Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Date of Meeting	01 July 2025
Report Title	Shifting the Balance of Care – A Community-Focused Approach to Delivery of Frailty and Specialist Rehabilitation Services within Aberdeen City Health & Social Care Partnership
Report Number	HSCP.25.054
Lead Officer	Julie Warrender, Chief Nurse and Lead for Frailty and Specialist Rehabilitation
Report Author Details	Sarah Gibbon, Programme Manager
Consultation Checklist Completed	Yes
Directions Required	Yes
Exempt	No
Appendices	1. Integrated Impact Assessment 2. Direction to NHS Grampian and Aberdeen City Council
Terms of Reference	2. Any function or remit delegated under the Aberdeen City Integration Scheme, which is bound to be undertaken by the IJB itself.

ABERDEEN CITY COUNCIL NHS Grampian

INTEGRATION JOINT BOARD

1. Purpose of the Report

1.1. This report builds on an update with the Chief Officer's report[1] considered on 13 May 2025, and the August 2023[2] IJB paper, to provide an overview of interrelated projects relating to the 'Discharge Without Delay' national programme, highlighting the implications for rebalancing the provision of care from inpatient settings to support within the patients home[3] where possible.

2. Recommendations

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

a) Endorse the approach for modernising service delivery and shifting the balance of care from in-patient, bed-based settings, by investing in services provided within the community at the person's home in line with local and national strategy, as outlined in this report;

b) Agree to a gradual, phased reduction in bed capacity at the intermediate facility at Rosewell House resulting in the eventual withdrawal of services provided by ACHSCP from the facility by 31st March 2026, in support of the Discharge without Delay commitments;

c) Instruct the Chief Officer to implement the withdrawal of in-house services at Rosewell House accordingly, ensuring each reduction in bed capacity at Rosewell House is monitored to ensure no significant impact on flow within hospital setting;

d) Instruct the Chief Officer to make and implement any necessary and reasonable arrangements in furtherance of the decision at c) above; and

e) Make the Direction, as at Appendix 2, and instructs the Chief Officer to issue the Direction to NHS Grampian

[1] (Public Pack)Agenda Document for Integration Joint Board, 13/05/2025 10:00

[2] Decisions 22nd-Aug-2023 10.00 Integration Joint Board.pdf

[3] For the purposes of this report, a person's home refers to their usual 'homely setting', included care home placements where this applies

f) Instruct the Chief Officer to bring back a future report demonstrating the progress and impact of the Discharge without Delay programme of work and shifting the balance of care.

3. Strategic Plan Context

There is cohesive strategic direction through from government at the highest level to local level in the form of the latest consultation draft of the ACHSCP Strategic Plan, to support the modernising of service delivery and shifting the balance of care from in-patient bed-based settings to the person's home. This will be summarised below as essential context to this report:

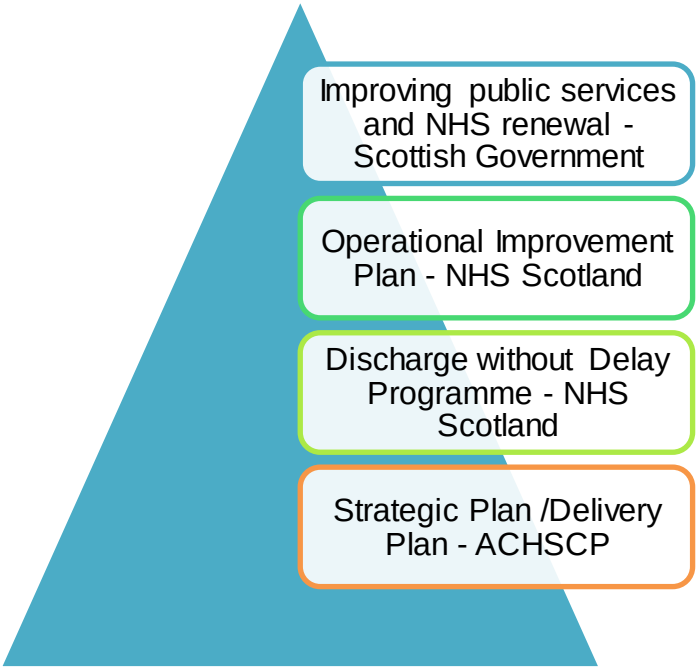


Figure 1: Strategic Context

3.1. National Strategy & Policy Framework

The Scottish Government have emphasised reform within our NHS services, towards a fundamentally patient-centred and interconnected health and social care whole-system[4]. It repeated the messaging which has been woven into the ACHSCP Strategic Plan for some time:

"Sometimes the appropriate setting is in hospital. More often, it is not"

[4] Improving public services and NHS renewal: First Minister's speech - 27 January 2025 - gov.scot

To support a systematic shift of the balance of care into communities and into homes, focus will be on three key actions:

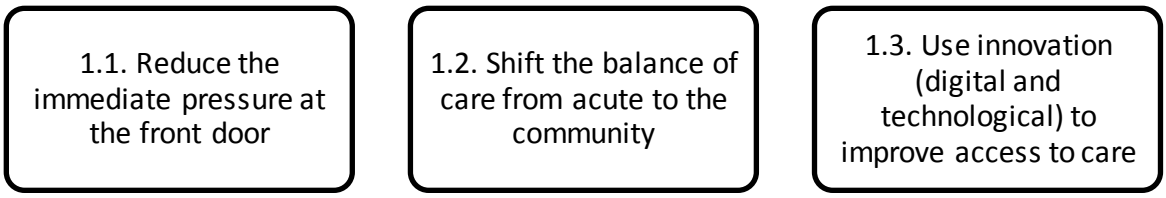


Figure 2: Key Actions from Scottish Government

The subsequent NHS Scotland Operational Improvement Plan re-emphasises the importance of these actions, and highlights the interconnected key areas to shifting the balance of care and modernising adult services, of which the following have relevance to this paper:

- Reducing the pressure in our hospitals
- Hospital at Home
- Specialist Frailty Services
- Frailty at the Front Door of the Emergency Department

Again, focusing on the impact for patients and their families, the plan seeks to *"ensure people receive the right care in the right place, recognising that acute hospitals are not always best for patients or their families".*

Operationalising the improvement plan, the programme of work seeking to progress the 'Shifting the Balance of Care' elements is the National Discharge Without Delay (DWD) Collaborative which was launched in 2025.

DWD is "*a whole-system programme for frail older people currently accessing Scottish hospitals, pulling best practice, individual services and pathways into an integrated model that strives to deliver Comprehensive Geriatric Assessment (CGA) in the timeliest manner, while ensuring no negative impact from hospital induced harm or dependency to the person*"[5]. The DWD Collaborative has an associated programme of work with four key workstreams:

[5] Quote from 2025 Discharge without Delay Paper

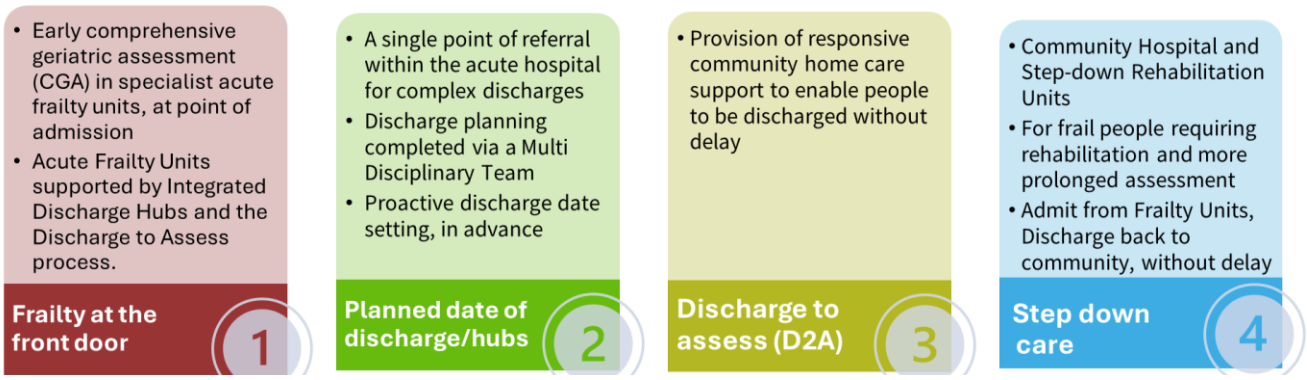


Figure 3: DWD Collaborative 4 Priority Programmes

The key to the successful implementation of the DWD programme is a whole-system, integrated approach between acute and community – current models in isolation delivery marginal impact on overall service delivery.

The outcomes of the DWD Work locally are outlined in figure 4 (below). Whilst these metrics are focused on the improvements from a systems perspective, from a patient's perspective this will mean more timely and effective access to acute-level care; a shorter hospital stay helping reduce the chances of deconditioning or negative consequences (such as hospital acquired infection), and a smoother, more supported transition back home after their hospital stay.

- Reduce acute geriatric length of stay (LOS) by >20% by end March 2026
- Reduce community hospital/ step-down LOS by > 20% (ideally less 28 days) by end March 2026
- Reduce respective HSCP delayed discharges by >20% by end March 2026 as consequence of improved flow
- With improved downstream capacity, the DWD Collaborative aims to improve 4-hour whole system performance by 3-5 % points.

Figure 4: DWD Outcomes

3.2. Local Strategy & Policy Framework

The new Strategic Plan (2025-2029) consultation draft was approved at the IJB in March 2025, with the final version on today's agenda. Within the refreshed strategic plan, there is an aim focusing on 'Modernising Service Delivery', which will be supported by delivery of the proposals within this paper. These commitments will be reflected through the inclusion of the DWD priorities within the associated ACHSCP Delivery Plan.

The consultation process on the draft Strategic Plan has shown good support for modernising our service delivery by shifting the balance of care as outlined in this paper. From 24 March 2025 to 18 May 2025, the Community Planning Aberdeen partners joined up to hold a large-scale engagement to inform their various strategic plans. This included the Health & Social Care Partnership Strategic Plan.

There was strong support for more community and home-based provision. Respondents were asked to indicate if they agree that the following statement should be a priority: "*review the allocation of social care resources to ensure more community and home-based service allowing people to live independently in their own homes*". 93.4% of 731 respondents agreed that it is right to focus on this as a priority within the draft Aberdeen City Health & Social Care Partnership Strategic Plan.

4. Summary of Key Information

4.1. Current Model & Timeline of Decisions

In 2020, the redesign of the Frailty Pathway was commissioned in line with the strategic direction of Operation Home First. This saw the transfer of resources and the realignment of staff to better support the flow of frailty patients across NHS Grampian in community settings rather than acute settings – an early example of ACHSCP's commitment to shifting the balance of care.

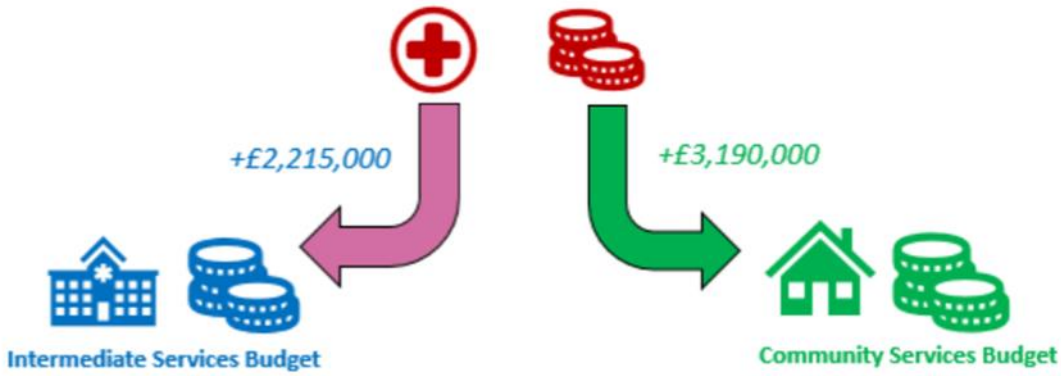


Figure 5: Resource Shift from Frailty Pathway Redesign

Alongside the shifting of resource and staffing from in-patient to community settings, key successes of the redesign of the Frailty Pathway were:

- the provision of Geriatricians within Acute Medical Initial Assessment (AMIA);
- an initial step towards shifting the balance of care from acute-hospital settings, with the establishment of an intermediate care facility at Rosewell House;
- additional capacity in the Community Rehabilitation team which improved the discharge of patients;
- the development and expansion of the Aberdeen City "Hospital at Home" service.

The priority actions of DWD reinforce these successes and further progresses the commitment of the initial Frailty Programme.

4.2. Need for Change

Nationally, the demand on Frailty services continues to grow[6] leading to challenges managing the flow of patients within the hospital, evidenced most visibly in increased ambulance 'stacking' and pressure at the Front Door of the hospital.

[6] The number of people aged 65 and over in Scotland is projected to grow by nearly a third by 2045 (National Records of Scotland, 2023)

Locally, Rosewell House has been an important component of the Frailty pathway however it has struggled to function as originally intended (as a 60 bedded integrated, intermediate care facility delivered in partnership with Bon Accord Care, offering both step up and step down provision):

Year	Beds	Notable Changes in Service Provision
2020	60 total	Plans for creating an integrated, intermediate care facility registered with the Care Inspectorate at Rosewell House are approved by the Integration Joint Board in October 2020, however Covid19 measures restricted the ability to implement these plans.
2021	30 Aberdeen City Frailty Beds 10 Aberdeenshire Frailty Beds 20 Rehabilitation Beds[7]	Restriction on access to available capacity, due to guidance on managing Covid19 in registered Care Homes has reduced patient flow and constrained capacity across multiple step-down facilities and sites. As a result, the IJB approved an interim arrangement to utilise part of Rosewell House as an NHS facility (HIS as regulator). In August 2021, it was agreed that all 60 beds would be the responsibility of NHS Grampian.
2022	30 Aberdeen City Frailty beds 10 Aberdeenshire Frailty Beds 20 Rehabilitation beds	Issues in providing clinical oversight of the rehabilitation beds and quality of care emerge.
2023	30 Aberdeen City Frailty Beds 10 Aberdeenshire Frailty Beds 20 Beds closed	Issues providing clinical oversight of the 20-rehabilitation beds exacerbate, with a lack of assurance on quality of care improvements, leading to the closure of these 20 beds in October 2023.
2024	40 Aberdeen City Frailty Beds 20 Acute Winter Surge Beds	In March 2024 the 10 Aberdeenshire frailty beds cease due to funding and are absorbed by Aberdeen City IJB. Opening of 20 winter surge beds in the vacant Rehabilitation beds in Rosewell House in December 2024 for frailty patients.

[7] supported with a service level agreement with a GP Practice

2025	30 Aberdeen City Frailty Beds 20 Acute Winter Surge Beds 10 Beds Closed	Closure of 10 beds within City Frailty due to staffing risks and an increase in adverse events reported. NHSG CET agreed to close the 20 Acute Winter Surge Beds (10 June 2025).

The changes that have taken place within the system highlight the need to deliver on the Discharge without Delay Collaborative's programme of work with ethos of shifting the balance of care from inpatient to peoples own homes as a matter of priority. Delivering on this will ensure sustainability of the system whilst putting patients and their needs at the forefront.

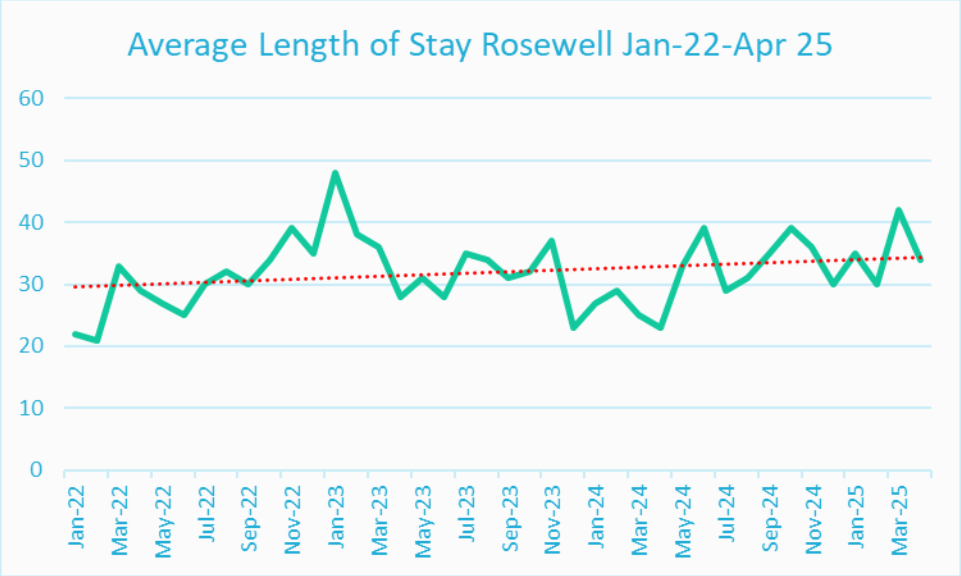
Crucially, it also demonstrates the challenges in maintaining the bed-based provision at Rosewell House, emphasising the need to shift the balance of care and resources further into a community-based model as close to a person's home as possible.

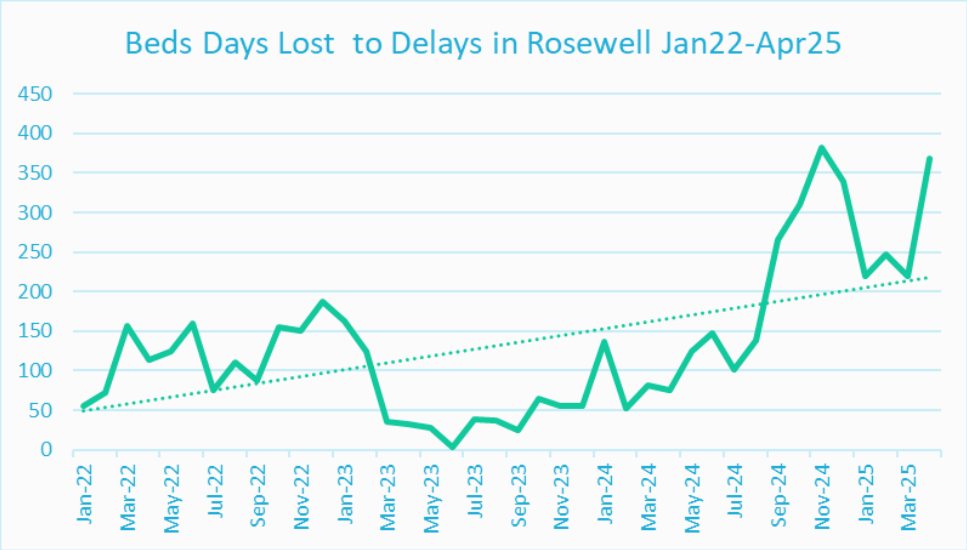
4.3. Analysis of Current Model

4.3.1. Rosewell House

Over the past 3 years, from 2022 to 2024, Rosewell House has seen a slight trend of increasing length of stay, increased number of bed days lost to delays, and a decreasing number of admissions per month. This reduces the amount of capacity the service has to meet demand, though it should be recognised that this can be affected by factors outwith the service's direct control.

Adverse event reporting in Rosewell House had also been on a decreasing-trend until the opening of the Winter Surge beds, which showed an increase in adverse events, related to the increased pressures on staffing and leadership.





Key challenges for Rosewell House over time have included:

1. **Workforce:** The 2023 evaluation of the Rosewell House identified challenges with staffing as a key issue for the service, and this has exacerbated with ongoing difficulties recruiting and retaining staff, including for leadership roles (1 WTE Senior Charge Nurse at facility), resulting in high levels of dependency on temporary staffing impacting quality and

continuity of care. There are also high levels of short and long term absence within the team (as of mid-May there was over 20% absence rate).

2. **Admission Pathway (Step-Up):** The proportion of step-up admissions at Rosewell House have been decreasing over the same time period, from around 6% of admissions, to 3.5% of admissions, indicating that the model is not functioning as originally intended and is not preventing admissions into an acute-setting, but functioning primarily as a step-down facility. This means that the opportunities to further the prevention agenda and limit the negative impacts of a hospital stay are not being realised.

3. **Front Door Pressures:** The 2023 evaluation also highlighted that there was a risk that the low proportion of step-up admissions, felt at the time to be due to prioritising of providing support to hospital-based services to improve flow during the Covid19 pandemic would become business as usual. Reprioritising resource to support Frailty patients at the Front door could reduce the need for these patients to be admitted to hospital in the first place, which would be a preferred outcome rather than admission and step-down to Rosewell.

4. **Finance:** The service has struggled with acute budget pressures, arising from the acquisition of the additional 10 Aberdeenshire beds (which was unaccounted for in the initial budget), and a high proportion of spend on bank nursing to compensate for staffing difficulties. It is a costly service per bed provided. The average cost of providing a bed within Rosewell House is approximately £167k per bed per annum.

4.3.2. Ward 102

Between January 2022 and April 2025, the average length of stay in Ward 102 has remained stable for Aberdeen City (average 2.7 days) and has increased for Aberdeenshire (average 3.3 days in 2022 to 4.3 over the past 12 months), resulting in an overall increase in length of stay. The number of admissions and average monthly boarders has decreased overall (noting a spike in boarders in Jan 2024, following a sharp decrease on opening surge beds). The number of bed days lost to delays in Ward 102 has increased, mirroring the increased in bed days lost at Rosewell House.

Delayed discharges (numbers) from City have remained very sporadic (only 6 delayed discharges total noted between Jan 22 to Dec 24), however Aberdeenshire have seen a noted and sustained increase in delayed discharges from December 2023.

There has been no notable impact of the closure of 10 Aberdeen City Frailty Beds based on the available data.

4.3.3. Hospital at Home (H@H)

In combination with the key elements of the Discharge Without Delay Programme of work, the Scottish Government remain committed to the expansion of Hospital at Home services in order shift the balance of care. The H@H service in ACHSCP has expanded over the last few years and is an essential and embedded part of the Frailty Pathway. The majority of admissions (approximately 73%) to the service come as Admission Avoidance (Step-Up), thereby bypassing the inpatient portion of the patient journey and reducing pressures on the Scottish Ambulance Service, front door and inpatient services. In the last 12 months the H@H service in Aberdeen City has saved approximately 10,000 bed days in the secondary care system.

Government expectations are that further expansion takes place, however funding to support this has yet to be agreed. Based on a commitment of 2,000 additional Hospital @ Home 'beds' and applying the National Resource Allocation Formula (NRAC) to identify a local target, it is likely that City's H@H service will be required to expand from a maximum capacity of 48 beds to 80 beds. This will further support the rebalance of care from in-patient to people's homes, potentially reducing demand for services at Rosewell House and meeting the step-up demand that it was initially envisaged that Rosewell House would provide.

4.4. Future Model & High Level Project Timescales

The DWD Collaborative programme consists of 4 closely related initiatives, with more detail given bellow. The Collaborative provided a set of 'guiding principles' which allowed HSCPs and Health Boards to assess their current performance against these principles to identify local key priorities and actions.

4.4.1. Discharge To Assess (D2A)

To ensure timely discharge and minimise hospital-induced dependency, services must offer responsive, community-based home care support, enabling patients to return home without unnecessary delay. As well as the benefits for the acute-system in terms of reducing length of stay, this model of care reduces the ongoing care need for an individual – the test of change demonstrated that 36% of patients cared for were able to remain at home with no further package of care.

Locally, Aberdeen City are making good progress developing plans to implement this service within the financial year. There is a paper on today's IJB agenda (01 July 2025) seeking approval of a business case to provide up to 1,000 hours of care at home, to support delivery of the Discharge to Assess service. It is difficult to quantify the number of people who can be supported by the service, given the varying levels of care needs, however it is a substantial increase to our capacity in the community to support discharge.

4.4.2. Frailty at the Front Door

Acute hospitals should implement early comprehensive geriatric assessment (eCGA) for identified frail older people, in Acute Frailty Units, as early in admission as possible. These units should be supported by Integrated Discharge Hubs, rehabilitation services, and when necessary, D2A pathways, facilitated through the Planned Date of Discharge (PDD) process. This approach ensures timely discharge and minimises the risk of hospital-induced dependency.

4.4.3. PDD/Integrated Discharge Hub

Acute hospitals should aim to establish a single point of referral for complex discharges, supported by a proactive multidisciplinary team (MDT) approach. This includes this team, with discharge facilitator input, setting a planned date of discharge (PDD) that is realistic and will result in discharge happening.

4.4.4. Community Rehab

These facilities should be adequately staffed and empowered to care for frail individuals requiring rehabilitation and extended assessments, ideally transitioning

from Frailty Units. Discharge back to the community should occur promptly through an agreed PDD process, ensuring no delays.

4.5. Achieving Our Future Model - Changing the Balance of Care

The aspirational model is one that delivers an integrated, multidisciplinary community model which can respond 24/7 as early as possible when a frail older person begins to show signs of a deteriorating condition. This will limit acute illness and ultimately, the need for hospital admission.

As the progress of implementing the nationally directed DWD initiatives and Hospital at Home expansion becomes apparent, it will provide opportunities to further reallocate our resource to support patients within their own homes and the community. Given the well-documented limited financial framework HSCPs are working in, it is necessary to realign existing resources in line with success from this national direction.

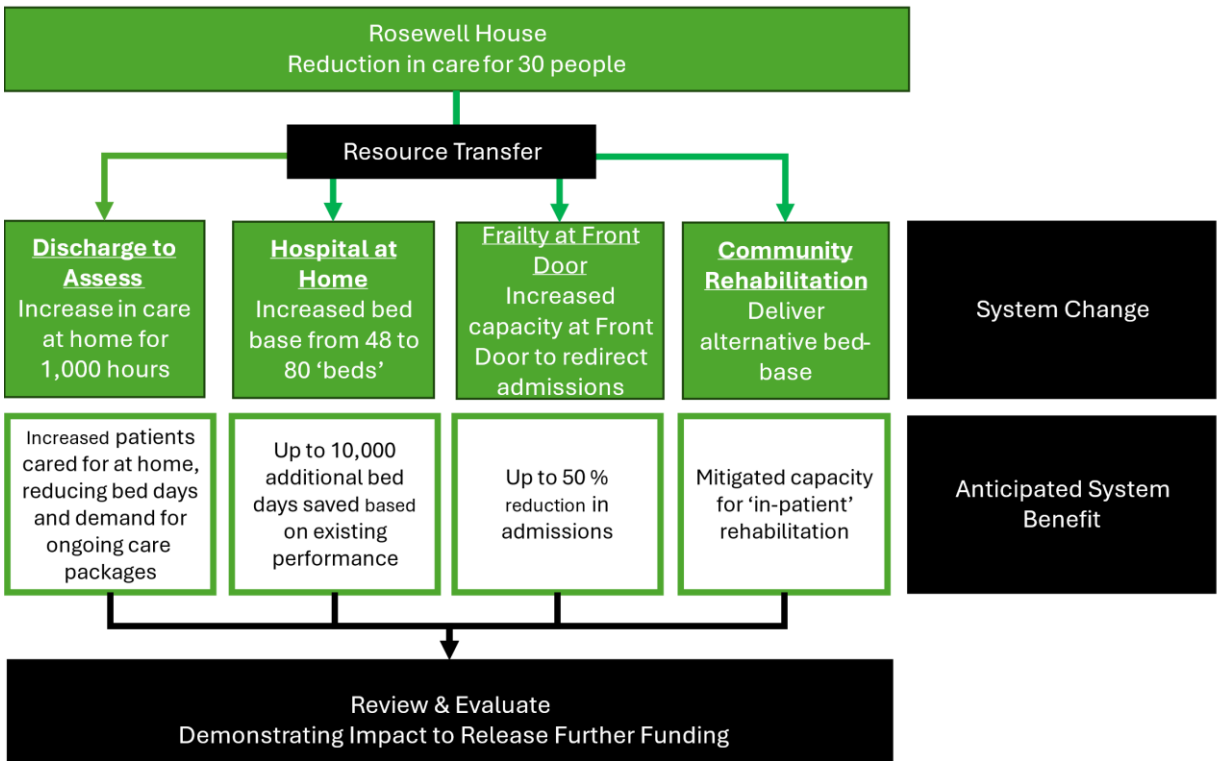
If the DWD initiatives are implemented successfully, it is expected that demand for bed-based intermediate care facilities will reduce, consequently reducing the need for the type of care provided at Rosewell House. For example, a 'Day of Care' audit of Aberdeen City patients who were delayed in Rosewell House in May, indicated that out of 16 delayed patients, up to 12 patients could have been more appropriately cared for through the Discharge to Assess model if funding had been released to explore a different model. Additionally, up to 50% of admissions at the Front Door could be avoided if geriatrician resource was freed up to support Frailty at the Front Door.

Therefore, the consequence of achieving the metrics set out by Discharge to Assess (see above) would be a reduction in demand at the Front Door and a reduction in demand for intermediate care, and the facility at Rosewell could be phased-down in response to this reduction in demand, freeing up more resource (both in terms of staffing and finances) to support further roll-out of the successful initiatives and delivery of their benefits:

- **Discharge To Assess (D2A)** – financial resource freed to support delivery of social care provider; realignment of Allied Health Professional staff to the service; increase in care in community of 1,000 hours supported by enhanced therapy input to mitigate reduction in bed base.

- **Frailty at the Front Door –** increased geriatrician capacity to support Front Door activity, realignment of Rosewell House staff to support Frailty at Front Door and Liaison service reducing the number of admissions required by up to 50%[8];
- **PDD/Integrated Discharge** – no direct resource transfer at this point.
- **Community Rehabilitation –** options are being explored to deliver several rehabilitation beds to support the revised model for those patients who are unable to return home directly.
- **Hospital at Home** – potential realignment of Rosewell House staff to support recruitment to expansion of the service through the organisational change process, increase in capacity from 48 to 80 beds (up to +10,000 bed days).

The below diagram summarises the intended system change and benefits. This demonstrates a clear link between reducing the in-house service at Rosewell House, and building on our capacity in the community in line with the strategic intent highlighted earlier in this paper. This will provide clear mitigations against the loss of capacity for these types of beds within Rosewell House, reducing demand and enabling more timely discharges.



[8] As anecdotally evidenced in small scale tests of change

The physical building at Rosewell House provides further opportunities to recommission a care model (such as residential or nursing care; or a complex care facility) which will further enhance capacity within the community.

The closure of beds within Rosewell House will commence following approval of this IJB paper, closing in 10-bed increments, with an aim of full closure by the end of the financial year. However the timeline for each phase of closure will require to be flexible to allow for increase in Discharge to Assess and impact on bed reduction to be reviewed as we step down Rosewell and step up Discharge to Assess.

In order to facilitate the phased closure, and ensure a mitigation should the intended benefits not be realised, there is a contingency fund to allow for ACHSCP to continue to hold the building running costs until the end of the financial year (March 2026). Therefore, if progress is not positive, capacity remains at Rosewell House.

This paper seeks endorsement of the approach for changing the balance of care, and the gradual moving of our resources to support this. To sustain the Discharge to Assess model, shifting resource from existing services is required:

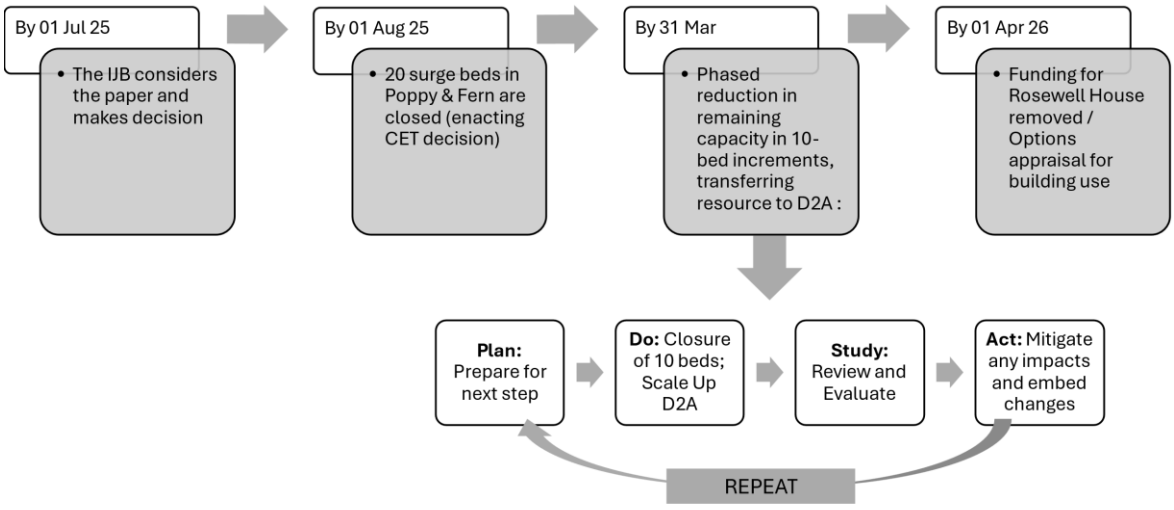


Figure 6: High Level Timeline

4.6. Assurance for the Future Model

The development and implementation of the future model is being taken forward with a Grampian-wide approach to governance and assurance. The ACHSCP Chief Officer sits on the Unscheduled Care Programme Board, ensuring clear assurance and oversight from the IJB's perspective. Project support is provided on a pan-Grampian basis at the project-level, with Aberdeen City contributing specifically towards the Frailty at the Front Door and Discharge to Assess Projects. The existing Discharge without Delay Group (chaired by the ACHSCP Chief Officer) will disband and realign into the downstream delivery group. Extensive communication and engagement has taken place across the system focusing on these governance changes, which has ensured good understanding and ownership of the different elements.

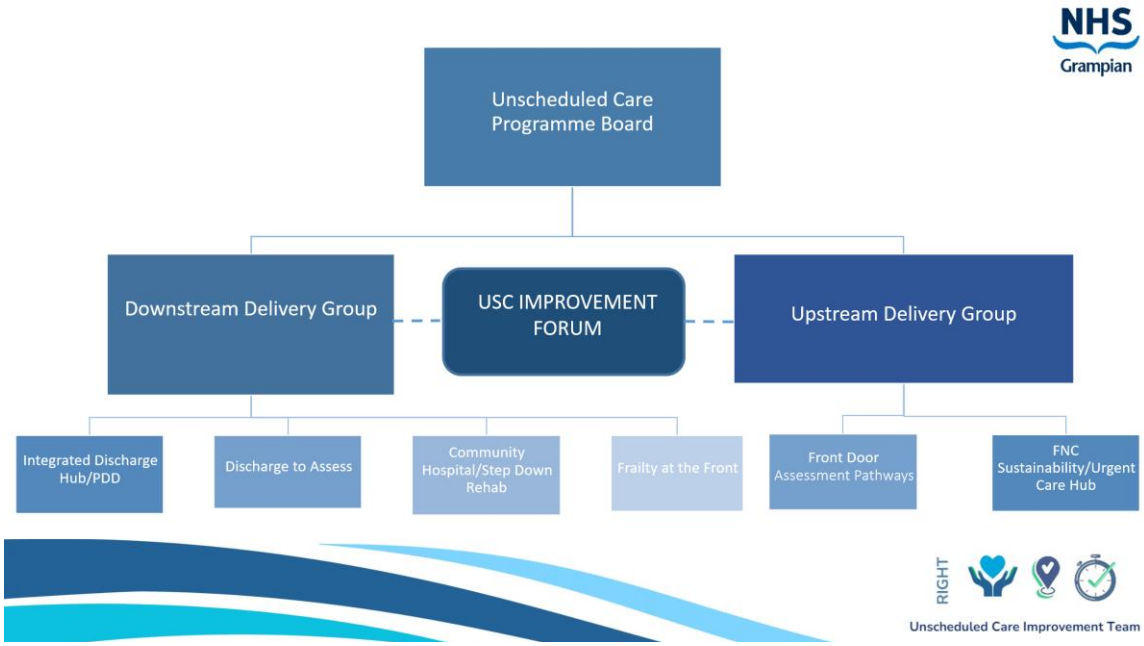


Figure 7: Governance diagram for DWD within NHS Grampian

5. Implications for IJB

5.1. **Equalities, Fairer Scotland and Health Inequality:** An integrated impact assessment has been completed and is included at appendix 1 of this report.

5.2. **Financial:** There are the following financial implications as arising from the recommendations of this report:

The total costs of delivering the service at Rosewell House was £6.4million per annum. Delivery of the DWD Commitments will be supported by redirecting this budget.

The closure of 10 beds from the ACHSCP-led bed base to ensure safe staffing levels will release £800,000 of financial resource in-year from reduction in bank spend. This resource will be realigned to support the introduction of the new Discharge to Assess service (contract value £1.6m per annum - see business case included with report HSCP.25.062 for further details)Further savings will be realised when Rosewell House is closed.

There is the possibility of additional specific funding from Scottish Government, to support the implementation of Discharge without Delay initiatives. However, due to the implications of NHS Grampian being in Level 4 of the Scottish Government's 'Support and Intervention' Framework, no funding will be confirmed locally until after the external review has been completed. Additionally, it is expected that once funding has been confirmed, it will be provided on a 'on delivery' basis – meaning that projects will need to demonstrate their impact *before* funding is released. Both of these factors mean that there is a greater need to shift our own resources to support delivery in the community in the first instance.

5.3. **Workforce:** There are implications for the workforce arising from the programmes of work outlined in this support. There will need to be a transfer of staff from in-patient settings to community-based services within people's homes in order to support the shift in the balance of care. Where this arises, the project will ensure to follow all formal organisational change processes and legislative requirements, as well as maintaining positive informal relationships with teams, trade unions and staff-side representatives to ensure a smooth transition for any affected staff members. There will be further positive implications for staffing including the opportunities provided by working closely as a multidisciplinary team in the community, working closely with other community partners who are not traditionally based in hospital settings, and supporting people in their own home.

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

5.5. **Unpaid Carers:** There are no direct implications for unpaid carer arising from the recommendations of this report, however the work outlined seeks

to improve service provision for their cared-for person and is expected to have a positive impact on unpaid carers.

5.6. **Information Governance:** There are no direct implications relating to information governance arising from the recommendations of this report. Each project outlined within the DWD Collaborative Programme may require information governance support to implement new processes or systems for information required to deliver the improvements. Information Governance from NHS Grampian has been closely involved in the development of the governance arrangements and is aware of the possibility of a request for their input as the projects progress.

5.7. **Environmental Impacts:** There is a possibility that the successful implementation of the Discharge without Delay Commitments reduces our need for a physical buildings footprint, which may have positive environmental impact. This will be countered to some degree by an increase in carbon footprint for staff travel however.

5.8. **Sustainability:** The proposals outlined in the paper aim to increase the IJBs sustainability both in terms of service provision and financial sustainability, by modernising service delivery and shifting the balance of care to meet anticipated demand.

5.9. **Other:** There are no other implications arising from the recommendations of this report.

6. Management of Risk

Risk Appetite Statement

Achievement of the priorities of the Discharge without Delay programme, and shifting the balance of care, will require the acceptance of a certain level of risk to support transitioning services to realise the benefits of the opportunities presented, which is within the tolerances as set out in the risk appetite statement linked above.

6.1. Identified risks(s)

Risk 1: There is a risk of impact on the Acute Sector (Front Door) during the transition between models outlined in the paper, resulting in increasing presentations and pressure for a time-limited period (Service Risk).

Cause	The period of time between phasing down existing service provision and implementing the alternative services.		
Effect /Event	Increased presentations at the Front Door.		
Likelihood	Medium	**Impact**	Medium
Controls		**Additional Mitigating Actions**	
• Monitoring of the impact of closure of 10 beds at Rosewell House have identified limited impact to date • Ongoing monitoring and evaluation		Options to mitigate the impact, which could be implemented in the case of evidence of increased impact include: • Implementation of DWD Initiatives will mitigate the impact on the Front Door. • Temporarily reinstating beds within Rosewell House or an alternative site within Woodend • Review of phased approach to shifting balance of care and pause / stop as appropriate	
Risks of non-implementation of the recommendations of this report			
The sustained and increasing delayed discharges and length of stay within Rosewell, coupled with the anticipated increasing demand in demographic changes, means that the risk of inaction results			

Risk 2: There is a risk that funding for the DWD initiatives, as a part of the Unscheduled Care, is unconfirmed (Financial Risk) .

Cause	Scottish Government have indicated that financial resource for the implementation of the DWD is likely to be awarded on delivery of the intended outcomes.		
Effect /Event	This could result in temporary financial pressures within ACHSCP awaiting confirmation and receipt of the funding.		
Likelihood	Medium	**Impact**	Low
Controls		**Additional Mitigating Actions**	
• Robust financial monitoring and internal audit processes		• Shifting balance of resource as outlined in this paper	
Risks of non-implementation of the recommendations of this report			
Not implementing the recommendations of this report could still result in increased financial risk due to the continued overspend on temporary staffing to support the current service model.			

Risk 3: There is a risk that elements of the programme are delayed due to interdependencies with other parts of the programme (Programme Risk).

Cause	Projects or partnership areas progress elements of DWD at different paces.		
Effect /Event	This may have an impact on the successful implementation of other parts of the programme – for example, successful delivery of elements of Frailty at the Front Door is dependent on an adequate resource in the community (Discharge to Assess)		
Likelihood	Medium	**Impact**	Medium
Controls		**Additional Mitigating Actions**	
• Robust governance process involving all three HSCPs and Acute NHS Grampian		• NA	
Risks of non-implementation of the recommendations of this report			
There is a risk that there continues to be inequity of delivery across the different areas of Grampian.			

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

Strategic Risk	**How might content of report impact or mitigate risk**
Risk 2 : There is a risk of IJB financial failure and projection of overspend	Outlines a process for shifting our internal resource to support delivery of priorities
Risk 3: There is a risk that hosted services do not deliver the expected outcomes, fail to deliver transformation of services, or face service failure	Outlines the identified priorities for the transformation of Frailty services, including the hosted element of acute frailty at ARI
Risk 4: There is a risk that the IJB, and the services it directions and has operational oversight of, fails to mee the national, regulatory and local standards	Outlines the plans for delivering on the Discharge without Delay commitments
Risk 5: There is a risk that the IJB experiences failure to deliver transformation and sustainable systems change	Outlines the identified priorities for the transformation of Frailty services and plans to deliver these
Risk 8: There is a risk that buildings across the city, operated by, or overseen by, the IJB /ACHSCP are not being used to maximum efficiency and are not in line with statutory /regulatory requirements	Outlines plans to withdraw from a building which is currently not being used to maximum efficiency

6.3 How might the content of this report impact or mitigate the known risks: see above