Public Document Pack

Aberdeen City Health & Social Care Partnership
A caring partnership

To: Members of the Integration Joint Board

Town House,
ABERDEEN 4 October 2022

INTEGRATION JOINT BOARD

The Members of the **INTEGRATION JOINT BOARD** are requested to meet in **Virtual - Remote Meeting on TUESDAY, 11 OCTOBER 2022 at 10.00 am.**

VIKKI CUTHBERT
INTERIM CHIEF OFFICER - GOVERNANCE

B U S I N E S S

1.1 Welcome from the Chair

DECLARATIONS OF INTEREST

2.1 Declarations of Interest and Transparency Statements

Members are requested to intimate any Declarations of Interest or Transparency Statements.

DETERMINATION OF EXEMPT BUSINESS

3.1 Exempt Business

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

STANDING ITEMS

4.1 Video Presentation: Drug Deaths - Reducing Stigma - When Heroin Took My Dad

4.2 Minute of Board Meeting of 30 August 2022 (Pages 5 - 16)

4.3 Minute of Risk, Audit and Performance Committee of 9 August 2022 (Pages 17 - 22)

4.4 Business Planner (Pages 23 - 24)

4.5 Seminar and Workshops Planner (Pages 25 - 26)

4.6 Chief Officer's Report - HSCP.22.088 (Pages 27 - 34)

GOVERNANCE

5.1 ACHSCP Meeting Dates 2023/24 - HSCP.22.085 (Pages 35 - 40)

PERFORMANCE AND FINANCE

6.1 Audited Final Accounts 2021/22 - HSCP.22.081 - to follow as late circulation

6.2 Strategic Risk Register and revised Risk Appetite Statement - HSCP.22.083 (Pages 41 - 74)

STRATEGY

7.1 Surge Plan - HSCP.22.084 (Pages 75 - 88)

TRANSFORMATION

8.1 Carers' Strategy - HSCP.22.080 (Pages 89 - 174)

8.2 Complex Care Market Position Statement - HSCP.22.082 (Pages 175 - 238)

8.3 Rubislaw Park Evaluation - HSCP.22.087 (Pages 239 - 282)

ITEMS THE BOARD MAY WISH TO CONSIDER IN PRIVATE

9.1 None at the time of issuing the agenda

DATE OF NEXT MEETING

10.1 Date of Next Meeting - Tuesday 29 November 2022 at 10am

A PRIVATE WORKSHOP SESSION WILL FOLLOW AT 1.00PM

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

Should you require any further information about this agenda, please contact Emma Robertson, emmrobertson@aberdeencity.gov.uk

This page is intentionally left blank

Aberdeen City Health & Social Care Partnership
A caring partnership

ABERDEEN, 30 August 2022. Minute of Meeting of the INTEGRATION JOINT BOARD.

Present:- Luan Grugeon, Chair; Councillor John Cooke, Vice Chair; and Councillor Christian Allard, Steven Close, Kim Cruttenden, Councillor Martin Greig, Councillor Deena Tissera, John Tomlinson, Mike Adams, Alan Chalmers, Jim Currie, Maggie Hepburn, Dr Caroline Howarth, Phil Mackie, Sandra MacLeod, Alison Murray and Graeme Simpson.

Also in attendance:- Martin Allan, Lisa Allerton, Daniela Brawley, Councillor Lee Fairfull, John Forsyth, Sarah Gibbon, Andrea Gilmartin, Michelle Grant, Vicki Johnstone, Catherine King, Emma King, Stuart Lamberton, Graham Lawther, Alison MacLeod, Peter McAndrew, Fiona Mitchelhill, Jason Nicol, Shona Omand-Smith, Simon Rayner, Sandy Reid, Amy Richert, Iain Robertson, Angela Scott, Kundai Sinclair, Neil Stephenson, Councillor Kairin van Sweeden and Claire Wilson.

Apologies:- June Brown, Jenny Gibb, Shona McFarlane and Paul Mitchell.

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

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

WELCOME FROM THE CHAIR

1. The Chair extended a warm welcome to everyone and in particular the new members who were joining for the first time.

The Chair highlighted key points on the agenda, noting the selection of Rosewell House as finalists for the Scottish Social Services Awards and achievements of the local team in respect of the Fast Track Cities report, while recognising there was no room for complacency and that the National Indicators in the Annual Performance Report identified key areas for improvement.

The Board resolved:-
(i) to note the Chair's remarks;
(ii) to record its appreciation to Dr Malcolm Metcalfe, former IJB Secondary Care Advisor who had stepped down from his role;
(iii) to welcome Christine Hemming and Steven Close who would be replacing Dr Metcalfe as NHS secondary care advisors to the IJB; and

INTEGRATION JOINT BOARD
30 August 2022

(iv) to welcome Fraser Bell, Paul Mitchell and Shona Omand-Smith to the Partnership.

DECLARATIONS OF INTEREST AND TRANSPARENCY STATEMENTS

2. Members were requested to intimate any declarations of interest or transparency statements in respect of the items on the agenda.

The Board resolved:-

(i) to note that the Chair advised that she had a connection in relation to agenda item 6.3 (Supplementary Work Plan – Social Care) by virtue of her role as Chief Executive of Alcohol and Drugs Action until 2018, however having applied the objective test she did not consider that she had an interest and would not be withdrawing from the meeting; and

(ii) to note that Alan Chalmers declared an interest in relation to agenda item 6.3 by reason of his position as a Volunteer with Alcohol and Drugs Action. Mr Chalmers confirmed that he would be withdrawing from the meeting prior to the Board's consideration of the item.

EXEMPT BUSINESS

3. The Chair indicated that item 6.3 Supplementary Report on Social Care - HSCP.22.066, contained exempt information and therefore it was recommended that it be considered in private.

The Board resolved:-
to consider the exempt sections of items 6.3 with the press and public excluded.

VIDEO PRESENTATION: FRESH COMMUNITY WELLNESS

4. The Board received a video presentation entitled FRESH Community Wellness.

The Board resolved:-
to note the video.

MINUTE OF BOARD MEETING OF 7 JUNE 2022

5. The Board had before it the minute of its meeting of 7 June 2022.

The Board resolved:-

(i) to agree that the actions at Article 17 (Project Search) had been completed and note that several participants had been offered full time jobs; and
(ii) to otherwise approve the minute as a correct record.

MINUTE OF RISK, AUDIT AND PERFORMANCE COMMITTEE OF 23 JUNE 2022

6. The Board had before it the minute of the Risk, Audit and Performance Committee of 23 June 2022, for information.

The Board resolved:-
(i) in response to a question regarding waiting times for CAMHS appointments following the initial choice appointment, to note that the Chair of RAPC and Chief Officer would seek clarification and circulate to Members; and
(ii) to otherwise note the minute.

DRAFT MINUTE OF CLINICAL AND CARE GOVERNANCE COMMITTEE OF 10 AUGUST 2022

7. The Board had before it for information, the draft minute of the Clinical and Care Governance Committee of 10 August 2022.

The Board resolved:-
to note the minute.

BUSINESS PLANNER

8. The Board had before it the Business Planner which was presented by the Chief Operating Officer who advised Members of the updates to reporting intentions and that further items would be added to future reporting cycles.

The Board resolved:-
(i) to note that the report on hybrid meetings was being removed from the Planner but would be included in the report to committee on 11 October 2022 regarding Committee Dates for 2023/24; and
(ii) to otherwise agree the Planner.

INTEGRATION JOINT BOARD
30 August 2022

SEMINAR AND WORKSHOPS PLANNER

9. The Board had before it the Seminars and Workshops Planner which was presented by the Chief Operating Officer, who advised Members that this would be a standing item on the agenda going forward.

The Board resolved:-
to note the Planner.

CHIEF OFFICER'S REPORT

10. The Board had before it the report from the Chief Officer, ACHSCP, which presented an update on highlighted topics. The Chief Finance Officer spoke in furtherance of the report and responded to questions from members.

The report recommended:-
that the Board note the detail contained in the report.

The Board resolved:-
(i) to note that the General Practice Sustainability report being prepared for the Clinical and Care Governance Committee meeting on 25 October 2022 would be circulated to Members;
(ii) to note that that Local Outcome Improvement Plan Annual Outcome Improvement Report would be circulated to Members; and
(iii) to otherwise note the details contained in the report.

EQUALITIES AND EQUALITIES OUTCOMES - HSCP.22.067

11. The Board had before it a report providing an update on progress towards evidencing compliance with the Human Rights Act 1998, the Equality Act 2010, the Scottish Specific Duties contained within the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012, and the Fairer Scotland Duty 2018, outlining how person-centred equality and human rights culture was being delivered across all services.

The Strategy and Transformation Lead presented the report and responded to questions from Members.

The report recommended:-
that the Board:
(a) note the progress made to date and the future plans in relation to continued assurance of compliance with our legislative duties in relation to Equality, Human Rights and Fairer Scotland duties;

(b) instruct the Chief Officer to submit an annual report on the progress made to make the equality duty integral to the exercise of the IJB functions to the Risk Audit and Performance Committee;
(c) instruct the Chief Officer to submit a progress report on its Equality Outcomes and Mainstreaming Framework every two years, in advance of publication; and
(d) instruct the Chief Officer to review the IJB's Equality Outcomes and submit these to the IJB for approval in advance of the next required renewal date of April 2025.

The Board resolved:-
(i) to instruct the Strategy and Transformation Lead to feedback to Public Health Scotland a suggestion to make 'access to health' explicit in future Equalities guidance; and
(ii) to otherwise approve the recommendations.

APPOINTMENT OF CHAIRS - RISK, AUDIT AND PERFORMANCE COMMITTEE (RAPC) AND CLINICAL CARE GOVERNANCE (CCG) - HSCP.22.076

12. The Board had before it a report seeking approval of the appointment of new Chairs to the Risk, Audit and Performance (RAPC) and Clinical and Care Governance Committees (CCGC).

The report recommended:-
that the Board:
(a) appoint Councillor Martin Greig as Chairperson of the Risk, Audit and Performance Committee for a period not exceeding three years with effect from 1 November 2022; and
(b) appoint Kim Cruttenden as Chairperson of the Clinical and Care Governance Committee for a period not exceeding three years with effect from 1 November 2022.

The Board resolved:-
(i) to record the Board's thanks to John Tomlinson for his three years as Chair of the Risk, Audit and Performance Committee and to Councillor Allard for his time as Chairperson of the Clinical and Care Governance Committee; and
(ii) to otherwise approve the recommendations.

INTEGRATION JOINT BOARD
30 August 2022

REVISED STRATEGIC RISK REGISTER AND REVISED RISK APPETITE STATEMENT - HSCP.22.075

13. The Board had before it a report updating the next steps required to review its Risk Appetite Statement (RAS) and Strategic Risk Register (SRR) following the IJB workshop held on 15 August 2022.

The Business Manager spoke to the report and responded to questions from members.

The report recommended:-
that the Board:
(a) note the outcomes of the strategic risk workshop on 15 August 2022; and
(b) note that a revised Risk Appetite Statement and Strategic Risk Register would be submitted to the IJB at its meeting on 11 October 2022.

The Board resolved:-
(i) with respect to cost of living increases, to instruct the Business Manager to discuss the risks of these with the Leadership Team, with any revisions in this regard to be presented to the IJB on 11 October 2022; and
(ii) to otherwise approve the recommendations.

ACHSCP ANNUAL REPORT - HSCP.22.070

14. The Board had before it the Annual Performance Report for 2021-22 and a report seeking approval of its publication.

The Lead for Strategy and Transformation presented the report and responded to questions from members.

The report recommended:-
that the Board:
(a) note the performance that had been achieved in 2021/22, the final year of the last Strategic Plan;
(b) approve the publication of the Annual Performance Report 2021-22 (as attached at Appendix A of the report) on the Aberdeen City Health and Social Care Partnership's (ACHSCP) website; and
(c) instruct the Chief Officer to present the approved Annual Performance Report to both Aberdeen City Council and NHS Grampian Board.

The Board resolved:-
(i) to note that Councillor Tissera and Phil Mackie would further discuss premature mortality rates offline; and
(ii) to otherwise approve the recommendations.

INTEGRATION JOINT BOARD
30 August 2022

In accordance with article 2 of this minute, Alan Chalmers withdrew from the meeting prior to the presentation of this report.

SUPPLEMENTARY REPORT ON SOCIAL CARE - HSCP.22.066

15. The Board had before it a report providing information about the work done to develop social care services for the community, and seeking approval to carry-out the commissioning and procurement work involved in this regard.

Neil Stephenson - Strategic Procurement Manager, spoke to the report.

The report recommended:-
that the Board:
(a) approve the extension for one year, of two contracts for drug and alcohol services, and approve the opportunity to advertise to the market a five-year contract for drug and alcohol services, as detailed in Appendices A1 and C of the report;
(b) approve the direct award of a contract for an outreach support service for three years, as detailed in Appendices A1 and D of the report;
(c) approve the extension for one year, of a contract for mental health services as detailed in Appendices A1 and E of the report;
(d) approve the extension for one year, of a contract for suicide prevention services as detailed in Appendices A1 and F of the report;
(e) approve the direct award of a contract for Intensive Housing Support Services for five years, as detailed in Appendices A1 and G of the report; and
(f) make the Direction, as attached at Appendix B of the report and instruct the Chief Officer to issue the Direction to Aberdeen City Council.

The Board resolved:-
to approve the recommendations.

LOCALITY PLANS - HSCP.22.071

16. The Board had before it the draft Annual Report 2021/22 in relation to delivery of the three Locality Plans.

Andrea Gilmartin – Public Health Researcher, presented the report and responded to questions from Members.

The report recommended:-
that the Board:
(a) consider the Annual Locality Planning Report 2021/2022;

(b) endorse the further development of locality working including the continued delivery of Locality Planning and the Aberdeen City Health and Social Care Partnership (ACHSCP) Strategic Plan;
(c) to instruct the Chief Officer to present the Annual Report on Locality Plans to Community Planning Aberdeen Board on 14 September 2022; and
(d) to instruct the Chief Officer to report to the Risk, Audit and Performance committee in 12 months with an update on locality planning.

The Board resolved:-
(i) to note that the ACC Chief Executive would investigate the profile of support provided for free school physical education classes and how activities were assessed, and discuss this offline with Alison Murray;
(ii) to note that Phil Mackie would work with colleagues to deliver a Population Health Approach seminar which considered the IJB's role in prevention/population health and to consider Sport Aberdeen input at the same seminar; and
(iii) to otherwise approve the recommendations.

WORKFORCE PLAN - HSCP.22.073

17. The Board had before it a report presenting the first draft of the Aberdeen City Health and Social Care Partnership Workforce Plan for 2022 – 2025.

Stuart Lamberton - Transformation Programme Manager, spoke to the report and responded to questions from Members.

The report recommended:-
that the Board:
(a) consider the initial draft ACHSCP Workforce Plan 2022 – 2025 as attached at Appendix A of the report and instruct the Chief Officer to bring the final version of the ACHSCP Workforce Plan 2022 – 2025 to the IJB on 11 October 2022; and
(b) to endorse the continued work of the short life working group with the ongoing wider staff consultation and incorporation of the feedback from Scottish Government

The Board resolved:-
to approve the recommendations.

FAST TRACK CITIES - HSCP.22.078

18. The Board had before it an annual update on the actions against the action plan submitted to the Integration Joint Board (IJB) on 21 January 2020.

Daniela Brawley - Clinical Lead for HIV, NHS Grampian/Service Lead for Sexual Health Services, NHS Grampian presented the report and responded to questions from members.

The report recommended:-
that the Board:
(a) note the progress on the action plan; and
(b) endorse the proposed actions for 2022/23, noting that the action plan was a live document; and instruct the Chief Officer to provide an update on progress in January 2023.

The Board resolved:-
to approve the recommendations.

LINK PRACTITIONER SERVICE CONTRACT- HSCP.22.062

19. The Board had before it a report seeking approval of the Link Practitioner Service Business Case and its recommended option to undertake collaborative commissioning to procure a provider to deliver the new Link Practitioner Service contract on behalf of Aberdeen City Health and Social Care Partnership.

Iain Robertson - Senior Project Manager, spoke to the report and responded to questions from members.

The report recommended:-
that the Board:
(a) approve the Business Case attached at Appendix A of the report, and the recommended option to issue a tender for a provider to deliver the Link Practitioner Service for four years from 1 April 2023, with an option to extend the contract for an additional three years;
(b) delegate authority to the Chief Officer to extend the Link Practitioners contract to the contract holder in the event of a satisfactory Year 3 contract review for a further three years up to 31 March 2030;
(c) request an update within the Chief Officer's Report on the outcome of the tender process at the IJB's meeting on 29 November 2022; and
(d) make the Direction attached at Appendix B of the report and instruct the Chief Officer to issue the Direction to NHS Grampian.

The Board resolved:-
(i) to instruct the Senior Project Manager to provide an annual overview of the contract delivery and a performance review from the service provider to be contained within the Chief Officer's report;

(ii) to instruct the Senior Project Manager to report any significant changes to the contract at the end of the year four review; and
(iii) to otherwise approve the recommendations.

ROSEWELL HOUSE - IJB/BAC JOINT EVALUATION - HSCP.22.074

20. The Board had before it a report presenting the findings of an evaluation of Rosewell House.

Fiona Mitchelhill - Lead Nurse, ACHSCP, spoke to the report and responded to questions from members.

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

The Board resolved:-
(i) to commend the Team on their continuing work and being shortlisted for the Scottish Social Services Awards – Showcasing an Integrated Workforce; and
(ii) to otherwise note the content of the report.

SUPPLEMENTARY REPORT ON SOCIAL CARE - HSCP.22.066 - EXEMPT APPENDICES

21. The Board had before it the exempt appendices in respect of this item, as approved at Article 15.

The Board resolved:-
to note that the recommendations had been approved at Article 15.

DATE OF NEXT MEETING

22. The Board had before it the date of the next meeting:

11 October 2022, at 10am.

The Board resolved:-
to note the date of the next meeting.

CALL FOR VIEWS - NATIONAL CARE SERVICE - DRAFT RESPONSE

INTEGRATION JOINT BOARD
30 August 2022

23. <u>The Board resolved:</u>-
to note that this item would be held in a separate private workshop session.
- LUAN GRUGEON, <u>Chair</u>

This page is intentionally left blank

Aberdeen City Health & Social Care Partnership
A caring partnership

Risk, Audit and Performance Committee

Minute of Meeting

Tuesday, 9 August 2022
10.00 am Virtual - Remote Meeting

ABERDEEN, 9 August 2022. Minute of Meeting of the RISK, AUDIT AND PERFORMANCE COMMITTEE. Present:- John Tomlinson Chairperson; and Councillors John Cooke and Martin Greig; Fraser Bell, Jamie Dale, Alison MacLeod, Paul Mitchell and Shona Omand-Smith.

Also in attendance: Martin Allan, John Forsyth, Michelle Grant, Vicki Johnstone, Stuart Lamberton, Councillor Sandra Macdonald (from Item 6.1) and Val Vertigans (as a substitute for Claire Wilson).

Apologies: June Brown, Amy Richert and Claire Wilson.

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

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

WELCOME AND INTRODUCTIONS

1. The Chair welcomed everyone to the meeting.

The Committee resolved:-
to welcome the new Chief Operating Officer, Chief Finance Officer and Commissioning Lead to their first meeting of the Committee.

DECLARATIONS OF INTEREST AND TRANSPARENCY STATEMENTS

2. Members were requested to intimate any declarations of interest in respect of the items on the agenda.

For the purpose of clarity, John Forsyth assisted members with the following definition:

A transparency statement is used when a Member feels that they have a connection to a matter in the agenda, but having considered the objective test thinks that this does not amount to a declarable interest.

For reasons of transparency, Members can make a transparency statement - explaining that they have considered the matter but will not be withdrawing.

The Committee resolved:-
(i) to note the definition of Transparency Statements as provided by the Solicitor; and
(ii) to otherwise note that there were no Declarations of Interest or Transparency Statements intimated.

EXEMPT BUSINESS

3. There was no exempt business.

MINUTE OF PREVIOUS MEETING OF 23 JUNE 2022

4. The Committee had before it the minute of its previous meeting of 23 June 2022, for approval.

The Committee resolved:-
(i) with regard to Article 4(i) of the Minute (Minute of the previous meeting of 26 April 2022), to note that the Strategy and Transformation Lead had circulated information providing further assurance regarding numbers of carers;
(ii) with regard to Article 7 Audit Scotland - Drug and Alcohol Service Briefing, to note that the Self Assessment form would be complete by the end of September 2022 and that the Alcohol and Drugs Partnership Lead would report back to Committee on 1 November 2022 in this regard; and
(iii) to otherwise approve the minute as a correct record.

BUSINESS PLANNER

5. The Committee had before it the Committee Business Planner.

The Committee resolved:-
(i) to note that a lead officer would be identified to present the Planner to RAPC and IJB; and
(ii) to otherwise note the content of the Planner.

WHISTLEBLOWING UPDATES AND REPORT ON POLICY & REPORTING - HSCP.22.057

6. The Committee had before it a report providing an overview of whistleblowing policies relevant to the IJB and the Aberdeen City Health and Social Care Partnership.

The report recommended:
that the Committee note the details contained in the report.

The Committee resolved:-
(i) to note that the Business Manager would circulate the NHS Annual Report on Whistleblowing; and
(ii) to otherwise note the details contained within the report.

ASP INSPECTION REPORT - HSP.22.054

7. The Committee had before it a report on the findings of the recent Joint Inspection of Adult Support and Protection (ASP) in Aberdeen which were published on 21st June 2022.

Val Vertigans - Lead Strategic Officer Adult Public Protection, HSCP spoke to the report and responded to questions from members.

The report recommended:-
that the Committee note the findings of the recent Joint Inspection of Adult Support and Protection in Aberdeen and next steps.

The Committee resolved:-
(i) to commend the Adult Support Team on the positive inspection report;
(ii) to instruct the Lead for Social Work to report back to Committee in 2023 with an update regarding progress on the Next Steps; and
(iii) to otherwise approve the recommendation.

INTERNAL AUDIT REPORT AC2210 - LEARNING DISABILITIES - HSCP.22.055

8. The Committee had before it the Internal Audit Report on Learning Disabilities which presented the outcome from the planned audit of Learning Disabilities Income and Expenditure that was included in the 2020/21 Internal Audit Plan for Aberdeen City Council.

Jamie Dale - Chief Internal Auditor, spoke to the report and responded to questions from Members.

The report recommended:-

that the Committee review, discuss and comment on the issues raised within this report.

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

BEST VALUE IN INTEGRATION JOINT BOARDS - LETTER FROM ACCOUNTS COMMISSION - HSCP.22.065

9. The Committee had before it for information, a letter from the Chair of the Accounts Commission regarding Best Value in Integration Joint Boards.

The Committee resolved:-
(i) to note that any questions from Members regarding the information contained within the letter should be addressed to the Business Manager for referral to the Accounts Commission; and
(ii) to otherwise note the information provided.

HOSTED SERVICES SLAS - HSCP.22. 064

10. The Committee had before it a report on Grampian Out of Hours (OOH) Primary Care Services (GMEDs) and early sight of a draft Service Level Agreement (SLA) for Sexual Health Services for comment to feed into further development.

The Strategy and Transformation Lead spoke to the report and responded to questions from members.

The report recommended:-
that the Committee note and comment on the GMED report and the draft Sexual Health Services SLA.

The Committee resolved:-
(i) to instruct the Strategy and Transformation Lead to ask for clarification from colleagues in Moray regarding the statement at item 3.4 on page 41 of the GMED report and to report back to Committee in this regard; and
(ii) to otherwise note the content of the GMED report and the draft Sexual Health Services SLA.

STRATEGIC PLAN DELIVERY PLAN DASHBOARD - HSCP.22.063

11. The Committee had before it a report providing information regarding the reporting framework for the Strategic Plan and the progress on the delivery plan as set out within the Strategic Plan 2022-2025

Michelle Grant - Senior Project Manager, introduced the report and responded to questions from members.

The report recommended:-
that the Committee note the Delivery Plan Reporting Framework, Quarter 1 Overview and Dashboard as appended to the report.

The Committee resolved:-
to approve the recommendation.

SCOTLAND'S FINANCIAL RESPONSE TO COVID - HSCP.22.068

12. The Committee had before it the Accounts Commission report on Scotland's financial response to Covid-19 and covering report from Paul Mitchell - Chief Finance Officer.

The Chief Finance Officer spoke to the report and responded to questions from members. Members noted that the report contained three recommendations for the Scottish Government and three recommendations for the Scottish Government, councils, NHS boards and integration authorities.

The report recommended:-
that the Committee note the recommendations made by Audit Scotland in the "Scotland's Response to Covid-19" report.

The Committee resolved:-
to approve the recommendation.

CONFIRMATION OF ASSURANCE

13. The Chair enquired of Members if they were satisfied on matters presented before the Committee or if further examination was required.

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.

RISK, AUDIT AND PERFORMANCE COMMITTEE
9 August 2022

DATE OF NEXT MEETING - TUESDAY 1 NOVEMBER 2022 AT 10AM

14. The Committee had before it the dates for future meetings:

- Tuesday 1 November 2022 at 10am; and
- Tuesday 28 February 2023 at 10am

The Board resolved:-
to note the future meeting dates
- **JOHN TOMLINSON, Chair**

	A	B	C	D	E	F	G	H	I	J
1	INTEGRATION JOINT BOARD BUSINESS PLANNER - The Business Planner details the reports which have been instructed by the Board as well as reports which the Functions expect to be submitting for the calendar year.									
2	**Date Created**	**Report Title**	**Minute Reference/Committee Decision or Purpose of Report**	**Report Number**	**Report Author**	**Lead Officer / Business Area**	**ORGANISATION ACHSCP/ACC/NHSG**	**Update/ Status (RAG)**	**Delayed/ Deferred or Recommended for removal or transfer, enter either D, R, or T**	**Explanation if delayed, removed or transferred**
8	**11 October 2022**									
9	Standing Item	Video Presentation	To note the regular video presentation from a choice of partner organisations							
10	Standing Item	Chief Officer Report	To note the regular update from the Chief Officer	HSCP22.088	Kay Diack	Chief of Staff	ACHSCP			
11	Standing Item	Health & Social Care Partnership Meeting dates - 2023/2024	To seek approval of meeting dates from 1 April 2022 to 31 March 2023.	HSCP22.085	Emma Robertson	Clerk	ACC			
12	Standing Item	Audited Accounts	To seek approval of the Audited Final Accounts for 2021/22.	HSCP22.081	Paul Mitchell	Chief Finance Officer	ACHSCP	Members noted at IJB on 7 June 2022 that the Audited Accounts would be ready at the end of September 2022 and would be considered by the appropriate Committee thereafter.		
13	09.09.2022	Strategic Risk Register & Revised Risk Appetite Statement	To approve the updated versions of its Risk Appetite Statement and Strategic Risk Register (SRR).	HSCP22.083	Martin Allan	Business Lead	ACHSCP			
14	09.09.2022	Surge Plan	To note the overview of the ACHSCP Surge Plan focusing on prevention and anticipating demand; operational resilience; increase capacity; staff health and wellbeing and communication.	HSCP22.084	Martin Allan	Business Lead	ACHSCP			
15	07.06.22	Carers' Strategy	To note the draft Carers' Strategy , ahead of the final version being presented on 29 November 2022.	HSCP22.080	Alison MacLeod / Amy Richert	Strategy and Transformation Team	ACHSCP			
16	26.07.2022	Complex Care Market Position Statement	To seek approval of the Complex Care Market Position Statement - This is a new piece of work to bring together information on needs around Complex Care services and is one of the delivery plan priorities; the development of the Market Position Statement is linked to this.	HSCP22.082	Jenny Rae / Kevin Dawson	Strategy and Transformation Team	ACHSCP			
17	07.06.2022	Rubislaw Park Evaluation	To note the findings from the evaluation of the Rubislaw Park End of Life Care Beds Test of Change.	HSCP22.087	James Maitland / Michelle Grant	Strategy and Transformation Team	ACHSCP	Deferred to October will allow further data to be captured from the newer pathways into the EoL beds at Rubislaw.		
18	26.04.2021	Workforce Strategy	To seek approval from members following the consultation at IJB in August 2022. This strategy supports the Strategic Plan.	n/a	Sandy Reid / Stuart Lamberton		ACHSCP		**D**	feedback. Scottish Government feedback was expected during first week of September but this has not been received yet meaning it will not be ready in time for the IJB on 11 October. An SLT & OLT development session is planned for the workforce plan on 5 October,
19	28.04.22	Analogue to Digital telecare	To seek approval from the IJB for funding, and update on the progress of the project	n/a	Pete McAndrew /Nadir Freigoun / Valerie Taylor	Strategy and Transformation Team	ACHSCP		**D**	Request to defer to IJB on 31st January 2023. The purpose of the report was amended to include funding approval. More time is required to confirm funding requirements. For the meantime, update to be provided via Chief Officer report.
20	**29 November 2022**									
21	Standing Item	Chief Officer Report	To note the regular update from the Chief Officer		Kay Diack	Chief of Staff	ACHSCP			
22	Standing Item	Video Presentation	To note the regular video presentation from a choice of partner organisations							
23	06.07.2021	Local Survey 2022	To note the results of the Local Survey 2022.		Alison Macleod	Lead Strategy and Performance Manager	ACHSCP			
24	02.11.2021	Rosewell House Travel Plan - update	To note the impact of the travel plan and report back after 12 months on the outcomes and any measures that might be required.		Sarah Gibbon	Project Manager	ACHSCP			
25	18.07.22	PCIP Update	To provide an update on PCIP.		Susie Downie / Emma King	Primary care Leads	ACHSCP			
26	12.07.2022	Marywell Service Redesign	To note the findings of the review following Marywell Medical Practice not being awarded a contract following the 2c tendering process. A multi-agency review is being conducted. This report will show the outcomes of the review and the options for the service moving forward with a recommendation to seek IJBs approval.		Susie Downie / Emma King	Primary Care Leads	ACHSCP			
27	17.08.22	Carers' Strategy	To seek approval of the final version of the Carers' Strategy.							
28	26.07.2022	MHLD Commissioning Review	To seek approval to fund and issue Mental Health Residential Care Home contracts aligned to the development and implementation of the MHLD Residential and Supported Living Accommodation Market Position Statement.		Jenny Rae / Kevin Dawson	Strategy and Transformation Team	ACHSCP			Provisional date at present. May move to January 2023.
29	16.09.2022	Change of Contract	To seek approval of a business case for the changing of a contract of a contract from existing to another provider from 9 January 2023 for 15 months.		Shona Omand-Smith / Neil Stephenson	Commissioning Lead	ACHSCP			
30	27.09.22	Public Bodies' Statutory Climate Change Duties	To seek approval to submit the work that has been undertaken in relation to identifying emission reduction targets; and to seek approval for the proposed resource alignment and progress reporting approach. This is in respect of the Scottish Government's expectation for Public Bodies to show leadership on the global climate emergency - new requirements have been included in the mandatory annual reporting.		Sophie Beier	Strategy and Transformation Lead	ACHSCP			

	A	B	C	D	E	F	G	H	I	J
1	INTEGRATION JOINT BOARD BUSINESS PLANNER - The Business Planner details the reports which have been instructed by the Board as well as reports which the Functions expect to be submitting for the calendar year.									
2	**Date Created**	**Report Title**	**Minute Reference/Committee Decision or Purpose of Report**	**Report Number**	**Report Author**	**Lead Officer / Business Area**	**ORGANISATION ACHSCP/ACC/NHSG**	**Update/ Status (RAG)**	**Delayed/ Deferred or Recommended for removal or transfer, enter either D, R, or T**	**Explanation if delayed, removed or transferred**
31	16.09.2022	Interim and Respite Bed Provision	To seek approval to increase expenditure around the capacity of interim and respite beds.		Shona Omand-Smith	Commissioning Lead	ACHSCP			
32	**31 January 2023**									
33	Standing Item	Video Presentation	To note the regular video presentation from a choice of partner organisations							
34	Standing Item	Chief Officer Report	To note the regular update from the Chief Officer		Kay Diack	Chief of Staff	ACHSCP			
35	23.03.2021	Integration Joint Board Membership - HSCP.21.022	To reconsiderany changes to arrangements by report to the IJB prior to 31 March 2023.		Clerk	Chief Officer	ACHSCP			
36	10.03.22	Mental Health and Learning Disabilities	To provide the Board with updates on any variation to the hosting of MHLD services by the city.		Paul Mitchell	Chief Finance Officer		At Budget on 10 March 2022, Board agreed to note that in respect of article 3.14 on page 64 of the report (specialist Mental Health and Learning Disabilities (MHLD) Services) it was recommended that the transitional period be extended to March 2023 and if anything were to vary with this matter, the Chief Finance Officer would bring a specific report back to the Board		
37	**28 March 2023**									
38	Standing Item	Chief Officer Report	To provide a regular update from the Chief Officer		Kay Diack	Chief of Staff	ACHSCP			
39	Standing Item	Video Presentation	To note the regular video presentation from a choice of partner organisations							
40	24.08.21	Rosewell House - evaluation report	Chief Officer to bring a full evaluation report of the service being delivered at Rosewell House to the IJB in March 2023;		Sarah Gibbon	Project Manager	ACHSCP	Rosewell House - Options Appraisal and Recommendations - HSCP.21.088 (IJB 24/08/21) instruct the Chief Officer, to bring a full evaluation report of the service being delivered at Rosewell House to the IJB board in March 2023;		
41	Standing Item	Annual Procurement Workplan 2023/2024	To present the Annual Procurement Work Plan for 2023/24 for expenditure on social care services, together with the associated procurement Business Cases, for approval.		Neil Stephenson	Procurement Lead	ACC			
42	Standing Item	Medium Term Financial Framework - 2023/24	To provide an update on the final levels of funding delegated by Aberdeen City Council and NHS Grampian for health and social care activities in 2023/24 and to seek final approval of the medium-term financial framework.		Alex Stephen	Chief Finance Officer	ACHSCP			
43		Grant Funding to Counselling Servies	To advise the Board of grant funding requirements for the financial year 2023/2024 to grant funded organisations - and to inform the Board of preliminary and proposed work to review the service activity and ensure it is aligned to the whole system service provision across Aberdeen City.		Shona Omand-Smith	Commissioning Lead	ACHSCP			
44	Standing Item	Annual Resilience report - Inclusion of Integration Joint Boards as Category 1 Responders under Civil Contingency Act 2004	To provide information of the inclusion of IJB's as Category 1 Responders, in terms of the Civil Contingencies Act 2004 and an outline of the requirements that this inclusion involves.		Martin Allan	Business Lead	ACHSCP	On 23.03.21, IJB resolved :- (iii)to instruct the Chief Officer to bring a report, annually, providing assurance on the resilience arrangements in place to discharge the duties on the IJB under the 2004 Act		This is an annual report and was last considered at IJB on 7 June 2022.
45	25.05.2021	Community Nursing Digitalisation	On 25 May 2021 IJB agreed - to instruct the Chief Officer, ACHSCP to present an evaluation report on implementation of the project to include outcomes within 1 year		Michelle Grant / Craig Farquhar	Chief Officer	ACHSCP	June 2022 - Strategic Plan Delivery Plan outline timeline for development and evaluation of this project to Spring 2023. Report deferred to 28 March 2023.		
46	**TBC Future Meetings**									
47	16.08.22	Fast Track Cities	To provide an annual update on the actions against the action plan submitted to the Integration Joint Board (IJB) on 21 January 2020.		Daniela Brawley / Lisa Allerton					Last presented to IJB on 30 August 2022. This is an annual report.
48	16.08.22	Neuro Rehabilitation Pathway	Following the Special meeting on 1 March 2022, to report back with an Options Appraisal on how service needs can be met, including a full assessment on the impact of any change for existing service users and how that can be mitigated.		Jason Nicol	Head of Service Specialist Older Adults and Rehabilitation Services				Outline draft expected end of March 2023, to come to next IJB after that.
49		ACHSCP Annual Report	To seek approval of the ACHSCP Annual Report - 22 August 2023 meeting		Aliosn MacLeod	Lead Strategy and Performance Manager				
50	Standing Item	Equalities and Equalities Outcomes	To note the progress towards evidencing compliance with the Human Rights Act 1998, the Equality Act 2010, the Scottish Specific Public Sector Equality Duties 2012 and the Fairer Scotland Duty 2018, outlining how person-centered equality and human rights culture is being delivered across all services. At IJB on 25 May 2021 Members resolved to instruct the Chief Officer, ACHSCP to submit 6-monthly reports alternately to the RAPC (starting December 2021 and then IJB - June 2022).		Alison Macleod	Lead Strategy and Performance Manager	ACHSCP	Went to RAPC on 01/03/22 and to IJB on 30 August 2022.		
51		IJB Scheme of Governance Annual Review	Considered at IJB on 7 June 2022 - this is an annual review so date to be established for approx June 2023 review		John Forsyth	Solicitor ACC	ACHSCP			

Seminars/Workshops				
	Purpose	**Timescale**	**Lead Officer**	**Update**
Planned Sessions				
2C Story so far		11 October 2022	Emma King/Susie Downie	At the end of IJB meeting.
Mental Health		07 November 2022	Jane Fletcher/Kevin Dawson	Invitations sent to hold 10am-4pm on 7 November 2022; venue TBC
Population Health - Sport Aberdeen - how to help further the health and wellbeing agenda through sport and activity	To deliver a Population Health Approach seminar to consider the IJB's role in prevention/population health and to consider Sport Aberdeen's input at the same seminar.	07 November 2022	Alison MacLeod/Phil Mackie	Invitations sent to hold 10am-4pm on 7 November 2022; venue TBC .
Dates to be Identified				
Procurement (Fair and Transparent)]			Neil Stephenson/Shona Omand-Smith	To be taken with Ethical Commissioning
Ethical Approach to Commissioning]			Shona Omand-Smith/Neil Stephenson	To be taken with Procurement
Delivery Plan (including Strategic Objectives)			Alison Macleod	
Strategic Intent			Sandra Macleod	
Neuro Rehabilitation	To provide information in order to assist Members with the decision on the Neuro Rehabilitation Pathway expected in 2023 as per the IJB Business Planner		Jason Nicol	
Previous Sessions				
Primary Care – lessons learned/benefits of 2 C Redesign		13-Jul-22	Susie Downie	Completed; virtual workshop 13 July 2022.
Risk		15-Aug-22	Martin Allan	Completed; workshop at Beach Ballroom 15 August 2022.
National Care Service - Call for Views		30-Aug-22	Alison MacLeod	Completed; virtual workshop following IJB 30 August 2022.
ADP		20-Sep-22	Simon Rayner	Completed; Workshop at Beach Ballroom on 20 September 2022
Culture		20-Sep-22	Jason Nicol	Completed; Workshop at Beach Ballroom on 20 September 2022
Governance		20-Sep-22	Fraser Bell	Completed; Workshop at Beach Ballroom on 20 September 2022

This page is intentionally left blank

Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Date of Meeting	11 October 2022
Report Title	Chief Officer's Report
Report Number	HSCP.22.088
Lead Officer	Sandra MacLeod
Report Author Details	Name: Kay Diack Job Title: Chief of Staff Email Address: kdiack@aberdeencity.gov.uk Phone Number: 07778 872309
Consultation Checklist Completed	Yes
Directions Required	No
Appendices	None

1. Purpose of the Report

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

2. Recommendations

2.1. It is recommended that the IJB note the detail contained in the report.

3. Summary of Key Information

3.1. Local Updates

Staff Wellbeing

- Active distribution of winter safety items for staff, including personal alarms, torches and winter driving kits
- Increased levels of free complimentary therapies being provided, with the most popular being pedicures
- Sandwiches/teas/coffees still being distributed across City

- Promotion of mindfulness and listening services (face to face and virtual)
- Focus on iMatter action plans in things most important to staff

Primary Care Demand

Demand continues to increase within Primary Care. Maintaining adequate capacity within the sector to meet the demand on practices continues to be challenging. Within this context, practices are considering all options, including the consolidation of practices. A number of workstreams are being led by the Primary Care Team to address the immediate challenges, for example:

- The review of boundaries protocol and a workshop with all City practices is planned following requests for boundary changes;
- a City Communications and Engagement Group has been created and is leading on a pan-Grampian media campaign to increase public awareness of the wider roles in primary care;
- a new Health Assessment Team has been implemented to support the health needs of Ukrainian Refugees across Grampian; and
- the joint review of Marywell Medical Practice is ongoing, with a final workshop to be held in early October.

A sustainability report that is inclusive of all City practices is being collated for Clinical Care and Governance Committee in October 2022 and will provide more detail on levels of sustainability and the Primary Care team's response to the challenges.

The Scottish Government has confirmed PCIP funding for Aberdeen City for 2022/23. This incorporates underspend from 2021/22 funding. The PCIP project group is working alongside GP Sub-Committee (advisory group for the Area Medical Committee) and the Local Medical Council (LMC) to prioritise areas of spend to best fulfil the GP contract. Revised forecasts are being collated and submitted for November alongside a refreshed plan. Engagement sessions are currently underway with stakeholders to inform the plan.

Plans to meet mental health needs in Primary Care (First Contact Mental Health Workers) is not being progressed meanwhile as Scottish Government is currently reviewing all 2022/23 budget plans in light of the known

conclusion of in-year COVID-19 consequentials. This has placed unprecedented pressure on existing Health and Social Care budgets and therefore recruitment and related activity has been paused.

Also, Enhanced Services payment protection for practices, which was live throughout COVID-19, will stop on 1st October 2022 for almost all services as planned. This will see progress towards a return to baseline levels of activity, for example for long-acting reversible contraception.

Support for Refugees
Service Level Agreement (SLA) now in place for General Medical Services (GMS) provision and work is ongoing to register all Ukrainians staying within Welcome Hubs with GP practices.

Recruitment is ongoing to support the new 'Health Assessment Team'. This includes one service manager, two team leaders and 5 Care Navigators. These roles will work across the Welcome Hubs in the Grampian area to provide a first point of contact for all Welcome Hub guests, signposting to relevant services, and assisting with GMS registrations.

Housing Support Update
As of the 10 January 2023, and for 14 months we are looking to make a direct award to Castlehill Housing Association for the housing support to tenants in their sheltered housing complexes. This will allow for engagement and assessment around future models of care. This is following the end of the current contract with current provider Cornerstone. A Business Case on this work will be presented at the November 2022 meeting.

Analogue to Digital Telecare Programme (A2DT)
The first project board meeting was held on the 6th of September to discuss the project charter. This included the scope, objectives, governance and estimated costs, as well as the major risks and issues. The project charter was approved by the board which is a major milestone for the programme.

Due to complexity of funding, a finance sub-group was selected from the project board to organise the funding required for the project and advise on the appropriate committees and boards to approach for spending approval.

The Scottish Digital Office is scheduled to release the tender for the shared Alarm Receiving Centre (ARC) Technology Solution by end of September

2022. The procurement exercise will be concluded with a single supplier framework for the ARC which will be ready to call off from by end of February 2023. The decision on the community alarm unit replacements depends on the outcome of testing which is still ongoing as well as suppliers' lead time.

Culture Working Groups

The Culture sub-group continues to meet and is co-chaired by Luan Grugeon and Jason Nicol and is open to any IJB/SLT member to join. The recent work has focussed on three elements;

1. Buddying arrangements for IJB members with colleagues on the IJB or SLT.
2. Connecting with the Kings Fund, we are considering an 'observer' role for use in IJB development sessions.
3. Progressing use of BOOM (Best Out Of Me) boards where SLT and IJB members are invited to develop a slide or physical board which through images which they talk to, colleagues share more of themselves as a leader; a story of what makes them the person they are, their values, likes and dislikes, ways of getting the best out of them. Early testing and use of this has generated positive feedback on the sense of connection and understanding this is fostering, with a further BOOM session planned for the 7th November seminar.

Integration Scheme

The Public Bodies (Joint Working) (Scotland) Act 2014 requires Local Authorities and Health Boards to jointly prepare an Integration Scheme, which sets out the key arrangements for how Health and Social Care Integration is to be planned, delivered, and monitored within their local area. The legislation requires Integration Schemes to be reviewed and revised every 5 years. Although Aberdeen City's Integration Scheme was implemented in 2016, it was reviewed in 2018 following the implementation of the Carers (Scotland) Act 2016. It is therefore due to be reviewed by March 2023.

The Integration Scheme is 'owned' by our two statutory partners – Aberdeen City Council (ACC) and NHS Grampian (NHSG) and the Scottish Government have final approval of it. The Senior Leadership Team and ACC legal advisors have been working on updating the scheme and it has

been presented to the Strategic Planning Group for community representative input. It is about to go out for wider consultation which IJB members will be involved in. The revised scheme will then be submitted through ACC and NHSG governance routes in December 2022 with a view to receiving approval to submit it to the Scottish Government in January 2023. This should allow sufficient time for their review, comment and any further revisions in advance of the March 2023 deadline.

Woodlands Care Home Update

We have seen an increasing demand in our acute settings which has often resulted in prolonged ambulance stacking at Emergency Departments and patients being treated in ambulances or corridors whilst waiting for beds to be become available. To create urgent capacity in the system, we require additional emergency discharge beds in the community to ensure continued maximisation of patient flow. This will also create much needed capacity as we head into winter. With the opening of a new eighty-one bedded care home, we have the opportunity to increase the bed base within Aberdeen City by potentially up to forty-three beds. These additional beds will support flow and prevent additional pressures on the system. We would like to carry out a small test of change on seven of the beds which will be trialled as a GP led unit. There are currently no GP led units in care homes in Aberdeen. Similar units have been very successful in other areas, including Aberdeenshire.

3.2. Regional Updates

Regional awareness of North East Alliance

The North East Alliance has recently been established as a forum to develop a learning system that explores shared challenges, tests solutions and seeks to implement 'what works' at scale and pace. The current membership includes Local Authorities, Health and Social Care Partnerships, Fire and Rescue and Police. It will seek to shape collective conversations and actions with a diverse range of people to deliver a vision of thriving communities which live fulfilled lives. The Forum will use the King's Fund's four pillars to frame action to improve population health:

- Wider determinants of health
- Behaviours and lifestyles

- Places and communities
- Integrated health and care system

NHSG Population Health Committee

NHS Grampian is committed to preventing harm, promoting wellbeing and integrating services to support communities to thrive. In this, it recognises that it needs to rebalance activities to become an organisation that has a clear focus on population health, through promoting preventative approaches and reducing health inequalities.

To make this happen, the Population Health Committee has been established by the Grampian NHS Board to provide the necessary assurance that it is delivering this ambition in four key areas:

(1) ensuring the effective delivery of the Board's Public Health work;
(2) creating equity and reducing health inequalities;
(3) ensuring that NHS Grampian is working closely with partner agencies and with the people and communities it serves to plan and deliver health programmes; and
(4) providing robust governance for the work of the committee on behalf of the NHS Board

The Committee will be chaired by John Tomlinson and include 6 Non-Executive NHS Board members. Executive Lead will be shared between Susan Webb, Director of Public Health, and Stuart Humphreys, Director of Marketing & Corporate Communications. The terms of reference for the new committee also require that the Chief Officer of each IJB is in attendance at the Committee. As a formal Committee of the NHS Board, the IJB will have a clear opportunity to feed into this work, as it does with any of the other Committees and structures in which the IJB participates. However, the commitment to ensuring close collaboration in co-producing population health planning and delivery means that both formal and informal relationships will need to be clarified and – where necessary – enhanced.

3.3. National Updates

National Care Service

Following the presentation and discussion with members of the Integrated Joint Board (IJB), a response on behalf of the IJB to the consultation on the

National Care Service (Scotland) Bill was submitted to the Scottish Parliament. The response can be found here:

https://yourviews.parliament.scot/health/national-care-service-bill/consultation/view_respondent?show_all_questions=0&sort=submitted&order=ascending&_q__text=aberdeen+city&uuId=556815647

The Scottish Parliament is continuing to review all consultation responses received. The Scottish Government has committed to a period of co-design with relevant stakeholders and the Health and Social Care Partnership in Aberdeen stands ready to engage with the process. Further updates on the Bill's progress through the Scottish Parliament and the co-design process will be provided to members of the IJB as required.

Current State of National Demand
A number of meetings have been held, including with the Cabinet Secretary, in order to discuss and confirm improvement plans and trajectories for national Emergency Department Performance. A number of key development areas have now been identified.

4. Implications for IJB

4.1. **Equalities, Fairer Scotland and Health Inequality** - There are no implications in relation to the IJB's duty under the Equalities Act 2010 and Fairer Scotland Duty.

4.2. **Financial** - There are no immediate financial implications arising from this report.

4.3. **Workforce** - There are no immediate workforce implications arising from this report.

4.4. **Legal** - There are no immediate legal implications arising from this report.

4.5. **Covid-19** – There are no immediate 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 other immediate implications arising from this report.

5. Links to ACHSCP Strategic Plan

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

6. Management of Risk

6.1. Identified risks(s)

The updates provided 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:

3 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 potential of integrated & collaborative working. This risk covers the arrangements between partner organisations in areas such as governance; corporate service; and performance.

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

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

The Chief Officer will monitor progress towards mitigating the areas of risk closely and will provide further detail to the IJB should she deem this necessary.

Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Date of Meeting	11 October 2021
Report Title	Health and Social Care Partnership Meeting Dates 2023-24
Report Number	HSCP.22.085
Lead Officer	Sandra MacLeod, Chief Officer
Report Author Details	Name: Emma Robertson Job Title: Committee Services Officer Email Address: emmrobertson@aberdeencity.gov.uk
Consultation Checklist Completed	Yes
Directions Required	No
Appendices	None

1. Purpose of the Report

1.1. To seek approval of the Integration Joint Board (IJB), Risk Audit and Performance Committee (RAPC) and Clinical and Care Governance Committee (CCGC) meeting dates for 2023-24 and the approach to hybrid meetings.

2. Recommendations

2.1. It is recommended that the Integration Joint Board:

(a) review and approve the Meeting Schedule for 2023-24 as at section 3.6; and

(b) note the update regarding the meeting format.

INTEGRATION JOINT BOARD

3. Summary of Key Information

3.1. As per Standing Orders, Article 9(5), the Board is required to approve an annual meeting schedule prior to the new financial year, which runs from 1 April to 31 March annually.

3.2. At its meeting on 27 March 2018, the Board agreed to annually review its meeting arrangements.

3.3. The IJB will continue to meet on Tuesday mornings, on a 6-8-week cycle. No meetings have been scheduled during public holidays and no meetings currently clash with (known) Aberdeen City Council or NHS Grampian Board meetings.

3.4. All meetings of the IJB are scheduled to run between 10:00am and 2:00pm.

3.5. As per the IJB Budget Protocol agreed on 7 March 2017, a dedicated budget meeting has been scheduled to allow the Board to agree a budget following Aberdeen City Council and NHS Grampian Board setting their annual budgets. In line with the IJB Scheme of Governance, additional meeting dates can be set at the Chair's direction.

3.6. The Board is requested to review and approve the following Meeting dates for the period 2023 to March 2024:

IJB – Tuesdays at 10am	RAP – Tuesdays at 10am	CCG – Tuesdays at 10am
31 January 2023 (already scheduled)	28 February 2023 (already scheduled))	21 February 2023 (already scheduled)
28 March 2023 (already scheduled) (**Budget**)	2 May 2023 (unaudited accounts)	18 April 2023
6 June 2023	13 June 2023	1 August 2023
22 August 2023	19 September 2023	31 October 2023
10 October 2023	28 November 2023	27 February 2024
5 December 2023	23 January 2024	
6 February 2024	26 March 2024	
2 April 2024 (**Budget**)		

3.7. Should members approve the meeting schedules, they will be published on the Aberdeen City Health and Social Care Partnership (ACHSCP) and Aberdeen City Council (ACC) websites as appropriate.

3.8. As per the decision of the Board on 28 August 2018, stand-alone developmental workshop sessions will be scheduled throughout the year.

Meeting Format

3.9. The IJB has met in the Virtual – Remote Meeting format since the onset of the COVID-19 pandemic in March 2020. The Virtual – Remote Meeting format has proved to be effective and has allowed the IJB to continue its business. It has also enabled access to meetings which some board members may not have otherwise been able to attend. Remote IJB meetings have been recorded and the recording placed online to ensure public access to the discussions and decisions of the IJB.

3.10. As the country continues to emerge from the pandemic, the format of meetings has investigated by officers. It is possible to facilitate hybrid meetings, where some Members physically attend at a meeting room and others attend remotely via Microsoft Teams. This would permit members of the press and public to attend the meetings as they happen.

3.11. Providing the public with the opportunity to attend IJB meetings 'live', either in person or online, would increase the transparency of IJB proceedings and promote public scrutiny of decision making.

3.12. The Health Village and Council Chamber are able to host hybrid meetings. The Health Village's capacity is however more limited. It is the intention of officers to test the appetite for members to attend 'in person' via completion of a short questionnaire and this will inform the most appropriate venue should the chair use their discretion to direct that a meeting take place by hybrid means.

INTEGRATION JOINT BOARD

4. Implications for IJB

4.1. **Equalities, Fairer Scotland and Health Inequality** - Officers will seek to ensure that meeting recordings are still available online even where meetings are held in the hybrid format to maximise accessibility.

4.2. **Financial -** None directly arising from this report.

4.3. **Workforce** - It is anticipated that a meeting schedule which is publicly available on the Partnership's website would be beneficial for Aberdeen City Council, NHS Grampian and Partnership workforces. By scheduling IJB meeting dates up to March 2024, Board members, officers, auditors and stakeholders would be able to plan ahead and effectively prepare for Board meetings.

4.4. **Legal -** Approval of the meeting schedule complies with the IJB Standing Orders and helps ensure transparency with respect to when the IJB and its committees shall meet.

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 (LOIP), NHS Grampian's Clinical Strategy and Aberdeen City Council's Local Housing Strategy.

5.2. ACHSCP and its governance body, the IJB, have now been operating for over five years. During this time, real progress has been made to integrate the health and social care services delegated from its partners, Aberdeen City Council and NHS Grampian. The Integration Scheme requires adoption of good governance which has proven essential to delivery of the partnership's services and developments.

INTEGRATION JOINT BOARD

6. Management of Risk

6.1. **Identified risk(s):** The Board would be unable to take timely and informed decisions without an agreed meeting schedule; this would undermine the effectiveness of the Board's governance arrangements.

6.2. **Link to risk number on strategic or operational risk register:** Strategic Risk Register (3) Failure of the IJB to function, make decisions in a timely manner etc.

6.3. **How might the content of this report impact or mitigate the known risks:** By agreeing a meeting schedule the Partnership would be able to ensure reports captured the views of key stakeholders during the consultation process. The Board would then be in a position to take informed and timely decisions to support the functions and strategic objectives of the Partnership.

This page is intentionally left blank

Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Date of Meeting	11 October 2022
Report Title	Strategic Risk Register and Revised Risk Appetite Statement
Report Number	HSCP22.083
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
Directions required	No
Appendices	Appendix A - Risk Appetite Statement Appendix B - Strategic Risk Register

1. Purpose of the Report

1.1. To present to the Integrated Joint Board (IJB) updated versions of its Risk Appetite Statement and Strategic Risk Register *(*SRR*).*

2. Recommendations

2.1. It is recommended that the IJB:

a) Approve the IJB revised Risk Appetite Statement at Appendix A;
b) Approve the IJB revised Strategic Risk Register at Appendix B; and
c) Note that the documents will be reviewed by the IJB as per the Board Assurance and Escalation Framework with an additional review in the first quarter of 2023/24.

3. Summary of Key Information

Revised Risk Appetite Statement

3.1. The IJB's Risk Appetite 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. 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.

3.2. The IJB Members, at a workshop on 15 August 2022, considered the Board's Risk Appetite Statement and made some amendments to this document to reflect the Board's risk appetite as at August 2022. The revised Risk Appetite Statement is attached as Appendix A to this report and shows the proposed changes to the narrative to the Statement.

Updates on Strategic Risk Register

3.3. The fundamental purpose of the Strategic Risk Register is to provide 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.

3.4. Since the Strategic Risk Register was last submitted to the IJB, the Strategic Plan 2022-2025 has been approved and agreed by the IJB in June 2022.

3.5. At its meeting on 15th December 2021, the IJB agreed that the Strategic Risk Register was to be reviewed in full following the approval of the Strategic Plan.

3.6. The IJB members at its workshop on 15th August 2022 fully reviewed the Strategic Risk Register.

3.7. The updated version of the Strategic Risk Register is attached at Appendix B, based on comments and views expressed at the Workshop. The risk

owners have undertaken both updates/additions (in red text) to reflect the Workshop outcomes as well as general housekeeping of the risks (not highlighted in the Appendix)

3.8. The IJB at its meeting on the 30th of August 2022 considered the high level outcomes of the Workshop and agreed, with respect to cost of living increases, to instruct the Business and Resilience Manager to discuss this with the Risk Owners and the Senior Leadership Team, with any revisions in this regard to be presented to the IJB on 11 October 2022. The attached revised Strategic Risk Register references cost of living increases in relevant risks.

3.9. Appendix B also reflects the views at the Workshop that 3 of the strategic risks should be de-escalated. These are risks 4, 6 and 10. The views at the Workshop were that risks 4 and 6 were no longer strategic risks and related to risks at an earlier point of integration, whilst risk 10 was operational. Risk 10 will be managed through the Partnership's Civil Contingencies Group.

3.10. Based on the Board Assurance and Escalation Framework, the Strategic Risk Register is submitted to the IJB or Risk Audit and Performance Committee (RAPC) quarterly for formal review, whilst the RAPC reviews the Strategic Risk Register for the effectiveness of the process annually.

3.11. The IJB at its meeting on the 30th of August 2022 also agreed to review the Risk Appetite Statement and Strategic Risk Register after 6 months, given the changes happening in the health and social care sector and wider in the external environment. It is proposed that the review take place during the first quarter of 2023/24 and will form a workshop for IJB members with the outcomes being reported to the IJB. This will be an additional review of the strategic risks.

4. Implications for IJB

4.1. **Equalities, Fairer Scotland and Health Inequality -** While there are no direct implications arising directly as a result of this report, equalities implications will be taken into account when implementing certain mitigations.

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

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

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

4.5. **Covid-19 -** There are no Covid-19 implications arising directly from the report, however the strategic risks have been reviewed to reflect the Partnership's response to the pandemic.

4.6. **Unpaid Carers -** There are no unpaid carers implications arising directly from 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. Ensuring a robust and effective risk management process will help the ACHSCP achieve the strategic priorities as outlined it its strategic plan, as it will monitor, control and mitigate the potential risks to achieving these. The Strategic Risks have been aligned to the Strategic Plan 2022-2025.

6. Management of Risk

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

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

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

IJB Risk Appetite Statement -October 2022

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 partnership, existing in a mixed economy where safety, quality and sustainability of services are of mutual benefit to local citizens and to all 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 risk appetite will evolve and change over time.

The IJB 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 IJB 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 " very high (none, low, medium, high, very high)" 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 medium. 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 low risk in relation to breaches of regulatory and statutory compliance.
Risks to quality and innovation outcomes	Low to medium (quality and innovation outcomes which predict clearly identifiable benefits and can be managed within statutory safeguards)
Risk of harm to patients/clients and staff	Similarly, it will accept low risks of harm to patients/clients or to staff. By low risks, the IJB means it will only accept low risk to patients/clients or staff when the comparative risk of doing nothing is higher than the risk of intervention
Reputational risk	It will accept medium 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 low tolerance for risks relating to patient/client safety and service quality. It has medium to high tolerance for risks relating to service redesign or improvement where as much risk as possible has been mitigated.

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

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

This page is intentionally left blank

Aberdeen City Health & Social Care Partnership
A caring partnership

Strategic Risk Register

Revision	Date
1.	March 2018
2.	September 2018
3.	October 2018 (IJB & APS)
4	February 2019 (APS)
5.	March 2019 (IJB)
6.	August 2019 (APS)
7.	October 2019 (LT)
8.	November 2019 (IJB workshop)
9.	January 2020 (ahead of IJB)
10	March 2020 (RAPC)
11	July 2020 (IJB)
12	October 2020 (IJB Workshop)
13	November 2020 (IJB)
14	January 2021 (RAPC)
15	May 2021 (IJB)
16	June 2021 (RAPC)
17	September 2021 (RAPC)
18	November 2021 (Following IJB Workshop and ahead of IJB meeting in Dec)
19	February 2022 (RAPC)
20	August 2022 (ahead of IJB Workshop)
21	Review reflecting workshop-IJB Oct 22

Introduction & Background

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

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

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

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

Appendices

- Risk Tolerances
- Risk Assessment Tables

Aberdeen City Health & Social Care Partnership

A caring partnership

Colour – Key

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

Risk Summary:

1	Description of Risk: Cause: The commissioning of services from third sector and independent providers (eg General Practice and other primary care services) requires all stakeholders to work collaboratively to meet the needs of local people. Event: Potential failure of commissioned services to deliver on their contract Consequence: There is a gap between what is required to meet the needs of local people, and services that are available. Consequences: to the individual include not having the right level of care delivered locally, by suitably trained staff. Consequences: ability of other commissioned services to cope with the unexpected increased in demand. Consequences to the partnership includes an inability to meet peoples needs for health and care and the additional financial burden of seeking that care in an alternative setting	**High**
2	Cause: IJB financial failure and projection of overspend Event: Demand outstrips available budget Consequence: IJB can't deliver on its strategic plan priorities, statutory work, and projects.	**High**
3	Cause: Under Integration arrangements, Aberdeen IJB hosts services on behalf of Moray and Aberdeenshire, who also hosts services on behalf of Aberdeen City. Event: hosted services do not deliver the expected outcomes, fail to deliver transformation of services, or face service failure. Consequence: Failure to meet health outcomes for Aberdeen City, resources not being maximised and reputational damage.	**High**
4	Cause: Relationship arrangements between the IJB and its partner organisations (Aberdeen City Council & NHS Grampian) in areas such as governance, human resources; and performance Event: Relationships are not managed in order to maximise the full potential of integrated & collaborative working. Consequence: Failure to deliver the strategic plan and reputational damage	**Low**
5	Cause: Performance standards/outcomes are set by national and regulatory bodies and those locally-determined performance standards are set by the board itself. Event: There is a risk that the IJB, and the services that it directs and has operational oversight of, fails to meet the national, regulatory and local standards. Consequence: This may result in harm or risk of harm to people.	**High**
6	Cause**:** Complexity of function, decision making, and delegation within the Integration Scheme. Event: IJB fails to manage this complexity	**High**

	Consequence: reputational damage to the IJB and its partner organisations	
7	Cause: Demographic & financial pressures requiring IJB to deliver transformational system change which helps to meet its strategic priorities. Event: Failure to deliver transformation and sustainable systems change. Consequence: people not receiving the best health and social care outcomes	**High**
8	Cause: Need to involve lived experience in service delivery and design as per Integration Principles Event: IJB fails to maximise the opportunities created for engaging with our communities Consequences: Services are not tailored to individual needs; reputational damage; and IJB does not meet strategic aims	**Medium**
9	Cause- The ongoing recruitment and retention of staff. Event: Insufficient staff to provide patients/clients with services required. Consequence: Potential loss of life and unmet health and social care needs, leading to severe reputational damage.	**Very High**
10	Cause: IJB's becoming Category 1 Responders under the Civil Contingencies Act 2004. Event: Potential major impact to the citizens of Aberdeen if IJB does not manage its responsibilities under the Act Consequence: Potential risk to life, loss of buildings, reputational damage.	**High**

-1-

Description of Risk: Cause: The commissioning of services from third sector and independent providers (eg General Practice and other primary care services) requires all stakeholders to work collaboratively to meet the needs of local people.

Event: Potential failure of commissioned services to deliver on their contract

Consequence: There is a gap between what is required to meet the needs of local people, and services that are available.

Consequences: to the individual include not having the right level of care delivered locally, by suitably trained staff.

Consequences: ability of other commissioned services to cope with the unexpected increased in demand.

Consequences to the partnership includes an inability to meet peoples needs for health and care and the additional financial burden of seeking that care in an alternative setting

Strategic Aims: Caring Together
Strategic Enablers: Relationships and Infrastructure

Leadership Team Owner: Lead Commissioner and Primary Care Lead

Risk Rating: low/medium/high/very high

HIGH

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

Risk Movement: increase/decrease/no change

INCREASE 03.10.22

Rationale for Risk Rating:

- There continue to be significant gaps in our ability to engage at a strategic level with some parts of the social care sector eg care home owners, and therefore a lack of alignment in our strategic response to the demands placed upon the whole system. Evidence of the impact of this includes a mismatch between the physical capacity we have available to meet the outcomes of people and the suitability and appropriateness of that capacity eg unsuitable accommodation, and a lack of appropriately trained staff
- Increased demand in primary care and widespread recruitment difficulties continues to impact on practices, which has led to practices handing back their contracts or closing their lists.
- Increased risk of reduction in General Dental Practitioners capacity as a result of patient deregistration activity seen in some regions
- The removal of the Covid-19 supplier relief funding will have an impact on providers.
- Recruitment difficulties in residential and non-residential businesses.
- Delayed implementation of Primary Care Improvement Plan (PCIP) due to staff redeployment due to Covid and lack of available workforce for recruitment.

Rationale for Risk Appetite:

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

Controls:

- Conscious cultural shift to change relationships, with all strategic commissioning activity proceeding in a collaborative manner.
- Examples of collaborative commissioning models used as exemplar models within the City. Care at Home, Mental Health / Learning disability accommodation review.
- Strategic Commissioning Programme Board (includes representatives from third and independent sectors)

Mitigating Actions:

- All opportunities to work in a collaborative manner to commission services are advertised on Public Contract Scotland, as well as individual invitations made to CEOs / owners of social care services.
- Additional offers are made to encourage dialogue where the provider is unavailable to attend collaborative commissioning workshops etc.
- Agreed strategic commissioning approach for ACHSCP.

• Local Medical Council • GP Sub Group • Clinical Director and Clinical Leads • Primary Care Contracts Team • Residential and Non-Residential Oversight Groups-meet depend on the needs of the sector • Providers Huddle (meets weekly) • Primary Care Integrated Management Group • GP Contract Oversight Group • ACHSCP PCIP Project Group • Grampian Sustainability Group	• Strategic commissioning programme board (SCPB members) established to provide governance framework for commissioning activity. • Sustainability meetings with all Practices in Aberdeen City
Assurances: • Progress against our strategic commissioning workplan • Market facilitation opportunities and wide distribution of our market position statements • Oversight of both residential and non-residential social care services • Inspection reports from the Care Inspectorate • Monitoring of Primary Care Improvement Plan • Daily report monitoring • Good relationships with GP practices, ensuring communication through agreed governance routes • Links to Dental Practice Advisor who works with independent dentists • Director of Dentistry co-ordinating Grampian contingency planning to • • horizon scan for regional deregistration activity • • proactively work with practices that wish to deregister patients • • plan suitable contingency arrangements in the event patients are deregister • Part of the Eye Health Network and Clinical Leads for Optometry in Shire & Moray and the overall Grampian Clinical Lead • Roles of Clinical Director and Clinical Leads, including fortnightly Grampian wide Clinical Lead Meetings • Peer Support	**Gaps in assurance:** • Market or provider failure can happen quickly despite good assurances being in place. For example, even with the best monitoring system, the closure of a practice can happen very quickly, with (in some cases) one partner retiring or becoming ill being the catalyst. • Market forces and individual business decisions regarding community optometry, general practice and general dental practitioners cannot be influenced by the Partnership. • We are currently undertaking service mapping which will help to identify any potential gaps in market provision • Public Dental Services staffing capacity to flexibly increase service provision in short term • Difference between National Care Home Contract rate (last reviewed in 2013) and providing a 24 hour residential service. • Inability to benchmark accurately due to variation of service models • Contract Monitoring visits (enhanced services)
Current performance: • We now have established a care at home strategic providers group, with agreed terms of reference. Their strategic ambition is to ensure the safe and effective delivery of care at home across Aberdeen. • We have recently published and distributed market position statements for both residential and training and skills development for service users with either mental health or learning disability. Both have been co-produced with providers through a series of workshops which had been advertised locally and through public contracts Scotland. • A financial risk rating of each residential care home/setting is being undertaken, to give intelligence on the risk across these businesses. • Regular GP practice status reports which notes operational performance levels	**Comments:** Cost of living will impact on the provision of the service and the staff ability to get to work due to fuel prices. Lack of space for MDT working. Sustainability report has a limited predictability due to the ever changing nature of primary care.

Aberdeen City Health & Social Care Partnership
A caring partnership

-2-

Description of Risk: Cause-IJB financial failure and projection of overspend

Event-Demand outstrips available budget

Consequence-IJB can't deliver on its strategic plan priorities, statutory work, and projects.

Strategic Aims: All
Strategic Enablers: Finance

Leadership Team Owner: Chief Finance Officer

Risk Rating: low/medium/high/very high

HIGH

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

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

INCREASE 03.10.2022

Rationale for Risk Rating:

- If the partnership does not have sufficient funding to cover all expenditure, then in order to achieve a sustainable balanced financial position, decisions will be required to be taken which may include reducing/stopping services
- If the levels of funding identified in the Medium Term Financial Framework are not made available to the IJB in future years, then tough choices would need to be made about what the IJB wants to deliver. It will be extremely difficult for the IJB to continue to generate the level of savings year on year to balance its budget.
- The major risk in terms of funding to the Integration Joint Board is the level of funding delegated from the Council and NHS and whether this is sufficient to sustain future service delivery. There is also a risk of additional funding being ring-fenced for specific priorities and policies, which means introducing new projects and initiatives at a time when financial pressure is being faced on mainstream budgets.
- IJB is currently experiencing significant pressures due to inflation, cost of living, staff costs, energy costs.

Rationale for Risk Appetite:

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

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

Controls:

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

Mitigating Actions:

- The Senior Leadership Team are committed to driving out efficiencies, encouraging self-management and moving forward the prevention agenda to help manage future demand for services.
- The Senior Leadership Team have formalised arrangements to receive monthly financial monitoring statements.

• Medium-Term Financial Strategy. • Medium Term Financial Strategy review.	
Assurances: • Risk, Audit and Performance Committee oversight and scrutiny of budget under the Chief Finance Officer. • Board Assurance and Escalation Framework. • Quarterly budget monitoring reports. • Regular budget monitoring meetings between finance and budget holders. • Monthly financial monitoring to SLT	**Gaps in assurance:** • The financial environment is challenging and requires regular monitoring. The scale of the challenge to make the IJB financially sustainable should not be underestimated. • Financial failure of hosted services may impact on ability to deliver strategic ambitions. • There is a gap in terms of the impact of transformation on our budgets. Many of the benefits of our projects relate to early intervention and reducing hospital admissions, neither of which provide early cashable savings
Current performance: • Year end audited annual accounts 2021/22 submitted to IJB in October 2022 • The IJB is currently forecasting a slight underspend, but this is not expected to continue once the full effect of the emerging pressures are known (as detailed in the rationale for risk rating above).	**Comments:** • The financial position in future years will be challenging as the IJB recovers from the Covid pandemic. Discussions are continuing with ACC and NHSG regarding level of funding for future years.

- 3 -

Description of Risk: Cause: Under Integration arrangements, Aberdeen IJB hosts services on behalf of Moray and Aberdeenshire, and who also hosts services on behalf of Aberdeen City.

Event: hosted services do not deliver the expected outcomes, fail to deliver transformation of services, or face service failure.

Consequence: Failure to meet health outcomes for Aberdeen City, resources not being maximised and reputational damage.

Strategic Aims: All
Strategic Enablers: Relationships

Leadership Team Owner: Chief Officer

Risk Rating: low/medium/high/very high

HIGH

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

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

NO CHANGE 03.10.2022

Rationale for Risk Rating:

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

Rationale for Risk Appetite:

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

Controls:

- Integration scheme agreement on cross-reporting
- North East Partnership Steering Group
- Aberdeen City Strategic Planning Group (ACSPG)
- North East System Wide Transformation Group

Mitigating Actions:

- Development of Service Level Agreements for 9 of the hosted services considered through budget setting process.
- In depth review of the other 3 hosted services.
- Quarterly reporting to ACSPG and annual reporting on budget setting to IJB (once developed).

Assurances:

- These largely come from the systems, process and procedures put in place by NHS Grampian, which are still being operated, along with any new processes which are put in place by the lead IJB.
- North East System Wide Transformation Group (Officers only) led by the 4 pan-Grampian chief executives. The aim of the group is to develop real top-level leadership to drive forward the change agenda, especially relating to the delegated hospital-based services.
- Both the CEO group and the Chairs & Vice Chairs group meet quarterly. The meetings are evenly staggered between groups, giving some six weeks between them, allowing progressive work / iterative work to be timely between the forums.
- The Portfolio approach and wider system approach demonstrates closer joint working across the 3 Health and Social Care Partnerships and the Acute Sector.

Gaps in assurance:

- Ongoing review of hosted through development of SLA's.

Current performance:	Comments:
• Once the SLA's are reported to the Risk, Audit and Performance Committee, the IJB will be informed on current performance on an ongoing basis.	

Aberdeen City Health & Social Care Partnership
A caring partnership

- 4 -

Description of Risk:

Cause: Relationship arrangements between the IJB and its partner organisations (Aberdeen City Council & NHS Grampian) in areas such as governance, human resources; and performance

Event: Relationships are not managed in order to maximise the full potential of integrated & collaborative working.

Consequence: Failure to deliver the strategic plan and reputational damage.

Strategic Aims: All
Strategic Enablers: Relationships

Leadership Team Owner: Chief Officer

Risk Rating: low/medium/high/very high

Low

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

Risk Movement: (*increase/decrease/no change*)
No Change 03.10.2022

Rationale for Risk Rating:

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

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

Controls:

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

Mitigating Actions:

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

Assurances:

- Regular review of governance documents by IJB and where necessary Aberdeen City Council & NHS Grampian.

Gaps in assurance:

- None currently significant.

Current performance: • Most of the major processes and arrangements between the partner organisations have been tested and no major issues have been identified.	**Comments:**

- 5 -

Description of Risk:

Cause: Performance standards/outcomes are set by national and regulatory bodies and those locally-determined performance standards are set by the board itself.

Event: There is a risk that the IJB, and the services that it directs and has operational oversight of, fails to meet the national, regulatory and local standards.

Consequence: This may result in harm or risk of harm to people.

Strategic Aims: All
Strategic Enablers: Technology

Leadership Team Owner: Strategy and Transformation Lead

Risk Rating: low/medium/high/very high

HIGH

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

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

NO CHANGE 03.10.2022

Rationale for Risk Rating: Service delivery is broad ranging and undertaken by both in-house and external providers. There are a variety of performance standards set both by national and regulatory bodies as well as those determined locally and there are a range of factors which may impact on service performance against these. Poor performance will in turn impact both on the outcomes for service users and on the reputation of the IJB/partnership. Given current situation with increased demand and staffing pressures there might be times that the likelihood of services not meeting standards is possible.

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

Controls:

- Clinical and Care Governance Committee and Group
- Risk, Audit and Performance Committee
- Data and Evaluation Group
- Performance Framework
- Linkage with ACC and NHSG performance reporting
- Annual Performance Report
- Chief Social Work Officer's Report
- Ministerial Steering Group (MSG) Scrutiny
- External and Internal Audit Reports
- Links to outcomes of Inspections, Complaints etc.
- Contract Management Framework
- Weekly Senior Leadership Team Meetings
- Daily Operational Leadership Team Huddles

Mitigating Actions:

- Continual review of key performance indicators
- Review of and where and how often performance information is reported and how learning is fed back into processes and procedures.
- On-going work developing a culture of performance management and evaluation throughout the partnership
- Refinement of Performance Dashboard, presented to a number of groups, raising profile of performance and encouraging discussion leading to further review and development
- Recruitment of additional resource to drive performance management process development
- Risk-assessed plans with actions, responsible owners, timescales and performance measures monitored by dedicated teams
- Restructure of Strategy and Transformation Team which includes an increase in the number of Programme and Project Managers will help mitigate the risk of services not meeting required standards.

• Urgent and Unscheduled Care Programme Board	• Use of Grampian Operational Pressure Escalation System (G-OPES) and Daily and Weekly System Connect Meetings help to mitigate the risk of services not meeting standards through system wide support. • Four focus areas of the system wide critical response to ongoing system pressures
Assurances: • Joint meeting of IJB Chief Officer with two Partner Body Chief Executives. • Agreement that full Dashboard with be reported to both Clinical and Care Governance Committee and Risk, Audit & Performance Committee. Lead Strategy and Performance Manager will ensure both committees are updated in relation to the interest and activity of each. • Annual report on IJB activity developed and reported to ACC and NHSG • Care Inspectorate Inspection reports • Capture of outcomes from contract review meetings. • External reviews of performance. • Benchmarking with other IJBs	**Gaps in assurance:** • Formal performance reporting against the Strategic/Delivery Plan has continued to be developed in consultation with the SLT. • Further work required on linkage to Community Planning Aberdeen reporting. • Review of the Locality Plans, this will include prioritisation of actions.
Current performance: • Performance reports submitted to IJB, Risk, Audit and Performance and Clinical and Care Governance Committees. • Various Steering Groups for strategy implementation established. • Close links with social care commissioning, procurement and contracts team have been established • IJB Dashboard has been shared widely. • Weekly production of surge and flow dashboard will be part of Surge Planning • Annual Performance Report – approved by IJB in August 2022. • ACHSCP are involved in 1 of the focus areas (increase of Hospital @ Home provision) • SLT encouraged to identify any additional ideas and opportunities for change	**Comments:** As part of the Scottish Government's expectation for Public Bodies to show leadership on the global climate emergency, new requirements have been included in the mandatory annual reporting whereby, by the end of November 2022, Aberdeen City IJB need to confirm direct and indirect emission reduction targets, the alignment of resources, and how they will publish progress reports towards achieving the targets set.

- 6 -

Description of Risk:

Cause: Complexity of function, decision making, and delegation within the Integration Scheme.

Event: IJB fails to manage this complexity

Consequence: reputational damage to the IJB and its partner organisations.

Strategic Aims: All
Strategic Enablers: Relationships

Leadership Team Owner: Business and Resilience Manager

Risk Rating: low/medium/high/very high
HIGH

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

Risk Movement: (*increase/decrease/no change)*
NO CHANGE 03.10.2022

Rationale for Risk Rating:

- Risk rating has increased to acknowledge the complexity of operating in current pandemic environment.

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

Controls:

- Senior Leadership Team Weekly Meetings
- Operational Leadership Team Daily Huddles
- IJB and its Committees
- Board Assurance and Escalation Framework process
- Standards Officer role
- Locality Governance Structures

Mitigating Actions:

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

	carried out with service users, staff and partners throughout service change processes to gain detailed feedback and act upon it. • Through the Locality Empowerment Groups help inform plans which will identify priorities to improve health and wellbeing for local communities, seeking the views and input of the public on these Groups.
Assurances: • Role of the Chief Officer, Chief Operating Officer, Chief Finance Officer, Senior Leadership Team Weekly Meetings and Operational Leadership Team Daily Huddles • Performance relationship with NHS and ACC Chief Executives • Communications plan / communications staff	**Gaps in assurance:** None known at this time
Current performance: • Additional communications support recruited (starting in February 2022). • Regular and effective liaison by Communications staff with local and national media during various and current stages of the pandemic to: 1) mitigate potentially harmful media coverage of Partnership and care providers during the emergency; and 2) secure significant positive media coverage of effective activity by the Partnership and its partners during the Covid crisis, highlighting necessary changes to working practices and the work of frontline staff • Partnership comms presence on the NHSG Comms Cell • Close liaison with ACC and NHSG comms teams to ensure consistency of messaging and clarity of roles	**Comments:** • Communications strategy and action plan in place and being led by the HSCP's Communications staff • External and internal websites are regularly updated with fresh news/information; both sites continue to be developed and refined • Regular Chief Officer (CO) and Chief Executives (Ces) meeting supports good communication flow across partners as does CO's membership of the Corporate Management Teams of both ACC and NHSG

-7-

Description of Risk:

Cause: Demographic & financial pressures requiring IJB to deliver transformational system change which helps to meet its strategic priorities.

Event: Failure to deliver transformation and sustainable systems change.

Consequence: people not receiving the best health and social care outcomes

Strategic Aims: All
Strategic Enablers: Technology and Infrastructure

Leadership Team Owner: Strategy and Transformation Lead

Risk Rating: low/medium/high/very high

HIGH

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

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

NO CHANGE 03.10.2022

Rationale for Risk Rating:

- Recognition of the known demographic curve & financial challenges, including cost of living, which mean existing capacity may struggle
- This is the overall risk – each of our transformation programme work streams are also risk assessed with some programmes being a higher risk than others.
- Given current situation with increased demand and staffing pressures there might be times when it is likely that transformational projects delivery may be delayed.
- System Wide demand on Information Governance Services for data sharing agreements

Rationale for Risk Appetite:

- The IJB has some appetite for risk relating to testing change and being innovative.
- The IJB has no to minimal appetite for harm happening to people – however this is balanced with a recognition of the risk of harm happening to people in the future if no action or transformation is taken.

Controls:

- Governance Structure and Process (Senior Leadership Team meetings, Operational Team Daily Huddles/Executive Programme Board and IJB and its Committees)
- Quarterly Reporting of Delivery Plan progress to Risk, Audit & Performance Committee
- Annual Performance Report
- External and Internal Audit

Mitigating Actions:

- Programme management approach being taken across whole of the Partnership
- Regular reporting of progress on programmes and projects to Executive Programme Board
- Increased frequency of governance processes Executive Programme Board now meeting fortnightly and creation of huddle delivery models.
- A number of plans and frameworks have been developed to underpin our transformation activity across our wider system including: Primary Care Improvement Plan and Action 15 Plan.
- Continue to recruit to the new structure of the Strategy and Transformation Team to become fully established.

Assurances:

- Risk, Audit and Performance Committee Reporting

Gaps in assurance:

• Robust Programme Management approach supported by an evaluation framework • IJB oversight • Board Assurance and Escalation Framework process • Internal Audit has undertaken a detailed audit of our transformation programme. All recommendations from this audit have now been actioned. • The Medium-Term Financial Framework prioritises transformation activity that could deliver cashable savings • The Medium-Term Financial Framework, Portfolio Management Approach aims and principles, and Programme of Transformation have been mapped to demonstrate overall alignment to strategic plan.	• Our ability to evidence the impact of our transformation: documenting results from evaluations and reviewing results from evaluations conducted elsewhere allows us to determine what works when seeking to embed new models. • All Programme and Project Managers to be trained in the appropriate level of Managing Successful Programmes methodology • Continue to recruit to the new structure of the Strategy and Transformation Team to become fully established.
Current performance: • The Strategic/Delivery Plan has been approved and Strategy and Transformation resource has been allocated to deliver on the projects within the Plan.	**Comments:**

- 8 –

Description of Risk

Cause: Need to involve lived experience in service delivery and design as per Integration Principles

Event: IJB fails to maximise the opportunities created for engaging with our communities

Consequences: Services are not tailored to individual needs; reputational damage; and IJB does not meet strategic aims.

Strategic Aims: All
Strategic Enablers: Relationships

Leadership Owner: Chief Officer

Risk Rating: low/medium/high/very high

MEDIUM

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

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

NO CHANGE 03.10.2022

Rationale for Risk Rating:

- Now that localities governance and working arrangements are established the impact of not maximising the opportunities is moderate but at the moment, in the early stages of the arrangements, the likelihood remains a possibility.
- Cost of living and digital exclusion are potential barriers for community engagement

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

Controls:

- Locality Empowerment Groups (LEGs)
- Senior Leadership Team Meetings and Operational Leadership Huddles
- CPP Community Engagement Group
- Equalities and Human Rights Sub-Group

Mitigating Actions:

- Strategic Planning Group (SPG) Pre-Meeting Group set up to support locality empowerment group members on the SPG.
- Continued joint working with Community Planning colleagues to oversee the ongoing development of locality planning

Assurances:

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

Gaps in assurance

- Demographic and diversity representation on Locality Empowerment Groups. The Equalities and Human Rights Sub Group has been tasked to address this.

Current performance:

- LEGs representatives attend the SPG on a regular basis and participate in the meetings.
- Review of joint locality planning arrangements is underway

Comments:

- 9 -

Description of Risk: Cause-The ongoing recruitment and retention of staff

Event: Insufficient staff to provide patients/clients with services required.

Consequence: Potential loss of life and unmet health and social care needs, leading to severe reputational damage.

Strategic Aims: All

Strategic Enablers: Workforce

Leadership Team Owner: People & Organisation Lead

Risk Rating: low/medium/high/very high

VERY HIGH

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

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

NO CHANGE 03.10.2022

Controls:

- Clinical & Care Governance Committee reviews tactical level of risk around staffing numbers
- Clinical & Care Governance Group review the operational level of risk
- Oversight of daily Operational Leadership Team meetings to maximise the use of daily staffing availability
- Revised contract monitoring arrangements with providers to determine recruitment / retention trends in the wider care sector-*replicate wording in risk 1 and include pc risk*
- Establishment of daily staffing situational reports (considered by the Leadership Team)
- NHSG and ACC workforce policies
- Daily Grampian System Connect Meetings and governance structure
- Daily sitreps from all services (includes staffing absences)
- ACHSCP Delivery Group for Workforce Plan

Rationale for Risk Rating:

- The current staffing complement profile changes on an incremental basis over time.
- However the proportion of over 50s employed within the partnership (by NHSG and ACC) is increasing rapidly (i.e. 1 in 3 nurses are over 50).
- Totally exhausted work force with higher turnover of staff (particularly over 50)
- Current very high vacancy levels and long delays in recruitment across ACHSCP services.
- Increased numbers of early retirement applications and requests for reduced hours
- Economic upturn in North East post covid
- Post Covid 19 landscape

Rationale for Risk Appetite:

- 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.

Assurances:

ACHSCP Workforce Plan
Agreed governance arrangements
Formal performance reporting against the Strategic/Delivery Plan has continued to be developed in consultation with the SLT.
Staff side and union representation on daily Operational Leadership Team meetings

Mitigating Actions:

- Significantly increased emphasis on health/wellbeing of staff
- establishment of ACHSCP recruitment programme, including Social Media schedule
- promotion and support of the 'We Care' and 'Grow of own' approaches
- embrace the use of new/improved digital technologies to develop and support the ACHSCP infrastructure & develop a road map with a focus on enablement for staff
- flexible/hybrid working options to become 'normal' working practice that benefit staff time & supports their wellbeing

	• Greater use of commissioning model to encourage training of staff • Increased emphasis on communication with staff • increased collaboration and integration between professional disciplines, third sector, independent sector and communities through Localities to help diversity of the workforce • Increased monitoring of staff statistics (sickness, turnover, CPD, complaints etc) through Senior Leadership Team and daily Operational Leadership Team meetings, identifying trends. • Awareness of new Scottish Government, NHSG and ACC workforce policies and guidelines
Current performance: • Managing workforce challenges through daily Operational Leadership Team meetings and Daily Connect Meetings and structures • Managing very high level vacancies in comparison to neighbouring Health Boards • ACHSCP Workforce Plan is being consulted upon by Scottish Government and wider ACHSCP staff, with IJB comments incorporated. The Plan will be submitted to the IJB in November for approval.	**Gaps in assurance** • Dedicated Project Support of Delivery Group for Workforce Plan
	Comments: • Ongoing consultation on National Care Service. Any updates arising from the progress of the Service that has a bearing on the risk will be updated in due course. • The ACHSCP Workforce Plan will be submitted to IJB in November with feedback from the Scottish Government incorporated when received.

Aberdeen City Health & Social Care Partnership
A caring partnership

- 10 -

Description of Risk:

Cause: IJB's becoming Category 1 Responders under the Civil Contingencies Act 2004.

Event: Potential major impact to the citizens of Aberdeen if IJB does not manage its responsibilities under the Act

Consequence: Potential risk to life, loss of buildings, reputational damage.

Strategic Aims: Keeping People Safe at Home
Strategic Enablers: Relationships

Leadership Team Owner: Chief Officer

Risk Rating: low/medium/high/very high
HIGH

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

Risk Movement: (increase/decrease/no change):
NO CHANGE 03.10.2022

Rationale for Risk Rating:

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

Rationale for Risk Appetite:

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

Controls:

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

Mitigating Actions:

- The Grampian Local Resilience Partnership (GLRP) identifies risks which are likely to manifest. The Partnership require to have controls in place to manage these risks, particularly the ability to respond to these in an emergency situation.
- Aberdeen City Council are currently reviewing the risks in the City within its risk registers to ensure that the control actions listed are sufficient to mitigate risks. During this process, the additional risks may well be identified, based on risk assessment within operational areas, which may impact on the ability to respond. The result will be a risk register incorporating all risks relating to organisational resilience for the City. The City Resilience Group will be responsible for managing these risks through its membership and liaison with other services not represented on the Group.

	• Senior Manager On Call governance documents and arrangements within the Aberdeen City Health and Social Care Partnership (stored on Teams and hard copy), and links into the equivalent structures in ACC and NHSG. • The Partnership's Civil Contingencies Group has a requirement to monitor Business Continuity Plans across the Partnership, including an overarching Partnership Business Continuity Plan (BCP). • The Partnership's Communications staff are available to issue media releases and to answer any media enquiries relating to ACHSCP services which would be or could be impacted in an emergency, in close consultation with ACHSCP Leadership Team members. IJB members, senior elected members of Aberdeen City Council, and appropriate senior management members at the city council and NHS Grampian would be kept informed in advance of information which was due to be released by ACHSCP into the public domain. A log would be kept of all information released internally and externally in order that an audit trail is maintained of all communications activity. • Data taken off Care First system to identify vulnerable people to help emergency response. • Recruitment of volunteers to the position of "Managers on Call" who will support the Senior Managers on Call specifically in concurrent risks (eg patient flow and weather events)
Assurances: • Internal Audit undertaken in 2020 on Civil Contingency arrangements in Aberdeen City Council, including Care For People Plan. • Ongoing discussions around development of Aberdeen City Vulnerable Persons Database using Geographical Information Mapping System (this will include data from Care First) as well as regional and national discussions on Persons at Risk Database (PARD). • The Partnership's Senior Managers On Call have access to the relevant sections of the Council's Resilience Hub so that key messages can be received.	**Gaps in assurance:** • Development of National Persons at Risk Database (PARD) • Training for Senior Managers On Call – Partnership's Civil Contingencies Group to address. Liaise with GLRP, Council and NHS Grampian on training and testing planned (include tabletop exercising) as well as look at running "local" training and testing in the Partnership.
Current performance: • Meetings regarding the development of the PARD have been set up. The Partnership will be attending these meetings. These meetings are at both a Grampian and Aberdeen level. • Recruitment of Managers on Call to support Senior Managers on Call (starting February 2022) • Recruitment of additional comms support for Partnership (starting February 2022) • Restructuring of post (Resilience Officer) to help support IJB's roles under the Act (started February 2022) • Recruitment of post (Emergency Planning, Resilience and Civic Officer) shared with Aberdeen City Council to further support the IJB's roles under the Act (started August 2022)	**Comments:**

Appendix 1 – Risk Tolerance

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

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

Table 1 - Impact/Consequence Definitions

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

Table 2 - Likelihood Definitions

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

Table 3 - Risk Matrix

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

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

Table 4 - NHSG Response to Risk

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

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

This page is intentionally left blank

Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Date of Meeting	11 October 2022
Report Title	Surge Plan 2022/23
Report Number	HSCP22.084
Lead Officer	Sandra Macleod, Chief Officer
Report Author Details	Name: Martin Allan Job Title: Business Manager Email Address: martin.allan3@nhs.scot
Consultation Checklist Completed	Yes
Directions required	No
Appendices	Appendix A -Surge Plan 2022/23

1. Purpose of the Report

1.1. To present to the Integrated Joint Board (IJB) the Aberdeen City Health and Social Care Partnership (ACHSCP) Surge Plan 2022/23.

2. Recommendations

2.1. It is recommended that the IJB note the ACHSCP Surge Plan 2022/23 as outlined in the Appendix to the report and that the Plan will be monitored on an ongoing basis by the ACHSCP's Senior Leadership Team (SLT).

3. Summary of Key Information

3.1. In previous years the Partnership has developed a winter plan to prepare for additional demand in the health and social care system over the winter period. Following the response to the pandemic and the various waves of Covid infections, a more generic approach to surge planning is required

3.2. The wave of Covid infections in March/April 2022 and the sustained pressure on the system during the summer of 2022 is evidence that this type of planning is required.

3.3. Work has been ongoing to develop a Surge Plan and an accompanying risk assessment for the ACHSCP. ACHSCP's SLT has developed and populated the Plan and assessment, taking into consideration national studies and recommendations (eg The Scottish Government's National Lessons from Healthcare Planning and Response to Winter 2021-22).

3.4. NHS Grampian (NHSG) are drafting modelling which the ACHSCP's Plan has been sense checked against, and there are weekly meetings looking at winter planning that the ACHSCP are involved in. The ACHSCP have also been liaising with colleagues in NHSG on surge/capacity planning across the system The Plan is attached at the Appendix to this report.

3.5. The Plan is split into different sections: prevention and anticipating demand; operational resilience; increase capacity; staff health and wellbeing and communication.

3.6. The Plan sets out specific actions under the sections, a delivery deadline, RAG status and narrative.

3.7. The Plan also has a risk assessment, looking at different causes of risk, the events that could happen and the consequence of the risk cause and event. The risk assessment also outlines the mitigations against the risk cause. The actions contained in the main body of the Plan will help to mitigate the overall risks outlined.

3.8. It is proposed that the SLT continue to monitor and update the Plan at its meetings, whereat strategic and operational risks will also be looked at as well as any emerging risks. In addition to this, clinical risks are scrutinised on a weekly basis at the Clinical Care Risk Meeting and would be fed through the clinical care risk governance structures (Clinical Care and Governance Group and Committee) which would include both SLT and if at a strategic level the IJB (through the Strategic Risk Register). The Plan would be updated to take account of any emerging risks.

4. Implications for IJB

4.1. **Equalities, Fairer Scotland and Health Inequality -** While there are no direct implications arising directly as a result of this report, equalities implications will be taken into account when implementing certain actions and mitigations.

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

4.3. **Workforce -** There are no workforce implications arising directly as a result of this report but reference to staff health and wellbeing is contained as a section in the Surge Plan.

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

4.5. **Covid-19 -** There are no Covid-19 implications arising directly from the report, however the Surge Plan will help to mitigate any further waves of Covid infection.

4.6. **Unpaid Carers -** There are no unpaid carers implications arising directly from 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. Ensuring a robust and effective risk management process will help the ACHSCP achieve the strategic priorities as outlined it its strategic plan, as it will monitor, control and mitigate the potential risks to achieving these. The Risk Assessment contained in the Surge Plan has been aligned to the Strategic Plan 2022-2025.

INTEGRATION JOINT BOARD

6. Management of Risk

6.1. Identified risks(s) – The Risk Assessment contained in the Surge Plan outlines the identified risks.

6.2. Link to risks on strategic or operational risk register: The Risk Assessment identifies specific risks. These risks are linked to the IJB Strategic Risks on commissioned services (Risk 1), finances (Risk 2), performance (Risk 5), and workforce (Risk 9)

6.3. How might the content of this report impact or mitigate these risks: Ensuring a robust and effective risk management process will help to mitigate all these risks. The Risk Assessment identifies the required mitigating actions.

Surge Plan and Risk Assessment 2022

Key Action	Date Started	Delivery Deadline	Lead Officer	RAG Status	Progress/Comments
Prevention and Anticipating Demand					
Deliver Covid and Flu Vaccinations		31/12/22	Lead for People and Organisation and Lead Nurse		Significant promotional efforts ongoing to maximise take up from eligible staff . Operational delivery of autumn / winter vaccination programme 'on track' if required to offer appointments by Christmas, but if Scottish Government instruct acceleration of delivery by 5 December. There is a significant staffing gap at present to deliver to this timescale
Major Infectious Diseases Plan		31/10/22	Business and Resilience Manager		NHSG are in the process of reviewing their Major Infectious Diseases Plan. The 3 Health and Social Care Partnerships will feed into this Plan.
Identify and risk assess particularly vulnerable people in Aberdeen City (including People At Risk Database (PARD))		31/10/22	Social Work Lead/Business and Resilience Manager		Aberdeen City PARD Working Group meeting to identify all relevant data sets for PARD. Aim to have a working draft in place and tested by end of October, 2022.
Create links to receive early warning of adverse weather events		30/09/22	Business and Resilience Manager		All Senior Managers On Call (SMOC's) have access to the Met Office and Scottish Environment Protection Agency (SEPA) early warning alerts. Further reminder to be issued. Senior Leadership Team (SLT) have an agreed process when amber and red weather warnings are received.
Create links with Aberdeen City Council (ACC) roads in relation to prompt clearing of designated roads and pathways		30/09/22	Business and Resilience Manager		ACC have a priority route plan, which outlines specific roads that are

Key Action	Date Started	Delivery Deadline	Lead Officer	RAG Status	Progress/Comments
					prioritised. Good links with Roads and Flooding team at ACC.
Continued delivery of targeted Stay Well Stay Connected and Public Health initiatives		31/10/22	Lead for Strategy and Transformation		Collectively the Public Health Co-ordinators, Health Improvement Officers, and Wellbeing Coordinators continue to deliver initiatives in relation to Mental Health & Wellbeing, Poverty, Social Exclusion, Inequalities, Diet, Physical Activity, and cognitive decline helping to keep people as well as they can be and hopefully avoid the need for support from Aberdeen City Health and Social Care Partnership (ACHSCP) formal services
Operational Resilience					
Review SMOC and Manager on Call (MOC) arrangements and ensure resilient cover over public holidays and festive period.		31/10/22	Business and Resilience Manager		SMOC and MOC arrangements currently being reviewed. SLT have agreed to remove the MOC rota having being assured that controls and actions are in place to meet demands. SLT are to make decisions on future SMOC arrangements in October 2022. Started process of arranging SMOC cover for festive period.
Ensure regular arrangements for Situational Awareness (Daily Huddles)		30/09/22	Business and Resilience Manager		Daily Operational Leadership Team huddles are in place Mon-Fri, with weekend huddles being chaired by the SMOC on Sat and Sun. These arrangements will allow discussion around any resilience matter on a daily basis (e.g. weather warnings)

Key Action	Date Started	Delivery Deadline	Lead Officer	RAG Status	Progress/Comments
Ensure regular arrangements for access to system wide awareness and support		30/09/22	Business and Resilience Manager		Additional resilience support is in place (shared resource with ACC). Agreement to more closely align training and awareness for SMOC's and DERC's. Daily Operational Leadership Team huddles are in place Mon-Fri, with weekend Partnership huddles being chaired by the SMOC on Sat and Sun. The SMOC also attends the Daily OLT meetings as well as attending the twice daily "Daily System Connect" meetings (Mon to Fri) and the weekend equivalent which allows for the system wider awareness and support aspect.
Review Business Continuity Plans (In-House Services)		31/10/22	Senior Leadership Team		All NHSG and ACC service Business Impact Analysis have been updated and overarching ACHSCP Business Continuity Plan being updated to incorporate these. Presently the other business continuity documents are being reviewed/updated and should be completed by the end of October. These include the Response and Recovery Plan, Lockdown Plan, SMOC Guidance etc. The Control Room Operating Guide is being updated to reflect the move to a virtual operation.
Review Business Continuity Plans (Commissioned Providers)		31/10/22	Commissioning Lead		Work is ongoing with the Oversight group and providers at the weekly provider forum to ensure continuity plans and winter preparedness is discussed and actioned. Each provider

Key Action	Date Started	Delivery Deadline	Lead Officer	RAG Status	Progress/Comments
					has their own continuity plan with an expectation that they will cascade to their staff. Oversight team will support the providers with ensuring plans are robust. Financial risk assessments are being carried out by Contracts team to inform us of providers who are more at risk financially. Emergency contacts and protocols to be followed in the event of a winter emergency promoted at provider forum.
Review arrangements and equipment for staff working from home if required		31/10/22	Senior Leadership Team		During response to the pandemic, all services identified staff needs to allow them to work from home. Managers will continue to monitor this and assist staff where required.
Re-instate Surge and Flow and Staff Absence reporting		30/09/22	Lead for Strategy and Transformation		Staff standing by to re-implement this reporting as soon as it is required. Same templates and processes will be used as previously.
Increase Capacity					
Review Redeployment Policy		30/09/22	Lead for People and Organisation		The Partnership will work with both NHS Grampian (NHSG) and ACC on any redeployment requirements, within the employers' policies.
Make arrangements for 7 day and/or Public Holiday working to be introduced as required		31/10/22	Senior Leadership Team		The Partnership introduced rotas to enable 7 day working as part of the response to the pandemic. In addition to this some services are further embedding 7 day working in other areas of their business. The Partnership has a festive rota with

Key Action	Date Started	Delivery Deadline	Lead Officer	RAG Status	Progress/Comments
					information on the services open over the holiday season (and staff working). The Senior Managers On Call also have a festive rota.
Develop Volunteer Protocol including a list of tasks with associated risk assessments		31/10/22	Lead for People and Organisation/Care For People (CFP) Group		Existing volunteer protocols are in place with the 3rd and Voluntary Sectors in the City which have been tested over Covid, the response to storms and providing volunteer capacity at city mass vaccination centre.
Promote volunteer register		31/10/22	Lead for People and Organisation/CFP Group		It is proposed to "check-in" with existing volunteer agencies and ask for their capacity over next 6 months Promote through Care For People Group members. This will include ask on the co-ordination of volunteers by the 3rd sector.
Deliver volunteer training if required		30/11/22	Lead for People and Organisation/CFP Group		To be arranged (including refresher training), linked to above co-ordination action. There will need to be training undertaken by the host/receiving service organisation.
Review support arrangements for commissioned providers		30/09/22	Social Work Lead/ Commissioning Lead		Oversight group support Care homes & Care at home services through regular interactions, weekly Provider forum meetings and provider escalations email address to escalate any concerns. The Care Home and Care at Home Oversight Team have been expanded to include the review team which reduced the additional workload from the Care Management Team.

Key Action	Date Started	Delivery Deadline	Lead Officer	RAG Status	Progress/Comments
Determine need and funding for Interim Beds and make arrangements to commission if required.		30/09/22	Commissioning Lead		Currently working with Social Work Lead around use of interim beds and respite that will be required over winter building on the beds we already commission – Working on opportunities within the City to create step up beds/GP beds using the learning from the Emergency Discharge beds. The IJB will receive a paper in November with plans for additional beds and the cost of this.
Review key pathways to streamline and increase capacity where possible		31/10/22	Senior Leadership Team		The Partnership has been involved in the whole system working approach that has been developed through the response and then the recovery from the pandemic This includes the SMOC attending the Daily System Connect meetings, and a daily review of risk across the Partnership (including SOARS and Mental Health)
Further increase Hospital at Home capacity		30/11/22	Lead Nurse		Currently have 23 beds. The plan is to have 45 beds in place by 1st of November, 2022.
Explore potential for key partners (Bon Accord Care (BAC) & Grampian Care Consortium (GCC)) to create additional capacity as required		30/09/22	Commissioning Lead		Exploring creative approaches to test the use of technology to support medication administration and digital support hub to triage care needs (at business case development stage and plan to run a test of change) promoting sustained move away from task and time and more focus on person led support with providers. Working jointly with GCC and BAC around increasing

Key Action	Date Started	Delivery Deadline	Lead Officer	RAG Status	Progress/Comments
					capacity for over winter and releasing capacity through a robust review programme
Continue to work with colleagues in ACC Housing Registered Social Landlords to ensure that properties are suitably adapted and promptly available for people who are ready to be discharged from hospital		31/10/22	Strategy and Transformation Lead		Integration and Housing Meeting being reconvened with a focus on discharge. Disabled Adaptations Group continues to meet regularly monitoring adaptations and sharing best practice.
Deliver the cross system social care sustainability projects in relation to Care at Home	01/08/22	30/09/22	Social Work Lead		Workshop undertaken and projects identified for each Health and Social Care Partnership. Leads also identified and each project progressing individually. Still to determine how best to share learning across the system however discussions are ongoing with Healthcare Improvement Scotland and we will identify a way to do this within the next couple of weeks.
Staff Health and Wellbeing					
Monitor staff absences		30/09/22	SLT		SLT receive daily updates on staffing, helping to monitor the reasons for absence and provide support to staff.
Make arrangements for winter safety packs to be available for relevant staff		31/10/22	Lead for People and Organisation		Ordering of various winter safety items for staff has commenced and earlier distribution on track. Significant increase in provision of complimentary therapy, sandwiches, teas/ coffees on track
Continue with promotion of health and well being initiatives and ensure there is capacity to increase these in times of most need		31/10/22	Lead for People and Organisation		There is a planned suite of wellbeing initiatives available for staff in the Partnership up to end of March 2023.
Communication					

Key Action	Date Started	Delivery Deadline	Lead Officer	RAG Status	Progress/Comments
Plan public safety messages with statutory partners (vaccinations, walk like a penguin etc.)		30/09/22	Business and Resilience Manager		Partnership will continue to assist the issue of public safety messages along side partners. Including repeating any messages being sent out by statutory partners, including Scottish Government.
Remind all staff re Adverse Weather Policy		30/09/22	Senior Leadership Team		Control Room will issue relevant policies (ACC/NHSG) for onward distribution to staff.
Ensure communication channels are available with commissioned providers		30/09/22	Commissioning Lead		Regular communications with the providers via the Oversight group and provider forums
Repetition of know who to turn to message to divert demand from hospital and prevent system becoming overwhelmed		30/09/22	Business and Resilience Manager		Partnership will continue to assist the issue of public safety messages along side partners. Including repeating any messages being sent out by statutory partners, including Scottish Government. The Partnership will provide links to statutory messages on website.

	Deadline not met
	Risk to delivery by deadline
	on course for completion by deadline
	Complete

RISK ASSESSMENT

Cause	Event	Consequence	Mitigation
ACHSCP is organised to deliver services based on a sustained level of demand.	Certain events cause unexpected rising demand e.g., new variant increasing transmission rate, and ACHSCP's ability to cope even with normal demand can dip meaning anything that can be done to divert demand can help the whole system maintain service provision.	If ACHSCP does not plan and prepare for future or unexpected surges in demand or reduction in capacity, it will be unable to maintain service delivery.	Anticipating potential surges in demand and the implementation of related prevention measures in advance can help reduce demand before it presents
ACHSCP is organised to deliver services under normal circumstances.	Unexpected situations require a degree of planned resilience to ensure ACHSCP has the ability to respond.	A lack of resilience exposes ACHSCP to the risk of not being able to cope when unexpected situations arise.	Developing operational resilience helps ensure that arrangements are in place early to help staff and providers cope with periods of pressure

The system is running at capacity, barely managing to cope with current demand.	Certain events cause unexpected rising demand and/or impact on staff capacity to cope e.g., new variant increasing transmission rate, adverse weather event, and/or increase in staff absence	Reduced capacity impacts on the amount and the quality of care that can be provided leading to increased unmet need, people receiving care in inappropriate locations and delays to discharge from hospital	Increasing capacity helps the wider system cope during times of increased demand
The system is running with a significant number of vacancies with difficulty in recruitment in some areas.	In times of increased pressure and/or staff absences staff that turn up have to work harder during shifts, work longer hours or sacrifice days off to pick up additional shifts.	Staff can experience fatigue or burnout and their health and wellbeing can be negatively impacted potentially resulting in them having a period of absence.	Supporting staff health and wellbeing helps them maintain resilience and enables them to continue delivering during periods of high pressure
Times of intense pressure requires a change in behaviour of staff, providers and the public.	Lack of information about the situation and/or what staff, providers and the public can do to help.	Staff, providers and the public do not change their behaviours to help cope with the situation that has arisen.	A wide range of communication to staff, providers and the public raises awareness of issues and sources of information to help cope with or avoid these issues.

Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Date of Meeting	11 October 2022
Report Title	Draft ACHSCP Carers Strategy
Report Number	HSCP22.080
Lead Officer	Alison Macleod (Strategy and Transformation Manager)
Report Author Details	Name: Amy Richert Job Title: Senior Project Manager Email Address: arichert@aberdeencity.gov.uk Phone Number: 07970065991
Consultation Checklist Completed	Yes
Directions Required	No
Appendices	Appendix A – Draft ACHSCP Carers Strategy Appendix B – Draft ACHSCP Carers Strategy Action Plan Appendix C – Stage 3 Health Inequalities Impact Assessment (HIIA) Appendix D – Overview of engagement activity on the ACHSCP Carers Strategy

1. Purpose of the Report

1.1. The purpose of this report is to provide an update on progress with the development of the Aberdeen City Carers Strategy and provide opportunity to comment on the Draft Strategy included at Appendix A in advance of a period of public Consultation on the Strategy.

2. Recommendations

INTEGRATION JOINT BOARD

2.1. It is recommended that the Integration Joint Board:

a) Endorse the Draft Strategy included in Appendix A and Action plan in Appendix B.
b) Endorse the engagement overview and consultation timeline included in Appendix D.
c) Note that there will be a period of public consultation on the draft strategy.
d) Instruct the Chief Officer of the IJB to present the final version of the Aberdeen City Carer Strategy for approval at the next IJB meeting on 29th November 2022.

3. Summary of Key Information

3.1. On 1 April 2018 The Carers (Scotland) Act 2016 (the "2016 Act") came into effect. The 2016 Act places a duty on local authorities and health boards to prepare and publish a local Carers Strategy covering both adults and young carers. This is delegated to Integration Joint Boards under the Public Bodies (Joint Working) (Prescribed Local Authority Functions Etc.) (Scotland) Amendment (No. 2) Regulations 2017 and the Public Bodies (Joint Working) (Prescribed Health Board Functions) (Scotland) Amendment Regulations 2017. On 27 March 2018 the IJB approved Aberdeen City's Carers Strategy 'A Life Alongside Caring'. The strategy had a three-year life span ending March 2021.

3.2. The COVID-19 pandemic had a significant impact on the ability of the Aberdeen City Health and Social Care Partnership (ACHSCP) to review the Strategy in line with the original timeline to March 2021. A desktop review of the existing strategy was completed and on 6th July 2021 the IJB agreed to extend the lifespan of the existing Carers Strategy to March 2022, and this was subsequently extended to October 2022.

3.3. The 2016 Act provides a definition of a Carer. This is someone who provides or intends to provide care for another individual. An Adult Carer is defined as a carer who is at least 18 years old but is not a young carer. A Young Carer is defined as a carer who is under 18 years old or has attained the age of 18 years while a pupil at a school, and has since attaining that age remained a

pupil at that or another school. The definition of a Carer excludes paid Carers, for example those working for a care agency, and Volunteers. For this reason, the Carers to whom the 2016 Act refers are often referred to as 'Unpaid Carers' to provide this distinction. Other exclusions include Foster Carers and parents of dependent children. The Statutory guidance for the 2016 Act states that, "parents of dependent children with additional care and support needs can still be 'carers' to the extent that the care is or would be provided by virtue of something other than the child's age", therefore Parent Carers are referred to within the Strategy where this circumstance applies. For ease of reading the term 'Carers' is used throughout the Strategy with the above explained in the 'Who are Carers?' section.

3.4. The strategy is supported by a Carers Strategy Implementation Group (CSIG) who meet regularly to review actions and work together in the development of Carers support in Aberdeen City. A recent update on progress made to support Unpaid Carers in Aberdeen City was included in our Annual Report 2021-2022 which was presented to the IJB on 30th August 2022.

3.5. In Aberdeen City we have 803 Carers known to our Adult Carer Support Service and 135 Young Carers known to our Young Carer Support service. The 2011 Census estimated that there were 222,793 people living in Aberdeen and that 15,571 are Carers. With 6,229 stating that they provide more than 20 hours of unpaid care per week. The Scottish Health Survey (SHeS) presents that 11% of Aberdeen's population identify as a Carer. This is lower than the national average of 15%. This would take us to a figure of 24,500 unpaid carers in Aberdeen. Of these numbers there are estimated to be approximately 2000 Young Carers.

3.6. There is therefore a significant gap between the estimated number of people who are acting as Carers in Aberdeen and those known to us, however, not all unpaid carers wish to be recognised as such or wish to register for support. The unpaid caring role is often a journey with support only being sought when a crisis point is reached. Whilst we are mindful that each caring role is individual, we are committed to increasing awareness of the support available to unpaid carers and encouraging more of them to come forward for this.

3.7. The Adult Carer Support Service changed provider in December 2020. This followed a tendering process with Quarriers taking over. During the provider transition Quarriers were also not able to be provided with the information held on 'known Carers' by the previous provider meaning they were required to start from the beginning. Whilst they have been proactive in promoting the service it is recognised that a change of service during the height of the pandemic, when the public and our workforce were focussed on the pandemic response, has meant there is still a lack of knowledge about the Adult Carer service available as we look to implement the strategy.

3.8. The Scottish Health and Care Experience Survey indicated a reduction in satisfaction of Carers who feel supported to continue in their caring role in Aberdeen City from 34% in 2019/20 to 32% in 2021/22. Whilst higher than the national percentage of 30% in 2021/22, this still indicates that 66% of Carers do not feel supported in their caring role.

3.9. Nationally the Independent review of Adult Social Care (Feeley report) focussed specifically on the challenges experienced by Unpaid Carers in Scotland and, where actionable within existing legislation, these are included within the Draft Strategy. The Scottish Government have also indicated their intention to publish a National Carer Strategy, something which has not been in place previously. The Action Plan will be a working document and will be flexible to incorporate any additional requirements made by the Scottish Government when the National Carer Strategy is published.

3.10. The Draft Strategy included in Appendix A is intended to be both informative and forward thinking. It provides an overview of some of the support currently available in Aberdeen City as well as areas where there is a need for further development or improvement to ensure there is suitable support available for all Unpaid Carers supporting cared for people in Aberdeen City.

3.11. This Strategy is for all Carers including Young Carers. For this reason, it has also been presented to the Children's Services Board for their comment.

3.12. The Draft Strategy outlines 4 Strategic Priorities.

- Identifying as a Carer and the first steps to support
- Accessing Advice and Support
- Supporting future planning, decision making and wider Carer involvement
- Community support and services for Carers

3.13. The Strategy is accompanied by an Action Plan which highlights currently identified actions. This is intended to be a live document with new actions being added as they are identified. We are considering ways to ensure that this is kept up to date in the public domain.

4. Implications for IJB

4.1. Equalities, Fairer Scotland and Health Inequality

A stage 3 Health Inequalities Impact Assessment (HIIA) is included in Appendix B.

The strategy aims to enhance equality of opportunity for all Carers. Ensuring that all Unpaid Carers have access to support is a golden thread through the Strategy. During the first stages of engagement, it was recognised that we did not have a thorough understanding of the perspective of Carers from minority ethnic communities in Aberdeen. Whilst further engagement is underway to address this, with regard to, strategy development it is recognised that ongoing engagement is required to ensure that 'less heard communities' are aware of their rights within the Act and that local supports and services are developed with the needs of all Carers in mind. The CSIG will work alongside members of the Equality and Human Rights sub-group to continue to develop our understanding of the needs of all communities in Aberdeen.

4.2. Financial

The ACHSCP budget for Carers is £2,537,067. This is made up of the £1,768,067 budget from 21/22 plus £769,000 of additional SG funding for 22/23. This budget includes provision of social care services provided via

our adult social work teams where these provide a break to the Carer as well as the specific Carer support services listed above.

The actions outlined within the Strategy and Action Plan would be delivered within the existing resource envelope and through additional, applied for, funding streams where available.

4.3. Workforce

The Strategy will be delivered by the workforce in partnership with Unpaid Carers and the wider community.

Members of the ACHSCP, NHS Grampian, Aberdeen City Council, independent and third sector workforces have been engaged with during the development of this Strategy. Several recommendations are included within the Strategy with the aim of improving the knowledge of all members of the workforce on the rights of Carers and appropriate routes to support.

It is recognised that members of our workforce may be Unpaid Carers themselves and we will link in with the work of the ACHSCP Workforce Plan to support them.

4.4. Legal

Having a local Carer Strategy in place meets the legal obligations on the IJB within The Carers (Scotland) Act 2016. The Act and subsequent regulations outline the nine specific areas which are to be included within a Local Carer Strategy. These are listed below along with the relevant section within the Strategy where these are addressed.

Local Carer Strategy Checklist	ACHSCP Draft Strategy relevant section
• Plans for identifying relevant carers and obtaining information about the care they provide (or intend to provide) to cared-for persons in the local authority's area	Priority 1

INTEGRATION JOINT BOARD

Local Carer Strategy Checklist	ACHSCP Draft Strategy relevant section
• An assessment of the demand for support to relevant carers	Who are Carers? (Page 14)

• Support available to relevant carers in the authority's area from -
  ○ the authority,
  ○ the relevant health board,
  ○ any other organisations that the authority and health board consider appropriate
	Commissioned Carers Support services in Aberdeen (Page 12)
	Priority 2 & 4

• An assessment of the extent to which demand for support to relevant carers is currently not being met	Who are Carers? Priority 1,2,3, 4 & Action Plan
• Plans for supporting relevant carers	Priority 3
• Plans for helping relevant carers put arrangements in place for the provision of care to cared-for persons in emergencies,	Priority, 2,3 & 4
• an assessment of the extent to which plans for supporting relevant carers may reduce any impact of caring on relevant carers' health and wellbeing,	Priority 3
• the intended timescales for preparing adult carer support plans and young carer statements.	Carers Support services in Aberdeen
• information relating to the particular needs and circumstances of young carers.	Priority 2 & 4

4.5. COVID-19

COVID-19 has had a significant impact on the time taken to develop this strategy. The pandemic has disproportionately impacted on Carers and this impact is considered specifically within the draft Strategy.

4.6. Unpaid Carers

The recommendations and proposals within this report are focused on improving experiences of Unpaid Carers. They will continue to be fully involved in the planning and delivery of services designed to support them.

5. Links to ACHSCP Strategic Plan

5.1. The development of this Strategy is a specific action identified within the ACHSCP Strategic Plan 2022-2025 under the strategic aim of 'Caring Together'.

6. Management of Risk

6.1. Identified risks(s)

Supporting Carers is an important element of our approach to prevention in our Strategic Plan 2022-2025. By supporting Carers to continue Caring we will support the wider population to live well for longer at home and potentially reduce the demand on other Health and Social Care services, for example, unplanned Hospital admissions.

There is a risk that if we do not continue to have a robust Carers Strategy that the voices of unpaid carers are unheard, and services designed to support them will not meet their needs. There is also a risk that the IJB fails to meet its obligations within the Carers (Scotland) Act 2016.

INTEGRATION JOINT BOARD

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

This report links to Risk 5 on the Strategic Risk Register:

Cause: Performance standards/outcomes are set by national and regulatory bodies and those locally determined performance standards are set by the board itself.

Event: There is a risk that the IJB, and the services that it directs and has operational oversight of, fails to meet the national, regulatory and local standards.

Consequence: This may result in harm or risk of harm to people.

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

This report recommends an approach which aims to continue to develop Carers support services and improve the experience of Unpaid Carers supporting people living in Aberdeen City.

This page is intentionally left blank

Aberdeen City Carers Strategy 2022-2026

"A City for all Carers"

Aberdeen City Health & Social Care Partnership

A caring partnership

Contents

Foreword

We are delighted to present our new Carers Strategy for Aberdeen City. Carers play an incredibly important role in supporting the people of Aberdeen to remain independent, enjoy life, endure ill health and they also provide emotional support to those they care for. This is often in very challenging circumstances.

Whilst presented by the Aberdeen City Health and Social Care Partnership (ACHSCP) this Strategy has been informed by collaboration and involvement of multiple partners across the City and, most importantly, Carers themselves. There are strong links between this strategy and the ACHSCP Strategic Plan 2022-2025, The NHS Grampian Plan for the Future and Community Planning Aberdeen's Local Outcome Improvement Plan (LOIP).

The Strategy focuses on 4 Strategic Priorities.

Priority 1 – Identifying as a Carer and the first steps to support.

Priority 2 – Accessing advice and support

Priority 3 – Future Planning, decision-making and wider Carer involvement

Priority 4 – Community Support and services for Carers

It is accompanied by a detailed Action Plan which sets out how we aim to improve the experience of Carers in the 4 priority areas.

Central to delivering these priorities is creating the conditions for a 'Carer Sensitive' approach within Aberdeen. This means having support for Carers as a central focus and working alongside Carers to develop that support.

This Strategy is an action within the 'Caring Together' aim of the ACHSCP Strategic Plan with the aim to 'deliver better support to unpaid Carers'. This Strategy adopts the same Strategic Enablers as the ACHSCP Strategic Plan. These are the main ways we will support delivery of the Actions identified – **Workforce, Technology, Finance, Relationships and Infrastructure.** The 2021/22 Scottish Health and Care Experience (HACE) Survey indicated that only 32% of Aberdeen City Carers surveyed said they felt supported in their caring role. This is down from 34% in 2020/2021. The overarching Aim of this Strategy is to improve the experience of all Carers in Aberdeen City making best use of available resources to do so. It takes a focused but flexible approach to doing this over the next 3 years.

We will demonstrate overall improvement by aiming to increase our percentage of Carers feeling supported within the 2025/26 HACE survey to 42%.

PLAN ON A PAGE

'A City for All Carers' -
Aberdeen City Carer Strategy 2022-2026
Aim : **We will demonstrate overall improvement by aiming to increase our percentage of Carers feeling supported to 42%.**

Aberdeen City Strategic Plan Priority - **'Caring Together'**
Strategic Enablers - **WORKFORCE - TECHNOLOGY - FINANCE - RELATIONSHIPS - INFRASTRUCTURE**
These enablers are the key resources which will support the implementation of the Aberdeen City Carer Strategy 2022-2026

Priority 1 - Identifying as a Carer and the first steps to support	**Priority 2** - Access to advice and support for Carers	**Priority 3** - Supporting future planning, decision making and wider Carer involvement	**Priority 4** - Community support and services for Carers
What we want Carers to be able to say about their Support			
I am supported to identify as a Carer and am able to access information about the support I may need	I am supported as a Carer to Manage my Caring Role	I am respected, listened to and involved in the planning and development of the services and support which I and the person(s) I care for receive	I have a sense of belonging and a life alongside caring, <u>if i choose to.</u>"
What will each priority focus on?			
This priority focuses on the importance of carer's being recognised by themselves and others and having an easy entry point to support.	*This priority focuses on support and advice which is universally accessible to anyone who identifies as a Carer in Aberdeen City.*	*This priority focuses more specifically on support with future planning as a Carer and accessing more intensive support where the caring role requires this both for the Carer and the Cared for person. It also includes how carers can be involved in the wider development of support for carers.*	*This priority is focussed on the practical supports available to Carers to support them to be well connected to their communities and have a life alongside their caring role including hobbies and employment. There will be a strong emphasis on Carer choice here and that no one size fits all.*
What actions will we take to achieve these priorities?			
1.1 Proactively create opportunities for more people across Aberdeen City to identify as a Carer. 1.2 Improve the knowledge of Carer's Rights and Carers support services with the Education, Health and Social Care Workforce. 1.3 Improve the Knowledge of the wider Community of Aberdeen City of Carers Rights and Carers Support Services.	2.1 Ensure Young Carers have access to a Young Carer Support Service who can provide individual advice and support. 2.2 Ensure Adult Carers have access to an Adult Carer Support Service who can provide individual advice and support.	3.1 Young Carers have the opportunity to be leaders in planning their own support (Future Planning) 3.2 Young People with Carer responsibilities experiencing transition from Child to Adult Services have access to individual advice and support to enable future planning 3.3 Ensure Adult Carers have the opportunity to be leaders in planning their own Support (Future planning) 3.4 Carers have the opportunity to be involved in planning the support of the person they care for. 3.5 There are opportunities to access independent sources of support for both the Carer and the Cared for Person 3.5 There are opportunities to access independent sources of support for both the Carer and the Cared for Person	3.1 Young Carers have the opportunity to be leaders in planning their own support (Future Planning) 3.2 Young People with Carer responsibilities experiencing transition from Child to Adult Services have access to individual advice and support to enable future planning 3.3 Ensure Adult Carers have the opportunity to be leaders in planning their own Support (Future planning) 3.4 Carers have the opportunity to be involved in planning the support of the person they care for. 3.5 There are opportunities to access independent sources of support for both the Carer and the Cared for Person 3.5 There are opportunities to access independent sources of support for both the Carer and the Cared for Person

Carers (Scotland) Act (2016)

The Act was implemented on 1st April 2018. It represented a shift from previous reactive approaches to Carers support to one with Prevention at the centre introducing new rights for Carers and duties for Local Authorities and Health and Social Care Partnerships.

The Act brought in new duties and powers in relation to:

- Adult Carer Support Plans and Young Carer Statements
- Eligibility Criteria
- Carer Involvement
- Local Carer Strategies
- Information and Advice
- Short Breaks Statement

The Act is accompanied by statutory guidance and the Carers Charter which outlines the key rights Carers have in relation to;

- Am I a Carer?
- Adult Carer Support Plans
- Young Carer Statements
- Support as a Carer
- Carer involvement in services
- Hospital Discharge

Introduction – 2022 and beyond

Progress

This Strategy is the second one for the ACHSCP. Our first Strategy ran from 2018 to 2021 and was extended into 2022 in response to wider operational demands brought about by the COVID-19 pandemic. Our strategy is for all Carers who provide support in Aberdeen whether they be Young Carers caring for siblings or parents, Parent Carers caring for children of all ages or Adult Carers caring for family, friends or neighbours.

Our first Strategy demonstrated our commitment to embedding the Carers (Scotland) Act 2016 and for that reason a key focus was implementing many of the new duties and powers of the Act within Aberdeen City including, significantly, the introduction of Adult Carer Support Plans and Young Carer Statements. We have also commissioned new support services from Barnardos (Young Carers) and Quarriers (Adult Carers) to ensure information, advice and support is available. Developing this Strategy has been a process of reflection and planning ahead. There have been many achievements in developing support in Aberdeen and these are highlighted in **spotlight on** sections throughout our strategy. We also include **lived experience case study** sections throughout. These are anonymised but based on the experiences of Carers living in Aberdeen.

Challenges

Whilst progress has been made through our first strategy there continue to be significant challenges in meeting the needs of Carers in Aberdeen. Each of our priorities is aimed at addressing these challenges. The current financial climate also poses challenges, and we will be required to ensure that we work within our available resources to meet demand. This requires flexibility and creativity ensuring that resources are targeted to where they will achieve the most benefit for Carers.

Priority 1 focuses on identifying Carers and supporting them to access support because we know there are more people in caring roles than are known to us. We recognise that a change of Adult Support Service provider during the pandemic has led to a knowledge gap amongst our workforce and the wider public in Aberdeen City and this requires targeted action to ensure people are kept informed.

Priority 2 focuses on developing our support services with those who access them. We know that those who currently use the services find them supportive however, as with Priority 1, we know that many Carers do not access them therefore we need to be informed by new Carers as they become known to us and adapt our offer of support, as needed, to meet the needs identified.

Priority 3 focuses on ensuring Carers have involvement in decision-making processes both personally and strategically (by being involved in decisions made by the ACHSCP which affect Carers). Carers continue to feedback that they are not always involved in decisions which impact them and this needs to improve. A Carers' reference group was an aspiration of our first Strategy, and this was stalled due to the pandemic. In order to ensure all Carers voices are heard this is a key action.

Priority 4 focuses on continuing to develop a variety of support options for Carers in Aberdeen City. Feedback tells us that there are many situations where Carers find that they are unable to take a break from their caring role. We recognise that there is not a 'one size fits all' solution to this and that creativity is required to develop options which are both sustainable, flexible and able to meet the needs of both Carer and Cared for person within our available financial resources.

The COVID-19 pandemic had a significant impact on Carers, and this cannot be underestimated. It is important to recognise the important role they played in keeping their loved ones safe and well cared for and the emotional toll this has taken on many Carers.

Now is the time for our approach to Carer's support to move beyond initial implementation and we have identified areas for ongoing improvement or innovation to ensure Aberdeen is a truly supportive place for Carers, and those they care for, to live.

The National Approach to Carer's Support

The Carers (Scotland) Act (2016) outlines the Scottish Government's expectations of how Carers Support is provided in each Local Authority Area.

As a result of the pandemic the Scottish Government have also committed to developing a National Carer Strategy which may bring with it additional recommendations for how we can help support Carers locally.

Nationally we also expect significant legislative change as a result of the National Care Service (Scotland) Bill. This Bill is informed by the Independent Review of Adult Social Care which highlighted the following recommendations for Carer Support in Scotland;

- Carers need better, more consistent support to carry out their caring role well and to take a break from caring with regular access to quality respite provision. Carers should be given a right to respite with an amendment to the Carers Act as required, and a range of options for respite and short breaks should be developed.
- A new National Care Service should prioritise improved information and advice for carers, and an improved complaints process. It should take a human rights-based approach to the support of carers.
- Local assessment of Carers' needs must, in common with assessment of the needs of people using social care support services and supports, better involve the person themselves in planning support.
- Carers must be represented as full partners on the Integration Joint Boards and on the Board of the National Care Service.

We have taken relevant recommendations into account and, where possible, incorporated these into our Action Plan. For example, the Actions included within Priority 4 will focus on ensuring we have a range of options available for Carers to support the 'right to a break from caring'. The ACHSCP will be an active participant in the national debate regarding Carers Support and the National Care Service as the National Care Service (Scotland) Bill progresses whilst actively preparing for any changes required from new and emerging legislation.

Aberdeen City has recently been one of five Health and Social Care Partnerships to participate in the Care Inspectorate's Inquiry (link to report when available) into Adult Carer Services in Scotland. We welcome this external scrutiny and the feedback from the Care Inspectorate will inform the direction of this Strategy and Action Plan.

The Aberdeen City approach to Carer's support

Responsibility for developing a Carer Strategy for Aberdeen City sits with the Aberdeen City Health and Social Care Partnership (ACHSCP) however this strategy represents a combined approach to support for Carers which connects across various partners including those within Aberdeen City Council, NHS Grampian and the third sector. Carers come from all walks of life and will come into contact with a range of health, social care and education organisations. For example, Young Carers and Parent Carers are in frequent contact with Education and Children's services provided by Aberdeen City Council. Support to Carers is also an important element of the Aberdeen City Local Improvement Plan (LOIP) which includes an improvement project aimed at improving the experience of Adult Carers. This is also incorporated within our Action Plan.

"We need Organisations to listen when we ask for help." – Aberdeen Carer

A Carer Strategy would be nothing without the perspective of Carers themselves. There have been many challenges to engaging with Carers during a pandemic and we are grateful to those Carers who have taken the time to contribute to this Strategy through various engagement sessions, surveys and in more formal roles, including our IJB Carer Representatives. We recognise how challenging this can be whilst juggling the responsibilities of caring for a loved one. There is much more to do to ensure Carers are fully involved. We need to create the conditions for carer involvement in terms of opportunity to participate, be involved, for them to codesign with us, and also co-evaluate. A key component will be consideration of how we can do this in a way that suits the lifestyle of Carers and is representative of the population of Aberdeen

Commissioned Carer Support Services in Aberdeen

Under the Carers (Scotland) Act 2016 each local authority must establish and maintain an information and advice service, covering a range of mandatory areas for carers either resident in that local authority area, or caring for someone in that local authority area. There are currently two support services in Aberdeen City which are contracted to provide a dedicated to support service for Carers.[1]

Barnardos Young Carer's service

"Barnardo's Aberdeen Young Carers Service supports young carers in Aberdeen City to live a happy and fulfilled life alongside caring. Our aim is to develop the service to support young carers with individual identified needs, reduce the impact of caring, allow them to receive a short break from caring, help to reduce social isolation, improve wellbeing and increase their resilience.

"Barnardos have a range of support opportunities on offer for Young Carers including.

- One-to-one support
- Advocacy on behalf of the Young Carers or their families to support them in having their voice heard and needs recognised with other professionals, schools etc
- Volunteer Befriender's
- A range of support groups for children of all ages, including monthly LGBT+ groups for 11-14 and 15+ age groups
- Access to music, sports and arts therapy and groups including during school holidays.
- Developing partnerships with the community and third sector to support Young Carers Financial support opportunities through the Aberdeen City Council Young Carers Grant, Social Security Scotland, Young Scot and other funding platforms for both Young Carers and their Families
- Signposting to other organisations and professionals within Aberdeen City and Nationally to gain tailored support for Young Carers and their Families
- SVQ in Health and Social Care for Young Carers over 16 or Adult Carers in partnership with Bon Accord Care
- Weekly Adult Support Group for Adult Carers, Cared For and other adult family members involved with the Young Carer to receive peer support and information

[1] These contracts are regularly reviewed based on expected levels of performance. Contracts are subject to change based on local service demand.

- Volunteering opportunities for Young Carers over 16 and adults involved with the service"

Quarriers Aberdeen Carers Support Service

Aberdeen Carers Support Service, based at 37 Albert Street, Aberdeen, is a co-produced service working in partnership with carers. They offer all carers who register with the service an Adult Carer Support Plan which can give an accurate reflection of the care role provided and record any negative impacts it might be having on the carer's health and wellbeing. Together Family Wellbeing Workers, Carer Advisors and carers can then record the outcomes they would like to achieve and work together to meet them.

The service produces a quarterly newsletter with input from carers and information for carers. Online training is offered as well as support groups for parent carers, a men's group, a woman's mental health group, a health and wellbeing book group and dementia support group.

The service now has a new Respitality Bureau that carers can call on 01224 914035 or visit in person during office hours where the staff will be able to look at carers' break funding such as Time to Live grants or Respitality breaks.

Quarriers also offer an Enhanced Service for Adult Carers. The main aim of the enhanced service is.

- To work innovatively to co design services which enable the early identification of carers and ensure accessibility to services and information to a wide range of people.
- In a situation where there is an added complexity. This could be the complexity of the cared for person, carer or where there is a co-dependency within a relationship between carer and cared for person, and more intensive and specialist support is required.
- Support carers who could present with complex roles which will vary but could include Complexity due to substance or alcohol misuse or Complexity due to mental health condition which may include dementia.
- Connect and provide support to harder to reach, caring situations
- Connect with and provide the necessary support to carers to achieve individual outcomes through a carer support plan where appropriate

For carers who are online they have a Facebook page at https://www.facebook.com/aberdeencarerssupportservice and you can access useful information through the Virtual Carers Centre at https://carers.quarriers.org.uk/. If you would like to register, please call on 01224 914036.

Who are Carers?

The Carers (Scotland) Act 2016 defines who is considered as a Carer in Scotland. The Scottish Government's Carers Charter further describes the caring role as follows.

Meaning of carer

You are a 'Carer' if you provide (or intend to provide) care for another person – but ***not*****:** -

- if this is **only** because of that person's age (where they are under 18); or
- if you are caring because you have a contract or as voluntary work.

The previous definition for being identified as a 'carer' does not apply. You can be caring for someone for any number of hours. You do not need to be providing a substantial amount of care for someone on a regular basis.

Meaning of young carer

You are a 'young carer' if you are a carer (as above) and are also:

- under the age of 18; or
- 18 or over, but still attending school.

Meaning of adult carer

You are an 'adult carer' if you meet the criteria for a carer above and are aged 18 or over, and not attending school.

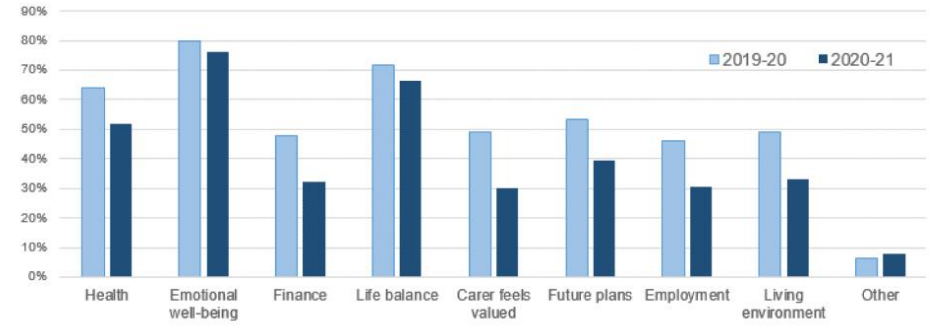
Kinship carers

A kinship carer (usually a relative or close friend looking after a child in place of their parents) can be a carer under the Act, even where they have a kinship carer agreement with the local authority. This is only for kinship carers who meet the other requirements of the meaning of 'carer' above, so not where the care is simply because of the child's age.

Sometimes Carers (as defined in the Act) are referred to as 'Unpaid Carers' to show a difference between those the Act refers to and a paid carer role. For clarity this strategy refers to 'Carers' as those who meet the definition as above. We also refer to the person being cared for as the 'Cared For person' for clarity of role. In other documents the Cared For person may be listed as the Supported Person, Patient, Service User, Adult or Child.

Many people who meet this definition are not aware that they do and may not see themselves as Carers. Often, they consider their role as simply part of being a spouse, parent, child or friend. Supporting those who are eligible for support to identify as Carers is highlighted in **Priority 1.** Members of ethnic minority communities described that those who meet the definition are less likely to recognise themselves as such, as from a cultural perspective caring for a family member is viewed as part of family responsibilities and not as the responsibility of public services or the government.

Being a Carer can have multiple impacts both positive and negative. The National Carer Census identified the following main impacts of the role on Carers;



Source: Carers Census, Scotland, 2019-20 and 2020-21

Caring relationships are varied and span all ages, communities and socio-economic groups. Some examples include but are not limited to.

- Caring for a partner or spouse living with dementia
- Caring for a child with profound and multiple disabilities
- Caring for a parent living with mental health issues
- Caring for a sibling living with disabilities
- Caring for a friend living with substance misuse issues

Many of our Carers may have their own needs beyond their caring role. This includes older Carers and Young Carers. We have included some **Lived Experience case studies** throughout this strategy to highlight the range of caring roles across Aberdeen City.

The experience of Young Carers can vary from Adult Carers. The Carers Census Scotland outlined that nationally, "in 2020-21, adult carers were more likely than young carers to experience impacts on their health (56% compared to 27%), finance (34% compared to 20%) and future plans (43% compared to 19%). These differences were slightly more pronounced in 2019-20. Young carers were more likely to experience an impact on their emotional well-being due to their caring role than adult carers in both years. In 2020-21, data suggested that 89% of young carers experienced an impact on their emotional well-being, compared to 74% of adult carers".

How many Carers are supporting people in Aberdeen?

It is difficult to come to an accurate figure for how many carers there are in Aberdeen. Our available estimates are based on figures gathered before the COVID-19 pandemic. It is also important to note that many Carers travel into Aberdeen to care for a friend or loved one. The responsibility to support them lies with us as the home of the cared for person.

The 2011 Census estimated that there were **222,793** people living in Aberdeen and that **15,571** are Carers. With **6,229** stating that they provide more than 20 hours of unpaid care per week. The Scottish Health Survey (SHeS) presents that 11% of Aberdeen's population identify as a Carer. This is lower than the national average of 15%. This would take us to a figure of **24,507.** Of these numbers there are estimated to be approximately **2000** Young Carers.

There is a significant gap between these estimates and those Carers known to services in Aberdeen.[2]

Adult Carers open to Quarriers Adult Carer Support Service (including enhanced support service)	803
Adult Carers known to Social Work services (with an adult Carer Support Plan in Place)[3]	620
Young Carers open to Barnardos Young Carer Support Service	135
Young Carers known to Childrens services (education)	51

National statistics indicate that women are more likely than men to report providing regular unpaid care. This is reflected in our local data with 58% of supported Young Carers identifying as female and 77% of supported Adult Carers identifying as female.

"Ensure that everyone can access health and social care services equally, regardless of age and disability, and ensure that families who have caring responsibilities are involved in the discussions and decisions for the person that requires care". – Respondent Grampian Regional Equality Council, Equality Outcomes Survey December 2020

Aberdeen City has a diverse population. In 2021 Community Planning Aberdeen published, 'Aberdeen City: Population Needs Assessment', which outlines the diverse make up of our population.

> "Recent figures (year ending June 2020) from National Records of Scotland estimate that 24.7% of the City's population was born outside the UK (compared to 9.8% for Scotland). Of those, it is estimated that 41.1% are from EU countries and 58.9% from non-EU countries (compared to 50% for both groups in the year to end December 2019). The estimated proportion of those born outside the UK has fluctuated in the last few years, from 24% in the year ending June 2017, down to 19% in year ending June in both 2018 and

[2] Information based on most recent monitoring reports August & September 2022. It is not possible to determine if a Carer may be included in more than one of these figures as they are from separate data sources.

[3] Recently the management system for Social Work records has been replaced. The previous system was not able to always provide the level of detail we would like on the circumstances of Carers in Aberdeen City. We will work to improve the information which can be pulled from the new system to support a better understanding of carers needs.

2019, before rising again to 24.7% in the year to end June 2020. At the time of the 2011 Census, Aberdeen City had the third highest proportion of non-white ethnic minority people in Scotland at 15.6%. This was more than double the Scotland rate at 7.6%."

The majority of identified Carers in Aberdeen are white with 89.5% of supported Young Carers identifying as white and 76% of Adult Carers. Our engagement on this strategy has highlighted that we do not know enough about the needs of Carers from some of our communities, including minority ethnic communities and the LGBTQ+ community. Making stronger links to communities is identified in our action plan and will be taken forward with partners from our commissioned support services and the ACHSCP's Equality and Human Rights sub-group. We will also work to ensure that Carers who themselves have disabilities do not experience barriers to accessing support both in their own right and as a result of their caring role.[4]

"As a Carer, I have found it very difficult to access support." – Respondent to Carer Workforce Survey

Whilst our statutory responsibility lies with supporting Carers who care for people in Aberdeen, we also recognise that many of our own workforce are also Carers, and this can have a significant impact on their wellbeing. This is considered within the ACHSCP Workforce Plan (Link to be included when published).

Carers and COVID-19

"Many people have deteriorated seriously during the pandemic and are less able to partake in activities." - Aberdeen City Carer

The COVID-19 pandemic had a substantial impact on all Carers. The stopping of many face-to-face support services during lockdown removed the ability of Carers to access support and breaks from caring which they relied upon to maintain their caring role. Subsequent lockdowns and understandable concerns for the potential of catching COVID-19 also made it less likely that Carers re-engaged in face-to-face services when they were available. Where possible alternative options were offered, for example, online support and some face-to-face support for those with significant levels of need. Many Carers, however, remained without support during pandemic restrictions.

For Young Carers the closure of Schools had a big impact on their education and emotional wellbeing leading to them missing out on opportunities to socialise, learn and have a break from their caring role.

[4] Carers (Scotland) Act 2016: statutory guidance - updated July 2021 – Annex B

A Carers Trust survey published in July 2020 on the impact of Coronavirus on Young Carers showed a steep decline in the mental health and wellbeing of the hundreds of thousands of young people across Scotland who provide unpaid care at home for family members or loved ones. 45% of young carers in Scotland stated that their mental health was worse since the pandemic and 71% of Young Carers were feeling more stressed, 74% of Young Carers were feeling less connected to others, 11% of young carers reported an increase of 30 hours or more in the amount of time they spend caring per week, and 64% of young carers were spending over 90 hours a week caring for a family member or friend.

This impact was similarly felt by adult carers particularly where the cared for person had substantial support needs. As part of Stay Well, Stay Connected work on dementia support during the pandemic a targeted survey was carried out to measure the impact of the pandemic on those with cognitive impairments and their Carers. Many staff felt a dereliction of care and increased risk to the cared for person, which impacted on their resilience and mental wellbeing. Staff spoke of the barriers to supporting people with cognitive or hearing impairments, or lack of knowledge or access to technology. Staff and Carers described witnessing increased low mood, anxiety, and earlier decline of people living with Dementia. This resulted in families' loss of precious time with loved ones and their premature need for increased or long-term care. The restrictions also negatively impacted on Carers making them feel depressed, alone and isolated.

The legacy of the pandemic may also result in a new group of Carers who are supporting someone with the symptoms of Long Covid. The longer-term impacts of this and impact on Carers is not yet fully understood but we will be required to consider how to best support this group.

For those Carers and cared for people with health conditions the pandemic has led to longer waiting times for treatment and in some circumstances poorer health as a result.

An unexpected impact of the COVID-19 restrictions, reported by both staff and Carers included an increased understanding and use of technology. This facilitated communication, information sharing and supporting and connecting with others. Staff described how the pandemic had raised awareness around the specialist care required for people with dementia, however, carers identified that in the event of future pandemics, vulnerable people and those who care for them should be protected and not isolated.

What do Carers think of Carer Support in Aberdeen?

We have engaged with Carers in a variety of ways to inform this Strategy including face to face, online, via surveys, through partners and in 1:1 discussion.

Feedback included.

"I feel you never get enough support from the professionals. It is with luck that I have a family support network. But parents are getting older and won't always be there to give the support. Also, my health isn't the best, but I don't have time for myself as all my time is consumed by making sure my child is safe and secure which is my main priority." – Aberdeen City Carer

The Care Inspectorate Inquiry into Adult Social Care Support indicated that those who access support services in Aberdeen are reasonably satisfied but many do not know what is available or don't believe there is a suitable available service and as a result are struggling.

"At present [support], it is advice and guidance, which is always forthcoming. I am so very grateful for this." – Aberdeen City Carer

The Scottish Health and Care Experience Survey indicated a reduction in satisfaction of Carers who feel supported to continue in their caring role in Aberdeen City from 34% in 2019/20 to 32% in 2021/22. Whilst higher than the national percentage of 30% in 2021/22. This still indicates that 66% of Carers do not feel supported in their caring role.

"Quarriers have been a huge help to me." – Aberdeen City Carer

The main themes identified by Carers were. [This will be a graphic for final version}

Adult Carers		**Young Carers**	
Challenges	**Positives**	**Challenges**	**Positives**
Access to advice and information	Experiences of those who have accessed the adult carer support service	Access to advice and information	Experiences of those who have accessed the adult carer support service
Accessing the right services (including social work, health and Mental Health support)	Increased Young carer awareness amongst professionals	Accessing the right services (including social work, health and Child and Adolescent Mental Health (CAMHs) support)	Increased Young carer awareness amongst professionals

Lack of awareness of dementia and other conditions	Opportunities for social activity and exercise.	Coping with the caring role (impact on mental health, feeling alone, being bullied)	Support from some education staff
Coping with the caring role (including the emotional impact of caring)	Support from extended family	Multiple challenges due to being different (including LGBTQ+ young people)	
The Impact of COVID-19	Support from other professionals (including GPs)	The Impact of COVID-19	
Accessing day support and Day Care		Accessing day support and Day Care	
Being recognised as an equal partner in planning support		Social Isolation & lack of social activities	
Financial Pressures		The impact of COVID-19 restrictions	
Hospital Discharges			
Social Isolation & lack of social activities			
Poor Mental Health (including worries about the future)			
Access to breaks (including respite)			
Tiredness and a lack of time for ones self			
Taking a break is dependent on meeting the needs of the Cared			

for person. If they are not met. The break isn't possible.			
Communication challenges			

Lived Experience Case Study - Sam's story

Sam is a 16-year-old young carer who provides a substantial caring role to their parent who has a diagnosed physical condition which impacts on their ability to manage day to day tasks, for example shopping, personal care, and household tasks. As well as going into their 6th year of secondary education, this young carer has taken on many responsibilities within their caring role and has struggled with their own mental health throughout their childhood. Initially, fortnightly one-to-one sessions were provided by the young carer support service, either face-to-face or virtually during the pandemic to understand the impact of their caring role and to support them to access a break from caring. As the one-to-one sessions progressed, the focus of support changed to allowing the young carer a space to explore healthy coping strategies, to develop a higher level of self-esteem/ confidence, developing peer relationships and to enable them to access additional supports to manage their poor mental health.

Alongside a significant package of 1-1 support, this young carer was offered social opportunities through the variety of young carers groups and other young carer activities. They accessed the Young Carers Grant and other financial opportunities to allow them to have a life alongside caring which enabled them to purchase activities during lockdown and fund trips to museums, parks and different cities with their family. The young carer feedback of the services provided are as follows,

"*As a young carer who hasn't had support in the past, the services offered to me have been supportive both physically and mentally. It's been great having one on one support as well as the group sessions where I can meet others who are going through the similar things as I am. I find it to be a safe environment so I can express how I feel about what's going on at home and in other areas of my life".*

They are currently using their experience of being a young carer within the group opportunities to develop an in-school young carers group. The goal is to raise awareness of young carers within their school, create regular informal group sessions to allow young carers in their school to have a break from caring, and will enable other pupils that are young carers access supports through the school or Barnardo's by use of a 'buddy' like approach.

Priority 1 – Identifying as a Carer and the first steps to support

What we want Carers to be able to say –

"I am supported to identify as a Carer and am able to access information about the support I may need"

This priority focuses on the importance of carer's being recognised by themselves and others and having an easy entry point to support.

On page 13 we presented that there are many Carers across the City that are not being identified and therefore not able to access the support available. People need to know that they are a Carer before appropriate support can be made available.

Respondents to our workforce survey highlighted that there are interlinked challenges in taking the first steps to support.

"I'm not sure that I agree that a person needs to define themselves as a Carer in order to access support."

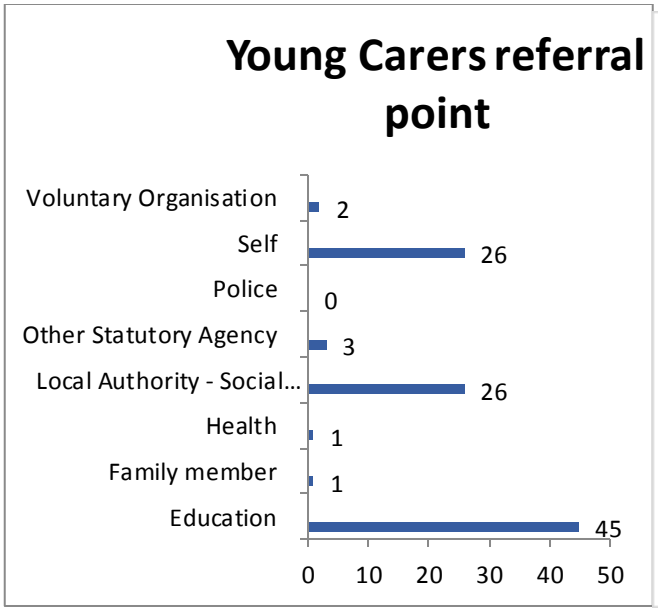
"I would agree that it is a priority to workers to support carers and the importance of carers being recognised by themselves and others and having an easy entry point of support. However sometimes family members/loved ones do not see themselves as a carer and they wish to keep it that way therefore we have to respect their decisions."

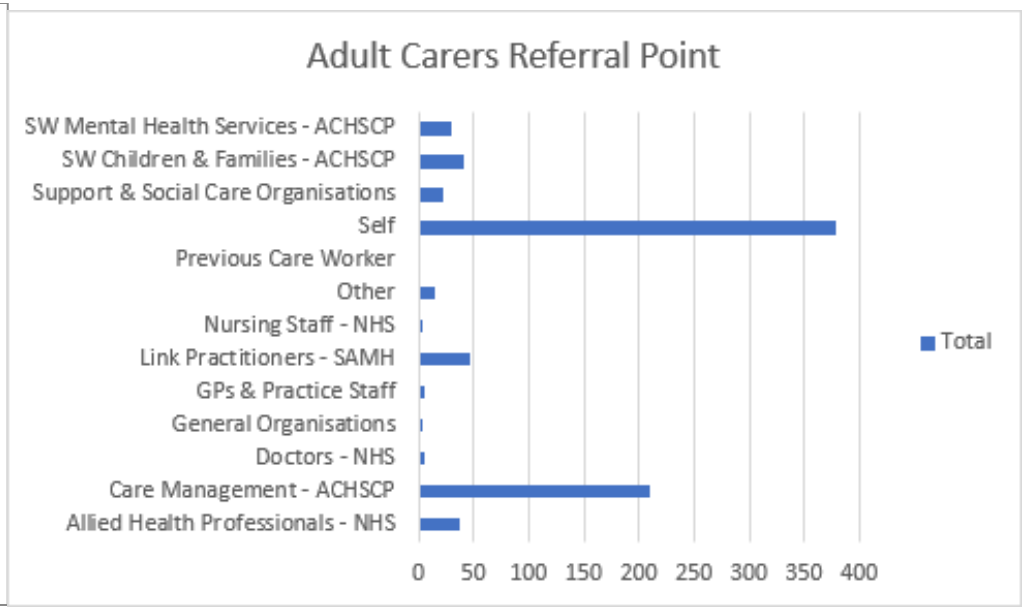
"Most unpaid carers do not realise they are a Carer, particularly older people caring for their partner. This group also have difficulty accessing and applying for information online, and we have found this to be one of the biggest issues as most information is not accessed digitally."

This shows that merely encouraging people to state they are a Carer is not enough. Everyone needs to understand what their rights are and what support could be available so they can make an informed decision about whether they want to access it and how they wish to define themselves. Those working with Carers also need to be proactive in identifying Carers and bridging the gap to support.

Current routes to identifying as a Carer

Information suggests that Young Carers are most likely to be identified by Education. Adult Carers are most likely to self-refer.





The most common reason for Young Carers to seek support is due to the physical health of the cared for person. Within Adult services it is also physical health with Dementia in the cared for person being particularly prominent.

This information, combined with the gap between those Carers we know about and those Carers we expect to be supporting people within Aberdeen indicates more needs to be done to support Carers to identify themselves and access support, if they choose to.

"The biggest impact is because of the difficulty finding out information about support available. Then even when knowing that 'support' is available, accessing support is difficult" – Aberdeen City Carer

Our Workforce is a key entry point to support for all Carers. Information from engagement with our workforce indicates that awareness of the support services available is not consistent across our workforce.[5] Carers told us that it was often difficult to navigate the system and

[5] Carers workforce Survey September 2022 indicated confidence in signposting at 3.19 with 1 (not confident) and 5 (very confident).

understand how to get support. Many people were not aware of the change of adult support provider, to Quarriers Carer Support, and more awareness of this change and how this support is accessed is required.

Recent work carried out by Glasgow HSCP highlighted the importance of family members being given information about Carers Support Services at the point where a family member receives a diagnosis of any kind. Whilst support may not be needed at that point ensuring that the option of support is available as early as possible is important. We want to encourage all those who come into contact with carers, essentially everyone, to take a Carer sensitive approach and have an awareness of the many challenges Carers can face. With this in mind Carers Support Services are promoted within the wider work of the ACVO Hospital Homecoming project which aims to facilitate speedier hospital discharge for those who may be isolated utilising third sector resources to support this.

The Care Inspectorate Inquiry into Adult Carers Support Services indicated that within Aberdeen City the numbers of people accessing Carers Support Services is low however those that do are generally satisfied with the support they receive. Therefore, a key action is to increase awareness of support if we are to improve the overall experience of Carers in Aberdeen City.

Spotlight on developing our approach to supporting Carers from all communities

As part of our work to develop this strategy we have taken a different approach to seeking the views of minority ethnic communities within Aberdeen City. We posed a short series of targeted questions and provided these to Grampian Regional Equality Council's (GREC) network of health champions via their Community Connectors to support discussions on their views as well as an exchange of information on support currently available. Participants included members of Muslim, African and Polish communities.

The response to the targeted questions indicated both cultural differences in whether an unpaid Carer would recognise themselves or feel able to seek support beyond the family, "family is the welfare system", as well as a lack of awareness of what support could be available and whether they would be eligible. There were additional challenges faced by those who do not speak English with Carers who are short of time not having the ability to access English lessons. Respondents indicated that they would look to community leaders for advice and support.

This information will inform ongoing work to understand the needs of all Carers in Aberdeen. Quarriers Adult Carer Support service had already recognised the need to better understand communities across Aberdeen. They are recruiting to a Diversity Officer role, and we look forward to working together on this approach going forward.

During the pandemic work took place to develop information resources for Carers and the wider community. The AGILE booklet and web page. provides a range of important information on what is available locally for Adult Carers and is translated into a range of languages. Ensuring suitable information is available for all Carers is essential and we will work to improve our range of accessible information.

ACTIONS (linked to Action Plan)

1.1 Proactively create opportunities for more people across Aberdeen City to identify as a Carer.
1.2 Improve the knowledge of Carer's Rights and Carers support services with the Education, Health and Social Care Workforce
1.3 Improve the Knowledge of the wider Community of Aberdeen City of Carers Rights and Carers Support Services

Lived Experience Case Study – Ellen's story

"I am a parent carer for my son who is diagnosed with Autism and ADHD. I was really struggling with his behaviour and did not know where to turn for help when a friend advised me to contact Quarriers carers service. I contacted Quarriers who came and visited me at home, and we completed an adult carer support plan together detailing where I felt I needed support. The carer adviser contacted my son's school and requested that we have a GIRFEC meeting and invite social work along to gain some respite for us as a family.

The adviser also contacted Barnardo's young carers project and got them to come to our home and discuss support for our daughter who is affected by her brother's diagnosis and behaviour. The adviser also advised that we get the Child and Adolescent Mental Health Service (CAMHS) involved to support us to manage our sons' behaviours. I contacted the school, and they completed the referral and invited them to attend the GIRFEC meeting. The adviser came to the GIRFEC meeting with us and I felt this was the first time since my son was born that someone listened to us and could empathise how caring was having an impact on all the family's wellbeing. After a few months we were provided with support through social work by giving us regular respite breaks and CAMHS have been instrumental in supporting us with strategies we use to manage our son's behaviour at home.

My daughter is fully enjoying meeting with other children who have siblings like her brother and loves the activities that Barnardo's provide. My adviser has also got us some funding to have a break away as a family for the very first time which we really enjoyed. Most of all I have someone I can call who gets me and where I am coming from and can advise me with practical solutions. I have also had regular sessions with a counsellor through Quarriers carers service that has allowed me space and time to think on what I need as a Carer."

Priority 2 – Accessing Advice and Support

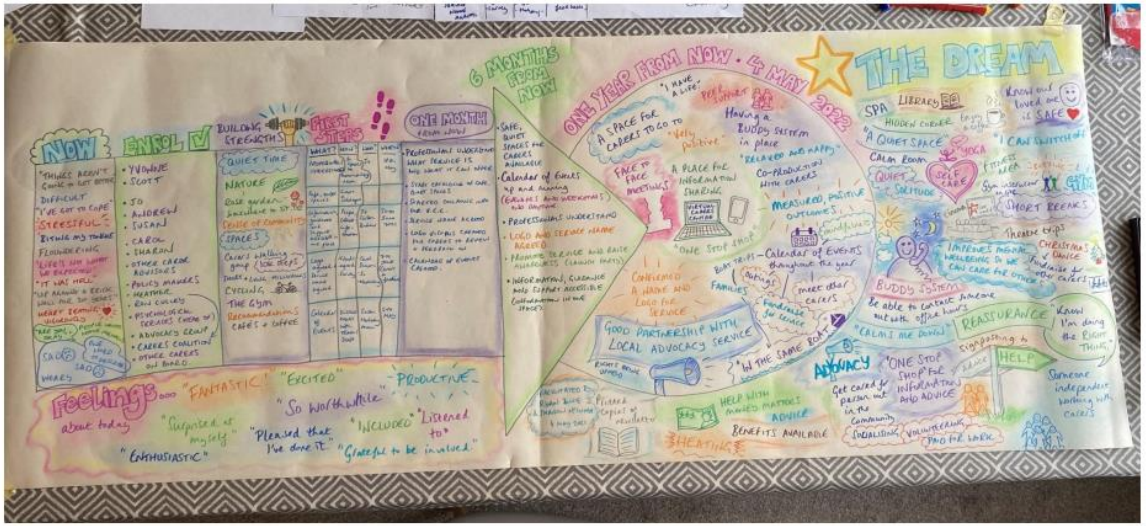
What we want Carers to be able to say - "I am supported as a Carer to Manage my Caring Role"

This priority is about Carer specific support and advice which is universally accessible to anyone who identifies as a Carer in Aberdeen City.

Once Carers have been identified we are required to ensure that Carers have access to appropriate advice and support to enable them to be supported in their caring role. The support required will vary significantly depending on the needs of the Carer, their age, community, family circumstances and stage of life.

An introduction to the support available from our current support service providers – Barnardos Young Carers Service and Quarriers Carers Support service is included on page 12.

The Quarriers Adult Carer Service took a co-production approach to developing their service alongside Carers to scope what it would look like. The image below demonstrates what was considered during this process.



These support services do not operate in isolation and support for Carers comes in many forms including from those working in Health and Social Care, Education, the third sector and the wider community is demonstrated in Ellen's Story (Page 28). Important information on a range of support options is available from the Scotland's Service Directory and Aberdeen Council of Voluntary Organisations (ACVO) who are our third sector interface.

The range of areas where Carers may require support include.

- Information on their rights, including those set out in the Carer's Charter
- Income maximisation and links to employment advice (For example Council Tax discount)
- Education and training
- Advocacy/Brokerage
- Peer support
- Support with LGBTQ+ issues
- Health and wellbeing advice, including specific support with Mental health
- Bereavement support
- Emergency care planning
- Information on Future care planning, including the development of Adult Carer Support Plans (ACSPs) and Young Carer Statements (YCS).
- Signposting to a specialist support service, e.g., Legal advice, Domestic Abuse support
- Substance use support

Spotlight on Quarriers base at Cornhill

The Quarriers Enhanced service predominantly supports Carers where support is required with Mental health issues both for the Carer themselves and the Cared for person. In June 2022 Quarriers launched a base within Cornhill Hospital to provide a space for Carers to meet with Family Wellbeing workers and receive advice and support.

ACTIONS (linked to Action Plan)

2.1 Ensure Young Carers have access to a Young Carer Support Service who can provide individual advice and support

2.2 Ensure Adult Carers have access to an Adult Carer Support Service who can provide individual advice and support

Lived Experience Case Study – Alex's Story

Alex is a 7-year-old young carer who supports and cares for his older sibling, James, who has disabilities. Due to James' complex needs, the family are unable to leave the family home and go out socially due to their sibling being described as very high risk in relation to his safety when outside.

His parents want Alex to have the same opportunities as his peers to have fun, enjoy positive experiences, and be able to experience activities that they, as a family were unable to do due to James' needs. Alex was offered to be involved in the service on a group only basis. He positively engaged in all the supports offered in a variety of ways; including accessing the Aberdeen City Council Young Carers funding to purchase items that helped with his health and wellbeing such Lego, a new bike and games. He attended the school holiday programme and thoroughly enjoyed making new friends, meeting other young carers, and having fun. The family attended a joint family activity to Innoflate whereby all the family members joined in. Alex was also identified as someone who would benefit from attending the weekly Music Therapy group to increase his self-confidence and self-esteem. He thoroughly enjoys these therapeutic sessions and always looks forward to the next one. Further support has been offered to the family including sign posting to other services and relevant support groups. Alex's said of his support, *"I enjoy the group, meeting friends there, taking part in the activities and play, I don't want to miss a single day. Everyone there is kind and I have lots of fun."*

Alex's Mum said, *"Before joining Barnardo's young carers groups, he was very timid at school. This is because his exposure to activities was very limited due to our difficulties as a family with a special needs child needing a very high level of care. His timidness had an adverse effect on his performance in school because he was so quiet and hesitant to express himself or answer questions even if he knew the answers. He is now visibly a different confident child thanks to his experience in the young carer's groups. This has directly reflected on his school assessments where he is now on target and above target right across the curriculum".*

Priority 3 – Supporting future planning, decision making and wider Carer involvement

What we want Carers to be able to say -

"I am respected, listened to and involved in the planning and development of the services and support which I and the person(s) I care for receive"

This section specifically on support with future planning as a Carer both for the Carer and the Cared for person. It also includes how carers can be involved in the wider development of support for carers.

We have split this priority into three key areas.

- Planning Support for the Carer
- Planning Support for the cared for person
- Carer involvement in developing and informing Carers Services and the work of the wider ACHSCP

Planning Support for the Carer

All Carers must be offered an Adult Carer Support Plan (ACSP) or a Young Carer Statement (YCS) in accordance with the Carer (Scotland) Act 2016. The expectations of ACSPs and YCSs are included within the statutory guidance on the Carers (Scotland) Act 2016. Carers will be offered support to complete a support plan (ACSP or YCS) and an **emergency plan**. The completion of an emergency plan allows for an anticipatory focus and allows the Carer to consider the support, they and the Cared for person may need in the advent of an emergency which impacts on their ability to provide care.

What is an Adult Carer Support plan?

An Adult Carer Support Plan provides a tool to support Carers to identify their own personal outcomes (goals they want to achieve) and identify their needs as a Carer. They enable Carers to focus in on what is important to them and what support, if any, they need to continue in their caring role. They may also support Emergency planning. We have a duty to offer an ACSP, Carers are not required to complete one however they are encouraged to do so to support them in identifying what is important to them.

What is a Young Carer Statement?

The Young Carer Statement provides an opportunity for the young person to consider their personal outcomes (goals they want to achieve) and identify their needs as a Carer. An important distinction is that is intended to ensure that young carers are seen as children and young people first and foremost and are protected from undertaking caring responsibilities and tasks which are inappropriate having regard to their age and maturity

In Aberdeen our ACSPs are carried out by the Carer with either a member of the Quarriers Carer Support service or a Social Worker / Care Manager within one of our Adult Social Work teams. YCSs are carried out by the young person supported by the Barnardos Young Carer Service. Whilst the timescale for completion will vary in each circumstance, they should be completed within 6 weeks.

The support required is varied. For some people the support already provided by the Carer Support Service, outlined in **priority 2**, will support the Carer to achieve their Outcomes. In other circumstances signposting to further services, including those within the third sector, or a package of support will also be needed. Parent Carers expressed challenges in meeting their own support needs in circumstances where the cared for person is their child. We will work with the support services and third sector organisations to explore all opportunities to support families and find creative approaches to breaks from caring.

Under the Carers (Scotland) Act 2016, each local authority must set the local eligibility criteria which it is to apply in its area for Carers. Local eligibility criteria are the criteria by which the local authority must determine whether it is required to provide support to carers to meet carers' identified needs. The duty to set local eligibility criteria for carers has been delegated to the IJB. This includes support provided to Carers as part of a self-directed support package.

The Aberdeen City Eligibility Criteria for Adult Carers was published in 2018. There are 7 indicators in Aberdeen City Health and Social Care Partnership's Eligibility

Criteria: -

1. Health and Wellbeing
2. Relationships
3. Living Environment
4. Employment and Training

5. Finance
6. Life Balance
7. Future Planning (including planning for emergencies)
   Carers can access

Carers are eligible for formal funded support to be provided if an impact or risk on the Carer from any of the eligibility indicators is deemed to be substantial or critical. Using the discretionary power available under the Act, Aberdeen City Health and Social Care Partnership, in certain circumstances, will consider an approach to interventions where the impact/risk is not critical or substantial but where intervention would be a means to prevent these impacts and risks becoming substantial or critical.

Spotlight on – The Carer SVQ

Many Carers do so on a fulltime basis, often reducing their work hours or giving up work, to care for someone. The ACHSCP has recently introduced the Carer SVQ. This supports Carers to achieve their SVQ 2 Health and Social Care whilst they are caring with their role as Carer providing the evidence base for this qualification. This then enables the Carer to develop their knowledge and skills and potentially seek employment in health and social care in future.

There is a dependency between Adult Carer Support Plans and Eligibility Criteria. The plan needs to be completed in order that the carer's needs and outcomes are identified and that the impact on their lives and the risks to them being able to continue their caring role assessed. Once the level of impact and risk are known they can be assessed against the Eligibility Criteria and a decision made on eligibility to access funded support.

Our Young Carers will often continue to provide support to their loved one as they grow into adulthood. This transition from child to adult is already a sensitive time. Carers, families and our workforce fed back that there can be a support gap between what is provided to children in our Young Carer service and what is provided for adults in our Adult Support Service. Ensuring there is a continuation of support and the right support for young people in this situation is essential. The Young Carer support service currently supports young people in this situation by providing after care support for a period to support transition. The Young Carer service and Adult Carer Service will work together to continue to develop this approach.

Spotlight on – Volunteer Mentoring in the Young Carer service

The Young carer service provides Young Adult Carers will have the opportunity to volunteer or become volunteer mentors for the younger generation of Young Carers – either within group opportunities or as a Befriender. Initially they will have the opportunity to informally volunteer by becoming a 'helper' before going through the formal process of registering as a volunteer and receiving relevant training. This provides opportunities for them to use lived experience to support others and develop skills in volunteering.

ACTIONS (Linked to Action Plan)

3.1 Young Carers have the opportunity to be leaders in planning their own support (Future Planning)

3.2 Young People with Carer responsibilities experiencing transition from Child to Adult Services have access to individual advice and support to enable future planning

3.3 Ensure Adult Carers have the opportunity to be leaders in planning their own Support (Future planning)

Planning Support for the Cared for Person

"Half an hours' notice to discharge a patient is not good enough." – Aberdeen City Carer

The Cared for person should always be the lead in the support they receive and this is outlined in the Social Work (Scotland) Act 1968 and the Social Care (Self-directed Support) (Scotland) Act 2013.

Carers play an important role in supporting the person they care for including in decision making about the support the cared for person requires. Every caring relationship is unique however it is important that there is a distinction between the needs of both and that there are supportive mechanisms in place to support this relationship.

Where the cared for person chooses to have their Carer involved in planning their support this should be facilitated as much as possible. This includes within the context of hospital discharges where there is a specific requirement within the Carers (Scotland) Act 2016, to identify unpaid Carers and consider their needs in discharge planning. We will continue to work with colleagues across NHS Grampian, including Aberdeenshire HSCP and Moray HSCP to further develop and improve our approach.

At times there can be differences of opinion between the Carer and the cared for person. In this circumstance it is important that both have access to the independent support they need and that those working with them are trauma-informed in their practice and have knowledge of domestic abuse including coercive control. Examples of this would include Advocacy advice for both where an Adult Support and Protection Concern has been raised and routes to independent advice and support for those experiencing domestic abuse.

ACTIONS (Linked to Action Plan)

3.4 Carers have the opportunity to be involved in planning the support of the person they care for.

3.5 There are opportunities to access independent sources of support for both the Carer and the Cared for Person

Carer Involvement in developing and informing Carers Services and the work of the wider ACHSCP

We are committed to ensuring that Carers voices are heard when developing support and services. One way in which Carers can have an important role in representing other Carers in their community and be involved in the wider work of the Aberdeen City HSCP is as a Carers Representative on the Integration Joint Board (IJB). This is a required role within the IJB and is formally appointed. The Representative sits on the Integration Joint Board and, potentially, other sub-groups including the Carers Strategy Implementation Group (who will monitor delivery of this strategy). The role of the representative is generally taken on over a 3-year period and there are two members who sit on the IJB.

Developing a Carers reference group was identified as an intention within our last Strategy. Progress with this was stalled during the pandemic however we have continued to benefit from the input of our IJB Carers Reps and aim to widen the scope of involvement of Carers in taking forward the Actions outlined in this Strategy using the Coalition of Carers, 'Equal, Expert & Valued' approach as a benchmark for this. We need to ensure we have a range of Carer's voices representative of the wider community who can provide a Carers perspective on all aspects of delivery of support in Aberdeen.

We also aim to continue to embed this into our approach to the contracts for Carer Support services. This has been the approach to both the Quarriers and Barnardos support services where Carers have had a central role in co-producing what support service and groups are provided based on the needs of those they support.

ACTIONS (Linked to Action Plan)

3.5 There are opportunities to access independent sources of support for both the Carer and the Cared for Person

Lived Experience Case Study – Raymond's Story

Raymond aged 91, cares for his 90-year-old wife, Anne, who has dementia. They have been married for 65 years and have 2 children. Anne first received her dementia diagnosis in 2013. Raymond is fit and healthy for his age, but he says that his caring role is not easy. Raymond does all the shopping, cooking, cleaning, laundry and medication. He receives Attendance Allowance benefit for Anne, but says it barely covers the costs relating to his caring role. He has tried to make the home as comfortable as possible for his wife as all he wants is for her to be happy, and he is determined to keep her at home as long as he can. He really wants to do the best for his wife.

Raymond says Anne has become very clingy and wants to be with him all the time. When she feels alone, she gets up to look for him. She gets depressed when she sees how much he does for her. Anne is prone to falls and Raymond has to be on guard all the time. Raymond once told a doctor that he felt life was like a stuck gramophone needle at times as Anne is always asking the same questions. "You want to scream, but you can't"

He finds it difficult to think for two people and wonders what will happen if he's ill or not there. He goes to bed exhausted and get up tired. He also says he spends a lot of time looking for lost items, hearing aids, teeth, glasses, earrings, etc! He doesn't like to complain but admits its hard work.

The couple have carers who come twice a week and will take his wife out for 3 hours in the afternoon to allow him some respite, however Raymond states that there is not much you can do in 3 hours. There is carer support in the evening for a night-time settle, and Anne also attends a day centre once a week. A lot of the care and support has been instigated and followed up by their daughter through their local Care Management (Social Work) Team. Raymond says he sees and hears from a lot of people, so it's difficult to keep track of who's who and who does what.

Priority 4 – Community support and services for Carers

What we want Carers to be able to say - "I have a sense of belonging and a life alongside caring, if I choose to."

This section is focussed on the practical supports available to Carers to support them to be well connected to their communities and have a life alongside their caring role including hobbies and employment as well as more intensive supports for the Carer and Cared for person when these are needed. There is a strong emphasis on Carer choice here and that no one size fits all.

"Access to respite came up repeatedly as a priority. Carers need to be able to take a break and respite should be viewed as integral to carer support. However, a greater range and ***more imaginative options*** *should be developed for both the supported person and Carers to better meet needs and preferences."* – Independent Review of Adult Social Care

We have outlined within Priority 2 our approach to delivering our Carer specific support services and outlined the support we will provide with planning in Priority 3. In order for Carers to feel well supported they also require access to breaks from caring and, where required, suitable care for the cared for person. What constitutes the right support will be personal to the Carer and the cared for person. Considerable work has taken place over recent years to take a more holistic approach to support in line with the principles of self-directed support, the recommendations of the Independent review of Adult Social Care and the Carers Act. These focus on ensuring that Carers have choice and control in relation to the support they can access.

The below outlines a range of supports that may be needed so that Carers and the cared for Person can feel well supported and have a life beyond the caring role.

Adult Carers	**Young Carers**	**Cared for Person**
Peer support	Peer support	Peer support
Emotional Support	Emotional Support	Emotional Support
Access to hobbies	Access to Hobbies	Access to Hobbies
Employment Support	Education support	Employment Support
Specialist advice and support (for example, Marie Currie/ CLAN,	Specialist advice and support (for example, Marie Currie/ CLAN, Dementia support, Domestic Abuse advice)	Condition specific advice and support (for example, Marie Currie/ CLAN, Dementia support, Domestic Abuse advice)

Dementia support, Domestic Abuse advice)		
Short Breaks (time to relax, enjoy leisure activity, catch up on sleep)	Short Breaks (for example, Activity Breaks)	Care and Support (1:1 support at home, residential respite, Day support in the community)
Access to exercise	Access to exercise	Access to exercise

[This will be a graphic for final version with intersections between support]

We have split this priority into three key areas.

- Developing a culture of Creativity to encourage innovative approaches to Carers Support
- Supporting the development of a range of mainstream supports and services to enable Carers to receive a break from caring
- Continue to develop a range of support options for Carers where the Cared For person has high level needs

Develop a culture of Creativity to encourage innovative approaches to Carers Support

One of the unforeseen impacts of the COVID-19 pandemic was a need to quickly rethink how support could still be provided in very different ways. Whilst many services were closed providers worked to develop alternative methods of supporting people. This approach to creativity sets a good foundation for more creative approaches going forward beyond the pandemic.

Spotlight on Creativity within Learning Disabilities services during the Pandemic leading to ongoing change

Archway @ Home (a commissioned respite service for people living with Learning Disabilities)

During the Pandemic while respite services were closed, Archway began providing online activities to provide opportunities for people to keep in touch and have things to do during lockdown. These have proved to be really popular and because of this they are continuing to provide a range of activities and social opportunities for all their service users and families. They have been successful in securing grant funding to cover the costs of employing an Activity Co-ordinator and this role is going from strength to strength with the addition of having somewhere that people can go to meet up together.

Len Ironside Day Centre

During the pandemic The Len Ironside Centre changed their registration with the Care Inspectorate to provide support at home for the service users who had attended the day centre. They also provided on-line activities and some family and staff were able to overcome their fear of computers. This took time but was a lifeline at the time and allowed staff and families to build on relationships, particularly as some staff worked from home due to shielding. The Centre provided wellbeing packs, summer packs and regular welfare calls to all the families and on special events. At Christmas staff dressed up and did doorstep calls.

The day centre continues to provide some support at home along with support at the day centre with some families preferring to have the support at home as it best meets the needs of their loved one. As a service they are also now able to provide as required care at home support in unexpected or emergency circumstances. This supports the whole system in meeting the needs of service users and is a major change to how this support could be delivered prior to the pandemic.

Within Aberdeen City we have been considering the recommendations of the Promoting Variety guide published by Shared Care Scotland. This outlines approaches to Market Shaping for Short Breaks for Carers based on developing an outcome focused collaborative approach to Short Breaks where Carers, Service Users and providers work together to be innovative in meeting the needs of Carers. The ACHSCP will aim to work with the Promoting Variety Programme for 2022-2023 to learn from and collaborate with other Partnerships to develop a range of short break supports for people in Aberdeen City, including creative breaks, respite and day support services.

ACTIONS (linked to Action Plan)

4.1 Promote a culture of Creativity to develop innovative approaches to Carers Support

Support the development of a range of mainstream supports and services to enable Carers to receive a break from Caring

Having "a sense of belonging and a life alongside caring" is not always easy for Carers. Often they can find themselves so focussed on the needs of the cared for person they can be blind to their own needs. The delivery of this strategy depends on the community working together to support Carers. This includes third sector, Community groups and businesses working together to consider Carers in the way mainstream activities are provided.

"If young carers are going to build resilience alongside their young caring role, then they need to know that opportunities and activities are available for them to help them lead a full and sustained life, alongside caring. It is important that they can access groups and services which accommodate their schedule and offer a sufficient array of opportunities that can help them succeed in the future" – Workforce Survey respondent

For Young Carers it is particularly important that they have opportunities to participate in activities and education that other children are able to and that their individual needs are recognised and supported by those who support them including schools. There are lots of isolating factors being a young carer. They experience different challenges from their peers for example lack of sleep and feeling tired etc. Young Carers described that bullying is prevalent and friendships are even more difficult to navigate. They indicated a need for more opportunities to develop group work to support socialising opportunities and meaning full friendships in a safe environment.

Spotlight on - Stay Well, Stay Connected

Providing the right support to meet the needs of all Carers is very challenging. The Stay Well Stay Connected (SWSC) programme was launched during the pandemic with a focus on community-based activity run in conjunction with other partnerships, health, third sector organisations, community groups, and volunteers.

The SWSC programme applies an intersectional approach which incorporates consideration of adult carers needs. SWSC acknowledges the value that carers bring to the provision of early intervention and prevention of ill health that promotes independence at home. SWSC has four main themes namely Social Isolation, Physical Activity, Mental Wellbeing and Digital Divide.

While all activities are themed, they provide one or more benefits for example, a **relaxed match day experience** at Aberdeen Football Club will have a benefit to a carer attending a mass participation event. These events are inclusive, dementia friendly and both the carer and the person they care for will be able to share the experience together. During the relaxed match day event there are several other benefits such

as increased social connections, improved mental wellbeing, engaging in meaningful conversations, sharing food and inclusion in a mainstream activity.

As outlined breaks from caring are an essential support and it is likely that a 'right to a break' will be introduced in the near future. In December 2018 the ACHSCP issued our Short breaks statement for Carers which committed to the development of outcome-focused Short breaks. The outcomes of a break will be personal to each carer and cared-for person, but may include:

- Having more opportunities to enjoy a life outside/alongside the caring role
- Feeling better supported
- Improved confidence (for example, more confident as a carer)
- Increased ability to cope

- Reduced social isolation and loneliness, for example increasing social circles, connections and activities
- Increased ability to maintain the caring relationship - and sustain the caring role
- Improved health and wellbeing
- Improved quality of life
- Reduced likelihood of breakdown and crisis
- Improved educational attainment
- Reaching positive destinations post school leaving age

Spotlight on Respitality

Quarriers Carer Support Service have recently opened a Respitality bureau who are dedicated to supporting Carers to access Short Breaks funding through various sources. This includes accessing voucher schemes for hotel breaks and leisure breaks. The Bureau supports Carers to complete any necessary paperwork which aims to lessen the administrative burden Carers often experience and which can put them off applying for additional sources of support.

ACTIONS (linked to Action Plan)

4.2 Support the ongoing development of a range of mainstream supports and services to enable Carers to receive a break from Caring in line with the proposed 'right to a break' within the National Care Service Bill

Continue to develop a range of support options for Carers where the Cared For person has high level needs

"[I need] me time. To know our loved ones are being well looked after entertained and happy to let us relax and enjoy a well-earned break" – Aberdeen Carer

Unpaid Carer's expressed to us that they can only really enjoy a break if the Cared for person is also experiencing a good break. Where the cared for person, adult or child, has a high level of need which requires ongoing supervision and support there is an added difficulty in ensuring they have access to meaningful and enjoyable replacement care or support to facilitate the break for the Carer. This may include the support of a personal assistant at home, Respite care in a Care Home or supported living environment and Day support at home or in the community.

The Social Care (Self-directed Support) (Scotland) Act 2013 brought in options for support for eligible Carers and cared for people which emphasise having a choice over whether you want to organise that support yourself, SDS option 1 (direct payment), direct someone else in how to organise it (SDS Option 2), access support which has been commissioned on your behalf (SDS Option 3) or a mixed approach (SDS Option 4). The amount of control Carers wish to have over their support varies. This is why we need a range of options which are developed based on the requirements of Carers in Aberdeen including packages at home, in the community, and where required, residential settings.

"I would like Respite, i.e. Daycentre for person I care for so I know she's safe and in with other people with Dementia. I can then have the break from my role without worrying." – Aberdeen City Carer

Spotlight on Developments in Older Adult Respite provision

Prior to the COVID-19 pandemic planned respite was available within dedicated respite rooms within Rosewell House Care Home. During the pandemic these rooms were repurposed to support the redesign of the frailty pathway from Aberdeen Royal Infirmary. Changing their focus to step-down from hospital or step-up from the community where there is an acute medical need. This change has had a positive impact on ensuring patients can move quickly through hospital and minimise any lengthy delays which may lead to poorer recovery for the patient.

Whilst the re-purposing of the Rosewell rooms was necessary it also meant the provision of planned respite for older people had to be reviewed and a different model developed. Those Carers and Cared for who had accessed Rosewell previously also had to adapt to a different respite environment. As part of 'Stay well, Stay Connected' a survey of carers was undertaken in July 2021. The key findings were

that Carers wanted respite based in their local area (Locality) in order that they could maintain their community connections, be close to family and their ordinary health services.

Working with providers we commissioned planned respite contracts in various Care Homes across the City, ensuring residential and nursing home beds were available for advance respite bookings. This has enabled Carers, and the Cared for person, to plan ahead and be able build positive relationships with their local Care Home. This activity has provided a foundation and ongoing engagement with Carers accessing this respite has highlighted areas for further development. This strategy will continue this work to develop a sustainable long-term model for Locality Based respite, increasing capacity. Additionally in order to enhance the experience for the Cared for person providers, Carers and the ACHSCP are actively involved in co-designing the enhancement of respite stays through the introduction of TEC in order that breaks car be personalised further.

"Haven't had respite for 2 and a half years and now it seems there is no facilities especially for age group of 54 very physically debilitated but mentally aware." – Aberdeen City Carer

The above work was focused on Older Adults requiring respite and therefore exploring and addressing gaps in services for younger adults and Young Carers will also be a focus. We recognise that Respite options are important to Carers. Within Adult Social Work they are in the early stages of developing a short breaks bureau which will allow Carers to consider a range of opportunities available in the City and beyond.

Being a Carer is a challenging role and often this involves supporting a loved one who's health is poor and, in some circumstances, where they require end of life care. Carers and staff from our Support Services highlighted the need to ensure that Carers have support beyond their Caring role in circumstances where the cared for person has died or where they have moved into a different environment, for example, a longer-term Care Home Placement. In both these circumstances the Carer Support Service would continue to work with them and signpost on to additional support services, for example grief counselling.

ACTIONS (linked to Action Plan)

4.3 Continue to develop a range of support options for Carers, where the cared for person has high level needs, which allow choice and control in line with the proposed 'right to a break' within the National Care Service Bill

How we will monitor performance of this Strategy

Monitoring performance is how we will know if what we are trying is working. The Carer Strategy Implementation Group are made up of Partners across the ACSCP, Children's services, the third sector and Carers. They will monitor performance and delivery of the Strategy over the next 3 years. There will be 6 monthly reporting into the Strategic Planning Group and an Annual report to the Integration Joint Board.

The Action Plan included in the next section outlines the specific actions being taken forward as we embark on this strategy however it is a working document and will evolve based on evidence of performance and feedback from Carers on their local needs. This is important as we embark on developing a better understanding of caring Communities we have not yet engaged with.

The Action Plan incorporates actions as follows.

- Those that are ongoing from our previous Strategy, particularly where we have a statutory duty to continue.
- New ideas identified through development of this Strategy and supported by local and national data.
- Actions identified through development of the ACHSCP Strategic Plan 2022 -2025.
- Actions identified through the NHS Grampian Plan for our Future
- Actions identified through Community Planning Aberdeen's Local Outcome Improvement Plan (LOIP) and Resilient, Included Supported Outcome Improvement Group which aims to improve the experience of Carers by 10% by 2023.
- Actions identified through Aberdeen City's Locality Plans
- Actions identified through the ACHSCP Workforce Plan

Below are four additional steps we will take to monitor this strategy.

What will we do?	When will we have done it by?	How will we know it is working?	Who will be responsible?
Demonstrate an increase in Carers feeling supported. 2021/22 baseline of 32% with 2025/26 target of 42%	Annual Health and Care Experience survey	Increase in percentage indicating they feel supported.	Senior Project Manager (Strategy)
Monitor the implementation of the Carers Strategy and report regularly on progress.	Ongoing, Annual reporting to IJB, Children's Board and ACC	Monitoring of delivery of action plan through CSIG meeting minutes Annual reports delivered to IJB, Children's Board and ACC	Carer's Strategy Implementation Group
Review strategy after 3 years	November 2025	Strategy revised, approved, published and implemented	Carer's Strategy Implementation Group
Ensure Carers views are surveyed regularly, and the feedback informs future support planning	Annually, baseline data	Survey results and revised plans	Carer's Strategy Implementation Group

	October 2022		
Yearly review of all systems in place for complaints/feedback, such as Care Opinion, the NHS ombudsman etc , to make sure that any carer issue is identified, resolved, and has provided insights into the carer strategy for future improvement.	Annual	Feedback incorporated into annual reporting on strategy.	Organisations that could be actively involved in providing feedback would be Quarriers, Barnados, Advocacy Aberdeen, Citizens Advice Bureau (CAB), Care Homes, LGBT+ Communities, ethnic minority communities, any others?
Develop performance information on the new D365 records system which will improve our understanding of Carers in Aberdeen. Including. - Known Carers - Carers with ACSPs and YCSs - Carers holding SDS Budgets and chosen SDS Options	TBC		

ACTION PLAN CURRENTLY IN SEPARATE DOCUMENT FOR EASE OF REVIEW, TO BE INCLUDED AT END OF THIS DOCUMENT ONCE AGREED.

Aberdeen City Health & Social Care Partnership
A caring partnership

If you require further information about any aspect of this document, please contact:

Aberdeen City Health & Social Care Partnership
Business Hub 8, 1st Floor North
Marischal College
Broad Street
Aberdeen
AB10 1AB

t: 01224 523237
e: ACHSCPEnquiries@aberdeencity.gov.uk
w: aberdeencityhscp.scot
t: twitter.com/HSCAberdeen

ABERDEEN CITY COUNCIL

NHS Grampian

This page is intentionally left blank

ACHSCP Carer Strategy 2022-2026 Action Plan

Priority 1

"I am supported to identify as a Carer and am able to access information about the support I may need"

Identifying as a Carer and the first steps to support

1.1 Proactively create opportunities for more people across Aberdeen City to identify as a Carer.

What will we do?	When will we have done it by?	How will we know it is working? Performance / Measuring impacts	Who will be responsible?	Progress Update
1.1.1 Hold database(s) of carers in Aberdeen City.	Ongoing	Stats available from database(s) on no. of Carers	Adult Carers Support Service Young Carer Support Service	THIS SECTION IS INTENTIONALLY BLANK. UPDATES WILL BE MADE ONCE PLAN IS IN PLACE AND PROGRESS HAS BEEN MADE.
1.1.2 Work with commissioned and internal services and carers themselves to review the information available particularly in relation to accessibility.	June 2023	To be determined	Adult Carers Support Service Young Carer Support Service Social Work Carer Rep Senior Project Manager (Strategy)	
1.1.3 Work with commissioned and internal services to ensure we are encouraging and supporting Carers to identify as such and making every opportunity count in this regard. Incorporates;	Ongoing	Increased numbers of adult and young carers identified.	Senior Project Manager (Strategy) Adult Carers Support Service Young Carer Support Service CSIG professional lead reps	

Identify early intervention and prevention support for Carers in the community with a view to addressing gaps and support. **South Locality Plan**				
1.1.4 'Review information 'and channels to reach carers, identify the touch points within the current systems, process and Tests of Change programmes etc which come across carers in their daily activity'	Ongoing	Increased numbers of adult and young carers identified.	ACVO	
1.1.5 Understand the support needs of all Carers in Aberdeen. • Develop approaches to engaging with minority ethnic Carers • Develop approaches to engaging with LGBTQ+ Carers	March 2023	Increased number of Carers from Minority Ethnic and LGBTQ+ communities accessing support. Increased knowledge of support needed by these communities	Equalities and Human Rights Sub-group Senior Project Manager (Strategy)	
1.1.6 Review the information held online for Carers to ensure it is easy to access, signposts correctly and is kept up to date.	March 2023	Monitor numbers accessing online information	Senior Project Manager (Strategy) Adult Carers Support Service Young Carer Support Service CSIG professional lead reps	
1.2 Improve the knowledge of Carer's Rights and Carers support services with the Education, Health and Social Care Workforce				
What will we do?	**When will we have done it by?**	**How will we know it is working?**	**Who will be responsible?**	**Progress Update**
1.2.1 Improve knowledge of the workforce through targeted training and development opportunities.	Ongoing with benchmarking every year	No. and % of Adult Social Work Care Managers attending carers rights training/information sessions	Senior Project Manager (Strategy) CSIG professional lead reps	

		No. of staff aware of carers rights No. of staff reporting increased awareness of carers rights Campaign analytics		
1.2.2 Test whether information sessions/training co-produced by carers for Adult Social Work Care Managers increases staff awareness/knowledge of carers rights and sharing of available support offered to carers at the earliest opportunity. **LOIP Change idea**	March 2023	Gather workforce feedback before and after sessions.	Senior Project Manager (Strategy) Adult Social Work lead Rep	
1.2.3 Consider any further requirements for Young Carers linked to shared responsibilities with education and children's services	March 2023	Feedback to CSIG group and incorporate any additional actions	ACC Children's lead Rep	
1.3 Improve the Knowledge of the wider Community of Aberdeen City of Carers Rights and Carers Support Services				
What will we do?	**When will we have done it by?**	**How will we know it is working?**	**Who will be responsible?**	**Progress Update**
1.3.1 Test whether an awareness raising campaign providing information on rights, eligibility criteria, and opportunities increases awareness of and uptake of support (South Locality Plan) **LOIP Change Idea** Incorporates; Test whether sessions/capacity building with community groups/organisations on carers rights/needs etc increases the no. of informal and free support available for carers to access. (North Locality Plan)	March 2023	Gather community feedback before and after sessions.	Carers Strategy Implementation Group	

1.3.2 Test whether promotional activities targeted to businesses on the benefits of the Carer Positive Award Scheme in Aberdeen through different channels (social media, case studies, website page) increases the number of businesses who are members of the scheme and having 'carer friendly' policies and working practices to support carers who might need to work in a more flexible manner. **LOIP Change Idea**	March 2023	'Number of businesses and organisations participating in the scheme and achieving awards	Lead Strategy and Performance Manager (ACHSCP)	

Priority 2

"I am supported as a Carer to Manage my Caring Role"

Access to Advice and support for Carers

2.1 Ensure Young Carers have access to a Young Carer Support Service who can provide individual advice and support

What will we do?	When will we have done it by?	How will we know it is working?	Who will be responsible?	Progress Update
2.1.1 Carry out review of Young Carer Support service	December 2022	The performance measures within the contract evidence a that Carer outcomes are being met	ACC Children's services lead	
2.1.2 Tender for revised Young Carer Support Service at end of existing contract	Date to be determined	Completion of tender for new service	ACC Children's services lead	

2.2 Ensure Adult Carers have access to an Adult Carer Support Service who can provide individual advice and support

What will we do?	When will we have done it by?	How will we know it is working?	Who will be responsible?	Progress Update
2.2.1 Review performance of Adult Carer Support service	Annually	The performance measures within the contract evidence a that Carer outcomes are being met	Quarriers Carers Strategy Implementation Group	
2.2.2 Ensure members of our Workforce who are also Carers are supported	Lifespan of workforce plan	Measures as determined in Workforce plan	Transformation Programme Manager (Strategy) Workforce plan	

Priority 3

"I am respected, listened to and involved in the planning and development of the services and support which I and the person(s) I care for receive"

Supporting future planning, decision making and wider Carer involvement

3.1 Young Carers have the opportunity to be leaders in planning their own support (Future Planning)

What will we do?	When will we have done it by?	How will we know it is working?	Who will be responsible?	Progress Update
3.1.1 Review use of Young Carer's Statements.	Annually	Increase number of completed Young Carer Statements. Annual audit of the value of the completed plans with the individual carers.	Integrated Children's Services (ACC) Commissioned Service	

3.1.2 List all types of youth groups running youth programmes, engage them in ensuring young carers are identified and could they support them in being leaders in planning their own support, encourage these organisations also to be Carer Positive.	December 2023	Groups identify as 'Carer Positive'	ACVO	

3.2 Young People with Carer responsibilities experiencing transition from Child to Adult Services have access to individual advice and support to enable future planning

What will we do?	When will we have done it by?	How will we know it is working?	Who will be responsible?	Progress Update
3.2.1 Develop a pathway and protocol for transition planning from Young to Adult Carer, including response to and provision for 16 & 17 year old Young Carers.	July 2023	Transitions pathway and protocol developed and utilised	ACC Children's Lead Quarriers Barnardos	
3.2.2 Identify all 3rd sector organisations that support families including those involved with children transitioning into adult services.	December 2023	Comprehensive list compiled	ACVO	

3.3 Adult Carers have the opportunity to be leaders in planning their own support (Future Planning)

What will we do?	When will we have done it by?	How will we know it is working?	Who will be responsible?	Progress Update
3.3.1 Review Eligibility Criteria for Adult Carers.	March 2023	Revised Eligibility Criteria approved, published and utilised	Adult Social work & Quarriers Supported by Carers Strategy Implementation Group	

3.3.2 Review templates and procedures for Adult Carer Support Plans, Anticipatory Care Planning and Patient Admission/Discharge. The former to include sections for Emergency Arrangements and Future Planning. Have one ACSP template used by Quarriers and Adult Social Work	March 2023	Templates revised and in use.	Adult Social work & Quarriers Supported by Carers Strategy Implementation Group	
3.3.3 Review use of Adult Carer Support Plans	Annually Starting April 2023	Increase number of completed Adult Carer Support Plans Annual audit of the value of the completed plans with the individual carers.	Adult Social Work Quarriers Commissioned Service	
3.3.4 Ensure staff are aware of and implementing guidance on support for those carers caring for people with a terminal illness	July 2021	Guidance developed and in use	Lead Strategy and Performance Manager (ACHSCP)	
3.4 Carers have the opportunity to be involved in planning the support of the person they care for				
What will we do?	**When will we have done it by?**	**How will we know it is working?**	**Who will be responsible?**	**Progress Update**
3.4.1 Review progress so far and develop guidance in relation to carer involvement in the hospital discharge process, including awareness and recognition of the role of Young Carers. 'Discharge without delay'	Review by March 2023, ongoing actions likely to follow	Guidance developed and in use.	CSIG SW Lead	

3.4.2 Review support guidance for Carers when the cared for person is moved to a Care Home.	March 2023	Guidance understood and in use.	Scottish Care	

3.5 There are opportunities to access independent sources of support for both the Carer and the Cared for person

What will we do?	When will we have done it by?	How will we know it is working?	Who will be responsible?	Progress Update
3.5.1 Develop an overview of Carer Support services which can provide independent advice to Carers and the Cared for person in specific circumstances where independent support is required to ensure they are signposted correctly, e.g. Advocacy, Adult Protection, Domestic Abuse	December 2023	Quarriers to build in reporting on onward referral to their performance information	Senior project manager (Strategy) Quarriers	

3.6 All Carers have opportunities to be involved in decision making about Carer Support Services, the Carer Strategy and the wider work of the ACHSCP (Participation and Engagement)

What will we do?	When will we have done it by?	How will we know it is working?	Who will be responsible?	Progress Update
3.6.1 Develop a reference group made up of carers with different experiences of caring to support the IJB carer representatives and improve access to and communication with them.	July 2023	Reference group in place Communication arrangements in place	Development Officer (Consultation and Engagement) & Senior Project Manager (Strategy)	

3.6.2 Implementation and awareness of Carer and Service User Engagement protocol for planning services, including awareness and recognition of the role of Young Carers.	December 2023	Protocol understood and in use.	Carers Strategy Implementation Group Specific remit of Development Officer Post	
3.6.3 Co-design local Carers resources and support. **North Locality plan**	Ongoing	Carers have ongoing co-design involvement in development of support provided by Quarriers as per the existing contract. Carers co-design the next service when the contract is due for re-tender.	Quarriers Carers Reference Group (when established) Carers Strategy Implementation Group Strategic commissioning and procurement board	
3.6.4 Carers to be involved in the wider planning of and future commissioning of ACHSCP services and are recognised as a specific consultation group.	Ongoing	Carers Reference Group (when established) engaged in services through commissioning work planning.	Lead Commissioner (ACHSCP)	
3.6.5 Ensure Carers views are surveyed regularly, and the feedback informs future support planning.	Ongoing with annual review	Survey results and revised plans.	Lead Strategy and Performance Manager (ACHSCP)	
3.6.6 Provide on-going support as required to the carer representatives to the IJB in consultation with them as to their specific needs.	Ongoing	Feedback from carers representatives	Lead Strategy and Performance Manager (ACHSCP), Development Officer (Consultation & Engagement), Quarriers	

Priority 4

"I have a sense of belonging and a life alongside caring, if I choose to."

Community support and services for Carers

4.1 Promote a culture of Creativity to develop innovative approaches to Carers Support

What will we do?	When will we have done it by?	How will we know it is working?	Who will be responsible?	Progress Update
4.1.1 Develop a Culture of Creativity through embedding the Promoting variety approach into development of Carers Support including; mainstream, services, Carer support services and Self-Directed Support option for Carers with eligible needs and Cared for with high level needs.	Ongoing review of 'unmet need' and support gaps	New projects being added to Action Plan to address specific areas as identified through community engagement	Carers Strategy Implementation Group Carers Reference Group LOIP Resilient, Included & Supported Group	
4.1.2 Maximise opportunities for carers to access Community groups and activities. Incorporates; Increase the number of informal opportunities for Carers across the locality. **North Locality Plan**	Ongoing	Feedback from carers indicates opportunities are available Identified opportunities are available in North Locality. Whilst identified in the North Locality plan this will be progressed for Central and	Carers Strategy Implementation Group - ACVO - Wellbeing Project Manager - Quarriers - Barnardos Carers Reference Group (when established) Locality Empowerment Groups	

		South to ensure equality of opportunity across Localities.		
4.2 Support the ongoing development of a range of mainstream supports and services to enable Carers to receive a break from Caring in line with the proposed 'right to a break' within the National Care Service Bill				
What will we do?	**When will we have done it by?**	**How will we know it is working?**	**Who will be responsible?**	**Progress Update**
4.2.1 Test whether a 'Respitality' scheme with businesses increases the range of co-designed respite/short break provisions available. (North Locality Plan) **LOIP Change Idea & North Locality Plan**	March 2023	Performance reported via LOIP Outcome Improvement Group. 'Resilient, Included, Supported'.	Quarriers	
4.2.2 Review 'Short Breaks statement'	July 2023	Review completed	Senior Project Manager (Strategy)	
4.3 Continue to develop a range of support options for Carers, where the cared for person has high level needs, which allow choice and control in line with the proposed 'right to a break' within the National Care Service Bill				
What will we do?	**When will we have done it by?**	**How will we know it is working?**	**Who will be responsible?**	**Progress Update**
4.3.1 Increase number of eligible Carers being offered the SDS Options and associated budgets.	Ongoing with Annual review	SDS Statistical Report.	Lead Social Work Manager (ACHSCP)	
4.3.2 Increase the range of supports available to eligible Carers under each SDS Option therefore providing true choice for Carers.	Ongoing with Annual review	SDS Statistical Report.	Lead Social Work Manager (ACHSCP)	

4.3.3 Develop a sustainable model of Locality based residential respite for Older people and people with physical disabilities.	Ongoing	Evidence that provision meets demand. Qualitative feedback indicates satisfaction with the service	CSIG SW Rep	
4.3.4 Ensure a Carer's perspective is considered within digital projects, e.g. Analogue to digital transfer	Ongoing	Increased number of telecare packages in place.	Strategy and Transformation Lead	
4.3.5 Develop a respite bureau	June 2024	Bureau in place	CSIG SW Rep	

Health Inequality Impact Assessment

Stage 3

Analysis of findings and recommendations

Report Title

Please detail a summary of the purpose of the proposal being developed or reviewed including the aims, objectives and intended outcomes

In line with the Carer (Scotland) Act 2016 the Aberdeen City Health and Social Care Partnership (ACHSCP) has a responsibility to plan support for all Carers in Aberdeen City via a Local Carer Strategy. The ACHSCP's existing Strategy was extended from 2021 to 2022 due to the varying impacts of the COVID-19 Pandemic.

The Carers (Scotland) Act 2016 and subsequent regulations outline the nine specific areas which are to be included within a Local Carer Strategy. These are listed below;

- Plans for identifying relevant carers and obtaining information about the care they provide (or intend to provide) to cared-for persons in the local authority's area
- An assessment of the demand for support to relevant carers
- Support available to relevant carers in the authority's area from -
    - the authority,
    - the relevant health board,
    - any other organisations that the authority and health board consider appropriate

- An assessment of the extent to which demand for support to relevant carers is currently not being met
- Plans for supporting relevant carers
- Plans for helping relevant carers put arrangements in place for the provision of care to cared-for persons in emergencies,
- An assessment of the extent to which plans for supporting relevant carers may reduce any impact of caring on relevant carers' health and wellbeing,
- The intended timescales for preparing adult carer support plans and young carer statements.
- Information relating to the particular needs and circumstances of young carers.

The Draft Strategy identifies four main priorities (and a fifth priority focussed on performance management). These are;

- Identifying as a Carer and the first steps to support
- Accessing Advice and Support
- Supporting future planning, decision making and wider Carer involvement
- Community support and services for Carers

The associated Action Plan determines how we aim to deliver on these priorities. The Strategy is focussed on supporting 'All Carers' and as such consideration of inequalities and human rights is embedded within our approach as outlined below.

An 'All Carers' approach fosters good relations by ensuring all Carers are recognised whilst also ensuring that individual circumstances, including intersectionality across a range of protected Characteristics, are considered.

Equality Act 2010 – Relevant Protected Characteristics as identified in Stage 1 (remove those that do not apply)

Protected Characteristic	Equality Duty		What impact and or difference will the proposal have	How will you know - Measures to evaluate

Age	Eliminating discrimination, harassment, victimisation, or any other prohibited conduct	x	This Strategy aims at improving outcomes for all Carers. Specific impacts related to Age are; • Continued provision of specific support services for Young carers to ensure they are able to continue to live life as a child, have access to opportunities for all children and improve quality of life. • The Young Carers service has a role in educating the wider system on Young carer issues which will foster good relations. • The Strategy includes specific actions to ensure Carers individual support needs are assessed and further referral to support is available. For Older carers this may include support to meet their own health needs, condition specific advice, e.g. Dementia Support.	Specific Actions are included in the Action Plan which will monitor support for Young carers. Older people – Specific Actions within the action plan focus on provision of care which meets the specific needs of both older carers and older people who are being cared for.
	Advancing equality of opportunity	x		
	Fostering good relations by reducing prejudice and promoting understanding	x		
Disability	Eliminating discrimination, harassment, victimisation, or any other prohibited conduct	x	The Strategy aims to ensure available Carer Support is accessible for Carers living with Disabilities. This is a specific action with regard to ensuring information is available in accessible formats. Our Support Service providers are responsible for ensuring that groups and activities are accessible for those living with disabilities.	Specific actions are included with the Action plan in relation to accessibility. Performance reporting from our Support Service Providers will highlight any complaints or areas of concern where accessibility issues were highlighted.
	Advancing equality of opportunity	x		
	Fostering good relations by reducing prejudice and promoting understanding	x		

			Ensuring accessibility will support the Strategy to advance equality of opportunity for Disabled carers and foster good relations. In the majority of circumstances the cared for person is living with a disability as defined in the Equality Act 2010. Carers play an essential role in supporting the Cared for. Ensuring that a range of support is available for all Carers will indirectly enhance equality of opportunity for the Cared for person and foster good relations.	The detailed Action Plan for the Strategy outlines a range of measures to support Carers to continue caring which will have an enhancing impact on Cared for people living with a disability. This will be monitored on an ongoing basis with Annual review built.
Gender Reassignment	Eliminating discrimination, harassment, victimisation, or any other prohibited conduct		The Strategy identifies specific areas where we have knowledge gaps around the experience of some Carers. This includes Adult Carers who have undergone, or are undergoing, gender reassignment. The Strategy includes consideration of how to better understand the support needs of LGBTQ+ Carers. The Young Carers service includes an LGBTQ+ group which supports young people with Young Carer specific support related to their gender identity.	This will be taken forward in partnership with the Strategic Planning Group's Equality and Human Rights sub-group. The aim is to better understand support needs and develop services accordingly. The Quarriers Adult support service are also developing a specific role within their service with a focus on better understanding the diverse needs of Carers. Evaluation of the impact of this role will inform further developments.
	Advancing equality of opportunity	x		
	Fostering good relations by reducing prejudice and promoting understanding			
Marriage and Civil Partnership	Eliminating discrimination, harassment, victimisation, or any other prohibited conduct	x	Caring relationships often occur between married parties or those in civil partnerships. There are no actions proposed within the strategy which would adversely impact on marriage or civil partnership however supporting Carers in their caring role may have an indirect positive impact.	Actions within Priority 3 will be monitored.
	Advancing equality of opportunity	x		
	Fostering good relations by reducing prejudice and promoting understanding	x		

			Priority 3 highlights the importance of recognising the individual needs of both parties in a caring relationship and the need for staff to be mindful of domestic abuse and coercive control therefore minimising the likelihood of victimisation and fostering good relations.	
Pregnancy and Maternity	Eliminating discrimination, harassment, victimisation, or any other prohibited conduct		There have been no identified impacts related to pregnancy or maternity. We do however recognise the diverse group that have the role of Carers in Aberdeen City and that there may be an impact for those pregnant in a caring role.	We will monitor with all parties over the lifetime of the strategy to determine if any further actions are required.
	Advancing equality of opportunity	x		
	Fostering good relations by reducing prejudice and promoting understanding			
Race	Eliminating discrimination, harassment, victimisation, or any other prohibited conduct	x	The Strategy identifies specific areas where we have knowledge gaps around the experience of some Carers. Engagement on the strategy has involved working with Grampian Regional Equalities Council to gauge how aware our minority ethnic Carers are of their rights and support services available which will inform ongoing service development.	Actions within the strategy aim to work with communities to better understand the needs of Carers and have options for support which meet those needs. This will be carried out in partnership with the Equality and Human Rights sub-group.
	Advancing equality of opportunity	x		
	Fostering good relations by reducing prejudice and promoting understanding	x		
Religion & Belief including non-belief	Eliminating discrimination, harassment, victimisation, or any other prohibited conduct	x	The Strategy identifies specific areas where we have knowledge gaps around the experience of some Carers.	Actions within the strategy aim to work with communities to better understand the needs of Carers and have options for support which meet those needs. This will be carried out in partnership with the Equality and Human Rights sub-group.
	Advancing equality of opportunity	x		
	Fostering good relations by reducing prejudice and promoting understanding	x		

Sex	Eliminating discrimination, harassment, victimisation, or any other prohibited conduct	x	Evidence indicates that the majority of Carers across all Age groups are female. Therefore the impact of the Caring role disproportionately impacts on women. Ensuring support is available for all Carers will have an enhancing effect for women. Consideration is also made within Priority 3 with regard to ensuring the cared for and the Carer have access to support in their own right, including where required, Adult Protection and Domestic abuse advice.	Actions within Priority 3 will be monitored.
	Advancing equality of opportunity	x		
	Fostering good relations by reducing prejudice and promoting understanding	x		
Sexual Orientation	Eliminating discrimination, harassment, victimisation, or any other prohibited conduct	x	The Strategy identifies specific areas where we have knowledge gaps around the experience of some Carers. Similar to Gender reassignment we do not know enough about the experience of Lesbian, Bisexual or Gay Adult Carers in Aberdeen and whether the support currently provided is supportive of their specific needs recognising that LQBTQ+ communities are more likely to experience discrimination and that for older members of the LGBTQ+ community, who have historically lacked legal protections , they may have had negative experiences of health and social care services which may put them off seeking support.	Actions within the strategy aim to work with communities to better understand the needs of Carers and have options for support which meet those needs. Young carers have already identified a need for specific support and have established an LGBTQ+ group within the Young Carer service.
	Advancing equality of opportunity	x		
	Fostering good relations by reducing prejudice and promoting understanding	x		

Human Rights – Reference those identified in Stage 1 (remove those that do not apply)

Article	Enhancing or Infringing	Impact and or difference will the proposal have	How will you know - Measures to evaluate

Right to Liberty	Enhancing	Whilst not a formal restriction of liberty Carers can often feel unable to take time away from their caring role due to the dependency of the Cared for person. This strategy promotes development of more options for carer breaks and as such more ability to have freedom to pursue their life beyond the caring role.	Carers express that they have been able to experience breaks from their caring role.
Right to respect for private and family life, home and correspondence	Enhancing	Many Caring roles take place within the home or within a close family caring relationship. Ensuring suitable support is available for all Carers, including Young Carers will have an enhancing impact on this right.	Carers are well supported and family life is supported.

Fairer Scotland Duty

Identify changes to the strategic programme/proposal/decision to be made to reduce negative impacts	Consideration has been made to socio-economic deprivation within this strategy. Carers Support services are non-chargeable. Support services are available to Carers from all areas within Aberdeen.
Identify the opportunities the strategic programme/proposal/decision provides to reduce or further reduce inequalities of outcome	Any specific services developed from this strategy will be subject to further impact assessment and as such will further consider any additional inequalities of outcome at that time.

Health Inequality Impact Assessment Recommendations

What recommendations were identified during the HIIA process:

Recommendation	Recommendation owned by:	Date recommendation will be implemented by	Review Date
Identified impacts to be monitored as a specific action within the performance reporting for the Carer Strategy	Amy Richert (Senior Project Manager)	November 2022	Annual

Monitoring Impact – Internal Verification of Outcomes

How will you monitor the impact this proposals affects different groups, including people with protected characteristics?

The Carers Strategy Implementation Group will have a role in monitoring the overall impact of the strategy.

Procured, Tendered or Commissioned Services (SSPSED)

Is any part of this policy/service to be carried out wholly or partly by contactors and if so, how will equality, human rights including children's rights and the Fairer Scotland duties be addressed?

The Adult Carer Support service and Young Carer Support service are required to provide performance reporting. This includes any information on Complaints / feedback and the gathering of equalities monitoring data. Specific impact assessments will be carried out should these services, or any newly identified, are required to be tendered during the lifespan of the strategy.

Communication Plan (SSPSED)

Please provide a summary of the communication plan which details how the information about this policy/service to young people, those with a visual or hearing sensory impairment, difficulty with reading or numbers, learning difficulties or English as a second language will be communicated.

A period of public Consultation will take place in October / November 2022 which will be followed by annual surveys. Accessibility of carers information is an identified action within the strategy with this reviewed within 2023.

Signed Off By: **Alison Macleod**

Name Strategic Lead: Amy Richert

Date 30/09/2022

This page is intentionally left blank

APPENDIX D

OVERVIEW OF ENGAGEMENT WORK TO INFORM THE ACHSCP CARERS STRATEGY 2022 -2025 & PLANNED CONSULTATION ON THE FINAL CARERS STRATEGY

'A City for All Carers' has been developed by a core group of partners who form the Carers Strategy Implementation Group. The group members have had the opportunity to be involved at all stages of development of this strategy. This includes representation as follows;

- Strategy and Transformation Lead
- Transformation Programme Manager (Strategy)
- Senior Project Manager Strategy
- Nursing (Community Nurses, School Nurses, Health Visitors)
- Allied Health Professionals
- Social Work
- Development Officer
- Commissioning
- ACC Children's Services (Young Carers)
- ACVO
- Scottish Care
- Bon Accord Care
- IJB Carer Rep
- Adult Carer Support Service
- Young Carer Support Service

Engagement phase – July 2021 – October 2022

The engagement phase of this strategy has been influenced by fluctuations in capacity of those required to be involved as a result of the ongoing COVID-19 pandemic. Considerable work took place between July and December 2021 which gathered an overview of views from Carers in Aberdeen. Carers were told that their feedback would inform the strategy and that further engagement would take place when a more detailed overview of the new priorities for Carers was prepared. The requirement to contribute to the pandemic response then delayed the development of a document.

In March 2022 ACHSCP were given the opportunity to participate, as one of five HSCPs, in a national Care Inspectorate Inquiry into Adult Carer support services. This provided a vehicle to further gauge the views of Carers in Aberdeen on their experience of Carer Support services. This focused specifically on Adult Carers (excluding Young Carers and Parent Carers) and included input from the Adult Carer Support Service and Adult Social Work Staff. In order to ensure that Carers were not being overwhelmed by requests to participate in engagement no further events / requests were made of Adult Carers at this stage beyond what was coordinated by the Care Inspectorate.

Further targeted sessions were then offered to Parent and Young Carer Groups via the support services to give their views on the proposed priorities within the draft Strategy. Targeted sessions and a specific survey were also available for workforce groups, including those from the third sector, to gather their views.

The final phase in developing the strategy will be the consultation phase. This will provide an opportunity for all with an interest to see the draft Strategy and Action Plan and provide comment in advance of this being finalised. A plan of consultation events is included below.

Overview of participation numbers

Phase 1 – Information gathering to inform initial direction of the strategy July 2021 – December 2021

All Carers

Aberdeen City wide Carer Survey – 93 individual responses (October – December 2021)
Grampian Regional Equalities Council, Equality Outcomes survey (December 2020) – 43 of 192 participants identified as Carers.
Fit Like – Unpaid Carers Survey – 25 unpaid Carer responses (July 2020), 131 responses in total.

Adult Carers

Quarriers Male Carer Café – 4 people
Quarriers Dementia Carer Café – 6 people
Parent of Young Carers – 4 people

Young Carers

Woodside young Carers group – 3 young people
Young carers LGBTQ+ group – 4 young people
Primary School Age children – 12 young people
Senior School Age children – 7 young people
Parent of Young Carers – 4 people

Phase 2 – Further information gathering January 2022 – October 2022

All Carers

NHS Plan for the future survey (31st August 2021) – 11 City Carers responded

Adult Carers

Care Inspectorate Inquiry into Adult Carer Support in Scotland

- Include participation numbers when received

Parent Carer Support Group – targeted session with 2 Carers in attendance.
GREC targeted Carer discussions – 10 respondents
Young Carer Support Service Session – targeted session with 2 Young Carers in attendance followed up by the Support Service supporting guided conversations with a further 5 Young Carers.

Workforce

Targeted sessions with Workforce (HSCP & 3rd Sector) – 7 sessions
Workforce Survey – 43 individual responses

Phase 3 – Consultation on Draft Strategy - October 2022 – November 2022

12th October – 12th November (1 month period)

All dates are provisional and to be confirmed

Online Consultation Survey for all (Carers, Workforce, Public)
Citizen Space - Running 12th October to 12th November 2022
Online Consultation sessions – Adults

- 31st October – 10am (Teams)

- 4th November – 1.30pm (Teams)
- 10th November – 7.30pm (Teams)

In-person Consultation sessions

Young Carers

- St Machar Young Carer Group - Date TBC
- NesCol Young Carers – Date TBC
- Barnardos Young Carer service – Date TBC

Adult Carers

- Learning Disability parent event – Len Ironside building – 12th October 2022 6.30pm
- Older Adult Carer event - TBC
- Adult Carer event – Len Ironside building – 2nd November 2022 6.30pm
- Adult Carer event – Quarriers – Date TBC

How has the information gathered informed the Carer Strategy?

The views of those we have engaged with are central to the Strategy and how it has been developed. Within the document quotes are included which reference specific feedback as well as **lived experience case studies** and **spotlight on** sections which highlight areas of good practice or service development. All relevant data will be held by the CSIG to inform future actions. This is not presented in its entirety due to a need for confidentiality but is themed below.

Adult Carers

The main themes identified by Adult Carers were;

Challenges	Positives
Access to advice and information	Experiences of those who have accessed the adult carer support service
Accessing the right services (including social work, health and Mental Health support)	Increased Young carer awareness amongst professionals
Lack of awareness of dementia and other conditions	Opportunities for social activity and exercise.
Coping with the caring role (including the emotional impact of caring)	Support from extended family
The Impact of COVID-19	Support from other professionals (including GPs)
Accessing day support and Day Care	
Being recognised as an equal partner in planning support	
Financial Pressures	
Hospital Discharges	
Social Isolation & lack of social activities	
Poor Mental Health (including worries about the future)	

Access to breaks (including respite)	
Tiredness and a lack of time for ones self	
Taking a break is dependent on meeting the needs of the Cared for person. If they are not met. The break isn't possible.	
Communication challenges	

Young Carers

The main themes identified by Young Carers were;

Challenges	**Positives**
Access to advice and information	Experiences of those who have accessed the adult carer support service
Accessing the right services (including social work, health and Child and Adolescent Mental Health (CAMHs) support)	Increased Young carer awareness amongst professionals
Coping with the caring role (impact on mental health, feeling alone, being bullied)	Support from some education staff
Multiple challenges due to being different (including LGBTQ+ young people)	
The Impact of COVID-19	
Accessing day support and Day Care	
Social Isolation & lack of social activities	
The impact of COVID-19 restrictions	

Workforce

We asked our workforce how confident they felt about signposting Carers to unpaid Carer support services in Aberdeen with 1 (not confident) and 5 (very confident). The average response was 3.19 indicating that the majority have a moderate level of confidence. This will support our feedback from Carers themselves who indicated staff do not always have the knowledge needed and is included within Priority 1 of our Action Plan.

Our Workforce were also asked to comment on whether they agreed with the four priorities included in the draft Strategy with 1 (strongly disagree) and 5 (strongly agree). The average response was above 4 for all four priorities.

Our workforce echoed many of the themes expressed by Carers themselves especially with regard to ensuring access to information so they are equipped to support Carers and ensuring access to Short Breaks / Respite is available.

Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Date of Meeting	11 October 2022
Report Title	Complex Care – Market Position Statement
Report Number	HSCP 22.082
Lead Officer	Kevin Dawson, Lead for Community Mental Health, Learning Disabilities & Substance Misuse Services
Report Author Details	Jenny Rae Programme Manager Jenrae@aberdeencity.gov.uk 07917559399
Consultation Checklist Completed	Yes
Directions Required	No
Appendices	Appendix A: Summary of Complex Care MPS Appendix B: Complex Care Market Position Statement Appendix C: Stage 3 Health Inequality Impact Assessment

1. Purpose of the Report

1.1 This report seeks approval from the Integration Joint Board of the Complex Care Market Position Statement.

2. Recommendations

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

a) Approve the Complex Care Market Position Statement (Appendix B)

b) Note that progress on delivery of the Complex Care Market Position Statement will be reported to Integration Joint Board annually

c) Note that finance specific updates will be reported annually (at a minimum) to Risk, Audit and Performance Committee

d) Instruct the Chief Officer to continue to explore with partners future new building and property redevelopment opportunities to provide facilities for people requiring complex care

e) Instruct the Chief Officer to continue to work jointly with Chief Officer for Children & Family Services to ensure planning and provision of complex care for young people moving into adulthood

3. Summary of Key Information

3.1. The Complex Care Market Position Statement (MPS) has been developed to express our ambition of providing suitable local services for people with Complex Care needs, who often can be in Out of Area (OOA) placements, delayed in hospital or at risk of placement breakdown. The audience for the Complex Care MPS is providers of support and/or accommodation, which includes Registered Social Landlords and the Local Authority. A summary of the Complex Care MPS is provided in Appendix A.

3.2. In 2022 ACHSCP published a co-produced Market Position Statement (MPS) for Mental Health and Learning Disability (MHLD) Residential and Supported Living Accommodation. Complex Care sits as a sub-area of ACHSCP Mental Health and Learning Disability Services (MHLD). A Complex Care MPS (Appendix B) has been produced, which is designed to complement previous work, and supply detail to the marketplace on the needs of this group. We have engaged with currently contracted Complex Care providers in the development of the MPS and received positive feedback on the approach detailed within the document. The MPS, if approved by the IJB, is for a period of 5 years (2022-2027).

3.3. Complex Care is a recognised term for people with a learning disability and is the focus of the MPS. People with Complex Care needs are low in number yet high in complexity. This group requires a strategic response to their needs, particularly considering how suitable support and appropriate environments are delivered to meet these needs. People with a complexity of need may require some similar support or environmental aspects but not to the same intensity or extent. As such, the themes of the MPS can, in part, be considered transferrable to other people or groups with complexity of need.

3.4. The Complex Care MPS will support sustainable planning for current and future needs, which includes children and young people in this group as they transition into adulthood.

3.5. A Framework agreement is in place for the provision of Complex Care services, and this is currently in year 1 of a potential 2-year extension. The Framework has already been in place for 2 years and incorporated the possibility of 2 x 1-year extensions. The intention to add the re-provision of the Framework into the Procurement Workplan (to be agreed at IJB Q4 of 22/23) and to commence work to inform the future Framework agreement shortly after this, utilising the 2nd 1 year extension to support this process. This is aligned to the aims of the MPS and will be a mechanism by which individual need can be commissioned for. This work will be jointly undertaken by Commercial and Procurement Services, MHLD Programme Manager and relevant Service Managers as endorsed by the Strategic Commissioning and Procurement Board. Engagement with providers tells us that a longer-term contract will provide more sustainability, echoing other contractual work which is being progressed. The intention is to explore the creation of a 5 year plus agreement as this could better support development of local Complex Care services.

4. Implications for IJB

4.1. **Equalities, Fairer Scotland, and Health Inequality** – A Health Inequalities Impact Assessment (HIIA) has been carried out (Appendix C). The ethos of this work is protective of human rights and seeks to provide people with Complex Care needs rights to local, suitable, and affordable accommodation and associated services. By the IJB accepting the MPS it is anticipated that the rights of people with Complex Care needs to access local services will be promoted and enhanced. It is not anticipated that this will adversely affect other groups and the implementation of the MPS may provide learning which can utilised for other groups (for example the creation of local services for non-Complex Care needs). If the MPS is not agreed or delivered in the intended way people with Complex Care needs be more likely to have a lack of opportunity to live as independently as possible in safe, appropriate, and local services.

4.2. **Financial** - There may be financial implications to the ACHSCP budget in the delivery of Complex Care services. There is limited budget availability in the form of Community Living Change Fund however this is non-recurring funding to be used by March 2024 There is likely to be an evidenced cost neutral position by creating more local Complex Care services however

there will be a cost for accommodation from which services operate, work is ongoing to understand these costs and budget implications. Any specific proposals taken forward in the context of the MPS will require to be fully costed.

4.3. **Workforce** - There are workforce implications arising from the recommendations in this report in that the aim is to see further development of local Complex Care services. Within the ACHSCP Strategic Plan there is a Delivery Plan project specifically looking at the Complex Care workforce. The project will be commenced in October 2022 and will engage with all current provider as well as looking to best practice guidance.

4.4. **Legal** - There are no direct legal implications arising from the recommendations of this report however the intention to create a longer-term contractual agreement for the provision of Complex Care services which will require to satisfy contractual and procurement regulations. This will be detailed further by the inclusion of this procurement activity within the Procurement Workplan to be agreed by the IJB in Q4 of 22/23.

4.5. **Covid-19** - There are no direct Covid-19 implications arising from the recommendations of this report.

4.6. **Unpaid Carers** - There are no direct Unpaid Carers implications arising from the recommendations of this report. However, bringing people with Complex Care needs into suitable local services will support families to remain connected and for unpaid carers to be supported to maintain family relationship which may or may not have an unpaid carer aspect to them.

5. Links to ACHSCP Strategic Plan

5.1. The recommendations in this report complement the strategic priorities outlined in the Partnership's Strategic Plan. Complex Care is referenced as a specific focus area and has a range of Delivery Plan projects, all of which will contribute to providing more suitable, robust, and sustainable local services for people with Complex Care needs. They will aid the development of person-centred approaches to care and support and enable people to strengthen their connection and contribution to their local community.

6. Management of Risk

6.1. Identified risks(s)

INTEGRATION JOINT BOARD

Description	Mitigation	Ownership
Key leadership is not aware of the current Human Rights/Equality infringements of Complex Care individuals, because suitable accommodation that would allow these individuals to live locally and independently in their community, is not available.	The Complex Care Market Position Statement clearly outlines the Scottish Government recommendations, needs of Complex Care individuals and the accommodation, funding, and recruitment challenges in Complex Care.	Lead for Community Mental Health, Learning Disabilities & Substance Misuse Services/Programme Manager
ACHSCP will lose access to this funding if it is not used/allocated by March 2024.	Meet with Finance leadership to discuss how the Community Living Change Fund, allocated to ACHSCP, can be used to deliver Complex Care accommodation; to understand how the available funding can be maximised to meet Complex Care needs.	Lead for Community Mental Health, Learning Disabilities & Substance Misuse Services/Programme Manager and Chief Finance Officer
ACHSCP receives no interest from market, due to challenging economic climate, to invest in new purpose built or redeveloped facilities with suitable environments.	Continue to work with partners to explore future new building and redevelopment of existing properties to provide suitable facilities and environments for people requiring complex care and support.	Lead for Community Mental Health, Learning Disabilities & Substance Misuse Services/Programme Manager and Chief Finance Officer

ACHSCP does not adequately prepare for accommodation needs by those who may require Complex Care support as an adult.	Continue to meet with Children Social Work Services and Adult Services to discuss the number of children/young people who currently meet the definition of Complex Care with a specific focus on 15 to 18 age range; to forecast the number of Complex Care accommodation units that will be required for individuals going forward and the process for continuous review.	Lead for Community Mental Health, Learning Disabilities & Substance Misuse Services/Service Manager Learning Disabilities

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

(1) The strategic commissioning of services from third and independent sector providers requires both providers and ACHSCP to work collaboratively (provider with provider and provider and ACHSCP) in order to strategically commission and deliver services to meet the needs of local people. This is a new dynamic, based on mutual trust.

(2) IJB financial failure and projection of overspend

(7) Demographic & financial pressures requiring IJB to deliver transformational system change which helps to meet its strategic priorities.

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

The content of this report seeks to mitigate the known risks by recommending a decision which supports the budget availability of the IJB & Partnership, the implementation of the Complex Care Market Position Statement seeks to strengthen local support for people with Complex Care needs in suitable and sustainable services/accommodation whilst working to budgetary availability and alongside partners who share responsibility for the delivery of aspects such as accommodation and housing benefits. There are risks that need will be unmet due to the dependencies out with the Partnership remit.

The risk is medium.

Aberdeen City Health & Social Care Partnership
A caring partnership

Complex Care Market Position Statement – Summary

Introduction

Complex Care, as a sub-area of Mental Health and Learning Disability (MHLD) services, affects a small number of people however they have a high level of need and are disproportionately affected by hospital delays and out of area placements, there is also a high level of cost associated with service provision. Service provision includes the care provided and where someone lives.

Who are we?

MHLD Services provides social care and health services to people with Complex Care needs who have a range of communication and environmental requirements in addition to any diagnosed learning disability or other health condition.

Why do we need this plan?

There are not enough Complex Care services in Aberdeen to meet current or future need. People with Complex Care needs are often delayed in hospital, living in inappropriate settings or cared for in out of area placements. There is a focus on improving availability of local services for people with Complex Care by the Scottish Government through the Coming Home Implementation Report.

What do we want to do?

Create more local services for people with Complex Care needs.

There are 2 key requirements for Complex Care services, the care service, and the accommodation. Both are required for sustainable and safe support to be provided.

The Market Position Statement (MPS) is designed to aid the understanding of the marketplace. The marketplace in the context of Complex Care includes providers of support and/or accommodation, which includes Registered Social Landlords (RSLs) and the Local Authority. The MPS will run for 5 years when approved and has a range of actions to support implementation which are aligned to the ACHSCP Strategic Plan and Delivery Plan (2022) where Complex Care is set as a priority area.

How will we do this?

Work with providers of support and/or accommodation, including Aberdeen City Council and RSLs to develop local services. We will:

- work with housing partners to explore what funding is available for accommodation settings
- establish a common design guidance/environmental specification for accommodation
- work with providers to develop support and staffing models
- work with providers to look at the skills required by staff
- develop a register of people with Complex Care needs including young people

What will help us to do this?

We have a Framework of Complex Care providers and will continue to have a Complex Care contract/framework.

We have established strategic and working groups to undertake projects/actions.

We are working with Scottish Government and other local areas to share learning and best practice.

We have non-recurring funding from the Community Living Change Fund to help us make improvements.

What next?

We will communicate our needs by publishing the MPS and discussing the key points with partners, which include:

- continuing to work with partners in housing to explore accommodation options
- working with providers to explore service model options and development opportunities.
- re-provisioning the Complex Care Framework to create a more sustainable marketplace

Complex Care remains a priority area for the partnership and all delivery plan actions and associated projects will continue to be progressed.

Aberdeen City
Health & Social Care
Partnership
A caring partnership

Complex Care
Market Position Statement
2022 – 2027

Contents

Foreword

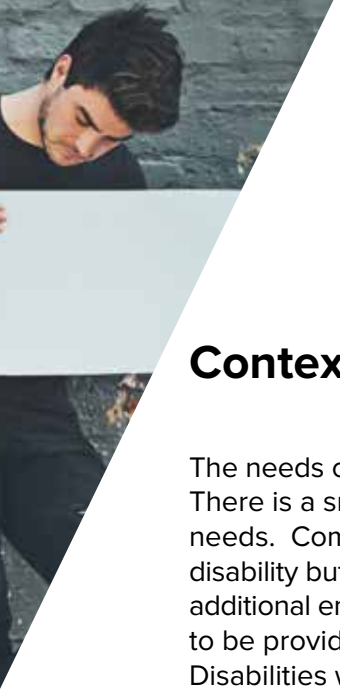
This document outlines our vision, commitment and expectations for services which support people with learning disabilities and Complex Care needs in Aberdeen City from 2022 until 2027. Aberdeen City Health and Social Care Partnership (ACHSCP) has worked with providers of Complex Care services, colleagues and teams within ACHSCP and Aberdeen City Council (ACC) to develop a detailed approach to how people with Complex Care needs should be supported. This Market Position Statement is not prescriptive. However, it sets out an aspiration that will help to ensure, through best practice and innovation, that everyone can live locally in safe, suitable and affordable accommodation. This right goes hand in hand with receiving the care and support they need to 'lead full, healthy, productive and independent lives in their communities, with access to a range of options and life choices' (vision of the Coming Home Implementation Report, Scottish Government, 2022).

In developing this document, ACHSCP hope to establish a shared understanding of the needs of people with learning disabilities and Complex Care requirements. There are low numbers of people with these needs, but they are disproportionately affected by delays in hospital discharge, out of area placements and breakdown in community support services. This is primarily because people with Complex Care needs have a range of communication and environmental requirements in addition to any diagnosed learning disability or other health condition. People with Complex Care needs require a co-ordinated response to create successful community services. They need accommodation which has additional, and often costly, environmental or build features such as larger space of accommodation, toughness of features such as walls, doors and windows, secure gardens and elements which support the person's safety and wellbeing as well as that of staff.

The Coming Home Report (Scottish Government, 2018) and associated Coming Home Implementation Report (Scottish Government, 2022) shine an uncomfortable spot light on people with Complex Care needs who have been placed out of area inappropriately or are delayed in hospital pending suitable local service availability. It is clear that this is unacceptable and Complex Care has been identified as a priority with the ACHSCP Strategic Plan and Delivery Plan (2022).

ACHSCP have developed a range of activity to support the progress of Complex Care services locally. Some challenges have been identified in this work, relating to the availability of the type of accommodation people with Complex Care require and in relation to funding. There are also challenges more broadly relating to recruitment, and these will be echoed in Complex Care services. ACHSCP are working closely with partners to understand these challenges and to overcome them and will continue to involve providers, people who use services and their loved ones in this work. ACHSCP want to see all people with Complex Care needs living in their local communities, accessing the best services for their needs and this being complemented by appropriate accommodation environments which can become people's homes for as long as they need them. ACHSCP want to see communities playing an active role in people's experience of care and support, promoting robust community connections and inclusion.

Complex Care services should become part of our standard offer of local services for those who need this. By clearly demonstrating the priority we place on this and outlining how ACHSCP will work with partners, we hope to see significant and meaningful progress in the development of Complex Care services for people in Aberdeen City.



Context

The needs of people who require health and social care support are changing. There is a small, yet growing number, of people who have Complex Care needs. Complex Care is recognised as terminology for people with a learning disability but other groups with complexity of need may also require some additional environmental factors to be considered and more specialist support to be provided, such as mental health or brain injury. People with Learning Disabilities who have Complex Care needs may also be autistic, have a mental illness or other physical illness or disability.

Complex Care significantly affects the way in which care, support and environments must be delivered. This is largely in part to the ways in which people with Complex Care needs can exhibit challenging behaviour, which challenge services and support providers and is a *'communication from the individual and a product of the environment they live in and of the support they receive'* (Coming Home Implementation Report, 2022). There is a clear gap in the availability of suitable accommodation for people with Complex Care needs, in part due to the additional environmental specification for accommodation. Those with Complex Care needs require different accommodation than is generally provided by housing services and this poses challenge in the funding and planning undertaken to build accommodation. Without the availability of suitable accommodation service models for Complex Care will be compromised. Due to these issues, it is important to set out the ways in which services are to be delivered in the future for people with Complex Care needs.

In early 2022 ACHSCP published a co-produced Market Position Statement (MPS) for Mental Health and Learning Disability (MHLD) Residential and Supported Living Accommodation. The MPS did not specifically cover Complex Care needs; this new Market Position Statement for Complex Care is designed to complement previous work and provide detail to the marketplace. The marketplace in the context of Complex Care includes providers of support and/or accommodation, which includes Registered Social Landlords and the Local Authority. The focus is primarily on the area of most need, learning disability Complex Care, however the themes are broadly transferrable to other groups with complexity of need.

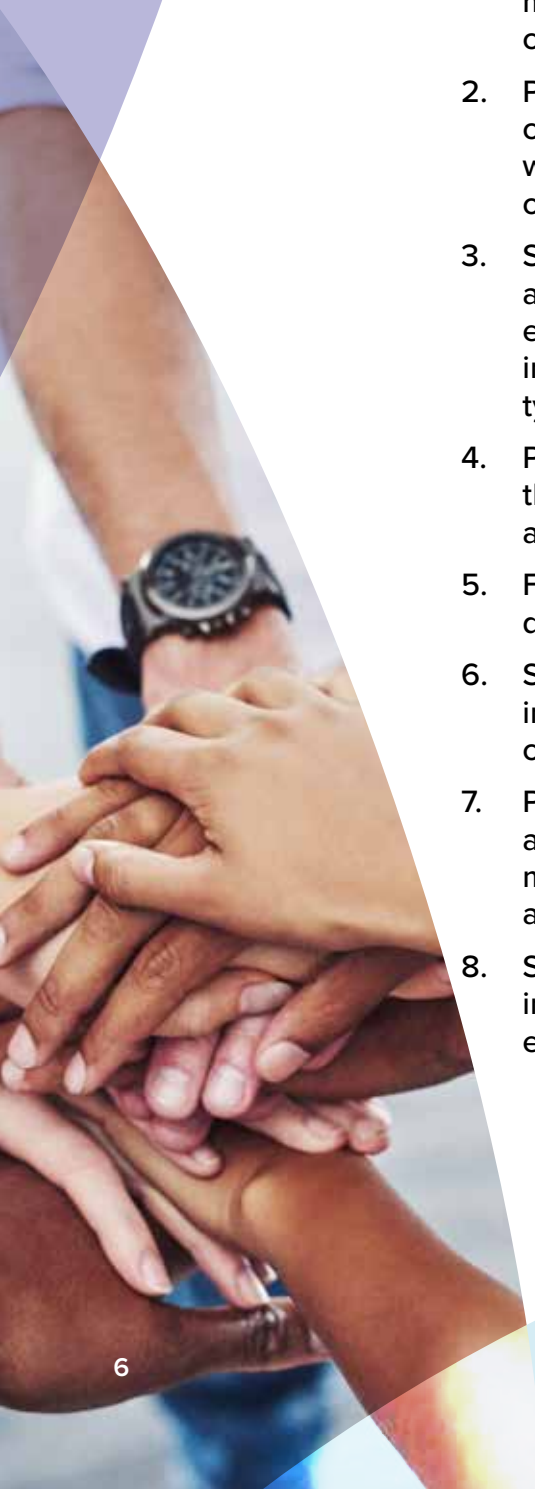
There is a range of National work taking place aligned to the Coming Home Implementation Report which ACHSCP are part of. There has been the allocation of a £20m Community Living Change Fund (Appendix C), with a one-off allocation to all Health and Social Care Partnerships (HSCPs) designed to support service development for learning disability Complex Care, focusing on inappropriate Out of Area placements and Delayed Discharge from Hospital. There is also to be national Dynamic Support Register and Support Panel. The Register will be maintained locally to support strategic planning and monitoring; the Panel will provide support and expertise to HSCPs and checks and balances for local management of the Register.

Outcomes

In the MHLD Residential and Supported Living Market Position Statement a range of outcomes were co-produced and linked to our local strategic vision for Mental Health and Learning Disabilities.

These outcomes remain relevant for the development and delivery of Complex Care services:

1. Support is provided at the right place at the right time – acknowledging that at any given time, people's support needs may fluctuate, and the level of support should adapt to that change
2. People are supported and involved in decisions about their care and support, including who provides their support and where they live and who they live with, and specific personal outcomes to be achieved through the support provided
3. Support is designed to enable people to live as independent a life as possible. The accommodation environment will enable people to live as independent a life as possible including wherever possible the location, the size, and the type
4. Protecting and enhancing people's human rights is at the centre of service design and delivery, including accommodation environments
5. Families and Carers are recognised as key partners in the design and delivery of services
6. Support is delivered in a way which enables community involvement and the building of genuine community connections for people who are supported
7. People who are supported are recognised for their skills and abilities, consideration of how these attributes may be shared more broadly in the local community should be considered by all
8. Service delivery and environments will support and promote improvements in physical and mental health and wellbeing ensuring use of technology is maximised



How we are providing services now

Locally

Within Aberdeen City there are 2 multi-person Supported Living services which meet the needs of people with Complex Care. In addition to this ACHSCP have a small number of 1 person services (individuals who live in a property with a full 24/7 support team) in which the person has Complex Care needs. There are some services provided for young people in which some of the people may have Complex Care needs.

We also have a small number of people who are classified as 'delayed discharge' with Complex Care needs. These individuals are classed as 'receiving appropriate care while they go through a complex and lengthy reprovisioning exercise, so their discharge is on-going' (ISD Definition of Code 100 patients). There are no set timescales for such discharge and reprovisioning arrangements and all local options for patients will have been examined and progressed when suitable.

Our existing local services range in size from 1 person to 24 person services. There is sharing of accommodation and use of communal spaces within some services and not all of the accommodation aligns to the environmental specification for Complex Care (Appendix B). At times, placements within these services can be difficult to sustain due to factors such as compatibility when sharing spaces with others, increases in challenging behaviour due to the environment and/or volume of people (both other service users and staff) and risk management protocols. These factors can also cause difficulty in placing people within any vacancies which arise.

Out of Area Placements

As Aberdeen City is a small geographical area at times service provision for people is required out with the City boundaries. This is known as an Out of Area (OOA) Placement. Out of Area placements are in Residential Care Homes, Supported Living Services, and specialist services, such as private hospitals. ACHSCP further define Out of Area Placements into the following categories:

- **Placements in Aberdeenshire** – these placements are made due to the availability of suitable services within close proximity of Aberdeenshire to Aberdeen City.
- **Out of Area – within Scotland** These placements are a mix of provision, at times private hospital services or residential care facilities
- **Out of Area – out with Scotland** These placements are very rare and are often for specialist services or due to family choice

These categories can also be split into appropriate and inappropriate placements. Appropriate placements are where individual, or family choice of service is clearly demonstrated. Inappropriate placements have been identified as requiring to be brought back into Aberdeen City.

Complex Care Framework

ACHSCP operate a Framework Contract for Complex Care which has 8 providers at present. The Framework, although for care providers, seeks to align the housing needs and care needs of Complex Care together. Providers were asked to demonstrate their ability to develop service options which include housing.

The Framework has already been in place for 2 years and had approval for 2x 1-year extensions. We are currently in year 1 of an extension. The Framework allows for the development of Complex Care services in different ways. These include:

- **Mini-competition** – where we identify need for a service and ask providers to bid for this
- **Direct Award** – where either providers or ACHSCP can trigger a process of collaborative decision-making leading to the co-production of a service option

Although the Framework is currently in use for people with a Learning Disability who have Complex Care needs it is possible for other groups to be covered and for the Framework to be opened for new providers to join at any point.

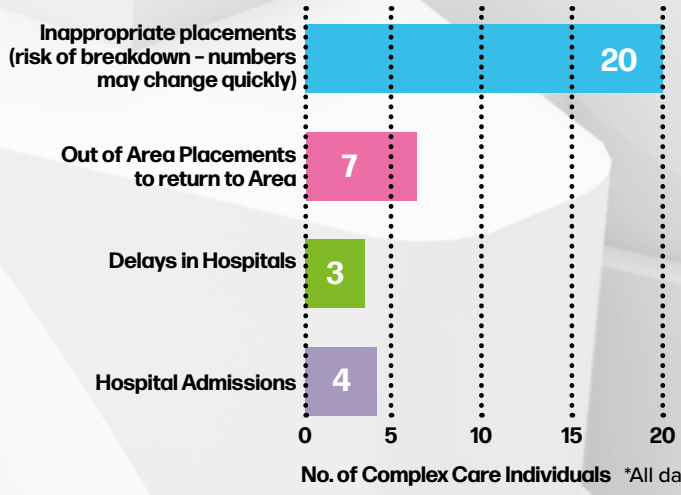
The commencement of the Framework was in May 2020, during the start of the Covid-19 pandemic, which has limited the success of the Framework to date. This is in part due to the natural focus of the HSCP and providers in sustaining safe care and support for people and knock-on effects for the development of building works such as increasing costs and reductions in the available workforce. We have entered into dialogue with a number of service providers on the potential development of services and wish to continue this approach.

ACHSCP still believe that this Framework is the best mechanism available to create the range and scale of provision required for Complex Care and we will continue to explore ways that the Framework can support the development of services, including the potential of expanding the life of the Framework and opening it up to additional providers.

Current and future need

Data systems for Complex Care need further development. The establishment of a National Dynamic Support Register (for learning disability Complex Care) will support locally owned and maintained data systems to become more robust. In an indicative data collation exercise the following numbers of people with Complex Care were identified:

Aberdeen City Health & Social Care Partnership Current Number* (July 2022)



*All data solely relates to learning disabilities only

ACHSCP are developing our local Dynamic Support Register, hosting different aspects of data which will support the commissioning process and understanding of specific needs that people may have (such as location or type of environment). We are working with Scottish Government on the development of the National Dynamic Support Register alongside other HSCPs.

As it currently stands a total of 30 people (31 when ready for discharge) require complex care provision. It must be noted that support requirements can change very quickly, and these numbers may change at pace, this can be due to:

- new hospital admissions or successful discharges
- transitions into adult services (which at times may not be anticipated)
- changes in health/needs
- changes in the current service provision (such as placement breakdown at home or in services or the change in circumstances of family carers)

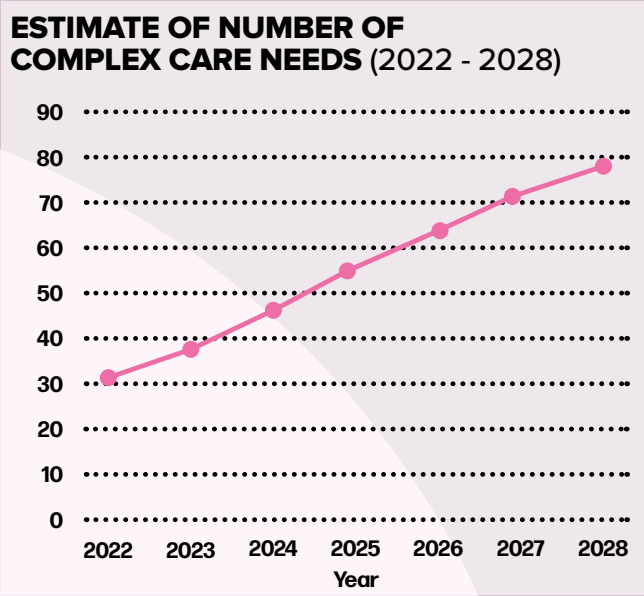
Future support needs can be hard to predict for many of the reasons above and there may be no obvious trends. The number of people with Complex Care needs is low in relation to more general MHLD social care needs, however this number is growing, and the complexity people present with has also intensified. There is a link between inappropriate services and environments and placement breakdown. This does not always equate to Complex Care but does tell us there is an incompatibility in what environments and services we have available and what people need.

One of the ways ACHSCP will convey Complex Care needs internally and externally is by using a Pen Picture of the individual. The Pen Picture will provide an overview of people's needs along with key information on how they should be supported, as well as some of their history/evidence of what has worked well or not so well in the past. It is hoped that by having a clear picture of the person this will help with the design of accommodation and services which will best meet their needs. It will support providers to understand the range of needs for everyone and to think about who could be supported in the same model or type of environment. We already use a Pen Picture template, and this has been revised to provide more information in an anonymised format which can be regularly updated and shared with relevant people. **(Appendix A – Pen Picture Template).**

As part of our approach to the Dynamic Support Register, ACHSCP will work with Children and Families' Services to understand the numbers of young people with Complex Care needs, including those currently placed Out of Area.

In relation to transitions of young people into adult service alone, there are between 6 and 12 referrals per year where young people are currently in OOA placements. This would typically indicate that a high proportion of the young people would meet the criteria for complex care (which often prompts the beginning of an OOA placement). Using this referral information, it is reasonable to expect that up to an additional 8 people per year will have need for Complex Care services.

Estimate of Complex Care need per year:



It may also be the case that some people currently with Complex Care needs no longer require this level of provision in the long term, although the likelihood of this is small.

There is some existing services for Complex Care locally; as natural movement occurs through these services some of the current/ future need will be accommodation by these existing services. The numbers relating to this are not predictable, but by using these existing services, a smaller number of people will need a new service development. However, there is still a clear requirement for new service developments for Complex Care.

How we plan to provide services in the future

Learning from what works well for Complex Care needs, and using the evidence base available, is important in developing sustainable and robust services.

The profile of need for those with Complex Care requirements is typically:

- The provision of specialist and more intensive care/support services, delivered by a trained and supported staff team
- The requirement for providers to be able to de-escalate behaviour, which require specialist training and insurances, typically via the provision of a Positive Behaviour Support Team/Model
- Individuals require robustly built environments which support their care needs
- Individuals require more spacious accommodation with access to outdoor spaces and separate staff welfare areas
- Individuals require their own accommodation without the need to share with others but services to be delivered in a way which does not isolate individuals or staff
- The inclusion of welfare facilities which adhere to Infection Prevention and Control (IPC) measures

Service Model

Residential or Supported Living Accommodation (care and support with housing) registrations can be suitable for Complex Care. Consideration should be made as to how the model supports people to live as independently as possible and considers factors such as compatibility, physical design of the service, management of IPC measures relating to outbreaks or infections of future pandemics and financing.

The Care Inspectorate have provided guidance on the size of residential care homes for people with a learning disability, advising a size of no more than 6 places within any newly registered care homes.

The optimum size of any service for Complex Care is no more than 8 people when in a Supported Living model. Although it is recognised that services of between 4 and 8 people can offer some benefits in terms of staffing volume and the requirement for accommodation. Services of under 4 people pose challenges in the sustainability of the service model to providers and can lead to issues such as inability of staff to respond to crisis situations. There are some 1 person services delivered at present which can lead to increased staff burnout, lack of support/management structures in place as well as lack of social interaction and community for people living in the service.

Larger service models pose their own challenges; although people do not live together, compatibility of people is still important, and more people can make this harder to manage. Also of concern is the ability to safely staff large models of care, in terms of recruitment challenges in health and social care and the more specialist nature of training and support model required. There are 2 large Complex Care services at present which require large volumes of staff, this can cause issues with training and practice development as well as consistency of approach. There are also practical issues in relation to the size of office/staff space and available parking which require consideration. These larger service models, whilst not institutions, can unfortunately be perceived in such a way by the local community and at times some practices might reflect this historic model rather than showcase personalised care and support methods.

Housing and Environment

All services developed should support people to live in their own homes or homely environments and not in shared facilities. One person units of accommodation are required, potentially with additional rooms dedicated for activities. With up to 8 units on any one site, with the specific inclusion of space for staff welfare and office requirements.

An environmental specification has been developed for Complex Care by the multi-disciplinary team (Appendix B). The specification will be used to describe Complex Care and work will be undertaken to align this with building standards and regulations. Should there be individual considerations which are not common, additional environmental assessment work will be completed. Some of the key points of this specification are:

- Individual ground floor/single level accommodation which is for 1 person with no sharing. The provision of additional 'bedrooms' may support the space required by people for activities and there will be a separate staff space/building for staff welfare
- At least 4 units need to be located together for staffing and financial purposes and the preferred number of units is no more than 8
- Cottage/bungalow design, with the potential to look at modular building methods and units
- Multi-level accommodation would not be suitable unless the upper levels were solely for staff use and soundproofed with separate entry points from individual accommodation
- Individuals should have their own front doors with no communal areas unless these are solely for staff use to navigate between units of accommodation
- Potential of observation points for staff to reduce interactions but keep people staff and ability for exit routes from rooms to support staff safety
- Buildings need robust features to prevent/minimise damage and injury
- Secure garden access and parking for mobility vehicles and staff vehicles
- Ability for sustainability of accommodation, larger footprints of units with ability to add in functionality of hoists, mechanical baths, or wet rooms for example
- Ability to close off kitchen space or have kitchenette facilities with potential full kitchen/cooking facilities being out with a person's own home
- Ability to isolate gas/electric/water and to control access (if legal powers exist) to kitchens
- Location is flexible as there are no specific areas in which the services must be delivered. Considerations should include access to gardens and parking, likely excluding city centre locations
- Other location considerations relate to people who may be vulnerable or pose risks to others so avoiding areas right next to schools, busy main roads (or have secure features to protect people if needed) and known areas of criminality/anti-social behaviour issues
- People should be linked to their communities and have access to local amenities

Staffing

Services should consider both the volume of staff required and the skill set needed to deliver Complex Care services. Experience tells us that having a staffing and management model, wrapped around 1 person only, in a single person service is isolating for staff. It can increase staff burnout, it is more costly and does not always support the individual in the best possible way. Evidence also shows, where service models are larger, the sheer volume of staff required poses continual recruitment and retention challenges in an already difficult area. It can lead to a lack of consistency of approach, which is often key to meeting Complex Care needs. Staffing is key to the success of most care and support services, and this holds true for Complex Care services.

Staff should be supported by a robust service model which has onsite management/leadership support and expertise on communication challenging behaviour (potentially in the form of Positive Behaviour Support teams/practitioners). All staff should be appropriately trained and have dedicated time to refresh training as well as putting training into practice in a safe manner. Staffing teams should be large enough to provide safe care to individuals within the service and support people to meet their outcomes. Technology should be used to complement staffing and support models, perhaps reducing the need for multiple staff to be in people's own homes whilst still providing crisis/ emergency response as needed.

Training and continued practice development should be promoted, particularly with reference to supporting challenging behaviour. Dedicated time to enable staff to undertake necessary training and practice development should be established. Adherence to best practice guidance in the delivery of support for challenging behaviour should also be demonstrated by the Provider/Service and aspects such as these may be assessed and reviewed through Contract Monitoring processes.

Staff should be remunerated appropriately for their skills in working with Complex Care needs. There should also be a clear understanding of how staff will work with families to ensure they are a key partner in their loved one's care and support. Staff welfare and wellbeing should form a key part of how service models are designed. Ensuring access to separate welfare facilities and office space, protection of break times and opportunities for debrief and peer support.

Multi-disciplinary Team (MDT) Working and Assessment Methods

There are typically a variety of multi-disciplinary staff involved in an individual's care and support, where Complex Care needs are present. This includes Learning Disability Nursing, Occupational Therapy (OT), Speech and Language Therapy (SLT), Social Work, Psychology and Psychiatry, as well as other specialisms. Members of the MDT can provide a wide range of support to people with Complex Care needs, and this also extends to their service provision and environment. Service Providers, as experts in the delivery of care and support, are an extension of a person's own MDT and broader support structure. Service Providers can engage with members of the MDT on issues within services and particular aspects of support plans and strategies. Good working relationships between providers and an individual's MDT are encouraged to support people's needs and outcomes in the best way possible.

Services will require to work with people to support their transition from their current placement into the new model of support and environment. For some people this will be a significant change and transition planning will require to be individually considered, which will be supported by MDT and the existing service placement. It is recognised that the initial assessment of a person's needs and their abilities can reflect the suitability or otherwise of their environment. Services for Complex Care will need to have robust assessment and support planning in place. This should be continually monitored in an iterative process as people transition and experience their new service model and environment.

Working with Young People

Young people with Complex Care needs require support to transition into adult life and into Adult Social Work services. At present there can be a gap in support for young people and their families depending on when the young person leaves education with many aspects of adult support starting at either 16 or 18 years of age. To improve outcomes for young people an improved transitions process between Children and Adult Social Work services (and health services) is required. Some young people may require an earlier transition to be supported in local services and maintain family connections, processes need to be shaped to support this to happen which will include risk management and compatibility assessments. Support providers should consider their registration requirements for Complex Care services to support those people who may be younger than 18 but will benefit from the service model and environments of Complex Care services.

Partnership Working

Working in collaboration with partners is crucial to the delivery of sustainable Complex Care services. We see providers of care and housing as key partners and bringing their knowledge and innovation into service developments is essential to success. There are multiple ways in which services may be funded, designed, developed, and implemented and we want to explore all options for their merits. Delivery of the range and volume of services, required to meet current and estimated future need, will require a hybrid approach. This will remain a central component of the way in which we look to deliver services now and in the future. The Complex Care Framework will be the key mechanism by which we work with providers.

Opportunities

- **Innovation in service model and delivery, including technology** – there is flexibility of approach to the design and delivery of Complex Care services, supporting providers to establish models of care which are responsive to need. There are clear benefits to the use of technology to support both individuals and staff within services, and use of technology solutions are encouraged, especially when linked to the environmental needs of people.
- **Address needs gap and delivery local services** – there is a clearly defined needs gap and desire to deliver services more locally for people with Complex Care needs. A Framework Contract is in place for Complex Care providers, which can support new and existing providers to develop services in Aberdeen City. As demonstrated, ACHSCP have a current and predicted level of need which will support sustainability of service models and provider investment.
- **Create Expertise** – by providing a wider range of services for Complex Care, local expertise in the delivery of this care will be built up. There are opportunities for closer working between HSCP staff and providers in the development and evaluation of care and support models, which will showcase best practice.
- **Employment Opportunities** – as detailed there is a gap in service provision and the opportunity for staff recruitment into a variety of roles, from service management and development to delivery.

Challenges

- **Funding Availability** – the cost of Complex Care services is notably higher than other care and support provision. This is in part due to staffing costs and in relation to the built environment. Whilst there is an allocation of money from the Community Living Change Fund to ACHSCP, this funding is a one-off payment and is insufficient to address the need and demand for Complex Care services. The costs of services can be split into Care and Housing Costs, each with their own challenges.
    - **Care Costs** – some people will already be in services and have an identified budget for their services. Where people are placed OOA we stop paying the OOA costs and can reassign these to care costs within the local area. Where people are in local services, ACHSCP may not be able to reassign their costs to new Complex Care services as we often still need the services they have been using, so there is an additional cost of services to consider. People in hospital do not have any identified budget and therefore there is no budget for reassignment leading to increased budget pressures.
    - **Housing Costs** – as we have no current stock of accommodation available for use which is suitable for Complex Care there are costs in developing new housing options regardless of the options progressed. There is no capital budget within ACHSCP and HSCPs are not able to own property. As such we must work with partners such as Local Authorities and Health Boards, Registered Social Landlords, Developers and Providers to look at suitable housing options.
- **Enhanced Specification of Property** – the provision of accommodation which is suitable for people with Complex Care needs (demonstrated in the environmental specification) differs significantly from the features in general needs accommodation. These additional yet necessary features for Complex Care mean that providing Complex Care housing is more expensive. This is in part due to the features within the accommodation (doors, windows, robust features) but also linked to the type of building suited to Complex Care (single level rather than multi-floor flatted accommodation). The additional specification required for Complex Care does not receive any additional grant funding from general needs housing stock (as provided by Scottish Government) and there are limited monies available within either the Local Authority or the HSCP to fund these requirements.
- **Housing Benefit and rent costs** – ACHSCP and partners aim to ensure that housing and accommodation solutions are sustainable long-term. Rent and service charges should be affordable without the reliance on additional sources of income to make up shortfalls. This is to ensure that people are not left in a vulnerable position should they not qualify for assistance with housing costs. Assistance with rent costs is subject to financial assessment. Housing benefit claims are administered by the local authority and operate in line with the guidance set out by the UK Government. The Local Housing Allowance rates, which are updated annually, can be considered as a benchmark to determine affordability. Top-ups through discretionary housing benefit payments are funded through local authority budgets and may be subject to change.

Telecare costs, when incorporated into rent or service charges, are not eligible for housing benefit. Landlords may be able to claim Intensive Housing Management if the properties are deemed to be 'specified accommodation', in that some services are provided by or on behalf of the landlord (eligible housing support and tenancy related tasks). There is no guarantee of eligibility for either the service or any individual in relation to financial support/benefits claims as these are assessed on their own merits.

- **Land Availability** – Aberdeen City is a small geographic area with limited land availability which is at a premium. The lack of availability of land, as well as affordability contributes to increased costs. Additionally, the building model for Complex Care (single storey property) is not as affordable as general needs housing where accommodation is built upwards in a multi-floor flatted model. The cost per unit of accommodation for Complex Care can be estimated to be double the cost of general needs housing.
- **Staff Recruitment and Retention** – it is widely recognised that recruitment and retention in health and social care services is significantly challenged. The development of new Complex Care services will require further joint working to take place to overcome staff shortages and to ensure staff have the right attitude and skill set for this area of work. The cost of Complex Care services will be higher than other types of provision to provide the number of staff required with the appropriate training. There may also be movement of staff from other care services particularly as roles are expected to be at a higher wage level, this may cause more issues for these care services.
- **Use of the Community Living Change Fund and other monies** – monies received from Scottish Government for Complex Care (and other related monies) require to be spent in line with identified criteria and timescales. This can pose challenges as some ways in which the funding could be utilised are not supported by the guidance provided. Appendix C provides further information on the Community Living Change Fund criteria.

Principles and Actions

The following principles will underpin how ACHSCP and partners will deliver Complex Care services for Aberdeen City:

- **Focus on demand** – using the Dynamic Support Register and other available data to create a clear picture of current and future need
- **Evidence needs** – maintaining robust assessments of need by our multi-disciplinary team approach and using our pen picture template to communicate these needs to providers of care and housing
- **Pursue housing options** – embedding our demand and need profile into the Strategic Housing Investment Plan (SHIP), Housing Need and Demand Assessment (HNDA), Local Development Plans and other relevant documents to create opportunities for, and delivery of, service developments
- **Work with individuals and families** – to provide local services, reducing the need for out of area placement and creating robust anticipatory planning for people with complex needs
- **Work with providers** – to co-create long term sustainable services and the associated workforce skills for Complex Care services
- **Contribute to local, regional, national work** – share learning and representing the Complex Care needs of people within Aberdeen City

Principle	Actions	By When
Focus on demand	Work with Scottish Government on the National Dynamic Support Register development	October 2022
Focus on demand	Develop and Maintain Local Dynamic Support Register	November 2022, reviewed every 3 months
Evidence needs	Complete Pen Pictures for everyone on the Dynamic Support Register and review regularly	October 2022, reviewed every 6 months
Work with providers	Develop a programme of provider engagement	December 2022
Focus on Demand	Support the completion of anticipatory care plans for all on the Dynamic Support Register	June 2023
Work with individuals and families		
Work with providers	Consider re-provision the Complex Care Framework with a minimum duration of a 5-year contract	December 2022

Principle	Actions	By When
Work with providers	Consider opening up the Framework to other care group providers	December 2022
Focus on demand	Work with Children's Social Work services to include information on young people in the Dynamic Support Register	November 2022, reviewed every 3 months
Evidence needs		
Evidence needs	Work with building standards and regulation to develop design guidance using the Envrionmental Specification	December 2022
Pursue housing options		
Evidence needs	Complete all individual environmental needs assessments	March 2023
Work with providers	Develop a core skills framework in conjunction with providers aimed at enhancing the workforce for Complex Care	June 2023
Contribute to local, regional, national work	Work with neighbouring areas to understand the scale of current service needs for complex care across Grampian.	December 2022, with regular engagement
Contribute to local, regional, national work	Engage with Scottish Government on Complex Care developments	March 2023, with regular engagement
Pursue housing options	Continue to explore future new building and property redevelopment opportunities with partners to provide facilities for people requiring Complex Care	March 2024
Work with providers		
Pursue housing options	Implement the programme plan and associated project groups and activity to achieve Complex Care solutions	March 2024
Pursue housing options	Plan for and invest monies from Community Living Change Fund	March 2024
Work with providers		
Work with individuals and families	Capture stories of positive outcomes	March 2024
Work with providers		

How will we know that we have made a difference?

Measures for people we care for	How will we know?
We meet people's individual outcomes	• People and their families will tell us, and it will be clear from their care plans
People receive the right care in the right place for them	• Services and support will be flexible to changing need
	• People can move out of hospital and into suitable accommodation without delay due to lack of available accommodation or people with the right skills to care for them
	• We will plan for people transitioning between children's and adult services, including where they will live
	• We will minimise the number of people who have to move away to receive care because we cannot provide it more locally
	• People's needs will be met and placement breakdown will be reduced
Families and carers are involved as appropriate	• We will ask for feedback using advocacy where appropriate
Measures for people who deliver care	**How will we know?**
Staff will feel confident to deliver the care that people need	• We will work with providers and staff to understand any specific requirements for training
	• We will ask providers for staff feedback
Staff will be valued and motivated in their job	• We will monitor provider retention of staff in their caring role, monitoring aspects such as turnover rates, vacancies, length of time to recruit to posts, length of time in service
	• Staff will be supported, evidenced via one-to-one meetings, group supervisions, staff training and engagement in development of the service
Measures for our organisation	**How will we know?**
Better performance against national requirements	• Less delays for people as they move out of hospital
	• Number of people who have to move away for care
Proactive planning	• Fewer placement breakdowns
	• Less people waiting for care
Improved quality of care delivered	• Accommodation needs incorporated into strategic planning documents
	• Development of local services
	• Care inspectorate reports
Market confidence	• A greater level of investment based on sound knowledge

Our Commitment

Within the Scottish Government Coming Home Implementation Report (2022) they define what good will look like:

By March 2024 we expect to have seen out-of-area residential placements and inappropriate hospital stays greatly reduced, to the point that out-of-area residential placements are only made through individual or family choice and people are only in hospital for as long as they require assessment and treatment.

Aberdeen City Health and Social Care Partnership echo this view and we are committed to working in partnership with those who use and provide services. We believe this approach will ensure that our shared outcomes are met, and our collective actions progressed.

People with Complex Care needs do have additional requirements in their accommodation and support needs compared to the general population, however there is *"equal right of all persons with disabilities to live in the community, with choices equal to others"* Convention on the Rights of People with Disabilities. We support the work of the Scottish Commission for People with Learning Disabilities (SCLD) who advocate that 'Housing is a Human Right'.

Getting the right accommodation for people with Complex Care needs supports the delivery of good care and support leading to positive outcomes.

We will work together to provide local, suitable, and sustainable services for people with Complex Care needs in Aberdeen City.

Appendix A Pen Picture Template

The template provided has been developed for internal use and may be modified when supplied to external partners/ providers for the purposes of developing service provision or placements. It will be anonymised/redacted to protect the identity of individuals.

Complex Care Pen Picture

Complex Care is formally undefined (Coming Home Implementation Report, 2022). The following criteria are based on the definition in the quoted report.

Please indicate which criteria (in addition to a diagnosis of a Learning Disability) the individual meets:	
• Severe challenging behaviour (may include high risk behaviours and behaviours which are not severe in themselves, but becomes severe due to their high frequency)	
• Forensic support needs	
• Mental health needs	
• Autism	
• Profound and multiple disabilities	
• Is currently in hospital	
• Has been discharged from hospital within the last 6 months	
• Living in unsuitable/inappropriate out-of-area placement	
• At risk of placement breakdown (due to increase of challenging behaviour, concern about suitability, stability, sustainability, such as end of school placement; family carer no longer able to be carer)	
Please indicate the Complex Care provision the individual requires:	
• Complex Care Staffing Support Only*	
• Complex Care Staffing Support and Environment* (if 'yes', please specify type of environment below)	
• Internal space requirements	
• Equipment (e.g. Smart Technology)	
• Gate Keeping requirements	
• Communal space	
• Location considerations	
• Accessibility	
• Garden space requirements	
• Robust/tough environment (see Complex Care Environmental Specification for detail)	

Please provide further details about the individual in the boxes below:
Who am I? (Age, Gender, Location)
What you need to know about me? (Example: Specific Health and Care Needs, Diagnosis, Medical/Health Needs, PBS Plan, Previous CLDT Health Involvement, Specific Sensory Needs, Specific Communication Needs)
Who is important in my life? (Family, Professionals, Support Structures)
What are my outcomes? (What is the support helping me to achieve for both my mental and physical health?)
I meet the requirement for complex care because... (Please provide detail regarding each of the criteria for complex care that apply to the individual. If applicable, include a history of failed or compromised placements/hospital stays; and what led to historic placement breakdown)
I require support by a complex care service provider because... (Specific details of support provision and why these require specialist support. Specific details regarding interests, training requirements, specialist knowledge and experience that support staff need to have)

I require support in a complex care environment because... Specific details of environmental needs, as indicated earlier, and why these cannot be met in standard accommodation (with minor adaptations), for example:	
Space requirements - how much space do they need / space for equipment **Equipment** - SMART technology / telecare **Gate Keeping requirements** - core and cluster / locked door etc. **Communal space** - do they need access to a communal area / communal living **Location** – impact of environmental noise/ neighbours/traffic	**Accessibility** - considering long term needs / physical health needs - single story / wide doors / corridors **Accessibility** - for shower rooms / bathrooms **Garden space requirements** - enclosed/ robust & high fences/ sensory needs **Robust/tough environment (see Complex Care Environmental Specification)** – robust/toughness of walls / floor / fixtures and fittings / flexibility in the space to move things around (e.g. if staff need to leave an area and ensure environment is still safe) / sensory needs
What specific support do I require? (Hours of support, where should support be based, specific activities, when & where, where I need my own support and where this could be shared, transport to activities)	

I have the following legislation in place to support my care needs... (Details of all relevant legislation and processes in place or required, e.g. guardianship, CPA, intervention order, MAPPA)
Environments and supports I could share... (The type of people that I may live with or share support with, are there any shared interests, any compatibility issues)
What behaviours might I engage in and how should they be responded to: (What risks need to be managed)
You may also be interested in knowing... (Additional comments on support required, current situation)

Who within this individual's multi-disciplinary group completed this PEN profile?		
Name	**Role**	**Date**

*These selections indicate the current needs of the individual and do not guarantee the receipt of complex care support and/or complex care accommodation.

Appendix B - Complex Care Environmental Specification

Environmental General Specifications

The recommendations in this report outline general recommendations to support planning and building design of accommodation for any new proposed robust style housing development for adults with Autism, Learning Disability and challenging behaviours.

Due to the complex needs of this client group it is envisaged that the physical and social environment is paramount and needs to allow for clients to safely participate in daily activities. Clients will not have the ability due to their level of function to understand risks and how harm can occur.

Space requirements and layout of building design

The property should be detached, single storey and have a large standard space both indoors and outdoors. It may be appropriate to have additional 'bedroom' spaces for either staff or individual activity use, wet room for client and provision of closely located staff facilities with office and welfare space in addition to a bathroom consisting of a shower, WC and sink. The property should have wide corridors and large rooms with high ceilings. Living room / kitchen area should have 2 access points with door access to garden area. Good lighting in each room through window design and natural lighting.

Key points:

- Larger spaces are required as people with Autism can be sensitive to personal space around them. Clients may exhibit challenging behaviour and staff will be required to support a person and maintain their safety without doing so in a restricted space, therefore corridors and rooms need to allow for this to be undertaken safely.
- The layout of the building needs to allow for clients to establish and engage in routines with specified rooms / spaces for required purposes i.e. bedroom to function as a sleeping area, kitchen for food preparation.
- Addition bedrooms or staff space would be required. Staff will require a room to store files, write notes which is not accessible to the client. They will also need independent access to a toilet and shower room which should be situated within the home as to not disturb the client. They will also require to use a room/space as a base to provide 24/7 support.
- An additional bedroom would be advantageous to provide an activity space, sensory suite and/or use as a de-escalation space if the client is experiencing levels of high arousal and presenting with challenging behaviour to others, again this also links back to each room having its own purpose.
- Living room/kitchen area should have 2 points of access and located next to each other with windows to view outdoor areas. Staff safety is paramount therefore 2 exit points are required to allow staff to exit safely and quickly if clients are exhibiting challenging behaviour.
- It may be necessary to restrict access to kitchen areas (if legal powers permit) to ensure safety

- Larger shower room consisting of wet floor shower, sink and toilet is required in order for staff to support clients with personal care. Clients with autism may require a large personal space and be fearful of unpredicted touch. Staff will need to support, model and assist clients participate in daily personal care routines. Some people with additional physically disabilities may benefit from access to a mechanical bath but this is not a standard requirement.
- Rooms should be positioned and fitted with windows to increase natural lighting and provide views of garden area to enhance clients' mood and wellbeing.
- Clients may need/seek to run, jump and bounce within their internal/external property to meet their sensory needs therefore adequate space is required.
- Clients may damage fixtures, equipment such as smoke detector, water sprinkler systems so these need to be concealed, flush fitted and/or out of reach for potential damage and to maintain safety and security of the building.
- Thermostatic temperature controls, accessible only by staff, should be fitted to all water supplies in the property. Clients would be at risk of scalding therefore water requires to be thermostatically controlled.
- Water isolators, accessible only by staff, would be required to be fitted to all water supplies within property Client may seek to turn on taps, engage in water play which can result in flooding and water damage to property.
- Electrical isolators would be required to fitted for all electrical appliances and accessed by staff only.
- Gas isolators would be required to fitted for all gas appliances and accessed by staff only.

Access

Key points:

- Automatic door lock system on front door access that will deactivate in event of fire for exit in an emergency.
- Access door to garden area which has the ability to be locked back in open position to prevent environmental damage to property. Some clients may seek to slam and bang doors repeatedly into a wall.
- External lighting at front access and/or rear of property activated by timers rather than motion sensors. This will ensure predictability of when lights are activated and can be managed by staff.
- Waste bins to be located outside of garden in secure storage area. Clients may seek to empty, search or eat contents of bin putting them at risk of harm.
- Allocated parking area at entrance of each property. This would be required to enable a safe and smooth transition of clients to and from their vehicle.

Garden/outer building

Key points:

- Exterior walls to the property should not be rendered with harling chips or pebbles that can be picked or brushed off and potentially eaten by the client.
- Loose stones/pebbles should not be used in the garden area for ornamental or drainage purposes, again there is the risk that these may be consumed or used as projectiles at times of high arousal.
- Drainpipes should be robust or protected by a robust drainpipe cover as clients may damage or attempt to climb particularly at times of high arousal.
- Enclosed rear garden area ideally not overlooked, with secure robust high fence, double slatted with no footholds and lockable gate. Clients may seek to climb and abscond from the garden. Fencing should provide privacy and dignity as clients may remove their clothes during high levels of arousal. Staff will require to know where the client is at all times when in the garden.
- Garden area would be required to accommodate space for the client to engage in a variety of meaningful activities i.e. trampoline, swing, sensory equipment. This would not only provide the client with exercise but also meet their sensory needs.
- Any external clothing drying system would need to be securely cemented into ground and have the option of being removable.
- Do not use plants which are poisonous as clients may ingest.

Walls

Key points:

- Strengthened walls require to be fitted with impact resistant plasterboard, plywood or solid brick walls. Clients may seek to test the structure of the building and may pick at plasterboard, bang, kick or throw objects causing damage to walls if not strengthened.
- Soundproofing of walls and ceilings would be required to reduce transmission of noise to neighbouring houses. Clients may be vocal, this can often be louder at times of increased arousal. Soundproofing will help to reduce the impact of any noise and prevent reverberation of sound produced by clients.
- Plain decor, no busy patterns. Autism friendly muted matt colour schemes. Painted walls that are wipeable. Colour is important as this enables clients to identify rooms and move through the environment more fluidly. Muted autism friendly colours can have a calming and organising effect on the senses.

Windows

Key points:

- Toughened safety glass throughout property. Clients may seek to hit, bang or throw objects at windows thus breaking glass. Toughened glass will help to reduce risk of harm to clients.
- Avoid windows with large glass area panels as smaller panels will be easy and less expensive to replace.
- Integral horizontal blinds fitted within window glazing, electronically remote controlled by staff. Blind controls are not to be accessible to clients as they may be tampered with and destroyed. Client's dignity would need to be protected as they may remove clothing during high levels of arousal. Consideration of window location and whether overlooked by neighbours.
- Windows should be flush with walls with no window sills to avoid climbing.
- Lockable windows with lockable window restrictors. Windows require to be robust and lockable. Window openings should be located higher up and open outwards to prevent clients from attempting to climb out and allow for windows to be fixed open without ability to be slammed shut by clients or trapping of body parts.
- Frosted glass required for wet room/ensuite to protect dignity/privacy.

Doors

Key points:

- All doors need to be solid core, reinforced and fitted with heavy duty hinges and flush fitted, handless door handles. Door frames should be robust and reinforced. Clients may repeatedly bang and slam doors against walls and into door frames. Doors should be contrasting colour to door frames and handles should be contrasting colour to door. Any locks should be two-way safety locks so can be opened from both sides if required.
- Anti barricade doors that have ability to open both ways and ability to be locked in an open position within a room. Clients may have epilepsy and following seizure activity inadvertently restrict access to a room preventing essential emergency care.
- Doorstops fitted to prevent doors being pushed back into walls. No mechanical door closers. Door silencers can be used within door frames which help to absorb sound of door closing. Clients may repeatedly bang doors at force into walls. Doors that can be locked in an open position into a door frame is a suitable solution to help prevent this and reduce structural damage.
- Shower room door to open outwards allowing staff to access in an emergency fitted with 2-way safety lock.
- Doors should have locks fitted so areas can be ‘zoned off’ for safety, cleaning purposes and allow access as required. Staff may require to clean or secure a room to reduce risks to the client during an occurrence of challenging behaviour from clients.
- Internal doors should have observation panels fitted to enable staff to observe clients at all times. Staff may require to withdraw to a dedicated space for their own safety when clients are displaying high levels of arousal but will still require to monitor the clients wellbeing and safety.

Lighting

Key points:

- No florescent lighting or rose ceiling flexes. Lighting requires to be recessed into the ceiling. Use of dimmer switches in living room and bedroom areas can help to promote soft lighting and be calming. Remotely controlled dimmers which do not emit noise are a good option to use in these rooms which can be operated by staff. Clients with autism can be affected by flickering of harsh lighting. Hanging ceiling bulbs can be broken, electrical cable flex damaged and cause a serious risk to clients.
- Use of creative high windows and building design would allow for natural lighting to radiate into the room to provide a relaxed calming environment.
- Use of integrated blinds fitted within window frame would be required for any accessible windows clients would be able to access as standard freestanding blinds, curtains have the potential to be pulled down and destroyed.

Electrics

Key points:

- Robust metal light flush fitted switches and plug sockets fitted with plug locks. Consideration of discreet locations of switches and plug sockets to discourage tampering. Clients can damage by banging, attempting to pull from the wall, tampering with switches and putting fingers into sockets due to clients having no awareness of danger.
- Increased number of plug sockets to support varied equipment needs of people, including sensory and medical equipment
- Individual circuit breakers would be required for each room for mains power supply and electrical appliances including cooker, refrigerator. This would enable staff to maintain clients' safety and secure electrical zones as required.
- Fuse box located in locked cupboard only accessible by staff which should be securely locked to prevent any potential access by clients.
- Electrical appliances such as television, CD/DVD, should be locked within a purpose build robust and lockable unit with toughened polycarbonate panels with no exposed wires or cabling. Clients can tamper, bang, damage and destroy appliances causing a serious risk of harm. Unit surface should be sloped to prevent client climbing on.

Heating

Key points:

- Under floor heating would be the best option to use. Temperature regulation can be controlled and zoned off in each room. Isolated thermostatic controls should be locked within a lockable secure storage unit/room only accessible by staff. Remotely controlled isolated thermostatic controls may also be an option to consider. Clients can damage, tamper, climb on radiators and pull radiators off walls.

Flooring

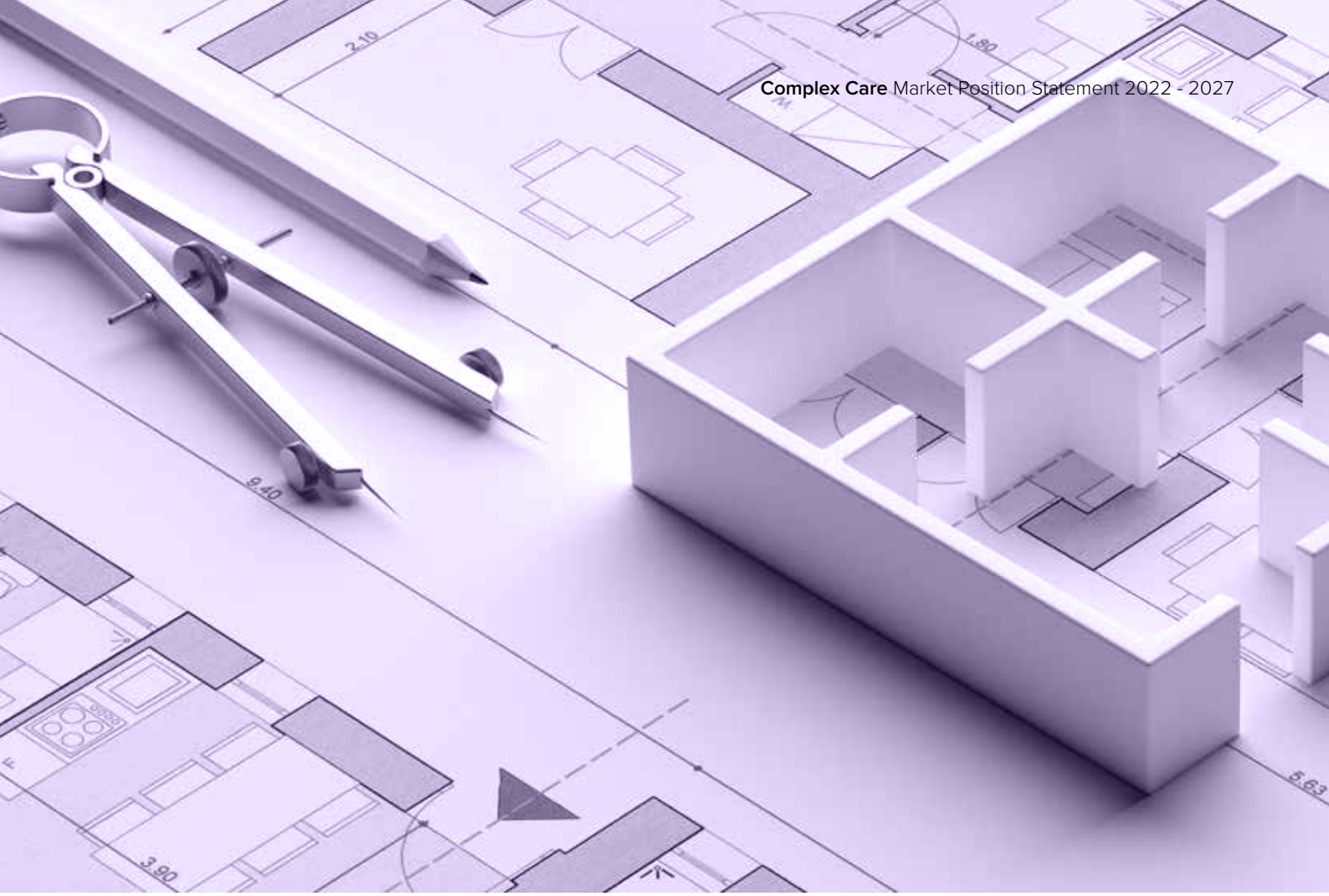
Key points:

- Avoid Patterned, busy flooring as this can be confusing and cause anxiety to clients.
- Non-slip, waterproof vinyl flooring throughout property fitted with acoustic reducing underlay to reduce noise transmission and footfall.
- Non-slip, waterproof vinyl flooring turned up at walls with sealed coving in shower room. Clients may be doubly incontinent and therefore require easily cleaned floor surfaces. Flooring turned up at walls will reduce the risk of structural damage from water ingress.

Shower room / Toilet

Key points:

- Wet room with ceiling flush fitted 'rain shower' and shower controls external to the shower room that are controlled by staff. Clients may seek to tamper and damage shower fittings. Clients with autism may enjoy water play with a fascination of water and may flood the bathroom therefore water isolators and controls require to be managed by staff.
- Walls require to be fitted with heavy duty splash back material and flooring turned up at walls with sealed coving. Clients may bang and smash tiling causing risk of harm and damage to property.
- Silent extractor fan remotely located to minimise noise. Clients with autism are often sensitive to noise.
- Toilet requires to be concealed / boxed in toilet cistern, robust anti vandalism style toilet, large bore toilet waste pipe, push button / sensor flush recessed into the wall at rear of toilet would be required. Clients may seek to tamper e.g. repeatedly banging toilet seat, flushing toilet, pull toilet from wall/floor and may put inappropriate items down the toilet.
- No visible or accessible pipe work. Clients may seek to tamper with pipe work/ plumbing.
- Sink recessed into wall fitted with sensor taps and water flow that can be limited, if required. Clients may seek to climb on the sink, turn on the taps and flood the bathroom.
- Thermostatic temperature controls should be fitted to all water supplies in the property. Clients would be at risk of scalding therefore water requires to be thermostatically controlled.
- Water isolators would be required to be fitted to all water supplies within property. Client may seek to turn on taps, engage in water play which can result in flooding and water damage to property.



Kitchen

Key points:

- No open plan - Separate kitchen with lockable door off hallway and rear door access from kitchen into garden area. Clients will only access the kitchen with support to engage in daily living tasks. Clients with autism benefit from understanding the function of a room and where a specific activity occurs. Open plan access to a kitchen increases risks and safety issues to client when accessing unsupervised.
- Integral kitchen with locks on all cupboards including locks / concealment of cooker (induction hob style), fridge, freezer, washing machine. Clients may attempt to access cupboards containing food, sharps, hazardous substances and damage items in the kitchen.
- Gas, halogen/ceramic hobs and solid plate/metal rings should be avoided due to taking too long to cool down and have no visual indicator they are still hot.
- Robust cupboards with reinforced hinges and handless/flush fitted handles. Clients can have difficulties with hand dexterity and regulation of force therefore cupboards need to be strong and durable.
- Durable kitchen non reflective/patterned matt finish worktops with rounded edges which are heat resistant and easily cleaned. Clients with autism can be affected by busy patterns and potential glare from work surfaces. Clients may also have epilepsy therefore high risk of injury within kitchen area.
- Electric isolators for all kitchen appliances.
- Water isolator for kitchen taps.

Living room

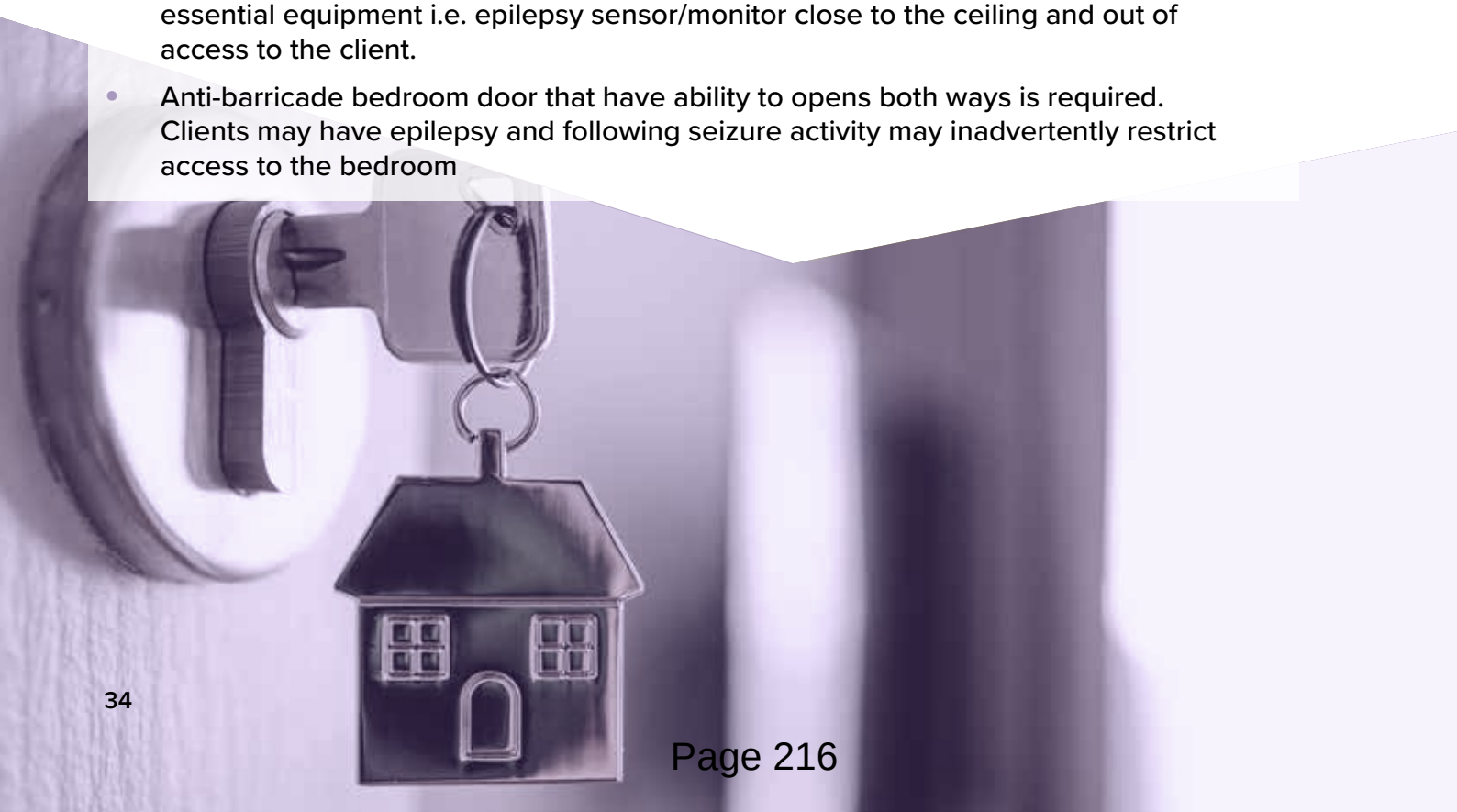
Key points:

- Strong, robust, weighted furniture including table with non reflective matt finish, dining chairs, sofa/chair. Clients may seek to jump, move, damage furniture therefore it needs to be able to withstand this.
- Electrical appliances such as television, CD/DVD, should be locked within a purpose build robust and lockable unit with toughened polycarbonate panels with no exposed wires or cabling. Clients can tamper, bang, damage and destroy appliances causing a serious risk of harm. Unit surface should be sloped to prevent client climbing on.
- 2 access points within the living room area would be required with a door allowing access directly to the garden area. This would allow staff to safely exit when client may be exhibiting challenging behaviour. Direct access to the garden area only from the living room enables the client to understand that they are going to undertake an activity in the garden.

Bedroom

Key points:

- Large bedroom space would be required containing a robust bed and a built-in wardrobe with strong, robust lockable doors.
- Minimal electrical sockets would be required in clients' bedrooms. These would require to be metal flush fitted and lockable. Consider fitting electrical sockets for essential equipment i.e. epilepsy sensor/monitor close to the ceiling and out of access to the client.
- Anti-barricade bedroom door that have ability to opens both ways is required. Clients may have epilepsy and following seizure activity may inadvertently restrict access to the bedroom



Storage

Key points:

- Any storage units will need to be lockable and securely fixed to the wall. Clients may attempt to dismantle, destroy or pull units off walls causing potential harm to themselves, others and damage to the environment.
- Lockable and secure cabinet for medication accessed only by staff. This would be required for safe storage of medication and not stored in a location accessed by the client.

Smart Technology

Key points:

- Alerting devices will need to be installed – door exit sensor, window alarms, motion sensors in bedroom, flood sensors in bathroom, emergency call responders for staff to gain assistance - All linked to staff responder system i.e. Tunstall/Possum. Clients can display challenging behaviour which results in high levels of risk. it is vital smart technology is fitted for staff to acknowledge what the client is doing at all times and to summon assistance from other staff to maintain their own safety when required in challenging situations.

Guidance has also been utilised from the following information documents which should be referred to for further information and design specifications.

- Whitehurst Teresa, Research & Development Officer, Sunfield Research Institute, 2007 Evaluation of Features specific to an ASD Designed Living Accommodation.
- Brand Andrew, Helen Hamlyn Centre, Royal College of Art, 2010 Living in the Community Housing Design for Adults with Autism.
- Gaudion Katie, and McGinley Chris, Helen Hamlyn Centre for Design, Royal College of Art 2012 Green Spaces Outdoor Environments for Adults with Autism.
- Ryde Sue, Godwin Julia and Swallowe Kim, Housing Learning and Improvement Network, London, 2019 Building the right homes for adults with learning disabilities and autism in Oxfordshire.
- The National Autistic Society, https://www.autism.org.uk/advice-and-guidance

Appendix C -
Scottish Government Community Living Change Fund Guidance

1. This Scottish Government guidance follows up the letter from Richard McCallum of 5 February 2021 to NHS Directors of Finance and IJB Chief Finance Officers, which included early detail of a £20m allocation to Integration Authorities for a Community Living Change Fund

Introduction

2. The early part of the pandemic contrasted a significant reduction in delayed discharges with the more intransigent and long-standing delays of people with severe learning disabilities, many of whom had been in hospital for several years.

3. In their regular meetings to discuss delayed discharges, the Cabinet Secretary for Health and Sport and Councillor Currie, the COSLA Health and Social Care Spokesperson, asked for a piece of work to examine the main reasons for, and solutions to, these delays. Recognising the financial implications of arranging alternative packages of support in the community, Ms Freeman and Councillor Currie asked for this work to look at how this might be addressed. A Short-Life Working Group (SLWG) was established, co-chaired by David Williams, SG Director of Delivery, Integration, and Jane O'Donnell, Head of Policy from COSLA, which recommended the development of a "Community Living Change Fund".

Background

4. 'The Same as you?' [1] recommended that "but for a few people, health and social care should be provided in their own homes or in a community setting, alongside the rest of the population". It was clear that people's home should not be in hospital. This is also emphasised in the Hospital Based Complex Clinical Care guidance from May 2015 [2], which says "as far as possible, hospitals should not be places where people live – even for people with on-going clinical needs. They are places to go for people who need specialist short-term or episodic care. Hospitals are highly complex institutions which should focus on improving the health of people with acute conditions before discharging them back into the community".

5. The recent Independent Review of Adult Social Care [3] recommends that "investment in alternative social care support models should prioritise approaches that enable people to stay in their own homes and communities, to maintain and develop rich social connections and to exercise as much autonomy as possible in decisions about their lives". On 16 February, in a Parliamentary debate on the independent review, the Cabinet Secretary announced this fund would consist of £20 million "to deliver a redesign of services for people with complex needs, including intellectual disabilities and autism, and those who have enduring mental health problems. The fund will focus on delivering a proper sense of home for people with complex needs, including those who have encountered lengthy hospital stays or who might have been placed outside of Scotland, and who could, and should, be more appropriately supported closer to home". The full £20m was allocated to Integration Authorities, via NHS Boards, in February.

6. The 'Coming Home' report [4] , commissioned by the Scottish Government, made recommendations to improve the support for individuals with learning disabilities who have complex needs, and who are either placed out-of-area, or are currently delayed in hospital based assessment and treatment units. The Community Living Change Fund should be seen as the funding to ensure implementation of that report.

Data

7. In 2018/19 (the latest complete year of costed data), there were 23,255 hospital bed days linked to people who did not need to be in hospital (10,336 code 9 and 12,899 ode 100 cases [5]). The bed days were used by a total of 108 patients delayed for some period during the year, but average out at 63 per day.

8. There were a total of 69,500 overall bed days in learning disability specialties so around a third were taken by people who shouldn't be in hospital. There are relatively few patients using the inpatient services but a high average length of stay, with over half in hospital for more than a year and about a third for more than three years. Most of the inpatient beds are for assessment and rehabilitation, yet we effectively have people living their lives in these hospital beds. This outcome is the opposite of the objective of the Same as You? policy and most likely reflects the fact that, despite real terms increases in social care learning disability expenditure since 2008/09, these have not been sufficient to keep pace with increased need due to demographic change. In looking at the overall provision, if we could reduce the overall lengths of stay and remove the delayed discharge element, overall capacity should reduce by about half. The cost of all learning disability inpatient stays was estimated at £48m, with the cost of the delayed cohort estimated at £16m (or averaging £252,000 per person, full cost).

9. In addition, the SLWG surveyed local partnerships to ascertain the level and cost of placements outside of Scotland. Not all partnerships provided data but using the returns from the majority of partnerships, and comparing it with the 2019 long-stay inpatient survey, assumed 90 individuals placed in accommodation in the rest of the UK at an annual cost of £15m (or an average of £167,000 per person).

10. Scotland Excel estimated the average cost of a package of care in the community for people with severe learning disability at £172,000 (taking in to account only packages that were valued over £100,000 – there are likely to be far smaller packages of care where family members provide most support). These packages ranged from £108,000 to £201,000. The data provided by Scotland Excel only captures services that are purchased from the framework therefore an individuals care package may be greater than where other services and supports are provided in addition.

Tackling the problems

This cohort of people will be delayed in hospital or placed outside of Scotland, mainly because of a lack of funding, accommodation or suitable care package, or most likely a combination of all three. The SLWG heard from providers that they can structure complex care packages and from housing specialists who suggested access to capital funding should not be a major issue.

11. A paper to the Cabinet Secretary and Councillor Currie, that initiated this work, highlighted the problem:

    "Most of these individuals will have been previously supported in community placements but their package has broken down due to usually as a result of challenging behaviours that carers have been unable to manage. The issues for this group of individuals in providing an opportunity to succeed in community living include the level of continuous long-term revenue funding; capacity and capability of the provider sector to deliver sustainable care, appropriate low arousal accommodation and available capital funding; lengthy transition costs requiring double funding."

12. The SLWG has also highlighted difficulties in commissioning for a fairly small cohort, noting that in some areas more could be done to ensure planning is co-produced with service users and carers. It suggested there could be greater joined up working and longer term planning between Integration Authorities and Local Authority Housing Departments and registered social landlords.

13. So, much of the problem is about transition costs, accessing sufficient funding and suitable accommodation, and taking a truly collaborative approach to commissioning. The SLWG therefore suggested tackling these through a short-term Community Living Change Fund, adopting a programme budgeting approach and disinvestment planning to ensure resource is directed to the community where possible and developing additional guidance on commissioning and procurement for these client groups.

Community Living Change Fund

15. It is clear that change will not happen overnight, that in many areas a radical redesign is needed in how services are provided in the local community. The Community Living Change Fund will be available to accommodate the re-provisioning of long-term hospital and out of area care and create a powerful lever for a longer term shift from institutional care. The Fund is not intended to replicate the current inappropriate spend but rather act as a facilitating mechanism to bring about change.

16. It is estimated that in order to facilitate the discharge and transfer of the cohort mentioned at paragraphs 7 and 9 would require £20m spread over three years. **The funding, which issued in February 2021, should be held in reserve within individual Integration Authorities to be used as plans are developed and completed to an outer time limit of March 2024.** Releasing the funding in a single allocation allows those partnerships who are further developed to commence at pace, while others will need a longer lead in time (several Finance Directors and managers told us that some of the very complex cases will need a two to three year transition period).

17. It is important that the Community Living Change Fund should drive further service redesign that adopts a preventative and anticipatory approach to supporting people with very complex needs that avoids the need for institutional care in the future. Acknowledging that some partnerships will be able to advance plans more quickly, the Fund should be used over the course of three years to bring home those that are placed outside of Scotland, to discharge those that have endured long stays in a hospital setting and design community based solutions that negate or limit future hospital use and out of country placements.

Disinvestment

18. It is appreciated that during and after this period, a shift in resources will be required so that long-term funding follows the individuals to the community. Appreciating that alternative accommodation would need to be organised, in the case of out of country cases this would in simple terms see subsequent money spent in Scotland rather than other countries. For those in hospital in Scotland, plans would need to be collaboratively agreed that would see replacement funding at the end of the Community Living Change Fund period (March 2024) being released from institutional care.

19. Disinvestment decisions will need to be taken, potentially resulting in a reduction in hospital based functions. However, the necessary disinvestment in these cases is not about cost savings, but about improving outcomes and the quality of care, while improving value, so the reasons for change will need to be effectively communicated.

Allocation of funding

20. The work stream discussed various distribution and allocation methods, including making the fund open to local bids and allocation based on the scale of the delayed discharge and out of area cases. However, it agreed that the fairest method was to allocate via an established combination of health and local government formulae (a mix of relevant GAE and NRAC) to Health Boards, for onward distribution to Integration Authorities. They would be expected to work collaboratively and agree between themselves (where there are multiple Integration Authorities) the spend. The allocation split is detailed in annex A.

21. Led by Integration Authorities, the local use of the Fund should be subject to a set of principles, laid out in annex B, signed off by representation from NHS Boards, local authorities, third sector providers and service users. The proposals agreed under these sign off arrangements must bring in to play the wider resources under discussion, including large hospital budgets (the "set aside"), third sector funding and housing contributions. It is acknowledged that complex reprovisioning might need a longer lead in but funding would need to be used by March 2024.

Monitoring

22. The Community Living Change Fund should be used to provide more appropriate care and support for the people highlighted in paragraphs 7 and 9. By March 2024 we expect to have seen out of area placements and inappropriate hospital stays greatly reduced, to the point that out of area placements are only made through individual family choices and people are only in hospital for genuine short-term assessment and treatment.

23. The use of each Integration Authority's share of the £20m should be recorded in their annual financial statement and the outcomes delivered detailed in their annual performance report. **Where the funding has been carried over in reserves, this must be earmarked separately and reported to the Scottish Government through the quarterly monitoring.**

Appendix D -
Complex Care Needs - Pen Pictures (Behaviours and Needs)

These quotes have been taken from individual PEN profiles. They have been redacted to remove any personal information. PEN profiles are completed on behalf of the individual with Complex Care needs, by their multi-disciplinary team, using their experience, observations, and professional opinion.

Behaviours	Needs
"When in hospital I have bitten and hit staff and other patients. I have opened windows and moved furniture to help me climb out."	• Space for de-escalation and staff safety • Ground floor property to reduce risk of injury • Robust, enclosed fencing to prevent injury
"I do not like loud noises so need to live in a quiet area but close to a bus route. I need a ground floor flat that has excellent sound proofing as I do not like noise and where my bedroom is in the property is important, so I do not hear neighbours' noises.	• Soundproofing to prevent escalating behaviours due to discomfort • Accessibility needs e.g. level access shower room, grab rails • Ground floor property to reduce risk of injury
"I climb out of windows and over fences. I need frosted glass or opaque coverings on my bedroom window."	• Privacy film, integrated blinds, or opaque covering on windows • Robust, enclosed fencing to prevent injury • Telecare
"I was engaging in risky behaviour including directing traffic and throwing objects on to busy roads."	• Low traffic flow or measures to reduce injury due to absconding
"When I am in hyper manic state, I am a danger to myself and others. I start checking doors, light switches, sorting curtains or picking crumbs off the table and my behaviour becomes very controlling."	• Robust fixtures due to frequency of use, habitual or aggressive behaviour
"I am very curious and like to touch and smell everything in sight which could cause me harm both at home and in the community. I must not be left near hot taps, hobs etc. Due to my sensory needs, I will touch things that are very hot without insight that I will be injured."	• Ability to close off or restrict access to certain rooms or storage to prevent injury
"I need supervision whilst in the shower also, as I may spend a lot of time playing with the water and spraying shower gel everywhere. This creates a slip hazard and means I may not always focus on washing myself properly. I have no sense of road danger and/or how to keep myself safe in the community."	• Robust fixtures due to frequency of use, habitual or aggressive behaviour • Low traffic flow or measures to reduce injury due to absconding
"I am not overly interested or keen on building relationships with people I live with and can find unpredictability and noise very distressing."	• Low traffic flow or measures to reduce injury due to absconding • Noise because of multi-storey living could escalate challenging behaviours • Co-habitation could also raise issues of conflict due to noise • Soundproofing to prevent escalating behaviours due to discomfort

"It is essential that my environment is of low stimulus. I am very tactile and sensory however there are risks in relation to me experiencing "sensory overload." I am not able to cope with busy/loud/overly stimulating environments."	• Low traffic flow or measures to reduce injury due to absconding • Noise because of multi-storey living could escalate challenging behaviours • Co-habitation could also raise issues of conflict due to noise • Soundproofing to prevent escalating behaviours due to discomfort
"I have complex health needs. I have spastic quadriplegia, developmental delay, severe learning disability, a visual impairment, and I also have limited speech. I was diagnosed with bi-polar affective disorder in [date]. I have a baclofen pump fitted which is refilled every six months and I also wear contact lenses to assist my sight. I use an electric wheelchair and specialist equipment to assist with mobility and transfers. I have a hoist and changing table/shower table in my bathroom."	• Accessibility needs e.g. shower room • Ground floor property to reduce risk of injury • Space for equipment and staff movement
"When distressed, [individual] presents with episodes of self-injurious behaviour which take the form of him throwing himself to the floor and scratching at the lining of his mouth necessitating restraint to prevent him from harming himself. In the past, he has also thrown himself at walls and attempted to self-asphyxiate."	• Reduced-Ligature Fixtures • Space for de-escalation and staff safety • Robust fixtures due to frequency of use, habitual or aggressive behaviour
"It is noted that these may be manifested by my attempts to scratch, bite, or pull hair/ lashing out at property/walls, continuous flushing of the toilet and banging on windows/ doors. I do not like staff or peers to stand too close to me and I'm more likely to avoid peers."	• Space for de-escalation and staff safety • Robust fixtures due to frequency of use, habitual or aggressive behaviour
"During these times I will begin to pace, stare at people, shout, make derogatory comments towards staff and others before physically reacting (I have attempted to strike and bite people unexpectedly). I will require support to manage all aspects of independent living including support to take my medication, follow a structured routine and manage any episodes which challenge others. If I am not well supported there is a real risk of re-offending. I have previously stated that I wanted to be the youngest serial killer and had planned how to kill my mother."	• Space for de-escalation and staff safety • Robust fixtures due to frequency of use, habitual or aggressive behaviour • Prevention of anti-social behaviour • Location of accommodation may prevent self-injury or injury to others
"I experience difficulties with my mobility and tend to seek support from others by taking their arm when out and about. Whilst in hospital I have been using a walking frame when outside as I can struggle with longer distances (I was reluctant to use any walking aids when I lived at home)."	• Accessibility needs e.g. shower room • Ground floor property to reduce risk of injury

"I was admitted to XX Ward at XX Hospital on an informal basis after committing an act of arson by setting a mop on fire in my accommodation."	• Prevention of anti-social behaviour • Robust fixtures due to frequency of use, habitual or aggressive behaviour • Space for de-escalation and staff safety
"I am paranoid about drivers of cars staring at me, I direct the traffic (from the road), and I kick out or throw big stones at cars. I can be aggressive to members of the public without any provocation. I may not take notice of my support staff and can be aggressive towards them if they pursue me or try to reason with me. Equally I can be aggressive towards any person who approaches me, however well meaning, and this is a risk for all concerned."	• Prevention of anti-social behaviour • Robust fixtures due to frequency of use, habitual or aggressive behaviour • Space for de-escalation and staff safety
"Support helps me to deal with regulating my emotions. I can be very unpredictable when I'm anxious and very impulsive. This has caused many difficulties in the past, including me being [injured] when I absconded from staff. This happened when I was extremely anxious and unable to recognise my emotions or cope with them."	• Space for de-escalation and staff safety • Low traffic flow or measures to reduce injury due to absconding • Location of accommodation may prevent self-injury
"I must be made to feel safe. This is extremely important to me. If I don't feel safe, my risk-taking behaviours will escalate which is a risk to myself and others around me."	• Location of accommodation may prevent self-injury • Space for de-escalation and staff safety • Robust fixtures due to frequency of use, habitual or aggressive behaviour
"If I live with others, I get on well with people who keep themselves to themselves and who do not speak a lot and expect things of me. I like to talk with people but not people who are loud or don't listen to me."	• Low traffic flow or measures to reduce injury due to absconding • Noise because of multi-storey living could escalate challenging behaviours • Co-habitation could also raise issues of conflict due to noise • Soundproofing to prevent escalating behaviours due to discomfort
"It is essential that my sensory needs are met and that I get time outdoors though do not become over-stimulated."	• Ample outdoor, community and enclosed space i.e. garden • Robust, enclosed fencing to prevent injury
"It is essential that I have garden space within any proposed new service. I love being outside – sometimes it can be struggled to get me to come inside, even if it's snowing! I am a very sensory person and benefit hugely from engaging in activities in the garden however garden space must be secure with no opportunities for me to evade staff sight. I would be at significant risk of harm if I evaded staff support and entered the community on my own"	• Ample outdoor, community and enclosed space i.e. garden • Location of accommodation may prevent self-injury • Space for de-escalation and staff safety • Robust fixtures due to frequency of use, habitual or aggressive behaviour • Robust, enclosed fencing to prevent injury

"I can share accommodation however consideration must be given to compatibility. I would struggle significantly to share with lots of different people as this would be busy, loud, and unpredictable. I also do not cope well with conflict. Being in this type of environment makes me very anxious and uncertain which increases risks in relation to aggressive behaviour."	• Low traffic flow or measures to reduce injury due to absconding • Noise because of multi-storey living could escalate challenging behaviours • Co-habitation could also raise issues of conflict due to noise • Soundproofing to prevent escalating behaviours due to discomfort • Space for de-escalation and staff safety
"...there have been past incidents where I have evaded staff support by running away from my accommodation or running away from staff whilst in the community. It is therefore essential that my environment is secure."	• Ample outdoor, community and enclosed space i.e. garden • Location of accommodation may prevent self-injury • Space for de-escalation and staff safety • Robust fixtures due to frequency of use, habitual or aggressive behaviour
"I have my own mobility vehicle that I use to go out on day trips or out for meals with my staff. This vehicle also allows my support staff to support me to travel to places that I like visiting. In addition to this, my car is important to me as it allows me to access various places across Aberdeen/ Aberdeenshire which helps me maintain contact with those who are important to me."	• Ample parking facilities for staff and mobility vehicles • Location of accommodation may prevent self-injury
"I was admitted to [facility] following an attack on my mother whereby I bit her and threatened to stab her (she sustained a small cut to her hand). The Police were contacted by my care manager as my mother refused to do so and I was detained."	• Space for de-escalation and staff safety • Robust fixtures due to frequency of use, habitual or aggressive behaviour • Location of accommodation may prevent self-injury or injury to others • Prevention of anti-social behaviour
"I have verbally abused staff in public and pushed them/ tried to remove items from their pockets. I have verbally abused older members of the public when on buses/ waiting for a bus. I can be racially abusive and find it difficult to respond to younger females."	• Prevention of anti-social behaviour • Location of accommodation may prevent self-injury or injury to others • Space for de-escalation and staff safety
"Any package of support would have to ensure that [individual] has a very detailed, care plan supported by telecare to alert staff if he is having a self-injurious episode during the night. He will also require an experienced, trained and well supported staff team who can implement a predictable, clear, and consistent care plan in a supportive, reassuring manner including administering physical restraint to manage his self-injurious behaviour."	• Space for de-escalation and staff safety


Aberdeen City
Health & Social Care
Partnership
A caring partnership


ABERDEEN
CITY COUNCIL
NHS
Grampian

Health Inequality Impact Assessment

Stage 3

Analysis of findings and recommendations

Complex Care

Please detail a summary of the purpose of the proposal being developed or reviewed including the aims, objectives and intended outcomes

The Coming Home Report (Scottish Government, 2018) and associated Coming Home Implementation Report (Scottish Government, 2022) has shone an uncomfortable spotlight on people with Complex Care needs who have been placed out of area inappropriately or are delayed in hospital pending suitable local service availability. It is clear that this is unacceptable and Complex Care has been identified as a priority with the Aberdeen City Health & Social Care Partnership (ACHSCP) Strategic Plan and Delivery Plan (2022).

In partnership with Aberdeen City Council and NHS Grampian, ACHSCP has outlined two documents: a Complex Care Market Position Statement and Complex Care Business Case, which outline the current and proposed landscape of Complex Care.

<u>Complex Care Market Position Statement</u>

Aims:

- Set out a vision, commitment and expectations for services which support people with learning disabilities and Complex Care needs in Aberdeen City from 2022 until 2027

- Establish a shared understanding of the needs of people with learning disabilities and Complex Care requirements
- Demonstrate commit to aligning with the Scottish Government's Coming Home Implementation Report 2022

Objectives:

- Focus on demand: Using a Dynamic Support Register and other available data, create a clear picture of current and future need
- Evidence needs: Maintaining robust assessments of need by our multidisciplinary team approach and using our pen picture template to communicate these needs to providers of care and housing
- Pursue housing options: Embedding our demand and need profile into the Strategic Housing Investment Plan (SHIP), Housing Need and Demand Assessment (HNDA), Local Development Plans and other relevant documents to create opportunities for, and delivery of, service developments
- Work with individuals and families : To provide local services, reducing the need for out of area placement and creating robust anticipatory planning for people with complex needs
- Work with providers: To co-create long term sustainable services and the associated workforce skills for Complex Care services
- Contribute to local, regional, national work : Share learning and representing the Complex Care needs of people within Aberdeen City

Intended Outcomes:

- Support is provided at the right place at the right time – acknowledging that at any given time, people's support needs may fluctuate, and the level of support should adapt to that change
- People are supported and involved in decisions about their care and support, including who provides their support and where they live and who they live with, and specific personal outcomes to be achieved through the support provided
- Support is designed to enable people to live as independent a life as possible. The accommodation environment will enable people to live as independent a life as possible including wherever possible the location, the size, and the type
- Protecting and enhancing people's human rights is at the centre of service design and delivery, including accommodation environments
- Families and Carers are recognised as key partners in the design and delivery of services
- Support is delivered in a way which enables community involvement and the building of genuine community connections for people who are supported
- People who are supported are recognised for their skills and abilities, consideration of how these attributes may be shared more broadly in the local community should be considered by all
- Service delivery and environments will support and promote improvements in physical and mental health and wellbeing ensuring use of technology is maximised

Complex Care Business Case

Aims:

- The provision of specialist and more intensive care/support services, delivered by a trained and supported staff team
- The requirement for providers to be able to de-escalate behaviour, which require specialist training and insurances, typically via the provision of a Positive Behaviour Support Team/Model
- Robustly built environments which support individual care needs
- Spacious accommodation with individual access to outdoor spaces and separate staff welfare areas
- Individual accommodation without the need to share with others but services to be delivered in a way which does not isolate individuals or staff

Objectives:

- Provision of suitable built environments which meet a Complex Care specification
- Accommodation which is Cost Neutral to ACHSCP
- Adequate volume of services to meet identified and future needs
- Support independent living principles and advance human rights
- Reduction in hospital admissions and delays in hospital; inappropriate out of area placements; placement breakdown
- Support people to live in and contribute to their communities
- Accommodation requirements met within a short timescale

Intended Outcomes:

- People live locally in the community
- People live in more suitable environments
- Staff have support from managers and peers
- Staff have training and skills to provide Complex Care
- There is a reduction in the number of people living out of area inappropriately
- New developments will have rental costs aligned to Local Housing Allowance
- Appropriate environments will decrease the number of housing repairs
- Better oversight of the number of people awaiting services
- A well-developed programme of Complex Care services

Equality Act 2010 – Relevant Protected Characteristics as identified in Stage 1 (remove those that do not apply)

Protected Characteristic	Equality Duty		What impact and or difference will the proposal have	How will you know - Measures to evaluate
Disability	Eliminating discrimination, harassment, victimisation, or any other prohibited conduct		These proposals will ensure that individuals with Complex Care needs can: • Live independently, healthily, and safely within their local communities • Receive the necessary care services to enable them to live independently • Receive the necessary care services to enable them to pursue their individual interests and life choices	• Less delays for people as they move out of Hospital • Number of people who have to move away for care reduces • Fewer placement breakdowns • Less people waiting to access care services • Care inspectorate reports
	Advancing equality of opportunity		These proposals will ensure that individuals with Complex Care needs can: • Participate in community living • Easily access community services/ resources • Build strong relationships with their families and wider support network • Access accommodation suitable to their Complex Care needs	• People and their families will tell us, and it will be clear from their care plans • We will ask for feedback using advocacy where appropriate • We will ask providers for staff feedback • Accommodation needs are incorporated into strategic planning documents • Development of local services
	Fostering good relations by reducing prejudice and promoting understanding		These proposals will ensure that individuals with Complex Care needs can: • Access appropriate local Housing	• People and their families will tell us, and it will be clear from their care plans • We will ask for feedback using advocacy where appropriate

			• Participate in community activities and use community services • Engage with others within their community, highlighting the community's diversity and building an understanding of the different needs within communities, including Complex Care needs	• We will ask providers for staff feedback

Human Rights – Reference those identified in Stage 1 (remove those that do not apply)

Article	Enhancing or Infringing	Impact and or difference will the proposal have	How will you know - Measures to evaluate
Right to Life	Enhancing	These proposals will ensure individuals with Complex Care needs can live independently, healthily, and safely within their local communities, participate in their communities, and explore their own interest and life choices.	• People and their families will tell us, and it will be clear from their care plans • We will ask for feedback using advocacy where appropriate • We will ask providers for staff feedback • Accommodation needs are incorporated into strategic planning documents • Development of local services
Right not to be tortured or treated in an inhumane or degrading way	Enhancing	These proposals will ensure individuals with Complex Care needs can receive appropriate care and support; promoting Positive Behavioural Support, closer family ties and specialised accommodation that allows for Positive Behavioural Support but can also sustain any behavioural reactions to stress.	• People and their families will tell us, and it will be clear from their care plans • We will work with providers and staff to understand any specific requirements for training • We will ask providers for staff feedback • Reduction in Housing Repairs

			• Reduction in incidents towards staff
Right to Liberty	Enhancing	These proposals will ensure individuals with Complex Care needs can live independently, healthily, and safely within their local communities, participate in their communities, and explore their own interest and life choices.	• People and their families will tell us, and it will be clear from their care plans • We will ask for feedback using advocacy where appropriate • We will ask providers for staff feedback • Accommodation needs are incorporated into strategic planning documents • Development of local services
Right to respect for private and family life, home, and correspondence	Enhancing	These proposals will ensure individuals with Complex Care needs can live independently, healthily, and safely within their local communities, participate in their communities, and explore their own interests and life choices. Individuals will be able to enjoy closer family ties and specialised accommodation that enables Positive Behavioural Support but can also sustain any behavioural reactions to stress, as it relates to their Complex Care needs.	• People and their families will tell us, and it will be clear from their care plans • We will ask for feedback using advocacy where appropriate • We will ask providers for staff feedback • Accommodation needs are incorporated into strategic planning documents • Development of local services • Reduction in Housing Repairs • Reduction in incidents towards staff
Right to freedom of thought, conscience, and religion	Enhancing	These proposals will ensure individuals with Complex Care needs can explore their own interests and life choices.	• People and their families will tell us, and it will be clear from their care plans • We will ask providers for staff feedback
Right to freedom of expression	Enhancing	These proposals will ensure individuals with Complex Care needs can explore their own interests and life choices.	• People and their families will tell us, and it will be clear from their care plans • We will ask providers for staff feedback

Protection from discrimination in respect of these rights and freedom	Enhancing	These proposals ensure commitment to the Scottish Government's Coming Home Implementation Report (2022) and its vision for individuals with Complex Care needs, "to lead full, healthy, productive and independent lives in their communities, with access to a range of options and life choices".	• Approval of the Complex Care Market Position Statement • Approval of the recommendations within the Complex Care Business Case

Fairer Scotland Duty

Identify changes to the strategic programme/proposal/decision to be made to reduce negative impacts	• Alignment with the Scottish Government's Coming Home Report and Coming Home Implementation Report (2022) to deliver equitable living for those with Complex Care needs. • Complex Care has been identified as a priority with the ACHSCP Strategic Plan and Delivery Plan (2022) • Participation in Scottish Government's development of a National and Local Dynamic Support Registers to visualise and understand the scale of Delayed Discharge, Out of Area Placement and Placements at Risk of Breakdown, across Scotland
Identify the opportunities the strategic programme/proposal/decision provides to reduce or further reduce inequalities of outcome	• Future proofing access to specialised housing, for those with Complex Care needs, by embedding the need in Aberdeen City Council's Strategic Housing Investment Plan. • Exploring capital projects with Care Providers and Registered Social Landlords • Non-recurring allocation of funding from the Scottish Government's Community Living Change Fund • Highlights emerging training and skill requirements within the workforce • Partnership approach to addressing recruitment need across Complex Care and how it can be better supported

Health Inequality Impact Assessment Recommendations

What recommendations were identified during the HIIA process:

Recommendation	Recommendation owned by:	Date recommendation will be implemented by	Review Date
Share draft Complex Care Market Position statement for feedback by Care Providers	Jenny Rae, Programme Manager	11/08/2022	31/08/2022
Implement a regular meeting to share learning and best practice of Complex Care, across NHS, ACHSCP and Care Providers	Jenny Rae, Programme Manager	11/08/2022	31/08/2022

Monitoring Impact – Internal Verification of Outcomes

How will you monitor the impact this proposal affects different groups, including people with protected characteristics?

- Individual Care Plans
- Advocacy of Staff and Family
- Development of a Dynamic Support Register
- Care Inspectorate Reports
- Complex Care specialised accommodation needs are incorporated into Aberdeen City Council's Strategic Housing Investment Plan

Procured, Tendered or Commissioned Services (SSPSED)

Is any part of this policy/service to be carried out wholly or partly by contactors and if so, how will equality, human rights including children's rights and the Fairer Scotland duties be addressed?

Complex Care services are provided by external care providers as part of a procurement Complex Care Framework. Health & Inequality Impact Assessments are a necessary requirement of the procurement process for any care provider to be part of the Complex Care Framework.

Communication Plan (SSPSED)

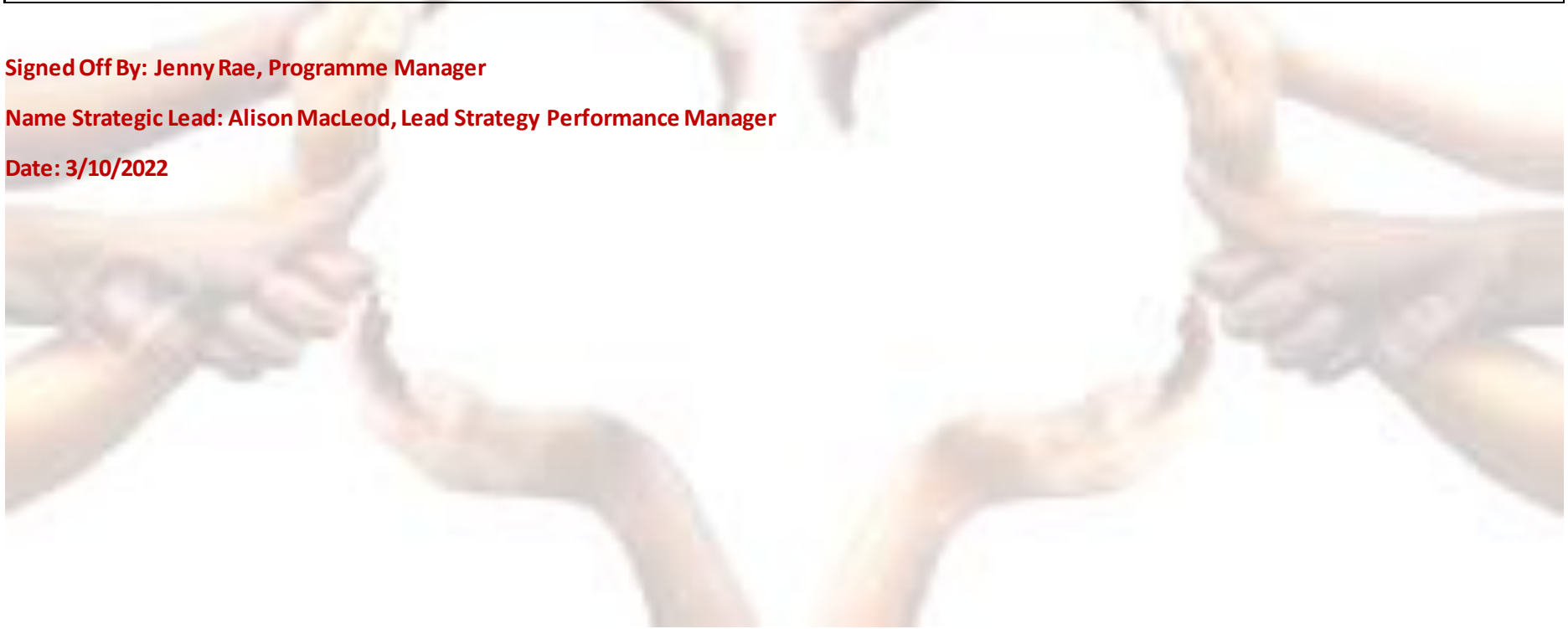
Please provide a summary of the communication plan which details how the information about this policy/service to young people, those with a visual or hearing sensory impairment, difficulty with reading or numbers, learning difficulties or English as a second language will be communicated.

These proposals will be available online and have been designed to meet accessibility needs and to be used with screen readers. The Programme Team responsible for these documents regularly attends a Public Engagement and Empowerment Group (PEG) where these proposals can be discussed with individuals with lived experience of Mental Health and/or supporting another individual with their Mental Health or Learning Disabilities. Other formats of, or support to understand, these proposals will be available on request.

Signed Off By: Jenny Rae, Programme Manager

Name Strategic Lead: Alison MacLeod, Lead Strategy Performance Manager

Date: 3/10/2022



This page is intentionally left blank

Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Date of Meeting	11th October 2022
Report Title	Rubislaw Park End of Life Care Beds Evaluation
Report Number	HSCP.22.087
Lead Officer	Shona Omand-Smith
Report Author Details	Michelle Grant Senior Project Manager migrant@aberdeencity.gov.uk
Consultation Checklist Completed	Yes
Directions Required	No
Appendices	a. Rubislaw Park End of Life Care Beds Evaluation

1. Purpose of the Report

1.1. This report seeks to inform the Integration Joint Board of the findings from the evaluation of the Rubislaw Park End of Life Care Beds Test of Change.

2. Recommendations

2.1. It is recommended that the Integration Joint Board:

a) Note the evaluation presented within Appendix A
b) Instruct the Chief Officer to initiate a Business Case on the End of Life Care beds and report this back to Integration Joint Board in November 2022.

3. Summary of Key Information

3.1. As part of a whole system pathway of care and ACHSCP planning for winter surge, initial approval was given for five interim beds within Rubislaw Park Nursing Home in December 2021 for End-of-Life Care. This evaluation

follows on from the initial approval for the test of change and looks to evaluate its success and make several recommendations for the future of the service.

3.2. The Evaluation looked at 30 patients who were referred to the service between 5th January 2022 and 30th June 2022. A holistic evaluation was conducted looking at feedback from Next of Kin/Carers regarding the service. Feedback was also sought from the Rubislaw Park team, Hospital at Home (H@H) team and other services who were in contact with the patient.

3.3. Feedback received from the Next of Kin included the following key points:

- 88% of the Next of Kin surveyed felt that the patients needs were fully met during their stay
- 100% of the Next of Kin surveyed felt that they were involved with the patient's care as much as they would have liked to be.
- 88% would recommend the service to others in a similar position

3.4. Feedback from the Rubislaw Park team, the H@H team, Macmillan Nursing, GP's and consultants from AMIA/Ward 102 who were all involved with the test of change also responded positively with many citing that they would hope that the service would continue into the future.

3.5. Demographic data collected regarding the patients stay shows that the bed occupancy level over the evaluation period for the five End of Life Care beds at Rubislaw Park was 43.3%. This was lower than expected, however it was noted that occupancy rates for this setting would be less than the generally accepted ideal of 80-85% in acute wards and sometimes can be as low as 45% in community settings. However, the expansion to allow referrals from all acute sources would help to increase the occupancy level over time.

3.6. Following the conclusion of the evaluation, it is recommended that the service continues with the following considerations:

- Following feedback from Next of Kin, the environment surrounding the End-of-Life beds should be reviewed to ensure it is appropriate
- The referral pathway should be scaled up to allow patients to be referred from all acute services which should enable the bed occupancy level to rise and would anticipate that this would also impact on the wider system to free up services.

- The communications plan requires to be reviewed and enhanced to ensure that patients, next of kin and services are all appropriately informed about the service provided.
- At this point in time, it is too soon to show the impact this has had on the wider system and acknowledge that a further evaluation to be conducted 18months after the pathway has been scaled up. This should focus occupancy levels and the impact on Community Services and Admissions Avoidance which has been challenging to obtain during this initial evaluation.
- A Health Inequalities Impact Assessment to be completed and provided along with the Business Case to Integration Joint Board in November 2022

4. Implications for Integration Joint Board

4.1. Equalities, Fairer Scotland and Health Inequality

The recommendations from this report should not directly impact upon Equalities. However, data from the evaluation, does demonstrate that the service was equitable on gender basis and looking at Scottish Index of Multiple Deprivation (SIMD) data collected that the service was received by equal numbers of patients from deprived and non-deprived areas of Aberdeen.

4.2. Financial

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

4.3. Workforce

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

4.4. Legal

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

4.5. Covid-19

While Covid 19 regulations were in place during the period the evaluation was conducted and some of the feedback received from the Next of Kin relates to the Covid 19 regulations in place at the Rubislaw Park Care Home, there are no direct Covid 19 related implications arising from the recommendations of this report.

4.6. Unpaid Carers

The evaluation of the Rubislaw Park End of Life Care beds shows that there was a direct impact upon the unpaid carers and family members surrounding each patient of Rubislaw Park. Patients were referred when the nursing care was too challenging for the Next of Kin/Carer to continue to carry out but did not medically warrant an acute admission.

When the Next of Kin/Carer's were asked whether the service impacted upon their wellbeing, they fed back that in some cases it allowed them to be family again with one respondent stating "Initially we were upset [when the patient was referred to Rubislaw Park], but there was an element of relief. We had cared for them both [next of kin's parents] for 2 years and we were exhausted". While the evaluation itself has no direct implications for unpaid carers, the findings confirm the services ongoing support for the next of kin/carer.

4.7. Other

5. Links to ACHSCP Strategic Plan

The Contract clearly links to priorities set out in Aberdeen City's Health & Social Care Partnership's Strategic Plan (2019-2022): Personalisation: Ensuring that the right care is provided in the right place and at the right time.

6. Management of Risk

6.1. Identified risks(s)

No specific risks raised from this evaluation, and the recommendation to proceed to a business case will endeavour to outline any risks with continuing with the service.

INTEGRATION JOINT BOARD

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

Performance standards/outcomes are set by national and regulatory bodies and those locally determined performance standards are set by the board itself.

Demographic & financial pressures requiring Integration Joint Board to deliver transformational system change which helps to meet its strategic priorities.

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

This evaluation helps to ensure that performance standards are maintained and that the services we fund are fit for purpose for the patients and their families who are impacted by their work.

The Rubislaw Park End of Life Care beds evaluation assists in maintaining our ability to respond to the needs of our population, both now and in the future since an aging population is likely to require more palliative care services.

This page is intentionally left blank

Aberdeen City Health & Social Care Partnership
A caring partnership

Rubislaw Park End of Life Care Beds

Test of Change Evaluation.

Michelle Grant, Senior Project Manager, ACHSCP

Dr Calum Leask, Lead for Evaluation, NHSG

September 2022

Key Points

- As part of Aberdeen City Health and Social Care Partnership's (ACHSCP) winter planning and a whole system pathway of care, five interim beds within Rubislaw Park Nursing Home were approved for use in December 2021 for End-of-Life Care.
- An evaluation was conducted of the service taking into account the views from patients' next of kin, the team at Rubislaw Park and the Hospital at Home (H@H) team alongside other services who came into contact with the patient and service.
- Thirty patients were admitted to Rubislaw Park between January-June 2022. This gave a bed occupancy level of 43.3%.
- Patients were referred from 16 different GP Practices across Aberdeen City and patients who were referred came from an equal spread of Scottish Index of Multiple Deprivation (SIMD) areas.
- 88% of the next of kin surveyed felt that the patient's needs were fully met during their stay
- 88% of next of kin surveyed would recommend the service to others who may find themselves in a similar position.
- When asked to rate the experience of working with the team at Rubislaw Park, the H@H team rated them 9 out of 10.
- The evaluation recommends for the service to continue with the following points considered:
    - Review the environment surrounding the End-of-Life beds
    - The referral pathway should be scaled up to allow patients to be referred from all acute services
    - The communications plan requires to be reviewed and enhanced
    - Further evaluation to be conducted 18months after the pathway has been scaled up.

Executive Summary

Background

As part of Aberdeen City Health and Social Care Partnership's (ACHSCP) winter planning and a whole system pathway of care, five interim beds within Rubislaw Park Nursing Home were approved for use in December 2021 for End-of-Life Care. Originally approved for a 6-month test of change by the Integration Joint Board (IJB), this contract was extended to November 2022 to allow for an evaluation to take place outlining a recommendation and for further service negotiations to take place to ensure service continuity dependent upon the outcome of the recommendations.

Methodology

In order for a robust evaluation to take place, the Steering Group and Evaluation Team co-created an approach to ensure that feedback could be taken into account from all users of the service. This centred engaging with the following key stakeholders:

- Next of kin/carers
- The Rubislaw Park team
- Hospital at Home (H@H) team
- Other staff groups who referred into the service or continued to be involved with the care of the patient.

Results

Between January and June 2022, 30 patients were admitted to Rubislaw Park for End-of-Life Care beds as funded for by ACHSCP. The bed occupancy levels during the period of the evaluation were 43.3%. The patients were referred from a variety of GP Practices across Aberdeen City.

Feedback from the patient's next of kin regarding the service received from Rubislaw Park has been positive and there was confidence in the service, patients reported to feel safe and secure knowing that there was someone there 24 hours a day and importantly, it allowed family and friends to leave their caring role and resume their role as family or friend.

The services who worked alongside the Rubislaw Park team, including H@H, Macmillan Nursing, General Practitioners (GP's) and Secondary Care referrers also reporting positively, with one respondent from the H@H survey reporting that *"The team at Rubislaw are excellent, motivated, caring and professional at all times".*

Conclusions and Recommendations

This report concludes that the service provided from the team at Rubislaw Park was well received by patients, family and carers, and staff. The need for this service is only likely to

increase with current population projections. It recommends that the service is continued with some attention paid to the following areas:

1. The environment surrounding the End-of-Life beds should be assessed
2. The Referral Pathway should be scaled up to allow referrals from all acute services to ensure that the bed base occupancy is fully utilised while ensuring that continuity of care from the Rubislaw Park and H@H team can continue.
3. Communications Plan requires to be reviewed.
4. A further evaluation to be conducted 18 months after the referral pathway has been scaled up and implemented.

Contents

1. Introduction

The population of Aberdeen City is changing, and projections show that the number of people living in Aberdeen City aged 75 and over will increase by 28.2% by 2033 (National Records Scotland, 2018). In addition, there has been a 25% increase in people living with long term conditions, and by 2035, it is estimated that 66% of adults over 65 will be living with multi morbidities (NIHR, 2018). It is expected that the number of people dying each year will increase by 16% between 2016 and 2040 (Scottish Partnership for Palliative Care, 2021). Therefore, how health and care services are planned and delivered need to be adapted accordingly.

Taking into account the population projections of Aberdeen City, it can surmised that there will be an increase in Palliative and End of Life (EOL) care needs. End of Life care can be defined as care that *"addresses the medical, social, emotional, spiritual and accommodation needs of people thought to have less than one year to live. It includes a range of health and social services and disease specific interventions as well as palliative and hospice care for those with advanced conditions who are nearing the end of life." (WHO, 2015).* Up to 50% of health and social care delivery takes place in the last year of life, with spending typically increasing in the last days of life, when care at home or in-patient bed usage is at its greatest. (Lyons, P. and Verne, J., 2011.). On average, someone in the last year of life will spend one month in secondary care, spread out over several admissions. The total cost for this is around £10,000, with inpatient admissions accounting for over 80% of this (Diernberger, K. et al, 2021). Demand across Scotland within Acute hospital settings is increasing, and this cohort of patients in particular require access to appropriate nursing care in the most appropriate location for their needs.

General trends in Scotland show that the number of deaths which occur in acute hospitals has fallen from 58% in 2004 to 50.1% in 2016 (Diernberger, K. et al, 2021). The Grampian Wide Strategy Framework for Palliative and End of Life Care (Draft) (2022) shows that in 2019, 910 deaths occurred at Acute Hospitals, which accounted for 42% of all deaths in Aberdeen City. A further 26% occurred in domiciliary locations (likely at home) and 24% happened in care/nursing homes. In addition, 164 deaths (7%) occurred at Roxburghe House. Similar figures can be found in 2020 and 2021 where 44% and 46% of patients died in acute settings. With the number of people dying in acute care reducing and the population increasing, the Rubislaw Park End of Life care beds service looks to ensure that for those people who need increased levels of nursing care on an around the clock basis which the family cannot provide, but that does not warrant acute care intervention, that there is an appropriate option within the community that supports the patient and their family.

2. Methodology

2.1 Service Model

The Palliative and End of Life Care needs of patients in Grampian can often be effectively managed by primary and secondary care resources. For those patients who remain in the community a collaborative approach across health and social care teams helps to support and meet their needs. General Practitioners (GP's), Community Nursing, Macmillan Nursing, Hospital at Home (H@H) and Care Management alongside informal carers may be involved in the provision of individualised care with input from other teams as and when needed.

A perceived a gap exists where the patient (and their support structure) requires a level of nursing care that cannot be provided at home but does not necessarily warrant admission to an acute or specialist setting. A solution was investigated which would look to alleviate the situation for carers, allowing them to resume a supportive role while providing an elevated level of nursing care for the patient. As part of the whole system pathway review, and winter surge planning, five interim beds within Rubislaw Park Nursing Home were approved for use in December 2021 for End-of-Life Care. The Nursing team at Rubislaw Park were already skilled in delivering palliative care and a small number of the Care Home nursing team had received specialised palliative care training in order to be able to set up and administer medication through syringe drivers which normally would require input from the District Nursing team. Nursing care and management resides with the nursing team within the home, and support is provided where appropriate by the Community and Out of Hours nursing team and Hospital @ Home. The beds were financed for use by ACHSCP.

The first phase of the project focused on establishing the pathway for community referrals through district nursing and general practice via H@H. In May 2022, the End-of-Life Care pathway was expanded to receiving referrals from the Acute Medical Initial Assessment and the Emergency Department (AMIA/ED) within Aberdeen Royal Infirmary (ARI), Rosewell House, MacMillan Nursing and Ward 102 - Frailty Unit, Aberdeen Royal Infirmary (ARI).

The overall ambition for the Service was to provide increased End of Life Nursing Support on a 24/7 basis for patients and their next of kin who are unable to continue living and being supported at home. This was to allow for the most appropriate care to be provided at the right time for the patient whilst also providing support to their family.

2.2 Evaluation Approach

Much of the literature around End-of-Life care focuses on the 'preferred place of death' as a measurement. This is a subjective measure, and it may change considerably over the course of the patient's pathway. It also gives no real indication of the quality of care received by the patient or the experience of the next of kin/carer (Hoare, 2022). This evaluation wanted to attempt a more holistic review of the experience of the staff, patients and next of kin/carers. In order to do this, the evaluation explored three different areas:

1. Understand the realised benefits for patients, next of kin/carers and staff
2. Understand whether the service is managed in an effective manner, regarding the business processes, communication etc.
3. Based upon the findings from Point 1 and 2 above, make an assessment and recommendation regarding the future provision of the service.

To answer this, an evaluation framework was co-created with the Steering Group to meet these needs. The following gives an overview of the main methods used to gather feedback and assess success.

2.2.1 Patient Data.

Throughout the test of change at Rubislaw Park, demographic data was collected regarding the patient's stay. The data collected was largely quantitative in nature and allowed the evaluation team to review the patient's referral criteria, geographic spread and age demographic. Due to the nature of the patient's condition at the point of entry into the service, it was deemed inappropriate to ask patients to directly take part in the evaluation process. Consent was received from the next of kin to take part in the Service Evaluation.

The following list gives an overview of the patient data captured:

- Name
- Date of Birth
- Postcode
- Scottish Index of Multiple Deprivation (SIMD*) Score
- GP Practice
- Palliative Performance Score (PPS**) upon Referral
- Referral Source
- Referral Date
- Discharge Date
- Length of Stay
- Reason for Discharge
- Next of Kin Name and Phone Number

*SIMD is the is the Scottish Government's standard approach to identifying areas of multiple deprivation in Scotland.

**PPS is a tool used for assessing a patient's functional status

2.2.3 Carer/ Next of Kin Survey

As part of the data shared with the Evaluation Team, the next of kin details were used as a means to conduct a survey to understand their experience of the service and what they perceived the patient's view of the service to be. The Rubislaw Park team informed the next of kin that a service evaluation was due to take place and asked for their consent to share these details. This meant that the data collected within was categorised as a service evaluation, meaning no ethical approval was required.

The survey was created using Microsoft Forms and the next of kin was contacted following the patients discharge and they were given the option to complete it using an online link or over the telephone during a conversation with the evaluation team. Ten questions were then asked to the next of kin relating to the service received at Rubislaw Park, whether they felt any improvements could be made and whether they would recommend the service to others. Results from the survey were gathered anonymously.

Due to the nature of the service and the individuals who were taking part in the questionnaire, input was sought from specialists in palliative care on how the questions were formulated and where appropriate, signposting was given to bereavement support resources in case the discussion evoked a strong emotional response from those involved.

Results received were a combination of qualitative and quantitative data. These were analysed using thematic analysis in order to capture key themes that were identified from feedback, and key quotes were lifted from the data where appropriate.

2.2.4 Feedback from Rubislaw Park Palliative Care Team

A Focus Group was held with three of the Nursing Team from Rubislaw Park in order to discuss whether they felt the test of change had been successful. The discussion focused on the benefits, challenges and any comments regarding the pathway and business processes surrounding it and whether they could suggest any changes to the service if it was to remain in place in the future. The information gathered was qualitative and was used to gain their perspective of the service. It was later analysed by the evaluation team using a mind map to pick out themes.

2.2.5 Feedback from the Hospital at Home (H@H) team

A questionnaire was sent to six key members of the Hospital service who work with the team at Rubislaw Park on a regular basis. They were questioned on a number of criteria including day to day communication and management, the referral process and the overall care of patients.

2.2.6 Feedback from Referrers/other Staff Groups

Feedback was sought from services who had referred patients to the service. Other services who worked closely with the patient were also contacted and asked whether they would like to take part in the evaluation. A Microsoft Form was created and tailored to each service. Responses were largely qualitative in nature and were analysed as part of the evaluation process.

3. Results

3.1 Patient Profile

Between 5th January and 30th June 2022, 30 patients were accepted into the End-of-Life Care Service at Rubislaw Park. In the majority of cases (28), clinical responsibility remained with the GP, while in 2 cases clinical responsibility was passed to H@H.

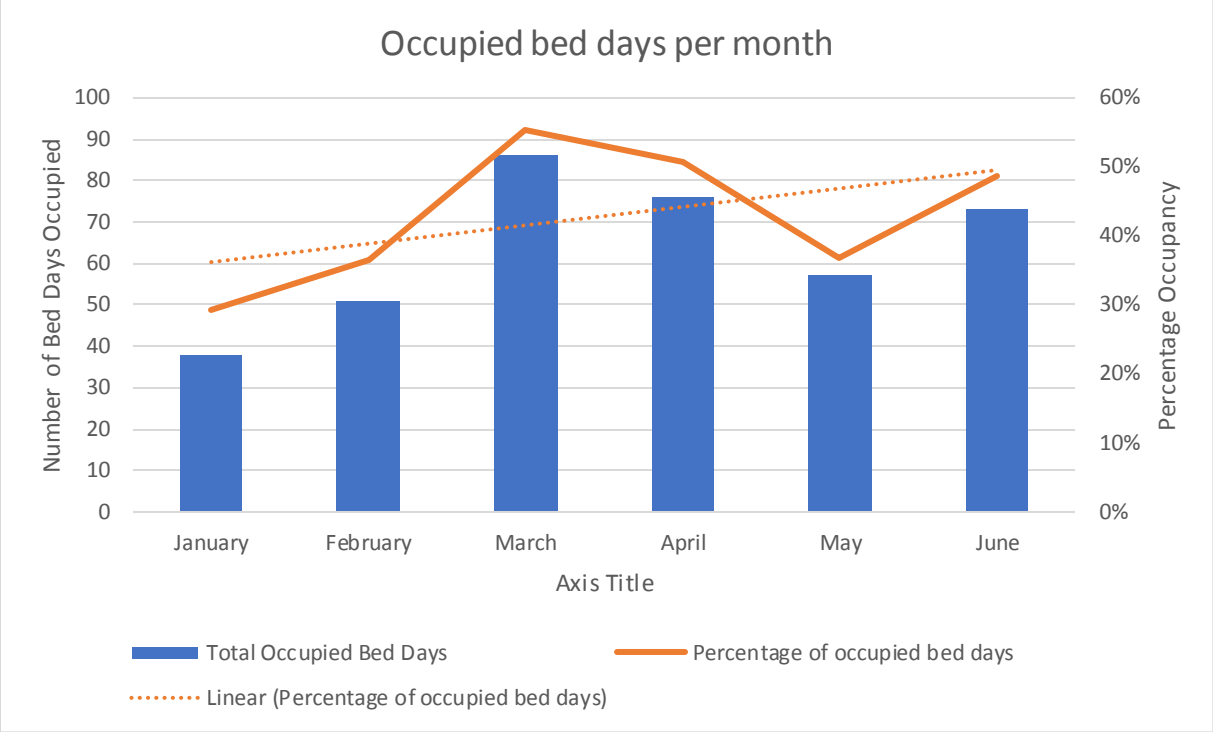
Table 1 displays the general patient characteristics.

Patient Characteristics	Total
Caseload, N	30
Gender, Male	53.3%
Age, mean [Range]	80.9 [67-97]
SIMD Scores	
1	9.7%
2	29%
3	9.7%
4	9.7%
5	29%
Not reported	13%
Palliative Performance Score (PPS), mean	31%
Days on caseload, mean [range]	12.7 [2-70]

Table 1: Profile of Patients.
Note: SIMD= Scottish index of multiple deprivation with scores from 1 (most deprived) to 5 (least deprived)

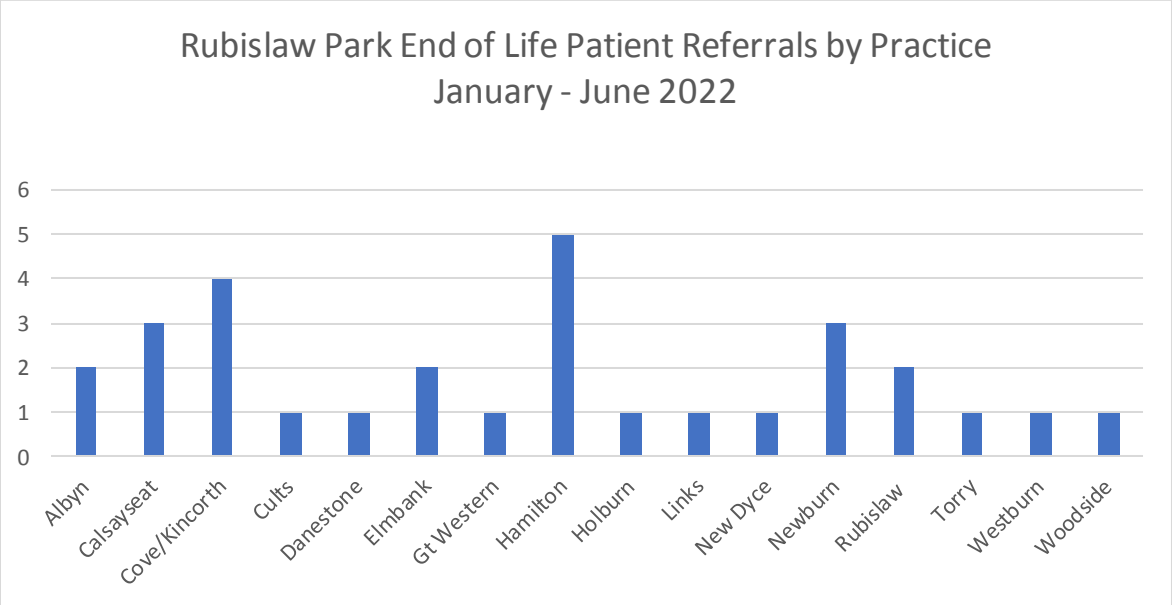
Over this period of time, the beds were occupied on 381 days out of a possible 880 bed days. This equates to the five beds having an occupancy rate of 43.3%.

Graph 1 displays bed days occupied per month alongside a line graph displaying the percentage trend of occupancy month on month. As can be seen, the occupancy of the beds fluctuated month on month with a peak of 55% bed day occupancy in March 2022. The dotted line represents the trend line throughout the evaluation period and this displays a general increase in bed days.



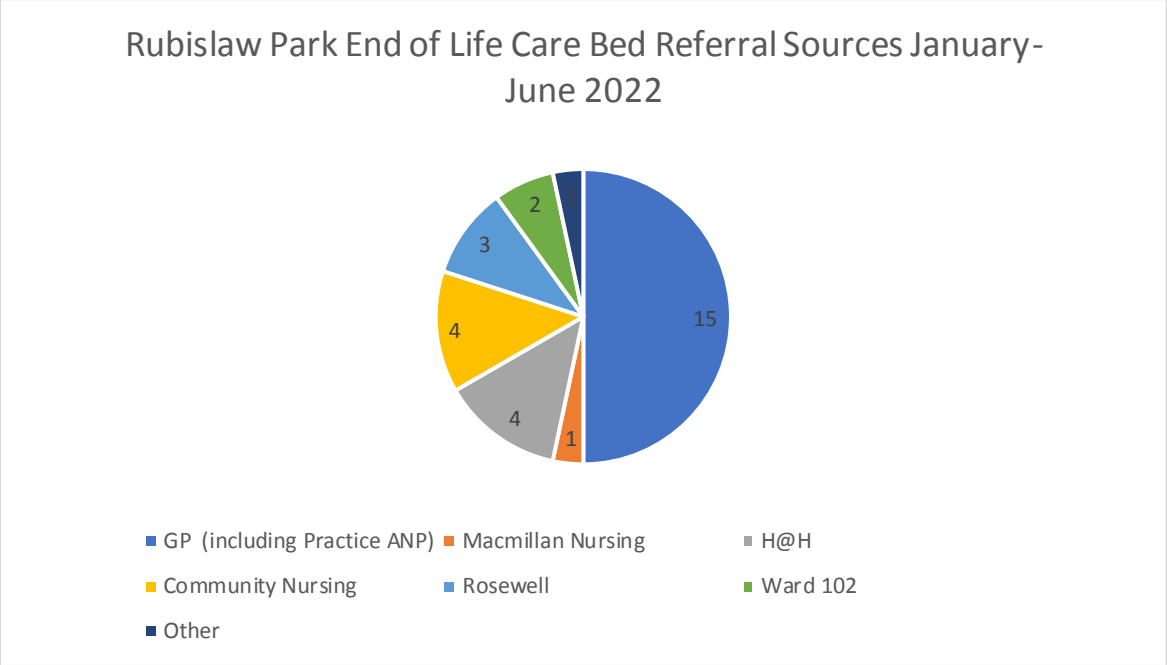
Graph 1: Bed Day occupancy by month. Total number and percentage.

All patients were residents of Aberdeen, apart from one who was transported from Blairgowrie. Looking at the geographic spread of patients and the GP Practices they were registered with, the service accommodated patients from across Aberdeen City. This is also implied from the SIMD data of the patients as displayed in Table 1 which shows that patients were referred from an equal balance of deprived and non-deprived addresses in Aberdeen City.



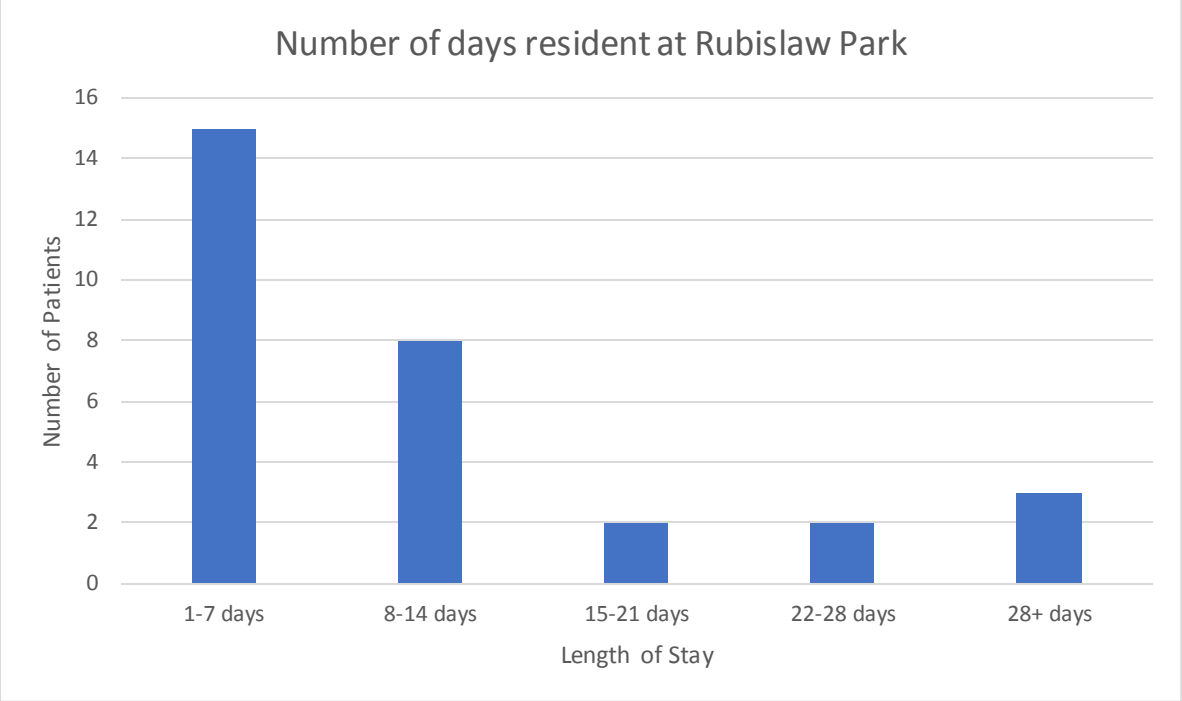
Graph 2: Patient Referrals by GP Practice

Table three demonstrates that half of patients were referred from their GP Practice. Many with input from community nursing. The pathway opened for referrals to be received from Rosewell and Ward 102 in May 2022.



Graph 3: Sources of referrals received by Rubislaw Park for End-of-Life Care beds.

Looking at patient's length of stay, half of those who were accepted for care at Rubislaw Park were resident for a week or less. The average length of stay was 12.7 days. This appears to be in line with the referring PPS score in Table 1 of 31% which would demonstrate low functional status and indicate patients referred to the service are appropriate for end-of-life care.



Graph 4: Number of days patients were resident at Rubislaw Park

3.2 Next of Kin and Carer Survey Results

The next of kin or Carer for fifteen of the patients who were cared for at Rubislaw Park were contacted by telephone and asked to take part in an evaluation. Of those contacted, eight consented and completed the questionnaire. Six interviews were carried out by the Evaluation Team over the phone, while a further two of the respondents chose to complete an online form. A full excerpt of responses from the next of kin survey can be found in Appendix 1.

The following displays the results from the survey which was conducted by the next of kin or Carer. These have been displayed according to the themes which were identified as part of the thematic analysis conducted. Below we have an indication of the quantitative results derived from the survey and some of the general comments received regarding the service.

Question	Respondents answer and percentage.
Do you feel their needs were fully met during their stay?	Yes- 88% No- 13%
Were you involved with their care as much as you would have liked?	Yes- 100% No- 0%
For those who find themselves in a similar position, would you recommend the service?	Yes- 88% No- 13%

Table 2: Next of Kin Quantitative Survey Results

"It's a great service, and I would be disappointed if it were to stop".
"The idea of the palliative care beds are brilliant"
"It was a huge relief for us all to know that he was being cared for by the team at Rubislaw Park, as it wasn't safe for him to still be at home"

3.2.1 Referral and Palliative Care provision.

The respondents were asked to provide an overview of how the patient came to need the services of Rubislaw Park. All respondents referenced a deterioration in condition combined with the support network being unable to cope with the level of care required.

Respondent number	Primary Reason for admission.
1	Lack of Support at Home to continue care
2	Patient deteriorated quickly and couldn't care for herself.
3	Deterioration in the condition at home. Needed personal care that both felt increasingly uncomfortable and challenging to provide.
4	Challenging to support at home once the patient's needs increased.
5	The patient stayed at home as long as possible. The patient had a real fear of needles and hospitals.

6	High level of palliative care required
7	Health Declined Rapidly and required additional care that we couldn't provide
8	Increasing levels of unconsciousness and the carer was finding it hard to deal with. Patient would not have wanted to go into an acute clinical setting for care.

Table 3: Primary Reasons for referrals to Rubislaw Park EoL patients, as identified by Next of Kin.

3.2.2 Impact on the Next of Kin

While the physical, emotional and spiritual needs and care of the patient was of primary importance, the respondents identified several different areas whereby the service had a positive impact on their wellbeing and not just that of the patient.

"Initially we were upset [when the patient was referred to Rubislaw Park], but there was an element of relief. We had cared for them both [next of kin's parents] for 2 years and we were exhausted."

"It allowed me to go about life as normal without…attending to [the patient]."

"A huge relief to know that [the patient] was getting round the clock care by health care professionals"

3.2.3 Service Provision and Staffing

The respondents to the survey gave generally positive reviews of the staff which they had encountered at Rubislaw Park. One respondent said, *"Everyone there was a 'true carer' rather than going through the motions",* while another stated *"[the staff were] very caring and accommodating, nothing was a problem".*

There were some concerns raised regarding communication and clarity around medication and when it would be received, however others commented that *"For the first two days I found it difficult to let go and my main concern was pain relief. By the third day I could see that they had it in hand".*

3.2.4 Rubislaw Park Environment

Comments which were received regarding the facilities in Rubislaw Park were generally positive. For example, one respondent commented on how her friend "*didn't want a clinical environment*" and that "*the staff were professional and caring rather than clinical".*

Another respondent commented "*the location of the palliative care beds within Rubislaw Park were in amongst the general rooms and often overheard staff members and service users… [I was] delighted that staff were happy at their work, however a more subdued area may have been more appropriate*.", conversely another respondent found these aspects of the environment comforting "*other people at Rubislaw Park were going about their day-to-day routine, very homely, and the dog was lovely*".

3.2.5 Processes and Regulations.

Several comments were received regarding the Covid-19 regulations that were in place at Rubislaw Park and some concerns were raised by one respondent that there were inconsistences on how some of the Covid Regulations were followed depending on the whether it was a weekday or weekend. The Covid regulations were in place for the whole Care Home and these in general were out with the control of the project, however many found these to be needlessly complicated. "W*e supported and followed the strict Covid Guidelines required of us by the Care home and the associated paperwork forms, however we did have some difficulty in filling in these forms".*

Finally, some comments were received regarding access to the facility and the entrance not always being manned *"[there was] nobody there to meet us when we got there [it was] quite traumatic having to wait".*

3.3 Rubislaw Park Staff Focus Group

On 25th April 2022, three of the Rubislaw Park team who worked closely with the patients who use the palliative care facility took part in a focus group. The results are outlined below and are presented as either a benefit, drawback, relating to the general experience and processes and whether there were any recommendations the service would make going forward it the service was to continue.

3.3.1 General Feedback and Benefits

Overall, the Rubislaw Park team reported that they had enjoyed the experience of taking part in the test of change and felt that it had made a difference to the patients and their next of kin/carer's lives and experience of death and dying. They felt that they were able to provide a service which was "*tailored to the needs of their patients*" while also helping the family or carer to fulfil their supportive role to the patient without having to worry about administering nursing or personal care, unless they wanted to.

The team at Rubislaw Park commented on how fundamental the relationship with the H@H team had been throughout the test of change. To start with there had been continuous communication between the two services and it was felt that as the relationship had developed and trust had been gained around their practices and experience that this had reduced to a manageable level for both teams.

"Interaction with the Hospital at Home team have been great, they are on the ball and responsive to our needs"

"Hospital at Home used to come out every day, but now its probably once a week unless needed or a new patient is admitted, its very positive"

The respondents felt that the service was professionally fulfilling for the team as they are already specialists in End-of-Life care. The impact of the service was also discussed in relation to Community Nursing and it was hoped that it would result in a decrease in unscheduled call outs for Community Nursing to administer break through medication and positively impact on acute admission avoidance. For the patient this would result in the removal of unnecessary delays in receiving medication.

There was general agreement from the team that they would wish for the service to continue.

3.3.2 Experience of the Referral Pathway and the associated Business Processes.

Some of the feedback generated from the focus group centred around how the participants experienced the referral pathway and the related business processes which were put in place throughout the patients stay.

The Rubislaw Park team cited frustration at the challenges around the referral process and communication. The decision for a patient to be removed from their home for end-of-life care can often be a stressful and emotional time for all involved and it was felt that there were sometimes unrealistic expectations from the family members that could have been better managed by ensuring that information packs were disseminated prior to arrival at Rubislaw Park. *"[The] patient's family had no idea what to expect, they were very derogatory about the service thinking it was a dementia unit and the patient didn't come in with any meds. We had to work hard to turn it around from there…we got a thank you card afterwards"*

There appeared to be occasional inappropriate referrals made to the service where a patient did not necessarily meet the criteria and they suspected that had these patient's been admitted that they would have required longer term nursing needs rather than end-of-life care. It was commented that during the test of change, there had been a high level of scrutiny and communication around referrals, and this would need to continue to ensure that only those who genuinely required end of life care were accepted into the facility.

Once patients had been accepted into the service, there seemed to be some confusion regarding the referrer responsibilities and who was required to arrange transport for the patient, ensure that medication was present and that a Covid test was completed prior to admission. This seems to have added unnecessary stress to both the staff, patient and their next of kin. The service commented that admissions from Rosewell House can be particularly complex.

3.3.3 Drawbacks and Limitations

Since the team at Rubislaw Park are a third party, they do not have access to any of the clinical systems (e.g. Trakcare) to record or verify any patient information. This means that they are reliant on either the H@H team, GP or the family to provide information relating to the patient and their past medical history and ongoing needs if it has not been recorded as part of the referral process. There is also reliance on the H@H team for prescribing and this relies on the H@H team being able to act upon requests in a timely manner.

Finally, many of the concerns raised by Rubislaw Park were acknowledged as 'coming with the territory' of with dealing with end-of-life patients and as a result staff members could sometimes be used as a "*natural punchbag for families*" for perceived failings of care prior to admission to Rubislaw Park.

3.3.4 Future recommendations

The staff at Rubislaw Park stated that they would like to see the service continue as they believe that it makes a substantial difference to the patient and to their families and "*Allows family to be family again*". Two recommendations were made by the Rubislaw Park staff who were interviewed as to how the service could be improved:

- The information packs are to be provided to patients/Next of Kin and Carers prior to admission. It was believed that this would help to alleviate some of the unrealistic expectations experienced.
- H@H team screen referrals and thereafter pass these to Rubislaw Park to discuss the patient directly with the referrer. H@H would provide referral decision making support if required.

3.4 Hospital at Home (H@H) Feedback

Selected members of the H@H team were sent a Microsoft Form to submit feedback, four members of staff responded. Table 4 gives an overview of these results.

Question	Respondents answer and percentage.
The Referral Process to access the End-of-Life Care beds at Rubislaw Park is easy to follow	Agree-75% Disagree-25%
The Staff at Rubislaw Park are easy to work with	Strongly Agree- 75% Neither Agree or Disagree- 25%
The Rubislaw Park team communicate well with my team	Strongly Agree- 75% Neither Agree or Disagree- 25%
The patients are well cared for and supported	Strongly Agree- 75% Not applicable- 25%

Table 4: Overview of H@H survey results

The H@H team were also asked what they believe the benefits are of having the End-of-Life Care beds at Rubislaw Park. The following shows some of the responses received:

"Beneficial to those who are alone, or have no support, or have family/friends unable to provide support for final days of life. Allows family and friends to leave the carer role and have the family/friend relationship. It's a good service!"

"Patients are cared for in a safe environment which can reduce the mental and physical distress and discomfort of the patient and family - allowing them to spend time together in their final period of life.

Rubislaw provides a higher level of care than they can receive at home but still maintains a comfortable homely environment."

When asked about areas about the service that could be improved, the comments largely centred around the referral process. One respondent suggested that the H@H team be removed from the management of patients, suggesting that this may sit better with Community Nursing. While another respondent commented upon that some of the unnecessary delays around the referral process could be due to ambulances/patient transport not being booked and Covid testing swabs not being undertaken in a timely manner.

When asked to rate their experience working with the Rubislaw Park team, respondent averaged 9 out of 10 (where 10 was the best). And one respondent commented that

"The team at Rubislaw are excellent, motivated, caring and professional at all times"

9.00 Average Rating

3.5 Referrer Feedback

As part of the evaluation process, we contacted other services who may refer into the Rubislaw Park End of Life Care Service or who may have continue to have contact with the patients during their stay. We collected responses for GP Practices (3 respondents), Acute referrers from Ward 102 and AMIA (2) and Macmillan Nursing (1). The results in Table 5 show the overall feedback from this group.

Question	Respondents answer and percentage.
The Referral Process to access the End-of-Life Care beds at Rubislaw Park is easy to follow	Strongly Agree- 20% Agree- 60% Disagree- 20%
The Staff at Rubislaw Park are easy to work with	Strongly Agree- 20% Agree- 40% Neither Agree or Disagree- 40%
The Rubislaw Park team communicate well with my team	Strongly Agree- 20% Agree- 40% Neither Agree or Disagree- 20% Disagree- 20%
The patients are well cared for and supported	Strongly Agree- 80% Neither Agree or Disagree- 25%

Table 5: Overview of Staff group's survey results.

"A really useful resource and they have provided excellent care for several of our palliative patients with the help of the H@H team also. Feedback from relatives has been universally positive. A useful additional resource to Roxburgh and essential for our increasingly frail elderly population where access to social care can be very difficult." And that

"I think this has been a fantastic initiative and should be continued if not expanded!"

"An excellent facility, much needed in the community. Found to be best place of care for end of life for those patients known to our Macmillan team who have been admitted."

4. Discussion

By utilising the original questions and statements set out in section 2.2, the results can be discussed and assessed whether these have been met to a satisfactory level.

4.1 Understand the realised benefits for patients, next of kin/carers and staff.

This section is broken down into the benefits highlighted throughout the evaluation pertaining to each perspective.

4.1.1 Patient Perspective.

The project set out to provide an equitable service for the whole of Aberdeen City. The SIMD data provided in Table 1 and the spread of GP Practices found in Graph 2 appears to support this. As can be seen in Table 2, we can conclude that on the whole the largest proportion of respondents indicated that the needs of the patients were fully met and comments supplied by the Next of Kin appears to support this with many suggesting that the patient was relaxed and peaceful after admission with the knowledge that someone would be there throughout the day and night and that they would not be alone. This supports the notion of an increase in care to a 24/7 service compared with a community service input while the patient was cared for in their home.

Looking at Table 3 regarding the primary reason for referral, the Next of Kin has identified that it is the combination of increased nursing care and decreased ability from the Next of Kin to provide this which led to the patient's admission. This appears to be in line with the intention of the service to provide a service for patients who required increased nursing care which their next of kin was unable to support them with and therefore were unable to continue being cared for at home. This information may also be useful going forward for promotion of the service to patients, their next of kin and to colleagues.

4.1.2 Staff perspective

Looking at the results in Table 4 and 5, we can see that from those who responded, 80% of staff and 75% of H@H staff believe that patients were well cared for and supported. There also appears to be evidence from the feedback received that the service can *"reduce the mental and physical and distress and discomfort of the patient and family, allowing them to spend time together".*

4.1.3 Next of Kin/Carer Perspective

The Next of Kin/Carers who were approached appear to feel well supported in their role and as Table 2 shows, 100% of respondents said that they were involved with their care as much as they would like. Respondents also demonstrated the impact that the support of the

Rubislaw Park team had on enabling them to resume their role as family member or friend with many mentioning an element of relief upon admission.

There were some concerns raised around the building facilities and location of the beds. Some of these comments were regarding Covid 19 restrictions, and although these have been taken on board, it would be hoped that these are not longstanding due to the continuing lifting of many restrictions. Other comments regarding the location of the rooms within Rubislaw Park are a little more difficult to act upon. The rooms are near each other, but Rubislaw Park are unable to provide a separate wing of the building for only this purpose therefore even if the rooms were moved to a different area, the care home, its staff and residents would still be part of the environment.

Ultimately, 85% of respondents agreed that they would recommend the service to others that found themselves in a similar situation and The Hospital at Home team also rated the experience of working with the Rubislaw Park team as 9 out of 10.

4.2 Understand whether the service is managed in an effective manner, regarding the business processes, communication etc.

From the feedback provided as part of the evaluation, three main themes appeared:

1. Communication
2. Referral Pathway
3. Bed Base Occupancy

Each of these will be discussed in turn.

4.2.1 Communication

The concerns raised regarding communication relates to external communications with the patient and Next of Kin about the service. It was suggested that further communication from the outset may have helped manage the expectations of the service. There could be a variety of reasons for this, such as being a newly established service and other staff's uncertainty about what the service provides or where to locate the pertinent Patient Information Leaflet to pass across to patient's and their Next of Kin/carers. Certainly, if the service was to continue, a robust Communications Plan would require to be formulated in order to ensure that the effect on this on the service could be reduced.

4.2.2 Referral Pathway

In line with the introduction of a new referral pathway, there were several challenges highlighted from the feedback received. Some carers and next of kin raised the challenges of getting referred, or only particular people being aware of the service. The Rubislaw Park and H@H teams mentioned the uncertainty and impact upon referral and admission of who was responsible for providing patient transport, medication and Covid testing. Feedback from the Macmillan team added that changes to the referral protocol in May when it was opened up to Ward 102 and AMIA may have added to this confusion. Despite these challenges, it appears that the referral pathway in place and the rigorous process in place from the H@H team appears to have assisted in ensuring that the service is used only by those who are effectively in the last few days of life. This is demonstrated by the PPS score in Table 1 and the Length of Stay in Graph 3. Interestingly, the average length of stay is 12.7 days which is also in line with the average Length of Stay in Roxburghe House in 2021 (Roxburghe House is a specialist palliative care unit in Aberdeen) the similarity of the figures here help to demonstrate the appropriateness of the referrals received.

In order for the service to continue or expand, the referral protocol should be reviewed and effectively communicated to referrers and their teams in order to gain clarity over the situation. Risks over service provision where key members of staff are on leave or leave employment should also be taken into consideration so that consistency of care and referral pathways can be assured.

4.2.3 Bed Base Capacity

In Graph 1, the occupied bed base figures per month are displayed with an average of 43.3% occupancy over the evaluation period. There were occasions where all five beds were in use. Prior to the service commencing, there was no real indication on what the need for the service would be. We can see that there is a general upward trend in Graph 1 so it may be the case that the complications over the referral pathway is having an impact on those referred, or that there is still some uncertainty as to who the referral pathway is available for and that this is having an impact on the occupancy levels. If a decision was taken to open these beds to other patients who are not end-of-life, then there would be a risk of patients who have longer term continuing care needs utilising the provision and there would be an inability for those genuinely in need of the service to access it.

Looking at the population data for Aberdeen City, as outlined in the introduction to this evaluation, the need for palliative care support across the city is likely to increase over the next two decades. It was suggested by feedback provided by GP practices that the service should be opened to other acute services rather than only Ward 102, AMIA and Rosewell. This may increase the bed base occupancy rates and give a true reflection of the service need while also reserving these beds for those truly in need of the service. Optimal Bed Base occupancy is generally considered to be between 80-85%, however some literature points towards 45% for smaller hospitals (Ravagi et al, 2020), so it may be the case that the

Steering Group need to review the occupancy levels and consider what is appropriate for the service and for the delivery teams involved.

4.3 An assessment and recommendation regarding the future provision of the service

The population projections outlined in the introduction demonstrates that in order to meet our future needs, there is a need to look at options for end-of-life care that is outside of the traditional models of either home or hospital. The evaluation of the Rubislaw Park service looked to ascertain whether this model met its original intentions, and whether a recommendation could be made to continue the service.

From the information collected for this evaluation, it can be concluded that the service met the needs of the patients and their next of kin/carer's, and on this basis it is recommended that the service is to continue. However, it was also expected that the service would have an impact upon admission avoidance, and that it would lessen the impact on community services with regards to unscheduled call outs to give breakthrough medication etc. While this is likely the case, it has been challenging to obtain and make judgement on the service's impact upon these areas. This has been due to the small numbers involved in the service up to this point and the difficulty in obtaining data which can truly reflect the impact upon community services. Going forward, it would be beneficial to take this into account so that data can be collected and measured on these factors to make this assessment more robust.

5. Conclusions and Recommendations

The evaluation of the Rubislaw Park end-of-life care beds has highlighted the positive impact that the service has had on the patient and their next of kin/carer's wellbeing. Staff and the patient's next of kin confirmed that it allows them to resume the role of family or friend rather than the primary care giver and as such provide an important emotional role to the patient as part of their end-of-life Care.

The evaluation concludes that the service provision at Rubislaw Park appears to satisfy its original intention to provide a service to those patients who have increased end-of-life care needs beyond the capacity for their support network to provide but does not require specialist intervention. The evaluation has also found that in order for the service to continue its success and to operate at capacity that a number of recommendations are being made:

1. Attention to the environment surrounding the End-of-Life beds should be assessed, for example whether the beds could be located in a separate area or separated from the general goings on of the larger care home environment.
2. The Referral Pathway should be scaled up to allow referrals from all acute services to ensure that the bed base occupancy is fully utilised to an appropriate level while also ensuring that continuity of care from the Rubislaw Park and H@H team can continue.
3. Communications Plan requires to be reviewed. Work to enhance the current level of communication needs to take place, including
    a. Publicising the service,
    b. Setting expectations for patients, their family members and/or carers.
    c. Internal communications between services regarding the referral processes and for those admitting patients, what needs to be in place (for example transport, medication etc upon arrival.)
4. A further evaluation should be conducted 18months after the scaled up service is established. This would allow for bed base occupancy trends to be reviewed and monitored over a period of time. The impact on the Community Teams (Community Nursing, social work etc) should also be reviewed as part of this further evaluation alongside an assessment on admission avoidance.

Finally, based upon this evaluation and its recommendations, a business case should be developed and presented to the Aberdeen City Integration Joint Board outlining the case for the service to continue.

References

Diernberger, K et al., 2021. Healthcare use and costs in the last year of life: a national population data linkage study. BMJ Supportive & Palliative Care 2021: 0: 1-8.

Hoare, S et al., 2022. End of life Care Quality Measures: beyond place of death. BMJ Supportive & Palliative Care 2022:0:pp1-9

Lyons, P. and Verne, J., 2011. Pattern of hospital admission in the final year of life. BMJ supportive & palliative care, 1(1), pp.81-82.

National Records Scotland (2018), Population projection for Scottish Areas. Available from: Projected Population of Scotland (2018-based) | National Records of Scotland (nrscotland.gov.uk). Accessed 11th July 2022.

National Institute for Health and Care Research., 2018. Multi-morbidity to increase in the UK over the next 20 years. https://evidence.nihr.ac.uk/alert/multi-morbidity-predicted-to-increase-in-the-uk-over-the-next-20-years/

NHS Grampian 2022. Grampian Wide Strategic Framework for Palliative and End of Life Care (Draft).

Ravaghi, H., Alidoost, S., Mannion, R. *et al.* Models and methods for determining the optimal number of beds in hospitals and regions: a systematic scoping review. *BMC Health Serv Res* **20**, 186 (2020). https://doi.org/10.1186/s12913-020-5023-z

Scottish Partnership for Palliative Care., 2021. Every Story's Ending: Proposals to improving people's experiences of living with serious illness, dying and bereavement in Scotland. Available from: Every-Storys-Ending.pdf(palliativecarescotland.org.uk). Accessed 10th August 2021

WHO (2015) Palliative Care. Available from: Palliative care (who.int) Accessed 11th July 2022.

Appendix 1- Next of Kin/Carer Feedback

The following displays the qualitative next of kin or Carer feedback received as part of the evaluation. The feedback collected as part of the evaluation was done so anonymously, so where any ambiguity remains in the feedback, this has changed to non-gender specific referencing where appropriate to ensure that anonymity remains. Any added text which has been added to increase readability has been surrounded by brackets []. On a couple of occasions, text has been redacted completely where a patient's specific diagnosis was discussed or where specifics regarding a patient has been mentioned which may jeopardise their anonymity.

	Tell me about your experience and interactions with Rubislaw Park?
1	*I can't really fault it. Staff were really good. One concern continuity at the door - not checking if you did your covid test. Constantly had telephone to get someone down from the ward to come down. Continuity at front of house would be helpful. No continuity in terms of PPE what they had to wear.*
2	*[Patient] went in on Tuesday and died on Thursday. The two nurses who we seen were very nice are caring and said that it was a pity they didn't get a chance to know her better. Nothing was ever a problem for them and all the staff were very polite.*
3	*Very good interactions with all staff. [The patient] was in for 2 weeks*
4	*Everyone was lovely*
5	*taken in on Saturday after [the patient] was set up with a Morphine Pump on Thursday. Initially staff were brilliant. However, went up on Sunday and we didn't see anyone, [the patient] was very agitated. It took the staff 20minutes to answer the buzzer and 40 mins to come back with break through meds. On Monday [the patient] was agitated again and although [the patient] was drugged up [the patient] knew they needed the toilet and was trying to get up. The nurse came in and said that [the patient] was wearing a pad and that [the patient] could just let it go. In the end [the patient's family] helped [the patient] use a bed pan. no one came to see if the pad needed changed. [The patient] died on Tuesday and the nurse that day was brilliant and very attentive.*
6	*Our experience was very good with all concerned at Rubislaw especially how Fiona and her team dealt with the situation.*
7	*As a family we had both positive and negative experiences / interactions with the Rubislaw Park team.* *[The patient] was picked up by Ambulance [redacted] from [the patient's] home, it was the morning of [redacted] and there was a lot of snow, making it difficult for driving. I realised that they hadn't taken his emergency medication that had been issued the day before including the sedative Midazolam*

with [the patient]. I phoned the care home, they said they would greatly appreciate it, if we could drop it off. Which we did, we didn't visit dad that day.
I then got a phone call from the Care Home asking if we could bring in all his other prescribed medication including [redacted], which we did the following day (Saturday).

On our first visit on Saturday 19th February, we were surprised to see a can of coke , a cookie and a glass of orange juice on dad's tray table. [The patient] had an extensive oropharyngeal carcinoma and had difficulty swallowing, [the patient] had stopped eating food earlier in the week, and we wondered if the staff were fully aware of [the patient's] condition.
[The patient] was tossing and turning in [their] bed trying to sleep during our visit, but was laying very close to the edge, [the patient's family] who was visiting, informed the duty RGN [nurse] that [they] were worried [the patient] would fall out of the bed. [the nurse] came into the room put on the light and in a loud voice she asked [the patient] to move over the bed which disturbed [the patient].
Later that evening, I received a phone call from [the nurse] to say that [the patient] had fallen out of bed. [the nurse] said that they didn't want to put the sides of the bed up, in case [the patient] got [their] leg stuck through it.

[redacted] *We all followed the Covid Protocol as required by Rubislaw Park Care Home, [the patients family] was asked to fill in a set of 4 forms for [their] visit.*
It was a pleasant visit. [The patient] had been shaved and although very tired , [the patient] did communicate with us for a short while. We brought in some straws to enable [the patient] to drink and also [the patient's] supply of [redacted] drinks.
[The patients family] handed them over to the duty RGN and asked her what medication he was getting and was told [the patient] was getting [redacted], no mention of [redacted] or anything else.

On Monday 21st February, [the patient's family] phoned Rubislaw Park and spoke with the care home manager to check with her that [the patient] was definitely in for Palliative Care and not Respite Care. [The patients family] was assured that he was in for Palliative Care and that the staff would know when the time was right to administer [redacted].
[The patients family] informed the manager that she would be visiting dad later on in the afternoon.

When they arrived at Rubislaw Park Care Home, they were asked to wait outside in the cold by the receptionist while other visitors complete the required paperwork forms. There was an issue in filling out the forms and [a family member] who has dementia, has very little patience and was moaning about the time it was taking. [A patients family member] was taken aside by the manager and given a bit of a talking to in her office.
[The patient] was very poorly, it was a very distressing visit for them both.

On Tuesday 22nd February, I got a call @ 8.10 am from [the nurse] RGN to say [the patient] had taken a turn for the worse and we should get there ASAP, I then got another call from her to say [the patient] passed away @ 8.56am.

	We arrived at 11.30am to say our final goodbyes, again we filled out the required paperwork forms , pretty dismayed that we were given the " The Visitor Feedback Form" to fill in even although we'd told the receptionist that our [family member] had died. *[The nurse] was very kind to us and showed us to [the patient's] room, we were taken aback to see him lying there with [their] eyes and mouth open, again it was very distressing, we didn't expect that. We packed up all [the patients] things there and then and left.* *The care assistants were extremely pleasant and helpful.*
8	*First impression was that it was a homely environment that was really friendly. The staff were efficient, professional and friendly. [The patient] had a quick admission which we were really grateful for.*

What led to their admission to Rubislaw Park rather than being cared for at home?	
1	*Husband died during covid. No family. Diagnosed with cancer pre christmas, battle with care management to get her into care. No availability for care at home. Very grateful for care @ home. No receipt of care before that - in sheltered housing before that through Bon Accord Care.*
2	*Patient deteriorated quickly and couldn't care for herself and kept falling out of bed [The patient] dreaded going to sleep as [the patient] was by herself. Seemed like [the patient] relaxed once she went into Rubislaw Park and went to sleep.*
3	*Deterioration in the condition at home. Needed personal care that both felt increasingly uncomfortable and challenging to provide.*
4	*[The patient's spouse] died 16weeks before [The patient]. [The patient] had their lung drained regularly but quite quickly went downhill after [The patient's spouse] died and took to [their] bed. Thereafter needed a lot of personal care. Was already in sheltered housing. [another family member] went to Rosewell unit and expected Rubislaw to be a similar place and for him to get more medical attention to build him up again.*
5	*[The patient] stayed at home as long as possible. [The patient] had a real fear of needles and hospitals. [The patient] was also an alcoholic.*
6	*[The patient] required a high level of palliative care which Rubislaw were well placed to provide.*
7	*[The patient's] health declined rapidly in [the patient's] last week of life and although [the patient] had originally stated that [they] wanted to be cared for at home, [the patient] became so weak, and was unable to walk that [the patient] changed [their]*

	mind and wished to be admitted to hospital. There were no available beds at Roxburghe House, and they advised us against a hospital admission for Palliative care, so the Macmillan Nurse and GP arranged for [the patient] to be admitted to Rubislaw Park Care Home the next day on [redacted]. The Rubislaw Park Care Home was out with the area covered by [redacted] GP Practice, so we were informed he was being cared for by the Hospital at Home Team.
8	*Increasing levels of unconsciousness and I was finding it hard to deal with. Rubislaw Park was recommended to us. I knew that [the patient] wouldn't want to go into a clinical environment, [the patient] was at Roxburghe for treatment and didn't want to go back there as it was too clinical. I liked that I could come and go and be there as much I as I liked. [The patient] was unconscious throughout their stay.*

Please add any further comments (relating to whether their needs were fully met during their stay).	
1	*[The patient] said they were lovely "more than accommodating than what [the patient] wanted"*
2	*[The patient's] admission allowed [the patient] to relax in a way [they] couldn't at home.*
3	*From a nursing perspective, always seemed that [the patient's] needs were met. We were there every day from 9am-evening and always attentive*
4	*Only drained lung once which was a surprise, however not a complaint just wasn't sure why it wasn't done more often*
5	*We didn't feel that [the patient] had dignity up until the end. We considered supplying feedback but just wanted to draw a line under it*
6	*The main purpose of keeping [the patient] comfortable and pain free was achieved throughout [the patient's] final days.*
7	*Found it difficult to answer yes but couldn't answer no as unsure what other care /treatment he could have been offered*
8	*Asked if there was anything more they could do or I would want to do. For the first two days I found it difficult to let go and my main concern was pain relief. By the third day I could see that they had it in hand*

What do you think they valued the most about the support the Rubislaw Park team provided?

1	*the staff - very attentive. originally questioned whether [the patient] made the right decision but thought it feels quite nice.*
2	*Knowing there was someone there during the night.*
3	*Overnight personal care*
4	*[The patient] was an easy going character and they treated [the patient] as a person. Everyone there was a 'true carer' rather than going through the motions.*
5	*[The patient] was terrified of dying on [their] own so it provided comfort that there was someone near by at all times. It was also a more comfortable surrounding for us as [the patient] had sold a lot of his belongings.*
6	*Because of [the patient's] condition [the patient] probably couldn't appreciate the care [they were] getting although it was clear to us.*
7	*[The patient] realised that [they] couldn't be cared for at home as [a family member] has multiple health issues and was unable to look after [the patient] at home. It was very distressing for them both. On [the patient's] last evening spent in their home, as [the patient] had been catheterised and kept trying to get up to the toilet and ended up falling several times. [The patient] would have valued having round the clock care, professionals on hand to help [them] and not be causing [another family member] any further worry.*
8	*The staff were professional and caring rather than clinical. [The patient] didn't want a clinical environment.*

Please add any further comments (about whether you were involved in their care as much as you would have liked).	
1	*Had doubts originally about [the patient] going in, had some negative feedback originally. staff very welcoming.*
2	*we had lots of contact with the team*
3	*Allowed to be involved as much as we liked. Made clear by [the nurse] who asked a few times whether there was anything else we would like to do*

4	*Lateral flow on admission was a little frustrating as just wanted to get in and see [the patient]*
5	*Had more involvement than perhaps wanted at times. The nurse on Sunday was very respectful towards us and him at the end*
6	*The team were always receptive to my requests if I felt was requiring further medication to ease pain and they would take time out to explain various points regards treatment.*
7	No Comment Made
8	*I still felt in charge and involved*

How did their admission to Rubislaw Park impact on you?	
1	*negative initially because [the patient] didnt want [them] to go in. changed when [the patient] met the care staff, very caring and accommodating, nothing was a problem. "cant fault them"*
2	*It was a relief that [the patient] had someone there 24/7*
3	*Positive impact. We had a system at home where [the patient] would call through if [they] needed my help, however i often felt a dread on what I would find. Increasingly both felt uncomfortable at providing personal care. We were aware that there would be an increased time dependency on us travelling to see [the patient] at Rubislaw Park, however happy to take that decision so that [the patient's] needs could be met*
4	*Initially we were upset, but there was an element of relief. We had cared for them both for 2 years and were exhausted.*
5	*Relief to us to have someone there.*
6	*It allowed me to go about life as normal without the added burden to attending to [my family member].*
7	*[the patient] was only in Rubislaw Park Care Home for 4 days, so it didn't have much of an impact on my health and well being apart from it being a huge relief to know that [the patient] was getting round the clock care by health care professionals. We had come to the conclusion that [the patient] couldn't continue being looked after at home, it just wasn't feasible anymore.*

	As a family, we'd tried very hard to keep our parent's together for as long as possible. *Since [the patient's] diagnosis* [redacted] *we had supported our parents. We followed up on medical appointments, ordered medication, arranged for social care help in their sheltered home, applied for attendance allowance for him via Macmillan Support (much later than he was entitled to it, as we weren't made aware to apply for it), contacted district nurses, doctors, pharmacists and the Macmillan Nurse(s), did their shopping, cooked meals for them, bought items to make life more comfortable for [the patient], made frequent visits to their home, everything we possibly could do to help.* *[the patient], loved [their] life and didn't want to give it up, miraculously [the patient] made it to* [redacted] *birthday in November, saw Christmas and New Year, [a family member's] birthday at the beginning of February but it just got too much to bear and [the patient] deteriorated quite rapidly in the end.* *[The patient's] last week at home was putting a huge strain on the family, especially on the Thursday night before his admission to Rubislaw Park Care Home the next day.*
8	*Relief. All the care/decisions were not only mine anymore. It was a different atmosphere there, it wasn't morbid other people at Rubislaw Park were going about their day to day routine, very homely. and the dog was lovely.*

How do you think the service could be improved?	
1	*only allowed one visitor. feedback about needing to change before going to visit (was wearing care equipment).*
2	*The patient was there for 2 days, so not sure it was enough time to really comment on anything*
3	*It took a lot to try and get [the patient] into palliative care facility and the DN needed to be quite forceful in order for [the patient] to be taken in, although understand that other facilities (e.g. roxburghe) were full at the time. It was a very stressful time for the whole family.*
4	*[the patient] was there a week, so don't think we were there long enough to comment on anything*
5	*Overall great service. Staff had their hands full and the general environment was great*
6	*Very difficult to say how it could be improved as it appeared faultless to us.*

7	*Patient safety is a concern and I certainly think better communication from the Nursing staff to the family would help improve the service.* *To hear that [the patient] fell out of [their] bed on the Saturday evening after [a family member] had flagged it up with the RGN as a potential issue, was not satisfactory. If permission from the family was needed to raise the sides of the his bed to prevent this, why was it not asked for on the Saturday?, when it was asked for on the Monday by another RGN. The reception staff might benefit from some training in how to deal with family visiting Palliative Care patients. We didn't feel it was appropriate to be given a visitor feedback form to fill in, on the morning [the patient] had died when we had already informed her that he had just passed away. Of course we supported and followed the strict Covid Guidelines required of us by the Care home and the associated paperwork forms, however we did have some difficulty in filling in these forms.* *The first 2 forms were very straightforward, visitor details ,name address, contact telephone number, tick box Yes/No answers and a box to record your temperature reading taken from the digital thermometer at the entrance. The third form headed with ??GCC Logo was poorly set out and difficult to know how to answer some of the statement/questions. There was a small box at the LHS of the each statement/ question , was unsure if we had to tick it or write a response. We asked the receptionist for some guidance as to what was expected and she asked another member of staff, who told us it was mandatory for us to fill it in. Not very helpful. We weren't refusing to fill it in, just wanted some guidance. Staff could possibly benefit from some training in helping visitors fill in forms.* *The fourth form was the visitor feed back form.The last issue, would be, continuity concerning face coverings and hand sanitising. Saturday Visit - Entered the reception area and into the main care home accompanied by the duty RGN , wearing a face covering, sanitised hands using the alcohol gel provided.* *Sunday Visit - same as above* *Monday Visit - The visitors were told by the receptionist and manager to go to the toilet , take off their old masks, wash their hands, put on fresh masks and then sanitise their hands. If Monday's procedure is the correct method, then the weekend staff should also insist that visitors follow that.*
8	*nothing I can think of*

Do you have any other comments you would like to make?	
1	*nobody there to meet us when we got there - quite traumatic having to wait. the staff there genuinely did care and didnt just go through the motions.*
2	*Going in the door there wasn't always someone there, however wasn't a big issue, it just meant waiting a couple minutes*

3	*Nothing additional to add*
4	*[The patient] was there a week, so dont think we were there long enough to comment on anything else*
5	*The idea of the palliative care beds are brilliant. Only found out about these from his care worker. However, we were disappointed in how they attended to [the patient's] personal care.*
6	*Our first contact was [a nurse] and she gave us comfort from outset that my mother would receive excellent care in her final day. All the team were very obliging when we visited and presented a friendly and concerning image which again helped us through this sad period.*
7	*It was a huge relief for us all to know that [the patient] was being cared for by the team at Rubislaw Park, as it wasn't safe for [the patient] to still be at home. However we did expect [the patient] to be a bit more sedated / comfortable than [they] were on our visits, [the patient] was very restless on the Saturday, and on the Sunday [the patient] was saying [they] had a sore belly, we didn't expect [the patient] to be complaining of any pain whatsoever.*
8	*It's a great service, and I would be disappointed if it were to stop.*