Annual Report 2020-2021

#ACHSCP

Thank You

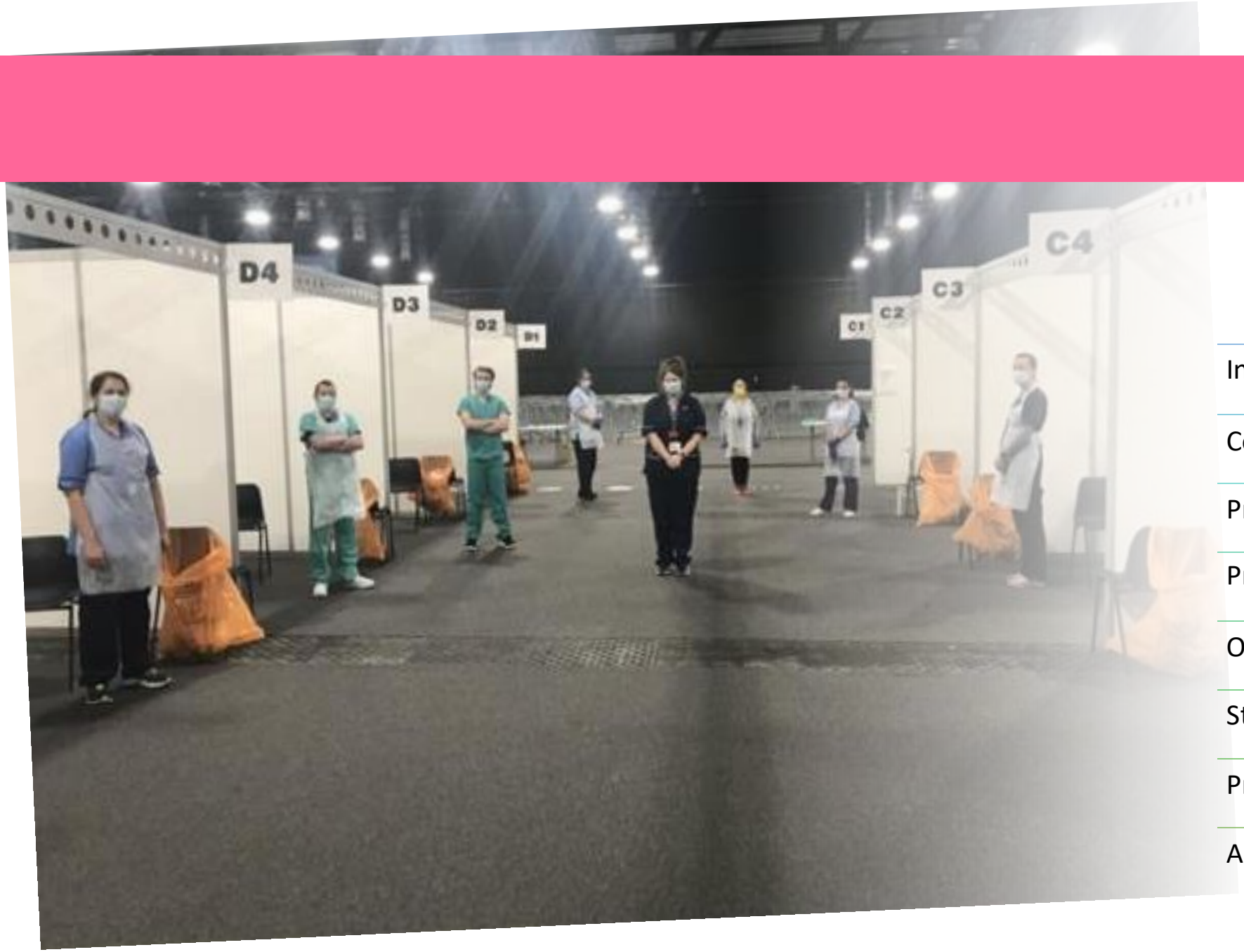
Aberdeen City Health & Social Care Partnership

A caring partnership

ABERDEEN CITY COUNCIL

NHS Grampian

Contents



Introduction

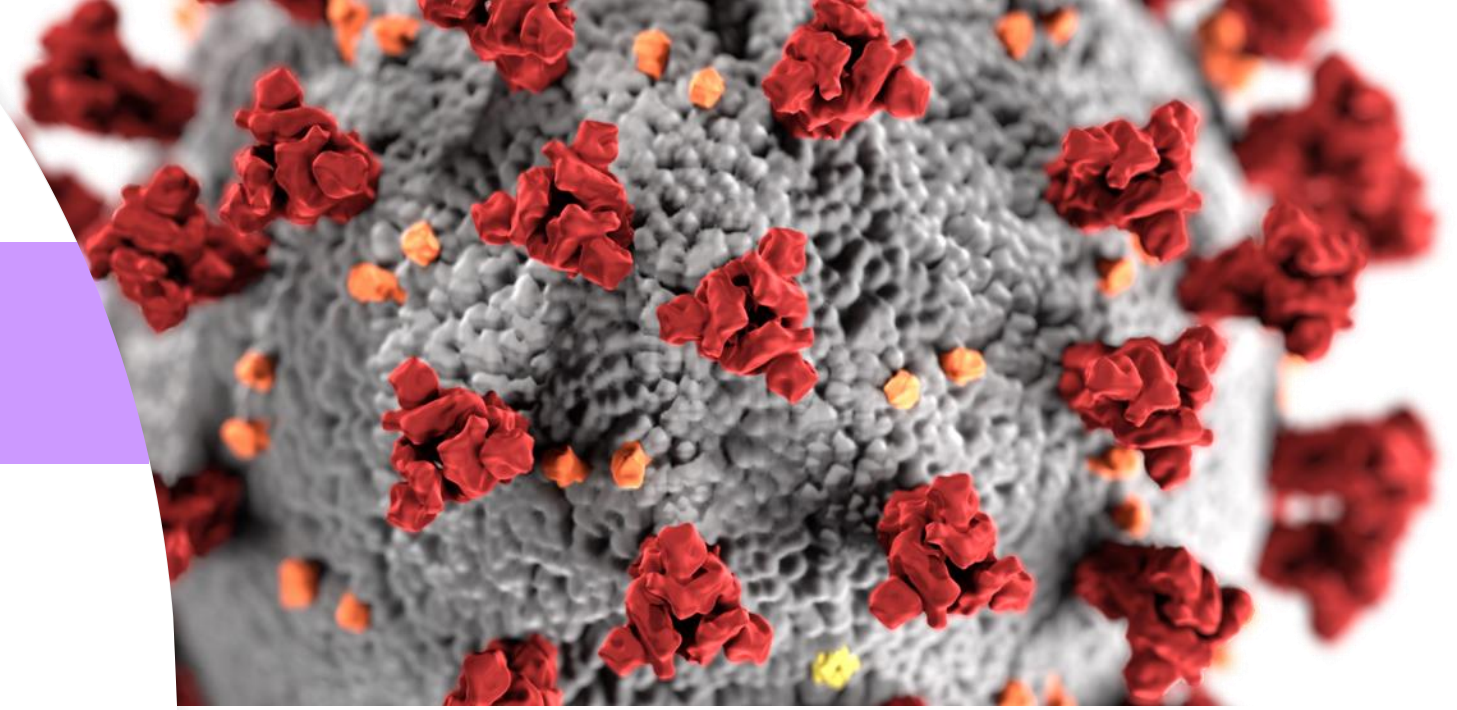
The first year of the Covid-19 pandemic brought unprecedented challenges for patients, clients, staff and partners of Aberdeen City Health and Social Care Partnership.

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

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

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

Covid19 Response and Lessons Learned



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

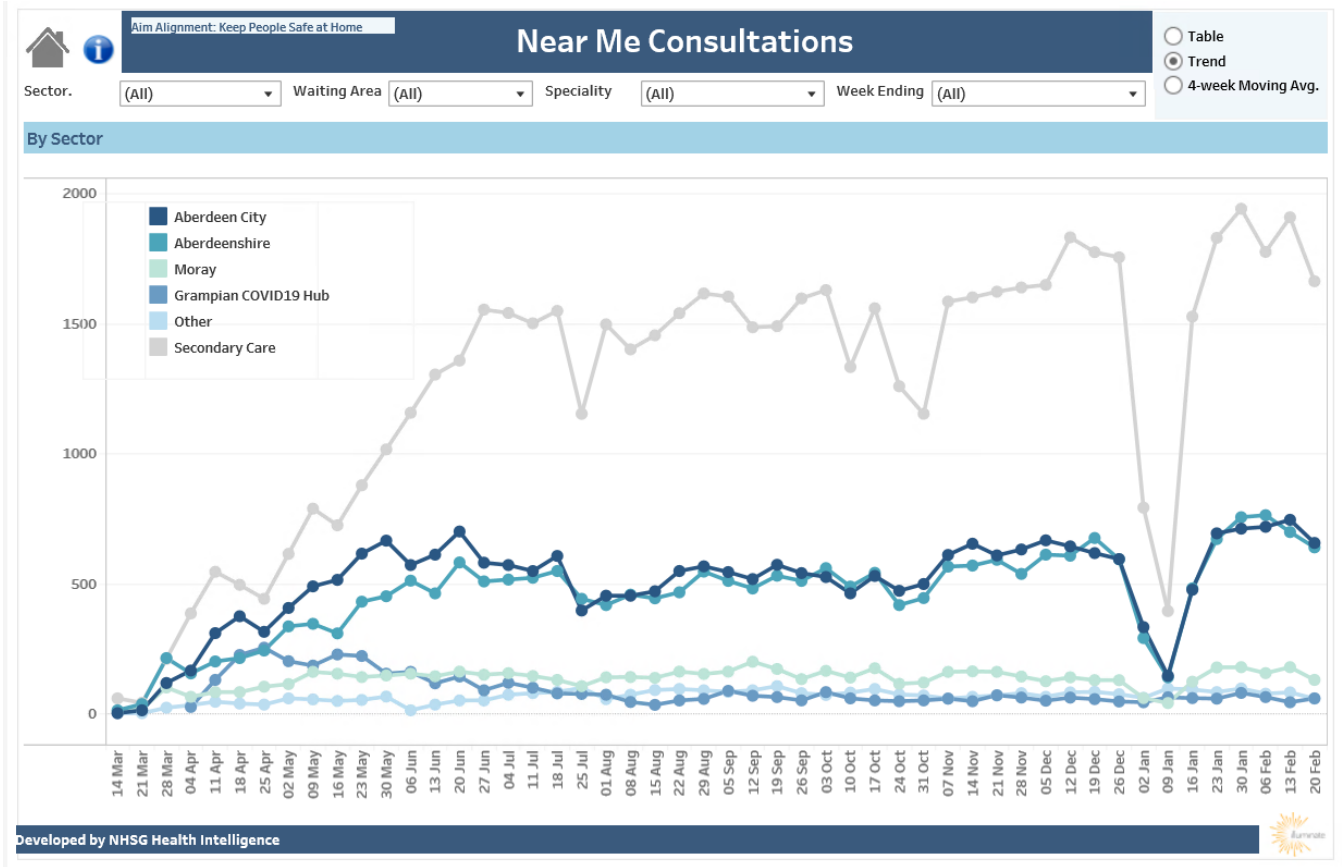
Here are some of the areas where our Partnership responded to the crisis and the lessons we learned that we will use to structure our services in the future.

Covid19 Response and Lessons Learned

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

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

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



Covid19 Response and Lessons Learned

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

Rachel Anderson, Community MacMillan CNS, Team Leader

Covid19 Response and Lessons Learned

Staff response to the crisis is exceptional.

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

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

#ACHSCP

Thank You

Covid19 Response and Lessons Learned

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

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

Although, support was provided in the form of the Psychological Hub and initiatives like Project Wingman, other wellbeing measures were introduced such as reduced meeting times and encouraging taking downtime and participating in physical activity and online social opportunities. It is acknowledged, however, that staff wellbeing has nonetheless been impacted. The Leadership Team has recognised the importance of ensuring that staff are supported to recover from the significant impact on their health and wellbeing and this is their top priority in terms of objectives for 2021/22. "Staff Health and Wellbeing will be a priority and we will ensure a collaborative, compassionate and supportive approach to recovery. Staff will be given time, space, and resources to recover from the pandemic and prepare for recovery and planning of next steps".

PROJECT WINGMAN

"Helping NHS Staff Unwind, Decompress and Destress"

Covid19 Response and Lessons Learned

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

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

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

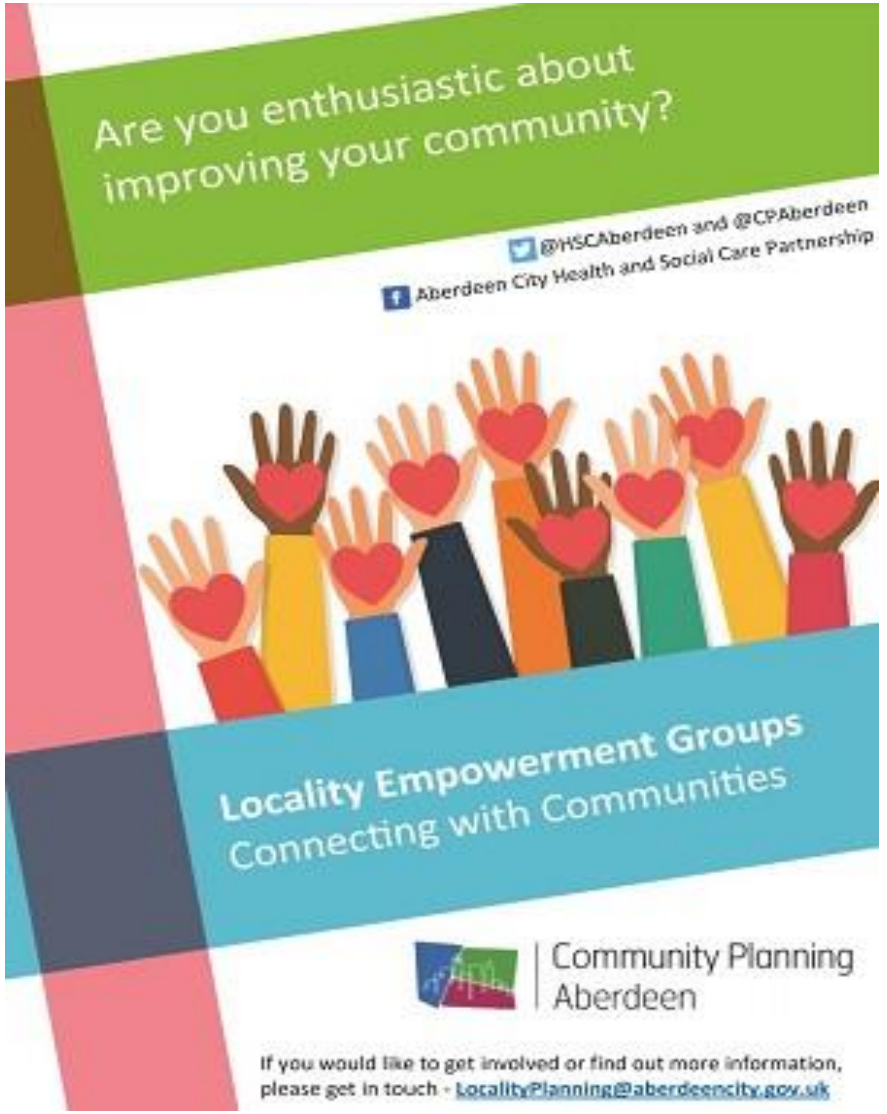
Aberdeen City Health and Social Care Partnership: Equality Outcomes and Mainstreaming Framework 2021-25

Covid19 Response and Lessons Learned

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

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

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



Covid19 Response and Lessons Learned

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

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

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

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

Stay Well, Stay Connected

COVID19 Mass Vaccination Programme

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

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

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

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

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

Prevention

Prevention - Primary Care

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

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

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

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

COVID19 Hub – Health Village

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

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

Dr Stuart Reary, GP Partner

Prevention

Living Well with Diabetes – Type 2 Peer Support Group

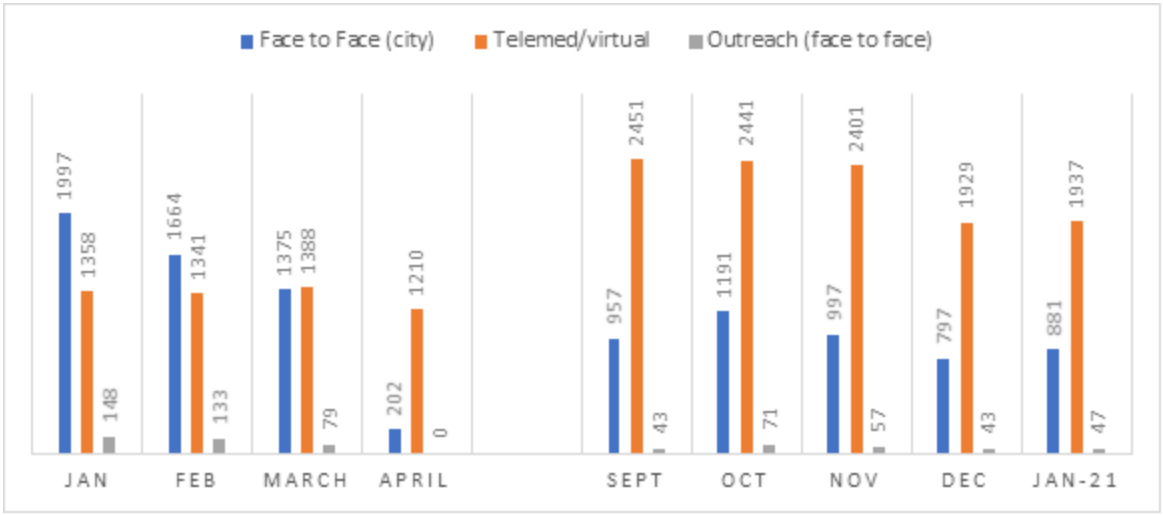
The Living well With Diabetes peer support group is made up of individuals across Aberdeen City who have Type 2 Diabetes, as part of the group there are 5 Diabetes UK trained peer supporters. The group met monthly to share tips and information, as well sharing struggles they are facing with self-managing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

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

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

Grampian Sexual Health Response

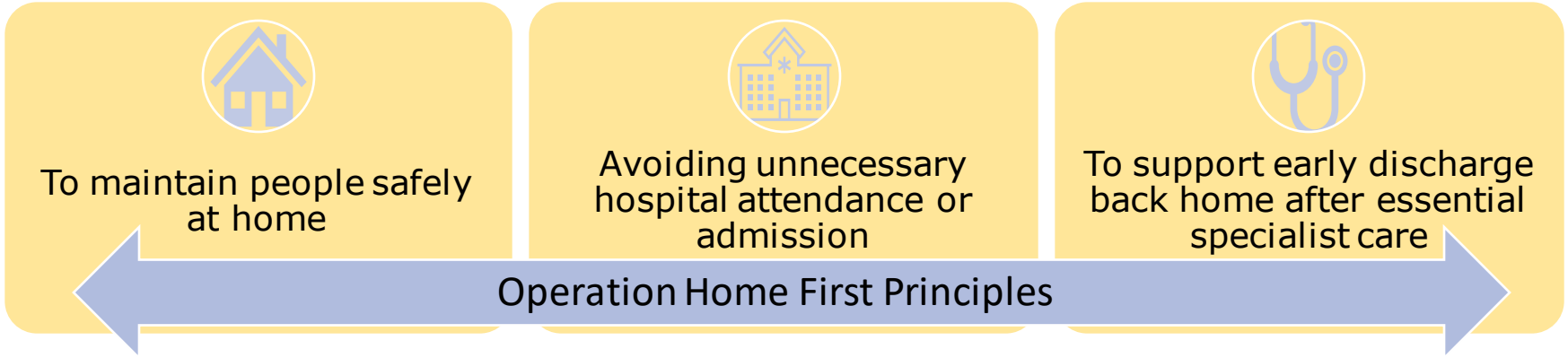
As part of the first wave Covid19 pandemic response, Grampian Sexual Health service was rapidly redesigned to prioritise essential care only. This rapid change was in response to reduced capacity, staff redeployment for Covid19 work streams, urgent relocation to alternative accommodation, reduced laboratory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



Resilience

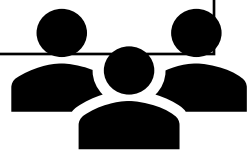
Frailty Pathway Redesign

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



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

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



What is frailty?

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

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

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

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

Age UK website

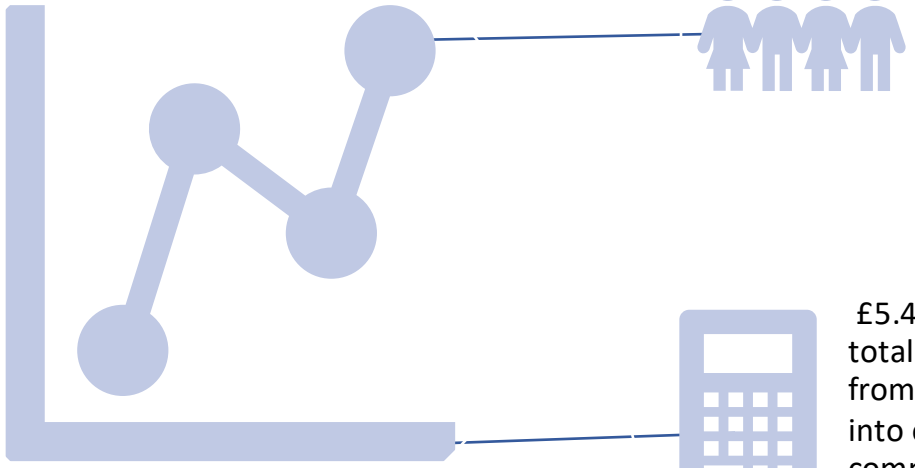
What is frailty syndrome?

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

Resilience

What do changes in the Frailty Pathway look like?

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



What next for the Frailty Pathway?

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

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

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

Personalisation

Care Homes

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

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

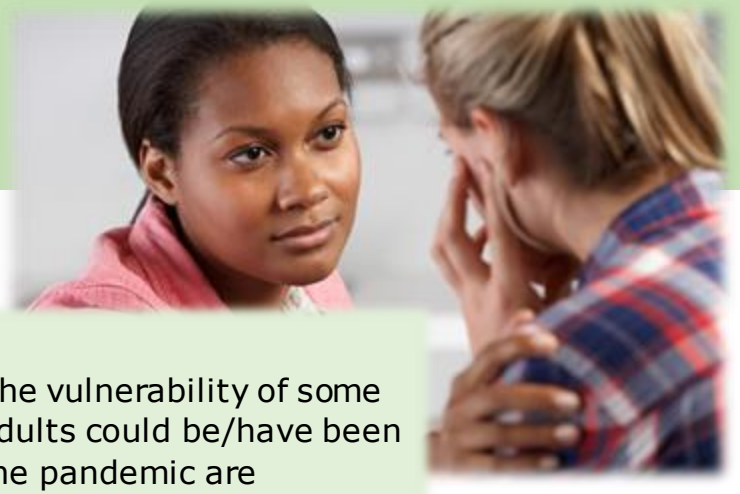
By 8 January 2021, all eligible care home residents in Aberdeen City, totalling 1092, had received their first Covid vaccination.

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

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

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

Personalisation



Adut Support and Protection (ASP) – 2020-2021

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

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

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

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

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

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

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

Personalisation

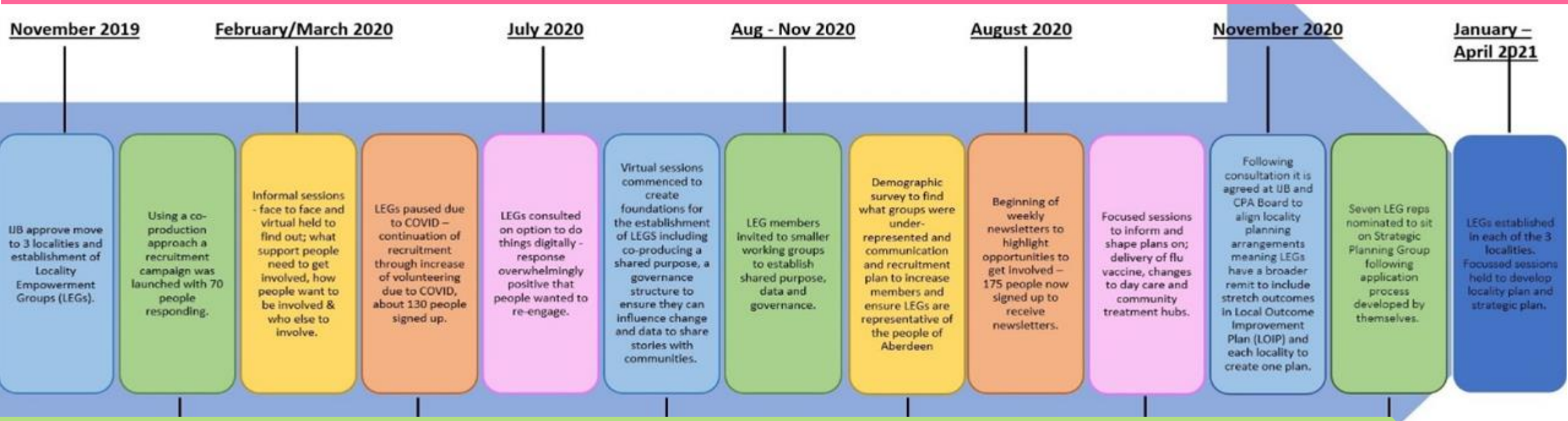
The Out of Hours Primary Care (GMED) Service delivers unscheduled primary care to patients who cannot wait until their GP Practices open. GMED service provides multidisciplinary assessment of patients. The team is made up of General Practitioners and Advanced Nurse Practitioners with a logistics and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

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

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

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

Communities - Locality Empowerment Groups



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

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

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

Communities - Locality Empowerment Groups

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

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

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

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

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

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

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

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

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

Project – One Seed Forward

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

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

Background and activities

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

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

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

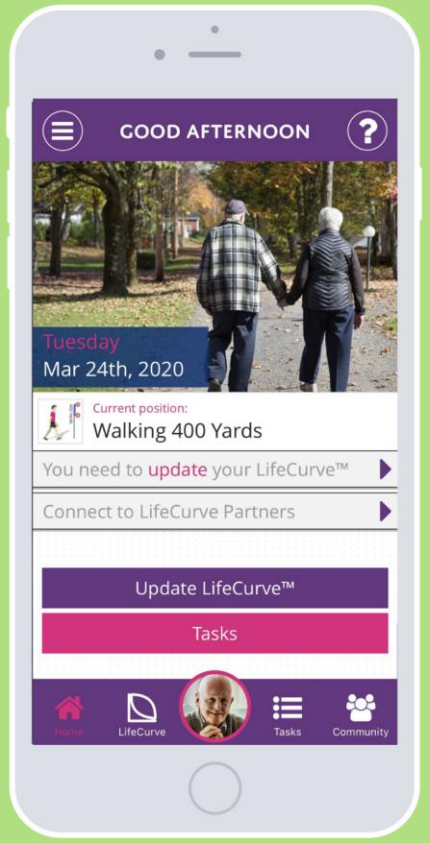
The project engaged schools and it successfully acts as a platform for getting children and young people outdoors and physically active.

Key Achievements

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

Communities - Health Improvement Fund

Connections



LifeCurve App Project

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

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

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

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

Connections

Shielding Communities – Afternoon Teas

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

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

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

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

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

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

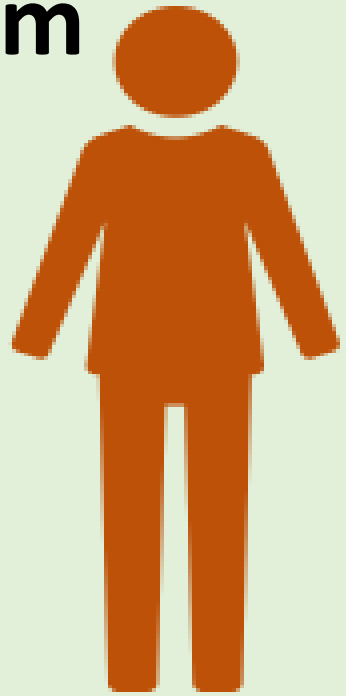
I have had positive feedback about the new systems and use of Near Me. I look forward to continuing to work in this way."

Lizzie Smith, School Nurse

Connections

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

Jim



Referral from Advanced Nurse Practitioner:

Social Isolation

Main challenges:

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

What services/groups did Jim access?

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

Outcomes achieved?

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

Next steps;

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

Progress against our Enablers

Principled Commissioning

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

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

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

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

Modern & Adaptable Infrastructure

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

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

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

Empowered Staff

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

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

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

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

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

Digital Transformation

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

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

Progress against our Enablers – Sustainable Finance

Sustainable Finance

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

Comprehensive Income and Expenditure Statement

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

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

Our Governance

Care Inspection – Justice Social Work

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

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

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

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

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

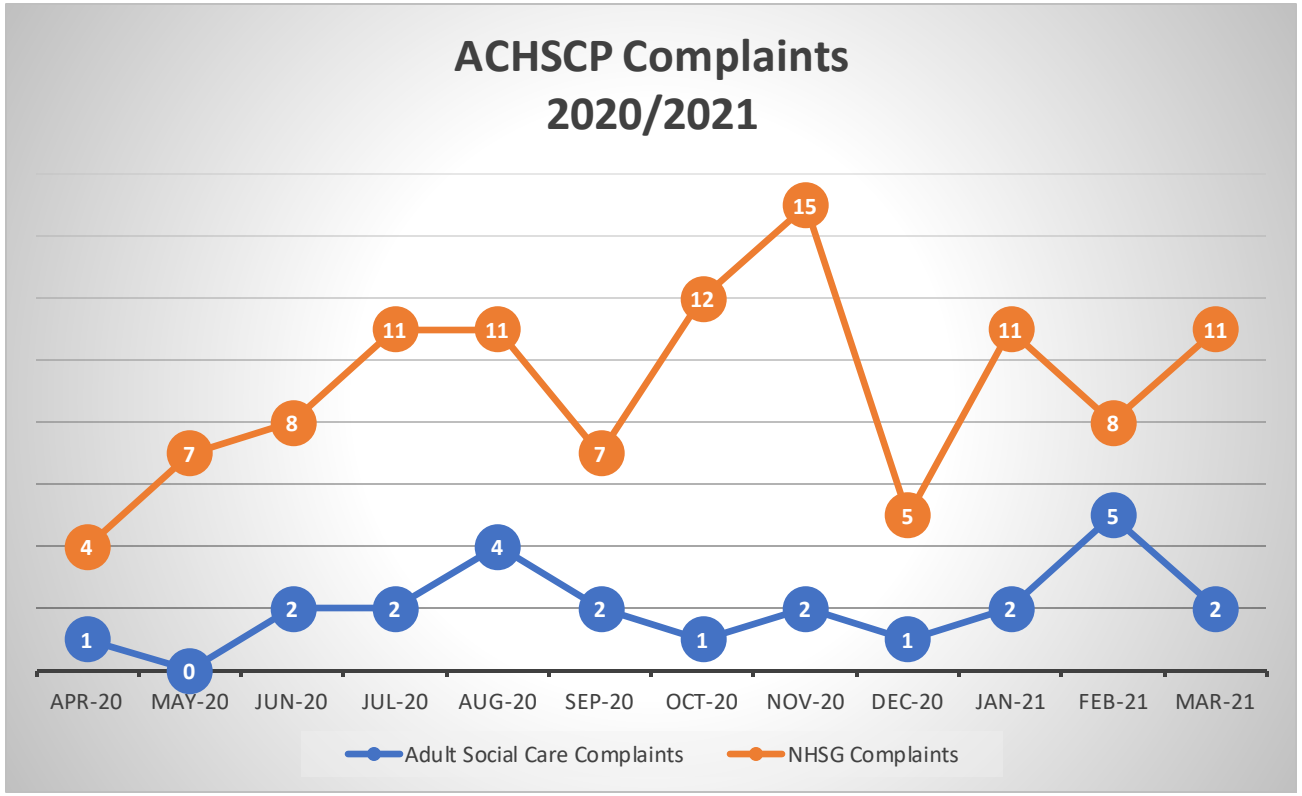
		Grade
What key outcome have we achieved	Improving the life chances and outcomes for people subject to a community payback order	Good
How well do we meet the needs of our stakeholders	Impact on people have committed offences	Excellent
How good is our delivery of services	Assessing and responding to risk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

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

To enable robust oversight and increased ability to demonstrate outcomes and impact, senior officers should ensure that the Justice Service Delivery Plan and Performance Management Framework are agreed and implemented and associated reporting cycles established.

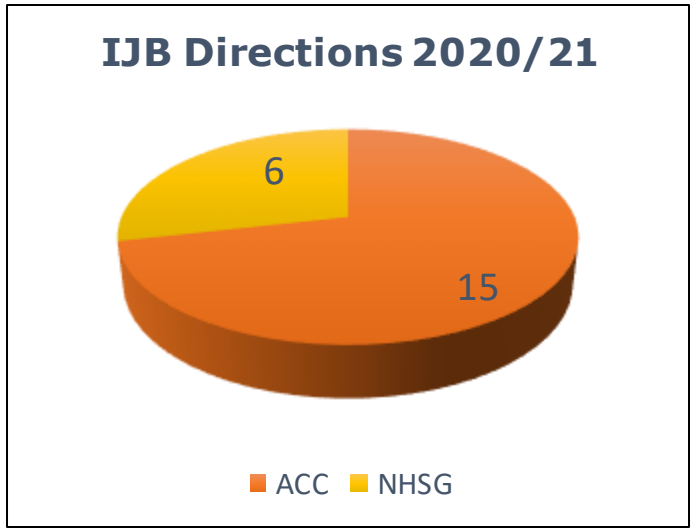
To ensure the effective delivery of key processes, senior managers should further strengthen quality assurance mechanisms to support the consistent, confident and timely application of risk assessment and case planning processes, particularly those relating to risk of serious harm.

Our Governance



Strategic Risk Register

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



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

Strategic Plan Development

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

or ACHSCPEnquiries@aberdeencity.gov.uk

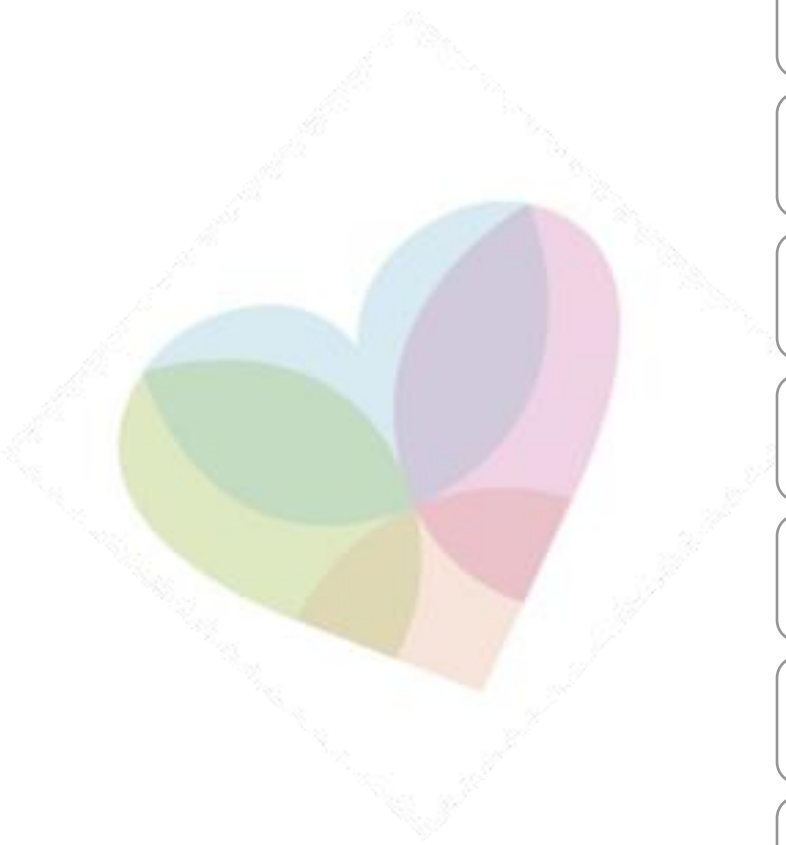
Oct 20 – Jun 21
Refresh of LOIP and development of Locality Plans

Mar 21 – Nov 21
Consultation and development of initial draft

Dec 21
Draft approved for public consultation

Mar 22
Final Strategic Plan approved and published

Next years' Priorities



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

Appendix A – Ministerial Steering Group (MSG) Indicators

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

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

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

Appendix B – National Indicators

Aberdeen City Core Suite of National Integration Indicators - Annual Performance

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

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

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

Appendix B – National Indicators

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

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

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

RAG scoring based on the following criteria

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

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

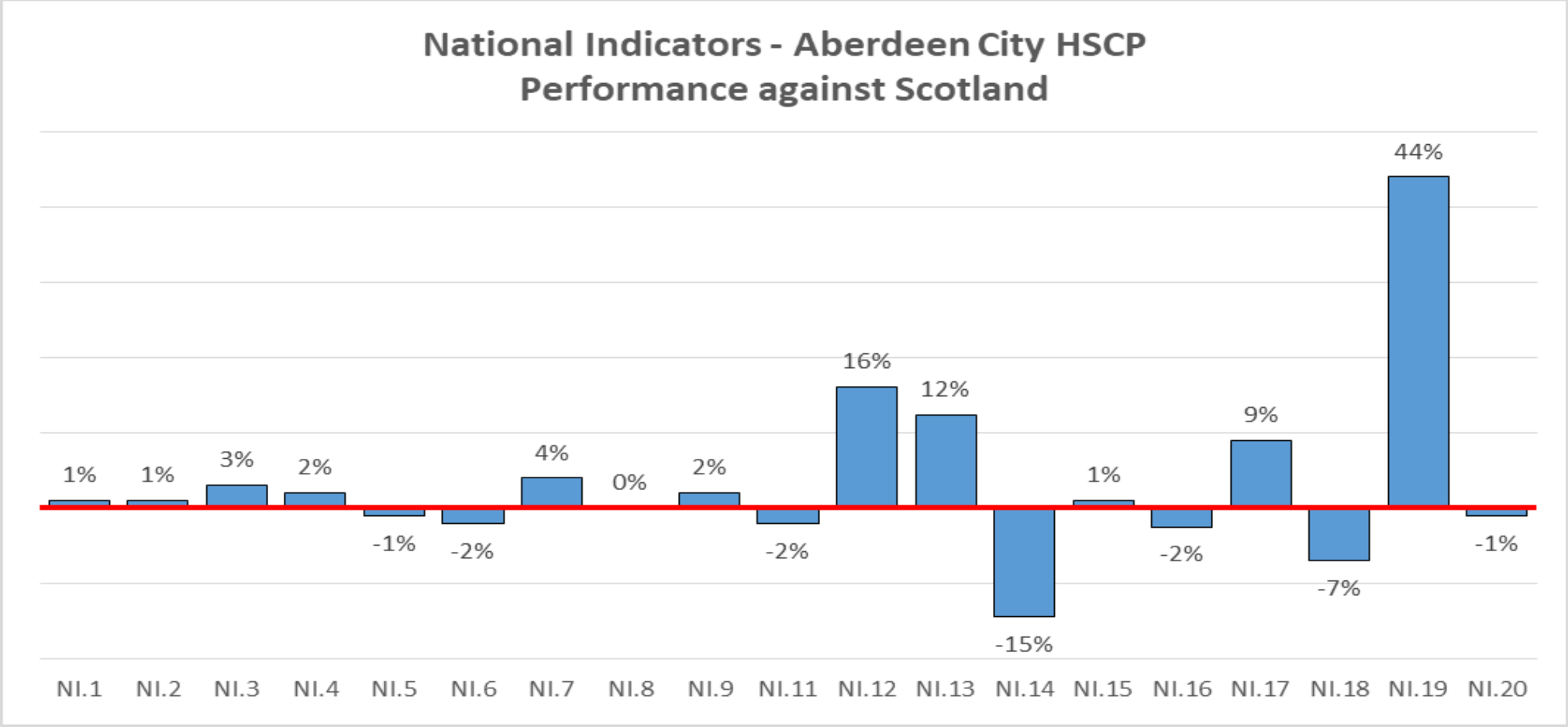
If Current position is worse than Scotland by more than 5% then "Red"

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

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

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

Appendix B – National Indicators



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

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