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Aberdeen City Health & Social Care Partnership
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To: Members of the Audit and Performance Systems Committee

Town House,
ABERDEEN 22 October 2019

AUDIT AND PERFORMANCE SYSTEMS COMMITTEE

The Members of the **AUDIT AND PERFORMANCE SYSTEMS COMMITTEE** are requested to meet in **Meeting Room 4 / 5, Health Village on TUESDAY, 29 OCTOBER 2019 at 10.00 am.**

FRASER BELL
CHIEF OFFICER - GOVERNANCE

B U S I N E S S

TERMS OF REFERENCE

DECLARATION OF INTERESTS

1 Members are requested to intimate any declarations of interest (Pages 7 - 8)

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 Minute of Previous Meeting of 20 August 2019 (Pages 9 - 14)

4 Business Planner (Pages 15 - 16)

WORKFORCE ISSUES

5 Growing the Primary Care Workforce (Pages 17 - 58)

AUDIT

6 Internal Audit Report AC1908 - Non-Residential Care Charging Policy (Pages 59 - 62)

7 Internal Audit Report AC1924 - Integration Joint Board Directions (Pages 63 - 72)

FINANCE

8 Review of Financial Regulations (Pages 73 - 100)

PERFORMANCE

9 Performance Dashboard (Pages 101 - 104)

10 Transformation Progress Report (Pages 105 - 234)

EXEMPT / CONFIDENTIAL BUSINESS

11 None Declared

CONFIRMATION OF ASSURANCE

12 Confirmation of Assurance

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

Aberdeen City Health & Social Care Partnership
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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.

DECLARATIONS OF INTEREST

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

I declare an interest in item (x) for the following reasons ……

For example, I know the applicant / I am a member of the Board of X / I am employed by…
and I will therefore withdraw from the meeting room during any discussion and voting on that item.

OR

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

OR

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

(a) a devolved public body as defined in Schedule 3 to the Act;
(b) a public body established by enactment or in pursuance of statutory powers or by the authority of statute or a statutory scheme;
(c) a body with whom there is in force an agreement which has been made in pursuance of Section 19 of the Enterprise and New Towns (Scotland) Act 1990 by Scottish Enterprise or Highlands and Islands Enterprise for the discharge by that body of any of the functions of Scottish Enterprise or, as the case may be, Highlands and Islands Enterprise; or
(d) a body being a company:-
i. established wholly or mainly for the purpose of providing services to the Councillor's local authority; and
ii. which has entered into a contractual arrangement with that local authority for the supply of goods and/or services to that local authority.

OR

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

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

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

Minute of Meeting

Tuesday, 20 August 2019
10.00 am Meeting Room 4 / 5, Health Village

Present: John Tomlinson; and Luan Grugeon, Councillor Philip Bell and Councillor John Cooke (as substitute for Councillor Cllr Gill Al-Samarai)

Also in attendance; Alex Stephen (Chief Finance Officer, ACHSCP), Alison MacLeod (Lead Strategy and Performance Manager, ACHSCP), Kenneth O'Brien (Service Manager, ACHSCP), Martin Allan (Business Manager, ACHSCP), Graham Lawther, (Communications Manager, ACHSCP), Alan Thomson, Kundai Sinclair and Derek Jamieson (Governance, Aberdeen City Council (ACC)), and Colin Harvey (Internal Audit)

Apologies: Cllr Al-Samarai

The agenda and reports associated with this minute can be found here. Please note that if any changes are made to this minute at the point of approval, these will be outlined in the subsequent minute and this document will not be retrospectively altered.

DECLARATIONS OF INTEREST

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

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

DETERMINATION OF EXEMPT BUSINESS

2. The Committee determined that there was no exempt business to be considered with the press and public excluded.

MINUTE OF PREVIOUS MEETING OF 28 MAY 2019

3. The Committee had before it the minute of the meeting of 28 May 2019.

The Committee resolved:-
(i) to amend the mis-spelling of Tomlison to Tomlinson on page 9, and
(ii) to otherwise approve the minute as a true record.

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BUSINESS PLANNER

4. The Committee had before it the Business Planner as presented by the Chief Officer Finance.

The Committee heard that the new planner would give a picture of current and future business reporting across this Committee but would also capture the business of the Integration Joint Board and the Clinical Care Governance Committee to minimise double reporting.

The Committee resolved:-
to note the updated business planner.

ANNUAL REPORT

5. The Committee had before it a report by the Chief Officer which provided information on the Aberdeen City Health & Social Care Partnership Annual Report 2018-19.

The report recommended : -
that the Committee -
a) review the ACHSCP Annual Report 2018-19, and
b) provide feedback and comment to the Lead Strategy and Performance Manager for inclusion in the finalised report.

The Committee heard a summary of the report and the variety of measures taken during its composition together with an explanation of consultation carried out during the various topics discussed in the report.

The Committee provided comment to the report author to assist completion of the report.

The Committee resolved :-
(i) to note the ACHSCP Annual Report 2018-19.
(ii) to provide feedback to the Lead Strategy and Performance Manager for inclusion in the finalised report.

STRATEGIC RISK REGISTER

6. The Committee had before it a report by the Chief Officer Finance which accompanied the ACHSCP Risk Register.

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The report recommended: -
that the Committee –
a) Approve and provide comment on the revised risk register, as detailed in the Appendix to the report; and
b) Undertake an in-depth review of risks 4, 5, 6 and 10, within the strategic risk register.

The Committee heard a full review on each of the selected risks.

Risk 4 – Description of Risk: There is a risk that relationship arrangements between the IJB and its partner organisations (Aberdeen City Council & NHS Grampian) are not managed in order to maximise the full potential of integrated & collaborative working to deliver the strategic plan. This risk covers the arrangements between partner organisations in areas such as governance arrangements, human resources; and performance.

The Committee heard that this was a critical requirement across all areas of the Partnership functions. Examples of good relationships at senior, leadership and operational levels were presented and that lessons learned were adopted within both continuing and developing relationships.

Feedback suggested that the IJB was working well.

Risk 5 – Description of Risk: There is a risk that the IJB, and the services that it directs and has operational oversight of, fail to meet both performance standards/outcomes as set by national and regulatory bodies and those locally-determined performance standards as set by the board itself. This may result in harm or risk of harm to people.

The Committee heard that whilst focus on this risk had previously been more strategic, focus was now more towards the operational challenges of the risk and that mapping exercises, self evaluation learning and data analysis all featured within a developing Action Plan at the regular Leadership meetings which would be presented to a future IJB (March 2020).

Risk 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.

The Committee heard that this risk applied across all areas of the Partnership's activities and that any failures involving partners and providers would by default impact on the Partnership. The Committee heard that a proactive approach including environmental scanning and awareness together with intelligence gathering would ensure a strong position to be able to manage and mitigate developing issues.

A strategy was being developed and this would be reported to a future IJB meeting.

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The Committee heard that as change was happening and would continue to happen, it was important that this risk was managed and mitigated fully.

Risk 10 - Description of Risk: There is a risk that ACHSCP is not sufficiently prepared to deal with the impacts of Brexit on areas of our business, including affecting the available workforce and supply chain. Whilst the impact on health and social care services of leaving the EU is impossible to forecast, it is clear that a number of issues will need to be resolved. Key areas for health and social care organisations to consider include: staffing; medical supplies; accessing treatment; regulation (such as working time directive and procurement/competition law, for example); and cross border issues.

The Committee heard that the Partnership continues to engage together with partners and participate on local and national EU Brexit discussions following Scottish Government guidance. Contingency planning had been developed and was subject to monitor and review with the Leadership Team. Considerations included, but not restricted to, impacts on staff, buildings, facilities, medications, services, financial impact and general disruption.

The Committee heard that a previous workshop session on the Strategic Risk Register was beneficial and that this would be repeated.

The Committee resolved:-

(i) to provide comment on the revised risk register, as detailed in the Appendix to the report;
(ii) to review risks 4, 5, 6 and 10, within the strategic risk register, and
(iii) to direct that updates be made to the Risk Register as detailed during the review.

FINANCE MONITORING REPORT

7. The Committee had before it a report by the Chief Officer Finance, which provided a summary of the current year revenue budget performance for the services within the remit of the Integration Joint Board (IJB) as at Period 3 and of on any areas of risk and management action relating to the revenue budget performance of the IJB services. The report also included details on the budget virements required.

The report recommended: -
that the 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, and
b) notes the budget virements indicated in Appendix E.

The Committee heard that providing the Partnership services involved a budget of over £300 million, not all of which was under direct control. If there was any overspend, the principle partners of Aberdeen City Council and NHS Grampian would be required to provide additional funding.

Previously, the availability of reserves had eased budget demands however an amended fund allocation model and a shift in transformation work to business-as-usual had indicated likely overspend forecast which was to be the subject of a report to the Leadership Team. It was hoped that the remedial action suggested would resolve the forecasted overspend.

The Chief Finance Officer informed the Committee that an overspend of £607,000 was currently forecast on mainstream services and that the senior leadership team have reviewed this position and identified potential savings to bring the budget back in on target by the end of the financial year.

The Committee resolved:-
to approve the recommendations.

WINTER DEBRIEF REPORT AUGUST 2019

8. The Committee had before it a report by the Chief Officer which provided the Winter Planning Debrief for 2018/2019.

The report recommended: -
that the Committee note the information contained in this report relating to winter 2018/19 and the learning that is being incorporated into winter planning for period 2019/20.

The Committee heard that the report was one part of the wider overall winter plan which the Leadership Team were involved with and would be presented to the IJB in September 2019. The report built upon events and learning to develop the plan, together with the anticipated EU Exit.

The Committee resolved:-
to approve the recommendation.

CONFIRMATION OF ASSURANCE

10. The Chair provided Members with an opportunity to request additional sources of assurance for items on today's agenda, and thereafter asked the Committee to confirm

it had received reasonable assurance to fulfil its duties as outlined within its Terms of Reference.

The Committee resolved:-
to confirm that they had received sufficient assurance from the reports presented.
- **JOHN TOMLINSON, Chairperson**

	A	B	C	D	E	F	G	H	I	J
1	AUDIT AND PERFORMANCE SYSTEMS COMMITTEE BUSINESS PLANNER The Business Planner details the reports which have been instructed by the Committee as well as reports which the Functions expect to be submitting for the calendar year.									
2	**Date Created**	**Report Title**	**Minute Reference/Committee Decision or Purpose of Report**	**Report Number**	**Report Author**	**Lead Officer / Business Area**	**Directorate**	**Update/ Status (RAG)**	**Delayed or Recommended for removal or transfer, enter either D, R, or T**	**Explanation if delayed, removed or transferred**
3	**29 October 2019**									
4	Standing Item	Review of Financial Regulations	Per APSC Terms of Reference	HSCP/19054	Alex Stephen	Chief Finance Officer	ACHSCP			
5	Standing Item	Review of Terms of Reference	Per APSC Terms of Reference		Alan Thomson	Legal Officer	Governance		T	November IJB for approval
6	Standing Item	Review of relevant Audit Scotland reports	Good practice to see national position		Alex Stephen	Chief Finance Officer	ACHSCP		D	No Additional Audit Reports
7	Standing Item	Board Assurance & Escalation Framework	Review following close of CCG, Strategic Risk & H&S Work		Martin Allan	Business Manager	ACHSCP		D	Due to staff changes - MAllan - will defer to February
8	Standing Item	Internal Audit Report AC1908 - Non-Residential Care Charging Policy	Assurance that services are operating effectively	HSCP/19055	David Hughes	Chief Internal Auditor	Governance			
9	Standing Item	Internal Audit Report AC1924 - Integration Joint Board Directions	Assurance that services are operating effectively	HSCP/19056	David Hughes	Chief Internal Auditor	Governance			
10	04.09.2019	PCIP evaluation framework			Gail Woodcock	Transformation Lead	ACHSCP		D	Will be presented to APS in February 2020
11	04.09.02019	Growing the Primary Care Workforce & Audit Scotland Workforce Audit Report	To present a report following from the Audit Scotland Report	HSCP/19058	Sandy Reid	People & Development	ACHSCP			
12		Strategic Plan Performance DashBoard	For APS to have sight of 1st Draft of the new SP Performance Dashboard	HSCP/19057	Alison Macleod	Strategy and Performance	ACHSCP			
13	Standing Item	Transformation Programme Monitoring	Quarterly Reporting	HSCP/19059	Gail Woodcock	Transformation Lead	ACHSCP			
14	**25 February 2020**									
15	Standing Item	Financial Monitoring Report	Nov-19 (IJB), 25 Feb (APS)		Alex Stephen	Chief Finance Officer	ACHSCP			
16	Standing Item	Review of relevant Audit Scotland reports	Good practice to see national position		Alex Stephen	Chief Finance Officer	ACHSCP			
17	Standing Item	Quarterly Performance Monitoring	Per APSC Terms of Reference		Alison Macleod	Lead Strategy Manager	ACHSCP			
18	Standing Item	Review of Risk Appetite Statement	Per APSC Terms of Reference		Martin Allan	Business Manager	ACHSCP			
19	Standing Item	Transformation Programme Monitoring	Quarterly Reporting		Gail Woodcock	Transformation Lead	ACHSCP			
20	Standing Item	Internal Audit Reports and Plan	Assurance that services are operating effectively		David Hughes	Chief Internal Auditor	Governance			
21	Standing Item	External Auditor Annual Plan	Per APSC Terms of Reference		Andy Shaw	External Audit	ACHSCP			
22	Standing Item	Strategic Risk Register	Bi-Annual - August and February		Martin Allan	Business Manager	ACHSCP			
23	**28 April 2020**									

	A	B	C	D	E	F	G	H	I	J
2	**Date Created**	**Report Title**	**Minute Reference/Committee Decision or Purpose of Report**	**Report Number**	**Report Author**	**Lead Officer / Business Area**	**Directorate**	**Update/ Status (RAG)**	**Delayed or Recommended for removal or transfer, enter either D, R, or T**	**Explanation if delayed, removed or transferred**
24	28.05.2019	APS Duties Report	APS 28.05.2019 - Request that the Chief Finance Officer presents this report to the APS on an annual basis at the start of each financial year.		Alex Stephen	Chief Finance Officer	ACHSCP			
25	Standing Item	Review of relevant Audit Scotland reports	Good practice to see national position		Alex Stephen	Chief Finance Officer	ACHSCP			
26	Standing Item	Transformation Programme Monitoring	Quarterly Reporting		Gail Woodcock	Transformation Lead	ACHSCP			
27	Standing Item	Internal Audit Reports	Assurance that services are operating effectively		David Hughes	Chief Internal Auditor	Governance			
28	Standing Item	Review of Local Code of Governance	To provide assurance on Governance Environment		Alex Stephen	Chief Finance Officer	ACHSCP			
29	Standing Item	Review of Financial Governance	To provide assurance on Governance Environment		Alex Stephen	Chief Finance Officer	ACHSCP			
30	Standing Item	Approval of unaudited Accounts	Per APSC Terms of Reference		Alex Stephen	Chief Finance Officer	ACHSCP			
31	Standing Item	Annual Governance Statement	To provide assurance on Governance Environment		Alex Stephen	Chief Finance Officer	ACHSCP			
32	**2 June 2020**									
33	Standing Item	Internal Audit Annual Report	Assurance that services are operating effectively		David Hughes	Chief Internal Auditor	Governance			
34	Standing Item	Review of relevant Audit Scotland reports	Good practice to see national position		Alex Stephen	Chief Finance Officer	ACHSCP			
35	Standing Item	Transformation Programme Monitoring	Quarterly Reporting		Gail Woodcock	Transformation Lead	ACHSCP			
36	Standing Item	Internal Audit Reports	Assurance that services are operating effectively		David Hughes	Chief Internal Auditor	Governance			
37	Standing Item	Review of Code of Conduct	Per APSC Terms of Reference		Derek Jamieson	Committee Officer	Governance			
38	Standing Item	Approval of Audited Accounts	Per APSC Terms of Reference		Alex Stephen	Chief Finance Officer	ACHSCP			
39	Standing Item	External Audit Report	Per APSC Terms of Reference		Andy Shaw	External Audit	KPMG			
40	Standing Item	Contract Register Annual Review	Annual - to APS in May/June; to IJB in Nov/Dec - last reported September 2018		Anne McKenzie	Lead Commissioner	ACHSCP			

Aberdeen City Health & Social Care Partnership
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AUDIT & PERFORMANCE SYSTEMS COMMITTEE

Date of Meeting	29 October 2019
Report Title	Growing the Primary Care Workforce
Report Number	HSCP.19.058
Lead Officer	Sandra Ross, Chief Officer
Report Author Details	*Name:* Sandy Reid *Job Title: Lead, People & Organisation* *Email Address: sandy.reid1@nhs.net*
Consultation Checklist Completed	*Yes*
Appendices	*a.* Audit Scotland Report

1. Purpose of the Report

The purpose of this report is to draw the committee's attention to the Audit Scotland report "NHS workforce planning – part 2 - The clinical workforce in general practice", attached at Appendix A, which was published in August 2019 and highlights the significant challenges to increasing the number of people working in primary care and Aberdeen City Health and Social Care Partnership's response to these.

2. Recommendations

It is recommended that the Audit & Performance Systems Committee:

a) Note the significant challenges to increasing the primary care workforce

b) Instructs the Chief Officer to bring back a fuller report on the mitigating actions in light of the work being undertaken to reconsider the Primary Care Improvement Plan (PCIP) and implement the Workforce Plan.

AUDIT & PERFORMANCE SYSTEMS COMMITTEE

3. Summary of Key Information

3.1 Expanding the primary care workforce is central to delivering the five strategic aims in the IJB's Strategic Plan particularly in relation to Prevention, Resilience and Personalisation.

3.2 Primary care services face growing demand from an ageing population and an increase in the number of people with multiple chronic conditions. At the same time, there are pressures on workforce supply, including an ageing workforce and problems with recruitment and retention. Audit Scotland confirm that over one in three GPs, and over half of nurses employed by GP Practices are aged 50 or over.

3.3 Recent tax changes may also result in some GPs working less hours, to achieve a higher income. Long-established pension arrangements mean it is beneficial for some GPs and nurses to retire in their 50s.

3.4 Aberdeen City Health and Social Care Partnership is aware of these challenges and is actively investigating ways in which they can be mitigated. Early thinking is that action will fall under three categories –

- Current System Redesign
- Supporting the Current Workforce
- Attracting the Future Workforce

3.5 Related to this new GP contract is the provision of transformation funding to help them with the capacity to undertake their roles as Expert Medical Generalist. Each IJB was required to set out our aims and priorities for releasing GP capacity within a Primary Care Improvement Plan (PCIP). Aberdeen City's PCIP was approved at IJB in August 2018. The plan looks at ways to divert demand from GP practices and is looking at the following areas.

i. The Vaccination Transformation Programme
ii. Pharmacotherapy Services
iii. Community Treatment and Care Services
iv. Urgent Care
v. Additional Professional Roles
vi. Community Links Practitioners

The redesign of these areas should release GP capacity to enable a smaller cohort to manage the future level of demand relevant to their expertise. The PCIP along with our other transformation programmes are continually developing and it is currently being reconsidered in light of the five new transformation portfolios approved at IJB in September 2019. It is proposed that the Chief Officer brings forward a more detailed report to the committee in relation to the projects within the PCIP that will contribute to mitigating the primary care workforce challenges once that review is compete.

3.6 Our Empowered Workforce Plan was approved by IJB in March 2019 and is in the process of being implemented across the partnership. It includes actions to improve the health of our workforce, reduce sickness absence and longevity of careers. In addition, activities such as regular attendance at school 'career fairs' in Aberdeen and Aberdeenshire; encouraging work placements and working with Job Centre Plus colleagues enables the partnership to become much more proactive in seeking to attract its future workforce. Again it is proposed that the Chief officer brings forward a more detailed report on the implementation of the Workforce Plan particularly in relation to projects that support the current and attract the future primary care workforce.

4. Implications for Audit and Performance Systems Committee

4.1. Equalities

The activities described in this report will be undertaken with regards to equalities ensuring those with protected characteristics are not discriminated against in any way.

4.2. Fairer Scotland Duty

There are no negative implications relating to Fairer Scotland Duty within this report.

4.3. Financial

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

4.4. Workforce

The implications for Workforce are described throughout this report.

4.5. Legal

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

5. Links to ACHSCP Strategic Plan

5.1. This Report links to the implementation of the IJB Workforce Plan 2019/2021

6. Management of Risk

6.1. Identified risks(s)

There is a risk that the IJB will not be able to deliver on its Strategic Plan if it does not take action to mitigate the current challenges with the primary care workforce.

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

There are significant links to Strategic Risk 9 - There is a risk of failure to recruit and that workforce planning across the Partnership is not sophisticated enough to maintain future service delivery.

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

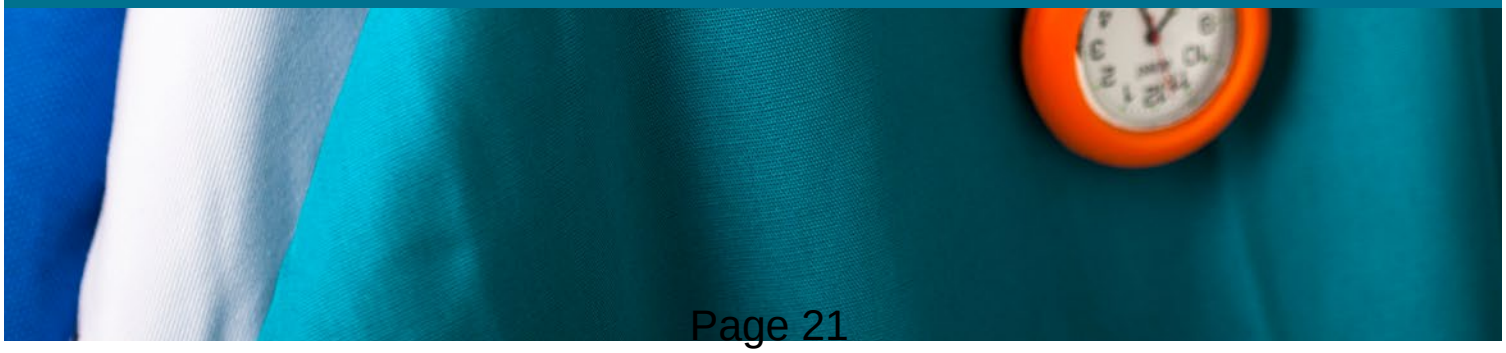
Providing the ability for the Audit and Performance Systems Committee to consider in detail the actions being taken to mitigate the challenges of the primary care workforce will enable them to gain assurance that appropriate plans are in place to maintain future service delivery.

NHS workforce planning – part 2

The clinical workforce in general practice

AUDITOR GENERAL

Prepared by Audit Scotland
August 2019



Auditor General for Scotland

The Auditor General's role is to:

- appoint auditors to Scotland's central government and NHS bodies
- examine how public bodies spend public money
- help them to manage their finances to the highest standards
- check whether they achieve value for money.

The Auditor General is independent and reports to the Scottish Parliament on the performance of:

- directorates of the Scottish Government
- government agencies, eg the Scottish Prison Service, Historic Environment Scotland
- NHS bodies
- further education colleges
- Scottish Water
- NDPBs and others, eg Scottish Police Authority, Scottish Fire and Rescue Service.

You can find out more about the work of the Auditor General on our website: www.audit-scotland.gov.uk/about-us/auditor-general 

Audit Scotland is a statutory body set up in April 2000 under the Public Finance and Accountability (Scotland) Act 2000. We help the Auditor General for Scotland and the Accounts Commission check that organisations spending public money use it properly, efficiently and effectively.

Contents

Links

PDF download

Web link

Interactive Tableau exhibit, where further information can be viewed online

Exhibit data

When viewing this report online, you can access background data by clicking on the graph icon. The data file will open in a new window.

Audit team

The core audit team consisted of: Mark Ferris, Dharshi Santhakumaran, Nichola Williams and Erin McGinley, with support from other colleagues and under the direction of Claire Sweeney.

Key facts

General practice-based multidisciplinary workforce (WTE)[1]

6,194

3,575 GPs in 2017

1,541 nurses in 2017

Investment in GP recruitment and retention since 2015/16

£15 million

over 1 in 3 GPs are aged 50 or over

Funding paid to GP practices in 2017/18

£794 million

over half Nurses employed by GP practices are aged 50 or over

Notes:
1. Based on survey data.

Summary

Key messages

1 Expanding the primary care workforce is central to the government's 2020 vision of delivering more care at home and in the community. Primary care services face growing demand from an ageing population and an increase in the number of people with multiple chronic conditions. There are also pressures on workforce supply, including an ageing workforce and problems with recruitment and retention. The Scottish Government acknowledges these workforce pressures but has not estimated the impact they will have on primary care services.

2 The Scottish Government is working to improve primary care workforce data, but progress has been slow. There is a lack of national data on the current numbers in the workforce, workforce costs, activity and demand. This makes it difficult to plan the workforce effectively or to monitor the impact of major policy changes, such as the new General Medical Services contract.

3 The Scottish Government's commitments to train additional GPs, paramedics, nurses and midwives are on track, but it is not clear how this increase in training will translate into numbers employed in the primary care workforce. The Scottish Government has implemented a range of initiatives to improve recruitment and retention of GPs but these have had limited success to date. UK-wide pressures on the workforce and increasing demand mean the government will find it challenging to meet its GP target of an 800 (headcount) increase over ten years. Meanwhile, similar workforce pressures will make it difficult for integration authorities to increase the multidisciplinary workforce by 2021/22.

4 People are generally positive about their experiences of primary care and would be happy to receive care from professionals other than doctors in a GP practice if they understood more about their roles. However, not enough has been done to engage with the public on a national level about these changes and why they are important.

5 Progress on national workforce planning has been slow, and there has been a series of delays to planned outputs by the Scottish Government. Responsibility for planning the primary care workforce is split across different policy areas, risking duplication of work. This complexity could further slow progress because of a lack of clarity about who is responsible for making decisions.

Recommendations

The Scottish Government should:

- undertake scenario planning to identify the potential impact of workforce pressures on all staff groups and set out how it plans to address these. This should make use of the NHS Education for Scotland (NES) data platform and include analysis of vacancy rates and the demographics of the workforce
- work with NHS boards and integration authorities to model how training and recruitment numbers across all healthcare staff groups will meet estimated future demand for primary care
- provide a clear breakdown of the costs of meeting projected demand through additional training and recruitment across all healthcare staff groups
- implement plans to collect data from GP practices on workforce numbers, activity, income and expenses. Whole time equivalent (WTE) as well as headcount data should be collected on workforce numbers. This data should be used to:
  - better understand the current workforce
  - underpin workforce planning
  - monitor progress against commitments
- collect data on the impact of workforce pressures on staff in primary care and set out how any issues will be addressed. This should include:
  - workload
  - sickness absence levels
  - staff morale
  - intention to leave the workforce
- work with primary care professionals to develop a coordinated national approach to engaging with the public about the changes to how primary care services are delivered
- monitor the impact of the GMS contract, including:
  - progress towards achieving the aim of changing the role of the GP and reducing GP workload
  - impact on rural and deprived areas
  - impact on staffing of out-of-hours services
  - impact on staff
  - impact on patients, including quality and continuity of care
- monitor progress towards meeting workforce commitments, including identifying the barriers to meeting the commitments and putting plans in place to meet demand if they are not achieved
- implement plans to simplify the workforce planning governance structure and clearly identify roles and responsibilities both nationally and locally.

Background

1. The Scottish Government's long-term vision for health and social care is to shift the balance of care so that there is a greater focus on keeping people well in their own homes and the community. This vision is set out in a range of policy documents and plans, going back to 2005, and is central to the government's 2020 Vision, published in 2011 (Exhibit 1, page 8). Primary care plays a major role in achieving this vision, as primary care professionals can identify issues early and support people to manage their own health as far as possible.

2. The Scottish Government intends to support the shift in the balance of care by increasing funding for primary care. In *Health and Social Care: medium term financial framework,* it committed to increasing primary care funding by £500 million over five years, so that, by 2021, 11 per cent of the frontline NHS Scotland budget should be spent on primary care.[1] The financial framework did not set out how the Scottish Government defines primary care spending, or what proportion of this increase will be spent on the workforce.

3. As well as increasing funding for primary care, the Scottish Government also aims to change the way primary care services are delivered. It plans to expand the primary care workforce, so that care will be provided by a range of professionals working together in multidisciplinary teams (MDTs). The Scottish Government wants people to receive care from the most appropriate member of the MDT. The size and make-up of these MDTs will vary according to local need, but MDTs may include nurses, advanced nurse practitioners (ANPs), physiotherapists, pharmacists and paramedics. MDTs may also include non-clinical staff, such as community link workers, who can support patients to access wider services.

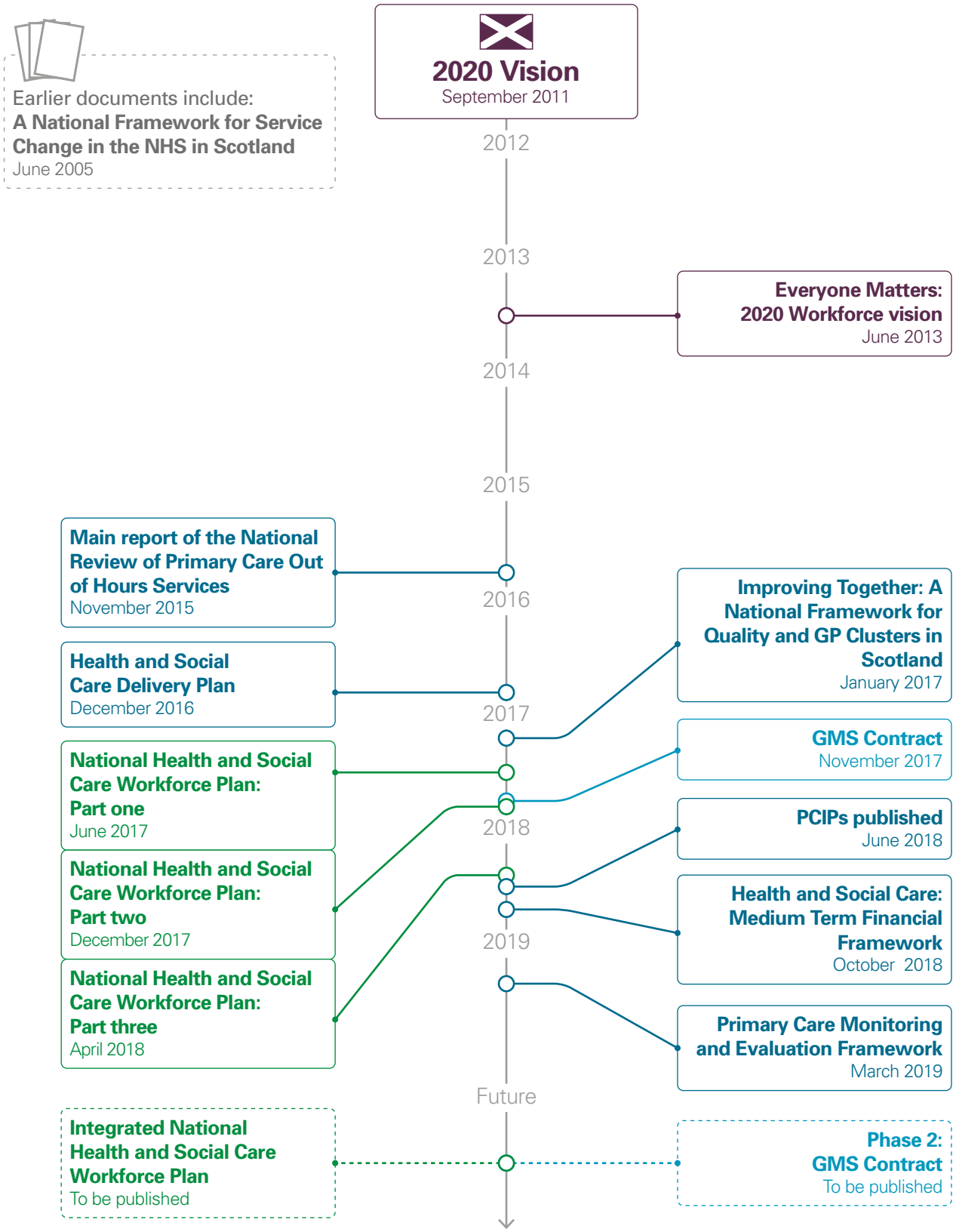
4. MDTs may be based in individual GP practices or work across a cluster of practices. These teams are the focus of this audit, but they do not work in isolation. To carry out their role, they need to work closely with other primary care professionals, for example, district nurses and the wider community nursing team, and colleagues working in hospitals and in social care. Any changes to the way that professionals work in the MDT has an impact on those working in the rest of the system. The Primary Care Clinical Professions Group have set out a joint statement on their vision for the future of primary care, and how the different professions will work together, based on 21 principles.[2]

5. Reform of primary care is complex and challenging. It is not solely the responsibility of the Scottish Government; NHS boards and integration authorities (IAs), which are partnerships between NHS boards and councils, have a crucial role. The voluntary sector also has a role to play, particularly in the development of the community link worker workforce. Locally, IAs are responsible for planning and resourcing primary care services. As the multidisciplinary workforce grows, the aim is that members of MDTs will be employed by NHS boards rather than GP practices. In the longer term, NHS boards will also take on more responsibility for owning practice premises.

Exhibit 1

Policy timeline

The Scottish Government's vision to shift the balance of care has been in place since 2011.



Note: PCIPs – primary care improvement plans, produced by integration authorities.

Source: Audit Scotland

6. These changes to primary care will require effective national and local workforce planning to make sure the right workforce is in place to meet the needs of Scotland's population. In our 2013 report, *Scotland's public sector workforce*, we define workforce planning as 'the process that organisations use to make sure they have the right people with the right skills in the right place at the right time'. For primary care, this means that the Scottish Government, NHS boards and IAs have to understand the needs of the population, both now and in the future, and plan the workforce to meet demand. We have previously highlighted the risk that the NHS workforce is being planned in response to budget pressures rather than strategic needs.[3]

7. Primary care is usually a person's first point of contact with the NHS. It is provided in the community by generalist health professionals, and includes general practice, community pharmacy, dentistry and optometry services. It covers both physical and mental health, and all age groups and health conditions.

8. Most GPs are self-employed. GP partners are GPs who own and run practices, usually in partnership. Historically, they have been responsible for employing their own staff, including other salaried GPs. Practices are contracted by NHS boards to provide primary care services.

9. Data on the size and make-up of the primary care workforce is limited (paragraphs 57–58), so workforce estimates are based on available survey data (Exhibit 2, page 10).

10. In April 2018, the new General Medical Services (GMS) contract came into effect. This contract aims to:

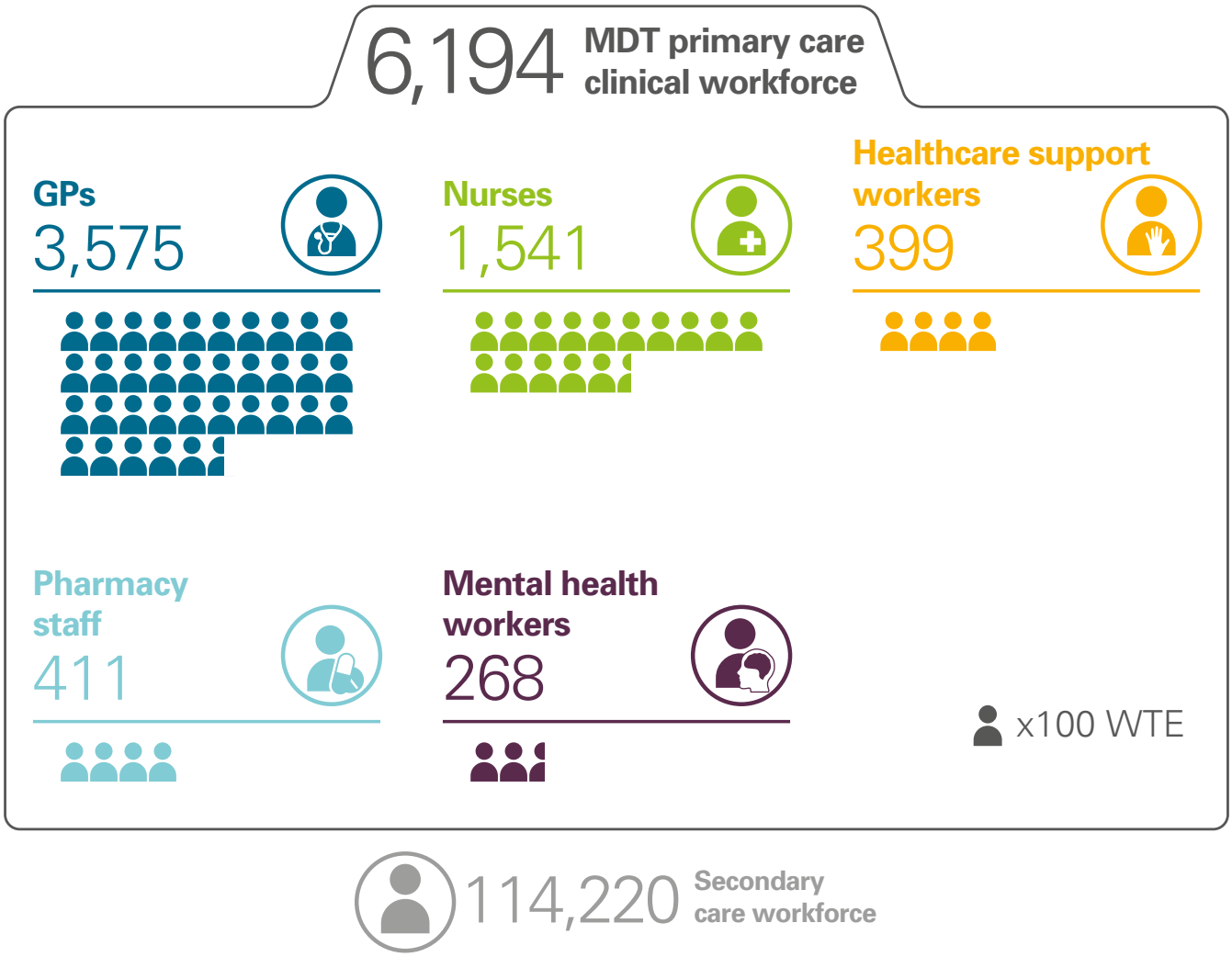
- refocus the role of GPs as expert medical generalists
- reduce GP workload and allow them to concentrate on patients with more complex care needs
- provide better care and improved access for patients
- improve infrastructure and reduce risk.

11. The contract is accompanied by a memorandum of understanding (MOU), which sets out the role of the GP as the senior clinical decision-maker at the head of the MDT. The increased role of other professional groups in the practice is intended to free up GP time and make it easier for patients to access the most appropriate care. The MOU also sets out priorities for reform to support the implementation of Phase 1 of the contract, from 1 April 2018 to 31 March 2021. As part of the contract, all IAs were required to work with NHS boards and GPs to develop primary care improvement plans (PCIPs). These plans should explain how the priorities set out in the MOU will be implemented locally. More information on the background and aims of the GMS contract is provided in our *General Medical Services contract in Scotland: a short guide*.[4]

Exhibit 2

The multidisciplinary primary care workforce in Scotland

A number of professional groups make up the MDTs based in GP practices.



Notes:

1. Figures given are whole time equivalent.
2. The figures for GPs, nurses and healthcare support workers are estimates made as part of the 2017 National Primary Care Workforce Survey carried out by ISD Scotland. These figures will only include staff members employed by the GP practice. Allied health professional data is not available.
3. The secondary care WTE figure excludes administrative staff and may include some staff employed by the NHS board but working in a GP practice, as it is not possible to separately identify these staff members.

Sources: Secondary care, ISD Scotland workforce trend data for March 2017 (2017 data used to be consistent with the latest primary care workforce survey); Pharmacy staff data provided by the Scottish Government, as at March 2019; Mental health workers, Mental health worker quarterly performance report, as at July 2019 (2019 data used for pharmacists and mental health workers, as 2017 data not available); Other staff groups, ISD Scotland National Primary Care Workforce Survey 2017.

About this audit

12. In July 2017, the Auditor General published the first in a series of audit reports on NHS workforce planning.[5] That report focused on clinical staff in a hospital setting and concluded that:

- the Scottish Government and NHS boards had not planned effectively for the long term
- responsibility for NHS workforce planning was confused
- there was a risk of further fragmentation as health and social care planning and planning for specialist medical centres developed.

It found that NHS staff were raising concerns about workload, and that NHS services were under increasing pressure. The Scottish Government expects demand for health and social care to increase but is yet to provide a clear analysis of the skills and workforce numbers needed to meet this demand. A summary of progress against the recommendations made in the first report is set out in Appendix 1 (page 33).

13. The aim of this audit was to establish how effectively the Scottish Government is planning and developing the primary care clinical workforce to meet the needs of the Scottish population. We set out to answer four key questions:

- How effectively is national workforce planning for the primary care clinical workforce addressing current pressures on staff and patient care?
- How well are national primary care clinical workforce planning arrangements considering the future needs of the Scottish population?
- What are the anticipated workforce costs to meet demand for primary care services and how effectively are these being planned for?
- What impact will the new GMS contract have on the Scottish Government's ability to deliver its vision of primary care?

14. This audit looked mainly at the national approach to workforce planning and how well it supports planning at regional and local levels. It focused on the general practice-based workforce of GPs and the wider clinical MDT, including nurses, allied health professionals (AHPs), pharmacists and others, as they are central to the implementation of the new GMS contract. AHP is a term which covers a range of healthcare professionals including paramedics, physiotherapists, occupational therapists and podiatrists. For the purposes of this report, when we refer to the primary care workforce, we mean the general practice-based clinical workforce. Although the dentistry, optometry, community nursing and care home workforce fell outwith the scope of this audit, they are an important part of the overall primary care workforce, and many of the issues highlighted in this report are also relevant to planning for the wider workforce.

15. This report is in two parts:

- Part 1 examines current pressures on the primary care workforce.
- Part 2 focuses on planning the future workforce to meet the needs of the Scottish population.

Part 1

The primary care landscape

There are significant pressures facing the primary care workforce

Demographic issues put increasing pressure on primary care services

16. Scotland's population is ageing. People aged over 75 are projected to be the fastest-growing age group in Scotland, expected to grow by 27 per cent between 2016 and 2026. The average number of patients registered at a GP practice is increasing. Between 2013 and 2018, the average practice list size across Scotland increased by eight per cent, from 5,602 to 6,073 patients.[6] Scotland's ageing population means that more people will be living longer with multiple long-term conditions, putting increasing pressure on the NHS.[7] This places pressure on general practice as GPs manage growing numbers of patients with multiple and complex health needs.

17. There are significant health inequalities across Scotland. People living in the most deprived areas have a lower life expectancy than those living in more affluent areas. They are also likely to spend more years living with ill health. From 2015 to 2017, the difference in healthy life expectancy between the ten per cent most deprived and ten per cent least deprived areas was 22.5 years for males and 23 years for females.[8] Primary care services in deprived areas face particular issues in meeting the complex needs of their patients, who are more likely to have multiple chronic conditions linked with poverty.

Recruitment and retention issues create pressures on the workforce

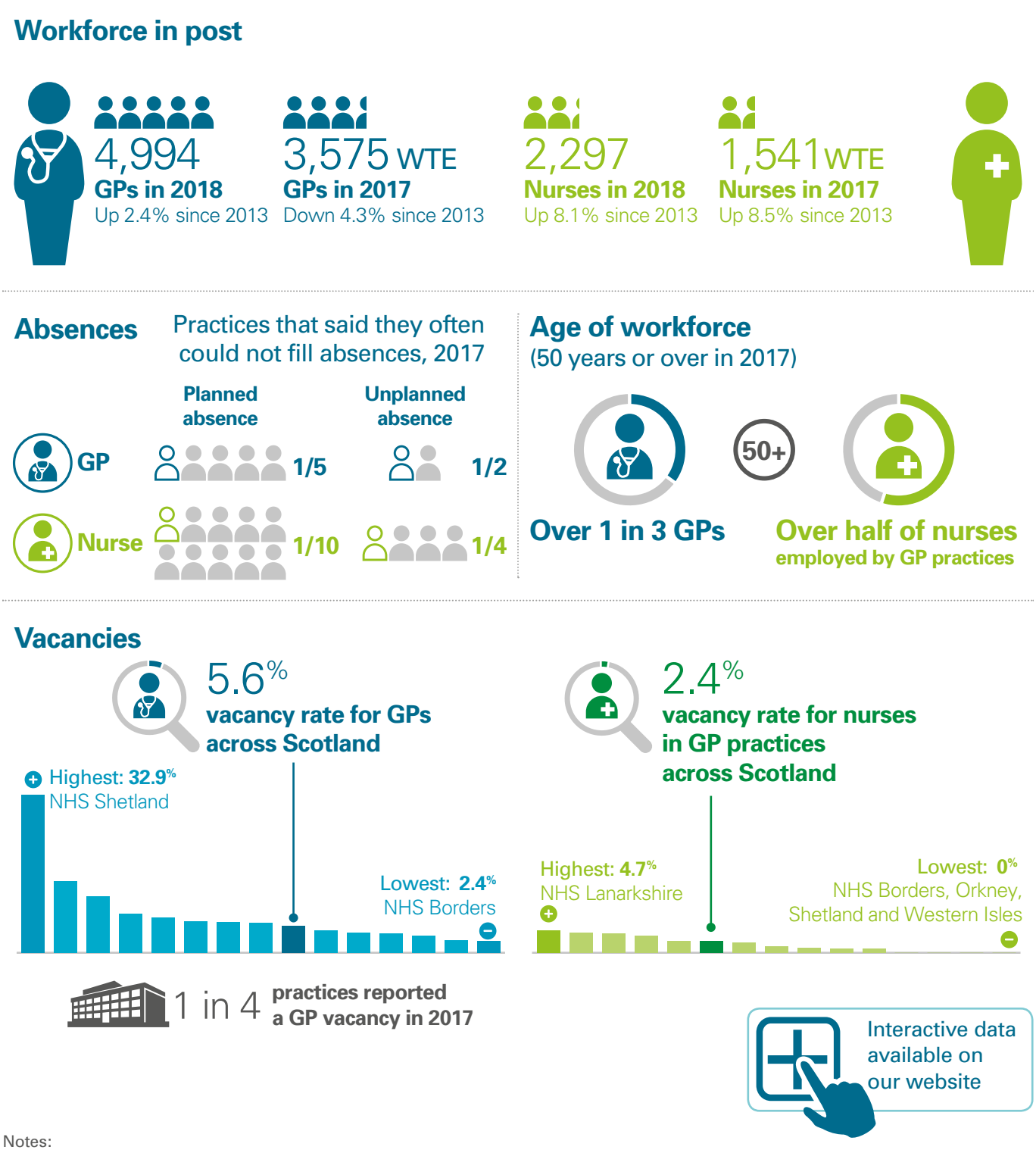
18. Recruitment and retention difficulties are one of the key issues facing the primary care workforce (Exhibit 3, page 13). Although there has been a slight increase in the overall headcount of GPs, the number of GPs who are partners has decreased, from 3,721 in 2013 to 3,396 in 2018. The number of practices being taken over by NHS boards has been rising.[9] This means that the practice is run by the NHS board instead of by GP partners as independent contractors, often because of difficulties recruiting new partners or retaining existing ones. The Royal College of General Practitioners (RCGP) Scotland recently reported that 26 per cent of GPs think they are unlikely to be working in general practice in five years' time.[10]

19. Until 2017, the main source of data on staff and vacancies in GP practices was a primary care workforce survey, run by ISD Scotland, on behalf of the Scottish Government. This was completed by GP practices and run every two years. The survey was voluntary and had a response rate of 82 per cent in 2017, up from 58 per cent in the previous survey, run in 2015. Fifty-nine per cent of GP vacancies that occurred in 2017 were filled, but 27 per cent of those took more than six months to fill. Commonly reported challenges in filling GP vacancies in 2017 included a shortage of applicants and the fact that the practice was in a rural area. The most commonly reported reasons for difficulty in filling nursing positions were a lack of candidates and the quality of the candidates applying.

Exhibit 3

Pressures on the primary care workforce

The available data shows workforce numbers increasing, but there is wide variation in vacancy rates across the country.



Notes:

1. The GP total includes 564 third-year trainees in 2018 and 490 third-year trainees in 2013. The figure for nurses includes only those employed by a GP practice, and not those employed by an NHS board.
2. WTE – Whole-time equivalent.
3. Trend data not used for vacancies and age of workforce, as these figures are based on a survey with large differences in response rates between years.
4. This level of detail is only available for GPs and nurses.

Source: Audit Scotland using ISD Scotland data

20. Out-of-hours services are a fundamental part of the health system, providing primary care services outwith GP practice opening times. Pressures on the primary care workforce are also reflected in the delivery of out-of-hours services. NHS boards completed the part of the primary care workforce survey that asked about out-of-hours care. Boards reported that 90 per cent of out-of-hours shifts were filled but noted the amount of effort this took. The most commonly reported actions taken to fill shifts were the use of financial incentives such as increased rates and staff working longer shifts. Other issues reported included:

- instances of both nurses covering GPs' shifts and GPs covering nurses' shifts
- out-of-hours services being delivered through NHS 24 and a hospital ward because of difficulties in filling shifts
- a reduction in the number of locations where out-of-hours services were provided.[11]

The primary care workforce is changing

21. The primary care workforce survey data is used to estimate the whole-time equivalent (WTE) GP workforce across the country. The data shows a fall in the WTE GP workforce from 3,645 in 2015 to 3,575 in 2017. This suggests that, although the overall number of GPs may be increasing, more are choosing not to work full-time. A GP session is about five hours, and one WTE represents eight sessions a week. The demographics and changing working patterns of the primary care workforce pose a challenge to future supply:

- A higher proportion of GPs aged between 50 and 59 are working eight or more sessions a week.
- Those aged 25-49 years are more likely to be working four to seven sessions a week.
- Partners are often working more sessions a week than salaried GPs.

The increase in the proportion of GPs who are salaried rather than partners, and the pattern of younger GPs increasingly working part-time, is likely to mean that for every GP that retires more than one will need to be trained and recruited to replace them.

22. Recent changes to pension and tax arrangements may have an impact on GP recruitment and retention. The British Medical Association (BMA) has raised concerns that limits on annual and lifetime allowances, which govern how much GPs can contribute to their pension funds before incurring a tax charge, will lead to GPs retiring early or reducing their workloads. The BMA has also expressed concerns about the impact of UK Government changes to increase employer pension contributions by six percentage points, from 14.9 per cent to 20.9 per cent, from April 2019. The UK Government has committed to provide funding to cover some of the cost of increased pension contributions to the NHS. In June 2019, the Scottish Government confirmed that it would provide additional funding to cover the remaining £48.4 million for 2019/20.

23. The Scottish Government has identified EU withdrawal as having a major impact on the health and social care workforce, but it has not set out potential scenarios or how it plans to respond. Although data on the nationality of doctors

is available only for those who took up a licence to practice in the UK from June 2017, the General Medical Council (GMC) holds data on country of qualification for all doctors. This data shows that, in 2018, 3.7 per cent of Scottish GPs had graduated in a European Economic Area (EEA) member country. Remote and rural areas of Scotland, including Argyll and Bute, Orkney, Shetland and the Western Isles are more reliant than other areas on non-UK-licensed doctors.[12] The GMC has looked at the relationship between where medical students qualified and their nationality. It concluded that using place of qualification as a proxy for nationality is likely to result in an underestimate of the number of doctors who were EU nationals working in the UK.[13]

24. As at March 2018, five per cent of nurses and midwives in the UK had first registered in the EEA. Between 2016/17 and 2017/18, there was a drop of 87 per cent in the number of EEA-qualified nurses and midwives joining the UK register, and an increase of 29 per cent in those leaving it.[14] This suggests that EU withdrawal will exacerbate existing workforce pressures.

The Scottish Government does not collect enough information on the impact that primary care workforce pressures are having on staff

25. There is a lack of data on the impact of workload pressures on staff in primary care. The Scottish Government's national staff survey is completed only by staff employed by NHS boards, and not those employed by GP practices, or most GPs themselves.

26. The GMC runs an annual survey of trainees and their trainers, including those in general practice, which includes questions about workloads.[15] Those delivering training were more likely to report a heavy or very heavy workload than those training in other specialties, 78 per cent compared with an average of 59 per cent across all other specialties. They were also more likely to work beyond normal working hours, with 59 per cent doing so daily. Among doctors in GP training posts, although overall satisfaction was high, responses to questions on workload indicate this is an area of concern. Thirty-five per cent rated their workload during the day as heavy or very heavy, and 46 per cent were working beyond scheduled hours at least weekly.

27. A recent RCGP survey of Scottish GPs found that 37 per cent feel so overwhelmed by their daily tasks that they cannot cope at least once a week. Workload pressures may have an impact on patient experience as well as staff morale; 35 per cent said that their stress levels have an impact on their ability to make decisions.[16]

28. Without national data on, for example, staff morale or sickness absence levels for all staff groups, the Scottish Government cannot identify and monitor the impact that workload pressures may be having on the primary care workforce. When making major changes to the workforce, the Scottish Government needs to understand the challenges facing the workforce and monitor the impact of policy changes on the people delivering those changes.

Patients are generally happy with the quality of care from their GP practice

29. The Scottish Government carries out a health and care experience survey every two years. This asks the public about their experience of health and care services; it covers GP practices and out-of-hours care. The latest survey, in 2017/18, reported a mixed picture regarding patient experience. There is a national target that 90 per cent of people should be able to access a GP, or an

appropriate healthcare professional, within 48 hours if they need to. The survey found that this target was met, with 93 per cent of people able to see a GP within two days. All NHS boards, and all except two IAs, met this target. North Lanarkshire and Aberdeenshire each missed it by one percentage point.

30. Although the responses to some questions in the survey indicated a decline in patient satisfaction, satisfaction remains high overall (Exhibit 4, page 17). Eighty-three per cent of people rated the overall care provided by their GP practice as good or excellent in 2017/18, a slight fall from 87 per cent in 2011/12.

31. When asked about recent experiences with a health professional at their GP practice, 93 per cent of people were positive about feeling listened to and 95 per cent understood the information they had been given. However, there was a lower percentage of positive responses when people were asked if they felt their treatment had been well coordinated (78 per cent) and if they knew the health professional well (50 per cent).

More engagement with the public is needed on changes to primary care

32. The Scottish Government's vision for primary care represents a significant change to how services will be delivered. It intends to expand GP-led MDTs to enable people to receive care from the most appropriate member of the MDT (Case study 1, page 18). The various professional groups believe a national campaign is needed to ensure that members of the public understand why they may be asked more questions than before when they want to make an appointment, and why they will not necessarily see a GP. We have previously reported on the need for greater public engagement by the Scottish Government, NHS boards and IAs to build support for change by increasing understanding.[17] Following discussions between the primary care professions and the Cabinet Secretary for Health and Sport, the Scottish Government is currently developing its approach to public engagement on this issue.

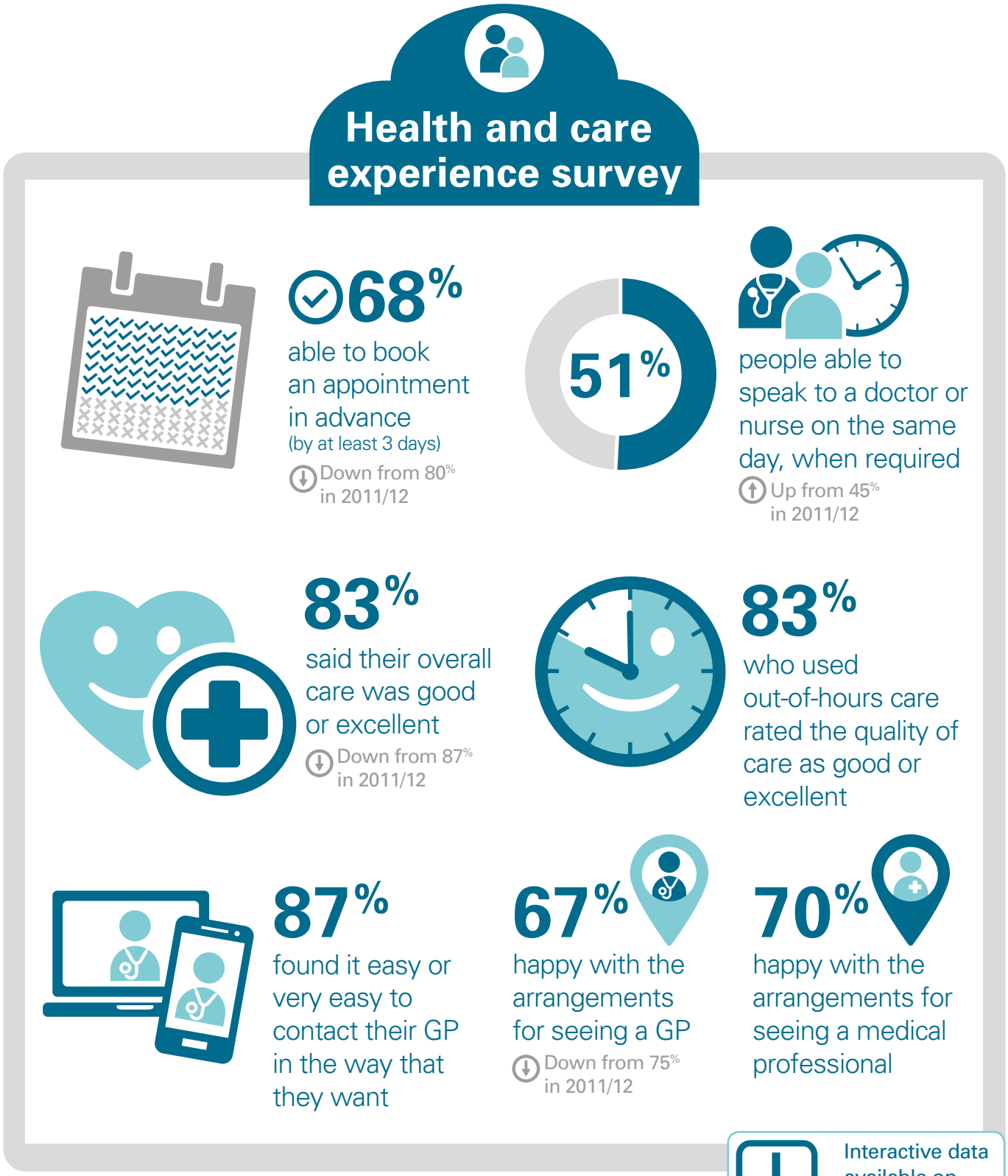
33. Some public engagement has suggested that people may be happy to see other staff members within a GP practice when they understand more about the roles of these staff members and are confident in the quality of care. A survey was carried out by Our Voice Citizens' Panel to ask people about primary healthcare and their views on seeing non-GP medical professionals.[18] Seventy-eight per cent of respondents said that they would consider going directly to non-GP healthcare professionals if they were happy with the treatment that they had received from them previously. Three-quarters would be more likely to accept an appointment with a health or social care professional who was not a GP if they understood more about their role.[19]

34. The Scottish Government commissioned a study on pharmacists working in GP practices, carried out through surveys and interviews with patients and the other members of the MDTs in the practices. Both the patients and the teams had positive feedback about the quality of the care, and the knowledge and ability of the pharmacists. Eighty-four per cent of patients surveyed said that they were confident that the pharmacist would prescribe as safely as a GP and 83 per cent said that they were more interested in the quality of the care they received than in who delivered it. However, 43 per cent still said that, given the choice, they would prefer to see a GP rather than a pharmacist.[20]

Exhibit 4

Health and care experience survey

The results of the survey show that patients are mostly satisfied with their care, although in some areas there has been a drop in satisfaction.



Note: Trend data not available for all questions.

Source: Audit Scotland using the Scottish Government's health and care experience survey

Case study 1

Musculoskeletal (MSK) physiotherapists

MSK conditions are estimated to account for about one in five GP appointments, and are the second biggest cause of sickness absence in the UK. MSK advanced practitioner physiotherapists as a first point of contact in primary care MDTs have the potential to:

- improve access for patients
- support greater self-management
- reduce GP workload
- reduce referrals to orthopaedic specialists.

Several areas around Scotland have introduced MSK physiotherapist pilots to show the impact that this can have on general practice. For example:

Nov 2015

NHS Forth Valley recruited 2.4 WTE MSK advanced practitioner physiotherapists to work across two GP practices.

Over the first two years, 8,417 patients accessed the service, with 60 per cent of people able to self-manage following the appointment. Orthopaedic referrals decreased across both practices by approximately 212 referrals a year.

Jun 2016

Inverclyde appointed an MSK advanced practitioner physiotherapist (0.88 WTE) to work across three GP practices.

The pilot concluded in June 2017. During the pilot, the physiotherapist saw 55 per cent of MSK consultations across the three practices and 56 per cent of referrals were made directly by receptionists to the physiotherapist. It was reported that the proportion of consultations where people needed to be prescribed medication decreased from 80 per cent to 20 per cent for patients presenting with an MSK problem. The evaluation highlighted the need for better routine data collection to enable monitoring of the impact on GP time and on referrals to secondary care services.

Source: Audit Scotland using *Evaluation of New Models of Primary Care: Inverclyde Case Study*, Scottish School of Primary Care, January 2018 and information provided by NHS Forth Valley

The new GMS contract will affect the primary care workforce

The new GMS contract is accompanied by a new funding formula that may affect rural areas

35. The new contract is accompanied by a new funding formula for GP practices. The aim of the new formula is to better reflect the workload of GPs. The practices that stand to lose funding because of this new formula have received a guarantee from the Scottish Government that their funding will be protected. Some rural GPs

have expressed concerns that the formula will have a disproportionate impact on rural GP practices, as under the new workload calculation they are less likely to receive an increase in funding than urban practices.

36. Under the previous formula, rural practices received more funding per patient than practices in urban areas, an average of £264.1 per patient in the most rural areas in 2017/18, compared with £101.2 per patient in the most urban areas.[21] Although funding has been protected so that no practice will see its funding drop, difficulties in recruiting and retaining staff may increase when these practices have to compete for staff with practices with increased funding. This could also have an impact on the morale of staff. These concerns have been raised in response to a petition to the Scottish Parliament on medical care in rural areas.[22]

37. The Rural GP Association of Scotland carried out a survey with a small sample of 66 rural GPs on the new contract, in March 2018. Sixty-eight per cent felt less confident that the changes would benefit rural practices and about 70 per cent felt less confident about the sustainability of their practice. Concerns were specifically expressed about the funding formula, recruitment and retention issues, and out-of-hours service delivery.

The Scottish Government should do more to measure the impact of the GMS contract on patients and staff

38. The Scottish Government carried out an equality impact assessment on the GMS contract, in which it considered the impact that the contract could have on specific groups, including certain age groups, different genders and those from deprived areas and rural areas.[23] The GP contract impact assessment split this into:

- the impact on GPs
- the impact on the rest of the primary care team
- the impact on patients.

39. The impact assessment does not fully consider the concerns expressed about some aspects of the new contract. For example, the assessment concludes that there will be a positive impact on rural practices because protected funding mitigates the potential negative impact of the funding formula. As the impact assessment does not fully acknowledge potential risks it does not set out how any negative impact could be monitored, or concerns addressed.

40. The Scottish Government published a primary care monitoring and evaluation strategy in March 2019.[24] This includes indicators on the size of the workforce and involves the use of the health and care experience survey to measure patients' views. There are no measures that would allow the Scottish Government to monitor the direct impact of the GMS contract, including the intended effects on the role of the GP, recruitment and retention, and any impact on staff or patient care. The Scottish Government is due to publish an evaluation work plan to provide more detail on how it will monitor the priority areas set out in the strategy. Health Scotland is also due to produce a report on primary care in Scotland later in 2019, which is planned to include data across a wider range of indicators.

Part 2

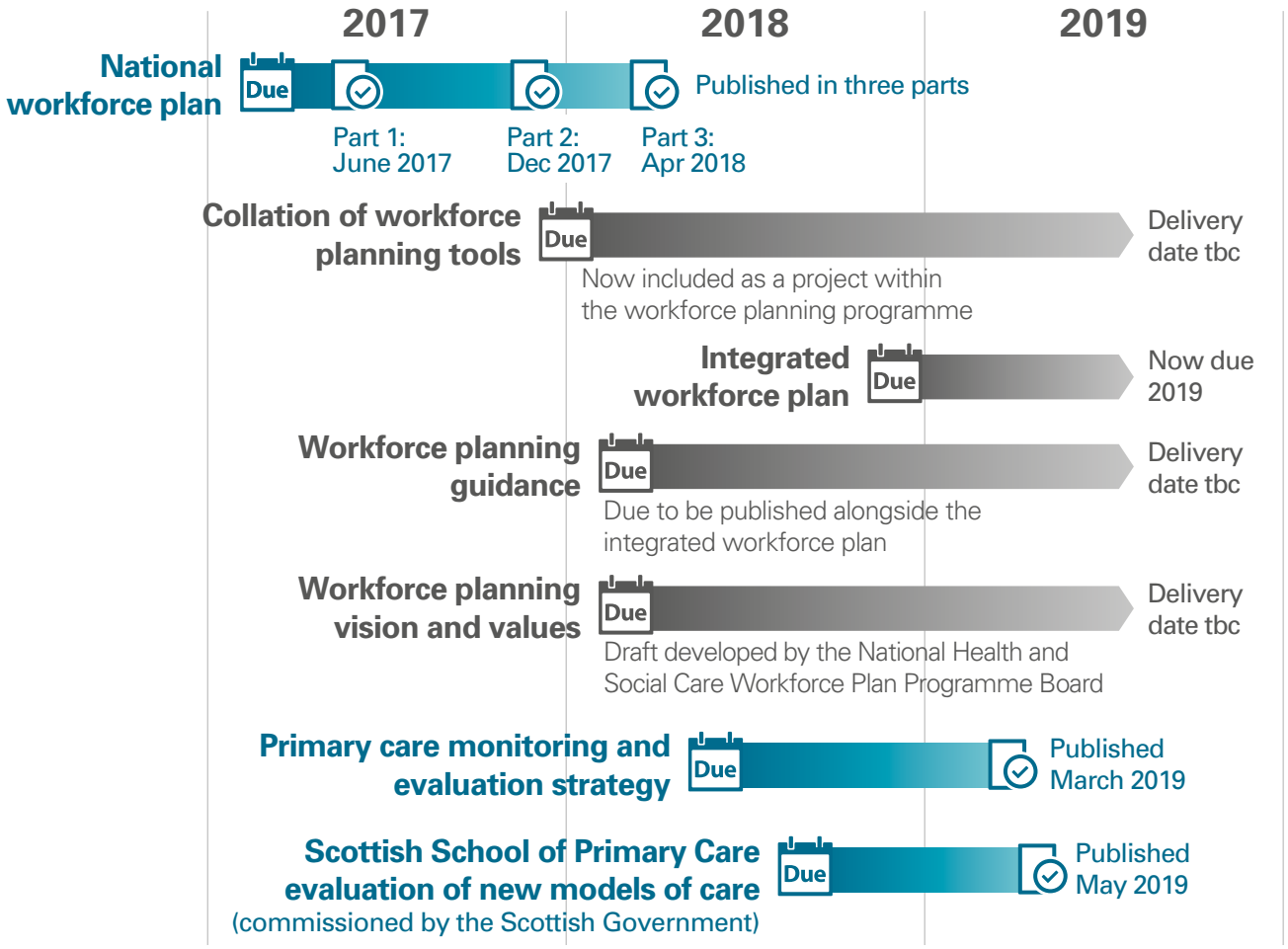
Planning the future workforce

The Scottish Government is developing its approach to workforce planning but progress has been slow

41. The Scottish Government initially planned to publish a national workforce plan in spring 2017, covering the entire health and social care workforce. It then revised its approach, publishing the plan in three parts, covering the NHS workforce, the social care workforce and the primary care workforce. This was to be followed by an integrated national health and social care workforce plan, a joint publication with the Convention of Scottish Local Authorities (COSLA), in 2018. This is now due to be published in 2019 (Exhibit 5).

Exhibit 5

Workforce planning and primary care outputs have been delayed



Source: Audit Scotland

42. The third part of the plan, published in April 2018, considers how primary care workforce arrangements will change.[25] The plan sets out the intention to reform primary care in Scotland by building and expanding primary care MDTs. The plan recognises the challenges facing primary care, including that demand for primary care services is increasing, because of the ageing population and a rise in people suffering from two or more chronic conditions. It also notes the pressures arising from an ageing workforce, but it does not include projections of what this might mean in terms of numbers leaving the workforce.

43. The Scottish Government acknowledges that it needs to develop a more sophisticated approach to workforce modelling. It also recognises that more needs to be done to improve primary care data to inform workforce planning. In *NHS workforce planning: The clinical workforce in secondary care*, we recommended that the Scottish Government should:

- improve understanding of future demand
- demonstrate how training and recruitment numbers will meet estimated demand
- provide a clear breakdown of the costs of meeting projected demand through additional recruitment.

44. In April 2019, NHS Education for Scotland launched a data platform to bring together data on workforce supply. The platform includes data on different stages of the GP training pipeline and will give a better picture of how the numbers entering training will translate into the number entering employment in NHS Scotland, as well as the numbers of trainees leaving Scotland or going to work in other areas of the health service. The platform is available to both national and local workforce planners and should enable a more joined-up approach to workforce planning across the health service. The extent to which it can be used for primary care workforce planning will be limited until better data on the primary care workforce is available.

Workforce planning is fragmented

45. Nationally, responsibility for health and social care workforce planning sits in one division of the Scottish Government and responsibility for primary care sits in another (Exhibit 6, page 22). This creates a risk that workforce planning for different elements of the workforce is carried out separately, without a coordinated, strategic approach to planning the whole primary care workforce. The Scottish Government intends to create a revised structure to move towards a more strategic approach. This is due to be in place by November 2019.

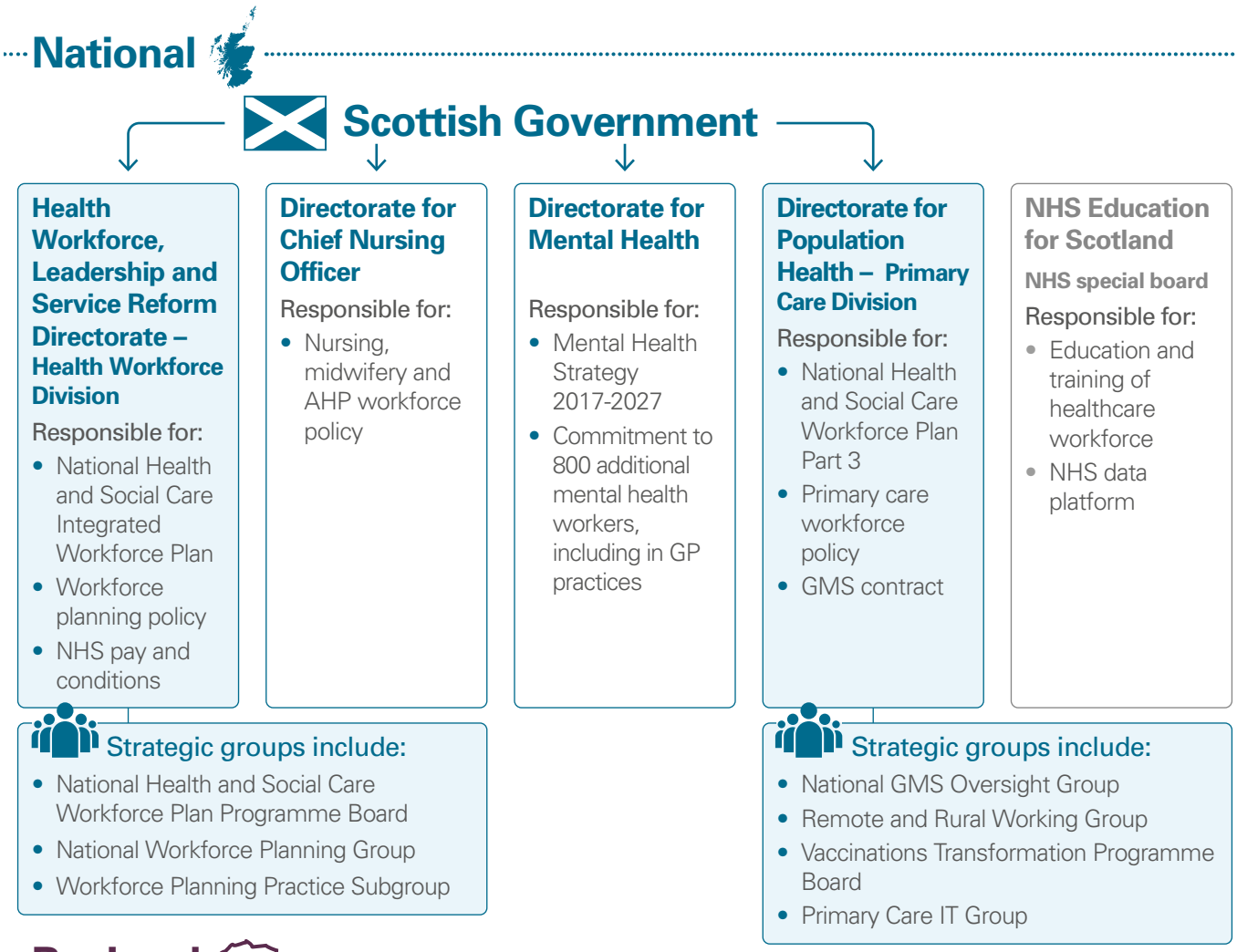
46. Locally, NHS boards and integration authorities need to work together to plan the primary care workforce.

- NHS boards are responsible for contracting with GP practices to provide general medical services in their area. They are required to submit annual workforce plans and workforce projections, but most of their plans do not specifically mention primary care.
- IAs are responsible for planning, designing and commissioning primary care services. IAs are supposed to produce workforce plans, but not all have done so. They are also responsible for the development of primary care improvement plans, in collaboration with NHS boards and local GP subcommittees.

Exhibit 6

Workforce planning roles and responsibilities

Responsibility for planning the primary care workforce is fragmented.



Source: Audit Scotland

47. The National Health and Social Care Workforce Plan Programme Board was set up in November 2018. This is a group of representatives from the Scottish Government, COSLA and the Scottish Social Services Council. It was set up to oversee the development and delivery of the whole health and social care workforce planning programme and to provide clearer governance. Progress against the workforce commitments in the plans is the responsibility of the relevant policy teams in the Scottish Government.

48. The National GMS Oversight Group is responsible for overseeing implementation of the new GMS contract across Scotland. This group includes representatives from the Scottish Government, NHS boards, IAs and the Scottish General Practitioners Committee (SGPC). It does not include the professional organisations which represent the different healthcare staff groups which make up MDTs. In addition, there are several groups that provide advice and support on a range of issues such as remote and rural, IT and premises.

49. In *NHS workforce planning: The clinical workforce in secondary care*, we reported on the risk that the number of workforce plans and workforce groups could become a barrier to effective working. It is important that NHS boards and IAs work together with the Scottish Government to ensure their different plans align and that their respective roles are clear.

It is not clear how the Scottish Government's workforce commitments will contribute to the wider ambitions for primary care

50. The Scottish Government has made several commitments to train and recruit a range of primary care professionals (Exhibit 7, page 24). Planning the primary care workforce at a national level has been complex and challenging because most practices are run by self-employed GP partners who have been responsible for employing other practice staff. This has made it difficult to both understand the size and make-up of the existing workforce and also to plan for changes to the future workforce.

51. The commitments to train additional staff are either on track or have already been achieved. For the commitments relating to staff groups who work across the health service, such as nurses and paramedics, it is difficult to assess what the impact will be on the primary care workforce specifically, as those trained may go on to work outwith Scotland or in other parts of the health system. The Scottish Government's intention to increase the primary care workforce and expand the role of MDTs is clear, but it has not set out in detail how it anticipates that its workforce commitments will:

- reduce GP workload
- improve patient care and access
- meet future demand.

52. It is also unclear how these commitments link to workforce decisions being made at a local level. IAs are responsible for specifying the future primary care workforce they need to deliver services in their area. The Scottish Government did not use information from IAs about their requirements to inform its commitments and such information is not being used to monitor progress towards achieving them.

Exhibit 7

NHS workforce commitments

The Scottish Government has made a number of commitments to increase the NHS workforce.

Primary care commitments	Status	Progress
800 more GPs (headcount) over next 10 years	Not on track	Further information in paragraphs 53-54
100 more GP specialist training places from 300 to 400	Achieved	This was achieved in 2016 and 2017. There was a change in the way GP training was delivered in 2018, moving from a mixture of three- and four-year courses to only three-year courses. As a result, the number of new places advertised fell, but the overall number of training posts increased.
500 more health visitors by 2018	Achieved (late)	There was an increase of between 509.1 and 575.9 WTE, between March 2014 and March 2019. This is based on estimated 2014 data.
All GP practices to have access to pharmacist support by the end of 2021	Incomplete data	Funding for this has been provided by the Primary Care Transformation Fund. This had funded pharmacy support for about 68 per cent of GP practices as at December 2018. There is no information on how many of the remaining 32 per cent have pharmacy support funded through other means.
Up to 250 community link workers to work in GP surgeries by 2021 at least 40 being recruited in the coming year	Incomplete data	It is difficult to assess whether this commitment is on track because there is a lack of complete data on the current number of these workers, and on trends. Primary Care Improvement Plans report 120 community link workers in post in 2018/19.
Wider commitments with primary care impact		
2,600 more nursing and midwifery training places by 2021	On track	The Scottish Government sets the number of nursing university places for Scottish students. This increased to 4,006 for 2019/20. If current trends continue, it looks likely that an additional 2,600 places cumulatively will be achieved by 2021.
500 additional ANPs trained by 2021	On track	1,023 nurses received funding to undertake training, 425 from a primary or community care background, during 2017/18 and 2018/19. As at December 2018, 60 nurses had completed ANP education, with the Scottish Government expecting an additional 95 to have completed it by September 2019.
1,000 more paramedics training in the community over five years including 50 with enhanced skills to work in the community	On track	518 paramedics trained, and 57 more recruited between 2016/17 and 2018/19.
800 additional mental health workers over 5 years in A&Es, GP practices, police custody suites and prisons	On track	An additional 268 mental health workers were appointed as of 1 July 2019; 99 were in GP surgeries.

Incomplete data | Not on track | On track | Achieved

Source: Audit Scotland

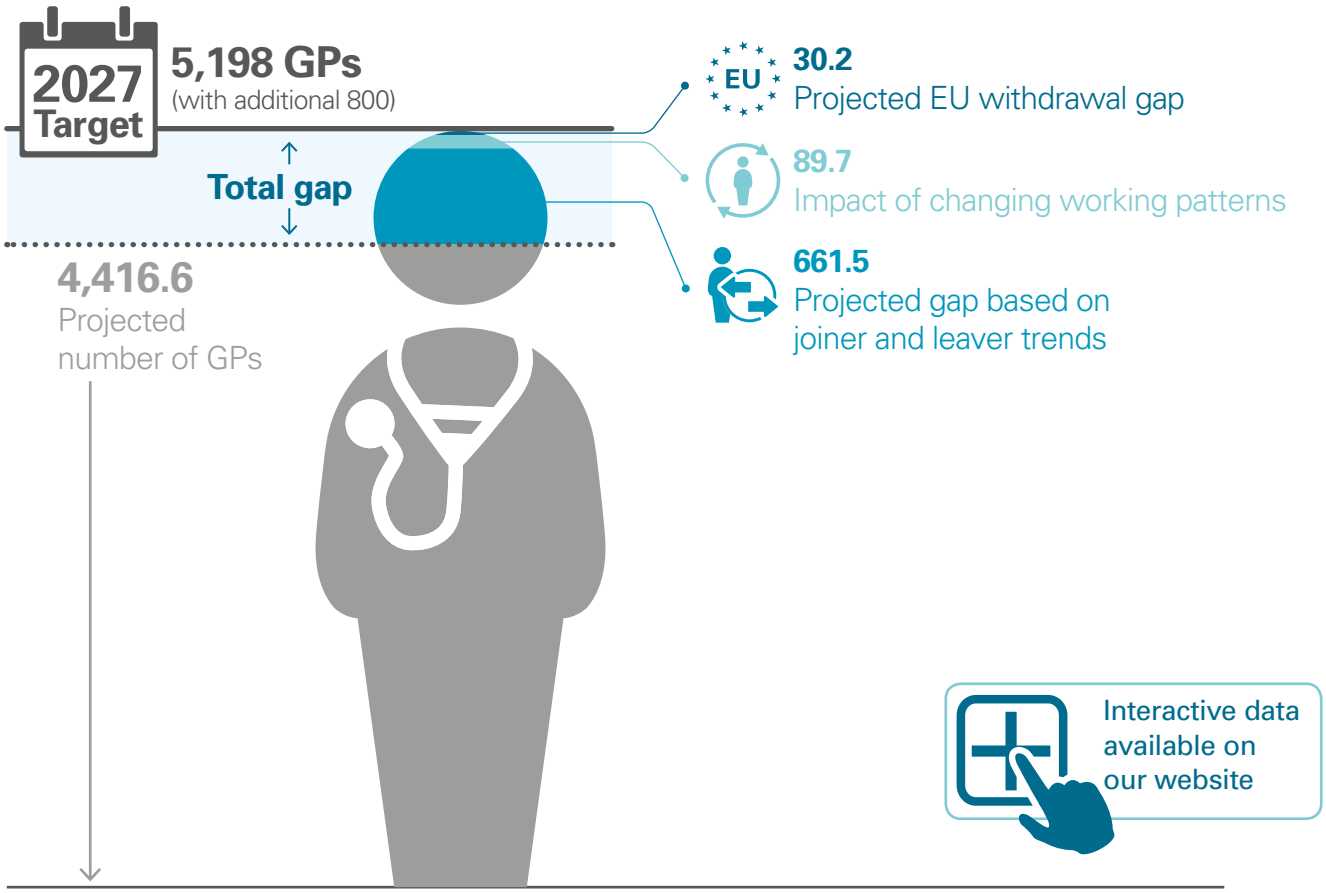
53. One of the most ambitious workforce commitments is the plan to have an additional 800 GPs over a ten-year period. Taking 2017 as the baseline, an additional 800 GPs would represent an 18 per cent increase, from 4,398 to 5,198. The Scottish Government has not set out what impact these additional GPs will have or how the target reflects retirement rates or changes in working patterns. It has not provided an assessment of how policy initiatives will contribute to reaching the target, or identified what the risks are if it is not achieved.

54. We have analysed the trend in GPs joining and leaving the NHS workforce in Scotland over the last ten years, the potential impact if ten per cent of GPs from the EU were to leave the workforce and the impact of changing working patterns. Our analysis indicates that GP numbers will remain broadly stable over the period 2017–27. Exhibit 8 shows the potential gap between the Scottish Government's commitment and the likely number of GPs, taking account of past trends and future pressures.

Exhibit 8

Potential shortfall in the number of GPs, 2027

Factors such as changing working patterns and past trends in GP joiners and leavers indicate that GP numbers are likely to remain fairly stable, which will make achieving the Scottish Government's commitment challenging.



Note: See Appendix 2 for methodology.

Source: Audit Scotland using ISD Scotland data

55. The target is based on a headcount of GPs, rather than WTE. With more GPs working part-time, this is likely to translate into considerably less than 800 additional WTE GPs (paragraph 21). This makes it difficult to assess:

- what impact achieving this commitment would have on the primary care workforce and pressures in primary care
- how it would contribute to the Scottish Government's aim to change the way primary care is delivered through the use of MDTs.

56. Some individual boards have considered these issues as part of local workforce planning. For example, in 2017, before the new GMS contract came into effect, the IAs in Ayrshire and Arran looked at the age profile of their GP population and at trends in recruitment and working patterns. On this basis, they calculated that for every GP leaving the workforce they would need to recruit an additional 1.6 GPs to maintain workforce capacity. Based on trends in retirement, they projected that they were likely to need an additional 80 GPs by 2022, without factoring in any additional recruitment needed to increase the workforce. This level of GP recruitment was assessed as being difficult to achieve. To address this the IAs developed a primary care programme to focus on implementing multidisciplinary working in practices and to divert activity away from GP practices where appropriate.

A lack of data on the primary care workforce will make it difficult to assess whether the GMS contract is achieving its aims

57. In 2008, in our report on the previous GMS contract, we highlighted that there was a lack of basic data on general practice, making it difficult to plan the workforce effectively. We recommended that:

- the Scottish Government collect robust data before implementing major schemes so that it could base decisions on accurate information
- the Scottish Government and NHS boards collect comprehensive data on GP numbers and GP practice staff numbers to support workforce planning at national and local levels.[26]

58. Between 2004 and 2018, GP practices were not obliged to provide data on staff employed by the practice. Lack of data on practice-employed staff means that there are no accurate figures on the size and make-up of the primary care workforce.

59. In 2018/19, £870.5 million was spent on GMS funding, making up 6.4 per cent of the total health budget. This is a real terms increase of 13 per cent since 2013/14, when GMS funding made up six per cent of the health budget.[27] The latest published data on GP practice funding is for 2017/18. About £794 million was paid to GP practices. This covers the cost of delivering core primary care services, including payments to GP partners and staff salaries for those employed directly by the practice. It also includes additional payments for premises, seniority payments for staff and payments for some additional services commissioned by NHS boards. There is no data available on how much of this is spent on staff, so primary care workforce costs cannot be separately identified.

60. Accurate workforce data is essential for effective workforce planning both nationally and locally. Without a clear picture of the size and make-up of the primary care workforce, WTE as well as headcount, it is difficult to plan the workforce to meet future need and to assess progress against plans to increase the workforce. Similarly, without accurate information on the costs of the primary care workforce, it is difficult to project what the cost of expanding the workforce will be. Some work has been done to assess the pharmacy workforce needed to meet future demand (Case study 2).

Case study 2

Pharmacy modelling

The Scottish Government commissioned the University of Strathclyde and Robert Gordon University to carry out some work on the involvement of pharmacists in GP practices. The results were published in November 2018. The universities looked at the pharmacy workforce across Scotland to get an understanding of the workforce and to model future demand.

They wanted to calculate the potential workforce needed to take on two areas of work: polypharmacy clinics, for patients receiving prescriptions for four or more medications, and requests for non-repeat medication. To do this, they carried out case studies in NHS Greater Glasgow and Clyde and NHS Lothian. As both NHS boards already collect data on pharmacy activity and demand, it was possible to project the number of WTE pharmacists required to meet demand in these areas and model this nationally.

For example, for acute medication requests they calculated the time taken and corresponding WTE figure using both the NHS Greater Glasgow and Clyde model, and the NHS Lothian model.

	Process two acute prescriptions for all patients	
	Estimated hours	Estimated WTE staff
Scotland (NHS GGC 3 mins per acute prescription)	**196,702 hrs**	**114.0 WTE**
Scotland (NHS Lothian 8.6 mins per acute prescription)	**563,880 hrs**	**326.9 WTE**

As part of this work, they recommended that NHS boards follow a consistent approach to collecting and reporting data on pharmacy activity.

Source: Audit Scotland using *Evaluation of pharmacy teams in GP practice report*, Robert Gordon University and the University of Strathclyde

61. As part of the new GMS contract, GP practices will be required to provide data on income and expenses and on practice-employed staff. Arrangements for the collection of this data were not in place when the contract came into effect in April 2018. The contract document states that data collection to inform phase 2 would start in 2018/19. This data collection was piloted in April 2019 and is due to be rolled out to all GP practices over the summer of 2019. This data will be used to inform the development of Phase 2 of the contract. It is expected to include the data previously collected through the primary care workforce survey.

62. As part of Phase 2, the Scottish Government plans to introduce a guaranteed income range for GPs, similar to that currently in place for consultants, and to directly reimburse practice expenses. This is due to come into effect from 2020/21, but there is a risk that Phase 2 will be delayed or based on limited data.

National data on activity and demand has not been available since 2012

63. Since 2012, the Scottish Government has been working with NHS National Services Scotland to improve the extraction of data from GP practice records by developing the Scottish Primary Care Information Resource (SPIRE). In December 2018, SPIRE had been deployed in 93 per cent of Scottish GP practices.

64. Until 2013, data on consultations with GPs and other members of practice teams was collected from a sample of six per cent of practices. This was used as the basis for estimates for Scotland. SPIRE is intended to provide an improved source of activity data and was originally due to be operational in 2016. As implementation has taken longer than planned, estimates of practice workload are considerably out of date, including those used as the basis for the funding allocation formula for the new GMS contract.

65. As part of the GMS contract, the Scottish Government intends to collect information on hours worked by GPs, but there is no clear timetable in place for when this data collection will begin. To fully understand primary care activity and demand, data is needed on the number of consultations with all staff groups. The Scottish Government is in the early stages of modelling work intended to give it a better understanding of demand and to assess the potential impact of the range of commitments included in its Health and Social Care Delivery Plan. This work is currently limited in its ability to model the impact of primary care commitments by the lack of robust data. However, the Scottish Government hopes that in the longer term it will have an analytical model in place that can be used to model workforce capacity across health and social care.

66. As SPIRE is not yet fully deployed, there is no up-to-date information at a national level on what activity is being moved to other MDT members and the impact that this is having on GP workload. Without this data, the Scottish Government will not be able to assess whether the new contract is achieving the aim to change the role of the GP and reduce GP workload.

67. The development of MDTs depends on having the digital and physical infrastructure in place to enable joint working. Different professional groups currently use different records management systems. This makes it difficult for MDT members to share information. MDTs will operate differently in different local contexts, but for those based in GP practices there can be challenges in accommodating an expanded MDT on the existing premises. The Scottish Government has asked IAs to clearly set out in the second iteration of the PCIPs how they are identifying the digital and physical infrastructure needed locally to

deliver the priorities set out in the MOU accompanying the GMS contract. The costs of digital infrastructure to support additional staff are to be included in the PCIPs as core workforce costs.

Putting the workforce in place to deliver the planned primary care changes will be challenging

68. The Scottish Government has implemented a range of initiatives to increase recruitment and retention of GPs. Between 2015/16 and 2016/17, it invested £2.5 million on recruitment and retention. In 2017/18, it increased this funding to £5 million and provided a further £7.5 million in 2018/19, bringing the total investment to £15 million. Initiatives include:

- ScotGEM: a four-year graduate entry medical course, open to students who have graduated with a degree other than medicine. The course has a focus on general practice and rural working. Students can also apply for a bursary of £4,000 per year if they agree to work in Scotland's NHS for at least one year for every year they received the bursary, after graduating. There are currently 55 students enrolled on the course.

- Pre-medical entry courses at Glasgow and Edinburgh universities: these courses are designed to widen access to medical training by providing 40 places for students from disadvantaged backgrounds to prepare for undergraduate medical training.

- The Scottish Rural Medicine Collaborative: this is a programme to develop ways to improve recruitment and retention in rural areas.

- A relocation package and 'golden hello' scheme: these measures are intended to encourage GPs to work in 160 eligible rural practices.

- A marketing and recruitment campaign: the campaign aims to attract GPs from the rest of the UK and overseas to work in Scotland.

- Mentoring and coaching programmes: the objective is to help retain the existing workforce.

- The Scotland GP returners programme: designed to make it easier for GPs who have taken a break to return to general practice.

69. The Scottish Government has reported that, between 2015/16 and 2017/18, an additional 39 GPs were recruited as a result of this recruitment and retention funding. Despite the additional funding, based on the number of additional GPs recruited to date, and the scale of pressures on the workforce, it will be challenging for the Scottish Government to recruit an additional 800 GPs by 2027.

70. Some areas have implemented local initiatives to improve recruitment and retention of GPs. NHS Ayrshire and Arran runs a 'GPs with enhanced role' programme, which enables GPs to work part time in a practice and part time in an acute specialty.

71. The expansion of the MDT workforce depends on the availability of staff across the various professional groups with the necessary skills and experience. Although the Scottish Government has made commitments to train additional

GPs, nurses, ANPs and paramedics, this increase in supply will take time to result in an increase in the available workforce. The Scottish Government does not currently control the number of training places for AHPs, making it harder to plan for numbers entering the workforce. The National Health and Social Care Workforce Plan Part 3 notes that NHS boards have indicated that there are challenges with recruitment across the AHP workforce and states that the Scottish Government is considering options for taking a more managed approach to training AHPs. There is no published timescale for this work.

More needs to be done locally to plan the future workforce

72. In support of the 2018 GMS contract, all 31 integration authorities were asked to develop the first versions of their primary care improvement plans by 1 July 2018. There was considerable variation in the detail provided in the initial plans, particularly in relation to projected workforce numbers and costs. The Scottish Government provided additional guidance on what the second iteration of PCIPs should cover. These were due as soon as possible after 1 April 2019. IAs are now also required to submit a tracker every six months to report on progress against the PCIPs.

73. PCIPs also provide an opportunity for the Scottish Government to collect local-level information on demand. Some plans use local monitoring data to assess trends in demand. For example:

- The three IAs in Ayrshire and Arran worked together to collect data on the recent increase it has seen in demand on primary care services, including a seven per cent increase in the rate of consultations per 1,000 patients since 2015.

- East Dunbartonshire IA has projected demand in 2025 based on a model using data from practices across Scotland and population estimates for NHS Greater Glasgow and Clyde. It estimates that face-to-face GP consultations across Greater Glasgow and Clyde will increase from 3.77 million to 4.26 million per year. It also projects a rise in district nursing contacts of 25.7 per cent by 2025.

74. Based on an analysis of national trend data, for some staff groups the PCIP projections would require the workforce to grow at a much faster rate than it has in previous years (Exhibit 9, page 31). This indicates that local projections will be difficult to achieve, regardless of available funding, without a substantial increase in workforce supply across the country over the next three years.

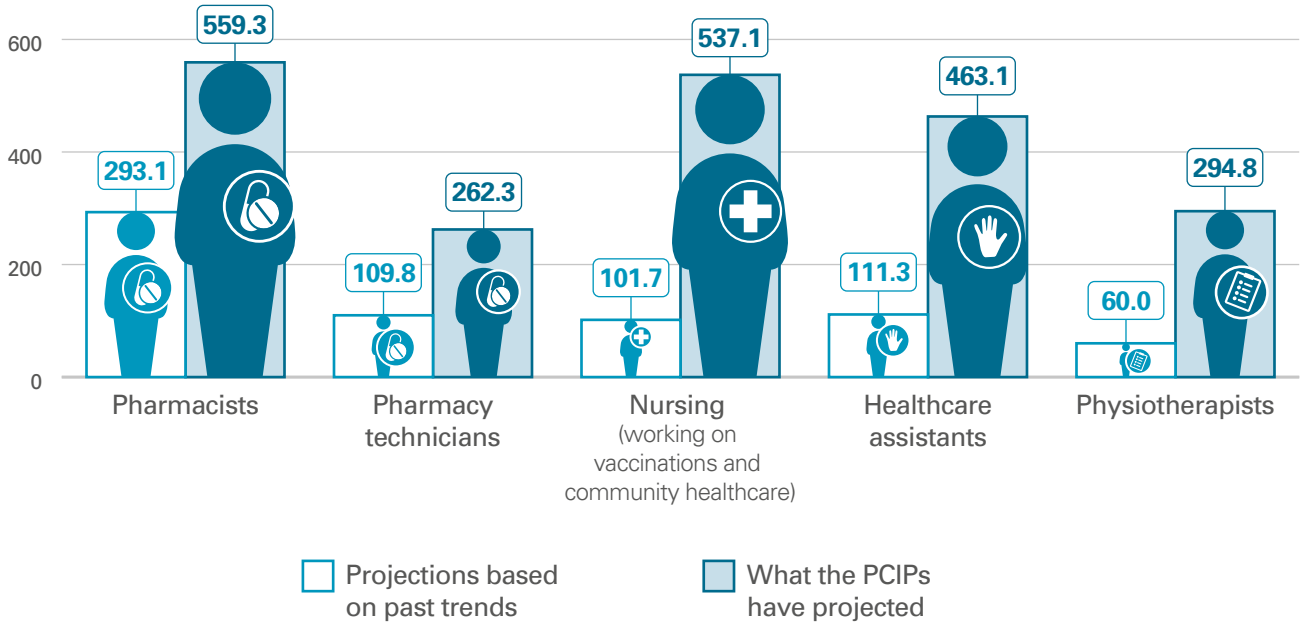
75. Integration authorities have identified issues with the availability of staff as one of the main barriers to implementing their PCIPs. As all IAs are working to expand their primary care workforce during Phase 1 of the GMS contract, there is a significant risk that they will be in competition for the same limited workforce. This may cause additional recruitment challenges in rural areas, where recruitment is already difficult.

76. Locally, some NHS boards and IAs are taking steps to support the expansion of the workforce and development of new roles. For example, to help support the recruitment and training of ANPs, NHS boards in the west of Scotland have come together to establish the West of Scotland Advanced Practice Academy. The academy has developed a coordinated training and development programme for ANPs, working in collaboration with general practice.

Exhibit 9

Workforce projections

The numbers of staff that IAs are projecting that they will need over the next three years represent much larger increases in staff than have been seen in recent years.



Source: Audit Scotland using PCIPs and ISD Scotland workforce data

77. It is likely that the expansion of the primary care practice-based workforce will have unintended consequences for workforce numbers in other parts of the NHS. In some areas, NHS boards are struggling to find staff to work in out-of-hours services. There is a risk that this situation will worsen if staff find working in a practice more attractive. For example, over the period 2017/18 to 2018/19, 12 nurses left the out-of-hours service in NHS Lothian to work in GP practices. Similarly, pharmacists have raised concerns that the increase in pharmacists working in GP practices is leading to staff shortages in community and hospital pharmacies.

78. Part 3 of the national workforce plan does not assess the potential impact of primary care workforce expansion on other parts of the healthcare system. In *Changing models of health and social care*, we reported on the benefits of taking a whole-system approach to planning health and social care services, which would assess the impact of changes to the primary care workforce on the NHS more widely.

Endnotes

1 *Health and social care: medium term financial framework*, the Scottish Government, October 2018.

2 *The future of primary care in Scotland: A view from the professions*, Primary Care Clinical Professions Group, September 2016 (updated May 2017).

3 *Health and social care integration*, Audit Scotland, December 2015.

4 *General Medical Services contract in Scotland: a short guide*, Audit Scotland, May 2019.

5 *NHS workforce planning: The clinical workforce in secondary care*, Audit Scotland, July 2017.

6 *General practice – GP workforce and practice list sizes 2008–2018,* ISD Scotland, December 2018.

7 *NHS in Scotland 2018*, Audit Scotland, October 2018.

8 *Healthy life expectancy for Scottish areas, 2015-2017,* National Records of Scotland, 2019.

9 *General practice – GP workforce and practice list sizes 2008–2018,* ISD Scotland, December 2018.

10 *From the frontline – the changing landscape of Scottish general practice*, Royal College of General Practitioners Scotland, June 2019.

11 *Primary care workforce survey Scotland 2017,* ISD Scotland, March 2018.

12 *Health select committee inquiry: Impact of a no-deal Brexit on health and social care*, General Medical Council, 2018.

13 *The relationship between the primary medical qualification region and nationality at the time of registration, 2017 and 2018*, General Medical Council, November 2018.

14 *The NMC register*, Nursing and Midwifery Council, March 2018.

15 2018 National training survey, General Medical Council.

16 *From the frontline – The changing landscape of Scottish general practice,* Royal College of General Practitioners Scotland, June 2019.

17 *NHS in Scotland 2018*, Audit Scotland, October 2018.

18 Our Voice Citizens' Panel is a large, demographically representative group of citizens selected at random. The panel is used to gather information on the views of the public on health and social care policy and services.

19 *Survey on the use of digital technologies for healthcare improvement, using and sharing personal health and social care information and access to healthcare professionals other than doctors,* Our Voice Citizens' Panel, January 2018.

20 *Evaluation of pharmacy teams in GP practice,* Robert Gordon University and University of Strathclyde, November 2018.

21 *NHS Scotland payments to general practice 2017-18*, ISD Scotland, November 2018, *Practice populations by urban/rural classification,* ISD Scotland, December 2018. Urban/rural classifications are based on the location of the practice, patients may not necessarily live in areas with the same urban/rural classification as the practice itself.

22 *Rural GP Association of Scotland submission of 14 October 2018*, The Scottish Parliament, October 2018.

23 *Equality impact assessment on the new GMS contract*, Scottish Government, 2018.

24 *Primary care: National monitoring and evaluation strategy*, Scottish Government, March 2019.

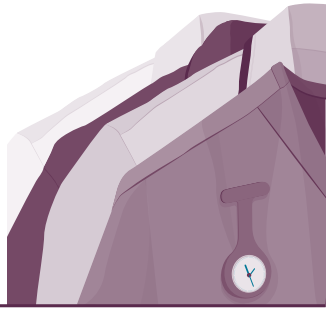
25 *National Health and Social Care Workforce Plan Part 3 – Improving workforce planning for primary care in Scotland*, Scottish Government, April 2018.

26 *Review of the new General Medical Services contract*, Audit Scotland, July 2008.

27 *Scottish Budget: draft budget 2018-19*, Scottish Government, December 2018.

Appendix 1

Progress on implementing the recommendations made in *NHS workforce planning: The clinical workforce in secondary care*



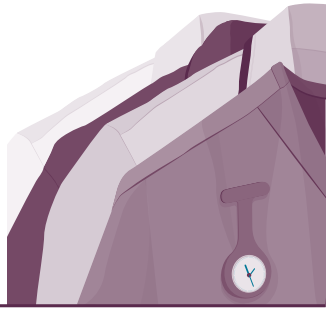
Recommendation	Progress
The Scottish Government should:	
Improve understanding of future demand to inform workforce decisions, including: • collating, comparing and monitoring NHS boards' assessments of demand and supply to help form a national picture and manage risks • carrying out scenario planning on the future population health demand and workforce supply changes (such as staff retiring), including how this will affect the types of treatments provided • considering and clarifying potential future skills mix with NHS boards and stakeholders to determine how a future team can work to meet this demand.	The medium-term financial framework was published in 2018, and includes estimates of increases in demand, as a percentage per year. NHS NES launched a data platform in April 2019, bringing together a wide variety of NHS and social care workforce data. It includes both training and employment data. The platform is being tested and developed in collaboration with stakeholders. Once further developed, this will give workforce planners a better picture of supply and allow scenario planning on future workforce numbers. Still in development: • the publication of the integrated health and social care workforce plan, originally expected in 2018. This may address some of these issues, including scenario planning for future demand • updated workforce planning guidance for boards, originally due in 2018 • further development and implementation of the modelling tool that could be used to look at demand, workforce and cost.
Demonstrate how training and recruitment numbers will meet estimated demand for healthcare – if it does not, document and cost how the gap between demand and supply in the future will be covered.	The NHS NES data platform will give a better picture of numbers coming through training and into employment from the supply side. We would hope to see more on this in the upcoming workforce plan.
Provide a clear breakdown of the costs of meeting projected demand through additional recruitment across all healthcare staff groups.	We would hope to see this in the upcoming workforce plan.

Cont.

Recommendation	Progress
Demonstrate how policy initiatives, such as safe staffing levels and elective centres, are expected to affect staffing requirements in NHS boards.	We would hope to see this in the upcoming workforce plan.
Set out the expected transitional workforce costs and expected savings associated with implementing NHS reform. This includes collating transitional costs in relation to moving staff into elective centres and into the community, and savings through increased efficiencies.	We would hope to see this in the upcoming workforce plan.
Determine the data required for decisions on the workforce. This will include data on the training pipeline for medical and AHP staff, data on EU citizens working in the NHS in Scotland, and agency spending by professional group.	NHS Education for Scotland work on the data platform will bring together the workforce data sources available, to be used for workforce planning. This went live in April 2019.
Progress arrangements to create national and regional staff banks.	A national service model for radiology is due to be launched in summer 2019. For most other specialties, the Scottish Government has decided against the creation of a national staff bank because evidence suggests staff are only likely to accept shifts within a 15-mile radius of their home.
NHS boards should:	
Produce future plans as well as supply criteria. This would include: • projecting their future workforce against estimated changes in population demography and health factors • producing plans which detail the expected workforce required, supported by analysis of workforce supply and demand trends.	Not in the scope of this audit.
Fully cost the workforce changes needed to meet policy directives, such as the shift to community-based care, proposed elective centres, safe staffing levels and more regional working.	Not in the scope of this audit.
Improve the accuracy of budgeting for agency spending.	An analysis of financial performance report data for the NHS in Scotland in 2018 found that 12 of 14 boards overspent against their pay budget.

Appendix 2

Methodology



Methodology for GP projections (Exhibit 8, page 25)

- Total number of current and historic GPs is based on the GP headcount, excluding trainees, published by ISD Scotland. The number of GPs needed in the future has been calculated by taking the headcount in 2017 and adding 800.

- Leaver and joiner projections are calculated by forecasting forward based on trends over the previous ten years, using data on GPs starting or leaving the NHS in Scotland provided by ISD Scotland. Alternative scenarios used factored in the number of ScotGEM graduate training places and the impact of increasing numbers of retirements.

- Potential gap due to EU withdrawal has been calculated by assuming 3.7 per cent of GPs are from the EU (based on GMC data for all doctors). Surveys have shown as many as 40 per cent of doctors from the EU are intending to leave, so we have assumed ten per cent may genuinely leave. These potential leavers due to EU withdrawal have been removed from the overall GP number, as well as future GP new starts.

- Given that the GP workforce demographics show a decreasing number of GP partners, an increasing number of women and that about one in three are over 50, it is likely that an increasing number of new GPs will be needed to replace those who leave, due to changing working patterns. To demonstrate the impact that this could have we have assumed that the current ratio of about 1.2 GPs for every 1 WTE will increase to about 1.4.

- For each of these factors a range of scenarios was produced, and those that may be most likely, based on the available evidence, were selected. Further data on the alternative scenarios is presented in the linked background data.

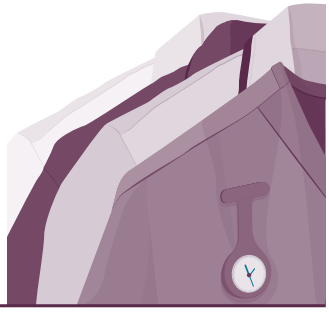
Methodology for cost per patient (paragraph 36, page 19)

- The cost per patient for the most rural and most urban practices uses data from the ISD Scotland GP payments publication and published data on the urban/rural categorisation of GP practices.

- Cost per patient for each practice was calculated by dividing the global sum plus correction factor by the number of people on the practice list. Then the average was calculated for the most and least rural practices, for comparison.

Appendix 3

Advisory group members



Audit Scotland would like to thank members of the advisory group for their input and advice throughout the audit. Members sat in an advisory capacity only. The content and conclusions of this report are the sole responsibility of Audit Scotland.

Member	Organisation
Richard Foggo	Scottish Government
Miles Mack	Rural GP
Moya Kelly	NHS Education for Scotland
Lorna Greene	Royal College of Nursing Scotland
Robert Peat	Allied Health Professions Federation for Scotland
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David Prince	British Medical Association
Aileen Bryson	Royal Pharmaceutical Society Scotland
David Leese	Renfrewshire Health and Social Care Partnership

NHS workforce planning – part 2

The clinical workforce in general practice

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ISBN 978 1 913287 07 8 AGS/2019/5

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Aberdeen City Health & Social Care Partnership
A caring partnership

AUDIT AND PERFORMANCE SYSTEMS COMMITTEE

Date of Meeting	29.10.2019
Report Title	Internal Audit Report AC1908 Non-Residential Care Charging Policy
Report Number	HSCP.19.055
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 the Non-Residential Care Charging Policy that was included in the 2018/19 Internal Audit Plan for Aberdeen City Council.

2. Recommendations

2.1. It is recommended that the Audit & Performance Systems Committee review, discuss and comment on the issues raised within this report.

3. Summary of Key Information

3.1. On 29 September 2015, Aberdeen City Council's Audit, Risk and Scrutiny Committee agreed that Internal Audit reports relating to Adult Social Care would be provided to the Aberdeen City Integration Joint Board Audit and Performance Systems Committee after being considered by Audit, Risk and Scrutiny Committee. A reciprocal arrangement was agreed by the Audit and Performance Systems Committee on 11 August 2016. Whilst the

AUDIT AND PERFORMANCE SYSTEMS COMMITTEE

Audit, Risk and Scrutiny Committee receives the full Internal Audit report, the Audit and Performance Systems Committee subsequently agreed that it wished to receive summary reports from Internal Audit rather than the full report.

3.2. The following summary of the Internal Audit report relating to the Non-Residential Care Charging Policy was considered by the Council's Audit, Risk and Scrutiny Committee on 26 June 2019. After some discussion of the issues identified, the Committee noted the report and endorsed the recommendations for improvement.

3.3. Although there is no 'duty' placed upon councils to charge for community care services, they are currently empowered by statute to make decisions about whether or not to charge for community care services, and, if they choose to, to develop and administer local charging policies. Financial and demographic pressures across the public sector increase the need to focus on potential revenue streams. Guidance and principles have been set out by CoSLA, and are updated annually, to assist in developing local policies.

3.4. Aberdeen City Council's Social Work non-residential charging policy was last updated in 2011 and is based on the principle that the level of services provided should be based on the service user's need, not their ability to pay and that a free service should continue to be provided to people on low incomes.

3.5. Aberdeen City Health and Social Care Partnership has ultimate responsibility for the delivery of the Charging Policy. Assistance in the delivery of the policy is provided by the Carefirst Team, the Financial Assessment Team, and the Business Services Transaction Team, within the Council.

3.6. In 2018/19, non-residential charging income of £7.5m was achieved against a budget of £8.3m.

3.7. The objective of this audit was to provide assurance that there is a clear charging policy and that it is being complied with.

3.8. In 2015 the Education and Children's Services Committee agreed that the basis for charging should be adjusted, from the previous policy agreed in 2011 based on set rates for different services, so that individuals would contribute proportionally towards the cost of their care in the same way, regardless of how those services were provided, subject to a financial assessment of their ability to pay, and a limited number of exceptions. As previously reported (Internal Audit report AC1617 Self-Directed Support (October 2016)) this was not implemented as planned. This, and delays in identifying and invoicing for chargeable services may (depending on the outcome of financial assessments) have resulted in material sums of income being foregone.

3.9. Some delays in concluding financial assessments were also identified, and there is limited evidence in support of cases where charges have been waived. The Service has agreed to review the evidentiary requirements, monitoring and escalation process.

3.10. Approval for a new policy is being sought from the City Growth and Resources Committee in June 2019 *(note – this was approved)*, and the Service has agreed to progress with further development and implementation of new systems and process changes to ensure charges under the new policy are raised correctly and timeously.

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

AUDIT AND PERFORMANCE SYSTEMS COMMITTEE

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
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Internal Audit Report

Aberdeen City Health & Social Care Partnership

Integration Joint Board Directions

Issued to:
Sandra Ross, Chief Officer, Aberdeen City Health & Social Care Partnership
Alex Stephen, Chief Finance Officer, Aberdeen City Health & Social Care Partnership
Gail Woodcock, Lead Transformation Manager, Aberdeen City Health & Social Care Partnership
Sarah Gibbon, Executive Assistant to Chief Officer, Aberdeen City Health & Social Care Partnership
External Audit

Date of Issue: July 2019 **Report No. AC1924**

EXECUTIVE SUMMARY

Aberdeen City Health & Social Care Partnership (ACH&SCP) manages its strategy and operations via an Integration Joint Board (IJB), supported by Committees, an Executive Team, and officers within the Partners reporting to the Chief Officer. Resources and budgets have been delegated to the Partnership, which directs services from the Partners via official Directions in order to fulfil the requirements of its Strategic Plan. A Direction must be given in respect of every function that has been delegated to the IJB.

The objective of this audit was to provide assurance that the arrangements in place for issuing Directions, and the Directions themselves, are appropriate, and that adequate procedures are in place for monitoring performance.

The Partnership introduced new procedures for issuing and documenting Directions in 2018 which are clear and comprehensive. Since their introduction Directions have generally been consistently recorded. However, errors were identified including the budgeted values and dates of issue included in final printed and issued Directions. A reminder has been issued to report authors to ensure the correct information is recorded.

Directions are typically supported by proposals or business cases. These were not always clear as to the specific and measurable benefits and contributions a project or action would be expected to make towards each of the strategic priorities which had been listed. A reminder has been issued to report authors to ensure the rationale is clearly recorded.

Whilst budgets are monitored regularly and projects are subject to exception reporting, there is currently no periodic reporting to the IJB or its Audit and Performance Systems Committee regarding progress with implementing Directions. The Service plans to produce an annual monitoring report.

1. INTRODUCTION

1.1 Aberdeen City Health & Social Care Partnership (ACH&SCP) manages its strategy and operations via an Integration Joint Board (IJB), supported by Committees, an Executive Team, and officers within the Partners reporting to the Chief Officer. Resources and budgets have been delegated to the Partnership, which directs services from the Partners via official Directions in order to fulfil the requirements of its Strategic Plan. A Direction must be given in respect of every function that has been delegated to the IJB.

1.2 The objective of this audit was to provide assurance that the arrangements in place for issuing Directions, and the Directions themselves, are appropriate, and that adequate procedures are in place for monitoring performance.

1.3 The factual accuracy of this report and action to be taken with regard to the recommendations made have been agreed with Sandra Ross, Chief Officer, ACH&SCP, Gail Woodcock, Lead Transformation Manager, ACH&SCP and Sarah Gibbon, Executive Assistant to the Chief Officer, ACH&SCP.

2. FINDINGS AND RECOMMENDATIONS

2.1 Written Procedures

2.1.1 Comprehensive written procedures which are easily accessible by all members of staff can reduce the risk of errors and inconsistency. They are beneficial for the training of current and new employees and provide management with assurance that correct and consistent instructions are available to staff, important in the event of an experienced employee being absent or leaving. They have increased importance where new systems or procedures are being introduced.

2.1.2 The Service has a flow chart detailing the steps which should be undertaken prior to recommending to the IJB that a Direction be issued. These include details of information which should be present in supporting reports. The steps also emphasise the importance of ensuring that all relevant Officers are consulted and given the opportunity to query any issue. The instructions largely mirror the 'Good Practice Note: Directions from Integration Authorities to Health Boards and Local Authorities' produced by the Scottish Government.

2.1.3 COSLA in conjunction with the Scottish Government has recently (February 2019) completed a review of progress in relation to Health and Social Care Integration and has made proposals in relation to improvements in processes. One of these is that revised statutory guidance will be produced in relation to the use of Directions. It is anticipated that local guidance will be updated in the event that changes are required.

2.2 Directions

2.2.1 Prior to a Direction being issued it should be evidenced that the underlying issue and reason for the Direction have been carefully considered and discussed with relevant parties and that appropriate authorisation has been given to proceed. The Directions themselves should tie in with the strategic priorities as noted in the ACH&SCP Strategic Plan.

<u>2016-19 Priorities:</u>

1) Develop a consistent person centred approach that promotes and protects the human rights of every individual and which enable our citizens to have opportunities to maintain their wellbeing and take a full and active role in their local community.

2) Support and improve the health, wellbeing and quality of life of our local population.

3) Promote and support self-management and independence for individuals for as long as reasonably possible.

4) Value and support those who are unpaid carers to become equal partners in the planning and delivery of services, to look after their own health and to have a quality of life outside the caring role if so desired.

5) Contribute to a reduction in health inequalities and the inequalities in the wider social conditions that affect our health and wellbeing.

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

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

2.2.2 For a sample of eight Directions, background reports or business cases were presented to the IJB, showing that appropriate consideration had been given to them. In general, the proposals were clear, and set out their anticipated benefits, and a link to one or more of the Strategic Priorities. However, there were instances where some anticipated benefits could be difficult to accurately measure, and where links to further Strategic Priorities had been included without a clear explanation of how the project would directly affect them. This could make monitoring the effectiveness and impact of Directions more difficult.

Recommendation
The Service should ensure that the alignment of proposed Directions with its Strategic Priorities is clear.

Service Response / Action
Agreed. Officers have been reminded of the need to ensure a clear rationale for links to Strategic Priorities is set out to support each Direction.

Implementation Date	Responsible Officer	Grading
Implemented	Chief Finance Officer	Significant within audited area

2.2.3 Directions include the dates on which they have been approved by the IJB. However, in two instances the instruction from the IJB was that the Directions should only be issued following approval of Business Cases by the Executive Programme Board. In these instances, the date of the IJB's conditional approval was included on the Directions, rather than the date on which these conditions were met. As the core record of the IJB's instructions, Directions should be dated as of the date of issue.

2.2.4 In three cases the Directions included a different budget than that originally sought and approved. In one case an error resulted in the final printed Direction being issued for £191,500 instead of £189,500. In another case a late amendment to the report resulted in agreement to increase a budget to £84,000, but the Direction remained at £78,000. In the third case approval was given for a budget of £243,000, pending agreement from the Executive Programme Board, which agreed £211,000, but the Direction was issued for £243,000.

2.2.5 As the legal basis through which the IJB conducts its business and delivers its Strategic Priorities, Directions need to reflect its agreed intentions.

Recommendation
The Service should ensure that Directions accurately reflect the IJB's instructions.

Service Response / Action
Agreed. Officers have been reminded of the need to ensure values and dates of Directions are accurate.

Implementation Date	Responsible Officer	Grading
Implemented	Chief Finance Officer	Significant within audited area

2.3 Monitoring

2.3.1 There are various means of monitoring and reporting progress in respect of activity which is subject to a Direction – including budget monitoring, and governance arrangements put in place in respect of the transformation programme. A variety of supporting records is maintained in respect of these.

2.3.2 In addition to planned progress updates in respect of individual Projects, the Service maintains a Dashboard to which financial updates (figures and commentary) are input showing anticipated spend to year-end for Projects (which are generally subject to a Direction). Project Managers have access to the Dashboard and are responsible for ensuring that updates are provided timeously. It was noted that the Dashboard had not been updated in a number of instances. The Service explained that it is currently working on producing a new Dashboard and therefore there may currently be missing entries. Spend on the Dashboard is separated into financial years, and includes items not covered by Directions, therefore it is not currently in a suitable format to demonstrate that the scope of Directions is being adhered to.

2.3.3 The Service has also set up a spreadsheet showing Directions which have been issued since formation of the IJB. This contains the Direction title, the associated report title and budget, when it was approved, the Lead Officer and the effective dates of the Direction and a column for updates. Whilst the spreadsheet accurately reflected a sample of Directions and associated reports to the IJB in respect of specific transformation projects, it was not fully up to date: Directions issued as part of agreement of the 2018/19 Budget and Medium Term Financial Strategy were not included.

2.3.4 Therefore, although there are various records there is currently no consolidated overview of the implementation and status of all Directions issued by the IJB. As there is no regular monitoring, the IJB is not generally informed in advance of instances where a Direction is unlikely to be completed within the timeframe or budget initially projected – and therefore where a Direction may have to be amended – though depending on the scale this may be highlighted as part of budget monitoring or a specific report to the IJB or Audit and Performance Systems Committee. The Service has indicated plans to produce an annual monitoring report. More regular reporting would provide additional assurance.

Recommendation
The Service should develop and implement regular consolidated Directions progress monitoring for the IJB.

Service Response / Action
Agreed. This had not previously been progressed due to staffing changes in the Partnership. A report will be collated to demonstrate implementation of Directions as originally planned and presented to the IJB or an appropriate Committee.

Implementation Date	Responsible Officer	Grading
March 2020	Chief Finance Officer	Significant within audited area

AUDITORS: D Hughes
C Harvey
D Henderson

Appendix 1 – Grading of Recommendations

GRADE	DEFINITION
Major at a Corporate Level	The absence of, or failure to comply with, an appropriate internal control which could result in, for example, a material financial loss, or loss of reputation, to the Council.
Major at a Service Level	The absence of, or failure to comply with, an appropriate internal control which could result in, for example, a material financial loss to the Service/area audited. Financial Regulations have been consistently breached.
Significant within audited area	Addressing this issue will enhance internal controls. An element of control is missing or only partial in nature. The existence of the weakness identified has an impact on a system's adequacy and effectiveness. Financial Regulations have been breached.
Important within audited area	Although the element of internal control is satisfactory, a control weakness was identified, the existence of the weakness, taken independently or with other findings does not impair the overall system of internal control.

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AUDIT AND PERFORMANCE SYSTEMS COMMITTEE

Date of Meeting	29.10.2019
Report Title	Internal Audit Report AC1924 – Integration Joint Board Directions
Report Number	HSCP.19.056
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	a. Directions Audit Report

1. Purpose of the Report

1.1. The purpose of this report is to present the outcome from the planned audit of Integration Joint Board Directions 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 review, discuss and comment on the issues raised within this report.

3. Summary of Key Information

3.1. The Committee has previously expressed a wish to receive a summary of Internal Audit reports. However, at the pe-agenda meeting, a request was made that the full report be presented to the Committee in this instance.

3.2. The Executive Summary of the attached Internal Audit report contains the summary of key information.

AUDIT AND PERFORMANCE SYSTEMS COMMITTEE

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.

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AUDIT & PERFORMANCE SYSTEMS COMMITTEE

Date of Meeting	29.10.19
Report Title	Review of Financial Regulations
Report Number	HSCP.19.054
Lead Officer	Chief Finance Officer
Report Author Details	Alex Stephen Chief Finance Officer AleStephen@aberdeencity.gov.uk
Consultation Checklist Completed	*Yes*
Appendices	*a.* Financial Regulations – Oct 2019 *b.* Reserves Policy

1. Purpose of the Report

1.1. The purpose of this report is to present the Audit & Performance Systems Committee with a revised version of the Integration Joint Board's (IJB's) Financial Regulations for approval.

2. Recommendations

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

a) Approve the revised Financial Regulations, as at Appendix A.

3. Summary of Key Information

3.1. The IJB commissions services from Aberdeen City Council and NHS Grampian. The management of services within these organisations is governed by their own financial regulation.

3.2. Under the Local Government (Scotland) Act 1973, the IJB is required to make arrangements for administration of its financial affairs. At its meeting on the 26th of March 2016, the IJB agreed a set of financial regulations

which detailed the responsibilities, policies and procedures that govern the IJB.

3.3. The IJB requested that the financial regulations are reviewed regularly.

3.4. The revised financial regulations are attached at appendix A. The main changes are

- Financial monitoring – is currently being prepared quarterly for the IJB. NHS Grampian continue to produce information monthly and send this through to the Chief Finance Officer. Aberdeen City Council have moved to quarterly financial reporting to align with the stock market requirements. The change to the financial regulations is to highlight that the financial information should be received based on a timetable agreed by the Chief Finance Officer, Director of Finance for NHS Grampian and Section 95 officer, Aberdeen City Council. APS committee may wish to note that in future the relevant financial reports for the IJB will be based on period 5 and period 8 financial information instead of period 6 and period 9, this is to aid the scheduling of work within the finance teams.

- Grant funding – The main change is that officers will only need to report applications for grant funding to the IJB where match funding requirements have been identified that are over £50,000 and have either not previously been agreed by the IJB or are not contained within current budgets. The rationale for this change is to make it easier and quicker for officers to bid for grant funding to support the delivery of the strategic plan.

3.5. There is one area where the IJB are not currently compliant (item 3.3.4 regarding information on the set-aside budget). Work progresses both with NHS nationally and locally in Grampian to determine whether the set-aside usage can be received quarterly.

4. Implications for IJB

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

4.2. **Fairer Scotland Duty –** there are no direct implications relating to the Fairer Scotland Duty as a result of this report.

AUDIT & PERFORMANCE SYSTEMS COMMITTEE

4.3. **Financial –** These financial regulations detail the financial responsibilities, and policies and procedures that govern the Integration Joint Board.

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

4.5. **Legal –** approval of these financial regulations will allow the IJB to comply with its obligation to make arrangements for its financial affairs under the Local Government (Scotland) Act 1973.

4.6. **Other –** there are no other implications arising from the recommendations of this report.

5. **Links to ACHSCP Strategic Plan -** Development and management of robust financial arrangements acknowledges the IJB Strategic Intent and enables delivery of the strategic aims

6. Management of Risk

6.1. **Identified risks(s) & link to 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.

6.2. **Link to risks on strategic or operational risk register:** Number 2 (Strategic Risk Register)

6.3. **How might the content of this report impact or mitigate these risks:** The regular review of our financial regulations aims to maintain the integrity of the IJB's financial system and as such will help to mitigate this risk.

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Aberdeen City Health & Social Care Partnership
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ABERDEEN CITY INTEGRATION JOINT BOARD

FINANCIAL REGULATIONS

Date Created	Date Implemented	Review Date
11 March 2016	1 April 2016	23 September 2019

Developed By
Chief Finance Officer

VERSION 2.1

ABERDEEN CITY INTEGRATION JOINT BOARD

FINANCIAL REGULATIONS: INDEX

1. INTRODUCTION and INTERPRETATION

1.1 The Public Bodies (Joint Working) (Scotland) Act 2014 was passed by the Scottish Parliament on 25 February 2014 and provides a framework for the effective integration of adult health and social care services. The Act required the submission of a partnership agreement, known as the Integration Scheme for approval by the Scottish Government. Following a detailed consultation process, the scheme was submitted for approval in December 2015. Following approval by the Cabinet Secretary for Health, Wellbeing and Sport an Order was laid before the Scottish Parliament on 8 January 2016 and the Aberdeen City Integration Joint Board was established as an autonomous legal entity with effect from 6 February 2016. The Integration Scheme has since been reviewed by the IJB and passed to the Scottish Government in March 2018.

1.2 Aberdeen City Council and NHS Grampian recognise that they each have continuing financial governance responsibilities and agreed to establish Aberdeen City Integration Joint Board as a 'joint arrangement' as defined by IFRS 11. IFRS 11 is the international accounting standard that clarifies the reporting procedures that apply where parties recognise the rights and obligations arising from the joint arrangements.

1.3 The main objective of these Financial Regulations is to detail the financial responsibilities and policies and procedures that govern the Integration Joint Board. Representatives and Committees of Aberdeen City Integration Joint Board must comply with these Financial Regulations in dealing with the financial affairs of Aberdeen City Integration Joint Board.

1.4 The Aberdeen City Integration Joint Board has appointed a Chief Officer who will be the accountable officer of the Integration Joint Board in all matters except finance where there will be joint accountability with the Chief Finance Officer. The Chief Officer is accountable to the Chief Executives of NHS Grampian and Aberdeen City Council.

1.5 The Aberdeen City Integration Joint Board has appointed a Chief Finance Officer who is the proper officer for the purposes of Section 95 of the Local Government (Scotland) Act 1973. The Chief Finance Officer has a statutory duty to ensure that proper financial administration of the financial affairs of Aberdeen City Integration Joint Board is maintained. The Aberdeen City Integration Joint Board has regard to the current CIPFA guidance on the role of the Chief Finance Officer in Local Government.

http://www.cipfa.org/policy-and-guidance/reports/the-role-of-the-chief-financial-officer-in-local-government

1.6 Should any difficulties arise regarding the interpretation or application of these financial regulations, individuals must seek advice from the Chief Finance Officer before any action is taken.

1.7 The Aberdeen City Integration Joint Board commissions services from Aberdeen City Council and NHS Grampian. The management of services within each of these organisations continues to be governed by the existing Standing Financial Instructions, Financial Regulations, Schedule of Reserved Decisions, Operational Scheme of Delegation and any other extant financial procedures approved by their respective Governance structures. Officers, staff, committees, councillors and non-executive members of these organisations should ensure they comply with their respective financial governance arrangements.

1.8 Any breach or non-compliance with these Regulations must, on discovery, be reported immediately to the Chief Officer or the Chief Finance Officer of Aberdeen City Integration Joint Board. They must then consult with the NHS Grampian Chief Executive and Aberdeen City Council Chief Executive or another nominated or authorised person as appropriate to decide what action should be taken.

1.9 For the avoidance of doubt the breach of or non-compliance with these Regulations may result in disciplinary action being taken against the relevant individuals in line with the policies of the employing organisation.

1.10 These financial regulations should be read in conjunction with the Standing Financial Regulations of NHS Grampian and Aberdeen City Council:

2. ROLES and RESPONSIBILITIES

2.1 INTEGRATION JOINT BOARD MEMBERS RESPONSIBILITY

The Board are responsible for ensuring that proper accounting records are kept, which disclose at any time, the true and fair financial position and enable the preparation of financial statements that comply with the applicable Code of Practice. The Board are also responsible for ensuring that procedures are in place to ensure compliance with all statutory obligations.

2.2 CHIEF OFFICER RESPONSIBILITIES

2.2.1 The Chief Officer has a direct line of accountability to the Chief Executives of NHS Grampian and Aberdeen City Council for the delivery of integrated services. The Chief Officer is responsible for ensuring that progress is being made in achieving the national outcomes and that any locally delegated responsibilities for health and wellbeing and for measuring, monitoring and reporting on the underpinning measures and indicators (including financial) that will demonstrate progress.

2.2.2 The Chief Officer is responsible for ensuring that the decisions of the Board are carried out.

2.2.3 The Chief Officer shall ensure that the Financial Regulations and all associated procedure manuals and documents are made known to appropriate staff members and shall ensure full compliance with them.

2.2.4 The Chief Officer shall prepare budgets following consultation with the Chief Finance Officer. The Chief Officer is also responsible for the preparation of Service Plans and relevant business cases relating to the Services. The Chief Officer shall ensure that the Chief Finance Officer is informed of financial matters that will have a significant impact on the Services, seeking financial advice where necessary.

2.3 CHIEF FINANCE OFFICER RESPONSIBILITIES

2.3.1 The Chief Finance Officer is responsible for governance of the Board's financial resources, ensuring the Partners utilise these in accordance with the Strategic Plan and that the Strategic Plan delivers best value.

2.3.2 The Chief Finance Officer shall ensure that suitable accounting records are maintained and is responsible for the preparation of the Board's Financial Statements following the Code of Practice on Local Authority Accounting in the UK.

2.3.3 The Chief Finance Officer shall ensure that these Financial Regulations are reviewed and kept up to date.

2.3.4 The Chief Finance Officer shall provide the Chief Officer and the Board with an annual governance statement.

2.3.5 The Chief Finance Officer shall be entitled to report upon the financial implications of any matter coming before Aberdeen City Integration Joint Board. To allow the Chief Finance Officer to fulfil this obligation, the Chief Officer will consult with the Chief Finance Officer on all matters involving a potential financial implication that is likely to result in a report to the Board.

2.3.6 The Chief Finance Officer shall ensure that arrangements are in place to properly establish the correct liability, process and accounting for VAT. For major works,

service transformation and other changes in service delivery, the Chief Finance Officer must be consulted on the financial impacts, including VAT implications.

3. FINANCIAL PLANNING and MANAGEMENT

3.1 ANNUAL BUDGET

3.1.1 The Chief Finance Officer will report to Aberdeen City Integration Joint Board each year on the process, timetable, format and key assumptions in drafting the annual budget.

3.1.2 The Chief Finance Officer of Aberdeen City Integration Joint Board, Section 95 Officer of Aberdeen City Council and the Director of Finance of NHS Grampian will agree a timetable for preparation of the annual budget of Aberdeen City Integration Joint Board and the exchange of information between Aberdeen City Integration Joint Board, Aberdeen City Council and NHS Grampian.

3.1.3 The Chief Officer will submit annually to the Board a Strategic Plan setting out proposals for the delivery of services within the remit of the Board for, at minimum, the next 3 years. This will include the Integrated Budget and the notional budget for directed hospital services. The Strategic Plan will detail the reason for any projected surplus or deficit and how this will be used / addressed.

3.1.4 The Chief Officer and the Chief Finance Officer will develop a case for the Integrated Budget based on the Strategic Plan and present it to the Council and NHS Grampian for consideration and agreement as part of the annual budget setting process.

3.1.5 The Chief Finance Officer will prepare and issue guidance, instructions and a timetable to all involved in the preparation of the annual budget.

3.1.7 Following agreement of the Strategic Plan by the Board, and confirmation of the Integrated Budget by the Partners, the Chief Officer will provide Directions in writing to the Partners regarding operational delivery of the Strategic Plan. The Directions will include the functions that are being directed, how they are to be delivered and the resources to be used in delivery of the direction in accordance with the Strategic Plan. Directions will be confirmed by the Chief Officer by 31 March of the financial year proceeding the financial year under Direction.

3.1.8 The responsibility for delivering the delegated services for Aberdeen City Integration Joint Board to Aberdeen City Council and NHS Grampian shall lie with the Chief Officer of the Integration Joint Board.

3.2 ACCOUNTING POLICIES

3.2.1 The IJB is subject to the audit and accounts provisions of a body under section 106 of the Local Government (Scotland) Act 1973. The Chief Finance Officer is responsible for the preparation of the Board's Financial Statements following the Code of Practice on Local Authority Accounting in the UK.

3.3 BUDGET MONITORING

3.3.1 It is the joint responsibility of the Chief Officer and the Chief Finance Officer of the Aberdeen City Integration Joint Board to report to the Board regularly, timeously and accurately on all matters of budget management and control. The reports should include projections for the full financial year and any implications for the following financial years. These reports will include recovery action proposed where a year end budget variance is identified.

3.3.2 The Director of Finance, NHS Grampian and the Section 95 Officer, Aberdeen City Council will provide the Chief Finance Officer of the Aberdeen City Integration Joint Board with information regarding the costs incurred for the services directly managed by them. Information should be provided based on an agreed format and timetable.

3.3.3 The Director of Finance, NHS Grampian will provide the Chief Finance Officer of Aberdeen City Integration Joint Board with financial information on a monthly basis regarding the hosted services. Information should be in an agreed format and produced timely to enable inclusion in the financial monitoring reports.

3.3.4 The Director of Finance, NHS Grampian will provide the Chief Finance Officer of Aberdeen City Integration Joint Board with information regarding the use of the amounts set aside for hospital services. A frequency will be formally agreed but as a minimum, information will be provided on a quarterly basis.

3.3.5 The Chief Finance Officer will report monthly to the Chief Officer on the financial performance and position. These reports will be timely, relevant and reliable and will include information, analysis and explanation in relation to:

- Reviewing budget savings proposals
- Actual income and expenditure
- Forecast outturns and annual budget
- Explanations of significant variances
- Reviewing action required in response to significant variances
- Identifying and analysing financial risks
- Use of reserves
- Any adjustments to the annual budget (e.g. new funding allocations)

3.3.6 The Chief Finance Officer will work with the Section 95 Officer of Aberdeen City Council and Director of Finance of NHS Grampian to ensure managers are provided with monthly financial reports that are timely, relevant and reliable. These reports will include information and analysis in relation to:

- Budget available to managers
- Actual income and expenditure
- Forecast outturns.

3.3.7 The Chief Finance Officer will be consulted on all reports being submitted to the Board to ensure that any financial implications arising have been considered. Each Board report should include a Financial Implications section.

3.3.8 It is a requirement of the Public Bodies (Joint Working) (Scotland) Act 2014 that an annual performance report is presented to the Board and the financial contents therein should comply with the requirements as set out in the Act.

3.4 VIREMENT

3.4.1 Virement is the process of transferring budget between budget headings with no change to the overall net budget.

3.4.2 The Chief Officer is expected to deliver the agreed outcomes within the total delegated budget. Any virement must not create additional overall budget liability, unless additional income is being passed on from either of the partners.

3.4.3 Any proposal for virement involving a new policy, or variation of existing policy, which will impact upon the strategic plans of the Aberdeen City Integration Joint Board, will be subject to the approval of the Aberdeen City Integration Joint Board.

3.4.4 Virement can be used in the following situations and with reference to the flow chart at **APPENDIX 1**;

- The Chief Finance Officer has been notified; and
- The virement does not create an additional financial commitment into future financial years unless funded by additional income.

3.4.5 The virement process cannot be used in the following situations:

- for transfers between IJB and non-IJB budgets;
- for expected savings on finance costs or recharges;

- any savings against a property which has been declared surplus under the Council's or NHS's surplus asset procedure;

- to reinstate an item deleted by the Integration Joint Board during budget considerations unless approved by the Integration Joint Board.

3.4.6 The Chief Finance Officer must maintain separate budgets for any hosted services managed on behalf of Grampian wide partners. Virement to and from these to Integration Joint Boards requires authorisation of all the three Integration Joint Boards before being implemented.

3.4.7 To the extent that any virement would transfer budget between Partners the Chief Finance Officer is required to notify the Partner bodies.

3.5 FINAL ACCOUNTS PREPARATION

3.5.1 The Public Bodies (Joint Working) (Scotland) Act 2014 requires that the Aberdeen City Integration Joint Board is subject to the audit and accounts provisions of a body under Section 106 of the Local Government (Scotland) Act 1973 (Section 13). This will require audited annual accounts to be prepared with the reporting requirements specified in the relevant legislation and regulations (Section 12 of the Local Government in Scotland Act 2003 and regulations under Section 105 of the Local Government (Scotland) Act 1973).

3.5.2 Financial statements will be prepared to comply with the Code of Practice on Local Authority Accounting and other relevant professional guidance.

3.5.3 The draft annual accounts and final accounts shall be submitted to the Board and Audit and Performance Systems Committee (if applicable) for their scrutiny and review.

3.5.4 The timetable for audit and publication of Aberdeen City Integration Joint Boards annual accounts shall be agreed in advance with the external auditors of Aberdeen City Council and NHS Grampian. Audited annual accounts shall be signed and published in line with statutory deadlines.

3.6 TREASURY MANAGEMENT

3.6.1 The Integration Joint Board will not undertake any cash transactions but rather these will be on a notional basis through the Direction of expenditure undertaken by the Partners. Any cash correction arising as a result of the direction by the Board will be undertaken directly between the Partners. The Integration Joint Board will not operate a bank account.

3.7 RESERVES

3.7.1 The Public Bodies (Joint Working) (Scotland) Act 2014 empowers the Integration Joint Boards to hold reserves, which should be accounted for in the financial accounts and records of Aberdeen City Integration Joint Board. Aberdeen City

Integration Joint Board has a Reserves Policy that is held outwith these Financial Regulations.

3.7.2 Unless otherwise agreed, any unspent budget will be transferred into the reserves of the Aberdeen City Integration Joint Board at the end of each financial year.

3.7.3 A policy on reserves has been prepared by the Chief Finance Officer and was approved by the Aberdeen City Integration Joint Board. The policy will be reviewed annually, during the medium term financial strategy process and is attached as an appendix to these regulations.

3.8 GRANT FUNDING APPLICATIONS

3.8.1 Where opportunities arise to attract external funding, relevant officers shall consider the conditions surrounding the funding to ensure they are consistent with the aims and objectives of Aberdeen City Integration Joint Board and the Strategic Plan.

3.8.2 Grant funding to be secured by the Aberdeen City Integration Joint Board from external bodies is required to receive approval from the Integration Joint Board prior to an application being made by the accountable body to ensure that any match funding requirements are considered. Where the match funding required is greater than £50,000 and has either been agreed by the IJB previously or is included within the current revenue budget, then approval by the Integration Joint Board is not required prior to bidding for grants. Where the match funding element is less that £50,000 and is included within the current revenue budget then approval by the Integration Joint Board is not required prior to bidding for grants. The Chief Finance Officer will be responsible for determining whether funding is contained within the current revenue budget and should be consulted before any grant funding bids are made by officers

3.8.3 The Chief Finance Officer shall ensure that arrangements are in place to:-

- receive and properly record such income in the accounts of the accountable body;
- ensure the audit and accounting arrangements are met; and
- ensure the funding requirements are considered prior to entering into any agreements.

4. FINANCIAL SYSTEMS and PROCEDURES

4.1 INCOME

4.1.1 There is no income to the Integration Joint Board by way of cash transaction. Transfer of resources will be made by NHS Grampian and Aberdeen City

Council in respect of the agreed delegated functions. Payment will then be made by the Integration Joint Board for the delivery of these services. The accounting for these transactions will be via book entries in the ledgers of NHS Grampian and Aberdeen City Council.

4.2 AUTHORITY TO INCUR EXPENDITURE

4.2.1 The Chief Officer shall have the authority to incur expenditure within the approved delegated resources from Aberdeen City Integration Joint Board to Aberdeen City Council and NHS Grampian in-line with any supplementary budget that has been approved by the Aberdeen City Integration Joint Board, and subject to the provisions of these Financial Regulations.

4.2.2 Expenditure shall be aligned with the Strategic Plan.

4.3 SCHEME of DELEGATION

4.3.1 Detail included in separate documentation.

4.4 PROCUREMENT and COMMISSIONING

4.4.1 The Public Bodies (Joint Working) (Scotland) Act 2014 provides that the Aberdeen City Integration Joint Board may enter into a contract with any other person in relation to the provision to the Integration Joint Board of goods and services for the purposes of carrying out functions conferred on it by the Act.

4.4.2 Procurement activity will be undertaken in accordance with the guidance prevailing in the Partner organisation to which the Board has given operational Direction for the use of financial resources.

4.5 IMPRESTS

4.5.1 There will be no facility for petty cash unless authorised by the Aberdeen City Integration Joint Board Chief Finance Officer and the necessary security arrangements have been established and have been deemed adequate.

4.5.2 Imprest facilities will be operated within NHS Grampian and Aberdeen City Council and will be contained within their respective established arrangements.

5. FINANCIAL ASSURANCE

5.1 AUDIT & PERFORMANCE SYSTEMS COMMITTEE

5.1.1 Aberdeen City Integration Joint Board is required to make appropriate and proportionate arrangements for overseeing the system of corporate governance and internal controls. For this purpose the Aberdeen City Integration Joint Board has agreed to the establishment of an audit committee (the Audit and Performance Systems Committee) and will approve terms of reference. This

Committee should operate in accordance with Financial Reporting Council professional guidance for Audit Committees.

5.2 EXTERNAL AUDIT

5.2.1 The Accounts Commission will appoint the external auditors to the Aberdeen City Integration Joint Board.

5.2.2 External Audit will be required to submit an annual plan to the Aberdeen City Integration Joint Board / Audit & Performance Systems Committee.

5.2.3 External Audit will be required to submit a final report to Aberdeen City Integration Joint Board / Audit & Performance Systems Committee.

5.2.4 The External Auditor appointed to Aberdeen City Integration Joint Board for the purposes of conducting their work, shall:-

- Have a right of access to all records, assets, personnel and premises, including those of partner organisations in carrying out their duties in relation to IJB activity.
- Have access to all records, documents and correspondence relating to any financial and other transactions of the Board and those of partner organisations where it relates to their business with the Board.
- Require and receive such explanations as are necessary concerning any matter under examination.

5.3 INTERNAL AUDIT - RESPONSIBILITY

5.3.1 The role of Internal Audit is to understand the key risks faced by the Aberdeen City Integration Joint Board and to examine and evaluate the adequacy and effectiveness of the system of risk management and internal control as in support of the governance arrangements operated by the Board.

5.3.2 The Aberdeen City Integration Joint Board shall secure the provision of a continuous internal audit service to provide an independent and objective opinion on the control environment comprising risk management, governance and control of the delegated resources.

5.3.3 Following a decision by Aberdeen City Integration Joint Board on who will provide the Internal Audit service, a Chief Internal Auditor will be nominated.

5.3.4 Where the internal audit services are provided by either NHS Grampian or Aberdeen City Council (or indeed a shared service), such provision should be subject to a formal service level agreement and subject to periodic review.

5.3.5 The operational delivery of internal audit services within NHS Grampian and Aberdeen City Council will be contained within their respective established arrangements.

5.3.6 The Internal Audit Service provided to Aberdeen City Integration Joint board will undertake its work in compliance with the Public Sector Internal Audit Standards.

5.3.7 Prior to the start of each financial year the Aberdeen City Integration Joint Board Chief Internal Auditor will prepare and submit a strategic risk based audit plan to the Aberdeen City Integration Joint Board for approval. It is preferable that this be shared with the relevant Committees of NHS Grampian and Aberdeen City Council.

5.3.8 The Chief Internal Auditor shall report to the Integration Joint Board via the Audit & Performance Systems Committee at regular intervals throughout the year on the outcomes of audit work completed and on progress towards delivery of the agreed annual plan; and provide an annual assurance opinion based on the overall findings from the audit.

5.3.9 Such Internal Audit work shall not absolve senior management of the responsibility to ensure that all financial transactions are undertaken in accordance with the Financial Regulations and Standing Orders and that adequate systems of internal control exist to safeguard assets and secure the accuracy and reliability of records.

5.3.10 It shall be the responsibility of senior management to ensure that access and explanations requested by Internal Audit are provided in a timely manner.

5.3.11 The Chief Internal Auditor has the right to report direct to the Integration Joint Board in any instance where he or she deems it inappropriate to report to the Chief Officer, Chief Finance Officer or Audit & Performance Systems committee.

5.3.12 Where recommendations resulting from Internal Audit work have been agreed, the Chief Officer shall ensure that these are implemented within the agreed timescale. Regular progress reports will be sought by Internal Audit and it is the responsibility of the Chief Officer to ensure that these are provided when requested along with explanations of any recommendations not implemented within the agreed timescale.

5.4 INTERNAL AUDIT - AUTHORITY

5.4.1 The Chief Internal Auditor or their representatives shall have the authority, on production of identification to obtain entry at all reasonable times to any premises or land used or operated by Aberdeen City Integration Joint Board in order to review, appraise and report on the areas detailed below:-

- The adequacy and effectiveness of the systems of financial, operational and management control and their operation in practice in relation to the business risks to be addressed.

- The governance arrangements in place by reviewing the systems of internal control, risk management practices and financial procedures.

- The extent of compliance with policies, standards, plans and procedures approved by the Board and the extent of compliance with regulations and reporting requirements of regulatory bodies.

- The suitability, accuracy, reliability and integrity of financial and other management information and the means used to identify, measure and report such information.

5.4.2 In addition, the Chief Internal Auditor or their representatives, for the purposes of conducting their work, shall:-

- Have a right of access to all records, assets, personnel and premises, when carrying out their duties in relation to IJB activity.

- Have access to all records, documents and correspondence relating to any financial and other transactions of the Board and those of partner organisations where it relates to their business with the Board.

- Require and receive such explanations as are necessary concerning any matter under examination.

5.5 FRAUD, CORRUPTION & BRIBERY

5.5.1 Every member of Aberdeen City Integration Joint Board and its representatives shall observe these Financial Regulations within the sphere of their responsibility. They have a duty to bring to the immediate attention of the Chief Finance Officer/ Chief Internal Auditor any suspected fraud or irregularity in any matter that would contravene these regulations.

5.5.2 There are a range of confidential routes available to the Aberdeen City Integration Joint Board and its representatives who wish to ask for advice or to report suspected fraudulent activity;

- Your Line Manager
- Your HR Manager
- NHS Counter Fraud Services (CFS) Fraud Hotline on – 08000 15 16 28
- NHS Grampian's Fraud Liaison Officer – Assistant Director of Finance (Financial Services) on 01224 556211
- Aberdeen City Council's Corporate Investigations Team on 01224 522585

All information provided is treated in the strictest of confidence and individuals who raise genuine concerns are protected by law, regardless of the outcome of any investigation that they initiate.

The fraud policies of both NHS Grampian and Aberdeen City Council are available via their respective Intranets.

5.5.3 When a matter arises where it is suspected that an irregularity exists in the exercise of the functions of Aberdeen City Integration Joint Board, the Chief Finance Officer in conjunction with the Chief Internal Auditor and the Chief Officer, will take such steps as may be considered necessary by way of investigation and report.

5.6 INSURANCE

5.6.1 The Chief Officer in conjunction with the Chief Finance Officer will ensure that the risks faced by the Board are identified and quantified and that effective measures are taken to reduce, eliminate or insure against them.

5.6.2 As of 1 April 2016 the Aberdeen City Integration Joint Board will apply to become members of the Clinical Negligence and Other Risks Scheme (CNORIS) scheme. Initially, the cover provided will be in relation to indemnity for Aberdeen City Integration Joint Board Members only. The cover to be provided is in respect of decisions made by Members in their capacity on the Board. All other cover required should be provided by NHS Grampian and Aberdeen City Council.

5.6.3 The Chief Officer is responsible for ensuring that there are adequate systems in place for the prompt notification in writing to the Chief Finance Officer of any loss, liability, damage or injury which may give rise to a claim, by or against the Board.

5.6.4 The Chief Officer in conjunction with the Chief Finance Officer shall annually or at such other period as may be considered necessary, review all insurances. Any required changes should be reported to Aberdeen City Integration Joint Board.

5.6.5 The Chief Officer in conjunction with the Chief Finance Officer of Aberdeen City Integration Joint Board will review the requirement for membership of the Scottish Government (CNORIS) on an annual basis.

5.7 VAT

5.7.1 HMRC have confirmed that there is no VAT registration requirement for Integration Joint Boards under the VAT Act 1994 as it will not be delivering any services that fall within the scope of VAT.

5.7.2 Should the activities of the Board change in time and it becomes empowered to provide services, then it is essential the VAT treatment of any future activities or services delivered are considered in detail by the Chief Finance Officer to

establish if there is a legal requirement for the Integration Joint Boards to register for VAT.

5.7.3 The Chief Officer and Chief Finance Officer must remain cognisant of possible VAT implications arising from the delivery of the Strategic Plan. The Partner organisations should be consulted in early course on proposals which may have VAT related implications for them.

5.8 GIFTS and HOSPITALITY / REGISTER of INTEREST

5.8.1 Members and employees should comply with their respective codes of conduct when offered gifts, gratuities and hospitality. NHS Grampian and Aberdeen City Council both maintain a register of gifts and hospitality offered.

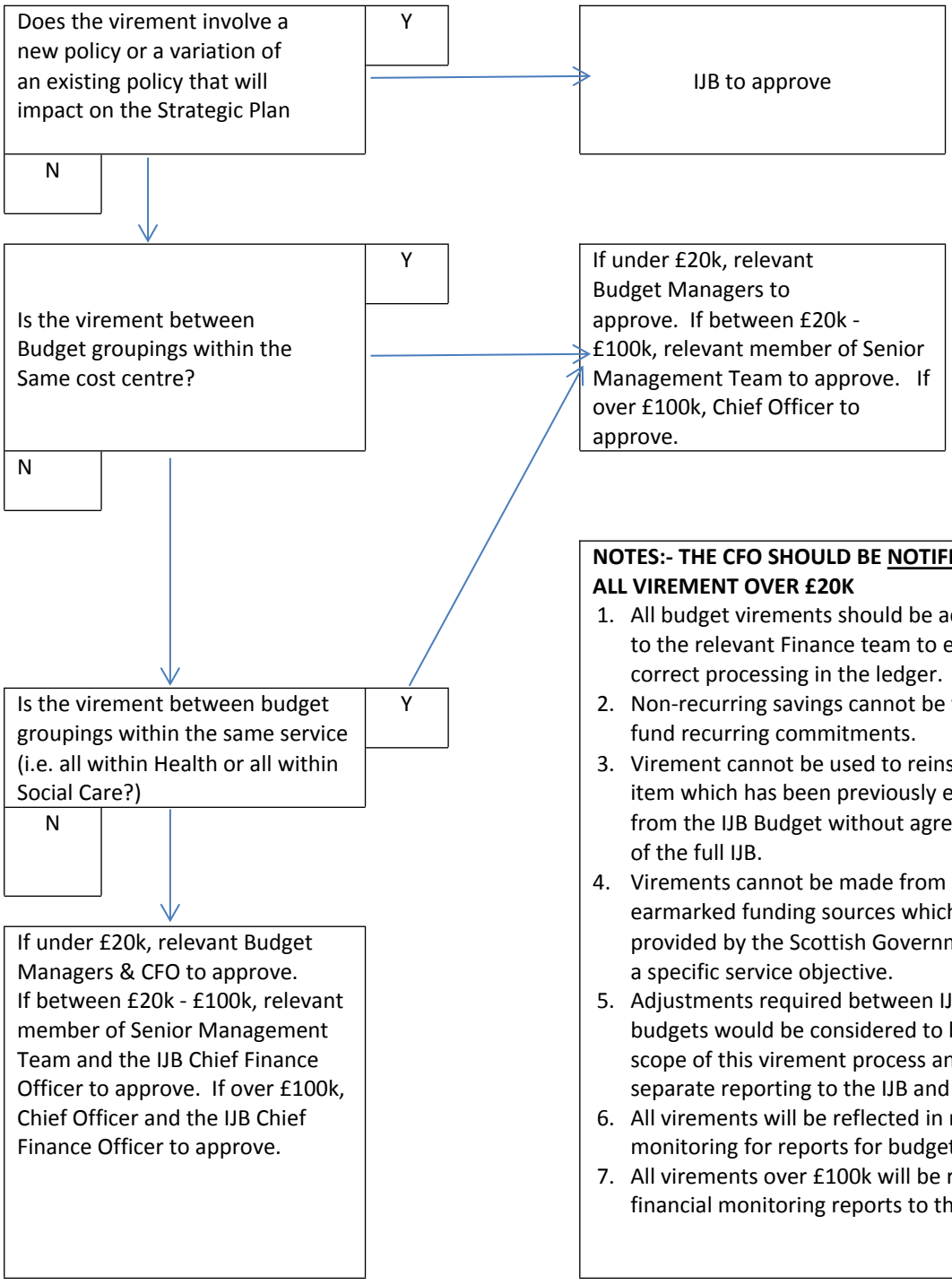
5.8.2 A central register of gifts and hospitality will be maintained by the Aberdeen City Integration Joint Board. For the offers of any hospitality or gift, approval must be sought from the relevant line manager prior to acceptance and for offers exceeding £30 details must be intimated in writing for including in the register. Reference should be made to the respective codes of conduct.

5.8.3 A separate Register of Interests for board members is to be maintained by the Clerk to the Aberdeen City Integration Joint Board.

6 REVIEW OF FINANCIAL REGULATIONS

6.1 These Financial Regulations shall be subject to review on an ongoing basis, and at a minimum of every year by the Aberdeen Integration Joint Board Chief Finance Officer and where necessary, subsequent amendments will be submitted to Aberdeen City Integration Joint Board for approval. Financial Regulations should be considered alongside other Governance documents including Standing Orders and Scheme of Delegation.

APPENDIX 1 – IJB VIREMENT APPROVAL RESPONSIBILITY CHART



NOTES:- THE CFO SHOULD BE NOTIFIED OF ALL VIREMENT OVER £20K

1. All budget virements should be advised to the relevant Finance team to ensure correct processing in the ledger.
2. Non-recurring savings cannot be vired to fund recurring commitments.
3. Virement cannot be used to reinstate an item which has been previously excluded from the IJB Budget without agreement of the full IJB.
4. Virements cannot be made from earmarked funding sources which are provided by the Scottish Government for a specific service objective.
5. Adjustments required between IJB and non IJB budgets would be considered to be outside the scope of this virement process and require separate reporting to the IJB and the Partners.
6. All virements will be reflected in monthly monitoring for reports for budget managers.
7. All virements over £100k will be reported in the financial monitoring reports to the IJB.

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Aberdeen City Integration Joint Board

RESERVES POLICY

Date Created	Date Implemented	Review Date
September 2016	October 2016	October 2019

Developed By Chief Finance Officer	Reviewed By Chief Officer	Approved by

VERSION 1.1

CONTENTS

1. Background

1.1 In July 2014 CIPFA, through the Local Authority Accounting Panel (LAAP), issued guidance in the form of LAAP bulletin 99 - *Local Authority Reserves and Balances* in order to assist local authorities (and similar organisations) in developing a framework for reserves. The purpose of the bulletin is to provide guidance to local authority chief finance officers on the establishment and maintenance of local authority reserves and balances in the context of a framework, purpose and key issues to consider when determining the appropriate level of reserves.

1.2 The Aberdeen City Integration Joint Board (IJB) , Audit and Performance Committee (APS) is subject to the audit and accounts regulations and legislation of a body under Section 106 of the Local Government (Scotland) Act 1973 and is classified as a local government body for accounts purposes by the Office for National Statistics (ONS). The IJB is able to hold reserves which should be accounted for in the financial accounts of the Board.

1.3 The purpose of this Reserves Policy is to:

- outline the legislative and regulatory framework underpinning the creation, use or assessment of the adequacy of reserves;
- identify the principles to be employed by the IJB in assessing the adequacy of the its reserves;
- indicate how frequently the adequacy of the IJB's balances and reserves will be reviewed and;
- set out arrangements relating to the creation, amendment and the use of reserves and balances.

1.4 In common with local authorities, the IJB can hold reserves within a usable category.

2. Statutory / Regulatory Framework for Reserves

Usable Reserves

2.1 Local Government bodies - which includes the IJB for these purposes - may only hold usable reserves for which there is a statutory or regulatory power to do so. In Scotland, the legislative framework includes:

Usable Reserve -	Powers
General Fund -	Local Government (Scotland) Act 1973

2.2 For each reserve there should be a clear protocol setting out:

- the reason / purpose of the reserve;
- how the reserve links to the strategic plan,
- how and when the reserve can be used;
- procedures for the reserves management and control; and
- The timescale for review to ensure continuing relevance and adequacy.

3. Operation of Reserves

3.1 Reserves are generally held to do three things:

- create a working balance to help cushion the impact of uneven cash flows and avoid unnecessary temporary borrowing;

- create a contingency to cushion the impact of unexpected events or emergencies – this also forms part of general reserves; and

- create a means of building up funds, often referred to as earmarked reserves, to meet known or predicted liabilities, including ring fencing funding allocations from the Scottish Government which are required to be spent on specific projects.

3.2 The balance of the reserves normally comprises of three elements:

- funds that are earmarked or set aside for specific purposes. In Scotland under Local Government rules, the IJB cannot have a separate Earmarked Reserve within the Balance Sheet, but can highlight elements of the General Reserve balance required for specific purposes. The identification of such funds can be highlighted from a number of sources including:

    - future use of funds for a specific purpose, as agreed by the IJB; or

- funds which are not earmarked for specific purposes, but are set aside to deal with unexpected events or emergencies; and

- funds held in excess of the target level of reserves and the identified earmarked sums. Reserves of this nature can be spent or earmarked at the discretion of the IJB.

4. Role of the Chief Finance Officer

4.1 The Chief Finance Officer is responsible for advising on the targeted optimum levels of reserves the IJB would aim to hold (the prudential target). The IJB, based on this advice, should then approve the appropriate reserve strategy as part of the budget process

5. Adequacy of Reserves

5.1 There is no guidance on the minimum level of reserves that should be held. In determining the prudential target, the Chief Finance Officer must take account of the strategic, operational and financial risks facing the IJB over the medium term and the IJB's overall approach to risk management.

5.2 In determining the prudential target, the Chief Finance Officer should consider the IJB's Strategic Plan, the medium term financial outlook and the overall financial environment. Guidance also recommends that the Chief Finance Officer reviews any earmarked reserves as part of the annual budget process and development of the Strategic Plan.

5.3 In light of the size and scale of the IJB's responsibilities, over the medium term it is proposed to hold a prudent level of general reserves. The reserves will be reviewed annually as part of the IJB's Budget and Strategic Plan; and in light of the financial environment at that time. The level of other earmarked funds will be established as part of the annual financial accounting process.

6. Reporting Framework

6.1 The Chief Finance Officer has a fiduciary duty to ensure proper stewardship of public funds.

6.2 The level and utilisation of reserves will be formally approved by the IJB based on the advice of the Chief Finance Officer. To enable the IJB to reach a decision, the Chief Finance Officer should clearly state the factors that influenced this advice.

6.3 As part of the budget report the Chief Finance Officer should state:

- the current value of general reserves, the movement proposed during the year and the estimated year-end balance and the extent that balances are being used to fund recurrent expenditure;

- the adequacy of general reserves in light of the IJB's Strategic Plan, the medium term financial outlook and the overall financial environment;

- an assessment of earmarked reserves and advice on appropriate levels and movements during the year and over the medium term; and

- if the reserves held are under the prudential target, that the IJB should be considering actions to meet the target through their budget process.

7. Accounting and Disclosure

7.1 Expenditure should not be charged direct to any reserve. Any movement within Revenue Reserves is accounted for as an appropriation and is transparent. Entries within a reserve are specifically restricted to ‘contributions to and from the revenue account’ with expenditure charged to the service revenue account.

Aberdeen City Health & Social Care Partnership
A caring partnership

AUDIT AND PERFORMANCE SYSTEMS

Date of Meeting	29 October 2019
Report Title	Performance Dashboard
Report Number	HSCP.19.057
Lead Officer	Sandra Ross, Chief Officer
Report Author Details	Name: Alison MacLeod Job Title: Lead Strategy and Performance Manager Email: alimacleod@aberdeencity.gov.uk
Consultation Checklist Completed	Yes
Directions Required	No
Appendices	N/A

1. Purpose of the Report

1.1. The purpose of this report is to present the latest draft of the Performance Dashboard that is linked to the current IJB Strategic Plan.

2. Recommendations

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

a) Review the draft Performance Dashboard.

b) Provide verbal feedback and comment to the Lead Strategy and Performance Manager to inform further development of the Dashboard.

c) Instruct the Lead Strategy and Performance Manager on the format and frequency of the committee's future performance reporting requirements and how this might align to performance information reported to the Clinical and Care Governance Committee.

AUDIT AND PERFORMANCE SYSTEMS

3. Summary of Key Information

3.1. The IJB approved the Strategic Plan for 2019 to 2022 at its meeting in March 2019. The plan contains five Strategic Aims and a suite of performance measures was provided for each.

3.2. In order to facilitate collation of the performance data, a master spreadsheet was created which captures the source, the frequency of reporting, whether trend or benchmarking data is available and where this is currently reported to. This spreadsheet enables us to track what information is available and where the gaps are. It also provides assurance as to the quality and accuracy of the data. The spreadsheet can be made available for the committee to view should this be required.

3.3. The Chief Officer of Aberdeen City Health and Social Care Partnership has responsibility for the delivery of the Strategic Plan and uses these performance measures as part of her ongoing performance review meetings with the Chief Executives of Aberdeen City Council and NHS Grampian.

3.4. Initially these measures were depicted in excel spreadsheet format showing current data and data covering previous periods in order that progress could be demonstrated, and areas of concern identified. There is a lot of data and the spreadsheet was busy and difficult to read.

3.5. In conjunction with colleagues from NHS Grampian Health Intelligence, a Performance Dashboard has been compiled using the Tableau software which provides a much more visual and easier to read version of the same data.

3.6. A demonstration of the Dashboard will be provided at the October meeting of the Audit and Performance Systems Committee and the November meeting of the Clinical and Care Governance Committee with the opportunity for committee members to make comment both on the visual appeal of this and of the content.

3.7. Following feedback, further development of the Dashboard will take place and subsequent versions will be presented to future meetings of both committees as part of the iterative development process.

3.8. It should be noted that data is not yet available for all of the performance measures and these are indicated in grey on the Performance Dashboard. Work is ongoing to address this. It is also our intention to add data from our

AUDIT AND PERFORMANCE SYSTEMS

commissioned services to our performance dashboard and discussions are ongoing as to the mechanisms for achieving this. It is difficult to put a timescale on when the missing information will be available but regular updates will be provided to the committee on progress.

3.9. In addition, some of the data that is available is only reported on an annual or bi-annual basis, so committee members will not necessarily be able to track performance between meetings. The annual version of the Dashboard will be used to inform the 2019/20 Annual Report.

3.10. The original intention had been to share consideration of performance against the five Strategic Aims between the two committees however it is proposed that both committees may wish to re-consider that approach in light of the information now presented. There is the possibility that each member of the IJB and both Committees could have direct access to Tableau and to the reports relevant to them. The Lead Strategy and Performance Manager would be grateful for instruction as to how the committees would wish to receive performance information in future.

3.11. In addition to the Chief Officer having a Performance Dashboard, work is ongoing to develop Dashboards for each member of the Leadership Team depicting progress against their objectives. These will be used at the quarterly performance meetings with the Chief Officer.

4. Implications for Audit and Performance Systems

4.1. Equalities – this report has no direct implications in relation to equalities.

4.2. Fairer Scotland Duty – this report has no direct implications in relation to the Fairer Scotland Duty.

4.3. Financial – there are no direct financial implications arising from the recommendations of this report.

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 in this report.

4.6. Other – none.

AUDIT AND PERFORMANCE SYSTEMS

5. Links to ACHSCP Strategic Plan

5.1. The Performance Dashboard demonstrates progress made against the five Strategic Aims within the Strategic Plan.

6. Management of Risk

6.1. Identified risks(s)

If we do not monitor and report on our performance there is a risk that the services we are delivering are not of the best quality and that we miss opportunities to improve.

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 both performance standards/outcomes as set by regulatory bodies and those locally determined performance standards as set by the board itself. This may result in harm or risk of harm to people*.

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

The report gives assurance on the areas where we are performing well and highlights areas where performance could be improved allowing remedial activity to be employed where required.

Aberdeen City Health & Social Care Partnership
A caring partnership

AUDIT & PERFORMANCE SYSTEMS COMMITTEE

Date of Meeting	29th October 2019
Report Title	Transformation Progress Report
Report Number	HSCP.19.059
Lead Officer	Sandra Ross, Chief Officer
Report Author Details	Susie Downie Transformation Programme Manager sdownie@aberdeencity.gov.uk 01224 523945
Consultation Checklist Completed	Yes
Directions Required	No
Appendices	a. Transformation Programme: Acceleration and Pace Highlight Report: June – October 2019 b. Aberdeen Links Service Evaluation c. West Visiting Evaluation Published d. Aberdeen Links Quarter 2 Data

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, and detailed evaluation of the Link Working Service in Aberdeen.

Finally, the report brings to the attention of the committee the first formal published report produced by the partnership: “Patient’s Perspectives of the INCA Service”.

2. Recommendations

AUDIT & PERFORMANCE SYSTEMS COMMITTEE

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), was updated in line with the refreshed Strategic Plan in March 2019 and consists of the following programmes of activity which aim to support the delivery of the strategic plan:

Transformation Programme of Work	Links to Strategic Aims	Links to Strategy Enablers	Comments
Primary Care Improvement Plan	Resilience Enabling Communities		Agreed by IJB in July 2018 Specific Funding Source.
Action 15 Plan	Prevention Resilience Enabling Communities	Workforce	Agreed by IJB in July 2018 Specific Funding Source.
Alcohol and Drugs Partnership Plan	Prevention Enabling Communities		Agreed by IJB in Spet 2019 Part of Community Planning Aberdeen's Local Outcome Improvement Plan. Specific funding source.
Locality Development Transformation Programme	Prevention Resilience Enabling Communities Connections		Will capture change actions identified in Locality plans. Will also include significant cross-cutting projects such as Unscheduled Care and Social Transport.
Digital Transformation Programme	Prevention Resilience Enabling Communities Connections	Digital Transformation	Will support the delivery of the Digital Strategy.
Organisational Development	Prevention Resilience	Empowered Staff	Will support the delivery of the Workforce Plan.

AUDIT & PERFORMANCE SYSTEMS COMMITTEE

Transformation Programme	Enabling		
Efficient Resources Transformation Programme	Prevention Enabling	Sustainable Finance	Will utilised Lean Six Sigma methodology, working deep within teams delivering services to reduce variation and increase efficiency.
Resilient, Included and Supported Outcome Improvement Plan	Prevention Resilience Communities Connections		Part of Community Planning Aberdeen's Local Outcome Improvement Plan. No specific funding source.

Future Focus of Integration

3.3. At the Integration Joint Board (IJB) on 3rd September the Chief Officer presented an update which set out the major risks and challenges considering both macro and micro environment. Noting the progress made to date, there is a clear message from national bodies that the pace and scale of reform needs to increase across all integration partnerships. In order to address the Chief Officer has set out five key programmes (linked to the strategic aims)

- Programme 1: An approach to Demand Management implemented through a strategic commissioning approach
- Programme 2: A deliberate shift to prevention
- Programme 3: A Data and Digital Programme
- Programme 4: Conditions for Change
- Programme 5 Accessible and responsive infrastructure

3.4. These programmes are our focus for delivery of the strategic plan. Therefore we aligning current reporting to this new approach over the next 6 months and as such the attached Acceleration and Pace progress report for the period May to October 2019 (Appendix A), consists of updates covering most but not all of the current programme activity.

3.5. 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.

Aberdeen Links Service Evaluation

3.6. A six-month evaluation of the Aberdeen Links Service (ALS) has been completed (see Appendix B for details of the methodology followed and the full report). Notable findings include:

- People who engaged with the ALS reported statistically significant improvements in quality of life (p=.009), loneliness (p=.001) and happiness (p=.02) scores between first contact and at six-month follow up
- There was a trend towards a reduction in the mean number of GP contacts. Although this did not reach statistical significance, it decreased from 1.7 face-to-face GP appointments at baseline to 1.2 face-to-face GP appointments at follow-up.
- The Link Practitioners reported high role satisfaction (average score 83%).

3.7. The findings have been accepted for oral presentation at the Faculty of Public Health conference in November 2019 and a research article derived from this evaluation report is currently being re-written to publish in an international journal.

Publishing of West Visiting Service evaluation

3.8. The evaluation of the West Visiting Service, brought to the board in February 2019, has been published in the Journal of Research in Nursing (see Appendix C). The Journal is run by SAGE Publishers, a global organisation releasing more than 1000 journals per year. This is the second research article to be published by the Partnership following from the INCA research paper published in AIMS Public Health in April 2019 and increases our reputation and visibility at an international level.

Community Treatment and Care (CTAC) Services Development

3.9. The scoping of Community Treatment and Care (CTAC) Services commenced in July 2019 with a workshop held with a range of stakeholders. A framework for service development has been created using best practice from the 90 Day Learning Cycle report[1] on CTACs published by Health Care Improvement Scotland. Key priority areas identified are, IT systems, Workforce and agreement of service provision.

[1] https://ihub.scot/improvement-programmes/primary-care/community-treatment-and-care/

Work is ongoing with Elective Care colleagues to ensure appropriate linkages with the development of their community hubs both in Aberdeen and across Grampian

Lean Six Sigma Day of Success

3.10. The 'Sharing the learning, Learning to Improve' event took place on 29th August 2019. This event brought project teams, IJB and leadership team members together to recognise and celebrate success of projects using Lean Six Sigma methodology. Each of the first phase of projects presented results and progress. There was broad discussion and reflection on the learning from the projects. The next steps will be to do a second round of projects using the methodology to better understand future implantation of the approach. The feedback has anecdotally been very positive, and we are currently evaluating project staff views on the experience. There is also work underway to understand what improvement skills and knowledge there is across the partnership in order to harness this for supporting future projects in a more innovative approach.

Alcohol and Drug Partnership (ADP) Programme

3.11. The Scottish Government has provided Alcohol and Drug Partnerships (ADPs) across Scotland with additional recurring funding. For Aberdeen City this equates to £666,404 per year. The funding is allocated to locally deliver the national strategy: Rights, Respect, Recovery[2]. The ADP programme is a change and improvement programme for Alcohol and Drug Treatment and Support within Aberdeen City.

3.12. The IJB is accountable for the financial governance of this investment. The spend proposal was presented to the IJB at its September 2019 meeting to allow ratification of the ADP proposal and to direct NHS Grampian and Aberdeen City Council accordingly. IJB approved this.

3.13. There are five workstreams under this programme:

- Workstream 1: Whole Family Approach
- Workstream 2: Prevention
- Workstream 3: Service Quality Improvement
- Workstream 4: Supporting Recovery

[2] https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2018/11/rights-respect-recovery/documents/00543437-pdf/00543437-pdf/govscot%3Adocument/00543437.pdf

- Workstream 5: Intelligence-led Delivery

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.

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.

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.

2. There is a risk of financial failure, that demand outstrips budget and IJB cannot deliver on priorities, statutory work, and project an overspend.
9. Failure to deliver transformation at a pace or scale required by the demographic and financial pressures in the system.

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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Aberdeen City Health & Social Care Partnership
A caring partnership

Appendix A

Transformation Programme

Acceleration and Pace Highlight Report

Reporting Period: June 2019 – October 2019

- Organisational Development Transformation Programme
- Alcohol and Drugs Programme
- Digital Transformation Programme
- Primary Care Improvement Plan
- Action 15
- Locality Development Transformation Programme
- Efficient Resources Transformation Programme
- ADP

Highlight Report 8.0

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. The programme has recently been restructured and this report starts to align the progress reporting with this new structure. Further refinement will come in subsequent reports.

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.

Due to the current process of re-aligning the projects and workstreams in line with the new strategic plan, work is still underway to finalise the overall programme expenditure and this information will be provided in this next transformation progress report.

Abbreviations used throughout the report:

ACHSCP:	Aberdeen City Health and Social Care Partnership
EPB:	Executive Programme Board
ODCC:	Organisational Development & Cultural Change

Organisational Development Transformation Programme

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 with the people who make it.

The work is 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 may feel as we integrate at every point of delivery, aligning with our values of caring, person centred and enabling.

2. Key Milestones during reporting period

Key milestones deliverables	**Planned Date**	**Achieved Date**	**Update**	**Comments**
Anticipated milestones from previous Programme Status Report:				
iMatter	June 2019	October 2019	iMatter reports have been completed and action plan discussions should have been completed with teams and uploaded. We had a 68% response rate overall. All managers should now have shared their team's responses with their teams. Currently 13% of staff (18/09) have uploaded. The overarching report will be drafted in the coming period.	Next phase for questionnaire to be sent and completed.
Foundation and Modern apprenticeship increased intake	June 2019	Ongoing	A joint partner project group made up of ACC and NHSG staff has been looking at increasing places and better coordination and communication. This is a cross organisation effort and is an investment of staff time in developing a future workforce. We are gathering a baseline to note increasing numbers over the period of the plan.	Ongoing.
Healthy Working Lives	June 2019	Oct 2019	HWL activities have been significantly increased over this period. This is due to a successful partnership identified and agreed with North-East College to give students 'free clients' by offering beauty and hair treatment/sessions for staff for free. This benefits the students but also increases engagement with health and social care as well as offering 'downtime' for staff in pressured work conditions.	This is new concept and benefits are to be considered.

Training passport outline business case	April 2019	Ongoing	Initial scoping meeting with key senior leads held 5th April. Change ideas and drivers have been developed and delivered. This project has now moved towards test of change phase which identifies a small scope in order to gain agreement from cross-providers to progress.	
Career Ready & Internships (2018-2020 intake)	June 2019	Ongoing	The two students undertook their internship in July and produced a report for the Psychological Therapy Service on patient experience which entailed the evaluation of a large number of patient questionnaires. The report they produced was well received by both the Service and the Service Lead. On returning to Northfield Academy, the Career Ready Interns were visited by John Swinney, Scottish Government Cabinet Secretary for Education, he singled out both ACH&SCP Interns and commended them for the "excellent" report they had produced and was very interested to hear about their experience.	
Senior Leadership OD development – commission of coaching	March 2019	Complete	Coaching support has now been successfully commissioned and some of the leadership team have begun their sessions. This is ongoing.	
Reduced sickness absence at Woodend	April 2019	Ongoing	This project looks to reduce sickness absence at Woodend Hospital. The project group have identified improvement actions such as increase healthy working lives programme to be delivered onsite, staff survey to understand issues and barriers and to increase understanding and use of attendance management policies and support. A baseline of information has also been gathered.	
Engagement Ambassadors Group	May 2019	Complete.	This group has now been set up with volunteers from across the organisation. This looks to increase and improve internal communications.	

3. Change Control

Change	Impact	
	Budget/Resource	Schedule
n/a		

4. Issues and Opportunities *New and Update*

The workforce and OD group have agreed three priority areas for action from the publication of the plan back in March 2019. These are: Improving Health and Wellbeing; Increasing Staff Retention & attraction and development of the young workforce.

ACHSCP has now secured a new partnership with Northfield Academy. This presents many opportunities for both the partnership and the young people at the school. A programme of work has been developed and will be undertaken over the coming months. This includes 121 discussions, work experience and shadowing as well as more informal meet ups at the schools where school children have the opportunity to ask questions and hear more about what working within health and social care is like.

A service level agreement with the Dept. of Work and Pensions (JobCentre plus) has been agreed and will mean increased opportunities of work experience for those presenting with I the DWP into health and social care. There has also been continued leadership involvement and visibility via attendance at career fairs and visits to local schools to raise awareness and encourage young people into the health and social care sector. An issue has been the amount of time required by staff over a short period of time to induct and support those students. This has been identified as an area requiring further understanding and guidance for our staff involved in these 'mentoring/supporting' young people in the workforce.

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:

- ACHSCP Annual Conference to be delivered and evaluated. The theme is connections (Get Involved, Get Inspired, Get Connected is the strapline).
- Career Ready (2019-21) intake with 4 mentors mentoring young people from Northfield academy which ties in with the agreement that was signed with the Academy and partnership in August 2019. This has been facilitated through Developing the Young Workforce.
- Developing of the programme with DWP into increase workforce opportunities for young people.
- iMatter action plans to be finished and organisational report to be reported.
- Phase 2 of colocation of staff to Marischal College.
- Planning for Heart Awards (staff recognition event) will begin.

Alcohol and Drugs Programme

1. Programme Summary and Anticipated Benefits

This investment programme supports a range of action across the Alcohol and Drugs Partnership, the Health and Social Care Partnership and Community Planning Partnership to work together to tackle drug and alcohol related issues. It supports whole system approaches and seeks to include and involve localities, the public, service users and those with lived experience of recovery.

The investment is spread across a range of strategic interventions with allocations approximately distributed as:

- 46% prevention and early intervention,
- 43% treatment and tertiary prevention,
- 4% invested in recovery,
- 4% invested in improving intelligence,
- 3% not allocated to be carried forward.

The five business cases were presented to the AHSCP Executive Programme Board of the 14th August 2019 and subsequently agreed by the IJB at its September meeting.

The values invested don't necessarily represent the "priority level" of an activity –they also reflect the cost of "doing" something. Within the ADP delivery plan and the Community Planning Aberdeen LOIP there are a significant number of improvement projects that intend to use existing resources differently and more effectively, therefore the investment does not represent the totality of activity that the ADP aspires to.

2. Key Milestones during reporting period

Key milestones deliverables	Planned Date	Achieved Date	Update	Comments
Anticipated milestones from previous Programme Status Report: ADP Programme is a new section in this report				
IJB Approval of ADP Workstream Business Cases	Sept 2019	Sept2019	All Business Cases approved	

3. Change Control

Change	Impact	
	Budget/Resource	Schedule
n/a		

4. Issues and Opportunities *New and Update*

None to report at present

5. Major Risks *New and Update*

The ability to recruit clinical staff is seen as a potential risk to delivery. This has been partly offset through investing in an improvement programme to encourage recruitment into the sector. Employment of clinical staff is the preferred option, however, if this is unsuccessful we will revisit other options. The investment will support an overall redesign of services towards longer term sustainable models of delivery.

6. Outlook and Next Period

Anticipated milestones for the coming period include:

- Recruitment to roles identified in business cases
- Development of Project Charters and improvement plans

Digital

1. Programme Summary and Anticipated Benefits

This programme includes the delivery of a range of projects which aim to improve efficiency and quality of service delivery through digital means.

There are clear links between this enabler work stream and service delivery programmes, including the provider of smart devices to support our workforce directly caring for people in our communities; and 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 development	June 2019	Ongoing	Further Development on the ACHSCP Intranet Connect is in progress. Additional content blocks for embedding content to the site and additional document icons have been developed for Word, Excel and Powerpoint. The staff Noticeboard is also progressing after early development issues and its hopeful this will be available in the coming weeks. A request has been submitted for the Intranet to open along with the Zone when ACC Partnership employees access Internet Explorer or Google Chrome.	Further investigation is ongoing on the development required to provide a joint directory for NHS and ACC staff. The additional content blocks have now been deployed and document icons display as per type. A new embed block is now available to allow for SSD block to be embedded.
Business Case developed for replacement for Care First.	March 2019	ongoing	Business case approved by SCC. Carefirst extended to 2023 for purchasing and migration for new solution. Proceeding to tender identifying framework and vendors. Approval of tender and cost model will go to IJB and	After identifying appropriate framework outcome of tender would be expected 1st quarter 2020
Mobile devices	May 2019	Ongoing	Community Nursing are testing a proof of concept for mobile working, utilising lightweight laptops with 3g/4g sim cards.	This is currently delayed due to issues with the rollout of V2 of the software which supports working in an offline manner – Ehealth has direct management of this project.
Digital collaboration	Phase 1: April	ongoing	NHSG has now given a timeline of completion of rollout of O365 . This	This will be ongoing until 2021

with intranet diaries and file sharing etc.	2019		is expected to be completed nationally across Scotland in 2021. Federation with any other public organisation like council will be thereafter.	
Implementation of GovRoam (a public sector wifi solution).	May 2019	ongoing	GovRoam is now available within Council buildings for NHS staff and vice versa at NHS. Technically it does and can work for all staff. However, there are some performance issues with NHS at ACC buildings which are being investigated.	The solution is anticipated to take some time to achieve. Paul Finlayson at NHSG has now provided a trial process to access GovRoam for NHS staff. This is being trialled with School Nurses at Northfield Academy
Clinical Care and Governance complaint process review	March 2019	ongoing	Reviewing the processes for recording complaints and clinical governance across ACC and NHSG and how these can be effectively reported upon.	Delay due to review of scope and investigation into falls data.
Other milestones delivered				
Scottish Government funding award – TEC Pathway Programme	April 2019	ongoing	£195,000 awarded to partnership to further investigate the current recovery pathways for survivors of abuse: • Project manager recruited starts in October 7th • Event in service design with other TEC pathway participants end of September • Data gathering and analysis and research into existing knowledge abuse and exploitation in Grampian and Scotland Meetings with key stakeholders	Project Manager Recruited. Will be hosted within ACVO. Start date 8th October 2019
Health Visitor Digitialisation Options Appraisal	June 2019		Solution identified. . Business case approved. Procurement has taken place. Project Design phase initiated.	Rollout of technology for caseload management and scheduling expected 1st quarter 2020
TEC National Scale Up of BP Home Health Monitoring Programme (Florence)	April 2020	ongoing	Bid for funding has been successful which will see the scale up of the Blood Pressure Home Health Monitoring Project called 'Florence' across the three partnerships in Grampian.	Project is led by Aberdeenshire HSCP. Project delayed to national data sharing agreement unapproved.

3. Change Control

Change	Impact	
	Budget/Resource	**Schedule**
NA		

4. Issues and Opportunities *News and Update*

Following on from the successful 2 week placement of a pupil from Harlaw Academy. The digital team will be hosting a student 1 day a week from North East Scotland College (NESCOL). This placement will start at the beginning of October. James Maitland – Senior Project Manager has started his participation in the Career Ready Mentoring Programme for Young Adults. This is a 2 year programme which includes a 4 week Internship for the young adult within the Partnership.

5. Major Risks *New and Update*

Health Visiting digitalisation project. Risk that the project is unable to recruit a system support analyst within adequate project time scales.

6. Outlook and Next Period

Anticipated milestones for the coming period include:

- Health & Social Care Caseload Management (Carefirst replacement) tender progress.
- Interim device solution for health visitor's Rollout
- Office 365 additional training for Partnership staff
- Office Move – Phase 2 underway/ complete

Primary Care Improvement Plan

1. Programme Summary and Anticipated Benefits

This workstream includes projects, improvements and strategies to support the introduction of the new GP contract and the delivery against commitments set out in the underpinning Memorandum of Understanding (MOU) between Scottish Government and GPs.

The vehicle to support this change is the Primary Care Improvement Plan which seeks to provide additional support to GPs so that their capacity can be released thus enabling them to develop their role from General Practitioner to that of Expert Medical Generalist.

The key areas outlined in the MOU are:

- Vaccinations
- Pharmacotherapy Services
- Community Treatment and Care Services
- Urgent Care
- Additional Professional Roles
- Community Link Practitioners

2. Key milestones during reporting period

Key milestones deliverables	Planned Date	Achieved Date	Update	Comments
Vaccinations	Jan 2020	ongoing	A city programme board is now established with several workstreams considering Need, Supply and Demand.	A paper setting out progress is scheduled to come to IJB in January 2020.
Workflow Optimisation	Dec 2019	Implementation ongoing	After a competitive tendering process, provider has been appointed. Webinars with practices are being offered to encourage quicker uptake and gains. A new audit tool has been developed as a work around to address IT issues with EMIS practices.	Roll-out of system to practices underway through training, support and development workshops.
House of Care (HoC) Cohort 3 of practices completed training Cohort 4 practice recruitment commenced in September.	September 2019	November 2019	House of Care currently being promoted to Gp Practices across the city. It is hoped that 2 practices will take up the opportunity. Recruitment closes in early November.	Having completed their training it is hoped that 2 practices from Cohort 3 will “go live” with House of Care in November 2019 (Whinhill Medical Practice) and February 2020 (Calsayseat).

Community Treatment and Care Services (CTAC) Scoping of CTAC Services commenced.	July 2019	January 2020	CTAC Workshop held with Stakeholders in July 2019. Week of Care (WOC) Audit launched across all Aberdeen GP Practices in September First in a series of workshops with Elective Care colleagues completed to inform the development of Community Hubs to complement CTAC services.	WOC audit data collated by November 2019 and will inform development of CTACs. Approach to working with elective care and identified workstreams agreed by November 2019.
'**Additional Professional Roles'**	March 2019	April 2020	MSK First Contract Practitioner (FCP) trial complete. Modelling process undertaken in August/ September to inform phased approach to roll out service (pending ability to recruit).	Ongoing recruitment to allow next phase of expansion of MSK FCP rol Referral information available in appendix A of this report e across city.
Aberdeen Links Full complement of Link Practitioners recruited and in post resulting in service being able to fully respond all 29 GP Practices in Aberdeen	September 2019	Ongoing	IJB approved funding from the Alcohol and Drug Partnership to recruit an additional 1FTE Link Practitioner which will be based within Kittybrewster custody suite. Link Practitioners will be receiving training to undertake Post Diagnostic Support for Dementia and Alcohol Brief Interventions in Q3.	Referral information available in appendix A of this report.

3. Change Control

Change	Impact	
	Budget/Resource	Schedule
NA	No impact	No impact

4. Issues and Opportunities *New and Update*

The refreshed PCIP plan was agreed by LMC on 19th August and by IJB on 3rd September 2019. Following this a communication has been sent to all GP practices providing an update against each of the workstreams. Development and implementation of a wider communication plan that involves a range of stakeholders, including the public is ongoing.

Workflow optimisation has been on an agreed planned hiatus for the majority of practices over the summer period due to GP workforce pressures. There is now work underway to ensure uptake however this has put back the timelines by 8-9 weeks.

5. Major Risks *New and Update*

There is a risk that full implementation of commitments under Memorandum of Understanding between Scottish Government and GPs will not be deliverable with corresponding resource allocated through the Primary Care Fund.

There is a risk that we will not be able to recruit enough qualified staff to support implementation of commitments under Memorandum of Understanding between Scottish Government and GPs. This risk will be mitigated through ongoing engagement with key stakeholders and the ongoing refinement of implementation proposals to deliver the plans.

There is a risk that we lack infrastructure to enable new ways of working set out within the PCIP (i.e. building space/ICT). This risk will be mitigated by working with partners and key stakeholders to investigate sustainable options to work differently to best achieve the PCIP objectives.

Data sharing continues to be a challenge for Aberdeen Links Service. Work is ongoing with NHSG and ACC to ensure appropriate information sharing and data processing agreements are in place.

Risk of workflow optimisation delivering on scheduled – this is currently delayed at 8-9 weeks. Webinars are being offered to mitigate this risk by the provider.

6. Outlook and Next Period

Anticipated milestones for next reporting period include:

- Expansion of Musculoskeletal (MSK) Physiotherapy First Contact Practitioner Role
- Workforce Optimisation System live across the city
- Priorities for expanding the Links Approach across Aberdeen City identified
- Work to scope CTACs for the Aberdeen city complete
- House of Care cohort 4 practices identified and cohort 3 practices ready to “go live”

Action 15

1. Programme Summary and Anticipated Benefits

Action 15 is part of the Scottish Government's Mental Health Strategy 2017-2027, which maps out a 10-year vision to improve mental health services across Scotland.

Action 15 – one of 40 'actions' in the strategy – aims to grow the mental health workforce across the country so that people can get the right help, at the right time in the right place. Specifically, by increasing the number of mental health workers to give better access to dedicated mental health professionals to Accident & Emergency, all GP practices, the police station custody suite, and to our local prison.

2. Key milestones during reporting period

Key milestones deliverables	Planned Date	Achieved Date	Update	Comments
Anticipated milestones from previous Programme Status Report:				
Community Chaplaincy Listening (CCL) Service	August 2019	August 2019	CCL post has been successfully recruited to. The coordinator will now develop a plan of action to increase volunteer capacity in the city.	This project is linked to the Primary Care Improvement Plan
Primary Wellbeing Psychologists – approval of business case	Sept 2019	Sept 2019	4WTE posts have been agreed by the IJB as a commissioned 3rd sector service. This will be an integrated model which will be collocated with existing Psychological Therapies team. Work is underway on the service specification and tender documentation including a DPIA. The first evaluation workshop supported by Research and Evaluation took place Sept 2019. A second one has been set.	This project is linked to the Primary Care Improvement Plan
Mental Wellbeing Out-Of-Hours Hub– approval of business case	Sept 2019	Sept 2019	Multi-agency and provider collaboration working together to agree a model for an out of hours triage service to support individuals in distress. 3.2WTE posts were approved by the IJB to be a commissioned service. Work is underway on the service specification and tender documentation including a DPIA. A meeting to discuss and agree an evaluation framework has been set for end of October 2019.	

Action 15 national engagement	Ongoing	Ongoing	Ongoing discussions are held with Mental Health colleagues in Scottish Government to continue to understand and develop performance and guidance for this part of the Mental Health strategy. Projections are required on a quarterly basis.	

3. Change Control

Change	Impact	
	Budget/Resource	Schedule
n/a		

4. Issues and Opportunities *New and Update*

With cross agency and community models of working data sharing will potentially be an issue for increasing access to mental health services in key settings, with regards to the sharing of information with individuals. Information Governance colleagues from both partners and project teams are currently mapping pathways and information flows to gain better understanding of this. This will be included in any tender documentation. There are also several overlaps with other projects such as the ADP Custody Link Worker project, which present opportunities and challenges within a complex landscape.

5. Major Risks *New and Update*

- Time slippage to deliver projects due to scoping of several options and then potential tendering for services which can be lengthy and convoluted. Workstreams have been set up to help mitigate against this risk.
- Ability to spend allocation of funds – due to lengthy commissioning process this may take 3-4 months to award a contract. Dedicated capacity has been identified to support this through the process.
- Available skilled workforce to deliver the services

6. Outlook and Next Period

Anticipated milestones for the coming period include:

- To develop evidence-based models and update and finalise business cases for the new ideas of projects.
- To work up service specifications, DPIA and tender documentation
- To consider and agree evaluation implementation.

Locality Development Transformation Programme

1. Programme Summary and Anticipated Benefits

This workstream includes a range of projects, improvements and strategies to support the implementation of integrated locality working.

The benefits of integrated operational working include:

- Improved outcomes for local residents and communities through collaboration, co-location and integration of services
- Improved customer focus through strategic data-sharing and delivery planning.
- Enhanced and purposeful alignment between wider locality plans and smaller area plans.
- Establishment of empowered integrated multi-agency teams to manage demand at a local level
- Development of a cross-system response to complex issues like obesity and population-wide public health priorities.
- Appropriate teams to be based together, guiding what is planned and progressing initiatives by involving a range of staff teams and partner organisations.

2. Key milestones during reporting period

Key milestones deliverables	Planned Date	Achieved Date	Update	Comments
Unscheduled care: Development of operating model and business case covering Unscheduled Care (UC)(incorporating Acute Care at Home and Unscheduled Visiting Service); GP and public engagement session on development of Unscheduled Care approach	April 2019	ongoing	Business Case development underway. Testing ability to integrate UC model articulated in business case within wider primary care system thus enabling spread and scale-up through MDTs.	Business Case to be presented at August IJB. Work is progressing slower than anticipated due to emerging complexities. Tests of Change progressing on issues that have been surfaced which enable the development of processes, protocols and procedures to support more rapid roll-out city-wide.

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	Mapping event in planning looking at entire available transport fleet
Care about Physical Activity (CAPA) (Programme managed and delivered in partnership with the Care Inspectorate)	March 2019	May 2020	19 Care Home across Aberdeen signed up to participate in CAPA, either as "Evaluation & Impact partners" (data gathers to inform research) or Cascade partners deliver activity based on the learning Change ideas being implemented across participating care homes and data collection commenced. Additional CAPA Engagement Event took place on 2nd July with care homes and care at home providers to share best practice	Data collection ongoing to support evidence base and inform best practice approaches for care homes in Aberdeen City longer term Leads within ACHSCP and Scottish Care continue to work closely with the Care Inspectorate to take this work forward
Scotland's Service Directory (SSD)	December 2018	October 2019	Work progressing to capture city information live on digital platform ongoing. Currently there are 120 Services live on the SSD with 182 Aberdeen based services live on ALISS. Further work ongoing to ensure city information is added and maintained.	Project live date moved to October 2019 due to national delay in the integration between ALISS (A Local Information System for Scotland) and SSD information.
Agreement to move to 3 Localities	March 2019	March 2019	Approved by IJB March 2019. Localities Position Statement in Place	Further work ongoing to plan next steps. IJB Development session on localities planned for October 2019.

3. Change Control

Change	Impact

	Budget/Resource	Schedule
N/A	-	-

4. Issues and Opportunities *New and Update*

None to report at current time.

5. Major Risks *New and Update*

None to report at current time.

6. Outlook and Next Period

Anticipated milestones for next reporting period include:

- Testing of a Single Point of Contact / Access in city for Unscheduled Care referrals
- Workforce modelling for establishing MDTs
- Scotland's Service Directory 'live' in Aberdeen City
- Care about Physical Activity changes ideas and data collation complete
- Localities planning at advanced stage aligned to roll-out of Stepped Care Approach.

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

Sharing the Learning Event	29 Aug 19	29 Aug 19	The ' sharing the learning event took place on 29th August and was an event to recognise and celebrate success. Each of the projects presented results and progress. There was discussion and reflection on the learning from the projects and next steps. Feedback has been very positive. Currently evaluating project staff views on the experience.	A 'pipeline' of next projects are being identified via an intranet form and a couple are just getting off the ground.
Improvement and Transformation Network	June 19	Ongoing	The partnership is looking to increase its capacity in improvement methodology in the widest sense by using previously trained staff in these types of methodologies. A communication has gone out asking if people would like the opportunity to be involved and to highlight areas of expertise and knowledge. 45 responses have been made so far to date.	
Communication for Lean Six Sigma – Vlogs	October 2019	October 2019	Video feedback from each of the projects have been made and will be shown on the Intranet and at the conference to encourage participation, share successes and the learning so far.	
Learning Disability Transport	June 2019	ongoing	Initial investigation found lack of process or information around which (if any) clients were in receipt of double funding. Process improvements around accessing this information as part of assessment and transport planning identified and in development	Introduction of Contributing to your Care Policy, Financial Assessment processes are key dependencies.
Prepaid card	April 2019	ongoing	Pre-paid Financial Card service provider currently being procured – procurement process currently live.	Expiry of Surrey Framework in February extended timeline for procurement vis alternative framework.

Social Work Financial Assessments	May 2019	ongoing	The new financial form is now implemented and both guidance and form has had good feedback. There have been some initial teething issues eg. old forms still in circulation however this is being addressed. There has been timely improvement anecdotally, but this is still being currently measured. A business case is being developed to look at addressing the backlog of assessments required.	
Sexual Health Services	May 2019	ongoing	Project to focus on delays/ barriers to people accessing Sexual Health Services. Initial meetings held in Feb 2019. Workshop to kick-off project planned for October 2019.	Capacity within the Sexual Health Team has meant this project was put on hold until October 2019 (revised commencement date).
School Immunisation Programme	May 2019	December 2019	Base line data has been collated and change ideas identified. Change idea are in the process of being implemented, e.g. automated class lists, training on functionality of SEEMIS and access to SEEMIS all releasing immunisation team capacity, by reducing administrative tasks associated with immunisation prep work	Data will be collated to demonstrate the impact of change ideas. It is anticipated that the project will be concluded by December 2019.
Nursing – increasing patient facing time	May 2019	ongoing	Project has included working with nursing teams to identify processes, wastage, improvements. Improvements are now in process of being implemented and revised measurements will then be taken.	

3. Change Control

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

4. Issues and Opportunities *New and Update*

No new issues or opportunities during current reporting period.

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:

- To undertake staff evaluation of round 1 projects.
- To utilise ACHSCP conference to communicate and share learning.
- Next round of projects identified, and initial work to be commenced.
- Steering group to agree phase 2 of programme and communication plan.

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 ***Draft Final***

Distribution

This document has been distributed as follows

Name	Responsibility	Date of issue	Version
To be completed			

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 B

Aberdeen Links Service

Evaluation Report

July 2019

Katherine Karacaoglu

Public Health Researcher

Aberdeen City Health & Social Care Partnership | NHS Grampian

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Transformation Programme Manager (Research & Evaluation Lead)

Aberdeen City Health & Social Care Partnership | NHS Grampian

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Executive summary

Introduction

Epidemiological and financial challenges are placing unsustainable demand on health and social care services. It is well recognised that alternate models of care delivery should be sought, with one approach emphasising the targeting of upstream activity, such as prevention and self-management of health and wellbeing. Social prescribing, characterised by linking individuals to non-medical forms of support within a community setting, is one such approach which may facilitate reducing pressure on primary care.

The aim of this evaluation is to understand the implementation and impact of a social prescribing service in Aberdeen City.

Methods

The Aberdeen Links Service became operational in September 2018. The team consisted of nine Primary Care Link Practitioners (LPs, 5 x LPs located across the city based on perceived need, 4 x Senior LPs who line managed LPs and each based in one of the four localities). LPs were aligned to 18 General Practices across Aberdeen City. Service inclusion criteria was those requiring support for any of the nine social determinants of health.

The evaluation framework was co-created with the project team. Patient data collected at baseline and six months included: self-reported quality of life, happiness and loneliness. Additional patient data included: number of GP (General Practitioner) contacts, number of significant others and three patient case studies. Service level data collected included: referrals by practice / month, referral reason and number of LP contacts. Staff level data from LPs included: goal setting at baseline and six months, job satisfaction and in-depth interviews were carried out which explored barriers and facilitators to implementation (analysed thematically). Additional General Practice staff data collected at baseline and six month follow-up included: knowledge and awareness of the LP role, perceived value and openness to the links approach and knowledge and understanding of local community assets and signposting.

Results

Service Perspective: Results described are inclusive of the first six months of service operation (10/09/19 – 10/03/19). There were a total of 694 referrals to the service, most of which were received from a GP (82.4%). The most common reasons for referral to the service included mental health (24.8%), social isolation (17%) and benefits (8.8 %).

Patient perspective: Mean quality of life (p=.009, N=37), happiness (p=.02, N=37) and loneliness (p=.001, N=36) scores all significantly improved from baseline to six month follow-up. There was a trend towards a reduction in mean number of GP contacts (self-reported by patient) from baseline (mean = 1.7, SD=1.1) at follow-up (mean = 1.2, SD=0.9), p=.1.

Staff perspective: Staff interviews and questionnaire responses (N=9) identified high LP job satisfaction (average score 83%) and strong communication within the LP team (average score 96%). Positive team dynamic was facilitated by the intensive induction period, project enthusiasm and caring personalities, whilst maintained through extensive communication channels. Staff highlighted unmanageable workloads at times and utilised their extensive within team relationships as a support mechanism to cope with challenging patients. LP patient support style varied, with those more confident and knowledgeable within a subject area, more likely to attempt to solve more problems themselves rather than refer onwards. Staff described that flexibility to vary care provision, in the presence of clear boundaries, may have facilitated improvements in patient outcomes. Co-location, having a presence in practice and providing feedback on improved patient outcomes appeared to facilitate development of within practice relationships and links approach adoption. Third sector relationships appeared positive, however less developed (e.g. mainly email correspondence), which appeared to be due to a lack of LP capacity to develop relationships due to large caseloads.

General Practice staff questionnaire responses at baseline (N=114) and follow-up (N=85) demonstrated that GP Practice staff awareness of the LP role remained consistently high (92% baseline, 94% follow-up). Knowledge of the LP role (19% increase) and perceived value of link working (13% increase) both increased from baseline to six months, however confidence in signposting (44% baseline and follow-up), openness to the links approach (85% baseline, 83% follow-up) and confidence in knowledge of community assets (43% baseline, 48% follow-up) remained relatively constant.

Conclusions

The Aberdeen Links Service is acceptable to those delivering the service and may reduce pressure on primary care. The presence of an extensive within team support system and manageable workload is necessary to ensure LP wellbeing. Practitioner support style varied depending on expertise, and considering the breadth of knowledge LPs are required to have, developing specialised team members may create efficiencies. When co-location is not available within GP practices, additional efforts are necessary to build General Practice staff increase links approach adoption. Tailoring the service function to geographical needs may be a useful strategy in facilitating adoption of the links approach within General Practice. The provision of adequate time to engage with third sector organisations may strengthen relationships.

Key points

- Significant improvements in patient outcomes (improved quality of life, improved happiness and reduced loneliness) have been demonstrated.
- The Aberdeen Links Service is highly acceptable to those delivering the service due to strong, trusting relationships, a shared enthusiasm for the project and support systems developed within the LP team.
- The presence of a manageable workload (e.g. strategies in place to support workload management) and extensive support system appears to be necessary for practitioner wellbeing and staff retention.
- The Aberdeen Links Service appears to contribute to reducing the number of GP contacts, therefore has the potential alleviating pressure on primary care.
- Specialisation of practitioners may be a useful strategy to create efficiencies within the team.
- Factors that appear to facilitate development of General Practice staff relationships and adoption of the links approach are co-location, having a presence in practices and providing positive patient feedback to General Practice staff.
- A tailored approach to promoting service function may be a useful strategy in increasing practice engagement.
- Workload volume limits capacity to build relationships with community organisations, and dedicated time to develop these may strengthen relationships.
- Social prescribing requires abundant community assets, and gaps should be identified in order to promote funding or develop innovative solutions to address these.
- Bespoke IT systems leads to higher quality data and more robust findings.

1. Introduction

The increasing epidemiological and financial challenges placed on health and social care services are well documented. Based on current care delivery, hospital activity will have to increase by a projected 40% over the next 15 years to account for a growing and ageing population[1]. These pressures will be augmented in General Practice, where 90% of all patient contacts are conducted[2], exacerbated by increasing vacancies in General Practitioners (GPs), with almost one quarter of Practices not being fully recruited to[3]. To improve wellbeing at a population level, an alternate approach to delivering care is championed, that may be achieved through increased upstream activity towards targeting prevention and self-management of health and wellbeing[4].

One advocated approach towards achieving the required shift in care delivery is social prescribing. Despite varying definitions, social prescribing is typically characterised by linking individuals to non-medical sources of support, usually within a community setting[5]. Given the pre-established associations that exist between non-medical issues (such as social isolation) and frequency of General Practice attendance[6], such an approach would appear to be a logical strategy to reducing pressure on Primary Care. However, notwithstanding the increasing implementation of social prescribing, there is currently limited evidence demonstrating its effectiveness and impact[7]. Therefore, further work needs to be done to rigorously evaluate the implementation of such initiatives to determine what effect, if any, they have.

The purpose of this evaluation is to understand the implementation and impact of a social prescribing service in primary care.

[1] Charlesworth et al. (2018). Securing the future: funding health and social care to the 2030s. London: Institute for Fiscal Studies
[2] Scottish Government. (2018). The 2018 general medical services contact in Scotland. Edinburgh: Scottish Government
[3] Audit Scotland (2018). NHS in Scotland 2018. Edinburgh: Audit Scotland.
[4] Audit Scotland (2018). NHS in Scotland 2018. Edinburgh: Audit Scotland.
[5] ALLIANCE. The role of signposting and social prescribing in improving health and wellbeing. Available at: https://www.alliance-scotland.org.uk/wp-content/uploads/2017/10/ALLIANCE-Developing-a-Culture-of-Health.pdf [accessed 13/05/2019]
[6] Cruwys et al. (2018). Social isolation predicts frequent attendance in primary care. *Ann Behav Med*, 52(10), 817-829.
[7] Bickerdike et al (2017). Social prescribing: less rhetoric and more reality. A systematic review of the evidence. *BMJ Open*; 7:e013384.

2. Methods

2.1 Service design

The Aberdeen Links Service (ALS) went live in September 2018. This evaluation describes the implementation and impact of the first six months of delivery. This service was part of Aberdeen City Health & Social Care Partnership's (ACHSCP) programme of activity to integrate health and social care. Funding for the service was obtained through the ACHSCP Integration Joint Board.

As part of the first phase of implementation, nine Link Practitioners (LPs, 5 x Link Practitioners, 4 x Senior Link Practitioners who line managed the LPs) were aligned to 18 General Practices across Aberdeen City. Senior LPs were located in each of the four localities whilst LPs were located based on perceived need within the city. LPs received referrals via General Practice staff. The service did not utilise strict referral criteria, however eligibility were characterised by needs non-medical in nature and aligned to the nine social determinants of health: abuse; addictions; bereavement; anxiety & depression; benefits & finances; housing & homelessness; weight management & physical activity; relationships; social isolation[8]. LPs would work with individuals to identify person-centred priorities to address and subsequent refer / signpost that individual to appropriate community-based services as required. Prior to this service becoming operational, there was no standardised approach in primary care for individuals requiring this type of support.

[8] The Health and Social Care Alliance (2016). Social Determinants in Primary Care, Scottish Government, Glasgow. [Available at: https://www.alliance-scotland.org.uk/wp-content/uploads/2017/11/Social-Determinants-in-Primary-Care-Module-Final.pdf]

2.2 Data collection and analysis

2.2.1 Evaluation framework development

The same co-creation methodology utilised for other large-scale pilots locally (for more detailed information, see [9] and [10]), was implemented here, underpinned by co-creation principles described elsewhere [11]. Co-creation workshops were held with a variety of stakeholders (including but not limited to: LPs, General Practitioners, Public Health Researchers and Third Sector Partners) to achieve a collective perspective on locally-relevant metrics to assess and strategies to collate this information. The findings detailed in this report stem from a consensus across co-creators regarding the metrics of interest at a local level.

2.2.2 Service-level data

A variety of service-level data were collected, including: referrals per practice / per month; primary referral reasons; onward referral categories and number of LP contacts. Data regarding the number of unpaid carers that were supported through the service were also collected. To ensure the service was not increasing health inequalities, demographic information regarding employment status, SIMD and ethnicity were also collated. These were stored on a bespoke-designed section of SAMH.net (hosted on SAHMH servers), which has enabled caseload management.

A logic model was also co-created to describe how the model would theoretically work in the local context (Figure 1).

[9] Leask, C. 2018. Integrated Neighbourhood Care Aberdeen (INCA) Test of Change – Evaluation Report. Available at: https://committees.aberdeencity.gov.uk/documents/s93533/3.2%20Appendix%20B%20-%20INCA%20Evaluation%20Report%20Final.pdf?txtonly=1

[10] Karacaoglu, K., & Leask, C. 2019. Acute Care @ Home (AC@H) Test of Change – Evaluation Report. [Under consultation]

[11] Leask, CF. et al. 2019. Framework, principles and recommendations for utilising participatory methodologies in the co-creation and evaluation of public health interventions. *RIAE*, 5:2.

2.2.3 Patient measures

Whilst in this non-medical model, individuals whom LPs worked with were not defined as "patients", within this report the term "patient" is used to provide a clear distinction between the variety of stakeholders who were either involved in the delivery or receipt of this service.

Outcomes collected included self-reported quality of life; happiness and loneliness (Appendix A). Patients also reported on: 1) the number of GP contacts in the previous four weeks; and 2) the number of contacts with significant others, both paid and unpaid, in the previous four weeks. This data was collected at baseline (i.e. the first appointment with a LP) and at six-month follow-up to assess any potential changes in outcomes. Case studies were also collected to describe the patient journey for a variety of different referral reasons to portray the diversity of the LP role.

2.2.4 Staff measures

2.2.4.1 Link Practitioner measures

LPs completed a goal-setting session for personal and professional goal development four weeks into their role (Appendix B). These were then reviewed six months post-implementation to ascertain whether the role was delivering on the person-centred aspirations of each LP (Appendix C).

LP satisfaction was measured at six months. Components were assessed using Likert scales and included: communication with General Practice staff; perceived training and development opportunities; and workload (Appendix D).

In-depth interviews were conducted with all LPs to understand barriers and facilitators to implementing the service (topic guide, Appendix E). Interviews lasted no more than 60 minutes

and were open ended. These were audio recorded, transcribed and analysed thematically, a process congruent with the large-scale evaluations conducted previously[12], [13].

2.2.4.2 General Practice staff measures

Outcomes assessed included understanding of local community assets and confidence in social prescribing. These were assessed at baseline and six months and administered using an online survey. Further constructs assessed were perceived value and openness of adopting a links approach within their practice.

As this was a service evaluation, ethical approval was not required.

[12] Leask, C. 2018. Integrated Neighbourhood Care Aberdeen (INCA) Test of Change – Evaluation Report. Available at: https://committees.aberdeencity.gov.uk/documents/s93533/3.2%20Appendix%20B%20-%20INCA%20Evaluation%20Report%20Final.pdf?txtonly=1

[13] Karacaoglu, K., & Leask, C. 2019. Acute Care @ Home (AC@H) Test of Change – Evaluation Report. [Under consultation]

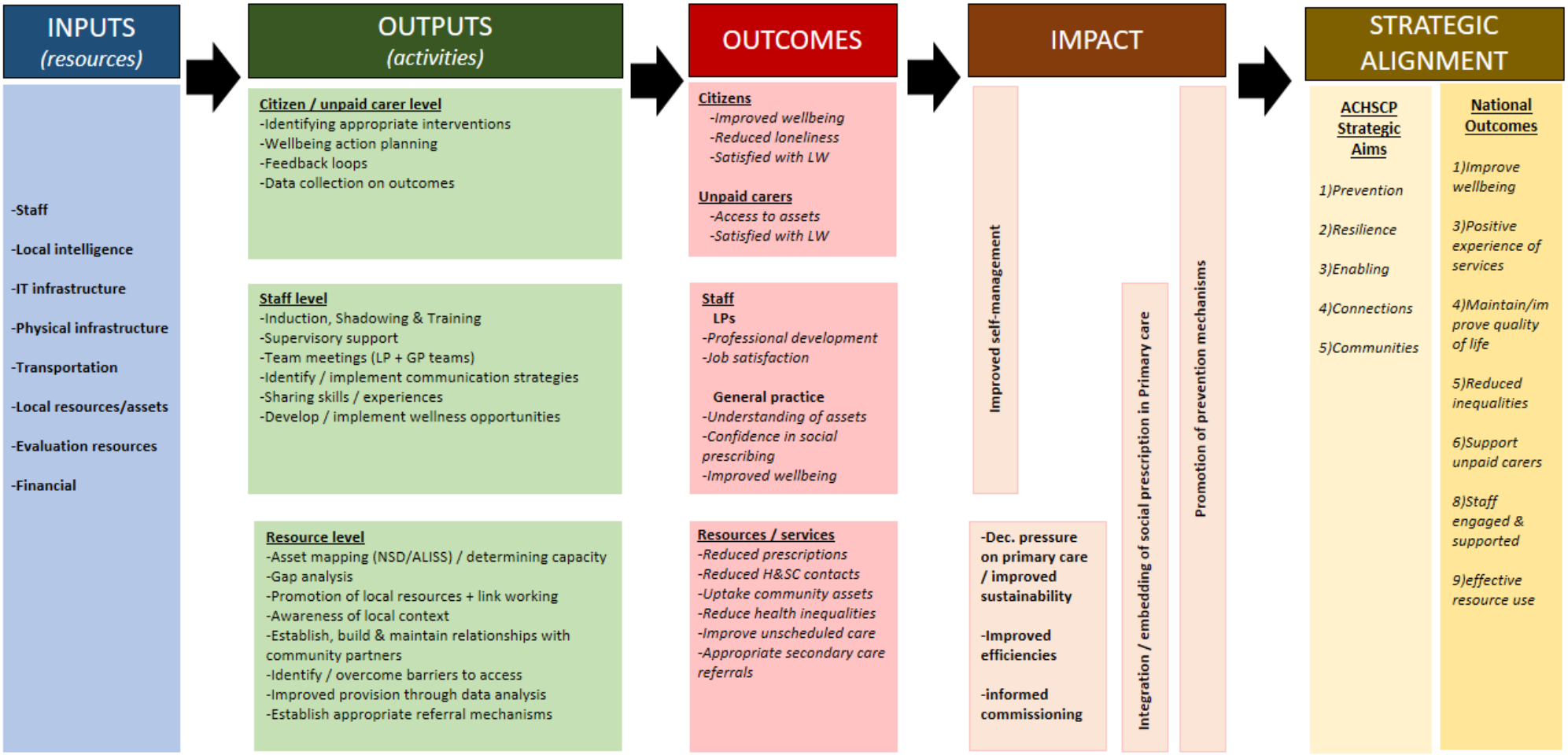

Figure 1.Aberdeen Links Service logic model

3. Results

3.1 Service overview

3.1.1 Caseload characteristics

To provide consistency, the results described were collected for the first six months of service operation (10/09/2018 - 10/03/19) unless otherwise stated. Table 1 displays characteristics of the LP caseload. There were more females than males entering the service, and spanning all adult age groups (16 – 98 years). There was a roughly even split of those entering the service from the most affluent (SIMD 4 & 5, 39.5%) and most deprived areas (SIMD 1 & 2, 38.4%), suggesting that the service does not increase health inequalities. The small proportion (6.1%) of missing SIMD postcode data was a consequence of the conversation algorithm unable to recognise newly built properties. When calculating 'caseload days', blank entries were assumed as still on the caseload.

Table 1. Characteristics of Link Practitioner caseload

Characteristic	Total
Caseload, N	694
Gender, N (%)	
Male	277 (39.9)
Female	415 (59.8)
Transgender	2 (0.3)
Age, mean (range)	54.4 (16-98)
SIMD Scores N (%)	
1	81 (11.7)
2	185 (26.7)
3	112 (16.1)
4	134 (19.3)
5	140 (20.2)
Not reported/N/A	42 (6.1)
Caseload days, mean (range)	75.08 (1-220)

Missing data was apparent for some LP caseload characteristics and are referred to in the graphs below as “not reported”. Practitioners often felt that the first meeting was not an appropriate time to ask for this information and that it would be more appropriate to collect at follow up. However, as our results only include a small cohort of patients at follow-up, results may appear skewed.

Employment status and those who reported disabilities in the LP caseload are displayed in Figure 2 & 3 respectively.

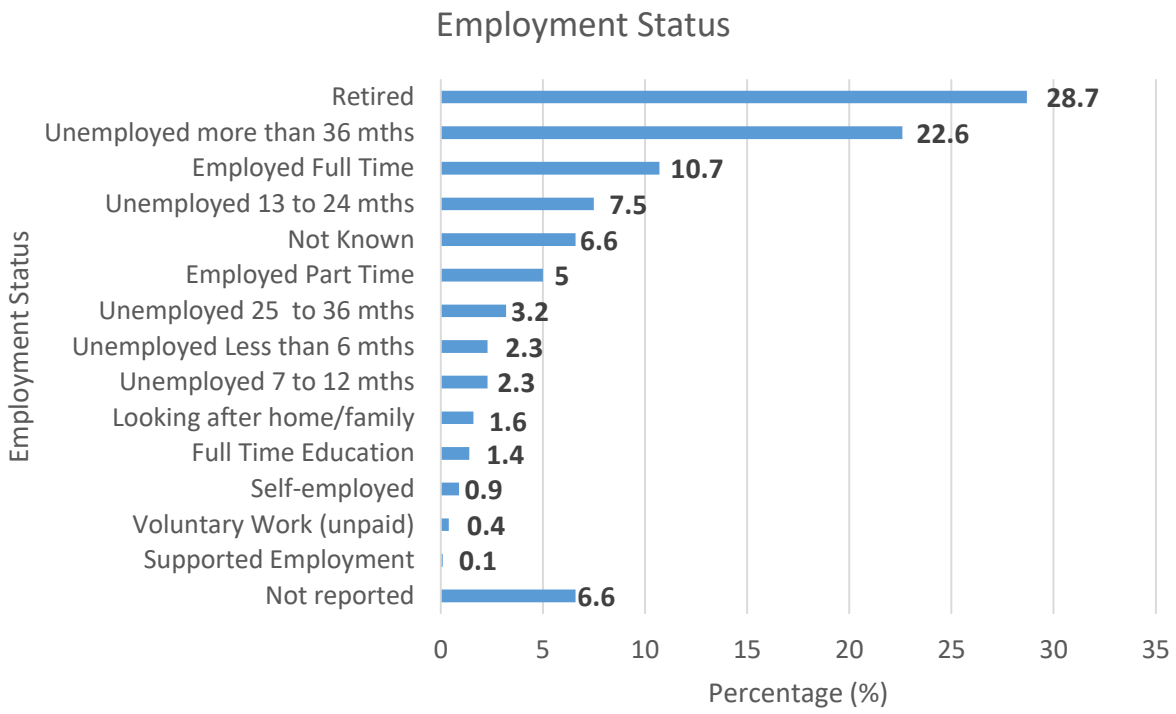

Figure 2. Reported employment status of the Link Practitioner caseload (N=694)

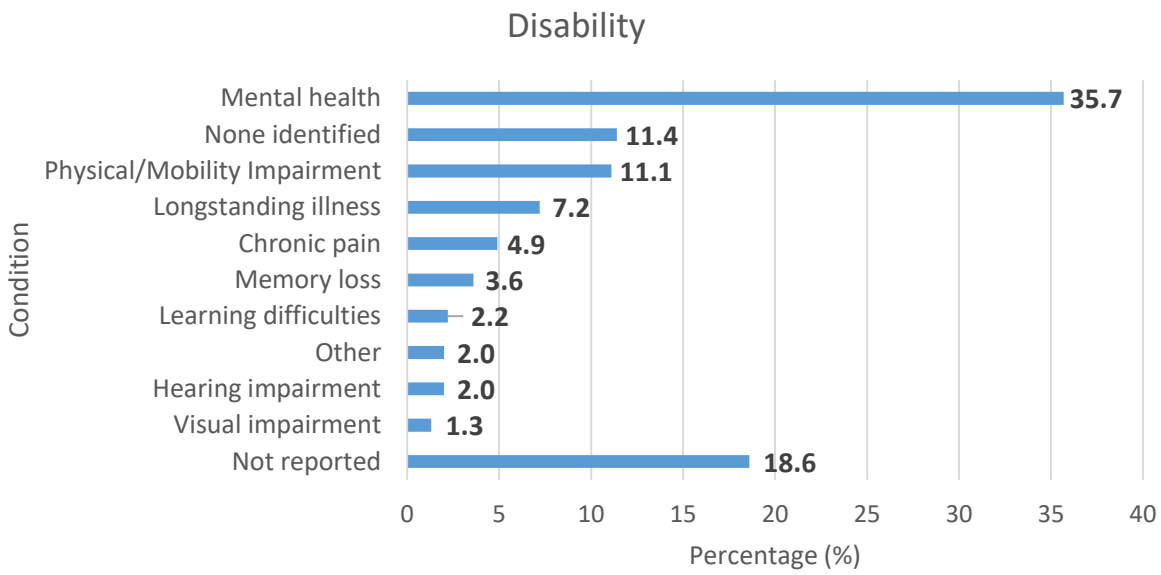

Figure 3. Reported disabilities in the Link Practitioner caseload (N=694)

Figure 4 displays the proportion of the LP caseload that identified as an unpaid carer. The proportion of the LP caseload who identified as receiving support from an unpaid carer is displayed in Figure 5.

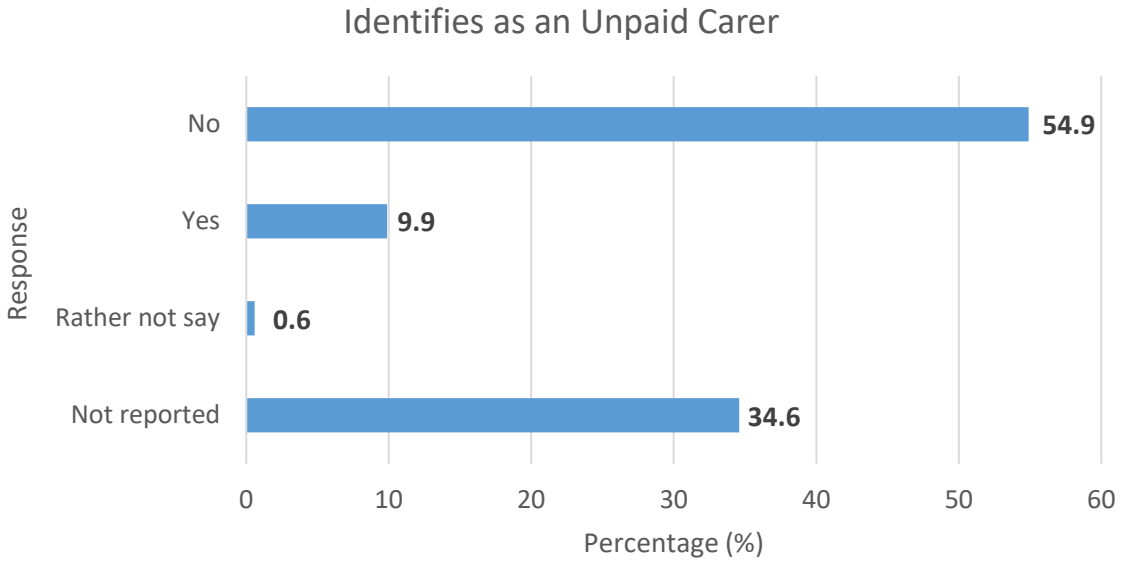

Figure 4. Percentage of the Link Practitioner caseload that identify as an unpaid carer (N=694)

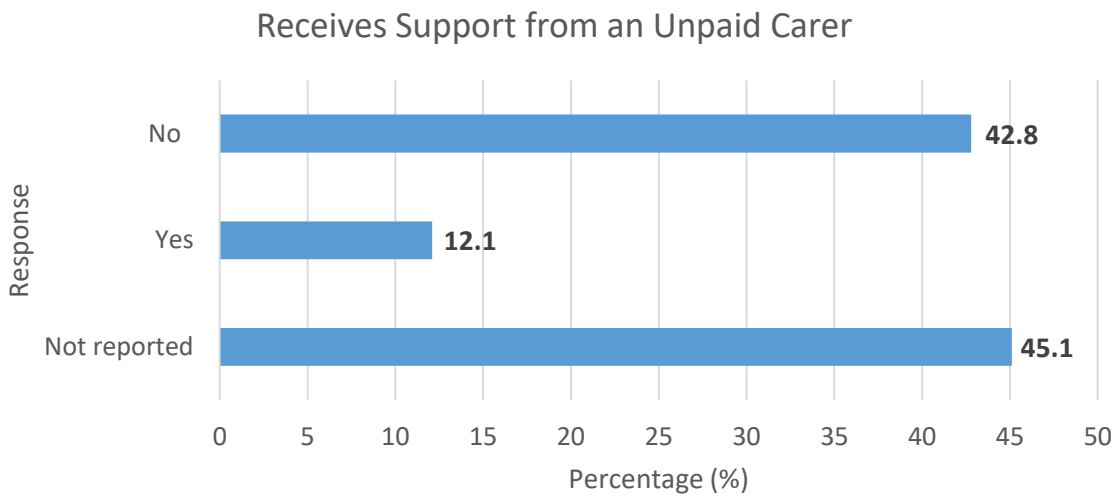

Figure 5. Link Practitioner caseload that receives support from an unpaid carer (N=694)

3.1.2 Referrals

Figure 6 reports the number of referrals the service received. Data is inclusive of 10/09/18 – 31/03/19 to display a full month of data for March 2019, however half a month of data is presented for September as the service became operational on 10/09/18. On average the service received 109 referrals per month, approximately 12 referrals per LP per month.

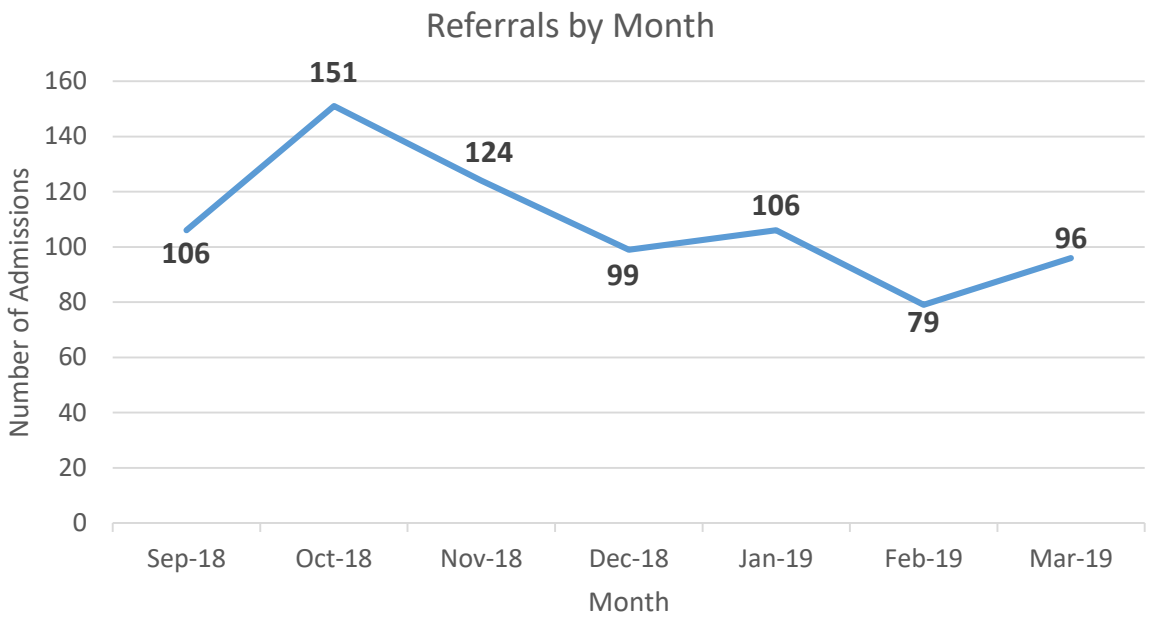

Figure 6. Referral rates to the Link Practitioner service (N=761)

Primary referral reason is shown in Figure 7. The priority referral reason agreed between the LP and the patient, where reported, is displayed in Figure 8. There was a large proportion not reported (67.7%) and these were excluded from the graph.

The majority of patients were referred from their GP (82.4%). Other most frequently reported referral sources included: Health Visitor (5.6%) and Advanced Nurse Practitioner (4.9%). Within the first month of service operation, only GPs could refer into the service whilst the systems were tested, which may have skewed results.

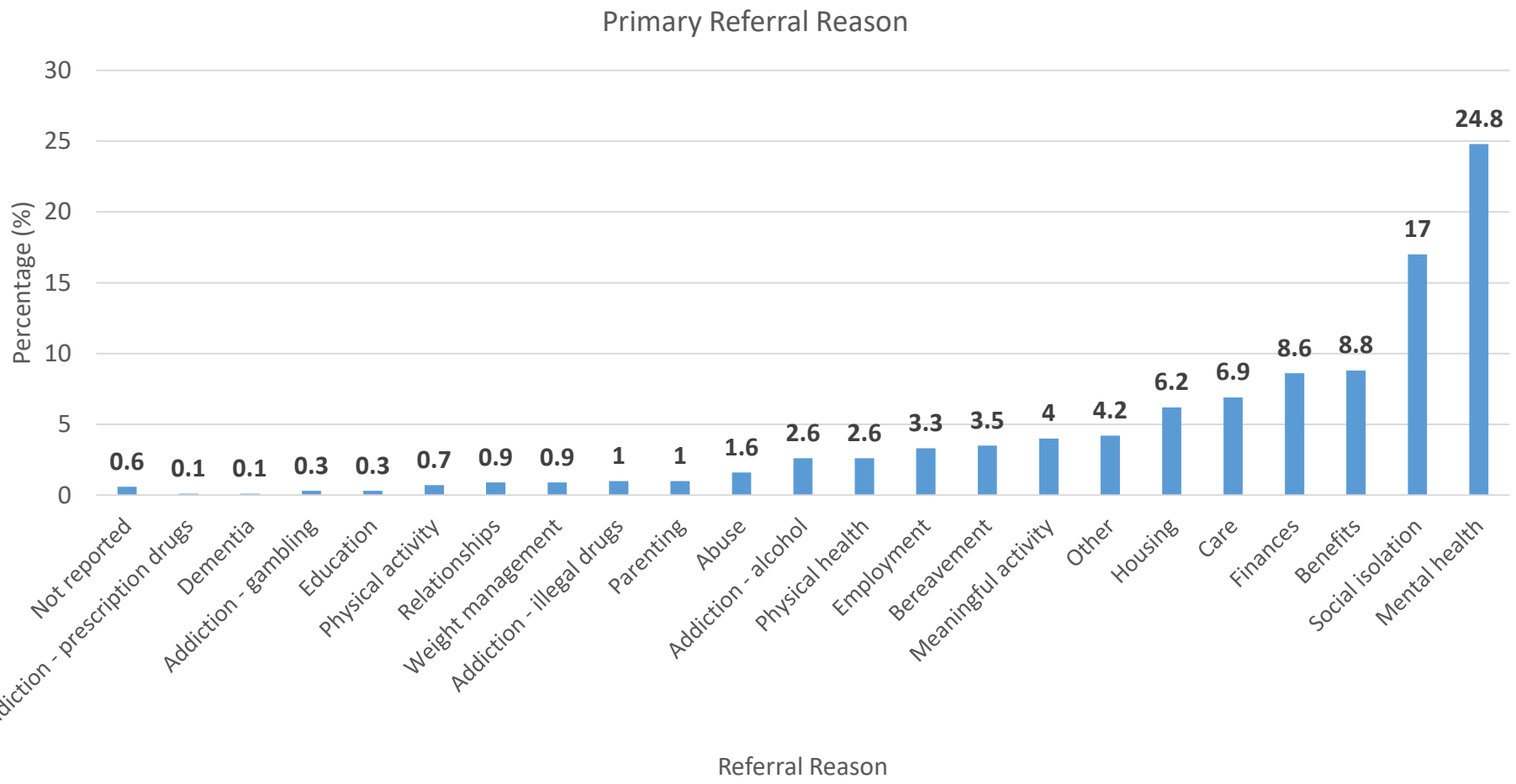

Figure 7. Primary reason for referral to the Link Practitioner service (N=694)

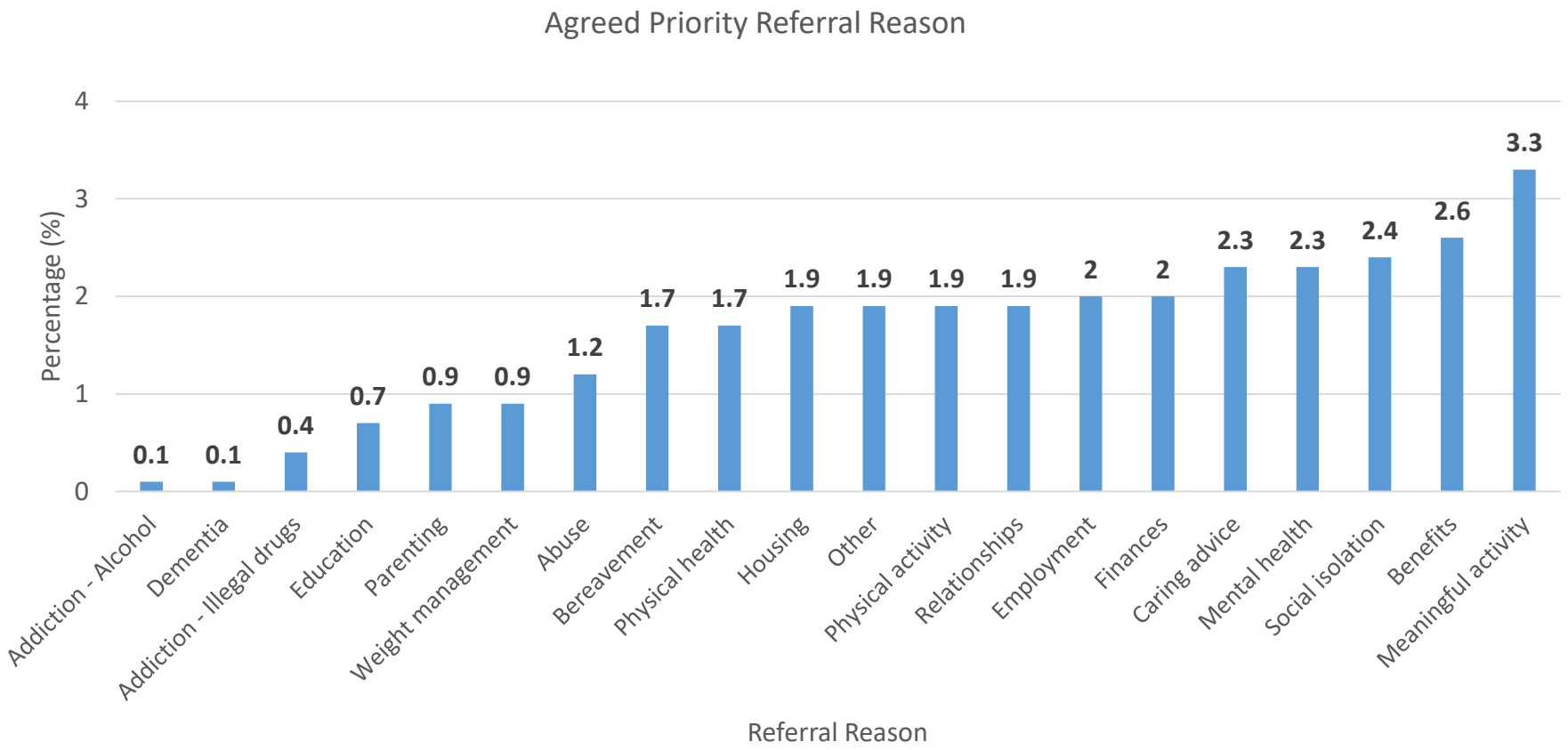

Figure 8. Priority referral reason agreed between the Link Practitioner and the patient (N=224)

The number of referrals received to the ALS by GP practice and referrals received per 1000 of the GP practice population are displayed in Figure 9 and 10 respectively. In Figure 10, not reported data (n=3) was excluded from the graph. Nineteen General Practices are displayed in these results despite LPs only being assigned to one of 18 practices. Rosemount medical practice was not allocated a LP as part of the initial roll-out of the programme. However, a LP provided support to a number of vulnerable patients when transferring to a new medical practice.

Figure 11 displays the categories of onward referrals made by LPs (N=734) and includes data up to 18/03/19.

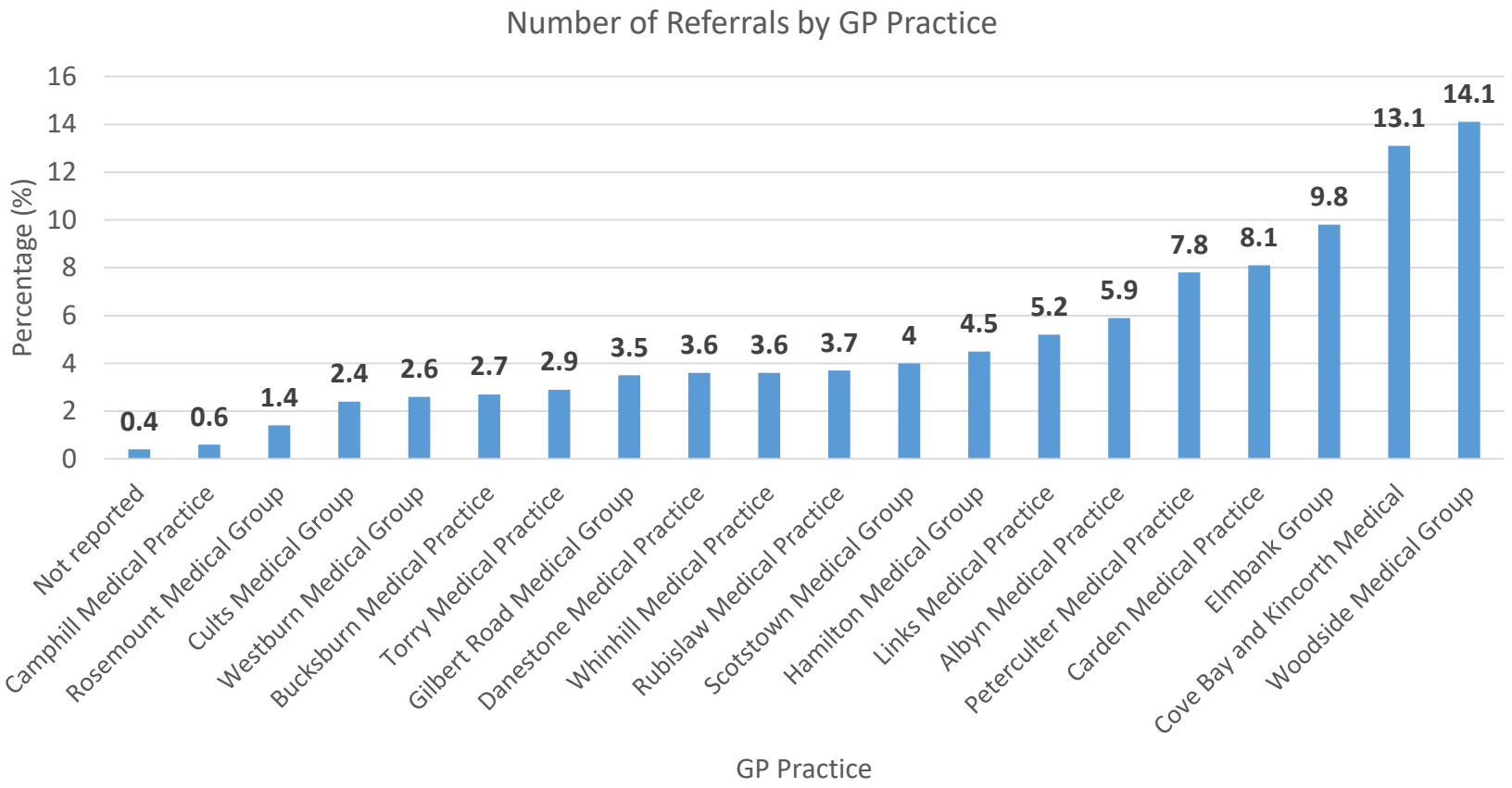

Figure 9. Referrals by GP practice (N=694)

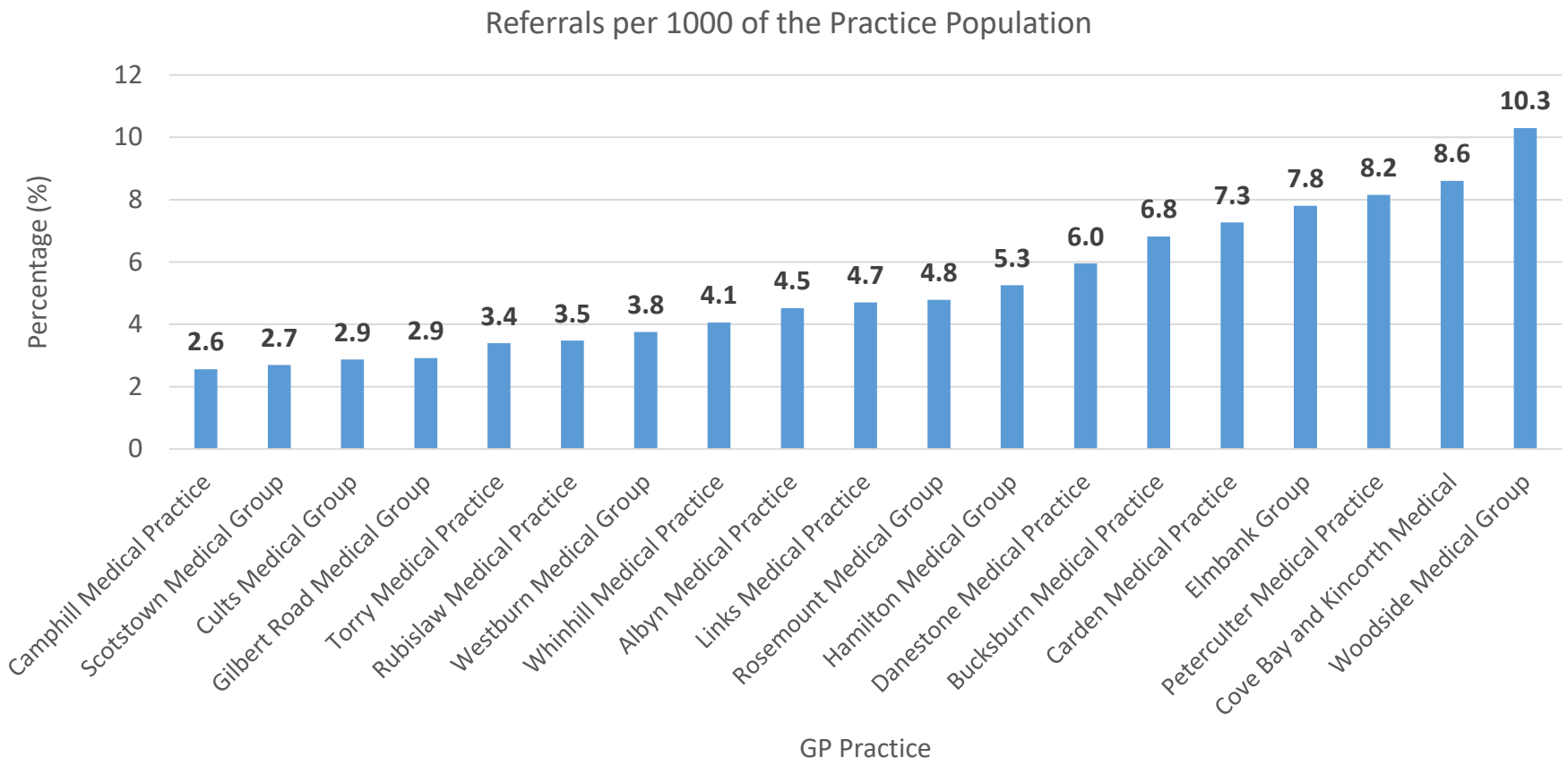

Figure 10. Referrals per 1000 of the Practice Population (N=691)

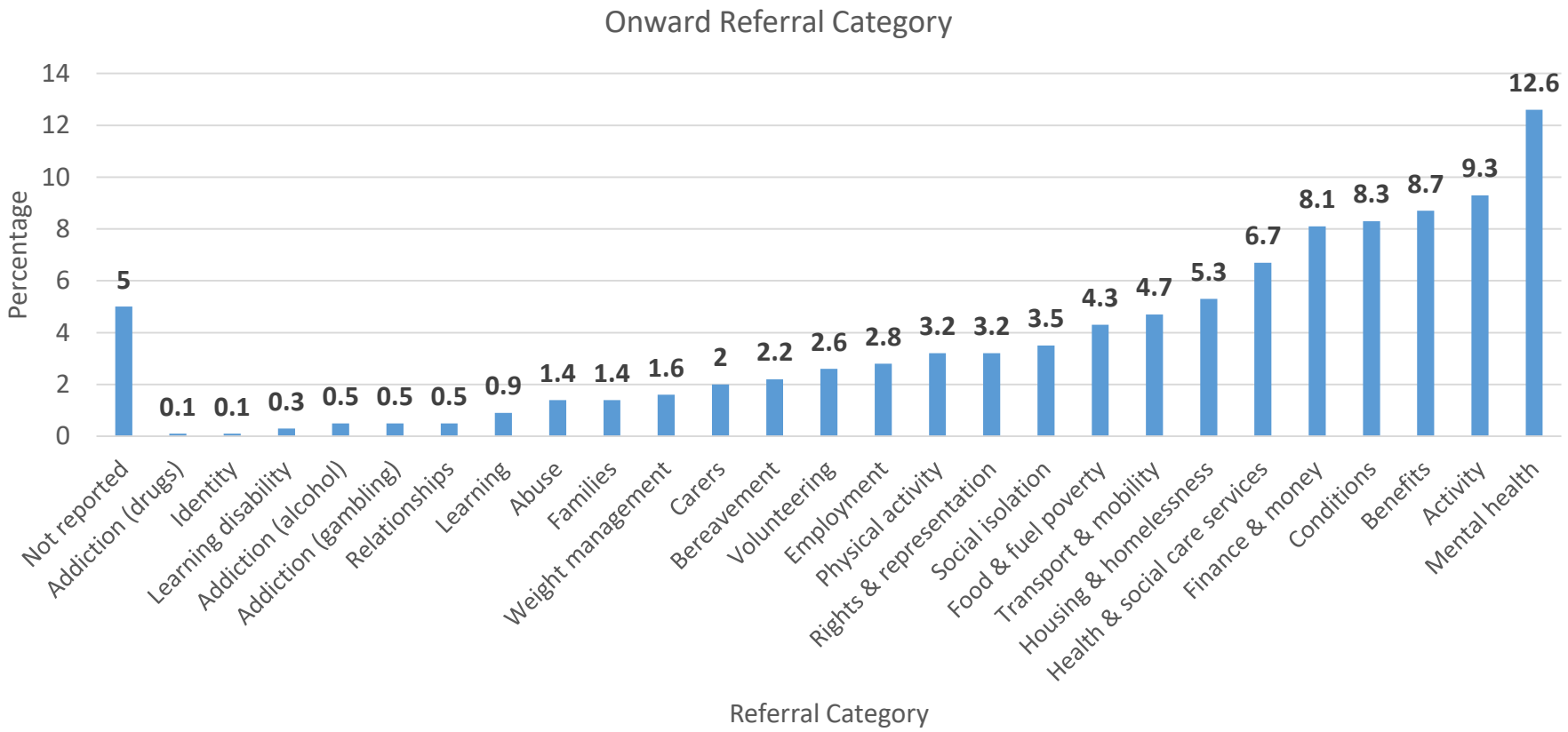

Figure 11. Categories of onward referrals made by Link Practitioners (N=734)

Figure 12 displays the number of LP organised contacts (face to face). Out of all appointments made with the LP service, 12.3% were not attended, a score higher than the average for General Medicine (most recent statistics 2002-12, Females 7%, Males 6%)[14]. There was an average of 619 total contacts per month, with each LP carrying out an average of 69 contacts per month. As described previously, each LP received approximately 12 referrals per month, therefore each referral required approximately six face to face contacts.

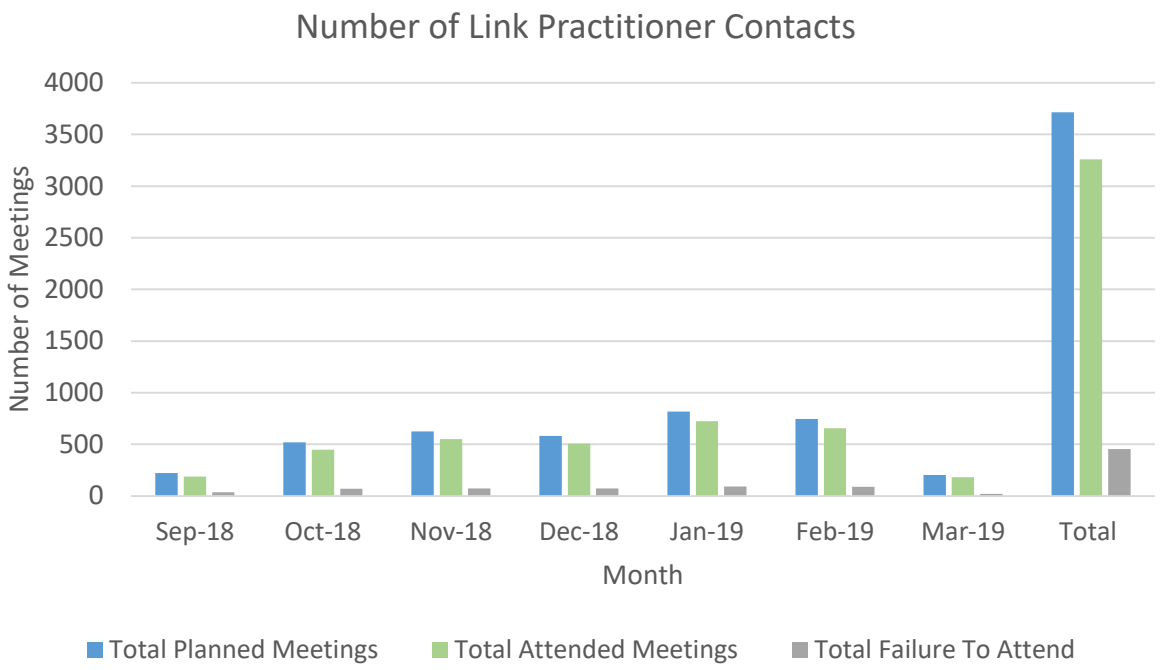

Figure 12. Number of Link Practitioner face to face contacts (N=3917)

3.2 Patient Outcomes

Patient outcomes for quality of life, happiness and loneliness are described below. Data collected for each of these outcomes did not meet normality assumptions (e.g. the data was not normally distributed), however for illustrative purposes, parametric tests were conducted

[14] Campbell, K., Millard, A., McCartney, G. and McCullough, S. (2015). Who is least likely to attend? An analysis of outpatient appointment 'Did not Attend' (DNA) data in Scotland, NHS Health Scotland, Edinburgh, Available at: [https://www.scotpho.org.uk/media/1164/scotpho150319-dna-analysis-in-scotland.pdf].

(and non-parametric results are also reported for reference). As follow-up data was collected at six months, and data collection was assigned a one month period, outcomes data is inclusive of 10/09/18 – 10/04/19.

3.2.1 Quality of life

Figure 13 displays mean self-reported quality of life scores (N=37). A paired t-test showed that mean quality of life scores significantly improved from baseline (*M*=2.3, SD=1.1) to six month follow-up (*M*=2.9, SD=1.3), t(26) = -2.8, p=.009 (95% CI of the difference -1.1 to -.2). This was also significant using non-parametric tests: Wilcoxon signed-rank test (baseline *Mdn*=2, follow-up *Mdn*=3), Z=-2.5, p=.01.

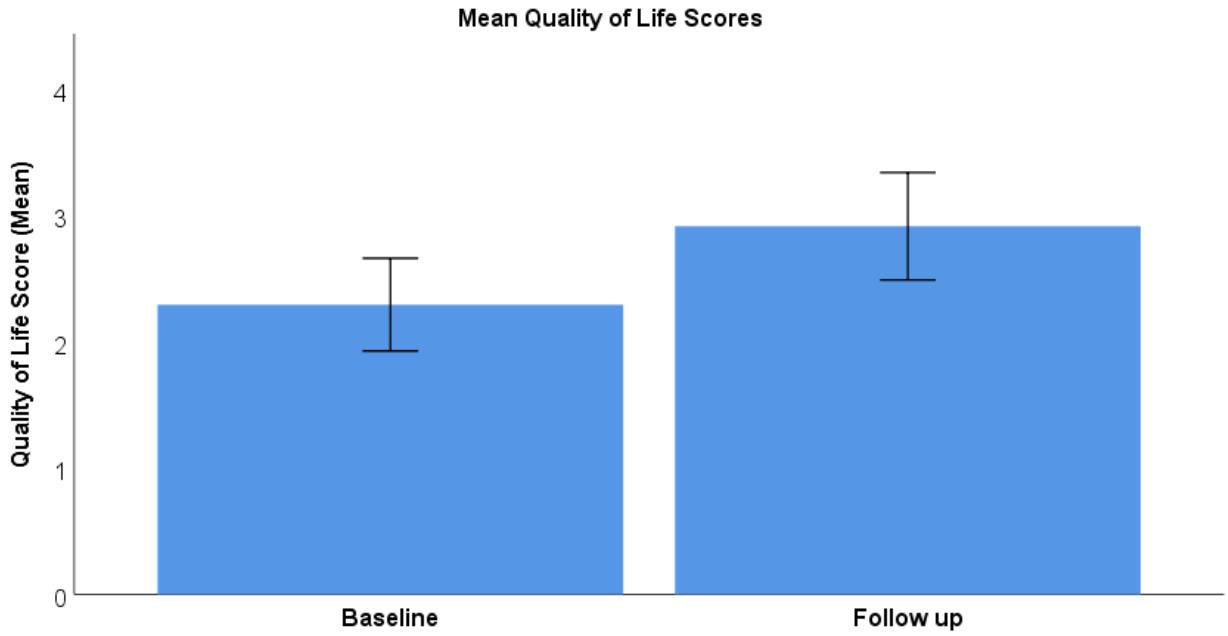

Figure 13. Mean quality of life scores (N=37)

3.2.2 Happiness

Figure 14 displays median self-report happiness scores (N=37). A paired t-test showed there was a significant improvement in happiness scores from baseline (*M*=2.5) to six month follow – up (*M*=3.0), t(36)= -2.8, p=.02 (95% CI of the difference -.8 to -.1). This was also significant

using non-parametric tests: Wilcoxon signed-rank test (baseline *Mdn*=3, follow-up *Mdn*=3), Z=-2.2, p=.03.

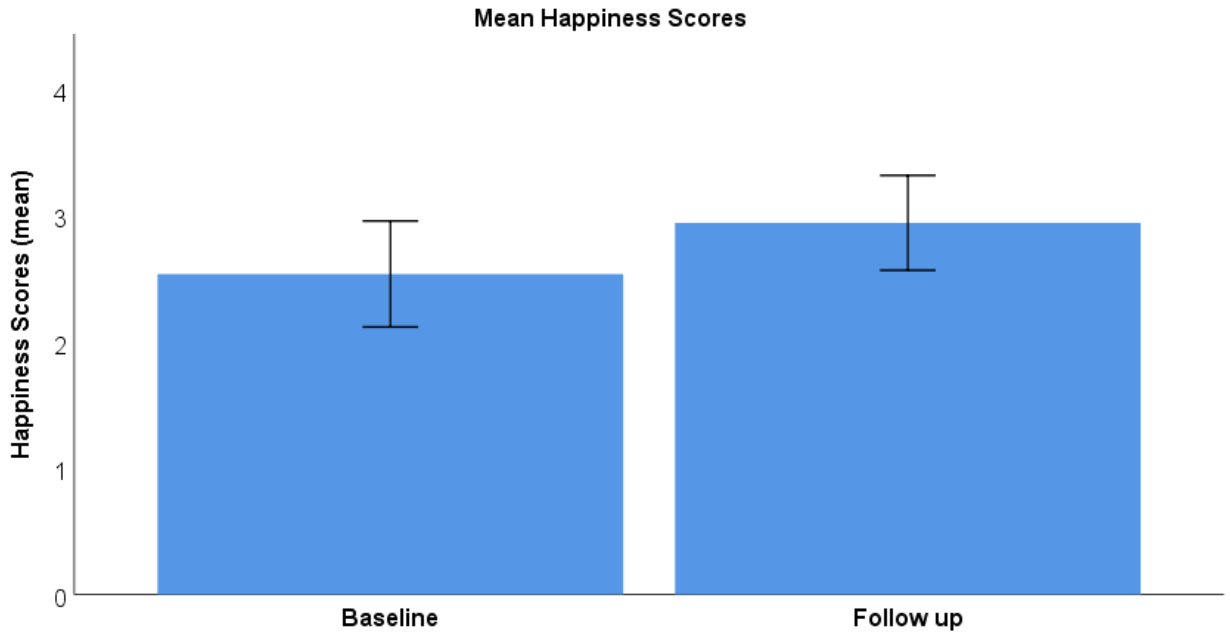

Figure 14. Mean happiness scores (N=37)

3.2.3 Loneliness

Mean self-reported loneliness scores are displayed in Figure 15 (N=36). A paired t-test showed there was a significant decrease in loneliness scores from baseline (*M*=7) to six month follow-up (*M*=5.3), t(35)=3.7, p=.001 (95% CI of the difference .8 to 2.7). This was also significant using non-parametric tests: Wilcoxon signed-rank test (baseline *Mdn*=8, follow-up *Mdn*=3.5), Z=-3.2, p=.001.

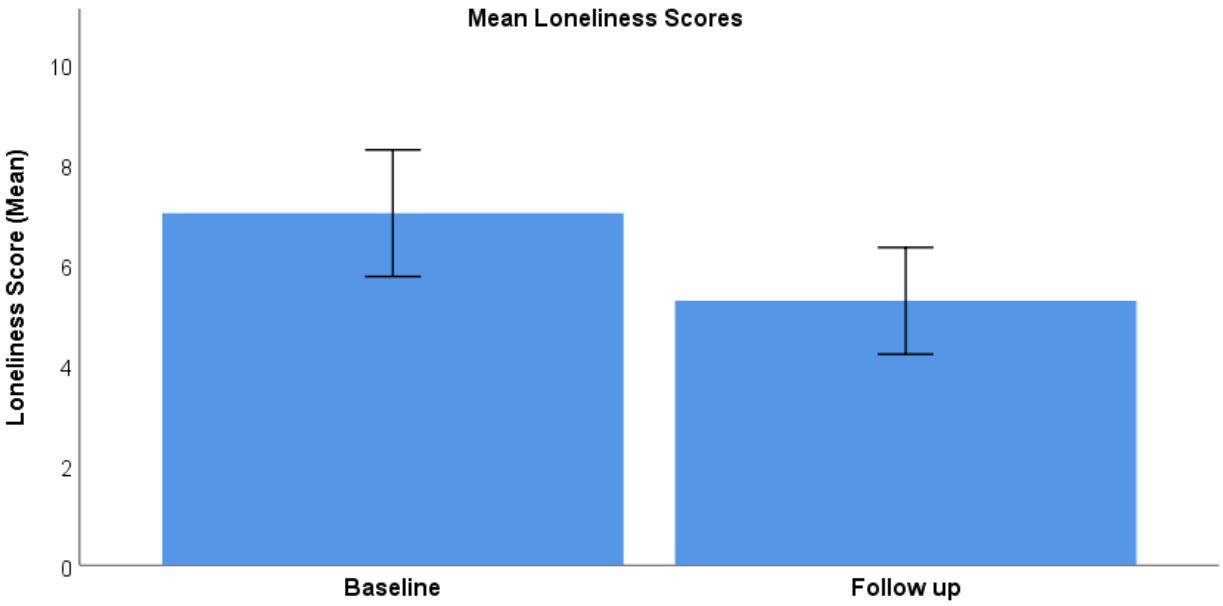

Figure 15. Mean loneliness scores (N=36)

The average number of patient's self-reported number of important people in their life at baseline and at six months is displayed in Figure 16 (N=34).

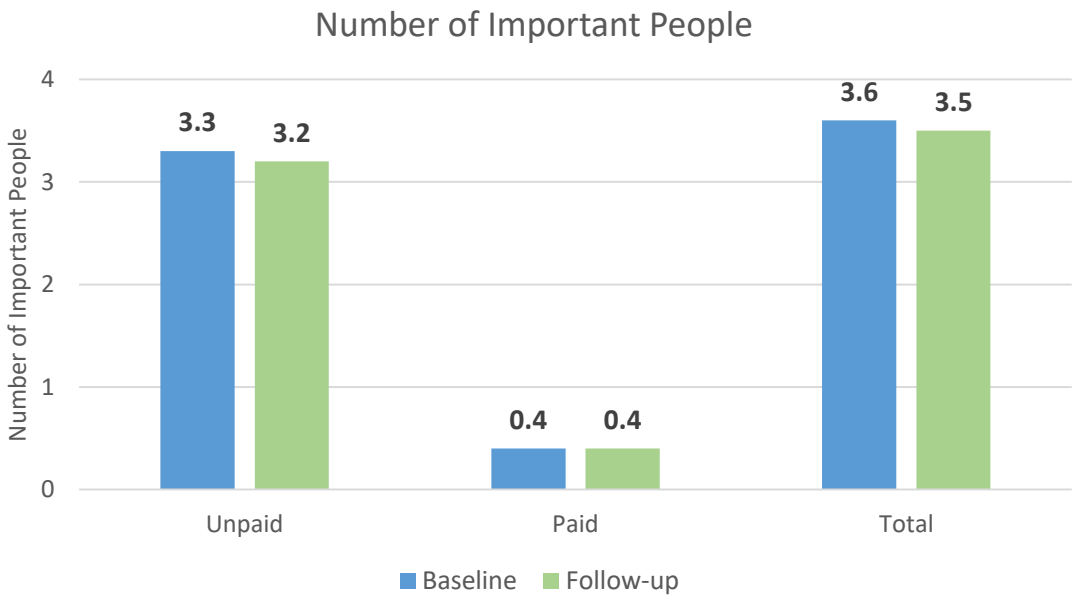

Figure 16. Number of reported important people

The mean number of self-reported GP contacts attended in practice per person from the LP caseload is displayed in Figure 17. Data is inclusive of 10/09/18-21/03/2019. Despite normality assumptions not being met, parametric tests were conducted for illustrative purposes. On average, patients reported attending 1.7 (SD=1.1) GP appointments in the practice in the previous four months at baseline and 1.2 (SD=0.9) appointments in the four weeks prior to follow-up (N=19) although this did not reach significance, t(18)=1.8,p=.1 (95% CI -.1 – 1.0). Projecting these findings would amount to 170 GP contacts at baseline and 120 contacts at follow-up per 100 people, a reduction of 50 GP contacts over a six month period. Over a one year period, this would result in each patient requiring one less GP appointment.

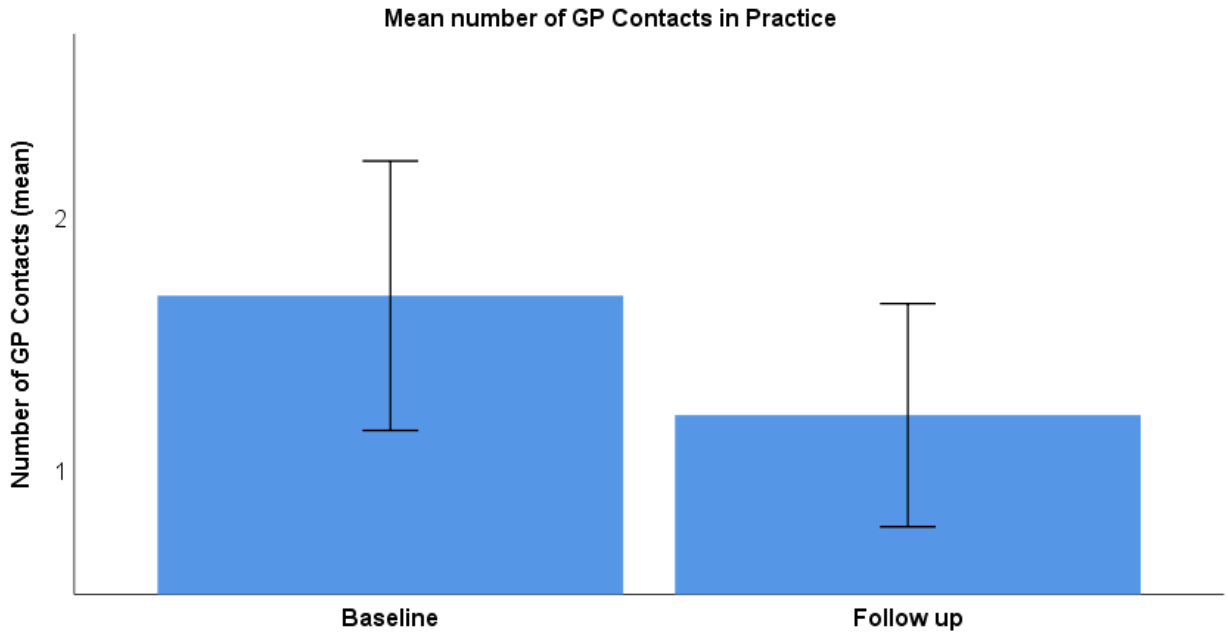

Figure 17. Mean number of GP contacts (per person)

3.3 Patient case studies

Three case studies described below, illustrate some of the challenges that the LP supported patients with. Demographic details of each case is described in Tables 2 – 4.

Table 2. Case study 1: Ms A's characteristics

Characteristic	Description
Age	88 Years
Sex	Female
Ethnicity	White Scottish
Patient location	Living alone in private sheltered housing
Past medical history	Epilepsy
Primary challenge	Social isolation
Referral source	GP

Ms A's Story

Ms A was referred to the ALS due to being socially isolated, which was primarily due to having epileptic fits. Her epilepsy was a new diagnosis in the last five years and struggled with this. This was impacting Ms A as she was feeling increasingly lonely, particularly as she had no family nearby. She felt being old was difficult and disliked being unable to carry out tasks. Ms A was not withdrawn and was very bubbly and talkative. She enjoyed social interaction and loved talking to people, even strangers, and missed this now she felt restricted to her house. Ms A struggled with other people's perceptions of her epilepsy seizures and felt that people were nervous to go places with her in case she had a seizure.

The main aim for Ms A was to try and get support for her to get out and about again, in particular going into Aberdeen to do some shopping. The LP referred Ms A to the Royal Voluntary Service (RVS) for help with shopping and to the epilepsy organisation in Aberdeen for support with her epilepsy diagnosis. RVS had not yet been in contact, however, Ms A was very thankful of being listened to. She said she really enjoyed the session and felt that she could relax and tell the LP all of her problems. The LP suggested the Chaplaincy Listening service (CLS) and Ms A felt this would be a good idea. The LP referred Ms A to the CLS service and she awaited further contact.

Key learning from this case was that social isolation happens to people who do have the confidence to go out and the barrier sometimes is the person's disability. By removing this barrier and putting support in place for a disability, those can enable people to live how these desire and consequently improve their quality of life.

Table 3. Case study 2: Ms B's characteristics

Characteristic	Description
Age	60 years
Sex	Female
Ethnicity	White British
Patient location	Rented accommodation
Past medical history	Fibromyalgia, osteoarthritis, poor mental health
Primary challenge	Physical health
Referral source	GP

Ms B's Story

Ms B was living alone in rented accommodation and had been unemployed for a number of years. She had been diagnosed with fibromyalgia and osteoarthritis but also had poor mental health and a potentially undiagnosed eating disorder. Ms B was referred to the ALS by her GP due to her physical health as she struggled with longstanding illness. She also disclosed having previously been in an abusive relationship which had a significant impact on her general self-esteem and confidence. She presented as anxious during appointments and asked for the LPs support frequently when attempting to engage more in community resources.

The initial aim of the LP was to work with Ms B to identify what type of support she required. She was very weight orientated and expressed significant desire and motivation to lose weight, therefore, this became the primary focus. The LP sought advice from North East Eating Disorder Support (NEEDS) Scotland who advised of a monthly support group that Ms B could attend without formal diagnosis. The LP provided Ms B with information regarding a

monthly NEEDS support group and Ms B was interested in attending this with the LP's support. The LP also made a referral to Move More at Sport Aberdeen. Ms B attended an appointment to find out more about the types of low level activity that Sport Aberdeen provided and has since, with the LP support, attended an exercise class which she enjoyed and intended to go back regularly.

The key learning from this case included that the primary referral reasons were related to physical health (conditions), bereavement and finances but actually the person wanted support with weight management and physical activity to improve her physical and emotional wellbeing. It is important to ensure that the person is in control of what they do and don't want support with and this may differ from the referrer's perspective.

Table 4. Case study 3: Mr C's characteristics

Characteristic	Description
Age	27 years
Sex	Male
Ethnicity	British
Patient location	Homeless
Past medical history	Depression
Primary challenge	Addictions, anxiety & depression, housing & homelessness

Mr C's Story

Mr C had significant problems due to his gambling addiction. He was currently homeless and had been sleeping on a friend's sofa. Mr C had minimal food and had not eaten for a few days. He was feeling low and depressed and had started taking anti-depressants. Mr C's benefits have also been sanctioned as he did not turn up for his appointments at the job centre. Mr C was referred to the ALS due to his housing and food difficulties, caused by his gambling addiction. He has previously lived in council accommodation, however lost his accommodation

due to high levels of rent arrears. Mr C had a previous criminal conviction and has struggled to find a job. The primary aims identified by the LP and Mr C was support to find accommodation, support to deal with gambling addiction and to find some meaningful activity.

During the LP appointment, it become apparent that Mr C was suicidal and had made potential plans, stating he had come to the GP as a last resort. The main protective factor for Mr C not carrying out these plans was that he had two children with a previous partner. Mr C explained he had been sleeping on a friend's sofa but had outstayed his welcome as unable to contribute financially. The LP suggested presenting as homeless to the council however Mr C advised that he has used up these options and would not qualify for council support. The LP then called Cyrenians, a homeless charity, where a meeting was organised. At Cyrenians, Mr C was supported to contact his housing officer to help him fully understand his housing situation. He was supported to find a private flat with the organisation acting as a reference to maintain this flat and find a deposit. Mr C stayed in a Bed and Breakfast until all the paperwork arrived. Mr C was also supported to purchase a phone, as his had been stolen, and given food to last until his benefits come through.

Mr C was also referred, by the LP, onto APEX for support in developing employability skills and to develop his CV. The LP also signposted him to Skills Development Scotland for support to work towards developing undertaking some meaningful activity. In addition, Mr C was also encouraged to contact the Job centre to re-sign on for benefits. Where he was offered an appointment which he attended and his benefits were re-instated.

The LP then explored supporting Mr C with his Gambling addiction. Mr C had been to Gamblers Anonymous in the past, however did not want to participate in a group support. He had a desire to do something as felt he had lost a lot of friendships and relationships due to gambling. The LP referred Mr C onto the RCA trust, an organisation that supports those with gambling additions, to speak to a gambling practitioner. Mr C met with the Gambling Practitioner and was offered 15 weeks CBT addictions counselling.

At a follow-up appointment, Mr C appeared in a brighter mood and stated he felt he had been given some hope. Unfortunately, the Service user disengaged from the Links Service at this point.

One learning point from this case is how effective it can be to work in partnership to help an individual during the difficulties they are experiencing, as this keeps the intervention person centred and not overwhelming.

3.4 Link Practitioner staff results

3.4.1 Link Practitioner goal setting

An overview of the goal setting results are visible in Table 5. Overall, the majority of LPs self-reported to fully achieve their personal goals for the first six months within their role, whilst one-quarter reported to fully achieve their professional goal. All responders (N=9) had reported making some progress towards their goals.

Table 5. Self-reported Link Practitioner goal attainment (N=9)

Degree of goal attainment	Type of goal	
	Personal goal	Professional goal
Fully achieved (%)	63	25
Partially achieved (%)	37	75
Not at all achieved (%)	0	0

Examples of fully achieved personal goals were predominantly behavioural traits, for example improvements in assertiveness, perceived competence and self-confidence. Through attaining these goals, LPs reported to be delivering a higher quality service to both patients and General Practice staff. The most commonly identified professional goal that was partially achieved was increasing awareness of the LP role, with responders describing varying degrees of success of embedding a links approach in Practices. However, one LP who identified the same goal reported to have fully achieved it, reporting to have scheduled dedicated time to building relationships with colleagues.

3.4.2. Link Practitioner staff satisfaction

Table 6 displays the LP staff questionnaire responses. Staff were highly satisfied with working in the ALS (average score 83%). In particular, staff reported that they strongly agreed there was good communication and team work within the LP team.

Table 6. Staff satisfaction questionnaire scores (N=9)

Questionnaire components	Mean Score (%)
Supported: SAMH	82
Supported: GP	80
Training	82
Development	91
Communication - LPs	96
Communication - GP	76
Workload	71
Progression	71
Recognition	82
Teamwork: LPs	93
Teamwork: GP	82
Systems	73
Satisfaction	83

3.4.3 Link Practitioner staff experience

Characteristics of the LP team, interviewed in March 2019, are displayed in Table 7. Where reported, the majority of the team had five years or less experience working in either health or social care (87.5%). To ensure anonymity with a small sample of interviewees, participant ID was removed from quotes provided in the interview analysis and referred to as “Responder x”. In this section, to distinguish between the two types of LP role, link practitioner and senior link practitioner are referred to as ‘LP’ and ‘SLP’ respectively. When both LPs and SLPs are described together, they are referred to as ‘practitioners’.

Table 7. Characteristics of interviewed Link Practitioner staff (N=9)

Participant ID	Sex (M/F)	Experience (yrs.)	Role
P1	F	2-5	Link Practitioner
P2	F	<2	Link Practitioner
P3	F	2-5	Senior Link Practitioner
P4	F		Senior Link Practitioner
P5	F	6-10	Senior Link Practitioner
P6	M	2-5	Senior Link Practitioner
P7	F	<2	Link Practitioner
P8	F	2-5	Link Practitioner
P9	F	2-5	Link Practitioner

3.4.3.1 Themes

Four key themes with corresponding subthemes emerged from the thematic analysis of the staff interviews; 1) Development and sustainability (the components required for a LP/SLP to thrive within the role), 2) Service provision (characteristics of the support LPs/SLPs provided), 3) Embedding the links approach (mechanisms that influenced attitudes to the approach) and 4) Community asset considerations (factors influencing interacting organisation utilisation) (Table 8).

Table 8. Themes and sub-themes derived from Link Practitioner interview analysis

Theme	Sub-theme
Development and sustainability	Support systems
	Work-life balance
	Training
	Autonomy
Service provision	Caseload
	Workload
	Support style
	Systems
Embedding the links approach	Co-location
	Practice staff relationships
	Awareness raising
Community asset considerations	Service quality
	Gaps in service provision
	Third sector relationships

3.4.3.1.1 Development and sustainability

Support systems – Staff consistently identified the induction process as a key period in which a strong team bond developed. This appeared to be influenced by no pre-existing relationships being evident in the team, in addition to all staff coming into a newly-developed service: "*I think the fact we were all in the same position meant that we all put in the effort to get to know each other*" (Responder x). Interviewees reported a positive group dynamic due to similar attitudes, such as project enthusiasm, and compatible qualities: "*we all come from a kind of caring background. I think that has helped in building a team like this as well*" (Responder

x). Consequently, trust developed which enabled practitioners to comfortably seek out peer support: "*I am not shy or scared to call anyone within the team to ask for help. We have a very strong relationship between all of us. I think team training really helped to develop that*" (Responder x).

Maintaining within team relationships was managed without difficulty, despite working remotely across different GP practices. Along with weekly team meetings, multiple communication pathways were regularly utilised including group emails, a WhatsApp group, work phones to call and texts throughout the day (including before and after a home visit or to gather information) and a group chat on their personal phones (e.g. to arrange social events). This enabled a strong peer support system within the team: "*we are all really good friends, which is really nice to have support there is needed, it is nice to know if you are struggling with something they are there and probably going through the same thing*" (Responder x). In addition, strong relationships allowed practitioners to share previously acquired knowledge and expertise and consequently upskill from each other: "*I think the fact we had all come from different areas was really good and the fact that we all have previous experience so we can all kind of learn from each other*" (Responder x).

Most LPs felt supported by their line manager, the SLP, who frequently checked in with them to ensure they were managing, particularly with difficult patients and as they were not co-located. LPs felt equally comfortable contacting their line manager for support: "*Whenever I have maybe had a tough person in…I know I can just phone her straight away*" (Responder x). One LP, however, felt they had not received adequate management support: "*I have been to different locality meetings and spoken to different seniors and it is not the same as what I am getting*" (Responder x). From the SLP perspective, it appeared that the heavy caseload, in addition to line management responsibilities, hindered the support they could provide LPs: "*I have not had the capacity to give as much support to [LPs name] as I would have liked*" (Responder x). SLPs reported receiving variable management support. Some described inadequate support due to sickness absence, and therefore a lack of regular supervision meetings which resulted in improvements to practice not picked up promptly: "*I got six months of stuff*

that they thought I could do better, getting thrown at me at once. Whereas if I had a standard monthly supervision, this would have been picked up a lot sooner" (Responder x).

Work-life balance - The difficult nature of some issues LPs were supporting patients with, made some struggle with switching off from work, feeling burnt out and emotionally drained: "*I have multiple dreams about working, I worry most nights. If I watch TV or read a book, anything can be related to what we do, it is really difficult…you cannot un-hear what you have heard from people*" (Responder x). Coping strategies were sought out by practitioners such as limiting undertaking additional work hours, keeping caseloads a manageable size, utilising stress management apps and seeking support from team members: "*debriefing with somebody…it does not necessarily have to be a line manager just somebody else within the team that you are close to and feel that you can speak to*" (Responder x). One patient was moved onto a manager's caseload as they were emotionally burdensome on the LP: "*this person was taking up so much of her emotional energy that she was actually struggling in other parts of the jobs but taking that pressure off her and taking that persons onto my caseload really made a big difference*" (Responder x).

Training – Interviewees felt most information they received during their induction was useful in broadening knowledge of local services, however, some felt the amount of information provided was overwhelming and consequently difficult to absorb: "*There was a lot of information to take on within that time and some of the things just went straight over our heads*" (Responder x). Some practitioners felt the induction would have benefited from allocated time to look over policies and procedures, additional time to learn referral processes and the database and to have received ASIST training during this period: "*I did not work with people who were suicidal before and never worked with people with mental health, so that training would have been really useful for me to have earlier*" (Responder x). Feelings of uncertainty were raised about what the LP/SLP role would entail and many felt shadowing another LPs/SLPs would have been beneficial, however this was not possible as this was a new role: "*It is really great to be part of it from the start but also you are aware that you cannot really*

copy someone else, you're all trying to find that ground together as to what that role looks like" (Responder x).

Interviewees described variability in issues practitioners would support patients with dependent on allocated GP practice, resulting in team members requiring variable upskilling requirements: "*The people that I see in my area even my line manager who is also based in the [locality] is seeing completely different people because it is different geographical area, different economical situations and things like that. It would be so difficult to hone in on the exact things we need training on*" (Responder x). Practitioners were emailed about upcoming training courses, were able to seek out specific upskilling opportunities and where the team collectively identified a training need, practitioners sought out organisations to delivery training to the whole team: "*If we are seeing a pattern between the teams that are many lacking in some knowledge or lacking in some information of services, then we invite them to our team meeting to do a presentation on that service*" (Responder x). However, some training was not provided locally and for others, only limited numbers of staff we able to attend training: "*a lot of the training is that only a couple of people can go and maybe I have not jumped at the chance because I do not know how relevant it is…so I have not actually done that much continuous training*" (Responder x).

Autonomy – Staff felt empowered with the flexibility they possessed in how they provided patient care (including appointment structure, length of appointments, number of appointments, appointment location), which allowed practitioners to adapt the support required depending on the individual's needs: "*we do not have a limited amount of time that we can work with people, so it is not like a twelve weeks programme, so it is basically up to them how much they want to engage and it is up to them how often we see then…Similarly some people just want telephone contact rather than face to face appointments*" (Responder x). In addition, interviewees had the freedom to plan their working day to suit their preferences which was new to most and seen as particularly satisfactory: "*Previous roles you always had certain times where you were doing things, whereas we have the freedom to do that ourselves but also*

develop our own kind of ways of working. I have really enjoyed that you have the freedom to do that" (Responder x).

3.4.3.1.2 Service Provision

Caseload – The service provided support to a heterogeneous population, spanning all adult age groups, including those requiring support for all nine social determinants of health. Support provided ranged from those who required a single telephone call or appointment with some signposting, to those requiring more extensive support including multiple face to face appointments, home visits and support to attend community groups. It appeared those requiring longer ongoing support were generally those with more complex needs: "*Other people, who might be facing multiple challenges, need a lot more ongoing support to be able to work through those… it is more about that kind of hand holding through the process as well. So that can be empowering them to go on their own, giving them a follow-up phone call to see how they got on or a follow-up meeting to see how they got on with something*" (Responder x). Staff sought to promote independence and self-management, and avoid creating a dependency, through setting clear expectations and boundaries during the initial appointment of the support they were able to provide, and slowly reducing the level of input required as confidence increased: "…*some people need a lot more input and others will not and then gradually pulling that away. I think it is about being very clear at the beginning about what your role is that you are not a Support Worker, you are not a Social Worker*" (Responder x).

Workload – Large variability in caseload volumes was described, location dependent, with approximately half reported their caseload currently felt unmanageable. Some practices were slower to refer which some felt was due to perceived lack of service benefit or limited service knowledge, however referrals increased as both service awareness and patient improvements became apparent and trust was built: "*Once the GP's start realising that we are actually there and what we can do, it kind of gets a bit more full on and then it got to a point where you get so many referrals that you feel like you cannot physically see any more people*" (Responder x). In addition, administrative tasks were described as labour intensive including in-

putting new referrals, sending out appointment letters, discharge letters, making appointments, writing up case notes, sending referrals, liaising with agencies, re-adding information to the developing database and the tasks involved with non-engagers: "*It is a relatively small proportion but at the same time those who do not engage, the time that is required to support them in their engagement significantly outweighs what I feel it should I guess*" (Responder x). Some SLPs found having a comparable workload to the LPs, coupled with current management responsibilities and anticipation of increased responsibilities, challenging and unsustainable: "*The workload is incredibly high…I am expected to manage three potentially four practitioners that workload definitely needs adjusted so I can cover both sides of my job*" (Responder x).

Interviewees described workload coping strategies such as dedicating one day a week to administration tasks, prioritising immediacy of appointments due to perceived complexity and the development of a caseload management tool: "*I have like a traffic light system, it is red it is discharged, amber they are waiting for next appointment and I do not necessarily have anything to do in the meantime and green if there is something. I can narrow things down in that way*" (Responder x). Planning appeared challenging to some due to the unpredictable nature of the caseload and it was felt that developing a consistent process to manage high referral rates would be beneficial: "*I would say that everyone in the current team is probably at capacity at the moment. I do not think there are consistent procedures for dealing with that*" (Responder x).

Support style – Despite being provided a 'primary referral reason' for new cases, practitioners described approaching the initial meeting without preconceived ideas of the patient's needs: "*Not necessarily rushing to think of what organisations to refer people to, actually just taking the time to listen to peoples stories, listen to what has been going on for them.*" (Responder x). Patients could present with a multitude of differing issues, and some practitioners who were less knowledgeable in the presenting areas, found this challenging to manage and consequently more likely to refer onwards, as opposed to trying to solve the issue themselves: "*If they come to me with a completely new problem that I do not know anything about, I just*

do not like not knowing and it knocks my confidence…I like to refer to other services where maybe other people deal with things themselves" (Responder x). Those more experienced in a particular area would attempt to support the patient to solve the issue, rather than referring onward: "*if you can fix a problem for somebody with a bit of support rather than referring out, you are also going to get a better outcome, when you start putting extra layers to that persons work and bringing other people in, that person would not get the support that they need*" (Responder x). Practitioners had specific areas of expertise through previous experiences which others could gain support from when necessary. One interviewee felt that having an LP who possessed or acquired expertise in a particular area, could be utilised across several sites: "*I think having potentially someone within the team that specialises in that and can work across a number of practices to give that support to people would be a huge benefit*" (Responder x).

Systems – The ALS had a bespoke information system that was satisfactory to most in terms of usability and was able to record a variety of service user information: *"we can record meeting notes, we can record other information and it has been very valuable in terms of being able to be adapted to be use for our own data collection as well" (Responder x).* The system was independent of the GP practice system which created challenges including: considerable time to input new referrals, having to ask reception staff to contact practitioners when patients arrived for an appointment or for additional patient information (including changes of address, phone number) and being unaware if patient circumstances changed: "*I have had maybe three or four times going to doors and people are not there because they have been admitted to hospital and calling the next of kin and it is maybe a really sensitive time for them. One time I had gone to a person's house for a visit, he was not in and I called his son and the man had just died. It was really insensitive of me but I did not know*" (Responder x). Stronger relationships between practitioners and General Practice staff facilitated increased awareness of patients changes: "*there is an advanced practitioner that I work quite closely with in the practice who I have a really good relationship with and she is very supportive, very communicative about her patients so if there is an update about any of them, she would let me know either by email or when I see her in the practice*" (Responder x).

3.4.3.1.3 Embedding the Links Approach

Co-location – Visibility within the GP practice was seen to influence success in developing relationships, with more positive experiences described when practitioners were based in close proximity to General Practice staff, and in turn service uptake increased: "*I get a room that is in the middle of the doctor's rooms. I get to interact with the GP's, Receptionist, Nurses, Midwives and the rest of the practice on a daily basis. I think this is one of the big reasons why I have had so many referrals from [practice name] because I do have that day to day contact*" (Responder x). Practitioners who were based in offices away from the practice team, due to availability of space, described building relationships more challenging due to its isolating nature: "*no one would speak to me if I did not open my door or if I did not walk through to reception. I need to make sure that I am really present otherwise I could just sit here all day and no one would know that I am here. It is difficult because everyone is busy*" (Responder x). These challenges were enhanced when practitioners were only present in their practice for a short periods each week: "*I am on my own in the room all the time…I don't see GP's, Health Visitors or Nurses, so it was difficult to build relationships and because I was only there a day and half a week, it was just a bit more difficult"* (Responder x).

Practice staff relationships – Differing levels of engagement and enthusiasm from practices was described, which seemed apparent as soon as practitioners entered the practice. Some described receiving shadowing opportunities and were more successfully able to build relationships during their practice induction whilst other practices were more resistant to the new service: "*[practice name] and the GP's allowed me to and actually sit with them as an observer on all the consultation… as well as the midwife, as well as the nurse practitioners, as well as home visits, etc. At [practice name] this was not available and the GP's did not buy into that at all*" (Responder x). Some practices in more affluent areas were less likely to see the service as valuable: "*one member of staff said to me, I do not know who you will be seeing unless it is people who are having problems with their cleaners…that is not the case at all. With money come so many problems…*" (Responder x). One practice had particular challenges

building relationships due to the large number of locum GPs and high turnover of administrative staff: "*The receptionists staff turnover rate here is enormous, so I do not really know any of them*" (Responder x).

Awareness raising – Having a presence in practice facilitated building practice relationships, particularly when practitioners were not in close proximity to other General Practice staff. Interviewees described seeking out opportunities to increase their visibility including leaving their room door open, having lunch with other staff, spending time with reception staff, leaving chocolates in the staff room and attending GP weekly meetings: "*At [practice name] it has worked really well because I was able to go to all the practice meetings. So all the GP's and Nurses would go to the meetings, it would be most of the afternoon you would spend there, we would talk and chat, I found that helpful*" (Responder x). Some felt uncomfortable attending GP meetings in more practices who were less adopting of the links approach: "*I try to go to but a lot of the time if I am not feeling that confident I do not want to go because I feel, why am I there. They talk about a lot of medical things and at the end I can speak out things, if I want too. I went yesterday and it was good, some of the GP's just do not speak to me*" (Responder x). Practice meetings were used as a platform to raise awareness of the service function and to share examples of success stories from input by a LP/SLP, with the aim of increasing practice engagement in the service: "*So being able to say, over in this practice we've had this feedback and allowing the practices to communicate that between each other as well, you know using case studies, sending them around using the evaluation data as well you know just being able to look at the in the future I'm sure will boost the buy in where there have been challenges*" (Responder x). Practitioners felt that once GPs could see patient improvements as a result of the LP/SLP, they then better see the service value and increase utilisation: "*we find that once some of the GPs start seeing the benefits of the referral they will generally talk between themselves and then the other GP's kind of come on board a little bit*" (Responder x).

3.4.3.1.4 Community asset considerations

Service quality – Despite a range of potential organisations available for practitioners to refer or signpost patients onto, these varied widely in efficiency (including waiting list times, rate of picking up referrals) and perceived value (whether support provided suited the patient's needs). When practitioners had a negative experience with an organisation, this knowledge was shared throughout the team and consequently they were unlikely to continue to utilise that service: "*if you refer onto something and they don't pick up the referral for a long time or they are not really useful you just know that and next time you just refer somewhere else and you check with your team, where's the best place to refer that person*" (Responder x). Practitioners developed a resource, available on their shared drive, with information about different organisations (including what service they provide and how to access these). Interviewees described further developing this resource to include service quality: "*We are actually going to start to look at the services we are continually referring to and actually say well go here and you will get a good service but if you send someone here they are not hearing from them for three months or whatever*" (Responder x).

Gaps in service provision – Interviewees described limited support available for patients in certain areas, with a frequently reported lack of service for addressing loneliness in younger adults: "*This gap at late 20s is really bad, there is a lot of people, social isolated. There is not a service for them. Even students at University feeling socially isolated and having issues with their mental health*" (Responder x). Limited service provision was cited due to budget cuts, and some practitioners described innovative solutions to address this challenge: "*Is it finding that maybe 3-4 patients are having the same issue they are facing in their day to day life, can we bring them together and get them, to help them to support, to make a group*" (Responder x). Limited service provision was also apparent in geographically remote locations, which posed additional barriers if patients had to travel to attend services: "*if that is there only mode of transport [bus] to get in for free counselling within the city or any mental health support services that are within the city, it is a huge barrier for them and a lot of the time, they do not have the money to get a taxi into the city so. There are no free counselling or support groups in [location], there's no support groups anything like that*" (Responder x).

Third sector relationships – Practitioners felt that there was a general awareness across organisations of their role due wide promotion (including though newsletters, talks to organisations) prior to service start date, and consequently practitioners were warmly received by organisations: "*Building relationships in the community, like everyone has been welcoming of the project and everyone really wanted to know about it, it was easy because it was highly promoted project and everyone knew about us*" (Responder x). However, some were unclear of the specific remit of the LPs/SLPs: "*People had heard of us but were not really clear about what we do. I think we have all done that to be fair, anytime you're going out your talking about the service and exactly what the service can do*" (Responder x). Interviewees approached interacting organisations to develop relationships, raising awareness and understanding of the LP role, in addition to upskilling themselves: "*I have also gone around a lot of different organisations just to again build up that kind of partnership network and getting to know local resources and some of the local forums*" (Responder x). In addition, some practitioners had already established relationships which facilitated both the development of relationships and awareness raising: "*I have obviously worked in the third sector a long time… I think it has helped the wider services and obviously to understand what it is about, you know what the LPs actually is about*" (Responder x).

Although most relationships were described as positive, and generally interacting organisations were helpful when practitioners contacted them, relationships were not well developed: "*…It was not difficult [referring to organisations] and I would not say I had the strongest relationship with them because you do not see them that often but usually with the organisations that you refer more often to, you keep in contact with people working there so you just like email them from time to time or see them in meetings and talk to them*" (Responder x). Staff described that a lack of capacity, due to heavy caseloads, hindered development of stronger relationships: "*Community wise, again I feel that recently I've not had that much opportunity to be able to build community relationships so that's something that's maybe slipped a little bit. On the whole, the community relationships that I've build to that point throughout this role have been positive ones, you know everyone's quite time constrained, there's not always*

the time to chit chat and meet up all the time but maintaining them is largely done through the referrals or through email and they've all been positive" (Responder x).

3.6 General Practice staff responses

Table 9 describes General Practice staff's self-reported knowledge and awareness of the LP role at baseline and six month follow-up. Awareness of the LP role remained approximately constant, however, knowledge of the LP role increased by 19% from baseline to six month follow-up.

Table 9. General Practice staff knowledge and awareness of the Link Practitioner role at baseline and follow-up

		Baseline	6 months
	N	114	85
Job category, N(%)	Reception	15(13)	15(18)
	Administration	27(24)	18(21)
	GP	31(27)	26(31)
	Nurse	15(13)	5(6)
	Practice Manager	19(17)	12(14)
	Advanced Practitioner	3(3)	2(2)
	Health Care Assistant	2(2)	2(2)
	Other	2(2)	5(6)
Awareness of LP role, N(%)	Yes	92(92)	79(94)
	No	14(13)	5(6)
	Not sure	6(5)	0(0)
Knowledge of LP role, N(%)	Yes	80(70)	76(89)
	No	19(17)	5(6)
	Not sure	15(13)	4(5)

Table 10 describes General Practice staff's self-reported perceived value of LPs and openness to adopting the links approach at baseline and six month follow-up. Practice staff's perceived value of LPs increased by 13% whilst openness to the links approach remained constant across the six month period.

Table 10. General Practice staff perceived value and openness to the links approach

	Perceived value of link working		**Openness to adopt links approach**	
%	Baseline	Follow-up	Baseline	Follow-up
Strongly disagree	13	8	10	9
Disagree	3	0	0	0
Neither agree / disagree	6	5	3	7
Agree	39	40	45	41
Strongly agree	34	46	40	42
Don't know	5	1	0	1
% agreement	73	86	85	83

Table 11 describes General Practice staff's confidence in their knowledge of community assets and their confidence in signposting patients to community assets. Practice staff's confidence in their knowledge of community assets increased by 5%, whilst confidence to signpost to community assets remained constant from baseline to six month follow-up.

Table 11. General Practice staff knowledge of community assets and signposting

	Confidence in knowledge of community assets		Confidence in signposting to community assets	
%	Baseline	Follow-up	Baseline	Follow-up
0	1	1	5	0
1	5	11	5	15
2	17	5	13	10
3	20	9	17	11
4	9	12	13	12
5	20	29	16	26
6	9	12	8	10
7	10	11	13	8
8	8	7	8	5
9	1	3	1	1
10	0	1	1	3
mean score(SD)	4.3(2.1)	4.8(2.4)	4.4(2.2)	4.4(2.3)

Discussion

This report describes the evaluation findings of the ALS, in particular the impact on patients, staff and resources. Results presented explore components of implementation that emerged as functioning sufficiently and recommendations to inform service development and direction, which is of particular importance due to the limited evidence at present on the effectiveness of social prescribing schemes[15].

Patient perspective

Significant improvements in patient self-reported quality of life, happiness and loneliness scores were demonstrated at six month follow-up, utilising validated quantitative measures. Happiness appears not to have been previously measured, however improvements in mental wellbeing including loneliness and quality of life have been described predominantly though qualitative research[16] [17]. One study reported that when people have the opportunity to attend activities where they can socialise in the community, this reduced social isolation and improved self-confidence[18]. In contrast to our findings, one recent large scale study utilising validated quantitative methods to measure quality of life, found no significant improvement at nine month follow-up[19]. However, their patient cohort focused on more deprived areas (% SIMD 5: Deep end 79.3%, ALS 11%), contained a larger proportion of dis-engagers (Deep end 18.3%, ALS 12.3%) and had less face to face appointments with the LP (Deep end: mean 2.54

[15] Bickerdike et al (2017). Social prescribing: less rhetoric and more reality. A systematic review of the evidence. *BMJ Open*; 7:e013384
[16] Chatterjee, H. J., Camic, P. M., Lockyer, B., & Thomson, L. J. (2018). Non-clinical community interventions: a systematised review of social prescribing schemes. *Arts & Health*, *10*(2), 97-123.
[17] Mossabir, R., Morris, R., Kennedy, A., Blickem, C., & Rogers, A. (2015). A scoping review to understand the effectiveness of linking schemes from healthcare providers to community resources to improve the health and well-being of people with long-term conditions. *Health & Social Care in the Community*, *23*(5), 467-484.
[18] Moffatt, S., Steer, M., Lawson, S., Penn, L., & O'Brien, N. (2017). Link Worker social prescribing to improve health and well-being for people with long-term conditions: qualitative study of service user perceptions. *BMJ open*, *7*(7), e015203.
[19] Mercer, S. et al. (2017). Evaluation of the Glasgow 'Deep End' Links Worker Programme. NHS Health Scotland, Edinburgh.

appointments per patient for those who engaged with the service[20], ALS: average 6 appointments per patient) which may in part explain discrepancies. Our findings appear novel in demonstrating improved happiness scores, aligning with previous research which has shown participation in group activities, a fundamental element of social prescribing, is associated with greater happiness[21]. Considering declining mental health (including loneliness, social isolation and happiness) is associated with both poorer health outcomes (such as all-cause mortality, cardiovascular disease and mental health) [19] [22] and increased utilisation of healthcare resources[23], this finding has implications at both patient and system levels.

A flexible approach to care provision appeared to facilitate improvements in patient outcomes including autonomy to vary the level (which ranged from 1 – 220 days) and location of support, approaching initial consultations without preconceived ideas and actively involving the patient in identifying and supporting their needs, with the aim of encouraging self-managing behaviours and avoiding dependency by setting boundaries. Practitioner autonomy has been cited previously as an enabling mechanism for the delivery of high quality patient care in the community due to staff flexibility to provide the level of support that person requires[24] [25]. However, setting clear boundaries and expectations along with utilising onward referrals and a multi-agency approach are necessary to mitigate against risks of developing a dependency[26]. Our findings align with specific guidelines by The National Institute for Health and Care

[20] Mercer, S et al. (2017). Evaluation of the Glasgow 'Deep End' Links Worker Programme. Additional unpublished data. NHS Health Scotland, Edinburgh.
[21] Liu, B., Floud, S., Pirie, K., Green, J., Peto, R., Beral, V., & Million Women Study Collaborators. (2016). Does happiness itself directly affect mortality? The prospective UK Million Women Study. *The Lancet*, *387*(10021), 874-881.
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[23] Gerst-Emerson, K., & Jayawardhana, J. (2015). Loneliness as a public health issue: the impact of loneliness on health care utilization among older adults. *American journal of public health*, *105*(5), 1013-1019.
[24] Leask, C. (2018). Integrated Neighbourhood Care Aberdeen (INCA) Test of Change: Evaluation Report. Aberdeen City Health & Social Care Partnership.
[25] Mercer, S. et al., (2017). Evaluation of the Glasgow 'Deep End' Links Worker Programme. NHS Health Scotland, Edinburgh.
[26] Wildman, J. M., Moffatt, S., Penn, L., O'Brien, N., Steer, M., & Hill, C. (2019). Link workers' perspectives on factors enabling and preventing client engagement with social prescribing. *Health & social care in the community*, *27*(4), 991-998.

Excellence that care and support received by patients should be decided through active participation of patients[27]. In addition, joint decision making has been shown to increase treatment adherence[28] and improve knowledge of options available[29]. It appears practitioner flexibility and joint decision making, in the presence of clear boundaries, contributed to improvements in mental wellbeing in this context.

The type of support provided by practitioners varied, with those skilled and confident in a particular area more likely to work with the individual to help solve challenges, whilst others would likely refer onwards to organisations for them to provide support. It is well recognised that the LP is a highly skilled and demanding role, which requires sufficient bespoke training to both prepare and retain staff[30]. One strategy to manage the breadth of knowledge required for the role and LP skillset variation was the development of specialised LPs, where those who had expert knowledge in a particular area, could be a resource for other staff if they required advice. This approach has been utilised successfully in other social prescribing models where LPs gained expertise in particular areas (known as champion leads) and the team could seek champion leads out for support if they were unsure how to support a patient[31]. Specialisation has been successful in other healthcare disciplines such as General Practitioners, and shown to be satisfactory to patients and reduce wait times[32]. Our findings suggest that practitioner specialisation may be a useful strategy to create efficiencies within the team.

[27] National Institute for Health and Care Excellence, *Patient experience in adult NHS* 366 *services: improving the experience of care for people using adult NHS services*. 367 London: NICE, 2012.
[28] 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.
[29] Stacey, D et al. (2017). Decision aids for people facing health treatment or screening decisions. *Cochrane database of syst rev.*
[30] Wildman, J. M., Moffatt, S., Penn, L., O'Brien, N., Steer, M., & Hill, C. (2019). Link workers' perspectives on factors enabling and preventing client engagement with social prescribing. *Health & social care in the community*, *27*(4), 991-998.
[31] Woodall, J., Trigwell, J., Bunyan, A. M., Raine, G., Eaton, V., Davis, J., ... & Wilkinson, S. (2018). Understanding the effectiveness and mechanisms of a social prescribing service: a mixed method analysis. *BMC health services research*, *18*(1), 604.
[32] Nocon, A., & Leese, B. (2004). The role of UK general practitioners with special clinical interests: implications for policy and service delivery. *Br J Gen Pract*, *54*(498), 50-56.

Service perspective

There appeared to be a trend towards a reduction in self-reported GP contacts from baseline to six month follow up, which would amount to the equivalent of one less GP contact per person (who engaged in the ALS service) over a 12 month period in Aberdeen City. Previous research has been mixed in relation to utilisation of primary care resources, with reported reductions in demand for General Practice ranging from 2% - 70% (average 28%)[33]. Some evidence suggests that social prescribing schemes may increase likelihood of patients utilising community assets as opposed to health systems to address their health and social care needs[34]. In contrast, attending a social prescribing service has been shown to increase patient awareness of their health and as a result expose issues requiring primary care support[35]. Subsequently, it is debated whether a reduction in healthcare utilisation is a useful measure of social prescribing effectiveness due to the complex nature of patients, and that improvements in mental health outcomes such as quality of life may be a more useful measure[36]. From our results, it appears that the ALS has not increased pressures on GPs and instead may have alleviated some strain suggesting they are effectively treating underlying conditions, and considering the pressures placed on General Practice this is of particular importance[37]. Our findings provide some evidence that General Practice pressures may be reduced by shifting appropriate, patients to the ALS for support.

Staff perspective

Practitioners reported high job satisfaction (average score 83%) and excellent within team communication (average score 96%) and team working (average score 93%), enabled by the

[33] Polley, M. J., & Pilkington, K. (2017). *A review of the evidence assessing impact of social prescribing on healthcare demand and cost implications*. University of Westminster.
[34] YHCS, S. J. (2015). NHS Leeds West Clinical Commissioning Group Patient Empowerment Project (PEP) Final Year One Report.
[35] Loftus, A. M., McCauley, F., & McCarron, M. O. (2017). Impact of social prescribing on general practice workload and polypharmacy. *Public health*, *148*, 96-101.
[36] Carnes, D., Sohanpal, R., Frostick, C., Hull, S., Mathur, R., Netuveli, G., ... & Bertotti, M. (2017). The impact of a social prescribing service on patients in primary care: a mixed methods evaluation. *BMC health services research*, *17*(1), 835.
[37] Scottish Government (2018). The GMS General Medical Services Contract in Scotland. Scottish Government, Edinburgh.

intensive induction which facilitated strong trusting relationships and the presence of compatible team qualities (including project enthusiasm, caring personalities). Bonds were maintained, despite dispersion across the city, through numerous communication methods resulting in strong peer support which helped practitioners to cope with challenging situations (such as difficult patients). This contrasts with a local community model (INCA, Integrated Neighbourhood Care Aberdeen), where colleagues were based in two separate locations (and worked in isolation frequently), who faced within team communication challenges, with contributing factors including a brief induction period, clashes in personality traits (including negative attitudes) and challenges with open and honest dialogue[38]. A second local model of care (AC@H, Acute Care at Home), where the team was co-located, described a positive team dynamic due to compatible personality traits (caring personality, open-minded), inclusive decision making and management who were seen as approachable and supportive. Similar to our findings, the positive team dynamic enabled practitioners to gain expertise from each other, they could discuss patients from multiple perspectives and care coordination was more efficient[39]. It appears that particularly when team members will not be co-located, an intensive induction process can facilitate positive team building, in addition to recruitment of those who are enthusiastic about the project and possess caring qualities. Consequently, this can allow the team to gain support opportunities from colleagues but does require extensive communication channels to maintain relationships.

What appeared to differ from local community models of care described (INCA, AC@H) was the levels of emotional strain many LPs reported, particularly those less experienced, due to the challenging patient cohort (e.g. including those who were suicidal) in which staff relied on the team support system to cope with this. In addition, approximately half of practitioners reported an unmanageable workload at times including some Senior LPs who identified that

[38] Leask, C. F., & Gilmartin, A. (2019). Implementation of a neighbourhood care model in a Scottish integrated context—views from patients.
[39] Karacaoglu, K., & Leask, C. 2019. Acute Care @ Home (AC@H) Test of Change – Evaluation Report. [Under consultation]

balancing their caseload and management responsibilities as challenging. Increased emotional strain may be partly due to the nature of the role[40], and partly due to comparably less experience in health and social care (87.5% of the team with five or less years' experience), and thus having limited exposure to managing complex needs[41 42]. Indeed LPs are at risk of burnout due to the challenging nature of patients, unmanageable workload, and being undervalued[43]. One study described, similar to our findings, LPs reporting difficulties in not becoming too emotionally involved with patients and they utilised strategies such as reinforcing boundaries, creating distance by doubling, swapping LPs and emphasising the importance of empowering behaviours[44]. In addition, and in line with our findings, effective social support from supervisors and colleagues is associated with reduced emotional exhaustion and an increase in personal accomplishment[45]. Recruitment and retention challenges are apparent locally (annual NHS staff turnover 10.3%)[46], and considering the relationships between low job satisfaction and increased turnover of staff[47], ensuring a manageable workload and an extensive support system is in place, particularly when the team consists of less experienced staff, appears to be a necessary for both retaining staff and supporting practitioner wellbeing.

LP experience building relationships within General Practice staff varied considerably across practices, with key facilitators including co-location, being present in practices and presenting LP data at practice meetings. Practitioners who were based in the same office space as other General Practice staff, as opposed to their own room, described more positive experiences of

[40] Wildman, J. M., Moffatt, S., Penn, L., O'Brien, N., Steer, M., & Hill, C. (2019). Link workers' perspectives on factors enabling and preventing client engagement with social prescribing. *Health & social care in the community*, *27*(4), 991-998.
[41] Leask, C. (2018). Integrated Neighbourhood Care Aberdeen (INCA) Test of Change: Evaluation Report. Aberdeen City Health & Social Care Partnership.
[42] Karacaoglu, K., & Leask, C. 2019. Acute Care @ Home (AC@H) Test of Change – Evaluation Report. [Under consultation]
[43] University of Westminister (2017). Making sense of prescribing. University of Westminister, London.
[44] Wildman, J. M., Moffatt, S., Penn, L., O'Brien, N., Steer, M., & Hill, C. (2019). Link workers' perspectives on factors enabling and preventing client engagement with social prescribing. *Health & social care in the community*, *27*(4), 991-998.
[45] Woodhead, E. L., Northrop, L., & Edelstein, B. (2016). Stress, social support, and burnout among long-term care nursing staff. *Journal of Applied Gerontology*, *35*(1), 84-105.
[46] NHS Grampian (2018). Workforce plan 2018-2021.
[47] Greco, P., Laschinger, H. K. S., & Wong, C. (2006). Leader empowering behaviours, staff nurse empowerment and work engagement/burnout. *Nursing Leadership*, *19*(4), 41-56.

relationship building, whilst others had to make additional efforts for interaction opportunities. Co-location has been demonstrated in other local care community models to impact on General Practice staff rapport building, with those located within practices reporting stronger partnership working[48]. Partnership working cannot be guaranteed along with co-location, but it does increase opportunity for informal interactions which can promote collaborative working[49]. Sustained co-location benefits also require a satisfactory office environment which are not overcrowded and noisy[50]. In addition, presenting positive case studies and statistics about the ALS at practice meetings facilitated practice 'buy-in'. Feedback by LPs to General Practice staff on patient progress during regular meetings or through letters has been shown previously to be an effective strategy to maintain and encourage referrals through acting as a service reminder and increasing perceived service value[51]. Our results suggest this strategy was successful General Practice staffs' both perceived knowledge of the LP role (19%) and perceived value of link working (13%) increased from baseline to six months. It appears that both co-location and providing staff feedback facilitates practice relationships and improves service perception, and when co-location is not available, additional efforts to be present in practice and provide regular positive feedback to staff is required.

Openness to the links approach varied across practices, with practitioners reporting varying attitudes to the ALS. In line with these findings, General Practice staff reported little improvement in openness to adopt links approach and confidence in signposting to community assets over the first six months of service operation. This is not surprising as this requires culture change in which substantial time is necessary for this to be demonstrated[52]. Practices that have little or no engagement with the service or adopting the links approach is a key barrier

[48] Leask, C. (2018). Integrated Neighbourhood Care Aberdeen (INCA) Test of Change: Evaluation Report. Aberdeen City Health & Social Care Partnership.
[49] Jong, J. D. (2008). *Explaining medical practice variation: Social organization and institutional mechanisms*. Utrecht: Utrecht University.
[50] Karacaoglu, K., & Leask, C. 2019. Acute Care @ Home (AC@H) Test of Change – Evaluation Report. [Under consultation]
[51] Southby, K., & Gamsu, M. (2018). Factors affecting general practice collaboration with voluntary and community sector organisations. *Health & social care in the community*, *26*(3), e360-e369.
[52] Farenden C, Mitchell C, Feast S, Verdenicci S. Community navigation in Brighton & Hove. Evaluation of a social prescribing pilot. 2015.

to implementation[53]. In contrast, when practice culture supports holistic and psychosocial approaches, GPs are more likely to refer onto a LP[54]. Culture change was established within the project team as a longer term outcome, with the first stage focusing on feasibility and acceptability of the service[55]. LPs described some General Practice staff in more affluent areas felt that the service was not required in their area and were less adopting of the approach. The service covered a broad spectrum of patients (e.g. covering all nine social determinants of health) from both deprived and affluent areas with presenting issues varying depending on practice location. Indeed, variability in challenges faced can vary depending on location within Aberdeen, with those in more deprived areas having a substantially lower total household income than those living in the most affluent areas (median household income; Cults: £60,250 SIMD 5, Middlefield: £17,442 SIMD 1)[56]. In contrast, the highest prevalence of excess alcohol consumption (e.g. more than 14 units a week) was present in the most affluent areas (30% SIMD 5, 12% SIMD 1)[57]. Framing interventions in the form of a 'gain frame message' (e.g. emphasising the benefits of uptake rather than the consequences of not utilising) has been shown to be more likely to increase engagement[58]. A useful strategy may be framing the ALS to emphasise how it can best support the challenges specific to that geographical area to increase ALS value and 'buy-in'. Adopting the links approach is a substantial, long term culture shift for practices and a tailored approach to promoting service function may be a useful strategy in increasing practice engagement.

Relationships between LPs and third sector appeared positive, with interacting organisations being generally aware of their posts, however not always clear on their specific remit. Despite

[53] Pescheny, J. V., Pappas, Y., & Randhawa, G. (2018). Facilitators and barriers of implementing and delivering social prescribing services: a systematic review. *BMC health services research*, *18*(1), 86.
[54] Friedli L, Themessl-huber M, Butchart M. Evaluation of Dundee equally well sources of support: social prescribing in Maryfield. 2012.
[55] Bowen, D. J., et al. (2009). How we design feasibility studies. *American Journal of Preventative Medicine*. 36(5), 452-457.
[56] Aberdeen City Council (2017). Household income by neighbourhood. Aberdeen City Council, Aberdeen.
[57] Bardsley et al. (2018). Scottish Health Survey 2017 Edition, volume 1, main report. National Statistics for Scottish, Scottish Government, Scotland.
[58] Gallagher, K. M., & Updegraff, J. A. (2011). Health message framing effects on attitudes, intentions, and behavior: a meta-analytic review. *Annals of behavioral medicine*, *43*(1), 101-116.

positive relationships, most were not well-developed particularly as practitioner caseload demands limited the time available to form and maintain these relationships. Having well established relationships with interacting organisations requires regular formal (e.g. meet teams, attend team meetings to raise service awareness) and informal communication methods[59] [60], and when successful, facilitates practitioner good working knowledge of community assets[61]. In addition, providing feedback on patients can provide reassurance of productive collaboration and built relationship confidence[62]. Our findings demonstrate a tension between increasing referral numbers entering the service and staff capacity to build relationships with community organisations, and dedicated time would be beneficial to practitioners in order to strengthen these relationships.

Practitioners were limited by gaps in community assets, in particular a lack of social isolation resources for young adults, and raised concerns that lack of service funding limited potential services. This led to novel solutions utilised such as bringing together socially isolated patients where no services were available. Indeed social prescribing service success is heavily influenced by appropriate funding for a range of available services to signpost/refer patients to, and without this the service may not be able to address patient's needs[63]. Previous studies have also reported service gaps as a barrier to social prescribing services, including affordable and accessible groups for those aged 40s-50s and service who accommodate drop-ins[64]. Sus-

[59] Woodall, J., Trigwell, J., Bunyan, A. M., Raine, G., Eaton, V., Davis, J., ... & Wilkinson, S. (2018). Understanding the effectiveness and mechanisms of a social prescribing service: a mixed method analysis. *BMC health services research*, *18*(1), 604.
[60] Southby, K., & Gamsu, M. (2018). Factors affecting general practice collaboration with voluntary and community sector organisations. *Health & social care in the community*, *26*(3), e360-e369.
[61] Woodall, J., Trigwell, J., Bunyan, A. M., Raine, G., Eaton, V., Davis, J., ... & Wilkinson, S. (2018). Understanding the effectiveness and mechanisms of a social prescribing service: a mixed method analysis. *BMC health services research*, *18*(1), 604.
[62] Southby, K., & Gamsu, M. (2018). Factors affecting general practice collaboration with voluntary and community sector organisations. *Health & social care in the community*, *26*(3), e360-e369.
[63] Woodall, J., Trigwell, J., Bunyan, A. M., Raine, G., Eaton, V., Davis, J., ... & Wilkinson, S. (2018). Understanding the effectiveness and mechanisms of a social prescribing service: a mixed method analysis. *BMC health services research*, *18*(1), 604.
[64] Wildman, J. M., Moffatt, S., Penn, L., O'Brien, N., Steer, M., & Hill, C. (2019). Link workers' perspectives on factors enabling and preventing client engagement with social prescribing. *Health & social care in the community*, *27*(4), 991-998.

tainability concerns have also been raised that social prescribing could overburden small organisations with increasing referrals[65]. A wide range of community assets are critical for social prescribing success, and gaps should be identified to order to promote funding or develop innovative solutions to address these.

Systems perspective

Practitioners reported satisfaction with IT systems they used (average score 73%), which reflects findings that systems were made bespoke to service requirements and this allowed appropriate data to be collected. However a key concern was that the LP system did not communicate with the General Practice system, therefore practitioners did not have access to changes in patient circumstances (e.g. hospital admission, deceased). Issues in sharing information across healthcare systems has been reported previously locally[66], and can limited care coordination if effective health information exchanges are not utilised (including electronic summary transferred, information sharing incentives)[67]. In the absence of communicating IT systems, solutions should be sought out to improve patient communication between LPs and General Practice staff.

Strengths and limitations

A key strength of this evaluation was the ability to build a bespoke caseload management and data extraction system prior to service go live. This contrasts with previous projects whereby the data collection was limited by using pre-existing systems that were not fit for purpose[68]. The rigorous data the system enabled collection of, increased confidence in the ability to draw more definite conclusions about this new service. This partially demonstrates the effective

[65] South, J., Higgins, T. J., Woodall, J., & White, S. M. (2008). Can social prescribing provide the missing link?. *Primary Health Care Research & Development*, *9*(4), 310-318.
[66] Karacaoglu, K., & Leask, C. 2019. Acute Care @ Home (AC@H) Test of Change – Evaluation Report. [Under consultation]
[67] Graetz, I., Reed, M. E., Shortell, S. M., Rundall, T. G., Bellows, J., & Hsu, J. (2014). The next step towards making use meaningful: electronic information exchange and care coordination across clinicians and delivery sites. *Medical care*, *52*(12), 1037.
[68] Leask, C. (2018). Integrated Neighbourhood Care Aberdeen (INCA) Test of Change: Evaluation Report. Aberdeen City Health & Social Care Partnership.

collaboration between ACHSCP and the Third Sector in the development and implementation of this service.

There are some important limitations to consider in this evaluation. From a patient perspective, feedback on experience with the ALS was not collected, however this was not deemed appropriate due to the complexity and vulnerable nature of the majority of the caseload. Despite this, statistically significant improvements in patient outcomes suggests patients are likely to be satisfied with the service. Results did not explore whether specific cohorts of patients required particular levels of LP support, if outcome improvements where more apparent for certain groups of individuals, or require specific levels of input from LPs. At six months of service operation, the caseload size was too small to carry out this analysis, however this could be explored at 12 months. In addition, future research should explore whether these benefits are sustained longer term (e.g. at 12 month follow-up). Lastly, patient experience with signposted/referred services was not explored (e.g. did they attend, barriers and facilitators to attending, their experience with the service and what key components helped them the most), which should be considered in future research.

From a service perspective, the relationship between the quantity and frequency of LP contacts and type/number of issues patient's presented with was not explored. In addition, the impact of LPs on primary care workload (particularly GP workload) was not measured. However, self-reported GP contacts was collected as a proxy measure in this evaluation. These outcomes all required a larger caseload to be explored and should be considered at 12 month follow-up. From a staff perspective, barriers and facilitators to embedding the links approach were not gained from a General Practice staff perspective due to limited capacity.

Conclusions and recommendations

Significant improvements in the patient outcomes, happiness, loneliness and social isolation, were demonstrated at six month follow-up suggesting patients were satisfied with the service. Practitioner support flexibility and joint decision making with patients, in the presence of clear boundaries, appears to have contributed to improved outcomes. These mechanisms

should remain an integral system component of the social prescribing service when considering future scaling. In addition, the type of support provided by practitioners varied depending on LP confidence and skillset, and practitioner specialisation may be an effective solution in creating within team efficiencies.

A trend towards a reduction in GP contacts was demonstrated, however this did not reach statistical significance. Reduction in healthcare utilisation may not always a useful measure for social prescribing schemes, however as GP contacts did not increase, our findings provide some evidence that General Practice pressures may be reduced by shifting appropriate patients to social prescribing services for support.

From a staff perspective, practitioners described excellent communication and extensive social support system within the team, facilitated by an intensive induction process, LP project enthusiasm and caring personalities, whilst maintained through extensive communication channels. In addition, as practitioners are working with challenging and complex patients which can be emotionally challenging, an extensive support system is necessary for a LP well-being and a sustainable workforce.

Practitioner relationships with General Practice staff appeared to be facilitated by co-location, having a presence in practice and the provision of positive feedback about patient progress. Where co-location is not possible, additional efforts (including to be present in practice, service framing and providing positive service feedback) appear beneficial to relationship building and adoption of the links approach.

Relationships with community organisations were described as positive but underdeveloped (e.g. primarily through email communication) due to practitioners demanding workloads. Providing LPs with increased opportunity to interact with organisations may strengthen relationships. A wide range of community assets are required for social prescribing service success, therefore service gaps should be identified and innovative solutions sought out to address these.

Acknowledgments

The following are acknowledged for their contribution to this report: The Aberdeen Links Service team, General Practice staff and patients for engaging in the evaluation process and providing feedback on the service; John Stoner from SAMH for carried out data extraction; Jenny McCann (Transformation Programme Manager and previously Community Links Development Manager), Cliff Watt (Community Business Manager, SAMH) and Cat Anderson (Service Manager, SAMH) for leading the implementation of this project.

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Appendix

Appendix A. Patient outcome questionnaire

About you

Q1 Assessment

Initial assessment ..... ☐ 6 month assessment.. ☐ 12 month assessment ☐

Q2 Employment status

Employed Full Time ..... ☐	Employed Part Time ..... ☐
Full Time Education ..... ☐	Looking after home/family ..... ☐
Retired ..... ☐	Self-employed ..... ☐
Supported employment ..... ☐	Transitional employment ..... ☐
Unemployed less than 6 months ..... ☐	Unemployed 7 – 12 months ..... ☐
Unemployed 13 – 24 months ..... ☐	Unemployed 25 - 36 months ..... ☐
Unemployed more than 36 months ..... ☐	Voluntary work (unpaid) ..... ☐

Q3 Ethnicity

Prefer not to say ..... ☐	Not Known ..... ☐
Any mixed background ..... ☐	Asian Bangladeshi ..... ☐
Asian Indian ..... ☐	Asian Pakistani ..... ☐
Any other Asian background ..... ☐	Black African ..... ☐
Black Caribbean ..... ☐	Any other Black background ..... ☐
Chinese ..... ☐	White British ..... ☐
White Irish ..... ☐	White Other British ..... ☐
White Scottish ..... ☐	Any other White background ..... ☐
Other ethnic background ..... ☐	

Q4 Do you have a Major Health or Disability Issue? (*tick all that apply*)

Chronic pain ..... ☐	Hearing impairment ..... ☐
Learning difficulties ..... ☐	Longstanding illness ..... ☐
Memory loss ..... ☐	Mental health ..... ☐
None identified ..... ☐	Physical/Mobility Impairment ..... ☐
Visual Impairment ..... ☐	Other ..... ☐

Q5 **How would you rate your quality of life during the past 4 weeks?**
"Quality of life is made up of many different things, such as overall life satisfaction, physical and mental wellbeing, social support, education, employment and safety"

Very poor ☐	Poor ☐
Neither good or poor ☐	Good ☐
Very good ☐	

Q6 **In general, what sort of person do you consider yourself?**

Very unhappy ☐	Unhappy ☐
Neither happy or unhappy ☐	Happy ☐
Very happy ☐	

Q7 **To what extent do you agree with the following statements?**

	Stongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
"I am content with my friendships and relationships"	☐	☐	☐	☐	☐
"I have enough people I feel comfortable asking for help at any time"	☐	☐	☐	☐	☐
"My relationships are as satisfying as I would want them to be"	☐	☐	☐	☐	☐

Think of up to **5 important people in your life**. For each, tell me if they are paid (such as a health or social care professional) or not paid (such as a friend or family member) to be in your life, and the number of contacts you've had with them **in the last 4 weeks**:

Q8	**Important Person 1**	
	Paid or Unpaid	
	Number of face-to-face contacts	
	Number of virtual contacts *(e.g. over the phone / internet)*	
Q9	**Important Person 2**	
	Paid or Unpaid	
	Number of face-to-face contacts	
	Number of virtual contacts *(e.g. over the phone / internet)*	
Q10	**Important Person 3**	
	Paid or Unpaid	
	Number of face-to-face contacts	
	Number of virtual contacts *(e.g. over the phone / internet)*	

Q11	**Important Person 4**	
	Paid or Unpaid	
	Number of face-to-face contacts	
	Number of virtual contacts *(e.g. over the phone / internet)*	

Q12	**Important Person 5**	
	Paid or Unpaid	
	Number of face-to-face contacts	
	Number of virtual contacts *(e.g. over the phone / internet)*	

Q13	**How many contacts have you had with your GP in the last 4 weeks that were:**	
	in the GP Practice?	
	over the phone?	
	home visits?	
	other types of contact?	

Q14	**What was the total number of contacts you had with your GP in the last 4 weeks?**	

Q15a **Do you regularly participate in activities at different types of organisations? *(tick all that apply)***

- No, I do not participate in any group activities. ☐
- Faith-based activities ☐
- Interest groups (e.g. art groups, music groups or evening classes) ☐
- Social Clubs (e.g. rotary club, women's institute, working men's clubs etc) ☐
- Physical activity Groups (e.g. sports club, gym or exercise classes) ☐
- Volunteering ☐
- Other ☐

Q15b **If "Other" please give details of the group/s?**

Q15c	Please detail how often have you participated in each of these groups in the last 4 weeks?	
	Group 1 Name	
	Number of contacts in last 4 weeks	
	Group 2 Name	
	Number of contacts in last 4 weeks	
	Group 3 Name	
	Number of contacts in last 4 weeks	
	Group 4 Name	
	Number of contacts in last 4 weeks	

Q16 **Do you have any other comments?**

Thank you for taking the time to complete this questionnaire

Appendix B. LP goal setting template (baseline)

Link Practitioners Evaluation - Goal Setting

Part of our anticipated staff benefits to the Link Working project is fulfilling your job aspirations. To understand whether we achieve this or not, we will be doing a goal setting exercise with each of you.

There are two types of goals that we would like you to think about: 1) **Professional goals** (for example, your training or delivery of care) and 2) **Personal goals** (for example, your traits and characteristics). For each of these, think about a goal you would like to achieve within the next 6 months and another goal you would like to achieve within the next 12 months. Think about the following when setting your goals:

1) Specific (not ambiguous)
2) Measurable (we can track the changes)
3) Achievable (i.e. it isn't impossible!)
4) Relevant (it's appropriate to your work)
5) Time-bound (achievable within the next 6/12 months)

Over the page, please complete the template provided.

Full name: _____

Type of goal	**How will this benefit you?** (eg. Better at your job, more confident etc).	**How long do you think it will take you to complete this?** (eg. 2 weeks / 3 months)	**What do you need to complete this?** (eg. Support, training, relationships etc.)	**What might stop you completing this?** (eg. Lack of time, not important enough)
Professional goals ***(for example, your training, supervisory support, your delivery of care)***				
My goal for the next 6 months is …				
My goal for the next 12 months is …				
Personal goals ***(for example, your traits and characteristics)***				
My goal for the next 6 months is …				
My goal for the next 12 months is …				

Appendix C. LP goal setting template (six months)

Link Practitioners Evaluation - Goal Setting Follow-up

Part of our anticipated staff benefits to the Link Working project is fulfilling your job aspirations. To understand whether this has been achieved or not, we will be reviewing the goal setting exercise each of you completed 6 months ago.

In the previous session you identified **Professional goals** (for example, your training or delivery of care) and **Personal goals** (for example, your traits and characteristics) that you would have liked to achieve over the next 6 and 12 months. We would now like to see if you have reached the goals you set out, if anything has helped you or stopped you achieving your goals and what impact achieving any goals has had.

Over the page, please complete the template provided.

Full name: _____

Goals that I have made	**Have you achieved this goal?** (delete all that are inappropriate)	**If fully/partially, what helped you achieve this goal?**	**If not all/partially, what stopped you fully achieving this goal?**	**If fully/partially, what impact had this had?**
<u>Professional goals</u> ***(for example, your training, supervisory support, your delivery of care)***				
My goal for the next 6 months was … •	Fully Partially Not at all			
<u>Personal goals</u> ***(for example, your traits and characteristics)***				
My goal for the next 6 months was … •	Fully Partially Not at all			

ID: (Research team use only)
_____

Appendix D. Link Practitioner satisfaction questionnaire

How many years' experience do you have working in either health or social care (circle one option)?

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

To what extent do you agree with the following statements (tick one box only):

Construct	**Question**	**Strongly disagree**	**Disa-gree**	**Neither agree / disagree**	**Agree**	**Strongly agree**
Supported - SAMH	*I feel supported by SAMH management staff*					
Supported – General Practice	*I feel supported by General Practice staff*					
Training	*I am provided with all neces-sary training to do my job*					
Develop-ment	*I have adequate opportuni-ties to develop my profes-sional skills*					
Communica-tion – Link Practitioners	*I feel I can easily communi-cate with other Link Practi-tioners*					
Communica-tion – Gen-eral Practice	*I feel I can easily communi-cate with colleagues from all levels of General Practice*					
Workload	*The amount of work I am ex-pected to finish each week is reasonable*					
Progression	*I am satisfied with my chances for promotion*					
Recognition	*I am appropriately recog-nised when I perform well at my regular work duties*					
Teamwork – Link Practi-tioners	*The Link Practitioners and I work well together*					
Teamwork – General Practice	*My colleagues in General Practice and I work well to-gether*					
Systems	*The IT systems I use to do my job are fit for purpose*					

Satisfaction	*How would you rate a career as a Link Practitioner on a scale of 1 (the worst) to 10 (the best) (circle 1 option)?*	1 2 3 4 5 6 7 8 9 10 Worst ……..best

Any additional comments?

Thank you for taking the time to complete this questionnaire

Appendix E. LP interview topic guide

Introductory Questions

1. Tell me about your experience of working as a Link Practitioner?
2. How have you found working as part of a newly formed team?
3. Tell me about the training you have received for this job?
    a. Prompts: during induction and ongoing training. Have these met your needs?
4. Tell me about the caseload of patients that you have worked with?
    a. Prompts: numbers; type
5. How have you got on interacting with colleagues outside of the team?
    a. Prompts: General Practice; Third sector
6. How have you got on embedding a links approach within your General Practice?

Positives of working in this way/Enablers

7. What has worked well in the Aberdeen Links Service?
    a. Prompts: team; within practice; working with individuals
8. Was there anything that helped to make this new way of working successful?
9. What have you enjoyed most about this way of working?
10. Were these positives common for all Link Practitioners?

Negatives of working in this way/Barriers

11. What have been the (biggest) challenges to this new way of working?
12. How did you try and overcome these? Was this successful?
    a. Prompts: Has this learning be shared? If no, why not?
13. Were there any barriers that stopped you overcoming these challenges?
14. Did all Link Practitioners face different types of challenges?
    a. Prompts: If so, what were they? Why were there differences?

Future considerations

15. If a new Link Practitioner started, what advice would you give them coming into this new way of working?
16. In what way do you think the Aberdeen Links Service could be improved in Aberdeen?
17. Is there anything else you would like to tell me about your experience working as a Link Practitioner

Check for updates

Appendix C

Journal of Research in Nursing
0(0) 1–14
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Evaluation of an unscheduled care model delivered by advanced nurse practitioners in a primary-care setting

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Abstract

Background: Considering new models of delivery may help reduce increasing pressures on primary care. One potentially viable solution is utilising Advanced Practitioners to deliver unscheduled afternoon visits otherwise undertaken by a General Practitioner (GP).

Aims: Evaluate the feasibility of utilising an Advanced Nurse Practitioner (ANP) to deliver unscheduled home visits on behalf of GPs in a primary care setting.

Methods: Following a telephone request from patients, ANPs conducted unscheduled home visits on behalf of GPs over a six-month period. Service-level data collected included patient-facing time and outcome of visits. Practice staff and ANPs participated in mind-mapping sessions to explore perceptions of the service.

Results: There were 239 accepted referrals (total visiting time 106.55 hours). The most common outcomes for visits were 'medication and worsening statement given' (107 cases) and 'self-care advice' (47 cases). GPs were very satisfied with the service (average score 90%), reporting reductions in stress and capacity improvements. Given the low referral rejection rate, ANPs discussed the potential to increase the number of practices able to access this model, in addition to the possibility of utilising other practitioners (such as paramedics or physiotherapists) to deliver the same service.

Conclusions: It appears delivering unscheduled care provision using an ANP is feasible and acceptable to GPs.

Keywords

advanced and specialist practice, community, evaluation research, home care, innovation and improvement

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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 and 2030 (United Nations, 2015). This is particularly resonant in Scotland, with more recent estimates showing increases in the 45–64 and over-75 age groups (10% and 16% respectively) over the last decade (National Records of Scotland, 2018). The association between an ageing society and disease prevalence is well established, with one in two Scots having a minimum of one morbidity by the age of 50 (Barnett et al., 2012). 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 and 64 leaving General Practice doubled from 2005 to 2014 (Baird et al., 2016). Therefore, there is a need to test new ways of delivering primary care to address these challenges.

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 (Scottish Government, 2018). 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 increasing their capacity to conduct other tasks within General Practice, ultimately reducing the pressures on primary care (Scottish School of Primary Care, 2018). As a result, it may be valuable to consider other approaches to delivering unscheduled care in order to understand the impact these may have in a localised context.

This paper 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. Prior to the commencement of this service, GPs would typically visit patients themselves. Here however, patients would be visited by an Advanced Nurse Practitioner (ANP) based within G-MED, with a driver transporting the ANP to patients' homes. The ANPs were highly experienced professionals educated to Masters' Level in Advanced Practice. All had a minimum of 10 years' experience before joining G-MED through a mix of both community and acute backgrounds. As clinical leaders, they could prescribe medications in addition to managing referrals, admissions and discharge of appropriate cases. A recent systematic review found that ANPs demonstrate equal or better outcomes than Physicians for indicators including cost, patient satisfaction and physiological measures (Swan et al., 2015). Following the home visit, the ANP would contact the GP if required (for example in case of a hospital admission) and complete all necessary caseload documentation (described in the service descriptive data section).

This service was available to seven General Practices within the West Locality of Aberdeen City. The rationale for this was twofold: (a) it contains a higher proportion of

elderly patients compared to the other localities within the city; and (b) it has a large geographical catchment area (approximately 140 square miles), meaning home visits would require a considerable amount of travel time to complete. Inclusion criteria were patients unable to attend the surgery; home visit was requested between 1300–1730 hours; patient's clinical condition was suitable to be managed by an ANP; and the patient agreed to being seen by an ANP. 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 referring practices; 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 by the authorship team using Microsoft Excel. Analysis included number of referrals per practice, average and total patient-facing time and financial savings associated with GP time.

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 within healthcare service settings to provide a pragmatic yet detailed approach to data collection (Burgess-Allen and Owen-Smith, 2010).

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 facilitated by the lead author, with the second author 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.

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, three 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 the authorship team. Once the session was

Table 1. West Locality General Practice characteristics.

Practice	Practice population	Number of GPs
1	10,509	9
2	1694	4
3	7148	5
4	10,092	12
5	6830	6
6	5829	5
7	8020	6
Average	7160	6.7

completed, the topics were refined and synthesised into key themes and restructured into a refined mind-map.

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 (1694–10,509) and number of GPs (4–12) vary widely across the seven practices.

Visits overview

In the six-month period from 7 November 2017 to 7 May 2018, 241 visits were referred to the service, with 239 accepted. However, as rejections were only documented if GPs referred after discussion with G-MED colleagues who were 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.

GP practice usage of service

Figure 1 shows the number of visits per 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 had 68 and 7 referrals respectively. It is important to note that November and May were incomplete months, thus skewing the data.

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, with large variance between the minimum (8 minutes) and the maximum

Table 2. Demographic characteristics of patients visited ($N = 239$).

Characteristic	N
Age, mean (range)	79 years (24–97)
Female (%)	156 (65)
Practice 1 referrals	42
Practice 2 referrals	7
Practice 3 referrals	35
Practice 4 referrals	68
Practice 5 referrals	49
Practice 6 referrals	13
Practice 7 referrals	24

Note: one referral practice not reported.

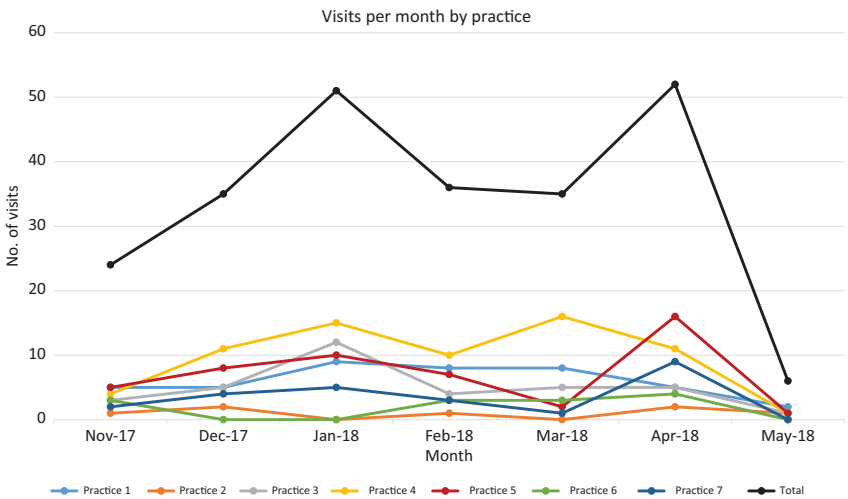

Figure 1. Overview of visits per month by practice.

(113 minutes) length of visit. Longer visits were typically associated with patients being admitted to hospital.

Outcome of visits

Figure 2 shows the outcome of ANP visits. Providing 'medication and worsening statement given (WSG)' was attributable for almost half of the visits (107 cases). 'Self-care advice' was the outcome for 47 cases, with 28 cases resulting in a hospital admission.

GP experience

To ensure anonymity, each practice was assigned a unique practice number. The attendees, service satisfaction scores and whether participants would recommend the service, are shown

Table 3. Time allocation of visits and referrals.

Characteristic	Time (minutes)
Visit time	
Mean (SD)	27 (14.2)
Median	24
Minimum	8
Maximum	113
Total visiting time (hours)	106.55
Time from G-MED referral to ANP arrival	
Mean (SD)	43 (32.8)
Median	32
Minimum	8
Maximum	224

Note: 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.

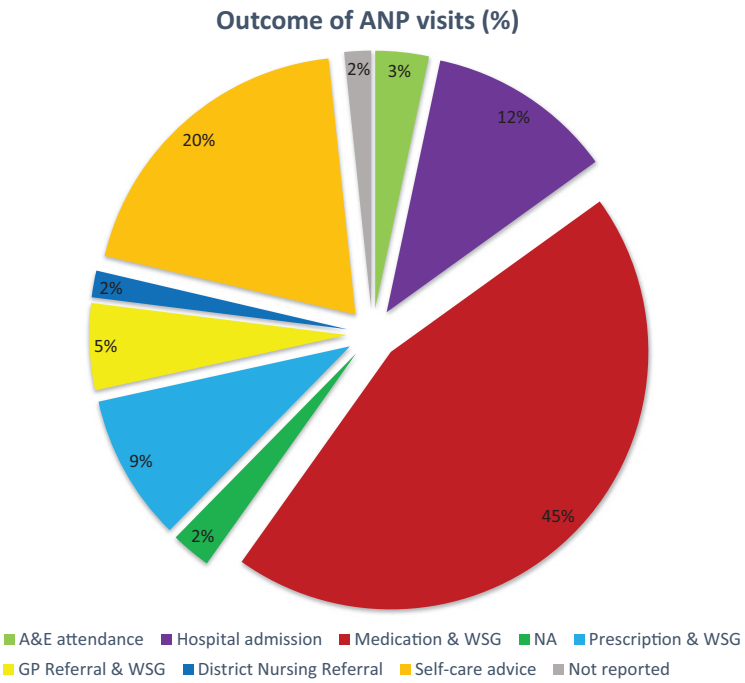

Figure 2. Outcome of ANP visit.

in Table 4. In total, five out of seven practices attended mind-mapping sessions, with one practice providing feedback electronically and one practice declining to participate. Overall, satisfaction was 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 4. Attendees, usage and satisfaction scores during mind-mapping process.

Practice number	Mind-mapping attendees	Satisfaction score	Recommend? (Y/N)
1	1 × GP	8	Y
2	1 × GP	10	Y
3	1 × GP 1 x Practice Manager	7.5	Y (with changes)
4	n/a	10	Y
5	1 × GP	9.5	Y
6	1 × GP	9	Y
7	–	–	–
Average		9	

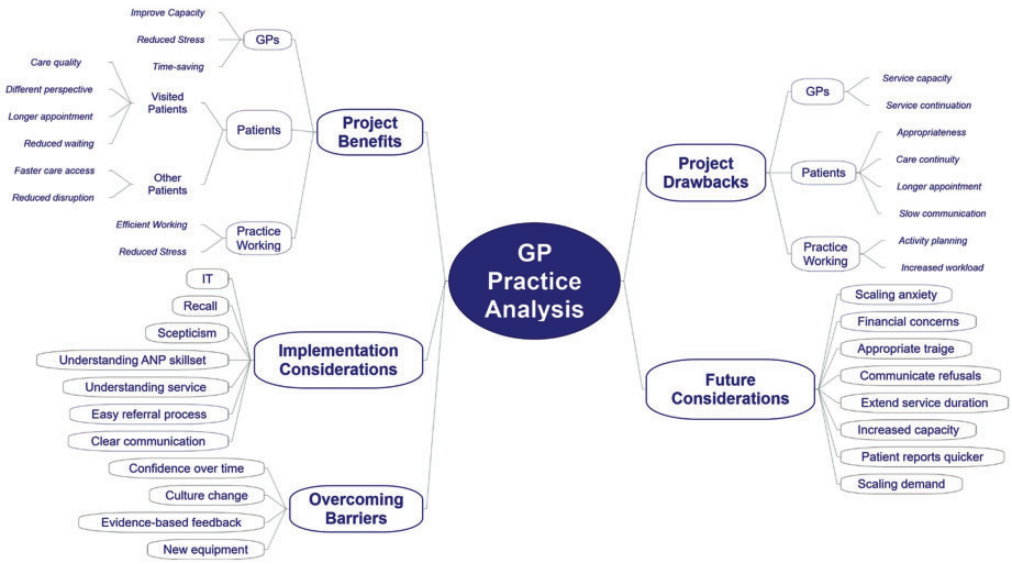

Figure 3. Synthesised mind-map of key practice themes.

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 referenced 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 two 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).

Implementation considerations. 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 in 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: (a) a feeling that scaling the service city-wide could dilute the effectiveness of the service that they receive; (b) 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 is shown in Figure 4.

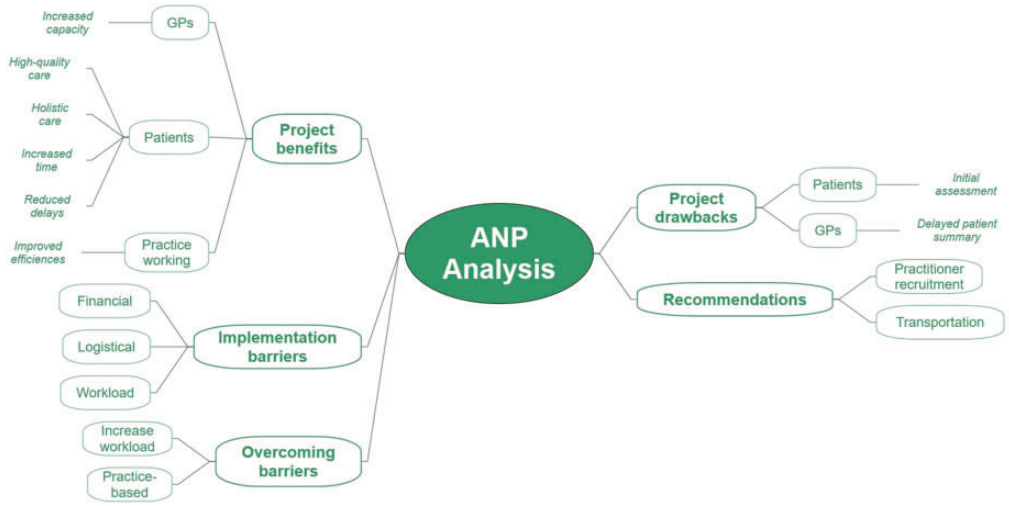

Figure 4. Synthesised mind-map of key ANP themes.

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: (a) most of the patients were new to the ANPs, 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; (b) 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 considerations. Whilst there were limited barriers identified to implementing this test of change, the attendees did highlight three areas needing adaption 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).

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).

Discussion

This report describes the evaluation of a new unscheduled care service delivered through an ANP resource. Given the increasing pressures on primary care, it is important to consider how innovative models of service delivery can be utilised to reduce this pressure. Over a six-month period, ANPs completed a total of 239 visits on behalf of GPs, saving almost 107 hours of their time in the process.

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 (Baird et al., 2016).

The skillset and knowledge of the ANPs was regularly advocated by GPs. This is reinforced by a recent systematic review showing that substituting Physicians for nurse-led care may have positive effects on mortality, patient satisfaction and improved disease-specific outcomes (Laurant et al., 2018). However, GPs were also mindful that, depending on the reasons for referral, a variety of different professionals could also be incorporated into this model, including Physiotherapists and Occupational Therapists. Such a multi-disciplinary team would dovetail with other initiatives including hospital-in-the-home models that utilise a variety of professionals to care for individuals in a homely setting (Lee et al., 2017).

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 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.

There are some limitations to consider. First, the mind-mapping strategy implemented is unlikely to have captured all experiences as accurately as other methods may have, for example audio recorded interviews and subsequent thematic analysis. Although desirable, time and resource constraints did not allow this level of detail to be captured. Despite this, the consistent reporting from clinicians of the high levels of satisfaction of this service cannot be overlooked. Further, this study did not conclude whether this new model is more cost-effective than usual care, however it should be noted that this was not the primary aim.

Conclusion

It appears that it is feasible to use ANPs to conduct unscheduled home visits instead of a GP. Future work should look to embed this model on a larger scale and determine its cost-effectiveness compared to the traditional model.

Key points for policy, practice and/or research

- It is feasible to use ANPs to conduct unscheduled visits instead of a GP.
- Utilising ANPs is a practical solution to reduce the pressure on primary care.
- GPs report reduced stress and improved capacity as a result of having unscheduled visits met.

Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Ethics

As the data collection methods utilised fall under the categorisation of a service evaluation, ethical approval was not required.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

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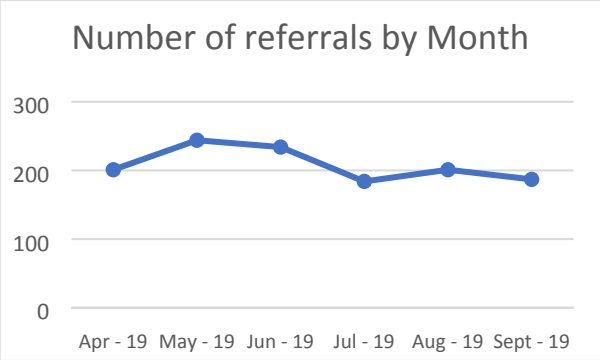
Calum Leask obtained a BSc (Hons) in Sport and Physical Activity from the University of Strathclyde 2013, followed by a PhD in Public Health from Glasgow Caledonian University in 2016. Currently he works as the Research & Evaluation Manager for Aberdeen City Health and Social Care Partnership and leads the evaluation of new integrated models of health and social care being piloted in the region. Dr Leask also worked as a Researcher and Lecturer for Glasgow Caledonian University and has taught on a variety of programmes, from undergraduate Physiotherapy to Postgraduate Master's in Research Methods. His current research areas of interest include the co-creation of public health interventions and he has delivered training nationally to colleagues looking to implement this approach. Previously he has published both qualitative and quantitative research predominantly in the field of active ageing, including co-authoring a chapter in the recently published *Sedentary Behaviour and Epidemiology*.

Heather Tennant joined the Aberdeen City Health and Social Care Partnership as Transformation Programme Manager in September 2018. Heather graduated from Robert Gordon University with a Degree in Adult Nursing in 1997, she specialised in critical care nursing and occupied various specialist nurse roles. Following a change of direction in her career Heather undertook further study and attained an MSc in Health Improvement and Health Promotion from Robert Gordon University in 2014. Heather has been leading a number of health and social care transformation and strategic implementation projects over the last six years.

Appendix F: Aberdeen Links Quarters 1 and 2 2019/20 Report

Fig 1: Aberdeen Links Referral Numbers for Q1 and Q2



Referrals by quarter for 2019/20	
Q1	679
Q2	572
Q3	
Q4	
TOTAL	1251

Fig 2: Referrals Split by Gender for Q1 and Q2

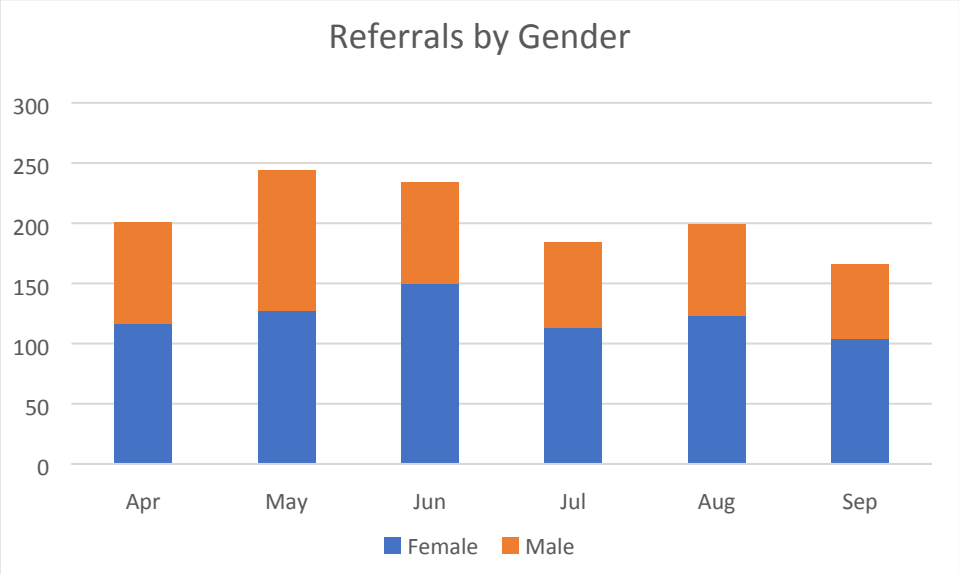
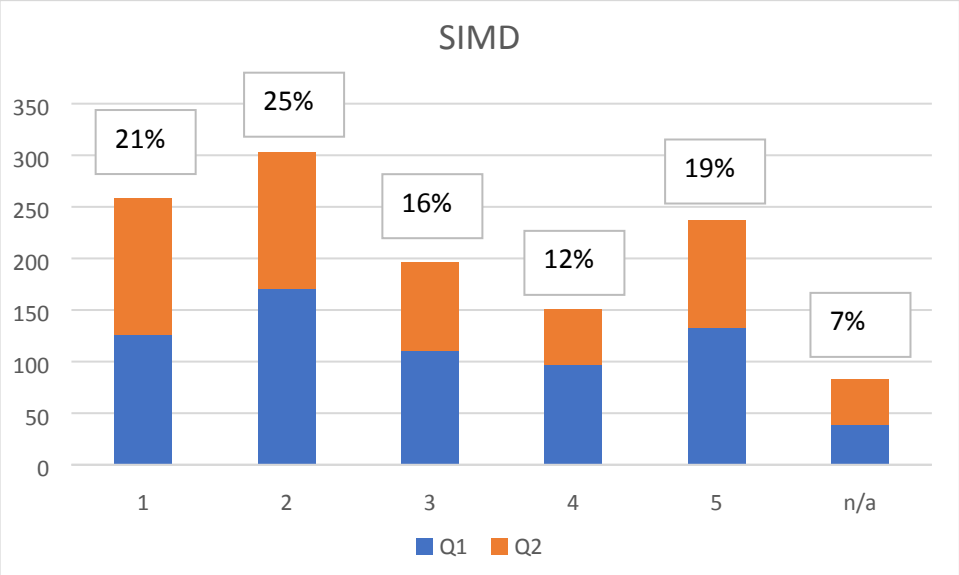


Fig 3: Referrals split by Age for Q1 and Q2

Age	Q1	Q2		Q3	Q4	TOTAL
<24	57	65				122
25-44	215	196				411
45-64	229	171				400
65+	178	140				318
Average	51	51				51
Min	16	16				16
Max	96	98				98

Fig. 4: Referrals Split by SIMD* Quintiles for Q1 and Q2 Number of referrals



** 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.

Fig. 5: Primary Reason for Referral Broken by Q1 and Q2

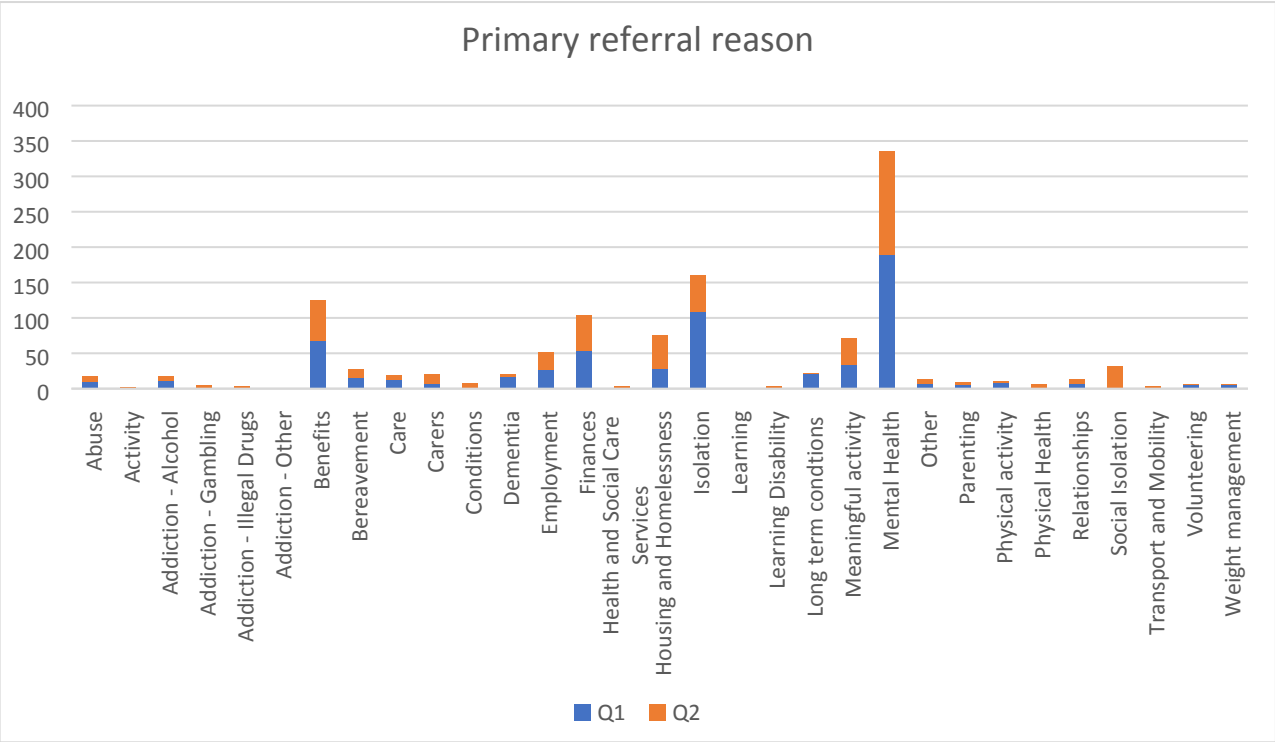
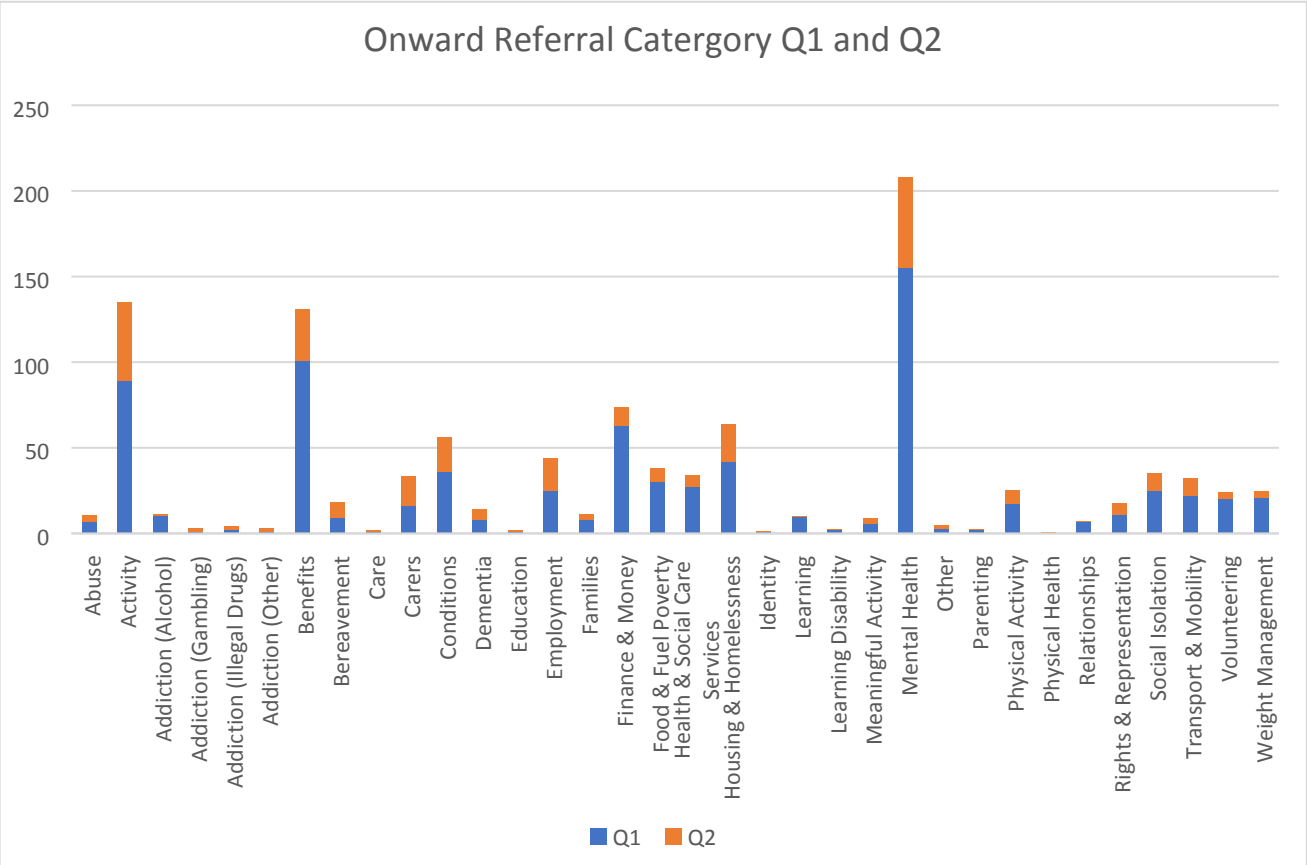


Fig. 6: Onward Referrals by Category for Q1 and Q2



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