Public Document Pack

Aberdeen City Health & Social Care Partnership
A caring partnership

To: Members of the Audit and Performance Systems Committee

Town House,
ABERDEEN 16 September 2021

RISK, AUDIT AND PERFORMANCE COMMITTEE

The Members of the **RISK, AUDIT AND PERFORMANCE COMMITTEE** are requested to meet in **Virtual - Remote Meeting on THURSDAY, 23 SEPTEMBER 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 22 June 2021 (Pages 5 - 12)

5 ACHSCP Planner for RAP (Pages 13 - 18)

GOVERNANCE

6 Review of Financial Regulations - HSCP.21.109 (Pages 19 - 40)

7 Business Assurance and Escalation Framework - HSCP.21.101 (Pages 41 - 82)

8 IJB Whistleblowing Policy-Quarter 1 - HSCP.21.102 (Pages 83 - 86)

9 IJB Records Management Plan - Review and Action Plan - HSCP.21.103 (Pages 87 - 94)

10 IJB Annual Performance Report 2020/2021 - HSCP.21.105 (Pages 95 - 138)

AUDIT

11 Directions - 6 monthly reporting - HSCP.21.104 (Pages 139 - 144)

PERFORMANCE

12 Primary Care Improvement Plan (Progress to Date) - HSCP.21.106 (Pages 145 - 172)

13 Leadership Team Objectives - Update on Delivery - HSCP.21.107 (Pages 173 - 188)

14 MWC YP Monitoring Report 2019-20 - HSCP.21.108 (Pages 189 - 250)

CONFIRMATION OF ASSURANCE

15 Confirmation of Assurance

COMMITTEE DATES

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
A caring partnership

Risk, Audit and Performance Committee

Minute of Meeting

Tuesday, 22 June 2021
10.00 am Virtual - Remote Meeting

Present:	John Tomlinson (Chair); and Luan Grugeon, Councillor Philip Bell and Councillor John Cooke
Also in attendance;	John Forsyth, Derek Jamieson and Alex Stephen.
Apologies:	Jessica Anderson and Sandra Macleod.

The agenda, reports and meeting recording associated with this minute can be found here.

Please note that if any changes are made to this minute at the point of approval, these will be outlined in the subsequent minute and this document will not be retrospectively altered.

INTRODUCTION

1. The Chair welcomed all to the meeting.

The Chair intimated that Article 10 - Audited Accounts - HSCP.21.056 and Article 11 - External Audit Report - HSCP.21.057 had been submitted late however in terms of Section 12(2) of the Standing Orders these were accepted as matters of urgency.

The Chair advised that these matters would be heard following presentation of Article 5 – Business Planner.

INTIMATION OF DECLARATIONS OF INTEREST

2. The Chair enquired of members if they wished to declare any interests in matter before the Committee.

There were no declarations.

DETERMINATION OF EXEMPT BUSINESS

3. There was no exempt business.

RISK, AUDIT AND PERFORMANCE COMMITTEE
22 June 2021

MINUTE OF PREVIOUS MEETING OF 27 APRIL 2021

4. The Committee had before it the minute from its previous meeting.

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

BUSINESS PLANNER

5. The Committee had before it the Business Planner.

Members heard from the Chief Finance Officer/Deputy Chief Officer who provided context around future reporting.

The Committee resolved :-
to note the business planner.

EXTERNAL AUDIT REPORT - HSCP.21.057 - LATE REPORT

6. The Committee had before it the report from the External Auditor, KPMG which presented the 'Annual Audit Report to the Members of Aberdeen Integration Joint Board and the Controller of Audit for the year ended 31 March 2021'.

The Chair welcomed Michael Wilkie and Matthew Moore of KPMG to the meeting and invited a summary presentation of the report.

Members heard apologies on late submission of the report which was due to Aberdeen City IJB being one of the first organisations in Scotland to present their accounts, which when combined with the challenges of new pandemic accounting policies had caused additional demands on all.

The External Auditors (KPMG) expressed appreciation to the Chief Finance Officer and his team for the assistance provided during preparation of the report.

Members were advised that pending completion of a couple of minor points, that KPMG's conclusions at the highest level indicated that they would be able to provide a qualified opinion on the assurance of the accounts.

Members heard that there had been a late adjustment to the Accounts which KPMG were satisfied was the correct treatment in terms of financial management and financial sustainability and in line with other funding indications aligned to the pandemic throughout the report.

KPMG referenced the Executive Summary at page 3 of the report, page 71 of the Additional pack which provided their assurance.

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

The Committee resolved :-
to approve the recommendation.

AUDITED ACCOUNTS - HSCP.21.056 - LATE REPORT

7. The Committee had before it the report from the Chief Finance Officer (CFO), ACHSCP which presented the IJB Audited Accounts for 2020/2021.

Members heard of the challenging financial activities in consequence of pandemic delivery and that monies in connection with the pandemic had been treated as directed by Scottish Government direction.

Members were advised that the high level of reserve funds was due to funding being received which was required to be spent during the next financial year, some of which was aligned to the pandemic funding arrangements.

The CFO wished to reinforce that the IJB was not in possession of a large balance of 'spare funding' and that anticipated continued pandemic demands together with financial scrutiny and savings, would still be applied during the next year. This would see a reduction in reserve funding to more normal levels.

KPMG provided assurance to Members that these statements were correct and a common theme to all IJB's throughout Scotland.

The report recommended :-
that the Committee -
a) consider and agree the Integration Joint Board's (IJB) Audited Accounts for 2020/21, as attached at Appendix A;
b) instruct Officers to submit the approved audited accounts to NHS Grampian and Aberdeen City Council; and
c) instruct the Chief Finance Officer to sign the representation letter, as attached at Appendix B.

RISK, AUDIT AND PERFORMANCE COMMITTEE
22 June 2021

The Committee resolved :-
(i) to approve the recommendations; and
(ii) to instruct the Chief Finance Officer to review the ACHSCP Digital Strategy at a future Workshop.

JUSTICE SOCIAL WORK PERFORMANCE MANAGEMENT FRAMEWORK - HSCP.21.053

8. The Committee had before it the report from the Lead for Social Work, ACHSCP which presented the newly-developed Justice Social Work Performance Management Framework.

Members heard a summary of the development of the framework which developed from the recent inspection and included a considerable volume of data gathering and management which was presented to the Social Work Performance Management Board. This enabled more coherent and coordinated discussions to produce Key Performance Indicators (KPI's).

Members were advised that this was a particularly complex area of the ACHSCP activities and involved national drivers combined with statutory obligations and inter dependency with local Strategy and the ACC Local Outcome Improvement Plan (LOIP).

Members heard that whilst this was the first iteration of the framework, it was intended to continue development which would include output from the forthcoming IJB Workshop.

The report recommended :-
that the Committee –
a) approve the Justice Social Work Performance Management Framework and agree to its implementation by the justice service; and
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.

The Committee resolved :-
(i) to approve the Justice Social Work Performance Management Framework as a first iteration of work in progress and agree to its implementation by the justice service; and
(ii) to 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.

DELIVERY OF LEADERSHIP TEAM OBJECTIVES - HSCP.21.072

9. The Committee had before it the report from the Deputy Chief Officer, ACHSCP which sought to provide assurance on the arrangements in hand to monitor and report on delivery of the 2021/22 Leadership Team Objectives.

Members heard a summary of the Objectives which were aligned to Operation Home First, the ACC LOIP and would be adapted to include the refreshed Strategic Plan.

Members were advised of the intended Performance Indicators which would be reported to Committee and would be considered work-in-progress to develop and enhance performance.

The report recommended :-
that the Committee –
a) note the arrangements described in this report and the accompanying appendices for the delivery of the Leadership Team Objectives and monitoring progress; and
b) instruct the Deputy Chief Officer to submit progress reports to the 23 September 2021, 21 December 2021 and 1 March 2022 meetings of the RAPC.

The Committee resolved :-
to approve the recommendations.

CONTRACT REGISTER / COMMISSIONING ANNUAL REVIEW - HSCP.21.073

10. The Committee had before it the report from the Chief Officer, ACHSCP which presented the review of the contracts register / commissioning activity for 2020/21 within the Aberdeen City Health and Social Care Partnership (ACHSCP).

Members were advised that presentation of the report had been delayed from the previous year due to the pandemic response and now presented an update on previous commissioning activity together with intended activity.

Members heard of the significant volume of work which required to be adapted to respond to the pandemic and from which the Community Workplan activities had further developed.

Members were advised that all commissioning activity remained on track so much so that there had been no instance of contract extensions being sought due to late considerations.

Members indicated their appreciation of these activities against the challenging pandemic responses.

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

The Committee resolved :-
(i) to approve the recommendation; and
(ii) to express appreciation and acknowledge the progress on production and development of the Commissioning approach.

STRATEGIC RISK REGISTER - HSCP.21.074

11. The Committee had before it the report from the Chief Officer, ACHSCP which presented the latest version of the Aberdeen City Health & Social Care Partnership's (ACHSCP) Strategic Risk Register.

Members heard a summary of the amendments that had been applied to the Risk Register following a considerable volume of work with the IJB and its Committees.

Members were reminded of a forthcoming Risk Workshop when a deep dive would be applied to the Register.

Members discussed that risk of public communications and involvements to ensure awareness of the services available to them from the ACHSCP.

The report recommended :-
that the Committee note the revised Strategic Risk Register at Appendix A.

The Committee resolved :-
(i) to approve the recommendation; and
(ii) to instruct the Chief Officer, ACHSCP, to consider the appropriateness of inclusion of a risk around public awareness of ACHSCP services.

RISK, AUDIT AND PERFORMANCE COMMITTEE
22 June 2021

OPERATION HOME FIRST - EVALUATION REPORT - HSCP.21.075

12. The Committee had before it the report from the Chief Officer, ACHSCP which provided and update on progress on the evaluation of the Aberdeen City Priorities relating to Operation Home First (OHF).

Members received a short presentation which provided a summary and explanation of the extensive reports presented to the Committee.

Members expressed a desire that learning outcomes from OHF would be included within future reports and strategic planning.

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

The Committee resolved :-
(i) to approve the recommendation; and
(ii) to note that learning outcomes from OHF reporting would feature within future reporting on Leadership Team Objectives and Strategic Planning.

CONFIRMATION OF ASSURANCE

13. 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**

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	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	**23 September 2021**									
4	Standing Item	OHF Report	Quarterly Reporting (Amalgamated within OHF Report and Op Snowdrop)		Calum Leask	Lead Strategy and Performance Manager	ACHSCP		R	Approved within in report HSCP.21.075 at June RAPC recommendation ii) to note that learning outcomes from OHF reporting would feature within future reporting on Leadership Team Objectives and Strategic Planning.
5	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.	HSCP.21.101	Martin Allan	Business Manager	ACHSCP			
6	Standing Item	Financial Regulations Review	Regular review of the Finanical Regulations.	HSCP.21.109	Alex Stephen	Chief Finance Officer	ACHSCP			
7	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	HSCP.21.104	Alex Stephen	Chief Finance Officer	ACHSCP			
8	Standing Item	IJB / ACHSCP Annual Report	Annual Report	HSCP.21.105	Alison MacLeod	Performance Lead	ACHSCP			
9	Standing Item	Whistleblowing Updates	At IJB on 06.07.21: (ii)to instruct the Chief Officer to report on a quarterly basis on any whistleblowing incidents raised under the Standards to the Risk, Audit and Performance Committee and NHS Grampian Board	HSCP.21.102	Martin Allan	Business Manager	ACHSCP			
10	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		Defer	Delayed pending review of new portfolio arrangements.

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11	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		Defer	Whilst RAPC preagenda June 21 - all three Hosted Services to be reported on 23 September 2021; now to be reported initially to Strategic Planning Group on 22.09.2021, then to RAPC on 21.12.2021
12	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		Defer	Whilst RAPC preagenda June 21 - all three Hosted Services to be reported on 23 September 2021; now to be reported initially to Strategic Planning Group on 22.09.2021, then to RAPC on 21.12.2021
13	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	HSCP.21.105	Emma King	Sandra Macleod	ACHSCP			
14	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	HSCP.21.108	Alex Pirrie	Mental Health Services	NHS Grampian			
15	07.06.2021	Records Management Plan (RMP)	Feedback from National Records of Scotland on sugested improvement actions and an action plan	HSCP.21.103	Martin Allan	Business Manager	ACHSCP			
16	22.06.2021	Digital Strategy Workshop	On 22.06.21, from Audited Accounts - HSCP.21.056; to instruct the Chief Finance Officer to review the ACHSCP Digital Strategy at a future Workshop.		Alex Stephen	Chief Finance Officer	ACHSCP		Defer	The Strategic Plan Workshop in October will review this requirement and an amended updated will be presented to RAPC on 21.12.2021 (though IJB on 15.12.2021 may have a report)
17	22.06.2021	LT Objectives - Updates on Delivery	On 22.06.21, from Delivery of Leadership Team Objectives - HSCP.21.072; (ii)to instruct the Deputy Chief Officer to submit progress reports to the 23 September 2021, 21 December 2021 and 1 March 2022 meetings of the RAPC.	HSCP.21.107	Alison Macleod	Lead Strategy and Performance Manager	ACHSCP			
18										
19	**21 December 2021**									
20	Standing Item	Strategic Risk Register	Bi-Annual - last report June 2021		Martin Allan	Business Manager	ACHSCP			

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21	Standing Item	OHF Report	Quarterly Reporting		Calum Leask	Lead Strategy and Performance Manager	ACHSCP		R	Approved within in report HSCP.21.075 at June RAPC recommendation ii) to note that learning outcomes from OHF reporting would feature within future reporting on Leadership Team Objectives and Strategic Planning.
22	Standing Item	Whistleblowing Updates	At IJB on 06.07.21: (ii)to instruct the Chief Officer to report on a quarterly basis on any whistleblowing incidents raised under the Standards to the Risk, Audit and Performance Committee and NHS Grampian Board;		Martin Allan	Business Manager	ACHSCP			
23	22.06.2021	LT Objectives - Updates on Delivery	On 22.06.21, from Delivery of Leadership Team Objectives - HSCP.21.072; (ii)to instruct the Deputy Chief Officer to submit progress reports to the 23 September 2021, 21 December 2021 and 1 March 2022 meetings of the RAPC.		Alison Macleod	Lead Strategy and Performance Manager	ACHSCP			
24	22.06.2021	Public Awareness Risk	On 22.06.21, from Strategic Risk Register - HSCP.21.074; (ii)to instruct the Chief Officer, ACHSCP, to consider the appropriateness of inclusion of a risk around public awareness of ACHSCP services.		Martin Allan	Business Manager	ACHSCP			
25										
26	**1 March 2022**									
27	Standing Item	OHF Report	Quarterly Reporting		Calum Leask	Lead Strategy and Performance Manager	ACHSCP		R	Approved within in report HSCP.21.075 at June RAPC recommendation ii) to note that learning
28	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			
29	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							
30	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			
31	Standing Item	Whistleblowing Updates	At IJB on 06.07.21: (ii)to instruct the Chief Officer to report on a quarterly basis on any whistleblowing incidents raised under the Standards to the Risk, Audit and Performance Committee and NHS Grampian Board;		Martin Allan	Business Manager	ACHSCP			

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32	22.06.2021	LT Objectives - Updates on Delivery	On 22.06.21, from Delivery of Leadership Team Objectives - HSCP.21.072; (ii)to instruct the Deputy Chief Officer to submit progress reports to the 23 September 2021, 21 December 2021 and 1 March 2022 meetings of the RAPC.		Alison Macleod	Lead Strategy and Performance Manager	ACHSCP			
33										
34	**First Meeting 2022/2023 Session**									
35	Standing Item	Internal Audit Reports	Assurance that services are operating effectively		Colin Harvey	Interim Chief Internal Auditor	Governance			
36	Standing Item	Review of relevant Audit Scotland reports	Good practice to see national position		Alex Stephen	Chief Finance Officer	ACHSCP			
37	Standing Item	Review of Local Code of Governance	To provide assurance on Governance Environment		Alex Stephen	Chief Finance Officer	ACHSCP			
38	Standing Item	Review of Financial Governance	To provide assurance on Governance Environment		Alex Stephen	Chief Finance Officer	ACHSCP			
39	Standing Item	Approval of unaudited Accounts	Per RAPC Terms of Reference		Alex Stephen	Chief Finance Officer	ACHSCP			
40	Standing Item	Annual Governance Statement	To provide assurance on Governance Environment		Alex Stephen	Chief Finance Officer	ACHSCP			
41	Standing Item	Whistleblowing Updates	At IJB on 06.07.21: (ii)to instruct the Chief Officer to report on a quarterly basis on any whistleblowing		Martin Allan	Business Manager	ACHSCP			
42	22.06.2021	Justice Social Work Performance	On 22.06.21, from Justice Social Work Performance Management Framework - HSCP.21.053; (i)to approve the Justice Social Work Performance Management Framework as a first iteration of work in progress and agree to its implementation by the justice service; and (ii)to 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.		Claire Wilson	Lead for Social Work	ACHSCP			
43	Standing Item	Justice Social Work Annual Report	On 06.07.21 at IJB 08/07/2021 (ii)to instruct the Chief Officer, ACHSCP to present an annual update to the Risk, Audit and Performance Committee on the progress being made with the implementation of this delivery plan.		Claire Wilson	Lead for Social Work	ACHSCP			to amalgamate within above entry
44										
45	**Second Meeting 2022/2023 Session**									
46	Standing Item	Internal Audit Reports	Assurance that services are operating effectively		Colin Harvey	Interim Chief Internal Auditor	Governance			
47	Standing Item	External Audit Strategy 202/22			Michael Wilkie	KPMG	KPMG			
48	Standing Item	Review of relevant Audit Scotland reports	Good practice to see national position		Alex Stephen	Chief Finance Officer	ACHSCP			
49	Standing Item	Strategic Risk Register	Bi-Annual - last report December 2021		Martin Allan	Business Manager	ACHSCP			

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50	Standing Item	OHF Report	Quarterly Reporting		Calum Leask	Lead Strategy and Performance Man ager	ACHSCP		R	Approved within in report HSCP.21.075 at June RAPC recommendation ii) to note that learning outcomes from OHF reporting would feature within future reporting on Leadership Team Objectives and Strategic Planning.
51	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 21 December 2021		Alex Stephen	Chief Finance Officer	ACHSCP			
52	Standing Item	Whistleblowing Updates	At IJB on 06.07.21: (ii)to instruct the Chief Officer to report on a quarterly basis on any whistleblowing incidents raised under the Standards to the Risk, Audit and Performance Committee and NHS Grampian Board;		Martin Allan	Business Manager	ACHSCP			
53										
54	**Third Meeting 2022/2023 Session**									
55	Standing Item	Internal Audit Reports	Assurance that services are operating effectively		Colin Harvey	Interim Chief Internal Auditor	Governance			
56	Standing Item	Review of relevant Audit Scotland reports	Good practice to see national position		Alex Stephen	Chief Finance Officer	ACHSCP			
57	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			
58	Standing Item	Financial Regs Review	Annual Review		Alex Stephen	Chief Finance Officer	ACHSCP			
59	Standing Item	Whistleblowing Updates	At IJB on 06.07.21: (ii)to instruct the Chief Officer to report on a quarterly basis on any whistleblowing incidents raised under the Standards to the Risk, Audit and Performance Committee and NHS Grampian Board;		Martin Allan	Business Manager	ACHSCP			
60	06.07.21		At IJB on 06.07.21: (iii)to instruct the Chief Officer, ACHSCP to report to the Risk, Audit and Performance Committee in 12 months with an update on locality planning including implementation of the locality plans.		Alison Macleod	Lead Strategy and Performance Manager	ACHSCP			
61	**Fourth Meeting 2022/2023 Session**									
62	Standing Item	Internal Audit Reports	Assurance that services are operating effectively		Colin Harvey	Interim Chief Internal Auditor	Governance			
63	Standing Item	Review of relevant Audit Scotland reports	Good practice to see national position		Alex Stephen	Chief Finance Officer	ACHSCP			
64	Standing Item	Strategic Risk Register	Bi-Annual - last report December 2021		Martin Allan	Business Manager	ACHSCP			

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66	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 21 December 2021		Alex Stephen	Chief Finance Officer	ACHSCP			
67	Standing Item	Whistleblowing Updates	At IJB on 06.07.21: (ii)to instruct the Chief Officer to report on a quarterly basis on any whistleblowing incidents raised under the Standards to the Risk, Audit and Performance Committee and NHS Grampian Board;		Martin Allan	Business Manager	ACHSCP			

Aberdeen City Health & Social Care Partnership
A caring partnership

RISK, AUDIT AND PERFORMANCE COMMITTEE

Date of Meeting	23 September 2021
Report Title	Review of Financial Regulations
Report Number	HSCP.21.109
Lead Officer	Chief Finance Officer
Report Author Details	Alex Stephen Chief Finance Officer AleStephen@aberdeencity.gov.uk
Consultation Checklist Completed	Yes
Appendices	Appendix A - Financial Regulations – September 2021

1. Purpose of the Report

1.1. The purpose of this report is to present the Risk, Audit and Performance Committee (RAPC) with an update on the Chief Finance Officer's review of the Integration Joint Board's (IJB) Financial Regulations.

2. Recommendations

2.1. It is recommended that RAPC:

a) Note that the Chief Finance Officer (CFO) considers no changes to the Financial Regulations are required from his review as at September 2021. The Financial Regulations are attached at Appendix A.

3. Summary of Key Information

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

3.2. Under the Local Government (Scotland) Act 1973, the IJB is required to make arrangements for administration of its financial affairs. At its meeting on the 26 March 2016, the IJB agreed a set of financial regulations which detailed the responsibilities, policies and procedures that govern the IJB.

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

3.4. The previous review was in 2019, and a report to the 1 November 2019 meeting of the IJB (report HSCP.19.054) highlighted two main changes around financial monitoring and grant funding and we continue to work within those approved changes.

3.5. We also reported that we were not then compliant with regards set-aside budget; there has been no progress but this is not impacting on performance or financial control. Work progresses both with NHS nationally and locally in Grampian to determine whether the set-aside usage can be received quarterly.

3.6. The financial regulations have been reviewed and we consider continue to support the integrity of our financial records. No amendment is required from our review in September 2021. A copy of the Financial Regulations attached as Appendix A on this report.

4. Implications for IJB

4.1. **Equalities, Fairer Scotland Duty and Health Inequalities –** there are no direct implications as a result of this report.

4.2. **Financial –** the IJB Financial Regulations detail the financial responsibilities, and policies and procedures that govern the Integration Joint Board.

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

4.4. **Legal –** approval of these Financial Regulations will allow the IJB to comply with its obligation to make arrangements for its financial affairs under the

Local Government (Scotland) Act 1973. Should a major change be required to the financial regulations then this would need to be passed through to the IJB for final approval.

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

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

6. Management of Risk

6.1. **Identified risks(s):** Without regular review of the Financial Regulations and adherence to them, there is a risk of financial failure and a negative impact on the delivery of the ACHSCP priorities.

6.2. **Link to risks on strategic or operational risk register:** Risk 2 (Strategic Risk Register) - There is a risk of financial failure, that demand outstrips budget and IJB cannot deliver on priorities, statutory work, and projects an overspend.

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

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

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Aberdeen City Health & Social Care Partnership
A caring partnership

ABERDEEN CITY INTEGRATION JOINT BOARD

FINANCIAL REGULATIONS

Date Created	Date Implemented	Review Date
11 March 2016	1 April 2016	02 September 2021

Developed By
Chief Finance Officer

VERSION 2.1

ABERDEEN CITY INTEGRATION JOINT BOARD

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6. REVIEW OF FINANCIAL REGULATIONS

1. INTRODUCTION and INTERPRETATION

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

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

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

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

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

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

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

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

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

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

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

2. ROLES and RESPONSIBILITIES

2.1 INTEGRATION JOINT BOARD MEMBERS RESPONSIBILITY

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

2.2 CHIEF OFFICER RESPONSIBILITIES

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

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

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

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

2.3 CHIEF FINANCE OFFICER RESPONSIBILITIES

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

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

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

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

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

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

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

3. FINANCIAL PLANNING and MANAGEMENT

3.1 ANNUAL BUDGET

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

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

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

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

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

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

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

3.2 ACCOUNTING POLICIES

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

3.3 BUDGET MONITORING

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

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

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

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

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

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

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

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

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

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

3.4 VIREMENT

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

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

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

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

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

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

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

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

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

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

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

3.5 FINAL ACCOUNTS PREPARATION

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

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

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

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

3.6 TREASURY MANAGEMENT

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

3.7 RESERVES

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

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

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

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

3.8 GRANT FUNDING APPLICATIONS

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

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

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

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

4. FINANCIAL SYSTEMS and PROCEDURES

4.1 INCOME

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

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

4.2 AUTHORITY TO INCUR EXPENDITURE

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

4.2.2 Expenditure shall be aligned with the Strategic Plan.

4.3 SCHEME of DELEGATION

4.3.1 Detail included in separate documentation.

4.4 PROCUREMENT and COMMISSIONING

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

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

4.5 IMPRESTS

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

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

5. FINANCIAL ASSURANCE

5.1 AUDIT & PERFORMANCE SYSTEMS COMMITTEE

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

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

5.2 EXTERNAL AUDIT

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

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

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

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

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

5.3 INTERNAL AUDIT - RESPONSIBILITY

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

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

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

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

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

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

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

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

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

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

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

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

5.4 INTERNAL AUDIT - AUTHORITY

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

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

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

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

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

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

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

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

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

5.5 FRAUD, CORRUPTION & BRIBERY

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

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

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

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

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

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

5.6 INSURANCE

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

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

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

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

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

5.7 VAT

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

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

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

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

5.8 GIFTS and HOSPITALITY / REGISTER of INTEREST

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

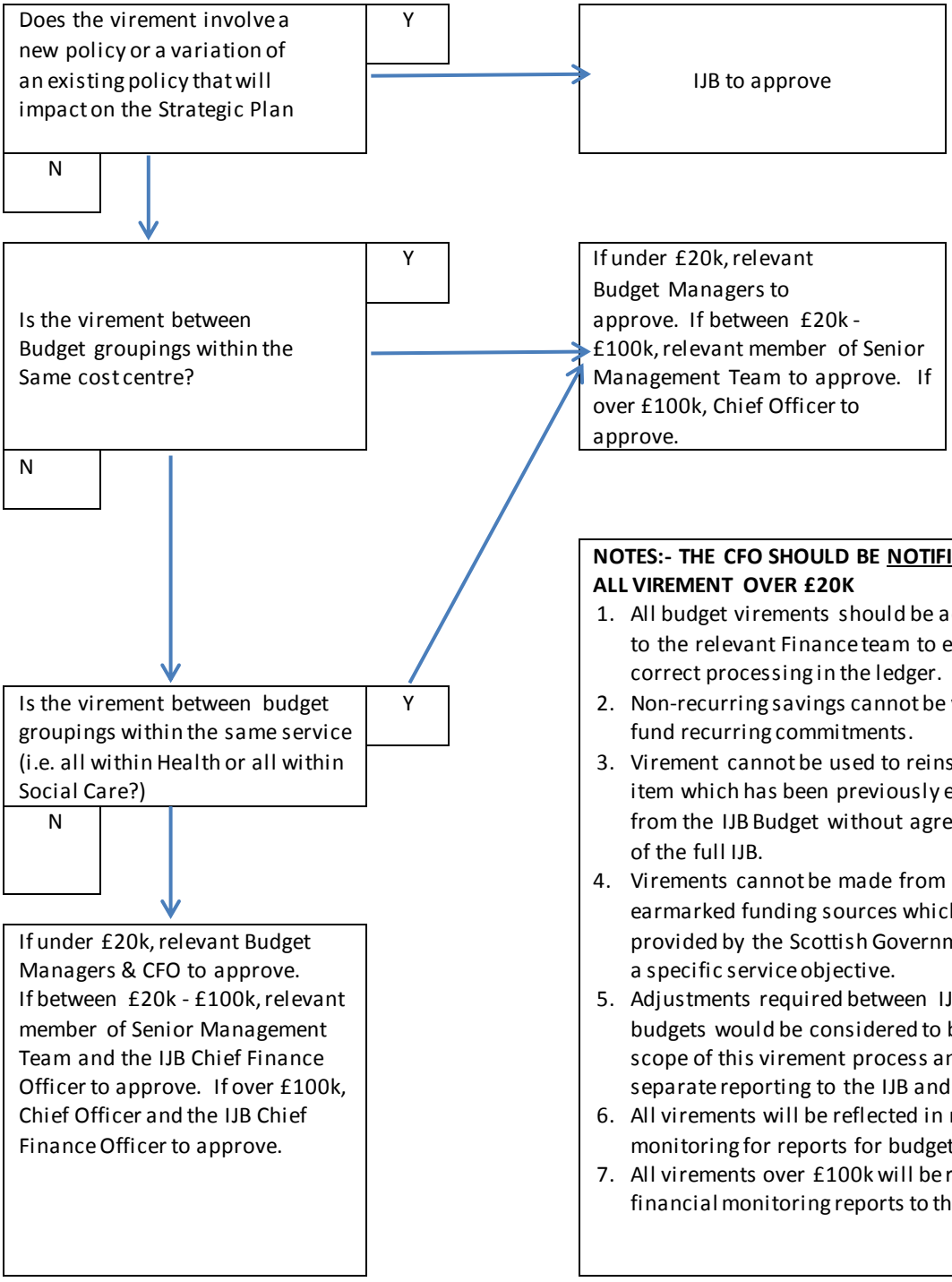
5.8.2 A central register of gifts and hospitality will be maintained by the Aberdeen City Integration Joint Board. For the offers of any hospitality or gift, approval must be sought from the relevant line manager prior to acceptance and for offers exceeding £30 details must be intimated in writing for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

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

6 REVIEW OF FINANCIAL REGULATIONS

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

APPENDIX 1 – IJB VIREMENT APPROVAL RESPONSIBILITY CHART



NOTES:- THE CFO SHOULD BE <u>NOTIFIED</u> OF ALL VIREMENT OVER £20K

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

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Aberdeen City Health & Social Care Partnership
A caring partnership

Risk, Audit and Performance Committee

Date of Meeting	23 September 2021
Report Title	Review of Board Assurance and Escalation Framework
Report Number	HSCP.21.101
Lead Officer	Alex Stephen, Chief Finance Officer
Report Author Details	Name: Martin Allan Job Title: Business Manager Email Address: martin.allan3@nhs.net
Consultation Checklist Completed	Yes
Appendices	Appendix A - Board Assurance and Escalation Framework Revised 2021

1. Purpose of the Report

1.1. To present the annual review of the Integration Joint Board's (IJB) Board Assurance and Escalation Framework (BAEF) as part of the Risk, Audit and Performance Committee's (RAPC) annual review of the Framework.

2. Recommendations

2.1. It is recommended that the Committee:

(a) Approve the revised Board Assurance and Escalation Framework (BAEF) as attached at Appendix A.

(b) Agree that the Framework continue to be reviewed annually by RAPC.

3. Summary of Key Information

Board Assurance and Escalation Framework (BAEF)

3.1. In order to fulfil its remit, the IJB must demonstrate an effective governance process whereby it can be assured that key risks to the achievement of

integration objectives are appropriately identified, communicated and addressed.

3.2. The BAEF describes the regulatory framework of the IJB to support its vision, values and principles, within which the RAPC will work. Fundamental to the framework are the IJB's strategic priorities and the appetite for risk that exists across these priorities.

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

3.4. A key element of the assurance framework is the risk management system, whose outputs (i.e. strategic and corporate risk registers, and other reports) contribute significantly to assurance on key risks to objectives. The appendices illustrate the landscape in which the IJB operate:

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

3.5. The RAPC performs the key role of reviewing and reporting on the effectiveness of the governance structures in place and on the quality of the assurances the Board receives.

3.6. The BAEF was formally approved by the IJB in 2016 and was last reviewed by RAPC on 26 August 2020. The 2021 review has been undertaken and the revised version is attached as Appendix A to this report.

3.7. Largely, the content of the BAEF remains unchanged following the revision, with minor housekeeping undertaken on the document.

3.8. The main change to the framework relates to governance arrangements for the reporting of clinical and non-clinical risks through the governance structures in place in Aberdeen City Health & Social Care Partnership (ACHSCP) and IJB (as outlined at pages 12-15 in Appendix A). These

changes will clarify the reporting of clinical and non-clinical risks through the operational and strategic risk registers, as well as explaining which governance groups will scrutinise the risks.

3.9. It is proposed that the BAEF continue to be reviewed on an annual basis. The review for 2022 will reflect the development of a new Strategic Plan for ACHSCP.

4. Implications for IJB

4.1. **Equalities, Fairer Scotland and Health Inequality** – there are no direct implications arising directly as a result of this report, however the BAEF outlines the regulatory framework of the IJB, supporting its vision, values and principles in terms of equalities, the principles within the Fairer Scotland Duty and tackling health inequalities.

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

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

4.4. **Legal –** there are no direct legal implications arising directly as a result of this report.

4.5. **Covid 19**- there are no direct implications relating to Covid 19 or response as a result of this report.

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

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

5. Links to ACHSCP Strategic Plan

5.1. The Strategic Plan sets out the aims, commitments, and priorities of the Partnership, in alignment with Community Planning Aberdeen's Local

Outcome Improvement Plan, NHS Grampian's (NHSG) Clinical Strategy and Aberdeen City Council's (ACC) Local Housing Strategy. Since its inception, the ACHSCP and its governance body, the Integration Joint Board, have progressed integration of the health and social care services delegated from our partners, ACC and NHSG. Part of the Governance around the IJB is the development and revision of the BAEF.

6. Management of Risk

6.1. Identified risks(s): Reputational Damage.

6.2. Link to risks on strategic or operational risk register: The development and revision of the BAEF will help to mitigate all of the risks on the IJB's Strategic Risk Register, however the main risk that it will help mitigate is "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:

This report helps to mitigate the risks as it commits to an annual review of the BAEF to ensure it is updated appropriately. Further, the information provided in the BAEF helps to mitigate the impact of a number of risks in the strategic risk register, by providing the necessary assurance and escalation processes.

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

Aberdeen City Health & Social Care Partnership

A caring partnership

Board Assurance and Escalation Framework

Approved xxxxx. Next review 2022.

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Part 1: Introduction

1.1 Background

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

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

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

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

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

1.2 Regulatory framework

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

The IJB will make recommendations or give directions where appropriate (i.e. where funding for employment is required) to the decision-making arms of ACC and NHSG as required.

1.3 Purpose of the framework

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

It is underpinned by the principles of good governance (Good Governance Institute and Health Care Quality Improvement Partnership 1, Scottish Government Risk Management Public Sector Guidance 2, and the Chartered Institute of Public Finance and Accountants and the International Federation of Accountants-International Framework :Good Governance in the Public Sector 3) , [1] [2] [3] and by awareness that ACHSCP is committed to being a leading edge organisation in the business of transforming health and social care.

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

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

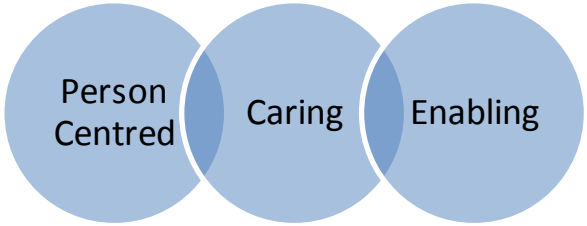
[3] Chartered Institute of Public Finance and Accountancy (CIPFA) and the International Federation of Accountants® (IFAC®). *International Framework: Good Governance in the Public Sector*, (2014) - http://www.cipfa.org/policy-and-guidance/standards/international-framework-good-governance-in-the-public-sector

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

The structures and systems described are those in place from July 2021. In order to ensure that the framework can best support the IJB in its ambitions going forward, it is reviewed annually.

1.4 An integrated approach to governance for health and social care

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



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

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

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

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

- Embedding continuous improvement
- Providing robust assurance of high quality, effective and safe clinical and care services
- The identification and management of risks to and failure in services and systems
- Involvement of service users/carers and the wider public in the development of services
- Ensuring appropriate staff support and training
- Ensuring clear accountability

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

Table 1: Assurance and Compliance Framework

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

Part 2: The Framework

2.1 Strategic priorities

From the nine strategic outcomes identified nationally as desired outcomes form integration, the ACHSCP has, in its current Strategic Plan[6] (approved in March 2019-work is currently underway for a refresh of the Plan) articulated five broad strategic aims, which form the basis of its governance framework and which meet the nine strategic outcomes.

[6] Aberdeen City Health and Social Care Partnership Strategic Plan 2019-2022

These priorities underpin:

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

2.2 Risk Management Policy

a) Risk appetite

Risk appetite can be defined as:

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

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

b) Risk Appetite Statement

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

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

The full risk appetite statement is outlined below:
Aberdeen City Health and Social Care Integration Joint Board (the IJB) recognises that it is both operating in, and directly shaping, a collaborative health and social care economy where safety, quality and sustainability of services are of mutual benefit to local citizens, to stakeholders and to organisational stakeholders. It also recognises that its appetite for risk will change over time, reflecting a longer-term aspiration to develop innovation in local service provision based on evidence of benefits and on a culture of continuing, planned engagement with the public and other stakeholders, including those involved in service delivery. As a result, the IJB is working towards a mature risk appetite over time.
It recognises that achievement of its priorities will involve balancing different types of risk and that there will be a complex relationship between different risks and opportunities. The risk appetite approach is intended to be helpful to the board in decision-making and to enable members to consider the risks to organisational goals of *not* taking decisions as well as of taking them.
The board has identified several broad dimensions of risk which will affect the achievement of its strategic priorities. The IJB will set a level of appetite ranging from "none" up to "significant" for these different dimensions. Higher levels of all risk types may be accepted if specific and effective controls are demonstrably in place and there are clear advantages for integration objectives. The dimensions of risk and corresponding risk appetite are:

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

The IJB has an appetite to take decisions which may expose the organisation to additional scrutiny and interest. Wherever possible, decisions will be taken following consultation/co-production with the public and other key stakeholders. Concerted efforts will be made to explain reasons for decisions taken to the public transparently in a way which is accessible and easy to understand.
This risk appetite statement will be reviewed regularly, at least as often as the IJB's strategic plan is reviewed and more often when required.

c) Risk Management Framework

The Risk Appetite statement, risk management system, strategic and operational risk registers together form the risk management framework.

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

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

d) Risk Assessment methodology

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

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

The ***likelihood*** of this occurring will be affected by the strength of fire safety precautions (prevention). The ***consequence*** or ***severity*** of the incident if it does occur will be affected by contingency management (containment, firefighting, evacuation procedures, emergency help, communications etc. by fire safety response and by effective Business Continuity Planning (BCP) to ensure that essential services continue to be delivered, even if at a reduced level for a period). BCP serves to reduce consequence of risk events mostly in major structural or physical risks such as fire, flood, terrorism or natural disaster.

It is important to note that in most areas of risk identified and managed by ACHSCP, the aim is to managed down the likelihood of a risk event and that in most cases, the consequence or severity of a risk event will remain the same throughout the lifetime of the risk. For example, if there is a shortage of key clinical specialists one month, the consequence for service users could be a poorer health or wellbeing outcome. If vacancies are filled in a subsequent month, the likelihood of that consequence is reduced but if the risk event nevertheless occurs, the consequence for patients or clients may still be 'major' depending on the nature of the service involved.

[7] Standards New Zealand, AS/NZS ISO 31000:2009 Risk Management

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

A key point to remember when assessing a risk for the first time is what controls are currently in place to prevent a risk event. The ACHSCP risk assessment procedure requires the identification of an **initial,** or **gross,** level of risk. This is the risk assessment where it is assumed no controls are in place. This is useful in order to determine and absolute severity of a risk but in practice, the second assessment, or current risk level, is particularly important in risk management terms. This identifies the level of risk taking into account any controls (and gaps in controls) which currently exist. The third level of risk assessment comprises the stage aspired to where the level of risk may be tolerated within the terms of the Risk Appetite once all effective actions have been completed and the controls are at optimal strength. This is the **target** level of risk.

The IJB's risk measurement table is shown below:

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

Risk Matrix

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

The outputs from risk assessment are as follows:

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

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

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

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

The risks are identified by:

- Discussions at Leadership Team
- Review of Performance data and dashboards
- Reports from Project Management Board on review of Performance Management Office (PMO) dashboards
- Review of the Operational Risk Register (ORR) (see below) including 'deep dives' on areas of operational risk aligned to strategic risk

- Review of Chief Officer reports and reports from IJB sub committees

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

RAPC reviews the SRR for the effectiveness of the process annually.

Corporate Level: Operational Risk Register

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

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

Risks from service risk registers and locality risk registers (once developed) are escalated to the ORR according to their risk assessment scores. New risks and risks proposed for escalation, will be discussed at the Clinical and Care Risk Meetings. New risks proposed for escalation can also be discussed at the Leadership Team daily huddles as well as at the 6 weekly Business Meetings of the Leadership Team.

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

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

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

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

Table 2: Risk Recording Format

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

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

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

The Chief Officer owns the ORR, and the Clinical and Care Governance Group moderate risks escalated to ensure consistency and appropriateness of issues identified for inclusion and removal. The Clinical Care and Governance Group will meet every 2nd month and will identify any new risks. New or escalated risks are reported to the Clinical and Care Governance Committee (CCGC) so that the Committee are aware of the evolving profile of operational risks.

The Leadership Team reviews the Operational Risk Register at its 6 weekly Business Meetings and it will be reported to the CCGC in its entirety, bi-annually demonstrating the changes in the risk profile of the IJB.

Occupational health and safety risks will be reported to the Partnership's Health and Safety Committee. Some risks may be reported to both the Clinical Care and Governance Group and the Health and Safety Committee. Governance arrangements are in place to capture these risks at source and share with the other forum.

Non clinical/non occupational health and safety risks will be reported to the Risk, Audit and Performance Committee.

The risk register is shared with the NHSG and ACC through the report consultation process.

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

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

Where risks cannot be satisfactorily managed locally, or where they are above scores as set out in the escalation flowchart, they will be escalated for possible entry onto the ORR. New risks and those identified for escalation will be considered at the regular Clinical Care Risk Meetings and recommendations made for the attention of the Clinical and Care Governance Group. The Leadership Team will also receive regular feedback from the Clinical Care Risk Meetings. It is critical to emphasise that the risk management system cannot rely on escalation through the risk register process alone. The Leadership Team, through the operational group management structure, has a key role in helping to manage and find solutions to risk issues at all levels of the organisation.

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

2.3 Roles and Responsibilities for governance

a) Committee structure

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

The board has established two sub-committees, as follows: **RAPC** and **CCGC These** committees have powers conferred upon them by the IJB.

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

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

It also assures the IJB that services respond to requirements arising from regulation, accreditation and other inspections' recommendations. The Committee will consider and approve high value clinical and care risks, consider the adequacy of mitigation, the assurance provided for that mitigation and refer residual high risks to the Board. It has a key role in assuring the board that learning from governance systems across services, including learning arising from incidents, complaints, identified risks and Duty of Candour (DOC) investigations, is shared and embedded as widely as possible. The Committee will receive the full Operational Risk Register twice per year.

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

There are existing **governance arrangements within the providers of services delegated to the IJB**. Arrangements to standardise reporting systems through the IJB's governance structures have been further progressed in 2020/21.

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

b) Individual responsibilities

1. Board and corporate level:

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

The Board and all its members must as a corporate body ensure good governance through the structures and systems described in this document. To ensure that the IJB is well-led and that all members are supported in this responsibility, a board development programme will be constructed to transfer knowledge and skills. To provide assurance that the Board has the capability and competence required, an annual self-assessment and periodic (minimum 3 yearly) independent assessment will be undertaken. This was last carried out in 2020.

2. Professional level:

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

- Lead Nurse
- Chief Social Work Officer
- Lead Allied Health Professional (AHP)
- Primary Care Clinical Leads (GPs)
- Public Health Lead
- Clinical Director (GP)

3. Locality level:

The BAEF is aligned with the locality structure. This will require that there is a direct line of sight to the appropriate clinical and professional lead roles and must take into account the location of services: some are locality based and others not. The development

plan is that each of the six delivery points will have a single leader responsible for the good clinical and care governance of services within their remit.

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

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

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

FOCUS	**Assurance of compliance, performance, improvement and transformation**						
				Reporting and feedback processes			
	Individuals	**Plans / activities**	**Groups / Partners**	**Compliance with standards**	**Risk escalation and review**	**Performance monitoring**	**Improvement and Transformation reporting**
Board level	Chair Chief Officer Board members Chairs / CEOs of the Partners	Strategic plan Strategic Risk Assurance Register Operational Risk register Performance framework Audit plan Standing Orders Integration Scheme	Board Leadership Team Risk, Audit and Performance Committee Clinical and Care Governance Committee Other IJBs	Review of BAEF Review of risk scoring Review of Performance dashboard Transformation Performance Report Audit reports to Board Exception and action plan review Bi-annual review of integration scheme Bi-annual review of strategic plan			

			Scrutiny / governance arms of Parties	
Corporate level	Chief Officer Deputy Chief Officer/Chief Finance Officer Leadership Team Members	Strategic and Operational risk registers Performance dashboard Business planning Budget monitoring Joint Complaints Procedure	Leadership Team Senior Management Teams Strategic Planning Group Clinical and Care Governance Group Executive Programme Board Portfolio Programme Boards	Financial monitoring Strategic and Operational risk register review Risk moderation and review
Service level	Clinical leads and Professional leads Service managers	Engagement, Participation and Empowerment Strategy Clinical and care governance policies Risk registers and assessments	Community partners Service governance forums 'Deep Dive' activity	Risk register system Governance reports Real time feedback Response to complaints Learning from Duty of Candour events Service level dashboards
Individual level	Staff members Service users Carers	Engagement, Participation and Empowerment Strategy Complaints policy Safeguarding alerts Risk assessment Incident reporting	Staff forums IJB engagement activity Locality Empowerment Groups	Objective setting and review Supervision and line management Staff surveys Feedback mechanisms (see assurance source section) Community engagement feedback

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

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

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

2.5 Sources of assurance

a) Quality of services

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

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

b) Engagement

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

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

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

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

Newsletters	Groups		Other
• Partnership Matters Newsletter • Health Village newsletter • NHSG Team Brief • Scottish Care newsletter/ e-bulletin	• Care at Home Providers Group Forum • Individual Independent providers • Care and Support Providers Aberdeen • Individual Third sector providers	• Sheltered Housing Network • Joint Strategy groups • Locality Empowerment Groups • Local Community Councils • LOIP Outcome Improvement Groups	• 'Connect' – ACHSCP intranet • ACHSCP Website: https://www.aberdeencityhscp.scot/

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

c) Other internal and external sources of assurance

In addition to the assurances emanating from the IJB's Clinical and Care Governance Framework, and its engagement with partners and stakeholders, there are numerous internal and external sources which relate to the delegated services. These include:

- Internal Audit
- External Audit
- External inspection agencies (Care Inspectorate and Healthcare Improvement Scotland)
- Health and Safety Executive
- Mental Welfare Commission
- Externally commissioned independent investigations e.g. Ombudsman and homicide investigations
- Clinical Audit
- Scottish Council for Voluntary Organisations (SCVO)
- Royal College reviews
- Accreditation
- Information Services Division (ISD) Scotland
- Benchmarking with other health and social care providers
- Involvement in and learning from case reviews
- Voluntary Health Scotland
- Crown Office / Procurator Fiscal Reports
- The IJB will also commission external reviews of specific services where the need for additional independent assessments and assurance are identified.

Appendices

Appendix 1 – Strategic risk register format

<table>
<tr><th colspan="3">- 1 -</th></tr>
<tr><td colspan="3">Description of Risk:</td></tr>
<tr><td colspan="2">Strategic Priority:</td><td>Lead Director:</td></tr>
<tr><td>Risk Rating: low/medium/high/very high

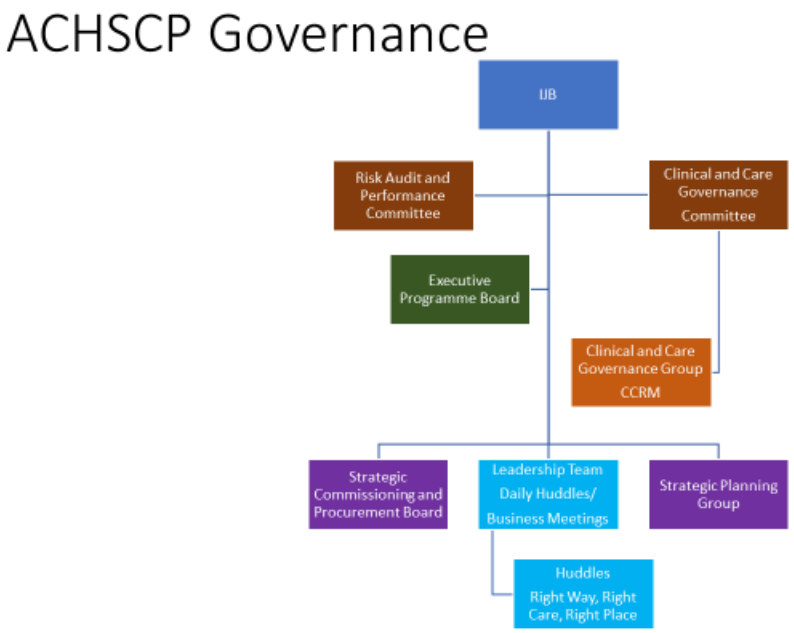
Medium</td><td rowspan="2">Rationale for Risk Rating:

Rationale for Risk Appetite:</td><td rowspan="2"></td></tr>
<tr><td>Risk Movement: increase/decrease/no change

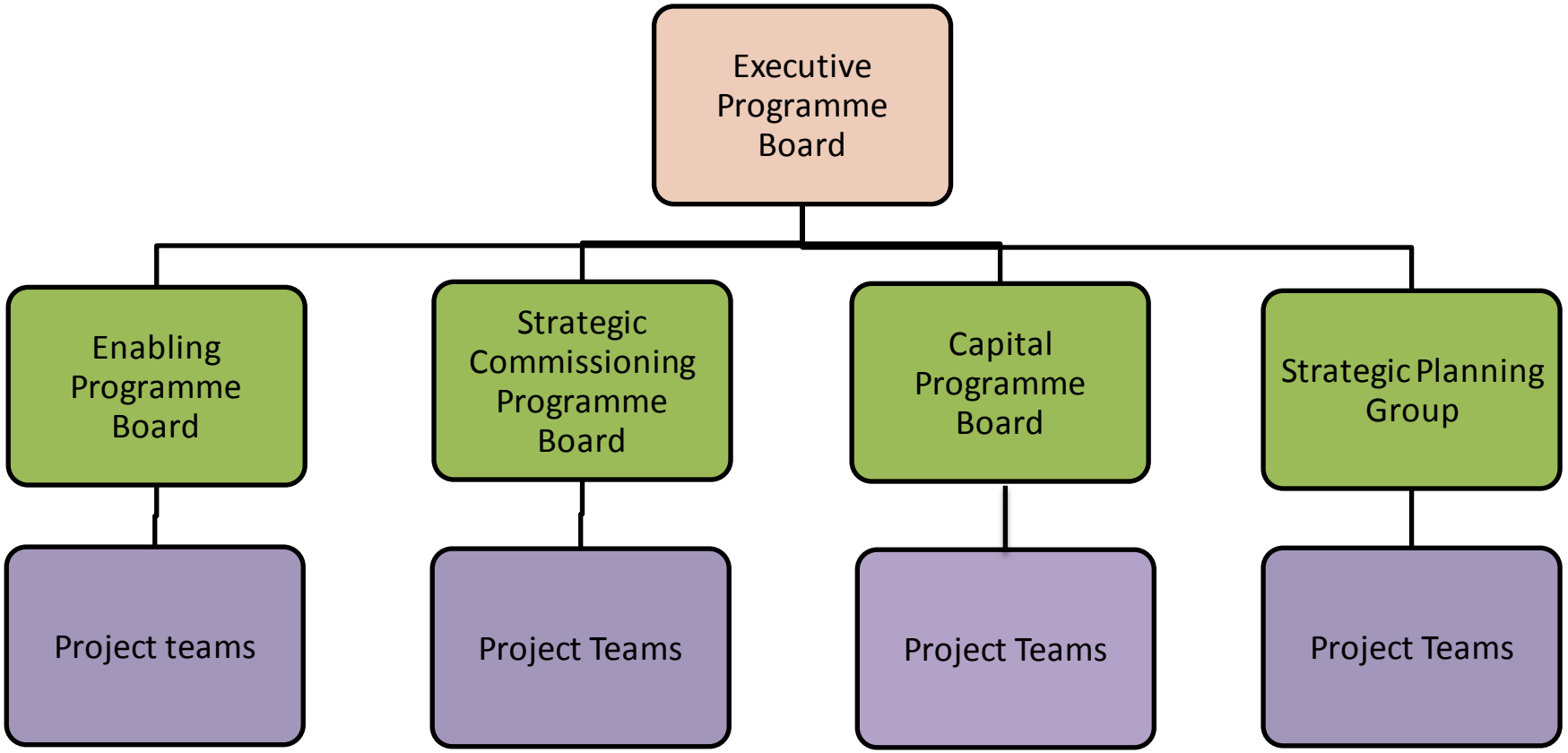
NO CHANGE</td></tr>
<tr><td colspan="2">Controls:</td><td>Mitigating Actions:</td></tr>
<tr><td colspan="2">Assurances:</td><td>Gaps in assurance:</td></tr>
</table>

Current performance:	Comments:

Appendix 2 - Board Committee diagram



Appendix 3 – Transformation Programme Structure



Appendix 4 – Roles of the Governance Groups

Principal function/s	Membership	Reports to	Reports received / reviewed
Leadership Team			
Robust and effective management processes are required to ensure management oversight of: • Care and Clinical Governance • Risk Management and oversight of Service and Corporate Risk Registers • Financial governance and performance oversight • Service performance • Staff governance • Health and Safety • Executive oversight of change programmes • Ensuring IJB's strategic plan is delivered • Good decision making and approval of business cases	The core membership is as follows: • Chief Officer – chair • Chief Finance Officer – financial reporting • Clinical Director (GP) – Clinical Governance reporting • Lead, Strategy and Performance • Business Management Lead • Transformation Lead • Communications Lead • People and Organisation Lead • AHP Lead • Lead Nurse • Social Work Lead • Rehabilitation Lead • Mental Health & LD Lead • Commissioning Lead • Primary Care Lead • Primary Care Lead	IJB	The following will report as required to the Leadership Team : • Leadership team members • Service Managers • Transformation Programme Managers • Chief Officers – Moray and Aberdeenshire in relation to performance of 'hosted services' • Designated service health and safety leads • Partnership representatives / trade union representatives • Service Improvement and Quality • Chief Social Work Officer • Health Intelligence • Business Managers
Strategic Planning Group			

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

Principal function/s	Membership	Reports to	Reports received / reviewed
To provide assurance to the IJB on the systems for delivery of safe, effective, person-centred care in line with the IJB's statutory duty for the quality of health and care services.	The Committee shall be established by the IJB and will be chaired by a voting member of the IJB. The Committee shall comprise of: • 4 voting members of the IJB • Chief Officer • Chief Social Work Officer • Chair of the Clinical and Care Governance Group / Clinical Director (GP) • Chair of the Joint Staff Forum • Professional Lead – Nurse/AHP • Public Representative • Third Sector representatives	IJB	CCG Group report Feedback/Incidents Reporting Escalations from CCG Group
Clinical & Care Governance Group			
To oversee and provide a coordinated approach to clinical and care governance issues and risks within the Aberdeen City Health and Social Care Partnership.	• Clinical Director (GP) (Chair) • Lead Social Work Manager • Lead Nurse • Public Health Lead • Patient/Public Representative • Lead Allied Health Professional • GP Representative • Dental Clinical Lead or Dental Service Representative • Lead Optometrist • Representative from Sexual Health Service • General Practice Patient Safety Lead • Woodend Hospital and Link@ Woodend Representative • Representative from Commissioned Service • Partnership Representative	Leadership Team Clinical and Care Governance Committee NHSG Clinical Quality & Safety Group ACC Public Protection Committee	Reports from services: AHP Dentistry Optometry Pharmacy Nursing General Practice Social Work/Care Woodend Hospital and Links @ Woodend Biannual Reports Falls Pharmacy/medication Patient Safety in Primary Care New and escalated risks

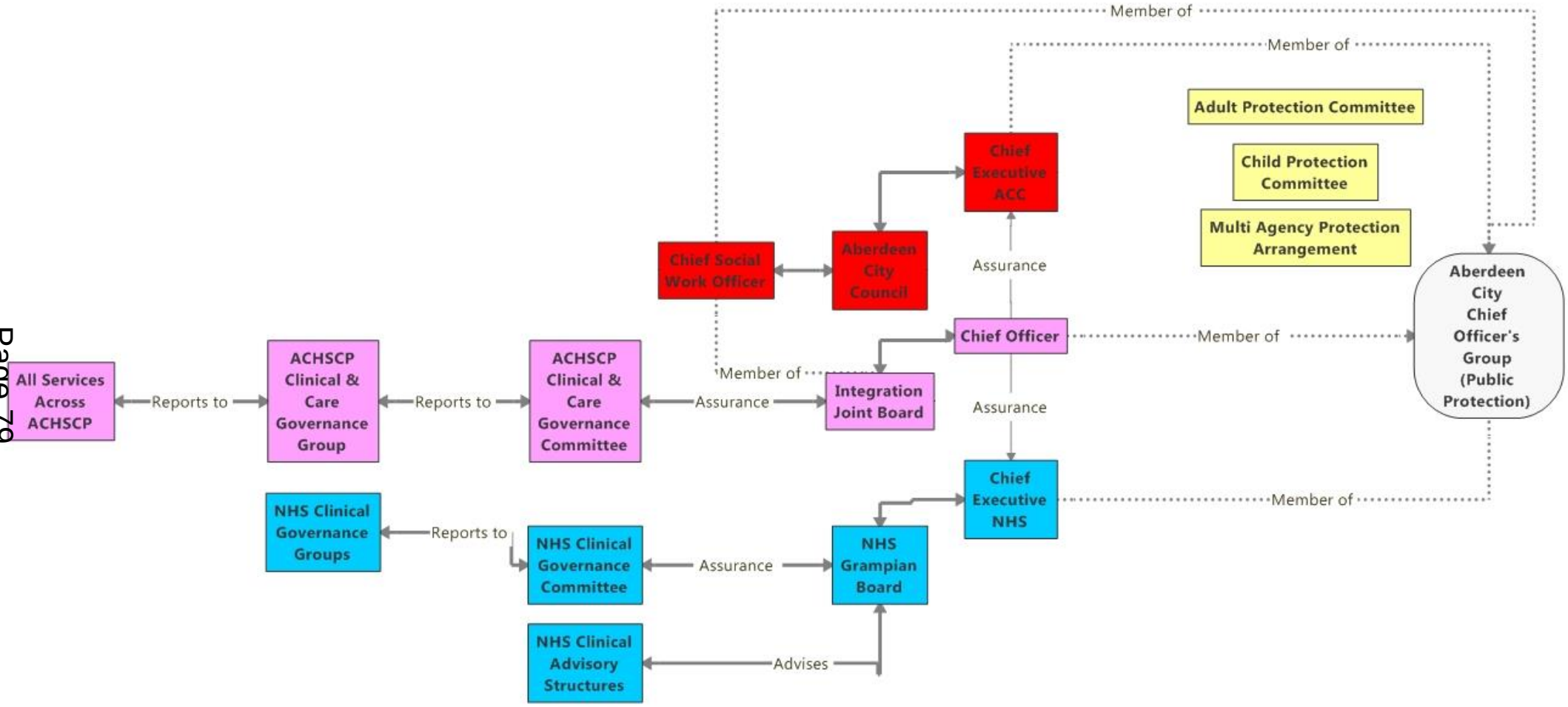
Principal function/s	Membership	Reports to	Reports received / reviewed
	• Representative from Community Mental Health and Learning Disability Services • Representative from Acute Sector • Public Partner		
Locality Empowerment Groups			
To deliver the locality planning requirements of the Public Bodies (Joint Working) (Scotland) Act 2014, in respect of the Aberdeen City Health and Social Care Partnership. The Locality Empowerment Groups play a key role in ensuring the delivery of the Aberdeen City Health and Social Care Strategic Plan, including contributing to the delivery of its associated strategic outcomes. The role of the Locality Empowerment Groups includes developing and ensuring appropriate connections and partnerships across the Locality to help to improve the health and wellbeing of the locality population and reduce the health inequalities that we know impact poorly on people's lives. The locality leadership group will influence, and be influenced by, the city's Strategic Planning Group and ultimately the Integration Joint Board.	Community Members Public Health Coordinator	Strategic Planning Group	Locality Plans Health Improvement Fund report

Principal function/s	Membership	Reports to	Reports received / reviewed
The locality leadership group will also influence and be influenced by the Aberdeen City Community Planning Partnership.			
Executive Programme Board			
• Provide direction to programme board and working groups • Identify prioritised projects • Approve Business Cases • Ensure programme progress including ensuring that progress is supported to continue at pace • Approve significant changes to programmes	• Chief Officer • Chief Finance Officer • Clinical Lead • Lead Transformation Manager • Other Leadership Team Members (rotating)	Seek IJB approval to incur expenditure for projects where required under standing orders (full life costs) Report on progress and performance to IJB	Papers from Enabling / Strategic Commissioning / Capital Programme Boards & Strategic Planning Group All planned decisions All IJB papers
Programme Boards (Enabling, Strategic Commissioning, Capital)			
• Support and enable progress at pace across transformation portfolio • Review and approve Project Proposal Documents • Consider "deep dives" into working group programmes to be assured of progress	• Selected Leadership Team Members (Chair and VC) • Operational Managers • Transformation Programme Managers • Independent Sector • Third Sector • ACC Communities and Housing	Executive Programme Board	Workstreams and project groups Business Case Programme Management documentation

Principal function/s	Membership	Reports to	Reports received / reviewed
Ensure delivery of anticipated benefits and where these are no longer deliverable, redirect projects/ programmes accordingly	• Acute Sector Finance		

Appendix 5 – Clinical and care governance diagram

The diagram on the following page provides an overview of the clinical & care governance processes within ACHSCP. The processes draw upon the existing clinical & care governance within ACC and the NHS. Clinical & care governance matters relating to the ACHSCP are considered by its Clinical & Care Governance Group. The Clinical & Care Governance group has representation from all services across ACHSCP and report to the ACHSCP Leadership Team, CCGC and provide assurance to ACC and NHS clinical and safety structures.


Member of
Member of
Adult Protection Committee
Child Protection Committee
Multi Agency Protection Arrangement
Chief Executive ACC
Chief Social Work Officer
Aberdeen City Council
Assurance
Aberdeen City Chief Officer's Group (Public Protection)
Chief Officer
Member of
Member of
Integration Joint Board
Assurance
All Services Across ACHSCP
Reports to
ACHSCP Clinical & Care Governance Group
Reports to
ACHSCP Clinical & Care Governance Committee
Assurance
Chief Executive NHS
Member of
NHS Clinical Governance Groups
Reports to
NHS Clinical Governance Committee
Assurance
NHS Grampian Board
NHS Clinical Advisory Structures
Advises

NHS Scotland Core Risk Assessment Matrices

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/ Projects	Barely noticeable reduction in scope, quality or schedule.	Minor reduction in scope, quality or schedule.	Reduction in scope or quality of project; project objectives or schedule.	Significant project over-run.	Inability to meet project objectives; reputation of the organisation seriously damaged.
Injury (physical and psychological) to patient/ visitor/staff	Adverse event leading to minor injury not requiring first aid.	Minor injury or illness, first aid treatment required.	Agency reportable, e.g. Police (violent and aggressive acts). Significant injury requiring medical treatment and/or counselling.	Major injuries/long term incapacity or disability (loss of limb) requiring medical treatment and/or counselling.	Incident leading to death or major permanent incapacity.
Complaints/ Claims	Locally resolved verbal complaint.	Justifiable written complaint peripheral to clinical care.	Below excess claim. Justifiable complaint involving lack of appropriate care.	Claim above excess level. Multiple justifiable complaints.	Multiple claims or single major claim. Complex justifiable 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 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. Ongoing problems with staffing levels.	Late delivery of key objective/ service due to lack of staff. **Moderate error** due to ineffective training/ implementation of training.	Uncertain delivery of key objective /service due to lack of staff. **Major error** due to ineffective training/implementation of training.	Non-delivery of key objective/ service due to lack of staff. Loss of key staff. **Critical error** due to ineffective training/ implementation of training.
Financial (including damage/loss/ fraud)	Negligible organisational/ personal/financial loss (£<1k).	Minor organisational/ personal/financial loss (£1-10k).	Significant organisational / personal financial loss (£10-100k).	Major organisational/personal financial loss (£100k-1m).	Severe organisational/ personal financial loss (£>1m).
Inspection/Audit	Small number of recommendations which focus on minor quality improvement issues.	Recommendations made which can be addressed by low level of management action.	Challenging recommendations that can be addressed with appropriate action plan.	Enforcement action. Low rating. Critical report.	Prosecution. Zero rating. Severely critical report.
Adverse Publicity/ Reputation	Rumours, no media coverage. Little effect on staff morale.	Local media coverage – short term. Some public embarrassment. Minor effect on staff morale/ public attitudes.	Local media – long-term adverse publicity. Significant effect on staff morale and public perception of the organisation.	National media/adverse publicity, less than 3 days. Public confidence in the organisation undermined. Use of services affected.	National/International media/ adverse publicity, more than 3 days. MSP/MP concern (Questions in Parliament). Court Enforcement. Public Enquiry/FAI.

Table 2 - Likelihood Definitions

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

Table 3 - Risk Matrix

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

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

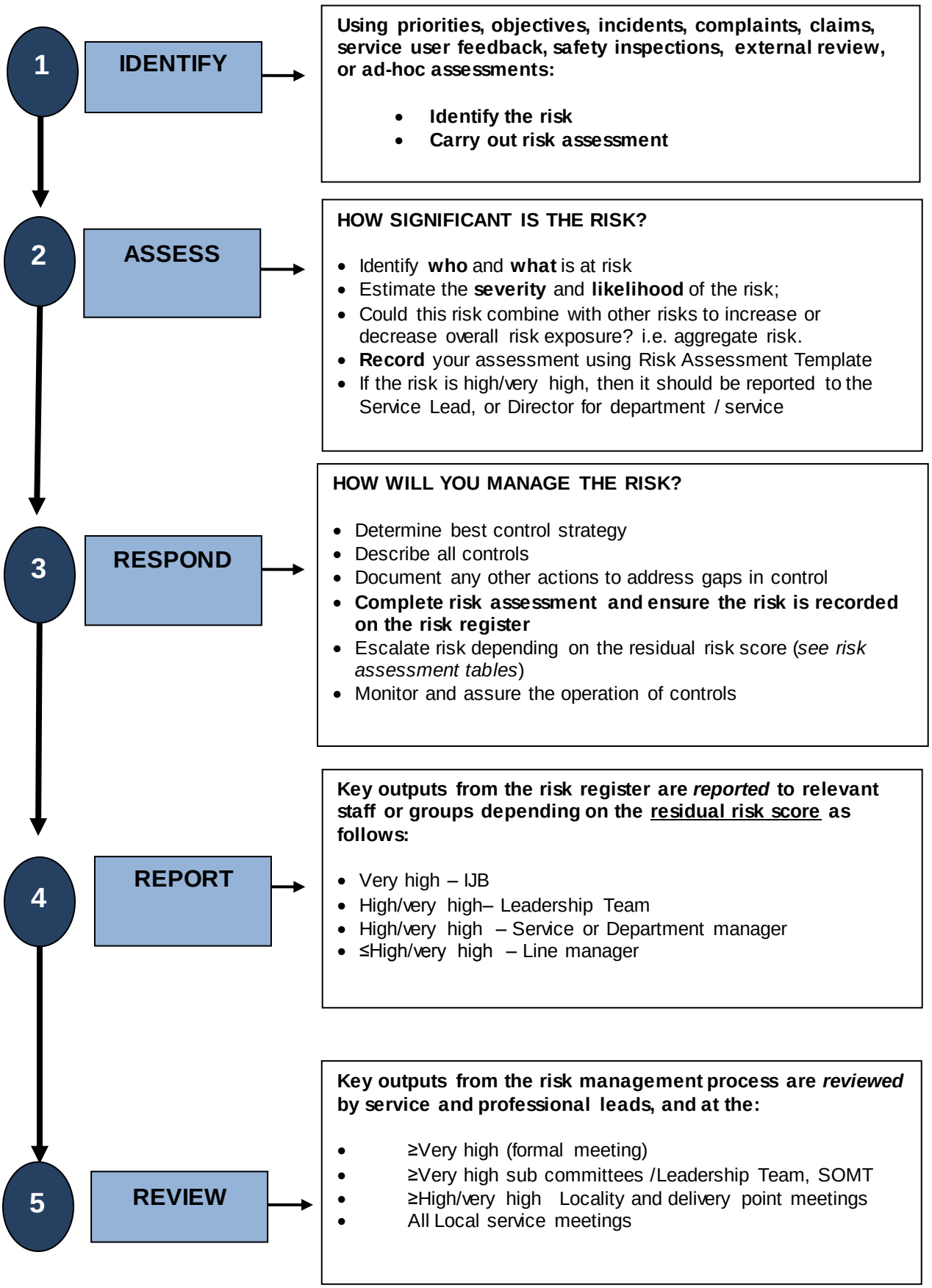
Table 4 - NHSG Response to Risk

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

Level of Risk	Response to Risk
Low	Acceptable level of risk. No additional controls are required but any existing risk controls or contingency plans should be documented. Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective.
Medium	Acceptable level of risk exposure subject to regular active monitoring measures by Managers/Risk Owners. Where appropriate further action shall be taken to reduce the risk but the cost of control will probably be modest. Managers/Risk Owners shall document that the risk controls or contingency plans are effective. Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective. Relevant Managers/Directors/Assurance Committees will periodically seek assurance that these continue to be effective.
High	Further action should be taken to mitigate/reduce/control the risk, possibly urgently and possibly requiring significant resources. Managers/Risk Owners must document that the risk controls or contingency plans are effective. Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective. Relevant Managers/Directors/Executive and Assurance Committees will periodically seek assurance that these controls to be effective and 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 systems or information integrity, significant incidents(s) of regulatory non-compliance, potential risk of injury to staff and public.
Very High	Unacceptable level of risk exposure that requires urgent and potentially immediate corrective action to be taken. Relevant Managers/Directors/Executive and Assurance Committees should be informed explicitly by the relevant Managers/Risk Owners. Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective. The Board will seek assurance that risks of this level are being effectively managed. However NHSG may wish to accept opportunities that have an inherent very high risk that may result in reputation damage, financial loss or exposure, major breakdown in information systems or information integrity, significant incidents(s) of regulatory non-compliance, potential risk of injury to staff and public.

Version March 2013

Appendix 7 – Risk escalation process



Appendix 8: Ownership & Version Control

Ownership:

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

Version Control

1. Version Control/Document Revision History (begun 24.11.2017)			
Version	Reason	By	Date
1.	Revisions to the BAEF requested by the Audit & Performance Committee at its meeting on the 21st of November 2017	Sarah Gibbon, Executive Assistant	24.11.2017
2.	Additional revisions to BAEF pending submission to IJB	Sarah Gibbon, Executive Assistant	22.01.2018
3.	Acceptance of changes	Sarah Gibbon, Executive Assistant	31.01.2018
4.	Annual Review	Sarah Gibbon Executive Assistant	18.01.2019
5.	Annual Review	Neil Buck Support Manager	22.04.2020
6.	Annual Review	Martin Allan Business Manager	September 2021

Aberdeen City Health & Social Care Partnership
A caring partnership

Risk, Audit and Performance Committee

Date of Meeting	23 September 2021
Report Title	IJB Whistleblowing Policy-Quarter 1
Report Number	HSCP.21.102
Lead Officer	Alex Stephen, Chief Finance Officer
Report Author Details	Name: Martin Allan Job Title: Business Manager Email Address: martin.allan3@nhs.net
Consultation Checklist Completed	Yes
Appendices	None

1. Purpose of the Report

1.1. To provide Risk, Audit and Performance Committee (RAPC) with a quarterly update on whistleblowing incidents raised under the Integration Joint Board's (IJB) Whistleblowing Policy.

2. Recommendation

2.1. It is recommended that the RAPC note that no whistleblowing incidents have been raised under the IJB's Whistleblowing Policy since the Policy was approved by IJB on 6 July 2021.

2.2. It is further recommended that the RAPC agree that future "nil returns" be reflected in the Committee's Business Planner rather than via a separate report.

Risk, Audit and Performance Committee

3. Summary of Key Information

IJB Whistleblowing Policy

3.1. On 6 July 2021 the IJB approved their Whistleblowing Policy. The Policy relates to all IJB Members and Office Holders of the Board and is committed to dealing responsibly, openly and professionally with any genuine concerns held by staff of the Aberdeen City Health and Social Care Partnership (ACHSCP), Members of the Board or Office Holders, encouraging them to report any concerns about wrongdoing or malpractice within the IJB, which they believe has occurred.

3.2. The aim of the policy is to ensure that staff and Members are fully aware of the types of matters that they should report and the reporting procedure they should follow to raise any genuine concerns about any possible wrongdoing or malpractice, at an early stage, without fear of penalty or victimisation.

3.3. The IJB agreed that any whistleblowing incidents raised through the Policy would be reported to RAPC by the Board's Standards Officer on a quarterly basis.

3.4. During the time period since the Policy was approved, the Standards Officer has not received any incidents relating to the Policy.

3.5. It is proposed that future "nil returns" be reported through the Committee's Business Planner, rather than via a separate report.

3.6. In terms of publicising the Policy, work has been undertaken to publish the Policy on the Partnership's Internet and intranet as well as sharing the Policy details with the Partnership's Leadership Team for distribution through their Teams.

Risk, Audit and Performance Committee

4. Implications for IJB

4.1. **Equalities, Fairer Scotland and Health Inequality** – there are no direct implications arising directly as a result of this report.

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

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

4.4. **Covid-19** – There are no implications relating to Covid-19 in this report.

4.5. **Unpaid Carers**-There are no implications relating to unpaid carers in this report.

4.6. **Legal –** there are no direct legal implications arising directly as a result of this report.

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

5. Links to ACHSCP Strategic Plan

5.1. The report is linked to all the strategic aims of the Partnership's Strategic Plan.

6. Management of Risk

6.1. Identified risks(s): The update provided links to the Strategic Risk Register, specifically around reputational damage.

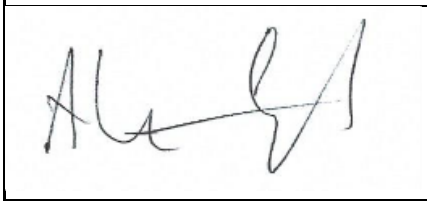
6.2. **Link to risks on strategic or operational risk register:**

Risk 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.

Risk, Audit and Performance Committee

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

Reporting on Whistleblowing incidents to the RAPC provides transparent reporting of any whistleblowing incidents.

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

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

Date of Meeting	23 September 2021
Report Title	IJB's Records Management Plan - Review and Action Plan
Report Number	HSCP.21.103
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	Appendix A – Records Management Improvement Plan

1. Purpose of the Report

1.1. To present the Risk, Audit and Performance Committee (RAPC) with an update on the Integration Joint Board (IJB) Records Management Plan as submitted to the Keeper of Records for Scotland. The report explains the basis of the approval and outlines our action plan for improvement and review of the plan.

2. Recommendations

It is recommended that RAPC:

2.1. Note the formal approval of the IJB's Records Management Plan (RMP) by the Keeper of Records for Scotland;

2.2. Approve the Records Management Improvement Plan as recommended by the Keeper of Records for Scotland as outlined at Appendix A and

2.3. Instruct the Chief Officer, Aberdeen City Health and Social Care Partnership (ACHSCP) to review the RMP annually and to thereafter report on this review

to the RAPC (including updates on the Records Management Improvement Plan).

3. Summary of Key Information

3.1. At the meeting of the IJB on 8 September 2020, the Board approved the IJB RMP for submission to the Keeper of Records for Scotland (Keeper), as required under the Public Records (Scotland) Act 2011.

3.2. The Keeper responded to the Chief Officer on 7 June 2021 explaining that the RMP sets out proper arrangements for the management of Aberdeen City Integration Joint Board's public records and that the Keeper would publish the assessment report for the IJB on the National Records of Scotland website. This report is available here : https://www.nrscotland.gov.uk/files//record-keeping/public-records-act/keepers-assessment-report-aberdeen-city-integration-joint-board.pdf

3.3. In reaching this determination, the Keeper expects the IJB to implement the agreed RMP to meet its full obligations under the Act. The Keeper reminded the IJB that, under section 5 of the Act, an authority must:
(a) keep its records management plan under review, and
(b) if the Keeper so requires (whether at the time of agreement of the plan or otherwise) carry out a review of the plan by such date ("the review date") as the Keeper may determine in accordance with subsections 2 to 4 of the Act.

3.4. Whilst the IJB RMP has been agreed by the Keeper, certain conditions have been highlighted and require to be met. The Keeper is able to do this for certain elements under what are termed an 'improvement plan'.

3.5. In summary these conditions relate to the plan elements as follows:

- 04 Business Classification
- 05 Retention Schedule
- 09 Data Protection: Information Commissioner's Office (ICO) registration and public Privacy Notice.

3.6. The RMP Improvement Plan, attached to this report at Appendix A, provides the detail for each of these elements, the improvement the Keeper suggests in more detail along with the proposed action to satisfy these conditions. The Keeper will be kept updated on the progress undertaken.

3.7. The Keeper recommends that the IJB publish the agreed plan, for the information of staff and service users and to assist in the sharing of best practice across Scottish public authorities. Arrangements will therefore be made to publish the agreed Plan on the Partnership's Website.

3.8. We recommend that the RMP be reviewed annually and reported to RAPC, along with updates on the Records Management Improvement Plan.

4. Implications for IJB

4.1. **Equalities, Fairer Scotland and Health Inequalities –** there are no direct equalities implications arising from this report.

4.2. **Financial –** there are no direct financial implications arising from this report.

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

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

4.5. **Covid-19 –** there are no direct Covid-19 implications arising from this report.

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

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

RISK, AUDIT AND PERFORMANCE COMMITTEE

5. Links to ACHSCP Strategic Plan

5.1. Having a robust and effective records management process will help the ACHSCP achieve the strategic priorities as outlined it its Strategic Plan.

6. Management of Risk

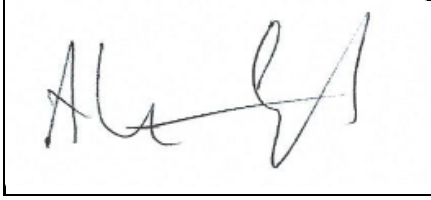
6.1. **Identified risks(s):** The detail in this report link to the Strategic Risk Register in a variety of ways, as detailed below.

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

Risk 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.

Risk 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:** Ensuring a robust and effective records management process will help to mitigate the identified strategic risks.

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

Element	The Keeper of the Records of Scotland's comments	Aberdeen City Health and Social Care Partnership's Planned actions
4. Business Classification	The Keeper of the Records of Scotland (the Keeper) expects that the public records of an authority are known and are identified within a structure. It has been determined that all IJB records are held electronically. Although the public records of the IJB are held on the records management systems of Aberdeen City Council, the IJB has created a separate business classification scheme and file plan covering their records. Copies of these documents have been provided to the Keeper. The Keeper has been provided with a minute of the meeting of the IJB dated 8th September 2020 at which the Board approved the *Business Classification Scheme.* The *File Plan* is designed to expand the *Business Classification Scheme* to include retention information and information on the systems on which the records are managed (shared drives, business system management system etc.). This is potentially a useful business tool for the authority. **The IJB have confirmed to the Keeper that the File Plan is to be amended to complete all sections of the Plan and then will be further amended (as detailed below).** **Aberdeen City Council is currently consolidating their records management provision around an O365 cloud solution. It is assumed that the public records of the IJB will transition alongside the record of the Council. The**	Confirmation has been sought from Aberdeen City Council as to the progress of O365 and the consolidation of ACC records. The Council's Records Manager has confirmed that the Council will submit evidence on this element to the Keeper in 2022. In the meantime, the IJB's records continue to be managed by the Council's Committee Services Management system. Work has been undertaken and will continue on the IJB File Plan.

Element	The Keeper of the Records of Scotland's comments	Aberdeen City Health and Social Care Partnership's Planned actions
	***File Plan* column 'location' will then require to be changed. IJB records will no longer be held on shared drives for example. Some IJB records may remain outside the principal records management solution. For example, on Council 'line-of-business' systems such as "ACC's Committee Services Management Programme". The Keeper has determined that the RAG status of a *Records Management Plan* of any authority, whose records are managed on the systems of a separate authority, cannot be higher than that awarded to the 'host' authority. As noted above, Aberdeen City Council is in a transition period and carries an amber status against this element.** **Therefore, the Keeper can agree element 4 on the same 'improvement model' terms as the Council.**	
5. Retention Schedule	The Keeper expects an authority to have allocated retention periods to its public records and for those records to be retained and disposed of in accordance with a retention schedule. All the public records of the IJB are held on Aberdeen Council systems, which (as detailed under element 4 above) are currently being transitioned to an O365 solution. **The Keeper has agreed the Council's *Records Management Plan* on an 'improvement model' basis for this element as the operation of retention labels against record type has not been finalised in the new system.** The Keeper notes that the IJB *File Plan* has appropriate retention decisions allocated to IJB public records. **However, see element 4 regarding the completeness of the *File Plan*.**	Confirmation has been sought from Aberdeen City Council as to the progress of O365 and the consolidation of ACC records. The Council's Records Manager has confirmed that the Council will submit evidence on this element to the Keeper in 2022. In the meantime, the IJB's records continue to be managed by the Council's Committee Services Management system.

Element	The Keeper of the Records of Scotland's comments	Aberdeen City Health and Social Care Partnership's Planned actions
	The IJB have provided the Keeper with a screenshot from the Council's Retention Schedule showing that their public records are included. **In January 2015, The Keeper agreed this element of Aberdeen City Council's plan. However, he did so under 'improvement model' terms. This was in recognition of a major change in the record keeping systems at the Council (see element 4 above).** **The Keeper therefore agrees this element of the IJB *Plan* under the same improvement model terms as the 'host' authority.**	
9. Data Protection	The Keeper expects a Scottish public authority to manage records involving personal data in compliance with data protection law. Aberdeen City Integration Joint Board is a data controller. This is clearly stated in the *Memorandum of Understanding*. The IJB is currently working with its appointed Data Protection Officer (DPO) to ensure that they fulfil all the requirements of the Data Protection Act 2018 including registration with the Information Commissioner. The IJB adopts the Data protection Policy of Aberdeen City Council, which the Keeper has already agreed as appropriate (2015). However, the RMP, as submitted also includes references to the data protection provision in NHS Grampian. The IJB has now committed to take out these references as they may cause confusion. The IJB have provided the Keeper with links to the relevant pages on the Council website. **The Keeper suggests that these might also be linked from the HSCP page.**	Work has been undertaken to complete the registration with the Information Commissioner. Still awaiting confirmation from Commissioner on registration. Links from the Partnership's Website to the Council's Records Management pages on the Council's website will be arranged.

Aberdeen City Health and Social Care Records Management Plan-Improvement Plan - Appendix A

Element	The Keeper of the Records of Scotland's comments	Aberdeen City Health and Social Care Partnership's Planned actions
	The Keeper can agree this element of the Aberdeen City Integration Board's Records Management Plan under improvement model terms. This means that there is an identified gap in provision, but the Keeper recognises that the IJB have put process in place (in conjunction with their DPO) to close that gap.	

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

Date of Meeting	23 September 2021
Report Title	IJB Annual Performance Report 2020/2021
Report Number	HSCP.21.105
Lead Officer	Sandra MacLeod, Chief Officer
Report Author Details	Name: Alison MacLeod Job Title: Lead Strategy and Performance Manager Email Address: alimacleod@aberdeencity.gov.uk
Consultation Checklist Completed	Yes
Directions Required	No
Appendices	Appendix A - IJB Annual Report 2020-21 Appendix B - Annual Performance Report Public Summary

1. Purpose of the Report

1.1. The purpose of this report is to share with the Risk, Audit and Performance Committee (RAPC) the Integration Joint Board's (IJB) Annual Performance Report (APR) for 2020-21 as approved by the IJB on 24 August 2021. To review the report from a RAPC perspective for any potential further performance related assurance.

2. Recommendations

2.1. It is recommended that the RAPC:

(a) Notes the contents of this report and reviews from RAPC perspective and commends the work and progress of the partnership through 2020/21.

RISK, AUDIT AND PERFORMANCE COMMITTEE

3. Summary of Key Information

3.1. The Public Bodies (Joint Working) (Scotland) Act 2014 obliges the integration authority to prepare an Annual Performance Report (APR) for the previous reporting year which in this case is 1 April 2020 to 31 March 2021. The 2020-21 performance report therefore relates to the second year of the IJB's current Strategic Plan.

3.2. The APR must outline a description of the extent to which the arrangements set out in the Strategic Plan have achieved, or have contributed to achieving, the national health and wellbeing outcomes.

3.3. Neither the legislation nor accompanying guidance prescribes a specific template to be used for the APR. Each partnership can design its own format to best explain and illustrate its performance. The design of this year's report is based mainly on the very visual and easy read format used for the Strategic Plan itself and which was well received for last year's APR.

3.4. In February 2019, the Ministerial Strategic Group (MSG) undertook a Review of Progress with Integration, which set out that Integration Authorities should improve the consistency and read across of their Annual Performance Reports. In line with this, we have previously agreed that we would report against national and MSG performance indicators in a common tabular format, with RAG status, which allows easy benchmarking and comparisons across Scotland, this can be found at Appendix A and B within the APR.

3.5. The 2020-21 APR covers the period of response to the Covid-19 pandemic, and we have devoted a section to that. The rest of the APR follows the agreed format of detailing progress under each of the Strategic Aims. Similar to last year we have included a section on our Enablers (as per the Strategic Plan), our Governance and our Priorities for 2021-22.

3.6. It was our intention to include more of the voices of those with lived experience of the health and care system via the use of the Care Opinion tool, but our progress on implementing this was limited during 2020-21. We do however have plans to move forward with this during 2021-22 and

the detail of these are contained within the Engagement report (HSCP.21.060) which was approved by the IJB on 24 August 2021.

3.7. During June and July of 2021, we had a group of Career Ready students working on health and social care related projects. One of these projects was for the students to review the content of the APR and provide feedback on how understandable the content was to people with limited knowledge of the health and social care partnership and the services it provides. The students presented this feedback to the Leadership Team on 14 July 2021 and their comments have been used to compile an easy read Public Summary version of the APR as attached at Appendix B.

4. Implications for RAP

4.1. **Equalities, Fairer Scotland and Health Inequality** – the annual report demonstrates our performance in general across services delivered to the whole population dependent on need, including those with protected characteristics such as age and disability and people experiencing inequality. It helps us identify areas for improvement. The IJB approved the ACHSCP Equality Outcomes and Mainstreaming Framework and reporting schedule in May 2021. This will enable reporting in future APRs on service developments designed to improve access for those experiencing inequality.

4.2. **Financial** – There are no direct financial implications arising from the recommendations of this report. All services are delivered within existing agreed budgets.

4.3. **Workforce** – There are no direct workforce implications arising from the recommendations of this report. All services are delivered by existing workforce under the terms and conditions of the employing organisation.

4.4. **Legal** – under the terms of the Public Bodies (Joint Working) (Scotland) Act 2014 we have a statutory obligation to publish an Annual Performance Report. As in other years, due to governance arrangements, we are unable to publish a final report within the stipulated timescale (4 months after the end of the financial year i.e., 31 July 2021). This is similar to many Partnerships and there is an acceptance at government level that this

is the case. If the Annual Performance Report was not to be approved and published, we would be in breach of our legal obligation which would damage the reputation of the IJB and give rise to uncertainty around its performance.

4.5. **Covid** – there are no direct Covid implications in relation to the APR. The report itself covers the response to Covid and the lessons learned.

4.6. **Carers –** there are no direct implications for Carers in relation to the APR. Value and Support Unpaid Carers is a commitment under the Resilience aim of the Strategic Plan. It is anticipated that the work undertaken to refresh of the Carers Strategy will feature in next year's APR.

4.7. **Other** – none.

5. Links to ACHSCP Strategic Plan

5.1. The Annual Performance Report demonstrates the progress made in the second year of our Strategic Plan.

6. Management of Risk

6.1. Identified risks(s)

There is a risk that we breach our legal obligation under the Public Bodies (Joint Working) (Scotland) Act 2014 (as described at 4.4 above) and also that we are not transparent and open about our performance.

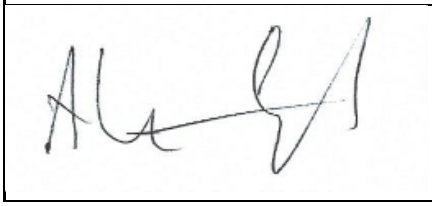
6.2. Link to risks on strategic or operational risk register:

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

RISK, AUDIT AND PERFORMANCE COMMITTEE

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

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

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

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Annual Report 2020-2021

#ACHSCP

Thank You

Aberdeen City Health & Social Care Partnership

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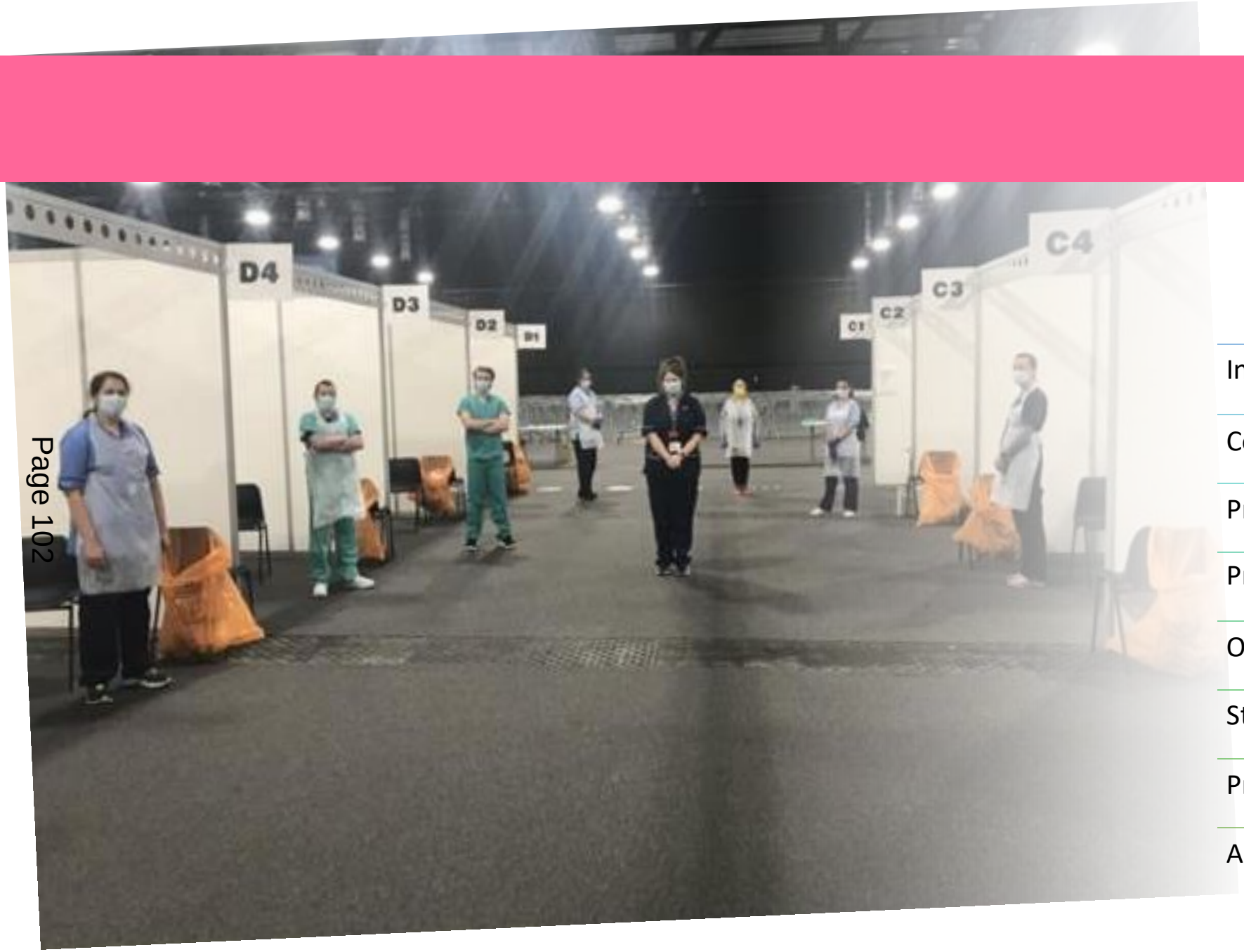
ABERDEEN CITY COUNCIL

NHS Grampian

Contents



Introduction

Covid19 Response and Lessons Learned

Progress against our Strategic Aims

Progress against our Enablers

Our Governance

Strategic Plan Development

Priorities for next year

Appendices – MSG and National Indicators

Introduction

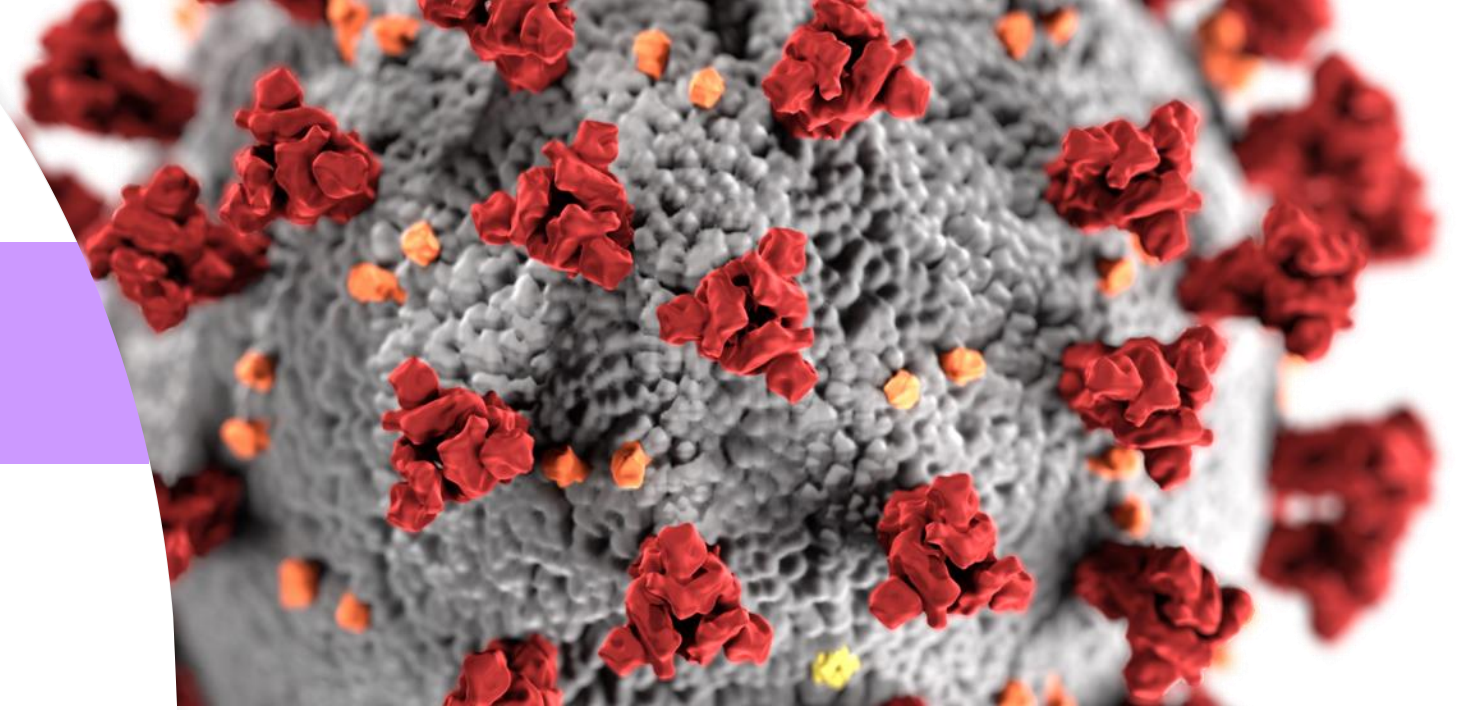
The first year of the Covid-19 pandemic brought unprecedented challenges for patients, clients, staff and partners of Aberdeen City Health and Social Care Partnership.

Our Annual Report for 2020/21 acknowledges these challenges and some of the lessons we learned from them that will help shape future service provision.

It also stands as a lasting record of the exceptional response to the pandemic from staff and the communities within Aberdeen City. We have always held the view that our staff were our greatest asset. They more than proved us right over the last year. In addition, we have always valued the support we get from our partners and our communities but the way they stepped up to the challenges of the pandemic surpassed all of our expectations.

We'd like to take this opportunity to say, "Thank You".

Covid19 Response and Lessons Learned



Since March 2020, the global pandemic has impacted all our lives both on a personal and a professional level. A lot has changed, from the way we socialise, to the way we work, and it is still uncertain when, or even if, things will return to the way they were.

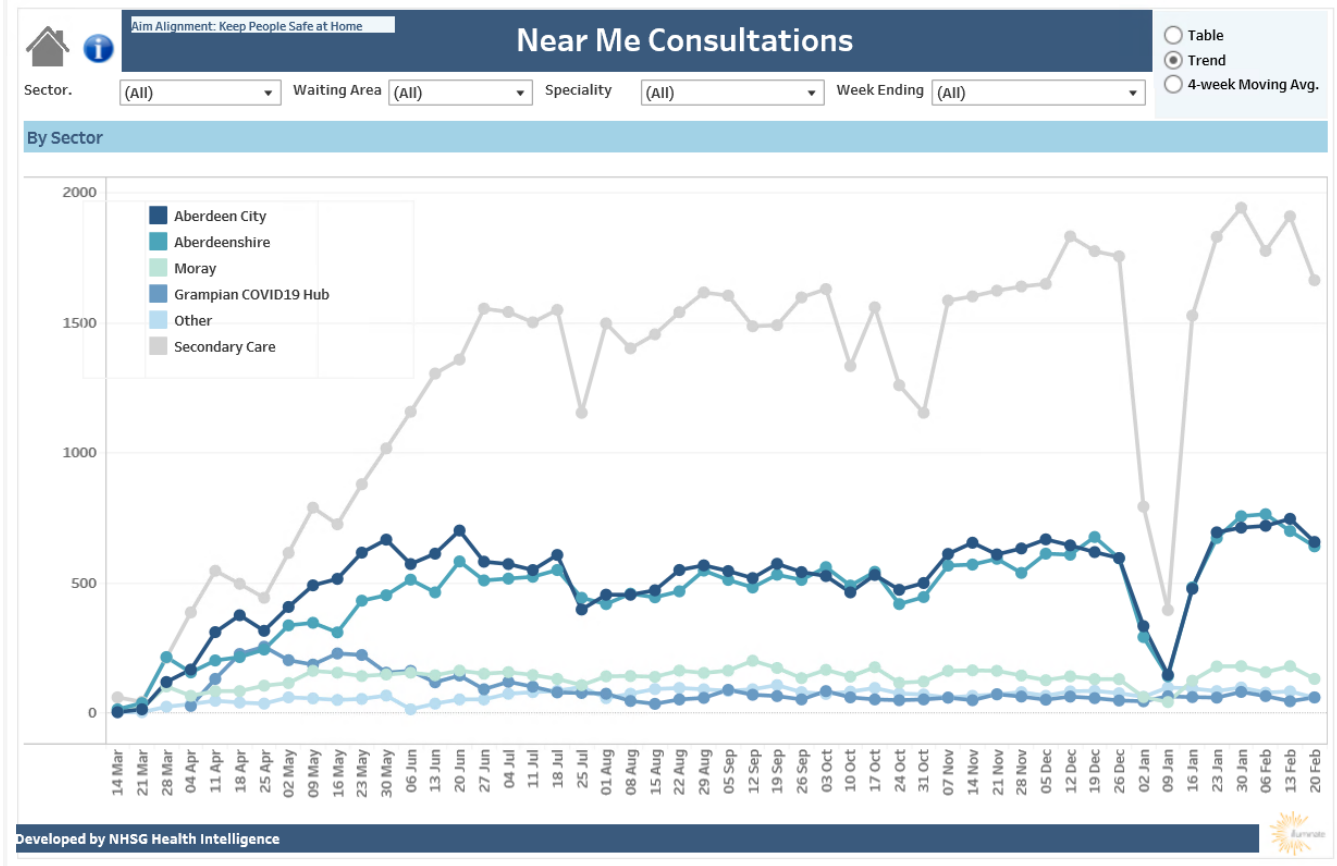
Here are some of the areas where our Partnership responded to the crisis and the lessons we learned that we will use to structure our services in the future.

Covid19 Response and Lessons Learned

In a crisis, we can transform at pace, cutting through normal organisational, financial, and administrative barriers.

The best example of this is the implementation of Near Me. We were able to get the equipment and get people using it in a fraction of the time it would have taken us to do that previously. Across Grampian, there were 80 consultations per week pre Covid19, and there are 3,500 now. 16 sites were using the technology pre Covid19, and 200 now. E-consult has been another innovation that was rolled out during Covid19, this allowed an additional, on-line route for patients who wanted, and were able to seek advice from their GP in this way, freeing up face to face appointment time for those patients who most needed this method. The Health Village closed down normal operations and was set up as the Covid19 Hub for Aberdeen over a weekend.

We have also learned that transformation at pace, whilst necessary at the time, can also adversely impact on some of our clients and patients. In the case of digital developments this often means people who do not have the desire, opportunity or knowledge to access and use the required technology, are at a disadvantage. Whilst a variety of options to meet people's individual needs and preferences have always been available, we can improve the way we communicate this and support people to access these options.



Covid19 Response and Lessons Learned

"The City Community Macmillan CNS team started using Near Me, like many others, last year during the first lockdown. Having this option for contacting patients and assessing them has been beneficial to our service when we had to stop all face to face visiting. It enabled patients and their families to meet us in person and have a connection so that they can 'put a face to the name'. This service also helps us assess how people physically look, pick up on the non-verbal cues that could be missed in a telephone call, and involve other family members in the assessment process. Now as restrictions have been easing, we are continuing to use this facility for assessing patients in conjunction with phone calls and home visits."

Rachel Anderson, Community MacMillan CNS, Team Leader

Covid19 Response and Lessons Learned

Staff response to the crisis is exceptional.

To show our appreciation and thanks, at the Heart Awards Digital Event in December 2020, we featured a Thank you video to our Health and Social Care staff and partners – please use the QR code to view the video.

As soon as the extent of the impact of Covid19 became apparent, staff from all sections of the partnership, the Council and NHS Grampian stepped forward to do whatever they could to support. This was often undertaking tasks that were not within their usual remit and prompted by the staff themselves asking what they could do to help. In addition to staff working differently, and often working longer hours, many staff rapidly learned new skills. Probably the best example of this is the staff from enabling functions who undertook training as Care Workers and provided additional support to those Care Homes in the City who were struggling to maintain staffing levels during the crisis. This additional support helped maintain safe levels of care in these homes and enabled those most vulnerable to the virus to continue to receive the support they needed.

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Covid19 Response and Lessons Learned

Over time the nature of the Covid19 response, and now the new pressures faced from remobilising services are taking their toll on staff health and wellbeing and we need to ensure they are supported to recover.

During the Covid19 response staff worked long hours, often in challenging situations whilst also dealing with the personal and social effects of the global pandemic. The respite after the first wave was short lived and, before any real time for recovery, staff were back facing the effects of the second wave, arguably worse than the first. Even now that we are into the remobilisation phase, the pressure is still present with staff who are already tired and low on resilience facing long waiting lists and dealing with very sick patients who have put their healthcare needs on hold during the pandemic.

Although, support was provided in the form of the Psychological Hub and initiatives like Project Wingman, other wellbeing measures were introduced such as reduced meeting times and encouraging taking downtime and participating in physical activity and online social opportunities. It is acknowledged, however, that staff wellbeing has nonetheless been impacted. The Leadership Team has recognised the importance of ensuring that staff are supported to recover from the significant impact on their health and wellbeing and this is their top priority in terms of objectives for 2021/22. "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".

PROJECT WINGMAN

"Helping NHS Staff Unwind, Decompress and Destress"

Covid19 Response and Lessons Learned

Covid19 has a greater impact on those experiencing health inequalities and we now need to redouble our efforts to try to address these.

There is a wealth of data that indicates that those in the older age groups, those from the Black, Asian, and Minority Ethnic (BAME) communities, those with disabilities and chronic underlying health conditions, and those living in areas of deprivation are more susceptible to serious illness and death from Covid. Not only that, but we also know that vaccination uptake has been lower in the BAME and other ethnic communities and in deprived communities. This further exacerbates the already challenging disadvantages these sections of the population face.

Our focus for the future will be on encouraging vaccine uptake in the "cold spots" across the City and delivering on our Equality Outcomes and Mainstreaming Framework which was developed towards the end of 2020/21.

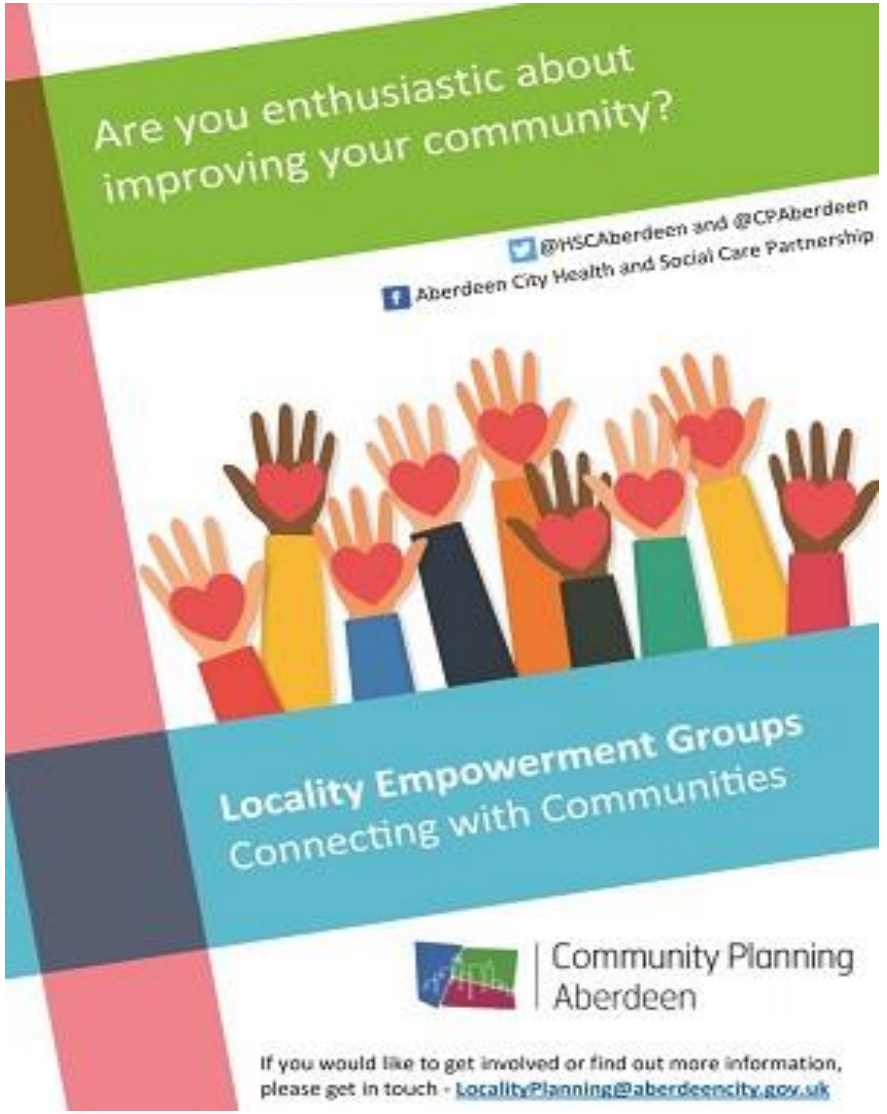
Aberdeen City Health and Social Care Partnership: Equality Outcomes and Mainstreaming Framework 2021-25

Covid19 Response and Lessons Learned

We have a wealth of resource in our communities and there is a willingness to step up and help in a crisis.

The national lockdown and particularly the arrangements for those who were shielding meant there were many people in our communities who found themselves unable to access basic, critical, and sometimes emergency supplies. Although staff and partners were involved in setting up systems to coordinate the provision of assistance, it was, in the main, our communities themselves who rallied round and responded to the needs of their neighbours by providing food and prescription deliveries as well as often offering the only face to face social interaction those who were shielding had during that testing time. We know that we have a challenge to continue to deliver a level of health and social care services within our existing resources. We need to harness the resource available within communities to help us maximise the diversity of services on offer, particularly in relation to prevention activities.

The work we are doing in communities alongside our Community Planning partners and in particular with Aberdeen Council for Voluntary Organisations (ACVO), via the Locality Empowerment Groups, Priority Neighbourhood Partnerships and Neighbourhood Leads will build on this momentum, and we will continue to explore ways of maximising the power of volunteering.



Covid19 Response and Lessons Learned

National Lockdown and Covid19 restrictions had unintended consequences on patients and clients which, in turn, will influence the support they require from our services.

With lockdown and the message to stay at home, save lives, protect the NHS, came the temporary cessation of a number of services which normally were provided either in close proximity to vulnerable clients or in group settings. This left clients and their carers confused with a greater burden on carers who normally would have access to respite services. Family and friends who would not normally have undertaken a caring role, found themselves doing so, without the usual support provided, in the absence of formal care.

In Summer 2020 the Scottish Human Rights Commission published a report on the impact of the Covid19 pandemic on people's rights particularly in respect of care at home and support in the community. There was concern that services would not be reinstated; a call for services not to assume that family supports, which had been in place during lockdowns, would be sustainable over the long term: and, when able to do so, a request that services should fairly and systematically assess need. Looking back there is an appreciation that some of these changes to services could have been better communicated and, knowing what we know now, we may have been able to continue some services safely.

Our work in developing new approaches to opportunities for day care and respite, known as Stay Well Stay Connected, has learned from this experience. People with lived experience, their carers, and service providers are all working alongside the partnership in understanding what services for the future need to look like and coproducing these together.

Stay Well, Stay Connected

COVID19 Mass Vaccination Programme

Aberdeen City Health and Social Care Partnership began the Covid19 Vaccination programme in early December 2020 with the initial, nationally defined priority groups. GPs helped vaccinate the over 80s, and Community Nursing quickly mobilised to vaccinate care home residents. An average of 38,000 vaccinations has taken place every month since the beginning of the programme.

Over 250 staff were rapidly recruited and/or deployed to deliver the mass vaccination programme which commenced on 1st February 2021 at P& J Live. Roles included, not only vaccinators, health care assistants and pharmacists, but also support staff for reception, administration and logistics, and of course, the senior team to help coordinate it all. During the early days of setting up, the military were temporarily deployed to assist. P&J Live staff coordinated the smooth running of the venue and their experience in managing major events proved invaluable to delivering the vaccination programme which is the largest logistical operation in Scotland.

Colleagues from Aberdeen City Council also assisted with the programme for example in arranging road signage, the provision of the local call centre, and in helping to coordinate access to community facilities for the "pop-up" clinic phase of the programme.

Flexibility was key to the successful delivery of the programme which brought many challenges. P&J Live operated 12 hours a day, seven days a week. National guidance was updated regularly, and the changes had to be communicated to all staff timeously. There were particular challenges in relation to vaccine management, not only in terms of storage but also in responding to actual versus anticipated attendance rate and close monitoring by pharmacy staff and Team Leaders in order to minimise vaccine wastage.

Everyone involved in the programme deserves enormous thanks for helping to save the lives of the residents of Aberdeen.

Prevention

Prevention - Primary Care

Primary Care services evolved their models of care across GP's, Pharmacy, Dentistry, Optometry and Psychological Therapy, to ensure our communities needs we met within the limitations and restrictions we faced.

Covid19 Assessment Hubs were collaboratively set up across the three partnerships in Grampian. Located in Aberdeen Health Village and The Oaks in Elgin, these assessment hubs worked closely with GMEDs and NHS24 to assess and triage patients to the correct point of care.

The assessment Hubs a provided safe environment for staff and patients who were triaged first by NHS24 and then by a group of clinicians who, over time, became more and more skilled in COVID triage. All clinicians received comprehensive inductions based on learning from practices already well established in remote consulting. Teams channels were devoted to supporting videos and documents and protocols for clinicians.

Primary Care services and teams would like to take this opportunity to thank all the residents that adhered to the restrictions and lockdown guidance, as well as our Health and Social Care staff for ensuring our services stayed open and available to patients.

COVID19 Hub – Health Village

"I remember it seemed like almost overnight the IT folk came in and put in the electric cables, the desking and all the new screens and computers. There was also the rapid development of clinical pathways and establishing the flow through the building (when required) and what areas were green and which were red. The speed of the appeal and the response to that appeal from clinicians to help the hub was superb - I am sure there were approx. 200 clinicians signed up at one stage. The training and support to those clinicians who all initially came in wide eyed is also worth celebrating. It was a combined team clinically with good links with GMEDs and also support from secondary care both the rehab consultants and sexual health. Some folk came out of retirement to help and do shifts. Good liaising with secondary care to streamline the referral process and get over the barrier that most patients could be admitted without a face-to-face assessment which was a new concept at the time. The secondary care team also offered real time near me support. Training around resuscitation procedures was provided by the BASICs team.

My overall feeling, is just one of astonishment, that a whole new 24 hours a day, 7 day a week service was set up in what was not much more than a matter of days. It really changed my concept of "the art of the possible" and makes me more impatient when faced with delays in other aspects of my work now!"

Dr Stuart Reary, GP Partner

Prevention

Living Well with Diabetes – Type 2 Peer Support Group

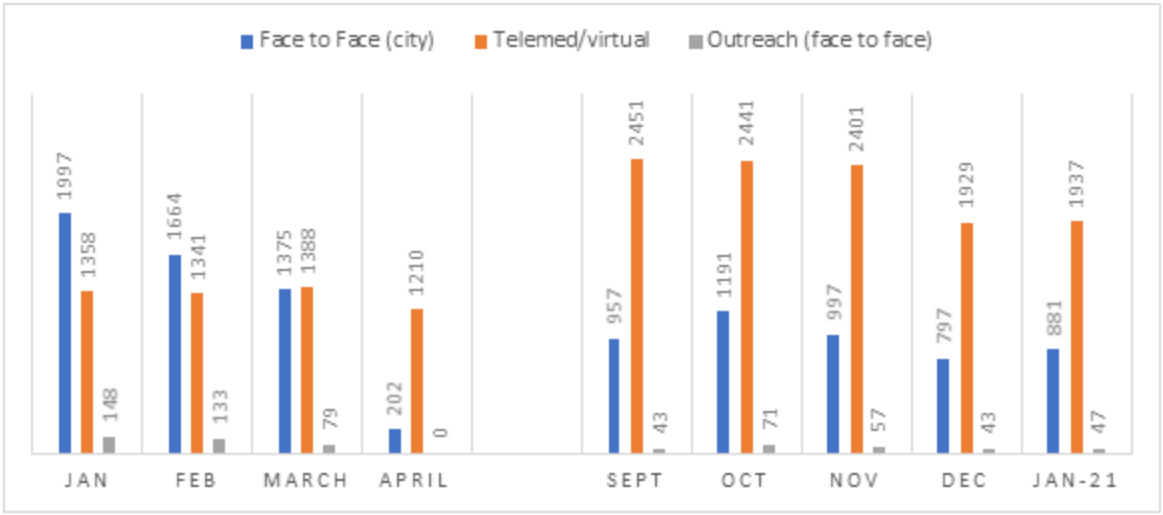
The Living well With Diabetes peer support group is made up of individuals across Aberdeen City who have Type 2 Diabetes, as part of the group there are 5 Diabetes UK trained peer supporters. The group met monthly to share tips and information, as well sharing struggles they are facing with self-managing their condition. There would regularly be a health professional in attendance to answer any queries the group had e.g. Senior Diabetes Nurse, Optometrist. The group have formed a very strong bond and has been a safe space in which members can share their stories.

Covid-19 restrictions have been preventing the Living Well with Diabetes peer support group from meeting in person since February 2020. The group have stayed in touch virtually via email sharing their favourite recipes or new lockdown finds.

During December 2020 some of the group members teamed up with the Fraserburgh Type 1 Diabetes group to compete in a "Christmas Bake Off", a challenge that followed the format of the well-known "Great British Bake Off". The challenge was to create a Christmas themed bake that was as "diabetic-friendly" as possible. The "Bake Off" was held on Microsoft Teams with each person sending in a picture of their bake and describing how the bake was created on the call (ingredients and decorations!). Everyone pulled out all the stops and showed they had what it takes to be a Star Baker.

Grampian Sexual Health Response

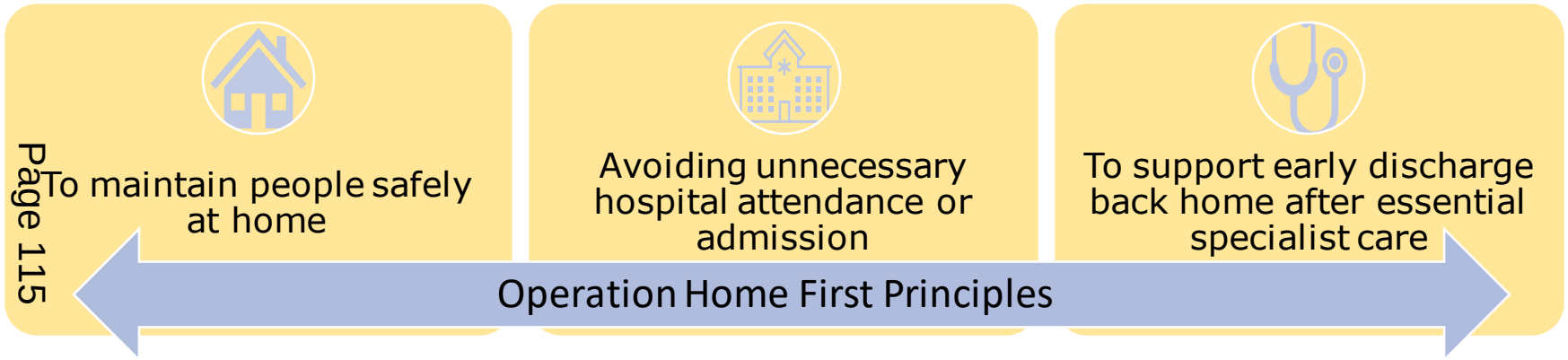
As part of the first wave Covid19 pandemic response, Grampian Sexual Health service was rapidly redesigned to prioritise essential care only. This rapid change was in response to reduced capacity, staff redeployment for Covid19 work streams, urgent relocation to alternative accommodation, reduced laboratory testing capacity and a reduction in face-to-face care provision to protect both staff and patients. Efforts were made to maintain care provision based on public health priorities to prevent unplanned pregnancies and onward transmission of sexually transmitted infections (STIs) and blood borne viruses (BBVs) and due to the implications, any impact on other health services or implications for patient care and wellbeing.



Resilience

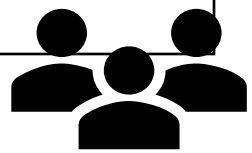
Frailty Pathway Redesign

This year we have been working hard, alongside colleagues in the acute sector and Aberdeenshire, to deliver improvements to our services which care for people living with frailty. This involved major change to how we deliver our services, in line with the 'Operation Home First' principles.



The work on the Frailty Pathway has involved transforming the way we work, so that resources that used to be within a hospital-setting are transferred to boost the community teams which help to prevent people going to hospital and support them to come home sooner.

"People, especially older populations remain fitter and healthier the longer they remain at home and outcomes for many people following a stay, even a short one, in hospital can be negatively impacted. It makes sense that we try to provide more services in people's homes and communities, which is what people tell us they would prefer to a hospital admission" Chief Officer for Acute Services, 2020



What is frailty?

"The term frailty or 'being frail' is often used to describe a particular state of health often experienced by older people. But sometimes it's used inaccurately.

If someone is living with frailty, it doesn't mean they lack capacity or are incapable of living a full and independent life. When used properly, it actually describes someone's overall resilience and how this relates to their chance to recover quickly following health problems.

In practice being frail means a relatively 'minor' health problem, such as a urinary tract infection, can have a severe long-term impact on someone's health and wellbeing.

This is why it is so important that people living with frailty have access to well-planned, joined-up care to prevent problems arising in the first place – and a rapid, specialist response should anything go wrong."

Age UK website

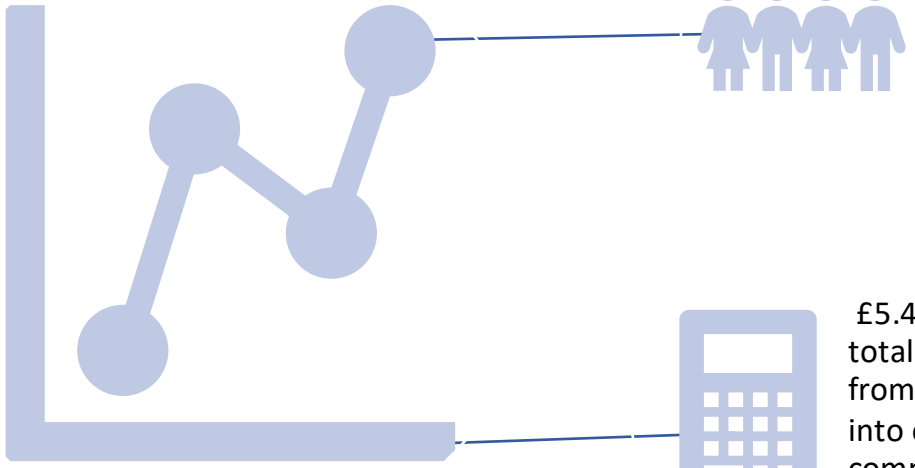
What is frailty syndrome?

Frailty syndrome can involve presenting with problems such as falls, confusion, rapid functional decline and advanced frailty. People experiencing frailty syndrome are looked after by the Frailty Pathway.

Resilience

What do changes in the Frailty Pathway look like?

Early Supported Discharge/ Hospital @ Home (Shire)	Development of a brand new community based model which will provide enhanced support at home for patients across Aberdeenshire. The team will include Geriatrician support, Nursing, Allied Health Professionals and Health Care Support Workers and will work Monday to Friday on an 8am – 6pm basis. Geriatrician support will be available up to 9pm with out of hours medical support provided by G-Meds. There will also be 7 day a week support from our Aberdeenshire Responders for Care at Home Service (ARCH) who can assist with care and rehabilitation.
Hospital at Home (City)	Additional capacity for the City Hospital @ Home teams, who support people within their own home in Aberdeen. This supports extended hours of service provision and an increase in how many people the team can look after. The team works to reducing admissions to hospital and supporting early discharge from hospital. There will also be additional Allied Health Professionals in the team (Occupational Therapy, Physiotherapy, Dietetics and Speech and Language Therapy).
Rosewell House (City)	Rosewell House created an integrated, intermediate care facility, which focuses on rehabilitation, step-up care from the community, and step-down care from acute settings in a more homely setting. This was delivered in partnership with Bon Accord Care. It works towards reducing admissions to an acute setting and supporting early discharge from hospital for people who are not able to return home straight away.
Discharge Hub (Shire)	Additional Physiotherapy, Occupational Therapy and Care Management Capacity from Aberdeenshire working within the discharge hub in Aberdeen Royal Infirmary will ensure that the patient returns home with initial assessment and treatment planning underway and will support both the patients entering the Shire Hospital at Home pathway and those who can more quickly return to the mainstream multi-disciplinary teams across Aberdeenshire.
Community Allied Health Professions (City)	Additional capacity to support extended hours of service provision across physiotherapy and occupational therapy. To support prevention of admission, timely discharge and community rehabilitation and extended working hours for these services to support needs.
Aberdeen Royal Infirmary	Admission pathways via unscheduled care and direct GP referral. 25 acute bed assessment capacity with rapid access to diagnostics and skill mix facilitating acute intervention in frailty syndrome. Additional Discharge Co-Ordinator capacity to support a 7-day service. Refocusing some of the consultant, physiotherapy and occupational therapy team at the front door of the hospital (i.e. emergency department) to help prevent admissions where appropriate to do so.



What next for the Frailty Pathway?

Whilst a lot of work has been done, there is still more to do. There is ongoing work in Rosewell House to nurture the 'One Team' culture and to open the remaining beds. We need to focus on creating the capacity for step-up referrals which will be critical to avoiding preventable hospital admissions and we will need to regularly monitor these to ensure we are achieving our goal. The scale-up of Hospital @ Home will be crucial to offering residents safe care in their own home as an alternative to a hospital stay.

The Frailty Pathway has focused on a series of enablers to ensure the whole system operates more efficiently with an improved patient experience. The development of criteria led discharge and the implementation of the Rockwood Clinical Frailty Score within the Emergency Department are examples of these enablers. An evaluation of the Frailty Pathway noted that the intermediate care facility at Rosewell House effectively reduced the pressure on secondary care during the winter period by allowing flow out of Aberdeen Royal Infirmary which in turn allowed them to meet the increased demand from the combined pressures of winter and Covid.

Funding transferred from hospital based to community-based services	
Rosewell House	2,215,000
Aberdeen City Hospital @ Home	925,000
Aberdeen City Allied Health Professionals	521,000
Aberdeenshire Discharge to Assess Model	1,462,000
Aberdeenshire ARI Discharge Hub	282,000
Total	5,405,000

Personalisation

Care Homes

Throughout 2020/21 intensive work has continued, to support care homes and to meet oversight and governance requirements as per the terms of the Coronavirus (COVID-19): enhanced professional clinical and care oversight of care homes, instructed by Scottish Government on 17 May 2020.

There were actions put in place to mitigate risk and escalate issues daily, this included Care Homes reporting in a system called TURAS, to monitor the situation with each Care Home in relation to Covid19 cases, staff testing, PPE supplies and staffing availability/capacity. This allowed an overview of those Care Homes that were still open for referrals and those that were closed to admissions which was a constantly changing picture. Regular telephone contact with all care homes was maintained throughout the pandemic to identify any issues at the earliest opportunity and assist with maintaining resilience.

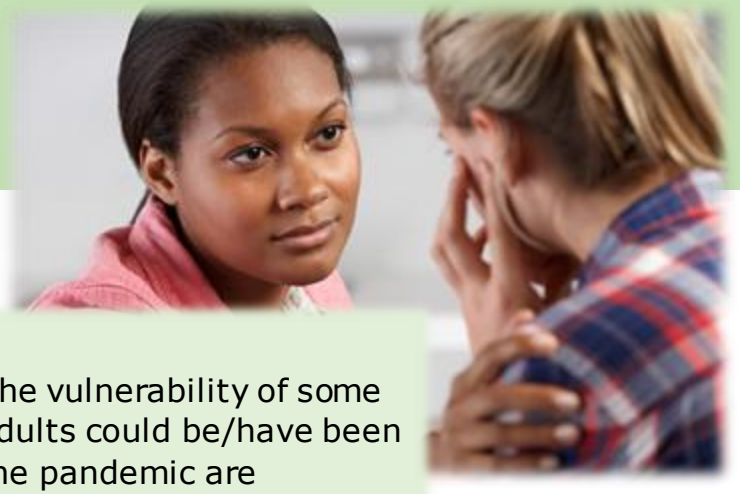
By 8 January 2021, all eligible care home residents in Aberdeen City, totalling 1092, had received their first Covid vaccination.

By 26 February 2021, all eligible care home residents had received their second vaccination. For residents who were unwell at the time of the second dose, or who had a recent detected COVID-19 result, arrangements were made to follow these up at a later, appropriate time.

With the significant number of residents having received both vaccinations, and a good uptake amongst care home staff, as well as the reducing community prevalence (7-day positivity rate under 1% as of 22 February 2021), there has been a clearly evidenced stabilisation within care homes.

All care homes have had at least two Support and Assurance visits, with some care homes having had several visits during outbreaks. A Grampian wide tool is now in use to support a consistent approach to these visits across all three partnerships. This tool was developed by oversight team members using the mandated Scottish COVID-19 Care Home Infection Prevention and Control Addendum published on 16 December 2020.

Personalisation



Adut Support and Protection (ASP) – 2020-2021

The wide-ranging implications of the Covid-19 pandemic continue to emerge, including the likelihood that the vulnerability of some adults will have increased because of the additional pressures placed on families and communities. Some adults could be/have been at risk of harm and neglect, where that would not otherwise have been the case. The harms ' hidden' by the pandemic are emerging, now that things are opening up.

The prevention of and response to harm has remained a priority for Aberdeen's Adult Protection Committee and partners during the pandemic, with the challenges in terms of response being similar to those experienced across services (e.g. moving to remote contact, virtual case conference meetings, implications of covid on staff, etc etc).

Notwithstanding, some of the above challenges have been converted into opportunities. Having to work remotely has meant that partners are more easily able to attend case conferences, and wider staff have been able to be involved at different stages of ASP. Aberdeen Advocacy now support adults and their families to attend case conferences through the use of IPads. Meetings are able to be arranged more quickly without travel restrictions. There are new opportunities to modernise Learning & Development for ASP.

The number of referrals under the Adult Support & Protection (Scotland) Act 2007 decreased during 2020-21 to 1,377, a reduction of 84 from the previous year (1,461), which suggests that some harm has remained 'hidden' due to the COVID restrictions.

The Adult Protection Unit has continued to receive more concerns for older adults and adults with infirmity, coming primarily from Police Scotland, NHS Grampian and the Scottish Fire and Rescue Service. Harm takes place mainly in the adult's own home or in a care home.

'No Further Action' remains the predominant outcome of concerns/referrals, for a number of reasons, e.g. adequate services are found to be in place, advice or information was provided, individuals were already subject to ASP, concerns were not substantiated, individuals were referred to other services, or alternative legislation was used.

The biggest reduction in types of harm related to physical (82 v 45 the previous year) followed by Psychological (43 v 27).

Personalisation

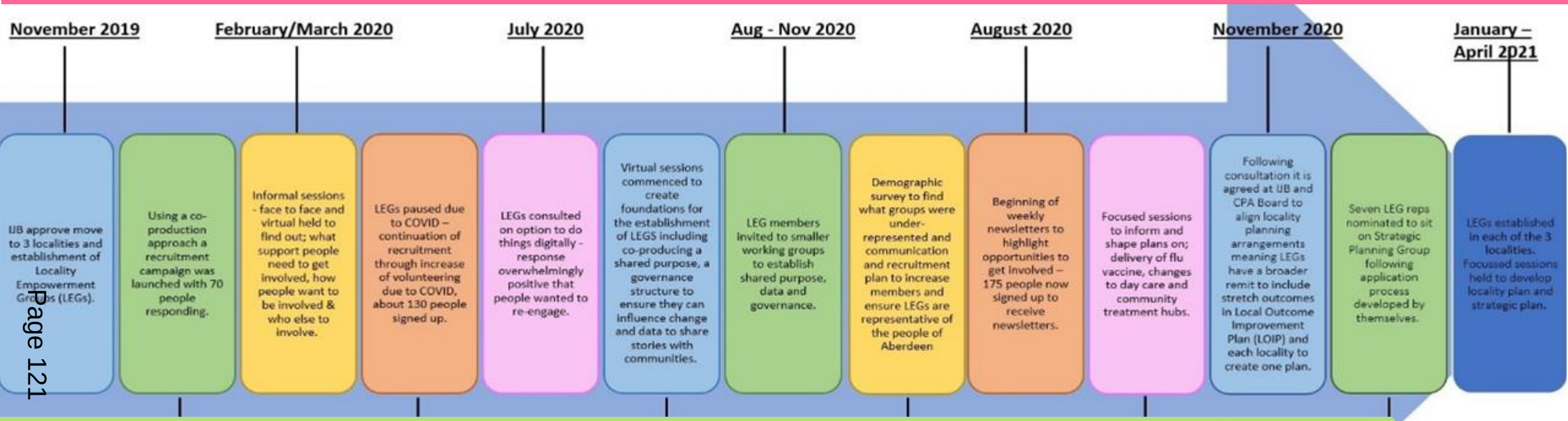
The Out of Hours Primary Care (GMED) Service delivers unscheduled primary care to patients who cannot wait until their GP Practices open. GMED service provides multidisciplinary assessment of patients. The team is made up of General Practitioners and Advanced Nurse Practitioners with a logistics and transport team. GMED's main centre is Aberdeen, with seven satellites across Grampian: Stonehaven, Banchory, Huntly, Inverurie, Elgin, Peterhead and Fraserburgh. Logistics team operates from the Aberdeen centre. The service is hosted by Health and Social Care Moray on behalf of Moray, Aberdeen City and Aberdeenshire Health and Social Care Partnerships (HSCPs).

On 25th March 2020, the Service was relocated from the Emergency Care Centre, ARI, to the Aberdeen Health and Care Village to establish the NHS Grampian Covid Assessment Hub as a part of NHS Grampian's response to the Covid-19 pandemic. Working closely with NHSG and Aberdeen City HSCP teams, the operational infrastructure and building works required by the GMED Service and Covid Hub were put in place in the Health Village.

The service is now embedded within the Health Village. As other services were remobilised GMED has relocated to the Green Zone within the building on a permanent basis. GMED clinical, admin and logistics teams continue to provide ongoing support to the Covid Hub.

It is recognised that the move allows progressing the service's objectives around improving clinical governance, patient care/ education and staff wellbeing. The move enables GMED and ACHSCP to work together closely as a part of one healthcare system, which positively impacts patient care and outcomes.

Communities - Locality Empowerment Groups



Locality Empowerment Groups are made up of people interested in improving the quality of life for those living in Aberdeen. Members use their own knowledge and experiences to influence priorities and help determine solutions. There are groups for Central, North and South of Aberdeen but there is also focus on needs that may be Citywide e.g., sharing your experience as a person living with a disability. We currently have over 300 people signed up to the Locality Empowerment Groups, with new members joining regularly.

Due to staff redeployment the Locality Empowerment Groups were paused for 2 months before a kick start again in July 2020. As members were unable to meet in person, Microsoft Teams was used to host the locality meetings. There were some hurdles to overcome as many community members were unfamiliar with Teams and required some support, a "Microsoft Teams – Getting Online" handbook was created and shared. The handbook was a success with many individuals being able to navigate their way online.

The Locality Empowerment Groups have been pivotal in providing feedback and suggestions on important matters such as Flu Vaccinations and Covid-19 Focus Groups. Members have been able to highlight venues they think would be most suitable for pop-up vaccination clinics and have highlighted barriers some members of the community are facing when accessing vaccinations. For example, people with sight loss were missing their Covid-19 vaccination appointment letter, this was relayed to the National Vaccination Team who organised for those individuals to be telephoned with their appointment time. Without this information, we would not have been able to make these improvements to the process.

Communities - Locality Empowerment Groups

A governance structure was agreed which led to seven people representing the Locality Empowerment Groups on the Aberdeen City Health and Social Care Partnership Strategic Planning Group (SPG). The members went through an application process which the Locality Empowerment Group members had collectively created. These members represent the wider groups and ensure information is shared.

In December 2020 the IJB and Community Planning Board, approved a new model of locality planning in Aberdeen which saw the remit of the Locality Empowerment Groups widen to cover all the priority outcomes within community planning. This also meant there is now a shared description of localities and priority neighbourhoods along with the development of shared locality plans.

Most notably the Locality Empowerment Group members have been crucial in the work to refresh Community Planning's Local Outcome Improvement Plan (LOIP) and the three Locality Plans. More information on this work will be reported in our Annual Report next year.

A 6-month evaluation of the members experience of the Locality Empowerment Group was carried out. The feedback received has helped to shape the way we communicate with the Locality Empowerment Groups and has indicated where we need to increase representation. The highlights from the evaluation are shown opposite. The full outcome of the evaluation can be viewed - Click here to view

More information on the Locality Empowerment Groups and how to get involved can viewed on the following leaflet - Click here to view

You said the **Locality Empowerment Groups** are:

- ✓ Welcoming
- ✓ Well organised
- ✓ Have connected me to like-minded people
- ✓ An exciting opportunity to improve the health and wellbeing of communities in Aberdeen
- ✓ A good start but need to continue to have more community representation across Aberdeen City

How to get involved!
Aberdeen is made up of a diverse population and we want to ensure all ages and communities get involved, therefore we particularly welcome minority groups.

If you would like to get involved please email localityplanning@aberdeencity.gov.uk with your name, address and first part of your postcode so we can ensure you are given the details of your local group.

Project – One Seed Forward

"So I definitely think quite an active CPD is good just to see how its done…you've probably been on loads of CPDs when someone is just talking to you."

"Yes absolutely, I feel a bit more confident. I wasn't confident at the start with things like that but over time, now I am, and I think I would be ready to take this forward."

Background and activities

The OSF Garden Schools initiative was a partnership between One Seed Forward and the School of Education in the University of Aberdeen

The key objectives of the project involved the development of a training program for student teachers and any other interested educators to help support outdoor learning carried out in schools.

The students assisted in creating educational materials by analysing previous materials and, from that, creating educational activities which linked into the Curriculum for Excellence. The students engaged in workshops to develop creative school activities. For example, students created lessons around fast fashion and building scarecrows form waste material.

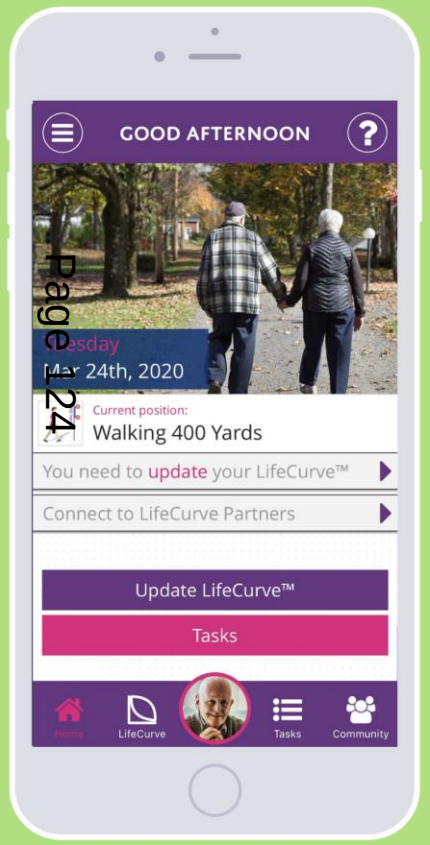
The project engaged schools and it successfully acts as a platform for getting children and young people outdoors and physically active.

Key Achievements

1. We developed a new website to support the project and we managed to create a digital platform to showcase our modules on Youtube.
2. We worked with students and lecturers at the Universities of Aberdeen and Edinburgh to develop the educational scripts, PowerPoints and films of the children for the Youtube channel.
3. Lecturers from the University of Edinburgh and University of Aberdeen featured in numerous videos on the Youtube channel.

Communities - Health Improvement Fund

Connections



LifeCurve App Project

A number of different initiatives have taken place during the past year involving the LifeCurve App. The App provides a way for people to improve or maintain their functional ability and supports self-management. In Occupational Therapy we have tested using the App with people in the community via a 4th year student placement. The student introduced the App and supported people to identify where they were on the Life Curve. Following this she worked with the participants to set tasks on the App that would help work towards goals, improve function and improve each person's position on the Life Curve. One of the people who took part lived in a Sheltered Housing block and shared the App with her friends and neighbours so that they could do it together. This resulted in a further piece of work (currently in progress) where residents in a Sheltered Housing block are being offered the opportunity to use the LifeCurve App. This project has pulled together the "Connecting Scotland" initiative to provide devices, Bon Accord Carers to support residents to work towards specific goals, Robert Gordon University Occupational Therapy students to support residents to use the App and a Kickstart worker from the Library service to support general use of IT. The project is currently working with an initial cohort of six residents with the aim of growing the number of residents engaged in this work over coming months.

Speech and Language Therapy have developed their website as part of their universal level of service, to provide information directly to people who use their service. Click the picture to go to the site.

MSK Physiotherapy Grampian page on the internet. – a great resource to support patients including signposting to local resources. Click on the picture to go to the site.

Development of the **Healthy Weight Grampian** webpage further during COVID. This now provides information on a range of clinical conditions, from overweight to malnutrition. Click on the logo to go to the site.

Connections

Shielding Communities – Afternoon Teas

Orka Café, in Partnership with the Transforming Health and Wellbeing (THAW) team from ACHSCP and Aberdeen Soup, donated afternoon teas to those shielding during the first lockdown last year. The THAW team identified shielding individuals in the community and delivered these, two afternoons a week during the summer, to lift their spirits and give them a much-needed pick-me-up! The Afternoon Teas were warmly welcomed by those who participated.

"As a school nurse service our appointments have historically been face to face. Prior to the first lock down, we as a service had started to use a workload tool. This identified our active case load and also highlighted priorities, using the RAG system, so at a glance we would have an idea of the level of vulnerability.

I cover the Aberdeen Grammar School. I am pleased to report that I had an outstanding response to my 'active' pupils using Near Me. Initially I made contact with them via their school Gmail and asked if they wanted to continue their regular support appointments via Near Me video link and explained the process. I even called and spoke some of them through the first appointment. I used the Teams Calendar to allocate my appointments via the pupils Gmail addresses.

During the lock downs I have had an active list of between 40-60 pupils and managed to consistently average 35 Near Me appointments per week. This allowed me to have regular contact with some of my vulnerable pupils, continue assessments, support anxiety management as well as support to young people that were self-harming and struggling with low mood.

The kids live in a virtual world, and I felt that this was the first time that we had been working at their level.

I have continued to offer Near Me appointments as an option. This is helpful when pupils do not wish to be seen in school or for example during exam time when they have a lot of study time. Sometimes they just really want a parent present. I would also note that they are often more relaxed in their home environment, and it also aids in your assessment by visually seeing them and their surroundings.

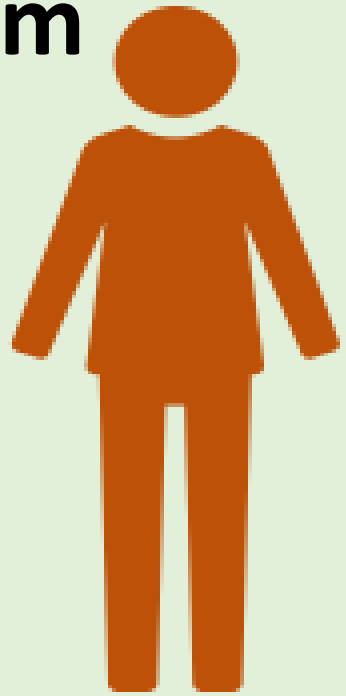
I have had positive feedback about the new systems and use of Near Me. I look forward to continuing to work in this way."

Lizzie Smith, School Nurse

Connections

A Primary Care Link Practitioner supported Jim to link in with services, groups and activities.

Jim



Referral from Advanced Nurse Practitioner:

Social Isolation

Main challenges:

1. Social Isolation
2. Finances
3. Lack of safety

What services/groups did Jim access?

- Before lockdown looked at the groups within Torry Community Centre.
- Referred to Befriending scheme but wished to place this on hold until restrictions ease
- Referred to Bon Accord Care to have community alarm fitted.
- SCARF – to look at changing energy providers and support with dispute regarding electric bill
- Referral to CFINE for foodbank
- Referral to The Money Advice Team for benefit check.
- Support to complete application for Scottish Welfare fund.
- Referral to ACC for support through the Covid19 psychological resilience hub.

Outcomes achieved?

1. Feels safe within home now due to community alarm being fitted.
2. Feels well supported through emotional check in calls particularly during lockdown periods.
3. Able to access emergency funds in time of need

Next steps;

As lockdown restrictions ease Jim will consider groups but found emotional check in throughout by Link Practitioner beneficial.

Progress against our Enablers

Principled Commissioning

Over the past 12 months we have continued to use our strategic commissioning approach to work with providers and service users to redesign provision of care, with a clear focus on outcomes.

We have moved to an outcomes focussed model for the provision of care at home, redesigned our day care and day opportunities, and also commissioned carers support services.

We recognise that our shared ambition for this provision of care and support demonstrates a significant departure from our previous model, and we will continue to work with our providers and members of the community as the models evolve.

We have created a market position statement for our day opportunities redesign and will progress to a larger scale market position statement which is aligned to our strategic plan.

Modern & Adaptable Infrastructure

During 2020/21 most of our capital projects were put on hold and the focus was on repurposing existing buildings to respond to the Covid pandemic and putting in measures to ensure safer workplaces that met the guidelines on social distancing.

Aberdeen Health and Care Village was repurposed as the Community Assessment Hub for Aberdeen City. This was a focussed service for people experiencing COVID-19 symptoms and was a direct and dedicated route to clinical advice and support. It could only be accessed through NHS24 by calling 111 day or night.

Following an assessment, callers may have been given advice to help them continue to self-isolate at home or their call could have been transferred to specialist Doctors located in the hub who could undertake a virtual clinical assessment. Following this a patient could have been admitted to hospital; referred back to the GP practice or local health and social care teams for care; or if there was a clinical need to be seen by a healthcare professional to assist decision making, callers may have been given an appointment to attend the assessment hub.

Empowered Staff

Our staff engagement remains key to delivering quality and transforming the services we deliver. In the past year this has been delivered in many different ways.

High on the agenda has been engagement to promote staff wellbeing. In response to the Everyone Matters Survey, Focus Groups were held to promote Staff Wellbeing. Work to support colleagues who were shielding and then returning to work has taken the form of Check-Ins both on a local and system wide basis.

In the transformation of services, engagement has been wide and varied. A checklist has been developed to ensure all project plans consider the engagement of staff. This has led to initiatives such as a virtual support network for the new care at home arrangements as well as face to face sessions with colleagues across the Frailty Pathway.

As teams begin to embrace the changes and move into future ways of working, there has been a growing level of engagement around the building of new team structures. It is anticipated that this form of engagement will continue to grow over the coming months.

Finally, a significant amount of engagement has been initiated by colleagues themselves involving everything from regular huddles and check-ins to informal team get togethers and team challenges.

Digital Transformation

The increased use of Near Me described earlier in this report is one example of the digital transformation that has taken place over the last year. eConsult is another development which enables patients to submit their symptoms to a GP electronically, and offers round the clock NHS self-help information, signposting to services, and a symptom checker. Both of these systems are in addition to either a telephone or 'in person' appointment and the most appropriate route will be used depending on a patients needs and preferences. We are aware that not everyone has the same access to devices or internet, and this will be a focus of our future digital planning.

Technology also assisted staff to continue to work from home during the pandemic with the roll out of Microsoft Teams allowing face to face meetings, on-line collaboration, sharing files, instant messaging etc. Our partners and our communities were also able to continue to collaborate with us in this way. Initially not all staff had the necessary devices, and due to high demand, there was a delay in obtaining these with the Covid Assessment Hub and Test and Protect being prioritised. Supply has now stabilised, and most staff now have the equipment they require.

Progress against our Enablers – Sustainable Finance

Sustainable Finance

Financial Year 2020/21 was challenging as our normal expenditure pattern was disrupted by Covid. Spending in some areas decreased as service delivery was postponed or reduced and in other areas it massively increased as we responded to the pandemic. Robust arrangements were put in place to identify and monitor the financial impact and to ensure we were able to access additional funding available, firstly to mobilise our response and subsequently to re-mobilise normal services where possible. Our Income and Expenditure for 2020/21 is shown to the right. We were able to restore our reserves to the 2019/20 position. Our Medium-Term Financial Framework for 2021/22 to 2027/28 was approved at IJB on 23rd March 2021 and our Annual Audited Accounts were approved by the Risk, Audit and Performance committee in June 2021.

Comprehensive Income and Expenditure Statement

This statement shows the cost of providing services for the year according to accepted accounting practices.

2019/20				2020/21		
Gross Expenditure	Gross Income	Net Expenditure		Gross Expenditure	Gross Income	Net Expenditure
£	£	£		£	£	£
34,797,252	0	34,797,252	Community Health Services	36,773,002	0	36,773,002
24,234,025	0	24,234,025	Aberdeen City share of Hosted Services (health)	23,009,740	0	23,009,740
35,146,542	0	35,146,542	Learning Disabilities	34,344,973	0	34,344,973
20,240,395	0	20,240,395	Mental Health & Addictions	21,098,094	0	21,098,094
78,465,627	0	78,465,627	Older People & Physical and Sensory Disabilities	79,024,830	0	79,024,830
1,783,412	0	1,783,412	Head office/Admin	326,346	0	326,346
0	0	0	Covid	17,239,540	0	17,239,540
4,734,327	(4,642,640)	91,687	Criminal Justice	5,046,774	(4,955,087)	91,687
1,477,205	0	1,477,205	Housing	746,121	0	746,121
40,842,789	0	40,842,789	Primary Care Prescribing	40,447,093	0	40,447,093
41,140,761	0	41,140,761	Primary Care	42,512,697	0	42,512,697
2,000,719	0	2,000,719	Out of Area Treatments	2,750,857	0	2,750,857
46,410,000	0	46,410,000	Set Aside Services	47,802,300	0	47,802,300
3,778,609	(96,814)	3,681,795	Transformation	4,437,062	0	4,437,062
335,051,663	**(4,739,454)**	**330,312,209**	**Cost of Services**	**355,559,429**	**(4,955,087)**	**350,604,342**
0	(327,335,768)	(327,335,768)	Taxation and Non-Specific Grant Income (Note 5)	0	(366,238,226)	(366,238,226)
335,051,663	**(332,075,222)**	**2,976,441**	**Surplus or Deficit on Provision of Services**	**355,529,429**	**(371,193,313)**	**(15,633,884)**
		2,976,441	**Total Comprehensive Income and Expenditure**			**(15,633,884)**

Our Governance

Care Inspection – Justice Social Work

Aberdeen City Council was advised in November 2019 that an inspection of its Justice Social Work (JSW) service with a particular focus on Community Payback Orders (CPOs) was to be undertaken by the Care Inspectorate.

The inspection was to be conducted in line with the Inspection of Justice Social Work services in Scotland guidance and evaluate the service against quality indicators drawn from the Guide to Self-Evaluation for Community Justice in Scotland.

Notification of the commencement of the inspection triggered a 28-week inspection timeline which outlined the respective responsibilities of the Care Inspectorate and the justice service including:

- Submission of self-evaluation with supporting evidence
- Case file reading of approximately 100 files
- Meet with individuals who are (or have been) the subject of CPOs
- Meet with staff and other stakeholders

After postponement due to the lockdown restrictions, the Care Inspectorate on Tuesday 23rd February 2021, published its report of the inspection of the Justice Social Work service. The evaluation against selected quality indicators was as follows:

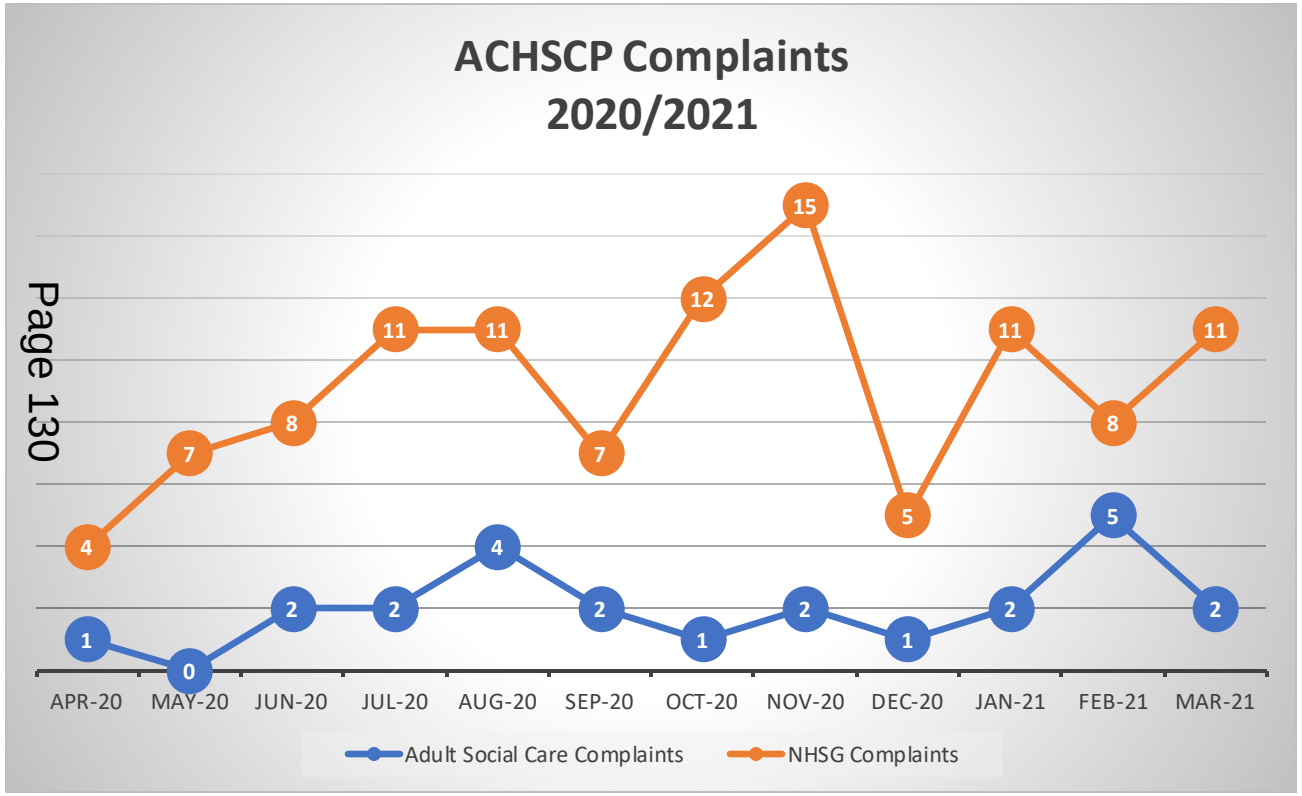
		Grade
What key outcome have we achieved	Improving the life chances and outcomes for people subject to a community payback order	Good
How well do we meet the needs of our stakeholders	Impact on people have committed offences	Excellent
How good is our delivery of services	Assessing and responding to risk and need	Good
	Planning and providing effective intervention	Very Good
How good is our Leadership	Leadership of improvement and Change	Very Good

Given these evaluations, the Care Inspectorate identified the following areas of improvement for the service to progress and complete:

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.

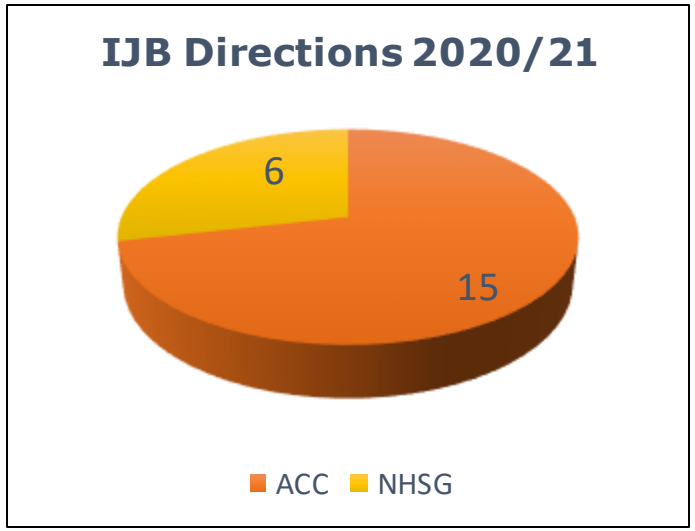
To ensure the effective delivery of key processes, senior managers should further strengthen quality assurance mechanisms to support the consistent, confident and timely application of risk assessment and case planning processes, particularly those relating to risk of serious harm.

Our Governance



Strategic Risk Register

Our Strategic Risk Register is reviewed by the IJB and the Risk, Audit and Performance Committee four times a year. The main movements in the strategic risks during 2020/21 have been the removal of the risk of the UK leaving the EU and the inclusion of the risk of the IJB becoming a Category 1 Responder under the Civil Contingencies Act, 2004. The IJB also held a workshop in October 2020 where it reviewed the Board's risk appetite statement as well as undertaking a review of the high and very high risks on the register.



In 2020/21 the IJB issued 6 Directions to NHSG and 15 to ACC. This is an increase from 2 and 9 respectively the previous year andis an indication of the IJB's appetite to effect change across the system.

Strategic Plan Development

Our current Strategic Plan is now in its third and final year. Below is our timetable for refreshing the plan and we will do this in a co-produced way with our communities, our staff and our partners. If you want to be involved, contact your local Locality Empowerment Group via localityplanning@aberdeencity.gov.uk or ACHSCPEnquiries@aberdeencity.gov.uk

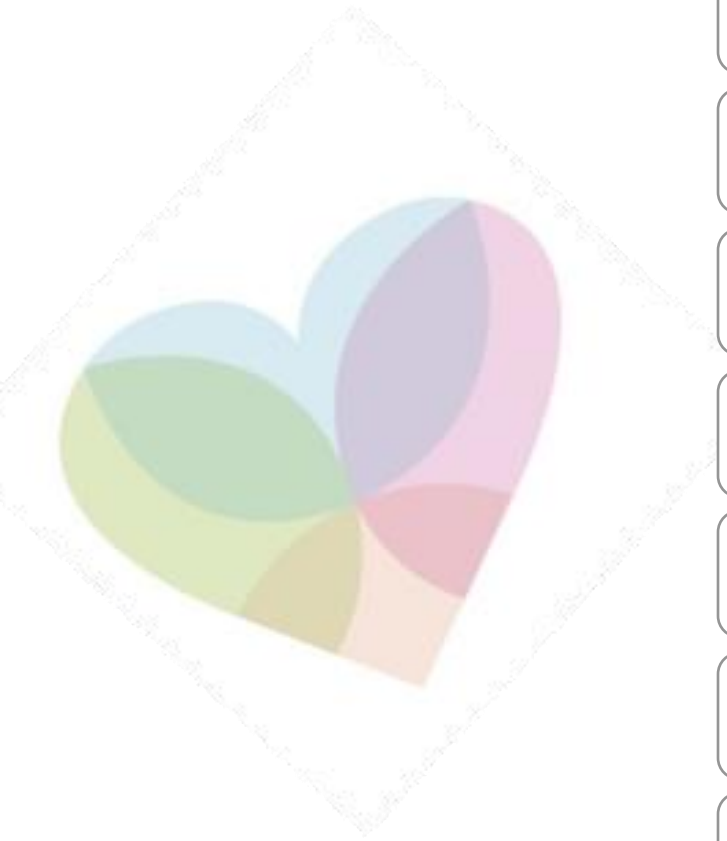
Oct 20 – Jun 21
Refresh of LOIP and development of Locality Plans

Mar 21 – Nov 21
Consultation and development of initial draft

Dec 21
Draft approved for public consultation

Mar 22
Final Strategic Plan approved and published

Next years' Priorities



- Living with and Responding to Covid19
- Staff and Health Wellbeing
- Reshaping our relationship with Communities
- Reshaping our Commissioning approach
- Whole system and connected remobilisation
- Inequality, Mental Health and Human Rights
- Strategic Plan Refresh
- Local Survey 2022

Appendix A – Ministerial Steering Group (MSG) Indicators

2020/21 has been a challenging year for everyone due to the Coronavirus pandemic and as a result has impacted on how ACHSCP services have been delivered throughout the whole of 2020/21. The impact of the changes in service delivery throughout the pandemic can be seen clearly in the data with large decreases, for example, in the number of emergency admissions, hospital occupied bed days, A&E attendances and delayed discharge figures. These large drops in activity mean that we are not able to monitor our performance against previous years as normal. Figures for MSG indicators 1 to 4 have all improved comparing to the baseline year however this is mainly due to the pandemic and these figures will likely increase as services get back to normal. How long this will take, and to what level activity will increase is not known.

There has been a 3% increase in the percentage of people spending the last 6 months of life in the community (indicator 5a) and an 13% increase in number of days during the last 6 months of life spent in the community (indicator 5b) comparing to baseline year (2015/16). These increases look encouraging and may have been positively impacted by the work of the partnership to enable people to continue to live at home or in a homely setting.

	MSG Indicator	Aberdeen City Reporting Period					
		2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
1	Number of emergency admissions 18+	18,797	18,416	18,842	18,690	18,978	16,691
2a	Number of unscheduled hospital bed days; acute specialties 18+	154,464	144,741	141,366	132,229	138,038	99,566
2b	Number of unscheduled hospital bed days; Mental Health specialties 18+	66,807	63,680	60,506	57,464	55,827	51,364
3a	A&E Attendances 18+	35,311	35,046	35,879	36,433	36,945	25,929
4	Delayed Discharge bed Days (all reasons)	43,944	27,353	19,202	13,172	12,272	5,923
5a	Percentage of last 6 months of life spent in Community (all ages)	88.0%	88.9%	88.6%	89.5%	88.7%	91.7%
5b	Number of days during last 6 months of life spent in the community (all ages)	318,612	317,971	341,684	304,589	335,318	359,697
6	Balance of Care: Percentage of population 65+ living at home (supported and unsupported)	95.3%	95.5%	95.6%	95.8%	95.8%	N/A

Appendix B – National Indicators

Aberdeen City Core Suite of National Integration Indicators - Annual Performance

Data for the Core Suite of Integration Indicators, NI - 1 to NI - 23 are populated from national data sources and data is issued nationally. Indicators 1 to 10 are outcome indicators based on survey feedback and are updated bi-annually. Data for National Indicators 11 to 23 are derived from organisational/system data and are updated quarterly. Data for indicators 10, 21, 22 and 23 are not yet available.

Data Source: Public Health Scotland (PHS)
Last Refreshed: June 2021

	Indicator	Title	Aberdeen City		Scotland	RAG
			Previous score* 2017/2018	Current score 2019/20	Current score 2019/20	
Outcome indicators	NI - 1	Percentage of adults able to look after their health very well or quite well	94% (4205)	94% (4551)	93%	G
	NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	82% (185)	82% (329)	81%	G
	NI - 3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	79% (186)	78% (330)	75%	G
	NI - 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	76% (187)	76% (328)	73%	G
	NI - 5	Total % of adults receiving any care or support who rated it as excellent or good	83% (200)	79% (335)	80%	A
	NI - 6	Percentage of people with positive experience of the care provided by their GP practice	82% (3632)	77% (3913)	79%	A
	NI - 7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	79% (182)	84% (327)	80%	G
	NI - 8	Total combined % carers who feel supported to continue in their caring role	40% (496)	34% (489)	34%	G
	NI - 9	Percentage of adults supported at home who agreed they felt safe	84% (187)	85% (331)	83%	G
	NI - 10	Percentage of staff who say they would recommend their workplace as a good place to work	NA	NA	NA	

Appendix B – National Indicators

	Indicator	Title	Aberdeen City		Scotland	RAG	
			Previous score	Current score	Current Score		
Data indicators	NI - 11	Premature mortality rate per 100,000 persons *(European age-standardised mortality rate per 100,000 for people aged under 75)*	465 2018	435 2019	426	A	
	NI - 12	Emergency admission rate (per 100,000 population)	10,289 2019/20	9,319 2020	11,100	G	*
	NI - 13	Emergency bed day rate (per 100,000 population)	105,407 2019/20	89,246 2020	101,852	G	*
	NI - 14	Readmission to hospital within 28 days (per 1,000 population)	117 2019/20	131 2020	114	R	*
	NI - 15	Proportion of last 6 months of life spent at home or in a community setting	89% 2019/20	91% 2020	90%	G	*
	NI - 16	Falls rate per 1,000 population aged 65+	23 2019/20	22.2 2020	21.7	A	*
	NI - 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	91% 2019/20	91% 2020/21	83%	G	
	NI - 18	Percentage of adults with intensive care needs receiving care at home	53% 2018	56% 2019	63%	R	
	NI - 19	Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population)	579 2019/20	273 2020/21	488	G	
	NI - 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	27% 2019/20	22% 2020	21%	A	*
	NI - 21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home	NA	NA	NA		
	NI - 22	Percentage of people who are discharged from hospital within 72 hours of being ready	NA	NA	NA		
	NI - 23	Expenditure on end of life care, cost in last 6 months per death	NA	NA	NA		

* Please note previous scores are not directly comparable to figures for 2019/20 due to changes in methodology

* Current scores uses calendar and not financial year for indicators 12 to 16 and 20 as recommended by PHS as data is more complete

RAG scoring based on the following criteria

If Current position is the same or better than Scotland then "Green"

If Current position is worse than Scotland but within 5% then "Amber"

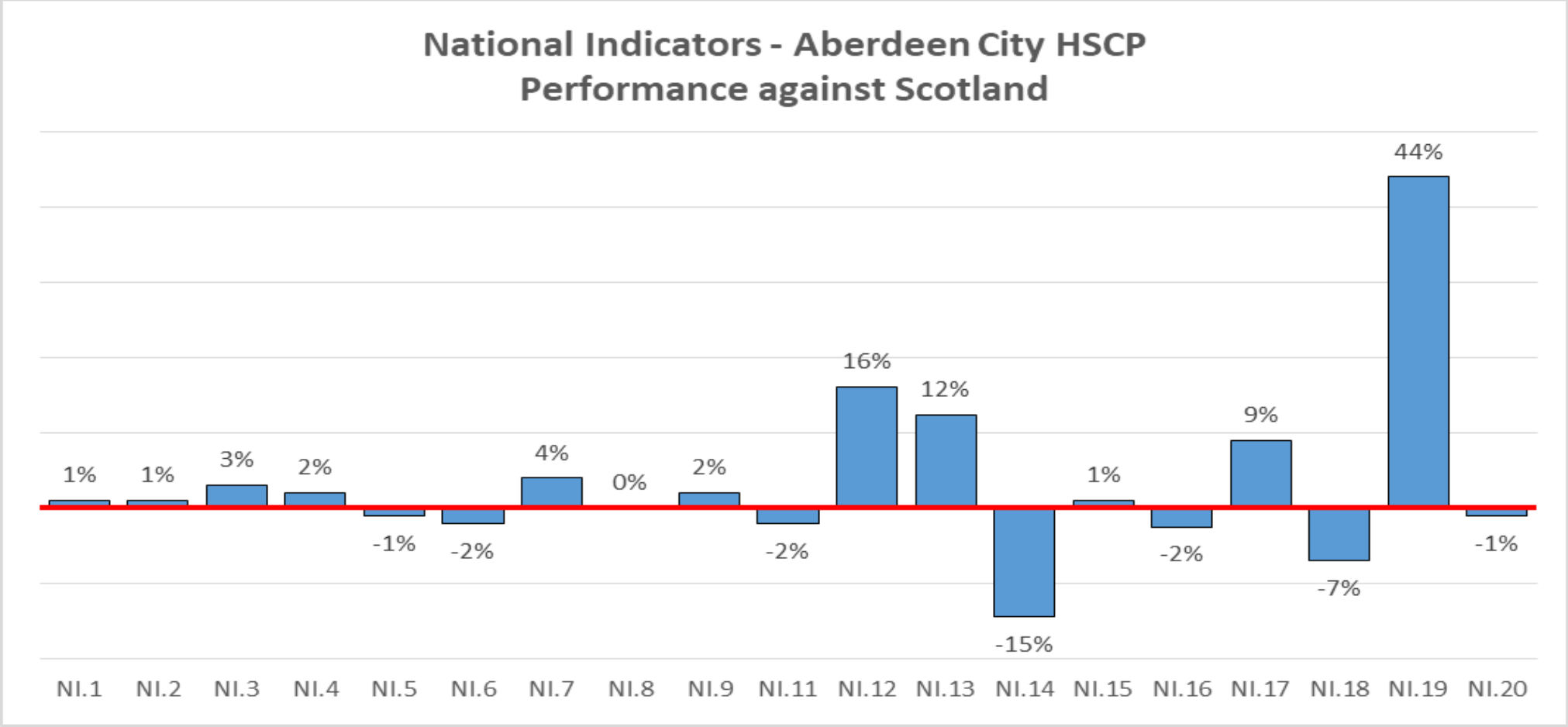
If Current position is worse than Scotland by more than 5% then "Red"

N14 - Readmissions to hospital within 28 days (per 1,000 population)" Readmission rates in Aberdeen City have remained above the Scottish rate from 2015/16. In 2020/21 15 of the 33 HSCP in Scotland (45%) had a re-admission rate higher than the Scottish average. Aberdeen City had the 7th highest readmission rate in 2020/21.

Readmission rates across Scotland appear to have increased from 2019/20 to 2020/21. City saw a 12% increase in readmission rate from 2019/20 to 2020/21, while Scotland saw a 9% increase. We have previously investigated this indicator to try to understand whether there were specific underlying causes. None were found at the time however we plan to make this a focus of further investigation, as it is thought this area would benefit from improvement activity

N18 - Percentage of adults with intensive care needs receiving care at home". The aim is to have a higher proportion of people to be cared for at home so a higher percentage rate for this indicator would be better. The most recent data available for this indicator is for 2019. A lot of work has been undertaken since then to Aberdeen City's performance has improved from 53% in 2018 to 56% in 2019, however this still sits below the Scotland 2019 level of 63%. Despite this, RAG status remains Red as the 2019 figure of 56% is more than 5% less than the 2019 Scotland figure of 63%.

Appendix B – National Indicators



The red line shows the Scotland position and the bars show for each indicator the percentage Aberdeen City HSCP's performance differs from Scotland's performance for the current reporting period. Positive bars show where Aberdeen City HSCP is performing better than Scotland and negative bars show where Aberdeen City HSCP performance is worse than Scotland's.

For the current reporting period Aberdeen City HSCP performed better or the same as Scotland for 11 of the 19 national indicators, with 7 performing worse than Scotland. This is the same as the last reporting period. Note that of the 23 national indicators only 19 have data available for reporting.

Aberdeen City Health & Social Care Partnership

A caring partnership

Annual Report 2020-2021

Public Summary

Covid19 response and lessons learned

- In a crisis, we can transform the way we deliver services at pace.
- Communities step up in a crisis.
- Our staff response is exceptional.
- Covid19 will have a lasting impact.
- Staff wellbeing is one of our priorities.
- Technology can enable and disable.
- We need to continue to respond to health inequalities.

To read the full version of our Annual Report, please click HERE to head to our website.

#ACHSCP

Thank You

To show our appreciation and thanks, at the Heart Awards Digital Event in December 2020, we featured a Thank you video to our Health and Social Care staff and partners – please use the QR code to view the video.

Priorities for 2021/22

- Living with and Responding to Covid19
- Staff and Health Wellbeing
- Reshaping our relationship with Communities
- Reshaping our Commissioning approach
- Whole system and connected remobilisation
- Inequality, Mental Health and Human Rights
- Strategic Plan Refresh
- Local Survey 2022

Covid Hub/GMEDs

Stay Well, Stay Connected

Aberdeen City Health & Social Care Partnership
A caring partnership

Annual Report 2020-2021
Public Summary

Locality Empowerment Groups

The groups are interested in making the quality of life better, focus on citywide needs and provide feedback in important matters. Around 300 people (more joining regularly) have made an improvement to the community already.
More information on how to get involved in leaflet here

You said the **Locality Empowerment Groups** are:
- ✓ Welcoming
- ✓ Well organised
- ✓ Have connected me to like-minded people
- ✓ An exciting opportunity to improve the health and wellbeing of communities in Aberdeen
- ✓ A good start but need to continue to have more community representation across Aberdeen City

Our Strategic Aims are still important to us and have remained our priority through 20/21
1. Prevention
2. Resilience
3. Personalisation
4. Connections
5. Communities

Frailty Pathway Redesign

To maintain people safely at home

Avoiding unnecessary hospital attendance or admission

To support early discharge back home after essential specialist care

Operation Home First Principles

Projects to progress change in the Frailty Pathway

- Early Supported Discharge/ Hospital @ Home (Shire)
- Hospital at Home (City)
- Rosewell House (City)
- Discharge Hub (Shire)
- Community Allied Health Professions (City)
- Aberdeen Royal Infirmary

ABERDEEN CITY COUNCIL

NHS Grampian

Aberdeen City Health & Social Care Partnership
A caring partnership

RISK, AUDIT & PERFORMANCE COMMITTEE

Date of Meeting	23 September 2021
Report Title	Directions – 6 monthly reporting
Report Number	HSCP.21.104
Lead Officer	Alex Stephen, Chief Finance Officer
Report Author Details	Name: Carol Wright Job Title: Support Manager Email Address: cawright@aberdeencity.gov.uk
Consultation Checklist Completed	Yes
Directions Required	No
Appendices	Appendix A - Direction Tracker 23092021

1. Purpose of the Report

1.1. This report presents the Risk, Audit & Performance Committee (RAPC) with an update on Directions instructed to Aberdeen City Council (ACC) and National Health Service – Grampian (NHSG) since the previous report to the 27 April 2021 RAPC.

2. Recommendations

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

a) Note the contents of this report.

3. Summary of Key Information

3.1. As per the Roles and Responsibilities Protocol of the Integration Joint Board (IJB) and its Committees, the IJB are obliged to "to issue Directions to the Partners under sections 26 and 27 of the Public Bodies (Joint

Working) (Scotland) Act 2014, in line with the Integration Scheme and legislative framework sitting around the CEO's of the Partners."

As agreed by Committee on 23 September 2020 a report will be presented every 6 months to provide Committee the opportunity to overview the ongoing directions.

3.2. The Directions Tracker, as shown at Appendix A indicates when they were submitted to the constituent organisation(s), the financial commitment, and the status of each direction. Most of the Directions issued by the IJB are to incur financial expenditure and are therefore centred around commissioning or our transformation programme.

3.3. The Directions Tracker is provided for review at the Chief Officer's monthly performance meeting. This ensures overview from ACC and NHSG Chief Executives and the Chair and Vice Chair of IJB. The tracker is regularly updated by the leadership team and lead officers. There are two classifications of status for a direction:

1. Complete – represents a direction where the date has expired and the direction is either no longer required or has been superseded by a new direction,

2. Ongoing – represents where the current direction is still valid.

4. Implications for IJB

4.1. **Equalities, Fairer Scotland and Health Inequality –** there are no direct implications arising from this report.

4.2. **Financial –** there are no direct implications arising from this report.

4.3. **Workforce -** there are no direct implications arising from this report.

4.4. **Legal –** Scottish Government guidance which provides that there should be a log kept of all Directions made - Health and Social Care Integration Statutory Guidance- Directions from Integration Authorities to Health

Boards and Local Authorities (Jan 2020). RAPC monitoring and reviewing Directions issued ensures that the IJB is discharging this requirement.

4.5. Other – NA

5. Links to ACHSCP Strategic Plan

5.1. Ensuring that the RAPC has overview of the Directions process will help ensure that the IJB achieves the strategic aims and priorities as set out in the strategic plan.

6. Management of Risk

6.1. Identified risk(s):

Good governance and ensuring that the IJB's committees are delivering on their roles and responsibilities are fundamental to the delivery of the Strategic Plan and therefore applicable to most of the risks within the Strategic Risk Register.

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

This report links to Risk 5 on the Strategic Risk Register, "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".

RISK, AUDIT & PERFORMANCE COMMITTEE

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

This report shows the progress which has been made in the Directions as part of our governance framework, and in the discharge of or requirements within the statutory guidance outline at paragraph 4.4 above.

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

Direction	Associated Budget	Report on:	Report Number	Approved at	Lead Officer	ACC/NHSG	Date Submitted	Effective From	Effective Until	Status at April 2021	Status at Sep 2021	Narrative
Implementing the integration scheme	NA	NA	NA	IJB 160416	J. Proctor	ACC	NA (prior to process)	26/04/2016	NA	Ongoing	Ongoing	Directions which set the IJB off delivering the integration scheme
Implementing the integration scheme	NA	NA	NA	IJB 160416	J. Proctor	NHSG	NA (prior to process)	26/04/2016	NA	Ongoing	Ongoing	Directions which set the IJB off delivering the integration scheme
Intensive Support Service	Within current LD budget	Learning Disability Commissioning	HSCP.17.116	IJB 300118	J. Rae	ACC	20/02/2018	01/10/2018	30/09/2021	Ongoing	Ongoing	Ongoing review of commissioned services – extension request September 2021
BAC Contract	Within existing budgets	BAC Contract Review	HSCP.18.035	IJB 220518	S. Shaw	ACC	05/06/2018	01/08/2018	31/07/2024	Ongoing	Ongoing	Monitored through quarterly process.
Social Transport	£347,600.00	Transformation Decisions Required	HSCP.18.059	IJB 280818	A Macleod	ACC	04/09/2018	01/04/2018	31/03/2022	Ongoing	Ongoing	Ongoing review of commissioned services, annual workplans
Musculoskeletal (MSK) Physiotherapy First Contact Practitioner service in Primary Care	£1,184,825.00	Transformation Decisions Required	HSCP.18.059	IJB 280818	A Macleod	NHSG	04/09/2018	28/08/2018	28/08/2022	Ongoing	Ongoing	PCIP
Primary Care Psychologists	£2,514,445.00	Transformation Decisions Required	HSCP.18.059	IJB 280818	A Macleod	NHSG	04/09/2018	28/08/2018	28/08/2022	Ongoing	Ongoing	PCIP
Maternity Vaccinations	£157,776.00	Transformation Decisions Required	HSCP.18.117	IJB 111218	A Macleod	NHSG	19/12/2018	01/04/2019	01/01/2022	Ongoing	Ongoing	Ongoing
Link Working (Extension)	£698,564.00	Transformation Decisions Required	HSCP.18.151	IJB 260319	A Macleod	ACC	15/04/2019	26/03/2019	07/01/2022	Ongoing	Ongoing	Ongoing review of commissioned services, annual workplans
Chaplaincy Listening Service	£178,369 (4 years)	Transformation Decisions Required	HSCP.18.151	IJB 260319	A Macleod	NHSG	15/04/2019	26/03/2019	31/03/2023	Ongoing	Ongoing	Ongoing (in line with Action 15)
Contract Award Report	£737,936.00	Commissioning	HSCP.19.022	IJB 110619	S. Macleod	ACC	04/07/2019	01/04/2019	31/03/2022	Ongoing	Ongoing	Ongoing review of commissioned services, annual workplans
Transformation Report - Delayed Discharge Reporting	£25,440.07	Transformation Decisions Required	HSCP.19.026	IJB 110619	A Macleod	ACC	04/07/2019	01/12/2017		Ongoing	Ongoing	Ongoing (in line with Action 15)
Kingswells Care Home	£3,100,000.00	Commissioning	HSCP.19.032	IJB 110619	C.Wilson	ACC	04/07/2019	01/04/2019	30/03/2024	Ongoing	Ongoing	Ongoing (in line with Action 15)
Action 15 - Psychological Wellbeing Practitioners	£691,429.00	Transformation Decisions Required	HSCP.19.058	IJB 030919	L. McKenna	NHSG	19/09/2019	03/09/2019	30/04/2022	Ongoing	Ongoing	Ongoing (in line with Action 15)
Action 15 - Mental Wellbeing - Out of Hours	£659,814.00	Transformation Decisions Required	HSCP.19.058	IJB 030919	K. Gunn	NHSG	19/09/2019	03/09/2019	30/04/2023	Ongoing	Ongoing	Ongoing (in line with Action 15)
Action 15 - Mental Wellbeing - Out of Hours	£659,814.00	Transformation Decisions Required	HSCP.19.058	IJB 030919	C.Wilson	ACC	19/09/2019	03/09/2019	30/04/2023	Ongoing	Ongoing	Ongoing (in line with Action 15)
Contracts and Commissioning Annual Report	£123,242,747.00	Commissioning	HSCP.19.062	IJB 191119	J. Stewart-Coxon	ACC	03/12/2019	01/04/2020	30/09/2024	Ongoing	Ongoing	Ongoing review of commissioned services, annual workplans
Grant to Voluntary Organisation	£276,000.00	Grant Award	HSCP.19.073	IJB 191119	A. McKenzie	ACC	03/12/2019	01/01/2020	31/12/2023	Ongoing	Ongoing	Ongoing review of commissioned services, annual workplans
Supplementary Work Plan Report	£2,852,417.00	Commissioning	HSCP.19.121	IJB 240320	J. Stewart-Coxon	ACC	05/02/2020	01/04/2020	31/08/2024	Ongoing	Ongoing	Ongoing review of commissioned services, annual workplans
Supplementary Work Plan Report	£3,616,748	Commissioning	HSCP.20.001	IJB 090620	J. Stewart-Coxon	ACC	26/06/2020	01/07/2020	30/06/2022	Ongoing	Ongoing	Ongoing review of commissioned services, annual workplans
Grant to Independents	£394,371.00	Grant Award	HSCP.20.002	IJB 090620	A.McKenzie	ACC	26/06/2020	31/07/2020	30/07/2023	Ongoing	Ongoing	Ongoing review of commissioned services, annual workplans
Frailty Pathway Redesign – Re-Registration	ACHSCP Adult Social Care Budget - Existing	Commissioning	HSCP.20.052	IJB 021020	A. Stephen	ACC	21/10/2020	02/10/2020	31/03/2022	Ongoing	Completed	Direction of October 2020 for re-registration rescinded and replaced with Direction for new model of service delivery at Rosewell House (Report reference HSCP.21.088 below)
Financial Update and Approvals - National Care Homes	£12,950,000.00	Commissioning	HSCP.20.053	IJB 021020	A. Stephen	ACC	21/10/2020	02/10/2020	31/03/2024	Ongoing	Ongoing	Revised contract value
Transformation - Decisions Required: Action 15 (Prison)	£194,786 (for 4 years)	Transformation Decisions Required	HSCP.20.050	IJB 281020	S. Macleod	NHSG	13/01/2021	28/10/2020		Ongoing	Ongoing	Progressing recruitment/service delivery
Transformation - Decisions Required: Action 15 (First Contact)	£1,462,733 (for 4 years)	Transformation Decisions Required	HSCP.20.051	IJB 281020	S. Macleod	NHSG	13/01/2021	28/10/2020	01/01/2024	Ongoing	Completed	See Supplementary Plan below (Report reference HSCP.21.069)
Aberdeen City Primary Care Sustainability Programme (Stage 1 – 2C Remodelling)	£5,773,129.00	Commissioning	HSCP.20.049	IJB 011220	S. Macleod	NHSG	13/01/2021	01/12/2020	01/06/2021	Ongoing	Completed	Contract award completed 7 June 2021;work progressing on the transition to new providers.
Alcohol Drug Partnership Update (Blood Borne Viruses)	£65,000.00	Commissioning	HSCP.20.068	IJB 011220	S. Macleod	ACC	13/01/2021	01/12/2020	Ongoing	Ongoing	Ongoing	Progressing, no specified end date for expenditure
Alcohol Drug Partnership Update (Blood Borne Viruses)	£65,000.00	Commissioning	HSCP.20.068	IJB 011220	S. Macleod	NHSG	13/01/2021	01/12/2020	Ongoing	Ongoing	Ongoing	Progressing, no specified end date for expenditure
Alcohol Drug Partnership Update (tele-health care tech)	£70,000.00	Commissioning	HSCP.20.068	IJB 011220	S. Macleod	ACC	13/01/2021	01/12/2020	Ongoing	Ongoing	Ongoing	Progressing, no specified end date for expenditure
Alcohol Drug Partnership Update (tele-health care tech)	£70,000.00	Commissioning	HSCP.20.068	IJB 011220	S. Macleod	NHSG	13/01/2021	01/12/2020	Ongoing	Ongoing	Ongoing	Progressing, no specified end date for expenditure
Annual Procurement Plan	£56,205,827 -sourced from various budgets	Commissioning	HSCP.21.008	IJB 230221	J. Stewart-Coxon	ACC	23/02/2021	01/04/2021	30/09/2026	Ongoing	Ongoing	Ongoing review of commissioned services, annual workplans
Medium Term Financial Framework (MTFF)	The associated budget for these functions and services is £237m of which £23m relates to Aberdeen City's share for services to be hosted. £46m is set aside for large hospital services.	Commissioning	HSCP.21.025	IJB 230221	A. Stephen	NHSG	23/02/2021	01/04/2021	31/03/2022	Ongoing	Ongoing	Updated Annually
Medium Term Financial Framework (MTFF)	£97,029,000.00	Commissioning	HSCP.21.025	IJB 230221	A. Stephen	ACC	23/02/2021	01/04/2021	31/03/2022	Ongoing	Ongoing	Updated Annually
Grant funding to counselling services 2021-22	£199,224.00	Commissioning	HSCP.21.021	IJB 230321	S. MacLeod	ACC	23/02/2021	01/04/2021	31/03/2022	Ongoing	Ongoing	Annual award of grant funding
Supplementary Procurement Plan - Tender for a First Contact Mental Health and Wellbeing Service	£1,462,733.00	Commissioning	HSCP.21.045	IJB 250521	S. Macleod	ACC	15/06/2021	01/09/2021	31/08/2025	N/A	Ongoing	Budget from Scottish Government (Action 15) provided to HSCPs for the delivery of the National Mental Health Strategy. Contract in place.
Community Nursing Digitalisation	From existing budgets and change fund. Net Cost £390,924.78	Commissioning	HSCP.21.069	IJB 250521	A. Stephen	NHSG	15/06/2021	25/05/2021	25/05/2024	N/A	Ongoing	Procurement of a digital solution to support the modernisation of the delivery of Community Nursing Services.
Immunisation Blueprint Refresh	£55,558,291.81	Commissioning	HSCP.21.066	IJB 240821	F. Mitchelhill	NHSG	24/08/2021	24/08/2021	Ongoing	N/A	Ongoing	To develop and implement the New Service Delivery Model for vaccination services from 2021 (including flu and covid boosters).
Navigator - Unscheduled Care	From existing budgets: Year 1 - £72,000.00; Year 2 - £74,160.00	Commissioning	HSCP.21.086	IJB 240821	A.Stephen	NHSG	24/08/2021	01/10/2021	30/09/2023	N/A	Ongoing	Navigator service to be embedded within the Emergency Department as a test of change for two years.
Rosewell House - Frailty Pathway	From existing budgets - Net Cost £5,598,300.00	Commissioning	HSCP.21.088	IJB 240821	S. Macleod	ACC	24/08/2021	23/10/2021	23/10/2023	N/A	Ongoing	Provide an integrated, intermediate care facility by NHSG and ACC, delivered in partnership with Bon Accord Care.
Rosewell House - Frailty Pathway - Provide an integrated, intermediate care facility by NHSG and ACC, delivered in partnership with Bon Accord Care	From existing budgets - Net Cost £5,598,300.00	Commissioning	HSCP.21.088	IJB 240821	S. Macleod	NHSG	24/08/2021	23/10/2021	23/10/2023	N/A	Ongoing	Provide an integrated, intermediate care facility by NHSG and ACC, delivered in partnership with Bon Accord Care.
Technology Fund	HSCP Budget - £480,000	Grant Award	HSCP.21.087	IJB 240821	S. Macleod	ACC	24/08/2021	01/11/2020	31/10/2022	N/A	Ongoing	Fund available in support of Care at Home and Supported Living Services
Aberdeen Links Service	Primary Care Improvement Fund £985,575.00	Commissioning	HSCP.21.089	IJB 240821	S. Macleod	ACC	24/08/2021	08/01/2022	31/03/2023	N/A	Ongoing	Continuity of provision of Aberdeen Links Service (ALS)

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

Date of Meeting	23 September 2021
Report Title	Primary Care Improvement Plan (Progress to Date)
Report Number	HSCP.21.106
Lead Officer	Emma King, Lead for Primary Care
Report Author Details	Sarah Gibbon, Programme Manager
Consultation Checklist Completed	Yes
Appendices	Appendix A - PCIP Update for EPB August 2021 Appendix B - Copy of GMS MoU 2

1. Purpose of the Report

1.1. This report presents the Risk, Audit & Performance Committee (RAPC) with an update regarding progress implementing the Primary Care Improvement Plan (PCIP).

1.2. It also presents a paper, which was considered by the Executive Programme Board in early September 2021, which outlines the potential impact of the revised Memorandum of Understanding (MoU) on delivery.

2. Recommendations

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

a) Note the update presented on the PCIP, as outlined in this report and its appendices.

b) Requests that a further PCIP update is presented to the committee in Spring 2022 (unless required by exception).

c) Notes that an additional report will be presented to the Integration Joint Board at its meeting on 02 November 2021, with a supporting seminar on wider primary care to be delivered prior to the meeting.

3. Summary of Key Information

Background

3.1. The PCIP sets out how the Partnership intends to transform general practice services, utilising the Primary Care Improvement Fund (PCIF) to release capacity of General Practitioners to allow them to undertake their role as Expert Medical Generalists as set out in the new General Medical Services Contract. The initial PCIP was approved by IJB on 28 August 2018.

PCIP Implementation Update

The following services are being delivered as a part of the PCIP programme:

Vaccination Transformation Programme

3.2. Pre-school vaccinations, the school-based vaccination programme and the influenza programme have all been transferred successfully from GP practice delivery. The travel vaccination and At-Risk age group services are on track to be transferred by the end of March 2022. A refreshed Immunisation Blueprint was approved by the IJB on 24 August 2021. The vaccination programme will focus on a vaccination centre in the central locality (recently confirmed at the former site of John Lewis), supported by smaller venues in the North (Bridge of Don) and South (Airyhall) localities. Pop-up clinics will also be used to support uptake.

Pharmacotherapy

3.3. The model for pharmacotherapy delivery is based on 1 WTE pharmacy staff member per 10,000 population, with a skill mix of 60% pharmacist and 40% pharmacy technician time. Recruitment to the pharmacotherapy team is ongoing.

Community Treatment & Care (CTAC) Services

3.4. CTAC services will be delivered in a hub-and-spoke model, focusing on practice-based delivery supported by centralised hubs of CTAC services in each locality. Transfer of the practice-based CTAC services was completed in May 2021. This involved the TUPE transfer of existing staff from practice employment to NHS Grampian (NHSG) employment. A Doppler ABPI[1] clinic is in development with the podiatry service. Colleagues are identifying capacity within the existing ACHSCP estate to deliver services from hubs – this will focus on providing services across the GP practices and will allow for the specialisation of some services such as ear suction. Initial conversations with secondary care colleagues are taking place to identify how CTAC services can be aligned with the secondary care phlebotomy work.

Urgent Care

3.5. All GP practices within Aberdeen City now have access to the City Visits service. There is an ongoing recruitment drive for both Health Care Support Workers and Advanced Clinical Practitioners.

Community Link Workers

3.6. The Aberdeen Links service is well-established, with over 5,000 referrals received by the service since the commencement of the service in 2018. They have also made 6,588 onwards referrals to over 400 community-based services or resources. On 24 August 2021 the IJB approved a direct award to the Scottish Association of Mental Health (SAMH) until March 2023. This allows further stabilisation for the service in a time where it is anticipated that it will experience increased demand, as well as allowing the future re-tender to consider any implications of any changes from the Scottish Government Independent Review of Adult Social Care (Feeley) report.

Additional Professional Roles

3.7. PCIP also funds the following additional professional roles (only a partial contribution to the psychological therapist service, which is also funded by Scottish Government via Action 15.

a) *MSK Physiotherapy First Contact Practitioners:* Services are now being provided to 10 GP practices within the City. A member of the team has recently passed their non-medical prescribing course, which will allow

[1] Doppler is a service which checks the circulation of blood flow to the legs and feet.

further service development. A rolling programme of recruitment will allow the service to expand to further practices as additional staff join the team.

b) *Psychological Therapists:* The team is now at full establishment and are working to reduce waiting times, with positive effect. Patients are still being seen virtually, by phone or video, and the team are keen to get back into practice when it is safe to do so.

Memorandum of Understanding (MoU)

3.8. A new Memorandum of Understanding (MOU 2021-2023) for the General Medical Services (GMS) contract implementation for Primary Care Improvement has been published, taking into account the learning and experience to inform next iteration.

3.9. Appendix A presents a report submitted to the Executive Programme Board on 02 September 2021, outlining the implications of the MoU on the projects within the PCIP Programme. A copy of the MoU is provided at Appendix B.

3.10. The new MoU also makes provision for transitionary payments to be made to practices, from the PCIF, and any associated reserves. At the time of drafting this report, meetings were ongoing with Scottish Government representatives to understand how exactly the transitionary payments should be allocated and whether a formula will be provided to calculate the levels of payment required. It is hoped that advice and guidance will be provided to HSCPs in early autumn 2021. Colleagues from ACHSCP are represented as appropriate at these meetings.

Underspend Proposals

3.11. Colleagues from the PCIP Implementation Group have developed a series of proposals for allocating the accumulated underspend to non-recurring projects or investments. They have been developed by the services and evaluated and scored by a sub-set of the PCIP group. The scoring reflected the prioritisation of the PCIP projects (CTAC, pharmacy & immunisations) as a part of the evaluation. The GP Sub Committee were due to consider the proposal on the 16th of August, but the discussion had to be deferred to their 20th September meeting. Proposals included:

- Promotion campaign for Pharmacy 1st – *this has also been expanded to include wider messaging around the changes which implementing PCIP will mean for patients.*
- Pharmacotherapy IT equipment
- CTAC Hub equipment
- Doppler (ABPI) equipment
- Leadership training for practices
- Coaching training for practices
- Dedicated PCIP programme management support
- Immunisations IT equipment
- City Visits equipment
- Additional funding for back-scanning paper records in practices
- Funding for non-medical prescriber courses and supervision
- Clinical and/or non-clinical rooms at Torry Community Hub
- Additional staffing resource for vaccination transformation programme
- Mobile unit for delivery of PCIP services such as CTAC and immunisation

3.12. Proposals developed reflected the learning curve in the implementation of the PCIP, identifying resource required in relation to programme management and immunisations, which reflects a maturity of thinking and that there is a need for more management to ensure timely delivery of the PCIP outcomes.

3.13. The proposals were considered by the GP Sub Committee at their meeting on 20 September 2021.

Consultation and Engagement Activities

3.14. Overall, the implementation of the PCIP will change how patients access specific services in primary care, which will change the public's experience of primary care. There has been a lot of consultation and engagement work, both locally and nationally, to understand patients' perspectives and how the PCIP will affect them.

3.15. National surveys and consultations include the Health & Care Experience survey; the 'Creating a Healthier Scotland' survey and 'What Should Primary Care Look like for the Next Generation" survey.

Service	Activity	Date
CTAC	Patient Survey (over 700 respondents); focus groups; discussions with locality empowerment groups; GP practice workshops	Autumn 2020
Pharmacotherapy	No noticeable difference from a patient perspective as it is a 'behind the scenes' service	NA
Immunisations	Patient survey (over 250 respondents) engagement sessions[2]	Spring 2021
Link Workers	Interim evaluation gathered patient perspectives of impact and demonstrated improvement from baseline to 6 month follow up	Summer 2019
MSK FCP Physios	Patient feedback methods are in development and will be implemented shortly	Autumn 2021
Psychological Therapists	Patient experience questionnaires post-therapy. PHD student research	Ongoing
Urgent Care	Evaluation of the West Visits pilot service (precursor to the City Visits) ; ongoing patient feedback gathered.	2018

4. Implications for IJB

4.1. **Equalities, Fairer Scotland Duty, Health Inequalities:** The National Health Service (General Medical Services Contracts)(Scotland) Regulations 2018 (GMS) has had a comprehensive, nationally led Equalities Impact Assessment completed and can be accessed here: https://www.legislation.gov.uk/ssi/2018/66/pdfs/ssieqia_20180066_en.pdf This is applicable to the PCIP Programme. Individual projects will have Health Inequality Impact Assessments completed for them as required.

4.2. **Financial:** There is specific ringfenced funding available in respect to the implementation of the Primary Care Improvement Plan. Whilst the funding is currently non-recurring, HSCPs have been advised by Scottish Government to plan delivery as if the funding was recurrent. A high-level summary of the available funding allocated to deliver the PCIP is as set out in the table below. It demonstrates a large underspend, which the PCIP Implementation group has developed proposals for one-off or non-recurring projects to help PCIP delivery. It should be noted that any

[2] There were also a number of additional events / surveys related specifically to Covid19 vaccinations, but the lessons learned can be applied to the PCIP vaccinations where appropriate. These included community leaders meetings; 18-29 years survey; and public focus groups.

transitional arrangements paid to practices in light of the new MoU may also need to be funding from the PCIF underspend.

Budget allocation	2020/21	2021/22	2022/23
Total Available Funding	**5055**	**6234**	**7630**
Commitments			
Vaccinations	496	905	1100
Pharmacotherapy	723	1078	1344
CTAC	68	500	1577
Link Workers	787	790	850
Additional Professional Roles			
MSK FCP Physio	202	533	876
Visiting Service	242	547	763
Total Recurring Commitment	**2518**	**4353**	**6510**
Total surplus/(deficit)*	**2537**	**1881**	**1120**

**funding received AND carried forward to next year*

4.3. **Workforce:** There is ongoing recruitment to acquire the appropriate workforce to support implementation of the PCIP. This is progressed by each service, with an overview by the PCIP implementation, and is detailed for some services in appendix A.

4.4. **Legal:** The PCIP seeks to provide the capacity within General Practice to support the implementation of the new GMS Contract. Any commissioning and procurement of services is required to implement the plan has and will continue to be progressed in a compliant manner.

4.5. **Carers:** There are no direct implications of implementing the PCIP for carers, however they and their cared for person will benefit from increased capacity of GPs to act as expert medical generalists, and from the increased range of services available in primary care.

4.6. **Covid19:** Delivery of the immunisation element of PCIP will need to be aligned with longer-term delivery of Covid19 immunisations and boosters (though funded separately).

4.7. **Other:** NA

RISK, AUDIT AND PERFORMANCE COMMITTEE

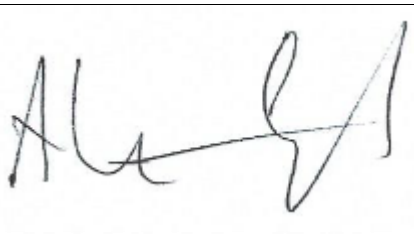
5. Links to ACHSCP Strategic Plan

5.1. The PCIP is identified as a key delivery plan within the ACHSCP Strategic Plan. It is also identified as a key priority within the strategic plan, demonstrating the importance of delivery of the PCIP to achieving ACHSCP's strategic aims and objectives, particularly to "*reshape our community and primary care sectors".*

6. Management of Risk

6.1. **Identified risks(s) and link to risks on strategic or operational risk register:** 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.

6.2. **How might the content of this report impact or mitigate these risks:** As recorded in the strategic risk register, delivery of the PCIP (and subsequently the implementation of the GMS contract) is a mitigating action against the risk identified above.

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

Aberdeen City Health & Social Care Partnership
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Primary Care Improvement Plan

Update for EPB 02 September 2021

Contents

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Submission Dates:

1. **Issued to Project Leads:** 23rd July 2021
2. **PCIP Group meeting:** 10th August 2021
3. **Executive Programme Board**: 2nd of September

Introduction

A new memorandum of understanding (MOU 2021-2023) for the GMS contract implementation for Primary Care Improvement has been published, taking into account the learning and experience to inform next iteration. The MoU2 is accessible via. this link. Progress will be reviewed in March 2022.

All six MoU areas remain areas of focus, however, the focus for 2021-22 should be on the following three priority services:

1. Vaccination Transformation Programme
2. Community Treatment & Care (CTAC) Services
3. Pharmacotherapy Service

Funding

Integration Authorities should endeavour to ensure that ring-fenced Primary Care Improvement Fund ("PCIF") funding supports the delivery of the three priority areas for 2021-22 before further investment of PCIF monies in the other MoU commitments.

Transitionary Arrangements

The MoU also describes the arrangements for transitionary payments to practices as the MoU is delivered. The funding for the transitionary payments will come out of the PCIF and any associated reservices.

Colleagues are currently trying to understand whether we will be provided with national guidance on determining the levels of transitionary payments to be made to practices.

There are several queries:

1. What if practices have fully developed access other services i.e. Link Practitioners?
2. What if the practice does not have the service due to a resignation from an existing team member i.e. a natural vacancy?

At the time of drafting this report, these queries were being discussed with colleagues from Scottish Government.

Underspend Proposals

Colleagues from the PCIP Implementation Group have developed a series of proposals for allocating the accumulated underspend to non-recurring projects or investments. They have been developed by the services and evaluated and scored by a sub-set of the PCIP group. The scoring reflected the prioritisation of the PCIP projects as a part of the evaluation. The GP Sub Committee were due to consider the proposal on the 16th of August, but the discussion had to be deferred to their September meeting. Proposals included:

- Promotion campaign for Pharmacy 1st
- Pharmacotherapy IT equipment
- CTAC Hub equipment
- Doppler (ABPI) equipment
- Leadership training for practices
- Coaching training for practices
- Dedicated PCIP programme management support
- Immunisations IT equipment
- City Visits equipment
- Additional funding for back-scanning paper records in practices
- Funding for non-medical prescribers courses and supervision
- Clinical and/or non clinical rooms at Torry Community Hub
- Additional staffing resource for vaccination transformation programme
- Mobile unit for delivery of PCIP services such as CTAC and immunisation

Vaccination Transformation Programme

MOU Summary

- The programme should be implemented in full by April 2022
- Child Immunisations & vaccines / immunisation additional services to be removed from GMS contract in October 2021.
- All historic income from vaccinations will transfer to Global sum in April 22.
- Travel Health Group to determine solution for travel vaccinations by October 2021, and to be in place by April 2022.

Programme Overview

Current Position
Pre-school vaccinations, the school-based vaccination programme and the influenza programme have all been transferred successfully from GP practice delivery. The travel vaccination and At-Risk age group services are on track to be transferred by the end of March 2022. A refreshed Immunisation Blueprint was approved by the Integration Joint Board (IJB) on 24 August 2021. The vaccination programme will focus on a mass vaccination centre in the Central locality (recently confirmed at the former site of John Lewis), supported by smaller venues in the North (Bridge of Don) and South (Airyhall) localities. Pop-up clinics will also be used to support uptake.
Impact of the new MoU
ACHSCP have already successfully transferred child immunisations & vaccines, which are due to be removed from the GMS contract in October. Await outcomes of the travel health group and ensure solutions for travel vaccinations is in-line with this.
Next steps for implementation
Next steps: 1. Transfers of travel vaccination and at-risk age group services by end of March 2022 to ensure full delivery by timescales indicated in the MoU. 2. Additional resource for VTP has been identified in work on the PCIP Underspend Proposals. In line with the MoU, this should be prioritised ahead of spend on other non-priority elements of PCIP. Possible barriers to implementation: *Recruitment & workforce – mitigations for inability to recruit*

Pharmacotherapy

MOU Summary

- Focus on delivery of a pharmacotherapy service as a whole to ensure interdependencies between Level One service and Level 2/3
- Regulations amended by SG in early 2022 so that NHS board is responsible for service by April 22.

Programme Overview

Current Position
Working on the agreed model of 1WTE pharmacy staff member per 10,000 population (+25% additional to cover for leave). Recruitment outstanding: • 5.5 WTE Band 5 technicians • 1 WTE Band 7 pharmacist • 2.4WTE Band 8a pharmacist Confident in recruiting to the pharmacist posts. Full recruitment to remaining technician posts is unlikely due to shortage of available, trained workforce. From national discussions, the view is that a model of 2.5WTE pharmacy staff per 5,000 population is closer to what would be required for full delivery of Level 1 services.
Impact of the new MoU
• New MOU recognises that a balance between Level 1, 2, and 3 services is important for delivery of a sustainable service and for recruitment & retention to the team. This would seem to allow a move away from a total focus on Level 1 services and look at delivery of the service as a whole. • Highlights the need for national workforce plans that reflect the staffing requirements to deliver the pharmacotherapy service. • Further information and guidance from the national Pharmacotherapy Strategic Implementation Group should support a consistent 'direction of travel' in terms of delivery of the service across NHS Scotland. This would be welcomed as currently there is a wide range of staffing models and delivery of services.
Next steps for implementation
Next steps: • Revised MOU will be on the agenda at the next NHS Grampian Pharmacotherapy Service Development Group as there is a need to fully consider the implications (as 'NHS Boards' are responsible for providing the service to practices by April 22) • Discussion required on whether finance could / should be diverted from other areas of the PCIP to provide additional resource for pharmacotherapy. Possible barriers to implementation: 1. **Technician workforce:** Inability to recruit the required number of trained pharmacy technicians despite multiple rounds of recruitment. MOU highlights that Level One service should be delivered principally by pharmacy technicians rather than pharmacists. **Mitigation:** continuing to pursue the proposal to use PCIP funding for trainee pharmacy technician posts. National workforce plans should include a pharmacy technician training pipeline. 2. **Physical Hub:** Challenges in finding physical hub accommodation for the additional +25% staffing that will provide partial cover for periods of leave ('relief' cover would have to be provided remotely). **Mitigation:** currently being scoped

Community Treatment & Care (CTAC) Services

MOU Summary

- Regulations amended by SG in early 2022 so NHS board responsible for service by April 22.
- Given this service draws primarily on a nursing workforce, local areas should also consider how CTAC and the Vaccination Transformation Programme could be aligned to increase the pace of implementation and efficiency.

Programme Overview

Current Position
• All practices in Aberdeen City have partial access to a CTAC service. All existing staff whose role primarily delivering CTAC services have been TUPE'd into NHS Grampian employment as of May 2021. • A successful test of change delivered a temporary 'hub' to cover a period of high annual leave within the practices. • The CTAC team lead is working to deliver the doppler clinic.
Impact of the new MoU
• The new MoU highlighted that this is a priority for delivery, so CTAC services should be higher priority within the infrastructure group priorities. • Closer working is required with the vaccination transformation programme and with secondary care phlebotomy hubs
Next steps for implementation
Next steps: Work is ongoing to develop the supporting 'hub' element of the CTAC service model. Key priorities will be identifying suitable premises within the ACHSCP and designing the supporting IT solutions for appointments and information sharing. • CTAC services will need prioritised in premises allocations to facilitate delivery by April 2022. • Additional funding will be required to adopt IT solution, ideally working on a pan-Grampian basis Previous recruitment into the CTAC service has attracted a high volume of applicants at HCSW level , so recruitment is not anticipated to be a challenge for implementation. Discussion required on whether finance could / should be diverted from other areas of the PCIP to provide additional resource for CTAC service delivery. Additional resource for CTAC has been identified in work on the PCIP Underspend Proposals. In line with the MoU, this should be prioritised ahead of spend on other non-priority elements of PCIP. Possible barriers to implementation: • **IT systems solution** – proposal to explore dedicated IT project support resource • **Identification of suitable premises** – proposal to prioritise the CTAC service within the primary care premises group (alongside VTP / Pharm as per priorities)

Other

MOU Summary (Overall)

- Plans for Urgent Care, Community Link Workers and Additional Professional roles should continue and services already in place should be maintained, but the expectation for 2021-

22 is that their further development, where required, may progress at a slower pace to allow the commitments around VTP, CTAC and pharmacotherapy to be accelerated.

Urgent Care

MOU Summary (Urgent Care)

- The Scottish Government will bring forward secondary legislation so that Boards are responsible for providing an Urgent Care service from 2023-24.

Programme Overview

Current Position
23 GP Practices across Aberdeen now have access to the Urgent Care City Visiting Service which provides home visits to those patients with an urgent, unscheduled need. Workforce: • This service is provided by 4.5 wte Advanced Clinical Practitioners (ACP). • There are 5.5wte ACP vacancies. • The team have access to 2 fully equipped GMED Out of Hours service cars only. • 1.0wte Band 7 ACP post has been redesigned to provide 2.0wte Band 3 healthcare support worker roles. These HCSWs undertake urgent bloods, observations and monitoring which supports GPs with diagnosis following telephone / video consultations. The HCSW function is currently provided to those GP practices not yet accessing the ACP City Visiting service. The original evaluation of the pilot service highlighted the benefit of the Advanced Nurse Practitioner (ANP) attending with access to drug box should immediate drug therapy be required, venepuncture and other clinical equipment. The current team only have access to 2 drug boxes (from the GMED cars), the rest of the team providing only diagnosis and prescriptions.
Impact of the new MoU
The new MoU states that it will be the responsibility of NHS Boards to provide an Urgent Care service therefore further planning and development of the City Visiting service needs to be linked with local ongoing work in relation to the Redesign of Urgent Care services
Next steps for implementation
Next steps: Recruitment process currently ongoing to recruit 4.5wte ACPs and 1.0wte ACP position will a rotational post for an Advanced Paramedic Practitioner from the Scottish Ambulance Service Possible barriers to implementation: • Lack of available suitably qualified Advanced Clinical Practitioner workforce. *Mitigation*: Recruit to trainee posts under Annexe 21 conditions • Lack of clinical equipment and drugs as well as lack of storage facilities for storage of medicines. *Mitigation:* Allocate use of drug boxes/GMED cars on basis of triage of referrals. Lack of permanent staff base – the team are currently located in a temporary base at Woodend Hospital in a room in a closed ward, with no telephone/computer ports or appropriate facilities (e.g. storage, printer, blood label machines) *Mitigation*: Remaining close by to the Hospital at Home (H@H) team means they can share some facilities. Future planning needs to consider co-location with appropriate clinical services (e.g. H@H, GMED/OOH services)

Community Link Workers

MOU Summary (Community Link Workers)

- Consideration will need to be given by April 2022 as to how the Link Worker workforce interfaces with the Scottish Government's commitment to delivering 1,000 Mental Health Link Workers by the end of this Parliament

Programme Overview

Current Position
Aberdeen City has fully established Link Worker programme, delivered by SAMH, which has been successfully running for a number of years. A business case will be presented to the IJB. This is for direct award for 15 months b which will allow time to understand the impact of the commitment Scottish Government is keen to support a national CLW network, which will help to further develop the CLW programme of work. Initial scoping of a group has been undertaken on behalf of SG. This group could also help to shape the Scottish Government's commitment in relation to 1000 mental health link workers and what the CLW role means for this new commitment.
Impact of the new MoU
This is still being explored and it isn't clear yet whether these link workers will be building on the current programme or be additional workers
Next steps for implementation
Next steps: Explore the links between the local programmes that could impact on the Mental Health Link Workers and how they can be aligned to maximise impact. *Recruitment & workforce – mitigations for inability to recruit*

Additional Professional Roles

MOU Summary (Additional Professional Roles)

Programme Overview

Current Position
Aberdeen City has now employed the following First Contact Practitioners (FCP): • 2 x Band 8A's (2.0 WTE) • 7 x Band 7's (5.2 WTE), one of which is off on maternity leave and another 0.5 WTE awaiting a confirmed start date. We currently cover the following surgeries: • Torry - 4 sessions • Cove and Kincorth – 7 sessions • Elmbank – 5 sessions (2 not covered due to M/L) • Gilbert Road – 5 sessions

- Danestone – 3 sessions
- Carden – 4 sessions
- Rubislaw – 4 sessions
- Calsayseat - 4 sessions
- Oldmachar – 5 sessions

We are about to start 2 new staff into patient facing FCP roles in the next 2-3 weeks, to enable Oldmachar to increase to 9 sessions and also look at starting in Hamilton medical practice once further discussions take place.

Currently awaiting a further round of interviews/applications in near future.

Currently have 1 FCP successfully completed Non-Medical Prescriber course and another Band 8 FCP hoping to start in September- reduce further workload to rest of MDT for prescription requests/describing etc.

Impact of the new MoU

Unsure how it will impact FCP, current funding was agreed with increase in year 4 for further staff employment. Current roll out plan is discussed regularly with representatives from practice management and GP colleagues.

Next steps for implementation

Next steps:
Identify further appropriate staff from interview process.
Identify surgeries for staff to work in.

Further roll out is based on needs within localities and are done in a way to ensure equity across the city as best as possible

Possible barriers to implementation:
Recruitment can be troublesome as staff needed for FCP level are of Band 7 level.
Available workforce/successful recruitment. Funding available to support courses. Space in GP practices for implementing FCP services- Carden has previously offered use of the triage room as a potential FCP Hub area if needed although being part of the MDT on site for at least some of the sessions would be ideal.

Recruitment & workforce – mitigations for inability to recruit

Programme-wide limitations / barriers

- **Recruitment & Workforce** – there is a common theme of difficulty to recruit into certain roles such as pharmacy technicians / physiotherapy etc. Mitigations include developing alternative skills mixes; recruitment campaigns etc. However recruitment does drive the speed of delivery in some cases.

- **Infrastructure & Estates Capacity** – there is a limited estate for the new workforce, and competing priorities (including with acute phlebotomy hubs and other clinics). Many

practices do not have space to support hosting the additional services in practice. Mitigations include: remote working

- **IT solutions –** world-wide shortage of semi-conductors is impacting delivery of IT kit for proposals within the PCIP programme, for example for setting up a pharmacy hub or support remote working.

Governance Updates

Ensuring links to GMS Oversight group to keep linked in nationally

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Memorandum of Understanding (MoU) 2

GMS Contract Implementation for Primary Care Improvement – Agreement between Scottish Government, British Medical Association (BMA), Integration Authorities (IAs) and NHS Boards

Introduction

The 2018 GP Contract Offer ("the Contract Offer") and its associated Memorandum of Understanding ("MoU") was a landmark in the reform of primary care in Scotland. The principles and values expressed in it remain undiminished, and three years on we now have considerable learning and experience to draw on to inform this next iteration of the MoU. Our key aim remains expanding and enhancing multidisciplinary team working to help support the role of GPs as Expert Medical Generalists, to improve patient outcomes. We remain committed to a vision of general practice and primary care being at the heart of the healthcare system where multidisciplinary teams come together to inform, empower, and deliver services in communities for those people in need of care.

This revised MoU for the period 2021-2023 between the Scottish Government, the Scottish General Practitioners Committee of the British Medical Association (SGPC), Integration Authorities and NHS Boards refreshes the previous MoU between these parties signed on 10 December 2017. The MoU Parties recognise we have achieved a great deal and it is important we do not lose sight of that. But we must recognise we still have a considerable way to go to fully deliver the GP Contract Offer commitments originally intended to be delivered by April 2021. It also reflects the early lessons as we continue to respond collectively to the Covid-19 pandemic, recognising the full extent of its impact is still to be understood. While this MoU runs until 31 March 2023, the National GMS Oversight Group will review progress in March 2022 to ensure it remains responsive to the latest situation.

The focus of this renewed Memorandum of Understanding remains the delivery of the General Practice Contract Offer, specifically the transfer of the provision of services from general practice to HSCP/Health Boards. Delivery of the GP Contract Offer should be considered in the wider context of the Scottish Government's remobilisation and change programme across the Scottish national health and social care landscape, including the four overarching Care and Wellbeing Programmes and the National Care Service (NCS). These programmes encompass Place, Preventative and Proactive Care, Unscheduled and Integrated Planned Care and together with the NCS seek to improve national system wide outcomes for population health, connect better with citizens and remove silos between health and other public sector bodies, and reduce health inequalities. The National GMS Oversight Group will consider at a national level the synergies between these Programmes of work and delivery of the GP Contract Offer. The National GMS Oversight Group will proactively develop policy and funding proposals to improve healthcare system co-ordination, collaboration, and patient outcomes.

Priorities

Multidisciplinary Team – Prioritised Services for 2021/22

Implementation of multidisciplinary team working should remain underpinned by the seven key principles outlined in the previous MoU: safe, person-centred, equitable, outcome focussed, effective, sustainable, affordable and value for money.

All six MoU areas remain areas of focus for the MoU signatories. However, following the joint SG/SGPC letter of December 2020, the parties acknowledge that the focus for 2021-22 should be on the following three services.

Vaccination Transformation Programme

GP practices will not provide any vaccinations under their core contract from 1 April 2022. All vaccines provided under Additional Services will be removed from the Additional Services Schedules of the GMS Contract and PMS Agreement regulations in October 2021. All historic income from vaccinations will transfer to the Global Sum in April 2022 including that from the five historic vaccination Directed Enhanced Services. The Vaccine and Immunisations Additional Service is broader than the Travel Vaccinations that are part of the Vaccination Transformation Programme. The Travel Health sub-group will consider how these remaining vaccinations[1] will be transferred from GP delivery.

Boards have assumed overall logistical responsibility for implementing vaccination programmes, facilitated through national digital solutions such as the vaccination management tool and NVSS appointment system. Learning from the delivery of last year's adult seasonal flu and pneumococcal programme, as well as the ongoing Covid-19 vaccination programme, should be capitalised on to ensure the implementation of the programme in full by April 2022.

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[1] Note that additional service vaccines relate only and specifically to:

Anthrax – to be offered to those identified as coming into contact with an identifiable risk of Anthrax, mainly those coming into contact with imported animal products

Hepatitis A – for those in residential care or an educational establishment who risk exposure if immunisation is recommended by the local director of public health

Measles, Mumps and Rubella (MMR) – For women who may become but are not pregnant and are sero-negative and for male staff working in ante-natal clinics who are sero-negative

Paratyphoid – Note no vaccine currently exists

Rabies (pre-exposure) – For lab workers handling rabies virus; bat handlers; and persons who regularly handle imported animals

Smallpox – Note the vaccine exists but is not available to contractors

Typhoid – For hospital doctors, nurses and other staff likely to come into contact with cases of typhoid and lab staff likely to handle material contaminated with typhoid organisms

Although general practice should not be the default provider of vaccinations, we understand that a very small number of practices may still be involved in the delivery of some vaccinations in 2022-23 and thereafter. There will be transitionary service arrangements in the regulations for practices in areas where the programme is not fully complete as well as permanent arrangements for those remote practices, identified by the options appraisal, where there are no sustainable alternatives to practice delivery.

The Travel Health sub-group will be reconvened to develop a Once for Scotland solution with substantial input from local areas, particularly on delivery of travel vaccinations. This solution will be determined by October 2021 and put in place by April 2022. This will also be covered by transitional arrangements in the regulations.

GPs will retain responsibility for providing travel advice to patients where their clinical condition requires individual consideration.

Pharmacotherapy

All parties acknowledge the progress that has been made with the majority of practices receiving some pharmacotherapy support.

Managing acute and repeat prescriptions, medicines reconciliation, and the use of serial prescribing (which form a substantive part of the level one service described in the GP Contract Offer) should be delivered principally by pharmacy technicians, pharmacy support workers, managerial, and administrative staff. Progress with all parts of the level one service should be prioritised to deliver a more manageable GP workload.

In tandem, focus on high-risk medicines and high risk patients, working with patients and using regular medication and polypharmacy reviews to ensure effective person-centred care are being delivered principally by pharmacists (the levels two and three described in the Contract Offer). This is helping manage this demand within GP practices and developing a sustainable service which will attract and retain pharmacists and further develop MDT working in Primary Care.

Whilst the Contract Offer and Joint Letter emphasise implementing the level one pharmacotherapy service, there are interdependencies between all three levels that require focus on the delivery of the pharmacotherapy service as a whole.

Regulations will be amended by Scottish Government in early 2022 so that NHS Boards are responsible for providing a pharmacotherapy service to patients and practices by April 2022. The use of medicines to treat and care for patients will remain an important part of GP work. The delivery of electronic prescribing is an essential requirement for all involved in prescribing, which will be prioritised by the ePharmacy Programme Board, supported by National Services Scotland and the NES Digital Service. Greater local standardisation and streamlining of prescribing processes in collaboration with GP subcommittees / Local Medical Committees will help enable delivery of a consistent service across practices. The national Pharmacotherapy Strategic Implementation Group will design and support the ongoing development of the pharmacotherapy service in line with existing contract

agreements, enabling a national direction of travel with local flexibility supported by agreed outcome measures. The group will develop guidance to clearly define GP, pharmacist, pharmacy technician, managerial and administrative staff roles in the overall prescribing process and will report to the National GMS Oversight Group. The guidance will be agreed with SGPC to ensure it is consistent with the requirements of the GMS contract agreements and will ultimately be ratified by the National GMS Oversight Group.

NHS Directors of Pharmacy, supported by National Education Service for Scotland, will support the delivery of national workforce plans that will reflect the staffing requirements of the pharmacotherapy service, in particular what is required for delivery of a level one service for each practice and the appropriate use and mix of skills by pharmacy professionals. This will be overseen by the Chief Pharmaceutical Officer and link into the wider Scottish Government workforce directorate plans

CTAC

Regulations will be amended by Scottish Government in early 2022 so that Boards are responsible for providing a Community Treatment and Care service from April 2022.

These services will be designed locally, taking into account local population health needs, existing community services as well as what brings the most benefit to practices and patients.

The previous MoU outlined that Community Treatment and Care Services include, but are not limited to, phlebotomy, basic disease data collection and biometrics (such as blood pressure), chronic disease monitoring, the management of minor injuries and dressings, suture removal, ear syringing and some types of minor surgery as locally determined as being appropriate. Given this service draws primarily on a nursing workforce, local areas should also consider how CTAC services and the Vaccination Transformation Programme could be aligned to increase the pace of implementation and efficiency.

Healthcare Improvement Scotland will establish a CTAC implementation group to help build mutual understanding as well as share best practice in the delivery of CTAC services. This Group will report to the National GMS Oversight Group.

Other Multi-Disciplinary Team Services

Plans for Urgent Care, Community Link Workers and Additional Professional roles should continue and services already in place should be maintained, but the expectation for 2021-22 is that their further development, where required, may progress at a slower pace to allow the commitments around VTP, CTAC and pharmacotherapy to be accelerated. Their development should also take into account wider system redesign, and opportunities to make connections and add value by exploring the joining up of pathways.

Urgent Care – The Scottish Government will bring forward secondary legislation so that Boards are responsible for providing an Urgent Care service from 2023-24.

Evidence from the Primary Care Improvement Plans suggests there is variation in how this service is being delivered.

Further guidance will be provided by the National GMS Oversight Group on delivery of this commitment in advance of April 2022. Consideration in particular will need to be given about how this commitment fits into the wider system Redesign of Urgent Care work currently in progress.

Community Link Workers – Link workers have proved valuable in helping deliver better patient outcomes, addressing financial exclusion and helping patients access support, particularly in areas of multiple deprivation, as well as improving linkages with the third sector. Consideration will need to be given by April 2022 as to how the Link Worker workforce interfaces with the Scottish Government's commitment to delivering 1,000 Mental Health Link Workers by the end of this Parliament.

Additional Professional Roles – MoU Parties will consider how best to develop the additional professional roles element of the MoU by the end of 2021. In particular with Mental Health, there is a need to consider how PCIF funded posts interface with Action 15 funded posts as well as new policy commitments for mental health. The Primary Care Mental Health Development group in Scottish Government is taking this consideration forward. Separate to this MoU and the arrangements in place to fund it, the commitment of additional Mental Health Link Workers is currently being considered in the context of the locally led model proposed by the Mental Health in Primary Care Short Life Working Group.

Expert Medical Generalist Role

The Contract Offer set out a re-focussed role for the GP, working as part of an extended multidisciplinary team as an expert medical generalist (EMG):

"This role builds on the core strengths and values of general practice-expertise in holistic, person-centred care-and involves a focus on undifferentiated presentation, complex care including mental health presentations and whole system quality improvement and leadership. All aspects are equally important. The aim is to enable GPs to do the job they train to do and enable patients to have better care."

The EMG role is not a new role, but the time GPs can commit to being EMGs is to an extent contingent on the delivery of MDT services and the identified need for 800 additional GPs by 2027 to meet Scotland's current health needs.

Feedback to date suggests there is variation in the understanding on how the EMG role works in practice and what else can be done to support GPs in this role. A group consisting of the MoU parties and a wider range of stakeholders, including NES and RCGP, will examine how GPs can be supported in this role and will publish a report of its findings by the end of 2021.

Transitionary Arrangements

Following Regulation change, HSCPs and Health Boards will be responsible for providing vaccination, pharmacotherapy and CTAC services to patients and GP practices.

GP practices will support HSCPs and Health Boards to provide MoU services in two ways to help ensure patient safety:

- The treatment of patients requiring medical care that is immediately necessary such as an immediate need for wound care, phlebotomy or repeat prescriptions. HSCP/Health Board MoU service provision must minimise the need for immediately necessary support from GP practices.
- Temporary support of routine MoU services, where necessary, under transitionary service arrangements from 1 April 2022.

Consistent with the commitments of the joint letter, SG and SGPC will negotiate transitionary service and payment arrangements where practices and patients still do not benefit from nationally agreed levels of HSCP/HB vaccination, pharmacotherapy, and CTAC services after 1 April 2022.

Transitionary service arrangements are not the preferred outcome of MoU parties, or something we see as a long-term alternative. All parties locally should remain focused on the redesign of services and delivery of the MoU commitments and transitionary arrangements should not be seen as a desired alternative.

Scottish Government and SGPC will develop a set of principles for how transitionary services and payment arrangements will work in practice by the end of Summer 2021. Acknowledging the invaluable expertise of Health Boards and Health and Social Care Partnership they will be fully consulted in the development of this work via the Oversight Group.

Funding

Integration Authorities should endeavour to ensure that ring-fenced Primary Care Improvement Fund ("PCIF") funding supports the delivery of the three priority areas for 2021-22 before further investment of PCIF monies in the other MoU commitments. Other services delivered to date, or planned and signed off by the IJB, should continue to be maintained and only developed where there is available funding to do this.

The MoU parties are committed to determining the full cost of delivering MoU services and refining the evidence base for this purpose. The Primary Care Improvement Plan Trackers have been amended to reflect this. All MoU parties are committed to developing an integrated PCIF proposition for financial years 2022-25 by Autumn 2021 for evaluation and approval by Scottish Ministers utilising Value for Money principles and a methodology that assumes at least £155m of funding per annum uprated in line with inflation, which will include increases in staff pay as set by the Scottish Government.

NHS Boards and Integration Authorities should also assume that the PCIF and any associated reserves would meet any funding required for transitionary service arrangements negotiated between Scottish Government and SGPC. Boards and Integration Authorities should also consider where wider resources may support the delivery of MoU services as well as other earmarked funds such as Action 15 monies.

Any change to the scope of the Primary Care Improvement Fund will be agreed jointly by MoU Parties. The present scope of the call on the PCIF remains unchanged, except for the inclusion of costs of transitionary services, by this MoU and it is expected that any further increase in scope will be supported by additional resources.

GP Subcommittee participation in the development of PCIPs has been enabled to date by dedicated annual funding to support their work. For planning purposes, partners should assume that this funding will continue for the duration of this MoU period.

Governance

Primary Care Improvement Plans

Primary Care Improvement Plans ("PCIPs") will continue to be developed locally in collaboration between Integration Authorities, Health Boards and GP Sub-Committees and will be agreed with Local Medical Committees. Six monthly trackers will be provided to the Scottish Government to allow for national analysis to be produced.

In remote and rural areas, the rural options appraisal process has also been developed to determine whether it is necessary for the anticipated small number of local GP practices to continue delivering MoU services due to their specific remote/rural circumstances. Options appraisals should be developed as part of the PCIP process and submitted to the National GMS Oversight Group for review.

Written plans only go so far in providing intelligence nationally on service redesign. A Primary Care Improvement Leads group has been convened to share best practice on implementation of MoU services as well as feed into Oversight Group discussions. The Scottish Government is also committed to holding informal meetings with 31 HSCPs and Health Boards where appropriate by the end of 2021 to gain understanding of on the ground issues and listen to what further support can be provided to accelerate implementation locally.

Oversight Group

The National GMS Oversight Group will continue to oversee implementation of this MoU and the commitments in the national Contract and will be reinvigorated to allow it to fulfil its originally envisaged role of providing proactive intervention and support where necessary to implement the contractual arrangements outlined in this MoU within the agreed timescales. A key function will be to assess the extent to which additional resources and workforce are required to deliver the MoU services. As we

enter a new administration, the Oversight Group's Terms of Reference will need to be refreshed to ensure it complements and links with future primary care reform programmes and governance structures.

The individual responsibilities of the parties to the MoU established in the previous MoU continue to form the basis by which each party will contribute to the ongoing work of contract implementation.

Enablers

The MoU parties recognise that progressing work on key enablers is fundamental to delivering this MoU – workforce, data requirements, digital and premises.

Workforce

MoU implementation relies on having access to an available workforce. Partners recognise the current constraints that a finite workforce has on planning for service transfer and that the pandemic will likely have a significant impact on the development of workforce.

Workforce planning and pipeline projections, building on the primary care improvement plan trackers, are required to support the delivery of the MoU. A 'task and finish' group will be established involving all 4 partners (Integration Authorities represented by Chief Officers, Scottish Government, BMA and NHS Boards) to direct and oversee this work. The Group will be a sub-group of the National GMS Oversight Group and its recommendations will be used to inform the next iteration of the National Health and Social Care Integrated Workforce Plan.

Data-Driven Delivery

The pandemic has further highlighted the need for consistent, good quality data on which can be made available to the practice, the cluster, the Integration Authority and collated nationally to support sustainability, planning and the evolution of the extended multidisciplinary team. It is also important as a means to developing more robust interface working. The MoU parties place particular focus on the following areas:

Workforce – the GP Practice Workforce Survey will be run on an annual basis by NSS. Alongside the primary care improvement trackers, this will give us a comprehensive overview of GP workforce capacity. All parties to the MoU support this activity.

Activity – PHS has been carrying out a temporary weekly survey of activity of GP practices. The MoU parties are committed to developing long-term solutions for the extraction of activity data from general practice.

Quality – It was agreed as part of the Contract Offer that GP practices would engage in quality improvement planning through clusters. This should be supported by a national quality dataset. An initial version of this dataset will be agreed in Summer 2021. This will aid local service planning, and future MDT development.

Premises

It is acknowledged that with an increase in MDT working that premises will need to be able to support new ways of working that support more care/services being provided closer to home. Consideration should be given to remote, blended as well as co-location in considering implementation of MDT Services.

We remain committed to supporting the agreed National Code of Practice for GP premises and a shift to a new model in which GPs no longer will be expected to provide their own premises. Assistance to GPs who own their premises is being provided through the GP Premises Sustainability Fund.

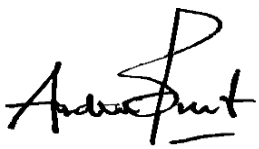
Digital

Developing systems that facilitate the seamless working of extended Board-employed multidisciplinary teams linked to GP Practices is fundamental to the delivery of this MoU.

As part of this, NHS Boards have commissioned a procurement competition to provide the next generation of GP clinical IT systems for GPs in Scotland. This commitment is ongoing with the first product becoming available in Autumn 2021. All signatories recognise the need to progress the rollout of these clinical systems at pace.

Signatories

Signed on behalf of the Scottish General Practitioners Committee, BMA

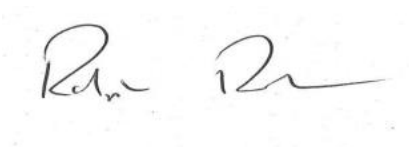


Name: Andrew Buist, Chair, Scottish General Practitioners Committee, BMA
Date: 30 July 2021

Signed on behalf of Health and Social Care Partnerships

Name: Judith Proctor, Chair, Health and Social Care Scotland
Date: 30 July 2021

Signed on behalf of NHS Boards



Name: Ralph Roberts, Chair, Chief Executives, NHS Scotland
Date: 30 July 2021

Signed on behalf of Scottish Government

Name: Tim McDonnell, Director of Primary Care, Scottish Government
Date: 30 July 2021

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

Date of Meeting	23 September 2021
Report Title	Leadership Team Objectives – Update on Delivery
Report Number	HSCP.21.107
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	Appendix A - Leadership Team Objectives Progress Quarter 1

1. Purpose of the Report

1.1. The purpose of this report is to provide an update to the Risk, Audit and Performance Committee (RAPC) on progress on the delivery of the 2021/22 Aberdeen City Health and Social Care Partnership (ACHSCP) Leadership Team Objectives.

1.2. RAPC on 22 June 2021 agreed that progress reports would be submitted to the September 2021, December 2021 and March 2022 meetings.

2. Recommendations

2.1. It is recommended that RAPC:

a) Notes the progress update in relation to the delivery of the ACHSCP Leadership Team Objectives.

b) Notes that further progress reports will be submitted to the 21 December 2021 and 1 March 2022 meetings of RAPC.

RISK, AUDIT AND PERFORMANCE COMMITTEE

3. Summary of Key Information

3.1. At the meeting of RAPC on 22 June 2021, report HSCP.21.072 outlined the proposed plans for delivering and monitoring the 2021/22 Leadership Team Objectives which included organising the objectives into projects and programmes; allocating support; creating Huddles to oversee delivery; identifying key performance measures; and developing a Performance Dashboard.

3.2. The programmes and projects have all be clarified, leads have been allocated and they have been split between the three Huddles. The Transformation Team has recently been merged with the Strategy and Performance Team and the Capital and Assets Team. The organisational change process, which has taken some months, is now complete and although recruitment to vacant posts is now underway there is currently a 37% vacancy rate in the merged team. The project and programmes that support the Leadership Team Objectives have been prioritised as the team has been unable to support all of them at this time. Whilst support and delivery of our objectives will accelerate when the posts are filled there is nonetheless a risk to overall delivery which will be closely monitored over the coming months.

3.3. Appendix A contains a visualisation of the progress made to date on our development of a Performance Dashboard. We continue to develop and review performance measures for all projects whether underway or planned.

3.4. We have detailed our measurable performance indicators against each objective, however some of these indicators will develop as we progress our projects/programmes. The Surge and Flow Dashboard has enabled our day-to-day management of flow in and out of Hospital to Community, and has created greater collaboration between ACHSCP, the Acute sector and commissioned social care providers. Plans are in place with Health Intelligence to help analyse the data within the dashboard identifying patterns and trends since its creation at the beginning of the year. We will include these findings in the report to the December RAP meeting.

3.5. Staff Health and Wellbeing continues to be at the forefront of the Leadership Teams Objectives. There was concern over the impact Covid 19 related

absences could have on service delivery and this initiated development of a daily staffing situation report (sitrep) which detailed vacancies, annual leave and absences of all types per service. This has proved to be an invaluable monitoring tool to identify potential problem areas enabling pre-emptive action to be taken which ensures our services continue to be safe. This tool confirmed our understanding that the most disruptive impact on service delivery is the number of staff absent due to psychological issues such as anxiety and stress.

3.6. We are developing our data and performance dashboard alongside the refresh of the Strategic Plan performance framework. The resultant framework will consist of key performance measures which demonstrate delivery of the Strategic Plan.

4. Implications for RAP

4.1. **Equalities, Fairer Scotland Duty and Health Inequalities** - The Leadership Team Objectives were agreed as part of the Medium-Term Financial Framework (HSCP.21.025, Integration Joint Board 23 March 2021) for which a full equalities and human rights impact assessment was undertaken. The assessment, on the whole, was positive in relation to the impact on equality and diversity within Aberdeen, however any equality impacts on individual project work will be kept under review.

4.2. **Financial** – Delivering the Leadership Team Objectives within existing budgets is key to ensuring financial sustainability of the ACHSCP.

4.3. **Workforce** – The Leadership Team Objectives are to be delivered using existing resources although as noted in paragraph 3.2 above that the recruitment process is underway to bring the Strategy and Transformation team to full capacity.

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

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

4.6. **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.

4.7. **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 – support 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 of ACHSCP be negatively impacted, but will negatively 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.

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

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Aberdeen City Health & Social Care Partnership

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Leadership Team Objectives

Progress to date – Quarter 1 2020/2021

Leadership Team Objectives

1. Staff Health & Wellbeing

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

2. 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.

3. Whole system and connected remobilisation

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.

4. 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.

5. Living and responding to COVID

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

The table opposite lists the performance indicators identified for the Leadership Team Objectives and how these have been allocated across the Huddles

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		✓	

Huddles

Huddles are now in place and underway. Some projects have been prioritised over others but will progress as capacity becomes available.

Right Way – All projects are already underway. IJB Workshop planned on digitisation and Leadership Team Development Session early October will focus on "What is Locality Working?"

Right Care – Workforce/ Staff Wellbeing is a main focus. See later slides for details on Q1 absence rates and reasons and some of the plans and progress to help mitigate absences and support staff. Immunisation Blueprint agreed at Aug IJB, Covid Vaccinations ongoing.

Right Place – Currently reviewing return to office-based working. Engagement on MHLD Residential Commissioning has taken place - 4 workshops with current providers to coproduce a Market Position Statement for the future needs of the services.

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

Objective – Staff Health and Wellbeing

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.

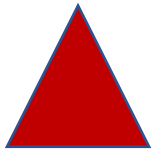
Huddle	Programmes/ Projects included
Right Way	Staff Wellbeing
Right Way	Care Home Support
Right Care	Workforce
Right Way	Recover from Covid19
Right Way	Stay Well, Stay Connected

Measurable performance indicators for this Objective

- 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 *

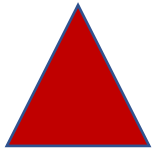
* Data still being sourced/ verified for these indicators.

ACC Services Absence Rates

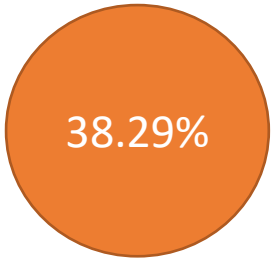


Increase of 204 days lost due to sickness in quarter 1 compared to previous year.

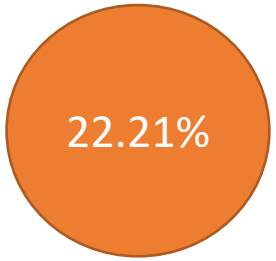
NHS Services Absence Rates



Increase to 3.94% absence rate. (Awaiting comparative data)



38.29% of ACHSCP ACC Services absences have been due to Psychological Reasons for the month of June



22.21% of ACHSCP NHS Services absences have been due to Psychological Reasons for the month of June

Staff Survey iMatters Report 20/21

This is due to be produced in the next few weeks. ACHSCP Staff Return rate is currently at 52%. Results will be included in December Report.

Top Absence Reasons

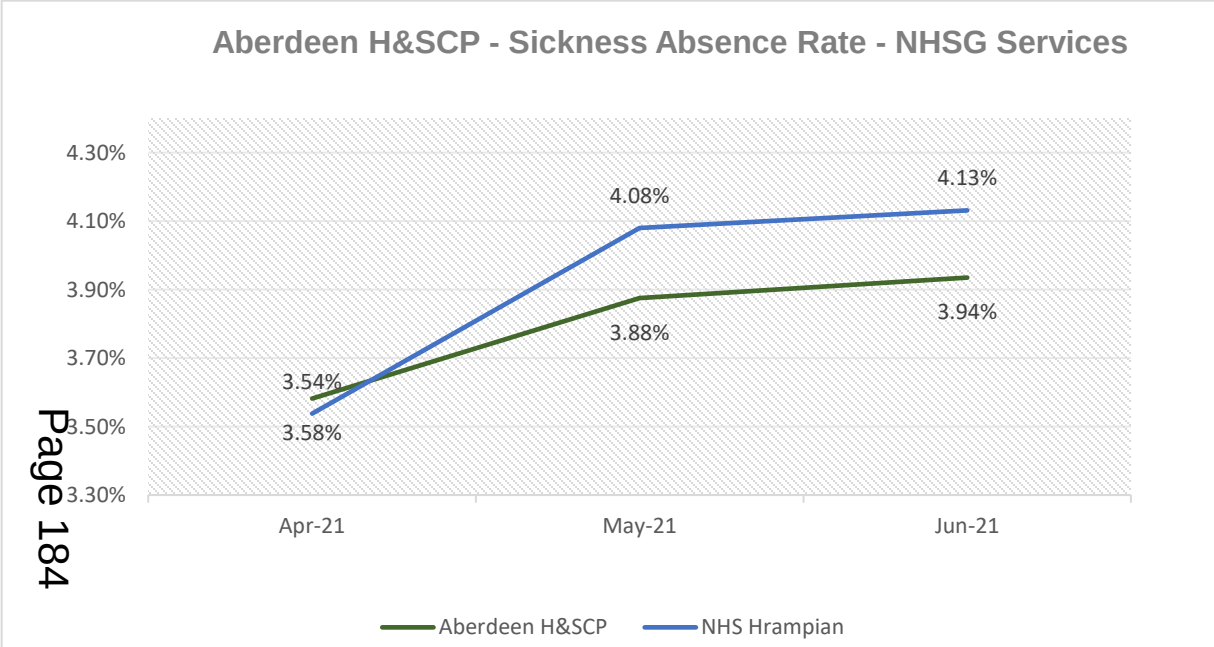
Psychological issues, such as Stress and Anxiety is highest reason with musculoskeletal then Gastro-intestinal issues next. Covid19 Absences are not included within these figures.

Health and Safety Committee – Deep Dive

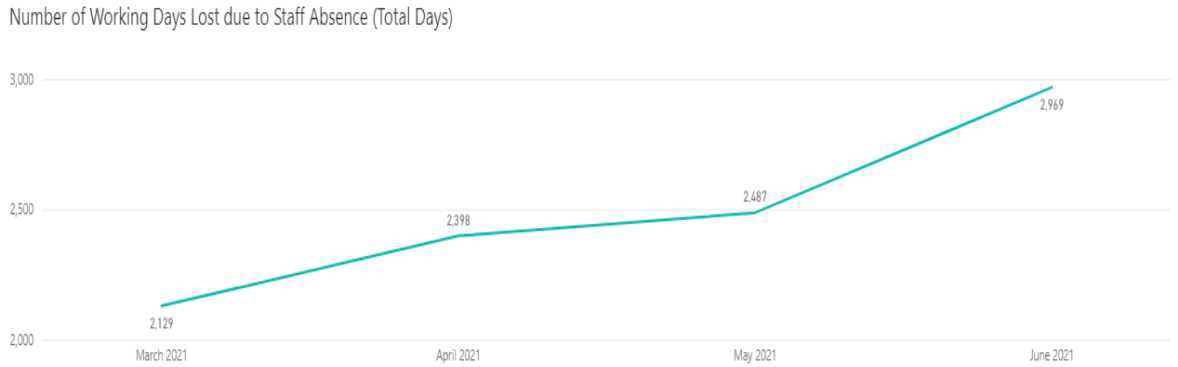
Health and Safety Committee will be conducting a deep dive into staff absences and sickness reasons, report can be shared/ included in December paper.

Objectives – Staff Health and Wellbeing

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.



Sickness Absences – ACHCSP – ACC Services



Absence Reason	Aberdeen H&SCP Absence Rate			NHSG Absence Rate		
	Apr-21	May-21	Jun-21	Apr-21	May-21	Jun-21
Anxiety/stress/ depression/other psychi atric illnesses	15.09%	20.62%	22.22%	20.25%	22.14%	20.94%
Other musculoskeletal problems	12.76%	7.20%	7.21%	10.52%	8.64%	9.23%
Back problems	3.40%	5.39%	6.62%	5.53%	6.66%	5.88%
Injury, fracture	6.64%	2.78%	4.03%	6.34%	5.13%	7.18%
Gastro-intestinal problems	3.63%	4.92%	3.96%	7.20%	6.72%	5.85%

SICKNESS_CATEGORY	June 2021
Psychological	38.29%
Gastro-intestinal	19.54%
Neurological	12.16%
Musculoskeletal	11.42%
Other	7.61%
Gynaecological	4.35%
Respiratory	3.57%
Hospitalisation	2.29%
Covid-19 Related	0.44%
Viral	0.17%
Malignancy	0.13%
Unauthorised Absence	0.03%

The Leadership Team have been monitoring Sickness Absence, Vacancy Rates and Covid Related absences over the past 3 months on a daily basis. Sickness and Absence reasons remain similar across our services, while Covid related absences have been disruptive to service delivery, the bigger concern is the level of staff off with psychological issues such as stress and anxiety.

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.

Huddle	Programmes/ Projects included
Right Way	Care Home Reporting Care Home Support Care Home Occupancy/ Capacity Review of Referral Pathways
Right Place	Commissioning

Measurable performance indicators for this Objective

- 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 *

* Data still being sourced/ verified for these indicators.

We are able to review the occupancy levels, delayed discharge, level of unmet need and our interim bed situation through our Surge and Flow Dashboard, this has enabled ACHSCP Staff, Granite Care Consortium, Bon Accord Care and other providers to work collaboratively throughout the pandemic period and is also now informing how we prepare for Winter pressure.

The use of the TURAS online reporting platform has enabled our providers to keep us informed of occupancy, staffing and vacancy rates and escalate issues as necessary.

MHLD Residential Commissioning

- The Strategic Review of MH/LD Residential Services began in July 2021 and over a series of 4 collaborative workshops with around 40 attendees at each meeting from an audience of providers, 3rd Sector and independent interfaces. We are now working towards a draft codesigned Market Position Statement which outlines the main challenges, relevant demand and activity data, and actions over the short, medium and longer term which is focused on enablement, connections to the community and independent living.

Strategic Commissioning Programme Board

- The SCPB has now been established with representation from ACHSCP commissioners, ACCCPSS and third and independent sector interfaces. It is meeting on a monthly basis to ensure effective and forward strategic planning of commissioning activity

Whole System and Connected Remobilisation

Huddle	Programmes/ Projects included
Right Care	Immunisations Pathways and Redesign
Right Way	Digitisation Data and Evaluation
Right Place	Primary Care

Measurable Performance Indicators for this Objective.

- Number of GP Practices in the City
- Practices Stability Rate (% Green) *
- % Services Remobilised *
- Immunisation Figures and increases in uptake rates

Immunisations
Report approved at August IJB for the Immunisations Blueprint/ plan for the next 3 years across Aberdeen with the establishment of new model of working that is an integral part of the Vaccination Transformation Programme.

Currently existing vaccination uptake data is available on a city and practice level on a quarterly basis, around 6 months following each quarter (Reports for quarter 1 will be available for December report). It has been identified that in order to continue to make improvements and be confident that these improvements are having a positive impact on our vaccination uptake levels, frequent, quality data is required at a community/ locality level.

During COVID19, public health data on uptake is now available to the service at a community level on a daily basis to support the vaccination programme to identify areas that require further promotion and support. Work is ongoing with NHS Health Intelligence to ensure this information is available for all vaccination programmes.

Data and Evaluation
We are developing our data and performance dashboard alongside the refresh of the Strategic Plan performance framework. Our Leadership Team
Objectives, programmes and operational teams' performance data will inform our Strategic Plan. We are creating a dashboard that will have our
operational measures and show how they feed into each Leadership Team Objective, and subsequently into
overall strategic measures within the Strategic Plan.

Reshaping our relationships with our 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.

Huddle	Programmes/ Projects included
Right Way	Pathways and Redesign Redesign of Adult Social Work
Right Care	Quality Improvement
Right Place	Recover from Covid19 Commissioning Stay Well Stay Connected Primary Care Urgent Care

Measurable Indicators for this Objective

- Headcount v establishment
- Travel costs*
- Space usage *
- Redesign of social work in line with locality working and system working across MHLD and Adults.

* Data still being sourced/ verified for these indicators.

Stay Well, Stay Connected

Evaluation is progressing well. A framework has been drafted and work is progressing to develop measures and baselines for each of the 4 workstreams using a logic model approach.

Day Care – currently reviewing budgets to understand resource to support this workstream. 40 people are currently attending Kingswood Court and 18 receiving 1:1 care as an alternative with waiting lists of 4 and 5 people respectively. This is an equal / favourable position to the situation pre covid

Dementia Workstream -Workshop with staff and community members looking at dementia friendly activities has taken place. Looked at activities pre/during and post covid (what worked well, what can we adapt) and now have a few activities that we will be concentrating on. A thematic review of responses from staff, carers and clients is in draft format and will be shared.

Physical Activity- Step out September update: Website now live and week of walks have been created. People are encouraged to make a pledge for themselves or their organisation to take part. Alternative Activities resource has also been created and is available on the website. Evaluation methods being developed for this initial pilot of Step Out September: Website: https://www.sportaberdeen.co.uk/step-out-september

Digital - Working with Ability Net and Silver City Surfers (third sector digital support providers) Promotion of services and increase in capacity of volunteers across Aberdeen. Using connecting Scotland as a way to measure a baseline for the city.

Respite – We have 1 nursing care and up to 8 residential care (flexible use which includes respite) beds for bookable respite. This is working well and bookings are being made months in advance so far. There is an evaluation process in place to gain feedback from clients and their carers. Emergency Respite is currently being spot purchased were possible due to a lack of market uptake. Anecdotal feedback is that demand is not being met due to lack of provider uptake. Group agreed to review this in September and meets this week. Data capture data is a priority to understand demand/occupancy.

Adult Social Work Redesign

A proposed locality structure for adult social work has been shared with staff through a webinar and teams. A social work organisational change group has been established, they will be tasked to oversee change process, develop and implement the action plan and timeline, staff engagement and consultation plan. Q&A sessions will be held in the near future to get feedback from all staff.

Living and Responding to Covid19

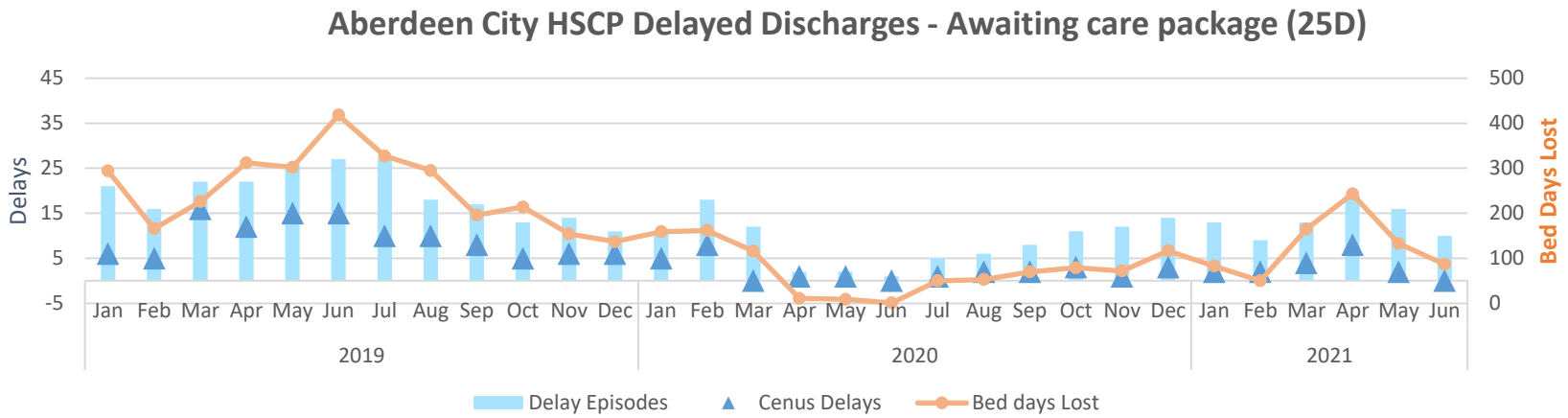
Huddle	Programmes/ Projects included
Right Way	Pathways and Redesign
Right Care	Quality Improvement
Right Way	Primary Care Urgent Care

Measurable Indicators for this Objective

- Unplanned Admissions/ reasons/ areas of city/ GP practice
- 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. **

*indicators that will be available with progression of eMar Project.

** Data still being sourced/ verified for these indicators.



From Jan 21 to May 21	**Grampian**	**Ave Rest of Scotland**
A&E Attendances	+58.1%	+59.9%
Emergency Admissions	+16%	+17.1%
Delayed Discharges (Bed Days)	-2%	+0.6%

With a cross over to the data we are overviewing within the Surge and Flow Dashboard, we are also monitoring how we are progressing against the rest of Scotland, we are below the Scottish average across A&E attendances, Emergency Admissions and Delayed Discharges. This has fluctuated in the same pattern to when we have been in lockdown/restrictions. However, our percentage rate has not exceeded pre Covid rates.

Aberdeen City Health & Social Care Partnership
A caring partnership

RISK, AUDIT AND PERFORMANCE COMMITTEE

Date of Meeting	23 September 2021
Report Title	Briefing re Young People Monitoring Report 2019-20, Mental Welfare Commission
Report Number	HSCP.21.108
Lead Officer	Jane Fletcher, Lead for Mental Health and Learning Disability Inpatient Services, Specialist Services and CAMHS
Report Author Details	Alex Pirrie, Service Manager, Child & Adolescent Mental Health Services (CAMHS) alex.pirrie@nhs.scot
Consultation Checklist Completed	Yes
Appendices	Appendix A - Young People Monitoring Report 2019-20, Mental Welfare Commission Appendix B – National CAMHS Service Specification

1. Purpose of the Report

1.1. The purpose of this report is to provide the Risk, Audit and Performance Committee (RAPC) with a brief overview of the Young People Monitoring Report 2019-20, highlight any implications for our services and provide assurance regarding our progress in relation to the recommendations made by the Mental Welfare Commission.

1.2. It is important to note that, of the mainland Child and Adolescent Mental Health Services (CAMHS) in the North of Scotland, Grampian had the lowest admission rate for children and young people to non-specialist wards, with a total of 4 young people admitted to a non-specialist setting for the care and treatment of their mental health in 2019-20.

RISK, AUDIT AND PERFORMANCE COMMITTEE

2. Recommendations

2.1. It is recommended that RAPC:

a) Note the recommendations made by the Mental Welfare Commission in the Young People's Monitoring Report 2019-20 (Appendix A) and the IJB's progress in relation to these.

b) Agree to receive at the 1 March 2022 RAPC a further paper from the Service Manager (CAMHS) following the publication of the 2020-21 report that provides an overview, highlights any implications for our services and provides assurance regarding our progress in relation to any new recommendations made.

3. Summary of Key Information

3.1. Since the implementation of the Mental Health (Care & Treatment) (Scotland) Act 2003 (the 'Act') health boards in Scotland have a legal duty to provide appropriate services and accommodation for young people who are under the age of 18 years and who are admitted to hospitals for treatment of their mental illness. The Mental Welfare Commission (MWC) monitors the use of this legislation in relation to young people to ensure that their rights are respected, to identify and highlight any deficiencies in care, and, more recently, to monitor and record the provision of age appropriate services under the Act.

3.2. Under article 24 of the United Nations Convention for the Rights of the Child (UNCRC), children have a right to the highest attainable standards of health within available resources and have a right to access health services for their care and treatment. In a significant majority of instances where a young person needs inpatient care and treatment for the mental illness, this is provided in a regional or national specialist child and adolescent inpatient unit. Specialist adolescent units and wards are designed to meet the needs of young people with mental illness. These units and wards differ from adult mental health wards and adult Intensive Psychiatric Care Units (IPCU) in staff training and the ward environment and a young person's needs may not be fully met in an adult mental health ward or IPCU.

3.3. The MWC publishes a report annually showing the trend of admissions of young people to non-specialist wards. Between 1 April 2019 and 31 March 2020 there were 103 admissions for children and young people to non-specialist wards. This equates to 30.6% of overall admissions of children and young people under the age of 18 for care and treatment of their mental health in Scotland to non-specialist wards – primarily adult mental health wards and adult IPCUs.

3.4. Reasons for young people being admitted to adult wards include a shortage of specialist beds and a lack of provision for:

- Highly specialised care for young people with learning disabilities
- Young people who have offended due to mental health difficulties and require forensic care
- Young people who require intensive psychiatric care provided in specialised beds
- Young people who are in distress and need a safe space during a crisis but are unable to return to the home environment or due to a breakdown in their care placement

3.5. In comparison to the national figure of 103 admissions (30.6% of overall admissions) of children and young people under the aged of 18 to non-specialist wards for care and treatment of their mental health, Grampian's figure was significantly low, with a total of 4 admissions to non-specialist wards in 2019-2020.

3.6. Of the mainland CAMHS in the North of Scotland, Grampian has the lowest admission rate for children and young people to non-specialist wards. There are several reasons for this:

- We continue to focus on the expansion of community CAMHS to provide intensive treatment at home and in the community as an alternative to hospital admission wherever possible. This is supported by our highly skilled and dedicated Tier 4 clinicians, including the Tier 4 Network Liaison Nurse for Grampian.
- Grampian CAMHS provides a service for children and young people up to the age of 18 years, regardless of whether or not they are in education,

which has a positive impact on the number of admissions for 16-18 year olds to non-specialist wards. Some CAMH services in Scotland will only provide a service to young people age 16-18 years if they are in education – other young people in this age bracket who are not in education are managed by adult services for their mental illness and are more likely to be admitted to a non-specialist ward.

3.7. Grampian CAMHS is part of the Tier 4 North of Scotland Obligate Network. The Network works on the principle of "as local as possible and as specialist as necessary" where admission of young people to a non-specialist setting only occurs where it is deemed to be necessary.

3.8. All young people admitted to non-specialist beds in Grampian receive input from a CAMHS Responsible Medical Officer and other clinical members of the CAMHS multi-disciplinary team, and we work to ensure that their admission is as short as possible.

3.9. The MWC makes three recommendations in the Young People Monitoring Report 2019-20, attached at Appendix A:

Recommendation 1: The Commission recommends that work to explore the accessibility and provision of intensive psychiatric care facilities (IPCU) for the under 18s in Scotland is sufficiently prioritised, resourced and supported by Scottish Government to ensure that its work can be brought to completion within an appropriate timescale and result in meaningful change nationally for young people having access to IPCU facilities that are age appropriate.

Recommendation 2: Health Board Managers with a duty to fund and provide advocacy services for individuals with mental health difficulties in their area should review the availability of dedicated advocacy support for children and young people with mental health difficulties locally and ensure the resourcing and provision of any dedicated specialist advocacy service is sufficient to be able to meet the needs of young people with mental health problems and to support and protect their rights.

Recommendation 3: Hospital managers should ensure that whenever a child or young person is admitted to a non-specialist ward that consideration and exploration of their educational needs and their right to education should

be a standard part of care planning for the young person during their hospital admission.

3.10. The progress of Grampian CAMHS regarding these recommendations is monitored and evaluated in relation to our implementation of the National CAMHS Service Specification (attached at Appendix B). Sections 1-7 of this Service Specification detail the minimum standards to be delivered by all CAMHS in Scotland. A summary of CAMHS Grampian progress in relation to the three recommendations in the Young People Monitoring Report 2019-20 is as follows:

Recommendation 1: Links to Standards 1, 3 and 7 of the National CAMHS Service Specification – (1) High Quality Care and Support that is Right for Me; (3) High Quality Interventions and Treatment that are Right for Me; (7) I Have Confidence in the Staff who Support Me. Grampian CAMHS has actively contributed to the scoping review of intensive psychiatric inpatient care provision for young people in Scotland. The Scottish government recently published the report which can be accessed via the following link - Scoping review of intensive psychiatric inpatient care provision for young people in Scotland: report - gov.scot (www.gov.scot)

Recommendation 2: Links to Standard 4 of the National CAMHS Service Specification – My Rights Are Acknowledged, Respected and Delivered. Advocacy Services in Grampian are commissioned via the Local Authority and/or Health and Social Care Partnership. Grampian CAMHS will routinely audit whether young people admitted to non-specialist wards are offered advocacy going forward and will work collaboratively to ensure provision of and access to dedicated advocacy support.

Recommendation 3: Links to Standard 3 of the National CAMHS Service Specification (see above) and in particular 3.2 – *take account of children and young people's education needs and, with informed consent, work with school and education authority staff to contribute to the child or young person's educational support*. Going forward, Grampian CAMHS will monitor whether consideration of and exploration of children and young people's educational needs and their right to education are a standard part of care planning during their hospital admission and will work collaboratively with education providers.

3.11. The MWC intends to publish the 2020-21 report by 21 October 2021 and will then ask Chief Officers to respond to the recommendations from both reports over the following six months.

4. Implications for IJB

4.1. **Equalities, Fairer Scotland and Health Inequality** - There are no direct implications in relation to Equalities, Fairer Scotland or Health Inequality arising from the recommendations in this report.

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

4.3. **Workforce** - There are no direct workforce implications arising from the recommendations in this report.

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

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

5. Links to ACHSCP Strategic Plan

5.1. This report ensures that our service delivers within all the headings of the Strategic Plan – Prevention, Resilience, Personalisation, Connections and Communities.

6. Management of Risk

6.1. Identified risks(s)

Risk 3 – outcomes are not delivered and non-performance is not identified

Risk 5 – risk of harm to people

Risk 6 – risk of reputational damage to the IJB and its partner organisations

RISK, AUDIT AND PERFORMANCE COMMITTEE

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

Risk 3 - There is a risk that the outcomes expected from hosted services are not delivered and that the IJB does not identify non-performance 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.

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

Risk 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:

Our review of the annual report by the Mental Welfare Commission and reporting to RAPC on our position against any findings ensures we meet our requirements within the Mental Health (Care & Treatment) (Scotland) Act 2003 and we consider the risk to be low against all three risks noted above.

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

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mental welfare commission for scotland

Young people monitoring report 2019-20

Statistical Monitoring

June 2021

Our mission and purpose

Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

Our Purpose

We protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

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What we do

We protect and promote the human rights of people with mental health problems, learning disabilities, dementia and related conditions.

We do this by:

- Checking if individual care and treatment is lawful and in line with good practice.
- Empowering individuals and their carers through advice, guidance and information.
- Promoting best practice in applying mental health and incapacity law.
- Influencing legislation, policy and service development.

Executive Summary

1. Under article 24 of the United Nations Convention for the Rights of the Child (UNCRC), children have a right to the highest attainable standards of health within available resources and, have a right to access health services for their care and treatment.

2. In its concluding observations to the fifth and latest periodic report from the UK[1] in 2016, the Committee on the Rights of the Child expressed concerns regarding the treatment of children (in Scotland and England) in hospitals far away from home, with inadequate provision of child-specific attention, support and placement in adult facilities. The CRC recommended that the prohibition of placement of children with mental health needs, in adult psychiatric wards, should be expedited while ensuring age appropriate mental health services and facilities were provided to children and young people.

3. The Mental Health (Care and Treatment) (Scotland) Act 2003 places a legal obligation on health boards to provide appropriate services and accommodation for young people admitted to hospital for treatment of their mental ill health.

4. In 2019-20, the number of young people under the age of 18 admitted to non-specialist hospital wards – primarily adult wards - for treatment of their mental health difficulties in Scotland was 103 admissions involving 88 young people. This is a slight fall from the 2018-19 figures which were 118 admissions involving 101 young people and appears to reflect a downward trend in admissions since 2013.

5. In a significant majority of instances where a young person needs inpatient care, this is provided within the regional or national specialist child and adolescent inpatient units. According to Public Health Scotland data, between1 April 2019 and 31st March 2020 30.6 % of overall admissions of children and young people under the age of 18 for care and treatment of their mental health were to non-specialist wards[2].

[1] Para 60c and 61c.
http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=6QkG1d%2FPPRiCAqhKb7yhskHOj6VpDS%2F%2FJqg2Jxb9gncnUyUgbnuttBweOlylfyYPkBbwffitW2JurgBRuMMxZqnGgerUdpjxij3uZ0bjQBOLNTNvQ9fUlEOvA5LtW0GL
[2] PHS (2021) Quality Indicator Profile for Mental Health
https://beta.isdscotland.org/find-publications-and-data/conditions-and-diseases/mental-health/mental-health-quality-indicator-profile/

6. Reasons for young people being admitted to adult wards include a shortage of specialist beds, and a lack of provision for:
    a. Highly specialised care for young people with learning disability,
    b. Young people who have offended due to mental health difficulties and require forensic care; and
    c. Young people who require intensive psychiatric care provided in specialised units.

7. In some instances it may be appropriate for a child or a young person to be admitted to a non-specialist setting if available alternatives would not be in their best interests. However the United Nations Convention of the Rights of the Child indicates the necessity of ensuring special safeguards for children and young people due to their stage of development.

8. The majority of admissions of young people to non-specialist wards continue to be short in length, however 41% remain on those wards (mostly adult) for over a week.

9. A positive finding is the specialist medical staff either supporting or available to support these admissions remains high – 57% of the doctors in charge of care or Responsible Medical Officers (RMO) were child specialists and in a further 28% of admissions a CAMHS consultant was available to give support, if needed.

10. Of all the young people admitted to non-specialist wards, 22% were care experience and looked after and accommodated by a local authority.

11. Access to specialist advocacy remains limited. We were disappointed to note that while 70% of young people had access to advocacy, only 20% had access to advocacy that specialised in the particular needs and rights of young people.

12. We are aware that CAMHS clinicians continue to provide support to young people in non-specialist inpatient wards, but over recent years the proportion of young people being able to access non-medical specialist CAMHS input whilst an in-patient on a non-specialist ward has not improved.

13. Action 20 of the Mental Health Strategy is a commitment to scoping the level of highly specialist mental health inpatient services for young people and act on the findings. The Commission notes the progress towards developing inpatient facilities for children and young people who require specialist forensic care and for those young people who have a learning disability.

14. The Commission is encouraged that, following a recommendation last year, work has begun once again to explore the needs of young people who require CAMHS specialised intensive psychiatric care unit (IPCU) support in Scotland. This has been a recommendation of ours for a number of years in annual monitoring reports, and we continue to emphasise the importance of this work and the need for it to be prioritised and brought to a conclusion. However we remain concerned that young people's access to intensive psychiatric care unit (IPCU) facilities have not been given similar prominence to Learning Disability and Forensic provision for the under 18s. We are aware of the complexity of this task and that previous initiatives to explore this question have been unsuccessful. We continue to emphasise the importance of addressing the need for IPCU facilities nationally for young people. It is important that any work looking at access to IPCU facilities is sufficiently supported by Scottish Government to be able to come to a conclusion that will have meaningful change for young people across Scotland in the delivery of intensive psychiatric services and accommodation.

Recommendations

Recommendation 1:

The Commission recommends that work to explore the accessibility and provision of intensive psychiatric care facilities (IPCU) for the under 18s in Scotland is sufficiently prioritised, resourced and supported by Scottish Government to ensure that its work can be brought to completion within an appropriate timescale and result in meaningful change nationally for young people having access to IPCU facilities that are age appropriate.

Recommendation 2:

Health Board Managers with a duty to fund and provide advocacy services for individuals with mental health difficulties in their area should review the availability of dedicated advocacy support for children and young people with mental health difficulties locally and ensure the resourcing and provision of any dedicated specialist advocacy service is sufficient to be able to meet the needs of young people with mental health problems and to support and protect their rights.

Recommendation 3:

Hospital managers should ensure that whenever a child or young person is admitted to a non-specialist ward that consideration and exploration of their educational needs and their right to education should be a standard part of care planning for the young person during their hospital admission.

Cases

The following composite cases illustrate the problems this report seeks to highlight. These are not real cases but are based on the information that Commission is aware of through our work.

JD is a 15 year old young person who is a secondary school student, and lives with their family. JD developed an episode of psychosis and required admission to a regional CAMHS inpatient unit located over fifty miles away from his home. Whilst there, as part of their illness, JD became paranoid about the staff and other young patients. This led to episodes of aggression, and the clinical team felt JD's care needs required more intensive psychiatric care. There are no IPCU facilities for young people in Scotland and the adult IPCU nearest to the regional CAMHS inpatient unit suggested JD would be better placed in the IPCU nearest to his home. However, JD's home IPCU said that they could not accept a 15 year old and advised them to speak to other IPCUs elsewhere. This lack of clarity was difficult for the young person, the family and JD's clinical team. JD remained on the adolescent unit whilst unwell but this had significant impact on JD and the other young people in the CAMHS unit. The lack of a specialised IPCU facility for young people and the lack of a clear protocol for how to progress the request for more support was unhelpful.

SK is a 16 year old person who enjoys dancing and painting. She has diagnoses of autism and mood disorder. She developed an episode of mania and required an admission to a regional young people's inpatient unit. She was very distressed and hit out on several occasions at her support workers. This led to an admission to the local adult IPCU to ensure the level of care and support she needed. However this was on a ward with very unwell adults and adults involved in the criminal justice system and she was vulnerable. This required her to have staff placed with her constantly and she perceived this as intrusive and restrictive although she understood it was for her safety. The clinical team informed the Mental Welfare Commission of the admission of this young person to a non-specialist ward and the MWC collected information about her stay on the ward and access to CAMHS clinicians, education and age appropriate recreation. Despite the efforts of the CAMHS team, local adult mental health services, the admission was difficult for SK and her friends and family who were concerned about the environment in which she was placed.

Introduction

The United Convention on the Rights of the Child (UNCRC) is an international human rights treaty that comprehensively outlines a range of rights that are applicable to all children (a child is an individual who is younger than 18 years old in UNCRC). In 1991 the UK government ratified UNCRC and made a commitment to take steps to ensure that the rights described in UNCRC should apply to all children in the UK. The body responsible for monitoring compliance of states with UNCRC is the Committee of the Rights of the Child (CRC) which reviews and responds to the periodic submission of a report by the UK government which details the progress made in implementing UNCRC within the UK and describes areas of concerns and makes recommendations to the UK government or devolved administrations (where relevant mandates such as for example health in Scotland fall under their jurisdiction). On the 1st September 2020 the UNCRC (Incorporation) (Scotland) (Bill) was introduced to the Scottish Parliament and was passed unanimously on 16th March 2021. The Bill's main purpose is to bring UNCRC into Scots law with the aim for it to be passed before the end of the current parliamentary term.

The importance of children's mental health and access to appropriate mental health services is reflected in a number of UNCRC rights and these in turn have shaped existing mental health legislation:

Article 6 describes the right to life and maximum survival and development of any child and is one of the core principles of UNCRC.
Article 19 describes the rights of children to be protected from all forms of violence including mental or physical violence and also requires measures to be taken to help protect children from suicide and self-injury.
Article 24 describes the rights for children to attain the highest standard of health including mental and emotional health within available resources and includes the children's rights to access health services for treatment and rehabilitation of health. Article 24 also requires that states "strive to ensure that no child is deprived of his or her right to access health care services".
Article 37 requires that children deprived of their liberty are treated "in a manner that takes account of the needs of the person of his or her age" and goes to state that "every child deprived of their liberty shall be separated from adults unless it is considered in the child's best interests not to do so."

In addition to these health related rights children have a number of other rights which may be feature during admission to hospital. These include:

Article 12 which describes the rights of children who are capable of forming their view to be able to express them in all matters that affect them with due weight given to their views depending on their age and maturity. Advocacy is a right that all individuals with mental illness and related conditions have a right to under the Mental Health Act and access to specialist children's advocacy is an important mechanism by which children's rights can be protected.
Article 28 describes the right to equal access to education for children. Specialist child and adolescent units have access to educational facilities as a standard feature of inpatient provision.
Article 31 describes a child's right to recreational facilities, leisure and play and to take part in cultural activities.

In its concluding observations to the fifth and latest report periodic report from the UK[3] in 2016 the Committee on the Rights of the Child outlined concerns regarding the treatment of children (in Scotland and England) in hospitals far away from home, with inadequate provision of child-specific attention and support and placement within adult facilities. The CRC recommended that the prohibition of placement of children with mental health needs within adult psychiatric wards should be expedited while ensuring the provision of age appropriate mental health services and facilities to children and young people.

Since the implementation of the Mental Health (Care & Treatment) (Scotland) Act 2003 (the 'Act') in 2005 health boards in Scotland have had a legal duty to provide appropriate services and accommodation for young people who are under the age of 18 years and who are admitted to hospitals for treatment of their mental disorder (or mental illness, as we refer to it in this report).

The Code of Practice to the Act states "whenever possible it would be best practise to admit a child to a unit specialising in child and adolescent psychiatry "and that young people should be admitted to a non-specialist ward only in "exceptional circumstances"[4].

The Commission believes that admitting a young person to an adult ward should only be acceptable in rare situations. This would depend upon the individual needs and circumstances of the young person e.g. their maturity, the nature of mental health difficulties and the care they require and the distance to the regional unit and what is in their best interests. When an admission to a non-specialist ward does become unavoidable then every effort should be made to provide for the young person's needs as fully as possible.

Specialist adolescent units and wards designed to treat the needs of adults with mental illness differ in staff training and the ward environment and a young person's needs might not be fully met on an adult ward.

Since the inception of the Act, the Commission has monitored the admissions of young people to adult wards to ensure that their rights are respected, to identify and highlight any deficiencies in care, and to monitor and record the provision of age appropriate services under the Act. We publish our findings annually.

The most common non-specialist wards to which young people are admitted are adult mental health wards and adult intensive psychiatric care units (IPCUs). [5]

[3] Para 60c and 61c.
http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=6QkG1d%2FPPRiCAqhKb7yhskHOj6VpDS%2F%2FJqg2Jxb9gncnUyUgbnuttBweOlylfyYPkBbwffitW2JurgBRuMMxZqnGgerUdpjxij3uZ0bjQBOLNTNvQ9fUIEOvA5LtW0GL
[4] Code of Practise Volume 1, chapter 1 paragraph 50.
https://www2.gov.scot/Publications/2005/08/29100428/04302
[5] Adult IPCU facilities are specialised psychiatry wards designed to provide a care setting for adults when they are very unwell and present with high levels of risk either to themselves or others.

Numbers of admissions can vary across the country. We have been told that approaches to try and reduce admission rates have included investing in and increasing the capacity of the specialist adolescent inpatient estate and promoting the development of CAMHS intensive services in the community to provide alternatives to admission and help reduce length of stay within adolescent units.

Although this goal has not been achieved completely across Scotland, in 2015-2016 and 2016-2017 we did see numbers of young people admitted to non-specialist wards fall substantially and admission figures have remained lower from that point. We welcome this development. Enquiries at the time suggested that the role of CAMHS community intensive treatment services has been a key contributory factor along with approaches to help co-ordinate and streamline admission and discharge procedures of the specialist inpatient units. Additionally the stability of staffing within the inpatient units and the expansion of capacity to deliver evidence based and intensive treatment in Tier III CAMHS within the community and thereby avoid the need for admission were also key.

The Scottish Government's current approach to mental health is outlined in In the Mental Health Strategy 2017-2027 which outlines a number of actions to further develop services across Scotland. Some of these actions are specific to Child and Adolescent Mental Health Services (CAMHS) with the aim of promoting and protecting children's and young people's mental health and wellbeing and improve their access to timely, evidenced based intervention and support[6].

As part of Action 19 of the Strategy the CAMHS Lead Clinician's Group was commissioned to develop a nationally agreed best practice guideline to ensure a clear protocol and standards for those occasions when a young person is admitted to a non- specialist ward. The Commission made a significant contribution to this activity which was published in June 2020 and our young person's monitoring data collection reflects a key number of these standards. [7]

Action 20 of the Mental Health Strategy 2017-2027 states plans to: "Scope the required level of highly specialised mental health inpatient services for young people and act on its findings." The services referred to in this action are those that would meet the needs of young people who also have learning disability or autism or who due to the nature of their illness may have committed offences that require care to be delivered in specialist child and adolescent psychiatric forensic care.

Currently Scotland does not have these inpatient facilities and the Commission has highlighted the continued lack of provision in these areas previously.

NHS Ayrshire and Arran has been chosen as the site for the building of a National Secure CAMHS Inpatient Facility (National Secure Adolescent Inpatient Service (NSAIS)) and encouragingly progress on the project has continued so that building work is anticipated to start in 2021 with an expectation that admissions should begin in 2022. This proposed development would meet the needs of those young people who require specialised forensic psychiatric care. The Commission has been involved

[6] Mental Health Strategy 2017-2027 published March 2017 http://www.gov.scot/Publications/2017/03/1750
[7] www.gov.scot/publications/best-practice-guideline-admission-adult-mental-health-wards-under-18s-mental-health-problems-adaptation-scotland/pages/2/

in supporting appropriate contingency planning for the unit to ensure that this respects and upholds young people's rights.

NHS Lothian has been chosen as the location for the development of a four-bedded unit for young people between the ages of 12 and 18 with a learning disability and facilities for the under 12s with a learning disability are to be developed within the National Child Inpatient Unit in Glasgow. Work on this project is continuing but is at a less advanced stage than the forensic unit NSAIS. The Commission has been involved in the planning of this unit to ensure that CAMHS management remains involved in the unit activity rather than the unit being managed under adult learning disability services.

In recent years the Commission has been highlighting the lack of IPCU provision for young people in Scotland and the impact that this has on young people and their families. The need for IPCU facilities is quite different from the forensic needs that NSAIS is designed for. Last year we again made recommendations about IPCU provision for young people in Scotland. Historically work has taken place by different parties and at different times to explore ways in which the needs of young people for IPCU care may be addressed in Scotland. Unfortunately these previous attempts have never been able to come to a conclusion and no solution has been found as to how best meet the needs of young people for IPCU in an age appropriate manner in a way that is practical, sustainable and accessible for the whole of Scotland.

Since our recommendations last year we are pleased to hear that that work has started to explore the need for IPCU provision for young people in Scotland. Young people's views are to be collected as part of this project and, although work to bring about changes in the ability of young people to access IPCU facilities nationally remains in the early stages we very much welcome this development.

Recommendation 1: The Commission recommends that work to explore the accessibility and provision of intensive psychiatric care facilities (IPCU) for the under 18s in Scotland is sufficiently prioritised, resourced and supported by Scottish Government to ensure that its work can be brought to completion within an appropriate timescale and result in meaningful change nationally for young people having access to IPCU facilities that are age appropriate.

Specialist Child and Adolescent Inpatient Services in Scotland

In Scotland, there are three NHS regional adolescent in-patient units for young people aged between 12-18. These units are:

Skye House is a 24 bedded specialist adolescent unit based in Stobhill Hospital, Glasgow. that receives admissions of young people from NHS Dumfries and Galloway, NHS Ayrshire and Arran, NHS Greater Glasgow and Clyde, NHS Lanarkshire and NHS Forth Valley (West of Scotland region).

The Young People's Unit in Edinburgh is a 12 bedded unit in the Royal Edinburgh Hospital campus and receives admissions of young people from NHS Lothian, NHS Borders and NHS Fife (East of Scotland region).

Dudhope House in Dundee is a purpose-built 12 bedded unit that receives admissions of young people from NHS Highland, NHS Grampian, NHS Tayside, NHS Shetland and NHS Orkney (North of Scotland region).

In addition to these regional units for adolescents the National Child Inpatient Unit based in Glasgow receives admissions of children under the age of 12 years with mental health difficulties from across Scotland (6 beds).

In February 2019 the 10 bedded non-NHS Huntercombe Hospital in West Lothian which admitted patients between the ages of 12 and 18 closed.

The Young Person's Monitoring Process

The Commission collects information through notifications from health boards about the admissions of young people under the age of 18 years when they are admitted to wards for mental health care that are not in any of the units mentioned above. Information from mental health act forms also feed into this routine collection process and Commission staff are alerted to the admissions of young people to a non-specialist ward.

The Commission does not collect information on those admissions that are less than 24 hours in duration, are solely related to drug or alcohol intoxication or are solely for the medical treatment of self-harm.

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Once we have been notified about an admission we send out a questionnaire to the consultant in charge of the young person's care (or RMO) to find out further information about the admission.

In order to improve accuracy of our data collection in addition to the above routine process, every three months medical records staff from each Health Board area are required to submit details of any young person under the age of 18 who have been admitted to non-specialist wards in their Health Board area and who meet our criteria. Commission staff then cross reference this information with the admissions we have been notified about and chase ones that are missing from routine notification processes.

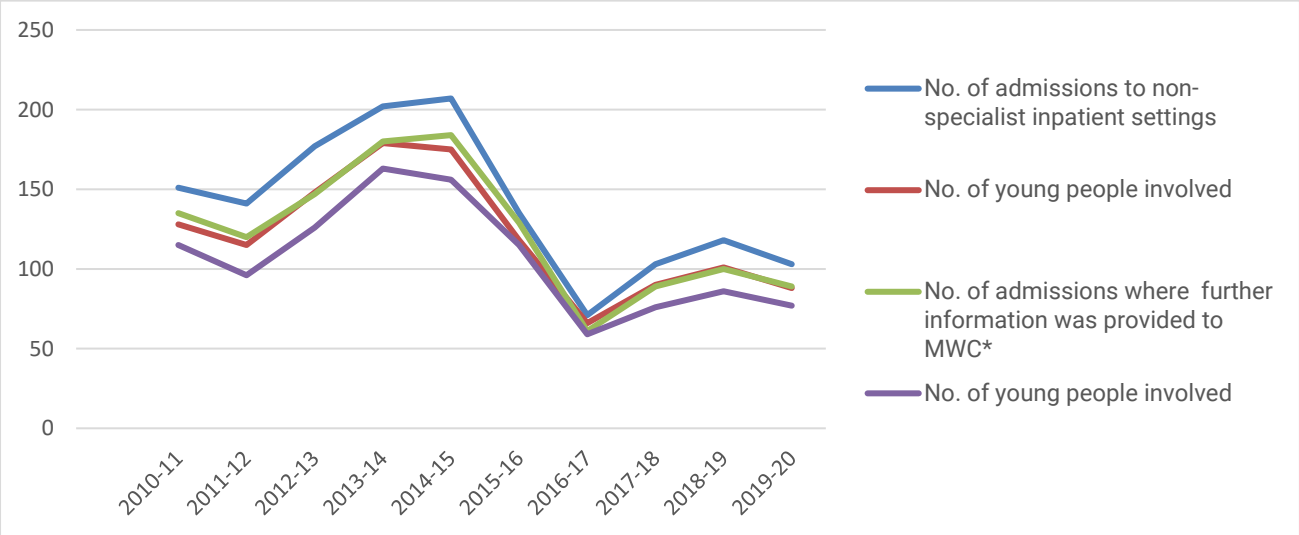
Young people (under 18) admitted to non-specialist facilities, by year 2010-2020

Table 1: Young people (under 18) admitted to non-specialist facilities, by year 2010-20

	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020
No. of admissions to non-specialist inpatient settings	151	141	177	202	207	135	71	103	118	103
No. of young people involved	128	115	148	179	175	118	66	90	101	88
No. of admissions where further information was provided to MWC*	135	120	147	180	184	129	61	89	100	89
No. of young people involved	115	96	126	163	156	115	59	76	86	77

*admissions where completed monitoring form returned to MWCS

Figure 1: Young people (under 18) admitted to non-specialist facilities, by year 2010-19



In 2019-2020 we were notified of 103 admissions to non-specialist wards which involved 88 young people. We received further information on 89 of these 103 admissions.

This is a slight decrease from last year when the figures had increased to 118 admissions involving 101 young people.

The lowest numbers were collected in 2016-2017 (71 admissions involving 66 young people).

This year's figures, however, remain an improvement on 2013-14 and 2014-2015 figures when admissions above 200 were recorded each year and also an improvement from figures before 2013 when admission numbers were higher than present levels. We welcome this development and are keen that ongoing review of the specialist adolescent inpatient estate in Scotland together with services that provide an alternative to admission remains ongoing to enable admissions of children and young people to non-specialist wards to be reduced further. This will be particularly important if specifications for CAMHS services in Health Boards which look after young people who are age 16 and 17 only if they are in full time education are altered which would likely increase demand for specialist adolescent inpatient provision.

Public Health Scotland (PHS) also collect information on admission to non-specialist wards using SMR04 (the name of a form) data completed by medical records staff at the time of discharge. We are keen to work with PHS colleagues to explore PHS and Commission data collection and review the processes to optimise the collection and reporting of children and young people to non-specialist admissions and intend to undertake a project with PHS in the near future to further our knowledge in this regard.

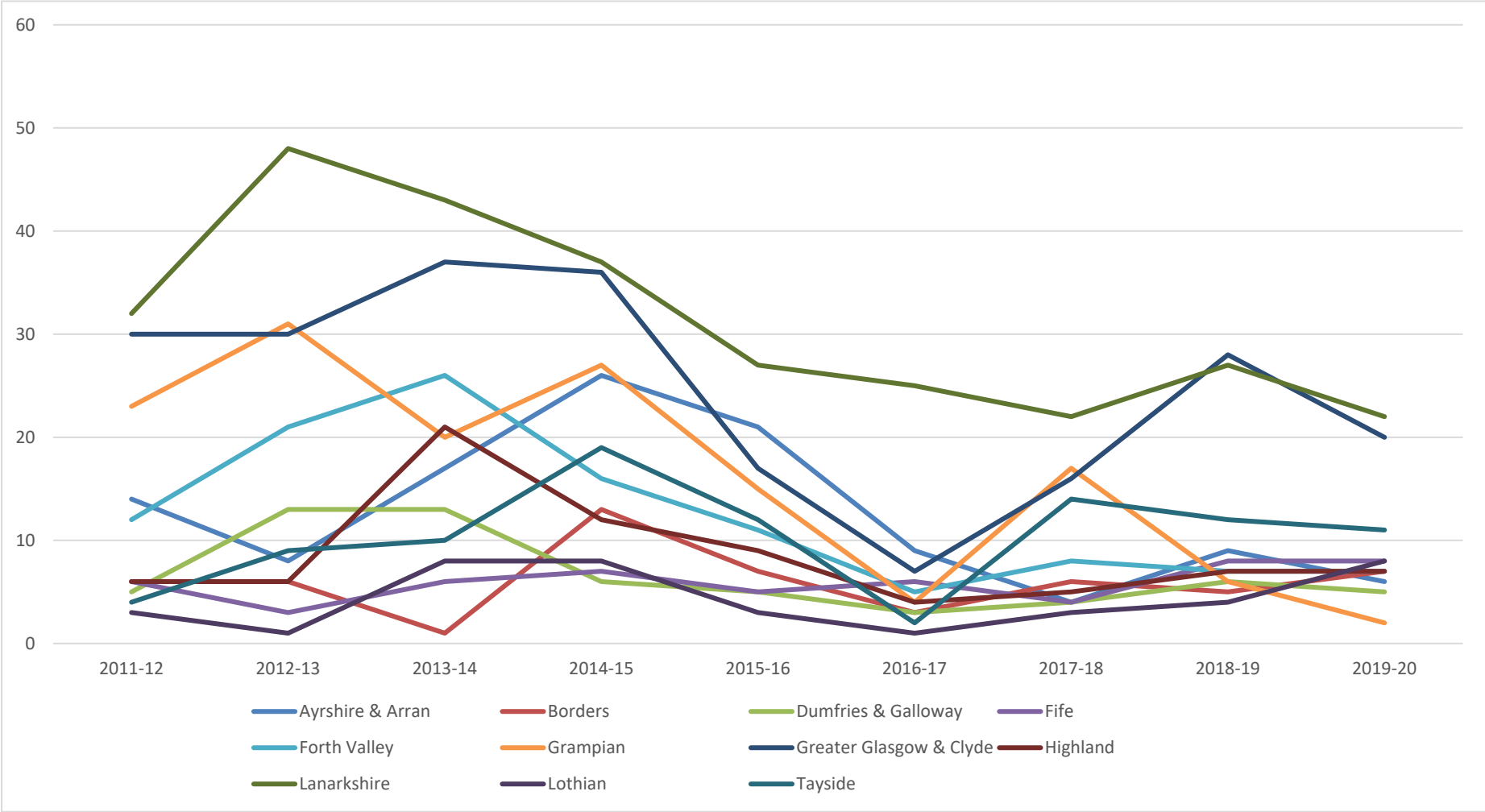
Young people admitted to non-specialist facilities by NHS board, by year 2012-2020

Table 2: Young people admitted to non-specialist facilities within an NHS board, by year 2012–2020

Health Board	2012 – 2013		2013 – 2014		2014 – 2015		2015 – 2016		2016 – 2017		2017 – 2018		2018 – 2019		2019 – 2020	
	Admissions	Young People Involved	Admissions	Young People Involved	Admissions	Young People Involved	Admissions	Young People Involved	Admissions	Young People Involved	Admissions	Young People Involved	Admissions	Young People Involved	Admissions	Young People Involved
Ayrshire & Arran	8	8	17	15	26	21	21	17	9	8	<5	<5	9	9	6	5
Borders	6	5	<5	<5	13	6	7	7	<5	<5	6	<5	5	<5	7	5
Dumfries & Galloway	13	10	13	9	6	6	5	5	<5	<5	<5	<5	6	<5	5	5
Island Boards*****	0	0	0	0	<5	<5	<5	<5	<5	<5	0	0	<5	<5	<5	<5
Fife	<5	<5	6	5	7	<5	5	5	6	6	<5	<5	8	6	8	6
Forth Valley	21	19	26	25	16	15	11	9	5	5	8	8	7	7	7	6
Grampian	31	22	20	17	27	23	15	12	<5	<5	17	14	6	5	<5	<5
Greater Glasgow & Clyde	30	24	37	34	36	30	17	16	7	7	16	14	26	23*	20	18
Highland	6	6	21	19	12	11	9	8	<5	<5	5	<5	7	7	7	<5
Lanarkshire	48	40	****43	****38	37	34	27	24	25	22	22	19	27	21*	22	18
Lothian	<5	<5	8	7	8	8	<5	<5	<5	<5	<5**	<5**	<5	<5	8	8
Orkney	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
State	<5	<5	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Tayside	9	9	10	9	19	17	12	11	<5	<5	14	12	12	10	11	10
Independent (Ayr Clinic)***	0	0	0	0	0	0	0	0	<5	0	0	0	0	0	0	0
Scotland	**177**	**148**	**202**	**179**	**207**	**176**	**135**	**118**	**71**	**66**	103	90	118	101	103	88

* GGC total =23 as 1 YP also admitted to Lanarkshire. Some of these figures (<3) relate to young people looked after by Esteem. **We were informed that one admission to NHS Lothian was an out of area admission from NHS Greater Glasgow and Clyde (2017/2018).*** Ayr Clinic shown as independent rather than included in NHS Ayrshire and Arran figures. This admission followed a preceding admission to a non-specialist ward in Scotland. It is therefore not included in the individual data due to the young person being counted already elsewhere.**** We were informed that one admission to NHS Lanarkshire was an out of area admission from NHS Greater Glasgow and Clyde (2013/14).***** Island Boards comprise Eilean Siar (Western Isles) , Shetland and Orkney. The figures have been pooled in line with good practise relating to the publication of small numbers.

Figure 2: Graph showing Annual number of admissions within each Health Board area



The Mental Health Act places a clear legal duty on health boards in relation to the provision of child inpatient care and the Act has a clear principle that the child's welfare should be most important in framing service response The Commission's view is that when a young person requires in-patient treatment, their individual clinical needs should be given paramount importance.

When comparing admissions to non-specialist facilities by NHS board area, the Commission is looking to see whether there have been significant changes in the number of admissions within a specific area compared with the previous year.

There continues to be differences in the configuration of CAMHS across the country with varying eligibility criteria for young people for CAMHS versus Adult Mental Health services depending on their age and educational status. Some CAMHS provide mental health services for children and young people under the age of 16 years and only for young people between the ages of 16 and 18 years who are in full time education. Others provide mental health services for children and young people up to the age of 18 years. Importantly this difference in service configuration can affect the numbers of young people admitted to non-specialist wards. In the Commission's 2015-6 report an additional monitoring exercise[8] showed that young people aged between 16 and 18 who were not in full time education and were looked after ordinarily by general adult mental health teams in certain health boards were unlikely to access a specialist adolescent bed when admitted to hospital due to perceived continuity and consistency issues for the local adult psychiatric team. Recently published Scottish Government CAMHS specifications suggest that all CAMH services in Scotland should provide services for all children and young people up to the age of 18.[9]

Figures in Table 2 compare admissions to non-specialist in-patient mental health beds for young people up to the age of 18 years within an NHS board area from 2011-12 to 2019-20. This year, admission numbers for each NHS board areas in Scotland are mainly either similar to last year's figures or show some slight falls (Greater Glasgow and Clyde, Lanarkshire). Lothian figures showed a slight increase. We maintain the view that a single year's figures are difficult to interpret and several years of data collection is required in order to be able to make conclusions about trends with any confidence.

There does, however, appear to be a moderate but definite reduction in overall admission numbers from previous levels across the country since 2013 although there are regional differences in annual admissions figures and the number of admissions continue to affect the care and treatment of a sizeable number of children and young people.

[8]Young Person Monitoring 2015-2016. October 2016.
http://www.mwcscot.org.uk/media/343729/young_person_monitoring_report_2015-16.pdf
[9] National Service Specifications for CAMHS February 2020 https://www.gov.scot/publications/child-adolescent-mental-health-services-camhs-nhs-scotland-national-service-specification/

Length of stay in non-specialist wards, by year 2015 to 2020

We have been aware, from our monitoring activity and from our visits to young people that lengths of stay in non-specialist environments can vary considerably and a small but significant minority of young people are looked after for long periods of time on wards which are not designed for their needs.

The length of stay is the amount of time that a young person remained in a non-specialist ward during an admission.

We believe that length of stay together with standards of care provided while a young person is looked after in a non-specialist environment are important quality issues to keep in mind alongside the overall numbers of young people admitted to non-specialist wards nationally.

Table 3: Length of stay in non-specialist wards, by year 2016-2019

Length of Stay*	**2015/ 2016**	**%**	**2016/ 2017**	**%**	**2017/ 2018**	**%**	**2018/ 2019**	**%**	**2019/ 2020**	****%**
1-3 days	36	27%	25	35%	29	27%	35	30%	36	35%
4-7 days	28	21%	17	24%	23	22%	37	31%	25	24%
8-14 days 1-2 weeks	28	21%	8	11%	20	19%	13	11%	19	18%
15-21 days 2-3 weeks	13	10%	4	6%	10	9%	12	10%	9	9%
22-28 days 3-4 weeks	11	8%	7	10%	3	3%	6	5%	0	0%
29-35 days 4 weeks+	7	5%	3	4%	2	2%	5	4%	<5	1%
36 days or more 5 weeks +	12	9%	7	10%	19	18%	10	8%	13	13%
Total	**135**	**100%**	**71**	**100%**	106	100%	118	100%	103	100%
Mean (days)	15		19		23		16		21	

*The Commission collects data on admissions that are 24 hours and above. Totals are based on the total number of admissions for that year. ** Based on 103 admissions

The majority of admissions continue to be short in length (35% are between 1 and 3 days). However, sizable numbers of young people remain inpatients in a non-specialist environment for longer periods (41% last over 7 days, 23% last over two weeks and 13% lasted over 5 weeks).

When we looked into the admissions which were over five weeks in length many involved young people for whom there was no national provision of inpatient beds for their age group and/or mental

health needs. This often relates to young people who have learning disability and does again this year (see page 30/31). All 13 of the young people who were admitted to a non –specialist ward for over five weeks were either 16 or 17 years old. Five needed an IPCU admission as part of their hospital stay at some point and three were care experienced young people.

In longer admissions of young people to non-specialist wards, it is very important that the young person has access to a range of CAMHS specialist care relevant to their needs and provided by differing professional groups as appropriate.

While a small majority of admissions are less than one week in length, this still represents a considerable amount of time for young people in a non-specialist environment, many of whom have never been in hospital before.

Specialist health care provision for young people in non-specialist care, 2019/20

The Commission requests information as to whether specialist child and adolescent mental health support is available to a young person admitted to a non-specialist ward, to ensure that appropriate care and treatment is being provided to the young person, and that relevant guidance and support is available for staff in non-specialist units who will have less experience of providing treatment and support to young people.

Access to specialist child and adolescent services following admissions of a young person to an adult ward continues to vary across the country.

Table 4: Specialist health care for admissions of young people in non-specialist care, 2019/20

Specialist medical provision	Age 0-15	Age 16-17	All	*%
RMO at admission was a child and adolescent specialist	10	41	51	57%
CAMHS consultant available to give support other than as RMO	6	19	25	28%
Nursing staff with experience of working with young people were available to work directly with the young person	15	27	42	47%
Nursing staff with experience of working with young people were available to provide advice to ward staff	16	52	68	76%
The young person had access to other age appropriate therapeutic input	9	28	37	42%
None of the above	1	9	10	11%
Total admissions*	19	70	89	100%

* Total=89, all admissions where further information was provided; percentages may sum to more than 100% as more than one type of specialist medical provision might be provided at any one admission.

Once again in 2019-2020 there has been no substantial improvement in the percentages of young people receiving specialist care input from CAMHS staff during their admission to a non-specialist unit and the figures have now remained at a similar level over several years.

In some circumstances where an admission might be of very short duration, the provision of direct specialist clinical contact might not be as important in terms of provision of care as stays of longer duration.

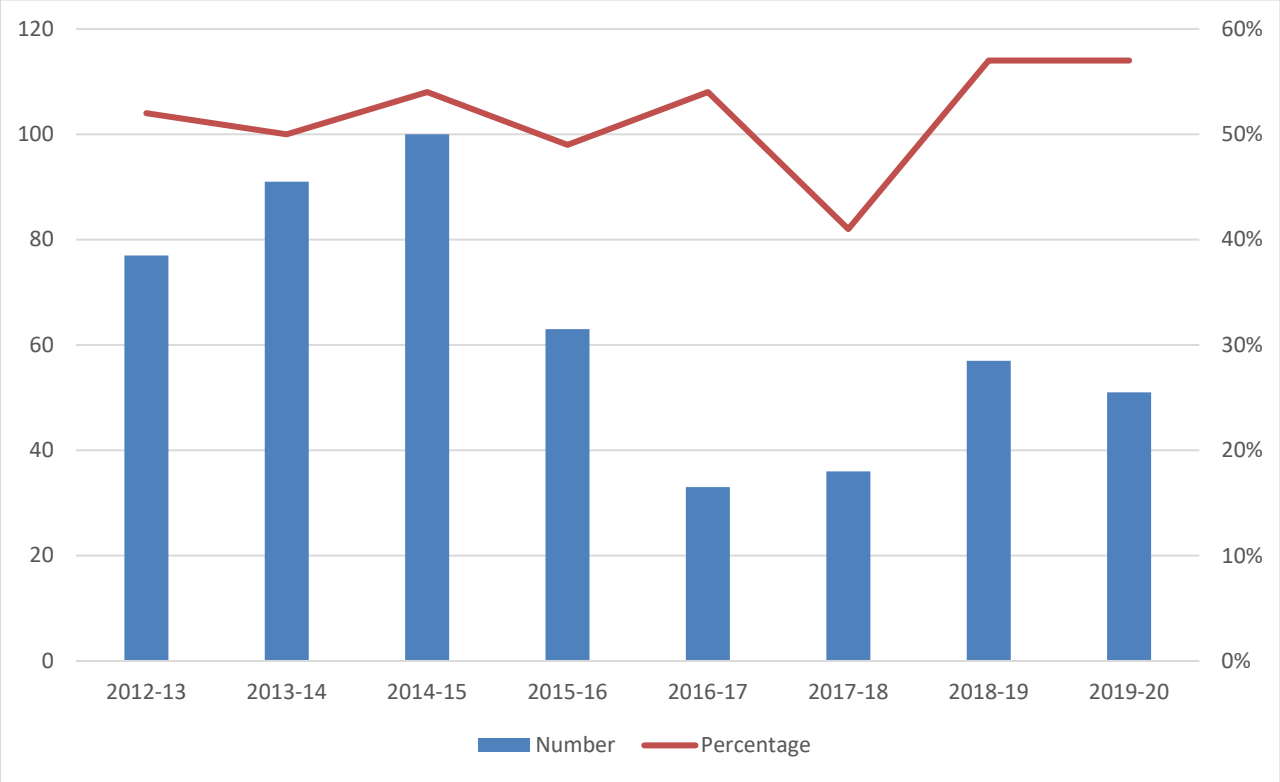
However, even in short admissions the task of liaison, communication and co-ordination of care around discharge and discharge planning is crucial for young people presenting in crisis.

In 2019-2020 the consultant in charge of a young person's care (or RMO) was a child and adolescent specialist in 51 out of 89 admissions (57%). This compares with 57% in 2018-2019, 41% in 2017-2018,

54% in 2016-2017, 49% in 2015-2016, 54% of admissions in 2014-2015, 50% in 2013-2014 and 52% in 2012-2013.

In 2019-2020 there were a further 25 admissions (28%) where a CAMHS consultant was available for advice for the admissions although was not the actual consultant in charge of care.

Figure 4a: RMO as Child Specialist



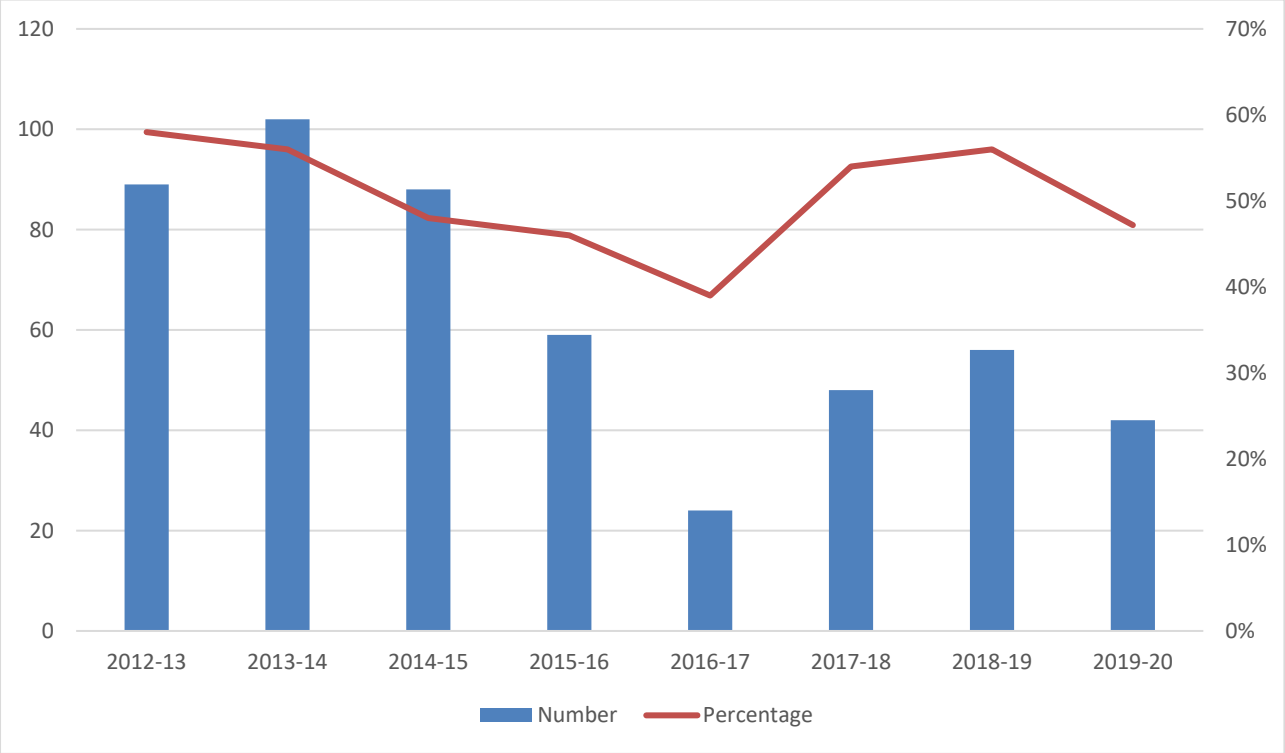
Data is based on the further information provided to the Commission (89 admissions) and reported on annually.

Once again in a large proportion of admissions there was no direct input from nurses experienced in working with children and adolescents.

In 2019-2020 42 out of 89 admissions (47%) experienced direct nursing care from child and adolescent experienced nurses.

This compares with 56% in 2018-2019, 54% in 2017-2018, 39% in 2016-2017, 46% in 2015-2016, 48% in 2014-2015, 56% in 2013-14 and 58% in 2012-2013. The percentage of admissions where there have been nurses available with relevant CAMHS experience to provide advice to ward staff also remains similar to previous years 68 admissions (76%). This compares with 80 out of 100 admissions (80%) in 2018-2019 85% in 2017-2018, 84% in 2016-2017, 78% in 2015-2016, 85% in 2014-2015, 80% in 2013-2014, and 76% in 2012-2013. This data reports the number of admissions when nurses with CAMHS experience were available for advice if needed but not whether that advice was ever sought.

Figure 4b: Direct Specialist Nursing Care provided



Data is based on the further information provided to the Commission (89 admissions) and reported on annually.

In 2019-2020 37 out of 89 admissions (42%) were able to access additional age appropriate therapeutic input.

This compares with 46% in 2018-2019, 41% in 2017-2018, 49% in 2016-2017, 38% in 2015-2016, 59% in 2014-2015, 51% in 2013-2014 and 88% in 2012-2013.

When looking at the information provided to the Commission in relation to the admissions of young people to non-specialist wards it is often not clear what factors influence whether a young person receives input from CAMHS whilst an inpatient.

For those health boards where adult mental health services provide services for some 16-17 year olds, such young people would not necessarily be expected to receive input from CAMHS while in hospital. Of the 10 admissions in which the young person received no input at all from clinicians specifically trained and experienced in child and adolescent mental health all but one admissions occurred in a health board whose CAMHS service does not included everyone under the age of 18 years.

Where admissions are very short or over a weekend, for example, specialist input may not be provided.

These factors do not explain many findings, however. This year, as in previous years, the provision of specialist care is inconsistent across non-specialist admissions.

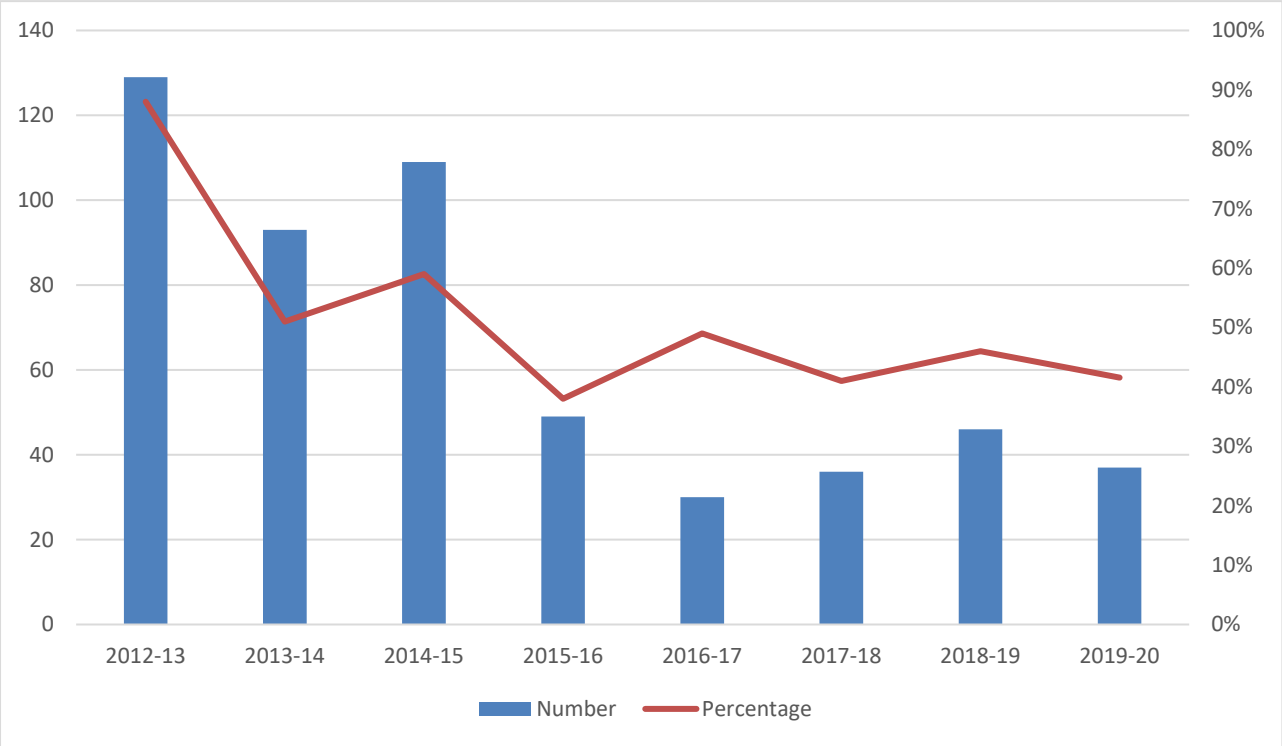
Concerningly in the 10 admissions which received no specialist input from child and adolescent clinicians during their hospital stay, 50% related to admissions lasting longer than one week and 20% lasted longer than 5 weeks. 2 of these 10 admissions also required IPCU admission at some point during their hospital stay.

Of the 13 admissions involving young people that lasted longer than 36 days, a high percentage ten (77%) had either a consultant in charge of their care who was a child specialist or a CAMHS consultant available for advice if needed. Only six of these 13 admissions had direct CAMHS nursing provision provided to the admission (46%) and only 7 (54%) had other age appropriate therapeutic intervention provided.

Of the 89 admissions that we obtained additional information about, 36 neither received direct specialist nursing support or specialist therapeutic input (40%) during their stay. Of these 36 admissions, 14 lasted between 1-3 days (39%), 10 lasted between 4-7days (28%), five lasted between 8-14days (14%), two lasted between 15-21 days (6%) and five lasted longer than 36 days (14%).

It is not clear if capacity issues in community CAMHS staff impacts negatively on the availability of nursing and other clinical staff to support non-specialist admissions of young people.

Figure 4c: Other specialist therapeutic care provided



Data is based on the further information provided to the Commission (89 admissions) and reported on annually.

Admissions of care experienced young people and social work provision for admissions of all young people to non-specialist care, 2019/20

Table 5: Social work provision for admissions of young people to non-specialist care, 2019/20

Social work provision	Age 0-15	Age 16-17	All	*%
Young person was looked after and accommodated by the local authority	7	13	20	22%
No information	1	3	4	4%
Young person had access to social work	16	47	63	71%
No information	3	17	20	4%
Total	19	70	89	100%

*Total=89, based on all admissions where further information was provided to the Commission.

Many young people admitted to a non-specialist facility will have had no prior involvement with social work services, but our expectation would be that if social work input is felt to be necessary at the time when an admission is being considered, or after admission, there should be clear local arrangements to secure that input.

The Commission is particularly concerned about vulnerable groups of individuals and is interested in the provision of services to care experienced or "looked after" children[10]. A young person is described as being 'looked after 'if, under the provisions of the Children (Scotland) Act 1995, they are under the care of their local authority and either subject to voluntary or statutory measures and looked after at home, or looked after away from home in foster or kinship care, a residential care home, a residential school or secure young people unit.

There is evidence that such children generally experience poorer mental health and there is an established national requirement that NHS boards ensure that the health care needs of care experienced or 'looked after' children are assessed and met, including mental health needs[11]. The Guidance on Health Assessments for Looked after Children and Young People[12] emphasises that

[10] Children and young people looked after by the local authority or young people leaving care wish to be known collectively as care experienced. For this report we retain the use of the term 'looked after and accommodated' to describe a specific group of children and young people who are care experienced and are accommodated by the local authority.
[11] Action 15 Looked After Children and Young people: We can and must do better. January 2007 https://www2.gov.scot/resource/doc/162790/0044282.pdf
[12] The Scottish Government (28 April 2009) CEL16 http://www.sehd.scot.nhs.uk/mels/CEL2009_16.pdf
The Scottish Government (2014) *Guidance on Health Assessments for Looked After Children and Young People in Scotland* http://www.gov.scot/Resource/0045/00450743.pdf

mental health problems for care experienced young people are markedly greater than for their peers in the community.

In the recent Mental Health Strategy 2017-2027[13] Action 5 addresses particular issues "for young people on the edges of and in secure care" and seeks to ensure mental health needs are considered in the pathway of care for these children and young people.

We have been collecting information about young person's admissions to non-specialist wards and whether they are 'looked after and accommodated' since 2014. We would assume that any 'looked after' young person admitted to a non-specialist facility should have an identified social worker.

Twenty (22%) of the admissions for which we received further information involved young people who were described as being 'looked after and accommodated'. This compares with 21% in 2018-2019, 16% in 2017-2018, 13% in 2016-2017, 13% in 2015-2016 and 13% of young people in 2014-2015. Of the twenty admissions of young people this year, seven were admissions of young people under the age of 15 or and 13 related to admissions of young people aged 16 to 17 years. In terms of length of stay, three of the admissions (15%) lasted longer than five weeks, four were longer than two weeks (20%) and eight (40%) were longer than one week. A similar number of admissions to 2018-2019 involving young people who were "looked after and accommodated "also had an identified learning disability (three out of twenty admissions 15%).

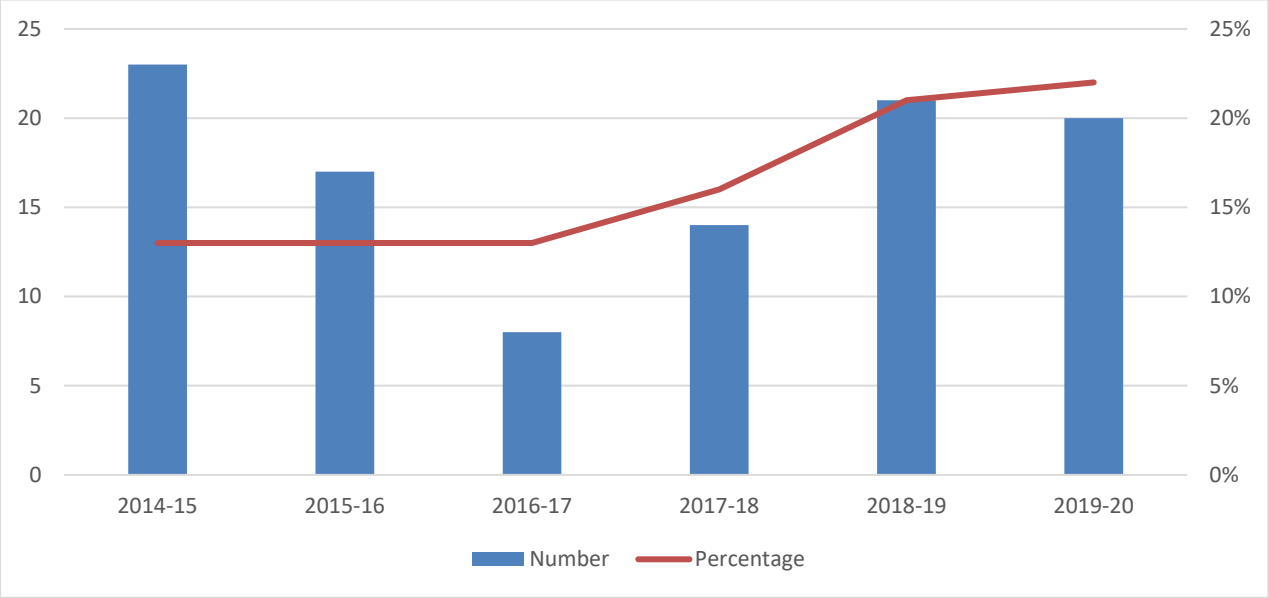
There were fifteen IPCU admissions of young people in 2019-2020 and five of these involved young people who were for looked after and accommodated.

A small number of young people who are 'looked after' accommodated by a local authority are admitted to non-specialist wards at a time of crisis and breakdown of their care placement. At times there are substantial concerns about the young person's mental health at this time and these admissions are entirely appropriate. However, we are aware of other occasions when it appears that a lack of suitably available and/or suitably adapting care provision appears to be the important factor behind admission and the young person is admitted as a result of a need of a place of safety rather than for assessment or treatment of mental health difficulties.

In 2019-2020 63 out of 89 admissions (71%) had access to a social worker. This compares with 71% in 2018-2019, 64% of the admissions we were given additional information about in 2017-2018, 77% in 2016-2017, 71% in 2015-2016, 74% in 2014-15, 76% in 2013-2014, and 74% in 2012-2013.

[13] Mental Health Strategy. March 2017. http://www.gov.scot/Publications/2017/03/1750

Figure 5: Admissions involving Care Experienced Young People



Data is based on the further information provided to the Commission (89 admissions) and reported on annually

Supervision of young people admitted to non-specialist care 2019/20

The Commission asks for specific information about the supervision arrangements for young people admitted on non-specialist facilities to monitor whether the need for increased observation is being carefully considered.

In previous reports the Commission has reported that young people report feeling lonely and bored due to intense supervision that might be in place on a ward on which they might be more vulnerable than they might be if on a ward with peers of a similar developmental age.

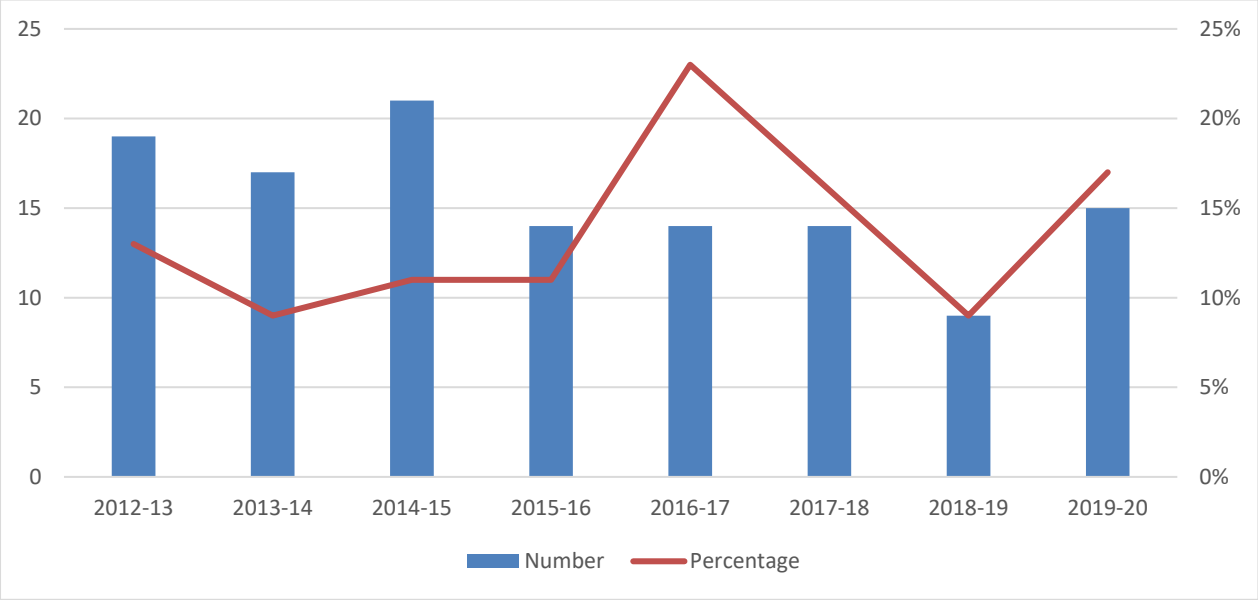
Table 6: Supervision of young people admitted to non-specialist care, 2019/2020

Supervision arrangements	**Age 0-15**	**Age 16-17**	**All**	**%****
Transferred to an IPCU or locked ward during the admission*	<5	13	15	17%
Accommodated in a single room throughout the admission	19	64	83	93%
Nursed under enhanced observation	18	48	66	74%
Constant observation because of ward policy	11	42	53	60%
Constant observation following an individual assessment of the young person	15	40	55	62%
Total**	19	70	89	100

*This is taken from information recorded on the forms.

**Total=89, based on all admissions where further information was provided to the Commission; percentages may sum to more than 100% as more than one of the above arrangements may apply.

Figure 6: IPCU admissions



Data is based on the further information provided to the Commission (89 admissions) and reported on annually.

This year fifteen of the 89 admissions (17%) where further information was supplied to the Commission were cared for in an IPCU or locked ward at some point during their hospital stay. during admission.

This contrasts with 9% of 100 admissions in 2018-2019, 16% of admissions in 2017-2018, 23% of admissions in 2016-2017 , 11 % in 2015-2016, 11% in 2014-2015, 9% of admissions in 2013-2014 and 13% of admissions) in 2012-2013.

In 2019-2020 two young people under the age of 16 were admitted to an IPCU (13% of IPCU admissions). In previous years the proportion of the young people admitted to an IPCU or locked ward under the age of 16 has been around 25% of those admitted to an IPCU overall and in 2017-2018 this figure rose to 36%.[14]

The lack of specialist adolescent IPCU service provision and the lack of clear pathways around access to adult IPCU facilities that are equipped to cater to the needs of younger people can add significant difficulties for the young person, their family and their clinical team when a bed for the young person within a secure hospital environment is required. Clinicians continue to inform the Commission that this is particularly difficult for young people under the age of 16 and for female young people in general requiring IPCU care.

We are also concerned that, because of the lack of any IPCU some young people have to be cared for with significant restrictions in place in an attempt to manage risk on an open ward; a situation which may prove to be unsuitable for the young person and the other patients on the ward.

[14] MWCS Young Person's Monitoring report 2017/2018 www.mwcscot.org.uk/publications

The figures we report are likely to underrepresent the number of young people whose care needs indicate the need for IPCU facilities as the lack of IPCU provision means that clinicians have to try to manage these needs in other ways.

In last year's report the Commission once again highlighted the importance of the lack of provision of IPCU facilities for young people under the age of 18 in Scotland and the lack of established and co-ordinated process and protocols to ensure that young people requiring IPCU facilities have access to appropriate provision when needed. We welcome the news that work has again begun to look at the issue of IPCU for young people in Scotland.

Other care provision for young people, 2019/20

Table 7: Other care provision for young people, 2018/19

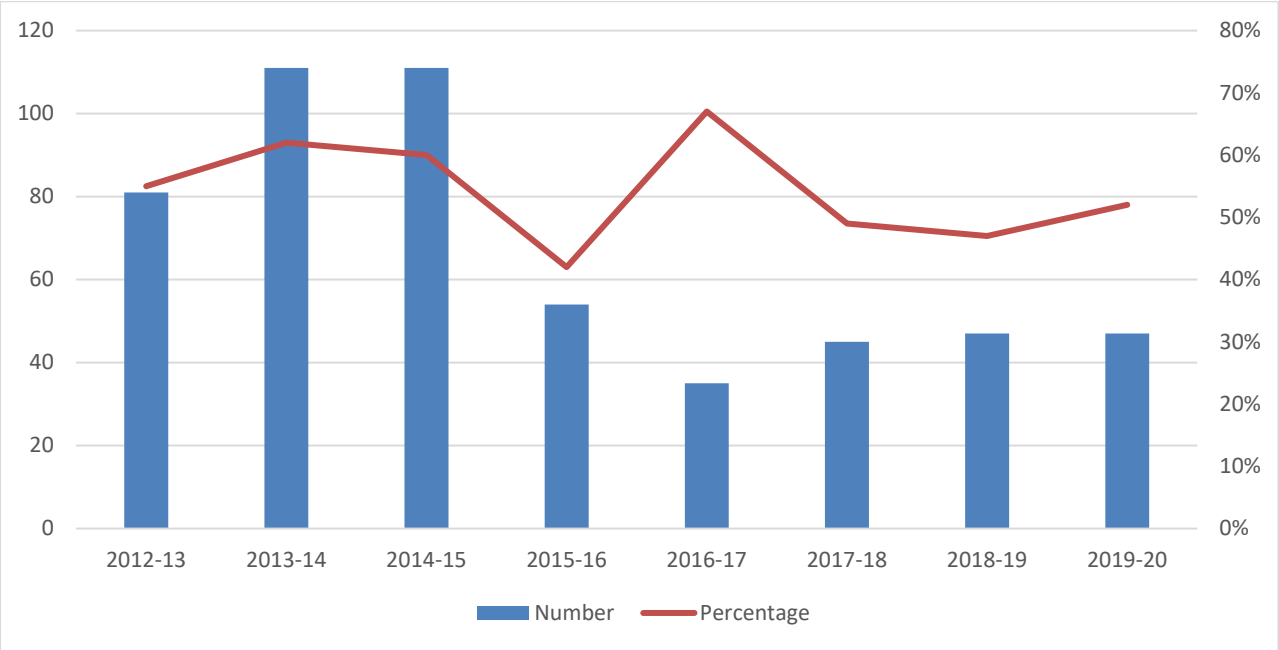
	Age 0-15	Age 16-17	All	*%
Access to age appropriate recreational activities	6	41	47	52%
Appropriate education was provided	2	3	5	6%
Access to advocacy service	9	53	62	70%
Has access to specialist advocacy service	3	15	18	20%
Total*	19	70	89	100%

*Total =89 admission where further information provide to the Commission

As part of our monitoring the Commission asks about access to other provisions to develop a clearer picture of how NHS boards are fulfilling their duty to provide age-appropriate services to young people. The importance of access to age-appropriate recreational activities and consideration of access to education becomes more important as the length of stay in the non-specialist environment increases.

In 2019-2020 the proportion of admissions where a young person was described as having access to age-appropriate recreational activity rose slightly to 52% (47 out of 89 admissions). This compares to 47% in 2018-2019, 49% in 2017-2018, 67% in 2016-2017, 42% in 2015-2016, 60 % in 2014-2015, 62% in 2013-2014 and 55% in 2012-2013.

Figure 7: Access to Age Appropriate Activity



Data is based on the further information provided to the Commission (89 admissions) and reported on annually.

Every year we ask for information about the activities that young people are able to access while they were receiving care and treatment as in-patients. Many young people are reported to have access to electronic games, their phones and to music and DVDs. Some young people are reported to be able to access gym facilities. In previous reports we have suggested that, even when admitted for a relatively short space of time, staff looking after the young person should give sufficient attention to structuring daily activity for young people with clear documentation regarding decisions made regarding appropriate activities available to a young person (involving the young person's views) and how these can be provided[15].

Article 12 of UNCRC describes the rights of all children to express their views freely in all matters that affect them and have their views "given due weight in accordance with their age and maturity. " A key way in which this right can be promoted relates to the accessibility and availability of independent advocacy services for children. In our monitoring process we enquire whether independent advocacy services are readily available which is a right that anyone with a mental disorder has in being able to access this service. In the 2015 amendments to the 2003 Mental Health Act, health boards were given new responsibilities to demonstrate how they are discharging their legal responsibilities in relation to the provision of advocacy.

In 2019-2020, 70% of young people (52 out of 89 admissions in which further information was provided to the Commission) had access to advocacy. This compares with 76% of young people in 2018-2019, 67% in 2017-2018, 61% in 2016-2017, 65% in 2015-2016, 72% in 2014-2015, 65% in 2013-14 and 70% in 2012-2013.

Of the young people who had access to advocacy during the admission, 18 of the 89 admissions (20%) had access to advocacy which specialised in the particular needs and rights of young people. This result remains disappointing and compares with 2017-2018 data of 18%, 20% in 2016-2017, 17% in 2015-2016 and 29% in 2014-2015.Our data does not provide information about whether the young people accessed advocacy during their admission, only that advocacy services might have been available should they have wished to have used them.

We expect advocacy support to be available and to be routinely offered to young people. It may be that during a very brief admission there is no time to involve advocacy to support a young person. However, the findings from our monitoring project described in 2016 raised concerns about the accessibility of advocacy supports during young people's admissions to non-specialist wards. [16]

Recommendation 2: Health Board Managers with a duty to fund and provide advocacy services for individuals with mental health difficulties in their area should review the availability of dedicated advocacy support for children and young people with mental health difficulties locally and ensure the resourcing and provision of any dedicated specialist advocacy service is sufficient to be able to meet the needs of young people with mental health problems and to support and protect their rights.

[15] Young Person Monitoring 2015-2016. October 2016.
http://www.mwcscot.org.uk/media/343729/young_person_monitoring_report_2015-16.pdf
[16] Young Person Monitoring 2015-2016. October 2016.
http://www.mwcscot.org.uk/media/343729/young_person_monitoring_report_2015-16.pdf

Article 28 of the UNCRC gives rights to children to access education and this applies whether the child is in hospital or not. In its general comments in 2007 the CRC stressed that "every child of compulsory school age has the right to education suited to his/her needs and abilities "[17].As part of our monitoring activity, we ask for information about whether education has been considered for and discussed with the young person and, if not, to give reasons why. If education has been considered for a young person, we ask whether education has been provided.

In 2019-2020 twenty two out of the 89 admissions in which further information was provided to the Commission were reported to have had a discussion regarding access to education during their inpatient stay (25%) and five young people had educational materials provided to them during their admission. These figures are comparable to previous years. The remaining young people were described as being either too unwell to access education, their admission was too short or the young person either was no longer in education or had not been in education due to their mental health difficulties. Of the nineteen admissions during 2018-2019 which involved young people who were under the age of sixteen and therefore of statutory school age, education was discussed in only six admissions and in only two was educational material provided.

It may not always be appropriate or relevant to discuss access to education or learning if an admission is for a very short period of time or during a weekend or school holidays or when the young person is no longer in education.

However, we are aware from previous reports[18] that access to education remains a fragile area of service provision when a young person has been admitted to a non-specialist facility. Education authorities have a duty to arrange for the education of young people who cannot attend school because of prolonged ill-health. We do think it is important that education needs are considered when a young person is admitted to an adult ward for a sustained period and remain concerned that staff in adult wards may not know how to access education services should that be appropriate while a young person is in hospital.

Recommendation 3: Hospital managers should ensure that whenever a child or young person is admitted to a non-specialist ward that consideration and exploration of their educational needs and their right to education should be a standard part of care planning for the young person during their hospital admission.

[17] UN Committee of the rights of the child, general comment no 10 (2007) Children's rights in juvenile justice, para 89.
[18] Visits to young people who use mental health services: Report from our visits to1 young people using in-patient and community mental health services in Scotland 2009 (2010) http://www.mwcscot.org.uk/media/53171/CAMHS_report_2010.pdf

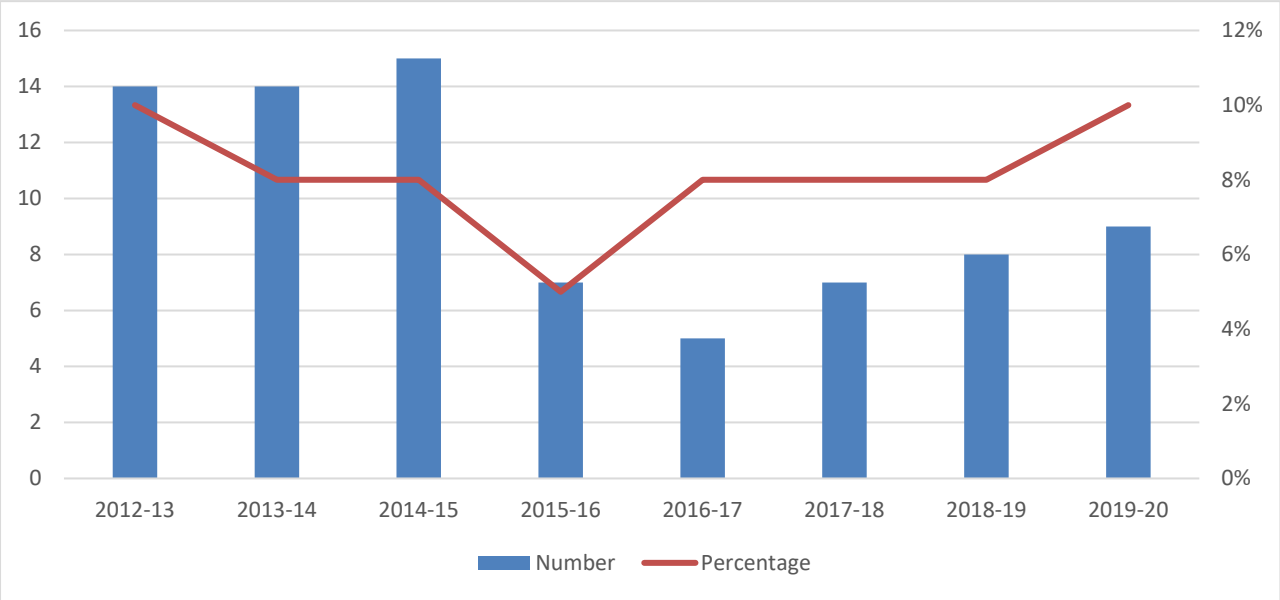
Young People with a Learning Disability 2019/20

Table 8: Admissions involving a Young Person with a learning disability

	Age 0-15	Age 16-17	All	*%
Young person has a learning disability	<5	7	9	10%
Total *	19	70	89	100

Total = 89 admissions where further information was provided to the Commission

Figure 8: Admissions involving a Young Person with a learning disability



Data is based on the further information provided to the Commission (89 admissions) and reported on annually.

The number of admissions to non-specialist settings where additional information was provided and the young people was described as having a learning disability in 2019-2020 was nine out of 89 admissions (10%). This is similar to previous years in terms of percentages: 8% in 2018-2019, 2017-2018 and 2016-2017, 5% in 2015-2016; 8% in 2014-2015 and 2013-14 and 10% in 2012-2013.

Of the nine admissions this year only four (44%) were for less than seven days and three for more than five weeks (33%).

Three of the fifteen admissions to an adult IPCU (20%) in 2019-2020 involved individuals with a diagnosed learning disability, In 2019-2020 three of the nine admissions of young people with a learning disability were also looked after and accommodated by their local authority (33%).

Age and gender 2019/20

We are interested in the age and gender of young people admitted to non-specialist settings to identify trends that develop over time that might indicate particular unmet needs.

In 2019-2020 there were ten children aged 14 years or younger who were admitted to a non-specialist environment. Half of these were admitted to a paediatric ward in the local hospital.

In 2019-2020 the proportion of 16 and 17 year old young people admitted to a non-specialist environment was comparable with previous years (67 out of 88 young people in total, 76%). In 2018-2019 the proportion of 16 and 17 year old young people admitted was 75%, 72% in 2017-2018, 82% in 2016-2017 and in 2015-2016 , 69% in 2014-15, 65% in 2013-14 and 62% in 2012-13.

The higher rates of admissions of young people in the 16-17 year age range reflects current understanding of the prevalence and the types of mental health difficulties affecting young people in this age group in particular.[19]

Table 9: Age of young person by gender

	2016-2017			2017-2018			2018-2019			2019-2020		
Age (yrs)	**F**	**M**	**Total**	**F**	**M**	**Total**	**F**	**M**	**Total**	**F**	**M**	**Total**
15	<5	<5	6	9	<5	12	10	<5	13	5	6	11
16	10	6	16	12	12	24	16	8	24	17	3	20
17	20	18	38	21	20	41	28	24	52	27	20	47
Total*	**37**	**29**	**66**	**51**	**39**	**90**	**62**	**39**	**101**	**56**	**32**	**88**

*Total describes all individuals admitted over the year, including where no further information was supplied to the Commission. The data for young people 14 years and under is included in this total but not provided in the table due to the low numbers. F=Female. M=Male

[19] https://dera.ioe.ac.uk/32622/1/MHCYP%202017%20Summary.pdf https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017 Mental Health of Children and Young People in England 2017.

Figure 9a: Young people admitted to non-specialist wards by gender (number of individuals), by year 2008-2018

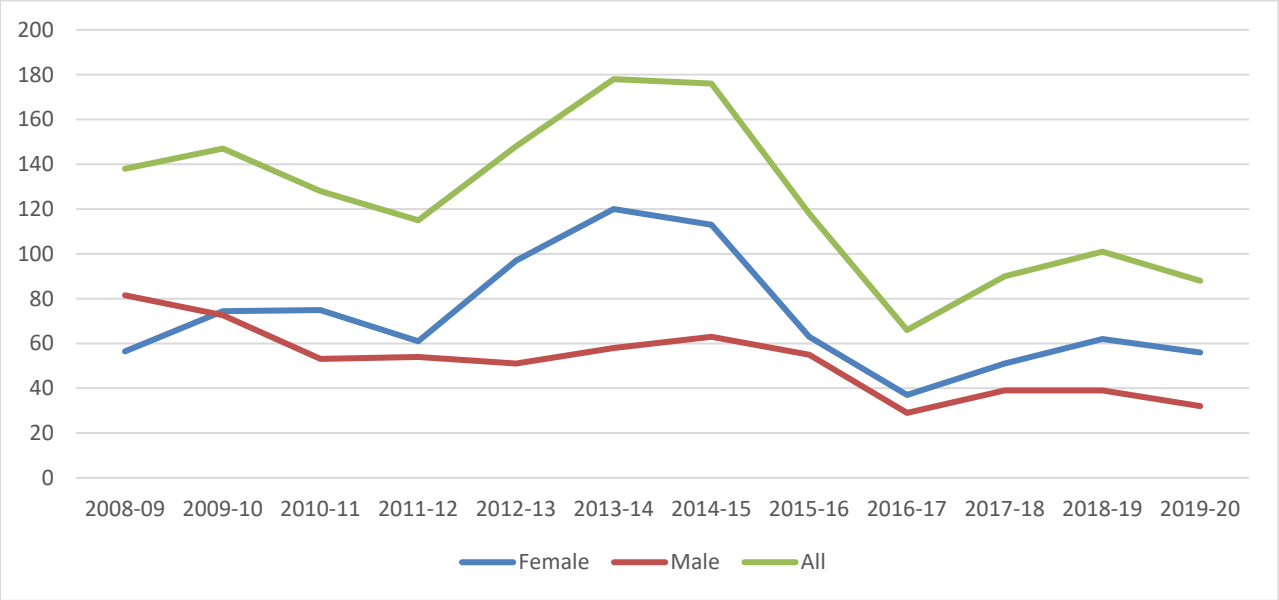
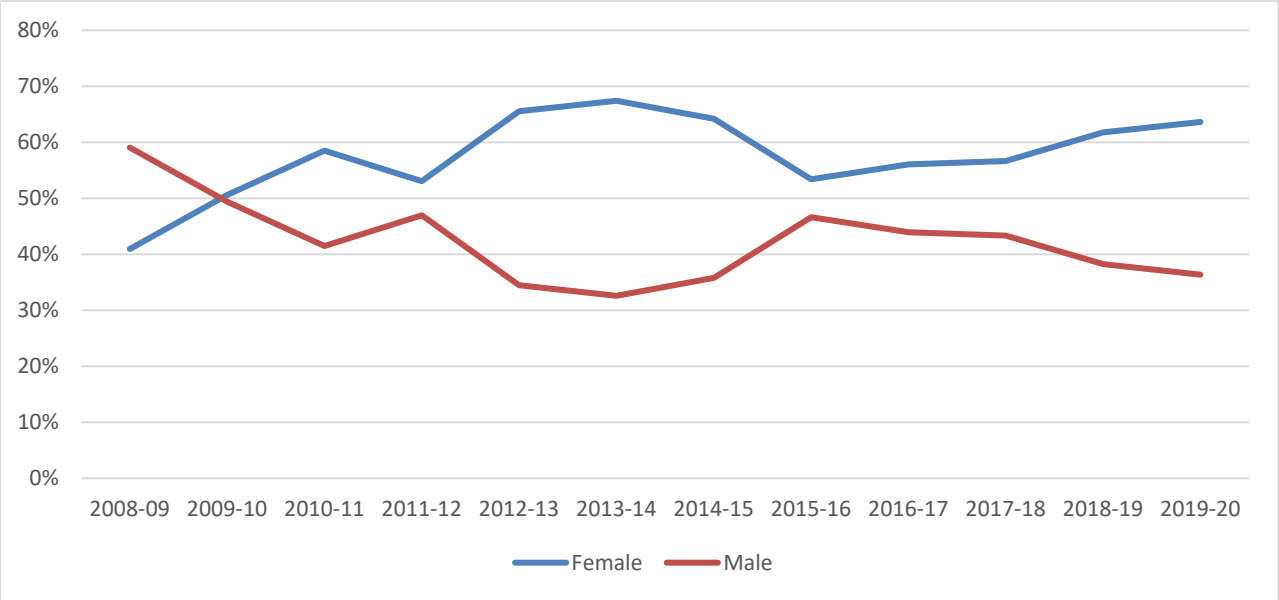


Figure 9b: Young people admitted to non specialist wards by gender (%), by year 2008-2018



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Child and Adolescent Mental Health Services (CAMHS)

NHS Scotland National Service Specification

February 2020

Scottish Government
Riaghaltas na h-Alba
gov.scot

Child and Adolescent Mental Health Services (CAMHS)

NHS Scotland National Service Specification

Introduction

NHS Scotland Child and Adolescent Mental Health Services (CAMHS) are multi-disciplinary teams that provide (i) assessment and treatment/interventions in the context of emotional, developmental, environmental and social factors for children and young people experiencing mental health problems, and (ii) training, consultation, advice and support to professionals working with children, young people and their families.

All children and families should receive support and services that are appropriate to their needs. For many children and young people, such support is likely to be community based, and should be easily and quickly accessible.

Children, young people and their families will be able to access additional support which targets emotional distress through Community Mental Health and Wellbeing Supports and Services. Community supports and services should work closely with CAMHS and relevant health and social care partners, children's services and educational establishments to ensure that there are clear and streamlined pathways to support where that is more appropriately delivered by these services.

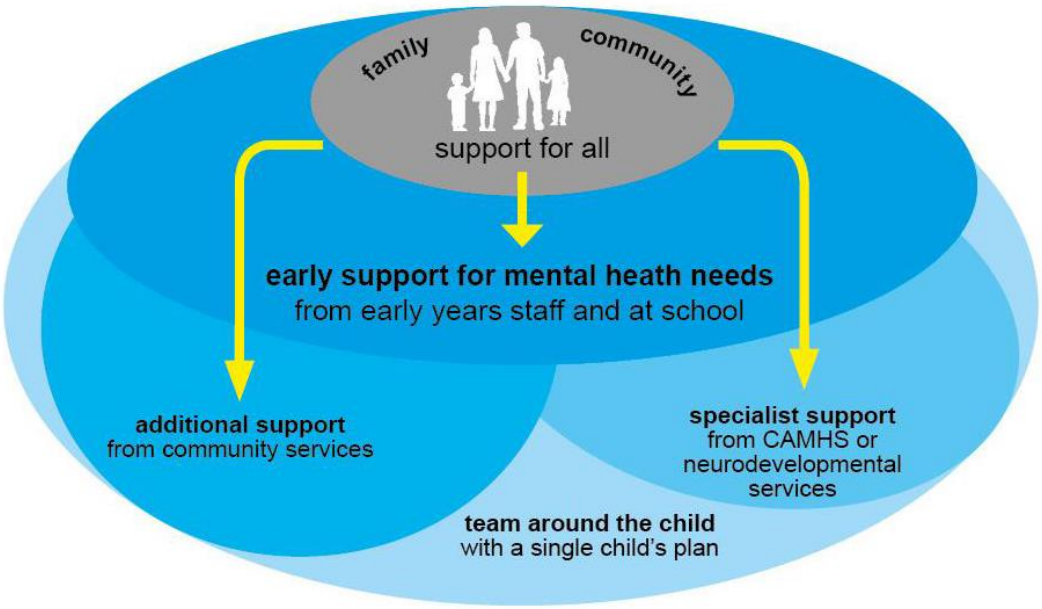
CAMHS will support both universal and additional children and young people's services, including new and enhanced Community Mental Health and Wellbeing Supports, by providing consultation, advice and training, and where appropriate, supervision of those staff providing psychological interventions. Children, young people and their families supported in CAMHS will also have access to supports provided within universal and additional services.

Most young people requiring CAMHS will present with mental health problems that are causing significant impairments in their day-to-day lives, and where the other services and approaches described above have not been effective, or are not appropriate. These presentations can result in both the need for scheduled and/or unscheduled care.

CAMHS will be available for all children and young people who are aged 0 – 18, and who meet the agreed CAMHS referral criteria in Scotland (see Annex 1 - National Referral Pro-forma for Child and Adolescent Mental Health Services (CAMHS) in Scotland). CAMHS will accept requests for assistance and referrals from all children's services professionals, adults with concerns and young people where the National Referral Criteria are met.

CAMHS are usually provided within a stepped and matched care model described in Tiers. This is consistent with the Getting it Right for Every Child (GIRFEC) model and principles (and the model agreed by The Children and Young People's Mental Health and Wellbeing Programme Board). CAMHS works within the network of children's service providers, both statutory and third sector, and will be fully engaged in Children's Services Planning Partnerships. CAMHS will aim to treat children and young people in the right place, at the right time and as close to home as possible.

Diagram 1: CAMHS within the agreed Children and Young People's Mental Health and Wellbeing model:



CAMHS supports universal and targeted community services (Tier 1 and Tier 2), but primarily works as a multi-disciplinary team within a local area - CAMHS Locality Teams (Tier 3), supported by services that have specific and additional expertise, often provided over a larger area (e.g. Forensic CAMHS, Psychiatric Inpatient Care) (Tier 4).

Sections 1 to 7 below are the minimum service standards to be delivered by all NHS Scotland CAMHS and these standards will be reviewed regularly, and in the first instance, in June 2020 on the basis of learning from the implementation process. All statements should be read with the preface "CAMHS in Scotland will":

1. High Quality Care And Support That Is Right For Me

These are the CAMHS 'experience of service' standards to be delivered for children, young people and their families:

1.1 Publish information in a clear, accessible format about what and who CAMHS is for, and how children, young people and their carers can access CAMHS.

1.2 Offer a first appointment to all children and young people who meet the CAMHS Scotland referral criteria. This first appointment, unless in unscheduled or urgent care, should be as soon as possible and no later than 4 weeks.

1.3 Provide support and personalised, meaningful signposting to the child/young person and their family/carers, with informed consent, to access other services within the children and young people's service network, in cases where families' needs are best met elsewhere.

1.4 Conduct a full initial assessment, based on the information from the referrer, and the Child's Plan where completed and available, which includes a comprehensive psychosocial assessment.

1.5 Assure that the member of staff undertaking the initial assessment is appropriately trained and experienced to undertake assessments, to identify strengths and difficulties including identification of mental health disorders, supported by formulation or diagnosis where appropriate.

1.6 Provide interventions and treatments, where required and agreed with children, young people and families/carers, as soon as possible, and no later than 18 weeks from first referral, with the median experienced wait for treatment being no longer than 12 weeks.

2. I Am Fully Involved In The Decisions About My Care

Getting It Right For Every Child (GIRFEC) stresses the importance of care planning and collaboration between professionals as the required standard for delivery of children's services in Scotland, and CAMHS will work to the GIRFEC principles on a multi professional and agency basis.

2.1 Build on and contribute to other parts of agreed multi-agency care pathways.

2.2 Agree through a process of shared decision making the goals of the child and family and regularly review those interventions and progress towards the goals.

2.3 Ensure that the rationale for formulation and diagnosis, evidence considered, and decisions made will be fully documented. This will be shared with the child/young person and parent/carer in writing as appropriate. Share and involve the child, young person and family/cares in the information to be shared with the referrer e.g. that the assessment has taken place and the goals of the care plan.

2.4 Develop a risk management plan, if required, in collaboration with the child/young person and their families/carers, including crisis planning where relevant.

2.5 Ensure that initial and continuous care planning involves all members of the CAMHS team providing care, the child/young person and their families/carers.

2.6 Ensure that care plans are in place for all children and young people receiving support from CAMHS.

2.7 Ensure care plans: are coordinated across agencies (using the GIRFEC principles), teams and disciplines; are clearly written; identify the case holder/care coordinator; are developed in collaboration with children/young people and families and carers (e.g. The Triangle of Care)

2.8 Provide copies of the care plan to children, young people and their families/carers, and, with informed consent, those professionals in other agencies working with the child, young person and families/carers such as social work, schools and children's services providers and primary care (e.g. GPs).

3. High Quality Interventions And Treatment That Are Right For Me

CAMHS has a specific role in the assessment and provision of interventions/treatment of children and young people's mental health problems and this section summarises the main components of CAMHS Tier 3 and Tier 4 services:

3.1 Provide recommendations for interventions and treatment options in consideration of:

- Engagement, accessibility, flexibility and choice.
- Age-appropriate best practice/evidence-based psychological intervention.
- Environmental and occupational/educational interventions or support.
- The availability of a multimedia prevention packages.
- Psychosocial and Pharmacological and interventions.

3.2 Take account of children and young people's educational needs and, with informed consent, work with school and education authority staff to contribute to the child or young person's educational support. This will include responding to requests for assistance under the terms of the Additional Support for Learning Act.

3.3 Provide specific support for the mental health of Looked After Children, including support to the system of care (e.g. advice, consultation, training) and, via the Child's Plan and requests for assistance, children and young people who are experiencing mental health problems.

3.4 Provide a liaison mental health service to all children and young people who are receiving treatment in acute settings such as hospitals, including, in partnership with acute colleagues and other agencies, a robust clinical emergency service with out of hours, weekend and bank holiday capability.

3.5 Provide and/or contribute to a 24/7 mental health crisis response service for children and young people, including support and advice to front line services, assessment and interventions/treatment for mental health crisis presentations, and access to inpatient medical and/or psychiatric care.

3.6 CAMHS Locality Teams (Tier 3) will provide services for:

- Severe Depression and Anxiety
- Moderate to severe emotional and behavioural problems, including severe conduct, impulsivity, and attention disorders
- Psychosis
- Obsessive-compulsive disorders
- Eating disorders
- Self-harm
- Suicidal behaviours
- Mental health problems with comorbid drug and alcohol use
- Neuropsychiatric conditions
- Attachment disorders
- Post-traumatic stress disorders
- Mental health problems comorbid with neurodevelopmental problems

- Mental health problems where there is comorbidity with mild/moderate intellectual disabilities and/ or comorbid physical health conditions, additional support needs and disabilities including sensory impairments
- Children and young people in the above categories and who require Intensive Home Treatment and Support

3.7 CAMHS Locality Teams (Tier 3) response to the above, but will also be supported by services providing additional and specific expertise to children and young people supported in CAMHS who, have more complex and/or specific difficulties. These services are often delivered across board boundaries, regionally or nationally and include Psychiatric In Patient Units. The areas of specific expertise required are children and young people with mental health problems and

- an intellectual disability
- forensic risks and needs
- experience of complex trauma
- an eating disorder
- an admission to an acute hospital
- substance misuse
- questioning or experiencing distress about their gender
- placement in secure care (where secure care facilities are within the relevant NHS Board)
- a complex neurodevelopmental problems
- an early onset psychosis
- a need for inpatient psychiatric care

4. My Rights Are Acknowledged, Respected and Delivered

CAMHS will commit to working within a rights based approach and, given the impact of inequality and discrimination on positive mental health, it's important that children, young people and their families know the actions taken to ensure their rights are respected and they are included. Partner organisations are reminded of their duties under the Equality Act 2010 and the Equality Act 2010 (Specific Duties) Regulations (Scotland) to assess the impact on persons who share a protected characteristic in the delivery of this service.

4.1 Ensure CAMHS are available to all children and young people, taking into account all protected characteristics. Where it is deemed clinically appropriate, alternative services may be established that meet the specific needs of one or more groups within a community. Such services will enhance rather than detract from the minimum standards.

4.2 Ensure CAMHS is delivered in timely, age-appropriate, accessible, and comfortable settings, as close to home as possible, and that meet the needs of children and young people.

4.3 Ensure that informed consent issues around both sharing of information within the family and with other agencies and around interventions/treatment are clearly explained and documented.

4.4 Provide care/interventions that will reduce the risk of and/or prevent unnecessary admission to an inpatient bed and promote safe discharge and recovery.

4.5 Ensure that all service developments and/or redesigns are undertaken using best standards of engagement, involvement of children, young people and their families including co-production.

4.6 Provide and act upon a risk assessment for all those children who did not attend/were not brought, including, implementation of local 'unseen child' protocols and standards. (NB: CAMHS should not close a case due to non-attendance/engagement without discussion with the referrer that the child or young person has not attended/was not brought. See Child Protection Guidance for Health Professionals SG 2013)

4.7 Publish clear re-engagement policies and make them available to referrers, children/young people and families and carers.

4.8 Offer creative and acceptable alternatives to face to face clinical work where the children and young people live at a distance from clinical bases e.g. the use of approved technology like Attend Anywhere or advice to a local professional who is working with the child, young person and their family.

5. I Am Fully Involved In Planning And Agreeing My Transitions

Transitions for children and young people are known to increase risks, particularly for the most vulnerable. The Scottish Government published the Transition Care Planning Guidance in 2018 and this describes the standards required in the planning of good transitions for young people moving from CAMHS to Adult Mental Health Services. The Principles of Transition guidance is relevant in planning and supporting all transitions for children and young people.

5.1 Implement the Scottish Government's Transition Care Planning Guidance. CAMHS will have protocols in place to ensure that transitions between CAMHS and other services are robust and that, wherever possible, services work together with the service user and families/carers to plan in advance for transition (this is especially critical in the transfer from CAMHS to adult mental health services and primary care or other services, e.g. voluntary/third sector).

5.2 Ensure the Transition Care Plan provides children and young people with continuity of care and that any risks and child and adult support and protection concerns are clearly identified and documented.

Groups of children and young people who are more at risk to adversity during transitions and require robust transition plans include:

- Looked after children
- Care leavers moving to independent living
- Young people entering or leaving inpatient care

- Young people entering or leaving prison
- Young offenders
- Children and young people with intellectual disabilities
- Unaccompanied asylum-seeking minors
- Children and young people with caring responsibilities
- Those not in education, employment or training
- Children supported under the Additional Support for Learning Act
- Young Parents
- Young people entering college or university study and, in particular, those moving health board area

6. We Fully Involve Children, Young People And Their Families And Carers

The Children and Young People's Mental Health Programme has been built on and informed by significant involvement of children, young people and their families: in particular, but not limited to, the Rejected Referrals Report, The Youth Commission on Mental Health and the Children and Young People's Mental Health Taskforce. CAMHS will work in partnership with children, young people and their families in all aspects of service design and delivery.

6.1 Provide clear ways and simple to use means for children, young people and/or families/carers to provide regular feedback or to complain. This feedback should be used to improve the support offered.

6.2 Ensure independent advocacy and support services to the whole system are well signposted and children, young people and/or families/carers are supported to access the help available.

6.3 Seek feedback from children, young people and/or families/carers, and other professionals involved with the child or young person with agreement, each time they are supported and are involved in reviewing progress, goals and outcomes.

6.4 Involve children, young people and/or families/carers in all decisions/plans that affect them. This includes the design, planning, delivery and review of services.

6.5 Develop leaflets, websites, social media and other communications aimed at children, young people and/or families/carers in partnership with them.

7. I Have Confidence In The Staff Who Support Me

No public service can provide quality of care without a commitment to develop and sustain a high quality workforce. The variation in workforce levels, professional mix, skill mix, activity, productivity and outcomes in CAMHS was noted in both the Rejected Referrals report and the Audit Scotland report. CAMHS workforce development is a critical element of the delivery of high quality and consistent care across Scotland.

7.1 Provide sufficient staff resources to meet the recommended standards for:

(i) minimum critical mass for CAMHS Tier 3 and Tier 4 services, taking into account specific local circumstances;

(ii) demand and capacity, taking into account wider provision for children and young people's mental health care, and current demand for locality CAMHS teams, ensuring Fair Work standards, and quality of care standards, are met;

(iii) an assessment of population level need.

[NB: Further guidance will follow on Scottish Government's recommended CAMHS capacity and workforce model which will include Fair Work Standards, and the Health and Care (Staffing) Scotland Act]

7.2 Involve children, young people and/or their families/carers, and their views taken into account, in recruitment and appointment of staff.

7.3 Involve children, young people and/or families/carers in the design, delivery and/or evaluation of staff training.

7.4 Provide opportunities for team / service away days to build team relationships, facilitate learning and service development. This should be done on a multi professional/agency basis wherever possible.

7.5 Develop effective relationships and pathways with key local organisations to ensure the holistic needs of children, young people and/or families/carers are met in a timely and appropriate manner, in line with the GIRFEC National Practice Model, The Child's Plan (where completed).

7.6 Clearly describe the roles of professionals in CAMHS, including the capacity for supporting children, young people and their families, and including administration support, team meetings and supervision, and make this information available in a range of audiences and formats.

7.7 Ensure sufficient resources are available for professional, clinical and managerial supervision, including supervision regarding the arrangements for the safety of children and young people.

7.8 Provide opportunities for CAMHS professionals to participate in small group case discussions about case goals and outcomes, and on a multi-agency basis where possible.

7.9 Include children, young people and/or families/carers' views of their experience in CAMHS professional appraisals, and provide systems and processes to gather views appropriately, and with consent, for this purpose.

7.10 Ensure systems and processes are in place (IT and others) to monitor, report on, analyse and respond to, fluctuations in the local planned capacity calculations, but also to report on outcomes of interventions and treatment.

7.11 Ensure CAMHS staff are supported to grow and develop the necessary compassion, values and behaviours to provide person-centred, integrated care and enhance the quality

of experience through education, training and regular continuing personal and professional development that instils respect for children/young people and families/carers.

7.12 Ensure the workforce capacity, current and for the future, is sufficient ensuring an appropriate skill mix and scope of practice to deliver a range of recommended evidence-based interventions within the recommended delivery and capacity model.

ANNEX 1 - National Referral Pro-forma for Child and Adolescent Mental Health Services (CAMHS) in Scotland

Child and Adolescent Mental Health Services (CAMHS) are core clinical multi-disciplinary teams with expertise in the assessment, care and treatment of children and young people experiencing serious mental health problems. Specialist services for those at risk and with specific conditions are also provided, including inpatient care. CAMHS works with and provides support to the wider system of mental health care for children, young people and their families within the Getting It Right For Every Child (GIRFEC) model.

Specialist CAMHS are for children and young people age 0 – 18th birthday with clear symptoms of mental ill health which place them or others at risk and/or are having a significant and persistent impact on day-to-day functioning. While some children and young people will need to come straight to CAMHS i.e. those requiring urgent mental health care, most will require this service when an intervention within primary care, education or a community-based service has not been enough.

Name and demographics of the child or young person - including contact details and Next of Kin – as per ISD requirements.

Who has given consent for this referral?

If the young person is alone, how should we contact them for appointments?

Reason for referral; please specify:
mental health symptoms, risk to child or young person and/or others and impact on day to day life.

Are there any child protection concerns about the child or young person?

What else has been done to address the problem? Please give details e.g. the name of the service, intervention etc.

Past medical history *Physical and Mental Health*
Medication *Current & Past*
Allergies
Family History

If referral relates to a suspected eating disorder:
Physical health data: HR, BP, Height, Weight, BMI, date and results of any recent investigations.

Please ask child or young person to add any further information from them and school/college if appropriate about the difficulties and add this to your referral.

Are there any special requirements for appointments e.g. wheelchair access, interpreter Y/N
If Yes, please specify:

Referrer's details…….

ANNEX 2

Definition of CAMHS Professionals and Services

Tier 3 CAMHS

Tier 3 CAMHS works with children and young people from 0 years up to the age of 18 years who present with significant mental health problems. The team is based in a local area, is multi-disciplinary, made up of nurses, clinical and applied psychologists, social workers, psychiatrists and occupational therapists as the main professions, with access to systemic and family psychotherapists, child and adolescent psychotherapists, speech and language therapists and dieticians as required. These professionals provide consultation and advice to other professional groups and agencies. CAMHS provides specialist diagnostic assessment and provides psychological, systemic and/or pharmacological therapy. They also work with other the staff in the other services out with CAMHS. CAMHS is available for consultation to other professionals concerned about children and young people's emotional wellbeing and mental health issues. CAMHS Tier 3 teams deliver the National Referral to Treatment Standard so are key to delivering the CAMHS Service Specifications.

Substance Misuse Service

CAMHS substance abuse services provide support for the management and treatment of children and young people with co-morbid mental health and substance misuse problems. This may be provided with the Tier 3 CAMHS team, or by a more specialist Tier 4 team over a larger area. CAMHS substance abuse services will work along with other community based agencies that deliver services to help young people who are misusing substances whether legal or illegal. Therapeutic intervention will be aimed at reducing or stopping substance misuse through discussion on the physical, psychological, social, educational, systemic and legal issues related to their substance misuse. CAMHS substance abuse services also offers opportunities for consultation and educational group sessions to professionals, children and young people their families and carers.

Eating Disorders Service

CAMHS Eating Disorders services treat children and young people under 18 years who have difficulties with their eating patterns. Examples of eating disorders are Anorexia Nervosa, Bulimia Nervosa and Eating Disorders Not Otherwise Specified (EDNOS). This can be provided within a Tier 3 CAMHS team, or by a dedicated Tier 4 team working across a larger area. CAMHS/Eating Disorders services will provide a family and individual assessment and a range of interventions are available, such as Motivational Work, Individual Therapy, Family Therapy (e.g. Family Based Treatment), Individual Nutritional Assessment, education and reviews. Various group supports may also be provided such as nutritional education and carers support which may be provided over a specific number of weeks.

Intensive Home Treatment Service

A CAMHS nursing/medical/AHP team available in the community to reduce and/or manage children and young people who are at immediate risk or who need intensive therapeutic care. The primary objective of this service is to prevent admissions to acute hospital care. Where admission is required, this service is aimed to provide earlier step down from in-patient psychiatric care.

Crisis Service

CAMHS crisis services provides a 24/7 emergency/crisis response assessment and management service, working alongside other agencies (Police, ED, SWS etc.) and may provide support as required to these agencies. CAMHS Crisis services work intensively with children and young people and their families/carers as required to respond to mental health crisis immediately. CAMHS crisis services ensure children and young people are safe and receive appropriate follow up care, including medical and psychiatric inpatient care where require, social work and other services response. CAMHS crisis services will work closely with the Crisis supports under development for the Children and Young People's Mental Health and Wellbeing Programme Board.

Gender Identity Service

This service will provide assessment, specialist interventions/treatment and therapeutic support to young people who have issues regarding their gender and also includes work with families. These services often work over a larger area, and works in collaboration with Tier 3 CAMHS teams offering consultation and liaison (and with wider children's services) as necessary and appropriate. Gender identity services link with and/or signpost users and carers to other relevant voluntary/community sector organisations for additional information and support. This service could be delivered on a regional or a national basis.

Forensic CAMHS

This service supports a range of agencies and professionals in addressing the mental health and risk management needs of young people presenting with high risk behaviors. This is conducted through clinical consultations and specialist assessments. This will often include young people in the criminal justice system, prison and secure care. This service should be delivered on a regional basis with links to and from the National Secure Inpatient Psychiatric Service (opening in 2022).

LD/Intellectual Disability CAMHS Service

This service works with children and young people with Intellectual Disabilities/Learning Disabilities (ID/LD) and mental health difficulties or complex behavioral difficulties. It provides comprehensive assessment and specialist, multidisciplinary, therapeutic interventions, broadly similar to mainstream CAMHS, with additional interventions/treatment approaches tailored to the needs of children young people with ID/LD e.g. behavioral and communication interventions. ID/LD CAMHS understands the complex genetic, neurological or physical health difficulties which often impact on the mental health and development of children and young people with ID/LD and tailor their approach accordingly.

ID/LD CAMHS work along with other specialist services involved with children and young people with ID/LD particularly education, social work and community paediatric teams. NHS Scotland are considering the case for a National CAMHS Inpatient Service. Children and Young People with Complex Neurodevelopmental Problems and mental health risks and impact may also be referred to this team where the risks and impact are beyond the supports available in Core CAMHS and wider children's services.

Liaison CAMHS

This service provides CAMHS input to acute physical healthcare settings, recognising that children and young people who are frequent attenders and in-patients have a higher incidence of mental health disorders. This is particularly the case for children and young people with neurological conditions and chronic health conditions. Psychiatrists, nurses and clinical psychologists work with paediatric and adult healthcare colleagues to provide mental health promotion, early intervention and treatment services so that children and young people receive high quality holistic care for emergency and routine presentations. They also support children and young people admitted to acute healthcare settings as a consequence of mental health disorders e.g. for physical stabilisation of a child or young person with an eating disorder or where they present with an acute crisis. Therapeutic work comprises of psychological and psychopharmacological therapies based on careful assessments and joined up working with acute physical healthcare colleagues.

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