INTEGRATION JOINT BOARD

Date of Meeting	11 August 2020
Report Title	Recovery: Operation Home First
Report Number	HSCP.20.015
Lead Officer	Sandra MacLeod, Chief Officer
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Consultation Checklist Completed	Yes
Directions Required	No
Appendices	a. Flash Reports

1. Purpose of the Report

1.1. The purpose of this report is to provide an overview to the Integration Joint Board (IJB) on the current position and priorities of our Covid-19 response and steps towards recovery.

2. Recommendations

2.1. It is recommended that the IJB notes the current progress towards progressing Operation Home First in the city, in line with our strategic plan, and notes that further reports will be brought to IJB as we move beyond our initial Covid-19 response, and as specific decisions are required.

3. Summary of Key Information

Background

3.1. In March 2020, the Aberdeen City Health and Social Care Partnership (ACHSPC) Medium Term Financial Framework (MTFF) was agreed at IJB. This reflected the ambition of the IIB as identified through the Programme

of transformation and the Strategic plan. The IJB were made aware of the financial challenges that 2020/21 would bring and 5 key objectives were shared in which would be the focus on the delivery through 2020/21. These 5 objectives were linked to both the Strategic Plan and the Programme of Transformation.

3.2. March 2020 also brought with it the Covid-19 pandemic and the past 4 months have been firmly set in response phase across the health and social care system in Aberdeen City. Currently we find ourselves in response phase, while many partners are already marching towards recovery. Within this current context as a whole system we have sought to understand what has changed; to embed what has been positive, to look forward and understand our new starting position.

3.3. In May 2020 IJB received a report which set out the initial response to the current pandemic and highlighted some of the changes that had been put in place as part of the initial response. Assurance was provided that these changes are aligned with our planned strategic direction, and indeed in many cases had enabled us to accelerate the delivery of our ambitions.

3.4. Our response and recovery work continues, at pace, as we continue to ensure that we are able to provide the very best care as we continue to live with the virus.

3.5. This report sets out the relationships between our Medium Term Financial Framework and specifically the five priority objectives that were at the heart of the framework, our agreed Programme of Transformation, and the ambitions and activities of Operation Home First, both in terms of the initial response and current ongoing response. The report also provides an update on some of our ongoing activities.

3.6. The diagram on the following page demonstrates the clear links between the aims of Operation Home First, and our own strategic priorities, which then in turn influenced the creation of the Medium-Term Financial Framework and our transformation programmes.

Aberdeen City Health & Social Care Partnership

A caring partnership

Maintain People Safely at Home

Avoid Unnecessary Hospital Attendance or Admission

Support Early Discharge Back home

Prevention

Resilience

Connections

Communities

Personalisation

ACHSCP Strategic Aims

Programmes of Transformation

- Manage Demand
- Prevention
- Data and Digital
- Conditions for Change
- Accessible & Responsive Infrastructure

Medium Term Financial Strategy Objectives

- Commissioned Services
- Improved sustainability through digital innovation
- Operational Alignment to Localities
- Locums and Agency Staff
- Partnership GP Practice Remodelling

The ACHSCP strategic aims were central when creating our programmes of transformation and medium term financial framework objectives. They are key to all strategic planning and projects within ACHSCP

Extensive mapping has demonstrated clear links between our strategic aims, medium term financial framework and our programmes of transformation (see previous IJB Papers)

The aims of "Operation Home First" connect strongly with our strategic aims

Operation Home First

3.7. The ambition of Operation Home First is to maintain people safely at home; avoiding unnecessary hospital attendance or admission; and to support early discharge back home after essential specialist care.

3.8. Operation Home First is being delivered through a whole system collaboration, including ACHSCP, Aberdeenshire Health and Social Care Partnership (AHSCP), Health and Social Care Moray (MHSCP) and NHS Grampian (NHSG). Key performance indicators continue to be developed and will as part of this for example include:

- Preventing admission to hospital for care home residents
- Reduction in emergency 'front door' attendances

3.9. The principles of Operation Home First have significant alignment with our strategic plan:

o'Home First' for all care	oWorking within the agreed strategic direction set out by the IJBs & NHS Grampian	oFocus on outcomes for people	oWhole system working and improving primary/secondary care joint working
oMaintain agile thinking and decision making	oRetain flexibility to respond to surge (covid/winter)	oWork within constraints of segregation/ shielding/ physical distancing measures/ reduced hospital bed base	oMaximise digital solutions

3.10. As set out in the initial recovery report considered by IJB in May 2020, there were eleven transformations that were initial responses to the Covid-19 emergency. These are:

- Closure of care of the elderly beds at ARI
- Shifting workforce and beds to Woodend
- Moving GMED from ARI to Health Village
- Collective GP Response Calls
- NHS Near-Me

- Closure of and shift of learning disability beds at Cornhill
- Increased outreach from hospital-based services to support community-based care pathways
- Reduction in minor injury and community beds
- Reduction in A&E attendance due to shared intention of community support
- Hospital @ Home and Virtual Ward capacity due to consultant access.

3.11. Some of these changes have now been embedded and other activities are now ongoing to further embed these changes and continue to deliver the objectives of Operation Home First and hence our own strategic priorities. Some of these have been done within the partnership, and others within Acute or across the wider system.

Current projects which are underway to respond to, maximise benefits from and ensure that these changes are embedded are outlined in the following table (Note those shaded reflect the five MTFF objectives.)

Project	Strategic Links	Description	Links to initial changes in response to Covid19 and OHF Principles
Care of elderly pathways	**MTFF:** NA **Transformation Programme:** Prevention / Demand Management	Ensure effective and streamlined pathways for frail and elderly out of Woodend Hospital into the community – at home or a homely setting.	Initial Changes: • Closure of care of the elderly beds at ARI • Shifting workforce and beds to Woodend OHF Principles: • Outcomes for people • Whole system working
Respiratory pathways post covid support; spirometry work; MCN developing	**MTFF:** NA **Transformation Programme:** Prevention / Demand Management	Ensure effective and streamlined pathways for those with respiratory issues so that they can receive the support they need in the community – at home or a homely setting, and self-managing where suitable.	Initial Changes: • Increased outreach from hospital based services to support community-based care pathways OHF Principles: • Outcomes for people • Whole system working
Hospital at home scale up	**MTFF:** Operational alignment to localities **Transformation Programme:** Demand Management	We started with this service which initially provided supported discharge, allowing people to come out of hospital earlier than previously would have been the case. During the last few months, we continue to work on expanding the service so that more people can be supported to not only come out of hospital sooner, but also can receive some acute care at home (where appropriate) rather than going into a hospital setting. Clearly this approach not only has benefits in terms of reducing the need for hospital beds which is particularly important at the current time when we need to ensure physical distancing, but the approach is also helpful in terms of overall patient wellbeing and for reducing rehabilitation times. Early evaluation has found the friends and family (unpaid carers) prefer their loved ones being cared for at home rather than hospital, and this coupled with the reduced risk of infections that exist as a result of being in hospital are key benefits of this approach.	Initial Changes: • Increased outreach from hospital based services to support community-based care pathways • Hospital @ Home and Virtual Ward capacity due to consultant access. OHF Principles: • Home first for all care • Outcomes for people • Whole system working • Flexibility for surge • Work within constraints
Mental health services – transforming the service following a reduction in bed base	**MTFF:** Locums and agency staff **Transformation Programme:** Demand Management, Conditions for Change	To ensure a sustainable model of care whilst we deliver a protracted response to COVID-19 with a significant reduction in available beds in inpatient services for Mental Health in Seafield Hospital (Moray), Inverurie Hospital, Inverurie, Banchory Hospital (Aberdeenshire) and the Royal Cornhill Hospital (Grampian-wide and North of Scotland) further compounded by the reduction in beds across the wider Grampian-wide Acute Care System.	Initial Changes: • Closure of and shift of learning disability beds at Cornhill OHF Principles: • Home first for all care • Outcomes for people • Whole system working • Flexibility for surge • Work within constraints
Public health messaging – KWTTT, immunisations	**MTFF:** NA **Transformation Programme:** Prevention	A number of changes have happened as a result of the COVID-19 situation: there have been fewer attendances at A&E and in General Practice settings. This change in behaviour has been for a number of reasons, however some of these changes have meant that people have effectively managed their conditions by themselves and received health and social care support without using tradition face to face methods. A robust social media plan has supported this – making sure that we are communicating the right social media messages at the right time. This work will continue to be	Initial Changes: • Reduction in A&E attendance due to shared intention of community support • Changes in public behaviour, maintaining of positive behaviours OHF Principles: • Home first for all care

Project	Strategic Links	Description	Links to initial changes in response to Covid19 and OHF Principles
		developed through a multi-channel health promotion plan – reiterating national and regional advice and providing local information where appropriate.	• Outcomes for people • Maximise digital solutions
Technology/ digital health • **Near me roll out** • **Remote monitoring**	**MTFF:** Improved sustainability through digital innovation **Transformation Programme:** Data & Digital	The roll out of Near Me digital consultations has seen a significant growth during the Covid-19 period, with Grampian continuing to one of the highest users of this technology. Work is continuing to embed this as a sustainable and effective way of working as well as spreading it to more health and social care services.	Initial Changes: • NHS Near Me OHF Principles: • Home first for all care • Outcomes for people • Maximise digital solutions
Green hubs – CTACs	**MTFF:** NA **Transformation Programme:** Demand Management	Around 16,000 people in Grampian have been identified as having an existing medical condition that puts them at the highest clinical risk of severe illness from COVID-19, requiring them to sustain a strict period of isolation (shielding) to protect their health. This necessitated the formation of stringent "green" pathways in the community to enable them to receive the care that they need during the pandemic, such as phlebotomy, would care and any relevant chronic disease monitoring. This were known as "Green Community Hubs for Shielding Patients". There is an opportunity to align work ongoing for green community hubs, to provide further services in line with the Primary Care Improvement Plan (transfer of community treatment and care services (CTACS) from GP practice to HSCPs) and with work relating to Elective Care (i.e. pre-op assessment bloods taken in the community)	Initial Changes: • Home-visits for shielding people; green areas within practices • Interim hubs for immunisations, and sexual health services being delivered in one Aberdeen Community. OHF Principles: • Outcomes for people • Work within constraints of shielding • Whole system working
Integrated Access Point	**MTFF:** Improved sustainability of services **Transformation Programme:** Demand Management, Data & Digital	As we move into the next phase of our COVID response, "Aberdeen Together" are considering the best ways to support the people in our communities. One of these approaches is to consider the potential development of an Integrated Access Point – which would be an integrated access point (using a range of channels) for handling requests and needs of people across some of our health and social care services. The aim would be to make it easier for people to receive the right support at the right time in a person-centred way. It will also aim to ensure that staff can maximise their time spent caring for those in need. During the current, scoping stage, we are working with colleagues to understand how people currently access services, in order to understand which services, or parts of services might benefit from being included in an Integrated Access Point. We are also reviewing feedback and will be supporting focus groups involving people in our communities to find out which channels would be most suitable from a person-centred perspective to access services when support is required.	Initial Changes: • NA – scoping stage OHF Principles: • Maximise digital solutions • Focus on outcomes for people
Partnership GP Practice Remodelling	**MTFF:** Partnership GP Practice Remodelling **Transformation Programme:** Accessible and Responsive Infrastructure	Enhancing the sustainability and efficiencies of our Partnership managed General Practices (also known as 2C practices). Work is progressing to develop a blue-print for how our Partnership managed GP practices may operate in the future. This work takes consideration of the patient profile as well as seeking to achieve a model which helps to minimise the need for additional locums and agency staff. The significant steps forward in relation to virtual consultations provide new opportunities for this area of service design.	Initial Changes: • Collective GP Response Calls • Moving GMED from ARI to Health Village OHF Principles: • Focus on outcomes for people • Maintain agile thinking • Work within constraints • Maximise digital solutions
Connecting Aberdeen (digital)	**MTFF:** Improved sustainability through digital innovation **Transformation**	Reducing the gap of people in our communities who do not have digital access and are therefore not able to benefit from digital health and social care support	Initial Changes: • Near Me OHF Principles: • Focus on outcomes for people

Project	Strategic Links	Description	Links to initial changes in response to Covid19 and OHF Principles
	Programme: Data & Digital		• Maximise digital solutions
Stepped Care Approach • **Daily locality USC huddles**	**MTFF:** NA **Transformation Programme:** Manage Demand / Prevention	To deliver a coordinated response to unscheduled care needs across Aberdeen City through early identification and management of patients using a multi-disciplinary approach within localities so that all citizens get the right level of support at the right time by the right person. The approach primarily aims to reduce hospital admissions by providing rapid assessment and diagnostics within the community enabling a decision to be made whether treatment and care can be delivered at home or whether hospital admission is most appropriate for the individual. (the stepped care approach incl. linkages to H@H)	
Reablement at home or homely environment first	**MTFF:** NA **Transformation Programme:** Manage Demand / Prevention	To ensure that all reablement is delivered at home or in a homely environment at all possible times rather than extending hospital stays for this purpose.	Initial Changes: • Closure of care of the elderly beds at ARI • Increased outreach from hospital-based services to support community-based care OHF Principles: • Home First for all care • Focus on outcomes for people • Work within constraints (reduced hospital bed base)
Rosewell flow	**MTFF:** NA **Transformation Programme:** Manage Demand / Prevention	The project will help ensure that recent reductions in delayed discharge and improvements in patient flow is maintained despite a reduction in available beds and increasing activity. It will include looking at options for improved flow (interim beds); admissions to care homes; respite provision and creating plans for a short-notice surge facility if required. This is linked to the delivery of our collective mobilisation plan, Operation Home First, which seeks to embed pathways changed during the Covid19 response to ones which can adjust to living with covid and winter surge across the system.	Initial Changes: • Closure of care of the elderly beds at ARI • Increased outreach from hospital-based services to support community-based care OHF Principles: • Home First for all care • Retain flexibility to respond to surge • Focus on outcomes for people • Work within constraints (reduced hospital bed base)
Strategic Commissioning Review	Medium Term Financial Framework Objective	Commissioning is the largest part of our budget and accounts for over £100 million of our available budget. A Strategic Commissioning Board has been established to review our contracts and the services which we commission. The focus of the Board is to ensure that we continue to adopt the principles of our strategic commissioning approach. Recommendations from this Board will be escalated to the Executive Programme Board (EPB) and IJB as appropriate. Commissioning decisions will continue to be made at the Integration Joint Board throughout the financial year. The work of the Board is aligned to both strategic plan, strategic commissioning plan and medium-term financial plans The current focus of attention includes the commissioning of care at home and supported living contract. The final submission date for this contract was the 30th June and work has commenced to evaluate these submissions in advance of the final award. The new arrangements will be in place in November 2020. The Board will be pleased to understand that there has been a good response to this tender, despite COVID-19. We believe that the level of response is partly attributed to the collaborative approach we have taken throughout the process. The procurement of Carer Support services is also underway and new arrangements will be in place at the beginning of September.	OHF Principles • 'Home First' for all care • Focus on outcomes for people • Whole system working and improving primary/secondary care joint working • Work within constraints of segregation/ shielding/ physical distancing measures/ reduced hospital bed base • Maximise digital solutions

Project	Strategic Links	Description	Links to initial changes in response to Covid19 and OHF Principles
		Finally, work continues to model the provision of day care and day opportunities. It is acknowledged that this work is taking a significant amount of time, but the implications of COVID-19 on what has traditionally been a buildings based service, and our requirement to ensure that any service we commission is provided in a way which reduces the risk of transmission of the disease calls again for significant change. An update report on progress with this work will be available for the IJB members on the 11th August.	
Locums and agency	Medium Term Financial Framework Objective	**Locums and Agency Staff –** This objective sought to reduce the use of locum and agency staff within the partnership to reduce the level of spend primarily in Woodend Hospital, Mental Health community services and medical practices directly managed by the partnership. This included a focus on understanding and improving staff absences to reduce the reliance on supplementary staff. This objective has been difficult to drive forward since March due to increased staff absence as a result of the ongoing COVID-19 situation where staff have been both directly affected by the virus and have also had to self isolate where there was a risk of virus transmission.	• Whole system working and improving primary/secondary care joint working • Work within constraints of segregation/ shielding/ physical distancing measures/ reduced hospital bed base
Operational alignment of staff to Localities	Medium Term Financial Framework Objective	There continues to be positive progress towards the delivery of this objective. By the end of March, all staff were aligned to a locality and were aware of which locality they were aligned to. Community nursing services have been reconfigured based on smaller areas within localities and are moving towards being aligned to patients based on where they live rather than by which GP practice they are registered with. Work is ongoing to develop improved integrated team working, focussed around localities, including with providers and with partner services. Hospital at Home (H@H) - have increased patient capacity by 5 (total of 15 virtual 'beds') supporting more people to receive hospital level care in their own homes. All City GP practices can refer to H@H. City Visiting team (urgent care element of the PCIP) - have increased capacity and are supporting 16 GP practices across the city to provide home visits Number of admissions to H@H between 23rd March - 30th June is 174, with an average Length of stay 6.0 days.	• 'Home First' for all care • Working within the agreed strategic direction set out by the IJBs & NHS Grampian • Focus on outcomes for people • Whole system working and improving primary/secondary care joint working
Improved Sustainability of services through digital innovation	Medium Term Financial Framework Objective	This objective seeks to improve the sustainability of services and reduce the impact on primary and secondary care. It includes the implementation of initiatives such as Care Messenger and ARMED. **ARMED** - ARMED solution combines pioneering predictive analytics modelling with innovative wearable technology and health and social care data. Cost benefit analysis of using "ARMED" Predictive TEC within in Very Sheltered Housing – a cohort of people with a higher level of needs than in initial Lorburn study. Project is part of a National collaborative - testing the model in a range of settings (rural/urban/SIMD), need & age range. To reduce the number of falls at Cloverfield Grove VSH by 20% by 30/06/20. Paused on 13/03/20 because of Covid 19. Planned review end of July 2020. **Care Messenger** - Care Messenger is a communication messaging system that allows citizens to connect with friends, family and other services by using technology to send messages and pictures from your mobile or computer to the citizens smart television. Reducing the gap of people in our communities who do not have digital access and are therefore not able to benefit from digital health and social care support. Currently scoping is underway to determine the feasibility of implementing locally.	• Focus on outcomes for people • Maximise digital solutions

4. Implications for IJB

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

4.2. Fairer Scotland Duty: It is anticipated that the implementation of these plans, will have a positive impact on people affected by socio-economic disadvantage, as per the ambitions within our strategic plan.

4.3. Financial: There are no specific financial implications directly as a result of this report, however the report is clearly aligned with the ACHSCPs Medium Term Financial Framework. Specific projects with financial implications will be brought as separate reports to IJB as and when decisions are required.

4.4 Workforce: Required workforce changes will continue to be progressed in consultation with affected staff and in partnership with our staff side and trade union reps in line with usual process on a project by project basis. During the Covid-19 response stage, staff side and trade unions have been integral members within our operational governance decision making processes.

4.5 Legal: There are no specific implications as a direct result of this report.

4.6 Other - NA

5. Links to ACHSCP Strategic Plan

5.1. The areas of work progress referred to in this report directly align with the delivery of our strategic plan. Specifically:

- **Prevention:** maintaining safe services for those who are shielding will prevent potential negative health impacts if this vulnerable group were to contract COVID-19; closure and shift of LD beds at Cornhill, aligned with Action Plan for Learning Disabilities.
- **Resilience:** retaining the ability to respond to Covid demand; closure of Care of the Elderly beds at ARI; shifting workforce and beds to Woodend; moving GMED from ARI to Health Village; collective GP response calls; improved

access to commissioned pathways; reduction in minor injury and community beds; and the reduction in A&E attendances due to shared intention of community support will all build resilience into our system

- **Personalisation**: avoidance of admission and delays at discharge, continuing to improve delayed discharge experience; adopting home first principles for all care; increasing outreach from hospital-based services to support community-based care pathways; and the scaling up of Hospital @Home and virtual ward capacity due to consultant access will help to ensure that people get the right care in the right place at the right time.
- **Connections:** responding to prolonged periods of physical distancing; and the use of Near-me (digital consultation system) will help people stay connected within their communities and reduce social isolation.
- **Communities:** person centred care within community settings with the removal of barriers between primary and secondary care will help develop a divers and sustainable care provision.

It is highlighted that due to the nature and circumstances of the initial COVID response, most of the activities and principles that we are seeking to embed align most closely with the prevention, resilience and personalisation aims within our strategic plan, however there are aspects of these activities which cover more than one aim.

We anticipate that the transformations will directly affect the following Strategic Plan indicators and progress will be tracked and reported to Risk, Audit and Performance Committee:

- Reduced attendances at A&E
- Increase % of people living independently in the community
- Improved healthy life expectancy
- Increase in % of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life
- Increase in % of adults supported at home who agree that their health and social care services seemed to be well coordinated
- Increase in % of adults receiving any care or support who rate it as excellent or good
- Increase in number of people with positive experience of care provided by their GP practice

The table on the following page further reinforces these links:

Transformation Programme of Work	**Sub Programmes**	**Operation Home First and MTFF Projects**	**Links to Strategic Aims**	**Links to Strategy Enablers**
Demand Management	Unscheduled Care Action 15 Primary Care Improvement Plan (PCIP) Hosted Services Immunisations	Hospital at Home Scale Up Stepped Care Approach Commissioning	Resilience Personalisation Communities	Medium Term Financial Strategy (MTFS) Commissioning
Prevention	Locality Development Links Approach Resilient, Included & Supported (RIS) Alcohol & Drugs Partnership plan (ADP)	Care of Elderly Pathways Respiratory Pathways Mental Health Services Public Health Messaging	Prevention Resilience Connections Communities	MTFS
Data & Digital	Front line service technology Back office digitisation	Technology/ digital health Improved Sustainability of services through digital innovation	Prevention Resilience Personalisation Connections	MTFS Workforce
Conditions for Change	Lean Six Sigma Workforce Plan Staff digital & Estates Operationalisation of Localities	Stepped Care Approach Connecting Aberdeen Operationalisation of Localities Locums and agency	Resilience Connections Communities	MTFS Workforce Infrastructure
Accessible & Responsive Infrastructure	Place Shaping Place Planning	Partnership GP Practice s remodelling Green Community Hubs	Prevention Connections	Infrastructure

6. Management of Risk

6.1. Identified risks(s)

The main risk is that the positive transformations that have taken place during the last few weeks are unable to sufficiently embed within our culture and system. Other risks include staff willingness to adopt new ways of working, support from staff partnership/ trade unions, and the public. These risks will be identified and mitigations identified and put in place on a project by project basis. Overall mitigations in relation to risks around staff and public acceptance will be via ongoing and active engagement and a co-production approach as far as possible.

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

This report links to Risk 11 on the Strategic Risk Register: - There is a risk that the Coronavirus (Covid-19) outbreak leads to high numbers of incidences within the city, impacting public health and the delivery of essential health and care services through significantly increased demand and reduced workforce capacity. This reduced capacity arising as a result of frontline workforce absence and self-isolation requirements. Operation Home First is the beginning of our recovery from the initial phase of the Covid-19 pandemic, ensuring services can continue to be delivered in a safe, but transformed way, whilst also preparing to be equipped for any future re-emergence of virus within the community.

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

Appendices – Flash Reports (crtl & click to jump to page)

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Flash Report – Care of Elderly Pathways

Name of project: Elderly Care Pathways	**Objective of project:** Design a service model required going forward that is consistent of the ambitions of Operation Home 1st and identify whole-system actions required to achieve this model.
Context: Operation Home 1st is the next phase in the response to COVID- 19 across Grampian. All 3 HSCPs working closely with the Acute sector will begin to expand services and provide more services in, or close to people's homes. The redesign of the elderly care pathways is one of a number of ambitions.	**The challenge:** There is currently an unsustainable demand on services with the need to redesign care of elderly pathways across the system. The bed base is now reduced across the whole system due to bed base reconfiguration within ARI, DGH, Woodend and Community Hospitals in Aberdeenshire and Moray. This provides an opportunity to realign resources to support new Home 1st models.
Next steps • Agree high level pathway across the whole system • Scoping and the collection of data (including capturing patient/ carer experience) to inform new pathways • Agree new models of care to rapidly test	**Success criteria:** • Agreed and collective approach across Acute and 3 HSCP • Realign and upskill for workforce to support deliver of care throughout new pathway • Reconfiguration of beds across the system complete • Efficient and streamlined flow across the whole system

Flash Report – Hospital @ Home Scale Up

Name of project: Hospital at Home	**Objective of project:** to scale-up and develop the H@H service to reach its full potential in providing acute level care and treatment in people's own homes/homely setting, thereby preventing admission to hospital.
Context: • Reduction in acute geriatric hospital beds • Older adults requiring longer phase of treatment/recovery post-covid • National drive to support all boards/to develop H@H services • OHF ambition is to maintain people safely at home, preventing unnecessary admission to hospital and support early discharge • Substantive Consultant Geriatrician input to H@H team	**The challenge:** • Supporting the advanced practice education and training requirements of the existing workforce within Aberdeen City HSCP • Redistribution of resource to and within community services • Access to imaging services & monitoring equipment • Other services changing and adapting systems may have impact on capacity for H@H
Next steps • Developing competence levels of the existing Nursing workforce with underpinning advanced clinical practice knowledge • Development of a med-long term plan for developing the Nursing workforce i.e. to grow our own • Development of AHP capacity in H@H for each locality to support responsive H@H level care. • Develop pathways for accessing imaging and protocols for clinical care to support a higher level of patient acuity e.g. IV and O2 therapies for HF, COPD • Procurement of monitoring equipment	**Success criteria:** • Increase number of admission avoidance referrals from GP practices to H@H requiring Acute Care and Treatment • Reduction in acute presentations at front door services in older adults with frailty • Appropriately skilled and educated workforce

Develop plan for Community Nursing Workforce Education Development & Recruitment

Test of change to determine AHP capacity required in H@H ACHSCP

Develop pathway for imaging

Equipment

Protocol development for all clinical pathways

collaborate with other HSCPs in Grampian to share learning

Flash Report – Mental Health Services (*transforming service after bed base reduction)*

Name of project: Grampian-wide Mental Health Services (transforming service after bed base reduction)

Objective of project: to ensure a sustainable model of care whilst we deliver a protracted response to COVID-19 with a significant reduction in available beds in inpatient services for Mental Health in Seafield Hospital (Moray), Inverurie Hospital (Aberdeenshire), Inverurie (Aberdeenshire), Banchory Hospital (Aberdeenshire) and the Royal Cornhill Hospital (Grampian-wide and North of Scotland) further compounded by the reduction in beds across the wider Grampian-wide Acute Care System. The project will consider all actions in line with the MH Transformation Programme work and strategy.

Context: the following emergency measures were put in place during Phase 1: Operation Rainbow and will now be embedded in Phase 2: Operation Home First:

- Embed Near Me
- Embed the close and shift of Learning Disability inpatient services to the main RCH site
- Embed the increased outreach from hospital-based to community based care pathway, and
- Embed improved access to commissioned pathways

The challenge: changes will require the ongoing support of NHSG and Aberdeen City, Aberdeenshire and Moray IJBs.

Staffside and the respective Medical / Nursing Committees are expressing formal concerns regarding the changes to the Older Adult Pathway. Additional concern has been expressed with regard to the short timeline which they feel does not enable the usual extensive consultation (3 months minimum up to 6 months for Major Service Change) or time for coproduction. These concerns will be reviewed in the context of the work previously carried out by the Alliance.

Next Steps:

- Scope equipment and costs to fully embed Near Me
- Full Option Appraisal for LD at RCH approved by SORT
- Report on actions and risks from Aberdeen City, Aberdeenshire and Moray CMHT and RCH work streams and compete an Older Adult Pathway delivery plan
- Undertake assessment for costed Enablement Works
- Engage with Staff Partnership, patients and the public on draft plans. Including mapping of services and linkages with other system wide huddles

Success criteria:

- Embed Near me (timely access)
- Embed close and move of Learning Disability inpatient service at Royal Cornhill Hospital (safe and equitable services)
- Increased outreach from hospital-based to community-based services (patient centred and equitable services)
- Improved access to commissioned pathways (timely and efficient)

Set Up (May 20) Governance and Project Plan	Ongoing communication and consultation wuith staff and partners	Establish sector working groups / options appraisal for LD at RCH site & Older Adults pathway agreed	Implementation (Aug 20)	Progress report to Transformation Boards (Sept 20)	Progress report to IJBs (Dec 20)

Flash Report – Public Health Messaging

<table>
<tr><td>Name of project: Public Health Messages (Operation Home First)</td><td>Objective of project: to implement a social media plan to ensure the public and key stakeholder were aware of the latest information in relation to public health messages from the HSCP</td></tr>
<tr><td>Context:
Creation of a coordinated social media plan with partners to ensure the public were aware of crisis support, changes to services and ways to maintain wellbeing during the Coronavirus outbreak.
Promotion of – immunisation location change and importance, Test & Protect, key messages from the partnership around shielding, ACC crisis line, know who to turn to and volunteer support and NHS Near Me evaluation survey. Updates to ensure people knew the NHS/HSCP is still able to help people who did not have Coronavirus symptoms. General useful updates.
Dedicated staff members with a remit around social media to ensure content was timely and up to date.
A number of other communication methods were used to reach those not on social media, such as poster distributions and sharing information via local community groups.</td><td>The challenge:
Not everyone has access to digital technology and not everyone follows HSCP on social media. Information is constantly changing and need to ensure it is kept up to date.</td></tr>
<tr><td>Next steps
Continue to have dedicated staff members within partnership working with key stakeholders to plan content and share/post relevant information.
Promote HSCP so more of the public engage (include on email signatures, HSCP communications etc.)
Continue to identify alternative ways to reach those without technology (radio/tv ads, flyers in public spaces)
Continue to share key public health messages tailored to current situations in the community e.g. alcohol consumption, social isolation.
Sharing good news stories about initiatives that keep people well in communities. Such as Health Improvement Fund Annual Report, afternoon tea deliveries for people who were shielding.</td><td>Success criteria:
Over 200 new “likes” on Facebook since start of lockdown.
Thank You for participating in volunteer’s week post reached over 8000 people, 7 shares and 12 likes. One of the volunteer videos received 2.3k views.
First NHS Near Me survey post reached almost 7000 people, 18 shares and 5 likes on Facebook.
First location change of immunisation post reached over 8000 people, 41 shares, 9 likes on Facebook.
Most posts receive engagement but not always as high as previously mentioned successes.
HIF annual report reached over 20,000 people, 20 shares and 19 likes on Facebook and the Evening Express ran a 2-page article.
One key public health message on Twitter had 34 retweets and 31 likes.</td></tr>
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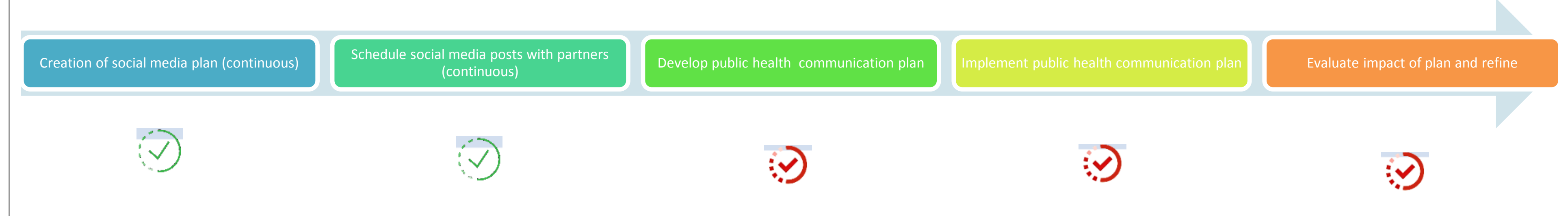

Flash Report – Technology and Digital Health *(NHS Near Me & Remote Monitoring)*

<table>
<tr><td>Name of project: Near Me Roll Out Aberdeen City</td><td>Objective of project: To rapidly scale up virtual video consultation within health and social cares services.</td></tr>
<tr><td>Context: Aberdeen City Health and Social Care Partnership are currently working collaboratively with NHS Grampian, Aberdeenshire HSCP and Moray HSCP to transform the way people are accessing health and care services. In response to COVID-19, a 12 week scale up plan was launched on 9 March 2020.</td><td>The challenge:
Aberdeen City had only a handful of GPs who had accessed the video conferencing platform. Virtual waiting rooms would be required to be set up for all practices. A training plan was required for scale and investigation of the technical set up of all practice areas. The first priority scale up was within Primary care. Barriers to increase scale up include a lack of equipment, current models of care, and patient and clinician confidence using new technology.</td></tr>
<tr><td>Next steps
Training for local Near Me leads on new national reporting tool
Contribute to national evaluation
Further roll out of IT infrastructure awaiting delivery end of July 2002
Care Home Scale up in line with national programme in line with guidance from the Care Inspectorate.</td><td>Success criteria:
Increase in citizens able to access near me virtual consultations
maintain current user statistics for Aberdeen city
increase number of other ACHSCP services using Near me
users reporting positive experience of using Near me
Week 16 stats:
636 calls – 165 consultation hours (GP, Community Nurses, Link Practitioners, Podiatry, OT, Physio, SALT and Orthotics).</td></tr>
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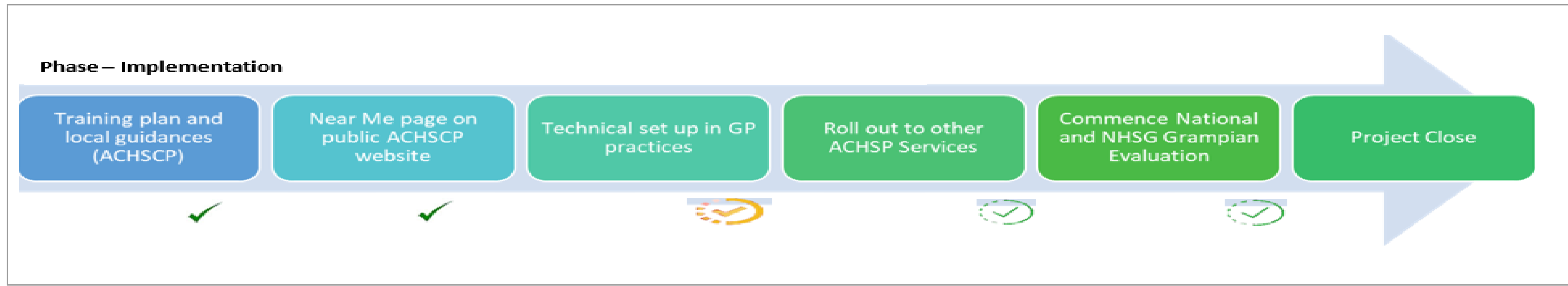
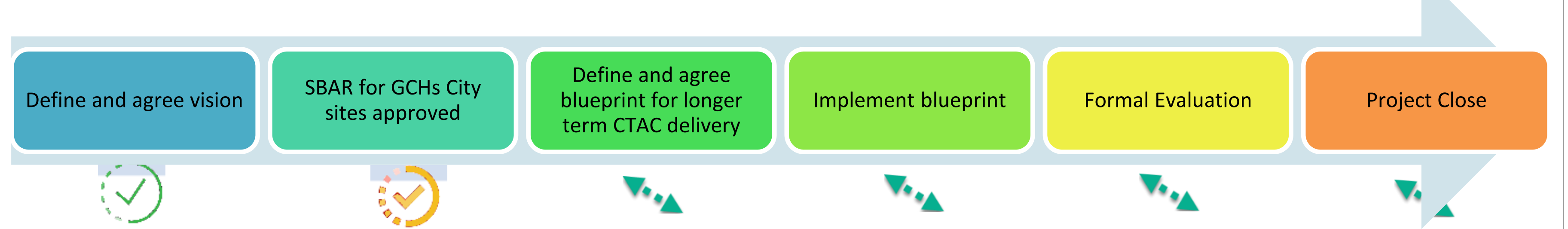


Flash Report – Green Community Hubs for Shielding People (CTAC)

Name of project: Green Community Hubs (GCHs) for Shielding People	**Objective of project:** to implement green community hubs for shielding people in several sites across Aberdeen City, with a long-term view to strategically aligning work relating to shielding patients; the delivery of community treatment and care services; and the delivery of elective care community hubs.
Context: • Creation of stringent "green" pathways in the community to enable shielding patients to access essential nursing care; • 2018 General Medical Services Contract in Scotland requires delivery of community treatment & care (CTAC) services by ACHSCP; • Operation Home First priority to ensure increased outreach from hospital-based services to support community-based care pathways i.e. elective care assessments in community	**The challenge:** Increasing demand for CTAC services, due to factors including increasing co-morbidities and an ageing population. There is also a lack of space within many GP Practices: delivering GCHs and CTACs services needs to be aligned long-term with plans for premises (i.e. 10-year lifespan).Remote/virtual consultations by secondary care have increased demand for bloods in the community. Preparation is required for a possible second surge which may require rapid access to GCHs in future.

Next steps	**Success criteria:**
• Submission of GCHs SBAR to Operation Home First Huddle • Implementation of Green Community Hubs within Aberdeen City • Development of a blueprint for longer term delivery of CTAC services from identified sites and further possible "spokes"	• Increased capacity and resilience in general practice; • Quicker access to CTAC services for patients, including choice of location and appointments; • Reduction in patient attendance at hospital i.e. for pre-assessment bloods;

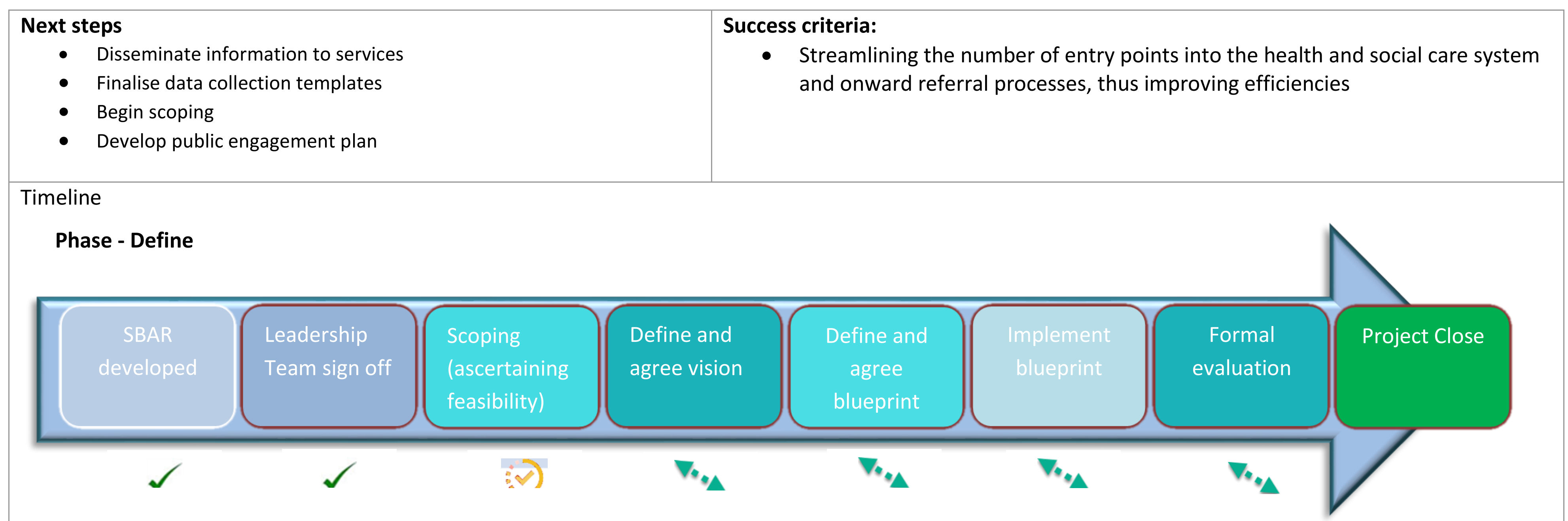


Flash Report – Integrated Access Point

Name of project: **Integrated Access Point**	**Objective of project:** Scope the feasibility of developing and implementing a single point of contact for handling requests across health and social care services.
Context: The recent partnership working approach across Aberdeen City Health and Social Care Partnership and Aberdeen City Council, under the theme "Aberdeen Together" has enabled many improvements to be put in place, at pace, during the initial Covid response. As we move into our next period of response, this collaboration is continuing and has identified several workstreams which could benefit from a wider system support. An Integrated Access Point may be one enabler towards providing accessible and seamless care for the people of Aberdeen.	**The challenge:** The health and social care landscape is complex and as such, may be difficult to navigate for people who need to access services. There are upwards of 40 services areas delegated to ACHSCP, with each varying in both referral routes (such as self-referral; referral by professional; or referral by significant other) and referral modes (such as face-to-face conversation; letter; online form or telephone conversation). Streamlining how these services are accessed would help achieve some of the key ambitions of the integration agenda, including people having accessible services and receiving care seamlessly.

Next steps	Success criteria:
• Disseminate information to services • Finalise data collection templates • Begin scoping • Develop public engagement plan	• Streamlining the number of entry points into the health and social care system and onward referral processes, thus improving efficiencies

Timeline



Flash Report – Partnership GP Practices (2C) Remodelling

Name of project:	Objective of project:
Partnership GP Practice Remodelling	Improving the sustainability, efficiency and effectiveness of the 2C General Practices in Aberdeen City

Context: Aberdeen City Health & Social Care Partnership are currently responsible for the delivery of six 2C General Practices. Compared to the traditional independent General Practice model, this allows more autonomy over how improvements can be made to enhance the sustainability, efficiency and effectiveness of the service.	**The challenge:** The numbers of General Practitioners in Aberdeen City are steadily declining, whilst the population increases, associated with increasingly complex health and social care needs. The current model of delivery is not fit to meet these challenges and as such, remodelling is necessary whilst still ensuring patient safety and staff satisfaction.
Next steps • Scoping • Agree high-level options • Organise workshop with Practice staff • Develop public involvement plan	**Success criteria:** • Improvements in: ***what*** services are delivered (such as exploring usage of asynchronous consulting); ***where*** services are delivered (such as scaling up and embedding NearMe for remote consultations; and ***who*** delivers services (such as multi-disciplinary teams as outlined in the Primary Care Improvement Plan)
Timeline **Phase - Define** Strategic document developed → Scoping (ascertaining feasibility) → Define and agree vision → Define and agree blueprint → Implement blueprint → Formal evaluation → Project Close	

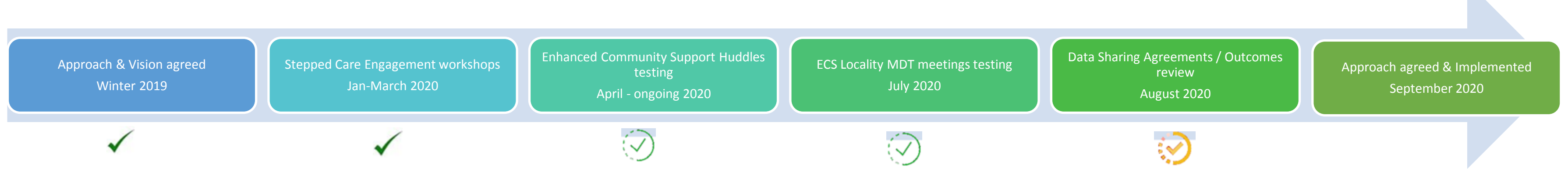
Flash Report – Connecting Aberdeen (Digital)

Name of project: Connecting Aberdeen	**Objective of project:** to increase digital connectivity and literacy for people in our communities so that they are able to access services digitally
Context: Working collaboratively with Aberdeen City Council and community organisations to identify people in our communities who are not digitally connected or digitally literate, to prioritise our support, and respond to other digital connectivity challenges. Devices have been allocated through a national programme.	**The challenge:** Those who are not digitally connected are often socially isolated. The first priority cohort are those who are shielding, have no/ limited digital connectivity and are on low incomes. Challenges around providing devices and training to these individuals while maintaining strict physical distancing.
Next steps • Confirm first cohort to receive devices and support • Confirm community digital champions • Supply devices and training – training to include how to access Near me • Gather feedback	**Success criteria:** • Increase in citizens able and confident to access near me virtual consultations and other digital health and social care supports • Reduction in number of citizens traditionally at risk of not being digitally connected.
Timeline Phase -1 Create city digital community network → Develop virtual training to get online → Assess applications for CS devices → Identify & train digital champions → Phase 1 devices issued (1st 100) → Remaining phase 1 devices issued → Identify other emerging opportunities → Connecting Aberdeen Phase 2	

Flash Report – Stepped Care Approach *(daily locality unscheduled care huddles)*

Name of project: Stepped Care Approach for Unscheduled Care
Objective of project: to deliver a coordinated response to unscheduled care needs across Aberdeen City through early identification and management of patients using a multi-disciplinary approach within localities so that all citizens get the right level of support at the right time by the right person. The approach primarily aims to reduce hospital admissions

by providing rapid assessment and diagnostics within the community enabling a decision to be made whether treatment and care can be delivered at home or whether hospital admission is most appropriate for the individual. (the stepped care approach incl. linkages to H@H)	
Context: Following the agreement to adopt the stepped care approach in 2019 and the successful testing and adoption of Hospital at Home and West Visiting. The project continued to develop the layers via 3 workshops in Jan-March 2020. Tests of change were identified however following emergency measures which put in place during the response to Covid crisis via Operation Rainbow, the MDT triage and allocation huddles were implemented immediately. An additional layer was added at this point in recognition that many older people who are currently well or have long term conditions may find their resilience compromised. Linking people up to local resources may help to ensure people emerge as fit and able as possible.	**The challenge:** • Lack of a coordinated approach across services to Unscheduled Care which potentially causes an increased number of those admitted via ED and AMIA. • Large volume of referrals between professionals causing additional work • Data sharing between partners requires an effective IT solution or process. Work is underway to remove barriers to effective care and reduced room for error and duplication for patients with urgent needs • Identifying the most appropriate community based & local resources to meet individual requirements. • Ensuring the resources available reflected and matched citizen needs. • Keeping community-based resources at the forefront in decision making thus allowing for a more rounded step down from service input.
Next steps • Tests of change continue with lunchtime Triage and Allocation Huddles for professionals to rapidly problem solve and access each other services. • Enhanced Community Support MDT Locality meetings across the 3 localities to be tested • Agreement on format and representation to be agreed • Communication and engagement plan to be drafted and implemented • Data & patient stories to be collated and reviewed to inform model & next steps • Data Impact Assessment and Information Sharing to be negotiated and agreed • Proactive case finding and community resource MDT huddles established.	**Success criteria:** • Faster access to care and support • Improved care pathway for those requiring care eg. reduced onwards referrals, increased ACPs • Increased staff satisfaction, empowerment & professional development • Reduced / avoided hospital admissions (ED / AMIA) • Sustainable model of primary care (MDT approach) • Higher inclusion of community based resources when stepping down from service. • Improvement of patient experience when stepping down from service. • Improved cross sector working.



Flash Report - Reablement at Home or Homely Environment First

Name of project: Advanced Care and Enablement	**Project Manager: Susie Downie / Helen Chisholm**

Objective of project: To ensure care is provided at home or in a homely environment as a first choice. There is an opportunity to build on advanced clinical skills and enablement skills to ensure that home first is prioritised at the earliest possible opportunity. This workstream will align with the stepped care approach being progressed in the city, and will bring together a range of services including nursing and AHPs as well as care at home support.

Context: This workstream is at an early stage of discussion. The idea behind this is to focus in on a challenge which overlaps two other projects -*Enhanced Community Support* and *Hospital at Home* - both of which are part of the **Stepped Care Approach** to Unscheduled Care. This piece of work seeks to consolidate the progress made so far and focuses on supporting the workforce to be able to deliver this new approach.	**The challenge:** - Ensure that individuals are getting the right support at the right time in their home or homely setting. - Potential duplication of effort when working as an MDT with individuals
Next steps Agreed workplan and deliverables for this workstream as well as identifying the key stakeholders. This piece of work should focus on 2 topics. 1. Development of capacity and skills within the localities to be able to embed the Stepped Care Approach specifically the Hospital at Home approach within the localities. This would require a variety of tasks to ensure this can be achieved. 2. Increasing understanding & sharing of roles across the multi-disciplinary team within the Enhanced Community Support huddles. Allowing for opportunities to both learn from each other, the breaking down of barriers and increasing capacity through the key worker model eg. sharing of tasks as appropriate	**Success criteria:** • Appropriately skilled and educated workforce enabled to embed the stepped care approach within localities • Better outcomes for our citizens • To have greater understanding across the multi-disciplinary team in roles and responsibilities • Reduction in length of stay in hospital as people are able to receive services at home • Reduction in emergency admissions as people are cared for in a proactive and enabling manner with rapid access to support as and when they need it

Develop agreed delvierables & plan

Milestones to be agreed

Flash Report – Rosewell Flow

Name of project: Rosewell Flow	**Objective of project:** Implementation of a new integrated service delivery model at Rosewell (60 beds in total) to support system wide flow through the older people's pathway and to prevent admissions to hospital from within our communities and aligned to the Home First vision.
Context: As Operation Rainbow comes to an end in June 2020, a Re-Mobilisation Plan was developed and submitted to the Scottish Government, explaining the approach moving forward which includes implementing Operation Home First which supports care being provided closer to home as appropriate. As part of the COVID-19 response 20 beds within Rosewell which were allocated to residential respite have been temporarily realigned to support COVID-19 surge capacity and whole system flow.	**The challenge:** Reduced bed base across the city, and in addition the demands placed upon the whole system are anticipated to rise exponentially as mobilisation plans are implemented and as public confidence in engaging with services grows, in addition anticipated pressures and preparation required in relation to winter surge planning . Within Rosewell some of the bed base is currently unoccupied; however the consequence of repurposing the 20 residential respite beds requires us to seek an alternative solution for the delivery of planned residential respite within the city of Aberdeen.
Next steps • Establish task and finish/Implementation groups and identify key colleagues and stakeholders (Rosewell Commission & Day Care/Respite Provision) • Collation of relevant data to inform service delivery model • Completion of project documentation, including Terms of Reference, Implementation/Risk and Communications Plans • To begin development of the agreed pathway into Rosewell • Alternative models for respite will be developed in consultation with providers and cared for/carers • Plan communications and engagement with those directly and indirectly impacted by the planned changes	**Success criteria:** • An agreed pathway into Rosewell for step up or step down care • Commission documentation and alternative solution for planned residential respite completed and submitted to the ACHSCP Executive Programme board on 5th August 2020 • Alternative solution for planned residential respite identified and fully operational • A model which focuses on achieving people's outcomes with discharge home being the focus and maximises flow through efficient and effective delivery

Phase - Define

Development of Project Documents → Identification of key colleagues & → Collation and review of data → Define and agree new pathway & → Plan engagement activities → New Service Level Agreements in → Formal evaluation → Project Close