



Audit, Performance and Risk Committee

Thursday, 24 June 2021

remote locations via video conference

NOTICE IS HEREBY GIVEN that a Meeting of the **Audit, Performance and Risk Committee** is to be held at **remote locations via video conference**, on **Thursday, 24 June 2021** at **10:30** to consider the business noted below.

AGENDA

1. **Welcome and Apologies**
2. **Declaration of Member's Interests**
3. **Minute of the Meeting of 25 March 2021** 5 - 8
4. **Action Log of Meeting of 25 March 2021** 9 - 10
5. **Quarter 4 Performance** 11 - 50
6. **Internal Audit Update - Annual Opinion** 51 - 64
7. **Strategic Risk Register - June 2021** 65 - 92
8. **Internal Audit Plan** 93 - 96
9. **Primary Care Improvement Plan Update** 97 -
102
10. **Home First Performance and Risk** 103 -
178

MORAY INTEGRATION JOINT BOARD

MEMBERSHIP

Mr Sandy Riddell (Chair)

Professor Nicholas Fluck (Member)

Councillor Frank Brown (Member)

Councillor Theresa Coull (Member)

Mr Steven Lindsay (Non-Voting Member)

Ms Heidi Tweedie (Non-Voting Member)

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Clerk Email:	committee.services@moray.gov.uk



MINUTE OF MEETING OF THE INTEGRATION JOINT BOARD

AUDIT, PERFORMANCE AND RISK COMMITTEE

Thursday, 25 March 2021

remote locations via video conference

PRESENT

Councillor Theresa Coull, Councillor Frank Brown, Mr Sandy Riddell, Ms Tracey Abdy, Mr Simon Bokor-Ingram, Mrs Jane Mackie, Ms Elidh Brown and Mr Atholl Scott

APOLOGIES

Mr Sean Coady, Mr Nick Fluck and Mr Steven Lindsay

IN ATTENDANCE

Also in attendance at the above meeting was Mr Bruce Woodward, Senior Performance Officer; Mrs Jeanette Netherwood, Corporate Manager; Maggie Bruce, Audit Scotland; Pauline Maloy, Health Intelligence; Jo Duncan, Quality Improvement and Performance; and Mrs Isla Whyte, Interim Support Manager, as clerk to the Board.

1. Chair of Meeting

The meeting was chaired by Cllr Coull.

2. Welcome and Apologies

The Chair welcomed everyone to the meeting and apologies were noted.

3. Declaration of Member's Interests

There were no declarations of Members' Interest in respect of any item on the agenda.

4. Minute of Board Meeting dated 26 November 2020

The Minute of the meeting dated 26 November 2020 was submitted for approval.

The Board agreed to approve the minute as submitted.

5. Action Log of Board Meeting dated 26 November 2020

The Action Log of the meeting dated 26 November 2020 was discussed and updated accordingly at the meeting.

6. Quarter 3 (October - December 2020) Performance Cover Report

A report by the Chief Financial Officer updates the Committee on its performance as at Quarter 3.

Bruce Woodward reported performance has improved over the last quarter. Impact of COVID-19 is now evident through indicators presented. Changes to routine procedures in services has resulted in improvements in both indicators relating to mental health and delayed discharges. Development on key social work indicators is underway to understand the pressures within the social care system.

Data measures on operational indicators is presented to the appropriate management groups for ongoing consideration and refinement. Work will continue to review and reassess the indicators and set targets that are realistic taking into consideration and aligning to new ways of working. Comparisons to previous years' trends will be drawn once services fully re-mobilise.

It should be recognised that the long-term implications of the pandemic are yet to be realised.

Appendix 2 provides information to the Committee around emergency readmissions and why rates have increased and that they are returning to normal.

CLlr Brown asked for further information around the outstanding social work assessments. Mrs Mackie stated the backlog is a result of the pandemic. Outcome based work will mitigate this risk long term. Short term, social care are prioritising work and it may be additional hours are required to reduce backlog.

After discussion the Committee agreed the target set for delayed discharges is too high. Mr Bokor-Ingram suggested the target should be 10. A comprehensive narrative should then be included if delayed discharges reach double figures.

The Committee noted the performance of local indicators for Quarter 3 and the analysis of the local indicators that have been highlighted and actions being undertaken to address the performance that is outside of acceptable target ranges.

The Committee also agreed an additional recommendation:

- I. Reset the delayed discharge target at 10 with a commensurate reduction in target for bed days to be agreed.

7. Internal Audit Update

A report by the Chief Internal Auditor provides the Committee with a progress update since the last meeting of the Committee in November and on the implications for audit planning for the 2021/22 financial year.

While work on service specific audits has been limited during the year, a focus has been maintained on the integrity of key system ie payroll and creditor payments.

A further meeting is scheduled for mid-April to progress joint working across NHS Grampian. Should the Moray Integration Joint Board (MIJB) seek greater assurances from the Health Board than current arrangements provide, further work will be required to assess how this can be achieved. Through integration and activities such as Discharge to Assess (D2A) there may potentially be aspects that need to be brought together for audit.

Some discussion with external audit is still to take place to reach a definitive review with regards to audit opinion.

Audit planning for 2021/22 is underway, aim to have a firm program to take back to the next Committee meeting once the position with lockdown easing becomes clearer.

The Committee noted the audit update.

8. Strategic Risk Register – March 2021

A report by the Chief Officer provides the Committee with an overview of the current strategic risks, along with a summary of actions which are in place to mitigate those risks, updated March 2021.

Long term impact of COVID-19 on services, population and staff health & wellbeing are yet to be identified.

It was agreed to change the wording within the risk register under the mitigating actions for the first risk to 'MIJB member briefings' as opposed to 'MIJB voting member briefings'. It was confirmed weekly newsletters have been and will continue to be issued to members. MIJB development sessions are also now taking place regularly, although it was noted it will be beneficial when these can take place face to face again.

The Committee noted the contents of the report and the updated Strategic Risk Register, noting it will be further refined to align with the transformation plans as they evolve.

9. Civil Contingencies – Resilience Standards

A report by the Corporate Manager informs the Committee of HSCM's progress against the NHS Grampian's Resilience Improvement Plan 2019-2021 and provide an overview of the work of the HSCM Civil Contingencies Group.

The Committee was informed that from 17 March 2021 IJBs are included as Category 1 Responders under the Civil Contingencies Act 2004 (Scotland). This places some additional duties on IJBs. From December 2020 HSCM have been

attending Local Resilience Partnership (LRP) meetings. Managers are working closely with colleagues in the LRP, Moray Council and NHS Grampian to ensure that necessary plans are in place.

There have been two recent gas outages in Keith and Huntly. Debriefs are being undertaken at the moment and that will help inform any improvement actions required.

The Committee noted the contents of this report alongside the HSCM Civil Contingencies Group action plan and progress to date and request an annual assurance report from the HSCM Civil Contingencies Group.

11. External Audit Plan for Year Ending 2020-21

A report by the Chief Financial Officer informs the Committee of the Auditor's Annual Plan for 2020/21.

Maggie Bruce, Audit Scotland, attended the meeting to take members through the annual audit plan. It was noted the plan follows the same format as previous years.

MIJB is required to submit the Unaudited Annual Accounts along with supporting working papers to Audit Scotland by 30 June 2021 following consideration by those charged with governance at the meeting of the MIJB on 24 June 2021. The MIJB will be asked to approve the audited annual accounts and to consider the Annual Audit Report at its meeting of 25 November 2021.

The Committee considered and noted the contents of the External Auditor's Annual Plan for 2020/21.



MEETING OF MORAY INTEGRATION JOINT BOARD

AUDIT, PERFORMANCE AND RISK COMMITTEE

THURSDAY 25 MARCH 2021

ACTION LOG

ITEM NO.	TITLE OF REPORT	ACTION REQUIRED	DUE DATE	ACTION BY
1.	Action Log of Meeting dated 27 August 2020	Payment Verification Assurance Update – once through appropriate NHSG Governance route	June 2021	Sean Coady
2.	Civil Contingencies – Resilience Standards Progress	Annual Assurance report requested from Health and Social Care Moray Civil Contingencies Group	March 2022	Jeanette Netherwood
3.	Strategic Risk Register – August 2020	Report on Home First approach – setting out changes required and evaluation of current position, performance and risks	June 2021	Simon Bokor-Ingram
4.	Strategic Risk Register	To be circulated to Clinical and Care Governance Committee for oversight and scrutiny in future	ongoing	Jeanette Netherwood
5.	Internal Audit Update – March 2021	Present Audit Programme for 2021/22	June 2021	Atholl Scott



REPORT TO: MORAY INTEGRATION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE ON 24 JUNE 2021

SUBJECT: QUARTER 4 (JANUARY – MARCH 2021) PERFORMANCE COVER REPORT

BY: CHIEF FINANCIAL OFFICER

1. REASON FOR REPORT

1.1 To update the Audit, Performance and Risk (APR) Committee on performance as at Quarter 4 (January – March 2021).

2. RECOMMENDATION

2.1 It is recommended that the APR Committee consider and note:

- i) the performance of local indicators for Quarter 4 (January – March 2021) as presented in the Performance Report at APPENDIX 1;
- ii) the analysis of the local indicators that have been highlighted and actions being undertaken to address performance that is outside of acceptable target ranges as detailed in APPENDIX 1;
- iii) the published National Indicators for Moray for 2019/20 are included in APPENDIX 2. A further update report on performance for 2020/21 will be provided to this committee in August 2021
- iv) The draft Annual Performance Report will be submitted to this committee in August 2021.

3. BACKGROUND

3.1 The purpose of this report is to ensure the Moray Integration Joint Board (MIJB) fulfils its ongoing responsibility to ensure effective monitoring and reporting on the delivery of services and on the programme of work as set out in its Strategic Plan.

3.2 **APPENDIX 1** identifies local indicators for the MIJB and the functions delegated by NHS Grampian and Moray Council, to allow wider scrutiny by the Board.

4. **KEY MATTERS RELEVANT TO RECOMMENDATION**

- 4.1 Local Indicators are assessed on their performance via a common performance monitoring Red, Amber, Green (RAG) traffic light rating system.

<i>RAG scoring based on the following criteria:</i>	
GREEN	If Moray is performing better than target.
AMBER	If Moray is performing worse than target but within agreed tolerance.
RED	If Moray is performing worse than target by more than agreed tolerance.

- 4.2 The detailed performance report for quarter 4 is attached in **APPENDIX 1**.

Summary

- 4.3 Performance within Health and Social Care Moray (HSCM) as demonstrated by the agreed indicators up to the end of quarter 4 of the financial year 2020/21 is showing as mixed. While three of the indicators are presenting as green, one is amber and 2 are now red.
- 4.4 The two indicators shown under the Delayed Discharge heading (DD-01 and DD-02) are red and are currently well above the new targets set at the end of quarter 3. However it should be noted that this is the third quarter in a row there has been a decrease in both measures and there has been a significant decrease in comparison to the figures shown at quarter 4, 2019/20. Efforts remain focussed on sustaining progress made and continuing to reduce these figures.
- 4.5 Hospital Re-admissions (HR-01 and HR-02) relate to the rates for Moray residents of % emergency readmissions to hospital in a given month, within 7 or 28 days of a previous discharge. A detailed explanation was provided to this committee on 25 March 2021 (para 6 of the minute refers) The rates remain high as anticipated for this quarter, however it is predicted an improvement will be shown once elective admissions and treatment restart, which will result in the total discharges from hospital increasing.
- 4.6 An expanded summary is contained in section 2 of **APPENDIX 1**, along with detailed information for each indicator.
- 4.7 The table below (Figure 1) gives a summary and the historical trend by indicator since quarter 4 2019/20.

Figure 1 – Performance Summary

Code	Barometer (Indicator)	Q4 1920	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Target	Deviation
DD	Delayed Discharge (New Targets for Q4)							
DD-01	Number of delayed discharges (including code 9, Census snapshot, at end of quarter)	35	10	27	23	17	10	
DD-02	Number of Bed Days Occupied by Delayed Discharges per quarter (inc code 9) 18+ population	1,208	242	803	672	496	304	
EA	Emergency Admissions							
EA-01	Rate of emergency occupied bed days for over 65s per 1000 population	2,170	2,087	2,040	1,840	1,780	2,107	
EA-02	Emergency Admissions rate per 1000 population for over 65s	182.7	178.6	179	180	174.8	179.8	
EA-03	Number of people over 65 years admitted as an emergency in the previous 12 months per 1000 population	125.2	122.3	123.3	123	119.4	124.6	
AE	Accident and Emergency							
AE-01	A&E Attendance rate per day per 1000 population (All Ages)	17.5	15.8	17.9	16.8	17.8	21.7	
HR	Hospital Re-Admissions							
HR-01	% of Emergency Readmissions to hospital within 28 days - Moray Patients	6.5%	11.0%	9.8%	9.2%	9.8%	8.4%	
HR-02	% of Emergency Readmissions to hospital for within 7 days - Moray Patients	3.1%	4.3%	4.6%	4.2%	5.0%	4.2%	
UN	Unmet Need							
UN-01	Number of Long Term Home Care hours unmet at weekly Snapshot	-	623	523	578	465	Data only for first year	
UN-02	Number of People requiring Long Term homecare hours unmet at weekly Snapshot	-	36	44	35	31	Data only for first year	
OA	Outstanding Assessments							
OA-01	Number of Reviews Overdue at end of quarter snapshot	-	1506	1608	1655	1242	Data only for first year	
MH	Mental Health							
MH-01	Percentage of patients commencing Psychological Therapy Treatment within 18 weeks of referral	25%	24%	23%	100%	100%	90%	
SM	Staff Management							
SM-01	NHS Sickness Absence (% of Hours Lost)	4.60%	3.10%	3.60%	3.60%	3.10%	4%	
SM-02	Council Sickness Absence (% of Calendar Days Lost)	9.08%	6.43%	6.13%	6.22%	6.21%	4%	
* Figure taken from Management Data, not yet verified ** Figure taken from Feb 21 Data NYA - Not Yet Available								

4.8 **Appendix 2** shows the Moray information for the National Core Suite of Integration Indicators for 2019/20.

4.9 Indicators NI-1 to NI-9 are generated from the Health and Care experience survey 2019/20 (HACE) which is undertaken every two years. The HACE asks about people’s experiences of; accessing and using their GP practice and Out of Hours services; aspects of care and support provided by local authorities and other organisations caring responsibilities and related support. In Moray there were 2,237 respondents out of a 6,438 (35% response rate). The results are showing a decrease in performance which is not in line with strategic intention. This information has been recently published so there is a need for further consideration of the results and comparison with local data to identify actions that need to be taken.

4.10 Indicators NI-12, 13, 14, 15, 16 and 20 show Moray is maintaining good performance against the national average during 2019/20. (Indicators 10, 21, 22 and 23 are not currently reported as either national data is not available or there is not yet a nationally agreed definition).

4.11 Information relating to 2020/21 indicators was only published on 10 June 2021 so is in the process of being reviewed. An updated report on progress against these indicators will be submitted to this committee in August 2021.

4.12 The Scottish Government have advised that the Coronavirus Scotland Act (2020) has been extended to 30 September 2021. Subsequently, Integration

Authorities can delay the release of their Annual Performance Report until November 2021 using the same mechanisms as last year and as laid out in Coronavirus Scotland Act (2020), Schedule 6, Part 3. Public Health Scotland (PHS) have also issued guidance to Integration Authorities for 2020/21 Annual Performance Reports in relation to which release of Core Suite Integration Indicators to be referred to. It is therefore intended that the draft Annual Performance Report for 2020/21 will be submitted to this committee in August 2021 and then subsequent consideration by the Board in September 2021 prior to approval and publishing.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan “Moray Partners in Care 2019 – 2029”

Performance management reporting is a legislative requirement under section 42 of the Public Bodies (Joint Working) (Scotland) Act 2014.

In addition to publishing an Annual Performance Report, the Moray Integration Scheme requires that the MIJB will “monitor the performance of the delivery of integrated services using the Strategic Plan on an ongoing basis” (para 5.2.2 of the Moray Integration Scheme refers).

(b) Policy and Legal

None directly associated with this report.

(c) Financial implications

None directly associated with this report.

(d) Risk Implications and Mitigation

There are no risk issues arising directly from this report. The long term impact of the COVID-19 on the Health and Social Care system are still unknown and performance measurement will remain flexible to enable the service to be prepared and react to any future developments.

(e) Staffing Implications

None directly associated with this report.

(f) Property

None directly associated with this report.

(g) Equalities/Socio Economic Impact

An Equality Impact Assessment is not required for the Performance Framework because there will be no impact, as a result of the report, on people with protected characteristics.

(h) Consultations

Chief Officer, Strategic Planning and Performance Lead/DCO, Chief Financial Officer, Corporate Officer and Service Managers in relation to respective areas, HSCM and Tracey Sutherland, Committee Services Officer, Moray Council have been consulted and comments incorporated in the report.

6. CONCLUSION

- 6.1 This report provided the MIJB with an overview of the performance of specified Local and National indicators and outlines actions to be undertaken to improve performance in Section 4 and expanded on in APPENDIX 1.**
- 6.2 The National Core Suite of Integration Indicators for 2020/21 have recently been published and will be presented to the next committee along with the draft Annual Performance Report.**

Author of Report: Bruce Woodward, Senior Performance Officer
Background Papers: Available on request
Ref:



PERFORMANCE REPORT

QUARTER 4 2020/21

(1 JANUARY 2021 – 31 MARCH 2021)

1. TABLE OF CONTENTS

1. Table of Contents.....	1
2. Performance Summary	3
Commentary.....	3
Delayed Discharge – RED	3
Emergency Admissions - GREEN	3
Accident and Emergency - GREEN	3
Hospital Re-admissions - RED	3
Unmet Need – DATA ONLY	4
Outstanding Assessments – DATA ONLY	4
Mental Health - GREEN.....	4
Staff Management – AMBER	4
Barometer Overview	5
3. Delayed Discharge - RED.....	6
DD-01: Number of delayed discharges (including code 9, Census snapshot, at end of quarter)	7
DD-02: Number of Bed Days Occupied by Delayed Discharges per quarter (inc code 9) per 1000 18+ population	8
4. Emergency Admissions - GREEN.....	9
EA-01: Rate of emergency occupied bed days for over 65s per 1000 population.....	10
EA-02: Emergency Admissions rate per 1000 population for over 65s	11
EA-03: Number of people over 65 years admitted as an emergency in the previous 12 months per 1000 population	12
5. Accident and Emergency – GREEN	13
AE-01: A&E Attendance rates per 1,000 population (All Ages).....	14
6. Hospital Re-admissions - RED	15
HR-01: Percentage of Emergency Re-admissions to hospital within 28 days - Moray Patients	16
HR-02: Percentage of Emergency Re-admissions to hospital within 7 days - Moray Patients	17
7. Unmet Need – For Info	18
UN-01: Number of Long-Term Home Care hours unmet at weekly Snapshot.....	19
UN-02: Number of People with Long-Term Care hours unmet at weekly Snapshot	20
8. Outstanding Assessments – For Info	21
OA-01: Number of REVIEWS OUTSTANDING AT END OF QUARTER SNAPSHOT	22
9. Mental Health - GREEN.....	23
MH-01: Percentage of patients commencing Psychological Therapy Treatment within 18 weeks of referral.....	24
10. Staff Management - RED	25

SM-01: NHS Sickness Absence % of Hours Lost	26
SM-02: Council Sickness Absence (% of Calendar Days Lost).....	27
Appendix 1: Key and Data Definitions	28
RAG Scoring Criteria	28
Peer Group Definition	28
Appendix 2: Strategic Priorities.....	29
Appendix 3: National Health and Wellbeing Outcomes	31

2. PERFORMANCE SUMMARY

COMMENTARY

DELAYED DISCHARGE – RED

It was agreed at the Audit, Performance and Risk Committee meeting on 25 March 2021 that the target for the snapshot number of Delayed Discharges was to change to 10 from 25. As a result the target for number of bed days occupied has been adjusted to 304. These changes to targets are effective from this quarter onwards.

The number of delays at snapshot (**17**) and number of bed days lost due to delayed discharges (**496**) have decreased again this quarter. Whilst there was a sharp increase and resultant peak in October there has been a steady decrease in both measures and it is hoped the continued focus on refining the process will result in continued improvements.

EMERGENCY ADMISSIONS - GREEN

There was a reduction of 18% in the number of Bed Days Occupied from Mar 20 (**2,170**) to Mar 21 (**1,780**) that is not mirrored in the number of people over 65 admitted in an emergency, which only reduced by 5% (**125.2** to **119.4**)

In line with infection prevention and control guidelines there has been a reduction in the number of beds available at Dr Gray's and Community Hospitals, this is likely to have had an impact on the number of admissions.

ACCIDENT AND EMERGENCY - GREEN

There has been an increase in the rate per 1,000 this quarter from 16 to **17.8**. This is still below the target of 22. This is just below the number presenting at the over the same period last year. While the rate in January 2021 was low (likely due to increased lockdown measures and the Flow Navigations Hub redirecting people) there has been an increase in this rate through February and March.

This increase is in number of those in Flow 1 presenting (Minor Injury and Illness, including care provided in A&E Departments, in Minor Injury Units and through schemes such as See and Treat). Flows 2, 3 and 4 remain at relatively consistent levels as they have done throughout the pandemic.

HOSPITAL RE-ADMISSIONS - RED

Both indicators in this barometer are red and are not decreasing significantly since the Q1 2020-21 spike. 28 day re-admissions are **9.8%** and 7 day Re-admissions are at **5%**. These are both above target.

Elective treatment is yet to be resumed and this means that the total discharge numbers remain low and consequently the rate per Discharge remains high.

UNMET NEED – DATA ONLY

The number of people and the number of unmet homecare hours at the weekly snapshot have both reduced over the last quarter. The number of hours outstanding is 465 spread across 31 people.

This indicator was developed to provide some information regarding areas where there is demand for services that is not currently being met. It has been identified that there are other areas where demand exceeds supply and these are being collated and reviewed at an operational level to ensure appropriate prioritisation.

OUTSTANDING ASSESSMENTS – DATA ONLY

Due to a change in the reporting method and a data cleansing exercise the data from Q1, 2 and 3 is not comparable with Q4 data (therefore no trend line is presented). It is notable that the data is still showing a high number of reviews outstanding with 1,242.

Over the last two years an average of 364 reviews have been closed every month.

MENTAL HEALTH - GREEN

After 24 months below target and a year at around 20% this measure is at **100%** for the second quarter in a row.

Adult mental health are currently experiencing staffing difficulties due to long term absence and a member of staff leaving to take up a post elsewhere in Scotland. Interviews this week for replacement. However, despite this, the service continues to see patients within targets. The situation will be kept under review.

STAFF MANAGEMENT – AMBER

Council Health and Social Care Moray employees maintain a **6.2%** days lost absence rate. This represents a significant decrease on the 9.1% rate in Q4 2019-20 however it remains 2.2% above the target of 4%.

NHS Staff sickness is **3.1%** against a target of 4%.

Staffing levels are being monitored closely especially with the potential impacts on teams if individuals are required to self-isolate as a result of potential exposure to Covid-19.

BAROMETER OVERVIEW

Moray currently has **14 local indicators underpinning 8 Barometers**. Of these Barometers **3 are Green** and **2 are Red** and **1 is Amber**. There are 2 barometers that are new and have targets pending.

Figure 2 – Performance Summary

Code	Barometer (Indicator)	Q4 1920	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Target	Deviation
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	* Figure taken from Management Data, not yet verified ** Figure taken from Feb 21 Data NYA - Not Yet Available							

3. DELAYED DISCHARGE - RED

Trend Analysis

The number of delays at snapshot (17) and number of bed days lost due to delayed discharges (496) have decreased again this quarter. While there was a sharp increase and resultant peak in October there has been a steady decrease in both measures to what would have been well below the previous target of 25, but is well above the new target of 10.

Operational Actions and Maintenance

The level of work being undertaken across the Moray system continues to strive to attain targets. All teams across the system are continuing with improvement work across the system.

The aims continue:

- To support a reduction in delayed discharge
- To reduce the risks to patients from unnecessary time spent in hospital
- To ensure that processes are sustainable
- That we have appropriately resourced teams across the system

Work continues with the recognized Areas of Improvement, with particular emphasis on:

- Communications
- Pathways
- Capacity and Performance
- Planned Discharge Dates

A great deal of work has been embarked on and that work continues to be progressed to support the aims of Delayed Discharges. For example:

- Community Hospital Waiting lists continue to be monitored
- Patient transport for transfer and discharge being explored
- Prescriptions for discharge being progressed with e-Health
- A Business Case to secure permanent Discharge Coordinator(s)
- Ongoing improvement work with Dr Gray's, Aberdeen Royal Infirmary and Moray Community Hospitals
- Process mapping work at both Grampian and Moray levels

This continues to have a positive impact on our performance since Q2 and it is anticipated that this will continue to progress, despite some marginal glitches in the flow in recent weeks.

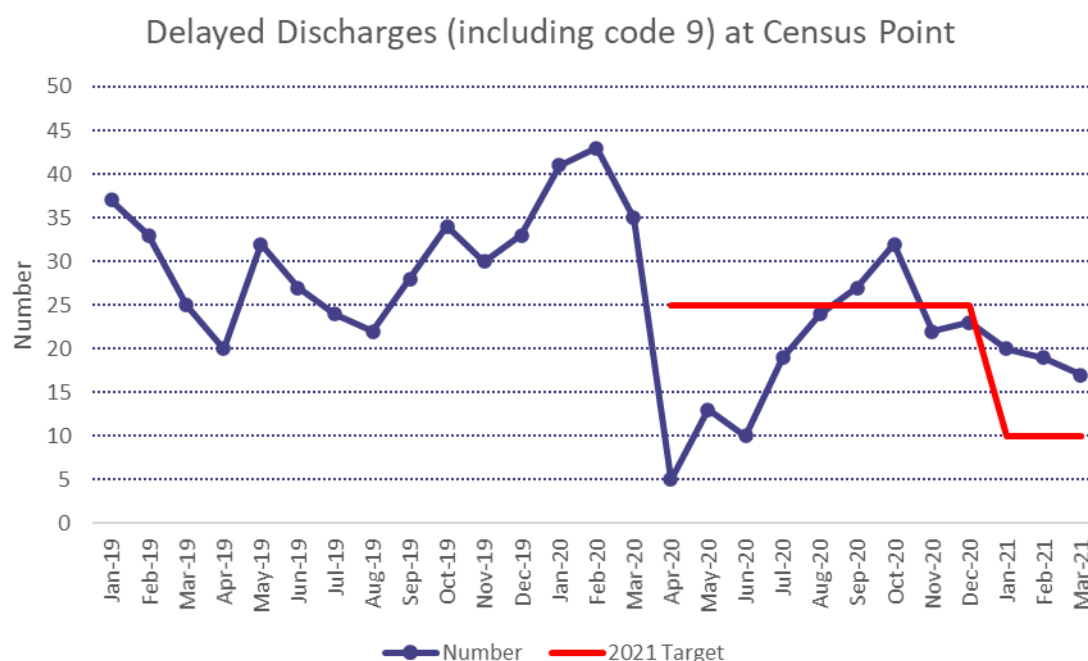
Next Steps

Delayed Discharges remain the subject of an outcome focused model which, in working in collaboration, should maximise capacity across Moray further addressing delayed discharges.

DD-01: NUMBER OF DELAYED DISCHARGES (INCLUDING CODE 9, CENSUS SNAPSHOT, AT END OF QUARTER)

Purpose	Reliably achieving timely discharge from hospital is an important indicator of quality and is a marker for person centred, effective, integrated, and harm free care.					
Strategic Priority	2: HOME FIRST		Linked Indicator(s)	DD-02		
National Health & Wellbeing Outcomes			2, 3, 5, 7			
Target	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21
10	33	35	10	27	23	17

Figure 1



Indicator Trend

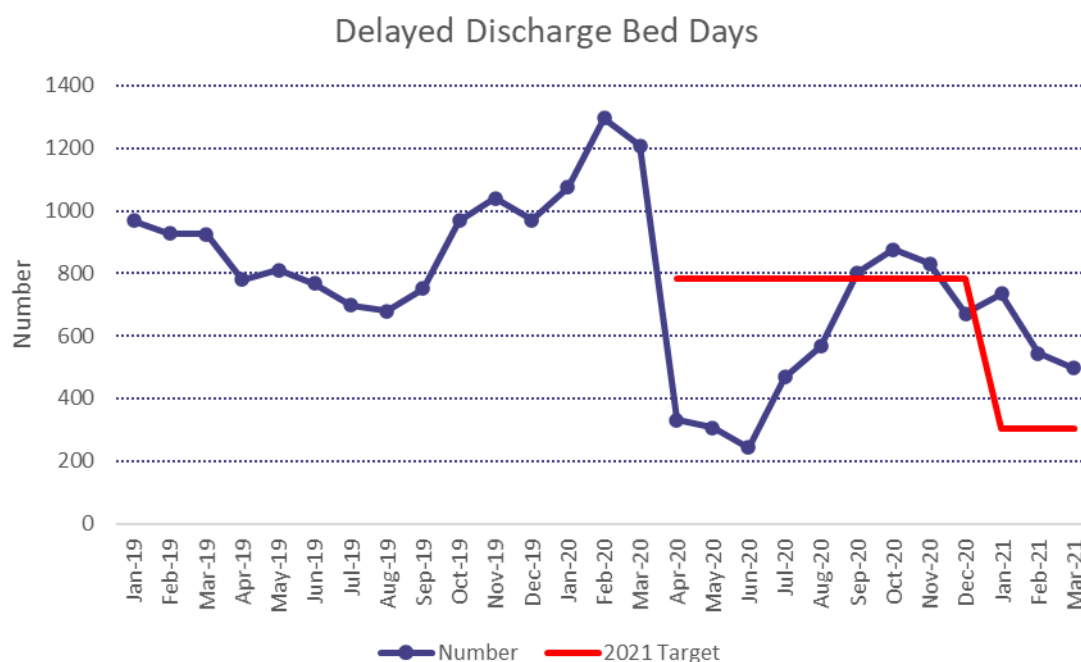
The number of delayed discharges has continued to decrease since an October peak of 32 to 17 at the end of February 2021.

Scotland Trend	TBC
Peer Group	TBC
Last Reported	April 2021 for Quarter 4 data
Next Update Due	July 2021 for Quarter 1 2021-22 data
Source	Public Health Scotland

DD-02: NUMBER OF BED DAYS OCCUPIED BY DELAYED DISCHARGES PER QUARTER (INC CODE 9) PER 1000 18+ POPULATION

Purpose	This monitors the number of people delayed in hospital once medically fit for discharge. Longer stays in hospital are associated with increased risk of infection, low mood, and reduced motivation.					
Strategic Priority	2: HOME FIRST	Linked Indicator(s)			DD-01	
National Health & Wellbeing Outcomes		2, 3, 5, 7				
Target	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21
304	971	1,208	242	803	672	496

Figure 2



Indicator Trend

The number of bed days occupied by a delayed discharge have continued to decrease since an October peak of 876 to 496 at the end of February 2021.

Scotland Trend	TBC
Family Group	TBC
Last Reported	April 2021 for Quarter 4 data
Next Update Due	July 2021 for Quarter 1 2021-22 data
Source	Public Health Scotland

4. EMERGENCY ADMISSIONS - GREEN

Trend Analysis

There was a reduction of 18% in the number of Bed Days Occupied from Mar 20 (2,170) to Mar 21 (1,780) that is not mirrored in the number of people over 65 admitted to in an emergency, which only reduced by 5% (125.2 to 119.4)

In line with infection prevention and control guidelines there has been a reduction in the number of beds available at Dr Gray's and Community Hospitals, this is likely to have had an impact on the number of admissions.

Operational Actions and Maintenance

The Flow Navigation Hub for Moray was established in early January 2021 and will continue to monitor and provide up to date weekly data to enable management teams to be responsive to any concerning trends.

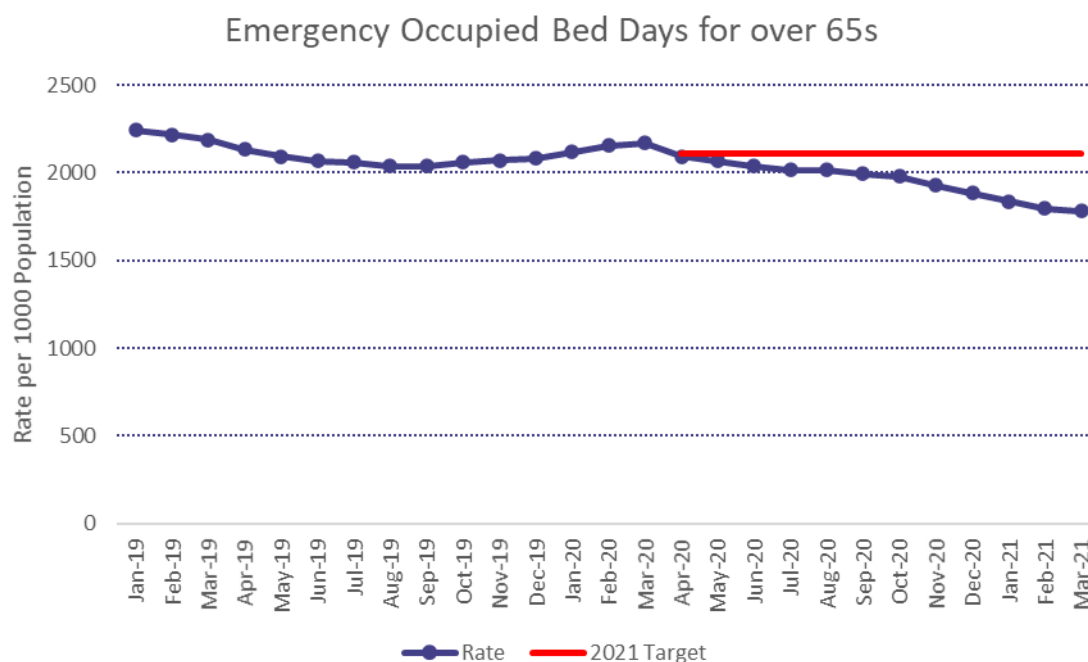
Next Steps

Work will progress on collating trend information and once sufficient data has been collected it will be analysed and reported as appropriate.

EA-01: RATE OF EMERGENCY OCCUPIED BED DAYS FOR OVER 65S PER 1000 POPULATION

Purpose	EA-01, EA-02, and EA-03 are all interconnected and provide a narrative when viewed together of whether emergency admissions and bed days are within tolerance and indicate where potential risks could arise.					
Strategic Priority	1: BUILDING RESILIENCE	Linked Indicator(s)		EA-02 , EA-03		
National Health & Wellbeing Outcomes		1, 2, 3, 5				
Target	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21
2,107	2,082	2,170	2,087	2,040	1,840	1780

Figure 3



Indicator Trend

This indicator is on a very noticeable downward trend.

Scotland Trend Not Available

Peer Group Not Available

Last Reported April 2021 for Quarter 4 data

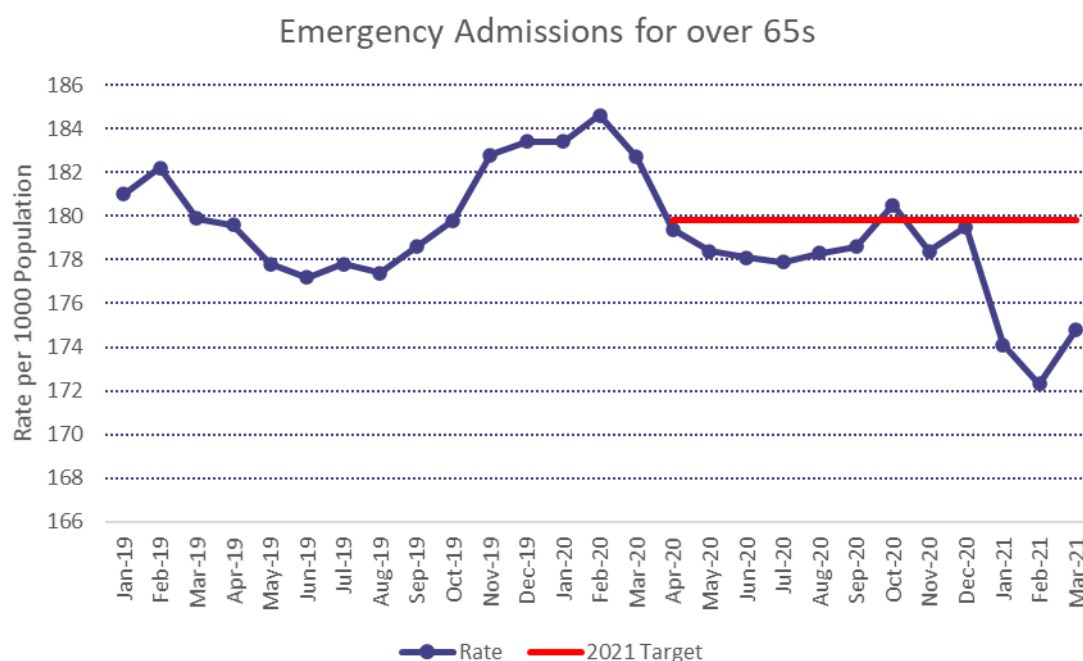
Next Update Due July 2021 for Quarter 1 2021-22 data

Source Health Intelligence

EA-02: EMERGENCY ADMISSIONS RATE PER 1000 POPULATION FOR OVER 65S

Purpose	EA-01, EA-02, and EA-03 are all interconnected and provide a story when viewed together of whether emergency admissions and bed days are within tolerance and indicate where potential risks could arise.					
Strategic Priority	1: BUILDING RESILIENCE	Linked Indicator(s)		EA-01 , EA-03		
National Health & Wellbeing Outcomes		1, 2, 3, 5				
Target	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21
179.8	183	183	179	179	180	175

Figure 4 - Emergency Admissions rate per 1000 population for over 65s



Indicator Trend

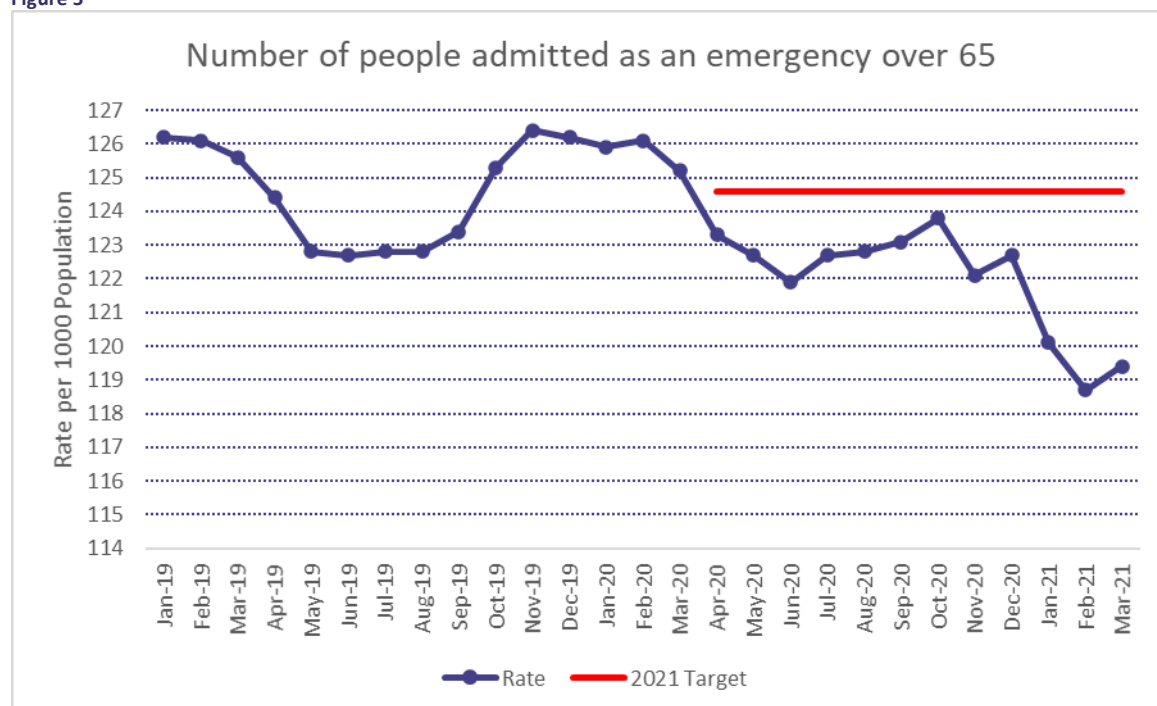
This indicator had a sharp drop in Q4. This does follow a pattern of Q3 to Q4 reductions in the last 3 years.

Scotland Trend	Not Available
Peer Group	Not Available
Last Reported	April 2021 for Quarter 4 data
Next Update Due	July 2021 for Quarter 1 2021-22 data
Source	Health Intelligence

EA-03: NUMBER OF PEOPLE OVER 65 YEARS ADMITTED AS AN EMERGENCY IN THE PREVIOUS 12 MONTHS PER 1000 POPULATION

Purpose	EA-01, EA-02, and EA-03 are all interconnected and provide a story when viewed together of whether emergency admissions and bed days are within tolerance and indicate where potential risks could arise.					
Strategic Priority	1: BUILDING RESILIENCE	Linked Indicator(s)			EA-01 , EA-02	
National Health & Wellbeing Outcomes		1, 2, 3, 5				
Target	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21
124.6	126	125	122	123	123	119

Figure 5



Indicator Trend

This indicator is now on a consistent downward trend. The Q4 number is the lowest figure since at least Q4 2015-16.

Scotland Trend	Not Available
Peer Group	Not Available
Last Reported	April 2021 for Quarter 4 data
Next Update Due	July 2021 for Quarter 1 2021-22 data
Source	Health Intelligence

5. ACCIDENT AND EMERGENCY – GREEN

Trend Analysis

There has been an increase in the rate per 1,000 this quarter from 16 to 17.8. This is still below the target of 22. This is just below the number presenting at the over the same period last year. While the rate in January 2021 was low (likely due to increased lockdown measures and the Flow Navigations Hub redirecting people) there has been an increase in this rate through February and March.

Operational data from Dr Gray's implies that this increase is in number of those in Flow 1 presenting (Minor Injury and Illness, including care provided in A&E Departments, in Minor Injury Units and through schemes such as See and Treat). Flows 2, 3 and 4 remain at relatively consistent levels as they have done throughout the pandemic.

Operational Actions and Maintenance

The MIJB Strategic Plan 2019-29 has reduction in levels of Unscheduled Care as a key goal: shifting unplanned hospital activity to preventative interventions; ensuring appropriate, responsive service delivery as locally as possible and as specialist as necessary; and positive team co-ordination.

The Flow Navigation Hub (FNH) has been running since 17th Jan 2021 and data for analysis is still limited, however we will continue monitor up to date weekly data to enable more responsive action from management teams.

The close monitoring of data continues to identify opportunities for improvement i.e. walk in patients have been re-assigned to scheduled care from unscheduled via the FNH.

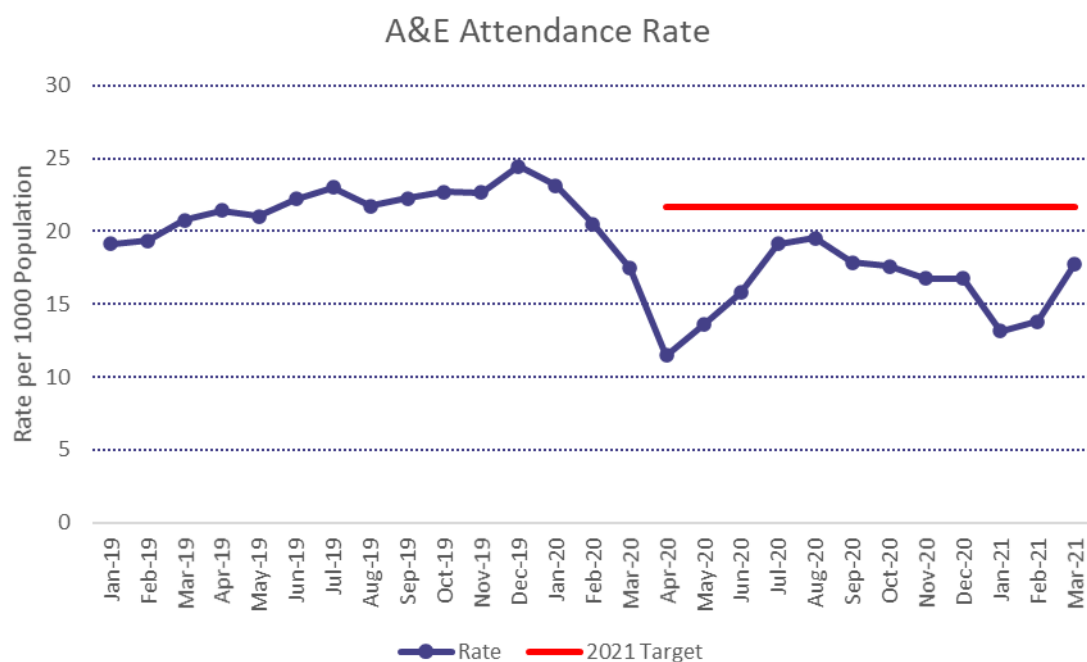
Next Steps

The Flow Navigation hub is a relatively new service and figures are being monitored closely on a weekly basis. At this point there is no meaningful trend information, however once available this will be shared.

AE-01: A&E ATTENDANCE RATES PER 1,000 POPULATION (ALL AGES)

Purpose	A greater system-wide understanding of how people access emergency care, and why certain choices are made, will allow local health systems to develop intelligence about avoidable attendances at emergency departments and target their responses.					
Strategic Priority	3: PARTNERS IN CARE	Linked Indicator(s)		HR-01 , HR-02		
National Health & Wellbeing Outcomes		1, 2, 3, 5				
Target	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21
21.5	25	18	16	18	16.8	17.8

Figure 6



Indicator Trend

There has been an increase in the rate per 1,000 this quarter.

Scotland Trend Moray has mirrored the rest of Scotland trend.

Peer Group Unknown

Last Reported April 2021 for Quarter 4 data

Next Update Due July 2021 for Quarter 1 2021-22 data

Source Health Intelligence

6. HOSPITAL RE-ADMISSIONS - RED

Trend Analysis

Both indicators in this barometer are red and are not decreasing significantly since the Q1 2020-21 spike. 28 day re-admissions are **9.4%** (February data) and 7 day Re-admissions are at **5%**. These are both above target.

Elective treatment has yet to be resumed and this means that the total number of discharges remain low and consequently the rate per discharge remains high.

Operational Actions and Maintenance

This indicator covers all hospitals and all patients in Moray.

More detailed information is available for each hospital and Locality managers have oversight of this performance information.

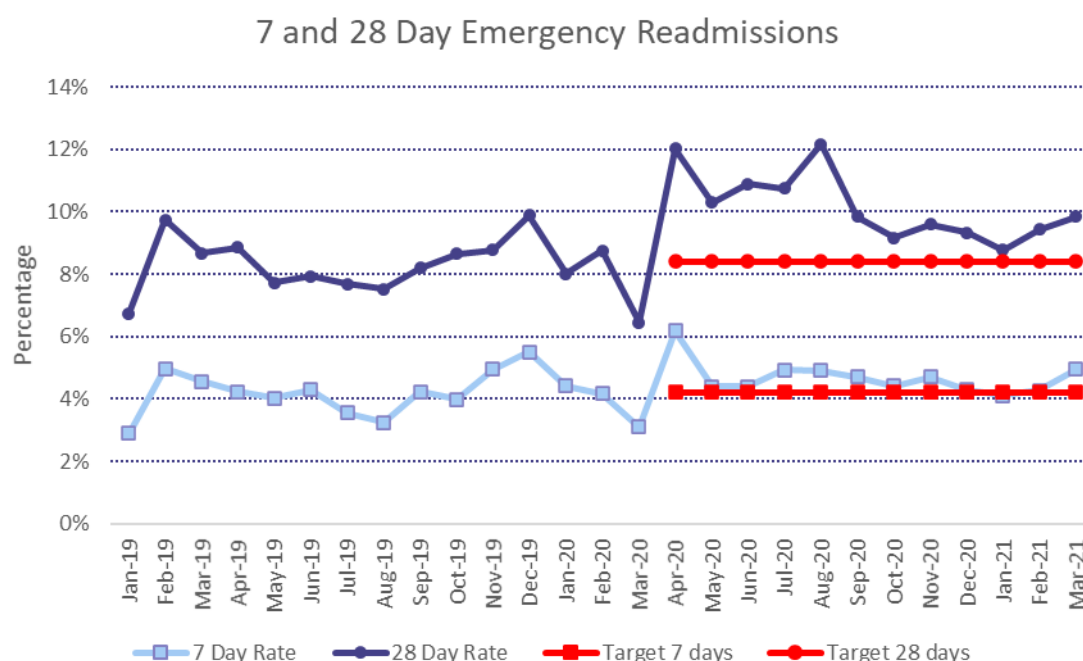
Next Steps

Continue to work with Locality managers to monitor data at a community hospital level on a regular basis, with the aim of identifying potentially avoidable readmissions and any associated improvement actions.

HR-01: PERCENTAGE OF EMERGENCY RE-ADMISSIONS TO HOSPITAL WITHIN 28 DAYS - MORAY PATIENTS

Purpose	Re-admissions are often undesirable for patients, and have also been shown to be associated with the quality of care provided to patients at several stages along the clinical pathway, including during initial hospital stays, transitional care services and post-discharge support. (This measure lags by a month due to the time required for a potential 28 day discharge to occur)					
Strategic Priority	1: BUILDING RESILIENCE	Linked Indicator(s)		HR-02 , AE-01		
National Health & Wellbeing Outcome		1, 2, 3, 5				
Target	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21
8.4%	9.9%	6.5%	11.0%	9.8%	9.2%	9.4%*

Figure 7



Indicator Trend

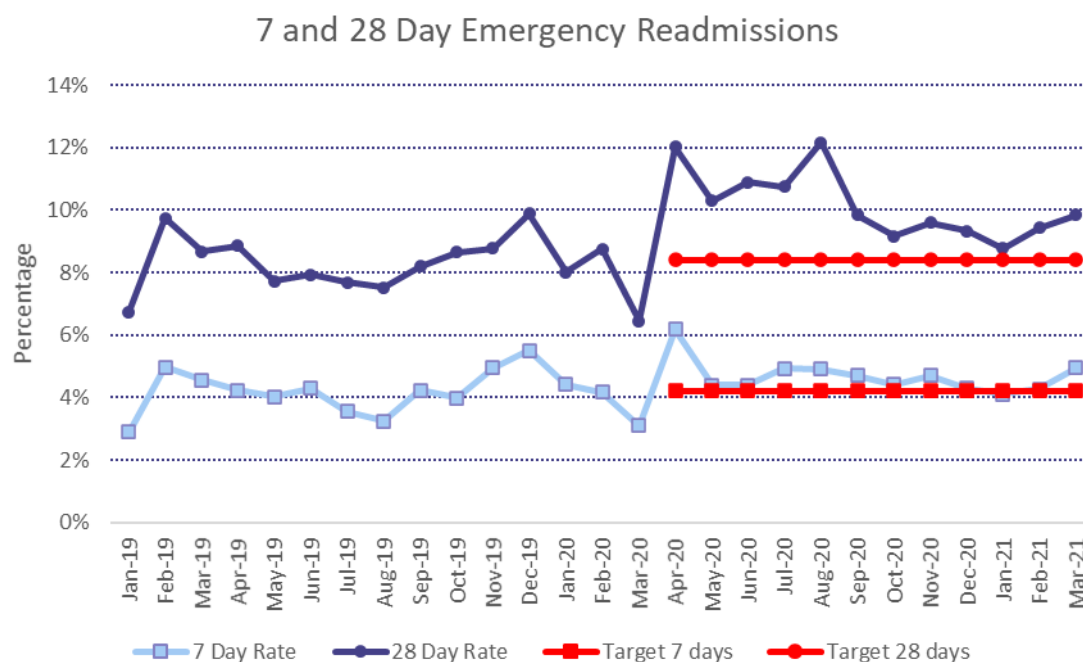
28 day Hospital Re-admissions have remained around the 9.5% rate over the last 3 quarters.

Scotland Trend	Unknown
Peer Group	Unknown
Last Reported	April 2021 for Quarter 4 data
Next Update Due	July 2021 for Quarter 1 2021-22 data
Source	Health Intelligence

HR-02: PERCENTAGE OF EMERGENCY RE-ADMISSIONS TO HOSPITAL WITHIN 7 DAYS - MORAY PATIENTS

Purpose	Re-admissions are often undesirable for patients, and have also been shown to be associated with the quality of care provided to patients at several stages along the clinical pathway, including during initial hospital stays, transitional care services and post-discharge support.					
Strategic Priority	1: BUILDING RESILIENCE	Linked Indicator(s)			HR-01 , AE-01	
National Health & Wellbeing Outcome	1, 2, 3, 5					
Target	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21
4.2%	5.5%	3.1%	4.3%	4.6%	4.2%	5.0%

Figure 9



Indicator Trend

The rate of 7 day re-admissions has increased to 5% in Q4.

Scotland Trend Unknown

Peer Group Unknown

Last Reported April 2021 for Quarter 4 data

Next Update Due July 2021 for Quarter 1 2021-22 data

Source Health Intelligence

7. UNMET NEED – FOR INFO

Trend Analysis

The number of people and the number of unmet homecare hours at the weekly snapshot have both reduced over the last quarter.

Operational Actions and Maintenance

This information has been closely monitored as part of the daily performance flow throughout the response to Covid.

During quarter 3 the application of the critical and substantial eligibility criteria recommenced. Following the assessment of need an increase of service users were prioritised as either critical or substantial under the eligibility criteria. The resource available continued to meet the demand of the high risk needs, increasing the numbers of those waiting under the substantial criteria.

There also remained a continued focus on supporting those awaiting for care on discharge from hospital as a priority, which also added to the increase of need within the community, reflected in the unmet need list at point of reporting.

Action was taken to focus on reduction of this by considering options for increasing the capacity of resource available within care at home. Commissioning of a further two external providers has commenced.

Next Steps

Close monitoring of this indicator will continue where it is anticipated there will be a decrease in the levels of unmet need.

UN-01: NUMBER OF LONG-TERM HOME CARE HOURS UNMET AT WEEKLY SNAPSHOT

Purpose	It is important to monitor the number of people who require long-term care who are awaiting that care. The numbers of those with an unmet need is an important indicator of the health of the Health and Social Care system.					
Strategic Priority	2: HOME FIRST		Linked Indicator(s)	UN-02		
National Health & Wellbeing Outcome	1, 2, 3, 5					
Target	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21
For Info	ND	ND	623	523	578	465
Indicator Trend						
This indicator is on a downward trend.						
Scotland Trend	Unavailable					
Peer Group	Unavailable					
Last Reported	April 2021 for Quarter 4 data					
Next Update Due	July 2021 for Quarter 1 2021-22 data					
Source	Brokerage					

UN-02: NUMBER OF PEOPLE WITH LONG-TERM CARE HOURS UNMET AT WEEKLY SNAPSHOT

Purpose	It is important to monitor the number of people who require long-term care who are awaiting that care. The numbers of those with an unmet need is an important indicator of the health of the Health and Social Care system.																				
Strategic Priority	2: HOME FIRST		Linked Indicator(s)	UN-01																	
National Health & Wellbeing Outcome	1, 2, 3, 5																				
Target	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21															
For Info	ND	ND	36	44	35	31															
<table border="1"> <caption>Indicator Trend Data</caption> <thead> <tr> <th>Quarter</th> <th>#People</th> <th>Target</th> </tr> </thead> <tbody> <tr> <td>Q1</td> <td>36</td> <td>40</td> </tr> <tr> <td>Q2</td> <td>44</td> <td>40</td> </tr> <tr> <td>Q3</td> <td>35</td> <td>40</td> </tr> <tr> <td>Q4</td> <td>31</td> <td>40</td> </tr> </tbody> </table>							Quarter	#People	Target	Q1	36	40	Q2	44	40	Q3	35	40	Q4	31	40
Quarter	#People	Target																			
Q1	36	40																			
Q2	44	40																			
Q3	35	40																			
Q4	31	40																			
Indicator Trend																					
After a peak in Q2 this indicator is now on a decreasing trend.																					
Scotland Trend	Unavailable																				
Peer Group	Unavailable																				
Last Reported	April 2021 for Quarter 4 data																				
Next Update Due	July 2021 for Quarter 1 2021-22 data																				
Source	Brokerage																				

8. OUTSTANDING ASSESSMENTS – FOR INFO

Trend Analysis

Due to a change in the reporting method and a data cleansing exercise the data from Q1,2 and 3 is not comparable with Q4 data (therefore no trend line is presented). It is notable that the data is still showing a high number of reviews outstanding.

Over the last two years an average of 364 reviews have been closed every month.

Operational Actions and Maintenance

Continued scrutiny of this indicator has highlighted some differences in the use of the system between the Social Work teams and work is being undertaken to introduce a more consistent approach to recording this measure.

Next Steps

Practice Governance Group are reviewing and refining key indicators for teams. This review is anticipated to be complete by September 2021.

OA-01: NUMBER OF REVIEWS OUTSTANDING AT END OF QUARTER SNAPSHOT																
Purpose	Those awaiting assessments are at risk of not receiving the service they require in good time, and can then put pressure on other, more resource intensive primary and acute services.															
Strategic Priority	3: PARTNERS IN CARE		Linked Indicator(s)													
National Health & Wellbeing Outcome			1, 2, 3, 5													
Target	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21										
For Info	ND	ND	1,506	1,608	1,655	1242										
<p># Overdue Reviews</p> <table border="1"> <caption>Overdue Reviews Data</caption> <thead> <tr> <th>Quarter</th> <th>Number of Overdue Reviews</th> </tr> </thead> <tbody> <tr> <td>Q1</td> <td>1,506</td> </tr> <tr> <td>Q2</td> <td>1,608</td> </tr> <tr> <td>Q3</td> <td>1,655</td> </tr> <tr> <td>Q4</td> <td>1,242</td> </tr> </tbody> </table>							Quarter	Number of Overdue Reviews	Q1	1,506	Q2	1,608	Q3	1,655	Q4	1,242
Quarter	Number of Overdue Reviews															
Q1	1,506															
Q2	1,608															
Q3	1,655															
Q4	1,242															
Indicator Trend																
No trend is discernible due to a change in data recording in Q1,2 and 3 to Q4.																
Scotland Trend	Not Available															
Peer Group	Not Available															
Last Reported	April 2021 for Quarter 4 data															
Next Update Due	July 2021 for Quarter 1 2021-22 data															
Source	TBC															

9. MENTAL HEALTH - GREEN

Trend Analysis

After 24 months below target and a year at around 20% this measure is at 100% for the second quarter in a row.

Operational Actions and Maintenance

Adult mental health are currently experiencing staffing difficulties due to long term absence and a member of staff leaving to take up a post elsewhere in Scotland. Interviews this week for replacement. However, despite this, the service continues to see patients within targets. The situation will be kept under review.

Primary care staff continue to be redeployed to the Psychological Resilience Hub. Recruitment to all primary care posts has now concluded and staff will continue to support the Psychological Resilience Hub until the end of July. Primary care have now remobilised with the PRH being the single point of referral, cases are then allocated accordingly.

Nursing staff trained in MBT have dedicated time to support the psychotherapy service however there remains a gap in service provision following the retiral of the consultant psychotherapist in October 2020 and the inability to recruit to a MBT practitioner post. Service discussions are ongoing about how the patients requiring this service can be best supported.

Next Steps

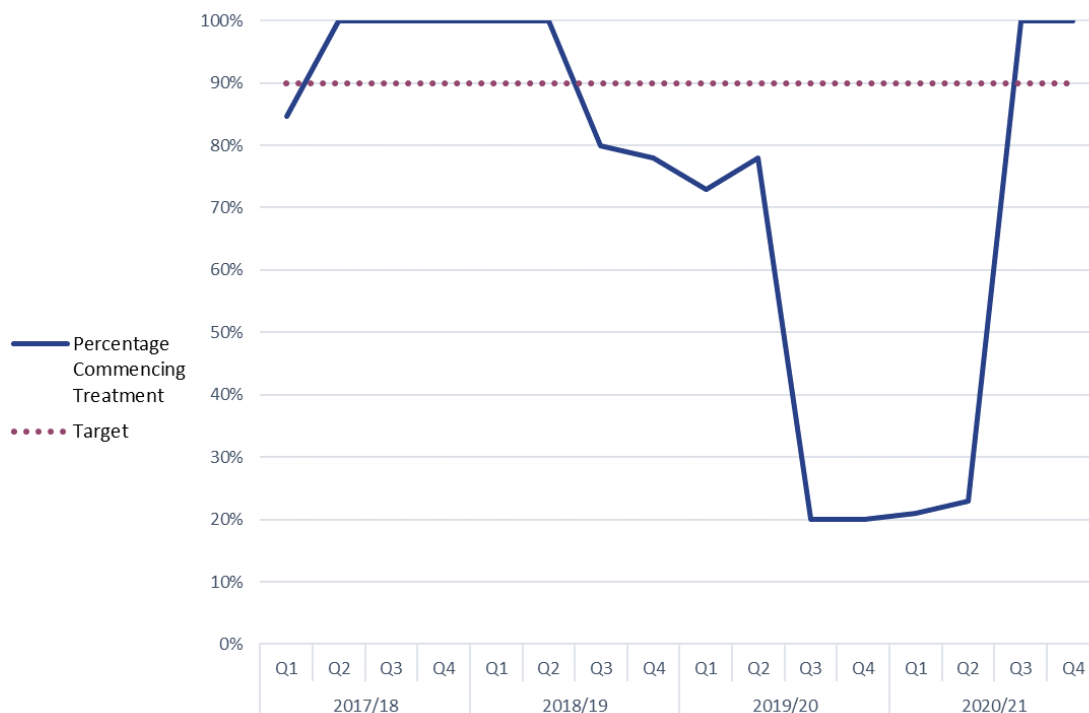
Staff from the older adult team continue to be redeployed on a part time basis to the Psychological Resilience Hub but this is not currently affecting the ability to see secondary care patients in the service. This will be reviewed before the end of July 2021.

Referrals into the adult mental health secondary care service are currently stable and manageable following an increase in January 2021.

MH-01: PERCENTAGE OF PATIENTS COMMENCING PSYCHOLOGICAL THERAPY TREATMENT WITHIN 18 WEEKS OF REFERRAL

Purpose	Timely access to healthcare is a key measure of quality and that applies equally in respect of access to mental health services.					
Strategic Priority	3: PARTNERS IN CARE		Linked Indicator(s)			
National Health & Wellbeing Outcome	1, 2, 3, 5					
Target (-5%)	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21
For Info	20%	20%	21%	23%	100%	100%

Figure 80 - Percentage of patients commencing Psychological Therapy Treatment within 18 weeks of referral (adults only)



Indicator Trend

This measure remains at 100% for the second quarter in a row.

Scotland Trend	Unavailable
Peer Group	Unavailable
Last Reported	April 2021 for Quarter 4 data
Next Update Due	July 2021 for Quarter 1 2021-22 data
Source	Health Intelligence

10. STAFF MANAGEMENT - RED

Trend Analysis

Council Health and Social Care Moray employees maintain a 6.2% days lost absence rate. While this is stable and below 9.1% rate in Q4 2019-20 it is 2.2% above the target of 4%.

Across the general population, during the lockdown period with Covid measures in place and with improved hand hygiene there has been a reduction in the levels of colds, respiratory infections and flu, which may be being reflected in the current reduction of absence rates.

As the lockdown measures relax it will be of interest to note if rates being to rise again.

Operational Actions and Maintenance

Managers continue to focus on supporting staff and following good absence management practice. Staff wellbeing is a key focus given the pressures and challenges people have faced during the Covid-19 response.

Moray Council will be undertaking a survey of staff in relation to their wellbeing and the outputs will inform actions that will be undertaken to maintain and improve support to staff.

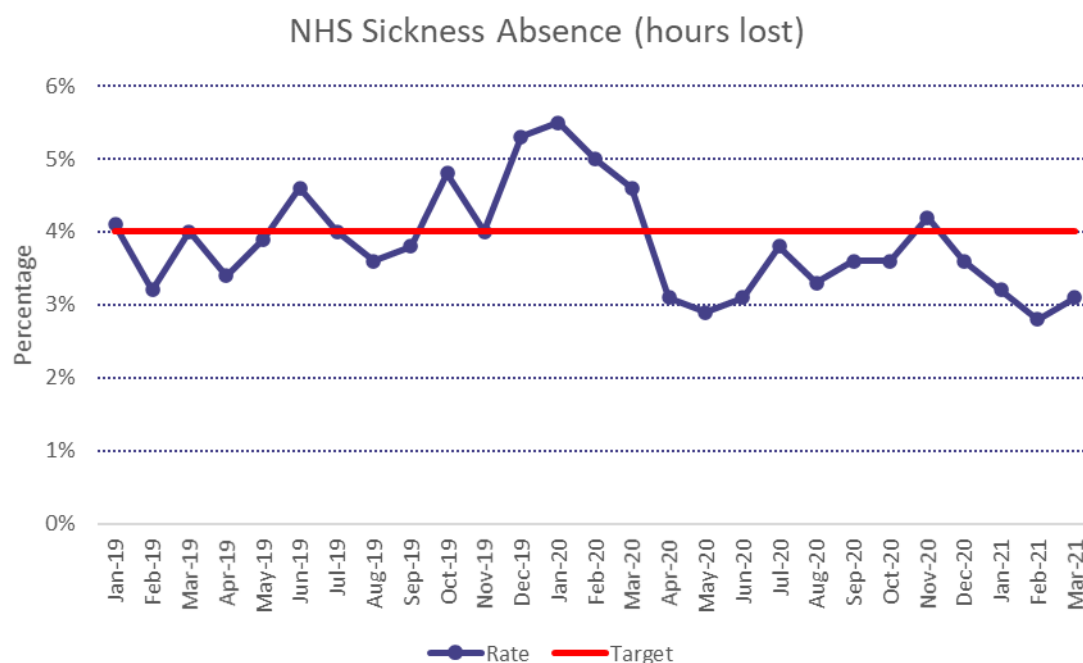
Next Steps

Managers will continue to monitor absence management and are aware of the continued need to support staff through the transitions of coming out of lockdown.

SM-01: NHS SICKNESS ABSENCE % OF HOURS LOST

Purpose	Attendance at work of all employees is essential in the interests of the effective and efficient operation of services.					
Strategic Priority	1: BUILDING RESILIENCE	Linked Indicator(s)		SM-02		
National Health & Wellbeing Outcome	8					
Target (+10%)	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21
4%	5.3%	4.6%	3.1%	3.6%	3.6%	3.1%

Figure 91



Indicator Trend

This indicator remains low as it has been since March 2020.

Scotland Trend Unknown

Peer Group Unknown

Last Reported April 2021 for Quarter 4 data

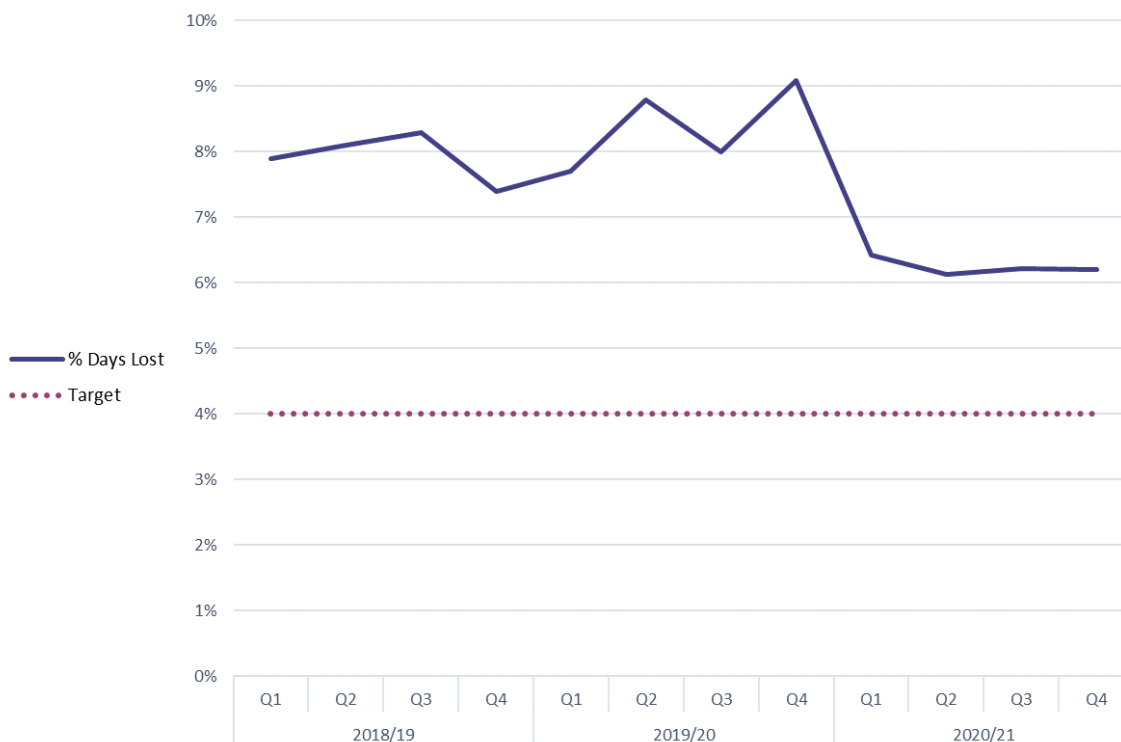
Next Update Due July 2021 for Quarter 1 2021-22 data

Source Health Intelligence

SM-02: COUNCIL SICKNESS ABSENCE (% OF CALENDAR DAYS LOST)

Purpose	Attendance at work of all employees is essential in the interests of the effective and efficient operation of services.					
Strategic Priority	1: BUILDING RESILIENCE	Linked Indicator(s)			SM-01	
National Health & Wellbeing Outcome		1, 2, 3, 5				
Target	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21
4%	8.0%	9.1%	6.4%	6.1%	6.2%	6.2%

Figure 102 - Council Sickness Absence (% of Calendar Days Lost)



Indicator Trend

This indicator remains above target up to the end of quarter 4 2020/21 but it has dropped significantly from quarter 4 2019/20 where it was at a peak.

Scotland Trend	Unknown
Peer Group	Unknown
Period Last Reported	April 2021 for Quarter 4 data
Next Update Due	July 2021 for Quarter 1 2021-22 data
Source	Council HR

APPENDIX 1: KEY AND DATA DEFINITIONS

RAG SCORING CRITERIA

GREEN	If Moray is performing better than target.
AMBER	If Moray is performing worse than target but within specified tolerance.
RED	If Moray is performing worse than target but outside of specified tolerance.
▲ - ▼	Indicating the direction of the current trend.

PEER GROUP DEFINITION

Moray is defined as being in Peer Group 2 in the Local Government Benchmarking Framework

Family Group 1	Family Group 2	Family Group 3	Family Group 4
East Renfrewshire	Moray	Falkirk	Eilean Siar
East Dunbartonshire	Stirling	Dumfries & Galloway	Dundee City
Aberdeenshire	East Lothian	Fife	East Ayrshire
Edinburgh, City of	Angus	South Ayrshire	North Ayrshire
Perth & Kinross	Scottish Borders	West Lothian	North Lanarkshire
Aberdeen City	Highland	South Lanarkshire	Inverclyde
Shetland Islands	Argyll & Bute	Renfrewshire	West Dunbartonshire
Orkney Islands	Midlothian	Clackmannanshire	Glasgow City

APPENDIX 2: STRATEGIC PRIORITIES

1. THE HEALTH AND SOCIAL CARE STRATEGY AT A GLANCE

WE ARE PARTNERS IN CARE

OUR VISION: “We come together as equal and valued partners in care to achieve the best health and wellbeing possible for everyone in Moray throughout their lives.”

OUR VALUES: Dignity and respect; person-centred; care and compassion; safe, effective and responsive

OUTCOMES: Lives are healthier – People live more independently – Experiences of services are positive – Quality of life is improved – Health inequalities are reduced – Carers are supported – People are safe – The workforce continually improves – Resources are used effectively and efficiently

THEME 1: BUILDING RESILIENCE - Taking greater responsibility for our health and wellbeing

THEME 2: HOME FIRST - Being supported at home or in a homely setting as far as possible

THEME 3: PARTNERS IN CARE - Making choices and taking control over decisions affecting our care and support

TRANSFORMATION (DELIVERY) PLAN supported by enablers:



BUILDING RESILIENCE

- **EA-01:** RATE OF EMERGENCY OCCUPIED BED DAYS FOR OVER 65S PER 1000 POPULATION
- **EA-02:** EMERGENCY ADMISSIONS RATE PER 1000 POPULATION FOR OVER 65S
- **EA-03:** NUMBER OF PEOPLE OVER 65 YEARS ADMITTED AS AN EMERGENCY IN THE PREVIOUS 12 MONTHS PER 1000 POPULATION
- **HR-01:** PERCENTAGE OF EMERGENCY RE-ADMISSIONS TO HOSPITAL WITHIN 28 DAYS - MORAY PATIENTS (DR GRAY'S)
- **HR-02:** PERCENTAGE OF EMERGENCY RE-ADMISSIONS TO HOSPITAL WITHIN 7 DAYS - MORAY PATIENTS (DR GRAY'S)
- **SM-01:** NHS SICKNESS ABSENCE % OF HOURS LOST
- **SM-02:** COUNCIL SICKNESS ABSENCE (% OF CALENDAR DAYS LOST)

HOME FIRST

- **DD-01:** NUMBER OF DELAYED DISCHARGES (INCLUDING CODE 9, CENSUS SNAPSHOT, AT END OF QUARTER)
- **DD-02:** NUMBER OF BED DAYS OCCUPIED BY DELAYED DISCHARGES PER QUARTER (INC CODE 9) PER 1000 18+ POPULATION
- **UN-01:** NUMBER OF LONG-TERM HOME CARE HOURS UNMET AT WEEKLY SNAPSHOT
- **UN-02:** NUMBER OF PEOPLE WITH LONG-TERM CARE HOURS UNMET AT WEEKLY SNAPSHOT

PARTNERS IN CARE

- **OA-01:** NUMBER OF REVIEWS OUTSTANDING AT END OF QUARTER SNAPSHOT
- **MH-01:** PERCENTAGE OF PATIENTS COMMENCING PSYCHOLOGICAL THERAPY TREATMENT WITHIN 18 WEEKS OF REFERRAL
- **AE-01:** A&E ATTENDANCE RATES PER 1000 POPULATION (ALL AGES)

APPENDIX 3: NATIONAL HEALTH AND WELLBEING OUTCOMES

1 - PEOPLE ARE ABLE TO LOOK AFTER AND IMPROVE THEIR OWN HEALTH AND WELLBEING AND LIVE IN GOOD HEALTH FOR LONGER.

2 - PEOPLE, INCLUDING THOSE WITH DISABILITIES OR LONG-TERM CONDITIONS, OR WHO ARE FRAIL; ARE ABLE TO LIVE, AS FAR AS REASONABLY PRACTICABLE, INDEPENDENTLY AT HOME, OR IN A HOMELY SETTING IN THEIR COMMUNITY.

3 - PEOPLE WHO USE HEALTH AND SOCIAL CARE SERVICES HAVE POSITIVE EXPERIENCES OF THOSE SERVICES, AND HAVE THEIR DIGNITY RESPECTED.

4 - HEALTH AND SOCIAL CARE SERVICES ARE CENTRED ON HELPING TO MAINTAIN OR IMPROVE THE QUALITY OF LIFE OF PEOPLE WHO USE THOSE SERVICES.

5 - HEALTH AND SOCIAL CARE SERVICES CONTRIBUTE TO REDUCING HEALTH INEQUALITIES.

6 - PEOPLE WHO PROVIDE UNPAID CARE ARE SUPPORTED TO LOOK AFTER THEIR OWN HEALTH AND WELLBEING, INCLUDING TO REDUCE ANY NEGATIVE IMPACT OF THEIR CARING ROLE ON THEIR OWN HEALTH AND WELLBEING.

7 - PEOPLE USING HEALTH AND SOCIAL CARE SERVICES ARE SAFE FROM HARM.

8 - PEOPLE WHO WORK IN HEALTH AND SOCIAL CARE SERVICES FEEL ENGAGED WITH THE WORK THEY DO AND ARE SUPPORTED TO CONTINUOUSLY IMPROVE THE INFORMATION, SUPPORT, CARE, AND TREATMENT THEY PROVIDE.

9 - RESOURCES ARE USED EFFECTIVELY AND EFFICIENTLY IN THE PROVISION OF HEALTH AND SOCIAL CARE SERVICES.

Appendix 2 – Moray Core Suite Integration Indicators

Indicator	Title	2013/14	2015/16	2017/18	2019/20	Scotland rate	Moray Sparklines
NI - 1	Percentage of adults able to look after their health very well or quite well	97%	96%	93%	94%	93%	
NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	82%	74%	83%	70%	81%	
NI - 3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	78%	73%	75%	63%	76%	
NI - 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	74%	71%	73%	64%	74%	
NI - 5	Percentage of adults receiving any care or support who rate it as excellent or good	81%	79%	80%	64%	80%	
NI - 6	Percentage of people with positive experience of care at their GP practice	84%	86%	80%	77%	83%	
NI - 7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	82%	83%	79%	67%	80%	
NI - 8	Percentage of carers who feel supported to continue in their caring role	43%	38%	39%	31%	37%	
NI - 9	Percentage of adults supported at home who agreed they felt safe	82%	79%	84%	70%	83%	
NI - 10	Percentage of staff who say they would recommend their workplace as a good place to work	NA	NA	NA	NA	NA	

Indicator	Title	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	Scotland rate	Sparklines
NI - 11	Premature mortality rate per 100,000 persons (Data per Calendar Year, Latest 2019)	349	399	360	372	394	358	426	
NI - 12	Emergency admission rate (per 100,000 population)	8841	8714	8802	9276	8974	9321	12,417	
NI - 13	Emergency bed day rate (per 100,000 population)	97997	95860	97430	95707	90537	89420	118,055	
NI - 14	Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges)	74	76	75	84	77	78	103	
NI - 15	Proportion of last 6 months of life spent at home or in a community setting	89.4%	90.0%	90.2%	89.4%	90.0%	90.6%	88.4%	
NI - 16	Falls rate per 1,000 population aged 65+	15.1	16.8	15.7	15.3	15.2	15.1	22.7	
NI - 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	78.3%	78.4%	70.7%	84.7%	81.8%	75.2%	81.8%	
NI - 18	Percentage of adults with intensive care needs receiving care at home	66.6%	75.7%	67.2%	65.8%	67.9%	62.5%	63.1%	
NI - 19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	795	764	1,095	936	1,063	768	774	
NI - 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	20.2%	20.1%	20.3%	21.0%	20.6%	20.6%	24.0%	
NI - 21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home	NA	NA	NA	NA	NA	NA	NA	
NI - 22	Percentage of people who are discharged from hospital within 72 hours of being ready	NA	NA	NA	NA	NA	NA	NA	
NI - 23	Expenditure on end of life care, cost in last 6 months per death	NA	NA	NA	NA	NA	NA	NA	



REPORT TO: MORAY INTEGRATION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE ON 24 JUNE 2021

SUBJECT: INTERNAL AUDIT UPDATE/ANNUAL OPINION

BY: CHIEF INTERNAL AUDITOR

1. REASON FOR REPORT

1.1 To provide an update on audit work progressed since the last meeting of the Committee and an annual internal audit opinion.

2. RECOMMENDATION

2.1 **The Audit, Performance and Risk Committee is asked to consider and note this audit update and the Chief Internal Auditor's opinion that reasonable assurance can be placed on the adequacy and effectiveness of the MIJB's system of governance, risk management and internal control for the year ended 31 March 2021.**

3. REPORT

Context

3.1 Public Sector Internal Audit Standards require the Chief Internal Auditor to prepare and present reports to committee on Internal Audit's activity, outcomes, and any other relevant matters.

3.2 Usual reporting practice has been suspended during the pandemic with internal audit having to alter the focus of its work given restrictions arising from working from home and services subject to audit having to adapt sometimes significantly to prioritise immediate and pressing service demands. While the audit approach may have changed the emphasis has remained on seeking to provide assurances around the proper use of public funds, and this is consistent with Audit Scotland's view that audit quality cannot be compromised.

Audit work completed - Key Systems

3.3 While work on service specific audits has been limited during the year, a focus has been maintained on the integrity of key systems notably those which

cover the main expenditure of the Board's activities, namely payroll and creditor payments.

Payroll

- 3.4 Payroll audit work has been undertaken in two phases; the first earlier in the year looked at a sample of new starts and leavers to ensure appropriate documentation was available and that the correct initial and final salary payments had been made as appropriate. The audit validated pay and allowances for a sample of continuing employees including verifying their employment status with relevant service managers. The audit also looked at the reconciliation processes between payroll and the ledger and at the computation of amounts remitted monthly for PAYE (Income Tax), National Insurance and Pension Contributions. The audit work was concluded in satisfactory terms.
- 3.5 Updating this work more recently, a ledger review of payroll costs to the end of Month 10 (January 2021) showed these costs to be well within budget as a consequence of service restrictions and vacancies across most service areas funded from council budgets. Work has been concluded on this second phase review and a summary of the audit findings is provided as **Appendix 1**.

Creditor Payments

- 3.6 Internal audit has also monitored samples of creditor payments, looking not only at the payment processing arrangements during the pandemic but also at the extent to which it has been feasible to maintain established procurement practices. This work has covered supplies and services costs across services including social care so as to provide assurances relevant to the Integration Joint Board.
- 3.7 The process has been protracted with invoices being extracted direct from the ledger and requests then being made by email to services and the procurement team in respect of any queries arising. In consequence progress has been much slower than would normally be the case. However, from the samples reviewed, the integrity of the systems and the rationale for payments made have been confirmed, while noting that some service contracts due for review and renewal have meantime been extended.
- 3.8 In concluding this audit, supporting information for a small number of invoice charges from service providers was not made available, an indication that that there is more work to be done on social care commissioning to better align contracts to current service user need. A summary of the audit findings is provided as **Appendix 2**.

Adaptations - Private and Council Housing

- 3.9 As previously reported, this review was substantially completed pre pandemic and the audit report remains in draft. The budget for adaptations work is an amalgam of funding from Social Care and Housing and a number of recommendations were made that required responses from three different officers. These have now been obtained and agreement reached on the recommendations in principle, however, the programme of works has been

stalled by the pandemic, and the waiting list for adaptations has grown substantially. The Adaptations Governance group is now scheduled to meet on 5 July and it is hoped the responses to the audit recommendations can be agreed at that meeting.

Follow up work - Learning Disabilities (LD) and Care first

- 3.10 Committee has previously been advised that Internal Audit had been asked to conduct further work to assess progress being achieved in redesign of LD services, having prepared an audit report on this topic in 2018. It was noted then that there was a clear intention to transform services and the Chief Internal Auditor had concluded from Board papers and the report of the Chief Social Work Officer that the Board is well sighted on what needs to happen. Doubtless the pace of change will have been impacted by workload pressures in recent months. For now; this will remain as a pending audit review until the timing is considered right to conduct further audit work on LD services.
- 3.11 Similarly, work to follow up the recommendations made in the 'Carefirst Information Governance' audit completed last year has still to be finalised with some delays occurring due to staff changes within Children's Services.

Joint working

- 3.12 Exploratory meetings have been held at the request of the Chair to assess the feasibility of joint working across internal audit teams from the three IJBs and NHS Grampian. This on the basis that as integration becomes more embedded across sectors then the audit processes should be similarly aligned. The outcomes from these informal meetings were favourable albeit the selection of audit topics and the resourcing of the audit work are challenges that still need to be addressed. Certainly from a Chief Internal Auditor perspective there is limited internal audit resource available to support extensive cross sectoral work and this will need further consideration at audit planning stage if a programme of 'joint' audit working is proposed going forward.

Audit Assurance Opinion

- 3.13 In the context of audit work completed, the Chartered Institute of Public Finance and Accountancy (CIPFA) published guidance on the provision of internal audit assurances for the 2020/21 financial year. This was reported to the meeting of this Committee in March and noted that, in order to comply with Auditing Standards, the Chief Internal Auditor is required to consider whether he can provide the 'normal' annual internal audit opinion or whether there needs to be a 'limitation of scope'. A 'limitation of scope' arises where the Chief Internal Auditor is unable to draw on sufficient assurances to issue a 'complete' annual opinion in accordance with the Standards.
- 3.14 The guidance has been taken into account in developing the Chief Internal Auditor's opinion which concludes that there has been no material limitation of scope and that as such reasonable assurance can be given on the adequacy and effectiveness of the systems of governance, risk management and internal control for the year to 31 March 2021, all as detailed in **Appendix 3**.

4. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcome Improvement Plan (LOIP))

Not directly applicable.

(b) Policy and Legal

The internal audit service is provided in terms of paragraph 7:1 of the Local Authority Accounts (Scotland) Regulations 2014, and there is a requirement to provide a service in accordance with published Public Sector Internal Audit Standards.

(c) Financial Implications

No implications directly arising from this report.

(d) Risk Implications

The pandemic continues to generate challenges for all services, and with the new normal as yet uncertain internal audit's focus will be to do what it can to support good governance and the integrity of systems; to learn from the experience and give consideration to how best we can continue to provide the audit assurance required in terms of Internal Auditing Standards.

(e) Staffing Implications

No implications

(f) Property

No implications.

(g) Equalities/ Socio Economic Impacts

No implications.

(h) Consultations

The MIJB Chief Financial Officer has been consulted in respect of this report.

5. CONCLUSION

5.1 This report considers audit work recently completed and provides the Chief Internal Auditor's annual assurance opinion for the year ended 31 March 2021.

Author of Report: Atholl Scott, Chief Internal Auditor
Background Papers: Internal Audit Files
Ref: mjb/ap&rc/24062021

Internal Audit Section

Appendix 1

INTERNAL AUDIT REPORT

SOCIAL CARE - PAYROLL

Executive Summary

As part of the annual coverage of core systems, a review was undertaken of the payroll system, controls and processes in operation in making salary payments to employees within Social Care. A payroll audit was performed earlier in the 20/21 financial year covering all employees processed through the Council's payroll system and therefore included Social Care employees. However, this exercise currently being reported was undertaken to extend the verification of Social Care Adult Services payroll costs and assess the robustness of any changes in practices during the pandemic period.

In terms of scale an average monthly cost of £1.7 million is processed through the payroll system for Social Care employees. The review has covered the systems in place within the 20/21 financial year with testing focused on payroll transactions incurred in the period from July 2020 to January 2021 inclusive. The audit was carried out in accordance with Public Sector Internal Audit Standards (PSIAS).

The significant audit testing work undertaken has involved examination of the processes followed for new starts; terminations of employment; completion, authorisation and submission of timesheets; and claims for overtime, unsocial hours and mileage in order to confirm accurate, supported and timely payments are being made to employees. A sample of persons paid have also been verified as bona fide employees as part of the audit work. This has involved not only the Payroll team but also the managers and administrators of a range of social care services and also the examination of information provided by the HR team.

Audit testing identified no concerns in terms of the validity, accuracy and accounting arrangements for payroll costs. It is considered from the checks undertaken, that appropriate controls are operating effectively and the integrity of systems has been maintained. This is a positive outcome given the introduction of remote working and changes to processing practices required as a result of response to the Covid19 pandemic.

For example/...

Moray Council

Internal Audit Section

For example, instead of a volume of timesheets being submitted to the payroll section for processing, many services such as Care At Home, Community Support Workers, Barlink, Waulkmill and Woodview etc., are now submitting electronic summaries of hours to generate payments. As this carries the risk of less central and independent scrutiny being involved, audit focus was given to sample testing this new process and found accurate employee timesheets being retained within the individual services as supporting source documents for the summary detail submitted to payroll, giving confidence in the continuing integrity of payments despite changing processes.

Internal Audit Section

Appendix 2

INTERNAL AUDIT REPORT

SOCIAL CARE - PROCUREMENT

Executive Summary

As part of the annual coverage of core systems, a review was undertaken of payments made to suppliers of goods and services for Social Care. The purpose of the audit was to confirm ongoing compliance with procurement and payment processing regulations during the pandemic period.

Approximately £16 million was paid in the six months to September 2020. Through the use of computer audit software a sample of 30 invoices was selected for audit with a total value of £737,000. However, many of these invoices were for recurring monthly or quarterly service provision, effectively increasing the value of expenditure falling within the scope of the review to £2.88 million. The process reviewed the randomly selected invoices and also sampled high value invoices which by definition are potentially higher risk. The audit work also involved a separate exercise of extracting multiple invoices with the same value as a check for duplicate payments.

The audit had regard to the Audit Scotland publication 'Public Sector Counter-Fraud' issued in July 2020. The publication provides examples of potential fraud indicators within procurement which can be used to inform the audit programme and highlight the need for additional testing. Red flags include bid manipulation, lack of segregation of duties and single tender award. Recent Audit Scotland publications on additional risks emerging due to the Covid-19 pandemic have also been considered in undertaking the verification work. The audit was carried out in accordance with the Public Sector Internal Audit Standards (PSIAS).

The audit testing work which was possible to complete identified no issues of concern in terms of contracted suppliers used, sums paid, authorisations and accounting treatment. It is considered from the checks undertaken, that appropriate controls are operating effectively and the integrity of systems has been maintained. This is a positive outcome given the introduction of remote working and changes to processing practices required as a result of response to the pandemic.

However,/....

Moray Council

Internal Audit Section

However, supporting information for a small number of sampled payments was not available for audit, despite repeated requests being made. These payments mainly covered invoices from suppliers of commissioned services. Internal audit previously carried out some work on Learning Disabilities commissioning when it was reported that there was more work required to update service contracts to better align these with current policy and service user needs. While it was noted that work on commissioning has been restricted during the period of the pandemic, it is hoped that some impetus can be given to reinvigorating the commissioning process when resources can be made available to undertake this task. Progress on this will be monitored and further work scheduled through the audit planning process.

APPENDIX 1

HSCM Logo

INTERNAL AUDIT
ANNUAL REPORT and OPINION
1 APRIL 2020 to 31 MARCH 2021

1. Background

- 1.1 This report is issued in compliance with the Public Sector Internal Audit Standards (PSIAS) which requires the Chief Internal Auditor to deliver 'an annual internal audit opinion and report that can be used by the organisation to inform its governance statement', and which 'must conclude on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control'.
- 1.2 The annual report must incorporate:
- the scope, including the time period to which the opinion relates, and any scope limitations;
 - consideration of all related requirements including reliance on other assurance providers
 - a summary of the information that supports the opinion; and
 - the risk or control framework or other criteria used as a basis for the overall opinion
 - the overall opinion, judgement or conclusion reached
- 1.3 The annual report must also include a statement on conformance with the Public Sector Internal Audit Standards and the results of the quality assurance and improvement programme.

2. Basis of Opinion

- 2.1 The opinion is based on my knowledge of the Moray Integration Joint Board's governance, risk and control processes and from internal audit activity completed during the period to 31st March 2021. The provision of the opinion is an important source of assurance and any 'limitations in the scope' as a consequence of the pandemic require to be disclosed.
- 2.2 Factors identified by the Chartered Institute of Public Finance and Accountancy as having the potential to impact on the availability of assurance from Internal Audit during the pandemic include:
- the changing risks and impacts on the organisation;
 - whether key governance, risk management and internal control arrangements have deteriorated or been maintained;
 - changes to the resource base of internal audit whether staff or budget related;
 - demands made on Internal Audit for any advisory or non-audit support activity that does not directly support the audit opinion;

- operational disruption that impacts on the access of internal audit to key staff, information or systems resulting in greater inefficiency and reduced outputs

3. Risk or Control framework informing the Opinion

3.1 Assessing each of the above factors in turn:

- There were significant risks and impacts arising as the services falling within the scope of the MIJB moved to respond to the emergency and lockdown. Internal audit noted the mechanisms established to secure continuity of essential services. In March 2020, the MIJB granted delegated authority to the Chief Officer to take decisions in respect of matters that would ordinarily require Board approval, and using digital technology, the Board was able to meet remotely and the planned timetable of MIJB meetings was fulfilled. A further report was presented to the MIJB in September 2020 where it was no longer considered necessary for the Chief Officer to hold emergency decision making powers and consequently these were removed.
- Key governance, risk management and internal control arrangements have been maintained with resources of Health and Social Care Moray (HSCM) directed by an emergency response group that has been operational since the end of March 2020. HSCM has been represented on the emergency response groups of Partner organisations, providing the necessary links and flow of information to ensure a co-ordinated response on a pan-Grampian basis and locally within Moray. The evolving picture in relation to the management of risk has been captured in a regularly updated risk register that is presented to the Audit, Performance and Risk Committee, and towards the end of the year the Board considered and approved an Organisational Governance Framework that provides an overview of how the MIJB is managed and controlled.
- The audit staff resource was maintained for the full year with all posts within Internal Audit's staffing establishment filled. Some of the resource was diverted to advisory or non-audit duties linked to the pandemic, including supporting the administration of COVID-19 Business Grant awards and dealing with appeals relating to eligibility for grant support made under various schemes.
- The operational efficiency of internal audit has not been impacted to the extent it might have been with staff having remote access to main financial systems. Audit work was successfully carried out on these systems it being noted that controls in place remained effective, with in some cases controls being successfully adapted to accommodate remote working. It also continued to participate in a

working group providing advice on controls relative to the provision of self-directed support care packages to eligible service users.

- There have been some limitations on the scope of internal audit activity occasioned by delays in being able to access key staff who themselves were encountering significant workload demands; by being unable to access certain facilities due to homeworking restrictions, and by being unable to access systems that potentially could be subject to audit. Setting this in context, any restrictions applying were not considered to be material in terms of affecting the audit opinion, when assessed alongside other available assurances referenced throughout this report.

4. Summary of Work that supports the Opinion

4.1 The audit assessment of the adequacy and effectiveness of the Council's system of internal control comprises the following elements:

- Governance – from a review of the annual governance statement prepared for inclusion with the MIJB accounts, it was noted that the statement had been prepared in line with good practice guidance issued by CIPFA / SOLACE. The statement included an assessment of the effectiveness of governance arrangements within the MIJB in terms of the seven principles of good governance identified within the guidance. It also referenced the governance processes of the principal partner bodies (NHS Grampian and Moray Council) as sources of additional assurance.
- Risk Management – procedures are well developed with a risk management policy and strategy in place, a risk appetite statement has been developed and a risk register reviewed and updated at regular intervals. The recently updated Risk Register summarises the principal risks facing the organisation under nine themes; these themes focus on critical risk areas including finance, environment and operational continuity, together with transformation risks associated with change, and infrastructure risks given the reliance of the IJB on support from both the council and the NHS.
- Internal Control Environment – the internal control environment has been evaluated through completion of a range of audit projects. Audit planning this year was more agile given the emerging situation, yet remained risk-based, with work undertaken throughout the year to provide assurances that the main payroll and payments systems continued to operate with suitable controls in place. The plan was also flexible so as to allow emerging control systems to be assessed e.g. for the distribution of funding streams linked to the pandemic.

- In completing the audit of payments, supporting information for a small number of sampled social care charges was not available for review. This related to invoices from suppliers of commissioned services, and linked to findings from prior audit work that reported there was more work required to update service contracts to better align these with current policy and service user needs. It was noted that work on commissioning has been restricted during the period of the pandemic, and it is expected that some impetus will be given to reinvigorating the commissioning process when resources can be made available to undertake this task.
- The council's participation in the National Fraud Initiative co-ordinated by Internal Audit also provided positive assurances on a range of datasets. Most of the matched data made available for review in this latest period has been linked to recent changes of circumstances or has signposted a need for data cleansing, as opposed to highlighting fraud or other irregularity involving public funds. The need for prompt cancellation of blue badges no longer required has been highlighted as an issue and systems are being changed to address this system weakness.
- Internal audit operates independently within the organisation and while there may have been limitations in the scope of the audit as a consequence of the pandemic, there have been no limitations imposed by management on the scope of audit work performed. The internal audit opinion has been informed by the audit work completed during the year with substantial reliance placed on the assurances provided by the management of NHS Grampian as the other assurance provider in informing this opinion.

5. Statement on Conformance with the Public Sector Internal Audit Standards

- 5.1 The Local Authority Accounts (Scotland) Regulations 2014 require public bodies to operate a professional and objective internal auditing service in accordance with recognised standards and practices in relation to internal auditing, the Public Sector Internal Audit Standards.
- 5.2 The Scottish Local Authorities Chief Internal Auditors' Group, comprising the audit managers or equivalent of all Scottish Councils, has developed a checklist for assessing conformance with the Standards. This supports the requirement for periodic self assessments and external assessments as part of Internal Audit's Quality Assurance and Improvement Programme.
- 5.3 During the year, the focus for the Chief Internal Auditor has been to continue to progress the implementation of recommendations made following an external quality assessment of internal audit in 2019. This

work is now largely completed with recommendations relative to audit work for the MIJB implemented in full.

6. Quality Assurance and Improvement Programme

- 6.1 The external inspection confirmed that the MIJB's internal audit service generally conforms to the required Public Sector Internal Audit Standards, and this position has been strengthened with the application of the recommendations given in the inspection report. Internal monitoring of performance against the Standards will continue until the next External Quality Assessment, scheduled for 2023, is completed.

7. Opinion

- 7.1 Any system of control can only ever provide reasonable and not absolute assurances that control weaknesses or irregularities do not exist or that there is no risk of error, fraud, or breaches of laws or regulations. Furthermore, it is the responsibility of management to establish an appropriate and sound system of internal control and to monitor the effectiveness of that system, and it is the responsibility of the Chief Internal Auditor to provide an annual assessment of the robustness of the internal control system.
- 7.2 The provision of this annual assessment and opinion has had regard to the consequences of the pandemic relative to service disruption and audit staff working from home. The effect of these impacts was to reduce the outputs of the internal audit team although setting this in context, any restrictions applying were not considered to be material in terms of affecting the audit opinion, when assessed alongside governance practices referenced throughout this report and the controls assurances provided separately by NHS Grampian and Moray Council. *(NHS assurances are available in interim form at the time of drafting this report – tbc following Board meeting in August.)*
- 7.3 Having regard to the factors outlined above, it is my opinion, as the Chief Internal Auditor, that reasonable assurance can be placed on the adequacy and effectiveness of the Moray Integration Joint Board's framework of governance, risk management and internal control for the year ended 31 March 2021.

Atholl Scott, CMIIA
Chief Internal Auditor
16 June 2021



REPORT TO: MORAY INTEGRATION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE ON 24 JUNE 2021

SUBJECT: STRATEGIC RISK REGISTER – JUNE 2021

BY: CHIEF OFFICER

1. REASON FOR REPORT

1.1 To provide an overview of the current strategic risks, along with a summary of actions which are in place to mitigate those risks, updated June 2021.

2. RECOMMENDATION

2.1 It is recommended that the Audit, Performance and Risk Committee (APR) agree to:

- i) consider and note the updated Strategic Risk Register included in APPENDIX 1; and**
- ii) note the Strategic Risk Register will be further refined to align with the transformation plans as they evolve.**

3. BACKGROUND

3.1 The strategic risk register is reviewed regularly by the Senior Management Team as part of a robust risk monitoring framework, to identify, assess and prioritise risks related to the delivery of services in relation to delegated functions, particularly any which are likely to affect the delivery of the Strategic Plan.

3.2 The Moray Integration Joint Board (MIJB) Strategic Risk Register is attached to this report at **APPENDIX 1** and sets out the inherent risks being faced by the MIJB, together with a current assessment on the level of the risks and mitigating actions being taken to reduce the impact of the risks.

3.3 Risk scores are weighted, based on assessment according to their likelihood and corresponding impact, as per Section 5 of the MIJB Risk Policy.

- 3.4 The Strategic Risks received an initial review to ensure they align to the Moray Partners in Care 2019 – 2029 strategic plan which was agreed at MIJB on 28 November 2019 (para 13 of the minute refers).

4. KEY MATTERS RELEVANT TO RECOMMENDATION

- 4.1 The Risk Management Framework review was completed and outcome was approved by the Board on 25 June 2020 (para 9 of the minute refers). The approved Risk Appetite Statements have been included in **APPENDIX 1**.
- 4.2 The impact of COVID-19 has delayed the development of some aspects of transformation plans. Work overseen by North East Partnership on Home First programme continues to be progressed, in line with our Strategic Plan objectives. However the lockdown from December to March 2021 and the additional spike in Covid-19 numbers in Moray in April required the focus of efforts to be placed on vaccinations. These aspects continue to impact on delivery of developmental work as staff have to continually adjust to respond to the Covid-19 situation. Where the numbers of Covid-19 Delta variant continue to increase, the impact of reduced capacity for developmental work is predicted to continue over the summer months, where there will an increased risk of staff absence due to requirements to isolate.
- 4.3 There continues to be significant financial planning and budgetary work with partner organisations to maintain oversight of the additional funding and resource that have been made available from Scottish Government and endowments. This work will need to continue over the year as budgets return to their pre-Covid levels and services adjust.
- 4.4 Recruitment and selection to staff vacancies is proving challenging across the services. The challenges occur in relation to lack of appropriate applications to some posts and also the time taken to for the recruitment process in employing organisations to be followed. There are also delays incurred from external partners such as obtaining PVG confirmations. There are still staff on redeployments and acting up arrangements and there will be a period of time before services and staff return to “business as normal”. Staff wellbeing continues to be a key priority and a significant emphasis is being placed on ensuring that everyone is provided with the support that is available, where it is needed.
- 4.5 As plans evolve, the Strategic Risk Register will be updated to ensure that it reflects any barriers to realising the ambitions we are not enacting, to achieve the vision set out in our Strategic Plan.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan “Moray Partners in Care 2019-2029”

The MIJB requires effective governance arrangements for those services and functions delegated to it and Risk Management systems are integral to this.

(b) Policy and Legal

As set out in the terms of reference, the Board has responsibility to provide assurance of the adequacy of the risk management framework.

There are no legal implications arising from this report.

(c) Financial implications

There are no direct financial implications arising from this report however the Board should note the failure to manage risks effectively could have a financial impact for the MIJB.

(d) Risk Implications and Mitigation

This report forms part of the governance arrangements for identifying and managing strategic risks of the MIJB.

(e) Staffing Implications

There are no additional staffing implications arising from this report. Senior Management Team have considered areas of high risk and are seeking to redeploy staff to address these as a matter of urgency.

(f) Property

There are no property implications arising from this report.

(g) Equalities/Socio Economic Impact

An Equalities Impact Assessment is not required because there are no service, policy or organisational changes being proposed.

(h) Consultations

Consultations have been undertaken with the Senior Management Team and Chief Internal Auditor and comments have been incorporated in this report.

6. CONCLUSION

6.1 This report and appendices contains proposed risk appetite statements that, when approved, will underpin the MIJB approach to strategic decision making.

6.2 The report also outlines the current position in relation to the impact of COVID-19 on progress with transformation plans, and recommends the Board note the revised and updated version of the Strategic Risk Register.

Author of Report: Jeanette Netherwood, Corporate Manager
Background Papers: held by author
Ref:

HEALTH AND SOCIAL CARE MORAY STRATEGIC RISK REGISTER

AS AT 8 JUNE 2021

RISK SUMMARY

1. The Moray Integration Joint Board (MIJB) does not function as set out within the Integration Scheme, Strategic Plan and in-line with Standing Orders and fails to deliver its objectives or expected outcomes.
2. There is a risk of MIJB financial failure in that the demand for services outstripping available financial resources. Financial pressures being experienced by the funding Partners will directly impact on decision making and prioritisation of MIJB.
3. Inability to recruit and retain qualified and experienced staff to provide safe care whilst ensuring staff are fully able to manage changes resulting from integration.
4. Inability to demonstrate effective governance and effective communication and engagement with stakeholders.
5. Inability to cope with unforeseen external emergencies or incidents as a result of inadequate emergency and resilience planning.
6. Risk to MIJB decisions resulting in litigation/judicial review. Expectations from external inspections are not met.
7. Inability to achieve progress in relation to national Health and Wellbeing Outcomes. Performance falls below acceptable level.
8. Inability to progress with delivery of Strategic Objectives and Transformation projects as a result of inability to resolve data sharing and data security requirements.
9. Requirements for support services are not prioritised by NHS Grampian and Moray Council.

RISK RATING	LOW	MEDIUM	HIGH	VERY HIGH
RISK MOVEMENT	DECREASE	NO CHANGE	INCREASE	

The process for managing risk is documented out with the MIJB Risk Policy.

1	
Description of Risk: <i>Regulatory</i>	The Integration Joint Board (IJB) does not function as set out within the Integration Scheme, Strategic Plan and Scheme of Administration and fails to deliver its objectives or expected outcomes.
Lead:	Chief Officer
Risk Rating:	Low/ medium/ high/ very high MEDIUM
Risk Movement:	Increase/ decrease/ no change NO CHANGE
Rationale for Risk Rating:	<p>The strategic plan “Partners in Care” 2019 to 2029 was developed and launched in December 2019. Membership of IJB committees has been relatively stable and the majority of members have attended several cycles of meetings. An amendment to the Scheme to increase membership by one from each of the partner organisations is being considered by the Scottish Government following approval by Moray Council and NHS Grampian Board. During the initial Covid 19 response, normal business was suspended and emergency arrangements were implemented. IJB, CCG and APR meetings restarted during August 2020. In addition weekly meetings of Chair/Vice Chair and Chief Officer are continuing.</p> <p>Progress is being made with the development of the cross system focus on “Home First” and these actions will be incorporated into the Transformation plan that underpins “Partners in Care”</p>
Rationale for Risk Appetite:	<p>The Board, staff and providers across Moray are all committed to ensuring high standards of clinical care & governance through operational policies. Innovation and new ways of working may mean traditional regulations do not exist, or are contradictory.</p> <p>We will only take regulatory risks knowingly, following consultation with the relevant regulatory body and where we have clear risk mitigation in place.</p>
Controls:	<ul style="list-style-type: none"> • Integration Scheme. • Strategic Plan “Partners in Care” 2019 to 2029 • Governance arrangements formally documented and approved by MIJB January 2021. • Agreed risk appetite statement. • Performance reporting mechanisms. • Consultation with legal representative for all reports to committees and attendance at committee for key reports. • Standing orders have been reissued to all members

Mitigating Actions:	<p>Induction sessions are held for new IJB members. IJB member briefings are held regularly. Conduct and Standards training held for IJB Members in December 2020 with updates provided by Legal Services as appropriate.</p> <p>SMT regular meetings and directing managers and teams to focus on priorities.</p> <p>Regular development sessions held with IJB and System Leadership Group Strategic Plan and new management structure is in place and wider system re-design and transformation governance structures are being developed for implementation. The work that has been progressed through the Covid19 response has escalated developments in some areas as a matter of priority. This has been done through collaborative working with partner organisations and the third sector.</p>
Assurances:	<ul style="list-style-type: none"> • Audit, Performance and Risk Committee oversight and scrutiny. • Internal Audit function and Reporting • Reporting to Board.
Gaps in assurance:	<p>The Covid 19 Response has caused a delay in producing the Transformation Plans which in turn has impacted on communication and engagement with staff and partners in respect of the intended outcomes. Work has been undertaken and will further progress over the next quarter to address this gap.</p>
Current performance:	<p>Scheme of administration is reported when any changes are required. An initial meeting has been held with legal advisors to establish the governance requirements for the review of the integration scheme in relation to the proposed delegation of Children's and Criminal Justice Services.</p> <p>Report presenting the Strategic Plan, Communication Strategy, Organisational Development and Workforce Plans, Performance Framework and the draft Transformational Plan were presented and approved at MIJB on 28 November 2019</p> <p>Appointment of Standards Officer agreed by IJB September 2020.</p> <p>Members Handbook has been updated and circulated to all members in June 2021.</p> <p>Governance Framework was approved by IJB 28 January 2021</p>
Comments:	<p>Strategic Planning and Commissioning Group approved the generic Terms of Reference and Chairs of the transformation boards at the meeting on 19 December 2019. It was intended that these boards would be established by April 2020 however this work has been on hold due to Covid19 and is being restarted but will incorporate the changes Covid is causing on ways of working. The Strategic Planning and Performance Lead is now taking this forward.</p>

	<p>The Scheme of Integration requires to be amended to incorporate the agreed increase in membership. The public consultation completed on 5 March 2021 and Moray Council Legal services are progressing with Scottish Government for ratification.</p>
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2	
Description of Risk: <i>Financial</i>	There is a risk of MIJB financial failure in that the demand for services outstrips available financial resources. Financial pressures being experienced both by the funding Partners and Community Planning Partners will directly impact on decision making and prioritisation of MIJB.
Lead:	Chief Officer/Chief Financial Officer
Risk Rating:	Low/ medium/ high/ very high VERY HIGH
Risk Movement:	Increase/ decrease/ no change NO CHANGE
Rationale for Risk Rating:	<p>Whilst the 2019/20 and 2020/21 settlement saw additional investment for health and social care that was passed through to the MIJB, there remains a significant pressure as much of the new investment related to new commitments. Financial settlements are set to continue on a one year only basis, which does not support sound financial planning. In addition, many uncertainties have arisen through the Covid reponse and continue as we continue to remobilise. The full impact is not yet quantifiable.</p> <p>Demand on services is greater than before and the IJB has no remaining general reserves. There is however earmarked reserves of £4.7m that will be used to support the Covid response and Primary Care Improvement Plan</p> <p>The unaudited annual accounts will be presented to the IJB meeting of 24 June 2021 and show a surplus of £6.3m This in the main is derived from late allocation as payment in advance from Scottish Government in relation to Covid spend in 2021/22. The available general reserve of £1.5m has been utilised in balancing the revenue budget for 2021/22 as approved by the IJB in March 2021.</p>
Rationale for Risk Appetite:	<p>The Board recognises the financial constraints all partners are working within. While we are cautious and open about accepting financial risks this will be done:</p> <ul style="list-style-type: none"> • Where a clear business case or rationale exists for exposing ourselves to the financial risk • Where we can protect the long term sustainability of health & social care in Moray <p>Covid-19 places additional risk on the MIJB finances as we continue through the pandemic and continue to remobilise</p>
Controls:	<p>Chief Finance Officer appointed - this role is crucial in ensuring sound financial management and supporting financial decision making, budget reporting and escalation.</p> <p>. The CFO and Senior Management Team continue to work together to address further savings which will be presented to the Board for approval during the 2021/22 financial year. A revised Financial Framework will be developed during the year to support the emerging situation</p>
Mitigating Actions:	<p>Risk remains of the challenge that the MIJB can deliver transformation and efficiencies at the pace required. Financial information is reported regularly to both the MIJB, Senior Management Team and System Leadership Group.</p>

	<p>The Chief Officer and Chief Financial Officer (CFO) continue to engage in finance discussions with key personnel of both NHS Grampian and Moray Council. These conversations have continued through the pandemic phase.</p> <p>Chief Officer and CFO will continue to engage with the partner organisations in respect of the financial position throughout the year. Cross partnership performance meetings are in with partner CEOs, Finance Directors and the Chair/Vice Chair of the IJB.</p> <p>The focus for 2021/22 will be close monitoring to assess the continuing impacts of Covid-19 and the costs of remobilisation in addition to identifying further efficiencies and seeking IJB approval</p>
Assurances:	MIJB oversight and scrutiny of budget. Reporting through MIJB, NHS Grampian Board and Moray Council.
Gaps in assurance:	None known
Current performance:	For the 2020/21 year an underspend is reported at the end of the financial period Reliance has been place on Covid – 19 funding to support under-delivery of savings will has beendrawn-down to create a general reserve. This has been required to support a balanced budget for 2021/22
Comments:	Senior managers to work with Chief Officer and Chief Financial Officer to address the continuing financial challenge, continuing to seek efficiencies and opportunities for real transformation and forecast overspend as we progress through the current pandemic. Through reporting, regular updates will be provided to the MIJB, Moray Council and NHS Grampian as part of the risk sharing arrangement in place.

3	
Description of Risk: <i>Human Resources (People):</i>	Inability to recruit and retain qualified and experienced staff to provide and maintain sustainable, safe care, whilst ensuring staff are fully able to manage change resulting from response to external factors such as the impact of Covid and the actions that will arise from the recommendations from the Independent Review of Adult Social Care 2021..
Lead:	Chief Officer
Risk Rating:	Low/ medium/ high/ very high HIGH
Risk Movement:	Increase/ decrease/ no change NO CHANGE
Rationale for Risk Rating:	There continues to be issues with recruitment to some front line services that require specific skills and experience. This has been the case for some time now and continues to place pressure on existing staff. There are additional tasks to be

	<p>undertaken which include flu immunisation and this is using considerable resource which will not be available to support other frontline services over winter.</p> <p>The roll out of the Covid vaccine placed a significant strain on the Partnerships resources across frontline and support functions and this has resulted in delays for the progress of projects relating to the achievement of strategic objectives.</p> <p>The Care Homes in Moray have done extremely well to maintain their staffing levels throughout the pandemic and whilst the difficulty with recruitment and retention of staff to caring roles is still being experienced there has not been a direct impact on HSCM teams for additional support from contractors. Neither has Covid 19 cause significant disruption to staffing as a result of positive cases or notification of Test, Trace and Isolate .</p> <p>There have been some achievements in the recent appointment to the Geriatrician post and an agreed model for orthopedics and anesthetics in Dr Grays. There is further work being undertaken to develop the model for General medicine. The benefit of these appointments are being felt across the whole system.</p> <p>The transition from EU membership has not presented any specific concerns for workforce and this will continue to be monitored.</p> <p>The impact of budgetary decisions by the Council in relation to reducing staffing levels has reduced levels of support provided in some key areas for Health and Social Care Moray (HSCM), such as ICT, HR, Legal and design. This has been further impacted due to Covid 19 and Committee Officer support will not be available for APR and CCG committees until the new year.</p>
Rationale for Risk Appetite:	<p>Safety risks that could result in harm to service users, staff or the public are inherent in Health & Social Care services. The safety of individuals is paramount therefore standards of safety management and clinical care have to be high, and the Board will continue to seek assurances this is the case.</p> <p>The Board's ambition is for health & social care to be people centred. This means supporting people in decision making about their own health & care, which may expose individuals to higher risk where they make an informed decision.</p> <p>The Board will also seek to balance individual safety risks with collective safety risks to the community.</p>
Controls:	<p>Management structure in place with updates reported to the MIJB.</p> <p>Organisational Development plan in place and Workforce Plans are being updated to align to the new strategic plan.</p> <p>Continued activity to address specific recruitment and retention issues. The chief social worker reviewed the situation with managers and employed a Consultant Practitioner to develop options for addressing some of the particular issues affecting social work services in Moray and to provide support to managers and staff.</p> <p>Management competencies continue to be developed through Kings Fund training although this is suspended due to Covid19.</p>

	<p>Communications & Engagement Strategy was approved in November 2019 and is being implemented.</p> <p>Council and NHS performance systems in operation with HSCM reporting being further developed and information relating to vacancies, turnover and staff absences is integral to this. This has been expanded to collate details of staff shielding or isolating so arrangements can be made to utilise staff resources as effectively as possible.</p> <p>SMT review vacancies and approve for recruitment.</p> <p>Managers are highlighting any areas of concern and where appropriate this is identified in operational risk registers.</p>
Mitigating Actions:	<p>System re-design and transformation.</p> <p>Organisational Development Plan and Workforce plan has been updated and was approved by MIJB in November 2019 and it being progressed by the Workforce Forum.</p> <p>Staff Wellbeing is a key focus and there are many initiatives being made available to all staff including training, support, information and access to activities. .</p> <p>Locality Managers are developing the Multi-disciplinary teams in their areas.</p> <p>Workforce planning has recommenced and an initial draft was prepared and submitted in April 2021. This will be taken forward alongside plans for NSHG and Moray Council with a detailed version being prepared for March 2022.</p> <p>Lead Managers are involved in regional and national initiatives to ensure all learning is adopted to improve this position.</p> <p>Lead Managers and Professional Leads are linked to University Planning for intakes and programmes for future workforce development.</p> <p>Close monitoring of Covid infection rates and potential impacts for services are considered at the weekly Response Group meeting.</p>
Assurances:	<p>Operational oversight by Moray Workforce Forum has resumed and will report to MIJB in accordance with the agreed Governance framework.</p> <p>The HSCM Response Group has been in place over the whole period of the Covid19 pandemic providing focussed leadership around emerging issues and resolving them.</p>
Gaps in assurance:	<p>Further work required to develop workforce plans to reflect strategic plan implementation programmes once they are agreed.</p>
Current performance:	<p>The full IMatter surveys did not take place during 2020 however an IMatter pulse survey was undertaken in September 2020 to get a snap shot of what staff are feeling. Results were published 20 November 2020 and although there was a lower response rate of the 36% the “working within the organisation satisfaction” score was 6.91 compared with 6.94 in 2019. Work is underway in preparation fo the Imatter survey that will take place during July/August</p> <p>Discussions are underway with HR in both Council and NHS to develop access to appropriate HR information at a summarised level to facilitate the necessary workforce planning and subsequent monitoring of plans.</p>
Comments:	<p>Staffing issues are owned by the Systems Leadership Group who will work collaboratively across the system to seek opportunities to make jobs more attractive where it has proved difficult to recruit in the past.</p>

4	
Description of Risk: <i>Reputation:</i>	Inability to demonstrate effective governance and effective communication and engagement with stakeholders.
Lead:	Chief Officer
Risk Rating:	low/medium/high/very high MEDIUM
Risk Movement:	increase/decrease/no change INCREASING
Rationale for Risk Rating:	<p>Locality planning assessed as medium in relation to ability to work at the pace required and current workforce capacity.</p> <p>Performance framework to be further developed from a planning perspective to show the links through operational service delivery to strategic objectives.</p> <p>The Third Sector rep has stood down from MIJB and the substitute is only able to commit to attending until August 2021 so there is a need to recruit.</p> <p>Recent engagement with individuals representing their communities or third sector organisations in a variety of forums is highlighting that problems with their capacity to fulfil our needs so more co-ordination and clearer focus is required to ensure that the communication, engagement and outcomes are meeting identified needs.</p>
Rationale for Risk Appetite:	<p>The Board is cautious but open about risks that could damage relationships with different stakeholders. It recognises many of our aspirations depend on effective collaboration, coproduction and partnership working with a range of stakeholders. The appetite also recognises that while the aspiration is to be a co-operative partner, some partners will not be able to move at the same pace as us all the time.</p> <p>We will seek to protect relationships in the long term and will not set out to antagonise stakeholders deliberately. For example, we must not be seen to exclude or prevent participation in the design of services where there is an appetite to do this.</p> <p>We must be mindful that repairing relationships is easier when there is already a well of goodwill to draw on, and that further damage to an already damaged relationship will not be conducive to good long term outcomes.</p> <p>Traditional methods of engagement are not possible at present as social distancing rules apply however alternative mechanisms for engaging with stakeholders are being used along with social media</p>

Controls:	<p>Governance Framework approved by IJB January 2021 Communication and Engagement Strategy approved November 2019 Annual Governance statement produced as part of the Annual Accounts 2019/20 and submitted to External Audit. Annual Performance Report for 2019/20 was published in August 2020 Performance reporting mechanisms in place and being further developed through performance support team, home first group and system leadership team. Community engagement in place for key projects areas such as Forres and Keith with information being made available to stakeholders and the wider public via HSCM website. Participation of stakeholders in Home First project meetings.</p>
Mitigating Actions:	<p>Schedule of Committee meetings and development days in place and implemented.</p> <p>Good working relationship established with Audit Scotland, the MIJB's appointed external auditors since 16/17.</p> <p>Annual Performance Report for 2019/20 published in August 2020. Social media is actively used as a method of engaging with the public, with short videos focussing on particular services being trialled.</p>
Assurances:	<p>Oversight and scrutiny by Clinical and Care Governance Committee, Audit Performance and Risk Committee and MIJB. Summary reports of minutes of MIJB meetings are submitted to Council committee and NHS Board.</p>
Gaps in assurance:	<p>Progress on implementation of the Communication and Engagement Strategy has been impacted by the Covid 19. Due to the impact of COVID and requirement for social distancing the normal mechanism for engagement are not all available. More use is being made of social media and Microsoft teams and other options and methods for engagement with staff are being used via NHSG such as videos on Youtube and one question surveys.</p>
Current performance:	<p>Communications Strategy was reviewed approved by IJB November 2019. Annual Performance Report 2019/20 published August 2020. Audited Accounts for 2019/20 were publicised by deadline 30 September 2020</p> <p>Due to Covid19 there have been increased levels of briefings to staff, the public and Chair/Vice Chair of MIJB with a focus on the key elements of the response. Staff have been involved in co-ordinating services for and communicating with shielded and vulnerable people.</p>
Comments:	<p>A communication cell was established as part of the Local Resilience Partnership response with representation from Councils, HSCP and NHSG. This was led by Aberdeen City Council and was an example of the collaborative working that took place. This forum provides assurance that messages to all stakeholders are consistent. It also ensures that</p>

	<p>there is support for our Communications Officer and resilience provided with the access to other communication officers.</p> <p>There has been representation from the Home first project at the Wellbeing forum to facilitate sharing of information and seeking views.</p>
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5	
Description of Risk: <i>Environmental:</i>	Inability to cope with unforeseen external emergencies or incidents as a result of inadequate emergency and resilience planning.
Lead:	Chief Officer
Risk Rating:	low/medium/high/very high HIGH
Risk Movement:	increase/decrease/no change NO CHANGE
Rationale for Risk Rating:	<p>Due to the response requirements for Covid 19 progress has been made in a number of areas. SMOC information is updated, control room guidance updated and expanded, control centre protocols were implemented and remain in place and management teams have responded in an agile, responsive and collaborative way under very challenging conditions.</p> <p>HSCM did not have a collectively approved list of critical functions at the start of the response however this was quickly completed and used to prioritise allocation of resources to the response. This list has been recently reviewed to take into account remobilised services and the winter/surge action plan has been further defined and implemented</p> <p>Whilst the rates of Covid infection in Moray at the moment are relatively low the situation could change. Risk identification, assessment and initial response plans have been developed for potential impacts across the whole system.</p> <p>MIJB will be redefined as a Category 1 responder under the Civil Contingencies (Scotland) Act and there are additional requirements for preparedness that is being taken forward in partnership with NHSG and Moray Council emergency planners.</p>
Rationale for Risk Appetite:	The MIJB understand the requirement to meet the statutory obligations set out within the Civil Contingencies Act and the Category 1 status applied in March 2021, and work with partner organisations to meet these obligations
Controls:	<p>Winter/Surge Plan updated and was tested alongside NHSG plans for winter with participation from officers in cross system table top exercises. Further work is being undertaken to identify learning from recent incidents to strengthen plans.</p> <p>HSCM Civil Contingencies group established and meeting regularly to address priority subjects.</p> <p>NHS Grampian Resilience Standards Action Plan approved (3 year).</p>

	<p>Business Continuity Plans in place for most services although overdue a review in some areas. Knowledge of critical functions and ability to respond quickly and effectively has been in evidence during recent incidents such as Gas outages in Keith and Covid response – debriefs carried out and learning identified</p>
Mitigating Actions:	<p>Information from the updated BIA/BCP has informed elements of the Winter Plan (Surge plan).</p> <p>A Friday huddle is in place which gathers the status of services across the whole system to provide information and contact details to the Senior Manager on Call (SMOC) over the weekend.</p> <p>NHS Grampian have amended their approach to Pandemic preparation so HSCM Pandemic plan requires redrafting and testing</p> <p>Lesson learnt from the response to Covid will be incorporated into the Surge (Winter) Plan and training needs identified will be addressed.</p> <p>Practitioner group established for Moray with representation from HSCM, Dr Grays, Moray Council and NHSG to discuss matters arising from the Local Resilience Forum and within our respective organisations. In addition it will provide a forum for discussion of the linkages between organisational response plans to ensure there are no gaps or over reliance on particular local resources.</p> <p>HSCM continues to monitor the local situation regarding Covid-19 and is engaged with NHSG emergency planning arrangements and Council Response and Recovery management team to be ready to escalate response if required. There will be some planning with partner organisations to ensure that arrangements are in place to facilitate widescale testing should the need arise.</p>
Assurances:	<p>Audit, Performance and Risk Committee and NHS Grampian Civil Contingencies Group oversight and scrutiny.</p>
Gaps in assurance:	<p>Recent experience has highlighted the need for additional staff to be trained to be control centre managers, loggists and general awareness of response structures and meeting protocols. This will be incorporated into training schedules going forward. It has also highlighted the need for a more robust arrangement for out of hours contact and clarity of roles and responsibilities across the system which is being progressed with partners in Moray.</p> <p>Some table top exercises have been completed but the intended programme for 2020 will require to be rescheduled once we are out of response phase.</p> <p>Progress has been made however further work is required to address the targets in the implementation plan that have not been met and the Resilience standards as identified by the NHSG Civil Contingencies Group.</p> <p>Pandemic flu plans will require to be updated with the learning from this incident</p>

<p>Current performance:</p>	<p>The Senior Management Team participated in Strategic Leadership in a Crisis training in 2020 and a programme of further training for the wider management team is scheduled.</p> <p>Many services have business continuity arrangements and some are overdue for an update. Work has progressed in identification of a critical functions list for agreement by System Leadership Group that will inform planning arrangements going forward. There will need to be changes made to business continuity plans following the implementation of additional ICT resources in services which have provided a greater deal of resilience for some services and functions – albeit reliant on electricity supply.</p> <p>Annual report on progress against NHS resilience standards was reviewed by APR committee on 25 March 2021..</p>
<p>Comments:</p>	<p>Once the response phase is complete the HSCM Civil Contingencies group will schedule and review progress in achieving the NHSG resilience standards, reporting updates to System Leadership Group.</p>

6	
Description of Risk: <i>Regulatory</i>	Risk to MIJB decisions resulting in litigation/judicial review. Expectations from external inspections are not met.
Lead:	Chief Officer
Risk Rating:	low/medium/high/very high MEDIUM
Risk Movement:	increase/decrease/no change INCREASING
Rationale for Risk Rating:	Considered medium risk due to the impact of Covid-19 and resultant efforts required to remobilise services and/or the increase in workloads stretching a workforce that has been under sustained pressure for a considerable time.
Rationale for Risk Appetite:	<p>The Board, staff and providers across Moray are all committed to ensuring high standards of clinical care & governance through operational policies. Innovation and new ways of working may mean traditional regulations do not exist and require to be developed, no longer apply, or are contradictory.</p> <p>We will only take regulatory risks knowingly, following consultation with the relevant regulatory body and where we have clear risk mitigation in place.</p>
Controls:	<p>Clinical and Care Governance (CCG) Committee established and future reporting requirements identified</p> <p>High and Very High operational risks are reviewed by System Leadership Group monthly and a review of all risks will be undertaken as part of the risk management framework.</p> <p>Complaints and compliments procedures in place and monitored.</p> <p>Clinical incidents and risks are being reviewed on a weekly basis to ensure processes are followed appropriately and consistently and responses are recorded in a timely manner.</p> <p>Adverse events and duty of candour procedures in place and being actioned where appropriate and summary reports submitted to CCG committee.</p> <p>Reports from external inspections reported to appropriate operational groups and by exception to SMT for subsequent reporting to CCG or Audit Performance and Risk Committee as appropriate.</p> <p>Care Home Oversight Group is meeting daily to oversee and manage risks in care homes.</p> <p>Children and Adult Protection services are being delivered and reported to their respective committee on a regular basis.</p>
Mitigating Actions:	<p>This risk is discussed regularly by the three North East Chief Officers.</p> <p>Additional resource has been allocated to support the analysis of information for presentation to CCG committee</p> <p>Process for sign off and monitoring actions arising from Internal and External audits has been agreed</p>

Assurances:	Audit, Performance and Risk and Clinical and Care Governance Sub-Committees oversight and scrutiny. Governance Framework in place and operational.
Gaps in assurance:	Process for highlighting recurring themes or strategic expectations from external inspections requires further development to ensure Committee has sight of significant issues. There has been a reduction in staff resources around clinical and care governance due to the need to deploy staff to the vaccination team. This is being addressed.
Current performance:	External inspection reports are reviewed and actions arising are allocated to officers for taking forward. A summary of inspections was included in the Annual Performance report
Comments:	No major concerns have been identified for HSCM services in any audits or inspections this year. The equipment store has received a follow up internal audit and the initial verbal feedback was positive.

7	
Description of Risk: <i>Operational Continuity and Performance:</i>	Inability to achieve progress in relation to national Health and Wellbeing Outcomes. Performance of services falls below acceptable level.
Lead:	Chief Officer
Risk Rating:	low/medium/high/very high HIGH
Risk Movement:	increase/decrease/no change NO CHANGE
Rationale for Risk Rating:	Potential impacts to the wide range of services in NHS Grampian and Moray Council commissioned by the MIJB arising from reductions in available staff resources as budgetary constraints impact. Unplanned admissions or delayed discharges place additional cost and capacity burdens on the service. The level of delayed discharges has fluctuated over the last two months but reduced in recent weeks and has reflected the sustained focus and collective efforts by all those working in the pathway. However this is a complex area and will require continued effort to continue reductions and maintain them.

Rationale for Risk Appetite:	<p>The Board is cautious but open about risks that could affect outcomes that are priorities for people in Moray. There is a slightly higher appetite to risks that may mean nationally set outcomes – that by design are not given a high priority in Moray - are not met.</p> <p>This will only be accepted where there is a clear rationale, and preferably also a way of demonstrating what the IJB is doing to meet the aspiration the outcome was created for.</p>
Controls:	<p>Performance Management reporting framework. 2019 to 2029 “Partners in Care” Strategic Plan approved and Transformation Plan being developed. Performance regularly reported to MIJB. Revised Scorecard being developed to align to the new strategic priorities. Best practice elements from each body brought together to mitigate risks to MIJB’s objectives and outcomes. Chief Officer and SMT managing workload pressures as part of budget process.</p>
Mitigating Actions:	<p>Service managers monitor performance regularly with their teams and escalate any issues to the System Leadership Group for further discussion to provide wider support, developing shared ownership and a greater understanding across the whole system.</p> <p>Key performance data is being circulated daily to all managers in a “Performance Flow” dashboard to ensure any potential issues are identified quickly so action can be taken. This dashboard is being reviewed and will be further developed with the intention of further dashboards to provide a whole system overview</p>
Assurances:	<p>Audit, Performance and Risk Committee oversight. Operationally managed by service managers, summary reports to Practice Governance and clinical and care governance group and to System Leadership Group.. Strategic direction provided by Senior Management Team.</p> <p>HSCM Response Group continues to meet and reviews the key performance information and actions that are required to deliver the priority services.</p>
Gaps in assurance:	<p>Development work in performance to establish clear links to describe the changes proposed by actions identified in the Strategic Plan has recommenced but is at an early stage. Progress will be reported to future Board meetings.</p>
Current performance:	<p>Covid19 has impacted on all areas of the service and work is underway to take the learning and experience gained during the response to collate performance information in dashboards to support managers interpret the impact of Covid19 on their services, now and going forward.</p> <p>There are likely to be changes to ways of working and this may also have impact on the performance information required.</p>

Comments:	<p>Work has progressed with development of performance monitoring and reporting of key performance indicators for locality managers.</p> <p>The delayed discharge group has produced an action plan for implementation and progress is being made.</p> <p>Practice Governance have been reviewing their operational performance requirements.</p> <p>The Home First priorities are being taken forward and updates are reported to this committee or MIJB on a regular basis.</p>
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8	
Description of Risk: <i>Transformation</i>	Inability to progress with delivery of Strategic Objectives and Transformation projects.
Lead:	Chief Officer
Risk Rating:	low/medium/high/very high HIGH
Risk Movement:	increase/decrease/no change NO CHANGE
Rationale for Risk Rating:	<p>There are many issues that will impact on the ability to progress to deliver Strategic Objectives.</p> <p>The transformation plan is being developed and will be presented to the Board for approval and will form the basis for monitoring progress on delivery of the objectives. The appointment of the Strategic Planning and Performance Lead provides additional capacity to take this forward and to align the priorities arising nationally, Grampian-wide and locally.</p> <p>The remobilisation plan for HSCM services that were suspended or reduced is progressing with Providers services and social work implementing the IJB decision to return to delivery of both substantial and critical eligibility criteria. Work has progressed and risk assessments are completed and assessments have been or are in the process of being reviewed to ensure equality. The restrictions of social distancing on services mean that capacity for services is impacted which means that service users will not have the same level as before Covid however it is anticipated that a hybrid service will be offered which will facilitate tailoring of services to meet specific individual outcomes where this is appropriate.</p> <p>The time period and extent of Covid 19 the impact on the population of Moray will not be fully understood until well after the response is over. It is therefore not possible to predict the extent of the impact on the ability to progress with delivery of Strategic Objectives. There are some aspects that have progressed very well such as introduction of Near Me consultations but there are others that are more difficult to progress.</p> <p>There is concern that due to the workloads and challenges over the last year that teams are weary and/or do not have capacity at this moment in time, to progress with delivery of development plans at this moment in time. Managers are</p>

	<p>working with teams to establish “readiness” and their capacity and sense of wellbeing and a report will be collated that will inform plans going forward.</p> <p>One key aspect to facilitate transformation is the need for progress in relation to ICT infrastructure, data sharing and data security across the whole system. Work was undertaken by NHS GRAMPIAN and partners to address the needs for ICT kit and information during the response to Covid and it is hoped that this progress can be built on</p>
Rationale for Risk Appetite:	<p>The Board has a high appetite for risks associated with delivery of the Transformation plan. The following should be considered when accepting these risks:</p> <ul style="list-style-type: none"> • We understand and can mitigate other risk types that may arise, e.g. safety or financial within appetite • Service users are consulted and informed of changes in an open & transparent way • We will monitor the outcome and change course if necessary
Controls:	<p>Home First strategic theme is being progressed across the whole system and a local Home First Group is meeting fortnightly. The Home First Transformation Board has also been established for Grampian – the output of these meetings will go through appropriate governance frameworks. A newsletter is being produced to keep staff and partners informed.</p>
Mitigating Actions:	<p>Integrated Infrastructure Group established, with ICT representation from NHSG and Moray Council, to consider and provide solutions to data sharing issues and ICT infrastructure matters. Linkages to Infrastructure board and Information sharing groups have been established albeit these meetings are not taking place regularly at the moment</p> <p>Data sharing groups for Grampian and Health and Social Care Moray have been established and meetings were held regularly but have not taken place for several months due to Covid. These meetings have oversight of any issues arising from Data protection and GDPR matters from either Council or NHS systems.</p>
Assurances:	<p>Strict ICT and data sharing policies and protocols in place with NHS Grampian and Moray Council.</p>
Gaps in assurance:	<p>Transformation Plan is being developed that will detail the outcomes.</p> <p>Protocol for access to systems by employees of partner bodies to be documented. Information Management arrangements to be developed and endorsed by MIJB. Process of identification of issue and submission to data sharing group requires to be reinforced to ensure matters are progressed.</p> <p>Meetings have not been taking place due to Covid.</p>



Current performance:	Training programme to be developed on records management, data protection and related issues for staff working across and between partners.
Comments:	Where national systems are involved it may not be possible to identify a solution however the issues will be able to be raised at the appropriate level via the Grampian Data Sharing Group where all three partnerships are represented.

9	
Description of Risk: <i>Infrastructure</i>	Requirements for support services are not prioritised by NHS Grampian and Moray Council.
Lead:	Chief Officer
Risk Rating:	low/medium/high/very high HIGH
Risk Movement:	increase/decrease/no change NO CHANGE
Rationale for Risk Rating:	<p>Changes to processes and necessary stakeholder buy-in still bedding in.</p> <p>Moray Council is undertaking a Property review of office and depot accommodation and the potential impact for HSCM services requires consideration. The output was anticipated in October 2019 however due to changes with roles and responsibilities within the Council however the paper has been out for consultation. The changes required to places of work as a result of Covid19 continue to restrict the number of people that can use an office. These decisions are being made by NHSG and Moray Council and we await their development of policy regarding workspace and availability of facilities going forward. NHSG have advised that staff should aim to work from home until December 2021 although an update will be provided in August 2021.</p> <p>ICT infrastructure service plans in NHS Grampian and Moray Council are not yet visible to HSCM and development of communication and engagement process is required.</p> <p>The impact of Covid has resulted in a change in ICT strategy for Moray Council. Staff requiring mobile technology have now been provided with it and many staff are working from home. This is a necessity where the number of desks available in offices has been reduced due to implementation of social distancing guidance.</p> <p>There is still an issue with availability of kit for NHS employed staff which has been escalated and progressed but it is not yet complete. The volume of requests received was the major factor.</p>
Rationale for Risk Appetite:	Low tolerance in relation to not meeting requirements.
Controls:	Chief Officer has regular meetings with partners Computer Use Policies and HR policies in place for NHS and Moray Council and staff are required (through an automated process) to confirm they have read these every 6 months

	<p>PSN accreditation secured by Moray Council</p> <p>Infrastructure Programme Board established with Chief Officer as Senior Responsible Officer/Chief Officer member of CMT. Process for submission of projects to the infrastructure board approved and implemented to ensure appropriate oversight of all projects underway in HSCM. The Board is not meeting at present so project requests are being processed via Senior Management Team.</p>
<p>Mitigating Actions:</p>	<p>Membership of the Board was reviewed and revised to ensure representation of all existing infrastructure processes and funding opportunities.</p> <p>Process for ensuring infrastructure change/investment requests developed</p> <p>Infrastructure Manager in post and linking into other Infrastructure groups within NHSG & Moray Council to ensure level of 'gatekeeping'.</p> <p>Dr Gray's site development plan is being produced collaboratively with input from NHSG and HSCM management</p>
<p>Assurances:</p>	<p>Infrastructure Programme Board functions to provide robust governance and assurance that proposed projects have a robust business case and meets requirements of the respective partner organisations. This board reports to Strategic Planning and Commissioning Group. Both of these groups are being refreshed and remobilised.</p> <p>Workforce Forum meeting regularly with representation of HR and unions from both partner organisations</p>
<p>Gaps in assurance:</p>	<p>Further work is required on developing the process for approval for projects so that they are progressed timeously. Need to review all existing processes in relation to infrastructure changes/projects/investments and streamline to avoid duplication of effort.</p> <p>Infrastructure Board is not currently meeting</p> <p>Committee services support is reduced at this time due to a vacancy at this time. HSCM staff are clerking CCG and APR committees. Legal services have reduced capacity to provide support due to budget cuts so any requests may take longer.</p> <p>Recruitment for vacancies takes considerable time due to various factors and is presenting a strain on services to maintain normal service whilst covering vacancies. There have been several posts that have had to go out to advert more than once extending the time other staff are covering gaps.</p>

<p>Current performance:</p>	<p>The Infrastructure Board is currently suspended. Its purpose is for highlights/exceptions to be taken to SLG for communication and information purposes.</p> <p>Access to support for development of HSCM priorities is difficult at time because projects/requests are prioritised against all other services in the partner organisations. The challenges for HSCM staff and managers to work using networks/systems from two organisations, which cannot be accessed by all members of teams due to data sharing matters is significant.</p>
<p>Comments:</p>	<p>Existing projects will be reviewed as part of the development of the transformation plans for the Strategic Plan to ensure resources are being dedicated appropriately and aligned to the emerging Strategic priorities. Our requirements for support will be communicated via appropriate channels</p>



REPORT TO: MORAY INTEGRATION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE ON 24 JUNE 2021

SUBJECT: INTERNAL AUDIT PLAN

BY: CHIEF INTERNAL AUDITOR

1. REASON FOR REPORT

- 1.1 To provide the Moray Integration Joint Board (MIJB) Audit, Performance and Risk Committee with information on the proposed internal audit coverage for completion in the current 2021/22 financial year.

2. RECOMMENDATION

- 2.1 **It is recommended that the Committee considers this report and agrees the proposed audit coverage.**

3. BACKGROUND

- 3.1 Scottish Government Integrated Resources Advisory Group (IRAG) guidance requires each IJB to establish adequate and proportionate internal audit arrangements for the review of risk management, governance and control of delegated resources.
- 3.2 The guidance recommends that a risk based audit plan should be developed by the Chief Internal Auditor of the IJB and be approved by the IJB or other Committee (in Moray, the Audit, Performance and Risk Committee). Importantly it also notes that the operational delivery of services within the Health Board and local authority on behalf of the IJB will be covered by their respective internal audit arrangements as at present.
- 3.3 NHS Grampian and Moray Council for their own respective interests will agree their own annual audit plans. Audit reports on topics contained within these plans will be reported in the first instance to the relevant audit committees of each organisation. Where these audit reports contain information pertinent to the MIJB, these will then be presented to the MIJB Audit, Performance and Risk Committee as an additional source of assurance.

- 3.4 During 2020/21 discussions were held to explore the possibility of developing closer working relationships between the internal audit services for the MIJBs of Moray, Aberdeen City, Aberdeenshire councils and the appointed internal auditor of Grampian Health Board. The principle of joint working has been established and it is expected these meetings will continue for the purpose of developing a more joined up audit approach to align to the requirement for greater integration of services.
- 3.5 Moray Council's Audit and Scrutiny Committee at its meeting on 16 June 2021 approved an audit plan which provided for a total of 50 days input for audit work relating to the MIJB and Social Care. While the number of days assigned specifically to the MIJB is less than previous years, it is hoped once the staffing issues within the Internal Audit Section are resolved, additional audit days will be made available before the end of 2021/22.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

- 4.1 In selecting audit topics, a full evaluation of the council's resource inputs to the activities directed by the MIJB has been undertaken, with consideration given to:
- materiality (based on expenditure or income)
 - consultation with senior management for areas of work where it was considered internal audit could make a contribution through its work programme
 - time elapsed since an area was last subject to review
 - overall audit assessment of the control environment
- 4.2 The following areas are considered for inclusion within the 2021/22 Audit Plan:-
- **Client Monies** - An audit of the management and accounting of social care clients where the Council manages an individual's personal finances.
 - **Self-Directed Support** - An audit of Self Directed Support financial monitoring arrangements The review will also check to ensure monies awarded correspond to a service users support plan.
- 4.3 The pandemic has resulted in significant changes within current working practices that make audit planning challenging, and uncertainty still remains regarding these arrangements in the period ahead. All audit staff are still working from home which brings some limitations to the audit process. Team members have been fortunate to be classed as mobile workers each with a dedicated work laptop and mobile phone but lack of face to face contact has slowed the pace of audits. Also, many of the employees internal audit would ordinarily work with have had a focus elsewhere to ensure continuity of service in front facing services. Committee should therefore be aware of the possible disruption in the service provided by the Internal Audit Section due to the limitations placed on current and potential future working practices from the impact of the pandemic.
- 4.4 The Public Sector Internal Audit Standards require the Internal Audit Manager

to consider whether or not the audit staffing resources are sufficient to meet the audit needs of the organisation, and where it is believed that the level of resources may impact adversely on the provision of the annual internal audit opinion, and to draw this to the attention of the Committee. With the specific number of days allocated to Social Care audits relatively low there will be capacity to undertake this work although it should be noted that the Chief Internal Auditor is retiring from the council. This coupled with another vacancy in the audit team may impact on the capacity of the team to meet all the requirements of the Public Sector Internal Audit Standards. It will also be necessary for the MIJB to consider interim arrangements for the Chief Internal Auditor appointment which was scheduled to be reviewed again in March 2022.

- 4.5 In considering the audit coverage, the Audit, Performance and Risk Committee should be aware that the responsibility for developing and maintaining a sound control environment rests with management and not with Internal Audit. Similarly it will be recognised that Internal Audit is not the only scrutiny activity within the MIJB, with services challenged through other mechanisms including external audit and inspection, and separate reporting on clinical and care governance.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan “Moray Partners in Care 2019 – 2029”

The work of internal audit supports good governance and provides independent assurances to the MIJB on use of its resources.

(b) Policy and Legal

The report has been prepared having regard to IRAG guidance issued by Scottish Government.

(c) Financial implications

There are no financial implications arising directly from this report.

(d) Risk Implications and Mitigation

The work of internal audit provides assurances on the adequacy and effectiveness of the internal control systems established by management in support of service delivery arrangements and use of resources in selected areas. Positive assurances together with recommendations covering areas for improvement mitigate the risk of desired outcomes not being achieved.

(e) Staffing Implications

A number of staffing issues within Internal Audit require to be addressed as outlined in this report although it is not expected these will directly impact on the projects to be undertaken specifically for the

MIJB.

(f) Property

None arising from this report.

(g) Equalities/Socio Economic Impact

None arising from this report.

(h) Consultations

Consultations have taken place with the MIJB Chief Officer, Chief Financial Officer, Head of Service/CSWO, Corporate Manager, HSCM and Tracey Sutherland, Committee Services Officer, Moray Council, whose comments have been incorporated within the report.

6. CONCLUSION

6.1 The Committee is asked to consider and agree the planned audit coverage for the MIJB for 2021/22.

Author of Report: Dafydd Lewis, Senior Auditor
Background Papers: Audit working papers
Ref: MIJB/aprc/240621



REPORT TO: MORAY INTEGRATION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE ON 24 JUNE 2021

SUBJECT: PRIMARY CARE IMPROVEMENT PLAN - UPDATE

BY: HEAD OF SERVICE

1. REASON FOR REPORT

1.1. To inform the Board of Health and Social Care Moray's (HSCM) progress towards implementation of the Primary Care Improvement Plan (PCIP).

2. RECOMMENDATION

2.1. It is recommended that the Board consider and note:

- i) the progress made towards implementation; and**
- ii) the potential impact should all PCIP elements be fully implemented.**

3. BACKGROUND

3.1. The memorandum of understanding (MoU) between the Scottish Government, the British Medical Association, Integration Authorities and NHS Boards for the new GMS contract was agreed in April 2018. The memorandum sets out the principles by which primary care redesign will be delivered to allow GPs to focus on being expert medical generalists and medical leaders with support from the Multi-Disciplinary Team (MDT).

3.2. The development of primary care service redesign in the context of delivery of the new GMS contract should meet the following key principles:

- safe
- person-centred
- equitable
- outcome focused
- effective
- sustainable
- affordable

3.3 As a result of the new Contract, all Integration Authorities now have locally-agreed Primary Care Improvement Plans (PCIP). The MoU priorities have been identified as:-

- Vaccination Services,
- Pharmacotherapy,
- Community Treatment and Care Services,
- Urgent Care Service and
- Additional Professional Roles

3.4 Plans for 2019 to 2021 included local workforce planning, infrastructure development and patient engagement – work which aims to improve the primary care people receive in their communities.

3.5 Partnerships are expected to report their progress on PCIP to Scottish Government each May and September. The most recent round of reporting was referred to as PCIP 4 and covered the period September 2020 to May 2021.

3.6 Due to slippage the above timescale was revised in December 2020, extending some elements of the MoU to April 2022 and beyond. A further update to the MoU is anticipated in June 2021.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1. The updated position as at May 2021 for each of the priority areas is included in the extract of the Local Implementation Tracker Template at **Appendix 1**. The key points are as described in paragraphs 4.2 to 4.6 below.

4.2. Vaccination Services: The majority of immunisations have transferred from general practice as of 31/03/21 with adult and travel immunisations scheduled to do so by 31/03/22.

4.3. Pharmacotherapy: All practices have access to Level 1 Phramacotherapy currently. All are anticipated to have access to Levels 1-3 by 31/03/22.

4.4. Community Treatment and Care Services: Over 90% of practices currently have access to all CTAC Services. All will have access by 31/03/22.

4.5. Urgent Care Service: Limited access at present, with full access predicted by 31/03/22.

4.6. Additional Professional Roles:

- Physiotherapy/MSK – Only partial access anticipated by 31/03/22, primarily due to recruitment challenges.
- Mental Health Workers – Limited access presently, full access planned by 31/03/22
- Community Link Workers - Limited access presently, full access planned by 31/03/22

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan “Moray Partners in Care 2019 – 2029”

PCIP implementation is consistent with the goals and aims of the above.

(b) Policy and Legal

Progress with delivery of the PCIP is monitored regularly to ensure that it is achieving the agreed targets in relation to the nationally negotiated contractual agreement for General Practice.

(c) Financial implications

PCIP is currently underspent due to certain elements not being in place yet, which is largely due to recruitment challenges. However, should all elements of PCIP be delivered in full it would result in an overspend in the region of £1.85m. This has been highlighted to Scottish Government. HSCM's position is similar to the other partnerships in Grampian, and others across Scotland.

(d) Risk Implications and Mitigation

It is felt that full implementation of all elements of the MoU will be difficult to achieve by 31/03/22, especially due to recruitment challenges. In such an instance Scottish Government has advised that Transitional arrangements need to be put in place and are clear that this would not be their preferred option. Clarity on these transitional arrangements has been requested but these are currently subject to discussion and detail has not yet been provided.

(e) Staffing Implications

There are no staffing implications directly relating to this report other than the challenges in recruiting skilled staff to deliver the PCIP elements.

(f) Property

None arising directly from this report.

(g) Equalities/Socio Economic Impact

An Equality Impact Assessment is not required because there are no changes to policy arising from this report.

(h) Consultations

The MoU and PCIP form part of a nationally negotiated contractual agreement for general practice and consultation with stakeholders formed a part of this.

The Chief Officer, Chief Financial Officer and Corporate Manager, HSCM and Tracey Sutherland, Committee Services Officer, Moray Council have been consulted on this report and comments incorporated for their areas of responsibility.

6. CONCLUSION

6.1. PCIP progress in Moray is on track to achieve the principles outlined in the MoU by 31/03/22.

Author of Report: Peter Maclean – Service Manager, Primary Care Contracts

Background Papers: Moray PCIP4 Submission to Scottish Government

Ref:



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REPORT TO: MORAY INTEGRATION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE ON 24 JUNE 2021

SUBJECT: HOME FIRST PERFORMANCE AND RISK JUNE 2021

BY: HEAD OF SERVICE

1. REASON FOR REPORT

1.1. To update the Committee of the current performance and risks associated with Home First in Moray.

2. RECOMMENDATION

2.1. It is recommended that the Audit, Performance and Risk (APR) Committee consider and note the information provided in this report and at APPENDIX 1.

3. BACKGROUND

3.1. Operation Home First is the collective priorities of the three North-East Health and Social Care Partnerships in collaboration with the Acute sector of NHS Grampian. It is a portfolio that has emerged through positive, cross-system working during the COVID19 pandemic and emphasises the importance of shifting the balance of care, when safe and appropriate to do so, from acute settings to community settings. There are three aims to Operation Home First:

- To maintain people safely at home
- To avoid unnecessary hospital attendance or admission
- To support early discharge back home after essential specialist care.

3.2. The principles of Operation Home First are:

- Home First for all care
- Working within the agreed strategic direction set out by the Integration Joint Boards and NHS Grampian
- Focus on outcomes for people
- Whole system working and improving primary/secondary care joint working
- Maintain agile thinking and decision making

- Work within constraints of segregation/shielding/physical distancing measures/reduced hospital bed base
- Maximise digital solutions.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1. Recognising the importance of being able to accurately measure the benefits of the Operation Home First portfolio, an Evaluation Working Group was established in October 2020. The cross-system group is comprised of membership from NHS Grampian, the Health and Social Care Partnerships and Public Health Scotland who have expertise in complex evaluation, public health research and data analysis. The purpose of this group is to determine to what extent each of the initiatives within the Operation Home First portfolio help achieve its three aims.

- The primary aim of this evaluation was to demonstrate the impact of the Operation Home First (OHF) priorities against the OHF aims.
- Evaluating a complex portfolio such as this, comprised of multiple interconnections and interdependencies, will result in complex answers being generated.
- This evaluation was carried out during the winter planning period (October 2020 – April 2021) and within this time, variability was evident with regard to the degree and scale of implementation across OHF priorities.
- Several initiatives have been small scale and have demonstrated positive impact for a small cohort of people. Such initiatives require scale-up to recognise marked impact at a population level.
- Implementing such a cross-system portfolio with a variety of interdependent initiatives will likely result in prioritisation (and subsequent acceleration / deceleration) having to occur to account for challenges in capacity in resources.
- Having external evaluation support in the design and delivery of initiatives at project and programme level appears to be perceived valuable by portfolio leads.
- We understand that there is strategic appetite for the ethos of “Home First” to become more embedded in business as usual for integrated health and care services across Grampian. To help it become so, it is intended to continue with project and programme evaluation, and that it is maintained as an integral part of the Strategic Commissioning Cycle, complementary to other key steps in that cyclical “Plan, Do, Study, Act” (PDSA) process.

Management of Risks

4.2. Risks relating to the Home First Programme are managed throughout the transformation development and implementation processes. The Home First Delivery Group have a key role to ensure that risks to the successful delivery of specified outcomes are identified and appropriately managed. High level risks to programme delivery and mitigating actions are highlighted within progress

reports reported on a regular basis to this Committee and Moray Integration Joint Board (MIJB).

Links to Risks on Strategic or Operational Risk Register

- 4.3. The main strategic risk relates to not achieving the transformation that Health and Social Care Moray (HSCM) aspire to, and the resultant risk around the delivery of the strategic objectives, and therefore the ability to sustain the delivery of statutory services within the funding available.
- 4.4. There is a risk of financial failure: that demand outstrips budget and the MIJB cannot deliver on priorities and statutory work, within budget.
- 4.5. Failure to deliver transformation at a pace or scale required by the demographic and financial pressures in the system.
- 4.6. There is a risk that if the current system does not redesign services from traditional models in line with the current workforce marketplace, this will have an impact of the delivery of the MIJB Strategic Plan.

Mitigation

- 4.7. This paper brings to the attention of the APR Committee information about the progress of evaluation to the priority areas that will help provide assurance of whether proposed changes in activity are / are not successful and for what reasons.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan “Moray Partners in Care 2019 – 2029”

Primary strategic drivers for Discharge to Assess (D2A) in Moray are set out in the Strategic Plan 2019-2029, Living Longer Living Better in Moray Plan 2013-2023, the Active and Independent Living Programme for AHPs and the 6EA programme, as well as the Operation Home First agenda.

(b) Policy and Legal

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

(c) Financial implications

Transformation is key to ensuring financial sustainability of the partnership. The resource to evaluate the impact of the Home First Transformation priorities has been at first secured through fixed term secondments from across the organisation, aside from D2A which is now fully established. Funding for this has been identified from existing budgets as well as additional Scottish Government bids for Hospital at Home and the Carer Wellbeing Worker.

(d) Risk Implications and Mitigation

Risks and mitigation are outlined in sections See 4.3 – 4.7 above

(e) Staffing Implications

D2A in Moray has now completed recruitment phase for the new posts. Recruitment has now commenced for back-fill posts. A bid has been made to Scottish Government for funding for Hospital at Home and if successful will see further posts recruited for a 12 month period.

(f) Property

There are no property implications at present, although it should be recognised that Dr Gray's Hospital is reconfiguring the site under remobilisation priorities.

(g) Equalities/Socio Economic Impact

The content of this paper aligns with the MIJB Strategic Plan, for which a full equalities and human rights impact assessment has been undertaken. The assessment, on the whole, was positive in relation to the Strategic Plan's impact on equality and diversity within Moray.

(h) Consultations

This report was developed in consultation with Operation Home First Evaluation Working Group, namely Dr Calum Leask and Mr Duncan Sage. Moray information was provided in consultation with the HSCM Home First Delivery Group.

The Chief Officer, Chief Financial Officer, Corporate Manager, Health and Social Care Moray and Tracey Sutherland, Committee Services Officer, Moray Council have been consulted and comments incorporated into this report.

6. CONCLUSION

6.1. This report provides an overview of the collaborative approach to Operation Home First across Grampian, with the assessment of associated risks and the First Portfolio Evaluation Report in Appendix 1, for consideration and comment.

Author of Report: Dr Calum Leask, Lead for Research & Evaluation, Duncan Sage, Principal Information Analyst and Sean Coady, Head of Service, HSCM

Background Papers: with authors

Ref:



Operation Home First Portfolio Evaluation Report June 2021

This report was prepared by the Operation Home First Evaluation Working Group:-

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Contents

Key Points.....	2
Introduction / Context	3
The Aims of Operation Home First	3
The Operation Home First Portfolio	4
Evaluation Scope and Approach	6
Evaluation Findings	9
Priority / Project Durations	9
Priority / Project Reach	11
Impact on Operation Home First Aims	14
Overview of priorities mapped versus OHF aims.....	14
Impact of Priority vs OHF Aims	15
Performance Monitoring / Dashboard Development.....	20
Additional reflections.....	22
Notes on Cost Dimensions	22
Health Inequalities Synthesis	25
Operation Home First Evaluation Working Group Priority Appraisal	31
Strategic Context / Next Steps	36
Summary / Discussion.....	40
Cumulative Impact	40
Data Collection Considerations.....	41
Resourcing.....	41
Equity of Evaluation Support	42
Perceived Value of External Evaluation Support	42
Limitations	45
Acknowledgements.....	46
Appendix A: Interim Evaluation (including project Flash Reports).....	47

Key Points

- The primary aim of this evaluation was to demonstrate the impact of the Operation Home First (OHF) priorities against the OHF aims. However, this evaluation aimed to address as far as reasonably possible, further questions that have been posed to the Evaluation Working Group at recent committees (for example impact on costs and health inequalities).
- Evaluating a complex portfolio such as this, comprised of multiple interconnections and interdependencies, will result in complex answers being generated.
- This evaluation occurred during and soon after the winter planning period (October 2020 – March 2021) and within this time, variability was evident regarding the degree and scale of implementation across OHF Priorities.
- Several initiatives have been comparatively small scale and have demonstrated positive impact for a small cohort of people. Such initiatives require scale-up to recognise marked impact at a population level.
- Implementing such a cross-system Portfolio with a variety of interdependent initiatives will likely result in prioritisation (and subsequent acceleration / deceleration) having to occur to account for challenges in capacity in resources.
- Having external evaluation support in the design and delivery of initiatives at project and programme level appears to be perceived valuable by Priority Leads.
- We understand that there is a strategic appetite for the ethos of “Home First” to become more embedded in Business as Usual for integrated health and care services across Grampian. To help it become so, we would recommend that project and programme evaluation is maintained as an integral part of the Strategic Commissioning Cycle, complementary to other key steps in that cyclical “Plan, Do, Study, Act” (PDSA) process.

Introduction / Context

This report aims to evidence the impact of the Operation Home First (OHF) Portfolio. It follows on from an interim evaluation report published in February 2021 that should be read prior to this report for further context. The interim report, available as Appendix A, provided an overview of OHF; the evaluation methodology implemented across the Portfolio; and an update on progress across each of the OHF Priorities. This report views the evaluation of the Portfolio through a strategic lens, with greater emphasis placed on the cumulative impact of individual Priorities and key learning / considerations that may be valuable to adopt in the future.

The Aims of Operation Home First

This portfolio has three main aims:

- 1) To maintain people safely at home
- 2) To avoid unnecessary hospital attendance or admission
- 3) To support early discharge back home after essential specialist care

Operation Home First Portfolio Evaluation
Draft for Consultation

The Operation Home First Portfolio

The below figure illustrates the constituent parts of the OHF Portfolio that were included within the scope of this evaluation. As such, it does not contain the entirety of the activity that is undertaken across the three North-East Health & Social Care Partnerships (HSCPs) + Acute sector. The initiatives deemed as Priorities within this time period were selected and agreed by the OHF Steering Group.

It should be noted that some Priorities are standalone projects, whereas others are programmes of work (i.e. a group of projects). In other instances, particular initiatives span across more than one Priority area (for example, Hospital @ Home in Aberdeen City is aligned to the Frailty Pathway; the Stepped Care Approach; and the Respiratory pathway). These are depicted in Figure 1.

Figure 1. List of the OHF Priorities and their constituent parts (where applicable)

Care @ Home Contract Implementation (Aberdeen City)
<p>Frailty pathway (pan-Grampian)</p> <ul style="list-style-type: none"> •Hospital @ Home expansion (Aberdeen City) •Hospital @ Home development (Aberdeenshire) •Rosewell Intermediate Care Facility (Aberdeen City and Aberdeenshire) •Ward 102 (pan-Grampian)
Near Me (pan-Grampian)
<p>Palliative & End of Life Care (pan-Grampian)</p> <ul style="list-style-type: none"> •The Oaks Virtual Programme (Moray)
Redesign of Urgent Care (Flow Navigation Centre) (pan-Grampian)
<p>Respiratory Pathway (pan-Grampian)</p> <ul style="list-style-type: none"> •Home Oxygen Service (pan-Grampian) •Hospital @Home expansion: Respiratory Team (Aberdeen City) •Prevention & Self Management (Physical Activity) (3 similar projects in Aberdeen City, Aberdeenshire, Moray) •Pulmonary Rehabilitation: addition of 1-to-1 / Home support (Aberdeenshire) •Extension to Pulmonary Rehab/Respiratory Physio and associated publicity/education campaign (Moray)
<p>Stepped Care Approach (Aberdeen City)</p> <ul style="list-style-type: none"> •Enhanced Community Support Huddles (Aberdeen City) •Stay Well Stay Connected workstream (variety of initiatives) (Aberdeen City) •Hospital @ Home (Aberdeen City)
Virtual Community Ward (Aberdeenshire)
<p>Whole System Approach to Discharge (Moray)</p> <ul style="list-style-type: none"> •Discharge to Assess (Moray)

Operation Home First Portfolio Evaluation

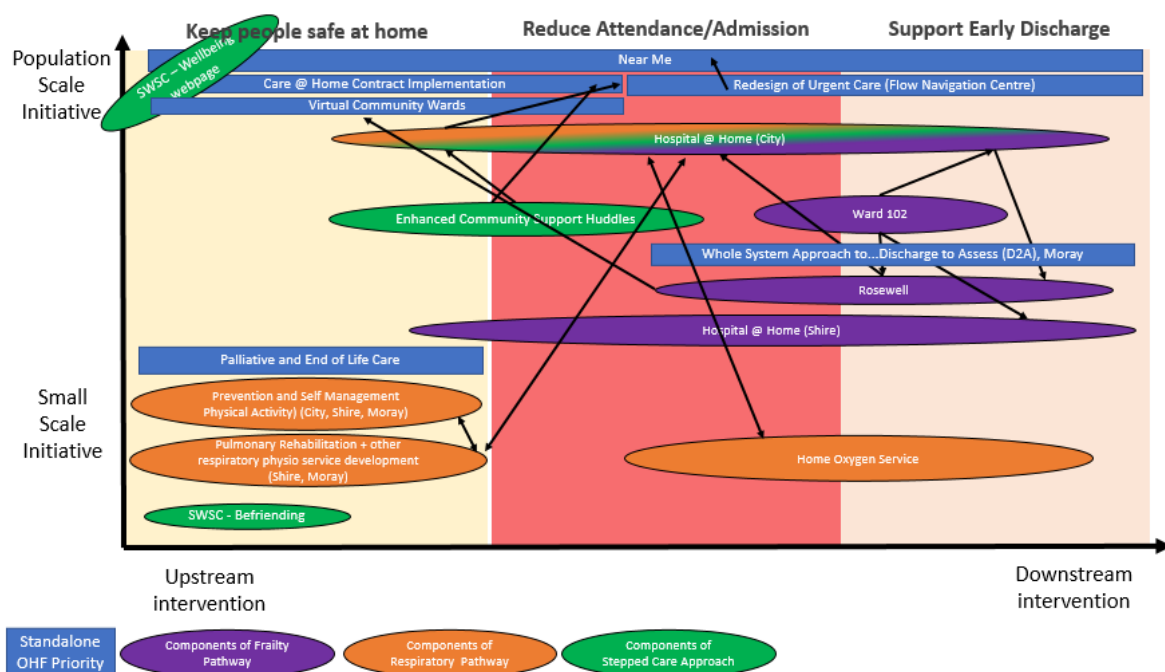
Draft for Consultation

Whilst Figure 1 provides a ‘neat list’ of the OHF Priorities, it falls short of conveying the true complexity of the Portfolio. Examples of such complexities include but are not limited to:

- *Priority composition* – Whether the Priority is a standalone project or a programme (i.e. a group of projects)
- *Priority scale* – Whether initiatives within the Portfolio are either being conducted at a small scale or a population level
- *Impact on OHF aims* – Not all OHF Priorities impact on all OHF aims
- *Priority emphasis* – Some priorities have a focus on upstream, preventative work, whereas others have a downstream, acute-based focus
- *Interdependencies* – Most OHF Priorities do not operate within a silo. They interact with other parts of the system (for example, Ward 102 will refer into the Aberdeenshire Hospital @ Home service when this becomes operational, meaning that performance on one part of the system can often be directly impacted by another part of the system).

Figure 2 is one such attempt to show these multiple complexities within one visual. It is intentionally convoluted to recognise that evaluation occurring within a complex system will always generate complex answers. It is important to note that this is illustrative only and designed to be a notional presentation of how the entire Portfolio interlinks with each other within the evaluation period defined above (i.e. not a direct comparison as to whether Priority ‘x’ or Priority ‘y’ is larger).

Figure 2: Complexity visual of OHF priorities and projects



NB – ‘Hospital @ Home (City)’ is multi-coloured to represent its presence under several OHF Priority areas.

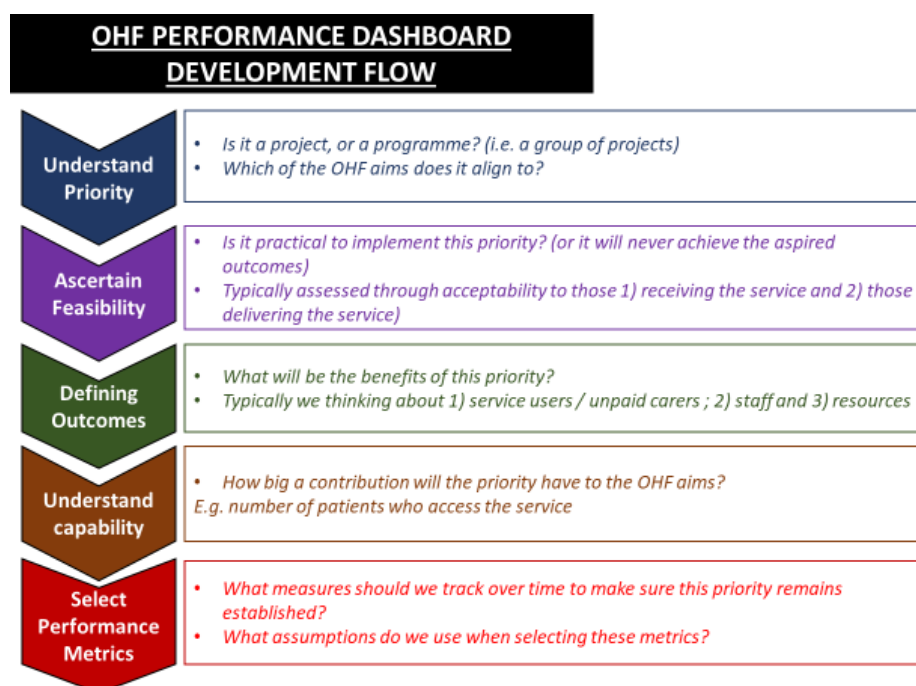
Evaluation Scope and Approach

The principal ask of the original commission was two-fold:

- 1) Evaluate the impact of the OHF Priorities against the OHF Aims
- 2) Develop a performance dashboard for ongoing monitoring of Priorities at a strategic level.

The Evaluation Working Group developed and applied a consistent methodology across Priorities, that is visually depicted and described below:

Figure 3. OHF Performance Dashboard Development Flow



Understanding the Priorities individually – Some of the OHF priorities are individual projects (such as Implementation of Near Me). Others are programmes (i.e. a group of projects, such as the Stepped Care Approach). In the latter scenario, the full impact of the programme cannot be understood until individual projects are understood. During this stage, priorities were mapped against the OHF aims, which helps inform the data collection process.

Ascertaining feasibility – Service changes / developments cannot realise benefits if they are not practical to implement. As such, a critical component to new initiatives is determining whether they are acceptable to those delivering the service (i.e. staff) and to those receiving the service (i.e. service users and unpaid carers).

Defining outcomes - If initiatives pass the feasibility test, consideration can be given as to what benefits these will have. These benefits can usually be categorised by 1) benefits to service users / unpaid carers; 2) benefits to staff; 3) benefits to resources / services.

Understanding capability – This helps answer the question as to the impact individual priorities have against the aims of OHF. For example, a small-scale test of change will not have a substantial impact on reducing hospital attendances but is helpful to prove a new concept or to determine how it may make a positive contribution should it be scaled up.

Operation Home First Portfolio Evaluation

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Selecting performance metrics - The goal here is to distil each priority down to a minimal number of measures that can provide an indicative overview as to how that priority is functioning. Key to this is developing assumptions that provide as rationale as to why that metric was selected.

The above would culminate in bespoke evaluation frameworks being developed across Priorities. This typically followed a standard template for monitoring purposes, illustrated below.

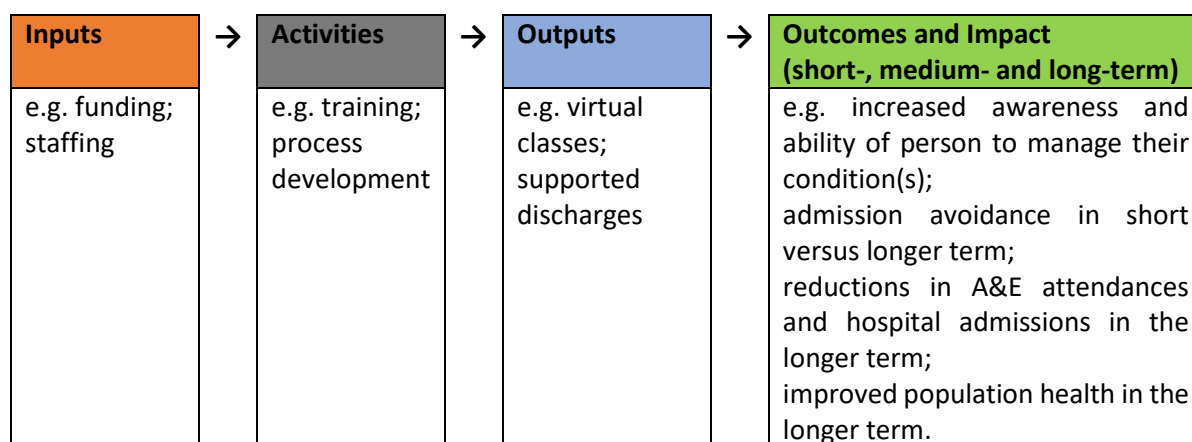
Figure 4. OHF Evaluation Framework Template

Ref	Measures	Aim alignment	Measurement tool / source	Measure frequency	Owner	RAG	Update / comments
1. Service User / Unpaid Carer outcomes							
1.1							
2. Staff outcomes							
2.1							
3. Resource / Service outcomes							
3.1							
4. Process / descriptive measures							
4.1							

NB – Template may / may not include multiple lines under each header. These were co-created and agreed with Priority Leads

All initiatives require a period of embedding before sufficient evaluation can be undertaken. Evaluation has to consider the inputs and processes required to deliver a project, as without these the subsequent outputs cannot be achieved and as such, the impact of the project cannot be realised. This notion is delineated in a simplified manner in the below example logic model.

Figure 5. Simplified Logic Model



NB – Content within logic model above aims to provide a balance of commonly applicable elements whilst not trying to exhaustively represent all the individual priorities within OHF Portfolio.

EXAMPLE CASE STUDY

CARE @ HOME CONTRACT IMPLEMENTATION (ABERDEEN CITY)

Under the new model, the provision of care will move away from the current schedule of tasks which are timed. Instead, teams will work together with people receiving care, their families, and other practitioners within each locality to provide care tailored to individual needs. Local assets will also be used to connect people back into their community.

At the time of evaluation, the new Care @ Home Contract had been implemented (i.e. the Inputs), however changes had not been made to care packages (i.e. the Outputs). Due to this, the perceived benefits of the project (i.e. the Outcomes and Impact) are not currently quantifiable.

This is a good example of an initiative that has the foundations successfully implemented, though requires more time to elapse before a judgement can be made as to whether it has made the desired impact.

The awareness and interest in the OHF Portfolio has grown over the winter period. Due to this, a variety of additional questions, beyond the original commission, have been posed to the Evaluation Working Group as potential areas of interest to explore over the course of its implementation. Given the range of these requests, coupled with the complexities and breadth of the Portfolio itself, a pragmatic approach has been taken within this evaluation. Whilst this report aims to provide a blend of relevant evidence and reflections, it is not a silver bullet and is not possible to be an exhaustive judgement across all facets described below given the timescales in which it was conducted. However, it is hoped that the information gathered and presented here will be beneficial for senior leaders and decision makers in aiding and shaping future service innovation and delivery.

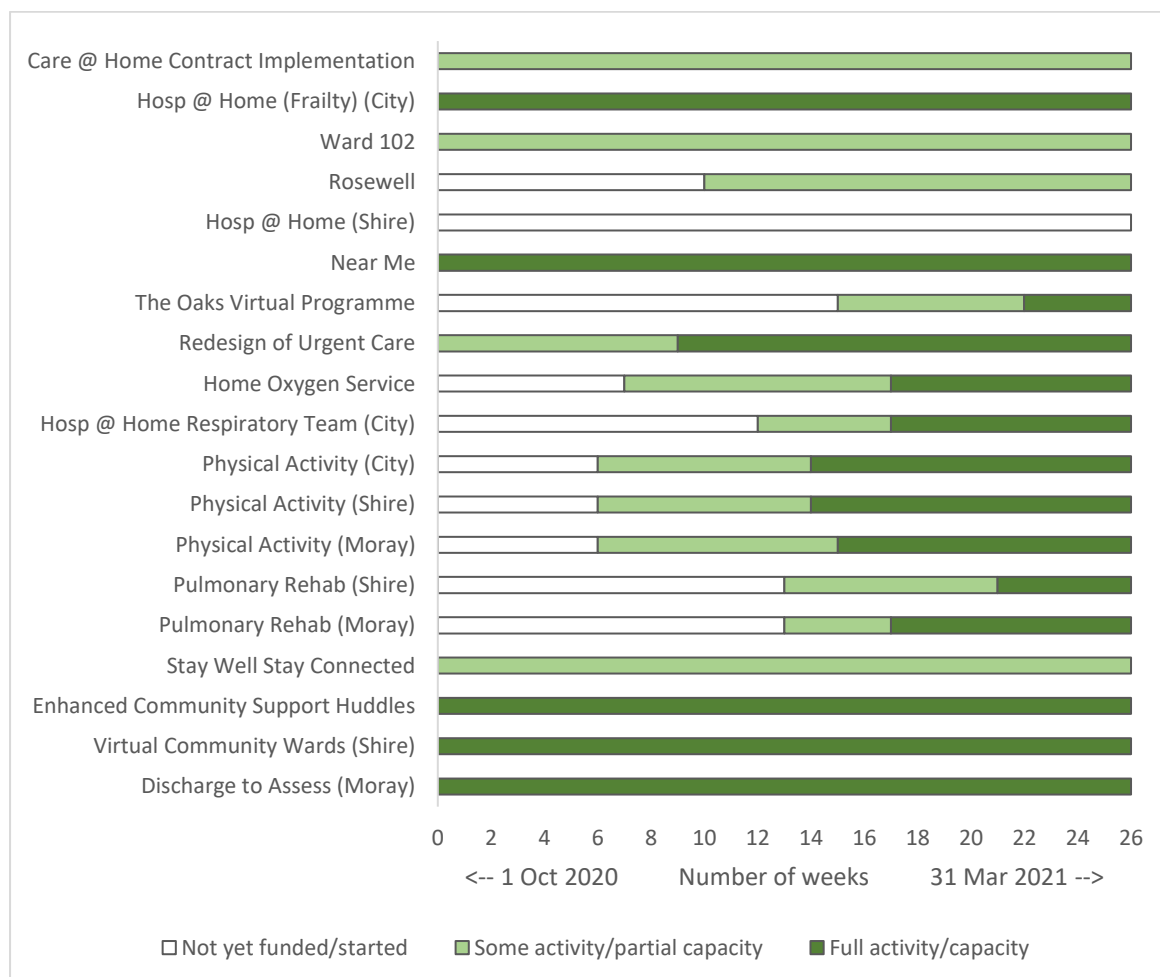
Evaluation Findings

Priority / Project Durations

The below visual aims to depict the degree of activity across different initiatives during the winter planning period. The purpose of this is not to provide a judgement on individual initiatives, instead it is to emphasise that different initiatives have been implemented to various degrees during this period and as such, will have different demonstrable impact.

This emphasises the different degrees of implementation across OHF Priorities. For example, NearMe has been implemented at scale during the winter period, whilst the Hospital @ Home service in Aberdeenshire is still in development. This means that both these initiatives cannot generate the same amount of data and impact within this time period.

Figure 6. Simplified Gantt Chart of OHF Priority Implementation



NB – The time ranges provided within this chart are indicative and subject to the interpretation of the Evaluation Working Group. It is designed to be illustrative for the purposes of demonstrating the differing degrees of implementation across Priorities.

EXAMPLE CASE STUDY

PALLIATIVE CARE CELL (PAN-GRAMPIAN)

The Palliative Care COVID-19 Cell was set up to focus on the issues pertaining to the pandemic and lots of work was progressed very quickly in response to COVID. It became apparent that finalisation of the Palliative and End of Life Strategic Framework, which had been almost ready to launch prior to the COVID outbreak, was a priority, ensuring that the final document reflected any lessons learned during the pandemic.

The main outcomes of the strategic framework are; to ensure people are supported at home at end of life (should that be their choice), reduce inappropriate admissions to acute hospitals and to allow the individual to fulfil their choices at end of life; these ambitions chiming with the ethos of OHF. Unlike the OHF Respiratory Priority which retained the wider Respiratory Cell working group and continued to meet on a weekly basis to progress programmes of work, the Palliative Care COVID-19 Cell was disbanded in September 2020 and responsibility for developing workstreams handed back to the Palliative and End of Life MCN Strategic Advisory Group.

The MCN group met in October (where the Chair announced his imminent retirement) and again in November, however subsequent meetings were cancelled, and the group has not met again during the period this report relates to. The framework has been finalised and is going through the approval process for launch Summer 2021.

The framework was always intended to be devolved to the three HSCPs and Acute sector to implement at a local level. A project that the OHF Evaluation Group has supported is the evaluation of The Oaks Virtual Programme. This was the translation of the palliative day service previously held at The Oaks, Elgin, into a four-week block of hosted virtual classes. Unfortunately, due to staff sickness, the project only ran for three weeks out of the planned four during the OHF evaluation period, with seven people attending. Feedback from patients and staff was generally positive towards this concept:

“Your service brought people in similar situations together. The chat was fun. I feel you are trying to cater for a variety of interests.” [Participant]

“The Virtual Programme enabled the patients to form a bond, support network which helped them to arrive happy and comfortable for my online sessions.” [Staff]

Roxburghe House, which provides palliative and end of life care for residents across Grampian as well as linking with the Western Isles, Orkney and Shetland, have successfully transitioned their model of day care into a virtual programme and have groups running concurrently.

Priority / Project Reach

As individual initiatives begin, we can start to capture early feedback from people receiving a service, and people providing it (see Appendix A for examples of this from across the Portfolio). Data on the acceptability (or otherwise) of services to patients and staff is an important part of the evidence base for further service development/expansion. Furthermore, for many initiatives in the OHF Portfolio, even in a period of a few months, it has been possible to demonstrate positive impacts on the people directly supported – such as improved clinical measurements and/or improved confidence in their ability to help manage their own condition(s) (again, see Appendix A for examples).

Beyond the immediate (short term) impacts on service users and staff, there has been a desire to evaluate (where possible) the impact (actual/potential) on usage of the health and social care system, and the potential to impact upon the wider population. In this report's section on the Impact on Operation Home First (Table 4), we have collated data on some of the main impacts at system level that it has been possible to source in this comparatively short time frame (from existing IT systems or new data collections developed specifically for OHF evaluation purposes). However, it is also important to be mindful that many of the OHF priorities have been tests of change or have for other reasons operated at relatively small scale. The number of people supported by an initiative may be somewhat smaller than the cohort of people who might be potentially eligible to benefit from it. Thus, whilst initiatives can have positive impact on the relatively small numbers of people they can help, they would need to be sustained/scaled up if they are to reach more of those within the potentially eligible cohort(s). Figure 7 below shows a conceptual example of a project providing support to some of the potentially eligible population, who in turn, are a subset of the whole population. In Table 4, we have collated data on the numbers of people supported by each of the OHF projects during winter 2020/21 (or the part thereof for which they were operational) – the yellow (top) part of this triangle. On the following pages, we provide further statistics, for broad context, on the green (middle) and blue (bottom) parts of this triangle.

Figure 7. Conceptual example of project reach.

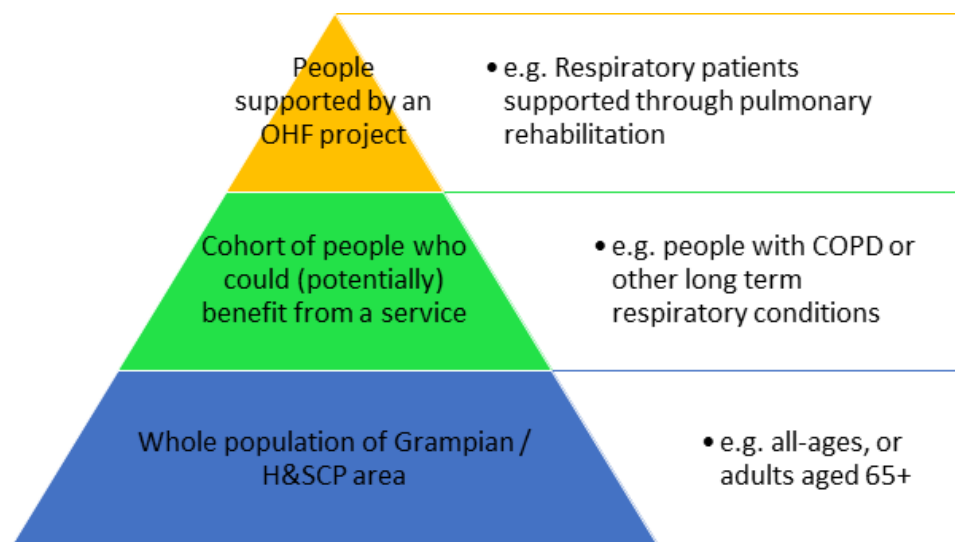


Table 1. Cohorts of people who could (potentially) benefit from a service pathway

Urgent Care											
<ul style="list-style-type: none"> • Anyone of any age may find that they require urgent care, therefore our potentially eligible cohort is our entire population. • In financial 2019/20 there was an average of nearly 7,400 ED attendances per month at ARI and Dr Gray’s Hospital, of which c.4,400 attendances per month were from self-presenters, with a reduced self-presenting footfall during the pandemic, between April and November 2020, of c.2,600 attendances per month. • Average attendances per month at Minor Injury Units were c.2,700 in financial 2019/20 and c.1,300 in financial 2020/21 up to the soft launch of the Flow Navigation Centre in December 2020. 											
Respiratory Pathway											
<ul style="list-style-type: none"> • Chronic Obstructive Pulmonary Disease (COPD) is a cause of morbidity and mortality in Scotland, and (along with Asthma) is one of the main long-term respiratory conditions for which population prevalence estimates are available. • The Scottish Burden of Disease Study estimates that around 11,000 people in Grampian are living with COPD. Numbers by Partnership area are shown in the table below. • Generally speaking, just over half those with a COPD diagnosis are aged 65+, and just under half are younger adults. 											
<table border="1"> <thead> <tr> <th>HSCP/Area</th> <th>Estimated number of people living with COPD (rounded to nearest 100)</th> </tr> </thead> <tbody> <tr> <td>Grampian</td> <td>11,200</td> </tr> <tr> <td>Aberdeen City</td> <td>4,000</td> </tr> <tr> <td>Aberdeenshire</td> <td>5,000</td> </tr> <tr> <td>Moray</td> <td>2,200</td> </tr> </tbody> </table>		HSCP/Area	Estimated number of people living with COPD (rounded to nearest 100)	Grampian	11,200	Aberdeen City	4,000	Aberdeenshire	5,000	Moray	2,200
HSCP/Area	Estimated number of people living with COPD (rounded to nearest 100)										
Grampian	11,200										
Aberdeen City	4,000										
Aberdeenshire	5,000										
Moray	2,200										
Source: Scottish Burden of Disease Study											
<ul style="list-style-type: none"> • Whilst preventable and increasingly treatable, the airflow obstruction seen in COPD is usually progressive. It is thus (amongst other respiratory conditions), an example of where supports can be put in place relatively upstream (e.g. physical activity classes) and otherwise in community settings (e.g. pulmonary rehabilitation) to delay or avoid hospital admissions in the months or years ahead. 											
Frailty Pathway											
<p>Healthcare Improvement Scotland have estimated that <i>“there are approximately 560,000 people living with frailty in Scotland - just over 10% of the population. Of this, 355,000 people are living with mild frailty, 151,000 with moderate frailty, and 50,000 with severe frailty. Growing numbers of older people are being admitted to hospital in an emergency and some of those admitted will deteriorate further or experience a delay in returning home due to being frail. Evidence shows that delivering early and effective Comprehensive Geriatric Assessment (CGA) for people living with frailty has potential to improve their outcomes and experience of care.”</i></p> <p>Source: The Frailty at the Front Door Collaborative Impact report December 2019</p>											
<p>If we apply these estimated numbers to the Grampian population – assuming that levels of frailty are similar to elsewhere in Scotland - this would translate as</p>											

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- Roughly 60,000 people living in Grampian with some degree of frailty, of whom
- Roughly 5,000 may be living with severe frailty.

Palliative and End of Life Care

Research published in 2020 projects that across Scotland, by 2040, the number of people requiring palliative care will increase by at least 14%; and by 20% if multi-morbidity is factored in. <https://bmjopen.bmj.com/content/11/2/e041317>.

Whole population of Grampian and our three Health and Social Care Partnership areas.

The estimated Grampian population (all ages) is 585,700. The totals by Health and Social Care Partnership are: 261,210 in Aberdeenshire, 228,670 in Aberdeen City, and 95,820 in Moray.

Approximately 1 in 5 people in our population are aged 65 and over (although this varies between 15.8% for Aberdeen City and 21.6% for Moray). Projected population change in Grampian over the 10 years from 2018 to 2028 is expected to reflect increases in the numbers of people aged 65+ (up by 20%), and decreases in the numbers of younger adults, and children.

Table 2. Grampian population by age group, 2019.

	Under 15	15-24	25-44	45-64	65+	% aged 65+
Grampian	94,839	64,733	159,549	158,633	107,946	18.4%
Aberdeen City	33,642	28,745	75,359	54,767	36,157	15.8%
Aberdeenshire	46,107	25,661	62,120	76,249	51,073	19.6%
Moray	15,090	10,327	22,070	27,617	20,716	21.6%

Source: [National Records of Scotland mid-year population estimates](#)

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Impact on Operation Home First Aims

Overview of priorities mapped versus OHF aims

The below table maps each of the OHF Priorities against each of the aims. To iterate, the aims of home first are:

- Aim 1) To maintain people safely at home
- Aim 2) To avoid unnecessary hospital attendance or admission
- Aim 3) To support early discharge back home after essential specialist care

Whilst this mapping demonstrates the intended impact against each of the aims, it does not mean that at the time of writing, Priorities are delivering on this. As stated above, Priorities that are still in development or operating at a small scale will only have minimal impact, with more time warranted before these aspirations can be fully achieved. Priorities that do not deliver against particular aims should not be perceived as inferior, as it was never the intention of all Priorities to directly impact on all aims.

Table 3. OHF Priorities Mapped Against OHF Aims

Priority Name	OHF Aim 1	OHF Aim 2	OHF Aim 3
Stepped Care Approach (Stay Well Stay Connected Workstream)	✓		
Stepped Care Approach / Frailty Pathway / Respiratory (Hospital @ Home Aberdeen City)	✓	✓	✓
Stepped Care Approach (Enhanced Community Support Huddles)	✓	✓	✓
Stepped Care Approach / Respiratory Pathway (Hospital @ Home expansion: Respiratory Team)	✓	✓	✓
Frailty Pathway (Ward 102)	✓	✓	✓
Frailty Pathway (Rosewell)		✓	✓
Frailty Pathway (Hospital @ Home Aberdeenshire)	✓	✓	✓
Care @ Home Contract Implementation	✓	✓	✓
Redesign of Urgent Care (Flow Navigation Centre)	✓	✓	
NearMe	✓	✓	
Respiratory Pathway (Home Oxygen Service)		✓	✓
Respiratory Pathway (Physical Activity Classes)	✓		
Respiratory Pathway (Pulmonary Rehabilitation)	✓		
Respiratory Pathway (Extension to Pulmonary Rehab / Respiratory Physio)	✓		
Palliative & End of Life Care (The Oaks Virtual Programme)	✓		
Whole system approach to discharge (Discharge 2 Assess)		✓	✓
Virtual Community Wards	✓	✓	

NB –Boxes in dark shade with tick mark denote association between Priorities and Aims. Less / no association is denoted by light shading. Mapping was done in collaboration between Evaluation Working Group Members and associated Priority leads.

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Impact of Priority vs OHF Aims

The below table expands on the above mapping exercise by providing illustrative examples of how Priorities have impacted upon different aims. Its purpose is to provide information whereby the strongest correlations between Priorities and the OHF aims are present and quantifiable.

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Table 4. OHF Priorities Mapped Against OHF Aims

Priority Name	Impact vs OHF Aim 1 (Keep people safe at home)	Impact vs OHF Aim 2 (Reduce unnecessary hospital attendance / admission)	Impact vs Aim 3 (Support early discharge)
Stepped Care Approach	'Wellbeing Matters Webpage' (part of Stay Well Stay Connected workstream) received more than 1100 visits over a 12 month period, providing a number of helpful resources of keeping and staying well (though it is not possible to quantify whether this directly resulted in keeping people safe at home).	330 patients brought to the Enhanced Community Support Huddles since June 2020 whom would be at risk of hospital admission if interventions had not been implemented.	Hospital @ Home in Aberdeen City have cared for 184 patients through the Supported Discharge route in the last 12 months, helping get people out of hospital in a timely manner.
Frailty Pathway	General Practitioners have direct access to senior clinicians in Ward 102, meaning admissions have been avoided (and people kept safely at home when appropriate to do so) through discussing presentations and reviewing care options.	Hospital @ Home in Aberdeen City have cared for 321 patients through the 'Alternative to Admission' route in the last 12 months. Rosewell accepted one step-up admission into the facility that otherwise would have been a hospital admission.	Rosewell accepted 85 step-down admissions in the first two months of operation, thus reducing the pressure on secondary care services.
Care @ Home Contract Implementation	As of May 2021, Granite Care Consortium are supporting 1063 individuals.	Impact not yet reviewed as changes to type of care provision were not implemented at the time of writing.	Impact not yet reviewed as changes to type of care provision were not implemented at the time of writing.
Redesign of Urgent Care	Nearly 5,500 referrals have been made from NHS 24, with over 1,000 directed to the Flow Navigation Centre (FNC) and nearly 4,500 to the Minors Decision Queue, at an average of c.200 clinical referrals per week allowing people to stay safe at home and only attend hospital when absolutely necessary following a virtual consultation.	Only 58% of patients referred to the FNC and the Minors Decision Queue (FNC: 45%; Minors: 60%) have required a face-to-face appointment minimising the need for patients to attend ED or a minor injury unit, with 42% given self-care advice or re-directed to primary care following a virtual consultation.	Not applicable as Priority not adjudged to be aligned to aim.

Operation Home First Portfolio Evaluation

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Priority Name	Impact vs OHF Aim 1 (Keep people safe at home)	Impact vs OHF Aim 2 (Reduce unnecessary hospital attendance / admission)	Impact vs Aim 3 (Support early discharge)
NearMe	Service deals with over 3500 remote consultations per week as of February 2021, allowing people to stay safe at home.	44% of patients referred to the FNC and Minors Decision Queue did not need to attend a face-to-face appointment following a Near Me consultation.	Not applicable as Priority not adjudged to be aligned to aim.
Palliative & End of Life Care	The Oaks Virtual Programme: During the month of March 2021, 7 palliative patients were able to attend a 4-week programme of hosted virtual sessions from the comfort of their own homes.	Not applicable as Priority not adjudged to be aligned to aim.	Not applicable as Priority not adjudged to be aligned to aim.
Respiratory Pathway	Hospital @ Home (H@H): During the 11 weeks to end March, 11 respiratory patients were admitted; between them this came to 60 H@H bed days.	H@H: Of the 11 patients admitted during this short period, 4 were 'Alternative to Admission' to Aberdeen Royal Infirmary.	H@H: Of the 11 patients admitted during this short period, 7 were 'Active Recovery / Supported Discharge'.
	Not applicable as Priority not adjudged to be aligned to aim.	Home Oxygen Service: In the last weeks of the financial year, the Team developed a rapid assessment service for immediate/urgent referrals for oxygen to prevent admission. Seven referrals were received and assessed the same day and oxygen supplied in four cases, with an average installation time of 128 minutes.	Home Oxygen Service: Over the course of 9 weeks the Team were able to directly assess 36 inpatients for home oxygen. 28 patients were discharged within 2 days of assessment. A case review estimated average savings of 4.8 bed days per patient.
	Pulmonary Rehabilitation (PR) (Shire): In 10 weeks late Jan-end March, 51 patients had initial assessments. 27 started 1 to 1 (Home) PR block, of which 23 completed. 11 patients declined or unsuitable to continue.	PR (Shire): Unknown due to short timescale of project. Had capacity and follow-up time allowed, we would have looked at admissions up to 6/12 months pre- and post-intervention.	PR (Shire): Not impacted during this short project life span, but there is potential for it to do so in future.

Operation Home First Portfolio Evaluation

Draft for Consultation

Priority Name	Impact vs OHF Aim 1 (Keep people safe at home)	Impact vs OHF Aim 2 (Reduce unnecessary hospital attendance / admission)	Impact vs Aim 3 (Support early discharge)
	<p>Extension to Pulmonary Rehab (PR) / Respiratory Physio – Moray: In 12 weeks early Jan-end March, 54 patients assessed (43 for PR + 11 for other respiratory physio), of which 17 started virtual PR and 7 completed block of virtual classes. And a further 8 started and completed Home PR.</p> <p>Leisure Projects / Physical Activity Classes (Grampian): Between January and March 2021, 64 people with chronic respiratory conditions participated in 6-week blocks of instructor-lead, online physical activity classes.</p>	<p>PR / Respiratory Physio (Moray): Unknown due to short timescale of project.</p> <p>Not applicable as Priority not adjudged to be aligned to aim.</p>	<p>PR / Respiratory Physio (Moray): Not captured during this short project life span, but there is potential for it to do so in future.</p> <p>Not applicable as Priority not adjudged to be aligned to aim.</p>
Whole system approach to discharge	Not applicable as Priority not adjudged to be aligned to aim.	Discharge 2 Assess (D2A): Over the 25 weeks of the Discharge 2 Assess project 9 patients were redirected from Dr Gray’s Emergency Department, saving an estimated 81 bed days.	D2A: Between October 2020 and March 2021 48 in were discharged via D2A. This reduced average length of stay by 1 day saving 48 bed days.
Virtual Community Wards (VCW)	<p>For FY2020/21 quarter 3, 213 VCW admissions were reported by 17 GP practices who submitted returns (out of the 25 GP practices signed up to the VCW SLA) .*</p> <p>* In 2019/20 average of over 330 VCW admissions per quarter. It was not mandatory for GP practices to submit VCV quarterly returns in FY2020/21 however they were asked to submit data where available., It is planned that formal reporting on a quarterly basis, to monitor and understand the impact of VCW, will resume for 2021/22 for all practices signed up to the VCW SLA.</p>	A previous audit found that the VCW model was able to manage 66.3% of all admissions at home, subsequently reducing unnecessary hospital admissions. This percentage was 38.3% greater than the presumed patient outcome as predicted by clinicians.	Not applicable as Priority not adjudged to be aligned to aim.

Operation Home First Portfolio Evaluation

Draft for Consultation

NB – The above data is not exhaustive, nor is it all collected over the same time frames (given the data provided previously regarding when Priorities went live and the scale at which they operate)

Operation Home First Portfolio Evaluation

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Performance Monitoring / Dashboard Development

One key output of the original commission was to develop a performance dashboard for the ongoing monitoring of priorities at a strategic level. This performance dashboard has been developed as part of an iterative process and consists of a minimal set of key performance metrics, aligned to the three OHF aims, that have been identified following the five-step development process set out in Figure 3. This performance dashboard has been designed to provide the OHF Steering Group with an indicative impact of the Portfolio at a high-level.

One key enabler in the development of such a performance dashboard is the need for it to be supported by a robust data and intelligence infrastructure. To achieve this goal we have adopted a tiered approach to performance monitoring, building on existing reporting and working to capture better data and address any data gaps, to get the right information to the right people at the right time and help facilitate data-driven decision-making across the OHF Portfolio of programmes and projects. As just like a house, strong foundations and pillars are required to support the roof (i.e. the performance dashboard).

Our tiered approach to performance monitoring and dashboard development, from the operational level up to the OHF Steering Group, consists of relevant and timely metrics structured across three tiers.

- Tier One (i.e. the roof) comprises of the performance dashboard for the OHF Steering Group. The performance dashboard contains a minimal set of outcome-based key metrics that most directly align with OHF aims and can be used to understand the overall impact of the portfolio at a high-level. Updated monthly, this performance dashboard consists of an overall summary that can be filtered by metric, aim alignment, priority alignment and sector, and supplemented by a high-level dashboard for each individual priority area that allows further drill-down of the respective key performance metrics within.
- Tier Two (i.e. the pillars) comprise of a suite of dashboards covering a wider set of metrics. We have currently developed tier two dashboards for the larger scale initiatives within the OHF portfolio. These dashboards, developed based on the respective needs of the Frailty Pathway Delivery Group and Redesign or Urgent Care Governance Group, help explain the causes of variation in Tier One performance for these Priority areas and why performance is improving or declining. Within the Tier Two dashboards the end-user can make a variety of selections, including specifying date range, the filters to apply for drill-down and choose the view (e.g. snapshot, trend or date table). These dashboards are updated weekly.
- Tier Three (i.e. the foundations) builds on the existing routine reporting in place. The metrics within these dashboards align with detailed daily operations that drive performance and ultimately provides the foundation for the first and second tiers. These dashboards are updated daily and drives the development of daily operational plans for achieving the desired outcomes and for monitoring progress.

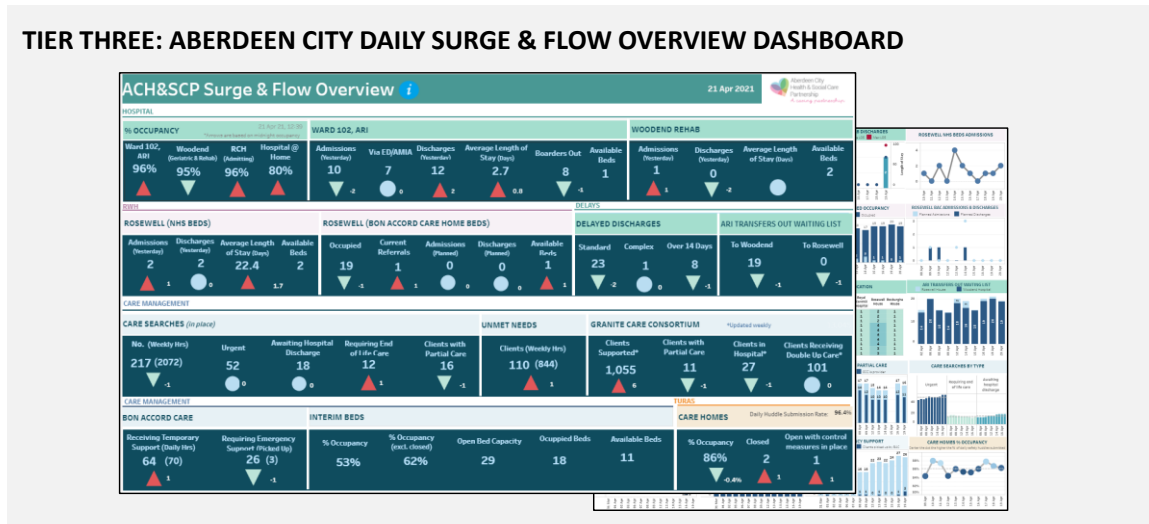
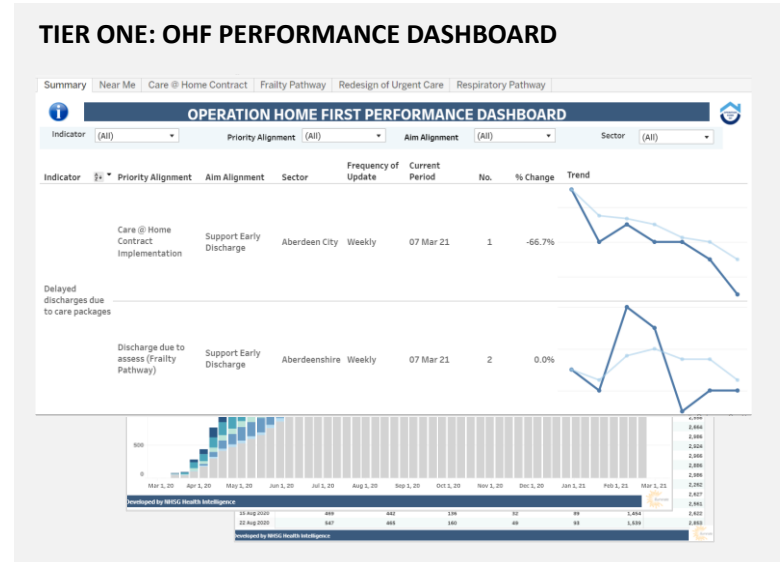
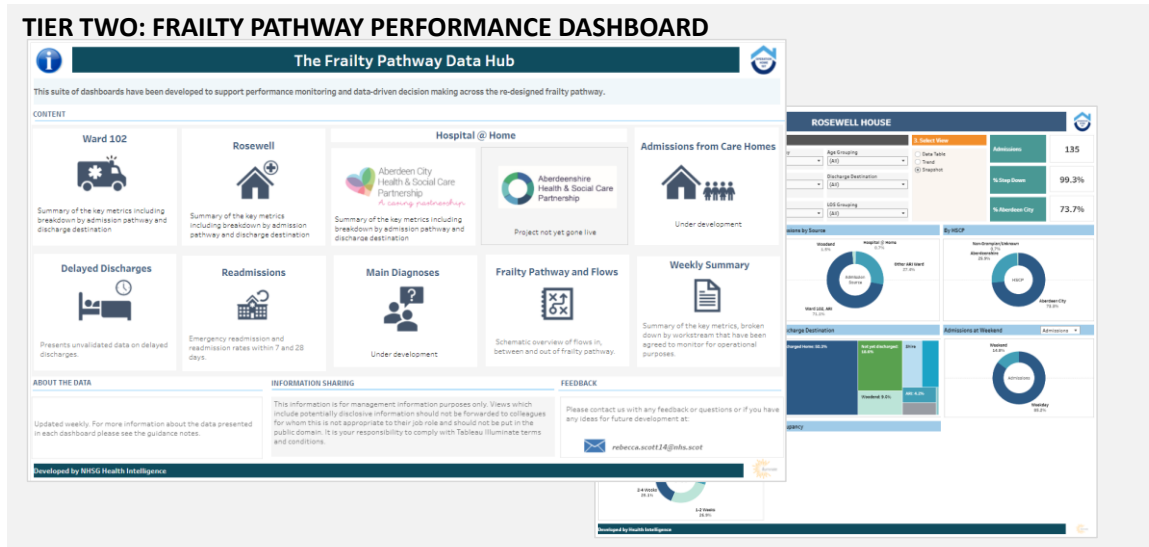
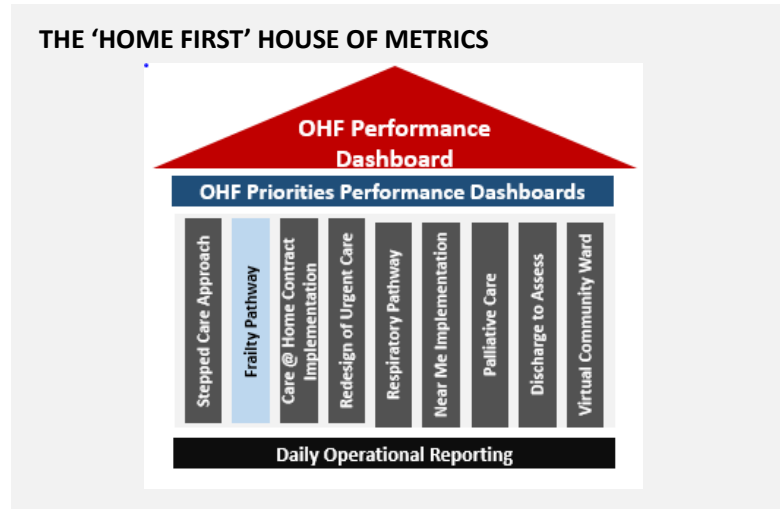
This suite of dashboards will help provide a sustainable solution for measuring and reporting of performance from the operational level up, for projects both within the OHF Portfolio and as they transition to 'business as usual'.

Figure 8 below provides an example of the tiered approach to performance monitoring we have implemented for the frailty pathway.

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Figure 8. Example of Tiered Approach to Performance Monitoring Related to the Frailty Pathway



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Additional reflections

Notes on Cost Dimensions

This report is not the product of a cost-effectiveness exercise. The primary drivers behind OHF were about keeping people safe at home during a global pandemic and avoiding / reducing hospital usage, where possible, in what was expected to be an even more challenging winter planning period than usual.

The OHF Portfolio consists of numerous initiatives targeting one or more of its aims (see Table 3: OHF Priorities Mapped Against OHF Aims on page 14). A multitude of factors influenced the development of individual projects: aligned priority, governance, perceived short-term vs. longer term benefit, scale, requirement for initial funding, resource, etc. Some tests of change were essentially ready to go at the time the Evaluation Working Group was formally commissioned, others developed during the evaluation reporting period and for some, the benefits of a change are yet to be recognised (Figure 6. Simplified Gantt Chart of OHF Priority Implementation). With these points in mind, an attempt to validate the full OHF Portfolio on economic grounds would meet with little success. However, economic-specific data collection practices have been utilised in some initiatives within this Portfolio to better understand this dimension and, in some instances, provide a basis for securing sustained investment. Discharge 2 Assess in Moray is one such example (see Figure 9. D2A Case Study Infographic for details).

The Discharge 2 Assess (D2A) project introduced an established model of intermediate care, utilised in other parts of the country, to Moray. Its focus is those patients who are clinically stable and do not require acute hospital care but who may still require rehabilitation and care support in the short term. Assessment in the patient's home helps prevent admissions from A&E and reduces length of stay in acute wards. Length of stay, measured in bed days, is a standard NHS metric. By comparing the length of stay for the patients seen by the D2A team with the average for the specialties or wards most benefitting from D2A involvement, it is possible to calculate a bed days saved figure. In turn this can be converted to a cost or cost saving using figures obtained from national publications such as the NHS Costs Book.

Table 5. Bed Day Calculation used in Discharge 2 Assess

Item	Bed Days
Average Length of Stay in Dr. Gray's Hospital (Ortho-trauma & Geriatric Specialties)	9
Average Length of Stay in Dr. Grays Hospital for inpatients seen by D2A	8
Number of inpatients seen by D2A	48
Number of inpatient bed days saved through D2A [(9 – 8) x 48]	48
Number of patients attending A&E Department discharged to D2A	9
Number of bed days saved through admission avoidance [9 x 9]	81
<i>Total number of bed days saved [48 + 81]</i>	<i>129</i>

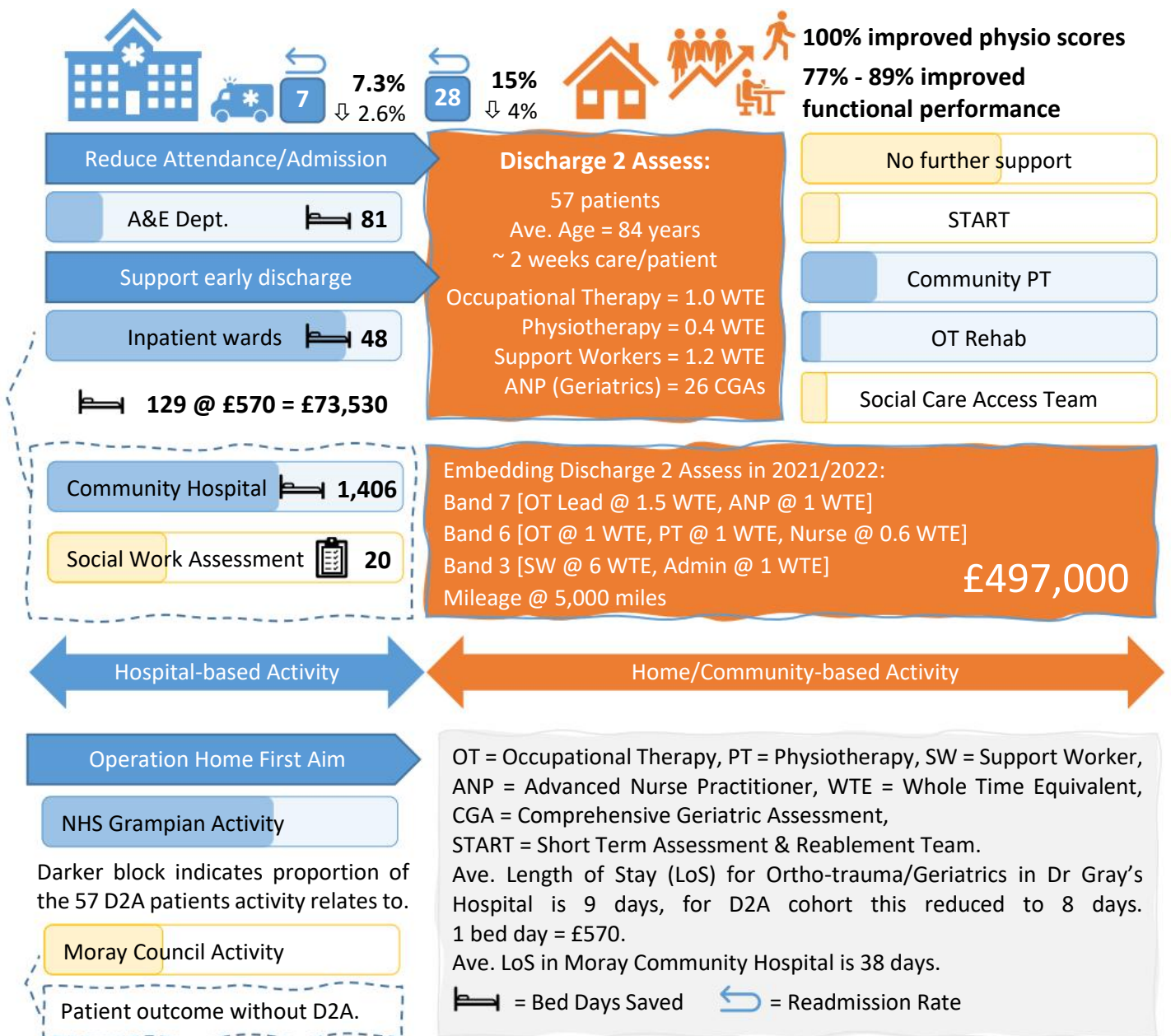
The NHS Costs Book puts a figure of £570 per bed day for the named specialties in Dr. Grays so simply multiplying the number of bed days saved by this gives an indication of potential savings:

$$129 \times £570 = £73,530$$

Operation Home First Portfolio Evaluation

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Figure 9. D2A Case Study Infographic



D2A limits the transfer patients to Moray's community hospitals to those with more complex rehabilitation or discharge needs; it is estimated that two thirds of the patients seen by D2A team would otherwise have been placed in a community hospital. The average length of stay in Moray's Community Hospitals is 38 days so the so the saving in bed days is great (37 x 38 = 1,406). Traditionally, social care assessments are carried out prior to discharge and this can result in delayed stays in hospital and packages of care that are not required or are over-specified. Figures for the average cost of care package for patients who were assessed in the relevant wards in Dr Gray's Hospital could have been obtained from Health & Social Care Moray and compared with the average cost of ongoing social care packages for patients managed by D2A, however this was felt to be unnecessary in the face of strong NHS evidence.

"I wanted care for my Mum and thought this was what Mum needed but these (D2A) therapists found she was far more able then we thought and she was able to manage at home."

Operation Home First Portfolio Evaluation

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The results from the D2A project are positive, with only a few patients being referred for ongoing support, much of it temporary in nature e.g. modifications to their home to enable the patient's ongoing independent living. Indeed, whilst indicative costs in terms of Bed Days Saved were provided in the formal business case to Senior Leadership Team and Moray IJB, the mapping of actual outcomes against a non-D2A model and overwhelming support from key stakeholders, the patients and their carers, negated the need for an in-depth costings exercise.

D2A provides a good example of how easy to obtain and well understood hospital data can quickly add an economic dimension to the evaluation of a project. In theory then, with time allowing, OHF projects seeking to tackle Aim 2 (Preventing hospital attendance/admission) and Aim 3 (supporting early discharge) could follow suit should that be a primary driver of interest.

The Physiotherapy-lead, Pulmonary Rehabilitation project in Aberdeenshire added an economic dimension to the evaluation by combining hospital financial data with project specific costings. Evidence from published sources makes a strong case for pulmonary rehab effectively preventing future admissions to acute care. The spend-to-save model is shown in Table 6.

Table 6. Spend to save model used in Pulmonary Rehabilitation project

Item	Cost per client (£)
Average direct cost for Respiratory Admission at ARI (see Table 7: Estimated costs associated with hospital inpatient stays)	3,615
Pulmonary Rehab service average cost (inc. travel)	267
<i>Average saving per patient</i>	<i>3,348</i>

Table 7: Estimated costs associated with hospital inpatient stays

Hospital	Specialty	Sum of direct costs per case	Average length of stay (days)	Average cost per bed day
Aberdeen Royal Infirmary	General Medicine	£1,492	3.7	£403
Dr Gray's	General Medicine	£1,289	4.0	£322
Aberdeen Royal Infirmary	Geriatric Assessment	£3,412	5.2	£656
Dr Gray's	Geriatric Assessment	£2,902	6.6	£440
Aberdeen Royal Infirmary	Respiratory Medicine	£3,615	6.2	£583

Source: NHS Costs Book 2019/20 (R040 tables) <https://beta.isdscotland.org/find-publications-and-data/healthcare-resources/finance/scottish-health-service-costs/>

The more upstream / preventative the project, the less relevant published hospital data becomes and other financial models become necessary to express the economic benefits of funding these projects. For example, being physically active could prevent hospital admission for many years, so presenting the benefit of the virtual exercise classes by comparing costs of delivering the service with a hospital admission is not necessarily a strong correlation. Third sector organisations are used to using Social Return on Investment (SROI) approaches to attract funding, whilst health economists might argue the benefits of Cost-Benefit or Cost-Consequence models. Whilst recognising these approaches, they were out of scope for a Portfolio-level evaluation, and would require a separate methodology to be systematically implemented across all initiatives to understand more fully.

Operation Home First Portfolio Evaluation

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Health Inequalities Synthesis

By health inequalities we mean systematic, avoidable and unjust differences in health and wellbeing between different groups of people which arise because of the conditions in which they are born, grow, live, work and become older. Legislation exists to address health inequalities in the UK including the Health and Social Care Act 2012, which addresses inequalities in access to health services and outcomes of different groups of people¹.

Ensuring equitable access to services is a key priority to address issues of inequalities in health. In the below table, the Evaluation Working Group have provided an appraisal to each Priority through a health inequalities lens, specifically how initiatives actively address this, or whether closer monitoring is required as time progresses. It should be noted though that this evaluation is not (and was never designed to be) a rigorous Health Inequalities Impact Assessment. Such an assessment should be conducted as a separate commission if this is desirable, though the below appraises elements of such with particular reference to access of services.

¹ Reducing Health Inequalities – The Health and Social Care Act 2012. Available [here](#)

Operation Home First Portfolio Evaluation

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Table 8. OHF Priority Appraisal through a Health Inequalities Lens

Priority Name (Project name in brackets)	Appraisal through a Health Inequalities Lens
Stepped Care Approach (Stay Well Stay Connected - Wellbeing Matters Webpage) Aberdeen City	Whilst being an initiative of Aberdeen City Health & Social Care Partnership, the webpage is technically available to anyone with an internet connection. For the small cohort of individuals who do not have access to the internet, wellbeing manuals have also been developed in paper copies to provide information of wellbeing resources locally.
Stepped Care Approach (Stay Well Stay Connected - Student Befriending Pilot) Aberdeen City	Befriending pilot exists to support those who already may experience health inequalities, as reasons for referral included social isolation, bereavement or being geographically distant from family members. Initiative still at small scale to prove the concept, therefore mechanisms of identifying appropriate individuals should be considered as part of the scale-up plan to minimise the impact of potentially exacerbating health inequalities.
Stepped Care Approach (Enhanced Community Support Huddles) City	With a recent Audit of service provision demonstrated that patients brought to the Huddle from North, Central and South localities was 36%, 30% and 34% respectively, this suggests that the model is operating effectively with regard to geographical reach (though further analysis of patient deprivation not conducted within would reinforce these findings). Multi-disciplinary team input across a variety of professions mean that the reach across different population cohorts is large. This will be further improved as participation of Primary care services increases.
Stepped Care Approach / Respiratory Pathway (Hospital @Home expansion: Respiratory Team) Aberdeen City	Although a very small team, operating only in the latter weeks of the Winter 2020/21 period, the Hospital @ Home Respiratory service was about to support referrals via both the Alternative to Admission route and 168 via the Supported Discharge route, showing that both routes had access into this service. Service delivered in a person's home, reducing the need for them to travel to access services.

Operation Home First Portfolio Evaluation

Draft for Consultation

Priority Name (Project name in brackets)	Appraisal through a Health Inequalities Lens
Respiratory Pathway (Home Oxygen Service) Pan-Grampian	Inpatient assessment for home oxygen to support discharge was made available to non-Respiratory consultants in ARI, with virtual support provided to consultants in DGH. In 9 weeks, the Home Oxygen team enabled the discharge of 28 patients, including 2 young palliative patients who were able to die at home surrounded by their families, which otherwise would not have been possible. The rapid home assessment service aimed at preventing hospital admission was only available to those living in or around Aberdeen City.
Respiratory Pathway (Prevention & Self-Management (Physical Activity) Online Classes) Pan-Grampian	The delivery of online, instructor-led, physical activity classes for patients with chronic respiratory diseases was identified as a proactive approach to halt and reverse the decline in health due to lack of opportunities to partake in exercise. Successful bids for Winter Funding via the Respiratory Cell enabled the purchase of equipment to ensure those who may otherwise have been excluded from the classes, could fully participate. 1:1, telephone-based, instruction was also provided to a few patients, for whom the digital technology was not appropriate. Links with the Pulmonary Rehab projects ensured people were able to access the most suitable option for their condition. Feedback showed that participation in these classes provided confidence to use digital technology for other purposes.
Respiratory Pathway (Physiotherapy-led Pulmonary Rehabilitation addition of 1-to-1 / Home support) Aberdeenshire	Delivered home pulmonary rehabilitation to patients who were unable to access online classes. Additionally, to contribute to reducing health inequalities, the team supported those with no access to transport who, in normal circumstances, would struggle to attend classes due to the rurality and lack of infrastructure around public transport.
Respiratory Pathway (Extension to Pulmonary Rehabilitation/Respiratory Physiotherapy and associated publicity/education campaign) Moray	This project has been Moray-wide (access to virtual pulmonary rehabilitation is not dependent on where someone lives) whereas before it was locality-based (depended on sufficient people to be worth running the face-to-face class, otherwise they would be offered a class in a different locality). Digital access is now within the team's current establishment to increase sign posting to community digital services, and potential for loanable technology to help reduce digital access inequalities (they are awaiting arrival of ordered iPads). The Moray physiotherapy team are still doing home pulmonary rehab to help reach patients for whom support via Digital is not an option/not appropriate (previously coming into the class was the only option, the team did very little home PR).

Operation Home First Portfolio Evaluation

Draft for Consultation

Priority Name (Project name in brackets)	Appraisal through a Health Inequalities Lens
Frailty Pathway (Hospital @Home) Aberdeen City	Service now operates at scale across Aberdeen City, with referrals accepted both from community-referring services (i.e. General Practices across the City) and secondary care service (i.e. Geriatric Assessment Unit in Aberdeen Royal Infirmary). Recent audit showed 308 referrals via the Alternative to Admission route and 168 via the Supported Discharge route, showing that both routes have access into the service. Service delivered in a person's home, reducing the need for them to travel to access services.
Frailty Pathway (Hospital @Home) Aberdeenshire	Service is not currently live so a health inequalities appraisal is not yet appropriate. However, close collaboration with developers of the Hospital @ Home model in Aberdeen City will help produce insights of best practice of implementing such models to reduce the likelihood of health inequalities occurring.
Frailty Pathway (Ward 102) Pan-Grampian	Given reductions in the number of geriatric beds, this does result in Ward 102 frequently carrying a proportion of boarders in different wards (i.e. patients who should be cared for in the ward but instead are elsewhere in this hospital). Reducing this is directly dependent upon capacity being scale up elsewhere in the system to facilitate flow, for example scaling up the Hospital @ Home model, or increasing the bed base at Rosewell.
Frailty Pathway (Rosewell) Aberdeen City & Aberdeenshire	Whilst Rosewell appropriate received almost exclusively step-down admissions from secondary care settings during its initial period of implementation, the longer-term vision for the facility was that of a community-facing intermediate care setting. Given this, the proportion of Step-Up vs. Step-Down referrals should be monitored closely to ensure there is equitable service provision focussing not just on accelerated discharge from hospital, but also avoiding admission to hospital by accessing the service.
Care @ Home (Contract Implementation) Aberdeen City	The move away from timed tasks to providing care tailored to the need of individuals may mean that more person-centred care can be delivered. The development of Granite Care Consortium is hoped to enhance market stability, meaning that the total hours of unmet need reduce over time. Whilst changes have not been made at the time of evaluation, this should be monitored as implementation develops. Service delivered in a person's home, reducing the need for them to travel to access services.

Operation Home First Portfolio Evaluation

Draft for Consultation

Priority Name (Project name in brackets)	Appraisal through a Health Inequalities Lens
<p>NearMe Pan-Grampian</p>	<p>NearMe provides a digital solution, thus making services broadly more accessible, particularly to those living in geographically dispersed areas. However, telephone consultation can still be used between patients and clinicians and face to face consultations can still be had if physical examinations are necessary. As such, there are other means by which individuals can access services, should they not be digitally connected.</p>
<p>Redesign of Urgent Care (Flow Navigation Centre)</p>	<p>All NHS Boards in Scotland have been required to establish Flow Navigation Centres as part of the Scottish Government’s Redesign of Urgent Care national programme. An initial “Discovery Report” commissioned by the Scottish Government, noted: that <i>“A fundamental part of the unscheduled and urgent care redesign is that this does not further disadvantage or widen health inequalities.”</i></p> <p><i>“Key Findings:</i></p> <ul style="list-style-type: none"> • <i>The level of understanding and comprehension of current and future systems was low.</i> • <i>More deprived individuals have low levels of access to telephony and to appropriate spaces to make telephone calls.</i> • <i>The emotional and practical needs of users must be met to provide a satisfactory experience.</i> • <i>Frustrations with primary care drive self-presentation at A&E.</i> <p><i>The service as it stands today does not build in additional measures to prevent a further widening of health inequalities. We would recommend Mitigation steps.”</i></p> <p>The Scottish Government are leading/commissioning further analysis and work on the service redesign, to further identify and plan further service changes to mitigate against widening inequalities. National evaluation of the redesign of urgent care is recommencing, and it would be desirable for Grampian’s evaluation activities to link in with the national work, where possible.</p>

Operation Home First Portfolio Evaluation

Draft for Consultation

Priority Name (Project name in brackets)	Appraisal through a Health Inequalities Lens
Palliative & End of Life Care (The Oaks Virtual Programme) Moray	The restrictions in place to prevent the transmission of COVID-19 prohibited the reintroduction of a face-to-face service for this vulnerable patient group at the current time. The translation of the palliative day service previously held at The Oaks, Elgin, into a four-week block of hosted virtual classes ensures support to this cohort is maintained. Issues of access to technology is a potential barrier to participation, though can be addressed through partnering with agencies whose specific remit is to encourage uptake of digital access. This in turn, reduces another barrier to participation through physical travel across the area to attend a class in person.
Whole system approach to discharge (Discharge 2 Assess (D2A), Moray)	For most people, being cared for at home, rather than hospital, is preferable and produces better outcomes (i.e. reductions in functional decline). D2A directly addresses the needs often associated with (prolonged) stays in hospital, through a multi-disciplinary, patient-centred approach. By instilling the confidence to continue to live as independently as possible, the provision of support services are kept to a minimum, freeing up capacity in the health and social care system for those who require more sustained treatment.
Virtual Community Wards Aberdeenshire	Model is established and used through Aberdeenshire. Particularly beneficial given the geographical dispersion of the area that allows for people of interest to be monitored closely if required. Service delivered remotely, reducing the need for people to travel to access services.

Operation Home First Portfolio Evaluation

Draft for Consultation

Operation Home First Evaluation Working Group Priority Appraisal

Given the data provided above, with specific regard to Priority timescales; degree of implementation and evidencable impact, the below Table provides an appraisal, from the Evaluation Working Groups perspective, as to the delivery of each of the OHF Priorities.

Table 9. Evaluation Working Group Appraisal of OHF Priorities

Priority Name	Evaluation Working Group Appraisal
Stepped Care Approach (Stay Well Stay Connected Workstream)	Staff working on workstream were redeployed to support other system-wide priorities during time of evaluation, including COVID vaccinations and Surge & Flow, resulting in some work slowing. Priorities within workstream have now been refreshed to account for the new context and should be allowed sufficient time to be developed and implemented before concluding their effectiveness.
Stepped Care Approach / Frailty Pathway / Respiratory (Hospital @ Home Aberdeen City)	Hospital @ Home model has been subject to rigorous evaluation previously, demonstrating acceptability to service users; unpaid carers and staff. Model delivers strong benefits aligned to OHF through caring for people at home and subsequently reducing pressure on secondary care. Given the ambitions of OHF, scaling this service further would be valuable.
Stepped Care Approach (Enhanced Community Support Huddles)	The huddles directly support the reduction of potential admissions or re-admissions to hospital by providing wraparound support using a virtual multi-disciplinary team approach. The huddles care for similar numbers of patients across Aberdeen City's localities and demonstrate high levels of acceptability from staff who attend, the majority of whom agree that this model improves patient care. Further work to engage Primary Care services will enhance their function.
Frailty Pathway (Ward 102)	Priority has focused on enablers to ensure the system operates more optimally, for example the development of criteria-led discharge and implementation of Rockwood scoring within the Emergency Department. The 'performance' in Ward 102 is inextricably linked to Hospital @ Home / Rosewell Priorities, with capacity required out-with the hospital setting to facilitate flow. The scale-up of Hospital @ Home and ability to open the remaining 10 beds in Rosewell may both help reduce the number of boarders the Ward faces.
Frailty Pathway (Rosewell)	The intermediate care facility effectively reduced the pressure on secondary care during the winter period by allowing flow out of Aberdeen Royal Infirmary. Ongoing organisational development work is required to support the growth of a 'One Team' culture, and such an ethos will require patience to manifest. Increasing the proportion of Step-Up referrals will be critical to avoid preventable hospital admissions and should be regularly monitored to ensure this is achieved.
Frailty Pathway (Hospital @ Home Aberdeenshire)	The model was under development during the evaluation period, meaning there are no deliverable benefits yet. However, there is strong evidence from the Aberdeen City Hospital @ Home model, and other similar models implemented nationally, that this will be valuable to adopt. More time is required to allow this service to go live before reviewing its impact.

Operation Home First Portfolio Evaluation

Draft for Consultation

Priority Name	Evaluation Working Group Appraisal
Care @ Home Contract Implementation	<p>During the evaluation period, the new Care @ Home contract had been implemented, however changes had not been made to the type of care that service users received. Therefore, more time is required to make a judgement on the impact of this new contract. However, Granite Care Consortium staff reported to be satisfied within their caring role and cited numerous perceived advantages to this way of working, including more flexibility as service users' wellbeing increases and decreases.</p>
NearMe	<p>Service has been scaled up since the COVID-19 pandemic and continues to support large numbers of people to be cared for across community and secondary care services virtually. It is highly acceptable to service users and staff. It is only used when safe and appropriate to do so, with telephone and face-to-face consultations still options if required. This is now an established model of delivery that will be valuable to continue in future.</p>
Redesign of Urgent Care (Flow Navigation Centre)	<p>This work is part of an ongoing, Scotland-wide, programme to build on opportunities to support people to access the Right Care in the Right Place at the Right Time, and as part of this, to reduce attendances at A&E/Minor Injuries Units if there are more appropriate sources of help and support. The programme leads within Grampian, and nationally, will continue to develop the service further, and with it, monitoring of relevant data to support both service operation and evaluation.</p>
Stepped Care Approach / Frailty Pathway / Respiratory Pathway (Hospital @ Home expansion: Respiratory Team)	<p>Local and national evaluations have shown that the Hospital @ Home model is well received and delivers good outcomes. This expansion of Hospital @ Home capacity in Aberdeen City was only for a short period and at small scale but again delivered good results, with substantial opportunities for future development. This is reinforced in Policy Direction/further funding opportunities at Scotland level. We would therefore suggest that there is merit in restarting and extending the Hospital @ Home respiratory team. UK researchers are doing further work on the economic evaluation of Hospital @ Home.</p>
Respiratory Pathway (Home Oxygen Service)	<p>The potential for changes to the Home Oxygen Team's way of working was demonstrated but not fully realised due to the unsuccessful recruitment of an additional staff member. There was no promotion of changes due to concerns over inundating the delivery of the existing service. The inpatient assessment test of change, supported by winter funding, highlighted the fact that home oxygen is not solely for patients suffering pulmonary conditions; most assessments and facilitated early discharges were for non-Respiratory specialties. Professional and patient support for this project was very high. Continued engagement between the evaluation team and Home Oxygen lead is necessary to understand key learning points from these brief tests of change and identify ways that service could implement these.</p>

Operation Home First Portfolio Evaluation

Draft for Consultation

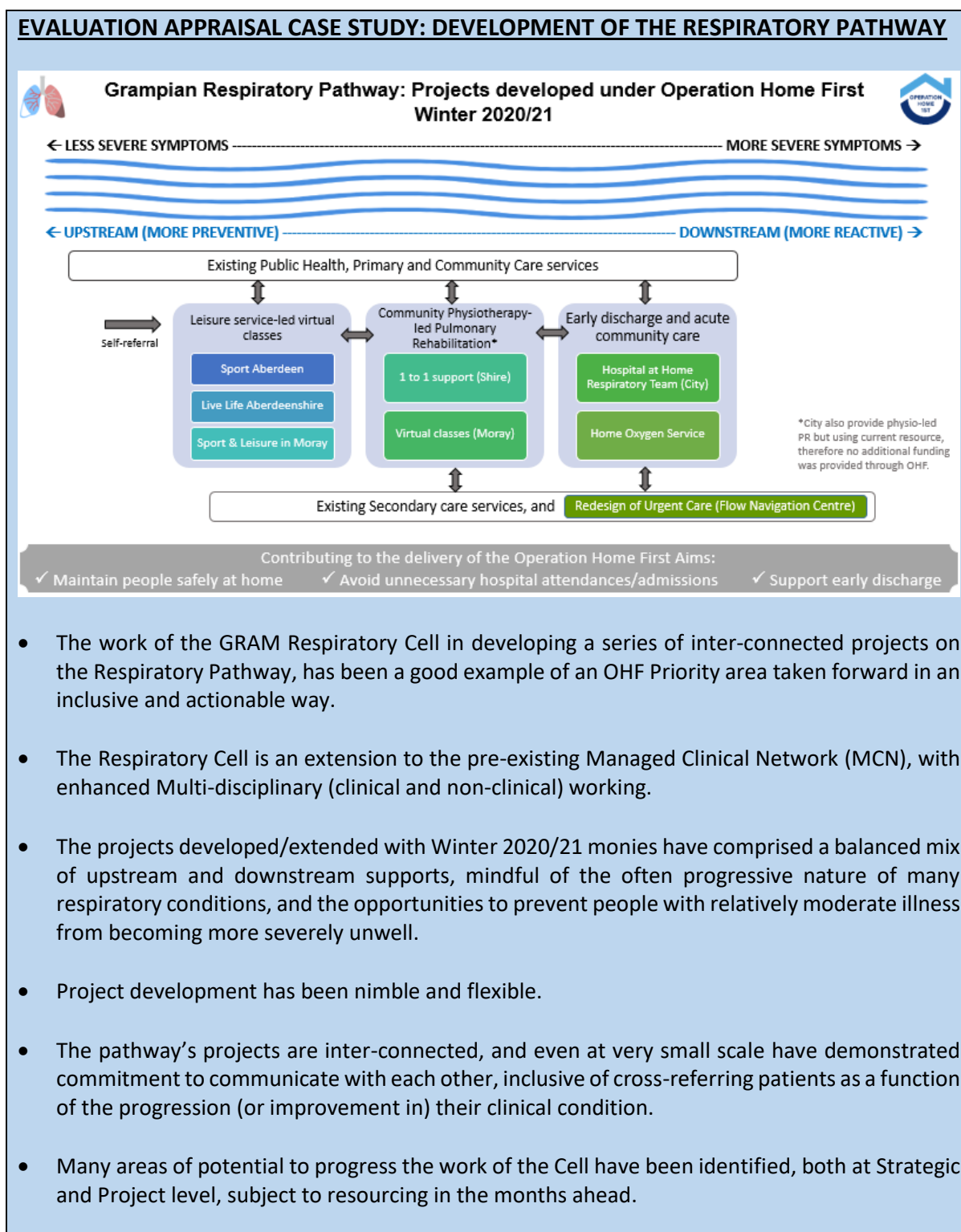
Priority Name	Evaluation Working Group Appraisal
<p>Respiratory Pathway (Pulmonary Rehabilitation - Aberdeenshire)</p>	<p>This project successfully delivered home-based, 1 to 1 Pulmonary Rehabilitation, to patients who could clinically benefit from it, but who were not able to access support via Digital means (or it was not suitable for them). Thus, even at its small scale, it played a part in helping to reduce inequalities. Additionally, as with other projects on the Respiratory pathway, the team communicated and cross-referred with other project teams, e.g. the Home Oxygen Service and Live Life Aberdeenshire (Physical Activity Classes). This was a good demonstration of integrated working. The Scottish Government’s Respiratory care - action plan: 2021 to 2026 makes clear that <i>“A critical part of the respiratory care pathway is access to pulmonary rehabilitation”</i>, and whilst the Shire physiotherapy team are continuing to provide group classes, consideration should be given again funding to further develop this service, e.g. to continue providing 1 to 1 support for those who are unable to access digital options, or for whom the group support is not appropriate (i.e. not to widen inequalities); to further develop links with the Home Oxygen Service / Acute.</p>
<p>Respiratory Pathway (Extension to Pulmonary Rehab / Respiratory Physiotherapy - Moray)</p>	<p>The team developed and delivered virtual Pulmonary Rehabilitation (PR) classes for the first time in Moray. They also undertook other small tests of change, including support for Home Oxygen reviews (saving staff and patient travel to/from hospital). This project used OHF funding to raise awareness of the existence (and benefits of) PR and respiratory physiotherapy, and associated referral pathways, amongst fellow health professionals in Moray. The team developed training and resources to increase capacity, within existing establishment, to take PR/Respiratory physiotherapy referrals – and saw an increase in such referrals during Jan-Mar 21 relative to Jan-Mar 2019. Even at small scale, this has been a very positive example of service development and (subject to ongoing resourcing) has the potential to continue to grow as part of an integrated respiratory pathway.</p>
<p>Respiratory Pathway (Physical Activity Classes)</p>	<p>Established with winter funding via the Respiratory Cell, the local sports providers (Sport Aberdeen, Live Life Aberdeenshire, Moray Council) developed programmes of instructor-led, physical exercise classes delivered virtually to patients whose respiratory illness had likely become compromised during the pandemic. A common evaluation framework was agreed to enable outcomes to be measured at both individual provider and collective Grampian levels. Whilst the late application for funding and time from award to implementation did mean that the number of weeks the classes could run was limited, feedback from those who participated (patients and the instructors) was very positive. The approach taken with this project shows great potential for expanding to include those with non-respiratory long-term conditions, making the service more viable. The benefits are wider than just improving physical health, with known links to improved mental wellbeing, peer-group support, reduced isolation, increasing digital literacy and so forth. A more robust evaluation framework over a longer period would surely yield benefits across the entire system.</p>

Operation Home First Portfolio Evaluation

Draft for Consultation

Priority Name	Evaluation Working Group Appraisal
<p>Palliative & End of Life Care (The Oaks Virtual Programme)</p>	<p>Despite only being able to deliver 3 of the 4 intended weeks for the first Virtual Programme, feedback from the patients who attended was very positive and showed that physical, group sessions are not the only acceptable format for supporting people’s palliative care needs. The fact that Roxburghe House is continuing to develop their virtual offering further supports this view, although the experience of the team at Roxburghe House does show that frequent (weekly) 1:1 support will be essential for some patients. The design of a Grampian-wide Virtual Programme, complemented by individual support, when necessary, may help to promote equity of access, although there are significant resource implications requiring further consideration. Evaluation support for development of this programme will be essential to fully recognise the value of such an offering.</p>
<p>Whole system approach to discharge (Discharge 2 Assess)</p>	<p>Discharge 2 Assess is a great example of the adoption of a tried initiative that has been developed elsewhere in the country to fill a gap in local service provision. Whilst the figures from the D2A pilot are very encouraging at patient, staff and service levels, without a doubt the service lead’s enthusiasm and tireless campaigning played a huge role in the successful implementation of the service. It is no coincidence that whilst D2A is currently “offline” for staff recruitment, Moray once again is struggling to manage its Delayed Discharge numbers. Funding for the service through 2021-2022, should be accompanied with evaluation support to maximise the service potential and cement the business case for permanent funding.</p>
<p>Virtual Community Wards</p>	<p>No significant changes to delivery during evaluation period whilst resources were diverted to developing Aberdeenshire’s Hospital @ Home model. However, this Priority has been established as business as usual and its impact well evidenced.</p>

Figure 10. Development of the Respiratory Pathway

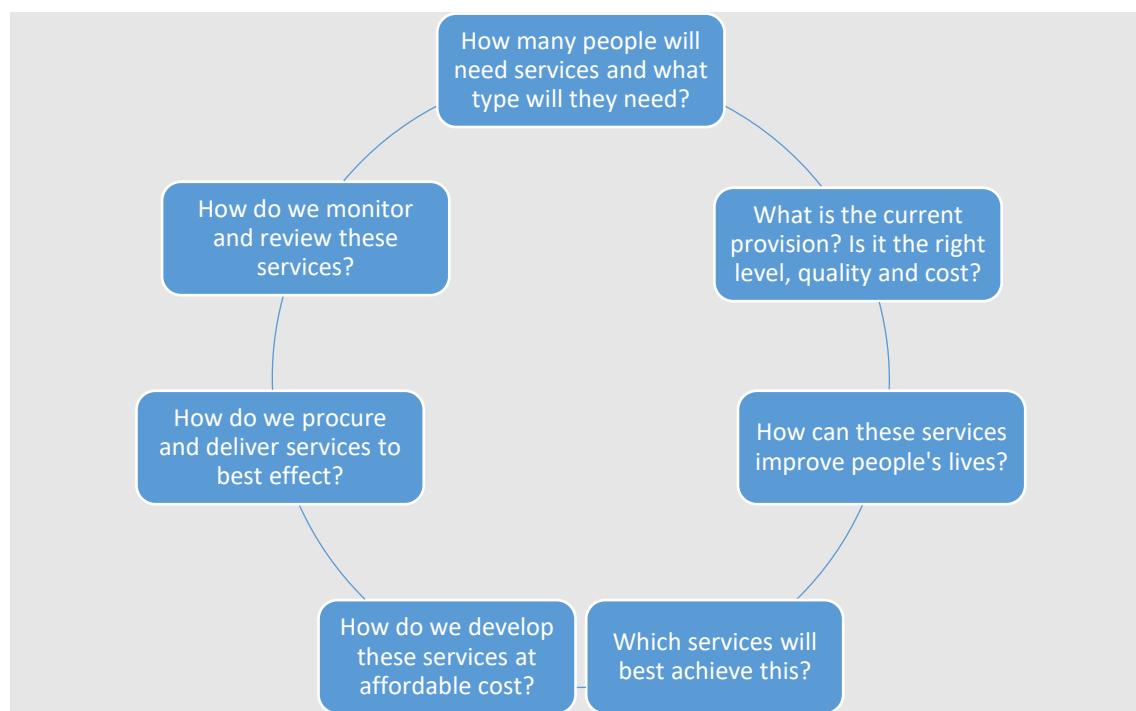


Strategic Context / Next Steps

The development of the OHF Portfolio was driven in large part by the combination of a requirement to remobilise services amidst ongoing COVID-19 restrictions, and to mitigate against expected pressures on acute services during the October 2020 – March 2021 winter period. The evaluation of OHF has taken place during a (COVID-19 necessitated) acceleration of service (re)development and (tests of) change. Many elements of work were reflective of existing Strategic Plans (and have good alignment with the aims of health and social care integration), but with additional, more reactive layers.

Taken as a whole, this is a complex portfolio, with many programme strands at different stages and paces of development. Over the course of various exchanges with staff over (and after) the life span of OHF, it appeared that awareness in the wider workforce of OHF as a concept may not have been high as a whole, sitting as it did in conjunction with the winter planning period, and between Grampian’s two other “Operation” phases of Rainbow and Snowdrop. We understand, however, that there is a strategic appetite for the ethos of “Home First” to become more embedded in Business as Usual for integrated health and care services across Grampian. To help it become so, we would recommend that project and programme evaluation is maintained as an integral part of the Strategic Commissioning Cycle, complementary to other key steps in that cyclical “Plan, Do, Study, Act” (PDSA) process. The visual below, drawn from the [Scottish Government’s Strategic Commissioning Plans Guidance](#), illustrates that amongst the questions pertinent throughout the commissioning process, there is a natural place for a range of Evaluation activities, alongside other relevant work such as Needs Assessments and Performance Monitoring. Such evaluation may be in respect of the ongoing “Home First” Portfolio, and/or other areas of relevant service provision.

Figure 11. Questions pertinent throughout the Strategic Commissioning Process



Redrawn from: <https://www.gov.scot/publications/strategic-commissioning-plans-guidance/>

Operation Home First Portfolio Evaluation
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It is also relevant to consider again where the strands of the OHF Portfolio sit in relation to regional and national policy and strategy, inclusive of key documents that were published during the winter 2020/21 period or shortly thereafter. We have bulleted, and then tabulated, some of these below. It is not an exhaustive list, but we have included here as they are of relevance in informing strategic decision-making going forward.

- The Redesign of Urgent Care will continue to be a priority for the Scottish Government (SG), with further actions and evaluation anticipated.
- The SG, with support from Healthcare Improvement Scotland, are continuing to promote the development of Hospital @ Home services. A paper published earlier this year has added to the evidence base around the benefits of Hospital at Home.
- The SG have in recent weeks published their Respiratory care - action plan: 2021 to 2026. Amongst the recommendations in this is that Pulmonary Rehabilitation services be provided in all areas.
- The Independent Review of Adult Social Care in Scotland (“the Feeley Report”) is of particular significance, and we can anticipate that this will have substantial implications going forward.
- Other portfolio-relevant themes such as Frailty, and Intermediate Care, remain on the national agenda for the continuation/continued development of services with a “Home First” focus.

Table 10. Some Relevant Key Strategic Literature Relevant to the OHF portfolio (with particular focus on those published during the winter 2020/21 period)

<p>Redesign of Urgent Care (Flow Navigation Centre)</p>
<p>Healthcare standards: Urgent Care (Scottish Government) https://www.gov.scot/policies/healthcare-standards/unscheduled-care/ <i>“It is considered that approximately 20% of patients who self-present at A&E could be helped to access more appropriate services for their needs and often care that is closer to home. The need for new ways of delivering services during COVID-19 has demonstrated what can be achieved to keep people safe and that there are a range of alternative ways to access NHS services which are available, in addition to traditional face to face care. The Redesign of Urgent Care looks to build on these opportunities to support the public to access the Right Care in the Right Place at the Right Time.”</i></p>
<p>Hospital at Home</p>
<p>Shepperd et al (2021). Summary on Hospital at Home Society website: https://www.hospitalathome.org.uk/hah-study-rct, links to full paper at https://www.acpjournals.org/doi/10.7326/M20-5688 Results of a randomised trial of >1,000 H@H patients in the UK.</p> <ul style="list-style-type: none"> • Providing healthcare at home to selected older people who experience a deterioration in health rather than in hospital could reduce pressure on hospital resources and be less disruptive to older people • In this study, outcomes for patients who received ‘Hospital @ Home’ care were just as good six months later, as for those who were admitted to hospital • There were higher levels of patient satisfaction with Hospital @ Home care. • It is not yet known whether Hospital @ Home care is cheaper than hospital-based care, but the research team are investigating this in an economic analysis.

Intermediate Care

Maximising Recovery, Promoting Independence: An Intermediate Care Framework for Scotland (Scottish Government, 2012) <https://www.gov.scot/publications/maximising-recovery-promoting-independence-intermediate-care-framework-scotland/>.

The framework encourages the development of a range of integrated services that can provide alternatives to hospital admission, and provide step-down care after a hospital admission.

The landscape for bed-based intermediate care in Scotland (Royal College of Nursing, 2017) <https://www.rcn.org.uk/about-us/our-influencing-work/policy-briefings/sco-pol-the-landscape-for-bed-based-intermediate-care-in-scotland>.

“There is a small but growing evidence base on how bed-based intermediate care supports improved system and individual outcomes.” (...) *“Intermediate care beds are also seen as a mechanism to deliver more cost-effective care. However, a recent paper by Nuffield Trust looking at delayed transfers of care in England noted ‘it cannot be assumed that alternatives to hospital will save large amounts of money unless far more radical changes to the system are made’. Looking at intermediate care beds specifically, there is mixed evidence on whether the use of intermediate care beds increases or reduces costs in comparison to hospital care.”*

Respiratory pathway

Respiratory care - action plan: 2021 to 2026 (Scottish Government, 24 March 2021)

<https://www.gov.scot/publications/respiratory-care-action-plan-scotland-2021-2026/>

This plan *“identifies key priorities and commitments to improve outcomes for people living with respiratory conditions in Scotland. The plan encourages new and innovative approaches and intends to share best practice. It sets out our desire to see a whole system approach to respiratory care, across health and social care.”* It notes that *“provision of high quality, joined-up respiratory care across Scotland must be the priority. New investment in well trained, multi-disciplinary healthcare teams is critical, right now.”* Examples of Priorities as applicable to the Operation Home First Portfolio include (but are not limited to), the following:

Priority 2- Diagnosis, management and care.

“A critical part of the respiratory care pathway is access to pulmonary rehabilitation. [This offers] a structured exercise and education programme designed for people living with a respiratory condition.” (...) *“Pulmonary Rehabilitation is one of the most effective forms of management for people living with respiratory conditions. 90% of people who complete the programme experience improved exercise capacity or increased quality of life. However, Chest Heart and Stroke Scotland (CHSS) estimates that only 2% to 21% of those who might benefit are being referred to pulmonary rehabilitation. Pulmonary rehabilitation is best established within treatment for COPD, however there is evidence of clear benefit in asthma, pulmonary fibrosis and bronchiectasis.”*

Priority 3 – Supporting Self-Management

“Self-management (...) requires a strong partnership with health professionals and access to a wide range of support networks.” (...) *“Self-management techniques are well established within long-term conditions and during the COVID-19 pandemic, they became more important than ever. With access to hospital and community services disrupted, people were forced to take a different approach to manage their condition.”*

Priority 5. Workforce

“Allied Health Professionals (AHPs) play a significant role in the treatment and care of respiratory conditions in Scotland. The development of more advanced roles means we are seeing more AHP-led services.”

“We recognise the importance of including wider sectors within workforce planning. There is vast support available within the third sector and we should consider opportunities of developing pathways and partnerships with organisations such as Chest Heart Stroke Scotland and Asthma UK and the British Lung Foundation.”

Frailty

The Frailty at the Front Door Collaborative Impact report December 2019 (Healthcare Improvement Scotland iHub). <https://ihub.scot/media/6870/201912-frailty-at-the-front-door-collaborative-impact-report-v10.pdf>

“There is compelling evidence to support the benefits of early and effective Comprehensive Geriatric Assessment (CGA), re-enablement and intermediate care for people living with frailty. The benefits for people and organisation include:

- *improved care experience,*
- *a reduction in the need for hospital care by consideration of a range of care options,*
- *people who are more likely to be supported in their own home with the appropriate level of care, and*
- *shorter periods of time in hospital if admission is required.”*

https://www.cochrane.org/CD006211/EPOC_comprehensive-geriatric-assessment-older-adults-admitted-hospital

Independent Review of Adult Social Care in Scotland, February 2021 (“the Feeley Report”).

<https://www.gov.scot/publications/independent-review-adult-social-care-scotland/>.

There were 53 recommendations in this report, many of which reinforce messages inherent to the aims of Health and Social Care Integration, such as outcomes focussed commissioning, and preventive/upstream services. Below are some excerpts from those recommendations that have particular relevance to the OHF Portfolio (although this should not be taken to mean that the other recommendations do not). We can expect actions around the 53 recommendations to come to the fore as preparatory work for the establishment of a National Care Service gets more fully underway.

Models of care

“28. The Scottish Government should carefully consider its policies, for example on discharge arrangements for people leaving hospital, to ensure they support its long held aim of assisting people to stay in their own communities for as long as possible.”

“31. Investment in alternative social care support models should prioritise approaches that enable people to stay in their own homes and communities, to maintain and develop rich social connections and to exercise as much autonomy as possible in decisions about their lives. Investment in, or continuance of, models of social care support that do not meet all of these criteria should be a prompt for very careful reflection both by a National Care Service and local agencies.”

Finance

“50. Careful analysis by a National Care Service, with its partners in the National Health Service, Integration Joint Boards and beyond, of opportunities to invest in preventative care rather than crisis responses, to avoid expenditure on poor outcomes such as those experienced by people who are delayed in hospital.”

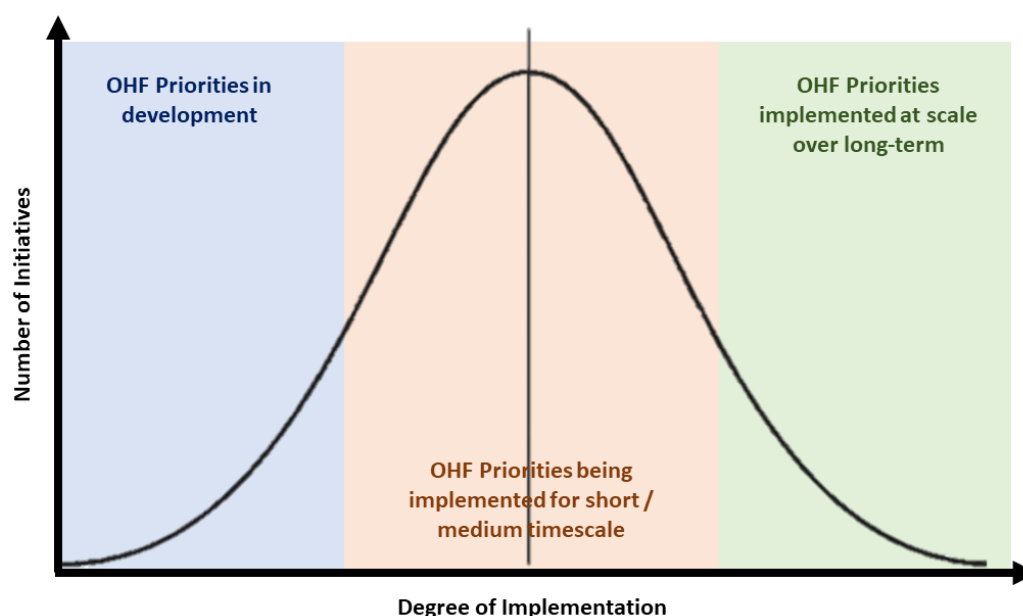
“51. Additional investment in order to:

- *expand access to support including for lower-level preventive community support”*

Summary / Discussion

The purpose of this report was to evidence the impact of the OHF Portfolio against its three aims of maintaining people safely at home, reducing unnecessary hospital attendances/admissions, and/or supporting early discharge. The report has also aimed to address a variety of additional queries that have been posed to the Evaluation Working Group over the course of its lifespan, including evidence of health inequalities; evidence related to cost; and the potential scalability / population-wide reach of different Priorities. Given the complexity of the Portfolio, the answers of its impact are complex, with different initiatives occurring at different scales over different time periods. Broadly speaking, Priorities in their infancy still demonstrate acceptability to service users and staff, whilst numerous Priorities have been evidenced to directly impact on the OHF aims. These are typically activities that strongly correlate to reducing pressure on secondary care, such as Hospital @ Home. Overall, the implementation of the OHF Portfolio can be illustrated using a bell curve to denote different initiatives sitting at different stages of development/implementation.

Figure 11. Bell curve illustrative of OHF priorities being implemented to varying extent.



Cumulative Impact

This evaluation intentionally stops short of providing grand totals, either for the cumulative impact on each of the OHF aims, or for other factors deemed of interest (such as financials). There are inter-related reasons for this:

- 1) The OHF portfolio is vast and heterogeneous, even within the deceptive simplicity of its three key aims. It has a mixture of upstream / downstream activity, Priorities occurring as small tests of change / at scale and Priorities impacting on one or more aims. Providing such grand totals would be a reductionist interpretation of the true value of the Portfolio.
- 2) Provided the context above, it is not possible to, with 100% accuracy, determine the totality of the Portfolio. Even with sweeping assumptions across the suite of activities within, it would likely underestimate the full impact.
- 3) Additionally, we are mindful that to attempt a detailed Economic Evaluation of the portfolio would require us to secure further resource, with the requisite skill base required to be

Operation Home First Portfolio Evaluation

Draft for Consultation

implemented concurrently with a separate, systematic methodology applied across all initiatives within the Portfolio, for that particular type of analysis.

This provides some key insight into how / what an evaluation of a complex Portfolio looks like. It is important to reiterate that this Portfolio emerged through a variety of complex social-economic / political factors (though primarily out of necessity given a global pandemic) and as such, required the implementation of an agile, multi-modal and pragmatic evaluation approach to concurrently run alongside.

Data Collection Considerations

Key to determining the impact of any initiative is the data that are available / able to be gathered. The more data that can be gathered, the more confident and robust conclusions can be. However, this requires more time and capacity to be invested in order to make this happen.

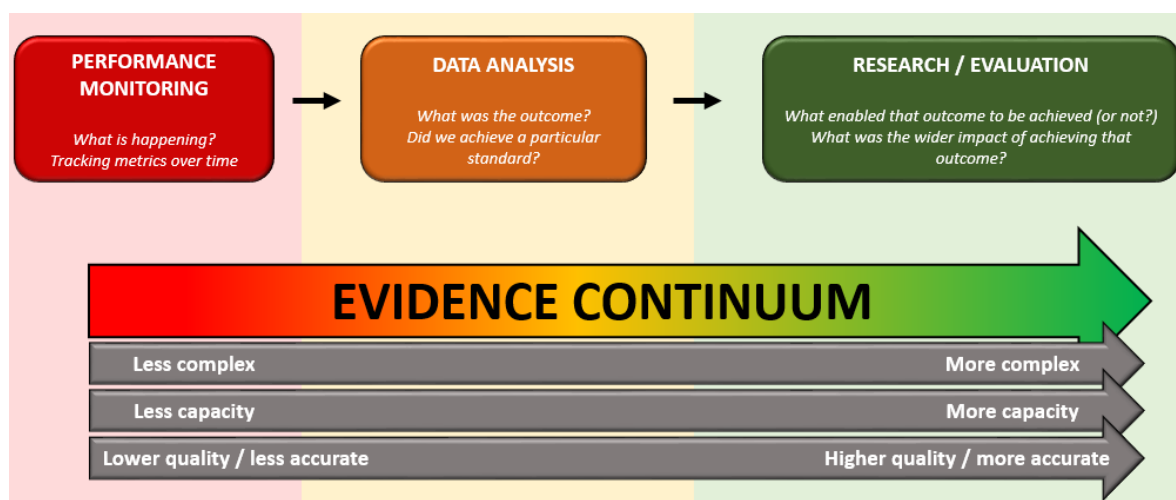


Figure 12. Evidence Continuum

For each initiative described within, the trade-off between time, capacity and evidence considerations had to be reviewed and judged at an individual level. Initiatives in their development phase during the evaluation period were able to closer align their data collection methods and requirements to that of the aims of the Portfolio. Other initiatives that were already implemented prior to this period have existing performance monitoring frameworks that are not necessarily feasible to adapt, particularly if they are long established. However, having an evaluation team with strategic oversight of such a Portfolio allow for connections / linkages to made across different initiatives to provide a clearer perspective on its cumulative impact. This also means that operational staff can focus more time on service delivery, a particularly pertinent point given the pressures the health and social care system have been under during the COVID-19 pandemic.

Resourcing

As aforementioned, not all OHF Priorities have been implemented to the same degree across the period of evaluation. One reason for this is challenges around resourcing and competing priorities. For example, a survey circulated to the OHF Priority leads (N=17) at the beginning of the evaluation period returned a mean score of 5/10 with regard to perceived confidence that the necessary resources (i.e. staffing) were available to deliver the change. In some instances, changes to particular Priorities were slowed to allow for acceleration in others (for example, the Palliative Care workstream decelerated activity as the relevant Occupational Therapists were assigned to Moray's Discharge 2 Assess project

Operation Home First Portfolio Evaluation

Draft for Consultation

instead). As highlighted in Figure 2, it is to be expected that implementing such a Portfolio with a variety of interdependencies would consequently result in prioritisation having to occur.

The long-term resourcing of Priorities within the OHF Portfolio is also variable. Some initiatives, such as the Respiratory Cell's Home Oxygen and Leisure projects were delivered using winter monies and, whilst demonstrating measurable benefits, are not subject to long-term investment. This is where the value of implementing a robust evaluation framework becomes apparent, as it provides senior leaders and decision makers with information to support decision making towards investing in initiatives that are thought to deliver tangible benefits. One such example is the Discharge 2 Assess project in Moray, which received the necessary ongoing funding from their Integration Joint Board to scale up and care for more people. It is recognised that in some instances, the long-term investment in one initiative may only be possible with the disinvestment in others, however a judgement on potential areas of disinvestment was out of scope for this report.

Equity of Evaluation Support

As mentioned above, initiatives competing for the same resources has meant that some projects have been prioritised over others. The same tension is evident within the capacity of the Evaluation Working Group to support all initiatives equitably. Given the pressure secondary care services were under during the winter period, initiatives that directly impact on this typically received greater emphasis of evidencing impact than upstream activities. One example of this was the rapid evaluation of the Rosewell Intermediate Care Facility, that was completed within a five-week period to inform the future direction of the service. It should also be recognised that the capacity of colleagues to engage with the evaluation process can be variable, particularly if service areas are under pressure. In these situations, the priority of the Evaluation Working Group is to minimise the additional burden of primary data collection and to review existing data infrastructure to draw as accurate conclusions as possible given the constraints.

Perceived Value of External Evaluation Support

The OHF Portfolio was novel, insofar as dedicated evaluation resource, comprised of a cross-system working group, was established to evidence this impact. Below, case studies were voluntarily written by Leads of some OHF Priorities to explain, from an implementation perspective, the value that this external support provided.

Reflections on Evaluation Support for the GRAM Respiratory Cell

"I think having you both [Evaluation Working Group Members] involved from the outset has allowed us to not only think about evaluation (in terms of looking back and seeing how something has worked or not worked) but to consider evaluation in advance and in the design stage. This has resulted in not only some new questions being asked or issues considered at the design stage but has helped sharpen focus and bring additional perspective to our projects."

"I think being able to use data / information / feedback for assessment is incredibly valuable, but I think being able to use that prospectively and having that be an integral part of project working on an ongoing and evolving basis is even more valuable. This helps underpin our work with a level of intelligence and assurance and allows us to have a much stronger basis for recommending things start, continue, adapt or stop and I think that has been to our considerable benefit."

"From my discussions with Kris [Cell Deputy chair] and Angie [Cell chair] I am confident that the above is reflective of their views also."

Robert O'Donnell, MCN Co-ordinator, NHS Grampian.

Reflections on Evaluation Support for Rosewell (Frailty Pathway)

"As we explore and try out new models of integrated working, it is critical that we can evidence the impact of the change that we are making. This information will let us see: how much progress we are making; whether that progress is in the intended direction; and at the pace we need."

The establishment of a new integrated model at Rosewell was achieved at pace, during the second wave of the pandemic and at a time of intense winter pressures. The model, while in line with the strategic intent for Rosewell as a key component of Operation Home First and the Frailty Pathway, was implemented in response to the civil contingencies crisis at that time.

A rapid evaluation within two months of implementation allowed the project team to be clear (supported by robust data), about the impact the new model was making - in terms of feasibility to staff and service users. This has allowed direct focus on specific areas as the interim model continues. This will allow for focussed modifications to be made during the extended test period, concurrently with other changes to the system as a result of remobilisation and changes in demand, allowing robust information to inform decisions on what will be best to put in place in the longer term.

There is no doubt, that without the initial capacity around the rapid evaluation, very early on in the change process, we would not be in such an informed position, which could have resulted in negative impacts, such as a longer required test period, and/or the project not meeting its desired outcomes."

Gail Woodcock, Interim Managing Director (Bon Accord Care)

Reflections on Evaluation Support for the GRAM Redesign of Urgent Care (RUC) Governance Group

“The evaluation team have brought a clear insight, direction, and drive. They have understood exactly what was asked of them to complement the governance of the RUC programme. I would argue that they are integral to the programme moving forward as we continue to evaluate in more depth the feedback from patients, but also staff as to the effectiveness or otherwise of the RUC programme.”

John Thomson, Divisional Clinical Director, Division of Unscheduled Care, NHS Grampian

Limitations

This evaluation, whilst it has covered a lot of ground, is not a silver bullet. Given the breadth of the Portfolio, the variety of questions that were posed along the way and challenges with time and resources, it is not possible to provide an exhaustive oversight on all facets described within. Should this report result in outstanding questions of interest that remain unanswered, these can be reviewed in the future. Furthermore, it has been conducted over a relatively short timescale in the midst of a global pandemic, meaning that its conclusions must be viewed within that context. Understanding the longer-term impact of these Priorities would require a longer-term monitoring of their outputs.

Acknowledgements

The Evaluation Working Group would like to acknowledge the following groups / individuals in the production of this report:

- The OHF Steering Group for establishing and ongoing commitment to the evaluation process.
- The OHF Priority Leads (and other close colleagues) for their enthusiasm and engagement.
- All service users and unpaid carers who volunteered to engage with numerous initiatives described within.
- The three North-East Health & Social Care Partnerships (Aberdeen City; Aberdeenshire and Moray); NHS Grampian; and the three North-East Local Authorities (Aberdeen City Council; Aberdeenshire Council and Moray Council) for their support and investment into the evaluation process.
- To Public Health Scotland for providing human resources to support the Portfolio evaluation

Appendix A: Interim Evaluation (including project Flash Reports)

OPERATION HOME FIRST

Evaluation Progress Report

March 2021

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Executive Summary

This report provides an update on the evaluation of Operation Home First (OHF). OHF is the collective priorities of the three North-East Health & Social Care Partnerships in collaboration with the Acute sector of NHS Grampian. The information contained within is predominantly for the purposes of providing assurances that a robust process has been implemented to evidence the impact of these priorities.

In general, positive progress is reported on most of the priorities. This includes: 1) an approximate 40-fold increase in the average number of NearMe consultations per week in the last 12 months; 2) the opening of 30 NHS beds in Rosewell as an interim care facility; 3) the implementation of a new Care @ Home contract, moving away from a time and task model to an outcomes-based approach. Of priorities that have been operational for an adequate period, evidence of acceptability to both service users and service providers is a critical first step towards ensuring that these initiatives are feasible to implement and subsequently, may deliver positive outcomes.

The full impact of the OHF portfolio cannot yet be fully quantified. This is for several reasons, for example: 1) several initiatives have only been operational for a limited period (such as the interim service model in Rosewell going live on 18.01.21), meaning more time must be given in these circumstances to generate enough data to robustly determine their function and 2) other priorities have moved at a slower pace given the recent Civil Contingency status that Grampian has been placed under since January 2021 (such as the sign-off and implementation of recommendations made in the Grampian-wide Strategic Framework for Palliative and End of Life Care). However, with reference to OHF priorities with a more acute focus, strong causation can be drawn of their direct impact against the aims of OHF. For example, every admission to Hospital @ Home that is identified as an 'alternative to admission' means that the person is not admitted unnecessarily to the ARI wards, but instead is supported safely at home. Furthermore, this helps to lessen pressures that can otherwise lead to patients being "boarded" in ARI beds out with the specialty whose care they are under.

A further report is due to be published towards the end of Spring 2021, with greater detail on the impact of each individual priority against the aims of OHF. This time allows for additional data to be collected and further analysis to be conducted. This, in turn, will ensure more meaningful conclusions and future recommendations can be derived.

Introduction

Operation Home First (OHF) is the collective priorities of the three North-East Health & Social Care Partnerships in collaboration with the Acute sector of NHS Grampian. It is a portfolio that has emerged through positive, cross-system working during the COVID19 pandemic and emphasises the importance of shifting the balance of care, when safe and appropriate to do so, from acute settings to community settings. There are three aims to OHF:

- 1) To maintain people safely at home
- 2) To avoid unnecessary hospital attendance or admission
- 3) To support early discharge back home after essential specialist care

More background information about OHF, including its underlying principles, can be viewed [here](#).

In October 2020, The OHF Steering Group commissioned an evaluation working group to evidence the impact of the OHF portfolio. The remit of the working group was two-fold:

- 1) Understand the impact of each OHF priority, and how they contribute towards achieving the aims of OHF
- 2) Develop a high-level, performance dashboard of meaningful metrics to monitor overtime to understand the performance of the portfolio.

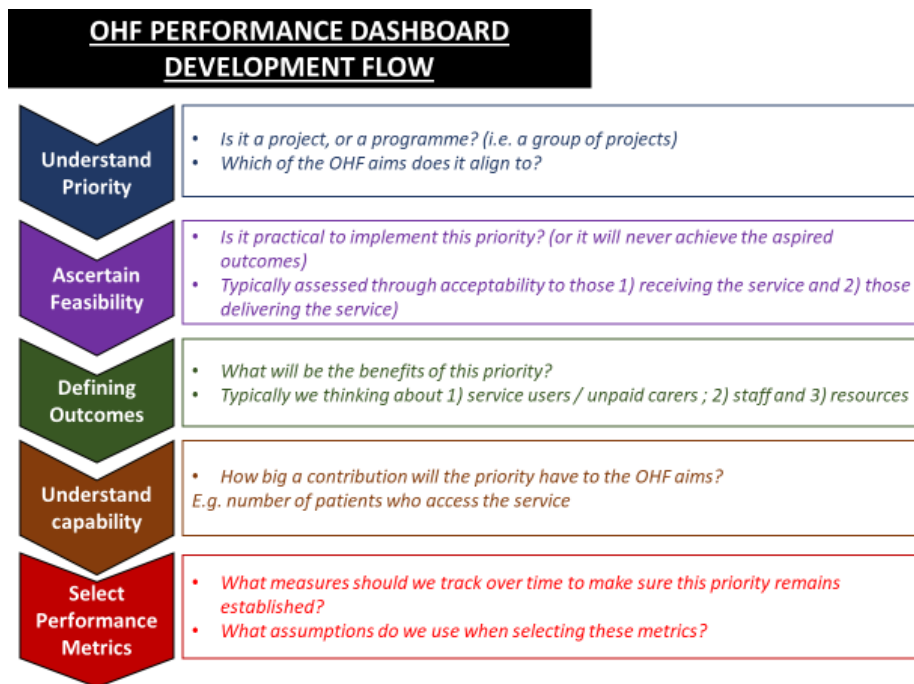
This report outlines the progress made against the above as of February 2021. In particular, it is designed to provide assurances that a robust process has been designed and implemented to evidence the impact of this portfolio.

A further report is due to be published towards the end of Spring 2021, with greater detail on the impact of each individual priority against the aims of OHF. This additional time allows for additional data to be collected and further analysis to be conducted. This, in turn, will ensure more meaningful conclusions and future recommendations can be derived.

Methods

Evaluation process

To develop a meaningful, performance dashboard of high-level metrics that may be positively influenced should a complex portfolio of this nature be implemented as theoretically planned, an understanding must first be sought of each individual priority. The figure below describes, at a strategic level, the approach that the evaluation working group took across priority areas. These are elaborated upon below:



Understanding the Priorities individually – Some of the OHF priorities are individual projects (such as Implementation of Near Me). Others are programmes (i.e. a group of projects, such as the Stepped Care Approach). In the latter scenario, the full impact of the programme cannot be understood until individual projects are understood. During this stage, priorities were mapped against the OHF aims, which helps inform the data collection process.

Ascertaining feasibility – Service changes / developments cannot realise benefits if they are not practical to implement. As such, a critical component to new initiatives is determining whether they are acceptable to those delivering the service (i.e. staff) and to those receiving the service (i.e. service users and unpaid carers).

Defining outcomes - If initiatives pass the feasibility test, consideration can be given as to what benefits these will have. These benefits can usually be categorised by 1) benefits to service users / unpaid carers; 2) benefits to staff; 3) benefits to resources / services.

Understanding capability – This helps answer the question as to the impact individual priorities have against the aims of OHF. For example, a small-scale test of change will not have a substantial impact on reducing hospital attendances but is helpful to prove a new concept or to determine how it may make a positive contribution should it be scaled up.

Selecting performance metrics - The goal here is to distil each priority down to a minimal number of measures that can provide an indicative overview as to how that priority is functioning. Key to this is developing assumptions that provide as rationale as to why that metric was selected.

Pragmatic considerations

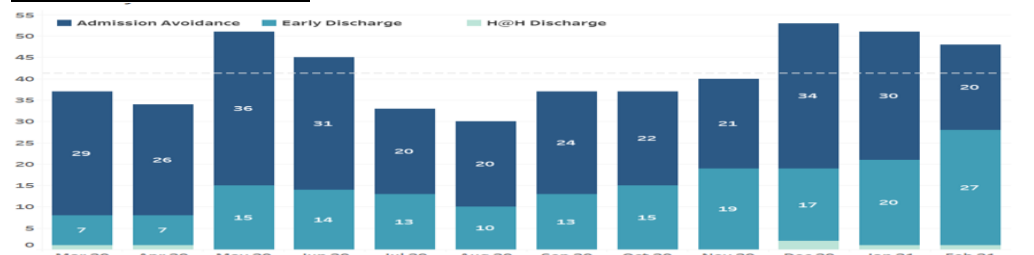
Evaluation of a portfolio of this scale is a complex undertaking. There are multiple reasons for this, including but not limited to:

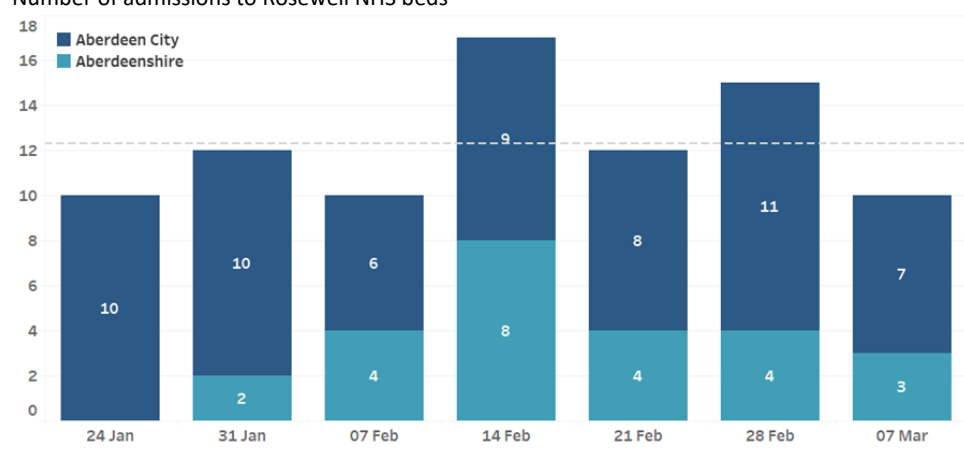
- *Degree of implementation:* The priorities within the OHF portfolio did not all begin at the same time, with the same capacity and resources to deliver them. As such, by October 2020 (and at the time of writing) priorities were ranging from being delivered at scale to still being in a planning phase. In some cases, therefore, data collection is required to be retrospective, in others it can be planned before initiatives commence.
- *Pace of implementation:* Some initiatives have stricter deadlines than others, for example due to time-limited funding. Given this and other extraneous factors, such as Grampian being placed within Civil Contingencies level 4 in January 2021, this means some priorities were accelerated with their implementation, whilst others have moved at a slower speed.
- *Downstream vs Upstream Activity* – Given the pressures that COVID19 has had on secondary care provision, evaluation activity has been prioritised on those initiatives that are closer to this part of the system.

Priority Updates

The following section provides an update of each of the priorities. These are in the form of one-page flash reports that are designed to provide an overview of progress to date. Where possible, links are also provided to relevant metrics that will be integrated into the OHF performance dashboard that will be used to monitor priorities over time.

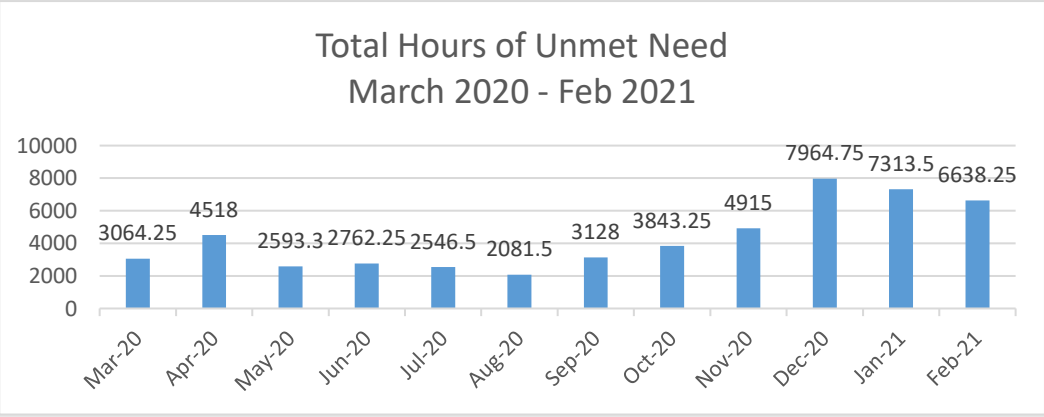
Operation Home First Priority Stepped Care Approach	Priority Workstream (if applicable) Stay Well Stay Connected	RAG Status	
Operation Home First Aims this aligns to <i>Keep people safe at home</i>			
<u>Brief description of priority</u> The Stay Well Stay Connected workstream is the bottom level of the Stepped Care Approach. The core aim is improving self-management and reablement within the community.			
<u>Update as of February 2021</u> A review of the workstream is being undertaken to understand progress to date and highlight areas of focus moving forward. Three working groups have been developed, each with a different focus: 1) <i>Respite</i> [overnight and/or residential]; 2) <i>Buildings Based Day Activities</i> [to be established]; 3) <i>Prevention</i> [restructuring to align to strategic aims]			
<u>Impact to date</u> <p><i>Community / Staff Engagement:</i> 93 people responded to the 'Fit Like' Survey, that aimed to understand and identify key issues to address to improve health and wellbeing in communities. For this, eight problem statements were identified, for example: 1) 40% of respondents did not have a device or internet and 2) over 50% of responders report they don't, or would like to get out and about and described having low mood.</p> <p>The result of this has been the implementation of a variety of initiatives across communities. For example: 1) <i>"Wellbeing Matters Webpage"</i>: that provides a number of helpful resources on keeping and staying well (and received more than 1100 visits in the last 12 months); 2) <i>Physical Activity packs for people at home</i>: collaboration with physiotherapy students including exercise instructions, walking routes and information on government guidelines; 3) <i>Boogie in the Bar</i>: currently holding virtual boogies for older adults during COVID via Facebook, YouTube and twice weekly on SHMU radio.</p>	<u>Case Study / Testimonials</u> <p><i>The Student Befriending Pilot was a collaboration working between Robert Gordon University (RGU) and Aberdeen City Health & Social Care Partnership. In this pilot, 12 students (six Occupational Therapists and six Physiotherapists) were paired six older adults over a period of 6-8 weeks with the aim to provide befriending and identify links to enhance wellbeing.</i></p> <p><i>John and Vera (pseudonyms) were one elderly couple who engaged in the pilot. Versa newly lost sight in both her eyes, whilst John had a recent stroke, leaving weakness down one side and with no speech.</i></p> <p><i>The outcomes they wanted to achieve through the pilot were to shop online, keep in touch with family and take advantage of health care appointments.</i></p> <p><i>At the end of the pilot, John and Vera had created their first email account and received their first online shopping delivery much to their excitement They have been referred into Occupational Therapy for further input.</i></p> <div data-bbox="1131 917 2172 1077" style="background-color: #4a86e8; color: white; padding: 10px; border-radius: 5px;"> <p><i>"The pilot was a very positive experience for me, I enjoyed it very much. Building the relationship both with the befriender and my physio partner was a highlight of my placement"</i></p> </div> <p><i>(Occupational Therapy Student).</i></p>		
<u>Aligned performance indicator</u> To be developed aligned to the Prevention workstream review currently being undertaken.	<u>Additional comments</u> Analysis of current and predicted demand across our client groups is underway to inform future commissioning requirements regarding planned respite. To ensure a comprehensive approach is taken, an overview of all commissioning beds for interim, surge and respite is being summarised to ensure a balance across the system which responds to the needs of our population.		

Operation Home First Priority Stepped Care Approach / Frailty Pathway	Priority Workstream (if applicable) Hospital @ Home (H@H)	RAG Status																																																																		
Operation Home First Aims this aligns to <i>Keep people safe at home; Reduce unscheduled attendances / admissions; Supporting early discharge.</i>																																																																				
<u>Brief description of priority</u>																																																																				
Hospital @ Home provides acute care for geriatric patients in their own home via a multi-disciplinary team. There are two admissions routes: 1) alternative to admission (whereby otherwise the individual would be admitted to hospital) and 2) supporting discharge (referrals from hospital to return home sooner and receive the final part of their care at home). The service has been operational since June 2018 and has had 957 admissions during this period (up to February 2021).																																																																				
<u>Update as of February 2021</u> Detailed information about the development of the respiratory component of H@H is visible in the associated flash report.																																																																				
<u>Impact to date</u>	<u>Case Study / Testimonials</u>																																																																			
<p><i>Service metrics:</i> 476 referrals in the last 12 months (Admission Avoidance=308; Early Discharge=168). Both Hospital @ Home (71%) and GAU (72%) show similar proportion of patients at home / in a community setting 90 days post discharge.</p> <p><i>Service User / Unpaid Carer Acceptability:</i> Previous feedback from 16 patients demonstrated high satisfaction in the service (mean score = 4.1/5) and confidence in the team (mean score = 4/5). One said: "I was amazed at the amount of help I received. Each person knew exactly what they were going to do and did it all so cheerfully and willingly. Thank you all" (Responder x).</p> <p>A sample of unpaid carers (n=16) rated the H@H team strongly on providing them encouragement and support (mean score = 4.8/5) and providing them with extra knowledge or skills to look after their cared for person (mean score = 4.6/5). One stated: "This home team is a great service, more info was passed on and explained than during the hospital stay. The nurses were able to spend time with my relative, listen to him, watch him and make a true assessment of his needs. The help put in place will allow him to stay at home and have as good a quality of life as possible. This service has also given us as a family peace of mind" (Responder x).</p> <p><i>Staff outcomes:</i> A previous staff satisfaction survey found a mean satisfaction score of 73%, which is 5% higher than the average NHS employee. A sample of services who regularly work with H@H, including General Practice and District Nursing, had high agreement of how easy the referral process was into H@H (mean agreement = 84%).</p>	<p>"Mrs B fell when she was walking to her local shop. She was taken to GAU where she was x-rayed and no fractures were found. Mrs B had sustained a superficial injury to her foot. She was referred to H@H from ED, avoiding a hospital admission.</p> <p>During Mrs B's initial visit from the H@H team, the PT & ANP suspected she had delirium. The HCSW took routine observations such as blood pressure, temperature, respirations, oxygen saturations and pulse. On next visit, Mrs B was hallucinating and a urine sample test confirmed a urinary tract infection. Mrs B's mood was low on several occasions, stating she felt a burden as well as a nuisance towards her family and AC@H staff.</p> <p>The AC@H team recommended Mrs B should have carers 3 x daily care to support with personal hygiene, diet and medication prompt. Mrs B required regular reminders not to go out walking alone, due to high fall risk. Family members were sign posted to relevant services which may benefit Mrs B's ability to remain at home safely (e.g. community alarm, key safe, city home helpers). The family decided to install a key safe following this advice. The TL completed a care management care plan. Due to care package not being in place and husband still in hospital, AC@H decided not to discharge Mrs B.</p> <p>A&E informed AC@H that Mrs B fallen overnight and was in the department with a head injury receiving treatment. AC@H was informed Mrs B was to be admitted to GAU, however after discussion it was decided that AC@H would take over care, preventing hospital admission.</p> <p>AC@H staff continued to provide 3 x daily care while awaiting Mrs B care package. The P Tech liaised with care providers regarding medication. Mrs B was then discharged from AC@H and her care was handed over to the DN regarding Mrs B's ongoing care of foot dressing as well as the staple removal from head injury". (Advanced Practitioner, H@H).</p>																																																																			
<u>Aligned performance indicator</u>																																																																				
 <table border="1"> <caption>Hospital@Home Admissions by Month</caption> <thead> <tr> <th>Month</th> <th>Admission Avoidance</th> <th>Early Discharge</th> <th>H@H Discharge</th> <th>Total</th> </tr> </thead> <tbody> <tr><td>Mar 20</td><td>29</td><td>7</td><td>0</td><td>36</td></tr> <tr><td>Apr 20</td><td>26</td><td>7</td><td>0</td><td>33</td></tr> <tr><td>May 20</td><td>36</td><td>15</td><td>0</td><td>51</td></tr> <tr><td>Jun 20</td><td>31</td><td>14</td><td>0</td><td>45</td></tr> <tr><td>Jul 20</td><td>20</td><td>13</td><td>0</td><td>33</td></tr> <tr><td>Aug 20</td><td>20</td><td>10</td><td>0</td><td>30</td></tr> <tr><td>Sep 20</td><td>24</td><td>13</td><td>0</td><td>37</td></tr> <tr><td>Oct 20</td><td>22</td><td>15</td><td>0</td><td>37</td></tr> <tr><td>Nov 20</td><td>21</td><td>19</td><td>0</td><td>40</td></tr> <tr><td>Dec 20</td><td>34</td><td>17</td><td>0</td><td>51</td></tr> <tr><td>Jan 21</td><td>30</td><td>20</td><td>0</td><td>50</td></tr> <tr><td>Feb 21</td><td>20</td><td>27</td><td>0</td><td>47</td></tr> </tbody> </table>	Month	Admission Avoidance	Early Discharge	H@H Discharge	Total	Mar 20	29	7	0	36	Apr 20	26	7	0	33	May 20	36	15	0	51	Jun 20	31	14	0	45	Jul 20	20	13	0	33	Aug 20	20	10	0	30	Sep 20	24	13	0	37	Oct 20	22	15	0	37	Nov 20	21	19	0	40	Dec 20	34	17	0	51	Jan 21	30	20	0	50	Feb 21	20	27	0	47			
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Hospital@Home Admissions by Month	<u>Additional comments</u> This performance indicator assumes 1) all admission avoidance referrals directly result in one less admission to Ward 102 in Aberdeen Royal Infirmary 2) each 'early discharge' referral directly reduces pressure on secondary care and 3) increasing referrals to Hospital @ Home mean more people are being cared for in a more appropriate setting.																																																																			

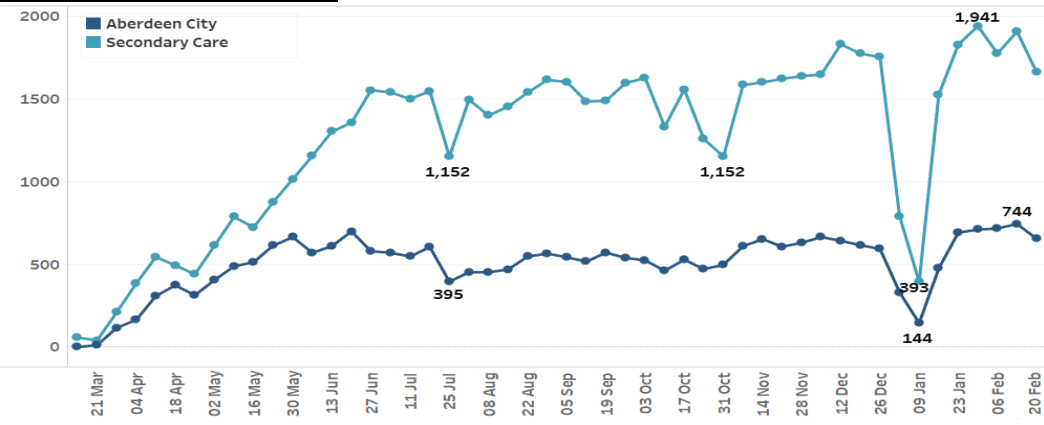
<p>Operation Home First Priority Frailty Pathway</p>	<p>Priority Workstream (if applicable) Rosewell</p>	<p>RAG Status</p>																							
<p>Operation Home First Aims this aligns to <i>Keep people safe at home; Reduce unscheduled attendances / admissions; Supporting early discharge.</i></p>																									
<p><u>Brief description of priority</u> Rosewell House is being developed as an enhanced pathway and service model. This would see an integrated service providing intermediate care for both step down from hospital and step up from community. The model will increase capacity in the system as well as meeting our aim of delivering the right services, in the right place at the right time whilst also reducing the need for unscheduled admissions and enabling the safe discharge of patients from hospital who require further care prior to returning home.</p>																									
<p><u>Update as of February 2021</u> To facilitate an urgent response to surge and flow during the latest Covid19 wave, Rosewell House was opened as an interim NHSG facility on 18.01.21. This involved 20 beds remaining under Bon Accord Care's registration, with the remaining 40 beds transferring to NHS Grampian on a temporary 16-week basis. As of 22.02.21, 30 out of 40 of these NHS beds are open and accepting admissions. Work continues to develop the longer-term model ahead of the end of the period for interim arrangements (10.05.21).</p>																									
<p><u>Impact to date</u> <i>Transfer of staff:</i> The current nursing workforce for the NHS beds is 20WTE (21 headcount), supported by 26.8WTE HCSW (30 headcount) and a headcount of 25 BAC support workers. This staffing has been supported by the movement of workforce from two wards in Woodend Hospital that have now been closed, meaning that more people can be cared for closer to home when safe and appropriate to do so.</p> <p><i>Service metrics:</i> Since January 18th there have been 86 admissions to NHS Rosewell beds (61 patients from Aberdeen; 25 from Aberdeenshire). All except one from H@H have been step-down admissions from hospital. 51 patients have subsequently been discharged/transferred from Rosewell (34 patients discharged home, nine transferred to a Shire community hospital, three to WGH, one re-admitted to ARI, one stepped-down to H@H and three who died). The average length of stay for patients who have been discharged/transferred has been 12.4 days with a maximum length of stay of 36 days.</p>	<p><u>Case Study / Testimonials</u> <i>"In January 2021, as a result of significant pressures on hospital services in Aberdeen, under civil contingencies, it was agreed to allow NHSG to operate 40 beds within the 60 bedded Rosewell Care home (with the remaining beds remaining as care home rehabilitation beds.) Since that time, 30 beds have been utilised by NHSG teams supported by BAC staff.</i> <i>This arrangement, although put in place as an emergency measure, have provided a unique opportunity for us to learn from a different model at Rosewell. Including: how staff from different organisations can work effectively together as integrated teams; a better understanding of the nature of the care demands that may present at a peak period, and latterly a more usual level; and how flow between hospital, intermediate care, rehabilitation care and community care can be made more efficient.</i> <i>It is intended that the learning from this model, which was established due to necessity, will enable the longer term model that is developed to be fit for purpose in a system of varying demand over time."</i></p>																								
<p><u>Aligned performance indicator</u> Number of admissions to Rosewell NHS beds</p>  <table border="1"> <caption>Number of admissions to Rosewell NHS beds</caption> <thead> <tr> <th>Date</th> <th>Aberdeen City</th> <th>Aberdeenshire</th> </tr> </thead> <tbody> <tr> <td>24 Jan</td> <td>10</td> <td>0</td> </tr> <tr> <td>31 Jan</td> <td>10</td> <td>2</td> </tr> <tr> <td>07 Feb</td> <td>6</td> <td>4</td> </tr> <tr> <td>14 Feb</td> <td>9</td> <td>8</td> </tr> <tr> <td>21 Feb</td> <td>8</td> <td>4</td> </tr> <tr> <td>28 Feb</td> <td>11</td> <td>4</td> </tr> <tr> <td>07 Mar</td> <td>7</td> <td>3</td> </tr> </tbody> </table>	Date	Aberdeen City	Aberdeenshire	24 Jan	10	0	31 Jan	10	2	07 Feb	6	4	14 Feb	9	8	21 Feb	8	4	28 Feb	11	4	07 Mar	7	3	<p><u>Additional comments</u> An evaluation of the interim model was commenced 22.02.21 and will be completed 26.03.21 to inform its future direction.</p>
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Operation Home First Priority Frailty Pathway	Priority Workstream (if applicable) Ward 102	RAG Status <div style="background-color: green; width: 20px; height: 20px; display: inline-block;"></div>																																																											
Operation Home First Aims this aligns to <i>Support early discharge; Reduce unnecessary hospital attendances and admissions</i>																																																													
Brief description of priority Safe, effective patient flow in and out the Geriatric Assessment Unit within Aberdeen Royal Infirmary, ensuring the right patients (i.e., those with decompensated frailty) are managed appropriately within the right area of the health and social care system in a timely manner.																																																													
Update as of February 2021 Five workstreams have recently been developed to support the progression of this priority: 1) Admission and Flow Group; 2) Discharge; 3) HAME and Front Door Frailty Identification; 4) Establish 102 Workforce; 5) Operational principles and escalation practices.																																																													
Impact to date <p><i>Direct access</i> – General Practitioners can contact a clinician within Ward 102, for example when the first signs of delirium are present in their patients. This allows them to have timely access to specialist advice, resulting in care being provided in the most appropriate setting (whether that is at home, in hospital or other).</p> <p><i>Implementation of Rockwood scoring within Emergency Department</i> – patients are now scored using Rockwood Frailty Scale at point of admission. This allows for early identification of frailty and subsequent implementation of a frailty bundle that outlines the appropriate early interventions required. This has been used with 65 patients to date. The next phase will be exploring its implementation with Scottish Ambulance Service.</p> <p><i>Escalation plan developed</i> – required in response to managing flow (i.e. managing beds). Outlines each members of staff roles within the plan to ensure efficiency of service delivery.</p> <p><i>Development of criteria-led discharge</i> – leading to a more timely and efficient discharge, with the goals being person-centred as opposed to medically-led.</p> <p style="text-align: center;"><u>Aligned performance indicator</u></p> <table border="1" style="margin-top: 10px;"> <caption>Ward 102 referrals from Emergency Department / AMIA by month for the last 12 months</caption> <thead> <tr> <th>Month</th> <th>Via ED/AMIA</th> <th>W102 Admissions</th> <th>Total</th> </tr> </thead> <tbody> <tr><td>Jan 20</td><td>298</td><td>302</td><td>599</td></tr> <tr><td>Feb 20</td><td>306</td><td>310</td><td>616</td></tr> <tr><td>Mar 20</td><td>190</td><td>211</td><td>401</td></tr> <tr><td>Apr 20</td><td>330</td><td>380</td><td>710</td></tr> <tr><td>May 20</td><td>377</td><td>446</td><td>823</td></tr> <tr><td>Jun 20</td><td>391</td><td>466</td><td>857</td></tr> <tr><td>Jul 20</td><td>220</td><td>287</td><td>507</td></tr> <tr><td>Aug 20</td><td>190</td><td>281</td><td>471</td></tr> <tr><td>Sep 20</td><td>189</td><td>305</td><td>494</td></tr> <tr><td>Oct 20</td><td>201</td><td>277</td><td>478</td></tr> <tr><td>Nov 20</td><td>180</td><td>257</td><td>437</td></tr> <tr><td>Dec 20</td><td>200</td><td>278</td><td>478</td></tr> <tr><td>Jan 21</td><td>181</td><td>254</td><td>435</td></tr> <tr><td>Feb 21</td><td>155</td><td>231</td><td>386</td></tr> </tbody> </table>	Month	Via ED/AMIA	W102 Admissions	Total	Jan 20	298	302	599	Feb 20	306	310	616	Mar 20	190	211	401	Apr 20	330	380	710	May 20	377	446	823	Jun 20	391	466	857	Jul 20	220	287	507	Aug 20	190	281	471	Sep 20	189	305	494	Oct 20	201	277	478	Nov 20	180	257	437	Dec 20	200	278	478	Jan 21	181	254	435	Feb 21	155	231	386	Case Study / Testimonials <p><i>“GP access to a senior clinical decision maker available in Ward 102 has been facilitative of timely intervention and admission to hospital only when agreed as essential and unavoidable.</i></p> <p><i>Admissions have been avoided when GPs contact the ward direct to discuss patients’ presentations and to explore with the Geriatrician / Registrar management options. The exclusion of delirium alongside other management considerations when frailty significantly impacts patients recovery, wellbeing and activities of living.</i></p> <p><i>Discussions between GP and geriatrician ensure medication review, minimise unnecessary polypharmacy and optimise medications.”</i> (Staff member, Ward 102)</p>
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Operation Home First Priority Stepped Care Approach	Priority Workstream (if applicable) Enhanced Community Support Huddles	RAG Status																																							
Operation Home First Aims this aligns to <i>Keep people safe at home; Support early discharge; Reduce unnecessary hospital attendances and admissions</i>																																									
<u>Brief description of priority</u> Huddles have been established to support unscheduled care in the community for discussion for those individuals who are at risk of admission or re-admission, for those that are potentially stepping down from acute services, and to provide rapid wraparound support using a virtual multi-disciplinary team approach. Huddles function within each of the 3 localities and there are two levels (1 daily triage huddle, rapid conversation with unscheduled individual, take action that day) and 2 (weekly MDt meeting [wrap around support for individuals who are stable but with room for improvements regarding functioning etc]).																																									
<u>Update as of February 2021</u> The ECS huddles have been functioning since April 2020 and have used an iterative improvement methodology approach that has been staff led that pragmatically works well. Exploring how we can increase attendances at huddles to ensure equitable access for all services across the city, for example services within Primary Care.																																									
<u>Impact to date</u> <p><i>Performance metrics:</i> Nearly 380 requests (relating to over 330 patients) have been brought to ECS since June, an average of 42 cases per month. Overall spread of patients with ECS input across each locality has been similar, although has fluctuated month on month, with 36% of cases brought by Aberdeen North and 30% and 34% by Aberdeen Central and Aberdeen South respectively.</p> <p><i>Staff acceptability:</i> 48 attendees of the Huddle provided feedback on its function. Overall responses were positive – Huddles received a mean score of 7.6/10. Components strongest rated included improved patient care (91.3% agreement) and improved multi-disciplinary working (89.4% agreement). It was also suggested that this approach saved staff time (63.8% agreement). Service outcomes:</p>	<u>Case Study / Testimonials</u> <p><i>“The ECS Huddles provide a platform for front line health and social care staff to discuss individuals who would benefit from an increase in care or therapy due to a change in their circumstances. It is designed to ‘pick up’ individuals who have an unscheduled event and need a more urgent care and or therapy intervention to enable them to remain at home. The huddle also enables staff working within the Acute Sector to provide information to the community teams on any individuals being discharged that may be ‘fragile’ and need additional support at the point of discharge.</i></p> <p><i>Benefits include</i></p> <ul style="list-style-type: none"> • <i>Right service at the right time delivered by the right person in the right place</i> • <i>Daily forum for any member of the MDT (in its widest sense) to discuss any individual that is giving them concern – making it a timely response</i> • <i>Weekly follow-on huddle per locality for more in-depth discussion/learning opportunities</i> • <i>Locality and MDT approach to assessment, and interventions</i> • <i>Shared learning/understanding of the roles of the MDT team</i> • <i>Building relationships within the localities</i> • <i>Joint ownership – self managing MDT</i> • <i>Supported by senior members of the locality leadership huddle</i> • <i>Quality improvement approach to development” (Occupational Therapist feedback)</i> 																																								
<u>Aligned performance indicator</u> <p>Patients accepted for Enhanced Community Support by locality</p> <table border="1"> <caption>Patients accepted for Enhanced Community Support by locality</caption> <thead> <tr> <th>Month</th> <th>Aberdeen North</th> <th>Aberdeen Central</th> <th>Aberdeen South</th> </tr> </thead> <tbody> <tr><td>Jun 20</td><td>18</td><td>11</td><td>17</td></tr> <tr><td>Jul 20</td><td>14</td><td>14</td><td>20</td></tr> <tr><td>Aug 20</td><td>17</td><td>12</td><td>14</td></tr> <tr><td>Sep 20</td><td>20</td><td>7</td><td>20</td></tr> <tr><td>Oct 20</td><td>14</td><td>17</td><td>22</td></tr> <tr><td>Nov 20</td><td>20</td><td>14</td><td>10</td></tr> <tr><td>Dec 20</td><td>12</td><td>6</td><td>14</td></tr> <tr><td>Jan 21</td><td>13</td><td>14</td><td>7</td></tr> <tr><td>Feb 21</td><td>8</td><td>17</td><td>5</td></tr> </tbody> </table>	Month	Aberdeen North	Aberdeen Central	Aberdeen South	Jun 20	18	11	17	Jul 20	14	14	20	Aug 20	17	12	14	Sep 20	20	7	20	Oct 20	14	17	22	Nov 20	20	14	10	Dec 20	12	6	14	Jan 21	13	14	7	Feb 21	8	17	5	<u>Additional comments</u> The more cases that are brought to the huddles, the less likely that those at risk of admission / re-admission manifest. This, in turn, helps to keep people safe at home. Note – data does not include patients presented but not accepted / not appropriate for ECS
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Operation Home First Priority Care @ Home Contract Implementation	Priority Workstream (if applicable) Not applicable	RAG Status																									
Operation Home First Aims this aligns to <i>Keep people safe at home; Support early discharge; Reduce unnecessary hospital attendances and admissions</i>																											
<u>Brief description of priority</u> Under the new model, the provision of care will move away from the current schedule of tasks which are timed. Instead, teams will work together with people receiving care, their families, and other practitioners within each locality to provide care tailored to individual needs. Local assets will also be used to connect people back into their community. The incoming Granite Care Consortium (GCC) is made up of 10 care providers who have worked closely with colleagues to problem solve and coproduce solutions in an agile and innovative delivery model.																											
<u>Update as of February 2021</u> A multidisciplinary group is now meeting weekly to review care packages within the Granite Care Consortium (GCC) unmet needs list. The aim being that this approach will be widened in the future to provide a consistent holistic approach to the whole of the unmet need population. A working group has also been set up to progress risk assessed care, this will help to plan and find sustainable solutions for increased demand on our systems in the future, we will look at where correctly assessed equipment can be used to enhance and support the care delivered while first and foremost keeping people safe.																											
<u>Impact to date</u> <p><i>Staff perceptions</i> – A baseline survey was distributed to GCC staff in Dec 20 that 62 people responded to. Overall, staff felt very supported by their colleagues (mean score 8.5/10) and those who deliver care to service users felt satisfied in their caring role (mean score 7.4/10). Perceived advantages included being more reactive to peoples needs: <i>“The flexibility will be good for our clients who have varying presentation and needs, as their illness worsens or improves”</i> (Care Provider).</p> <p><i>Market stability</i> – Baseline metrics were collected to understand the workforce of the GCC (total of 637 as of Dec 20) and the total number of eligible clients within Aberdeen City (N=1484). This will be reviewed in Summer 21 to understand how these metrics are impacted.</p>	<u>Case Study / Testimonials</u> <p><i>“Granite Care Consortium (GCC) was established in March 2020, as a concept to achieve market stability and improved outcomes for service users in the provision of care at home across the City of Aberdeen.</i></p> <p><i>GCC is at the centre of improvements to adult social care support in the City of Aberdeen and Scotland. It is a pathfinder model and to our knowledge, the first of its kind from an operational and commissioning context, primarily in terms of the outcomes it looks to achieve for and with people who use our services.</i></p> <p><i>The journey for GCC over the next 3 years is summarised as:</i></p> <ol style="list-style-type: none"> <i>1. Shift the cultural paradigm on how we step up, step down and enable those receiving care at home.</i> <i>2. Strengthen the foundations of care at home in Aberdeen, through market stability, the development of our workforce and their employment stability.</i> <i>3. Redesign the system, bringing together those cared for, social care managers and social care staff in assessment and delivery, shifting the cultural and operational paradigm.</i> <p><i>GCC will challenge some of the historic narratives about social care and care at home support. GCC will deliver effective social care support based on positive outcomes for everyone who receives care at home from GCC in the City of Aberdeen.</i></p> <p><i>A foundation to GCC is our social care and care at home workforce. For us to achieve the improvements and developments we seek to achieve in partnership with the ACHSCP, our goal is to establish and build a workforce that feels engaged, valued, and rewarded for the very important work that they do.</i></p> <p><i>GCC will develop an approach that builds trusting relationships between its social care providers, rather than competition. We will foster partnerships, not market-places and we will encourage the voice of lived experience at every level in our service delivery. We will co-produce our new model of delivery with the people who it is designed to support, both individually and collectively.”</i> (Executive, GCC)</p>																										
<u>Aligned performance indicator</u> <div data-bbox="56 906 1097 1324" style="border: 1px solid #ccc; padding: 10px; margin-top: 10px;"> <p style="text-align: center;">Total Hours of Unmet Need March 2020 - Feb 2021</p>  <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th>Month</th> <th>Total Hours of Unmet Need</th> </tr> </thead> <tbody> <tr><td>Mar-20</td><td>3064.25</td></tr> <tr><td>Apr-20</td><td>4518</td></tr> <tr><td>May-20</td><td>2593.3</td></tr> <tr><td>Jun-20</td><td>2762.25</td></tr> <tr><td>Jul-20</td><td>2546.5</td></tr> <tr><td>Aug-20</td><td>2081.5</td></tr> <tr><td>Sep-20</td><td>3128</td></tr> <tr><td>Oct-20</td><td>3843.25</td></tr> <tr><td>Nov-20</td><td>4915</td></tr> <tr><td>Dec-20</td><td>7964.75</td></tr> <tr><td>Jan-21</td><td>7313.5</td></tr> <tr><td>Feb-21</td><td>6638.25</td></tr> </tbody> </table> </div>	Month	Total Hours of Unmet Need	Mar-20	3064.25	Apr-20	4518	May-20	2593.3	Jun-20	2762.25	Jul-20	2546.5	Aug-20	2081.5	Sep-20	3128	Oct-20	3843.25	Nov-20	4915	Dec-20	7964.75	Jan-21	7313.5	Feb-21	6638.25	<u>Additional comments</u>
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Oct-20	3843.25																										
Nov-20	4915																										
Dec-20	7964.75																										
Jan-21	7313.5																										
Feb-21	6638.25																										

Operation Home First Priority Redesign of Urgent Care (Flow Navigation Centre) (Pan-Grampian)	Priority Workstream (if applicable): Not applicable	RAG status																																																																																											
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<i>Keep people safe at home</i> ✓	<i>Reduced unscheduled attendances / admissions</i> ✓																																																																																												
Brief description of priority This work is part of a Scotland-wide programme to build on opportunities to support people to access the Right Care in the Right Place at the Right Time, and as part of this, to reduce attendances at A&E/Minor Injuries Units if there are more appropriate sources of help and support. The public are asked to call NHS 24 – 111 - day or night when they think they need A&E but it is not life-threatening. NHS 24 will offer advice on what care is required and where is the best place to access this. If necessary, they will refer on to NHS Grampian urgent care staff. Each local health board has established a Flow Navigation Centre (hub) that will directly receive clinical referrals from NHS 24. The FNC offers rapid access to a senior clinical decision maker within the multidisciplinary team, optimising digital health through a telephone or video consultation where possible. Through this consultation they may again signpost or refer to other services available to best meet health care concerns raised. If the senior clinical decision maker determines the patient needs to go to A&E or a Minor Injuries Unit, they will be offered an appointment to attend in person.																																																																																													
Update as of February 2021																																																																																													
This new service went live in Grampian and across Scotland on 01 December. Phase 2 underway will build on the work already achieved by the Redesign of Urgent Care Programme, to establish a single access route which delivers efficient, safe and effective person-centred care.																																																																																													
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Over 2,600 patients have been referred from NHS 24, to the FNC and Minors Decision Queue, an average of 200 clinical referrals per week (FNC: 38 per week; Minors: 162 per week). Only 59% of patients have required a face-to-face appointment minimising the need for patients to attend ED or a minor injury unit, with 36% given self-care advice and 5% re-directed to primary care following a virtual consultation. Since the soft launch of the FNC, the self-presenting patient footfall at ARI ED has significantly reduced and is currently over 40% down, with a reduction of 32% seen in the number of Aberdeen City patients self-presenting at ARI ED. However, with many variables including lockdown it is too early to estimate the true impact of the redesign.																																																																																													
Case Study / Testimonials <ul style="list-style-type: none"> A survey has been developed to gather patient feedback on experience and views and is expected to launch in March. Questions in Grampian’s Redesign of Urgent Care survey overlap with those to support local and national evaluation of Near Me video consultations and as such are expected to provide information of mutual benefit to multiple workstreams. 	Aligned performance indicator Numbers of self-presenters at Emergency Departments and Minor Injuries Units <table border="1"> <caption>ARI ED Self-Presenters Data</caption> <thead> <tr> <th>Date</th> <th>Aberdeen City</th> <th>Non-Grampian</th> <th>Moray</th> <th>Aberdeenshire</th> </tr> </thead> <tbody> <tr><td>08 Nov</td><td>296</td><td>136</td><td></td><td></td></tr> <tr><td>15 Nov</td><td>328</td><td>114</td><td></td><td></td></tr> <tr><td>22 Nov</td><td>291</td><td>121</td><td></td><td></td></tr> <tr><td>29 Nov</td><td>260</td><td>120</td><td></td><td></td></tr> <tr><td>06 Dec (FNC Live)</td><td>253</td><td>114</td><td></td><td></td></tr> <tr><td>13 Dec</td><td>227</td><td>94</td><td></td><td></td></tr> <tr><td>20 Dec</td><td>184</td><td>90</td><td></td><td></td></tr> <tr><td>27 Dec</td><td>149</td><td>87</td><td></td><td></td></tr> <tr><td>03 Jan</td><td>243</td><td>100</td><td></td><td></td></tr> <tr><td>10 Jan</td><td>136</td><td>46</td><td></td><td></td></tr> <tr><td>17 Jan</td><td>114</td><td>42</td><td></td><td></td></tr> <tr><td>24 Jan</td><td>113</td><td>44</td><td></td><td></td></tr> <tr><td>31 Jan</td><td>141</td><td>46</td><td></td><td></td></tr> <tr><td>07 Feb</td><td>125</td><td>55</td><td></td><td></td></tr> <tr><td>14 Feb</td><td>146</td><td>62</td><td></td><td></td></tr> <tr><td>21 Feb</td><td>192</td><td>82</td><td></td><td></td></tr> <tr><td>28 Feb</td><td>177</td><td>51</td><td></td><td></td></tr> </tbody> </table>			Date	Aberdeen City	Non-Grampian	Moray	Aberdeenshire	08 Nov	296	136			15 Nov	328	114			22 Nov	291	121			29 Nov	260	120			06 Dec (FNC Live)	253	114			13 Dec	227	94			20 Dec	184	90			27 Dec	149	87			03 Jan	243	100			10 Jan	136	46			17 Jan	114	42			24 Jan	113	44			31 Jan	141	46			07 Feb	125	55			14 Feb	146	62			21 Feb	192	82			28 Feb	177	51		
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Operation Home First Priority NearMe	Priority Workstream (if applicable) Not applicable	RAG Status	
Operation Home First Aims this aligns to <i>Keep people safe at home</i>			
Brief description of priority NearMe is a video consulting service, allowing people to attend health and social care appointments from wherever is convenient for them. The service has been operational across Grampian since 2019, being used in both Primary Care and Secondary Care settings.			
Update as of February 2021 Near Me is now embedded within service models for many services. Focus is now shifting to sustaining the change and supporting new models of care, eg; how NearMe can help to deliver multi-disciplinary clinics or shared decision making across primary and secondary care.			
Impact to date <p><i>Patient satisfaction:</i> 93% (N=2012) of patients self-reported their NearMe experience as ‘very good’ or ‘good’. 97% rated the quality of care provided as either ‘very good’ or ‘good’</p> <p><i>Staff outcomes:</i> 38% (N = 755) of clinicians self-reported saving travel as a result of using the NearMe platform. One-fifth felt it took less time than regular consultations.</p> <p><i>Service performance:</i> In Feb 20, we were conducting ~80 video appointments per week; in Feb 21 that number is >3500 per week. In the same time period, the number of active NearMe service waiting areas has increased from 16 to ~200, and the number of laptops issued to facilitate the service provision has risen from 2800 to ~5500.</p>	Case Study / Testimonials <div style="background-color: #4a90e2; border-radius: 15px; padding: 10px; margin-top: 10px;"> <p><i>“I elected to have my initial pain management clinic appointment via video.</i></p> <p><i>I received all the information, did the test call and today accessed the appointment with a lovely Female Registrar ... I had a good, focused, no noise, no waiting or travelling (being in pain or knowing you can have a bad day without warning knowing I wouldn't have to travel made things easier), appointment, I was able to listen to the questions, answer them, have time to explain, definitely a more focused appointment, I know not for everyone but I certainly felt more comfortable especially as my husband didn't have to take time off work to take me etc.</i></p> <p><i>The Registrar was brilliant, put me at ease, explained and reflected back. Yes I will need a face to face but the medical history, my concerns and expectations etc have all been done”</i></p> </div> <p>(Near Me Service User).</p>		
Aligned performance indicator  <p><i>NearMe Consultations by month</i></p>	Additional comments This performance indicator assumes that 1) digital is the preferable mode of delivering consultations when it is safe and appropriate to do so, and 2) may be a more efficient mode of delivery for both staff and patients.		

Operation Home First Priority Respiratory Pathway + Stepped Care Approach	Priority Workstream Hospital at Home expansion: Respiratory Physiotherapy	RAG status	
Operation Home First Aims this aligns to			
<i>Keep people safe at home ✓</i>	<i>Reduced unscheduled attendances / admissions ✓</i>	<i>Support early discharge ✓</i>	
<u>Brief description of workstream</u>			
This expansion to the H@H service is helping to avoid unnecessary respiratory admissions and readmissions. It includes a focus on supported discharge so that people – often with substantial anxiety around their condition – are not readmitted. Funding was approved to second/recruit respiratory physiotherapy staff (2.0 WTE) to join the existing H@H team.			
<u>Update as of February 2021</u>			
1.0 WTE B7 (comprised of 2 x 0.5 WTE) have been seconded into H@H as of mid-December 2020. 1.0 WTE B6 has been recruited and is only just in post – since 1st February. B7s have been taking referrals and starting to provide support from 7th January, on part capacity until the B6 in post. We will be providing 7-day cover over the month of March.			
<u>Impact to date</u> Whilst clinicians have reported seeing less in the way of exacerbations of COPD than would normally be the case in winter, because many people are shielding due to the COVID pandemic, we have still seen demand for our services:- <ul style="list-style-type: none"> • 13 patients have been referred to us since 7/1/21, of which 9 have been admitted to H@H (4 alternative to hospital admission and 5 active recovery/supported discharge). We have since discharged 8 of them. • In this short space of time we have provided 49 H@H bed days, of which 36 were for patients we have discharged, and 13 is the running total (at 28/02/21) for the 1 patient we are currently supporting. • For context, across the patients we have supported so far, in the 12 months prior to us starting to give them respiratory physio support, there were 28 admissions for respiratory conditions, totalling 193 bed days (163 acute bed days and 30 H@H bed days). 	<u>Case Study / Testimonial</u> <div data-bbox="1384 624 2204 767" style="background-color: #4a90e2; color: white; padding: 10px; border-radius: 15px; margin-bottom: 10px;"> <p><i>"The patient was able to remain at home and improved after his exacerbation. He has also been referred to Pulmonary Rehab for appropriate follow up."</i></p> </div> <div data-bbox="1384 810 2204 1034" style="background-color: #2e7d32; color: white; padding: 10px; border-radius: 15px;"> <p><i>"During the short time the service has been available, the expansion of the H@H team to support respiratory patients has already had a huge impact on patient care and service delivery. The service has been shown to be a cost-effective intervention, supporting all three of the OHF aims."</i></p> </div>		
<u>To illustrate the comparative costs:-</u> <ul style="list-style-type: none"> • Average cost per case of our H@H respiratory physio intervention to date is £254.73. So, across our 4 alternative to hospital admission patients this comes to £254.73 x 4 = c.£1,019. • Average direct cost per inpatient case in Aberdeen Royal Respiratory Medicine = £3,615. So, if these 4 patients had been admitted to ARI this could have cost £3,615 x 4 = £14,460. • Average cost per Respiratory inpatient bed day in ARI = £583, so had our 49 bed days been delivered in ARI, this would have equated to £583 x 49 = £28,567. • As the H@H service continues to expand and develop in scope, we expect that further work will be required to assess the impacts that this has on average bed day costs in H@H. <p><i>Source for ARI costings: NHS Costs Book 2019/20 R040 tables. Direct Costs per inpatient case (staff, theatre, laboratory). This was then divided by specialty average length of stay to estimate average cost per inpatient bed day.</i></p>		<u>Additional Comments</u> <ul style="list-style-type: none"> • We have promoted the H@H Respiratory service to referring clinicians by email: respiratory consultants and all GPs via their primary care bulletin. <u>Aligned performance indicators</u> <ul style="list-style-type: none"> • Numbers of people supported by H@H • Numbers of respiratory admissions (note: OHF are working on a broader measurement from several respiratory projects combined). 	

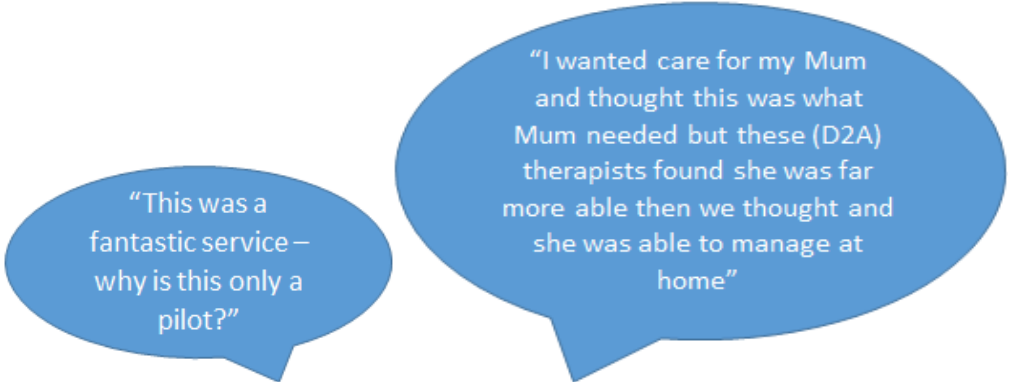
Operation Home First Priority Respiratory Pathway		Priority Workstream (if applicable) Home Oxygen Service	RAG status							
Operation Home First Aims this aligns to										
<i>Keep people safe at home ✓</i>		<i>Reduced unscheduled attendances / admissions</i>	<i>Support early discharge ✓</i>							
<u>Brief description of priority</u> Changes to way that consultants in non-respiratory specialties engage with Home Oxygen Team and efficiencies brought about by move to Office 365 suite of applications have enabled Home Oxygen team to directly assess inpatients at ARI and those needing support in the community far quicker than previously was the case.										
<u>Update as of 01 March 2021 – Current status:</u> Over three-week period since implementation Home Oxygen Teams have conducted 21 inpatient assessments – 17 the same day as referral received and 4 the following day. Unable to recruit the 1xB4WTE that funding from OHF Respiratory Cell was secured for, so having to utilise additional hours from existing B7 and B3 staff. Inpatient service due to finish at end of March 2021.										
<u>Impact to date</u>		<u>Case Study / Testimonials</u>								
<table border="1"> <tr> <td>Discharged same day as assessment</td> <td>6</td> </tr> <tr> <td>Discharged day after assessment</td> <td>6</td> </tr> <tr> <td>Discharge 2 days after assessment</td> <td>5</td> </tr> </table> <ul style="list-style-type: none"> Feedback received from 13 individuals regarding 11 patients all of whom felt that the patient was discharged earlier as a result of the intervention and that it saved their time. It was estimated that an average of 4.8 bed days were saved per patient 7 patients from in or around Aberdeen were referred for urgent/immediate oxygen to prevent admission. All patients were seen the same day and 4 were supplied with oxygen after assessment – the oxygen installation was completed on average 128 minutes after time of referral 		Discharged same day as assessment	6	Discharged day after assessment	6	Discharge 2 days after assessment	5	<p><i>Staff: 'It enabled Discharge far quicker than I had thought possible'</i></p> <p><i>'Gives the patient confidence and reassurance on Discharge'</i></p> <p><i>'Oxygen teams input in organising the oxygen for this patient was very helpful, as he would likely have stayed in hospital far longer'</i></p> <p><i>'Patient absolutely delighted to be getting home, felt he would be able to do more at home and recover quicker'</i></p> <p><i>Patient: 'Overall, the Oxygen team allowed me to overcome this difficult time with much more confidence, providing the means to allow me returning home, comfortable with the fact that i would not be breathless during my recovery.'</i></p>		
Discharged same day as assessment	6									
Discharged day after assessment	6									
Discharge 2 days after assessment	5									
<u>Aligned performance indicator</u> Bed days saved; Number of admissions avoided		<u>Additional comments</u> Lack of ongoing funding may mean both projects cease at the end of March 2021, or shortly thereafter.								

Operation Home First Priority Respiratory Pathway	Priority Workstream (if applicable) Prevention & Self-management (Physical Activity)	RAG status	
Operation Home First Aims this aligns to			
<i>Keep people safe at home ✓</i>	<i>Reduced unscheduled attendances / admissions</i>	<i>Support early discharge</i>	
Brief description of priority Multiple projects within the Respiratory Pathway priority focus on health improvement for patients with COPD and other respiratory conditions providing: 1) Physical Activity (PA) classes; 2) Pulmonary Rehabilitation (PR) and 3) Respiratory Physiotherapy support within Hospital at Home. These projects are linked in that patients referred to one may subsequently be redirected to another depending on their current level of health. The Physical Activity classes are a natural progression for patients who have been on the PR programme. Whilst there may be local differences in implementation, leads for the projects in each of Grampian’s three Health and Social Care Partnership areas are working together to ensure consistency, where appropriate, in their approach to reporting and evaluation. In Aberdeen the PA project is being delivered by Sport Aberdeen, whose instructors have developed the online delivery of classes using the Zoom video-conferencing app. <i>[Note: In Aberdeen PR is being delivered on a business-as-usual basis and is not one of the OHF-funded projects].</i>			
Update as of 01 March 2021 – Current status: <ul style="list-style-type: none"> • Programme is operating on a rolling 6-session basis with participants joining as Sport Aberdeen triage them into the programme. • The first couple of participants reached their 6th session at the end of February and a few more will do so during the first week of March. • There is plenty capacity within the virtual classes, so participants who have completed their initial 6-week block can stay so they’re able to continue exercising, however a more challenging class is being introduced from week beginning 8th March for those who are ready to move into something new. 			
Impact to date There have been 63 referrals received to the programme (6 from Health Professionals and 57 Self-Referrals). Of these Sport Aberdeen have: 17 attending virtual exercise classes; 4 receiving 1-to-1 phone call support as they don’t have access to online classes; 18 were signposted to the Pulmonary Rehabilitation Physio Team because they didn’t meet inclusion criteria for Sport Aberdeen programme . Of the others there are a mix of people who haven’t been able to participate due to other health conditions/injuries and some who were referred into Live Life Aberdeenshire or Moray programmes due to their addresses.	Case Study / Testimonials  <p>A YouTube video has a further testimonial in the form of an interview with participant Peter Hall, see: Winter Pulmonary Rehabilitation Programme Case Study</p>		
Aligned performance indicator Number of participants completing the block	Additional comments Patient and instructor feedback surveys are planned to be implemented from week commencing 1 st March. These will contribute a more quantitative element to the evaluation of the Physical Activity workstream.		

Operation Home First Priority Palliative & End of Life Care		Priority Workstream (if applicable) Virtual Programme	RAG status	
Operation Home First Aims this aligns to				
<i>Keep people safe at home ✓</i>	<i>Reduced unscheduled attendances / admissions</i>	<i>Support early discharge</i>		
<u>Brief description of priority</u> The focus within this Priority has been on the draft Grampian-Wide Strategic Framework for Palliative and End of Life Care, which sets out the vision for the next three years. Workstreams within this Priority have not been developed to the same stage as other Priority areas.				
<u>Update as of February 2021</u> Staff at both The Oaks in Elgin and Roxburghe House in Aberdeen are modifying their palliative care offering to patients so that these can be delivered remotely. Evaluation and measurement frameworks are under development and these will look to capture feedback from patients and their carers/family and from staff delivering these services. Working with the project leads, the OHF Evaluation team will help to foster a rounded understanding of the costs and benefits of delivering PEOLC support to patients via online platforms and the consequences (intended or otherwise) to all palliative services and the wider connected system.				
<u>Impact to date</u> Not available at this time		<u>Case Study / Testimonials</u> Not available at this time		
<u>Aligned performance indicator</u> For the virtual palliative classes this may be Number of participants completing the block. This would align with other Workstreams in aiming to Keep people safe at home.		<u>Additional comments</u>		

Operation Home First Priority Frailty Pathway	Priority Workstream (if applicable) Early Supported Discharge (H@H) - Aberdeenshire	RAG status	
Operation Home First Aims this aligns to			
<i>Keep people safe at home ✓</i>	<i>Reduced unscheduled attendances / admissions ✓</i>	<i>Support early discharge ✓</i>	
<u>Brief description of priority</u> As part of the whole system redesign of the Frailty Pathway the Aberdeenshire Frailty Pathway workstream were tasked with developing an Aberdeenshire model. Having considered a range of options the planned model is an Early Supported Discharge model which aspires to being Hospital at Home. A service model has been developed which will include additional community capacity from our Aberdeenshire Responders for Care at Home (ARCH), 2 specific teams consisting of Nurses and AHPs and technology enabled care.			
<u>Update as of February 2021</u> At present we are awaiting a final decision on the workforce financial split to be agreed before we can move to formal organisational change.			
<u>Impact to date</u> Virtual ward has been agreed, similar to the functionality that Hospital @ Home in Aberdeen City use on TrakCare, and is now in development. This will be used as a basis for collating performance data for the project, including caseload numbers; length of stay and discharge location. Evaluation framework has been agreed and established for the project. This includes a bespoke feedback survey have been populated to assess patient and unpaid carer acceptability, focusing on constructs of hospital discharge; home assessment; receipt of care and discharge from the pathway. Staff acceptability of the new model will also be assessed once the project has had adequate opportunity to be embedded into business practice.	<u>Case Study / Testimonials</u> None available at this time.		
<u>Aligned performance indicator</u> Performance indicators are not yet operational for this project as it has not gone live. However, metrics including patient location at 90 days; 7-day readmission rates; and medically fit date of discharge vs actual date of discharge will all be monitored.	<u>Additional comments</u> We've been successful in receiving H.I.S. Hospital at Home funding which will support the use of technology enabled care and for improving Staff skill base. We also have funding for a specific post for Project Management/Development		

Operation Home First Priority Aberdeenshire Virtual Community Ward		Priority Workstream (if applicable)	RAG status	
Operation Home First Aims this aligns to				
<i>Keep people safe at home ✓</i>		<i>Reduced unscheduled attendances / admissions ✓</i>	<i>Support early discharge ✓</i>	
<u>Brief description of priority</u> The Virtual Community Ward (VCW) works by bringing together multidisciplinary health and social care teams who provide care for patients who need regular or urgent attention, with the aim of avoiding unnecessary hospital admissions. The model is GP-led and operates upstream of acute services, with local health and social care teams working together within the boundaries of GP practice populations. The VCW is very effective at identifying individuals who need health and social care services at an earlier stage, which can significantly improve patient outcomes and experience. The approach involves a daily short huddle (typically 15 minutes) of the core team, where vulnerable / at risk individuals are discussed as well as the progress of those already within the VCW. Co-ordination of short term wrap-around care (personal and nursing care the most frequent requirements) is agreed, mobilised and monitored for those admitted to the VCW.				
<u>Update as of February 2021</u> The VCW model had already been embedded across Aberdeenshire prior to the Covid 19 pandemic. The model of working has continued to remain very important as part of the whole system response to Covid and as health and social care teams have required to adapt with flexible community nursing teams involving District Nursing, community hospital nurses, urgent care practitioners and others. VCWs moved to virtual meetings allowing more team members to participate.				
<u>Impact to date</u> Nearly all Aberdeenshire GP practices signed up to VCW in 2019/20 with an average of over 330 VCW admissions per quarter. For 2020/21, in-line with other enhanced services, it has not been mandatory for GP practices to submit VCV quarterly returns however they have been asked to submit data where available. Health Intelligence will analyse the 2020/21 submissions once the data for the final quarter is in. It is planned that formal reporting on a quarterly basis, to monitor and understand the impact of VCW, will resume for 2021/22 for all practices signed up to the VCW SLA.		<u>Case Study / Testimonials</u> Previous feedback from staff on the VCW model following initial implementation highlighted improved and more effective communication as a result of daily huddles, which was felt to have led to: <ul style="list-style-type: none"> • Better use of resources and prioritisation of resources to individuals. • Quicker access to interventions. • Improved care pathways (better organisation, more integrated/seamless pathways). • More holistic / person centred care. • Reduction in hospital admissions. • Better overall staff experience. 		
<u>Aligned performance indicator</u> Existing dataset collated from GP Practices on a quarterly basis (not mandatory during Covid-19 pandemic) collates demographic information of patients admitted to VCW and in addition: <ul style="list-style-type: none"> • Reason for VCW admission and length of stay • Outcome of VCW admission and presumed outcome were VCW not available. 		<u>Additional comments</u> Given allocation of resource to other Home First priorities, the VCW has remained in a 'business as usual' context with no significant changes to service delivery.		

Operation Home First Priority Whole system approach to discharge	Priority Workstream (if applicable) Discharge to Assess (D2A)	RAG status	
Operation Home First Aims this aligns to:			
<i>Keep people safe at home</i>	<i>Reduced unscheduled attendances / admissions ✓</i>	<i>Support early discharge ✓</i>	
<u>Brief description of priority</u> Sparked by a relatively high number of delayed discharges, Health & Social Care Moray senior management team recognised that far greater awareness of the upstream and downstream factors influencing discharges from hospital was required. The lack of intermediate care services to assist in the management of patient flow into and out of Dr Gray's Hospital was identified as a key gap in provision. An Occupational Therapy (OT) lead, Discharge to Assess (D2A) model was identified as a possible solution. In the Moray D2A model, OT and Physiotherapy staff would provide two weeks of intensive support to patients in their own home. As an intermediate care service, D2A will support early discharge for inpatients assessed as appropriate in Dr Gray's Hospital (DGH) and offer an alternative to admission for people attending the A&E department.			
<u>Update as of March 2021</u> Following a successful pilot and extended test of change, core funding for the Discharge to Assess service was confirmed by Moray IJB on the 25 th March 2021. Funding will allow the seconded staff to return to their substantive posts and recruitment to commence for the permanent AHP and nursing staff required to run the service.			
<u>Impact to date [5th Oct 2020 to 17th Feb 2021 (19 weeks)]</u> <ul style="list-style-type: none"> • 48 patients seen by D2A Team – 40 inpatients and 8 redirected from A&E. • Saved an estimated 112 acute bed days through supported early discharge and admission avoidance. • 32 patients directed away from community hospital resulting in an estimated saving of 1,216 bed days. • Readmission rates lower for D2A patient cohort at both 7 and 28 days. • Just 5 patients required onward referral to START, demonstrating a reduction in the requirement for care following a D2A intervention. • 81% - 91% of patients saw improvement in OT assessment scores with remainder maintaining their scores. • All patients saw improvement in Physiotherapy assessment scores. • Patients and carers provided very positive feedback on their experience of D2A. • Fully supported by Senior Management & Clinicians in Dr Gray's Hospital. • High degree of interest in Moray D2A from across Grampian. 	<u>Case Study / Testimonials</u> 		
<u>Aligned performance indicator</u> Hospital bed days saved. [average length of stay (LOS) for key specialties of Geriatric Medicine and Ortho-trauma in DGH is 9 days; D2A average LOS is 8 days.]	<u>Additional comments</u> Final figures for the test of change period which ended on the 31 st March 2021 are currently being prepared.		

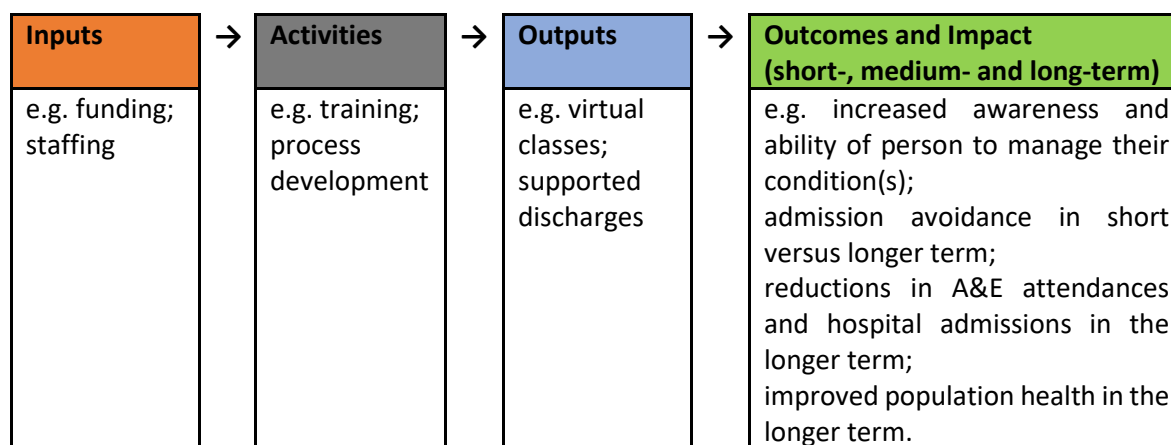
Operation Home First Priority Respiratory Pathway	Priority Workstream (if applicable) Physiotherapy-led Pulmonary Rehabilitation: Aberdeenshire	RAG status	Amber: Uncertain future
Operation Home First Aims this aligns to			
<i>Keep people safe at home</i> ✓			
<u>Brief description of priority</u> This project's aim was to support patients with long term lung conditions to stay safe at home and reduce subsequent related unscheduled attendances/admissions. Increasing activity levels and provision of education to support self-management were core and were met through the delivery of a home based 1:1 Pulmonary Rehabilitation (PR) Programme (in addition to our existing PR service, which had already switched to virtual classes). Provision of an equitable service to those unable to access digital technology was paramount.			
<u>Update as of end March 2021</u> Significant time was required at the start of the project to focus on start-up i.e. staff secondment/recruitment, followed by fundamental corporate and in-house training. 1.0 WTE B6, 2 x 0.5 WTE B4s, then 2 further WTE B4's were established in post with caseload by the end of Jan and Feb 2021, respectively. We delivered home PR to patients who were unable to access online classes, or who would have been unsuitable for such classes (or indeed standard PR group programmes). Additionally, to contribute to reducing health inequalities, we supported those with no access to transport who, in normal circumstances, would struggle to attend classes due to the rurality and lack of infrastructure around public transport. We were also able to link with Acute colleagues in Oxygen Clinic to provide feedback regarding Oxygen (levels).			
<u>Impact to date</u> To date – 51 patients assessed, 27 currently undertaking PR programme, 4 completed, 6 on waiting list. 11 patients declined or unsuitable to continue. Results – of those 4 patients completing the PR programme before the end of March: <ul style="list-style-type: none"> • All reported that their condition was improved or much improved following PR. • All reported that they achieved completion of at least one of their personal goals. • All consented to onward referral to Live Life Aberdeenshire for further support. • Clinical scores improved: COPD Assessment Test (CAT) scores improved in 4/4 (by 6 points on average); number of sit-to-stand in 1 minute improved in 4/4 (by 57.5% on average); and MRC breathlessness scale scores improved in 2/4 (50%). <u>Aligned performance indicators (to develop if project continues beyond March 2021)</u> <ul style="list-style-type: none"> • Number of referrals to the service, by quarter • Number of people completing PR support block, by quarter <u>Additional comments</u> Lack of ongoing funding will mean the project will cease after the end of March 2021, and these patients may then deteriorate, potentially leading to unscheduled attendances/admissions. If we were to secure further funding in the future we would aim to extend to support more acute admission avoidance and early discharges.	<u>Feedback / Testimonials</u> <div data-bbox="1120 751 1599 895" style="background-color: #4CAF50; color: white; padding: 5px; border-radius: 10px; margin-bottom: 10px;"> I was very surprised at the exercises I can do on my own at home </div> <div data-bbox="1599 711 2197 895" style="background-color: #2196F3; color: white; padding: 5px; border-radius: 10px; margin-bottom: 10px;"> Please keep up the one to one programme. It's been so helpful and gives you a chance to ask more personal questions. Also helped me explain to my family about COPD </div> <div data-bbox="1120 895 2197 1070" style="background-color: #9C27B0; color: white; padding: 5px; border-radius: 10px; margin-bottom: 10px;"> I feel much better in myself now I have been doing the exercise and can push myself knowing my limits. Walking further and have taken up golf again, starting to love gardening </div> We surveyed primary and secondary care staff involved in Respiratory care; all 18 responders agreed or strongly agreed for the need for a service to support PR by means of virtual classes (in addition to our face to face classes) and to support PR by means of 1:1 telephone/home support (for people who can't join classes). <div data-bbox="1120 1230 2197 1370" style="background-color: #FF9800; color: white; padding: 5px; border-radius: 10px;"> <i>[GP practice team member] The provision of pulmonary rehab & physio is very limited in Aberdeenshire (...) residents getting to a venue can be difficult therefore missing out on a valuable, beneficial service for our Respiratory patients within our surgery</i> </div>		

Operation Home First Priority Respiratory Pathway	Priority Workstream (if applicable) Physiotherapy-led Pulmonary Rehabilitation: Moray	RAG status	Amber: Uncertain future
Operation Home First Aims this aligns to			
<i>Keep people safe at home ✓</i>			
Brief description of priority This project's aim was to support patients with long term lung conditions to stay safe at home and reduce subsequent related unscheduled attendances/admissions. Increasing activity levels and provision of education to support self-management were core and were met through the transition from face to face classes to Virtual Pulmonary Rehabilitation (PR), and expansion of our 1:1 PR for housebound/frailer patients. Provision of an equitable service to those unable to access digital technology was paramount.			
<u>Update as of end March 2021</u> Funding for this project was confirmed 03/12/20. 2 B7s and 2 x B3s were established in post by Feb - March 2021, respectively. In this short space of time, we redesigned our procedures and paperwork for transition of our PR service (including education and self-management material), and up skilled our whole physiotherapy team in new Virtual and home PR. As well as delivering PR to respiratory patients, we have scoped local respiratory requirements; completed training/education and liaised with a range of stakeholders in Dr Gray's Hospital, Oxygen Service Aberdeen, GP practices, community AHPs, and 3 rd sector/leisure services, to help raise awareness and improve pathways between services.			
<u>Impact to date</u> To date – 56 referrals received, 32 patients assessed, 5 completed Virtual PR, 4 currently undertaking virtual PR, 8 undergoing Home PR, 7 declined PR (respiratory advice given). Results – Amongst 6 virtual class participants for whom we have clinical scores pre- and post-support, we saw improvements: COPD Assessment Test (CAT) scores improved in 4/6 (66%); number of sit-to-stand in 1 minute improved in 5/6 (83%), and MRC breathlessness scale scores improved in 3/6 (50%). <ul style="list-style-type: none"> • Amongst the 5 patients completing a block of 6 virtual classes by 31/3/21, 4 reported that their condition was improved or much improved following PR, and 3 reported that they achieved 100% completion of at least one of their personal goals. • 10 patients (virtual and home PR) did not need complete block of support from us; 7 have subsequently engaged with long term exercises. Demand - We have seen increased referrals for PR and a wider range of specialist respiratory physiotherapy in Jan-Mar 2021, compared with Jan-Mar 2019. Numbers indicate increased need/perception of need. For example, referrals for PR increased from 42 to 56; for specialist intervention increased from 3 to 15; for Oxygen service review/monitoring increased from 0 to 15. Capacity – Within our current establishment to; support the increasing numbers of patients referred; to reduce digital access inequalities with loanable technology and increase sign posting to community digital services.	<u>Feedback / Testimonials</u> <div data-bbox="1144 719 2190 871" style="background-color: #ADD8E6; padding: 10px; border-radius: 15px; margin-bottom: 10px;"> I had to stop once crossing garden, my wife did all meals and all housework. After the class, this morning I have gone for a walk, painted the garden fence, did the hoovering and now I make breakfast for my wife every day. </div> <div data-bbox="1144 887 2190 1054" style="background-color: #388E3C; color: white; padding: 10px; border-radius: 15px; margin-bottom: 10px;"> I wanted to try anything to help, had tried all the medications which didn't help. Had been told in the past I would never improve due to my age. I like being able to go out and do things I enjoy, I am a much happier person. </div> Questionnaires from 9 stakeholder staff pre and post training/education/liasing showed an improved perception of PR and specialist physiotherapy intervention. <u>Aligned performance indicators (to develop if project continues beyond March 2021)</u> <ul style="list-style-type: none"> • Number of referrals to the service, by quarter • Number of people completing PR support block, by quarter <u>Additional comments</u> Scoping has highlighted need for further funding to meet need of respiratory service in Moray. Identified capacity requirements to upscale current PR service to prepare for next winter – PR consists of 6 week cohorts so need to start now.		

Comments / Observations

To date, all priorities that have been operational for an adequate period have demonstrated sufficient feasibility (i.e. they are broadly acceptable to both service users and service providers). For some priorities within in this context, it is too early to determine fully the benefits they will deliver at current scale, and potentially if scaled up. The simplified model for service change and evaluation, below, illustrates that in order to achieve the desired outcomes and impacts, the right inputs must be in place, relevant activities performed, and the required outputs delivered. However, our evaluation to date provides an important basis in ensuring that any changes in service provision can be sustained longer-term. For example, previously in-depth evaluations conducted across the health and social care system have typically taken place after six months of implementation (see the ‘West Visiting Service’ evaluation [here](#) and the ‘Acute Care @ Home’ evaluation [here](#)) which provides a useful barometer of the balance that is required to be struck between evolving initiatives at pace whilst ensuring enough data is generated to inform future service provision.

Simplified Logic Model for theory of change / service evaluation



One key enabler that is important to emphasise within the context of reporting progress is the access to and development of an intelligent data infrastructure. For example, the ‘patient location at 90 days’ outcome articulated within the Stepped Care Approach / Frailty Pathway Hospital @ Home flash report above exists due to the creation of a virtual ward within the TrakCare system and then a further automated code that runs daily to determine whether patients who have received care in that service are back in hospital (or another setting). In other initiatives, such as the Enhanced Community Support huddles, the performance data was manually pulled off electronic systems by one member of staff who is no longer working in the North East.

One aspect that might temper the potential success of the OHF programme was the use of Winter Planning funds to develop several projects under the Respiratory Priority. These monies allowed purchase of kit and staff training for the Physical Activity Classes for participants with COPD, however without establishing a revenue model for this preventative approach to health care, the programme may not be able to be supported beyond the 2020/21 financial year. The same is true of the Home Oxygen Team, for which funding enabled additional temporary staffing resource allowing them to explore projects aimed at supporting early discharge and avoiding unnecessary hospital admissions. In these examples, whilst initial data looks very positive, the funding came late in the day and as such

none of the above projects have been established long enough to fully evaluate their impact on the OHF top-line.

Such a wide-ranging portfolio as OHF is unlikely to ever have a neat end point. This is because it is cross-system by design and naturally evolves over time based on evidence and key learning. For example, the Stay Well Stay Connected workstream within the Stepped Care Approach have identified social isolation as a key area of required focus moving forward in response to physical distancing that has emerged from the COVID19 pandemic. This means that, rather than evaluation being viewed as an activity that is undertaken at the 'end' of a project, it could be perceived as a tool that does not just determine the benefits of a particular initiative but is also used as a basis to guide future activities based on evidence. We would recommend that thought is given to maintaining a rolling programme of evaluation, underpinning the cyclical process of strategic planning and commissioning.

Next Steps

A more formal evaluation report on the progress of OHF is due to be produced towards the end of Spring 2021, including recommendations on the future direction of the portfolio.

Acknowledgements

We would like to thank all the project / programme teams involved in the development of this work. Additionally, we would like to thank the OHF Steering Group for their support and advocacy of this evaluation.

