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Aberdeen City Health & Social Care Partnership
A caring partnership

To: Members of the Integration Joint Board

Town House,
ABERDEEN 18 April 2023

INTEGRATION JOINT BOARD

The Members of the **INTEGRATION JOINT BOARD** are requested to meet in **Room 5 - Health Village on TUESDAY, 25 APRIL 2023 at 10.00 am. This is a hybrid meeting and Members may also attend remotely.**

JENNI LAWSON
INTERIM CHIEF OFFICER – GOVERNANCE (LEGAL)

B U S I N E S S

1.1 Welcome from the Chair

DECLARATIONS OF INTEREST OR TRANSPARENCY STATEMENTS

2.1 Members are requested to intimate any declarations of interest or transparency statements

DETERMINATION OF EXEMPT BUSINESS

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

STANDING ITEMS

4.1 Video Presentation

4.2 Minute of Board Meeting of 31 January 2023 (Pages 5 - 12)

4.3 Draft Minute of Risk, Audit and Performance Committee of 28 February 2023 (Pages 13 - 18)

4.4 Draft Minute of Clinical and Care Governance Committee of 21 February 2023 (Pages 19 - 24)

4.5 Business Planner (Pages 25 - 26)

4.6 Seminar and Workshops Planner (Pages 27 - 28)

4.7 Chief Officer's Report - HSCP.23.036 - late paper, to follow

GOVERNANCE

5.1 IJB Scheme of Governance Annual Review - HSCP.23.023 (Pages 29 - 206)

PERFORMANCE AND FINANCE

6.1 Annual Resilience report - HSCP.23.021 (Pages 207 - 216)

6.2 Equality Outcomes and Mainstreaming Framework - HSCP.23.024 (Pages 217 - 258)

6.3 Hosted Services - HSCP.23.025 (Pages 259 - 308)

6.4 Supplementary Procurement Work Plan (Social Care) for 2023/24 - HSCP.23.018 (Pages 309 - 320)

Please note there are exempt appendices contained within the Private Section of this agenda below.

STRATEGY

7.1 Creating Hope Together: Scotland's Suicide Prevention Strategy and Action Plan - HSCP.23.019 (Pages 321 - 338)

7.2 Prevention and Early Intervention - HSCP.23.026 (Pages 339 - 368)

TRANSFORMATION

8.1 Community Nursing Digitalisation - Morse - HSCP.23.022 (Pages 369 - 402)

ITEMS THE BOARD MAY WISH TO CONSIDER IN PRIVATE

9.1 Supplementary Procurement Work Plan (Social Care) for 2023/24 - HSCP.23.018 - Exempt Appendices (Pages 403 - 410)

DATE OF NEXT MEETING

10.1 6 June 2023

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

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

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Aberdeen City Health & Social Care Partnership
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ABERDEEN, 31 January 2023. Minute of Meeting of the INTEGRATION JOINT BOARD.

Present:- Luan Grugeon, Chair; Councillor Cooke, Vice Chair; and Councillor Christian Allard, June Brown, Kim Cruttenden, Councillor Martin Greig, Mike Adams, Steven Close, Jenny Gibb, Maggie Hepburn, Dr Caroline Howarth, Phil Mackie, Sandra MacLeod, Brenda Massie (as a substitute for Jim Currie), Paul Mitchell, Alison Murray and Graeme Simpson.

Also in attendance:- Martin Allan, Caroline Anderson (for Article 15), Jess Anderson, Gale Beattie, Fraser Bell, Matthew Carter (for Article 10), Kay Diack, Susie Downie, Stella Evans, Councillor Lee Fairfull, Vicki Johnstone, Catherine King (for Article 11), Stuart Lamberton, Graham Lawther, Stephen Main (for Article 15), Alison Macleod, Shona Omand-Smith, Sandy Reid, Amy Richert, Neil Stephenson (for Article 11), Denise Thomson, Councillor Kairin van Sweeden and Claire Wilson.

Apologies:- Councillor Deena Tissera, Jim Currie, Shona McFarlane and Angela Scott.

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. She acknowledged the current increased pressures and demand in the health and care system across the north east and the country as a whole.

The Chair reported that by building on the delivery of the IJB Strategic Plan, ACHSCP colleagues were bringing a renewed focus on the task of increasing capacity in the system, with initiatives (1) to ensure that wherever possible the health and care needs of residents were met at the earliest opportunity to prevent people from becoming acutely ill and requiring inpatient hospital treatment; (2) discharging people from hospital to an appropriate setting as soon as was appropriate; and (3) freeing up capacity in hospital settings by introducing additional interim beds in care homes. The Chair noted that early indications were that these initiatives were making a positive difference and she expressed her thanks to all staff across the health and social care system for continuing to meet the challenges nearly three years after the start of the pandemic.

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The Chair advised that teams were continuing to listen to colleagues and service users to respond to concerns to coordinate efforts with partners, to enhance communications with the public and to capture the learnings from the experience. She stated that doing this would ensure we come out of this difficult period with important learnings and actions which would strengthen our system for the months and years ahead and help build a more sustainable health and care system.

The Chair noted that agenda items of the Carers' Strategy, Annual Procurement Workplan and Grant Funding arrangements were important elements of how to build that sustainable system which was community focused and informed by experience to date, the views of local people and staff.

The Board resolved:-
to note the Chair's remarks.

DECLARATIONS OF INTEREST OR 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 Maggie Hepburn advised that she had a connection in relation to agenda item 6.2 (Grant Funding Arrangements) as she was Chief Executive of the Aberdeen Council of Voluntary Organisations (ACVO), however, having applied the objective test she did not consider that her connection amounted to an interest which would prevent her from remaining for the item but she would not take part in the discussion on the item; and
(ii) to note that Alison Murray advised that she had a connection in relation to agenda item 5.1 (Carers' Strategy) as she was a Carer Representative to the IJB, however, having applied the objective test she did not consider that her connection amounted to an interest which would prevent her from participating in the discussion on the item.

EXEMPT BUSINESS

3. The Chair indicated that item 6.1 Annual Procurement Workplan - HSCP.23.002, item 6.2 Grant Funding Arrangements – HSCP.23.005 and item 7.3 Aberdeen City Vaccination Centre – HSCP.23.007 contained exempt information and therefore it was recommended that they be considered in private.

The Board resolved:-

to consider the exempt sections of items 6.1 and 6.2 and the full report at item 7.3 with the press and public excluded.

VIDEO PRESENTATION

4. The Board received a video presentation entitled 'Get Active @Sheddocksley Renovation' which had been filmed following the redevelopment of the venue and highlighted the role sport and physical activity could play in supporting good mental and physical health. The clip showed the collaborative work going on and the impact it was having on communities, contributing to the IJB's shared preventative and rehabilitation agenda.

The Chair reported that the Health and Social Care Partnership was looking to work with Sport Aberdeen to extend the work in the video with a test of change at Sport Aberdeen's new facility in Northfield, where the initiative created a health and social care community hub called Get Active @Northfield which included access to community space it was hoped to support local people to continue to improve their health through sustained physical activity. Members would receive an update on the project and its outcomes towards the end of 2023.

The Board resolved:-
to note the video.

MINUTE OF BOARD MEETING OF 29 NOVEMBER 2022

5. The Board had before it the minute of its meeting of 29 November 2022. In respect of Article 15 (Primary Care Improvement Plan Update – HSCP.22.099), members heard that clarification was still awaited from the Scottish Government in this regard and was expected to be available for the meeting in April 2023.

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

DRAFT MINUTE OF RISK, AUDIT AND PERFORMANCE COMMITTEE OF 17 NOVEMBER 2022

6. The Board had before it the draft minute of the Risk, Audit and Performance Committee of 17 November 2022, for information.

The Board resolved:-
to note the minute.

INTEGRATION JOINT BOARD
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BUSINESS PLANNER

7. 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 the additional meeting of the Integration Joint Board scheduled for 25 April 2023; and
(ii) to otherwise agree the Planner.

SEMINAR AND WORKSHOPS PLANNER

8. The Board had before it the Seminars and Workshops Planner which was presented by the Chief Operating Officer.

The Board resolved:-
(i) to note that a Teams meeting would be scheduled for Members regarding finance matters in advance of the Budget meeting on 28 March 2023;
(ii) to note that dates for workshops were in the process of being planned; and
(iii) to otherwise note the Planner.

CHIEF OFFICER'S REPORT - HSCP.23.008

9. The Board had before it the report from the Chief Officer, ACHSCP, who presented an update on highlighted topics and responded to questions from members.

Members discussed the use of Microsoft Teams for meetings and noted that there was no national guidance with regard to meeting etiquette, length of meetings and taking breaks.

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

The Board resolved:-
(i) to note that the Chair would discuss guidance on Teams meetings with the Chair of NHS Grampian Staff Governance; and
(ii) to otherwise agree the recommendation.

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CARERS' STRATEGY - HSCP.22.003

10. The Board had before it the final version of the Aberdeen City Carers Strategy 2023 – 2026, following the draft report consultation period running from 12 October to 31 December 2022.

The Chair thanked everyone who had attended the Carers' Strategy Workshop on 17 January 2023.

Stuart Lamberton – Transformation Programme Manager – Strategy, and Amy Richert - Transformation Programme Manager – Services & Pathways, ACHSCP presented the report and responded to questions from Members in respect of alignment with the Children's' Services Plan and other relevant strategies.

In response to a question regarding the category of disability - and the associated barriers to providing and accessing care and support - not being listed specifically under the Equalities section of the Action Plan, the Transformation Programme Manager gave assurance on the importance of receiving the perspective of carers who had disabilities within the equalities work and the Reference Group. She undertook to strengthen this category with the Plan.

Members noted the proposal to launch the Strategy in spring 2023 and that a short animation to bring together key points around the strategy was being devised along with an easy read version which would be rolled out to smaller groups and communities.

The report recommended:-
that the Board:
(a) approve the final full version of the Aberdeen City Carers Strategy 2023 – 2026 as attached at Appendix B of the report;
(b) approve the final summary version of the Aberdeen City Carers Strategy 2023 - 2026 as attached at Appendix C of the report ;
(c) approve the publishing of an easy-read version of the Aberdeen City Carers Strategy 2023 - 2026 as part of the launch of all documents;
(d) approve the Aberdeen City Carers Strategy 2023 – 2026 Action plan as attached at Appendix D of the report;
(e) approve the Engagement and Consultation overview of the Aberdeen City Carers Strategy 2023 - 2026 as attached Appendix A of the report;
(f) instruct the Chief Officer of the IJB to coordinate a launch period to promote the Strategy; and
(g) instruct the Chief Officer of the IJB to report back on progress with the Carers Strategy and Action Plan annually.

The Board resolved:-

(i) to note that an annual consultation event would be held in advance of each annual review;
(ii) to instruct the Transformation Manager to strengthen the references to disabled carers within the Action Plan; and
(iii) to otherwise approve the recommendations.

ANNUAL PROCUREMENT WORKPLAN - HSCP.23.002

11. The Board had before it a report on the Annual Procurement Work Plan for 2023/24 and the associated procurement Business Cases in respect of expenditure on social care services.

The report recommended:-
that the Board:
(a) approve the Direct Award, for a period of 5 years of a contract for a physical disability residential service, as detailed in Appendices A1 and C of the report;
(b) approve the Direct Award, for a period of 5 years of a contract for a learning disability residential service, as detailed in Appendices A1 and D of the report;
(c) approve the Direct Award, for a period of 4 years of a contract for a day service for young adults, as detailed in Appendices A1 and E of the report;
(d) approve the extension for 6 months to the existing contract, and approve the recommendation to go out to tender for the provision of dementia advice and support services as detailed in Appendices A1 and F of the report;
(e) approve the extension for 1 year to the existing contract, and approve the recommendation to go out to tender for the provision of care at home and housing support services as detailed in Appendices A1 and G of the report;
(f) approve the extension for 1 year, of 25 National Care Home Contracts (NCHC) for residential services for older people, as detailed in Appendices A1 and H of the report;
(g) approve the Direct Award, for a period of 5 years of a contract for a supported living service, as detailed in Appendices A1 and I of the report;
(h) approve the Direct Award, for a period of 3 years of a contract for a Huntington's disease advice and support service, as detailed in Appendices A1 and J of the report;
(i) approve the additional expenditure on the framework agreement for Adult Supported Living Services that commenced 01/09/2020, as detailed in Appendices A1 and K of the report;
(j) approve the Direct Award, for a period of 5 years of a contract for a residential service for adults with neurodisabilities, as detailed in Appendices A1 and L of the report;
(k) approve the Direct Award of two care at home and housing support services contracts to one provider, for a period of three years, as detailed in Appendices A1 and M of the report;

(l) approve the recommissioning of the Pre-Paid Card Service and subsequent award of a 3-year contract with the option to extend by up to a further 2 years, as detailed in Appendices A1 and N of the report;
(m) make the Direction, as attached at Appendix B and instruct the Chief Officer to issue the Direction to Aberdeen City Council; and
(n) note the update to Individual Out of Area Placements at item 3.8 of the report and note potential supplementary work plans at item 3.4 of the report.

The Board resolved:-
to approve the recommendations.

GRANT FUNDING ARRANGEMENTS - HSCP.23.005

12. The Board had before it a report requesting approval to direct Aberdeen City Council (ACC) to extend grant funding arrangements. The report also advised of the key focus of attention expected of providers, and the opportunities offered to support the delivery of the Aberdeen City Health and Social Care Partnership (ACHSCP) strategic aims, and transformational activity.

The report recommended:-
that the Board:
(a) approve the expenditure for the Third sector interface as set out in Appendix A and business case in Appendix B of the report;
(b) approve the expenditure for the Independent social care sector representative as set out in Appendix A and business case in Appendix C of the report;
(c) approve the expenditure for four counselling services and a transport service, as set out in Appendix A and business case in Appendix D of the report; and
(d) make the Direction in Appendix A of the report to Aberdeen City Council and instruct the Chief Officer to issue that Direction to Aberdeen City Council.

The Board resolved:-
(i) to provide an uplift to the grant funded providers to ensure equity with other social care providers; and
(ii) to otherwise approve the recommendations.

ANNUAL PROCUREMENT WORKPLAN - HSCP.23.002 - EXEMPT APPENDICES

13. The Board resolved:-
to note that the recommendations had been approved at Article 11.

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31 January 2023

GRANT FUNDING ARRANGEMENTS - HSCP.23.005 - EXEMPT APPENDICES

14. **The Board resolved:**-
to note that the recommendations had been approved at Article 12.

In accordance with the decision taken under article 3 above, the following item was considered with the press and public excluded.

ABERDEEN CITY VACCINATION CENTRE - HSCP.23.007

15. The Board had before it a report from the Immunisation Programme Manager requesting authority for the Chief Officer to take any necessary steps to secure appropriate accommodation for the provision of vaccinations in the city.

The report recommended:-
that the Board delegate authority to the Chief Officer, following consultation with the Chair and Vice-Chair of the Integration Joint Board, to take any necessary steps to secure appropriate provision for a vaccination centre.

The Board resolved:-
to approve the recommendation.

IJB MEETINGS - 28 MARCH 2023 (BUDGET) AND 25 APRIL 2023 (ADDITIONAL)

16. The Board had before it the date of the next meetings:

28 March 2023, at 10am (Budget)
25 April 2023.

The Board resolved:-
to note the dates of the next meetings.

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

Minute of Meeting

Tuesday, 28 February 2023
10.00 am Virtual - Remote Meeting

ABERDEEN, 28 February 2023. Minute of Meeting of the RISK, AUDIT AND PERFORMANCE COMMITTEE. Present:- Councillor Martin Greig Chairperson; and Councillor John Cooke, June Brown (from Article 9), Luan Grugeon, Jamie Dale, Alison MacLeod and Paul Mitchell (until Article 9).

Also in attendance: Martin Allan, Alan Bell (for Article 9), Michelle Grant, Vicki Johnstone, Stuart Lamberton, Graham Lawther and Shona Omand-Smith.

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DECLARATIONS OF INTEREST AND TRANSPARENCY STATEMENTS

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

The Committee resolved:-
to note that there were no Declarations of Interest or Transparency Statements intimated.

EXEMPT BUSINESS

2. There was no exempt business.

MINUTE OF PREVIOUS MEETING OF 17 NOVEMBER 2022

3. The Committee had before it the minute of its previous meeting of 17 November 2022, for approval.

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

RISK, AUDIT AND PERFORMANCE COMMITTEE
28 February 2023

BUSINESS PLANNER

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

In respect of a question regarding whistleblowing, the Business Manager confirmed that this was information collated from the Integration Joint Board, Aberdeen City Council and NHS Grampian.

The Committee resolved:-
to approve the content of the Planner.

BOARD ASSURANCE AND ESCALATION FRAMEWORK (BAEF) - HSCP.23.009

5. The Committee had before it the annual review of the Integration Joint Board's (IJB) Board Assurance and Escalation Framework (BAEF) as part of the Risk, Audit and Performance Committee's (RAPC) annual review of the Framework.

Members discussed community empowerment and engagement and the importance of embedding this when connecting with stakeholders.

Members noted that NHS Grampian had set up a Short Life Working group looking at the Collaborative Governance approach, and that the IJB Chair would report to the IJB in this regard.

The report recommended:-
that the Committee:
(a) approve the revised BAEF as attached at Appendix A of the report;
(b) agree that the Framework continue to be reviewed annually by RAPC; and
(c) agree that once the IJB approved the revised Scheme of Governance (including the terms of reference for the IJB and its committees) that the BAEF be updated to reflect any changes made to the Scheme.

The Committee resolved:-
to approve the recommendations.

INTERNAL AUDIT PLAN 2023-26 - HSCP.23.016

6. The Committee had before it the Internal Audit Update Plan 2023-26 prepared by the Chief Internal Auditor which sought approval of the Internal Audit Plan for the Aberdeen City Integration Joint Board for 2023-26.

The report recommended:-

that the Committee approve the Internal Audit Plan for 2023-26 as attached at Appendix A of the report.

The Committee resolved:-
to approve the recommendation.

INTERNAL AUDIT UPDATE REPORT - HSCP.23.012

7. The Committee had before it the Internal Audit Update Report prepared by the Chief Internal Auditor which presented an update on Internal Audit's work. Details were provided of the progress against the approved Internal Audit plans, audit recommendations follow up, and other relevant matters for the Committee to be aware of.

The report recommended:-
that the Committee:
(a) note the contents of the RAPC - Internal Audit Update Report for February 2023 ("the Internal Audit Update Report"), as appended at Appendix A of the report, and the work of Internal Audit since the last update;
(b) note the progress against the approved 2021-22 and 2022-23 Internal Audit plans as detailed in the Internal Audit Update Report; and
(c) note the progress that had been made with implementing recommendations agreed in Internal Audit reports as outlined in the Internal Audit Update Report.

The Committee resolved:-
to approve the recommendations.

INTERNAL AUDIT - TRANSFORMATIONAL PROGRAMME - HSCP.23.013

8. The Committee had before it a report prepared by the Chief Internal Auditor which presented the outcome from the planned audit of the IJB Transformational Programme that was included in the Internal Audit Plan for Aberdeen City Integration Joint Board.

The report recommended:-
that the Committee review, discuss and comment on the issues raised within the report.

The Committee resolved:-
to note the information provided.

RISK, AUDIT AND PERFORMANCE COMMITTEE
28 February 2023

INTERNAL AUDIT - DATA SHARING - HSCP.23.014

9. Members welcomed Alan Bell - Head of Information Governance and Data Protection Officer, NHS Grampian, to the meeting.

The Committee had before it an Internal Audit report prepared by the Chief Internal Auditor regarding IJB Data Sharing, which presented the outcome from the planned audit of the IJB Data Sharing that was included in the Internal Audit Plan for Aberdeen City Integration Joint Board.

The Chief Internal Auditor explained that the objective was to ensure that the IJB had appropriate assurance over the arrangements and procedures for data sharing within its partners. He reported that Aberdeen City, Aberdeenshire and Moray Councils had completed their data sharing reviews, however NHS Grampian and its auditors had not been able to facilitate the work due to commitments of the Information Commissioner's recent review. Nevertheless, it was still the intention to provide an overarching executive summary to be presented to Committee on completion.

Members heard from the Head of Information Governance who responded to questions from Members and undertook to bring a position summary back to RAPC once the Information Commissioner's review was complete.

The report recommended:-
that the Committee review, discuss and comment on the issues raised within this report.

The Committee resolved:-
to note the information provided.

QUARTER 3 FINANCIAL MONITORING UPDATE - HSCP.23.017

10. The Committee had before it the Quarter 3 (2022/23) Financial Monitoring Update 2022/2023 reporting on the revenue budget performance for the services within the remit of the Integration Joint Board (IJB) for quarter 3 (period ended 31 December 2022).

The Chief Financial Officer presented the report and responded to questions from Members regarding primary care services overspend, prescribing and payments to care homes.

The report recommended:-
that the Committee:

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

The Committee resolved:-
(i) to instruct the Chief Financial Officer to circulate an update to the Committee following the meeting on 28 February 2023 regarding prescribing; and
(ii) otherwise approve the recommendations.

STRATEGIC PLAN 2022-2025: DELIVERY PLAN QUARTER 3 UPDATE - HSCP.23.015

11. The Committee had before it the Strategic Plan 2022-2025: Delivery Plan Quarter 3 Update which sought to provide assurance relating to the progress of the Year 1 projects of the Delivery Plan as set out within the Aberdeen City Health and Social Care Partnership (ACHSCP) Strategy Plan for 2022-2025.

Alison MacLeod - Lead for Strategy and Transformation, ACHSCP, introduced the report and responded to questions from Members regarding the data provided. In respect of data reporting, the Strategy and Transformation team agreed to take on board (1) in respect of falls, reporting of 'falls with harm' to provide more meaningful data to the Committee; (2) reporting of context for comparisons with other regions; (3) where appropriate to append Local Outcome Improvement Plan reports where there was a connection, e.g. in terms of Make Every Opportunity Count (MEOC) training; and (4) going forward to consider a deeper dive of a particular programme of projects.

Members praised the new format and BRAG (blue/red/amber/green) reporting status.

The report recommended:-
that the Committee note the Delivery Plan Quarter 3 Update and Dashboard as appended to the report at appendices a and b respectively.

The Committee resolved:-
(i) to note the suggested additions to reporting; and
(ii) to otherwise approve the recommendation.

DATE OF NEXT MEETING - TUESDAY 2 MAY 2023 AT 10AM

12. The Committee had before it the dates for future meetings, all at 10am:

- 2 May 2023
- 13 June 2023
- 19 September 2023

RISK, AUDIT AND PERFORMANCE COMMITTEE
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- 28 November 2023
- 23 January 2024
- 26 March 2024

The Board resolved:-
to note the future meeting dates.
- COUNCILLOR MARTIN GREIG, Chair

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CLINICAL AND CARE GOVERNANCE COMMITTEE

ABERDEEN, 21 February 2023. Minute of Meeting of the CLINICAL AND CARE GOVERNANCE COMMITTEE. Present:- Kim Cruttenden Chairperson; and Luan Grugeon (NHS Grampian Board Member) and Councillor Deena Tissera.

In attendance: Caroline Howarth, Lynn Morrison, Fiona Mitchellhill, Graeme Simpson, Laura Mcdonald, Val Vertigans, Barbara Dunbar, Campbell Thomson, Stella Evans, Shona Omand-Smith, Stuart Lamberton, Susie Downie and Mark Masson (Clerk).

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WELCOME AND APOLOGIES

1. The Chairperson welcomed everyone to the meeting.

An apology for absence was intimated on behalf of Councillor Allard.

DECLARATIONS OF INTEREST AND TRANSPARENCY STATEMENTS

2. There were no declarations of interest or transparency statements intimated.

MINUTE OF PREVIOUS MEETING OF 11 NOVEMBER 2022, FOR APPROVAL

3. The Committee had before it the minute of its previous meeting of 11 November 2022, for approval.

The Committee resolved:-
to approve the minute.

BUSINESS PLANNER

4. The Committee had before it their Business Planner for consideration.

The Committee resolved:-
(i) to note the reasons for the reporting delay in relation to item 5 (Long Covid Update) and that a summary update report would be submitted to the next

meeting of the Committee, with a full report being submitted at a later date in the year;

(ii) to remove item 17 (Workforce Plan) from the planner for the reasons outlined therein;

(iii) to note that the Chairperson would liaise with Caroline Howarth to discuss arrangements for a Committee Development Session and also a Joint Development Session with the Clinical and Care Governance Group;

(iv) to otherwise note the planner.

CCG GROUP MONITORING REPORT - UPDATE - HSCP.23.006

5. The Committee had before it a report by Lynn Morrison and Michelle Grant which provided information and data to provide assurance that operational activities were being delivered and monitored effectively and that patients, staff and the public were being kept safe whilst receiving high quality service from ACHSCP.

By way of summary, the report indicated (a) that this quarter had continued to see significant and enduring pressures across all health and social care services, with teams and services having to manage rising demand in some areas and increasing complexity, acuity and delayed presentations, coupled with continued workforce availability challenges due to recruitment and retention challenges and staff absences; (b) that the Clinical and Care Governance group continue to hear of pressures across service areas, however with some positive news too around some recruitment successes in some teams; (c) that winter surge planning, contingency planning around industrial action had also been undertaken and there had been a pause in any strike activity pending further pay negotiations, however, this remained a risk until this was resolved; (d) that information governance delays continued to be a concern and work to improve this was being taken forward by the Chief Operating Officer to try and find a way to enable service initiatives in a number of services within the partnership to be able to progress where there had been significant delays due to information governance sign-off requirements not being able to be resolved; (e) that there were many examples of excellent improvement work and other initiatives to improve the care being delivered to the people of Aberdeen and wider Grampian and to support staff wellbeing and development; (f) that the entire health and social care partnership workforce were to be thanked and commended for their continued commitment and hard work delivering the best services they could despite the ongoing challenging circumstances they were having to work through; (g) that this would be Lynn Morrison's last report to the committee as Chair of the Group, having been asked to step in on an interim basis in May 2021; and (h) that the role of chair was now passing back to the Lead Officer for Clinical Governance for the partnership, with this role sitting as part of the remit of the Lead for Medical Clinicians under the revised Senior Leadership Team arrangements.

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

CLINICAL AND CARE GOVERNANCE COMMITTEE
21 February 2023

Lynn Morrison provided a comprehensive summary of the report, in particularly, making reference to the various workforce challenges and pressures and outlining ongoing mitigations across services. In response to questions from members, the following was noted:-

- that there were challenges within the maternity service due to recruitment and the two-year training requirement for nurses before commencing duties, although a new National Workforce Tool was being utilised and a business case to increase staffing was being considered – the situation continued to be monitored;
- that there was a need to develop a shared approach to define, monitor and escalate risk, particularly where there may be a risk of harm to patients;
- that a new system, namely 'G-Pass' would be used by GP staff to help monitor patient complaints, pressures and impact;
- that there continued to be positive intergenerational work for care home residents including physical activity; and
- that consideration would be given on how GP practice feedback from patients and reporting of complaints could be captured and included within future reports and also how this information could be shared for learning and improvement.

The Committee resolved:-

(i) to note that updates in relation to 'Information Governance', 'GP pressures and potential improvements including usage of the G-Pass system', and 'Duty of Candour' would be considered in future reports;
(ii) to note that Michelle Grant would investigate whether comparative data information (City/Shire/Moray) from the Datex system could be used and included within future reports;
(iii) to note that a further update on the Moray Abortion Care Scanning Pathway would be included with the report at the next meeting;
(iv) to note that there continued to be pressures in relation to NHS Dental Services and de-regulation and it was important that the situation was regularly monitored by the Committee;
(v) to express thanks to Lynn Morrison for all her work in terms of presenting the Group Monitoring reports and for chairing the CCG Group effectively; and
(vi) to otherwise approve the recommendation contained within the report.

STAFF WELLBEING - WORK OF THE CITY STAFF PARTNERSHIP FORUM - HSCP.23.010

6. The Committee had before it a report by Sandy Reid which provided an update on staff wellbeing issues within ACHSCP.

CLINICAL AND CARE GOVERNANCE COMMITTEE
21 February 2023

The report outlined the most recent absence sickness rate for partnership staff (NHSG employees only) which showed that sickness absence as of December 2022 was 5.93% and listed the top five recorded reasons for sickness absence as follows:-

- Anxiety/stress/depression (14.06%);
- Colds/coughs/flu (12.98%);
- Gastrointestinal problems (8.04%);
- Back problems (5.55%); and
- Covid (5.13%).

The report advised that in total there were 14,174 hours lost to sickness absence in ACHP in December 2022 alone.

The report recommended:-
that the Committee note and discuss the report.

The Committee heard from Sandy Reid who highlighted the key information from the report and responded to questions from members.

During discussion, the following was noted:-

- that in terms of the wellbeing of the workforce, staff were reminded by operational managers, that annual leave (2022) should be taken by the end of March 2023;
- that if possible, future reports in this regard should include comparable figures with other IJB areas;
- that there was a need for the organisation to look at the retention and recruitment of staff, but also to address workloads, repeat absences and how best to support the workforce in this regard;
- that managers in Aberdeen City Council complete mental health assessments for staff;
- that complimentary therapies at Woodend Hospital, including physiotherapy sessions funded through endowments were helpful for staff; and
- that managers should be reminded to ensure that staff take regular breaks each day to support staff wellbeing, in line with statutory minimum legal requirements.

The Committee resolved:-
(i) to request that future reports on staff wellbeing/sickness absence include comparison details from other IJB areas; and
(ii) to otherwise approve the recommendation.

UPDATE ON MENTAL WELFARE COMMISSION VISITS AND ACTION PLAN - HSCP.23.011

CLINICAL AND CARE GOVERNANCE COMMITTEE
21 February 2023

7. The Committee had before it a report by Kathryn Kinnear which provided an update on visits from the Mental Welfare Commission (MWC) in the past 12 months for the Mental Health and Learning Disability Inpatient and Specialist Services.

The report had attached the following appendices in relation to the 8 visits at Royal Cornhill Hospital in 2022:-

- Strathbeg and Loirston Ward Report;
- Corgarff Report;
- Polmuir Road Report;
- Intensive Psychiatric Care Unit Report;
- Great Western Lodge Report;
- Forensic Acute/Rehab Report;
- Brodie Ward;
- Skene Ward; and
- Action Plans arising from reports.

The report recommended:-
that the Committee –
(a) instruct officers to submit this report on progress to both the Aberdeenshire and Moray IJBs (in a pdf format, attached to their respective reporting templates);
(b) note the positive experience of the Mental Welfare Commission following their visits; and
(c) note the progress being made on the action plans created following the visits.

The Committee heard Kathryn Kinnear provide an overview of her report, making reference to (1) the three themes running through the reports including communication, environmental and the recording of care in the notes; and (2) action plans, the process following the service receiving the report and governance arrangements.

During discussion, the following was noted:-

- that the action plans required to be submitted to the MWC within three months;
- that the MWC refer to the action plans when they undertake future visits to seek information on progress being made; and
- that it was acknowledged that further work would be required in relation to cascading feedback from the visits to other hospitals for learning purposes and a formulated mechanism to do this would be considered by Kathryn and her team.

It was noted that Kathryn Kinnear would liaise with Matt Jobson, in relation to the work of the NHS Grampian Quality and Safety Forum regarding a governance structure for cascading feedback from visits.

The Committee resolved:-
to approve the recommendations.

CLINICAL AND CARE GOVERNANCE COMMITTEE
21 February 2023

ITEMS WHERE ESCALATION TO IJB IS REQUIRED

8. The Committee considered whether any items required escalation to the IJB.

With reference to article 8 of the previous meeting of 11 November 2022, relating to Information Governance and its effects on the Community Pharmacy Team, the Hubs and the Third Sector, it was noted that the Chair and Luan Grugeon were to receive feedback from Lynn Morrison following her discussion with Fraser Bell and Sandra McLeod. Luan Grugeon sought an update in this regard.

The Committee resolved:-
to note that Lynn Morrison would liaise with Fraser Bell and circulate a summary update on the progress being made in relation to the above.
- KIM CRUTTENDEN, Chairperson

	A	B	C	D	E	F	G	H	I	J	K
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**	**Delayed/ Deferred or Recommended for removal or transfer, enter either D, R, or T**	**Explanation if delayed, removed or transferred**	
3	**2023 Meetings**										
8	**25 April 2023**										
9	Standing Item	Chief Officer Report	To provide a regular update from the Chief Officer		Ross Baxter	Chief Officer	ACHSCP				
10	Standing Item	Video Presentation: NESS - promoting the range of services that North East Sensory Services delivers.	To note the regular video presentation from a choice of partner organisations								
11	04.11.2022	IJB Scheme of Governance Annual Review	To seek approval of the revised Scheme of Governance. Considered at IJB on 7 June 2022 - this is an annual review.	HSCP.23.023	Jess Anderson/John Forsyth/Vicki Johnstone	Legal ACC	ACHSCP				
12	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. Annual report, last considered at IJB on 7 June 2022.	HSCP.23.021	Martin Allan	Business Lead	ACHSCP				
13	30.11.22	Biennial Progress report on delivery of our Equality Outcomes and Mainstreaming Framework	To approve publication and submission of the report to the Equality and Human Rights Commission This is a statutory obligation to report on progress every two years after approval; last done in May 2021	HSCP.23.024	Alison Macleod	Strategy and Transformation Team	ACHSCP				
14		Aberdeenshire HSCP Hosted Services	To note an update on Aberdeenshire HSCP Hosted Services	HSCP.23.025	Lisa Pratt / Corinne Millar / Alison McGruther		Aberdeenshire HSCP				
15	01.12.22	Governance Arrangements - Inpatient, Specialist Services and CAMHS report for the Mental Health and Learning Disability Service	To note the governance arrangements for the Mental Health and Learning Disability (MHLD) Inpatient and Specialist Services and the Child and Adolescent Mental Health Service (CAMHS).	HSCP.23.035	Kathryn Kinnear	Service Manager, RCH	ACHSCP				
16	23.02.23	Supplementary Procurement Work Plan (Social Care) for 2023/24	To seek approval for the Supplementary Procurement Work Plan for 2023/24 for expenditure on social care services, together with the associated procurement Business Case.	HSCP.23.018	Neil Stephenson	Strategic Procurement	ACHSCP				
17	13.10.22	Creating Hope Together: Scotland's Suicide Prevention Strategy and Action Plan	To note the recently published national Suicide Prevention Strategy & Action Plan and to provide assurance on activities locally.	HSCP.23.019	Kevin Dawson / Jennifer Campbell	Strategy and Transformation Team	ACHSCP				
18	22.03.23	Prevention and Early Intervention	To provide an update on a report on Prevention and Early Intervention that was approved at Aberdeen City Council on 1 March 2023 and the steps that the Chief Officer is taking to deliver her action in relation to it.	HSCP.23.026	Alison MacLeod	Strategy and Transformation Team	ACHSCP				
19	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	HSCP.23.022	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.			
20	17.01.2023	Primary Care Improvement Plan (PCIP) Governance	To provide members with an outline of the governance arrangements supporting the Primary Care Improvement Plan.		Jess Anderson	Governance	ACC		D	Deferred until the meeting on 6 June 2023 to allow for a meeting to take place with representatives of the Scottish Government in early May 2023.	
21		Neuro Rehab Strategic Review and Implementation Plan	To seek approval of the Strategic Review work and draft Implementation Plan. Outline draft expected end of March 2023, to come to next IJB after that.		Grace Milne/Jason Nicol	Head of Service Specialist Older Adults and Rehabilitation Services			D	Request to defer to the August 2023 IJB due to continuing discussions regarding the scope and direction of the review.	
22	**6 June 2023**										
23	Standing Item	Chief Officer Report	To provide a regular update from the Chief Officer		Ross Baxter	Chief of Staff	ACHSCP				
24	Standing Item	Video Presentation	To note the regular video presentation from a choice of partner organisations								
25	09.09.2022	Strategic Risk Register & Revised Risk Appetite Statement	IJB agreed on 11 October 2022 to note that the documents would be reviewed by the IJB as per the Board Assurance and Escalation Framework with an additional review in the first quarter of 2023/24	HSCP22.083	Martin Allan	Business Lead	ACHSCP				
26		Bon Accord Care Strategy	To note Bon Accord Care Strategy		Pamela MacKenzie	Managing Director	Bon Accord Care				
27	**22 August 2023**										
28	Standing Item	Chief Officer Report	To provide a regular update from the Chief Officer		Ross Baxter	Chief of Staff	ACHSCP				
29	Standing Item	Video Presentation	To note the regular video presentation from a choice of partner organisations								
30		ACHSCP Annual Report	To seek approval of the ACHSCP Annual Report - 22 August 2023 meeting		Alison MacLeod / Amy Richert	Lead Strategy and Performance Manager					
31	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.	

	A	B	C	D	E	F	G	H	I	J	K
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32	24.08.21	Rosewell House - evaluation and recommendation reports	To note the evaluation and to seek approval of a formal recommendation on the future of Rosewell to allow 4 months to implement the outcomes of the recommendation, ahead of the current direction ceasing in December 2023. Chief Officer to bring a full evaluation report of the service being delivered at Rosewell House to the IJB in March 2023;		Sarah Gibbon/Fiona Mitchelhill	Transformation Team	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;		Deferred from March 2023 to allow a full year between the interim and final evaluations, giving more time to embed the recommendations from the first evaluation.	
33	**10 October 2023**										
34	Standing Item	Chief Officer Report	To provide a regular update from the Chief Officer		Ross Baxter	Chief of Staff	ACHSCP				
35	Standing Item	Video Presentation	To note the regular video presentation from a choice of partner organisations								
36	Standing Item	Audited Accounts	To seek approval of the Audited Final Accounts for 2022/23.		Paul Mitchell	Chief Finance Officer	ACHSCP	Expected September/October 2023			
37	26.07.2022	Complex Care Market Position Statement	To seek approval of the Complex Care Market Position Statement. IJB agreed on 11 October 2022 to note that progress on delivery of the Complex Care Market Position Statement would be reported to the Integration Joint Board annually.		Jenny Rae / Kevin Dawson	Strategy and Transformation Team	ACHSCP				
38		Climate Change Project and Reporting	Members agreed on 29 November 2022 to receive an annual progress report on the climate change work.		Sophie Beier	Strategy and Transformation Team	ACHSCP				
39	**5 December 2023**										
40	Standing Item	Chief Officer Report	To provide a regular update from the Chief Officer		Ross Baxter	Chief of Staff	ACHSCP				
41	Standing Item	Video Presentation	To note the regular video presentation from a choice of partner organisations								
42	**6 February 2024**										
43	Standing Item	Chief Officer Report	To provide a regular update from the Chief Officer		Ross Baxter	Chief of Staff	ACHSCP				
44	Standing Item	Video Presentation	To note the regular video presentation from a choice of partner organisations								
45	17.01.2023	Grant Funding	Annual report on to seek approval to direct Aberdeen City Council (ACC) to extend grant funding arrangements.		Shona Omand-Smith	Commissioning Lead	ACHSCP				
46	31.01.2023	Carers' Strategy	To provide an update and annual review of the strategy approved by IJB on 31 January 2023. Members agreed on 31.01.23 to instruct the Chief Officer of the IJB to report back on progress with the Carer Strategy and Action Plan annually.		Stuart Lamberton	Strategy and Transformation Team	ACHSCP				
47	Standing Item	Annual Procurement Workplan 2024/2025	To present the Annual Procurement Work Plan for 2024/25 for expenditure on social care services, together with the associated procurement Business Cases, for approval.		Neil Stephenson	Procurement Lead	ACC				
48	07.02.2023	Annual Grants Workplan 2024/25	To seek approval of the grant funding for 2024/25.		Shona Omand-Smith	Commissioning	ACHSCP				
49	**26 March 2024 (Budget)**										
50	Standing Item	Chief Officer Report	To provide a regular update from the Chief Officer		Ross Baxter	Chief of Staff	ACHSCP				
51	Standing Item	Video Presentation	To note the regular video presentation from a choice of partner organisations								
52		IJB Budget	To approve the Budget.		Paul Mitchell	Chief Finance Officer	ACHSCP				
53	**TBC Future Meetings**										
54	29.11.2022	Marywell Service Redesign Business case	Members agreed on 29 November 2022 to instruct the Chief Officer to report to the Integrated Joint Board on the next phase of the redesign of the Marywell Service, with a Business Case to outline the future provision of services within 18 months		Susie Downie / Emma King / Teresa Waugh	Primary Care Leads	ACHSCP	Expected April/May/June 2024			
55	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	Expected April 2024			
56											

	Seminars/Workshops				
	Title	Purpose	Agreed Date	Lead Officer	Update
1	Delivery Plan and Key Metrics (including Strategic Objectives)	Review of progress, share data / 'show case' progress areas / conversational and questions	06 June 2023	Alison Macleod	Postponed from 7 November 2022
2	Strategic Intent		06 June 2023	Sandra Macleod	Also available December IJB
3	GIRFE Pathfinder	To update Members on the GIRFE Pathfinder progress and to get feedback on the draft principles of GIRFE and how we can all start to apply the principles all our work.	20 June 2023	Shona Omand-Smith	
4	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	Paper expected 22/08/23, workshop must take place prior to this IJB. Awaiting confirmation from Lead Officer.
5	Procurement (Fair and Transparent)]		22 August 2023	Neil Stephenson/Shona Omand-Smith	To be taken with Ethical Commissioning
6	Ethical Approach to Commissioning]		22 August 2023	Shona Omand-Smith/Neil Stephenson	To be taken with Procurement
7	Mental Health	How to help further the health and wellbeing agenda through mental wellbeing.		Judith Mclenan/Kevin Dawson	Postponed from 7 November 2022. See separate email waiting for P Mackie to confirm.
8	Population Health	To introduce IJB members to (i) the Population Health approach; and (ii) the newly created Population Health Committee within NHS Grampian and its relationship with the IJB.		Phil Mackie	Postponed from 7 November 2022. See separate email waiting for P Mackie to confirm.
9	Population Health - Sport Aberdeen	How to help further the health and wellbeing agenda through sport and activity.		Alison MacLeod/Sport Aberdeen	Postponed from 7 November 2022. Check with A MacLeod.
10	Climate Change Awareness	To provide Members with further information on climate awareness following the report to IJB on 29 November 2022.	10 October 2023	Sophie Beier & Rachel Flett	

11	Age Friendly Aberdeen	Stay Well Stay Connected lead by Danny Ruta and Phil Mackie our PH Consultant - paper written by Danny Ruta on Community interventions to promote wellbeing and independence in older people in Aberdeen and will enable us to explore how we can take a step towards being an Age Friendly Aberdeen. We are in the process of planning a conference to bring people from across the city to share with them how we can:(1) Retire well; (2) Help shape a social movement around keeping people well and connected to their communities as well as how they can contribute (social prescribing really); and (3) Explore and learn more about the Age Friendly Cities approach.	10 October 2023	Proposed by Shona Omand-Smith - Phil Mackie to lead	Looks like 10 October, checking P Mackie's availablity and need to check with S Omand-Smith if she needs to attend.
12	Complex Care	Seminar on Complex Care after FBC approval (August)	05 December 2023	Requested by Luan Grugeon	
13	BOOM Board Session	Ongoing: helping to get the 'Best of out me'		Jason Nicol	Awaiting confirmation from Lead Officer (annual leave)
14	GP Sustainability			Emma King/Susie Downie	Awaiting confirmation from Lead Officers (annual leave).
15	Collaborative Governance			Sandra MacLeod/Martin Allan	Awaiting confirmation from Lead Officers (annual leave).
16	Carers' Strategy Workshop	Briefing in advance of the end of Year 1 of the Strategy.	23 January 2024	Stuart Lamberton	23 January 2024 proposed, S Lamberton has confirmed availability.
17	Pre Budget Finance briefing	TBC before IJB Budget once papers have been issued - so 20/21/22 March 2024	21 March 2024	Paul Mitchell	To take place before IJB Budget but once final papers have been issued - so 20/21/22 March 2024 to ensure members have the opportunity to read papers.

Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Date of Meeting	25 April 2023
Report Title	Integration Scheme and IJB Scheme of Governance Review
Report Number	HSCP23.023
Lead Officer	Fraser Bell, Interim Chief Operating Officer
Report Author Details	Name: John Forsyth Job Title: Solicitor Email Address: jforsyth@aberdeencity.gov.uk
Consultation Checklist Completed	Yes
Directions Required	No
Appendices	Appendix A – Revised Integration Scheme Appendix B – Revised Standing Orders Appendix C – Revised Terms of Reference Appendix D – Revised Roles and Responsibilities Protocol Appendix E – Revised Code of Conduct Appendix F – Table of Changes to Scheme of Governance Appendix G – Table of Changes to the Integration Scheme Appendix H – HIIA Summary

1. Purpose of the Report

1.1. The purpose of this report is to present the revised Integration Scheme to the Integration Joint Board (IJB) for endorsement and to present the revised Scheme of Governance to the IJB for comment and approval.

2. Recommendations

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

a) Endorse the amended Integration Scheme (as attached at Appendix A);
b) Approve the Revised Standing Orders for the IJB (as attached at Appendix B), with effect from 1 May 2023;
c) Approve the Revised Terms of Reference (as attached at Appendix C, with effect from 1 May 2023);
d) Approve the Revised Roles and Responsibilities Protocol (as attached at Appendix D, with effect from 1 May 2023);
e) Approve the Revised Code of Conduct (as attached at Appendix E), with effect from 1 May 2023;
f) Instruct the Chief Officer of the IJB to report to the IJB through the regular Chief Officer's report when the Scottish Government has approved the revised Integration Scheme; and
g) Agrees to appoint the Chief Operating Officer to substitute for Chief Officer in the absence of the Chief Officer.

3. Summary of Key Information

Introduction

3.1. The Integration Scheme is the legal document through which Aberdeen City Council and NHS Grampian delegate functions to the IJB. The Integration Scheme is endorsed by both of these partner organisations before being submitted to the Scottish Government for final approval. The Scottish Government have received the revised Integration Scheme and are currently reviewing it.

3.2. The Aberdeen City Integration Scheme was first approved in 2016 ahead of the formation of the IJB. It was then revised in 2018. This first revision was primarily to take account of the introduction of the Carers (Scotland) Act 2016, but also changed a wide variety of other areas of the Scheme.

3.3. The Public Bodies (Joint Working) (Scotland) Act 2014 requires that the Integration Scheme be reviewed at least once every five years. This means that the partner organisations were required to complete a review in 2023. The partner organisations have approved the revised Integration Scheme and have submitted it to the Scottish Government for final approval. The

changes made to the Integration Scheme and the rationale for these changes are set out below and at Appendix G.

3.4. The 'Scheme of Governance' is the name given to the suite of documents which set out how the IJB will operate and do business. The Scheme of Governance is comprised of the Standing Orders, Terms of Reference, Roles and Responsibilities Protocol and Code of Conduct. The Scheme of Governance is reviewed on an annual basis, with any changes being presented to the IJB for approval. The IJB last approved changes to the Scheme of Governance in June 2022.

3.5. In recent previous years, the review of the Scheme of Governance has necessarily been limited by the response to the COVID-19 pandemic. However, this year, officers have been able to conduct a more thorough review of the Scheme. Officers believe that the proposed revisions to the Scheme of Governance will assist the IJB to continue making high-quality decisions.

3.6. The proposed changes made to the Scheme of Governance and the rationale for these changes are set out in more detail below. Given the wide-ranging nature of these changes, there is also a summary document attached at Appendix F which lists the changes in an easy-to-read format.

Integration Scheme

3.7. As noted above, the Integration Scheme is the legal document through which Aberdeen City Council and NHS Grampian delegate functions to the IJB. The Public Bodies (Joint Working) (Scotland) Act 2014 makes it clear that the Integration Scheme is a document prepared and approved by the partner organisations, rather than by the IJB itself. Accordingly, the IJB is asked to endorse the changes made to the Integration Scheme, rather than to approve them.

3.8. However, officers have ensured that the Chair and Vice-Chair of the IJB and the Aberdeen Health and Social Care Senior Leadership Team and officers were involved in the process of revising the scheme. Officers widely consulted on the changes to the Integration Scheme before presenting the

revised scheme to the partner organisations for approval in February 2023. As required by law, officers consulted a wide variety of groups on the Integration Scheme. This consultation was carried out in late 2022 and feedback from consultees was incorporated into the proposed Integration Scheme.

3.9. Following consultation, the partner organisations have approved a significant number of changes to the Integration Scheme, which are set out in detail at Appendix G. The most significant changes are:

- The inclusion of the recently approved Whistleblowing Policy
- More robust reflection of the recently agreed joint Locality Planning Arrangements
- More community involvement in planning
- The inclusion of hosted Mental Health Services
- The addition of pharmaceutical services for under 18's

3.10. In addition, the partner organisations agreed to create a new post; the Chief Operating Officer. The Chief Operating Officer shall support the Chief Officer of the IJB, be responsible for the strategic leadership of the Partnership and the delivery of the IJB's Strategic Plan. If approved by the IJB, the Chief Operating Officer shall also substitute for the Chief Officer in the absence of the Chief Officer.

3.11. The newly revised Integration Scheme will remain in place for a maximum of five years. However, given the ongoing plans to implement a National Care Service within that period, it is likely that new arrangements will need to be put in place before 2028.

Standing Orders

3.12. The IJB's Standing Orders regulate the manner in which meetings of the IJB and its committees are managed. This includes the manner in which meetings are called, speaking at meetings and voting.

3.13. Currently, the Terms of Reference for both of the IJB's committees also contain some standing orders for each of those committees. These have been removed and incorporated within the Standing Orders in the revised

version of the Scheme of Governance. This is intended to ensure clarity about the procedures to be followed at committees and at the IJB.

3.14. Aside from now incorporating all Standing Orders in one document, the revised version at Appendix B has also made some substantive changes to the Standing Orders themselves. As detailed in Appendix F, these are largely aimed to improve the clarity of the Standing Orders and to remove duplicate wording. However, there are a number of more substantial changes to the documents, which are listed below:

- More clarity provided on how live webcasting of meetings is to take place and permitting the Chair to make decision on public access
- Making it explicit that the Chair has the power to accept late papers onto the agenda
- Making the process of moving a motion or an amendment clearer
- Permitting Members to requisition a meeting by email, rather than requiring a wet-ink signature.

Terms of Reference

3.15. The Terms of Reference set out the remit and responsibilities of the IJB and its committees. The current Scheme of Governance sets out the terms of reference for the IJB, the Risk, Audit and Performance Committee (RAPC) and the Clinical Care and Governance Committee (CCGC) across three documents. Officers propose combining these into one document, titled 'Terms of Reference'.

3.16. This proposal is intended to make it easier to find, read and compare the Terms of Reference. The revised Terms of Reference also have an added structure chart and introduction. Again, both of these additions are intended to make it easier to understand how the IJB operates and how the committee structure works.

3.17. As noted above, the current terms of reference for RAPC and CCGC contain what are effectively standing orders for each committee. These have been removed in the revised document order to ensure that there is clarity about the procedure to be followed at each committee.

3.18. The revised Terms of Reference at Appendix C has also made some changes to the terms of reference themselves. As highlighted in Appendix F, the majority of changes made to the Terms of Reference were made for clarity and ease of understanding. In a number of areas, the current Terms of Reference refer to documents which have been superseded. In these cases, the references have been changed.

3.19. The most substantial change made to the Terms of Reference relates to the IJB's status as a Category One Responder under Civil Contingencies legislation. In practice, the Risk, Audit and Performance Committee has been responsible for monitoring the IJB's performance in this area. This has been formalised in the revised Terms of Reference, making it explicit that RAPC are responsible for this area.

Roles and Responsibilities Protocol

3.20. The Roles and Responsibilities Protocol sets out the responsibilities and remit of the Chief Officer, Chief Finance Officer, Chief Operating Officer and key personnel within the Aberdeen City Health and Social Care Partnership.

3.21. The current Roles and Responsibilities Protocol also sets out the terms of reference for the IJB. As noted above, officers propose moving this part of this document into a new combined Terms of Reference.

3.22. In addition to the change above, the revised Roles and Responsibilities Protocol at Appendix D also has a number of changes to improve the clarity and readability of the Protocol. These are highlighted in the table at Appendix F.

Code of Conduct

3.23. The IJB has a Code of Conduct which all IJB Members are required to follow when acting as a Board Member. The IJB is required to have a Code of Conduct in place. The IJB's Code of Conduct is approved by the Scottish Government.

3.24. The current IJB Code of Conduct was approved by the IJB in June 2022. The current code significantly revised the previous Code of Conduct to reflect a new Model Code of Conduct for Public Bodies, which was published by the Standards Commission in late 2021.

3.25. The revised Code of Conduct at Appendix E does not significantly alter the current Code of Conduct. Importantly, the revised Code of Conduct does not alter the obligations or responsibilities of Members in any way. Instead, as Members will see from the changes highlighted in Appendix F, the revisions made to the Code of Conduct are technical and non-material in nature. Officers have confirmed with the Standards Commission that the revisions are non-material and will not require Scottish Government approval.

4. Implications for IJB

4.1. Equalities, Fairer Scotland and Health Inequality

In accordance with Scottish Government guidance, a Health Inequality Impact Assessment workbook summary was completed. This summary did not identify any unexpected differential impacts. The summary is attached at Appendix H.

4.2. Financial

There are no direct financial impacts arising from this report.

4.3. Workforce

There are no direct workforce impacts arising from this report.

4.4. Legal

As noted above, the Integration Scheme is a document prepared by the partner organisations, rather than the IJB itself. As such, the Integration Scheme is not approved by the IJB.

INTEGRATION JOINT BOARD

The Scheme of Governance is reviewed on an annual basis. This ensures that the IJB's governance arrangements remain in line with the law. In particular, the annual review of the standing orders ensures that the IJB complies with its obligations under The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014,

4.5. COVID-19

There are no direct COVID-19 impacts arising from this report.

4.6. Unpaid Carers

There are no direct unpaid-carer impacts arising from this report.

5. Links to ACHSCP Strategic Plan

5.1. Annual reviews of the IJB's Scheme of Governance help ensure that the Board and its Committees are functioning effectively, which in turn feeds into the achievement of the ACHSCP Strategic Plan.

6. Management of Risk

6.1. Identified risks(s)

The Scheme of Governance directly impacts on IJB Governance, which in turn directly impacts on a wide array of identified risks. Good governance is an effective control against many of the risks identified on the risk register.

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

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 support services; and performance.

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 regular review of the Scheme of Governance aims to maintain the integrity of the IJB's governance system and as such will help to mitigate these risks.

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Health and Social Care Integration Scheme for Aberdeen City

April 2023

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Document Control

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1. Introduction

The Public Bodies (Joint Working) (Scotland) Act 2014 provides a framework for the effective integration of adult health and social care services. Its policy ambition is to:

"…improve the quality and consistency of services for patients, carers, service users and their families; to provide seamless, joined-up quality health and social care services in order to care for people in their own homes or a homely setting where it is safe to do so; and to ensure resources are used effectively and efficiently to deliver services that meet the increasing number of people with longer term and often complex needs, many of whom are older."

To realise this ambition, the Aberdeen City Health and Social Care Partnership (the Integration Authority) has been established with a remit to engage with the people who use our services, their carers, our workforce, the third and independent sectors and community representatives in the planning and delivery of integrated adult health and social care services that will make a positive difference to the health and wellbeing of our City's population.

2. Aims and Outcomes of the Integration Scheme

NHS Grampian and the Council have a strong and shared sense of commitment and motivation to work closely with the residents and communities of Aberdeen to deliver good quality, person centred integrated health and social care services.

This commitment is reflected in the Partnership's vision "***A caring partnership working together with our city communities to enable people to achieve fulfilling and healthier lives and wellbeing".***

The underpinning values that will inform the Partnership's approach to planning and service delivery are:

- Honesty
- Empathy
- Equity
- Respect
- Transparency

The parent bodies are required to take into account the integration principles when preparing this Integration Scheme. These principles clearly state that the main purpose of integrated services is to improve the wellbeing of service users and these services should be provided in a way in which, so far as possible:

- Is integrated from the point of view from recipients
- Takes account of the particular needs of different recipients
- Takes account of the particular needs of recipients from different parts of the area in which the service is being provided
- Takes account of the particular characteristics and circumstances of different service users
- Respects the rights of service users
- Takes account of the dignity of service users
- Takes account of the participation by service users in the community in which service users live
- Protects and improves the safety of service users
- Improves the quality of the service
- Is planned and led locally in a way which is engaged with the community (including in particular service users, those who look after service users and those who are involved in the provision of health or social care)
- Best anticipates needs and prevents them arising, and
- Makes the best use of the available facilities, people and other resources

The Partnership will be obliged to evidence how well the nine National Health and Wellbeing outcomes are being met; these are:

1. People are able to look after and improve their own health and wellbeing and live in good health for longer.

2. People, including those with disabilities or long-term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

3. People who use health and social care services have positive experiences of those services, and have their dignity respected.

4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

5. Health and social care services contribute to reducing health inequalities.

6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.

7. People using health and social care services are safe from harm.

8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

9. Resources are used effectively and efficiently in the provision of health and social care services.

Integration Scheme

The parties:

THE ABERDEEN CITY COUNCIL, established under the Local Government etc. (Scotland) Act 1994 and having its principal offices at Town House, Broad Street, Aberdeen AB10 1AQ (hereinafter referred to as "the Council" which expression shall include its statutory successors);

And

GRAMPIAN HEALTH BOARD, established under section 2(1) of the National Health Service (Scotland) Act 1978 (operating as "NHS Grampian") and having its principal offices at Summerfield House, 2 Eday Road, Aberdeen AB15 6RE (hereinafter referred to as "NHS Grampian" which expression shall include its statutory successors)

(together referred to as "the Parties", and each being referred to as a "Party")

1. Definitions and Interpretation

1.1 In this Integration Scheme, the following terms shall have the following meanings: -

"Accountable Officer" means the NHS officer appointed in terms of section 15 of the Public Finance and Accountability (Scotland) Act 2000.
"Acute" services are those services specified in Annex 4 of this Scheme.

"Chief Officer" means the Officer appointed by the Integration Joint Board in accordance with section 10 of the Act.

"Delegated services" means the functions and services listed in Annexes 1 and 2 of this Scheme.

“Direction” means an instruction from the Integration Joint Board in accordance with section 26 of the Act.

“IJB” means the Aberdeen City Integration Joint Board established by Order under section 9 of the Act.

“IJB Order” means the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014.

Integrated Budget” means the Budget for the delegated resources for the functions set out in the Scheme.

“Outcomes” means the Health and Wellbeing Outcomes prescribed by the Scottish Ministers in Regulations under section 5(1) of the Act and are those listed on Page 4 of this Scheme.

“Payment” means all of the following:
a) the Integrated Budget contribution to the Integration Joint Board;
b) the resources paid by the Integration Joint Board to the Parties for carrying out directions, in accordance with section 27 of the Act and
c) does not require that a bank transaction is made;

Strategic Plan” means the plan which the Integration Joint Board is required to prepare and implement in relation to the delegated provision of health and social care services to adults in accordance with section 29 of the Act;
and
“Section 95 Officer” means the statutory post under the Local Government (Scotland) Act 1973 being the Accountable (Proper) Officer for the administration and governance of the financial affairs of the Council.

“The Act” means the Public Bodies (Joint Working) (Scotland) Act 2014;

"The Integration Scheme Regulations" means the Public Bodies (Joint Working) (Integration Scheme) (Scotland) Regulations 2014.

"The Parties" means the Aberdeen City Council and NHS Grampian.

"The Scheme" means this Integration Scheme.

1.2 In implementation of their obligations under the Act, the Parties hereby agree as follows:

1.3 In accordance with section 1(2) of the Act, the Parties agreed that the integration model set out in sections 1(4)(a) of the Act would be put in place for the IJB, namely the delegation of functions by the Parties to a body corporate that is to be established by Order under section 9 of the Act. The IJB was established by Parliamentary Order on 6 February 2016.

2. Local Governance Arrangements

2.1 The remit of the IJB is to prepare and implement a Strategic Plan in relation to the provision of health and social care services to adults in its area in accordance with sections 29-39 of the Act.

3. Board Governance

3.1 The arrangements for appointing the voting membership of the IJB in accordance with the IJB Order are as follows: -

3.1.1 The Council shall nominate four councillors: and

3.1.2 NHS Grampian shall nominate four health board members.

3.2 The voting membership of the IJB shall be appointed for a term of up to 3 years.

3.3 Provision for the disqualification, resignation and removal of voting members is set out in the IJB Order.

3.4 Whilst serving on the IJB its voting members carry out their functions under the Act on behalf of the IJB itself, and not as delegates of their respective Parties. Accurate record-keeping and minute-taking will be essential for transparency and accountability purposes.

3.5 The IJB is required to co-opt non-voting members to the IJB.

3.6 The non-voting membership of the IJB is set out in the IJB Order and includes (subject to any amendment of the IJB Order):

a) the chief social work officer of the local authority.
b) the Chief Officer, appointed by the IJB.
c) the proper officer of the integration joint board appointed under section 95 of the Local Government (Scotland) Act 1973.
d) a registered medical practitioner whose name is included in the list of primary medical services performers prepared by the Health Board in accordance with Regulations made under section 17P of the National Health Service (Scotland) Act 1978.
e) a registered nurse who is employed by the Health Board or by a person or body with which the Health Board has entered into a general medical services contract; and
f) a registered medical practitioner employed by the Health Board and not providing primary medical services.

In addition, the following will be co-opted onto the IJB

g) A Public Health Consultant employed by the NHS Board who shall be a non-voting member.

and at least one member of each of the following groups:

h) staff of the constituent authorities engaged in the provision of services provided under integration functions.

i) third sector bodies carrying out activities related to health or social care in the area of the local authority.

j) service users residing in the area of the local authority; and

k) persons providing unpaid care in the area of the local authority.

3.7 NHS Grampian will determine the non-voting representatives listed in d)-f) above, in terms of the IJB Order.

3.8 The arrangements for appointing the Chair and Vice Chair of the IJB are as follows:

3.8.1 The first Chair was nominated by the Council.

3.8.2 After the term of the first Chair came to an end, the Vice Chair became the next Chair and the outgoing Chair's organisation nominated the next Vice Chair, which the IJB appointed.

3.8.3 The term of the first Chair ended on 31 December 2016.

3.8.4 The second term of Chair began on 1 January 2017, with further terms of Chair beginning on the first day of January every two years thereafter.

4. Delegation of Functions

4.1 The functions that are to be delegated by NHS Grampian to the IJB are set out in Part 1 of Annex 1 and are subject to the exceptions and restrictions specified or referred to. The services to which these functions relate, which are currently provided by NHS Grampian, and which are to be integrated, are set out in Part 2 of Annex 1. For the avoidance of doubt, the functions listed in Part 1 of Annex 1 are delegated only in so far as they relate to the services listed in Part 2 of Annex 1 and there are certain services in respect of which functions are delegated for all age groups and certain services in respect of which functions are delegated for all people over the age of 18 only.

4.2 The functions that are to be delegated by the Council to the IJB are set out in Part 1 of Annex 2 and are subject to the exceptions and restrictions specified or referred to. The services to which these functions relate, which are currently provided by the Council, and which are to be integrated, are set out in Part 2 of Annex 2. For the avoidance of doubt, the functions listed in Part 1 of Annex 2 are delegated only to the extent that they relate to the services listed in Part 2 of Annex 2 and are provided to persons of 18 years and over.

4.3 In the delegation of functions, the Parties recognise that they will require to work together and with, the IJB, to achieve the Outcomes. Through local management, the Parties will put arrangements in place to avoid fragmentation of services provided to persons under 18 years. In particular, the community health services for persons under 18 years of age set out in Part 3 of Annex 1 shall be operationally devolved by the Chief Executive of NHS Grampian to the Chief Officer of the IJB who will be responsible and accountable for the operational delivery and performance of these services.

4.4 In exercising its functions, the IJB must take into account the Parties' requirements to meet their respective statutory obligations, standards set by government and other organisational and service delivery standards set by the Parties. Apart from those functions delegated by virtue of this Scheme, the Parties retain their distinct statutory responsibilities and therefore also retain their formal decision-making roles.

4.5 In the delegation of functions, the Parties recognise that they will require to work together, and with the IJB to achieve the required National Health and Wellbeing outcomes and desired local outcomes. To achieve these outcomes, the Parties will put appropriate arrangements in place that reflect the integration principles and ensure improved personal outcomes for the individuals who use the services.

4.6 The delegation of functions from the Parties to the IJB shall not affect the legality of any contract made between either of the Parties and any third party, which relates to the delivery of delegated or non-delegated services. The IJB

shall be mindful of the Parties existing contracts and shall enter into a joint commissioning strategy with the Parties.

4.7 Some delegated services may be hosted by the IJB on behalf of other integration authorities, or some delegated services may be hosted by another integration authority on behalf of the IJB. The IJB will consider and agree the hosting arrangements.

5. Local Operational Delivery Arrangements

5.1 The local operational arrangements agreed by the Parties are:

5.2 The responsibilities of the membership of the IJB in relation to monitoring and reporting on the delivery of delegated services on behalf of the Parties are as follows: -

5.2.1 The IJB is responsible for the planning of delegated services and achieves this through the Strategic Plan. It issues Directions to the Parties to deliver services in accordance with the Strategic Plan.

5.2.2 The IJB will continue to monitor the performance of the delivery of delegated services using the Strategic Plan on an ongoing basis.

5.2.3 The Parties expect the IJB to develop a framework which provides a mechanism for assurance and monitoring of the management and delivery of integrated services. This will ensure appropriate use of resources and enable appropriate scrutiny of performance which the Parties will support.

5.3 The IJB makes decisions on matters of strategy, policy and the annual budget as well as having oversight of, and obtaining assurance on, the performance of delegated services, including services that it hosts but not including the health services listed in Annex 4 or services which are hosted by another integration authority. NHS Grampian will be responsible for the operational oversight of the services listed in Annex 4 and already has in place an existing mechanism for the scrutiny and monitoring of delivery of

these services. Appropriate links will be made between this structure and any governance framework to be put in place by the IJB in terms of paragraph 5.6 below.

5.4 The IJB will take decisions in respect of delegated services for which it has operational oversight.

5.5 The IJB shall ensure that resources are managed appropriately for the delivery of delegated services for which it has operational oversight, in implementation of the Strategic Plan.

5.6 The Parties expect the IJB to develop a governance framework to provide itself with a mechanism for assurance and monitoring of the management and delivery of integrated services. This will enable the scrutiny of performance and of appropriate use of resources. If required, the Parties will support the IJB in the development of this framework.

5.7 The IJB is responsible for the operational delivery of criminal justice services. The IJB is a statutory partner on the Community Justice Group.

5.8 The Chief Officer is accountable to the IJB for the planning and operational delivery of the delegated services and the outcomes they achieve. The Chief Officer will make decisions which, in their opinion, is required to discharge their responsibilities for the planning and operational delivery of these delegated services. The Parties acknowledge that the Chief Officer's role in operational delivery will represent an important means by which closer integration of services, in accordance with the integration delivery principles specified in the Act, can be achieved.

5.8.1 The Chief Officer shall be accountable to the Parties in relation to the operational management of some of the delegated services and shall report to the Chief Executives of both Parties in this respect.

5.8.2 The Chief Officer shall work closely with those other persons who are responsible for operationally managing those services referred to in Part 2 of

Annex 1 hereof which the Chief officer is not directly responsible for, to ensure that the outcomes for the delivery of those services are achieved.

5.8.3 For the avoidance of doubt, the Chief Officer's role in operational delivery shall not displace:

(a) the responsibilities of each Party regarding compliance with directions issued by the IJB; or

(b) the principle that each Party's governance arrangements must allow that Party to manage risks relating to service delivery.

5.9 For delegated Acute services that the IJB does not have operational oversight of, the IJB shall be responsible for the strategic planning of those services. The IJB shall monitor performance of those delegated services in terms of outcomes delivered via the Strategic Plan.

5.10 NHS Grampian and the Council will be responsible for the operational delivery of delegated services in implementation of Directions of the IJB.

5.11 The Parties shall provide such information as may be reasonably required by the Chief Officer, the IJB and the Strategic Planning Group to enable the planning, monitoring and delivery of delegated services.

5.12 NHS Grampian and the IJB will work together to ensure that the planning and delivery of integrated (and non-integrated) hospital services are consistent.

6. Corporate Support Services

6.1 The Parties recognise that the IJB requires various corporate support services in order to fully discharge its duties under the Act.

6.2 The Parties shall identify, and may review, the corporate resources it requires, including the provision of any professional, technical or administrative services

for the purpose of preparing a Strategic Plan and carrying out delegated functions. This assessment shall be made available to the Parties.

6.3 The Parties shall be responsible for ensuring that the IJB has provision of suitable resources for corporate support to allow it to fully discharge its duties under the Act.

6.4 The Parties and the IJB shall reach an agreement in respect of how these services will be provided to the IJB which will set out the details of the provision.

6.5 The Parties and the IJB will review the support services being provided on an annual basis to ensure that these are sufficient. The Parties and the IJB shall agree on the arrangements for future provision, including specifying how these requirements will be built into the IJB's annual budget setting and review process.

7 Support for Strategic Planning

7.1 The Parties shall share with such other relevant integration authorities, the necessary activity and financial data for services, facilities or resources that relate to the planned use of services provided by those integration authorities for the users of adult health and social care services of Aberdeen City.

7.2 The Parties shall consult with the IJB on any plans to change service provision of non-delegated services which may have a resultant impact on the Strategic Plan.

7.3 The Strategic Plan is written for users of adult health and social care services within Aberdeen City. A number of individuals will receive services across a boundary of an integration authority. For example, a certain percentage of Aberdeenshire residents access GP primary care in Aberdeen City. NHS Grampian will provide support to enable the appropriate planning of such services for these individuals. This shall be done in pursuance of the duty under s30 (3) of the Act.

8. Targets and Performance Measurement

8.1 The Parties shall inform the IJB what performance targets and improvement measures it considers the IJB should take account of, in the planning and delivery of delegated functions for which responsibility should transfer exclusively to the IJB.

8.2 Where the responsibility for achieving the targets span delegated and non-delegated services, the Parties and the IJB will work together to deliver these.

8.3 A set of shared principles for targets, measures and indicators known as a Performance Framework, will be maintained and agreed by the Parties and the IJB. This will take into account the Scottish Government's Guidance on the Outcomes and the associated core suite of indicators for integration.

8.4 The performance framework will be underpinned by the Outcomes and will drive change and improve effectiveness. The framework will be informed by an assessment of current performance arrangements and the development of a set of objectives which the framework is intended to achieve.

9. Clinical and Professional Governance

9.1 Outcomes

9.1.1 The IJB and the Parties will provide assurance on Outcomes through its clinical and professional governance arrangements.

9.1.2 The Parties and the IJB will have regard to the integration planning and delivery principles and will determine the clinical and professional governance assurances and information required by the IJB to inform the development, monitoring and delivery of its Strategic Plan. The Parties will provide that assurance and information to the IJB.

9.2 General Clinical and Professional Governance Arrangements

9.2.1 The Parties and the IJB are accountable for ensuring appropriate clinical and professional governance arrangements for their duties under the Act.

9.2.2 The Parties remain responsible for the clinical and professional governance of the services which the IJB has instructed the Parties to deliver.

9.2.3 The Parties remain responsible for the assurance of the quality and safety of services commissioned from the third and independent sectors in line with the requirements set out in the Strategic Plan.

9.2.4 The IJB will have regard to healthcare and social care governance, quality, aims, and risks when developing and agreeing its Strategic Plan and its corresponding Directions to the Parties. These risks may be identified by either of the Parties or the IJB and may include professional risks.

9.2.5 The Parties and the IJB will establish an agreed approach to measuring and reporting to the IJB on the quality of service delivery, organisational and individual care risks, the promotion of continuous improvement and ensuring that all professional and clinical standards, legislation, and guidance are met. This will be set out in a report to the IJB for it to approve.

9.3 Clinical and Professional Governance Framework

9.3.1 NHS Grampian seeks assurance in the area of clinical governance, quality improvement and clinical risk from the NHS Grampian Clinical Governance Committee, through a process of constructive challenge. The Clinical Governance Committee is responsible for demonstrating

compliance with statutory requirements in relation to clinical governance, authorising an accurate and honest annual clinical governance statement and responding to scrutiny and improvement reports by external bodies such as Healthcare Improvement Scotland (or any successor). To achieve this, the Committee oversees a governance framework including a strategy, annual work programme, infrastructure of governance groups and an annual report.

9.3.2 The Council is required by law to appoint a Chief Social Work Officer to oversee and make decisions in relation to specified social work services, some of which are delegated in relation to integration functions, and to report to and alert the Council and elected members of any matters of professional concern in the management and delivery of those functions. He or she has a duty to make an annual report to the Council in relation to the discharge of the role and responsibilities. The Chief Social Work Officer will be a non-voting member of the IJB. If required, he or she shall make an annual report to the IJB in relation to the aspects of his or her position which relate to the delivery of integrated functions. The Chief Social Work Officer will retain all of the statutory decision-making and advisory powers given by statute and guidance, and the Medical and Nursing Directors shall not be entitled to countermand or over-rule any decisions or instructions given by the Chief Social Work Officer in carrying out that statutory role.

9.3.3 External scrutiny is provided by the Care Inspectorate (Social Care and Social Work Improvement Scotland) (or any successor), which regulates, inspects, and supports improvement of adult social work and social care.

9.3.4 The Scottish Government's *Clinical and Care Governance Framework for Integrated Health and Social Care Services in Scotland, 2015* (or any updated version or replacement) outlines the proposed roles, responsibilities and actions that will be required to ensure governance

arrangements in support of the Act's integration planning and delivery principles and the required focus on improved Outcomes.

9.3.5 The IJB has established a Clinical and Care Governance Committee and a Risk, Audit and Performance Committee. The Clinical Care Governance Committee oversee the clinical and professional governance arrangements for integrated services and the Risk, Audit & Performance Committee oversee risk management, financial management, and service performance. It is chaired by a non-office bearing voting member of the IJB and the Chair will rotate between NHS Grampian and Aberdeen City Council. The Committee is comprised of four members, two nominated by each partner. The Committee may also have additional members appointed by the IJB.

9.3.6 The role, remit and membership of the Clinical and Care Governance and the Risk, Audit & Performances Committees is set out in the IJB's terms of reference for each sub-committee which may be reviewed and amended by the IJB.

9.3.7 The Clinical and Care Governance and the Risk, Audit & Performance Committees will provide relevant advice and support to the IJB, the Strategic Planning Group, the Chief Officer and any professional groups established in localities as and when required. This can be done through the Chair of the Committees (or such other appropriate members) informing and advising the IJB, the Strategic Planning Group, the Chief Officer and any other Group, Committee, or locality of the IJB as and when required. The IJB and the Chief Officer shall also be able to obtain professional advice from the IJB non-voting membership of the Committees.

9.4 Staff Governance

9.4.1 The Parties will ensure that staff working in integrated services have the right training and education required to deliver professional standards of care and meet any professional regulatory requirements.

9.4.2 The IJB and the Parties shall ensure that staff will be supported if they raise concerns relating to practice that endangers the safety of service users and other wrongdoing in line with local policies and regulatory requirements. There are three main Whistleblowing policies relevant to the IJB the National Whistleblowing Standards, Aberdeen City Council's Whistleblowing Policy and the IJB's Whistleblowing Policy.

National Whistleblowing Standards have been produced by the Independent National Whistleblowing Officer's Department and came into effect on 1 April 2021. Whistleblowing Concerns can be raised by anyone who is (or has been) providing services for the NHS or working to provide services with NHS staff.

Aberdeen City Council Whistleblowing Policy -This policy applies to all employees and workers, including agency staff, workers who are self-employed, sub-contractors and workers employed by an outsourced contractor providing Council services.

IJB Whistleblowing Policy - This Policy relates to all IJB Members and Office Holders of the Board and is committed to dealing responsibly, openly and professionally with any genuine concerns held by staff of the Aberdeen City Health and Social Care Partnership, Members of the Board or Office Holders, encouraging them to report any concerns about wrongdoing or malpractice within the IJB, which they believe has occurred. The aim of this policy is to ensure that staff and Members are fully aware of the types of matters that they should report and the reporting procedure they should follow to raise any genuine concerns

about any possible wrongdoing or malpractice, at an early stage, without fear of penalty or victimisation.

9.4.3 Staff employed by NHS Grampian are bound to follow the NHS Staff Governance Standard. This Standard is recognised as being very laudable and the IJB will encourage it to be adopted for all staff involved in the delivery of delegated services. The Staff Governance Standard requires all NHS Boards to demonstrate that staff are:

- Well informed.
- Appropriately trained and developed.
- Involved in decisions which affect them.
- Treated fairly and consistently, with dignity and respect, in an environment where diversity is valued; and
- Provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients, and the wider community.

9.4.4 The Standard places a reciprocal duty on staff to:

- Keep themselves up to date with developments relevant to their job within the organisation.
- Commit to continuous personal and professional development.
- Adhere to the standards set by their regulatory bodies.
- Actively participate in discussions on issues that affect them either directly or via their trade union/professional organisation.
- Treat all staff and patients with dignity and respect while valuing diversity; and
- Ensure that their actions maintain and promote the health, safety and wellbeing of all staff, patients, and carers.

9.5 Interaction between the IJB, Strategic Planning Group and Localities

9.5.1 Section 32 of the Public Bodies (Joint Working) (Scotland) Act 2014 requires an Integration Joint Board to establish a Strategic Planning Group comprising of members from Aberdeen City Council, NHS Grampian, staff from integrated services, a person to represent the interests of each locality, and representatives of such groups of persons appearing to the Scottish Ministers to have an interest. The Strategic Planning Group ensures that key strategic, policy, performance and improvement decisions relating to integration functions are informed and co-developed by partners and the organisations and communities they represent.

9.5.2 Aberdeen City Integration Joint Board have adopted joint Locality Planning arrangements with Aberdeen City Council. Each Locality has a Locality Empowerment Group (LEG) and a Priority Neighbourhood Partnership (PNP) supported jointly by integrated services staff and local authority staff. The LEGs and the PNPs are the main focus for consultation and engagement with the communities of Aberdeen and where Aberdeen City Integration Joint Board aim to ensure integrated services are planned and led locally.

9.6 Professional Leadership

9.6.1 The Act does not change the professional regulatory framework within which health and social care professionals work, or the established professional accountabilities that are currently in place within the NHS and local government. The Act through drawing together the planning and delivery of services aims to better support the delivery of improved outcomes for the individuals who receive care and support across health and social care.

9.6.2 Directors of Public Health, Medical Directors and Nursing Directors are ministerial appointments made through health boards to oversee systems of professional and clinical governance within the Health

Board. Their professional responsibilities supersede their responsibilities to their employer. These Directors continue to hold responsibility for the actions of NHS Grampian clinical staff who deliver care through delegated/integrated services. They, in turn, continue to attend the NHS Grampian Clinical Governance Committee which oversees the clinical governance arrangements of all services delivered by health care staff employed by NHS Grampian.

9.6.3 In addition to the Clinical and Care Governance Committee, advice can be provided to the IJB and the Strategic Planning Group through the Clinical Executive Directors of NHS Grampian and the Chief Social Work Officer of the Council on professional / workforce, clinical / care and social care / social work governance matters relating to the development, delivery, and monitoring of the Strategic Plan, including the development of integrated service arrangements. The professional leads of the Parties can provide advice and raise issues directly with the IJB either in writing or through the representatives that sit on the IJB. The IJB will respond in writing to these issues, where asked to do so by the Parties.

9.6.4 The key principles for professional leadership are as follows:

- Job descriptions will reflect the level of professional responsibility at all levels of the workforce explicitly.
- The IJB will name the clinical lead and ensure representation of professional representation and assurance from both health and social care. The Director of Public Health, the Executive Nurse Director and Medical Director will continue to have professional managerial responsibility.
- All service development and redesign will outline participation of professional leadership from the outset, and this will be evidenced in all IJB papers.
- The effectiveness of the professional leadership principles will be reviewed annually.

10.1 Chief Officer

10.1.1 The IJB shall appoint a Chief Officer in accordance with section 10 of the Act. The arrangements in relation to the Chief Officer agreed by the Parties are:

10.1.2 An interim Chief Officer may be appointed by arrangements made jointly by the Chief Executives of both Parties at the request of the IJB.

10.1.3 The Chief Officer will be responsible for the operational management of the delegated services. Further arrangements in relation to the Chief Officer's responsibilities for strategic planning and operational management are determined by the Parties and set out in a separate document, which the IJB may amend from time to time.

10.1.4 The Chief Officer will be responsible for the development and monitoring of operational plans which set out the mechanism for the delivery of the Strategic Plan. The Chief Officer may sub-delegate decision making powers that have been delegated by NHSG and ACC where, in their opinion, it is appropriate and legitimate to do so.

10.1.5 The Chief Executive of NHS Grampian is the Accountable Officer for the delivery of the acute services that the IJB only has strategic planning responsibility for. The Chief Officer is accountable to the Chief Executive of NHS Grampian for the effective strategic planning of these services in line with current strategies or policies. NHS Grampian will agree with the IJB an appropriate performance and scrutiny framework to ensure that performance is delivered in line with strategic ambitions and national Outcomes.

10.1.6 The Chief Officer is a member of the appropriate senior/corporate management teams of NHS Grampian Health Board and the Council. This enables the Chief Officer to work closely with senior management of both Parties to carry out the functions of the IJB in accordance with the Strategic Plan.

10.1.7 The Chief Officer is line managed by and will report to the Chief Executive of the Council and the Chief Executive of NHS Grampian.

10.1.8 The Chief Officer will develop close working relationships with elected members of the Council and non-executive and executive NHS Grampian board members.

10.1.9 The Chief Officer will establish and maintain effective working relationships with a range of key stakeholders across NHS Grampian, the Council, the third and independent sectors, communities, service users and carers, the Scottish Government, trade unions and relevant professional organisations.

10.1.10 The Chief Officer will work with trade unions, staff side representatives and professional organisations to ensure a consistent approach to their continued involvement in the integration of health and social care.

10.2 NHS Grampian and the Council have established the post of Chief Operating Officer. The Chief Operating Officer shall support the Chief Officer of the IJB, be responsible for the strategic leadership of the Partnership and the delivery of the IJB's Strategic Plan. Further arrangements in relation to the Chief Operating Officer's responsibilities are determined by the Parties. Additionally, the Parties agree that the Chief Operating Officer shall act as Chief Officer, in the absence of the Chief Officer of the IJB, and that the IJB shall appoint the Chief Operating Officer in this capacity at the next meeting of the IJB, following the appointment of the Chief Operating Officer.

11. Workforce

11.1 The arrangements in relation to their respective workforces agreed by the Parties are:

11.2 Staff engaged in the delivery of delegated services shall remain employed by their existing organisations on the date the IJB is established. If the roles of staff are to be transferred, the Parties will ensure that the principles of TUPE will be adhered to. The Parties will develop an agreed process for this which will be set out in a separate document.

11.3 The IJB is planning to have a fully integrated management arrangement where it is recognised teams will have individuals reporting through a person employed by the other organisation. Both Parties are in agreement that staff employed by them will be subject to direction from a manager from the other organisation.

11.4 Both Parties have workforce plans, and as the integrated teams are developed, so the integrated workforce plan will follow. The joint workforce plan will relate to the development and support to be provided to the workforce who are employed in pursuance of integrated services and functions.

11.5 The joint workforce plan will cover the strategic organisational development outcomes of the Parties and the IJB, including workforce planning and development, and will support the workforce in the delivery of integrated services. The plan will cover staff communication, staff engagement, staff and team development, leadership development and the training needs for staff that will be responsible for managing integrated teams. This will encourage the development of a healthy organisational culture. The Parties will work together in developing this plan along with stakeholders. The latest revision of the Workforce Plan was presented to the IJB in August 2022 although further development is required. The plan will continue to be reviewed regularly

through an agreed process to ensure that it takes account of the development needs of staff.

12. Finance

12.1 Financial Governance

12.1.1 Details of financial governance and Financial Regulations are contained in a separate document out with this Scheme.

12.2 Payments to the IJB – General

12.2.1 The payment made by each Party is not an actual cash transaction for the IJB. There will be a requirement for an actual cash transfer to be made between the Parties to reflect the difference between the payment being made by a Party and the resources delegated by the IJB to that Party to deliver services.. A final transfer will be made at the end of the financial year on closure of the annual accounts of the IJB to reflect in-year budget adjustments agreed.

12.2.2 Resource Transfer – The existing resource transfer arrangements will cease upon establishment of the IJB and instead NHS Grampian will include the equivalent sum in its budget allocation to the IJB. The Council payment to the IJB will accordingly be reduced to reflect this adjustment.

12.2.3 Value Added Tax (VAT) – the budget allocations made will reflect the respective VAT status and treatments of the Parties. In general terms budget allocations by the Council will be made net of tax to reflect its status as a Section 33 body in terms of the Value Added Tax Act 1994 and those made by NHS Grampian will be made gross of tax to reflect its status as a Section 41 body in terms of the Value Added Tax Act 1994.

12.3 Payments to the IJB

12.3.1 The payment that will be determined by each Party requires to be agreed in advance of the start of the financial year. Each Party agrees that the baseline payment to the IJB for delegated functions will be formally advised to the IJB and the other Party by 28th February each year.

12.3.2 In subsequent years, the Chief Officer and the Chief Finance Officer of the IJB will develop a case for the Integrated Budget based on the Strategic Plan and present it to the Council and NHS Grampian for consideration as part of the annual budget setting process, in accordance with the timescales contained therein. The case should be evidence based with full transparency on its assumptions and analysis of changes, covering factors such as activity changes, cost inflation, efficiencies, legal requirements, transfers to / from the "set aside" budget for hospital services and equity of resource allocation.

12.3.3 The final payment into the IJB will be agreed by the Parties in accordance with their own processes for budget setting.

12.3.4 Assuming 12.3.1 is complied with, the IJB will approve and provide direction to the Parties by 31st March each year regarding the functions that are being directed, how they are to be delivered and the resources to be used in delivery.

12.4 Method for determining the amount set aside for hospital services

12.5.1 The IJB will be responsible for strategic planning, in partnership with the hospital sector, of those hospital services most commonly associated with the emergency care pathway.

12.5.2 The IJB and the hospital sector will agree a method for establishing the amount to be set aside for services that are delivered in a large hospital as part of the emergency care pathway which will show consumption by the residents of the IJB.

12.5.3 The method of establishing the set aside budget will take account of hospital activity data and cost information. Hospital activity data will reflect actual occupied bed day and admissions information, together with any planned changes in activity and case mix.

12.6 Financial Management of the IJB

12.6.1 The Council will host the financial transactions specific to the IJB.

12.6.2 The IJB will appoint a Chief Finance Officer who will be accountable for the annual accounts preparation (including gaining the assurances required for the governance statement) and financial planning (including the financial section of the Strategic Plan) and will provide financial advice and support to the Chief Officer and the IJB. The Chief Finance Officer will also be responsible for the production of the annual financial statement in terms of section 39 of the Act.

12.6.3 As part of the process of preparing the annual accounts of the IJB the Chief Finance Officer of the IJB will be responsible for agreeing balances between the IJB and Parties at the end of the financial year and for agreeing details of transactions between the IJB and Parties during the financial year. The Chief Finance Officer of the IJB will also be responsible for provision of other information required by the Parties to complete their annual accounts including Group Accounts.

12.6.4 Recording of all financial information in respect of the integrated services will be in the financial ledger of the Party which is delivering the services on behalf of the IJB.

12.6.5 The Parties shall agree what financial administration agreements are required to enable the transactions for delegated functions (e.g., payment of suppliers, payment of staff, raising of invoices etc.) to be administered and financial reports to be provided to the Chief Finance Officer of the IJB.

12.7 Financial reporting to the IJB and the Chief Officer

12.7.1 Financial reports for the IJB will be prepared by the Chief Finance Officer of the IJB. The format and frequency of the reports shall be agreed by the Parties and the IJB but will be at least on a quarterly basis. The Director of Finance of NHS Grampian and the Section 95 Officer of the Council will work with the Chief Finance Officer of the IJB to ensure that the information that is required to produce such reports can be provided.

12.7.2 To assist with the above the Parties will provide information to the Chief Finance Officer of the IJB regarding costs incurred by them on a quarterly basis for services directly managed by the IJB. Similarly, NHS Grampian will provide the IJB with information on use of the amounts set aside for hospital services. This information will focus on patient activity levels and not include unit costs; the frequency will be agreed with the IJB but will be at least quarterly.

The Chief Finance Officer of the IJB will agree a timetable for the preparation of the annual accounts in partnership with the Director of Finance of NHS Grampian and the Section 95 Officer of the Council.

12.7.3 In order to give assurance to the Parties that the delegated budgets are being used for their intended purposes, financial monitoring reports will be produced for the Parties in accordance with timetables to be agreed at the start of each financial year. The format of such reports to be agreed by the Director of Finance of NHS Grampian and the Section 95

Officer of the Council, in conjunction with the Chief Finance Officer of the IJB.

12.8 The process for addressing in year variations in the spending of the IJB

12.8.1 Increases in payment by Parties to the IJB

The Parties may increase in-year the payments to the IJB for the delegated services with the agreement of the IJB.

12.8.2 Reductions in payment by Parties to the IJB

12.8.2.1 The Parties do not expect to reduce the payment to the IJB in-year unless there are exceptional circumstances resulting in significant unplanned costs for the Party. In such exceptional circumstances the following escalation process would be followed before any reduction to the in-year payment to the IJB was agreed: -

a) The Party would seek to manage the unplanned costs within its own resources, including the application of reserves where applicable.

b) Each Party would need to approve any decision to seek to reduce the in-year payment to the IJB.

c) Any final decision would need to be agreed by the Chief Executives of both Parties and by the Chief Officer of the IJB and be ratified by the Parties and the IJB.

12.8.3 Variations to the planned payments by the IJB

12.8.3.1 The Chief Officer is expected to deliver the agreed outcomes within the total delegated resources of the IJB. Where a forecast overspend against an element of the operational budget emerges during the financial year, in the first instance it is expected that the Chief Officer, in conjunction with the Chief

Finance Officer of the IJB, will agree corrective action with the IJB.

12.8.3.2 If this does not resolve the overspending issue then the Chief Officer, the Chief Finance Officer of the IJB and the Director of Finance of NHS Grampian and the Section 95 Officer of the Council must agree a recovery plan to balance the overspending budget.

12.8.4 IJB Overspend against payments

12.8.4.1 In the event that the recovery plan is unsuccessful and an overspend is evident at the year-end, uncommitted reserves held by the IJB, in line with the reserves policy, would firstly be used to address any overspend.

12.8.4.2 In the event that an overspend is evident following the application of reserves, the following arrangements will apply for addressing that overspend: -

12.8.4.3 In future years of the IJB, either:

a) A single Party may make an additional one-off payment to the IJB,

or

b) The Parties may jointly make additional one-off payments to the IJB in order to meet the overspend. The split of one-off payments between Parties in this circumstance will be based on each Party's proportionate share of the baseline payment to the IJB, regardless of in which arm of the operational budget the overspend has occurred in.

12.8.4.4 The recovery plan may include provision for the Parties to recover any such additional one-off payments from their baseline payment to the IJB in the next financial year.

12.8.4.5 The arrangement to be adopted will be agreed by the Parties.

12.8.5 IJB underspend against payments

12.8.5.1 In the event of a forecast underspend the IJB will require to decide whether this results in a redetermination of payment or whether surplus funds will contribute to the IJB's reserves.

12.8.5.2 The Chief Officer and Chief Finance Officer of the IJB will prepare a reserves policy for the IJB, which requires the approval of the IJB and the Director of Finance of NHS Grampian and the Section 95 Officer of the Council. The reserves policy will be reviewed on a periodic basis.

12.8.5.3 In the event of a return of funds to the Parties, the split of returned payments between Parties will be based on each Party's proportionate share of the baseline payment to the IJB, regardless of which arm of the operational budget the underspend occurred in.

12.8.6 Planned Changes in Large Hospital Services

12.8.6.1 The IJB and the hospital sector will agree a methodology for the financial consequences of planned changes in capacity for set aside budgets in large hospital services.

12.8.6.2 Planned changes in capacity for large hospital services will be outlined in the IJB Strategic Plan. A financial plan (reflecting any planned capacity changes) will be developed and agreed that

sets out the capacity and resource levels required for the set aside budget for the IJB and the hospital sector, for each year. The financial plan will take account of :-

- activity changes based on demographic change;
- agreed activity changes from new interventions;
- cost behaviour;
- hospital efficiency and productivity targets;
- an agreed schedule for timing of additional resource / resource released.

12.8.6.3 The process for making adjustments to the set aside resource to reflect variances in performance against plan will be agreed by the IJB and the Health Board. Changes will not be made in year and any changes will be made by annual adjustments to the Strategic Plan of the IJB.

12.9 Capital

12.9.1 The use of capital assets in relation to integration functions

12.9.1.1 Ownership of capital assets will continue to sit with each Party and capital assets are not part of the payment or "set aside".

12.9.1.2 If the IJB decides to fund a new capital asset from revenue funds, then ownership of the resulting asset shall be determined by the Parties.

12.9.1.3 The Strategic Plan will drive the financial strategy and will provide the basis for the IJB to present proposals to the Parties to influence capital budgets and prioritisation.

12.9.1.4 A business case with a clear position on funding is required for any change to the use of existing assets or proposed use of new assets. The Chief Officer of the IJB is to develop business cases for capital investment for consideration by NHS Grampian and the Council as part of their respective capital planning processes.

12.9.1.5 The Chief Officer of the IJB will liaise with the relevant officer within each Party in respect of day-to-day asset related matters including any consolidation or relocation of operational teams.

12.9.1.6 It is anticipated that the Strategic Plan will outline medium term changes in the level of budget allocations for assets used by the IJB that will be acceptable to the Parties.

12.9.1.7 Any profits or loss on sale of an asset will be held by the Parties and not allocated to the IJB.

12.9.1.8 Depreciation budgets for assets used on delegated functions will continue to be held by each Party and not allocated to the IJB operations in scope.

12.9.1.9 The management of all other associated running costs (e.g. maintenance, insurance, repairs, rates, utilities) will be subject to local agreement between the Parties and the IJB.

13. Participation and Engagement

13.1 A joint consultation on the Scheme took place before it was first put in place. Whenever the scheme is reviewed in future, there will be further joint consultation.

13.2 Media notifications will be issued for members of the public that reside within Aberdeen. Staff will be alerted to the proposed revisions to the scheme. An email address will be supplied for people to send their views.

13.3 The consultation draft Scheme will then be presented to NHS Grampian Board and elected members of the Council.

13.4 Principles endorsed by the Scottish Health Council and the National Standards for Community Engagement were agreed by the Parties and followed in respect of the consultation process, including the following:

13.4.1 It will be a genuine consultation exercise: the views of all participants are valued.

13.4.2 It will be transparent: the results of the consultation exercise will be published.

13.4.3 It will be an accessible consultation: the consultation documentation will be provided in a variety of formats.

13.4.4 It will be led by the Chief Officer: the Chief Officer and the IJB will be answerable to the people of Aberdeen City in terms of the content of the Scheme.

13.4.5 It will be part of an on-going dialogue: the Integration Scheme will establish the parameters of the future strategic plans of the IJB.

13.5 The stakeholders consulted in the development of this Scheme were:

- Health professionals.
- Users of health care.
- Future users of health care.
- Carers of users of health care.
- Commercial providers of health care.
- Non-commercial providers of health care.
- Social care professionals.
- Users of social care.
- Future users of social care.

- Carers of users of social care.
- Commercial providers of social care.
- Non-commercial providers of social care.
- Staff of NHS Grampian and the Council who are not health professionals or social care professionals.
- Non-commercial providers of social housing.
- Third sector bodies carrying out activities related to health or social care; and
- Other local authorities operating with the area of NHS Grampian preparing an integration scheme.

13.6 The Parties enabled the IJB to develop a Communications and Engagement Strategy by providing appropriate resources and support. The Communications and Engagement Strategy ensures significant engagement with, and participation by, members of the public, representative groups and other organisations in relation to decisions about the carrying out of integration functions. The Parties encourage the IJB to access existing forums that the Parties have established, such as Public Partnership Forums, Community Councils, groups and other networks and stakeholder groups with an interest in health and social care.

14. Information Sharing and Confidentiality

14.1 The Parties have agreed to an appropriate information sharing accord for the sharing of information in relation to integrated services. The information sharing accord sets out the principles, policies, procedures, and management strategies around which information sharing is carried out. It encapsulates national and legal requirements.

14.2 The Parties will work together to progress the specific arrangements, practical policies and procedures, designated responsibilities and any additional requirements for information sharing for any purpose connected with the preparation of an integration scheme, the preparation of a strategic plan or the carrying out of integration functions.

14.4 If the Parties consider that a further high-level accord or information sharing protocol is required, or if amendments are necessary to existing ones, they shall prepare these and make them available with their recommendation to the IJB in the first instance for comment.

14.5 If a new information sharing accord and/or procedures for information sharing are necessary, these will be agreed to by the Parties. . Where the Parties agree that the arrangements for information sharing do not require the drafting of a new information sharing protocol, each Party shall confirm to its staff that the guidance in place is appropriate and up to date.

14.6 The information sharing accord may be amended or replaced by agreement of the Parties and the IJB.

14.7 The Parties will continue to develop information technology systems and procedures to enable information to be shared appropriately and effectively between the Parties and the IJB.

15. Complaints

15.1 The Parties agree the following arrangements in respect of complaints:

15.2 Complaints should continue to be made to the Parties using the existing mechanisms.

15.3 Complaints can be made to the Parties through any member of staff providing integrated services. Complaints can be made in person, by telephone, by email, or in writing. On completion of the complaints procedure, complainants may ask for a review of the outcome. At the end of the complaints process, complainants are entitled to take their complaint to the Scottish Public Services Ombudsman (or any such successor). Where appropriate,

complainants will also be advised of their right to complain to the Care Inspectorate (or any such successor).

15.4 The Parties shall communicate with each other in relation to any complaint which requires investigation or input from the other organisation.

15.5 The Chief Officer will have an overview of complaints made about delegated services and subsequent responses. Complaints about delegated services will be recorded and reported to the Chief Officer on a regular and agreed basis.

15.6 The Parties and the IJB shall develop a process for complaints against the IJB and the Chief Officer which will follow any Scottish Government Guidance and existing statutory complaints procedures which operate within the respective Parties.

15.7 The Parties and the IJB will use complaints as a valuable tool for improving services and to identify areas where further staff training may be of benefit.

15.8 The Parties and the IJB will ensure that all staff working in the provision of delegated services are familiar with the complaints procedures and that they can direct individuals to the appropriate complaints' procedures.

15.9 The complaints procedures developed and referred to, at clause 15.6 above will be clearly explained, well-publicised, accessible, will allow for timely recourse and will sign-post independent advocacy services.

15.10 The Parties and the IJB will aspire to have a streamlined process for complaints, to ensure that there is an integrated approach to the handling of the complaint from the complainer's perspective. When this is achieved, the Scheme will be amended using the procedure required by the Act.

15.11 In developing a streamlined process for complaints, the Parties shall ensure that all statutory requirements will continue to be met, including timescales for responding to complaints.

15.12 In developing a single complaints process, the IJB will endeavour to develop a uniform way to review unresolved complaints before signalling individuals to the appropriate statutory review authority.

16. Claims Handling, Liability & Indemnity

16.1 The Parties and the IJB recognise that they could receive a claim arising from or which relates to the work undertaken on behalf of the IJB.

16.2 The Parties agree to ensure that any such claims are progressed quickly and in a manner which is equitable between them.

16.3 So far as reasonably practicable the normal common law and statutory rules relating to liability will apply.

16.4 Each party will assume responsibility for progressing and determining any claim which relates to any act or omission on the part of one of their employees.

16.5 Each party will assume responsibility for progressing and determining any claim which relates to any heritable property which is owned by them. If there are any heritable properties owned jointly by the Parties, further arrangements for liability will be agreed upon in consultation with insurers.

16.6 In the event of any claim against the IJB or in respect of which it is not clear which party should assume responsibility then the Chief Officer (or his/her representative) will liaise with the Chief Executives of the Parties (or their representatives) and determine which party should assume responsibility for progressing the claim.

16.7 If a claim is settled by either party, but it subsequently transpires that liability rested with the other party, then that party shall indemnify the party which settled the claim.

16.8 Claims regarding policy and/or strategic decisions made by the IJB shall be the responsibility of the IJB. The IJB may require to engage independent legal advice for such claims.

16.9 If a claim has a "cross boundary" element whereby it relates to another integration authority area, the Chief Officers of the integration authorities concerned shall liaise with each other until an agreement is reached as to how the claim should be progressed and determined.

16.10 The IJB will develop a procedure for claims relating to hosted services with the other relevant integration authorities. Such claims may follow a different procedure than as set out above.

16.11 Claims which pre-date the establishment of the IJB will be dealt with by the Parties through the procedures used by them prior to integration.

17. Risk Management

17.1 A shared risk management strategy is in place which includes risk monitoring and a reporting process for the Parties and the IJB. This will be updated as needed and particularly when this scheme is revised, and any additional functions delegated so that it is updated by the time such functions are delegated to the IJB. In developing this shared risk management strategy, the Parties reviewed the shared risk management arrangements in operation, including the Parties' own Risk Registers.

17.2 There will be shared risk management across the Parties and the IJB for significant risks that impact on integrated service provision. The Parties and the IJB will consider these risks as a matter of course and notify each other where the risks may have changed.

17.3 The Parties will provide the IJB with support, guidance and advice through their respective Risk Managers, in order to be reassured that the IJB's Risk Register is credible and appropriate.

17.4 A single Strategic Risk Register has been developed for the IJB. The process used in developing a single Risk Register involved members of the IJB establishing a risk framework by identifying risks to the development of the Strategic Plan. This risk framework in turn was used by operational units of integrated services and each unit was required to contribute towards the Risk Register by identifying relevant risks and mitigation of those risks.

17.5 The single Risk Register will continue to be developed alongside the Strategic Plan and will be modified as necessary in line with the development of the Strategic Plan. The single Risk Register will be completed and available to the IJB for the date functions are delegated to the IJB.

17.6 Any changes to risk management strategies shall be requested through formal paper to the IJB.

18. Dispute resolution mechanism

18.1 This provision relates to disputes between NHS Grampian and the Council in respect of the IJB or in respect of their duties under the Act. This provision does not apply to internal disputes within the IJB itself.

18.2 Where either of the Parties fails to agree with the other on any issue related to this Scheme and/or the delivery of delegated health and social care services, then they will follow the process as set out below:

(a) The Chief Executives of NHS Grampian and the Council and the Chief Officer of the IJB will meet to resolve the issue.

(b) If unresolved, NHS Grampian and the Council and the IJB will each prepare a written note of their position on the issue and exchange it with the others within 21 calendar days of the meeting in (a).

(c) Within 21 calendar days of the exchange of written notes in (b) the Chief Executives and Chief Officer must meet to discuss the written positions.

(d) In the event that the issue remains unresolved, the Chief Executives and the Chief Officer will proceed to mediation with a view to resolving the issue. The Chief Officer will appoint a professional independent mediator. The cost of mediation, if any, will be split equally between the Parties. The mediation process will commence within 28 calendar days of the meeting in (c).

(e) Where the issue remains unresolved after following the processes outlined in (a)-(d) above and if mediation does not allow an agreement to be reached within 6 months from its commencement, or any other such time as the parties may agree, either party may notify Scottish Ministers that agreement cannot be reached.

(f) Where the Scottish Ministers make a determination on the dispute, that determination shall be final and the Parties and the IJB shall be bound by the determination.

Annex 1
Part 1

Functions delegated by the Health Board to the Integration Joint Board

The functions which are to be delegated by NHS Grampian to the Integration Joint Board are set out in this Part 1 of Annex 1 and are subject to the exceptions and restrictions specified or referred to. The services to which these functions relate are set out in Part 2 of this Annex 1.

Schedule 1 Regulation 3

Functions prescribed for the purposes of section 1(8) of the Act

Column A	*Column B*
The National Health Service (Scotland) Act 1978	

All functions of Health Boards conferred by, or by virtue of, the National Health Service (Scotland) Act 1978	Except functions conferred by or by virtue of—
	
	section 2(7) (Health Boards);
	
	section 2CB([1]) (Functions of Health Boards outside Scotland);
	
	section 9 (local consultative committees);
	
	section 17A (NHS Contracts);
	
	section 17C (personal medical or dental services);
	
	section 17I([2]) (use of accommodation);

([1]) Section 2CA was inserted by S.S.I. 2010/283, regulation 3(2).

section 17J (Health Boards' power to enter into general medical services contracts);

section 28A (remuneration for Part II services);

section 38([3]) (care of mothers and young children);

section 38A([4]) (breastfeeding);

section 39([5]) (medical and dental inspection, supervision and treatment of pupils and young persons);

section 48 (provision of residential and practice accommodation);

section 55([6]) (hospital accommodation on part payment);

section 57 (accommodation and

([2]) Section 17I was inserted by the National Health Service (Primary Care) Act 1997 (c.46), Schedule 2 and amended by the Primary Medical Services (Scotland) Act 2004 (asp 1), section 4. The functions of the Scottish Ministers under section 17I are conferred on Health Boards by virtue of S.I. 1991/570, as amended by S.S.I. 2006/132.

([3]) The functions of the Secretary of State under section 38 are conferred on Health Boards by virtue of S.I. 1991/570.

([4]) Section 38A was inserted by the Breastfeeding etc. (Scotland) Act 2005 (asp 1), section 4. The functions of the Scottish Ministers under section 38A are conferred on Health Boards by virtue of S.I. 1991/570 as amended by S.S.I. 2006/132.

([5]) Section 39 was relevantly amended by the Self-Governing Schools etc. (Scotland) Act 1989 (c.39) Schedule 11; the Health and Medicines Act 1988 (c.49) section 10 and Schedule 3 and the Standards in Scotland's Schools Act 2000 (asp 6), schedule 3.

([6]) Section 55 was amended by the Health and Medicines Act 1988 (c.49), section 7(9) and Schedule 3 and the National Health Service and Community Care Act 1990 (c.19), Schedule 9. The functions of the Secretary of State under section 55 are conferred on Health Boards by virtue of S.I. 1991/570.

services for private patients);

section 64 (permission for use of facilities in private practice);

section 75A([7]) (remission and repayment of charges and payment of travelling expenses);

section 75B([8])(reimbursement of the cost of services provided in another EEA state);

section 75BA ([9])(reimbursement of the cost of services provided in another EEA state where expenditure is incurred on or after 25 October 2013);

section 79 (purchase of land and moveable property);

section 82([10]) use and administration of certain endowments and other property held by Health Boards);

section 83([11]) (power of Health Boards and local health councils to hold property on trust);

([7]) Section 75A was inserted by the Social Security Act 1988 (c.7), section 14, and relevantly amended by S.S.I. 2010/283. The functions of the Scottish Ministers in respect of the payment of expenses under section 75A are conferred on Health Boards by S.S.I. 1991/570.

([8]) Section 75B was inserted by S.S.I. 2010/283, regulation 3(3) and amended by S.S.I. 2013/177.

([9]) Section 75BA was inserted by S.S.I. 2013/292, regulation 8(4).

([10]) Section 82 was amended by the Public Appointments and Public Bodies etc. (Scotland) Act 2003 (asp 7) section 1(2) and the National Health Service Reform (Scotland) Act 2004 (asp 7), schedule 2.

([11]) There are amendments to section 83 not relevant to the exercise of a Health Board's functions under that section.

section 84A([12]) (power to raise money, etc., by appeals, collections etc.);

section 86 (accounts of Health Boards and the Agency);

section 88 (payment of allowances and remuneration to members of certain bodies connected with the health services);
section 98 ([13]) (charges in respect of non-residents); and

paragraphs 4, 5, 11A and 13 of Schedule 1 to the Act (Health Boards);

and functions conferred by—

The National Health Service (Charges to Overseas Visitors) (Scotland) Regulations 1989 ([14]);

The Health Boards (Membership and Procedure) (Scotland) Regulations 2001/302;

The National Health Service (Clinical Negligence and Other Risks Indemnity Scheme) (Scotland)

([12]) Section 84A was inserted by the Health Services Act 1980 (c.53), section 5(2). There are no amendments to section 84A which are relevant to the exercise of a Health Board's functions.
([13]) Section 98 was amended by the Health and Medicines Act 1988 (c.49), section 7. The functions of the Secretary of State under section 98 in respect of the making, recovering, determination and calculation of charges in accordance with regulations made under that section is conferred on Health Boards by virtue of S.S.I. 1991/570.
([14]) S.I. 1989/364, as amended by S.I. 1992/411; S.I. 1994/1770; S.S.I. 2004/369; S.S.I. 2005/455; S.S.I. 2005/572 S.S.I. 2006/141; S.S.I. 2008/290; S.S.I. 2011/25 and S.S.I. 2013/177.

Regulations 2000/54;

The National Health Services (Primary Medical Services Performers Lists) (Scotland) Regulations 2004/114;

The National Health Service (Primary Medical Services Section 17C Agreements) (Scotland) Regulations 2004;

The National Health Service (Discipline Committees) Regulations 2006/330;
The National Health Service (General Ophthalmic Services) (Scotland) Regulations 2006/135;

The National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009/183;

The National Health Service (General Dental Services) (Scotland) Regulations 2010/205; and

The National Health Service (Free Prescription and Charges for Drugs and Appliances) (Scotland) Regulations 2011/55([15]).

Disabled Persons (Services, Consultation and Representation) Act 1986

([15]) S.S.I. 2011/55, to which there are amendments not relevant to the exercise of a Health Board's functions.

Section 7
(Persons discharged from hospital)

Community Care and Health (Scotland) Act 2002

All functions of Health Boards conferred by, or by virtue of, the Community Care and Health (Scotland) Act 2002.	

Mental Health (Care and Treatment) (Scotland) Act 2003

All functions of Health Boards conferred by, or by virtue of, the Mental Health (Care and Treatment) (Scotland) Act 2003.	Except functions conferred by— section 22 (Approved medical practitioners); section 34 (Inquiries under section 33: co-operation) ([16]); section 38 (Duties on hospital managers: examination notification etc.) ([17]); section 46 (Hospital managers' duties: notification) ([18]); section 124 (Transfer to other hospital); section 228 (Request for assessment of needs: duty on local authorities and Health Boards);

([16]) There are amendments to section 34 not relevant to the exercise of a Health Board's functions under that section.
([17]) Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards under that Act.
([18]) Section 46 is amended by S.S.I. 2005/465.

section 230 (Appointment of a patient's responsible medical officer);

section 260 (Provision of information to patients);

section 264 (Detention in conditions of excessive security: state hospitals);

section 267 (Orders under sections 264 to 266: recall);

section 281([19]) (Correspondence of certain persons detained in hospital);

and functions conferred by—

The Mental Health (Safety and Security) (Scotland) Regulations 2005([20]);

The Mental Health (Cross Border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005([21]);

([19]) Section 281 is amended by S.S.I. 2011/211.
([20]) S.S.I. 2005/464, to which there are amendments not relevant to the exercise of the functions of a Health Board. Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards.
([21]) S.S.I. 2005/467. Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards.

	The Mental Health (Use of Telephones) (Scotland) Regulations 2005([22]); and The Mental Health (England and Wales Cross border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2008([23]).

Education (Additional Support for Learning) (Scotland) Act 2004

Section 23 (other agencies etc. to help in exercise of functions under this Act**)**	

Public Services Reform (Scotland) Act 2010

All functions of Health Boards conferred by, or by virtue of, the Public Services Reform (Scotland) Act 2010	Except functions conferred by— section 31(Public functions: duties to provide information on certain expenditure etc.); and section 32 (Public functions: duty to provide information on exercise of functions).

([22]) S.S.I. 2005/468. Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards.
([23]) S.S.I. 2008/356. Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards.

Patient Rights (Scotland) Act 2011	
All functions of Health Boards conferred by, or by virtue of, the Patient Rights (Scotland) Act 2011	Except functions conferred by The Patient Rights (Complaints Procedure and Consequential Provisions) (Scotland) Regulations 2012/36([25]).
Carers (Scotland) Act 2016 Section 31 (Duty to prepare local carer strategy)[24]	

Part 2

Services currently provided by the Health Board which are to be delegated

Interpretation of this Part 2 Annex 1

A

Interpretation of Schedule 3

1. In this Part—

"Allied Health Professional" means a person registered as an allied health professional with the Health Professions Council;

[24] Inserted by Public Bodies (Joint Working) (Prescribed Health Board Functions) (Scotland) Amendment Regulations 2017/381 (Scottish SI) reg. 2 (December 18, 2017)

([25]) S.S.I. 2012/36. Section 5(2) of the Patient Rights (Scotland) Act 2011 (asp 5) provides a definition of "relevant NHS body" relevant to the exercise of a Health Board's functions.

"general medical practitioner" means a medical practitioner whose name is included in the General Practitioner Register kept by the General Medical Council;

"general medical services contract" means a contract under section 17J of the National Health Service (Scotland) Act 1978;

"hospital" has the meaning given by section 108(1) of the National Health Service (Scotland) Act 1978;

"inpatient hospital services" means any health care service provided to a patient who has been admitted to a hospital and is required to remain in that hospital overnight, but does not include any secure forensic mental health services;

"out of hours period" has the same meaning as in regulation 2 of the National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004([26]); and

"the public dental service" means services provided by dentists and dental staff employed by a health board under the public dental service contract.

B

Provision for people over the age of 18

The functions listed in Part 1 of this Annex 1 are delegated only to the extent that:

a) the function is exercisable in relation to persons of at least 18 years of age;

b) the function is exercisable in relation to care or treatment provided by health professionals for the purpose of health care services listed at numbers 2 to 7 below, and

c) the function is exercisable in relation to the following health services

2. Accident and Emergency services provided in a hospital.

([26]) S.S.I. 2004/115.

3. Inpatient hospital services relating to the following branches of medicine—

(a) general medicine.

(b) geriatric medicine.

(c) rehabilitation medicine;

(d) respiratory medicine; and

(e) psychiatry of learning disability.

4. Palliative care services provided in a hospital.

5. Inpatient hospital services provided by General Medical Practitioners.

6. Services provided in a hospital in relation to an addiction or dependence on any substance.

7. Mental health services, including –

(a) Inpatient and specialist services at the Royal Cornhill Hospital
(b) Inpatient and specialist services at Elmwood at Royal Cornhill Hospital
(c) Residential Community Rehabilitation Service at Polmuir Road
(d) Residential Forensic Community Rehabilitation Facility at Great
(e) Western Lodge
(f) Psychotherapy (outpatient)
(g) Eating Disorder Service (outpatient)
(h) Eden Unit (North of Scotland)
(i) Managed Clinical Network for Eating Disorders
(j) Adult Liaison Psychiatry Service
(k) Older Adult Liaison Psychiatry Service
(l) Unscheduled Care
(m) Rehabilitation Services (outpatient) for Adult Mental Health
(n) Forensic Services
(o) Perinatal Services
(p) Gender Identity Services
(q) Child and Adolescent Mental Health Service
(r) Business and Support Management Services across inpatient and specialist services

(s) Psychiatry of learning disability

8. District nursing services.

9. Services provided outwith a hospital in relation to an addiction or dependence on any substance.

10. Services provided by allied health professionals in an outpatient department, clinic, or outwith a hospital.

11. The public dental service.

12. Primary medical services provided under a general medical services contract, and arrangements for the provision of services made under section 17C of the National Health Service (Scotland) Act 1978, or an arrangement made in pursuance of section 2C(2) of the National Health Service (Scotland) Act 1978([27]).

13. General dental services provided under arrangements made in pursuance of section 25 of the National Health (Scotland) Act 1978([28]).

14. Ophthalmic services provided under arrangements made in pursuance of section 17AA or section 26 of the National Health Service (Scotland) Act 1978([29]).

([27]) Section 2C was inserted by the Primary Medical Services (Scotland) Act 2004 (asp 1), section 1(2) and relevantly amended by the National Health Service Reform (Scotland) Act 2004 (asp 7), schedule 1, and the Tobacco and Primary Medical Services (Scotland) Act 2010 (asp 3), section 37.
([28]) Section 25 was relevantly amended by the Smoking, Health and Social Care (Scotland) Act 2005 (asp 13), section 15.
([29]) Section 17AA was inserted by the National Health Service (Primary Care) Act 1997 (c.46), section 31(2) and relevantly amended by the Smoking, Health and Social Care (Scotland) Act 2005 (asp 13), section 25. Section 26 was relevantly amended by the Health and Social Security Act 1984 (c.48), Schedule 1, and the Smoking, Health and Social Care (Scotland) Act 2005 (asp 13) section 13.

15. Pharmaceutical services and additional pharmaceutical services provided under arrangements made in pursuance of sections 27 and 27A of the National Health Service (Scotland) Act 1978([30]).

16. Services providing primary medical services to patients during the out-of-hours period.

17. Services provided outwith a hospital in relation to geriatric medicine.

18. Palliative care services provided outwith a hospital.

19. Community learning disability services.

20. Mental health services provided outwith a hospital.

21. Continence services provided outwith a hospital.

22. Kidney dialysis services provided outwith a hospital.

23. Services provided by health professionals that aim to promote public health.

24. Sexual health services provided in the community.

([30]) Section 27 was relevantly amended by the Health Services Act 1990 (c.53), section 20; the National Health Service and Community Care Act 1990 (c.19), Schedule 9; the Medicinal Products: Prescription by Nurses etc. Act 1992 (c.28), section 3; the National Health Service and Community Care Act 1997 (c.46), Schedule 2 and the Health and Social Care Act 2001 (c.15), section 44.

C

Provision for people under the age of 18

The functions listed in Part 1 of Annex 1 are also delegated to the extent that:

a) the function is exercisable in relation to persons of less than 18 years of age; and

b) the function is exercisable in relation to the following health services:

25. The public dental service.

26. Primary medical services provided under a general medical services contract, and arrangements for the provision of services made under section 17C of the National Health Service (Scotland) Act 1978, or an arrangement made in pursuance of section 2C(2) of the National Health Service (Scotland) Act 1978([31]).

27. General dental services provided under arrangements made in pursuance of section 25 of the National Health (Scotland) Act 1978([32]).

28. Ophthalmic services provided under arrangements made in pursuance of section 17AA or section 26 of the National Health Service (Scotland) Act 1978([33]).

([31]) Section 2C was inserted by the Primary Medical Services (Scotland) Act 2004 (asp 1), section 1(2) and relevantly amended by the National Health Service Reform (Scotland) Act 2004 (asp 7), schedule 1, and the Tobacco and Primary Medical Services (Scotland) Act 2010 (asp 3), section 37.
([32]) Section 25 was relevantly amended by the Smoking, Health and Social Care (Scotland) Act 2005 (asp 13), section 15.
([33]) Section 17AA was inserted by the National Health Service (Primary Care) Act 1997 (c.46), section 31(2) and relevantly amended by the Smoking, Health and Social Care (Scotland) Act 2005 (asp 13), section 25. Section 26 was relevantly amended by the Health and Social Security Act 1984 (c.48), Schedule 1, and the Smoking, Health and Social Care (Scotland) Act 2005 (asp 13) section 13.

29. Pharmaceutical services and additional pharmaceutical services provided under arrangements made in pursuance of sections 27 and 27A of the National Health Service (Scotland) Act 1978([33]).

Part 3

Services currently provided by the Health Board to those under 18 years of age, which are to be operationally devolved to the Chief Officer of the Integration Joint Board.

1. Health Visiting

2. School Nursing

3. All services provided by Allied Health Professionals, as defined in Part 2A of this Annex 1, in an outpatient department, clinic, or outwith a hospital.

4. Child and Adolescent Mental Health Service

Annex 2

Part 1

Functions delegated by the Local Authority to the Integration Joint Board

Schedule 2 Regulation 2

Part 1

Functions prescribed for the purposes of section 1(7) of the Public Bodies (Joint Working) (Scotland) Act 2014

Column A	*Column B*
Enactment conferring function	*Limitation*
National Assistance Act 1948([34])	
Section 48 (Duty of councils to provide temporary protection for property of persons admitted to hospitals etc.)	
The Disabled Persons (Employment) Act 1958([35])	
Section 3 (Provision of sheltered employment by local authorities)	
The Social Work (Scotland) Act 1968([36])	

([34]) 1948 c.29; section 48 was amended by the Local Government etc. (Scotland) Act 1994 (c.39), Schedule 39, paragraph 31(4) and the Adult Support and Protection (Scotland) Act 2007 (asp 10) schedule 2 paragraph 1.

([35]) 1958 c.33; section 3 was amended by the Local Government Act 1972 (c.70), section 195(6); the Local Government (Scotland) Act 1973 (c.65), Schedule 27; the National Health Service (Scotland) Act 1978 (c.70), schedule 23; the Local Government Act 1985 (c.51), Schedule 17; the Local Government (Wales) Act 1994 (c.19), Schedules 10 and 18; the Local Government etc. (Scotland) Act 1994 (c.49), Schedule 13; and the National Health Service (Consequential Provisions) Act 2006 (c.43), Schedule 1.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 1 (Local authorities for the administration of the Act.)	So far as it is exercisable in relation to another integration function.
Section 4 (Provisions relating to performance of functions by local authorities.)	So far as it is exercisable in relation to another integration function.

([36]) 1968 c.49; section 1 was relevantly amended by the National Health Service (Scotland) Act 1972 (c.58), schedule 7; the Children Act 1989 (c.41), Schedule 15; the National Health Service and Community Care Act 1990 (c.19) ("the 1990 Act"), schedule 10; S.S.I. 2005/486 and S.S.I. 2013/211. Section 4 was amended by the 1990 Act, Schedule 9, the Children (Scotland) Act 1995 (c.36) ("the 1995 Act"), schedule 4; the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13) ("the 2003 Act"), schedule 4; and S.S.I. 2013/211. Section 10 was relevantly amended by the Children Act 1975 (c.72), Schedule 2; the Local Government etc. (Scotland) Act 1994 (c.39), Schedule 13; the Regulation of Care (Scotland) Act 2001 (asp 8) ("the 2001 Act") schedule 3; S.S.I. 2010/21 and S.S.I. 2011/211. Section 12 was relevantly amended by the 1990 Act, section 66 and Schedule 9; the 1995 Act, Schedule 4; and the Immigration and Asylum Act 1999 (c.33), section 120(2). Section 12A was inserted by the 1990 Act, section 55, and amended by the Carers (Recognition and Services) Act 1995 (c.12), section 2(3) and the Community Care and Health (Scotland) Act 2002 (asp 5) ("the 2002 Act"), sections 8 and 9(1). Section 12AZA was inserted by the Social Care (Self Directed Support) (Scotland) Act 2013 (asp 1), section 17. Section 12AA and 12AB were inserted by the 2002 Act, section 9(2). Section 13 was amended by the Community Care (Direct Payments) Act 1996 (c.30), section 5. Section 13ZA was inserted by the Adult Support and Protection (Scotland) Act 2007 (asp 10), section 64. Section 13A was inserted by the 1990 Act, section 56 and amended by the Immigration and Asylum Act 1999 (c.33), section 102(2); the 2001 Act, section 72 and schedule 3; the 2002 Act, schedule 2 and by S.S.I. 2011/211. Section 13B was inserted by the 1990 Act sections 56 and 67(2) and amended by the Immigration and Asylum Act 1999 (c.33), section 120(3). Section 14 was amended by the Health Services and Public Health Act 1968 (c.46), sections 13, 44 and 45; the National Health Service (Scotland) Act 1972 (c.58), schedule 7; the Guardianship Act 1973 (c.29), section 11(5); the Health and Social Service and Social Security Adjudications Act 1983 (c.41), schedule 10 and the 1990 Act, schedule 9. Section 28 was amended by the Social Security Act 1986 (c.50), Schedule 11 and the 1995 Act, schedule 4. Section 29 was amended by the 1995 Act, schedule 4. Section 59 was amended by the 1990 Act, schedule 9; the 2001 Act, section 72(c); the 2003 Act, section 25(4) and schedule 4 and by S.S.I. 2013/211.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 8 (Research.)	So far as it is exercisable in relation to another integration function.
Section 10 (Financial and other assistance to voluntary organisations etc. for social work.)	So far as it is exercisable in relation to another integration function.
Section 12 (General social welfare services of local authorities.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 12A (Duty of local authorities to assess needs.)	So far as it is exercisable in relation to another integration function.
Section 12AZA (Assessments under section 12A - assistance)	So far as it is exercisable in relation to another integration function.
Section 13 (Power of local authorities to assist persons in need in disposal of produce of their work.)	
Section 13ZA (Provision of services to incapable adults.)	So far as it is exercisable in relation to another integration function.
Section 13A (Residential accommodation with nursing.)	
Section 13B (Provision of care or aftercare.)	

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 14 (Home help and laundry facilities.)	
Section 28 (Burial or cremation of the dead.)	So far as it is exercisable in relation to persons cared for or assisted under another integration function.
Section 29 (Power of local authority to defray expenses of parent, etc., visiting persons or attending funerals.)	
Section 59 (Provision of residential and other establishments by local authorities and maximum period for repayment of sums borrowed for such provision.)	So far as it is exercisable in relation to another integration function.
The Local Government and Planning (Scotland) Act 1982([37])	
Section 24(1) (The provision of gardening assistance for the disabled and the elderly.)	
Disabled Persons (Services, Consultation and Representation) Act 1986([38])	

([37]) 1982 c.43; section 24(1) was amended by the Local Government etc. (Scotland) Act 1994 (c.39), schedule 13.
([38]) 1986 c.33. There are amendments to sections 2 and 7 which are not relevant to the exercise of a local authority's functions under those sections.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 2 (Rights of authorised representatives of disabled persons.)	
Section 3 (Assessment by local authorities of needs of disabled persons.)	
Section 7 (Persons discharged from hospital.)	In respect of the assessment of need for any services provided under functions contained in welfare enactments within the meaning of section 16 and which have been delegated.
Section 8 (Duty of local authority to take into account abilities of carer.)	In respect of the assessment of need for any services provided under functions contained in welfare enactments (within the meaning set out in section 16 of that Act) which are integration functions.
The Adults with Incapacity (Scotland) Act 2000([39])	
Section 10 (Functions of local authorities.)	
Section 12 (Investigations.)	

([39]) 2000 asp 4; section 12 was amended by the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13), schedule 5(1). Section 37 was amended by S.S.I. 2005/465. Section 39 was amended by the Adult Support and Protection (Scotland) Act 2007 (asp 10), schedule 1 and by S.S.I. 2013/137. Section 41 was amended by S.S.I. 2005/465; the Adult Support and Protection (Scotland) Act 2007 (asp 10), schedule 1 and S.S.I. 2013/137. Section 45 was amended by the Regulation of Care (Scotland) Act 2001 (asp 8), Schedule 3.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 37 (Residents whose affairs may be managed.)	Only in relation to residents of establishments which are managed under integration functions.
Section 39 (Matters which may be managed.)	Only in relation to residents of establishments which are managed under integration functions.
Section 41 (Duties and functions of managers of authorised establishment.)	Only in relation to residents of establishments which are managed under integration functions.
Section 42 (Authorisation of named manager to withdraw from resident's account.)	Only in relation to residents of establishments which are managed under integration functions.
Section 43 (Statement of resident's affairs.)	Only in relation to residents of establishments which are managed under integration functions.
Section 44 (Resident ceasing to be resident of authorised establishment.)	Only in relation to residents of establishments which are managed under integration functions.
Section 45 (Appeal, revocation etc.)	Only in relation to residents of establishments which are managed under integration functions.
The Housing (Scotland) Act 2001([40])	
Section 92 (Assistance to a registered for housing purposes.)	Only in so far as it relates to an aid or adaptation.
The Community Care and Health (Scotland) Act 2002([41])	

([40]) 2001 asp 10; section 92 was amended by the Housing (Scotland) Act 2006 (asp 1), schedule 7.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 5 (Local authority arrangements for of residential accommodation out with Scotland.)	
Section 14 (Payments by local authorities towards expenditure by NHS bodies on prescribed functions.)	
The Mental Health (Care and Treatment) (Scotland) Act 2003([42])	
Section 17 (Duties of Scottish Ministers, local authorities, and others as respects Commission.)	
Section 25 (Care and support services etc.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 26 (Services designed to promote well-being and social development.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 27 (Assistance with travel.)	Except in so far as it is exercisable in relation to the provision of housing support services.

([41]) 2002 asp 5.
([42]) 2003 asp 13; section 17 was amended by the Public Services Reform (Scotland) Act 2010 (asp 8), section 111(4), and schedules 14 and 17, and by the Police and Fire Reform (Scotland) Act 2012 (asp 8), schedule 7. Section 25 was amended by S.S.I. 2011/211. Section 34 was amended by the Public Services Reform (Scotland) Act 2010 (asp 8), schedules 14 and 17.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 33 (Duty to inquire.)	
Section 34 (Inquiries under section 33: Co-operation.)	
Section 228 (Request for assessment of needs: duty on local authorities and Health Boards.)	
Section 259 (Advocacy.)	
The Housing (Scotland) Act 2006([43])	
Section 71(1)(b) (Assistance for housing purposes.)	Only in so far as it relates to an aid or adaptation.
The Adult Support and Protection (Scotland) Act 2007([44])	
Section 4 (Council's duty to make inquiries.)	
Section 5 (Co-operation.)	

([43]) 2006 asp 1; section 71 was amended by the Housing (Scotland) Act 2010 (asp 17) section 151.

([44]) 2007 asp 10; section 5 and section 42 were amended by the Public Services Reform (Scotland) Act 2010 (asp 8), schedules 14 and 17 and by the Police and Fire Reform (Scotland) Act 2012 (asp 8), schedule 7. Section 43 was amended by the Public Services Reform (Scotland) Act 2010 (asp 8), schedule 14.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 6 (Duty to consider importance of providing advocacy and other.)	
Section 7 (Visits)	
Section 8 (Interviews)	
Section 9 (Medical Examinations)	
Section 10 (Examination of records etc)	
Section 11 (Assessment Orders.)	
Section 14 (Removal orders.)	
Section 16 (Moving adult at risk in pursuance of removal order)	
Section 18 (Protection of moved persons' property.)	
Section 22 (Right to apply for a banning order.)	
Section 40 (Urgent cases.)	
Section 42 (Adult Protection Committees.)	

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 43 (Membership.)	
Social Care (Self-directed Support) (Scotland) Act 2013([45])	
Section 5 (Choice of options: adults.)	
Section 6 (Choice of options under section 5: assistances.)	
Section 7 (Choice of options: adult carers.)	
Section 9 (Provision of information about self-directed support.)	
Section 11 (Local authority functions.)	
Section 12 (Eligibility for direct payment: review.)	
Section 13 (Further choice of options on material change of circumstances.)	Only in relation to a choice under section 5 or 7 of the Social Care (Self-directed Support) (Scotland) Act 2013.
Section 16 (Misuse of direct payment: recovery.)	

([45]) 2013 asp 1.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 19 (Promotion of options for self-directed support.)	
Carers (Scotland) Act 2016	
Section 6 ([46]) (Duty to prepare adult carer support plan)	
Section 21([47]) (Duty to set local eligibility criteria)	
Section 24([48]) (Duty to provide support)	
Section 25([49]) (Provision of support to carers: breaks from caring)	
Section 31([50]) (Duty to prepare local carer strategy)	
Section 34([51]) (Information and advice service for carers)	
Section 35([52])	

([46]) Inserted by Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Amendment (No. 2) Regulations 2017/… (Scottish SI) reg. 3(2) (December … 2017)
([47]) Inserted by Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Amendment Regulations 2017/190 (Scottish SI) reg.2(2) (June 16, 2017)
[48] Inserted by Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Amendment (No. 2) Regulations 2017/… (Scottish SI) reg. 3(2) (December … 2017)
[49] Inserted by Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Amendment (No. 2) Regulations 2017/… (Scottish SI) reg. 3(2) (December … 2017)
[50] Inserted by Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Amendment (No. 2) Regulations 2017/… (Scottish SI) reg. 3(2) (December … 2017)
[51] Inserted by Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Amendment (No. 2) Regulations 2017/… (Scottish SI) reg. 3(2) (December … 2017)
[52] Inserted by Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Amendment (No. 2) Regulations 2017/… (Scottish SI) reg. 3(2) (December … 2017)

Column A *Enactment conferring function*	*Column B* *Limitation*
(Short breaks services statements)	

Part 2

Functions, conferred by virtue of enactments, prescribed for the purposes of section 1(7) of the Public Bodies (Joint Working) (Scotland) Act 2014

Column A	*Column B*
Enactment conferring function	*Limitation*
The Community Care and Health (Scotland) Act 2002	
Section 4([53]) The functions conferred by Regulation 2 of the Community Care (Additional Payments) (Scotland) Regulations 2002([54])	

([53]) Section 4 was amended by the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13), schedule 4 and the Adult Support and Protection (Scotland) Act 2007 (asp 10), section 62(3).
([54]) S.S.I. 2002/265, as amended by S.S.I. 2005/445.

Part 3

Functions, conferred by virtue of enactments, prescribed for the purposes of section 1(5) of the Public Bodies (Joint Working) (Scotland) Act 2014

In addition to the functions that must be delegated, the Council has chosen to delegate the following functions to the extent that they relate to adults.

Column A	*Column B*
Enactment conferring function	*Limitation*
Criminal Procedure (Scotland) Act 1995	
Section 51(1)(aa), 51(1)(b) and 51(5) (Remand and committal of children and young persons in to care of local authority).	
Section 203 (Local authority reports pre-sentencing.)	
Section 234B (Report and evidence from local authority officer regarding Drug Treatment and Testing Order.)	
Section 245A (Report by local authority officer regarding Restriction of Liberty Orders.)	
Management of Offenders etc. (Scotland) Act 2005	
Section 10 (Arrangements for assessing and managing risks posed by certain offenders.)	

Section 11
(Review of arrangements.)

Column A *Enactment conferring function*	*Column B* *Limitation*
Social Work (Scotland) Act 1968	
Section 27 (Supervision and care of persons put on probation or released from prison.)	
Section 27ZA (Advice, guidance and assistance to persons arrested or on whom sentence is deferred.)	

Part 2

Services currently provided by the Local Authority which are to be integrated

- Social work services for adults and older people
- Services and support for adults with physical disabilities and learning disabilities
- Mental health services
- Drug and alcohol services
- Adult protection and domestic abuse
- Carers support services
- Community care assessment teams
- Support services
- Care home services
- Adult placement services
- Health improvement services
- Aspects of housing support, including aids and adaptions
- Day services
- Local area co-ordination
- Respite provision
- Occupational therapy services
- Reablement services, equipment and telecare
- Criminal justice services

Annex 3

Hosted Services

NHS Grampian has noted the services that are currently hosted across the areas of the Grampian IJBs and offer this for consideration to the IJB as they take forward strategic planning:

Service	Current Host
Sexual Health Services	Aberdeen City
Woodend Assessment of the Elderly (including Links Unit at City Hospital)	Aberdeen City
Woodend Rehabilitation Services (including Stroke Rehab, Neuro Rehab, Horizons, Craig Court and MARS)	Aberdeen City
Mental Health Services	Aberdeen City
Marie Curie Nursing	Aberdeenshire
Heart Failure Service	Aberdeenshire
Continence Service	Aberdeenshire
Diabetes MCN (including Retinal Screening)	Aberdeenshire
Chronic Oedema Service	Aberdeenshire
HMP Grampian	Aberdeenshire
Police Forensic Examiners	Aberdeenshire

Annex 4

This Annex lists the services provided within hospitals which the IJB will have strategic planning responsibilities for which will continue to be operationally managed by NHS Grampian:

Services:

- Accident & Emergency Services provided in a hospital.
- Inpatient hospital services relating to: general medicine, geriatric medicine, rehabilitation medicine and respiratory medicine; and
- Palliative Care services provided in a hospital.

In so far as they are provided within the following hospitals:

- Hospitals at the Foresterhill Site, Aberdeen (which includes Aberdeen Royal Infirmary, Royal Aberdeen Children's Hospital and Aberdeen Maternity Hospital)
- Hospitals in Elgin (which includes Dr Gray's Hospital)

Aberdeen City Health & Social Care Partnership
A caring partnership

SCHEME OF GOVERNANCE

Approved by the Aberdeen City Integrated Joint Board, 25 April 2023

ABERDEEN CITY INTEGRATED JOINT BOARD,

SCHEME OF GOVERNANCE

1. Purpose and Interpretation

1.1 The Aberdeen City Integration Joint Board ("the IJB") is the Integration Authority for Aberdeen City. It was delegated functions from NHS Grampian (NHSG) and Aberdeen City Council ("the Council") in 2016 and is a separate legal entity. The delegated functions are set out in the IJB's Integration Scheme. The IJB is responsible for the strategic planning of functions which have been delegated to it, and as such, issues Directions to both NHSG and the Council to deliver health and social care services to the people of Aberdeen.

1.2 This Scheme of Governance contains key governance documents which facilitate the way in which the IJB operates. It is one of the primary sources of assurance required to demonstrate the effectiveness of the IJB's internal controls. It governs how the IJB makes decisions, business will be determined, meetings are conducted, the membership of the IJB, behaviours and conduct of IJB members and sets out the roles and responsibilities of key personnel around the IJB.

1.4 The Scheme of Governance comprises the following:

Document	Purpose
Aberdeen City Integration Scheme	Sets out the arrangements between the Council and the NHSG to delegate functions to the IJB in respect of adult social care and health care services.
Aberdeen City Integrated Joint Board Standing Orders	Rules of procedure for meetings of the IJB and its committees.
Aberdeen City Integrated Joint Board- Roles and Responsibilities	Explanation of the key roles within the Aberdeen City Health and Social Care Partnership (ACHSCP).
Aberdeen City Integrated Joint Board- Code of Conduct	Rules governing conduct of IJB members.
Aberdeen City Integrated Joint Board- Combined Terms of Reference for the IJB and its Committees	Powers reserved to the IJB and the decision making authority delegated by the IJB to its committees.

Aberdeen City Health & Social Care Partnership
A caring partnership

Aberdeen City Integrated Joint Board

Standing Orders

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1. Introduction

1.1 The Aberdeen City Integration Joint Board ("the IJB") comprises voting representatives of Aberdeen City Council ("the Council") and the Grampian NHS Board ("the NHS Board") ("the constituent authorities") and non-voting advisory representatives.

1.2 These Standing Orders are made under The Public Bodies (Joint Working) (Scotland) Act 2014 and the subordinate legislation[1] and any provision, regulation or direction issued by Scottish Ministers shall have precedence over anything written here in the event of any conflict.

1.3 These Standing Orders regulate the conduct and proceedings of the IJB and its committees.

1.4 All meetings of the IJB and its committees shall be regulated by these Standing Orders, which the IJB may amend as it so determines, except that all requirements of The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 in relation to Standing Orders shall be met.

1.5 Any amendments to these Standing Orders shall be effective from the meeting following the one at which the changes were agreed.

1.6 Except where prohibited by statute, it shall be competent for any member at any time during a meeting to move the suspension of the whole or any specified part of these Standing Orders. Such a motion shall, if seconded, be put to the vote immediately without discussion.

1.7 A two thirds majority of voting members in attendance shall be required to suspend Standing Orders. For the avoidance of doubt, if the figure is not a whole number it shall be rounded up.

1.8 Standing Orders shall be reviewed by the IJB on an annual basis.

1.9 Non-material amendments can be made to Standing Orders by the Chief Officer, following consultation with the Chair and Vice Chair of the IJB, without the requirement to report to the IJB. Members shall be notified once such amendments have been completed.

2. Membership

2.1 The IJB shall include the following voting members:-

a. Four councillors nominated by the Council; and

[1] The Public Bodies (Joint Working) (Integration Joint Boards) Scotland Order 2014/285

b. Four members nominated by the NHS Board, of whom three shall be non-executive directors and one an executive director.

2.2 The IJB shall include the following non-voting members, with those at (d), (e) and (f) to be appointed by the NHS Board:-

a. The Council's Chief Social Work Officer;
b. The IJB Chief Officer;
c. The IJB Chief Finance Officer appointed under S95 of the Local Government (Scotland) Act 1973;
d. A registered medical practitioner on the list of primary medical services performers prepared by the NHS Board;
e. A registered nurse employed by the NHS Board or by a person or body with which the NHS Board has a contract; and
f. A registered medical practitioner employed by the NHS Board and not providing primary medical services;

2.3 The IJB must appoint, in addition, at least one member, whom shall be non-voting, from each of the following groups:-

a. Staff of the constituent authorities providing services under integration functions, of whom one shall be a trade union representative and one a partnership representative;
b. Third sector bodies carrying out activities related to health or social care in the Council area;
c. Service users living in the Council area; and
d. People providing unpaid care in the Council area.

2.4 The IJB shall appoint a Public Health Consultant employed by the NHS Board who shall be a non-voting member.

2.5 The IJB may appoint such additional (non- voting) members as it sees fit, but such members shall not be councillors or non-executive NHS Board members.

3. Appointment of the Chair and Vice Chair of the IJB

3.1 The Chair shall be appointed by one of the constituent authorities for an appointing period not exceeding two years.

3.2 The constituent authority which does not appoint the Chair must appoint the Vice Chair for that appointing period.

3.3 The Chair and the Vice Chair appointments referred to in 3.1 and 3.2 shall alternate automatically in each successive appointing period.

3.4 A constituent authority may change the person appointed by that authority as Chair or Vice Chair during the appointing period for the remaining period.

3.5 The constituent authorities may only appoint a Chair and Vice-Chair from their membership set out under Standing Order 2 (2.1) above.

4. Term of Office

4.1 The term of office of an IJB member shall be such period as the IJB shall determine which shall not exceed three years.

4.2 A member appointed under Standing Order 2 (2.2) (a) - (c) above shall remain a member for as long as they hold the office in respect of which they are appointed.

4.3 At the end of a term of office set out under Standing Order 4.1 (1) above, a member may be reappointed for a further term of office.

4.4 This paragraph is subject to Standing Order 6 (resignation of members) and 7 (removal of members) below.

4.5 In the event that a voting member ceases to become an IJB member in the circumstances set out in Standing Orders 5, 6 or 7, the constituent body will require to appoint an IJB member in accordance with Standing Order 2.1 and where necessary, Standing Order 3.

5. Disqualification

5.1 A person is disqualified from being a member of the IJB where:

a. A person who has within the period of five (5) years immediately preceding the date of appointment been convicted of any criminal offence in respect of which the person has received a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine);
b. a person who has been removed or dismissed for disciplinary reasons from any paid employment or office with a Health Board or local authority;
c. a person who is insolvent;
d. a person who has been removed from a register maintained by a regulatory body, other than where the removal was voluntary; and
e. a person who has been subject to a sanction under section 19(1)(b) to (e) of the Ethical Standards in Public Life etc. (Scotland) Act 2000.

6. Resignation of Members

6.1 A member may resign their membership of the IJB at any time by giving the IJB notice in writing.

6.2 Where a voting member of the IJB resigns, the IJB must inform the constituent authority which nominated them.

6.3 This section does not apply to the non-voting members listed in Standing Order 2 (2.2) (a) to (f).

6.4 Other non-voting members of the IJB shall hold office during each three-year period until they are replaced by the appropriate nominating body.

7. Removal of Members (Voting and Non- Voting)

7.1 If a member has not attended three consecutive meetings of the IJB and/or its committees, and such absence is not due to illness or other reasonable cause as the IJB may determine, the IJB may remove that member from office by providing them with one month's notice in writing.

7.2 If a member acts in a way which brings the IJB into disrepute or in a way which is inconsistent with the proper performance of the IJB's functions or its Code of Conduct for Members, that conduct will be addressed in line with the IJB's Code of Conduct for Members.

7.3 If a member is disqualified during a term of office for a reason referred to in Standing Order 5 (5.1) above, they are to be removed from office immediately.

7.4 Where a Council or NHS Board member ceases for any reason to be a Councillor or an NHS Board member during the term of office, they are to be removed from office with effect from the day on which they cease to be a Councillor or an NHS Board member.

7.5 Subject to the above paragraphs, a constituent authority may remove a member which it nominated by providing one month's notice in writing to the member and to the IJB.

8. Substitutes

8.1 A voting member who is unable to attend a meeting of the IJB or its committees shall, insofar as possible, arrange for a suitably experienced substitute, who is a member of the appropriate constituent authority, to attend in their place with voting rights.

8.2 A non-voting member who is unable to attend a meeting of the IJB may arrange for a suitable substitute to attend the meeting in their place.

8.3 Where the Chair or Vice Chair is unable to attend a meeting of the IJB, any substitute attending in their place shall not preside over the meeting.

9. Temporary Vacancies in Voting Membership

9.1 Where there is a temporary vacancy in the voting membership of the IJB, the vote which would otherwise have been cast by the member appointed to that vacancy may be cast by the other members nominated by the appropriate constituent authority.

8.4 Where, because of temporary vacancies, the number of members nominated by a constituent authority is one or zero and that constituent authority is to appoint the Chair, the Chair must be appointed temporarily by the other constituent authority.

8.5 Where a temporary vacancy, or the temporary appointment of the Chair in the circumstances set out in the paragraph above, persists for more than six months, the Chair of the IJB must notify the Scottish Ministers in writing of the reasons why the vacancy remains unfilled.

9.4 The Chief Officer shall determine an item of urgent business in consultation with the Chair/Vice Chair of the IJB and the Chief Executives of the Council and NHS Board during the period between the date of a Local Government Election and the appointment of voting members by the Council only in the situation where the IJB does not have a quorum of members - on the basis that any such action shall be reported to the next meeting of the IJB as an item on the agenda.

10. Effect of Vacancy in Membership

10.1 A vacancy in the membership of the IJB will not invalidate anything done by or any decision of the IJB.

11. Calling meetings

11.1 The Chair may call a meeting of the IJB at such times as they see fit.

11.2 A request for a special meeting of the IJB to be called may be made by a requisition signed by at least five of the voting members, which shall specify the

business proposed to be transacted and which shall be presented to the Chair. Email confirmation of the request for a special meeting will discharge the requirement for the notice to be signed.

11.3 If the Chair refuses to call a meeting requisitioned under the above paragraph or does not call a meeting within seven days after the making of the request, the members who signed the requisition may call the meeting.

11.4 The business to be transacted at any requisitioned meeting shall be limited to the business specified in the requisition.

11.5 The IJB's annual calendar of meetings shall run from 1 April to 31 March of the following calendar year. A schedule of meetings shall be approved by the IJB prior to 1 April of the new meeting year.

12. Notice of Meetings

12.1 Prior to each meeting of the IJB or one of its committees, a notice of the meeting specifying the time, place and business to be transacted shall be sent electronically to every member or sent to the usual place of residence of every member, so as to be available to them at least 7 calendar days before the meeting. Email confirmation of the notice of the meeting by the Chair, or a member authorised to act on the Chair's behalf, will discharge the requirement for the notice to be signed by the Chair.

12.2 A failure to serve notice of a meeting on a member in accordance with the paragraph above shall not affect the validity of anything done at the meeting.

12.3 In the case of a meeting of the IJB called by members in accordance with Standing Order 11, email confirmation from those members requisitioning the meeting shall discharge the requirement in Standing Order 12.1 for the notice to be signed by the members who requisitioned the meeting.

12.5 In the event that an item of business has to be considered on an urgent basis, a meeting of the Board may be called at 48 hours' notice by the Chair following consultation with the Vice Chair and Chief Officer. The Urgent Business meeting would retain all the IJB's functions and powers, and these Standing Orders would apply.

12.6 If the office of Chair is vacant or the Chair is unable to act for any reason, the Vice Chair may at any time call an Urgent Business meeting in terms of Standing Order 12.5 following consultation with the Chief Officer.

13. Access to meetings

13.1 Members of the public and representatives of the media shall be admitted to meetings of the IJB to observe the proceedings, unless IJB adopt a resolution to exclude the public and media on grounds that publicity for any item under discussion would be prejudicial to the public interest due to the confidential nature of the business to be transacted or for other reason specified in Appendix B. However, members of the public and representatives of the media shall not be admitted to meetings of the IJB committees.

13.2 Other than the live webcasting or recording of IJB meetings, any video or sound recordings or broadcasting of meetings by any other means, or the taking of any photographs, will be at the Chair's discretion.

13.3 Members of the public may at the Chair's sole discretion be permitted to address the IJB for an agreed period but shall not generally be permitted to participate in discussion at a meeting.

13.4 Nothing in these Standing Orders shall preclude the Chair from requiring the removal from a meeting of any person or persons who persistently disrupts the meeting.

14. Remote attendance

14.1 A member who is unable to be present for a meeting of the IJB or any of its committees at the venue identified in the notice calling the meeting shall notify the Clerk and the Chair at least 3 days (or, if this is not possible, as soon as practicable) in advance of the meeting. Any member unable to be present at a meeting shall be able to take part remotely in any way which reasonably allows the Members participation. For the avoidance of any doubt, such participation includes voting. A member remotely participating in this way is referred to in this Standing Order as a "Remote Member". A Remote Member is encouraged to activate their video camera (if possible) for the duration of the meeting.

14.2 Where the Chair is participating remotely, the Vice Chair will take the Chair, except in respect of Standing Order 14.7 where the Chair will take the Chair.

a. The Member chairing the meeting must be physically present at the meeting venue, therefore where both the Chair and Vice Chair are participating remotely or have sent apologies, Members present at the meeting venue will appoint a Chair to chair the meeting from amongst their number.

b. In the event that no agreement is reached between those Members present, the decision will be taken by means of a procedural motion.

14.3 Remote Members will be counted for the purposes of determining whether there is a quorum.

14.4 A Remote Member will cast their vote as if participating in a roll call vote.

14.5 Any Remote Member who has declared an interest in an item and withdrawn must pause/exit the video/communication link whilst the item is being considered. The Clerk will inform/re-invite the Remote Member (whether by email or otherwise) when to re-start the link and resume their participation.

14.6 Any Remote Member must confirm that they are in a secure private location, and that no-one else is able to hear or view the proceedings from the device being used by that Remote Member, before they can participate in the Committee's consideration of any confidential and/or exempt item of business.

14.7 The Chair (whom failing, the Vice Chair) may direct that a meeting shall be conducted solely by means of the participation of Remote Members. Such a direction may be made during a meeting or otherwise.

14.8 The Guidance for attending remote meetings via Microsoft Teams is found in Appendix A below.

15. Business

15.1 The notice of a meeting shall include an agenda of items of business which shall be considered in the order in which they are listed except where the Chair, at his or her discretion, may determine otherwise.

15.2 Acceptance of late items of business is at the Chair's discretion having regard to any special circumstances which requires it to be considered as a matter of emergency.

16. Reports by Officers

16.1 Reports must be produced in draft and sent to the following officers for consultation in accordance with the published timetable prior to being accepted onto the IJB final agenda:-

a. Chair of the IJB;

b. Vice Chair of the IJB;
c. Chief Officer, ACHSCP;
d. Chief Finance Officer, ACHSCP;
e. Chief Social Work Officer, the Council
f. Chief Operating Officer, ACHSCP;
g. Chief Executive, the Council;
h. Chief Executive, NHSG;
i. Chief Officer – Finance, the Council;
j. Director of Finance, NHSG;
k. Chief Officer – Governance, the Council
l. IJB Data Protection Officer;
m. Nursing and Medical Directors;
n. Public Health Consultant; and
o. Clerk to the IJB.

16.2 The Council's Leader(s) and Convener of the Finance and Resources Committee shall be consulted on draft reports relating to the IJB Budget in line with the requirements of the IJB Budget Protocol.

16.3 Where the report is for an IJB Committee, the draft reports must be sent to the following officers for consultation;

a. the Chair of that Committee
b. Lead Officer for the Committee
c. Chief Officer, ACHSCP
d. Chief Finance Officer, ACHSCP
e. Chief Operating Officer, ACHSCP
f. Chief Executive, the Council
g. Chief Executive, NHSG
h. Chief Social Work Officer,
i. Chief Officer- Finance, the Council
j. Director of Finance, NHSG,
k. Legal Services, the Council
l. Director of Commissioning, the Council
m. IJB Data Protection Officer, NHSG;
n. Nursing and Medical Directors;
o. Public Health Consultant;
p. Committee Clerk, the Council

17. Quorum

17.1 No business is to be transacted at a meeting of the IJB or its committees unless at least one half of the voting members is present. For meetings of the IJB, this shall mean that two voting members of each constituent authority shall be present and for a meeting of an IJB Committee, one voting member of each constituent authority shall be present.

18. Conduct of Meetings

18.1 At each meeting of the IJB, or one of its committees, the Chair of the IJB or Committee, if present, shall preside.

18.2 If the Chair is absent from a meeting of the IJB, the Vice Chair shall preside.

18.3 If the Chair and Vice Chair are both absent from a meeting of the IJB, a voting member chosen at the meeting by the other voting members attending the meeting, shall preside at the meeting. For the avoidance of doubt, this shall not be the substitute for the Chair or Vice Chair as is specified in Standing Order 8.3.

18.4 No Vice Chairs shall be appointed to IJB committees. In the event that the Chair of a committee is absent, a voting member chosen at the meeting by other voting members attending the meeting shall preside.

18.5 If it is necessary or expedient to do so, the Chair or, whom failing the Vice Chair, may adjourn a meeting of the IJB, or a committee to another date, time or place.

18.6 No filming, recording or use of cameras shall be permitted without the Chair's prior consent.

18.7 Following the introduction of an item of business by the Chair, all members shall be entitled to ask questions of the Report Author, through the Chair, and discuss the item as openly as possible.

18.8 When, in the opinion of the Chair, members have had a reasonable opportunity to consider the item of business, the Chair shall move to a determination of the matter.

18.9 Every effort shall be made by members to ensure that as many decisions as possible are made by consensus. Where the IJB or an IJB Committee has been unable to reach a decision by consensus following the procedure in this paragraph, the Chair shall invite the IJB to move to a vote. The process followed at paragraph 23 shall apply.

18.10 The IJB shall schedule a dedicated budget meeting to consider and agree the IJB budget and adhere to the provisions set out in the IJB Budget Protocol.

18.11 Clerking support to the IJB and its committees shall be provided by the Council.

19. Power and Duties of Chair

19.1 It shall be the duty of the Chair:-

a. To preserve order and ensure that any member wishing to speak is given due opportunity to do so and to a fair hearing;
b. To call members to speak according to the order in which they caught the Chair's eye;
c. To decide on all matters of order, competency and relevancy;
d. To ensure that the sense of the meeting is duly determined; and,
e. If requested by any member, to ask the mover of a recommendation (motion) or amendment to state its terms.

19.2 The Chair shall have authority to determine all procedural matters during IJB meetings following consultation with the Clerk, excepting the suspension of Standing Orders as outlined in paragraph 1.6.

19.3 The ruling of the Chair on all matters in these Standing Orders shall be final.

19.4 Deference shall, at all times, be paid to the authority of the Chair. The Chair shall be heard without interruption and all members shall address the Chair when speaking.

20. Declarations of Interest and Transparency Statements -

20.1 Members must adopt the 3- stage approach (Connection – Interest-Participation) set out in section 5 of the (Declarations of Interests) of the IJB Code of Conduct.

20.2 A member will declare their interest as early as possible in meetings. Where they have declared an interest, they must withdraw from the meeting room (including from any public gallery). They must not participate in any way in those parts of meetings where they have declared an interest . If the meeting is being held online, or the member is participating remotely, the member must retire to a separate breakout room or leave and re-join after the discussion on the matter has concluded. It is not sufficient for them to turn off their camera and/or microphone for the duration of the matter.

20.3 When making a declaration, a member should provide enough information for those at the meeting to understand why they are making a declaration.

20.4 Members should consider whether it is appropriate for transparency reasons for them to state publicly in the meeting where they have a connection, which they do not consider amounts to an interest. Such a statement s referred to in these Standing Orders as a "Transparency Statement".

21. Minutes

21.1 A record must be kept of the names of the members attending every meeting of the IJB or of one of its committees.

21.2 Minutes of the proceedings of each meeting of the IJB or its committee, including any decision made at that meeting, are to be drawn up and submitted to the subsequent meeting of the IJB or the committee for agreement after which they must be agreed by the IJB as an accurate record of the meeting.

21.3 Draft Minutes from the IJB's committees will be presented to the IJB for noting.

22. Alteration or Revocation of Previous Decision

22.1 No decision of the IJB shall be altered or revoked within six months of it having been taken unless a recommendation to that effect is approved by the IJB.

23. Voting

23.1 In the event that the IJB has been unable to reach a decision after following the procedure outlined in Standing Order 18, and a vote is required, the provisions of this Standing Order shall apply.

23.2 Where the recommendation (motion) or amendments are proposed prior to a meeting, members should provide a copy of the proposed wording to the Clerk as soon as is reasonably practicable and, if possible, before the meeting commences.

23.3 Each recommendation (motion) put to a meeting of the IJB shall be decided by a majority of the votes of those members attending and entitled to vote.

23.4 The Chair will have the prior right to the recommendation in the report (the motion), except where the Chair waives that right.

23.5 A recommendation and any amendments thereto, shall be moved and seconded. Movers shall be entitled to speak for ten minutes and all other members, including movers when summing up at the conclusion of debate, shall be entitled to speak for five minutes. No member shall speak in support of a recommendation (motion) until it has been seconded. Any member who has moved or seconded a recommendation (motion) shall not be entitled to enter the debate. A member shall not be entitled to speak more than once in debate, except the mover when summing up. A member shall be entitled, however, to ask a question.

23.6 All recommendations (motions) and amendments must relate to the item of business on the agenda and all amendments must differ from the recommendation substantially.

23.7 The Chair shall determine whether a recommendation (motion) or an amendment is competent and relevant and may seek advice from officers in this regard.

23.8 A recommendation (motion) or amendment is incompetent it if would require the incurring of expenditure and the source of the funding is not identified.

23.9 A recommendation (motion) or amendment moved, but not seconded, or which is ruled incompetent by the Chair, will not be put to the vote but will be recorded in the minute.

23.10 If a recommendation (motion) or an amendment is withdrawn, the mover or seconder can move or second and speak in support of a further recommendation (motion) or amendment.

23.11 A member can make minor alterations to their recommendation (motion) or amendment with consent of the Chair.

23.12 Votes shall be taken by roll call except where an electronic voting system is available, in which case it shall be used in preference to any other method.

23.13 Where there is a tied vote, there shall be no casting vote afforded to the Chair or to any other member or group of members and in that event:-

(i) The Chair shall, call on the Chief Officer to outline the consequences of each potential outcome, to provide such clarification that may be appropriate or requested and to set out the ramifications to the IJB of withdrawing the matter and maintaining the status quo and, thereafter, to make a recommendation.

(ii) The Chair shall then immediately without further discussion call for a roll call on the recommendation (motion) that is before the meeting.

(iii) If the result remains a tie, the Chair may:

a. call a recess of the meeting for such period as the Chair thinks fit to allow members to further consider matters and once the meeting is reconvened defer to (ii) above; or,

b. suspend further discussion on the issue of contention and defer the matter to the next meeting of the IJB; or

c. where the Chair is of the view that a special meeting of the IJB requires to be convened in accordance with Standing Order 11.2, suspend further discussion on the issue of contention and defer the matter to that special meeting.

(iv) Where, in the event that following the recess in terms of Standing Order 23.13 (iii) (a) there is still a tied vote, the Chair shall, at the

Chair's discretion, either; call a further recess in terms of the said Standing Order 23.13 (iii) or chose to proceed with either option in terms of Standing Order 23.13(iii) (b) or Standing Order 23.13 (iii) (c).

(v) Once the meeting is reconvened in accordance with (iv) above and the matter has been discussed in terms of Standing Order 18, the Chair shall call for a roll call in terms of Standing Order 23.13(ii). In the event of a tied vote the Chair shall determine whether the matters should be deferred in terms of Standing Order 23.13(iii) (b) or Standing Order (iii) (c). Where this is the case, the Chair shall direct the Chief Officer to provide such clarification that may be appropriate or requested and to set out the ramifications to the IJB of withdrawing the matter and maintaining the status quo and bring that back to a future meeting.

(vi) At a future meeting of the IJB in accordance with Standing Order 23.13(iii)(b) and (c), the matter shall be discussed in terms of the procedure set out in Standing Order 18 and the Chair shall invite members to vote in accordance with 23.13 (ii) above.

a. If there remains–a tied vote the Chair shall direct the Chief Officer to provide such clarification that may be appropriate or requested together with the options available to the IJB, including an outline of the ramifications of remaining with the status quo and invoking the dispute procedure under the Integration Scheme.
b. The Chair shall invite members to consider and discuss these options in terms of Standing Order 18 and vote in accordance with Standing Order 23.13 above on the issue.
c. In the event of a further tied vote, a vote will be put to members on whether to withdraw the matter or have the status quo apply.

24. Expenses

24.1 The IJB may pay the reasonable travel and other expenses of unpaid carer representatives and other unpaid representatives who are appointed as member of the IJB in accordance with the policy at Appendix C[2].

25. Committees

25.1 The IJB may establish such committees as it may determine for the undertaking of its functions.

[2] Approved by the IJB on 11 August 2020

25.2 The IJB must appoint the Chair of each committee it establishes for an appointing period not exceeding three years.

25.3 The IJB may change the person appointed as Chair during the appointing period for the remainder of that period.

25.4 The IJB Chair/Vice Chair shall not chair an IJB Committee.

25.5 The IJB shall appoint two voting members from each constituent authority to serve on each committee to ensure equal representation.

25.6 Any decision of a committee must be agreed by a majority of the votes cast by the voting members of that committee.

25.7 The Committee shall meet four times each financial year. The Chair may, at any time, convene additional meetings of the Committee.

25.8 The IJB will review and alter the Terms of Reference of any of its committees annually, as part of its annual review of the Scheme of Governance. Before the annual review date of the Scheme of Governance, the IJB may alter the Terms of Reference at any time where it considers it necessary to do so.

25.9 All IJB members shall be entitled to receive committee papers and an open invitation shall be extended to members to attend Committee meetings.

25.10 The level of participation for non-committee members in these proceedings shall be at the discretion of the committee Chair, though non-committee members may not propose or second a recommendation (motion) or amendment, or vote.

25.11 Committee meetings shall be conducted in accordance with these Standing Orders.

25.12 A Committee will formally provide a copy of its minutes to the IJB for inclusion on the agenda of subsequent meeting.

25.13 Following agreement from a majority of members, a committee may refer or escalate an item of business to the next IJB meeting for consideration. The Clerk of the committee shall make the necessary arrangements.

26. General Powers of IJB

26.1 The IJB may enter into a contract with any other person for the provision of goods and services for the purpose of undertaking the functions conferred on it by the Act, including but not limited to administrative support, accounting or legal services.

27. Register of Interests and Code of Conduct

27.1 The IJB Standards Officer shall keep and maintain a Register of Interests, which shall be published on the Internet, in which all members shall record their interests and hospitality offered by virtue of their membership of the IJB. The Standards Officer shall be the officer so designated by the Standards Commission, following a nomination by the IJB. All members are required to complete a register of interests in a standard format to comply with their obligations under the IJB Code of Conduct, within a month of appointment and when any changes occur. A form to register interests will be sent to all members on appointment and members must submit an updated form when there are any changes.

27.2 All members shall be bound by the terms of the Code of Conduct for members of Aberdeen City Health and Social Care Partnership Integrated Joint Board Public Bodies, provided for under the Ethical Standards in Public Life etc (Scotland) Act 2000.

28. Deputations

28.1 The competency of a deputation (in respect of Standing Orders 28 (6) (a) - (d) will be determined by Chair. If the Chair deems a deputation to be incompetent it will not be heard at the meeting.

28.2 Every request for a deputation must be in writing and submitted to the Clerk of the IJB at least two working days before the meeting to which it relates.

a. For example, for a meeting on a Thursday, requests must be received by the end of the Monday; and for a meeting on a Tuesday, requests must be received by the end of the previous Thursday.

28.3 In the event that a report has not been published to enable a deputation request to comply with the deadline set out in Standing Order 12, deputation requests may still be submitted and put on to the agenda. In such instances, Standing Order 12 would require to be suspended at the meeting for the deputation to be heard.

28.4 The request must state the report on which the deputation wants to be heard and the action (if any) the deputation would like the IJB to take in relation to the report.

28.5 A competent deputation request will be placed on the agenda for the relevant meeting of the IJB.

28.6 The following deputation requests are not competent:

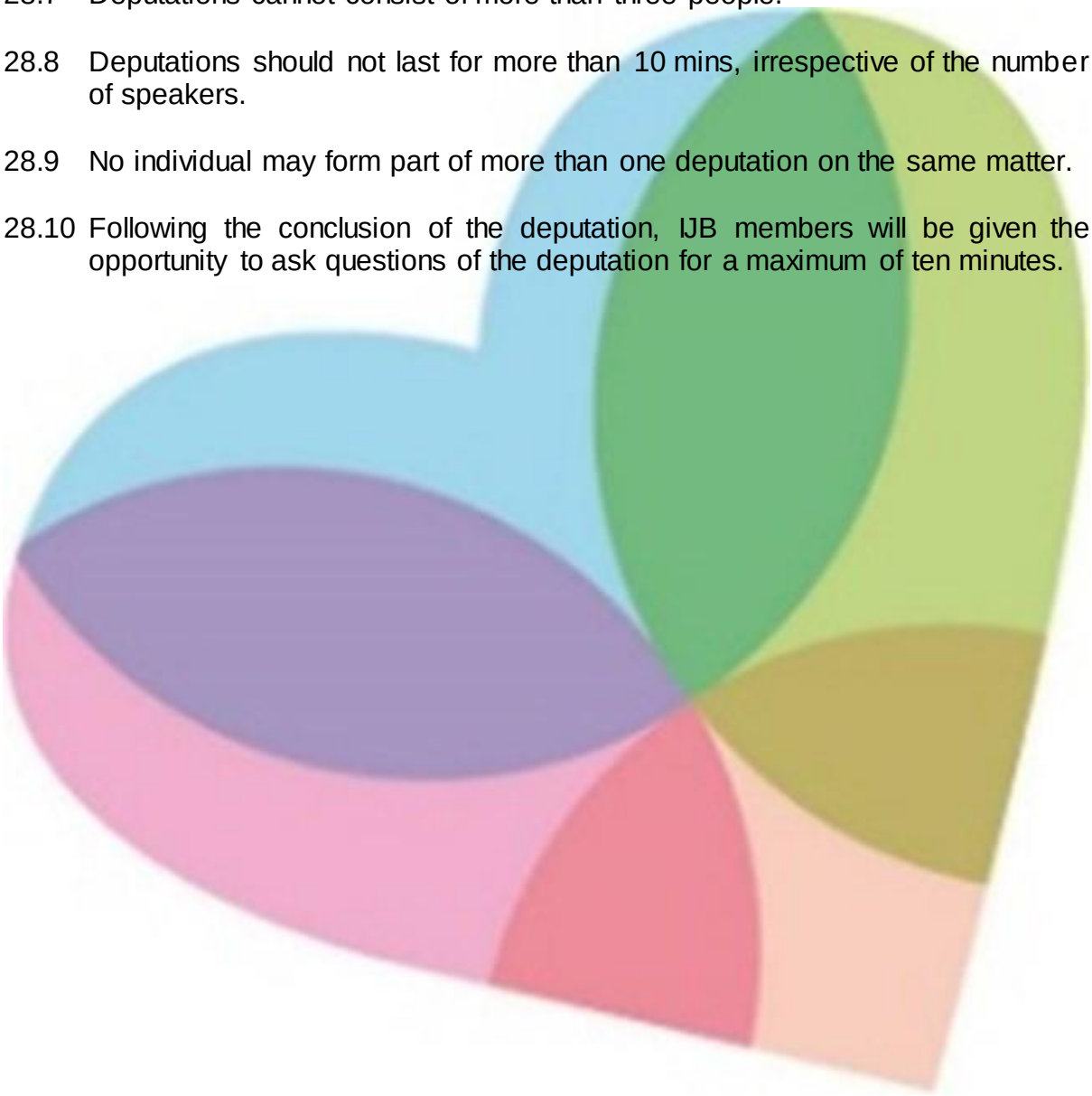
a. Deputations which fail to comply with Standing Order 28.2;
b. Deputations which relate to reports containing confidential information;
c. Deputations which relate to the annual budget; and
d. Deputations which do not relate to a report on an agenda.

28.7 Deputations cannot consist of more than three people.

28.8 Deputations should not last for more than 10 mins, irrespective of the number of speakers.

28.9 No individual may form part of more than one deputation on the same matter.

28.10 Following the conclusion of the deputation, IJB members will be given the opportunity to ask questions of the deputation for a maximum of ten minutes.



Appendix A –Remote Attendance Guidance

This short guide is intended to assist you to participate in a remote meeting and is not a replacement for fuller Teams instruction provided by your constituent authorities.

You will have received an invitation from the Clerk in either Outlook (email) or Teams to participate in a Teams Meeting. You can join the meeting via your laptop/tablet or from a standard telephone.

In advance of the meeting

Members should:-

- Ensure that they have downloaded the agenda papers and saved these on their desktop for easy access.
- Inform the Clerk if they are unable to attend or may be late.
- Inform the Clerk if they have any query, or potential amendment to the minute to allow this to be considered and investigated in advance. (This should then be raised in the normal manner during the meeting).

On the day of the meeting

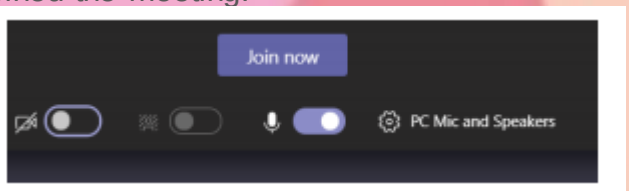
Members should:-

- Ensure they are located as close to their broadband router as possible or connect their computer direct to the router by cable.
- Join the Teams meeting 5 minutes before the start time.
- Ensure that their microphone remains at mute unless they have been invited to speak by the Chair.
- Activate their video camera (if possible).
- Ensure that any personal items on display in the background cannot be picked up on video camera.

Access the meeting remotely

Laptop/Tablet Device

Open your agenda for the meeting. Then open your invitation within Outlook email or Teams. Select Join and your screen will default to the Meeting. Select *'Join Now'* and you have remotely joined the meeting.

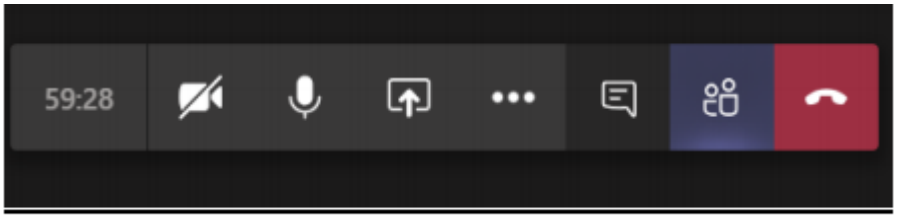


Telephone - Joining a Meeting

Call the telephone number in the Outlook appointment which has been sent to you and use the conference code provided in that invitation as set out below. You will be guided by the voice message.

Join Microsoft Teams Meeting
+44 20 3443 9692 United Kingdom, London (Toll)
Conference ID: *******#

Joined the Meeting
If you have joined the meeting via Teams you will then see the *Options Bar* as per the image below (shows 8 options) – this should appear at the centre of the Teams screen. Thereafter you will see the *Options Bar*



From the right

- Hang Up / Terminate – Participants can terminate the call via the red handset which allows them to leave the meeting and re-join if they select the "join" button from the invitation.
- Show Participants (2nd from right) – Displays a list of all remote participant.
- Show Conversation (3rd from right) – This allows you to 'chat' with all other participants in the meeting. NB - this is NOT Private Chat but Meeting Chat. Private chat remains available via the Chat icon on the top left of the side.
- Ellipsis (more options) button (4th from right) provides a further 8 options as advised.
- Share (5th from right) provides sharing options.
- Microphone (6th from right), you can mute/unmute the microphone.
- Camera (7th from right), you can select camera on/ off.
- Timer (furthest left) shows the duration of the meeting.

How to participate
You should use the 'hands' facility or Teams Chat facility (3rd from right on the options bar) to alert the Chair if you wish to participate. The Clerk will alert the Chair and the Chair will call your name.

Viewing Agenda whilst in Remote Meeting
You should already have your agenda open and can access this from Teams via the toolbar at the bottom of your screen. This will allow you to switch between Teams and your agenda.

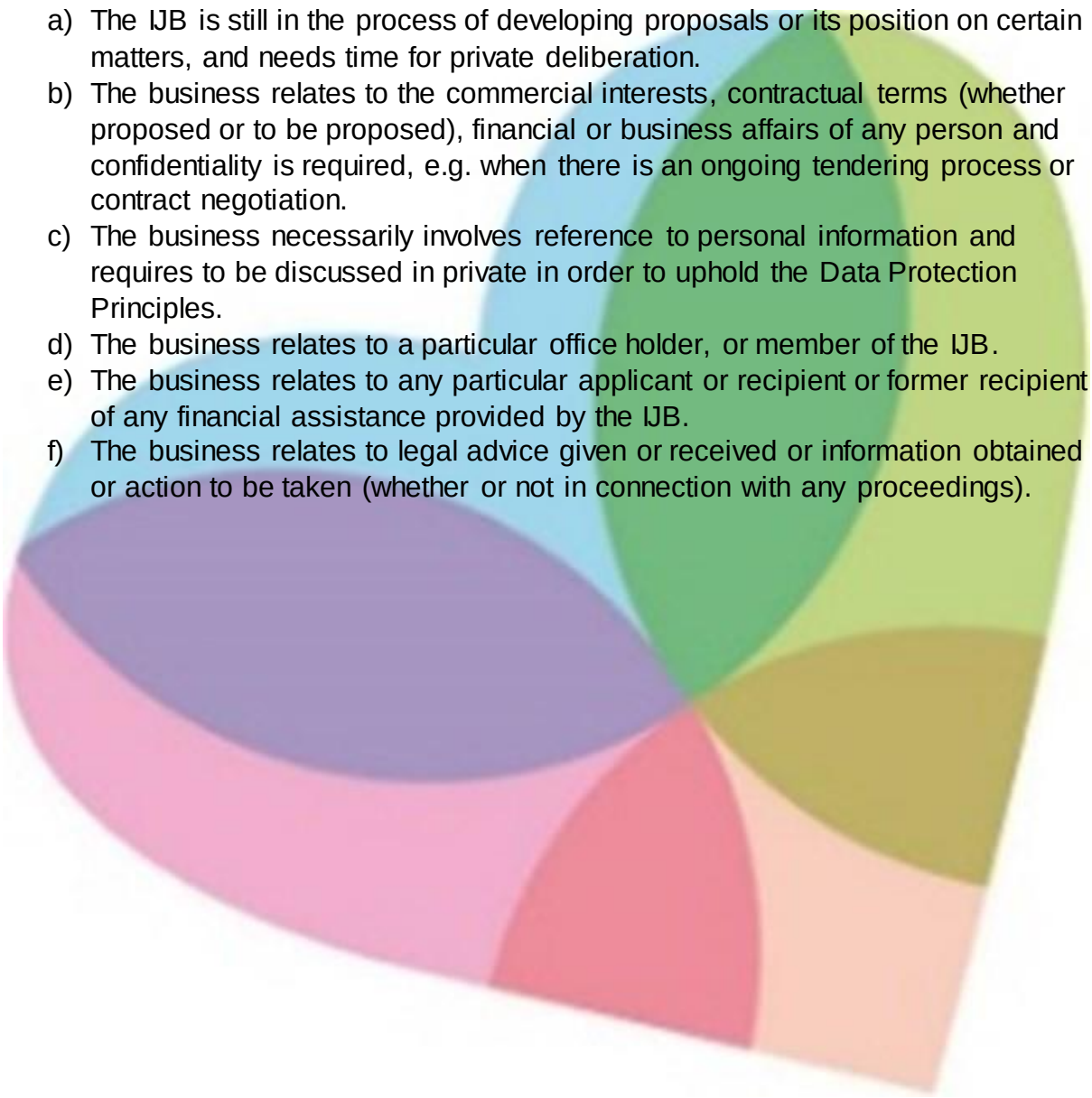
Declaring an Interest
If you have declared an interest in a report and intend to leave the meeting during discussion at the appropriate time, you should hang up (using the telephone symbol on the Options Bar) in order to remove yourself from the meeting and the Clerk will reinvite you when that business is concluded.

You should NOT re-join the meeting until you receive an invitation from the Clerk. This invitation will pop up on your screen, and you should select 'video call' from the two options given.

Appendix B- Exempt and Confidential Information

In accordance with Standing Order 13, the IJB may pass a resolution to meet in private in order to consider certain items of business, and may decide to do so for the following reasons;

a) The IJB is still in the process of developing proposals or its position on certain matters, and needs time for private deliberation.
b) The business relates to the commercial interests, contractual terms (whether proposed or to be proposed), financial or business affairs of any person and confidentiality is required, e.g. when there is an ongoing tendering process or contract negotiation.
c) The business necessarily involves reference to personal information and requires to be discussed in private in order to uphold the Data Protection Principles.
d) The business relates to a particular office holder, or member of the IJB.
e) The business relates to any particular applicant or recipient or former recipient of any financial assistance provided by the IJB.
f) The business relates to legal advice given or received or information obtained or action to be taken (whether or not in connection with any proceedings).



Appendix C – Aberdeen City Integrated Joint Board Expenses Policy

Who is the expenses policy for?

This policy is for unpaid carer representatives who are appointed as a member of the Aberdeen City Health and Social Care Partnership Integration Joint Board (IJB) as per the Standing Orders 3b), c) and d) and any associated groups or committees. It can also be used for other unpaid representatives on IJBs, such as service users.

Why does this expenses policy exist?

This policy ensures that any unpaid carer or other representatives who are members of the IJB and associated groups or committees are not out of pocket as a result of carrying out their duties (as defined in the Public Bodies (Joint Working) (Scotland) Act 2014).

When does this expenses policy apply?

This expenses policy applies to enable unpaid carer and other representatives to undertake the work required in their capacity as IJB members. This includes preparatory work for, and attendance at:

- IJB meetings (including Workshop and Development Sessions)
- Strategic Planning Groups
- Locality Groups
- Other associated groups or committees
- IJB related duties and events (e.g. meeting a community group to explain the Strategic Commissioning Plan)

What expenses are included in this policy?

The following are included but prior approval must be sought before any expense is incurred

- **Travel costs**
  - public transport (excludes first class travel - receipts to be provided)
  - mileage (45p/mile)
  - parking (receipts to be provided)
  - taxi costs - where public transport arrangements are not suitable (receipts to be provided)
- **Subsistence (where no meals or refreshments are provided)**
  - Reimbursement of reasonable lunch expenses as per current Local

Council guidelines (receipts to be provided)

- Reimbursement of reasonable dinner expenses as per current Local Council guidelines (receipts to be provided)
- Overnight accommodation and reimbursement of reasonable expenses for overnight stays, if and when required, as per current Local Council guidelines (receipts to be provided)

- **Preparatory work and administration to carry out duties**
  - IT / communication costs (e.g. phone / iPad / laptop) although a Council owned laptop will normally be loaned for the period of tenure NB: there will be a requirement to agree to abide by the relevant policies in relation to use of IT equipment, data protection etc.

- **Replacement care / care cover**
  - for attendance at IJB meetings
  - for attendance at other meetings/events relating to role
  - for travel times to meetings
  - for preparation time (if and when required – to be discussed and agreed in advance)

- **Loss of income to attend meetings**
  - Where appropriate, loss of earnings income to attend IJB meetings will be considered (to be discussed and agreed in advance – NIHR Guidelines for public involvement in health and social care research could help inform these discussions).
  - Any potential impact on social security benefits to be considered and discussed.

Example: one HSCP has allocated resources to their local carers centre to enable carers to support other carers around strategic planning. This allows carers to be recompensed on a sessional basis to support engagement.

What is the process for claiming expenses?

- A named contact person will be identified to support communication, completion and agreement of all expenses claims.
- Expenses forms will be provided in electronic or paper format before or at each meeting / event to claim travel and subsistence expenses (receipts to be provided).
- For preparatory and administrative costs, reimbursement of costs as spent.
- For replacement care and loss of income reimbursement, discussion and agreement with named contact person in advance.
- All expenses will be paid in accordance with normal expenses processing deadlines following receipt of a properly completed expenses claim form. However, to ensure equity of involvement and engagement, if required

immediate payments may be made. A payment schedule with dates of reimbursement will be provided.

- Payments will be made via BACS transfer where possible. Bank details will require to be provided to enable payment. Where BACS payment is unsuitable alternative payment arrangements (such as cheque/cash) can only be agreed by the Chief Finance Officer.

Reviewing this policy

This policy will be reviewed annually with the relevant recipients. Any proposed changes to this policy will be discussed with those covered by the policy before implementation.

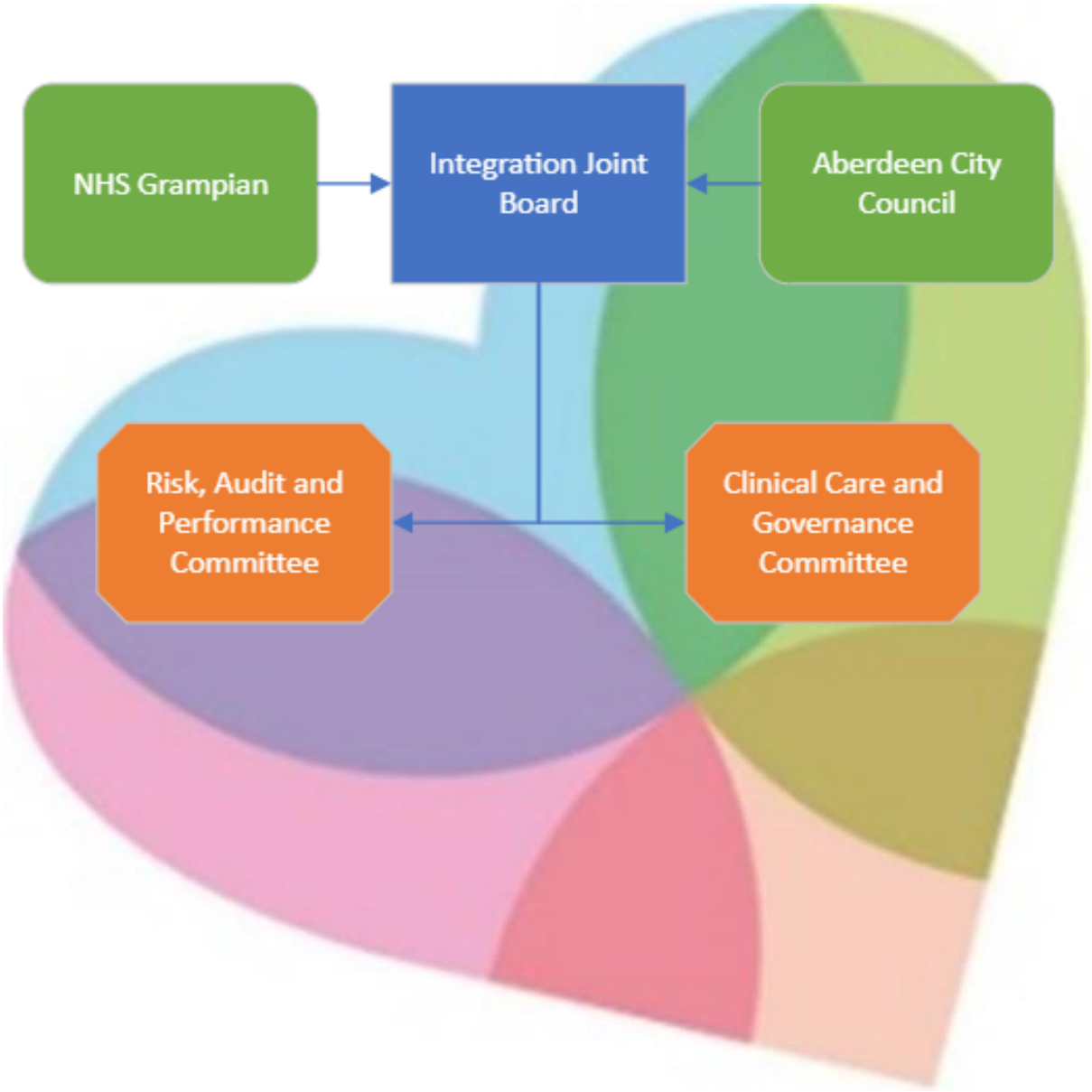
Aberdeen City Health & Social Care Partnership
A caring partnership

Aberdeen City Integration Joint Board

Terms of Reference

Date Created:	November 2022	
Version:	V 2.0	
Location:	Governance	
Author (s) of Document:	John Forsyth, ACC Legal Services	
Approval Authority	IJB	
Scheduled Review:	April 2024	
Effective Date:	1 May 2023	
Changes:	March 2023	

IJB Structure Chart



Introduction

1. The Integration Joint Board (IJB) ultimately derives its authority from the Public Bodies (Joint Working) (Scotland) Act 2014. It was created by Aberdeen City Council (the Council) and NHS Grampian (NHSG). Both of these partner organisations delegated functions to the IJB, which are detailed in the Integration Scheme.

2. The IJB is permitted by clause 17 of The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 to form committees for the purpose of carrying out such of its functions as it determines.

3. The IJB has formed two committees: the Risk, Audit and Performance Committee and the Clinical and Care Governance Committee.

4. Any decision taken by a committee is deemed to be a decision of the IJB as a whole.

5. The IJB may determine a matter which would ordinarily fall within the remit of a committee.

6. The IJB sets the Terms of Reference for its committees annually when reviewing the Scheme of Governance. As part of this process, the Chief Officer will ensure that officers will review the Terms of Reference.

7. Non-material amendments to the Terms of Reference may be made by the Chief Officer, following consultation with the Chair and Vice-Chair of the IJB and the Chairs and Vice-Chairs of the Committees. Any such amendments do not need to be approved otherwise by the IJB.

8. Any non-material amendments will be notified to the Members of the IJB when completed.

Title	Aberdeen City Integration Joint Board (IJB)		
Lead	Chief Officer		
Date	April 2023	**Version**	1

Quorum
Four voting Members, with at least two Members from each constituent authority

Matters Reserved to the IJB

The powers which are reserved to the IJB are comprised of those which:

- Must be reserved by law; and
- those which the IJB has chosen to reserve.

1. Any functions or remit which is, in terms of statute or legal requirement, bound to be undertaken by the IJB itself;

2. Establishing such committees as may be considered appropriate to conduct business and to appoint and remove Conveners, Depute Conveners and members of committees and outside bodies in accordance with the IJB's Standing Orders;

3. The approval of the Medium-Term Financial Framework.

4. The approval or amendment of the Scheme of Governance;

5. Contracts, in so far as it relates to business services, the engagement of consultants, or external advisors for specialist advice, subject to necessary approvals through the Partners' own procurement rules and Schemes of Delegation;

6. The decision to co-operate or combine with other Integration Joint Boards in the provision of services other than by way of collaborative agreement;

7. The approval or amendment of the Strategic Plan and on going monitoring of its delivery through the Annual Performance Report;

8. Issuing Directions to the Partners under sections 26 and 27 of the Public Bodies (Joint Working) (Scotland) 2014 Act, in line with the Integration Scheme and legislative framework;

9. Approving the Clinical Care Governance Framework.

Clinical and Care Governance Committee

Title	Clinical and Care Governance Committee		
Executive Lead	Medical Lead		
Date	April 2023	**Version**	1

Purpose

The Committee shall be responsible for the oversight of clinical and care governance within Aberdeen City Health and Social Care Partnership (ACHSCP). Specifically, it will:

a. Provide assurance to the Integration Joint Board (IJB) on the systems for delivery of safe, effective, person-centred care in line with the IJB's statutory duties for the quality of health and care services.

b. Provide assurance to the IJB that clinical and care governance is being discharged within the Partnership in relation to the statutory duty for quality of care and that this is being led professionally and clinically with the oversight of the IJB.

c. Escalate any risks that require executive action or that pose significant threat to patient care, service provision or the reputation of the Partnership to the IJB.

Quorum

Two voting Members, one representative each from the Council and NHSG.

Remit and Responsibilities

1. Instruct further investigation on any matters which fall within its remit, reporting the findings of such an investigation to the IJB.

2. Agree the ACHSCP clinical and care governance priorities and give direction on clinical and care governance activities.

3. Oversee the work of the Clinical and Care Governance Group and Staff Governance Groups by receiving regular reporting for consideration and assurance.

4. Review unresolved risks that require executive action or that pose significant threat to patient care (including service users, patients and carers), service provision or the reputation of the ACHSCP.

5. Contribute to the regular review of the IJB Risk Register from a clinical and care governance/staff governance perspective and escalate any risks to the IJB, NHS Grampian or Aberdeen City Council, as appropriate.

Principal Advisors

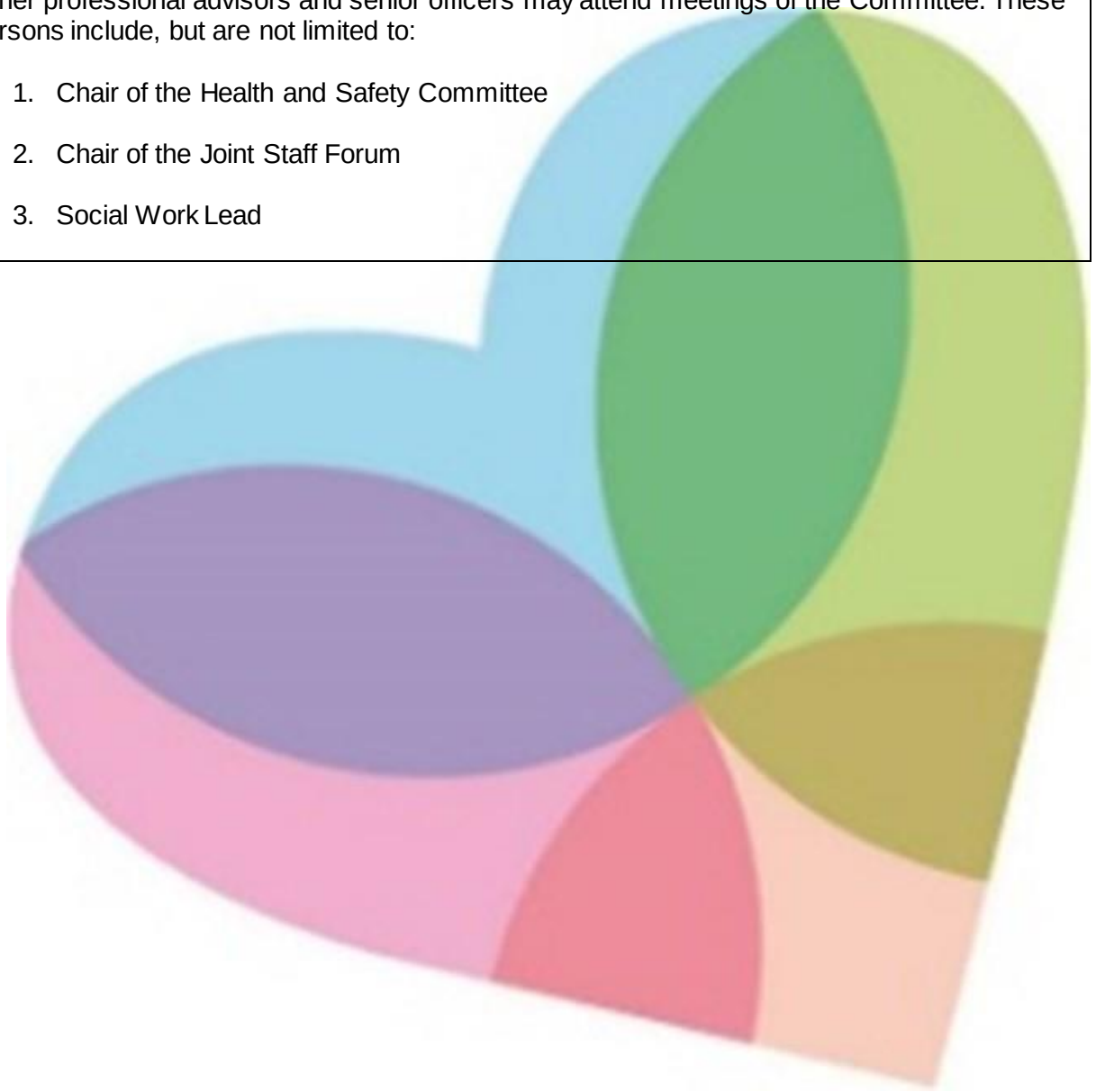
The Executive Lead to the Committee is the Medical Lead.

They will routinely be supported by:

1. Chief Social Work Officer;
2. Professional Nursing Lead; and
3. Allied Health Professional Lead.

Other professional advisors and senior officers may attend meetings of the Committee. These persons include, but are not limited to:

1. Chair of the Health and Safety Committee
2. Chair of the Joint Staff Forum
3. Social Work Lead



Risk, Audit and Performance Committee

Title	Risk, Audit and Performance Committee		
Executive Lead	Chief Finance officer		
Date	April 2023	**Version**	1

Purpose

To ensure that the IJB has robust arrangements for:

- risk management;
- financial management;
- service performance; and
- governance.

This includes services hosted by Aberdeen City's IJB on behalf of other integration authorities.

Quorum

Two voting Members, one representative each from the Council and NHSG.

Remit and Responsibilities

Investigation

1. Instruct further investigation on any matters which fall within its remit, reporting the findings of such an investigation to the IJB.

Audit

2. Review and approve the annual audit plans (internal and external) on behalf of the IJB, receiving reports, overseeing and reviewing actions taken on audit recommendations and escalating to the IJB as appropriate.

3. Be aware of, and receive assurance on actions taken in response to Audit Scotland, national and UK audit findings, inspections, and regulatory advice as appropriate.

Performance

4. Approve, monitor and review a performance framework for the IJB in respect of its policy objectives and priorities in relation to all functions of the IJB. This includes ensuring that the Chief Officer establishes and implements satisfactory arrangements for reviewing and appraising service performance against the national health and wellbeing outcomes, the associated core suite of indicators and other appropriate local objectives and priorities.

5. Receive and scrutinise performance reports and receive assurance that actions in respect of emerging trends are proportionate to the IJB's Risk Appetite Statement.

6. Instruct Performance Reviews and related processes.

7. Support the IJB in delivering and expecting cooperation in seeking assurance that hosted services run by partners are working.

8. Monitor the IJB's work and performance as a Category One Responder under the Civil Contingencies Act 2004.

Risk and Governance

9. Monitor the risk appetite and/or tolerance established by the Board Assurance Framework to ensure effective oversight and governance of the partnership's activities.

10. Ensure the existence of, and compliance, with an appropriate risk management strategy including: reviewing risk management arrangements; receiving biannual Strategic Risk Management updates and undertaking in-depth review of a set of risks and annually review the IJB's risk appetite document with recommendations being brought to the IJB.

11. Approve the sources of assurance used in the Annual Governance Statement.

12. Review the overall Internal Control arrangements of the Board and make recommendations to the Board regarding signing of the Governance Statement, having received assurance from all relevant Committees.

Financial

13. Consider and approve annual financial accounts and related matters

14. Receive regular financial monitoring reports

15. Approve budget virements

Principal Advisors

The Executive Lead to the Committees is the Chief Finance Officer.

Other professional advisors and senior officers may be required to attend meetings of the Committee. These persons include, but are not limited to:

1. External Audit
2. IJB Lead Strategy and Performance Manager
3. IJB Lead Transformation Manager
4. IJB Business Manager
5. IJB Commissioning Lead

Aberdeen City Health & Social Care Partnership
A caring partnership

Aberdeen City Integrated Joint Board

Roles and Responsibilities

Date Created:	November 2022
Version:	V 2.0
Location:	Governance
Author (s) of Document:	Jessica Anderson, ACC Legal Services
Approval Authority	IJB
Scheduled Review:	April 2024
Effective Date:	1 May 2023
Changes:	March 2023

1 INTRODUCTION

1.1 The Roles and Responsibilities of the Aberdeen City Integrated Joint Board (hereinafter referred to as the "Protocol") was approved by Aberdeen City Integration Joint Board (hereinafter referred to as the "IJB") on 27 March 2018. Its purpose is to explain the remit of the statutory officers within the IJB, namely, the Chief Officer and the Chief Finance Officer and other key personnel within the Aberdeen City Health and Social Care Partnership (ACHSCP).

2 OPERATIONAL PROTOCOL

2.1 Chief Officer

2.1.1 Aberdeen City Council and NHS Grampian (hereinafter referred to as "the Partners") have delegated functions to the IJB under the Integration Scheme. The IJB is responsible for setting strategic direction and setting appropriate policies. Applying the delegated authority provided to them by the Partners, the Chief Officer is responsible for implementing approved strategy and policy and for the operational management of the workforce. The IJB is required by law to appoint a Chief Officer[1]. The Chief Officer is responsible for ensuring compliance with all relevant statutory provisions in respect of the delegated functions; shall direct and ensure that coordinated and appropriate arrangements are in place to discharge the requirements and duties of the IJB as a Category 1 Responder under the Civil Contingencies Act 2004 and other relevant legislation; and shall comply with the roles and responsibilities of the Chief Officer as detailed in the IJB's Financial Regulations.

2.2 Chief Finance Officer

2.2.1 The Chief Finance Officer has overall responsibility for Finance including Audit and Financial Management. The IJB is required to appoint the Chief Finance Officer[2] who shall discharge their duties in accordance with the powers as delegated to them by the Partners under their respective approved Schemes of Delegation. In discharging their duties and in making any recommendation to the IJB, the Chief Finance Officer will account for the policies and procedures of the Partners as appropriate.

[1] Section 10 of the Public Bodies (Joint Working) (Scotland) Act 2014

[2] Under section 3 of the Public Bodies (Joint Working) (Integrated Joint Board) (Scotland) Order 2014/285

2.2.2 The Chief Finance Officer shall:-

a) act as the Proper Officer responsible for the administration of the financial affairs of the IJB in terms of section 95 of the Local Government (Scotland) Act 1973;

b) adhere to IJB and the Partners Financial Regulations and relevant Codes of Practice of the Board for the control of all expenditure and income;

c) comply with the roles and responsibilities of the Chief Finance Officer as detailed in the IJB's Financial Regulations;

d) monitor the IJB's revenue budget during the course of each financial year and report thereon to the IJB;

e) determine all accounting procedures and financial record keeping of the IJB, to ensure the IJB is fully compliant with the CIPFA Statement of Recommended Practice;

f) have financial oversight of any procurement for the engagement of consultants, external advisors for specialist advice entered into directly by the IJB (but not procurement carried out on behalf of the IJB);

g) be the primary point of contact with both internal and external audit and provide information as appropriate; and

h) develop the IJB's Medium Term Financial Framework.

2.3 Medical Lead

2.3.1 The Medical Lead shall be the Clinical Lead of the IJB and the Clinical and Care Governance Committee and a member of the Senior Leadership Team within ACHSCP. The roles and responsibilities of the Medical Director may be shared between more than one person.

2.3.2 The Medical Lead will be expected to provide leadership, advice, and support to:

a) the ACHSCP Senior Leadership Team;
b) staff working within ACHSCP services, and particularly medical practitioners and those working across primary and community care and within services hosted by or on behalf of the ACHSCP; NHS Grampian Medical Director and Medical Directorate colleagues and clinicians; in relation to clinical and care safety;

c) GPs and other NHS external contractors working within Aberdeen City and in partnership with those across all 3 Grampian Health and Social Care Partnerships as required; and
d) the IJB as a formal advisor to the IJB on clinical and care matters.

2.4 Chief Operating Officer

2.4.1 The Chief Operating Officer shall support the Chief Officer of the IJB, be responsible for the strategic leadership of the ACHSCP and the delivery of the IJB's Strategic Plan including of transformative initiatives. The Chief Operating Officer will deputise for the Chief Officer and Portfolio Lead for NHS Grampian's Medicine and Unscheduled Care Portfolio where this is necessary.

Aberdeen City Health & Social Care Partnership
A caring partnership

Code of Conduct

for

Members

of

Aberdeen City Integration Joint Board

Date Created:	November 2022	
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Changes:	March 2023	

CONTENTS

SECTION 1: INTRODUCTION TO THE CODE OF CONDUCT

1.1 This Code is substantially based on the Model Code of Conduct for Members of Devolved Public Bodies issued by the Scottish Ministers, with the approval of the Scottish Parliament, as required by the Ethical Standards in Public Life etc. (Scotland) Act 2000 (the "Act").

1.2 The purpose of the Code is to set out the conduct expected of those who serve on the Aberdeen City Integration Joint Board ("the IJB").

1.3 The Code has been developed in line with the nine key principles of public life in Scotland. The principles are listed in Section 2 and set out how the provisions of the Code should be interpreted and applied in practice.

IJB Ethos and Values

1.4 The IJB is built on a foundation of trust and respect amongst all its members and between Aberdeen City Council and NHS Grampian. The IJB is a caring partnership, which works with communities to enable the people of Aberdeen to achieve fulfilling and healthier lives. The IJB has core values of being caring, person-centred and enabling. The IJB works to maintain and uphold these values through collaboration, effective communication, and strong local relationships.

1.5 The IJB's values and vision are supported by the Code of Conduct. The Key Principles of the Code of Conduct align with the behaviours evidenced by and expected of all IJB members. By adhering to the Code of Conduct, IJB members not only uphold public confidence in the Board and its decisions, but also help to further the aims, vision, value and strategic intent of the IJB.

My Responsibilities

1.6 I understand that the public has a high expectation of those who serve on the boards of public bodies and the way in which they should conduct themselves in undertaking their duties. I will always seek to meet those expectations by ensuring that I conduct myself in accordance with the Code.

1.7 I will comply with the substantive provisions of this Code, being sections 3 to 6 inclusive, in all situations and at all times where I am acting as a board member of the IJB, have referred to myself as a board member or could objectively be considered to be acting as a board member.

1.8 I will comply with the substantive provisions of this Code, being sections 3 to 6 inclusive, in all my dealings with the public, employees and fellow board members, whether formal or informal.

1.9 I understand that it is my personal responsibility to be familiar with the provisions of this Code and that I must also comply with the law and the IJB's rules, standing orders and regulations. I will also ensure that I am familiar with any guidance or advice notes issued by the Standards Commission for Scotland ("Standards Commission") and the IJB, and endeavour to take part in any training offered on the Code.

1.10 I will not, at any time, advocate or encourage any action contrary to this Code.

1.11 I understand that no written information, whether in the Code itself or the associated Guidance or Advice Notes issued by the Standards Commission, can provide for all circumstances. If I am uncertain about how the Code applies, I will seek advice from the Standards Officer of the IJB, failing whom the Chief Officer. I note that I may also choose to seek external legal advice on how to interpret the provisions of the Code.

1.12 I will engage with all IJB development and training which upholds the Code of Conduct and supports the IJB ethos and values.

Enforcement

1.13 Part 2 of the Act sets out the provisions for dealing with alleged breaches of the Code, including the sanctions that can be applied if the Standards Commission finds that there has been a breach of the Code. More information on how complaints are dealt with and the sanctions available can be found at **Annex A**.

SECTION 2: KEY PRINCIPLES OF THE CODE OF CONDUCT

2.1 The Code has been based on the following key principles of public life. I will behave in accordance with these principles and understand that they should be used for guidance and interpreting the provisions in the Code.

2.2 I note that a breach of one or more of the key principles does not in itself amount to a breach of the Code. I note that, for a breach of the Code to be found, there must also be a contravention of one or more of the provisions in sections 3 to 6 inclusive of the Code.

The key principles are:

Duty
I have a duty to uphold the law and act in accordance with the law and the public trust placed in me. I have a duty to act in the interests of the IJB and in accordance with the core functions and duties of the IJB.

Selflessness
I have a duty to take decisions solely in terms of public interest. I must not act in order to gain financial or other material benefit for myself, family or friends.

Integrity
I must not place myself under any financial, or other, obligation to any individual or organisation that might reasonably be thought to influence me in the performance of my duties.

Objectivity
I must make decisions solely on merit and in a way that is consistent with the functions of the IJB when carrying out public business including making appointments, awarding contracts or recommending individuals for rewards and benefits.

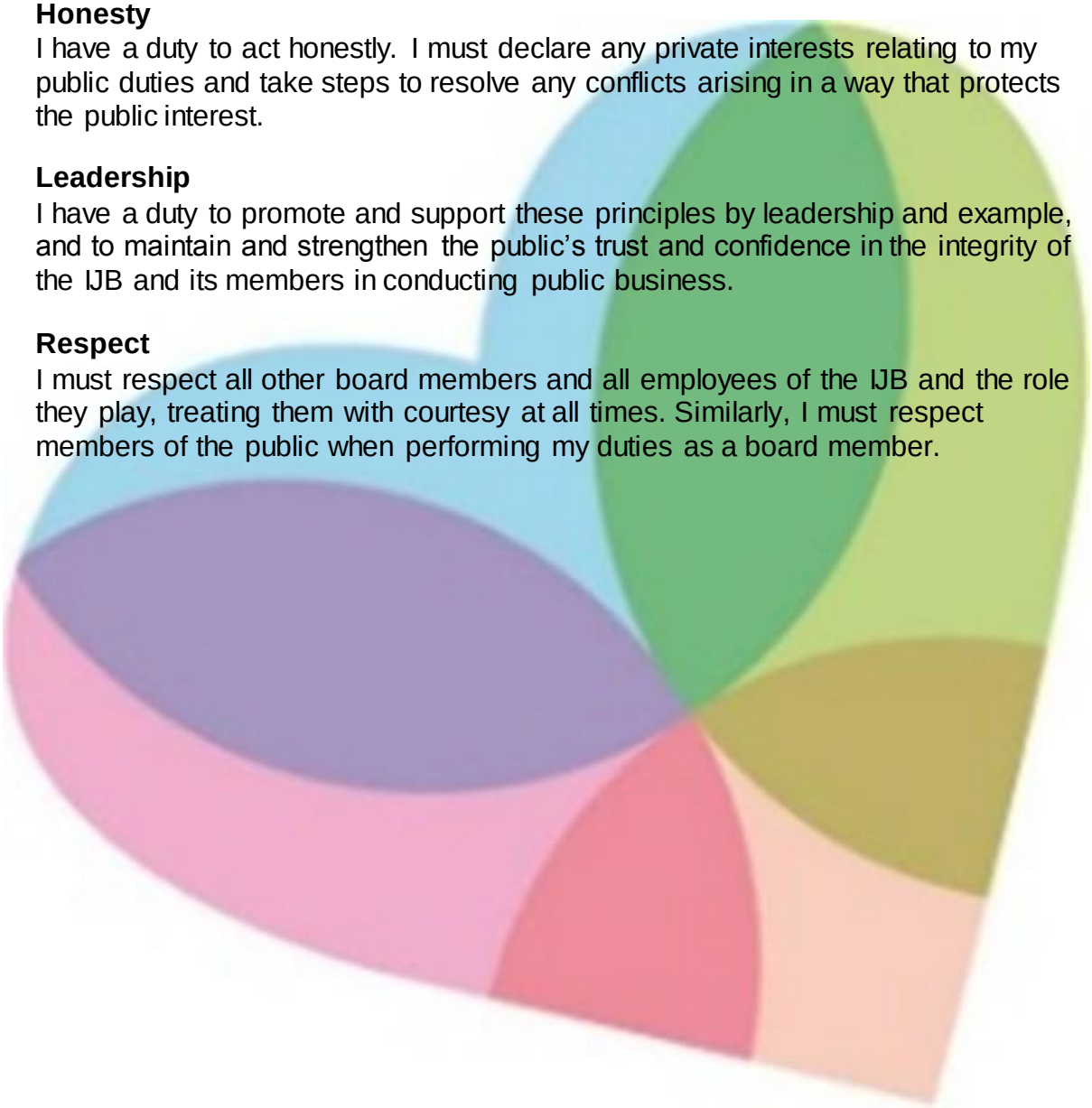
Accountability and Stewardship
I am accountable to the public for my decisions and actions. I have a duty to consider issues on their merits, taking account of the views of others and I must ensure that the IJB uses its resources prudently and in accordance with the law.

Openness
I have a duty to be as open as possible about my decisions and actions, giving reasons for my decisions and restricting information only when the wider public interest clearly demands.

Honesty
I have a duty to act honestly. I must declare any private interests relating to my public duties and take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership
I have a duty to promote and support these principles by leadership and example, and to maintain and strengthen the public's trust and confidence in the integrity of the IJB and its members in conducting public business.

Respect
I must respect all other board members and all employees of the IJB and the role they play, treating them with courtesy at all times. Similarly, I must respect members of the public when performing my duties as a board member.



SECTION 3: GENERAL CONDUCT

Respect and Courtesy

3.1 I will treat everyone with courtesy and respect. This includes in person, in writing, at meetings, when I am online and when I am using social media.

3.2 I will not discriminate unlawfully on the basis of race, age, sex, sexual orientation, gender reassignment, disability, religion or belief, marital status or pregnancy/maternity; I will advance equality of opportunity and seek to foster good relations between different people.

3.3 I will not engage in any conduct that could amount to bullying or harassment (which includes sexual harassment). I accept that such conduct is completely unacceptable and will be considered to be a breach of this Code.

3.4 I accept that disrespect, bullying and harassment can be:

a) a one-off incident,
b) part of a cumulative course of conduct; or
c) a pattern of behaviour.

3.5 I understand that how, and in what context, I exhibit certain behaviours can be as important as what I communicate, given that disrespect, bullying and harassment can be physical, verbal and non-verbal conduct.

3.6 I accept that it is my responsibility to understand what constitutes bullying and harassment and I will utilise resources, including the Standards Commission's guidance and advice notes, the IJB's, Aberdeen City Council's or NHS Grampian's policies and training material (where appropriate) to ensure that my knowledge and understanding is up to date.

3.7 Except where it is written into my role as Board member, and / or at the invitation of the Chief Officer, I will not become involved in operational management of the IJB. I acknowledge and understand that operational management is the responsibility of the Chief Officer.

3.8 I will not undermine any individual employee or group of employees, or raise concerns about their performance, conduct or capability in public. I will raise any concerns I have on such matters in private with senior management as appropriate.

3.9 I will not take, or seek to take, unfair advantage of my position in my dealings with employees of the IJB or bring any undue influence to bear on employees to take a certain action. I will not ask or direct employees to do something which I know, or should reasonably know, could compromise them or prevent them from undertaking their duties properly and appropriately.

3.10 I will respect and comply with rulings from the Chair during meetings of:

a) the IJB, its committees; and
b) any outside organisations that I have been appointed or nominated to by the IJB or on which I represent the IJB.

Remuneration, Allowances and Expenses

3.11 I will comply with the rules, and the policies of the IJB, on the payment of remuneration, allowances and expenses.

Gifts and Hospitality

3.12 I understand that I may be offered gifts (including money raised via crowdfunding or sponsorship), hospitality, material benefits or services ("gift or hospitality") that may be reasonably regarded by a member of the public with knowledge of the relevant facts as placing me under an improper obligation or being capable of influencing my judgement.

3.13 I will never **ask for** or **seek** any gift or hospitality.

3.14 I will refuse any gift or hospitality, unless it is:

a) a minor item or token of modest intrinsic value offered on an infrequent basis;
b) a gift being offered to the IJB;
c) hospitality which would reasonably be associated with my duties as a board member; or
d) hospitality which has been approved in advance by the IJB.

3.15 I will consider whether there could be a reasonable perception that any gift or hospitality received by a person or body connected to me could or would influence my judgement.

3.16 I will not allow the promise of money or other financial advantage to induce me to act improperly in my role as a board member. I accept that the money or advantage (including any gift or hospitality) does not have to be given to me directly. The offer of monies or advantages to others, including community groups, may amount to bribery, if the intention is to induce me to improperly perform a function.

3.17 I will never accept any gift or hospitality from any individual or applicant who is awaiting a decision from, or seeking to do business with, the IJB.

3.18 If I consider that declining an offer of a gift would cause offence, I will accept it and hand it over to the IJB at the earliest possible opportunity and ask for it to be registered.

3.19 I will promptly advise the IJB's Standards Officer if I am offered (but refuse) any gift or hospitality of any significant value and / or if I am offered any gift or hospitality from the same source on a repeated basis, so that the IJB can monitor this.

3.20 I will familiarise myself with the terms of the Bribery Act 2010, which provides for offences of bribing another person and offences relating to being bribed.

Confidentiality

3.21 I will not disclose confidential information or information which should reasonably be regarded as being of a confidential or private nature, without the express consent of a person or body authorised to give such consent, or unless required to do so by law. I note that if I cannot obtain such express consent, I should assume it is not given.

3.22 I accept that confidential information can include discussions, documents, and information which is not yet public or never intended to be public, and information deemed confidential by statute.

3.23 I will only use confidential information to undertake my duties as a board member. I will not use it in any way for personal advantage or to discredit the IJB (even if my personal view is that the information should be publicly available).

3.24 I note that these confidentiality requirements do not apply to protected whistleblowing disclosures made to the prescribed persons and bodies as identified in statute.

Use of IJB Resources

3.25 I will only use the IJB's resources, including employee assistance, facilities, stationery and IT equipment, for carrying out duties on behalf of the IJB, in accordance with its relevant policies.

3.26 I will not use, or in any way enable others to use, the IJB's resources:

a) imprudently (without thinking about the implications or consequences);
b) unlawfully;
c) for any political activities or matters relating to these; or
d) improperly.

Dealing with the IJB and Preferential Treatment

3.27 I will not use, or attempt to use, my position or influence as a board member to:

a) improperly confer on or secure for myself, or others, an advantage;
b) avoid a disadvantage for myself, or create a disadvantage for others or
c) improperly seek preferential treatment or access for myself or others.

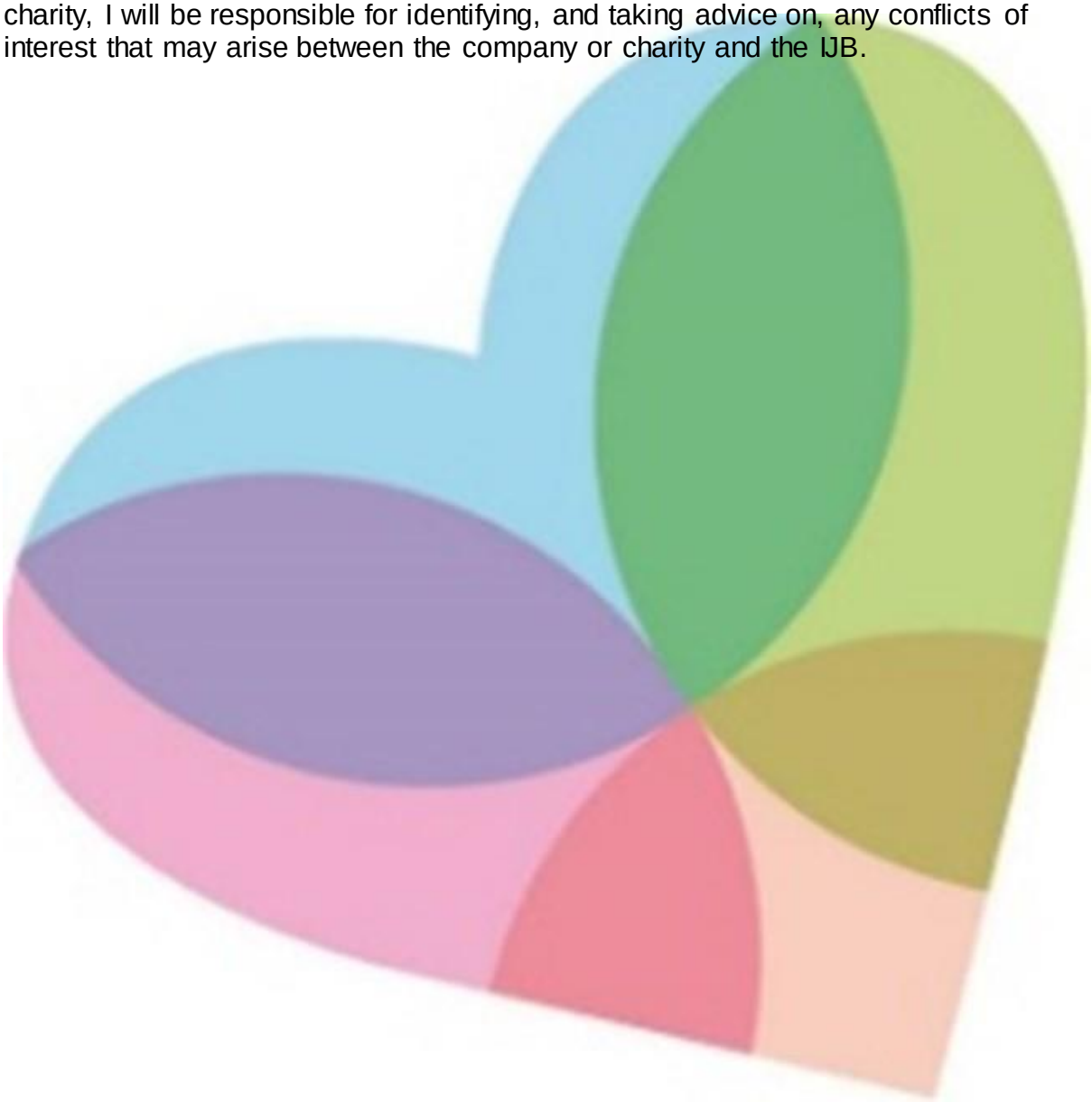
3.28 I will avoid any action which could lead members of the public to believe that preferential treatment or access is being sought.

3.29 I will advise employees of any connection, as defined at Section 5, I may have to a matter, when seeking information or advice or responding to a request for information or advice from them.

Appointments to Outside Organisations

3.30 If I am appointed, or nominated by the IJB, as a member of another body or organisation, I will abide by the rules of conduct and will act in the best interests of that body or organisation while acting as a member of it. I will also continue to observe the rules of this Code when carrying out the duties of that body or organisation.

3.31 I accept that if I am a director or trustee (or equivalent) of a company or a charity, I will be responsible for identifying, and taking advice on, any conflicts of interest that may arise between the company or charity and the IJB.



SECTION 4: REGISTRATION OF INTERESTS

4.1 The following paragraphs set out what I have to register when I am appointed and whenever my circumstances change. The register covers my current term of appointment.

4.2 I understand that regulations made by the Scottish Ministers describe the detail and timescale for registering interests; including a requirement that a board member must register their registrable interests within one month of becoming a board member, and register any changes to those interests within one month of those changes having occurred.

4.3 The interests which I am required to register are those set out in the following paragraphs. Other than as required by paragraph 4.23, I understand it is not necessary to register the interests of my spouse or cohabitee.

Category One: Remuneration

4.4 I will register any work for which I receive, or expect to receive, payment. I have a registrable interest where I receive remuneration by virtue of being:

a) employed;
b) self-employed;
c) the holder of an office;
d) a director of an undertaking;
e) a partner in a firm;
f) appointed or nominated by the IJB to another body; or
g) engaged in a trade, profession or vocation or any other work.

4.5 I understand that in relation to 4.4 above, the amount of remuneration does not require to be registered. I understand that any remuneration received as a board member of the IJB does not have to be registered.

4.6 I understand that if a position is not remunerated it does not need to be registered under this category. However, unremunerated directorships may need to be registered under Category Two, “Other Roles”.

4.7 I must register any allowances I receive in relation to membership of any organisation under Category One.

4.8 When registering employment as an employee, I must give the full name of the employer, the nature of its business, and the nature of the post I hold in the organisation.

4.9 When registering remuneration from the categories listed in paragraph 4.4 (b) to (g) above, I must provide the full name and give details of the nature of the business, organisation, undertaking, partnership or other body, as appropriate. I recognise that some other employments may be incompatible with my role as board member of the IJB in terms of paragraph 6.8 of this Code.

4.10 Where I otherwise undertake a trade, profession or vocation, or any other work, the detail to be given is the nature of the work and how often it is undertaken.

4.11 When registering a directorship, it is necessary to provide the registered name and registered number of the undertaking in which the directorship is held and provide information about the nature of its business.

4.12 I understand that registration of a pension is not required as this falls outside the scope of the category.

Category Two: Other Roles

4.13 I will register any unremunerated directorships where the body in question is a subsidiary or parent company of an undertaking in which I hold a remunerated directorship.

4.14 I will register the registered name and registered number of the subsidiary or parent company or other undertaking and the nature of its business, and its relationship to the company or other undertaking in which I am a director and from which I receive remuneration.

Category Three: Contracts

4.15 I have a registerable interest where I (or a firm in which I am a partner, or an undertaking in which I am a director or in which I have shares of a value as described in paragraph 4.20 below) have made a contract with the IJB:

a) under which goods or services are to be provided, or works are to be executed; and
b) which has not been fully discharged.

4.16 I will register a description of the contract, including its duration, but excluding the value.

Category Four: Election Expenses

4.17 If I have been elected to the IJB, then I will register a description of, and statement of, any assistance towards election expenses relating to election to the IJB.

Category Five: Houses, Land and Buildings

4.18 I have a registrable interest where I own or have any other right or interest in houses, land and buildings, which may be significant to, of relevance to, or bear upon, the work and operation of the IJB.

4.19 I accept that, when deciding whether or not I need to register any interest I have in houses, land or buildings, the test to be applied is whether a member of the public, with knowledge of the relevant facts, would reasonably regard the interest as being so significant that it could potentially affect my responsibilities to the IJB and to the public, or could influence my actions, speeches or decision-making.

Category Six: Interest in Shares and Securities

4.20 I have a registerable interest where:

a) I own or have an interest in more than 1% of the issued share capital of the company or other body; or
b) Where, at the relevant date, the market value of any shares and securities (in any one specific company or body) that I own or have an interest in is greater than £25,000.

Category Seven: Gifts and Hospitality

4.21 I understand the requirements of paragraphs 3.13 to 3.21 regarding gifts and hospitality. As I will not accept any gifts or hospitality, other than under the limited circumstances allowed, I understand there is no longer the need to register any.

Category Eight: Non–Financial Interests

4.22 I may also have other interests and I understand it is equally important that relevant interests such as membership or holding office in other public bodies, companies, clubs, societies and organisations such as trades unions and voluntary organisations, are registered and described. In this context, I understand non-financial interests are those which members of the public with knowledge of the relevant facts might reasonably think could influence my actions, speeches, votes or decision-making in the IJB (this includes its Committees and memberships of other organisations to which I have been appointed or nominated by the IJB).

Category Nine: Close Family Members

4.23 I will register the interests of any close family member who has transactions with the IJB or is likely to have transactions or do business with it.

SECTION 5: DECLARATION OF INTERESTS

Stage 1: Connection

5.1 For each particular matter I am involved in as a board member, I will first consider whether I have a connection to that matter.

5.2 I understand that a connection is any link between the matter being considered and me, or a person or body I am associated with. This could be a family relationship or a social or professional contact.

5.3 A connection includes anything that I have registered as an interest.

5.4 A connection does not include being a member of a body to which I have been appointed or nominated by the IJB as a representative of the IJB, unless:

a) The matter being considered by the IJB is quasi-judicial or regulatory; or
b) I have a personal conflict by reason of my actions, my connections or my legal obligations.

Stage 2: Interest

5.5 I understand my connection is an interest that requires to be declared where the objective test is met – that is where a member of the public with knowledge of the relevant facts would reasonably regard my connection to a particular matter as being so significant that it would be considered as being likely to influence the discussion or decision-making.

Stage 3: Participation

5.6 I will declare my interest as early as possible in meetings. I will not remain in the meeting nor participate in any way in those parts of meetings where I have declared an interest.

5.7 I will consider whether it is appropriate for transparency reasons to state publicly where I have a connection, which I do not consider amounts to an interest.

5.8 I note that I can apply to the Standards Commission and ask it to grant a dispensation to allow me to take part in the discussion and decision-making on a matter where I would otherwise have to declare an interest and withdraw (as a result of having a connection to the matter that would fall within the objective test). I note that such an application must be made in advance of any meetings where the dispensation is sought and that I cannot take part in any discussion or decision-making on the matter in question unless, and until, the application is granted.

5.9 I note that public confidence in a public body is damaged by the perception that decisions taken by that body are substantially influenced by factors other than the public interest. I will not accept a role or appointment if doing so means I will have to declare interests frequently at meetings in respect of my role as a board member. Similarly, if any appointment or nomination to another body would give rise to objective concern because of my existing personal involvement or affiliations, I will not accept the appointment or nomination.

SECTION 6: LOBBYING AND ACCESS

6.1 I understand that a wide range of people will seek access to me as a board member and will try to lobby me, including individuals, organisations and companies. I must distinguish between:

a) any role I have in dealing with enquiries from the public;
b) any community engagement where I am working with individuals and organisations to encourage their participation and involvement, and;
c) lobbying, which is where I am approached by any individual or organisation who is seeking to influence me for financial gain or advantage, particularly those who are seeking to do business with the IJB (for example contracts/procurement).

6.2 In deciding whether, and if so how, to respond to such lobbying, I will always have regard to the objective test, which is whether a member of the public, with knowledge of the relevant facts, would reasonably regard my conduct as being likely to influence my, or the IJB's, decision-making role.

6.3 I will not, in relation to contact with any person or organisation that lobbies, do anything which contravenes this Code or any other relevant rule of the IJB or any statutory provision.

6.4 I will not, in relation to contact with any person or organisation that lobbies, act in any way which could bring discredit upon the IJB.

6.5 If I have concerns about the approach or methods used by any person or organisation in their contacts with me, I will seek the guidance of the Chair, Chief Officer or Standards Officer of the IJB.

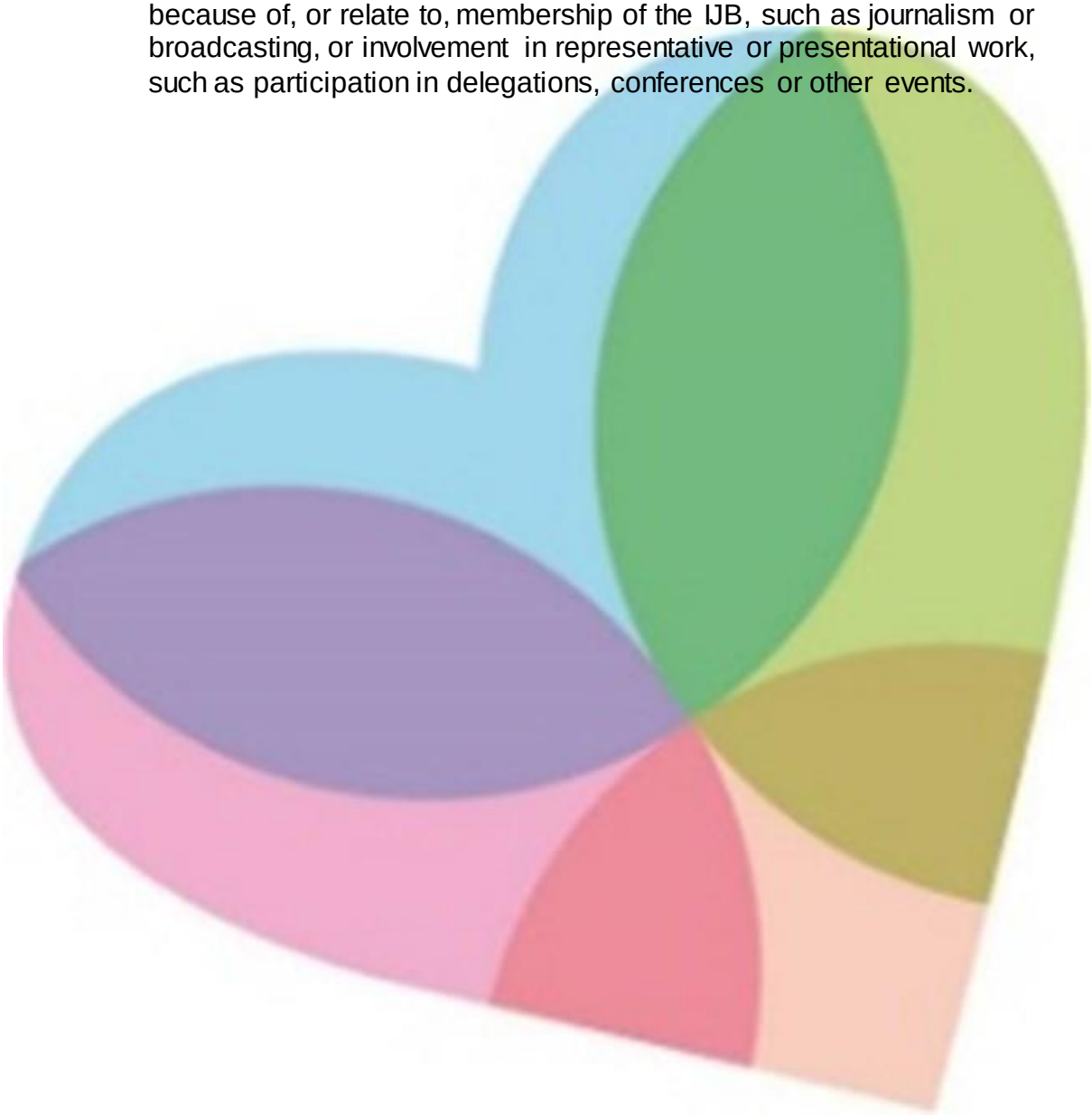
6.6 The public must be assured that no person or organisation will gain better access to, or treatment by, me as a result of employing a company or individual to lobby on a fee basis on their behalf. I will not, therefore, offer or accord any preferential access or treatment to those lobbying on a fee basis on behalf of clients compared with that which I accord any other person or organisation who lobbies or approaches me. I will ensure that those lobbying on a fee basis on behalf of clients are not given to understand that preferential access or treatment, compared to that accorded to any other person or organisation, might be forthcoming.

6.7 Before taking any action as a result of being lobbied, I will seek to satisfy myself about the identity of the person or organisation that is lobbying and the motive for lobbying. I understand I may choose to act in response to a person or organisation lobbying on a fee basis on behalf of clients but it is important that I understand the basis on which I am being lobbied in order to ensure that any action taken in connection with the lobbyist complies with the standards set out in this Code and the Lobbying (Scotland) Act 2016.

6.8 I will not accept any paid work:

a) which would involve me lobbying on behalf of any person or organisation or any clients of a person or organisation.

b) to provide services as a strategist, adviser or consultant, for example, advising on how to influence the IJB and its members. This does not prohibit me from being remunerated for activity which may arise because of, or relate to, membership of the IJB, such as journalism or broadcasting, or involvement in representative or presentational work, such as participation in delegations, conferences or other events.



ANNEX A: BREACHES OF THE CODE

Introduction

1. The Ethical Standards in Public Life etc. (Scotland) Act 2000 ("the Act") provided for a framework to encourage and, where necessary, enforce high ethical standards in public life.

2. The Act provided for the introduction of new codes of conduct for local authority councillors and members of relevant public bodies, imposing on councils and relevant public bodies a duty to help their members comply with the relevant code.

3. The Act and the subsequent Scottish Parliamentary Commissions and Commissioners etc. Act 2010 established the Standards Commission for Scotland ("Standards Commission") and the post of Commissioner for Ethical Standards in Public Life in Scotland ("ESC").

4. The Standards Commission and ESC are separate and independent, each with distinct functions. Complaints of breaches of a public body's Code of Conduct are investigated by the ESC and adjudicated upon by the Standards Commission.

5. The first Model Code of Conduct came into force in 2002. The Model Code of Conduct has since been reviewed and re-issued in 2014. The 2021 Model Code of Conduct has been issued by the Scottish Ministers following consultation, and with the approval of the Scottish Parliament, as required by the Act.

Investigation of Complaints

6. The ESC is responsible for investigating complaints about members of devolved public bodies. It is not, however, mandatory to report a complaint about a potential breach of the Code to the ESC. It may be more appropriate in some circumstances for attempts to be made to resolve the matter informally at a local level.

7. On conclusion of the investigation, the ESC will send a report to the Standards Commission.

Hearings

8. On receipt of a report from the ESC, the Standards Commission can choose to:

    - Do nothing;
    - Direct the ESC to carry out further investigations; or
    - Hold a Hearing.

9. Hearings are held (usually in public) to determine whether the member concerned has breached their public body's Code of Conduct. The Hearing Panel comprises of three members of the Standards Commission. The ESC will present evidence and/or make submissions at the Hearing about the investigation and any conclusions as to whether the member has contravened the Code. The member is entitled to attend or be represented at the Hearing and can also present evidence and make submissions. Both parties can call witnesses. Once it has heard all the evidence and submissions, the Hearing Panel will make a determination about whether or not it is satisfied, on the balance of probabilities, that there has been a contravention of

the Code by the member. If the Hearing Panel decides that a member has breached their public body's Code, it is obliged to impose a sanction.

Sanctions

10. The sanctions that can be imposed following a finding of a breach of the Code are as follows:

- **Censure**: A censure is a formal record of the Standards Commission's severe and public disapproval of the member concerned.
- **Suspension**: This can be a full or partial suspension (for up to one year). A full suspension means that the member is suspended from attending all meetings of the public body. Partial suspension means that the member is suspended from attending some of the meetings of the public body. The Commission can direct that any remuneration or allowance the member receives as a result of their membership of the public body be reduced or not paid during a period of suspension.
- **Disqualification**: Disqualification means that the member is removed from membership of the body and disqualified (for a period not exceeding five years), from membership of the body. Where a member is also a member of another devolved public body (as defined in the Act), the Commission may also remove or disqualify that person in respect of that membership. Full details of the sanctions are set out in section 19 of the Act.

Interim Suspensions

11. Section 21 of the Act provides the Standards Commission with the power to impose an interim suspension on a member on receipt of an interim report from the ESC about an ongoing investigation. In making a decision about whether or not to impose an interim suspension, a Panel comprising of three Members of the Standards Commission will review the interim report and any representations received from the member and will consider whether it is satisfied:

- That the further conduct of the ESC's investigation is likely to be prejudiced if such an action is not taken (for example if there are concerns that the member may try to interfere with evidence or witnesses); or
- That it is otherwise in the public interest to take such a measure. A policy outlining how the Standards Commission makes any decision under Section 21 and the procedures it will follow in doing so, should any such a report be received from the ESC can be found here.

12. The decision to impose an interim suspension is not, and should not be seen as, a finding on the merits of any complaint or the validity of any allegations against a member of a devolved public body, nor should it be viewed as a disciplinary measure.

ANNEX B: DEFINITIONS

"Bullying" is inappropriate and unwelcome behaviour which is offensive and intimidating, and which makes an individual or group feel undermined, humiliated or insulted.

"Chair" includes Board Convener or any other individual discharging a similar function to that of a Chair or Convener under alternative decision-making structures.

"Code" is the Code of Conduct for members of the IJB, which is based on the Model Code of Conduct for members of devolved public bodies in Scotland.

"Cohabitee" includes any person who is living with you in a relationship similar to that of a partner, civil partner, or spouse.

"Confidential Information" includes:

- any information passed on to the public body by a Government department (even if it is not clearly marked as confidential) which does not allow the disclosure of that information to the public;
- information of which the law prohibits disclosure (under statute or by the order of a Court);
- any legal advice provided to the public body; or
- any other information which would reasonably be considered a breach of confidence should it be made public.

"Election expenses" means expenses incurred, whether before, during or after the election, on account of, or in respect of, the conduct or management of the election.

"Employee" includes individuals employed:

- directly by the public body;
- as contractors by the public body, or
- by a contractor to work on the public body's premises.

"Gifts" a gift can include any item or service received free of charge, or which may be offered or promised at a discounted rate or on terms not available to the general public. Gifts include benefits such as relief from indebtedness, loan concessions, or provision of property, services or facilities at a cost below that generally charged to members of the public. It can also include gifts received directly or gifts received by any company in which the recipient holds a controlling interest in, or by a partnership of which the recipient is a partner.

"Harassment" is any unwelcome behaviour or conduct which makes someone feel offended, humiliated, intimidated, frightened and / or uncomfortable. Harassment can be experienced directly or indirectly and can occur as an isolated incident or as a course of persistent behaviour.

"Hospitality" includes the offer or promise of food, drink, accommodation, entertainment or the opportunity to attend any cultural or sporting event on terms not available to the general public.

"Relevant Date" Where a board member had an interest in shares at the date on which the member was appointed as a member, the relevant date is – (a) that date; and (b) the 5th April immediately following that date and in each succeeding year, where the interest is retained on that 5th April.

"Public body" means a devolved public body listed in Schedule 3 of the Ethical Standards in Public Life etc. (Scotland) Act 2000, as amended.

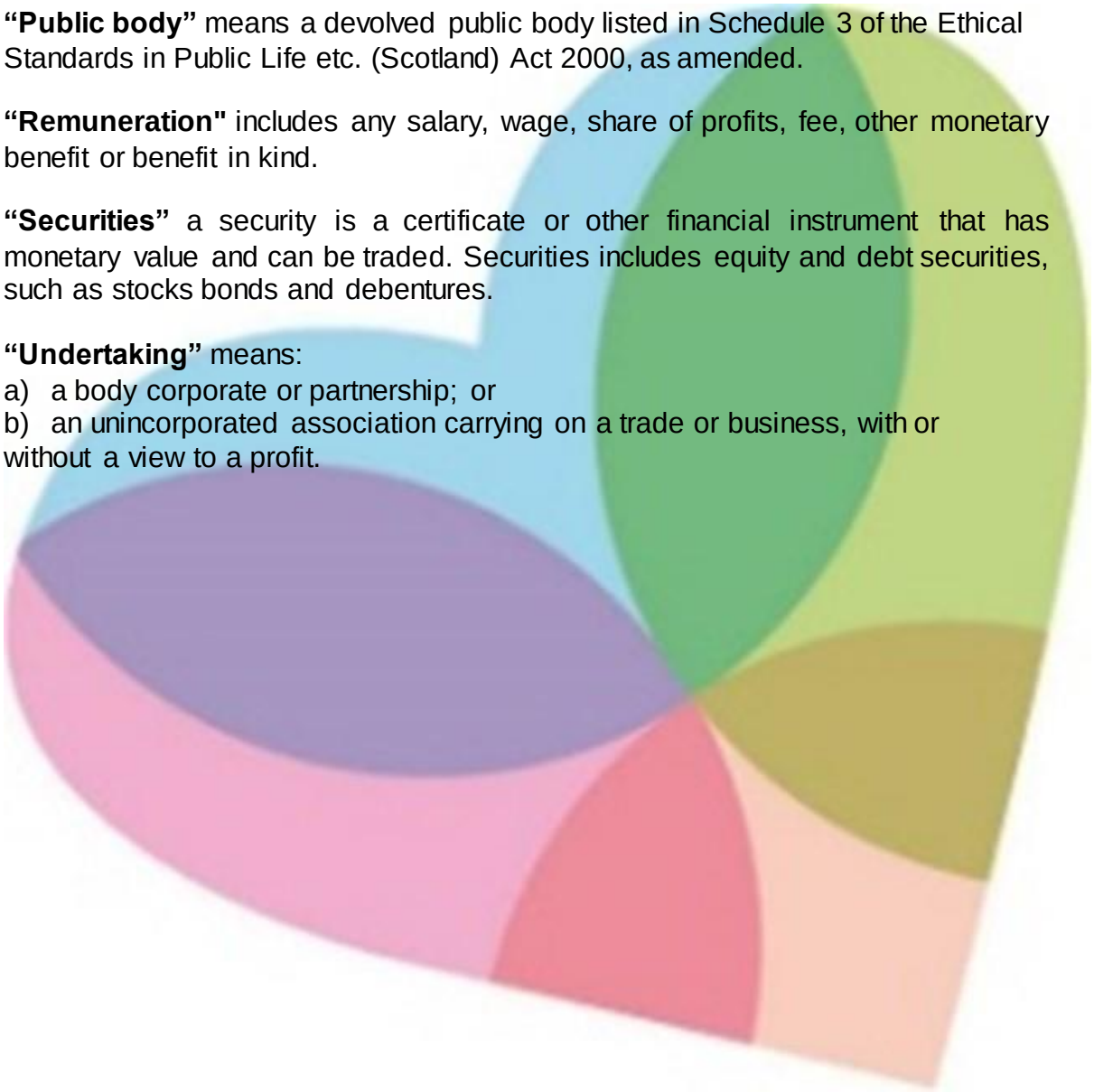
"Remuneration" includes any salary, wage, share of profits, fee, other monetary benefit or benefit in kind.

"Securities" a security is a certificate or other financial instrument that has monetary value and can be traded. Securities includes equity and debt securities, such as stocks bonds and debentures.

"Undertaking" means:

a) a body corporate or partnership; or

b) an unincorporated association carrying on a trade or business, with or without a view to a profit.



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DOCUMENT	PAGE/ SECTION	CHANGE	REASON
Standing Orders	Page 6	Amendment to the Introduction – see 1.1-1.2	To move sections of the Standing Orders which relate to general principles to the Introduction.
	Section 2- page 6	Insertion of "whom shall be non voting, from each of the following group" at 2.3 and "additional (non-voting) members" at 2.4.	To ensure that it is clear which members of the IJB are voting members.
	Section 3, page 7	Amended 3.3 to refer to automatic alternating appointments	Amended for clarity. The alternating appointment happens automatically so reference to this has been made.
	Section 5- page 8	Amendments to the circumstances where a member can be disqualified	Replicated the terms of disqualification in the SI 2014/285 to provide clarity.
	Section 12- para 11	To make amendments to the Notice of Meetings section around the requirement to sign a notice calling a meeting- see 12.3	particularly around the use of email notification to permit the requisitioning of a meeting and digital signatures.
	Section 13- page 11	Amendments to the Access to Meetings section to reflect hybrid meetings and public access thereof- see 13.2/ 13.3	To provide clarity on live webcasting or recording of IJB meetings and permitting the Chair to have discretion around public access.
	Section 14 – page 12	Removal of Chair's permission for a member to take part remotely	To amend the requirement to notify the Clerk and Chair of a member wishing to participate remotely in the meeting.
	Section 15- page 13	Insertion of "Acceptance of late items of business is at the Chair's discretion having regard to any special circumstances which requires	To add into the Standing Orders the ability for the Chair to accept a late paper.

		it to be considered as a matter of emergency". .	
	Section 16- page 13	Clarity around who draft reports are sent to for the IJB and its committees and inclusion of the Chief Operating Officer	To clarify who draft reports are to be sent to for IJB meetings and the meetings of its committees and include the Nursing/ Medical Directors and Public health Consultant
	Section 18- page 14	Insertion of "For the avoidance of doubt, this shall not be the substitute for the Chair or Vice Chair as is specified in Standing Order 8.3".	Addition of wording to make it clear that this SO is different to 8.3
	Section 20- page 16	Deletion of section on conflict of interest and addition of Declarations of Interest and use of Transparency statement	To update this section to reflect the requirements of the IJB Code of Conduct.
	Section 23- page 17	Addition of process re the making of a motion or an amendment and amendment to clauses numbering see 23.2-23.9	To make the process for considering a motion or amendment clear and reflect the role of the Chair in that process.
	Section 24 –page 19	Insertion of "unpaid carer representatives and other unpaid representatives"	Clarification required as to who the IJB Expenses Policy referred to and when it the IJB approved it.
	Section 27- page 20	Deletion of text and reference to the IJB Code of Conduct- see 27.2	Removal of duplicate wording which is contained in the IJB Code of Conduct
	Appendix B- page 24	Addition of new Appendix A – setting out the reasons why a	To provide clarity for IJB on what the IJB could determine in private and the reasons for that.

		matter might be considered in private	
	Appendix C, Page 25	Insertion of IJB Expenses Policy	The policy was referred to in the previous Standing Orders but difficult to locate. Attached as an Appendix for ease of reference.
Code of Conduct	Section 1.1 – page 3	Minor changes to wording in 1.1. including insertion of the words "*for Members of Devolved Public Bodies*".	To clarify that the Code of Conduct was based on the Model Code of Conduct for Members of Devolved Public Bodies.
	Section 1.2 – page 3	Insertion of the word "*City*" after "*Aberdeen*" and insertion of "*Integration Joint Board ("the IJB")*" instead of "IJB".	To explain what is meant by the "*Aberdeen IJB*".
	Section 1.4 – page 3	Change from "*Members*" to "*members*".	So that there is consistency throughout the Code of Conduct
	Sections 1.6 – 1.13 – page 3	Change to numbering of the Sections.	Due to duplication of section 1.5 - the incorrect numbers of sections are referred to
	Section 1.12 – page 4	Change to "*Code of Conduct*" instead of "*code of conduct*".	Minor amendment to ensure consistency throughout Code of Conduct.
	Section 2.2 – page 4	Change from "*that body*" to "*the IJB*"	So that it is clear that it relates to the IJB.
	Section 5.9 – page 13	Insertion of the words "*public body*" after *"I note that public confidence in a*".	Words had been previously been omitted

	Section 6.5 – page 14	Deletion of the word "Executive" after the word "*Chief*" and insertion of the word "*Officer*".	The IJB has a Chief Officer not a Chief Executive.
	Annex A para 5 – page 16	Change to "*Model Code of Conduct*" instead of "Code of Conduct"	To clarify that this relates to the Model Code of Conduct and not the Code of Conduct for members of the IJB.
	Annex B – definition of "Code" – page 18	Change to "*the IJB*" instead of "*your devolved public body*"	So that it is clear that the "Code" relates to the Code of Conduct for members of the IJB.
Roles and Responsibilities	1. Introduction	Deletion of wording in the introduction of the Protocol	Clarity and ease of reading
	2. Core Principles	Entire section deleted	Redundant wording
	3. Specific Powers Reserved for the Integration Joint Board	Entire section deleted	This will now form part of the Terms of Reference – IJB document
	4. Operational Protocol	Deletion of wording – now refers to Chief Officer, Chief Finance Officer and other key personnel within the Aberdeen City Health and Social Care Partnership	
	4.1 Chief Officer	Deletion of wording re roles and responsibilities of Chief Officer	This is covered in other documents.
	4.2 Chief Finance Officer	Deletion of wording re roles and responsibilities of Chief Finance Officer	This is covered in other documents.
	4.3 Clinical Director	Deletion of "Clinical Director" and replaced with "Medical Director". Inclusion of the words "*The roles and responsibilities of the Medical*	Restructured post of Medical Director has been created

		Director may be shared between more than one person"	
	Chief Operating Officer	Inclusion of new post of Chief Operating Officer	New post of Chief Operating Officer has been created
Terms of Reference - IJB	Overall Change	Combined with the Terms of Reference for RPAC and CCGC. This has involved the removal of the IJB's ToR from the Roles and Responsibilities Protocol, where it currently sits. As a whole, numbering across the document has changed. Where specific parts of the document have been altered, the new paragraph number is noted.	Ease of reading and comprehension.
	Structure Chart	Added Structure Chart, setting out the structure of the IJB, committees and partner organisations	Adds visual aid to the structure.
	Introduction	Added introduction, setting out legal basis for terms of reference.	Adds context and explanation
	3.1	Shortened and added as an introductory sentence.	Clarity.
	3.2(b)	Removal of 'sub-committees and joint committees'	Statutory Instrument limits IJB's power to creating committees only
	3.2(d)	Changed to simply refer to 'Scheme of Governance'. Now at point 4 in the revised ToR.	Clarity, and removal of unnecessary words
	3.2(d)	Some of the information contained in 3.2(d) has been split into a separate point 5.	Clarity and ease of reading

	3.2(e)	Removed	Changes to 3.2(d) make this point redundant.
	3.2(h)	Removed	This point became redundant with the addition of the introductory paragraph.
	3.2(g)	Addition of wording about monitoring Strategic Plan Moved to point 7 in new document.	Clarity.
	3.2(i)	Removed informal wording and changed to be more formal. Now at Point 8.	More suitable for Scheme of governance
Terms of Reference - CCGC	Overall change	As above, combined with the ToR for the IJB, with new introduction and structure chart added. As above, considerable change to the style and layout of the document.	As above
	1 (1)-(2)	Removed	Wording redundant following the changes
	1(3)-(4)	Retained but moved elsewhere in the new version	Clarity and ease of reading.
	2	Removed	Better incorporated in a single standing orders document for the entire IJB
	3	Removed	As above
	4	Retained but moved elsewhere	Clarity and ease of reading

	5(1)-(2)	List of principal advisors changed to better reflect actual practice	Ensuring SoG matches practice and ensures committee functions properly
	5(3) –(8)	Removed	Better incorporated in Standing Orders
	6 – 8	Removed	As above.
	9 – 11	Retained but moved elsewhere in the document	Clarity and ease of reading
	10	Removed	Better incorporated in Standing Orders
Terms of Reference – RAPC	Overall	As above, combined with the ToR for the IJB, with new introduction and structure chart added. As above, considerable change to the style and layout of the document.	As above
	1 (1)-(2)	Removed	Wording redundant following the changes
	1(3)-(4)	Retained but moved elsewhere in the new version	Clarity and ease of reading.
	2	Removed	Better incorporated in a single standing orders document for the entire IJB
	3	Removed	As above
	4	Retained but moved elsewhere	Clarity and ease of reading
	5(1)-(2)	List of principal advisors changed to better reflect actual practice	Ensuring SoG matches practice and ensures committee functions properly
	5(3) –(8)	Removed	Better incorporated in Standing Orders
	6, 7, 9	Removed	As above.

	8	Retained and moved to new remit and Responsibilities Section	Clarity and ease of reading
	10 (with the exceptions noted below)	Retained and moved to new remit and Responsibilities Section	As above.
	10(2)	Removed	Duplicated work undertaken by the IJB
	10(4)	Removed	Made redundant by other changes to the document
	10(5)	Wording changed slightly to better reflect current practice	Clarity and correctness.
	10(6) –(8)	Removed	New document encompasses these priorities elsewhere,
	10(17)	Removed	Wording was unclear and did not provide enough clarity to remain as a responsibility.
	11 – 12	Removed	Better incorporated in Standing Orders

Aberdeen City Integration Scheme Changes (Jan 23)

Page	Section	Amendment
4	2	'citizens' changed to 'residents' New values from revised Strategic Plan added
7	Definitions	Removed reference to Shadow Board and to SASPI (Scottish Accord on the Sharing of Information Dec 2011 (on advice of ACC Legal Services)
10	3	3.6g) Addition of reference to a Public Health Consultant as a non-voting member at g.
13	5	5.3 and 5.7 reworded for clarity.
15	6	Deleted references to Shadow Board (Transitional Leadership Group)
17	8	8.3/8,4 clarification of the term 'Performance Framework" used to describe the targets, measures and indicators.
20	9	9.3.5 onwards amended to reflect the role of the Risk Audit and Performance Committee and condensed.
21	9	9.4.2 now includes reference to Whistleblowing policies.
23	9	9.5 amendments to include reference to Strategic Planning Group and joint Locality Planning Arrangements.
23	9	9.6.2 and 9,6.4 now include reference to Directors of Public Health.
25	10	10.1.4 Inclusion of new post of Chief Operating Officer. Acknowledgment that post shall act as Chief Officer of the IJB in the Chief Officer's absence
26	10	10.1.9 Inclusion of 'communities' in the list key stakeholders the Chief Officer will maintain effective working relationships with.
26	10	Inclusion of paragraph 10.2 in relation to the post of Chief Operating Officer
27	11	11.5 Amended reference to the date of the latest Workforce Plan
27	12	12.2.1 Clarification of reference to cash transfers between the Parties
28	12	12.3 Deletion of references to payments to be made in the first financial year
30	12	12.6.5 amended wording indicating mutual agreement around financial administration arrangements
30	12	12.7.2 Amendment of frequency of financial information provided from monthly to quarterly and deletion of reference to further guidance being issued from the Scottish Government in relation to the timetable for the production of annual accounts.
33	12	12.8.4.2 Deletion of reference to first Financial Year
36	13	Deletion of reference at 13.1 to the joint consultation which took place in 2015 and change of tense thereafter from past to future.

Page	Section	Amendment
38	14	14.1 Change of tense from future to past in relation to information sharing.
38	14	14.4 Deletion of references to the Joint Information Sharing Group
38	14	14.5 Deletion of the phrase “by the time functions are delegated to the IJB”.
52	Part 2, Annex 1 B	Addition of reference to Mental Health Services at 7.
57	Part 2, Annex 1 C	Addition of Pharmaceutical services and additional pharmaceutical services provided under arrangements made in pursuance of sections 27 and 27A of the National Health Service (Scotland) Act 1978(33) at 29. NB: this was an omission from the original
57	Part 3	Addition of Child and Adolescent Mental Health Services at 4.
72	Annex 3	Deletion of (Royal Cornhill Hospital) after Mental Health Services

Health inequalities impact assessment: Workbook for workshop participants

Introduction

Carrying out a Health Inequalities Impact Assessment (HIIA) will help you to consider the impact of your policy* on people. Using this workbook, alongside the HIIA: Answers to frequently asked questions guide, will help you to work through the process and strengthen your policy's contribution towards health equity.

The workshop is a core element of the HIIA and, together with a group of key stakeholders, you will work through six questions to identify any impacts your policy will have on: different population groups; health inequalities; and people's human rights. Policies do not impact on people in the same way – impact assessment is a way to consider how people will be affected differently. It will also help you to meet the requirements of the Public Sector Equality Duty by considering those groups who are protected under the Duty (information about the Duty is available at www.scotland.gov.uk/Topics/People/Equality/PublicEqualityDuties. During the workshop, the facilitator or lead for the impact assessment will take you through the process and outline the next steps.

The six questions in the workshop are:

1 Who will be affected by this policy?

2 How will the policy impact on people?

3 How will the policy impact on the causes of health inequalities?

4 How will the policy impact on people's human rights?

5 Will there be any cumulative impacts as a result of the relationship between this policy and others?

6 What sources of evidence have informed your impact assessment?

* The word 'policy' represents any option, procedure, practice, strategy or proposal being assessed.

You should identify impacts as positive or negative, remembering that some policies may have no impacts for a population group.

Positive impact: would demonstrate the benefit the policy could have for a population group: how it advances equality, fosters good relations, contributes to tackling health inequalities or upholds human rights.

Negative impact: would mean that a population group is at risk of being disadvantaged by the policy, there is a risk of breaching the human rights of people or the requirements of the Equality Duty, or that there is a risk of widening health inequalities.

No impact: If you find that the policy will have no impacts for some groups, you do not need to record this information.

Further information on Health Inequalities is available from NHS Health Scotland Website

http://www.healthscotland.scot/health-inequalities

Question 1: Who will be affected by this policy?

Example: Keep this brief, such as 'Children aged 5–12 years'.

There is no need to explore subgroups yet, just provide an indication of how well-defined the target group is at this stage.

Primarily Members of the IJB and attendees at the IJB or its committees.

There may also be indirect impacts on the service users impacted by IJB decisions. However, these service users are more likely to be affected by the content of the decisions made, rather than by the governance framework.

Question 2: How will the policy impact on people?

When thinking about how the policy might impact on people, think about it in terms of the right for **everyone** to achieve the highest possible standard of health. The Right to Health includes both the right to healthcare and the right to a range of factors that can help us lead a healthy life (the determinants of health). Equality and non-discrimination are fundamental to this right.

The Right to Health has four related concepts: goods, facilities and services should be available, accessible, acceptable and of good quality.

When thinking about how the policy might impact on people, their human rights and the factors that help people to lead healthy lives, consider and discuss:

- Is the policy **available** to different population groups?
- Is the policy **accessible**, (e.g. in terms of physical access, communication needs, transport needs, health literacy, childcare needs, knowledge and confidence)?
- Is the policy **acceptable** to different population groups (e.g. is it sensitive to age, culture and sex)?
- Is the policy of good **quality**, enabling it to have its desired effects and support the above?

Apply these questions to each population group in the following table. Try to identify any factors which can contribute to poorer experiences of health and any potential positive or negative impacts of the policy. Think about people, not characteristics, such as how the policy impact on the right to health of a disabled older man with low literacy who lives in a deprived area.

Population groups and factors contributing to poorer health	Potential Impacts and explanation why	Recommendations to reduce or enhance such impacts
Age: older people; middle years; early years; children and young people.	None identified	
Disability: physical impairments; learning disability; sensory impairment; mental health conditions; long-term medical conditions.	**Positive –** The Revised standing orders formalise the process for hybrid meetings. Hybrid meetings provide the widest access to meetings of the IJB and committees. By doing this, the Standing Orders increase the ability of people with disabilities to attend meetings in a way that best suits them.	Continue to promote a flexible and person-focused approach to the chairing/running of meetings. This will ensure that meetings are held as hybrid whenever this is needed and will enhance the access to the meeting.
Gender Reassignment: people undergoing gender reassignment	None identified.	
Marriage & Civil Partnership: people who are married, unmarried or in a civil partnership.	None Identified.	
Pregnancy and Maternity: women before and after childbirth; breastfeeding.	**Positive –** As above, the revised standing orders formalise the process for hybrid meetings. Hybrid meetings should increase the ability of pregnant people and new parents to attend meetings.	Continue to promote a flexible and person-focused approach to the chairing/running of meetings. This will ensure that meetings are held as hybrid whenever this is needed and will enhance the access to the meeting.

Race and ethnicity: minority ethnic people; non-English speakers; gypsies/travellers; migrant workers.	None identified.	
Religion and belief: people with different religions or beliefs, or none.	None identified.	
Sex: men; women; experience of gender-based violence.	None identified.	
Sexual orientation: lesbian; gay; bisexual; heterosexual.	None identified.	
Looked after (incl. accommodated) children and young people	None identified.	
Carers: paid/unpaid, family members.	Positive Carer representatives on the IJB have previously noted that hybrid or remote meetings have made it easier for them to attend. By formalising this in the new SoG, this should have a positive impact on their ability to advocate for Carers at the IJB.	Continue to promote a flexible and person-focused approach to the chairing/running of meetings. This will ensure that meetings are held as hybrid whenever this is needed and will enhance the access to the meeting.
Homelessness: people on the street; staying temporarily with friends/family; in hostels, B&Bs.	None identified.	
Involvement in the criminal justice system: offenders in prison/on probation, ex-offenders.	None identified.	

Addictions and substance misuse	None identified.	
Staff: full/part time; voluntary; delivering/accessing services.	None identified.	
Low income	None identified.	
Low literacy / Health Literacy includes poor understanding of health and health services (health literacy) as well as poor written language skills.	None identified.	
Living in deprived areas	**Positive -** The revised Integration Scheme ensures that communities will have a greater role in IJB locality planning. This will help to ensure that people living in deprived areas can contribute meaningfully to IJB policy development	Continue to promote an awareness of the differential needs of different communities and promote the ability to contribute in deprived areas in order to ensure the voices of people from these areas are heard.
Living in remote, rural and island locations	None identified.	
Discrimination/stigma	None identified.	
Refugees and asylum seekers	None identified.	

Any other groups and risk factors relevant to this policy	None identified.	

To comply with the general equality duty of the Equality Act 2010 when conducting impact assessment, you must demonstrate 'due regard' for the need to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Act;
- advance equality of opportunity between people who share a relevant protected characteristic and those who do not share it;
- foster good relations between people who share a relevant protected characteristic and those who do not share it.

This means that you must identify, record and eliminate (through appropriate policy changes) any impacts that could amount to unlawful discrimination under the act. Wherever possible you should also try to identify, record and enhance any impacts that enable the policy to advance equality of opportunity or foster good relations.

Question 3: How will the policy impact on the causes of health inequalities?

The wider environmental and social conditions in which we are born, grow, live, work and age are shaped by the distribution of power, money and resources. These conditions can lead to health inequalities. While considering how your policy will impact on people and their right to health, it is also important to think about how it may impact on the causes of health inequalities (see the table below). Further information on the causes of health inequalities can be found in NHS Health Scotland's Health Inequalities Policy Review.

Not all policies will be able to act or impact on these causes, but it will be useful to reflect on whether yours will. Think about any opportunity this policy might offer to reduce inequalities and also try to identify any ways in which it might inadvertently increase inequalities (you may find the prompts in Appendix 1 helpful).

You may have discussed some of these issues when considering question 2.

Will the policy impact on?	Potential impacts and any particular groups affected	Recommendations to reduce or enhance such impacts
Income, employment and work • Availability and accessibility of work, paid/ unpaid employment, wage levels, job security. • Tax and benefits structures. • Cost/price controls: housing, fuel, energy, food, clothes, alcohol, tobacco. • Working conditions.	None identified.	
The physical environment and local opportunities • Availability and accessibility of housing, transport, healthy food, leisure activities, green spaces. • Air quality and housing/living conditions, exposure to pollutants. • Safety of neighbourhoods, exposure to crime. • Transmission of infection. • Tobacco, alcohol and substance use.	None identified.	

Education and learning • Availability and accessibility to quality education, affordability of further education. • Early years development, readiness for school, literacy and numeracy levels, qualifications.	None identified.	
Access to services • Availability of health and social care services, transport, housing, education, cultural and leisure services. • Ability to afford, access and navigate these services. • Quality of services provided and received.	None identified.	
Social, cultural and interpersonal • Social status. • Social norms and attitudes. • Tackling discrimination. • Community environment. • Fostering good relations. • Democratic engagement and representation. • Resilience and coping mechanisms.	None identified.	

Question 4: How will the policy impact on people's human rights?

Human rights are the basic rights and freedoms which everyone is entitled to in order to live with dignity. They can be classified as **absolute**, **limited** or **qualified**. Absolute rights must not be restricted in any way. Other rights can be limited or restricted in certain circumstances where there is a need to take into account the rights of other individuals or wider society.

Not all policies will be able to demonstrate an impact against human rights but it will be useful to consider if yours will. Think about the potential impacts you have identified and consider whether these could help fulfil or breach legal obligations under the Human Rights Act. Can you think of any actions that might promote positive impacts or mitigate negative impacts? The following table includes rights that may be particularly relevant to health and social care policies.

Articles	Potential areas for consideration	Potential impacts and any particular groups affected	Recommendations to reduce or enhance such impacts
The right to life (absolute right)	• Access to basic necessities such as adequate nutrition, clean and safe drinking water. • Suicide. • Risk to life of/from others. • Duties to protect life from risks by self/others. • End of life questions. • Duties of prevention, protection and remedy, including investigation of unexpected death.	None identified.	
The right not to be tortured or treated in an inhuman or degrading way (absolute right)	• Should not cause: fear; humiliation; intense physical or mental suffering; or anguish. • Prevention of ill-treatment, protection and rehabilitation of survivors of ill-treatment.	None identified.	

	• Duties of prevention, protection and remedy, including investigation of reasonably substantiated allegations of serious ill-treatment. • Dignified living conditions.		
The right to liberty (limited right)	• Right not to be deprived of liberty in an arbitrary fashion. • Detention under mental health law. • Review of continued justification of detention. • Informing reasons for detention.	None identified.	
The right to a fair trial (limited right)	• When a person's civil rights, obligations or a criminal charge against a person comes to be decided upon. • Staff disciplinary proceedings. • Malpractice. • Right to be heard. • Procedural fairness. • Effective participation in proceedings that determine rights such as employment, damages/ compensation.	None identified.	
The right to respect for private and family life, home	• Family life, including outwith blood and formalised relationships. • Privacy. • Personal choices, relationships.	None identified.	

and correspondence (qualified right)	• Physical and moral integrity (e.g. freedom from non-consensual treatment, harassment or abuse). • Participation in community life. • Participation in decision-making. • Access to personal information. • Respect for someone's home. • Clean and healthy environment. • Legal capacity in decision-making. • Accessible information and communication e.g. phone calls, letters, faxes, emails.		
The right to freedom of thought, belief and religion (qualified right)	• Conduct central to beliefs (such as worship, appropriate diet, dress).	None identified.	
The right to freedom of expression (qualified right)	• To hold opinions. • To express opinions, receive/impart information and ideas without interference by a public authority.	None identified.	
The right not to be discriminated against	• All of the rights and freedoms contained in the Human Rights Act must be protected and applied without discrimination. • Discrimination takes place when someone is treated in a different way compared with someone else in a similar situation.	None identified.	

	• Indirect discrimination happens when someone is treated in the same way as others that does not take into account that person's different situation. • An action or decision will only be considered discriminatory if the distinction in treatment cannot be reasonably and objectively justified.		
Any other rights relevant to this policy e.g.	• Convention on the Rights of the Child • Convention on the Elimination of All Forms of Discrimination against Women • Convention on the Rights of Persons with Disabilities	None identified.	

Question 5: Will there be any cumulative impacts as a result of the relationship between this policy and others?

Consider the potential for a build-up of negative impacts on population groups as a result of this policy being combined with other policies, e.g. relocation of services at the same time as changes to public transport networks.

No cumulative effect has been identified.

This HIIA accompanies a report on the Scheme of Governance, and will not impact directly on service delivery.

Question 6: What sources of evidence have informed your impact assessment?

Formal sources of evidence to consider include population data and statistics, consultation findings and other research. However, your professional or personal experience and knowledge of individuals and communities (and the potential impact of a policy on them) is equally as valuable. Further information can be found in the planning a workshop section. http://www.healthscotland.scot/publications/planning-resources-hiia-scoping-workshop

What evidence have you used to support your impact assessment thinking? Have you identified any areas where more evidence is needed or where there are gaps in your current knowledge to inform the assessment?

Evidence type	Evidence available	Gaps in evidence
Population data e.g. demographic profile, service uptake.		
Consultation and involvement findings e.g. any engagement with service users, local community, particular groups.		

Research e.g. good practice guidelines, service evaluations, literature reviews.		
Participant knowledge e.g. experiences of working with different population groups, experiences of different policies.		

Summary of discussion

The facilitator or lead for the impact assessment will bring the workshop to a close and will recap on how your group has:

- identified what the potential impacts of the policy are on people and their right to health
- identified what potential impacts the policy may have on the causes of health inequalities
- identified what potential impacts the policy may have on people's human rights as set out in the Human Rights Act.
- considered how the policy impacts on the specific requirements in the Public Sector Equality Duty
- identified any actions to tackle these impacts, promote equality and the right to health
- identified any potential effects as a result of the relationship between this policy and others
- identified evidence sources to draw on and where there are gaps in your evidence.

Next steps

A report of this discussion will be written to identify the next steps. You will be asked to comment on this report to ensure that it provides an accurate record of this workshop. Next steps will be coordinated by the project lead and may involve prioritising the impacts, identifying and gathering further sources of evidence (including any consultation) in order to make recommendations from the impact assessment, followed by undertaking and monitoring any actions identified.

Thank you for participating in this workshop.

Appendix 1: Messages from the Health Inequalities Policy Review

Structural		Behavioural
Fundamental causes	**Wider environmental influences**	**Individual experiences**
Global economic forces Macro socio-political environment Political priorities and decisions Societal values to equity and fairness Unequal distribution of power, money and resources Poverty, marginalisation and discrimination	**Economic and work** • Availability of jobs. • Price of basic commodities (e.g. rent, fuel).	**Economic and work** • Employment status. • Working conditions. • Job security and control. • Family or individual income. • Wealth. • Receipt of financial and other benefits.
	Physical • Air and housing quality. • Safety of neighbourhoods. • Availability of affordable transport. • Availability of affordable food. • Availability of affordable leisure opportunities.	**Physical** • Neighbourhood conditions. • Housing tenure and conditions. • Exposure to pollutants, noise, damp or mould. • Access to transport, fuel poverty. • Diet. • Exercise and physical activity. • Tobacco, alcohol and substance use.
	Learning • Availability and quality of schools. • Availability and affordability of further education and lifelong learning.	**Learning** • Early cognitive development. • Readiness for school. • Literacy and numeracy. • Qualifications.
	Services	**Services** • Quality of service received. • Ability to access and navigate.

	• Accessibility, availability and quality of public, third sector and private services; activity of commercial sector.	• Affordability.
	Social and cultural • Community social capital, community engagement. • Social norms and attitudes. • Democratisation. • Democratic engagement and representation.	**Social and cultural** • Connectedness, support and community involvement. • Resilience and coping mechanisms. • Exposure to crime and violence.
Key components of a health inequalities strategy		
Fundamental causes	**Wider environmental influences**	**Individual experiences**
• Policies that redistribute power, money and resources • Social equity and social justice prioritised	• Legislation, regulation, standards and fiscal policy. • Structural changes to the physical environment. • Reducing price barriers. • Ensuring good work is available for all. • Equitable provision of high quality and accessible education and public services.	• Equitable experience of socio-economic and wider environmental influences. • Equitable experience of public services. • Targeting high risk individuals. • Intensive tailored individual support. • Focus on young children and the early years.
Examples of effective interventions		
Fundamental causes	**Wider environmental influences**	**Individual experiences**
• Minimum income for health (healthy living wage) • Progressive taxation (individual and corporate). • Active labour market policies	• Housing: Extend Scottish Housing Quality Standard; Neighbourhood Quality Standard. • Air/water: Air pollution controls; water fluoridation. • Food/alcohol: restrict advertising; regulate retail outlets; regulate trans-fats and salt content. • Transport: drink-driving regulations, lower speed limits, area-wide traffic calming schemes.	• Training – culturally/inequalities sensitive practice. • Linked public services for vulnerable/high risk individuals. • Specialist outreach and targeted services.

	• Price controls: Raise price of harmful commodities through taxation; reduce price barrier for healthy products and essential services.	

Interventions requiring people to opt-in are less likely to reduce health inequalities. Consider the balance of actions at structural and individual levels.

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Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Date of Meeting	25th April, 2023
Report Title	Annual Resilience Report
Report Number	HSCP23.021
Lead Officer	Sandra MacLeod, Chief Officer
Report Author Details	Name: Martin Allan Job Title: Business and Resilience Manager Email Address: mallan@aberdeencity.gov.uk Phone Number:07870 998345
Consultation Checklist Completed	Yes
Directions Required	No
Appendices	None

1. Purpose of the Report

1.1. To provide the annual assurance report on the Integration Joint Board's (IJB's) resilience arrangements in fulfilment of its duties as a Category 1 responder under the Civil Contingencies Act 2004

2. Recommendations

2.1. It is recommended that the Integration Joint Board:

a) notes the progress made in further embedding the IJB's resilience arrangements during 2022/23.

3. Summary of Key Information

3.1. The IJB has emergency planning responsibilities to fulfil as a Category 1 responder, as defined by the Civil Contingencies Act 2004. These responsibilities were confirmed in April 2021. This report provides an annual

position statement on our activity and preparedness in the areas set out in the Act, including details of further planned improvements to ensure that the IJB and the Aberdeen City Health and Social Care Partnership are in as strong a position as possible to respond to emergencies and incidents affecting the public.

3.2. To recap, our responsibilities under the 2004 Act are as follows:

- To assess the risk of emergencies occurring and using this to inform Contingency planning.
- To maintain emergency plans and business continuity plans.
- To inform the public about civil protection matters and to maintain arrangements to warn, inform and advise the public in the event of an emergency.
- To share information with other local responders to enhance coordination, and to co-operate with other local responders to enhance co-ordination and efficiency.

3.3. The Partnership is represented on a variety of governance groups established by NHSG and Aberdeen City Council, as well as the Grampian Local Resilience Partnership (GLRP).

3.4. The Partnership's Senior Managers on Call (SMOCs) remain on call 24/7 throughout the year and are responsible for assessing and managing risks during emergency response.

3.5. In 2022/23, the Partnership have also looked at the resources that are required to meet the duties under the Act. The relevant post in the Senior Leadership Team has been amended to include "Resilience Lead" within the job role, additional resilience support has been secured (in partnership with Aberdeen City Council) and participating in training and exercising at a local (Aberdeen City), Grampian-wide and national level has increased.

3.6. Since April 2021, the Partnership have been assisting in the management of flow of patients through the frailty pathway. The SMOC's have taken an active role in a cross-system approach, attending daily connect meetings as well as weekend huddles.

3.7. The Partnership continues to monitor and manage concurrent risks around COVID-19 and EU Exit. These risks are now embedded in the Strategic Risk Register as "business as usual" risk management activity. Strategic risks are monitored by the Senior Leadership Team and the Risk, Audit and Performance Committee, whilst members of the Senior Leadership Team monitor operational risks regularly, including horizon scanning for new or escalated risks.

3.8. Resilience structures were activated to assess and manage the risk associated with the resettlement of asylum families and those displaced by conflict and war. This involved risks being assessed and mitigated in collaboration with public sector partners, and Scottish and UK Governments.

3.9. Similarly, resilience structures were activated to plan and prepare for the impacts of industrial action in health services. The use of our Incident Management Team processes, helped to ensure that staff across the Partnership were fully sighted on the planning arrangements and mitigations of the Partnership and providing support around the potential consequences.

3.10. Key members of the Partnership's Civil Contingencies Group have met regularly during numerous debriefs, both internal and multi-agency. The following priority actions have been identified by the Group based on an assessment of risk to vulnerable people in the City. These have been progressed throughout the year and further detail is included later in this report:

- Creation of a City Persons at Risk Database (PARD)
- Volunteers, Community, Business and Individual Resilience
- Power Resilience

3.11. The Partnership has also responded to a number of concurrent incidents and effectively managed these through the Partnership's emergency response structures. A summary of the incidents and resulting improvements is below:

Incident / Event	Activity
Storms Malik and Corrie Debriefs (April)	Incident Management Team (IMT) Debriefs

INTEGRATION JOINT BOARD

Incident / Event	Activity
	Grampian Local Resilience Partnership (GLRP)
Industrial Action	IMT
Weather event – flooding (Nov)	IMT Debriefs GLRP
Weather event- storm Otto (Feb)	IMT GLRP

A summary of the incidents that have resulted in improvements being identified is below:

Incident	Improvements identified	Status
Storms	NHSG Mutual Aid Request – template and procedure required	Completed. Adopted by GLRP in early 2022
Weather event November	Rota creation to manage rest centre managers. Linked to Care For People response Aberdeen City Council are looking at increasing staff volunteers pool to support emergency response incidents as well as increasing the pool of rest centre managers.	Priority actions for Aberdeen City Council in 2023 Q1

3.12. Exercising and training continues to be a priority for the organisation, with full support from the Senior Leadership Team. The following have been completed this year:

- Unannounced activation of GLRP – November 2022 (multi agency)

- Winter preparedness / training and presentation across GLRP partners – November 2022
- Senior Manager on Call and Council's Duty Emergency Response Co-ordinator refresher presentation – December 2022
- Power Resilience x 2 sessions – scenario planning for planned power cuts (Rota Load Disconnections and Demand Control - OC6) November & December 2022
- Council Emergency Response Teams and ALEOs (including the Partnership), Winter preparedness exercise December 2022
- The Partnership will continue to be notified of exercising by the GLRP and will attend where appropriate, this will include training and exercises from both ACC and NHSG as well as other partners in the GLRP.

3.13. Training and development will continue throughout 2023 to ensure that the Partnership's emergency response teams, partner organisations (Aberdeen City Council and NHS Grampian) and community groups are clear on their roles and how to execute these in the event of risks manifesting, individually or concurrently. This is done through a combination of:

- Page turn exercises on emergency plans and business continuity plans;
- Presentations/discussions to check assumptions and shared understanding e.g. winter preparedness;
- Tabletop exercises which facilitate role play including concurrency of factors as part of a single emergency as well as concurrent incidents e.g. mass evacuation;
- Live play exercises which are as close as safely possible to an actual incident e.g. power resilience failure; and
- Drills which are coordinated and supervised closely and test existing protocols and plans.

3.14. The continued use of Aberdeen City Council's internal Resilience Hub, a SharePoint site which provides a toolkit for emergency response teams (including the Senior Managers on Call), has continued with a strong focus over the year and its content is steadily growing. This assists with situational awareness, sharing of historical data and lessons learned, partnership contacts, relevant legislation and regulation reference documents. The Resilience Hub is also a central place to share information and updates on

incidents and acts as the single point of contact for current information e.g. emergency plans and activation packs.

- Monthly updates posted UK PROTECT Bulletin
- Links to reports such as Coronavirus lessons learned to date UK Parliament
- Sharing of partner rotas
- Weather updates, official warnings as well operational updates
- SMOC and DERC channel to allow immediate information flow between managers on call in the Partnership and the Council
- Templates for managing incidents and debriefs from incidents
- Media reports of interest
- Changes in legislation or guidance
- Training opportunities from other partners

3.15. Risks are also assessed and monitored regularly through the GLRP which manages a risk register and resulting workplan. The Business and Resilience Manager and Emergency Planning Response Officer represents the Partnership on the GLRP Working Group which meets every six weeks.

3.16. As mentioned previously, Integrated Joint Boards (IJB) became Category 1 responders under the Civil Contingencies Act in April 2021. The Partnership and the Council have been working very closely on civil contingency matters, Partnership staff have been involved in meetings of the GLRP and had also participated in the response to a number of incidents in the past year. The Care for People Plan was reviewed and updated then approved by the Care for People Group in October 2022. In terms of governance, representatives from the Partnership are members of various Council and NHS Grampian groups and boards which helps to further enhance the working arrangements.

3.17. Preparation continues around the Partnership's role in response to a National Electricity Transmission System (NETS) failure (previously known as 'Blackstart) which is an unplanned prolonged power outage affecting the whole of the UK, or the whole of Scotland. This is a significant piece of work being progressed through a GLRP Task and Finish Group, a separate Resilient Telecommunications Group, and internally at the Partnership,

through the IMT established to update critical services in the Partnership ahead of industrial action and planned and unplanned power outages and through continued liaison with ACC and NHSG on their plans.

3.18. As mentioned above the IMT has also considered planned power outages which have emerged as a low likelihood risk for winter 2022/2023. Known as Rota Load Disconnections (RLD) and Demand Control-OC6, these planned power outages may have short term 3-hour impacts in predefined small geographic areas aligned with postcodes (i.e., AB11) again spread across all of the UK at the same time. The scenario planning has allowed Business Continuity Plans to be reviewed and adapted, risks identified and mitigated for and for some risks to be tolerated.

3.19. A UK government led, and Scottish Government supported, national power resilience exercise involving all local authorities and other partners, is to take place in March 2023 which is anticipated will significantly inform the planning for both NETS Failure and RLD and Demand Control- OC6.

3.20. The Partnership's Communications staff operates a 24/7/365 on-call rota (tied into ACC's out of hours rota) as part of which they will inform the public and media of an emergency situation. There is an agreed Emergency Incident Response Protocol which sets out a clear pathway for how the public are informed.

3.21. The Partnership's Communications staff are also members of the GLRP Public Communications Group – this group plays a crucial role in coordinating of public communications.

3.22. The Partnership has continued to work closely with all local responders during the year, particularly to manage the response to Storms Arwen, Malik and Corrie, and in order to support our resettled communities.

3.23. Key learnings from storm debriefs included:

- Building and promotion of Community Resilience for all
- All responders to consider their own Business Continuity Plans
- Ongoing discussions with power companies to map out the Local Authority areas to improve situational awareness in future incidents

- SSEN to share learning from England and Wales with the group on data sharing/mapping.

3.24. A number of multi-agency resilience workshops have taken place, with attendance by our key emergency planning and response staff. 2023 will see a significant review of the Partnership's emergency response plans and their resource to ensure the effectiveness of their emergency response. The effectiveness and suitability of the SMOC resource, is being reviewed to align with the procedures in ACC and the DERCs role. This provides real assurance that in the North East we have strong communication links with our partners and common language and understanding in the response to an emergency.

ADDITIONAL PRIORITIES

Persons at Risk Database (PARD)

3.25. Considerable efforts continue to be directed at the development of an Aberdeen City Persons at Risk Database (PARD). This will allow responders to easily and accurately access and assess the vulnerability of persons affected by an emergency. PARD has been discussed for many years but post learnings from the Storms of late 2021 / early 2022 it has been identified as a priority by all three local authorities. An interim PARD is now in place, with a view to a more complete PARD by winter 2023.

Awards and Achievements

3.26. Aberdeen City Star Awards – in 2022 the Aberdeen City Emergency Response team (including the Partnership, Bon Accord Care and voluntary organisations) won the collaboration award at the Council's Star Awards for their response to Storm Arwen. This was a fantastic team effort and shows the commitment and loyalty that the staff have in ensuring the city responds in the most effective and efficient way to emergencies. It also proved that the structures, preparation and planning we have in place works and can be scaled up and down accordingly.

INTEGRATION JOINT BOARD

4. Implications for IJB

4.1. Equalities, Fairer Scotland and Health Inequality

While there are no direct implications arising as a result of this report, equalities implications are considered when operating a response to an incident via the current checking of D365 for vulnerable clients and in the future through the use of the PARD.

4.2. Financial

The Senior Managers on Call receive a standby allowance for being on call which equates in total to approximately £10,000 per annum. In addition to this, overtime for major incidents have been claimed, however it is difficult to predict the costs around this.

4.3. Workforce

Minor changes have been made to the job descriptions of posts to help support the IJB becoming a Category 1 Responder.

4.4. Legal

This report outlines the duties that IJB's have under the Civil Contingencies Act 2004 and explains how the IJB has been meeting its duties.

4.5. Covid-19

There are no direct implications relating to Covid-19 in this report.

4.6. Unpaid Carers

There are no direct implications relating to unpaid carers in this report.

4.7. Other

There are no other implications that require detailing.

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 well as the IJB's duties under the Civil Contingencies Act, as it will monitor, control, and mitigate the potential risks to achieving these. The Operational Risk relating to the IJB becoming a Category 1 Responder has been aligned to the Strategic Plan.

6. Management of Risk

6.1. Identified risks(s)

The Risk on the IJB fulfilling its requirements under the Civil Contingencies Act 2004 was de-escalated from the Strategic Risk Register to the operational level. The controls and mitigating actions that have been outlined in this report around the IJB's duties have managed to reduce the risk. The development of the PARD, continued review of plans and the exercising of these plans will help to further reduce the risk.

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

As detailed above the risk around the IJB fulfilling its duties under the Act are contained at the operational level and are managed by the Business and Resilience Manager and monitored by the Partnership's Civil Contingencies Group on a quarterly basis.

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

As detailed above, the controls and mitigating actions that have been outlined in this report around the IJB's duties have managed to reduce the risk. The development of the PARD, continued review of plans and the exercising of these plans will help to further reduce the risk.

Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGATION JOINT BOARD

Date of Meeting	25 April 2023
Report Title	Equality Outcomes and Mainstreaming Framework
Report Number	HSCP23.024
Lead Officer	Sandra Macleod Chief Officer
Report Author Details	Alison Macleod Strategy and Transformation Lead
Consultation Checklist Completed	Yes
Appendices	**Appendix A** – Biennial Progress Report 2021 - 2023 **Appendix B** – Guidance on Assessing the Impact of Policy and Practices **Appendix C** – Revised Equality Outcomes and Mainstreaming Framework 2023-2025

1. Purpose of the Report

1.1. To request approval from the Integration Joint Board (IJB) to publish the Biennial Progress Report in relation to the Equality Outcomes and Mainstreaming Framework and to request approval of the revised Guidance on Assessing the Impact of Policy and Practices (which now incorporates requirements under the United Nations Convention for the Rights of the Child (UNCRC)) and the revised Equality Outcomes and Mainstreaming Framework 2023-2025.

2. Recommendations

2.1. It is recommended that the Integration Joint Board:

a) Approves the Biennial Progress Report in relation to the Equality Outcomes and Mainstreaming Framework.

b) Instructs the Chief Officer to publish the Progress Report and advise the Equality and Human Rights Commission (EHRC) when this is done.
c) Approves the revised Guidance on Assessing the Impact of Policy and Practices.
d) Approves the revised Equality Outcomes and Mainstreaming Framework 2023-2025.

3. Summary of Key Information

3.1. At its meeting of 25th May 2021, the IJB approved the Equality Outcomes and Mainstreaming Framework (EOMF) 2021 – 2025 for Aberdeen City. The aim of the EOMF was to embed a culture of equality and human rights across all services. The Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012 places a duty on the IJB to report progress every two years therefore the first progress report on the EOMF approved in May 2021 is due to be published by May 2023. The Progress Report is contained at Appendix A and approval to publish is requested.

3.2. The report provides progress updates against the 31 success factors in the current EOMF. Whilst there has been a lot of activity and good progress is being made, the collation of the updates highlighted that the volume of success factors and the breadth of scope covered by them had been ambitious.

3.3. At the beginning of 2022 the EHRC undertook a review of compliance with the Public Sector Equality Duty (PSED) for all IJBs and in July 2022 they wrote to each IJB with the outcome of their review, offering further support to advance equality through improved compliance. In October and November 2022 EHRC ran two Workshops on setting SMART, evidence-based Equality Outcomes, and how and when to undertake robust equality impact assessments. Aberdeen City participated in these Workshops and took a great deal of learning from them.

3.4. Although EHRC confirmed that they consider Aberdeen City IJB to be compliant with the duties to publish a Mainstreaming Report, set of Equality Outcomes, and Equality Outcomes Progress Report, they encouraged us to

reflect upon the learning from the workshops and consider how it could help improve our future performance.

3.5. As part of their review, the EHRC undertook a search of ACHSCP's website and highlighted that our published Impact Assessments were not as accessible as they could be. They advised that a member of the public should be able to find these through a simple search. They requested that we review our policies and practices in relation to impact assessments and develop and agree a functioning system which should include how Aberdeen City will meet the Specific Duty, impact assess proposed new or revised policies and practices, and keep them under review.

3.6. The Guidance on Assessing the Impact of Policy and Practices attached at Appendix B is the result of that review incorporating all of the learning from the EHRC as well as feedback from staff who have been working with the current system over the last two years. It also includes anticipated duties in relation to UNCRC. The Guidance currently includes those areas the IJB is mandated to impact assess however it is our intention to update this as required with areas of best practice. We are anticipating a requirement to impact assess against the impact of Climate Change.

3.7. The templates used in the Impact Assessment process have been streamline and simplified ensuring that they focus on our specific duties. In particular the Guidance specifically confirms the requirement to publish in an accessible manner. Refinements to the website have been made to ensure we can meet our obligations in relation to this. The Guidance also introduces the need to identify performance measures where relevant, incorporating these into routine reporting, and the requirement to monitor and review impact over time.

3.8. The intention remains to grow and develop the DiversCity Officers Group which will enable the sharing of learning and support in undertaking Impact Assessments and assist in embedding compliance with PSED.

3.9. The EHRC workshop on SMART Equality Outcomes caused us to review and rethink our current ones. Proposed, revised Equality Outcomes along with specific actions, measures and Lead Officers are contained in Appendix C. It is proposed that these replace the existing outcomes for the next two

years to May 2025. The Equality Outcomes are closely linked to our current Strategic Plan which also runs to 2025 and it is proposed we revise both at the same time. The main learning that has informed these revised Equality outcomes include: -

- Be specific and prioritise tackling the inequalities most significant in our area.
- Link the Equality Outcomes to our Strategic Aims
- Make the Equality Outcomes something we can achieve within remit and resources.
- No need to duplicate existing legislative requirements
- No need to cover all groups with protected characteristics.

3.10. As an ongoing opportunity to improve knowledge and confidence an IJB Equality Peer Support Group has been set up by equality practitioners in the sector following the workshops and ACHSCP will be represented on this.

3.11. IJB are asked to approve these revised Equality Outcomes noting that they are closely linked to existing work detailed in the Delivery Plan and therefore work that is already being progressed.

4. Implications for IJB

4.1. Equalities, Fairer Scotland and Health Inequality

This report confirms arrangements for the IJB's compliance with the Human Rights Act 1998, Equality Act 2010, the Scottish Specific Public Sector Equality Duties 2012 and the Fairer Scotland Duty 2018.

4.2. Financial

There are no direct financial implications arising from the recommendations of this report. All equality and human rights activities will be undertaken within existing budgets.

4.3. Workforce

There are no additional workforce implications arising from the recommendations in this report. Officers will deliver compliance as part of their ongoing duties.

4.4. Legal

The risks associated with not implementing the recommendations include:

- Non-compliance with legislation
- Legal challenge which could impact on service redesign to deliver financial efficiencies.
- Regulatory/enforcement action

4.5 Unpaid Carers

Unpaid Carers are one of the groups considered in terms of impact assessment and, where relevant, would be consulted on the development of any new policy or practice.

5. Links to ACHSCP Strategic Plan

5.1. This report links directly to delivery of the strategic aims and priorities of the IJB and supports achieving the stated approach of services being planned and led locally.

6. Management of Risk

6.1. Identified risks(s)

There is a risk that the IJB fails to maximise opportunities to engage with people with protected characteristics when planning and delivering services which could potentially lead to harm or exclusion of certain groups.

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

This report links to Strategic Risk 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

This risk is currently sitting at Medium.

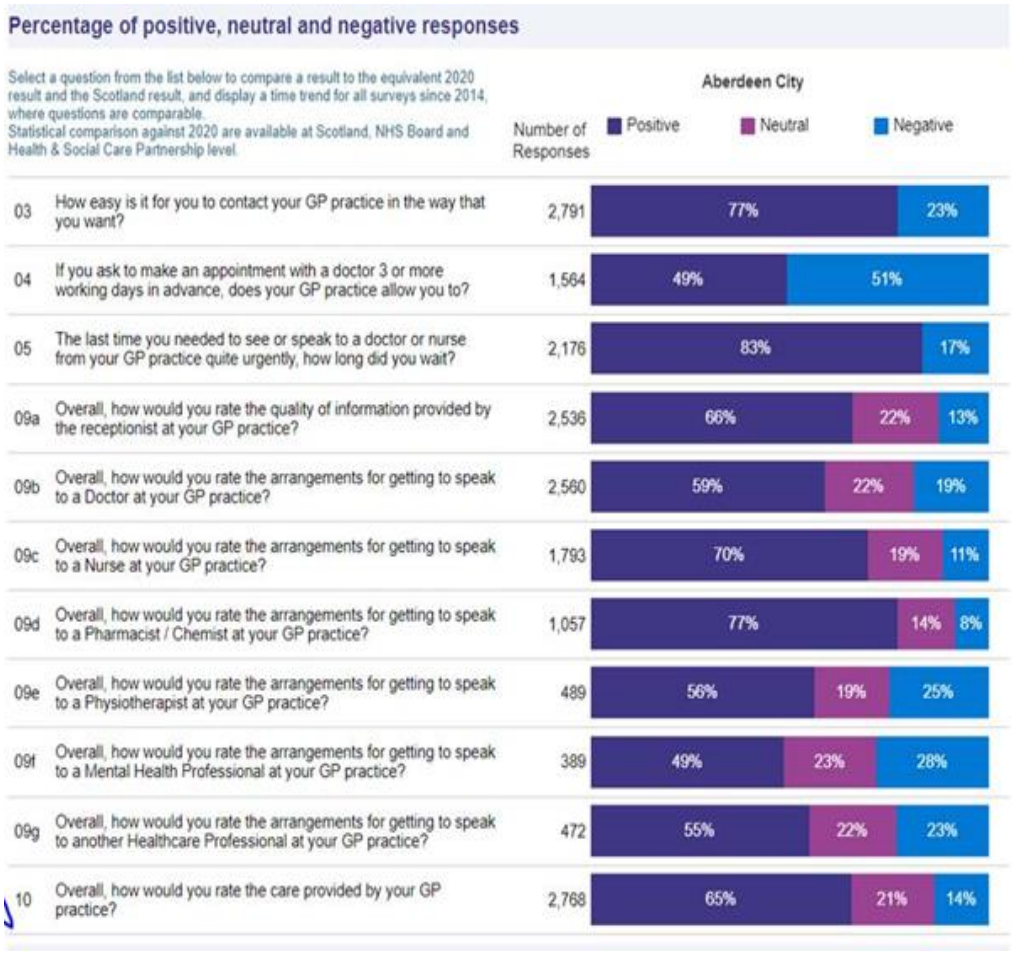
6.3. How might the content of this report impact or mitigate these risks:

The process, documentation and approach described in this report will improve the IJB's ability to demonstrate its due regard to the equality duty to the Scottish Parliament's appointed regulator. The quality of life for people who share a protected characteristic, have shared lived experiences and groups experiencing inequality will also improve as services are coproduced and become more accessible.

ACHSCP Equality Outcomes and Mainstreaming Framework – Progress Report April 2023

Outcome 1 Improved accessibility and confidence in using health and social care services.

1.1 Information and advice will be delivered in accessible formats that best suits people's needs	
Understanding Needs	**Experience of accessing GP** Below are the results from the most recent Health and Care Experience survey public health Scotland publications - health and care experience survey ratings results.



Analysis of cool spots for Vaccinations

The Aberdeen City Vaccination Service currently have access to vaccination uptake by postcode area which highlights areas of lower uptake. We use this information to target and organise pop up clinics in these areas. The service ensures that these clinics are advertised widely through posters in local shops, social media posts and information available on the Immunisation Website. The Public Health and Wellbeing Coordinators promote these clinics further within local communities. Information is shared with local councillors to support and advertise clinics in their ward areas. The service have also built good working relationships with local community centres, churches, and organisations such as GREC (Grampian Regional Equality Council) to support us to target minority groups. Over the Autumn/Winter 2022/23 period we have held local pop-up clinics at the Jesus House Church on Holburn Street and the Masjid Alhikmah Mosque and Community Centre on Nelson Street. The Vaccination Service link into the Weekly Health Project

	Group for Refugees and Asylum Seekers to ensure vaccinations are promoted and pop-up clinics put in place to support refugees within Aberdeen City. These have been held at the Rosemount Community Centre (Refugee Hub).The Vaccination Team have also been attending weekly Warm Space sessions at Pittodrie Community Hub, Tillydrone Community Hub, Seaton Hub, Kincorth Roadshow and the Staying Ward and Well Winter Roadshow at Cummings Park Community Centre to promote vaccinations to Aberdeen city residents in attendance.
Accessibility	GREC offer translation services on request to support attending GP appointments in person or by phone. The new Carers Strategy and the Strategic Plan are both available in range of versions including short animations and as easy read summary versions. The Carers Strategy Implementation Group (CSIG) are currently establishing a Carers Reference Group to provide more opportunities for discussion and engagement around the accessibility of information and the services involved in directly supporting Carers. The **Adult Carers** Support service provided by Quarriers continues to register new carers to the service. Support is offered both remotely and face-to-face dependent on the carers preference. Quarriers Calendar includes service events for carers meeting outcomes such as reducing isolation, access to information, own health and wellbeing etc. New leaflets have been distributed to other services along with new posters. There are two staff members attached to Royal Cornhill Hospital on a Monday and Tuesday targeting Carers of people with Mental Health problems. Quarriers is now working with Viewpoint to have the registration form and Adult Carers Support Plan adapted for use on mobile phones and a QR code added to leaflets that will take Carers straight to the registration form. The service has continued to book Time to Live breaks for carers through its Respitality Bureau. The **Young Carers** Support service is provided by Barnardo's who tailor support to every Young Carer and their family, whilst incorporating the needs of each individual into their service delivery. Different levels of support are offered from one-to-one allocated project workers to groups only supports, which can be altered throughout dependant on need and preference. Young Carers are involved throughout the process of developing Young Carers Statements. Feedback is welcomed from Young Carers and their families to further develop the opportunities available to them and the aim is to build new partnerships with other Aberdeen City projects to meet the service delivery needs. Information and signposting opportunities appropriate to individual families are provided and support can be provided to further access these – for example, referrals to adult services during transition from Academy. **Aberdeen Guide to Independent Living and Enablement (AGILE)** is delivered by the Wellbeing Team has a target demographic of people aged 65 and over for their families and carers to use. The brochure considers racial discrimination and intersectionality of this cohort by targeting services and information to support self-determination, independence by mainstreaming physical activity, connection to community, considering carers needs,

	targeting minority groups and those encountering physical emotional and language barriers, visually impaired, deaf blind people, LGBTQ+, people for whom English is not their first language by enabling them to access information both digitally and in print. AGILE is part of the solution to mainstream access to services and information that help reduce harm, abuse and exploitation of older people.
Co-production	GREC have developed the Directory of Community Groups for Engagement & Participation in Aberdeen City – Grampian Regional Equality Council (grec.co.uk) The directory is important in engagement and knowing where to go when you need to reach certain groups. The Post Diagnostic Support (PDS) Information Pack was developed in 2019, in order to address the concern that people given a dementia diagnosis were not generally given the information required and even when they were, this was often outdated. This concern was raised by people living with dementia and their carers during consultation. Sessions with people living with Dementia and their Carers identified the key information that is required, and it was this information that was included in the pack and in the PDS section of the Partnership Dementia webpages. Partnership staff are able to print off any information that their patient/client requires. This information was reviewed to include information specific to Covid-19 and reviewed again mid-April 2023 to make sure the information is still relevant. Further work will be required to be undertaken when the new Dementia Outcomes Focused Strategy is published in the summer of 2023. In relation to the branding for the Adult Carers Support Service, Quarriers held and facilitated a session for carers to consider the priorities for the service and develop their own branding which is now used on all Aberdeen leaflets and social media. Carers are also supported on 1-1 basis to complete a co-produced Adult Carers Support Plan which outlines the main areas of their care role and can then be used to consider a carers SDS package if they meet the Eligibility Criteria. Having this 1-1 discussion can help the carer to see where support would be helpful and to fully understand the social care process which in turn helps build confidence.
1.2 Proactive partnership arrangements which support ACHSCP demonstrate a welcoming environment with informed and understanding staff	
Raising Awareness	ACVO coordinate and publish a calendar of events ensuring that there is no duplication and attendance, participation, and outcomes can be maximised especially for volunteers and supporters. This is a live tool https://acvo.org.uk/opportunities/events/ Quarriers Calender of service for carers against outcomes.jpg (Command Line)
Training	Making Every Opportunity Count (MEOC) training enables and encourages workers, volunteers and community members to engage people in brief conversations about improving their health and wellbeing. A brief conversation can take between 30 seconds and 3 minutes which could encourage someone to think about making a change and help them to access

	the right support. Training makes reference to health inequalities and social determinants of health. Key Indicators are: - - Number of people trained , Service/Job role and Locality. - Confidence to have a brief intervention. - Confidence In how to find referral and signposting information. NHS and ACC staff undergo regular mandatory equalities training. Making Every Opportunity Count training was refreshed in December 2022. Feedback from front line organisations had highlighted the need to support people to have brief interventions about health focussed topics. Online courses are available however, it was felt that the focussed in-person session was more favourable to build on experiences of both the people attending the training as well as the trainees. MEOC courses have been offered to services from January 2023and from then until March 2023 68 people have been trained including Community Learning and Development, City Libraries Service and Warm Space Volunteers. Confidence to have a brief intervention went up 53% from the baseline to post training. Confidence to find referral and signposting information went up 44% from baseline to post training. Further training is planned with Aberdeen City Council Housing Support staff in June 2023 and information is to be circulated across teams to promote the MEOC training to other services and organisations. MEOC Confidence to Undertake a Conversation Pre & Post Training
Evaluation	The Equalities and Human Rights (EHR) group's aim is to ensure that the Equality Outcome and Mainstreaming Framework (EOMF) is delivered including successful and appropriate use of Health Inequality Impact Assessments (HIIAs) and other framework activity will guarantee that reporting and evaluation does not feel like extra work but business as usual.

1.3 All premises that the ACHSCP work out of or deliver services from have been collaboratively reviewed in terms of location, ramped access, signage, transportation links etc

Aberdeen City IJB does not have sole responsibility for the accessibility of the premises we use. The Equality and Human Rights commission has advised that we should avoid committing to something that is out with our remit. This action will therefore be removed for the revised Equality Outcome and Mainstreaming Framework.

1.4 ACHSCP adheres to the Public Sector Bodies (Websites and Mobile Applications) No. 2) Accessibility Regulations 2018

There has been a review of the website accessibility undertaken and an estimated 80hrs of work required to be completed by NHS IT team to address accessibility issues have been identified. Unfortunately, NHS IT support for the site has always been on an ad-hoc basis so this work remains outstanding. An SLA / contract is being negotiated and funding needs to be identified. There are, however, some accessibility improvements that we can make in the meantime such as reducing the use of PDFs.

1.5 2012 SSPSED embedded into the Partnership's commissioning and procurement processes

The Scottish Specific Public Sector Equality Duties (2012) is now embedded within our commissioning and procurement processes. Before a procurement decision is reached by the IJB, a full Health Inequalities Impact Assessment (HIIA) is completed and is available as part of the IJB decision making process. This approach is part of the standard IJB reporting process and the HIIA is then monitored and updated as required throughout the life of the contract:

Outcome 2 Enabling people to live as independently for as long as possible.

2.1 More disabled and older people engaged in exercise, self-care and meaningful activities	
Exercise	Stay Well Stay Connected (SWSC) Implementation has moved forward into delivery projects within the agreed four categories. All activities, where possible, are accessible in order to offer equity of participation, regardless of age, means, or ability. The projects focus on opportunities to increase physical activity, falls prevention, reduce social isolation, close the digital divide, and achieve greater inclusion of people with cognitive decline. The Technogym 'Easy Line' equipment provides access to physical activity for older people or with limited mobility. We are in the process of launching Learning Disability (LD) Health Checks which may capture some more general health information relating to exercise and to earlier detection of dementia and other conditions to improve health inequalities. Utilising the GetActive@Northfield Studio and Community Room, we have introduced Pulmonary Rehabilitation classes helping support those with respiratory conditions. The Pulmonary Rehabilitation Team have had the opportunity to have classes running in the Studio with an additional assessment space available in the Community Room to support waiting lists. The Community Listening Service have also introduced a half-day session per week, helping to support mental health with the aim to be a listening ear. This is a self-referral service. Other activities co-ordinated by the Public Health team are healthy weight programmes, breastfeeding, weaning and toilet training classes to support new families; Physio led rehabilitation exercise with use of the Technogym equipment in conjunction with Robert Gordon University (RGU) students in training to meet demand for future Physiotherapists.
Self-Care	This work includes the 'Your Care' Wellbeing Portal; Mental Health 'First Aid at Work; Mental Health Training for managers and supervisors; free physical exercise taster sessions with partner organisations e.g. Aberdeen Sports Village, Sport Aberdeen; Weekly Wellbeing Blogs; and Wellbeing Awareness Campaigns in line with national and local campaigns
Meaningful activities	Working with Care Management we have identified a possible place in the digital hub at the Quay where we hope to have projects supporting the digital divide. Other projects to be revisited are the Life Curve; the analysis survey to identify the digital gap and need; promotion to increase local providers in programs such as Abilitynet, Silver City Surfers, City Libraries. The Wellbeing Coordinators are supporting the ACC wide digital group in the community. There has also been work undertaken in relation to the review of how day

	centres operate and the programme of activities on offer, reviewing activities in care homes membership of the Grampian Meaningful Activity Network (GMAN) and the uptake of the Care About Physical Activity (CAPA) Principle by the Care Inspectorate to reduce falls and increase the quality of life for residents. The following have been introduced by ACC in an attempt to reduce employer discrimination • Introduction of a number of initiatives which focus on digital inclusion and accessibility bot, live captions, immersive reader and translate in teams (Race and Disability) • Introduction of a 'Star Award' for diversity and inclusion, the first winners were selected in 2022 • Creation of various Yammer employee peer support groups in topics such as mental health and wellbeing, tinnitus and hearing loss and general equality and diversity and inclusion. • Input from staff working groups into smarter working review and creation of an intranet page with guidance and advice for mangers on ensuring inclusivity when considering smarter working groups for their team(s) • Socially inclusive events for employees interested in diversity and inclusion organised by out LGBT+ working group. • Creation of a Microsoft team channel for equality and diversity and inclusion communication with the development of a shared diversity calendar • Introduction of a dignity and respect at work policy and guidance to replace the councils managing bullying and Harassment at work policy and guidance.
2.2 Number of people engaged in Stay Well – Stay Connected activities.	
We currently have 1,029 attendees across the Stay Well Stay Connected (SWSC) programme. It is our intention to work with the Data and Digital team to build a performance management framework for SWSC for regular monitoring and reporting.	
2.3 ACHSCP's future planning and commissioning plans are linked with Aberdeen City's Local Housing Strategy, Housing Need & Demand Assessment (HNDA) and the Joint Strategic Needs Assessment	
Information on the housing needs of complex care grouping has been collated and provided to ACC Housing colleagues and more widely to increase awareness and investigate opportunities to improve the offers available for this group. We have also contributed to the Housing needs Demand Assessment (HNDA) and housing strategic planning process. We are working with ACC Housing colleagues on developing proposals for Housing for Varying Needs (HVN) looking at variety of workstreams and themes including the Very Sheltered Housing/Sheltered Housing provision, Charging Policy, Meal Provision, Special Lettings Initiative, Telecare etc. This work could potentially include the transition of some Sheltered Housing stock into Very Sheltered Housing depending on the demand and needs analysis being undertaken. Work is in the early stages but will involve engagement with service users and their families. We are also reviewing the Market Position Statements (MPS) for Sheltered Housing and Very Sheltered Housing which was last updated in 2021.	

2.4 ACHSCP's Assistive Technology and Digital Inclusion evidenced as supporting an increase in the number of people living independently in their own communities.

There are early indications that the input of the Care Technologist within Care Management has led to reductions of in-person care hours required as technology has met these needs. Bon Accord Care have been delivering awareness raising sessions with a range of organisations and there are further sessions both (NHS and Learning Hub) which are well booked. A Quality Improvement (QI) Plan/Do/Study/Act (PDSA) cycle approach has been undertaken with the impact of these planned and additional sessions reviewed. Work is being undertaken to increase the use of Technology Enabled Care (TEC) locally though little data, such as increased numbers living independently is available to evidence impact at this stage. This is one of the areas we need to develop as we go forward, and a TEC Database is proposed as a project in the TEC Plan that is being developed. In terms of the Analogue to Digital (A2DT) project this doesn't directly impact on the numbers of Telecare users, but is necessary to ensure that we can continue to deliver the service as the analogue network is switched off. It will also deliver benefits in relation to the transformation opportunities that moving from an analogue to a digital system offer both for customers and the service.

A series of drop in sessions for all Adult Social Work staff have been delivered in relation to Telecare provision and the script for the video for the TEC room has been finalised. This will give us greater coverage across adult services to promote the use of TEC. We are awaiting additional TEC to trial, KOMP, Guardian 111 and the Melody Care Phone. The plan is to trial these and gauge whether they would be viable for greater financial investment. They would be an alternative to Alexa (which is well known) and would be better for clients that cannot interact at their end, as the functionality is automated. All providers within Granite Care Consortium (GCC) have been given TEC questionnaires and will support clients to complete these. The responses we have had to date have been analysed and follow up guidance and advice for the clients that have expressed an interest has been provided. Borrowing from the TEC library is being arranged with some appointments being scheduled using Alexa as a reminder of appointments. Alexa is also being used to remind clients when their support workers are due to visit. Medication dispensers support further independence using TEC. Other services to be included shortly are turning lights on and off commands.

2.5 Number of disabled adaptations completed in private and social housing. (Major and Minor adaptations)

The Disabled Adaptations Group (DAG) have developed a reporting template to capture data in relation to adaptations. This is in the early stages of implementation and all tenure representatives are currently trialling capturing and inputting their data. A few teething issues have been identified but it is hoped that these can soon be resolved and that from the beginning of financial year 2023/24 we will be producing regular quarterly reports, reviewing the data and using this to challenge performance and lobby for equity in budget and adaptation provision.

Outcome 3: Health and support services are delivered in a compassionate way, respecting the dignity of the individual and are co designed with people who experience poor mental health to ensure they flourish and thrive, build resilience and continue in recovery.

3.1 Develop a quality indicator profile in mental health which will include measures across six quality dimensions - person-centred, safe, effective, efficient, equitable and timely.
This work is, in part, aligned to the development of the national strategy which is in progress but not yet completed. We have a strategic framework for the transformation of Grampian wide services which has an associated programme plan. Some specific work to enhance lived experience is needed. We are working with commissioned providers following on from completion of the Market Position Statement work to look at the sustainability of services versus the current and future need/demand profile
3.2 A rights-based approach which is consistent, intentional and evident in the everyday experience of everyone using mental health support (including but not limited to, unpaid carers and families and people working within the mental health sector) is embedded
The Aberdeen Carers Support Service is commissioned from Quarriers to provide an enhanced service for adult carers over the age of 18 years. The service working with ACC IT has streamlined data collection processes ensuring the implementation of a bespoke Outcome Measurement Framework based on the NHS five steps to wellbeing and the national outcomes for carers. For the quarter ending December 2022 the service was supporting 128 carers. 14 Archived and 7 adult support plans were completed in that time. The service administered 'Time to Live' awards to 4 carers from the enhanced service where the recipient can receive a maximum of up to £300 for clothes shop and coffee out, driving lessons, days out and stay with out of town family. Training was provided by Connexions to 12 people and the male carers group supported 10 carers. ACHSCP understand the value of being a Trauma Informed leadership by recognising that psychological trauma affects the workforce and why it matters. A trauma informed approach realises the prevalence of trauma, recognises the impact of trauma, responds with that recognition in mind, to do no harm, support recovery, create systems that remove potential trauma related barriers, supports resilience, and understands that relationships matter. It also resists re-traumatisation and understands that trauma memories, feelings, and responses can be triggered often by subtle or innocuous event and or relationships. A trauma informed workforce will support progression of ACHSCP strategic plan by empowering communities to be involved in planning and leading services locally.
3.3 The transition from children and young people's services to adult services is designed to enhance life outcomes in their adulthood
Work is being undertaken on the development of a Transitions Plan starting with a focus on Learning Disabilities. There will be specific data available on positive destinations of young people; the work underway is aimed at providing a suite of information which will support transitions without the default being social work intervention (which arguable does not enhance life outcomes for all); this work is still under development and is still to be tested. The project is concurrently running with the GIRFE principles pilot for the Scottish Government Transition Framework in co-production and with the Social Care re-design project.

3.4 People better understand what their rights are to mental health care and support, and duty bearers should be focused on realising these rights rather than being hampered by considerations of eligibility, capacity and cost

Collaborative commissioning between ACC, ACHSCP and SAMH for links practitioners in the city has been undertaken to ease the pressure on GP consulting hours where service users are supported when appropriate to find other non-medical solutions to their presenting issue at the practice.

The MHLD disability project in Kincorth and Cove is a pilot with patients who are seen by an experienced MH practitioner and benefit from extended appointments times. There is a thorough assessment of presenting issue, risk and referral to the most suitable service appropriate to patients need (MH service in Primary Care, Psychological Therapy, Community MH teams, Drugs and Alcohol services, Eating Disorder etc.). The programme facilitates a consultative approach to care where GP's and ANP's can seek patient review, recommendations, and suggestions which offer positive outcomes as this model supports optimal self-empowerment models, through collaborative and connected supports and pathways which reduce ineffective use of resources. Over 8 weeks 1,245 minutes of GP appointments were reallocated for specialised GP need. The MH practitioner role saves secondary care time as the initial referral is detailed and allows for an easier decision within the CMHT to be reached.

3.5 Gaps in service provision, which are specific to the needs of people with protected characteristics, are identified and fed into the strategic planning and commissioning process.

We have developed our own HIIA process and to date we have completed five full HIIAs. These were for our strategic plan, our new Carers Strategy, our new Workforce Plan 2022 – 2025, our MHLD Commissioning, and our Analogue to Digital Transformation. Our DiversCity Officer Network is being established to further develop our processes and support IJB reporting with HIIAs being completed across the partnership.

3.6 Supporting employers to have an improvement plan for workplaces in making continuous improvement to their culture, practices and policies, to directly tackle stigma and discrimination e.g., attaining See Me in Work

ACC as an employer of some of the staff in ACHSCP has undertaken the following: -

Disability

- Introduction of Deaf Awareness and British Sign Language for beginners to 99 Employees.
- Guidance on reasonable adjustment launched.
- Mental health awareness intranet page created for managers.
- Various internal communications on topics such as neurodiversity, Tinnitus Parkinson's Autism, access to work carers week Tourette's, UK Disability History Month, Scottish Learning Disability Week, International day of Disabled persons, multiple sclerosis society
- Posters created to raise awareness of sensory awareness.
- Reasonable adjustments passports approved at committee (Due to be Implemented)
- Promotions of 'quiet space' virtual working sessions organised by autism understanding Scotland.
- Confidential survey undertaken on mental health and wellbeing during the Covid19 pandemic.

- Implementation new online courses on mental health in the workplace and a series of mental health and wellbeing webinars for staff were run in partnership with the Scottish Association for Mental Health (SAMH). options, immersive reader and translate in teams (Disability, Race) All · Introduction of a Star Award for Diversity and Inclusion, the first winner of which was selected at the Star Awards 2022 · Creation of various Yammer employee peer support groups in topics such as mental health and wellbeing, tinnitus and hearing loss and general equality, diversity and inclusion · Input from staff working groups into the Smarter Working review and creation of an intranet page with guidance and advice for managers on ensuring inclusivity when considering smarter working options for their team(s) · Socially inclusive events for employees interested in diversity and inclusion, organised by our LGBT+ working group · Creation of a Microsoft Teams channel for equality, diversity and inclusion communications with the development of a shared diversity calendar · Introduction of a Dignity and Respect at Work policy and guidance to replace the Council Managing Bullying and Harassment
- in the workplace and a series of mental health and wellbeing webinars for staff run in partnership with the Scottish Association for mental Health (SAMH). Options, immersive reader and translate in teams (Disability and Race)
- were run in partnership with Scottish for mental health guidance at Work policy.

Race, Religion or Belief

- Race and terminology document created for people and organisational development advisors.
- 2021 and 2022 intranet posts for the Black History Month
- Internal promotion and staff tours of the art gallery's 'reframing the collections' exhibition.
- CoreHR imaging amended to reflect Lunar New Year 2023
- Black History Month 2022 – panel discussions organised including employees and external partners, including a panel on the intersectionality of race and disability

Sex, Gender Reassignment, Sexual Orientation

- Staff communications and intranet awareness raising for International Women's Day 2023
- Launch of a colleague recognition and celebration nomination process for international women's day 2023
- University of Aberdeen webinars for international women's day promoted to ACC empleey34
- Intranet posts on Empowering Women in Digital Leadership including an example of a woman's experience as a conference panellist in a digital transformation / cyber security environment
- During the Covid-19 pandemic, communications were issued to staff about domestic violence and support available, including the Council's Gender Based Violence policy Multiple
- A large focus has been placed on supporting employees through menopause including:
  -A menopause intranet page created with advice and guidance
  -Menopause co-lab café's organised and promoted in partnership with partner organisations
  -Internal menopause peer group created on Yammer
  -Promotion of events for autistic people going through menopause run by autism understanding Scotland

- Updating of the Employee Maternity Checklist to ensure that those who are breastfeeding get access to a private room in the workplace for expressing
- Mx introduced as a little option on core HR
- Grampian pride promoted to internal employees and experiences of staff attendees shared with the workforce

All

- Introduction of a number of initiatives which focus on digital inclusion and accessibility bot, live captions, immersive reader and translate in teams (Race and Disability)
- Introduction of 'A Start Award' for diversity and inclusion, the first winners was selected at the start Awards 2022
- Creation of various Yammer employee peer support groups in topics such as mental health and wellbeing, tinnitus and hearing loss and general equality and diversity and inclusion.
- Input from staff working groups into smarter working review and creation of an intranet page with guidance and advice for mangers on ensuring inclusivity when considering smarter working groups for their team(s)
- Socially inclusive events for employees interested in diversity and inclusion organised by out LGBT+ working group
- Creation of a Microsoft team channel for equality and diversity and inclusion communication with the development of a shared diversity calendar
- Introduction of a dignity and respect at work policy and guidance to replace the councils managing bullying and Harassment at work policy and guidance.

The Staff Equalities Network is a coalition of staff from across the system who are passionate about equality, inclusion and allyship, working to coproduce systemic approaches to address systemic issues which aim to improve the experience of staff in health and care service. Everyone is welcome. Information on why the group was formed and its aims can be found here Staff Equalities Network (nhsgrampian.org).

The other initiative is We Care What is We Care (nhsgrampian.org), which is a staff health and wellbeing programme established to deliver, co-ordinate and enhance staff wellbeing. NHS Grampian also provides a comprehensive programme of Equality and Diversity training for staff across all levels via the digital platform Turas Learn. The NHS weekly bulletins provide health and wellbeing initiatives such as yoga meditation and many more.

Outcome 4 Community engagement, empowerment, and cohesion work across the City is strong and effective.

4.1 Increased participation, influence and voice from people with protected characteristics, with lived experiences, in the City's Locality Planning Processes
The dedicated Development Officer (Engagement) post has been tasked with updating Our Guidance for Public Engagement, and developing staff training that can be delivered in a face to face, virtual or blended format. Other documents will be used to inform and develop this training (Community Planning Aberdeen's Engagement and Empowerment Strategy as well as the COSLA/Scottish Government document Planning with People – Community Engagement and Participation Guidance.) Guidance for Public Engagement Human F An Integrated Locality Planning Team is being set up with Public Health Coordinators and Community Planning/Community Learning and Development (CLD) colleagues. An action plan has been prepared for integrated locality planning and the team will meet on a monthly basis. The integrated team will have operational responsibility for planning and facilitating Locality Empowerment Groups (LEGs) and Priority Neighbourhood Partnership (PNP) meetings, delivering Locality Plans; and ensuring strong and diverse community voices are listened to and actioned. PNPs represent the most deprived areas in Aberdeen City.
4.2 Adhere to the National Community Engagement Standards when engaging with communities of interest.
Working with colleagues in the planning and implementation of current and future community engagement activities, the Voice Tool is a free online system to help plan monitor and evaluate community engagement practice, which is endorsed within the National Standards for Community Engagement. This is promoted as a great starting point. To consider wider Ethical and legal duties associated with engagement activities, the 'Engagement Framework' (attached) from the GIRFE pathfinder programme will be used to help ensure compliance with data protection/GDPR regulations and our ethical duties towards participants. Engagement Framework - GIRFE p
4.3 NHS Scotland and Voluntary Health Scotland's Engagement Matrix is embedded into community engagement processes of ACHSCP
See 4.1 and 4.2 for relevant updates – nothing further to add under this heading.

Outcome 5 All staff delivering health and social care services, fully understand their legal duties and other responsibilities in keeping people living, working, studying or visiting Aberdeen City safe and free from harm

5.1 Interventions are early and effective, preventing domestic abuse, and maximising the safety and wellbeing of citizens, children, and young people affected by domestic abuse. Awareness of violence/ abuse and its related harms are better understood by staff working in Partnership services The launch of the Dynamic Database of support services will allow users to access 'one true source' of guidance and information about support service provision and referral pathways relating to domestic abuse in Aberdeen.
5.2 Improved services for those affected by hate crime and hate incidents in the City. Improved preventative work and a shared understanding of the causes enabling a reduction in hate crime and hate incidents
An analysis of staff working in ACHSCP services and their understanding of hate crime and hate incidents has been undertaken as has awareness raising activities to address the recommendations of the report presented to the Equality Subgroup. Participation in Hate Crime Awareness Week annually commenced October 2021. We are working with the Chinese, East and South-East Asian community members and representatives to co-design local initiatives to raise awareness of hate crime and prejudice. These actions will be measured by findings and recommendations reported to the Equality and Human Rights Subgroup which will include the number of incidents reported, and referrals made to appropriate services, details of and participation in events organised across ACHSCP services, and the number of hate incidents reported by staff working in partnership services and the number of people accessing appropriate support.
5.3 Improved services and support for those at risk of and those that are affected by Female Genital Mutilation (FGM). No specific actions have been progressed so far within this action.
5.4 Improved understanding of and development of a joined up approach to support those affected by human trafficking and exploitation. No specific actions have been progressed so far within this action.
5.5 Improved understanding of the causes of honour-based violence and the support services necessary to keep people safe. No specific actions have been progressed so far within this action.
Reducing Violence and Abuse | Aberdeen City Council Forced marriage awareness raising materials - gov.scot (www.gov.scot) There is appropriate ongoing representation from ACHSCP on the Violence Against Women Partnership (VAWP). We are working jointly with the VAWP to undertake public awareness raising campaigns to highlight what constitutes harmful behaviour. Impact can be assessed by trending topics on social media and the 'likes' and 'following' generated. There is support for partnership staff impacted by domestic and gender-based abuse by including information on the quarterly NHS and ACC bulletins. Work is ongoing to improve staff knowledge and awareness e.g., the Domestic Abuse Awareness Raising Tool (DAART) training, making available to staff 'Harm Help' fact sheets covering gender based abuse in all its forms, including how to respond, In addition, we are progressing 'Routine Enquiry' within the priority settings of maternity, mental health, substance misuse, ED, community nursing and sexual health services and supporting VAWP Development Session in terms of reaching seldom heard groups, improving the response to those with complex needs and ensuring appropriate procedures / pathways to specialist support are in place within ACHSCP services.

Outcome 6: We have a workforce that is reflective and representative of the communities we care for

6.1 Workforce data reflects ACHSCP service user data
Workforce data is available in the Workforce Plan which is available in accessible versions.
6.2 Flexible and targeted recruitment drives to address current gaps and the needs of future service users
The Workforce plan contains details on recruitment and links with Career Fairs, Further Education, Schools, and Aberdeen Business Gateway to support the provision of tailored support, advice and awareness raising events in the communities of Aberdeen in relation to the opportunities of a career with ACHSCP.
6.3 Staff have a shared understanding of cultural diversity and difference
See response to 3.6.

Outcome 7 We have a workplace where all staff feel valued and respected and have their needs met appropriately.

7.1 ACHSP has a responsive dignity and respect at work approach which all staff and managers are aware of
Promotion and marketing of Aberdeen City Council's and NHS Grampian's respective policies
7.2 ACHSCP supports the formation of staff groups which represent protected characteristics
Statements of support on ACHSCP website
7.3 ACHSCP embed an approach of learning and understanding to address findings of internal investigations to effect behavioural change and improve organisational. culture
This action has not been progressed as a result of the lack of information available.
7.4 Managers have a shared understanding of their responsibilities in relation to reasonable workplace adjustments
This action is a delegated duty and therefore not a SMART outcome!

Aberdeen City Health & Social Care Partnership
A caring partnership

ASSESSING THE IMPACT OF POLICIES AND PRACTICES

MARCH 2023

Context of Impact Assessments

Public Sector Equality Duty

Aberdeen City Integration Joint Board (IJB), and therefore Aberdeen City Health and Social Care Partnership (ACHSCP) have a duty to comply with the Public Sector Equality Duty (PSED). This is defined in The Equality Act 2010, Part 11, Chapter 1, Section 149 which states:"(1) A public authority must, in the exercise of its functions, have due regard to the need to: -

(a) eliminate discrimination, harassment, victimisation, and any other conduct that is prohibited under this Act,
(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it,
(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it."

The nine "protected characteristics" as defined by the Equality Act 2010 are:

1. Race
2. Disability
3. Age
4. Sex (male or female)
5. Sexual orientation
6. Gender reassignment
7. Pregnancy and maternity
8. Marriage and civil partnership
9. Religion or belief

Eliminating discrimination includes indirect discrimination and fostering good relations includes tackling prejudice and promoting understanding. Advancing equality of opportunity includes removing disadvantage, taking steps to meet the particular needs of people with protected characteristics, and encouraging their participation in service design and delivery.

The Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012

In addition to the PSED under the Equality Act 2010, additional specific duties are placed on Public Sector Bodies under the above Regulations in 2012. The Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012. These include: -

- Duty to report progress on mainstreaming the equality duty.
- Duty to publish equality outcomes and report progress.
- Duty to assess and review policies and practices.
- *Duty to gather and use employee information.*
- *Duty to publish gender pay gap information.*
- *Duty to publish statements on equal pay, etc.*
- Duty to consider award criteria and conditions in relation to public procurement.
- Duty to publish in a manner that is accessible, etc.
- Duty to consider other matters.

The duties in italics are not relevant to the IJB as they are not an employer.

The IJB publishes Equality Outcomes at least every four years along with a Mainstreaming Framework (or Action Plan) and reports progress against these every two years as per the legislation. The IJB consults with the Equality and Human Rights (EHR) sub group of the Strategic Planning group when preparing these. The EHR consists of representatives from organisations representing people with protected characteristics, who in turn consult with their networks on behalf of Aberdeen City IJB.

In relation to reviewing policies and practices, the above regulations stipulate that the IJB must consider evidence, take into account any assessment made, publish the results of the assessment within a reasonable time period, and make arrangements to review and revise any policy or practice and its impact accordingly.

Whilst the IJB is not a contracting authority it directs both Aberdeen City Council and NHS Grampian to contract on its behalf. It therefore needs to have regard to whether the conditions within contracts should include considerations to enable it to better perform the equality duty.

The IJB must publish all relevant information in relation to its PSED in a manner that makes the information accessible to the public and it is recommended that an existing means of public performance reporting is used. As such relevant information will be published on a dedicated page of the ACHSCP website.

Fairer Scotland Duty

The Fairer Scotland Duty places a legal responsibility on particular public bodies in Scotland to actively consider ('pay due regard' to) how they can reduce inequalities of outcome caused by socio-economic disadvantage, when making strategic decisions. To fulfil their obligations under the Duty, public bodies must be able to demonstrate that they actively consider how they can reduce inequalities of outcome in any major strategic decision they make. Strategic Decisions as defined in the guidance are key, high-level such as deciding priorities and setting objectives. In general, they will be decisions that affect how the IJB fulfils its intended purpose for example the Strategic Plan, other strategies, policies and proposals, commissioning decisions and service redesign or transformation.

Public Health Scotland Health Inequalities

The Scottish Government is committed to tackling the significant inequalities in Scottish society and one of Public Health Scotland's objectives is to put reducing health inequalities at the heart of all that they do. Health inequalities - Public Health Scotland

PHS notes that the fundamental causes of health inequalities are an unequal distribution of income, power and wealth. This can lead to poverty and marginalisation of individuals and groups. These fundamental causes also influence the distribution of wider environmental influences on health, such as the availability of work, education, and good quality housing. They can also influence access to services and social and cultural opportunities. The wider environment in which people live and work then shapes their individual experiences.

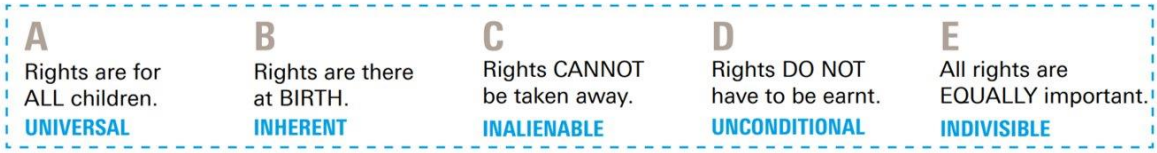
Health inequalities are largely shaped by the social inequalities and life experiences that disadvantage people and limit their opportunities for good health. However, this doesn't mean that ACHSCP has no role to play. Equity - of access to health and social care services and in the quality of care that people experience - is as important in reducing unequal health outcomes. Providing services in proportion to need is a fundamental element reducing health inequalities.

Human Rights

The Independent Review of Adult Care in Scotland (the Feeley Report) recommends establishing a consistent and intentional human rights and equality approach to social care service provision, engendering respect for the fundamental dignity of each and every person and ensuring access to services is universal depending on need. Human rights are rights inherent to all human beings, regardless of race, sex, nationality, ethnicity, language, religion, or any other status. Human rights include the right to life and liberty, freedom from slavery and torture, freedom of opinion and expression, the right to work and education, and many more. Everyone is entitled to these rights, without discrimination.

United Nations Convention on the Rights of the Child (UNCRC)

The UNCRC is the most complete statement of children's rights ever produced and is the most widely ratified international human rights treaty in history. UN Convention on the Rights of the Child The Convention has 54 articles that cover all aspects of a child's life and is a legally binding international agreement setting out the civil, political, economic, social and cultural rights that all children everywhere are entitled to. It also explains how adults and governments must work together to make sure all children can enjoy all their rights. The rights are as simple as ABCDE: -



The views of the child have to be seriously considered when taking any decision that directly impacts on their life which includes many of the strategies, policies and practices developed by Aberdeen city IJB . Whilst some services in ACHSCP e.g. Community Nursing do directly deliver services to children, children are generally part of a family group and any decisions we make in relation to service provision to adults in that family group could have a consequential impact on the child and this needs to be specifically considered as part of our impact assessment process. Although the Convention has 54 articles in total, articles 43–54 are about how adults and governments must work together to make sure all children can enjoy all their rights.

Complying with the various duties

The following is required to ensure we are adequately discharging the various duties we have to meet: -

Knowledge –awareness of the legislation and duties and a conscious approach and intent that is supported at the highest level. The duties cannot be delegated.
Information –sufficient information must be available to decision makers.
Consideration – this must form an integral part of the decision-making process. It is not a matter of box-ticking; it must be exercised in substance, with rigour and with an open mind in such a way that it influences the final decision.
Timeliness – compliance begins at the beginning of the decision process – not once the decision has been made. Retro fitting impact assessments is not acceptable.
Review – the duty continues to apply not only when a policy is developed and decided upon, but also when it is implemented and reviewed.

Impact Assessment Process

The above means that we need to: -

1. Consider equality in the development of any policy or practice referring to the 'areas for consideration' noted at Appendix A and using a proportionality and relevance test (see Stage 1 and Appendix B).
2. Should there be relevant potential equality impact, note which protected characteristic or area for consideration is impacted (from the lists in Appendix A) and engage and consult with relevant stakeholder groups to ensure we have the evidence and information we need to fully assess the impact and put in place relevant mitigation measures. Findings and actions should be summarised and shared as part of the policy or practice proposal. As part of this stage, you should identify any performance measures that will be incorporated into routine reporting to ensure the impact is as anticipated over time and set a date to review the policy or decision (see Stage 2 and Appendix C)
3. Publish the Summary of findings from the Integrated Impact Assessment on the dedicated page on ACHSCP's website.(see Stage 3)
4. Regularly review the policy or decision, reporting on any key performance indicators identified and re-visiting the policy or decision if the evidence indicates that it has had a more significant or detrimental impact than originally envisaged. (See Stage 4 and Appendix D)

Stage 1 – Proportionality and Relevance

The principle of proportionality is at the heart of many human rights claims as any restrictions must be a "proportionate means of achieving a legitimate aim". Consider the aim to be achieved by the policy or practice, and whether or not it is a legitimate aim. Then consider the means which are used to achieve that aim. Are they appropriate and necessary? Proportionality is often most clearly explained through the expression *"don't use a sledgehammer to crack a nut".*

Policies or practice can have positive, negative or no impacts.

- A positive impact would demonstrate the benefit the policy or decision could have for a population group, how it advances equality, fosters good relations, contributes to tackling health inequalities or upholds human rights.
- A negative impact would mean that a population group is at risk of being disadvantaged by the policy, there is a risk of breaching the human rights of people or the requirements of the PSED, or that there is a risk of widening health inequalities.
- If you find that the policy or decision will have no impacts for groups, you do not need to record this information.

At this initial screening stage, the aim is to try to assess whether these could be an obvious negative or adverse impact. If one has been identified (actual or potential) a full Integrated Impact Assessment must be undertaken. If none are arising from the proposal it is not necessary to undertake a full impact assessment. Any positive impacts should be recorded on the Proportionality and Relevance Template regardless of whether a full impact assessment will be carried out or not.

In general, the following questions all feed into whether an Integrated Impact Assessment is required:

- How many people is the proposal likely to affect?
- How significant is its impact?

- Does it relate to an area where there are known inequalities?
- Why are a person's rights being restricted?
- What is the problem being addressed by the restriction on someone's rights?
- Will the restriction lead to a reduction in the problem?
- Does that restriction involve a blanket policy, or does it allow for different cases to be treated differently?
- Are there existing safeguards that mitigate the restriction?

See Appendix B for the template to be used to undertake the Proportionality and Relevance Test.

Stage 2 – Impact Assess

The first step in the impact assessment process is to identify, from the list of Areas for Consideration at Appendix A, which may be impacted negatively from the policy or practice. If you have any evidence that confirms this impact that should be recorded whether that is quantitative data or qualitative information from previous engagement or consultation. You need to also consider cumulative impacts that may arise if this latest policy or practice, added to others that are existing or planned, will have an impact that may not have been the case if it was just this policy or practice that was being introduced.

Next you need to consider which groups of people you still require to consult or engage with and how that will be done. Following engagement and/or consultation you need to record the feedback from each group and also how this was used to inform policy or practice development. There may be multiple entries of this stage as you go back and check out any changes that have been made – each needs to be recorded separately.

Finally you should complete the Summary page at the front of the Impact Assessment confirming that you have considered all of the required areas (in Appendix A) and detailing the key information that you gathered in terms of the groups or rights impacted and what adjustments were made as a result of your engagement and consultation. You must also identify any performance measure that will be used to monitor the impact over time and confirm how and when these will be reported and monitored. You should also identify a review date and confirm the rationale for setting that timescale. This may be based on the length of time the policy is in force or be linked to risk where the higher the risk the shorter the review timescale should be. See Appendix C for the template to be used for Impact Assessment.

Stage 3 - Publish

Impact Assessments should be published where you would expect to find IJB information and where members of the public and other interested parties can easily find and view them. In the case of IJB Impact Assessments, this will be the dedicated Equalities page on the ACHSCP website. When publishing you must consider how the Impact Assessment is named. This should be something people will recognise easily, and which can be found using a simple search function.

Stage 4 - Review

Having set a date for review, schedule this so it is not forgotten. If the KPIs indicate the negative impact is greater than originally envisaged consider undertaking an earlier review of the policy or practice and identifying what adjustments could be made to address this. See Appendix D for the Review Template.

Support for Compliance with PSED

The responsibility for compliance with PSED is delegated to the Lead for Strategy and Transformation who is supported by both the Transformation Programme Manager (Strategy and Infrastructure) and the Senior Project Manager (Strategy).

The Equality and Human Rights (EHR) Group is a sub group of the Strategic Planning Group and consist of representatives of minority and seldom heard groups in Aberdeen covering the range of protected characteristics. The group can assist in the development of Impact Assessments by facilitating access to groups they represent and/or undertaking consultation and engagement on our behalf. They also keep ACHSCP up to date with relevant updates or particular concerns emerging.

A DiverCity Officers Group has been constituted which has representatives from each service within ACHSCP. The group support each other in the development of Impact Assessments through sharing knowledge, expertise and good practice, building a bank of exemplar Impact Assessments to assist others.

Accountability and Governance

Ultimately our compliance with the PSED is monitored by the Equality and Human Rights Commission (EHRC) in Scotland who liaise with nominated representatives and provide advice and guidance in improving our compliance. There is an IJB Equality Peer Support Group where IJB representative across Scotland share best practice and learning. The Equality and Human Rights Group review progress against our duty on a quarterly basis, cross referencing the Business Planner of the IJB and its Committees and ensuring that Impact Assessments are carried out where relevant and reviewing the quality of those produced.

Areas for Consideration of Impact **APPENDIX A**

Protected Characteristics

Age: older people; middle years; early years; children and young people.
Disability: physical impairments; learning disability; sensory impairment; mental health conditions; long-term medical conditions.
Gender Reassignment: people undergoing gender reassignment
Marriage & Civil Partnership: people who are married, unmarried or in a civil partnership.
Pregnancy and Maternity: women before and after childbirth; breastfeeding.
Race and ethnicity: minority ethnic people; non-English speakers; gypsies/travellers; migrant workers.
Religion and belief: people with different religions or beliefs, or none.
Sex: men; women; experience of gender-based violence.
Sexual orientation: lesbian; gay; bisexual; heterosexual.

Fairer Scotland Duty

Low income – those who cannot afford regular bills, food, clothing payments
Low Wealth – those who can meet basic living costs but have no savings for unexpected spend or provision for the future.
Material Deprivation – those who cannot access basic goods and services, unable to repair/replace broken electrical goods, heat their homes or access to leisure or hobbies
Area of Deprivation/Communities of Place - consider where people live and where they work (accessibility and cost of transport)
Socio-Economic Background - social class, parents' education, employment, income.

Health Inequality (those not already covered in the Fairer Scotland Duty)

Low literacy / Health Literacy includes poor understanding of health and health services (health literacy) as well as poor written language skills.
Discrimination/stigma – negative attitudes or treatment based on stereotyping. Discrimination can be direct or indirect and includes harassment and victimisation.
Health and Social Care Service Provision - availability, and quality/affordability and the ability to navigate accessing these.
Physical environment and local opportunities - availability and accessibility of housing, transport, healthy food, leisure activities, green spaces, air quality and housing/living conditions, exposure to pollutants, safety of neighbourhoods, exposure to crime, transmission of infection, tobacco, alcohol and substance use.
Education and learning - availability and accessibility to quality education, affordability of further education, Early Years development, readiness for school, literacy and numeracy levels, qualifications.

Other

Looked after (incl. accommodated) children and young people
Carers: paid/unpaid, family members.
Homelessness: people on the street; staying temporarily with friends/family; in hostels, B&Bs.
Involvement in the criminal justice system: offenders in prison/on probation, ex-offenders.
Addictions and substance misuse
Refugees and asylum seekers
Staff: full/part time; voluntary; delivering/accessing services.

Human Rights (note only the relevant ones are included below)

Article 2 – The right to no discrimination – not to be treated in a different way compared with someone else in a similar situation. Indirect discrimination happens when someone is treated in the same way as others that does not take into account that person's different situation. An action or decision will only be considered discriminatory if the distinction in treatment cannot be reasonably and objectively justified.
Article 3 - The right to life (absolute right) – everyone has the right to life, liberty and security of person which includes access to basic necessities and protection from risks to their life from self or others.
Article 5 - The right not to be tortured or treated in an inhuman or degrading way (absolute right) which includes anything that causes fear, humiliation intense physical or mental suffering or anguish.
Article 9 - The right to liberty (limited right) – and not to be deprived of that liberty in an arbitrary fashion.
Article 10 - The right to a fair trial (limited right) – including the right to be heard and offered effective participation in any proceedings.
Article 12 - The right to respect for private and family life, home and correspondence (qualified right) – including the right to personal choice, accessible information and communication, and participation in decision-making (taking into account the legal capacity for decision-making).
Article 18 - The right to freedom of thought, belief and religion (qualified right) including conduct central to beliefs (such as worship, appropriate diet, dress etc.)
Article 19 - The right to freedom of expression (qualified right) – to hold and express opinions, received/impart information and ideas without interference

UNCRC

Article 2 non-discrimination	**Article 15** freedom of association	**Article 30** children from minority or indigenous groups
Article 3 best interests of the child	**Article 16** right to privacy	**Article 31** leisure, play and culture
Article 4 implementation of the convention	**Article 17** access to information from the media	**Article 32** child labour
Article 5 parental guidance and a child's evolving capacities	**Article 18** parental responsibilities and state assistance	**Article 33** drug abuse
Article 6 life, survival and development	**Article 19** protection from violence, abuse and neglect	**Article 34** sexual exploitation
Article 7 Birth, registration, name, nationality, care	**Article 20** children unable to live with their family	**Article 35** abduction, sale and trafficking
Article 8 protection and preservation of identity	**Article 22** refugee children	**Article 36** other forms of exploitation
Article 9 separation from parents	**Article 23** children with a disability	**Article 37** inhumane treatment and detention
Article 10 family reunification	**Article 24** health and health services	**Article 38** war and armed conflicts
Article 11 abduction and non-return of children	**Article 25** review of treatment in care	**Article 39** recovery from trauma and reintegration
Article 12 respect for the views of the child	**Article 26** Benefit from social security	**Article 40** juvenile justice
Article 13 freedom of expression	**Article 27** adequate standard of living	**Article 42** knowledge of rights
Article 14 freedom of thought, belief and religion	**Article 28** right to education	

APPENDIX B

ACHSCP Impact Assessment – Stage 1 – Proportionality and Relevance

Name of Policy or Practice being developed	
Name of Officer completing Proportionality and Relevance Questionnaire	
Date of Completion	
What is the aim to be achieved by the policy or practice and is it legitimate?	
What are the means to be used to achieve the aim and are they appropriate and necessary?	
If the policy or practice has a neutral or positive impact please describe it here.	
Is an Integrated Impact Assessment required for this policy or decision (Yes/No)	
Rationale for Decision **NB: consider: -** • **How many people is the proposal likely to affect?** • **Have any obvious negative impacts been identified?** • **How significant are these impacts?** • **Do they relate to an area where there are known inequalities?** • **Why are a person's rights being restricted?** • **What is the problem being addressed and will the restriction lead to a reduction in the problem?** • **Does the restriction involve a blanket policy, or does it allow for different cases to be treated differently?** • **Are there existing safeguards that mitigate the restriction?**	
Decision of Reviewer	
Name of Reviewer	
Date	

APPENDIX C

ACHSCP Impact Assessment – Stage 2 – Impact Assessment

Description of Policy or Practice being developed including intended aim.	
Is this a new or existing policy or practice?	
Name of Officer Completing Impact Assessment	
Date Impact Assessment Started	
Name of Lead Officer	
Date Impact Assessment approved	

Summary of Key Information

Groups or rights impacted.	
Feedback from consultation and engagement and how this informed development of the policy or practice	
Performance Measures identified, where these will be reported and how impact will be monitored.	

Review

Date the Impact will be reviewed	
Rationale for Date	

Having considered all of the groups, duties and rights in the list at Appendix A of the Guidance on Impact Assessment could this policy or practice have a negative impact on any of the following. Please answer Yes or No. If you answer Yes, please specify precisely which particular group, duty or right will be impacted and how and also what (if any) current evidence you have.

	Yes/No	Details	Evidence
Protected Characteristics			
Fairer Scotland Duty			
Health Inequality			
Other Groups			
Human Rights			
UNCRC			

Will there be any cumulative impacts between this policy or decision and others	**Yes**		**No**	
Describe what this cumulative impact will be and include evidence mitigations in the sections below				

Please list below the groups of stakeholders to be engaged with or consulted, what feedback has been received and how this has influenced development of the policy or practice and what (if any) mitigating actions have been put in place.

Stakeholder Groups	Feedback Received	Influence on Policy or Practice/Mitigating Actions

Scottish Specific Public Sector Duties (SSPSED)

Procured, Tendered or Commissioned Services

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?

APPENDIX D

ACHSCP Impact Assessment – Stage 4 – Review

Name of Impact Assessment being reviewed	
Name of Officer completing review	
Date Review Commenced	
Reason for Review (scheduled or accelerated)	
Reason for Accelerated Review	
Name of Lead Officer	
Date Review Completed	

Summary of Key Information

What amendments have been identified to the original Impact Assessment?	
What evidence do you have for these amendments?	
What actions have you taken to review the policy or practice in light of the review?	

Having considered all of the groups, duties and rights in the list at Appendix A of the Guidance on Impact Assessment has the impact of this policy or practice changed from the original assessment? Please answer Yes or No. If you answer Yes, please specify precisely what change has occurred and which particular group, duty or right it affects and how and also what (if any) current evidence you have.

	Yes/No	Details	Evidence
Protected Characteristics			
Fairer Scotland Duty			
Health Inequality			
Other Groups			
Human Rights			
UNCRC			

Will there be any cumulative impacts between this policy or decision and others	**Yes**		**No**	
Describe what this cumulative impact will be and include evidence mitigations in the sections below				

Please list below the groups of stakeholders to be engaged with or consulted, what feedback has been received and how this has influenced development of the policy or practice and what (if any) mitigating actions have been put in place in light of the changes identified above.

Stakeholder Groups	Feedback Received	Influence on Policy or Practice/Mitigating Actions

ACHSCP Equality Outcomes (Revised March 2023) – all to be delivered by 30th April 2025

Equality Outcome 1:	People with both mental and physical disabilities have improved experiences of care.
Link to General Duty:	Eliminate discrimination and advance equality of opportunity
Evidence:	Out of Area Placements, Complex Care Delayed Discharges

Action	**Measure**	**Lead**
Review availability of the range of independent advocacy and implement any recommendations from the review	Services re-commissioned	Commissioning
Develop and deliver local and sustainable system flow and return to home pathways with partners, supporting reduced hospital admission, delays in hospital discharge and out of area placements	Out of Area Placements, Delayed Discharges	Home Pathways
Help people to ensure their current homes meet their needs including enabling adaptations	DAG Stats	Strategy and Transformation
Work with Children's Social Work and health services, to predict and plan for future Complex Care demand including developing and implementing a Transition Plan using the GIRFE multi-agency approach for those transitioning between children and adult social care services, initially for Learning Disabilities	Transition Plan Developed	Community MHLD
Undertake and implement a strategic review of the Neuro Rehabilitation Pathway	Review Complete and Implemented	AHP and Rehabilitation
Develop a Mental Health triage approach in Primary Care to improve patient experience and promote self-management	Patient Experience Surveys	Community MHLD
Further development of the Autism Assessment service and expansion to include neurodevelopmental assessment	Service Developed	Community MHLD
Develop and implement approaches to support Suicide Prevention and alignment to national Suicide Prevention Strategy	Suicide Rates	Community MHLD

Equality Outcome 2:	Older people receive the right care, in the right place, at the right time.
Link to General Duty:	Eliminate discrimination and advance equality of opportunity
Evidence:	Frailty Pathway and SWSC Stats

Action	**Measure**	**Lead**
Deliver the second phase of the Frailty pathway and undertake a review of implementation to date to identify further improvements to be incorporated into the programme plan.	ED & AMIA Waits for 102, 102 Boarders, Delayed Discharges H@H beds and usage	Nursing
Continue to deliver our Stay Well Stay Connected programme of holistic community health interventions focusing on the prevention agenda.	SWSC Stats	Strategy and Transformation
Explore ways we can help people access and use digital systems	SWSC Stats, Feedback from PC Group	Strategy and Transformation
Co-design Aberdeen as an Age Friendly City which supports and nurtures people to get ready for their best retirement and promotes the development of a social movement to encourage citizens to stay well and stay connected within their communities.	Attendance at conference, (other measures to be added later after outcome from conference are known)	Commissioning

Equality Outcome 3:	All residents of Aberdeen have equal access to health and care services.
Link to General Duty:	Eliminate discrimination and advance equality of opportunity
Evidence:	

Action	**Measure**	**Lead**
Undertake a strategic review of specific social care pathways utilising the GIRFE multi-agency approach where relevant and develop an implementation plan for improving accessibility and coordination.	Review complete and implemented	Chief Social Worker
Review Care for People arrangements	Review complete and implemented	Business Support, Communications and Contingency
Improve primary care stability by creating capacity for general practice	Sustainability Ratings (particularly for those practices in areas of deprivation)	Primary Care
Ensure all sections of the population have access to Vaccinations	Number Vaccinated in minority and hard to reach groups	Chief Nurse
Deliver the strategic intent for the Primary Care Improvement Plan (PCIP) including specifically arrangements for Refugees and Asylum Seekers and Homeless people	Quantification of Service delivered to Refugees and Asylum Seekers and Homeless people	Primary Care
Monitor and evaluate the impact of the Carers Strategy on an ongoing basis factoring in early preparations for the next revision	Progress reports on delivery of the Carers Strategy Action Plan	Strategy and Transformation

Equality Outcome 4:	The top preventable risk factors are tackled particularly in areas of deprivation (those experiencing inequality)
Link to General Duty:	Eliminate discrimination and stigma, advance equality of opportunity
Evidence:	Deaths from Drugs and Alcohol, Obesity Measures, Life Expectancy (by SIMD), Trauma Informed Training and Initiatives

Action	**Measure**	**Lead**
Reduce the use and harm from alcohol and other drugs including through the Drugs Related Deaths Rapid Response Plan	Deaths from Drugs and Alcohol	Alcohol and Drugs Partnership
Deliver actions to meet the HIS Sexual Health Standards	Compliance with Standards	Sexual Health Services
Continue the promotion of active lives initiatives with our partners, for example the Physical Activity Academy, Active Travel etc.	Obesity Measures, Life Expectancy (by SIMD)	Strategy and Transformation
Reduce smoking prevalence across population and prevent e-cigarette and emerging tobacco produce use among young people.	Smoking Cessation Statistics	Strategy and Transformation
Ensure our Workforce are Trauma Informed	Training Undertaken and Initiatives delivered	Lead for People and Organisation

Equality Outcome 5:	Service design and delivery is informed by the diversity of experience within Aberdeen communities.
Link to General Duty:	Advancing equality of opportunity and fostering good relations
Evidence:	Stats on numbers and the diversity of groups involved in various consultation exercises

Action	**Measure**	**Lead**
Data/Evidence		
Develop the membership and diversity of our Locality Empowerment Groups	Diversity Data of LEG membership	Strategy and Transformation
Increase community involvement through existing networks and channels	Community Involvement Statistics	Strategy and Transformation
Update of Our Guidance for Public Engagement and ensure its use is embedded	Staff Awareness and Training	Strategy and Transformation
Promote the use of Care Opinion to encourage patients, clients, carers and service users to share experiences of services, further informing choice.	Care Opinion Stories posted	Strategy and Transformation
Develop and deliver the Procurement Workplan incorporating our commissioning principles so that our commissioning is ethical, creative and co-designed and co-produced with partners and communities.	No. of co-designed commissioning undertaken	Commissioning

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Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGATION JOINT BOARD

Date of Meeting	25 April 2023
Report Title	Hosted Services
Report Number	HSCP23.025
Lead Officer	Sandra Macleod Chief Officer
Report Author Details	Alison Macleod Strategy and Transformation Lead
Consultation Checklist Completed	Yes
Appendices	**Appendix A** – Mental Health and Learning Disability Inpatient and Specialist Services. **Appendix B** – Specialist Older Adults and Rehabilitation Services **Appendix C** – Sexual Health Services **Appendix D** – Aberdeenshire Hosted Services **Appendix E** – GMED Hosted Services Report **Appendix F** – Primary Care Contracts Team Hosted Services Report

1. Purpose of the Report

1.1. To update the Integration Joint Board (IJB) on the performance of Hosted Services across Grampian.

2. Recommendations

2.1. It is recommended that the Integration Joint Board notes the performance information in relation to the Hosted Services contained in Appendices A to E.

INTEGATION JOINT BOARD

3. Summary of Key Information

3.1. There are 12 Hosted Services across the Grampian area ranging in size and complexity. The table below lists these along with the host and approximate budget to give an indication of scale only.

Service	Host	Budget (£M)
Inpatient & Specialist MHLD Services	City	40
Specialist Older Adult Assessment & Rehab Services (SOARS)	City	23
GMED	Moray	11
HMP Grampian	Shire	3
Sexual Health Services	City	2
Police Custody / Forensic Examiners	Shire	2
Retinal Screening / Diabetes MCN	Shire	1.0
Marie Curie Nursing	Shire	0.8
Continence Service	Shire	0.7
Primary Care Contracts	Moray	0.6
Heart Failure Service	Shire	0.3
Chronic Oedema Service	Shire	0.3
TOTAL		**85**

3.2. Three of the 12 services make up approximately 87% of the total budget, two of these are hosted by Aberdeen City. In terms of budget, the three Aberdeen City hosted services account for over three quarters.

3.3. The Integration Schemes of all three IJBs set out that, for hosted services, each individual Board retains strategic responsibility for the service. The hosting IJB has operational responsibility. Each IJB contributes a share of the funding for delivery of the service.

3.4. The North East Strategic Partnership Group (NESPG) commissioned work to consider how the visibility and accountability of the performance of Hosted Services in Grampian could be improved. The outcome of that is that it was agreed that performance monitoring should be proportionate and not place undue burdens on the services. As such, Service Level Agreements (SLAs) are to be developed for the nine smaller services (under £3 million) and the

three larger services will report directly to NESPG. A common template for the SLAs will be agreed between the Health and Social Care Partnerships and the completed SLAs will be submitted for approval to all of the IJBs with annul performance reporting against them and again, these will be submitted to each of the IJBs.

3.5. Work on developing the SLAs has not progressed as anticipated due to the services experiencing pressure in recent months but it is hoped that this can be revisited over the coming months. In the meantime, it was agreed that performance updates be submitted to all IJBs for all of the Hosted Services, and these are contained in appendices A to F of this report. IJB is asked to note these.

4. Implications for IJB

4.1. Equalities, Fairer Scotland and Health Inequality

There are no Equalities, Fairer Scotland or health Inequality implications arising from this report as it is presenting performance information. Should that information be used to change service provision in future an impact assessment will be undertaken at that point.

4.2. Financial

There are no direct financial implications arising from this report as it is presenting performance information. The performance monitoring process could prompt discussions around financing the Hosted Services, but any changes would be subject of a separate report.

4.3. Workforce

There are no direct workforce implications arising from this report as it is presenting performance information. The performance monitoring process could prompt discussions around workforce within Hosted Services, but any changes would be subject of a separate report.

4.4. Legal

There are no legal implications arising from this report.

4.5 Unpaid Carers

People cared for by Unpaid Carers may receive some of the services referred to in the Appendices to this report and the performance information may be of interest to them.

5. Links to ACHSCP Strategic Plan

5.1. Hosted Services contribute to the delivery of the Strategic Plans of all three Health and Social Care partnerships in the Grampian areas as well as to NHS Grampian's Plan for the Future.

6. Management of Risk

6.1. Identified risks(s)

There is a risk that hosted services do not deliver the expected outcomes and/or fail to deliver value for money in terms of the contribution made by Aberdeen City IJB.

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

This report links to Strategic Risk 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.

This risk is currently sitting at High.

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

This report provides visibility to performance information in relation to Hosted Services which IJB can consider and instruct any action they feel is necessary to provide any further assurance required.

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HEALTH & SOCIAL CARE PARTNERSHIPS - HOSTED SERVICES OVERVIEW

NAME OF SERVICE: Mental Health and Learning Disability Inpatient and Specialist Services.

HOST HSCP: Aberdeen City

SERVICE OVERVIEW

Please provide a brief overview of the service.

Royal Cornhill Hospital (RCH) is an in-patient Mental Health and Learning Disability service organised to ensure that those requiring longer term assessment and care, for example patients with dementia, are cared for as close to home as possible with units based in a number of community hospital sites.

Specialist Acute Mental Health assessment units are located at RCH and at Dr Gray's Hospital (DGH) in Elgin with all other specialist in patient services, for example Forensic Psychiatry and those with severe Learning Disabilities provided at RCH.

In addition to the hospital-based services, two in-patient units exist at Polmuir Road and Great Western Lodge in Aberdeen City to provide stepped rehabilitation. The hospital provides services for the whole of Grampian, Orkney, Shetland, and the Ministry of Defence and have a regional Eating Disorders Unit (Eden Unit) serving the North of Scotland.

The disposition and function of all in-patient Mental Health Units is summarised in Figure 1 and 1a below. Whilst the wards contained in Figure 1 do not form part of the Hosted Service, they do form part of the pathway for patients who have been admitted to Royal Cornhill Hospital. Patients may go to one of these Aberdeenshire Units if they live close by, to ensure patient centred care is delivered close to home.

Figure 1 NHS Grampian In-Patient Mental Health services November 2022

Location	Ward	No. of Beds	Type of service
Seafield Hospital Buckie	Muirton	8	Dementia assessment
Fraserburgh Hospital	Brucklay	12	Dementia assessment
Bennachie View Care Home, Inverurie	Ashcroft	10	Dementia assessment
Glen O'Dee Hospital, Banchory	Scolty	12	Dementia assessment
Dr Gray's Hospital, Elgin	Ward 4	18	Acute Mental Health Assessment

Figure 1a NHS Grampian In-Patient Mental Health services November 2022

Location	Ward	No. of Beds	Type of service
RCH, Aberdeen	Dunnottar	21	Adult Mental Health Admission Ward
RCH, Aberdeen	Fraser	21	Adult Mental Health Admission Ward
RCH, Aberdeen	Huntly	21	Adult Mental Health Admission Ward
RCH, Aberdeen	Fyvie	21	Older Adult/Adult Mental Healt Admission Ward
RCH, Aberdeen	Drum	21	Older Adult - Functional
RCH, Aberdeen	Skene	17	Older Adult - Dementia
RCH, Aberdeen	Brodie	10	Acquired Brain Injury Unit
RCH, Aberdeen	Corgarff	16	Rehabilitation
RCH, Aberdeen	Strathbeg	8	Learning Disability – close supervision unit (Forensic)
RCH, Aberdeen	Loirston	5	Learning Disability - admission

RCH, Aberdeen	Eden	10	Eating Disorders Unit	
RCH, Aberdeen	Blair Unit	8	Intensive Psychiatric Care Unit	
RCH, Aberdeen	Blair Unit	8	Low Secure Forensic Acute	
RCH, Aberdeen	Blair Unit	16	Low Secure Forensic Rehabilitation	
RCH, Aberdeen	Muick	21	Older Adult Ward	
RCH Aberdeen	Davan	21	Older Adult Ward	
Great Western Lodge		8	Rehabilitation Forensic Pathway	
Polmuir Road		10	Rehabilitation – Adult Mental Health Pathway (5x2 bedroom flats)	

ACTIVITY

Child and Adolescent Mental Health Service (CAMHS)

It has been a very successful year for our CAMHS service with the following work being progressed:

- CAMHS Grampian continues to meet the 90% Scottish National Waiting Time Standard
- Roll out of Enhanced Psychology Practitioner posts National Education for Scotland (NES) funded, also in Adult Mental Health to be aligned with early intervention within the three Health and Social Care Partnerships.
- Test of change site for two Silver cloud Cognitive Behavioural Therapist (CBT) programmes for those patients who may not need to be seen by CAMHS or who are waiting.
- Roll out of Trakcare to enhance reporting on waiting times and in preparation for electronic patient record.
- Creation of Dialectical behaviour therapy (DBT) team and roll out of DBT training.
- Roll out of Distress Brief Interventions (DBI) in particular areas.
- Therapeutic garden development at Links Unit
- Hosted the CAMHS Connection event which was a multi-agency networking event.
- Workforce wellbeing initiatives
- Brief Behavioural Activation pilot for people waiting to be seen by CAMHS.
- Roll out of Functional Assessment of the Care Environment (FACE) Caras risk assessment tool.
- Providing Multi-agency training - opening up our (Continued Professional Development) CPD programme to our partners.
- Part of the Health and Wellbeing collaborative - Aberdeen City

- Joint posts with Local Authority (FitLike Hubs, Psychology posts in Shire for 'The Promise').
- Social Work student placements embedded within CAMHS - pilot of this.
- Neurodevelopmental test of change in Aberdeen City, which is developing innovative solutions to accessing Neurodevelopmental assessments and diagnosis.
- Pilot for VCreate, which is secure video technology that connects patients/families and clinical teams for improved diagnostic management and enhanced family-focused care.
- Creation of a CAMHS Grampian Website

Transformation

Transformation work has commenced again following a delay due to the Covid-19 response and subsequent remobilisation. The work will be done in line with the Grampian Wide Strategic Framework for a future proof, Sustainable Mental Health and Learning Disability Service (April 2020-April 2025) document. The first workshop with a range of stakeholders present was held on the 5th December with the rest planned for early 2023 looking at what the priorities are for the Mental Health and Learning Disability Service as a whole and how change can be facilitated.

Ligature Reduction Work

In June 2017, following an incident at RCH and a subsequent inspection visit, the HSE issued NHS Grampian with an improvement notice which stipulated: "You have failed to ensure that the risks to the safety of patients receiving care at RCH who have been assessed as being at risk of self-harm or suicide have been reduced to as low as reasonably practicable in that you have failed to remove or adequately control environmental ligature risks within the private and communal areas of the wards. The work on the six wards at RCH is now substantially complete with occupation of the final two wards delayed due to a legacy water quality issue. Remedial work that was anticipated would sort the issue, has failed to do that and the service is unable to open the wards as anticipated. Work is ongoing to identify further solutions.

In May 2019, the HSE issued a further Notice of Contravention requiring the Board to demonstrate action to remove potential ligature points from other inpatient areas of accommodation where there is the potential of high-risk patients being accommodated. Accordingly, the Board approved a further programme of non-invasive ligature reduction measures in the Intensive Psychiatric Care Unit, Crathes, Drum, Bracken, Muick, Skene, Eden and Forensic Acute Wards. The work included replacement of beds, with the bespoke designed ligature reduction beds, replacement of hardware, e.g., door handles, locks, lamps, vents and other fittings with ligature reduction products and the sealing of frames, light switches, mirrors etc. with anti-pick sealant. This programme completed in March 2022.

The programme explained above has required £16m of investment to date.

Work has been completed on the final 2 wards; however, the service has been unable to open these wards following IP&C advice. This is due to water issues i.e., raised TVC's (Total Variable Counts) and water temperatures.

Ward 4 Dr Gray's Hospital

A formal programme governance structure has now been agreed to progress the ligature reduction works for Ward 4 at Dr Gray's Hospital, the remaining high risk ligature environment. A service solution to vacate the facility is still pending, and there is now sufficient confidence that a workable solution can be achieved and that a formal project governance structure is now in place with a view to preparing a business case for consideration and approval by the Board in the near future. There are obvious dependencies between this project and the planned MRI development at Dr Gray's Hospital and the programme management structure has been created to ensure the two projects are properly integrated.

Scolty Ward

RCH has been under increased pressure due to the closure of Scolty Ward for operational reasons. Scolty Ward is a 12 bedded Dementia Unit located in Glen O' Dee Hospital and does not form part of the Hosted service although it does form part of a pathway for the Older Adult patients who have a diagnosis of dementia and who may have been/or are an inpatient in Royal Cornhill Hospital. This ward was closed in October 22 for at least 6 months, with some of the patients moving to Morven Ward. Patients with more complex needs have been absorbed into the other 2 dementia units in Aberdeenshire, however this is also creating additional pressures on the Royal Cornhill Site.

CHALLENGES

Flow and Acuity

We have seen an increase in patient acuity with around 60% of our patients detained under the Mental Health Act. This has been due to a number of factors; lockdowns due to Covid-19 pandemic saw people isolated and not seeking support with mental health issues, the community teams supporting unwell patients out in the community as there is no capacity in the hospital to admit in a timely fashion and the change in the way clinicians worked i.e., no face-to-face appointments has been challenging for a variety of patients.

This has led to longer patient stays with our average length of stay 34.8 days in our acute adult admitting wards and 69.4 days in our Older Adult Wards. This gives us challenges in RCH regarding flow into the hospital, but it also causes challenge for colleagues in the community who cannot admit patients in a timely manner.

Workforce

RCH continues to have significant workforce challenges in regard to the recruitment and retention of registered staff; Nursing, AHP's and Medical. Appreciating the challenging nature of the work means that the service ensures there is a functioning Staff Partnership meeting every month and a Healthy Working lives group that meets monthly and highlights initiatives staff may want to take part in to improve wellbeing at work. For example, encouraging staff to take a walk round the site at lunchtime using one of the recognised routes.

Nursing: We have recently had our new graduate nurses' start and the NGNs were able to gain employment in the areas they selected. However, this was challenging this year by many students having to make up training time due to the pandemic interfering with their training. This meant that some failed exams or the course. Projected workforce plans had to be amended due to this.
A positive was the upgrade of the Band 2 HCSW to Band 3 due to the level of training specifically PMVA. It is hoped that this may help sustain the HCSW workforce, which is difficult to maintain, and we are with the service currently seeing a lack of suitable candidates.
A return to practice advert for Mental Health and Learning Disability Service has attracted some applicants, unfortunately none to the inpatient services as yet. Exploration of the Open University route into Mental Health Nursing is being encouraged for staff who would like to apply but do not have the academic grades for RGU.

Medical: In 2021 Grampian Mental Health and LD services launched the first ever sponsored CESR (Certificate of Eligibility for Specialist Registration) Fellowship in Scotland. The programme provides access to a sponsored route for GMC registration for international Psychiatrists keen to gain experience and work in Scotland. These doctors hold an international postgraduate qualification in Psychiatry and have extensive experience of working in mental health. The three-year programme provides valuable experience in a specific specialism in Psychiatry and facilitates experience in a variety of specialisms and other non-clinical experience needed for a successful CESR application. Our first CESR fellowship programme was advertised in January 2022 and received a high number of international applications. The GMC regulations around sponsorship and further visa delays due to global factors impacted the start dates for the fellows, but in September 2022 we welcomed 5 CESR fellows in General Adult Psychiatry in Grampian. We have further expanded the CESR fellowship to include CESR in OAMHS (Older Adult Mental Health) from 2023, and we are looking forward to a second round of recruitment by the end of 2022.

Allied Health Professionals: All disciplines apart from Speech & Language Therapy within in-patients hosted services (Dietetics, Physiotherapy and Occupational Therapy) have experienced some extended vacancy periods and levels of turnover in all grades of staffing, the same is being seen in the community and services are often pursuing the same staff.

Dietetics had Band 6 & 7 movement over the summer, this settled but notice has been received so further movement is imminent. For such a small team of 6 staff covering Eden Unit and the rest of mental health services any staff turnover is significant.
Physiotherapy has had maternity cover and their usual staff rotation with vacancies earlier in the year and over the summer, currently in an improved position. A band 6 post continues to be vacant; these posts are challenging to fill across a range of services.
Occupational Therapy in all areas has had a range of short- and longer-term vacancies with some posts now awaiting new incumbents but lengthy gaps meaning interim arrangements having to be put in place which spreads the strain further on existing staff.
Eden, Adult Mental Health, Older Adult Mental Health, Blair Unit and Learning Disabilities have all had a range of graded vacant posts throughout the year with a lot of work to redesign and skill mix to find the best options for filling posts and delivering services. Some posts remain unfilled despite recurrent advertising.

Along with the Band 4 Wellbeing and Enablement Practitioner work ongoing, services are redesigning to enable the sustainability of same. An example of this is the Occupational Therapy service looking to appoint to a dual role covering adult services and specialisms (specifically the forensic service).

Infrastructure

Although ageing, compared with other critical parts of the Board's physical estate, the accommodation occupied by our Mental Health in-patient services is in a relatively good physical condition. Like all parts of our estate there is a requirement for backlog maintenance to ensure the physical integrity and safety of the building and engineering infrastructure but in general terms the issues raised are not unusual and typically include:
Access to and maintenance of garden spaces,
Leaks in roof spaces,
Window repairs,
Repairs to sanitary facilities,
Decoration.

All regular maintenance issues are reported through the help desk facility managed by the Estates team who liaise with local management to review and prioritise all essential repairs. Where a matter requires substantial repair or significant investment in backlog or cyclical maintenance then this is risk assessed and prioritised against all other critical areas based on available funding and agreed through the Board's Asset Management Group. With the exception of some minor ongoing maintenance activity, there are currently no significant or high rated backlog maintenance risks associated with the building and engineering components of the accommodation.

Forensic Service

The *Barron Report*, an independent review of Forensic Services commissioned by the Scottish Government, was published is 2020. The report was particularly critical of the current dormitory style accommodation in NHS Grampian's Blair Unit "*the Review was*

disappointed to find people in one area were required to share rooms, including some in four bedded dormitory accommodation".

The report also highlights the general fabric of the building becoming a security risk as the condition deteriorates, a lack of dedicated female forensic beds, flow and privacy within the facility and a lack of en-suite provision as key issues.

Not-withstanding the recommendations arising from the *Barron Report* and the associated political pressure to make improvements, it should be recognised that a significant upgrade to the existing unit is unlikely to be feasible. The nature of the work will be invasive and will require vacant occupation of part or all of the facility during construction. Demand for the specialist services of the Blair Unit is very high and there is no other suitable facility that can be used to decant patients while we carry out the necessary works. The level of physical works that we can meaningfully deliver in the short term will therefore be restricted to only those elements that can be delivered with minimal impact and distress to the patients in situ.

We have commissioned an options appraisal to consider this and hope to be in a position to report back to the NHS Grampian Asset Management Group (AMG) with recommendations for a possible programme of deliverable short-term improvements by the end of December. To progress this work, we have recently agreed that the existing Ligature Reduction Programme Board (LRPB) which has overseen the highly successful programme of ligature reduction works in the Acute Mental Health Assessment wards, will now take responsibility for developing an improvement programme for the Blair Unit. This work will also include, in the longer term, the development of a business case for a new fit-for-purpose facility. Timing of this obviously would be dependent on the availability of capital funding from the Scottish Government.

Psychological Therapies

Extensive waits for Psychological Therapies (PT) within NHS Grampian have resulted in the Board receiving tailored support from the Scottish Government (SG) to create an improvement and development plan to understand and address issues. The Scottish Government mandates that waiting lists are reduced by March 2023. NHS Grampian has begun to engage with a process of improving performance, working alongside SG specialist advisors for mental health.

Historically, within NHS Grampian the landscape with regards to the provision of Psychological Therapies is heterogeneous and complex, with multiple distinct areas, teams and services. There is multi-professional delivery with varying Matrix level provision and different waits.

The Director of Psychology post has been vacant since early 2021, coinciding with the Covid-19 pandemic and huge associated pressures on Health and Social Care systems. In the absence of this post, there has been limited whole systems work focussed on PT planning and performance.

To ensure governance around Psychological Therapy waiting times there is an improvement board to support the delivery of an improvement plan. Assurance is given to the Hosted Senior Leadership team on progress of the improvement plan at the Hosted service monthly governance meeting which is chaired by the Chief Nurse. This then feeds into the Aberdeen City Clinical and Care Governance committee.

Audits

RCH has had an active 12 months in regard to Audit. We have a bi-monthly Quality Improvement and Audit meeting where the agenda is centred on the rolling programme of audits, audits completed and planned audits. We currently have 21 'live' audits ranging from quality of referrals to completion of Core Discharge Documents. Completed Audits are used to proactively improve service delivery.

Complaints

RCH has received 66 complaints from 01/01/2022 – 01/01/2023. 22 of these were directed to the CAMHS service, with the remainder (44) for the Hosted service. The below table offers further details:

Specialty	Number of Complaints	Early Resolution	Proceeded to Investigation
Acute Admission Wards	20	7	13 (1 upheld) (1 partially upheld) (5 not upheld) (6 ongoing responses).
Adult Liaison Psychiatry	3	1	2 (Upheld)
Clinical Psychology	1	0	1 (not upheld)
Eating Disorders	2	0	2 (ongoing)
Forensic Wards	6	3	3 (1 ongoing) (2 not upheld)
Long Stay Wards	1	0	1 (Partially upheld)
Older Adult Wards	2	0	2 (2 ongoing)
Gender Identity Clinic	6	2	4 (3 upheld) (1 ongoing)
Unscheduled Care	3	1	2 (not upheld)
CAMHS	22	6	16 (6 not upheld) (2 ongoing) (2 partially upheld) 5 (upheld) 1 (no consent)

Themes include waiting times for CAMHS and the Gender Identity Clinic, and disagreements with clinical staff on treatment options. We have had 0 complaints that have gone via the Ombudsman in 2022.

FINANCE

We are forecasting an overspend at year end of £1.25M which takes into account an increase in service usage over the winter period as well as the opening of the New Fyvie ward. The main causes of the overspend is a significant spend on Agency Nursing (£945K year to date) as well as an outstanding legacy target of £218K year to date (£326K for the year). This has been partly offset by an over-recovery in income of £462K related to Service Level Agreements with NHS Orkney and NHS Shetland.

The service is trying to identify 2% savings and are activity working on a savings plan however some costs are likely to increase i.e., use of agency staff.
The increased spend on Agency nursing is twofold. Firstly, the inability to recruit to nursing posts has meant that the service has often had to work below safe staffing numbers, this has meant increased pressure on the service to deliver safe and effective patient care. Secondly patient acuity in our forensic and Intensive Psychiatric Unit (IPCU) has meant that the service has had to request agency staff in order to maintain patient care and safety for staff and patients. Following the successful introduction of Band 4 Wellbeing and Enablement Practitioners into 3 of the ward areas, the service is looking to extend this into other ward areas. The practitioners undergo a 2-year course at the Robert Gordon University and are welcome additions to the wards.

HEALTH & SOCIAL CARE PARTNERSHIPS - HOSTED SERVICES OVERVIEW TEMPLATE

NAME OF SERVICE: Specialist Older Adults and Rehabilitation Services

HOST HSCP: Aberdeen City

SERVICE OVERVIEW

Specialist Rehabilitation services provide the following;

1. 4 specialist rehabilitation units (all at Woodend Hospital);
   - Neuro-Rehabilitation unit (12 beds); all Grampian residents
   - Stroke rehabilitation unit (28 beds); predominantly City and Shire, very rarely Moray
   - Ortho Rehabilitation Unit (20 beds); City and Shire only
   - Amputee rehabilitation unit (6 beds); all Grampian residents

2. Craig Court closed Dec 2022. A review of the neuro rehabilitation pathway is currently underway as part of the Delivery Plan and this will include recommendations regarding future provision of transitional living arrangements

3. Horizons Rehabilitation Centre; a one stop out-patient service for adults across Grampian with a neurological disability or impairment. The centre provides multi-professional input to support service users in managing their long-term condition and a focus on vocational rehabilitation where possible.

4. Mobility and Rehabilitation Services (MARS); provides Wheelchair and specialist seating services across Grampian and to the Northern Isles as well as Grampian-wide prosthetic and orthotic service (artificial limbs and splints).

5. Consultant in rehabilitation medicine – provide out-patient services; both general and sub-speciality - acquired brain injury, spinal cord injury, multiple sclerosis, amputee rehab, posture and movement (including baclofen pump implantation in conjunction with regional neuro-surgical service)

6. In-reach consultant rehabilitation medical and clinical leadership service to Major Trauma Centre

The Specialist Older Adults Service, including the Department of Medicine for the Elderly (DOME), provides (across City and Shire unless specified);

1. Acute geriatric service in ward 102, the Frailty Unit in Aberdeen Royal Infirmary – a 25 bedded assessment unit for older adults with decompensated frailty syndromes with full multi-disciplinary service model to enable rapid timely provision of comprehensive geriatric assessment.

2. Community geriatrician alignment; providing a variety of activity across Aberdeen city and Aberdeenshire such as GP practice visits for table-top discussion, community hospital ward rounds, out-patients clinics, consultant input to city specific Community Adult Assessment and Rehabilitation (CAARs) MDT

3. Sub-specialty OP service; movement disorders, Parkinsons, syncope

4. Liaison work in ARI (e.g. Consultant input to ARI wards following speciality referral, the, Discharge Hub, and Orthogeriatric ward rounds)

In addition, Rosewell House is a critical part of the Frailty pathway. It is a 40 bedded intermediate care integrated facility providing step-down and step-up care for 30 Aberdeen city residents. The remaining 10 beds are for temporary step-down from ward 102 for Aberdeenshire residents as part of the emerging frailty pathway model within the Aberdeenshire HSCP.

PERFORMANCE

This is an area requiring development and will be progressed during 2023/24. There have not been specific aims and targets set for this service as a whole however activity and performance are monitored within specific service areas. The service monthly finance meeting ensures a robust oversight of the financial performance. There is a need to review and agree the process to consider and manage cost pressures for hosted services.

ACTIVITY

Data can be provided if required. The full list of activity numbers would relate to;

1. Stroke Rehabilitation Unit
2. Ortho Rehabilitation Unit
3. Neuro-rehabilitation Unit
4. Prosthetic Amputee rehabilitation beds
5. Prosthetic service
6. Orthotics Service – split into three types of referral
7. Wheelchair service – split into three types of referral
8. Rehab Medical OP service – 5 sub-specialties
9. Horizons MDT service
10. Older Adults Rehabilitation service at Woodend
11. Continuing care/interim beds at Woodend
12. Ger med Medical OP service – 3 sub-specialties
13. Acute geriatric service at ARI

14. Community geriatrician alignment workload

FINANCE

Current forecast position is £700,000 overspend. However, this is offset by an approx. £600,000 contribution from Aberdeenshire for beds at Rosewell.

SERVICE ISSUES

- Increased demand across all services
- Rising demand for Shire community hospital or alternative provision capacity to reduce bed days waiting transitions of care.
- Increased complexity of clinical presentations – e.g., increase in demand for younger adult specialist care provision.
- Closure of Craig Court, alternative options for transitional living being considered as part of neuro rehab review.
- Difficulties in out of hours staffing across the Woodend site and Rosewell House, redesign of the medical/nurse practitioner workforce underway.
- Difficulties with Consultant geriatrician and nurse staffing on wards are consistent themes in regards workforce challenges.
- Current stage of frailty pathway whole system redesign means that bed capacity has been redesigned creating investment capacity but still in the process of investing this resource and designing the models of community-based response to mitigate reduction in bed capacity. This effectively bottle-necks the bed capacity for a period whilst the community investments are embedded/mature.

FINANCIAL ISSUES

1. Large overspends in some ward areas (Stroke, Neuro Rehab and 102) due to a number of factors around acuity of patients, staff sickness absence. Workload tools have been completed with neuro rehab staffing numbers being adjusted.

2. Wheelchairs - £103k overspend at Month 10 22/23. This is due to a number of factors including significant increase in equipment/carriage costs, increased demand and complexity of patient presentation. Work being undertaken to review service pressures and costs.

LONGER TERM PLANS

- Continued embedding and implementation of the frailty pathway redesign.
- Complete and implement the agreed plan from the current neuro-rehab pathway review.
- Review of specialist rehabilitation services and wider rehabilitation pathways across Grampian – a position paper outlining the current thinking is currently being prepared.

Completed by:

Lynn Morrison Lead for Allied Health Professions and Grampian Specialist Rehabilitation Services

Fiona Mitchelhill Chief Nurse and Frailty Lead

NHS Grampian Sexual Health- service and financial overview March 2023

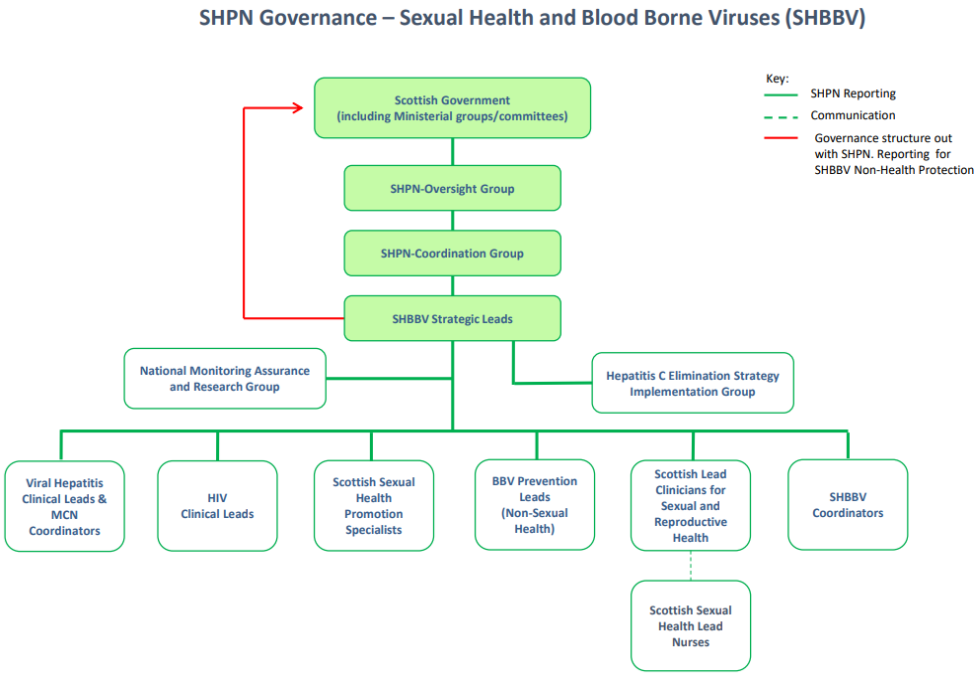
SERVICE OVERVIEW

Strategic overview

Grampian Sexual Health is a pan Grampian, ACHSCP hosted service providing holistic and comprehensive sexual health care. The service is underpinned strategically by the following key strategies,

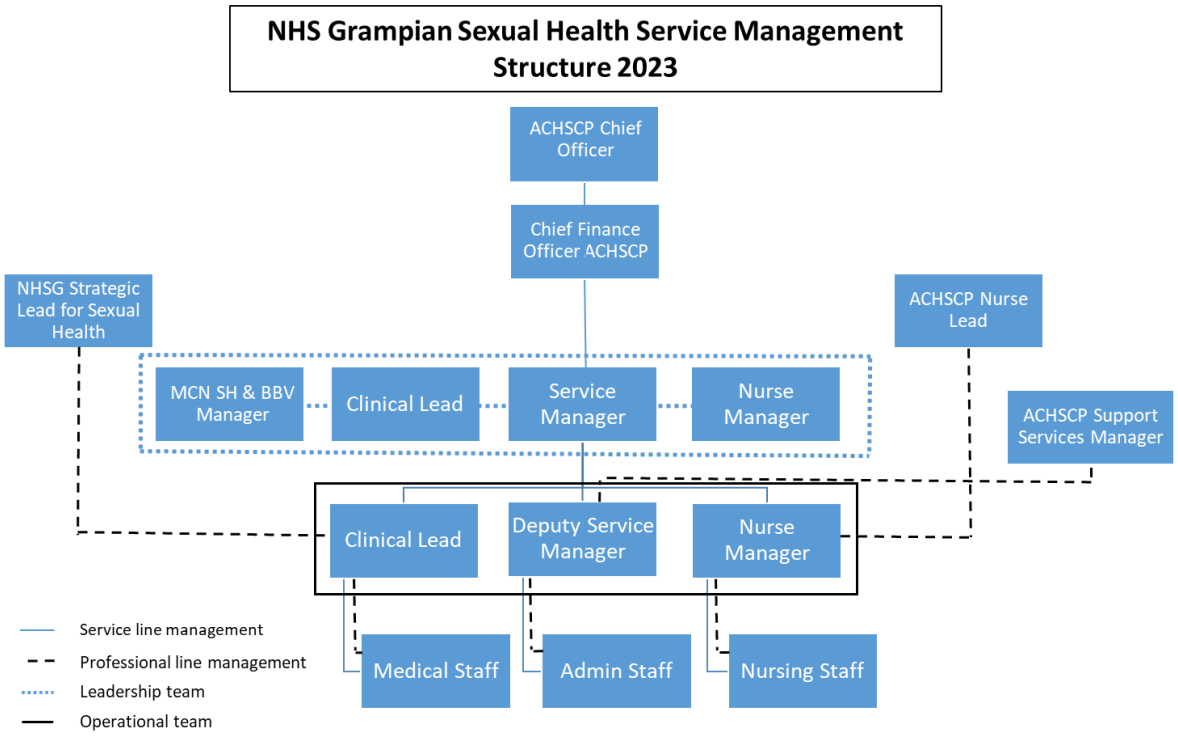
- Sexual Health and Blood Borne Virus (BBV) Framework 2015-2020 and Reset and Rebuild: Recovery Plan 2021. Refreshed Framework due Spring 2023
- Healthcare Improvement Scotland Sexual Health Standards 2022
- Women's Health Plan 2021-2024
- Aberdeen City Health and Social Care Partnership (HSCP), Aberdeenshire HSCP and Moray HSCP strategic plans
- NHSG Plan For the Future 2022-2028
- NHS Grampian Clinical Strategy 2016-2021
- Realistic Medicine

The service has a responsibility to locally implement some actions in all of these strategies, but most notably the Sexual Health and Blood Borne Virus Framework. The service is supported with strategic decision making and services planning by the NHS Grampian Sexual Health and BBV Managed Care Network (MCN), which in turn provides a proportion of funding to Grampian Sexual Health. Key members of Grampian Sexual Health management team also represent Grampian nationally on groups which feed directly to Scottish Government via the Scottish Health Protection Network, as shown below.



- SHBBV Strategic Leads Group: Dr Daniela Brawley
- Scottish Sexual Health Lead Clinicians Group: Dr Dianna Reed, Clinical Lead, Grampian Sexual Health
- HIV Clinical Leads Network: Dr Daniela Brawley, HIV Clinical Lead, NHS Grampian
- Scottish Sexual Health Lead Nurses Forum: Mrs Julia Penn, Nurse Team Lead, Grampian Sexual Health
- SHBBV Framework Co-ordination Group: Ms Lisa Allerton, SHBBV Manager, NHS Grampian
- Scottish Sexual Health Promotion Specialist Group: Mrs Penny Gilles, Public Health Practitioner, NHS Grampian

Service structure is shown on the organogram below with accountability to ACHSCP and NHS Grampian directly via the Sexual Health and BBV MCN and clinical staff line management.



The service team includes:

- 6 Medical consultants 5.7 WTE (0.2 WTE commencing July 2023)
- 4 Specialty Doctors 2.6 WTE
- 20 Nursing staff 12.5 WTE (Band 3 to 7) (1 WTE B6 vacancy)
- 16 Admin staff 10.6 WTE

Medical and nursing staff have allocated lead areas of responsibility and accountability.

<u>Clinical service overview</u>

The main service is based within the Aberdeen Community Health and Care Village with hub clinics in Dr Grays Hospital Elgin, Chalmers Hospital Banff, Fraserburgh Hospital and Peterhead Hospital. The service also supports HMP Grampian deliver sexual health care and since 2017 has ran the Exchange Clinic, a service for men who have sex with men in partnership with Alcohol and Drugs Action (ADA) in Aberdeen city centre.

A wide range of services are offered at the main and hub services including:

- Prevention methods, including HIV post- and pre- exposure prophylaxis (PEP/PrEP), testing and treatment for Sexually Transmitted infections (STIs) and Blood Borne Viruses (BBVs);
- Human Immunodeficiency Virus care for approx 250 patients;
- Priority access clinics for urgent sexual health care;
- Complex contraception including Long Acting Reversible Contraception (LARC);
- Young person's/<18s early evening clinics;
- Community gynaecology service, which receives 1800 primary care referrals per year and has a joint referral pathway with hospital gynaecology;
- Abortion care for residents in Aberdeen, Aberdeenshire and since 2022, providing cover for Moray in the absence of local provision. This is pending a more permanent solution and is not currently remunerated. Support is provided for NHS Shetland and Orkney;
- Psychosexual medicine care;
- Care post sexual assault. The Forensic Suite for the provision of forensic assessment in cases of sexual assault is contained within Aberdeen Health Village led by the forensic team in NHS Grampian. The service works closely with this team, seeing patients after forensic assessment for follow up care.

<u>Training and education</u>

In addition to clinical work the service provides training and education to clinical and non-clinical staff throughout Grampian, led by Dr Sinead Cook, Consultant lead for training and TPD for FSRH, Mrs Katy Henderson Lead Nurse for training, and supported by Ms Donna Brown Training and Education co-coordinator.

The service has been supporting primary care services to try and re-establish contraception and LARC services following Covid 19. The service trains approximately 40-44 clinical staff in the insertion of LARC and progresses 10-15 staff through the Diploma of Sexual and Reproductive Health each year. Furthermore the team, both medical and nursing provide regular sexual health updates for GP practices, Acute Services, 3rd sector, Schools throughout the year. A proportion of these activities are income generating to help sustain the teaching and training programme. However, are also essential in improving sexual health outcomes for all people living in Grampian.

<u>Young person's Service</u>

Young people are a priority group for SRH services and work has been underway within the sexual health service to improve the service for them over recent years and to increase attendance; throughout Scotland, attendance at services by under 18s had been declining. Dr Sinead Cook, Consultant SRH is the lead consultant for young people and Amanda Mackie is the lead nurse. In addition to two young persons dedicated clinics (which provide

a mixture of appointments and drop ins), a young persons and vulnerable adult multidisplinary team meeting occurs fortnightly. The team also feed into other Grampian and Aberdeen groups, including child protection and Child Sexual Exploitation.

Partnership working

As stated in the strategic overview the service has close links with the SH and BBV MCN in NHS Grampian. The MCN funds part of the service and also funds sessions for staff taking on HIV lead and Sexual Health lead roles. These roles involve leading the MCN team to address the higher level outcomes of the SH and BBV strategy from a Grampian wide perspective with both clinical, non-clinical and 3rd sector colleagues.

Partnership and integrated working also exists with Gynaecology, Infectious Disease colleagues (for HIV care), Hepatology Services (for co-infection of patients with Hepatitis and HIV); women and children's services, substance misuse services, community pharmacy, Dr Gray's, local authorities, Health and Social Care Partnerships (Moray and Aberdeenshire); Laboratories, Health Psychology, Forensic Services, Mental Health, Police Scotland and Public Health.

Research

Furthermore the service also actively participated in research. In 2021, the service collaborated with the SH/BBV MCN and Dr Den Daas to assess sexual health service access for priority groups and local sexual health behaviour post Covid19. In addition, the service was a recruitment site for Glasgow Caledonian University HIV Pre-Exposure Prophylaxis (PrEP) users study and a submission for a research grant is currently pending for a study involving HPV vaccination for vulnerable women and cervical cancer. Furthermore, the service has been a recruitment site for the VEMA study, in collaboration with NHS Lothian. Previous research: the service has been a recruitment site including UCON study, Medabon study and TV PCR study. Staff members have published multiple research publications, posters and presentations. List available on request.

PERFORMANCE AND GOVERNANCE

Nationally the service maintains and self-audits against the Sexual Health Service Standards, Health Improvement Scotland 2022.

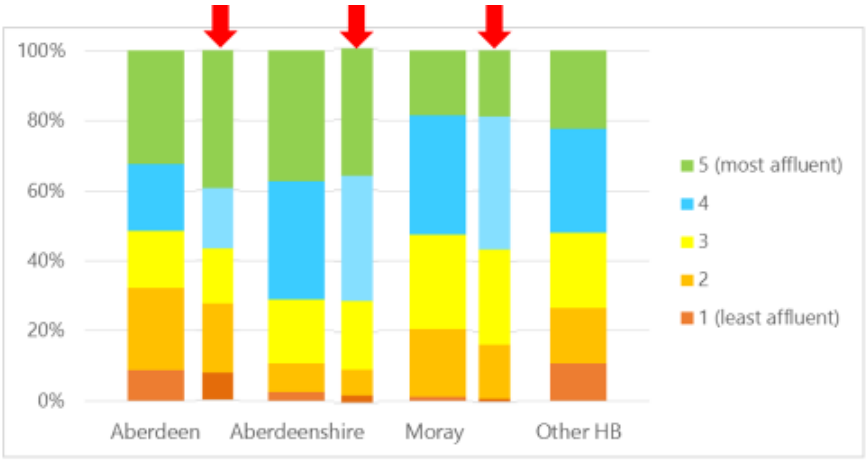
Sexual health standards (healthcareimprovementscotland.org)

These standards include targets for service provision and planning. The service is auditing current delivery against these standards. Expected completion Spring 2023.

The current management team have monthly operational/governance meetings and senior management to meet and discuss strategic aims, performance and governance. This teams feeds into ACHSCP management and governance structures and also SH/BBV MCN.

A service strategy was written in 2018/19 however has been superseded by local and national remobilisation plans following Covid19 pandemic. However the broad aims are unchanged with a focus on priority group access and care. This includes but is not limited to, people affected by deprivation, substance misuse and community justice, LGBT+ community, young people and those involved in the sex industry. Pre-Covid data shown

below compares SMID category of patients presenting to the service with a small proportion from the most deprived areas of the health board.



Whole SHS figures – by patients attending – 1,375 missing postcode

The service plans to work with partners to develop and support sexual health provision in the following areas:

- Support remobilisation of sexual health care across partners especially LARC provision in primary care with focus on areas of deprivation/priority groups
- Working in partnership with primary care to increase LARC provision, with a new referral pathway to 2 practices in within Aberdeen city whom have agreed to undertake additional LARC insertions.
- Late night opening in partnership with Alcohol and Drug Partnership for gay, bisexual and other men who have sex with men- re-commenced post Covid 19 September 2021
- Support for areas of deprivation with possible hubs or mobile clinic pilot in Kittybrewster, Westburn and North Corridor- currently on hold due to service pressures.
- Supporting termination of pregnancy pathway in NHS Shetland with SLA
- Supporting termination of pregnancy pathway in Moray (SRH are currently providing this service, without additional funding in a the absence or more local provision

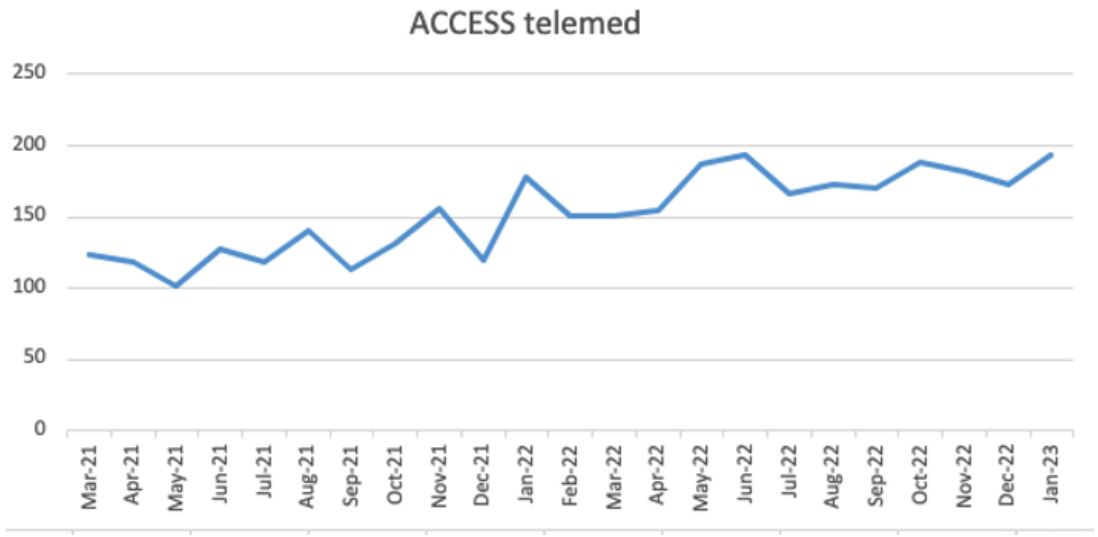
Additional partnership work includes

- Sexual health nursing staff chaperoning forensic examinations and self referral pilot
- Operation Begonia Police partnership work with those involved in sex work
- Exchange clinic expansion with PrEP service- commenced September 2021.

As a part of revising service plans, a population needs assessment will also be completed in 2023. We expect this to tie into the ambitions of the new Framework and sit alongside the HIS Standards for Sexual Health Services.

ACTIVITY

Pre-Covid the service provided approximately 36,476 patient contacts in 2019/20. This was a 12% increase from 2018/19. Once again, this has increased to approximately 40,000 patient contacts in 2022.Telemedicine has also been used within the service as standard with 43% seen virtually in 2019. There was an initial drop in activity with Covid19 restrictions however this has increased to above pre-Covid levels by autumn 2020 as shown in the data below.
In addition there has been a sustained increase in demand for abortion care since 2021 (see below ACCESS telemed data). Of note this activity is supported by less WTE staffing and also an increase in staffing required for the termination of pregnancy service specifically.



Due to the nature of the service, the majority of presentations are self referrals. However, pre COVID, there were also approximately 1500 GP referrals each year. This dropped in 2020 but has increased with 2022 receiving 1900 referrals into the service, with the monthly average higher than preCovid19 levels.

The current management team has established these activity benchmarks which are reviewed monthly to assist with capacity and service planning.

As of March 2023:

- Budget for 22/23 is £2.34 million, 10% of which is contributed by NHS Grampian SH/BBV MCN
- Regular review of budget and issues by management team
- Cost effective care regularly reviewed by HIV and SH pharmacists

Current and potential future cost pressures include:

- Increased service demand.
- Drugs budget overspent each year due to increase in activity. Zero based budgeting is being considered by ACHSCP Finance Leads

- MCN funding contribution at risk of being reduced in 2023/24 and in additional years.

SERVICE ISSUES AND FINANCIAL CHALLENGES- CURRENT AND FUTURE

There are several current challenges within the service,

1. Activity
   The service is under pressure due to a significant increase in demand/activity post Covid due to its own backlog and also a reduction in primary care and other services sexual health provision. The service plans to lead discussions pan Grampian with the publication of the HIS standards and to support partners remobilise this care.
2. Staffing.
   Staffing is lower than at preCovid levels due to vacancies and loss of specialty trainee post. This has also been exacerbated by the increased in activity post Covid19 and increased in staff required for the current termination of pregnancy service. Staffing is also required to support partners from a training and education perspective.
3. Service review and future planning.
   The service has been redesigned dynamically during the Covid19 pandemic. However a formal review is required to review if the aims are being achieved. This is to be started by benchmarking against the HIS standards combined with a population needs assessment.
4. Finance.
   Although the service is running under budget in 2022/23, this is due to staff shortages/vacancies which are not sustainable. With staffing improved and increase trend in activity, drugs, supplies and equipment costs will continue to increase. Service management team reviews service financial position on a monthly basis and makes continual attempts at cost savings (see above). There is an expected funding cut from MCN funding in 2023/2024.

Completed by: Dr Dianna Reed, Clinical Lead
Jennifer Matthews, Deputy Service Manager

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Aberdeenshire
Health & Social Care
Partnership

REPORT TO ABERDEENSHIRE INTEGRATION JOINT BOARD
7 DECEMBER 2022

ABERDEENSHIRE HOSTED SERVICES

1 Recommendation

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

1.1 Note the current position in relation to the services where Aberdeenshire Integration Joint Board are the 'host' IJB and agree that this report be shared with Moray and Aberdeen City Integration Joint Boards.

2 Directions

2.1 No direction requires to be issued to Aberdeenshire Council or NHS Grampian as a result of this report.

3 Risk

3.1 **IJB Risk 1 - Sufficiency and affordability of resource**

IJB Risk 6 - Service/business alignment with current and future need

4 Background

4.1 Hosted Services are services which have been delegated to Integration Joint Boards (IJB's) but are operated and manged on a Grampian wide basis. Hosting arrangements describe the situation where an IJB within the Grampian Health board area hosts a service on behalf of all three IJB's (Moray, Aberdeen City and Aberdeenshire). Operational oversight and management responsibility is held by the 'host' IJB. Strategic Planning for the use of these services should be undertaken by the three IJB's for their respective population. Provision for these hosted services is included within each IJB's Integration Scheme.

4.2 The services currently hosted by Aberdeenshire IJB all have a budget of less than £3m. This includes:

- HMP and YOI Grampian (£2.7m) – the health centre at HMP Grampian provides a range of health care including on-site nursing teams (Substance Use, Mental Health and Primary Care). Consultant Clinical Psychology, Allied Health Professionals, medical cover (provided by Peterhead Health Centre) and visiting specialists.

- Forensic and Custody Healthcare Service (£1.7m) – Provision of a full range of forensic and custodial medicine services, including all paediatric and sexual assault examinations, in sites in Aberdeen, Elgin and Fraserburgh. Since April 2022 this has also included delivery of the Sexual Assault Self-Referral Service.
- Marie Curie Nursing Service (836k) – Managed Care Service and out of hours service for Moray and Aberdeenshire HSCP's, including rapid response.
- Specialist Nursing Service for continence care/bladder and bowel health (£706k)
- Community Diabetes Specialist Nursing Team and Diabetic Eye Screening Service (£1.014m)
- Heart Failure Specialist Nursing Service (£313k)
- Chronic Oedema Service (£240k) - Specialist Therapy Service

4.3 HSCP's have been tasked to develop a Service Level Agreement (SLA) for the services currently hosted by them based on the principle of Quality, Safety and Efficiency. Progress on this will be reviewed through the North East Scotland Planning Group, with the intention to submit SLA's to IJB budget setting meetings in March 2023.

4.4 This main part of this report will provide an update on healthcare provision at HMP&YOI Grampian and the Forensic and Custody Healthcare Service. Reports on the other hosted services are attached to this report from page 6 onwards

HMP&YOI Grampian

4.5 Management responsibility for prison healthcare sits within the North Aberdeenshire locality management team and updates on key themes and issues are reported on a monthly basis through the north management team meeting. Starting in November we are also reporting monthly to the Clinical and Adult Social Work Governance Group on the risks identified on the risk register, in particular around recruitment and retention of staff. The team also report daily into the Daily Situation Update meeting and the staffing/bed huddle to ensure we have a clear picture of staffing levels across the service.

4.6 Inspections of prison health care are carried out jointly by Her Majesties Inspector of Prisons in Scotland (HMIPS) and Healthcare Improvement Scotland (HIS) using the Standards for Inspecting and Monitoring Prisons in Scotland. Outcomes of inspections and subsequent improvement plans are reported to the HSCP Clinical and Adult Social Work Governance Committee and to the Integration Joint Board where appropriate.

4.7 In the last year we have worked alongside Scottish Prison Service (SPS) colleagues to review and agree the best structure for ensuring joint oversight and reporting in relation the delivery of health care within the prison. The Governor at HMP Grampian chairs the Health Care Oversight Group and below

that the Primary Care, Mental Health and Substance Use Strategic Groups meet once a month with a structure below that for operational and weekly meetings. This reporting structure ensures resolution or escalation of issues as required.

4.8 The recruitment and retention of staff (particularly prison nursing) remains a key challenge. We have been undertaking workforce planning sessions on a regular basis to work towards a staffing model that is fit for purpose and reflects the changes to prison health care and to ensure that we have a model in place that will meet the changing needs of the prison population. We will be looking to take forward a strategic review of the prison workforce in the near future. The issues with prison health care staffing is a national issue and we continue to be part of the discussions through national forums.

4.9 In recent years there have been a number of achievements within prison health care, and listed below are a few of those:

- Progress made against improvement actions as identified by previous inspections (Controlled Drug Licence in place and funding for a pharmacy team in place)
- Development of joint oversight arrangements with SPS partners
- Staffing compliment has increased as a result of Action 15 funding to include additional psychology posts and OT posts on a permanent basis, this is to provide interventions for those prisoners presenting with lower level mental health issues. We have also secured temporary funding through Action 15 to support a pathway's for prisoners with brain injury and for older adults within the prison setting
- Funding via Aberdeenshire Alcohol and Drug Partnership to recruit 2 FTE Band 4 nurses to take on the role of Harm Reduction Workers and provide assertive outreach for those prisoners who are at risk of harm from Substance Use. We have successfully recruited into 1.5 of these posts and the other 0.5 has gone out to recruitment
- Given our challenges in recruiting nursing staff we are in the process of recruiting Band 4 Wellbeing and Enablement Workers to each of our core nursing teams. These workers will be supported through training at Robert Gordon University

Forensic and Custody Healthcare

4.10 Operational Management sits within the North Aberdeenshire locality management and report in through the daily situation update. We also attend monthly national meetings with Police Scotland and other custody healthcare colleagues to ensure consistency of practice across Scotland

4.11 The main custody healthcare site is at Kittybrewster Custody Suite where we have 24-hour nursing and forensic medical cover. There are a further two custody suites in Aberdeenshire (Fraserburgh and Elgin). Teams at Elgin and Fraserburgh were given additional resource to provide nurse cover for these sites. In Fraserburgh staff from the Minor Injury Unit provide the cover and in Elgin they have recently appointed a team of custody nurse practitioners who are based at the Dr Gray's Emergency Department. Both sites link into

Kittybrewster if Forensic Medical cover is required. With regards the model at Elgin, Aberdeenshire Health and Social Care Partnership and Moray Health and Social Care Partnership have worked together in the last year to ensure we have a robust staffing model in place for delivery of custody healthcare services in Elgin as the previous model based with GMED presented significant challenges for both services.

4.12 In addition to all custody medical services the team also deliver the Sexual Assault Response Coordination Service (SARC's). Until April this year this was for police referrals only but the implementation of the Forensic Medical Services (Victims of Sexual Offences) (Scotland) (Act) 2021 on 1st April 2022 also extended this to survivors who choose to self-refer for an examination. The service is required as part of this work to attend quarterly performance meetings with the Scottish Government to review and monitor performance around the SARC and implementation of the legislation.

4.13 The setting up of the self-referral pathway has been a significant achievement for the service. This legislation means that survivors of sexual assault can choose to self-refer without contacting the police. This allows for a forensic medical examination to take place and evidence gathered to allow the survivor the choice of when or if they want to proceed with a prosecution. Most importantly it allows survivors access to healthcare following an assault and we are working with colleagues in the Sexual Health Service to ensure we have the appropriate throughcare pathways in place so that survivors can access the necessary health and support services.

4.14 The service is not without it's challenges and currently we are experiencing gaps in the Forensic Medical Examiner (FME) rota due to an FME leaving and another reducing hours as part of a phased retirement. This has resulted in the use of agency to ensure 24/7 coverage for forensic services. We are currently working with HR to move our current FME group onto a salaried contract and this piece of work is near completion with a final agreement to be reached on a job plan. Historically the FME role has been difficult to fill but we are hoping that the move to a salaried form of payment will improve our recruitment.

4.15 The next 6-12 months will be focused on the continued implementation of the SARC service in line with the HIS Standards and ensuring that we have the correct skill mix of staff to be able to deliver this service and to ensure that there is no impact on the delivery of custody healthcare as a result.

5 Summary

5.1 The above report provides an update in relation prison and custody healthcare services and the board are asked to note the current position in relation to all hosted services and to agree to share this with Aberdeen City and Moray Integration Joint Boards as way of an update to them on the hosted services delivered by Aberdeenshire.

5.2 The Chief Officer, along with the Chief Finance Officer and the Legal Monitoring Officers within Business Services of the Council have been consulted in the preparation of this report and their comments have been incorporated within the report.

6 Equalities, Staffing and Financial Implications

6.1 An equality impact assessment is not required because this report is for information only on the services hosted by Aberdeenshire Integration Joint Board.

Pamela Milliken, Chief Officer
Aberdeenshire Health and Social Care Partnership

Report prepared by Corinne Millar, Location Manager (Central Buchan)
Date 15 November 2022

Service: Marie Curie Nursing Service	**Hosted: Aberdeenshire**	**Budget: £836k**
Description of Services: • Provision of managed care service and out of hours service for Moray and Aberdeenshire HSCPs, providing palliative nursing care to patients in the community including rapid response.		
Current Governance/Management Arrangements: Operational management through Aberdeenshire HSCP Chief Nurse. Service agreement in place with Marie Curie for provision of service - regular meetings held with Marie Curie with representation from HSCPs and NHSG Finance. Regular activity reports provided by the service – further analysis presently being undertaken around detail of type of visits and interactions with patients. Regular meetings held cross sector including GMED to ensure concerns re service provision are addressed.		
Current Issues: Marie Curie increased the cost of their contract at the end of 2020 which led to discussions across Shire and Moray to look at alternative models of service delivery. Due to pressures as a result of COVID this work remains ongoing. Relationships have improved greatly with the service and joint working to progress a sustainable model for future service delivery. Marie Curie attend daily the Shire Bed/Staff huddle to promote joint working and problem solving of service gaps. Joint working to relook at a more streamlined service with a reduction from 3 pods to 2 and the introduction of a Senior Nurse to Triage all calls. This will provide a more sustainable service over winter and allow planning and progress to review the service in more detail in 2023. Project Manager support has been identified to undertake this work in 2023.	**Achievements:** Strong working relationships Attendance daily for Pod cover update Good use of data to determine plans for service delivery Ongoing work across both Moray and Shire to look at Out of Hours Redesign options and costs	
Improvement Areas for consideration: There is the risk that any options for redesign will be out with the available financial envelope. Therefore if this is not an option to progress then support will be required from the Commissioning team to ensure a robust and measurable contract going forward.		

Service: Bladder and Bowel Specialist Service	**Hosted: Aberdeenshire**	**Budget: 706k**

Description of Services:

- Specialist nursing team in bladder and bowel health, providing education and training to both patients and NHS Grampian staff; voluntary staff; Agency staff; 3rd sector support, health care workers in residential and care home settings; Schools, students at university and colleges and AHPs across NHS Grampian.
- Advisory phone line 5 days per week
- Around 6500 patients currently prescribed containment products for bladder and bowel incontinence, patients reassessed annually
- Specialist nurse led clinics in Elgin, Aberdeen city, Inverurie, Peterhead, Stonehaven
- Advisory service for Children's bladder and bowel health
- MDT with colorectal, neuro rehab, Gynae, Urology, Urogynae, Paediatrics, Social work
- Representation of NHSG at national level, tender negotiation, formulary development, national guideline development
- Support to NHS Orkney provided by Band 8A

Current Governance/Management Arrangements:

Operational management through Aberdeenshire HSCP Chief Nurse. Line manages Nurse Manager (Band 8A).

Current Issues:	**Achievements:**
22/23 budget overspend of £115,321 due to national contract extension agreed by National Procurement and 15% cost increase. Ongoing issues with national contract impacting service ability to provide high standard of care to patients. Official letter of complaint has been submitted to National Procurement by NHSG and National leads group. Demand to service has increased out with current staffing capacity due to changes in community nursing workforce/Health visiting/School nursing post Covid19 Increased demand on service due to impact of secondary care waiting lists, Gynae, Urology, Gastro. Health point have highlighted increase in referrals they are directing to BB service as a result.	Current staffing allocation full, admin team vacancy recently recruited to. iMatter and Culture survey results show positive team environment and happy team members. Motivation and moral is high. High engagement with service teaching program across disciplines and IJBs Nursing staff have completed training to allow service to host student nurses. Collaborative working with Practice Education team to deliver NHSG catheterisation clinical skills learning pathway BB Service and PE invited to provide professional review of NES learning material to be used nationally. Currently working with Practice Education to develop clinical skills pathway for HCSWs

Up skilling new staff members in each nursing base Moving from paper records to electronic, progress is slow and fragmented. Building service on Trakcare to allow electronic referrals so self-referral route can be removed due to inappropriate use in primary care as a result of demand on GP services and access to appointments and community nursing workforce tasks. Service specialist clinic waiting lists around 24 weeks for new patients Availability of clinical space in City and Shire to allow us to increase clinical capacity Availability of office space in Inverurie to allow us to add staff to nursing team if staffing budget funds were found in order to develop the service. Community nursing/HV/SN workload could be reduced if service had additional staffing to take all continence assessment in house. I would also predict a budget saving as all patients would be prescribed a 12 week treatment plan before provision of products leading to better patient outcomes and service savings.	Currently working with local and national procurement to update catheter formulary and identify cost savings. Catheter project with Transformation team looking to reduce acute and community catheter workload Collaborative working with NHS Orkney to support them through an options appraisal of current service provision there and what support can be given by the Grampian service.

Improvement Areas for consideration:

Budget review, NP571/22 Continence pads and garments currently in tender process, initial indication from National Procurement is that next 5 year contract is likely to incur >15% increase in cost.

Review of service delivery

- Increase in nursing staff – Service would benefit from a band 7 post to allow band 8A to take a fully operational role. Additional band 5 in City/Shire team and HCSW and Admin support in Moray team would provide more equitable service pan Grampian.
- Increase in clinic capacity
- Moving all continence assessment in house
- Increasing teaching program, possibly working with other disciplines to deliver this
- Fully move to electronic records to provide more efficiency

- Develop service level agreement to formalise clinical support we provide to NHS Orkney once the review of their service and options appraisal is completed.

Service: Diabetes Specialist Nursing and Diabetic Eye Screening	**Hosted: Aberdeenshire**	**Budget: £1.014m**

Description of Services:

Community Diabetes Specialist Nurse Team (DSN) provides advice, guidance and support to health and social care professionals and people with diabetes across NHS Grampian to support self-management.

Diabetic Eye Screening Service provides screening to all patients with diabetes who are aged 12 years and older, with aim of detecting and offering timeous treatment for sight threatening diabetic retinopathy.

Current Governance/Management Arrangements:

Operational and Professional Management through Aberdeenshire HSCP Chief Nurse. Line manages Nurse Manager (Band 8A).

Diabetes Specialist Nursing

Current Issues:	**Achievements:**
Staff retirement and reduction of hours/staffing issues Change to service delivery - education to Heath Care Professionals and service users. Up skilling new staff members New technologies and how they will be rolled out to our patients, Increase in Freestyle libre 2, CGM Increased workload due to steroid therapies being used for treatment for Covid 19 Dr Grays (DHG) have no Inpatient DSN Service (test of change being done with Inpatient DSN from ARI remote working) DSN support for pregnancy patients DGH patients. Increase in workload for DSN with reduction in Consultant support in Moray	Appointment of new Staff member SANDRA course getting through to the QIC Diabetes Awards (Quality in Care Diabetes) and been Commended for this piece of work. Staff engagement is excellent post Covid 19 – open to thinking about what works well, what we can stop, start and keep in relation to the results of the Culture Survey DSN education training currently being offered across NHSG Virtually Staff have worked very conscientiously to provide a high quality service to patients and Primary care colleagues DSN outreach support sessions provided across NHSG

Improvement Areas for consideration:

Education delivery moving away from some online education into the classroom where it is felt that people learn and engage more

Consideration on business plan for part time Practice Educator for the Diabetes Specialist Nurse Team which would be of great benefit to the team, HCP and services users.

Working with the third sector more in relation to the Diabetes Improvement Plan.

Staffing levels to be reviewed to take into consideration the Increased demand for CGM/ Technology, Pre-pregnancy and Maternity services Inpatient DSN to improve patient care across NHSG

Inpatient DSN plan currently under a test of change being implementation in November, Ultimately looking at having a NHSG wide inpatient service.

Diabetic Eye Screening

Current Issues:	**Achievements:**
Additional screening resource has greatly contributed to recovery and reducing the current backlog, however this has added further pressure onto the administration team regarding workload increase relating to telephone call volumes, increased mailing volume, referrals to ophthalmology A concern that has been highlighted, by most boards who provide mobile screening, is that when problems/issues present with the mobile trollies there is no support as regards manufacturer to provide new replacements. This matter has been raised at service manager meetings of all 14 boards which the action it was noted as a procurement concern with National Services Division (NSD). Grampian currently have 3 trollies in operation of which the local medical physics team are on hand to support with what resource they can offer, the trollies have been in use in excess of fifteen years and adapted over this time to accommodate newer, varying models of cameras	Successful recruitment of screening staff to replace staffing hours reduced due to changed working hours following return of maternity leave, staff role progression within the service Additional camera secured at David Anderson building to aid higher volume of appointments to support recovery and to allow further sustainability of screening long term Until the end of October 2022 a mobile camera has been utilised at David Anderson building to aid recovery, now with additional resource, all mobile cameras can be fully operational across Aberdeenshire and Moray to aid further recovery beginning November 2022 With the further relaxing of covid 19 restrictions, this has allowed the service to increase the amount of appointments that can be honoured within sustainable parameters i.e time allocated per appointment within the time available to screen in a day. All screening locations have been recovered, with some sites granted pre bookings throughout the year

	Waiting list for optical coherence tomography for people living within the Moray area has now been cleared New public health consultant in post as of September 2022, John Mooney.
Improvement Areas for consideration: Although DES is now beginning to change trajectory towards a positive recovery, there remains areas to improve. Through support of the lead clinician and nurse manager, ways of creating a more robust administration team will be explored. The specialised screening software, Optomize, has a next software release in November 2022 which will include functions to provide a text message reminder, may support with increasing attendance uptake and reduce DNA rates which creates further administration; there will also be the option to offer people an online booking service with the added support for people to change their appointment online – these are optional features of the system for health boards to opt in to use. Further action is to note tasks undertaken by each role and who can support as a backfill during episodes of absence. Aim of this task is to identify fragility within roles and how these can be strengthened to avoid detriment to service.	

Service: Heart Failure Specialist Nursing Service	**Hosted: Aberdeenshire**	**Budget: £313k**
Description of Services: Provision of nurse led interventions and improving self-management for patients across Grampian with moderate to severe Left Ventricular Systolic Dysfunction (LVSD) from diagnosis, through exacerbations to stabilisation and deterioration, including supportive and palliative care for terminally ill patients.		
Current Governance/Management Arrangements: Operational management through Aberdeenshire HSCP Chief Nurse. Line manages Nurse Manager (Band 8A).		
Current Issues: Reduced staffing due to maternity leave/long term sick leave Increasing referrals/workloads The service secured permanent funding in 2013 and despite considerable service expansion, the staffing level is unchanged and does not align with current service expectation/sustainability.	**Achievements:** Service adaption and remobilisation following the pandemic Improved integrated working across NHSG along the continuous change journey, aligning patient care with Hospital at Home/CTAC/Urgent Care services – preventing hospital admissions and delivering right time/right place/right person care	

Delay in patient review due to reduced staffing levels and increasing workloads Components; acute sector are actively pursuing funding (through various routes) for two acute HF nurses / revamped inpatient service with early supported discharge pathway which will further increase service referrals.	Established Student Nurse Placement programme – supporting the future workforce Working towards securing funding for two acute HF nurses

Improvement Areas for consideration:

Increase Band 6 staffing level to 6.62 WTE (currently WTE: 4.62)

Aim to have all Heart Failure Specialist Nurses as Independent Nurse Prescribers

Support the set-up of the acute HF Service; navigating new pathways and staff development opportunities/support systems, so both services complement one another to streamline Heart Failure coordinated care/treatment planning and staff engagement

Heart Failure Digital Infrastructure; pursuing a common digital infrastructure across Scotland for heart failure. The idea is that across Scotland we procure, at national level, a digital platform to facilitate diagnostic pathways for heart failure, as well as downstream monitoring, follow-up and management of patients diagnosed with heart failure. We would have the opportunity to tailor the functionality of the platform to our required specification. This approach would hopefully streamline the diagnostic process and allow us to work towards common standards of care whilst maintaining flexibility for individual boards to tailor their pathway as they see fit according to local resources and service pressures.

Service: Chronic Oedema Service (COS) **this requires an update	**Hosted: Aberdeenshire**	**Budget: £267k**

Description of Services:

Specialist service providing assessment and management of patients with chronic oedema.

Education of other health care professionals to enable them to undertake or support self-management within their patient group.

Treatment provided within outpatient clinics, hospitals and domiciliary visits. Main clinical base in Aberdeen Health Village with satellite clinics in Stonehaven, Aboyne, Inverurie and commencement of a service in Moray This is a to be a 2 day a week service and is currently operating one day a week. Out of the Oaks in Elgin.

Referrals accepted via Consultants, GPs, Breast Care Nurses. 65% of caseload is cancer related.

Current Governance/Management Arrangements:
Operational management of service through Chronic Oedema Specialist reporting to HSCP Partnership Manager (South). Hosted service includes the staffing budget for all of Grampian and the consumables (garments). . The staffing budget for Moray HSCP transferred from 1st April 2022 into the Grampian service.

Current Issues:
Staffing:
1WTE 8b Oedema Specialist
0.4 WTE Band 6 Keyworker
0.4 WTE Band 7 to cover Moray
0.53 WTE Band 4 Admin support
Current active caseload - 1045 patients
New Referrals
October 2021 - November 2022 - 279
January 2022 - November 2022 - 247

Achievements:
Staff were redeployed from March 2020 – October 2020, since returning to COS staff have had to adapt to alternative ways of working as clinical space is still limited. The use of technology has been a vital part of enabling waiting times to be kept at a minimum (currently 3 week for non-urgent referrals).

During the 6 months of redeployment no reviews other than urgent reviews took place, to date all patients have now been reviewed and ongoing appointments are up-to-date.

Improvement Areas for consideration:
Funding of the money for the service in Moray has happened and there is active work underway to recruit to this post and while this happens, the services is being supported a day week from the main team.
Succession planning – as this is a small service, succession planning is vital for continuity of the service.

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REPORT TO ABERDEENSHIRE INTEGRATION JOINT BOARD
06 February 2023

NHS GRAMPIAN OUT OF HOURS PRIMARY CARE SERVICE (GMED)

1 Recommendation

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

1.1 **Notes the current positon in relation to Grampian Out of Hours (OOH) Primary Care Services with Moray as the Hosting Integration Joint Board (IJB).**

2 Directions

2.1 No direction requires to be issued to Aberdeenshire Council or NHS Grampian as a result of this report.

3 Risk

3.1 Risks are recorded on Health and Social Care Moray (HSCM) Risk Register.

4 Background

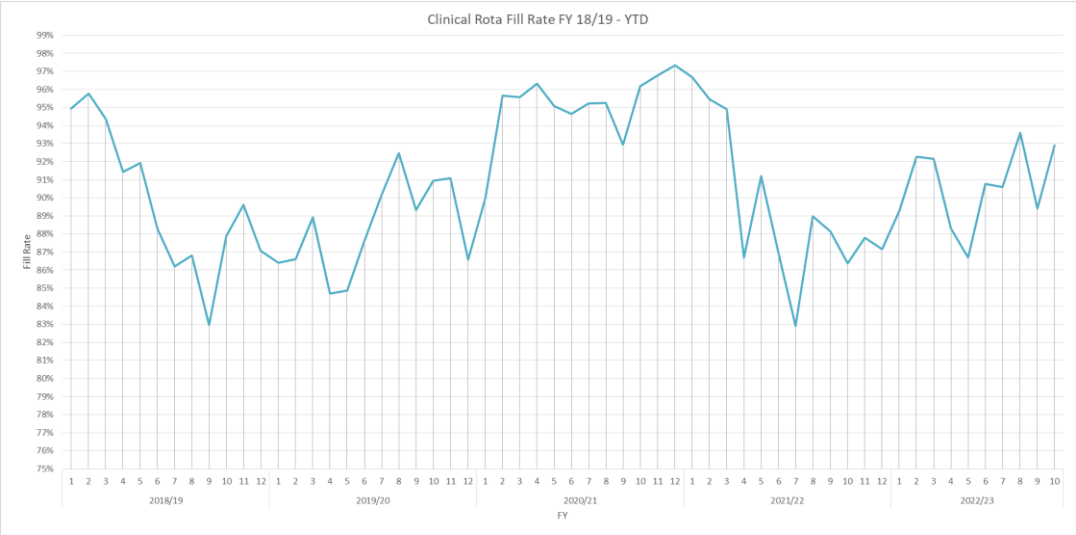
4.1 GMED provides urgent primary care services for the Grampian population in the out of hour's period (including Public Holidays).

4.2 **Workforce**:

4.2.1 GMED service continues to maintain similar rota fill rate levels comparing to previous years (with the exception of 2020). The average rota fill rate is 90% for the whole year, which is assessed to be at the G-OPES[1] Level 2.

4.2.2 Clinical rota is affected by unpredicted absence, Covid related absence and holiday periods. Furthermore, the majority of the GP workforce within the service is employed as bank staff, which contributes to challenges around sustainability and resilience of workforce. Ability to staff the rota is recorded on the HSC Moray Risk Register. Appropriate controls are in place.

[1] G-OPES: The Grampian Operational Pressure Escalation System; an enhanced approach to managing the operational pressures as a unified health and care system

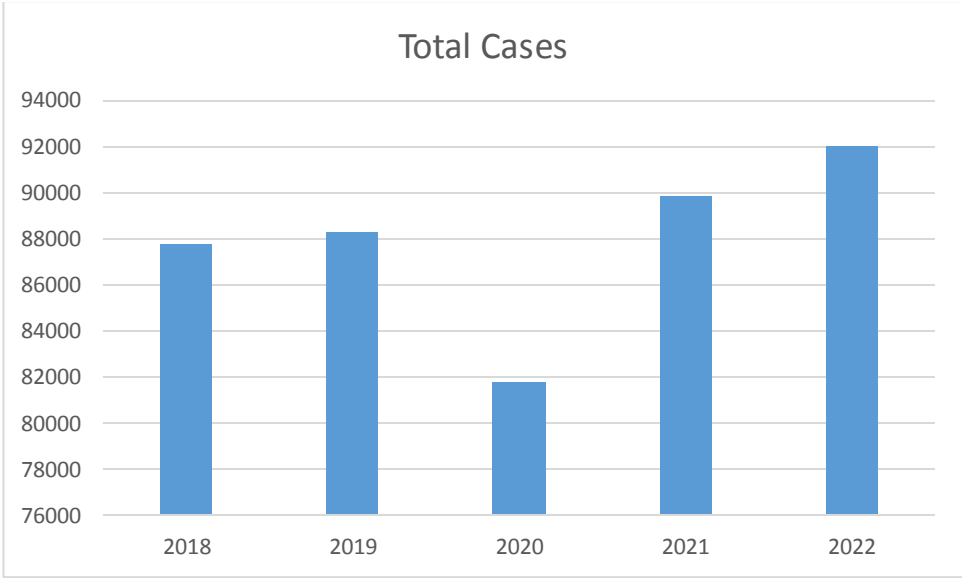


4.3 **Staff Governance and Engagement**:

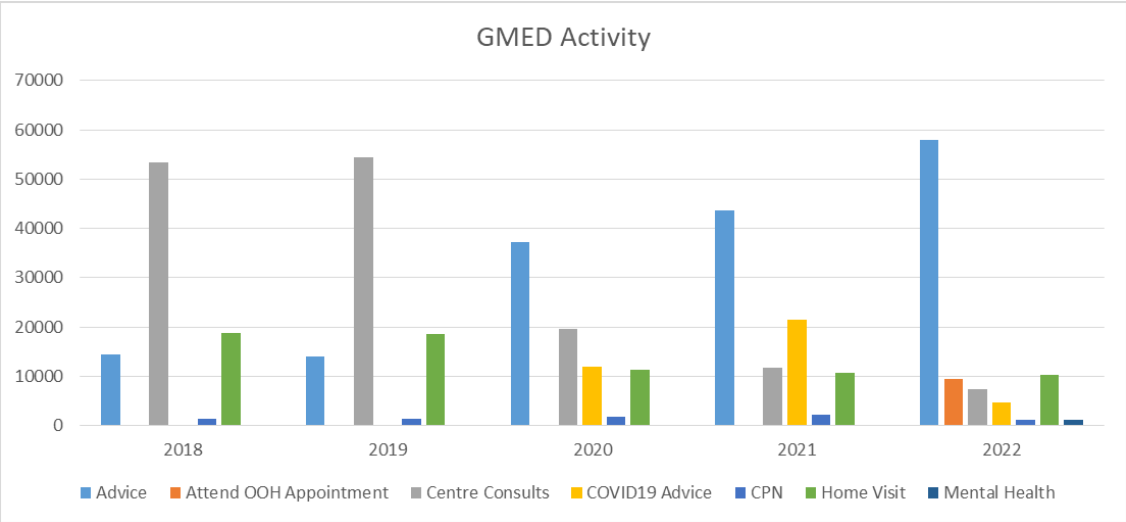
4.3.1 GMED Management Team continues to work with staff to improve employee experience; from the start of the recruitment process to day to day operations. Appropriate NHSG tools are used to measure satisfaction (i.e. iMatter) and internal surveys. Identified actions are taken forward together with staff to promote NHSG Shared Governance standards.

4.4 **Performance:**

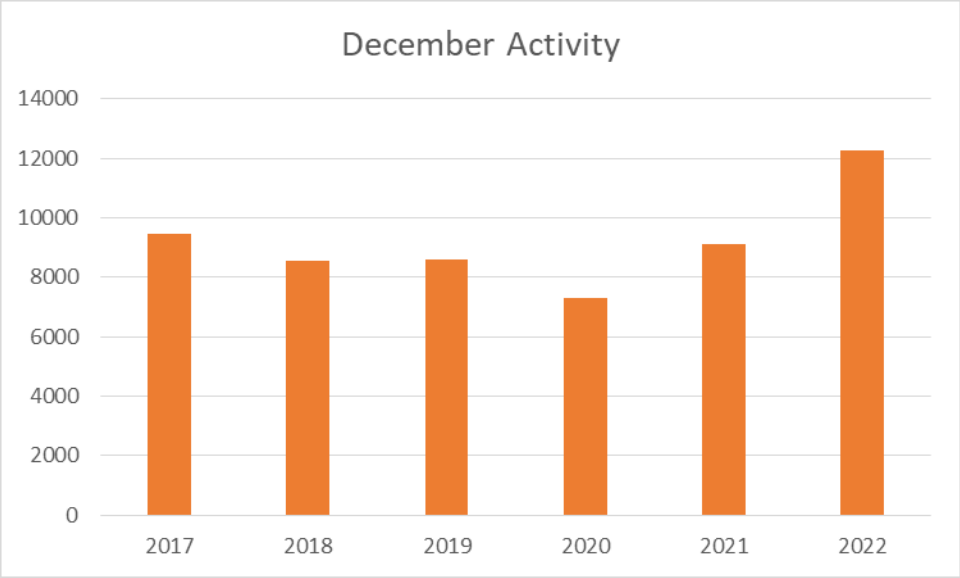
4.4.1 GMED activity continues to be predictable, however, activity is increasing with 2022 being the busiest year with 92020 cases received.



4.4.2 The service continues to employ advice first approach, where the patient is triaged over the telephone to establish if face to face assessment is required. Therefore, a shift from face to face (centre consult and home visit) to advice is seen.



4.4.3 December 2022 was the busiest December that the service observed in the last six years, and Festive Period 2022/2023 observed the highest demand since the start of measuring the demand (graph represents only last 6 years).



4.5 **Finance:**

4.5.1 GMED continues to observe an overspend on the budget.

4.5.2 YTD to M9 variance is (460630) which is 6% over the YTD budget. In comparison, in the same month last year GMED observed spend 5% over budget.

MORAY HOSTED SVS	9 months to December 2022

	Annual Budget	YTD Budget	YTD Actuals	YTD Variance	Period Budget	Period Actuals	Period Variance	Period Estab	Avg Wte	Period Wte
GMED	(270,820)	(203,115)	(154,572)	(48,543)	(22,568)	(18,166)	(4,403)	0.00	0.00	0.00
MISCELLANEOUS INCOME	**(270,820)**	**(203,115)**	**(154,572)**	**(48,543)**	**(22,568)**	**(18,166)**	**(4,403)**	**0.00**	**0.00**	**0.00**
GMED	10,577,305	7,932,979	8,197,281	(264,302)	948,109	923,049	25,059	95.78	89.91	93.91
PAY	**10,577,305**	**7,932,979**	**8,197,281**	**(264,302)**	**948,109**	**923,049**	**25,059**	**95.78**	**89.91**	**93.91**
GMED	294,527	213,649	361,434	(147,785)	26,818	52,288	(25,470)	0.00	0.00	0.00
NON-PAY	**294,527**	**213,649**	**361,434**	**(147,785)**	**26,818**	**52,288**	**(25,470)**	**0.00**	**0.00**	**0.00**
TOTAL	**10,601,012**	**7,943,513**	**8,404,143**	**(460,630)**	**952,359**	**957,172**	**(4,813)**	**95.78**	**89.91**	**93.91**

4.5.3 Further work is being undertaken with Finance to realign cost centres within the service.

4.6 **Unscheduled Care Review**:

4.6.1 The GMED service has been reviewing redirection and referral pathways out with NHS 24 pathways since August 2022. This is part of unscheduled care improvement work in response to the increased demands being experienced in Grampian and indeed across all unscheduled care services in NHS Scotland. Up until the start of the review, multiple services in the Out of Hours (OOH) period were able to refer to GMED, which was not in line with national protocols.

Such redirection pathways created an unprecedented pressure on the GMED service by allowing all professional to professional referrals to be accepted with a one hour priority, very often with no clinical indication for this. This led to lack of equity and fairness in how various patients access the service and these reviews are the improvement work by GMED to address these challenges GMED have engaged with various stakeholders across Grampian to build up an awareness of the redirection pathways, as well as to review and update existing protocols to ensure clinical effectiveness and safe, person centred care.

4.6.2 To date, the GMED service have addressed pathways for care homes referrals, pharmacy referrals, Scottish Ambulance Service Referrals.

4.6.3 GMED is currently engaging with Mental Health, Adult and Children Emergency Departments and Flow Navigation Centre to review referral pathways in line with the 'right care, right place' guidance.

4.7 **Clinical Governance**:

4.7.1 GMED continues to strengthen clinical governance within the service:

- Reporting into HSCM Clinical and Care Governance
- Reporting into HSCM Clinical Risk Management Committee
- GMED Clinical Governance Meeting

- Staff Educational Sessions.
- Identifying and taking learning from adverse event and complaint reviews.

4.8 **Adverse Events:**

4.8.1 The service recorded 78 adverse events in 2022.

Category	Count
Medication	19
Access, Appointment, Admission, Transfer, Discharge (Including Absconders)	15
Consent, Confidentiality or Communication	9
Diagnosis, failed or delayed	9
Other - please specify in description	7
Accident (Including Falls, Exposure to Blood/Body Fluids, Asbestos, Heat, Radiation, Needlesticks or other hazards)	5
Treatment, Procedure (Incl. Operations or Blood Transfusions etc.)	4
Clinical Assessment (Investigations, Images and Lab Tests)	3
Infrastructure or resources (Staffing, Facilities, Environment, Lifts)	3
Abusive, violent, disruptive or self-harming behaviour	2
Security (no longer contains fire)	2
Grand Total	78

4.9 **Patient Feedback**:

4.9.1 GMED received or was involved in 56 complaints, of which 16 were fully upheld and 9 partially upheld. 11 continue to be investigated.

5 Summary

5.1 GMED remains in a strong and steady position. Although there are issues GMED are facing as a service, these issues are being dealt with at both operational and strategic level.

5.2 The Head of Service has been consulted in the preparation of this report and their comments have been incorporated within the report.

6 Equalities, Staffing and Financial Implications

6.1 An equality impact assessment is not required because this report reflects delivery of a hosted service.

Magda Polcik-Miniach GMED Service Manager

NHS Grampian for Aberdeenshire Health and Social Care Partnership

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REPORT TO ABERDEENSHIRE INTEGRATION JOINT BOARD
6 February 2023

NHS GRAMPIAN PRIMARY CARE CONTRACTS TEAM (PCCT)

1 Recommendation

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

1.1 **Notes the current positon in relation to Grampian Primary Care Contracts with Moray as the Hosting Integration Joint Board (IJB).**

2 Directions

2.1 No direction requires to be issued to Aberdeenshire Council or NHS Grampian as a result of this report.

3 Risk

3.1 Risks are recorded on Health and Social Care Moray (HSCM) Risk Register.

4 Background

4.1 PCCT provides a professional listing, payment and contracting function for the four contractor groupings: Medical, Dental, Pharmacy and Optometry.

4.2 PCCT, in conjunction with NHSG finance, leads on Payment Verification to ensure appropriate financial governance.

4.3 PCCT provides committee support to several NHSG Committees e.g. GP Sub.

4.4 **Staff Governance and Engagement**:

4.4.1 PCCT continues to work with staff to improve employee experience; from the start of the recruitment process to day to day operations. Appropriate NHSG tools are used to measure satisfaction e.g. iMatter. Identified actions are taken forward together with staff to promote NHSG Shared Governance standards.

4.4.2 Staffing remains at full compliment.

4.5 **Finance:**

4.5.1 In the 9 months to December 2022 PCCT budget was in underspend position. This is consistent with the position 12 months previously.

HOSTED					PERIOD:	DECEMBER	2022	/	2023
	Annual Budget	YTD Budget	YTD Actuals	YTD Variance	Period Budget	Period Actuals	Period Variance	Period Estab	Avg Wte	Period Wte
PRIMARY CARE CONTRACTS TEAM	0	0	0	0	0	1,153	(1,153)	0.00	0.00	0.00
MISCELLANEOUS INCOME	**0**	**0**	**0**	**0**	**0**	**1,153**	**(1,153)**	**0.00**	**0.00**	**0.00**
PRIMARY CARE CONTRACTS TEAM	576,010	432,007	324,550	107,458	48,001	33,178	14,823	9.25	7.66	7.57
PAY	**576,010**	**432,007**	**324,550**	**107,458**	**48,001**	**33,178**	**14,823**	**9.25**	**7.66**	**7.57**
PRIMARY CARE CONTRACTS TEAM	74,581	55,936	54,208	1,728	6,215	9,845	(3,630)	0.00	0.00	0.00
NON-PAY	**74,581**	**55,936**	**54,208**	**1,728**	**6,215**	**9,845**	**(3,630)**	**0.00**	**0.00**	**0.00**
HOSTED	**650,591**	**487,943**	**378,758**	**109,186**	**54,216**	**44,176**	**10,040**	**9.25**	**7.66**	**7.57**

4.6 **Aberdeenshire specific issues**

4.6.1 A close working relationship is noted between PCCT and Aberdeenshire Primary Care Management.

4.7 **Adverse Events:**

4.7.1 None.

5 Summary

5.1 PCCT continues to provide contractual and listing support for the three HSCPs and NHS Grampian.

5.2 The Head of Service has been consulted in the preparation of this report and their comments have been incorporated within the report.

6 Equalities, Staffing and Financial Implications

6.1 An equality impact assessment is not required because this report reflects delivery of a hosted service.

Peter Maclean, Service Manager, PCCT
NHS Grampian for Aberdeenshire Health and Social Care Partnership

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INTEGRATION JOINT BOARD

NOT FOR PUBLICATION – This report contains exempt information as described in paragraph 6 (Information relating to the financial or business affairs of any particular person (other than the authority)) and paragraph 9 (Any terms proposed or to be proposed by or to the authority in the course of negotiations for a contract for the acquisition or disposal of property or the supply of goods or services) of Part 1 of Schedule 7A of the Local Government (Scotland) Act 1973, enacted by the Local Government (Access to Information) Act 1985. This is applied in this case because, in view of the nature of the business to be transacted or in the nature of the proceedings, if members of the public were present, there would be disclosure to them of exempt information as defined in the Schedule.

Not exempt: Covering report, Appendix A1

Exempt: Appendix A, Appendix C

Date of Meeting	25 April 2023
Report Title	Supplementary Procurement Work Plan (Social Care)
Report Number	HSCP23.018
Lead Officer	Sandra MacLeod, Chief Officer AHSCP
Report Author Details	Name: Neil Stephenson Job Title: Strategic Procurement Manager Email Address: NeStephenson@aberdeencity.gov.uk Phone Number: 07766 133528
Consultation Checklist Completed	Yes
Directions Required	Yes
Appendices	Non-Exempt: Appendix A1 - Supplementary Work Plan for 2023/24 Exempt: Appendix A - Supplementary Work Plan for 2023/24 Appendix C – Procurement Business Case Appendix B – Direction to Aberdeen City Council

INTEGRATION JOINT BOARD

1. Purpose of the Report

1.1. The purpose of this report is to present a Supplementary Procurement Work Plan for 2023/24 for expenditure on social care services, together with the associated procurement Business Case, for approval.

2. Recommendations

2.1. It is recommended that the Integration Joint Board:

a) Approves the **Tender**, for a period of up to five (5) years of a contract for Independent Advocacy Services, as is detailed in Appendices A1 and C
b) Makes the Direction, as attached at Appendix B and instructs the Chief Officer to issue the Direction to Aberdeen City Council.

3. Summary of Key Information

3.1 The Integration Joint Board (IJB) directs Aberdeen City Council (ACC) to purchase and enter into contracts with suppliers for the provision of services in relation to functions for which it has responsibility. ACC procures services through the Commercial and Procurement Shared Service (CPSS) in accordance with ACC's Scheme of Governance.

3.2 ACC Powers Delegated to Officers includes, at delegation 1 of section 7, that the Chief Officer of the Aberdeen City Integration Joint Board (also referred to and known as the Chief Officer of the Aberdeen City Health and Social Care Partnership (ACHSCP)) has delegated authority to facilitate and implement Directions issued to ACC from the IJB, on the instruction of the Chief Executive of ACC and in accordance with the ACC Procurement Regulations.

3.3 These Regulations require the submission of an annual procurement work plan prior to the commencement of each financial year detailing all contracts to be procured by Aberdeen City Council in the coming year with a value of £50,000 or more, to relevant Boards/Committees. In the case of adult social

care services, this is the IJB. The Regulations also require that procurement business cases to support items on the work plan are brought to the IJB prior to any tender being undertaken or contract awarded directly. Although the intention is that all procurement should be planned, there may be occasions, such as with this report, where this is not possible and supplementary work plans and/or business cases may be required.

3.4 This report presents a 2023/24 supplementary work plan. A supporting procurement business case is attached at Appendices C. The work plan comprises one (1) item - approval to go to tender for independent advocacy services.

3.5 The entry on the work plan describes a contract that is due to expire in the coming financial year, together with the aggregated value of these over the defined period.

3.6 Whilst this expenditure signifies an additional investment, the risks of not making this investment reduce the ACHSCP's opportunity to continue to offer the highest quality services and, subsequently, the achievement of outcomes for individuals.

3.7 Links with Strategic Commissioning

The procurement of works, goods and services is driven by strategic aims. The ACHSCP has established a Strategic Commissioning and Procurement Board (SCPB) to create a clearer link between the programmes of work, the associated budgets, and the procurement work plan and outcomes, in line with the Commissioning Cycle. Throughout the year, the SCPB has considered the items on this Supplementary Procurement Work Plan and determined that the services are required to support the delivery of strategic intentions.

4. Implications for IJB

4.1 **Equalities, Fairer Scotland and Health Inequalities** - As noted in the Business Case, a Health Inequalities Impact Assessment (HIIA) is being carried out by the Planning & Development Manager. There are no specific

equality or health implications from this report. Nor is there any direct implication for our Fairer Scotland Duty.

4.2 **Financial** - In estimating the contract values, we have assumed no change in demand for services, and have allowed 3% uplift for 2023/24 to accommodate an annual national increase including the Real Living Wage (RLW). Uplifts have been applied to the business case over each future year. The value of these contracts' forms part of the recurring base budget of the IJB and the uplift percentages have been taken into account when calculating future budget requirements within the Medium Term Financial Framework

4.3 **Workforce** - There are no specific implications for the Council's or Partnership's workforce arising from this report.

4.4 **Legal** - The procurement of care and support services is a complex area, it is given special consideration under procurement legislation, with specific statutory guidance and best practice guidance issued by The Scottish Government. Because of this special consideration, there is a discrete team within the CPSS to support and manage the commissioning, procurement and contract management of care and support services, and the Work Plan for these services is presented separately to other reports. Each Business Case has been considered and no risk significant enough to warrant a halt to proceeding has been identified.

4.6 **Covid-19** – There are no specific implications linked to Covid-19 arising from the recommendations in this report.

4.7 **Other** - none

5. Links to ACHSCP Strategic Plan

This report links to Strategic Aim 3 Personalisation "Ensuring that the right care is provided in the right place and at the right time when people are in need". It also links to Enabler 7.2, Principled Commissioning, and the commitment that all commissioned services enhance the quality of life for people and their carers.

INTEGRATION JOINT BOARD

6. Management of Risk

6.1. Identified risks(s)

There is a risk that the IJB does not get assurance and accountability for all the money that it spends on services provided by external bodies.

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

These proposals are linked to Risk 2 on the Strategic Risk Register "There is a risk of IJB financial failure and projecting an overspend, due to demand outstripping available budget, which would impact on the IJB's ability to deliver on its strategic plan (including statutory work)."

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

By maintaining formal contractual arrangements and robust processes to monitor contracts with external organisations the IJB has assurance not only that it is getting best value but also that this expenditure is aligned to their strategic priorities and is reviewed regularly.

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Supplementary Procurement Work Plan for 2023/24

Report Title:	Supplementary Procurement Work Plan (Social Care) HSCP23.018
Author:	Neil Stephenson (Strategic Procurement Manager)
Introduction	The purpose of this report is to present a Supplentary Procurement Work Plan for 2023/24 for expenditure on social care services, together with the associated procurement Business Cases, for approval. Almost always, the spend is related to services procured from external service providers – not internal ACC/Partnership/NHSG services This Supplementary Procurement Work Plan for 2023/24 is planned to meet the Delivery Plan and follow strategic direction
Who are we?	The social care contracts team sits within the wider Commercial & Procurement Shared Service (CPSS). We provide commissioning, procurement, and contracting support to the Aberdeen City Health and Social Care Partnership (ACHSCP). We guide the ACHSCP with governance matters and offer the full commissioning cycle to support services/teams.
Why does the IJB need this report?	The report seeks your approval for what are referred to as "Business Cases". On this occasion, you are seeing a supplementary work plan which is additional work we aim to undertake in 2023/2024 (financial year); although we have an annual work plan (presented in January 2023) naturally, as we are dealing with people, there can be subsequent work plans presented which are termed "supplementary".
What do we want to do?	We want to procure high quality services to deliver the right services to people in Aberdeen and commission these in a lawful, fair, and transparent manner. In this report, there is one (1) BC – you are recommended to approve "a" and "b". Please see section 2 of the IJB Report titled "Recommendations". The business case (BC) details the request – inviting you to consider the service's wish to go to tender. This is in section 1 (Recommendation) of the BC. The rest of each BC should offer you clarity on the

	expectations of the service, duration, annual and total cost. For reassurance, the BC is signed-off by Commercial & Procurement, Finance, Legal, and the Chief Officer.
How will we do this?	During the meeting someone from the social care contract team (usually the Strategic Procurement Manager) will briefly outline the report and the BC. This is your opportunity to ask questions/comment. The Chair will then ask for approval.
What will help us to do this?	As a starting point, I would recommend that you consider the Excel spreadsheet "2023-03-28 Appendix A Supplementary Procurement Plan 2023-24" – this gives a brief outline on each BC and allows you to consider the BCs of which you need more information.
What should I be asking?	If you cannot find details in the BC, we would encourage you to consider some, or all, of the following questions: • Am I clear that the service requested in the BC meets our strategic direction? • Are we commissioning ethically? • There is risk with every procurement – are the mitigations clear? • Do you think the people of Aberdeen City need the service requested – is this clear in the BC?
What next?	Each BC has a Lead Officer, and you should contact that person if you have questions. It is likely that they will be at the pre-agenda and full board meeting and can ask some/all of the questions noted above As the report author, if you have questions/comments, please contact the Strategic Procurement Manager directly at: nestephenson@aberdeencity.gov.uk – my team and I are always delighted to help where we can.

Team/Client Group	Description of Requirement	Est Contract/Contract Extension Start Date	Est Contract/Contract Extension End Date	Maximum Extension Period (Months)
Advocacy Services	Business Case C; the provision of Independent Advocacy Services; The requirement for the service is to meet the Council's statutory responsibilities and to provide an advocacy service to residents of Aberdeen City whose rights, as determined by the Human Rights Act, are at risk, and/or who are protected by Scottish legislation and/or who are marginalised and/or face discrimination;	01/10/2023	30/09/2028	24

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Aberdeen City Health & Social Care Partnership
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INTEGRATION JOINT BOARD

DIRECTION

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

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

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

Related Report Number: HSCP23.018

Approval from IJB received on 25/04/2023

Description of services/functions (business case reference)

a) Approves the **Tender**, for a period of up to 5 years of a contract for Independent Advocacy Services, as is detailed in Appendices A1 and C

Reference to the integration scheme: Annex 2, Part 2 – Support services

Link to strategic priorities (with reference to strategic plan and commissioning plan): This report links to the commissioning principles outlined as one of the enablers within our strategic plan

Timescales involved:

Start date: 01/10/2023

End date: 30/09/2029

Associated Budget:

Description of Requirement Please see "Appendix A Supplementary Procurement Plan Exempt 2023-24" for further details		Value to be approved by IJB £
	Total	**£2,059,612**

Details of funding source: This is money from the AHSCP budget

Availability: **Confirmed**

Aberdeen City Health & Social Care Partnership
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INTEGRATION JOINT BOARD

Date of Meeting	25th April 2023
Report Title	Creating Hope Together: Scotland's Suicide Prevention Strategy and Action Plan.
Report Number	HSCP23.019
Lead Officer	Kevin Dawson, Lead for Community Mental Health, Learning Disabilities and Drug and Alcohol Services.
Report Author Details	Name: Jenni Campbell, Job Title: Project Manager, Email: jenncampbell@aberdeencity.gov.uk, phone number: N/A
Consultation Checklist Completed	Yes
Directions Required	No
Appendices	a. Health Inequalities Impact Assessment b. CPP LOIP

1. Purpose of the Report

1.1. To note the recently published national Suicide Prevention Strategy & Action Plan and to provide assurance on activities locally.

2. Recommendations

2.1. It is recommended that the Integration Joint Board:

a) Note progress on delivery of the national Suicide Prevention Strategy, Action Plan and local implementation.
b) Instruct the Chief Officer to provide an update on progress annually to the Integration Joint Board.

INTEGRATION JOINT BOARD

3. Summary of Key Information

3.1. The national Suicide Prevention Strategy 'Creating Hope Together' was published in September 2022, jointly produced by the Scottish Government and COSLA. The new national 10-year strategy, and an associated action plan, replaces the current Suicide Prevention Action Plan 'Every Life Matters' which was published in 2018.

The vision is to reduce the number of suicide deaths in Scotland, whilst tackling the inequalities which contribute to suicide. To achieve this, all sectors must come together in partnership, and support our communities, to become safe, compassionate, inclusive, and free of stigma. The aim is for any child, young person or adult who has thoughts of taking their own life, or are affected by suicide, to get the help they need and feel a sense of hope. This vision will be adopted within Aberdeen City.

Full document available here: Creating Hope Together: Scotland's Suicide Prevention Strategy 2022-2032 (www.gov.scot)

3.2. There are a range of guiding principles, outcomes and priority areas for consideration and implementation locally.

There are 4 main long-term outcomes:

- The environment we live in promotes conditions which protect against suicide risk – this includes our psychological, social, cultural, economic and physical environment.
- Our communities have a clear understanding of suicide, risk factors and its prevention – so that people and organisations are more able to respond in helpful and informed ways when they, or others, need support.
- Everyone affected by suicide is able to access high quality, compassionate, appropriate and timely support – which promotes wellbeing and recovery. This applies to all children, young people and adults who experience suicidal thoughts and behaviour, anyone who cares for them, and anyone affected by suicide in other ways.
- Our approach to suicide prevention is well planned and delivered, through close collaboration between national, local and sectoral partners. Our work is designed with lived experience insight, practice, data, research

and intelligence. We improve our approach through regular monitoring, evaluation and review.

3.3. The 'Creating Hope Together' action plan details the actions for the next three years, which, implements the first stage of the Scottish Government and COSLA's 10-year suicide prevention strategy. Full document available here: Creating Hope Together: suicide prevention action plan 2022 to 2025 - gov.scot (www.gov.scot)

The actions in this plan are designed to support delivery of the four long term outcomes and are built around six action areas as set out below:

- Action area 1: Whole of Government and society approach
- Action area 2: Access to means
- Action area 3: Media reporting
- Action area 4: Learning and building capacity
- Action area 5: Supporting compassionate responses
- Action area 6: Data, evidence and planning

3.4. Aberdeen City Health and Social Care Partnership (ACHSCP), NHS Grampian and Aberdeen City Council (ACC), are already working jointly with Aberdeenshire and Moray partners (Health and Social Care Partnerships, via NHS Grampian and Local Authorities) within the Grampian Suicide Prevention Oversight Group. This group forms a pan-Grampian strategic collaborative approach to suicide prevention. This approach will meet the objectives and requirements of 'Creating Hope Together', in addition to ensuring robust links in and between organisational leadership and national forums such as the Scottish Delivery Collective.

3.5. This approach will support innovative partnership working and have flexibility to ensure local solutions. Importantly this will promote a strategic approach to Suicide Prevention work and projects across the North East of Scotland.

3.6. A recent procurement exercise took place on behalf of the Grampian Suicide Prevention Oversight Group partners which sought a strategic partner within the Third and Independent sector to assist in the local implementation of 'Creating Hope Together' in addition to supporting the wider delivery of aims of the Grampian Suicide Prevention Oversight Group. The Scottish

Association for Mental Health (SAMH) have been awarded this contract, commencing in April/May 2023. SAMH have information sharing agreements in place with key partners such as Police Scotland which supports the understanding of local trends (there is no data provided by NHS Grampian/ACC to SAMH).

3.7. A strategic working group is fully established with Grampian called the North East Suicide Prevention Leadership Group (NESPLG), whom meet quarterly to discuss the strategic aims, outcomes and delivery of the actions in the Suicide Prevention Strategy. Police Scotland convey data from City, Aberdeenshire and Moray to give a Grampian wide overview. Training updates are provided by SAMH and campaigns, workshops and initiatives are discussed. The NESPLG reports into the Grampian Suicide Prevention Oversight Group mentioned above.

3.8. As a result of local implementation of the national Suicide Prevention Strategy a range of outcomes are sough such as: changes and improvement in knowledge, awareness, skills, practice, behaviour, social action, and decision making. These outcomes will be measured, and updates provided to the Integration Joint Board annually. An outcomes framework, yet to be published by Scottish Government, will support the demonstration how the local activity is achieving the long-term outcomes of the national strategy. Over the lifetime of this strategy, the outcomes framework will be used to prioritise actions and investment to maximise our collective impact in reducing suicide deaths in Scotland.

3.9. Partners within the Grampian Suicide Prevention Oversight Group have earmarked non-recurring funding for the next 2 years (£250k per annum). The Scottish Government have indicated that additional national funding will made available over next 3 years with an anticipated Grampian allocation of approximately £47k per year for the next three years.

3.10. A new Aberdeen City sub-group is being established with multi-agency representatives, including children services, education, adult services, older adults' services, public health, housing and third sector organisations. This sub-group will have a remit to review Aberdeen City suicide related data and work with Police Scotland and SAMH to identify trends and associated improvement actions. Close working with Health Intelligence and Public

Health will support the use of key quantitative and qualitative data to benchmark and evidence improvements and trends. We will also work with key partners such as Police Scotland, NHS and Aberdeen City to follow existing process already in place in terms of shared learning after a suicide.

3.11. Of key consideration is continued and improved engagement with those who have lived and living experience. The Mental Health and Learning Disability (MHLD) Public Empowerment Group (PEG) is a forum for engagement on local implementation actions. Wider public engagement will also be a key focus of the role held by SAMH as the strategic partner. Details of national engagement and consultation work is provided for information and will inform approaches locally: Suicide prevention strategy development: early engagement - summary report - gov.scot (www.gov.scot)

4. Implications for IJB

4.1. **Equalities, Fairer Scotland and Health Inequality** - A Health Inequalities Impact assessment (HIAA) is in progress (Appendix a); however, the recommendations of this report seek to improve a range of supports for those in distress, experience of non-completed suicide attempt or sadly lived experience cause by bereavement to suicide.

From the national strategy it is known that:

- Just under three quarters of all suicides in Scotland are male
- Almost half (46%) were aged 35-54
- Death by suicide is approximately three times more likely among those living in the most socio-economically deprived areas than among those living in the least deprived area
- 88% of people that die by suicide are of working age with two-thirds of these in employment at the time of their death.

4.2. **Financial** - There may be financial implications if the anticipated monies from Scottish Government are not received or received at a reduced allocation. The NESPLG will monitor this and may require reviewing plans in accordance with budget availability.

4.3. **Workforce** - There are no known workforce implications arising from the recommendations of this report.

4.4. **Legal** - There are no direct legal implications arising from the recommendations of this report. Ongoing engagement relating to data implications will be undertaken.

4.5. **Covid-19** - There are no direct implications relating to Covid 19. However, a number of challenges linked to recent events, such as the COVID-19 pandemic, Brexit and the cost-of-living crisis are of consideration in terms of the impact on suicide and suicide prevention work. The national strategy, and its associated action plan, already reflect the work required to support the Covid-19 recovery and mitigate against other events.

4.6. **Unpaid Carers** - There are no direct unpaid carers implications arising from the recommendations of this report. However, it is important to note that support to unpaid carers who care for people at risk of suicide should be taken into account by promoting learning resources and awareness-raising on suicide prevention. creating-hope-together-scotlands-suicide-prevention-action-plan-2022-2025.pdf (www.gov.scot) (page 37).

4.7. **Other** - Every life lost to suicide is an enormous tragedy. And every life lost leaves devastating and long lasting impacts on families, friends and communities. Up to 135 people can be affected in some way by every suicide. Creating Hope Together: Scotland's Suicide Prevention Strategy 2022-2032 (www.gov.scot) (page 4). It is important to consider how we take care of those affected by such experiences as a Health and Social Care Partnership within our approaches well-being and enable a culture which reduces stigma and enables those in distress to receive timely support.

5. Links to ACHSCP Strategic Plan

5.1. The recommendations in this report complement the strategic priorities outlined in the Partnership's Strategic Plan. Suicide Prevention is referenced and aligned to the Grampian-wide Mental Health and Learning Disabilities Portfolio and forms a specific project within the Year 2 Delivery Plan. This work aims to strengthen the supports available to support suicide prevention

and support people to find meaning, connection and support within their local community.

Additionally, there is crossover with a range of local and national strategic approaches such as the Mental Health & Wellbeing Strategy, Self-Harm Strategy, Trauma Informed Practice, Local Outcome Improvement Plan, and strategies and plans developed by key sectors and organisations, such as Police Scotland and the Scottish Ambulance Service.

6. Management of Risk

6.1. Identified risks(s)

Failure to implement the Strategy and Action Plan.

This risk is minimal due to the ongoing engagement with partners. Failure to implement the Strategy and Action Plan could lead to reputational damage, to mitigate this the is an established oversight and working group structure which will report to the Integrated Joint Board annually.

Failure to receive necessary budget allocation.

This risk will be mitigated through monitoring and, if necessary, a review of the implementation approach.

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

(1) The commissioning of services from third sector and independent providers (e.g. General Practice and other primary care services) requires all stakeholders to work collaboratively to meet the needs of local people.

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

(6) Need to involve lived experience in service delivery and design as per Integration Principles.

INTEGRATION JOINT BOARD

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 taking an approach which is collaborative, recognises areas of challenge and seeks to place lived and living experience at the core of service design and delivery. There are risks that the local implementation actions may be compromised should financial allocations be reduced or withdrawn. This risk will be further mitigated in the remits of both the Grampian Suicide Prevention Oversight Group and the NESPLG.

The risk is low.

Health Inequalities Impact Assessment (HIIA) – Stage 1 Proportionality and Relevance

Completion of the template below will give senior officers the confidence that the Equality Duty, the Scottish Specific Public Sector Equality Duties, Human Rights and the Fairer Scotland Duty have been considered at the beginning of and throughout the proposal development and that action plans are in place, where applicable, to; identify relevant stakeholders, undertake robust consultation to deliver a collaborative approach to co-producing the HIIA.

What Integration Joint Board (IJB) report or Partnership decision does this proportionality and relevance assessment relate to:

- Note progress on delivery of the national Suicide Prevention Strategy, Action Plan and local implementation.
- Note that progress will be provided annually to the Integration Joint Board

This report is an overview of where we are now and as such does not propose any actions that will have an immediate impact on people with protected characteristics, however, those involved in taking this forward are fully aware of the need to impact assess once local actions are in development and recognise this is a whole life strategy approach affecting everyone in society.

From the national strategy it is known that:

- Just under three quarters of all suicides in Scotland are male,
- Almost half (46%) were aged 35-54,
- Death by suicide is approximately three times more likely among those living in the most socio-economically deprived areas than among those living in the least deprived area,
- 88% of people that die by suicide are of working age with two-thirds of these in employment at the time of their death.

These will be further explored and actioned.

Relevant protected characteristics materially impacted, or potentially impacted, by proposals (employees, clients, customers, people using the service) indicate all that apply

Age	Disability (Learning Disability, Learning Difficulty, Mental Health, Physical Autism/Asperger's	Sex	Gender Reassignment (Particularly in relation to allocation of single sex room)	Marriage and Civil Partnership	Pregnancy and Maternity	Race	Religion and Belief (including non-belief)	Sexual Orientation

N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Human Rights (enhancing or infringing)

Life	Degrading or inhumane treatment	Free from slavery or forced labour	Liberty	Fair Trial	No punishment without law	Respect for private and family life	Freedom of thought, conscience and religion	Freedom of expression	Freedom of assembly and association	Marry and found a family	Protection from discrimination
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Main Impacts	**Are these impacts positive or negative or a combination of both**	**Are the impacts significant or insignificant?**
N/A	N/A	N/A

Is the proposal considered strategic under the Fairer Scotland Duty?	No

HIIA to be undertaken and submitted with the report – Yes **If no – please attach this form to the report being presented for sign off**	No **Proportionality & Relevance Assessment undertaken by:** Jenni Campbell, Project Manager Jenny Rae, Programme Manager

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11.1 Reducing Suicides

Project Aim	Start Date	Testing End Date	Progress Scale	Project RAG
Reduce the rolling 3-year average number of suicides in Aberdeen to below 26 by 2023. **Project Manager:** Juliet Henderson, Police Scotland, Revised Charter Approved: Sept 2021	July 2020	Dec 2022	6 – Testing Underway	G – on track

Changes being tested		Are our changes resulting in improvement?
What changes are being tested?	**Which Locality and/ or test group**	**Current Position Oct 22** Data from September 2022 indicates **the overall rolling 3 year average is 28.** This shows an increase of 2 compared to baseline data in 2019. **Change idea 1 - Roll Out Online Suicide Prevention Training -** Over 1000 people trained in Aberdeen since training began. SAMH were subject to a Cyberattack and thereafter lost a large number of historical data to provide exact numbers on which areas training had been provided. 100% of all new recruits from A Division being provided with Suicide prevention Training during their 12 week initial training at Tulliallan. Feedback has been positive with officers having knowledge from the outset on how to deal and support someone who is having suicidal thoughts. Since March 2020, 206 North East probationary officers have received Suicide Prevention Training. A further 15 officers will be trained in November 2022. No specific data is available from Officers as to whether or not they have used their training. Since the roll-out of the training, deaths by suicide in Aberdeen have fallen by roughly 50%. However, it is not possible to demonstrate a causative link. The video on Community Planning Aberdeen's YouTube channel has had 192 views. We are awaiting the Analysis of Police Scotland's Social Media channels and the quantity of material circulated by AVCO to 3rd Sector organisations within Aberdeen. **Change idea 2 - Identifying and Reaching At Risk Groups – Additional Change Idea (September 2021) –** Analysis of Police data over a 6 month period in 2021 showed that 19% of all attempted suicides/self-harm calls occurred in Northfield
1. Roll Out Online Suicide Prevention Training We are continuing with the successful implementation of suicide prevention training provided by SAMH for free. In April to May 2022, new material for professionals who come into contact with those who are experiencing suicidal thoughts/have concerns of suicide will be rolled out across the City by electronic means. Listening to feedback, we understand that capacity can be a blocker to undertaking training. The material and an accompanying video is hosted on Community Planning Aberdeen's website and has been promoted and shared on Police Scotland Social Media channels. This material can be referred to immediately and will be made available to any and all who will find it beneficial. Suicide Prevention material has been made available to partners and circulated to all Community Councils. Additional training and materials have been made available to all Police Officers and staff with all new recruits from A Division being provided with Suicide prevention Training following their initial 12 week initial training at Tulliallan.	City wide/Teachers, Police, NHS staff, HR personnel within industries employing High Risk (i.e. Oil and Gas/Sea based occupations)	

2. Identifying and Reaching At Risk Groups – (Additional Change Idea September 2021) Engage with organisations and at risk groups to test the impact of • Providing organisations interacting with, representing or the groups themselves with material, including training about where they can seek help, • providing information about how to have conversations about suicide prevention or, • providing people/resource to support to these groups Work is ongoing with the LEGS and Localities to ensure that Suicide Prevention messaging and training is made available to the most vulnerable in our communities. Their support in identifying groups is crucial to reaching them.	City wide/Organisations interacting with, representing or those in an at risk group (Men & Oil and Gas/Sea based occupations, football). Additionally geographical areas where completed suicides may be elevated. Northfield	– the highest in Aberdeen. All of these occurred in a domestic setting. Engagement in Northfield area and within Northfield Academy was welcomed. Qualitative feedback indicated a strong desire for SAMH to deliver training within the School setting. During early 2022 Northfield Academy staff were offered appropriate training to better engage with vulnerable pupils, but there was minimal uptake. In the same 6 month period in 2021 there were 2 deaths by suspected suicide in Northfield*. For the same time period in 2022 there were 4 deaths by suspected suicide*. Changes to how attempted suicide data is now classified prevent a like-for-like comparison. That being said, attempted suicides in Aberdeen have fallen from 229 (Jan-Oct 2021) to 189 (Jan- Oct 2022), a fall of 17.5%. The areas with the four highest percentage of incidents, including Northfield, (16%-19%) are all indicated as deprived areas (SIMD). We are exploring training Housing Associations and Officers. Engagement has taken place. **<u>Change idea 3 - Prevent Suicide App</u>** Advertising and promotion of the App across various media platforms has seen the download rate almost double in less than one year. Figures from Faff Digital show between 1st January 2022 and 17 October 2022, 6513 people across Aberdeen City have used the Suicide Prevention App. By 17 October 2022, 23,383 people in Aberdeen had accessed the website. Since mid-2021 website traffic has more than doubled (exact figures not provided). There are clear peaks in usage in late spring/early summer and late summer where usage, briefly, more than doubles. This correlates with peaks in deaths by suicide seen in Police data. The 25-34 age group account for the most common users at 25% of those accessing the website. No data is available for the app. Males account for 57.9% of website users. Again, no data is available for the app. **<u>Change 4 – Changing room programme</u>** 19 participants completed The Changing Room programme. Participants from the first and second programme have referred current participants. Another
3. Creating and launching a prevent suicide app to increase access to supports. The prevent Suicide App was created as a safe place that could be accessed for meaningful local advice for those with suicidal feelings, for families of those with suicidal feelings and for professionals.	At Risk Groups/Individuals with suicidal feelings.	
4. Changing Room Programme Tested with SamH and Aberdeen FC**.** The Changing Room is a national programme supported by SAMH and funded by Movember and is already delivered or soon to be delivered at 21 other Scottish League Clubs.	Aberdeen FC Fans	
5. Development of Traumatic Death Packs for Officers to reduce impact of bereavement and bereavement by suicide (Collaboration with SAMH, PSOS & PETAL	Police Officers	
6. Connecting all People who feel suicidal and come to the attention of Police towards immediate support.	Police Officers	
7. Raising Awareness/Ongoing Communication Campaigns	The aim is to reach far and wide	

A media campaign highlighting the importance of Suicide Prevention will go live immanently focussing on community reassurance, that SP is everyone's business and empowering those in our communities to respond with compassion and confidence to those experiencing a crisis Regular Suicide Prevention messaging scheduled on all Police Scotland Social Media Accounts. A Year of Action has been planned for 2023 focussing on a different contributing factor each month.	throughout Aberdeen City. Collaboration with NHS means that multiagency messaging and content will be produced and shared in local press in June 2022.	participant is on the verge of launching his own Mental Health business and has trained to become a Mental Health First Aider and Trainer. Changing Room have had men who have found the strength to change occupations, address issues with colleagues and be able to reconnect with family and in general have tools and coping mechanisms to recognise and stop bad days or moments affecting them so much as they had done in the past. Given the success, groups are considering other groups to test with, however there are no firm plans as yet. As mentioned above, levels of distress in Aberdeen appear to be falling in recent months, but there is no provable causative link. **<u>Change Idea 5 Traumatic Death Packs for Officers</u>** To reduce impact of bereavement and bereavement by suicide on members of the public, information on support services focussing on Traumatic Death has been circulated to CID Officers. When Police Officers encounter someone who has been affected by suicide, they can provide these packs to the families etc. 100% positive qualitative feedback has been received from Officers and members of the public. As such, Police Scotland and SAMH are in the process of revising SAMH's After a Suicide booklet and will develop an After a Sudden Death booklet for Police Officers to offer to the bereaved. Outside of mental health concerns and substance misuse, bereavement is one of the most common contributing factors in suicide according to Police data. It was listed as a factor in 16% of male and 21% in female suspected deaths by suicide. In a recent study, following a bereavement by suicide, 38% of the 7,150 bereaved respondents contemplated taking their own lives.* **<u>Change Idea 6- Well Service</u>** Well Service was tested initially with concerns in the Tillydrone and Seaton areas on one late shift per week. This was the area identified where the largest number of relevant incidents had been identified and, during this initial stage, Well Aberdeen conducted training and recruitment was conducted. The Well

	Aberdeen service was then expanded across the entire city and extended to 4 days with a mix of early, late and weekend cover, the Saturday service being offered as part of the support provided within Kittybrewster Custody Suite. This service includes the ability to make referral for people in immediate crisis, including suicidal concerns. They assist in providing immediate support and also moving forwards. It is also an addition option to make a risk assessment as to whether the person is appropriate to be left or whether further services require to be contacted. The outcome/feedback of that testing was that those who used Well reported the staff as being knowledgeable, supportive, able to engage and provide onwards referral to services. The service hadn't been picked up as much as had been expected as yet but this is still the pilot period with a review being conducted at the end of October. Adaptations are being made in relation to times and dates the service is available and also to highlight the service to officers so it can be used more widely. Data of how many referrals made has been captured within the graph below. Information is still being sought as to whether any of these referrals related to suicide as a concern. **Change Idea 7** A Year of Action has been planned for 2023 focussing on a different contributing factor each month. Discussions are ongoing with SAMH and Police Scotland as how best to measure the impact this will have. For example, in April 2023 the focus will be on Anxiety and Depression. These are listed as contributing factors in 32% and 73% of female suspected deaths by suicide, and 24% and 44% of male suspected deaths by suicide respectively according to Police data. Analysis, over several months, will record social media interactions, the number of relevant Concern Reports (VPD) submitted, DBI referrals, attempted suicide incidents and deaths by suspected suicide. This will be compared to similar data from previous years. Although a causative link could never be proved, there may be correlations and coupled with qualitative or anecdotal evidence this may give reasonable to good indications of effectiveness. All analysis and findings will be reported from 2023 onwards.

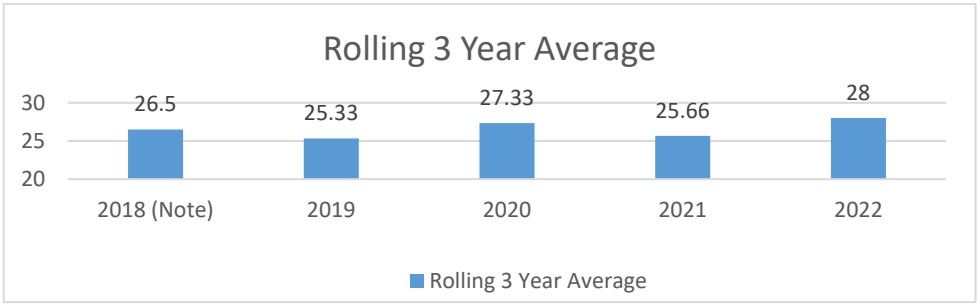
Emerging Threats

The Project team met with the North East Suicide Prevention Lead Group to plan its proactive response to the Cost of Living Crisis reported by several help organisations to be creating high demand from concerned people. The lead group have taken ownership of work to better inform financial help organisations of Suicide Prevention.

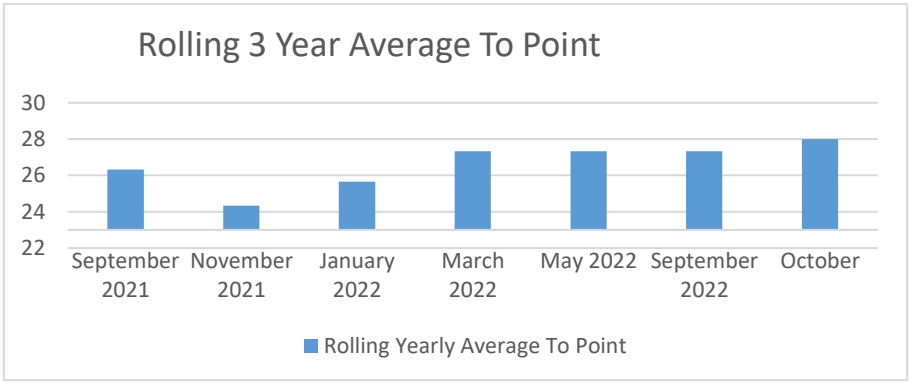
A greater input from, and a collaboration with Primary Care would be hugely advantageous to this project and other suicide prevention initiatives in Grampian.

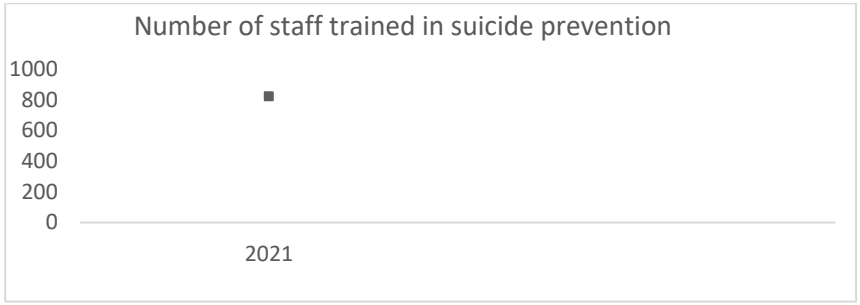
Relationship breakdown and being a victim of abuse, outside of mental health, is the biggest contributing factor in suspected deaths by suicide for males and females respectively according to police data. With increased family pressures due to the energy crisis, cost of living and the colder weather it is anticipated that instances leading to these circumstances will increase significantly. This is compounded by budget restrictions and potential reductions in support services.

Improvement Data



Note. Interrogation of 2018 data to establish Aberdeen as location has not been possible due to recording methods utilised at that time. Rolling 2 year average provided.





Due to SAMH losing historical emails due to a cyberattack, they have no way of providing an exact number of staff trained in Suicide Prevention. According to figures from Eventbrite, which is used to book courses, SAMH have trained 4500 people in the North east. Eventbrite does not record the locations of where attendees work or reside.

Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGATION JOINT BOARD

Date of Meeting	25 April 2023
Report Title	Prevention and Early Intervention
Report Number	HSCP23.026
Lead Officer	Sandra Macleod Chief Officer
Report Author Details	Alison Macleod Strategy and Transformation Lead
Consultation Checklist Completed	Yes
Appendices	**Appendix A** – Prevention and Early Intervention Report to Aberdeen City Council

1. Purpose of the Report

1.1. To update the Integration Joint Board (IJB) on a report on Prevention and Early Intervention that was approved at Aberdeen City Council on 1st March 2023 and the steps that the Chief Officer is taking to deliver her action in relation to it.

2. Recommendations

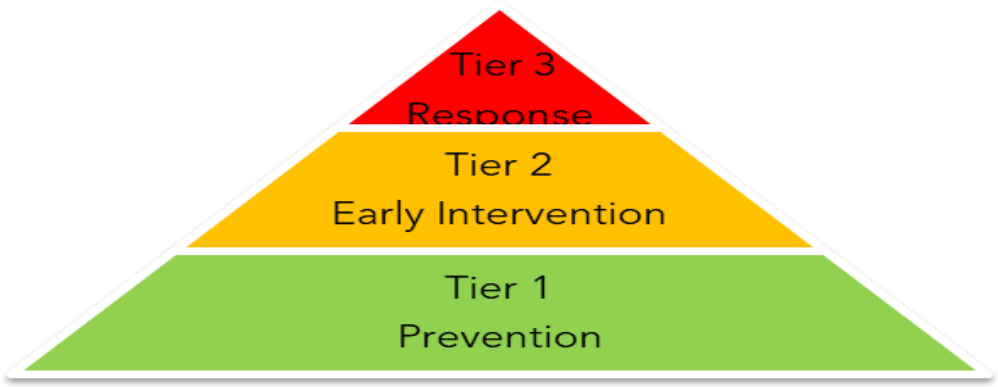
2.1. It is recommended that the Integration Joint Board notes the report on Prevention and Early Intervention at Appendix A and the Chief Officers intended action in relation to it detailed in paragraphs 3.4 and 3.5 of this report.

3. Summary of Key Information

3.1. The Prevention and Early Intervention report at Appendix A articulates very well the benefits to be gained through shifting the balance of focus more and more towards prevention. It references the Christie Commission and the direction to public bodies to make a deliberate shift to preventative spend. Prevention is a key tool for the IJB to ensure sustainable service provision in

the face of increasing demand and restricted funding and it is one of the four Aims of the Strategic Plan.

3.2. The report refers to a tiered approach to resource management allowing a greater understanding of the balance of spend.



3.3. Paragraph 2.9 of the report includes a recommendation that the Chief Officer includes tiered analysis on annual reporting against the Health and Social Care Partnership Strategic Plan 2022-25 as part of evidencing the shift to a preventative approach rather than a medical approach to ageing well and discussions have commenced on how we achieve that.

3.4. Members will be aware from the presentation of the Medium-Term Financial Framework and the Year 2 Delivery Plan at the IJB meeting on 28th March that there is the intention to link budget spend to each of the projects. It is also our intention to assign a Tier to each of the projects. This will enable us to report on the level of funding at each Tier and monitor how that shifts over time.

3.5. The Tiers will be included in the first monthly reporting to the Senior Leadership Team on 26th April 2023 and will feature in the quarterly reports to the Risk, Audit and Performance Committee from 13th June 2023. IJB will see the tiered reporting incorporated into the Annual Performance Report for 2023/24.

INTEGATION JOINT BOARD

4. Implications for IJB

4.1. Equalities, Fairer Scotland and Health Inequality

The implementation of the tiered approach to reporting will further the prevention agenda of the IJB which generally has a greater focus on those experiencing inequality.

4.2. Financial

The introduction of tiered reporting will provide greater visibility of how the IJB budget is allocated.

4.3. Workforce

There are no direct or immediate workforce implications arising from this report. Should the tiered reporting encourage a greater shift towards prevention this may impact on the skills and types of roles required however these will be the subject of the relevant reports as these changes are proposed.

4.4. Legal

There are no legal implications arising from this report.

4.5 Unpaid Carers

Any greater shift to prevention could reduce the burden of the unpaid caring role in future.

5. Links to ACHSCP Strategic Plan

5.1. This report relates directly to the delivery of the Strategic Plan with a focus on the Strategic Aim of Preventing Ill Health.

INTEGATION JOINT BOARD

6. Management of Risk

6.1. Identified risks(s)

There is a risk that demand for services exceeds the resources we have to meet those needs.

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

This report links to Strategic Risk 5:

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

This risk is currently sitting at High.

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

Adopting the tiered approach to reporting should help the IJB manage the demographic and financial pressures and deliver sustainable services for the future.

ABERDEEN CITY COUNCIL

COMMITTEE	Council
DATE	1st March 2023
EXEMPT	No
CONFIDENTIAL	No
REPORT TITLE	Prevention and Early Intervention
REPORT NUMBER	CUS/23/064
DIRECTOR	Gale Beattie
CHIEF OFFICER	Derek McGowan
REPORT AUTHOR	Derek McGowan
TERMS OF REFERENCE	24.5

1. PURPOSE OF REPORT

1.1 To advise the Council on the approach taken to embed Prevention and Early Intervention into the Commissioning cycle and shape budget decisions to positively deliver on outcomes for Aberdeen.

2. RECOMMENDATIONS

That the Council:-

2.1 Notes the development to date of the Council's approach to resource allocation in aid of supporting the deliberate shift to prevention as advocated by the Council's Target Operating Model and agrees to further develop it by instructing the following corporate wide developments;

a) Instructing the Chief Officer – Finance in consultation with the Chief Officer - Early Intervention and Community Empowerment to develop a new financial reporting template to capture the Prevention and Early Intervention tiered resource allocation model, and to include this in the annual Budget process, with effect from the 2024/25 budget cycle, to demonstrate the proposed allocation of resources per tier;

b) Instructing the Chief Officer – Finance, in consultation with the Chief Officer Governance and Head of Commercial and Procurement Services to work with the Group entities and Tier 1 ALEOs to prepare a statement of tiered resource allocation across the Aberdeen City Council family group, and to include this in the annual Budget process with effect from the 2024/25 budget cycle;

c) Instructing the Chief Officer – People and Organisational Development in consultation with the Chief Officer – Early Intervention and Community and Empowerment and Chief Officer – Finance to develop a training programme for staff and elected members on early intervention and prevention and report on delivery progress to the Staff Governance Committee;

d) Instruct the Chief Officer – Governance to amend the Committee reporting template to include commentary on tiered resource allocation on prevention, early intervention and response services; and

e) Instruct the Chief Officer – Data & Insights to work through the Aberdeen Health Determinants Research Collaborative to ensure that the Council's approach to resource allocation and the continued shift to prevention is supported by appropriate evidence, research and evaluation.

2.2 As part of the next stage of the development of the resource allocation approach to underpin the shift to prevention, agrees to instruct the following on-going spend analysis using the three tier intervention framework:

a) Instruct the Chief Officer – Strategic Place Planning to include a tiered analysis of resource requirements in the refreshed Local Housing Strategy to be presented for approval to the Communities, Housing and Public Protection Committee noting the significance of housing as one of the key determinants of population health;

b) Instruct the Chief Education Officer and Chief Officer Integrated Children and Family Services to undertake tiered analysis of the resource requirements to support the refreshed Integrated Children's Services Plan (2023-2026) and present the Integrated Children's Services Plan to the Education and Children's committee for approval noting the significance of early years interventions in population health; and

2.3 Note the Approved IJB Strategic Plan (2022-2025) and request the Chief Officer of Aberdeen City Health and Social Care Partnership to include tiered analysis on annual reporting against the Health and Social Care Partnership Strategic Plan 2022-25 as part of evidencing the shift to a preventative approach rather than a medical approach to ageing well; and

2.4 As part of demonstrating how the Council's expenditure is driving achievement of better outcomes through co-ordination and collaborative working:

a) Note the commitments contained in the Council Delivery Plan COM/23/074 which are aligned to the Local Outcome Improvement Plan outcomes,

b) Note the assessment of the Council Delivery Plan commitments using the tiered analysis detailed in this report, and

c) Instruct the Director of Commissioning, as Chair of the Community Planning Partnership Management Board, to encourage Community Planning Partners to adopt this approach to tiered analysis of organisational spend to support the development of a citywide perspective on resource allocation.

3. STRATEGIC CONTEXT

3.1 The Commission on the Future Delivery of Public Services (the Christie Commission) identified the importance of a deliberate shift to preventative services and spending based on the rising demand on public services, and the scale of reactive spending, specifically the targeting of resources at short term and immediate responses rather than long term planning to reduce demand and spend. This supports the findings of the Marmot review that identified health inequalities as a social justice issue, highlighting the links between socio-economic inequalities and poorer life outcomes. The United Nations Convention on the Rights of the Child sets out detailed rights for children, defined as being under 18 years old, and it is clear that the impending adoption of this into Scots Law will enhance the protective measures for children and young people, and lead to healthier adults over time.

3.2 The Christie Commission highlighted that almost half of public sector spend treated failure demand, and future projections are that around half of all future public expenditure will be on NHS services. This leaves the remainder of national public expenditure to be allocated across Police Scotland, the Scottish Fire and Rescue Service and the 32 Local Authorities amongst other agencies. In seeking to manage this fiscal environment in the years since the Christie Commission, Aberdeen City Council has developed and implemented preventative approaches and sought to reduce demand on services through increased use of data and insights.

3.3 Economics of prevention demonstrate that taking action to prevent harm occurring is more cost effective than treating the harm once it has occurred. The traditional focus of prevention and early intervention work has been on ages and stages of life and health related interventions, with a mix of targeted and whole population measures – both local and national. Examples include:

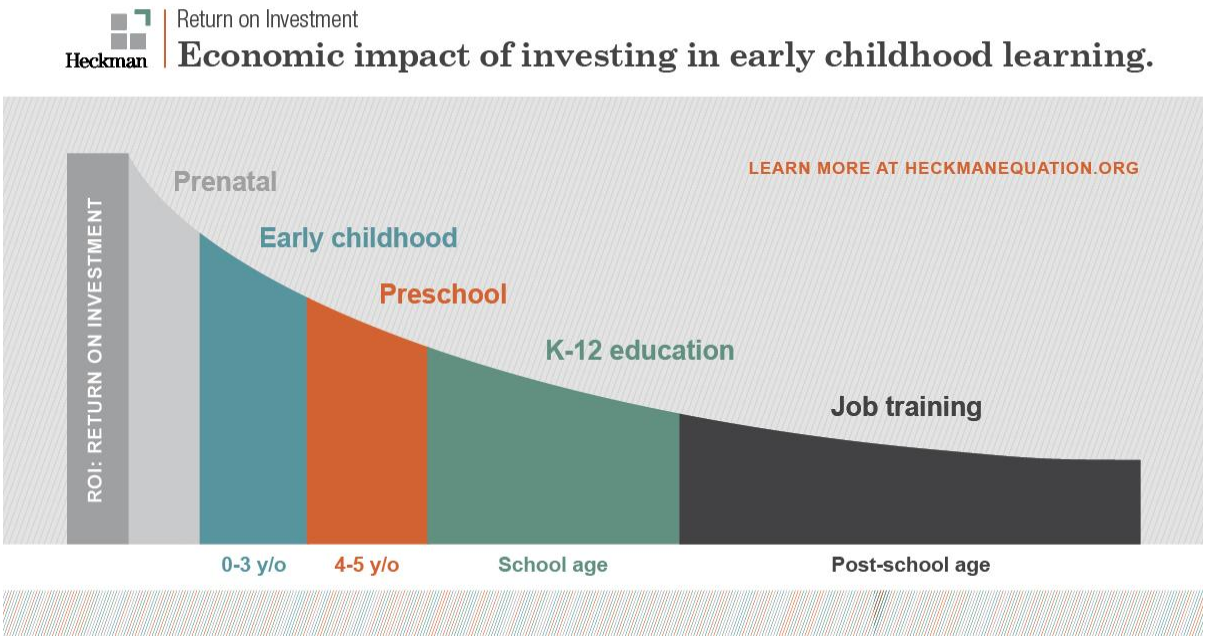
- Air quality
- Child poverty
- First 1000 days of life
- Home safety for the young and elderly
- Obesity
- Road traffic measures
- Smoking cessation
- Substance use
- Teenage pregnancy

3.4 This evidence and research base has meant that the collective focus on public health has increased, and partnership working through the Local Outcome Improvement Plan has been a priority – with excellent results so far across a range of economic, people and place based targets. Levers currently available in tackling demand and embedding a prevention and early intervention approach include legislation and policy such as:

- Bairns' Hoose
- Child Poverty (Scotland) Act 2017
- Climate emergency
- Community Justice (Scotland) Act 2016
- Council House building programme
- Covid recovery strategy
- Digital connectivity
- Drug Related Deaths Taskforce
- Free school meals
- Justice vision
- Proposed National Care Service
- Partnership statement
- Programme for Government
- The Promise
- Regional Economic Strategy
- Social Renewal Advisory Board
- United Nations Convention on the Rights of the Child (UNCRC)

4 PREVENTION AND EARLY INTERVENTION

4.1 The return on investment achievable through preventative spending is perhaps most easily demonstrated by the Heckman curve, which shows the benefits of Early Years and education spend:



4.2 This demonstrates that a child born and enjoying the full protections afforded by the United Nations Convention on the Rights of the Child will most likely allow the adult to flourish - but also that investment later in life does not afford the same protective factors. The conditions for healthy childhood development are well established – safe, secure and nurtured. However, the barriers to this are also well know – including domestic abuse, parental substance misuse, violence and poverty.

4.3 The most recent Population Needs Assessment for Aberdeen shows healthy life expectancy is up to 12 years greater in more affluent areas than in poorer ones; and that this mirrors educational attainment in those areas. Across the city this story is repeated, with the exception of alcohol and tobacco use. The poorer you are - and the poorer your environment - the poorer your life outcomes are predicted to be, and the shorter both your life expectancy and

healthy life expectancy are. People experiencing these factors are statistically more likely to suffer from diseases such as obesity, diabetes, heart disease or mental illness, will be more likely to have multiple contacts across public sector agencies, and will require greater resources from the public sector across their lifetime.

4.4 The concept of 'cumulative neglect' is important in this context. This encompasses:

- Physical neglect – basic needs such as food, clothing, housing, safety
- Educational neglect – where a parent doesn't ensure that their child is educated
- Emotional neglect – where a child doesn't receive the emotional support, nurturing and stimulation need
- Medical neglect – where a child doesn't receive medical support to ensure healthy development

The net effect of this cumulative neglect can be seen in adults, but is first experienced by children. Obesity, diabetes, cardiovascular morbidity and neuropsychiatric diseases can be considered paediatric diseases, with significant evidence demonstrating the impact of physical, social and environmental conditions on foetal and early years development, and life outcomes including health, employability and income. The deficit in the daily life of a community is also made clear through the number of people from a community that are in prison, who lack employment, who suffer from increasing inequality, and who lack fulfilment on a personal level. Cumulative neglect is addressed in the refreshed Children's Services Plan due to be agreed later this year.

4.5 The cost to the public sector of managing these lower health and social outcomes is vast, with some research suggesting this could be up to 10% of GDP. From a public health perspective, areas of multiple deprivation have a higher incidence of infectious and non-communicable diseases, including those caused or exacerbated by smoking, poor diet, mental health and violence – precisely the types of health challenges linked to adverse childhood experience, poverty and poor educational attainment. The Early Intervention Foundation identified the cost of intervening late in public health issues as £17billion annually (England and Wales figures 2016/17).

4.6 Looking at Return on Investment for specific interventions, evidence suggests that high returns and cost benefits can be found in public health measures such as:

- Preventing falls by the elderly
- Multisystemic therapy for juvenile offenders
- Intensive pre-school education for socioeconomically deprived families
- Road safety measures

4.7 While the case is clear for prevention and early intervention spending in public health terms, much organisational demand is still viewed independently and the consequences are not mapped across other clusters. An example of this would be the high level of internal demand placed on Customer Experience

due to complaints about services such as Waste and Cleansing or Housing. Our commissioning cycle must mature to identify how systematic prevention analysis can classify prevention activity, and then view that demand – and its reduction – at an institutional level while ensuring a link to multi-agency collaboration.

5 ORGANISATIONAL RESPONSE

5.1 Council has previously agreed an approach to demand management through the Commissioning cycle. This sets out the framework in which we develop our annual budget, and is now firmly embedded as the vehicle for identifying the annual Council Delivery Plan, commissioning intentions and service standards. In adopting this approach we have successfully introduced a demand data dashboard that provides Chief Officers with real time insight into demand on their services. This allows peer consultation and engagement, deep dives into specific areas of demand, and identification of single or multi service transformation projects to improve delivery and reduce demand.

5.2 Through this we have been able to interrogate key service data and identify demand management techniques. This approach helped us deliver the Target Operating Model and savings of £125m over the period 2017-2022. Prevention and Early Intervention analysis has been a factor throughout this, with consideration of national and local policy and legislation linking with understanding of demand to help identify new service delivery models.

5.3 Across Council services this has helped reduce external demand in areas such as:

a) Street lighting

The service has successfully responded to two aspects of demand. Firstly, the response to high numbers of street light faults and delays in fixing them. Changes made to processes, communication, contractor management, technology and staffing have helped to reduce the number of reported faults and improve our response times. Secondly, in terms of energy usage the Council is one of the leaders in adopting large-scale LED street lighting and has installed nearly 27,000 LED lights across the city. Street lighting is the biggest user of energy for most local authorities. Typically up to 75% of the energy used by high intensity discharge lamps can be saved by switching to LED streetlighting supported by a central management system, which allows lighting levels to be varied as the use of an area changes throughout the hours of darkness, as well as automatically reporting any issues.

b) Looked after children

Over the past three years there has been a steady reduction in the number of looked after children in Aberdeen City circa 15%. As of 30 September 2022, there were 485 children looked after by the local authority compared to 570 as of 1 April 2020. This decrease is across all care types and mirrors a trend at a national level. As we move to support more children in the community, utilising approaches that wherever possible mitigate the need for statutory measures of care, it is anticipated that the number of looked after children will continue to fall in the years to come. Efforts to bolster the support offer to

kinship carers, developing an integrated Family Support Model, and utilisation of the Whole Family Wellbeing Fund to enhance preventative and early intervention approaches continue to be moved forward at pace.

c) Homelessness

Interventions around homelessness over the last 3 years in Aberdeen have been developed in response to the Scottish Government request for all Local Authorities to develop a Rapid Rehousing Transition Plan. These 5 year plans (2019 to 2024) set out actions to reduce the amount of time that a household experiences homelessness, improve temporary accommodation and attempting to stop the cycle of homelessness re-occurring through projects such as Housing First. There has been significant success under the Rapid Rehousing Transition Plan with the homeless journey time reducing by 62 days, temporary accommodation stock reducing by 224 units and the gap between demand and supply, which causes the homeless backlog, reducing by 199 households.

5.4 The Council has established a series of internal governance boards to ensure a systematic approach to managing strategic outcomes, these are the Strategy Board, Performance Board, Transformation Board and Risk Board. The Strategy Board considers all internal and external factors to the Council to fully understand the current and future environment and its potential impact on the Council and the place of Aberdeen. In response to these internal and external factors, the Board ensures alignment of plans across the Council and it's group structure with the Council's strategic direction and the Local Outcome Improvement Plan, using the commissioning approach to support strategic resource allocation. This approach will help focus strategically on the three tiers of prevention identified in this report, which can be monitored and developed through the other three Boards identified.

5.5 The Net Zero strategy most recently exemplifies this approach, with the detail provided clearly showing the preventative and early intervention steps needed, along with the specialist response currently required to deal with climate change in the city. The IJB Strategic plan has been in place for one year and has a strong focus on prevention, including maintaining personal independence, reducing unscheduled care, intensive family support and preventing ill health. These are service areas where specialist spend is high but with great scope for achieving return on investment. The progress on developing the Integrated Children's Services Plan, which will be brought before Council later in the year for approval, and commencement of work on the new Local Housing Strategy mean we are at a crucial point in developing citywide strategies that we can undertake tiered analysis of to ensure we are able to allocate resource most effectively in the coming years, and continue to demonstrate we are operating within the legal requirements of continuous improvement and best value. The current strategy suite is included as Appendix A.

5.6 Following this process has enabled a richer understanding of the cross cluster *internal* demands placed on the system; and it is clear that in continuing to develop this approach more work is required to reduce and manage demand

created by failure demand on enabling services – for example Customer Experience, People and Organisation, and Finance. This will require the adoption of early intervention and prevention practices across all clusters, and greater understanding of the relationship between enabling services and operational services.

5.7 In identifying and projecting budgetary challenges the Council continues to face, the importance of the Christie Commission's direction to make a deliberate shift to preventative spend remains important context. In August 2022 Council agreed the adoption of Target Operating Model 1.2, to be delivered by 2027. A key aspect of this is the continuing adoption of a focus on Prevention and Early Intervention through one of four key enabling strategies. This seeks to build on the demand management approach introduced within TOM1.2, identifying key criteria to be applied across all budget areas to target where further work must be focussed, in order to alleviate pressure on budgets and ensure appropriate resource allocation.

5.8 In policy terms, this strategy will align with the key strategies identified to tackle both internal and external demand on the Council. This approach will further inform our commissioning cycle approach, ensuring enhanced demand analysis and elimination is a foundation of the medium term financial strategy.

5.9 Failure to tackle internal and external demand across all areas of the Council, may result in imbalanced and ineffective resource allocation and continuing cycles of annual response to failure demand being experienced. As stated earlier in this report, much evidence and research focuses on harm to individuals. It has been important therefore to identify set criteria for analysing the Council system as a whole. This will allow a full classification of services regarded as preventative, aggregate the resources allocated to preventing harm occurring, and resources required to intervene once harm is identified. This in turn will facilitate a more mature institutional understanding of the totality of risk around harm and its escalation, of risks faced when trying to prevent harm or intervene early once harm is identified; and present a coherent range of outcomes sought when commissioning services to prevent harm or intervene early.

5.10 At a city level, Community Planning Aberdeen has worked to tackle wicked issues such as poverty, environmental sustainability and employability through People, Place and Economic drivers. The Local Outcome Improvement Plan provides impetus and focus into how partners work together to tackle negative outcomes and adopt a more preventative approach. This allows the Council to tackle systemic problems and be part of sustainable solutions to infrastructure issues, resource management and household harm. The Local Outcome Improvement Plan is refreshed every two years to ensure we continue to adopt a data led approach to our improvement work in collaboration with partners. The Community Planning Partnership invites NHS Grampian's Director of Public Health to review the bi-annual refresh of the LOIP in order to confirm the emphasis on prevention within our proposed improvement activity.

5.11 Successful projects that improve the use of resources to improve outcomes, and cover the range of preventive, early intervention and specialist service delivery delivered through Community Planning over the last year include:

- 81% increase in unclaimed benefits
- Accessing support on liberation from prison
- Supporting unemployed people to start a business

5.12 As part of this approach, there is a requirement to develop Locality Plans, and these have recently been ratified by Community Planning Aberdeen Board. These help ensure a local focus by involving communities in identifying the outcomes and delivery where appropriate. The recent approval of a Community Empowerment Strategy and Outcome Improvement Group through Community Planning strengthens the multi-agency commitment to inclusion and lived experience in planning services.

5.13 This forensic assessment of demand across the Council, and developing approach in collaborative work, will result in a consistent approach to tackling demand and allocating resource across multiple service areas.

6 IMPLEMENTATION

6.1 Target Operating Model 1.2 was approved in August 2022, with a clear alignment with the Medium term Financial Strategy and four key enabling strategies:

- Customer, Digital and Data
- Estates and Assets
- Intervention and Prevention
- Workforce

6.2 Target Operating Model 1.2 will support deeper and broader service redesign, with digital enablement, that will be required to contribute to the savings required for the next 5 years from 2023/24 to 2027/28 as set out in the Medium-Term Financial Strategy. The objectives are to:

1. Support the Council to address the 5-year funding gap of £134m as outlined in the Medium Term Financial Strategy.

2. Continue to exploit digital technologies within the Council's Digital Transformation agenda to enable services to adopt technology for various activities and processes, thus enabling the Council to fully leverage technologies to accelerate their processes.

3. Develop an organisational workforce that is flexible ensuring all staff have the necessary skills to work effectively within the Council's operating model.

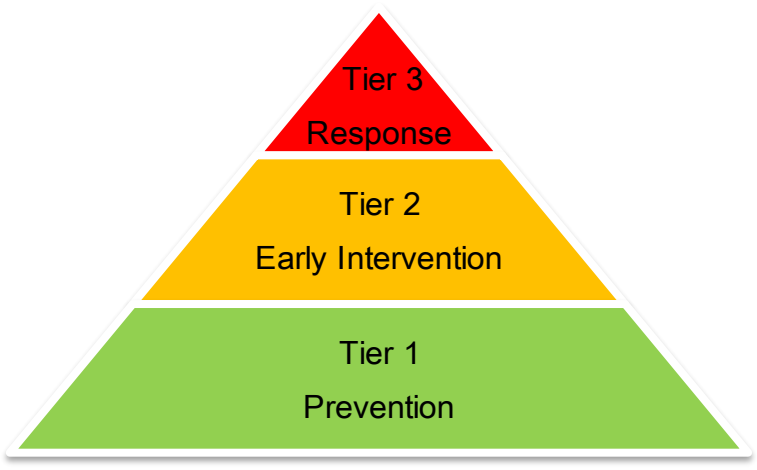
6.3 With regard to prevention and early intervention strategy, our intention is to make tiered analysis of resource allocation an integral part of our budget cycle. Therefore it is recommended that the Council receives a report on prevention and early intervention as part of the budget options report each

year. This will help assure Council that the deliberate shift intended is being achieved.

6.4 To undertake the tiered analysis and achieve this deliberate shift, it is necessary to have a set of agreed definitions, for 'prevention'; 'early intervention' and 'harm'; and with an important distinction to be drawn between human harm and resource demand:

Category	Definition	Origin of demand
Prevention	Taking action to prevent the occurrence of harm through universal measures	Human and Resource
Early Intervention	Interventions that ward off the initial onset of harm and create empowered resilient communities and staff	Human demand
Early Intervention	Intervening before further harm takes place in a way that avoids the later costs in both human and financial terms of handling the consequences of that harm	Resource demand
Harm	A negative impact on humans, the institution or resources available	Human and Resource

6.5 The first step in responding to these identified factors is the adoption of a systematic evaluation of demand, resource allocation and risk. A tiered approach to identifying demand across each cluster is being embedded, following the model of tiered intervention illustrated below. Adopting this human harm based assessment criteria and applying it to general resource management allows the Council to build on an effective model, allowing a greater understanding of spend in categories of Primary, Early and Specialist Intervention across the organisation.



6.6 The tiered model has been applied to all clusters to identify demand and spend using 22/23 data as a baseline, with three year trend analysis behind that. It is vital that organisational risk is understood and managed, and embedding the prevention and early intervention approach to commissioning means that risks that are currently understood and mitigated may change or be removed; and new risks may emerge. We will have a much deeper understanding of the interdependencies of risks across the tiered model, which will support the identification of mitigations to de-escalate risks safely. Identifying the risk factors per Service and the aggregation of a risk register per tier with mitigations will be crucial in creating a prioritisation list of transformation and demand elimination projects. The Council Delivery Plan COM/23/074 contains an assessment of commitments using the three tier model explained at section 6.5.

6.7 Three key themes emerge when attempting to fully articulate the demand being experienced within the Council, its origin, and the interdependencies in the system:

- External demand on external facing services
- Internal demand created by external services
- External and internal demand created by partner agencies

6.8 Through a citywide lens, assessment of the 75 projects in the current Local Outcome Improvement Plan shows that they are spread across the three tiers as follows:

Prevention	Early Intervention	Response
27	18	30

6.9 It is recognised that specialist services normally deal in failure demand associated with significant human harm, and therefore are more expensive either specifically in the case of dedicated staff dealing with a specific issue; or generally where a number of staff have to deal with repeated lower level issues. Many of these specialist services are commissioned externally. It is possible therefore that external commissioning will reduce, and therefore an important aspect of this work will be to examine the role of commissioned services with an enhanced role for the Demand Management Control Board in looking at the Council's contract register across all services. This will help identify how the anticipated demand could be avoided thereby managing or even negating the need for the spend.

6.10 A significant development in this sphere is the Aberdeen Health Determinants Research Collaborative (AHDRC). This initiative, funded initially for 5 years by the National Institute for Healthcare Research, has the aim of supporting Aberdeen City Council to develop a research-led approach to help improve the health and well-being for Aberdeen's communities. We will do this by working together with our partners including the University of Aberdeen, Robert Gordon University, NHS-Grampian, Public Health Scotland, The James Hutton Institute and our community partners and members of the public. We are collaborating on a number of key workstreams including:

- Commissioning and generating research
- Curating and translating research evidence to help inform decision making which supports people to be healthy post pandemic and through the challenges of the cost of living
- Creating a supportive and sustainable research and data environment
- Enabling the spread of a research culture and skills
- Engaging with the people of Aberdeen to ensure they're always at the heart of research and decision making.

6.11 Through this collaboration we will identify the priorities which are most important to the people of Aberdeen, with the aim of reducing current and preventing future health inequalities. These might include food insecurity, fuel poverty, transport, education, housing or any of the other council responsibilities which can impact on people's health, and the Aberdeen Health Determinants Research Collaborative will therefore have a crucial role in ensuring that this is underpinned by the use of research and evidence, focussing particularly on improving the city's health and reducing inequalities. As such, this research is of great relevance to the prevention strategy discussed in this report.

PROGRESS SO FAR

6.12 Having completed the initial tiered analysis mentioned in 6.3, a first look at organisational spend within each Tier of the model is available, showing how this proportion of spend in each cluster has changed over a three year period.

6.13 This trend analysis has identified clusters where Prevention and Early Intervention spending needs more focussed attention, as shown in Appendix B. These are:

- Commercial and Procurement – elevated spend in specialist response commissioning
- Corporate Landlord – reducing spend in prevention and increased spend in response commissioning
- Customer Experience – the impact of internal demand on specialist response commissioning
- Digital and Technology – increasing spend in specialist response commissioning
- Early Intervention and Prevention – elevated spend in specialist response commissioning
- Governance – the impact of internal demand on specialist response commissioning
- Integrated Children's Services – elevated spend in specialist response
- Operations and Protective Services – increasing spend in early intervention commissioning
- People and Organisational Development – increased spend in early intervention

6.14 It is important to stress that a high spend in one Tier of the model may not be unexpected or be viewed as a problem, for example it would be expected that majority of spend in Education would be in Prevention, and the majority of spend in Children's Social Work in Specialist services. An important element

therefore is reaching an enhanced understanding of what should be expected in each cluster, and the interplay of demand across the organisation as a whole, including partners within the ACC group structure.

7 NEXT STEPS

7.1 To help manage the embedding of this approach into the commissioning cycle, a series of problem statements have been identified. These problem statements identify gaps in our organisational knowledge and understanding of how we continue to make an enhanced shift towards the prevention approach. There are key issues identified including risk escalation and de-escalation, entry points to the system and referral routes to and from different tiers for human demand, and classification of cross cluster internal demand from external failure. A programme plan to ensure consistency of delivery has been developed, with key strands led by identified Chief Officers. This is led by the Chief Officer – Early Intervention and Community Empowerment and reports to the Transformation Board. Key workstreams are:

- Commissioning – Chief Officer, Procurement and Commercial Services
- Community Engagement – Chief Officer, Customer Experience
- Data and Insights – Chief Officer, Data and Insights
- Financial modelling – Chief Officer, Finance
- Prevention and Early Intervention implementation – Chief Officer, Early Intervention and Community Empowerment
- Risk management – Chief Officer, Governance
- Workforce – Chief Officer, People and Organisational Development

7.2 Work will continue on the steps required to embed the prevention and early intervention strategy, linked to the medium term financial strategy. On this basis, it is recommended that progress on embedding this approach be reported to the Council as part of the annual budget process.

8 FINANCIAL IMPLICATIONS

8.1 There are no direct, immediate cost implications arising from this report. It is important in this context to stress the correlation between demand, prevention and early intervention and reducing organisational costs. Embedding this approach into the Commissioning cycle will mean that resources can be allocated and that operating costs will reduce, helping the Council to deliver a balanced budget corresponding with the medium term financial strategy.

9 LEGAL IMPLICATIONS

9.1 There are no direct legal implications arising from the recommendations of this report. However, as the report indicates, risk management and external commissioning are core aspects of the prevention and early intervention approach. The legal implications of commissioning and any other legal implications will be considered at the appropriate point in time.

10 ENVIRONMENTAL IMPLICATIONS

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

11 RISK

Category	Risks	Primary Controls/Control Actions to achieve Target Risk Level	*Target Risk Level (L, M or H) *taking into account controls/control actions	*Does Target Risk Level Match Appetite Set?
Strategic Risk	There is a risk that the Council fails to deliver on strategic requirements, for financial reasons or through not being able to respond to emerging policy and legislative levers.	Internal governance is already in place, and the adoption of the prevention and early intervention will include alignment with existing and emerging strategic requirements locally and nationally.	L	Yes
Compliance	There is a risk that as the prevention and early intervention approach is embedded, the Council fails to comply with contractual or legislative requirements.	The adoption of a programme approach to managing and implementing the strategy, led by Chief Officers, mitigates this risk.	L	Yes
Operational	There is a risk of operational failure as the prevention and early intervention is embedded, due to organisational and structural transformation requirements being identified.	Any significant changes to how the Council operates will be managed through appropriate internal governance routes as they occur.	L	Yes

Financial	There is a risk that the Council is unable to deliver a balanced budget in the medium term.	The adoption of the Prevention and Early Intervention strategy to complement the demand management strategy will help mitigate this risk.	L	Yes
Reputational	There is a risk that failing to move strategic resource allocation to a model based fully on demand, and potential resulting harm being experienced by individuals and the organisation, will leave the Council open to reputational damage.	The Council has existing internal governance routes including Performance, Risk, Strategy and Transformation boards.	L	Yes

12 OUTCOMES

COUNCIL DELIVERY PLAN	
	Impact of Report
Aberdeen City Council Policy Statement	The recommendations in this report align with the Partnership agreement with regard to the mitigation of poverty and inequality, and advancement of opportunity and healthy lives.
Aberdeen City Local Outcome Improvement Plan	
Local Outcome Improvement Plan	The proposals in this paper impact on the four pillars of the Local Outcome Improvement Plan: Economy People (Children and Young People) People (Adults) Place

Regional and City Strategies	Children's Services Plan Regional Economic Strategy Regional Skills Strategy Local Housing Strategy Customer, Digital and Data Strategy Asset Management Strategy

13 IMPACT ASSESSMENTS

Assessment	Outcome
Integrated Impact Assessment	Stage 1 IIA to be completed.
Data Protection Impact Assessment	Not required

14 BACKGROUND PAPERS

None.

15 APPENDICES

Appendix A – Current strategies

Appendix B – Trend analysis of Prevention and Early Intervention spend

16 REPORT AUTHOR CONTACT DETAILS

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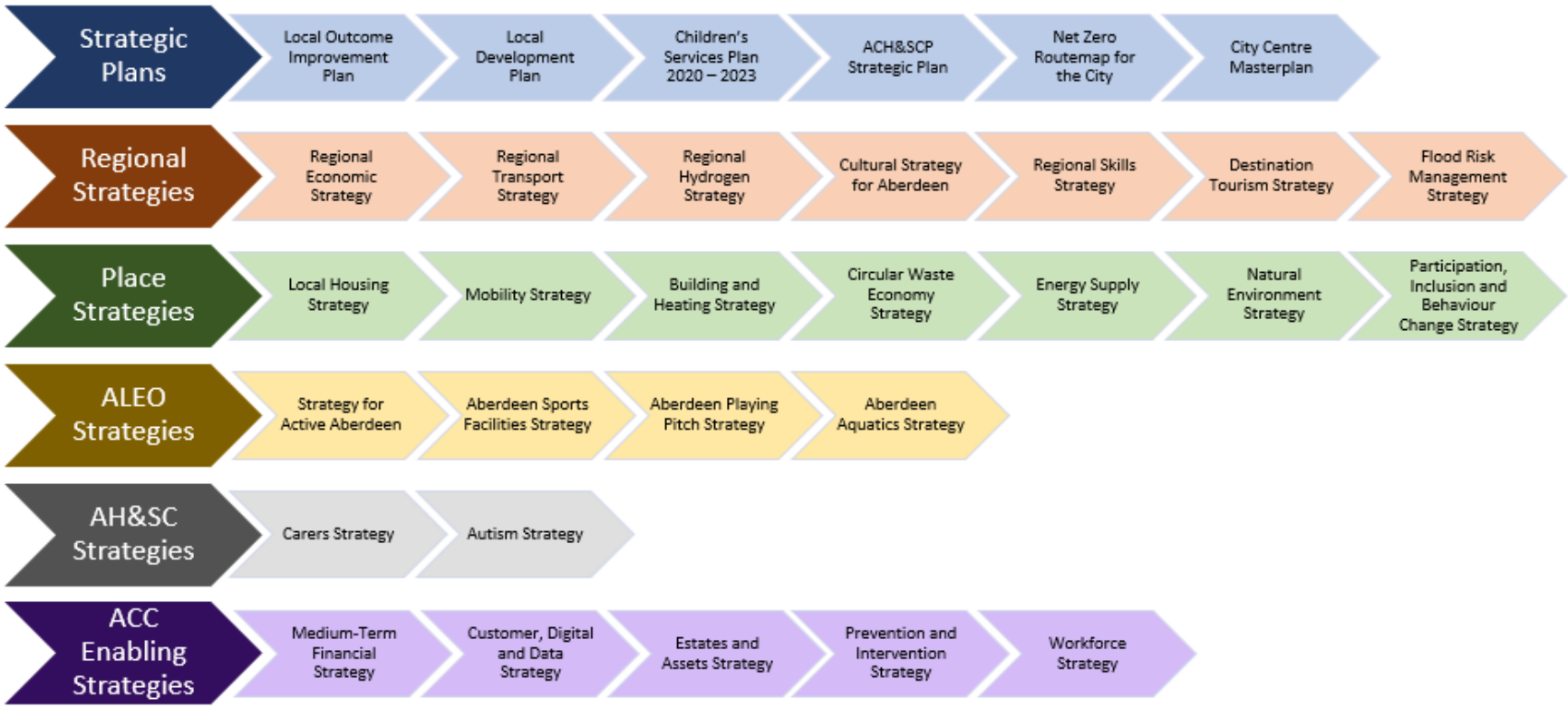
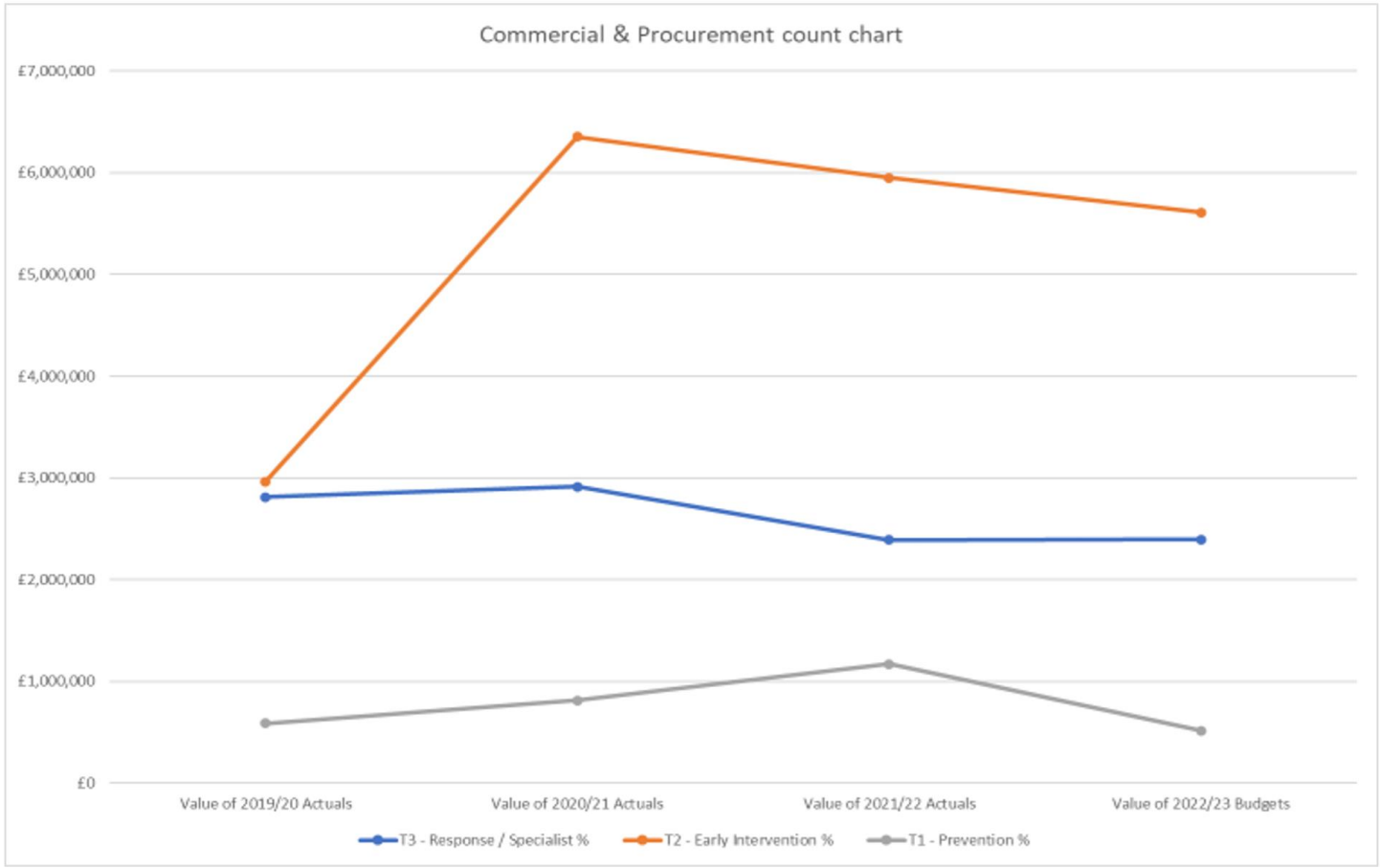
Tel	01224 522226

Appendix A

Strategy Framework



Appendix B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Value of 2022/23 Budgets
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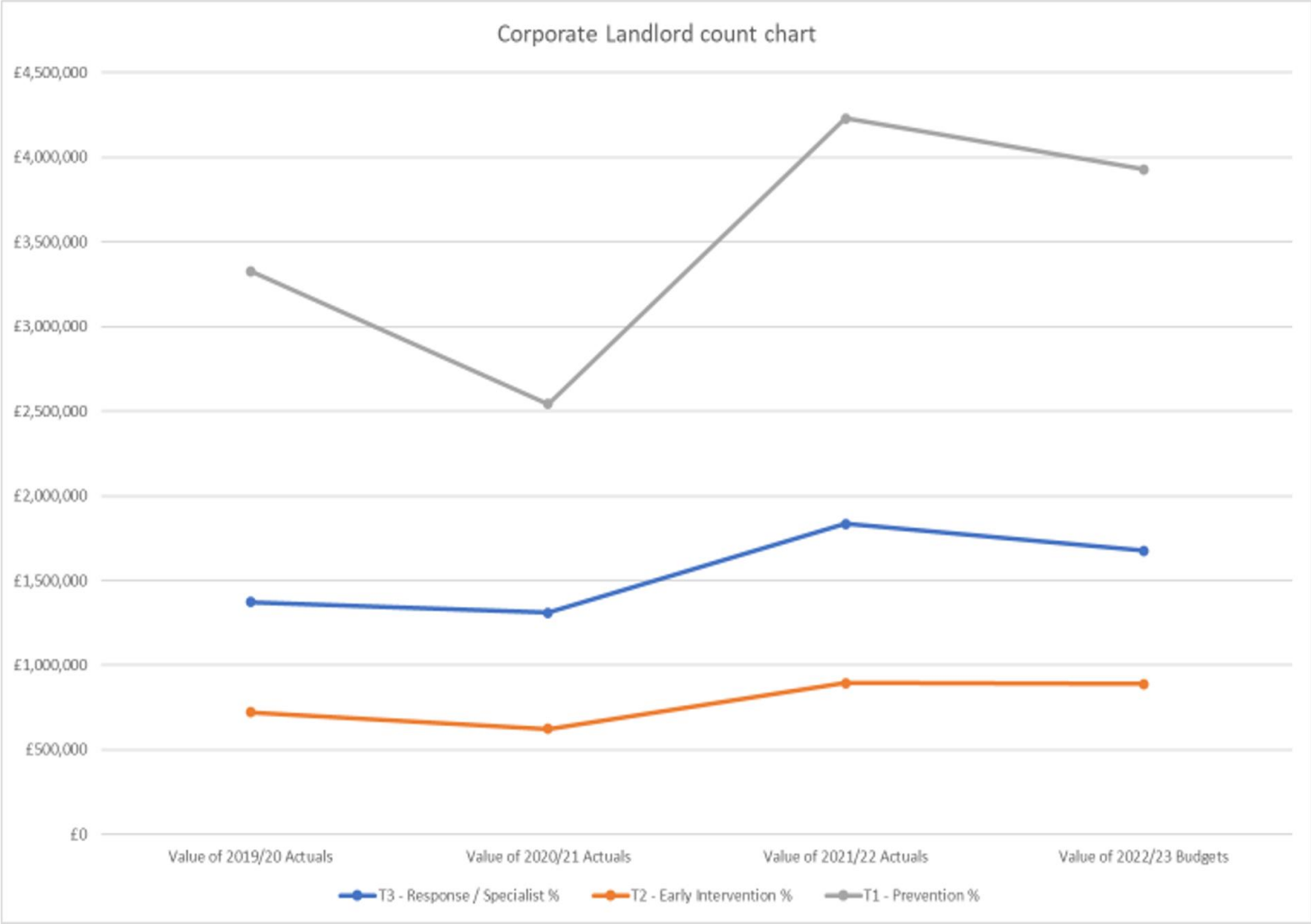
T2 - Early Intervention %
T1 - Prevention %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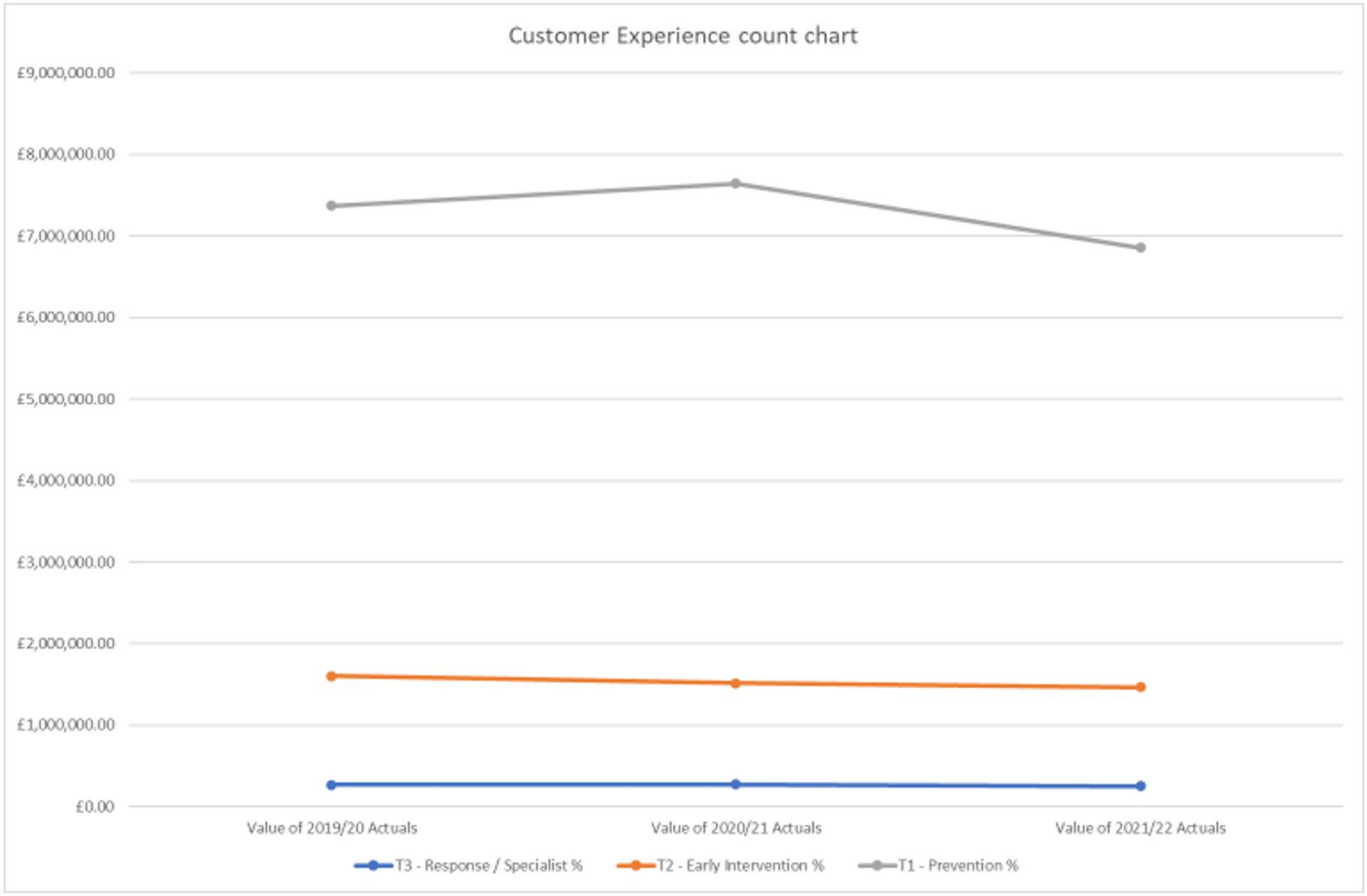
Value of 2022/23 Budgets
T3 - Response / Specialist %
T2 - Early Intervention %
T1 - Prevention %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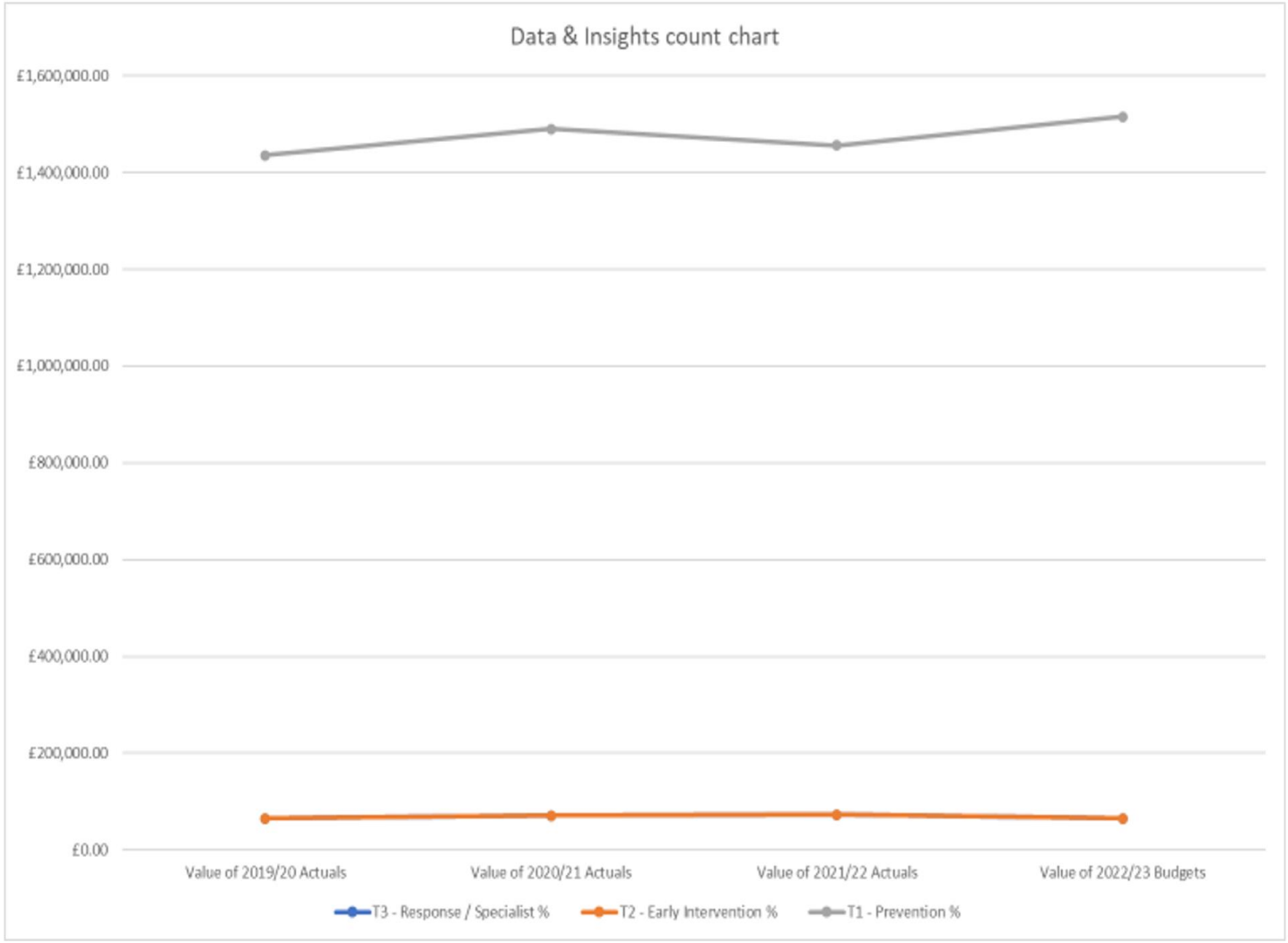
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T3 - Response / Specialist %
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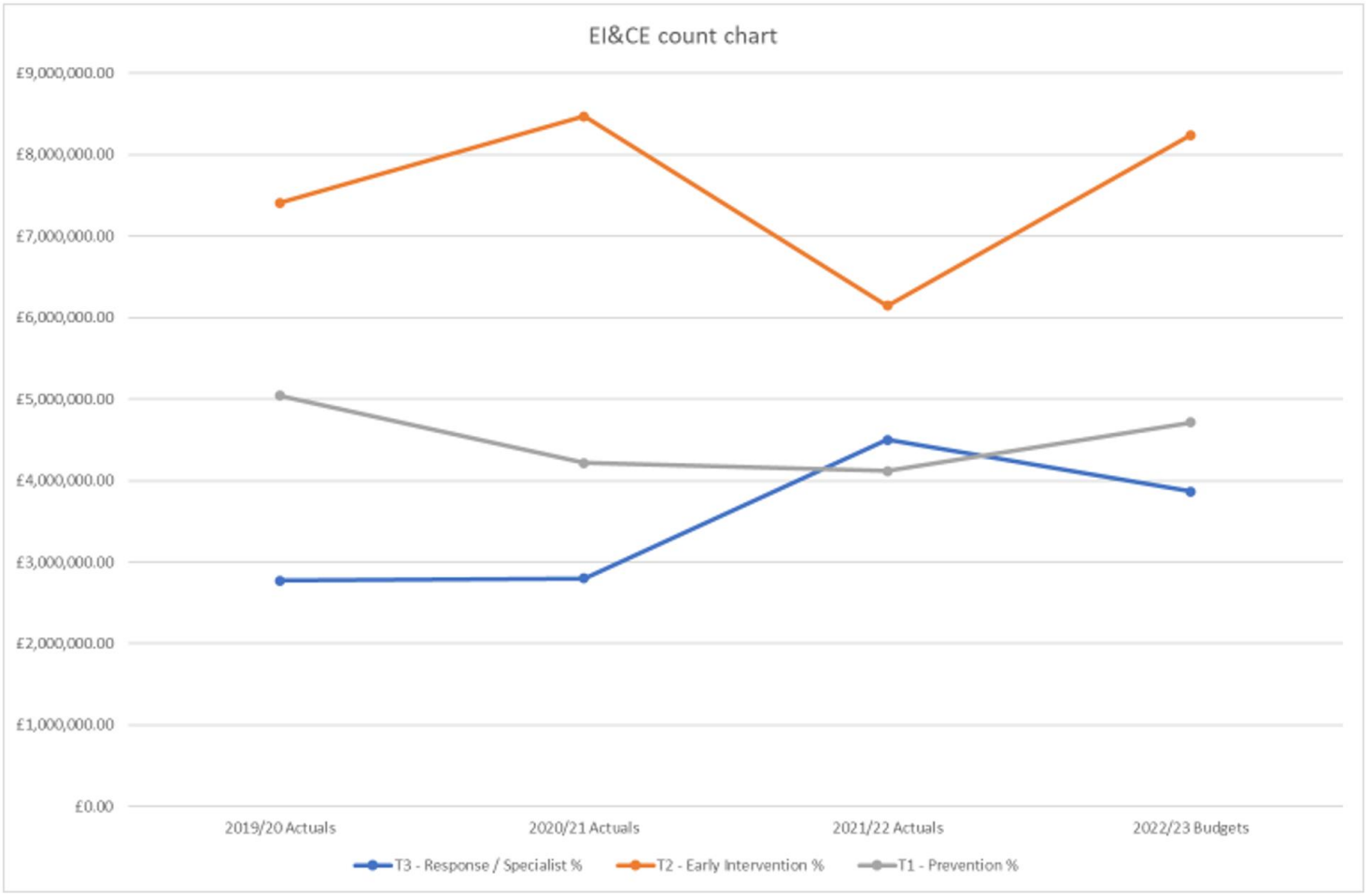
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T3 - Response / Specialist %
T2 - Early Intervention %
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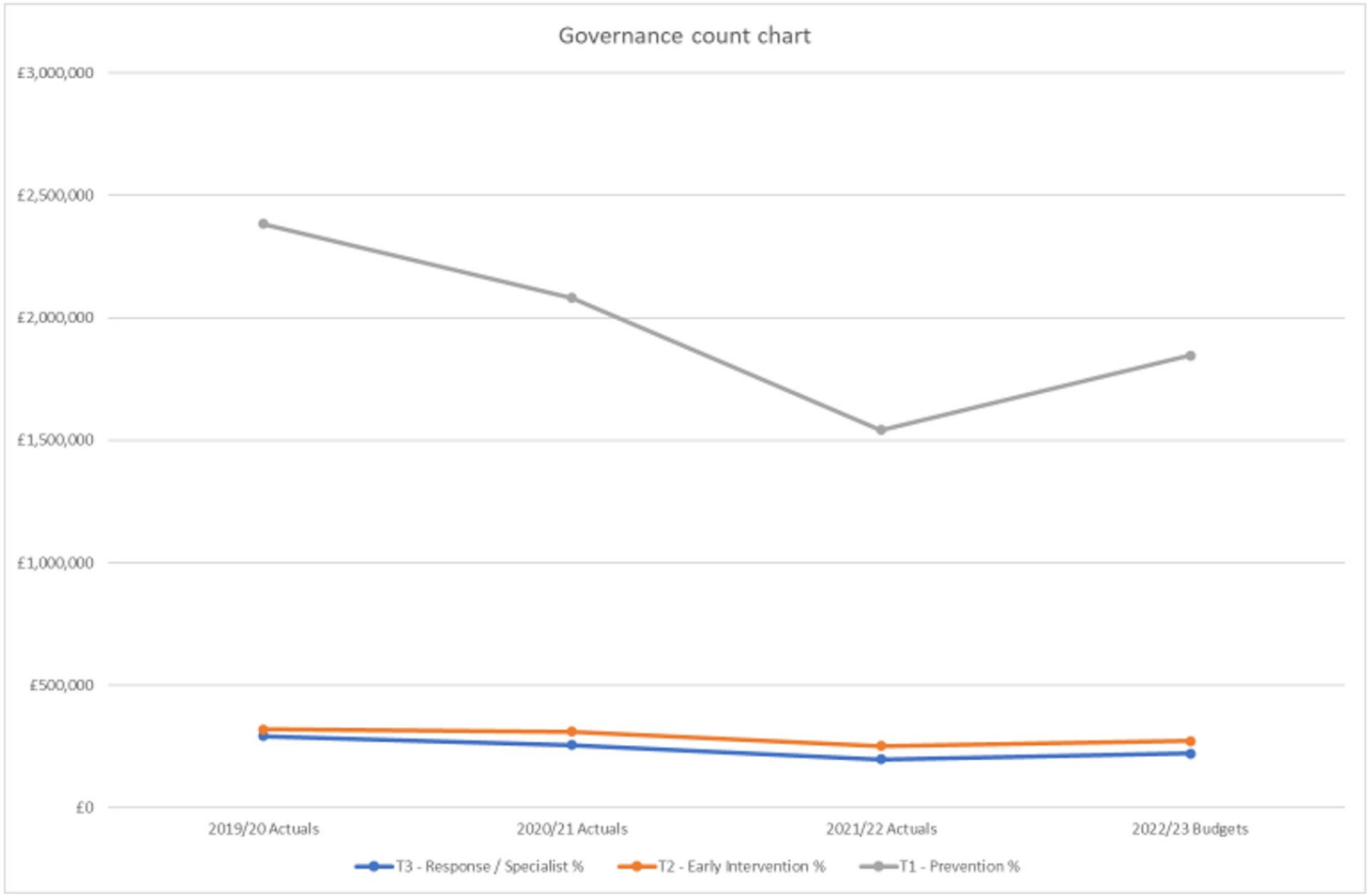
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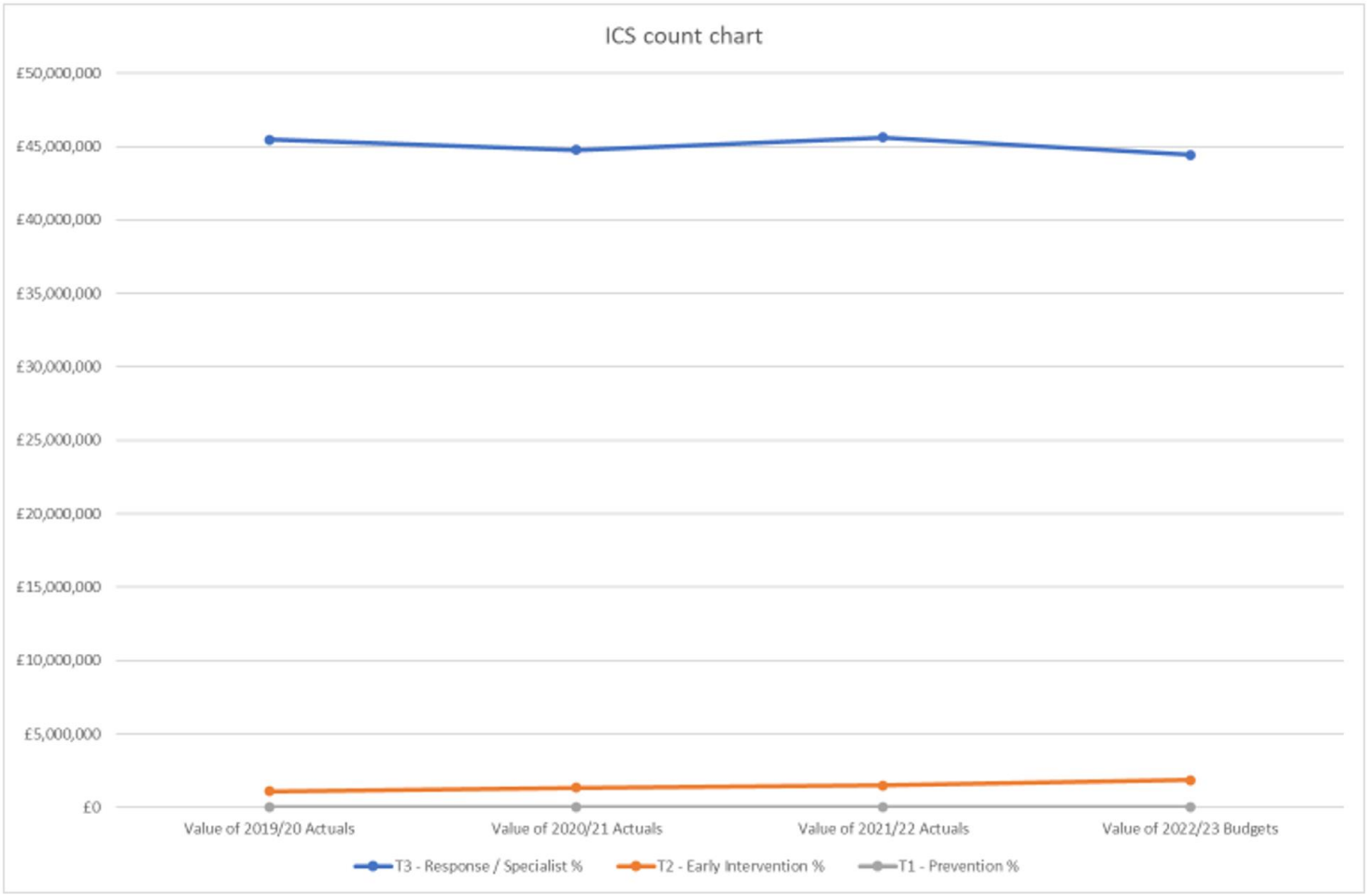
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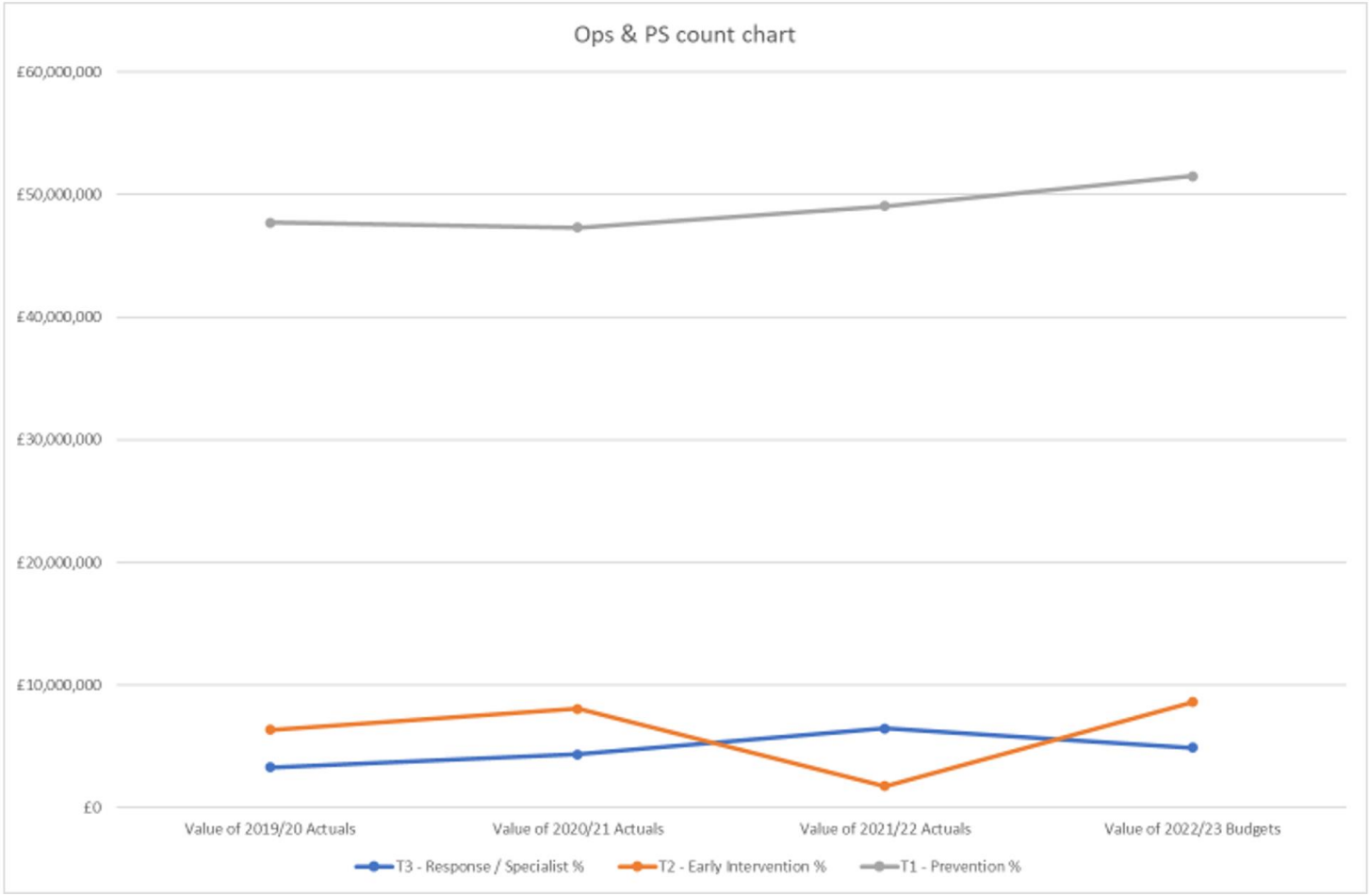
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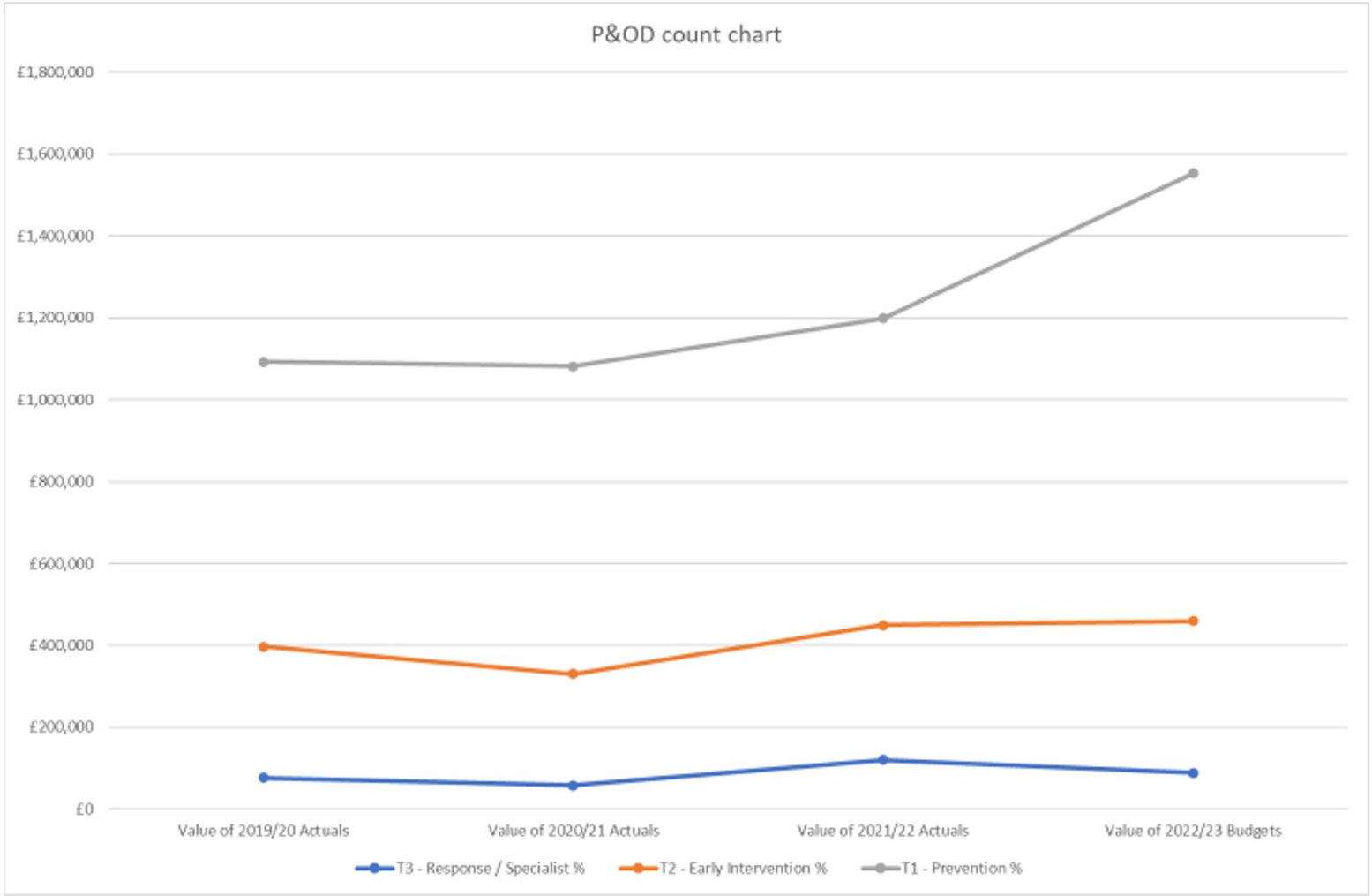
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Value of 2022/23 Budgets
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Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Date of Meeting	25th April 2023
Report Title	Evaluation of the Implementation of Morse to Community Nursing- user experience
Report Number	HSCP23.022
Lead Officer	Sandra MacLeod Chief Officer
Report Author Details	Michelle Grant Transformation Programme Manager- Data and Digital migrant@aberdeencity.gov.uk
Consultation Checklist Completed	Yes
Directions Required	No
Appendices	a. Evaluation of the implementation of Morse to Adult Community Nursing Teams

1. Purpose of the Report

1.1. This report is seeking to inform and provide assurance to the Integration Joint Board (IJB) regarding the Implementation of Morse to Adult Community Nursing Team within Aberdeen City Health and Social Care Partnership.

2. Recommendations

2.1. It is recommended that the Integration Joint Board:

a) Note the evaluation appended in appendix A.

2.2. The IJB are to review and note the evaluation and recommendations which are outlined in the Evaluation report appended in Appendix A.

INTEGRATION JOINT BOARD

3. Summary of Key Information

3.1. In May 2021, the evaluation of the Health Visiting Digitalisation alongside a paper presenting the recommendation for Morse to be procured and implemented to Community Nursing was presented to IJB (HSCP.21.069). This recommendation was accepted and an outcome of this was for a further evaluation to be conducted once the application had been implemented to the Community Nursing service to provide assurance to the IJB that the product was continuing to deliver a positive experience to users.

3.2. Following on from IJB approval, the Morse application which allows for electronic scheduling and patient record keeping was implemented to Community Nursing, Hospital at Home, Macmillan Nursing and School Nursing between August 2021 and June 2022.

3.3. The procurement and implementation of the Morse application was funded in a similar manner to that which was identified and successfully used during the implementation of Morse to Health Visiting. The Community Nursing service is currently running with 30WTE vacancies (as of March 2023), many of which are challenging to recruit to and there was agreement that the finance reserved for several of these posts would be used to fund Morse in order to realise the benefits that a digital record would bring to the service.

3.4. A survey was conducted in January-February 2023 providing the opportunity for users to provide feedback on the implementation of Morse into their service area. The results of the survey have informed the evaluation in Appendix A. The feedback has been positive overall while also recognising that many other service changes have occurred over the period. In line with the evaluation findings conducted with the Health Visiting Digitalisation in 2021, significant time savings have been identified from the reduction in the duplication of information. This accrues to over 15,000 hours per annum across the service from an identified reduction in the duplication of information of 30 minute per day per user.

3.5. Other areas where a positive assessment was made was in the communication between teams i.e. being able to see ongoing patient activity between services, ease of accessing records compared with paper-based notes and ease of inputting information into the electronic patient record.

3.6. There is an awareness that during the implementation, several challenges were faced regarding the scheduling of patients within the Community Nursing team. ACHSCP Community Nursing team were the first in Scotland to fully adopt the scheduling component and therefore there were teething issues which eHealth and the supplier assisted with rectifying. A recent upgrade to the system appears to have fixed many of these issues relating to scheduling and speed, but unfortunately took place out with the evaluation period and so has not been taken into account in users feedback.

3.7. The associated recommendations from the Evaluation are directed towards the Morse User Group which has been established for the ongoing support of the application and its users.

3.8. The ACHSCP Year 2 Delivery Plan outlines the intention to continue to implement Morse to Community AHP services. The outcome of the evaluation supports this. There is an interest to implement Morse to Community Nursing and Community AHP services across NHS Grampian which has broad agreement from the three Partnerships. The outcome of the evaluation is supportive of this.

4. Implications for IJB

4.1. Equalities, Fairer Scotland and Health Inequality

No impact as report is for assurance purposes only.

4.2. Financial

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

4.3. Workforce

There are no direct workforce implication arising for the recommendations of this report.

This report outlines the user experience during the initial implementation of a new system. The workforce involved with this change have been included in the project process from inception and this evaluation helps to ensure that a true reflection of the implementation is provided to IJB.

4.4. Legal

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

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 implications arising from the recommendations of this report related to unpaid carers.

4.7. Other

5. Links to ACHSCP Strategic Plan

5.1. The implementation of Morse to Community Nursing Services is represented within the Strategic Plan's Delivery Plan in Year 1 and in Year 2 it is planned for Morse to be implemented to appropriate Community AHP services.

6. Management of Risk

6.1. Identified risks(s)

Paper is for assurance only and therefore no linked risks to recommendations. Recommendations from the paper are for operational use only.

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

The strategic risk register identifies that:

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

6.3. How might the content of this report impact or mitigate these risks:
The implementation of Morse to Community Nursing Services have assisted in the production of reports to satisfy local and national reporting needs. Prior to its implementation, this was very challenging to obtain since information was held within paper-based records. This should assist in the mitigation of this risk.

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Evaluation of the Implementation of Morse to Adult Community Nursing Teams in Aberdeen City Health and Social Care Partnership.

March 2023

Michelle Grant, Transformation Programme Manager, ACHSCP

Samuel Ajibuwa, Graduate Intern, ACHSCP

Key Points

In May 2021, the Aberdeen City Health and Social Care Partnership Integration Joint Board (IJB) approved a paper to procure and implement Morse to Community Nursing, Hospital at Home (H@H), School Nursing and Macmillan Nursing Services. The recommendation was made to the IJB following the products successful implementation to the Health Visiting Service in 2020.

This evaluation investigates whether the implementation of Morse to Community Nursing, H@H and Macmillan Nursing was successful and whether the benefits felt by the Health Visiting service were also seen by adult community nursing teams. A survey was developed on the same basis of that which was sent to the Health Visiting service in order to ensure it was comparable. The survey was sent to all users of the application in January-February 2023.

The results are consistent with those found in the Health Visiting Evaluation, in that the majority of users found that there were benefits in communication from using the Morse application and that the use of an Electronic Patient Record had led to a reduction in the duplication of information. Based upon the feedback received, a 30minute saving in time could accrue to a time saving of 15,340 hours per annum across the Community Nursing service and in financial terms based upon a Band 5 could account for £365,245.

The results received from across the Adult Community Nursing Services were not as wholly positive as those received from the Health Visiting Service and as a result a number of recommendations are to be passed to the Morse User Group for further investigation. These are outlined in section 5 and are largely related to training, support and developing the features of the application further.

The evaluation is found to be in support of the ACHSCP Year 2 Delivery Plan for the Morse application to be implemented to Community Allied Health Professional (AHP) services with a similar financial model while being mindful of the interest at the Pan Grampian level for an implementation of Morse across all Community Nursing and Community AHP services where a need is identified.

1. Background

In 2019, a need was identified to implement an Electronic Patient Record (EPR) to Health Visiting teams in Aberdeen City Health and Social Care Partnership (ACHSCP) as a means of alleviating risks identified in the service relating to data sharing for Interagency Referral Discussions (IRDs), the inability to report on national pathway activity and the Community Health Activity Dataset (CHAD), and to minimise the effects of several vacancies in the service by creating a system which would reduce the duplication of information.

A business case was developed and approved by the Integration Joint Board (IJB) recommending the procurement of Morse in September 2019. In order to fund the procurement of Morse, a radical method was used where vacant Health Visiting Nursing posts were used to fund its implementation in recognition of the expected benefits to the service and the challenges the service was facing in terms of recruitment and retention of staff. Morse was rolled out during the first Covid lockdown and in January-March 2021 an evaluation was carried out reviewing the impact that the implementation of Morse had on the Health Visiting Service. The evaluation found that there had been a significant increase in communication, and a decrease in the duplication of information across the service. Based upon these outcomes, a recommendation was made to the IJB in May 2021 to implement Morse to the remaining ACHSCP Community Nursing Services including School Nursing, Community Nursing, Hospital at Home and Macmillan Nursing.

What is Morse?

Morse is an offline first electronic patient record which allows for scheduling, the recording of patient contacts and reporting via Business Objects (BOXI). Users enter information into the application using a laptop or iPad while with the patient and then uploads information when a wifi connection becomes established. This allows other users to see the information. The application automatically downloads 13months worth of information onto the users device meaning that they have a patient record available to see when in the patients home. This allows for access to accurate information and the ability to record information without the need for a wifi connection which has historically been a challenge for community-based services.

The project

In May 2021, the IJB approved the business case to procure an enterprise wide license for Morse and the associated hardware devices required to allow for School Nursing, Community Nursing, Hospital at Home and Macmillan Nursing to use Morse as their primary patient record. The business case included additional project configuration resource from eHealth and a project nurse role after recognising the impact that this support could give the services preparing for an implementation. The funding method was to be similar to that which had been successfully used for Health Visiting where funding in reserve for vacant posts was used to pay for the procurement and implementation of the application. This evaluation looks at the impact that the implementation of Morse has had to Community Nursing, Hospital at Home and Macmillan Nursing teams. School Nursing has been excluded from this evaluation since the School Nursing service in essence add into the already established

Community Child Record used by the Health Visiting Service. The services previously operated using a range of methods; the Community Nursing Service scheduled and outcome appointments on the Cegedim Community Module application while Macmillan Nurses used an unsupported Access Database and all services relied on paper based patient records. The implementation of Morse allowed these three services to retire the use of paper records, move onto the same platform for their work and configure it to their needs while also being able to see the patient interactions of other services using Morse.

2. Methodology

The evaluation looks to ascertain if the implementation of Morse was successful to the Adult Community Nursing services and whether comparable results can be found to those which were found in the previous Health Visiting Evaluation. In order to do this, a similar questionnaire was distributed to all members of the Community Nursing teams to complete. The slight deviation from the original survey used was the omission of covid related questions and those related to Interagency Referral Discussion (IRD's) since these are specific to the Health Visiting Service.

Surveys were run over the period of 5th January 2023 – 5th February 2023 using Microsoft Forms. Once data related to the surveys had been received, these were analysed and a thematic analysis took place at comments received related to the application.

3. Results

From the surveys issued to the Community Nursing, H@H and Macmillan teams, the following responses were received. It appears that there was a low response rate from Community Nursing, however the user base contacted also included a number of bank staff in order to accommodate all users and that this may have impacted the response rate.

Service	**Number of Responses Received (% of staff who completed survey)**
Community Nursing	53 (24%)
Hospital at Home	23 (51%)
Macmillan	4 (57%)

The following denotes the overall responses to the questions asked. Where significant deviations exist between teams, these have been noted. The full results can be found in Appendix 1 and 2 broken down by service.

The following tables demonstrate the results from the surveys issued to the users of Morse.

Table 1. Overall results relating to communication, duplication of information and support.

	Strongly Agree or Agree	Neutral	Disagree or Strongly disagree
I believe that the use of Morse has led to an improvement in communication with my team	34%	41%	25%
I believe that the use of Morse has led to an improvement in communication between the teams I work with*	36%	45%	19%
The use of Morse has led to a reduction in the amount of information required to be regularly duplicated	64%	24%	13%
Ongoing support has been essential to my use of Morse	64%	26%	10%

*this question was posed to Community Nursing only since they operate across teams within their service more frequently

Overall, the level of communication appears to have improved or stayed the same in the areas surveyed. *"I feel Morse is very effective for up-to-date communication between teams. It is very useful to be able to see MacMillan nurse notes, OOH (Out of Hours) nursing notes etc. We are able to read outcomes of visits"*

However, in H@H the results shows that the majority respondents felt that the level of communication had decreased since the implementation of Morse with 39% of respondent either disagreeing or strongly disagreeing with the statement that the level of communication had improved. Comments received regarding communication cites challenges with communicating with secondary care.

"One of the main issues remains is that it is a different system to ARI, so most ARI colleagues e.g. ED, AMIA, medical wards, 102, don't have access to notes on MORSE. This had led to a breakdown in communication".

Over 60% of respondents agreed that the use of Morse led to a reduction in the amount of information which they required to duplicate. When asked how much time they would estimate that this has reduced by, 38% suggested that up to 30minutes has been saved per day and a further 28% suggested that between 31 and 60minutes of time had been saved per day. Using a similar calculation which was as part of the Health Visiting Digitalisation Evaluation, using a Band 5 hourly rate at the mid point (based on 2022/23 costs), a 30minute time saving from the duplication of information across the Community Nursing service (118 WTE) could accrue to 150

minutes of time saved per 5-day week and a 15,340 hourly saving per annum across the service. In cost terms, a daily 30 minute saving of time across the Community Nursing Service could save £365,245 per annum.

Comments regarding training and support were seen from Community Nursing in particular "*I feel that once everything is finalised with Morse and no more changes are to be made to it for some time I would benefit from a class again from scratch not just a refresher as at the time of my training it was a working process morse"* while other services appear to have set up shared learning areas for ongoing support "*We have been meeting as a team and feeding back all the information that could improve this service".*

Table 2: Results comparing Morse with previous system, in user (electronic or paper based)

Overall, please rate the following areas of Morse compared to what was in place previously	**Very Good**	**Good or Fair**	**Poor**	**No Response**
Scheduling of appointments and Team Allocation	13%	60%	14%	14%
Updating all aspects of the patient record	24%	61%	10%	4%
Ease of Access	28%	53%	14%	4%
Sharing of information	28%	58%	9%	6%

The overall response to the updating of the patient record was very positive, with only 10% of respondents suggesting that the use of the patient record is less effective than what was in use prior to its implementation. There are several suggestions in how this could be improved, with several respondents suggesting that it can be 'clunky' to move from the patient's continuation note into the forms element. Other comments received related to the integration of other areas of information *"The ability to link with / upload information to / download information from Trakcare would be very useful".*

Respondents to the survey fed back that the sharing of information was beneficial with a respondent from Community Nursing suggesting *"I like the notes, easy to read and see what others have written before going into the patients home. Good to see what Macmillan and H@H have written"* and the access of the application appears to be straightforward, and the services are responsive to using an electronic record rather than a paper based record. Some comments were made regarding the reliability of hardware and the challenges of remembering to sync information.

	Yes	Maybe	No
Would you recommend Morse to a Colleague	41%	38%	20%

Overall, the majority of respondents agreed that they would recommend the use of Morse to a colleague.

4. Discussion

The results of the evaluation highlight several areas that require further discussion including training and support, interfaces, scheduling and the reduction of the duplication of information.

Financial Model

The implementation of Morse to the Health Visiting service demonstrated a financial model where money, which was in reserve for Health Visiting posts that had not been recruited to (due to challenges appointing to the posts), was used to fund the procurement and implementation of Morse to the service. A similar model was used for the Community Nursing service in an attempt to deliver the benefits of digital records to the service while making best use of the funds available from the public purse. The cost of the implementation of Morse to Community Nursing across three years (2021/22- 2023/24) was costed at £645,500 excluding VAT (including hardware). The annual breakdown of this is demonstrated below alongside the Whole Time Equivalent (WTE) of the Band 5 posts which would be required to fund this on an annual basis. The benefits found through this evaluation relating to the reduction in the duplication of information have also been added to Year 2 and Year 3. No benefits have been added to Year 1 since this was an implementation phase and the figure in Year 2 has been halved to take into account a bedding in period for the service and therefore providing a more realistic figure.

Year	Cost*	WTE of Band 5 (2022/23 costings used)	Benefits realised through reduction in the duplication of information.
Year 1 2021/22	£305,000	6.5	
Year 2 2022/23	£171,000	3.6	£182,622
Year 3 2023/24	£171,000	3.6	£365,245
Total	£647,000		£547,867

*Figures rounded for ease of calculation.

It should be noted that the Morse application licensing model was changed from a service based model, which was used for Health Visiting, to an enterprise wide license for Community Nursing. This means that the ongoing license costs also take into account those required for Health Visiting and are not in addition to this.

Were this model to continue to be used for implementing the application to the Allied Health Professions as outlined in Year 2 of the ACHSCP Delivery Plan then this would again be covered by the enterprise license cost. Therefore, the impact upon each service of the WTE utilised to fund this across ACHSCP would be lessened the more services use the application, while the demonstrable benefits from the reduction of the duplication of information (amongst other benefits such as communication) would continue to increase.

Training and Support

The training for Morse for the Community Nursing, H@H and Macmillan teams were implemented in a similar fashion to that which was employed by the Health Visiting Digitialisation. The onus was placed on the service for a ‘Train the Trainer’ approach

although it was recognised that this would be the limit of this approach since further implementations would increase the dependencies on other teams and services. The Macmillan team appear to have taken this approach and have organised regular meetings to look at Morse and ensure that it works for them and share learning. However, with larger teams this appears to be more challenging and the dissemination of training and the communication required for ongoing updates perhaps requires to be regularly reviewed for Community Nursing and H@H. This ongoing iterative process would be in place for written records to ensure consistency across the service and should firmly be part of the process for the adoption of electronic records. This would also assist with the data quality of information entered into the patients electronic record and what is able to be confidently extracted and reported on to senior management regarding the service.

Interfaces

The implementation of Morse to Adult Community Nursing was seen to be the first step to the electronic integration of information and assisting to bridge the gap between Community, Acute, Primary and Social Care information. There is recognition within the service that the established interface with Sci Store for demographic details does not go far enough and that the planned implementation of the interface with Trakcare PMS, Office 365 and extending the criteria of the SCI Store Interface to include the uploading of specified documents will assist in bridging this gap. Suggestions have also been made within the feedback that extending the Trakcare PMS interface may assist and securing a full medical history may also alleviate some of the gaps in information.

Scheduling

The implementation of Morse to Community Nursing was the first in Scotland to roll out the scheduling tool which allowed Community Nurses to assign to the team caseload and then assign prior to visiting the patient. As a result, there were a vast amount of responsive learning from Cambric (the supplier), eHealth and from the service. Initially the system copied vast amounts of data in this process which slowed the system, and which may account for some of the feedback remarks from Community Nursing regarding speed. A recent upgrade has attempted to resolve this, however occurred out with the evaluation feedback period and therefore has not been taken into account in the results.

Duplication of Information

The results show that the service estimates a 30minute daily decrease in the duplication of information as a result of the implementation of Morse. Using this as a baseline, the evaluation has tied this figure to an hourly saving per annum. This helps to demonstrate the benefit that the implementation of Morse has had on the Services involved.

It should be noted that any additional time recouped by the workforce is consumed their current day-to-day tasks and patient facing time. It should also be noted that other areas of the application may have required more input over the implementation period to assist users get used to the changes in how they record information and therefore may have subsumed the time saved from the reduction in duplication. The Community Nursing services are currently carrying several vacancies and therefore there is no expectation that this time saving would equate to a reduction in workforce.

Reporting

Historically, reporting from these services have been very challenging as the information held has largely been paper-based, and in the case of Community Nursing held in the patient's home. The implementation of Morse has allowed for service level and management level reporting to take place. Information is being collated within BOXI for service level reporting and an interface with Tableau has been established to allow management-based reporting. As with all implementations of this nature, there are data quality issues with some of the initial reports but the service is open to learning, and the Community Nursing team have put refresher training in place to assist with the clarification of information requirements and to improve reporting. Comments gathered within the surveys have suggested that full training rather than solely refresher training may be of benefit to the team.

Electronic Patient Record

Several comments were received from respondents regarding the challenge of viewing information side by side where the patient's continuation note, and forms were not easily accessible to read side by side. A recommendation will be made as an output from the report to review the potential issue raised in more detail and investigate with the Morse User Group and supplier whether this could be resolved by further training or by recommending development work in a further Morse release to attempt to resolve this.

Community Nursing and Health Visiting Evaluation: A comparison of results.

The following results demonstrate a comparison of the results obtained from the Health Visiting Digitalisation evaluation and the Community Nursing evaluation of Morse. For ease of comparison, the percentage given are those which agree with the statement.

	Health Visiting	Community Nursing
I believe that the use of Morse has led to an improvement in communication between the teams	56%	34%
The use of Morse has led to a reduction in the amount of information required to be regularly duplicated	81%	64%
Scheduling of appointments and Team Allocation	62%	44%
Ease of Access	66%	56%
Updating all aspects of the patient record	77%	59%
Would you recommend Morse to a Colleague	93%	41%

As can be seen, over all areas, the Community Nursing Service has seen decreased agreement with these statements when compared with the Health Visiting digitalisation. It is challenging to deduce why these differences exist, however from comments received during the survey and conversations with the service, there appears to be several contributing factors:

- there were various problems that the teams had experienced with the scheduling function which took several weeks to resolve;
- the 'editing an entire series' of appointments function, which similar to scheduling, required a great deal of time spent with Cambric to discuss and find a solution that worked for all, but initially caused confusion, errors and thus additional housekeeping;
- despite a "go live" date, not all Community Nursing teams were ready to begin using Morse at the same time due to delays in the transferring of patient caseloads from Community Vision to Morse

It is felt that these factors negatively affected the overall 'trust' in the system, and alongside other comments relating to training and support and an increased use of interfaces leads to a follow up recommendation to the Morse User Group to conduct a follow up survey to be disseminated to all users to ensure that fixes have remedied users concerns.

ACHSCP Delivery Plan

The ACHSCP Strategic Plan outlines a commitment to supporting the implementation of an electronic patient record and the Year 2 delivery plan points towards the implementation of Morse within community based AHP Services (where the use of

Trakcare has been highlighted as not suitable). This will further the work already achieved by the services and allow for further information sharing between Community Teams and demonstrate a holistic view of the patient incorporating all of the community health-based services who use Morse. It will also allow for comparable reporting to be extracted from Morse for all included which as previously mentioned has historically been challenging to obtain using paper-based records.

Pan Grampian Implementation

There is an awareness that there is interest in the implementation of Morse within Aberdeenshire and Moray HSCPs. This would bring the benefit of a shared record across Grampian and give wider benefits to the patient of information sharing. The feedback received during this evaluation should help and assist in the scoping of this work.

5. Conclusions and Recommendation

The evaluation concludes that the implementation of Morse to the Adult Community Nursing services within ACHSCP as outlined within the IJB paper submitted in May 2021 has been completed as per the original scope and that its use within the services have been successful.

It is noted that as the implementation of Morse to Community Nursing has been successful that its progression to the implementation to Community AHP services should continue as planned within the ACHSCP Year 2 Delivery Plan.

It is recommended that this report is directed to the Morse User Group to:

- Review approaches to training and support as part of the implementation to Community AHP's and any further services.
- Review the ongoing support model for H@H and Community Nursing to ensure that users feel supported on an ongoing basis and that changes to the system are well communicated.
- Ensure that interfaces to other systems are planned and implemented in order to bring further benefits to users and their patients. This will lower the risk of the system becoming an island information silo.
- That an investigation takes place by the Morse user group looking at the use of the continuation note and forms and whether this process can be slim lined. If appropriate, this discussion may also involve the third party supplier.
- That this survey is completed again in one years time and directed to all users of the system to ascertain whether benefits are longstanding once Morse has 'bedded into' service processes.
- To support the implementation of Morse on a Pan Grampian basis and to share knowledge and experience where possible.

Appendix 1- Results per service area

Community Nursing

Number of respondents=53				
	Strongly Agree or Agree	Neutral	Disagree or Strongly disagree	No Response
I believe that the use of Morse has led to an improvement in communication with my team*	20(38%)	22(42%)	11(21%)	
I believe that the use of Morse has led to an improvement in communication between the teams I work with**	19(36%)	24 (45%)	10(19%)	
The use of Morse has led to a reduction in the amount of information required to be regularly duplicated	35(66%)	12(23%)	6(11%)	
Ongoing support has been essential to my use of Morse	39 (74%)	11(21%)	3(6%)	
Overall, please rate the following areas of Morse	Excellent or Very Good	Good or Fair	Poor	No Response
Scheduling of appointments and Team Allocation	9(17%)	38 (72%)	6(11%)	
Updating all aspects of the patient record	14(26%)	35(66%)	4(8%)	
Ease of Access	17(32%)	29(55%)	7(13%)	
Sharing of information	15 (28%)	33 (62%)	3 (6%)	2(4%)
	Yes	Maybe	No	No Response
Would you recommend Morse to a Colleague	21(40%)	21(40%)	11(21%)	
Can you estimate the time per day from the duplication of information				
1-30minutes	16(30%)			
31-60 minutes	18 (34%)			
no impact	19(36%)			

Hospital at Home

Number of Responses=23				
	Strongly Agree or Agree	Neutral	Disagree or Strongly disagree	No Response
I believe that the use of Morse has led to an improvement in communication with my team*	4(17%)	10(43%)	9(39%)	
The use of Morse has led to a reduction in the amount of information required to be regularly duplicated	12(52%)	7(30%)	4(17%)	
Ongoing support has been essential to my use of Morse	9(39%)	9(39%)	5 (13%)	
Overall, please rate the following areas of Morse	Excellent or Very Good	Good or Fair	Poor	No Response
Scheduling of appointments and Team Allocation		7(30%)	5 (13%)	11(48%)
Updating all aspects of the patient record	4(17%)	12(52%)	4(17%)	3(13%)
Ease of Access	4(17%)	11(48%)	5 (13%)	3(13%)
Sharing of information	6(26%)	10(43%)	4(17%)	3(13%)
	Yes	Maybe	No	No Response
Would you recommend Morse to a Colleague	8(35%)	9(39%)	5 (13%)	1(4%)
Can you estimate the time per day from the duplication of information				
1-30minutes	12(52%)			
31-60 minutes	3(13%)			
no impact	7(30%)			
No Response				

Macmillan Nursing

Number of Responses =4				
	Strongly Agree or Agree	Neutral	Disagree or Strongly disagree	No Response
I believe that the use of Morse has led to an improvement in communication with my team*	3(75%)	1(25%)		
The use of Morse has led to a reduction in the amount of information required to be regularly duplicated	4(100%)			
Ongoing support has been essential to my use of Morse	3(75%)	1(25%)		
Overall, please rate the following areas of Morse	Excellent or Very Good	Good or Fair	Poor	No Response
Scheduling of appointments and Team Allocation	1(25%)	3(75%)		
Updating all aspects of the patient record	1(25%)	3(75%)		
Ease of Access	2(50%)	2(50%)		
Sharing of information	1(25%)	3(75%)		
	Yes	Maybe	No	No Response
Would you recommend Morse to a Colleague	4(100%)			
Can you estimate the time per day from the duplication of information				
1-30minutes	2(50%)			
31-60 minutes	1(25%)			
no impact				
No Response	1(25%)			

Appendix 2- Comments received.

Community Nursing

Why do you feel this way? (whether you would recommend the use of Morse to a Colleague)

Unable to access continuation sheets. Speed has been terrible. I don't find it user friendly at all.

Complex to use and understand. Feels like a very unfinished alpha test (not even a beta test). Forms are a mess and too many forms make it difficult to see the information you need. Other services not looking at previous entries and forms (looking at you H@H).

There are still some kinks to work out. The care plans showing up as incomplete when you leave a green section due to information not being relevant feels pointless. You can't easily allocate a second nurse/HCSW to a patient that requires a double visit. It is time consuming to add it on properly.
The timings on patient visits are in 30 minutes slots so you can't be honest and accurate with how long you spent with the patient.
Transferring all the patient information on to Morse isn't happening quickly. Still relying on going on to Trak to find out allergies, NOK because you can't edit it on Morse. You can't remove a contact number that another member of staff has put on Morse which needs updating, meaning it takes up a lot of time going through all the numbers to contact a patient or that important information isn't updated in the correct place

System can be very slow especially to sync at the start of your evening shift meaning you are slower getting out to see patients, also if you have numerous unscheduled visits you are working beyond your finishing time putting information on computer as not always practical evenings/night shifts to do this in patients house or sit in your car to complete.

there have been a lot of "teething problems" It can be very slow at times making it frustration at the time spent waiting it to load

No support at night with changes to morse. We are still writing and sending daily e-mails to the day teams of patients

It's a good system when it works well. Very beneficial to staff who are good with computers.

manageable to use , access to patient information which we would not have had previously

Very time consuming when making changes to interventions.

can be difficult to navigate, information is not updated until you return.

Just what I have heard about the last system they used it has a lot of room for improvement.

Due to being dyslexic I am finding it very difficult to not have the care plan in front of me and not being able to freely go to and from the care plan and written notes. The laptops do not have enough battery and the system does not allow more than one entity to be open at any given time. The spell checker also seems to be American?? I feel the imputing of the information is much more time consuming that when we had paper notes. The wound charts are good but take to long to fill out, especially if the patient has multiple wounds.

Access to patient information prior to visit so knowledge of patient is up to date

Very time consuming to access/add/update forms. Was so much easier to check paper copy of wound chart to see if improvement/ deterioration of wound. Now you have to scroll through it all if you can open it in patients home. First version was more user friendly to this latest wound chart. Notice staff not updating them regularly probably because it's not user friendly. Difficult to allocate patients to staff and takes too long. Unable to see on one screen what visits each member of staff has. Maybe in a small team with few patients it works better.

computers are the future no more writing of notes much easier once you get hang of morse

I like the notes. easy to read and see what other have written before going into patients home.
Good to see what macmillan and H@H have written
Dislike the allocation although improve still slow hard to see what you have allocated.

Has had a lot of issues through out

see below

I feel morse saves time in some ways but not always in every case.

The system is very 'glitchy'

Can feel a little clunky with some bugs still require ironing out.

we have found that MORSE is very time consuming, awkward to change interventions. can't see what other colleagues are doing when out as no access to team allocation offline.

I feel that the process of learning to use morse effectively has been very fragmented and protracted

Reduces amount of paperwork and variety of forms available to use on Morse.

I would recommend it as long as it is used correctly. Not all staff complete mandatory paperwork. Feel as though this is missed more compared to paper notes. I am computer friendly so prefer morse over paper notes.

I feel paper records were more easier at a glance too see what has been completed for each patient ie care plans/mandatory forms etc as you need to flick from page to page to see this information. It is easier to update the patients records at the visit as I found sometimes I would be rushing after my visits to update vision on return to the office - I work part time and found admin a rush afterwards due to the number of visits when I had a large caseload.

It is easier to access notes and information regarding updates on patients from multiple teams attending to the patient

just feel could be a little simpler

I just feel that there was a lot of teething problems , got use to how it worked then changed ,and that a lot of staff struggle that are not very good with computers that are excellent nurses , I think the whole process could have been simplified , I also feel that it could have been fine times before being completely rolled out , also the timing of it for some staff who were already getting over stress or under stress from the pandemic was not good and I feel that it may have added more pressure and causes some staff sickness I may be wrong , I feel it still causes some stress for some that don't fully understand all its functions which still often change , also the capability to not be able to go online to download when out and your workload may change can be a tad useless, if there was more areas where an internet connection in community could be picked up to sync then it may be more useful too especially if we needed to access information

quickly such as Trak care for a patient who we were visiting. No title at the top of my job description as it's not there on your option drop list

Its easy to navigate.

Scheduling remains time consuming and unreliable. Many teams after allocating are making a written copy too. The allocation has been disappearing or system entirely off on occasion.

Ignitions have to be switched off before using laptops as it is illegal otherwise. Some houses are not appropriate to be sitting with a laptop.
Often feel on edge having laptop out and about.
Can't see other people in teams work as easy.

The electronic side of things is ideal for forms automatically being populated however, communication between different teams etc still need to be over the phone on top of referral form.
GP vision/EMIS remain separate and duplication still needed to this and onwards referrals if required.

I feel MORSE is very effective for up-to-date communication between teams. It is very useful to be able to see MacMillan nurse notes, OOH nursing notes etc. We are able to read outcomes of visits which is very useful

Need training on how to use the forms so everyone is using the same forms across the board. I am not confident with technology. I have been learning from colleagues about the care plans and feel being shown from the start would have been better. Not confident in adding patients to the caseload either Also how to check who has a patient on a certain day.

Some appointments had fallen off morse and patients had been missed. Most notable were NPT and a recent catheter.
Allocating work proves complicated unless you have a written mind map infront of you. Red day reviews have been required as mandatory forms had not been completed and regular skin checks missed.

It is still early days with using Morse and we are still experiencing teething problems.

MORSE has been better than the previous system used, I think the team allocation could be slightly improved when allocating work as it sometimes can be a bit slow.

Quick and wider access , work better organized.

Clear and concise, compared to written reports.

Doesn't always work well when we are out on visits, need to always have pen and note pad on me to take notes of time and information for patients.

What could be added in the future to enhance the user experience

More IT assistance in OOH period .

Better front end experience, it should flow and be intuitive to use but currently it clearly isnt. It should integrate with Trakcare. Forms should be organized better into groups (im talking about used forms).

Features to fix mentioned above

New system, more support.

Morse able to prevent separate Audits being required.

Diagnosis of patient. Nursing assessment to be completed and kept up to date.

Care plans could be made more personal. Being able to change title of blank "care plan" to reflect what care plan is about. Work allocation could be better when list of patients unallocated downside - if patient has multiple interventions would be easier if they were beside each other and not got multiple patient's in between.

More training

being able to see other peoples list more easily.

Quicker responding time as can sometimes run slow.

refresher training

Able to edit pathways so you don't need to have 3 or 4 for the same patient. Have something that could flag up when needs addressed.

as above

able to attach documents eg tissue viability care plans

Make allocation of patients easier as hovering and dragging time consuming. Would be helpful to see on one page which members of staff are working that day instead of a huge long list of everyone along the top in team and other teams. Seeing who has which patient on same page would also help and ensure fair allocation of patients as green bar with how long it should take you to do round not accurate.

Didn't work here pre-Morse so can't say if it is an improvement on old methods.

improved allocation easier to what everyone has allocated.

better links between hospital / primary care

Clear entry to AM or PM visits
Ability to schedule visits on order of round
If intervention updated for example an unscheduled catheter change previous interventions when cancelled should disappear. Can be difficult to decipher what is a current intervention and what is cancelled
adding visits could be less time consuming, too many steps and pathways making creating a visit and then confirming difficult

Having appointments linked if a person has multiple interventions it would be good and save time signing each individual one of

Being able to unlock the continuation note if needed to edit your text.
Being able to go back easier to re-read previous entries instead of having to leave your own continuation notepage.
Easier use of wound care plans where patient has multiple wounds. can be confusing to navigate/add to.

More portable devices - ie ipad in a case with a strap. Some visits can require a lot to be taken in, for example - weighing scales - kit bag - sharps bin - epinephrine kit etc. Lap tops can be difficult to complete in house if cluttered or unkempt due to requiring a surface to type on.

easier editing of interventions

not duplicating forms that have already been completed/started for patients eg manual handling and nutritional assessment forms.

Unsure

Easier to use, would help.

Some section where you can add past medically history and previous diagnosis etc

Overall I think once morse adapted to all the issues that pop up, it will be a good system.

KIS/ACP information and possible access from other health professionals eg. OT, PT, care management,etc

As explained above , as with our phones we use our private phones data as it is to access Teams , make calls etc , if we urgently need info often it would be a case of using our hot spot on our phone to gain internet access in the laptop ?

Linking Morse to Trackcare

Education on filling out and locating forms. To have roaming data so that forms can be updated live also to check on sites like trac care while out on visits.

Take of the 'notify changes' pop up after saving intervention times etc.
Show staff time of working, instead of hours of work.
Alphabetic listing.Staff toggled off/on stay that way (as currently rarely stay saved correctly).
Better abilities to see what staff members have rather than a great big line of staff along the top of the screen and having to click on them to see workload (unsure how to improve this given the layout).

The option to add documents as files- such as ASP forms, photo consent forms

Training on how to use the forms and maybe more updates. Hard to get time at work to keep up to date

Prompts regarding catheters/NPTS and such or a better way to ensure no interventions are not missed.

Longer training and more practice before going live.

It would be very helpful to have an access to medical history from the Morse.

To continue with updates.

Any further Comments

Far too complex to use, not newcomer friendly and even experienced users have major issues from time to time.
Needs a dark mode as white is poor on the eyes.

Morse was introduced with no administrative help or superusers available at night to support staff .No extra time given to us to get used to dealing with new system resulting in us having to stay beyond our working hours to complete Morse .I was sad to see the stress that the introduction of Morse initially had on my colleagues who are very experienced dedicated nurses due to lack of support

Hopefully if system becomes quicker and more user friendly it will improve but so far it's not been the best experience. Sharing of laptops an issue at times for part timers as we have to return them to office on a Sunday after busy round of diabetics and already running past 4.30pm.

Appears to be mostly effective. Staff all still to be using paper diaries and notes instead of Morse however as they don't appear to have fully bought into it.

Staff workloads should be more clearly listed so can see how any visits each staff member has and who has capacity

I feel morse is a positive thing and the way forward to modernise community nursing. It does feel like everyone always has their head stuck in a laptop all day everyday when at work, as long as not impacting patientcare negatively then it is a positive.

Interventions cannot be edited.

People are not completing notes at time of visit - this causes inaccurate times when looking at notes - I do not agree with completing notes when back at base, sometimes several hours later.

When using out of hours can take a while for the information to be passed over - or gain access to electronically. This can either create a delay in care or going to see a unfamiliar patient with lack of information. Sometimes having to connect to phone while out to pull information or sync.

logging in to different laptops or PCs can take a very long time to sinc, often 20,000+ updates which can take along time to sinc waiting to go out and start visits.

i thought about when cancelling a patient appointment, if we could have a section that states " in hospital" or something to state, as i dont feel it is fair to say no access or cancelled as we dont know why the appointment would be cancelled if we look back and no access we look at if they are housebound or not

I feel that once everything is finalised with Morse and no more changes are to be made to it for some time I would benefit from a class again from scratch not just a refresher as at the time of my training it was a working process morse .

Could be a good system. But more training on all aspects would be really helpful

It is helpful that the notes are no long in the home so other relevant staff members can access notes when required.

I think it is well organized, easy to use, in a logical order, I like it:)

Hospital at Home

Why do you feel this way? (whether you would recommend the use of Morse to a Colleague)

As a team we don't sit fully in primary or secondary care and I feel morse is aimed at those working wholly within the primary sector, from that aspect sharing of information is good although causes lots of duplication when liaising with secondary care. As we are required to use both secondary and primary care platforms my preference is the one we use within secondary care. It may be that once we start utilising more functions within morse my preference might change.
It is good that we can have all forms on MORSE e.g. NEWS, TEP. The other benefit is that multiple users can use notes at the same time (unlike trakcare where a record gets locked). Problems are that it is a clunky system - it is difficult to scroll through. It is difficult to flick between continuation notes and forms. It is really time consuming to look through all information if you are doing a review - need to keep going between screens, and you can't type at the same time - almost needs a split screen or double screen function - one to type and one to view. We don't save significant time by not writing name and chi - any time saved is lost because the system is so clunky.
I find it a much easier and more accessible system than EPR on Trakcare
Multiple users can access patient information at the same time. Having different 'revision versions' of forms is really useful in accounting for changes made, especially in my pharmacy role, as you can access who has made a change and when.
clunky, need to go in and out of different pages, dont get overall picture, not linked to medical notes on trak
Barriers to access from desktop computers. Risk of losing input from unintuitive save/lock/sync interface. No continuity with electronic notes in ARI. No routine availability for patients admitted to AMIA to access Morse and review notes (especially out of hours).
I think Morse has much improved communication and is beneficial compared to paper notes. It is good can be used when out on home visits and that information between colleagues shared. However personally find the system very "clumpy" and difficult to navigate. System for uploading forms eg med rec, clerking, dnacpr takes a lot of time compared to using Trakcare system for the same information, and at times I feel duplicated work. Trakcare feels more streamlined and better for continuity. When patients are discharged from hospital for active recovery if it was on Trak then workload would be reduced as no need to repeat clerking and all the forms etc as could just continue on from discharge notes. However I appreciate in the community there are different needs and requirements such as DNs using morse and obviously is useful for them to see shared information also.
I feel that Morse is difficult to navigate and slow to load on the server. It is tricky to get an idea of the narrative of a persons care, as you need to open documents individually and it slow to do this. Bloods and other test results are not indicated.

Perhaps not an indication of the software itself but it is often problematic when asked to chase bloods in the evening and slow and difficult to interpret. Also, it is not possible to hand over to night staff if bloods are not back as they do not have access.
I find Morse a really useful platform. It enables all notes and patient records in a central location.
The system doesn't feel intuitive in the way that Trakcare does, with patients moving between the hospital and community I think it would provide better continuity and be safer for the same system to be used by hospital and hospital at home team.
Software good hardware is awful. Low battery life. I pads freeze work is sometimes lost. loads slow and unresponsive
Within H@H we are using Trak and Morse and the 2 systems do not communicate with each other and we are still duplicating work
I have no experience of the system used before Morse but I have extensive knowledge of using GP IT systems and Trak. Morse is a very limited system with a poor user experience due to the design
i think it is very efficient and safe to use , allowing teams to see involvement from other professionals has improved communication between teams
My biggest frustration with Morse is that it is not easy to read through the continuation notes. Instead of being able to see them as a continuous record (as you would in paper notes, or in other computer systems such as Trak Care), you need to keep coming in and out of each note entry to view them. This makes ease of access to patient information less good, and makes updating the record harder. In a similar vein, it is frustrating that you can't view the continuation notes from within the "view case" - you can only view them within "view patient", and yet we are discouraged from using "view patient" to add our continuation notes as this carries the risk that people will forget to link their note to the appropriate case. So this means that you need to keep coming in and out of different parts of the patient record in order to view continuation notes and add a new one. These factors impair communication - I feel that because it is not easy to view the notes as a continuous record, other people tend not to read the preceding entries in the notes, and important things get missed.
Morse provides the ability to see patient information without having to share a paper file and wait until someone else has finished with it.
More user friendly than EPR

What could be added in the future to enhance the user experience

Almost needs a split screen or double screen function - one to type and one to view. Would be helpful if you could copy and paste information - can't do this - need to go to print screen and then copy and paste.
Dont know if you can do this or not but ability to scan in assessment results
The ability to link with / upload information to / download information from Trakcare would be very useful.
change to trak care notes especially if expansion planned
If some of the information was built-in the system, ie Doctor's surgery phone number, Clinician etc, this would save considerable time
Honestly, I would prefer that Trakcare was used instead as I feel this is much more suitable for a hospital-equivelent service and would make transfers of care to ARI smoother for staff and especially for patients.

Additional functions available on Morse which aren't currently available on Live within Grampian.
None specific
Better hardware
Communication with other health care systems
Electronic prescribing Embedded data collection and coding of diagnoses and values
link with trak care
If the above issues could be resolved, it would be very good - so the continuation notes being visible as a continuous record at a glance, and the ability to read continuation notes from within the "view case" section.
I would love to be able to gather specific information together in one location instead of going in and out of separate records with multiple selections needed to get to the form required. For example I would find it extremely useful to be able to see all patient's medicine reconciliation forms in one location so I could review them more efficiently.
Link to Track Care

Any further Comments

One of the main issues remains is that it is a different system to ARI, so most ARI colleagues e.g. ED, AMIA, medical wards, 102, don't have access to notes on MORSE. This had led to a breakdown in communication.
Dont use MORSE to book appointments, havent used any support
if hah is to expand and deal with complex frail medically unwell patients who require medical input then we need to use trak notes HAH is consultant led as per national model therefore our documentation should be linked with ARI
Cannot answer a lot of the questions, as I don't use Morse in a medical capacity.
I found the implementation period of Morse quite difficult. I appreciate that at the time it was a new system and the support from Cambric was great, eHealth then came on board (the support is also fantastic) but the connecting up of all processes seemed a bit disjointed. Other than that, I really enjoy Morse and find it a great system to use.
When escalation and checking of results is required by the hospital team out of hours I think it would be safer for information to be readily accessible on Trakcare.
Using Trak would be more efficient and would allow our OOH and ARI colleagues to access information about H@H patients when necessary eg OOH
I dont use for appointments so not able to comment on that

MacMillan Nursing

Why do you feel this way? (whether you would recommend the use of Morse to a Colleague)

I don't know much about other systems available.
Its very good for keeping all your notes up to date on the day you see the patient ,the system improves every day I learn more and become more proficient in its use.
is useful as can access outwith the office. When covering for other colleagues able to access their notes on patient. Helpful to complete documentation while with the patient
ease of sharing information between colleagues

What could be added in the future to enhance the user experience

If Morse spoke to other systems used such as Trakcare, GP systems, etc.
We have been meeting as a team and feeding back all the information that could improve this service. Our next meeting this Friday to go over all our suggestions and recommendations.
when the patients locality is put on for them being added to Morse it doesn't have to be highlighted every time you add a continuation note

Any further Comments

Regular communication still required within MDT via email, etc. Still requires duplication of work but can be 'copy cut and pasted' which is time saving and easier.
Hopefully after our team meeting Friday we could forward the results .

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