Budget Scrutiny: Integration Authorities

The Committee has chosen to consider the integration of health and social care as part of its consideration of the Scottish Government’s budget. The following questions are designed to explore the budget setting process for 2016-17 and how budget allocation reflects the priorities set out in the performance framework.

1. Which integration authority are you responding on behalf of?
   Aberdeen City Health & Social Care Partnership

2. Please provide details of your 2016-17 budget:

<table>
<thead>
<tr>
<th>£m</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Health board</td>
<td>167.3</td>
</tr>
<tr>
<td>Local authority</td>
<td>88.2</td>
</tr>
<tr>
<td>Set aside budget</td>
<td>46.7</td>
</tr>
<tr>
<td>Total</td>
<td>302.2</td>
</tr>
</tbody>
</table>

3. Please provide a broad breakdown of how your integration authority budget has been allocated across services, compared with the equivalent budgets for 2015-16.

<table>
<thead>
<tr>
<th>£m</th>
<th>2015-16</th>
<th>2016-17</th>
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</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>46.7</td>
<td>46.7</td>
</tr>
<tr>
<td>Community healthcare</td>
<td>86.5</td>
<td>93.0</td>
</tr>
<tr>
<td>Family health services &amp; prescribing</td>
<td>72.9</td>
<td>74.3</td>
</tr>
<tr>
<td>Social care</td>
<td>90.3</td>
<td>88.2</td>
</tr>
<tr>
<td>Total</td>
<td>296.4</td>
<td>302.2</td>
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</table>

4. The 2016-17 budget allocated £250m for social care. Please provide details of the amount allocated to your integration authority and how this money has been utilised.

<table>
<thead>
<tr>
<th>£m</th>
<th>£m</th>
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</thead>
<tbody>
<tr>
<td>Total sum available</td>
<td>9,500</td>
</tr>
<tr>
<td>Amount utilised by the Council in setting its budget:</td>
<td></td>
</tr>
<tr>
<td>provision for costs of implementing living wage</td>
<td>1,600</td>
</tr>
<tr>
<td>additional provision for uplift on national care homes contract price</td>
<td>1,000</td>
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<tr>
<td>to provide budget for other growth pressures within adult social care</td>
<td>2,150</td>
</tr>
<tr>
<td>Sum available to the IJB for additional social care capacity</td>
<td>4,750</td>
</tr>
<tr>
<td>Partnership Detail</td>
<td>4,750</td>
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<td></td>
<td>9,500</td>
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</table>
The Aberdeen City Health and Social Care Partnership has set out an ambitious programme of transformation and has set itself the task of ensuring funding is aligned to its strategic priorities and transformation. The additional funding of £4.75 million has been allocated to the partnership to support the delivery this transformation programme – linking wherever possible our funding to the outcomes we are seeking to achieve and toward change.

This additional funding is being utilised, in conjunction with Integrated Care Funding and Delayed Discharge funding to drive the following transformational outcomes:

- Support a range of initiatives and activities designed to address the issue of Delayed Discharges in Aberdeen – ensuring solutions are person-centred and sustainably address the issue.
- Review and develop strategies for developing new commissioning models and strong IJB led market management in respect of care at home, care home placements, self-directed support and new models of care and support. This will support the drive toward our Localities being the engine room of change and delivery in Aberdeen.
- Support a range of interventions designed to develop an empowering and innovative organisational culture to successfully deliver our strategic priorities, including developing our leadership capacity throughout the organisation and organisational development of our IJB, Locality Leadership Groups and integrated staff teams.
- Modernising our primary and community care including collaborative working, in locality hubs, with increased provision of roles such as pharmacy, advanced nurse practitioners and physician associates; new service delivery models of primary and community care; and the development of integrated locality teams.
- Supporting self-management of long term conditions and building community capacity including: rolling out Link Workers attached to practices; building community capacity through the use of Community Builders; shifting the relationship between our communities and care providers.
- Acute Care at Home – supporting person centred and effective care and support for people with multiple health and care needs, outwith an acute hospital setting, and with a focus on prevention of admission.
- ICT infrastructure – ensuring that there is an appropriate ICT infrastructure in place to support our staff in the effective delivery of services and support our citizens to better manage their own health.
- Transformation: including an appropriate evaluation framework to provide assurance that our transformational activities are helping delivery of our strategic plan; programme management support and leadership to deliver our transformational priorities; and engagement and participation of citizens and stakeholders within the city.
Budget setting process

5. Please describe any particular challenges you faced in agreeing your budget for 2016-17

We would highlight the following challenges in respect of agreeing the IJB’s budget in 16/17. These related mostly to issues outwith the IJB’s control:

- Issues relating to the timescale for budget setting and the separate processes that a Council and Health Board undertake to make decisions
- The lateness of the grant settlement along with the lack of initial guidance in relation to the £250m caused difficulties in setting budgets.
- The balance between investing new funding on new services and integration, whilst at the same time having to make efficiency savings against core services.

6. In respect of any challenges detailed above, can you describe the measures you have put in place to address these challenges in subsequent years?

Good working relationships were established between senior finance officers in the Council and NHS when setting the IJB budget for 2016/17. In addition the Partnership has recruited to its Chief Finance Officer role and this partnership leadership, along with the good relationships already formed, will be useful in terms of setting the 2017/18 budget and managing any complexities and ‘unknowns’ in this first year of the Partnership being legally constituted.

Also, the Partnership is working its own financial strategy and process so that relevant information can be brought into the NHS and Council budget processes when required. NHS Grampian has brought forward its budget setting process to more closely follow the budget setting timeline in the Council which is, again, very helpful.

The Partnership has undertaken significant work in relation to understanding risk and developing a risk appetite statement that supports safe and effective services while also seeking to take positive attitude to risk in regard to innovation and transformation. We have set out our strategic commissioning approach to drive that innovation and change by linking budget decisions to transformational outcomes – looking to ensure investment is clearly driving change rather than maintaining current models that are unsustainable.

7. When was your budget for 2016-17 finalised?

Finalised in March 2016 and agreed at the April IJB meeting.

8. When would you anticipate finalising your budget for 2017-18?

A detailed budget setting timetable is in the process of being developed, but we would anticipate agreement on the budget by the end of February 2017.
Integration outcomes

9. Please provide up to three examples of how you would intend to shift resources as a result of integration over the period of your Strategic Plan:

1. **Community Link Practitioners**: we anticipate that the roll out of Community Link Practitioners will not only result in improved outcomes for our citizens, but will also positively impact on the workload of our GPs. Evidence for this will be sought as part of our overall evaluation framework, and negotiations will then take place with GPs around the long term revenue requirements for this resource.

2. **Acute Care at Home**: we anticipate that supporting more care to take place in a more homely setting will reduce admissions to acute hospital and enable us to support people safely and effectively in the community. We anticipate that this will therefore facilitate a reduction in bed requirements, allowing this resource to be shifted to the Acute Care at Home service and into the community.

3. **Improved IT systems and use of Digital technology**: will reduce the need for front line service providers, such as nurses to carry out administration from a base office (instead they will be able to access and update records remotely), thus supporting resources to be released from being tied up in buildings. Potential development of remote home monitoring and other digitally-enabled models is also being explored.

10. **What efficiency savings do you plan to deliver in 2016-17?**

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<tbody>
<tr>
<td>Savings from Council Budget</td>
<td>£2,574k</td>
</tr>
<tr>
<td>Savings from NHS Budget</td>
<td>£878k</td>
</tr>
<tr>
<td>Total</td>
<td>£3,452k</td>
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11. **Do you anticipate any further delegation of functions to the integration authority? (If so, please provide details of which services and anticipated timescales)**

NHS Grampian is considering the delegation of acute inpatient Mental Health and Learning Disability Services to be hosted by one of the 3 Grampian IJBs on behalf of all. Discussions on this are ongoing.
Performance framework

(a) Please provide details of the indicators that you will use to monitor performance and show how these link to the nine national outcomes

Aberdeen City Health & Social Care Partnership wishes to be recognised as a high performing organisation with an enabled and empowered culture and is developing a Performance, Governance and Improvement Framework underpinned by good intelligence and effective practice to support this ambition.

The main components of our approach include managing the ‘information challenge’, clarifying delegated accountability and establishing a systematic cycle of reporting to the IJB and its committees to develop (Figure 1) a system of ‘tiered intelligence’ where information is packaged intelligently to support effective service delivery, performance improvement, governance and strategic planning.

Figure 1: Tiered Intelligence.

At an operational level, data is often made accessible through the use of dashboards and business intelligence which can be drilled down to low levels (e.g. by location, service provider, practitioner, patient). The type of management information that is generally required includes:

• How many/how often/when/where (facts)
• How many should we be doing (targets/trajectories)
• How likely are we to meet the target given the current position (forecasting)
• How does it compare to others (benchmarking)

Beyond the performance improvement and governance of operational service delivery, intelligence for the Strategic Planning Group, Transformation Board and Executive Team will be required to help with insights affecting planning decisions, redesign and change. Tailored intelligence will be required for this to help answer the following types of questions:
• What is working well?
• What is the evidence about what works well?
• What is the impact on strategic aims, objectives and the national outcomes?
• Do we meet national standards & targets?
• What is the impact if we do not change?
• How well do other similar areas perform?
• Do we seek feedback from patients and staff, and act on it?
• What other things need to be considered in the future?

Intelligence to support strategic planning and organisational governance is needed to allow the IJB and Locality level senior teams to reflect on the progress of the Strategic Plan and the way the organisation is progressing. Intelligent questions posed in this context will include:
• What is our performance in context of our strategy for?
• How likely is it to change given trends & external influences?
• What signs suggest positive effects from our strengthened community assets?
• In what respect do our strategic plans reflect changes in the local economy and market forces?
• How do we describe progress towards reducing inequalities?
• As a patient or relative, how would you feel about?
• What other ways could needs be met?
• How variable is this across the Grampian, Scotland, Europe?

(b) If possible, also show how your budget links to these outcomes

This is a work in progress for the partnership and we are undertaking mapping across our outcomes, investment and budget at the time of responding.

<table>
<thead>
<tr>
<th>National Outcome</th>
<th>Indicators</th>
<th>2016-17 budget</th>
</tr>
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</table>
| People are able to look after and improve their own health and wellbeing and live in good health for longer. | • Percentage of adults able to look after their health very well or quite well.  
• Premature mortality rate.  
• Emergency admission rate. | |
People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

<table>
<thead>
<tr>
<th>National Outcome</th>
<th>Indicators</th>
<th>2016-17 budget</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>• Percentage of adults supported at home who agree that they are supported to live as independently as possible.</td>
<td></td>
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<tr>
<td></td>
<td>• Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Emergency admission rate.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Emergency bed day rate.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Readmission to hospital within 28 days.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Proportion of last 6 months of life spent at home or in a community setting.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Falls rate per 1,000 population aged 65+.</td>
<td></td>
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<tr>
<td></td>
<td>• Percentage of adults with intensive care needs receiving care at home.</td>
<td></td>
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<tr>
<td></td>
<td>• Number of days people spend in hospital when they are ready to be discharged, per 1,000 population.</td>
<td></td>
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<tr>
<td></td>
<td>• Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency.</td>
<td></td>
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<tr>
<td></td>
<td>• Percentage of people admitted to hospital from home during the year who are discharged to a care home.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Percentage of people who are discharged from hospital within 72 hours of being ready.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Expenditure on end of life care.</td>
<td></td>
</tr>
<tr>
<td>National Outcome</td>
<td>Indicators</td>
<td>2016-17 budget</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
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</tbody>
</table>
| People who use health and social care services have positive experiences of those services, and have their dignity respected. | • Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.  
• Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated.  
• Percentage of adults receiving any care or support who rate it as excellent or good.  
• Percentage of people with positive experience of the care provided by their GP practice.  
• Readmission to hospital within 28 days.  
• Proportion of last six months of life spent at home or in a community setting.  
• Proportion of care services graded ‘good’ (4) or better in care inspectorate inspections.  
• Number of days people spend in hospital when they are ready to be discharged, per 1,000 population.  
• Percentage of people who are discharged from hospital within 72 hours of being ready.  
• Expenditure on end of life care. | |
<table>
<thead>
<tr>
<th>National Outcome</th>
<th>Indicators</th>
<th>2016-17 budget</th>
</tr>
</thead>
</table>
| Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services. | • Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.  
• Emergency admission rate.  
• Emergency bed day rate.  
• Falls rate per 1,000 population aged 65+.  
• Proportion of care services graded ‘good’ (4) or better in care inspectorate inspections.  
• Number of days people spend in hospital when they are ready to be discharged, per 1,000 population.  
• Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency. |                |
| Health and social care services contribute to reducing health inequalities.      | • Premature mortality rate.  
• Emergency admission rate.                                                                                                                           |                |
<p>| 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. | • Percentage of carers who feel supported to continue in their caring role                                                                                                                                  |                |</p>
<table>
<thead>
<tr>
<th>National Outcome</th>
<th>Indicators</th>
<th>2016-17 budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>People who use health and social care services are safe from harm.</td>
<td>• Percentage of adults supported at home who agree they felt safe. \n• Emergency admission rate. \n• Emergency bed day rate. \n• Readmission to hospital within 28 days. \n• Falls rate per 1,000 population aged 65+. \n• Proportion of care services graded ‘good’ (4) or better in Care Inspectorate inspections. \n• Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency.</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td>• Percentage of staff who say they would recommend their workplace as a good place to work.</td>
<td></td>
</tr>
</tbody>
</table>
Resources are used effectively and efficiently in the provision of health and social care services.

- Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated.
- Readmission to hospital within 28 days.
- Proportion of last 6 months of life spent at home or in a community setting.
- Falls rate per 1,000 population aged 65+.
- Number of days people spend in hospital when they are ready to be discharged, per 1,000 population.
- Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency.
- Percentage of people who are discharged from hospital within 72 hours of being ready.
- Expenditure on end of life care.

The partnership recognises the value in aligning its budget with its strategic priorities and the outcomes (local and national) that it expects to see evidence of as a result of its transformational activity and delivery of service. Our Chief Finance Officer is considering how the IJB’s budget setting process can best support our strategic commissioning priorities, our developing locality model and our performance reporting requirements.

Work is continuing within our Performance Management work stream to further develop this framework with ‘local’, partnership specific indicators to supplement the core indicators. Our IJB have agreed that these indicators should be grouped into the following categories of performance:
• **Safe** – how well do our services protect people from abuse and avoidable harm

• **Effective** – how well does the care and treatment we provide and commission achieve good outcomes, help people maintain quality of life and is based on the best available evidence

• **Caring** - how well do staff involve and treat people with compassion, kindness, dignity and respect

• **Responsive** – how well are services organised to meet individual needs

• **Well-led** – how well does leadership, management and governance of the organisation make sure it is providing high quality care, encouraging learning and innovation, and providing an open and fair culture

Performance against each indicator will be colour coded red, amber and green and will be based largely on pre-determined thresholds or expectations, including benchmarks; trajectories and alerts.

In addition, the partnership is also utilising the scotpho health and wellbeing tool ([http://www.scotpho.org.uk/](http://www.scotpho.org.uk/)) to provide our emerging localities with locality specific information profiles in relation to various (56) public health indicators. Aberdeen’s profile shows that we are statistically worse than the national average in relation to:

• alcohol related hospital stays
• drug related hospital stays
• patients hospitalised with Chronic Obstructive Pulmonary Disorder (COPD)
• patients hospitalised with coronary heart disease
• road traffic casualties
• people aged 65 and over with high levels of care need who are cared for at home
- crime rate
- domestic abuse
- drug crimes recorded
- population within 500 m of a derelict site
- child dental health in p7
- immunisation uptake at 24 months (5 in 1)
- immunisation uptake at 24 months (MMR)

The graphic representation of the localities in comparison to each other against all the indicators will be used to inform our investment in improving the health and wellbeing of the local population and reducing health inequalities.

The IJB has agreed to adopt an integrated reporting approach with respect to its annual report showing how well it has implemented the strategic plan and performed against the national outcomes and core indicators. This approach seeks to incorporate views from stakeholders on the things that they value and wish to see sustained, developed or improved and will offer a wider narrative on the complexity and reach of our integrated service activity.
Delayed Discharges

In relation to delayed discharge the Committee is interested in three areas. The extent to which the IJB is able to direct spending, how much money is available to tackle delayed discharge and how well it is being spent to eradicate the problem.

1. **As an Integrated Authority what responsibility do you have for tackling the issue of delayed discharges?**

   This is an area of priority for the Partnership. The IJB has taken a lead role, locally, in the tackling of delayed discharges within Aberdeen City. Partnership staff currently lead on delivering our agreed action plan and on programmes focussed on reducing delayed discharges within the City, and progress is reported regularly to the IJB for the purposes of monitoring and scrutiny. There is an action plan for delayed discharges which is managed and monitored by Partnership staff – whilst working in conjunction with colleagues from the acute sector, housing, and the independent care sector. We have seen a steady improvement in our performance over the past 18 months but remain focussed and vigilant in improving further, recognising that too many people are still delayed inappropriately in an acute setting. We understand that more significant sustainable improvement can only be driven by developing new models of care at home and care home provision and these form key areas of priority for our transformation plan.

2. **What responsibility do you have for allocating expenditure including additional sums allocated by the Scottish Government to tackle delayed discharges?**

   The Aberdeen City IJB has full responsibility for allocating the £1.12 million pounds provided by the Scottish Government to specifically tackle delayed discharges. In addition, through the functions delegated to it via the local Health and Social Care Integration Scheme, the IJB has responsibility for the allocation/management of ‘baseline’ expenditure for services which directly impact on delayed discharges (intermediate care resources, hospital social work etc).

3. **How much was spent in 2015-16 on tackling delayed discharges? If necessary this answer can be based on your shadow budget for 2015-16.**

   In total £2,575,615 was spent in financial year 2015/16 to tackle delayed discharges within Aberdeen City. This figure includes the spend from the dedicated delayed discharge funding provided, alongside mainstream funded services devoted to preventing delayed discharges (hospital social work, step up/down beds etc).

4. **What is the total funding (in 2016-17) you are directing to address the issue of delayed discharges? Please provide a breakdown of how much money has been received from each of the following for this purpose:**

   a. NHS board - £184,414 + £2,041,000
   b. Local authority - £2,068,719.67
c. Other (please specify) - 0

The £1.12m dedicated funding from the Scottish Government is provided to the Partnership via the local NHS Board along with one-off funding of £921,000. Therefore a total of £2.041m dedicated funding is being applied to address delayed discharges in 2016/17.

In addition, other resources are being deployed to support discharge from hospital and preventing admissions (for example patient flow coordinators, hospital social workers and dedicated care home place purchases). These are not funded from dedicated monies for delayed discharge, but rather mainstream service funding which the Partnership chooses to fund on services that impact discharge from hospital.

Therefore, incorporating both the dedicated monies and ‘mainstream’ monies, the total allocated to addressing delayed discharge in Aberdeen City in 2016/17 is £4,294,133.67.

5. How was the additional funding allocated by the Scottish Government to tackle delayed discharges spent in 2015-16? How will the additional funding be spent in the current and next financial years?

The additional funding for 2015/16 was spent on multiple projects related to delayed discharge. This included increased social work capacity embedded within the hospital social work teams, technology enabled care, improved discharge data analysis and improved housing flow.

The current financial year (and 2017/18) will continue funding some of the projects that have been shown to be effective (additional social work capacity; interim bed provision), alongside new initiatives to address delayed discharges both at point of delay and via prevention (hospital at home services, housing based interim placements, initiatives to improve recruitment in the care at home market, streamlining provision of equipment at point of discharge etc).

In particular, we anticipate a number of larger scale projects (interim bed base expansion, hospital at home services) will span multiple financial years in regards to expenditure incurred.

6. What impacts has the additional money had on reducing delayed discharges in your area?

The various initiatives funded by the additional monies have had a significant impact on delayed discharges. It has allowed the Partnership to ‘trial’ different approaches to addressing delays alongside increasing capacity in service areas where there has been a known demonstrable impact on delayed discharge figures.

In 2014/15, Aberdeen City recorded 42,088 bed days lost due to both ‘standard’ and ‘code 9’ delays. This reduced in 2015/16 by 24% to 31,844 days lost. Based on current trend, we expect a further reduction in bed days lost for 2016/17 once the year concludes.

7. What do you identify as the main causes of delayed discharges in your area?
Current data shows two key drivers in regards to ‘standard’ delayed discharges within Aberdeen City. Availability of home based domiciliary care provision, (17% of total delays in 2015/16) alongside availability of care home places (47% of total delays in 2015/16).

A smaller volume of delays, (but which have very significant individual ‘lengths of delay’) relate to complex discharges involving the use of the Adults with Incapacity (Scotland) Act 2000.

8. What do you identify as the main barriers to tackling delayed discharges in your area?

One of the key current barriers is the general fragility of the wider local social care market at present and its limited capacity to expand to meet additional demand placed upon it – particularly due to recruitment issues within the sector. Providers report challenges in recruitment and retention of staff given the relatively buoyant employment market in jobs comparable to care. Work is ongoing in the partnership to address this but it is likely to remain a challenge in the foreseeable future.

9. How will these barriers to delayed discharges be tackled by you?

The City Partnership is currently undertaking longer term projects that will look at taking a more active market intervention approach to both the care at home and care home sectors. Additionally, the Aberdeen City Partnership is also working to improve social care recruitment via supporting suppliers in their payment of the new living wage, alongside activities such as sponsored training, accommodation and work placements.

10. Does your area use interim care facilities for patients deemed ready for discharge?

Yes. Aberdeen City currently commissions 9 supported accommodation flats, 8 residential level care home beds, alongside 6 nursing home level beds for use as interim placements for patients once they are ready for discharge. The Partnership is currently planning to expand its use of interim beds significantly during financial year 2016/17.

11. If you answered yes to question 10, of those discharged from acute services to an interim care facility what is their average length of stay in an interim care facility?

The current average length of stay is 65 days within the interim care facility before transfer to another care setting. Because of the relatively small numbers of interim beds currently in operation, occupancy does vary significantly based on the needs and complexity of the individual discharges. To highlight this, although the mean average occupancy is 65 days, the range of occupancy duration spans 12 days (shortest duration) through 151 days (longest duration).

12. Some categories of delayed discharges are not captured by the integration indicator for delayed discharges as they are classed as ‘complex’ reflecting the fact that there are legal processes which are either causing the delay (e.g. application for guardianship orders) or where there are no suitable facilities available in the NHS board area. Please provide the total cost for code 9 delayed discharges for 2015-
16? What is your estimate of cost in this area in the current and next financial years?

The IJB through both its regular review of performance and through its Clinical and Care Governance Committee has asked that further work is undertaken to analyse those delays that are not captured in the indicator and we are also undertaking work relating to why some discharges fail and the underlying causes.

The total number of bed days lost to ‘code 9’ delays in Aberdeen City for 2015/16 was 5407. This resulted in an estimated cost of £1,994,861.95 based on an average bed day cost within the hospital estate.

For 2016/17 so far, 1460 bed days have been lost to ‘code 9’ delays. This has resulted in an estimated cost of £666,881.47. Extrapolating to the end of the financial year, this would potentially result in a cost of £2,000,644.40 for 2016/17 in its entirety.

Beyond financial costs, the Partnership also recognises the wider costs that result from such delays – including poorer outcomes for those delayed in hospital and pressure on services due to the loss of capacity in those hospital settings accommodating ‘code 9’ delays.

This is driven by issues of complexity and the Partnership is looking at potential alternative commissioning approaches.
Social and Community Care Workforce

In relation to the social and community care workforce the Committee is interested in the recruitment of suitable staff including commissioning from private providers and the quality of care provided.

1. **As an Integrated Joint Board what are your responsibilities to ensure there are adequate levels of social and community care staff working with older people?**

   The majority of these services are outsourced in Aberdeen City it may therefore be relevant to note that staffing levels, competency and training are all a focus of the commissioning, procurement and contract management processes. However, given the Partnership’s responsibilities in ensuring sustainable care for citizens it takes an active role in supporting recruitment and retention initiatives and recognises its role in supporting and promoting careers in social care. The Partnership is engaged in work with provider organisations and representative groups as well as with local education providers in support of this.

2. **Are there adequate levels of these social and community care staff in your area to ensure the Scottish Government’s vision of a shift from hospital based care to community based care for older people is achieved? If not, please indicate in what areas a shortage exists.**

   In recent times there has been a shortage of carers in Aberdeen City as it has traditionally been an area of high employment in comparable jobs. Due in the main to the downturn in the Oil and Gas industry the carer situation is starting to stabilise but there is a shortage of nurses in care homes, as the providers are unable to compete with NHS rates of pay. It should also be noted that recruitment to community healthcare roles is also a challenge in Aberdeen.

3. **Other than social and community care workforce levels, are there other barriers to moving to a more community based care?**

   The ability to move at the pace we would want to and transform services is challenging, given the need to ensure ‘business as usual’ during any transition. We are also aware of the need to ensure that the inspection and registration requirements under current regimens can be challenged by new models and change there needs to keep pace with changes happening within Health and Social Care Partnerships.

   Suggested additional barriers include the challenges of the workforce in general and our ability to recruit and retain across all groups as well as develop and recruit to new roles such as that of the Physician Associate I Primary Care.

   In terms of developing new models of care in a care home setting, the age and adaptability of the care home estate along with GP cover for these models can be difficult – and the additional challenge of the fragility of the care home sector remains a risk for the Partnership.

4. **What are the main barriers to recruitment and retention of social and community care staff working with older people in your area?**

   The main barriers to recruitment are pay levels, and the perception of caring roles being high risk. We are working with providers in relation to Fairer Working Practices, including the requirement to pay the Scottish Living Wage. We are
also working to develop a Care Academy approach which would enhance the attractiveness of caring roles as a career as well as supporting career progression for people working in the care sector.

5. **What mechanisms (in the commissioning process) are in place to ensure that plans for the living wage and career development for social care staff, are being progressed to ensure parity for those employed across local authority, independent and voluntary sectors?**

Future tenders will include a highly weighted question on ‘workforce’ in line with the statutory guidance on the selection of tenderers and award of contracts, addressing Fair Work Practices, including the Living Wage in Procurement.

6. **What proportion of the care for older people is provided by externally contracted social and community care staff?**

100% - including significant elements delivered by the Council’s Arms Length External Organisation (ALEO) – Bon Accord Care.

7. **How are contracts monitored by you to ensure quality of care and compliance with other terms including remuneration?**

All social care contracts are monitored on a risk assessed basis following a process that assesses compliance with a range of criteria linked to contractual terms and conditions, together with a non-compliance process to support improvement and ultimate compliance.

Contract Monitoring and procurement is delivered on the Partnership’s behalf by Aberdeen City Council’s Contracts and Procurement Services which works closely with officers in the partnership. In addition, information on care services is included in performance management reporting through Operational services and up to the partnership’s Executive Team.