APPENDIX 1

Aberdeenshire Health and Social Care Partnership (AHSCP)

Report to Strategic Planning Group – 12th December 2023

Title: Social Care Sustainability Programme Board Update

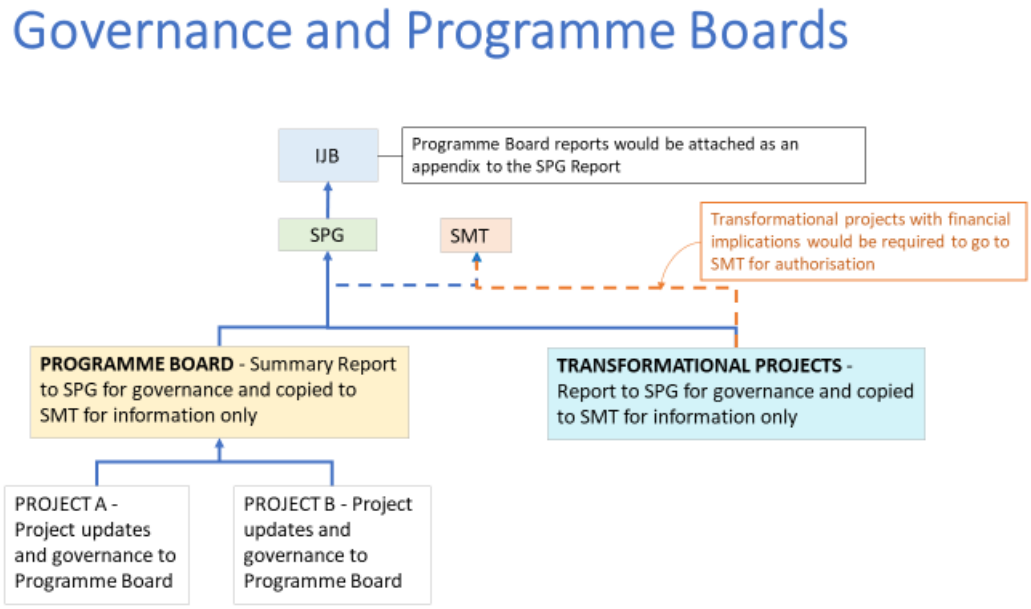
1 Purpose of report

1.1 To update the Strategic Planning Group (SPG) on the work of the Social Care Sustainability Programme, noting areas of progress and issues for escalation.

2 Background

2.1 The Social Care Sustainability Programme Board was established with the overarching aim: '*To reduce the level of unmet need in social care services for residents in Aberdeenshire and improve outcomes and experience for those who use social care services and for the staff delivering those services … by [c]reating self-improving and sustainable social care services through cultural, systems and transformational change.'*

2.2 The Board is chaired by Leigh Jolly, Chief Social Work Officer with representation from across the HSCP and responsibility for monitoring progress across a number of interdependent workstreams contributing towards delivery of the above overarching aim. As per the governance reporting structure outlined below, the Programme Board has a reporting line to the Strategic Planning Group to provide an overview of the key issues and any escalations arising from the various projects. This report provides an update following the Programme Board's last meeting on 22 November 2023.



3 Discussion

3.1 The Programme Board continues to be mindful of outputs and improvement areas identified from its annual review workshop in July 2023 to support it to work as effectively as possible. Following discussion at the previous Programme Board particular consideration is being given to how projects can embed the Getting It Right For Everyone (GIRFE) principles through implementation and to further develop Key Performance Indicators (KPIs) moving forward.

3.2 Two detailed project updates were presented and considered by the Programme Board for the In-House Care at Home – The Future and Rehab and Enablement workstreams, attached at Appendices 1 and 2 respectively, with items of note summarised below.

3.3 In-House Care at Home – The Future

3.3.1 Two specific proposals were presented for approval by the Programme Board. The first proposal covered the request to extend existing transformational funding for 1 x 0.6fte Home Care Manager post for backfill to release the workstreams leads (distributed into 2 days for Central, 1 day for South). Current budgetary pressures were highlighted. Accordingly the Programme Board was only able to approve in principle at this stage subject to further information regarding available budget, but noted the significant risks to the project and other parts of the system should this backfill not be funded given the momentum and significant progress made to date.

3.3.2 The second proposal for the ARCH service to move from external hired vans to hybrid vehicles with maintenance to be fully covered by Fleet Services was agreed noting the small spend to save efficiencies but also benefits for staff time, resilience and wellbeing.

3.4 Rehab and Enablement (R&E)

3.4.1 Consideration was given to the factors impacting on R&E becoming fully embedded in practice. There was support for further discussion around the proposed development of a 6-week intake assessment pathway for new referrals to care management.

3.4.2 The project was noted as being at a stage where support to transition to 'business as usual' would be the objective from early 2024, retaining project officer support to Location Managers to embed R&E locally and complete work in progress. The Programme Board was in agreement with the request to be made via Partnership Managers to look at funding for the Project Officer posts coming from team budgets on the understanding that transformational funding was not available, with exit strategies to be agreed if required.

3.5 Updates were noted in relation to the following additional workstreams:

3.5.1 **Effective Support for Carers and Self-Directed Support** – Following previous updates whereby the Programme Board had noted that delivery of this project

would be delayed until team posts had been recruited to, it was confirmed that key posts within the Training and Development team had now been filled, with the SDS and Carers Team Leader also now in the process of being advertised.

3.5.2 **Review of Very Sheltered Housing** – It was noted and agreed that this project would require to be paused whilst local operational issues are addressed before further options appraisal could continue.

3.6 The continued progress and significant work of project teams was acknowledged by the Programme Board recognising that this was being undertaken against a backdrop of continuing operational demands and pressures.

4 Recommendations

4.1 To note and provide comment on the progress of the Social Care Sustainability Programme Board and implementation of projects under the programme's remit.

4.2 To consider the risks escalated by the Programme Board should ongoing funding not be secured for continued progress of the In-House Care at Home and Rehab and Enablement projects.

Report submitted by:
Angela MacLeod, (Interim) Strategy and Transformation Manager

On behalf of Leigh Jolly, Chair, Social Care Sustainability Programme Board

Date: 07 December 2023

Appendices
Appendix 1 – Project Update for In-House Care at Home – The Future
Appendix 2 – Project Update for Rehabilitation and Enablement

Appendix 1

Aberdeenshire Health & Social Care Partnership

PROJECT UPDATE REPORT

Submitted by: Janine Howie			**Date of Report: 22 November 2023**	
Project title: In- House Care at Home – The Future	**Project ID Number:** SDP 23-25_DEC22-01	**Priority workstream (if applicable):** <insert>	**RAG status for current phase***	

Project phase

State estimated completion date for phase and highlight current phase that RAG status applies to

Initiation **	**Planning****	**Implementation****	**Close****
Completed	**31st August 2022**	**Some workstreams are at implementation some are still in the planning stage.**	<insert estimated completion date>

Which strategic priority does the project align to?

Prevention and early intervention	Reshaping care	Engagement	Effective use of resources	Tackling inequalities and public protection

Brief description of the project

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.

This project aligns with the AHSCP strategic priority of Reshaping Care. The project will consist of the following workstreams to address the challenges identified:

- Recruitment and Retention.
- Home care service posts – evaluation and creation.

- Staff and Service Development
- Review of the four pillars model
- Risk Assessed Care

Project update:

- Project Board meeting held on 27th October 2023.
- **Home care service posts evaluation and creation workstream** – Care Team Support Officers posts have gone out to advert recruiting to posts in each of North, Central and South Aberdeenshire
- Uniforms trialling ongoing with 20 Home Care staff with feedback being collated via a questionnaire.
- Proposal presented to the board to move from external hired vans to Toyota hybrid vehicles which will mean Fleet are in full control of all maintenance. Proposed move works out cheaper per year than hire and repair of current vehicles despite increased initial outlay being higher.
- Ongoing work around comfort breaks as some venues unsuitable and exploring options to access GP surgeries or other health buildings located across Aberdeenshire.
- **4 Pillars workstream** – workshop took place in August. Information collated has been broken down into themes for further action under headings of Location Manager Attention, Budget Implications, Themes, Commissioning Team. Further development planned once this has been fully complete and analysed.
- **Staff and Service Development workstream** – training has been sent to Home Care Managers and ARCH manager for discussion.
- Home care managers considering business case for a trainer for the service due to support for training requirements needed.
- **Recruitment and Retention workstream** – Workstream lead is linking with Aberdeen University and RGU to have taster sessions/internships for fixed-term/relief contracts out with term time.
- Also creating video presentation to link with Vacancies and school presentations.
- **Risk assessed care workstream** – pilot at Arduthie complete. Over 6-month period, 6 people had packages reduced from 2 carers, 4 times per day to a combination of 1 carer and equipment which each save 1456 carer hours per year. In addition, a 7th person was able to achieve their wish to go home to die with the addition of equipment and techniques to meet their needs.
- **Monthly data** – overall number of vacant posts were down in September compared to August. There were 66 posts advertised in September with 129 applicants and 2 posts offered. There was a slight increase in the number of people leaving Home care posts in September compared to August.

Key achievements	**Case Study / Testimonials – from Risk Assessed Care Workstream:**

<table>
<tr><td></td><td>February 2023: two patients seen on the ward. One required two carers four times a day, but this reduced to one carer for times a day. This gives a saving of £21900 per year (based on a carer costing £15 per hour)

March 2023: One referral – unable to place as Care Homes unable to meet needs. Assessed and alternative equipment provided. Care Home placement found.</td></tr>
<tr><td>Deliverables<table><tr><td>Produce an initial training plan.</td></tr><tr><td>Produce a proposal for transport and admin requirements.</td></tr><tr><td>Evaluation of rotas and shifts.</td></tr><tr><td>Scoping of the evaluation of the four pillars model.</td></tr><tr><td>Produce and implement an Aberdeenshire recruitment strategy.</td></tr><tr><td>Produce an options appraisal for the home care service structure and posts.</td></tr><tr><td>Produce an options appraisal for hybrid posts and cross system working.</td></tr><tr><td>Produce an initial Risk Assessed Care Training Plan</td></tr><tr><td>Produce evidence of budget savings</td></tr></table></td><td>Benefits<table><tr><td>A decrease in vacancies.</td></tr><tr><td>A decreasing trend of unmet care need.</td></tr><tr><td>Increasing trend in staff retention</td></tr><tr><td>Increased staff well-being.</td></tr><tr><td>Staff feedback about training.</td></tr><tr><td>Increase in positive reputation.</td></tr></table></td></tr>
<tr><td>Additional comments</td><td>Equalities</td></tr>
</table>

	Equality Outcome 1: We will enable people to have improved health and wellbeing as a result of access to person-centred, holistic services. **Equality Outcome 2**: People will be supported to look after their health and wellbeing and live well by accessing advice and support that is relevant to their needs. **Equality Outcome 3:** Through meaningful engagement, our health and social care services will understand and reflect the needs of their diverse service users. **Equality Outcome 4:** We will enable effective communication between patients/service users and staff to ensure person-centred care is provided.
Challenges and support Capacity of operational managers to progress the project.	**Engagement** Union rep on the Board has the opportunity to ask questions and is delighted with progress especially with the creation of the new post.

Appendix 2

Aberdeenshire Health & Social Care Partnership

PROJECT UPDATE REPORT

Submitted by: R&E Project team on behalf of Shona Campbell			**Date of Report: 20/11//2023**	
Project title: Rehabilitation and Enablement	**Project ID Number:** SDP22-25_Dec22_21	**Priority workstream (if applicable):** Reshaping Care	**RAG status for current phase***	Amber

Project phase *State estimated completion date for phase and highlight current phase that RAG status applies to*			
Initiation ** 05/09/2022	**Planning**** 16/02/2023	**Implementation**** 03/11/2023	**Close**** 29/12/2023

Which strategic priority does the project align to? <highlight below>				
Prevention and early intervention	Reshaping care	Engagement	Effective use of resources	Tackling inequalities and public protection

Brief description of the project

The aim of the project is to embed rehabilitation and enablement as the entry point to community health & social care services in Aberdeenshire for older people and adults with physical disabilities. The key objectives are to:

- Determine the current position with delivery of the rehabilitation and enablement action plan approved in 2015
- Develop an updated action plan
- Provide direction and support to teams to change practice
- Identify and manage barriers to realisation of the intended benefits
- Measure and evaluate the outcome of the project using agreed indicators

Project update as of 17/11/2023

- **Phase 1 - Hospital Discharges**: Project Officers continue to offer support to Community Hospital MDTs and the Discharge Hub to embed R & E as the default pathway on discharge (exclusions – end of life care and long-term care).
- **Phase 2 - Virtual Community Ward (VCW) & Phase 3 – Community Referrals:** These phases have been combined with greater focus on community referrals due to the natural impact of these upon VCWs and multidisciplinary teams. We are working closely with our community teams to encourage and promote a rehabilitation and enablement approach and gain a greater insight into

challenges our teams face. Data collection is underway to help us better understand the reasons why a service user may go down a particular pathway.

- **Local sub-groups**: Subgroups take place regularly across all Aberdeenshire areas and are facilitated by the Project Officers. These allow local teams to share examples of good practice and success stories, as well as identifying any barriers which impact on the ability of the teams to take a rehabilitation and enablement approach with service users. Barriers which cannot be resolved at a local level are escalated to the Leadership Group for discussion. Subgroups also provide opportunities to welcome guest speakers to enhance knowledge of third sector supports and other services within local areas.
- **Training**: Following an evaluation of current training resources, a short life working group was formed consisting of staff from a variety of professions within the AHSCP. The group have put forward recommendations for areas of development as follows:
    - Competencies - A final meeting with the short life working group is scheduled for 29th November and the proposed competencies will then go out for consultation and aim to have agreement at the next Leadership Group meeting on 7th December.
    - Terminology - Terminology and definitions have been agreed and are now in the updated version of the Rehabilitation and Enablement Support Plan template (to be issued shortly) and included in the ALDO training (updates in progress).
    - Online Training - Project Officers are working with ALDO to update the training including documentation, splitting into modules and hosting on TURAS. To date the course has been refreshed with new image tiles and includes the terminology list. Pockets of local training across Aberdeenshire continues such as home carer shadowing of Occupational Therapists.
- **Communications:**
    - Leaflet – the updated R&E leaflet and posters are now printed and being distributed to relevant teams. Email sent to Leadership Group to seek approval for distribution of leaflet to GPs, to enable them to give to patients at the point of referral and to provide clear expectations of the service that will be offered when referring for support at home.
    - Web pages – updates to both internal and external webpages are in progress. These updates position rehabilitation and enablement as the way our community teams work rather than as an additional service or project. We have framed this messaging in line with the LifeCurve.
    - Project Briefing 2 issued in September and Briefing 3 will be issued early December.
- **Digital Platform Project**: A project team has been identified and development of the project charter is in progress. This has been delayed due to lack of capacity and long-term sickness absence within the team.
- **Data for evaluation**: The project team are working with colleagues in Carefirst and Cygnum to expand the data available from Carefirst to enable the reporting of outcomes as well as activity. Work is underway to adapt an existing Carefirst form to include data that is currently being captured manually by teams. This will also be factored into Eclipse. Discussions with Carefirst, Finance and SDS on streamlining the process to record the financial process of R&E, such as FISs, meeting scheduled 5th December.
- **Home Care Capacity**: Lack of capacity for in-house home care continues to remain a limiting factor for the implementation of rehabilitation and enablement. This has been a continuous challenge due to staffing issues and external agency availability to take on care packages.

- **Medicines Management**: Lack of community pharmacy capacity for provision of compliance aids has been highlighted by our teams as a barrier. Discussions around this have also identified a broader issue about how we support people to regain and maintain their ability to manage their own medication. Via the subgroups our project officers have established that this presents an issue across all areas. This is something we are encouraging our teams to consider in greater detail when completing their assessments and setting goals for service users. Project officers have met with the lead Pharmacist for AHSCP for discussions around the current barriers relating to medication and this will be followed up at the local subgroups. Shona plans to meet with SCNs from our community hospitals to explore what can be done to support with rehabilitation for medication management prior to discharge.
- **Documentation**: The template for the Rehabilitation and Enablement Support Plan has been updated to include terminology and definitions. Following feedback from carers the Daily Progress Record template has been modified and the Project team are developing worked examples of these for inclusion in training modules.

Key achievements:

- Leadership Group established and currently meeting every second month with representation from operational teams and professional groups.
- Project Officers appointed and started in post.
- Local sub-groups established and meeting regularly. Issues not able to be resolved at the subgroups are being escalated to the Leadership Group for discussion/action.
- Training needs analysis completed and subgroup convened. Key areas for development identified and approved by Leadership Group.
- Competency development workshop held with core and specific competencies, short working group formed and aim to have approved by Leadership Group in December.
- Communications plan agreed and added to project tracker.
- Briefing 2 issued in September, with Briefing 3 planned for issue in December.
- Digital Project Mandate approved by SMT.

Case Study / Testimonials / Data:

- R&E data recently provided to share with Scottish Government. highlighting a sample of R&E cases across Aberdeenshire in 2023.
- R&E data from Carefirst is reported each month (September's report attached), this data is not completely accurate due to the different ways teams are working / recording on Carefirst. Work in progress with Carefirst to obtain more accurate data moving forward.

  2023 09 30 R&E Data.docx

  A target was set for 20% of referrals to care management going down the R & E pathway by March 2024. Percentages fluctuate month to month but comparing averages September 2021 - August 2022 (7.7%) with September 2022 - August 2023 (11.7%) show moving in the right direction.
- Community Hospital data has been collected during 2023, some areas have not submitted, Project Officers working with teams to address this.

 Project Mandate - Digital Platforms.docx • R&E terminology and definitions list identified and agreed, now on ALDO and included in new Support Plan template. • R&E leaflet updated and posters printed, distributed to teams across Aberdeenshire.	
Deliverables • Report on the current state and updated delivery plan February 2023 • Embed R & E as default pathway on discharge from hospital for older people and those with physical disability (exclusions end of life care and long-term care) • Embed R & E as default pathway on admission to Virtual Community Wards for older people and those with physical disability (exclusions as above) • Embed R & E as default pathway for all new requests for provision of care at home for older people and those with physical disability (exclusions as above) • Identify team training, development and support needs and develop resources to meet these needs • Identify stakeholder information needs and develop resources to meet these needs • Evidence the impact of rehabilitation and enablement at an individual and service level	**Benefits** • Team members, service users and their families understand the strategic direction and the benefits of rehabilitation and enablement • Multi-disciplinary team members are competent and confident to implement rehabilitation and enablement in practice • Multi-disciplinary team members work effectively and efficiently as a team to support service users to achieve agreed outcomes • Service users are supported to regain and maintain their abilities and independence, with reduced dependence on formal care services • Increased demand for care services met within existing resource • Clear understanding of the impact of rehabilitation and enablement at an individual and service level to inform future care at home demand and capacity analysis and workforce planning.
Additional comments	**Equalities** ***Highlight any areas in which the project supports the mainstreaming of equalities and contributes to the delivery of the Equalities outcomes agreed for 2020-2024***

Challenges and support	Engagement
I would like to ask for consideration and support for three recommendations/requests: 1. There continue to be challenges and barriers to implementing R & E in practice across Aberdeenshire and they all affect teams to a greater or lesser extent. None of our teams have fully embedded in practice that presumption for R & E first. The main issues surfaced by the Project Team are: • Belief that R & E is only for people who can be supported back to full independence after 6 weeks • Assumption that people have reached their maximum level of function and independence within the community hospital setting • Capacity of in-house home care to pick up new care packages (so service is commissioned from another provider under SDS instead) • Capacity of team members to act as key worker and to undertake review and adjustment of support plan in a timely manner • Lack of rehabilitation for management of medication in hospital and in the community • Wider system and public expectations about the service that will be provided The Project Officers have established positive relationships with teams through their local sub-groups and the project has gained momentum during this year. Our belief is that teams also need direction and support from their operational managers to address the specific challenges in their location and that we should begin the process of transitioning from "project" to "business as usual" in the first quarter of 2024. I would like to retain the project officers in post after the agreed	***What engagement outcomes is the project seeking to achieve? You can refer to VOiCE Software for further guidance on developing engagement outcomes.***

funding ends in December 2023 to support location managers in embedding R & E locally and to complete work in progress. I am aware that further funding cannot be provided through the Transformation budget. 2. The Digital Project has stalled due to lack of capacity resulting from unforeseen circumstances. James Black, Digital Project Manager, has been consulted and has agreed in principle to take the lead for this project. 3. Rehabilitation and enablement is currently recorded as one of three pathway options following care management assessment. The others are emergency interim support and self-directed support. Discussion with care management team managers, SDS team, Finance team and Carefirst colleagues indicate that moving to a 6 week "intake" assessment period for all referrals would support the embedding of rehabilitation and enablement in practice. Board members are asked to: • Consider whether support can be provided from operational teams/budgets to enable the project officers to continue in post for a further fixed period of 6 months • Approve the separation of the Digital Project from the Rehabilitation and Enablement Project and consider appropriate governance arrangements for this project • Approve further work by the project team to explore the development of a 6-week intake assessment pathway for new referrals to care management	

***RAG status explanations**

Green	**On track - no forecast issues with achieving project aims and milestones**
Amber	**Some issues but manageable by project team**
Red	**Significant issues requiring escalation to the SPG/SMT**

****Explanation of project phases and typical activities**

Initiation – This stage involves identifying the need for the project. Key activities may include forming a project group, undertaking research to investigate and understand the problem, data gathering, undertaking an options appraisal of possible solutions, identifying high level benefits, agreeing on a solution and developing a draft project charter.

Planning – In this stage the project solution is developed in detail. Key activities may include more detailed benefits mapping, risk planning, resource planning (e.g. staff and funding), communication and engagement planning, project planning and defining of key deliverables.

Implementation – In this stage the project plan is put into action. Key activities may include undertaking project tasks, monitoring progress and performance of the project, managing problems/change requests and executing the communication and engagement plan.

Close – In this stage the project is fully embedded into business as usual (BAU). Key activities may include handing over the project, releasing project resources, communicating project closure to key stakeholders, undertaking a review to capture lessons learnt and developing a control plan to monitor performance. The review of project benefits (Benefits Realisation) should also be undertaken at an appropriate time after the project has been closed, to measure the overall benefits of the project.