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Aberdeen City Health & Social Care Partnership
A caring partnership

To: Members of the Risk Audit and Performance Committee

Town House,
ABERDEEN 15 June 2021

RISK, AUDIT AND PERFORMANCE COMMITTEE

The Members of the **RISK, AUDIT AND PERFORMANCE COMMITTEE** are requested to meet in **Virtual - Remote Meeting on TUESDAY, 22 JUNE 2021 at 10.00 am.**

FRASER BELL
CHIEF OFFICER - GOVERNANCE

B U S I N E S S

1 Introduction

DECLARATION OF INTERESTS

2 Members are requested to intimate any declarations of interest (Pages 3 - 4)

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 Previous Meeting of 27 April 2021 (Pages 5 - 14)

5 Business Planner (Pages 15 - 18)

GOVERNANCE

6 Justice Social Work Performance Management Framework - HSCP.21.053 (Pages 19 - 28)

7 Delivery of Leadership Team Objectives - HSCP.21.072 (Pages 29 - 52)

8 Contract Register / Commissioning Annual Review - HSCP.21.073 (Pages 53 - 58)

RISK

9 Strategic Risk Register - HSCP.21.074 (Pages 59 - 86)

AUDIT

10 Audited Accounts - HSCP.21.056 - Late Report

11 External Audit Report - HSCP.21.057 - Late Report

PERFORMANCE

12 Operation Home First - Evaluation Report - HSCP.21.075 (Pages 87 - 162)

CONFIRMATION OF ASSURANCE

13 Confirmation of Assurance

COMMITTEE DATES

Thursday 23 September 2021
Tuesday 21 December 2021
Tuesday 1 March 2022

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

DECLARATIONS OF INTEREST

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

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

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

OR

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

OR

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

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

OR

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

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

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

Minute of Meeting

Tuesday, 27 April 2021
10.00 am Virtual - Remote Meeting

Present: John Tomlinson (Chair); and Luan Grugeon, Councillor Philip Bell, Councillor John Cooke and Alex Stephen

Also in attendance; Derek Jamieson (Clerk) and Kundai Sinclair (Solicitor)

Apologies: Sandra Macleod (Chief Officer)

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.

DECLARATIONS OF INTEREST

1. There were no declarations.

DETERMINATION OF EXEMPT BUSINESS

2. There was no exempt business.

MINUTE OF PREVIOUS MEETING OF 26 JANUARY 2021

3. The Committee had before it the minute from its previous 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/Deputy Chief Officer who provided context around future reporting.

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Members were advised that the intended report referenced at line 16 - COVID-19, Social Care and Human Rights: Impact Monitoring Report would now feature in a report to the IJB on 25 May 2021.

The Committee resolved :-
(i) to remove the proposed report referenced at Line 16 - COVID-19, Social Care and Human Rights: Impact Monitoring Report; and
(ii) to otherwise note the business planner.

REVIEW OF LOCAL CODE OF GOVERNANCE - HSCP.21.037

5. The Committee had before it the report from the Chief Finance Officer, ACHSCP (CFO) which presented the review of the local code of corporate governance for the Integration Joint Board (IJB) previously agreed by Audit & Performance Systems Committee (APS) to allow the Committee to comment on the sources of assurances used to measure the effectiveness of the governance principles contained in the CIPFA\SOLACE *'Delivering Good Governance in Local Government: Framework'* document.

The CFO advised members of the background to this review and provided summary on the processes undertaken to deliver the review which included agreement from the constituent partners (Aberdeen City Council and NHS Grampian) on the activities and assurance provided.

Members were advised that the report formed an essential element of the Annual Governance Statement contained within the Audit Statement.

The report recommended :-
that the Committee approve the sources of assurance, as highlighted in Appendix A.

The Committee resolved :-
to approve the recommendation.

REVIEW OF FINANCIAL GOVERNANCE - HSCP.21.038

6. The Committee had before it the report from the Chief Finance Officer (CFO), ACHSCP which presented the results of the review undertaken by the Aberdeen City Health and Social Care Partnership (AHSCP) Leadership Team, as at Appendix A, against financial governance requirements contained in the Chartered Institute of Public Finance and Accountancy (CIPFA)'s statement on the '*Role of the Chief Financial Officer in Local Government (2016)'* .

Members heard a summary of the report and that the CFO had been nominated the Deputy Chief Officer and been allocated additional responsibility.

Members stated that they wished assurance that the primary functions of the CFO would still be delivered and that the additional responsibilities would not impact on that role.

The report recommended :-
that the Committee note the content of the report and the accompanying results of the Executive team review contained at Appendix A.

The Committee resolved :-
(i) to approve the recommendation; and
(ii) to instruct the Chief Officer, ACHSCP, to review the role of the Chief Finance Officer to ensure sufficient support is available to allow the CFO to undertake the responsibilities allocated to the post and provide assurance to the Committee via a report when completed.

ANNUAL GOVERNANCE STATEMENT - HSCP.21.041

7. The Committee had before it the report from the Chief Finance Officer, ACHSCP which provided opportunity to comment on and approve in principle the Annual Governance Statement and agree that assurances on the government framework can be provided to Aberdeen City Council and NHS Grampian.

Members heard from the CFO who provided summary on the requirements to produce the Annual Governance Statement which had been produced in association and agreement with the constituent organisations.

Members heard from the Chief Internal Auditor who was in attedance and confirmed the description of actions provided by the CFO.

The report recommended :-
that the Committee -
a) comment on and approve the governance statement at Appendix A; and
b) note the statement from the Chief Internal Auditor at Appendix B.

The Committee resolved :-
to approve the recommendations.

RISK, AUDIT AND PERFORMANCE COMMITTEE
27 April 2021

APPROVAL OF UNAUDITED ACCOUNTS - HSCP.21.040 - LATE REPORT

8. The Committee had before it the report from the Chief Finance Officer (CFO), ACHSCP which presented information to allow the Committee to review and comment on the unaudited final accounts for 2020/21.

Members heard from the CFO who advised it was an annual challenge to prepare and present the accounts for the required timeline and acknowledged the input of the Leadership Team in assisting.

The CFO advised that whilst the Accounts had been prepared against a constant changing environment due to pandemic impact, he was satisfied with them albeit attention was required in only two areas – the pension information and the redeployment figures. These had been managed with a 3% set aside consideration.

Members were advised that whilst the IJB held a £15.5 million reserve, this was ring fenced against additional pandemic costs and future spend in the following year.

The Chair indicated an appreciation of the timely preparation and delivery by the CFO and his team of the accounts. This was endorsed by the Committee.

The report recommended :-
that the Committee consider and comment on the Unaudited Final Accounts for 2020/21 at Appendix A.

The Committee resolved :-
(i) to approve the recommendation; and
(ii) to acknowledge and endorse the efforts of the Chief Finance Officer and the Leadership Team in preparation and delivery of the Unaudited Accounts in a quick manner.

FINANCIAL MONITORING 31 MARCH 2021 - HSCP.21.049 - LATE REPORT

9. The Committee had before it the report from the Chief Finance Officer (CFO), ACHSCP which presented information to the Committee to review and comment on the unaudited final accounts for 2020/21.

The CFO provided members with a summary of the report which was presented in the similar format to previous reports.

Members heard of shifts in financial demand due to the pandemic and the volume of activity to plan and revisit spending which had added to the required virements.

Members discussed these challenges and explored areas of financial risk and mitigation and of the opportunities to influence the wider 'lessons learned' report being developed for the IJB.

The Chair stated his appreciation of the work of the CFO and his team which had assisted both the Committee and the IJB to discharge its responsibilities.

Members agreed that this should be recorded within the minute.

The report recommended :-
that the Committee –
a) note the report in relation to the Integration Joint Board (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 Committee resolved :-
(i) to approve the recommendations; and
(ii) to acknowledge the unique and at times difficult environment navigated over the pandemic periods and appreciate the work of the Chief Finance Officer and his team which has assisted the Committee and the IJB to discharge its responsibilities.

REVIEW OF DUTIES & YEAR END REPORT - HSCP.21.042

10. The Committee had before it the report from the Chief Finance Officer (CFO), ACHSCP which presented the review of reporting for 2020-21 and an intended schedule of reporting for 2021-2022 to ensure that the Committee is fulfilling all the duties as set out in its terms of reference.

The CFO provided members with a summary of activities and actions taken during the preceding year to provide assurance to the Committee.

The Chair remarked on the positive position delivered against the background of response required to the pandemic.

Members questioned the availability of assurances from partners who were delivering hosted services on behalf of the IJB and were advised that the CFO will review this and report back to Committee.

The report recommended :-
that the Committee note the content of Appendix A – Risk, Audit & Performance Duties report.

The Committee resolved :-
(i) to approve the recommendation; and
(ii) to note that Duty 10 (Support the IJB in delivering and expecting cooperation in seeking assurance that hosted Services run by partners are working) will be reviewed and addressed to the Committee on 23 September 2021.

DIRECTIONS UPDATE - HSCP.21.034

11. The Committee had before it the report from the Chief Finance Officer (CFO), ACHSCP which presented an update on Directions instructed to Aberdeen City Council (ACC) and NHS Grampian (NHSG) since the previous report to the September 2020 RAPC.

Members heard that the Directions update would be presented to Committee every six months as indicated on the Planner.

The report recommended :-
that the Committee note the contents of the report.

The Committee resolved :-
to approve the recommendation.

INTERNAL AUDIT ANNUAL REPORT 2020-21 - HSCP.21.044

12. The Committee had before it the report from the Chief Finance Officer, ACHSCP which presented the Internal Audit Annual Report for 2020/2021.

Members heard from the (Interim) Chief Internal Auditor who advised that whilst there had been fewer audits completed due to the pandemic, those audits conducted had not been limited in scope.

The report recommended :-
that the Committee -
a) note the Internal Audit Annual Report 2020/21;
b) note that the Chief Internal Auditor has confirmed the organisational independence of Internal Audit;
c) note that there has been no limitation to the scope of Internal Audit work during 2020/21; and
d) note the progress that management has made with implementing recommendations agreed in Internal Audit reports.

The Committee resolved :-
to approve the recommendations.

EXTERNAL AUDIT STRATEGY 2020/21 - HSCP.21.036

13. The Committee had before it the report from the External Auditor, KPMG which presented the draft external audit strategy for consideration.

Members heard from the External Auditor who provided explanation of the governance appointment of KPMG to this role which had been extended by Scottish Government from 5 to 6 years; this was the 5th Annual Report.

Members were advised that the strategy followed legislative requirements and industry practice and was similar in presentation to those presented over previous years.

The report recommended :-
that the Committee approve the approach to external audit, as outlined in Appendix A.

The Committee resolved :-
to approve the recommendation.

INSPECTION OF JUSTICE SOCIAL WORK SERVICE - HSCP.21.035

14. The Committee had before it the report from the Lead for Social Work, ACHSCP which presented the recent publication by the Care Inspectorate of its inspection report in relation to the ACHSCP's justice social work service which had also been presented to the Integration Joint Board (IJB) on 23 March 2021, and to the Clinical Care & Governance Committee (CCGC) on 6 April 2021.

Members heard from the Planning and Development manager, ACHSCP who explained the history and governance surrounding the inspection which had been interrupted during the pandemic.

Members were advised that the justice social work service had completed a self-assessment as part of the process and that the Care inspectorate had made particular reference to the honesty and depth of that assessment.

Members heard that a development plan would follow from the report's findings which would be presented to the IJB.

The report recommended :-
that the Committee note the contents of the published inspection report.

The Committee resolved :-
(i) to approve the recommendation;
(ii) to note that a delivery plan will be presented to the IJB; and
(iii) to add the Committee's appreciation and acknowledgement to those previously recorded at the IJB.

LOCAL GOVERNMENT IN SCOTLAND: FINANCIAL OVERVIEW 2019/20 - HSCP.21.016

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

The report presented information on two National Audits ; the Audit Scotland Financial Overview Report as published by the Accounts Commission from their high-level independent analysis of the financial performance of councils and Integration Joint Boards (IJBs) during 2019/20 and their financial position at the end of that year; and the National Health Service in Scotland 2020 Report as published by the Auditor General for Scotland.

The Chair advised members that the *'Guide for audit and risk committees*' referenced at page 180 of the pack was a useful guide to members.

The report recommended :-
that the Committee –
a) note the content of Appendix A - the Local Government Financial Overview report 2019/20; and
b) note the content of Appendix B – National Health Service in Scotland 2020 report.

The Committee resolved :-
to approve the recommendations.

RISK, AUDIT AND PERFORMANCE COMMITTEE
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INCLUSION OF ADDITIONAL RISK - HSCP.21.043

16. The Committee had before it the report from the Chief Officer, ACHSCP which presented the outcome of a review of the Aberdeen City Health & Social Care Partnership's (ACHSCP) Strategic Risk Register to reflect current business responsibilities.

Members heard from the Business Manager, ACHSCP who provided a summary of the report and specifics on each of the referenced risks.

Members were advised that NHS Grampian would be included in discussions around the risks, particularly around Risk 10 – EU Exit.

The report recommended :-
that the Committee –

a) **Add Risk 11:** consider Appendix A, the proposed addition to the Strategic Risk Register relating to the Integration Joint Board's (IJB) duties under the Civil Contingencies Act 2004; make comments and observations on the draft risk and endorse their concluded view to the Integration Joint Board at its meeting of 25 May 2021;
b) **Remove Risk 10:** consider removing Risk 10 (EU Exit) from the Strategic Risk Register, as detailed in the report and endorse their conclusions on this to the Integration Joint Board at its meeting of 25 May 2021; and
c) **Note review of Risk 3:** to note that a review of Risk 3 (Hosted Services) will be presented to the RAPC meeting in September 2021.

The Committee resolved :-
to consider the report and Appendix A and -

(i) to endorse inclusion of Risk 11 (the Integration Joint Board's (IJB) duties under the Civil Contingencies Act 2004) within the IJB Strategic Risk Register and to engage with NHS Grampian to develop further understanding of the risk and potential mitigation;
(ii) to endorse recommendation of removal of Risk 10 (EU Exit) from the Strategic Risk Register and include EU related workforce issues within Risk 9; and
(iii) to note that a review of Risk 3 (Hosted Services) will be presented to the Committee on 23 September 2021.

RISK, AUDIT AND PERFORMANCE COMMITTEE
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OPERATION HOME FRONT UPDATE REPORT - HSCP.21.033

17. The Committee had before it the report from the Chief Officer, ACHSCP which provided progress on the evaluation of the Aberdeen City Priorities relating to Operation Home First (OHF). In particular, the report was predominantly to provide assurance that a robust process has been implemented to evidence the impact of this portfolio.

Members heard from the Lead for Research and Evaluation, ACHSCP who provided an update on activities undertaken and planned around the project which involved partnership working and involved a cross service team involving Public Health Scotland and NHS Scotland Health Intelligence.

Members were reminded that updates on OHF are a Standing Item to report to the Committee.

The report recommended :-
that the Committee –
a) note the information provided in the report; and
b) note that OHF Update is a standing item on the Committee business planner and further updates will be provided as agreed.

The Committee resolved :-
to approve the recommendations.

CONFIRMATION OF ASSURANCE

18. The Chair enquired of Members regarding the degree of assurance received and/or sought during the meeting.

The Committee resolved :-
to note they had received Confirmation of Assurance from the reports and associated discussions presented and that further assurance had been evidenced by the activity of all staff in not only producing the necessary information but also by the delivery and modifications of processes and services in a regular and sustained manner.

- **JOHN TOMLINSON, Chair**

	A	B	C	D	E	F	G	H	I	J
1	RISK and AUDIT PERFORMANCE COMMITTEE BUSINESS PLANNER The Business Planner details the reports which have been instructed by the Committee as well as reports which the Functions expect to be submitting for the calendar year.									
2	**Date Created**	**Report Title**	**Minute Reference/Committee Decision or Purpose of Report**	**Report Number**	**Report Author**	**Lead Officer / Business Area**	**Directorate**	**Update/ Status (RAG)**	**Delayed or Recommended for removal or transfer, enter either D, R, or T**	**Explanation if delayed, removed or transferred**
3	**Beginning June 2021 - Accounts**									
4	Standing Item	Contract Register Annual Review	Annual - to RAPC in May/June; to IJB in Nov/Dec - last reported ??	HSCP.21.073	Anne McKenzie	Lead Commissioner	ACHSCP			An updated paper detailing journey to date will be presented.
5	Standing Item	Review of relevant Audit Scotland reports	Good practice to see national position	None	Alex Stephen	Chief Finance Officer	ACHSCP			None to report
6	Standing Item	External Audit Report	Per RAPC Terms of Reference	HSCP.21.057	Andy Shaw/ Michael Wilkie	External Audit	KPMG			Late Report
7	25.05.2021	Audited Accounts	Per IJB Terms of Reference	HSCP.21.056	Alex Stephen	Chief Finance Officer	ACHSCP			Late Report
8	**22 June 2021**									
9	Standing Item	Strategic Risk Register	Bi-Annual - last report January 2021	HSCP.21.074	Martin Allan	Business Manager	ACHSCP			
10	Standing Item	OHF Report	Quarterly Reporting	HSCP.21.075	Calum Leask	Lead Strategy and Performance Manager	ACHSCP			
11	Standing Item	Strategic Leadership Team Objectives		HSCP.21.072	Alison Macleod	Lead Strategy and Performance Manager	ACHSCP		D	To be reported on 22 June 2021
12	09.03.2021	CJSW Performance Framework Reporting		HSCP.21.053	Kevin Toshney	Planning and Development Manager	ACHSCP			
13	Standing Item	Strategic Objectives	20210427 RAPC ; To be reported on 22 June 2021	N/A	Martin Allan	Business Manager	ACHSCP		R	Will be included within Strategic Plan Review
14	**23 September 2021**									
15	Standing Item	OHF Report	Quarterly Reporting		Calum Leask	Lead Strategy and Performance Man ager	ACHSCP			Amalgamated within OHF Report and Op Snowdrop
16	Standing Item	Board Assurance and Escalation Framework (BAEF)	26.08.2020; The Committee resolved :- (iv) to note that the Framework will be reviewed by the Committee on an annual basis.		Martin Allan	Business Manager	ACHSCP			
17	Standing Item	Financial Regs Review	Annual Review		Alex Stephen	Chief Finance Officer	ACHSCP			
18	Standing Item	Directions Tracker	On 23.09.2020, RAPC : (iii) to direct the Chief Finance Officer to report on the Directions Tracker every 6 months - see 27 April 2021		Alex Stephen	Chief Finance Officer	ACHSCP			
19	Standing Item	IJB / ACHSCP Annual Report	Annual Report		Alison MacLeod	Performance Lead	ACHSCP			
20	27.04.2021	Deputy Chief Officer Impact on role of Chief Finance Officer	20210427 RAPC : (ii)to instruct the Chief Officer, ACHSCP, to review the role of the Chief Finance Officer to ensure sufficient support is available to allow the CFO to undertake the responsibilities allocated to the post and provide assurance to the Committee via a report when completed.		Sandra Macleod	Chief Officer	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**	**Directorate**	**Update/ Status (RAG)**	**Delayed or Recommended for removal or transfer, enter either D, R, or T**	**Explanation if delayed, removed or transferred**
21	27.04.2021	Assurance on Partner Delivery of Hosted Services	20210427 RAPC: The Committee resolved :-(i) to approve the recommendation; and (ii) to note that Duty 10 (Support the IJB in delivering and expecting cooperation in seeking assurance that hosted Services run by partners are working) will be reviewed and addressed to the Committee on 23 September 2021.		Alex Stephen	Chief Finance Officer	ACHSCP			RAPC preagenda June 21 - all three Hosted Services to be reported on 23 September 2021
22	27.04.2021	Stategic Risk Register : Review of Risk 3 - Hosted Services	20210427 RAPC : (iii to note that a review of Risk 3 (Hosted Services) will be presented to the Committee on 23 September 2021.		Martin Allan	Business Manager	ACHSCP			RAPC preagenda June 21 - all three Hosted Services to be reported on 23 September 2021
23	26.05.2021	PCIP - progress to date	Primary Care Improvement Plan - progress to date; information only report as presented to CE Business Meeting 25/05/21		Emma King	Sandra Macleod	ACHSCP			
24	11.06.2021	Mental Health Welfare Commission - Young People	Briefing paper on the Mental Health Welfare Commission - Young Person Monitoring Report 2019-20; and implications for ACHSCP		Alex Pirrie	Mental Health Services	NHS Grampian			
25	07.06.2021	Records Management Plan (RMP)	Feedback from National Records of Scotland on sugested improvement actions and an action plan		Martin Allan	Business Manager	ACHSCP			
26										
27	**21 December 2021**									
28	Standing Item	Strategic Risk Register	Bi-Annual - last report June 2021		Martin Allan	Business Manager	ACHSCP			
29	Standing Item	OHF Report	Quarterly Reporting		Calum Leask	Lead Strategy and Performance Man ager	ACHSCP			Amalgamated within OHF Report and Op Snowdrop
30										
31	**1 March 2022**									
32	Standing Item	OHF Report	Quarterly Reporting		Calum Leask	Lead Strategy and Performance Man ager	ACHSCP			Amalgamated within OHF Report and Op Snowdrop
33	Standing Item	Directions Tracker	On 23.09.2020, RAPC : (iii) to direct the Chief Finance Officer to report on the Directions Tracker every 6 months - see 27 April 2021		Alex Stephen	Chief Finance Officer	ACHSCP			
34	Standing Item	Annual / Biennial Report on Adult Social Care	At IJB on 25 May 2021 - agreed annual reporting . APC propose report annually to each committee							
35	Standing Item	Equalities and Equalities Outcomes	At IJB on 25 May 2021 - (v)to instruct the Chief Officer, ACHSCP to submit 6-monthly reports alternately to the RAPC and IJB.		Alison Macleod	Lead Strategy and Performance Manager	ACHSCP			
36	**First Meeting 2022/2023 Session**									
37	Standing Item	Internal Audit Reports	Assurance that services are operating effectively		Colin Harvey	Interim Chief Internal Auditor	Governance			
38	Standing Item	Review of relevant Audit Scotland reports	Good practice to see national position		Alex Stephen	Chief Finance Officer	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**	**Directorate**	**Update/ Status (RAG)**	**Delayed or Recommended for removal or transfer, enter either D, R, or T**	**Explanation if delayed, removed or transferred**
39	Standing Item	Review of Local Code of Governance	To provide assurance on Governance Environment		Alex Stephen	Chief Finance Officer	ACHSCP			
40	Standing Item	Review of Financial Governance	To provide assurance on Governance Environment		Alex Stephen	Chief Finance Officer	ACHSCP			
41	Standing Item	Approval of unaudited Accounts	Per RAPC Terms of Reference		Alex Stephen	Chief Finance Officer	ACHSCP			
42	Standing Item	Annual Governance Statement	To provide assurance on Governance Environment		Alex Stephen	Chief Finance Officer	ACHSCP			

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Aberdeen City Health & Social Care Partnership
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RISK, AUDIT AND PERFORMANCE COMMITTEE

Date of Meeting	22 June 2021
Report Title	Justice Social Work Performance Management Framework
Report Number	HSCP.21.053
Lead Officer	Claire Wilson, Lead for Social Work
Report Author Details	Kevin Toshney Planning and Development Manager KToshney@aberdeencity.gov.uk
Consultation Checklist Completed	Yes
Appendices	a. Justice Social Work Performance Management Framework

1. Purpose of the Report

1.1. The purpose of this report is to seek the Risk, Audit and Performance Committee's approval of the newly-developed Justice Social Work Performance Management Framework.

2. Recommendations

2.1. It is recommended that the Risk, Audit and Performance Committee (RAPC):

a) Approve the Justice Social Work Performance Management Framework and agree to its implementation by the justice service.

b) Instruct the Chief Officer (ACHSCP) to use this framework as the basis for a report outlining the performance of the justice service and present this report to RAPC no later than the end of Q1 2022-2023 and then similarly on an annual basis thereafter.

3. Summary of Key Information

3.1. The Justice service Programme Management Board (PMB) first initiated the development of a service-specific performance management framework as

a means of highlighting the effectiveness of the diverse, complex and busy service.

3.2. A draft performance framework was submitted to the Care Inspectorate in 2020 as part of the evidence portfolio supporting the service self-evaluation. As previously reported to the Committee, the inspection outcome was very positive with only two recommendations to be taken forward by the service, one of which said:

"To enable robust oversight and increased ability to demonstrate outcomes and impact, senior officers should ensure that the justice service delivery plan and performance management framework are agreed and implemented and associated reporting cycles established".

3.3. The inspection action plan which the partnership was required to submit to the Care Inspectorate no later than six weeks after the publication of the official inspection report said that a completed performance management framework would be submitted to the 22 June 2021 RAPC. To add further assurance, the action plan also stated that 'Framework KPIs' would be on the standing agenda for every PMB meeting and that an annual report in respect of justice social work performance and effectiveness would be submitted to RAPC.

3.4. Our inspection action plan was submitted to the Care Inspectorate in April 2021 along with our completed delivery plan, performance framework, QA plan, PMB action plan and JSW reporting cycles. The JSW delivery plan is on the agenda for the Integration Joint Board (IJB) on 6 July 2021.

3.5. The performance management framework has been shared with the partnership's Lead for Strategy and Performance and the Strategic Development Officer with a responsibility for performance reporting to ensure that there is a strong alignment with our other reporting mechanisms.

4. Implications for IJB

4.1. **Equalities** - There are no direct Equalities implications arising from this report.

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

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

4.4. **Workforce** - There are no workforce recommendations arising from this report.

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

4.6. **Other** - It is a regulatory requirement for the justice service to have an 'agreed and implemented' performance framework. Failure to do so would have a detrimental reputational impact.

5. Links to ACHSCP Strategic Plan

5.1. Aligns with all the Aims set out in the HSCP Strategic Plan, under the headings of Prevention, Resilience, Personalisation, Connections and Communities.

6. Management of Risk

6.1. Identified risks(s)

It is possible, though not very likely, that not having a service-specific performance framework could mean that regulatory or local determined performance standards/outcomes are not met. It is the case, as evidenced by the recent inspection report, that effective managerial oversight has mitigated the possibility of this and its likely negative impact. The implementation of a coherent performance framework that reflects the diversity and complexity of the service will be of additional significant value to that oversight at both a Service Manager and Lead for Social Work level.

In addition, not implementing a justice service-specific performance framework as required by an inspection report recommendation would very likely have a detrimental impact on the partnership's reputation and that of the service also with the Care Inspectorate. This is not very likely given the management of the service and the preparations that were put in place to ensure positive inspection outcomes.

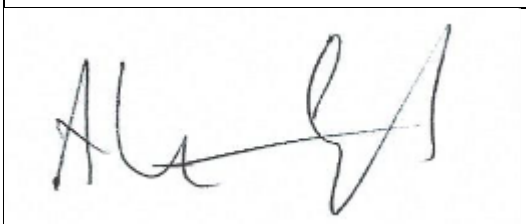
6.2. Link to risks on strategic or operational risk register:

5. There is a risk that the IJB, and the services that it directs and has operational oversight of, fail to meet both performance standards/outcomes

as set by regulatory bodies and those locally-determined performance standards as set by the board itself. This may result in harm or risk of harm to people.
6. There is a risk of reputational damage to the IJB and its partner organisations resulting from complexity of function, delegation and delivery of services across health and social care.

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

The oversight of the justice service that is undertaken by its PMB, chaired by the Lead for Social Work will ensure that this performance framework is implemented and that there is regular KPI reporting to the PMB as well as a submission to the RAP Committee of an annual report.

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

Justice Social Work Performance Management Framework

Justice social work delivers a range of statutory and non-statutory services to individuals in the justice system across the spectrum of risk and need. The justice social work service seeks to make Aberdeen a safer place in which to live, work and socialise by reducing offending, increasing the social inclusion of offenders and ex-offenders and enhancing public protection.

Our aim is to contribute to building safer, fairer, more inclusive communities based on equality, hope and compassion. The attainment of four key objectives will help achieve that aim:

1. **To contribute to the creation of safer and fairer communities**
2. **To fairly, effectively and proportionately implement court orders and release licences**
3. **To reduce offending by promoting desistance**
4. **To promote the social integration of people with convictions**

Strategic Connections

The Scottish Government's National Performance Framework outlines a vision for the national wellbeing covering a range of economic, health, social and environmental outcomes and objectives.

Justice social work is delegated by Aberdeen City Council to the Aberdeen Health and Social Care Partnership's (ACHSCP) Integration Joint Board (IJB) as set out by the Public Bodies (Joint Working) (Scotland) Act 2014. The partnership Strategic Plan 2019-22 sets out the priority objectives (Prevention; Resilience; Personalisation; Connections; Communities) for all of the delegated functions and services. In addition, the Scottish Government have outlined those national health and wellbeing outcomes which all partnerships must strive towards.

ACHSCP is a statutory member of the local community planning partnership, 'Community Planning Aberdeen'. The Community Empowerment (Scotland) Act 2015 sets out how public bodies should work together with their local communities to design and deliver better services. There is a strong alignment between the integration partnership's strategic plan and the community planning partnership's Local Outcome Improvement Plan 2016-26. This improvement plan outlines the "Prosperous People" stretch outcomes that will be sought to promote the safety and wellbeing of the local population and contribute to the city's overall prosperity.

AHSCP is also a statutory community justice partner and as such has a shared responsibility for the strategic planning and delivery of local community justice services. The new community justice model is underpinned by the Community Justice (Scotland) Act 2016 which sets out the

Outcomes, Performance and Improvement Framework as guidance to community justice partners on how to improve their local outcomes. Community Justice Scotland, the national corporate body has also produced a National Strategy for Community Justice designed to help community justice partners prioritise key areas, facilitate improvement and support communities to realise its vision of the country being safer, fairer and more inclusive.

Justice Social Work practice in Scotland is underpinned by National Outcomes and Standards (NOS) whose aim is to increase public awareness and understanding of the effectiveness of the interventions, many of them complex, that are undertaken.. The NOS defines outcomes, outlines consistent standards of practice and sets out principles of best practice in three key areas: public protection, justice and social inclusion.

Performance Framework

This framework, shown below, captures the scale and complexity of the justice service. It shows a coherent alignment between service outcomes and objectives, the Care Inspectorate's own outcomes, performance and improvement framework and those indicators which best demonstrate the efficiency and effectiveness of the service.
It is envisaged that the Performance Management Board will discuss performance trends against these indicators on a quarterly basis with an annual report being presented to the Risk, Audit and Performance committee.

The service knows and understands the clients with whom it works. It has been praised for the relationships that its practitioners develop and maintain and the progress made in respect of individual and statutory outcomes, no matter the complexity of need and the challenges that can arise from this. It is hoped that the implementation of this framework across the service will result in the discussion of quality, performance and improvement matters being even more embedded alongside a more coherent and co-ordinated overview of the informed insights that guide our practice and interventions.

Table 1.1 JSW Outcomes, Objectives and Indicators

Outcomes	Objectives	Themes	Outcomes, Performance and Improvement Framework Indicators	Service PIs	Reporting Frequency
Increased community safety and public protection. An efficient and effective justice social work service. Reduction in offending.	To contribute to the creation of safer and fairer communities	Collaboration with other Community Justice partners Community Empowerment Victim/Family/ Community Experiences and Opinions	2.2 Impact on victims 2.3 Impact on families 4.1 Impact on the Community 9.4 Leadership of improvement and change	• Number of CPOs	Quarterly
				• Number of individuals on CPOs	Quarterly
				• Number of Unpaid Work and Other Activity requirements	Quarterly
				• Number of UPW hours completed total	Annually
				• Number of individuals released on licence	Quarterly
				• Number of Significant Incident Reviews (SIRs)/Significant Case Reviews	Quarterly
				• Number of MAPPA clients (All Levels)	Annually
				• QA Reports/ Case files	Quarterly
	To fairly, effectively and proportionately implement court orders and release licences	Initial contact/ engagement with individuals. Timely, person-centred and effective interventions Where risk of serious harm is identified, there is evidence of use of multi-agency	5.1 Providing help and support when it is needed 5.2 Assessing and responding to risk and need 5.3 Planning and providing effective intervention	• Proportion of LSCMI assessments completed within 20 working days	Quarterly
				• Proportion of current Orders with a LSCMI-generated case management plan	Quarterly
				• Number of Caledonian assessments, requirements and non-Caledonian CPOs imposed for domestic abuse offences	Quarterly
				• Number of new CPO individuals seen within one working day	Quarterly
				• Number of first induction/case management meetings within 5 days	Quarterly
				• Number (%) of successful CPO completions	Quarterly

Outcomes	Objectives	Themes	Outcomes, Performance and Improvement Framework Indicators	Service PIs	Reporting Frequency
Increased social inclusion		risk management processes as appropriate Fulfilling statutory duties	5.4 Involving people who have committed offences and their families 6.1 Policies, procedures and legal measures 6.4 Performance management and quality assurance	• Number (%) of CPO breach applications	Quarterly
				• Number (%) of CPO breach outcomes	Annually
				• Number (%) of UPW orders which commenced within 7 days.	Quarterly
				• Number (%) of UPW requirements completed within specified timescales	Quarterly
				• Average time to complete UPW requirements	Quarterly
	To reduce offending by promoting desistance	Involvement of clients in service development/ improvement activities Building towards desistance	2.1 Impact on people who have committed offences	• Number of Supervision Exit Questionnaires (EQ) received	6 monthly
				• Comparison of 'before' and 'after' EQ scores	6 monthly
				• Number of UPW Exit Questionnaires received	6 monthly
				• Number of UPW hours undertaken on individual placements	Annually
				• Individual placement provider feedback	Annually
				• Number (%) of first reviews held within 3-month timescale	Quarterly
				• Number of re-engagement reviews held	Quarterly
				• Number of people on Diversion	Quarterly

Outcomes	Objectives	Themes	Outcomes, Performance and Improvement Framework Indicators	Service PIs	Reporting Frequency
	To promote the social inclusion of people with convictions	Complex, inter-dependent needs Alternatives to statutory orders	1.1 Improving the life chances and outcomes of people in the justice system	• Number of successful Diversion completions	Quarterly
				• Number of Fiscal Work Orders	Quarterly
				• Number of people on Bail Supervision	Quarterly
				• Number of successful Bail Supervision completions	Quarterly
				• Number of people on Problem-Solving	Quarterly
				• Number of successful Problem-Solving completions	Quarterly
				• Number of people on Structured Deferred Sentences	Quarterly
				• Number of people on successful Structured Deferred Sentences completions	Quarterly
				• Number of Women supported by the Women's Centre	Quarterly
				• Number of 16/17 year olds on CPOs	Quarterly
				• Number of referrals to Support Work team	Quarterly

Author: Kevin Toshney
Owner: Claire Wilson, Lead for Social Work
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Implementation: July 2021

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Aberdeen City Health & Social Care Partnership
A caring partnership

RISK, AUDIT AND PERFORMANCE COMMITTEE

Date of Meeting	22 June 2021
Report Title	Delivery of Leadership Team Objectives
Report Number	HSCP.21.072
Lead Officer	Alex Stephen, Deputy Chief Officer and Chief Finance Officer
Report Author Details	Name: Alison MacLeod Job Title: Lead Strategy and Performance Manager Email Address: alimacleod@aberdeencity.gov.uk
Consultation Checklist Completed	Yes
Appendices	A Leadership Team Objectives B Huddle Arrangements C Map of Performance Reporting

1. Purpose of the Report

1.1. The purpose of this report is to provide assurance to the Risk, Audit and Performance (RAP) Committee on the arrangements in hand to monitor and report on delivery of the 2021/22 Leadership Team Objectives.

2. Recommendations

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

a) Note the arrangements described in this report and the accompanying appendices for the delivery of the Leadership Team Objectives and monitoring progress.

b) Instructs the Deputy Chief Officer to submit progress reports to the 23 September 2021, 21 December 2021 and 1 March 2022 meetings of the RAP Committee.

RISK, AUDIT AND PERFORMANCE COMMITTEE

3. Summary of Key Information

3.1. On 23 March 2021 the Integration Joint Board (IJB) approved the Leadership Team Objectives for 2021/22. As outlined in Appendix A, 5 high level objectives were agreed: -

1. Staff Health and Wellbeing
2. Reshaping our relationship with our communities
3. Reshaping our commissioning approach
4. Whole system and connected remobilisation
5. Living and responding to Covid.

3.2. Each of the objectives has a range of projects associated with its delivery. These projects have been grouped into programmes and each has a lead officer from the Leadership Team allocated as being responsible for the delivery of it.

3.3. The programmes have been further grouped into three “huddles” entitled Right Way, Right Care and Right Place. Relevant lead officers from the Leadership Team form the membership of each huddle. The huddle has collective responsibility for delivery of all the programmes and projects within its remit. This collaborative approach was adopted during the delivery of Operation Home First and Operation Snowdrop during the response to Covid and it proved very successful. The approach has the benefit of bringing multiple perspectives to problem solving using a mixture of Action Learning Set (ALS) and Appreciative Inquiry (AI) methodology.

3.4. Programme and project management resource has been allocated from the Strategy and Transformation team to support delivery of the Leadership Team Objectives and a formal project management and Managing Successful Programmes (MSP) approach will be adopted. It should be noted that the team is currently undergoing organisational change and not all the resource is currently in post. Projects will be phased to accommodate delivery within the existing resource with a plan to scale up as vacant posts are filled.

3.5. The Project Managers (PMs) will lead project teams consisting of Business Change Managers from services and staff from enabling functions whose expertise will be vital for project success. PMs will develop project plans along with any necessary project documentation. They will also be responsible for ensuring the project makes appropriate progress within the required timescales, undertaking relevant reporting and communication, and escalating any risks or issues.

3.6. The Programme Managers will coordinate and oversee groups of programmes, ensuring benefits are delivered as expected, dealing with any risks or issues escalated, and managing any interdependencies between projects. The Programme Manager can also escalate risks and issues to the Leadership Team should they be unable to resolve these themselves.

3.7. The huddles will meet regularly at a frequency to be determined by each huddle themselves, but these meetings will be no less than weekly. Each of the huddles connects into the daily Leadership Team Huddle for situational awareness and further escalation/discussion of any wicked issues. Key decisions will be referred to the Executive Programme Board particularly should it be deemed necessary to request a decision of the Integration Joint Board.

3.8. The Leadership Team Objectives detail some key performance measure that will be used to measure success. Each project and programme will identify additional relevant performance measures. Collectively these will be brought together into a Performance Dashboard which will be reported on a regular basis to each huddle, to the Leadership Team Huddle, to the Executive Programme Board and to the Risk, Audit and Performance Committee.

3.9. Appendix B is an illustration of huddle make-up, remits, in terms of programmes and projects, and sample initial performance measures. The performance data will develop as the scope of the projects is explored and agreed. Some of the measures are already used within our Strategic Plan Dashboard, Operation Home First Evaluation Framework or as indicators for the Local Outcome Improvement Plan (LOIP) Stretch Outcomes. Appendix C shows how the Strategic Plan Key Performance Indicators map to these other reporting frameworks. It also lists the additional initial measures identified specifically for the Leadership Team Objectives.

4. Implications for RAP

4.1. **Equalities** - The Leadership Team Objectives were agreed as part of the Medium-Term Financial Framework, for which a full equalities and human rights impact assessment has been undertaken. The assessment, on the whole, was positive in relation to the impact on equality and diversity within Aberdeen, however any equality impacts of individual project work will be kept under review.

4.2. **Fairer Scotland Duty** - The Leadership Team Objectives were agreed as part of the Medium-Term Financial Framework, for which a full equalities and human rights impact assessment has been undertaken. The assessment, on the whole, was positive in relation to the impact on our Fairer Scotland Duty. The potential impacts of individual project work will be kept under review.

4.3. **Financial** – Delivering the Leadership Team Objectives is key to ensuring financial sustainability of the partnership. Existing resource from within existing budgets is being utilised.

4.4. **Workforce** - Resource to evaluate the impact of the Operation Home First programme has been identified and mobilised. Capacity was identified and mobilised to backfill the affected areas.

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

4.6. **Carers** – There are no implications for Unpaid Carers arising directly from the recommendations in this report.

4.7. **Covid-19** – Delivery of the Leadership Team Objectives will be undertaken with cognisance to the relevant guidance in relation to Covid-19. Most work continues to be carried out remotely and where it is necessary to get groups of staff together this is done in an environment where they can remain safely distant, wearing face masks, with good ventilation and access to hand washing or sanitising.

4.8. **Other** - none

5. Links to Aberdeen City Health & Social Care Partnership Strategic Plan

5.1. The Leadership Team Objectives contribute to the delivery of the Strategic Plan as follows:

Staff Health and Wellbeing – supports the enabler of Empowered Staff.
Reshaping our relationship with our communities – supports both the Prevention aim - promoting positive health and wellbeing, and the Resilience aim - promoting and supporting self-management and independent living for individuals.
Reshaping our commissioning approach – supports our enabler of Principled Commissioning.

Whole system and connected remobilisation – supports delivery of the Personalisation aim ensuring right care, right place, right time.
Living and responding to Covid – focuses on resilience in our communities particularly those communities that have been worse affected by Covid. It contributes to the Prevention aim - addressing the factors that cause inequality in outcomes in and across our communities.

6. Management of Risk

6.1. Identified risks(s) -

There is a risk, if the Leadership Team Objectives are not delivered as expected, that, not only will delivery of the Strategic Aims, Commitments and Priorities be negatively impacted but also that this will also impact on delivery of the Medium Term Financial Framework.

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

This report links to Risks 2, 5 and 7 on the Strategic Risk Register.

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

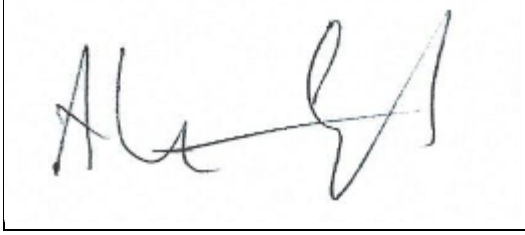
5. There is a risk that the IJB, and the services that it directs and has operational oversight of, fail to meet both performance standards/outcomes as set by regulatory bodies and those locally-determined performance standards as set by the board itself. This may result in harm or risk of harm to people.

7. Failure to deliver transformation at a pace or scale required by the demographic and financial pressures in the system.

RISK, AUDIT AND PERFORMANCE COMMITTEE

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

This report sets out the arrangements to ensure delivery of the Leadership Team Objectives which will be monitored in an open and transparent way with the opportunity for scrutiny by the RAP Committee who will be able to hold the Leadership Team to account.

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

Specific	Measurable	Attainable (Target)	Relevant	Key milestones/ workstreams	Timebound	Programme of Transformation
<u>Staff Health & Wellbeing</u> Staff Health and Wellbeing will be a priority and we will ensure a collaborative, compassionate and supportive approach to recovery. Staff will be given time, space and resources to recover from the pandemic and prepare for recovery and planning of next steps.	• Absence rates and cause. • Agency/Bank costs and hours • Locum costs and hours. • Overtime costs and Time in Lieu hours. • Proportion of Annual Leave taken throughout the year. • Staff Survey results, 360-degree feedback, and Staff Turnover rate • Training compliance rates • Psychological support uptake rates	£0.5 million locums	• Refresh workforce plan • Reduction (or as a minimum, maintenance) of absence rates to pre-2019/20 levels. • Reduction of Agency hours and costs across all ACHSCP from 2019/20 baseline. • Reduction in locum costs and hours across all ACHSCP from 2019/21 baseline. • Reduction in overtime and additional hours across ACHSCP from 2019/20. • Monitoring by all services to ensure staff have access to and take planned and contracted annual leave. • A supportive work environment evidenced through staff survey and 360-degree feedback to line manager. • Ensure access to training and education programmes monitor compliance rates via appropriate systems. • Ensure access to psychological support is well communicated, encouraged and supported through evidence at team meetings, shared information and monitoring of staff absence due to mental health/psychological reasons.	Dashboard produced for each LT member to reflect all key measurables. Process set up to review against measurable targets, incorporating detail and analysis of data – monthly at CCG Group\H&S Committee and quarterly at individual LT performance reviews.	Dashboard in place by 01.04.21 Measurable targets achieved by 31.03.22.	Conditions for Change\Demand Management

Reshaping our relationship with communities We will focus on an integrated approach to the way we think about physical, mental and social health, supporting individuals to manage and improve their health and wellbeing and building resilient networks to ensure that there is joint planning and co-ordination of critical elements that impact health e.g. education, food, housing and transportation We will embed our Operational teams who are aligned to locality areas and complete work to align those using the opportunity to redesign structure models to bring service delivery in line with available resource.	• Headcount v establishment • Travel costs • Space usage • Redesign of social work in line with locality working and system working across MHLD and Adults.	£2.466 million commissioning and reviews	• Redesign of Adult Social Work structure and pathways to reflect locality working and new pathways in place following commissioning changes. • Start to consider the implications of what new models of care and COVID have on the building used to deliver health and social care. • Monitor head count and whole time equivalent to determine the impact of 2019/20 and ensure that we maintain the 60 wte reduction in posts achieved through vacancy management in 2019/20. • Monitor, review and maintain reduction in travel costs compared to 2019/20 Costs. • A review of models of work regarding in office, at home, co-location and shared space to be undertaken by each LT member to identify current and future requirements and feed into review of the Capital Programme. • Develop plans for further community team digitisation and digital health and social care solutions.	Embed locality working across Nursing, AHP, ASW and Community Mental Health operational services. Undertake a review of referral pathways for Nursing, AHP and ASW and community Mental Health including consideration of a Single Access Point	Locality working in place by 30.09.21. Review complete by 31.03.22.	Conditions for Change

			• Identify where Lean Six Sigma could improve efficiencies across the system. • • Start to consider what the future of rehabilitation services might look like in Aberdeen.			
Reshaping our commissioning approach Commissioned services will be reviewed across ACHSCP to ensure that the model of delivery is in-line with our strategic commissioning plan and strategic aims of the IJB.	• Older people's residential bed availability and usage • MH residential bed availability and usage • LD residential bed availability and usage • C@H capacity and usage • Day Opportunities available and used. • Planned Respite available and used. • Number of Carers Supported • Carer and Service User satisfaction rates		• Contribute to the review of the national care home contract. • Review LD and MH commissioning arrangements using demand management methodology. • Further embed the new approach to care at home • Monitor and review monthly capacity and occupancy in care homes to determine if shift in market position from 2019/20 pandemic. • Review of grant funded organisations	Re-tender Day Opportunities and Planned Respite following review. Launch Market Position Statement Evidence of shift in community support from bed-based provision.	30.04.21 30.06.21 31.03.22	Demand Management

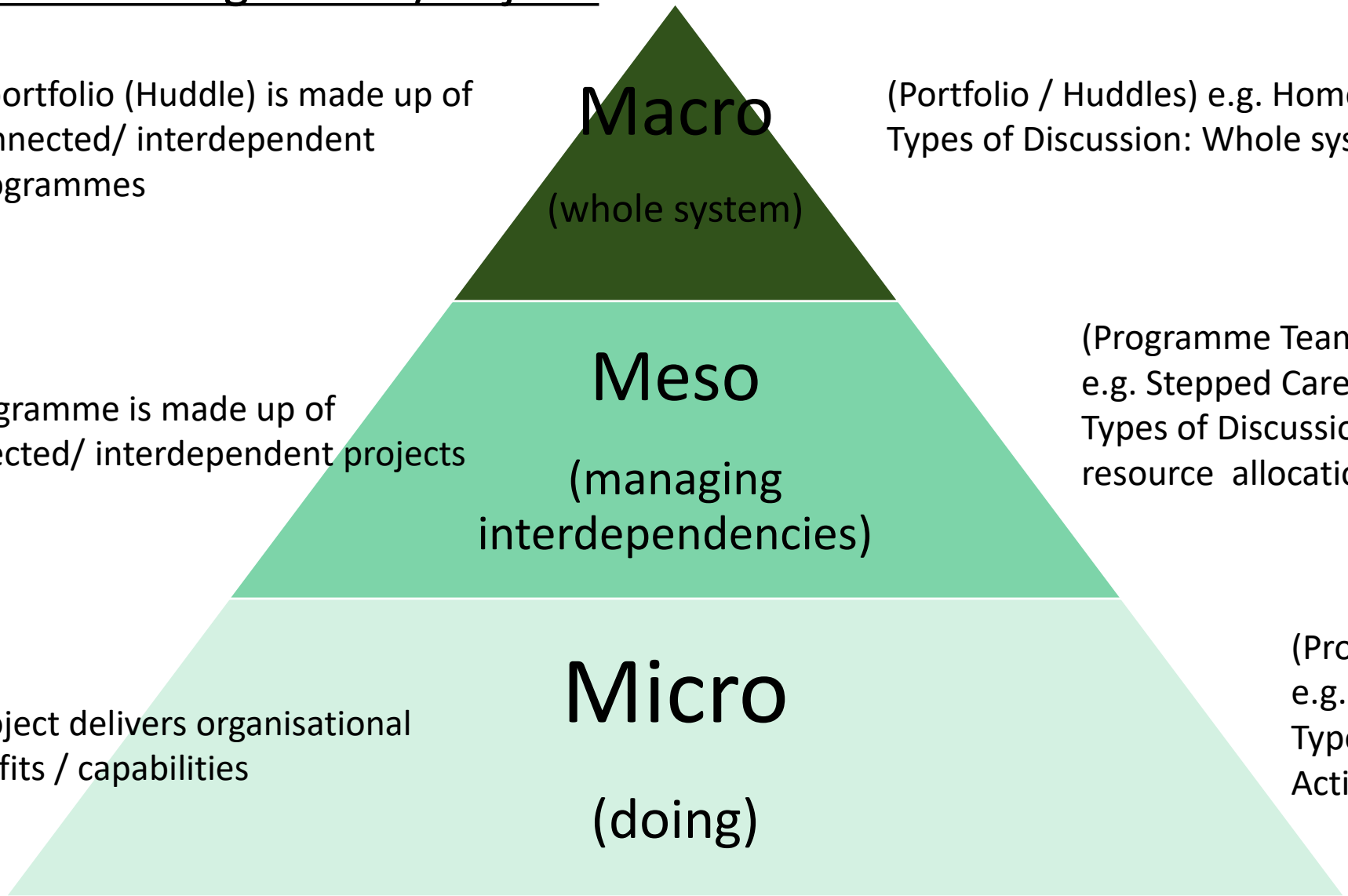
<u>Whole system and connected remobilisation</u> Remobilisation will be undertaken through a planned and measured approach to create stability and resilience across our health and care services and enable us to meet population needs and maximise the learning and changes we have implemented during the global pandemic response. We will undertake a redesign of 2c practices to deliver a sustainable service based on patient profile, population needs assessment and available resource will be completed. If redesign is not achievable within resource, then a merge of practices to match resources will be undertaken. We will continue to review our Primary Care delivery, modernising and improving outcomes where possible. .	• Number of GP practices in City • Practices stability rating (% at Green) • % services remobilised. • Immunisation figures increased across all age groups.	Redesign or merging of practices will bring £0.250m savings in the financial year 2022/23.	• Programme of delivery to be identified to achieve redesign/merge. • Model to have CTAC hubs which are based on population needs assessments for MDT • Primary, secondary and community care interface group to be established to share practice, innovation and build resilience across the city. • Planned programme for vaccinations delivered making maximum effectiveness and efficiency of resources. • Seek solutions to reduce health debt as a result of COVID. • Embed Frailty Pathway changes were working well and appropriate to do so	Implementation of phase 1 redesign complete Implementation of full blueprint complete Progress on our Primary Care Improvement Plan Design and implementation of immunisation delivery programme across ACHSCP	31.07.21 31.03.22 31.07.21 31.10.21	Accessible and responsive infrastructure

<u>Living and responding to COVID</u> Community resilience will be key and together with our partners we will be focused on supporting the recovery of those communities most impacted by COVID and making wider communities more resilient and better placed to cope as we learn to rebuild and renew our health services, our communities, education and economy. Improved sustainability of commissioned services across Aberdeen City to reduce impact on secondary and primary care and deliver better outcomes for people. Consider the impact of long Covid on our health and social care system	• Unplanned Admissions • A&E attendances • Delayed Discharges • No of prescribing items in care homes • Medication errors in care homes • No. of care home residents dying in hospital. • No. of GP call outs to care homes. •		• Near me and digital support to be introduced across Aberdeen City care homes. • E-Mar to be installed across all Aberdeen City care homes. • Care Home support team will be in place to work with providers to develop quality, efficiency and digital services. • Care home providers will continue to report into TURAS as standard operational practice. • Care Home oversight teams to operate within localities with triangulation of intelligence from HSCP/Public Health/Care Inspectorate to ensure early identification of risk and confirmation of action plans. • Care at home oversight team to operate as above within localities. • Wraparound MDTs for care home to be operational for all care homes with agreed expectations and ability to in reach specialist support when required. • Refresh the Primary Care Improvement Plan • Position to be agreed between GP practices and care homes as	E-Mar to be installed across all Aberdeen City care homes. Task and finish group to commence scoping work and secure funding by 1st April 2021. Resource to be secured through legacy/grant applications. Care Home support group to be maintained. Embed Covid Vaccinations into routine immunisation programme.	31.08.21 30.04.21 31.08.21	Digital & Data

			to shared understanding of support provided during a Covid outbreak or similar, with virtual ward rounds fully implemented during outbreak. • Once Covid has stabilised promote tests of change in relation to medication errors – see Report on the Medicines Improvement Project: Care Inspectorate: October 2020. • Consider the models of care required to support people with long Covid. • Work across the health and social care system to support the remobilisation, particularly in regard to any increased requirements for mental health services and support.			

Huddles & Programmes/Projects

A portfolio (Huddle) is made up of connected/ interdependent programmes



(Portfolio / Huddles) e.g. Home First
Types of Discussion: Whole system risks & barriers

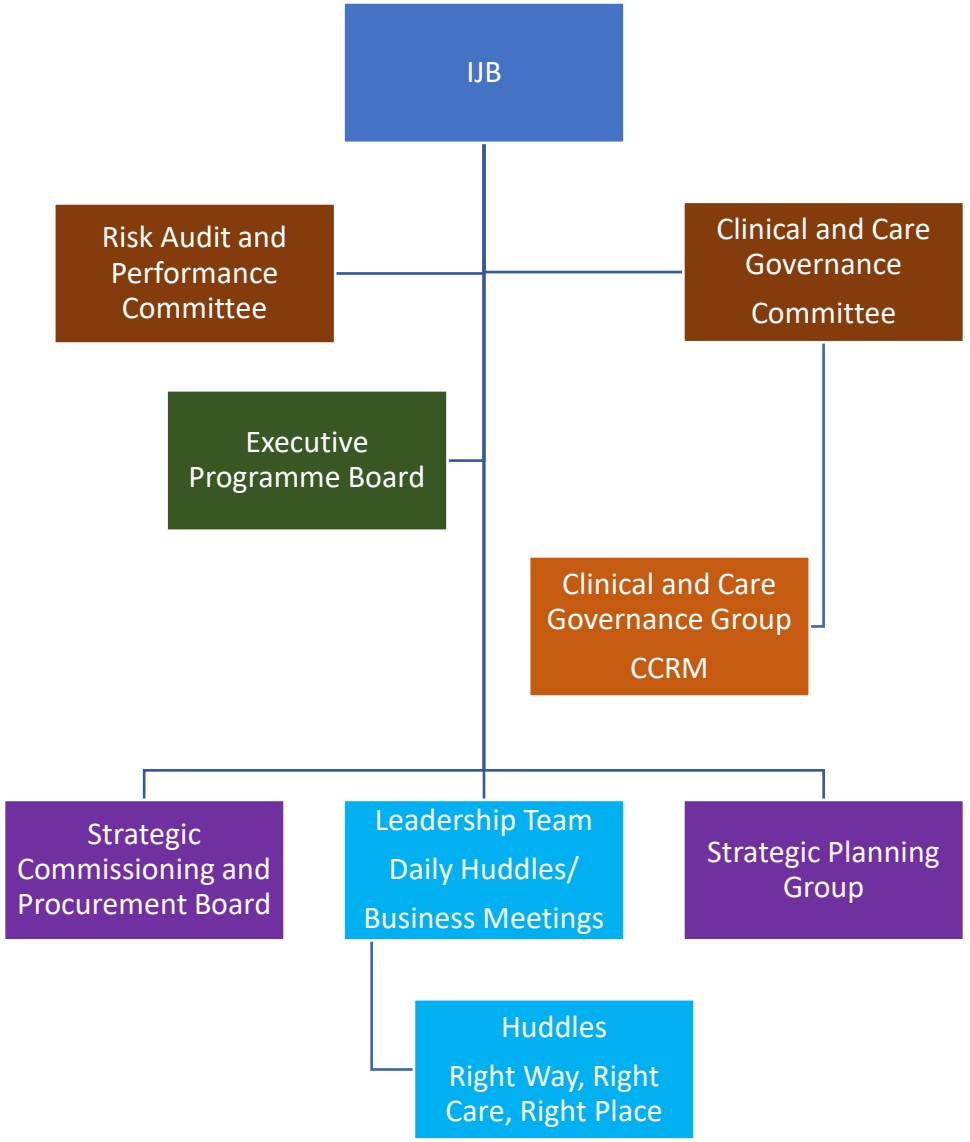
A programme is made up of connected/ interdependent projects

(Programme Teams)
e.g. Stepped Care, Stay Well Stay Connected,
Types of Discussion: Cross cutting themes / resource allocation

A project delivers organisational benefits / capabilities

(Project Teams)
e.g. Hospital at Home
Types of Discussion:
Actions, risks, implementation

ACHSCP Governance



Huddle Rules

- Focus on delivery of LT Objectives
- Whole system risks/barriers – ALS or AI approach
- Meeting frequency to be agreed/flexible as required but suggest meetings should be at least weekly and for an hour or less duration
- Membership - LT members, but can invite guests to present reports or to aid discussion/solution
- Consider work in “legacy” huddles – is this at the stage of being incorporated into Business as Usual? Can ongoing projects be integrated into the new Huddle remit?

Approaches

Action Learning Set

Appreciative Inquiry

Right Way

Staff Wellbeing

Support for Staff

Working Conditions

Embed Locality Working

Redesign of ASW

Digital

Digitisation

Pathways and Redesign

Care Home Reporting

Care Home Support

Capacity/Occupancy in Care Homes
Review Referral Pathways

Rehab Pathway

2C Redesign

Data & Evaluation

Dashboard Production

Measure Progress

Right Care

Workforce

Workforce Plan

Training and Education

General Practice

Agree GP Input to Care Homes

NHS Triage Model for GPs

Quality Improvement

Identify LSS Projects

Quality in Care Homes

Reduce Medication Errors

Interface Group

Models of Care for Long Covid

Reduce Health Debt

Immunisations

Immunisation Blueprint

Covid Vaccinations

Right Place

Recover from Covid

Review Models of Work

Reduction in Travel Costs

Rationalise Space Usage

Reduction in Headcount

Support Remobilisation

Commissioning

Review NCHC

MHLD Commissioning

C@H Oversight within Localities

Review Grant Funded Orgs

Stay Well Stay Connected

Market Position Statement

Primary Care

Refresh Primary Care Improvement Plan

Deliver Community Treatment &
Assessment Centres

Urgent Care

Embed Frailty Pathway

Redesign of Urgent Care

Performance Measures

Right Way

- Absence Rates
- % Annual Leave Taken
- Uptake of support
- iMatter Results
- Staff Turnover
- Vacancy Factor
- Agency costs
- Locum Costs
- Overtime Costs
- Digital Innovations Implemented
- Efficiencies from digitisation
- Use of Near Me/eConsult
- Compliance with Care Home Reporting
- Care Home Occupancy
- Covid Cases in Care Homes
- Care Home Residents Dying in Hospital
- Models of Care for Long Covid Developed

Right Care

- Training Uptake
- Production of Workforce Plan
- GP Support to Care Homes Agreed
- No. of GP Call Outs to Care Homes
- No. Items Prescribed in Care Homes
- Medication Errors in Care Homes
- LSS Projects Delivered
- Immunisation Statistics

Right Place

- Headcount
- Numbers WFH v in Office
- Travel costs
- Services Remobilised
- Space Usage Progress on Commissioning
- Tenders Awarded
- MPS Published
- PCIP Refreshed
- No. GP Practices
- GP Stability Rating
- CTACs delivered
- Frailty Pathway Closeout Report
- ED Attendances
- 4 hour Target Compliance
- Unplanned Admissions
- Delayed Discharges

Huddles

Programmes

Programme Managers

Projects

Project Leads

(Leadership Team

Key Support

(Project Management)

<u>Project Teams</u>

Business Change Managers (services)

Enablers (HR, Finance, Data, Infrastructure, Digital, Commissioning, Partners)

<u>Performance</u>

Dashboard/Key Measures

Programme Sit Rep

Project Flash Report

Individual Quarterly Performance

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Strategic Aim	Current Strategic Plan Indicators	OHF	Leadership Team Objectives/ Huddle Indicators	LOIP Stretch Outcomes
Prevention	ED Attendances	✓	✓	
Prevention	No of Alcohol Related Admissions		✓	
Prevention	Smoking Cessassion			✓
Prevention	Deaths related to cirulatory system issues			
Prevention	Life Expectancy SIMD Female			✓
Prevention	Life Expectancy SIMD Male			✓
Prevention	Child Dental Health P1			✓
Prevention	Child Dental Health P7			✓
Prevention	Coronary Heart Disease Hospitalisations			
Prevention	Alcohol Specific Deaths		✓	✓
Prevention	Cancer Related Deaths		✓	
Prevention	Drug Related Admissions		✓	
Prevention	Drug Related Deaths		✓	✓
Prevention	Immunisations 6in1 (12MONTHS)		✓	
Prevention	Immunisation MenB (12 MONTHS)		✓	
Prevention	Immunisations PCV (12MONTHS)		✓	
Prevention	Immunisations Rotavirus (12months)		✓	
Prevention	Immunisations Hib/Men C (24MONTHS)		✓	
Prevention	Immunisation MenB Booster (24 MONTHS)		✓	
Prevention	Immunisations mmr 1 (24 MONTHS)		✓	
Prevention	Immunisations PCVB (24 months)		✓	
Prevention	Immunisations Uptake S3 HPV		✓	
Prevention	Head and Neck Cancer Incidents			
Prevention	New Cancer Registrations			
Prevention	Breastfed babies at 6-8 weeks exclusively			✓
Prevention	% Men and Women who are obese			✓
Prevention	Self Reporting Smoking Prevalance 16+			✓
Prevention	Type 2 Diabetes Prevalance			✓
Resilience	Emergency Admissions	✓		

Strategic Aim	Current Strategic Plan Indicators	OHF	Leadership Team Objectives/ Huddle Indicators	LOIP Stretch Outcomes
Resilience	Falls rate per 1000 65+			
Resilience	% Adults able to look after their health very well or quite well			
Resilience	% People supported at home who agreed they are supported to live as independantly as possible			
Resilience	% New Dementia diagnosis who receive post diagnostic support			
Resilience	% Adults receiving Intensive Care needs receiving care at home.			
Resilience	Premature Mortality Rate			✓
Resilience	% Carers who feel supported to carry out their Caring Role			
Resilience	Average hours per month receiving Double Up Care	✓	✓	
Resilience	Number of people using Telecare/Community Alarm Services	✓	✓	
Resilience	Numbers of Unpaid Carers Supported			
Personalisation	% Adults supported at home who agree their services and support has impacted on improving or maintaining their quality of life			
Personalisation	% people with a positive experience of the care provided by their GP Practice			
Personalisation	% of Population 75+ Living in a community setting			
Personalisation	Proportion of last 6 months of life spent at home or in a community setting			
Personalisation	Total number of delays in a month	✓	✓	
Personalisation	Number of new referrals to initial investigation under Adult Support and Protection		✓	
Personalisation	Number of SDS Options Assessments Completed			
Personalisation	Offender Reconviction rate			✓

Strategic Aim	Current Strategic Plan Indicators	OHF	Leadership Team Objectives/ Huddle Indicators	LOIP Stretch Outcomes
Connections	Level of Social Isolation Reported			
Connections	Number of Clients Supported by Community Links Workers			
Communities	Average number of Residential Placements	✓	✓	
Communities	Home Care Hours Delivered	✓	✓	
Communities	NI 10 - Increase in the % of staff who would recommend their work			
Communities	Number of Adult Social Care Complaints			
Communities	Social Care Unmet Need	✓	✓	
Communities	Staff Turnover Rate		✓	
Communities	Total FTE Vacant		✓	
Communities	% adults supported at home who agree that their health and social care seemed well coordinated.			
Communities	Proportion of Care Inspectorate Gradings Good or better on care settings		✓	
Communities	Total % of adults receiving any care or support who rated it as excellent or good			

Huddle	Leadership Team Objectives/ Huddle Indicators	OHF	Leadership Team Objectives/ Huddle Indicators	LOIP Stretch Outcomes
Right Way	Absence Rates		✓	
Right Way	% Annual Leave Taken		✓	
Right Way	Uptake of support		✓	
Right Way	iMatter Results		✓	
Right Way	Staff Turnover		✓	
Right Way	Vacancy Factor		✓	
Right Way	Agency costs		✓	
Right Way	Locum Costs		✓	
Right Way	Overtime Costs		✓	
Right Way	Use of Near Me/eConsult		✓	
Right Way	Compliance with Care Home Reporting		✓	
Right Way	Care Home Occupancy		✓	
Right Way	Covid Cases in Care Homes		✓	
Right Way	Care Home Residents Dying in Hospital		✓	
Right Care	Training Uptake		✓	
Right Care	No. of GP Call Outs to Care Homes		✓	
Right Care	No. Items Prescribed in Care Homes		✓	
Right Care	Medication Errors in Care Homes		✓	
Right Care	LSS Projects Delivered		✓	
Right Place	Numbers WFH v in Office		✓	
Right Place	Travel costs		✓	
Right Place	Services Remobilised		✓	
Right Place	Space Usage		✓	
Right Place	Tenders Awarded		✓	
Right Place	No. GP Practices		✓	
Right Place	GP Stability Rating		✓	
Right Place	4 hour Target Compliance		✓	
Right Place	Unplanned Admissions		✓	
Right Place	Delayed Discharges		✓	

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RISK, AUDIT AND PERFORMANCE COMMITTEE

Date of Meeting	22 June 2021
Report Title	Contract Register / Commissioning annual review
Report Number	HSCP.21.073
Lead Officer	Sandra MacLeod, Chief Officer
Report Author Details	Name: Anne McKenzie Job Title: Lead Commissioner (Interim) Email Address: anne.mckenzie@nhs.scot
Consultation Checklist Completed	Yes
Appendices	None

1. Purpose of the Report

1.1. This report provides Risk, Audit and Performance Committee (RAPC) with a review of the contracts register / commissioning activity for 2020/21 within the Aberdeen City Health and Social Care Partnership (ACHSCP).

2. Recommendations

2.1. It is recommended that the Risk, Audit and Performance Committee (RAPC):

a) Note the content of the report.

3. Summary of Key Information

3.1. The 2020/21 annual procurement plan was approved by the ACHSCP Integration Joint Board (IJB) on 19 November 2019. The following narrative offers an update against the relevant commissioning and procurement activity which has taken place and which is planned for the remainder of the year. The 2021/22 procurement plan was approved by IJB at their meeting on 23 February 2021.

3.2. In May 2020, a complex care flexible framework commissioned jointly between Aberdeen City Council and Aberdeenshire Council was created,

working with providers to source both suitable accommodation and a suitably qualified workforce to provide the necessary care for people with complex needs.

3.3. In November 2020, the provision of Care at Home was successfully retendered and since that time, there has been a close collaboration between provider and partnership teams to ensure that the ambitions of the commission are being realised. There is significant pressure on the provision of Care at Home due to the consequence of COVID 19 and both parties continue to work to ensure that people's outcomes are being met, whilst at the same time maximising available capacity. At the same time, the future arrangements for the delivery of supported living services were secured for all client groups (rather than the previous arrangement where supported living was provided purely for people with a learning disability).

3.4. The redesign of Day Care and Day Opportunities (now Stay Well, Stay Connected) continues at pace with the procurement of sufficient capacity to provide very necessary residential respite under way and the opening up of buildings based day services. The strategic approach, and redesign were outlined for all in the market position statement which can be found at the following link:

https://www.aberdeencityhscp.scot/our-news/our-achscp-market-position-statement/

3.5. The procurement of a dual sensory service for people living within Aberdeen City suffering from auditory and visual impairment is underway, with contract implementation date due in September 2021.

3.6. A review of the requirements for residential services for both Mental Health services and Learning Disability services will commence within June 2021.

3.7. The provision of services for people living with dementia, provided by Alzheimer Scotland are being reviewed in collaboration with the provider.

3.8. The provision of counselling services funded in part by grant contributions from ACHSCP will be reviewed by March 2022.

3.9. The Strategic Commissioning and Procurement Board has reviewed its terms of reference and membership, which includes representation from Third and Independent sector providers, staff side and ACHSCP teams. The Board remains committed to oversee the implementation of the commissioning plan

and provides governance arrangements for the commissioning and procurement function within ACHSCP.

3.10. The Board members have committed to creating a workplan that provides a collective oversight of commissioning and procurement activity, taking account of the annual procurement plan (and therefore important procurement timelines), ACHSCP Leadership team objectives, grant funded services and market engagement activity (including the development of a market position statement and commissioning plan linked to the revised strategic plan). It is anticipated that this workplan will be finalised by the end of June.

3.11. Prioritisation of future commissioning work will be driven by several different factors which include:

- Contract end date
- Strategic priorities / strategic plan
- Leadership team objectives

The overall objective of working in this way is to ensure that work is planned, support to complete the work is accessed, and that there are no requests to extend contracts because there has been insufficient time to conduct a review and procure accordingly. This is a busy year and to date, we do not anticipate any such requests.

3.12. COVID 19 and the impact that the pandemic has had on social care providers has necessitated much closer engagement and a shared understanding of the associated risks. Over the past year, provider “huddles” for both providers of both residential and non-residential care were created and continue a weekly basis. These huddles have offered an opportunity for joint working, shared appreciation of risk, peer support and shared problem solving.

3.13. In addition to the huddles, there has been a requirement for assurance processes associated with COVID 19. There is now a care home assurance process with weekly submissions made to both the Grampian Oversight group and Scottish Government. Aberdeen City Council has also created an assurance process for the non-residential sector.

3.14. As we prepare for our revised Strategic Plan, and associated commissioning plan and market position statement, we have recognised that we now need to make provision for strategic and planning conversations with providers of Social Care. This forum will be of even greater importance as the

recommendations for the review of adult social care progress towards the formation of a National Care Service.

4. Implications for IJB

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

4.2. Fairer Scotland Duty – There are no implications from this report.

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

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

4.5. Legal–There are no direct legal implication arising from the recommendations from this report

5. Links to ACHSCP Strategic Plan

5.1. The commissioning principles adopted are clearly stated within our strategic plan.

6. Management of Risk

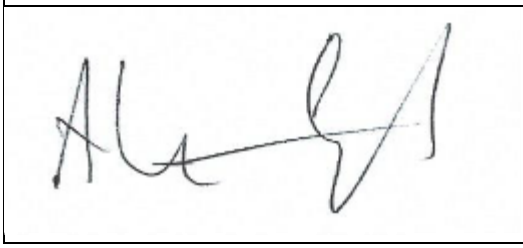
6.1. **Identified risks(s)** – There are no direct risks associated with this report.

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

The work of the procurement and commissioning team links to the Strategic Risk Register, specifically:
Risk 2 – Financial - There is a risk of financial failure, that demand outstrips budget and Integrated Joint Board cannot deliver on priorities, statutory work, and project an overspend.
Risk 1 - Market Stability - 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.

RISK, AUDIT AND PERFORMANCE COMMITTEE

6.3. How might the content of this report impact or mitigate these risks:
The Strategic Commissioning and Procurement Board forms part of the ACHSCP governance processes and takes into consideration both financial and market stability information as services are commissioned and procured. The annual procurement plan sets out the anticipated financial spend on commissioned services for the forthcoming year.

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

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Aberdeen City Health & Social Care Partnership
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RISK, AUDIT AND PERFORMANCE COMMITTEE

Date of Meeting	22.06.21
Report Title	Strategic Risk Register
Report Number	HSCP. 21.074
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. Strategic Risk Register

1. Purpose of the Report

1.1. To present the Risk, Audit and Performance Committee (RAPC) with the latest version of the Aberdeen City Health & Social Care Partnership's (ACHSCP) Strategic Risk Register.

2. Recommendations

2.1. It is recommended that the RAPC note the revised Strategic Risk Register at Appendix A.

3. Summary of Key Information

Updates on Strategic Risk Register

3.1. Since the Strategic Risk Register was last considered by the Committee in January 2021, the following major changes have been made: the risk on Exiting the EU has been removed from the Register (as agreed by the Integrated Joint Board (IJB) at its meeting on the 25 May 2021); and a new strategic risk has been added to the Register to reflect the inclusion of Integrated joint Boards as Category 1 Responders under the Civil Contingencies Act, 2004 (again agreed at the IJB in May 2021).

3.2. The IJB at its meeting in May 2021 also asked that the strategic risks be reviewed and edited to make the risks as up-to-date as possible ahead of the planned IJB workshop to be held in October 2021. At this workshop Members of the Board will review both the Board's Risk Appetite Statement as well as the strategic risks. The editing of the risks will be undertaken over the summer period, ahead of the workshop.

3.3. The IJB on 25 May 2021, when discussing Risk 2 (Finances), agreed to review this risk (specifically the risk rating). It was agreed appropriate to review the rating after the financial monitoring report for Quarter 1 of 2021/22 has been published.

3.4. At an IJB workshop in October 2020, Members discussed the strategic risks in detail and considered that there was a risk in relation to the financial oversight of Hosted Services and that performance across the services was mixed. It was suggested that the impact for this risk should be moved from moderate to major and that this should be discussed further at RAPC.

3.5. At RAPC on 21 January 2021 it was agreed that the "deep dive" on this specific risk be brought back to the committee once work had concluded on an audit being undertaken by NHS Grampian on hosted services. Further consideration between the Chair of Committee and officers determined that further work be undertaken to look at both the services hosted by the City IJB, as well as those services being hosted by Aberdeenshire and Moray IJBs. Included in this review will be an examination of control measures and mitigating actions in place in relation to hosted services to help provide assurance to the IJB.

3.6. RAPC on the 27 April 2021 considered a proposal that the outcome of this review (including a sense check against the outcomes of the NHS Grampian Audit) be reported to the Committee on 23 September 2021. The IJB at its meeting on 25 May 2021 noted the timeline for this review.

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 considered when implementing certain mitigations.

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

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

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

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

4.6. **Covid-19** – The risk register references the Partnership's involvement in various work and mitigations undertaken in the last 15 months relating to the COVID-19 pandemic.

4.7. **Unpaid Carers** – There are no implications relating to unpaid carers in this report

4.8. **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.

7. **Approvals**	
Sandra Macleod	Sandra Macleod (Chief Officer)
	Alex Stephen (Chief Finance Officer)

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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 (RAPC)
11	July 2020 (IJB)
12	October 2020 (IJB Workshop)
13	November 2020 (IJB)
14	January 2021 (RAPC)
15	May 2021 (IJB)
16	June 2021 (RAPC)

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	Risk of non-compliance with Aberdeen City IJB's responsibilities as a Category 1 Responder under the Civil Contingencies Act, 2004.	**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 1.06.21

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. Scottish Government via Chief Dental Officer has highlighted an increased risk of reduction in General Dental Practitioners capacity as a result of patient deregistration activity seen in some regions

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 • Director of Dentistry co-ordinating Grampian contingency planning to • • horizon scan for regional deregistration activity • • proactively work with practices that wish to deregister patients • • plan suitable contingency arrangements in the event patients are deregister • 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 • Public Dental Services staffing capacity to increase service provision in short term
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	**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.

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. • 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. • Public Dental Service (PDS) plan to maintain unscheduled care support for unregistered dental patients (usually undertaken by GDP contractors) • PDS developing plan to expand the above capacity should the number of unregistered / de-registered patients increase, including costings and need to recruit additional clinical staff • PDS working with DoD and PCCT to identify potential 'early-warning' signs and trigger events for patient deregistration	• Continuing to progress the tender for Care at Home and Supported Living

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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 1.6.2021

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.
- 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.

• Medium Term Financial Strategy review planned for 2021.	
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 1.06.2021

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 1.06.2021

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.

<table>
<tr><th colspan="7">- 5 -</th></tr>
<tr><td colspan="7">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.</td></tr>
<tr><td colspan="3">Strategic Priority: Prevention, Resilience, Personalisation, Connections and Communities.</td><td colspan="4">Leadership Team Owner: Lead Strategy & Performance Manager</td></tr>
<tr><td colspan="3">Risk Rating: low/medium/high/very high
MEDIUM</td><td colspan="4" rowspan="7">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.</td></tr>
<tr><td colspan="3">IMPACT</td></tr>
<tr><td>Almost Certain</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Likely</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Possible</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Unlikely</td><td></td><td></td><td></td><td>✓</td><td></td></tr>
<tr><td>Rare</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>LIKELIHOOD</td><td>Negligible</td><td>Minor</td><td>Moderate</td><td>Major</td><td>Extreme</td></tr>
<tr><td colspan="3">Risk Movement: (increase/decrease/no change)
NO CHANGE 1.06.2021</td></tr>
<tr><td colspan="3">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 Performance 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</td><td colspan="4">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</td></tr>
<tr><td colspan="3">Assurances:
Joint meeting of IJB Chief Officer with two Partner Body Chief Executives.</td><td colspan="4">Gaps in assurance:</td></tr>
</table>

• 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. Going forward the focus will be on delivering the Leadership Team objectives (agreed every year and linked to delivery of the Strategic Plan). One aspect of the objectives for 2021/22 is the development of dashboards for use as a tool to drive improvement performance. • Both the LOIP and the Strategic Plan are due to be refreshed during 2021. It is likely the current set of key indicators will change. Performance indicators will be considered at the same time as we set new aims and objectives based on the learning over the last couple of years. • 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 weekly meetings are now scheduled and taking place. • Various Steering Groups for strategy implementation established, although meetings were paused during the response to Covid we are beginning to pick this work back up again. • Close links with social care commissioning, procurement and contracts team have been established • IJB Dashboard has been shared widely.	**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.

Aberdeen City Health & Social Care Partnership
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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 1.06.2021

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 1.06.2021

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 although the latter are not currently all meeting due to Covid-19.

Mitigating Actions:

- Programme management approach being taken across whole of the transformation programme
- Transformation team 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 creation of huddle delivery models. Huddle delivery models will continue beyond Covid.
- 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, all of these are being revised in light of Covid and future priorities.
- 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 early cashable savings. • 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 as Action 15 and PCIP has slowed at the current time, although some aspects of these pieces of work have progressed • The agreed Leadership Team objectives are placing a renewed focus on how we structure our resources • Accelerated delivery of Vaccination program.	**Comments:** Further re-prioritisation has taken place due to staff changes. Transformation Team have temporarily merged with Strategy and Performance Team due to secondment of Lead Transformation Manager. Work on a merged structure is almost finalised. The new structure provides additional capacity and recruitment to these posts is due to begin imminently.

Aberdeen City Health & Social Care Partnership
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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 1.06.2021

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:

- Locality Empowerment Groups
- Leadership Team Huddle
- Community Planning Aberdeen
- Aberdeen Together
- CPP Community Engagement Group

Mitigating Actions:

- In December 2020 both the IJB and the CPA approved the implementation of a more integrated approach to locality planning which combines the focus of ACHSCP and Community Planning. The approach is 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.

Assurances:

- Strategic Planning Group (LEGs have representation on this group)
- Executive Programme Board
- IJB/Risk, Audit and Performance Committee
- CPA Board

Gaps in assurance

- Progress of developing and delivering locality plans. These will be developed by the Locality Empowerment Groups utilising the new integrated arrangements. The LOIP is due to be refreshed by June 2021 and the Strategic Plan by March 2022. Identifying the priorities for each locality will inform the Locality Plans and ultimately the LOIP and the Strategic Plan.

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 but has nonetheless been successful despite these circumstances with almost 180 people expressing an interest to be involved.
- 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

Comments:

All three Locality Plans and now well developed and will be submitted to the CPA Board at the end of June and the IJB in July.

A number of projects continue to be developed to enhanced operational locality working. These include: the development of multi-disciplinary teams (e.g. hospital at home and enhanced community support); further development of the Neighbourhood Lead model; and the Operationalisation of 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 1.06.2021

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
- Some expectations that 'system' will revert to 'normal ' post covid .
- Exhausted work force with little appetite for further change .

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.

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Description of Risk: Risk of non-compliance with Aberdeen City IJB's responsibilities as a Category 1 Responder under the Civil Contingencies Act, 2004.

Strategic Priority: Resilience and Connections.

Leadership Team Owner: Chief Officer

Risk Rating: low/medium/high/very high

HIGH

IMPACT

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

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

NO CHANGE 1.06.2021

Rationale for Risk Rating:

- Considered high risk due to the potential major impact to citizens if the IJB does not manage its responsibilities under the Act.

Rationale for Risk Appetite:

- There is a zero tolerance in relation to not meeting legal and statutory requirements.

Controls:

- Grampian Local Resilience Partnership Membership
- Aberdeen City Care For People Plan
- Aberdeen City Council's Organisational Resilience Group Membership
- NHS Grampian's Civil Contingencies Group Membership
- Aberdeen City Health and Social Care Partnership's Civil Contingencies Group (integrated Group to monitor Action Plan of Duties under the Act).
- Aberdeen City Care For People Group
- Integration scheme agreement on cross-reporting
- Partnership's overarching Business Continuity Plan
- Business Manager has access to Resilience Direct
- Senior Manager On Call Teams site

Mitigating Actions:

- The Grampian Local Resilience Partnership (GLRP) identifies risks which are likely to manifest. The Partnership require to have controls in place to manage these risks, particularly the ability to respond to these in an emergency situation.
- Aberdeen City Council are currently reviewing the risks in the City within its risk registers to ensure that the control actions listed are sufficient to mitigate risks. During this process, the additional risks may well be identified, based on risk assessment within operational areas, which may impact on the ability to respond. The result will be a risk register incorporating all risks relating to organisational resilience for the City. The Organisational Resilience Group will be responsible for managing these risks through its membership and liaison with other services not represented on the Group.
- Senior Manager On Call governance documents and arrangements within the Aberdeen City Health and Social Care Partnership (stored on Teams and hard copy), and links into the equivalent structures in ACC and NHSG.
- The Partnership's Civil Contingencies Group has a requirement to monitor Business Continuity Plans across the Partnership, including an overarching Partnership Business Continuity Plan (BCP).
- The Partnership's Communications Manager is available to issue media releases and to answer any media enquiries relating to ACHSCP services which would be or could be

	impacted in an emergency, in close consultation with ACHSCP Leadership Team members. Proactive dissemination of important information would be via releases emailed directly to the local and national media. The ACHSCP websites, both internal and external, would also carry that information as soon as it becomes available, along with the Partnership's social media channels, in order to inform the public and our staff in a timely manner of important developments and updates. ACHSCP would also contribute to public information being released by our partner organisations, where appropriate. ACHSCP Communications would liaise throughout the emergency with our public sector partners, including the police, fire and rescue, neighbouring local authorities, the Scottish Government and other partner organisations as appropriate. IJB members, senior elected members of Aberdeen City Council, and appropriate senior management members at the city council and NHS Grampian would be kept informed in advance of information which was due to be released by ACHSCP into the public domain. A log would be kept of all information released internally and externally in order that an audit trail is maintained of all communications activity. • Data taken off Care First system to identify vulnerable people to help emergency care for support.
Assurances: • Internal Audit undertaken in 2020 on Civil Contingency arrangements in Aberdeen City Council, including Care For People Plan. The Audit recommended that the Plan, although fit for purpose, be reviewed to make it shorter and easier to refer to when activation is required. • Ongoing discussions around development of Aberdeen City Vulnerable Persons Database using Geographical Information Mapping System (this will include data from Care First).	**Gaps in assurance:** • Development of National Persons at Risk Database (PARD) • the Partnership is a member of various groups, including the GLRP, groups established in ACC and NHSG, and Aberdeen City Care For People. Through these Groups the Partnership and IJB can share information with other responders and enhance co-ordination. The Partnership's Civil Contingencies Group require to agree on how this information can be shared effectively and in a co-ordinated way. • Training for Senior Managers On Call – Partnership's Civil Contingencies Group to address. Liaise with GLRP, Council and NHS Grampian on training and testing planned (include tabletop exercising) as well as look at running "local" training and testing in the Partnership.
Current performance: • The Care For People Group met on the 26th of May, 2021 to discuss the draft revised Care For People Plan. The Group agreed the revisions to the Plan (subject to small amendments being made). Internal Audit have closed this recommendation in their Audit. • The Partnership's Civil Contingencies Group met on the 21st of April, 2021 to assist in the operationalisation of the Category 1 duties and to agree the amendments to the Group's Terms of Reference. It is proposed that the Group meet in June 2021 to consider the gaps in assurance.	**Comments:** •

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.
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Aberdeen City Health & Social Care Partnership
A caring partnership

RISK, AUDIT AND PERFORMANCE COMMITTEE

Date of Meeting	22 June 2021
Report Title	Operation Home First – Evaluation Report
Report Number	HSCP.21.075
Lead Officer	Sandra Macleod, Chief Officer
Report Author Details	Name: Dr Calum Leask Job Title: Lead for Research & Evaluation Email Address: cleask@aberdeencity.gov.uk
Consultation Checklist Completed	Yes
Appendices	A Operation Home First Evaluation Report

1. Purpose of the Report

1.1. The purpose of this report is to provide progress on the evaluation of the Aberdeen City Priorities relating to Operation Home First.

2. Recommendations

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

a) Note the information provided in this report;

3. Summary of Key Information

3.1. Operation Home First is the collective priorities of the three North-East Health & Social Care Partnerships in collaboration with the Acute sector of NHS Grampian. It is a portfolio that has emerged through positive, cross-system working during the COVID19 pandemic and emphasises the importance of shifting the balance of care, when safe and appropriate to do so, from acute settings to community settings. There are three aims to Operation Home First:

- To maintain people safely at home
- To avoid unnecessary hospital attendance or admission
- To support early discharge back home after essential specialist care.

RISK, AUDIT AND PERFORMANCE COMMITTEE

3.2. The principles of Operation Home First are:

- 'Home First' for all care
- Working within the agreed strategic direction set out by the Integration Joint Boards and NHS Grampian
- Focus on outcomes for people
- Whole system working and improving primary/secondary care joint working
- Maintain agile thinking and decision making
- Work within constraints of segregation/shielding/physical distancing measures/reduced hospital bed base
- Maximise digital solutions.

3.3. Recognising the importance of being able to accurately measure the benefits of the Operation Home First portfolio, an Evaluation Working Group was commissioned in October 2020. The cross-system Group is comprised of membership from NHS Grampian, the Health and Social Care Partnerships and Public Health Scotland who have expertise in complex evaluation, public health research and data analysis. The purpose of this Group is to determine to what extent each of the initiatives within the Operation Home First portfolio help achieve its three aims.

3.4. An interim evaluation report was presented to the committee on 27.04.21 that provided an update on each of the Operation Home First priorities individually. Appendix 1 provides a Portfolio-level perspective on the cumulative impact of its constituent parts. Some of the key take home messages from this report are:

- The primary aim of this evaluation was to demonstrate the impact of the Operation Home First (OHF) priorities against the OHF aims. However, this evaluation aimed to address as far as reasonably possible, further questions that have been posed to the Evaluation Working Group at recent committees (for example impact on costs and health inequalities).
- Evaluating a complex portfolio such as this, comprised of multiple interconnections and interdependencies, will result in complex answers being generated.
- This evaluation occurred during the winter planning period (October 2020 – April 2021) and within this time, variability was evident with regard to the degree and scale of implementation across OHF Priorities.

- Several initiatives have been comparatively small scale and have demonstrated positive impact for a small cohort of people. Such initiatives require scale-up to recognise marked impact at a population level.
- Implementing such a cross-system Portfolio with a variety of interdependent initiatives will likely result in prioritisation (and subsequent acceleration / deceleration) having to occur to account for challenges in capacity in resources.
- Having external evaluation support in the design and delivery of initiatives at project and programme level appears to be perceived valuable by Priority Leads.
- We understand that there is a strategic appetite for the ethos of "Home First" to become more embedded in Business as Usual for integrated health and care services across Grampian. To help it become so, we would recommend that project and programme evaluation is maintained as an integral part of the Strategic Commissioning Cycle, complementary to other key steps in that cyclical "Plan, Do, Study, Act" (PDSA) process.

4. Implications for Integration Joint Board

4.1. Equalities - The content of this paper aligns with our Strategic Plan, for which a full equalities and human rights impact assessment has been undertaken. The assessment, on the whole, was positive in relation to the Strategic Plan's impact on equality and diversity within Aberdeen.

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

4.3. Financial - Transformation is key to ensuring financial sustainability of the partnership. The resource to evaluate the impact of the Home First Transformation priorities has been secured through fixed term secondments from across the organisation. Funding for this has been identified from existing budgets.

4.4. Workforce - Resource to evaluate the impact of the Operation Home First programme has been identified and mobilised. Capacity was identified and mobilised to backfill the affected areas.

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

RISK, AUDIT AND PERFORMANCE COMMITTEE

5. Links to Aberdeen City Health & Social Care Partnership Strategic Plan

5.1. The activities within the Operation Home First portfolio seek to directly contribute to the delivery of the strategic plan as illustrated below:

6. Management of Risk

6.1. Identified risks(s) –

Risks relating to the Transformation Programme are managed throughout the transformation development and implementation processes. The Executive Programme Board and portfolio Programme Boards have a key role to ensure that these risks are identified and appropriately managed. High level risks to programme delivery and mitigating actions are identified within progress reports reported on a regular basis to the Risk, Audit and Performance Committee.

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

The main risk relates to not achieving the transformation that we aspire to, and the resultant risk around the delivery of our strategic plan, and therefore our ability to sustain the delivery of our statutory services within the funding available.

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

RISK, AUDIT AND PERFORMANCE COMMITTEE

7. Failure to deliver transformation at a pace or scale required by the demographic and financial pressures in the system.
8. There is a risk that the Integration Joint Board does not maximise the opportunities offered by locality working.

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 Integration Joint Board Strategic Plan

6.3. How might the content of this report impact or mitigate these risks:
This paper brings to the attention of the Risk, Audit and Performance Committee information about the progress of evaluation to our priority areas that will help provide assurance of whether proposed changes in activity are / are not successful and for what reasons.

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

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Operation Home First
Portfolio Evaluation Report
June 2021

This report was prepared by the Operation Home First Evaluation Working Group:-

Dr Calum Leask	Lead for Research & Evaluation Aberdeen City Health and Social Care Partnership CLeask@Aberdeencity.gov.uk
Duncan Sage	Principal Information Analyst Local Intelligence Support Team (LIST), Public Health Scotland Duncan.Sage@phs.scot
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Contents

Key Points

- The primary aim of this evaluation was to demonstrate the impact of the Operation Home First (OHF) priorities against the OHF aims. However, this evaluation aimed to address as far as reasonably possible, further questions that have been posed to the Evaluation Working Group at recent committees (for example impact on costs and health inequalities).
- Evaluating a complex portfolio such as this, comprised of multiple interconnections and interdependencies, will result in complex answers being generated.
- This evaluation occurred during and soon after the winter planning period (October 2020 – March 2021) and within this time, variability was evident regarding the degree and scale of implementation across OHF Priorities.
- Several initiatives have been comparatively small scale and have demonstrated positive impact for a small cohort of people. Such initiatives require scale-up to recognise marked impact at a population level.
- Implementing such a cross-system Portfolio with a variety of interdependent initiatives will likely result in prioritisation (and subsequent acceleration / deceleration) having to occur to account for challenges in capacity in resources.
- Having external evaluation support in the design and delivery of initiatives at project and programme level appears to be perceived valuable by Priority Leads.
- We understand that there is a strategic appetite for the ethos of “Home First” to become more embedded in Business as Usual for integrated health and care services across Grampian. To help it become so, we would recommend that project and programme evaluation is maintained as an integral part of the Strategic Commissioning Cycle, complementary to other key steps in that cyclical “Plan, Do, Study, Act” (PDSA) process.

Introduction / Context

This report aims to evidence the impact of the Operation Home First (OHF) Portfolio. It follows on from an interim evaluation report published in February 2021 that should be read prior to this report for further context. The interim report, available as Appendix A, provided an overview of OHF; the evaluation methodology implemented across the Portfolio; and an update on progress across each of the OHF Priorities. This report views the evaluation of the Portfolio through a strategic lens, with greater emphasis placed on the cumulative impact of individual Priorities and key learning / considerations that may be valuable to adopt in the future.

The Aims of Operation Home First

This portfolio has three main aims:

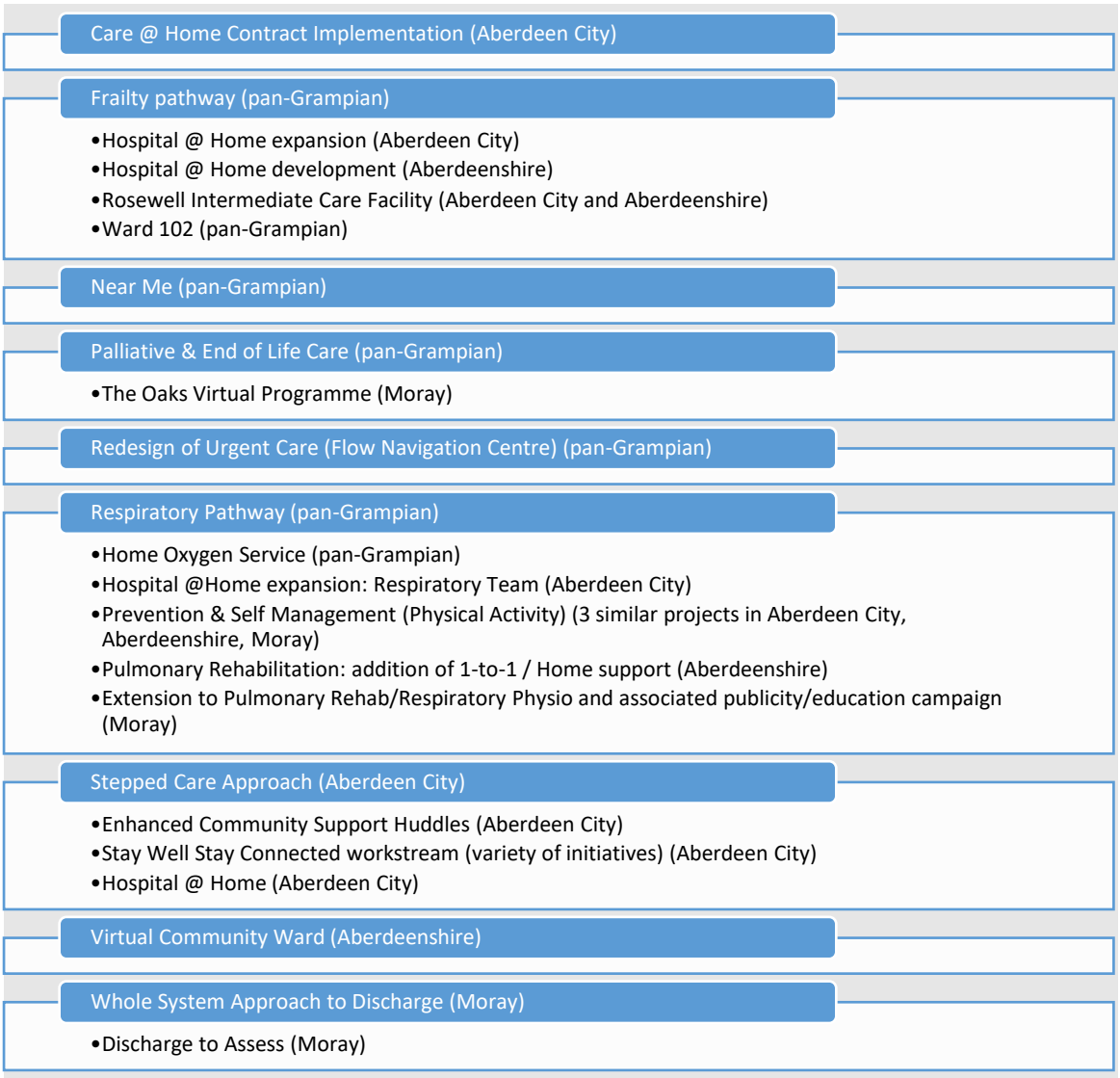
1) To maintain people safely at home
2) To avoid unnecessary hospital attendance or admission
3) To support early discharge back home after essential specialist care

The Operation Home First Portfolio

The below figure illustrates the constituent parts of the OHF Portfolio that were included within the scope of this evaluation. As such, it does not contain the entirety of the activity that is undertaken across the three North-East Health & Social Care Partnerships (HSCPs) + Acute sector. The initiatives deemed as Priorities within this time period were selected and agreed by the OHF Steering Group.

It should be noted that some Priorities are standalone projects, whereas others are programmes of work (i.e. a group of projects). In other instances, particular initiatives span across more than one Priority area (for example, Hospital @ Home in Aberdeen City is aligned to the Frailty Pathway; the Stepped Care Approach; and the Respiratory pathway). These are depicted in Figure 1.

Figure 1. List of the OHF Priorities and their constituent parts (where applicable)

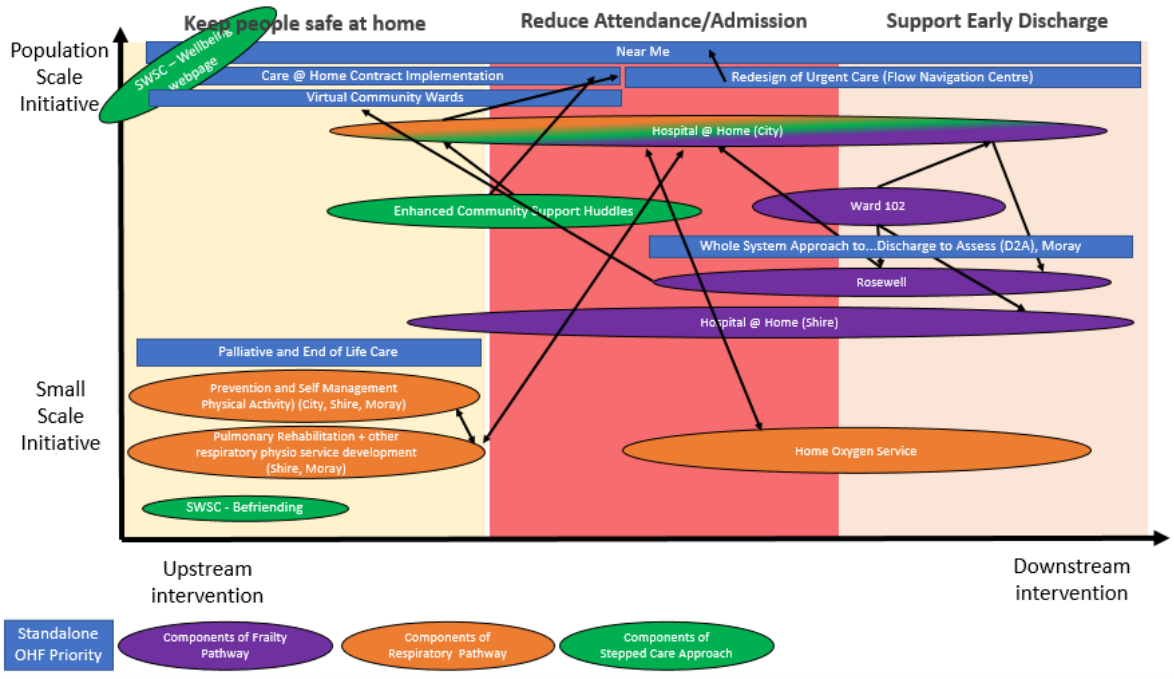


Whilst Figure 1 provides a 'neat list' of the OHF Priorities, it falls short of conveying the true complexity of the Portfolio. Examples of such complexities include but are not limited to:

- *Priority composition* – Whether the Priority is a standalone project or a programme (i.e. a group of projects)
- *Priority scale* – Whether initiatives within the Portfolio are either being conducted at a small scale or a population level
- *Impact on OHF aims* – Not all OHF Priorities impact on all OHF aims
- *Priority emphasis* – Some priorities have a focus on upstream, preventative work, whereas others have a downstream, acute-based focus
- *Interdependencies* – Most OHF Priorities do not operate within a silo. They interact with other parts of the system (for example, Ward 102 will refer into the Aberdeenshire Hospital @ Home service when this becomes operational, meaning that performance on one part of the system can often be directly impacted by another part of the system).

Figure 2 is one such attempt to show these multiple complexities within one visual. It is intentionally convoluted to recognise that evaluation occurring within a complex system will always generate complex answers. It is important to note that this is illustrative only and designed to be a notional presentation of how the entire Portfolio interlinks with each other within the evaluation period defined above (i.e. not a direct comparison as to whether Priority 'x' or Priority 'y' is larger).

Figure 2: Complexity visual of OHF priorities and projects



NB – 'Hospital @ Home (City)' is multi-coloured to represent its presence under several OHF Priority areas.

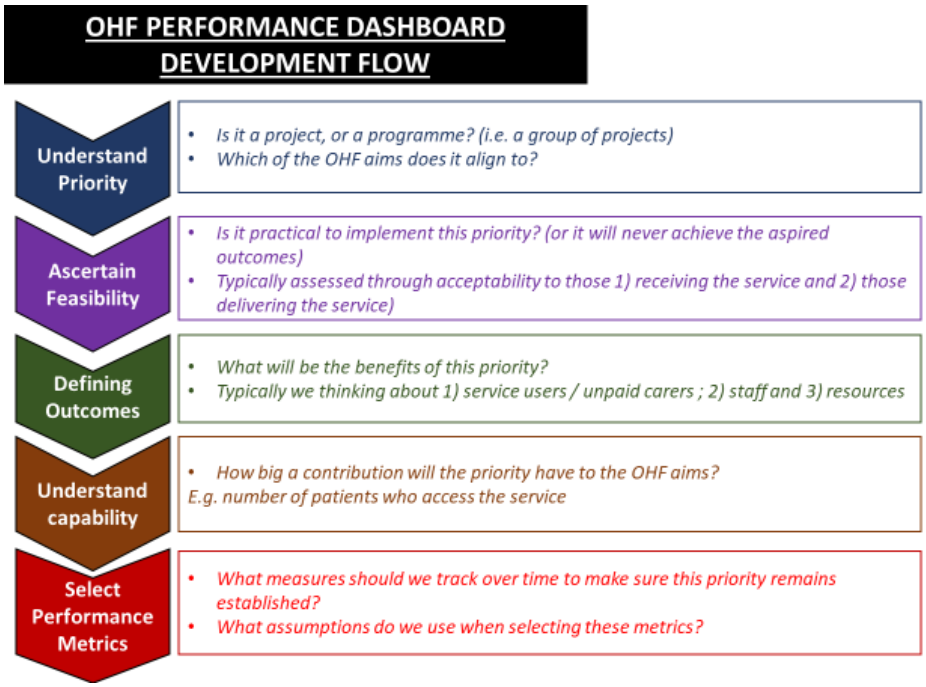
Evaluation Scope and Approach

The principal ask of the original commission was two-fold:

1) Evaluate the impact of the OHF Priorities against the OHF Aims
2) Develop a performance dashboard for ongoing monitoring of Priorities at a strategic level.

The Evaluation Working Group developed and applied a consistent methodology across Priorities, that is visually depicted and described below:

Figure 3. OHF Performance Dashboard Development Flow



Understanding the Priorities individually – Some of the OHF priorities are individual projects (such as Implementation of Near Me). Others are programmes (i.e. a group of projects, such as the Stepped Care Approach). In the latter scenario, the full impact of the programme cannot be understood until individual projects are understood. During this stage, priorities were mapped against the OHF aims, which helps inform the data collection process.

Ascertaining feasibility – Service changes / developments cannot realise benefits if they are not practical to implement. As such, a critical component to new initiatives is determining whether they are acceptable to those delivering the service (i.e. staff) and to those receiving the service (i.e. service users and unpaid carers).

Defining outcomes - If initiatives pass the feasibility test, consideration can be given as to what benefits these will have. These benefits can usually be categorised by 1) benefits to service users / unpaid carers; 2) benefits to staff; 3) benefits to resources / services.

Understanding capability – This helps answer the question as to the impact individual priorities have against the aims of OHF. For example, a small-scale test of change will not have a substantial impact on reducing hospital attendances but is helpful to prove a new concept or to determine how it may make a positive contribution should it be scaled up.

Selecting performance metrics - The goal here is to distil each priority down to a minimal number of measures that can provide an indicative overview as to how that priority is functioning. Key to this is developing assumptions that provide as rationale as to why that metric was selected.

The above would culminate in bespoke evaluation frameworks being developed across Priorities. This typically followed a standard template for monitoring purposes, illustrated below.

Figure 4. OHF Evaluation Framework Template

Ref	Measures	Aim alignment	Measurement tool / source	Measure frequency	Owner	RAG	Update / comments
1. Service User / Unpaid Carer outcomes							
1.1							
2. Staff outcomes							
2.1							
3. Resource / Service outcomes							
3.1							
4. Process / descriptive measures							
4.1							

NB – Template may / may not include multiple lines under each header. These were co-created and agreed with Priority Leads

All initiatives require a period of embedding before sufficient evaluation can be undertaken. Evaluation has to consider the inputs and processes required to deliver a project, as without these the subsequent outputs cannot be achieved and as such, the impact of the project cannot be realised. This notion is delineated in a simplified manner in the below example logic model.

Figure 5. Simplified Logic Model

Inputs	→	Activities	→	Outputs	→	Outcomes and Impact (short-, medium- and long-term)
e.g. funding; staffing		e.g. training; process development		e.g. virtual classes; supported discharges		e.g. increased awareness and ability of person to manage their condition(s); admission avoidance in short versus longer term; reductions in A&E attendances and hospital admissions in the longer term; improved population health in the longer term.

NB – Content within logic model above aims to provide a balance of commonly applicable elements whilst not trying to exhaustively represent all the individual priorities within OHF Portfolio.

EXAMPLE CASE STUDY

CARE @ HOME CONTRACT IMPLEMENTATION (ABERDEEN CITY)

Under the new model, the provision of care will move away from the current schedule of tasks which are timed. Instead, teams will work together with people receiving care, their families, and other practitioners within each locality to provide care tailored to individual needs. Local assets will also be used to connect people back into their community.

At the time of evaluation, the new Care @ Home Contract had been implemented (i.e. the Inputs), however changes had not been made to care packages (i.e. the Outputs). Due to this, the perceived benefits of the project (i.e. the Outcomes and Impact) are not currently quantifiable.

This is a good example of an initiative that has the foundations successfully implemented, though requires more time to elapse before a judgement can be made as to whether it has made the desired impact.

The awareness and interest in the OHF Portfolio has grown over the winter period. Due to this, a variety of additional questions, beyond the original commission, have been posed to the Evaluation Working Group as potential areas of interest to explore over the course of its implementation. Given the range of these requests, coupled with the complexities and breadth of the Portfolio itself, a pragmatic approach has been taken within this evaluation. Whilst this report aims to provide a blend of relevant evidence and reflections, it is not a silver bullet and is not possible to be an exhaustive judgement across all facets described below given the timescales in which it was conducted. However, it is hoped that the information gathered and presented here will be beneficial for senior leaders and decision makers in aiding and shaping future service innovation and delivery.

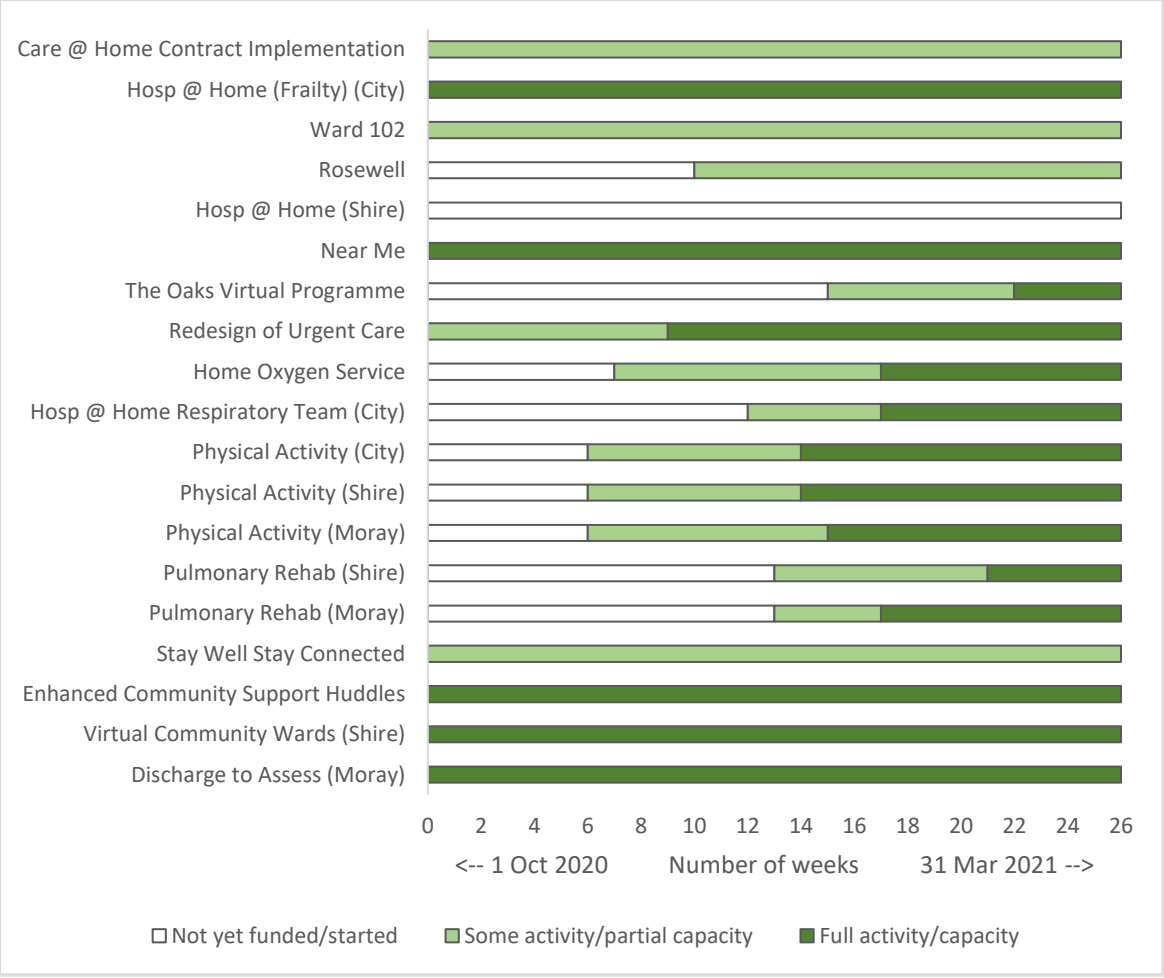
Evaluation Findings

Priority / Project Durations

The below visual aims to depict the degree of activity across different initiatives during the winter planning period. The purpose of this is not to provide a judgement on individual initiatives, instead it is to emphasise that different initiatives have been implemented to various degrees during this period and as such, will have different demonstrable impact.

This emphasises the different degrees of implementation across OHF Priorities. For example, NearMe has been implemented at scale during the winter period, whilst the Hospital @ Home service in Aberdeenshire is still in development. This means that both these initiatives cannot generate the same amount of data and impact within this time period.

Figure 6. Simplified Gantt Chart of OHF Priority Implementation



NB – The time ranges provided within this chart are indicative and subject to the interpretation of the Evaluation Working Group. It is designed to be illustrative for the purposes of demonstrating the differing degrees of implementation across Priorities.

EXAMPLE CASE STUDY

PALLIATIVE CARE CELL (PAN-GRAMPIAN)

The Palliative Care COVID-19 Cell was set up to focus on the issues pertaining to the pandemic and lots of work was progressed very quickly in response to COVID. It became apparent that finalisation of the Palliative and End of Life Strategic Framework, which had been almost ready to launch prior to the COVID outbreak, was a priority, ensuring that the final document reflected any lessons learned during the pandemic.

The main outcomes of the strategic framework are; to ensure people are supported at home at end of life (should that be their choice), reduce inappropriate admissions to acute hospitals and to allow the individual to fulfil their choices at end of life; these ambitions chiming with the ethos of OHF. Unlike the OHF Respiratory Priority which retained the wider Respiratory Cell working group and continued to meet on a weekly basis to progress programmes of work, the Palliative Care COVID-19 Cell was disbanded in September 2020 and responsibility for developing workstreams handed back to the Palliative and End of Life MCN Strategic Advisory Group.

The MCN group met in October (where the Chair announced his imminent retirement) and again in November, however subsequent meetings were cancelled, and the group has not met again during the period this report relates to. The framework has been finalised and is going through the approval process for launch Summer 2021.

The framework was always intended to be devolved to the three HSCPs and Acute sector to implement at a local level. A project that the OHF Evaluation Group has supported is the evaluation of The Oaks Virtual Programme. This was the translation of the palliative day service previously held at The Oaks, Elgin, into a four-week block of hosted virtual classes. Unfortunately, due to staff sickness, the project only ran for three weeks out of the planned four during the OHF evaluation period, with seven people attending. Feedback from patients and staff was generally positive towards this concept:

"Your service brought people in similar situations together. The chat was fun. I feel you are trying to cater for a variety of interests." [Participant]
"The Virtual Programme enabled the patients to form a bond, support network which helped them to arrive happy and comfortable for my online sessions." [Staff]

Roxburghe House, which provides palliative and end of life care for residents across Grampian as well as linking with the Western Isles, Orkney and Shetland, have successfully transitioned their model of day care into a virtual programme and have groups running concurrently.

Priority / Project Reach

As individual initiatives begin, we can start to capture early feedback from people receiving a service, and people providing it (see Appendix A for examples of this from across the Portfolio). Data on the acceptability (or otherwise) of services to patients and staff is an important part of the evidence base for further service development/expansion. Furthermore, for many initiatives in the OHF Portfolio, even in a period of a few months, it has been possible to demonstrate positive impacts on the people directly supported – such as improved clinical measurements and/or improved confidence in their ability to help manage their own condition(s) (again, see Appendix A for examples).

Beyond the immediate (short term) impacts on service users and staff, there has been a desire to evaluate (where possible) the impact (actual/potential) on usage of the health and social care system, and the potential to impact upon the wider population. In this report's section on the Impact on Operation Home First (Table 4), we have collated data on some of the main impacts at system level that it has been possible to source in this comparatively short time frame (from existing IT systems or new data collections developed specifically for OHF evaluation purposes). However, it is also important to be mindful that many of the OHF priorities have been tests of change or have for other reasons operated at relatively small scale. The number of people supported by an initiative may be somewhat smaller than the cohort of people who might be potentially eligible to benefit from it. Thus, whilst initiatives can have positive impact on the relatively small numbers of people they can help, they would need to be sustained/scaled up if they are to reach more of those within the potentially eligible cohort(s). Figure 7 below shows a conceptual example of a project providing support to some of the potentially eligible population, who in turn, are a subset of the whole population. In Table 4, we have collated data on the numbers of people supported by each of the OHF projects during winter 2020/21 (or the part thereof for which they were operational) – the yellow (top) part of this triangle. On the following pages, we provide further statistics, for broad context, on the green (middle) and blue (bottom) parts of this triangle.

Figure 7. Conceptual example of project reach.

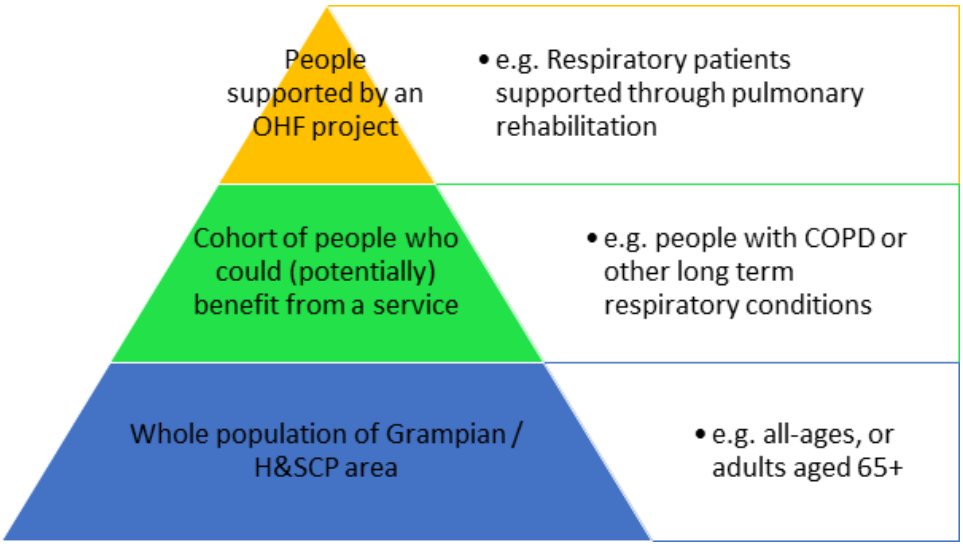


Table 1. Cohorts of people who could (potentially) benefit from a service pathway

Urgent Care

- Anyone of any age may find that they require urgent care, therefore our potentially eligible cohort is our entire population.
- In financial 2019/20 there was an average of nearly 7,400 ED attendances per month at ARI and Dr Gray's Hospital, of which c.4,400 attendances per month were from self-presenters, with a reduced self-presenting footfall during the pandemic, between April and November 2020, of c.2,600 attendances per month.
- Average attendances per month at Minor Injury Units were c.2,700 in financial 2019/20 and c.1,300 in financial 2020/21 up to the soft launch of the Flow Navigation Centre in December 2020.

Respiratory Pathway

- Chronic Obstructive Pulmonary Disease (COPD) is a cause of morbidity and mortality in Scotland, and (along with Asthma) is one of the main long-term respiratory conditions for which population prevalence estimates are available.
- The Scottish Burden of Disease Study estimates that around 11,000 people in Grampian are living with COPD. Numbers by Partnership area are shown in the table below.
- Generally speaking, just over half those with a COPD diagnosis are aged 65+, and just under half are younger adults.

HSCP/Area	Estimated number of people living with COPD (rounded to nearest 100)
Grampian	11,200
Aberdeen City	4,000
Aberdeenshire	5,000
Moray	2,200

Source: Scottish Burden of Disease Study

- Whilst preventable and increasingly treatable, the airflow obstruction seen in COPD is usually progressive. It is thus (amongst other respiratory conditions), an example of where supports can be put in place relatively upstream (e.g. physical activity classes) and otherwise in community settings (e.g. pulmonary rehabilitation) to delay or avoid hospital admissions in the months or years ahead.

Frailty Pathway

Healthcare Improvement Scotland have estimated that "*there are approximately 560,000 people living with frailty in Scotland - just over 10% of the population. Of this, 355,000 people are living with mild frailty, 151,000 with moderate frailty, and 50,000 with severe frailty. Growing numbers of older people are being admitted to hospital in an emergency and some of those admitted will deteriorate further or experience a delay in returning home due to being frail. Evidence shows that delivering early and effective Comprehensive Geriatric Assessment (CGA) for people living with frailty has potential to improve their outcomes and experience of care*."
Source: The Frailty at the Front Door Collaborative Impact report December 2019

If we apply these estimated numbers to the Grampian population – assuming that levels of frailty are similar to elsewhere in Scotland - this would translate as

- Roughly 60,000 people living in Grampian with some degree of frailty, of whom
- Roughly 5,000 may be living with severe frailty.

Palliative and End of Life Care
Research published in 2020 projects that across Scotland, by 2040, the number of people requiring palliative care will increase by at least 14%; and by 20% if multi-morbidity is factored in. https://bmjopen.bmj.com/content/11/2/e041317.

Whole population of Grampian and our three Health and Social Care Partnership areas.

The estimated Grampian population (all ages) is 585,700. The totals by Health and Social Care Partnership are: 261,210 in Aberdeenshire, 228,670 in Aberdeen City, and 95,820 in Moray.

Approximately 1 in 5 people in our population are aged 65 and over (although this varies between 15.8% for Aberdeen City and 21.6% for Moray). Projected population change in Grampian over the 10 years from 2018 to 2028 is expected to reflect increases in the numbers of people aged 65+ (up by 20%), and decreases in the numbers of younger adults, and children.

Table 2. Grampian population by age group, 2019.

	Under 15	15-24	25-44	45-64	65+	% aged 65+
Grampian	94,839	64,733	159,549	158,633	107,946	18.4%
Aberdeen City	33,642	28,745	75,359	54,767	36,157	15.8%
Aberdeenshire	46,107	25,661	62,120	76,249	51,073	19.6%
Moray	15,090	10,327	22,070	27,617	20,716	21.6%

Source: National Records of Scotland mid-year population estimates

Impact on Operation Home First Aims

Overview of priorities mapped versus OHF aims

The below table maps each of the OHF Priorities against each of the aims. To iterate, the aims of home first are:

Aim 1) To maintain people safely at home
Aim 2) To avoid unnecessary hospital attendance or admission
Aim 3) To support early discharge back home after essential specialist care

Whilst this mapping demonstrates the intended impact against each of the aims, it does not mean that at the time of writing, Priorities are delivering on this. As stated above, Priorities that are still in development or operating at a small scale will only have minimal impact, with more time warranted before these aspirations can be fully achieved. Priorities that do not deliver against particular aims should not be perceived as inferior, as it was never the intention of all Priorities to directly impact on all aims.

Table 3. OHF Priorities Mapped Against OHF Aims

Priority Name	OHF Aim 1	OHF Aim 2	OHF Aim 3
Stepped Care Approach (Stay Well Stay Connected Workstream)	✓		
Stepped Care Approach / Frailty Pathway / Respiratory (Hospital @ Home Aberdeen City)	✓	✓	✓
Stepped Care Approach (Enhanced Community Support Huddles)	✓	✓	✓
Stepped Care Approach / Respiratory Pathway (Hospital @ Home expansion: Respiratory Team)	✓	✓	✓
Frailty Pathway (Ward 102)	✓	✓	✓
Frailty Pathway (Rosewell)		✓	✓
Frailty Pathway (Hospital @ Home Aberdeenshire)	✓	✓	✓
Care @ Home Contract Implementation	✓	✓	✓
Redesign of Urgent Care (Flow Navigation Centre)	✓	✓	
NearMe	✓	✓	
Respiratory Pathway (Home Oxygen Service)		✓	✓
Respiratory Pathway (Physical Activity Classes)	✓		
Respiratory Pathway (Pulmonary Rehabilitation)	✓		
Respiratory Pathway (Extension to Pulmonary Rehab / Respiratory Physio)	✓		
Palliative & End of Life Care (The Oaks Virtual Programme)	✓		
Whole system approach to discharge (Discharge 2 Assess)		✓	✓
Virtual Community Wards	✓	✓	

NB –Boxes in dark shade with tick mark denote association between Priorities and Aims. Less / no association is denoted by light shading. Mapping was done in collaboration between Evaluation Working Group Members and associated Priority leads.

Impact of Priority vs OHF Aims

The below table expands on the above mapping exercise by providing illustrative examples of how Priorities have impacted upon different aims. Its purpose is to provide information whereby the strongest correlations between Priorities and the OHF aims are present and quantifiable.

Table 4. OHF Priorities Mapped Against OHF Aims

Priority Name	Impact vs OHF Aim 1 (Keep people safe at home)	Impact vs OHF Aim 2 (Reduce unnecessary hospital attendance / admission)	Impact vs Aim 3 (Support early discharge)
Stepped Care Approach	'Wellbeing Matters Webpage' (part of Stay Well Stay Connected workstream) received more than 1100 visits over a 12 month period, providing a number of helpful resources of keeping and staying well (though it is not possible to quantify whether this directly resulted in keeping people safe at home).	330 patients brought to the Enhanced Community Support Huddles since June 2020 whom would be at risk of hospital admission if interventions had not been implemented.	Hospital @ Home in Aberdeen City have cared for 184 patients through the Supported Discharge route in the last 12 months, helping get people out of hospital in a timely manner.
Frailty Pathway	General Practitioners have direct access to senior clinicians in Ward 102, meaning admissions have been avoided (and people kept safely at home when appropriate to do so) through discussing presentations and reviewing care options.	Hospital @ Home in Aberdeen City have cared for 321 patients through the 'Alternative to Admission' route in the last 12 months. Rosewell accepted one step-up admission into the facility that otherwise would have been a hospital admission.	Rosewell accepted 85 step-down admissions in the first two months of operation, thus reducing the pressure on secondary care services.
Care @ Home Contract Implementation	As of May 2021, Granite Care Consortium are supporting 1063 individuals.	Impact not yet reviewed as changes to type of care provision were not implemented at the time of writing.	Impact not yet reviewed as changes to type of care provision were not implemented at the time of writing.
Redesign of Urgent Care	Nearly 5,500 referrals have been made from NHS 24, with over 1,000 directed to the Flow Navigation Centre (FNC) and nearly 4,500 to the Minors Decision Queue, at an average of c.200 clinical referrals per week allowing people to stay safe at home and only attend hospital when absolutely necessary following a virtual consultation.	Only 58% of patients referred to the FNC and the Minors Decision Queue (FNC: 45%; Minors: 60%) have required a face-to-face appointment minimising the need for patients to attend ED or a minor injury unit, with 42% given self-care advice or re-directed to primary care following a virtual consultation.	Not applicable as Priority not adjudged to be aligned to aim.

Priority Name	Impact vs OHF Aim 1 (Keep people safe at home)	Impact vs OHF Aim 2 (Reduce unnecessary hospital attendance / admission)	Impact vs Aim 3 (Support early discharge)
NearMe	Service deals with over 3500 remote consultations per week as of February 2021, allowing people to stay safe at home.	44% of patients referred to the FNC and Minors Decision Queue did not need to attend a face-to-face appointment following a Near Me consultation.	Not applicable as Priority not adjudged to be aligned to aim.
Palliative & End of Life Care	**The Oaks Virtual Programme:** During the month of March 2021, 7 palliative patients were able to attend a 4-week programme of hosted virtual sessions from the comfort of their own homes.	Not applicable as Priority not adjudged to be aligned to aim.	Not applicable as Priority not adjudged to be aligned to aim.
Respiratory Pathway	**Hospital @ Home (H@H)**: During the 11 weeks to end March, 11 respiratory patients were admitted; between them this came to 60 H@H bed days.	**H@H:** Of the 11 patients admitted during this short period, 4 were 'Alternative to Admission' to Aberdeen Royal Infirmary.	**H@H:** Of the 11 patients admitted during this short period, 7 were 'Active Recovery / Supported Discharge'.
	Not applicable as Priority not adjudged to be aligned to aim.	**Home Oxygen Service:** In the last weeks of the financial year, the Team developed a rapid assessment service for immediate/ urgent referrals for oxygen to prevent admission. Seven referrals were received and assessed the same day and oxygen supplied in four cases, with an average installation time of 128 minutes.	**Home Oxygen Service:** Over the course of 9 weeks the Team were able to directly assess 36 inpatients for home oxygen. 28 patients were discharged within 2 days of assessment. A case review estimated average savings of 4.8 bed days per patient.
	Pulmonary Rehabilitation (PR) (Shire): In 10 weeks late Jan-end March, 51 patients had initial assessments. 27 started 1 to 1 (Home) PR block, of which 23 completed. 11 patients declined or unsuitable to continue.	**PR (Shire):** Unknown due to short timescale of project. Had capacity and follow-up time allowed, we would have looked at admissions up to 6/12 months pre- and post-intervention.	**PR (Shire):** Not impacted during this short project life span, but there is potential for it to do so in future.

Priority Name	Impact vs OHF Aim 1 (Keep people safe at home)	Impact vs OHF Aim 2 (Reduce unnecessary hospital attendance / admission)	Impact vs Aim 3 (Support early discharge)
	Extension to Pulmonary Rehab (PR) / Respiratory Physio – Moray: In 12 weeks early Jan-end March, 54 patients assessed (43 for PR + 11 for other respiratory physio), of which 17 started virtual PR and 7 completed block of virtual classes. And a further 8 started and completed Home PR.	**PR / Respiratory Physio (Moray):** Unknown due to short timescale of project.	**PR / Respiratory Physio (Moray):** Not captured during this short project life span, but there is potential for it to do so in future.
	Leisure Projects / Physical Activity Classes (Grampian): Between January and March 2021, 64 people with chronic respiratory conditions participated in 6-week blocks of instructor-lead, online physical activity classes.	Not applicable as Priority not adjudged to be aligned to aim.	Not applicable as Priority not adjudged to be aligned to aim.
Whole system approach to discharge	Not applicable as Priority not adjudged to be aligned to aim.	**Discharge 2 Assess (D2A):** Over the 25 weeks of the Discharge 2 Assess project 9 patients were redirected from Dr Gray's Emergency Department, saving an estimated 81 bed days.	**D2A:** Between October 2020 and March 2021 48 in were discharged via D2A. This reduced average length of stay by 1 day saving 48 bed days.
Virtual Community Wards (VCW)	For FY2020/21 quarter 3, 213 VCW admissions were reported by 17 GP practices who submitted returns (out of the 25 GP practices signed up to the VCW SLA) .* * In 2019/20 average of over 330 VCW admissions per quarter. It was not mandatory for GP practices to submit VCV quarterly returns in FY2020/21 however they were asked to submit data where available., It is planned that formal reporting on a quarterly basis, to monitor and understand the impact of VCW, will resume for 2021/22 for all practices signed up to the VCW SLA.	A previous audit found that the VCW model was able to manage 66.3% of all admissions at home, subsequently reducing unnecessary hospital admissions. This percentage was 38.3% greater than the presumed patient outcome as predicted by clinicians.	Not applicable as Priority not adjudged to be aligned to aim.

NB – The above data is not exhaustive, nor is it all collected over the same time frames (given the data provided previously regarding when Priorities went live and the scale at which they operate)

Performance Monitoring / Dashboard Development

One key output of the original commission was to develop a performance dashboard for the ongoing monitoring of priorities at a strategic level. This performance dashboard has been developed as part of an iterative process and consists of a minimal set of key performance metrics, aligned to the three OHF aims, that have been identified following the five-step development process set out in Figure 3. This performance dashboard has been designed to provide the OHF Steering Group with an indicative impact of the Portfolio at a high-level.

One key enabler in the development of such a performance dashboard is the need for it to be supported by a robust data and intelligence infrastructure. To achieve this goal we have adopted a tiered approach to performance monitoring, building on existing reporting and working to capture better data and address any data gaps, to get the right information to the right people at the right time and help facilitate data-driven decision-making across the OHF Portfolio of programmes and projects. As just like a house, strong foundations and pillars are required to support the roof (i.e. the performance dashboard).

Our tiered approach to performance monitoring and dashboard development, from the operational level up to the OHF Steering Group, consists of relevant and timely metrics structured across three tiers.

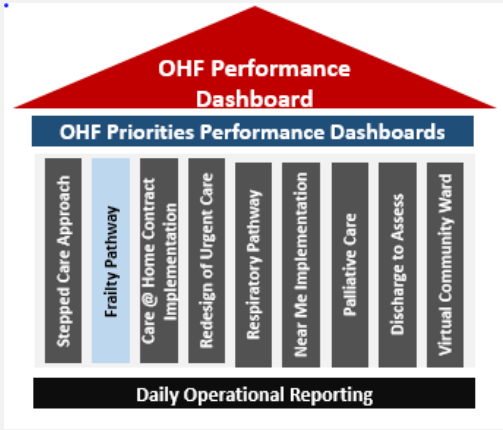
- Tier One (i.e. the roof) comprises of the performance dashboard for the OHF Steering Group. The performance dashboard contains a minimal set of outcome-based key metrics that most directly align with OHF aims and can be used to understand the overall impact of the portfolio at a high-level. Updated monthly, this performance dashboard consists of an overall summary that can be filtered by metric, aim alignment, priority alignment and sector, and supplemented by a high-level dashboard for each individual priority area that allows further drill-down of the respective key performance metrics within.
- Tier Two (i.e. the pillars) comprise of a suite of dashboards covering a wider set of metrics. We have currently developed tier two dashboards for the larger scale initiatives within the OHF portfolio. These dashboards, developed based on the respective needs of the Frailty Pathway Delivery Group and Redesign or Urgent Care Governance Group, help explain the causes of variation in Tier One performance for these Priority areas and why performance is improving or declining. Within the Tier Two dashboards the end-user can make a variety of selections, including specifying date range, the filters to apply for drill-down and choose the view (e.g. snapshot, trend or date table). These dashboards are updated weekly.
- Tier Three (i.e. the foundations) builds on the existing routine reporting in place. The metrics within these dashboards align with detailed daily operations that drive performance and ultimately provides the foundation for the first and second tiers. These dashboards are updated daily and drives the development of daily operational plans for achieving the desired outcomes and for monitoring progress.

This suite of dashboards will help provide a sustainable solution for measuring and reporting of performance from the operational level up, for projects both within the OHF Portfolio and as they transition to ‘business as usual.

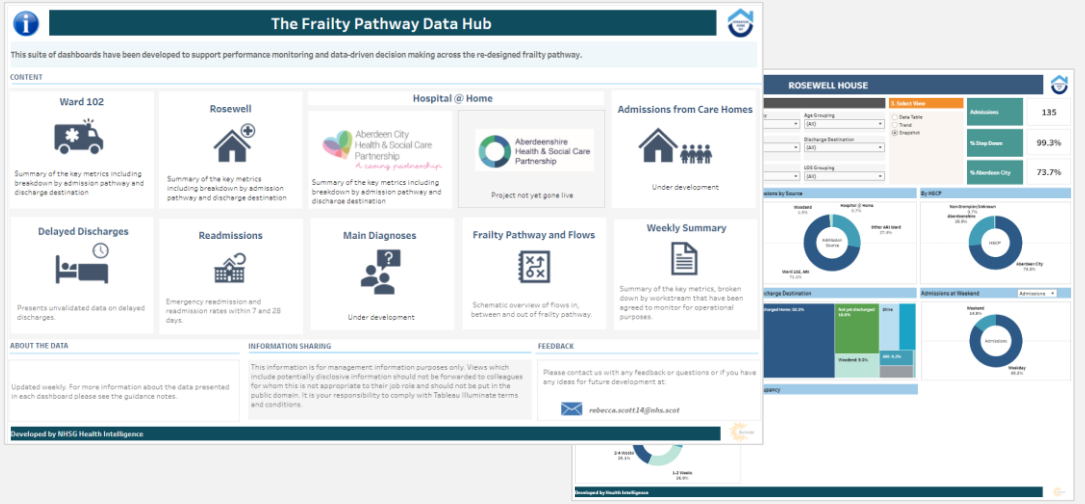
Figure 8 below provides an example of the tiered approach to performance monitoring we have implemented for the frailty pathway.

Figure 8. Example of Tiered Approach to Performance Monitoring Related to the Frailty Pathway

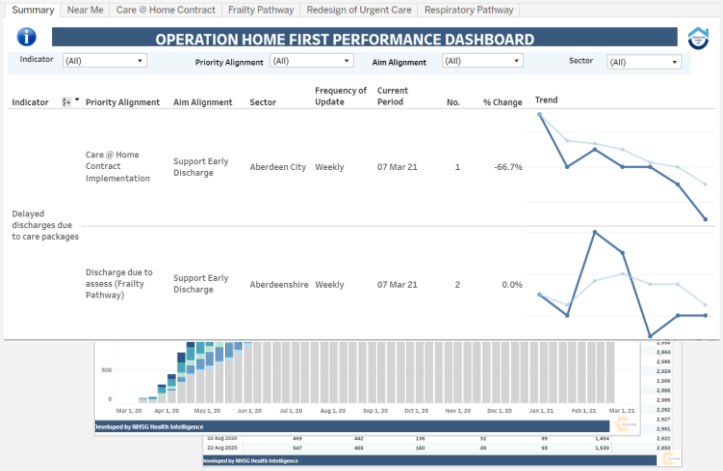
THE 'HOME FIRST' HOUSE OF METRICS



TIER TWO: FRAILTY PATHWAY PERFORMANCE DASHBOARD



TIER ONE: OHF PERFORMANCE DASHBOARD



TIER THREE: ABERDEEN CITY DAILY SURGE & FLOW OVERVIEW DASHBOARD

Additional reflections

Notes on Cost Dimensions

This report is not the product of a cost-effectiveness exercise. The primary drivers behind OHF were about keeping people safe at home during a global pandemic and avoiding / reducing hospital usage, where possible, in what was expected to be an even more challenging winter planning period than usual.

The OHF Portfolio consists of numerous initiatives targeting one or more of its aims (see Table 3: OHF Priorities Mapped Against OHF Aims on page 14). A multitude of factors influenced the development of individual projects: aligned priority, governance, perceived short-term vs. longer term benefit, scale, requirement for initial funding, resource, etc. Some tests of change were essentially ready to go at the time the Evaluation Working Group was formally commissioned, others developed during the evaluation reporting period and for some, the benefits of a change are yet to be recognised (Figure 6. Simplified Gantt Chart of OHF Priority Implementation). With these points in mind, an attempt to validate the full OHF Portfolio on economic grounds would meet with little success. However, economic-specific data collection practices have been utilised in some initiatives within this Portfolio to better understand this dimension and, in some instances, provide a basis for securing sustained investment. Discharge 2 Assess in Moray is one such example (see Figure 9. D2A Case Study Infographic for details).

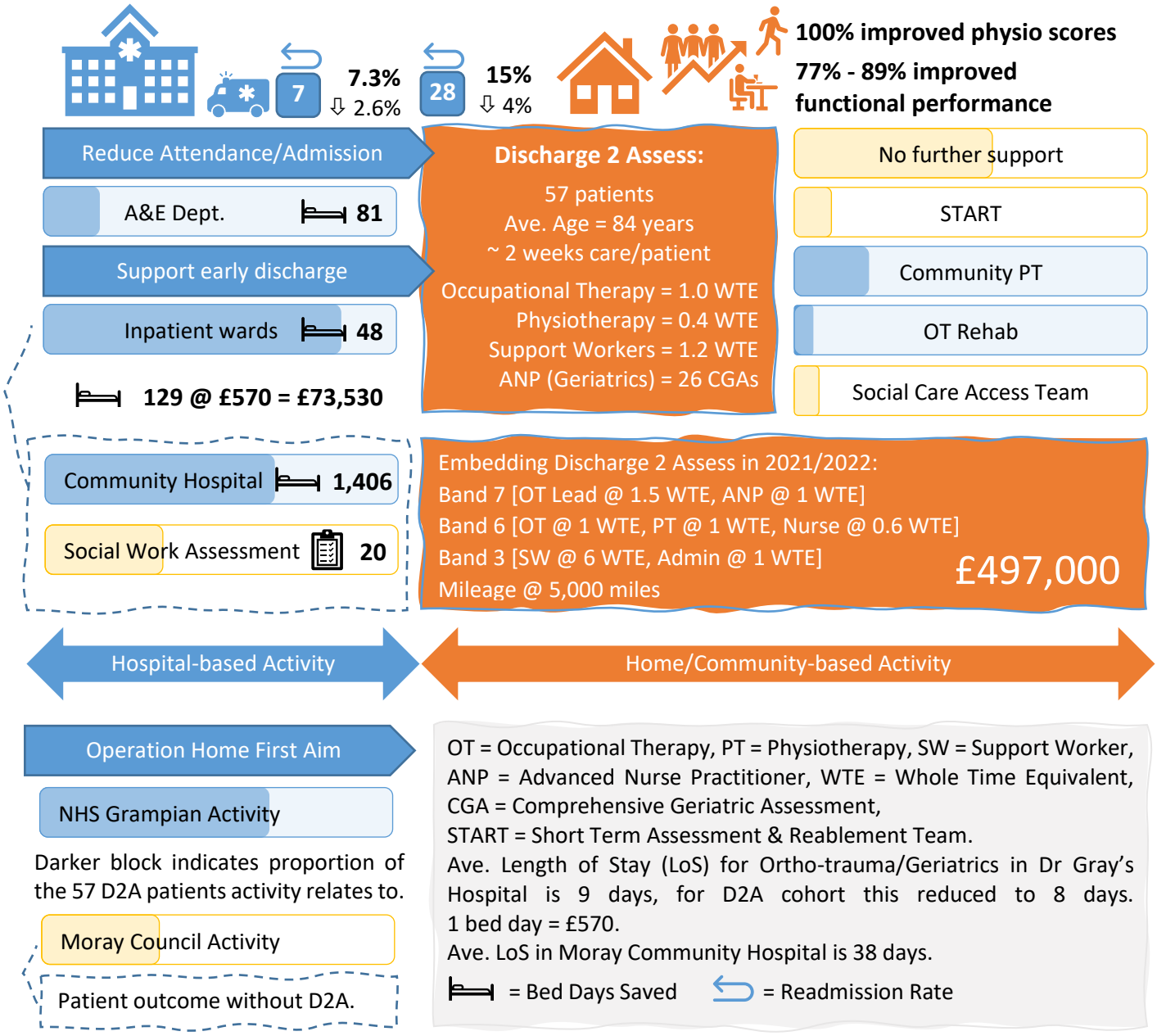
The Discharge 2 Assess (D2A) project introduced an established model of intermediate care, utilised in other parts of the country, to Moray. Its focus is those patients who are clinically stable and do not require acute hospital care but who may still require rehabilitation and care support in the short term. Assessment in the patient's home helps prevent admissions from A&E and reduces length of stay in acute wards. Length of stay, measured in bed days, is a standard NHS metric. By comparing the length of stay for the patients seen by the D2A team with the average for the specialties or wards most benefitting from D2A involvement, it is possible to calculate a bed days saved figure. In turn this can be converted to a cost or cost saving using figures obtained from national publications such as the NHS Costs Book.

Table 5. Bed Day Calculation used in Discharge 2 Assess

Item	Bed Days
Average Length of Stay in Dr. Gray's Hospital (Ortho-trauma & Geriatric Specialties)	*9*
Average Length of Stay in Dr. Grays Hospital for inpatients seen by D2A	*8*
Number of inpatients seen by D2A	*48*
Number of inpatient bed days saved through D2A [(9 – 8) x 48]	*48*
Number of patients attending A&E Department discharged to D2A	*9*
Number of bed days saved through admission avoidance [9 x 9]	*81*
Total number of bed days saved [48 + 81]	*129*

The NHS Costs Book puts a figure of £570 per bed day for the named specialties in Dr. Grays so simply multiplying the number of bed days saved by this gives an indication of potential savings: 129 x £570 = £73,530

Figure 9. D2A Case Study Infographic



D2A limits the transfer patients to Moray's community hospitals to those with more complex rehabilitation or discharge needs; it is estimated that two thirds of the patients seen by D2A team would otherwise have been placed in a community hospital. The average length of stay in Moray's Community Hospitals is 38 days so the so the saving in bed days is great (37 x 38 = 1,406).

Traditionally, social care assessments are carried out prior to discharge and this can result in delayed stays in hospital and packages of care that are not required or are over-specified. Figures for the average cost of care package for patients who were assessed in the relevant wards in Dr Gray's Hospital could have been obtained from Health & Social Care Moray and compared with the average cost of ongoing social care packages for patients managed by D2A, however this was felt to be unnecessary in the face of strong NHS evidence.

"I wanted care for my Mum and thought this was what Mum needed but these (D2A) therapists found she was far more able then we thought and she was able to manage at home."

The results from the D2A project are positive, with only a few patients being referred for ongoing support, much of it temporary in nature e.g. modifications to their home to enable the patient's ongoing independent living. Indeed, whilst indicative costs in terms of Bed Days Saved were provided in the formal business case to Senior Leadership Team and Moray IJB, the mapping of actual outcomes against a non-D2A model and overwhelming support from key stakeholders, the patients and their carers, negated the need for an in-depth costings exercise.

D2A provides a good example of how easy to obtain and well understood hospital data can quickly add an economic dimension to the evaluation of a project. In theory then, with time allowing, OHF projects seeking to tackle Aim 2 (Preventing hospital attendance/admission) and Aim 3 (supporting early discharge) could follow suit should that be a primary driver of interest.

The Physiotherapy-lead, Pulmonary Rehabilitation project in Aberdeenshire added an economic dimension to the evaluation by combining hospital financial data with project specific costings. Evidence from published sources makes a strong case for pulmonary rehab effectively preventing future admissions to acute care. The spend-to-save model is shown in Table 6.

Table 6. Spend to save model used in Pulmonary Rehabilitation project

Item	Cost per client (£)
Average direct cost for Respiratory Admission at ARI (see Table 7: Estimated costs associated with hospital inpatient stays)	*3,615*
Pulmonary Rehab service average cost (inc. travel)	*267*
Average saving per patient	*3,348*

Table 7: Estimated costs associated with hospital inpatient stays

Hospital	Specialty	Sum of direct costs per case	Average length of stay (days)	Average cost per bed day
Aberdeen Royal Infirmary	General Medicine	£1,492	3.7	£403
Dr Gray's	General Medicine	£1,289	4.0	£322
Aberdeen Royal Infirmary	Geriatric Assessment	£3,412	5.2	£656
Dr Gray's	Geriatric Assessment	£2,902	6.6	£440
Aberdeen Royal Infirmary	Respiratory Medicine	£3,615	6.2	£583

Source: NHS Costs Book 2019/20 (R040 tables) https://beta.isdscotland.org/find-publications-and-data/healthcare-resources/finance/scottish-health-service-costs/

The more upstream / preventative the project, the less relevant published hospital data becomes and other financial models become necessary to express the economic benefits of funding these projects. For example, being physically active could prevent hospital admission for many years, so presenting the benefit of the virtual exercise classes by comparing costs of delivering the service with a hospital admission is not necessarily a strong correlation. Third sector organisations are used to using Social Return on Investment (SROI) approaches to attract funding, whilst health economists might argue the benefits of Cost-Benefit or Cost-Consequence models. Whilst recognising these approaches, they were out of scope for a Portfolio-level evaluation, and would require a separate methodology to be systematically implemented across all initiatives to understand more fully.

Health Inequalities Synthesis

By health inequalities we mean systematic, avoidable and unjust differences in health and wellbeing between different groups of people which arise because of the conditions in which they are born, grow, live, work and become older. Legislation exists to address health inequalities in the UK including the Health and Social Care Act 2012, which addresses inequalities in access to health services and outcomes of different groups of people[1].

Ensuring equitable access to services is a key priority to address issues of inequalities in health. In the below table, the Evaluation Working Group have provided an appraisal to each Priority through a health inequalities lens, specifically how initiatives actively address this, or whether closer monitoring is required as time progresses. It should be noted though that this evaluation is not (and was never designed to be) a rigorous Health Inequalities Impact Assessment. Such an assessment should be conducted as a separate commission if this is desirable, though the below appraises elements of such with particular reference to access of services.

[1] Reducing Health Inequalities – The Health and Social Care Act 2012. Available here

Table 8. OHF Priority Appraisal through a Health Inequalities Lens

Priority Name (Project name in brackets)	Appraisal through a Health Inequalities Lens
Stepped Care Approach (Stay Well Stay Connected - Wellbeing Matters Webpage) Aberdeen City	Whilst being an initiative of Aberdeen City Health & Social Care Partnership, the webpage is technically available to anyone with an internet connection. For the small cohort of individuals who do not have access to the internet, wellbeing manuals have also been developed in paper copies to provide information of wellbeing resources locally.
Stepped Care Approach (Stay Well Stay Connected - Student Befriending Pilot) Aberdeen City	Befriending pilot exists to support those who already may experience health inequalities, as reasons for referral included social isolation, bereavement or being geographically distant from family members. Initiative still at small scale to prove the concept, therefore mechanisms of identifying appropriate individuals should be considered as part of the scale-up plan to minimise the impact of potentially exacerbating health inequalities.
Stepped Care Approach (Enhanced Community Support Huddles) City	With a recent Audit of service provision demonstrated that patients brought to the Huddle from North, Central and South localities was 36%, 30% and 34% respectively, this suggests that the model is operating effectively with regard to geographical reach (though further analysis of patient deprivation not conducted within would reinforce these findings). Multi-disciplinary team input across a variety of professions mean that the reach across different population cohorts is large. This will be further improved as participation of Primary care services increases.
Stepped Care Approach / Respiratory Pathway (Hospital @Home expansion: Respiratory Team) Aberdeen City	Although a very small team, operating only in the latter weeks of the Winter 2020/21 period, the Hospital @ Home Respiratory service was about to support referrals via both the Alternative to Admission route and 168 via the Supported Discharge route, showing that both routes had access into this service. Service delivered in a person's home, reducing the need for them to travel to access services.

Priority Name (Project name in brackets)	Appraisal through a Health Inequalities Lens
Respiratory Pathway (Home Oxygen Service) Pan-Grampian	Inpatient assessment for home oxygen to support discharge was made available to non-Respiratory consultants in ARI, with virtual support provided to consultants in DGH. In 9 weeks, the Home Oxygen team enabled the discharge of 28 patients, including 2 young palliative patients who were able to die at home surrounded by their families, which otherwise would not have been possible. The rapid home assessment service aimed at preventing hospital admission was only available to those living in or around Aberdeen City.
Respiratory Pathway (Prevention & Self-Management (Physical Activity) Online Classes) Pan-Grampian	The delivery of online, instructor-led, physical activity classes for patients with chronic respiratory diseases was identified as a proactive approach to halt and reverse the decline in health due to lack of opportunities to partake in exercise. Successful bids for Winter Funding via the Respiratory Cell enabled the purchase of equipment to ensure those who may otherwise have been excluded from the classes, could fully participate. 1:1, telephone-based, instruction was also provided to a few patients, for whom the digital technology was not appropriate. Links with the Pulmonary Rehab projects ensured people were able to access the most suitable option for their condition. Feedback showed that participation in these classes provided confidence to use digital technology for other purposes.
Respiratory Pathway (Physiotherapy-led Pulmonary Rehabilitation addition of 1-to-1 / Home support) Aberdeenshire	Delivered home pulmonary rehabilitation to patients who were unable to access online classes. Additionally, to contribute to reducing health inequalities, the team supported those with no access to transport who, in normal circumstances, would struggle to attend classes due to the rurality and lack of infrastructure around public transport.
Respiratory Pathway (Extension to Pulmonary Rehabilitation/Respiratory Physiotherapy and associated publicity/education campaign) Moray	This project has been Moray-wide (access to virtual pulmonary rehabilitation is not dependent on where someone lives) whereas before it was locality-based (depended on sufficient people to be worth running the face-to-face class, otherwise they would be offered a class in a different locality). Digital access is now within the team's current establishment to increase sign posting to community digital services, and potential for loanable technology to help reduce digital access inequalities (they are awaiting arrival of ordered iPads). The Moray physiotherapy team are still doing home pulmonary rehab to help reach patients for whom support via Digital is not an option/not appropriate (previously coming into the class was the only option, the team did very little home PR).

Priority Name (Project name in brackets)	Appraisal through a Health Inequalities Lens
Frailty Pathway (Hospital @Home) Aberdeen City	Service now operates at scale across Aberdeen City, with referrals accepted both from community-referring services (i.e. General Practices across the City) and secondary care service (i.e. Geriatric Assessment Unit in Aberdeen Royal Infirmary). Recent audit showed 308 referrals via the Alternative to Admission route and 168 via the Supported Discharge route, showing that both routes have access into the service. Service delivered in a person's home, reducing the need for them to travel to access services.
Frailty Pathway (Hospital @Home) Aberdeenshire	Service is not currently live so a health inequalities appraisal is not yet appropriate. However, close collaboration with developers of the Hospital @ Home model in Aberdeen City will help produce insights of best practice of implementing such models to reduce the likelihood of health inequalities occurring.
Frailty Pathway (Ward 102) Pan-Grampian	Given reductions in the number of geriatric beds, this does result in Ward 102 frequently carrying a proportion of boarders in different wards (i.e. patients who should be cared for in the ward but instead are elsewhere in this hospital). Reducing this is directly dependent upon capacity being scale up elsewhere in the system to facilitate flow, for example scaling up the Hospital @ Home model, or increasing the bed base at Rosewell.
Frailty Pathway (Rosewell) Aberdeen City & Aberdeenshire	Whilst Rosewell appropriate received almost exclusively step-down admissions from secondary care settings during its initial period of implementation, the longer-term vision for the facility was that of a community-facing intermediate care setting. Given this, the proportion of Step-Up vs. Step-Down referrals should be monitored closely to ensure there is equitable service provision focussing not just on accelerated discharge from hospital, but also avoiding admission to hospital by accessing the service.
Care @ Home (Contract Implementation) Aberdeen City	The move away from timed tasks to providing care tailored to the need of individuals may mean that more person-centred care can be delivered. The development of Granite Care Consortium is hoped to enhance market stability, meaning that the total hours of unmet need reduce over time. Whilst changes have not been made at the time of evaluation, this should be monitored as implementation develops. Service delivered in a person's home, reducing the need for them to travel to access services.

Priority Name (Project name in brackets)	Appraisal through a Health Inequalities Lens
NearMe Pan-Grampian	NearMe provides a digital solution, thus making services broadly more accessible, particularly to those living in geographically dispersed areas. However, telephone consultation can still be used between patients and clinicians and face to face consultations can still be had if physical examinations are necessary. As such, there are other means by which individuals can access services, should they not be digitally connected.
Redesign of Urgent Care (Flow Navigation Centre)	All NHS Boards in Scotland have been required to establish Flow Navigation Centres as part of the Scottish Government's Redesign of Urgent Care national programme. An initial "Discovery Report" commissioned by the Scottish Government, noted: that "*A fundamental part of the unscheduled and urgent care redesign is that this does not further disadvantage or widen health inequalities*." *"Key Findings:* • *The level of understanding and comprehension of current and future systems was low.* • *More deprived individuals have low levels of access to telephony and to appropriate spaces to make telephone calls.* • *The emotional and practical needs of users must be met to provide a satisfactory experience.* • *Frustrations with primary care drive self-presentation at A&E.* *The service as it stands today does not build in additional measures to prevent a further widening of health inequalities. We would recommend Mitigation steps."* The Scottish Government are leading/commissioning further analysis and work on the service redesign, to further identify and plan further service changes to mitigate against widening inequalities. National evaluation of the redesign of urgent care is recommencing, and it would be desirable for Grampian's evaluation activities to link in with the national work, where possible.

Priority Name (Project name in brackets)	Appraisal through a Health Inequalities Lens
Palliative & End of Life Care (The Oaks Virtual Programme) Moray	The restrictions in place to prevent the transmission of COVID-19 prohibited the reintroduction of a face-to-face service for this vulnerable patient group at the current time. The translation of the palliative day service previously held at The Oaks, Elgin, into a four-week block of hosted virtual classes ensures support to this cohort is maintained. Issues of access to technology is a potential barrier to participation, though can be addressed through partnering with agencies whose specific remit is to encourage uptake of digital access. This in turn, reduces another barrier to participation through physical travel across the area to attend a class in person.
Whole system approach to discharge (Discharge 2 Assess (D2A), Moray	For most people, being cared for at home, rather than hospital, is preferable and produces better outcomes (i.e. reductions in functional decline). D2A directly addresses the needs often associated with (prolonged) stays in hospital, through a multi-disciplinary, patient-centred approach. By instilling the confidence to continue to live as independently as possible, the provision of support services are kept to a minimum, freeing up capacity in the health and social care system for those who require more sustained treatment.
Virtual Community Wards Aberdeenshire	Model is established and used through Aberdeenshire. Particularly beneficial given the geographical dispersion of the area that allows for people of interest to be monitored closely if required. Service delivered remotely, reducing the need for people to travel to access services.

Operation Home First Evaluation Working Group Priority Appraisal

Given the data provided above, with specific regard to Priority timescales; degree of implementation and evidencable impact, the below Table provides an appraisal, from the Evaluation Working Groups perspective, as to the delivery of each of the OHF Priorities.

Table 9. Evaluation Working Group Appraisal of OHF Priorities

Priority Name	Evaluation Working Group Appraisal
Stepped Care Approach (Stay Well Stay Connected Workstream)	Staff working on workstream were redeployed to support other system-wide priorities during time of evaluation, including COVID vaccinations and Surge & Flow, resulting in some work slowing. Priorities within workstream have now been refreshed to account for the new context and should be allowed sufficient time to be developed and implemented before concluding their effectiveness.
Stepped Care Approach / Frailty Pathway / Respiratory (Hospital @ Home Aberdeen City)	Hospital @ Home model has been subject to rigorous evaluation previously, demonstrating acceptability to service users; unpaid carers and staff. Model delivers strong benefits aligned to OHF through caring for people at home and subsequently reducing pressure on secondary care. Given the ambitions of OHF, scaling this service further would be valuable.
Stepped Care Approach (Enhanced Community Support Huddles)	The huddles directly support the reduction of potential admissions or re-admissions to hospital by providing wraparound support using a virtual multi-disciplinary team approach. The huddles care for similar numbers of patients across Aberdeen City's localities and demonstrate high levels of acceptability from staff who attend, the majority of whom agree that this model improves patient care. Further work to engage Primary Care services will enhance their function.
Frailty Pathway (Ward 102)	Priority has focused on enablers to ensure the system operates more optimally, for example the development of criteria-led discharge and implementation of Rockwood scoring within the Emergency Department. The 'performance' in Ward 102 is inextricably linked to Hospital @ Home / Rosewell Priorities, with capacity required out-with the hospital setting to facilitate flow. The scale-up of Hospital @ Home and ability to open the remaining 10 beds in Rosewell may both help reduce the number of boarders the Ward faces.
Frailty Pathway (Rosewell)	The intermediate care facility effectively reduced the pressure on secondary care during the winter period by allowing flow out of Aberdeen Royal Infirmary. Ongoing organisational development work is required to support the growth of a 'One Team' culture, and such an ethos will require patience to manifest. Increasing the proportion of Step-Up referrals will be critical to avoid preventable hospital admissions and should be regularly monitored to ensure this is achieved.
Frailty Pathway (Hospital @ Home Aberdeenshire)	The model was under development during the evaluation period, meaning there are no deliverable benefits yet. However, there is strong evidence from the Aberdeen City Hospital @ Home model, and other similar models implemented nationally, that this will be valuable to adopt. More time is required to allow this service to go live before reviewing its impact.

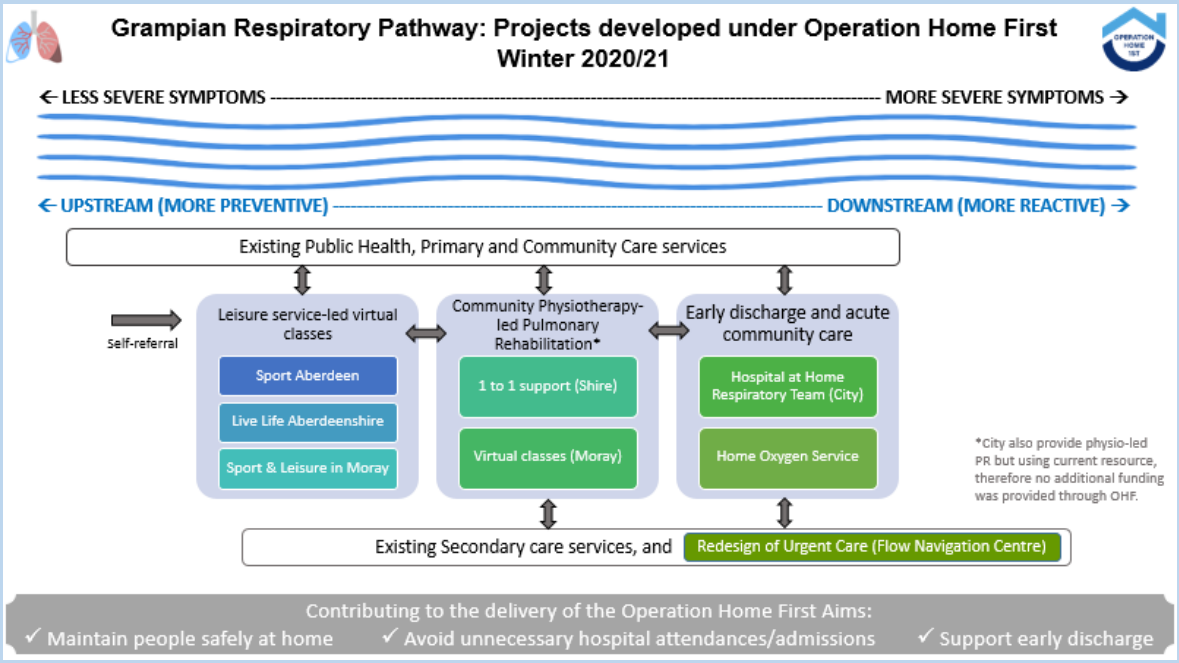
Priority Name	Evaluation Working Group Appraisal
Care @ Home Contract Implementation	During the evaluation period, the new Care @ Home contract had been implemented, however changes had not been made to the type of care that service users received. Therefore, more time is required to make a judgement on the impact of this new contract. However, Granite Care Consortium staff reported to be satisfied within their caring role and cited numerous perceived advantages to this way of working, including more flexibility as service users' wellbeing increases and decreases.
NearMe	Service has been scaled up since the COVID-19 pandemic and continues to support large numbers of people to be cared for across community and secondary care services virtually. It is highly acceptable to service users and staff. It is only used when safe and appropriate to do so, with telephone and face-to-face consultations still options if required. This is now an established model of delivery that will be valuable to continue in future.
Redesign of Urgent Care (Flow Navigation Centre)	This work is part of an ongoing, Scotland-wide, programme to build on opportunities to support people to access the Right Care in the Right Place at the Right Time, and as part of this, to reduce attendances at A&E/Minor Injuries Units if there are more appropriate sources of help and support. The programme leads within Grampian, and nationally, will continue to develop the service further, and with it, monitoring of relevant data to support both service operation and evaluation.
Stepped Care Approach / Frailty Pathway / Respiratory Pathway (Hospital @ Home expansion: Respiratory Team)	Local and national evaluations have shown that the Hospital @ Home model is well received and delivers good outcomes. This expansion of Hospital @ Home capacity in Aberdeen City was only for a short period and at small scale but again delivered good results, with substantial opportunities for future development. This is reinforced in Policy Direction/further funding opportunities at Scotland level. We would therefore suggest that there is merit in restarting and extending the Hospital @ Home respiratory team. UK researchers are doing further work on the economic evaluation of Hospital @ Home.
Respiratory Pathway (Home Oxygen Service)	The potential for changes to the Home Oxygen Team's way of working was demonstrated but not fully realised due to the unsuccessful recruitment of an additional staff member. There was no promotion of changes due to concerns over inundating the delivery of the existing service. The inpatient assessment test of change, supported by winter funding, highlighted the fact that home oxygen is not solely for patients suffering pulmonary conditions; most assessments and facilitated early discharges were for non-Respiratory specialties. Professional and patient support for this project was very high. Continued engagement between the evaluation team and Home Oxygen lead is necessary to understand key learning points from these brief tests of change and identify ways that service could implement these.

Priority Name	Evaluation Working Group Appraisal
Respiratory Pathway (Pulmonary Rehabilitation - Aberdeenshire)	This project successfully delivered home-based, 1 to 1 Pulmonary Rehabilitation, to patients who could clinically benefit from it, but who were not able to access support via Digital means (or it was not suitable for them). Thus, even at its small scale, it played a part in helping to reduce inequalities. Additionally, as with other projects on the Respiratory pathway, the team communicated and cross-referred with other project teams, e.g. the Home Oxygen Service and Live Life Aberdeenshire (Physical Activity Classes). This was a good demonstration of integrated working. The Scottish Government's Respiratory care - action plan: 2021 to 2026 makes clear that "*A critical part of the respiratory care pathway is access to pulmonary rehabilitation*", and whilst the Shire physiotherapy team are continuing to provide group classes, consideration should be given again funding to further develop this service, e.g. to continue providing 1 to 1 support for those who are unable to access digital options, or for whom the group support is not appropriate (i.e. not to widen inequalities); to further develop links with the Home Oxygen Service / Acute.
Respiratory Pathway (Extension to Pulmonary Rehab / Respiratory Physiotherapy - Moray)	The team developed and delivered virtual Pulmonary Rehabilitation (PR) classes for the first time in Moray. They also undertook other small tests of change, including support for Home Oxygen reviews (saving staff and patient travel to/from hospital). This project used OHF funding to raise awareness of the existence (and benefits of) PR and respiratory physiotherapy, and associated referral pathways, amongst fellow health professionals in Moray. The team developed training and resources to increase capacity, within existing establishment, to take PR/Respiratory physiotherapy referrals – and saw an increase in such referrals during Jan-Mar 21 relative to Jan-Mar 2019. Even at small scale, this has been a very positive example of service development and (subject to ongoing resourcing) has the potential to continue to grow as part of an integrated respiratory pathway.
Respiratory Pathway (Physical Activity Classes)	Established with winter funding via the Respiratory Cell, the local sports providers (Sport Aberdeen, Live Life Aberdeenshire, Moray Council) developed programmes of instructor-led, physical exercise classes delivered virtually to patients whose respiratory illness had likely become compromised during the pandemic. A common evaluation framework was agreed to enable outcomes to be measured at both individual provider and collective Grampian levels. Whilst the late application for funding and time from award to implementation did mean that the number of weeks the classes could run was limited, feedback from those who participated (patients and the instructors) was very positive. The approach taken with this project shows great potential for expanding to include those with non-respiratory long-term conditions, making the service more viable. The benefits are wider than just improving physical health, with known links to improved mental wellbeing, peer-group support, reduced isolation, increasing digital literacy and so forth. A more robust evaluation framework over a longer period would surely yield benefits across the entire system.

Priority Name	Evaluation Working Group Appraisal
Palliative & End of Life Care (The Oaks Virtual Programme)	Despite only being able to deliver 3 of the 4 intended weeks for the first Virtual Programme, feedback from the patients who attended was very positive and showed that physical, group sessions are not the only acceptable format for supporting people's palliative care needs. The fact that Roxburghe House is continuing to develop their virtual offering further supports this view, although the experience of the team at Roxburghe House does show that frequent (weekly) 1:1 support will be essential for some patients. The design of a Grampian-wide Virtual Programme, complemented by individual support, when necessary, may help to promote equity of access, although there are significant resource implications requiring further consideration. Evaluation support for development of this programme will be essential to fully recognise the value of such an offering.
Whole system approach to discharge (Discharge 2 Assess)	Discharge 2 Assess is a great example of the adoption of a tried initiative that has been developed elsewhere in the country to fill a gap in local service provision. Whilst the figures from the D2A pilot are very encouraging at patient, staff and service levels, without a doubt the service lead's enthusiasm and tireless campaigning played a huge role in the successful implementation of the service. It is no coincidence that whilst D2A is currently "offline" for staff recruitment, Moray once again is struggling to manage its Delayed Discharge numbers. Funding for the service through 2021-2022, should be accompanied with evaluation support to maximise the service potential and cement the business case for permanent funding.
Virtual Community Wards	No significant changes to delivery during evaluation period whilst resources were diverted to developing Aberdeenshire's Hospital @ Home model. However, this Priority has been established as business as usual and its impact well evidenced.

Figure 10. Development of the Respiratory Pathway

EVALUATION APPRAISAL CASE STUDY: DEVELOPMENT OF THE RESPIRATORY PATHWAY



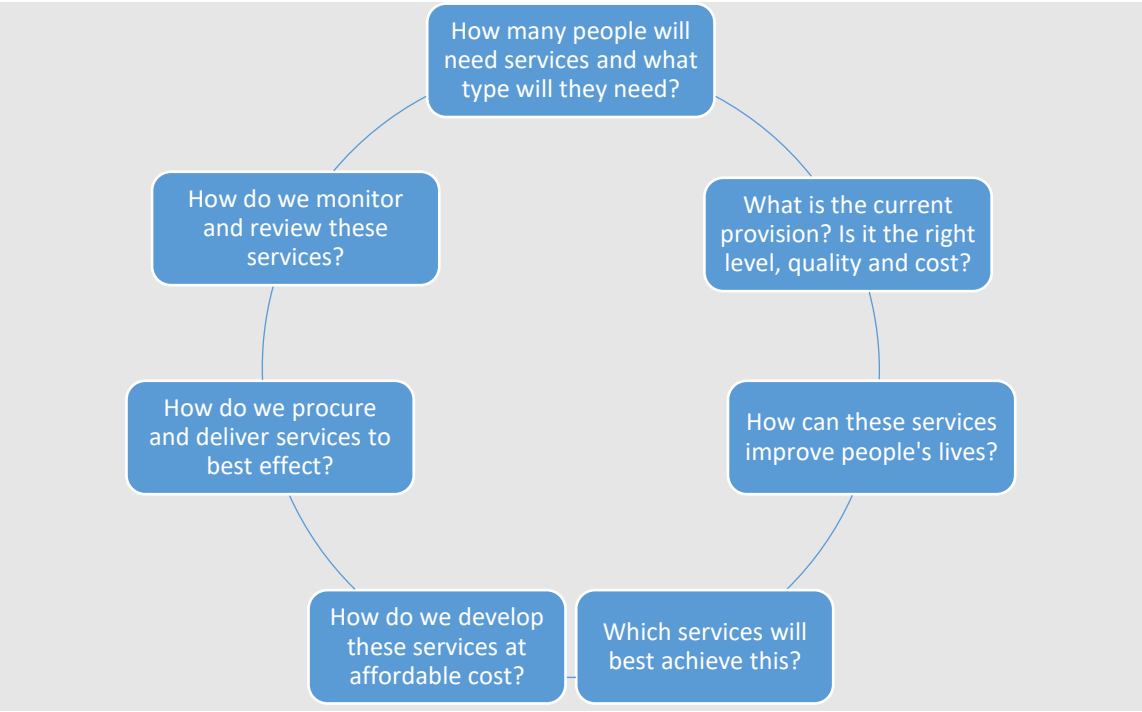
- The work of the GRAM Respiratory Cell in developing a series of inter-connected projects on the Respiratory Pathway, has been a good example of an OHF Priority area taken forward in an inclusive and actionable way.
- The Respiratory Cell is an extension to the pre-existing Managed Clinical Network (MCN), with enhanced Multi-disciplinary (clinical and non-clinical) working.
- The projects developed/extended with Winter 2020/21 monies have comprised a balanced mix of upstream and downstream supports, mindful of the often progressive nature of many respiratory conditions, and the opportunities to prevent people with relatively moderate illness from becoming more severely unwell.
- Project development has been nimble and flexible.
- The pathway's projects are inter-connected, and even at very small scale have demonstrated commitment to communicate with each other, inclusive of cross-referring patients as a function of the progression (or improvement in) their clinical condition.
- Many areas of potential to progress the work of the Cell have been identified, both at Strategic and Project level, subject to resourcing in the months ahead.

Strategic Context / Next Steps

The development of the OHF Portfolio was driven in large part by the combination of a requirement to remobilise services amidst ongoing COVID-19 restrictions, and to mitigate against expected pressures on acute services during the October 2020 – March 2021 winter period. The evaluation of OHF has taken place during a (COVID-19 necessitated) acceleration of service (re)development and (tests of) change. Many elements of work were reflective of existing Strategic Plans (and have good alignment with the aims of health and social care integration), but with additional, more reactive layers.

Taken as a whole, this is a complex portfolio, with many programme strands at different stages and paces of development. Over the course of various exchanges with staff over (and after) the life span of OHF, it appeared that awareness in the wider workforce of OHF as a concept may not have been high as a whole, sitting as it did in conjunction with the winter planning period, and between Grampian's two other "Operation" phases of Rainbow and Snowdrop. We understand, however, that there is a strategic appetite for the ethos of "Home First" to become more embedded in Business as Usual for integrated health and care services across Grampian. To help it become so, we would recommend that project and programme evaluation is maintained as an integral part of the Strategic Commissioning Cycle, complementary to other key steps in that cyclical "Plan, Do, Study, Act" (PDSA) process. The visual below, drawn from the Scottish Government's Strategic Commissioning Plans Guidance, illustrates that amongst the questions pertinent throughout the commissioning process, there is a natural place for a range of Evaluation activities, alongside other relevant work such as Needs Assessments and Performance Monitoring. Such evaluation may be in respect of the ongoing "Home First" Portfolio, and/or other areas of relevant service provision.

Figure 11. Questions pertinent throughout the Strategic Commissioning Process



Redrawn from: https://www.gov.scot/publications/strategic-commissioning-plans-guidance/

It is also relevant to consider again where the strands of the OHF Portfolio sit in relation to regional and national policy and strategy, inclusive of key documents that were published during the winter 2020/21 period or shortly thereafter. We have bulleted, and then tabulated, some of these below. It is not an exhaustive list, but we have included here as they are of relevance in informing strategic decision-making going forward.

- The Redesign of Urgent Care will continue to be a priority for the Scottish Government (SG), with further actions and evaluation anticipated.
- The SG, with support from Healthcare Improvement Scotland, are continuing to promote the development of Hospital @ Home services. A paper published earlier this year has added to the evidence base around the benefits of Hospital at Home.
- The SG have in recent weeks published their Respiratory care - action plan: 2021 to 2026. Amongst the recommendations in this is that Pulmonary Rehabilitation services be provided in all areas.
- The Independent Review of Adult Social Care in Scotland ("the Feeley Report") is of particular significance, and we can anticipate that this will have substantial implications going forward.
- Other portfolio-relevant themes such as Frailty, and Intermediate Care, remain on the national agenda for the continuation/continued development of services with a "Home First" focus.

Table 10. Some Relevant Key Strategic Literature Relevant to the OHF portfolio (with particular focus on those published during the winter 2020/21 period)

Redesign of Urgent Care (Flow Navigation Centre)
Healthcare standards: Urgent Care (Scottish Government) https://www.gov.scot/policies/healthcare-standards/unscheduled-care/ *"It is considered that approximately 20% of patients who self-present at A&E could be helped to access more appropriate services for their needs and often care that is closer to home. The need for new ways of delivering services during COVID-19 has demonstrated what can be achieved to keep people safe and that there are a range of alternative ways to access NHS services which are available, in addition to traditional face to face care. The Redesign of Urgent Care looks to build on these opportunities to support the public to access the Right Care in the Right Place at the Right Time."*
Hospital at Home
Shepperd et al (2021). Summary on Hospital at Home Society website: https://www.hospitalathome.org.uk/hah-study-rct, links to full paper at https://www.acpjournals.org/doi/10.7326/M20-5688 Results of a randomised trial of >1,000 H@H patients in the UK. • Providing healthcare at home to selected older people who experience a deterioration in health rather than in hospital could reduce pressure on hospital resources and be less disruptive to older people • In this study, outcomes for patients who received 'Hospital @ Home' care were just as good six months later, as for those who were admitted to hospital • There were higher levels of patient satisfaction with Hospital @ Home care. • It is not yet known whether Hospital @ Home care is cheaper than hospital-based care, but the research team are investigating this in an economic analysis.

Intermediate Care

Maximising Recovery, Promoting Independence: An Intermediate Care Framework for Scotland (Scottish Government, 2012) https://www.gov.scot/publications/maximising-recovery-promoting-independence-intermediate-care-framework-scotland/.
The framework encourages the development of a range of integrated services that can provide alternatives to hospital admission, and provide step-down care after a hospital admission.

The landscape for bed-based intermediate care in Scotland (Royal College of Nursing, 2017) https://www.rcn.org.uk/about-us/our-influencing-work/policy-briefings/sco-pol-the-landscape-for-bed-based-intermediate-care-in-scotland.
"There is a small but growing evidence base on how bed-based intermediate care supports improved system and individual outcomes." (…) *"Intermediate care beds are also seen as a mechanism to deliver more cost-effective care. However, a recent paper by Nuffield Trust looking at delayed transfers of care in England noted 'it cannot be assumed that alternatives to hospital will save large amounts of money unless far more radical changes to the system are made'. Looking at intermediate care beds specifically, there is mixed evidence on whether the use of intermediate care beds increases or reduces costs in comparison to hospital care."*

Respiratory pathway

Respiratory care - action plan: 2021 to 2026 (Scottish Government, 24 March 2021)
https://www.gov.scot/publications/respiratory-care-action-plan-scotland-2021-2026/
This plan "*identifies key priorities and commitments to improve outcomes for people living with respiratory conditions in Scotland. The plan encourages new and innovative approaches and intends to share best practice. It sets out our desire to see a whole system approach to respiratory care, across health and social care."* It notes that *"provision of high quality, joined-up respiratory care across Scotland must be the priority. New investment in well trained, multi-disciplinary healthcare teams is critical, right now."* Examples of Priorities as applicable to the Operation Home First Portfolio include (but are not limited to), the following:

Priority 2- Diagnosis, management and care.
"A critical part of the respiratory care pathway is access to pulmonary rehabilitation. [This offers] a structured exercise and education programme designed for people living with a respiratory condition." (…) *"Pulmonary Rehabilitation is one of the most effective forms of management for people living with respiratory conditions. 90% of people who complete the programme experience improved exercise capacity or increased quality of life. However, Chest Heart and Stroke Scotland (CHSS) estimates that only 2% to 21% of those who might benefit are being referred to pulmonary rehabilitation. Pulmonary rehabilitation is best established within treatment for COPD, however there is evidence of clear benefit in asthma, pulmonary fibrosis and bronchiectasis."*

Priority 3 – Supporting Self-Management
"Self-management (…) *requires a strong partnership with health professionals and access to a wide range of support networks."* (…) *"Self-management techniques are well established within long-term conditions and during the COVID-19 pandemic, they became more important than ever. With access to hospital and community services disrupted, people were forced to take a different approach to manage their condition."*

Priority 5. Workforce
"Allied Health Professionals (AHPs) play a significant role in the treatment and care of respiratory conditions in Scotland. The development of more advanced roles means we are seeing more AHP-led services."

"We recognise the importance of including wider sectors within workforce planning. There is vast support available within the third sector and we should consider opportunities of developing pathways and partnerships with organisations such as Chest Heart Stroke Scotland and Asthma UK and the British Lung Foundation."

Frailty

The Frailty at the Front Door Collaborative Impact report December 2019 (Healthcare Improvement Scotland iHub). https://ihub.scot/media/6870/201912-frailty-at-the-front-door-collaborative-impact-report-v10.pdf

"*There is compelling evidence to support the benefits of early and effective Comprehensive Geriatric Assessment (CGA), re-enablement and intermediate care for people living with frailty. The benefits for people and organisation include:*

- *improved care experience,*
- *a reduction in the need for hospital care by consideration of a range of care options,*
- *people who are more likely to be supported in their own home with the appropriate level of care, and*
- *shorter periods of time in hospital if admission is required*."

https://www.cochrane.org/CD006211/EPOC_comprehensive-geriatric-assessment-older-adults-admitted-hospital

Independent Review of Adult Social Care in Scotland, February 2021 ("the Feeley Report").

https://www.gov.scot/publications/independent-review-adult-social-care-scotland/.

There were 53 recommendations in this report, many of which reinforce messages inherent to the aims of Health and Social Care Integration, such as outcomes focussed commissioning, and preventive/upstream services. Below are some excerpts from those recommendations that have particular relevance to the OHF Portfolio (although this should not be taken to mean that the other recommendations do not). We can expect actions around the 53 recommendations to come to the fore as preparatory work for the establishment of a National Care Service gets more fully underway.

Models of care

"28. The Scottish Government should carefully consider its policies, for example on discharge arrangements for people leaving hospital, to ensure they support its long held aim of assisting people to stay in their own communities for as long as possible."

"31. Investment in alternative social care support models should prioritise approaches that enable people to stay in their own homes and communities, to maintain and develop rich social connections and to exercise as much autonomy as possible in decisions about their lives. Investment in, or continuance of, models of social care support that do not meet all of these criteria should be a prompt for very careful reflection both by a National Care Service and local agencies."

Finance

"50. Careful analysis by a National Care Service, with its partners in the National Health Service, Integration Joint Boards and beyond, of opportunities to invest in preventative care rather than crisis responses, to avoid expenditure on poor outcomes such as those experienced by people who are delayed in hospital."

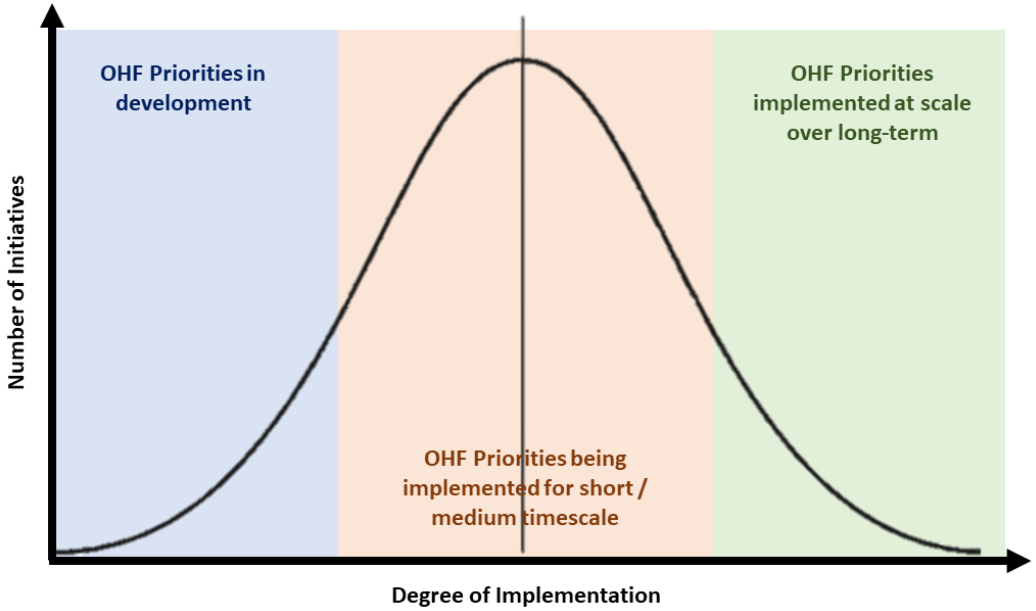
"51. Additional investment in order to:

- *expand access to support including for lower-level preventive community support"*

Summary / Discussion

The purpose of this report was to evidence the impact of the OHF Portfolio against its three aims of maintaining people safely at home, reducing unnecessary hospital attendances/admissions, and/or supporting early discharge. The report has also aimed to address a variety of additional queries that have been posed to the Evaluation Working Group over the course of its lifespan, including evidence of health inequalities; evidence related to cost; and the potential scalability / population-wide reach of different Priorities. Given the complexity of the Portfolio, the answers of its impact are complex, with different initiatives occurring at different scales over different time periods. Broadly speaking, Priorities in their infancy still demonstrate acceptability to service users and staff, whilst numerous Priorities have been evidenced to directly impact on the OHF aims. These are typically activities that strongly correlate to reducing pressure on secondary care, such as Hospital @ Home. Overall, the implementation of the OHF Portfolio can be illustrated using a bell curve to denote different initiatives sitting at different stages of development/implementation.

Figure 11. Bell curve illustrative of OHF priorities being implemented to varying extent.



Cumulative Impact

This evaluation intentionally stops short of providing grand totals, either for the cumulative impact on each of the OHF aims, or for other factors deemed of interest (such as financials). There are inter-related reasons for this:

1) The OHF portfolio is vast and heterogeneous, even within the deceptive simplicity of its three key aims. It has a mixture of upstream / downstream activity, Priorities occurring as small tests of change / at scale and Priorities impacting on one or more aims. Providing such grand totals would be a reductionist interpretation of the true value of the Portfolio.
2) Provided the context above, it is not possible to, with 100% accuracy, determine the totality of the Portfolio. Even with sweeping assumptions across the suite of activities within, it would likely underestimate the full impact.
3) Additionally, we are mindful that to attempt a detailed Economic Evaluation of the portfolio would require us to secure further resource, with the requisite skill base required to be

implemented concurrently with a separate, systematic methodology applied across all initiatives within the Portfolio, for that particular type of analysis.

This provides some key insight into how / what an evaluation of a complex Portfolio looks like. It is important to reiterate that this Portfolio emerged through a variety of complex social-economic / political factors (though primarily out of necessity given a global pandemic) and as such, required the implementation of an agile, multi-modal and pragmatic evaluation approach to concurrently run alongside.

Data Collection Considerations

Key to determining the impact of any initiative is the data that are available / able to be gathered. The more data that can be gathered, the more confident and robust conclusions can be. However, this requires more time and capacity to be invested in order to make this happen.

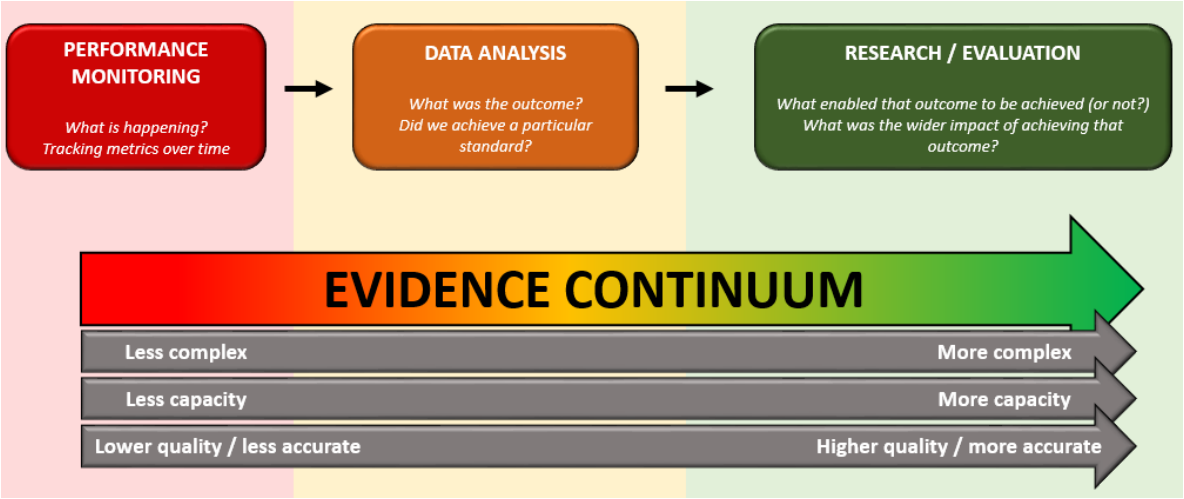


Figure 12. Evidence Continuum

For each initiative described within, the trade-off between time, capacity and evidence considerations had to be reviewed and judged at an individual level. Initiatives in their development phase during the evaluation period were able to closer align their data collection methods and requirements to that of the aims of the Portfolio. Other initiatives that were already implemented prior to this period have existing performance monitoring frameworks that are not necessarily feasible to adapt, particularly if they are long established. However, having an evaluation team with strategic oversight of such a Portfolio allow for connections / linkages to made across different initiatives to provide a clearer perspective on its cumulative impact. This also means that operational staff can focus more time on service delivery, a particularly pertinent point given the pressures the health and social care system have been under during the COVID-19 pandemic.

Resourcing

As aforementioned, not all OHF Priorities have been implemented to the same degree across the period of evaluation. One reason for this is challenges around resourcing and competing priorities. For example, a survey circulated to the OHF Priority leads (N=17) at the beginning of the evaluation period returned a mean score of 5/10 with regard to perceived confidence that the necessary resources (i.e. staffing) were available to deliver the change. In some instances, changes to particular Priorities were slowed to allow for acceleration in others (for example, the Palliative Care workstream decelerated activity as the relevant Occupational Therapists were assigned to Moray's Discharge 2 Assess project

instead). As highlighted in Figure 2, it is to be expected that implementing such a Portfolio with a variety of interdependencies would consequently result in prioritisation having to occur.

The long-term resourcing of Priorities within the OHF Portfolio is also variable. Some initiatives, such as the Respiratory Cell's Home Oxygen and Leisure projects were delivered using winter monies and, whilst demonstrating measurable benefits, are not subject to long-term investment. This is where the value of implementing a robust evaluation framework becomes apparent, as it provides senior leaders and decision makers with information to support decision making towards investing in initiatives that are thought to deliver tangible benefits. One such example is the Discharge 2 Assess project in Moray, which received the necessary ongoing funding from their Integration Joint Board to scale up and care for more people. It is recognised that in some instances, the long-term investment in one initiative may only be possible with the disinvestment in others, however a judgement on potential areas of disinvestment was out of scope for this report.

Equity of Evaluation Support

As mentioned above, initiatives competing for the same resources has meant that some projects have been prioritised over others. The same tension is evident within the capacity of the Evaluation Working Group to support all initiatives equitably. Given the pressure secondary care services were under during the winter period, initiatives that directly impact on this typically received greater emphasis of evidencing impact than upstream activities. One example of this was the rapid evaluation of the Rosewell Intermediate Care Facility, that was completed within a five-week period to inform the future direction of the service. It should also be recognised that the capacity of colleagues to engage with the evaluation process can be variable, particularly if service areas are under pressure. In these situations, the priority of the Evaluation Working Group is to minimise the additional burden of primary data collection and to review existing data infrastructure to draw as accurate conclusions as possible given the constraints.

Perceived Value of External Evaluation Support

The OHF Portfolio was novel, insofar as dedicated evaluation resource, comprised of a cross-system working group, was established to evidence this impact. Below, case studies were voluntarily written by Leads of some OHF Priorities to explain, from an implementation perspective, the value that this external support provided.

Reflections on Evaluation Support for the GRAM Respiratory Cell

"I think having you both [Evaluation Working Group Members] involved from the outset has allowed us to not only think about evaluation (in terms of looking back and seeing how something has worked or not worked) but to consider evaluation in advance and in the design stage. This has resulted in not only some new questions being asked or issues considered at the design stage but has helped sharpen focus and bring additional perspective to our projects."

"I think being able to use data / information / feedback for assessment is incredibly valuable, but I think being able to use that prospectively and having that be an integral part of project working on an ongoing and evolving basis is even more valuable. This helps underpin our work with a level of intelligence and assurance and allows us to have a much stronger basis for recommending things start, continue, adapt or stop and I think that has been to our considerable benefit."

"From my discussions with Kris [Cell Deputy chair] and Angie [Cell chair] I am confident that the above is reflective of their views also."

Robert O'Donnell, MCN Co-ordinator, NHS Grampian.

Reflections on Evaluation Support for Rosewell (Frailty Pathway)

"As we explore and try out new models of integrated working, it is critical that we can evidence the impact of the change that we are making. This information will let us see: how much progress we are making; whether that progress is in the intended direction; and at the pace we need.

The establishment of a new integrated model at Rosewell was achieved at pace, during the second wave of the pandemic and at a time of intense winter pressures. The model, while in line with the strategic intent for Rosewell as a key component of Operation Home First and the Frailty Pathway, was implemented in response to the civil contingencies crisis at that time.

A rapid evaluation within two months of implementation allowed the project team to be clear (supported by robust data), about the impact the new model was making - in terms of feasibility to staff and service users. This has allowed direct focus on specific areas as the interim model continues. This will allow for focussed modifications to be made during the extended test period, concurrently with other changes to the system as a result of remobilisation and changes in demand, allowing robust information to inform decisions on what will be best to put in place in the longer term.

There is no doubt, that without the initial capacity around the rapid evaluation, very early on in the change process, we would not be in such an informed position, which could have resulted in negative impacts, such as a longer required test period, and/or the project not meeting its desired outcomes."

Gail Woodcock, Interim Managing Director (Bon Accord Care)

Reflections on Evaluation Support for the GRAM Redesign of Urgent Care (RUC) Governance Group

"The evaluation team have brought a clear insight, direction, and drive. They have understood exactly what was asked of them to complement the governance of the RUC programme. I would argue that they are integral to the programme moving forward as we continue to evaluate in more depth the feedback from patients, but also staff as to the effectiveness or otherwise of the RUC programme."

John Thomson, Divisional Clinical Director, Division of Unscheduled Care, NHS Grampian

Limitations

This evaluation, whilst it has covered a lot of ground, is not a silver bullet. Given the breadth of the Portfolio, the variety of questions that were posed along the way and challenges with time and resources, it is not possible to provide an exhaustive oversight on all facets described within. Should this report result in outstanding questions of interest that remain unanswered, these can be reviewed in the future. Furthermore, it has been conducted over a relatively short timescale in the midst of a global pandemic, meaning that its conclusions must be viewed within that context. Understanding the longer-term impact of these Priorities would require a longer-term monitoring of their outputs.

Acknowledgements

The Evaluation Working Group would like to acknowledge the following groups / individuals in the production of this report:

- The OHF Steering Group for establishing and ongoing commitment to the evaluation process.
- The OHF Priority Leads (and other close colleagues) for their enthusiasm and engagement.
- All service users and unpaid carers who volunteered to engage with numerous initiatives described within.
- The three North-East Health & Social Care Partnerships (Aberdeen City; Aberdeenshire and Moray); NHS Grampian; and the three North-East Local Authorities (Aberdeen City Council; Aberdeenshire Council and Moray Council) for their support and investment into the evaluation process.
- To Public Health Scotland for providing human resources to support the Portfolio evaluation

Appendix A: Interim Evaluation (including project Flash Reports)

OPERATION HOME FIRST

Evaluation Progress Report

March 2021

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Executive Summary

This report provides an update on the evaluation of Operation Home First (OHF). OHF is the collective priorities of the three North-East Health & Social Care Partnerships in collaboration with the Acute sector of NHS Grampian. The information contained within is predominantly for the purposes of providing assurances that a robust process has been implemented to evidence the impact of these priorities.

In general, positive progress is reported on most of the priorities. This includes: 1) an approximate 40-fold increase in the average number of NearMe consultations per week in the last 12 months; 2) the opening of 30 NHS beds in Rosewell as an interim care facility; 3) the implementation of a new Care @ Home contract, moving away from a time and task model to an outcomes-based approach. Of priorities that have been operational for an adequate period, evidence of acceptability to both service users and service providers is a critical first step towards ensuring that these initiatives are feasible to implement and subsequently, may deliver positive outcomes.

The full impact of the OHF portfolio cannot yet be fully quantified. This is for several reasons, for example: 1) several initiatives have only been operational for a limited period (such as the interim service model in Rosewell going live on 18.01.21), meaning more time must be given in these circumstances to generate enough data to robustly determine their function and 2) other priorities have moved at a slower pace given the recent Civil Contingency status that Grampian has been placed under since January 2021 (such as the sign-off and implementation of recommendations made in the Grampian-wide Strategic Framework for Palliative and End of Life Care). However, with reference to OHF priorities with a more acute focus, strong causation can be drawn of their direct impact against the aims of OHF. For example, every admission to Hospital @ Home that is identified as an 'alternative to admission' means that the person is not admitted unnecessarily to the ARI wards, but instead is supported safely at home. Furthermore, this helps to lessen pressures that can otherwise lead to patients being "boarded" in ARI beds out with the specialty whose care they are under.

A further report is due to be published towards the end of Spring 2021, with greater detail on the impact of each individual priority against the aims of OHF. This time allows for additional data to be collected and further analysis to be conducted. This, in turn, will ensure more meaningful conclusions and future recommendations can be derived.

Introduction

Operation Home First (OHF) is the collective priorities of the three North-East Health & Social Care Partnerships in collaboration with the Acute sector of NHS Grampian. It is a portfolio that has emerged through positive, cross-system working during the COVID19 pandemic and emphasises the importance of shifting the balance of care, when safe and appropriate to do so, from acute settings to community settings. There are three aims to OHF:

1) To maintain people safely at home
2) To avoid unnecessary hospital attendance or admission
3) To support early discharge back home after essential specialist care

More background information about OHF, including its underlying principles, can be viewed here.

In October 2020, The OHF Steering Group commissioned an evaluation working group to evidence the impact of the OHF portfolio. The remit of the working group was two-fold:

1) Understand the impact of each OHF priority, and how they contribute towards achieving the aims of OHF
2) Develop a high-level, performance dashboard of meaningful metrics to monitor overtime to understand the performance of the portfolio.

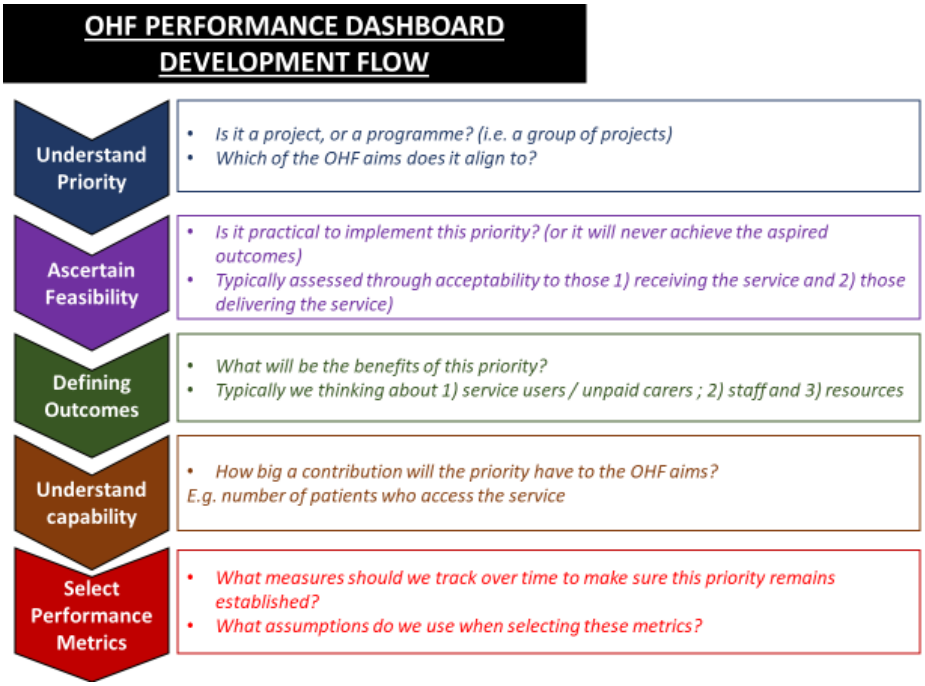
This report outlines the progress made against the above as of February 2021. In particular, it is designed to provide assurances that a robust process has been designed and implemented to evidence the impact of this portfolio.

A further report is due to be published towards the end of Spring 2021, with greater detail on the impact of each individual priority against the aims of OHF. This additional time allows for additional data to be collected and further analysis to be conducted. This, in turn, will ensure more meaningful conclusions and future recommendations can be derived.

Methods

Evaluation process

To develop a meaningful, performance dashboard of high-level metrics that may be positively influenced should a complex portfolio of this nature be implemented as theoretically planned, an understanding must first be sought of each individual priority. The figure below describes, at a strategic level, the approach that the evaluation working group took across priority areas. These are elaborated upon below:



Understanding the Priorities individually – Some of the OHF priorities are individual projects (such as Implementation of Near Me). Others are programmes (i.e. a group of projects, such as the Stepped Care Approach). In the latter scenario, the full impact of the programme cannot be understood until individual projects are understood. During this stage, priorities were mapped against the OHF aims, which helps inform the data collection process.

Ascertaining feasibility – Service changes / developments cannot realise benefits if they are not practical to implement. As such, a critical component to new initiatives is determining whether they are acceptable to those delivering the service (i.e. staff) and to those receiving the service (i.e. service users and unpaid carers).

Defining outcomes - If initiatives pass the feasibility test, consideration can be given as to what benefits these will have. These benefits can usually be categorised by 1) benefits to service users / unpaid carers; 2) benefits to staff; 3) benefits to resources / services.

Understanding capability – This helps answer the question as to the impact individual priorities have against the aims of OHF. For example, a small-scale test of change will not have a substantial impact on reducing hospital attendances but is helpful to prove a new concept or to determine how it may make a positive contribution should it be scaled up.

Selecting performance metrics - The goal here is to distil each priority down to a minimal number of measures that can provide an indicative overview as to how that priority is functioning. Key to this is developing assumptions that provide as rationale as to why that metric was selected.

Pragmatic considerations

Evaluation of a portfolio of this scale is a complex undertaking. There are multiple reasons for this, including but not limited to:

- *Degree of implementation*: The priorities within the OHF portfolio did not all begin at the same time, with the same capacity and resources to deliver them. As such, by October 2020 (and at the time of writing) priorities were ranging from being delivered at scale to still being in a planning phase. In some cases, therefore, data collection is required to be retrospective, in others it can be planned before initiatives commence.
- *Pace of implementation*: Some initiatives have stricter deadlines than others, for example due to time-limited funding. Given this and other extraneous factors, such as Grampian being placed within Civil Contingencies level 4 in January 2021, this means some priorities were accelerated with their implementation, whilst others have moved at a slower speed.
- *Downstream vs Upstream Activity* – Given the pressures that COVID19 has had on secondary care provision, evaluation activity has been prioritised on those initiatives that are closer to this part of the system.

Priority Updates

The following section provides an update of each of the priorities. These are in the form of one-page flash reports that are designed to provide an overview of progress to date. Where possible, links are also provided to relevant metrics that will be integrated into the OHF performance dashboard that will be used to monitor priorities over time.

Operation Home First Priority Stepped Care Approach	**Priority Workstream (if applicable)** Stay Well Stay Connected	RAG Status	

Operation Home First Aims this aligns to
Keep people safe at home

Brief description of priority
The Stay Well Stay Connected workstream is the bottom level of the Stepped Care Approach. The core aim is improving self-management and reablement within the community.

Update as of February 2021
A review of the workstream is being undertaken to understand progress to date and highlight areas of focus moving forward. Three working groups have been developed, each with a different focus: 1) *Respite* [overnight and/or residential]; 2) *Buildings Based Day Activities* [to be established]; 3) *Prevention* [restructuring to align to strategic aims]

Impact to date
Community / Staff Engagement: 93 people responded to the 'Fit Like' Survey, that aimed to understand and identify key issues to address to improve health and wellbeing in communities. For this, eight problem statements were identified, for example: 1) 40% of respondents did not have a device or internet and 2) over 50% of responders report they don't, or would like to get out and about and described having low mood.

The result of this has been the implementation of a variety of initiatives across communities. For example: 1) *"Wellbeing Matters Webpage":* that provides a number of helpful resources on keeping and staying well (and received more than 1100 visits in the last 12 months); 2) *Physical Activity packs for people at home*: collaboration with physiotherapy students including exercise instructions, walking routes and information on government guidelines; 3) Boogie in the Bar: currently holding virtual boogies for older adults during COVID via Facebook, YouTube and twice weekly on SHMU radio.

Aligned performance indicator
To be developed aligned to the Prevention workstream review currently being undertaken.

Case Study / Testimonials
The Student Befriending Pilot was a collaboration working between Robert Gordon University (RGU) and Aberdeen City Health & Social Care Partnership. In this pilot, 12 students (six Occupational Therapists and six Physiotherapists) were paired six older adults over a period of 6-8 weeks with the aim to provide befriending and identify links to enhance wellbeing.

John and Vera (pseudonyms) were one elderly couple who engaged in the pilot. Versa newly lost sight in both her eyes, whilst John had a recent stroke, leaving weakness down one side and with no speech.

The outcomes they wanted to achieve through the pilot were to shop online, keep in touch with family and take advantage of health care appointments.

At the end of the pilot, John and Vera had created their first email account and received their first online shopping delivery much to their excitement They have been referred into Occupational Therapy for further input.

"The pilot was a very positive experience for me, I enjoyed it very much. Building the relationship both with the befriendee and my physio partner was a highlight of my placement"

(Occupational Therapy Student).

Additional comments
Analysis of current and predicted demand across our client groups is underway to inform future commissioning requirements regarding planned respite. To ensure a comprehensive approach is taken, an overview of all commissioning beds for interim, surge and respite is being summarised to ensure a balance across the system which responds to the needs of our population.

Operation Home First Priority Stepped Care Approach / Frailty Pathway	**Priority Workstream (if applicable)** Hospital @ Home (H@H)	RAG Status	

Operation Home First Aims this aligns to *Keep people safe at home; Reduce unscheduled attendances / admissions; Supporting early discharge.*

Brief description of priority

Hospital @ Home provides acute care for geriatric patients in their own home via a multi-disciplinary team. There are two admissions routes: 1) alternative to admission (whereby otherwise the individual would be admitted to hospital) and 2) supporting discharge (referrals from hospital to return home sooner and receive the final part of their care at home). The service has been operational since June 2018 and has had 957 admissions during this period (up to February 2021).

Update as of February 2021 Detailed information about the development of the respiratory component of H@H is visible in the associated flash report.

Impact to date

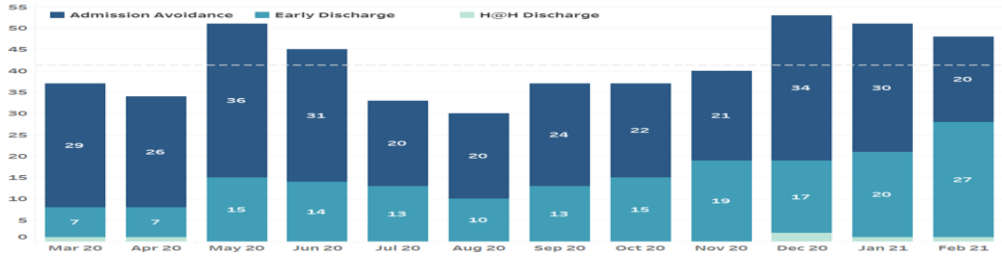
Service metrics: 476 referrals in the last 12 months (Admission Avoidance=308; Early Discharge=168). Both Hospital @ Home (71%) and GAU (72%) show similar proportion of patients at home / in a community setting 90 days post discharge.

Service User / Unpaid Carer Acceptability: Previous feedback from 16 patients demonstrated high satisfaction in the service (mean score = 4.1/5) and confidence in the team (mean score = 4/5). One said: "*I was amazed at the amount of help I received. Each person knew exactly what they were going to do and did it all so cheerfully and willingly. Thank you all*" (Responder x).

A sample of unpaid carers (n=16) rated the H@H team strongly on providing them encouragement and support (mean score = 4.8/5) and providing them with extra knowledge or skills to look after their cared for person (mean score = 4.6/5). One stated: "*This home team is a great service, more info was passed on and explained than during the hospital stay. The nurses were able to spend time with my relative, listen to him, watch him and make a true assessment of his needs. The help put in place will allow him to stay at home and have as good a quality of life as possible. This service has also given us as a family peace of mind*" (Responder x).

Staff outcomes: A previous staff satisfaction survey found a mean satisfaction score of 73%, which is 5% higher than the average NHS employee. A sample of services who regularly work with H@H, including General Practice and District Nursing, had high agreement of how easy the referral process was into H@H (mean agreement = 84%).

Aligned performance indicator



Hospital@Home Admissions by Month

Case Study / Testimonials

"*Mrs B fell when she was walking to her local shop. She was taken to GAU where she was x-rayed and no fractures were found. Mrs B had sustained a superficial injury to her foot. She was referred to H@H from ED, avoiding a hospital admission.*

During Mrs B's initial visit from the H@H team, the PT & ANP suspected she had delirium. The HCSW took routine observations such as blood pressure, temperature, respirations, oxygen saturations and pulse. On next visit, Mrs B was hallucinating and a urine sample test confirmed a urinary tract infection. Mrs B's mood was low on several occasions, stating she felt a burden as well as a nuisance towards her family and AC@H staff.

The AC@H team recommended Mrs B should have carers 3 x daily care to support with personal hygiene, diet and medication prompt. Mrs B required regular reminders not to go out walking alone, due to high fall risk. Family members were sign posted to relevant services which may benefit Mrs B's ability to remain at home safely (e.g. community alarm, key safe, city home helpers). The family decided to install a key safe following this advice. The TL completed a care management care plan. Due to care package not being in place and husband still in hospital, AC@H decided not to discharge Mrs B.

A&E informed AC@H that Mrs B fallen overnight and was in the department with a head injury receiving treatment. AC@H was informed Mrs B was to be admitted to GAU, however after discussion it was decided that AC@H would take over care, preventing hospital admission.

AC@H staff continued to provide 3 x daily care while awaiting Mrs B care package. The PTech liaised with care providers regarding medication. Mrs B was then discharged from AC@H and her care was handed over to the DN regarding Mrs B's ongoing care of foot dressing as well as the staple removal fro;m head injury". (Advanced Practitioner, H@H).

Additional comments

This performance indicator assumes 1) all admission avoidance referrals directly result in one less admission to Ward 102 in Aberdeen Royal Infirmary 2) each 'early discharge' referral directly reduces pressure on secondary care and 3) increasing referrals to Hospital @ Home mean more people are being cared for in a more appropriate setting.

Operation Home First Priority Frailty Pathway	**Priority Workstream (if applicable)** Rosewell	RAG Status	

Operation Home First Aims this aligns to

Keep people safe at home; Reduce unscheduled attendances / admissions; Supporting early discharge.

Brief description of priority

Rosewell House is being developed as an enhanced pathway and service model. This would see an integrated service providing intermediate care for both step down from hospital and step up from community. The model will increase capacity in the system as well as meeting our aim of delivering the right services, in the right place at the right time whilst also reducing the need for unscheduled admissions and enabling the safe discharge of patients from hospital who require further care prior to returning home.

Update as of February 2021

To facilitate an urgent response to surge and flow during the latest Covid19 wave, Rosewell House was opened as an interim NHSG facility on 18.01.21. This involved 20 beds remaining under Bon Accord Care's registration, with the remaining 40 beds transferring to NHS Grampian on a temporary 16-week basis. As of 22.02.21, 30 out of 40 of these NHS beds are open and accepting admissions. Work continues to develop the longer-term model ahead of the end of the period for interim arrangements (10.05.21).

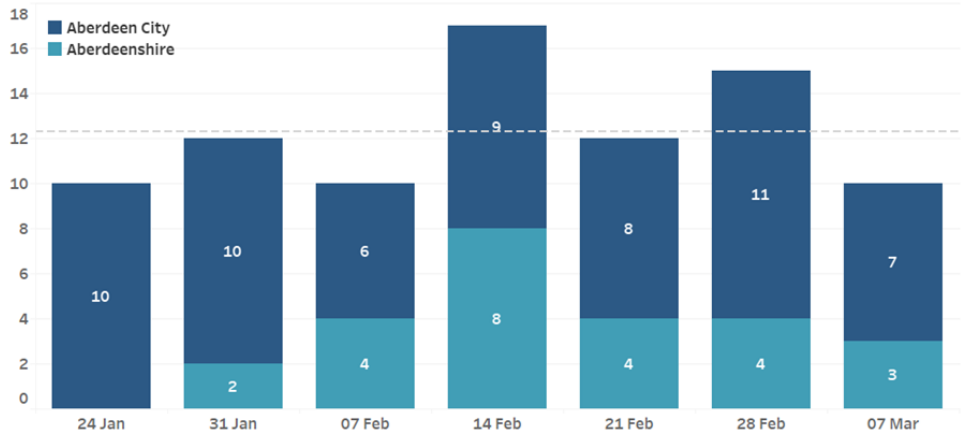
Impact to date

Transfer of staff: The current nursing workforce for the NHS beds is 20WTE (21 headcount), supported by 26.8WTE HCSW (30 headcount) and a headcount of 25 BAC support workers. This staffing has been supported by the movement of workforce from two wards in Woodend Hospital that have now been closed, meaning that more people can be cared for closer to home when safe and appropriate to do so.

Service metrics: Since January 18th there have been 86 admissions to NHS Rosewell beds (61 patients from Aberdeen; 25 from Aberdeenshire). All except one from H@H have been step-down admissions from hospital. 51 patients have subsequently been discharged/transferred from Rosewell (34 patients discharged home, nine transferred to a Shire community hospital, three to WGH, one re-admitted to ARI, one stepped-down to H@H and three who died). The average length of stay for patients who have been discharged/transferred has been 12.4 days with a maximum length of stay of 36 days.

Aligned performance indicator

Number of admissions to Rosewell NHS beds



Case Study / Testimonials

"In January 2021, as a result of significant pressures on hospital services in Aberdeen, under civil contingencies, it was agreed to allow NHSG to operate 40 beds within the 60 bedded Rosewell Care home (with the remaining beds remaining as care home rehabilitation beds.) Since that time, 30 beds have been utilised by NHSG teams supported by BAC staff.

This arrangement, although put in place as an emergency measure, have provided a unique opportunity for us to learn from a different model at Rosewell. Including: how staff from different organisations can work effectively together as integrated teams; a better understanding of the nature of the care demands that may present at a peak period, and latterly a more usual level; and how flow between hospital, intermediate care, rehabilitation care and community care can be made more efficient.

It is intended that the learning from this model, which was established due to necessity, will enable the longer term model that is developed to be fit for purpose in a system of varying demand over time."

Additional comments

An evaluation of the interim model was commenced 22.02.21 and will be completed 26.03.21 to inform its future direction.

Operation Home First Priority Frailty Pathway	**Priority Workstream (if applicable)** Ward 102	RAG Status	

Operation Home First Aims this aligns to

Support early discharge; Reduce unnecessary hospital attendances and admissions

Brief description of priority

Safe, effective patient flow in and out the Geriatric Assessment Unit within Aberdeen Royal Infirmary, ensuring the right patients (i.e., those with decompensated frailty) are managed appropriately within the right area of the health and social care system in a timely manner.

Update as of February 2021

Five workstreams have recently been developed to support the progression of this priority: 1) Admission and Flow Group; 2) Discharge; 3) HAME and Front Door Frailty Identification; 4) Establish 102 Workforce; 5) Operational principles and escalation practices.

Impact to date

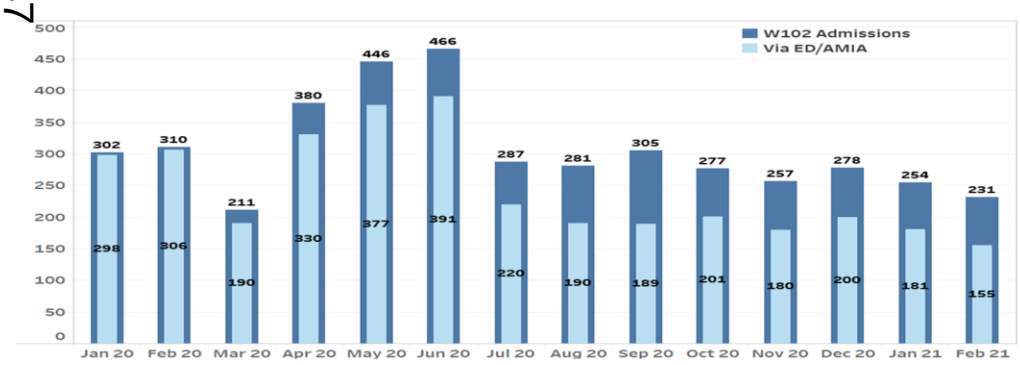
Direct access – General Practitioners can contact a clinician within Ward 102, for example when the first signs of delirium are present in their patients. This allows them to have timely access to specialist advice, resulting in care being provided in the most appropriate setting (whether that is at home, in hospital or other).

Implementation of Rockwood scoring within Emergency Department – patients are now scored using Rockwood Frailty Scale at point of admission. This allows for early identification of frailty and subsequent implementation of a frailty bundle that outlines the appropriate early interventions required. This has been used with 65 patients to date. The next phase will be exploring its implementation with Scottish Ambulance Service.

Escalation plan developed – required in response to managing flow (i.e. managing beds). Outlines each members of staff roles within the plan to ensure efficiency of service delivery.

Development of criteria-led discharge – leading to a more timely and efficient discharge, with the goals being person-centred as opposed to medically-led.

Aligned performance indicator



Ward 102 referrals from Emergency Department / AMIA by month for the last 12 months

Case Study / Testimonials

"GP access to a senior clinical decision maker available in Ward 102 has been facilitative of timely intervention and admission to hospital only when agreed as essential and unavoidable.

Admissions have been avoided when GPs contact the ward direct to discuss patients' presentations and to explore with the Geriatrician / Registrar management options. The exclusion of delirium alongside other management considerations when frailty significantly impacts patients recovery, wellbeing and activities of living.

Discussions between GP and geriatrician ensure medication review, minimise unnecessary polypharmacy and optimise medications." (Staff member, Ward 102)

Additional comments

Operation Home First Priority Stepped Care Approach	**Priority Workstream (if applicable)** Enhanced Community Support Huddles	RAG Status	

Operation Home First Aims this aligns to

Keep people safe at home; Support early discharge; Reduce unnecessary hospital attendances and admissions

Brief description of priority

Huddles have been established to support unscheduled care in the community for discussion for those individuals who are at risk of admission or re-admission, for those that are potentially stepping down from acute services, and to provide rapid wraparound support using a virtual multi-disciplinary team approach. Huddles function within each of the 3 localities and there are two levels (1 daily triage huddle, rapid conversation with unscheduled individual, take action that day) and 2 (weekly MDt meeting [wrap around support for individuals who are stable but with room for improvements regarding functioning etc]).

Update as of February 2021

The ECS huddles have been functioning since April 2020 and have used an iterative improvement methodology approach that has been staff led that pragmatically works well. Exploring how we can increase attendances at huddles to ensure equitable access for all services across the city, for example services within Primary Care.

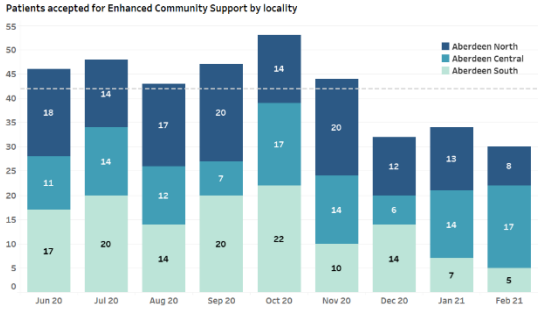
Impact to date

Performance metrics: Nearly 380 requests (relating to over 330 patients) have been brought to ECS since June, an average of 42 cases per month. Overall spread of patients with ECS input across each locality has been similar, although has fluctuated month on month, with 36% of cases brought by Aberdeen North and 30% and 34% by Aberdeen Central and Aberdeen South respectively.

Staff acceptability: 48 attendees of the Huddle provided feedback on its function. Overall responses were positive – Huddles received a mean score of 7.6/10. Components strongest rated included improved patient care (91.3% agreement) and improved multi-disciplinary working (89.4% agreement). It was also suggested that this approach saved staff time (63.8% agreement).

Service outcomes:

Aligned performance indicator



Case Study / Testimonials

"The ECS Huddles provide a platform for front line health and social care staff to discuss individuals who would benefit from an increase in care or therapy due to a change in their circumstances. It is designed to 'pick up' individuals who have an unscheduled event and need a more urgent care and or therapy intervention to enable them to remain at home. The huddle also enables staff working within the Acute Sector to provide information to the community teams on any individuals being discharged that may be 'fragile' and need additional support at the point of discharge.

Benefits include

- *Right service at the right time delivered by the right person in the right place*
- *Daily forum for any member of the MDT (in its widest sense) to discuss any individual that is giving them concern – making it a timely response*
- *Weekly follow-on huddle per locality for more in-depth discussion/learning opportunities*
- *Locality and MDT approach to assessment, and interventions*
- *Shared learning/understanding of the roles of the MDT team*
- *Building relationships within the localities*
- *Joint ownership – self managing MDT*
- *Supported by senior members of the locality leadership huddle*
- *Quality improvement approach to development" (Occupational Therapist feedback)*

Additional comments

The more cases that are brought to the huddles, the less likely that those at risk of admission / re-admission manifest. This, in turn, helps to keep people safe at home. Note – data does not include patients presented but not accepted / not appropriate for ECS

Operation Home First Priority Care @ Home Contract Implementation	**Priority Workstream (if applicable)** Not applicable	RAG Status	

Operation Home First Aims this aligns to

Keep people safe at home; Support early discharge; Reduce unnecessary hospital attendances and admissions

Brief description of priority

Under the new model, the provision of care will move away from the current schedule of tasks which are timed. Instead, teams will work together with people receiving care, their families, and other practitioners within each locality to provide care tailored to individual needs. Local assets will also be used to connect people back into their community. The incoming Granite Care Consortium (GCC) is made up of 10 care providers who have worked closely with colleagues to problem solve and coproduce solutions in an agile and innovative delivery model.

Update as of February 2021

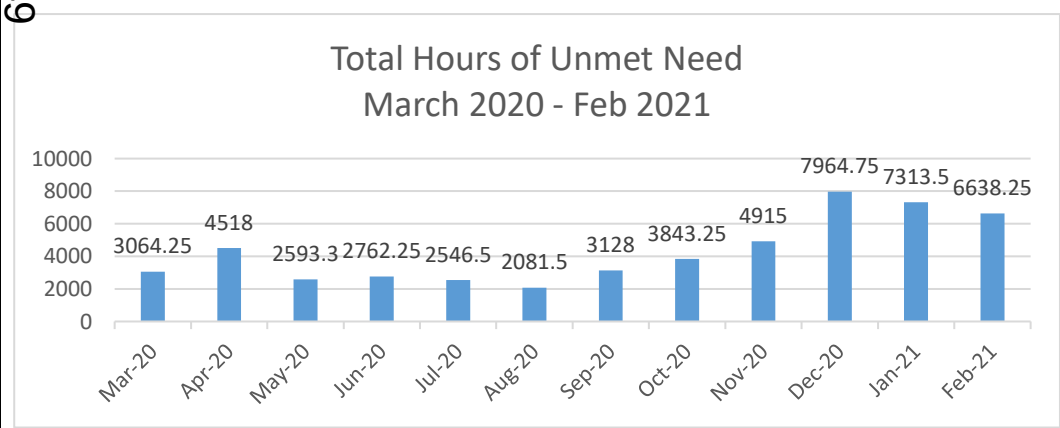
A multidisciplinary group is now meeting weekly to review care packages within the Granite Care Consortium (GCC) unmet needs list. The aim being that this approach will be widened in the future to provide a consistent holistic approach to the whole of the unmet need population. A working group has also been set up to progress risk assessed care, this will help to plan and find sustainable solutions for increased demand on our systems in the future, we will look at where correctly assessed equipment can be used to enhance and support the care delivered while first and foremost keeping people safe.

Impact to date

Staff perceptions – A baseline survey was distributed to GCC staff in Dec 20 that 62 people responded to. Overall, staff felt very supported by their colleagues (mean score 8.5/10) and those who deliver care to service users felt satisfied in their caring role (mean score 7.4/10). Perceived advantages included being more reactive to peoples needs: "*The flexibility will be good for our clients who have varying presentation and needs, as their illness worsens or improves*" (Care Provider).

Market stability – Baseline metrics were collected to understand the workforce of the GCC (total of 637 as of Dec 20) and the total number of eligible clients within Aberdeen City (N=1484). This will be reviewed in Summer 21 to understand how these metrics are impacted.

Aligned performance indicator



Case Study / Testimonials

"Granite Care Consortium (GCC) was established in March 2020, as a concept to achieve market stability and improved outcomes for service users in the provision of care at home across the City of Aberdeen.

GCC is at the centre of improvements to adult social care support in the City of Aberdeen and Scotland. It is a pathfinder model and to our knowledge, the first of its kind from an operational and commissioning context, primarily in terms of the outcomes it looks to achieve for and with people who use our services.

The journey for GCC over the next 3 years is summarised as:

1. Shift the cultural paradigm on how we step up, step down and enable those receiving care at home.

2. Strengthen the foundations of care at home in Aberdeen, through market stability, the development of our workforce and their employment stability.

3. Redesign the system, bringing together those cared for, social care managers and social care staff in assessment and delivery, shifting the cultural and operational paradigm.

GCC will challenge some of the historic narratives about social care and care at home support. GCC will deliver effective social care support based on positive outcomes for everyone who receives care at home from GCC in the City of Aberdeen.

A foundation to GCC is our social care and care at home workforce. For us to achieve the improvements and developments we seek to achieve in partnership with the ACHSCP, our goal is to establish and build a workforce that feels engaged, valued, and rewarded for the very important work that they do.

GCC will develop an approach that builds trusting relationships between its social care providers, rather than competition. We will foster partnerships, not market-places and we will encourage the voice of lived experience at every level in our service delivery. We will co-produce our new model of delivery with the people who it is designed to support, both individually and collectively." (Executive, GCC)

Additional comments

Operation Home First Priority Redesign of Urgent Care (Flow Navigation Centre) (Pan-Grampian)	**Priority Workstream (if applicable):** Not applicable	RAG status	

Operation Home First Aims this aligns to

Keep people safe at home ✓	*Reduced unscheduled attendances / admissions* ✓	

Brief description of priority

This work is part of a Scotland-wide programme to build on opportunities to support people to access the Right Care in the Right Place at the Right Time, and as part of this, to reduce attendances at A&E/Minor Injuries Units if there are more appropriate sources of help and support. The public are asked to call NHS 24 – 111 - day or night when they think they need A&E but it is not life-threatening. NHS 24 will offer advice on what care is required and where is the best place to access this. If necessary, they will refer on to NHS Grampian urgent care staff. Each local health board has established a Flow Navigation Centre (hub) that will directly receive clinical referrals from NHS 24. The FNC offers rapid access to a senior clinical decision maker within the multidisciplinary team, optimising digital health through a telephone or video consultation where possible. Through this consultation they may again signpost or refer to other services available to best meet health care concerns raised. If the senior clinical decision maker determines the patient needs to go to A&E or a Minor Injuries Unit, they will be offered an appointment to attend in person.

Update as of February 2021

This new service went live in Grampian and across Scotland on 01 December. Phase 2 underway will build on the work already achieved by the Redesign of Urgent Care Programme, to establish a single access route which delivers efficient, safe and effective person-centred care.

Impact to date

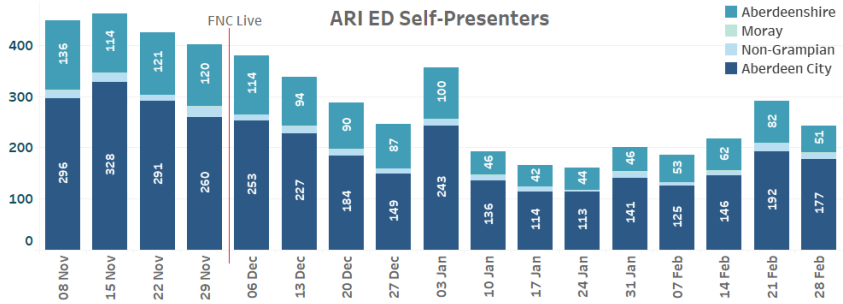
Over 2,600 patients have been referred from NHS 24, to the FNC and Minors Decision Queue, an average of 200 clinical referrals per week (FNC: 38 per week; Minors: 162 per week). Only 59% of patients have required a face-to-face appointment minimising the need for patients to attend ED or a minor injury unit, with 36% given self-care advice and 5% re-directed to primary care following a virtual consultation. Since the soft launch of the FNC, the self-presenting patient footfall at ARI ED has significantly reduced and is currently over 40% down, with a reduction of 32% seen in the number of Aberdeen City patients self-presenting at ARI ED. However, with many variables including lockdown it is too early to estimate the true impact of the redesign.

Case Study / Testimonials

- A survey has been developed to gather patient feedback on experience and views and is expected to launch in March.
- Questions in Grampian's Redesign of Urgent Care survey overlap with those to support local and national evaluation of Near Me video consultations and as such are expected to provide information of mutual benefit to multiple workstreams.

Aligned performance indicator

Numbers of self-presenters at Emergency Departments and Minor Injuries Units



Operation Home First Priority NearMe	**Priority Workstream (if applicable)** Not applicable	RAG Status	

Operation Home First Aims this aligns to

Keep people safe at home

Brief description of priority

NearMe is a video consulting service, allowing people to attend health and social care appointments from wherever is convenient for them. The service has been operational across Grampian since 2019, being used in both Primary Care and Secondary Care settings.

Update as of February 2021

Near Me is now embedded within service models for many services. Focus is now shifting to sustaining the change and supporting new models of care, eg; how NearMe can help to deliver multi-disciplinary clinics or shared decision making across primary and secondary care.

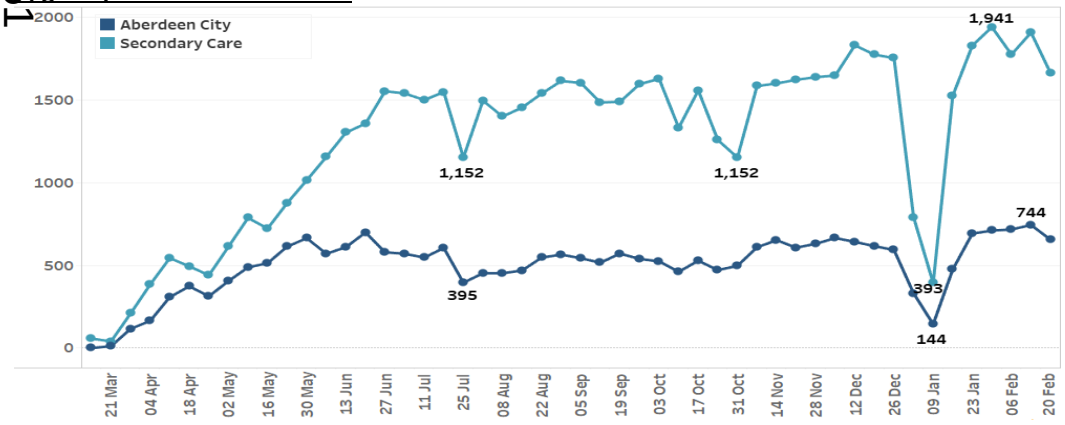
Impact to date

Patient satisfaction: 93% (N=2012) of patients self-reported their NearMe experience as 'very good' or 'good'. 97% rated the quality of care provided as either 'very good' or 'good'

Staff outcomes: 38% (N = 755) of clinicians self-reported saving travel as a result of using the NearMe platform. One-fifth felt it took less time than regular consultations.

Service performance: In Feb 20, we were conducting ~80 video appointments per week; in Feb 21 that number is >3500 per week. In the same time period, the number of active NearMe service waiting areas has increased from 16 to ~200, and the number of laptops issued to facilitate the service provision has risen from 2800 to ~5500.

Aligned performance indicator



NearMe Consultations by month

Case Study / Testimonials

"I elected to have my initial pain management clinic appointment via video.

I received all the information, did the test call and today accessed the appointment with a lovely Female Registrar … I had a good, focused, no noise, no waiting or travelling (being in pain or knowing you can have a bad day without warning knowing I wouldn't have to travel made things easier), appointment, I was able to listen to the questions, answer them, have time to explain, definitely a more focused appointment, I know not for everyone but I certainly felt more comfortable especially as my husband didn't have to take time off work to take me etc.

The Registrar was brilliant, put me at ease, explained and reflected back. Yes I will need a face to face but the medical history, my concerns and expectations etc have all been done"

(Near Me Service User).

Additional comments

This performance indicator assumes that 1) digital is the preferable mode of delivering consultations when it is safe and appropriate to do so, and 2) may be a more efficient mode of delivery for both staff and patients.

Operation Home First Priority Respiratory Pathway + Stepped Care Approach	**Priority Workstream** Hospital at Home expansion: Respiratory Physiotherapy	RAG status	

Operation Home First Aims this aligns to

Keep people safe at home ✓	*Reduced unscheduled attendances / admissions* ✓	*Support early discharge* ✓

Brief description of workstream

This expansion to the H@H service is helping to avoid unnecessary respiratory admissions and readmissions. It includes a focus on supported discharge so that people – often with substantial anxiety around their condition – are not readmitted. Funding was approved to second/recruit respiratory physiotherapy staff (2.0 WTE) to join the existing H@H team.

Update as of February 2021

1.0 WTE B7 (comprised of 2 x 0.5 WTE) have been seconded into H@H as of mid-December 2020. 1.0 WTE B6 has been recruited and is only just in post – since 1st February. B7s have been taking referrals and starting to provide support from 7th January, on part capacity until the B6 in post. We will be providing 7-day cover over the month of March.

Impact to date

Whilst clinicians have reported seeing less in the way of exacerbations of COPD than would normally be the case in winter, because many people are shielding due to the COVID pandemic, we have still seen demand for our services:-

- 13 patients have been referred to us since 7/1/21, of which 9 have been admitted to H@H (4 alternative to hospital admission and 5 active recovery/supported discharge). We have since discharged 8 of them.
- In this short space of time we have provided 49 H@H bed days, of which 36 were for patients we have discharged, and 13 is the running total (at 28/02/21) for the 1 patient we are currently supporting.
- For context, across the patients we have supported so far, in the 12 months prior to us starting to give them respiratory physio support, there were 28 admissions for respiratory conditions, totalling 193 bed days (163 acute bed days and 30 H@H bed days).

To illustrate the comparative costs:-

- Average cost per case of our H@H respiratory physio intervention to date is £254.73. So, across our 4 alternative to hospital admission patients this comes to £254.73 x 4 = c.£1.019.
- Average direct cost per inpatient case in Aberdeen Royal Respiratory Medicine = £3,615. So, if these 4 patients had been admitted to ARI this could have cost £3,615 x 4 = £14,460.
- Average cost per Respiratory inpatient bed day in ARI = £583, so had our 49 bed days been delivered in ARI, this would have equated to £583 x 49 = £28,567.
- As the H@H service continues to expand and develop in scope, we expect that further work will be required to assess the impacts that this has on average bed day costs in H@H.

Source for ARI costings: NHS Costs Book 2019/20 R040 tables. Direct Costs per inpatient case (staff, theatre, laboratory). This was then divided by specialty average length of stay to estimate average cost per inpatient bed day.

Case Study / Testimonial

"The patient was able to remain at home and improved after his exacerbation. He has also been referred to Pulmonary Rehab for appropriate follow up."

"During the short time the service has been available, the expansion of the H@H team to support respiratory patients has already had a huge impact on patient care and service delivery. The service has been shown to be a cost-effective intervention, supporting all three of the OHF aims."

Additional Comments

- We have promoted the H@H Respiratory service to referring clinicians by email: respiratory consultants and all GPs via their primary care bulletin.

Aligned performance indicators

- Numbers of people supported by H@H
- Numbers of respiratory admissions (note: OHF are working on a broader measurement from several respiratory projects combined).

Operation Home First Priority Respiratory Pathway	**Priority Workstream (if applicable)** Home Oxygen Service	RAG status	

Operation Home First Aims this aligns to

Keep people safe at home ✓	*Reduced unscheduled attendances / admissions*	*Support early discharge* ✓

Brief description of priority

Changes to way that consultants in non-respiratory specialties engage with Home Oxygen Team and efficiencies brought about by move to Office 365 suite of applications have enabled Home Oxygen team to directly assess inpatients at ARI and those needing support in the community far quicker than previously was the case.

Update as of 01 March 2021 – Current status:

Over three-week period since implementation Home Oxygen Teams have conducted 21 inpatient assessments – 17 the same day as referral received and 4 the following day.
Unable to recruit the 1xB4WTE that funding from OHF Respiratory Cell was secured for, so having to utilise additional hours from existing B7 and B3 staff.
Inpatient service due to finish at end of March 2021.

Impact to date

Discharged same day as assessment	6
Discharged day after assessment	6
Discharge 2 days after assessment	5

- Feedback received from 13 individuals regarding 11 patients all of whom felt that the patient was discharged earlier as a result of the intervention and that it saved their time. It was estimated that an **average of 4.8 bed days were saved per patient**
- 7 patients from in or around Aberdeen were referred for urgent/immediate oxygen to prevent admission. All patients were seen the same day and 4 were supplied with oxygen after assessment – the oxygen installation was completed on average 128 minutes after time of referral

Case Study / Testimonials

Staff: 'It enabled Discharge far quicker than I had thought possible'

'Gives the patient confidence and reassurance on Discharge'

'Oxygen teams input in organising the oxygen for this patient was very helpful, as he would likely have stayed in hospital far longer'

'Patient absolutely delighted to be getting home, felt he would be able to do more at home and recover quicker'

Patient: 'Overall, the Oxygen team allowed me to overcome this difficult time with much more confidence, providing the means to allow me returning home, comfortable with the fact that i would not be breathless during my recovery.'

Aligned performance indicator

Bed days saved; Number of admissions avoided

Additional comments

Lack of ongoing funding may mean both projects cease at the end of March 2021, or shortly thereafter.

Operation Home First Priority Respiratory Pathway	**Priority Workstream (if applicable)** Prevention & Self-management (Physical Activity)	RAG status	

Operation Home First Aims this aligns to

Keep people safe at home ✓	*Reduced unscheduled attendances / admissions*	*Support early discharge*

Brief description of priority

Multiple projects within the Respiratory Pathway priority focus on health improvement for patients with COPD and other respiratory conditions providing: 1) Physical Activity (PA) classes; 2) Pulmonary Rehabilitation (PR) and 3) Respiratory Physiotherapy support within Hospital at Home. These projects are linked in that patients referred to one may subsequently be redirected to another depending on their current level of health. The Physical Activity classes are a natural progression for patients who have been on the PR programme. Whilst there may be local differences in implementation, leads for the projects in each of Grampian's three Health and Social Care Partnership areas are working together to ensure consistency, where appropriate, in their approach to reporting and evaluation. In Aberdeen the PA project is being delivered by Sport Aberdeen, whose instructors have developed the online delivery of classes using the Zoom video-conferencing app. *[Note: In Aberdeen PR is being delivered on a business-as-usual basis and is not one of the OHF-funded projects].*

Update as of 01 March 2021 – Current status:

- Programme is operating on a rolling 6-session basis with participants joining as Sport Aberdeen triage them into the programme.
- The first couple of participants reached their 6th session at the end of February and a few more will do so during the first week of March.
- There is plenty capacity within the virtual classes, so participants who have completed their initial 6-week block can stay so they're able to continue exercising, however a more challenging class is being introduced from week beginning 8th March for those who are ready to move into something new.

Impact to date

There have been 63 referrals received to the programme (6 from Health Professionals and 57 Self-Referrals). Of these Sport Aberdeen have: 17 attending virtual exercise classes; 4 receiving 1-to-1 phone call support as they don't have access to online classes; 18 were signposted to the Pulmonary Rehabilitation Physio Team because they didn't meet inclusion criteria for Sport Aberdeen programme . Of the others there are a mix of people who haven't been able to participate due to other health conditions/injuries and some who were referred into Live Life Aberdeenshire or Moray programmes due to their addresses.

Case Study / Testimonials

A YouTube video has a further testimonial in the form of an interview with participant Peter Hall, see: Winter Pulmonary Rehabilitation Programme Case Study

Aligned performance indicator

Number of participants completing the block

Additional comments

Patient and instructor feedback surveys are planned to be implemented from week commencing 1st March. These will contribute a more quantitative element to the evaluation of the Physical Activity workstream.

Operation Home First Priority Palliative & End of Life Care		**Priority Workstream (if applicable)** Virtual Programme	RAG status	
Operation Home First Aims this aligns to				
Keep people safe at home ✓	*Reduced unscheduled attendances / admissions*	*Support early discharge*		
Brief description of priority The focus within this Priority has been on the draft Grampian-Wide Strategic Framework for Palliative and End of Life Care, which sets out the vision for the next three years. Workstreams within this Priority have not been developed to the same stage as other Priority areas.				
Update as of February 2021 Staff at both The Oaks in Elgin and Roxburghe House in Aberdeen are modifying their palliative care offering to patients so that these can be delivered remotely. Evaluation and measurement frameworks are under development and these will look to capture feedback from patients and their carers/family and from staff delivering these services. Working with the project leads, the OHF Evaluation team will help to foster a rounded understanding of the costs and benefits of delivering PEOLC support to patients via online platforms and the consequences (intended or otherwise) to all palliative services and the wider connected system.				
Impact to date Not available at this time		Case Study / Testimonials Not available at this time		
Aligned performance indicator For the virtual palliative classes this may be Number of participants completing the block. This would align with other Workstreams in aiming to Keep people safe at home.		Additional comments		

Operation Home First Priority Frailty Pathway		**Priority Workstream (if applicable)** **Early Supported Discharge (H@H) - Aberdeenshire**	RAG status	
Operation Home First Aims this aligns to				
Keep people safe at home ✓	*Reduced unscheduled attendances / admissions* ✓	*Support early discharge* ✓		
Brief description of priority As part of the whole system redesign of the Frailty Pathway the Aberdeenshire Frailty Pathway workstream were tasked with developing an Aberdeenshire model. Having considered a range of options the planned model is an Early Supported Discharge model which aspires to being Hospital at Home. A service model has been developed which will include additional community capacity from our Aberdeenshire Responders for Care at Home (ARCH), 2 specific teams consisting of Nurses and AHPs and technology enabled care.				
Update as of February 2021 At present we are awaiting a final decision on the workforce financial split to be agreed before we can move to formal organisational change.				
Impact to date Virtual ward has been agreed, similar to the functionality that Hospital @ Home in Aberdeen City use on TrakCare, and is now in development. This will be used as a basis for collating performance data for the project, including caseload numbers; length of stay and discharge location. Evaluation framework has been agreed and established for the project. This includes a bespoke feedback survey have been populated to assess patient and unpaid carer acceptability, focusing on constructs of hospital discharge; home assessment; receipt of care and discharge from the pathway. Staff acceptability of the new model will also be assessed once the project has had adequate opportunity to be embedded into business practice.		Case Study / Testimonials None available at this time.		
Aligned performance indicator Performance indicators are not yet operational for this project as it has not gone live. However, metrics including patient location at 90 days; 7-day readmission rates; and medically fit date of discharge vs actual date of discharge will all be monitored.		Additional comments We've been successful in receiving H.I.S. Hospital at Home funding which will support the use of technology enabled care and for improving Staff skill base. We also have funding for a specific post for Project Management/Development		

Operation Home First Priority Aberdeenshire Virtual Community Ward	**Priority Workstream (if applicable)**	RAG status	

Operation Home First Aims this aligns to

Keep people safe at home ✓	*Reduced unscheduled attendances / admissions* ✓	*Support early discharge* ✓

Brief description of priority

The Virtual Community Ward (VCW) works by bringing together multidisciplinary health and social care teams who provide care for patients who need regular or urgent attention, with the aim of avoiding unnecessary hospital admissions. The model is GP-led and operates upstream of acute services, with local health and social care teams working together within the boundaries of GP practice populations. The VCW is very effective at identifying individuals who need health and social care services at an earlier stage, which can significantly improve patient outcomes and experience. The approach involves a daily short huddle (typically 15 minutes) of the core team, where vulnerable / at risk individuals are discussed as well as the progress of those already within the VCW. Co-ordination of short term wrap-around care (personal and nursing care the most frequent requirements) is agreed, mobilised and monitored for those admitted to the VCW.

Update as of February 2021

The VCW model had already been embedded across Aberdeenshire prior to the Covid 19 pandemic. The model of working has continued to remain very important as part of the whole system response to Covid and as health and social care teams have required to adapt with flexible community nursing teams involving District Nursing, community hospital nurses, urgent care practitioners and others. VCWs moved to virtual meetings allowing more team members to participate.

Impact to date

Nearly all Aberdeenshire GP practices signed up to VCW in 2019/20 with an average of over 330 VCW admissions per quarter. For 2020/21, in-line with other enhanced services, it has not been mandatory for GP practices to submit VCV quarterly returns however they have been asked to submit data where available. Health Intelligence will analyse the 2020/21 submissions once the data for the final quarter is in.

It is planned that formal reporting on a quarterly basis, to monitor and understand the impact of VCW, will resume for 2021/22 for all practices signed up to the VCW SLA.

Case Study / Testimonials

Previous feedback from staff on the VCW model following initial implementation highlighted improved and more effective communication as a result of daily huddles, which was felt to have led to:

- Better use of resources and prioritisation of resources to individuals.
- Quicker access to interventions.
- Improved care pathways (better organisation, more integrated/seamless pathways).
- More holistic / person centred care.
- Reduction in hospital admissions.
- Better overall staff experience.

Aligned performance indicator

Existing dataset collated from GP Practices on a quarterly basis (not mandatory during Covid-19 pandemic) collates demographic information of patients admitted to VCW and in addition:

- Reason for VCW admission and length of stay
- Outcome of VCW admission and presumed outcome were VCW not available.

Additional comments

Given allocation of resource to other Home First priorities, the VCW has remained in a 'business as usual' context with no significant changes to service delivery.

Operation Home First Priority Whole system approach to discharge	**Priority Workstream (if applicable)** Discharge to Assess (D2A)	RAG status	

Operation Home First Aims this aligns to:

Keep people safe at home	*Reduced unscheduled attendances / admissions* ✓	*Support early discharge* ✓

Brief description of priority

Sparked by a relatively high number of delayed discharges, Health & Social Care Moray senior management team recognised that far greater awareness of the upstream and downstream factors influencing discharges from hospital was required. The lack of intermediate care services to assist in the management of patient flow into and out of Dr Gray's Hospital was identified as a key gap in provision. An Occupational Therapy (OT) lead, Discharge to Assess (D2A) model was identified as a possible solution. In the Moray D2A model, OT and Physiotherapy staff would provide two weeks of intensive support to patients in their own home. As an intermediate care service, D2A will support early discharge for inpatients assessed as appropriate in Dr Gray's Hospital (DGH) and offer an alternative to admission for people attending the A&E department.

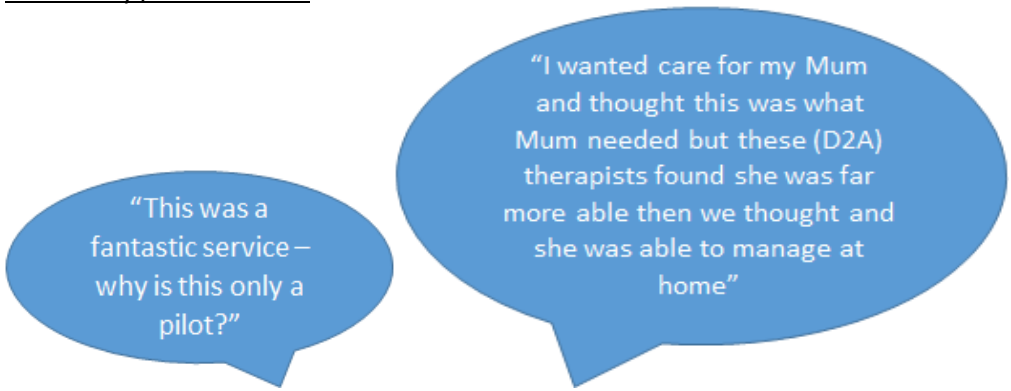
Update as of March 2021

Following a successful pilot and extended test of change, core funding for the Discharge to Assess service was confirmed by Moray IJB on the 25th March 2021. Funding will allow the seconded staff to return to their substantive posts and recruitment to commence for the permanent AHP and nursing staff required to run the service.

Impact to date [5th Oct 2020 to 17th Feb 2021 (19 weeks)]

- 48 patients seen by D2A Team – 40 inpatients and 8 redirected from A&E.
- Saved an estimated 112 acute bed days through supported early discharge and admission avoidance.
- 32 patients directed away from community hospital resulting in an estimated saving of 1,216 bed days.
- Readmission rates lower for D2A patient cohort at both 7 and 28 days.
- Just 5 patients required onward referral to START, demonstrating a reduction in the requirement for care following a D2A intervention.
- 81% - 91% of patients saw improvement in OT assessment scores with remainder maintaining their scores.
- All patients saw improvement in Physiotherapy assessment scores.
- Patients and carers provided very positive feedback on their experience of D2A.
- Fully supported by Senior Management & Clinicians in Dr Gray's Hospital.
- High degree of interest in Moray D2A from across Grampian.

Case Study / Testimonials



Aligned performance indicator

Hospital bed days saved.

[average length of stay (LOS) for key specialties of Geriatric Medicine and Ortho-trauma in DGH is 9 days; D2A average LOS is 8 days.]

Additional comments

Final figures for the test of change period which ended on the 31st March 2021 are currently being prepared.

Operation Home First Priority Respiratory Pathway	**Priority Workstream (if applicable)** Physiotherapy-led Pulmonary Rehabilitation: Aberdeenshire	RAG status	Amber: Uncertain future

Operation Home First Aims this aligns to

Keep people safe at home ✓		

Brief description of priority

This project's aim was to support patients with long term lung conditions to stay safe at home and reduce subsequent related unscheduled attendances/admissions. Increasing activity levels and provision of education to support self-management were core and were met through the delivery of a home based 1:1 Pulmonary Rehabilitation (PR) Programme (in addition to our existing PR service, which had already switched to virtual classes). Provision of an equitable service to those unable to access digital technology was paramount.

Update as of end March 2021

Significant time was required at the start of the project to focus on start-up i.e. staff secondment/recruitment, followed by fundamental corporate and in-house training. 1.0 WTE B6, 2 x 0.5 WTE B4s, then 2 further WTE B4's were established in post with caseload by the end of Jan and Feb 2021, respectively. We delivered home PR to patients who were unable to access online classes, or who would have been unsuitable for such classes (or indeed standard PR group programmes). Additionally, to contribute to reducing health inequalities, we supported those with no access to transport who, in normal circumstances, would struggle to attend classes due to the rurality and lack of infrastructure around public transport. We were also able to link with Acute colleagues in Oxygen Clinic to provide feedback regarding Oxygen (levels).

Impact to date

To date – 51 patients assessed, 27 currently undertaking PR programme, 4 completed, 6 on waiting list. 11 patients declined or unsuitable to continue.

Results – of those 4 patients completing the PR programme before the end of March:

- All reported that their condition was improved or much improved following PR.
- All reported that they achieved completion of at least one of their personal goals.
- All consented to onward referral to Live Life Aberdeenshire for further support.
- Clinical scores improved: COPD Assessment Test (CAT) scores improved in 4/4 (by 6 points on average); number of sit-to-stand in 1 minute improved in 4/4 (by 57.5% on average); and MRC breathlessness scale scores improved in 2/4 (50%).

Aligned performance indicators (to develop if project continues beyond March 2021)

- Number of referrals to the service, by quarter
- Number of people completing PR support block, by quarter

Additional comments

Lack of ongoing funding will mean the project will cease after the end of March 2021, and these patients may then deteriorate, potentially leading to unscheduled attendances/admissions. If we were to secure further funding in the future we would aim to extend to support more acute admission avoidance and early discharges.

Feedback / Testimonials

I was very surprised at the exercises I can do on my own at home

Please keep up the one to one programme. It's been so helpful and gives you a chance to ask more personal questions. Also helped me explain to my family about COPD

I feel much better in myself now I have been doing the exercise and can push myself knowing my limits. Walking further and have taken up golf again, starting to love gardening

We surveyed primary and secondary care staff involved in Respiratory care; all 18 responders agreed or strongly agreed for the need for a service to support PR by means of virtual classes (in addition to our face to face classes) and to support PR by means of 1:1 telephone/home support (for people who can't join classes).

[GP practice team member] *The provision of pulmonary rehab & physio is very limited in Aberdeenshire (…) residents getting to a venue can be difficult therefore missing out on a valuable, beneficial service for our Respiratory patients within our surgery*

Operation Home First Priority Respiratory Pathway	**Priority Workstream (if applicable)** Physiotherapy-led Pulmonary Rehabilitation: Moray	RAG status	Amber: Uncertain future

Operation Home First Aims this aligns to

Keep people safe at home ✓		

Brief description of priority

This project's aim was to support patients with long term lung conditions to stay safe at home and reduce subsequent related unscheduled attendances/admissions. Increasing activity levels and provision of education to support self-management were core and were met through the transition from face to face classes to Virtual Pulmonary Rehabilitation (PR), and expansion of our 1:1 PR for housebound/frailer patients. Provision of an equitable service to those unable to access digital technology was paramount.

Update as of end March 2021

Funding for this project was confirmed 03/12/20. 2 B7s and 2 x B3s were established in post by Feb - March 2021, respectively. In this short space of time, we redesigned our procedures and paperwork for transition of our PR service (including education and self-management material), and up skilled our whole physiotherapy team in new Virtual and home PR. As well as delivering PR to respiratory patients, we have scoped local respiratory requirements; completed training/education and liaised with a range of stakeholders in Dr Gray's Hospital, Oxygen Service Aberdeen, GP practices, community AHPs, and 3rd sector/leisure services, to help raise awareness and improve pathways between services.

Impact to date

To date – 56 referrals received, 32 patients assessed, 5 completed Virtual PR, 4 currently undertaking virtual PR, 8 undergoing Home PR, 7 declined PR (respiratory advice given).

Results – Amongst 6 virtual class participants for whom we have clinical scores pre- and post-support, we saw improvements: COPD Assessment Test (CAT) scores improved in 4/6 (66%); number of sit-to-stand in 1 minute improved in 5/6 (83%), and MRC breathlessness scale scores improved in 3/6 (50%).

- Amongst the 5 patients completing a block of 6 virtual classes by 31/3/21, 4 reported that their condition was improved or much improved following PR, and 3 reported that they achieved 100% completion of at least one of their personal goals.
- 10 patients (virtual and home PR) did not need complete block of support from us; 7 have subsequently engaged with long term exercises.

Demand - We have seen increased referrals for PR and a wider range of specialist respiratory physiotherapy in Jan-Mar 2021, compared with Jan-Mar 2019. Numbers indicate increased need/perception of need. For example, referrals for PR increased from 42 to 56; for specialist intervention increased from 3 to 15; for Oxygen service review/monitoring increased from 0 to 15.

Capacity – Within our current establishment to; support the increasing numbers of patients referred; to reduce digital access inequalities with loanable technology and increase sign posting to community digital services.

Feedback / Testimonials

> I had to stop once crossing garden, my wife did all meals and all housework. After the class, this morning I have gone for a walk, painted the garden fence, did the hoovering and now I make breakfast for my wife every day.

> I wanted to try anything to help, had tried all the medications which didn't help. Had been told in the past I would never improve due to my age. I like being able to go out and do things I enjoy, I am a much happier person.

Questionnaires from 9 stakeholder staff pre and post training/education/liaising showed an improved perception of PR and specialist physiotherapy intervention.

Aligned performance indicators (to develop if project continues beyond March 2021)

- Number of referrals to the service, by quarter
- Number of people completing PR support block, by quarter

Additional comments

Scoping has highlighted need for further funding to meet need of respiratory service in Moray. Identified capacity requirements to upscale current PR service to prepare for next winter – PR consists of 6 week cohorts so need to start now.

Comments / Observations

To date, all priorities that have been operational for an adequate period have demonstrated sufficient feasibility (i.e. they are broadly acceptable to both service users and service providers). For some priorities within in this context, it is too early to determine fully the benefits they will deliver at current scale, and potentially if scaled up. The simplified model for service change and evaluation, below, illustrates that in order to achieve the desired outcomes and impacts, the right inputs must be in place, relevant activities performed, and the required outputs delivered. However, our evaluation to date provides an important basis in ensuring that any changes in service provision can be sustained longer-term. For example, previously in-depth evaluations conducted across the health and social care system have typically taken place after six months of implementation (see the 'West Visiting Service' evaluation here and the 'Acute Care @ Home' evaluation here) which provides a useful barometer of the balance that is required to be struck between evolving initiatives at pace whilst ensuring enough data is generated to inform future service provision.

Simplified Logic Model for theory of change / service evaluation

Inputs	→	Activities	→	Outputs	→	Outcomes and Impact (short-, medium- and long-term)
e.g. funding; staffing		e.g. training; process development		e.g. virtual classes; supported discharges		e.g. increased awareness and ability of person to manage their condition(s); admission avoidance in short versus longer term; reductions in A&E attendances and hospital admissions in the longer term; improved population health in the longer term.

One key enabler that is important to emphasise within the context of reporting progress is the access to and development of an intelligent data infrastructure. For example, the 'patient location at 90 days' outcome articulated within the Stepped Care Approach / Frailty Pathway Hospital @ Home flash report above exists due to the creation of a virtual ward within the TrakCare system and then a further automated code that runs daily to determine whether patients who have received care in that service are back in hospital (or another setting). In other initiatives, such as the Enhanced Community Support huddles, the performance data was manually pulled off electronic systems by one member of staff who is no longer working in the North East.

One aspect that might temper the potential success of the OHF programme was the use of Winter Planning funds to develop several projects under the Respiratory Priority. These monies allowed purchase of kit and staff training for the Physical Activity Classes for participants with COPD, however without establishing a revenue model for this preventative approach to health care, the programme may not be able to be supported beyond the 2020/21 financial year. The same is true of the Home Oxygen Team, for which funding enabled additional temporary staffing resource allowing them to explore projects aimed at supporting early discharge and avoiding unnecessary hospital admissions. In these examples, whilst initial data looks very positive, the funding came late in the day and as such

none of the above projects have been established long enough to fully evaluate their impact on the OHF top-line.

Such a wide-ranging portfolio as OHF is unlikely to ever have a neat end point. This is because it is cross-system by design and naturally evolves over time based on evidence and key learning. For example, the Stay Well Stay Connected workstream within the Stepped Care Approach have identified social isolation as a key area of required focus moving forward in response to physical distancing that has emerged from the COVID19 pandemic. This means that, rather than evaluation being viewed as an activity that is undertaken at the 'end' of a project, it could be perceived as a tool that does not just determine the benefits of a particular initiative but is also used as a basis to guide future activities based on evidence. We would recommend that thought is given to maintaining a rolling programme of evaluation, underpinning the cyclical process of strategic planning and commissioning.

Next Steps

A more formal evaluation report on the progress of OHF is due to be be produced towards the end of Spring 2021, including recommendations on the future direction of the portfolio.

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