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Aberdeen City Health & Social Care Partnership
A caring partnership

To: Members of the Integration Joint Board

Town House,
ABERDEEN 24 November 2020

INTEGRATION JOINT BOARD

The Members of the **INTEGRATION JOINT BOARD** are requested to meet in **Virtual - Remote Meeting on TUESDAY, 1 DECEMBER 2020 at 10.00 am.**

FRASER BELL
CHIEF OFFICER - GOVERNANCE

B U S I N E S S

1 Welcome from the Chair

DECLARATIONS OF INTEREST

2 Members are requested to intimate any declarations of interest (Pages 5 - 6)

DETERMINATION OF EXEMPT BUSINESS

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

STANDING ITEMS

4 Minute of Board Meeting of 28 October 2020 (Pages 7 - 14)

5 Draft Minute of Risk, Audit and Performance Systems Committee of 3 November 2020 (Pages 15 - 18)

6 Draft Minute of Clinical and Care Governance Committee of 24 November 2020

This minute will not be prepared so will require a Chair Overview then presented at next IJB

7 Business Planner (Pages 19 - 20)

GOVERNANCE

8 Chief Officers Report - HSCP.20.066 (Pages 21 - 28)

9 Strategic Risk Register and Revised Risk Appetite Statement - HSCP.20.067 (Pages 29 - 62)

PERFORMANCE AND FINANCE

10 Update on Effective Working in Localities - HSCP.20.060 (Pages 63 - 102)

11 Mental Health Delivery Plan (Annual Report) - HSCP.20.069 (Pages 103 - 116)

STRATEGY

12 2C Remodelling Business Case - HSCP.20.049 (Pages 117 - 172)

Please note that Appendices C and D to this report are Exempt from publication.

13 Alcohol Drug Partnership Update - HSCP.20.068 (Pages 173 - 216)

TRANSFORMATION

14 Grampian-wide Mental Health and Learning Disability Services (Update Report) - HSCP.20.065 (Pages 217 - 230)

14.1 Transformation - Decisions Required: Action 15 (HMPYOI MH Support BC) - HSCP.20.050 (Pages 231 - 268)

ITEMS THE BOARD MAY WISH TO CONSIDER IN PRIVATE

15 2C Remodelling Business Case - HSCP.20.049 - Exempt Appendices (Pages 269 - 294)

DATE OF NEXT MEETING

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

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

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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
A caring partnership

ABERDEEN, 28 October 2020. Minute of Meeting of the INTEGRATION JOINT BOARD.

Present:-	Councillor Sarah Duncan, Chair; Luan Grugeon, Vice Chair; and Kim Cruttenden, Jim Currie, Councillor Lesley Dunbar, Dr Howard Gemmell, Maggie Hepburn, Dr Caroline Howarth, Sandra MacLeod, Shona McFarlane, Alison Murray, Graeme Simpson, Alex Stephen, John Tomlinson and Councillor John Cooke (as substitute for Councillor Gill Al-Samarai).
Also in attendance:-	Adam Coldwells, (NHS Grampian), John Forsyth (Solicitor) and Derek Jamieson (Clerk).
Apologies:-	Mike Adams, Councillor Gill Al-Samarai, Councillor Philip Bell, Jenny Gibb, Alan Gray and Chris Littlejohn

The agenda, reports and meeting recording 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.

INTRODUCTION

1. The Chair welcomed all to the meeting and intimated apologies for the late circulation of the Finance Report – HSCP.20.057 at Article 13 as this was unavoidable due to the constantly moving landscape around the pandemic.

DECLARATIONS OF INTEREST

2. There were no declarations of interest.

DETERMINATION OF EXEMPT BUSINESS

3. The Chair intimated that whilst there was no Exempt Business, Appendix 1 within Article 13, Commissioned Day Services and Day Activities - HSCP.20.045, was restricted and that if Members were minded to discuss or ask questions relating to the appendix, that it would be conducted in private.

MINUTE OF BOARD MEETING OF 8 SEPTEMBER 2020

4. The Board had before it the minute of its meeting of 8 September 2020.

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

MINUTE OF BOARD MEETING OF 2 OCTOBER 2020

5. The Board had before it the minute of its meeting of 2 October 2020.

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

DRAFT MINUTE OF RISK, AUDIT AND PERFORMANCE SYSTEMS COMMITTEE OF 23 SEPTEMBER 2020

6. The Board had before it the draft minute of the meeting of the Risk, Audit and Performance Committee (RAPC) on 23 September 2020.

Members heard from the Chair, RAPC who provided an overview of the meeting and indicated that the Committee had now caught up with the backlog of outstanding business.

The Board resolved :-
to note the minute.

DRAFT MINUTE OF CLINICAL AND CARE GOVERNANCE COMMITTEE OF 22 SEPTEMBER 2020

7. The Board had before it the draft minute of the meeting of the Clinical Care and Governance Committee (CCGC) of 22 September 2020.

Members heard from the Chair, CCGC who advised that the Committee had requested that a verbal report relating to the immunisation programme be provided to the next meeting of the IJB.

The Chair, IJB, indicated that this would follow in the Chief Officer's Report at Article 9.

The Board resolved :-
to note the minute.

INTEGRATION JOINT BOARD
28 October 2020

BUSINESS PLANNER

8. The Board had before it the Business Planner.

The Chief Finance Officer (CFO), ACHSCP advised Members that the planner contained several new items and that all reports for this meeting were as indicated. The CFO suggested that such was the volume of intended reports for the December 2020 meeting, Members may wish to approve an additional meeting date in January 2021 to spread the load of reporting.

The Board resolved :-
(i) to note the business planner;
(ii) to direct the Chief Officer to even the load of reports intended for December 2020; and
(iii) to approve an additional meeting date in January 2021 to balance the reporting workload.

CHIEF OFFICER'S REPORT - HSCP.20.046

9. The Board had before it the report from the Chief Officer, ACHSCP who provided additional commentary to the matters contained within the report.

The Chief Officer highlighted the continuing flu immunisation programme and that regular updates continued to be shared with members of the Board and Elected Members of Aberdeen City Council (ACC).

The Board resolved :-
to note the content of the report.

MEETING DATES 2021/2022 - HSCP.20.044

10. The Board had before it the report from the Chief Officer, ACHSCP, which proposed meeting dates for 2021/2022 for the Integration Joint Board (IJB), Risk Audit and Performance Committee (RAPC) and Clinical and Care Governance Committee (CCGC).

The Board heard that the proposed dates had been agreed with the respective Chairs and that planning had taken place to avoid known other business of the Members, whether Aberdeen City Council or NHS Grampian.

The Chair reminded Members of the complexity in arranging these dates given the volume of preparatory work and meetings that occurred before the actual meeting date.

INTEGRATION JOINT BOARD
28 October 2020

The report recommended :-
that the Board -
(a) review and approve the Meeting Schedule for 2021-22; and
(b) agree that the meeting schedule be published on the Aberdeen City Health and Social Care Partnership (ACHSCP) and Aberdeen City Council (ACC) websites as appropriate.

The Board resolved :-
to approve the recommendations.

FINANCE REPORT - HSCP.20.057

11. The Board had before it the report from the Chief Finance Officer (CFO), ACHSCP.

Members heard that whilst finances around the pandemic continued to adapt and change in quick time, delays on confirmed allocations from the Scottish Government continued.

The CFO provided commentary on some of the changes to the previous reports submitted in September 2020 although the picture remained broadly the same.

Members heard that a small reserve was still held by the IJB.

The report recommended :-
that the Board -
(a) note the report in relation to the IJB budget and the information on areas of risk and management action that are contained therein; and
(b) approve the budget virements indicated in Appendix F.

The Board resolved :-
(i) to approve the recommendations; and
(ii) to delegate authority to the Chief Finance Officer to arrange an additional IJB Meeting regarding Finance as necessary.

RENEWALS GROUP - HSCP.20.058

12. The Board had before it the report from the Director of Strategy & Deputy Chief Executive, (DoS&DCE) NHS Grampian.

INTEGRATION JOINT BOARD
28 October 2020

The report presented the findings of the Short Life Working Group (SLWG) which explored some medium term "renewal" from the COVID-19 pandemic.

The Chair introduced the DoS&DCE with a warm welcome to Members.

Members were provided with a summary of the report and how the SLWG was developing the four key themes which together sought to make a difference to all.

The DoS&DCE reminded that success required partner inclusion and involvement and that co-production within the group was essential to ensure this did not simply become a repository for the report and good ideas.

Members heard that similarity in approach across Grampian had already been evident which presented a strong foundation for an anchor agency.

Members agreed that the Locality Empowerment Groups (LEGs) would benefit from awareness of the SWLG and the report and that the awareness and participation of the local HSCP's and Elected Members across the three local authorities were all critical to success.

Members heard that the Chair and Chief Officer, ACHSCP would ensure such awareness.

The report recommended :-
that the Board –
(a) consider the report from the SLWG – renewal;
(b) consider how the IJB might wish to work with NHS Grampian on the four key themes identified within the report;
(c) consider how members of the IJB can influence their wider networks in pursuit of the findings of the report

The Board resolved :-
to support the Aims and Intentions as detailed in the report and discussed during the presentation.

COMMISSIONED DAY SERVICES AND DAY ACTIVITIES - HSCP.20.045

13. The Board had before it the report from the Chief Officer, ACHSCP which presented a proposal on future delivery of Commissioned Day Care and Day Activity.

The Lead Commissioner advised Members on the consultation that had been undertaken to develop the proposed model and sought to assure Members that

processes would be put in place to support current providers throughout any transitional period.

Members commented on the closure of the James Tyrell Centre and indicated the positive contributions they had made to day care should be acknowledged and recorded.

The report recommended :-
that the Board -

(a) note the outcome of the consultation process, the proposed implementation plan with a transitional phase between current and future model, including arrangements made to support current providers through this transition;
(b) approve the implementation of the future model for day care / day activity;
(c) approve the funding for current providers during the transitional phase, and make the direction as attached at appendix 3;
(d) instruct the Chief Officer to issue the direction to ACC to procure the service provided by Livingwell Café until 31st March 2021; and
(e) instruct the Chief Officer to proceed with the implementation of the new model.

The Board resolved :-
to approve the recommendations.

TRANSFORMATION - DECISIONS REQUIRED: ACTION 15 : FIRST CONTACT MENTAL HEALTH PROJECT - HSCP.20.051

14. The Board had before it the report from the Chief Officer, ACHSCP, which sought to progress a Locality First Contact Mental Health & Wellbeing Project to deliver against the ACHSCP strategic aims and progress towards the Scottish Government Action 15 programme plan, previously approved by the Integrated Joint Board (IJB) on 28 August 2018.

Members heard an overview of the proposal which sought to address one of the actions from the Scottish Government' s National Mental Health Strategy 2017-2027.

Members were reminded that in September 2019 they had approved a business case for the Mental Wellbeing Out of Hours Hub (Accident Emergency Department and Kittybrewster Custody Suite) which due to the continuing pandemic had not been progressed and that a new emergent need as the landscape of attendances and footfall in current services had changed, had resulted in a re-examination of the original business case. The new business case would help support emergent Mental Health needs as a result of Covid19.

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28 October 2020

The report recommended :-
that the Board -
(a) note the change to cancel the Mental Health & Wellbeing Out of Hours Hub business case previously approved by the IJB on the 19th September 2019;
(b) approve the expenditure, as set out in the Business Case at Appendix 1 relating to the Mental Health First Contact Support project which amalgamated & superseded the Mental Health & Wellbeing Out of Hours project above; and
(c) instruct the Chief Officer, ACHSCP to make the direction relating to the Mental Health First Contact Support project as per Appendix 2 and issue to Aberdeen City Council.

The Board resolved :-
(i) to approve the recommendations; and
(ii) to instruct the Chief Officer, ACHSCP, to ensure regular update reports on Action 15 be presented to the Risk, Audit and Performance Committee (RAPC).

TRANSFORMATION - DECISIONS REQUIRED: ACTION 15 (HMPYOI MENTAL HEALTH SUPPORT) - HSCP.20.050

15. The Board had before it the report from the Chief Officer, ACHSCP, which sought to progress the delivery of a tiered approach to support people in custody within HMP&YOI Grampian.

The project was to improve mental wellbeing recognising characteristics (such as trauma history, cognitive impairment, impact of substance misuse, socio-economic determinants) by providing a holistic and targeted service which addressed the Scottish Government Action 15 programme plan, previously approved by the Integrated Joint Board (IJB) on 28 August 2018.

Members heard that Aberdeenshire Health and Social Care Partnership had lead responsibility for the health and wellbeing of the population of HMP&YOI
Grampian and that the project had been developed in partnership with them, and that approval from the IJB to incur expenditure was required.

Members sought clarity around the funding distribution and options appraisal presented and were not sufficiently content with the information available.

INTEGRATION JOINT BOARD
28 October 2020

The report recommended :-
that the Board –
(a) approve the expenditure, as set out in Appendix 1, relating to the HMP&YOI Grampian – Joint City/Shire Prison-wide Mental Health service project;
(b) instruct the Chief Officer of Aberdeen City Health & Social Care Partnership to work with the Chief Officer of Aberdeenshire Health & Social Care Partnership to implement the project as set out in the Report; and
(c) instruct the Chief Officer to make the Direction relating to HMP & YOI Grampian Joint City/Shire Prison-wide Mental Health Project as per Appendix 2 and issue to NHS Grampian.

The Board resolved :-
to request submission of an amended report to its next meeting on 1 December 2020.

IJB MEETING - TUESDAY 1 DECEMBER 2020 AT 10.00AM

16. The Board noted that the next meeting date was Tuesday 1 December 2020.

- **Councillor SARAH DUNCAN, Chair.**

Aberdeen City Health & Social Care Partnership
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Risk, Audit and Performance Committee

Minute of Meeting

Tuesday, 3 November 2020
10.00 am Virtual - Remote Meeting

Present:	John Tomlinson (Chair); and Luan Grugeon, Councillor Philip Bell, Sandra MacLeod, Alex Stephen and Councillor John Cooke (as substitute for Councillor Gill Al-Samarai)
Also in attendance:	Jess Anderson (Legal), Derek Jamieson (Clerk) and Andrew Johnston (Senior Auditor)
Apologies:	Councillor Gill Al-Samarai, Colin Harvey (interim Head Auditor)

DECLARATIONS OF INTEREST

1. There were no declarations of interest.

DETERMINATION OF EXEMPT BUSINESS

2. There was no exempt business.

MINUTE OF PREVIOUS MEETING OF 23 SEPTEMBER 2020

3. The Committee had before it the draft minute of its last meeting.

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

BUSINESS PLANNER

4. The Committee had before it the Business Planner.

Members heard from the Chief Finance Officer (CFO), ACHSCP, who confirmed the reports being presented to this meeting and future reporting intentions.

The CFO advised that it was intended to present a Finance Report to the next RAPC and the IJB albeit these meetings were only one day apart; sensing the scrutiny element of RAPC would be beneficial to IJB. The CFO indicated this would be a late paper to both meetings due to the shifting nature of finances around the pandemic.

The Chair acknowledged the rationale around the report being presented to both IJB and RAPC and supported the late submission.

Members heard of an intended Inspection of Criminal Justice Services and sought confirmation that the Committee would be sighted on the outcomes.

The Committee resolved :-
(i) to note the business planner; and
(ii) to instruct the Chief Officer, ACHSCP, to submit a report following completion of the Inspection of Justice Services.

ASSET MANAGEMENT STRATEGIC STATEMENT - HSCP.20.055

5. The Committee had before it the report from the Lead Strategy and Performance Manager, ACHSCP.

The report sought to complete the outstanding recommendation from the 2017 Internal Audit AC1724 on Post Integration Review.

Members heard that whilst the report had been delayed due to a combination of staff changes, strategic planning attentions and the continuing pandemic, the report was now available to close the requirements of the outstanding Audit Recommendation.

Members were advised that ACHSCP did not own any assets and as such a Strategic Statement had been developed to accompany the Strategic Plan. ACHSCP were more involved in the management of assets owned or leased by partner organisations and/or service providers.

The Lead Strategy and Performance Manager advised that management of the assets included use requirements including community benefit and asset transfer, whilst also considering infection control criteria.

The report recommended :-
that the Committee note the Aberdeen City Health and Social Care Partnership's Asset Management Strategic Statement and the fact that this represented completion of the final recommendation the 2017 Internal Audit AC1724 on Post Integration Review.

The Committee resolved :-
to approve the recommendation.

RISK, AUDIT AND PERFORMANCE COMMITTEE
3 November 2020

ALCOHOL AND DRUG PARTNERSHIP FUNDING - HSCP.20.059

6. The Committee had before it the report from the Chief Finance Officer, ACHSCP.

The report sought support for Alcohol and Drug Partnership (ADP) investment plans that have been developed as a result of budget slippage and the impact of emergent issues following COVID 19.

Members heard from the ADP Lead that the report had been instructed by the IJB on 8 September 2020 following presentation of the ADP Annual Report 2018/2019 when information on redistributed funding had been shared.

Members were advised that following legal direction, whilst some of the project funding already agreed could be modified by the Committee, some of the intended projects not previously agreed, would require to be reported to the IJB for consideration and approval.

The ADP Lead provided a summary of the intentions to ensure best means to reconcile existing funding whilst also seeking to maximise use of available funding arising from the changing demand and the continuing pandemic.

The report recommended :-
that the Committee approve the proposals and agree that the ADP progresses developments.

The Committee resolved :-
(i) to approve the proposals and agree that the ADP progresses developments where appropriate.; and
(ii) to note that some projects highlighted within the report required to be remitted to the IJB for consideration, approval and a subsequent Direction made to the relevant Constitution Authority where appropriate.

PERFORMANCE - OPERATION HOME FIRST - ABERDEEN CITY PRIORITY PROJECTS - HSCP.20.056

7. The Committee had before it the report from the Chief Finance Officer, ACHSCP, which provided an update on the performance of the Aberdeen City Priority Projects relating to Operation Home First (OHF).

The Lead Strategy and Performance Manager, ACHSCP, advised members that the significant effort of the Partnership was devoted to aligning OHF with the Strategic Plan.

Members were advised that the Leads from each of the respective Priority Projects were present to provide clarity on any matter.

A summary of the 10 key priorities as described within Appendix 1 of the report was presented to the Committee.

Members applied considerable scrutiny to each area and heard from the respective Leads, Chief Officer and Chief Finance Officer as appropriate.

The report recommended :-
that the Committee note the information provided in this report.

The Committee resolved :-
to approve the recommendation.

CONFIRMATION OF ASSURANCE

8. The Committee indicated that they had received assurance from the reports presented.
- JOHN TOMLINSON, Chair.

	A	B	C	D	E	F	G	H	I	J
1	**INTEGRATION JOINT BOARD 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**	**ORGANISATION ACHSCP/ACC/NHSG**	**Update/ Status (RAG)**	**Delayed/ Deferred or Recommended for removal or transfer, enter either D, R, or T**	**Explanation if delayed, removed or transferred**
3	**01 December 2020**									
4	Standing Item	Chief Officer Report	A regular update from the Chief Officer	HSCP.20.066	Martin Allan	Business Lead	ACHSCP			
5	23.09.2020	Transformation - Decisions Required: Action 15 - HMP&YOI Grampian – Joint City/Shire Prison-wide Mental Health project	On 28.10.2020 IJB deferred this report until 01.12.2020	HSCP.20.050	Kevin Dawson	Lead for MH/ LD/SMS services	NHSG			
6	11.11.2019	Livingwell with Dementia	On 11.08.2020, IJB moved this report from September 2020 to 1 December 2020		Alison MacLeod	Performance Lead	ACHSCP		T	**It is intended to report this on 23 March 2021**
7	19.11.2019	Local Survey	On 19.11.2019, the IJB resolved to instruct the Chief Officer to bring forward a further report following publication of the results of the current national survey which are expected in April 2020 along with details of actions undertaken to address those areas of the survey which would benefit from improvement. This report will come to the June meeting of the IJB, then on 28.10.2020 transferred to 01.12.20		Alison MacLeod	Performance Lead	ACHSCP		T	**A National Report is awaited to inform this report which is now targeted for 23 February 2021.**
8	25.02.2020	Scottish Public Services Ombudsman - Revised Model Complaints Handling Procedure	To provide an update on the updated Model Complaints Handling Procedure (MCHP) for Scottish Government, Scottish Parliament and Associated Public Authorities. CoVid-19 measures: consider Service Update or report to RAPC. MA advised that this will be delayed until September IJB. Transferred from August IJB		Martin Allan	Business Lead	ACHSCP		T	**Works continues with ACC on developing this report which will be presented on 23 February 2021**
9	19.11.2019	Localities - Reshaping Community Services	On 19.11.2019, the IJB resolved (vi) to instruct the Chief Officer, to report back on the progress towards integrated locality working, on 1 December 2020,	HSCP.20.060	Alison MacLeod	Performance Lead	ACHSCP			
10	24.03.2020	Grampian-wide Strategic Framework for Mental Health and Learning Disability Service 2020-2025	The report recommended :- that the Board – a) approve the Grampian-wide Strategic Framework for Mental Health and Learning Disability (MHLD) 2020-2025 [appendix a]; b) note Aberdeen City Health and Social Care Partnership (ACHSCP), Aberdeenshire HSCP (ASHSCP) and Moray HSCP (MHSCP) plan to refresh their respective Mental Health and Learning Disability Strategy/(ies) for community-based services in 2022; c) instruct the Chief Officer to report back on the Performance Framework and Programme Transformation Plan to Aberdeen City IJB on the 25 June 2020, Aberdeenshire IJB on 24 June and Moray IJB on 26 June to provide assurance of detailed plans for service redesign, timelines and measures to monitor progress and sustainability. On 1th August IJB deferred to 01.12.2020	HSCP.20.069	Kay Dunn	Planning Manager Lead	ACHSCP			
11	13.08.2020	2C ReDesign	A report on 2C Redesign following Workshop input	HSCP.20.049	Lorraine McKenna	Primary Care Lead	ACHSCP			
12	26.03.2019	Diet, Activity and Healthy Weight	IJB 26.03.19 Article 17 - The Board instructed the Chief Officer that an annual update on ACHSCP GCGF is presented to the IJB, and (v) Instruct the Chief Officer that the Grampian consultation strategies for Tobacco and Diet, Activity and Healthy Weight are presented to the Board. To be reported to 23.06.20 meeting from PreAgenda on 29.01.20, then IJB on 11.02.20		Alison MacLeod	Performance Lead	ACHSCP		T	**Initially delayed due to CoVid-19 responses; will be reported on 01.12.2020, There is an updated on this topic within the Chief Officers Report; this report is delayed until 23 February 2021.**
13	29.01.2020	Mental Health Delivery Plan	CoVid-19 measures : moved from 24/03/20 to 01/12/20	HSCP.20.069	Kevin Dawson / Jenny Rae	Mental Health Lead	ACHSCP		R	**Contained within HSCP.20.069**
14	09.06.2020	Service User Representative on IJB	IJB 09.06.2020: Position extended until 31.03.2021, Report before then on update		Alison Macleod	Performance Lead	ACHSCP		D	**There is an update on this topic within the Chief Officers Report; this report is delayed until 23 February 2021.**
15	04.09.2019	Market Facilitation Update	Co-Vid-19 measures delay from 24/03/20		Anne McKenzie	Commissioning Lead	ACHSCP		R	**Delayed to June IJB, needs to be looked at and consider the impact of COVID on commissioning and market facilitation.**
16	08.09.2020	ADP Governance Report	ADP Annual Report - HSCP.20.038; to instruct the Chief Officer, ACHSCP to present a Governance overview of ADP to include an organisational chart, partnership working and decision flows to a future meeting;		Simon Rayner	ADP Lead	ACHSCP		R	**This has been adapted to a Workshop to better present and explain the ADP structures and Governance which may be followed by reference material.**
17	03.11.2020	ADP Funding Redistribution	ADP Annual Report - HSCP.20.038: 08.09.20 IJB Decision - (iv)to instruct the Chief Officer, ACHSCP to present a report on redistribution of funding aligned to ADP approved workstreams to the Risk, Audit and Performance Committee on 3 November 2020 ; On 03.11.2020, HSCP.20.059, RAPC resolved :- (i) to approve the proposals and agree that the APD progresses developments where appropriate; and (ii) to note that some projects highlighted within the report require to be remitted to the IJB for consideration, approval and a subsequent Direction made to the relevant Constitution Authority where appropriate.	HSCP.20.068	Chief Officer	ADP Lead	ACHSCP			
18	11.08.2020	Strategic Risk Report	Strategic Risk Report - HSCP.20.012 : On 11.08.2020, (i)to note the revised Strategic Risk Register in the Appendix to the report, (ii)to note the intended Planning and Risk Workshop on 20 October 2020 and request Member's feedback ahead of then to inform the content of the session; and (iii)to direct the Chief Officer to submit an amended report to the IJB on 1 December 2020.	HSCP.20.067	Martin Allan	Business Lead	ACHSCP			

	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**	**ORGANISATION ACHSCP/ACC/NHSG**	**Update/ Status (RAG)**	**Delayed/ Deferred or Recommended for removal or transfer, enter either D, R, or T**	**Explanation if delayed, removed or transferred**
19	**27 January 2021**									
20	Standing Item	Chief Officer Report	A regular update from the Chief Officer		Martin Allan	Business Lead	ACHSCP			
21	17.11.2020	Vaccination/Immunisation Report	At the request of the Chair and Vice Chair, a report arising from Flu Lessons learned should be presented		Alison Macleod	Performance Lead	ACHSCP			
22	17.11.2020	Bon Accord Care - Annual Report			Alison Macleod	Performance Lead	ACHSCP			
23	17.11.2020	Finance Update			Alex Stephen	Chief Finance Officer	ACHSCP			
24										
25	**23 February 2021**									
26	Standing Item	Chief Officer Report	A regular update from the Chief Officer		Martin Allan	Business Lead	ACHSCP			
27	Standing Item	Review of Scheme of Integration to incorporate Review of ACC Governance (delayed from June 2020)	Annual review. IJB 20200128 move to June 2020, then to September then December 2020. On 02.10.20 The Board resolved :- to amalgamate the intended 'Review of Governance (ACC)' report referenced at Line 21 on the Planner with the intended 'Review of Scheme of Integration' referenced at Line 20 on the Planner. On 28.10.20 the Board agreed to defer this report until 23.02.2021 to allow consultation with the Constituent Authorities		Jess Anderson	Chief Officer - Governance	ACC			
28	Standing Item	Annual Procurement Workplan 2021/2022			Jean Stewart-Coxon	Procurement Lead	ACC			Delayed from 1 December meeting to 23rd February 2021
29	11.12.2018	Autism Strategy and Action Plan	IJB 11.12.18 Article 13 - The Board noted that progress reports on the implementation of the above would be provided annually, with updates to the Clinical Care and Governance Committee in the interim. Suggested April 2020, then To be reported to 23.06.20 meeting and combined with Annual Update (from PreAgenda on 29.01.20 and IJB on 11.02.20).		Kevin Dawson	Learning Disabilities Lead	ACHSCP			To be reported to 23.02.20 meeting (delayed by CoVid) and combined with Annual Update (from PreAgenda on 29.01.20) ; CoVid-19 measures : Report to CCG then Service Update to IJB
30	21.01.2020	Fast Track Cities	On 21.01.20 from ; Fast Track Cities - HSCP.19.081 ; and instruct the Chief Officer to provide an update on progress in January 2021.		Elaine McConnachie	Public Health Coordinator	ACHSCP		T	Delay around pandemic activities, to be presented on 23.02.2021when full year update will be available.
31	02.06.2020	Covid-19 Response - Lessons Learned	From an IJB Workshop		Sandra MacLeod	Chief Officer	ACHSCP			
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INTEGRATION JOINT BOARD

Date of Meeting	1 December 2020
Report Title	Chief Officer's Report
Report Number	HSCP20.066
Lead Officer	*Sandra Macleod*
Report Author Details	*Sandra Macleod* *Chief Officer* *samacleod@aberdeencity.gov.uk*
Consultation Checklist Completed	*Yes*
Directions Required	*No*
Appendices	None

1. Purpose of the Report

1.1. The purpose of the report is to provide the Integrated Joint Board (IJB) with an update from the Chief Officer

2. Recommendations

2.1. It is recommended that the Integration Joint Board note the content of the report.

3. Summary of Key Information

Local Updates

3.1. Immunisations/Flu Preparedness

	LY	Target	Vaccinated	%	DNA	%	Total	%
>65	**73%**	**75%**	25,723	62	15,606	38	41,329	100
<65 "at risk"	**41%**	**65%**	10,081	58	7,449	42	17,530	100
Total			**35,804**	**61**	**23,055**	**39**	**58,859**	**100**

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The above is data (as of 19th November 2020), in relation to Flu Vaccination progress in Aberdeen City extracted from the Grampian Daily Flu Update. It shows the data for the two main cohorts of the current flu vaccination programme – over 65s and under 65 "at risk". The percentage rate vaccinated in each cohort last year is shown on the table, as is the target we were given for this year, and the actual achieved rates to date.
At the beginning of the flu vaccination programme this year, national planning was geared towards it running until March 2021, however local planning focused on completing the programme pre-Christmas 2020. All patients in Aberdeen City have been appointed to clinics running up until the end of November and plans are in place to run reports against GP data at the end of November to identify those who have not attended for any reason, and to offer them the opportunity to attend one of the "mop up" clinics scheduled for December.

The data in the Grampian update, whilst accurate from information available at the time, does not yet represent the complete picture in Aberdeen City. Details of those vaccinated needs to be manually captured at the remote Clinics and then input into GP IT systems. 50% of the GP practices in the City are entering that data for us, but a small admin team are entering the data for the rest. There can, therefore, be a delay in the true number of people vaccinated being recorded in the system and being reflected in the figures reported. Everyone who has not yet been vaccinated is recorded as a Did Not Attend (DNA, however some people may not have got their appointment letter, or have received it too late to attend the Clinic they were appointed to.

We are doing everything we can to encourage people to attend the clinics we have planned including the use of social media campaigns. Once we reach the end of our core clinic delivery at the end of November, and all of the data from these has been input, we will understand the number of people still to receive vaccinations and ensure there is sufficient capacity in the December clinics to allow all of this number to be vaccinated should they wish to.

Cabinet Secretary, Jeanne Freeman has now confirmed that Phase 2 of Seasonal Flu vaccinations should commence for the 60-64-year-old cohort, and that a decision will be made at the end of December of when to call the remaining 55-59-year-old cohort forward.
A formal review of the Flu Vaccination Programme began on 29th October, led by a civil contingencies' expert in NHS Grampian. The lessons learned from that have been fed into the planning for a Covid Vaccination

Programme which began at the same time. A report on both will be brought to the IJB in January 2021.

3.2. Health Improvement Plan-Prioritisation

The IJB was anticipating a report on Diet, Activity and Healthy Weight at the December meeting. This report would have been prepared based on work our Health Improvement Officers had been undertaking, most of which was paused during Covid whilst they assisted with the response. Pausing work and diverting resources was a common theme amongst the three Health Improvement Teams across Grampian. The three Health Improvement Leads, along with Public Health colleagues have agreed that existing Health Improvement priorities need to be reviewed in light of Covid and the ongoing, resultant work that is bringing. Work is ongoing on that review at the moment and the outcome will be communicated and will inform the workplan for the Health Improvement Officers going forward. It is recognised that each of the three HSCPs may have different priorities but also that there may be some commonality that can be coordinated Grampian wide.

3.3. Care at Home-Update

The new Care at Home contract went live on 1st November 2020. These new arrangements have been made possible through months of collaborative working of both providers and the ACHSCP. The incoming Granite Care Consortium (GCC) is made up of 10 care providers who have worked closely with ACHSCP colleagues to problem solve and coproduce solutions in an agile and innovative delivery model. This approach has been recognised by other areas as pioneering in terms of its coproduction and close working relationships which have been developed.

By removing time and task orientated provision, we look to offer greater flexibility to provide care and improve outcomes for people. Providers and ACHSCP teams need to work closely together to ensure that people receive an appropriate level of care, and to jointly embrace enablement approaches towards delivering outcomes.

An implementation group and relevant task and finish groups were set up to work on the different aspects of delivery – pathways, systems & processes, communication, transfer of packages and risk. Each group had a relevant cross section of representation from the care at home system. A weekly meeting for the implementation group was the focus for joint decision making and action focused discussions. From the beginning of November

these arrangements are being morphed into a delivery group for an operational focus alongside regular monthly review meetings.

We are in a transitional period and in order to allow the new consortium of providers to bed into the new arrangements we have put in place contingencies and mitigations as well as continued co-production for the improvement and refinement of processes and procedures. The journey is not complete and colleagues continue to work together to transform how care at home is delivered in Aberdeen.

3.4. Criminal Justice Inspection-Update

The Care Inspectorate have resumed their inspection under section 115 of the Public Services Reform (Scotland) Act 2010.
The inspection resumed at Stage 4 with remote onsite activity commencing on Monday 26 October 2020.

Stage 4 -Onsite activity – Remote onsite activity took place week commencing 26 October 2020 and 9 November 2020 with over 46 service users and 69 members of staff and stakeholders meeting with the Inspection Team through telephone calls and virtual meetings. The Inspectors were very complimentary about the logistical arrangements that had been put in place to facilitate the engagement with service users and staff during the ongoing COVID-19 Pandemic. An initial feedback meeting will take place with Senior officers on 24 November, with the initial draft inspection report issued to Officers just before Christmas. Officers will then have until January 2021 to respond to their findings and recommendations prior to the advanced publication of the report on 16 February 2021 and final publication on 23rd February 2021. A report on the findings will be submitted to a future meeting of the IJB.

3.5. IJB Service User Representative

At its meeting on 9th June 2020, the IJB were advised that the Service User representative on the IJB had agreed to an extension to his term of office until March 2021. The report also advised that we would intend to schedule a recruitment campaign to replace the Service User Representative around November 2020 with a view to that term commencing from March 2021 for a 3-year period. The 3-year period from March 2021 allows for a staggered recruitment commitment going forward for both the IJB Service User and the Carer representatives. Initial discussions have commenced with ACVO, who assisted us with the recruitment of the IJB Carers representatives. We will follow a very similar process which will begin with

contacting existing service user groups to communicate the opportunity and obtain expressions of interest. A focus group will then take place which provides interested parties with more information in relation to the role and allows them to raise questions and obtain clarification. We would hope to have shortlisted candidates available for informal interview with the Chair of the IJB and the Chief Officer by early January 2021 with a view to confirming the successful appointee and introducing them at the IJB meeting on 23rd February 2021. Their induction would commence immediately thereafter and they would be invited to shadow Howard's last meeting on 23rd March 2021.

National Updates

3.6. Adult Social Care Review-

The Review of Adult Social Care Advisory Panel has met every two weeks since it was established as part of the Programme for Government 2020-2021 announced by the First Minister at the beginning of September. Agenda items for discussion so far have included: Current Standards, Measures and Outcomes; Finance; Commissioning and Procurement; Self-Directed Support; Independent Living Fund; Regulation, Inspection and Improvement; Human Rights and Ethics in Social Care.

Briefing Papers have been supplied by the following organisations: Healthcare Improvement Scotland; Care Inspectorate; Socialist Health Association Scotland; Social Justice and Fairness Commission; Scottish Social Services Council; The Alliance; and the Institute for Public Policy Research.

Key discussions have taken place in respect of a Rights-based approach and in particular, how to strengthen the capability of rights holders to secure the outcomes to which they are entitled and what should be done to improve the ability of 'duty bearers' to deliver? The potential establishment of a National Care Service has also been discussed, its local/national operation and governance and the nature of its relationship with communities, local authorities, integration authorities and the NHS. The Panel will continue its discussions and produce its report by January 2021.

3.7. Adult Social Care Winter Preparedness Plan

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The Scottish Government has issued an Adult Social Care Winter Preparedness Plan which centres around four key principles:

• Learning from evidence to protect people who use social care support from the direct impact of COVID-19, and wider winter viruses.

• Ensuring that people have good physical and mental health and wellbeing, through provision of high quality integrated health and care services.

• Supporting the social care workforce to deliver safe support and care and to have positive mental health and wellbeing.

• Working in collaboration to plan and deliver high quality care.

The Partnership's Leadership Team have been discussing the Plan, looking at the four themes and identifying activity that is already in place ,new activity that is required to be implemented and outlining any impact these activities will have for the Partnership. The Leadership Team have an agreed summarised cross-system summary which will help them meet the requirements of the Plan.

A link to the Scottish Government document is below:

https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2020/11/adult-social-care-winter-preparedness-plan-2020-21/documents/adult-social-care-winter-preparedness-plan-2020-21/adult-social-care-winter-preparedness-plan-2020-21/govscot%3Adocument/adult-social-care-winter-preparedness-plan-2020-21.pdf

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4. Implications for IJB

4.1. **Equalities** – there are no implications in relation to our duty under the Equalities Act 2010.

4.2. **Fairer Scotland Duty** - there are no implications in relation to the Fairer Scotland Duty.

4.3. **Financial** – there are no immediate financial implications arising from this report.

4.4. **Workforce** – there are no immediate workforce implications arising from this report.

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

4.6. **Other**- there are no other immediate implications arising from this report.

5. Links to ACHSCP Strategic Plan

5.1. The Chief Officers update is linked to current areas of note relevant to the overall delivery of the Strategic Plan.

6. Management of Risk

6.1. Identified risks

6.2. The updates provided link to the Strategic Risk Register in a variety of ways, specifically to the strategic risks of partnership working, reputation and workforce.

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

The main issues in this report directly link to the following Risks on the Strategic Risk Register:

4-There is a risk that relationship arrangements between the IJB and its partner organisations (Aberdeen City Council & NHS Grampian) are not managed to maximise the full potentials of integrated & collaborative working. This risk covers the arrangements between partner organisations in areas such as governance; corporate service; and performance

INTEGRATION JOINT BOARD

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

9- There is a risk that if the System does not redesign services from traditional models in line with the current workforce marketplace in the City this will have an impact on the delivery of the IJB Strategic Plan.

6.4. How might the content of this report impact or mitigate these risks:
The Chief Officer will monitor progress towards mitigating the areas of risk closely and will provide further detail to the IJB should she deem this necessary

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

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INTEGRATION JOINT BOARD

Date of Meeting	1 December 2020
Report Title	Strategic Risk Register and Revised Risk Appetite Statement
Report Number	HSCP20.067
Lead Officer	Sandra Macleod, Chief Officer
Report Author Details	Name: Martin Allan Job Title: Business Manager Email Address: martin.allan3@nhs.net
Consultation Checklist Completed	*Yes*
Appendices	a. Risk Appetite Statement b. Strategic Risk Register

1. Purpose of the Report

1.1. To present the Integrated Joint Board (IJB) with (a) an amended version of the Board's Risk Appetite Statement and (b) the latest version of the Aberdeen City Health & Social Care Partnership's (ACHSCP) Strategic Risk Register.

2. Recommendations

2.1. It is recommended that the IJB comment on and approve the Board's Risk Appetite Statement and the revised Strategic Risk Register as appended to this report.

3. Summary of Key Information

Revised Risk Appetite Statement

3.1. The IJB Members, at the workshop on the 20th of October, considered the Board's Risk Appetite Statement and made some amendments to this document to reflect the experience of responding to Covid in the Spring, the subsequent remobilisation of services in summer, and the current situation of "living with Covid" within the current Scottish Government guidelines. The revised Risk Appetite Statement is attached as Appendix A to this report.

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Updates on Strategic Risk Register

3.2. Since the Strategic Risk Register was last submitted to the IJB, work has been undertaken on the template. This has included the introduction of a risk rating matrix for each of the strategic risks.

3.3. At the IJB's workshop on the 20th of October the revised template was considered. The Members of the IJB made suggested amendments and additions regarding the strategic risks and these have been made in the version attached to this report. Minor changes have been made to the template as well. The updated version of the Strategic Risk Register is attached as Appendix B to this report.

3.4. Members of the IJB will notice that in relation to strategic Risk 3, the Members at the Workshop felt that there was a risk in relation to the financial oversight of Hosted Services and performance across the services was mixed. It was suggested that the impact should be moved from moderate to major and that this should be discussed further at the Risk, Audit and Performance Committee.

3.5. In relation to Risk 7 – The Workshop suggested the risk owner be changed to the Lead for Strategy and Performance as transformation is about creating sustainable services and the true risk in this area was in the sustainability element.

3.6. In relation to Risk 8 – The Workshop agreed to change the impact from Major to Moderate, and as a result the risk rating from High to Medium, as new measures like NEAR ME and more digital solutions established and promoted during the response to Covid 19 had helped manage the geographic risk and had brought Locality Working forward.

4. Implications for IJB

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

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

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

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

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

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

5. Links to ACHSCP Strategic Plan

5.1. Ensuring a robust and effective risk management process will help the ACHSCP achieve the strategic priorities as outlined it its strategic plan, as it will monitor, control and mitigate the potential risks to achieving these. The Strategic Risks have been aligned to the Strategic Plan 2019-2022.

6. Management of Risk

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

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

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

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

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IJB Risk Appetite Statement

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

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

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

Dimension of Risk	**Corresponding Risk Appetite**
Financial risk	Low to moderate. It will have zero tolerance of instances of fraud. The Board must make maximum use of resources available and also acknowledge the challenges regarding financial certainty.

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

The IJB has an appetite to take decisions which may expose the organisation to additional scrutiny and interest. Wherever possible, decisions will be taken following consultation/co-production with the public and other key stakeholders. Concerted efforts will be made to explain reasons for decisions taken to the public transparently in a way which is accessible and easy to understand.

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

Strategic Risk Register

Revision	Date
1.	March 2018
2.	September 2018
3.	October 2018 (IJB & APS)
4	February 2019 (APS)
5.	March 2019 (IJB)
6.	August 2019 (APS)
7.	October 2019 (LT)
8.	November 2019 (IJB workshop)
9.	January 2020 (ahead of IJB)
10	March 2020
11	July 2020
12	October 2020
13	November 2020

Introduction & Background

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

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

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

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

Appendices

- Risk Tolerances
- Risk Assessment Tables

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Colour – Key

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

Risk Summary:

1	There is a risk that there is insufficient capacity in the market (or appropriate infrastructure in-house) to fulfil the IJB's duties as outlined in the integration scheme. This includes commissioned services and general medical services.	**High**
2	There is a risk of financial failure, that demand outstrips budget and IJB cannot deliver on priorities, statutory work, and projects an overspend.	**Very High**
3	There is a risk that the outcomes expected from hosted services are not delivered and that the IJB does not identify non-performance in through its systems. This risk relates to services that Aberdeen IJB hosts on behalf of Moray and Aberdeenshire, and those hosted by those IJBs and delivered on behalf of Aberdeen City.	**High**
4	There is a risk that relationship arrangements between the IJB and its partner organisations (Aberdeen City Council & NHS Grampian) are not managed to maximise the full potentials of integrated & collaborative working. This risk covers the arrangements between partner organisations in areas such as governance; corporate service; and performance.	**Low**
5	There is a risk that the IJB, and the services that it directs and has operational oversight of, fail to meet both performance standards/outcomes as set by regulatory bodies and those locally-determined performance standards as set by the board itself. This may result in harm or risk of harm to people.	**Medium**
6	There is a risk of reputational damage to the IJB and its partner organisations resulting from complexity of function, delegation and delivery of services across health and social care	**High**
7	Failure to deliver transformation at a pace or scale required by the demographic and financial pressures in the system	**High**
8	There is a risk that the IJB does not maximise the opportunities offered by locality working	**Medium**
9	There is a risk that if the System does not redesign services from traditional models in line with the current workforce marketplace in the City this will have an impact on the delivery of the IJB Strategic Plan.	**Very High**
10	There is a risk that ACHSCP is not sufficiently prepared to deal with the impacts of Brexit on areas of our business, including affecting the available workforce and supply chain.	**High**

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Description of Risk: There is a risk that there is insufficient capacity in the market (or appropriate infrastructure in-house) to fulfil the IJB's duties as outlined in the integration scheme. Commissioned services in this context include third and independent providers of care and supported living and independent providers of general medical services, community optometry and general dental services. Additional pressures from other parts of the system also add to market instability. For example, recruitment of care staff within a competing market, reduction of available beds and the requirement to care for more complex people at home. Most recently, sustainability for providers of both care at home and care homes has been compromised by the impact of COVID-19, including access to the necessary PPE and associated costs incurred, staff availability due to blanket testing and the occupancy levels within some of our care homes.

Strategic Priority: Prevention and Communities

Leadership Team Owner: Lead Commissioner

Risk Rating: low/medium/high/very high

HIGH

IMPACT					
Almost Certain					
Likely					
Possible				✓	
Unlikely					
Rare					
LIKELIHOOD	**Negligible**	**Minor**	**Moderate**	**Major**	**Extreme**

Risk Movement: increase/decrease/no change

NO CHANGE 19.11.20

Rationale for Risk Rating:

- There have been several experiences of provider failure in the past and this has provided valuable experience and an opportunity for learning. There is unmet need in the care sector evidenced by out of area placements and use of agency staff which would indicate that there are insufficient skills and capacity to meet the needs of the population
- There are difficulties in recruiting to vacant GP positions within the city which has led to GP practices closing
- Discussion with current providers and understanding of market conditions across the UK and in Aberdeen locally.
- Impact of Living Wage on profitability depending on some provider models (employment rates in Aberdeen are high, care providers have to compete within this market)
- The impact of Covid-19 on providers is not yet fully quantifiable. Bed occupancy has reduced and costs have increased potentially through maintaining existing staffing levels and procuring PPE.
- The impact of Covid-19 on independent GP practices, community optometrists and general dental practitioners is not yet fully quantifiable. Should supply of these contracted services reduce due to financial constraints and businesses fail, there may be insufficient capacity to provide services to patients. The responsibility to ensure patients have access to these services rests with the Partnership.

Rationale for Risk Appetite:
As 3rd and independent sectors are key strategic partners in delivering transformation and improved care experience, we have a low tolerance of this risk. It is suggested that this risk tolerance should be shared right throughout the organisation, which may encourage staff and all providers of primary health and care services to escalate valid concerns at an earlier opportunity.

Controls:

- Robust market and relationship management with the 3rd and independent sector and their representative groups, building a sense of shared risk, in an environment where people operate in a respectful and responsible fashion. In particular, with a sense of etiquette in the way in which businesses conduct themselves
- GP Contracts and Contractual Review and GP Sustainability Risk Review - workforce and role review in primary care.
- Funding arrangements which take into account the annual increase to support payment of the Scottish Living wage
- Contact monitoring arrangements – regular exchange of information between contracts and providers and progressing new contracts

Mitigating Actions: The IJB's commissioning model has an influence on creating capacity and capability to manage and facilitate the market :-

- The development of virtual provider huddles
- The development of the local PPE hub
- Consortium of providers purchasing PPE
- Risk fund set aside with transformation funding
- Implementation of GMS contract
- Remodelling of 2C practices
- Interim financial support from Scottish Government for community optometrists and general dental practitioners.

• Clinical and care governance processes – and the opportunity to provide assurance, including assurance that all appropriate leadership team members and staff have undertaken Adult Protection training. • Leadership team monthly discussion of operational and strategic risk – to ensure shared sense of responsibility and approach to potential challenging situations. • Close working between partnership (social work, medical and nursing practitioners), care inspectorate, and public health directorate • Clinical and Health Protection Scotland Guidance for social care settings. • GP Sub Committee of Local Medical Council	• Provider of last resort – Bon Accord Care • The development of risk predictor tools in association with the care inspectorate, and individual team escalation plans • Reconciliation process – working on a pan Grampian approach • Worked with care providers to develop key business contacts that providers can use over winter to help with their overall business continuity planning eg links to Flu vaccine details/NHS Inform/SEPA/Met office/Council Roads/Travel Providers. • Develop and implement the Residential Care Providers Early Warning System (once returned to new normal) with monthly returns from providers using MS Forms to gather intelligence and report to all relevant parties. • Intervention by Scottish Ministers and Public Bodies where financial failure evident • Grampian PH Team to provide advice on all aspects of prevention, testing and management of Covid incidences All care home staff offered weekly Covid testing
Assurances: • Market management and facilitation • Inspection reports from the Care Inspectorate • Contract monitoring process, including GP contract review visit outputs. • Daily report monitoring • Clinical oversight group – daily meetings • Good relationships with GP practices • Links to Dental Practice Advisor who works with independent dentists • Links to the Eye Health Network and Clinical Leads for Optometry in Shire & Moray and the overall Grampian Clinical Lead • Roles of Clinical Director and Clinical Leads	**Gaps in assurance:** • Market or provider failure can happen quickly despite good assurances being in place. For example, even with the best monitoring system, the closure of a practice can happen very quickly, with (in some cases) one partner retiring or becoming ill being the catalyst. • Market forces and individual business decisions regarding community optometry and general dental practitioners cannot be influenced by the Partnership. • We are currently undertaking service mapping which will help to identify any potential gaps in market provision
Current performance: • Most social care services are commissioned from care providers. Commissioning is the largest part of our budget and accounts for over £100 million of our available budget. • Additional costs incurred by residential providers to be supported by initial mobilisation funding provided by SG. Where care homes cannot occupy beds due to Covid-19 infection levels or other reasons, sustainability payments will be made to ensure the market is supported. • GPs and their practice teams are open as usual during the pandemic but are operating a triage system using telephone and video appointments. Remote consulting initiatives such as **Attend Anywhere** and the use of **GMEDs**, and the **OOH's** base were activated to encourage cross sector working. All non-urgent home visits have been suspended and all remaining visits are conducted either by the practice themselves or by the City Visiting or Hospital at Home services in order to deliver a safe and contained service. Most visits are undertaken by the practice. City Visiting are focusing their work on Covid patients although they are now undertaking a small number of visits from 17 practices. Hospital at Home continue to take referrals. . Any further remobilisation of paused services may be halted due to rising numbers of COVID cases.	**Comments:** • National Care Home Contract uplift for 2016/17 was 6.4% and 2.8% 2017/18.. NCHC uplift has been awarded for 2019/20. For other services (CAH, SL, Adult Res) a national agreement for a 3.3% uplift has exceptionally been agreed this year. • IJB agreed payment of living wage to Care at Home providers for 2016/17, 2017/18 and 2018/19 • During the Covid-19 outbreak, the Care Inspectorate have scaled back inspection and complaints handling activity. This will allow providers to focus on support for commissioning bodies during the pandemic but may increase the risk that market failure is difficult to predict. • Relationships between partnership and providers and between different providers have advanced over the past few months and there are good examples of providers working innovatively to support clients. • Collaborative working between providers including consortium for PPE purchase • Positive feedback from providers over the level of support offered to them. • Continuing to progress the tender for Care at Home and Supported Living

• Community optometrists and general dental practitioners were closed during lockdown but provided an emergency triage service for their own patients who have emergency or urgent need. Reopening is on a phased basis and community optometrists and general dental practitioners can now see routine patients, however they are prioritising those in most need. Due to Infection Prevention Control measures required, dental practitioners can provide Aerosol Generating Procedures for urgent care only and where any practice is unable to provide this, the Public Dental Service will do so on an emergency or urgent basis.	

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Description of Risk:

There is a risk of IJB financial failure and projecting an overspend, due to demand outstripping available budget, which would impact on the IJB's ability to deliver on its strategic plan (including statutory work).

Strategic Priority: Prevention and Communities

Leadership Team Owner: Chief Finance Officer

Risk Rating: low/medium/high/very high

VERY HIGH

IMPACT					
Almost Certain				✓	
Likely					
Possible					
Unlikely					
Rare					
LIKELIHOOD	**Negligible**	**Minor**	**Moderate**	**Major**	**Extreme**

Risk Movement: increase/decrease/no change***:***

No Change 19/11/2020

Rationale for Risk Rating:

- If the partnership does not have sufficient funding to cover all expenditure, then in order to achieve a sustainable balanced financial position, decisions will be required to be taken which may include reducing/stopping services
- If the levels of funding identified in the Medium Term Financial Framework are not made available to the IJB in future years, then tough choices would need to be made about what the IJB wants to deliver. It will be extremely difficult for the IJB to continue to generate the level of savings year on year to balance its budget.
- The major risk in terms of funding to the Integration Joint Board is the level of funding delegated from the Council and NHS and whether this is sufficient to sustain future service delivery. There is also a risk of additional funding being ring-fenced for specific priorities and policies, which means introducing new projects and initiatives at a time when financial pressure is being faced on mainstream budgets.
- The cost of the IJB's (Covid-19) mobilisation plan is still to be fully determined. An initial payment of £2.7 million was received from the SG in May to support additional costs with a significant part of this now allocated to support sustainability of the commissioned providers. Until the funding and costs for COVID-19 is confirmed the risk of a financial shortfall in relation to the IJB finances is increased.

Rationale for Risk Appetite:

The IJB has a low-moderate risk appetite to financial loss and understands its requirement to achieve a balanced budget. The IJB recognises the impacts of failing to achieve a balanced budget on Aberdeen City Council & its bond – an unmanaged overspend may have an impact on funding levels.

However, the IJB also recognises the significant range of statutory services it is required to meet within that finite budget and has a lower appetite for risk of harm to people (low or minimal).

Controls:

- Financial information is reported regularly to the Risk, Audit and Performance Committee, the Integration Joint Board and the Leadership Team
- Risk, Audit & Performance receives regular updates on transformation programme & spend.
- Approved reserves strategy, including risk fund
- Robust financial monitoring and budget setting procedures including regular budget monitoring & budget meeting with budget holders.
- Budgets delegated to cost centre level and being managed by budget holders.
- Medium-Term Financial Strategy reviewed and approved at the IJB in March 2020.

Mitigating Actions:

- The Leadership Team are committed to driving out efficiencies, encouraging self-management and moving forward the prevention agenda to help manage future demand for services. Lean Six Sigma methodology is being applied to carry out process improvements.
- An early review has been undertaken of the financial position and was reported in June to the IJB. These figures will be firmed up and the chief officer and chief finance officer have been asked to report back to the IJB in August and October with further information.

Assurances: • Risk, Audit and Performance Committee oversight and scrutiny of budget under the Chief Finance Officer. • Board Assurance and Escalation Framework. • Quarterly budget monitoring reports. • Regular budget monitoring meetings between finance and budget holders.	**Gaps in assurance:** • The financial environment is challenging and requires regular monitoring. The scale of the challenge to make the IJB financially sustainable should not be underestimated. • Financial failure of hosted services may impact on ability to deliver strategic ambitions.
Current performance: • Year-end position for 2019/20 • The impact of the coronavirus on the finances of the IJB are largely unknown. Some of these financial consequences will receive additional funding from the Scottish Government, and an initial payment in support of mobilisation was received in May 2020. However, at this time although some additional costs are known, many are yet to be determined. The level and timing of any further funding is currently unknown.	**Comments:** • Regular and ongoing budget reporting and management scrutiny in place. • Budget monitoring procedure now well established. • Budget holders understand their responsibility in relation to financial management. • Scottish Government Medium Term H&SC Financial Framework – released and considered by Risk, Audit and Performance Committee.

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Description of Risk: There is a risk that hosted services do not deliver the expected outcomes, fail to deliver transformation of services, or face service failure and that the IJB fails to identify such non-performance through its own systems and pan-Grampian governance arrangements. This risk relates to services that Aberdeen IJB hosts on behalf of Moray and Aberdeenshire, and those hosted by those IJBs and delivered on behalf of Aberdeen City.

Strategic Priority: Prevention and Connections.

Leadership Team Owner: Chief Officer

Risk Rating: low/medium/high/very high

HIGH

IMPACT					
Almost Certain					
Likely				✓	
Possible					
Unlikely					
Rare					
LIKELIHOOD	**Negligible**	**Minor**	**Moderate**	**Major**	**Extreme**

Risk Movement: (increase/decrease/no change):

NO CHANGE 19.11.2020

Rationale for Risk Rating:

- Considered high risk due to the projected overspend in hosted services
- Hosted services are a risk of the set-up of Integration Joint Boards.

Rationale for Risk Appetite:

- The IJB has some tolerance of risk in relation to testing change.

Controls:

- Integration scheme agreement on cross-reporting
- North East Strategic Partnership Group
- Operational risk register

Mitigating Actions:

- This is discussed regularly by the three North East Chief Officers
- Regular discussion regarding budget with relevant finance colleagues.
- Chief Officers should begin to consider the disaggregation of hosted services.

Assurances:

- These largely come from the systems, process and procedures put in place by NHS Grampian, which are still being operated, along with any new processes which are put in place by the lead IJB.
- North East Group (Officers only) led by the 4 pan-Grampian chief executives. The aim of the group is to develop real top-level leadership to drive forward the change agenda, especially relating to the delegated hospital-based services.
- A new role and remit for the Chairs and Vice Chairs of the three IJBs to come together. This is under development.
- Both the CEO group and the Chairs & Vice Chairs group meet quarterly. The meetings are evenly staggered between groups, giving some six weeks between them, allowing progressive work / iterative work to be timely between the forums. The dates are currently being arranged

Gaps in assurance:

- There is a need to develop comprehensive governance framework for hosted services, including the roles of the IJB's sub-committees.

• Operation Homefirst-Closer joint working across the 3 Health and Social Care Partnerships and the Acute Sector.	
Current performance: • The projected overspend on hosted services is a factor in the IJB's overspend position. This may in future impact on the outcomes expected by the hosted services. • Hosted services includes SOARS, Sexual Health and from 1/4/20, Mental Health and Learning Disability Services. All three have been impacted by the Coronavirus pandemic with covid positive patients at Woodend now transferred to ARI, Sexual Health Services temporarily relocated to Foresterhill Campus and a reduction of beds for LD patients at Cornhil with more reliance on community approaches.	**Comments:** • It is noted that NHS Grampian are currently undertaking an internal audit on the governance of hosted services.

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

Strategic Priority: Prevention, Resilience and Communities.

Leadership Team Owner: Chief Officer

Risk Rating: low/medium/high/very high

Low

IMPACT					
Almost Certain					
Likely					
Possible					
Unlikely					
Rare			✓		
LIKELIHOOD	**Negligible**	**Minor**	**Moderate**	**Major**	**Extreme**

Risk Movement: (*increase/decrease/no change)*

No Change 19.11.2020

Rationale for Risk Rating:

- Considered Low given the experience of nearly three years' operations since 'go-live' in April 2016.
- However, given the wide range and variety of services that support the IJB from NHS Grampian and Aberdeen City Council there is a possibility of services not performing to the required level.

Rationale for Risk Appetite:
There is a zero tolerance in relation to not meeting legal and statutory requirements.

Controls:

- IJB Strategic Plan-linked to NHS Grampian's Clinical Strategy and the Local Outcome Improvement Plan (LOIP)
- IJB Integration Scheme
- IJB Governance Scheme including 'Scheme of Governance: Roles & Responsibilities'.
- Agreed risk appetite statement
- Role and remit of the North East Strategic Partnership Group in relation to shared services
- Current governance committees within IJB & NHS.
- Alignment of Leadership Team objectives to Strategic Plan

RESILIENCE:

- The Grampian Local Resilience Partnership is part of the NSRRP. It is chaired by the Chief Executive of NHS Grampian and is the local forum for the Category 1 and 2 Responders including Aberdeen City Council; Aberdeenshire Council; The Moray Council; NHS Grampian; Police Scotland; Scottish Fire & Rescue Service; Scottish Ambulance Service; HM Coastguard; SEPA; MOD; and SSEN
- Strategic Response Team
- Tactical Response Team
- Operational Response Team

Mitigating Actions:

- Regular consultation & engagement between bodies.
- Regular and ongoing Chief Officer membership of Aberdeen City Council's Corporate Management Team and NHS Grampian's Senior Leadership Team
- Regular performance meetings between ACHSCP Chief Officer, Aberdeen City Council and NHS Grampian Chief Executives.
- Additional mitigating actions which could be undertaken include the audit programme and bench-marking activity with other IJBs.
- In relation to capital projects, Joint Programme Boards established to co-produce business cases, strategic case approved by IJB and economic, financial, commercial, management case approved by NHSG Board and ACC Committees

Assurances: • Regular review of governance documents by IJB and where necessary Aberdeen City Council & NHS Grampian. A review of the Scheme of Governance commenced in June 2019 and will be reported to the IJB in November 2019.	**Gaps in assurance:** • None currently significant though note consideration relating to possible future Service Level Agreements.
Current performance: • Most of the major processes and arrangements between the partner organisations have been tested for over two years of operation and no major issues have been identified. • A review of the Integration Scheme has been undertaken and the revised scheme has been approved by NHSG, Aberdeen City Council & Scottish Government. However this does not remove the risk as processes within the IJB and partner organisations will continue to evolve and improve. • The Grampian LRP set up the Grampian Coronavirus Assistance Hub, a new website and phoneline providing information to people all across Grampian on how to access social, practical and emotional support COVID-19.	**Comments:** • Nothing to update on the narrative for the risk.

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Description of Risk:

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

Strategic Priority: Prevention, Resilience, Personalisation, Connections and Communities.

Leadership Team Owner: Lead Strategy & Performance Manager

Risk Rating: low/medium/high/very high

MEDIUM

IMPACT					
Almost Certain					
Likely					
Possible					
Unlikely				✓	
Rare					
LIKELIHOOD	**Negligible**	**Minor**	**Moderate**	**Major**	**Extreme**

Risk Movement: (*increase/decrease/no change)*

NO CHANGE 19.11.2020

Rationale for Risk Rating: Service delivery is broad ranging and undertaken by both in-house and external providers. There are a variety of performance standards set both by national and regulatory bodies as well as those determined locally and there are a range of factors which may impact on service performance against these. Poor performance will in turn impact both on the outcomes for service users and on the reputation of the IJB/partnership.

Rationale for Risk Appetite:
The IJB has no to minimal tolerance of harm happening to people as a result of its actions, recognising that in some cases there may be a balance between the risk of doing nothing and the risk of action or intervention.

Controls:

- Clinical and Care Governance Committee and Group
- Risk, Audit and Performance Committee
- Data and Evaluation Group
- Performance Framework
- Risk-assessed plans with actions, responsible owners, timescales and performance measures monitored by dedicated teams
- Linkage with ACC and NHSG performance reporting
- Annual Report
- Chief Social Work Officer's Report
- Ministerial Steering Group (MSG) Scrutiny
- Internal Audit Reports
- Links to outcomes of Inspections, Complaints etc.
- Contract Management Framework

Mitigating Actions:

- Fundamental review of key performance indicators reported
- Review of systems used to record, extract and report data
- Review of and where and how often performance information is reported on and how learning is fed back into processes and procedures.
- On-going work developing a culture of performance management and evaluation throughout the partnership
- Production of Performance Dashboard, presented to a number of groups, raising profile of performance and encouraging discussion leading to further review and development
- Recruitment of additional resource to drive performance management process development
- Performance now a standing agenda item on Leadership Team meetings

Assurances:

- Joint meeting of IJB Chief Officer with two Partner Body Chief Executives.

Gaps in assurance:

• Agreement that full Dashboard with be reported to both Clinical and Care Governance Committee and Audit & Performance Committee. Lead Strategy and Performance Manager will ensure both committees are updated in relation to the interest and activity of each. • Annual report on IJB activity developed and reported to ACC and NHSG • Care Inspectorate Inspection reports • Capture of outcomes from contract review meetings. • External reviews of performance. • Benchmarking with other IJBs NB: unable to do this yet in 2020	• Formal performance reporting has not been as well developed as we had hoped. Focus/priorities have changed. Operation Home First is now driving a whole new suite of performance indicators although there are challenges in getting access to the data held by NHSG. Our key indicators will change and a refreshed performance and Risk Management Group will lead the development of these. • Work on understanding extent of operational performance reporting has stalled due to Covid 19 however will be picked up again as part of the Operation Home First reporting referred to above. • Further work required on linkage to ACC, NHSG and CPA reporting.
Current performance: • Performance reports submitted to IJB, Risk, Audit and Performance and Clinical and Care Governance Committees. • Data and Evaluation Group terms of reference and membership revised and regular meetings are now scheduled and taking place. • Various Steering Groups for strategy implementation established and reviewing performance regularly. • Performance data discussed at team meetings. • Close links with social care commissioning, procurement and contracts team have been established • IJB Dashboard has been shared widely. **Covid-19 Interim Arrangements** • The Terms of Reference-Interim Clinical and Care Governance Group CCGG)/Clinical Care Risk Management Group (CCRM)-were approved by the Leadership Team and the Clinical Care and Governance Committee. • Remit of Group-The interim Group will consider: CCRM dashboard and real-time risk management/ Social care equivalent dashboard/risks, with each sector continuing to manage their own dashboard ahead of the fortnightly meeting. Representatives from the sectors will present/provide assurance to this Group • Covid/ Non-Covid related clinical and care risks and assurance - this will include taking cognisance of any new related guidance, impact of deployment/ interim ways of working, oversight of the disease modelling and impact of this, recovery/renewal phase (services that have been stopped/services to start first) etc • Confirmation will be made at August IJB that we are now reverting to normal Standing Orders. • Additional NHSG support from Medical, Nursing Director and Public Health re care homes via Grampian oversight group.	**Comments:** • During the Covid-19 outbreak, Healthcare Improvement Scotland has reduced the reporting requirements placed on partnerships so that resources are freed up to support frontline critical functions. It will be important to maintain scrutiny of performance data however so that the risk can continue to be mitigated. • **Annual Performance Report** - In relation to performance for 2019/20, the ACHSCP Annual Performance Report was published as usual although due to the unavailability of full year data due to ISD and Health Intelligence colleagues being diverted onto Covid-19 specific work the appendices relating to national and MSG performance indicators have not yet been published.

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Description of Risk:

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

Strategic Priority: All

Leadership Team Owner: Communications Lead

Risk Rating: low/medium/high/very high

HIGH

IMPACT					
Almost Certain					
Likely					
Possible				✓	
Unlikely					
Rare					
LIKELIHOOD	**Negligible**	**Minor**	**Moderate**	**Major**	**Extreme**

Risk Movement: (*increase/decrease/no change)*

NO CHANGE 19.11.2020

Rationale for Risk Rating:

- Governance processes are in place and have been tested since go live in April 2017.
- Budget processes tested during approval of 3rd budget, which was approved.
- ***Risk rating has increased to acknowledge the complexity of operating in a Covid environment***.

Rationale for Risk Appetite:
Willing to risk certain reputational damage if rationale for decision is sound.

Controls:

- Leadership Team
- IJB and its Committees
- Operational management processes and reporting
- Board escalation process
- Standards Officer role
- Locality Governance Structure

Mitigating Actions:

- Clarity of roles
- Staff and customer engagement – recent results from iMatter survey alongside a well-establish Joint Staff Forum indicate high levels of staff engagement.
- Effective performance and risk management
- To ensure that ACHSCP have a clear communication & engagement strategy, and a clear policy for social media use, in order to mitigate the risk of reputational damage.
- Communications lead's membership of Leadership Team facilities smooth flow of information from all sections of the organisation
- Robust relationships with all local media are maintained to ensure media coverage is well-informed and accurate and is challenged when inaccurate/imbalanced.
- Locality Empowerment Groups established in each of the three localities, ensuring effective two-way communication between the partnership, partner organisations and a wide range of community representatives in North, South and Central. Consultation and engagement exercises are also

	carried out with service users, staff and partners throughout service change processes to gain detailed feedback and act upon it. • Through the Locality Empowerment Groups help inform plans which will identify priorities to improve health and wellbeing for local communities, seeking the views and input of the public on these Groups.
Assurances: • Role of the Chief Officer and Leadership Team • Role of the Chief Finance Officer • Performance relationship with NHS and ACC Chief Executives • Communications plan / communications manager	**Gaps in assurance:** None known at this time
Current performance: • Communications Officer in place to lead reputation management • Regular and effective liaison by Communications Lead with local and national media during pandemic to: 1) mitigate potentially harmful media coverage of Partnership and care providers during the emergency; and 2) secure significant positive media coverage of effective activity by the Partnership and its partners during the Covid crisis, highlighting necessary changes to working practices and the work of frontline staff • Partnership comms presence on the NHSG Comms Cell • Close liaison with ACC and NHSG comms teams to ensure consistency of messaging and clarity of roles	**Comments:** • Communications strategy and action plan in place and being led by the HSCP's Communications Manager • Communication and Engagement Group being strengthened by selection of 'Communications' Champions' across ACHSCP comprising of staff across the partnership to support us in ensuring key messages/internal news items are timely, appropriate and wide-reaching • External and internal websites are regularly updated with fresh news/information; both sites continue to be developed and refined • ***Locality Empowerment Groups established to build our relationship with communities and stakeholders*** • Regular Chief Officer (CO) and Chief Executives (Ces) meeting supports good communication flow across partners as does CO's membership of the Corporate Management Teams of both ACC and NHSG

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Description of Risk:

Failure of the transformation to delivery sustainable systems change, which helps the IJB deliver its strategic priorities, in the face of demographic & financial pressures.

Strategic Priority: All

Leadership Team Owner: Lead for Strategy and Performance

Risk Rating: low/medium/high/very high

HIGH

IMPACT					
Almost Certain					
Likely					
Possible				✓	
Unlikely					
Rare					
LIKELIHOOD	**Negligible**	**Minor**	**Moderate**	**Major**	**Extreme**

Risk Movement: (*increase/decrease/no change)*

NO CHANGE 19.11.2020

Rationale for Risk Rating:

- Recognition of the known demographic curve & financial challenges, which mean existing capacity may struggle
- This is the overall risk – each of our transformation programme work streams are also risk assessed with some programmes being a higher risk than others.

Rationale for Risk Appetite:

- The IJB has some appetite for risk relating to testing change and being innovative.
- The IJB has no to minimal appetite for harm happening to people – however this is balanced with a recognition of the risk of harm happening to people in the future if no action or transformation is taken.
- Although some transformation activity has speeded up due to necessity during the covid period, other planned activity such as plans to increase staff attendance has not been possible as a direct result of Covid implications.

Controls:

- Transformation Governance Structure and Process
- Risk, Audit & Performance Committee – quarterly reports to provide assurance of progress
- Programme Board structure: Executive Programme board and portfolio programme boards are in place.

Mitigating Actions:

- Programme management approach being taken across whole of the transformation programme
- Transformation team in place and all trained in Managing Successful Programmes methodology
- Regular reporting to Executive Programme Board and Portfolio Programme Boards
- Regular reporting to Risk, Audit & Performance Committee and Integration Joint Board
- Increased frequency of governance processes during Covid period – weekly Executive Programme Boards and engagement and involvement of wider LT through daily LT huddles

- A number of plans and frameworks have been developed to underpin our transformation activity across our wider system including: Programme for Transformation, Primary Care Improvement Plan, Action 15 Plan and Immunisation Blueprint.
- Transformation team amalgamated with public health and wellbeing to give greater focus to localities, early intervention and prevention.

Assurances:

- Risk, Audit and Performance Committee Reporting
- Robust Programme Management approach supported by an evaluation framework

Gaps in assurance:

• IJB oversight • Board escalation process • Internal Audit has undertaken a detailed audit of our transformation programme. All recommendations from this audit have now been actioned. • The Medium Term Financial Framework prioritises transformation activity that could deliver cashable savings • The Medium Term Financial Framework, Operation Home First aims and principles, and Programme of Transformation have been mapped to demonstrate overall alignment to strategic plan.	• There is a gap in terms of the impact of transformation on our budgets. Many of the benefits of our projects relate to early intervention and reducing hospital admissions, neither of which provide earlier cashable savings. • Impact on our ability to evidence the impact of our transformation: documenting results from evaluations and reviewing results from evaluations conducted elsewhere allows us to determine what works when seeking to embed new models.
Current performance: • Demographic financial pressure is starting to materialise in some of the IJB budgets. • **Covid-19 Developments** Some transformation has taken place at an accelerated pace out of necessity to meet immediate demands of the Covid-19 situation. Examples of this include the rapid introduction and scale up of Near Me; the use of Microsoft Teams for remote meetings; roll out of additional technology to enable remote working; changes to the Immunisation Service, moving services such as nursing into locality operational teams etc. Some transformation activity that has been paused includes work to reduce sickness absence and use of locum staff. While some of the planned mitigations have been put in place to support staff, clearly with the levels of absence as a result of the pandemic and the pace at which it has been moving, it is difficult to undertake and measure impacts of any change in this area. The pace of other pieces of work such Action 15, PCIP and remodelling of 2C practices has slowed at the current time, although some aspects of these pieces of work have progressed • Home First - a number of projects aligned with Operation Home First and our strategic plan is placing a renewed focus on how we structure our resources. • Accelerated delivery of Vaccination program.	**Comments:**

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Description of Risk

There is a risk that the IJB does not maximise the opportunities offered by locality working

Strategic Priority: All

Leadership Owner: Chief Officer

Risk Rating: low/medium/high/very high

MEDIUM

IMPACT					
Almost Certain					
Likely					
Possible			✓		
Unlikely					
Rare					
LIKELIHOOD	**Negligible**	**Minor**	**Moderate**	**Major**	**Extreme**

Risk Movement: (*increase/decrease/no change)*

DECREASE 19.11.2020

Rationale for Risk Rating:

- Localities are in an early, developmental stage and currently require strategic oversight so are included in this risk register. Once they are operational, they will be removed from the strategic risk register as a stand-alone item and will be included in the wider risk relating to transformation (risk 7).

Rationale for Risk Appetite:

The IJB has some appetite to risk in relation to testing innovation and change. There is zero risk of financial failure or working out with statutory requirements of a public body.

Controls:

- IJB/Risk, Audit and Performance Committee
- Locality Empowerment Groups
- Strategic Planning Group

Mitigating Actions:

- Continued broad engagement on locality working.

Assurances:

- Strategic Planning Group

Gaps in assurance

- Progress of developing and delivering locality plans.

Current performance:

- Locality Empowerment Groups commenced in March 2020. Engagement and involvement has been challenging as a result of physical distancing requirements due to Covid
- The groups have continued to meet virtually during this time.
- The response to Covid has enabled improved connections across our communities including volunteers, third sector and public sector agencies
- Work is ongoing jointly with Aberdeen City Council as part of Aberdeen Together to reduce complexity and duplication across the community and locality planning system.

Comments:

- The LLGs will ensure locality plans align to the broader Aberdeen Community Planning plans and will use existing networks to maximise the potential of community and front line staff engagement. They will work alongside operational locality delivery teams
- A further report on the implementation of the Localities was submitted to the IJB in November 2019. As we move into the next phase of our community response in **Covid-19 Update**
- partnership with the City Council and linked to the Care for People group, locality development and locality working has been identified as one of 5 priority working groups.
- All staff have now been aligned to a locality. This locality alignment is being built on through a number of projects including:
  - Operation Homefirst USC priority workstream is testing and developing a locality-based MDT model of delivery – hospital at home and enhanced community support.

	• Multi-Disciplinary Teams – through Aberdeen Together a test of change is being developed which will see conditions put in place for Aberdeen City Council and ACHSCP staff who support staff in a community in Aberdeen to work in a more joined up manner in order to improve outcomes in a number of areas including health and wellbeing • The Neighbourhood lead model that was implemented as part of the initial Covid Response is being developed with a view to it being embedded within our business as usual structures • Nursing services have been more fully aligned around people in localities.

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Description of Risk:

There is a risk that if the System does not redesign services from traditional models in line with the current workforce marketplace in the City this will have an impact on the delivery of the IJB Strategic Plan.

Strategic Priority: All

Leadership Team Owner: People & Organisation Lead

Risk Rating: low/medium/high/very high

VERY HIGH

IMPACT					
Almost Certain					
Likely					✓
Possible					
Unlikely					
Rare					
LIKELIHOOD -	**Negligible**	**Minor**	**Moderate**	**Major**	**Extreme**

Risk Movement: (*increase/decrease/no change)*

NO CHANGE 19.11.2020

Rationale for Risk Rating:

- The current staffing complement profile changes on an incremental basis over time.
- However the number of over 50s employed within the partnership (by NHSG and ACC) is increasing (i.e. 1 in 3 nurses are over 50).
- Current high vacancy levels and long delays in recruitment across ACHSCP services.
- Inability to fill vacancies

Rationale for Risk Appetite:

- Risk should be able to be managed with the adoption of agile and innovative workforce planning structures and processes

Controls:

- Clinical & Care Governance Committee reviews operational risk around staffing numbers
- Revised contract monitoring arrangements with providers to determine recruitment / retention trends in the wider care sector
- Establishment of Organisational Development Working Group
- Establishment of Performance Dashboard (considered by the Risk, Audit and Performance and Clinical and Care Governance Committees as well as the Leadership Team)

Assurances:

ACHSCP Workforce Plan

Mitigating Actions:

- ACHSCP Workforce Plan
- Rapid service redesign ongoing to deliver Operation Home First priorities
- Active engagement with schools to raise ACHSCP profile (eg Developing the Young Workforce, Career Ready)
- Active work with training providers and employers to encourage careers in Health and Social Care (eg Foundation Apprenticeships/Modern Apprenticeships through NESCOL, working with Department for Work and Pensions)
- Greater use of commissioning model to encourage training of staff
- Increased emphasis on health/wellbeing of staff
- Increased emphasis on communication with staff
- Greater promotion of flexible working
- increased collaboration and integration between professional disciplines, third sector, independent sector and communities through Localities.

	• Increased monitoring of staff statistics (sickness, turnover, CPD, complaints etc) through Performance Dashboard, identifying trends. • Developing greater digitisation opportunities, e.g. using Text Messaging to shift emphasis from GPs to increased use of Texts for pharmacology
Current performance: • Workforce planned developed for health and social care staff. Information expected from Scottish Government during over the next few months which should help improve workforce planning across all partnerships. • High levels of locum use and nursing vacancies in the psychiatry service, • 6 secondary schools have been visited by members of the Leadership Team between November 2019 and February 2020 • ACHSCP sickness absence rates to be updated and reported through the Performance Dashboard.	**Gaps in assurance** • Need more information on social care staffing for Performance Dashboard • Information on social care providers would be useful to determine trends in wider sector-For Performance Dashboard
•	**Comments:** • Health & Care (Staffing) (Scotland) Act This Act offers opportunities and risks to the Partnership. Development of guidance at both national and local level has been paused during Covid. Once work resumes, this strategic risk will need further review • **Covid-19 Update** The emergency has resulted in a requirement for employees to embrace new methods of carrying out their duties, whether this has involved 7-day rostering, remote working or increased flexibility and mobility. Some employees have been redeployed to pressured services during the pandemic. As we move into the next phase of our community response in partnership with the City Council and linked to the Care for People group, locality development and locality working has been identified as one of 5 priority working groups. There is uncertainty regarding the challenges coming in the winter period specifically around managing any local increase in Covid cases, flu outbreak, and increase in health issues caused by lockdown health debt. These could all have an impact on how staff are utilised in the coming months.

Aberdeen City Health & Social Care Partnership
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Description of Risk:

There is a risk that ACHSCP is not sufficiently prepared to deal with the impacts of Brexit on areas of our business, including affecting the available workforce and supply chain.

Whilst the impact on health and social care services of leaving the EU is impossible to forecast, it is clear that a number of issues will need to be resolved. Key areas for health and social care organisations to consider include: staffing; medical supplies; accessing treatment; regulation (such as working time directive and procurement/competition law, for example); and cross border issues.

Strategic Priority: Resilience and Communities.

Executive Team Owner: Business Manager

Risk Rating: low/medium/high/very high

HIGH

IMPACT					
Almost Certain					
Likely				✓	
Possible					
Unlikely					
Rare					
LIKELIHOOD	**Negligible**	**Minor**	**Moderate**	**Major**	**Extreme**

Risk Movement: (*increase/decrease/no change)*

NO CHANGE 19.11.2020

Rationale for Risk Rating:

• There is still a high level of uncertainty around 'Brexit' as impacts are difficult to forecast.

Controls:

- NHSG have held a voluntary survey of EU nationals. ACC currently undertaking a survey of all staff to gather similar information.
- NHSG - An initial operational assessment has been undertaken. A BREXIT co-ordinating group established with executive leadership. Engagement with staff who may be impacted by withdrawal of UK from the EU. Co-ordination with professional leads across Scotland and at SG - procurement, medicines, staff and resilience
- ACC- A Brexit Steering Group has been established. The Partnership is a member of this Group.
- National Procurement of NHS National Services Scotland has been working with Scottish Government, NHS Scotland Health Boards, DHSC and suppliers to try to minimise the impact of EU Exit on the supply of Medical Devices & Clinical Consumables. Activities range from increased stock holding in items supplied from our own National Distribution Centre to UK wide participation in centralised stock building and supplier preparedness.
- The Partnership established an Incident Management Team (IMT) ahead of daily reporting being re-established in 2019. The IMT will report through both the ACC and NHSG routes, as required.

Mitigating Actions:

• Mitigating actions have been developed on a national and local level through UK Government and Scottish Government guidance and the ACC and NHSG EU exit steering groups respectively. These actions are linked to the revised UK national Planning Assumptions (based on the reasonable worst case scenario-no deal).

The assumptions include:

• Travel, Freight and Borders disruption
• Continuity of medical supply and medical products
• Adult Social Care staffing
• NHS staffing
• Demonstrations and Disorder
• Scottish Workforce
• Energy supply disruption
• Food supply disruption
• Access to benefits

	• As the Partnership does not directly employ staff, The Chief Officer will work closely with partners to ensure that as implications become clear the Partnership are able to best represent and meet the needs of all staff. • The Partnership's Business Continuity Planning process is established which will identify key services to prioritise in any contingency event. These Plans have been exercised over the last 7 months through the Partnership's response/recovery to Covid-19. •Review ALEO contingency plans. Request evidence of risk assessment and mitigation from ALEOS for assurance of ability to deliver against contract. This is being considered and scrutinised through the ALEO Hub governance arrangements. •Worked with care providers to develop key business contacts that providers can use over winter to help with their overall business continuity planning eg links to Flu vaccine details/NHS Inform/SEPA/Met office/Council Roads/Travel Providers • The Partnership have taken part in reporting any EU exit implications through both the NHSG and ACC routes. The reporting timescales were roughly the same (around the previous 3 political deadlines in March, April and October 2019). No EU exit implications were reported by the Partnership at these times.
Assurances: • Understanding that current legislation will remain in effect immediate post Brexit	**Gaps in assurance:** • Uncertainty of final trade agreement with EU.
Current performance: Aberdeen City Council have restarted their EU Exit Working Group. The purpose of the Group is detailed below: The EU-Exit Group will support the Senior Responsible Owner (SRO) to identify, plan and manage the impacts of the EU-Exit affecting the Council (ACC) and its Partner Organisations. The Group will provide CMT Stewardship and the SRO with assurance that risks are identified, assessed and that plans are in place to mitigate the impacts as far as is practical. The Group will review and manage EU Exit risks contained within the Risk Register and recommend when risks should be escalated and/or de-escalated in accordance with Risk Management Policy and Guidance. The Group will also identify opportunities arising from an EU Exit and share these with the relevant Functions, Clusters and/or Partner Organisations. The Group met on the 27th of October, 2020. At the meeting the Group participants populated a local risk and mitigation document for the Grampian Local Resilience Partnership, based on the UK National Planning Assumptions as mentioned in the mitigating actions. The Group is meeting on the 23rd of November. The Group will consider and update the risk and mitigation document. In terms of NHSG, the Partnership is working closely with the Head of Procurement. A national Short Life Working Group has been established to oversee Brexit related activity and Heads of Procurement from each Health authority will receive fortnightly updates commencing from the end of October 2020.	**Comments:** • ACHSCP colleagues will need to ensure continued engagement with ACC and NHSG working groups.

There is a high level of interrelated and concurrent joint national and local activity addressing contingency requirements for Living with Covid-19, ongoing PPE needs, and all round winter pressures etc. Updates from the national procurement group, includes: - U.K. Supply Chain contingency planning arrangements that were set up in 2019 are being re-mobilised. This includes a European hub and supply chain that will facilitate NHS Supplies bypassing English Channel Port bottlenecks and subsequent containerised deliveries into NHS Supply Chain Distribution centres. - National stockholdings of items stocked by the National Distribution Centre are in the process of being re-built to a level of 6-8 weeks stock availability to cushion any potential delays in supply as a result of possible border controls. The Scottish Government has recently outlined action that NHS Boards will be required to take, which includes: □ Supporting Health Board Procurement teams in working closely with National Procurement on stock resilience and supplier engagement. □ Health Board Chief Executives are expected to liaise closely with their local authority counterparts who are directly responsible for the delivery and provision of all social care. In terms of resilience arrangements, the letter explains that the Scottish Government has established a Winter Planning and Response Group to work with Health Boards, Health and Social Care Partnerships (HSCPs) and other delivery partners to ensure a coordinated and effective response to all disruptions including those that may arise from the end of the EU Transition period. As part of the winter planning programme support has been provided to both boards and partnerships through a number of live online events to help them rigorously test their winter plans. The Head of Procurement in NHSG and his Team will be reporting on progress to the NHSG's System Leadership Team as well as providing updates and information to the Partnership. The letter has been shared with the ACC EU Exit Group for situational awareness.	

Appendix 1 – Risk Tolerance

Level of Risk	*Risk Tolerance*

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

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

Table 1 - Impact/Consequence Definitions

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

Table 2 - Likelihood Definitions

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

Table 3 - Risk Matrix

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

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

Table 4 - NHSG Response to Risk

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

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

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Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Date of Meeting	01 December 2020
Report Title	Update on Effective Working in Localities
Report Number	HSCP.20.060
Lead Officer	Sandra MacLeod, Chief Officer
Report Author Details	Name: Alison MacLeod Job Title: Lead Strategy and Performance Manager Email Address: AliMacLeod@aberdeencity.gov.uk Phone Number: 07741237034
Consultation Checklist Completed	Yes
Directions Required	No
Appendices	A: Integration of Locality Planning and Community Empowerment Models for Community Planning Aberdeen and Aberdeen City Health & Social Care Partnership

1. Purpose of the Report

1.1. The purpose of this report is to update the Integration Joint Board on the development of effective locality working in Aberdeen City.

2. Recommendations

2.1. It is recommended that the Integration Joint Board:

a) Notes progress of the development of effective locality working.

b) Endorses the proposed integration of locality planning and community empowerment models as described in the Community Planning Aberdeen paper at Appendix A.

3. Summary of Key Information

3.1. At the IJB meeting on 19th November 2019 approval was given to move to three Localities and the Chief Officer was instructed to report back to IJB on the progress towards integrated locality working in December 2020. The 2019 report detailed a phased approach which is shown in the table below and the subsequent text of this current report provides an update on progress against each of the phases.

Phase	Activity	Time-scale
1	Supporting the establishment and development of 3 Locality Empowerment Groups (LEGs)	**November 2019-November 2020**
2	Upskilling and development of both Locality Empowerment Groups and Operational Teams	**April 2020 onwards**
3	Redesign of staffing teams, aligned with our localities	**November 2019 to November 2020**
4	Integrated locality working	**January 2021 onwards**

Phase 1: Supporting the establishment and development of 3 Locality Empowerment Groups (LEGs)

To support the establishment and development of three LEGs an initial recruitment campaign took place in February 2020 to encourage anyone who could improve health and wellbeing in their community to get involved. The response to the campaign was very positive resulting in 75 people expressing an interest in being involved, with many having no previous involvement in the Locality Leadership Groups.

People were invited to three informal sessions in March, which were planned to take place across the City at different times of the day and evening. Approximately 20 to 25 people signed up for each event. The last session was held virtually due to the initial Covid-19 lockdown measures. The aim of these informal sessions was to start

the process of co-designing the LEGs with participants and understanding how they wanted to be involved, what support they needed, who else should be involved and what the next steps should be.

Following the COVID19 outbreak, the development of LEGs was paused initially. This was due to the large number of people volunteering in response to the pandemic. A survey was issued in June to re-connect with people already signed up. The survey asked if they were willing to continue to engage online to progress with the development of LEGs. The response was overwhelmingly positive and three online sessions were held in July with 40 people taking part. Two easy read documents were produced after the March and July sessions summarising feedback for those participating. Next steps have been compiled and shared with people who have expressed an interest in continuing to be involved. Themes such as flexibility; using plain English; and a motivation to empower and influence change were common which led to plans to develop a shared purpose session.

At present 177 people have expressed an interest to be involved in the LEGs. A communication and engagement plan has been established with 28 touch points which range from School Councils and Housing Tenant groups to community food networks. There have also been interfaces on the development of LEGs with the GP Clusters.

Demographic information on those signed up has been collated to ensure the LEGs are representative of the population of Aberdeen. A targeted recruitment drive has now been put in place to increase membership in line with the nine protected characteristics under the Equality Act 2010.

Phase 2: Upskilling and development of Locality Empowerment Groups

In line with the principles of co-production, initial engagement has focused on how people want to be involved; who should be involved; and what they need to get involved. Flexibility has been identified as key and therefore ways for people to get involved include various digital platforms (ensuring these comply with security/information governance protocols.. We will ensure people are not excluded by providing managed support.

Induction sessions were held for those wanting to understand the scope of health and social care better. A number of virtual sessions to co-create a shared purpose were also held and the LEGs will now decide how to represent the agreed statement visually.

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To ensure regular communication and to focus on the development of LEGs, six weekly updates have been provided to people who register as members of the Locality Empowerment groups.

It is important the LEGs are able to influence decisions and therefore a governance framework has been developed that shows the proactive exchange with the Strategic Planning Group. Discussions with the LEGs are underway as to how they will be represented on the Strategic Planning Group.

A number of virtual sessions have taken place to enable LEGs to influence key priority projects being undertaken across the partnership Huddles to deliver Operation home First (OHF). These include: information sharing and being part of communication plans; the review of day care, day activity services and respite; promoting and encouraging the uptake of the flu vaccine; and influencing the way Community Treatment and Care Services are delivered in the future.

It is envisaged the LEGs will have a key role in contributing to the development of the next version of the Strategic Plan ensuring this is truly coproduced, and a timeline has been created to enable this to take place.

Phase 2: Upskilling and development of Operational Teams and Phase 3: Redesign of staffing teams, aligned with our localities

Two workshops were held in March to describe and discuss what locality working would mean for staff.

Since June 2020 various operational teams have joined together to ensure delivery of key priorities within OHF. These are:

- The delivery of the new Care at Home Contract from 1st November
- The provision of multi-disciplinary teams (MDT) “wrap around support” for Care Homes
- The delivery of the different aspects of the “Stepped Care” approach
- The redesign of Day Care and Day Activity opportunities
- Workforce planning and the alignment of staff to localities

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The delivery of the Care at Home Contract

The tender for the delivery of Care at Home support was awarded to the Granite Care Consortium. A consortium of 10 providers in the City. The implementation date for the contract was November 1st. There has been a significant level of collaborative working amongst the providers and ACHSCP staff during the transitional phase. New pathways, systems and processes have been designed; a means of capturing outcomes has been developed; and care packages have been transferred.

MDT Wrap around support for Care Homes

The purpose of this work stream is to ensure that there is a more integrated approach to the delivery of care within our nursing and residential facilities within each locality in the City. The aim is to create a supportive and collaborative MDT aligned to each care home who work in partnership with providers to sustain good standards of care and ensure positive outcomes for our residents. Work has been undertaken to identify areas of good practice, and good integrated team working, and to replicate this approach in areas where this is not happening. Early findings suggest a link between previous areas of concern within our residential and care homes and the degree to which support is delivered by the wider health and care teams.

Delivering our "Stepped Care" approach

Currently there are three key areas of focus within our Stepped Care approach:

- Hospital at Home
- Enhanced Community Support
- Staying well staying connected

Hospital at Home

Hospital at home is a model of delivering care for people at home, rather than in hospital, where it is safe to do so. There are two elements of this model – prevention of admission and earlier / active recovery discharge planning. Whilst the work has been under development for the past two years, the recent focus has been to "scale up" the capacity within the team and also to create pathways with other relevant services – for example with GMED over the weekends.

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Enhanced Community Support

Over the past few months, there has been a lot of work done to develop opportunities to provide enhanced community support. One aspect of this has been the emergence of daily and weekly locality virtual multidisciplinary “huddles”. These huddles provide an opportunity for individual team members to raise immediate concerns that they may have regarding a member of the community and for the whole team to respond by stepping up their input to avoid any further deterioration in the person’s condition, or their need for a hospital admission.

Staying well, staying connected

This is a great example of partnership working between health and social care and the third and independent sector. The purpose of this group is to foster a stepped care approach ensuring that members of our community can move up and down the continuum as their needs fluctuate. There is a focus on “right person, right organisation” which allows for a wider engagement with partners who have not traditionally been involved in the delivery of health and care. The focus is on restoring and nurturing physical and mental well-being.

<u>The redesign of day care and day activities</u>

The redesign has strong links to our localities work and our stepped care approach, ensuring that we are able to sustain carers and cared for through the provision of an outcomes focussed model of delivery which incorporates short breaks. The implementation group consists of representatives of providers and ACHSCP staff.

<u>Workforce Planning</u>

There is a current focus on the design of workforce for community nursing and social work. In addition to this, there is a specific piece of work considering the workforce implications of scaling up the delivery of hospital at home.

Most services now have aligned team members to the locality in which they work. For the most part, team members are mainly delivering services in a virtual way, and therefore their physical presence in a geographical locality is extremely limited.

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Phase 4: Integrated locality working

Over the course of the last four years, it has become apparent that there is significant overlap and duplication between the two locality planning models for the Aberdeen City Health and Social Care Partnership and Community Planning Aberdeen (CPA). A review of the two models has identified significant benefits to be gained from implementing a more integrated approach to locality planning for communities, partners and staff.

The paper attached at Appendix A, describes the review and proposals for revised arrangements intended to reduce duplication of effort and simplify the landscape for community engagement offering a clear, streamlined route which makes it easier, simpler and more appealing for people to engage. It is hoped this will enable stronger representation of community views in service and strategic planning which will in turn lead to person led delivery and improved outcomes.

In essence the proposal is that locality planning for both the ACHSCP and CPA will be integrated, that the existing three locality areas (North, Central and South) as agreed by the IJB, will be known city wide as the localities; that the scope of Locality Empowerment Groups will expand to cover not only health outcomes, but all LOIP Stretch Outcomes; that the former CPA localities will be renamed Priority Neighbourhoods; that there will be shared Locality Plans which the LEGs will oversee delivery of; that the CPA Locality Partnerships will be renamed Priority Neighbourhood Partnerships and will continue to focus on the particular needs within these areas; that the Locality Plans will include a focus on Priority Neighbourhoods (with an option to separate out these plans for the Priority Neighbourhood audience).

The LEGs with their wider remit will continue to link to the Strategic Planning Group and the IJB will continue to be updated on their progress. The IJB will also sign off the health and social care aspects of the Locality Plans. The LEGs will help inform the refreshed LOIP and stretch outcomes which in turn will feed into the refresh of the IJB Strategic Plan. The paper at Appendix A is due to be considered at the CPA Board on 3rd December for approval. Detail of consultation work undertaken to date and further timelines is provided at section 7.1 of the CPA report but is included below for ease of reference: -

Key Milestones	**Timescale**
Draft report and recommendations considered by CPA Management Group	Completed

Complete review of shared resources to support delivery of the new integrated model	Completed
Online consultation events for community planning partners	Completed
Online consultation event with HSCP Locality Empowerment Group members	Completed
Consultation with CPA Locality Partnerships	Completed
ACC Transformation Board	24 Nov 20
ACHSCP Integration Joint Board	01 Dec 20
Final Report and recommendations approved by CPA Board	3 Dec 20
First meetings of the new integrated LEGs held by end January	Jan 21
Development of Locality Plans to align with development of refreshed LOIP	Jul 21
Revised CPA Improvement Programme to reflect totality of improvement projects taking place across the Partnership	Sep 21
Phase 2 review of connection with new integrated Locality Planning Model and partnership forums, community groups and community councils	Oct 21

Subject to agreement, a shared communications plan will be prepared to inform communities about the new arrangements and engage them in the implementation phase,

There is also the intention to initiate a second phase review of locality planning which will look in depth at the network of community groups in Aberdeen and how we connect with these going forward to expand neighbourhood planning.

4. Implications for IJB

4.1. Equalities - It is anticipated that this report will have a neutral to positive impact on the protected characteristics covered by the Equality Act 2010. The Strategic Plan and our locality approach have a focus on addressing inequalities in access to health and social care services.

4.2. Fairer Scotland Duty - It is anticipated that this report will have a neutral to positive impact on people affected by socio-economic disadvantage. The Strategic Plan and our locality approach have a focus on addressing inequalities in access to health and social care services.

4.3. Financial - There are no direct financial implications arising from the

recommendations of this report. Supporting the locality empowerment groups and the delivery of locality-based services will be undertaken within the existing Medium-Term Financial Framework.

4.4. Workforce - the shift to locality focus will directly impact on our workforce and as such we will provide support to staff to lead and deliver these changes

4.5. Legal - There are no anticipated legal implications in relation to this report.

4.6. Covid-19 – There were initial delays to progress of the phases due to re-prioritisation of work during the first wave of Covid-19. Significant progress has, however, been made since June and although some progress has still to be made, much ground has been caught up.

4.7. Other

5. Links to ACHSCP Strategic Plan

5.1. This report links directly to the Communities Aim of our current Strategic Plan and our commitment to "Enable our communities to utilise their energy, strengths, people and assets to self-organise and exercise autonomy" and specifically to the first five priorities within that commitment.

i. Promote community engagement, participation and empowerment
ii. Implement the new locality model
iii. Promote an asset- based approach
iv. Encourage co-design and co-production of services
v. Work with our partners in Community Planning to deliver on the LOIP

5.2. The work detailed in this report also supports the development of the next Strategic plan.

6. Management of Risk

6.1. Identified risks(s)

The IJB is required under the Public Bodies Joint Working Act 2014 to work in localities and by the Community Empowerment (Scotland) Act 2015 to engage with communities and help them to build capacity. There is a risk

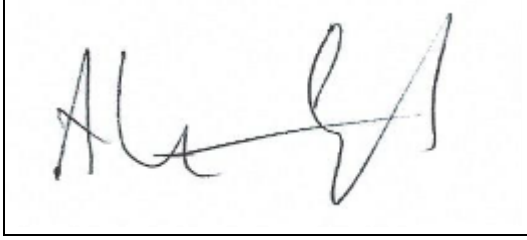
that, if we do not move to an empowering locality-based approach to service delivery, we will be failing in our duties in relation to these pieces of legislation.

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

This report links directly to Risk 8 on the Strategic Risk Register - There is a risk that the IJB does not maximise the opportunities offered by locality working.

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

Working in a collaborative and empowering way with communities will mitigate the above risk.

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

Community Planning Aberdeen

Progress Report	Integration of Locality Planning and Community Empowerment Models for Community Planning Aberdeen and Aberdeen City Health & Social Care Partnership
Lead Officer	Derek McGowan, Chief Officer Early Intervention & Community Empowerment Sandra McLeod, Chief Officer Aberdeen City Health & Social Care Partnership
Report Author	Michelle Cochlan, Community Planning Manager
Date of Report	20 November 2020
Governance Group	CPA Board – 3 December 2020

Purpose of the Report

This report sets out proposals for the integration of two locality planning models currently in place for Community Planning Aberdeen and Aberdeen Health and Social Care Partnership. Both models were established in response to legislation, namely the Public Bodies (Joint Working) (Scotland) Act 2014 and the Community Empowerment (Scotland) Act 2015. Following a review of locality planning conducted by staff from Aberdeen City Council and Aberdeen City Health and Social Care Partnership, it is proposed that there are significant benefits to be gained from a more integrated approach to locality planning for communities, partners and staff across the Community Planning Partnership. This paper presents recommendations for improvement following consultation with a broad range of partner staff and community members currently involved in locality planning groups.

Summary of Key Information

1 **BACKGROUND**

1.1 Aberdeen Together is the name of a group of officers from Aberdeen City Council and Aberdeen City Health and Social Care Partnership which formed in March 2020 to help ensure a coordinated response to the Covid 19 Pandemic in the care for individuals, families, friends and communities across Aberdeen. The Covid19 Response Plan sets out the work of the group during March to May 2020, which includes a range of activities to ensure vulnerable people in Aberdeen were identified and had access to the practical and emotional support they needed during this time. This did not include the immediate lifesaving activities well provided for by emergency services.

1.2 Partnership working between ACC and ACHSCP has been strengthened and expanded through the work of Aberdeen Together and it was agreed that the group had a remit beyond the initial response to the pandemic to progress shared priorities for longer term transformation.

1.3 The Aberdeen Together Plan has been reset to pursue a more integrated approach between ACC and ACHSCP across four transformation workstreams:

1. Data Analytics	How we predict harm and need to support early intervention and prevention
2. Shared Delivery Model	How we work together across organisational boundaries to delivery effective services and achieve best value
3. Locality Planning and Community Empowerment	How we work with and empower communities in the planning and delivery of interventions required at a locality level to improve short to medium and longer term outcomes
4. Anti-poverty	How we ensure a balance of initiatives which have an immediate impact on residents living in poverty and activities which will improve the life outcomes of residents in poverty in the longer term

1.4 This paper is the output to date of workstream three – Locality Planning and Community Empowerment. Locality Planning is the term used to describe community planning partners working within a locality or neighbourhood to improve outcomes. It is often easiest for community groups to participate in community planning at locality or neighbourhood level, where it can have most relevance to their lives and circumstances.

1.5 There are a number of pieces of legislation which require a localities approach, providing guidance on what localities are for, the principles upon which they should be established and ethos under which they should operate. However, the two main Acts which set out specific duties for Locality Planning by Community Planning Partners are the Public Bodies (Joint Working) (Scotland) Act 2014 and the Community Empowerment (Scotland) Act 2015. See Table 1 below for summary of duties.

1.6 Over the course of the last four years, it has become apparent that there is significant overlap and duplication of effort and resource between the two locality planning models for the Aberdeen City Health and Social Care Partnership and Community Planning Partnership which have evolved in response to the legislation. Therefore, a review of the two models has been conducted to identify recommendations for improvement.

1.7 The findings of stakeholder engagement (through Customer Journey and Customer Empathy Mapping) undertaken to help inform the review, indicated that those involved felt confused about current arrangements for Locality Planning, the roles of the different groups involved, and their alignment with each other. (See Appendix 4 for full list of 'Problem Statements' developed). A benchmarking exercise conducted with other Community Planning Partnerships confirmed that they experience the same issues with confusion and duplication and share our aspirations to join up more on locality planning, although we are one of the first CPPs attempting to do so – See Appendix 7.

Table 1	**Public Bodies (Joint Working) (S) Act 2014**	**Community Empowerment (Scotland) Act 2015**
Who is the legislation for?	Health and Social Care Integrated Joint Boards	Community Planning Partners specified within the statute, including the local Council and Health and Social Care Integrated Joint Boards
When did it come into force?	2014	2015
Purpose of the legislation	The Act puts in place the legislative framework to integrate health and social care services in Scotland.	The Act formalises Community Planning Partnerships, requiring that they exist in every Scottish local authority area.
What does it say about Localities and Locality Plans	The Act states that the IJB should establish at least two localities within its area. Statutory guidance requires each locality to have a plan.	The Act states that the CPP should identify localities within its area where people experience significantly poorer outcomes as a result of socio-economic disadvantage. For each of these areas, the Act states the CPP must publish a locality plan.
Arrangements we have put in place locally to meet the requirements of the Act?	• 3 localities identified: North, South, Central • Locality Empowerment Group for each currently being established • Aim to achieve 100% community membership, except for public health coordinator role • LEGs report to the IJB via the Strategic Planning Group	• 3 localities identified: Northfield, Mastrick, Middlefield, Heathryfold and Cummings Park; Torry; Tillydrone, Woodside, Seaton • Locality Partnerships in place for each • Membership comprises 50% community members, including local councillors, and 50% professionals • LPs report to the CPA Board via the Management Group

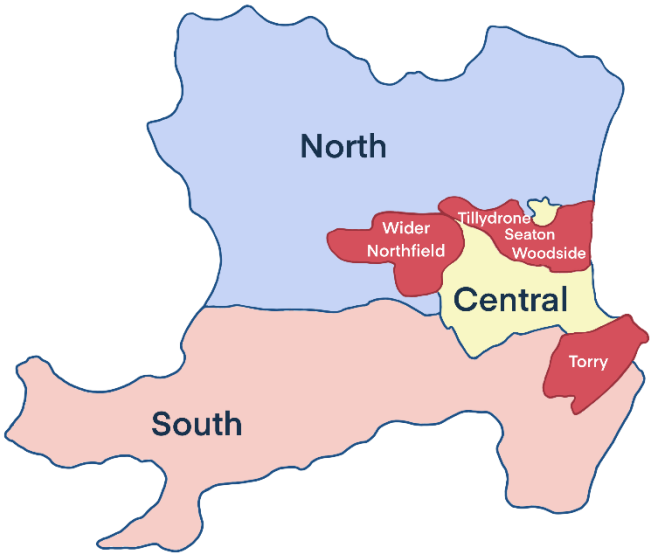
1.8 Aberdeen City Voice responses in 2020 showed that 55.8% of respondents would like to be involved in decisions that affect their community but 48.7% of these respondents said they didn't know how.

1.9 The recommendations contained in this paper are intended to provide the foundation for a simplified landscape for staff and communities. They should also enable a more efficient and effective way of working together and with communities to improve outcomes for Aberdeen.

1.10 Approval of these recommendations will lead to a second phase review of how the new integrated model connects with the wider network of community groups and community councils across Aberdeen and supports a strengthened approach to community empowerment and engagement. See Appendix 1 for scope.

2 SHARED LOCALITIES AND PRIORITY NEIGHBOURHOODS

2.1 One of the issues that the review has identified is that staff across the Community Planning Partnership and people in communities are often confused about the common use of the term localities, which has different meanings for the Aberdeen City Health and Social Care Partnership and Community Planning Aberdeen. To help differentiate between the two, they are often described as ACHSCP Localities and CPA or Priority Localities. However, this can still be confusing, especially to members of the public who may not be familiar with the CPP and ACHSCP criteria for localities. It also wrongly signals that these different types of 'localities' are distinct from each other, when they are in fact interconnected. It is proposed that from now, Community Planning Aberdeen and all partners, including ACC and ACHSCP shall know Localities to mean the three broad areas of the City: North, South and Central; and Priority Neighbourhoods to mean those areas within the North, South and Central Localities which experience poorer outcomes as a result of their socio-economic status.



Priority Neighbourhoods

North: Heathryfold, Middlefield, Northfield, Cummings Park, Mastrick

South: Torry

Central: Tillydrone, Seaton, Woodside

See para 3.6 and Appendix 2 for details of all neighbourhoods.

2.2 There are four other areas which, based on the latest data available from the Scottish Index of Multiple Deprivation (SIMD), might be considered a priority neighbourhood, or at least at risk of this. These are Kincorth, George Street, Ashgrove and Stockethill which all have at least one data zone in the 20% most deprived and at least half of their other datazones in the 40% most deprived.

2.3 It is proposed that in recognising these neighbourhoods as areas which also experience poorer outcomes than the rest of Aberdeen as a result of their socio-economic status, we can be more targeted in our early intervention and prevention work. This will ensure that these communities also benefit from some of the improvement being experienced in our current priority neighbourhoods as a result of Locality Planning. Support and interventions would be proportionate to the needs of these neighbourhoods and the needs of the wider Locality.

2.4 There are a further four neighbourhoods which, although they do not have a datazone in the 20% most deprived, do have at least half of their datazones in the 40% most deprived and may also benefit from a targeted approach. These are:

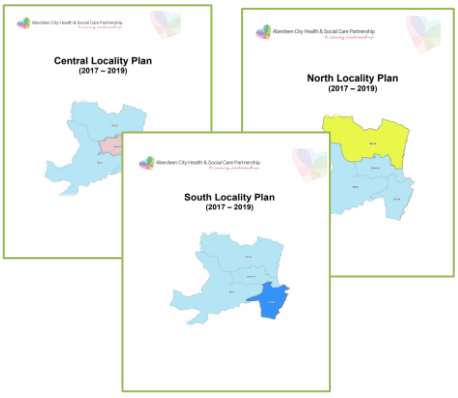
Garthdee - 4 out of 6 datazones in most deprived 40%
Old Aberdeen - 2 out of 3 datazones in most deprived 40%
Sheddocksley - 4 out of 5 datazones in most deprived 40%
Summerhill - 3 out of 5 datazones in most deprived 40%

3 SHARED LOCALITY PLANS

3.1 Having agreed our shared Localities and Priority Neighbourhoods, our attention turns to the requirement of both the Public Bodies (Joint Working) (Scotland) Act 2014 and Community Empowerment (Scotland) Act 2015 to have a plan in place to improve outcomes for each of these geographical areas.

3.2 At the moment there are two separate types of Locality Plan in place: Community Planning Aberdeen Locality Plans and Aberdeen City Health and Social Care Partnership Locality Plans. Both aim to improve outcomes for the local area. Whilst the ACHSCP plans cover the whole of Aberdeen, they focus on health and social care issues only. CPA Locality Plans cover our most deprived areas of Aberdeen, but they cover the broader range of outcomes identified within the city wide LOIP.

HSCP Locality Plans cover the whole of the City for LOIP Stretch Outcome 11: Healthy Life Expectancy



CPA Locality Plans cover our priority neighbourhoods for ALL LOIP Stretch Outcome 1-15

3.3 The outcomes of poor health and wellbeing are inextricably linked to the wider determinants of public health that the Community Planning Partnership is seeking to improve through its stretch outcomes 1-15. Therefore, it is proposed that plans to improve health at a locality level would be strengthened if they were set in the broader context of the locality. Both sets of Locality Plans aim to achieve improvement in the local area in conjunction with communities; and both plans are due to be refreshed.

3.4 There is an opportunity to bring the two types of plan together to provide a single Locality Plan for the area. The Locality Plan will specify the targeted work to be carried out in priority neighbourhoods, and indeed at risk neighbourhoods or other priority communities of interest, e.g. communities vulnerable to flooding, communities which need support implementing a new idea, or community members that need a bit more support - such as care experienced children and young people, people with disabilities, and minority groups. The plan will provide a holistic view of the area to help direct resources to the people and communities in greatest need; with an option to separate out the priority neighbourhood plan for the target audience. This alignment approach gives the CPP the scope to consider locality planning beyond the deprived areas.

3.5 The locality plans do not stand alone. They underpin the Aberdeen City Local Outcome Improvement Plan and Aberdeen City Health and Social Care Strategy, as well as other Partner strategies. They bridge the gap between the high level strategic direction of the Partnership and the aspirations and priorities of the people, communities and groups living and working in the area.

Aberdeen City Local Outcome Improvement Plan

Sets out 15 Stretch Outcomes for Partners to achieve working together and with communities

Community Planning Partner Corporate Plans

Shared Locality Plans

North Locality Plan	South Locality Plan	Central Locality Plan
Priority Neighbourhood Plans: Northfield etc	Priority Neighbourhood Plans: Torry	Priority Neighbourhood Plans: Woodside, Seaton, Tillydrone

3.6 Communities may also wish to come together as a group in their local areas to prepare their own neighbourhood plans with their own locally identified priorities and actions for improvement. Support for communities to do neighbourhood planning will be explored further in phase two of the review of locality planning, see section 6 of this report. See below list of all Aberdeen Neighbourhoods.

North	South	Central
1 Dyce 2 Danestone 3 Oldmachar 4 Denmore 5 Balgownie & Donmouth 6 Bucksburn 7 **Heathryfold** 8 **Middlefield** 9 Kingswells 10 **Northfield** 11 **Cummings Park** 12 Sheddocksley 13 **Mastrick** 14 Summerhill	1 Culter 2 Cults, Bieldside & Milltimber 3 Hazlehead 4 Braeside, Mannofield, Broomhill & Seafield 5 Garthdee 6 Ferryhill 7 Kincorth, Leggart & Nigg 8 **Torry** 9 Cove	1 **Tillydrone** 2 Old Aberdeen 3 **Seaton** 4 **Woodside** 5 Hilton 6 Stockethill 7 Ashgrove 8 George Street 9 Froghall, Powis & Sunnybank 10 Midstocket 11 Rosemount 12 City Centre 13 Hanover 14 West End

Note: **Priority neighbourhoods**
Proposed priority neighbourhoods (see para 2.2.)

4 SHARED LOCALITY EMPOWERMENT GROUPS

4.1 The Community Empowerment (Scotland) Act 2015 states that in preparing Locality Plans, Community Planning Partnerships should 'take into account the needs and circumstances of the people residing in the locality and consult as it considers appropriate'. It does not prescribe how this consultation takes place and neither does the Public Bodies (Joint Working) (Scotland) Act 2014.

4.2 Our aspirations for community involvement in Locality Planning go well beyond consultation and reach for empowerment, engagement and participation. We have seen how locality-based, community led approaches have worked well to deliver emergency services during the Covid-19 pandemic and they will be crucial again in the recovery process. This has created a precedent for much greater emphasis on community led approaches in longer term community and locality planning.

4.3 In recognition of this shift, the Scottish Government have established a Social Renewal Advisory Board (SRAB) with the aim of capitalising on the new level of community empowerment. It will report to the Scottish Government later this year with proposals on how this can be sustained and three Social Listening events have been held in Aberdeen to gather ideas from local people.

4.4 This newly established route for engaging on equality and social justice is complementary to the Community Planning Partnership's existing mechanisms to support community engagement, participation and empowerment. These are primarily the Aberdeen City Health and Social Care Partnership's Locality Empowerment Groups and Community Planning Aberdeen's Locality Partnerships.

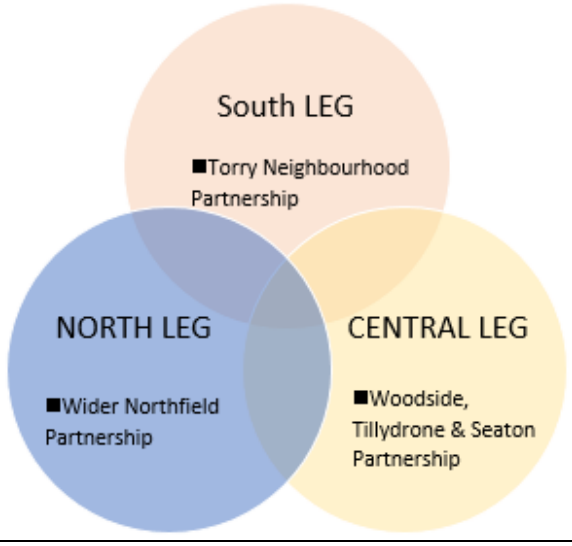
Group	Area Covered	Issues Covered
Locality Empowerment Groups	North, South, Central	Health outcomes
Locality Partnerships	Priority Neighbourhoods	ALL LOIP Stretch Outcomes and local priorities

4.5 It is proposed that these groups continue, going forward with the following changes:

- Locality Empowerment Groups will now cover all 15 Stretch Outcomes prioritised in the LOIP under the themes of People, Place and Economy
- Locality Partnerships will now be known as Priority Neighbourhood Partnerships

4.6 It is expected that these changes will be favourable with communities, based on feedback from staff involved in the review that work with these communities and from the consultation exercise conducted with broader staff and communities during November (See Appendix 7). It is worth noting that the Locality Empowerment Groups were newly formed by ACHSCP this year and due to Covid-19 are still in their infancy which allows us to work with communities to shape the direction they go in. They replace the four Locality Leadership Groups established by ACHSCP in 2017.

4.7 The Priority Neighbourhood Partnerships (formerly named Locality Partnerships) are more established, having continued to meet since 2017. It is proposed that they will continue, to provide additional support to the people and communities residing in these areas to engage with Locality Planning.



The Community Engagement Group will oversee the transition to the new arrangements, supporting collaboration between the LEGs, Outcome Improvement Groups and wider community groups on shared priorities

4.8 The link between the Locality Empowerment Groups and the Priority Neighbourhood Partnerships should be nurtured to be a strong one. Collaboration between professionals and community members will be essential to ensure these two groups complement each other, with the Locality Empowerment Group taking an overview of broad issues across the locality area and neighbourhood partnerships focussing on the local area that they cover. It is intended that the groups will be mutually supportive, with the LEGs being able to get involved in a number of cross cutting issues for the area and PNPs taking a lead on tackling the issues unique to their neighbourhood. Clarity and transparency will be key to ensuring that there is no duplication between the groups and indeed the work of the CPA Outcome Improvement Groups. See Appendix 5 for draft role and remits and Appendix 6 for overall structure.

4.9 It is proposed that the Community Planning Partnership's Community Engagement Group will continue to provide strategic oversight of community engagement across the Partnership through the Locality Empowerment Groups and Neighbourhood Partnerships as well as any other routes. The group was first established in 2016 to help support the Partnership's Outcome Improvement Groups to involve and engage communities in their improvement work. The group has an ongoing remit to support the LEGs and NPs in the transition to an integrated model, as well as continue to have responsibility for the CLD Strategy and City Voice. See Appendix 5 for role and remit. The CPA Management Group has appointed the Community Planning Manager as Chair, with continued support from the Chair of the Civic Forum as Vice Chair. The group has a pivitol role in ensuring the new integrated Locality Planning Model is effective in engaging and empowering communities across Aberdeen.

4.10 Throughout this review many ideas have been gathered on how we can improve community engagement and enlist people to get involved in our improvement work via the LEGs, NPs and the many other community groups and networks which already exist. There is a recognition that not everyone is willing/able to participate in a 'formal' group setting, that there is a need to engage more widely with those who wouldn't normally get involved, and different 'communities of interest, and that there is a desire to harness the benefits of digital opportunities in order to progress this. This was also highlighted by members of the LEGs in research done to inform the development of these Groups.

4.11 See below just some of the ideas captured which might be tested to improve in key areas. Many more will be possible and it is proposed that the Community Engagement Group works with the LEGs and NPs to explore and test these and any other ideas in establishing the new joint arrangements.

Problem Areas			
Ideas for testing	**Awareness/ Understanding**	**Perception of Impact**	**Accessibility**
	Joint Communications Plan	Clear, planned programme of work	Community Platforms/ digital forums to support virtual engagement
	Targeted social media	Communication on how work contributes to wider partnership	Chatbot to capture feedback from any partner website
	Locality Champions/ Network	Self assessment to consider effectiveness	
	Locality News Channel		

5 SHARED LEADERSHIP AND PARTNERSHIP WORKING

5.1 Approval of the proposals within this report will allow us to maximise the opportunity for collaborative working across the Community Planning Partnership and with communities. The Community Engagement Group, chaired by the Community Planning Manager will oversee the transition to the new arrangements and support the collaboration between the LEGs, Outcome Improvement Groups and wider community groups on shared priorities.

5.2 The table below confirms the Partnership staff currently responsible for locality planning who, going forward, will have a co-lead role in coordinating locality planning across the three City Localities.

North	South	Central
Locality Inclusion Manager, ACC Public Health Coordinator, ACHSCP	Locality Inclusion Manager, ACC Public Health Coordinator, ACHSCP	Locality Inclusion Manager, ACC Public Health Coordinator, ACHSCP

5.3 Working with the Chair of the Community Engagement Group, the Locality Planning co-leads for North, South and Central will develop the ‘how’ we work together in partnership with staff and communities to deliver the roles and remits in Appendix 5. The more we embody the following values, the more successful we expect to be in joining with partners and communities to improve outcomes at a City wide and locality level:

- **Collaborative**: working together with communities and partners to improve outcomes
- **Innovative**: creating shared solutions, testing and learning from our mistakes and successes
- **Excellence**: making a difference and improving outcomes for people and communities
- **Respectful**: valuing every contribution – individuals, professionals, community groups, people with lived experience, organisations
- **Integrity**: doing the right thing the right way, informed by evidence and data

5.4 It is intended that the LEGs will help strengthen and coordinate collaborative working between individuals, professionals, community groups, people with lived experience, partner organisations and the Community Planning Partnership as a whole.

5.5 The proposals within this report have been informed by feedback from communities. This includes feedback gathered during the process of developing the ACHSCP Locality Empowerment Groups, during which workshops were held with members of the Locality Leadership Groups (LLGs) to learn what worked well and what could have been better. Also, the insights of staff working with communities to facilitate the LEGs and Locality Partnerships have also helped shape thinking on these proposals. A formal consultation was launched in November with wider community planning partnership staff and communities involved in the LEGs and Locality Partnerships. Stakeholders were invited to attend a choice of online consultation sessions and/ or complete an online survey. A community friendly consultation document was produced to support staff and communities to participate in the consultation process. See Appendix 7 for summary of feedback.

6 PHASE TWO: WORKING WITH COMMUNITIES

6.1 The proposals within this report provide a solid foundation for greater collaboration with communities. A second phase of this review will seek to explore how the integrated Locality Planning Model connects and complements the work of wider partnership forums, community groups, networks and community councils. See scoping diagram in Appendix 1.

6.2 It will also consider how we can use this infrastructure to empower communities to expand the neighbourhood planning approach we have in place for our priority neighbourhoods. This will involve reaching out and working with established community councils and civic groups to get their input and ideas and explore what support is needed. For example, feedback from the consultation process has indicated that a toolkit for communities providing guidance on how to go about developing their own neighbourhood plan would be a useful resource. This would bring together a number of community toolkits already in existence, e.g. Community Resilience Plan Toolkit and Draft Local Place Plan Toolkit to support communities in the production on of a single multifaceted neighbourhood plan.

6.3 Working with communities to develop this toolkit, which enables them to deliver on concerns in their community and with partners, will also identify and develop the capacity building support required to enable communities to create and maintain their own neighbourhood plans. The Community Learning Strategy, which includes details of how the Council and partners deliver capacity building for community empowerment, is due to be refreshed at the end of 2021. It is intended that this second phase of the review of locality planning will inform the revision of the CLD Strategy, specifying the capacity building support required from partners to empower communities to own, develop, deliver and maintain their own neighbourhood plan.

7 NEXT STEPS

1.1 The table below includes the key milestones and indicative timescales for the implementation of the recommendations made within this report.

Key Milestone	**Timescale**
Draft Report and recommendations considered by CPA Management Group	Completed
Complete review of shared resources to support delivery of the new integrated model	Completed
Online consultation events for Community Planning Partners	Completed
Online consultation event with HSCP Locality Empowerment Group members	Completed
Consultation with CPA Locality Partnerships	Completed
ACC Transformation Board	24 Nov 20
ACHSCP Integration Joint Board	1 Dec 20
Final Report and recommendations approved by CPA Board	3 Dec 20
First meetings of the new integrated LEGs held by end January	Jan 21
Development of Locality Plans to align with development of refreshed LOIP	July 21
Revised CPA Improvement Programme to reflect totality of improvement projects taking place across the Partnership	Sep 21
Phase 2 review of connection with new integrated Locality Planning Model and partnership forums, community groups and community councils	Oct 21

Recommendations for Action

It is recommended that members of the CPA Board agree to the following recommendations:

Shared Localities and Priority Neighbourhood

i) the term Localities will be used by Community Planning Aberdeen and all partners to mean the three broad areas of the City: North, South and Central;
ii) the term Priority Neighbourhoods will mean those areas within the North, South and Central Localities which experience poorer outcomes as a result of their socio-economic status;
iii) George Street, Ashgrove, Stockethill and Kincorth will be considered Priority Neighbourhoods based on analysis of SIMD data;

Shared Locality Plans

iv) the introduction of three Integrated Locality Plans for North, South and Central Localities;
v) within these Locality Plans there will be included a focus on our Priority Neighbourhoods; with an option to separate out these plans for the Priority Neighbourhood audience;

Shared Locality Empowerment Groups

vi) the scope of Locality Empowerment Groups will expand to cover not only health outcomes, but all LOIP Stretch Outcomes;
vii) Locality Partnerships will now be known as Priority Neighbourhood Partnerships and these will continue to be supported by Partnership staff;
viii) the CPA Community Engagement Group will continue to provide strategic oversight and seek to improve community engagement and empowerment across the Partnership, including overseeing the transition to the new shared Locality Empowerment Groups;
ix) the Community Planning Aberdeen constitution is updated to reflect the core roles and remits of the groups included in Appendix 5;

Next steps

x) Preparation of a shared communications plan to inform communities about the new arrangements and engagement them in the implementation phase, subject to the agreement of the CPA Board;
xi) Note intentions to initiate a second phase review of locality planning which will look in depth at the network of community groups in Aberdeen and how we connect with these going forward to expand neighbourhood planning.

Consultation
The following people were consulted in the preparation of this report: Members of existing Locality Empowerment Groups and Locality Partnerships Members of CPA Management Group Members of the Review Team: • Interim Managing Director, Bon Accord Care • Community Justice Officer, ACC • Improvement Programme Manager, ACC • Lead Strategy Performance Manager, ACHSCP • Area Manager, ACC • Locality Inclusion Manager, ACC • Team Leader, ACC • Public Health Coordinator, ACHSCP • Team Leader, Masterplanning, Design & Conservation - ACC Members of Aberdeen Together: • Director, Customer - ACC • Chief Officer - ACHSCP • Chief Officer, Integrated Children & Family Services - ACC • Chief Officer, Data and Insights - ACC • Chief Officer, Customer Experience - ACC • Chief Officer, Early Intervention & Community Empowerment, ACC • Library and Information Services Manager, ACC

Background Papers
The following papers were used in the preparation of this report. Locality Planning Aberdeen Report – CPA Board, 20 June 2016 Locality Model – IJB, 26 March 2019

Contact details:
Michelle Cochlan
Community Planning Manager
Aberdeen City Council
Tel: 01224 522791
Email: mcochlan@aberdeencity.gov.uk

APPENDIX 1 TERMS OF REFERENCE

REVIEW OF LOCALITY PLANNING

1. AIM & OBJECTIVES

1.1 The aim of the review is to consider the effectiveness of the relationship between CPP's current locality planning structures to identify recommendations for improvement.

1.2 Objectives:

- Examine the CPP's current arrangements for locality planning, including Partnership Forums
- Understand the relationship/ connections between community groups
- Examine the resources required
- Identify and spread best practice
- Design a model which supports co-production and community empowerment
- Propose options for improvement to how we plan, coordinate and deliver locality planning in a way which meets the needs of both the CPP and customers and citizens;

2. SCOPE

2.1 Phase 1 of this review will examine the structures and arrangements which have been put in place by Aberdeen City Council and Aberdeen City Health and Social Care Partnership for locality planning and how these connect each other.

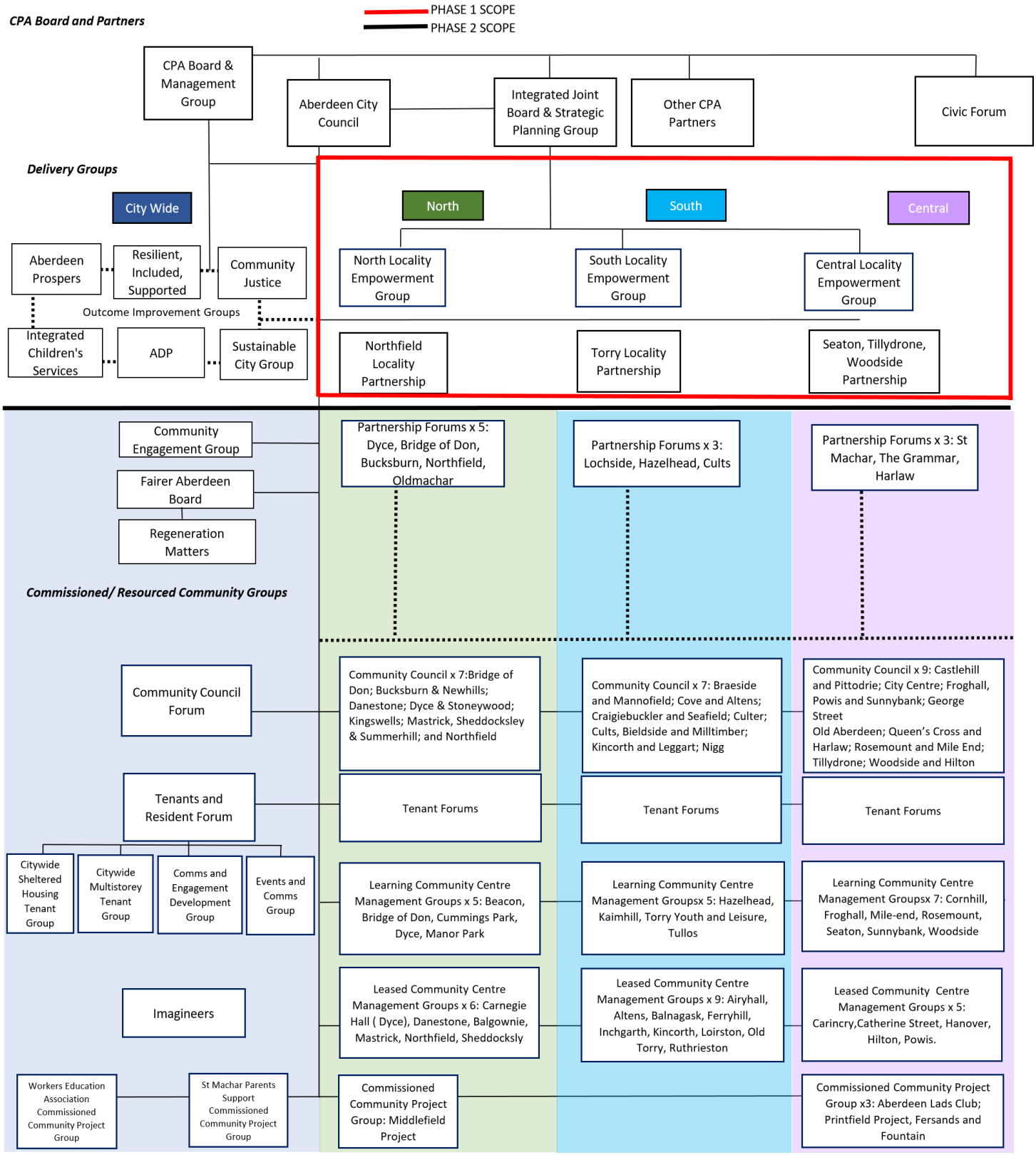
2.2 Phase 2 of this review will examine how proposals at phase 1 connect with wider partnership forums, community groups and community councils.

See diagram overleaf:

3. KEY DELIVERABLES AND TIMESCALES

3.1 Phase 1 of the review is planned to take place during June to October 2020. The key deliverables are as follows:

• Project team established	10 June
• Complete desk top analysis	June
• Further evidence gathering	June
• Identification of best practice	July
• Consultation with stakeholders	August
• Consultation on draft findings	September
• Draft report to CPA Management Group	29 October
• Final report to CPA Board	11 November
• CPA Board Meeting	3 December


CPA Board and Partners
PHASE 1 SCOPE
PHASE 2 SCOPE
CPA Board & Management Group
Aberdeen City Council
Integrated Joint Board & Strategic Planning Group
Other CPA Partners
Civic Forum
Delivery Groups
City Wide
North
South
Central
Aberdeen Prospers
Resilient, Included, Supported
Community Justice
Outcome Improvement Groups
Integrated Children's Services
ADP
Sustainable City Group
North Locality Empowerment Group
South Locality Empowerment Group
Central Locality Empowerment Group
Northfield Locality Partnership
Torry Locality Partnership
Seaton, Tillydrone, Woodside Partnership
Community Engagement Group
Fairer Aberdeen Board
Regeneration Matters
Partnership Forums x 5: Dyce, Bridge of Don, Bucksburn, Northfield, Oldmachar
Partnership Forums x 3: Lochside, Hazelhead, Cults
Partnership Forums x 3: St Machar, The Grammar, Harlaw
Commissioned/ Resourced Community Groups
Community Council Forum
Community Council x 7:Bridge of Don; Bucksburn & Newhills; Danestone; Dyce & Stoneywood; Kingswells; Mastrick, Sheddocksley & Summerhill; and Northfield
Community Council x 7: Braeside and Mannofield; Cove and Altens; Craigiebuckler and Seafield; Culter; Cults, Bieldside and Milltimber; Kincorth and Leggart; Nigg
Community Council x 9: Castlehill and Pittodrie; City Centre; Froghall, Powis and Sunnybank; George Street
Old Aberdeen; Queen's Cross and Harlaw; Rosemount and Mile End; Tillydrone; Woodside and Hilton
Tenants and Resident Forum
Tenant Forums
Tenant Forums
Tenant Forums
Citywide Sheltered Housing Tenant Group
Citywide Multistorey Tenant Group
Comms and Engagement Development Group
Events and Comms Group
Learning Community Centre Management Groups x 5: Beacon, Bridge of Don, Cummings Park, Dyce, Manor Park
Learning Community Centre Management Groupsx 5: Hazelhead, Kaimhill, Torry Youth and Leisure, Tullos
Learning Community Centre Management Groupsx 7: Cornhill, Froghall, Mile-end, Rosemount, Seaton, Sunnybank, Woodside
Imagineers
Leased Community Centre Management Groups x 6: Carnegie Hall (Dyce), Danestone, Balgownie, Mastrick, Northfield, Sheddocksly
Leased Community Centre Management Groups x 9: Airyhall, Altens, Balnagask, Ferryhill, Inchgarth, Kincorth, Loirston, Old Torry, Ruthrieston
Leased Community Centre Management Groups x 5: Carincry,Catherine Street, Hanover, Hilton, Powis.
Workers Education Association Commissioned Community Project Group
St Machar Parents Support Commissioned Community Project Group
Commissioned Community Project Group: Middlefield Project
Commissioned Community Project Group x3: Aberdeen Lads Club; Printfield Project, Fersands and Fountain

4. PROJECT TEAM

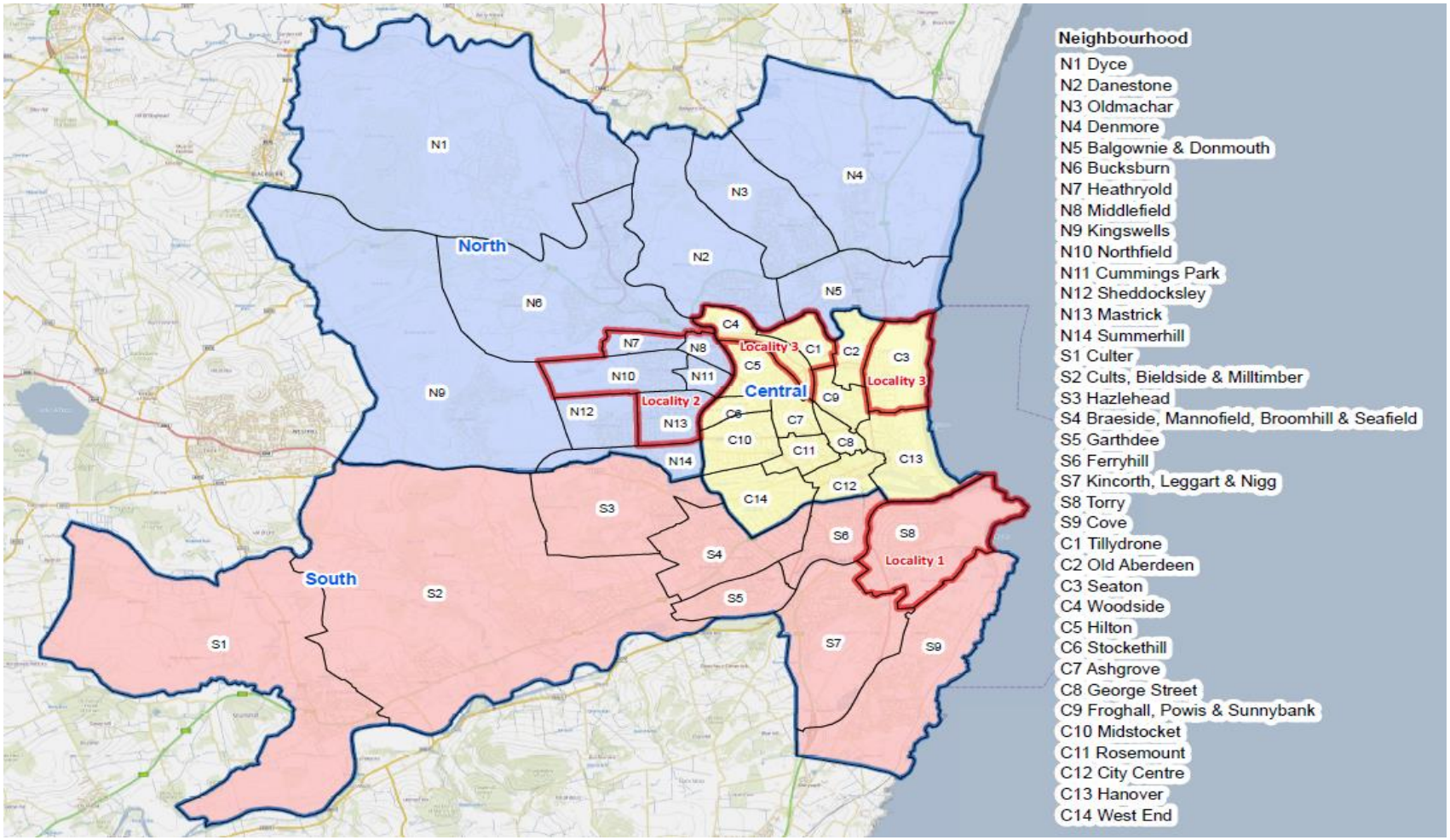
Project Sponsor	Andy MacDonald, Director of Customer, ACC
Project Board	Aberdeen Together Chaired by Derek McGowan and Sandra McLeod
Project Lead	Michelle Cochlan & Gail Woodcock
Project Team	Lead Strategy Performance Manager Communities and Housing Area Manager Locality Inclusion Manager Public Health Coordinator Team Manager Partnerships Improvement Programme Manager Community Justice Officer
Key Stakeholders/ Consultees	Chief Officer (Early Intervention and Community Empowerment) Chief Officer (Strategic Place Planning) Colleagues from Locality Partnerships/ Locality Empowerment Groups CPA Management Group CPA Lead Contacts Chief Officer, Integrated Children & Family Services Team Leader, Master planning, Design & Conservation
Benchmarking	Other Community Planning Partnerships

5. METHODOLOGY

5.1 The research methodology will include:

- Scottish Service Redesign Approach
- Desk top analysis of relevant legislation, strategies, policy, reports etc
- Gathering of evidence of best practice/ case studies etc
- Consultation with key stakeholders/ consultees
- Discussions/ interviews with external representatives e.g. colleagues from other Councils and external organisations where relevant
- Discussion of findings with key stakeholders/ consultees

APPENDIX 2 - LOCALITY BOUNDARIES



ACHSCP Localities:	Priority Localities
South	Locality 1 -Torry
North	Locality 2 - Northfield, Mastrick, Middlefield, Heathryfold, Cummings Park
Central	Locality 3 - Seaton, Woodside, Tillydrone

APPENDIX 3 LEGISLATION

- **Community Planning Partnerships and Locality Planning**
  The Community Empowerment (Scotland) Act 2015 introduces locality planning in respect of community planning for the first time. The Act requires every CPP to identify each locality in its area where people experience significantly poorer outcomes, as a result of socio-economic disadvantage, than those people living in other areas. The Act stipulates that localities should have a maximum population size of 30,000 residents.

  For each of these areas, the CPP must publish a locality plan (locality plans for other areas of the city are optional). The locality plan must set out the priority outcomes the CPP proposes to improve. This should be set out in terms of what will be different for communities in 10 years as well as the contributory actions, indicators and targets for the short (1 year) and medium (3 years) terms. In preparing the locality plans, the CPP must take into account the needs and circumstances of the people residing in the locality and consult as it considers appropriate. The CPP is required to review progress against each locality plan and report on this annually.

- **Health and Social Care Partnerships and Locality Planning**
  The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) puts in place the legislative framework to integrate health and social care services in Scotland and requires each Integration Authority to establish at least two localities within its area. Unlike the Community Planning localities which focus on areas of deprivation with a maximum population size of 30,000 residents, HSCP localities are required to divide the whole locality authority area into at least two. In Aberdeen we have recently elected to divide the City into three. These areas align with the Community Planning localities in that within the boundaries of each of the ACHSCP localities, we have a community planning priority locality. See Appendix 1 for visual.

- **Local Place Plans – Planning (Scotland) Act 2019**
  The Planning (Scotland) Act 2019 includes provisions for a planning authority to publish an invitation to local communities to prepare local place plans and that assistance would be made available for local communities to prepare the local place plans. There was previous discussion about the need to link local place plans to locality plans. However, I am not aware of any further thinking or progress with this.

- **The Requirements for the Community Learning and Development (Scotland)**
  Regulations 2013: Guidance for Local Authorities place a legal requirement on all Local Authorities to secure the delivery of community learning and development in their area, working with other CLD providers and communities to ensure communities particularly which are disadvantaged have access to the CLD support they need. To strengthen co-ordination between the full range of CLD providers ensuring that Community Planning Partnerships, Local Authorities and other public services respond appropriately to the expectations set by the CLD Strategic Guidance. In Aberdeen Governance of the CLD Plan at local level is done through the Partnership Forums, at Strategic level is done through the Community Engagement Group and ICS Board both of which are Outcome Improvement Groups in the Community Planning Partnership.

APPENDIX 4 CUSTOMER JOURNEY AND CUSTOMER EMPATHY MAPPING

(PROBLEM STATEMENTS)

- I am confused about current arrangements for Locality Planning
- I feel there are too many groups that cover the same issues and involve the same people
- As a new member I am confused about the role of members
- I don't know what difference all the groups are making
- I don't know how all the existing groups align or relate to each other
- I don't know what Locality Planning is, who should lead it, or who should be involved in it
- I don't know what the relationship between the Locality Plan and locality working is
- I don't know how to get involved in the decision-making processes in my area - I've never heard of Locality Planning

APPENDIX 5 PROPOSED CORE ROLE AND REMITS

Locality Empowerment Groups

Role: The Locality Empowerment Groups (LEGs) will support the development and delivery of the new integrated locality plans in each of the three localities (North, South and Central). These plans underpin the city wide Local Outcome Improvement Plan and individual partner strategies (e.g. ACHSCP Strategic Plan).

Remit:

- Work together to ensure the locality is a place where all people can prosper, regardless of their background or circumstances
- Engender collective ownership, leadership and responsibility for improving outcomes across the Locality
- Contribute to the population needs assessment for the Locality by drawing local data, information and community perspectives that deepen understanding of emerging needs and opportunities
- Co-produce, publish and keep under review a Locality Plan to deliver improved outcomes for people and communities across the locality to meet local need and capitalise local opportunities
- Engage in improvement activity, working alongside CPA partners and community groups and networks to test changes which aim to deliver the priorities within the Locality Plan
- Foster a close working and mutually supportive relationship with Priority Neighbourhood Partnerships, taking cognisance of the work happening in these areas of the locality, taking steps to support efforts or spread best practice across the locality as relevant
- Provide a voice on behalf of the people and communities across the locality. This will involve proactively engaging, connecting and collaborating with community members and community groups and networks
- Build and maintain effective working relationships with partners and/ or members of CPA Outcome Improvement Groups to maximise use of professional resources

Membership:
The Locality Empowerment Groups are open to any community member or representative of community group/network living in the area that has an interest in working collectively to improve outcomes for the Locality.

Public service representation will be minimised to ensure the group is predominantly community led, with a minimal number of Partnership staff attending to facilitate and support community participation.

Operating Model:
The Locality Empowerment Groups will hold regular meetings, at a frequency and time to be determined. A flexible approach will be taken to maximise participation in the LEGs. In addition to the regular meetings, whether these are face to face or virtual, we will explore and test further options for people to get involved in the LEGs. For example, focus groups, social media, digital forums.

Priority Neighbourhood Partnerships

Role: The Priority Neighbourhood Partnerships will ensure that North, South and Central Locality Plans include a specific and targeted plan for Aberdeen's current priority neighbourhoods. They will complement the Locality Empowerment Groups by taking a lead on tackling the issues unique to their neighbourhood which contributes to improvement across the wider Locality.

Locality	Priority Neighbourhood
North	Northfield, Mastrick, Middlefield, Heathryfold, Cummings Park
South	Torry
Central	Seaton, Woodside, Tillydrone

The remit of Priority Neighbourhood Partnerships contributes to and complements the work of the Locality Empowerment Groups for the priority neighbourhood area.

Remit:

- Work together to ensure the neighbourhood is a place where all people can prosper, regardless of their background or circumstances
- Engender collective ownership, leadership and responsibility for improving outcomes across the neighbourhood
- Contribute to the population needs assessment of the neighbourhood by drawing local data, information and community perspectives that deepen understanding of emerging needs and opportunities
- Co-produce, publish and keep under review a plan to deliver improved outcomes for people and communities across the neighbourhood to meet local need and capitalise local opportunities
- Engage in improvement activity, working alongside CPA partners and community groups and networks to test changes which aim to deliver the priorities for the neighbourhood
- Provide a voice on behalf of the people and communities across the neighbourhood. This will involve proactively engaging, connecting and empowering wider community groups and networks
- Foster a close working and mutually supportive relationship with the Locality Empowerment Groups, seeking support or spreading best practice across the locality as relevant
- Build and maintain effective working relationships with partners and/ or members of CPA Outcome Improvement Groups to maximise use of professional resources

Membership:
Membership of the Priority Neighbourhood Partnerships is determined at a local level based on local needs and priorities and aims to ensure that at least 50% of representation will be community representatives. Public service representation is capped to ensure the balance remains with communities. Representation may include the Locality Inclusion Manager, Local Police, Local Head Teacher and Local Health representative/ G.P.

Operating Model:
The Priority Neighbourhood Partnerships meet regularly throughout the year (this differs for each Partnership). They continue to explore and test ways of getting more people involved in the Priority Neighbourhood Partnerships. For example, focus groups, social media, digital forums.

Community Engagement Group

Role: The Community Engagement Group will oversee the new integrated locality planning arrangements to ensure they operate effectively in Aberdeen. The group will maintain an overview of the delivery of the Partnership's Engagement, Participation and Empowerment Strategy and participation requests and will advise and support the CPP Board, Management Group and Outcome Improvement Groups on effective approaches to engage and involve communities in the delivery of the LOIP and Locality Plans. It will be an important link between the strategic perspective of the CPA Board and the priorities and perspectives of communities across Aberdeen.

Remit:

- Oversee the transition to the new Locality Planning arrangements and support the collaboration between the LEGs, Priority Neighbourhood Partnerships, Outcome Improvement Groups and wider community groups on shared priorities
- Assist in the removal of any barriers which exist in the delivery of the LEGs/ PNPs and connection with wider community groups and networks. This includes overseeing phase 2 of the Locality Planning Review
- Plan, oversee and be accountable for the development and delivery by Community Planning partners of the Engagement, Participation and Empowerment Strategy through the Locality Empowerment Groups and Priority Neighbourhood Partnerships
- Ensure Community Planning Aberdeen is meeting its statutory duties in relation to community engagement and participation, as prescribed by the Community Empowerment Scotland Act 2015
- Advise on effective practice on how to involve and engage with communities and promote consistency and cohesion of approach across Outcome Improvement Groups
- Oversee, understand and share best practice in terms of community development and engagement initiatives, for example volunteering, recruitment and training
- Oversee delivery of the Community Learning and Development Plan
- Oversee delivery of City Voice, including approval of questionnaires on behalf of Community Planning Aberdeen prior to issue to the city voice citizens panel

Membership:
Core community planning partners are invited to have representation on the CPA Community Engagement Group. This includes statutory community planning partners and members of the Civic Forum. This group will also include the Chairs of the Locality Empowerment Groups, Chairs of the Priority Neighbourhood Partnerships, representation from Community Learning and Development and representation from City Voice. Other organisations can be co-opted onto the Community Engagement Group when appropriate.

Operating Model:
Meeting frequency determined by the Community Engagement Group.

Outcome Improvement Groups

There are six Outcome Improvement Groups (OIGs) within the CPA structure. Each are responsible for delivering on relevant sections of the Local Outcome Improvement Plan. The Outcome Improvement Groups are:

- Aberdeen Prospers (Chaired by SDS)
- Integrated Children Services (Chaired by ACC)
- Resilient, Included and Sustainable (Chaired by ACHSCP)
- Alcohol and Drugs Partnership (Chaired by ACHSCP)
- Community Justice Group (Chaired by Police Scotland)
- Sustainable City (Chaired by NHSG)

Role: Each group leads and is responsible for actions which support delivery of the Local Outcome Improvement Plan and underpinning locality plans. They are responsible for ensuring progress against the stretch outcomes and improvement projects set for the priority area they lead on.

Remit:

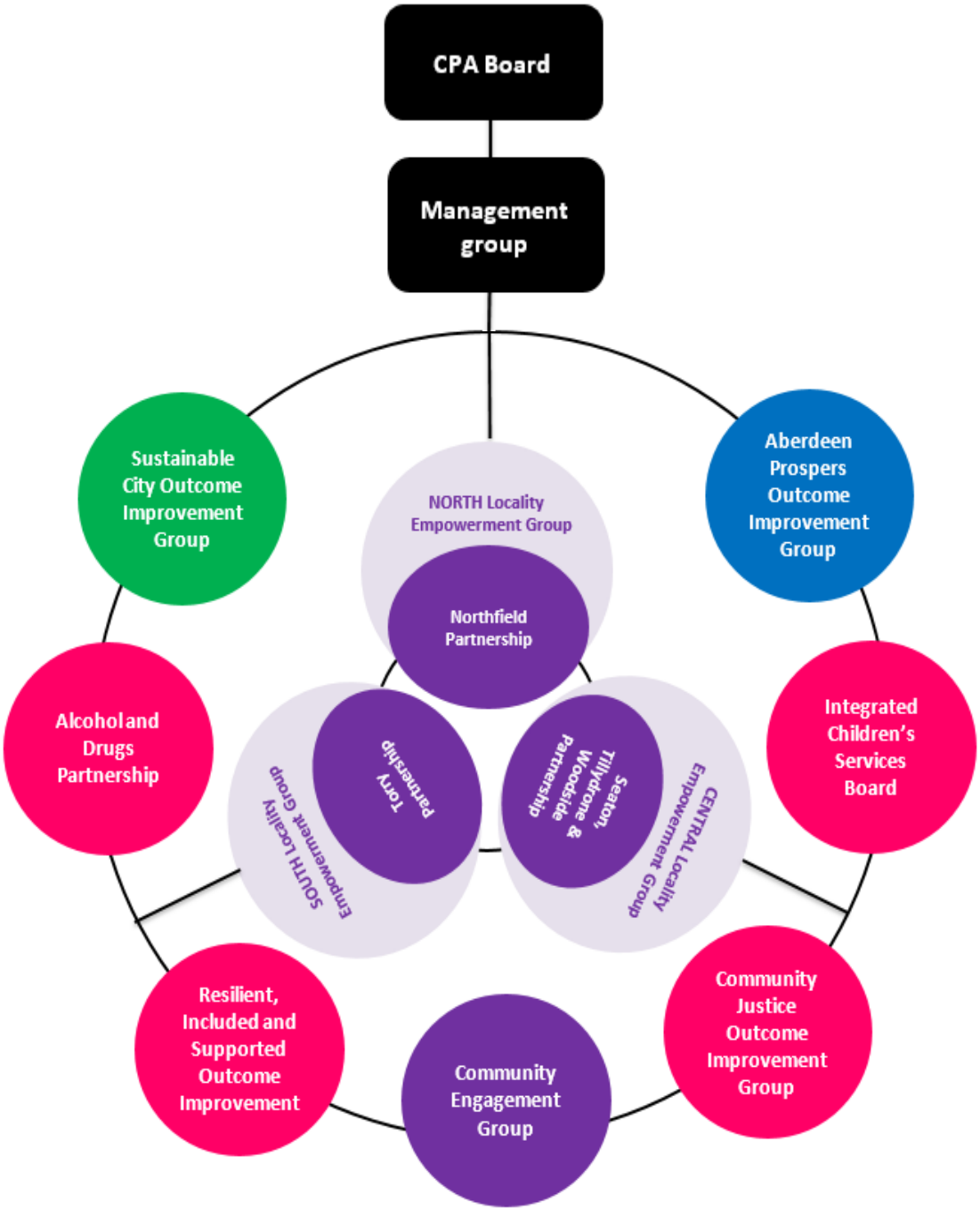
- Plan, oversee and be accountable for delivery of outcome improvement by Community Planning partners for the relevant stretch outcomes within the Local Outcome Improvement Plan and Locality Plans
- Deliver the stretch outcomes within the LOIP through the delivery of the LOIP improvement project aims
- Advise on, and be accountable for, how resources are aligned and allocated across Community Planning partners to support delivery of key actions
- Ensure communities are engaged in the planning and delivery of CPA's priorities through implementation of the Engagement, Participation and Empowerment Strategy and by liaising effectively with the Community Engagement Group, Locality Empowerment Groups and Priority Neighbourhood Partnerships
- Ensure the effective management of performance and risk in relation to delivery of the priorities and improvement outcomes for which the Outcome Improvement Group has oversight and report progress to the CPA Board on a six monthly basis via the Management Group
- Identify risks and barriers to effective delivery and advise the CPA Management Group on mitigating action required at CPA Board level

Membership:
Core community planning partners are invited to have representation on the CPA Outcome Improvement Groups. This includes statutory community planning partners and members of the Civic Forum. Other organisations can be co-opted onto the Outcome Improvement Groups when appropriate.

Operating Model:
Meeting frequency determined by the Outcome Improvement Group.

APPENDIX 6 COMMUNITY PLANNING ABERDEEN STRUCTURE

The addition of the Locality Empowerment Groups to the Community Planning Aberdeen structure will strengthen collaboration between all Community Planning Partners and all communities across Aberdeen. Priority Neighbourhood Partnerships will continue to support engagement of communities in our most disadvantaged areas to improve local outcomes.



APPENDIX 7 FEEDBACK FROM CONSULTATION

SUMMARY OF KEY POINTS (From consultation sessions and online survey)

- The proposed model is clearer, more focused and better for people, communities and all partners involved in community/locality/neighbourhood work and volunteering.

- The proposals successfully build on current arrangements and have great potential to strengthen community planning and locality planning and successfully build upon the positive aspects of the current arrangements.

- It seems clear from the proposals that, whilst we are not looking to reduce either support or ownership, we have the opportunity to streamline the locality planning and subsequently the delivery process.

- This can only be beneficial for our residents as they will be able to bring local influence to local solutions far more readily and hopefully means there will be decreased duplication of work and more effective working overall

- The locality plan approach will enable us to recognise and provide support and resources for communities which experience significant challenges for a variety of reasons but are not identified as a priority neighbourhoods. This approach will not only give others a view of the challenges faced by other parts of a locality but enable solutions to be sourced from across the area.

- A single Locality Plan addresses the fact that issues of concern for the Aberdeen City Health and Social Care Partnership, Aberdeen City Council, Civic Partners and Communities cannot be addressed in silos or isolation; there is significant common ground and shared agendas - persistent issues of concern are typically multifaceted and require an interdisciplinary and inclusive response.

- The current locality plans in place in our priority neighborhoods are good examples of single locality plans and can be seen as an example of best practice. The proposals need to maintain the same levels of performance and deliver the same benefits to the wider locality as the current Locality Partnerships are achieving. Priority areas must not get diluted in the larger locality area which will have so much diversity.

- Must guard against an increased duplication of effort between each the three localities which could be caused by working in silos. Must take account of existing services/resources in the area rather than re-inventing the wheel

- There is a need for two way dialogue between the Locality/neighbourhoods and Community Planning Partners. Not everyone wants to connect at strategic level but there needs to be a link between the LOIP and area plans to understand what needs are met and identify gaps and overlaps.

- A toolkit to support neighbourhood planning would be very positive, however it can only be possible if resources are made available to allow communities to use the toolkit and make meaningful plans, that includes consulting their residents and local partners.

ONLINE SURVEY RESULTS

Responses to this survey: **28**

1.Do you agree with the description of Locality?

Option	Total	Percent
Yes	25	89.29%
No	0	0.00%
Don't know	3	10.71%

2.Do you agree with the description of Neighbourhoods?

Option	Total	Percent
Yes	24	85.71%
No	0	0.00%
Don't know	4	14.29%

3.Do you agree with the description of Priority Neighbourhoods?

Option	Total	Percent
Yes	25	89.29%
No	0	0.00%
Don't know	3	10.71%

4.Do you agree with developing a single Locality Plan for each Locality?

Option	Total	Percent
Yes	23	82.14%
No	2	7.14%
Don't know	3	10.71%

5.Do you agree that as well as actions relevant to the wider locality, the Locality Plan should include actions targeted at Priority Neighbourhoods?

Option	Total	Percent
Yes	27	96.43%
No	1	3.57%
Don't know	0	0.00%

6.Do you agree that the Locality Plan should include actions targeted at specific neighbourhoods and communities of interest where there is a demonstrable need for this?

Option	Total	Percent
Yes	28	100.00%
No	0	0.00%
Don't know	0	0.00%

7.Do you agree with the Locality Empowerment Groups having a role in helping influence the work of the Community Planning Partnership to improve a broader range of outcomes for the Locality?

Option	Total	Percent
Yes	25	89.29%
No	0	0.00%
Don't know	3	10.71%

8.Do you agree that the Priority Neighbourhood Partnerships should continue to be supported to meet and consider the detailed issues affecting their areas?

Option	Total	Percent
Yes	28	100.00%
No	0	0.00%
Don't know	0	0.00%

9.Do you agree that a toolkit should be co-produced with communities to help empower community groups and networks to lead their own neighbourhood planning arrangements?

Option	Total	Percent
Yes	23	82.14%
No	2	7.14%
Don't know	3	10.71%

APPENDIX 6 BENCHMARKING ON LOCALITY PLANNING MODELS ACROSS SCOTLAND

Feedback from CPPs that responded are included below:

CPP	CPP Locality Plans and HSCP Locality Plans	Joint CPP an HSCP Locality Plans	CPP Locality Groups and HSCP Locality Groups	Joint Locality Groups	Future Plans/ Any other comments
Aberdeen	Our 3 CPP Locality Plans are separate from our 3 HSCP Locality Plans, although they make reference to each other.	No	CPP Locality Partnerships are established in our 3 regeneration localities. HSCP have 3 Local Empowerment Groups covering the whole of the City.	No	We are undertaking a review of Locality Planning to identify opportunities for more integrated arrangements between CPP and HSCP in locality planning.
Aberdeenshire	3 CPP Locality Plans in North Aberdeenshire (Peterhead, Fraserburgh and Banff & Macduff). They are separate to the 6 H&SC Locality Plans which cover our 6 Areas.	No	3 CPP Locality Plans are overseen by the Local Community Planning Groups and reported through the CPP structure by the Connected & Cohesive Communities (C&CC) Strategic Lead Group.	Actions within the locality plans are delivered either by individual thematic/ local groups or through the newly formed Hubs to take forward cross-cutting actions.	Just completed 3-year review of the LOIP and the locality plans.
Angus	Plans are separate but all aligned to the CPP vision – to make Angus a great place to live, work and visit	No – work has started to develop joint plans under the 3 priorities which takes into account the locality implementation partnerships and local improvement groups	Angus HSCP localities are not co-terminus with CPP localities. They have brought these closer together by having a HSCP Rep on the CCP Locality Planning Group and the CCP Locality Planning Group has membership on the HSCP Locality Improvement Groups.	No – we are currently reviewing the locality groups with the introduction of place plans	CPP moving to a demand management model which aligns to the place plan principles and should streamline the governance
Comhairle nan Eilean Siar	Plans are separate	No	Separate	No	We are without a Chief Executive for the IJB at the moment so things are on hold. This is something we would like to resolve as it must be confusing for people out there.

CPP	CPP Locality Plans and HSCP Locality Plans	Joint CPP an HSCP Locality Plans	CPP Locality Groups and HSCP Locality Groups	Joint Locality Groups	Future Plans/ Any other comments
East Ayrshire			HSCP Locality Planning Groups are co-terminus with CPP localities		
Midlothian	We have 3 locality outcome plans for our 3 priority areas, they have been developed jointly with partners including HSCP	Yes	No same group	Locality Planning Groups are co-terminus with CPP so no separate HSCP locality partnerships	Whole system is part of our neighbourhood planning model and now being reviewed
North Ayrshire		6 high level locality plans, with CPP and HSCP priorities included. More detailed underpinning plans are separate	All 6 HSCP Groups are co-terminus with CPP locality partnerships. Links in place.	North Ayrshire are piloting an integrated arrangement on Arran	Review of joint arrangement on Arran scheduled for spring 2021. Locality priorities originally agreed in 2017, currently being reviewed.
Orkney			Currently separate.		Orkney are currently looking at localities. It would make perfect sense to have one Locality Planning Group but don't know if they are at that stage.
Perth and Kinross	Each of our seven CPP localities has a Locality Plan. HSCPs have three localities, any plans are separate.	No	HSCP has a seat on each of the seven Local Action Partnerships	No	LOIP being reviewed, likely to include a more specific focus on wellbeing. PKC seeking to move to a locality working model which may have CPP implications
South Lanarkshire	We have several neighbourhood plans and these are currently separate to the HSCP locality plans	Currently separate	South Lanarkshire HSCP has 4 localities. These are not currently aligned with the CPP	Currently separate	We are currently looking at locality planning structures and have started to consider more integrated arrangements between HSCP and the CPP

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INTEGRATION JOINT BOARD

INTEGRATION JOINT BOARD

Date of Meeting	1 December 2020
Report Title	Mental Health Delivery Plan (Annual Report)
Report Number	HSCP20.069
Lead Officer	Sandra MacLeod, Chief Officer
Report Author Details	Kevin Dawson, Lead for MH/ LD/SMS services Kevin.dawson@nhs.scot 07818076228
Consultation Checklist Completed	Yes
Directions Required	No
Appendices	Appendix 1 – Mental Health Delivery Plan on a Page. Appendix 2 – Mental Health Delivery Plan – Action Plan Appendix 3 – Action 15 Funding commitments.

1. Purpose of the Report

This report provides the Integrated Joint Board (IJB) with an annual report of the work of Community Mental Health Services and seeks to highlight progress on the implementation of the Aberdeen City Mental Health Delivery Plan 2020-2023.

2. Recommendations

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

a) Note the progress against the Implementation of the Mental Health Delivery Plan Actions set out in Appendix 2.
b) Note the Action 15 spend and new service commitments as set out in Appendix 3.

3. Summary of Key Information

3.1 The Aberdeen City Community Mental Health Delivery Plan 2020 – 2023 was approved by the Integrated Joint Board in March 2020 and implementation was planned from April 2020 onwards. (See Appendix 1 – Delivery plan on a Page)

3.2 Following publication of the plan in March 2020, the service entered a phase of business continuity and recovery planning as part of COVID-19. Despite this, the service has made much more progress on the Mental Health Delivery Plan actions than we could have imagined, with COVID-19 response, escalating the need to progress some actions at pace.

3.2 Within the Aberdeen City Health & Social Care Partnership we are seeing an increase in referrals to Community Mental Health Services and are expecting to see a further increase with people that are struggling with their mental health as a result of COVID-19. The impact of COVID-19 is affecting the population in different ways, but particularly social isolation, job and financial loses and housing insecurities having a considerable impact on people's mental health & wellbeing. With the anticipated continuation of COVID-19 restrictions, particularly during the winter, it is inevitable that we will see a further deterioration of mental health and wellbeing within the population of Aberdeen City, and particularly in areas of deprivation. Similar patterns of referrals and requests for support are being experienced by the Primary Care Psychological Therapists and Link Practitioner Services, third sector providers and partners, the NHS Grampian Psychological Resilience Hub and Aberdeen City Council COVID19 Assistant Hub (both set up as part of the COVID response),

3.3 The Mental Health Delivery Plan was co-produced in consultation with staff, the public, service users and carers as well as third sector organisations. This plan

was brought together in conjunction with the Multi-agency Mental Health Partnership Group which has representation from Community Mental Health & Social Care Services, Aberdeen City Health & Social Care Partnership (ACHSCP) Leadership Team, Public Health, Child & Family Services, Police Scotland, Aberdeen Council of Voluntary Organisations (ACVO), Suicide Prevention, Penumbra, Housing and General Practice. The group meet bi-monthly to work together on linking the delivery of mental health and wellbeing services and to monitor progress on the Mental Health Delivery Plan (See Appendix 2). This group also ensure there are linkages and a clear pathway across all tiers of service provision to maximise capacity to address the increasing needs.

3.4 The actions outlined within the plan are still very relevant during and post pandemic, with a clear focus on supporting Tiers 1 and 2 with prevention, self-management and self-help. The plan delivers support in the form of First Contact Mental Health & Wellbeing Practitioners and Peer Support which aims to:

- Be the first point of contact for community based mental health support 7 days per week
- Reduce delays in accessing appropriate tiered support for mental health and wellbeing
- Help people navigate services within their communities
- Build on knowledge, skills and capacity within public and third sector organisations
- Develop localised peer support with people who have lived experience
- Non-medicalised model with direct access to low tiered support based within local communities and in particular focussing on areas of deprivation.
- Explore the needs of people who do not currently use our service with an element of reaching out within communities.

3.5 The delivery plan also aims to enhance digital service provision via telephone and NHS Near me as well as encourage the use of digital APPS and tools to support self-management, self-help and support the mental health and wellbeing of the population of Aberdeen City.

3.6 We will continue to monitor and identify emerging needs, as we work with our partners in localities and communities to ensure that all levels of service are available to respond accordingly.

4. Implications for IJB

4.1 Equalities

A full Equality and Human Rights Impact Assessment has been completed (2020) which the impact to be positive.

4.2 Fairer Scotland Duty

The Community Mental Health Delivery Plan is aligned with other strategic documents and their vision, such as the ACHSCP Strategic Plan and the Community Planning Aberdeen Local Outcome Improvement Plan, to improve outcomes for people with poor mental health and wellbeing. Additionally, the Delivery Plan is the community response to the Strategic Framework for Grampian wide Mental Health Services (which sit within and are managed by Aberdeen City Health and Social Care Partnership). The specific actions identified in the delivery plan seek to reduce inequalities and strengthen meaningful involvement of people in this process by co-producing solutions and measuring success.

4.3 Financial

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

However, note that on the 28th October, 2020, the IJB agreed investment from Action 15 monies for the development of nine additional mental health workers investing £1.4m over 4 years to pilot a First Contact Mental Health & Wellbeing Practitioner and Peer Support service within each of the three Aberdeen City Localities. This project was developed as per the following actions outlined within our Community Mental Health Delivery Plan

- Action 1 - “To explore the creation of community mental health & wellbeing workers”

- Action 14 – "Embed a human rights approach within mental health supports and services, advancing peer support and voice of people with lived experience"

These additional posts will enhance Community Mental Health Services alongside all other commitments to Action 15 funding as set out in Appendix 3.

4.4 Workforce

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

However, as above, investment via action 15 will result in an additional 9 mental health community workers.

4.5 Legal

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

4.6 Covid-19

Positive impact on Operation Home First; aim to reduce harm to vulnerable groups impacted as a result of COVID19.

5. Links to ACHSCP Strategic Plan

The recommendations in this report complement the strategic priorities outlined in the Partnership's Strategic Plan primarily by supporting the development of person-centred approaches to care and support and by enabling supported individuals to strengthen their connection and contribution to their local community.

INTEGRATION JOINT BOARD

6. Management of Risk

6.1 Identified risks(s)

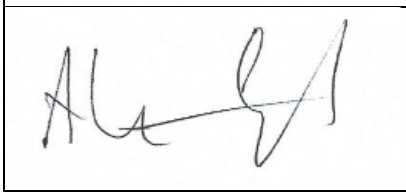
Failure to implement the Delivery Plan. This risk is minimal due to the ongoing engagement with partners. Failure to implement the Delivery Plan could lead to reputational damage, to mitigate this the Mental Health Partnership Group will oversee the implementation and provides reports to relevant operational and governance structures.

6.2 Link to risks on strategic or operational risk register:

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

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

The content of this report seeks to mitigate the known risks by recommending a decision which supports the reputation of the IJB & Partnership, the implementation of the Community Mental Health Delivery Plan promotes person centred approaches to care and support and the strengthening of community connections.
The risk is Low.

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

INTEGRATION JOINT BOARD

Appendix 3

ACTION 15 - An aim of the Scottish Government Mental Health Strategy 2017-2027 is to ensure access to treatment is joined up and accessible and builds on the principle of "ask once, get help fast". Action 15 aspires to increase access to dedicated mental health professionals in all A&E departments, GP practices, custody suites, and to our prisons by increasing the workforce to provide dedicated mental health support. Scottish Government have also encouraged Health & Social Care Partnerships to adopt a flexible approach to allow for these services to address the increasing and emerging COVID related mental health and wellbeing population needs.

Committed Funding	**WTE**	**2020/21 £k**	**2021/22 £k**	**2022/23 £k**	**2023/24 £k**
Primary Care Psychological Therapy Service	12.17	544	600	604	608
Beating the Blues	1.0	31	32	33	34
Community Listening Service (Currently 0.5wte increasing to 1.0wte in 2021/22)	1.0	31	55	57	59
Psychological Wellbeing Practitioners (Currently progressing through Commissioning process)	4.0	84	170	174	177
Mental Health & Wellbeing Practitioners & Peer Support Project (Currently progressing through Commissioning process)	9.0	60	361	367	375
Aberdeen City Contribution to HMP Grampian Prison Service Proposal (*with IJB for consideration)*	1.0	48	49	50	51
TOTAL	**28.17**	**£798k**	**£1.26m**	**£1.28m**	**£1.31m**

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APPENDIX 1


Community Mental Health Delivery Plan & Actions on a Page
OUR VISIONS
OUR STRATEGIC VISION: We echo the vision set out in the National Mental Health Strategy 2017 – 2027 "People can get the right help at the right time, expect recovery, and fully enjoy their rights, free from discrimination & Stigma."
OUR AIMS
Prevention - People are supported to enjoy the best possible mental health & Wellbeing
Self Management – People who experience poor mental health are supported to self-manage in their communities.
Recovery – people who experience mental illness are supported through their recovery
Dignity & Rights – Support provided respects the dignity and rights of the individual
Support for Carers – Carers of people with poor mental health will be supported to be equal partners
OUR ACTIONS
Explore the creation of community mental health and wellbeing workers
Improve & promote "Know who to turn to" information for mental health & wellbeing
Promote use of electronic tools to promote wellbeing activities in communities
Work with locality empowerment groups to ensure local needs are addressed
Increase trauma awareness within communities
Improve discharge planning into the community.
Improved engagement & feedback to support Improving services.
Early intervention with young people and Improved transitions moving to adult services
Using information from those with experience to develop services.
Work with partners To review service delivery & resources
Alternative treatment options through digital solutions
Support the role of carers
Promote use of Advanced Statements to improve care and treatment.
Improved patient pathways
Work with partners to showcase local supports
4

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APPENDIX 2

Mental Health Delivery Plan Progress

Date Developed - Jenny Rae	25/03/2020
Date last updated - Caroline Anderson	**24/11/2020**

On Track/Completed
Monitor progress to ensure timeline adhered to
Work required to ensure timeline adhered to
Urgent Attention

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Actions		Due (Month/Year)	Date Completed	Progress	Documents	Next Steps	Responsible
	Interim reporting to CCG (6 monthly)	Sep-20	Sep-20	Progress Report produced.			Mental Health Partnership Group
	Reporting to IJB (annually)	Dec-20	Nov-20	Profess Report produced			Mental Health Partnership Group
	Webpage Information Live	Apr-20	Apr-20				Jenny Rae
	Webpage Updates	April-2020 onwards					Mental Health Partnership Group
Delivery Plan - Action Plan		**Due (Month/Year)**	**Date Completed**	**Progress**	**Documents**	**Next Steps**	**Responsible**
1	Explore the creation of community mental health & wellbeing workers.	Mar-21	On Track	Business Case for additional 9 Mental Health & Wellbeing Workers (including paid Peer Support) presented to IJB on 28th October 2020. Total investment of circa £1.4m over 4 years to support each of the 3 Aberdeen City Localities with a First Contact MH & Wellbeing Practitioner Service. Business Case approved. Oversight & evaluation of project via the Mental Health Partnership Group / Action 15 Steering Group.		Work to develop outcome measures to inform commissioning process. Development of mapping flowchart to identify pathway and links to wider mental health & primary care services.	Primary Care Action 15 Work stream / Working Group
2	Promote use of Electronic and other information tools to tell people about wellbeing activities and groups availability within communities.	April-2020 onwards		As part of Covid 19 response - development and promotion of electronic tools to support wellbeing activities within the community (i.e. Enhancing Lives Through Technology Project)		Take part and circulate information on the guidance and launch of Scotland's Services directory. Encourage organisations to use and update these tools.	Community Mental Health Management Team.
3	Contribute to local digital & technology work streams to provide efficient alternative treatment options (e.g. NHS Near me)	April-2021 onwards	Completed September 2020	NHS Near Me rolled out within Mental Health Services in March 2020 as part of Covid-19 response. Promotion & support crib sheets produced for Staff to support roll-out & training.		Continue promotion and monthly monitoring reports. Provide representation on working group to look at delivering Group Work through digital platforms.	Community Mental Health Management Team.
4	Jointly with our partners (i.e. Police, Third Sector, Housing etc.) to review service delivery, current resources and future needs.	April-2020 onwards		Work to commence with ACVO to map existing services. Currently paused due to work around implementation of Care at Home Contract.		Mapping work to recommence shortly.	Mental Health Partnership Group
5	Work with Locality Empowerment Groups to ensure local needs are addressed as well as possible within resources.	April-2020 onwards		Transformation work commenced to align teams to locality structure.		Teams to be aligned to the locality structure and representatives will link into the Locality Engagement Groups. New MH & Wellbeing Posts to link into Local Engagement Groups to support building capacity.	Mental Health Partnership Group

	Delivery Plan - Action Plan	Due (Month/Year)	Date Completed	u	Documents	Next Steps	Responsible
6	Establish clear links with Integrated Children's Services partners and plans for children and young people's mental health and wellbeing.	April-2020 onwards	On Track	Integrated Children's Services represented within the Mental Health Partnership Group.		Build on links through Mental Health Partnership group and identify areas for development.	Mental Health Partnership Group
7	Review Discharge planning to enhance transition between hospital and home/other care settings.	Mar-21		Produce Admission/Discharge Planning flowchart to improve communication as part of Covid19 response.		Working Group to be established including representation from specialist and community mental health settings including social care and housing. On hold due to COVID19 priorities - to recommence early 2021.	
8	Work with partners (including Children's Services) to increase Trauma Awareness.	April-2021 onwards	On Track	2 Clinical Psychologists undertaken substantial work in improving trauma informed care at all levels from Trauma Informed to Trauma enhanced, including providing training for NHS, local authority and third sector partners for staff working with children and adults of all ages. Trauma Informed and Trauma skilled level training is ongoing online including Training for Trainers to further cascade. Currently exploring ways to embed within Learning & Development.		Explore ways to embed training with Learning & Development. Further Trauma Enhanced level training will continue once online materials are provided by NES. Following appointment of overall Trauma Champion for Grampian, next step to identify further Trauma Champions across wider areas of the organisation.	
9	Recognise, optimise and support the valuable role of Carers within MH Services.	April-2020 onwards		VSA rep invited to take part in consultation work around service development initiatives & mapping exercises. Opportunity to actively engage has been impacted by COVID 19 response.		Work with existing carers support services and groups to understand how this can be developed and achieved. Liaise with VSA to identify appropriate outcomes measures for carers as part of the First Contact Mental Health & Wellbeing practitioner service	
10	Enhance engagement with individuals and carers to ensure they are equal partners in care.	April-2020 onwards		As per 9 above.		As per 9 above.	
11	Promote knowledge and use of Advanced Statement to improve care and treatment.	April-2020 onwards		On hold due to COVID19.		Provide information/training to staff and partners including people with mental ill-health and their carers.	
12	Review and promote existing "Know wo to turn to" information on Mental Health & Wellbeing	Mar-21	Completed April 2020	Know where to turn to information updated for Covid-19 and available on AHSCP Website. Regular promotion via Facebook and twitter.		Review information & look at including innovative support (i.e. Man Chat)	Mental Health Partnership Group
13	Citizens have access to a clear pathway when accessing multiple services (i.e. People with more than one condition)	April-2021 onwards		To commence from April 2021 onwards		Link into Mental Health & Wellbeing Practitioner Service test of change to support identifying pathways. (Links to Action 1)	
14	Embed a human rights approach within mental health supports and services, advancing peer support and the voice of people with lived experience.	April-2020 onwards	On Track	As per Action 1 - Creation of additional 9 Mental Health & Wellbeing workers including peer support workers with lived experience.		Review progress through Mental Health Partnership Group.	Mental Heath Partnership Group.

15	Work with partners to showcase local supports for mental health and wellbeing, including protective factors which maintain good mental health.	Mar-21		On hold due to COVID19		Establish working group to support partnership to develop a socially distanced / virtual community event to showcase support in Aberdeen.	Mental Health Partnership Group

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Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Date of Meeting	01 December 2020
Report Title	Aberdeen City Primary Care Sustainability Programme (Stage 1 – 2C Remodelling)
Report Number	HSCP.20.049
Lead Officer	Sandra Macleod, Chief Officer (ACHSCP)
Report Author Details	Lorraine McKenna (Primary Care Lead) Emma King (Primary Care Lead) Sarah Gibbon (Programme Manager) Calum Leask (Programme Manager)
Consultation Checklist Completed	Yes
Directions Required	Yes (see appendix E)
Appendices	a. Business Case b. Procurement Summary c. Procurement Strategy (Confidential) d. Evaluation Criteria (Confidential) e. Direction to NHS Grampian

1. Purpose of the Report

1.1. The purpose of this report is to provide a brief overview to the Integration Joint Board (IJB) on the current position of one of the Partnership priority programmes (the remodelling of our 2C General Practices) and to seek approval for a recommended way forward.

1.2. This is part of a long-term programme of work to avoid increasing instability in Aberdeen's primary care system. The current system, if not addressed, will become increasingly fragile as evidenced in section 3.2 at a time when demand for primary care services is growing.

1.3. This report should be read in conjunction with the Business Case provided for full context.

1.4. Appendices B, C & D provide further information on the proposed procurement process outlined in this paper, however these appendices are exempt (private) information in line with the Local Government (Access to Information) 1973 Act, Schedule 7A, under paragraph 9 (Terms of Acquisition or Disposal): *"Any terms proposed or to be proposed by or to the authority in the course of negotiations for a contract for the acquisition or disposal of property or the supply of goods or services provided disclosure of these terms would prejudice the [Integration Joint Board] in these or any other negotiation"*

2. Recommendations

2.1. It is recommended that the Integration Joint Board:

a) Endorses, approves, and gives agreement to proceed with implementation for the preferred option outlined in paragraph 3.7, to enable the remodelling of the 2C GP practices;

b) Notes the intended procurement process to implement the preferred option (if approved) as at appendix B, C & D (exempt) to be delivered in conjunction with ongoing internal development with the 2C Practices, supported by ACHSCP;

c) Makes the direction as attached at appendix E and instructs the Chief Officer to issue a Direction to NHS Grampian; and

d) Requests that an update on the outcomes of the procurement process is brought back to the IJB in spring 2021.

3. Summary of Key Information

3.1. Background

In Primary Care, there are several different kinds of General Practitioner (GP) contract, outlined below:

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	Explanation	Managed By	Aberdeen City #
17J	A 'Section 17J' or 'GMS' (General Medical Services) practice is one that has a standard, nationally negotiated contract. Often referred to as an 'independent contract model'.	GP Partners	17
17C	A 'Section 17C' practice (formerly known as 'Personal Medical Services' or 'PMS' practice) is an independent practice that has a locally negotiated agreement, enabling, for example, flexible provision of services in accordance with specific local circumstances.	GP Partners	5
2C	In general terms, this is most likely to mean that the practice is run by the NHS Board.	ACHSCP / NHSG	6

In April 2004, a duty was placed on NHS Boards to provide or secure "primary medical services" for their population. When practices experience difficulties or sustainability issues which affect their ability to deliver services for a population, the NHS Board must take action to ensure their delivery, by either:

1. Making arrangements with another 17J or 17C practice (merger or procurement process); or
2. Providing the service directly as a 2C practice.

These actions are a necessary intervention where there is a risk that medical services may not be provided for a certain population, often with the aim that the practices ultimately transfer back into the independent model.

In Aberdeen, there are currently six 2C GP practices, some of which have been a 2C practice for an extended amount of time:

1. Camphill Medical Practice
2. Carden Medical Practice
3. Marywell Medical Practice
4. Torry Medical Practice
5. Old Aberdeen Medical Practice
6. Whinhill Medical Practice

3.2. The Need for Change

The need to remodel our 2C practices is reinforced by several inter-related factors, all of which highlight the need to work differently to ensure that Aberdeen City continues to be able to deliver safe, accessible and responsive general medical services.

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Primary care is facing increasing pressure, which is well-documented in national literature for reasons including (but not limited to):

a) Increasing Demand: across Scotland, there is increasing pressure across the system due to an increasing older population and increasing co-morbidities. Services need to be redesigned to meet this expected increase in demand.
b) Increasing Workforce Challenges: again, across Scotland there are well-documented workforce challenges in health and social care, which are exacerbated in primary care which is the first point of contact for many people. Aberdeen City has experienced a particular decrease in GP numbers over the years from 2009 to 2019 (ISD)

The combination of the factors outlined above has led to:

c) Increasing Risk Relating to Sustainability: there is an increasing risk relating to sustainability, as evidenced in the 2019 Practice Sustainability study[1], which indicated that only 5 of our 28 practices are considered "low risk". A comparison between the 2017 and 2019 scores indicates that even for seemingly "low risk" practices, this can quickly change. Work is required to improve sustainability **both** for our 2C and independent practices and to create capacity in our Primary Care Support Team to provide contingency support for other practices which may come into difficulty.

Over the past four years, Aberdeen City has experience with several practices who felt they are no longer sustainable:

- **Carden Medical Practice:** 4th May 2020 became a 2C practice after an unsuccessful procurement process.
- **Rosemount Medical Practice:** 31st January 2019: due to a small, geographically diverse patient list with suitable city-centre alternatives, undertook dispersal of practice patient lists between city practices, which absorbed much of the existing capacity.
- **Torry Medical Practice:** 1st July 2018 became a 2C practice.
- **Northfield Medical Practice:** became Aurora (separate business but owned by Denburn Medical Practice) in September 2017 after a successful procurement process and merged with Denburn (one business) in August 2018.

[1] based on the Scottish Government Practice Sustainability Assessment Tool

To address this and begin to create a sustainable, city-wide model of primary care, ACHSCP needs to ensure:

d) Implementation of new GMS Contract and Primary Care Improvement Plan: the new GMS Contract, supported by our Primary Care Improvement Plan, is one of the key ways in which ACHSCP is working towards improving sustainability in general practice in Aberdeen. Our services need to support the new ways of working; implement the primary care improvement plan and encourage better collaboration and more cross-system working. Key components of this include developing our multi-disciplinary teams to provide appropriate, person-centred care whilst freeing up capacity for our GPs to act as "expert medical generalists", utilising their time for more complex care.

e) Creating equity of resource across practices: In order to increase sustainability, ACHSCP needs to find ways to ensure that our resources are distributed amongst all GP practices in a way that promotes equity and enables support to be directed towards the demand.

Overall, the need for change outlined above, if not addressed, will have an impact on patients' access to primary care services from the right person; at the right time; in the right place.

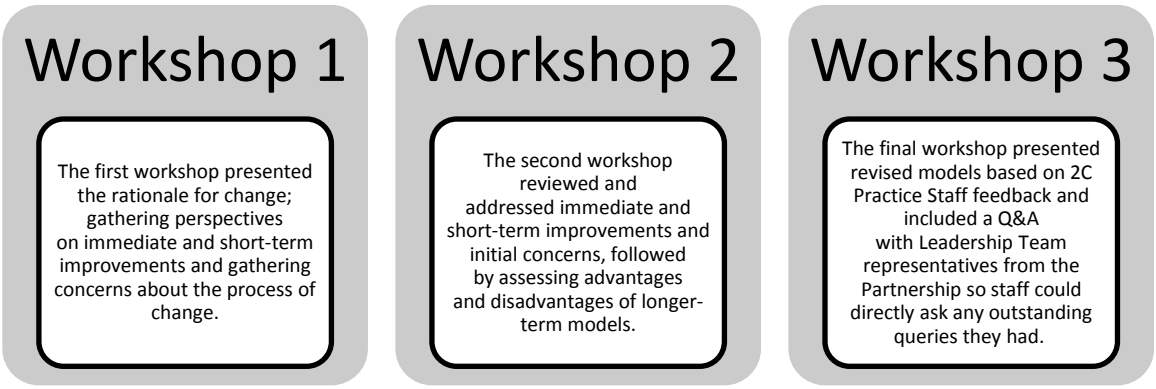
3.3. Why Are We Changing Now?

Given the challenges outlined above, ACHSCP needs to act now to begin a journey of improving primary care services across the city and rise to meet these challenges rather than wait for the impact to be realised fully. Remodelling our 2C practices will enable the start of this journey. Whilst patients won't see changes to how they access care immediately, as this project relates to "back-office" management change, it will help to ensure the continued delivery of local services across the city and ensure that primary care can continue to deliver safe, effective, person-centred care in light of the increasing demands on the service.

Additionally, the Covid-19 pandemic has accelerated many aspects of change within General Practice, with many practices adopting new technologies to enable remote consultation (such as NHS Near Me and eConsult); and to enable appropriate triage. Remodelling now will enable us to embed and reinforce the opportunities and benefits of new ways of working that Covid-19 has created.

3.4. Developing the Options to Facilitate Remodelling

ACHSCP held a series of workshops with 2C practice staff over the course of six weeks to help identify the best change mechanism for remodelling; to shape what the future 2C practice model might look like; and to consider cross system sustainability, both in the 2c practices as well as across the city. This engagement was at an early stage of the process; and before requirements of the Organisation Change Policy need to be met. Workshops were planned and delivered by a multi-agency project team, including representatives from Primary Care; the Local Medical Committee (LMC), GP Sub Committee of NHS Grampian's Area Medical Committee, Staff side representatives and HR.



Throughout the process, the project group facilitated many ways for staff to maintain their involvement, particularly those who could not attend. These included (but were not limited to):

1. All workshops were recorded and shared so staff could view at their convenience.
2. Briefings were circulated after every workshop.
3. Electronic forms distributed to all staff to input thoughts and comments on interactive tasks.
4. Multiple additional meetings with staff in practice and via Teams to explore further discussions.

Following staff feedback on the initial process, additional actions were taken in October and November, including:

5. Further 1-1 meetings including with HR
6. A series of smaller group workshops were held in November to provide further opportunity for discussion from all staff.

7. Presentation to the Joint Staff Forum.

2C practice staff were also offered the opportunity to vote on their preferred option and while not intended as a decision-making tool, the outcome was included in the business case to help the IJB understand the preferences of the staff. Out of 138 2C practice staff, there were 59 (crossing a variety of professional groups) who chose to vote, and their scoring is represented below. 12 staff advised that they would abstain as they either did not like the options or the process identified above. In total 42.75% of staff took part in a vote and the preferences are indicated below, demonstrating a preference towards partial merger and full merger options:

Options Voted on	1st Preference	2nd Preference	3rd Preference	4th Preference
Full Merger	5	24	10	9
Full Procurement	1	2	13	38
Partial Merger	47	20	11	5
Partial Merger & Partial Procurement Process	6	13	25	7

The workshop process identified positive suggestions for improvement, which included:

- Working across all practices to enable late visits
- Sharing specialisms between practices
- Centrally co-ordinated student training between practices
- Centralised triage for all practices

Additionally, a group of 2C practice staff have come together to create an internal proposal to facilitate a remodelling of the 2C practices, which has subsequently been included in the business case (see below). The internal 2C practice staff project team have been supported by the Primary Care Team, who have identified funding for a session a week (4 hours) from each practice for a staff representative on this group. This is initially for a three-month period and will be extended as required to facilitate ongoing involvement and development from the 2C practice staff.

3.5. What Were the Challenges with This Process?

The project has experienced difficulty in the change process so far, noting that culture differs from practice to practice, as does the practice's level of experience with change to date. For example, some 2C practices have recently experienced a lot of change, supported by GP Lead Roles and the Primary Care Team, which has enabled the practices to see why change is needed. However, other 2C practices have not been through/had the requirement of change put upon them until this process and are therefore not so familiar with service delivery change of this nature and appear very resistant to change.

Additionally, it became evident, for some staff there is a lack of understanding of the different contract types for general medical services and the direction of change, even within the practice themselves. This may have resulted in some resistance to change. Since then, an evening of open information sharing with representatives from Scottish Government Primary Care has been held by our Local Medical Committee colleagues, and focused on developing knowledge around the contractual arrangements and the direction of change relating to the GMS contract.

However, 2C practice staff members (primarily from one practice) have also raised several concerns and complaints around the remodelling process undertaken so far. Each of these has been responded to, either in writing or with follow-up meetings, and a summary is provided below:

- **Timescales were too tight:** The timescales around developing the options presented in this paper were fast but deemed necessary. ACHSCP received letters from 12 General Practitioners from some 2C practices who chose to abstain from voting. Two main reasons were cited for this: 1) the length of the process (which was deemed too short) and 2) the information provided on each of the longer-term options (which were deemed to be too vague). As a result, the paper to the IJB was deferred to allow for additional engagement and consultation.
- **TUPE:** 2C clinical staff raised concerns with the TUPE process and the protection of their terms and conditions. Colleagues from the Primary Care Support Team and from Human Resources have met with staff to discuss their concerns (09.11.2020). The offer to meet has been extended to other staff and practices.
- **New Model of Care:** there were also concerns raised that a new model of care may adversely impact on the population. This was particularly as the 2C practices have some specialised patient populations, such as those experiencing homelessness or people with learning disabilities. 2C clinical staff have raised concerns about potential health inequalities impact should a tender process be agreed by the IJB.

- **Remodelling:** 2C staff from a particular practice have raised concerns over the remodelling process in general and have requested that their practice is not included within the scope.

3.6. Options for Undertaking a Remodelling (Mechanism for Change)

During this process, several options to undertake this remodelling were developed and included:

1. Do Nothing / Do Minimum
2. Partial Merger of 2C Practices
3. Full Merger of 2C Practices
4. Partial Merger & Partial Tender
5. Full Procurement Process (individually, in groups or as a whole)

Through the workshop process and following discussion with representatives from 2C practices, a further option has been included in the business case. This option presents an internal proposal developed by the 2C practice staff. The proposal received was a more detailed version of option 3 above (full merger of 2C practices). As a result, option 3 in the business case was subsequently revised to reflect the new proposal; and scored against the same objectives as the other options. In the business case, option 3a refers to the original scoring of the full merger option and 3b refers to the full merger option re-scored considering the internal proposal.

3.7. Recommended Option

The options appraisal, as included in appendix A, indicates that the recommended option, and the preferred way forward, is option 5 to undertake a full procurement process.

Option 3b also scored strongly in the options appraisal. The *difference* in scoring between the initial full merger option and the 2C practice proposal was largely due to factors in the proposed service model which could also be achieved through a procurement process. However, option 5 aligns more closely to the Strategic Plan and provides additional benefits with more potential to deliver transformational change of primary care services in line with this strategic direction (these are more fully explored in section 4 below). Furthermore, option 5 provides the opportunity to mitigate against the broadest range of risks within the Strategic Risk Register (see section 4 and appendix 3). Representatives from the internal 2C staff project group will be invited to be involved in the procurement process, including on the evaluation panel, should the recommendations of this report be approved.

Officers are of the view that it is important to continue to develop internally with the involvement of the 2C practice staff as a procurement process develops – to ensure complementary progression of the two options in tandem. This will maximise the ability to create a more stable and secure primary care arrangement for Aberdeen. As such, there is ongoing improvement work in several practices which should continue, with the support of ACHSCP, throughout the process. Involvement from the 2C practice staff will be facilitated by the additional sessions funded by the partnership (as outlined above).

3.8. Benefits of the Recommended Option

3.8.1. Developing Our City-Wide Model of Primary Care

The recommended option provides the ability to look at the re-design of our primary care services, not only internally within our 2C practices, but across the city. A procurement process would invite innovative business cases which will stimulate the market to look at the possibilities for service delivery. The evaluation criteria (appendix D) allow ACHSCP to design and influence the business cases submitted.

This will allow ACHSCP to identify the interest in the City to stimulate effective models of delivery, providing opportunity for innovation and collaboration between independent practices to create future-proofed models of delivery.

3.8.2. Improving Sustainability Across Our Model of Primary Care

A procurement process would allow opportunities for improving sustainability across primary care in Aberdeen City, which an internal remodelling of our services would not provide. For example:

- Smaller 2C practices could be supported by larger GP practices to provide improved sustainability through shared resources and additional support;
- Independent GP practices could reinforce their own sustainability in line with national guidance on sustainable practice sizes; and
- ACHSCP would have a reduced responsibility for direct operational oversight of 2C practices, increasing the capacity to help support the delivery of the Primary Care Improvement Plan. This would also ensure capacity to pre-emptively support other practices that may experience difficulty in the future to mitigate chances of further practices terminating their contract.

3.8.3. IJB Strategic Risk Register

The analysis of the options against the risks in the IJB's Strategic Risk Register demonstrates how option 5 (procurement process) provides opportunity to mitigate against several of the IJB's key strategic risks. This is detailed further in section 5 below and is included in the business case provided at appendix B

3.8.4. Alignment with GMS Contract and increased ability to deliver on Primary Care Improvement Plan

Undertaking a procurement process is in-line with the national direction for primary care. The 17J/17C, or independent contractor model, is the model favoured nationally by the current GMS contract and locally by our Local Medical Committee. After consideration and wide discussion, both the SGPC and the Scottish Government have agreed that the GMS contract will continue as an independent model, demonstrating 82% support from GPs[2].

The new contract states that "a *strong and thriving general practice is critical to sustaining high quality universal healthcare and realising Scotland's ambition to improve our population's health and reduce health inequalities*.[2] Furthermore, the GMS contract reiterates very clearly that '*since the inception of the NHS, general practice has developed as an independent contractor model. Some of the greatest strengths of general practice exist because of the independent nature of GPs under this model and their ability to prioritise and advocate for their patients'.*

The independent model encourages innovation and the GMS contract, and work of the Primary Care Improvement plan, seeks to reduce the risk to GPs of this model. Examples include introducing sustainability loans to acquire premises risk and NHSG recruitment to additional roles in the multi-disciplinary team (MDT). The overall aim is to enable GPs to function as expert medical generalists.

However, we also have to take note of the fact that the GMS contract acknowledges whilst the majority of general practice will be delivered via an independent contractor model, "*there is an important, continuing role for non-GMS contractor GPs, often in salaried positions, in a wide range of circumstances"* and that salaried GP contracts should be on terms no less favourable than the BMA model contract.

Following a procurement process would allow Aberdeen City to rebalance its' practices between the 2C and 17J contractual models. Over the years, Aberdeen City's 2C practice model has differed to that of other cities as it has retained more 2C

[2] https://www.gov.scot/publications/gms-contract-scotland/pages/3/

practices for longer. Nationally, 4% Scottish general practices are of the "Section 2C Type".[3] This compares with 21% of Aberdeen City general practice.

3.9. Implementation of the Procurement Process

3.9.1. Procurement Process

The recommended option that emerged from the scoring process was to initiate a procurement process, whereby expressions of interest are invited by suitably qualified parties to assume responsibility for delivering the general medical services of a 2C General Practice. A visual summary of this process is provided at appendix B. The procurement strategy (see appendix C - exempt) indicates that this will be an open process and gives details of the proposed lots. The process will involve the submission of business cases, which are then evaluated against set criteria (see appendix D - exempt), before a shortlist are invited to interview. The evaluation panel will consist of key stakeholder, including representatives of the 2C Practice Project Team. The interview stage allows for more in-depth analysis of the proposals. This procurement process also allows for some degree of post-tender negotiation, allowing HSCP to ensure the proposal fully fits the needs of the service. The timescales for this process are also set out in the procurement strategy, though it is important to note that these could be extended, should the City's GP practices experience further increased operational demand due to Covid19 (for example due to vaccination delivery).

Details of the suggested procurement process are set out in appendices B, C and D.[3]

3.9.2. Evaluation Criteria

The evaluation criteria are an essential part of this process. These allow the ACHSCP to assess proposals and ensure that they are in line with the Strategic Plan and the future direction for primary care. The evaluation criteria included here (appendix D – exempt) are *draft* and will be consulted on if the recommendations of this report are approved. Critically, the evaluation criteria will strive to ensure no detrimental impacts on staff or patients, including those with protected characteristics. Furthermore, it is the intention of the project group to take these for consultation with the 2C practice staff project group *if* the recommendations of this report are approved. If proposals do not satisfy in terms of the evaluation criteria, ACHSCP is not obligated to accept any proposal.

[3] Please note appendices C & D are considered exempt information in line with the Local Government (Access to Information) 1973 Act, Schedule 7A, under paragraph 9 (Terms of Acquisition or Disposal)

3.10. Why Do We Think This Will Be Successful Now?

Previous procurement processes for GMS services have been unsuccessful, most recently Torry Medical Practice and Carden Medical Practice. There are several reasons which make this procurement process more likely to result in a suitable business case proposal:

- **Learning from previous tenders:** learning from previous tenders has indicated that practices were unaware of the procurement process and how to submit business cases. As a result, a workshop will be held by the Local Medical Committee (LMC) and/or AHCSCP on a city-wide basis to provide the information required for local independent contractors to feel confident submitting a business case. Further, feedback from previous tenders has indicated that the timescale allowed for submission of business cases was too short (i.e. the minimum requirement of 30 days). In this procurement process, a much-extended timescale is proposed of 40 *working* days to mitigate against this.
- **Changes in the service delivery:** Covid-19 has changed ways of working within primary care which may open more opportunities for innovative business cases. Many independent contractors have experienced changes in their service models which will allow for different business cases to be submitted as part of a procurement process.
- **Large and varied opportunity:** Undertaking a procurement process for all practices (albeit in separate lots) will provide an opportunity to create a business case that was not available when practices were individually tendered at different times in the past.

3.11. Next Steps: process

Remodelling our 2C services will require a flexible approach as progress is made towards the next steps. A procurement process will allow ACHSCP to fully understand the market and the potential solutions out there, working in tandem to support 2C Practices internally implement improvements to the service delivery model. Once we understand the potential market and appetite for procurement, this will inform the on-going work to co-design the primary care system in the City and will enable us to confirm / adjust the overall programme as required.

This represents the first steps in a journey to help ensure that Aberdeen's primary care services are sustainable and ready to adapt to the challenges that the future holds.

4. Implications for IJB

4.1. Equalities: An equalities and human rights impact assessment (EHRIA) has been completed for the recommendations of this report (i.e. to undertake a procurement process) which indicated a green assessment. However, at this stage any impacts arising from the specific proposals received cannot be assessed, as the proposals themselves are unknown. The procurement process is robust and considers equalities impacts through the process. NHS Grampian are also committed to ensuring that any procurement process does not increase health inequalities, for example through removal of service provision in areas of multiple deprivation, and this will be included in the procurement evaluation criteria.

4.2. Fairer Scotland Duty: The revised EHRIA form also considers the impact of the proposal on the Fairer Scotland Duty It is anticipated that the implementation of this plan, will have a positive impact on people affected by socio-economic disadvantage, as per the ambitions within the Strategic Plan.

4.3. Financial: The report is clearly aligned with the ACHSCP's Medium Term Financial Framework. Should the procurement process be successful, then the financial risk of these services overspending will be removed from the IJB as this would transfer to the independent contractor.

4.4. Workforce: It is recognised that change processes can be unsettling and stressful for staff, however the project team have taken steps to engage staff at an early stage and have been responsive to concerns as they have been brought forward. During the development stage, staff side and trade unions have been integral members within our operational governance decision making processes. Required workforce changes will continue to be progressed in consultation with affected staff and in partnership with our staff side and trade union reps in line with usual process on a project by project basis by organisational change if required. If an independent contractor is awarded the contract, employees will be protected under TUPE legislation (see below).

4.5. Legal: Procurement process will follow all necessary legislation as guided by our NHS Grampian colleagues. If a contract is awarded, then staff would transfer to the independent contractor in line with the "Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE).

4.6. Other – NA

5. Links to ACHSCP Strategic Plan

5.1. The areas of work referred to in this report directly align with the delivery of the Strategic Plan, which will be a key document for reference throughout the procurement process. The evaluation criteria of the business cases through the procurement process will be built to consider the strategic priorities of the partnership and to reflect the needs of stable GMS provision for the city, details of which are included appendix D (exempt).

- **Prevention:** The Partnership has a role to provide support to those practices at risk, if we do not transition those 2c practices that are stable to become part of an independent model this will have a significant negative impact on the Partnership's ability to meet the prevention agenda and maintain safe services for those who are in our communities, particularly those who reside in areas of multiple deprivation.
- **Resilience:** The potential of the procurement process to result in larger General Practices will work to make both the 2C and independent contractor more sustainable and puts less pressure on staff through economies of scale, cross-working and mutual support, thus improving the resilience of our workforce.
- **Personalisation**: Scaling up of services which are currently available at different times and locations will allow citizens in our communities to access these services at times and places which re convenient for them. Larger practices may be able to share more specialist services, as well as consider opportunities to improve access such as further extended opening hours.
- **Connections:** Ensuring a collaborative model to improve connections between general medical practices themselves; and between primary, community and secondary care will help to facilitate sustainability and build resilience.
- **Communities:** The overriding principle of General Practice is to ensure that person centred care is provided within community settings.

INTEGRATION JOINT BOARD

6. Management of Risk

6.1. Identified risks(s)

There are the following key risks identified if the recommendation to tender is approved:

Area	Risk	Mitigation
Workforce	There is a risk that the change processes impact on recruitment and retention in 2C practices. ACHSCP has received a number of GP resignations to date.	**Mitigation:** communication and engagement plan involving staff at earliest opportunity; additional supports to affected staff. **Contingency:** Development of robust business continuity plans for 2C practices, with the support of wider general practice.
Reputational	There is a risk of reputational damage to ACHSCP, due to a lack of understanding in the public of the independent nature of GP practices and a possible perception of "privatising the NHS"	**Mitigation:** Ensuring robust, pro-active communications strategy which will include the key messages relating to the independent contractor model of general practice.
Process	There is a risk that the tendering process does not result in submission of proposals. This could be compounded by operational demands relating to Covid-19 impacting on practices' capacity to develop business cases for submission.	**Mitigation:** Ensuring appropriate timescales; ensuring adequate promotion; ensuring support available for submitting applications; workshops for GP practice; scope to defer procurement process *if* likely to be impacted by operational demand

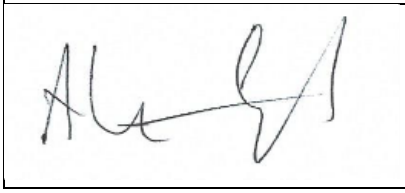
6.2. Link to risks on strategic or operational risk register:

By balance, there are also the following key risks if the recommendation to follow a procurement process is not agreed:

- **Risk 1:** The recommended option provides opportunities to stimulate the market; increase sustainability across the system; and promote innovation in general practice, reducing the risk of market failure, as identified in risk 1 of the IJB's

Strategic Risk Register. Should this option not be agreed by the IJB, there is the risk of further instability in the market and reduced capacity for ACHSCP to work pre-emptively supporting practices to prevent them reaching crisis point.

- **Risk 2:** The recommended option reduces the risk of financial failure by removing the risk of overspend on the 2C practices. Should this option not be agreed by the IJB, there is an increased risk of financial failure due to overspend in the service.
- **Risk 7:** The recommended option encourages innovation and provides potential for the widest range of possible solutions to deliver transformational change in the primary care system needed to meet demographic and financial pressures. Should this option not be agreed by the IJB, there is a risk that service re-modelling is not undertaken at the scale or pace required to meet demographic and financial pressures.
- **Risk 9:** The recommended option allows for innovative models to be put forward, potentially drawing on another workforce which may help the redesign from traditional models.

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

Risk	Option						Notes
	1	2	3a	3b	4	5	
1 *Market capacity*	Negative Impact	Neutral Impact	Neutral Impact	Neutral Impact	Positive Impact	Positive impact	Procurement process (options 4 & 5) is the only way of providing opportunities to stimulate the market; increase sustainability across the system and promote innovation across general medical services.
2 *Financial failure*	Negative Impact	Neutral Impact	Neutral Impact	Neutral Impact	Positive Impact	Positive impact	Options 2, 3a & 3b are assessed as neutral as whilst they may deliver some operational savings, risk of overspend lies with the IJB Options 4 & 5 removes/partially removes the risk of overspend therefore has a positive impact
3	NA – hosted services						Not a hosted service
4	NA – Partner organisations functions i.e. governance; performance						Does not relate to these functions
5 *Performance standards*	Negative Impact	Positive Impact	Positive Impact	Positive Impact	Positive Impact	Positive Impact	All options would seek to further improve services and meet performance standards and outcomes, except Option 1 which retains the status quo
6 *Reputational damage*	Negative Impact	Neutral Impact	Neutral Impact	Neutral Impact	Negative Impact	Negative Impact	Option 1 would have a negative impact on reputation (inaction) Options 2, 3a and 3b would have a neutral impact as internal process Options 4 & 5 have reputational risks associated with the procurement process
7 *Deliver transformation*	Negative Impact	Neutral Impact	Neutral Impact	Neutral Impact	Neutral Impact	Positive Impact	Option 1 does not support delivery of transformation Options 2, 3a, 3b and 4 limit opportunities for delivery of transformation Option 5 encourages innovation and has the potential for the widest range of possible solutions
8	NA – locality working						
9 *Redesign from transitional models*	Negative Impact	Neutral Impact	Neutral Impact	Neutral Impact	Positive Impact	Positive Impact	Option 1 does not support Option 2, 3a and 3b limits to redesign internally Options 4 & 5 provide opportunity to redesign internally and externally
10 *Brexit*	NA						

Project Name	2C GP Practice Remodelling	**Date**	09.11.20
Project Reference No.	HSCP.20.049	**Governance Programme Board(s)/ IJB**	Executive Programme Board / IJB
Project Manager/ Author	L McKenna (Primary Care Lead) S. Gibbon (Programme Manager) C Leask (Transformation Programme Manager)	**Date of Programme Boards/ IJB**	EPB 18.11.20 IJB 01.12.20

Contents

1. Summary of Project

This project seeks to remodel the six 2C General Practices in Aberdeen City to provide a sustainable model of service delivery that is person centred, takes cognisance of the learning and serviced delivery changes from the COVID pandemic, is high quality, affordable, and in line with the new GMS contract, the Primary Care Improvement Plan and the Partnership's Strategic Plan.

2. Background

3.1. In Primary Care, there are several different kinds of contract that a GP practice can have, which are outlined below:

	Explanation	Managed By	Aberdeen City #
17J	A 'Section 17J' or 'GMS' (General Medical Services) practice is one that has a standard, nationally negotiated contract.	GP Partners	17
17C	A 'Section 17C' practice (formerly known as 'Personal Medical Services' or 'PMS' practice) is one that has a locally negotiated agreement, enabling, for example, flexible provision of services in accordance with specific local circumstances.	GP Partners	5
2C	In general terms, this is most likely to mean that the practice is run by the NHS Board.	ACHSCP / NHSG	6

3. Business Need

2.1 Project rationale

The challenges faced by health and social care systems due to increasingly trying financial and epidemiological factors contributing to increasing demand are well documented. These include (but are not limited to):

1) Population increases (the figure below predicts an increasing population in Aberdeen City over the next 30 years, meaning there will be more people needing to be cared for)

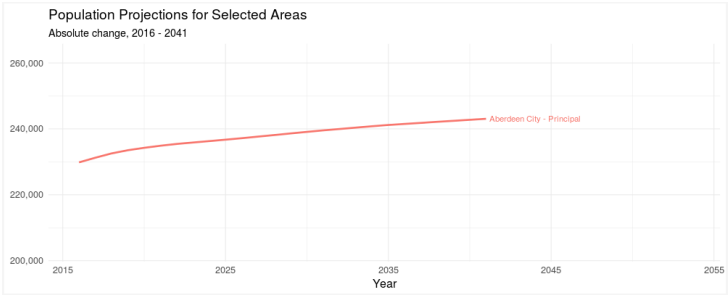
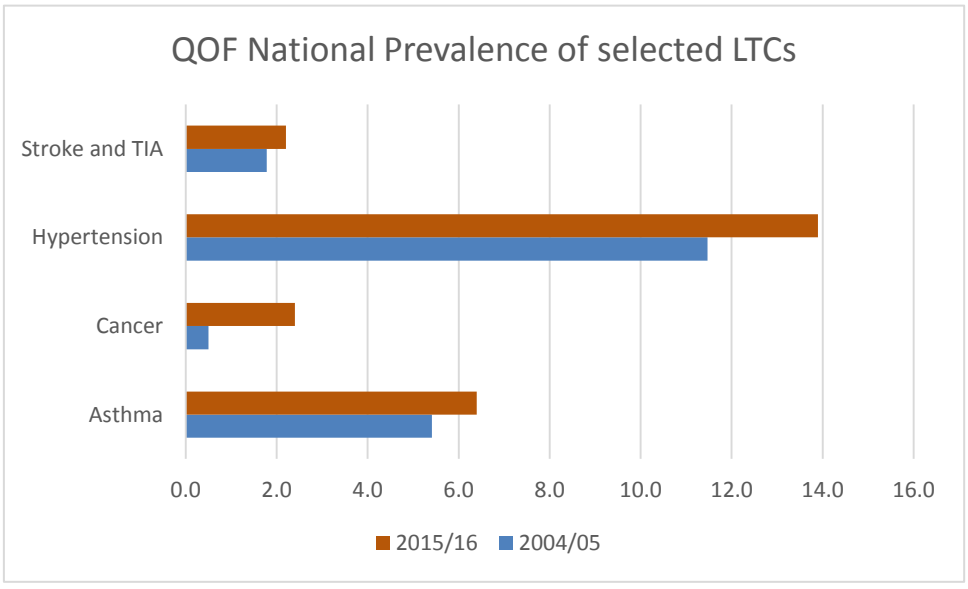


Figure 1. Aberdeen City Population Projections (Source: ISD)

2) Complexity (the figure below demonstrates the national rise in incidence of long-term conditions, meaning people are living with more complex needs, thus requiring more complex care)



3) Workforce Such challenges are exacerbated in General Practice, where most people interact with health and social care services in the first instance. Moreover, the

proportion of GPs between the ages of 55 – 64 leaving General Practice doubled from 2005 – 2014[1], resulting in a reduced workforce to undertake the required interventions. Locally, a declining number of GPs are evident.

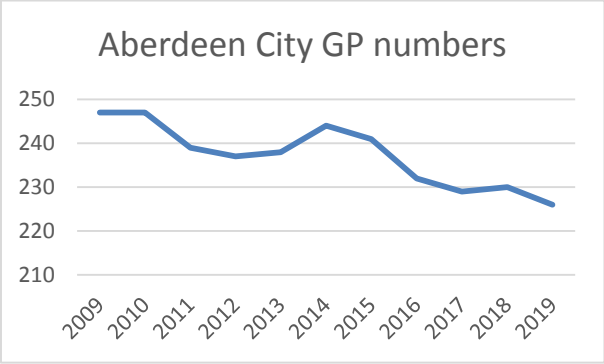


Figure 1. Aberdeen City GP numbers. Source: ISD

4) Sustainability: increasing demand; complexity and workforce challenges are resulting in increasing unsustainability across Aberdeen City, as evidenced in the 2019 Practice Sustainability Study (summary below)

High risk	>70
Medium Risk	50-70
Low risk	<50

Practice	Score 2019	Score 2017	Locality
REDACTED	135	61	Central
REDACTED	118	63	Central
2C Practice	113	69	Central
2C Practice	108	83	South
REDACTED	106	70	Central
2C Practice	90	52	South
2C Practice	88	75	North
REDACTED	87	75	North
REDACTED	86	77	North
2C Practice	85	67	North
REDACTED	85		Central
REDACTED	84		Central
REDACTED	83	57	Central
REDACTED	78	36	South
REDACTED	78	81	North
REDACTED	74	84	North
REDACTED	72	78	Central
REDACTED	71		South
REDACTED	70	66	South
REDACTED	70	38	North
REDACTED	64	76	Central
REDACTED	57	55	Central
REDACTED	53	77	Central
REDACTED	49		South
REDACTED	49	66	North
REDACTED	45	45	South
2C Practice	32	71	Central
REDACTED	29	50	Central

[1] Baird, B. et al. (2016). Understanding pressures in general practice. The King's Fund, London.

A key objective for this project is to support delivery of ACHSCP's strategic direction for primary care, as set out in documents such as the most recent General Medical Services contract[2] and Primary Care Improvement Plan. These highlight opportunities to transform how General Practice is delivered, emphasising that more of the same will not adequately address the aforementioned challenges.

2C Practice in Aberdeen City

In Aberdeen City, there are six 2C General Practices managed by ACHSCP and NHS Grampian, with a legal responsibility to provide a General Medical Service to these specific practice populations. The key characteristics of these practices are detailed below:

Table 1. Characteristics of the 2C Practices in Aberdeen City

2C Practice	Practice Postcode	Locality	SIMD Quintile	Practice Population	% Practice Population >65 years	GP Staff Hours per week	GP Staff Hours per week per 100 patients
Camphill	AB15 9EP	South	5	1854	15%	92	5.0
Carden	AB10 1UT	Central	5	8867	17%	244	2.8
Marywell	AB11 6FD	Central	2	226	0%	24	10.6
OAMP	AB24 3NG	North	5	11011	2.2%	213	1.9
Torry	AB11 8ER	South	4	6842	9.7%	40	0.6
Whinhill	AB11 7XH	Central	5	7026	13.8%	153	2.2

Aberdeen City has a higher proportion of 2C practices, some of which have remained 2C for a long period of time (21% of our total GP practices, compared with 4% nationally). This is different to other HSCP areas, where the 2C model is deployed to ensure continued provision of medical services to a population when an existing practice becomes unsustainable.

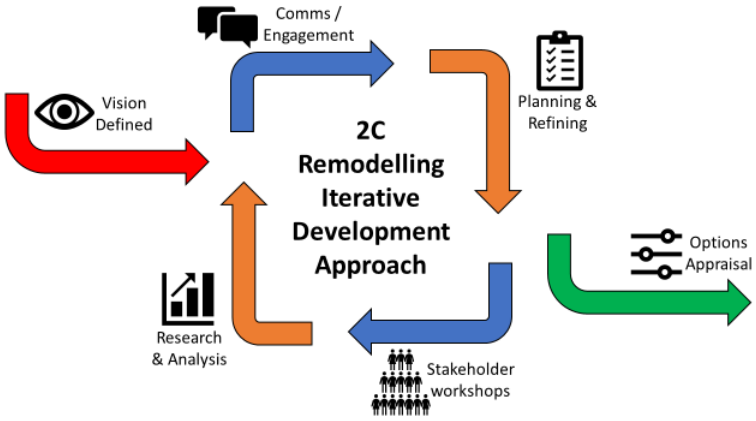
The funding context delineated in the medium term financial framework (available here) resulted in a revision of the Leadership Team's objectives on 7th January 2020 to address this; one of which being the focus of this paper (objective to "*A redesign of 2c practices to*

[2] Scottish Government. (2018). The 2018 general medical services contract in Scotland. Scottish Government, Edinburgh.

deliver a sustainable service based on patient profile, population needs assessment and available resource"). This was agreed by the IJB in March 2020.

2.2 Development to date

The options presented in Section 4 to deliver this project have been developed using a multi-stage, iterative approach (visual provided below). There were numerous components within this process that occurred in a cyclical nature (though it is important to realise that these are not necessarily sequential and often occurred frequently until the necessary outcome was achieved). A key stage in development was the inclusion of an internal proposal from 2C Practice staff following the initial stakeholder workshops.



Comms / Engagement

Ensuring that the appropriate stakeholders are engaged with at the appropriate times using the appropriate methods during the development phase was a priority. This included (but was not limited to):

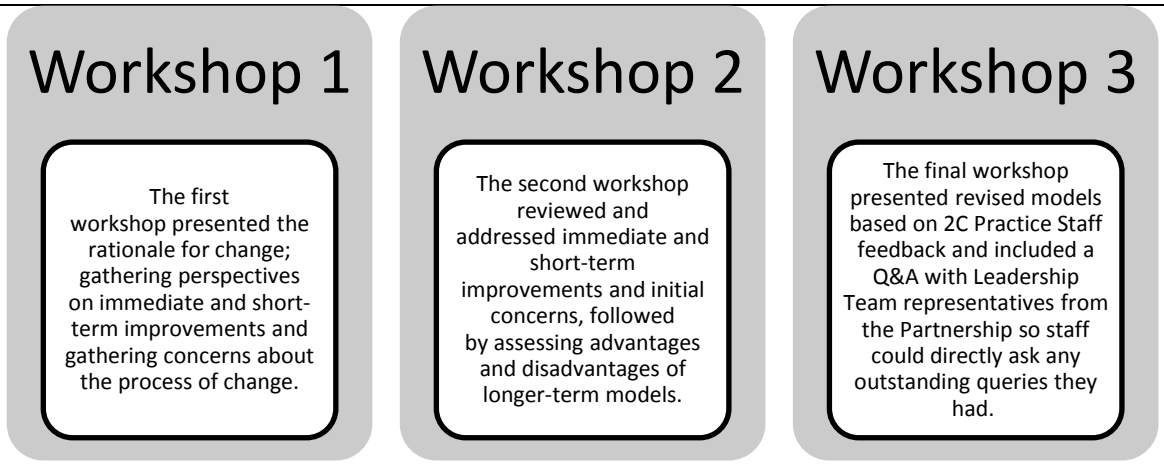
- Regular contact with 2C Practice Staff (such as email; Microsoft Teams and some face-to-face meetings within Practices and briefings before and after workshops)
- Colleagues from HR, Trade Unions and GP Sub / LMC (to ensure awareness of the process and to highlight any unintended consequences / further considerations to be aware of)

Planning & Refining

The options presented in Section 4 are the result of three stakeholder workshops held with 2C Practice Staff, and an additional internal proposal received after these workshops. An outline structure for each of these workshops were developed and refined by a project team and members of the 2C remodelling panel, this was evaluated and altered accordingly following discussions and outputs of subsequent workshops, in addition to ongoing research and analytical work. Workshops had representation from the 2C Practices and other stakeholders of interest, such as HR, Trade Unions and GP Sub / LMC.

Stakeholder workshops

The purpose and function of each workshop were:



Workshops were recorded and circulated to all 2C Practice Staff in the instances that some would be unable to attend.

Research & Analysis

Data collection and analysis has underpinned the process. Examples of this include:

- Desktop research to understand innovative models of General Practice implemented elsewhere, along with understanding the key principles required to implement an effective General Practice service that will be sustainable to meet the demands of the future
- Developing and distributing data collection methods to shape the future direction of the process (such as inviting 2C Practice staff to share their own innovative ideas for different ways of working and ranking the options provided by colleagues). Note – the preferences of the 2C Practice staff have been integrated into the scoring process in Section 4.1[3].

This approach, combined with the lived experience of those working in General Practice, allow a triangulated process that minimises bias. The culmination of these workshops were the identification of short-term improvements that can be implemented regardless of the outcome of this business case.

Short Term Improvements

During the first workshop, 2C Practice staff were invited to put forward ideas suggestions for improvements that could be made in the short-term, regardless of what option was put forward in this business case. Thematic analysis of this feedback indicated three key areas that were suggested to be progressed:

[3] It should be acknowledged that some 2C Practice Staff chose to abstain from voting. The two main reasons for this was the length of the development process (deemed too short) and the information provided on each of the options (deemed not specific enough).

Short-term Theme	Descriptor	Example feedback from 2C Practice Staff
Flexible workforce	The ability to utilise different staff to cross-cover with other Practices	"*Alignment of medical staff to days that practice has heaviest workload*".
Streamlined systems and processes	Standardising the use of electronic systems and different working processes across all Practices	"*Need to think about access to clinical systems … any possibility of amalgamating some / all of them?"*
Shared use of resources	Understanding how as a collective, Practices can support each other.	"*It would be helpful to have a grouping with another 2C Practice so that we could support each other*".

Whilst the preferred option described below is ongoing, these themes and the options offered up by staff during the workshops will be explored further to understand initiatives that can be mobilised in the short and medium term to improve efficiencies in service delivery.

4. Objectives

1. Ensure the chosen option can be achieved with limited adverse impact on staff / patients
2. Ensure service continuity whilst remodelling
3. Develop a future-proofed model that will mitigate against the increasing epidemiological and recruitment challenges
4. Develop a future-proofed model that will mitigate against the increasing financial challenges
5. Facilitates the implementation of shared resources, cross-practice working and supporting resilience (as per the Scottish GP contract 2018)
6. Has a direct link to the ACHSCP Strategic Plan

5. Options Appraisal

Option 1 – Do Nothing / Do Minimum	
Description	Continue the status quo of the six 2C General Practices functioning as individual General Practices.
Expected Costs	There are no additional costs associated with the implementation of this option, however existing budget pressures would not be addressed (for example locum use) and this option would not mitigate against increasing demand placing resulting in increasing financial pressure.
Risks Specific to this Option	There is a risk that this option will not prepare 2C General Practices for the future and current epidemiological, financial and workforce challenges highlighted previously, resulting in increasing unsustainability and a service which is not fit for purpose. **IJB Strategic Risk Register:** this option does not help the Partnership mitigate against any of the risks as identified in the Strategic Risk Register (see appendix 3).
Advantages & Disadvantages	<u>Advantages</u> • Causes minimal disruption to staff • Requires minimal resources to implement <u>Disadvantages</u> • Will require ongoing and increased Primary Care team support for the operational delivery of six, separate 2C Practices. • No benefit in terms of sustainability either for the 2C practices or the city as a whole. • Not aligned to the 2018 General Medical Contract in Scotland; will not achieve potential benefits of independent model. • Unlikely to enable the Partnership to utilise our assets to meet demand and service delivery in a flexible and efficient way. • Does not meet patients' needs for an increased demand on services in an innovative and future-proofed manner.

	• Unlikely to result in positive financial gain.
Other Points	

Option 2 – Partial Merger of 2C Practices	
Description	Some of the 2C General Practices would join to become a larger Practice.
Expected Costs	• Not fully identifiable currently, dependant on specific configuration. • Potential costs include any refurbishment or adaptations required for possible co-location following merger. • Potential savings include reduced locum costs and possible reduction in estates footprint.
Risks Specific to this Option	Risk that this minimal change will not prepare 2C General Practices for the future and current epidemiological, financial and workforce challenges highlighted previously **IJB Strategic Risk Register:** This option has limited, mainly neutral, impact on the Partnerships' ability to mitigate against risks in its Strategic Risk Register (see appendix 3)
Advantages & Disadvantages	<u>Advantages</u> • Causes minimal disruption to staff. • Likely to result in some limited economies of scale and scope from operating as larger Practices (such as shared use of resources). • Provides additional support for smaller practices • Partial creation of a more flexible workforce to meet increased patient needs • Most preferred option from the preference vote from 2C Practice Staff group (see appendix 2) <u>Disadvantages</u> • Will require ongoing Primary Care team support for the operational delivery of remaining 2C Practices. • Limited benefit in terms of sustainability either for the 2C practices or the city as a whole. • Not aligned to the 2018 General Medical Contract in Scotland; will not achieve potential benefits of independent model.

	• Unlikely to enable the Partnership to utilise our assets to meet demand and service delivery in a flexible and efficient way. • Does not meet patients' needs for an increased demand on services in an innovative and future-proofed manner. • Limited financial gain.

Option 3 – Full Merger of 2C Practices	
Please note that this option includes detail of an internal proposal received from 2C Practice Staff on 05.11.2020. The proposal (option 3b) was independently submitted to the project team and reflected the previous option of "Full Merger of 2C Practices" (option 3a). The analysis here summarises and adds additional consideration to the proposal, however the full, unedited proposal can be found at appendix 1	
Description	This option would see an organisational merger of all the 2C practices, however they would continue to operate from existing premises. The proposal includes details of the overall structure and organisation; clinical process; workforce; shared management and administration; teaching and training; and qualities improvement This proposal has been co-designed by staff from 2c practices and they would plan to continue to work in this way. Additionally they would create a patient representation group to participate in this process of co-design.
Expected Costs	Cost reductions: • Reduced locums spend due to increased cross-cover of pooled workforce • Proposal highlighted possibility of new income streams: from enhanced services contracts, training and teaching, improved processes around non-GMS work, extended hours.
Risks Specific to this Option	• The greatest risk from any service re-modelling would be loss of staff. This proposal specifically addresses this risk by ensuring ongoing staff co-design and retention of existing teams. • There is a risk of non-delivery of the service model • There is a risk that not all 2C Practices are as "bought-into" the proposed model resulting in resistance to

	change. ACHSCP has received complaints/concerns from 1 practice who would like to be withdrawn from the process. There is a risk that practices who have endorsed this approach may not continue to endorse this post-decision making. • There is a risk that this will not result in positive financial gain **IJB Strategic Risk Register:** This option has limited, mainly neutral, impact on the Partnerships' ability to mitigate against risks in its Strategic Risk Register (see appendix 3)
Advantages & Disadvantages	• Whilst initially this option (3a) was not the most preferred option from 2C practice staff, as indicated by the vote, the revised version (3b) has been a co-designed proposal from 2C Staff provides greatest opportunity for staff engagement and endorsement, reducing risk of resignation. • Reduced likelihood of any significant adverse effects upon staff or patients during any transition period to an independent contractor • Reduced impact on service continuity during the remodelling process. • This would provide a cost-effective modern well-coordinated primary care service that would be resilient to future pressures and demands. • In the longer term, this would not preclude other possible models of ownership or service configuration such as 17c arrangements, should ACHSCP/NHSG choose to revisit this issue in the future. **<u>Disadvantages</u>** • Will not realise the benefits of the independent (17J or 17c) model, in line with the new GMS contract, though does not preclude this as an option for the future. • Does not provide opportunity for other practices to improve their sustainability through procurement process • Does not increase capacity of the Primary Care Support Team to provide further support or to work preventatively with other practices that may require support in the future. • Proposal does not consider relocation or co-location of practices, stating practices will remain in own premises,

	therefore does not maximise use of existing assets (though recognises this could be progressed in future) • Limited internal redesign may not achieve significant changes required or within timescales • The detail outlined in the proposal describes a service model which could also be delivered by another of the options included in this business case, rather than a whole system approach which best mitigates the risks in the Strategic Plan.
Other Points	The willingness of the practises to collaborate will, if required, allow for some changes in the use of existing assets within the context of wider NHSG plans for the city. The proposal states that "*practices will also look at the feasibility of a Social Enterprise Model as a possible means to deliver this service model*". By retaining and improving the 2c model this proposal would increase the diversity of possible models that might provide effective solutions in the future for the problems facing primary care. However, this does not preclude a future change by NHSG to a different model of ownership, e.g. to 17c or 17j independent provider status.

Option 4 – Partial Merger and Partial Procurement Process	
Description	Some of the 2C Practices merge together to create a larger Practice, whilst ACHSCP undertakes a procurement process for the remaining Practices.
Expected Costs	Not fully identifiable at this time, dependant on specific configuration.
Risks Specific to this Option	Risk of staff turnover through dissatisfaction of the procurement process. This would be mitigated by a robust communication and engagement strategy and implementing a flexible workforce model to ensure that Practices cross-cover staffing absences as required. Additionally, business continuity planning has been undertaken by the Lead for Primary Care with neighbouring practices. **IJB Strategic Risk Register:** This option some potential to have a positive impact on most key risks as outlined in the Partnerships' Strategic Risk Register, though may have a

	negative impact on risk 6 (reputational damage) (see appendix 3)
Advantages & Disadvantages	<u>Advantages</u> • Allows ACHSCP to focus resources on a smaller number of 2C Practices deemed in more 'need' which is in line with the intentions of the 2C model nationally. • Allows elements of the internal 2C proposal to be implemented, whilst attaining some of the benefits associated with the 17J/17C independent model for others. • Opportunity for financial savings through potentially no longer having responsibility overspend for some practices. • Increased development to create a more flexible workforce to meet patient needs • Patient needs are partially met for an increased demand on services in an innovative and future-proofed manner • Increased likelihood that the Partnership can utilise the assets to meet demand and service delivery in a flexible and efficient way • Partially facilitates the implementation of shared resources, cross-practice working and supporting resilience (as per the Scottish GP Contract 2018) <u>Disadvantages</u> • Possibility that business cases submitted during the procurement process are not acceptable and as such, time is wasted during the process • Partial procurement process does not allow the Partnership to see all potential models of innovation and change from interested parties • Risk of staff turnover through dissatisfaction of the procurement process • Only partially facilitates the implementation of shared resources, cross-practice working and supporting resilience (as per the Scottish GP Contract 2018)

Option 5 – Procurement Process for all 2C Practices (individually, in groups or as a whole)	
Description	A procurement process is undertaken for all 2C practices as separate lots to determine whether other independent Practices would be suitable to take them on.
Expected Costs	Not fully identifiable at this time, dependant on specific configuration.
Risks Specific to this Option	• There is a risk of increased staff turnover through dissatisfaction of the procurement process. This would be mitigated by implementing a flexible workforce model to ensure that Practices cross-cover staffing absences as required, as well as undertaking robust business continuity planning alongside independent contractors. Additionally, business continuity planning has been undertaken by the Lead for Primary Care with neighbouring practices. • There is a risk of legal challenge regarding the outcomes of the procurement process. **IJB Strategic Risk Register:** This option some potential to have a positive impact on most key risks as outlined in the Partnerships' Strategic Risk Register, though may have a negative impact on risk 6 (reputational damage) (see appendix 3)
Advantages & Disadvantages	<u>Advantages</u> • Likely to produce business cases or solutions with higher levels of innovation which may be more likely to address pressures in the system. Encourages the widest range of possible options so does not limit the solution. • Provides opportunity to increase stability /sustainability of the independent contractors and the wider primary care system, as well as the 2C practice, reducing the risk of market failure as identified in risk 1 of the Strategic Risk Register • Option releases the biggest financial savings through potentially no longer having financial responsibility for

	any Practices and consequently any overspend on budgets. • Aligned with the current direction of the 2018 General Medical Contract in Scotland • Enables the Partnership to see if our assets can be utilised to meet demand and service delivery in a flexible and efficient way • Meet patient needs for an increased demand on services in an innovative and future-proofed way <u>Disadvantages</u> • Least favoured by the 2C practice staff as indicated by the 2C practice staff vote (see appendix 2); • Risk of staff turnover through dissatisfaction of the remodelling and procurement process; • Possibility that business cases submitted during the procurement process are not acceptable and as such, time is wasted during the process;

5.1 Scoring of Options Against Objectives

Use the table below to score options against the objectives to create a shortlist of options to be considered. 3a demonstrates the original scoring of a full merger option. Option 3b demonstrates the revised scoring of the full merger option *following* receipt of the internal 2C proposal.

OBJECTIVE	1	2	3a	3b	4	5
1.Ensure the chosen option can be achieved with limited adverse impact on staff / patients	0	2	1	3	1	1
2.Ensure service continuity whilst remodelling	2	2	2	2	1	1
3.Develop a future-proofed model that will mitigate against the increasing epidemiological and recruitment challenges	-1	0	1	1	2	2
4.Develop a future-proofed model that will mitigate against the increasing financial challenges	-1	0	1	1	2	3
5.Facilitates the implementation of shared resources, cross-practice working and supporting resilience (as per the Scottish GP contract 2018)	-1	0	2	2	1	3
6.Has a direct link to the ACHSCP Strategic Plan	-1	0	0	2	1	2
TOTALS	-2	4	7	11	8	12
RANKING	6th	5th	4th	2nd	3rd	1st

Scoring
Fully Delivers = 3
Mostly Delivers = 2
Delivers to a Limited Extent = 1
Does not Deliver = 0
Will have a negative impact on objective = -1

5.2 Recommendation

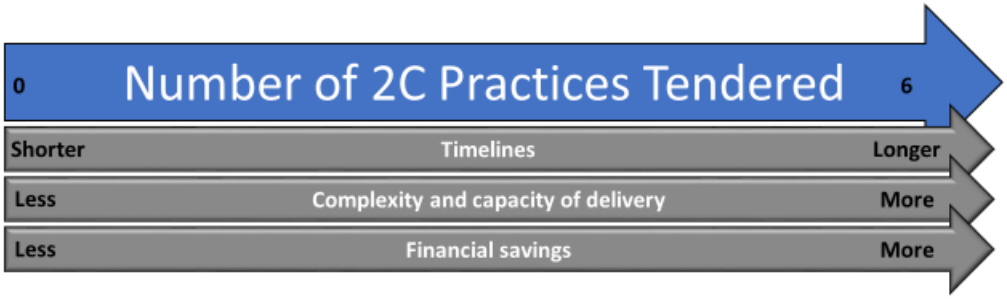
It is recommended that Option 5 (Procurement Process for all 2C Practices) is progressed as the highest scoring option outlined above. This would see a procurement process commence with an invitation by suitably qualified parties to express an interest in assuming responsibility for some / all of the six 2C General Practices in Aberdeen City. Whilst the process is underway, work can begin to implement short-term improvements as highlighted by 2C Practice Staff during the workshops.

Option 3b also scored strongly in the options appraisal. The *difference* in scoring between the initial full merger option and the 2C practice proposal was largely due to factors in the proposed service model which could also be achieved through a procurement process. However, option 5 aligns more closely to the strategic plan and provides additional benefits with more potential to deliver transformational change of primary car services in line with this strategic direction. Furthermore, option 5 provides the opportunity to mitigate against the broadest range of risks within the Strategic Risk Register (such as market or financial failure – see appendix 3).

6. Scope

Procurement Process

As aforementioned, the Procurement process will invite initial expressions of interest, from suitably qualified parties*, for the provision of Primary Medical Services through a General Medical Services contract in Aberdeen City. (*interested parties require to comply with the relevant terms of the National Health Service (Scotland) Act 1978, as amended, including & specifically Section 17L). Such a preferred option cannot have a clear blueprint developed before the process has been undertaken as there is no way of predicting what business cases will be submitted. The visual below highlights some of the complexities associated with such an approach:



However, there are numerous key considerations that are evident from the outset:

<u>Procurement Strategy</u>

The procurement strategy outlines key considerations as to how the procurement process should be undertaken. This includes determining the route to market and consideration of "lots". In this case, it is recommended that each practice is considered a separate lot to maximise the number of potential applicants and to provide the maximum number of configurations for consideration in a business case.

Evaluation

Development of robust evaluation criteria will be essential in ensuring the suitability of business cases. One critical criterion will be ensuring that the procurement process does not result in increasing health inequalities. For example, assurance will have to be provided to guarantee that services would not be removed from areas of multiple deprivation where the needs of such populations are higher. Such business cases that cannot provide these assurances will not be considered given the Partnership's commitment to reducing health inequalities and ensuring equitable provision for citizens across the City.

Note – given the numerous outcomes that there could be within this process, the costs outlined in Section 7 assume that all Practices are tendered, which includes all aspects of the service (such as staff and buildings). A full breakdown of costings has been developed and are available on request.

Evaluation criteria

Once business cases are received, the business case selection for interview award criteria is initially applied to all applicants. Interviews will be awarded on the basis of the business case submission/s which demonstrate a high level of scoring and feasibility, taking into consideration local context / conditions and other relevant factors. Selection panel members will use the evaluation criteria, together with the scoring guide, to assess overall viability to move to interview or not.

Contract award criteria

The contract will be awarded based on the submission/s which demonstrate a high level of scoring and feasibility, taking into consideration local context / conditions and other relevant factors. Please note that an applicant's proposal consists of the submitted Business Case, the oral presentation and answers to panel member's questions. Selection panel members will use an evaluation criteria, together with the scoring guide, to assess overall viability.

Given the context of ACHSCP being required to intervene and provide services for three other independent practices in the past 24 months, particular consideration must be given to the sustainability of business cases and alleviating the risk of Practices collapsing and requiring the Partnership to assume control of them again.

Note – ACHSCP are under no obligation to accept any tenders. This allows the opportunity to see what is out there.

This also acts as a potential bridge between Option 4 within the Options Appraisal (partial merger + partial procurement process) that could be explored later should the outcome of the procurement process not be as anticipated.

6.1 Out of Scope

(List any notable exclusion, those areas that may be viewed as associated with the project or the affected business area but which are excluded from the scope of the project.)

In the case of a procurement process, to enable practices to put forward innovative business cases for tender and merger, no practice will be deemed 'out of scope'.

6.2 Project Dependencies

Project dependencies include (but are not limited to):

- Other disciplines that are co-located within General Practice (such as Substance Misuse, Podiatry and Link Practitioners) that may be impacted by any changes. This could be mitigated with a statement of intent for the services potentially impacted within the procurement process.
- The 2018 General Medical Services (GMS) Contract In Scotland and the Memorandum of Understanding (MoU) – 'GMS contract implementation in the context of Primary Care Service Redesign'

7. Benefits

7.1 Citizen Benefits

Benefit	Measures	Source	Baseline	Expected Benefit	Expected Date	Measure Frequency
Improved access to services	Number of NearMe Consultations	Vision / EMIS	@ contract award	Patients more satisfied with care provision	Accrued impact over time	Monthly
	Number of E-Consult consultations	Vision / EMIS	@ contract award			
Receipt of more appropriate care	Increased number of consultations conducted by multi-disciplinary professionals	Vision / EMIS	@ contract award	Patients receive the right care from the right person		

7.2 Staff Benefits

Benefit	Measures	Source	Baseline	Expected Benefit	Expected Date	Measure Frequency
Improved resilience	Recruitment of additional professional roles	HR	@ contract award	Developing the General Practice model will enhance the experience for staff working within it	Accrued impact over time	Monthly
	Sickness / absence rates					

7.3 Resources Benefits (financial) – indicate whether these benefits are cashable or non-cashable

Benefit	Measures	Source	Capital or Revenue?	Baseline (£'000)	Saving (£'000)	Expected Date	Measure Frequency
Reduced financial pressure on ACHSCP	Cost of 2C model	Finance	Both	£5,254,724	£518,405 (assuming all Practices are successfully awarded)	August 2021	Baseline @ 3 months post award

8. Costs

8.1 Post- Project Revenue Expenditure & Income (Business as Usual)

(£'000)	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Total
Staffing Resources	4980										
Add cost items under each heading											
Non Staffing Resources	794										
	5774										
Revenue Receipts and Grants	(5255)										
Sub-Total	**518**										

9. Equalities Impact Assessment
An equalities impact assessment will be undertaken on the submitted business cases once the details are known.

10. Key Risks	
Description	**Mitigation**
2C Practice staff do not want the remodelling process to occur and have said a proportion will resign. This point is emphasised by the preferred option for full procurement process is the 'least preferred' option from 2C Practice Staff	Ensure an effective comms / engagement plan is in place. Practice staff have already engaged in numerous workshops and discussions to date.
There is a risk of 2C Practice Staff resignation because of the remodelling process, impacting on service delivery.	Business continuity planning for ensuring continued service delivery
There is a risk of reputational damage to the Partnership. Patients may be displeased at no longer attending 'their practice'. There may also be a wider perception that the Partnership are 'selling off' Practices, thus resulting in reputational damage	Develop and implement effective comms and engagement plans. Ensure those contractors submitting business cases are required to state how they will mitigate this should they be successful and awarded their contract.
There is a risk that no business cases are received through the procurement process	Ensure appropriate time and awareness raising of procurement process are implemented to maximise potential interest; open procurement process with individual lots to maximise possibilities. Deliver workshop on 'How to develop and submit a Tender'. Contingency: alternative to develop next highest scoring option from the business case if no proposals received.
Successful bidder for the contract is not able to accomplish the transition from 2C model to independent model and responsibility for the patients reverts to ACHSCP	Ensure robust criteria are developed by which to measure applications. ACHSP Primary Care Team – to work closely with those parties that have been awarded a tender to identify risks and support for success

11. Time

11.1 Time Constraints & Aspirations

Whilst the procurement process is underway, other potential solutions that were considered (such as the merger of some / all of the 2C General Practices) will be unable to progress as this will alter the terms of the procurement process. However, the key principles outlined in Section 5 (flexible workforce; streamlined systems and processes; and shared use of resources) can be commenced.

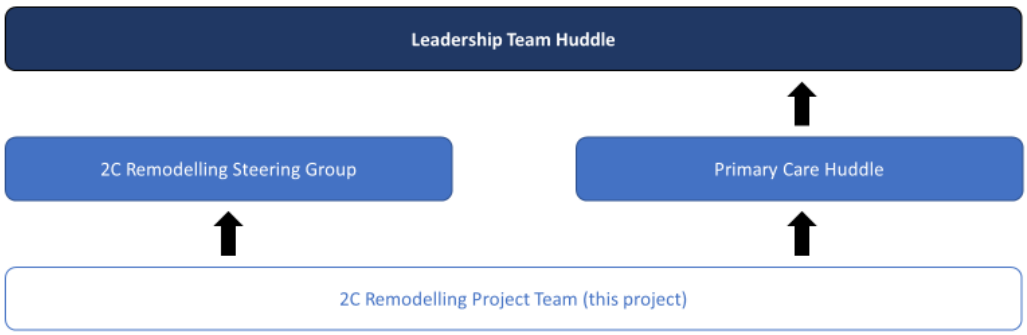
Full details on the proposed timelines are included in the procurement strategy and will be published alongside the procurement documents.

11.2 Key Milestones

Description	Target Date
Preferred option agreed	**01 December 2020**
Procurement Process go-live *Extended timescales for submission of proposals; evaluation; interview stages; and stand-still*	**25 January 2020**
Contract Award close / decision	**17 May 2021**
Full handover of tendered Practices (if successful)	**July- August 2021** *(dependent on number and details in transition plan)*

12. Governance

The governance structure is visible below.



The roles within the project team are described below. NB: This team are supported by a steering group of wider stakeholders, including colleagues from HR; Trade Unions and the LMC.

Role	Name

Project Lead	Lorraine McKenna
Business Change Managers	Emma King; Steve McMaster
Programme Manager / Research Lead	Calum Leask / Sarah Gibbon
Project Manager	Chris Smillie
Organisational Development Facilitator	Fiona Nairn
Clinical Lead / Independent Practice Rep	Alasdair Jamieson

13. Resources			
Task	**Responsible Service/Team**	**Start Date**	**End Date**
Effective delivery of transformational change Lead the tender process	Transformation team Primary Care Team NHSG Procurement Team	Oct 20 Ongoing Nov 20	Aug 21 Ongoing May 21
Intimate knowledge and expertise of Primary Care operations	Primary Care team Local Medical Council (LMC)	Ongoing	Ongoing
Knowledge of organisational change policy and procedures	HR / Trade Unions	Oct 20	Aug 21

14. Stakeholders

CONSULT

Finance
General Public
Independent General Practices
Capital Team
LMC
Modes of communication
Briefings; Face-to-face meetings (both in person and virtual)

COLLABORATE

2C General Practice Staff
2C Remodelling Project Team
Organisational Development
LMC
Modes of communication
Project team meetings; Workshops; Informal catch ups

INFORM

IJB
ACHSCP Colleagues
PCIP Project Team
LMC
Modes of communication
Briefings; Presentations

INVOLVE

Trade Unions
HR
Clinical Leads
LMC
Modes of communication
Briefings; Workshops

15. Assumptions

- Costings assume that the full tender is successful and all 2C Practices are taken on by independent Practices
- Preferred option assumes that there suitably qualified parties open to assuming responsibility of some / all of the current 2C Practices

16. Constraints

Document any known pressures, limits or restrictions associated with the project.

- There may be pressures to maintain service delivery should staff turnover be evident during the process
- If no appropriate tenders, full redesign may be restricted by long-term building and leasing options already in existence

17. ICT Hardware, Software or Network infrastructure		
Description of change to Hardware, Software or Network Infrastructure	**EA Approval Required?**	**Date Approval Received**
Scale up of NearMe	No	n/a
Scale up of E-Consult	No	n/a

18. Support Services Consulted				
Service	**Name**	**Sections Checked / Contributed**	**Their Comments**	**Date**
Finance	G Parkin	Costings	Costing inputted.	04/09/20
Procurement	Jennifer Yeoman Peter Obosi	Tender details	Inputted	07/09/20
Assistant Clinical Director	Alasdair Jamieson	All	Inputted	07/09/20
LMC	Emma Houghton	Process and eligibility of GMS provision & Change	Inputted	07/09/20
2C General Practice Staff	NA	Workshop process Internal proposal	Additional proposal included	06/11/20
Information Governance	A Bell	Information Governance Implications	Assessments required a future point in the project	06/11/20
Governance Legal Team	J. Anderson	Entire Business Case	Inputted into the business case	20/11/20

19. Document Revision History			
Version	**Reason**	**By**	**Date**
1.0	Initial creation	L McKenna	28/08/20

1.1	Further development	C Leask	31/08/20
1.2	Financial costings	G Parkin	04/09/20
1.3	Consultation document with project team; Trade Union and Clinical Leads	C Leask	04/09/20
1.4	Further input from project team	E King L McKenna	07/09/20
1.5	Comments integrated from Executive Programme Board	C Leask	14/09/20
1.6	Further iteration of comments from project team	C Leask	17/09/20
1.7	Updated following IJB Pre-Agenda meeting	S Gibbon	29/09/2020
1.8	Inclusion of 2C Practice Proposal and scoring	S. Gibbon	06/11/2020
1.9	Update following IJB Pre Agenda	S. Gibbon	17/11/2020
2.0	IJB Final Report Deadline	S. Gibbon	24/11/2020

Appendix 1

Option 3b	
Description	**Merger of 2c Practices** **Overall structure and organisation** **All practices would continue to operate from existing premises, although a permanent location for the homeless practice needs to be identified in the city centre. There would be significant integration and modernisation of services and enhanced workforce cross-cover as detailed below.** This would allow practices to retain their individual practice identities but financially they would constitute a single entity, increasing overall security and providing opportunities for working across practices and harmonising working practices. In the longer term, this would not preclude other possible models of ownership or service configuration such as 17c arrangements, should NHSG choose to revisit this issue in the future. The practices are also cognisant of the need to consider how all assets and premises are utilised to achieve the overall objectives of NHSG and would welcome being involved in future consultation and planning around this. This proposal has been co-designed by staff from all 2c practices and we would plan to continue to work in this way. Additionally we would create a patient representation group to participate in this process of co-design. **Clinical** **Our overall philosophy is *to provide person-centred, holistic care that is easily accessible with long-term relationships and continuity of care for patients where this is important; co-ordinating care for those patients who need this whilst grounding everything in local knowledge and a commitment to the local area.*** The 2c practices have a higher-than-average proportion of patients with complex needs and patients from vulnerable groups such as those with learning disabilities, alcohol and substance dependence, homelessness and multiple exclusions, as well as practices serving patients in areas of concentrated socio-economic deprivation. It is well-known that these groups require continuity of care, which would be guaranteed by our proposal. We already utilise innovative patient access and management systems such as eConsult, virtual wards and digital sign-posting as well as remote consultations, and we would plan to further develop and integrate these systems. However, equity of access requires that we also continue to provide more traditional routes of access for those patients who need these. Our teams already include a range of allied health professionals who effectively manage many patient needs, and we would plan a further extension of this provision. Improved Multi-Disciplinary Team (MDT) working and Advance Care Planning (ACP) are essential to effectively manage patients with complex needs. The significantly larger patient population and clinician group resulting from the merger would ensure efficient and effective use of the precious time resource of relevant specialists and allied health and social care colleagues.

This in turn would ensure their ongoing participation and would be facilitated by IT resources that already exist in practices. Staff from secondary and social care and Housing could thereby be more efficiently aligned to the 2c practices, e.g. care manager, support workers, link worker, psychological practitioner, paediatrician, geriatrician, adult and old age psychiatrists.
We would share clinical expertise across practices, e.g. minor surgery, sexual health, pessaries, diabetes, joint injections. Aside from providing care to patients closer to home and more quickly, this would reduce pressure on secondary care and provide additional income streams for the practices. It would also provide attractive career options and training opportunities.
We would create shared protocols and systems across practices, including standardisation of chronic disease management using successful systems already in place in practices. There would also be standardisation of consulting room layout. Collectively these changes would ensure ease of cross-working by staff between practices and would improve patient safety.
Instead of individual clinicians taking responsibility for specific clinical areas in their own practice, they could do so across a number of practices, further enabling quality improvement work, and freeing up more clinical time.
The combined effect of these changes and the enhanced MDT structure would also allow for improvements in QI processes including medicines rationalisation which would enable improvements in patient safety, reduce adverse events, and would reduce prescribing costs.
In order to anticipate and plan for future service needs, we would liaise closely with AHSCP's health intelligence data analysts.
We would improve door-to-door transport to care by utilising and where necessary creating voluntary resources within localities. We would invest in enhanced Link Worker functions and additional mentoring & wellbeing roles to support lifestyle change, including third sector and voluntary providers. We would utilise pooled resources and expertise in health literacy and patient education interventions. We would extend the House of Care model of chronic disease management across all practices as standard to optimise patient participation in the own care.

Workforce

In order to minimise and even eliminate locum use we would introduce contractual agreements across all staff groups to provide cover across all practices for planned and unplanned leave. This would require a small amount of additional permanent sessions across all areas (clinical and administrative), but would be vastly exceeded by savings in locum costs and improved staff welfare and resilience as well as improved patient safety.
We would realise the potential for incorporating shift type patterns with extended opening hours, e.g. '8 till 8', or even Saturday mornings. This would provide access to additional funding for extended hours and has proven to be a popular pattern of working for some staff.
Overall, a larger and more secure workforce will attract and retain staff, especially with increased opportunities for training and broader clinical experience.

Management and administration

A larger administrative team would enable sharing tasks such as summarising or coding, which also creates further opportunities for quality improvement and standardisation.
We would share management resource as required, e.g. leading for the whole group, rather than just for an individual practice, in a particular area (e.g. implementing quality improvement projects, HR issues, website maintenance, streamlining processes, training etc).
Working across practices in admin/secretarial areas, could be carried out for multiple practices at one location, or by a team working across practices.
In order to allow realisation of all income available from non GMS activities, we would propose the devolution of a small amount of financial and budgetary function to the practices themselves. Additionally some limited Human Resources function could also be helpfully devolved, all to be conducted within NHSG processes with appropriate oversight and governance. This would allow for some degree of budgetary responsibility and allow quick responsiveness to the needs of succession planning so as to avoid gaps in service provision which can rapidly erode staff wellbeing and lead to sickness absences and the use of expensive locums in a small workforce where patient demand is continuous and cannot otherwise be displaced, except to secondary and emergency care.

Teaching and training

Teaching and training of existing staff and also of undergraduate (UG) and postgraduate (PG) trainees are considered an essential element of a high-quality service, and are known to improve standards, increase job satisfaction, maximise future recruitment and long-term succession planning. They are also important additional streams of income and can augment the available workforce.
Administration and rotas for teaching could be done in one location with one (or more) clinicians taking the lead; teaching sessions could easily be undertaken across practices via technology such as Teams. By sharing UG and PG teaching and training across practices (e.g. one tutor delivering tutorial to four trainees), we would automatically increase the possible breadth of clinical experience for trainees and students. It would additionally reduce the time commitment for individual tutors and increase their availability for clinical work.
Likewise, there would be improved joint-educational opportunities for staff.
It would allow the further development of ties between the practices and the universities in Aberdeen and also with NHS Education Scotland.

Quality Improvement

There would be a quality improvement programme for all the practices, including coaching, training and collaboration.
Wider participation in MDT across practices would also enable more QI work and interfacing / vertical integration and service alignment with secondary care and with social care.
The cross-practice clinical oversight structure would also fit more easily within a clear explicit QI framework.
Significant Event Analysis could also be undertaken across practices, as appropriate, to optimise systems learning.

Expected Costs	Cost reductions: Reduced locums spend. Improved vertical (with secondary care) and horizontal (with rest of primary care) integration enabling more rational and effective use of limited resources. Enhanced MDT working reduces impacts on secondary care and emergency and unscheduled care by improved anticipatory planning and continuity of care. QI work across practices with a focus on prescribing will enhance rational prescribing and help reduce the medicines budget. Increased specialist elective services delivered in primary care such as minor surgery reduce costs in secondary care. New income streams: from enhanced services contracts, training and teaching, improved processes around non-GMS work, extended hours.
Risks Specific to this Option	The greatest risk from any service re-modelling would be loss of staff. This proposal specifically addresses this risk by ensuring ongoing staff co-design and retention of existing teams.
Advantages & Disadvantages	The changes overall would provide a stable resilient workforce further enabling retention and recruitment. The ongoing co-design process will ensure improved staff empowerment. We would not anticipate any significant adverse effects upon staff or patients nor any loss of service continuity during the remodelling process. It would help deliver primary care for the city within the limits of the medium term financial framework. This would provide a cost-effective modern well-coordinated primary care service that would be resilient to future pressures and demands. This model of care is outcome and patient-focused model rather than staff-focused. We anticipate that the service improvements facilitated by this proposal would increase the number of patients reporting a positive experience of GP services and also of care that they would rate as excellent or good. The proposal can be seen to link directly to the AHSCP Strategic Plan 2019-2022 across all relevant areas.
Other Points	The willingness of the practises to collaborate will, if required, allow for some changes in the use of existing assets within the context of wider NHSG plans for the city. The practices will also look at the feasibility of a Social Enterprise Model as a possible means to deliver this service model. By retaining and improving the 2c model this proposal would increase the diversity of possible models that might provide effective solutions in the future for the problems facing primary care. However, this does not preclude a

	future change by NHSG to a different model of ownership, e.g. to 17c or 17j independent provider status.

Appendix 2

Options Voted on	1st Preference	2nd Preference	3rd Preference	4th Preference
Full Merger	5	24	10	9
Full Tender	1	2	13	38
Partial Merger	47	20	11	5
Partial Merger & Partial Tender	6	13	25	7

Appendix 3 Analysis of the options against the IJB's Strategic Risk Register.

This is presented to provide further context to the options outlined above, and it not yet fully reflected in the Strategic Risk Register. Following the IJB decision, the risk register will be updated to reflect the preferred way forward.

Risk	Option						Notes
	1	**2**	**3a**	**3b**	**4**	**5**	
1 *Market capacity*	Negative Impact	Neutral Impact *Limited impact?*	Neutral Impact	Neutral Impact	Positive Impact	Positive impact	Procurement process (options 4 & 5) is the only way of providing opportunities to stimulate the market; increase sustainability across the system and promote innovation across general medical services.
2 *Financial failure*	Negative Impact	Neutral Impact	Neutral Impact	Neutral	Positive Impact	Positive impact	Options 2, 3a & 3b are assessed as neutral as whilst they may deliver some operational savings, risk of overspend lies with the IJB Options 4 & 5 removes/partially removes the risk of overspend therefore has a positive impact
3	NA – hosted services						Not a hosted service
4	NA – Partner organisations functions i.e. governance; performance						Does not relate to these functions
5 *Performance standards*	Negative Impact	Positive Impact	Positive Impact	Positive Impact	Positive Impact	Positive Impact	All options would seek to further improve services and meet performance standards and outcomes, except Option 1 which retains the status quo
6 *Reputational damage*	Negative Impact	Neutral Impact	Neutral Impact	Neutral Impact	Negative Impact	Negative Impact	Option 1 would have a negative impact on reputation (inaction) Options 2, 3a and 3b would have a neutral impact as internal process Options 4 & 5 have reputational risks associated with the procurement process
7 *Deliver transformation*	Negative Impact	Neutral Impact	Neutral Impact	Neutral Impact	Neutral Impact	Positive Impact	Option 1 does not support delivery of transformation Options 2, 3a, 3b and 4 limit opportunities for delivery of transformation Option 5 encourages innovation and has the potential for the widest range of possible solutions
8	NA – locality working						
9 *Redesign from transitional models*	Negative Impact	Neutral Impact	Neutral Impact	Neutral Impact	Positive Impact	Positive Impact	Option 1 does not support Option 2, 3a and 3b limits to redesign internally Options 4 & 5 provide opportunity to redesign internally and externally
10 *Brexit*	NA						

High Level Summary – Procurement Process

This document provides a high-level summary of the intended procurement process, should the recommendations of the report be approved.

6 Individual Lots in an Open Procurement Process:
maximise possible solutions and encourage larger number of applications

Camphill	Carden	Marywell	Old Aberdeen	Torry	Whinhill

2 Stage Procurement Process:
1. Submission of business case 2. Evaluation and Interview

Finalising The Procurement Process

Consultation on Evaluation Criteria Development Workshop Preparatory Work	1st December - 25th January

Invitation To Submit A Business Case

Extended period for submission of business cases	25th January - 25th March

Evaluation & Interviews

Evaluation by key stakeholders Shortlisted proposals for interview	29th March - 28th April

Contract Award

Stand-still period then award contract Develop and prepare for implementation of transition plan	29th April - 17th May

2C Practice Staff Involvement throughout process including developing evaluation criteria and representatives on the evaluation and interview panels

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INTEGRATION JOINT BOARD

DIRECTION

ISSUED UNDER S26-28 OF THE PUBLIC BODIES (JOINT WORKING) (SCOTLAND) ACT 2014

The **NHS GRAMPIAN** is hereby directed to deliver for the Board, the services noted below in pursuance of the functions noted below and within the associated budget noted below.

Services will be provided in line with the Board's Strategic Plan and existing operational arrangements pending future directions from the Board.

Related Report Number:- HSCP.20.049 "Aberdeen City Primary Care Sustainability Programme (Stage 1 – 2C Remodelling) "

Approval from IJB received on:- 1st of December 2020

Description of services/functions:-

- Provision of General Medical Services (GMS) for patient populations of the 2C Aberdeen City GP Practices including: Camphill; Carden; Marywell; Old Aberdeen; Torry and Whinhill.

- Specific instruction is for NHS Grampian to undertake a procurement process to identify expressions of interest from independent contracts for the operation and management of the 2C practices in a 17J or 17C independent model, in line with the preferred option referred to in paragraph 3.7 of the accompanying report.

Reference to the integration scheme:-

Under Annex 1, Part 1, ACHSCP has responsibility for the delegated function of:

Primary medical services provided under a general medical services contract, and arrangements for the provision of services made under section 17C of the National Health Service (Scotland) Act 1978, or an arrangement made in pursuance of section 2C(2) of the National Health Service (Scotland) Act 1978(26).

However, this direction is required to NHS Grampian in order to undertake the procurement process:-

All functions of Health Boards conferred by, or by virtue of, the National Health Service (Scotland) Act 1978. Except functions conferred by or by virtue of— section 17J (Health Boards' power to enter into general medical services contracts);

Link to strategic priorities (with reference to strategic plan and commissioning plan):- The links to the strategic priorities are detailed within the associated IJB report, with clear links to the Partnership's strategic plan; the Primary Care Improvement Plan and the Medium Term Financial Framework.

Timescales involved:-

- Start date:- 1st December 2020, with publication of the tender on 25th of January 2021

- End date:- Contract award on 1st June 2021 (estimate); contract ongoing.

Associated Budget:-

Details of funding source:- £5,773,129

Availability:- confirmed;

Aberdeen City Health & Social Care Partnership
A caring partnership

Date of Meeting	1st Dec 2020
Report Title	Alcohol Drug Partnership Update
Report Number	HSCP20.068
Lead Officer	Sandra MacLeod, Chief Officer
Report Author Details	Simon Rayner
Consultation Checklist Completed	Yes
Directions Required	Yes
Appendices	Appendix 1 IJB Direction Tracker Appendix 2 Directions to ACC Appendix 3 Directions to NHSG Appendix 4 Report to RAPC 3 Nov 2020

1. Purpose of the Report

1.1. The Scottish Government has provided Alcohol and Drug Partnerships (ADPs) across Scotland 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.

1.2. The IJB is accountable for the financial governance of this investment. This paper is presented to the IJB to allow ratification of the ADP proposal and to direct NHS Grampian and Aberdeen City Council accordingly. This report sets out the detail of the intended investment as discussed by the Risk Audit and Performance Committee (RAPC) on the 3rd November 2020.

2. Recommendations

2.1. It is recommended that the Integration Joint Board:

a) Approve the expenditure as set out in paragraph 3.4 and

b) Make the Directions as set out in Appendix 2 and Appendix 3 and instructs the Chief Officer to issue the Directions to the Aberdeen City Council and NHS Grampian respectively

c)

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

3. Summary of Key Information

3.1. The Alcohol and Drug Partnership (ADP) for Aberdeen City has made proposals for investment of funding in line with its 3 Year Delivery Plan.

3.2. Four of the proposals require the IJB to issue Directions to Aberdeen City Council and NHS Grampian.

3.3. These proposals have been discussed by the Risk Audit and Performance Committee (RAPC) of November the 3rd 2020.

3.4. The proposals are listed in the table below and full details of the proposals agreed by the RAPC can be seen in Appendix 4.1

Ref	New Projects	Cost	RAP Report Ref
b)	Young People Resilience Hub (@ 12 months)	£105,000	Page 18
c)	Prison Throughcare (@ 24 months)	£70,000	Page 19
f)	Drug Death Prevention - Accommodation Technology	£70,000	Page 22
g)	Fast Track BBV Test and Treat	£65,000	Page 23
	Total	**£310,000**	

3.5. Aberdeen City is directed to:

a) Procure from the 3rd sector, three drug and alcohol workers to contribute staffing to locality based young people's resilience hubs for a period of 12 months until 30th Nov 2021

b) Procure from the 3rd sector, a prison liaison worker to be based as part of the Assertive Outreach for a period of 24 months

3.6. NHS Grampian is directed to:

a) To purchase equipment and evaluation services up to the value of £70,000 to support the development of the use of tele-health care technology to reduce drug related deaths

b) To purchase equipment up to the value of £65,000 for the fast testing and treating of Blood Borne Viruses in Aberdeen City drug and alcohol services.

3.7. The full list of Directions made by the IJB in relation to the ADP can be found at Appendix 1 for context

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

4. Implications for IJB

4.1. Equalities

This investment will have a *positive* impact on communities and service users through additional service capacity, improved access to support and improved service quality.

This investment will have a *positive* impact on staff in relation to investment in training, professional development and increased staff numbers.

This investment will have *no negative* impact on employees, service users or other people who share characteristics protected by The Equality Act 2010

4.2. Fairer Scotland Duty
This investment will have a *positive* impact on reducing the inequalities of outcome which result from socio-economic disadvantage.

4.3. Financial – contained in Appendix 3 and summarised in para 3.4 above

4.4. Workforce – contained in Appendix 3 and summarised in para 3.4 above. We will seek procurement from existing expertise and arrangements within the Third Sector.

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

4.6. Other - There are no other anticipated implications as a result of this report.

5 Links to ACHSCP Strategic Plan

5.1 The Scottish Government expect to see alcohol and drugs as an identifiable section within the AHSCP Strategic Plan. This plan, the ADP Delivery Plan and priorities within the Community Planning Partnership should all be corporate and work is being undertaken to ensure this.

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

6 Management of Risk

6.1 Identified risks(s)

Recruitment of staff is a potential risk to delivery.

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 therefore our ability to sustain the delivery of our statutory services within the funding available. The resultant risk is that the Integration Joint Board fails to deliver against the strategic plan.

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

Risk 5. "There is a risk that the IJB, and the services that it directs and has operational oversight of, fail to meet performance standards or outcomes as set by regulatory bodies."

Risk 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 investment will bring additional service capacity, opportunity for redesign and partnership working which will help mitigate risks.

Procurement has been discussed with Contract Officers with the aim if building capacity into existing service provision from Third Sector Providers.

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

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

APPENDIX 1 IJB DECISION TRACKER

Ref	Direction	To	IJB Date	Status
1a	To provide leadership, develop resources and implement project charter, ensuring that 100% of schools have % of schools with a progressive, cohesive and relevant substance misuse curriculum	Aberdeen City Council	3rd Sept 2019	Live / Completed
2a	To provide, for a fixed period of 2 years, support to people who are homeless or rapidly re-housed and people who are at risk of overdose to specifically help reduce the rate of drug related deaths in this target group	Aberdeen City Council	3rd Sept 2019	Pending / Recruiting
2b	To provide a recurring Housing / Domestic Abuse development service in-conjunction with the Violence Against Women partnership to improve pathways, joint working, retention of tenancy, anti-social behaviour, rent arrears and to specifically support women into treatment services and specifically women affected by substance use and domestic abuse	Aberdeen City Council	3rd Sept 2019	Live / Completed
2d	To provide developmental capacity for a fixed period of 12 months to help support and engage localities to develop improvements and delivery ADP priorities and to support our ambition for our strategy to be rooted in community action in line with Local Outcome Improvement Plan	Aberdeen City Council	3rd Sept 2019	Stopped – redefined due to COVID
3a	To provide a recurring Social Work service to facilitate the extension of alcohol hubs to increase capacity and establish alcohol services in areas of greatest need with a plan to link longer term to Community Care and Treatment Hubs	NHS Grampian	3rd Sept 2019	Live / Completed
2c	To provide a recurring Advanced Nurse service to improve general health and respond to increasing presentations of poor general health from older drug users across the sector from a number of key service locations across the city	NHS Grampian	3rd Sept 2019	Pending / Recruiting
	Provide a recurring specialist alcohol mental health nursing service to facilitate the extension of alcohol hubs to increase capacity and establish alcohol services in areas of greatest need with a plan to link longer term to Community Care and Treatment Hubs.	NHS Grampian	3rd Sept 2019	Live / Completed
	Provide a recurring specialist alcohol mental health nursing service to facilitate the extension of alcohol hubs to increase capacity and establish alcohol services in areas of greatest need with a plan to link longer term to Community Care and Treatment Hubs.	NHS Grampian	3rd Sept 2019	Live / Completed
3b	To continue to provide alcohol hubs in Kincorth and in Woodside	NHS Grampian	3rd Sept 2019	Live / Completed
3c	To provide recurring additional specialist nursing service capacity within the Integrated Drug Service increase capacity and to facilitate improved service user retention, increase innovation and improve outcomes to meet national quality standards	NHS Grampian	3rd Sept 2019	Live / Completed

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

3d	To provide recurring a senior mental health nurse practitioner service to lead quality improvements, lead on non medical prescribing, lead on trauma informed care, provide outreach for complex cases and overdose incidence	NHS Grampian	3rd Sept 2019	Live / Completed
3e	To provide new way of working with Primary Care Vision system that will improve the ability of clinicians to performance manage BBV testing, Medicine Reviews, Contraception Reviews etc	NHS Grampian	3rd Sept 2019	Stopped – redefined due to COVID
3f	To provide a staff / workforce development / recruitment and retention programme to help mitigate against staff recruitment risks	NHS Grampian	3rd Sept 2019	Live / Completed
4a	To grant Fund Aberdeen In Recovery – (AiR) is a peer led recovery support group to under a range of supports, groups, activities.	NHS Grampian	3rd Sept 2019	Live / Completed
5a	To provide recurring data management capacity to reduce demand on practitioners and prepare for Scottish Government DAISY system coming on stream in January 2020.	NHS Grampian	3rd Sept 2019	Stopped – redefined due to COVID
5b	To provide over a fixed period a development programme to lead a cohort of senior officers and the ADP through process of "discovery" examining world class evidence to formulate innovations and improvements at a strategic level for the City	NHS Grampian	3rd Sept 2019	Stopped – redefined due to COVID
5c	Provide local communities with resources over a fixed period to ensure that the ADP Strategy meets the needs of the population allow communities to help deliver the ADP framework and support local grass roots activity to help shape the future ADP delivery plan through improved intelligence and co-production.	NHS Grampian	3rd Sept 2019	Amended to fund Young People Resilience Hubs
2d	Procure from the 3rd sector, three drug and alcohol workers to contribute staffing to locality based young people's resilience hubs for a period of 12 months until 30th Nov 2021	Aberdeen City Council	1st Dec 2020	Pending Decision
2e	Procure from the 3rd sector, a prison liaison worker to be based as part of the Assertive Outreach for a period of 24 months	Aberdeen City Council	1st Dec 2020	Pending Decision
2f	To purchase equipment and evaluation services up to the value of £70,000 to support the development of the use of tele-health care technology to reduce drug related deaths	NHS Grampian	1st Dec 2020	Pending Decision
2g	To purchase equipment up to the value of £65,000 for the fast testing and treating of Blood Borne Viruses in Aberdeen City drug and alcohol services.	NHS Grampian	1st Dec 2020	Pending Decision

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

Appendix 2

INTEGRATION JOINT BOARD

DIRECTION

ISSUED UNDER S26-28 OF THE PUBLIC BODIES (JOINT WORKING) (SCOTLAND) ACT 2014

The **ABERDEEN CITY COUNCIL** is hereby directed to deliver for the Board, the services noted below in pursuance of the functions noted below and within the associated budget noted below.

Services will be provided in line with the Board's Strategic Plan and existing operational arrangements pending future directions from the Board.

Related Report Number:- HSCP.XXXX

Approval from IJB received on:- xx December 2020

Description of services/functions:-

c) Procure from the 3rd sector, three drug and alcohol workers to contribute staffing to locality based young people's resilience hubs for a period of 12 months until 30th Nov 2021

d) Procure from the 3rd sector, a prison liaison worker to be based as part of the Assertive Outreach for a period of 24 months

Reference to the integration scheme:- Annex 1 Part 2: Part 2:

16.

20.

Link to strategic priorities (with reference to strategic plan and commissioning plan):-

The provision of this hub fits with all 5 strategic aims for ACHSCP: prevention; resilience; enabling; connections; and communities.

Timescales involved:-

Start date:- 1st Dec 2020

End date:- ongoing

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

Appendix 3

INTEGRATION JOINT BOARD

DIRECTION

ISSUED UNDER S26-28 OF THE PUBLIC BODIES (JOINT WORKING) (SCOTLAND) ACT 2014

The **NHS Grampian** is hereby directed to deliver for the Board, the services noted below in pursuance of the functions noted below and within the associated budget noted below.

Services will be provided in line with the Board's Strategic Plan and existing operational arrangements pending future directions from the Board.

Related Report Number:- HSCP.XXXX

Approval from IJB received on:- xx December 2020

Description of services/functions:-

e) To purchase equipment and evaluation services up to the value of £70,000 to support the development of the use of tele-health care technology to reduce drug related deaths

f) To purchase equipment up to the value of £65,000 for the fast testing and treating of Blood Borne Viruses in Aberdeen City drug and alcohol services.

Reference to the integration scheme:- Annex 1 Part 2: Part 2:

16.

20.

Link to strategic priorities (with reference to strategic plan and commissioning plan):-

The provision of this hub fits with all 5 strategic aims for ACHSCP: prevention; resilience; enabling; connections; and communities.

Timescales involved:-

Start date:- 1st Dec 202

End date:- ongoing

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

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Appendix 3 ADP Report to the RAPC approved 3rd Nov 2020

Date of Meeting	3rd November 2020
Report Title	ADP Funding
Report Number	HSCP.20.059
Lead Officer	Alex Stephen, Chief Finance Officer
Report Author Details	Name: Simon Rayner Job Title: ADP Lead Email Address: simon.rayner@nhs.net Phone Number: 07910171129
Consultation Checklist Completed	Yes
Directions Required	No
Appendices	1. Project Summaries 2. Progress Monitoring

5. Purpose of the Report

5.1. This report seeks support for Alcohol and Drug Partnership (ADP) investment plans that have been developed as a result of budget slippage and the impact of emergent issues as a result of COVID 19

6. Recommendations

6.1. It is recommended that the RAP:

a) Approve the proposals and agree that the APD progresses developments

7. Summary of Key Information

7.1. On the 3rd Sept 2019 the IJB agreed investment by the Alcohol and Drug Partnership (ADP) of £1.3m. Good progress has been made toward

recruitment and an annual report was presented to the IJB on the 8th Sept 2020. Due to some posts taking longer to fill than expected and the impact of COVID 19 on recruitment and operationalising plans the ADP has incurred slippage on planned investments. Further, due to COVID 19 some planned projects are no longer feasible or desirable in the short term and have therefore been reprioritised to ensure that resources are being utilised where there is evidenced need.

7.2. The request from the AHSCP Chief Finance Officer was for the ADP to engage and develop ideas that could 1) be deployed quickly 2) meet emergent short-term needs.

7.3. As with other projects that have been funded as tests of change, if successful, longer term recurring funding will be identified through service redesign and transformation as the ADP seeks to move towards a strategy based on earlier intervention. This is line with the "Alcohol and Drug Partnership (ADP) Investment Plan: Programme for government 2018-19: additional investment in services to reduce problem drug and alcohol use" agreed by the IJB on 11th Dec 2018.

7.4. These projects will be taken forward using Community Planning Partnership Improvement Methodology to demonstrate progress and outcomes.

7.5. Members of the ADP, including people with lived experience, the AHSCP and wider services were asked for ideas and suggestions which were then developed further.

7.6. The Scottish Government published its national drug and alcohol strategy in November 2018: **Rights, Respect, Recovery** which allowed us to ensure strategic fit with developing priorities. Funding allocated to ADPs is to locally deliver the national strategy: **Rights, Respect, Recovery.** The IJB is accountable for the financial governance of this investment.

7.7. The ADP membership has representatives of:

- Police Scotland
- Scottish Prison Service
- Aberdeen City Council (including Elected Members)
- NHS Grampian Public Health
- Aberdeen City Health and Social Care Partnership
- Scottish Fire and Rescue Service

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- Aberdeen's 3rd Sector Interface (ACVO)
- Civic Forum
- Aberdeen In Recovery (people with lived experience of addictions)

The ADP works in partnership with:

- Public, localities, communities of interest and service users
- Community Planning Partnership; specifically, Community Justice Board, Integrated Children's Services Board, Resilient, Included and Supported Group
- Public Health and Managed Clinical Network for Sexual Health and Blood Borne Viruses
- Aberdeen Health and Social Care Partnership staff

7.8. ADPs, although required by the Scottish Government, are non-constituted bodies and as such governance and scrutiny are provided by the IJB. ADP officers are employed through the IJB. The scope of an APD is wider than adult health and social care and therefore the ADP also sits as group within the Community Planning Partnership as an Outcome Improvement Group (OIG). Adult alcohol and drug treatment services are the responsibility of the Health and Social Care partnership

7.9. The Scottish Government published its national drug and alcohol strategy in November 2018: Rights, Respect, Recovery which allowed us to ensure strategic fit with developing priorities.

7.10. The ADP has developed a framework for investment based on Scottish Government priorities and local performance. The IJB is accountable for the governance of this investment. This was ratified by the IJB on 11 December 2018.

7.11. The ADP has established and prioritised 13 Improvement Aims within the LOIP based on local need with an overall stretch aim of the "Rate of harmful levels of alcohol consumption reduced by 4% and drug related deaths lower than Scotland by 2026"

7.12. The ADP established a Delivery Framework within five work streams to incorporate the Improvement Aims, national priorities from Rights, Respect

and Recovery and "single system" objectives such as service development and improvement. These themes are:

Theme 1: Whole-Family Approach

Theme 2: Reducing Harm, Morbidity and Mortality

Theme 3: Service Quality Improvement

Theme 4: Supporting Recovery

Theme 5: Intelligence-Led Delivery

7.13. Progress against the Delivery Plan can be found at Appendix 2

7.14. Projects that have been revised are:

Ref	Narrative	Sum to be redeployed
1	**Executive Programme** – this sought to invest £50k in CPD for senior officers in relation to drug and alcohol issues and to underpin proposals by Public Health Scotland to support a "whole-system" approach to the topic. It is proposed that this funding is utilised on emergent themes and the programme revisited next year when face-to-face CPD can be undertaken and Public Health Scotland are available. This will retain the ethos of developing innovative thinking to addressing complex system wide issues	£50,000
2	**Localities Development Worker** – this sought to fund a 1 year post at a cost of £43k to help facilitate community development of ideas and projects to take forward within the Local Outcome Improvement Plan. It is proposed that this funding is utilised to deal with more immediate emergent issues and the community development element is support from within "in-house" capacity.	£43,000
3	**GP Vision Programme** – this sought to invest £10k annually in licence fees to upgrade Vision to enable recall and flagging of at risk patients. This aspiration has been superseded by natural system improvements.	£10,000

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4	In the initial version of the financial plan we had an unallocated sum of £100k this has been revised as of October 21 to indicated unallocated available funding in 20/21 as £182k	£182,000
5	Slippage on operationalising funded posts is estimated at £43k. Recruitment process has been reactivated and the assumption is that costs will be incurred from November onwards.	£43,000
6	**Localities Funding** - as per update report to IJB in Dec 2019 funding of £300k that had been allocated equally to the three city localities was to be moved to be distributed through the Health Improvement Fund (HIF) process from August 2020. As there have been emergent issues in localities and new opportunities, in particular in relation to young people affected by substance use, drug and alcohol A&E attendances and prison liberations it is proposed to use £50k from each of the three localities to support initiatives to support communities.	£150,000
7	In total this equates to £478k (of which £10k is recurring) to be redeployed towards supporting emergent community themes and supports Operation Home First.	**£478,000**

7.15. The ADP Lead has spent time engaging with a range of stakeholders in developing ideas that fit with the overall ADP Delivery Plan objectives. The proposals have all been presented to the ADP members. The ADP now has a list of prioritised and scalable projects to progress as and when funding is available. There are some uncertainties and assumptions regarding finance that require clarification.

7.16. Proposed projects are:

7.17.

Ref	New Projects	Cost
a)	Public Protection Learning and Development	£25,000
b)	Young People Resilience Hub (@ 12 months)	£105,000
c)	Prison Throughcare (@ 24 months)	£70,000
d)	Link worker A&E (@ 14 months*)	£46,000
e)	IT for drug and alcohol services	£50,000

f)	Drug Death Prevention - Accommodation Technology	£70,000
g)	Fast Track BBV Test and Treat	£65,000
	Total	**£431,000**
	Balance	**£47,000**

*Depending on contract advice

The ADP have agreed that, due to timescales and social distancing, projects proceed as proposals, and that once high level agreement is achieved, fuller engagement with people with lived experience and other stakeholders is supported

8. Implications for IJB

8.1. Equalities

- This investment will have a *positive* impact on communities and service users through additional service capacity, improved access to support and improved service quality.
- This investment will have a *positive* impact on staff in relation to investment in training, professional development and increased staff numbers.
- This investment will have *no negative* impact on employees, service users or other people who share characteristics protected by The Equality Act 2010

8.2. Fairer Scotland Duty

This investment will have a positive impact on reducing the inequalities of outcome which result from socio-economic disadvantage.

8.3. Financial

No direct financial costs to HSCP

8.4. Workforce

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No direct impact to workforce of HSCP; positive impact for third sector workforce; positive impact for staff in alcohol and drug services

8.5. Legal

Contractual issues with existing providers

8.6. Covid-19

Positive impact on Operation Home First; aim to reduce harm to vulnerable groups impacted as a result of COVID19.

9. Links to ACHSCP Strategic Plan

9.1. This report seeks to support both the ACHSCP Strategic Plan and the ADP Delivery Plan and support the most vulnerable people impacted by drugs and alcohol through supporting Prevention, Resilience and Connections. The primary direct link is with the Prevention Aim and the commitment of addressing the factors that cause inequality in outcomes in and across our communities.

10. Management of Risk

10.1. Identified risks(s)

The main risk is from delay in agreeing priority investment whilst people continue to be harmed from the impact of alcohol and drugs

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

The main risk relates to not achieving the transformation that we aspire to, and therefore our ability to sustain the delivery of our statutory services within the funding available. The resultant risk is that the Integration Joint Board fails to deliver against the strategic plan.

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

Risk 5. “There is a risk that the IJB, and the services that it directs and has operational oversight of, fail to meet performance standards or outcomes as set by regulatory bodies.”

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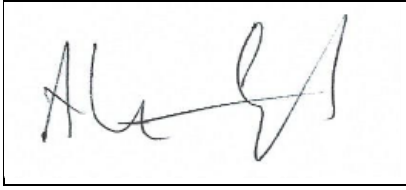
Risk 9. Failure to deliver transformation at a pace or scale required by the demographic and financial pressures in the system.

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

This report seeks to take forward projects that help invest ADP funding in projects that can be delivered quickly, meet needs of Operation Home First and the local requirements of the ADP.

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

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APPENDIX 1

a) Public Protection Learning and Development £25k

Evidence shows us that there are multiple cross cutting issues such as correlations between domestic abuse, alcohol use, child protection, adults at risk, drug related deaths, child neglect amongst many others

In June the Chairs and Lead Officers of four groups with roles in relation to public protection, Child Protection Committee, Adult Protection Committee, Alcohol and Drugs Partnership and the Violence Against Women Partnership, met jointly to discuss areas of common interest and to explore cross cutting themes. This was generally felt to have been a positive meeting and that emergent themes of risk management, data, cross cutting practice and a need for Public Protection learning and development were evident.

This proposal seeks to support system wide thinking and approaches to public protection to ensure a more preventative response to harm. Success will be gauged by the emergent data and plans that allow us to support Aberdeen Together and ensuring that cross cutting issues are routinely embedded in a whole systems approach to public protection.

To help support the joint Learning and Development approach the ADP is proposing to invest £25k into this area to help support:

- Resources to support senior officers outlining public protection strategic groups, their role and their interface
- Enhance the Getting It Right For Every Child (GIRFEC) website to host all L&D materials for professionals and to provide information to the public about public protection issues
- Commission L&D tutorials from specialists in their topics utilising local experts to ensure that it bespoke to Aberdeen
- Link in with national campaigns such as the current Safe Spaces campaign re domestic abuse

Those involved in developing this have been:

- Chief Social Work Officer
- Service Manager, Integrated Children & Family Services

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- Chairs and Lead officers of the APC, CPC, ADP, VAWP

Proposed funding source: use £25k of funding earmarked for Senior Officer CPD

This proposals supports with the ADP Delivery Plan Workstream 1 theme of **Whole Family Approach** to reducing and preventing harm, and with the AHSCP Strategic Plan intention of working with partners to achieve positive health outcomes for people and address the preventable causes of ill-health in our population.

b) Young People Resilience Hub – alcohol and drugs £105k

The COVID-19 pandemic has seen a significant change in the needs of children and families and Community Planning Partners had to quickly and proactively respond.

Children and Family Services identified that some children and young people would require a level of targeted support beyond that possible through schools' digital and enhanced contact and from planned contact with Children's Social Work professionals.

As a response three resilience hubs for young people were formed, combining, education, social work and community resources. The hubs, in recognition of the links between child poverty and neglect/family breakdown provide practical support which has been a critical success factor of the hub model.

During 6 weeks between 7th April and 12th May substance use was raised 91 times as an emergent issue / theme.

Data from the hubs clearly shows how the family environment is impacting on children and young people and highlights a need to link more fully with colleagues in health and across the Alcohol and Drugs Partnership in order to develop an appropriate local response.

The APD is proposing to invest in three workers aligned to each hub for a period of nine months. After this time a review take place to consider longer term requirements.

Workers will be procured from the Third Sector

3 x young people resilience workers @ £35k for 12 months £105k

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Those involved in developing this have been:

- Chief Social Work Officer
- Chief Education Officer

This proposal fits with the ADP Delivery Plan **Workstream 1** theme of Whole Family Approach to reducing and preventing harm, and with the AHSCP Strategic Plan intention of working with partners to achieve positive health outcomes for people and address the preventable causes of ill-health in our population.

c) Prison Through Care £70k

Proposal is to create a worker to engage with people being released from prison to ensure they actively accessed the appropriate services to maintain their recovery and wellbeing in the community. There have been seven drug related deaths of people liberated from prison within the last two months.

The worker would engage with people identified at the case management board who would require help to access relevant support. Discussions with the individuals would start in prison prior to release and would aim to have a plan to ensure all identified actions were complete. This would include benefits, health and recovery service, housing, counselling, practical support and any others identified. The aim of this worker is not to provide ongoing long term support but to case manage and ensure access to support is achieved.

The worker will be procured from the Third Sector.

1x Key worker for Prison @ two years £70k

Those involved in developing this have been:

- Head of Offender Outcomes, Scottish Prison Service, HMP & YOI Grampian
- Development Team Leader, Aberdeen City Council, Housing Access and Support

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This proposal fits with the ADP Delivery Plan **Workstream 2** theme of Reducing Harm, Morbidity and Mortality, and with the AHSCP Strategic Plan to support Connections and Resilience.

d) Link Worker – A&E

Proposal is to invest in a Link Worker to be based at the Emergency Department (ED) for test of change; they will be part of Primary Care network of support; help reduce the underlying causes of potential readmission across the full remit of Link Worker role: finance, housing, domestic abuse, drugs, alcohol, health and wellbeing etc. Data indicates:

- Alcohol related admissions dropped during COVID but are increasing and return to pre COVID 40 per week
- Using SPARRA data we see a significant number of patients at risk of alcohol related re-admission
- Twenty-seven (57%) Aberdeen postcode areas are above Scottish average for generating alcohol related admissions (deprivation)
- 2550 emergency alcohol related hospital admissions in 6 months to May 2016 (SPARRA) generated by 1117 people in Aberdeen City. 10 GP practices have 56% of the at risk of alcohol related readmission patients (SPARRA)
- About 30% of GP referrals to alcohol services don't appear
- We tracked back 2-year activity of 85 alcohol related deaths. 2977 bed days cost of £1.5m
- We have information about alcohol related admissions but not information about drug related admissions and in particular drug related overdoses
- Non-fatal overdose is a strong indicator for future fatal overdose.
- An assertive outreach team is being formed in the City to engage with people at risk of drug related death; there is an increasing list of risk criteria
- NHS Lothian have a scheme whereby specialist drug services are alerted when there is a drug overdose admission; the service then undertakes outreach to the individual

Those involved in developing this have been:

- AHSCP Senior Leadership Team
- Primary Care Lead GP Services
- Senior Operational Response Team

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- Divisional Operational Manager, Division of USC (ED, Acute Med, Short Stay Med, H@N, S&C

This proposal fits with the ADP Delivery Plan **Workstream 2** theme of Reducing Harm, Morbidity and Mortality, and with the AHSCP Strategic Plan to support Connections and Resilience. The proposal also supports Operation Home First in seeking to reduce admission to A&E and make better use of existing commissioned pathways.

e) IT Funding

There are 75 specialist drug and alcohol staff working in services who have access to four laptops, but this is predominantly Medical and Pharmacy staff.

An IT review has been undertaken for health and social care staff by MH&LD Support Manager. We require to get our community staff to a standard where they can proactively work flexibly moving forward, link into MS team meetings & online training, access clinical data from home and use NHS Near me. At present all their IT equipment is desktop computers in their existing offices which they now have limited access due to following social distancing guidance.

IT kit - £50k

Those involved in developing this have been:

- Frontline and Admin Staff
- Social Work Service Manager
- Substance Misuse Service Operational Management Team
- Assistant Service Manager MH, LD and SMS

This proposal fits with the ADP Delivery Plan **Workstream 4 theme** of Service Quality Improvement, and with the AHSCP Strategic Plan to support Prevention, Connections and Resilience.

f) Drug Death Prevention - Accommodation Technology

This proposal seeks to develop the use of tele-healthcare technology to prevent drug related deaths. By using existing kit that is used to help support older, frail and vulnerable people we seek to undertake a research project to evaluate the use of such technology in preventing drug related deaths. By using breathing,

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movement and vital signs trackers we aim to provide an early warning of when individuals encounter potentially life-threatening symptoms. Kit will be linked to response services and in particular an “on call” service delivered by Bon Accord Care and funded by ACC Housing Service.

This proposal will be supported from independent research undertaken by Chair of the National Drug Death Taskforce.

ADP funding will support the purchase of kit (£60k) and the research (£10k). The response service will be funded by ACC Housing Service.

Those involved in developing this have been:

- Development Team Leader, Aberdeen City Council, Housing Access and Support
- Bon Accord Care
- Professor of Substance Use, University of Stirling

This proposal fits with the ADP Delivery Plan **Workstream 2** theme of Reducing Harm, Morbidity and Mortality, and with the AHSCP Strategic Plan to support Prevention, Connections and Resilience.

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g) Fast Track BBV Test and Treat

This proposal seeks to fund the purchase of a mobile testing machine that will be able to be used to test for Blood Borne Viruses. Currently when a test is taken it is sent to virology labs for processing with the results taking up to 7 days to be available. Depending on the result further appointments are then required to follow up and initiate treatment.

This machine can be used to be near patients, produce results in 60 – 90 minutes which can allow treatment, if required, to be initiated immediately.

Data shows that through COVID the number of people accessing clean injecting equipment has dropped. Currently we don't know what this means – it could mean people are re-using equipment and / or sharing equipment which increase the risks of infection.

Glasgow currently has a significant outbreak of HIV amongst their drug using population. HEP C continues to be a prevalent blood borne virus within our population, with the Scottish Government setting eradication as a high level ambition.

This proposal will allow testing, results and treatment to be undertaken within 1 appointment whilst the patient is attending our Integrated Drug Service.

This proposal will run as a test of change and supports the principles of Operation Homefirst as well as giving us an "early warning" system for a potential outbreak of HIV or HEPc and allow appropriate Health Protection action to be undertaken.

The ADP funding will support the purchase of a testing machine and testing cartridges – this will cost £65k. Public Health Research will undertake evaluation of the project. The Peter Brunt Centre Liver Service will support and lead the development.

Those involved in developing this have been:

- Managed Clinical Network for Sexual Health and BBVs
- Substance Misuse Service
- Public Health Researcher

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This proposal fits with the ADP Delivery Plan **Workstream 2** theme of Reducing Harm, Morbidity and Mortality, and with the AHSCP Strategic Plan to support Prevention

Appendix 2

Progress Monitoring

This action plan captures progress against investment of ADP funds allocated by the Scottish Government via the 2018/19 Programme for Government investment of £666,404 per year. The investments were agreed by the ADP 31st May 2019 and ratified by the Health and Social Care Partnership Integrated Joint Board in Sept 2019

The ADP has developed a framework for investment based on Scottish Government priorities and local performance. The IJB is accountable for thegovernance of this investment. This was ratified by the IJB on 11 December 2018. This report highlights progress to date on taking the ADP agenda.

The Scottish Government published its national drug and alcohol strategy in November 2018: Rights, Respect, Recovery which allowed us to ensure strategic fit with developing priorities.

1) Established and prioritised 13 Improvement Aims within the LOIP based on local need with an overall stretch aim of the "**Rate of harmful levels of alcohol consumption reduced by 4% and drug related deaths lower than Scotland by 2026**"

2) The ADP established a Delivery Framework within five work streams to incorporate the Improvement Aims, national priorities from Rights, Respect and Recovery and "single system" objectives such as service development and improvement. These themes are:

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INTEGRATION JOINT BOARD

This approach encompasses prevention and early intervention. It seeks to reduce the impact of parental drug and alcohol use on children, to support young people most at risk of developing drug and alcohol problems and to ensure that there is a consistent and measureable approach to education and prevention activity. This will also help support the work of the Integrated Children's Services Board and ensure that children have the best start in life.

Theme 1: Whole-Family Approach

What will we do?	Timescale	How will we know it is working?	Who will be responsible?	Progress Update	RAG
1a *We will fund, in line with ADP specification, a Support Teacher part time for 12 months to develop resources and develop staff at the value of up to £45,000*	Jan 2020	*Worker in post with a focus on 100% of schools have a progressive, cohesive and relevant substance misuse curriculum by 2021*	Eleanor Sheppard / Integrated Children's Services	Recruited and in post. Development work started. COVID plan developed. Framework developed	
1b *We will fund, in line with ADP specification, a Lead Child and Family SW for 24 months to develop resources and develop staff at the value of up to £120,000*	Feb 2020	*Increase the % of Care experienced children and young people receiving educational and support input on alcohol/ drugs issues by 2021*	Tam Walker / Integrated Children's Services	Recruited and in post. Development work started. SWOT analysis of current services and pathways	

Improvement Charters All data updated monthly	Status	Progress	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21

INTEGRATION JOINT BOARD

	Increase the % of Care experienced children and young people receiving educational and support input on alcohol / drugs issues by 2021	Agreed by CP Board - Sept	*TW/SR*	4	4	4						4	4			
	100% of schools have a progressive, cohesive and relevant substance misuse curriculum by 2021	Agreed by CP Board - Sept	*GM/LM/SR*	4	4	4						4	4			

Commentary: Aug 2020

Very pleased to have manage to recruit during COVID. Work has begun on a multi-agency City wide framework for managing substance use and young people. This will be coming out or consultation in Sept. This will encompass universal and targeted specialist support for young people affected by their own or someone else's substance use. A specific action plan for managing substance use and young people during COVID as part of the ADP Public Protection role has been developed. A specific dashboard is being developed.

INTEGRATION JOINT BOARD

This approach encompasses primary, secondary and tertiary prevention in relation to reducing harm, morbidity and mortality. We will take whole-population approaches to reducing alcohol consumption, with the aim of preventing harm. Where people are using drugs and alcohol we will ensure there are appropriate supports to allow people to reduce risks and harm.

Theme 2 Reducing Harm, Morbidity and Mortality

What will we do?	Timescale	How will we know it is working?	Who will be responsible?	Progress Update	
2a Procure from the 3rd sector, in line with ADP specification, 2 x Assertive Outreach Workers for a fixed period of 2 years at a value of up to £135,000 to work with homelessness, rapid housing, overdose prevention	Feb 2020	2 x Assertive Outreach workers in post working as part of housing / homeless support and as part of an assertive harm reduction team	ACC	Discussions with provider progressed Finalising KPIs and contract signing.	
2b Fund in conjunction with Violence Against Women Funding, in line with ADP specification, a Housing / Domestic Abuse Worker at the value of up to £30,000 per year to improve tenancy retention, support women and pathways	March 2020	Worker in post developing pathways: increase in women in service, improved links with housing	ACC	This post has been recruited and person started.	
2c Fund, line with ADP specification, a Band 7 RGN Advanced Nurse Practitioner Nurse up to the value of £59,256 to improve general health and respond to increasing	March 2020	Nurse in post developing improved healthcare provision to at risk patients	NHS G / ACHSCP	This post has been recruited and person starting in Sept	

presentations of poor general health from older drug users across the sector					
2d Fund, for a fixed period of 12 months, in line with ADP specification a Locality Based Development Worker at the value of up to £43,177.to help support and engage localities to develop improvements and delivery ADP priorities and to support our ambition for our strategy to be rooted in community action	Feb 2020	Worker in post supporting the Localities develop responses to alcohol and drugs in line with ADP Framework.	ACC	Through review it is proposed that alternative investment is made. See report	
2e Fund, in line with ADP specification, 1x Custody Link Worker up to the value of £80,000 over a two year fixed period to support continuity of treatment and care between community and justice (previously agreed – included for context)	Feb 2020	Worker in post working with staff in Kittybrewster, identifying underlying health and wellbeing issues, linking with Primary Care	Chris Smillie / ACHSCP	This post is filled but delayed due to requirement for normal police checks and then restrictions due to COVID. Near Me being looked as an alternative model.	

Improvement Charters All data updated monthly		Status	Progress	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21
1	Reduce the incidence of fatal drug overdose through innovative developments and by	Agreed by CP	*TS/SR*	**6**	**6**							**6**	**6**				

INTEGRATION JOINT BOARD

	increasing the distribution of naloxone by 10% year on year by 2021.	Board - Sept															
2	Reduce the number of births affected by drugs by 0.6 %, by 2022	Agreed by CP Board - Sept	*SR*	**4**	**4**												
3	Increase by 100% the number of Alcohol brief interventions (ABI) delivered in Aberdeen City by 2021	Agreed by CP Board - Sept	*TS*	**6**	**6**							**6**	**6**				
4	Increase opportunities for individuals who have been at risk of Blood Borne Viruses, being tested and accessing treatment by 2021.	Agreed by CP Board - Feb	*SR/LA*	**5**	**5**							**6**	**6**				
5	Increase the number of alcohol licensed premises awarded Best Bar None status by 2021.	Agreed by CP Board - Sept	*MH*	**5**	**5**							**6**	**6**				

INTEGRATION JOINT BOARD

6	Increase % of the population who feel informed about using alcohol responsibly by 2021	Agreed by CP Board - Feb	*GR*	**5**	**5**							**6**	**6**			
7	Increase uptake of drug treatment and specifically within Locality Areas by 10% each year by 2021	Agreed by CP Board - Feb	*SR*	**5**	**5**							**6**	**6**			
8	Increase by 10% the percentage of adults in Aberdeen City who are non drinkers or drink alcohol in a low risk way by 2021.	Going to CP Board June 21						Charter required								
9	Increase the uptake of alcohol treatment by improving access to alcohol services and ensuring they are local, integrated and targets areas of greatest need by 10% year on year by 2021	Going to CP Board June 21													Charter required	

INTEGRATION JOINT BOARD

Commentary: Aug 2020

- We have made good progress in developing our Assertive Outreach team. We have successfully recruited a lead co-ordinator from Police Scotland and are in the process of finalising data sharing agreements between partners. This will allow... We are in the final stages of contracting of contracting two assertive outreach workers for to provide a frontline response for the most at risk of drug related death.

- Good progress in recruiting to a joint ADP / Violence Against Women Partnership Post to improve tenancy retention, support women and pathways for those vulnerable to gender based violence.

- We have also been successful in recruiting a Band 7 nurse to work as an Advanced Nurse Practitioner. This post will across our services providing a service to .....

- We have also been successful in recruiting a Clinical Lead GP for Substance Use. This post will help provide leadership across primary care to develop consistency and practice and provide decision support and quality assurance.

- Due to COVID it is proposed to reinvest funding ear-marked for an ADP specification a Locality Based Development Worker. This is on the basis that it is unlikely that face-to-face development work will be able to be undertaken and this would mean that the funds would be under-utilised whilst there is evident unmet need in the community.

- Due to COVID planned work with Public Health Scotland to examine and develop a “whole-system” approach to drug and alcohol issues has been impacted. This has a significant impact on the work we had been planning in relation to whole population approaches to harmful alcohol consumption.

This approach encompasses primary, secondary and tertiary prevention in relation to reducing harm, morbidity and mortality, and whole-population approaches to reducing alcohol consumption with the aim of preventing harm. Where people are using drugs and alcohol in risky ways, we will ensure there are appropriate supports to allow people to reduce harm and services to help facilitate this. We need to ensure that those at greatest risk of harm from drugs and alcohol have access to appropriate support to reduce risk as easily as possible.

Theme 3 Service Quality Improvement

What will we do?	Timescale	How will we know it is working?	Who will be responsible?	Progress Update	RAG
a Social Worker to work within the AHSCP Integrated Alcohol Service up to the value of up to £49,000 per year Extension of alcohol hubs by two this will increase capacity and establish alcohol services in areas of greatest need with a plan to link longer term to Community Care and Treatment Hubs.	Feb 2020	Worker in post supporting the development of the Alcohol Hubs; Demonstrate improvement and utilisation of the Alcohol Hubs in line with remit	ACC / Substance Misuse Service	Progressing to recruitment stage	
a Band 6 nurse to work in the Integrated Alcohol Service up to the value of £50,276 per year	Feb 2020	Worker in post supporting the development of the Alcohol Hubs; Demonstrate improvement and utilisation of the Alcohol Hubs in line with remit	NHS G / Substance Misuse Service	Appointed	

INTEGRATION JOINT BOARD

iii 12 GP sessions per year and 12 Consultant GI Sessions per year	March 2020	GP sessions in place supporting the development of the Alcohol Hubs; Demonstrate improvement and utilisation of the Alcohol Hubs in line with remit	NHS G / Practices / Substance Misuse Service	Consulting / paused	
3b continue to fund the existing Alcohol Hubs at a value of £12,000 for the provision of 12 GP sessions and 12 Consultant GI sessions per year	Exisiting	GP sessions in place supporting the development of the Alcohol Hubs; Demonstrate improvement and utilisation of the Alcohol Hubs in line with remit	NHS G / Practices / Substance Misuse Service	Continuing	
3c fund, line with ADP specification, four Band 6 nurses to work in the Integrated Drug Service up to the value of £50,276 per year each to increase capacity and to facilitate improved service user retention, increase innovation and improve outcomes to meet national quality standards	April 2020	Additional nursing in post; service capacity re-aligned; improvement work progressing		Appointed	
3d fund, line with ADP specification, a Band 8a nurse to work across the Integrated Drug Service and the Integrated Alcohol Service up to the value of £68,983 per year to lead quality improvements, lead on non medical prescribing, lead on trauma informed care, outreach for complex cases and overdose incidence	Feb 2020	Additional nursing in post; service capacity re-aligned; improvement work progressing		Appointed	
3e fund, in line with ADP specification, the development of a new way of working with Primary Care Vision / EMIS system at a value of £10,000	May 2020	Improvement project on line, demonstration of improved outcomes		Reconsider investment	

per year that will improve our ability to performance manage BBV testing, Medicine Reviews, Contraception Reviews etc					
3f fund, in line with ADP specification, Staff / workforce development / recruitment and retention programme at a value of £10,000 to help mitigate against staff recruitment risks	Existing	Programme in place and staff seconded onto placements		Progressing	

	Service Objectives – 3 Year	Outputs	Who will be responsible?	Progress Update	RAG
1	• Increase number of women engaged in the service • Increase uptake of male and female contraception • Increase the number of people who have sexual health education input • Increase the number of medicine reviews • Increase distribution of naloxone • Increase uptake of BBV testing	Support the roll out and use the Vision/ EMIS Guideline and ensure that associated tasks are identified and taken forward through the MDT Recovery Meeting	All Drugs / Primary care clusters	Services have predominantly been invested in developing response to COVID.	
2	BBV's Support the efforts to reduce risks associated with injecting behaviour and collaborate on the agenda to eradicate Hepatitis C by ensuring increase in the uptake and consistency of DBST and BBV treatment across the team.	Increase uptake of BBV testing / treatment within team. Ensure staff trained, supported, and confident	All		
3	As a minimum undertake an annual recovery meeting to review whole practice patient population.	MDT Recovery Meetings recorded	Drugs / Primary care clusters		

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4	Retention Develop and Support innovation to reduce the discharge rate from the service.	Ensure cases are appropriately managed and reviewed to ensure service is safe, effective, person centred Ensure that there are opportunities for those at risk to reduce harm and improve health and wellbeing outcomes.	Drugs		
5	Naloxone – Support culture of naloxone being available for all forms of opiod use including prescribed medications and ensure that all service users (including family and significant others) are supplied naloxone and routinely reoffered.	Increase distribution of naloxone. Ensure staff trained, supported, and confident	All		
6	Demonstrate improvement and utilisation of the Alcohol Hubs in line with remit	Baseline data improvement in uptake. Hospital admission data related to each Hub	Alcohol		
7	Increase the uptake of IAS and increase service caseload by 20% each year.	Caseload data. Duration of engagement	Alcohol		
9	*Waiting Times (SMS) – Current target 90% of patients to start treatment within 21 days of treatment. Production of Monthly Waiting Times Reports. Identify issues and develop plan to resolve.	Ensure cases are appropriately managed and reviewed to ensure service is safe, effective, person centred and can meet obligations to waiting time standard	All		
10	*Performance Monitoring (SMS) – Produce Performance review report for each SMS cluster and Service Level report. Data to be reviewed with Team Leaders and action plans put in place as required.	Ensure data requested is supplied accurately and on time National Quality Principles / Quality assurance measures (TBD) are reported	All		
11	*Customer Feedback (SMS) – Review Quality & performance measures as part of performance report which would include Service User Feedback & outcomes for Service Users.	Seek service user feedback from surveys, observed practice, shadowing, “you said, we did” etc	All		

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12	*Drug & Alcohol Related Deaths & Complaints – Ensure learning from DRDs/ Complaints are shared with all staff – distribution via email and Shared Learning Events.	Review forms are completed in conjunction with supervisor Cases / learning discussed at Communication meeting / team meetings, clinical forums	All		
13	Contribute to service development, implementation and reporting of Quality Assurance Framework and the National Quality Principles, Grampian Clinical Development and Governance Framework.	Participation / contribution to clinical leadership, observed practice, shadowing, supervision	All		
14	Support the implementation of the Scottish Government Daisy (Drug and Alcohol Information system).	Ensure data requested is supplied accurately and on time.	All		
15	Take forward recommendations in relation to "The Delivery of Psychological Interventions in Substance Misuse Services in Scotland Report".	Staff have training plans. Staff have access to supervision and coaching. Staff use and are supported to use core behavioural skills. Trauma is recognised in and discussed in care formulations and discussed in supervision.	All		
*IJB level objectives					

Commentary: Aug 2020

INTEGRATION JOINT BOARD

- Services have predominantly been invested in developing response to COVID. A number of actions have been undertaken:
- Including postal and doorstep delivery of injecting equipment, medicines, food and naloxone kits.
- Referral routes into drug and alcohol services have remained open albeit there has been a slight dip in alcohol referrals. Drug treatment referrals have remained constant.
- Contact with service users has mostly been via phone calls with some work undertaken vi packages such as Near Me. Many people with drug and alcohol problems don't have the resources to engage in digital based services. ADA have been able to supply some people with phones and SIM cards. We funded ADA to have a freephone number for their Helpline.
- Cases have all been assessed and scored on a RAG basis relating to risk

INTEGRATION JOINT BOARD

An individual's recovery from a drug or alcohol-related problem is personal to them. Different people will achieve recovery in different ways and it is our role to ensure that there are appropriate supportive opportunities to allow people to sustain their recovery in their community. Increasing the visibility of recovery gives strength and hope to others who are on their own journey. Increasing the visibility of recovery helps reduce stigma and can put a human face to the complex issues underlying drug and alcohol use. Ensuring that there are a range of options for people to engage in recovery helps give resilience and reduce isolation. We will seek to remove barriers to recovery and support housing, employability and education opportunities.

Theme 4 Supporting Recovery

What will we do?	Timescale?	How will we know it is working?	Who will be responsible?	Progress Update	RAG
4a grant fund, in line with ADP specification, Aberdeen In Recovery (Scottish Charity number SC049125) up to the value of £40,000 per year Grant Fund Aberdeen In Recovery to provide peer led recovery support group and undertake a range of groups, activities. AiR recently became established as a registered charity with OSCR.	Jan 2020	Grant fund in place, agreement in place; reporting and feedback from AiR.	ACHSCP / ADP	Funding in place. AiR continuing to operate through COVID albeit in a limit form. Awaiting data reporting	

Improvement Charters: All data updated monthly	Status	Progress	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21

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	Increase number of people undertaking recovery from drug and alcohol issues who are being supported to maintain drug / alcohol free lives in their community by 2021.	***Going to CP Board June 21***														***Charter required***		

Commentary: Aug 2020
• AiR have plans to develop their "Living Well With ORT" programme, develop peer Naloxone distribution and

Knowledge and understanding in relation to the underlying causes of drug and alcohol problems are increasing all the time and this understanding helps us develop effective evidenced-based strategies for reducing the negative impact on our society. We want to ensure that people have access to knowledge and information about drugs and alcohol to encourage personal choice and self-care. We want to hear from people and communities affected by drugs and alcohol and we want to be able to inform them of our work and how they can help. To do this we need to be able to measure our progress and report our performance against our aspirations.

Theme 5 Intelligence-led Delivery

What will we do?	Timescale	How will we know it is working?	Who will be responsible?	Progress Update	RAG
5a fund data management capacity at a value of £ £25,898 per year reduce demand on practitioners and prepare for Scottish Government DAISY system coming on stream in January 2020. Longer term we will develop a digital strategy for our addiction services	Jan 2020	Post filled, digital strategy developed and in place, Daisy Implemented	SMS	Post filled Digital strategy developed and progressing	
5b fund in line with ADP specification, a development programme at a value of £50,000 to lead a cohort of senior officers and the ADP through process of "discovery" examining world class evidence to formulate innovations and improvements at a strategic level for the City	Feb 2020	Programme delivered	Simon Rayner	Reconsider proposal	
5c make available, on a non recurring basis, £300,000 for the three City localities, North, Central and South to develop community based responses to drug and alcohol issues and to help local communities deliver the ADP Objectives	Ongoing	Resource utilised to inform test of change and future strategic direction.	ADP / AHSCP / CPP Localities	Reconsider proposal	

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Commentary: Aug 2020
• ADP Development Programme - this sought to invest £50k in CPD for senior officers in relation to drug and alcohol issues and to underpin proposals by Public Health Scotland to support a "whole-system" approach to the topic. It is proposed that this funding is utilised on emergent themes and the programme revisited next year when face-to-face CPD can be undertaken and Public Health Scotland are available. This will retain the ethos of developing innovative thinking to addressing complex system wide issues • Localities Funding - as per update report to IJB in Dec 2019 funding of £300k that had been allocated equally to the three city localities was to be moved to be distributed through the HIF process from August 2020. As there have been emergent issues in localities and new opportunities, in particular in relation to young people affected by substance use, drug and alcohol A&E attendances and prison liberations. It is proposed to use £50k from each of the three localities to support initiatives to support communities.

INTEGRATION JOINT BOARD

Score	Stage of Project	Description
1	Project area identified and agreed	Project has been identified as a priority from the Local Outcome Improvement Plan or Locality Plan
2	Project Charter and team in place	Draft Improvement Project Charter has been developed (rationale, initial aims, scope, resources, timescales, measures, expected outcomes) and project team formed.
3	Understanding baseline of current system	Current system is being analysed- applying tools such as process mapping; cause & effect diagrams etc to understand processes and people, including readiness for change and analysis of baseline data
4	Project Charter is endorsed by Community Planning Aberdeen Management Group	Knowledge of the system and other evidence of what could work have been brought together into a theory of change. This has been articulated in a final Improvement Project Charter which has been shared with the appropriate strategic leadership group e.g. Community Planning Aberdeen Management Group. (A driver diagram may also be developed to support this stage.)
5	Change ideas and project measures developed	Range of specific change ideas developed further, measurement plans established and initial PDSAs are being planned
6	Testing underway	Testing strategy developed and is being deployed. Data being gathered and analysed (e.g. through use of run charts)
7	Initial indications of improvement	Anecdotal evidence or feedback that changes are resulting in improvement can be reported.
8	Improvements achieved	Evidence of improvements shows in project measures and has been reported to Community Planning Aberdeen Management Group. Implementation and Spread plans are being developed and deployed.
9	Sustainable improvement	Implementation plans have been deployed for key changes. Spread plans are developed if appropriate. Data indicates sustainability of impact of changes implemented in system.
10	Project complete	The aim has been met or exceeded and improvement sustained and spread where appropriate. Changes are now part of business as usual.

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Aberdeen City Health & Social Care Partnership
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INTEGRATION JOINT BOARD

Date of Meeting	1st December 2020
Report Title	Update Report - Grampian-wide Mental Health and Learning Disability Services
Report Number	HSCP20.065
Lead Officer	*Sandra MacLeod, Chief Officer*
Report Author Details	*Name: Kay Dunn* *Job Title: Lead Planning Manager (Grampian-wide MHLD Review)* *Email Address: kay.dunn1@nhs.scot* *Phone Number: 01224 557840*
Consultation Checklist Completed	*Yes*
Directions Required	*No*
Appendices	*None*

1. Purpose of the Report

1.1. The purpose of the report is to update on the progress made to develop a Transformation Programme to deliver the strategic intent set out in the Grampian-wide Strategic Framework for Mental Health and Learning Disability (MHLD) 2020-2025 and first benchmark report against the Quality Assurance and Performance Management Framework.

2. Recommendations

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

a) Note the progress made in developing a Draft Grampian-wide Transformation Programme for Mental Health and Learning Disability (MHLD) 2020-2023 and instruct the Chief Officer to bring a final version to the IJB following consultation with key stakeholders to be considered for approval in April 2021.
b) Note the progress made on developing a benchmark report for the Grampian-wide Mental Health and Learning Disability Services and

agree a timeline of 1st of April 2021 to fully embed as a Performance Score Card in the Aberdeen City HSCP Tableau Dashboard.

c) Note that there will be an IJB workshop in early 2021 on Grampian-wide Mental Health and Learning Disability Services hosted by Aberdeen City IJB.

3. Summary of Key Information

3.1. Transition to Hosted Service

In October 2019, the Transition Steering Group (Grampian-wide MHLD) was established to manage the successful transition of Inpatient, Specialist and CAHMS Services from NHS Grampian (NHSG) to Aberdeen City Integrated Joint Board (IJB) to host on behalf of Aberdeenshire and Moray IJBs. Following the successful transfer of hosted services on 1st April 2020, the Transition Steering Group (Grampian-wide MHLD) was disbanded. The successful transfer to host arrangements took place on the 1st of April 2020 with no determinant or change to the terms and conditions of staff employed by Councils or NHS Grampian (NHSG).

3.2. Establishment of the Transformation Programme Board

In December 2019, the Transformation Board (Grampian-wide MHLD) was established to oversee the successful implementation of the Grampian-wide Strategic Framework for Mental Health and Learning Disability (MHLD) 2020-2025. Significant progress was made between January 2020 and March 2020 to finalise the Strategic Framework, develop the associated Programme Management Documentation and undertake initial consultation with Senior Managers on a Draft Transformation Programme Plan and Quality Assurance and Performance Management (QAPM) Framework.

In February 2020, a Systems-wide Leadership Workshop took place to solidify the culture and whole system leadership approach of the Transformation Board moving forward.

Work had been scheduled at the end of March 2020 to establish the Work Stream Groups to take forward engagement and consultation with staff, key stakeholders, service users, those with lived experience and carers before a final Draft Transformation Programme be submitted to the respective IJBs and NHSG Boards for approval.

INTEGRATION JOINT BOARD

3.3. Approval of the Grampian-wide Strategic Framework for MHLD

In March 2020, Aberdeen City IJB and Moray IJB approved the Grampian-wide Strategic Framework for Mental Health and Learning Disability (MHLD) in advance of emergency measure commencing in response to the pandemic. However, Aberdeenshire IJB had been scheduled to consider the report later in April 2020 and due to the move to urgent business only, approval was delayed. The Aberdeenshire IJB approved the final Framework in early November 2020. An update report will be now submitted to the NHSG Board in January 2021.

3.4. Responding to the Coronavirus Pandemic (COVID-19)

In March 2020 under Operation Rainbow, Control Rooms were established for Aberdeen City, Aberdeenshire and Moray HSCPs as well as a Control Room for Grampian-wide MHLD. The Control Rooms managed the implementation of Emergency Measures in line with Business Continuity Planning to reduce face to face contact, move routine appointments to virtual (Near Me) and protect the operation of critical services (e.g. inpatient services). Projects were established to mobilise at pace a Mental Health Hub for Unscheduled Care (Kildrummy Hub) and a Grampian Psychological Resilience Hub for both staff and the public who were experiencing distress arising from their experience of COVID-19.

In early June 2020 under Operation Home First, a Strategic Huddle for Grampian-wide MHLD was established to remobilise services and embed the changes to service delivery that were necessary to ensure a sustained and protracted response to COVID-19 during the winter period. These included:

Near Me / Microsoft Teams (MST)

In March 2020, an audit was undertaken across HSCPs to determine the volume of ICT equipment that would be required for managers to operate meetings virtually using MST and for operational staff to deliver remote services using Near Me. Usage of Near Me was initially inconsistent and there were ongoing concerns relating to the efficacy of the tool to assess people experiencing mental health problems. Further guidance notes were issued and risk assessment forms developed to support the implementation Near Me aligned to the roll out of Red, Amber Green (RAG) case management models. There is a further commitment to develop full and robust practice guidance on the use and efficacy of Near Me across Tier 1 – 4 services and this is scheduled to be delivered by the Aberdeen City HSCP CMHT and Director of Psychology for NHSG by the end of November 2011.

INTEGRATION JOINT BOARD

Move of isolated Learning Disability Services from Elmwood onto main Royal Cornhill Site

Since 2015, the Mental Welfare Commission has raised ongoing concerns in regard to the condition and functional suitability of the Elmwood estate and the risk of isolation had been on the NHSG Risk Register for a number of years. The risks of an isolated unit were further exasperated during COVID-19. In March 2020 under emergency measures, the Fern and Bracken Wards were relocated from Elmwood to Loirston Ward at the main Royal Cornhill Site (RCH). An Options Appraisal was undertaken to determine the most functionally suitable long term locations for the wards. In August 2020, the Assessment and Treatment Unit for Learning Disabilities (Bracken) was embedded at the current location on the Loirston Ward on the first floor RCH and reduced to an 8 bedded unit. The Close Supervision Unit for Learning Disabilities (Fern) was moved to Strathbeg Ward on the ground floor of RCH and continues to operate as an 8 bedded unit. The overall bed reduction is in line with expected utilisation levels to meet current demand.

A further recommendation was made for the Transformation Board to prioritise a Business Case to develop Fern (now Strathbeg) from a Close Supervision Unit to a Low Secure Unit in consultation with the Regional Collaborative for MHLD. This would reduce the number of people with Learning Disability being placed Out of Authority and the project will be taken forward in early 2021.

It should also be noted that the ward moves have been managed alongside changes to comply with social distancing and staff flow guidance for infection control as well as the ongoing delivery of the Ligature Reduction Programme.

Increase outreach from Hospital Based Services to Community Based Pathways

In March 2020, the Grampian Psychological Resilience Hub was established at pace to ensure streamlined access to mental health support for those experiencing stress and distress as a direct result of the pandemic. The team developed a self-management portal and a triage model for accessing Tier 1-4 7 days a week. Additional supported assistance was set up with the Grampian Assistance Hub undertaking a phone based assessment and onward referral for those unable to use the self-help page due to TEC access of their additional support needs. The delivery of service is ongoing and a review the future role of the Psychological Resilience Hub is being undertaken by the end of November 2020. Final decisions will be aligned to

the timeline for the wider review of NHSG Psychology Services, which has recently commenced.

In March 2020, the Mental Health Hubs for Unscheduled Care were established to assess and triage emergency in hours and urgent out of hours referrals. The Kildrummy Hub at RCH was established to manage referrals for Aberdeen City and Aberdeenshire populations and a Hub was established for the Moray Population in Elgin. In October 2020, a review and option appraisal was undertaken on the Kildrummy Hub Model (now referred to as the Mental Health Hub for Unscheduled Care). A revised referral process was established, resources secured and additional outreach in the community for up to 6 week is being implemented for cases 'not open' to CMHT and awaiting allocation. The Hub was relocated to a permanent base in the closed Lochhead Day Hospital area of the RCH Site. The review of the Moray Hub Model has completed and the HSCP aim to submit a final report by the end of November 2020. In November 2020, additional changes were made to the Process Flow Chart to take account of the Redesign of Emergency Care Pathway. It has been agreed that Mental Health referrals will continue to come directly from NHS24 to Primary Care (In Hours) and GMED (Out of Hours) for Primary Care Assessment with onward referral to CMHTs, where need is assessed. Those referred by NHS24 to the Flow Navigation Centre for Emergency Department triage will be assessed and where there is a need of support for their mental health they will be referred to the Mental Health Hubs for Unscheduled Care as a Single Point of Access (In hour and Out of Hours).

In June 2020, the Chief Officers commissioned a review of the Older Adult Pathway given the high number of dependencies with implementing the wider Operation Home First priorities. A system-wide Older Adults Work Stream was established in July 2020 with 3 x HSCPs Work Streams and an Inpatient and Liaison Work Stream delivering their engagement workshops by early August 2020. An overarching Workshop Report was produced at the end of August 2020, a Literature Review by the end of September 2020 and a final Older Adult Review Report was approved at the end of October 2020. The recommendations of the review include the following:

- Commission residential / nursing home surge beds (dementia and most beds are required in the City)

- Embed key business processes to ensure a multi-disciplinary focus on delayed transfer of care and delayed discharge

- Review the current models and multi-disciplinary team mix in Community Mental Health Teams to deliver Enhanced Community MHLD Services

- To optimise the use of 100 inpatient beds for Older Adult Mental Health across the System-wide System and ensure capacity to move from 2 'flex beds' to operate as 'surge beds' moving forward, this must ensure a reconfiguration of the bed base to take account of the need to ensure a clear pathway for stress and distress (previously delivered at Strathbeg Ward but relocated during COVID)

- Provision of high intensity psychological therapies particularly at Tiers 3 and 4

- Training and supported in utilising psychological approaches, such as trauma-informed care, to optimise interventions and ensure clinical best practise

- Major Service Change Assessment to be undertaken to determine the final decision on interim closures including Kildrummy Day Hospital, Lochhead Day Hospital, Intensive Support Service following the redesign and delivery of services in the new model of care

HSCPs were asked to review the inpatient services to ensure a sustainable model of care and that we optimum bed based across the system as part of the wider programme of Transformation.

Improved Access to Commissioned Pathways

As stated above in the Older Adult recommendations, a review of commissioning beds in the community for people with dementia and the development of Enhanced Community Mental Health Teams (CMHTs) that will better support commissioned services (e.g. Care Homes) is being taken forward.

Further recommendations were made for the Transformation Board to prioritise a review of IPCU, the Female Forensic Pathway, Low Secure Unit for LD and the development of a Market Shaping Statement and Commissioning Strategy, to be taken forward early in 2021.

Since early November 2020, the 4 Work Streams have commenced planning for implementation and a Draft Work Programme pulling together the actions

across all work streams is scheduled to be completed by the end of November 2020.

The analysis of data from the Older Adult Review shows that the greatest challenge is meeting the demand for beds for dementia care and ensuring a continued focus on delayed discharge and the delayed transfer of care. Data from the Unscheduled Care Review shows that the majority of referrals for urgent and emergency care come from emergency departments and the police. The ongoing demand for the Psychological Resilience Hub highlights the importance of the need to have a 7 day crisis support response. The team will continue to collate data from the new services to inform the future models of care.

On 2nd November 2020, we entered Phase 3 Operation Snow Drop and were directed to re-establish Control Rooms across the three HSCPs and Grampian-wide MHLD. The Transformation Board has now been re-established and the Strategic Huddle will transition into a System-wide Transformation Group (Grampian-wide MHLD) who will monitor the ongoing implementation of Home First Priorities as well as take forward the delivery of the Transformation Programme for Grampian-wide MHLD.

3.5. Development of the Transformation Programme Plan

Between January 2020 and March 2020, a Draft Transformation Programme was developed in consultation with Clinical, Nursing and Service Management Leads. However, due to the pandemic, further engagement across wider stakeholders, staff, service users, those with learned experience and their carers was put on hold. The re-establishment of the Transformation Board enabled the recommencement of that engagement process with lead officers across the three HSCPs CMHTs, partners including Primary Care, Allied Health Professionals, Staffside, Workforce, NHS24, Police Scotland, Scottish Fire and Rescue Service, Scottish Ambulance Service and from the Third Sector. Full engagement and consultation will commence from December 2020, when we establish the associated workstreams who will have to ensure the voices of staff, service users, those with learned experience and carers are engaged and consulted. A final version of the Transformation Programme will be submitted to the three IJBs and NHSG to consider approval in April 2021.

INTEGRATION JOINT BOARD

3.6. Development of Quality Assurance and Performance Management Framework

A Quality Assurance and Performance Management Framework for Grampian-wide MHLD was approved at the Transformation Board on 5th November 2020. Given the significant demand being placed on the NHSG Public Health and Health Intelligence Teams during COVID a request for support to develop a Benchmark Report was submitted to the Scottish Government LIST Team and Public Health Scotland. The Teams have committed to delivering a draft for consultation with local services by early December 2020. The benchmark report will enable us to better understand the baseline performance reporting capability, quality of data and priority development areas to embed KPI reporting electronically for the future. As well as the national indicators, there is a commitment to work with service managers to develop sustainability indicators and indicators for person centred outcomes. Improvement actions will be progressed as we work alongside NHSG Health Intelligence between now and March 2021 to embed an electronic Performance Dashboard for Grampian-wide MHLD within the Aberdeen City HSCP Dashboard on Tableau.

3.7. Review of Quality, Safety and Assurance Process

In September 2020, a review of the governance arrangements for Grampian-wide MHLD Services was undertaken by the Clinical and Care Governance Group (MHLD) with key representatives from hosted services and delegated services across the 3 HSCPs. The revised role and remit of the group will be to focus on Quality, Safety and Assurance with the Clinical Director MHLD and Chief Nurse MHLD in attendance and they will provide assurance for hosted services across the 3 IJBs and NHSG Clinical and Care Governance Groups. HSCPs will continue to provide assurance to IJBs for the delivery of delegated community and inpatient services across respective IJB governance process. The system wide group will ensure cross system learning as well as identifying areas for action to improve the quality, safety and equity of access and will report to respective Boards on progress against agreed priorities.

The final paper is awaiting approval by HSCPs Clinical and Care Governance Committees and we aim to move to the new role and remit with an appointed independent Chair as of December 2020. This will ensure we have a clear understanding of the governance and assurance processes in advance of the Transformation Board establishing Work Streams from January 2021.

INTEGRATION JOINT BOARD

4. Implications for IJB

4.1. Equalities

The Strategic Framework has been through an Equality Human Right Impact Assessment (EHRIA) by NHS Grampian and recommendations have been taken into account in the final version of this document.

Before submission for final approval in April 2021, further EHRIA assessments will be undertaken at a programme and project level to ensure the IJBs fully understand the impact of any recommended changes to service delivery.

The strategic intent set out in the Grampian-wide Framework for MHLD could lead to the following positive impacts on those with protected characteristics:

- **Age** - some services may be increased up to the age of 18 years for children and young people experiencing mental health problems / or both a learning disability and mental health problems (e.g. social work services in line with the national direction)
- **Disability** – redesigned provision to improve the support and crisis support upstream in Tiers 1 and 2 (community services) and a redesign of specialist and inpatient services for people in Grampian for those living with a Learning Disability to improve outcomes
- **Gender reassignment** – further development of the pathway to improve access to Gender Identity Services in Grampian
- **Marital Status** – no direct impact
- **Pregnancy and Maternity** – further development of the pathway to improve access to perinatal services in Grampian
- **Race, Religion or belief or Non-belief** – no direct impact
- **Sex, and** – no direct impact
- **Sexual Orientation** – no direct impact

4.2. Fairer Scotland Duty

Mental health and wellbeing affects all communities and people of all socio-economic status. However, there is a higher prevalence of mental ill health and mental illness in communities where there is socio-economic disadvantage. IJBs are committed through their Locality Plans to take account of socio-economic disadvantage in respective of the allocation of resources according to the needs of population. The design and delivery of Grampian-wide inpatient and specialist MHLD Services will require a balance of a population approach, person centred care and securing best value with

the available resource. The design and delivery of Grampian-wide services will take account of the population needs across the three IJB areas.

4.3. Financial

There are no direct financial implications arising from the approval of the Grampian-wide Strategic Framework for MHLD.

The delivery of the strategic intent set out in the report aims to ensure inpatient and specialist MHLD services are on a more sustainable footing for the future and delivered within the agreed budget to be set in consultation with the NHSG and 3 IJBs.

All redesign projects under the Transformation Programme Plan will go through robust and costed business case option appraisal and any funding requirements will be submitted to the IJBs and NHSG for scrutiny and consideration for approval.

4.4. Workforce

Any changes arising from the Transformation Programme Plan will go through the workforce, staff side and staff engagement processes set out by the respective employer Organisation Change processes (NHSG, Aberdeen City Council, Aberdeenshire Council and Moray Council). Staff will be engaged in the work streams arising from the Transformation Programme Plan and will receive regular briefings. Staff engagement has been identified in the Communication and Stakeholder Engagement Plan and Risk Register.

4.5. Legal

No direct legal implications have been identified.

4.6. Other

None identified.

5. Links to ACHSCP Strategic Plan

5.1. Resilience - working with our partners to support people so that they can cope with, and where possible, overcome the health and wellbeing challenges they may face.

5.2. Personalisation – ensuring that the right care is provided at the right place at the right time when people are in need. Ensuring that our systems as are simple and efficient as possible.

6. Management of Risk

6.1. Financial Risk

The Transformation Programme Plan will aim to ensure whole system collaboration to better balance a population approach, person centred care and secure best value with the available resource. The longer term aim is to ensure a sustainable services with a balanced budget.

6.2. Governance Risk

A Governance Framework setting out clinical, care and financial governance arrangements for delegated community services across Aberdeen City, Aberdeenshire and Moray IJBs and delegated inpatient and specialist services hosted by Aberdeen City IJB on behalf of the Aberdeenshire and Moray IJBs was developed. The Grampian-wide Quality, Safety and Assurance Group has been established to provide assurance within the governance arrangements of the three IJBs and NHSG.

6.3. Legal Risk

Any major change to service delivery arising from the development of the Transformation Programme Plan will be managed in line with the guidance set out in the Scottish Health Councils Major Service Change process and timeline for public consultation.

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

1.	There is a risk that there is insufficient capacity in the market (or appropriate infrastructure in-house) to fulfil the IJB's duties as outlined in the integration scheme. This includes commissioned services and general medical services.	High
2.	There is a risk of financial failure, that demand outstrips budget and IJB cannot deliver on priorities, statutory work, and projects an overspend.	High
3.	There is a risk that the outcomes expected from hosted services are not delivered and that the IJB does not identify non-performance in through its systems. This risk relates to services that Aberdeen IJB hosts on behalf of Moray and Aberdeenshire,	High

	and those hosted by those IJBs and delivered on behalf of Aberdeen City.	
4.	There is a risk that relationship arrangements between the IJB and its partner organisations (Aberdeen City Council & NHS Grampian) are not managed to maximise the full potentials of integrated & collaborative working. This risk covers the arrangements between partner organisations in areas such as governance; corporate service; and performance.	Low
5.	There is a risk that the IJB, and the services that it directs and has operational oversight of, fail to meet both performance standards/outcomes as set by regulatory bodies and those locally-determined performance standards as set by the board itself. This may result in harm or risk of harm to people.	Medium
6.	There is a risk of reputational damage to the IJB and its partner organisations resulting from complexity of function, delegation and delivery of services across health and social care.	Medium
7.	Failure to deliver transformation at a pace or scale required by the demographic and financial pressures in the system.	High

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

Risk 1 – the Transformation Programme Plan has identified key actions to (i) develop a Market Position Statement and (ii) a Commissioning Framework to ensure the Third Sector Interfaces across Grampian can support the market to develop the level of maturity required to support the delivery of Tier 1-4 MHLD Services.

Risk 2 – the approval of the revised Scheme of Integration Report MHLD to be considered by the IJB, Council and NHS Grampian Boards with regard to financial arrangements aims to mitigate the financial risk of the gap between the budget and actual spend for inpatient and specialist MHLD Services.

Risk 3 – the development of a Performance Dash Board for Grampian-wide MHLD Services will ensure implementation of the 30 National Quality Indicators and other nationally and locally directed Key Performance Indicators to ensure the effective monitoring and reporting of community, inpatient and specialist MHLD Services to the respective NHSG and IJB Boards.

Risk 4 – the Sponsoring Group for all delegated hosted services is the North East System Wide Transformation Board to ensure cross system working across NHSG, IJBs and Council partners.

INTEGRATION JOINT BOARD

Risk 5 – a Quality Assurance and Performance Management Framework to report on performance across the 30 National Mental Health Indicator and additional Quality Assurance Measures for Learning Disability are being developed on an NHSG Performance Scorecard Dashboard by 1st of April 2020. Most areas are still unable to report on all indicators and are awaiting further national guidance on reporting methodology to embed these within operational systems.

Risk 6 – the development of a robust Governance Framework for Grampian-wide MHLD Services (community, inpatient and specialist) will ensure clarity of function, delegation and delivery of services across health and social care for delegated community and delegated inpatient and specialist services hosted by the Aberdeen City IJB.

Risk 7 – in March 2020, a Whole System Leadership Development Session for the Transformation Board (Grampian MHLD) was delivered to ensure collective understanding and commitment to the change required (as articulated in the Executive Summary of the Framework). In addition, Managing Successful Programme Methodology (MSP) is being followed so that roles, responsibilities and accountabilities are clearly defined for the Transformation Steering Group (Grampian MHLD), Transformation Board (Grampian MHLD) and associated Work Streams (programme and project level). Further Whole System Leadership Development Sessions are to be planned in early 2021.

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

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Aberdeen City Health & Social Care Partnership
A caring partnership

Date of Meeting	December 2020
Report Title	Transformation - Decisions Required: Action 15
Report Number	HSCP 20.050
Lead Officer	Sandra MacLeod, Chief Officer
Report Author Details	Kevin Dawson, Lead for MH/ LD/SMS services Kevin.dawson@nhs.scot 07818076228
Consultation Checklist Completed	Yes
Directions Required	Yes
Appendices	**Appendix 1** - Her Majesty's Prison (HMP) & Young Offenders Institute (YOI) Grampian – Joint City/Shire Prison-wide Mental Health project **Appendix 2** – Direction **Appendix 3** – Aberdeen City Health & Social Care Partnership Action 15 Committed Funds.

1. Purpose of the Report

1.1. This report seeks approval to agree financial expenditure to progress projects to deliver against the ACHSCP strategic aims and progress towards the Scottish Government Action 15 programme plan, previously approved by the IJB on 28th August 2018.

1.2. This report requests approval from the IJB to incur expenditure, and for the Board to make a Direction to NHS Grampian.

2. Recommendations

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

a) Approve the preferred option 2, as set out in Appendix 1, relating to the HMP&YOI Grampian – Joint City/Shire Prison-wide Mental Health service project.

b) Instruct the Chief Officer of Aberdeen City Health & Social Care Partnership to work with the chief officer of Aberdeenshire Health &

Social Care Partnership to implement the project as set out in the report.

c) Instruct the Chief Officer to make the Direction relating to HMP & YOI Grampian Joint City/Shire Prison-wide Mental Health Project as per Appendix 2 and issue to NHS Grampian.

3. Summary of Key Information

3.1 The Scottish Government's National Mental Health Strategy 2017-2027 Link here to MH Strategy sets out forty national actions under five headings:

1. Prevention and early intervention;
2. Access to treatment, and joined up accessible services;
3. The physical wellbeing of people with mental health problems;
4. Rights, information use, and planning;
5. Data and measurement.

3.2 Action 15 of the National Mental Health Strategy seeks to improve accessibility of services, entailing whole system change, specifically: "Increase the workforce to give access to dedicated mental health professionals to all A&Es, all GP practices, every police station custody suite, and to our prisons. Over the next five years increasing additional investment to £35 million for 800 additional mental health workers in those key settings."

3.3 Aberdeen Health and Social Care Partnership has a Community Mental Health Delivery Plan 'Promoting Good Mental Health' Link to MH Delivery Plan which sets out local objectives, which include: *developing support in the community which promotes independence and self-management; early intervention and support from people with "lived experience" of mental health issues and support for carers*. This plan was co-produced as part of a community engagement and consultation process and a specific action to explore the creation of community mental health and wellbeing workers was agreed.

3.4 Alongside these strategic actions, there has also been a wider Mental Health and Learning Disabilities review which has focussed on long term sustainability and transition to community based services.

3.5 The Scottish Government's Mental Health Transition and Recovery plan for Scotland builds upon positive changes during Covid 19 including digital solutions and different ways of delivery services. The key commitments include: 1) Promoting and supporting conditions for good mental health & wellbeing at population level, 2) Providing accessible signposting to help, advice and support; 3) Providing a rapid and easily accessible response to those in distress.

3.6 To ensure there has been appropriate alignment between the national direction and local priorities, an Action 15 partnership group with representation from

Aberdeen City & Aberdeenshire HSCP Community Mental Health Services, Police, NHS Grampian (including A&E, Acute Mental Health, Primary Care) third sector providers has met and developed a business case to progress local objectives.

3.7 This proposal seeks to deliver a tiered approach to support people in custody within HMP&YOI Grampian to improve mental wellbeing recognising characteristics such as (trauma history, cognitive impairment, impact of substance misuse, socio-economic determinants) by providing a holistic and targeted service. This proposal will provide lower tier support as an alternative to the medicalisation of expressed need such as anxiety, depression and wellbeing issues faced by the identified population.

3.8 Action 15 funding will provide 1 whole time equivalent Mental Health Support worker and 0.6 whole time equivalent Occupational Therapist (OT) to be employed by NHS Grampian. These posts will support functional improvement so that people are better able to engage with opportunities for recovery and progression within the prison. This in turn will contribute to improved longer term and sustained outcomes in the transition out of prison and into communities. This business case will help support emergent mental health needs as a result of Covid19.

3.9 Aberdeenshire Health and Social Care Partnership (HSCP) have lead responsibility for the health and wellbeing of the population of HMP&YOI Grampian. This project has been developed in partnership with colleagues from Aberdeenshire HSCP. Aberdeenshire HSCP will take the lead role for the project in terms of recruitment, performance and outcomes. This proposal seeks agreement from Aberdeen City IJB to invest finance in the City share of costs.

3.10 The proportion of costs including the Aberdeen City population of Aberdeen accommodated with HMP&YOI Grampian is 65% at any given time. This is reflected in proportionate ratio of costs allocated to each partner in the proposal. The total cost of this will be £194,786 over four years.

3.11 The proposal seeks to embed this permanent recurring resource within existing structures as a supporting role to the extant psychology and wider prison healthcare team augmenting capacity and ensuring a seamless service.

3.12 Recruitment at the prison can be an ongoing challenge due to the specific nature of the environment and demands on workers. With the growing evidence base of the effectiveness of OT Provision and consistent numbers of individuals available and keen to take up the role of Assistant Psychologist, recruiting to both posts is not forseen to be problematic

3.13 Feedback from service users and stakeholders will be sought as part of the project evaluation going forward at 6 month intervals.

3.14 This project will be jointly accountable to both the Aberdeen City & Aberdeenshire's Health and Social Care Partnerships. It will be reported for

ACHSCP via the Action 15 Steering Group and ultimately the Executive Programme Board and IJB. This project has been led by Aberdeenshire HSCP (AHSCP) because the delivery of health services within HMP&YOI Grampian are hosted by Aberdeenshire Health and Social Care Partnership.

3.15 Specific ring fenced funding is available for the implementation of the Action 15 Plan which increases on a 4-year profile to £1.2million per annum from 2022/23. In addition the Psychological Therapies service is jointly funded with the Primary Care Improvement Fund as part of the delivery of the Primary Care Improvement Plan (PCIP).

3.16 Following presentation of this business case at the Integrated Joint Board on 28th October 2020, clarification was sought regarding the scoring of the business case and the reasoning for choosing option 2 over option 3 which would deliver a more comprehensive model for delivery of mental health care that would meet the very specialist needs of a prison population. Option 3 is, however, not at the present time recommended to the IJB; this is due to services not having the necessary financials within the allocation of Action 15 budget to fund the posts on a recurring basis. It is, however, hoped that it might be possible to secure temporary funding to trial and evaluate some elements of the option 3 model through slippage monies. For example, it would be possible to recruit to an Assistant Psychology post on a temporary basis with the focus of the post specifically upon the screening, liaison and delivery of low intensity intervention for the older adults and individuals with a brain injury. This would provide the essential evaluation evidence to consider future and recurring investment through other funding streams.

4. Implications for IJB

4.1 Equalities

Inequality, mental health and human rights are inextricably linked. This proposal will ensure mental health services are accessible and meet the needs of all in compliance with Equality legislation. These plans will have a positive impact on the protected characteristics as protected by the Equality Act 2010.

Under prison health care arrangements, prisoners are entitled to equivalent access to the same quality and range of health care services as the general population, and they have the same rights in relation to mental health care as other patients (The Mental Health (Care & Treatment) (Scotland) 2003 Act; The Equality Act, 2010). Aberdeen City Residents have access to clinical psychology within the community.

4.2 Fairer Scotland Duty

Implementation of the recommendations will have a neutral to positive impact on people affected by socio-economic disadvantage. These services will increase accessibility to mental health services in areas / populations of deprivation / disadvantage

4.3 Financial

Specific ring-fenced funding is available for the implementation of the Action 15 Plan. The recommendations in this report will result in financial expenditure from the Action 15 fund. Full details of the financial implications are set out in the business case (appendix 1) and an Action 15 commitments for Aberdeen City Health & Social Care Partnership are outlined in Appendix 3.

4.4 Workforce

Action 15 of the National Mental Health Strategy commits to providing an additional 800 Mental Health Workers in Scotland (Aberdeen City's share is approximately 36) over the next 5 years and this will result in the recruitment and development of supplementary staff, who will support local services. The workforce will be outcome focused and collaborative working in a multi-agency and collaborative manner. Services will be re-designed in future to ensure that these posts can be recruited to permanently.

4.5 Legal

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

4.6 Covid-19

Positive impact on Operation Home First; aim to reduce harm to vulnerable groups impacted as a result of COVID19.

5. Links to ACHSCP Strategic Plan

5.1 This report seeks to support both the ACHSCP Strategic Plan and the Community Mental Health Delivery Plan 'Promoting Good Mental Health' and support the most vulnerable people impacted by poor mental health through Prevention, Resilience and Connections.

The primary direct link is with the Prevention Aim and the commitment of addressing the factors that cause inequality in outcomes in and across our communities.

6. Management of Risk

6.1 Identified risks(s)

Implementation of any service requires consideration of cross-system impacts as well as any governance requirements. The specific projects included in this report aims to shift in the balance of care which requires to be carefully planned, implemented and evaluation to ensure continued stability of the system to meet needs. Implementation of these proposals will be underpinned by a risk management framework.

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 therefore our ability to sustain the delivery of our statutory services within the funding available. The resultant risk is that the Integration Joint Board fails to deliver against the strategic plan.

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

Risk 5. “There is a risk that the IJB, and the services that it directs and has operational oversight of, fail to meet performance standards or outcomes as set by regulatory bodies.”

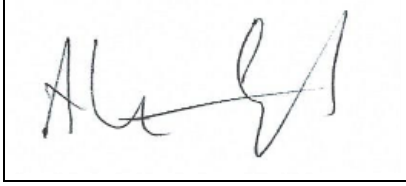
Risk 9. Failure to deliver transformation at a pace or scale required by the demographic and financial pressures in the system

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

Risk 2 – ring fenced funding has been identified and committed for these purposes.

Risk 5 – the Action 15 funding is within a specific envelope which to deliver on the WTE target would result in lower graded posts. The Steering Group agreed and have proposed projects which seek to address the needs of the city in an appropriate and proportioned manner. This was done in ensuring that all proposals are developed in consultation with partners, experts by experience and carers and that support the four key settings. All projects have been scrutinised to consider cross system links and best use of financial resource.

Risk 9 - Staff recruitment for the prison is an ongoing challenge, psychologists who would fit the requirements of this role and who need this type of experience are abundant within the wider health sector

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

Appendix 1

See separate Business Case attached.

Appendix 2

INTEGRATION JOINT BOARD

DIRECTION

ISSUED UNDER S26-28 OF THE PUBLIC BODIES (JOINT WORKING) (SCOTLAND) ACT 2014

NHS Grampian is hereby directed to deliver for the Board, the services noted below in pursuance of the functions noted below and within the associated budget noted below.

Services will be provided in line with the Board's Strategic Plan and existing operational arrangements pending future directions from the Board.

Related Report Number:- Transformation - Decisions Required: Action 15: HSCP 20.050

Approval from IJB received on:- 28th October 2020

Description of services/functions:-

1. **Provision of Mental Health support within HMP&YOI Grampian as described in the report.**

Provision of a tiered approach to support people in custody to support and improve mental wellbeing within HMP&YOI Grampian complementing existing service provision (0.6wte OT and 1wte x Mental Wellbeing Worker).

Reference to the integration scheme:- Annex 1

Part 2: 16. Services providing primary medical services to patients during the out-of-hours.
20. Mental health services provided outwith a hospital.

Link to strategic priorities (with reference to strategic plan and commissioning plan):-

This provision links to 3 strategic aims for ACHSCP: prevention; resilience; enabling.

Timescales involved:-

Start date:- 29.10.2020 (recruitment process begins). Posts to be in place January 2021. End date:- recurring (dependent on successful recruitment)

INTEGRATION JOINT BOARD

Associated Costs

(£)	Year 1	Year 2	*Year 3*	*Year 4*	Total
City Contribution	**46,908**	**48,081**	***49,282***	***50,515***	**194,786**
Shire Contribution (Agreed)	*25,253*	*25,890*	*26,537*	*27,200*	104,885
Total	72,166	73,970	75,819	77,715	299,670

£194,786

Details of funding source:- Scottish Government Action 15 Funding

Availability:- Confirmed

INTEGRATION JOINT BOARD

Appendix 3

ACTION 15 – Aberdeen City HSCP – Committed Funding

Committed Funding	WTE	2020/21 £k	2021/22 £k	2022/23 £k	2023/24 £k
Primary Care Psychological Therapy Service	12.17	544	600	604	608
Beating the Blues	1.0	31	32	33	34
Community Listening Service (Currently 0.5wte increasing to 1.0wte in 2021/22)	1.0	31	55	57	59
Psychological Wellbeing Practitioners (Currently progressing through Commissioning process)	4.0	84	170	174	177
Mental Health & Wellbeing Practitioners & Peer Support Project (Currently progressing through Commissioning process)	9.0	60	361	367	375
Aberdeen City Contribution to HMP Grampian Prison Service Proposal (*with IJB for consideration)*	1.0	48	49	50	51
TOTAL	**28.17**	**£798k**	**£1.26m**	**£1.28m**	**£1.31m**

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	Business Case	Project Stage **Define**

Project Name	Action 15: Increasing Mental Health support in HMP&YOI Grampian – city contribution (joint project with AHSCP)	**Date**	23/11/2020
Project Manager/ Author	Jeff Shaw, MH/LD Manager, Aberdeenshire HSCP Julia Wells, Aberdeenshire HSCP Susie Downie Transformation programme manager, ACHSCP	**Date of Programme Boards/ IJB**	EPB IJB December

Contents

	Business Case	Project Stage **Define**

1. Business Need

The Aberdeen City Health & Social Care Partnership (ACHSCP) recognises that redesigning services to meet people's needs across health and justice settings is complex and that it will require collaborative partnership working across organisational boundaries. The key leads and stakeholders from ACHSCP have been working with colleagues from Aberdeenshire to implement projects cross boundary with a focus on people's outcomes. This ensures the organisations are using resources effectively and most efficiently.

This project has been led by Aberdeenshire HSCP (AHSCP) because the delivery of health services within HMP&YOI Grampian are hosted by Aberdeenshire Health and Social Care Partnership. This paper seeks to agree funding for the Aberdeen City contribution towards mental health support in one of the key settings identified by Action 15, HMP&YOI Grampian.

The proposal recognises the need to deliver a matched step care model to support and improve mental wellbeing within HMP&YOI Grampian population. The proposal recognises common characteristics (trauma history, cognitive impairment, impact of substance misuse, socio-economic determinants) within the prison population and provides a holistic and targeted service. The desired outcome is to contribute to the improvement of peoples' functioning so that they are able to better engage with the opportunities which prison presents in terms of recovery and progression. This should then contribute to improved longer term and sustained positive outcomes in the transition out of prison and integration into communities.

Strategic Alignment

The Scottish Government Mental Health Strategy has committed to increase the mental health workforce by an additional 800 workers within key settings (A&E, Custody Suites, GPs, Prisons) in order to increase access to appropriate mental health support as early as possible. This project will improve access to workers within those key settings.

The project will contribute to the following aims of the strategic plan:

- Prevention – to provide timely interventions to those in prison
- Early intervention –a supportive response to de-escalate where possible

Under the new prison health care arrangements, prisoners are now entitled to equivalent access to the same quality and range of health care services as the general population, and they have the same rights in relation to mental health care as other patients (The Mental Health (Care & Treatment) (Scotland) 2003 Act; The Equality Act, 2010).

NHS Grampian is therefore required to provide equal access to mental health and mental wellbeing interventions to its prison population as is available to its community population. Within Aberdeen City and Aberdeenshire, community adult mental health service patients would have access to occupational therapists and clinical psychologists / CBT therapist at

tier 3/4 within the community mental health team; and would have access to mental wellbeing workers / psychological therapist at tier 1/2 primary care level. Access to Occupational Therapy (OT) provision within the prison setting reflects community provision, provides alternative and complimentary interventions to addressing mental health and wellbeing and further enhances delivery of clinical and psychological interventions, meeting the particular needs of the prison population and again contributing to the prevention of escalating behaviour and deteriorating mental health. Occupational Therapy provision in the setting of prison further contributes to early intervention, the environment sometimes being the catalyst for a distress reaction which can be managed in a more timely and appropriate manner without escalation to a clinical intervention.

In addition, within community settings there is a HEAT target requirement for psychological therapies to be commenced within 18 weeks of referral; current waiting time to the psychological therapies service is around 18 weeks with generally only high intensity / specialist referrals being submitted - and so waiting time would be likely to significantly increase if referrals for low intensity interventions were to commence given probable prevalence of common mental health problems. Community integration in the transition out of prison is enhanced by the care pathway between prison based OT and community led OT and other throughcare supports. This continuity of care informs what support should be established so again contributing to the reduction of risk of escalation in behaviour and deterioration in mental health and wellbeing given the difficult time which is known to be the transition experience leaving prison.

HMP&YOI Grampian: Prison Population

At 10/03/2020, the prison population at HMP & YOI Grampian was 454 of which 217 were from Aberdeen City and 93 Aberdeenshire. The remaining 144 were from other areas in Scotland and from England.

Prison Population (May 2020)	Total	%	% incl OOA
Overall Population	454		
City	217	48	64
Shire	93	20	36
Out of Area (OOA)	144	32	

Following the early prisoner release process during May 2020, at 23/06/2020, the prison population at HMP & YOI Grampian was 393 of which 194 are Aberdeen City and 78 Aberdeenshire. The remaining 121 are from other areas. A table below demonstrates the split of population between the 2 partnerships. As this is to be a Prison-wide service the OOAs would be split 50/50 between the organisations. A total percentage is given below. Demonstrating little variation in terms of the split although the numbers are reduced.

Prison Population (June 2020)	Total	%	% incl OOA
Overall Population	393		
City	194	49	**65**
Shire	78	20	**35**
Out of Area (OOA)	121	31	

Mental Health Needs of the prison population in UK:

It is widely known that people who are in prison are affected by mental health and mental wellbeing issues. Various needs analyses have highlighted high levels of mental health need within the prison population. In a psychiatric morbidity study in prison in England and Wales up to 90% of the population were found to have a mental health problem (Singleton et al, 1998). Light, Grant and Hopkins (2013) found that males and females in custody (aged 18 and over) reported much higher rates of ***anxiety*** (61% of females and 33% of males) and ***depression*** (65% of females and 37% of males) than general populations (mixed anxiety and depressive disorder: 11% of females and 6.9% of males; McManus et al., 2009). Rates of reported ***psychotic symptoms*** (25% of females and 15% of males) were also higher than in general populations (0.5% of females and 0.3% of males; McManus et al., 2009). Similarly, People in custody reported rates (21% of females and 7% of males) of ***suicide attempts*** in the year preceding custody higher than those in general populations (0.4% of males and 0.9% of females; McManus et al., 2009), and the same for rates (29% for females and 13% for males) of ***self-harm*** (general population: 3.5% of females and 3.4% of males; McManus et al., 2009).

Needs Identified in Needs Analysis Conducted in prisons in Scotland:

In a recent needs analysis of prisons in NHS Greater Glasgow and Clyde (2017) - **45%** of the total number of referrals to the Clinical Psychology and Psychological Interventions Service across all three prisons were as a result of ***trauma related difficulties***. This was followed by "**common mental health problems"** which accounted for **27%** of referrals to the service (Anxiety = 16%, Depression = 6%, and Poor Coping/Affect Regulation = 5%). Personality disorder and interpersonal difficulties accounted for a further 10% of referrals to the service, with the remainder attributed to neurodevelopmental disorders (3%), OCD (2%), Bipolar Affective Disorder (2%), Psychosis/Schizophrenia (1%) and "other" (10%).

Similarly in a recent needs analysis for prisons in NHS Forth Valley (2016) which involved review of a sample of current mental and substance use service caseload - high levels of common mental health difficulties were noted (i.e. anxiety, depression and stress) within caseloads in all prisons. There was also a high prevalence of childhood traumatic experiences, illicit drug use, complex and co-morbid mental health and substance misuse problems. Staff identified complex trauma as the key underlying need for mental health and substance misuse problems (Kreis, Ogilvie, Connor & Lowe, 2016).

HMP&YOI Grampian: Mental Health Referrals

Mental health referrals made to the Prison Health Centre during the year 2019, totalled 458 referrals. The nature of the referrals ranged in complexity and treatment need but the current service is targeted towards complex needs including severe and enduring mental health problems (similar to a CMHT model). Primary care mental health needs tend to be addressed by prison based GP services, and for example at March 2020, 131 people in custody were on medication for depression.

Based on current NICE guidelines for the treatment of the mental health difficulties most commonly identified in UK and Scottish prisons (i.e. depression, anxiety, trauma); all guidelines recommend Cognitive Behavioural Therapy based psychological interventions alone or in combination with drug treatment.

Additional Mental Health Needs of the Prison Population: Mental Health Needs of Older Adults and individuals with a Brain Injury

- **Brain Injury Population**

The prevalence rate of traumatic brain injury varies within the literature; however, a recent UK study showed that using a screening measure 47% of a prison population sample indicated they had experienced a traumatic brain injury with 76% of them experiencing more than one (Pitman et al., 2014), leading to mild to moderate cognitive impairment. The National Prisoners Healthcare Network published a document on Brain Injury and Offending (2016) which highlighted a recent study by the Division of Clinical Neuropsychology which found that around 12% of the prison population have a severe head injury. They highlight that there is a section of the prison population who have mild head injuries which still need to be considered in terms of responsivity to interventions. With increased resource to screen and detect head injuries, rehabilitation programmes and mental health input can be adapted, to better serve the needs of this population.

- **Older Adult Population**

Dementia is a progressive organic brain disease that gradually impairs cognitive abilities. Although dementia prevalence rates in UK prisons are still unclear, it has been estimated at somewhere between 1% and 4%, with an expectation that this will increase in the future due to an ageing population (Moll, 2013). Prisons in the UK, including in Scotland, have been repeatedly criticised for failing to meet the social care needs of prisoners with physical incapacities and personal care needs (Couper & Fraser, 2014; Le Mesurier 2011; Moll, 2013). In addition, in the UK, comparisons of older adults with younger prisoners suggest that there are higher rates of mental disorder among older prisoners with depressive disorders reportedly five times higher among older prisoners than younger prisoners (Fazel, Hope, O'Donnelly, & Jacoby, 2001), and studies estimating that 50% of older prisoners have a psychiatric disorder (Kingston et al., 2011). Several findings also indicate that many older prisoners have life-long unmet alcohol misuse needs, which may

be related to recidivism and number of times in custody (Arndt et al., 2002; Senior et al., 2013).

Evidence Base and Provision of Occupational Therapy Services for Mental Health Needs

Occupational therapists are already established in many statutory mental health services and the profession has been identified as one of the five key professions for mental health (RCOT 2018). There is growing interest in occupational therapy across the Scottish prison estate and through action 15 monies, several prison health services have been successful in obtaining Occupational Therapy posts.

There is a growing body of evidence within occupational therapy and occupational science literature evidencing the positive impact of and need, for occupational therapy in mental health. Kelly et all (2010) aimed to explore the relationship between recovery and occupation in service users with mental health problems. The participants' highlighted the benefits of occupation in their recovery facilitating feelings of social cohesion, meaning, purpose, normalisation, routine, competence, productivity, skill acquisition, routine and pleasure. These factors enabled the participants to re-establish self-concepts and subsequently promoted mental health.

Birken's 2017 study explored the experiences of people with a personality and mood disorder carrying out everyday activities following discharge from hospital. The findings of this study identified challenges people with a personality or mood disorder experience post-discharge regarding developing a daily routine, managing their home environment and participating in social activities. It also highlighted the negative impact of multiple admissions on activities of daily living and indicated the importance of occupational therapy provision following discharge from hospital.

Considering empirical findings when reviewing clinical findings from Occupational Therapy assessment in the Community Reintegration Unit (Unpublished report: Jamieson & Burnside 2015) and findings from reviewing clinical productivity in 2015 (HMP Grampian Occupational Therapy Service Activity Summary, Jamieson 2016) similar challenges exist for those who are released from prison, having implications on community reintegration, health, wellbeing and desistence**.**

Gaps in Service Provision and Action 15 Option Proposals

At present in HMP&YOI Grampian there is a consultant clinical psychologist able to offer psychological assessment and intervention for the most complex mental health problems and so delivery of highly specialist intervention (e.g. for individuals who often present with comorbid diagnoses including personality disorder, or who may experience psychotic symptoms). A Band 7 psychological therapist provides delivery of high intensity interventions. ***The gap, therefore, in the provision of psychological therapies in HMP & YOI Grampian is the delivery of low intensity interventions to support provision of matched stepped care model for individuals with mild to moderate mental health and / or substance use problems.***

At present within HMP & YOI Grampian there is provision for 0.1wte Band 8b neuropsychologist. There is a referral process which provides the opportunity for all agencies within the prison to make a referral to the neuropsychology service based at ARI. Referrals are placed on a waiting list; background information gathered; and patients are then offered appointments for neuropsychological assessment followed by a feedback appointment if appropriate. ***At present there is therefore, a gap in service in terms of sufficient clinical time to enable the psychology service to be based weekly within the prison; and as a consequence this limits opportunities for development of screening process and identification of individuals with brain injury; and limits also opportunities for liaison, consultation and training with other professionals.***

At present the older adult psychology service provides 0.1wte Band 8b clinical psychology service to HMP & YOI Grampian. There is a referral process by which healthcare staff, SPS staff and social work can make a direct referral for cognitive assessment related to potential dementia, chronic mental health problems, or long-term substance misuse. Referrals are placed on the waiting list; background information obtained; and patients then offered an appointment for assessment. Following completion of assessment, a summary of the assessment and recommendations are provided. ***At present there is therefore, a gap in service in terms of sufficient clinical time to enable the older adult psychology service to be based weekly within the prison; and as a consequence this limits opportunities for development of identification of individuals deteriorating cognitive functioning; limits opportunities for identification of emotional and mental health issues for older adults within the prison; limits also opportunities for liaison and support in the implementation of assessment recommendations.***

In HMP Grampian, the Occupational Therapy service has been in operation since January 2015 and consists of 0.5 WTE Band 7 Occupational Therapist (Approx. £26,588 per annum). It works with remand, short term, long term and life prisoners whose ability to participate in meaningful everyday occupations creates problems in relation to their health, prevents progression through the prison system or creates barriers to successful community reintegration. Those seen by the service often present with health comorbidities, are seen by multiple services and their needs span primary, secondary and at times, tertiary care. Many present with mental health problems which do not meet the criteria for secondary specialist mental health services. The service has an average attendance rate of 87%. The service however can only respond to 55% of referrals due to capacity. ***The gap in the provision of occupational therapy is more resource to increase access to this service and increase capacity of the current band 7 through an effective skills mix.***

<u>The options being proposed have been outlined in the Option Appraisal below (section 3).</u>

- **Option 1** seeks no change to the current service provision and so no further information describing this option is required.

- **Option 2** seeks funding for an Assistant Psychologist and Occupational Therapist and is described in more detail below.
- **Options 3** seeks funding for a Mental Health Worker, Assistant Psychologist for Brain Injury, Older Adult Psychologist, and increased Occupational Therapist resource and is also described below.

Option 2: the proposal seeks to secure:

- An Assistant Psychologist to build upon the existing psychology service and deliver low intensity interventions, tiers 1-2 of the stepped care model.
- An Occupational Therapist (OT) post to build on the existing OT provision and contribute to a more holistic needs led provision of care and support.

The Assistant Psychologist (1.0wte Band 5) would fulfil the following roles:

- To support the process of assessment of psychological needs in collaboration with Band 7 / 8c members of the psychological therapies team by gathering background records and extracting key information.
- Support patients to utilise psychologically informed guided self-help materials to support mental wellbeing and recovery (e.g. Northumberland Tyne and Wear prison-specific self-help guides already currently available to address anxiety, depression and trauma)
- Deliver individual protocol based interventions with clients using cognitive behavioural principles (e.g. problem solving) to support mental wellbeing and recovery
- Work with other psychological therapists to provide protocol based psychoeducational groups [the Forensic Network has available a range of protocolised low intensity treatment programmes to address a range of mental health needs)
- Identify motivational factors and potential barriers, and utilise motivational interviewing based approach to support change (including support with regard to mental health and substance use)
- To deliver the above interventions through regular liaison with primary care / GP services; mental health team, and substance use team.
- To support mental wellbeing and recovery through liaison with wider prison based services including SPS, housing, and education
- To support ongoing progress and reintegration through liaison and handover with community services if appropriate.
- To liaise with older adult psychology service to support process for the screening and early identification of possible dementia, or cognitive decline associated with chronic mental illness or substance misuse within HMP & YOI Grampian (such factors can significantly impact mental wellbeing and ability to engage in therapeutic and rehabilitation services).

- To liaise with neuropsychology service to support process for brain injury screening and assessment for potential brain injury within HMP & YOI Grampian (such factors can significantly impact mental wellbeing and ability to engage in therapeutic and rehabilitation services).
- To support evaluation of psychological therapies interventions by monitoring administration of psychometrics; maintaining database for evaluation purposes; and engaging in follow-up evaluation (including potential evaluation interview)

The Occupational Therapy (0.6WTE Band 6) Post would fulfil the following roles:

Within HMP & YOI Grampian, there have been significant opportunities created by employing an Occupational Therapist working from an occupational perspective and it would be expected that this would be extended with the recruitment of greater OT resource. These opportunities include:

- Health promotion and Self-Management

The use of occupation as therapeutic tool to support self-management, creating an additional approach to treatment and management of health conditions, complimenting existing pharmacological and psychological approaches.

> *"I have found this a more meaningful and positive approach. I have never had this kind of thing before – I've always thought about it but never had anyone look at it with me". Service User. Collated in 2016 via care measure*

- Supporting Access to Treatment

The occupational therapy service has been successful in identifying mental health issues which have been missed by traditional prison services given the concerns over stigma prisoners can experience and the capacity within the prison mental health teams. Occupational Therapy has successfully engaged such individuals, supported access to the right services and through an occupational approach has supported condition management, prevention, rehabilitation and recovery from mental health and wellbeing problems.

> "This approach (occupational therapy) produced some very positive results for prisoners who were not otherwise engaging positively in opportunities within the prison" HM Inspectorate of Prisons for Scotland Report on HMP & YOI Grampian, 2015: P7
>
> "There was evidence that this service had already provided positive support to prisoners who otherwise may have been 'missed' by more established interventions and teams" HM Inspectorate of Prisons for Scotland Report on HMP & YOI Grampian, 2015 : P55

- Early intervention and prevention of mental health problems

An occupational approach has been of significant value with prisoners who are struggling to adapt to prison life, using occupation based interventions to achieve a sense of meaning and purpose within their new circumstances. This has been valued in supporting the adaptive process and preventing a deterioration in mental health and wellbeing.

- Wider variety of treatment approaches available within prison mental health teams.

Having an occupational approach within the prison has offered an alternative approach to address mental health and wellbeing problems, complementing the existing medical and psychological approaches already available. A focus on the daily occupations people do and the roles they hold and where necessary addressing competencies within this, has been seen to reduce crisis presentations within mental health and substance misuse nursing teams and facilitated stability.

- Holistic approach addresses the physical health of those with mental health problems and can help prevent mental health issues in those with physical problems.

Occupational therapy's holistic approach, allows the profession to address physical issues which are contributing to or are a driver for poor mental health and wellbeing. Our holistic practice also ensures that the physical health needs of those with mental health conditions are recognised and addressed.

- Supporting community reintegration

Occupational therapy has assessment tools which are valuable in supporting preparation for release. Reports can be written outlining the supports that an individual with mental health challenges will need to manage daily expectations in the community. This is crucial in minimising stress and supporting health and wellbeing at the point of transition back to the community.

Recruitment Process – Option 2
Recruitment at the prison can be an ongoing challenge due to the specific nature of the environment and demands on workers. There is, however, consistently a significant number of individuals available and keen to take up a post as an Assistant Psychologist and so appointing to this post is not foreseen as problematic. In addition, given the growing evidence base of the effectiveness of OT provision within the setting of prison, the recruitment of an OT is likely to attract wide interest so again recruitment is not foreseen as problematic. NHSG have been consulted on the upcoming recruitment and a collaborative approach will be taken in this process. Aberdeenshire HSCP will be lead employer. The posts will be permanent.

Finance

Consideration ought to be given that there may be adjustment in the financial contributions. Any change will be by negotiation and agreement based on actual usage and will likely even out and not adversely affect our overall budget.
What is important is that a whole prison approach is taken in the delivery of the Action 15 services so that there is equity across the whole of the prison population. This leads to equal and fair access, is efficient in resource, ethical in approach, practicable in delivery and reduces potential disquiet across the prison estate.
There is sufficiency in funds available through Action 15 within the Aberdeenshire and Aberdeen City Action 15 allocation to fully meet the cost of Option 2.

Option 3: the proposal seeks to secure:

- 1wte x Band 6 Occupational Therapist (to provide enhanced resource to deliver occupational therapy interventions focused upon prevention and recovery)
- 1wte x Band 5 Mental Wellbeing Worker (to deliver low intensity MH interventions – similar role to the Assistant Psychologist in Option 2 above but without specific requirement to complete cognitive screening and liaise with specialist services)
- 0.2wte x Band 8a Clinical Psychologist (to deliver enhanced service for older adults with mental health needs)
    - To develop and implement a process for the screening and early identification of possible dementia, or cognitive decline associated with chronic mental illness or substance misuse.
    - To provide early cognitive assessment for those with dementia or cognitive decline associated with Mental Illness or substance misuse
    - To provide recommendations to support cognitive functioning and potential associated functional difficulties; and offer follow-up support with recommendations to patients and care teams
    - To offer specialist psychological assessment, intervention, guidance for older adults experiencing other mental health problems or substance related problems

- 0.5wte x Band 5 Assistant Psychologist (to deliver enhanced service for individuals with brain injury)
    - completion of initial screening for brain injury
    - review of medical records and brief clinical interview with patient for information gathering
    - delivery of psychoeducational low intensity intervention for mild to moderate brain injury on individual basis

Finance and Summary

Option 3 is proposed as a comprehensive model for the delivery of mental health care that would meet the very specialist needs of a prison population. Option 3 is, however, not at the present time recommended to the IJB; this is however only because there is not currently available the necessary finances within the allocation of Action 15 budget to fund the posts on a recurring basis.

It is, however, hoped that it might be possible to secure temporary funding to trial and evaluate the above option 3 model through slippage monies. For example, it would be possible to recruit to an Assistant Psychology post on a temporary basis with the focus of the post specifically upon the screening, liaison and delivery of low intensity intervention for older adults and individuals with a brain injury. This would provide the essential evaluation evidence to consider future and recurring investment through other funding streams.

2. Objectives
1. To improve people in custody outcomes and mental health support treatment and recovery within HMP&YOI Grampian
2. To meet the Scottish Government target of increasing mental health support in key settings (incl. HMP&YOI Grampian)
3. To introduce new roles and ways of working
4. To utilise resources effectively and efficiently
5. To ensure equity and equality of mental health support services within a prison setting
6. To maximise the available financial contribution from Action 15 budget

3. Options Appraisal

3.1. Option 1 – Do Nothing / Do Minimum	
Description	To not put in place support within HMP&YOI Grampian.
Expected Costs	No costs.
Risks Specific to this Option	This option is not viable as the partnership would not be meeting Scottish Government targets for key settings as per national strategy (Action 15).
Advantages & Disadvantages	**Advantages** • No funding is required. **Disadvantages** • Waiting times would continue to increase in current MH services supporting the prison population. • Inappropriate referrals to other services which would be not best use of current resources.
Other Points	None

3.2. Option 2 – Tiered Model complementing existing service provision (OT and Mental Wellbeing Worker)	
Description	This model looks to ensure that support is given to meet those wider mental health and wellbeing needs through intervention which may complement existing service provision or provide an alternative and more appropriate service. This approach is enabling and support positive decision making to improve MH outcomes. • 0.6wte x Band 6 Occupational Therapist • 1wte x Band 5 Assistant Psychologist (Mental Health)
Expected Costs	Cost: £72,166 per annum including on costs
Risks Specific to this Option	• Demand may exceed service capacity. • Failure to meet the needs of the custody population.
Advantages & Disadvantages	**Advantages** • Opportunity for the population within the setting of prison to have access to a stepped mental health and mental wellbeing support service • Opportunity for screening into specialist mental health services within the setting of prison • Enhances existing collaborative practice with other prison-based service providers such as public health and social work which already exists in the setting of prison • Creates improved care pathways and transition planning as part of throughcare provision **Disadvantages** • Limited service capacity given the size of the population in prison • Failure to meet need.
Other Points	n/a

3.3. Option 3 – Tiered Model Option 1 with Clinical Psychologist (Older Adult) and

Asst Psychologist (Brain Injury) and additional OT resource.	
Description	This model looks to ensure that support is given to meet those wider mental health and wellbeing needs through intervention which may complement existing service provision or provide an alternative and more appropriate service. It also includes the additional resource of a 0.5wte Asst Psychologist specialising in brain injury and 0.2wte Clinical Psychologist specialising in the mental health needs of older adults. This allows a level of response to people who are affected by potential brain injury or early onset dementia. It also includes the provision for additional occupational therapy resource to support prevention and recovery. • 1wte x Band 6 Occupational Therapist • 1wte x Band 5 Mental Wellbeing Worker (MH) • 0.2wte x Band 8a Clinical Psychologist (OA) • 0.5wte x Band 5 Assistant Psychologist (BI)
Expected Costs	Cost: £136,595 per annum (including on costs)
Risks Specific to this Option	• Older Adult and Brain Injury screening/intervention may create increased demand for other parts of the health centre provision • Demand exceeds service provision
Advantages & Disadvantages	Advantages: • Enhances delivery of existing OT and psychology services which are evidence based and will provide a stepped care model of service • Service will meet the demand of the population within the setting of prison, however, may have limited capacity • Provides screening opportunity into specialist services • Recognises characteristics within population specifically early onset dementia and brain injury so provides a fairly holistic and targeted service Disadvantages: • increasing concern regarding meeting potential demand to provide comprehensive service • more expensive model
Other Points	Any other relevant information.

	Business Case	Project Stage **Define**

3.4. Scoring of Options Against Objectives

#	Objectives	Option 1	Option 2	Option 3
1.	To improve People in custody outcomes and mental health support treatment and recovery within HMP Grampian/YOI	0	3	3
2.	To meet the Scottish Government target of increasing mental health support in key settings (incl. HMP Grampian/YOI	0	3	3
3.	To introduce new roles and ways of working within health and social care.	0	2	2
4.	To utilise resources effectively and efficiently by working with partners.	0	3	3
5.	To ensure equity and equality of mental health support services within a prison setting.	-1	2	3
6.	To maximise the available financial contribution from Action 15 budget	0	3	0
	Totals	-1	16	14
	Rank	**3**	**1**	**2**

Scoring
Fully Delivers = 3; Mostly Delivers = 2; Delivers to a Limited Extent = 1; Does not Deliver = 0; Will have a negative impact on objective = -1

3.5. Recommendation

From the scoring matrix Option 2 and Option 3 meet to varying degrees five objectives. although there is a difference in terms of Objective 5. The full specification of these Options have been explored previously. Option 3 which includes the provision of a specialist screening resource to identify people who may be impacted by brain injury does provide a much wider scope of service, therefore fulfilling the objective around equity and equality across the population of the prison. Option 2 builds on existing service provision which is established and is evidenced as effective within the environment of the prison. Option 2, however, lacks the earlier screening resource around the impact of brain injury so has a reduced scoring around equity and equality as the prevalence of undiagnosed impact due to brain injury within the population of people who are in the justice setting is noted. Option 2 also lacks the additional specialist resource for the screening and assessment of dementia and the provision of mental health interventions specifically adapted for the older adult

population. Option 2 also has reduced occupational therapy provision compared with Option 3.
Of note is the significant difference in the scoring of Objective 6. Option 3 scores zero given that the resource cost fully exceeds the available funds. Option 3 provides greater resource, however, fundamentally the costings of this Option cannot be met although the aspiration is to trial through temporary funding, fixed term posts to develop the evaluation evidence of the resource contained within Option 3 so that future funding from wider funding streams can be explored.

The recommendation of this Business Case is for the endorsement of Option 2 – Tiered Model complementing existing service provision (OT and Assistant Psychologist).

4. Scope

This project looks to be a prison-wide service to ensure equity of service.

This project will ensure smooth transition via a multi-disciplinary and multi-agency case management whom will support the reintegration of individuals back into the community within Aberdeen City. HMP Grampian's Offender Outcomes Team have a standardised procedure to engage with community partners, external agencies and appropriate organisations to assist those individuals. Partners will work together in ensuring adequate support has been identified and referrals have been made for prisoners prior to liberation (i.e. housing, mental health, employability, welfare, addictions). This will be based on individual needs. It will ensure that all individuals sentenced to short term sentences with no statutory or licence conditions leaving HMP Grampian and reintegrating back into the Aberdeen City.

4.1. Out of Scope

A recurring £30,000 for a part time permanent social work post has been committed by Aberdeenshire Health and Social Care Partnership to deliver support and low intensity interventions to people who are affected by substance misuse and mental health/ mental wellbeing issues. This post will work alongside the Action 15 posts delivering a service to people from Aberdeenshire.

Aberdeen city as part of the mental health redesign and in line with the recently consulted ACHSCP Promoting Good Mental Health Delivery Plan (2020) will work to ensure community mental health support across a 7-day week for those requiring tier 1 support.

4.2. Project Dependencies

This project is dependent on the successful and timely recruitment to posts.

	Business Case	Project Stage **Define**

5. Benefits

Benefits will be defined and monitored by the project team within Aberdeenshire HSCP and will be reported back via ACHSCP Action 15 Steering Group. Types of benefits are included below however these are not finalised nor exhaustive and will require further development once service is in place.

People in custody Benefits (TO BE AGREED)

Benefit	Measure	Source	Baseline	Expected benefit	Measure frequency
Wellbeing	Resilience	Outcome Questionnaire	On initial assessment	Improved citizen resilience	Baseline @ 6 &12 months
	Quality of life	Outcome Questionnaire	On initial assessment	Improved quality of life	Baseline @ 6 &12 months
	Happiness	Outcome Questionnaire	On initial assessment	Increased happiness	Baseline @ 6 &12 months
Satisfaction	Perception of MH Support project	Service Questionnaire & Interviews	n/a	Standard and satisfaction with care is no worse than usual care	@ 6 months

Staff Benefit (TO BE AGREED)					
Benefit	Measure	Source	Baseline	Expected benefit	Measure frequency
Satisfaction	Perception of improved outcomes	Service Questionnaire & Interviews	n/a	Standard and satisfaction with care is no worse than usual care	@ 6 months
	Perception of improved capacity				

6. Costs

6.1. Project Revenue Expenditure & Income

Funding required from Aberdeen City Health and Social Care Partnership for their contribution to provision of mental support within HMP&YOI Grampian: 1x Assistant Psychologist (Band 5) and 1x Occupational Therapist (Band 6). These are permanent posts however a 4-year projection has been given.

The total commitment is £46,908 (with added pay increases) on a recurring basis. Demonstrated below over a 4-year period.

Year	2020/21	2021/22	2022/23	2023/24	Total costs	Contrib. /Prison population %
City Contribution	**£46,908**	**£48,081**	**£49,282**	**£50,515**	**£194,786**	**65**
Shire Contribution	£25,258	£25,890	£26,537	£27,200	£104,885	35
Overall Service Cost	£72,166	73,970	75,819	77,715	£299,670	

7. Procurement Approach

If this project will involve the procurement of products or services, describe the approach that will be taken based upon the recommended option.

Not applicable. Aberdeenshire HSCP will recruit directly to the posts internally.

8. State Aid Implications

Indicate whether this project will have any state aid implications.

There are no anticipated state aid implications.

9. Equalities Impact Assessment

What equalities impacts (including health impacts) with the project have. Indicate whether an equalities impact assessment and/or health impact assessment has or will be undertaken.

The project will actively promote the engagement of people in custody from diverse and marginalised groups by:

- Engaging and supporting the engagement from diverse backgrounds
- Encourage processes to make it easy to find, understand and use information

10. Key Risks

Description	Mitigation
Fully explain any significant risks to the project, especially those which could affect the decision on whether and in what form the project goes ahead.	*Details of any mitigating action already taken or suggested*
Lack of buy in from the HMP Grampian staff, who therefore resist its implementation.	Cocreation of the project objectives with service managers involved in the development of the business need and proposed solutions. Sharing examples of best practice to demonstrate role value and purpose. Production of clear guidelines and appropriate documentation to ensure role clarity. Post holders to ensure communication and to champion project within/ out with the prison.
Lack of time in programme to achieve clear outcomes	Posts will be amalgamated with the existing structures to ensure assimilation and best use of resources using a team based approach.
For the proposed new model of service delivery	Communication and Engagement

to be effective and to maximise the benefits, full commitment and "buy in" to the new service model and the project from all partners and stakeholders is essential.	Strategy to be in place
Demand outstripping resources.	Resources will be reviewed regularly to ensure capacity is used to best effective within constraints.

11. Time
11.1. Time Constraints & Aspirations
The service looks to recruit and be in place from 2020/21 financial year.

11.2. Key Milestones	
Description	**Target Date**
Draft model, plan and funding stream identified	July-August 2020
Approval at City Action 15 meeting	13th August 2020
Approval at EPB	02 Sept 2020
IJB decision	October 2020
Implementation following decision	October 2020

12. Governance

Include any plans around the ownership and governance of the project and identify the people in the key project roles in the table below.

This project will be jointly accountable to both the Aberdeen City & Aberdeenshire's Health and Social Care Partnerships. It will be reported for ACHSCP via the Action 15 Steering Group 6-weekly and ultimately the Executive Programme Board and IJB.

Aberdeenshire HSCP as the lead for this project will be responsible for its delivery and have a local project team in place.

Role	Name
Project Sponsor	Kevin Dawson, Lead Mental Health / LD /SMS Services, ACHSCP / Julia Wells, Service Manager / MH/LD Manager, AHSCP
Programme Manager	Susie Downie, Transformation Programme Manager, ACHSCP
Project Manager	Carina Strachan – Strategic Development Manager, AHSCP
Implementation Lead	Dawn Leslie, Service manager, AHSCP

13. Constraints

Document any known pressures, limits or restrictions associated with the project.

Constraints are being defined and managed as the project progresses.

14. Resources

Task	Responsible Service/Team	Start Date	End Date
Third sector interface			
Data Sharing/ Information Governance Advice			
To review role and remit	OT-Lead		

15. Environmental Management

The project should have a neutral impact on the environment as the team will be based within the prison itself.

16. Stakeholders

Key stakeholders have been identified and AHSCP will develop a communications plan. Aberdeenshire will ensure relevant updates are provided to all stakeholders as required.

17. Assumptions

Plans and financial projections for this project will be developed on the assumption that it will be successful in delivering its anticipated benefits and that capacity within the third sector is available.

18. Dependencies

This project is part of a wider transformational programme across Aberdeen City intended to radically change the system of health and social care. Whilst this project will have great value on its own, when it is taken together with the other elements of implementing the integration strategies and plans it will provide essential and fundamental support for service change across the city.

Whilst this project is dependent upon the partner organisations successfully dealing with the challenges in a positive and proactive way, it is also a significantly contributing action that is part of the overall approach to dealing with these issues through:

-Promoting people's shared responsibility for prevention, anticipation and self-

management
- Improved integration across the ACHSCP and other public and third sector bodies
- Recognition, promotion and development of mental health wellbeing team
- Engagement and buy in from frontline and community based services

19. Constraints
Constraints are being defined and managed as the project progresses.

20. ICT Hardware, Software or Network infrastructure		
Description of change to Hardware, Software or Network Infrastructure	**EA Approval Required?**	**Date Approval Received**
Mobile device and ICT equipment to be provided by the Aberdeenshire HSCP for the post holders as required.	No	

21. Support Services Consulted				
Service	**Name**	**Sections Checked / Contributed**	**Their Comments**	**Date**
Finance	Gillian Parkin / Eve Bain	Finance	No amendments	13/08/2020
MH/LD	Service Managers	Whole Document	Re 3 sector applicability/ management of posts	14/08/2020
HMP&YOI Grampian	Dawn Leslie	Whole document	Amended options / Data	15//08/2020
Legal				

22. Document Revision History			
Version	**Reason**	**By**	**Date**
1.0	Initial draft for sub-group	D Leslie / J Shaw	26/07/2020
1.1	Amended financials	S Downie	11/08/2020
1.2	Finalised	S Downie	14/09/2020

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Exempt information as described in paragraph(s) 10, 11 of Schedule 7A of the Local Government (Scotland) Act 1973.

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