REPORT TO ABERDEENSHIRE INTEGRATION JOINT BOARD
7 DECEMBER 2022

WINTER RESILIENCE AND SURGE PLANS 2022-2023

1 Recommendation

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

1.1 Is informed about the preparation undertaken by the Aberdeenshire Health and Social Care Partnership with respect to winter resilience and surge plans for 2022-2023

1.2 Agree to receive a further update at the next meeting of the IJB in February 2023

2 Directions

2.1 No direction requires to be issued to Aberdeenshire Council or NHS Grampian as a result of this report.

3 Risk

3.1 IJB Risk 8 – Risk of failure to deliver the standards of care expected by the people of Aberdeenshire in the right time and place – working closely with wider partners in health and social care will help maintain essential and safe services for the people of Aberdeenshire.

4 Background

4.1 Every year additional pressures over the winter period have the potential to impact service delivery across the Health and Social Care Partnership. Last winter Aberdeenshire experienced some of the most extreme storm weather in its most recent history, as well as a surge in Covid-19 cases. This year, in addition, there is also the significant impact of the cost-of-living crisis, rising energy bills, staffing pressures and seasonal viruses.

4.2 The AHSCP held a workshop at the beginning of October to plan for winter, surge and reducing delayed discharges. The workshop was attended by representatives from the AHSCP senior and operational management teams, Aberdeenshire Council (HR and Live Life Aberdeenshire, and Aberdeenshire Voluntary Action (our Third Sector Interface). The primary outcome was to produce clear plans documenting existing controls and assurance and what actions are required to provide further assurance as to our preparedness and resilience moving into winter, working collaboratively with all partners.

4.3 On 12th October, the Cabinet Secretaries for Health & Social Care and Social Justice, Housing & Local Government requested that all Health Boards, Health and Social Care Partnerships and Local Authorities renew their focus on a range of action areas:

- Home First
- Discharge without Delay
- Criteria Led Discharge
- Hospital to Home transition teams with reablement focus / Discharge to Assess
- Hospital at Home
- Anticipatory Care Plans
- End of Life pathways in strong collaboration with Hospice colleagues

4.4 They also requested assurance on additional measures being undertaken to support flow, including:

- Discharge co-ordination
- Working with local colleagues and the Higher Education Institutions' (HEI) student workforce
- Investment in and funding local voluntary and third sector organisations to support care at home teams and provide practical support to people who are ready for discharge and across the wider community

4.5 Accordingly, the Winter Resilience and Surge Plans that were developed in the workshops at the beginning of October have been cross-checked with key action areas for focus and additional measures to support flow that have been outlined by the Cabinet Secretaries.

4.6 The Winter Resilience and Surge Plans have been provided to NHS Grampian Chief Executive and Aberdeenshire Council Senior Leadership Teams and have also been included for submission to Scottish Government as part of NHS Grampian's Checklist for Winter Preparedness. We have also provided copies of the plans to the Social Care Sustainability Programme Board, chaired by our Chief Social Work Officer, and our Clinical and Adult Social Work Governance Group and Committee.

5 Summary

5.1 Throughout 2022, the IJB and HSCP have focused on responding to service demand and progressing key areas of work to address these. Our strategic delivery plan has been reviewed in order to target our planning and delivery agenda on these priorities and this is being presented in a separate report to the IJB. Our approach has been to consider all service areas to identify improvements and changes which address service demand and prepare us for the increased pressure expected over winter.

5.2 However we recognise that there is no single solution to the challenges that we continue to experience in our efforts to minimise delayed discharges, plan for winter and respond to service pressures. Consequently, we have invested our winter funding in our in-house care homes, very sheltered housing, care at

home, including our rapid response team, care management, including resource in the community and at Aberdeen Royal Infirmary (ARI), and Allied Health Professionals to support re-enablement. We have also sought to address pressures on staff and to support their wellbeing. For example, we have recently worked with Aberdeenshire Council to change our approach to fuel reimbursement for care at home staff to assist with the increase in fuel prices.

5.3 A major challenge for us continues to be staffing levels across our services and teams, and our social care capacity. A paper was taken to the IJB on 24 August outlining our difficulties and the Social Care Sustainability Programme Board that has been commissioned and is being led by our Chief Social Work Officer.

5.4 The AHSCP continues to work collaboratively as part of the NHS Grampian Portfolio approach to ensure both effective and operational whole system working on a daily basis, as well as at a tactical level to address unscheduled care and planning for winter. We are also working closely with Aberdeenshire Council to maximise our social care capacity, including areas such as HR support to reduce absences, and having contingency plans in place to draw staff resources from other Council services if required, as well as volunteer support through Aberdeenshire Voluntary Action.

5.5 The workshop at the beginning of October focused on planning for winter resilience, surge and reducing delayed discharges through to March 2023, with the resulting winter resilience and surge plans being developed. The key areas of focus of our surge plans include how we can increase our bed base across our Community Hospitals, Care Homes, Very Sheltered Housing and commissioning interim / intermediate care, as well as focussing on the broader strategic redesign workstreams already underway to tackle challenges around capacity for adult social care.

5.6 Monitoring and development of these plans, which are live and therefore continue to be updated, sits with the AHSCP senior management team, and the plans are reviewed on a weekly basis. Copies of these plans, along with the Chief Officer's response to the Cabinet Secretaries letter of 12th October are provided in Appendix 1.

5.7 The Chief Officer, along with the Chief Finance Officer and the Legal Monitoring Officers within Business Services of the Council have been consulted in the preparation of this report and their comments have been incorporated within the report.

6 Equalities, Staffing and Financial Implications

6.1 The Screening section as part one of Stage one of the Integrated Impact Assessment process has not identified the requirement for any further detailed assessments to be undertaken because each individual project within the AHSCP Winter Resilience Plan 2022-2023 will have an Integrated Impact Assessment completed as part of the project process.

6.2 There are no specific financial implications for this paper as additional resources have previously been provided by the Scottish Government to respond to winter pressures.

Pamela Milliken, Chief Officer
Aberdeenshire Health and Social Care Partnership

Report prepared by Alex Pirrie, Strategy and Transformation Manager
14 November 2023

Aberdeenshire Health & Social Care Partnership

APPENDIX 1

Pam Milliken
Chief Officer
Aberdeenshire Health & Social Care Partnership
Woodhill House
Westburn Road
Aberdeen
AB16 5GB

Telephone: 01467 538909 / 07876 258 940

Email: pamela.milliken@aberdeenshire.gov.uk

Our Ref: PM / LP

Humza Yousaf BPA/MSP
Cabinet Secretary for Health & Social Care

Shona Robison MSP
Cabinet Secretary for Social Justice, Housing and Local Government

7 November 2022

Dear Mr Yousaf & Ms Robison,

Supporting our Health and Social Care System

I am writing in response to your letter, dated 12 October 2022, to provide assurance that the Aberdeenshire Integration Joint Board (IJB) and Aberdeenshire Health and Social Care Partnership (HSCP) are fully committed to minimising delayed discharges, planning for winter and responding to service pressures.

Throughout 2022 the IJB and HSCP has focussed on responding to service demand and progressing key areas of work to address these. Our strategic delivery plan has been reviewed in order to target our planning and delivery agenda on these priorities. Our approach has been to consider all service areas to identify improvements and changes which address service demand and prepare us for the increased pressure expected over winter. In doing this we recognise that there is no single solution to these challenges and that we must look for cumulative actions across all areas. Consequently, we have invested our winter funding in our in-house care homes, very sheltered housing, care at home, including our rapid response team, care management, including resource in the community and at Aberdeen Royal Infirmary (ARI), mental health officer capacity in ARI and allied health professionals to support re-enablement. We have also sought to address pressures on staff and to support their wellbeing; for example, we have recently worked with Aberdeenshire Council to change our approach to fuel reimbursement for care at home staff to assist with the increase in fuel prices.

A major challenge for us has been our social care capacity and in response a paper was taken to the IJB on 24 August 2022 outlining our difficulties and commissioning a Social Care Sustainability Programme led by our Chief Social Work Officer and including the Chief Officer and our leadership team. The programme includes review of in-house Home Care, rehabilitation and enablement, maximisation of Aberdeenshire's Support at Home Framework, training, recruitment and retention and providing risk assessed care.

Aberdeenshire Health and Social Care Partnership also works collaboratively as part of the NHS Grampian Portfolio approach to ensure both effective operational whole

Aberdeenshire Health & Social Care Partnership

system working on a daily basis as well as at a tactical level to address unscheduled care and planning for winter. We work closely with the Council to maximise our social care capacity, including areas such as human resource support to reduce absences and having in place contingency arrangements to draw staff resources from other Council services if required.

Recruitment has been a significant focus during the year in order to maximise the impact of the winter funding for social care and multidisciplinary teams as well as healthcare support workers. In relation to social care, over the winter 2021/22 period we invested in a Grampian wide recruitment campaign which was supported by all three HSCP's. For Aberdeenshire we found this had limited impact for our rural areas. Having learnt from this we have looked to use a more targeted, local approach to recruitment initiatives to better attract people who are invested in their own communities. We have also joined the Scottish Government's National Campaign Advisory Group for Social Care Recruitment.

The HSCP held a workshop in early October 2022 centred on planning for winter, surge and reducing delayed discharges through to March 2023. From this we produced winter resilience and surge plans which have been brought together as enclosed. The key areas of focus of our surge plan include how we can increase our bed base across our Community Hospitals, Care Homes, Very Sheltered Housing and commissioning Intermediate Care as well as focussing on our broader strategic redesign workstreams already underway to tackle challenges around capacity for adult social care.

I can also provide assurance that as a Senior Management Team of the HSCP we retain very tight oversight on our delayed discharges. This is undertaken operationally, reviewing each case, as well as through a management dashboard which reports on delayed discharges, capacity and demand for care homes, community hospitals and care at home. From this we know that within our delayed discharges we have a flow through of individuals with most delays being short term. We work very closely with our providers through our Care at Home and Care Home oversight arrangements in order to maximise capacity and have reinforced this with additional leadership capacity for a year. On receipt of your letter, we reviewed our winter resilience and surge plan to confirm that we have addressed and are progressing the interventions identified in Appendix A.

In common with health and care services across Scotland we have not seen a reduction in service demand across 2022 and I confirm that the leadership team of the HSCP and all services on a daily, weekly and monthly basis are responding innovatively and with commitment to provide care and support to our residents. Across all staff groups there has been pressure throughout the year due to increased referrals and acuity of needs. This has tested people's resilience and I am proud of how teams across the HSCP have come together to address these challenges and have prepared for winter. The IJB has maintained oversight and sought assurance in relation to this as well as recognising the commitment demonstrated. Despite this hard work, like many across Scotland, I am concerned about the pressures that this winter will bring.

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I hope that the attached plans demonstrate our commitment, and I can confirm that we have provided them for submission as part of NHS Grampian's Checklist for Winter Preparedness.

Yours sincerely,

[redacted]

Pam Milliken
Chief Officer
Aberdeenshire Health & Social Care Partnership

cc. Councillor Anne Stirling, Chair, Aberdeenshire IJB
Rhona Atkinson, Vice Chair, Aberdeenshire IJB
Jim Savege, Chief Executive, Aberdeenshire Council
Caroline Hiscox, Chief Executive, NHS Grampian

ABERDEENSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

WINTER RESILIENCE AND SURGE PLANS 2022-2023

Contents:

1. Introduction

On 5th October 2022 the Aberdeenshire Health and Social Care Partnership (AHSCP) held a workshop to plan for winter, surge and reducing delayed discharges. The workshop was attended by representatives from the AHSCP Senior and Operational Management Teams, and partners including representatives from Aberdeenshire Council, NHS Grampian and Aberdeenshire Voluntary Action (Third Sector Interface).

The primary outcome was to produce clear plans documenting existing controls/assurance and what actions are required to provide further assurance as to our preparedness and resilience moving into winter, working collaboratively with all partners.

The purpose of this paper is to outline the AHSCP Winter Resilience Plan and actions currently ongoing that are required to support the reduction in delayed discharges and enable maximisation of capacity in the Aberdeenshire Health and Social Care Partnership (AHSCP) through winter to March 2023.

The Winter Resilience Plan is set out in key themes:

- **Prevention and Anticipating Demand**
- **Operational Resilience**
- **Staff Health and Wellbeing**
- **Collaborative working to meet increased demand / collaborative working opportunities**

It also outlines **active workstreams undertaken by the AHSCP to contribute to surge capacity, reduce delayed discharges and support resilience**, cross-referenced with the **key action areas for focus and additional measures to support flow**, as outlined in the letter from the Cabinet Secretaries on 12th October 2022.

A summarised version of the Winter Resilience Plan is set out in Appendix 1 for ease of reference, and an overview of our surge plan is provided in Appendix 2.

Monitoring and development of these plans, which are live and therefore continue to be updated, sits with the AHSCP senior management team, and the plans will be reviewed on a weekly basis.

2. The Winter Resilience Plan

2.1. Prevention and Anticipating Demand

Key activities under this theme are summarised in Appendix 1 and include:

- Delivery of Covid and Flu Vaccinations
- Planning public safety messages with statutory partners
- Identifying and risk assessing particularly vulnerable people in Aberdeenshire (PARD)
- Creating links to access early warning of adverse weather events
- Creating links with Aberdeenshire Council Roads and Landscapes departments in relation to prompt clearing of designated roads and pathways
- Continued delivery of targeted “Stay Well Connected” and Public Health initiatives
- Repetition of “know who to turn to” messages to divert demand from hospital and prevent the system from becoming overwhelmed
- Support for patients who have powered medical / care equipment through the winter months.

Our Vaccine programme is ongoing and delivered by clinical staff across Aberdeenshire, with a current focus on older adults. **Since 5th September 2022, we have administered 22,000 Covid vaccines and 31,000 flu vaccines**. The most significant challenge continues to be staffing levels and we are undertaking the following actions in relation to staff and volunteer recruitment:

- Identifying volunteers who are registered appropriately with a regulatory body (i.e. NMC, GMC, HCPC or Dental Council) and training required
- Band 3 vaccinators in post and working under agreed protocol
- Identifying workforce from other services / teams who are trained and can support quickly if required
- HSCs student are being invited to take up roles across services.

Following the significant learning from Storms Arwen, Corrie and Malik in 2021-2022, Aberdeenshire’s work on the PARD (Persons at Risk Database) continues. The PARD is an information sharing tool designed to help identify people with a particular vulnerability who may be at an increased level of risk during a significant incident such as adverse weather.

A phased approach is currently underway using information from the Carefirst / Eclipse systems and in time will include information for the NHS and other partner organisations. A Power BI visual map is used to locate and map where vulnerable people are within a specific area or locality. Phase one of the workstream is underway and involves inputting the PARD categories into Carefirst, to enable the information to be pulled through to the Power BI map.

There is considerable activity through our delivery of targeted "Stay Well and Connected" and Public Health initiatives in Aberdeenshire, and in collaboration across Grampian.

The Public Health teams from Aberdeenshire, Aberdeen City and Moray Public Health teams, along with the wider NHS Grampian Public Health Directorate have adopted the Winter Wellness framework developed by Public Health Wales. The framework produces evidence on a range of potential interventions and specific initiatives that may contribute to winter preparedness. Five key priorities have been identified as areas likely to be effective in contributing to improving population health during winter and easing the pressure on health and social care services:

- Using an intelligence-led approach to support the uptake of vaccinations
- Increasing the uptake of vitamin D and the promotion of falls prevention work
- Keeping those with Long Term Conditions well through self-care / self-management
- The promotion of hand hygiene and 'COVID sense' advice and supporting people experiencing food and fuel poverty

The Public Health teams in Grampian have scoped a range of interventions currently in place and under development relating to each of the above priorities and this work continues to be progressed with a range of partners.

A Winter Wellness booklet, supporting web pages and a Winter Wellness pack, along with a range of supporting communications activity is under development. The anticipated launch of these is the first week in December. The Winter Wellness booklet and packs will be distributed to key settings and partners, with an emphasis on reaching the most vulnerable / at risk individuals / households in the first instance.

Aberdeenshire Council's Sports and Culture Services are delivered by Live Life Aberdeenshire (LLA). LLA provides a vast Health and Wellbeing programme, and key initiatives are ongoing over winter and is a key partner in our resilience planning. These include:

- Exercise programmes (both face-to-face and online) which run for 12 weeks for people with long term conditions. Programmes have an exited pathway to help people stay active.
- Health Checks – people can attend sports venues and libraries across Aberdeenshire to have their blood pressure and BMI checked
- The Live Life Essentials web page has now been launched and this provides information about all LLA activity programmes and where people can access a range of facilities and services free of charge.

Aberdeenshire Voluntary Action (AVA) is Aberdeenshire's Third Sector Interface and another key partner to the AHSCP. AVA is overseeing several initiatives that will contribute to public health and wellbeing over winter. These include:

- Community Mental Health and Wellbeing Fund – this is open for the second year this winter, with £639,000 available for community groups to bid for. This year, AVA's main aim is to enable groups to support those who are socioeconomically disadvantaged and the mental health impact of the cost-of-living crisis.
- Just Transition Participatory Budgeting Fund – AVA is currently receiving applications for the Warm Hub concept. Groups looking to set up Warm Hubs and places that people can go if they find themselves in difficulty can apply for funding for equipment and other items. This support is more localised and will help communities to be more self-sufficient.
- Supported Discharge Project – AVA continue to recruit volunteers to this project which supports people being discharged from hospital to their home with practical task such as shopping, walking pets and paying bills. It enables people to be discharged to their own home more quickly, with additional support in place where required.

2.2. Operational Resilience

The Aberdeenshire Integration Joint Board recognises that, as a Category 1 responder, it has a legal obligation, under the Civil Contingencies Act (CCA) 2004, to ensure emergency planning and preparedness in preventing, preparing for, responding to, and recovering from emergencies, and we have developed our AHSCP Resilience Framework accordingly.

Key activities under this theme are summarised in Appendix 1 and include:

- Review of Senior Manager On-call (SMOC) arrangements and ensure resilience cover over public holiday and festive periods
- Regular arrangements for situational awareness in place
- Regular arrangements for access to system-wide awareness and support
- Review Business Continuity Plans (BCPs) across in-house and commissioned providers
- Review of arrangements and equipment for staff to work from home if required
- Surge, Flow and Absence reporting arrangements and monitoring

All of the activity above is linked to the wider cross-system work in developing our Grampian Operational Pressure Escalation System (G-OPES) and includes daily bed huddles, situation updates, cross-system connect and wider system decision-making.

2.3. Staff Health and Wellbeing

The AHSCP, Aberdeenshire Council and NHS Grampian continue to work collaboratively to support and sustain staff health and wellbeing and this is a key area of focus over the winter period.

Staff absences continue to be monitored via our Bed Huddles and Daily Situation Update meetings, with teams equalising where possible to mitigate against disruption to service delivery.

We are making arrangements for winter safety packs to be available for relevant staff. The packs will provide staff with items such as torches, foil blankets and personal alarms when lone working in the community during the winter period.

Linking to Theme 1, Prevention and Anticipating Demand, we are continuing with our promotion of health and wellbeing initiatives for staff and ensuring there is capacity to increase these in times of most need:

- Live Life Aberdeenshire are working with Penumbra and SAMH to develop a plan to encourage staff to participate in physical activity and this will be available to the AHSCP.
- AVA supported a number of care homes with volunteers to relieve pressure on staff last year and are re-running the programme again this winter.
- The Public Health staff newsletter is being used to communicate a range of support services, tips and suggestions.
- Our Health and Safety newsletter is used to communicate important messages to staff in relation to health and safety. The focus this month is about preparedness for winter – winter driving, lone working – to support staff who may be vulnerable in their job role.
- The Aberdeenshire Wellbeing newsletter is sent out to staff monthly. This has tips and advice as well as signposting information about a variety of topics including mental health, staff benefits and discounts.

2.4. Collaborative Working to Meet Increased Demand / Collaborative Working Opportunities

Key activities under this theme are summarised in Appendix 1 and include:

- Communications – working closely with Aberdeenshire Council, NHS Grampian and the other HSCPs in Grampian to co-ordinate messages going out to the public on topics such as cost-of-living
- Collaborative working across service teams to support patients and meet demand, ensuring that work is spread evenly where possible so teams are sustained and decisions related to flow are linked to G-OPES
- Identifying work underway via Community Planning Partnership resilience plans that links to the AHSCP, to ensure that we are maintaining safe services and connections at a locality level
- Standing up initiatives that were developed during last winter:
  - Winter relief emergency pool
  - Contacting retired staff who may wish to return on temporary / relief contracts
  - Streamlining our process for requesting mutual aid from partners
  - Defining our trigger points within our G-OPES framework for pausing non-essential work to divert support to protect critical services
- Working in partnership on the development of Aberdeenshire's Community Resilience Strategy, which has focus on supporting communities to be more resilient throughout the year, including over winter.

2.5. AHSCP Active Workstreams contributing to Surge Capacity, Delayed Discharge and Resilience

There are a number of active workstreams underway in the AHSCP which will contribute to surge capacity, delayed discharge and resilience. A summary can be found in Appendix 1 and there are further workstreams that will be included as project charters are developed. We recognise that the impact of some of this work may not be immediately realised and will therefore likely be measurable in the longer term, but it is important to highlight this work.

Key activities under this theme include:

- A review of our Very Sheltered Housing model (vacant flats) with the aim of increasing capacity
- Use of interim beds in Older People's care homes to reduce the risk for patients and avoid hospital admittance due to lack of capacity to support patients at home
- Social Care Sustainability workstreams:
  - Review of the internal Home Care Service to improve recruitment and retention and ensure the sustainability and quality of service delivery to meet unmet need and service users' outcomes
  - Embedding rehabilitation and enablement as the entry point to community health and social care services in Aberdeenshire for older people and adults with physical disabilities
  - Mobilisation and maximisation of the use of the Support at Home Framework (commissioned services) in Aberdeenshire, promoting a culture of outcomes-based commissioning and weekly budgeting.

As indicated above, the AHSCP senior management team (SMT) has recently commissioned a formal review of our Very Sheltered Housing model, with a view to redesigning the model to make it fit for the future. AHSCP currently manage 6 Very Sheltered Housing services, which continue to experience difficulties with staff recruitment and retention. Added to this is the shift in the balance of care, which has resulted in more complex people being referred to the service and the staffing model no longer meeting requirements.

A priority area of focus at present is commissioning the use of interim beds in Older People's care homes to create additional capacity and support flow. Key updates include:

- Commercial and Procurement team are preparing the business case etc. required to approach the market
- All providers will be given the opportunity to apply for the interim beds.
- The contract will be for this financial year and reviewed early in 2023 to allow for the usual procurement process with the IJB and Committee approval, if it is decided to continue the contracts beyond the end of March 2023.

A summary of the current position across the private care homes in Aberdeenshire is as follows:

- **Current beds available in private Older People's care homes across Aberdeenshire = 1340**

- **TURAS and local intelligence indicate that there are currently 52 vacant beds (3.9%)**
- **Of these 52 vacant beds, 17 are currently available for occupation (1.3%)**
- **There are 2 care homes closed to admissions due to contractual non-compliance, accounting for 8 beds being unavailable**
- **There are 3 care homes operating under phased admissions at a rate of 1 per fortnight. The care homes in phased admissions are operating under these circumstances as they are emerging from being closed to admissions.**
- **There are 27 beds unavailable due to phased admissions. This is due to 1 care home being in contractual non-compliance for a long period of time and the vacancies at this care home are building up.**

The table in Appendix 1 summarises the immediate actions that are underway in relation to progressing interim care home beds. In addition, the Care Home vacancies list has been developed to ease the burden on Care Managers calling around care homes to establish if there are vacancies, and this list is also being shared with the Discharge Hub at Aberdeen Royal Infirmary.

To further address the challenges around capacity for adult social care in Aberdeenshire, and following discussion with the Integration Joint Board, the Chief Officer for the AHSCP commissioned Aberdeenshire's Chief Social Work Officer to convene a Social Care Sustainability Programme Board.

The Board is overseeing a programme of work to create self-improving and sustainable social care services through cultural, system and transformational change. There is no single solution to the issues of social care sustainability so consequently action is being progressed across a number of areas.

A Project Board, reporting to the Social Care Sustainability Board, has been established for the review of In-house home care. Workstreams under this review include:

- Recruitment and retention
- Home care service posts – evaluation and creation
- Staff and service development
- Review of the four pillars model
- Risk Assessed Care

As part of this project, a workshop is taking place week commencing 7th November to identify gaps in service provision in order to create new posts. There are two strands to this, with the aim to create additional posts to provide opportunities for career progression, as well as the creation of hybrid posts to bring in additional skill mixes to address some of the gaps in care provision. Whilst these posts will not be in place for this winter period, the aim is to create posts that are attractive to a wider pool of potential employees and reduce the overall number of vacancies at any time.

With regards to Risk Assessed Care (RAC) we have commenced a test of change to look at Care Management reviews of people with double-up care with a view to reducing care where possible and ensuring that double-up care is only recommended where required to manage risk to service users and carers. A Risk Assessed trainer

has completed the reviews of 12 people in receipt of double-up care. Of the 12 people reviewed, we have been able to reduce the amount of care for one person. In the other cases, we have been able to improve care by assessing and issuing alternative equipment.

We have experienced some resistance from family members and other professionals during the first phase of the test of change, so the team are planning awareness sessions. The second phase sees members of the Moving and Handling team working with the ward at Kincardine Community Hospital to support with discharges that would normally require double-up care, to see if this can be reduced prior to discharge, making discharges smoother and quicker. At the same time, workers will demonstrate and support ward members with RAC.

The AHSCP is also engaged in cross-system work in relation to Care at Home sustainability. The intended impact of this work is to release capacity for more care to be delivered whilst still keeping people safe at home. Three areas of focus in relation to Care at Home sustainability have been agreed with each HSCP leading on an area:

- Discharge to Assess (D2A) – led by Moray
- Risk Assessed Care (RAC) – led by Aberdeenshire
- Technology Enabled Care (TEC) – led by Aberdeen City

We have also noted that there are different discharge pathways for Rosewell/SOARS and Aberdeen Royal Infirmary, which is delaying access to equipment (mainly moving and handling equipment and adaptations). This has been raised as an issue, in particular for Rosewell where there are 12 Aberdeenshire patients. This issue delays discharges or the patient is then transferred to an Aberdeenshire Community Hospital to await further assessment for moving and handling equipment. A working group has been established with partners to map the processes and propose solutions for streamlining processes.

2.6. Winter & Surge Plans 2022-2023 – cross-check with Cabinet Secretary letter

On 12th October 2022 Cabinet Secretaries requested assurance that all Health Boards, Health and Social Care Partnerships and Local Authorities renew their focus on a range of action areas:

- Home First
- Discharge without Delay
- Criteria Led Discharge
- Hospital to Home transition teams with reablement focus / Discharge to Assess
- Hospital at Home
- Anticipatory Care Plans
- End of Life pathways in strong collaboration with Hospice colleagues

They also requested assurance on additional measures being undertaken to support flow, including:

- Discharge co-ordination

- Support for Care Homes
- Working with local colleges and the HEI student workforce
- Investment in and funding local voluntary and third sector organisations to support care at home teams and provide practical support to people who are ready for discharge and across the wider community.

A brief summary is provided in Appendix 1, with more detailed information below.

2.6.1. Home First

We continue to progress a range of developments in relation to Home First and these are outlined below:

- Additional investment in this service to recruit additional Care Team Co-ordinators (CTCs) and Responders to bolster our frailty pathway. Currently there are two Out of Hours CTCs for the Frailty Pathway and ARCH (our Home Care responder service) has successfully recruited 17 daytime and 17 evening Responders. We are actively recruiting for a further 3 daytime and 3 evening posts.
- ARCH will provide emergency response to assist if the person falls.
- ARCH continues to build a robust team around Frailty/Hospital at home with the permanent recruitment of three Care Team Co-ordinators (CTC) who create close links with the Discharge Hub Team in ARI, to improve communications and flow of information whilst working to discharge patients on the Frailty Pathway without delay. These posts enhance out-of-hours support already in place to ensure support for both staff and clients when needed.
- Commenced Risk Assessed Care test of change in Stonehaven to look at Care Management reviews of people with double-up care with a view to reducing care where possible and ensuring that double-up care is only recommended where required to manage risk to service users and carers.
- Further test of change in Arduthie ward – bolstering the ward and OT input to the ward with moving and handling assessors to assess/apply risk assessed care to those requiring moving and handling; we are also offering training to the ward on risk assessed care as a way of supporting moving and handling / streamlining discharges.

2.6.2. Discharge without Delay (use of Planned Date of Discharge [PDD] compulsory

The use of PDD's is in place and we are maintaining close management monitoring and oversight of the delays, recognising that there is a turnover within these figures so improving turn around on shorter delays is important as well as resolving more complex discharges.

2.6.3. Criteria Led Discharge

Criteria Led Discharge has been adopted in the AHSCP as a model of discharge planning. Early indications and data show that the multi-disciplinary teams have embraced this process within our community hospitals. Quality improvement

methodology is now required to fully evaluate the impact that this person-centred approach has within our ward environments. However, data from one ward has shown that the discharge rate doubled within one month of using this process and that the patient goals were all achieved within a three-week period.

2.6.4. Hospital to Home transition teams with reablement focus / Discharge to Assess

We are working to improve the hospital to home transitions for our patients by:

- Increased capacity in our team based at Aberdeen Royal Infirmary (including Nursing, Care Management, Social Work Practitioner, Enablement Support Co-ordinator and MHO roles) to improve assessment times and discharge planning from hospital.
- Investing in Discharge Co-ordinators who cover the weekends and enhanced our Care Management team with Team Manager support. Our Discharge Co-ordinators work 7 days per week to facilitate a safe and effective discharge of Aberdeenshire patients from an inpatient care stay at ARI to home, community rehabilitation and enablement, community hospital or other care setting in a timely and efficient manner, whilst ensuring minimal length of stay in an acute hospital setting.
- Improving the process for discharge using the Light Touch Assessment (LTA) and ARCH, pre a full and thorough community assessment:
  - This is provided for patients requiring new (or increased) care at home.
  - ARI Care Management will link with ARCH and ARCH provides any care needed until the community (SDS) assessment is completed and alternative resource is found. The provision of care provided by ARCH is assessed by Care Management through LTA prior to discharge.
  - ARCH will support enablement as identified by the Hospital at Home SSD team.
  - Medication management from ARCH is available when the patient is level MM2 or MM3.

2.6.5. Hospital at Home – Virtual Community Wards

The AHSCP's Virtual Community Wards (VCWs) commenced in 2016 with an initial pilot phase and this was then rolled out more widely in Aberdeenshire. The VCWs continued to operate throughout the Covid-19 pandemic.

The model was implemented to provide co-ordinated, short-term wrap around health and care at home as an alternative to hospital admission. This was achieved by utilising existing health and social care teams and wrapping them around the existing GP practice populations.

The aim of the VCWs is to ensure that health and social care teams communicate and work closely together to identify vulnerable people earlier, put in place support at short notice, avoiding crises and acute interventions where possible.

The objectives of the VCWs are:

- Better experience for all

- Wider cross-system collaboration
- Improved organisation of care
- Good quality anticipatory care
- Reduction in emergency hospital admissions
- Reduction in emergency hospital re-admissions
- Reduction in emergency occupied bed days
- Reduction in unplanned out of hours primary care contacts

Feedback from teams includes:

- Better communication between health and social care staff and greater understanding between services about what is available within and across teams.
- Interventions upstream of traditional pathways (avoiding many unscheduled admissions that otherwise would have happened).
- Increased and quicker interventions to services within communities.
- Better use and prioritisation of resources and less duplication.
- More integrated and seamless care pathways for patients.
- Better outcomes for patients and more holistic, person-centred care.
- Better / more positive staff experience and increased trust and morale.

During the Covid-19 pandemic, reporting on all our enhanced services in primary care was stopped. However our VCWs continued during this period. With the re-commencement of enhanced services and reporting, we are undertaking a review and refresh of our VCW service. We are currently collating baseline data with a view to doing a relaunch and looking at all our systems we have in place to support, enhance and also measure this valuable service. We know that each area has expanded the roles that sit within the VCW and we are seeing AHPs, Care Managers and Mental Health service involved.

Our last reporting from 2019 revealed:

- **There were 28 VCWs operating across Aberdeenshire**
- **36 months of monitoring data had been collected**
- **4.685 patients were admitted to and discharged from a VCW (to 31 March 2019)**
- **Personal care / home care / nursing care were cited as the most critical interventions required to meet the needs of VCW patients.**

A VCW group has been established, linking closely with our AHP Lead for Hospital at Home. Data is currently being reviewed and a workshop is scheduled to take place shortly and we are looking at measurable data. We are also linking with colleagues from USCC and LMC/GP Sub-committee who are very supportive of this direction.

2.6.6. Effective End of Life pathways

Being able to provide high quality, end of life care should be an integral part of every health care worker's role. In Aberdeenshire, we offer collaborative and holistic end of life pathways that adhere to the NICE Quality Standards.

We have 24/7 teams that include GPs, district nursing teams, MacMillan nurses, Marie Curie nurses and ARCH who all work together to ensure we can provide high quality end of life care. We link closely with our teams in Oncology who support with the cancer line and in addition we have a 24/7 dedicated access line to our hospice at Roxburgh House who can provide professional support to our teams.

We are fortunate to have a Cancer and Palliative Care Lead General Practitioner in Aberdeenshire who also holds a Grampian wide palliative role and represents us at all the regional updates. We are about to advertise for a second role that will work alongside this colleague.

We are currently in the process of reviewing our out of hours EOL service and looking at models that can best support our patient as a wraparound service. This work is ongoing and we are liaising with other boards in regards to differing models.

2.6.7. Support for Care Homes

We continue to ensure that our Care Homes are supported by having timely access to professional support and clinical advice.

Professional support is provided by our Lead Nurse for Care Homes and a nursing team, along with two Location Managers with strategic leadership remits.

We have an established Clinical and Professional Oversight Group for our Care Homes and Very Sheltered Housing. The Group meets weekly or more frequently depending on our G-OPES level and has a focus on the quality of care provided, infection and prevention control and provision of appropriate expert clinical and professional support for residents and staff. There is an overview of the TURAS safety huddle and staff screening data at each meeting. Each care home is discussed, and any relevant intelligence shared by care management who contact the care homes at least twice per week.

With regards to GP support to Care Homes, there is a GP identified to support each care home and there is a regular, weekly contact for review of residents that require clinical assessment and treatment. If a resident requires assessed out with that meeting, then the GP practice will provide a service. There is also planned District Nurse contact/input to care homes. Out of hours support is provided by NHS 24 /GMEDs.

2.6.8. Increasing / Supplementing the Workforce

We continue to work with local colleges and the HEI student workforce. For example, we are working alongside Robert Gordon University to encourage AHP and Nursing students to apply for jobs on the NMAHP bank.

We are in the process of interviewing Physiotherapy students who will finish their course this December. Once all their pre-employment checks are through, we can offer them a start date at Band 4 until their HCPC registration is through.

We also intend to over-recruit if we get enough Band 5 physiotherapy recruits and we are doing this on a risk-assessed basis with gaps at other grades. The aim is to encourage our students to stay local and the risk is being shared between Aberdeenshire, Aberdeen City and Acute.

With regards to our winter funding, we have agreed that all temporary posts that were filled can be made permanent and this is being progressed. **To date, we have created in excess of 199 fte permanent posts, recruiting to 184.65 fte so far, and converted 63.11 fte temporary posts to permanent**. Where posts are not being filled, alternative ways of working are being looked at and we are over-recruiting based on turnover.

Spend from the winter funding since April on permanent staff is approximately £1.55m, with £420,000 spent on temporary staff thus far. We are forecasting an underspend in this year's funding of at least £2m from our allocation of £6.9m recurring funding.

Given the ongoing challenges in achieving staffing levels in our community hospitals, the AHSCP Chief Officer has written to NHS Grampian's Director for People and Culture to request more strategic support for health care recruitment and retention. We are looking at wider approaches such as rotations, international recruitment and potential incentives.

As highlighted in previous sections in this report, during last winter the AHSCP worked with Aberdeenshire Council to develop resilience support for the winter period, whereby local authority staff volunteered to be deployed to support health and social care in Aberdeenshire. We are revisiting our list of Aberdeenshire Council volunteers who are prepared to work in health and social care to ensure that this is up-to-date and we are in a position to request support from Aberdeenshire Council and people deployed as required.

We continue to invest in and fund local voluntary and third sector organisations to support care at home teams and provide practical support to people who are ready for discharge and across the wider community. For example, our Supported Discharge project is managed by Aberdeenshire Voluntary Action (AVA), our Third Sector Interface outlined previously.

AVA also supported health and social care last winter by recruiting and training approximately 90 volunteers to be deployed to our care homes and very sheltered housing complexes. The volunteers engaged with residents on social activities, thus freeing up AHSCP staff to devote more time to residents' care. Feedback from both volunteers and our establishments was extremely positive so we intend to use these volunteers again this winter.

2.6.9. Commissioning Additional Capacity in Care Homes

This is mostly covered in section 2.5 above. We investigated working with Aberdeen City on commissioning capacity in a new care home, this could not progress due to lack of GP cover. We are also looking to commission intermediate care in our local

care homes as well as working very closely with care homes which are not open to new referrals due to quality issues, to bring them back on stream.

We have also been working intensively with a large care home to avoid a care inspectorate de-registration. We have recruited to two service manager posts to support care homes and maximise capacity over the next year.

3. Surge Plan 2022-2023

Outlined in Appendix 2 is a range of activity and actions underway to support our preparedness and ability to deal with a surge in demand and reduced delayed discharges, with other areas already highlighted in our Winter Resilience Plan. It should be noted that our location teams are currently updating our Surge Plan so the information provided is accurate at time of writing but may be subject to change.

3.1. Community Hospitals

Key areas of focus in relation to our Community Hospitals are efforts to increase our bed base to create additional surge capacity and to undertake cross-portfolio discussions to support flexible use of capacity across teams that are co-located on hospital sites.

As can be seen from the table in Appendix 2, our overall bed base in Aberdeenshire is 166 beds. Based on our registered nursing establishment, we have the potential to increase to 187 beds.

However, this needs to be progressed on a planned basis, ensuring appropriate risk assessments are undertaken and all resources are in place, in addition to the nurse staffing to open the beds safely. Issues being considered include:

- Bed spacing guidance
- 5 Factor HAI risk assessment
- Physical bed availability and furniture
- Catering/domestic cover
- AHP staffing
- Increase in linen services
- Clinical equipment checks
- Discussions with hospital medical directors
- Whether these beds are kept open or surged up and down

Appendix 2 outlines some of the actions that are being taken to progress an increase in our bed base.

3.2. Care Homes and Very Sheltered Housing

Appendix 2 reflects several areas that we are working on in relation to our Care Homes and Very Sheltered Housing (VSH) complexes, such as:

- Creating additional surge capacity
- How we might incentivise external providers to provide respite

- Ensuring Care Management have access to accurate information on bed availability so that people can be pulled through the system more efficiently
- Review of the vacant flats within our Very Sheltered Housing complexes to increase capacity
- Consideration of balance and availability of intermediate and interim care home beds.

Our teams are progressing a range of actions in relation to the above to ensure that we have an accurate picture of what is achievable this winter through to March 2023, and our action tracker will be reviewed and updated again this coming week.

It is important to remember that our internal Care Homes are **not** Nursing Homes. Doors are not necessarily locked at times, and staff are not qualified to undertake nursing tasks. Acuity of need must be considered for these placements.

Staff cohorting remains in place as this has been identified as good practice in limiting the spread of infection, along with contributing to a general reduction in falls. This involves some bedrooms being used as staff rooms but could be reviewed to support increased numbers.

It should be noted that dependency is different within our VSH complexes, where tenants should generally manage to live more independently, and they are staffed on this basis. Generally, the level of acuity is rising however, which places current staffing teams under significant pressure at times.

In considering the use of respite beds in Aberdeenshire, the AHSCP must consider how to balance this use against supporting the level of unmet need in the community with supporting flow through hospitals.

To conclude, our plan for winter preparedness – resilience and surge planning – continues to be reviewed and updated weekly and is monitored by the AHSCP SMT, with a report to the IJB scheduled for December.

Pamela Milliken
Chief Officer
7 November 2022

APPENDIX 1

ABERDEENSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP WINTER RESILIENCE PLAN 2022-2023

Key Theme 1 - Prevention and Anticipating Demand		
Activity	**Current Position**	**Additional Actions Required/In Progress**
Deliver Covid & Flu Vaccinations	Vaccine programme ongoing and delivered by clinical staff across Aberdeenshire. Current focus is older adults. Current position - 22,000 Covid vaccines and 31,000 flu vaccines administered since 5th September 2022. Reassurance that vaccines are being delivered is in place.	Staff recruitment continues and staffing levels in vaccination teams being monitored.
		Recruitment of volunteers:
		> Identifying volunteers who are registered appropriately with regulatory body (i.e. NMC, GMC, HCPC or Dental Council) and training required
		> Band 3 vaccinators in post working under protocol
		> Staff from other services / teams - identifying workforce who are trained and could support quickly if required
		> HSC students being invited to take up roles across services including vaccinations teams
Plan public safety messages with statutory partners	Awaiting the National Guidance being provided and a Grampian health and social care MID framework will be produced.	Develop AHSCP specific MID in line with the framework / guidance.
Identify and risk assess particularly vulnerable people in Aberdeenshire (PARD)	Work ongoing to develop Persons At Risk Database (PARD) - an information sharing tool which helps to identify people with particular vulnerability during a significant incident such as adverse weather.	Training for operational managers will be rolled out in a planned approach
Create links to access early warning of adverse weather event	Key Officers / Manager signed up to receive Met Office weather guidance.	Severe weather plan being finalised
Create links with Aberdeenshire Council Roads dept. in relation to prompt clearing of designated roads and pathways.	Aberdeenshire Council's Winter Maintenance Operational Plan in place. Arrangements in place via Landscape Services team to grit carparks and footways at Council owned and operated care homes and very sheltered housing facilities.	Information being included in AHSCP Severe Weather Plan.
	Public Health:	

Continued delivery of targeted "Stay Well Connected" and Public Health initiatives	> Aberdeenshire, Aberdeen City and Moray Public Health teams, along with NHSG Public Health Directorate have adopted the Winter Wellness framework developed by Public Health Wales.	
	> A Winter Wellness booklet, supporting web pages, a Winter Wellness pack and a range of supporting communications activity are under development - anticipated launch is first week in December 2022.	
	Live Life Aberdeenshire (Aberdeenshire Council):	
	> Exercise programmes (face-to-face & online) for people with long-term conditions	
	> Health Checks (blood pressure and BMI) at sports venues and libraries	
	> Live Life Essentials web page providing information on facilities and services that are free of charge	
	> AHP services conducting clinics in LLA facilities as alternative to a medical setting	
	Aberdeenshire Voluntary Action (AVA):	Supported Discharge Project is being delivered currently and work is ongoing with localities and NHSG in relation to information governance; awareness raising / promotion of the scheme is ongoing.
	> Community Mental Health and Wellbeing Fund - £639,000 available for community groups to bid for.	
	> Just Transition Participatory Budgeting Fund - applications currently being received related to the Warm Hub concept and resilience is one of the 8 outcomes set out in the fund priorities.	
	> Supported Discharge Project - enables people to be discharged to their own homes more quickly, with additional support in place where required.	
Repetition of "know who to turn to" messages to divert demand from hospital and prevent system from becoming overwhelmed	AHSCP linked with NHSG Communications team.	

Support for patients who have powered medical / care equipment through the winter months	Actions being confirmed via wider resilience / Care For People groups involving partners.	

Key Theme 2 - Operational Resilience		
Activity	**Current Position**	**Additional Actions Required/In Progress**
Review SMOC arrangements and ensure resilience cover over public holiday and festive period	> On-call arrangements are in place 24/7, 365 days per year and on NHS Grampian Rotawatch.	
	> Reviewing additional support arrangements across operational teams	
	> Aberdeenshire, Aberdeen City and Moray HSCPs working with NHS Grampian Head of System Flow on requirements for strategic, tactical and operational decisions for forward planning	
Ensure regular arrangements for situational awareness in place	Daily Bed Huddle, Daily Situational Update and Daily System Connect Meetings in place, along with clinical, adult social work and business oversight groups in place, lined to G-OPES levels.	
Ensure regular arrangements for access to system wide awareness and support	Arrangements in place	
Review Business Continuity plans - In-house services, Community Hospitals, Care Homes etc.	Review of Business Impact Assessments and Business Continuity Plans undertaken with new template being trialled.	
Support Primary Care BCP updates	In progress	
Business Continuity Plans - commissioned providers	Support to progress being provided by Contracts and Operational leads, and Oversight Groups	

Ensure communication channels are available with commissioned providers	> Procurement team providing interface between oversight groups and third sector commissioned services, providing 2-way flow of information that feeds into daily situation reports and data return to Scottish Government	
	> Information communicated via central Information Officer	
	> Procurement supplier database providing information around unmet need - registering / flagging areas as early risk or performance issues, e.g. staffing	
	> Care Home and Care at Home Oversight Groups meetings weekly or more regularly depending on G-OPES level	
Review arrangements and equipment for staff working from home if required	In place	
Surge > Flow > Absence Reporting arrangements	In place and being developed	
Remind all staff of Adverse Weather Policy	In place	

Key Theme 3 - Staff Health and Wellbeing		
Activity	**Current Position**	**Additional Actions Required/In Progress**
Monitor staff absences	Monitored via daily huddles and dashboards	
Winter Safety Packs for staff	In progress - providing staff with items such as torches, foil blankets and personal alarms when lone working in the community during the winter period	
Continue with promotion of health and wellbeing initiatives and ensure there is capacity to increase these in terms of most need (linked to Theme 1)	**> LLA** - working closely with Penumbra and SAMH to develop a plan which can be integrated with the AHSCP, encouraging staff to participate in physical activity	
	> AVA - Care Home Volunteer project supports a number of care homes	

	> Public Health - using range of staff newsletters to communicate support services, tips and suggestions for service and team level, with team focus	
	> Health & Safety - communications in place for staff and focus this month is on preparedness for winter, e.g. winter driving, lone-working, supporting staff who may be vulnerable in their job role	
	> Wellbeing Newsletters include advice and signposting information across a range of areas including mental health, staff benefits and cost-of-living	

Key Theme 4 - Collaborative Working to Meet Increased Demand / Collaborative Working Opportunities		
Activity	**Current Position**	**Additional Actions Required/In Progress**
Communications	> Communications group set up to work closely with NHSG and other HSCPs to co-ordinate messages going out to the public on topics such as cost of living > Focusing on communications about initiatives that keep people in their own homes, using joined up initiatives with partners such as Citizens Advice Bureau, SCARF and Welfare Rights Workers > Welfare Rights Workers can target support for vulnerable people > Ensure that there are Staff and Governance Groups maintain communication with the IJB so that the IJB are aware of decisions being taken	
Teams across services working collaboratively 24 hours a day to	> Ensuring that work is spread evenly where possible, so teams are sustained	

support patients and meet demand	> Decisions related to flow linked to Grampian Operational Pressures Escalation System (G-OPES)	
Community Planning Partnership resilience plans - identifying work underway that links to the AHSCP	Aberdeenshire has 17 local GIRFEC groups and we are looking at how we link with these groups around maintaining safe services and connections at a locality level	
Standing up initiatives developed during last winter	> Winter relief emergency pool > Contacting retired staff who may wish to return on temporary / relief contracts > Streamlining process for requesting mutual aid from partners > G-OPES framework in place and defining trigger points for pausing non-essential work to divert support to protect critical services	
Community Resilience Strategy - supporting communities to be more resilient throughout the year, including over winter	Emergency Planning Team are holding a series of workshops on resilience for community based groups with the aim of developing a strategy to support communities to be resilient throughout the year.	

AHSCP Active Workstreams contributing to Surge Capacity, Delayed Discharge and Resilience				
Area of Work	**Workstream**	**Aim of project / workstream**	**Current position**	**Additional Actions Required / In Progress**
Care Homes / Very Sheltered Housing	**Review of Very Sheltered Housing**	Review of model (vacant flats) with aim to increase capacity	AHSCP senior management team have approved this workstream	**Short Life Working Group being established to review options for redesign - will report to SMT and Social Care Sustainability Board**
	Interim beds	Use of interim beds in OP care homes to reduce risk for patients and avoid hospital admittance due to lack of capacity to support patients safely at	> Draft admission criteria out to Location Managers for comment	**All providers will be given the opportunity to apply for the interim beds. The contract will be for this financial year and reviewed early in 2023 to allow for the usual procurement process with the IJB and Committee approval, if it is decided to**

		home, ensuring equitable spread across Aberdeenshire	> Figures calculated based on 2 hours of additional carer hours per day in addition to the National Care Home Residential or Nursing rate	**continue the contracts beyond the end of March 2023.**
			> Commercial and Procurement team are preparing the business case etc required to approach the market	
			> Discussions underway re GP Service Level Agreements for interim beds across Aberdeenshire	
			> Working in partnership with Aberdeen City HSCP where possible to ensure a consistent approach	
			> Care Home Vacancies list developed to ease burden on Care Managers having to call around care homes to establish if there are vacancies	
Social Care Sustainability	**Review of In-House Home Care**	To review the internal Home Care Service, to improve recruitment and retention and ensure the sustainability and quality of service delivery to meet unmet need and service users' outcomes	> Project Board established and workstreams confirmed - Recruitment and Retention; Home care service posts - evaluation and creation; Staff and Service Development; Review of the four pillars model; Risk Assessed Care	**> Produce and implement a recruitment strategy for home care in Aberdeenshire**
			> Project management support secured and work ongoing	**> Develop options appraisal for the home care service structure and posts**
			> Business mileage - geographical mileage claims agreed and being implemented	**> Develop options appraisal for hybrid posts and cross-system working**
				> Develop training plan
				> Produce a proposal for transport and admin requirements
				> Evaluation of rotas and shifts
				> Evaluation of the four pillars model

				> Risk assessed care - project charter being completed
	Rehabilitation and Enablement	To embed rehabilitation and enablement as the entry point to community health and social care services in Aberdeenshire for older people and adults with physical disabilities	> Determining the current position with delivery of the rehab and enablement action plan that was previously approved and developing an updated delivery plan	**> Measure and evaluate the outcome of the project using agreed indicators**
			> Providing direction and support to teams to change practice and identifying and managing barriers to implementation	
	Support at Home Framework (commissioned services)	To mobilise and maximise usage of the Support at Home Framework in Aberdeenshire, promoting a culture of outcomes-based commissioning and weekly budgeting	> Provider engagement event held and planning further schedule of engagement events for staff and providers that promote the Framework	
			> Intelligence from Oversight Groups informing activities designed to promote the framework	
			> Ensuring engagement events for internal staff cover areas that include how we commission, outcomes-focused commissioning and weekly budgeting	
			> Ensuring that there is promotion of the Framework amongst teams that work with under-represented care groups	

Winter & Surge Plans - Cross-check with Cabinet Secretary letter of 12th October 2022	
SG requested area of focus	**Detail**
Home First	> Additional investment in ARCH service to recruit additional Care Team Co-ordinators and Responders to bolster our frailty pathway. Currently there are 2 OOH CTCs for the Frailty Pathway and ARCH has successfully recruited 17 daytime and 17 evening Responders. We are actively recruiting for a further 3 daytime and 3 evening posts.
	> ARCH will provide emergency response to assist if the person falls

	> ARCH continues to build a robust team around Frailty / Hospital at Home with the permanent recruitment of 3 Care Team Co-ordinators (CTCs) who create close links with the Discharge Hub Team in ARI, to improve communications and flow of information whilst working to discharge patients on the Frailty Pathway without delay. These posts enhance out-of-hours support already in place to ensure support for both staff and clients when needed.
	> Commenced Risk Assessed Care test of change in Stonehaven to look at Care Management reviews of people with double-up care, with a view to reducing care where possible and ensuring that double-up care is only recommended where required to manage risk to service users and carers.
	> Further test of change in Arduthie Ward - bolstering the ward and OT input to the ward with moving and handling assessors to assess / apply risk assessed care to those requiring moving and handling; we are also offering training to the ward on risk assessed care as a way of supporting moving and handling / streamlining discharges.
Discharge without Delay (use of Planned Date of Discharge [PDD] compulsory	The use of PDDs is in place and we are maintaining close management and oversight of the delays, recognising that there is a turnover within these figures so improving turnaround on shorter delays is important, as well as resolving more complex discharges.
Criteria Led Discharge	Criteria Led Discharge has been adopted in the AHSCP as a model of discharge planning.
Hospital to Home transition teams with re-ablement focus / Discharge to Assess	> Increased capacity in our team based at Aberdeen Royal Infirmary (including Nursing, Care Management, Social Work Practitioner, Enablement Support Co-ordinator and MHO roles) to improve assessment times in and discharge planning from hospital.
	> Invested in Discharge Co-ordinators who cover weekends and enhanced our Care Management team with Team Manager support.
	> Improving the process for discharge using the Light Touch Assessment (LTA) and ARCH, pre a full and thorough community assessment
Hospital at Home - Virtual Community Wards	> Currently undertaking a review and refresh of our VCW service, linking with colleagues from the Unscheduled Care Collaborative and LMC/GP Sub-committee
	> We have expanded the roles that sit within the VCW to include AHPs, Care Managers and Mental Health teams
Anticipatory Care Plans	> Updates provided to primary care reminding them of the importance of ACPs and KIS and also reminding them that although over 75s are an important age group, we must also remember other vulnerable populations - our mental health, learning disability and addiction patients.
	> Our renewed Care Home LES stipulates that over 90% of our care home patients should have ACPs and KIS in place and updated where necessary
Effective End of Life Pathways	> 24/7 teams in place that include GPs, district nursing teams, MacMillan Nurses, Marie Curie nurses, and ARCH wo work closely together

	> Linked with teams in Oncology who support the cancer line	
	> Dedicated access line to our hospice at Roxburghe House in place who can provide professional support to teams	
	> Currently reviewing our out of hours EOL service	
Support for Care Homes	> Arrangements in place for Care Homes to have timely access to professional support and clinical advice	
	> Have established Clinical and Professional Oversight Group for Care Homes and Very Sheltered Housing	
	> Identified GP support for each Care Home with regular weekly review or residents that require clinical assessment and treatment, planned District Nurse contact / input and out-of-hours support provided by NHS 24 / GMED	
Increasing / Supplementing the Workforce	> Continuing to work with local colleagues and the HEI student workforce - encouraging AHP and Nursing students to apply for jobs on the NMAHP bank.	
	> Over-recruiting to posts where appropriate	
	> With winter funding have created in excess of 199 fte permanent posts (social care), recruiting to 184.65 fte so far and converted 63.11 fte temporary posts to permanent	
	> Strategic support for healthcare recruitment and retention requested from NHS Grampian	
	> Working with the TSI on key projects using volunteers	
Commissioning Additional Capacity in Care Homes	Covered under 'AHSCP Workstreams'	

APPENDIX 2 – ABERDEENSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP SURGE PLAN 2022-23

Service	Description	Area	Current level	What is acheivable?	Risks / issues identified	Action being taken to progress
Community Hospitals	**Additional surge capacity (increased bed base)**	**Total - Aberdeenshire**	**166**	**187 (based on registered nursing est.)**	Breakdown by site below. Needs to be undertaken on a planned basis, ensuring appropriate risk assessments undertaken and all resources in place, in addition to nurse staffing to open beds safely and key issues considered.	Identifying additional support resources needed for each bed; clarifying bed spacing; developing SOP to guide SMOC decision-making in response to whole system requests - key steps and what to consider in decision making, risk assessment / risk tolerance and support for staff on shift; exploring winter funding options to support provision of domestic staff
		Aboyne	12	14	Temp closure due to staffing issues; establishment requires review	

		Arduthie	18	19	All single rooms. Day cases could be provided in MI room.	
		Ashcroft	10	10	All single rooms, no issues.	
		Banff	18	20	All single rooms. Increase to 20 beds if establishment allowed (renal ward has 2). New starts due soon. Requires day case space.	
		Brucklay	12	12	To remain at 12 beds.	

		Donbank	16	18	Could go to 18 beds if IP&C agree. Only 16 physical beds in the ward.	
		Morven	14	18	Currently up to 16 beds with support from Aboyne staff. Only 16 physical beds in ward.	
		Philorth	18	20	Staffing would allow an increase of 2 beds. Requires day case space.	

		Rothieden	8	8	Due to ongoing estates work, beds capped at 8. Due to roof being fixed the ward will have to close (date tbc). Upon completion of roof works, capacity to increase to 18. Establishment requires review.	Alternative bed base being progressed.

		Scolty	12	12	To remain at 12 beds. Establishment requires review.	
		Summers	16	22	To remain at 16 beds as per IP&C guidance - bed spacing and ventilation was a factor in outbreaks. Increase to 22 max only if derogation against IP&C.	

		Turriff	12	14	Due to ongoing estates work, beds are capped at 12. Capacity to increase to 14 once new room is completed.	
	Cross portfolio discussions to support flexible use of capacity across teams co-located on hospital sites	**Peterhead**	n/a	n/a		Initiating discussions with cross-system colleagues (initial focus on maternity)
		Shire-wide (potential)	n/a	n/a		Requesting support from Head of System Flow

Care Homes / Very Sheltered Housing	**Additional surge capacity**	Shire-wide	Breakdown by site below	As per below	Staffing dependent on the needs of the person; Internal residential homes are not nursing homes and staff are not qualified to undertake nursing tasks so acuity of need must be considered; Staff cohorting is good practice to limit spread of infection but could be reviewed to support increased numbers; Dependency different in VSH and staffed on basis that tenants should generally manage to live more independently; Consideration of how we can use VSH resource on Shire-wide basis to support those in the community with no care / reduce unmet need.	Risk assess and implement policy / process for supporting homes to revert from staff cohorting practice where other more significant risks need to be mitigated in surge situation.

		Allachburn - Aboyne		1 additional space	Staffing is not at an optimal level	
		Edenholme - Stonehaven			Unable to staff wing.	Plan being submitted to SMT
		Dalvenie Gardens - Banchory	24 flats	1 additional respite flat		
		Bennachie View		Potential interim beds (12)	Number of beds closed due to staffing issues.	Identifying what is required to re-open beds
		Durnhythe - Portsoy	18	35	Major refurbishment works remain ongoing (predicted completion in Dec). There are 18 beds at present, but plans are in place to increase from the end of December when work is completed. Full capacity is 35 but additional staff would need to be recruited to accommodate this number of individuals.	

		Faithlie - Fraserburgh	20	33	Flooring work nearing completion. Care Management have started identifying suitable potential residents. Currently 20 beds filled. Faithlie has 35 bedrooms but at least 2 of these are not fit for purpose as they are not large enough for residents to be supported by staff or have equipment in them. Staffing would need to be increased when numbers get into high 20s.	
		Grangepark - Peterhead	29	30	1 additional bedroom planned to be available from November onwards.	

		Doocot View - Banff			Respite room currently being used as staff area due to cohorting for IP&C. Currently checking whether this is till be required and if not, work to provide a respite room again. Furniture required for room in order to provide respite. Complex is generally full. Waiting list in place with robust allocation system so vacancies are quickly filled.	
		Ythanvale - Ellon		Up to 8 beds as interim or respite		

		Jarvis Court - Fraserburgh			Work currently underway with Housing Association to explore the use of the respite flat as a more permanent bed option. This is currently being used as a staff room to support cohorting. Appropriate furniture would need to be obtained. Staff remains and issue and recruitment slow. Only 2 staff per shift for 22 flats and currently 6 tenants require double-up care. Staffing numbers originally for tenants who could predominantly self care. Would need staff vacancies filled to increase capacity. Team has been under pressure for a significant period.	

	Incentivise providers to provide respite	Shire-wide		Shire wide - 1340 beds; 52 vacant beds - 17 available for occupation; 2 care homes closed to admission due to contractual non-compliance - 8 beds unavailable; 3 care homes operating under phased admissions at a rate of 1 per fortnight; 27 beds unavailable due to phased admissions - due to 1 care home being in contractual non-compliance		Cost analysis of incentives to private providers for respite services. Paper being submitted to SMT.

				for a long period of time and the vacancies at this care home are building up.		

	Care Management access to accurate information on bed availability	Shire-wide			Should be completed on TURAS.	Reminder issued to providers re need to complete TURAS safety huddle on a daily basis. Revert back to contracts team re providers who are in non-compliance.
	Review of Very Sheltered Housing	Shire-wide			Review of model (vacant flats) with aim to increase capacity	Paper going to SMT re review of VSH model to increase capacity
	Consideration of intermediate vs interim beds	Shire-wide		Equitable spread across Shire	Using interim beds to reduce risk for patient and avoid hospital admittance due to lack of capacity to support patient safely at home. Intermediate care beds would require a review of current staffing models. 10 beds at Rosewell for interim placement to LTC. Blockage of beds, patients awaiting LTC. Hybrid - not within own locality. Would need to monitor costs incurred and equality of service provided.	Commissioning and Procurement team preparing to go out to market for interim care home beds.

ABERDEENSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

WINTER RESILIENCE AND SURGE PLANS 2022-2023

Contents:

1. Introduction

On 5th October 2022 the Aberdeenshire Health and Social Care Partnership (AHSCP) held a workshop to plan for winter, surge and reducing delayed discharges. The workshop was attended by representatives from the AHSCP Senior and Operational Management Teams, and partners including representatives from Aberdeenshire Council, NHS Grampian and Aberdeenshire Voluntary Action (Third Sector Interface).

The primary outcome was to produc clear planS documenting existing controls/assurance and what actions are required to provide further assurance as to our preparedness and resilience moving into winter, working collaboratively with all partners.

The purpose of this paper is to outline the AHSCP Winter Resilience Plan and actions currently ongoing that are required to support the reduction in delayed discharges and enable maximisation of capacity in the Aberdeenshire Health and Social Care Partnership (AHSCP) through winter to March 2023.

The Winter Resilience Plan is set out in key themes:

- **Prevention and Anticipating Demand**
- **Operational Resilience**
- **Staff Health and Wellbeing**
- **Collaborative working to meet increased demand / collaborative working opportunities**

It also outlines **active workstreams undertaken by the AHSCP to contribute to surge capacity, reduce delayed discharges and support resilience**, cross-references the **key action areas for focus and additional measures to support flow**, outlined the letter from the Cabinet Secretary on 12th October 2022.

A summarised version of the Winter Resilience Plan is set out in Appendix 1 for ease of reference, and an overview of our surge plan is provided Appendix 2.

Monitoring and development of these plans, which is live and therefore continues to be updated, sits with the AHSCP senior management team, and the plans will be reviewed on a weekly basis.

2. The Winter Resilience Plan

2.1. Prevention and Anticipating Demand

Key activities under this theme are summarised in Appendix 1 and include:

- Delivery of Covid and Flu Vaccinations
- Planning public safety messages with statutory partners
- Identifying and risk assessing particularly vulnerable people in Aberdeenshire (PARD)
- Creating links to access early warning of adverse weather events
- Creating links with Aberdeenshire Council Roads and Landscapes departments in relation to prompt clearing of designated roads and pathways
- Continued delivery of targeted “Stay Well Connected” and Public Health initiatives
- Repetition of “know who to turn to” messages to divert demand from hospital and prevent the system from becoming overwhelmed
- Support for patients who have powered medical / care equipment through the winter months

Our Vaccine programme is ongoing and delivered by clinical staff across Aberdeenshire, with a current focus on older adults. **Since 5th September 2022, we have administered 22,000 Covid vaccines and 31,000 flu vaccines**. The most significant challenge continues to be staffing levels and we are undertaking the following actions in relation to staff and volunteer recruitment:

- Identifying volunteers who are registered appropriately with a regulatory body (i.e. NMC, GMC, HCPC or Dental Council) and training required
- Band 3 vaccinators in post and working under agreed protocol
- Identifying workforce from other services / teams who are trained and can support quickly if required
- HSC student are being invited to take up roles across services

Following the significant learning from Storms Arwen, Corrie and Malik in 2021-2022, Aberdeenshire’s work on the PARD (Persons at Risk Database) continues. The PARD is an information sharing tool designed to help identify people with a particular vulnerability who may be at an increased level of risk during a significant incident such as adverse weather.

A phased approach is currently underway using information from the Carefirst / Eclipse systems and intime will include information for the NHS and other partner organisations. A Power BI visual map is used to locate and map where vulnerable people are within a specific area or locality. Phase one of the workstream is underway and involves inputting the PARD categories into Carefirst, to enable the information to be pulled through to the Power BI map.

There is considerable activity through our delivery of targeted "Stay Well and Connected" and Public Health initiatives in Aberdeenshire, and in collaboration across Grampian.

The Public Health teams from Aberdeenshire, Aberdeen City and Moray Public Health teams, along with the wider NHS Grampian Public Health Directorate have adopted the Winter Wellness framework developed by Public Health Wales. The framework produces evidence on a range of potential interventions and specific initiatives that may contribute to winter preparedness. Five key priorities have been identified as areas likely to be effective in contributing to improving population health during winter and easing the pressure on health and social care services:

- Using an intelligence-led approach to support the uptake of vaccinations
- Increasing the uptake of vitamin D and the promotion of falls prevention work
- Keeping those with Long Term Conditions well through self-care / self-management
- The promotion of hand hygiene and 'COVID sense' advice and supporting people experiencing food and fuel poverty

The Public Health teams in Grampian have scoped a range of interventions currently in place and under development relating to each of the above priorities and this work continues to be progressed with a range of partners.

A Winter Wellness booklet, supporting web pages and a Winter Wellness pack, along with a range of supporting communications activity is under development. The anticipated launch of these is the first week in December. The Winter Wellness booklet and packs will be distributed to key settings and partners, with an emphasis on reaching the most vulnerable / at risk individuals / households in the first instance.

Aberdeenshire Council's Sports and Culture Services are delivered by Live Life Aberdeenshire (LLA). LLA provides a vast Health and Wellbeing programme, and key initiatives are ongoing over winter and is a key partner in our resilience planning. These include:

- Exercise programmes (both face-to-face and online) which run for 12 weeks for people with long term conditions. Programmes have an exited pathway to help people stay active.
- Health Checks – people can attend sports venues and libraries across Aberdeenshire to have their blood pressure and BMI checked
- The Live Life Essentials web page has now launched and this provides information about all LLA activity programmes and where people can access a range of facilities and services free of charge

Aberdeenshire Voluntary Action (AVA) is Aberdeenshire's Third Sector Interface and another key partner to the AHSCP. AVA is overseeing several initiatives that will contribute to public health and wellbeing over winter. These include:

- Community Mental Health and Wellbeing Fund – this is open for the second year this winter, with £639,000 available for community groups to bid for. This year, AVA's main aim is to enable groups to support those who are socioeconomically disadvantaged and the mental health impact of the cost-of-living crisis.
- Just Transition Participatory Budgeting Fund – AVA is currently receiving applications for the Warm Hub concept. Groups looking to set up Warm Hubs and places that people can go if the find themselves in difficulty can apply for funding for equipment and other items. This support is more localised and will help communities to be more self-sufficient.
- Supported Discharge Project – AVA continue to recruit volunteers to this project which supports people being discharged from hospital to their home with practical task such as shopping, walking pets and paying bills. It enables people to be discharged to their own home more quickly, with additional support in place where required.

2.2. Operational Resilience

The Aberdeenshire Integration Joint Board recognises that, as a Category 1 responder, has a legal obligation, under the Civil Contingencies Act (CCA) 2004, to ensure emergency planning and preparedness in preventing, preparing for, responding to, and recovering from emergencies, and we have developed our AHSCP Resilience Framework Accordingly.

Key activities under this theme are summarised in Appendix 1 and include:

- Review of Senior Manager On-call (SMOC) arrangements and ensure resilience cover over public holiday and festive periods
- Regular arrangements for situational awareness in place
- Regular arrangements for access to system-wide awareness and support
- Review Business Continuity Plans (BCPs) across in-house and commissioned providers
- Review of arrangements and equipment for staff to work from home if required
- Surge, Flow and Absence reporting arrangements and monitoring

All of the activity above is linked to the wider cross-system work in developing our Grampian Operational Pressure Escalation System (G-OPES) and includes daily bed huddles, situation update, cross-system connect and wider system decision-making.

2.3. Staff Health and Wellbeing

The AHSCP, Aberdeenshire Council and NHS Grampian continue to work collaboratively to support and sustain staff health and wellbeing and this is a key focus area over the winter period.

Staff absences continue be monitored via our Bed Huddles and Daily Situation Update meetings, with teams equalising where possible to mitigate against disruption to service delivery.

We are making arrangements for winter safety packs to be available for relevant staff. The packs will provide staff with items such as torches, foil blankets and personal alarms when lone working in the community during the winter period.

Linking to Theme 1, Prevention and Anticipating Demand, we are continuing with our promotion of health and wellbeing initiatives for staff and ensuring there is capacity to increase these in times of most need:

- Live Life Aberdeenshire are working with Penumbra and SAMH to develop a plan to encourage staff to participate in physical activity and this will be available to the AHSCP.
- AVA supported a number of care homes with volunteers to relieve pressure on staff last year and are re-running the programme again this winter.
- The Public Health staff newsletter is being used to communicate a range of support services, tips and suggestions.
- Our Health and Safety newsletter is used to communicate important messages to staff in relation to health and safety. The focus this month is about preparedness for winter – winter driving, lone working – to support staff who may be vulnerable in their job role.
- The Aberdeenshire Wellbeing newsletter is sent out to staff monthly. This has tips and advice as well as signposting information about a variety of topics including mental health, staff benefits and discounts.

2.4. Collaborative Working to Meet Increased Demand / Collaborative Working Opportunities

Key activities under this theme are summarised in Appendix 1 and include:

- Communications – working closely Aberdeenshire Council, NHS Grampian and the other HSCPs in Grampian to co-ordinate messages going out to the public on topics such as cost-of-living
- Collaborative working across service teams to support patients and meet demand, ensuring that work is spread evenly where possible so teams are sustained and decisions related to flow are linked to G-OPES
- Identifying work underway via Community Planning Partnership resilience plans that links to the AHSCP, to ensure that we are maintaining safe services and connections at a locality level
- Standing up initiatives that were developed during last winter:
  - Winter relief emergency pool
  - Contacting retired staff who may wish to return on temporary / relief contracts
  - Streamlining our process for requesting mutual aid from partners
  - Defining our trigger points within our G-OPES framework for pausing non-essential work to divert support to protect critical services
- Working in partnership on the development of Aberdeenshire's Community Resilience Strategy, which has focus on supporting communities to be more resilient throughout the year, including over winter

2.5. AHSCP Active Workstreams contributing to Surge Capacity, Delayed Discharge and Resilience

There are a number of active workstreams underway in the AHSCP which will contribute to surge capacity, delayed discharge and resilience. A summary can be found in Appendix 1 and there are further workstreams that will be included as project charters are developed. We recognise that the impact of some of this work may not be immediately realised and will therefore likely be measurable in the longer term, but it is important to highlight this work.

Key activities under this theme are summarised include:

- A review of our Very Sheltered Housing model (vacant flats) with the aim of increasing capacity
- Use of interim beds in Older People's care homes to reduce the risk for patients and avoid hospital admittance due to lack of capacity to support patients at home
- Social Care Sustainability workstreams:
  - Review of the internal Home Care Service to improve recruitment and retention and ensure the sustainability and quality of service delivery to meet unmet need and service users' outcomes
  - Embedding rehabilitation and enablement as the entry point to community health and social care services in Aberdeenshire for older people and adults with physical disabilities
  - Mobilisation and maximisation of the use of the Support at Home Framework (commissioned services) in Aberdeenshire, promoting a culture of outcomes-based commissioning and weekly budgeting

The AHSCP senior management team (SMT) has recently commissioned a formal review of our Very Sheltered Housing model, with a view to redesigning the model to make it fit for the future. AHSCP currently manage 6 Very Sheltered Housing services, which continue to experience difficulties with staff recruitment and retention. Added to this is the shift in the balance of care, which has resulted in more complex people being referred to the service and the staffing model is no longer meeting requirements.

A priority area of focus at present is commissioning the use of interim beds in Older People's care homes to create additional capacity and support flow. Key updates include:

- Commercial and Procurement team are preparing the business case etc. required to approach the market
- All providers will be given the opportunity to apply for the interim beds.
- The contract will be for this financial year and reviewed early in 2023 to allow for the usual procurement process with the IJB and Committee approval, if it is decided to continue the contracts beyond the end of March 2023

A summary of the current position across the private care homes in Aberdeenshire is follows:

- **Current beds available in private Older People's care homes across Aberdeenshire = 1340**
- **Turas and local intelligence indicate that there are currently 52 vacant beds (3.9%)**
- **Of these 52 vacant beds, 17 are currently available for occupation (1.3%)**

- **There are 2 care homes closed to admissions due to contractual non-compliance, accounting for 8 beds being unavailable**
- **There are 3 care homes operating under phased admissions at a rate of 1 per fortnight. The care homes in phased admissions are operating under these circumstances as they are emerging from being closed to admissions.**
- **There are 27 beds unavailable due to phased admissions. This is due to 1 care home being in contractual non-compliance for a long period of time and the vacancies at this care home are building up.**

The table in Appendix 1 summarises the immediate actions that are underway in relation to progressing interim care home beds. In addition, the Care Home vacancies list has been developed to ease the burden on Care Managers calling around care homes to establish if there are vacancies, and this list is also being shared with the Discharge Hub at Aberdeen Royal Infirmary.

To further address the challenges around capacity for adult social care in Aberdeenshire, and following discussion with the Integration Joint Board, the Chief Officer for the AHSCP commissioned Aberdeenshire's Chief Social Work Officer to convene a Social Care Sustainability Programme Board.

The Board is established is overseeing a programme of work to create self-improving and sustainable social care services through cultural, system and transformational change. There is no single solution to the issues of social care sustainability so consequently action is being progressed across a number of areas.

A Project Board, reporting to the Social Care Sustainability Board, has been established for the review of In-house home care. Workstreams under this review include:

- Recruitment and retention
- Home care service posts – evaluation and creation
- Staff and service development
- Review of the four pillars model
- Risk Assessed Care

As part of this project, a workshop is taking place week commencing 7th November to identify gaps in service provision in order to create new posts. There are two strands to this, with the aim to create additional posts to provide opportunities for career progression, as well as creation of hybrid posts to bring in additional skill mixes to address some of the gaps in care provision. Whilst these posts will not be in place for this winter period, the aim is to create posts that are attractive to a wider pool of potential employees and reduce the overall number of vacancies at any time.

With regards to Risk Assessed Care (RAC) we have commenced a test of change to look at Care Management reviews of people with double-up care with a view to reducing care where possible and ensuring that double-up care is only recommended where required to manage risk to service users and carers. A Risk Assessed trainer has completed reviews of 12 people in receipt of double-up care. Of the 12 people reviewed, we have been able to reduce the amount of care for one person. In the

other cases, we have been able to improve care by assessing and issuing alternative equipment.

We have experienced some resistance from family members and other professionals during the first phase of the test of change, so the team are planning awareness sessions. The second phase sees members of the Moving and Handling team working with the ward at Kincardine Community Hospital to support with discharges that would normally require double-up care, to see if this can be reduced prior to discharge, making discharges smoother and quicker. At the same time, workers will demonstrate and support ward members with RAC.

The AHSCP is also engaged in cross-system work in relation to Care at Home sustainability. The intended impact of this work is to release capacity for more care to be delivered whilst still keeping people safe at home. Three areas of focus in relation to Care at Home sustainability have been agreed with each HSCP leading on an area:

- Discharge to Assess (D2A) – led by Moray
- Risk Assessed Care (RAC) – led by Aberdeenshire
- Technology Enabled Care (TEC) – led by Aberdeen City

We have also noted that there are different discharge pathways for Rosewell/SOARS and Aberdeen Royal Infirmary, which is delaying access to equipment (mainly moving and handling equipment and adaptations. This has been raised as an issue, in particular for Rosewell where there are 12 Aberdeenshire patients. This issue delays discharges or the patient is then transferred to an Aberdeenshire Community Hospital to await further assessment for moving and handling equipment. A working group has been established with partners to map the processes and propose solutions for streamlining processes.

2.6. Winter & Surge Plans 2022-2023 – cross-check with Cabinet Secretary letter

On 12th October 2022 Cabinet Secretaries requested assurance that all Health Boards, Health and Social Care Partnerships and Local Authorities renew their focus on a range of action areas:

- Home First
- Discharge without Delay
- Criteria Led Discharge
- Hospital to Home transition teams with reablement focus / Discharge to Assess
- Hospital at Home
- Anticipatory Care Plans
- End of Life pathways in strong collaboration with Hospice colleagues

They also requested assurance on additional measures being undertaken to support flow, including:

- Discharge co-ordination
- Support for Care Homes

- Working with local colleges and the HEI student workforce
- Investment in and funding local voluntary and third sector organisations to support care at home teams and provide practical support to people who are ready for discharge and across the wider community.

A brief summary is provided in Appendix 1, with more detailed information below.

2.6.1. Home First

We continue to progress a range of developments in relation to Home First and these are outlined below:

- Additional investment in this service to recruit additional Care Team Co-ordinators and Responders to bolster our frailty pathway. Currently there are two OOH CTCs for the Frailty Pathway and ARCH (our Home Care responder service) has successfully recruited 17 daytime and 17 evening Responders. We are actively recruiting for a further 3 daytime and 3 evening posts.
- ARCH will provide emergency response to assist if the person falls.
- ARCH continues to build a robust team around Frailty/Hospital at home with the permanent recruitment of three Care Team Co-ordinators (CTC) who create close links with the Discharge Hub Team in ARI, to improve communications and flow of information whilst working to discharge patients on the Frailty Pathway without delay. These posts enhance out-of-hours support already in place to ensure support for both support for both staff and clients when needed.
- Commenced Risk Assessed Care test of change in Stonehaven to look at Care Management reviews of people with double-up care with a view to reducing care where possible and ensuring that double-up care is only recommended where required to manage risk to service users and carers.
- Further test of change in Arduthie ward – bolstering the ward and OT input to the ward with moving and handling assessors to assess/apply risk assessed care to those requiring moving and handling; we are also offering training to the ward on risk assessed care as a way of supporting moving and handling / streamlining discharges.

2.6.2. Discharge without Delay (use of Planned Date of Discharge [PDD] compulsory

The use of PDD's is in in place and we are maintaining close management monitoring and oversight of the delays, recognising that there is a turnover within these figures so improving turn around on shorter delays is important as well as resolving more complex discharges.

2.6.3. Criteria Led Discharge

Criteria Led Discharge has been adopted in the AHSCP as a model of discharge planning. Early indications and data show that the multi-disciplinary teams have embraced this process within our community hospitals. Quality improvement methodology is now required to fully evaluate the impact that this person-centred approach has within our ward environments. However, data from one ward has

shown that the discharge rate doubled within one month of using this process and that the patient goals were all achieved within a three-week period.

2.6.4. Hospital to Home transition teams with reablement focus / Discharge to Assess

We are working to improve the hospital to home transitions for our patients by:

- Increased capacity in our team based at Aberdeen Royal Infirmary (including Nursing, Care Management, Social Work Practitioner, Enablement Support Co-ordinator and MHO roles) to improve assessment times in and discharge planning from hospital.
- Investing in Discharge Co-ordinators who cover the weekends and enhanced our Care Management team with Team Manager support. Our Discharge Co-ordinators work 7 days per week to facilitate a safe and effective discharge of Aberdeenshire patients from an inpatient care stay at ARI to home, community rehabilitation and enablement, community hospital or other care setting in a timely and efficient manner, whilst ensuring minimal length of stay in an acute hospital setting.
- Improving the process for discharge using the Light Touch Assessment (LTA) and ARCH, pre a full and thorough community assessment:
  - This is provided for patients requiring new (or increased) care at home.
  - ARI Care Management will link with ARCH and ARCH provides any care needed until the community (SDS) assessment is completed and alternative resource is found). The provision of care provided by ARCH is as assessed by Care Management through LTA prior to discharge.
  - ARCH will support enablement as identified by the Hospital at Home SSD team.
  - Medication management from ARCH is available when the patient is level MM2 or MM3

2.6.5. Hospital at Home – Virtual Community Wards

The AHSCP's Virtual Community Wards (VCWs) commenced in 2016 with an initial pilot phase and this was then rolled out more widely in Aberdeenshire. The VCWs continue to operate and they continued throughout the Covid-19 pandemic.

The model was implemented to provide co-ordinated, short-term wrap around health and care at home as an alternative to hospital admission. This was achieved by utilising existing health and social care teams and wrapping them around the existing GP practice populations.

The aim of the VCWs is to ensure that health and social care teams communicate and work closely together to identify vulnerable people earlier, put in place support at short notice, avoiding crises and acute interventions where possible.

The objectives of the VCWs are:

- Better experience for all
- Wider cross-system collaboration
- Improved organisation of care

- Good quality anticipatory care
- Reduction in emergency hospital admissions
- Reduction in emergency hospital re-admissions
- Reduction in emergency occupied bed days
- Reduction in unplanned out of hours primary care contacts

Feedback from teams includes:

- Better communication between health and social care staff and greater understanding between services about what is available within and across teams.
- Interventions upstream of traditional pathways (avoiding many unscheduled admissions that otherwise would have happened).
- Increased and quicker interventions to services within communities.
- Better use and prioritisation of resources and less duplication.
- More integrated and seamless care pathways for patients.
- Better outcomes for patients and more holistic, person-centred care.
- Better / more positive staff experience and increased trust and morale

During the Covid-19 pandemic, reporting on all our enhanced service in primary care was stopped. However our VCWs continued during this period. With the re-commencement of enhanced services and reporting, we are undertaking a review and refresh of our VCW service. We are currently collating baseline data with a view to doing a relaunch and looking at all our systems we have in place to support, enhance and also measure this valuable service. We know that each area has expanded the roles that sit within the VCW and we are seeing AHPs, Care Managers and Mental Health service involved.

Our last reporting from 2019 revealed:

- **There were 28 VCWs operating across Aberdeenshire**
- **36 months of monitoring data had been collected**
- **4.685 patients were admitted to and discharged from a VCW (to 31 March 2019)**
- Personal care / home care / nursing care were cited as the most critical interventions required to meet the needs of VCW patients

A VCW group has been established, linking closely with our AHP Lead for Hospital at Home. Data is currently being reviewed and a workshop is scheduled to take place shortly. Data is being reviewed and we are looking at measurable data. We are also lining with colleagues from USCC and LMC/GP Sub-committee who are very supportive of this direction.

2.6.6. Effective End of Life pathways

Being able to provide high quality, end of life care should be an integral part of every health care worker's role. In Aberdeenshire, we offer collaborative and holistic end of life pathways that adhere to the NICE Quality Standards.

We have 24/7 teams that include GPs, district nursing teams, MacMillan nurses, Marie Curie nurses and ARCH who all work together to ensure we can provide high

quality end of life care. We link closely with our teams in Oncology who support with the cancer line and in addition we have a 24/7 dedicated access line to our hospice at Roxburgh House who can provide to professional support to our teams.

We are fortunate to have a Cancer and Palliative Care Lead General Practitioner in Aberdeenshire who also holds a Grampian wide palliative role and represents at all the regional updates. We are about to advertise for a second role that will work alongside this colleague.

We are currently in the process of reviewing our out of hours EOL service and looking at models that can best support our patient as a wraparound service. This work is ongoing and we are liaising with other boards in regards to differing models.

2.6.7. Support for Care Homes

We continue to ensure that our Care Homes are supported by having timely access to professional support and clinical advice.

Professional support is provided by our Lead Nurse for Care Homes, along with two Location Managers with strategic leadership remits.

We have an established Clinical and Professional Oversight Group for our Care Homes and Very Sheltered Housing. The Group meets daily and has a focus on the quality of care provided, infection and prevention control and provision of appropriate expert clinical and professional support for residents and staff. There is an overview of the TURAS safety huddle and staff screening data at each meeting. Each care home is discussed, and any relevant intelligence shared by care management who contact the care homes at least twice per week.

With regards to GP support to Care Homes, there is a GP identified to support each care home and there is a regular, weekly contact for review of residents that require clinical assessment and treatment. If a resident requires assessed out with that meeting, then the GP practice will provide a service. There is also planned District Nurse contact/input to care homes. Out of hours support is provided by NHS 24 /GMEDs.

2.6.8. Increasing / Supplementing the Workforce

We continue to work with local colleges and the HEI student workforce. For example, we are working alongside Robert Gordon University to encourage AHP and Nursing students to apply for jobs on the NMAHP bank.

We are in the process of interviewing Physiotherapy students who will finish their course this December. Once all their pre-employment checks are through, we can offer them a start date at Band 4 until their HCPC registration is through.

We also intend to over-recruit if we get enough Band 5 physiotherapy recruits and we are doing this on a risk-assessed basis with gaps at other grades. The aim is to encourage our students to stay local and the risk is being shared between Aberdeenshire, Aberdeen City and Acute.

With regards to our winter funding, we have agreed that all temporary posts that were filled can be made permanent and this is being progressed. **To date, we have created in excess of 199 fte permanent posts, recruiting to 184.65 fte so far, and converted 63.11 fte temporary posts to permanent**. Where posts are not being filled, alternative ways of working are being looked at and we are over-recruiting based on turnover.

Spend from the winter funding since April on permanent staff is approximately £1.55m, with £420,000 spent on temporary staff thus far. We are forecasting an underspend in this year's funding of at least £2m from our allocation of £6.9m recurring funding.

Given the ongoing challenges in achieving staffing levels in our community hospitals, the AHSCP Chief Officer has written to NHS Grampian's Director for People and Culture to request more strategic support for health care recruitment and retention. We are looking at wider approaches such as rotations, international recruitment and potential incentives.

As highlighted in previous sections in this report, during last winter the AHSCP worked with Aberdeenshire Council to develop resilience support for the winter period, whereby local authority staff volunteered to be deployed to support health and social care in Aberdeenshire. We are revisiting our list of Aberdeenshire Council volunteers who are prepared to work in health and social care to ensure that this is up-to-date and we are in a position to request support from Aberdeenshire Council and people deployed as required.

We continue to invest in and fund local voluntary and third sector organisations to support care at home teams and provide practical support to people who are ready for discharge and across the wider community. For example, our Supported Discharge project is managed by Aberdeenshire Voluntary Action (AVA), our Third Sector Interface outlined previously.

AVA also supported health and social care last winter by recruiting and training approximately 90 volunteers to be deployed to our care homes and very sheltered housing complexes. The volunteers engaged with residents on social activities, thus freeing up AHSCP staff to devote more time to residents' care. Feedback from both volunteers and our establishments was extremely positive so we intend to use these volunteers again this winter.

2.6.9. Commissioning Additional Capacity in Care Homes

This is mostly covered in section 2.5 above. We are working with Aberdeen City on commissioning capacity in a new care home, as well as working intensively with care homes which are not open to dew referrals due to quality issues, to bring them back on stream.

We have also been working intensively with a large care home to avoid a care inspectorate de-registration. We have also recruited to two service manager posts to support care homes and maximise capacity over the next year.

3. Surge Plan 2022-2023

Outlined in Appendix 2 is a range of activity and actions underway to support our preparedness and ability to deal with a surge in demand and reduced delayed discharges, with other areas already highlighted in Winter Resilience Plan. It should be noted that our location teams are currently updating our Surge Plan so the information provided is accurate at time of writing but may be subject to change.

3.1. Community Hospitals

Key areas of focus in relation to our Community Hospitals are efforts to increase our bed base to create additional surge capacity and to undertake cross-portfolio discussions to support flexible use of capacity across teams that are co-located on hospital sites.

As can be seen from the table in Appendix 2, our overall bed base in Aberdeenshire is 166 beds. Based on our registered nursing establishment, we have the potential to increase to 187 beds.

However, this needs to be progressed on a planned basis, ensuring appropriate risk assessments are undertaken and all resources are in place, in addition to the nurse staffing to open the beds safely. Issues being considered include:

- Bed spacing guidance
- 5 Factor HAI risk assessment
- Physical bed availability and furniture
- Catering/domestic cover (see below)
- AHP staffing
- Increase in linen services
- Clinic equipment check
- Discussions with hospital medical directors
- Whether these beds are kept open or surged up and down

Appendix 2 outlines some of the actions that are being taken to progress an increase in our bed base.

3.2. Care Homes and Very Sheltered Housing

Appendix 2 reflects several areas that we are working on in relation to our Care Homes and Very Sheltered Housing (VSH) complexes, such as:

- Creating additional surge capacity
- How we might incentivise external providers to provide respite
- Ensuring Care Management have access to accurate information on bed availability so that people can be pulled through the system more efficiently
- Review of the vacant flats within our Very Sheltered Housing complexes to increase capacity

- Consideration of balance and availability of intermediate and interim care home beds.

Our teams are progressing a range of actions in relation to the above to ensure that we have an accurate picture of what is achievable this winter through to March 2023, and our action tracker will be reviewed and updated again this coming week.

It is important to remember that our internal Care Homes are **not** Nursing Homes. Doors are not necessarily locked at times, and staff are not qualified to undertake nursing tasks. Acuity of need must be considered for these placements.

Staff co-horting remains in place as this has been identified as good practice in limiting the spread of infection, along with contributing to a general reduction in falls. This involves some bedrooms being used as staff rooms but could be reviewed to support increased numbers.

It should be noted that dependency is different within our VSH complexes, where tenants should generally manage to live more independently, and they are staffed on this basis. Generally, the level of acuity is rising however, which places current staffing teams under significant pressure at times.

In considering the use of respite beds in Aberdeenshire, the AHSCP must consider how to balance this use against supporting the level of unmet need in the community with supporting flow through hospitals.

To conclude, our plan for winter preparedness – resilience and surge planning – continues to be reviewed and updated weekly and is monitored by the AHSP SMT, with a report to the IJB scheduled for December.

Pamela Milliken
Chief Officer
7 November 2022

APPENDIX 1

ABERDEENSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP WINTER RESILIENCE PLAN 2022-2023

Key Theme 1 - Prevention and Anticipating Demand		
Activity	**Current Position**	**Additional Actions Required/In Progress**
Deliver Covid & Flu Vaccinations	Vaccine programme ongoing and delivered by clinical staff across Aberdeenshire. Current focus is older adults. Current position - 22,000 Covid vaccines and 31,000 flu vaccines administered since 5th September 2022. Reassurance that vaccines are being delivered is in place.	Staff recruitment continues and staffing levels in vaccination teams being monitored.
		Recruitment of volunteers:
		> Identifying volunteers who are registered appropriately with regulatory body (i.e. NMC, GMC, HCPC or Dental Council) and training required
		> Band 3 vaccinators in post working udner protocol
		> Staff from other services / teams - identifying workforce who are trained and could support quickly if required
		> HSC students being invited to take up roles across services including vaccinations teams
Plan public safety messages with statutory partners	Awaiting the National Guidance being provided and a Grampian health and social care MID framework will be produced.	Develop AHSCP specific MID in line with the framework / guidance.
Identify and risk assess particularly vulnerable people in Aberdeenshire (PARD)	Work ongoing to develop Persons At Risk Database (PARD) - an information sharing tool which helps to identify people with particular vulnerablility during a significant incident such as adverse weather.	Training for operational managers will be rolled out in a planned approach
Create links to access early warning of adverse weather event	Key Officers / Manager signed up to receive Met Office weather guidance.	Severe weather plan being finalised
Create links with Aberdeenshire Council Roads dept. in relation to prompt clearing of designated roads and pathways.	Aberdeenshire Council's Winter Maintenance Operational Plan in place. Arrangements in place via Landscape Services team to grit carparks and footways at Council owned and operated care homes and very sheltered housing facilitities.	Information being included in AHSCP Severe Weather Plan.
	Public Health:	

Continued delivery of targeted "Stay Well Connected" and Public Health initiatives	> Aberdeenshire, Aberdeen City and Moray Public Health teams, along with NHSG Public Health Directorate have adopted the Winter Wellness framework developed by Public Health Wales.	
	> A Winter Wellness booklet, supporting web pages, a Winter Wellness pack and a range of supporting communications activity are under development - anticipated launch is first week in December 2022.	
	Live Life Aberdeenshire (Aberdeenshire Council):	
	> Exercise programmes (face-to-face & online) for people with long-term conditions	
	> Health Checks (blood pressure and BMI) at sports venues and libraries	
	> Life Life Essentials web page providing information on facilities and services that are free of charge	
	> AHP services conducting clinics in LLA facilities as alternative to a medical setting	
	Aberdeenshire Voluntary Action (AVA):	Supported Discharge Project is being delivered currently and work is ongoing with localities and NHSG in relation to information governance; awarness raising / promotion of the scheme is ongoing.
	> Community Mental Health and Wellbeing Fund - £639,000 available for community groups to bid for.	
	> Just Transition Participatory Budgeting Fund - applications currently being received related to the Warm Hub concept and resilience is one of the 8 outcomes set out in the fund priorities.	
	> Supported Discharge Project - enables people to be discharged to their own homes more quickly, with additional support in place where required.	
Reptition of "know who to turn to" messages to divert demand from hospital and prevent system from becoming overwhelmed	AHSCP linked with NHSG Communications team.	

Support for patients who have powered medical / care equipment through the winter months	Actions being confirmed via wider resilience / Care For People groups involving partners.	

Key Theme 2 - Operational Resilience		
Activity	**Current Position**	**Additional Actions Required/In Progress**
Review SMOC arrangements and ensure resilience cover over public holiday and festive period	> On-call arrangements are in place 24/7, 365 days per year and on NHS Grampian Rotawatch.	
	> Reviewing additional support arrangements across operational teams	
	> Aberdeenshire, Aberdeen City and Moray HSCPs working with NHS Grampian Head of System Flow on requirements for strategic, tactical and operational decisions for forward planning	
Ensure regular arrangements for situational awareness in place	Daily Bed Huddle, Daily Situational Update and Daily System Connect Meetings in place, along with clinical, adult social work and business oversight groups in place, lined to G-OPES levels.	
Ensure regular arrangements for access to system wide awareness and support	Arrangements in place	
Review Business Continuity plans - In-house services, Community Hospitals, Care Homes etc.	Review of Business Impact Assessments and Business Continuity Plans undertaken with new tempate being trialled.	
Support Primary Care BCP updates	In progress	
Business Continuity Plans - commissioned providers	Support to progress being provided by Contracts and Operational leads, and Oversight Groups	
Ensure communication channels are available with commissioned providers	> Procurement team providing interface between oversight groups and third sector commissioned services, providing 2-way flow of information that feeds into daily sitution reports and data return to Scottish Government	

	> Information communicated via central Information Officer	
	> Procurement supplier database providing inforing around unmet need - registering / flagging areas as early risk or performance issues, e.g. staffing	
	> Care Home and Care at Home Oversight Groups meetings weekly or more regularly depending on G-OPES level	
Review arrangements and equipment for staff working from home if required	In place	
Surge > Flow > Absence Reporting arrangements	In place and being refined	
Remind all staff of Adverse Weather Policy	In place	

Key Theme 3 - Staff Health and Wellbeing		
Activity	**Current Position**	**Additional Actions Required/In Progress**
Monitor staff absences	Monitored via daily huddles and dashboards	
Winter Safety Packs for staff	In progress - providing staff with items such as torches, foil blankets and personal alarms when lone working in the community during the winter period	
Continue with promotion of health and wellbeing initiatives and ensure there is capacity to increase these in terms of most need (linked to Theme 1)	> LLA - working closely with Penumbra and SAMH to develop a plan which can be integrated with the AHSCP, encouraging staff to participate in physical activity	
	> AVA - Care Home Volunteer project supports a number of care homes	
	> Public Health - using range of staff newsletters to communicate support services, tips and suggestions for service and team level, with team focus	

	> Health & Safety - communications in place for staff and focus this month is on preparedness for winter, e.g. winter driving, lone-working, supporting staff who may be vulnerable in their job role	
	> Wellbeing Newsletters include advice and signposting information across a range of areas including mental health, staff benefits and cost-of-living	

Key Theme 4 - Collaborative Working to Meet Increased Demand / Collaborative Working Opportunities		
Activity	**Current Position**	**Additional Actions Required/In Progress**
Communications	> Communications group set up to work closely with NHSG and other HSCPs to co-ordinate messages going out to the public on topics such as cost of living	
	> Focusing on communications about initiatives that keep people in their own homes, using joined up initiatives with partners such as Citizens Advice Bureau, SCARF and Welfare Rights Workers	
	> Welfare Rights Workers can target support for vulnerable people	
	> Ensure that there are Staff and Governance Groups maintain communication with the IJB so that the IJB are aware of decisions being taken	
Teams across services working collaboratively 24 hours a day to support patients and meet demand	> Ensuring that work is spread evenly where possible so teams are sustained	
	> Decisions related to flow linked to Grampian Operational Pressures Escalation System (G-OPES)	
Community Planning Partnership reslience plans - identifying work underway that links to the AHSCP	Aberdeenshire has 17 local GIRFEC groups and we are looking a how we link with these groups around maintaining safe services and connections at a locality level	
Standing up iniatives developed during last winter	> Winter relief emergency pool	
	> Contacting retired staff who may wish to return on temporary / relief contracts	

	> Streamlining process for requesting mutual aid from partners	
	> G-OPES framework in place and defining trigger points for pausing non-essential work to divert support to protect critical services	
Community Resilience Strategy - supporting communities to be more resilient throughout the year, including over winter	Emergency Planning Team are holding a series of workshops on resilience for community based groups with the aim of developing a strategy to support communities to be resilient throughout the year.	

AHSCP Active Workstreams contributing to Surge Capacity, Delayed Discharge and Resilience				
Area of Work	**Workstream**	**Aim of project / workstream**	**Current position**	**Additional Actions Required / In Progress**
Care Homes / Very Sheltered Housing	**Review of Very Sheltered Housing**	Review of model (vacant flats) with aim to increase capacity	AHSCP senior management team have approved this workstream	Short Life Working Group being established to review options for redesign - will report to SMT and Social Care Sustainability Board
	Interim beds	Use of interim beds in OP care homes to reduce risk for patients and avoid hospital admittance due to lack of capacity to support patients safely at home, ensuring equitable spread across Aberdeenshire	> Draft admission criteria out to Location Managers for comment	All providers will be given the opportunity to apply for the interim beds. The contract will be for this financial year and reviewed early in 2023 to allow for the usual procurement process with the IJB and Committee approval, if it is decided to continue the contracts beyond the end of March 2023.
			> Figures calculated based on 2 hours of additional carer hours per day in addition to the National Care Home Residential or Nursing rate	
			> Commercial and Procurement team are preparing the business case etc required to approach the market	
			> Discussions underway re GP Service Level Agreements for interim beds across Aberdeenshire	

			> Working in partnership with Aberdeen City HSCP where possible to ensure a consisent approach	
			> Care Home Vacancies list developed to ease burden on Care Managers having to call around care homes to establish if there are vacancies	
Social Care Sustainability	**Review of In-House Home Care**	To review the internal Home Care Service, to improve recruitment and retention and ensure the sustainability and quality of service delivery to meet unmet need and service users' outcomes	> Project Board established and workstreams confirmed - Recruitment and Retention; Home care service posts - evaluation and creation; Staff and Service Development; Review of the four pllars model; Risk Assessed Care	> Produce and implement a recruitment strategy for home care in Aberdeenshire
			> Project management support secured and work ongoing	> Develop options appraisal for the home care service structure and posts
			> Business mileage - geographical mileage claims agreed and being implemented	> Develop options appraisal for hybrid posts and cross-system working
				> Develop training plan
				> Produce a proposal for transport and admin requirements
				> Evaluation of rotas and shifts
				> Evaluation of the four pillars model
				> Risk assessed care - project charter being completed
	Rehabilitation and Enablement	To embed rehabilitation and enablement as the entry point to community health and social care services in Aberdeenshire for older people and adults with physical disabilities	> Determining the current position with delivery of the rehab and enablement action plan that was previously approved and developing an updated delivery plan	> Measure and evaluate the outcome of the project using agreed indicators
			> Providing direction and support to teams to change practice and identifying and managing barriers to implementation	

	Support at Home Framework (commissioned services)	To mobilise and maximise usage of the Support at Home Framwork in Aberdeenshire, promoting a culture of outcomes-based commissioning and weekly budgeting	> Provider engagement event held and planning further schedule of engagement events for staff and providers that promote the Framework	
			> Intelligence from Oversight Groups informing activities designed to promote the framework	
			> Ensuring engagement events for internal staff cover areas that include how we commission, outcomes-focused commissioning and weekly budgeting	
			> Ensuring that there is promotion of the Framework amongst teams that work with under-represented care groups	

Winter & Surge Plans - Cross-check with Cabinet Secretary letter of 12th October 2022	
SG requested area of focus	**Detail**
Home First	> Additional investment in ARCH service to recruit additional Care Team Co-ordinators and Responders to bolster our frailty pathway. Currently there are 2 OOH CTCs for the Fraily Pathway and ARCH has successfully recurited 17 daytime and 17 evening Responders. We are actively recruiting for a further 3 daytime and 3 evening posts.
	> ARCH will provide emergency response to assist if the person falls
	> ARCH continues to build a robust team around Fraily / Hospital at Home with the permanent recruitment of 3 Care Team Co-ordinators (CTCs) who create close links with the Discharge Hub Team in ARI, to improve communications and flow of information whilst working to discharge patients on the Fraily Pathway without delay. These posts enhance out-of-hours support already in place to ensure support for both staff and clients when needed.
	> Commenced Risk Assessed Care test of change in Stonehaven to look at Care Management reviews of people with double-up care, with a view to reducing care where possible and ensuring that double-up care is only recommended where required ot manage risk to service users and carers.

	> Further test of change in Arduthie Ward - bolstering the ward and OT input to the ward with moving and handling assessors to assess / apply risk assessed care to those requiring moving and handling; we are also offering training to the ward on risk assessed care as a way of supporting moving and handling / streamlining discharges.
Discharge without Delay (use of Planned Date of Discharge [PDD] compulsory	The use of PDDs is in place and we are maintaining close management and oversight of the delays, recognising that there is a turnover within these figures so improving turnaround on shorter delays is important, as well as resolving more complex discharges.
Criteria Led Discharge	Criteria Led Discharge has been adopted in the AHSCP as a model of discharge planning.
Hospital to Home transition teams with re-ablement focus / Discharge to Assess	> Increased capacity in our team based at Aberdeen Royal Infirmary (including Nursing, Care Management, Social Work Practitioner, Enablement Support Co-ordinator and MHO roles) to improve assessment times in and discharge planning from hospital.
	> Invested in Discharge Co-ordinators who cover weekends and enhanced our Care Management team with Team Manaer support.
	> Improving the process for discharge using the Light Touch Assessment (LTA) and ARCH, pre a full and thorough community assessment
Hospital at Home - Virtual Community Wards	> Currently undertaking a review and refresh of our VCW service, linking with colleagues from the Unscheduled Care Collaborative and LMC/GP Sub-committee
	> We have expanded the roles that sit within the VCW to include AHPs, Care Managers and Mental Health teams
Anticipatory Care Plans	> Updates provided to primary care reminding them of the importance of ACPs and KIS and also reminding them that although over 75s are an important age group, we must also remember other vulnerable populations - our mental health, learning disability and addiction patients.
	> Our renewed Care Home LES stipulates that over 90% of our care home patients should have ACPs and KIS in place and updated where necessary
Effective End of Life Pathways	> 24/7 teams in place that include GPs, district nursint teams, MacMillan Nurses, Marie Curie nurses, and ARCH wo work closely together
	> Linked with teams in Oncology who support the cancer line
	> Dedicated access line to our hospice at Roxburghe House in place who can provide prfessional support to teams
	> Currently reviewing our out of hours EOL service
Support for Care Homes	> Arrangements in place for Care Homes to have timely access to professional support and clinical advice
	> Have established Clinical and Professional Oversight Group for Care Homes and Very Sheltered Housing

	> Identifed GP support for each Care Home with regular weekely review or residents that require clinical assessment and treatment, planned District Nurse contact / input and out-of hours support provided by NHS 24 / GMED
Increasing / Supplementing the Workforce	> Continuing to work with local colleagues and the HEI student workforce - encouraging AHP and Nursing students to apply for jobs on the NMAHP bank.
	> Over-recruiting to posts where appropriate
	> With winter funding have created in excess of 199 fte permament posts (social care), recruiting to 184.65 fte so far and converted 63.11 fte temporary posts to permanent
	> Strategic support for healthcare recruitment and retention requested from NHS Grampian
	> Working with the TSI on key projects using volunteers
Commissioning Additional Capacity in Care Homes	Covered under 'AHSCP Workstreams'

APPENDIX 2 – ABERDEENSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP SURGE PLAN 2022-2023

Service	Description	Area	Current level	What is acheivable?	Risks / issues identified	Action being taken to progress
Community Hospitals	**Additional surge capacity (increased bed base)**	**Total - Aberdeenshire**	**154**	**187 (based on registered nursing est.)**	Breakdown by site below. Needs to be undertaken on a planned basis, ensuring appropriate risk assessments undertaken and all resources in place, in addition to nurse staffing to open beds safely and key issues considered.	Identifying additional support resources needed for each bed; clarifying bed spacing; developing SOP to guide SMOC decision-making in response to whole system requests - key steps and what to consider in decision making, risk asessment / risk tolerance and support for staff on shift; exploring winter funding options to support provision of domestic staff
		Aboyne	12	14	Temp closure due to staffing issues; establishment requires review	
		Arduthie	18	19	All single rooms. Day cases could be provided in MI room.	
		Ashcroft	10	10	All single rooms, no issues.	
		Banff	18	20	All single rooms. Increase to 20 beds if establishment allowed (renal ward has 2). New starts due toon. Requires day case space.	

		Brucklay	12	12	To remain at 12 beds.	
		Donbank	16	18	Could go to 18 beds if IP&C agree. Only 16 physical beds in the ward.	
		Morven	14	18	Currently up to 16 beds with support from Aboyne staff. Only 16 physical beds in ward.	
		Philorth	18	20	Staffing would allow an increase of 2 beds. Requires day case space.	
		Rothieden	8	8	Due to ongoing estates work, beds capped at 8. Due to roof being fixed the ward will have to close (date tbc). Upon completion of roof works, capacity to increase to 18. Establishment requires review.	Alternative bed base being progressed.
		Scolty	0	12	Closed at present	

		Summers	16	22	To remain at 16 beds as per IP&C guidance - bed spacing and ventilation was a factor in outbreaks. Control measures in place. Staffing would allow an increase to 20 but this would be against bed spacing guidance. Increase to 22 max only if derogation against IP&C.	
		Turriff	12	14	Control measues in place. Could increase by 2 but this would be against bed spacing guidance. Due to ongoing estates work, beds are capped at 12. Capacity to increase to 14 once new room is completed.	
	Cross portfolio discussions to support flexible use of capacity across teams co-located on hospital sites	**Peterhead**	n/a	n/a		Initiating discussions with cross-system colleagues (initial focus on maternity)
		Shire-wide (potential)	n/a	n/a		Requesting support from Head of System Flow

Care Homes / Very Sheltered Housing	**Additional surge capacity**	Shire-wide	Breakdown by site below	As per below	Staffing dependent on the needs of the person; Internal residential homes are not nursing homes and staff are not qualified to undertake nursing tasks so acuity of need must be considered; Staff cohorting is good practice to limit spread of infection but could be reviewed to support increased numbers; Dependency different in VSH and staffed on basis that tenants should generally manage to live more independently; Consideration of how we can use VSH resource on Shire-wide basis to support those in the community with no care / reduce unmet need.	Risk assess and implement policy / process for supporting homes to revert from staff cohorting practice where other more significant risks need to be mitigated in surge situation.
		Allachburn - Aboyne		1 additional space	Staffing is not at an optimal level	
		Edenholme - Stonehaven			Unable to staff wing.	Plan being submitted to SMT

		Dalvenie Gardens - Banchory	24 flats	1 additional respite flat		
		Bennachie View		Potential interim beds (12)	Number of beds closed due to staffing issues.	Identifying what is required to re-open beds - work is ongoing to map the staffing compliment needed to fill the 12 vacant beds. Discussions are ongoing through the nursing directorate in relation to whether NHS employees can be utilised.
		Durnhythe - Portsoy	18	35	Major refurbishment works remain ongoing (predicted completion in Dec). There are 18 beds at present, but plans are in place to increase from the end of December when work is completed. Full capacity is 35 but additional staff would need to be recruited to accommodate this number of individuals.	

		Faithlie - Fraserburgh	20	33	Flooring work nearing completion. Care Maangement have started identifying suitable potential resisents. Currently 20 beds filled. Faithlie has 35 bedrooms but at least 2 of these are not fit for purpose as they are not large enough for residents to be supported by staff or have equipment in them. Staffing would need to be increased when numbers get into high 20s.	
		Grangepark - Peterhead	29	30	1 additional bedroom planned to be available from November onwards.	

		Doocot View - Banff			Respite room currently being used as staff area due to cohorting for IP&C. Currently checking whether this is till be required and if not, work to provide a respite room again. Furniture required for room in order to provide respite. Complex is generally full. Waiting list in place with robust allocation system so vacancies are quickly filled.	
		Ythanvale - Ellon		Up to 8 beds as interim or respite		

		Jarvis Court - Fraserburgh			Work currently underway with Housing Association to expore the use of the respite flat as a more permanent bed option. This is currently being used as a staff room to support cohorting. Appropriate furniture would need to be obtained. Staff remains and issue and recrutiment slow. Only 2 staff per shift for 22 flats and currently 6 tenants require double-up care. Staffing numbers originally for tenants would could predominantly self care. Would need staff vacancies filled to increase capacity. Team has been under pressure for a significant period.	

	Incentivise providers to provide respite	Shire-wide		Shire wide - 1340 beds; 52 vacant beds - 17 available for occupation; 2 care homes closed to admission due to contractual non-compliance - 8 beds unavailable; 3 care homes operating under phased admissions at a rate of 1 per fortnight; 27 beds unavailable due ot phased admissions - due to 1 care home being in contractual non-compliance for a long period of		Cost analysis of incentives to private providers for respite services. Paper being sumbitted to SMT.

				time and the vacancies at this care home are building up.		
	Care Management access to accurate information on bed availability	Shire-wide			Should be completed on TURAS.	Reminder issued to providers re need to complete TURAS safety huddle on a daily basis. Revert back to contracts team re providers who are in non-compliance.

	Review of Very Sheltered Housing	Shire-wide			Review of model (vacant flats) with aim to increase capacity	Paper going to SMT re review of VSH model to increase capacity
	Consideration of intermediate vs interim beds	Shire-wide		Equitable spread across Shire	Using interim beds to reduce risk for patient and avoid hospital admittance due to lack of capacity to support patient safely at home. Intermediate care beds would require a review of current staffing models. 10 beds at Rosewell for interim placement to LTC. Blockage of beds, patients awaiting LTC. Hybrid - not within own locality. Would need to monitor costs incurred and equality of service provided.	Commissioning and Procurement team preparing to go out to market for interim care home beds.