Aberdeen City Health & Social Care Partnership
A caring partnership

# INTEGRATION JOINT BOARD

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| **Date of Meeting** | 30th September 2025 |
| **Report Title** | Unscheduled Care Improvement – Aberdeen City Health & Social Care Partnership's Plan and Impact |
| **Report Number** | HSCP.25.074 |
| **Lead Officer** | Julie Warrender |
| **Report Author Details** | Julie Warrender, Chief Nurse and Lead for Frailty and Specialist Rehabilitation julie.warrender@nhs.scot |
| **Consultation Checklist Completed** | Yes |
| **Directions Required** | No |
| **Exempt** | No |
| **Appendices** | Appendix 1 – NHS Grampian Unscheduled Plan and Funding Phase 1 Overview |
| **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. |

## 1. Purpose of the Report

**1.1.** This report describes the detail of the Aberdeen City Health and Social Care (ACHSCP) part of the 2025 NHS Grampian Unscheduled Care (USC) plan and associated bid to the Scottish Government in April 2025 to help improve unscheduled care performance and patient outcomes (see appendix 1). The ACHSCP involvement is primarily focussed on the development and implementation of the Discharge without Delay (DwD) programme of work which links to the frailty pathway. ACHSCP has responsibility for frailty bed base in Aberdeen Royal Infirmary and wider city



ABERDEEN CITY COUNCIL NHS Grampian

residents (each HSCP has responsibility for their own bit of the frailty pathway). This links to paper HSCP.25.054 Shifting the Balance of Care – A Community-Focused Approach to Delivery of Frailty and Specialist Rehabilitation Services within Aberdeen City Health & Social Care Partnership submitted to the IJB on 1st July 2025.

## 2. Recommendations

**2.1.** It is recommended that the Integration Joint Board:

a) Note the details of ACHSCP's plan for the improvement of unscheduled care performance and patient outcomes in NHS Grampian, acknowledging the funding model and impact this is required to deliver.

b) Agree that in line with the ACHSCP Governance structure monitoring reports on this work should be routinely communicated via the ACHSCP Clinical Care and Governance Committee.

c) Financial oversight of spend against this additional money will be montiored through Risk, Audit & Performance Committee.

## 3. Strategic Plan Context

**3.1.** There is cohesive strategic direction that flows through from the Scottish Government to the ACHSCP Strategic Plan, which aims to support the modernising of service delivery and shifting the balance of care from an acute setting (in hospital) to the community. This forms the basis of the DwD programme of work.

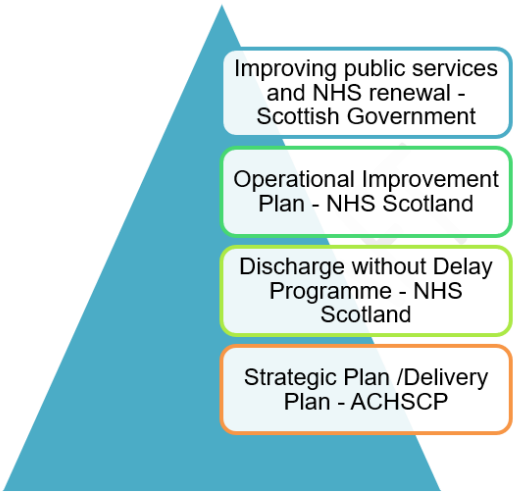


Figure 1: Strategic Context

## 4. Summary of Key Information

**4.1.** The ACHSCP Strategic Plan emphasises a whole system approach to reduce hospital occupancy and maximise community capacity. This will be achieved through the successful implementation of the DwD Programme which is committed to delivering outputs through winter 25/26 and shall be implemented fully by March 2026.

**4.2.** **Discharge Without Delay (DwD) Programme Summary:**
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*"[1].
The DwD programme has four key workstreams:


The outcomes of the DwD work locally are outlined in figure 2 (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

[1] Quote from 2025 Discharge without Delay Paper

deconditioning or negative consequences (such as hospital acquired infection), and a smoother, more supported transition back home after their hospital stay.

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| 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 programme aims to improve 4-hour whole system performance by 3-5 % points. |

Figure 2: DwD Key Outcomes

ACHSCP is represented on each of the four project workstreams of the DwD programme but has a lead role and focus on the successful implementation of Frailty at the Front Door and Discharge to Assess projects.

### 4.3. DwD – Frailty at the Front Door (F@FD)

The objective of this project is to provide specialist frailty assessment and intervention at the earliest stage of the patient journey, improving overall care and outcomes for frail patients by preventing unnecessary delays.

Resource & Funding: Funding of £803,000 has been approved as part of NHS Grampian's submission to the Scottish Government for the Unscheduled Care Plan. Payment is contingent upon demonstrated performance gains, which will be monitored by the Unscheduled Care Programme Board. The approved funds will recruit for the roles listed below.

| Role | Whole Time Equivalent (WTE) |
|---|---|
| Geriatrician | 1.3 |
| Allied Health Professionals (AHPs) | 6 |
| Discharge Coordinator | 2 |

Project Approach: The project will provide weekday Geriatrician coverage from 9am to 5pm for the frailty service, with Allied Health Professional support available daily from 7am to 7pm. Weekend Consultant support is provided by the on-call Geriatrician. The service includes Geriatricians in the Emergency Department (ED) and a multidisciplinary team following Home First principles, supporting frail patients across Aberdeen Royal Infirmary (ARI) site.

With funding secured, the F@FD team is focusing on developing, recruiting, and integrating these roles. A review of social work contribution on frailty wards and in the ED is underway to address barriers. Key objectives include identifying frail patients and documenting Clinical Frailty Scores in ED and AMIA to improve patient flow and experience at ARI.

Since June 2025, Geriatricians have been providing ad hoc consultations within the ED for patients in overspill areas. This initiative has resulted in approximately 50% of these patients being redirected from frailty wards, either through discharge or admission to a more appropriate specialty. The implementation of regular, structured Geriatrician engagement in the ED would allow for the assessment of a broader patient cohort, including those located in both majors and overspill areas. Additionally, enhanced community support and the development of a dedicated ED support team may facilitate earlier decision-making within the patient pathway, thereby increasing the number of patients managed appropriately outside of frailty wards.

The F@FD project is scheduled for completion by the end of March 2026, with anticipated impacts expected during the winter of 2025/26. Where evidence demonstrates positive outcomes from the project, funding will be allocated for 2026/27, and, contingent upon continued success, will become recurrent. Post-March 2026, efforts will focus on sustaining a holistic approach through ongoing evaluation and integration of DwD principles, in partnership with key stakeholders. This process will be monitored using defined datasets submitted at both national and local levels, specifically to the Unscheduled Care Programme Board and the Clinical Care and Governance Committee.

### 4.4. DwD – Discharge to Assess (D2A)

The primary objective of this project is to ensure that patients receive care in the most suitable setting, guided by a person-centred "Home First" philosophy. A critical component of this initiative is the provision of care specifically designed to facilitate prompt discharge from acute care settings, supporting individuals in their homes.

The D2A team will be responsible for conducting comprehensive care management assessments within the community, thereby minimising unnecessary hospital stays and enhancing patient outcomes. Care providers awarded the contract for the D2A service will collaborate closely with acute services, community teams, Allied Health Professionals (AHPs), and social care partners to deliver holistic support during the essential transition period.

This integrated model aims to maintain delayed discharges at ARI at no more than five patients wherever feasible, reflecting the joint commitment of Aberdeen City and Aberdeenshire HSCP's.

Resource & Funding: Resources are being reallocated from the closure of Rosewell House, an integrated care facility, to provide ongoing funding for the Discharge 2 Assess model. A new provider has been contracted, and therapy resources are being transitioned into the community to support this approach. The care provision team will integrate with the front door and integrated discharge hub teams to promote effective implementation of the Home First ethos.

Project Approach: Community therapy teams, Hospital at Home, and D2A will operate as a unified community service. Therapy resources will be deployed flexibly across teams to accommodate increased demand and facilitate step-down processes as required.

**4.5. Additional Funding Bid**

In addition to the confirmed funding of £803,000, an application for a further £656,300 has been submitted to enhance patient flow within ACHSCP's remit. This proposal is presently under review by the Scottish Government. Subject to approval, the additional resources will strengthen system capacity by increasing the availability of Interim Care Beds and expanding Care@Home hours, as outlined below:

**Interim Care Beds** – During the winter period, acute healthcare services face increased pressures stemming from respiratory illnesses, higher rates of frailty related admissions, and challenges in discharging patients. Interim care facilities serve as transitional environments for individuals who are medically fit for discharge but cannot immediately return home or transition to long-term care. Expanding the number of interim care beds reduces hospital occupancy, mitigates ambulance response times, and supports more efficient patient transitions. Funding five interim care beds over six months totals £168,000, contributing to overall system resilience, protecting

scheduled care activities, and optimising the use of both acute and community health resources during periods of peak demand.

**Care@Home** – The planned expansion of Care@Home provision is integral to reducing delayed discharges and ensuring individuals receive appropriate support in their own homes. By increasing service capacity, particularly during high-demand periods, this initiative facilitates timely hospital discharge, decreases unnecessary readmissions, and enhances patient outcomes. The proposed addition of 700 Care@Home hours per week, costing about £400,000, plus £88,300 allocated for equipment, aims to ease Discharge to Assess bottlenecks and enhance overnight care.

**4.6. Additional System Support - Hospital at Home (H@H) Expansion**

The expansion of H@H services forms an additional cornerstone of the unscheduled care plan, aligning with national priorities to shift the balance of care from acute settings to community-based provision. Within ACHSCP, the service has already demonstrated significant impact, saving approximately 10,000 bed days in the past year and achieving 73% of admissions through admission avoidance pathways.

Further expansion of the H@H service (from 48 to 80 beds) in line with the Scottish Government's commitment to deliver 2,000 beds nationally by December 2026 expansion aims to alleviate the strain on inpatient services and reduce ambulance turnaround times. Following discussions in September with Scottish Government colleagues, additional funds of £1.5M have been allocated for expansion of H@H. Preliminary discussions have considered extending the City service boundaries to encompass areas within Aberdeenshire, along with the establishment of a potential hub in the North of Aberdeenshire, overseen by Aberdeen City.

Collectively, these measures aim to create a resilient, whole-system response to unscheduled care demands while improving patient outcomes and equity of access.

## 5. Implications for IJB

**5.1. Equalities, Fairer Scotland and Health Inequality:** An integrated impact assessment has been completed, Shifting the Balance of Care – Community Focused Approach to Delivery of Frailty and Specialist

Rehabilitation Services within Aberdeen City Health & Social Care Partnership (see paper HSCP.20.054 1st July 2025)

**5.2.** **Financial:** Funding for the delivery of the DwD programme will be provided by the Scottish Government retrospectively as outcomes are delivered. For monies to be recurring the evidence of impact will be required to be sustained into 2026 – 2027.

**5.3.** **Workforce:** 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 the employing 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. Any new staff being recruited will have Job Descriptions that allows for working flexibly across the frailty pathway.

**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 relating to unpaid carers 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 information governance implications arising from the recommendations of this report.

**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 direct implications arising from the recommendations of this report.

## 6. Management of Risk

**Risk Appetite Statement**

Achievement of the ACHSCP 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 financial risk around funding for the DwD projects, it is essential that funding provided it recurring.

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|---|---|---|---|
| **Cause** | Scottish Government have recently agreed to release £3.3 million of funding to NHS Grampian to support their improvements to unscheduled care. £803,000 of this funding has been confirmed for Frailty at the Front Door, this funding will be provided retrospectively as outcomes are delivered, and any recurring monies will be performance based. | | |
| **Effect /Event** | This could result in temporary financial pressures within ACHSCP awaiting confirmation and receipt of the funding. | | |
| **Likelihood** | Medium | **Impact** | Low |
| **Controls** | | | |
| Robust financial monitoring and internal audit processes | | | |

**Risk 2:** There is a risk that elements of the DwD programme are delayed due to interdependencies with other parts of the programme.

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| **Cause** | Projects or partnership areas (Aberdeen Shire and Moray HSCP) 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 |
|---|
| Robust governance process involving all three HSCPs and Acute NHS Grampian with performance and risks shared across the three partnerships. |

**Risk 3:** There is a risk of an increase to workload on Primary Care, this also extends to the GMED service for out of hours cover.

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| **Cause** | With an increase in the number of patients with more complex care in the community. | | |
| **Effect /Event** | Any significant increase in workload on Primary Care / GMED will impact on the efficiency and capacity of these already stretched services. | | |
| **Likelihood** | Medium | **Impact** | Medium |
| **Controls** | | | |
| Robust criteria will be in place for identifying patients for the Discharge to Assess model.<br>Inpatient rehabilitation beds will continue to be provided for those patients with the greatest need.<br>The Discharge to Assess model includes care and support delivered over 24hrs.<br>The H@H service will support (where required) the 'step-up' of patients from the community setting.<br>Involvement of affected stakeholders to the development and integration of the Discharge to Assess model. | | | |

### 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 directs has operational oversight of, fails to meet 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 | Outlines the identified priorities for the transformation of Frailty services and plans to deliver these |

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| transformation and sustainable systems change | |
| 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 sections 6.1 and 6.2 above.