Aberdeen City Health & Social Care Partnership
A caring partnership

RISK, AUDIT AND PERFORMANCE COMMITTEE

Date of Meeting	23 September 2020
Report Title	Transformation Programme Evaluation
Report Number	HSCP.20.040
Lead Officers	**Gail Woodcock, Transformation Lead** Alison McLeod, Performance Lead
Report Author Details	**Dr Calum Leask** Research & Evaluation Lead / Transformation Programme Manager
Consultation Checklist Completed	Yes
Directions Required	No
Appendices	Appendix A: Considerations for evaluating the impact of Home First Appendix B: Flash Reports for the Priority Projects

1. Purpose of the Report

The purpose of this report is to provide an update on the proposed approach to evaluating the impact of the Operation Home First elements of the partnerships refreshed transformation programme priorities. The report also outlines plans for how the refresh of our Strategic Plan will drive what key measures will be used to identify ongoing transformation priorities.

2. Recommendations

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

a) Note the information provided in this report

3. Summary of Key Information

Background

3.1. The ACHSCP's current strategic plan identifies five aims: Prevention; Resilience; Connections; Communities and Personalisation. Aligned with this strategic plan are five programmes of transformation; our Medium Term Financial Framework and our performance data dashboard.

3.2. The COVID-19 pandemic resulted in a refocus and prioritisation of the activities undertaken by the Partnership to support the wider health and social care system. The initial recovery paper considered by IJB in May 2020 identified eleven transformations embedded during this period, including:

- 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.

3.3. The result of the effective cross-system working (highlighted above) between the North-East Health & Social Care Partnerships plus the acute sector brought about the Home First portfolio, which aligns the collective priorities of these organisations as we move into the next phase of living with COVID. Some of the current priority areas and how they link in a strategic context, are visible below:

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Programme	Strategic Links	Description	Links to initial changes in response to Covid19 and OHF Principles
Frailty Pathways	**MTFF:** NA **Transformation Programme:** Prevention / Demand Management **Operation Home First**	Ensure effective and streamlined pathways for frail and elderly out of Woodend Hospital into the community – at home or a homely setting. <u>Rosewell flow</u> 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.	<u>Initial Changes:</u> • Shifting workforce and beds to support a more streamlined pathway <u>OHF Principles:</u> • Outcomes for people • Whole system working

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Programme	Strategic Links	Description	Links to initial changes in response to Covid19 and OHF Principles
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
Mental health services – transforming the service following a reduction in bed base and redesign of the older adult mental health pathway	**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

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Programme	Strategic Links	Description	Links to initial changes in response to Covid19 and OHF Principles
Implementation of the new Care at Home Contract	**MTFF:** Operational alignment to localities **Transformation Programme:** Prevention / Demand Management	Moving from task-based commissioning to outcome based. Delivering the right care at the right time in the right way, improving people's personal resilience so that they can cope with and potentially improve their health and well-being. Utilising an asset based approach to the provision of care	OHF Principles: • Home first for all care • Focus on outcomes for people
Digital	**MTFF:** Improved sustainability through digital innovation **Transformation Programme:** Data & Digital **Operation Home First**	Near me roll out 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 • Devices and connectivity provided to those without digital connectivity who are identified as shielding. OHF Principles: • Home first for all care • Outcomes for people • Maximise digital solutions

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Programme	Strategic Links	Description	Links to initial changes in response to Covid19 and OHF Principles
		<u>Connecting Aberdeen (digital)</u> 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	
Community Treatment and Care (CTAC)	**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".	<u>Initial Changes:</u> • Home-visits for shielding people; green areas within practices • Interim hubs for immunisations, and sexual health services being delivered in one Aberdeen Community. <u>OHF Principles:</u> • Outcomes for people • Work within constraints of shielding • Whole system working

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Programme	Strategic Links	Description	Links to initial changes in response to Covid19 and OHF Principles
		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)	
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	<u>Initial Changes:</u> • City Crisis line established <u>OHF Principles:</u> • Maximise digital solutions • Focus on outcomes for people

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		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.	
Partnership GP Practice Remodelling	**MTFF:** Partnership GP Practice Remodelling **Transformation Programme:** Accessible and	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.	<u>Initial Changes:</u> • Collective GP Response Calls • Moving GMED from ARI to Health Village <u>OHF Principles:</u> • Focus on outcomes for people • Maintain agile thinking • Work within constraints

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Programme	Strategic Links	Description	Links to initial changes in response to Covid19 and OHF Principles
	Responsive Infrastructure	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.	• Maximise digital solutions
Stepped Care Approach	**MTFF:** Operational alignment to localities **Operation Home First Transformation Programme:** Manage Demand / Prevention	<u>Daily locality USC huddles</u> 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	<u>Initial Changes:</u> • Increased outreach from hospital based services to support community-based care pathways • Hospital @ Home and Virtual Ward capacity due to consultant access. <u>OHF Principles:</u> • Home first for all care • Outcomes for people

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Programme	Strategic Links	Description	Links to initial changes in response to Covid19 and OHF Principles
		hospital admission is most appropriate for the individual. (the stepped care approach incl. linkages to H@H) <u>Hospital@Home Scale Up</u> 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 <u>Reablement at home or homely environment first</u> To ensure that all reablement is delivered at home or in a homely environment at all possible times	

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Programme	Strategic Links	Description	Links to initial changes in response to Covid19 and OHF Principles
		rather than extending hospital stays for this purpose (includes links to Frailty Pathway).	

3.4. This refocus on priority areas, and other challenges relating to our COVID response, have meant that a number of pieces of work, that were identified as priorities prior to the COVID-19 pandemic, are currently progressing at a slower pace to ensure resources can be effectively targeted on the above. Some of the affected programmes include the Primary Care Improvement Plan; Action 15; scale up of House of Care and our Local Outcome Improvement (LOIP) Projects.

Evidencing the Impact of our Priorities

4. It is recognised that many of our performance metrics are aligned with the data that is currently available, that is required to be reported on nationally to monitor what is happening, including tracking changes.

4.1. As we plan the refresh of our strategic plan, we are clear that we wish to take a co-production approach to its development, including working in partnership with our Locality Empowerment Groups.

4.2. This approach will deliver new aims and objectives for the partnership, and associated metrics and interventions will then be identified to ensure the delivery of these aims and objectives.

4.3. In the meantime, evaluation resource will be focussed on the Home First portfolio within the current transformation priorities. This report sets out the evaluation approach that will be used for those programmes of change.

Home First

4.4. The Home First portfolio seeks to align the collective priorities of the three health and social partnerships and the acute sector within Grampian. There are three aims of this portfolio:

- Support early discharge back home
- Avoid unnecessary hospital attendance or admission
- Maintain people safely at home

This portfolio emerged as a consequence of the effective cross-system collaborations that occurred as a response to the COVID-19 pandemic. Home First emphasises the collective priorities that are evident as a cross-system agency but also recognises the local priorities that are the result of unique localised contexts. For example, initiatives such as NearMe, whereby citizens can have virtual consultations with clinicians, has occurred at scale

across Grampian, meaning people can stay safe at home whilst getting the professional advice they require.

4.5. One of the most important considerations when implementing such a portfolio is being able to accurately determine the impact of all these priorities on the three aims stated above. It is of even greater benefit to evaluate each priority individually, which will allow a deeper understanding of which priorities are more / less effective and as such, provides an informed basis on which to make future planning and investment decisions.

4.6. Evidencing the impact of a portfolio of this magnitude is both a sizable and complex undertaking. This is the case for a number of reasons, including but not limited to:

- The vast number of priorities occurring at both local and regional levels
- The number of external / confounding variables that are likely to influence changes in performance measurements (for example, further localised COVID19-related lockdowns; the flu season; etcetera)
- The 'status' for these priorities differ (for example, some are in their planning stages whereas others are currently being implemented at scale), meaning opportunities to standardise data collection across these is limited

4.7. A dedicated resource with a range of necessary areas of expertise has been identified to deliver this task.

Home First evaluation process overview

4.8. The scope of the work shall include all priorities outlined underneath the Grampian-wide umbrella of Home First incorporate both localised (i.e. from Aberdeen City Health & Social Care Partnership (ACHSCP); Aberdeenshire Health & Social Care Partnership (AHSCP); Moray Health & Social Care Partnership (MHSCP) and Acute) and regional (i.e. pan-Grampian and collective) priorities. The relevant programmes impacting on ACHSCP are:

- Care at home contract implementation
- Stepped Care Approach
- Frailty Pathways
- Implementation of NearMe

4.9. The outcome of the evaluations will ascertain to what degree Home First has achieved its three main aims:

- Support early discharge back home

- Avoid unnecessary hospital attendance or admission
- Maintain people safely at home

Other outcomes would be:

- Determine the financial implications of this portfolio
- Determine the impact on those being cared for who are affected by the change
- Determine the impact on those performing an unpaid caring role
- Determine the impact of those delivering the care who are affected by the change

4.10. Other outcomes of interest may emerge over time to reflect the changing landscape in which we operate. It is also expected that some form of process evaluation is undertaken to understand how and why particular outcomes have occurred.

4.11. The following constraints and parameters have been identified:

- A performance dashboard of relevant indicators. It is acknowledged that this will be an iterative process and should be refined to account for new data collection techniques.
- A detailed, interim evaluation ascertaining the impact thus far of Home First should be produced.
- Appreciating the breadth of scope, the commissioned person(s) should seek to strive a balance between producing 'deep dive' evaluations on projects / programmes occurring at scale, whilst also considering metrics that can be monitored at a systems level to derive overall impact. This should also account for, where possible, the ability to filter findings for local areas.
- It is possible that not all metrics of interest are not routinely collected. In such instances, the commissioned person(s) should produce and implement new data collection tools to address this gap.
- It is likely that, to derive a system-wide perspective, data from a variety of sectors (including but not limited to healthcare; social care; third sector) will require collation and analysis.

4.12. The evaluation will include engagement with a range of different stakeholders (though note this list is not necessarily exhaustive):

- Local authorities
- Health boards
- Public health Scotland

- Health and social care partnerships
- Third sector organisations
- Community members/ groups/ organisations
- Scottish Ambulance Service
- Acute Sector
- General Practice

4.13. A range of recognised data collection / analysis methods will be used, including:

Quantitative data

- Service-level data
- Audits
- Pre/post analysis
- Patient/ person outcome data
- Cost utilisation data

Qualitative data

- Interviews
- Focus groups
- Surveys

4.14. The following outputs are expected:

- Alignment matrix of all current Home First initiatives against the three aims
- Development of a performance dashboard of metrics directly impacted by the cumulative effort of all initiatives
- 'Deep dive' evaluations of priorities that are occurring at scale
- Regular 'flash reports' to provide assurances of progress, identify barriers etc.
- A report summarising key findings, including future recommendations

A summary the process including the anticipated outputs is included at Appendix A. Indicative timelines for key gateways are visible below, though it should be noted these may be altered to reflect emerging priorities areas of focus:

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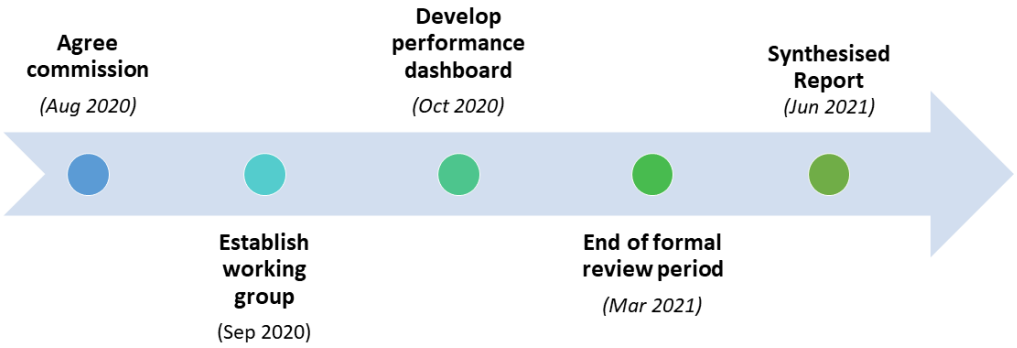

5. Implications for IJB

5.1. **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.

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

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

5.4. **Workforce** – Resource to evaluate the impact of the Home First program has been identified. Work is ongoing to identify capacity to backfill the affected areas.

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

5.6. **Other** - NA

6. Links to ACHSCP Strategic Plan

6.1. The activities within the Home First portfolio seek to directly contribute to the delivery of the strategic plan:

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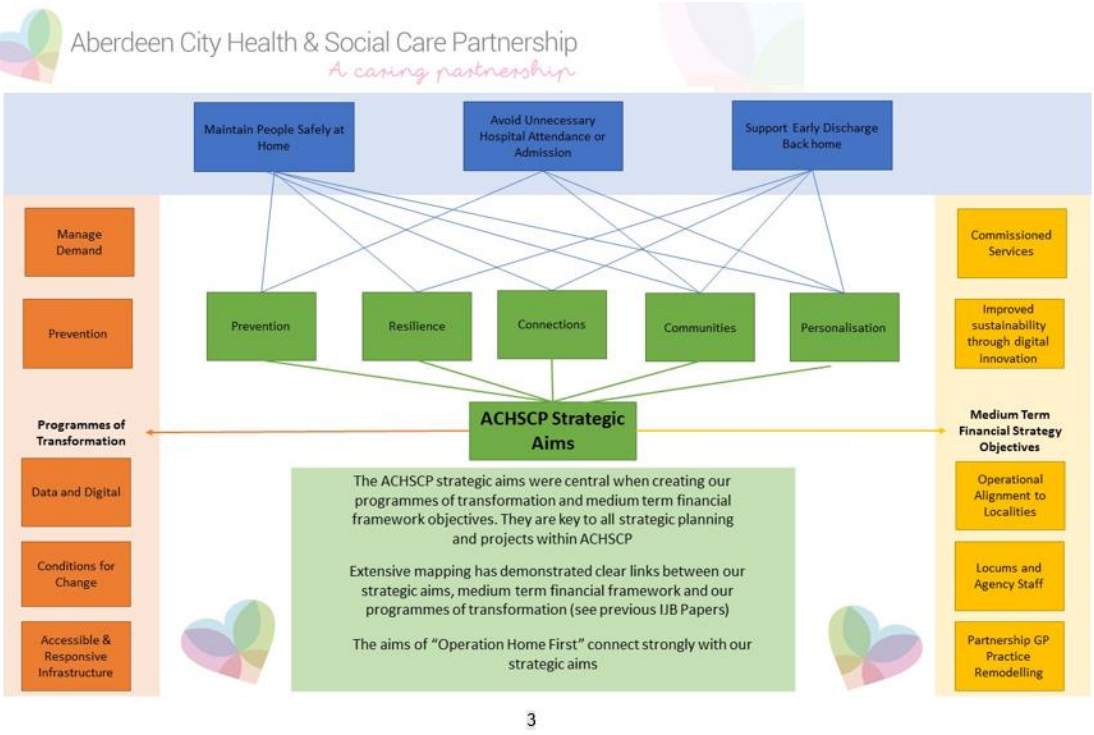

7. Management of Risk

7.1. Identified risks(s)

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

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

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

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

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7. Failure to deliver transformation at a pace or scale required by the demographic and financial pressures in the system.
8. There is a risk that the IJB does not maximise the opportunities offered by locality working.
9. There is a risk that if the system does not redesign services from traditional models in line with the current workforce marketplace in the city, this will have an impact on the delivery of the IJB Strategic Plan.

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

This paper brings to the attention of the Risk, Audit and Performance Committee information about our proposed evaluation approach to our priority areas that will help provide assurance of whether proposed changes in activity are / are not successful and for what reasons.

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

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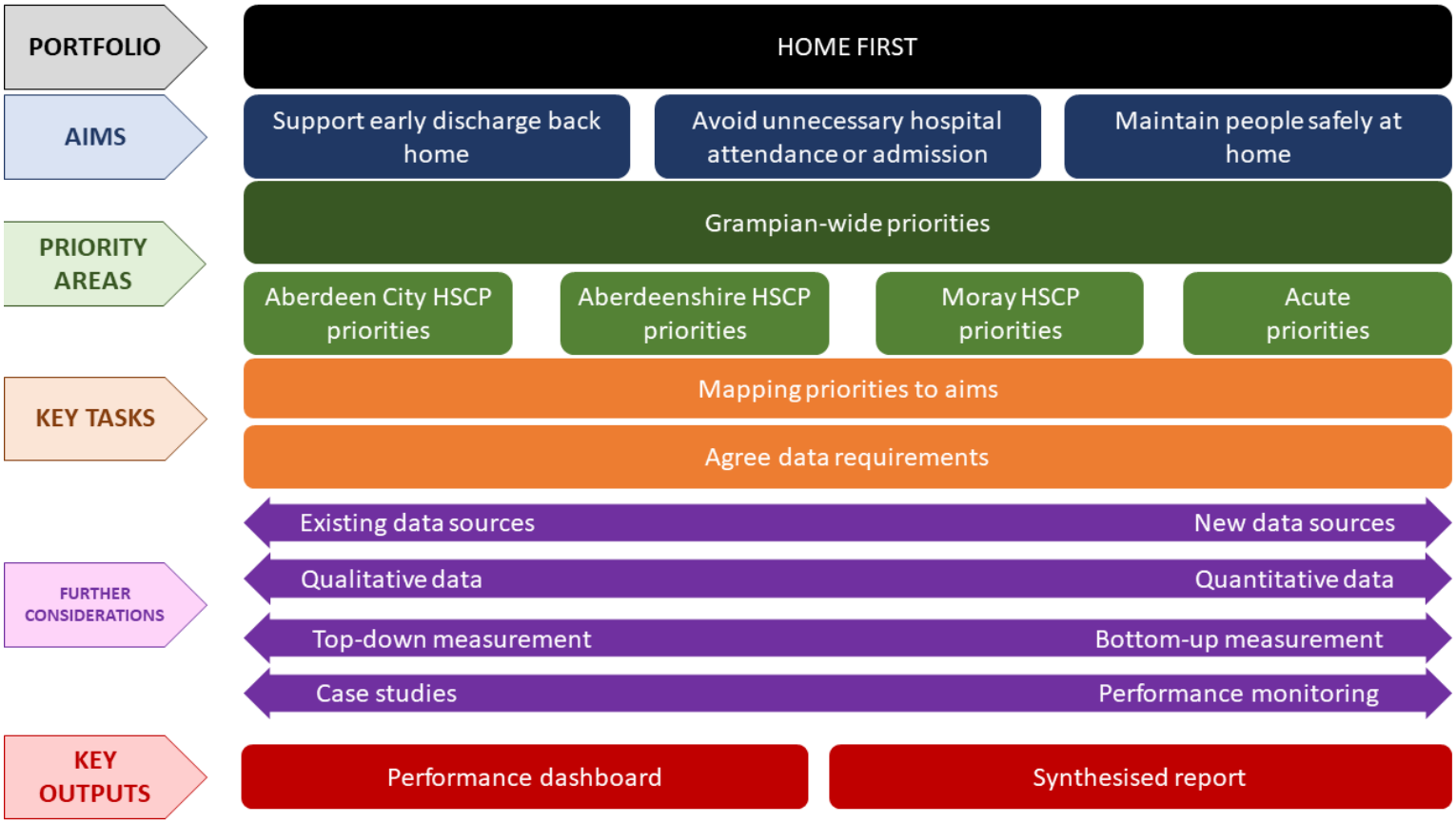
Appendix A. Considerations for evaluating the impact of Home First



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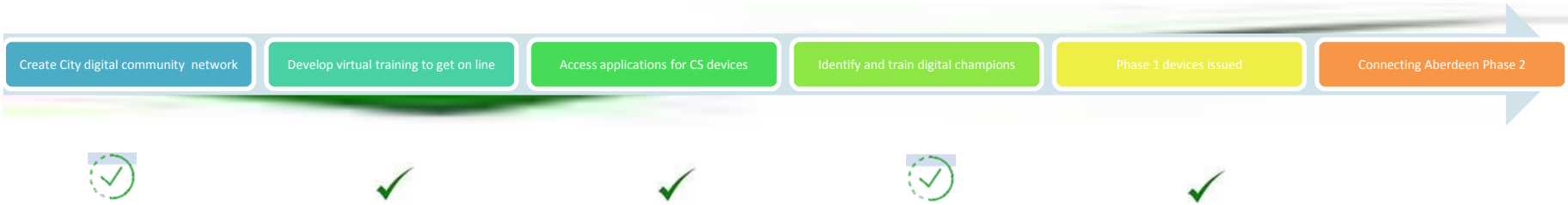
Appendix B. Flash Reports for the priority projects.

Name of project: Connecting Aberdeen	**Project Manager / Report Author:** Elaine McConnachie
Objective of project: to increase digital connectivity and literacy for people in our communities so 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 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. Identifying the scale and nature of the issue e.g. numbers of people not connected; lack of skills, ownership of suitable devices, access to broadband.
Next steps • Provide support to digital champions (DC) through; project guide, online training and access to SCVOs national network of DCs, creation of local network of DCs. • Evaluation of project in conjunction with SCVO • Complete baseline to identify who is connected across Aberdeen • Allocation of devices for phase 2 of project – Phase 2 has been released with confirmation focus will be on households with children and young people and care leavers – deadline for applications 5th October	**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. • Reduction in social isolation through citizens being able to keep in touch virtually with friends/family and participation in online activities. **What's Happened?** • Devices allocated as part of phase 1 of project • Communication plan in place – plans for media coverage week beg 24/08/20
OBJ  	

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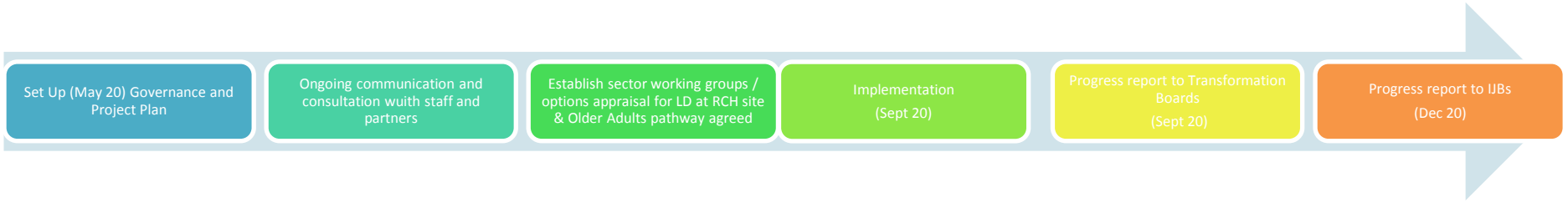
Name of project: **MH/LD System Wide**	Project Manager / Report Author: Susie Downie
Objective of project: to ensure a sustainable model of care whilst we deliver a protracted response to COVID-19 with a significant reduction in available beds in inpatient services for Mental Health across Grampian further 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; close and shift of Learning Disability inpatient services to the main RCH site; the increased outreach from hospital-based to community based care pathway, and improved access to commissioned pathways	**The challenge:** Support of, NHSG and City, Aberdeenshire and Moray IJBs & Staffside to implement change. Formal concerns by clinical staff re. changes to the Older Adult Pathway-delay of decision-making until reassurance is given. Need to support staff with training / equipment to ensure embedding of technology in place of face-to-face where possible
Next steps • Older Adult Works Stream Report completed. Literature Review to be completed by 31st August 2020 with final recommendations for consultation. • Unscheduled Care Work Stream review due to be completed by 4th of September 2020. • Near Me Practice Guidance for MHLD to be completed by revised timeline of 30th September 2020. • LD Fern and Brachan Wards embedded into Loirtson and Strathbeg Wards at RCH. NHSG PAD Team revised timeline to complete functional suitability assessment by 7th September to get costed enablement works. Update Report on Home First and wider Transformation Priorities to be drafted for first meeting of the Board on 24th September 2020.	**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)
	

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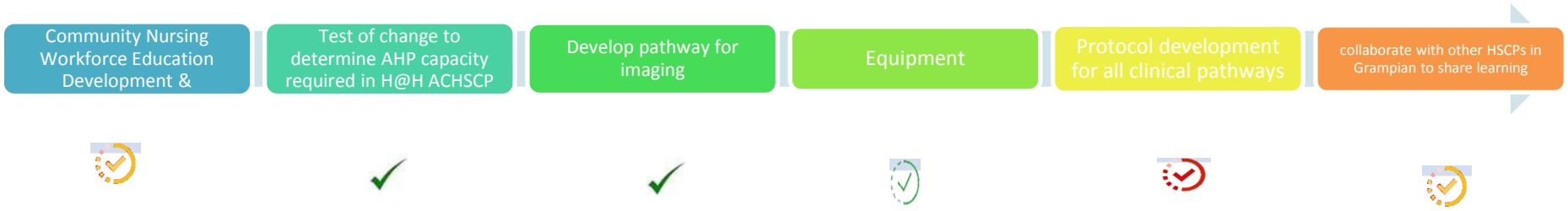
Name of project: Hospital at Home	**Project Manager / Report Author:** Susie Downie
Objective of project: to scale-up and develop the H@H service to reach its full potential in providing acute level care and treatment in people's own homes/homely setting, thereby preventing admission to hospital. This is inherently part of the Stepped Care approach to managing unscheduled care in the community.	
Context: • Reduction in acute geriatric hospital beds – further reduction planned for November 2020 • Older adults requiring longer phase of treatment and recovery post-covid infection • National drive to support all NHS Board areas and IJBs to develop H@H services • Operation Home First ambition is to maintain people safely at home, preventing unnecessary admission to hospital and support early discharge from hospital 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 monitoring/medical devices (e.g. infusion pumps) 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. • Developing protocols for clinical care to support a higher level of patient acuity e.g. IV and O2 therapies for HF, COPD – Primary Care Respiratory Specialist Nurse line management now aligned to Service Manager, H@H. Respiratory NS priorities - education of H@H team (and associated workforce), protocol development in H@H, development of communication, admission and discharge pathways between Respiratory and H@H (to support with advice and guidance for H@H staff caring for COPD patients with frailty)	**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



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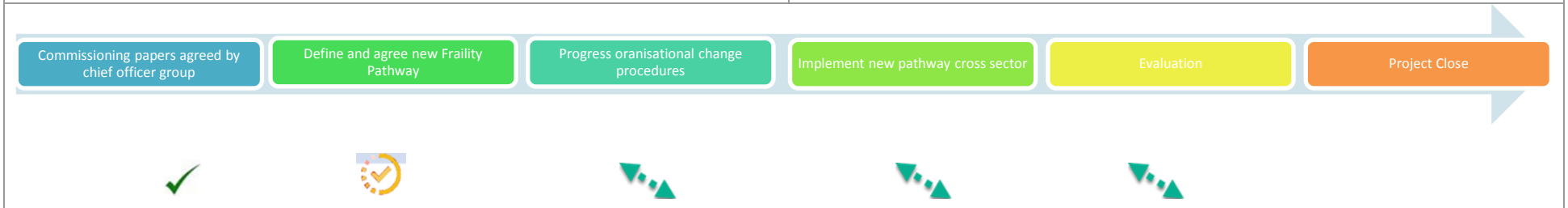
Name of project: Frailty Pathway	**Report author:** Heather Tennant **Date of report:** 24/08/2020

- **Objective of project:** Agree a redesigned frailty service delivery model. Informing this will include reviewing available data/information on activity levels prior to COVID in this patient cohort such as occupied bed days, length of stay, occupancy, workforce and variety of conditions supported to inform the new model.
- A robust, co-produced and cross-system redesign, which meets people's outcomes and is aligned to the Home First vision across City and Shire.
- Transfer of resource to follow activity across the frailty pathway in Aberdeen City and Aberdeenshire

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 Frailty Pathway is one of a number of key 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 • Frailty pathway co – designed and outcomes actioned • Action outcomes from the Rosewell commissioning paper once outcome confirmed • Finalise membership of working groups • Initial meeting of organisational steering group	**Success criteria:** • Agreed a collective approach across Acute and 3 HSCP's • Realign and upskill for workforce to support deliver of care throughout new pathway • Reconfiguration of beds across the system complete • Positive patient and staff experience • Efficient and streamlined flow across the whole system.



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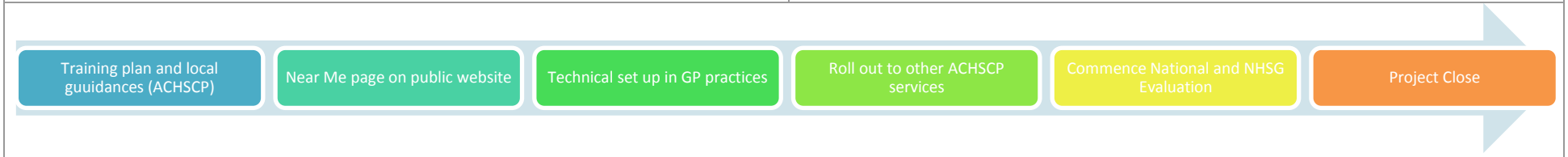
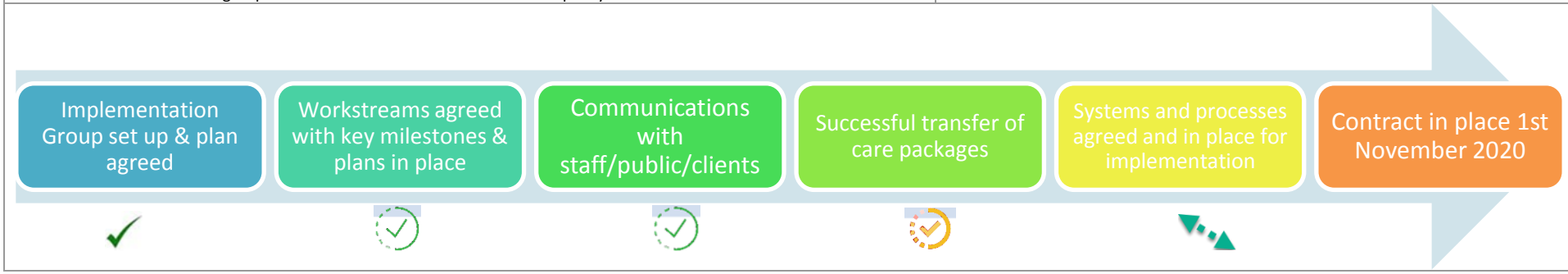
Name of project: Near Me Roll Out Aberdeen City	**Project Manager:** James Maitland/Heather Tennant **Date of report:** 24/08/2020
Objective of project: To rapidly scale up virtual video consultation within health and social cares services.	
Context: Aberdeen City Health and Social Care Partnership are 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.	**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.
Next steps • Training for local Near Me leads on new national reporting tool • Further roll out of IT infrastructure awaiting delivery end-August 2020 • First meeting held with NHS Near Me leads in relation to developing the Grampian wide plan for Near Me across our services – standardising of data reporting across Grampian, finalising end of call patient survey and reflection webinars were discussed for action.	**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 24 stats 16th August – 22nd August 2020:** ❖ **350** consultations – **107.5** consultation hours (GP, Community Nurses, Link Practitioners, Podiatry, OT, Physio, SALT and Orthotics) ❖ Since week 0 there have been over 52k consults in Grampian. ❖ Estimated over 2.9 million travel miles saved



Aberdeen City Health & Social Care Partnership
A caring partnership

RISK, AUDIT AND PERFORMANCE COMMITTEE

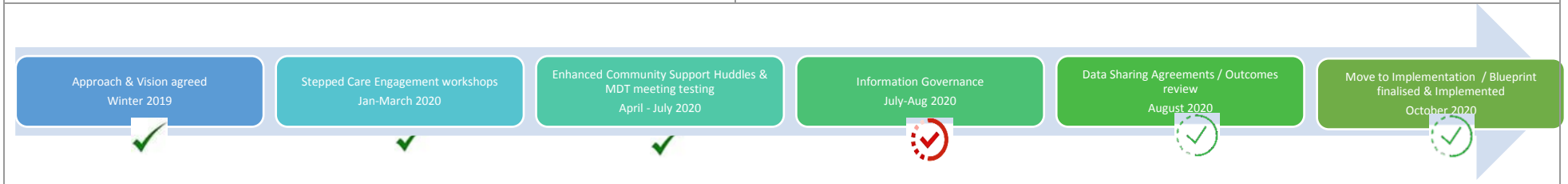
Name of project: Care at Home Implementation	**Report Author: Jayne Boyle** **Date of report: 28/08/2020**
Objective of project: To implement the new care at home contract by the 1st November 2020 and ensuring all necessary systems and process are in place and effectively communicated.	
Context: ACHSCP was required to review current arrangements because of the term of the current contract. The IJB agreed an extension until December 2020. Our strategic plan is the key driver – delivering the right care at the right time in the right way, improving people's personal resilience so that they can cope with and potentially improve their health and well-being. Having the opportunity to remain connected to their community and friends is pivotal to this.	**The challenge:** • Moving from task-based commissioning to outcome based • Demand outstrips our available capacity due to a time and task focussed approach. • Low use of technology • Asset based approach to the provision of care • Our teams are not currently arranged within localities and therefore we minimise the opportunities for integrated working. • There has been a level of market instability within Care at Home in particular • Our current arrangements do not foster a culture of collaboration.
Next steps • Implementation of successful communications plan • The development and implementation of an organisational development plan, including both ACHSCP and provider teams • The necessary adjustments to systems and processes including assessment of needs across a locality team, financial arrangements, recording arrangements • Refreshing and agreeing pathways, using recent outcomes focussed pathways as the basis for this refresh • The successful transition of care packages, recognising that some packages will be impacted by the revised definition of care at home and supported living. This transitional phase will provide an opportunity for packages to be reviewed and the group needs to ensure that there is sufficient capacity to do this	**Success criteria:** • Contract is successfully implemented on time • Care packages successfully transferred • Staff are engaged fully and work in a collaborative manner as part of a locality • Further benefits to be agreed via Evaluation plan



NHS Grampian
ABERDEEN CITY COUNCIL

RISK, AUDIT AND PERFORMANCE COMMITTEE

Name of project: Stepped Care Approach for Unscheduled Care	Report Author: Susie Downie Date of report: 31/08/2020
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. 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 in order to effectively respond to unscheduled care in the city, agreement to adopted stepped care approach in 2019 including the H@H and West visits models. Staff engagement session were run and the new model has been being tested since April 2020 during the response to Covid crisis via Operation Rainbow, the MDT triage and allocation huddles were implemented immediately. A prevention workstream 'Stay Well Stay Connected' was begun in July 2020 to increase community resilience. 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. Data Protection Impact Assessment is being progressed to mitigate risk.
Next Steps • Data Impact Assessment and Information Sharing to be finalised – meeting next week with NHSG IG • Proactive case finding and community resource MDT huddles established and continuing tests of change. • Data and evaluation	**Success Criteria** • Respond effectively to unscheduled demand • Prompt access to appropriate care & support • Improve locality opportunities & choice • Flexible, empowered & Skilled locality workforce • Streamlined referral pathways • Engagement & Participation of those who live in localities • Right care, in the right place, delivered by the right person (Home first mentality)
Progress/Updates since last report - Stepped care communication and engagement plan is in draft - Agreement on dataset for measurement and evaluation - Link working tests of change are running over a 2-week period at present to look at individual resilience and connections into the community to support enablement and rehab.	



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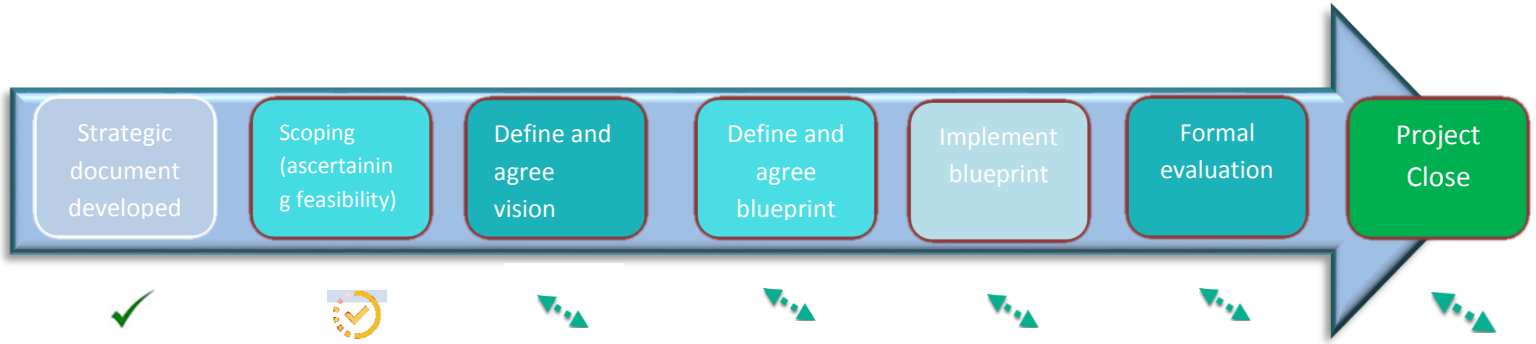
Name of project: Partnership GP Practice Remodelling	Objective of project: Improving the sustainability, efficiency and effectiveness of the 2C General Practices in Aberdeen City
Context: Aberdeen City Health & Social Care Partnership are currently responsible for the delivery of six 2C General Practices. 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 • Three workshops completed • Scoring of options appraisal with steering group commencing 02/09/2020 • Develop business case	**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)



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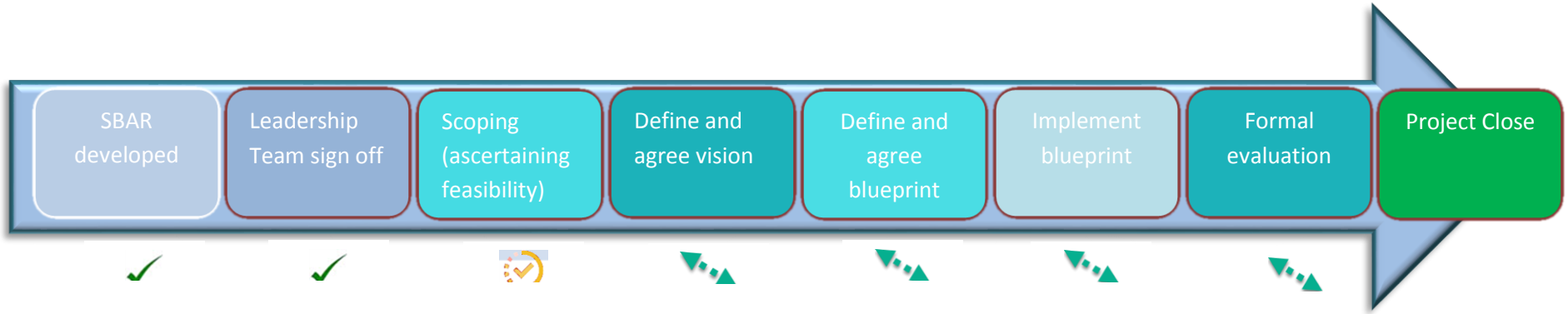
Name of project: **Integrated Access Point**	**Objective of project:** Scope the feasibility of developing and implementing a single point of contact for handling requests across health and social care services.
Context: The recent partnership working approach across Aberdeen City Health and Social Care 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 • Analysis of scoping work • Develop recommendations • Develop public engagement plan	**Success criteria:** • Streamlining the number of entry points into the health and social care system and onward referral processes, thus improving efficiencies



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Name of project: Locality Empowerment and Engagement/Public Messaging	**Report Author: Anna Gale** **Date of report: 1/09/20**
Objective of project: To establish Locality Empowerment Groups (LEGs) across the three localities and ensure people are kept informed of key public health messages via social media and other platforms	
Context: **Public Health Messaging** • Creation of a coordinated social media plan with partners to ensure relevant and up-to-date info is shared. • Dedicated staff members with a remit around social media to ensure content is timely and up to date. **LEGs** • Establishment of three Locality Empowerment Groups (LEGs)	**The challenge:** **Public Health Messaging** • 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. **LEGs** • Ensuring LEGs are demographically representative of Aberdeen City population • LEGs being used as consultation bodies as opposed to following a co-production approach and not able to influence change • Reliance on connecting with people digitally for development of LEGs with face to face limited at present due to COVID • Systems not set up to engage with people as they wish e.g. permissions to access zoom, facebook etc.
Next steps: **Public Health Messaging** • Continue to work with key stakeholders to plan content and share/post relevant information. • Ensure implementation of LEG action plan to establish LEGs in each locality including; communication plan, governance, reporting and project plan for LEGs involvement in key projects	**Success criteria:** **Public Health Messaging** • Increase followers on Facebook over the next 2 weeks (+10) and twitter (+5) **LEGs** • LEGs demographically representative of Aberdeen • LEG participants feel valued and engaged with process • LEGs established in each locality
Progress/Updates since last report **Public Health Messaging** • Promotion of – Track and Trace; regular updates around the local lockdown; update of flu vaccination; Locality Empowerment Groups; Mental Health and Wellbeing; Connecting Scotland; Nestrans Transport Strategy. • Increased engagement on social media - 51 mentions, 523 profile visits, 31 tweets. September we will aim for 55 mentions, 525 profile visits and 32 tweets. **LEGs**	

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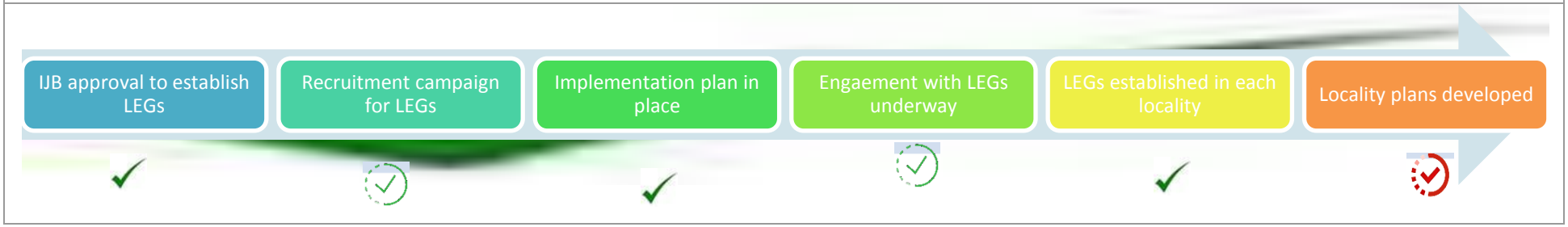
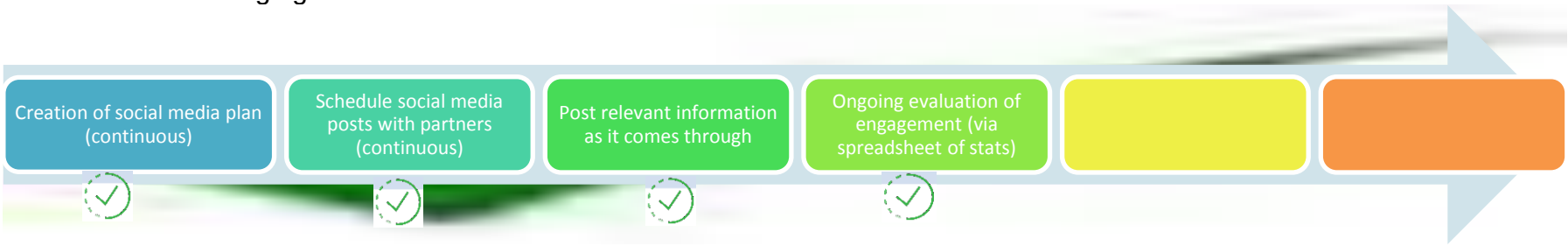
- 130 people registered an interest in LEGs and demographic information collated
  Implementation plan including comms plan and governance framework developed
- Induction sessions held for LEG members
- Weekly update converted to mailchimp
- Session for day support review arranged 7/9/20



Public Health Messaging



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Name of project: Community Treatment & Care Services (CTAC)	**Report Author:** Sarah Gibbon **Date of report:** 01.09.2020
Objective of project: to implement the transition of CTAC services to ACHSCP delivery in Aberdeen City, in conjunction with select secondary care services as a part of the elective care programme (i.e. secondary care generated phlebotomy)	
Context • 2018 GMS Contract = delivery of CTAC by ACHSCP by 01.04.20 • Operation Home First = priority to ensure increased outreach from hospital-based services to support community-based care pathways • Requirement to deliver 600 secondary care generated phlebotomy appointments in the community by October 2020.	**The Challenge** • Demographics: Increasing demand for CTAC services; increasing co-morbidities; ageing population • Workforce: decreasing capacity of existing GP workforce; recruitment & retention difficulties • Pandemic Proof: designing services that are safe, effective and able to continue delivery in a pandemic-situation
Success Criteria: Increased capacity / resilience | Less service disruption in event of "second surge" | Increased convenience for patients (choice of location/ appointment times) Reduction in patient attendance at hospital	
Progress since Last report • College Street: operational for imms & child community nursing teams; receptionist cover identified for 4 weeks from 01/09/2020 • Health Village: identified as preferred site for secondary care who will provide all clinics from this site going forward (2 days initially); • CTAC Blueprint: 1st draft considered by project group; • CTAC Programme Timeline – working draft submitted & awaiting feedback • CTAC Workforce: 4 x HCSWs recruited as replacements for natural vacancies in practice and due to commence in role following agreement of start date	**Next Steps** • **College St:** maintenance of immunisations / child community nursing clinics; recruitment to B2 receptionist role and B6 CTAC Team Leader role • **Health Village:** operationalisation of clinic space and scale up of clinics offered (in line with secondary care staffing provision) • **CTAC Blueprint:** final draft agreed by project team & submission to EPB (Sept) • **CTAC Service Specification:** development of a city-wide, locality based service specification for CTAC (including evaluation plan, communications & public involvement plan, and workforce plan) for longer-term delivery of CTAC from identified centralised sites (December 2020)