INTEGRATION JOINT BOARD

Date of Meeting	7 May 2024
Report Title	Marywell and Timmermarket Integrated Service Review
Report Number	HSCP24.027
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Consultation Checklist Completed	Yes
Directions Required	No
Exempt	No
Appendices	a. Service User/Patient Questionnaire (Summary) b. IIA (Integrated Impact Assessment)
Terms of Reference	1

1. Purpose of the Report

1.1. This report provides an update to the Integration Joint Board (IJB) on the Marywell and Timmermarket Integrated Service Review progress.

2. Recommendations

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

a) Notes the overall advancements achieved over the past 18 months since the initial report was presented to the IJB on 29 November 2022;

b) Notes the specific advancements and advantages resulting from the two-year Alcohol and Drug Partnership (ADP) funding;

c) Directs the Chief Officer to continue to mitigate health inequalities in Primary Care, in partnership with Aberdeen City Council, NHS Grampian Public Health, and Primary Care General Practice; and

d) Instructs the Chief Officer to proceed with an options appraisal and report back to the meeting of the IJB scheduled for 4 February 2025, outlining the future trajectory of the Marywell Practice.

3. Strategic Plan Context

3.1. The findings and proposals presented in this report are aligned with the strategic objectives in the Aberdeen City Health and Social Care Partnership (ACHSCP) Strategic Plan 2022–2025. These objectives encompass Preventing Ill Health, Caring Together, Keeping the Population Safe at Home and Achieve Healthy Fulfilling Lives.

3.2. The project outcomes, will directly enhance the realisation of the strategic objectives outlined by ACHSP, as follows:

Figure 1: Programme alignment to ACHSCP Strategic Priorities

ACHSCP Strategic Aims	ACHSCP Strategic Priorities (relevant to the programme)	Linked Programme Key Aims/Deliverables
Caring Together	✓ Undertake whole pathway reviews ensuring services are more accessible and coordinated ✓ Empower our communities to be involved in planning and leading services locally ✓ Create capacity for General Practice improving patient experience	Equitable and increased access to GMS services for most vulnerable ✓ Increase resilience and collaboration of cross system services and teams
Keeping People Safe At Home	✓ Reduce the impact of unscheduled care on the hospital	✓ Supporting people in their acute phase of need with support to transition to mainstream services

Preventing Ill Health	✓ Tackle the top preventable risk factors for poor mental and physical health including: - obesity, smoking, and use of alcohol and drugs ✓ Enable people to look after their own health in a way which is manageable for them	✓ Improved access for patients to healthcare and drug treatment in line with MAT standards; ✓ Effectively support & empower patients/service users to engage
Achieve Healthy Fulfilling lives.	✓ Help people access support to overcome the impact of the wider determinants of health ✓ Ensure services do not stigmatise people ✓ Improve public mental health and wellbeing ✓ Improve opportunities for those requiring complex care ✓ Remobilise services and develop plans to work towards addressing the consequences of deferred care	✓ Developing a Primary Care Health Inequalities Plan and network ✓ Reduce stigma and increase wider understanding in primary care. ✓ To recognise current resource constraints in terms of staffing, funding, Infrastructure and the need to ensure services are integrated;

4. Summary of Key Information

Background

4.1. On 29 November 2022, the IJB received a report updating them on the progress of the 'Marywell 2c Homeless Practice', Service Redesign. A 2c practice is a health board run practice. This means that the practice is not operated by an independent contractor model like other practices in the city, as per the General Medical Services Contract (2018). The report included several recommendations, one of which was to present updates on the next phase of the redesign to the IJB within 18 months. This report provides updates on the initial phase of the redesign and offers recommendations for the medium to long term to the IJB.

4.2. The Marywell Homeless Practice was established in 2001 to support people who were homeless was and who faced a barrier to registering with a practice when they didn't have an address or were sleeping rough.

4.3. A '2c' redesign of primary care across the city included the Marywell practice as part of a tender process. However, there were no expressions of interest to operate the Marywell practice and so it remains the only '2c' practice within Aberdeen.

4.4. The report to the IJB in November 2022 set out the considerations for this programme of work:

- The changing demographic of homelessness;
- The increased requirement on drug services to meet the complex needs of those at risk of drug related harm;
- The need for Health and Social Care drug treatment services to deliver Medication Assisted Treatment (MAT) Standards including a greater focus on direct access;
- The increasing need to support people facing health inequalities in areas of deprivation and with multiple complex needs;
- Recognise the increased pressure on primary care services and wrap additional support around those with patients in the deepest end of the health inequality spectrum;
- Recognise the increasing demand that health inequalities place on secondary care services and prevent, reduce and provide early intervention to reduce demand in the longer term;
- Recognise other service developments in line with the Community Planning Partnership, the Family Support Model and the work of Early Intervention and Community Empowerment Department;
- Support the development of locality-based care and support;
- Recognise current resource constraints in terms of staffing, funding etc. and the need to ensure services are integrated and supported to be resilient with an aspiration to support the population to access mainstream services where possible; and
- Recognise the strategic direction the Scottish Government has set out in relation to Homelessness, Public Health and Health Inequality, Drug Treatment, and Primary Care Health Inequality.

4.5. An essential aspect of the redesign involves enhancing collaboration among Marywell Practice, Integrated Drug Service (IDS), Aberdeen City Alcohol and Drug Partnership (ADP), and the Community Nursing Outreach Team (CNOT). This aims to prioritise person-centred care, allowing services to work more seamlessly together to meet the needs of the most vulnerable and address local health inequality. This has primarily focussed on the co-location of Marywell Practice and the CNOT at the Timmermarket Drug Treatment Clinic to improve health care for people seeking drug treatment whilst also developing opportunities for community outreach.

General Practice Vision

4.6. The programme of work is taking place in a context where the overall future of primary care is being re-envisioned. This acknowledges the crucial role that General Practice plays, and can play, in the broader health and care system and community planning. In partnership with the Integration Joint Boards of Aberdeen City, Aberdeenshire, and Moray, NHS Grampian commissioned work to develop a new vision along with associated strategic objectives for General Practice across Grampian. On 26 March 2024 the Aberdeen City IJB approved the vision and objectives for General Practice, this was also approved by Aberdeenshire IJB on the 20th of March 2024 and the Moray IJB on the 28 March 2024. This presents an opportunity to deliver General Practice services in a manner that is responsive to local needs and pressures. As a 2c practice in Grampian it is important to align to the general practice visioning programme, with the practice team participating in the various workshop and stakeholder events held.

Drug Related Deaths:

4.7. Aberdeen along with other areas of Scotland have seen an increasing and sustained rate of drug related deaths. In the past 5 years between 2018 and 2023 there have been 332 suspected drug related deaths in Aberdeen. The increase in drug deaths in Scotland has been described by the Scottish Government as a Public Health Emergency with the expectation that local public services collaborate to reduce harm as a priority.

4.8. Specialist drug treatment services in the city are well utilised and provide fast access to integrated multiagency treatment and support, however local reviews of drug deaths show that people at highest risk of death have multiple under diagnosed and undertreated health problems, partly due to substance use but also related to poverty and difficulty engaging. Of the 332 drug related deaths 76% were found to have significant underlying health conditions.

4.9. The situation remains a pressing concern, necessitating ongoing collaboration between primary care and secondary care drug services, social care and third sector services to support affected individuals and families.

4.10. Following a report being presented to the IJB on the ADP Investment Programme in June 2022, a recommendation was to align £480,000 of ADP funding to support the implementation of the Medication Assisted Treatment (MAT) Standards, and contribute funding to a collaborative service redesign, in partnership with primary care to improve primary healthcare outcomes.

4.11. This non-recurring transformational monies has been aligned to explore alternative and new ways of working / tests of change across the Marywell practice, Timmermarket Integrated Drug Service and within wider Primary Care.

Homelessness:

4.12. As highlighted in the IJB report of November 2022 very few people registered with the Marywell Practice were homeless, and this continues to be the case and most people experiencing housing difficulties will continue to be registered in mainstream general practice. The new Housing (Scotland) Bill published on 27 of March 2024 will introduce an 'ask and act' duty on social landlords and bodies, such as health boards and the police, to ask about a person's housing situation and act to avoid them becoming homeless wherever possible.

4.13. Aberdeen has however experienced an increase in homelessness in 2022 – 2023 and Aberdeen City Council continues to make significant innovative progress to reduce rough sleeping and homelessness in the city with a focus on early intervention and wrap around support.

4.14. Homelessness within Aberdeen City continues to be a key priority area of focus with continued effort to move towards a preventative approach, as evidenced, with the recent inclusion of Homelessness as a standalone stretch outcome within the Local Outcome Improvement Plan (LOIP) refresh and underpinned by the Rapid Rehousing Transition Plan 2019-2024.

4.15. Aberdeen City has also been selected to partner with the Royal Foundation as part of their Homewards programme, a 5-year partnership, that is locally led to support the formation of a coalition who will work together to create a plan to prevent and end homelessness, providing further growth and support of the ongoing work in the preventative space.

The Work Programme

4.16. This Integrated Service Review and programme of work outlines specific goals to reduce health inequality, improve life expectancy and improve access to primary health care for the most vulnerable populations in the city in the context of an overall re-envisioning of primary care in Grampian. The project team has adopted a phased strategy over the past 18 months to advance critical priorities (highlighted in bold) and

pilot initiatives during the approved two-year duration of supplementary ADP funding (November 2022 to November 2024).

1. To ensure equitable and increased access to General Medical Services (GMS) services for homeless/vulnerable adults, with multiple complex needs (wrap around);
2. To increase direct access for patients to healthcare and drug treatment in line with MAT standards;
3. To increase resilience and collaboration of Marywell and services currently provided at Timmermarket and staff to ensure outcomes are delivered;
4. To develop a Primary Care Health Inequalities Plan and network to proactively reduce health inequalities for those with complex needs with multiple co-morbidities
5. To effectively support & empower patients/service users to engage with wider relevant service incl. health & social care services, housing, benefits etc (Prevention & Early intervention);
6. To recognise current resource constraints in terms of staffing, funding, Infrastructure and the need to ensure services are integrated;
7. To ensure the service has the capacity to reach-out to people in an acute phase of need and provide interventions as required. Then when appropriate integrate back into mainstream services, to reduce stigma and increase wider understanding of this populations needs within the wider primary care settings.

4.17. To assess the delivery of the aims against the investment and work completed to date, the project team have produced the following information which provides a progress status overview of each aim and key priority. Further detail in relation to each is outlined within sections 4.25 to 4.49 below.

Figure 2: Programme priorities and status overview

Priorities	Aligned Workstream	% Completion	RAG Status
Aim 1: To ensure equitable and increased access to General Medical Services (GMS) for homeless / vulnerable adults, with multiple complex needs;			
✓ Health Assessments	Integrated Pathway	75%	In progress on track
✓ Expanded Patient Criteria	Integrated Pathway	75%	In progress on track
Aim 2: To increase direct access for patients to healthcare and drug treatment in line with MAT standards;			
✓ Direct Access Clinic	Integrated Pathway	50%	On Hold
Aim 3: To increase resilience and collaboration of Marywell and Timmermarket services and staff to ensure outcomes are delivered;			

✓ Integrated Front Door	Access and Outreach	60%	In progress – delayed
Aim 4: To develop a Primary Care Health Inequalities Plan and network to proactively reduce health inequalities for those with complex needs with multiple co-morbidities;			
✓ Aberdeen City GP Network	Data, Evaluation and Engagement	40%	In progress – delayed
Aim 5: To effectively support and empower patients/service users to engage with wider relevant service incl. health and social care services, housing, benefits etc;			
✓ Patient Engagement	Data, Evaluation and Engagement	100%	Completed
✓ Staff Engagement	Data, Evaluation and Engagement	100%	Completed
✓ Project Evaluation	Data, Evaluation and Engagement	50%	In progress on track
Aim 6: To recognise current resource constraints in terms of staffing, funding, infrastructure and the need to ensure services are integrated;			
✓ Options Appraisal (Feb 2025)	Business Modelling	0%	Not Started
Aim 7: To ensure the service has the capacity to reach-out to people in an acute phase of need and provide interventions as required. Then when appropriate integrate back into mainstream services, to reduce stigma and increase wider understanding of this population needs within the wider primary care settings.			
✓ Co-ordination and Transfer of Patients	Integrated Pathway	75%	In progress on track
✓ Hub and Spoke Model	Access and Outreach	50%	In progress on track
✓ Training & Development	Integrated Pathway	50%	In progress on track

Programme Management

4.18. A project team was established in May 2022, with key staff working across health and social care teams, including the independent and third sector, to develop a vision and plan for the short, medium, and longer-term future.

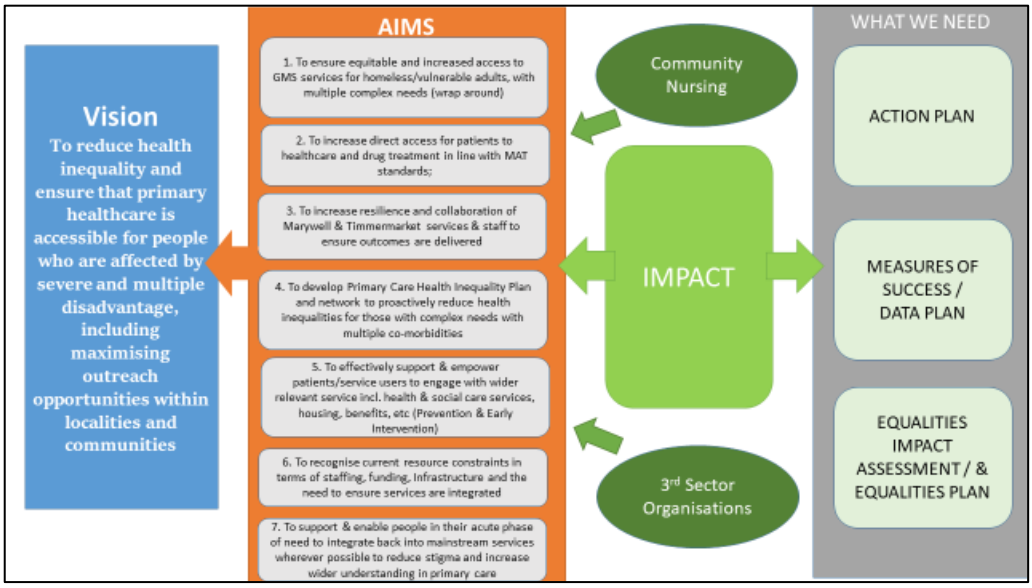
4.19. Through engagement involving multiple stakeholders, the overall vision for the programme has been developed and agreed upon:

"To reduce health inequality and ensure that primary healthcare is accessible for people who are affected by severe and multiple disadvantage, including maximising outreach opportunities within localities and communities"

4.20. It is important to note that this programme of work, associated vision and goals will be aligned to the ongoing work of the primary care visioning programme across Grampian.

4.21. A redesign framework has been developed to ensure a co-ordinated and systematic approach to achieve the vision and key aims of the programme as follows:

Figure 3: Redesign Framework



4.22. The diagram below outlines the governance and decision-making arrangements to oversee the programme of work as follows:

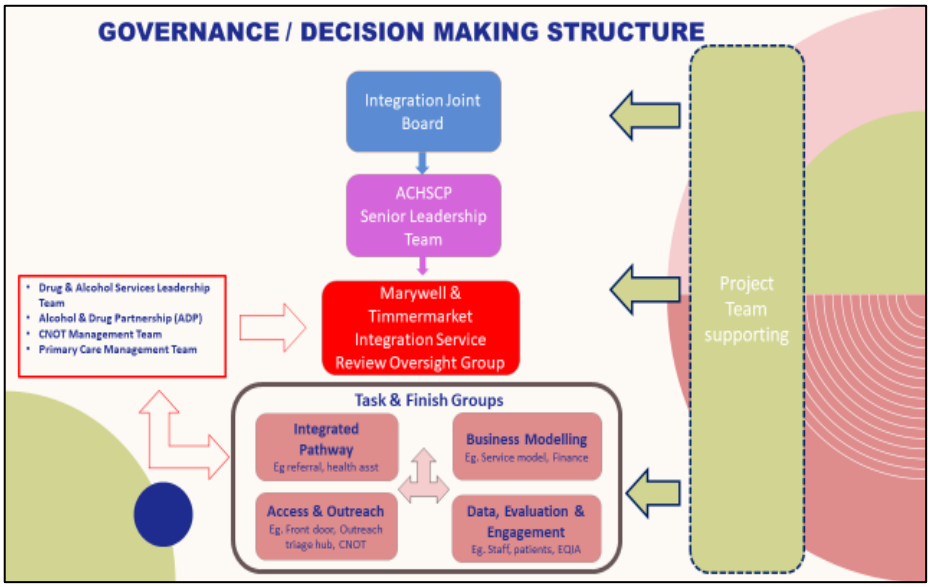


Figure 4: Governance Arrangements

4.23. Four work stream 'task and finish' groups which have been established:

1. Integrated Pathway

2. Access and Outreach
3. Business Modelling
4. Data, Evaluation and Engagement

4.24. A summary of progress to date is detailed below under the workstream headings.

Workstream 1: Integrated Pathway

4.25. **Health Assessments:** The project team has focused on developing Health Assessments for those entering drug treatment, given the high number of drug-related deaths linked to undiagnosed health conditions. Their aim is to ensure onward referral to suitable services.

4.26. A clinical standard has been established: *'Every patient referred to the Timmermarket IDS/Marywell Practice is offered a physical health check, including same-day reviews for acute illnesses, conducted by the CNOT and Marywell GPs'*.

4.27. A Clinical Lead GP was seconded for 23 months starting from 1 April 2023, to 1 May 2025, to spearhead the health screening initiative, funded through the ADP funding stream. Drawing on an evidence-base from other areas the Clinical Lead GP has advanced the implementation of a health screening initiative by developing a Health Assessment Standard Operating Procedure (SOP) for patients seeking services. All new clients attending the Timmermarket IDS undergo a comprehensive initial assessment by a combination of early intervention workers (EIW) and/or social workers (SW) and a prescriber. As part of this process, every client referred into the Timmermarket IDS is to receive the offer of a physical health check. This would also include the possibility of "same day" physical health reviews if clients present with acute illnesses (for example, wound infections/deep vein thrombosis/breathing concerns)

4.28. The clinical lead has gathered initial findings from completed health assessments. This confirms findings from drug death reviews that individuals having under-diagnosed and under-treated health conditions significantly increase the risk of drug related death. Our findings show specifically:

- 65% of patients had an abnormal BMI (higher or lower than normal)
- 20% had lower than normal oxygen saturation
- 50% had peak flow tests that potentially indicate abnormal respiratory function
- 54% had heightened cholesterol readings
- 15% had abnormal liver function levels

- 90% had Vitamin D deficiencies with potential symptoms including chronic fatigue, low mood and chronic pain
- Folic Acid levels were generally lower

4.29. Findings also show, 35% had an acute/on the day presentations that required immediate attention for physical health conditions at their initial appointment including treatment for:

- injecting-related infection
- respiratory complaints
- skin conditions
- suspected deep-vein thrombosis
- sexually transmitted infection

4.30. During the implementation phase, it has been noted that patients may not always be willing to undergo a full-health check on the same day due to time constraints, personal choice. Hence, a flexible approach is developing, with full health checks completed over multiple appointments to maximise patient engagement.

4.31. A complementary Clinical Lead session has also been funded by ADP, to support **Training and Development** from 1 May 2023, to 1 June 2025, focusing on enhancing links with primary care through individual practice visits to increase understanding and enhanced referral routes and improving substance use prescribing training. This post is part of a wider range of activities which support the integration of drug services and primary care to improve outcomes for the people of Aberdeen city.

4.32. **MAT Standards:** As work has progressed in delivering the Scottish Government Medication Assisted Treatment Standards for drug treatment slower progress has been made in terms of integrating hybrid working between Marywell and Timmermarket to support the delivery of MAT standards. Improvements in service staffing capacity and throughput to mainstream Primary Care are factors that will help support progress on this element.

4.33. The team have been working on creating an integrated shared space and to ensure the clinical and non-clinical space is maximised, this includes; new IT for staff, a new bookable room system throughout, three rooms now upgraded, and creation of two smaller rooms for quiet staff space. The back office open plan space now has a dedicated area for the practice team when not seeing patients.

4.34. New Criteria for Registering with Marywell Practice: The Marywell and Timmermarket Integrated Service Review strives to enhance equitable access to GMS services for homeless with complex needs, alongside improving direct access to healthcare and drug treatment. However, certain patients encountering homelessness or substance use may encounter difficulties registering with a mainstream GP practice, frequently appearing distressed, vulnerable, and with multiple complex needs. In addition, it is extremely high risk for secondary care services to initiate drug treatment without GP registration, therefore the ability to register people reduces clinical risk in those circumstances.

4.35. The project team have revised and expanded the patient criteria to include those who are; homelessness/rough sleeping/residing in temporary accommodation and/or using drugs with a health need and not registered with a GP practice. However, it should be noted that these criteria are not reasons or a requirement to de-register from existing GP registration. Patient registrations will undergo clinical review during biweekly multi-disciplinary team meetings to ensure comprehensive support and inclusive outreach services. The criteria will be implemented in April 2024, with evaluation overseen by the GP Clinical Lead.

4.36. Co-ordination and transfer of patients: Ensuring the service prioritises those most in need during periods of instability, ongoing coordination and transfer of patients to mainstream general practice is crucial. The previously known 'Moving on Policy' has been streamlined into the Co-ordination and Transfer of Patients Protocol, facilitating a seamless transition for patients with clinical input from GPs and aligned CNOT team members. Patients are then supported to transition to mainstream general practice, maintaining ongoing primary care input and continuity of care.

Workstream 2: Access and Outreach

4.37. Integrated 'Front Door': Feedback on ensuring easy to access / trauma-informed approaches has led to discussions to integrate Marywell Practice and Timmermarket Drug Service are merging primary and secondary care processes by integrating their reception areas and streamlining administrative roles. The teams are coordinating tasks and duties to create a single reception area, aiming to provide a more unified front door experience for patients while reducing duplication and improving efficiency. This process involves collaboration with affected staff, HR, and colleagues to ensure a coordinated approach over the next six months.

4.38. **Hub and Spoke Model:** One of the recommendations outlined in the IJB report presented on 29 November 2022 was to establish a triage clinic at West North Street with Aberdeen City Council. During 2023, the project team explored the viability of West North Street initially by scoping clinical reconfiguration designs and then assessing the venue's risks. Due to the high costs received from the design consultants (e.g. ventilation) and limited access for non-residents to this venue, the decision was made to consider alternative options across the city. A short life working group was set up to coordinate this work, as part of the Access and Outreach workstream.

4.39. The group have agreed to do several tests of change over the next 6 months to understand the best location, appropriate clinical input, and which approach should be taken to develop "Spokes". Discussions are exploring potential to focus on specific chronic diseases (e.g. COPD, Diabetes), as well as, on use of current community assets within areas of higher deprivation and consideration of using the existing community networks and teams.

4.40. The new Community Nursing Outreach Team (CNOT) has been developed in parallel with the review to reduce silos and improve integrated services. This team aimed to meet the nursing needs of a vulnerable population who might not engage with traditional health services, aligning well with the Marywell Review.

4.41. To further align the teams, it was agreed for the Marywell practice nurses to become an integral part of the CNOT team. The sharing of staff has allowed a breadth of skills and flexibility within one team as well as allowing for cross-cover to improve service consistency and mitigate downtime. The team works across both services in various locations, including Timmermarket Integrated Drug Service, Marywell Medical Practice, the Middlefield Hub and outreach venues like Alcohol and Drugs Action on Hadden Street, the Toastie Club on Urquhart Road, and the Women's' Centre at Spring Gardens. They also maintain important links with the West North Street Homelessness Hub. A training and skills plan has been developed for the team to enhance the team's capabilities and sharing of skills amongst team members which gives the staff more variety and interest to the role.

4.42. The team is committed to providing excellent care and as such, are currently undertaking additional education and training to further advance their clinical skills and broaden their knowledge to deliver comprehensive care with an enhanced understanding of vulnerabilities.

Workstream 3: Business Modelling

4.43. Considering the changing demographic of homelessness and the changing needs of the patient population this enabled an opportunity to review both the Marywell Practice and the Timmermarket Integrated Drug Services together. ADP funding remains in place until November 2024 with the seconded clinical lead posts funded and committed as part of the ADP funding until May 2025. We will continue to gather evidence and data from this to inform next steps.

4.44. The project team will now develop an options appraisal with key stakeholders to consider sustainable models post-funding November 2024 some of which is committed beyond until June 2025, based on the information gathered. In addition, this may provide opportunities to align to the ongoing visioning work of General Practice and its implementation.

Workstream 4: Data, Evaluation and Engagement

4.45. **Patient Engagement:** The IJB report from November 2022 outlined plans for extensive patient and staff engagement to understand their needs and aspirations.

4.46. The project team have conducted two patient surveys. In November 2022, 23 patients responded, with 74% expressing satisfaction with the Marywell Service, 60% finding the current location adequate, and 65% desiring more outreach clinics. Feedback also included requests for additional services in one location and appreciation for the care received.

4.47. The most recent survey in January and February 2024 received responses from 75 out of 78 patients approached, representing a response rate of 96%. At that time the overall combined patient population of both Marywell and Timmermarket was 526 patients/service users. Of the respondents, 20% were new to the services, 40% had been attending for 1 month to 2 years, and 24% for over 2 years. While 79% were content with the current location, 21% expressed a preference for services closer to home, with specific areas highlighted. Twenty one percent highlighted that they would prefer these services closer to home, specific areas were highlighted as follows; Torry/Kincorth/City Centre/Mastrick/Northfield/Tillydrone and Seaton. A further detailed report available on request.

4.48. **Staff Engagement:** A comprehensive staff engagement period was undertaken between 20 December 2023 until 7 February 2024, with 87% of the combined Marywell and Timmermarket teams involved. This provided a confidential space for open and honest discussion and reflection. Feedback from staff included that the

vision was not clear, staff didn't feel valued, poor communication as well as lack of rooms and space. These matters were addressed by a series of "you said we did" feedback directly to staff as well as an informal coffee catch up early in January 2024 to ensure specific actions and improvements to the concerns raised.

4.49. Stakeholder engagement and communication has included a wide range of teams and individuals with specialist input to the programme of work as follows:

- Aberdeen City Council - Housing Support Services
- Public Health
- Community Nursing Outreach Team
- Aberdeen City GP practices
- Sexual Health/BBV Managed Care Network (MCN)
- Deep End Steering Group
- Those with Lived Experience

Next Steps

4.50. In summary, the project will continue until November 2024 to progress any outstanding actions as described in the workstream updates above. The team will use the data gathered and lessons learned to inform the options appraisal for a sustainable service for this vulnerable cohort. It is clear from the work completed that continued innovation and agility is required to meet the ongoing needs of this group and this approach needs to be embedded as 'business as usual'. Further work to decrease silos and increase integrated working will be progressed through co location and integrated procedures and systems. The programme has been only a crucial, but small, part of addressing wider health inequalities in the city by focussing on those with the most complex needs.

4.51. The project team will provide an options appraisal to the IJB in February 2025 to outline a sustainable model for those with vulnerable complex needs in Aberdeen city.

5. Implications for IJB

5.1. Equalities, Fairer Scotland and Health Inequality

To comply with the Equality Act 2010, the project team have been working with NHS Grampian's Equality and Diversity Team to ensure due regard is given to assess the impact of any proposed changes before, during and after the developmental review period, integrated service review and ongoing programme. An Equalities Impact Assessment (EQIA) Rapid Impact Checklist (RIA) has been completed and in addition, an Integrated Impact Assessment (IIA) has also been completed, this is attached as Appendix b.

The RIA assessment concluded as of 21 of March 2023 outline that the programme will proceed as it has the majority of positive impacts and improves opportunity. The necessary mitigating action will be taken for any potential adverse impacts outlined.

In terms of the IIA both stage 1 – Proportionality and Relevance and stage 2 – Impact Assess have been completed.

This documentation highlighted above has been completed as of 21 March 2023, and will be reviewed and updated on an ongoing basis as the programme of work develops.

5.2. Financial

The non-recurring ADP transformation funding of £480,000 is aligned to the programme of work for a 2-year test of change which runs from November 2022 until November 2024, with some of this funding committed until June 2025. The current spend to date is £417,325.

The monies have been utilised to carry out tests of change with a focus on the key aims and priorities of the programme of work including the development of the health screening initiative, direct access clinic, establishing the Aberdeen city GP network as well as training and development across primary care. Only successful and sustainable tests of change/new ways of working will be progressed to provide a legacy for the residents of Aberdeen city, within the current financial envelope and budget as well as within current resources.

Taking the current financial climate into account the Marywell Practice is currently subsidised by the ACHSCP in order to provide services. This report recommends the development of an options appraisal to consider future options following the test of change to mitigate where possible any financial risk.

5.3. Workforce

The programme links to the Aberdeen City Health and Social Care Partnership Workforce Plan 2022 – 2025 key priorities:

- Recruitment and Retention
- Staff Mental Health and Wellbeing
- Growth and Development Opportunities

Any direct workforce implications arising from the recommendations of this report will be progressed in accordance with the relevant policies e.g. NHS Grampian Organisational Change.

5.4. Legal

There are no direct legal implications arising from the recommendations of this report.

5.5. Unpaid Carers

The Aberdeen City Health and Social Care Partnership has specific duties to support unpaid carers under the Carers (Scotland) Act 2016. This has been fully considered as

part of the EQIA and IIA development. There are no direct implications arising from the recommendations of this report.

5.6. Information Governance

There are no direct implications arising from the recommendations of this report. The project team will liaise with the Information Governance team on any relevant matters as necessary considering General Data Protection Regulation (GDPR), Data Protection Impact Assessment (DPIA) and Information Sharing Agreements (ISA)

5.7. Environmental Impacts

There are no direct environmental implications arising from the recommendations of this report.

5.8. Sustainability

The ACHSCP has a duty to act sustainably. Sustainable development refers to the balancing of social, economic, and environmental impacts. The recommendations from this report aim to have a positive impact on the future sustainability of services.

5.9. Other

6. Management of Risk

The Risk Appetite Statement approved by the IJB has been reviewed by the report authors during the development of this report to ensure the specific identified programme risks are consistent with the Risk Appetite Statement.

6.1. Identified risks(s)

Category	Description of Risk	Mitigation/Actions	Residual Risk
Service Model	Unable to progress the triage clinic at the West North Street facility due to high refurbishment costs which include Infection Prevention	Options Appraisal to consider other hub & spoke locations including costs Venue Risk Assessment Consider derogations of IPC advice	MEDIUM

	and Control (IPC) ventilation requirements		
Operational Delivery	Lack of clinical capacity for transformation project work and sustainable model going forward	Phased plan for the transition of Asylum Seekers to mainstream general practice underway Use of locum GPs to provide additional clinical capacity Vacant GP post advertised for the second time	MEDIUM
Operational Delivery	Lack of available clinical space within the Timmermarket facility	Maximisation of facility with flexible booking system Upgrading of 3 clinical rooms Home Office discussion to relocate the controlled drug cupboard, to free up additional clinical space. Exploring alternative delivery models	MEDIUM
Workforce	Possible lack of workforce engagement of those teams affected by the changes Lack of staff capacity and resilience due to workload constraints and staff absence	Staff feedback interviews undertaken during December 2023 – January 2024 Informal staff engagement sessions/drop in'/staff suggestion box Staff communications	MEDIUM
Communications and Engagement	Hard to engage with this complex vulnerable community	Use of various locations / accessible information and outreach opportunities to engage with patients EQIA/IIA completed to inform strategic and operational redesign High engagement with patient questionnaire demonstrates opportunities with outreach and further innovative approaches	MEDIUM
Finance	ADP funding ending in November 2024 (some committed until June 2025) and current financial landscape. Lack of scope to progress future sustainable model for Marywell Practice due to financial constraints	Due to changing financial landscape, there will be an options appraisal completed to outline the future trajectory of the Marywell Practice post ADP funding.	HIGH

6.2. Link to risks on strategic or operational risk register

Risk 1: The commissioning of services from third sector and independent providers (e.g. General Practice and other primary care services) requires all stakeholders to work collaboratively to meet the needs of local people.

Mitigation: The proposals within this report aims to mitigate this risk by developing a sustainable and integrated service.

Risk 5: Demographic & financial pressures requiring IJB to deliver transformational system change which helps to meet its strategic priorities.

Mitigation: The programme will be delivered within current resources and financial envelope / existing budgets and within any additional non-recurring funding aligned.

Risk 6: Need to involve lived experience in service delivery and design as per Integration Principles.

Mitigation: The programme of work has key stakeholder engagement which includes those with lived experience.

Risk 7: The ongoing recruitment and retention of staff.

Mitigation: There are ongoing challenges in terms of the recruitment of clinical staff specifically, however as outlined above the project team are taking the necessary action to mitigate this risk.