58 million increase (31 per cent) due to increase in primary school finance leases and increased long-term borrowing.
- Aberdeen City Council – with the largest increase in net debt of £211 million (28 per cent) represented by a reduction in investments and an increase in finance leases, associated with Marischal Square and the ongoing capital investment and use of reserves to support delivery of the transition to its 'Target Operating Model'.
- Perth and Kinross Council – increased debt by £75 million (21 per cent) represented by an increase in long-term borrowing for capital expenditure.

Exhibit 11

Sources of funding for capital expenditure, 2013/14 to 2017/18 (real terms)

Government grants and amounts from revenue continue to be the main sources of funding for capital expenditure.



Source: Audited financial statements, sources of capital financing in real terms 2017/18 prices

Other key elements in the audited financial statements

There were delays with the valuation of pensions liabilities in councils across Scotland in 2017/18

47. Councils account for their share of the Local Government Pension Funds (LGPS) in accordance with International Accounting Standard 19 - Employee Benefits (IAS19). This relies on valuations of pension fund assets and liabilities by the scheme's actuary. Actuarial reports across Scotland used estimated data for the final part of the year. Asset returns estimated by the actuary for the final part of the year were significantly lower than actual returns, as a result of significant changes in markets. This resulted in pension fund assets reported in the council's balance sheet being understated in the unaudited accounts. This issue was corrected in the majority of audited accounts across Scotland.

48. In updating the IAS19 report, an actuary also identified an omission in the original calculation of liabilities in three councils resulting in an increase to the council's net pension liability.

49. This issue affected councils and a significant number of subsidiary bodies that are also members of the LGPS.

The net pension liability has reduced substantially in 2017/18 compared to 2016/17

50. In 2017/18, councils' total net pension liabilities in the Scottish Local Government Pension Scheme (LGPS) reduced by 43 per cent from £11.5 billion in 2016/17 to £6.6 billion in 2017/18. All councils reduced their liability, except for Aberdeen City Council. This significant improvement was due to:

- an increase in pension fund assets of £1.1 billion, an increase of four per cent
- a reduction in scheme liabilities of £3.8 billion due to reductions in life expectancy, lower than assumed salary increases and increases in the discount factor used to value future benefits, based on bond rates.

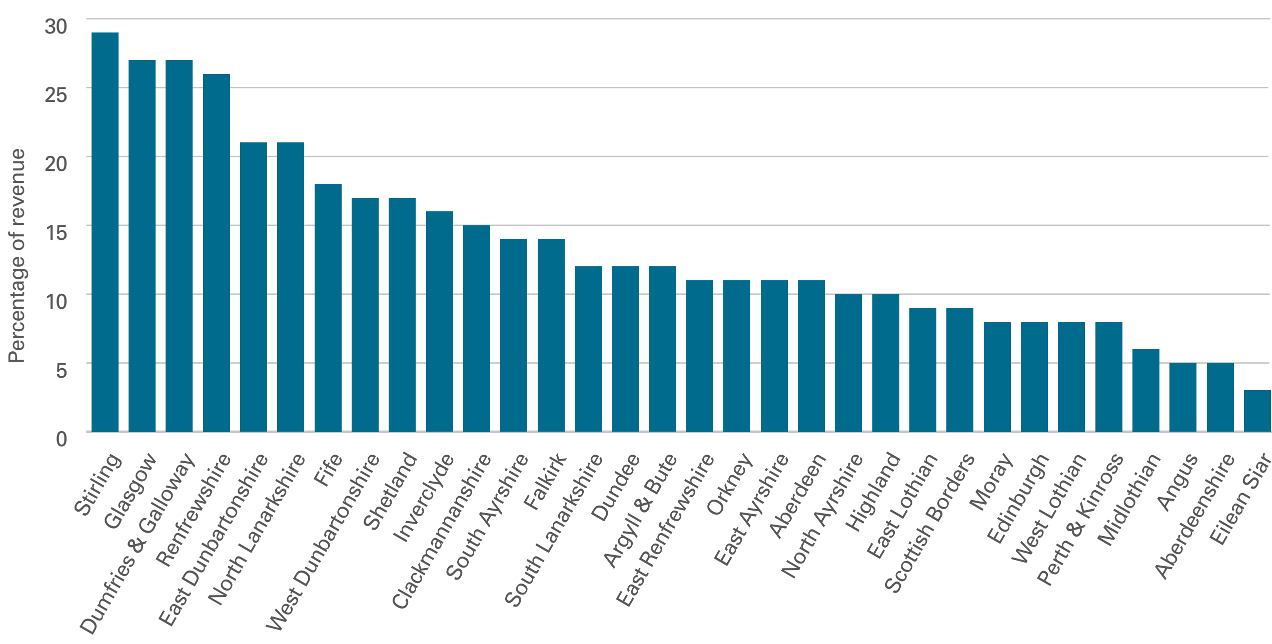
Unfunded LGPS liabilities vary significantly across councils

51. Unfunded liabilities are amounts that are not met by the Local Government Pension Schemes, but by individual employers. These can occur when an employer approves an early retirement, without actuarial reduction or with enhanced pension. Exhibit 12 shows that value of these unfunded benefits as a percentage of the annual revenues of each council. These ongoing commitments can represent annual payments of one to two per cent of revenue.

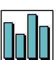
Exhibit 12

The total liability for LGPS unfunded liabilities as a percentage of annual council revenue

The amounts councils are committed to pay to pension funds for historic early retirements over the medium to long-term varies significantly.



Source: Audited financial statements 2017/18 and IAS19 valuation reports by actuaries



Glasgow City Council reports additional financial pressures that may arise from further equal pay claims

52. In our *Equal Pay in Scottish councils* report, we identified that all employers have a legal responsibility to ensure that women and men receive equal pay for equal work. In 1999, Scottish councils and trade unions reached the Single Status Agreement to harmonise local government pay and employment terms and conditions and eliminate pay inequality. Implementing the Single Status Agreement was a complex process that required all councils to undertake a large-scale job evaluation exercise. Councils underestimated the risks in this process and legal challenges continue to identify further issues.

53. Glasgow City Council has identified a new contingent liability[3] disclosure in 2017/18 for equal pay claims, which it is unable to estimate. This is based on a May 2017 ruling by the Court of Session on pay protection claims, affecting around 8,000 claimants and an August 2017 ruling on the council's Job Evaluation Scheme. This will take time to resolve and the potential scale is likely to be significant and impact on the council's financial planning.

Financial management, governance and transparency

Management commentaries could do more to explain council outturns in the accounts

54. Auditors' reviews of accounts are increasingly concerned with the transparency and clarity of the narrative contained within the management commentary that accompanies the financial statements. There are a few key aspects to an assessment of whether financial reporting is transparent in the narrative:

- Is the outturn against budget position for the year clearly shown with the reasons for significant variances obvious?
- Is the outturn reported in the narrative reconciled to the movement in General Fund contained in the financial statements and major differences explained?
- Some councils do not specifically report on progress against agreed savings in their accounts. Therefore, it is difficult to demonstrate if planned savings were achieved. Councils that did report this said they achieved 105 per cent of their planned savings.

55. We identified Comhairle Nan Eilean Siar's management commentary as an example of good practice. Financial performance in 2017/18 was clearly identified in the management commentary. This included the income, expenditure and surplus/deficit positions for significant elements of the council's budget that was consistent with overall movements on the General Fund.

56. There were improvements in this area in 2017/18. However, there are still circumstances where these basic expectations of transparency are not met and the financial outturn in the management commentary does not help the reader understand clearly how the council has performed against budget and how this is reconciled to the accounts.

Do budget monitoring reports clearly explain financial performance against plans and any changes to plans, including the reasons for change?

Does the management commentary clearly explain the council's financial performance and the changes to plans and reasons for those changes?

What additional training would you like to receive to develop your knowledge and skills for financial scrutiny?

Part 3

Integration Joint Boards' overview 2017/18

Key messages

1. Funding to the IJBs increased in 2017/18 by three per cent in cash terms. Most of this additional funding came from the NHS and includes additional Scottish Government funding to the NHS for IJBs of £107 million.
2. The majority of IJBs have underlying financial sustainability issues, with 11 out of 30 incurring deficits in 2017/18. A further eight would have incurred deficits without additional ('deficit') funding from their partners.
3. Reserve positions vary enormously between IJBs.
4. Medium-term financial planning is not used by most IJBs and further improvements to financial management should be introduced.

the majority of IJBs have underlying financial sustainability issues

57. Funding to the IJBs increased in 2017/18 by three per cent in cash terms. Including additional Scottish Government funding to the NHS for IJBs of £107 million. IJBs were established as a result of the Public Bodies (Joint Working) (Scotland) Act 2014 (the Act). They are partnerships between NHS boards and councils and are responsible for the delivery of adult health and social care, and in some council areas, for other services, such as children's services. We reported on progress in November 2018 in our report, *Health and social care integration – update on progress*.

58. In 2017/18, IJBs were responsible for directing £8.3 billion of health and social care resources, money that was previously separately managed by councils and NHS boards. In total, 29 per cent or £2.4 billion of IJB funding was allocated from councils, and £5.9 billion or 71 per cent from the NHS (Exhibit 13, page 28).

59. The total resources available to IJBs has increased by three per cent, in cash terms, from £8.1 billion in 2016/17. The majority of this £240 million was allocated from the NHS:

- £107 million was provided by Scottish Government to the NHS to direct towards social care services delivered by councils.
- In some cases, NHS boards directed additional funding to address overspends in prescribing.

What is the IJB's financial position? Is it financially sustainable?

What are the levels of reserve held by the IJB?

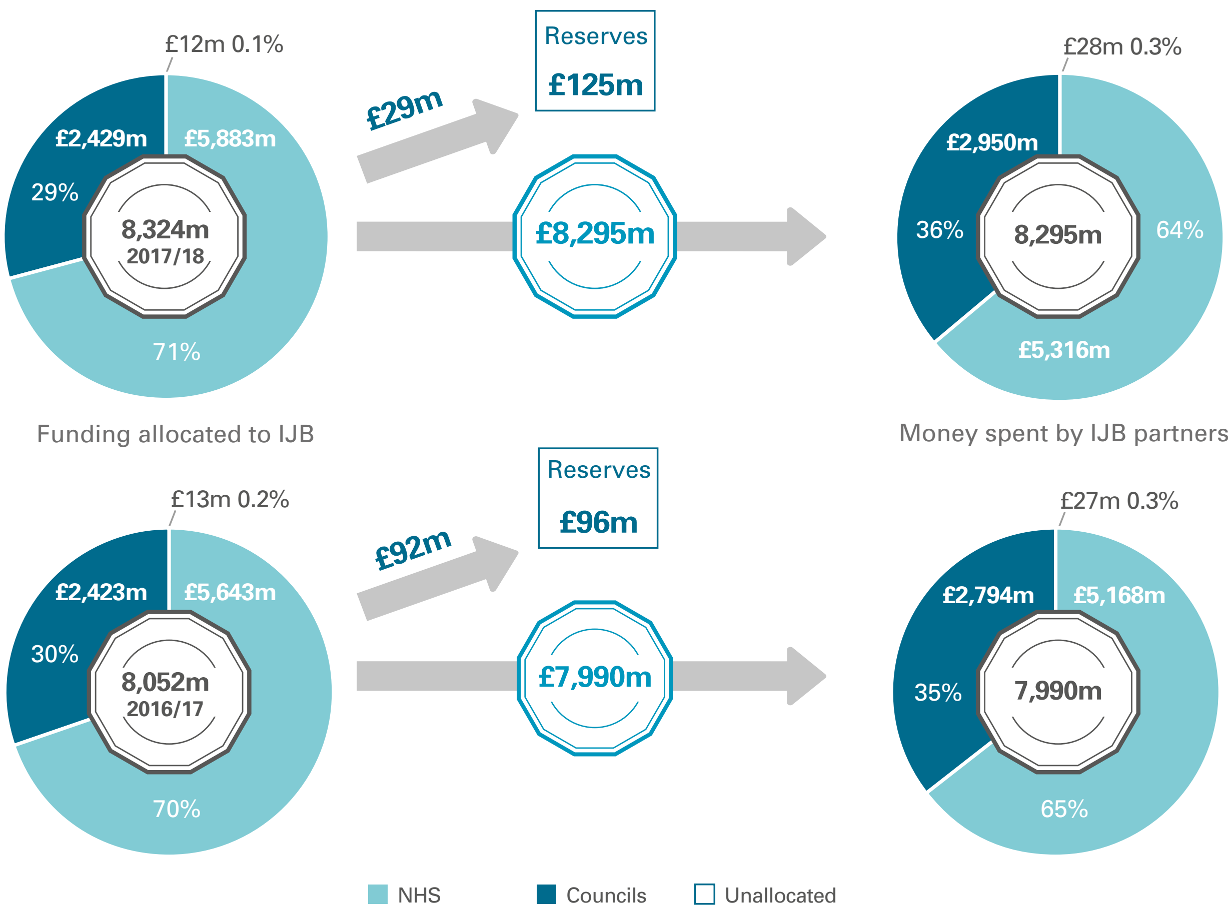
Are these in line with the IJB's reserve policy?

What does the IJB's financial position mean for the council and for the delivery of services?

Exhibit 13

Income and expenditure of Integration Joint Boards in 2016/17 and 2017/18

IJBs spent £8.3 billion on delivering health and social care services in 2017/18, 3.8 per cent (£305 million) more than in 2016/17. Of this 36 per cent was spent by councils and 64 per cent by the NHS.



Note: Some aspects of funding and expenditure is not attributed to either NHS or councils in a few audits. This represents about £15m and £12m of income in 2016/17 and 2017/18 respectively and around £28m of expenditure in both years.

Source: IJB audited accounts

60. IJBs spent £8.3 billion on delivering health and social care services in 2017/18, 3.8 per cent (£305 million) more than in 2016/17. Of this, 36 per cent was spent by councils and 64 per cent by the NHS.

61. The aim of the reform is to meet the challenges of Scotland's ageing population by shifting resources to community-based and preventative care at home, or in a homely setting. Therefore, it would be reasonable to expect the difference between what the NHS allocates to IJBs and what it receives for acute services to increase. In 2017/18, the difference was 6.6 percentage points compared to 5.1 percentage points in 2016/17, but this does not necessarily represent any operational shift in how services are provided.

The majority of IJBs have underlying financial sustainability issues and without year-end support from partners, 20 out of 30 would have reported deficits

62. Fourteen IJBs had a surplus in 2017/18 compared to 23 in 2016/17. Those with a surplus added a further £42 million to their reserves (£95 million in 2016/17). This does not properly identify the underlying position, as 19 IJBs had additional funding from their partners, which improved their outturn position by £51 million. Without additional funding, a further eight IJBs would have reported a loss in 2017/18, rather than the 11 that did. Eight of the IJBs drew on reserves from previous years to meet in-year deficits.

63. Auditors report that prescribing costs and adult social care costs appear to be the main reasons for overspends. Auditors noted that in NHS Greater Glasgow and Clyde a 'risk-share' agreement on prescribing pressures with the health board has ended in 2017/18 and this will present IJBs in that area with greater financial risk in 2018/19.

Reserve positions vary enormously

64. The total of reserves held by IJBs has grown from £96 million in 2016/17 to £125 million over 2017/18, and now represents 1.5 per cent of total income (compared to 1.2 per cent in 2016/17).

65. IJBs hold reserves for two main purposes that assist strategic financial management and risk management:

- to earmark, or build up, funds which are to be used for specific purposes in the future
- to provide a contingency fund to cushion the impact of unexpected events or emergencies.

66. Forty per cent of the total reserves are held by two IJBs: £31 million in Glasgow and £18 million in North Lanarkshire. Comhairle nan Eilean Siar has the highest reserve relative to its income at ten per cent (Exhibit 14, page 30). North Ayrshire is unusual in having a negative reserve of £5.8 million.

67. The auditor for North Ayrshire IJB highlighted concerns that 'in the medium term, the IJB is faced with an extremely challenging financial position'. In line with many other IJBs, it has not achieved short-term financial balance, but it has not been deficit funded by its partners.

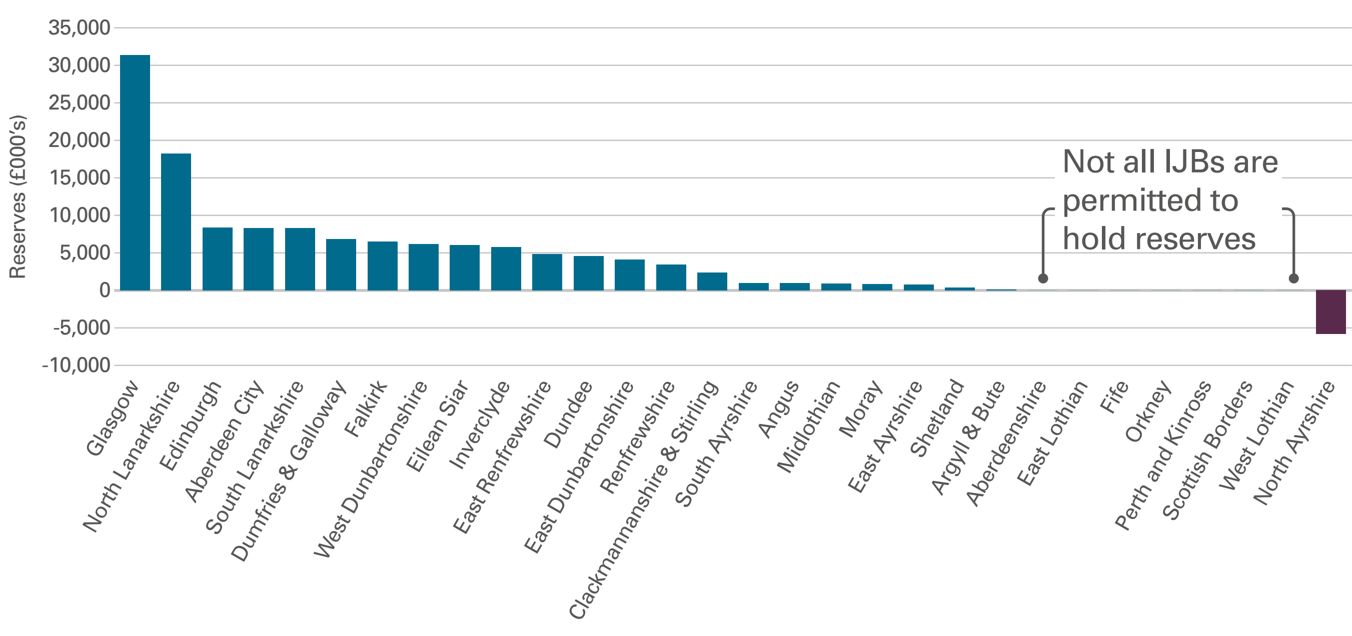
Funding gaps in 2018/19 are significant in IJBs and many do not have balanced budgets

68. Most auditors identified significant financial pressures in 2018/19 in their 2017/18 annual audit reports. The estimated funding gap for IJBs in 2018/19 was £248 million (three per cent of total income). Which is greater than identified in councils. Twelve of the IJBs still do not have balanced budgets for 2018/19 and a further four plan to incur deficits which will be met by accumulated reserves. We reported in November 2018, that these financial pressures make it difficult for IJBs to improve services.

Exhibit 14

Integration Joint Board reserves

Forty per cent of the total reserves are held by Glasgow and North Lanarkshire. North Ayrshire is unusual in having a negative reserve of £5.8 million.



Source: Audited financial statements 2017/18

IJB financial planning and financial management should be further improved

69. Only a third of IJBs have a medium-term financial plan, typically covering three years, and there is no evidence of longer term-financial planning.

70. Auditor's identified issues with financial management in the IJBs including:

- a lack of agreement or a late agreement of budgets
- poor financial monitoring due to delays and inaccuracies during the year
- instances where the projected outturns forecasts during the last quarter of 2017/18 were very different from those actually achieved.

71. As we reported in our *Health and social care report* these are fundamental issue which will limit the ability of Integration Authorities to improve the health and social care system.

Part 4

Councils' financial outlook

Key messages

1. In 2018/19, Scottish Government revenue funding to local government increased by 0.2 per cent after two years of real-terms reductions.
2. The Scottish Government published a five-year financial strategy in May 2018, but multi-year budgets are not yet being developed. The financial strategy identifies greater future uncertainty and likely further reductions of nine per cent in real terms over the next five years in 'other non-protected' council funding.
3. Many councils are in the early stages of delivering transformational change.
4. Medium-term financial planning has been adopted by almost all councils, but less than half have significant long-term plans over five years.
5. Councils expect to manage smaller funding gaps in 2018/19 of £0.3 billion (two per cent), with all 32 councils raising council tax rates by three per cent in 2018/19. There are no councils where the budgeted use of reserves is a critical issue over the next three years.
6. The impact of EU withdrawal is not yet clear, but councils need to identify the risks and develop contingency plans to manage these risks, as far as possible.

councils expect to manage smaller funding gaps in 2018/19 of £0.3 billion (two per cent)

Council future funding

Scottish Government revenue funding to local government increased by 0.2 per cent

72. The Local Government Settlement in 2018/19 increased by 1.7 per cent (cash terms) from 2017/18 to £9.8 billion. This was a real-terms increase of 0.2 per cent (Exhibit 15, page 32).

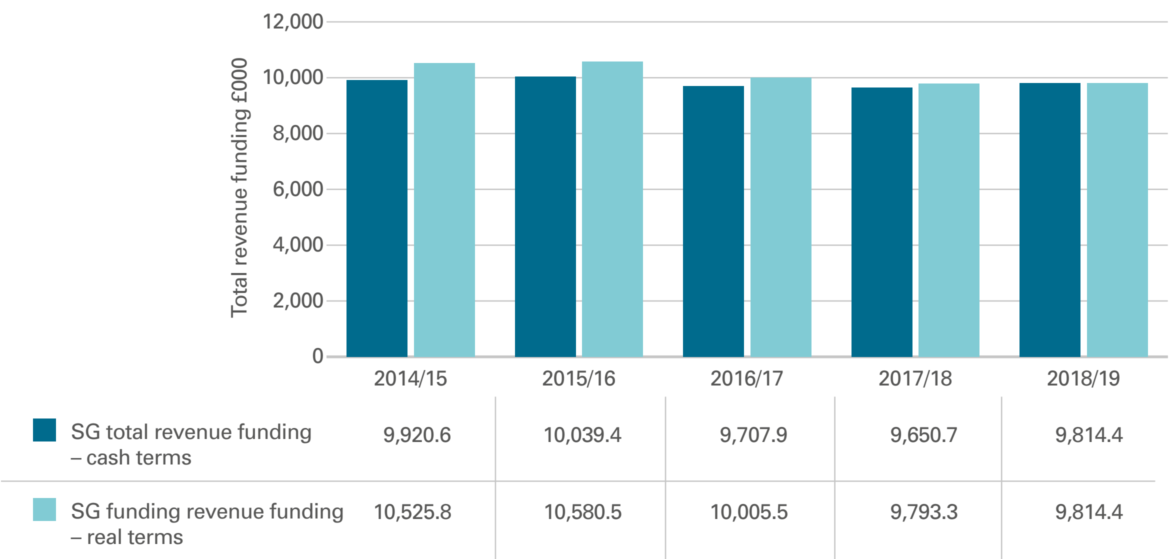
An increase in the 2018/19 settlement was late and the early payment of £35 million in 2017/18 reduced transparency in the funding available between the two years

73. On 31 January 2018, the Scottish Government announced an additional £160 million of general revenue grant funding for local authorities as part of the 2018/19 budget-setting process. Although welcomed by councils, this

Exhibit 15

Scottish Government funding to councils in real and cash terms

Scottish Government total revenue funding to councils increased in 2018/19 after two years of reduction.



	2014/15	2015/16	2016/17	2017/18	2018/19
SG total revenue funding – cash terms	9,920.6	10,039.4	9,707.9	9,650.7	9,814.4
SG funding revenue funding – real terms	10,525.8	10,580.5	10,005.5	9,793.3	9,814.4

Source: Audit Scotland; and Scottish Government financial circulars 2014/15 to 2018/19

announcement was late in the budget planning process (refer to paragraph 9, for comments on late funding allocations). Of the additional £160 million, £35 million was reallocated from projected 2017/18 underspends within the Scottish Government and was paid to councils on 28 March 2018. For accounting purposes, following consultation with auditors, this was treated as 2017/18 income by councils. By paying 2018/19 funding allocations to local authorities in the previous financial year, this reduced transparency in the effective funding for each year to councils and increased the reserves carried by councils at 31 March 2018.

The Scottish Government published a five-year financial strategy in May 2018

74. Funding settlements to councils continue to be provided on an annual basis. This makes it challenging for councils to plan and budget effectively for the medium term, given such a significant proportion of their income comes from Scottish Government funding. On 30 June 2017, the Budget Process Review Group[4] published its final report and this included a recommendation that the Scottish Government should develop a medium-term financial strategy. The Scottish Government's five-year financial strategy was published in May 2018.

Multi-year budgets are not yet being developed by the Scottish Government.

75. The five-year financial strategy identifies that 'in recent years the Scottish Government has delivered a series of annual budgets, an approach which will continue for the 2019-20 budget process', but also identifies 'an expectation that the next UK Spending Review (in 2019) will … provide the Scottish Government with the opportunity to develop a multi-year approach to the development of its budgets'.

76. The five-year financial strategy notes that 'as the Scottish Government moves away from being funded primarily through the block grant to a combination of devolved taxes and the block grant, the number of variables which will affect its longer-term funding outlook will increase'. Three key determinants are identified:

- changes in UK Government spending
- UK Government fiscal policy
- Scottish tax revenue relative to the rest of the UK.

77. The analysis suggests that, by 2022/23, the Scottish Budget could be around £37.6 billion, but scenario modelling indicates that the potential range for this could be between £35.5 billion and £39.7 billion, reflecting potential growth in the Scottish Budget between 2017/18 and 2022/23 of between £4.2 billion and £8.4 billion (in cash terms). The range of this variability amounts to around ±six per cent of the overall budget.

78. The key resource budget commitments of the Scottish Government’s social contract are Health, Police, Early Learning and Childcare, Attainment, Higher Education and Social Security. The financial strategy identifies greater future uncertainty and likely further reductions of nine per cent in real terms over the next five years in 'other non-protected' funding.

79. Two of these areas directly increase future local government funding settlements: early learning and childcare and attainment. Early learning and childcare commitments by the Scottish Government include further (recurring) uplifts in funding to councils of £210 million in 2019/20, £201 million in 2020/21 and £59 million in 2021/22. The Scottish Government has assumed a commitment to allocate additional specific revenue grants of £180 million in each of the three years 2018/19 to 2020/21 through the Pupil Equity Fund. However, other expenditure areas (non-protected areas), which are managed by councils, are not identified as a 'key resource budget commitment'.

80. The SPICe briefing paper in June 2018, identified that 'The Scottish Government’s Budget priority choices inevitably mean that other non-protected areas of spend must take up more of the slack from any future spending reductions. Under the range of scenarios provided by the Scottish Government, "other expenditure" will fall by between one and 16 per cent in real terms over the period to 2022/23, with the bulk of reductions occurring in 2019/20 and 2020/21… under the central scenario, other expenditure will fall in real terms by £1 billion (nine per cent). The largest element by far of "other expenditure" is the non-early learning and childcare part of Local Government.'

Financial pressures and planning

Councils continue to recognise significant financial challenges in the medium term

81. Most councils have identified financial challenges over the next few years including:

- decreasing revenue support grant and capital grant
- EU withdrawal and the risk of inflationary effects
- pay award pressures
- demand pressures, particularly the expected population growth in some council areas and the reduction in the relative proportion of working age to non-working age
- legislative changes which are not funded
- the economic performance of Scotland compared to the rest of the UK.

Many councils are in the early stages of delivering transformational change

82. Over half of councils began a new or refreshed transformation or change programme in the past year and one-third within the past three years. A few councils have yet to establish a programme. Because much of the transformation work is relatively recent it is too early to assess the effectiveness of the approaches taken.

83. The majority of work within transformational or change programmes is focused on service review and improvement work. Cross-organisational themes tend to focus on delivering, for example, staff and management restructures, office and property rationalisations, improvements in HR, payroll and finance systems. Some activity will have been more visible to the public such as digital approaches to customer services, increases in fees and charges, and redesign of waste management services. With funding expected to reduce further in the medium term, councils will need to consider more significant redesigns of how they operate and deliver services.

84. Transformation or change is challenging, and councils have highlighted a few common issues that have contributed to this including the effort and focus over recent years on establishing and progressing the health and social care arrangements with the NHS. Another factor is the long lead time and delays associated with ICT projects. With service and management redesign, the capacity of staff and management has been impacted. Over a third of councils have established training programmes to support transformation and change and over a third of councils have, or have recently agreed, to establish dedicated teams to support their programme.

85. The Accounts Commission recognises that with the financial pressures, councillors need to make difficult decisions. This requires effective political leadership and communications. It is essential that all councillors, not just the administration, work effectively with officers and other stakeholders to identify and deliver necessary savings. It is important that councils engage effectively with their communities about plans for savings and service redesign. We published a report *Roles and working relationships in councils – are you still getting it right?*, to support councillors in their role.

What is your council's financial position?

What particular challenges does the council face?

What new financial pressures are there for 2018/19 and 2019/20 and how much will these cost?

Does your council have a transformation plan?

Does it set out the aims and objectives and how and when these will be achieved?

Are projects within the transformation programme achieving their aims in terms of service quality, performance and cost?

How effectively are you engaged and informed about the council's transformation programme and kept informed about progress?

Are detailed options appraisals or business cases set out for changes to services planned within transformation activity?

Medium-term financial planning has been adopted by almost all councils, but less than half have significant long-term plans over five years

86. In previous reports we have emphasised the importance of medium and long-term planning to effective financial management. Councils have made good progress: 30 councils now have a medium-term financial plan. Councils' long-term financial planning is not as well developed. Sixteen councils do not yet demonstrate any long-term financial planning, some councils have elements of long-term financial plans evident such as long-term forecasting. Five councils have long-term financial plans that cover ten years or more. Only five of the plans that exceed five years appear to have considered the financial impact of population/demographic/demand changes over the longer term.

87. In the *Best Value Assurance Report on Fife Council* this year, we identified that the ten-year long-term financial model, based on demand forecasts, is an example of good practice among Scottish councils.

88. Around a third of councils use scenario planning within their medium or long-term financial planning. It is important that councils continue to consider potential funding scenarios and the implications for and options for services in the medium and longer term. Transformational change plans are likely to cover a number of years and should be consistent with financial planning. Financial plans should also consider the impact of demand changes over the longer term.

Does the transformation programme of work aim to make positive change to improve outcomes for communities?

Is it about seeking opportunities to do things differently to maintain or improve performance or is the focus only on make savings?

Councils' budgets 2018/19

Councils expect to manage smaller funding gaps in 2018/19 of £0.3 billion (two per cent)

89. Council's 2018/19 budgets identified total net expenditure budgets of £12.2 billion. These were not fully met by the remaining income from core Scottish Government and council tax. The shortfall or 'funding gap' was £0.3 billion (two per cent). The extent of funding gaps and savings plans is less in 2018/19 than 2017/18 and councils did not plan to use unearmarked reserves to support revenue budgets as they did in 2017/18.

90. All 32 councils raised council tax rates by three per cent in 2018/19, providing budgeted income of £2.5 billion.

91. In the 2018/19 budgets, all 32 councils increased council tax by the maximum three per cent, making the highest Band D rate, in Glasgow, at £1,286 and the lowest, in Eilean Siar, at £1,086.

Does your council have a long-term financial strategy (ten years or more) that reflects the anticipated changes in demographics and demands on services?

Do medium and long-term financial plans include a range of potential funding and financial scenarios?

Funding gaps are to be managed by planned savings, temporary use of reserves and additional fees and charges.

92. Councils presented balanced budgets with proposals to bridge the expected funding gap through:

- planned budget savings of £75 million (0.6 per cent of revenue funding)
- planned use of around £71 million of unearmarked reserves (0.9 per cent of net expenditure)
- increased fees and charges
- council tax increases.

Funding gaps vary between councils, there are no councils where the budgeted use of reserves would deplete them within three years

93. The number of councils budgeting to use unearmarked reserves in 2018/19 has reduced from 23 (in 2017/18) to 18. Last year we reported that three councils would run out of General Fund reserves within two to three years if they continued to use them at the levels planned in 2017/18. We are pleased to note that there are no councils in this position in 2018/19, with councils generally reducing their planned reliance on unearmarked General Fund reserves.

What is the likely use of unearmarked reserves for 2018/19?

How does the remaining unearmarked reserve compare to forecast funding gaps?

What are the plans for using different reserve funds in 2019/20 and beyond?

Are these plans appropriate and reasonable?

Withdrawal from the EU

94. The UK will leave the European Union (EU) on 29 March 2019. If the UK Government and EU agree the terms of the UK's withdrawal before this date, there will be a transition period to the end of 2020. Preparations for EU withdrawal across councils vary. Approaches commonly include monitoring and inclusion in risk registers as well as briefings and report to councillors. Some councils also reflect the risk in corporate and financial plans. Several councils have established working groups to focus on this issue.

95. If the UK Government and EU fail to agree arrangements for the UK's exit from the EU, there will be no transition period and organisations will need to respond immediately. There is an urgent need for all councils to identify the associated risks. It is critical they have contingency plans in place to allow them to manage these risks and respond rapidly in the event of the UK leaving the EU with no transition period.

96. The Scottish Government and COSLA are working with NHS boards, councils and other public bodies to draw together information on their workforces. This will be used to assess the potential impact of EU withdrawal on the delivery of services.

97. Audit Scotland produced a paper *Withdrawal from the European Union, Key audit issues for the Scottish public sector*, October 2018. We will consider further the implication of EU withdrawal for Scottish local government in our overview report *Local government in Scotland: Challenges and performance*, in March 2019. We have included questions from this key issues paper in *Supplement 1: Scrutiny tool for councillors* accompanying this report.

What planning and measures has your council undertaken in preparation for EU withdrawal?

What are the risks and potential impacts of EU withdrawal for the functions of your council and for the wider communities of your council area, in terms of workforce, regulation and funding?

Endnotes

1 PFI/PPP/NPD/HuB - PFI is an approach financing public infrastructure where the private partner finances, designs, builds, and operates the infrastructure asset. PPPs, on the other hand, may refer to a wider range of public-private collaboration, and include several business structures and partnership arrangements such as joint ventures, concessions, outsourcing, and PFI. PFI and PPP generally involve a long-term contractual agreement between the public and private sectors with financing and risk sharing by the private partner. Scotland's Non-Profit Distributing (NPD) model is a type of PPP agreement. It differs from the PFI model in that that private sector returns are capped and any excess profit goes back to the public sector. NPDs also promote enhanced governance and transparency through the appointment of a public interest director to the project company.

2 An increase in the underlying need to borrow could be funded by a council over the short/medium term from working capital including reduced cash and investments. It may not result in external borrowing in year. In fact, many councils chose not to borrow as they did not consider current borrowing rates to be favourable.

3 Contingent Liability – a possible obligation that arises from past events and will be confirmed only by the occurrence or nonoccurrence of one-or more uncertain future events not wholly within the control of the council.

4 The remit of the group was 'to carry out a fundamental review of the Scottish Parliament's budget process following the devolution of further powers in the Scotland Act 2012 and Scotland Act 2016'.

Local government in Scotland

Financial overview 2017/18

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