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Scottish Borders
Health and Social Care
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A meeting of the **Health & Social Care Integration Joint Board** will be held on **Wednesday, 8th May, 2019** at **10.00 am** in Committee Rooms 2 & 3, SBC HQ

AGENDA

Time	No		Lead	Paper
10.00	**1**	**ANNOUNCEMENTS & APOLOGIES**	**Chair**	Verbal
10.01	**2**	**DECLARATIONS OF INTEREST**	**Chair**	Verbal
10.03	**3**	**MINUTES OF PREVIOUS MEETING**	**Chair**	(Pages 3 - 8)
10.05	**4**	**MATTERS ARISING** Action Tracker	**Chair**	(Pages 9 - 12)
10.10	**5**	**CHIEF OFFICER'S REPORT**	**Chief Officer**	(Pages 13 - 16)
10.15	**6**	**FOR DECISION**		
	6.1	Strata Pathways TM - Proposed extension of the project	**Chief Officer**	(Pages 17 - 38)
	6.2	Primary Care Improvement Plan (April 2019 - March 2020)	**General Manager, Primary and Community Services; Chief Officer**	
	6.3	Integration Joint Board 2019/20 Financial Plan	**Chief Finance Officer**	(Pages 39 - 48)
	6.4	Outcomes from Development Session	**Chief Officer**	Presentation

	6.5	Ministerial Strategic Group for Health and Community Care - Integration Review	**Chief Officer**	(Pages 49 - 78)
11.30	**7**	**FOR NOTING**		
	7.1	NHS Borders 2018/19 Festive Period Report	**Hospital Manager**	(Pages 79 - 86)
	7.2	Monitoring of Integration Joint Budget 2018/19	**Chief Financial Officer**	Verbal
	7.3	Strategic Planning Group Report	**Chief Officer**	(Pages 87 - 88)
	7.4	Eildon Medical Practice Update	**Chief Officer**	Verbal
11.55	**8**	**ANY OTHER BUSINESS**	**Chair**	
12.00	**9**	**DATE AND TIME OF NEXT MEETING** Wednesday 12th June 2019 at 10.00am in the Council Chamber, Council Headquarters.	**Chair**	

Minutes of a meeting of the Health & Social Care **Integration Joint Board** held on Monday 25 February 2019 at 2.00pm in the Council Chamber, Scottish Borders Council.

Present:	(v) Cllr S Haslam	(v) Dr S Mather (Chair)
	(v) Cllr J Greenwell	(v) Mr M Dickson
	(v) Cllr E Thornton-Nicol	(v) Mrs K Hamilton
	(v) Cllr T Weatherston	
	Mrs J Smith	Dr C Sharp
	Mr D Bell	Mr J McLaren
	Mr S Easingwood	Mr M Porteous
	Ms L Gallacher	Mr R McCulloch-Graham
In Attendance:	Miss I Bishop	Ms S Henderson
	Mrs T Logan	Mrs S Holmes
	Mr S Burt	Ms S Horan

1. Apologies and Announcements

Apologies had been received from Cllr David Parker, Mr John Raine, Mr Tris Taylor, Mrs Nicky Berry, Dr Angus McVean, Mrs Jane Davidson and Mrs Carol Gillie.

The Chair confirmed the meeting was quorate.

The Chair welcomed Ms Sarah Horan to the meeting who was deputising for Mrs Nicky Berry.

The Chair welcomed a range of other attendees to the meeting including Mr Simon Burt and Ms Susan Henderson.

The Chair welcomed members of the public to the meeting.

2. Declarations of Interest

The Chair sought any verbal declarations of interest pertaining to items on the agenda.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the verbal declaration of Cllr Elaine Thornton-Nicol as being registered with the Eildon Medical Practice.

3. Minutes of Previous Meeting

The minutes of the previous meeting of the Health & Social Care Integration Joint Board held on 28 January 2019 were approved.

4. Matters Arising

4.1 Action 34: Alcohol & Drug Partnership: Mr Rob McCulloch-Graham advised that an update paper had been shared with the Integration Joint Board members privately as it contained commercially sensitive information. He advised there was no further update.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the action tracker.

5. Chief Officer's Report

Mr Robert McCulloch-Graham gave an overview of the content of the report and highlighted several key elements including: winter plan pressures; Hospital to Home services; step down facilities and funding of Garden View. He advised that a locality working groups summit had been held and a continuation of their development was being taken forward. They would also be utilised to provide service user representation on the Health & Social Care Integration Joint Board and Strategic Planning Group. He also commented on the on-going work in regard to Meridian Clinical Productivity and patient pathways out of hospital, the primary care improvement plan, and the development session being planned for 4 March.

Mrs Karen Hamilton welcomed the news that the Hospital to Home initiative was working well. Mr McCulloch-Graham advised that he turnaround time for Hospital to Home had been estimated at 6 weeks but was currently operating at 3-4 weeks.

Mr John McLaren sought assurance on supporting staff groups through the Meridian process. Mr McCulloch-Graham commented that the Meridian work was being linked to the Programme Management Office and reporting programme. He assured the Board that partnership were fully involved.

Mr John McLaren enquired about the forthcoming Development session and utilisation of the Prof John Bolton work. Mr McCulloch-Graham commented that several reports had been commissioned over the previous 2-3 years including the Prof John Bolton and Ann Hendry reports. He assured the Board that those reports had been used to inform practice and some of the recommendations had been taken forward such as the step down facilities recommendations which had assisted in formulating Hospital to Home and re-ablement facilities. The Development session would look back on the progress made and then forward to what should be achieved to benefit the care of the local population.

Mr Malcolm Dickson welcomed the assurance on system improvement through the Meridien methodology and enquired if there was a shared understanding in regard to the provision of high quality care verses quicker care. Mr McCulloch-Graham commented that mechanisms would be put in place to recognise a shared understanding.

Further discussion focused on the use of surge beds during the winter period and provision of link workers for mental health services through Action 15 funding.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the report.

6. Chairs Action - Integrated Care Fund Update

Cllr Shona Haslam commented that the start date had slipped in regard to the COPD project and she sought an update report for the next meeting.

Mr Mike Porteous commented that at the time of writing the paper the funding of the Transport hub had been tangled up with various funding streams. He assured the Board that the funding had been spent in accordance with the plan, however he was unable at that time to provide a definitive timeline to advise if the funding had been allocated for 1, 2 or 3 years.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** ratified Chairs Action which was to approve the recommendation to extend and fund 3 live projects to establish a Discharge Programme of work for future evaluation.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** ratified Chairs Action which was to approve the funding of the Community Outreach Team.

7. Chairs Actions – Strategic Risk Register

The Chair reminded the Board that at the previous meeting it had agreed that if there were any other issues identified they be communicated directly to Jill Stacey, Chief Internal Auditor.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** ratified Chairs Action which was to agree to receive a review of the IJB Strategic Risk Register on a six monthly basis.

8. Chairs Action – Eildon Medical Practice

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** ratified Chairs Action which was to seek a report on the next stage in the process, a report on all of the options considered and the final decision route to be taken.

9. Set Up of Shared Lives Scheme

Mr Simon Burt, General Manager for Mental Health & Learning Disability services gave an overview of the paper and highlighted the older adults fostering scheme for those with learning disabilities. He advised that it was an alternative to living in residential care and traditional respite care and also worked well for older adults.

Cllr Shona Haslam enquired how the impact of the model on individuals would be evaluated. Ms Susan Henderson advised that Shared Lives Plus had an outcome e-tool for evaluation purposes. The full business case contained the detail as well as a charter for the individual and the carers. In terms of baseline the outcomes tools would also be used.

Mrs Jenny Smith enquired if a similar scheme had been used in Borders previously. Mr Burt advised that previously a scheme had been managed in-house which had failed. The difference this time was in commissioning an external provider who were experts to provide the service.

Mr John McLaren asked what Plan B would be if the Board did not agree the proposal. Mr Burt commented that there were already 8 people living in foster care and the alternative for those people would be a more expensive option and likely to be detrimental to their choice.

Mr Malcolm Dickson enquired how success would be measured and who would own any savings. Mr Rob McCulloch-Graham commented that the savings would be to both the IJB in terms of commissioning and Scottish Borders Council who would deliver the service in budget.

Further discussion focused on current expensive out of area placements and repatriation back to Borders in line with the Learning Disability commissioning strategy; supporting people to have more choice if they require to move from their family home; reduction in stress on families visiting relatives out of area; average costs and tailoring the commissioning contract; and commitment that further funding would not be requested at the end of the proposal in 2 years time as it would be mainstreamed.

The Chair commented that the proposal appeared to be a good use of the Integrated Care Fund (ICF) resource resulting in a change for the better for the client group. The ICF was set up as a lever for change and the proposal was bringing that to fruition.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved ICF funding of £117,835.20 start up costs split over 2 financial years: 2019/20 and 2020/21. Ongoing funding will be met within the existing commissioning budget

Cllr Elaine Thornton-Nicol left the meeting.
Tracey Logan left the meeting.

10. Ministerial Strategic Group Review of Progress with Integration of Health & Social Care

Mr Rob McCulloch-Graham gave an overview of the content of the paper.

Cllr Tom Weatherstone noted that the paper suggested the IJB had to develop a reserves policy and he enquired how achievable that would be. Mr Mike Porteous commented that the vision was to try and create a reserve in the accounts in the current year and that would be made up of specified sums for specific things to spend on in the next financial year. He advised that a generic reserve was highly unlikely. If a reserve was built up it could also build up a negative reserve and he advised that at least one other IJB currently had a negative reserve, and his suggestion was to try and build a reserve in year possible.

Further discussion focused on the formation of the action plan with input from the third sector and locality working groups; and identification of what would and would not be achievable.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the proposals and timescales included within the report.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** requested the Health & Social Care Partnership Leadership Team create an action plan and priorities to address the proposals from the joint report for submission to the April Board meeting.

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11. Monitoring and forecast of the Health and Social Care Partnership budget 2018/19 at 31 December 2018

Mr Mike Porteous gave an overview of the content of the paper and commented that any overspends at the year end would require additional funding from the partner organisations to address the overspends. The overspend had reduced by 177k since the last report. Within the health care functions the forecast position was largely unchanged with a small improvement of about £12k. The main movement in the overspend was the forecast social care position which had improved by £167k largely as a result of corporate savings released and the identification of a small underspend in generic services with a small breakeven position in social care functions. In terms of set aside there was no change in the forecast position.

The Chair suggested an update from NHS Borders on the recovery plan would have been helpful to have been included in the report to understand better the reasons for the overspends occurring, so that the IJB might consider and make any suitable suggestions for mitigation.

Mr Porteous advised that he had taken the decision not to repeat previous statements but to include the drivers of the overspends in the report once they had been clearly determined and their impact fully understood.

He further commented that the NHS element of the overspend remained within the amount of brokerage that NHS Borders would receive.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the forecast overspend of (£7.372m) for the Partnership for the year to 31 March 2018/19 based on available information.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that any expenditure in excess of the delegated budgets in 2018/19 will require to be funded by additional contributions from the partners in line with the approved scheme of integration.

12. Draft Scottish Government Financial Settlement for 2019/20

Mr Mike Porteous presented the report into the outcome of the draft financial settlement for the public sector for 2019/20 and he provided an overview of the implications for the IJB.

Mr John McLaren advised caution in regard to the announcements put out from central government in regard to funding for the NHS as often by the time it reached the Health Boards it had been subject to various caveats and did not provide as much funding as had been initially intimated.

Ms Lynn Gallacher requested that the Carers Act was referred to in order to ensure that funding stream was not lost.

Mr Rob McCulloch-Graham commented that one of the IJBs in Edinburgh had recently refused the budget offered to it and he suggested Scottish Borders IJB could potentially be in

a similar situation in regard to the health service provision of the budget. At present the Council budget remained balanced, so work was continuing with NHS colleagues to get to an acceptable position over the next few months.

Cllr Shona Haslam sought clarification on the process to get to an agreed budget. Mr Porteous commented that whilst the SBC budget would be approved shortly the NHS budget position was still to be finalised and until the information as available on the NHS position there was little he could provide to the IJB for agreement.

Cllr Haslam requested a timeline be produced from that point forward as to when the IJB could receive the budget, scrutinise it and potentially accept it.

Mrs Jenny Smith enquired if the Edinburgh IJB had rejected its budget if that was a symbolic move and what the impact would be if Scottish Borders IJB did the same. Mr Porteous commented that if the IJB accepted the budget it accepted the accountability and then the officers would be held to account on the budget limits, therefore if a budget did not cover the provision of services it should not be accepted. Therefore in terms of the IJB it should acknowledge the situation, that services would not be withdrawn but there would not be sufficient funds to spend on those services for the financial year as the running costs would be more than the budget provision.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the impact of the financial settlements on the financial outlook for the IJB statutory organisations.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that further work is required to provide the IJB with indicative provision of resources figures for 2019/20 and beyond.

13. Any Other Business

13.1 Development Session: Mr McCulloch-Graham remaindered the Board that the Development session would be held on Monday 4 March at 1pm to 5pm at Dryburgh Abbey.

13.2 Future Meetings: The Chair advised the Board that a rearrangement of the IJB meetings away from Monday afternoons would also be progressed.

14. Date and Time of next meeting

The Chair confirmed that the next meeting of Health & Social Care Integration Joint Board would take place on Monday 25 March 2019 at 2.00pm in Council Chamber, Scottish Borders Council.

The meeting concluded at 3.50pm.

Signature: ……
Chair

Scottish Borders
Health and Social Care
PARTNERSHIP

Health & Social Care Integration Joint Board Action Point Tracker

Meeting held 12 February 2018

Agenda Item: Inspection Update

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
24	6	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the update and agreed to receive a presentation on the Public Protection Service at a Development session later in the year.	~~Murray Leys~~ Stuart Easingwood	~~December 2018~~ May 2019	**In Progress:** Item scheduled for 19 November 2018. **Update:** Session cancelled. Item scheduled to 27 May 2019 Development session. **Update:** Rescheduled to November Development session as a consequence of changing the IJB meeting dates.	G

Meeting held 23 April 2018

Agenda Item: Scottish Borders Health and Social Care Partnership 2017/18 Winter Period Evaluation Report

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
29	9	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD**	~~Claire Pearce,~~	~~December 2018~~	**In Progress:** Item scheduled for 17 December 2018.	G

		welcomed the opportunity to receive a report at a future meeting on Quality and Governance from Mrs Claire Pearce, Director of Nursing, Midwifery & Acute Services and Dr Angus McVean, GP Clinical Lead.	Nicky Berry, Angus McVean	April 2019	**Update:** Item rescheduled to April 2019 meeting. **Update:** Item rescheduled to June 2019 meeting due to reconfiguration of IJB meeting dates.	

Meeting held 28 May 2018

Agenda Item: Chief Officer's Report

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
30	6	Mr Murray Leys to provide a presentation to a future Development session on Demographics	~~Murray Leys~~ Stuart Easingwood	~~2018~~ 2019	**In Progress:** Item scheduled for 19 November 2018. **Update:** Session cancelled. Item rescheduled to 25 November 2019 Development session.	G

Meeting held 22 October 2018

Agenda Item: Alcohol and Drug Partnership Investment Plan 2018 – 2021

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
34	8	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the plan in principle and sought an update report in January 2019 with more detail and evidence of funding levels being adequate to fund a redesign of services.	Tim Patterson	January 2019	**In Progress:** Item scheduled to 28 January 2019 meeting **Update 28.01.19:** Mr Robert McCulloch-Graham advised that the report had been prepared, however it was	A

					commercially sensitive and would therefore require discussion in private. Given the meeting was not quorate it would be deferred to a future meeting on 25.02.19. **Update 25.02.19:** Mr Rob McCulloch-Graham advised that an update paper had been shared with the Integration Joint Board members privately as it contained commercially sensitive information. He advised there was no further update.	

Meeting held 28 January 2019

Agenda Item: Eildon Medical Practice

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
3	7	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** supported the use of Chairs action to seek a report on the next stage in the process, a report on all of the options considered and the final decision route to be taken, with the Chairs action being ratified at the next meeting.	Rob McCulloch-Graham	April 2019	**In Progress:** Chairs Action to be ratified at 25 February 2019 meeting. **Update:** Report scheduled to 29 April 2019 meeting.	G

Meeting held 25 February 2019

Agenda Item: Ministerial Strategic Group Review of Progress with Integration of Health & Social Care

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
5	10	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** requested the Health & Social Care Partnership Leadership Team create an action plan and priorities to address the proposals from the joint report for submission to the April Board meeting.	Rob McCulloch-Graham	April 2019	**In Progress:** Response being formulated.	

KEY:	
	Overdue / timescale TBA
	<2 weeks to timescale
	>2 weeks to timescale
Blue	**Complete** – Items removed from action tracker once noted as complete at each H&SC Integration Joint Board meeting

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 8 May 2019

Report By	Robert McCulloch-Graham, Chief Officer Health & Social Care
Contact	Robert McCulloch-Graham, Chief Officer Health & Social Care
Telephone:	01896 825528

CHIEF OFFICER'S REPORT

Purpose of Report:	To inform the Health & Social Care Integration Joint Board (IJB) of the activity undertaken by the Chief Officer since the last meeting.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Note** the report.

Personnel:	Not Applicable

Carers:	Not Applicable

Equalities:	Not Applicable

Financial:	Not Applicable

Legal:	Not Applicable

Risk Implications:	Not Applicable

Chief Officer Report

Primary Care Improvement Plan

On 26 March 2019, we welcomed 3 senior officers from Scottish Government Primary Care Division to our Primary Care Strategy Group meeting to provide a full overview of our Primary Care Improvement Plan (PCIP) implementation, following the GMS Contract. The ensuing conversation was very helpful and encouraging. They recognised the progress we had made and invited us to present at the National GMS Oversight Group for the PCIP.

We received notification from Scottish Government that an updated plan should be submitted as soon as possible from April 2019 onwards, with the approval of GP Sub Committee and the IJB.

Clinical Productivity

The Meridian team continue to spend significant time with Treatment Rooms staff to completely understand the current ways of working, focussing heavily on the patient pathway. Following initial data collection feedback, the Clinical Reference Group agreed to hold a workshop with all Treatment Room staff across all localities to brainstorm and develop a viable and consistent work pattern approach, for all 10 NHS Borders Treatment Rooms. Additionally, goals and expectations of the programme will be agreed over the course of three Executive Seminars planned over the coming few weeks.

In order to provide clarity on how to best deploy the resources available to SBCares Homecare, work has been undertaken to understand the activities required, the time required for each and in what quantities they are performed. With the recent addition of the Scheduler role to SBCares, this was an opportune time to clarify responsibilities and requirements across the localities.

The work with SBCares has run from the offset and has focussed on the following areas:

- Robust data capture mechanisms to accurately measure care hours delivered.
- Clearly defined management responsibilities and structure by locality following the introduction of the new Scheduler role.
- Improved assignment of work to carers through daily allocation controls and regular management following up, resulting in more effective use of paid time.
- Introduction of a resource planning tool to ensure the skills and people available in each locality align with the demand on the service.

In order to provide clarity on how to best deploy the resources available to SBCares Homecare, work has been undertaken to understand the activities required, the time required for each and in what quantities they are performed. With the recent addition of the Scheduler role to SBCares, this was an opportune time to clarify responsibilities and requirements across the localities. Also, the course of training workshops for the SBCares Management Team has now been completed.

Visit to Holland

Myself and various colleagues from Scottish Borders Council, NHS Borders and iHub travelled to Holland mid March to visit their Dementia Care Village. We recognise a need across the Borders to increase our level of care for people with advanced Dementia. Our

current practice is not suitable for our future needs. The experience was enlightening to say the least and has sparked a redirection of our future vision and several developing workstreams will ensure, so that we can implement a programme that will realise our intended vision.

We are currently liaising with colleagues in Stirling to arrange a visit to their Dementia Care Village, as well as expanding conversations with those involved in the visit to Holland. Much more to follow on this area of work.

Eildon Medical Practice

I attended a briefing for Newtown and Eildon Community Council on 26 March 2019, confirming that the Health & Social Care Partnership is currently working with the GP Partners to maintain the services out of the Newtown surgery for the mid-term. Detailed development work on the longer term options which arose from the option appraisal process last year will be undertaken in consultation with the Eildon Locality Working Group and the wider community.

Winter Debrief Session

The Unscheduled Care team organised a learning and sharing Winter Debrief Session on 30 April, which was a brilliant opportunity to review what worked well, what could have gone better and what would make a difference for next winter. There were presentations from Inpatient Adult wards, GP's, community teams, social services and a number of our extremely valuable clinical support services. The feedback, ideas and areas for improvement identified at this session will be taken into consideration and will influence plans made for Winter 2019/20.

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Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 8 May 2019

Report By	Rob McCulloch-Graham, Chief Officer Health & Social Care
Contact	James Lamb, Portfolio Manager
Telephone:	01896 825528

STRATA PATHWAYS™ – PROPOSED EXTENSION OF THE PROJECT

Purpose of Report:	To seek approval for ICF funding to extend and expand the Strata Prototyping Project

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Note** the attached Project Evaluation Report for the Strata project (Phase 1) b) **Approve** the proposed extension and expansion of the Strata Prototyping Project (Phase 2) relating to the Discharge Management Process for 12 months – with an interim evaluation after 6 months c) **Agree** that the scope of the project be extended to include Integrated Locality Teams and, if appropriate, Hospital to Home referrals. d) **Agree** that the extended project be funded from ICF funding e) **Agree** that Strata be included in the "Discharge Programme" with four other projects (Matching Unit, Hospital to Home, Garden View and Transitional Care) and be evaluated with them in September 2019.

Personnel:	There are no direct staffing implications relating to this report.

Carers:	There are no direct impacts on carers arising from this report.

Equalities:	No EQIA has been carried out. An EQIA was completed as part of the strategic planning process. EQIAs will be undertaken as appropriate for each project within the programme.

Financial:	It is proposed that the extension to the project will be funded from ICF. The cost of extending the pilot for 12 months is up to £185,000 – with a minimum commitment of £57,500 – based on: • £115,000 for Strata (licences, consultancy and support) based on £1/head of population per year. Strata have agreed to include a 6 month termination clause. Therefore, the minimum commitment is for 6 months at £57,500. • A provision of up to £50,000 for integration costs – this cost is still to be determined and funding would only be drawn down after negotiations with suppliers and following a positive interim evaluation report and agreement by the IJB after 6 months • A provision of up to £20,000 for penetration testing to ensure that the data (from NHS and SBC) is securely held over the integrated systems. As with integration costs, funding will only be drawn down following a successful interim evaluation report and agreement by the IJB

Legal:	N/A

Risk Implications:	Continued buy-in from providers, service managers and staff will be critical to the project. A 6-month break clause in the contract provides an early exit point from the project if it is not delivering the expected benefits as outlined in Section 2 of the attached evaluation report.

1. Purpose

This report seeks approval for ICF funding of up to £185,000 to extend and expand the Strata Discharge Management Prototyping Project for a further 12 months – with an interim evaluation after 6 months to September 2019. An evaluation of the Strata project to date (Phase 1) is attached as Appendix 1 and a brief for the extended pilot (Phase 2) is attached at Appendix 2.

2. Background

Strata is a cloud-based solution that enables improved, more efficient automated processes which match patient's needs to resources. It can be applied across any and all health and social pathways and therefore has the potential to be a critical tool in redesigning and improving all integrated services.

A prototyping project, funded with £75,000 from ICF, was initiated in August 2018 to:

- Gain an understanding of the challenges of applying the Strata system and approach to our operational environment
- Determine whether or not there was a business-led case for committing to Strata on a permanent basis and expanding it across further H&SC pathways.

In doing this, the project set out to apply Strata to the improvement and automation of the discharge management process – specifically, to the processes of discharging the person from the hospital (Borders General Hospital and the 4 Community Hospitals) to both residential care and care at home providers.

In the project, Strata is used by Care Providers to establish a live and dynamic directory of vacancies, capacity and services that, in turn is used by Health & Social Care Teams (START team and Matching Unit) to quickly source appropriate care. This does away with inefficient processes involving multiple staff, simultaneously ringing multiple providers to try to secure a place or package for the patient. Once a place is found, Strata enables personal and medical details to be sent digitally and securely through its system, rather than by email or post, to the provider so that essential information precedes the patient to the care provider.

3. Interim Project Evaluation (Phase 1)

An interim project evaluation report is attached at Appendix 1 and is summarised here.

The project was funded with £75,000 ICF to the end of March 2019, at which point, it was intended to evaluate before deciding to commit to Strata over the long term.

Initial engagement with providers and H&SC teams began in August last year and, over the following 2 months, existing processes were mapped, redesigned and validated. Training of all Residential Care providers took place in November with the system going live from December. Care at Home providers began to be added to the system from December with training provided at their offices.

Whilst good progress has been made and many clear potential benefits have been identified (see Section 2 of the attached interim evaluation report), the implementation across 29 residential care homes and 9 care at home providers has however proved to be more complex and taken longer than originally anticipated. For a number of reasons (particularly the time taken for providers to obtain business broadband providers addresses) some providers have not been able to go live on the system as early as hoped and, at the end of February, 5 providers were still not on the system. As a result, it has not been possible to discontinue old processes and move, fully, to the Strata system and, consequently, the data from a fully implemented system is still to be gathered.

4. Proposed Extension and Expansion of the Project (phase 2)

The potential benefits of this project are significant including:

- Quicker referrals – between 1 and 2 days/referral with a corresponding benefit in easing pressure on hospital beds
- Efficiency gains in Social Worker time of approximately 22 hours/month
- Administration efficiency gains for both the partnership and providers
- Improved real time management information – including visibility of capacity across providers
- Improved data security and data quality
- Compliance with an agreed process
- A better service for the patient, their families and carers.

A project brief for an extended and expanded project is attached at Appendix 2 and proposes that:

a. The project is extended for a further 12 months to September 2019 with an interim evaluation after 6 months to enable all providers to operate the discharge process via strata for a sustained period prior to evaluation. Previous manual processes would be discontinued and appropriate amendments made to provider contracts.
b. The scope of the project is broadened to include referrals to providers from the Integrated Locality Teams and, if appropriate, the Hospital to Home service.
c. Strata be included in the "Discharge Programme" of work along with four other projects (Matching Unit, Hospital to Home, Garden View and Transitional Care) and be evaluated with them in September 2019.
d. The extended project be funded from ICF with up to £185,000 with a minimum commitment of £57,500 for the first 6 months of the extended project (the remaining funding would only be drawn down subject to a positive interim evaluation in September 2019 and clarification of the costs of a technical integration of Strata with SBC and NHS case management systems). It should be noted that the recurring cost of the system is £115,000. This includes consultancy support in the redesign of processes as well as user training and support. The recurring cost is the same whether we apply Strata to the improvement and automation of a single pathway (e.g. the discharge pathway) or multiple pathways.

PROJECT EVALUATION

Project Number	49
Project Name	Strata
Evaluation Status & Date	Project Evaluation 18 April 2019
Project Owner	Murray Leys
Project Manager	James Lamb

Version control

Version	Date	Author	Comments
1.1	6 March 19	James Lamb	1st Draft
1.2	7 March 19	James Lamb	Editing and Graeme McMurdo's feedback
1.3	8 March 19	James Lamb	Editing, feedback/changes from Mark McElholm and outcome of meeting with Rob McCulloch-Graham, Mike Porteous, Suzan Bell and Michael Murphy with Mark on 8th March.
1.4	15 March	James Lamb	Editing and addition changes from Mark McElholm
1.5	21 March	James Lamb	Edit and changes from Murray Leys.
1.6	28 March	James Lamb	Metrics changes in section 2 and route to funding for extended pilot.
1.7	01/04/19	James Lamb	Finance section updated
1.8	09/04/2019	James Lamb	Finance section updated
1.9	18/04/2019	James Lamb	Finance section updated

SECTION 1 || Summary

1.1 Project description

Background

Strata enables improved, more efficient automated processes which match patient's needs to resources. It can be applied across all health and social care pathways and therefore has the potential to be a critical tool for the Partnership in enabling the redesign and improvement of all integrated services.

As a web-based system, Strata stands alone from both our NHS and SBC systems and IT architecture but can be securely integrated with both to enable automation of processes and improved information sharing. It also contributes to creating and maintaining a single view of the person. In future, the aim is to integrate Strata with MOSAIC and appropriate NHS systems, reducing paper work, avoiding duplication, error and the need for the patient to provide the same information multiple times.

This 6-month prototyping project set out to apply Strata to the improvement and automation of the discharge management processes – specifically the processes of discharging the person from the hospital (Borders General Hospital and the 4 Community Hospitals) to both Residential Care and Care at Home providers. As a prototyping project, the main aims were to:

- Gain an understanding of the challenges of applying both the Strata system and approach to our operational environment
- Determine whether or not there was a business-led case for committing to Strata on a permanent basis and expanding across further H&SC pathways

The Challenges

- **Staff time** – Across the discharge management processes, significant professional and administrative time is taken-up in trying to source appropriate external provision to meet clients' assessed needs – by post, telephone and email. This also involves significant provider time in fielding calls and responding to requests for information about current and expected vacancies/capacity.
- **Speed of Referrals** – The above inevitably affects the time it takes to complete a discharge and needs to be addressed if we are to address delayed discharges
- **Management Information** – There is a lack of real-time management information on capacity and flow across the discharge process that enables bottlenecks in system to be identified and addressed.
- **Compliance** – inconsistencies in process and practice as well as problems of completeness of information exist across the process.

Critical Success Factors

- Compliance - All those involved in the discharge process (the START Team, Matching Unit and Providers) need to be using the system in a compliant way and for a sustained period.
- Business ownership – Business ownership needs to be in place at 2 levels:
    - Those who own and manage the discharge process - actively recognising and leveraging the value of the system in the management and improvement of the process and service.
    - H&SC Management – recognising that the value of the solution, not only in terms of the discharge management process, but also the value in its wider application in terms of:
        - The redesign, improvement and automation of any H&SC pathway
        - The contribution to improved business intelligence
        - Contributing to a shared IT architecture across partner organisations.

1.2 Project aims - *Original project aims identified in the PID*

The aim of the project is to establish an improved, more efficient and automated discharge process by integrating health and care systems and digitising the currently slow manual processes. In particular, the project aimed to:

- Improve patient flow out of hospital.
- Reduce patient delays due to process.

This will be achieved by:

- Engaging with, training and setting-up the Matching Unit, START Team, Care at Home and Residential Care Providers on the Strata system
- Mapping and redesigning processes
- Using Strata to develop a live directory of Care at Home and Residential Care services.
- Digitisation of paper/manual processes.
- Building electronic pathways to automate decisions and actions.

1.3 Summary of progress against project aims and achievements

Engagement & Process Mapping.
Initial engagement with the START Team, Matching Unit and both Residential Care and Care at Home providers took place in August 2018. Over the period August-October, existing processes were mapped and validated. Redesigned, improved and automated, processes were also established.

Referrals to Residential Care Providers via the Start Team
Training of both START Team members and providers in the system was undertaken in November. Business Broadband details (Static IP Addresses) were requested from providers and, once obtained, Strata consultants visited each of Care Home to help providers to set-up the system which went live in December. However, a small number of providers were delayed for a variety of reasons ranging from a virus outbreak to the time taken to establish their Static IP address. One provider, declined to pay the additional £5/month cost of business broadband and still has not been included in the pilot.
There are 16 Providers covering a total of 29 Residential Care establishments (inc. Garden View). As at the end of Feb 11 Care Homes were actively posting vacancies, 16 are not active and 2 (Berwick Care Home and St. Andrews) are not on the system.

Referrals to Care at Home via the Matching Unit
There are 9 Care at Home providers in total. Only SB Cares covers the whole of the Borders and is currently the only provider in Berwickshire. Training of the Matching Unit (MU) and SB Cares in Berwickshire took place in November. The remaining suppliers were then scheduled to be trained in January. However, delays in obtaining providers' Static IP addresses has meant that not all providers are on the system.
As at end of Feb, 6 providers are trained and have access to the system. 3 are still in the process of being set-up on the system. None are regularly accessing the system. None are posting capacity regularly which may be due to lack of capacity – however, capacity is still being sourced by the MU via telephone and emailing and capacity is being returned to suppliers when packages come to an end. Without active use by the providers, the MU isn't able to use Strata to make referrals and, instead, are using the system as a waiting list.

Temporary Suspension of the System
During February, there was an urgent need to relieve pressure at the BGH and a decision was taken by SMT to temporarily suspend the use of Strata and revert to the old system (which still operates concurrently) as all providers – both Residential Care and Care at Home – were not yet fully operational on the system.

1.4	What areas of the Borders is the project covering

The project covers the whole of the Borders area.

1.5	Which care groups has the project supported?

All clients of Social Care & Health Teams who have social work managed care packages.

Section2 || Outcomes, outputs and benefits

2.1	Project outputs

Planned Output	Actual Output	Comment
A tool to support the discharge of patients	Strata is in place creating a system for both the START team and the Matching Unit to manage and support the discharge of patients.	Until mid-March, there were still 5 suppliers that were not live on the system and, as a result the old method is still running. It is only when STRATA becomes the only way of managing discharges that the value of the system can be measured.
A live and dynamic online directory of provider beds and services that can be used to match patients with an appropriate care setting.	Strata is operational, providing a live and dynamic directory which provides visibility of availability across those providers that are live and active on the system.	The directory is able to show provider capacity. For example on 20 Feb, the system showed 34 residential care or nursing beds available across the borders. However, a number of suppliers were either still not live on the system or not consistently posting their availability.
More Efficient – and wherever possible – automated processes	More efficient and automated processes have been designed and implemented.	Older processes are still in operation pending all providers being live on the system. Full automation of the process requires integration with MOSAIC and TrakCare. It has not been possible to achieve this within the pilot project and this would form part of a next phase. By adding this functionality we will ensure that the capture of all required information is enforced in the system which will allow us to build trusted referrals which will further speed up the transition process. Additionally, this will drive up data quality to support us with planning and decision making.

2.2 Project outcomes

Planned Outcome	Actual Outcome	Comment
Quicker Referrals (1- 2 days/referral)	By moving digital referrals to providers, it is estimated that there are savings of between 1 and 2 days through removing the need to post referrals or to email waiting lists on a twice-weekly basis. Instead, information is sent and received instantly with the correct information which should reduce the need for additional assessments. Quicker referrals of 1-2 days should help ease pressure on hospital beds. However, related cashable savings will only be achieved if it is possible to close a number of beds in one area. This project, on its own, can reduce occupied hospital bed days and therefore combined with a reduction in bed base result in cashable savings. From April 2018 to March 2019, 932 individuals were provided with a care package when discharged from Borders General Hospital and Community Hospitals. 658 patients were discharged to a residential care facility. Therefore in total, 1590 patients were discharged to a social care service. If we assume a conservative figure of saving 1 day within the matching process this would equate to an annual saving of £208,290, if we assume the cost of an occupied bed day being £131.	These figures are based on a fully-compliant implementation across all providers.
Social Worker Staff Time (Potential efficiency gain of 22hrs/month in Social Worker time) (approx. £7,000/year based on £47,000/year SW salary and on-costs)	It is estimated that there is a potential saving in Social Worker time of approximately 22hrs/month. This time-saving is could be more effectively redirected to focus on stranded and super-stranded patients (i.e. those patients experiencing significant delays in being discharged) to ensure that they are being found the appropriate services as quickly as possible and therefore freeing up acute beds. **Time saved through** • viewing matched bed vacancy via Strata instead of home ring around • Automatic Matching • All information in one place • No need for Care Home Assessment **Calculation based on following:-** Current process of ring around of 50% of homes per referral with each call approx. 2.5 mins, rounded up to account for % of engaged 1st calls = 30 mins per referral • Based on 10 Referrals per week • 30 mins x 10 referrals = 5 hours of SW time saved/week	This is time currently spent on sourcing potential vacancies through ringing-around and could be redirected to focus on those patients who have been on the waiting list for long periods of time.

	• 5 hours x 52 weeks / 12 months = Approx. 22 hours per month saved	
Potential Administrative Efficiency Gains (approx £27,664/yr)	There are potential cost savings across both sender and receiver of £23/referral based on: • £1 per referral saved in terms of paper/fax/telephone costs; • £13 per referral in staff time saved by sender; • £9 per referral in staff time saved by receiver of referral. Effectively £14/referral for Partnership staff. Therefore, assuming 38 referrals per week in the Matching Unit this would equate to: • Weekly saving 38 x £14 = £532. • Annual Saving 52 x £532 = £27,664	These projected savings are based on an independent study by NE & Cumbria Academic Health Science Network and include provider costs. Any notional saving assumes that there is full compliance.
Improved Management Information	Strata provides management with real-time visibility of capacity within the system across both Residential Care and Care at Home Providers. The management information yielded by Strata, in tandem with other IT systems such as Mosaic and CM2000, will enable a greater insight into both the flow of discharges and match both the capacity posted on Strata with provider capacity from CM2000. This will enabling improved business intelligence and contract management capability.	Again, the value of Strata in providing management information is dependent on confidence in all players using the system in a compliant way.
Compliance	Strata provides the opportunity to have mutually agreed and manageable process around which to build and enforce compliance. Mandatory fields within the system are already ensuring that referrals can only be made if the necessary information (e.g. assessment, medication, and next of kin contacts) are included with the referral. The audit trail and time-stamping of transactions enables the ability to identify and rectify areas of non-compliance.	The system is built around IJB protocols and we can decide to enforce certain information to be collected or actions to be taken in order to enforce compliance. Furthermore it fulfils all GDPR, IG and ISO standards.
Provider Services Management Platform	This project will provide our placement providers with a management tool that will allow them to broker their services directly to the council and hospital and ensure that the information they receive allows them to quickly accept a patient. It also provides them with a facility to allow them to catalogue the services and resources that they provide right down to the characteristics of the service, resource and staff skills. Furthermore, it will provide them with access to information around the quality of service that they provide and the referral activity and placement activity that happens over given time periods which will prove useful when	

	interacting with the social care teams at council.	
Total Financial Planned Outcome	OBD savings - £208,000 SW time saved - £7,000 Admin time saved - £28,000 Total – £243,000	

Additional unexpected outcomes:

Improved Data Security – referrals are currently sent to providers via post or through block-lists of patients on the waiting list via zipped files. These pre-existing processes carry known security risks which would be negated through the use of Strata. The provider sees only details of patients that relate to potential and actual referrals for their service and their vacancies – rather than everyone on the waiting list.

Completeness of information – as per compliance above, missing information with referrals was identified by providers as an issue. Enabling mandatory fields, where a referral cannot be sent without the requisite information is already helping address this.

Expansion to other services – The Strata solution can be used by many other parts of the Health and Care System to support Clinical, Public health, social care and social prescribing initiatives. The Strata Platform can be used by the NHS to manage referrals between NHS services such as Mental Health and Community Nursing and AHP services. The council can also use the solution for referring patients to social prescribing initiatives and services such as adult and child safeguarding services, disability services, addiction and cessation services. This will provide a single platform for all client facing referrals which deliver improved outcomes to patients and citizens.

Improved Data Quality
By enforcing the completion of mandatory fields and actions such as attaching required documents the system ensures that all necessary information is collected so that downstream services have all the information needed to make the correct decision for the patient. Through improving the data capture this will greatly improve data quality which can then be used for management and planning decisions.

Time saved in completing returns – both the Council and Providers are required to compile and submit statistical returns on a regular basis. Information from Strata will save time on gathering and presenting information.

2.3 Impact on individuals/Case studies /Quotes from service users –.

Residential Care

- **Residential Care Providers** - use Strata as a live and dynamic directory of their actual and pending capacity in their Care Homes. This includes information on the type of rooms and the skills and services that they have available. The information is updated as and when there are any changes in vacancies. The information is posted by each Care home, not by provider. The Residential Care provider accepts or declines the referral via strata.
- **START Team** – based in the BGH and Community Hospitals, the START team, having completed the client assessment, enter details of hospital patients to be discharged to residential care onto Strata (and, currently as Mosaic). Strata is then used to match patients to Care Homes based on available capacity and patient's needs and preference – effectively using the live and dynamic directory above. All necessary patient information (e.g. assessment, medication and next of kin) is sent to the provider via

Strata.
In future, when Strata is integrated with Mosaic and TrakCare, patient data will flow between systems. This will remove the need for manual keying of patient data and enable required fields in Strata to be populated automatically. In turn, this will reduce both duplication and risk of error as well as allowing better use of staff time.

Care at Home

- **Care at Home Providers** – like residential care providers, care at home providers will use Strata to post capacity (morning, afternoon, evening or no capacity) and accept referrals. Of the 9 Care providers, 4 are still not on the system. None are regularly posting available capacity. One of the reasons for this is understood to be due to lack of capacity due to recruitment issues or absence. This will be explored further with providers through engagement sessions over the next few weeks.
- **Matching Unit** – the START team, having completed the client assessment, enter details of hospital patients to be discharged with a Care at Home package onto Mosaic. The Matching Unit then add the patient details from Mosaic into Strata. Strata is then used to match patients to Care At Home provider based on available capacity and patient's needs and preference – effectively using the live and dynamic directory above. All necessary patient information (e.g. assessment, medication and next of kin) should be sent to the provider via Strata.
  Currently, as all providers are not yet on the system or publishing their vacancies regularly, the Matching Unit are unable to use Strata in the way described above. Over the coming weeks, there will be further engagement and training sessions with all providers to ensure compliance.
  As with the Residential Care process above, once integration has taken place with Mosaic and TrakCare, patient data will flow between systems reducing duplication and error as well as allowing better use of staff time.

Others

- **Service/Contract Management** – will have improved management information from Strata giving visibility of capacity across providers and the discharge process from hospital to residential care and home care. This will enable better business intelligence, particularly when data from strata is combined with data from other systems.
- **Patient** – the patient shouldn't see anything in terms of Strata itself, but should benefit from a quicker discharge process to an appropriate care setting that matches their needs and preferences.

SECTION 3 || Finance and resources

3.1 Approved budget 'v' actual expenditure - *Please complete the table below*

Year	Amount awarded	Amount spent	Comments
2018-19	£75,000	£75,000	This was G-CAT/ Framework price for 6-month fixed-cost Strata pilot. Spend was split 30% upfront, 40% on system going live and 30% at end of project.
Total	£75,000	£75,000	

SECTION 4 || Project Future/Sustainability

4.1 Project Future

The Strata project was funded until 31st March 2019 and aimed to develop a Business Case for mainstreaming Strata and applying the system to additional pathways. However, the implementation process across 16

residential care providers (29 Care Homes), 9 care at home providers and 19 staff in the START Team and Matching Unit has proved to be more complex and taken longer than originally anticipated. As the pilot has not yet been fully implemented across all providers and both the original and the Strata-based processes are still running concurrently (therefore the data from a fully implemented system has yet to be captured), it is proposed that:

- The pilot be extended for a further 6 months – with a view to operating fully from May 2019
- The scope of the pilot be extended to include:
    - Hospital to Home referrals from the START team
    - Referrals to both Care at Home and Residential Care from the community-based locality teams
- The project runs concurrently with other related ICF-funded projects within the wider "Discharge Programme". The Strata project therefore becomes part of the Discharge Programme and the Programme timelines (to September 2019) and that it becomes part of a collective evaluation for the mainstream funding for the Discharge projects, which are:
    - Hospital to Home
    - Matching Unit
    - Transitional Care
    - Garden View
- That integration between Strata and both Mosaic and TrakCare is pursued during the extended pilot but only so far as preparing costed plans for undertaking this work.

The cost of extending the pilot for 12* months would be up to £185,000 – with a minimum commitment of £57,500 – based on:

- £115,000 is the standard G-Cat (Government Procurement Catalogue) framework cost for Strata. This is based on £1/head of population. Going forward, if the partnership were to renew the contract, this cost would remain constant regardless of the number of pathways and processes we use Strata for (the cost would vary only by the size of our population – upwards or downwards). The cost includes not only the licence cost of the system, but also Strata consultancy time/expertise in redesigning processes and training all appropriate staff.
  Strata have agreed to include a 6-month termination clause, therefore the minimum commitment is for £57,500. If the outcome of the evaluation in September is not to proceed, this clause would be activated and no further costs would apply. We would then resort to the old manual processes.
- A provision of up to £50,000 to cover anticipated costs of the technical integration between Strata. These costs are still to be determined through negotiations with suppliers and will only be activated on a successful evaluation of the project in September and an associated further report to the IJB.
- A provision of up to £20,000 to cover the costs of technical penetration testing – this cost is still to be determined and would only be activated as per the above integration costs. Penetration testing would be required to show that technical integrations did not compromise data security.

It is proposed that the costs of up to £185,000 revenue associated with a further 12 month expansion and extension of the project be funded from the Integrated Care Fund. A project brief as part of the application for the funding accompanies this evaluation report.

4.2	**Resources released in order to sustain the project** – *What resources have been released to sustain the project at the end of the period of ICF funding? How will the project be funded?*

There are no resources to release to sustain the project at this stage. Evaluation of what resources could be released by the project would take place at the end of the extended pilot as part of a wider evaluation of the Discharge Programme.

4.3	If your project is to be terminated–*What is your exit strategy?*

If the Strata project was to be terminated then the process for discharge would resort to pre-existing processes. This would mean that the outputs, outcomes and benefits set out in section 2 above would not be realised.

Exit Strategy

- To communicate the end of the project to all stakeholders and advise them of the end date
- Care managers will return to sourcing residential care via telephone and using the post to send out referrals.
- Providers would return to fielding speculative calls from Care Managers and the Matching Unit on an ongoing basis.
- Matching Unit would continue to email the waiting list to Care at Home providers with inherent data security risks
- No renewal of contract with Strata

SECTION 5 || Lessons learned

5.1	Lessons learned

- **Complexity & Timescales** – We underestimated the complexity and timescales of implementing across all providers. Originally we considered limiting the pilot to a smaller group of providers based on the volume of referrals. Both providers and Senior Management expressed a clear direction that the pilot should encompass all providers and that there should not be a two-tier system.

- **Starting Before Winter Pressures** – Given the above it would have been helpful – but not possible – to have had an earlier project start date before the onset of winter with associated pressures on the discharge management process. In February for example, with not all providers live on the Strata system and extreme pressure in the general hospital, the decision was taken to temporarily suspend the use of Strata to manage discharges using the pre-Strata processes.

- **Avoiding Over-Lapping Processes** – There is a need to move more quickly to remove/stop pre-existing processes so that we don't have old and new processes running concurrently.

- **Business Ownership** – There was a change in senior management mid-project which meant that much of the experience and knowledge of the project from the business-side was lost and needed to be redeveloped. The project was perhaps over-reliant on a key manager in the business and arguably could have developed a broader business ownership for the project. This has already been addressed and will be in place for the proposed extended pilot.

- **Resistance to Change** - While those we engaged with were quick to see the benefits of Strata to them, the resistance to change or reluctance to give-up familiar ways was underestimated.

- **Project Management** – We had originally intended having a near-dedicated project manager to manage this project. Unfortunately, due to an ongoing review of programme and project management resources in the Council there were delays in recruitment which meant that this was not possible. As a result, there has not been the resource to manage the project in the level of detail that could have helped to move the project forward at a quicker pace. Appropriate project resource is now in place to manage the proposed extension of the pilot.

SECTION 6 || Declaration

6.1 Declaration	
I confirm this is a full and final evaluation of the project, approved by the Project Lead. I agree to supply any further information requested by the ICF programme team.	
Signed: (Project Manager)	
Date of signature:	

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Scottish Borders

Integrated Care Fund Project Brief

2015 – 2018

Project Name	Strata – Phase 2, Extending and expanding the Discharge Management Prototyping Project.		
Project Owner	Murray Leys	**Application Main Contact**	James Lamb
Main contact email	jlamb@scotborders.gov.uk	**Main Contact Telephone**	

1 Outline project description

Please summarise the project in no more than 250 words

This brief sets out a proposal for a second phase of the Strata project which will include:

- Extending the trial period of using Strata to improve and automate the discharges management process - from hospital to both residential and care at home providers – for a further 12 months (including an interim evaluation after 6 months).
- Widening the scope of the project to include not only the Matching Unit, START team, Care at Home and Residential Care Providers but also to Integrated Locality Teams and, if appropriate, the Hospital to Home service.
- Developing costed plans for the technical integration of Strata with systems in both NHSB and SBC
- Including the project in a wider "Discharge Management Programme" with 4 other ICF-funded projects – Garden View, Matching Unit, Hospital to Home and Transitional Care – and evaluating, jointly, by Sept 2019.
- Development of a case – as part of the above evaluation and based upon the data gathered from the extended trial period – for the continuation of the Strata project (Phase 3) beyond Sept 2019 and mainstreaming subsequent phases from April 2020.

Strata is a web-based system that enables improved, more efficient automated processes which match patient's needs to resources. It can be applied across all health and social care pathways and therefore has the potential to be a critical tool for the Partnership in enabling the redesign and improvement of all integrated services. **In terms of this project, care providers use Strata to set up a live and dynamic directory of vacant rooms/capacity and services that enable Social Work teams to view what is currently available and place the patient, quickly, into an appropriate care setting – doing away with the inefficient process of multiple staff, simultaneously ringing multiple providers to try to secure an appropriate place for the patient. Once a place is found, Strata enables the appropriate personal and medical details to be sent digitally (instantly as opposed to the postal service) to the provider so that the necessary information precedes the patient to the care provider.**

As a web-based system, Strata stands alone from both our NHS and SBC systems and IT architecture but can be securely integrated with both to enable automation of processes and improved information sharing. It also contributes to creating and maintaining a single view of the person. The aim is to integrate Strata with MOSAIC and appropriate NHS systems (TrakCare and EMIS), speeding up the referral process, reducing paper work, significantly reducing time spent phoning-around providers to find capacity, avoiding duplication, error and the need for the patient to provide the same information multiple times.

Over winter, an initial prototyping project (Phase1) set out to apply Strata to the improvement and automation of the discharge management processes – specifically the processes of discharging the person from the hospital (Borders General Hospital and the 4 Community Hospitals) to both Residential Care and Care at Home providers. An evaluation report for the project accompanies this brief.

One of the aims of Phase 1 had been to develop a case for mainstreaming the funding of Strata and developing a forward programme to apply the system to additional pathways. However, the implementation has proven to be more complex and taken longer than originally anticipated – particularly the challenges of getting all 29 Care Homes and 9 Care at Home providers up-and-running on Strata. The system had not been fully implemented in time to allow data to be gathered for a meaningful period of time – hence the proposed extension to the prototyping project to enable a meaningful evaluation of the system based on the full usage of the system.

2 Project's strategic fit (see guidance notes section 2)

Which local strategic objectives and Scottish Government ICF principles will it meet?

Borders IJB Strategic Plan objectives

1. **Improve the health of the population and reduce the number of hospital admission** – future work with Strata can address avoidance of hospital admissions. Elsewhere, Strata has worked with other H&SC partnerships on avoiding unnecessary admissions.
2. **Improve the flow of patients into, through and out of hospital** – The project is specifically aimed at speeding-up the discharge process out of hospital into Residential and Care at Home Providers and also the Hospital to Home service. It is anticipated that the project has the ability to speed-up the referral process by up to 2 days (equivalent to a saving of up to 2 hospital bed days per referral).
3. **Improve the capacity for people to better manage their own conditions and support those who care for them** – again, future projects involving Strata will improve associated processes.

Scottish Government ICF principles

1. Co-production –process have been reviewed and redesigned with stakeholders.
2. Sustainability – the project seeks to identify improvements and efficiency gains which will enable the service to do more with existing resources.
3. Locality – the project covers all localities and will support the work of locality teams. Data will be available at a locality as well as Borders-wide basis.
4. Leverage – the project will enable better value from existing systems in both the NHS and SBC in allowing data from both to be combined to improve the discharge process and improve management information.
5. Involvement – Providers and all stakeholders have been involved – and will continue to be involved – in the review and redesign of the discharge process.
6. Outcomes –outcomes are included in section 3 below.

3 Project Aims/ Achievements

Please give a high level description of what will success look like?

Strata will be used as a live and dynamic directory to manage the discharge process. All providers will have been actively using the Strata system as a directory for their services for a sustained period. They will be updating both their capacity and expertise in real time (giving information not only about current availability but also planned or expected availability). Social Work teams (Hospital START and Integrated Locality teams) and the Matching Unit will be using the system to place patients quickly and digitally into the appropriate care setting. The system will have demonstrated the following benefits:

1. **Quicker referrals** (between 1 and 2 days per referral) from hospital – It is estimated that there are savings of between 1 and 2 days through removing the need to post referrals or to email waiting lists on a twice-weekly basis. Instead, information is sent and received instantly with the correct information which should reduce the need for additional assessments.
2. **Contribution to Hospital Bed Day efficiencies (with other discharge-related projects) –** Quicker referrals should lead to corresponding efficiencies in terms of hospital beds being freed-up. Notional savings are set out below. These costs would only be cashable if it was possible to close a number of hospital beds. From April 2018 to March 2019, 932 individuals were provided with a care package when discharged from Borders General Hospital and Community Hospitals. 658 patients were discharged to a residential care facility. Therefore in total, 1590 patients were discharged to a social care service.
   If we assume a conservative figure of saving just 1 day within the matching process this would equate to an annual saving of £208,290, if we assume the cost of an occupied bed day being £131.

3. **Social Worker Time Efficiencies -** By avoiding the need for Social Workers having to ring round Care Homes to find places for patients, using Strata instead, it is estimated that 22 hours per month could be released. This time could be redirected to focus on more complex cases where patients that have been waiting to be discharged for longer periods of time. The potential annual value of this efficiency gain is £7,000 based on:
    a. **Time saved through**
        - viewing matched bed vacancy via Strata instead of home ring around
        - Automatic Matching
        - All information in one place
        - No need for Care Home Assessment
    b. **Calculation based on:**
        - 30 mins per referral (current process of ring around of 50% of homes per referral with each call approx. 2.5 mins, rounded up to account for % of engaged 1st calls)
        - 10 residential care referrals per week
        - 30 mins x 10 referrals = 5 hours of SW time saved/week
        - 5 hours x 52 weeks / 12 months = Approx. 22 hours per month saved
        - SW annual salary with on-costs @ £47,000
4. **Administrative Efficiencies** – By avoiding phone calls, postage and stationery as well as admin time spent on manual processes, there are administrative savings to both the Social Care teams and the Providers. The value of these administrative efficiencies is estimated to be in the region of £27,600/year. This is based on an independent study by the NE and Cumbria Academic Health Science Network showing potential cost savings across both sender and receiver of £23/referral based on:
        - £1 per referral saved in terms of paper/fax/telephone costs;
        - £13 per referral in staff time saved by sender;
        - £9 per referral in staff time saved by receiver of referral.

    This suggests there would be a saving of £14/referral for Partnership staff. Therefore, assuming 38 referrals per week in the Matching Unit this would equate to:
        - Weekly saving 38 x £14 = £532.
        - Annual Saving 52 x £532 = £27,664
5. **Improved Management Information** – The management information yielded by Strata, in tandem with other IT systems such as Mosaic and CM2000, will enable a greater insight into both the flow of discharges and match both the capacity posted on Strata with provider capacity from CM2000. This will enabling improved business intelligence and contract management capability.
6. **Compliance and Data Quality** – All stakeholders will have been involved in the review and redesign of processes around which compliance will be expected and monitored. Mandatory fields will ensure that the right information is included with all digital referrals.
7. **Improved Data Security** – Referrals are currently sent to providers via post or through block-lists of patients on the waiting list via zipped files. These pre-existing processes carry known security risks which would be negated through the use of Strata. The provider sees only details of patients that relate to potential and actual referrals for their service and their vacancies – rather than everyone on the waiting list.

A Business case for the implementation of the next phases and mainstreaming of Strata will also be made based upon a sustained period of operational data from the extended trial period.

4	**What areas of the Borders will the project cover** *Will the project affect the whole of the Borders or a specific locality, if so please state?*

The project covers all localities. Data from the system can be analysed at a locality level as well as Borders-wide.

5	**Which care groups will the project affect?** (see guidance notes section 4)

All those being referred to Residential and Care at Home providers and to the Hospital to Home Service.

6	**Estimated duration of project** *Please provide high level milestones and including planning and evaluation time*

The project is for 12 months with an interim evaluation at 6 months (September 2019) at which point a report will be brought back to the IJB making the case for:

- Continuing for a further 6 months
- Proceeding with the technical integration between Strata and SBC and NHSB case management systems
- Mainstreaming of Strata from April 2020.

7	**How much funding would the project need and how would it be spent?** (see guidance notes section 5) *Please break down into individual costs*

The project is seeking up to £185,000 – with a minimum commitment of £57,500 – which is broken down as follows:

- £115,000 is the standard G-Cat (Government Procurement Catalogue) framework cost for Strata. This is based on £1/head of population. Going forward, if the partnership were to renew the contract, this cost would remain constant regardless of the number of pathways and processes we use Strata for (the cost would vary only by the size of our population – upwards or downwards). The cost includes not only the licence cost of the system, but also Strata consultancy time/expertise in redesigning processes and training all appropriate staff.
  Strata have agreed to include a 6-month termination clause, therefore the minimum commitment is for £57,500. If the outcome of the evaluation in September is not to proceed, this clause would be activated and no further costs would apply. We would then resort to the old manual processes.
- A provision of up to £50,000 to cover anticipated costs of the technical integration between Strata. These costs are still to be determined through negotiations with suppliers and will only be activated on a successful evaluation of the project in September and an associated further report to the IJB.
- A provision of up to £20,000 to cover the costs of technical penetration testing – this cost is still to be determined and would only be activated as per the above integration costs. Penetration testing would be required to show that technical integrations did not compromise data security.

8	**What would happen if ICF didn't invest in the project?**

If there is no further investment in the project, the Strata system will be withdrawn and the discharge management process will continue in a manual format (i.e. postal mail, telephone and emailed lists). The potential benefits and efficiencies outlined in Section 3 above will not be realised and the opportunity to extend the system to further Health & Social Care pathways will not be exploited.

9	**How would the project release resources in order to sustain the project?** *What services would longer be provided or would be provided in different ways*

The project will release a number of significant efficiencies – in particular quicker real time referrals using a live and dynamic directory of services, the corresponding freeing-up of between 1 and 2 hospital bed days as well as efficiencies in Social Worker and administrative time through avoidance of inefficient manual

processes – i.e. non-targeted ringing-around, emailing and posting to suppliers to source appropriate care solutions.

While these savings are quantifiable, the route to cashing them is more complex – i.e. the saving of hospital bed days are only achievable when it is possible to close a hospital bed. This project can contribute, significantly, to that outcome but cannot, on its own, achieve that. A joint evaluation of this programme with Garden View, the Matching Unit, Transitional Care Facility and Hospital to Home in a single "Discharge Programme" will report in September.

10	**How would you identify/ recruit staff to support the project?**

Project management and support for 12 months has been identified from within the SBC Business Change and Transformation Team and is not funded from the ICF.

11	**Would the project require dedicated project support from the programme team** (see guidance notes section 6)

The project team for this is already in place.

Please return this form to the Programme Team
Email: IntegratedCareFund@scotborders.gov.uk
Phone: 01835 82 5080

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Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 8 May 2019

Report By	Robert McCulloch-Graham, Chief Officer Health & Social Care
Contact	Robert McCulloch-Graham, Chief Officer Health & Social Care
Telephone:	01896 825528

PRIMARY CARE IMPROVEMENT PLAN (APRIL 2019-MARCH 2020)

Purpose of Report:	To propose that the Integration Joint Board agrees the submission to the Scottish Government of the revised Primary Care Improvement Plan for the Scottish Borders, and to agree its implementation.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Agree** the revised Primary Care Improvement Plan.

Personnel:	There will be staffing implications to support the on-going development and implementation of the PCIP for both GP Practices and the Primary and Community Services.; these will be addressed through each work stream and through the Primary Care Strategy Group.

Carers:	N/A

Equalities:	The overall policy direction of the Primary Care Improvement Plan will apply equally where possible. Health Inequality Impact Assessments will be undertaken at individual work stream level.

Financial:	There will be staffing implications within the PCIP, these will be addressed through each work stream and funding applied within the overall budget limit of the plan.

Legal:	Introduction of a new approach to primary care provision requiring an agreement with the IJB Board, and the GP Sub Committee.

Risk Implications:	Risk Assessments will be undertaken at individual work stream level.

Summary

1.1 The Primary Care Improvement Plan (PCIP) aims to further support implementation of the GMS contract 2018 for General Practitioners and improve the overall efficiency and quality of Primary Care provision within the Scottish Borders.

1.2 Integration Authorities are required to;

1. develop three-year Primary Care Improvement Plans (PCIPs), of which this is the second iteration to be presented before the Integrated Joint Board (IJB), the first was approved in September 2018. It is stipulated that these must be agreed with the local GP Sub Committee.

2. commission, deliver and resource, through their plans, the six priority services identified in the Memorandum of Understanding (MoU) and the Contract document ("Blue Book") in support of the new GP contract.

1.3 The Primary Care Improvement Plan focuses on six priority work areas:

- Vaccinations;
- Pharmacotherapy;
- Community Treatment and Care;
- Urgent Care;
- Additional Professional Roles:
  - First Point of Contact Physiotherapy;
  - Community Mental Health Professionals;
- Community Link Workers.

1.4 The plan is an iterative document which aims to offer a high level summary of intentions across the work streams during the remaining period of the plan. Further on-going work is required across the partnership to further develop the required provision for individual elements, for example, the Vaccination Transformation Programme.

1.5 The first year of the plan has been supported through the Primary Care Strategy Group and the 6 work streams, all supported by local GPs. In developing this current update of the plan, it has been recognised that further support is required to enable productive input from GPs. To this end an executive group of the GP Sub has assisted, and will continue to assist in its implementation and further development.

1.6 The Primary Care Division of the Scottish Government have been involved throughout our preparations and remain supportive. We expect, as do all IJBs, that more detail will be added with each revision of the plan. The plan expects delivery within the remaining two years. Further reports and refinements to the plan will be taken to the Strategic Planning Group of the IJB, with highlight reports being brought to the IJB. The governance of the overall plan takes place at the Primary Care Strategy Board (PCSB) which contains members of all stakeholders.

Funding

2.1 The Scottish Government invested £962k from the Primary Care Improvement Fund (PCIF) during 2018/19 with a further anticipated investment of £1m during 2019/20.

2.2 The 2018/19 allocation was not fully utilised therefore £440,867 has been carried forward for use in 2019/20. The fund must be delegated in its entirety to Integrated Authorities (IA's).

Progress

3.1 Planning and workforce constraints have slowed progress; however, increased traction should be possible in year 2 of the plan with greater involvement of the partnership of GPs supported through GP Sub and its executive.

3.2 GP colleagues remain involved through all six workstreams and through the PCSG. Progress was discussed at the last PCSG, where lead Civil Servants from Scottish Government were present. They acknowledged the progress made to date and were able to share examples of good practice and some areas of continued challenge experienced across Health and Social Care Partnerships.

3.3 Borders Health & Social Care Partnership and the Chair of the GP Sub Committee, were invited to present the progress of PCIP implementation to the National GMS Oversight Group on 24 April 2019. This meeting highlighted the need for a number of national agreements still required to support the implementation of the new GMS Contract.

3.4 The 2019/20 plan presented here is supported by the GP Sub Committee for submission to the Scottish Government. GP Sub recognises that this is a further iteration of our shared plan and that further work will be required as we progress into the second year of implementation. The IJB are recommended to approve the 19/20 plan.

3.5 Further updates on each of the six work streams of the PCIP will be reported to the Strategic Planning Group of the IJB, with highlight reports brought to the IJB as necessary.

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Borders Health & Social Care Partnership

Primary Care Improvement Plan

2018 – 2021

NHS Borders

Scottish Borders Health and Social Care PARTNERSHIP

Scottish Borders COUNCIL

Contents

Foreword

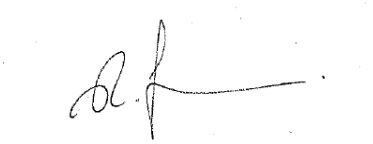
I would like to introduce Scottish Borders' updated Primary Care Improvement Plan as part of the Scottish Governments transformation of Primary Care essentially improving services for all.

From 1st April 2018 we now operate a new contract for our GPs across the country and here in the Scottish Borders we are looking forward to progressing the joining up of services supporting our local communities.

The Borders is a wonderful and beautiful place in which to live and work. It does however provide some particular challenges around access to Health and Social Care Services.

The new legislation and this updated plan developed by the professions within Primary Care are intended to better utilise our resources to meet these challenges.

It is not the final statement on Primary Care in the Scottish Borders, it is however our clear statement of our on-going intent, and we will continue to work across the professions and with the people of the Borders to provide a Primary Care Service, fit for purpose, for now and for the future.



Robert McCulloch Graham

Chief Officer, Scottish Borders Health and Social Care Partnership

Primary Care Improvement Plan

Scottish Borders

Financial Year: 2019/20

Introduction

This document forms the updated Scottish Borders Primary Care Improvement Plan (PCIP). The PCIP has been developed as a requirement of the national Memorandum of Understanding[1] between the Scottish Government, Integration Authorities (IA), the Scottish General Practitioners Committee (SGPC) of the BMA and NHS Boards. It is also consistent with our local priorities and objectives set out within the Scottish Borders Strategic Plan 2016 to 2019 and NHS Borders' Clinical Strategy which reflect the commitment of the Scottish Borders Health and Social Care Partnership (H&SCP) and its partner agencies to continuously improve the quality of treatment, support and community services provided to the population.

The PCIP therefore forms a crucial strand of a transformational programme for Primary Care Services overall which will be reflected in an emerging and overarching Primary Care Strategy.

This updated PCIP is a dynamic working document and through on-going liaison with all stakeholders will continue to be revised as the work streams progress and implementation proceeds.

Background

National Context

On 13th November 2017 the new GMS contract was published and was accepted by the GP community in January 2018 through a ballot of the profession. The contract is underpinned by four key documents:

- The Scottish GMS Contract Offer Document[2]
- The National Code of Practice for GP Premises[3]
- The National Health Service (GMS Contracts)(Scotland) Regulations 2018[4];
- Memorandum of Understanding (MoU) – to cover the transition period between 2018 and 2021

[1] *Memorandum of Understanding between the Scottish Government, Integration Authorities, BMA and NHS Boards: GMS Contract Implementation in the context of Primary Care Service Redesign. (Nov 2017)*

[2] *The Scottish GMS Contract Offer Document 2017 (http://www.gov.scot/Publications/2017/11/1343);*

[3] *The National Code of Practice for GP Premises 2017(http://www.gov.scot/Publications/2017/11/7592);*

[4] *The National Health Service (GMS Contracts)(Scotland) Regulations 2018*

The contract aims to refocus the role of GPs as Expert Medical Generalist's (EMG's) working within a Multi-disciplinary Team (MDT) in which the GP will focus on:

- Undifferentiated presentations;
- Complex care;
- Local and whole system quality improvement;
- Local clinical leadership for the delivery of General Medical Services (GMS).

Within the contract documents, the role of the Expert Medical Generalist is described as:

"Expert Medical Generalists will strive to ensure robust interface arrangements, connection to and coherence with other parts of the wider primary care team (e.g. nurses, physiotherapists), health and social care community based services and with acute services where required. The EMG will be supported by a multi-disciplinary team (MDT); maximising the contribution of both clinical and non-clinical staff in medicine, nursing, allied health professions, links workers, practice management, administration and others."

To enable the development of this EMG role, there will be a shift over time of GP workload and responsibilities - this will require a wide range of tasks currently undertaken by GPs to be completed by members of a wider primary care multi-disciplinary team where it is safe and appropriate to do so, while also demonstrating an improvement for patient care.

In support of the implementation of the contract in the context of Primary Care Service redesign, a Memorandum of Understanding (MoU) was agreed in November 2017 between Scottish Government, Integration Authorities, the Scottish General Practitioners Committee (SGPC) and NHS Boards. This is a key document that summarises the entire process.

It is a requirement of the MoU that Integrated Authorities develop and review a local Primary Care Improvement Plan (PCIP). The aim of the plan is to identify and integrate key areas to be transformed in order to achieve the GP contract goals with the expectation that reconfigured services will continue to be provided in or near GP practices.

The MoU states six nationally agreed priorities, which are evidence-based, for transformative service redesign in Primary Care in Scotland over a three year planned transition period between 2018 and 2022. These are:

- Vaccination services;
- Pharmacotherapy services;
- Community Treatment & Care Services (CT&CS);
- Urgent Care (Advanced Practitioners);
- Additional professional roles:
    - MSK Physiotherapy;
    - Community Clinical Mental Health Professionals;
- Community Link Worker's (CLW's).

GP's will retain the lead professional role in these areas in their capacity as EMG's.

The MoU outlines some key enablers of change linked to Premises, Information Sharing Arrangements and Workforce. Within the latter, it highlights the workforce implications of the MDT:

"As part of their role as EMG's, GPs will act as senior clinical leaders within the extended MDT as described in this MOU. Many of the MDT staff deployed in the priority areas listed above will be employed by the NHS Board and work with local models and systems of care agreed between the HSCP, local GPs and others. Staff will work as an integral part of local MDTs. NHS Boards, as employers, will be responsible for the pay, benefits, terms and conditions for these staff. Some MDT members will be aligned exclusively to a single GP practice while others may be required to work across a group of practices (e.g. Clusters).

Workforce arrangements will be determined locally and agreed as part of the HSCP Primary Care Improvement Plans. Existing practice staff will continue to be employed directly by practices. Practice Managers, receptionists and other practice staff will continue to have important roles in supporting the development and delivery of local services. Practices Managers should be supported and enabled to contribute effectively to the development of practice teams and how they work across practices within Clusters and in enabling wider MDT working arrangements"

Financial resource to support delivery of the PCIP's will be provided through the Primary Care Fund from the Scottish Government and, on the whole, will be allocated on an NRAC basis (National Resource Allocation Committee formula). Local collaboration between Health Boards, GP Sub Committees and Health & Social Care Partnerships (HSCPs) is key to prioritising the work streams within the plan and subsequently agree the internal funding arrangements.

The MoU is provided on Appendix 1.

Local Context

Scottish Borders covers an area of 4,743 square kilometres (1,831 square miles), with a population of approximately 118,484 people registered with a GP practice and a population density of 25 persons per square kilometre (compared to 65 persons per square kilometre for Scotland). Thus, suggesting a less densely populated geography.

The population distribution is based mainly within 13 towns ranging in size from around 2,000 to nearly 15,000 and many smaller villages and individual dwellings. In addition, the cross-border flow of patients is an important consideration particularly around Newcastleton, Coldstream and Eyemouth.

Following the implementation of The Public Bodies (Joint Working) (Scotland) Act 2014, one Health & Social Care Partnership/Integrated Authority was established covering Scottish Borders as a whole and with the responsibility for the strategic planning for a range of services provided by NHS Borders. Within the Scottish Borders Integrated Authority, 5 localities have been established: namely Berwickshire, Eildon, Cheviot, Tweeddale and Teviot. Four Quality Clusters are now in place in line with the revised GMS Contract and they span across the five localities.

There are currently 23 GP practices in Borders, with 18 health centres owned by NHS Borders.

The two overarching local strategic documents are Scottish Borders Strategic Plan, developed through the IA and NHS Borders' Clinical Strategy. Both are focussed on enabling people to access the right care and support to meet their needs in the right way, in the right place and to deliver services in an integrated and person-centred way.

Scottish Borders Strategic Plan has at its core the following three objectives:

1. We will improve the health of the population and reduce the number of hospital admissions;
2. We will improve the flow of patients into, through and out of hospital;
3. We will improve the capacity within the community for people who have been in receipt of health and social care services to better manage their own conditions and support those who care for them.

NHS Borders Clinical Strategy holds as its vision:

"*To provide personalised, evidence based care as close to home as possible. Working with people to define treatment goals and optimise outcomes. Supporting people to stay well; treat illness and manage crises.*"

The aims of the Clinical Strategy are as follows:

- Greater focus on prevention of ill health and reduction of health inequalities;
- Integrated community teams to provide support for prevention of illness to intensive care at home;
- Admission to hospital will only be required for specialist care;
- Proactive approach to Realistic Medicine;
- Sustainable, safe, high quality services across the care pathway informed by evidence supported by eHealth and digital technologies;
- A workforce that has the capacity, capability and adaptability to meet future demands.

Significant transformational change programmes are underway across the IA and NHS Borders with the aim of reshaping and improving resources in line with these principles and objectives in order to provide sustainable, safe service models within the means available. Part of this work will see the development and redesign of community services and will enable people to be supported within their own home and local communities wherever possible. The principles and aims of the PCIP along with its implementation are consistent with and inexorably linked to this wider Primary Care agenda.

Governance (Programme Board)

A, 'GP Away Day' was held on 22nd May 2018 at which each area of the plan was explored, including the governance arrangements for the development and implementation of the Primary Care Improvement Plan (PCIP).

The plan was developed and updated through working with GPs, the Primary and Community Services (P&CS) team and a wide range of stakeholders. The PCIP has been shared with bodies including the GP Sub-Committee, the IA and NHS Borders amongst others.

Following agreement, the IA issued directions to NHS Borders to implement the plan. This will be the responsibility of the Primary Care Strategy Board (PCSB). The Board has been established and meets on a bi-monthly basis. It includes representatives from the GP Sub-Committee, Cluster Quality Leads, IA and NHS Borders (including the Primary & Community Services team).

The PCSB has commissioned project groups to deliver implementation of 6 work streams identified as being key requirements of the GMS contract provision within the Scottish Borders. These are:

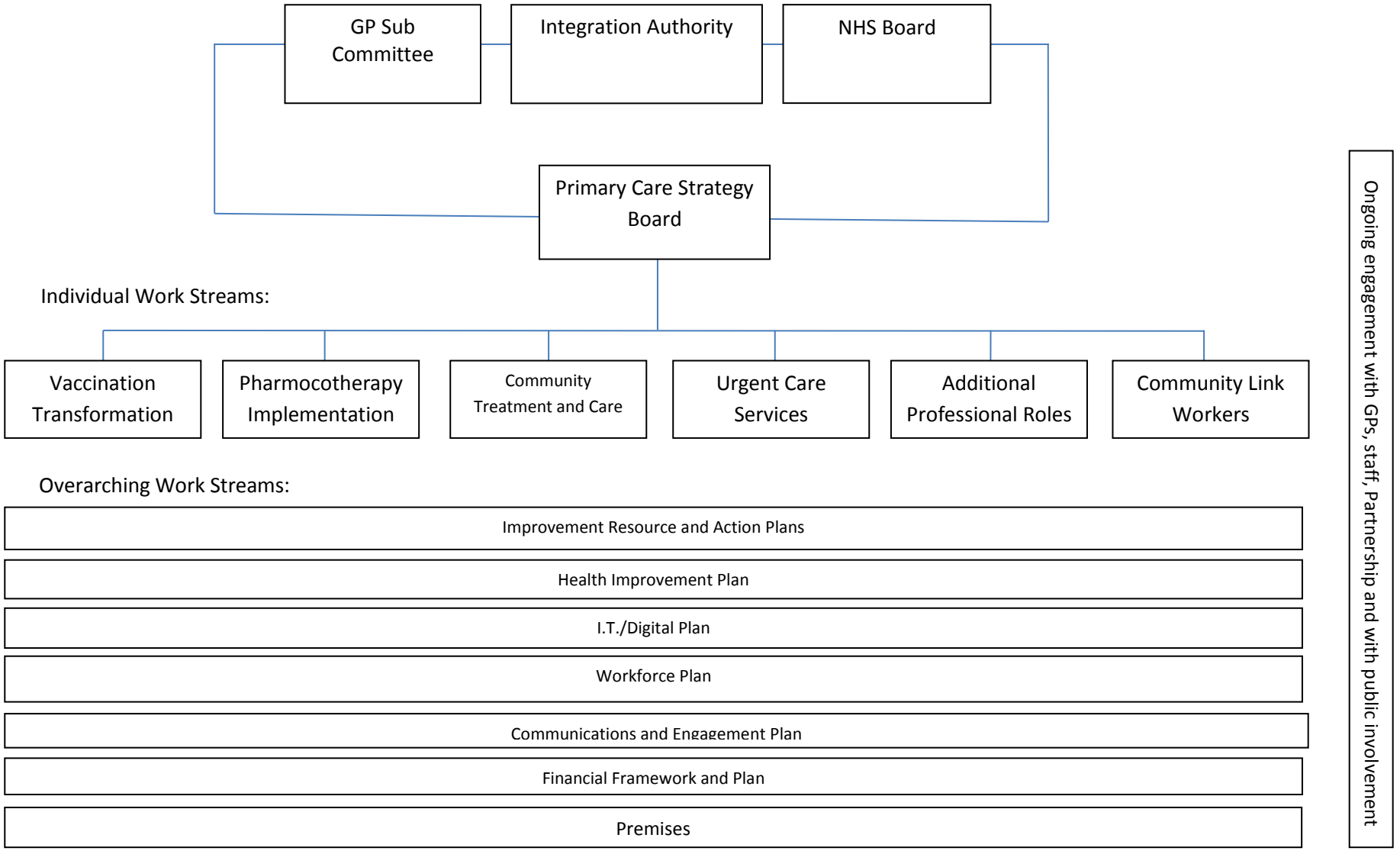
- Vaccinations Transformation Group;
- Pharmacy Services (via the Primary Care Prescribing Group & Pharmacotherapy Oversight Group);
- Community Care & Treatment Group;
- Urgent Care Group;
- Physiotherapy First Point of Contact Group;
- Primary Care Mental Health Group (to include Community Mental Health Professionals & Community Link Workers).

There are additional groups in place relating to premises (re-invigorated) and the newly established IT/ehealth group that will provide the foundations of transformation. During 2019/20 another work stream will be added to review appointment booking & administration services.

Each work stream will have an identified project sponsor, lead and/or practice representative and provide monitoring reports for submission to the PCSB. They will develop Key Performance Indicators (KPI's) clearly linked to outcomes, enabling shared learning and ensuring evaluation takes place. These will closely link to the Scottish Government's reporting template to be completed every 6 months. Project management methodology will be followed within each of the streams.

Public representation will be progressed in each group and via NHS Borders Public Reference Group (PRG). Consideration will be made to the re-establishment of Practice Patient Groups (PPG's).

The overall governance structure is shown over the page.


GP Sub Committee
Integration Authority
NHS Board
Primary Care Strategy Board
Individual Work Streams:
Vaccination Transformation
Pharmocotherapy Implementation
Community Treatment and Care
Urgent Care Services
Additional Professional Roles
Community Link Workers
Overarching Work Streams:
Improvement Resource and Action Plans
Health Improvement Plan
I.T./Digital Plan
Workforce Plan
Communications and Engagement Plan
Financial Framework and Plan
Premises
Ongoing engagement with GPs, staff, Partnership and with public involvement

Work Streams within the Primary Care Improvement Plan

This section provides information on progress during year 1 for each of the 6 key priority areas and the proposals for both year 2 (2019/20) and year 3 (2020/21).

1. The Vaccination Transformation Programme (VTP)

The Scottish Government announced in March 2017 the intention to develop a Vaccination Transformation Programme (VTP) this recognises both the increasing complexity of vaccine programmes and the changing role of the GP.

The VTP consists of the following elements:

- Pre-school Programme;
- School based Programme;
- Travel vaccinations and travel health advice;
- Influenza Programme;
- At risk and specific age group Programmes (shingles, pneumococcal, hepatitis B).

Each of these work streams will be incorporated into the overall Scottish Borders programme. The aim is to achieve seamless change by the end of the plan period (i.e. 31st March 2021).

National groups have been established to oversee vaccine transformation programmes within Health Boards. These are the Scottish Immunisation Programme Group and Business Change Manager's (BCM) Group. They will develop national strategies (e.g. information, monitoring, quality, risk management etc.), blueprints and plans that will influence local decision-making.

A Scottish Borders VTP Group has been established to drive forward local transition. This requires key stakeholder engagement and consultation with the local Area Medical Committee (AMC) as well as patient representatives (for example, via the NHS Borders Public Involvement Network). They have committed to deliver all VTP elements of the contract by March 2021.

The local VTP Business Change Manager (BCM) will act as the catalyst for change and is working on:

- Reviewing the current delivery model;
- Exploring opportunities within alternative facilities including the future option of Health Board provision (through centralised Hubs potentially at Kelso, Hawick, Peebles, Duns, Galashiels or the Borders General Hospital);
- Investigating a hybrid model.

A range of considerations and challenges have been identified during the early discussions regarding the delivery of transformation and these will be addressed as part of the programme. They include:

- The current complexity of immunisation programmes;
- Prioritising patient safety;

- Replicating the current high level of attainment of childhood and adult immunisation in General Practice;
- Public and patient expectations must be considered and appropriately managed;
- Existing GP IT systems support immunisation delivery and provide a complete record of an individual's medical history, reducing risk if inappropriate immunisation;
- Workforce considerations;
- An option's appraisal is required to agree the most appropriate service delivery model for the new programmes. It will need to be flexible and acknowledge that it may not be appropriate for all areas of the Scottish Borders;
- Immunisation locations will be identified, this will be challenging due to capacity issues within Primary Care premises;
- Delivery of the currently proposed VTP has significant financial implications.

The total programme of change is scheduled over the full 3 years of the plan in recognition of the time required to provide robust processes that ensure public safety (our main priority) with assurances that structures, roles and governance are established. During year 1 pertussis vaccines (whooping cough for pregnant women) has been transferred from general practice to NHS Borders midwives (one of the at risk elements). A review of the outcomes and learning from the implementation will occur prior to instigating the other elements of the work stream. At present cost information is being developed on the strands of the programme.

It is anticipated that years 2 and 3 will realise a greater realignment of provision outside GP practice.

Different models for each vaccination type (influenza, childhood immunisation, HPV, shingles, travel, pneumococcal etc.) will be developed. NHS Borders Public Health Department will re-create the current patient experience from beginning to end of the vaccine journey and will map the present vaccine demand by each element of the VTP. The simple timeline for the transition of the individual work streams is estimated to be:

Previously Completed		Year 1		Year 2		Year 3
• School programme (including flu vaccines)		• Pertussis/ whooping cough vaccine		• Continuation of 0-5 years programme work • Shingles (start) • Travel		• Shingles (completion) • Flu & Pneumococcal vaccines 65+ • Flu Vaccines (for those at risk)

Priorities for the Vaccine Transformation Programme are still under negotiation. Options will be reviewed regularly with discussion taking place at the GP Sub-Committee meetings. More detail will be added to the plan as it is reviewed.

2. Pharmacotherapy Services

The contract states that "From April 2018, there will be a three year trajectory to establish a sustainable pharmacotherapy service which includes Pharmacist and Pharmacy Technician support to the patients of every practice. This timeline will provide an opportunity to test and refine the best way to do this, and to allow for new Pharmacists and Pharmacy Technicians to be recruited and trained."

This is a fundamental change in the delivery and management of Pharmacy services as they will be based at individual practice level. By April 2021 all practices will benefit from Pharmacy delivering key core services, with some practices receiving additional services where possible.

Core services to be delivered by 2021 include:

- Authorising and action all acute and repeat prescription requests;
- Authorising and action hospital immediate discharge letters (IDL's);
- Medicines reconciliation;
- Medicine safety reviews/recalls;
- Monitoring high risk medicines;
- Non-clinical medication reviews.

Acute and repeat medicine prescription requests is a large area (a recent audit suggests 15 hours GP time, per practice, per week) which includes the authorising and action of:

- Hospital outpatient requests;
- Non-medicine prescriptions;
- Installment requests;
- Serial prescriptions;
- Pharmaceutical queries;
- Medicine shortages;
- Review of use of 'specials' and 'off-licence' requests.

This is to be managed by Pharmacists. Beyond this Pharmacy Technicians, who are in many cases already within practices at present, will also focus on:

- Monitoring clinics;
- Medication compliance reviews (patient's own home);
- Medication management advice and reviews (care homes);
- Formulary adherence;
- Prescribing indicators and audits.

Testing elements of the Pharmacotherapy Service within a practice will be the initial stage of implementation, followed by cluster working then expansion across the Scottish Borders based on a sustainable model.

Following the publication of, 'Prescription for Excellence' during 2013 and updated with, 'Achieving Excellence in Pharmaceutical Care' in 2017 the ethos of, 'Realistic Medicine' (also published in 2017) and polypharmacy have been followed.

There are a number of projects taking place within practices including:

- Regular patient facing review clinics (by an independent prescribing Pharmacist);
- Medicines Reconciliation (from hospital discharges when the Pharmacist is in the practice – in future a system is to be put into place);
- Polypharmacy and Care Home reviews;
- COPD/Pulmonary Rehabilitation/Inhaler Reviews;
- The Integrated Joint Board Care at Home-Pharmacy Project;
- Training & supporting practice administration teams to complete non-medication reviews.

Where practices already receive support this would be included in total enhanced team. The capacity impact on practice workload will be assessed during the span of the PCIP.

Furthermore, there are services being delivered within Community Pharmacy which help reduce GP workload. These include:

- The Medicine Review Service;
- Pharmacy First, incorporating treatment for Urinary Tract Infections and Impetigo;
- The Chronic Medication Service (CMS).

At present it is the ambition of the IA to increase pharmacy support to practices by expanding the current Pharmacy First services to include treatment of infected bites and exacerbations of Chronic Obstructive Pulmonary Disease (COPD).

During year one 3WTE experienced Prescriber Pharmacists and 2.2WTE Pharmacy Technicians were recruited. Further recruitment to build upon the pharmacy service roll out will take place during year two. The anticipated costs for 2019/20 are expected to be £379,974.

These services will cover core hours during the working week (i.e. Monday to Friday) and equates to approximately one Pharmacist per 10,000 patients.

When these employees are working within the practice they will use the practice's patient record system and work as part of the practice team. To provide daily support, it is expected that some of the time allocated to the practice will be provided remotely. This is to prevent 'batching' of work and help manage workflow. The team will work under a single governance structure but will have different tasks in different practices as roles and practices develop at varying paces.

Additionally, the unified repeat prescribing system across the whole of the Scottish Borders has been the first priority and responsibility of the NHS Borders Pharmacy department.

The annual Scottish Borders Pharmaceutical Care Services plan will provide more detail on the transitional process as it identifies the pharmaceutical care needs for both Community Pharmacy and Primary Care as a whole.

A general summary of the aims to be achieved by this enhanced team are:

Year 1	Year 2	Year 3
•Develop a unified repeat prescribing system •Ensure a sustainable process for hospital discharge letters •Establish a process for medicines reconciliations	•Embed the repeat prescribing system •Create a process for Level 2 pharmacotherapy services	•Roll out the medication review & high risk medicines processes •Develop support for the Level 3 pharmacotherapy services

3. Community Treatment and Care Services (CT&CS)

Community Treatment and Care Services are one of the three main priorities for PCIPs stated within the MoU which is aiming to deliver change on a safe and sustainable basis over the next 3 years with the initial focus on phlebotomy.

CT&CS will include but is not limited to the following:

- Phlebotomy;
- Basic disease data collection and biometrics (e.g. blood pressure etc.);
- Chronic disease monitoring;
- Management of minor injuries and dressings;
- Ear syringing;
- Suture removal;
- Some elements of minor surgery.

In the Scottish Borders phlebotomy services have been revised and successfully remodelled historically therefore was not a priority of the PCIP in year 1. The on-going focus locally will be in the other areas listed.

Currently CT&CS are provided across the Scottish Borders in a variety of ways and involve a range of clinical professions. This section also links with the local transformation programme for community services which is currently underway and will run concurrently with the PCIP. It will reshape community models of care, including community and day hospitals, rehabilitation services and community nursing services. The PCIP is an integral part of this overarching strategic direction for wider Primary Care in the Scottish Borders.

It has been identified that our local treatment rooms have an important role in the delivery of CT&CS, however, they will require a review to establish resources and suitability. There are 10 treatment rooms which provide services to 15 GP practices. Recognising the different starting points and challenges to be overcome in order to provide a consistent and safe service to patients it is important to establish a strong baseline to enable an appropriate treatment room model to be established.

During the first year the focus has been and will continue to be during year 2:

- Engaging with and applying national training structures and opportunities via the, 'Transforming Roles Programme';
- Agree set opening times and appropriate staffing levels/skill mix across all treatment rooms and community hospitals;
- Improve appointment booking systems (via the administration teams);
- Ensuring availability for both Primary and Secondary Care.

As noted previously, Community Treatment and Care Services are delivered across the whole Primary Care community, with links between GP practice's and other IA professionals/services. Community hospitals are a significant resource and redesigned care models have been considered within the recent research undertaken as part of the IA transformation programme.

The work being taken forward as part of the wider transformation programme will be linked with the delivery of this PCIP action point and together the following areas will be covered:

- Developing a Community Hospitals and Intermediate Care Framework;
- Review community employee levels (in Community Hospitals and Treatment Rooms);
- Create an improvement network across these services with connections to frailty and palliative care services;
- Support local working through the realignment of the Department of Medicine for the Elderly (DME) Consultant sessions.

The local Minor Injury Units (MIUs) are connected to community hospitals and as such a review of their current demand and the resulting safety implications of continuing or expanding the role of these units will be considered.

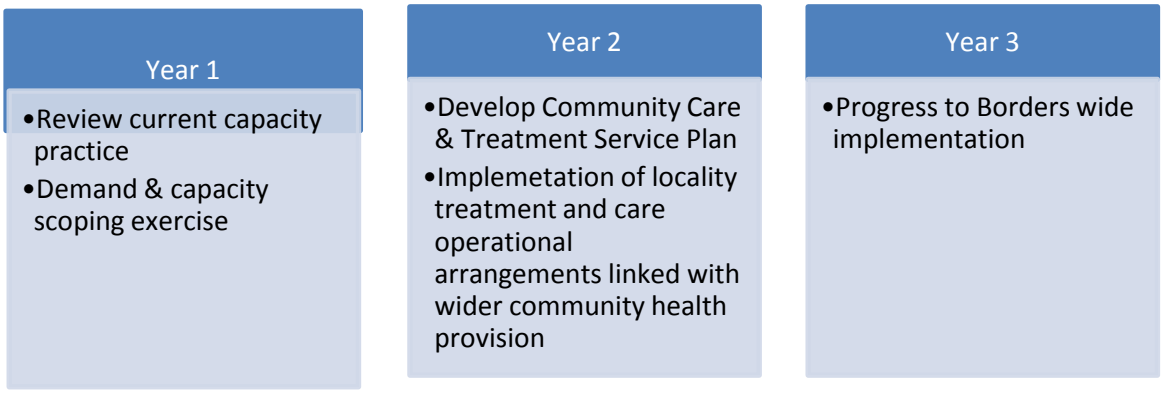
Key to these changes is the evolving role of the nursing profession and their training requirements. The national transforming roles programme is currently in phase 1 which is focussing on a consistent approach to Advanced Nurse Practitioners (ANP's) and developing an integrated community nursing team (containing ANP's, General Practice Nurses, District Nurses, Mental Health Nurses, Health Visitors, School Nurses etc.). The Scottish Borders are committed to being part of this process.

We therefore have the opportunity to support the education and clinical supervision for ANP's in Primary Care. There is a survey of ANP education requirements underway with a plan to work to a national definition of advanced nursing practice.

There is very close linkage between the CT&CS work and urgent care with ANP's being the catalyst for change. They will be able to provide professional guidance for treatment room staff going forward as well as support the role of the EMG (as they implement, 'House of Care').

Overall these models are a significant departure from the current process and will require developments in services, Information Technology (I.T), processes and governance in order to transfer the work from practices in a safe and sustainable manner.

The programme of work to establish new models of care is shown below:



4. Urgent Care (Advanced Practitioners)

To reduce GP workload and free up GP capacity the MoU supports the redesign of urgent and unscheduled care services. This aims at providing advanced practitioner resource (nurse or paramedic) to act as the first response to home visits or urgent call outs from patients. It is probable that these individuals will work across Clusters rather than individual practices in order to meet patient needs.

Testing of this approach has already taken place within the Scottish Borders (Hawick and Kelso) as noted on the GP contract document. During 2018/19 a further pilot took place within the South Cluster. The aim was to measure the benefits of the role and share learning from practices working collaboratively.

There continues to be wide ranging views about how this work stream should develop and which professional is the most appropriate to provide urgent care. Discussions will continue with the Scottish Ambulance Service (SAS) to enable the reintroduction of services (following positive evidence from the pilot schemes) at a later date. In the meantime, service redesign will focus on ANP's initially.

Commencing in January 2019, the recruitment of ANP's to cover the clusters in West and South is being progressed. The development of a local training pathway to enable Band 6 nurses to progress into these Band 7 roles is also being pursued. This is to address workforce difficulties and forms part of the ANP strategy that NHS Borders has in place.

To support the development of the ANP model it is planned to recruit a part-time senior nursing leadership role for 24 months. This role would be focussed on delivering the ANP model as well as supporting nursing within practices.

This would be at a potential cost of £259k in year 2 (see the funding elements below).

Priority for investment	Outline	Funds
Recruitment to a Primary Care Advanced Nurse Practitioners (ANP) Team	Recruitment of 6 x Band 7 ANP roles	£239,000
	Support development of existing ANP's working with Practices	£20,000
Leadership role	0.5 x Band 8a	£31,066
Total		**£290,066**

A simple timeline of this work stream is shown below:

Year 1	Year 2	Year 3
•SAS pilot in South Cluster •NHS Borders ANP strategy developed •ANP pilot in Knoll Community Hospital •Begin recruitment of nurses to ANP roles	•Develop local training pathway •Demonstrate ANP roles working in two cluster areas (West & South)	•Recruit remaining practitioners for coverage of all areas

5. Additional Professional Roles

Additional professionals' role will provide services for groups of patients with specific needs that can be delivered by other professionals as the first point of contact in the practice and community setting; this would be determined by local needs. Examples of this type of role include:

- First Contact Physiotherapy Service;
- Community Mental Health Workers.

5a. First Contact Physiotherapy (FCP) Service

First Contact Physiotherapy (FCP) means patients with a musculoskeletal problem who contact their local GP surgery are offered an appointment with a physiotherapist instead of a GP. An appropriately trained and experienced physiotherapist based within the practice is able to autonomously assess, diagnose and address the immediate needs of a large proportion of these patients, initiating further investigations and referrals where clinically appropriate. This approach puts physiotherapy expertise right at the beginning of the MSK pathway where patients can get the most benefit and in the place where they are most likely to first seek help.

Based on pilots in other NHS Board areas, FCP has been shown to complement the practice's approach with regard to health promotion, early intervention, use of medicines and investigations and onward referral to secondary care services such as orthopaedics. The FCP assesses diagnoses and acts upon the clinical findings, signposting to appropriate community resources and equipping people with the knowledge and advice to self-manage their condition. The FCP will also request investigations where clinically relevant and refer onward to the appropriate services.

The intended outcome of FCP is to reduce the burden on stretched GP practices in the Scottish Borders and improve the patient journey through early intervention, signposting, and treatment. Assuring the patient sees the right person first time should reduce the number of steps in the clinical pathway and minimise the time it takes for a patient to receive the appropriate services for their condition ensuring optimal outcomes. This approach is being implemented within the Scottish Borders.

The First Contact Physiotherapy (FCP) service has recently recruited 4 x Band 7 physiotherapists that are covering East and Central Cluster. Once imbedded the intention is to expand to the other cluster areas and explore sustainable models of service provision.

Priority for investment	Outline	Funds
Musculoskeletal focused physiotherapy services	• Appointed 4 x Band 7 First point of contact physiotherapists • Expand service in year two (options are to replicate East Cluster i.e. costs provided or explore an alternative model)	£191,462 £191,462
Total		**£382,924**

5b. Community Mental Health Professionals

Community clinical mental health professionals, based in practices, will work with individuals and their families assessing their mental health needs. The aim is to provide support for conditions such as low mood, anxiety and depression. The subsequent outcome to be achieved is improved patient care through more swiftly accessible and appropriate mental health input.

The 2017 – 2027 Mental Health Strategy (http://www.gov.scot/Publications/2017/03/1750/0) is aiming for multi-disciplinary teams to be based within Primary Care ensuring practices are able to support and treat patients with mental health issues. A test of change is taking place throughout 2018 relating to first responders for those in crisis. This is Scotland-wide.

This pilot plus the commitment to recruit 800 mental health workers across Scotland (this equates to 16.5 in the Scottish Borders) will indirectly benefit General Practice. The goal for the Scottish Borders over the lifetime of the plan is to recruit these individuals in line with national guidance.

There is significant complexity around mental health presentations within Primary Care and as such multi-layered, evidence based interventions is required. Therefore a multi-professional mental health team is required to be integrated with both practices and other mental health teams.

In year one the goals were to implement one single line management structure for the Public Health Advisors and provide a robust model of services. During January 2019 the NHS Borders Wellbeing Service was launched. Following implementation a review will take place:

- The review will evaluate and provide support for Community Psychiatric Nurses (CPN's), Lifestyle Advisors (LASS) and Counseling Services (including adolescent services);
- Clarity and general improvements to access methods and referral pathways will be provided;
- Make increased use of technology e.g. mobile telephone applications;
- Also for consideration is the application of computerised cognitive behavioural therapy (CBT) and additional mental health professional capacity in practices.

This section will be further developed to address Action 15 of the Mental Health Strategy and has strong linkage with the Community Link Worker (CLW) role.

6. Community Link Worker's (CLW's)

The CLW programme has been established to make connections between individuals and their communities via their GP practice. The aim is to mitigate the impact of the social determinants of health in people that live in areas of high socioeconomic deprivation.

The CLW role will assist people with financial, emotional or environmental problems. These may include housing, debt, social isolation, stress or fuel poverty problems. By providing advice, direction to other organisations/activities in the community or alternatively coping strategies the CLW will ensure people feel more supported in their community.

The Scottish Government manifesto is to provide 250 CLW's over the life of the Parliament therefore the target goal for the Scottish Borders is to enable 5 such roles across the area.

NHS Borders has in place a team called, 'The Scottish Borders Adult Mental Health Local Area Co-ordination (LAC) Service' whose remit is to provide, 'empowerment for people who have experienced mental health issues or mental illness'. Their role is to encourage and enable individuals who have experienced mental health issues or mental illness to live active, independent and purposeful lives in their community. They work closely with Scottish Borders Council (SBC) Community Link Workers who collaborate with individuals with a learning disability, their carers, and other organisations to enable them to pursue their personal outcomes within their own local communities.

With these two roles already in existence it has been evaluated as appropriate to expand their remit in order to fulfil the needs to the MoU. Therefore, the team will be expanded during year two.

Priority for investment	Outline	Funds
Employ additional Local Area Coordinators (LAC's) & Community Link Workers (CLWs)	Expand current work force to 4WTE LAC's & 4WTE CLW's	£110,795

7. I.T and Data/Information Collection

'The NHS National Digital Service is developing a national health & social care digital platform which will allow relevant real-time data and information from health & care records to be available to those that need it, when they need it, wherever they are, in a secure and safe way'.

In the period prior to this being delivered it is essential to improve digital technology for use in primary care. The Primary Care Digital Improvement Plan 2019/20 (still in draft) sets out the standards & expectations which Health Boards are to meet. This will include projects such as GP IT re-provisioning, SPIRE, the Primary Care website project, GP2GP (in 2 phases) & OOH GP IT.

Nationally there is a Primary Care Digital Programme Board at which Health Boards will provide progress updates. In addition to this there will be a GP IT Service Management Board that will lead on contracts for existing GP IT systems.

The draft plan states that the, 'people who use the technology need to be at the heart of any plan' and, 'the people who use it must also be supported to build their digital skills'. This will require, 'a consistent approach to training primary care staff'. 'Local GP IT facilitators (Louise Murray within NHS Borders) play an essential role' and this role, 'will become increasingly important as GP practices transfer to new clinical IT systems'. The plan is clear in that the, 'views of the users of primary care digital technology need to be clearly represented'. This will be executed via an additional sub-group of the Primary Care Strategy Board as part of the overall PCIP.

There will be financial investment, 'to improve GP IT hardware'; however, the amount is unknown at this point in time.

Specific pieces of work have been identified on the draft digital plan. These include:

- Server improvement – 'move to cloud-hosting as it provides greater cyber security and will assist with remote access and integration with other systems';
- 'Secure internet connection with sufficient bandwidth and latency is fundamental' therefore the Scottish Government's "Reaching 100" project' 'aims to connect all of Scotland to superfast broadband by the end of 2021';
- Wifi – investment will be made during 2019/20 'to allow Health Boards to install secure wifi in all GP practices for staff and public wifi for patients'.
- NHS National Services Scotland (NSS) has contracted with EMIS Health, Microtest Ltd & Vision Health to provide GP clinical IT systems. Implementation is planned to begin in the summer of 2020 & completed by December 2022. The current preferred operator within the Scottish Borders GP practices is EMIS Health & we will plan on this basis.
- It is intended that by 31st March 2021, 'all consulting rooms' will have twin screens, 'to improve safety allowing management decisions to occur with all relevant data at the same time'. 'All clinicians will be equipped with mobile devices', Windows 10 to be implemented (by 14th January 2020) followed by Office 365 (by 31st March 2021);

- The Scottish Borders is a pilot area for the upgrade of GP2GP & this was preceded by the implementation of Docman version 75500. Upgraded deployments of these will continue;
- Other specific projects include an options appraisal for a national referrals infrastructure (by July 2019), move to a national GP Order Communications system, rollout of the national clinical decision support programme, home & mobile health monitoring (i.e. use of Florence® in the Scottish Borders) to facilitate self-management for example, blood pressure monitoring amongst others, national NHS website for use by individual GP practices (to include the mapping of practice boundary areas);
- 'In 2019/20, the Scottish Government will provide £2m to Health Boards to fund the digitalisation of paper records, freeing up space within GP practices which can be used for clinical and training purposes';
- 'Each Health Board should have an IT service level agreement (SLA) in place with its GP contractors'. NHS Borders has an out-dated SLA that will be reviewed during 2019/20 to ensure it is fit-for-purpose & relates to the delivery of the PCIP;
- 'Health Boards will jointly designate Data Protection Officers (DPOs) with those of their GP contractors who wish them to do so at no cost to GPs'.
- A Programme of Technology Enabled Care (TEC) with increased use of, 'Attend Anywhere' (online face-to-face consulting software) that will benefit patient interactions as a method of addressing time and travel constraints as well as assisting more remote and rural practices will be implemented;
- Project support will be provided when implementing, 'House of Care';
- The use of mobile applications, websites and social media will be part of the overall Communications Strategy that will link in with the IJB and NHS Borders strategies in order to ensure information sharing;
- Added transparency to local decision making by creating space on the most appropriate website. This will include relevant meeting dates, remits, documents and minutes.

'* From the draft Primary Care Digital Improvement Plan 2019/20

8. Premises

The National Code of Practice for GP Premises was published by the Scottish Government in November 2017. The main aim of the document is to highlight sustainability pressures around the GP workforce and premises liabilities and highlights the preference to move away from this to more Health Board owned and maintained premises. From the total 23 practices within the Scottish Borders, there is one GP owned practice and one leased practice with the remainder being within Health Board accommodation. There are also branch surgeries that need to be considered.

From Scottish Government guidance it is clear that each practice will transfer over a period of 25 years to Health Board premises.

During the first year of the plan one GP practice and one branch surgery have applied and been accepted for the Scottish Government's Sustainability Loan Fund. There is potential for a further practice premises to apply during 2019/20. The process to implement the fund will be progressed in year two.

The processes and procedures relating to leased premises will also be released during year two and discussion with the relevant practice has begun.

Overseeing this progress is the NHS Borders Primary Care Premises Group that reformed during year one of the plan.

Further work is required over the next two years. This includes:

- Evaluating current GP practice premises (including capacity, condition & suitability);
- Developing a premises strategy around the entire Primary Care estate (to include GP practices);
- Creating a maintenance schedule (with clear areas of responsibility and to include fixtures & fittings such as vaccine fridges). NHS Borders Capital Planning & Estates Departments will lead on these.

9. Other Areas

Additional aspects of the contract will require revising or updating as more details become available. Operationally the Primary and Community Services (P&CS) Team within NHS Borders will evaluate these, consult with the wider stakeholder group and incorporate changes as necessary.

Identified areas include but are not restricted to:

- An annual assessment of the Enhanced Services (the level of funding will remain the same as indicated by the contract document);
- Practice boundary areas will to be reviewed and clarified. This will be assisted by the national mapping exercise;
- Improving practice sustainability (including GP recruitment & retention) by promoting use of the Practice Sustainability Assessment Tool as recommended by the national group (a GP Clinical Lead is being recruited for this purpose);
- A process surrounding the setting up of new practices is to be established (in 2019/20);
- Certificates and fee charges (Scottish Government guidance to follow);
- Review the current meeting structure, remits and resources to ensure the ethos of the tripartite agreement, transparency and collaboration are achieved (a review will begin in 2018/19, concluding in 2019/20 with adjustments over the remainder of the plan as appropriate);
- Local population health needs assessments will be undertaken by public health and by working closely with LIST analysts;
- Workforce planning is integral to all elements of the PCIP and key to more detailed plan is the National Health and Social Care Workforce Plan: Part 3 Primary Care (http://www.gov.scot/Publications/2018/04/3662). NHS Borders Human Resources (HR) Department will develop this.

10. Cluster Working

Clusters are groups of practices working together to ensure the provision of high quality care for their patients and communities. They will drive forward continuous improvement, facilitating strong collaborative relationships across clusters. This will involve learning, developing and improving together. They will work in collaboration with the Primary & Community Services team.

There are currently four clusters within the Scottish Borders (East, Central, West and South – see map). This is to be reviewed within the duration of the plan particularly in terms of access and linkage to other areas and SBC services.

To maximise the potential from cluster working the Scottish Government's 'Improving Together' paper states the following requirements:

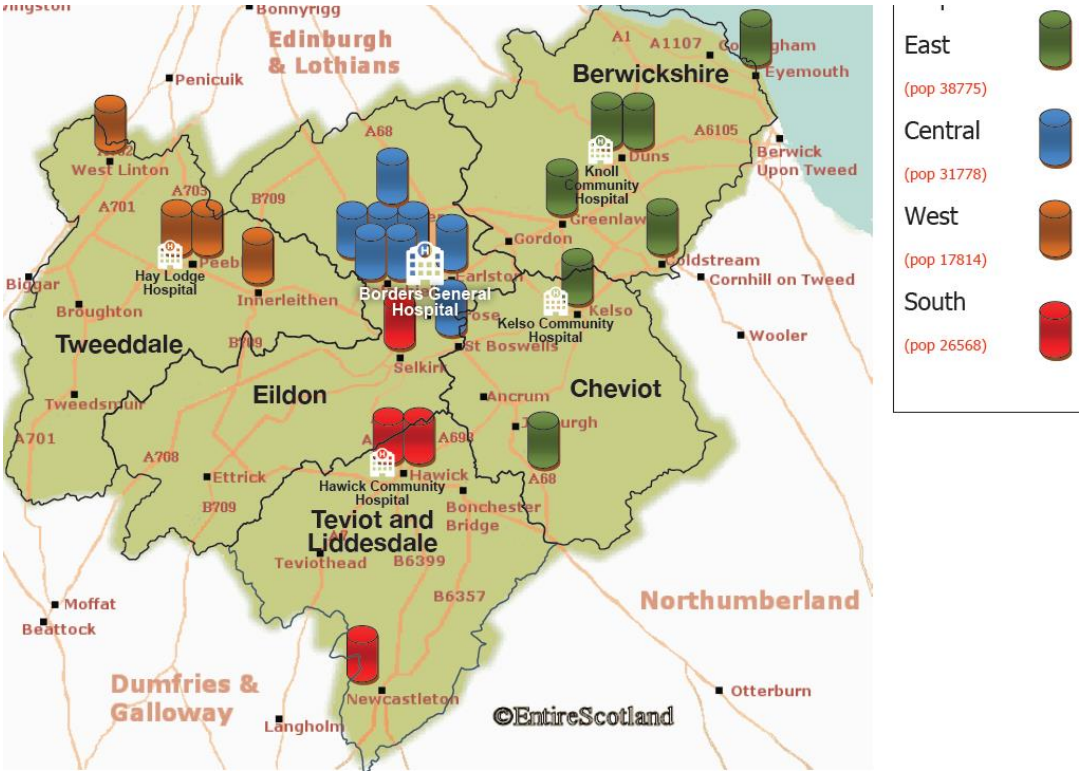
- Data;
- Health Intelligence Analysis;
- Facilitation (leadership provided through the clusters);
- Improvement Advice (national collaboration);
- Leadership (training for cluster leads).

'Better use of data and analytical tools' is the focus of cluster working. 'Investment will be made in 2019/20 to support GPs in improving the health of their local population utilising data and the new analytical tools available'. These include the Scottish Primary Care Information Resource (SPIRE), the Primary Care Information (PCI) dashboard and the Local Information Support Team (LIST).

Early in 2019/20 the Scottish Government (jointly with the BMA) will provide further guidance on cluster working. It is not available at this time therefore the plan will be updated once the guidance is published. In the meantime finalised recruitment process and job description will developed in partnership with the GP Sub-committee relating to the future appointment of these roles.

At present there are 4 GPs cluster lead positions at a cost of £46,080 per annum. A recurring funding source still needs to be found.

The map shows the layout of the practices by IA locality and cluster in the Scottish Borders:



11. Beyond General Practice

a) Borders Emergency Care Service (BECS)/Out-of-Hours (OOH)

'Pulling Together: Transforming Urgent Care for the People of Scotland' by Sir Lewis Ritchie (released November 2015) described a new model of care where a multidisciplinary, multi-sectoral urgent care co-ordination and communication function will be provided at Urgent Care Resource Hubs, which would be configured for both service delivery and training purposes. They would be established primarily to co-ordinate urgent care for OOH services, however, should be considered on a 24/7 basis.

Following tests of change, BECS will permanently employ a range of clinical colleagues to support the delivery of cost effective, sustainable urgent care. The redesign is demonstrated on Appendix 2.

Funding for OOH services sits outside the Primary Care Fund (PCF) yet service provision has an impact on daytime GP services.

b) Interface with Acute Services

Several strands of the PCIP have elements that span both Primary and Secondary Care Services, for example, MSK physiotherapy services, the Vaccination Transformation Programme (VTP) and Community Treatment and Care Services (CT&CS) – including phlebotomy. It is essential that good communication across the care sectors continues and further develops as the PCIP progresses. Formal discussions will take place through the evolving Area Medical Committee (AMC) which is still very much in its infancy. This aims to combine clinicians from both Primary and Secondary Care.

Smooth and cohesive interface working will benefit not only GPs and the wider MDT but the overall patient experience within the Scottish Borders.

12. Budget Planning

In February 2018 the Scottish Budget Bill confirmed an increase of the Primary Care Fund from £72m in 2017/18 to £110 in 2018/19 (with additional funds for Mental Health and Out-of-Hours). Within this is an allocation totalling £45.75m nationally which is the Primary Care Improvement Fund (previously the Primary Care Transformation Fund, pharmacy, recruitment and retention etc.). This has been merged with the view of providing increased flexibility for individual IA priorities.

It is recognised that the level of transformation expected will be challenging given the level of new funding being invested.

The process, cost and provision of adequate resource must be developed by the IA to ensure a safe transfer of workload. Service redesign will take into account the expectation that, where appropriate, the programme of delivery should continue to be conducted in or near GP practices.

The IJB Business Partner, situated within NHS Borders Finance Department, will work closely with the P&CS team to support them and will provide regular financial updates on expenditure related to the plan.

Funding of the GMS contract is, on the whole, via the Primary Care Fund (PCF). There are various programmes within this, one of which is the Primary Care Improvement Fund (PCIP). This allocation is facilitated through NHS Borders for implementation and totalled £962k in 2018/19. This is estimated to increase to £1m in 2019/20 (year 2) and £2.1m in 2020/21 (year 3) as the national pot grows from £72m to £110m. Confirmation will be provided as the allocation letters are released to NHS Borders from the Scottish Government. This is summarised on Table 1 below:

Table 1:	**Year 1 2018/19 £000's (Confirmed)**	**Year 2 2019/20 £000's (Estimated)**	**Year 3 2020/21 £000's (Estimated)**
PCIF Allocations	962	1,050	2,100

The funding will be released in two separate amounts just as in 2018/19 (tranche 1 delivered £561k, tranche 2 £240k – this is being carried forward). The second tranche was not released during 2018/19 due to slippage in expenditure. This will be accessed during 2019/20 alongside the increased allocation of £1m.

Several assumptions have been made that are important to note: the first being the level of allocation increase, the uplift applied to the pharmacy element and lastly, the ability to carry forward remaining resources from the previous financial year. The latter should not be a major concern due to the Scottish Government's recognition that funding will, 'clearly fall within the scope of the MoU' and are, 'ring-fenced resources' [letter dated 23rd May 2018 from Richard Foggo].

The actual level of expenditure recorded at the end of December 2018 is £97k. This is compared to the projected expenditure figure of £182k for the same period (see Table 2).

Table 2:	**Estimated/Planned Expenditure (6 Months during 2018/19) £000's**	**Year-to-date (YTD) 'Budget' in 2018/19 £000's**	**Actual Expenditure (to December 2018) in 2018/19 £000's**
2018/19 Allocation (1st Tranche – 70%)	561		
Expenditure:			
Vaccine Transformation Programme (VTP)	(60)	(30)	0
Pharmacotherapy:			
Pharmacy First & Prescription for Excellence (PfE)	(87)		
PCIP Priorities	(102)	(51)	38
Pharmacotherapy Sub-total	*(189)*		
CT&CS (incl. ANP's)	(106)	(53)	59
Additional Professional Roles:			
MSK Physiotherapy	(96)	(48)	0
Community Link Workers	0	0	0
TOTAL	**110**	**182**	**97**

It should be noted that these figures will change and require regular updating due to the planning assumptions made, timing of financial reporting, comparisons with the actual expenditure incurred and the potential for shifting priorities as the PCIP progresses.

13. Workforce

The National Health and Social Care Workforce Plan was published in June 2017, Part 3 of that plan, subsequently published in May 2018, outlines the Scottish Government's approach to the Primary Care workforce issues (see below). The Plan sets out a range of options at a national, regional and local level for the recruitment and retention of GPs, including the expansion of the capacity and capability of MDT's. This includes plans for recruitment, training and development of specific groups and roles. As such a Scottish Borders Workforce Plan still needs to be developed for Primary Care. NHS Borders HR department will lead on this piece of work.

It has been indicated that as part of their role as EMG's, GPs will act as senior clinical leader's within the extended MDT, as outlined in the MoU.

National Health and Social Care Workforce Plan: Part 3 – Improving workforce planning for Primary Care in Scotland (May2018)

SUMMARY OF KEY RECOMMENDATIONS AND NEXT STEPS

This Plan sets out recommendations and the next steps that will improve primary care workforce planning in Scotland. These complement the recommendations in parts one and two and, taken together, will form the basis of the integrated workforce plan in 2018. The recommendations below set out how we will enable the expansion and up-skilling of our Primary Care workforce the national facilitators available to enable this, and how this will be implemented to complement local workforce planning.

Facilitating primary care reform

Recommendations and commitments:

- Reform of primary care is driven by developing multidisciplinary capacity across Scotland. Workforce planners including NHS Boards, Integration Authorities and General Practices will need to consider the configuration of local multidisciplinary teams that offer high quality, person-centred care.
- In recognition of an ageing workforce, local planners have responsibility for workforce planning and managing anticipated levels of staff turnover.
- The implementation of the GP contract will require services to be reconfigured to maximise workforce competencies and capabilities, and ensure people see the right person, at the right time and in the right place.
- The National Workforce Planning Group will play a strategic role in implementing the recommendations of part three of the plan, and strengthen the development of approaches for the primary care workforce.

- An integrated workforce plan to be published later in 2018 will move towards a better articulated joint vision for health and social care workforce planning.

Building Primary Care workforce capacity

Recommendations and commitments:

- Significant investment will be made available over the next 3-5 years, as part of the First Minister's commitment to an additional £500 million for community health services, to plan for, recruit and support a workforce in general practice, primary care and wider community health, including community nursing.
- Scotland's multidisciplinary primary care workforce will become more fully developed and equipped, building capacity and extending roles for a range of professionals, enabling those professionals to address communities' primary healthcare needs.
- As part of national, regional and local activity to support leadership and talent management development, planners will need to continuously consider staff training needs in their workforce planning exercises; invest appropriately so that leaders in primary care are fully equipped to drive change; and enhance opportunities for the primary care workforce to further develop rewarding and attractive careers.

Improving data, intelligence and infrastructure in primary care

Recommendations and commitments:

- More integrated workforce data for primary care is required, in the context of the workforce data platform being developed by NHS Education for Scotland.
- Local planners should consider workforce planning tools (such as the six step methodology) in developing their workforce strategies to address local population needs.
- Planning for future staffing in primary care should identify and make use of available guidance and intelligence on local recruitment and retention issues, and of wider developments in workforce data and scenario planning.
- The Scottish Government will publish the Primary Care Monitoring and Evaluation Strategy 2018-2028 by summer 2018.

NHS Borders Workforce Plan:

A plan is to be developed taking into consideration the existing workforce employed within GP Practices in the Scottish Borders. This will underpin an enhanced understanding of the present Primary Care workforce and be utilised to inform the development of a local workforce plan. The next phase of this work will be completed by December 2019. The information will be used to inform the development of proposals for years 2&3.

14. Risk

Risk assessments and Health Inequalities Impact Assessments will be undertaken across the different work streams and any required action plans will then be developed. The main areas of risk identified are engagement, finance, recruitment (workforce recruitment is a major concern and therefore training of current staff may be an alternative option) and capability.

15. Engagement and On-going Development

The PCIP is a dynamic working document and will be developed through on-going dialogue and collaboration with GPs, GP practice teams, wider IA colleagues, partner agencies, patients and with public involvement.

16. Summary

The reviewed GP contract was released in November 2017 and agreed by the GP community in January 2018. It has provided the opportunity for transformation of Primary Care services across the Scottish Borders. The initial 3 year Primary Care Improvement Plan (PCIP) provided a backdrop for the main areas of focus in reshaping this facet of Primary Care. This update builds on that initial plan.

The key philosophies underlying the contract are communication, transparency and collaboration and the implementation of the plan is being progressed on that basis. By transforming the multi-disciplinary team and services around the role of the Expert Medical Generalist (EMG) we will achieve a robust and sustainable community model of primary care for the people of the Scottish Borders.

This process must be carried out in an informed, measured and sustainable way. Service delivery will continue as existing practice and will evolve in a phased manner to ensure seamless change. Projects and pilots schemes are already taking place with the opportunity to continue those that add value to services we commission.

APPENDIX 1

Memorandum of Understanding between Scottish Government, British Medical Association, Integration Authorities and NHS Boards
GMS Contract Implementation in the context of Primary Care Service Redesign

Introduction and Context
The principles underpinning the approach to general practice in Scotland were set out in a document General Practice: Contract and Context – Principles of the Scottish Approach published by the Scottish General Practitioners Committee ("SGPC") of the British Medical Association (BMA) and the Scottish Government in October 2016, noting that the Scottish Government and the SGPC are the two negotiating parties on commercial general practitioner (GP) contractual matters in Scotland. This Memorandum of Understanding ("MOU") between **the Scottish Government, the Scottish General Practitioners Committee of the British Medical Association, Integration Authorities and NHS Boards** builds on these arrangements and represents a landmark statement of intent, recognising the statutory role (set out in the Public Bodies (Joint Working) (Scotland) Act 2014) ("the Act") of Integration Authorities in commissioning primary care services and service redesign to support the role of the GP as an expert medical generalist. The MOU also recognises the role of NHS Boards in service delivery and as NHS staff employers and parties to General Medical Services ("GMS") contracts.

For the purposes of this MOU, we refer to Health and Social Care Partnerships (HSCPs) responsible for the planning and commissioning of primary care services.

As an Expert Medical Generalist (as defined in the Scottish GMS contract offer document for 2018 the "Scottish Blue Book"), the GP will focus on:

- Undifferentiated presentations,
- Complex care,
- Local and whole system quality improvement, and
- Local clinical leadership for the delivery of general medical services under GMS contracts.

Expert Medical Generalists will strive to ensure robust interface arrangements, connection to and coherence with other parts of the wider primary care team (e.g. nurses physiotherapists), health and social care community based services and with acute services where required. The EMG will be supported by a multi-disciplinary team (MDT); maximising the contribution of both clinical and nonclinical staff in medicine, nursing, allied health professions, links workers, practice management, administration and others.

Delivering improved levels of local care in the community will have a clear benefit for patients and must rely on effective collaboration between GPs, HSCPs, NHS Boards and other partners, both in and out of hours, valuing the respective contributions of those who deliver these services. This will require clear articulation of the respective roles and responsibilities of GPs and other members of the primary care team both generally and in respect of each of the services set out in a HSCP Primary Care Improvement Plan (see Sections F and G of this MOU).

The development of primary care service redesign in the context of delivery of the GMS contract should accord with seven key principles:

Safe –Patient safety is the highest priority for service delivery regardless of the service design or delivery model.

Person-Centred - Partnerships between patients, their families and those commissioning and delivering healthcare services work to provide care which is appropriate and based on an assessment of individual needs and values and is outcome focussed, demonstrates continuity of care (in the context of both professionals and services), clear communication and shared decision making.
Having regard to the five principles underpinning the Health and Social Care Standards:

dignity and respect, compassion, to be included, responsive care and support and wellbeing.

Equitable – fair and accessible to all.

Outcome focused – making the best decisions for safe and high quality patient care and wellbeing.

Effective - The most appropriate treatments, interventions, support and services will continue to be accessible, provided in the most appropriate place by the right person at the right time to everyone. Changes to service delivery should not result in any diminution of care or outcomes for patients.

Sustainable – delivers a viable long term model for general practice that is resilient in the context of the wider community care setting on a continuous basis; and promotes and supports the development of the skill mix within the practice setting.

Affordability and value for money – Making the best use of public funds; delivering the general practice model within the available resources; with appropriate quality assurance processes.

An important determinant of success will be how the planned changes are implemented, seek to influence and depend on wider services.

This change has already started with the move away from the Quality and Outcomes Framework introduced in the 2004 GMS contract. The new approach introduced by the GMS Statement of Financial Entitlements for 2016-17, sees GP practices working together in local Clusters with their HSCP and NHS Boards to identify priorities and improve the quality of services and outcomes for people.

Further key enablers for change include:

(1) Premises: The National Code of Practice for GP Premises sets out how the Scottish Government will support a shift, over 25 years, to a new model for GP premises in which GPs will no longer be expected to provide their own premises. The measures outlined in the Code represent a significant transfer in the risk of owning premises away from individual GPs to the Scottish Government. Premises and location of the workforce will be a key consideration in delivering the multi-disciplinary arrangements envisaged in the HSCP Primary Care Improvement Plan. Details on the criteria for lease transfer and for accessing interest free loans will be set out in the premises Code of Practice and summarised in the GMS contract offer document which sets out the terms of the Scottish GMS contract.

(2) Information Sharing Arrangements: The Information Commissioner's Office (ICO) has issued a statement that whilst they had previously considered GPs to be sole data controllers of their patient records; they now accept that GPs and their contracting Health Boards have joint data controller processing responsibilities towards the GP patient record.

The GMS contractual provisions in Scotland will reduce the risk to GPs of being data controllers by clarifying respective responsibilities within this joint controller arrangement. These contractual changes will support ICO's position that GPs are not the sole data controllers of the GP patient records but are joint data controllers along with their contracting NHS Board. The contract will clarify the limits of GPs' responsibilities and GPs will not be exposed to liabilities relating to data outwith their meaningful control.

The contractual provisions will lay the foundations for increased lawful, proactive and appropriate sharing of information amongst professionals working within the health and social care system for the purposes of patient care.

(3) Workforce: The national health and social care workforce plan published on 28 June 2017 noted that Part 3 of the Plan, which would determine the Scottish Government's thinking on the primary care workforce, would be published in early 2018 following the conclusion of the Scottish GMS contract negotiations. The Plan will set out a range of options at national, regional and local level for the recruitment and retention of GPs and the expansion of the capacity and capability of the multidisciplinary team. This will include plans for recruitment, training and development of specific professional groups and roles.

A. Purpose and aim of the MOU

This MOU will cover an initial 3 year period 1 April 2018 to 31 March 2021 and is structured to set out the key aspects relevant to facilitating the statement of intent the document represents:

Section A – Purpose and aim
Section B - Parties and their responsibilities
Section C - Key stakeholders
Section D - Resources
Section E - Oversight
Section F – Primary Care Improvement Plans
Section G – Key Priorities

It provides the basis for the development by HSCPs, as part of their statutory Strategic Planning responsibilities, of clear HSCP Primary Care Improvement Plans, setting how additional funding will be used and the timescales for the reconfiguration of services currently delivered under GMS contracts. Plans will have a specific focus on the key priority areas listed at Section G of this MOU with the aim of transitioning their delivery by the wider MDT between 2018 and 2021.

Taken together with the Scottish GMS contract offer document, the National Code of Practice for GP premises, and the National Health Service (General Medical Services Contracts) (Scotland) Regulations 2018, this MOU underpins the Scottish GMS contract; and enables the move towards a model for primary care that is consistent with the principles, aims and direction set by the Scottish Government's National Clinical Strategy (NCS) and the Health and Social Care Delivery Plan.

In addition, The National Health and Social Care Workforce Plan: Part 3 Primary Care, to be published following agreement on the Scottish GMS contract, will set out the context and arrangements for increasing the Scottish GP and related primary care workforce and both the

capacity and capability of the multi-disciplinary team.

This MOU will be reviewed and updated by the parties before 31 March 2021 through arrangements that will be agreed by March 2018.

B. Responsibilities (of parties to the MOU)

The respective responsibilities of the parties to this MOU are:

Integration Authority responsibilities (typically delivered through the Health and Social Care Partnership delivery organisations):

- Planning, design and commissioning of the primary care functions (including general medical services) delegated to them under the 2014 Act based on an assessment of local population needs, in line with the HSCP Strategic Plan.
- The development of a HSCP Primary Care Improvement Plan, in partnership with GPs and collaborating with other key stakeholders including NHS Boards that is supported by an appropriate and effective MDT model at both practice and Cluster level, and that reflects local population health care needs.
- Collaboration with NHS Boards on the local arrangements for delivery of the Scottish GMS contract.
- Section 2c of the National Health Service (Scotland) Act 1978 places a duty on NHS Boards to secure primary medical services to meet the reasonable needs of their NHS Board area. To achieve this, NHS Boards can enter into GMS contracts. HSCPs will give clear direction to NHS Boards under sections 26 and 28 of the 2014 Act in relation to the NHS Board's function to secure primary medical services for their area and directions will have specific reference to both the available workforce and financial resources.
- Where there is one or more HSCP covering one NHS Board area, the HSCPs will collaborate under section 22 of the 2014 Act in relation to the effective and efficient use of resources (e.g. buildings, staff and equipment) to achieve coherence and equity across service planning, design and commissioning.
- Ensuring that patient needs identified in care plans are met.

Scottish General Practice Committee responsibilities:

- Negotiating, with the Scottish Government, the terms of the GMS contract in Scotland as the negotiating committee of the BMA in Scotland.
- Conducting the poll (and any future poll) of its members on the terms of the GMS contract in Scotland.
- Representing the national view of the GP profession.
- Explaining the Scottish GMS contract to the profession (including communication with Local Medical Committees (LMC) and GP practices).
- Ensuring that GP practices are supported encouraged and enabled to deliver any obligations placed on them as part of the GMS contract; and, through LMCs and clusters, to contribute effectively to the development of the HSCP Primary Care Improvement Plan.

NHS Territorial Boards responsibilities:

- Contracting for the provision of primary medical services for their respective NHS Board Areas;
- Ensure that primary medical services meet the reasonable needs of their Board area as required under Section 2C of the NHS (Scotland) Act 1978;
- Delivering primary medical services as directed by HSCP as service commissioners;
- Arrangements for local delivery of the Scottish GMS contract via HSCPs;
- As employers, NHS Boards will be responsible for the pay, benefits, terms and conditions for those employees engaged in the delivery of the priority areas set out in Section G.

Scottish Government responsibilities:

- Setting the legislative framework underpinning the commissioning of primary medical services by HSCPs and delivery by NHS Boards.
- In collaboration with NHS Boards and with HSCPs, shaping the strategic direction and the development of commissioning guidance in respect of primary care that is in line with the aims and objectives set out in National Clinical Strategy and the Health and Social Care Delivery Plan.
- Providing financial resources in support of the Scottish GMS contract and primary care transformation (including the transfer of services) in line with the Scottish Government spending review process.
- Making arrangements with stakeholders to meet the future GP workforce requirements both in terms of numbers and education and training.
- Agreeing the metrics and milestones against which progress will be measured; with regular progress reporting as part of the existing statutory arrangements for reporting performance against Strategic Plans.

C. Key Stakeholders

HSCPs must collaborate with NHS Boards as partners in the development and delivery of their Strategic Plan (and the associated Primary Care Improvement Plan). Local and Regional Planning arrangements will need to recognise the statutory role of the HSCP as service commissioners; and the partnership role of NHS Boards as NHS employers and parties to the GMS contracts for the delivery of primary medical services in their Board area.

In addition to this, HSCPs have a statutory duty via the Public Bodies (Joint Working) (Prescribed Consultees) (Scotland) Regulations 2014 to consult a wide range of local stakeholders and professional groups on their Strategic Plans and take decisions on the size and shape of local health and social care services on a collective basis based on dialogue with the local communities and service users. In relation to the development of the Primary Care Improvement Plan that would include (but not be limited to):

- Patients, their families and carers
- Local communities
- SAS and NHS 24
- Primary care professionals (through, for example, GP subcommittees of the Area Medical Committee and Local Medical Committees)
- Primary care providers
- Primary care staff who are not healthcare professionals

- Third sector bodies carrying out activities related to the provision of primary care

In order to ensure that the provision of any new or reconfigured service has a patient-centred approach to care based on an understanding of patient's needs, life circumstances and experiences it is important that patients, carers and communities are engaged as key stakeholders in the planning and delivery of new services. HSCPs should ensure that patient engagement is a key part of their Primary Care Improvement Plans.
Good communications and understanding across the wider health and social care interfaces with both services and professional groups (e.g. primary/secondary, community health and social care services, district nursing, out of hours services, mental health services) will also be required to address direct patient care issues, such as prescribing, referrals, discharges, follow up of results and signposting. An important principle here is that each part of the system respects the time and resources of the other parts. There should not be an assumption that patient needs or work identified in one part of the service must be met by another without due discussion and agreement. This should ensure that patients do not fall through gaps in the health and care system.

D. Resources

General Practice funding – through the GMS contract funding allocated to NHS Boards, general practice funding represents a significant element of the public investment in community and primary care. The published draft Primary Medical Services budget was £821 million in 2017-18 – funding the remuneration of 4,460 General Practitioners; the c.3000 practice staff they employ, both nursing and non-clinical, and the non-staff expenses of running practices. This investment enables over 23 million healthcare interactions every year. The Primary Medical Services investment funds the part of the system that is the first port of call for most people's healthcare needs most of the time. In addition to the direct care enabled by this investment, the clinical decisions GPs make – whether to treat; how to treat; whether to refer to further specialist treatment – have a much wider impact on the health and social care system. The "GP footprint" is estimated to be as much as four times the direct investment in Primary Medical Services. This investment through the contract is, therefore, critical to the sustainability of the whole health and care system.

In March 2017 the Cabinet Secretary for Health and Sport announced that in addition to the funding for the provision of general medical services, funding in direct support of general practice will increase annually by £250 million by the end 2021-22. In 2017-18 £71.6 million was invested through the Primary Care Fund in direct support of general practice. Further investment will see this increase over the 3 financial years from 1 April 2018 to £250 million 2021-22.

Process

Specific levels of resource will be agreed as part of the Scottish Government's Spending Review and budget processes and allocated in line with the arrangements set out in this MOU.

Where appropriate these resources will be allocated to HSCPs through their NHS Board partners in line with the Scottish Government's National Resource Allocation formula (based on population need and taking account of geography and of life circumstances, including deprivation). Resources will be spent for the purposes set out in this Memorandum and in line with each HSCP Primary Care Improvement Plan to enable the transition to be managed and implemented effectively. The HSCP Plans must demonstrate how the funding will flow/be used to enable the redistribution of work from GPs to others and to optimise the role and functionality of the wider MDT. HSCPs will agree these

Plans locally. These plans will be developed in collaboration with local GPs and others and should be developed with GP Subcommittee (or representatives of by agreement locally) as the formally agreed advisors on general medical service matters. However, the arrangements for delivering the GMS contract will be agreed with the Local Medical Committee. Integration Authorities will hold their officers to account for delivery of the milestones set out in the Plan, in line with their responsibility to ensure delivery of Strategic Plans, and through regular reporting to the Authority. Key partners and stakeholders should be fully engaged in the preparation, publication and review of the plans.

The resources and any associated outcomes and deliverables (aligned to the Scottish Government's National Performance Framework and the six Primary Care Outcomes) will be set out in an annual funding letter as part of the Scottish Government's budget setting process.

The extent and pace of change to deliver the changes to ways of working over the three years (2018-21) will be determined largely by workforce availability, training, competency and capability, the availability of resources through the Primary Care Fund, and will feature as a key element of the National Health and Social Care Workforce Plan: Part 3 Primary Care.

E. Oversight

Oversight arrangements for the implementation of the GMS contract in the context of wider primary care transformation in Scotland will be developed including:

A National GMS Oversight Group ("the national oversight group") with representatives from the Scottish Government, the SGPC, HSCPs and NHS Boards will be formed to oversee implementation by NHS Boards of the GMS contract in Scotland and the HSCP Primary Care Improvement Plans, including clear milestones for the redistribution of GP workload and the development of effective MDT working.

National issue specific groups – A range of national issue specific groups with members drawn from a range of stakeholders, including NHS Boards, HSCPs and SGPC where appropriate will support and provide policy and professional advice to the national oversight group on a range of national policy areas relevant to the delivery of primary care transformation. These may include: GP Contract Implementation Group; GP premises; GP IT, e-Health; Data and Information; Remote and Rural; Nursing; GPN Group; Vaccination Transformation Programme; Patient Groups.

As well as the requirements on the HSCP to develop a Primary Care Improvement Plan as set out in Section D, NHS Boards with HSCPs will develop clear arrangements to deliver the commitments in respect of the Scottish GMS contract as set out in the Scottish GMS contract offer document. These arrangements will include the priority areas set out in Section G of this MOU and must be agreed with the LMCs.

HSCPs should establish local arrangements to provide them with advice and professional views on the development and delivery of the Primary Care Improvement Plan. Arrangements will be determined locally and will take account of the requirement to engage stakeholders as set out above. The HSCP Primary Care Improvement Plan should be agreed with the local GP subcommittee of the Area Medical Committee with the arrangements for delivering the GMS contract being agreed with the Local Medical Committee as set out above. HSCPs and NHS Boards will discuss and agree locally the arrangements for providing appropriate levels of support to enable this advice to

be provided.

Within HSCPs, GP clusters have a critical role in improving the quality of care in general practice and influencing HSCPs both regarding how services work and service quality. Improving Together: a new quality framework for GP Clusters in Scotland provides a framework for how that learning, developing and improving may be achieved. As GP Clusters mature, they will be expected to have a key role in proactively engaging with HSCPs, advising on the development of HSCP Primary Care Improvement Plans and working with their MDT and wider professional networks to ensure highly effective health and social care provision within and across the HSCP area and where relevant across HSCPs.

HSCPs will support and facilitate GP Clusters to ensure their involvement in quality improvement planning and quality improvement activity as part of whole system improvement. Healthcare Improvement Scotland will work in support of HSCPs where required to ensure that GP clusters have the support they need to engage effectively in quality improvement activity.

The *Local Intelligence Support Team* (LIST) already provides support to HSCPs and has been commissioned to provide support through HSCPs to GP clusters. This support involves on-site expert analytical advice to provide local decision-makers with meaningful and actionable intelligence, leading to improved outcomes for service users.

F. Primary Care Improvement Plan

The collaborative implementation of the GMS contract in Scotland should be set in the context of the HSCP Primary Care Improvement Plan. Plans must determine the priorities based on population healthcare needs, taking account of existing service delivery, available workforce and available resources. To support that aim HSCPs will collaborate on the planning, recruitment and deployment of staff.

Some services which are currently provided under general medical services contracts will be reconfigured in the future. Services or functions which are key priorities for the first 3 years from 2018 - 2021 are listed in Section G below. The expectation should be that, where appropriate, reconfigured general medical services should continue to be delivered in or near GP practices.

Additional investment is intended to provide additional MDT staff, which should, where appropriate, be aligned to GP practices to provide direct support to these practices under the oversight of GPs as senior clinicians. It will be important that GPs continue to work to their responsibility to ensure that their premises remain fit for purpose, services remain accessible to patients, that they are responsive to local needs and can maintain continuity of care; all of which will allow GPs to deliver an effective, integrated service as part of the MDT.

The HSCP Primary Care Improvement Plans will be considered alongside the NHS Board arrangements for the delivery of the GMS contract in Scotland in line with the requirements of the Scottish contract offer document.

The Plan should also consider how the MDT model will align and work with community based and where relevant acute services, subject to wider stakeholder engagement to be determined by the HSCP in line with their statutory duty to consult.

Key Requirements of the Primary Care Improvement Plan:

- To be developed collaboratively with HSCPs, GPs, NHS Boards and the stakeholders detailed in Section C;
- To detail and plan the implementation of services and functions listed as key priorities under Section G, with reference to agreed milestones over a 3 year time period;
- To give projected timescales and arrangements for delivering the commitments and outcomes in the priority areas under Section G and in particular to include intended timescales for the transfer of existing contractual responsibility for service delivery from GPs;
- To provide detail on available resources and spending plans (including workforce and infrastructure);
- To outline how the MDT will be developed at practice and cluster level to deliver primary care services in the context of the GMS contract;
- Initial agreement for the Primary Care Improvement Plan secured by 1 July 2018.

Key Priorities

Existing work to develop and test new models of care has shown benefits from the effective deployment of other professional staff working within a wider MDT aligned to general practice. The priority between 2018 and 2021 will be on the wider development of the services detailed below. Changes to services will only take place when it is safe to do so. The service descriptions and delivery timescales given here are provided for the purposes of this MOU.

(1) *The Vaccination Transformation Programme (VTP)* was announced in March 2017 to review and transform vaccine delivery in light of the increasing complexity of vaccination programmes in recent years, and to reflect the changing roles of those, principally GPs, historically tasked with delivering vaccinations.

In the period to 2021, HSCPs will deliver phased service change based on a locally agreed plan as part of the HSCP Primary Care Improvement Plan to meet a number of nationally determined outcomes including shifting of work to other appropriate professionals and away from GPs. This has already happened in many parts of the NHS system across Scotland for Childhood Immunisations and Vaccinations. This change needs to be managed, ensuring a safe and sustainable model and delivering the highest levels of immunisation and vaccination take up. As indicated above, there may be geographical and other limitations to the extent of any service redesign.

(2) Pharmacotherapy services – These services are in three tiers divided into core and additional activities, to be implemented in a phased approach.

By 2021, phase one will include activities at a general level of pharmacy practice including acute and repeat prescribing and medication management activities and will be a priority for delivery in the first stages of the HSCP Primary Care Improvement Plan. This is to be followed by phases two (advanced) and three (specialist) which are additional services and describe a progressively advanced specialist clinical pharmacist role.

(3) *Community Treatment and Care Services* - These services include, but are not limited to, basic disease data collection and biometrics (such as blood pressure), chronic disease monitoring, the

management of minor injuries and dressings, phlebotomy, ear syringing, suture removal, and some types of minor surgery as locally determined as being appropriate. Phlebotomy will be delivered as a priority in the first stage of the HSCP Primary Care Improvement Plan.

This change needs to be managed to ensure, by 2021 in collaboration with NHS Boards, a safe and sustainable service delivery model, based on appropriate local service design.

(4*) Urgent care (advanced practitioners)* - These services provide support for urgent unscheduled care within primary care, such as providing advance practitioner resource such as a nurse or paramedic for GP clusters and practices as first response for home visits, and responding to urgent call outs for patients, working with practices to provide appropriate care to patients, allowing GPs to better manage and free up their time.
By 2021, in collaboration with NHS Boards there will be a sustainable advance practitioner provision in all HSCP areas, based on appropriate local service design. These practitioners will be available to assess and treat urgent or unscheduled care presentations and home visits within an agreed local model or system of care.
(5) Additional Professional roles - Additional professional roles will provide services for groups of patients with specific needs that can be delivered by other professionals as first point of contact in the practice and/or community setting (as part of the wider MDT); this would be determined by local needs as part of the HSCP Primary Care Improvement Plan. For example, but not limited to:

- *Musculoskeletal focused physiotherapy services*
- *Community clinical mental health professionals (e.g. nurses, occupational therapists) based in general practice .*

By 2021 specialist professionals will work within the local MDT to see patients at the first point of contact, as well as assessing, diagnosing and delivering treatment, as agreed with GPs and within an agreed model or system of care. Service configuration may vary dependent upon local geography, demographics and demand.

(*6) Community Links Worker (CLW)* is a generalist practitioner based in or aligned to a GP practice or Cluster who works directly with patients to help them navigate and engage with wider services, often serving a socio-economically deprived community or assisting patients who need support because of (for example) the complexity of their conditions or rurality. As part of the Primary Care Improvement Plan HSCPs will develop CLW roles in line with the Scottish Government's manifesto commitment to deliver 250 CLWs over the life of the Parliament. The roles of the CLWs will be consistent with assessed local need and priorities and function as part of the local models/systems of care and support.

Workforce As part of their role as EMGs, GPs will act as senior clinical leaders within the extended MDT as described in this MOU. Many of the MDT staff deployed in the priority areas under (1) to (6) of Section G in the MOU will be employed by the NHS Board and work with local models and systems of care agreed between the HSCP, local GPs and others. Staff will work as an integral part of local MDTs. NHS Boards, as employers, will be responsible for the pay, benefits, terms and conditions for these staff. Some MDT members will be aligned exclusively to a single GP practice while others may be required to work across a group of practices (e.g. Clusters). Workforce arrangements will be determined locally and agreed as part of the HSCP Primary Care Improvement Plans.

Existing practice staff will continue to be employed directly by practices. Practice Managers,

receptionists and other practice staff will continue to have important roles in supporting the development and delivery of local services. Practices Managers should be supported and enabled to contribute effectively to the development of practice teams and how they work across practices within Clusters and in enabling wider MDT working arrangements.

Signatories
Signed on behalf of the Scottish General Practice Committee

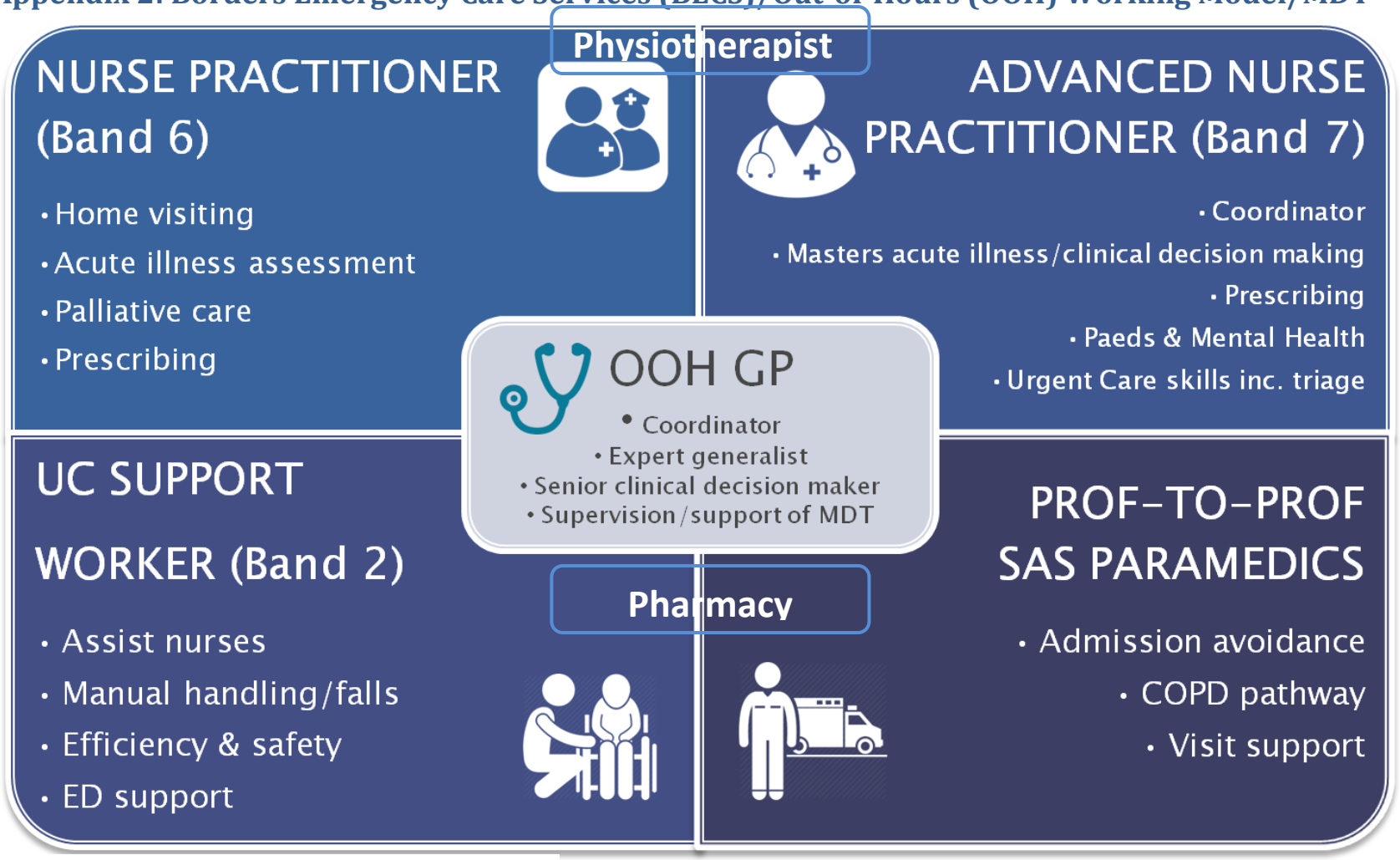
Name: Alan McDevitt, Chair, Scottish GP Committee of the British Medical Association
Date: 10 November 2017

Signed on behalf of Health and Social Care Partnership Chief Officers
Name: David Williams, Chief Officer, Glasgow HSCP and Chair, Chief Officers, Health and Social Care Scotland
Date: 10 November 2017

Signed on behalf of NHS Boards
Name: Jeff Ace, Chief Executive, NHS Dumfries & Galloway and Chair, Chief Executives, NHS Scotland
Date: 10 November 2017

Signed on behalf of the Scottish Government
Name: Paul Gray, Chief Executive, NHS Scotland
Date: 10 November 2017

Appendix 2: Borders Emergency Care Services (BECS)/Out-of-Hours (OOH) Working Model/MDT



Courtesy of Dr Rebecca Green

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Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 8 May 2019

Report By	Mike Porteous, Chief Financial Officer
Contact	Mike Porteous, Chief Financial Officer
Telephone:	07973981394

INTEGRATION JOINT BOARD 2019/20 FINANCIAL PLAN

Purpose of Report:	The purpose of this paper is to present the budget allocations from the Partners for 2019/20 and highlight the financial implications of these allocations for the IJB.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Note** the financial outlook for 2019/20 for Borders IJB based on the information provided by the Partners. **b) Note** the forecast financial gap of (£11.7m) for 2019/20 **c) Direct** the IJB Officers to continue to work with NHS Borders colleagues to produce a financial recovery plan to address the financial gap and mitigate the risks relating to Health services **d) Direct** the IJB Officers to continue to work with Scottish Borders Council colleagues to meet the financial pressures and risks relating to Council services.

Personnel:	There are no resourcing implications beyond the financial resources identified within the report. Any significant resource impact beyond those identified in the report that may arise during 2019/20 will be reported to the Integration Joint Board.

Carers:	N/A

Equalities:	The equalities impact of the contents of this report are not known at this stage. As the detailed outcomes of the settlements become apparent equalities impact assessments will be carried out.

Financial:	No resourcing implications beyond the financial resources identified within the report.

	The report draws on information provided in the finance reports presented to NHS Borders and Scottish Borders Council. Both partner organisations' Finance functions have contributed to its development.

Risk Implications:	To be reviewed in line with agreed risk management strategy. The key risks outlined in the report form part of the draft financial risk register for the partnership.

Background

2.1 The Scottish Government (SG) budget was approved by Parliament on 21st February 2019. The key aspects of the budget and their implications for NHS Borders (NHSB) and Scottish Borders Council (SBC) were highlighted in the paper presented to the IJB in February 2019. In summary they were

Health

- Uplift of 2.6% for NHS Borders
- Providing an additional £5.1m funding
- Requirement that the NHS payments to Integration Authorities for delegated functions must deliver a real terms uplift in baseline funding before the provision of funding for pay awards, over 18/19 cash levels.

Local Authority

- Overall a real terms reduction of 1.3% in the level of grant funding which equates to (£2.614m)
- Additional revenue funding totalling £148m nationally to fund the expansion of free personal and nursing care for under 65s, ongoing implementation of the Carers Act, and further investment in health and social care integration
- The ability for Local Authorities to offset their adult social care allocations to Integration Authorities in 2019/20 by up to 2.2% compared to 2018/19

2.2 The implications of these budget announcements for the IJB are detailed in the following sections of this report.

Delegated Resources 2019/20

3.1 The Scottish Borders Council agreed their budget on 28th February 2019. Their Financial Plan allocated the IJB a baseline budget totalling £49.1m for the delegated functions. A high level summary of baseline budget is provided below.

Scottish Borders Council	**£m**
2018/19 Recurring Budget	47.203
Local Government Allocation	
Investment in Integration	1.286
Free Personal Care	0.577
Carers Act	0.012
Total Delegated Resources	**49.078**

3.2 This recurring base funding assumes all 2018/19 savings plans have been delivered recurringly, and the allocations from Scottish Government will contribute directly to growth and capacity pressures aswell as the implications of new contract rates and national initiatives. The Council exercised its ability to offset their adult social care allocations to the IJB in 2019/20 by up to 2.2% compared to 2018/19

3.3 NHS Border's Financial Plan was approved by its Board on 4th April. At this meeting the Board separately received and approved a baseline provision of resources to the IJB. The table below summarises the baseline provision approved.

NHS Borders	**Core**	**Set Aside**	**Total**
	£m	**£m**	**£m**
2018/19 Recurring Budget	91.973	22.505	114.478
NHS Borders Allocation			
Social Care Fund	7.397		7.397
integrated Care Fund	2.130		2.130
2.6% Uplift	2.639	0.585	3.224
Total Delegated Resources	**104.139**	**23.090**	**127.229**

3.4 The allocation can be seen to include the funding streams of £7.4m for the Social Care Fund and £2.1m for the Integrated Care Fund (ICF), both of which have been baselined for 2019/20 onwards. The uplift for Core delegated functions is calculated on the total baseline of £101.5m, resulting in an allocation of £104.1m. The uplift for Set Aside delegated functions is £0.6m, resulting in an allocation of £23.1m for 2019/20.

3.5 It should noted that any additional funding increases received by the Board during the coming year which relate to the IJB will be passed on as in previous years. Funding of this nature is anticipated for Adult Mental Health Services and CAMHs and the Primary Care Improvement programme.

3.6 The funding allocated by SBC and by NHSB gives a combined allocation of £176.307m per **Table 1** below.

Total Funding Allocations 2019/20	**SBC**	**NHSB**	**Total**
	£m	**£m**	**£m**
2018/19 Recurring Budget	**47.203**	**124.005**	**171.208**
Uplift	1.055	3.224	4.279
Free Personal Care	0.577		0.577
Carers Act	0.243		0.243
Total Delegated Resources	**49.078**	**127.229**	**176.307**

Expenditure on delegated services 2019/20

4.1 With support from colleagues in SBC and NHSB the costs relating to the delegated services have been modelled in order to provide the IJB with an indication of the potential financial position for 2019/20. The work reflected the known and expected

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recurring and additional costs identified by services before any savings have been considered. Expenditure has been forecast based on the following assumptions:

- Pay costs will rise in line with Scottish Government pay policy guidelines
- NHS non pay inflation will be 2%
- Prescribing cost will rise by in line with estimates provided by NHSB
- Living wage and sleepovers rates have been applied and accepted by providers
- Demographics – known and expected costs based on the latest information and planned and agreed increases in older people and learning disabilities services.
- Contract inflation will be applied based on estimates of the impact of: implementing the new Scottish living wage of £9.00 from 1 April 2019, the negotiated settlement for the national care home contract; and addressing the Scottish Government policy of paying the Scottish living wage for sleepovers from 1st April 2019;
- The implementation of Free personal care for under 65's will not have an adverse financial impact on the cost of care
- Developments agreed within the respective NHSB and SBC financial planning processes will materialise at the planned level.
- Any underspend on the ICF fund in year will be carried forward

4.2 The financial implications of these assumptions are summarised in **Table 2** below.

Projected Expenditure	**Total £m**
Recurring Cost Base	171.208
Recurring 18/19 pressures	1.500
Unmet savings 18/19	0.621
Unidentified historical savings	8.219
2019/20 Pressures	
Pay and non pay uplift	2.995
Prescribing and Hospital Drugs	1.714
Agreed Developments	2.452
Other Expenditure Committments	0.913
Total Forecast Expendituire	**189.622**

4.3 The forecast expenditure for the IJB for 2019/20 is estimated at £189.6m. Further detail relating to the highlighted elements of the forecast expenditure is provided in the following sections:

Recurring 18/19 Pressures

These relate to ongoing pressures which were reported in 2018/19 and which continue to present in 2019/20. The key pressures include £0.5m for NHS Learning Disability patients transitioning to adult services, and a further £0.8m within Set Aside relating to the estimated costs of Winter this year. Work is underway to produce a costed 2019/20 Winter plan and identify mitigating actions to manage these pressures and reduce spend in year.

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Unmet 18/19 Savings

Although schemes to meet 2018/19 savings targets were identified a number of schemes did not deliver recurring savings. Within council plans a total of £0.2m remains outstanding and NHS targets totalling £0.4m remain outstanding.

Unidentified Savings

The unidentified savings targets relating to Core and Set Aside NHS functions totalling (£8.2m) remains outstanding and will be a pressure in 2019/20. The Financial Recovery Plan being compiled will set out options for addressing these recurring pressures over the coming years.

2019/20 Pressures

Pay and Non pay Uplift - the impact of pay and price uplift is calculated to be £3.0m across the delegated functions.

The additional costs of prescribing and hospital drug price pressures and growth in volumes is estimated to be £1.7m.

A number of developments have been agreed for 2019/20 resulting in additional costs of £2.5m. These primarily relate to unavoidable increases in costs for national contracts, demographic growth and the impact of legislative changes eg the provision of free personal care to under 65s.

Further expenditure commitments have also emerged, primarily in the cost of caring for a Learning Disability client requiring an enhanced level of care.

4.4 A comparison of the resources allocated (Table 1) and the forecast expenditure (Table 2) for the IJB results in a significant financial gap of £13.3m. **Table 3** below summarises.

Projected IJB Financial Position 2019/20	**IJB £m**
Provision of Resources	176.307
Forecast Expenditure	189.622
Forecast Savings requirement	**(£13.315)**

Savings and Efficiencies

5.1 As part of the financial planning process the impact of recurring and new cost pressures and expenditure committments exceeding allocated resources results in a requirement for additional savings to close the gap. The projected savings requirement identified above represents 7.55% of the IJB's baseline budget. It is clear that savings totalling (£13.3m) will not be achieved in 2019/20. However, a range of savings plans have been identified across Health & Social Care services which are expected to deliver efficiencies totalling £1.6m. **Table 4** below summarises these planned savings and a detailed breakdown is provided at **Appendix A**.

Efficiencies	£m	£m
Projected Savings Requirement		**(£13.315)**
Services Efficiencies	£0.875	
Prescribing	£0.464	
BAU Health Services	£0.300	£1.639
Resultant Savings Requirement		**(£11.676)**

5.2 These savings have a RAG rating of green and amber indicating they should deliver the planned level of savings. On the assumption that the full £1.6m of savings is realised, the remaining savings requirement is forecast to be (£11.7m).

5.3 In addition to the range of savings schemes already identified within Health, the impact of the work being undertaken by the Turnaround Team and the implementation of a Programme Management approach to identifying and delivering savings is expected to produce additional in year and recurring savings schemes which will increase the overall savings that will be delivered beyond the £1.6m above. However at this stage these savings remain unidentified and as such are unquantified.

5.4 The remaining gap comprises historical undelivered / unidentified savings schemes and new and emerging pressures for which savings schemes are required (eg Prescribing). Of the remaining gap (£11.1m) falls within NHSB and primarily relates to historical unidentified savings. The remaining (£0.6m) of unmet savings sit within SBC and relate to undelivered 2018/19 savings of (£0.2m) and significant slippage of (£0.4m) in a 2019/20 scheme.

5.5 A summary of all the above tables, presenting expenditure by service, is provided in **Appendix B.**

Delivering Financial Balance

6.1 The quantification of the financial gap and the shortfall in savings identified to mitigate the gap means the IJB is unable to present a balanced financial plan for 2019/20.

6.2 Delivering financial balance will require the IJB to request additional in year allocations from one or both Partner bodies and for them to be able to make such allocations. NHSB is currently forecasting a significant overspend in 2019/20 and will require brokerage to deliver a break even position. In addition, the Partner bodies are able to require the IJB to repay these additional allocations in the following financial year, although neither has invoked this clause to date.

6.3 The requirement to deliver (£11.7m) of savings in 2019/20 will place a significant challenge on the IJB's ability to commission and deliver sufficient levels of service to meet the needs of the Borders population. The work to produce a financial recovery plan which will identify savings across delegated functions over a 3 to 5 year period is key to bringing the delegated function into future financial balance.

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Risk

7.1 The key risk to the IJB is on their ability to deliver strategic change in the context of the forecast financial position.

7.2 There is also a risk that NHSB's requirement for brokerage increases, placing further pressure on services to cut costs. At this stage brokerage has not been agreed with the SG and there is a risk that the full requirement cannot be met through negotiations with them.

7.3 In addition there is a risk that the identified savings schemes do not deliver to their planned level.

7.4 The position outlined in this paper assumes a number of pressures will be managed or will not emerge. Challenges exist however with regard to Learning Disability patients transitioning to adult services and in the cessation of staffing pressures within Set Aside services. The financial impact of the implementation of Free Personal Care is being fully assessed and there is a further risk that the loss of income will exceed the funding received from Scottish Government.

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APPENDIX A

2019/20 Savings Schemes	Total	Green	Amber
	£m	£m	£m
Reduce Direct Payment Prepayment	0.250	0.139	0.111
Reassessment of existing care packages	0.100	0.100	
Corporate recruitment process	0.045	0.045	
Roll-out of Hospital to Home initiative in all localities	0.480		0.480
Mental Health Services - staffing	0.061	0.061	
Mental Health Services - non recurring	0.077		0.077
Primary & Community Services - admin	0.020	0.020	
Primary & Community Services - Dental	0.020	0.020	
Primary & Community Services - AHPs	0.075		0.075
Primary & Community Services - HQ	0.041	0.041	
Learning Disabilities - various	0.008	0.008	
Prescribing	0.464	0.464	
Total Savings	**1.640**	**0.898**	**0.742**

APPENDIX B

2019/20 IJB Financial Plan	**SBC**	**NHSB Core**	**Set Aside**	**Total**
	£m	**£m**	**£m**	**£m**
Total Delegated Resources	**49.078**	**104.139**	**23.090**	**176.307**
Expenditure Plans:				
Joint Learning Disability Service	14.551	4.577		19.128
Joint Mental Health Service	2.259	14.847		17.106
Older People Service	25.949			25.949
Physical Disability Service	3.507			3.507
Prescribing		24.265		24.265
Generic Services	4.288	67.431		71.719
Large Hospital Functions Set-Aside			27.948	27.948
Total Planned Expenditure	**50.554**	**111.120**	**27.948**	**189.622**
Forecast Savings Requirement	(1.476)	(6.981)	(4.858)	(13.315)
Savings Schemes Identified	0.875	0.764		1.639
Resultant Savings Requirement	**(0.601)**	**(6.217)**	**(4.858)**	**(11.676)**

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 8 May 2019

Report By	Robert McCulloch-Graham, Chief Officer Health & Social Care
Contact	Robert McCulloch-Graham, Chief Officer Health & Social Care
Telephone:	01896 825528

Ministerial Strategic Group for Health and Community Care
Integration Review

Purpose of Report:	To gain the views of the IJB of the progress made to date regarding the integration of our services.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Consider** the attached questionnaire and to prepare for a discussion at the IJB meeting on the Board's view as to the current state of Integration within the Borders.

Personnel:	There are no staffing implications.

Carers:	There is no direct impact on Carers.

Equalities:	N/A

Financial:	N/A

Legal:	N/A

Risk Implications:	N/A

Situation

There is an expectation that Health Boards, Local Authorities and Integration Joint Boards should collectively evaluate their current position in relation to the findings of the MSG review and take action to make progress.

In completing this template, the IJB need to identify a rating against each of the rating descriptors for each of the required proposals. Evidence and any additional relevent information should also be included to affirm and support the conclusive rating. Actions will be proposed in respect of each proposal to assist with local improvement planning.

Scottish Borders Council and NHS Borders will be submitting a seperate response from their organisational perspective.

All three proposed submissions will be discussed at the Executive Management Team meeting on 10 May, to review for similarities or differences and also identify any areas of further work as part of the development of the IJB.

The information obtained from the local self-evaluations will support useful discussions in local systems, sharing of good practice between local systems, and enable the Integration Leadership Group to gain an insight into progress locally.

Ministerial Strategic Group for Health and Community Care

Integration Review Leadership Group

Self-evaluation

For the Review of Progress with Integration of Health and Social Care

March 2019

COSLA

Scottish Government
Riaghaltas na h-Alba
gov.scot

MINISTERIAL STRATEGIC GROUP FOR HEALTH AND COMMUNITY CARE (MSG)
REVIEW OF PROGRESS WITH INTEGRATION OF HEALTH AND SOCIAL CARE - SELF EVALUATION

There is an expectation that Health Boards, Local Authorities and Integration Joint Boards should take this important opportunity to collectively evaluate their current position in relation to the findings of the MSG review, which took full account of the Audit Scotland report on integration published in November 2018, and take action to make progress. This evaluation should involve partners in the third and independent sectors and others as appropriate to local circumstances. This template has been designed to assist with this self-evaluation.

To ensure compatibility with other self-evaluations that you may be undertaking such as the Public Services Improvement Framework (PSIF) or those underpinned by the European Foundation for Quality Management (EFQM), we have reviewed examples of local self-evaluation formats and national tools in the development of this template. The template is wholly focused on the 25 proposals made in the MSG report on progress with integration published on 4th February, although it is anticipated that evidence gathered and the self-evaluation itself may provide supporting material for other scrutiny or improvement self-evaluations you are, or will be, involved in.

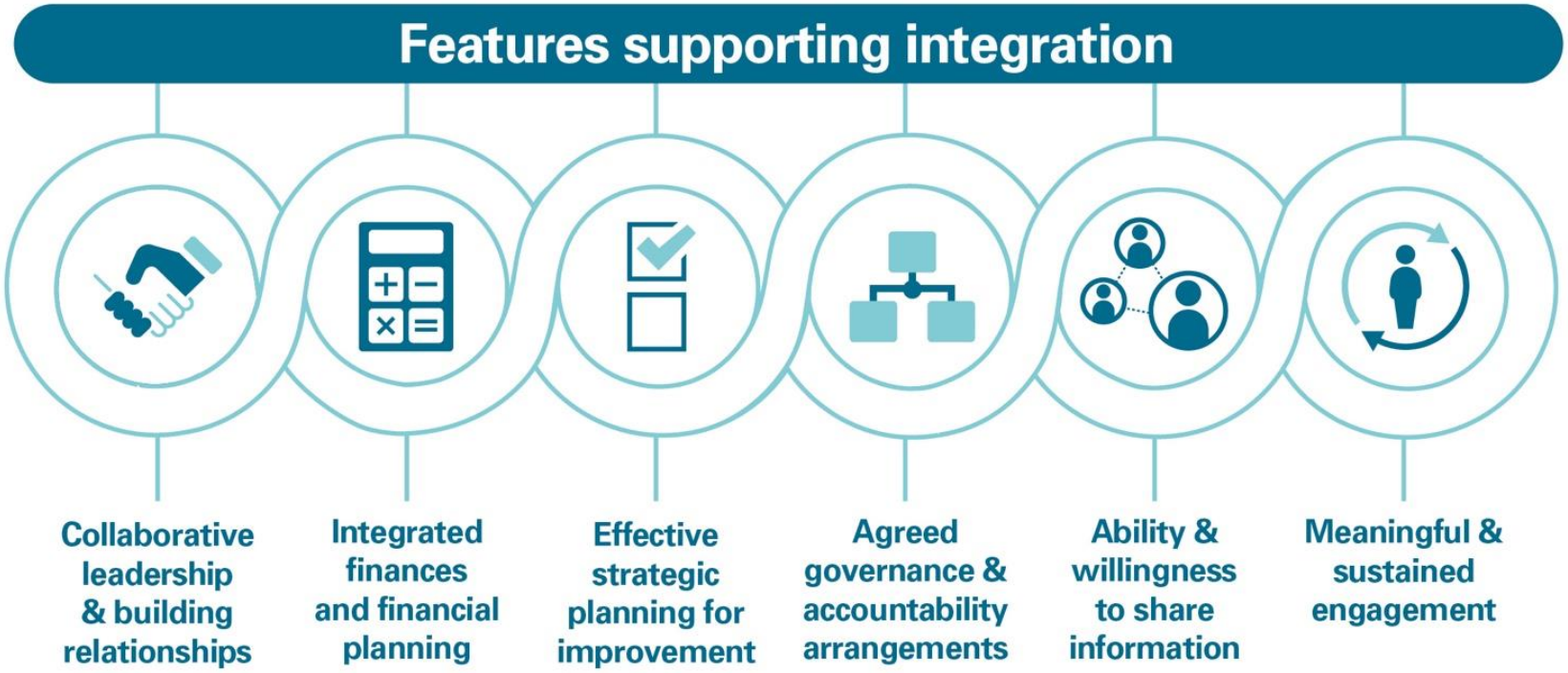
Information from local self-evaluations can support useful discussions in local systems, sharing of good practice between local systems, and enable the Integration Leadership Group, chaired by the Scottish Government and COSLA, to gain an insight into progress locally.

In completing this template please identify your rating against each of the rating descriptors for each of the 25 proposals except where it is clearly marked that that local systems should not enter a rating. Reliable self-evaluation uses a range of evidence to support conclusions, therefore please also identify the evidence or information you have considered in reaching your rating. Finally, to assist with local improvement planning please identify proposed improvement actions in respect of each proposal in the box provided. Once complete, you may consider benchmarking with comparator local systems or by undertaking some form of peer review to confirm your findings.

We greatly appreciate your assistance in ensuring completion of this self-evaluation tool on a collective basis and would emphasise the importance of partnership and joint ownership of the actions taken at a local level. **Please share your completed template with the Integration Review Leadership Group by 15th May 2019 – by sending to Kelly.Martin@gov.scot**

It is our intention to request that we repeat this process towards the end of the 12 month period set for delivery of the all of the proposals in order that we can collectively demonstrate progress across the country.

Thank you.
Integration Review Leadership Group
MARCH 2019



Name of Partnership	
Contact name and email address	
Date of completion	

Key Feature 1 **Collaborative leadership and building relationships**				
Proposal 1.1 **All leadership development will be focused on shared and collaborative practice.**				
Rating Descriptor	**Not yet established**	**Partly established**	**Established**	**Exemplary**
Indicator	Lack of clear leadership and support for integration.	Leadership is developing to support integration.	Leadership in place has had the ability to drive change with collaboration evident in a number of key areas. Some shared learning and collaborative practice in place.	Clear collaborative leadership is in place, supported by a range of services including HR, finance, legal advice, improvement and strategic commissioning. All opportunities for shared learning across partners in and across local systems are fully taken up resulting in a clear culture of collaborative practice.
Our Rating				
Evidence / Notes				
Proposed improvement actions				

Proposal 1.2 **Relationships and collaborative working between partners must improve**				
Rating	**Not yet established**	**Partly established**	**Established**	**Exemplary**
Indicator	Lack of trust and understanding of each other's working practices and business pressures between partners.	Statutory partners are developing trust and understanding of each other's working practices and business pressures.	Statutory partners and other partners have a clear understanding of each other's working practices and business pressures – and are working more collaboratively together.	Partners have a clear understanding of each other's working practices and business pressures and can identify and manage differences and tensions. Partners work collaboratively towards achieving shared outcomes. There is a positive and trusting relationship between statutory partners clearly manifested in all that they do.
Our Rating				
Evidence / Notes				
Proposed improvement actions				

Proposal 1.3 **Relationships and partnership working with the third and independent sectors must improve**				
Rating	**Not yet established**	**Partly established**	**Established**	**Exemplary**
Indicator	Lack of engagement with third and independent sectors.	Some engagement with the third and independent sectors.	Third and independent sectors routinely engaged in a range of activity and recognised as key partners.	Third and independent sectors fully involved as partners in all strategic planning and commissioning activity focused on achieving best outcomes for people. Their contribution is actively sought and is highly valued by the IJB. They are well represented on a range of groups and involved in all activities of the IJB.
Our Rating				
Evidence / Notes				
Proposed improvement actions				

Key Feature 2 **Integrated finances and financial planning**				
Proposal 2.1 **Health Boards, Local Authorities and IJBs should have a joint understanding of their respective financial positions as they relate to integration**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	Lack of consolidated advice on the financial position of statutory partners' shared interests under integration.	Working towards providing consolidated advice on the financial position of statutory partners' shared interests under integration.	Consolidated advice on the financial position on shared interests under integration is provided to the NHS/LA Chief Executive and IJB Chief Officer from corresponding financial officers when considering the service impact of decisions.	Fully consolidated advice on the financial position on shared interests under integration is provided to the NHS/LA Chief Executive and IJB Chief Officer from corresponding financial officers when considering the service impact of decisions. Improved longer term financial planning on a whole system basis is in place.
Our Rating				
Evidence / Notes				
Proposed improvement actions				

Proposal 2.2 **Delegated budgets for IJBs must be agreed timeously**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	Lack of clear financial planning and ability to agree budgets by end of March each year.	Medium term financial planning is in place and working towards delegated budgets being agreed by the Health Board, Local Authority and IJB by end of March each year.	Medium term financial and scenario planning in place and all delegated budgets are agreed by the Health Board, Local Authority and IJB by end of March each year.	Medium to long term financial and scenario planning is fully in place and all delegated budgets are agreed by the Health Board, Local Authority and IJB as part of aligned budget setting processes. Relevant information is shared across partners throughout the year to inform key budget discussions and budget setting processes. There is transparency in budget setting and reporting across the IJB, Health Board and Local Authority.
Our Rating				
Evidence / Notes				
Proposed improvement actions				

Proposal 2.3 **Delegated hospital budgets and set aside budget requirements must be fully implemented**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	Currently have no plan to allow partners to fully implement the delegated hospital budget and set aside budget requirements.	Working towards developing plans to allow all partners to fully implement the delegated hospital budget and set aside budget requirements, in line with legislation and statutory guidance, to enable budget planning for 2019/20.	Set aside arrangements are in place with all partners implementing the delegated hospital budget and set aside budget requirements. The six steps for establishing hospital budgets, as set out in statutory guidance, are fully implemented.	Fully implemented and effective arrangements for the delegated hospital budget and set aside budget requirements, in line with legislation and statutory guidance. The set aside budget is being fully taken into account in whole system planning and best use of resources.
Our Rating				
Evidence / Notes				
Proposed improvement actions				

Proposal 2.4 **Each IJB must develop a transparent and prudent reserves policy**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	There is no reserves policy in place for the IJB and partners are unable to identify reserves easily. Reserves are allowed to build up unnecessarily.	A reserves policy is under development to identify reserves and hold them against planned spend. Timescales for the use of reserves to be agreed.	A reserves policy is in place to identify reserves and hold them against planned spend. Clear timescales for the use of reserves are agreed, and adhered too.	A clear reserves policy for the IJB is in place to identify reserves and hold them against planned spend and contingencies. Timescales for the use of reserves are agreed. Reserves are not allowed to build up unnecessarily. Reserves are used prudently and to best effect to support full implementation the IJB's strategic commissioning plan.
Our Rating				
Evidence / Notes				
Proposed improvement actions				

Proposal 2.5 **Statutory partners must ensure appropriate support is provided to IJB S95 Officers.**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	IJB S95 Officer currently unable to provide high quality advice to the IJB due to a lack of support from staff and resources from the Health Board and Local Authority.	Developments underway to better enable IJB S95 Officer to provide good quality advice to the IJB, with support from staff and resources from the Health Board and Local Authority ensuring conflicts of interest are avoided.	IJB S95 Officer provides high quality advice to the IJB, fully supported by staff and resources from the Health Board and Local Authority and conflicts of interest are avoided. Strategic and operational finance functions are undertaken by the IJB S95 Officer. A regular year-in-year reporting and forecasting process is in place.	IJB S95 Officer provides excellent advice to the IJB and Chief Officer. This is fully supported by staff and resources from the Health Board and Local Authority who report directly to the IJB S95 Officer on financial matters. All strategic and operational finance functions are integrated under the IJB S95 Officer. All conflicts of interest are avoided.
Our Rating				
Evidence / Notes				
Proposed Improvement actions				

Proposal 2.6 **IJBs must be empowered to use the totality of resources at their disposal to better meet the needs of their local populations.**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	Total delegated resources are not defined for use by the IJB. Decisions about resources may be taken elsewhere and ratified by the IJB.	Total delegated resources have been brought together in an aligned budget but are routinely treated and used as separate health and social care budgets. The totality of the budget is not recognised nor effectively deployed.	Total delegated resources are effectively deployed as a single budget and their use is reflected in directions from the IJB to the Health Board and Local Authority.	Total delegated resources are effectively deployed as a single budget and their use is reflected in directions from the IJB to the Health Board and Local Authority. The IJB's strategic commissioning plan and directions reflect its commitment to ensuring that the original identity of funds loses its identity to best meet the needs of its population. Whole system planning takes account of opportunities to invest in sustainable community services.
Our Rating				
Evidence / Notes				
Proposed improvement actions				

Key Feature 3 **Effective strategic planning for improvement**				
Proposal 3.1 **Statutory partners must ensure that Chief Officers are effectively supported and empowered to act on behalf of the IJB.**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	Lack of recognition of and support for the Chief Officer's role in providing leadership.	The Chief Officer is not fully recognised as pivotal in providing leadership. Health Board and Local Authority partners could do more to provide necessary staff and resources to support Chief Officers and their senior team.	The Chief Officer is recognised as pivotal in providing leadership and is recruited, valued and accorded due status by statutory partners. Health Board and Local Authority partners provide necessary resources to support the Chief Officer and their senior team fulfil the range of responsibilities	The Chief Officer is entirely empowered to act and is recognised as pivotal in providing leadership at a senior level. The Chief Officer is a highly valued leader and accorded due status by statutory partners, the IJB, and all other key partners. There is a clear and shared understanding of the capacity and capability of the Chief Officer and their senior team, which is well resourced and high functioning.
Our Rating				
Evidence / Notes				
Proposed improvement actions				

Proposal 3.2 **Improved strategic inspection of health and social care is developed to better reflect integration.**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator				
Our Rating				
Evidence / Notes	NOT FOR LOCAL COMPLETION - NATIONAL INSPECTORATE BODIES RESPONSIBLE			

Proposal 3.3 **National improvement bodies must work more collaboratively and deliver the improvement support partnerships require to make integration work.**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator				
Our Rating				
Evidence / Notes	NOT FOR LOCAL COMPLETION - NATIONAL BODIES RESPONSIBLE			

Proposal 3.4 **Improved strategic planning and commissioning arrangements must be put in place.**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	Integration Authority does not analyse and evaluate the effectiveness of strategic planning and commissioning arrangements. There is a lack of support from statutory partners.	Integration Authority developing plans to analyse and evaluate the effectiveness of strategic planning and commissioning arrangements. The Local Authority and Health Board provide some support for strategic planning and commissioning.	Integration Authority has undertaken an analysis and evaluated the effectiveness of strategic planning and commissioning arrangements. The Local Authority and Health Board provide good support for strategic planning and commissioning, including staffing and resources which are managed by the Chief Officer.	Integration Authority regularly critically analyses and evaluates the effectiveness of strategic planning and commissioning arrangements. There are high quality, fully costed strategic plans in place for the full range of delegated services, which are being implemented. As a consequence, sustainable and high quality services and supports are in place that better meet local needs. The Local Authority and Health Board provide full support for strategic planning and commissioning, including staffing and resources for the partnership, and recognise this as a key responsibility of the IJB.
Our Rating				
Evidence / Notes				
Proposed improvement actions				

Proposal 3.5 **Improved capacity for strategic commissioning of delegated hospital services must be in place.**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	No plans are in place or practical action taken to ensure delegated hospital budget and set aside arrangements form part of strategic commissioning.	Work is ongoing to ensure delegated hospital budgets and set aside arrangements are in place according to the requirements of the statutory guidance.	Delegated hospital budget and set aside arrangements are fully in place and form part of routine strategic commissioning and financial planning arrangements. Plans are developed from existing capacity and service plans, with a focus on planning delegated hospital capacity requirements with close working with acute sector and other partnership areas using the same hospitals.	Delegated hospital budget and set aside arrangements are fully integrated into routine strategic commissioning and financial planning arrangements. There is full alignment of budgets. There is effective whole system planning in place with a high awareness across of pressure, challenges and opportunities.
Our Rating				
Evidence / Notes				
Proposed improvement actions				

Key Feature 4 **Governance and accountability arrangements**				
Proposal 4.1 **The understanding of accountabilities and responsibilities between statutory partners must improve.**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	No clear governance structure in place, lack of clarity around who is responsible for service performance, and quality of care.	Partners are working together to better understand the governance arrangements under integration to better understand the accountability and responsibilities of all partners.	Clear understanding of accountability and responsibility arrangements across statutory partners. Decisions about the planning and strategic commissioning of delegated health and social care functions sit with the IJB.	Clear understanding of accountability and responsibility arrangements and arrangements are in place to ensure these are reflected in local structures. Decisions about the planning and strategic commissioning of delegated functions sit wholly with the IJB and it is making positive and sustainable decisions about changing the shape of care in its localities. The IJB takes full responsibility for all delegated functions and statutory partners are clear about their own accountabilities.
Our Rating				
Evidence / Notes				
Proposed improvement actions				

Indicator 4.2 **Accountability processes across statutory partners will be streamlined.**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	Accountability processes unclear, with different rules being applied across the system.	Accountability processes being scoped and opportunities identified for better alignment.	Accountability processes are scoped for better alignment, with a focus on fully supporting integration and transparent public reporting.	Fully transparent and aligned public reporting is in place across the IJB, Health Board and Local Authority.
Our Rating				
Evidence / Notes				
Proposed improvement actions				

Proposal 4.3 **IJB chairs must be better supported to facilitate well run Boards capable of making effective decisions on a collective basis.**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	IJB lacks support and unable to make effective decisions.	IJB is supported to make effective decisions but more support is needed for the Chair.	The IJB Chair is well supported, and has an open and inclusive approach to decision making, in line with statutory requirements and is seeking to maximise input of key partners.	The IJB Chair and all members are fully supported in their roles, and have an open and inclusive approach to decision making, going beyond statutory requirements. There are regular development sessions for the IJB on variety of topics and a good quality induction programme is in place for new members. The IJB has a clear understanding of its authority, decision making powers and responsibilities.
Our Rating				
Evidence / Notes				
Proposed improvement actions				

Proposal 4.4 **Clear directions must be provided by IJB to Health Boards and Local Authorities.**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	No directions have been issued by the IJB.	Work is ongoing to improve the direction issuing process and some are issued at the time of budget making but these are high level, do not direct change and lack detail.	Directions are issued at the end of a decision making process involving statutory partners. Clear directions are issued for all decisions made by the IJB, are focused on change, and take full account of financial implications.	Directions are issued regularly and at the end of a decision making process, involving all partners. There is clarity about what is expected from Health Boards and Local Authorities in their delivery capacity, and they provide information to the IJB on performance, including any issues. Accountability and responsibilities are fully transparent and respected. Directions made to the Health Board in a multi-partnership area are planned on an integrated basis to ensure coherence and take account of the whole system.
Our Rating				
Evidence / Notes				
Proposed improvement actions				

Proposal 4.5 **Effective, coherent and joined up clinical and care governance arrangements must be in place.**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	There is a lack of understanding of the key role clinical and professional leadership plays in supporting safe and appropriate decision making is not well understood. Necessary clinical and care governance arrangements are not well established.	There is partial understanding of the key role clinical and professional leadership plays in supporting safe and appropriate decision making. Arrangements for clinical and care governance are not clear	The key role clinical and professional leadership plays in supporting safe and appropriate decision making is fully understood. There are fully integrated arrangements in place for clinical and care governance.	The key role clinical and professional leadership plays in supporting safe and appropriate decision making is fully understood. Arrangements for clinical and care governance are well established and providing excellent support to the IJB. Strategic commissioning is well connected to clinical and care governance and there is a robust process for sharing information about, for example, inspection reports findings and adverse events information, and continuous learning is built into the system.
Our Rating				
Evidence / Our Notes				
Proposed improvement actions				

Key Feature 5 **Ability and willingness to share information**				
Proposal 5.1 **IJB annual performance reports will be benchmarked by Chief Officers to allow them to better understand their local performance data.**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	Work is required to further develop Integration Authority annual reports to improve consistency in reporting, better reflect progress and challenges in local systems, and ensure all statutory required information is reported on by July 2019.	Work is ongoing to further develop Integration Authority annual reports to improve consistency in reporting, better reflect progress and challenges in local systems, and ensure all statutory required information is reported on, by July 2019.	Integration Authority annual reports are well developed to reflect progress and challenges in local systems, and ensure all statutory required information is reported on, by July 2019. Some benchmarking is underway and assisting consistency and presentation of annual reports.	Integration Authority annual reports are well developed to reflect progress and challenges in local systems, to ensure public accessibility, and to support public understanding of integration and demonstrate its impact. The annual report well exceeds statutory required information is reported on. Reports are consistently well presented and provide information in an informative, accessible and readable format for the public.
Our Rating				
Evidence / Notes				
Proposed improvement actions				

Proposal 5.2 **Identifying and implementing good practice will be systematically undertaken by all partnerships.**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	Work is required to improve the Integration Authority annual report to identify, share and use examples of good practice and lessons learned from things that have not worked.	Work is about to commence on development of the annual report to enable other partnerships to identify and use examples of good practice. Better use could be made of inspection findings to identify and share good practice.	The Integration Authority annual report is presented in a way that readily enables other partnerships to identify, share and use examples of good practice and lessons learned from things that have not worked. Inspection findings are routinely used to identify and share good practice.	Annual reports are used by the Integration Authority to identify and implement good practice and lessons are learned from things that have not worked. The IJB's annual report is well developed to ensure other partnerships can easily identify and good practice. Inspection findings and reports from strategic inspections and service inspections are always used to identify and share good practice. All opportunities are taken to collaborate and learn from others on a systematic basis and good practice is routinely adapted and implemented.
Our Rating				
Evidence / Notes				
Proposed improvement actions				

Proposal 5.3 **A framework for community based health and social care integrated services will be developed.**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator				
Our Rating				
Evidence / Notes	NOT FOR LOCAL COMPLETION - NATIONAL BODIES RESPONSIBLE			

Key Feature 6 **Meaningful and sustained engagement**				
Proposal 6.1 **Effective approaches for community engagement and participation must be put in place for integration.**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	There is a lack of engagement with local communities around integration.	Engagement is usually carried out when a service change is proposed.	Engagement is always carried out when a service change, redesign or development is proposed.	Meaningful engagement is an ongoing process, not just undertaken when service change is proposed. Local communities have the opportunity to contribute meaningfully to locality plans and are engaged in the process of determining local priorities.
Our Rating				
Evidence / Notes				
Proposed improvement actions				

Proposal 6.2 **Improved understanding of effective working relationships with carers, people using services and local communities is required.**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	Work is required to improve effective working relationships with service users, carers and communities.	Work is ongoing to improve effective working relationships with service users, carers and communities. There is some focus on improving and learning from best practice to improve engagement.	Meaningful and sustained engagement with service users, carers and communities is in place. There is a good focus on improving and learning from best practice to maximise engagement and build effective working relationships.	Meaningful and sustained engagement with service users, carers and communities is in place. This is given high priority by the IJB. There is a relentless focus on improving and implementing best practice to maximise engagement. There are well established and recognised effective working relationships that ensure excellent working relationships.
Our Rating				
Evidence / Notes				
Proposed improvement actions				

Proposal 6.3 **We will support carers and representatives of people using services better to enable their full involvement in integration.**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	Work is required to improve involvement of carers and representatives using services.	Work is ongoing to improve involvement of carers and representatives using services.	Carers and representatives on the IJB are supported by the partnership, enabling engagement. Information is shared to allow engagement with other carers and service users in responding to issues raised.	Carers and representatives of people using services on the IJB, strategic planning group and locality groups are fully supported by the partnership, enabling full participation in IJB and other meetings and activities. Information and papers are shared well in advance to allow engagement with other carers and service users in responding to issues raised. Carers and representatives of people using services input and involvement is fully optimised.
Our Rating				
Evidence / Notes				
Proposed improvement actions				

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 8 May 2019

Report By	Nicky Berry, Director of Nursing, Midwifery & Acute Services Rob McCulloch-Graham, Chief Officer Health and Social Care
Contact	Gareth Clinkscale, General Manager Unscheduled Care Meriel Carter, Planning and Performance Officer
Telephone:	01896 825528 / 828224

NHS BORDERS 2018/19 FESTIVE PERIOD REPORT

Purpose of Report:	The purpose of this report is to update the IJB on performance over the festive period only: 15th December 2018 until 2nd January 2019. This period was 19 days long with 3 weekends, which is the same as covered last year, 15th December 2017 until 2nd January 2018, making the periods comparative.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Note** the 2018/19 Festive Period Report and the performance of the system during this period.

Personnel:	Resource and staffing implications were addressed within the Winter Plan.

Carers:	Any impact has been assessed and included as part of the Winter Plan.

Equalities:	Any impact has been assessed and included as part of the Winter Plan.

Financial:	Resource and staffing implications were addressed within the Winter Plan.

Legal:	Any impact has been assessed and included as part of the Winter Plan.

Risk Implications:	The Winter Plan is designed to mitigate the risks associated with the winter and festive periods.

Background

NHS Borders, like all Health Boards, are required on an annual basis to produce a Winter Plan which outlines potential risks and contingency planning relevant to the winter season, with a particular focus on the festive period. This year the plan was developed jointly with the Scottish Borders Health and Social Care partnership as a whole system plan. The 2018/19 plan was discussed at both the Health Board and Integrated Joint Board and subsequently approved at the 9th September 2018 NHS Borders Board meeting.

After each winter period the Winter Planning Board convenes to assess what worked well, what could have been improved, the learning from the period, and key recommendations are taken forward in preparation for the next winter period. A full report on the winter period will come to the Board in April 2019.

Performance Summary

The period represented a significant improvement in performance when comparing to the previous winter; there were 97 fewer breaches for this period, a reduction of 66.4%. There were a number of factors behind this improved performance. Since summer 2018, an improvement programme has been delivered through the BGH aiming to improve safe patient flow and therefore 4-hour performance. This programme has delivered several key changes including a new BGH Escalation policy, process work to improve how flow is managed at the Safety Huddle and afternoon bed meeting, the development of a monthly patient flow improvement programme, the re-launch of Daily Dynamic Discharge, the implementation of Hospital to Weekend and a new Site & Capacity Team across seven days. This strengthening of process in the BGH has been complemented through key developments by the Health and Social Care Partnership including the development of a Hospital to Home service, focussed work to reduce length of stay in Community Hospitals and the Rapid Assessment and Discharge (RAD) service moving to seven days. In addition Scottish Borders Council increased the number of step down beds, intermediate care as well as increasing the number of high end Nursing care beds. All of these additional resources increase capacity significantly and improved patient flow. These system-wide developments have improved patient flow through the hospital and into the community.

Emergency Department (ED) and Acute Assessment Unit (AAU) Activity Summary

There were was a slight reduction in total attendances this festive period with 10 less patients arriving through the BGH front doors compared to last (equal to 0.6% less). A significant factor in the reduction in breaches was the work undertaken to protect the Gynaecological and Surgical Assessment (GSAU) and Acute Assessment Unit (AAU) areas from being bedded. These areas were protected through the festive period. Last winter GSAU was bedded before the festive period and AAU was bedded during the festive weeks. The improvement activities described above enabled this, with a new surge capacity plan developed that increased the site threshold for bedding these areas. This protected the site from the adverse impact that bedding GP assessment areas bring.

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Table 1: ED, AAU and SAU Total Attendances

Year	Total Attendance		Total Breaches		Weekend Attendance[2]		Weekend Breaches[2]		Public Holiday Attendance		Public Holiday Breaches	
2015/16	1,444		60		512		14		325		10	
2016/17	1,496	(+52) 3.6%	68	(+8) 13.3%	444	(-68) -13.3%	19	(+5) 35.7%	374	(+49) 15.1%	26	(+16) 160.0%
2017/18	1,698	(+202) 13.5%	253	(+185) 272.1%	542	(+98) 22.1%	61	(+42) 221.1%	372	(-2) -0.5%	62	(+36) 138.5%
2018/19	1,601	(-97) -5.7%	85	(-168) -66.4%	519	(-23) -4.2%	19	(-42) -68.9%	347	(-25) -6.7%	7	(-55) -88.7%
2018/19 (inc SAU)[3]	1,688	(-10) -0.6%	85	(-168) -66.4%	538	(-4) -0.7%	19	(-42) -68.9%	355	-17 (-4.6%)	7	(-55) -88.7%

*Figures in grey show the variance from previous year

[1] Previously reported data to the board included dates out with the reporting period which have now been updated.

[2] Please note: Weekend figures have adjusted for all years to include 3 full weekends (6 days) to enable an accurate year on year comparison.

[3] The Surgical Assessment Unit in Ward 7 was open throughout the festive period – but the 4 hour clock has not been applied to these attendances.

Chart 1: Total ED and AAU Attendances by Day in the Festive Period

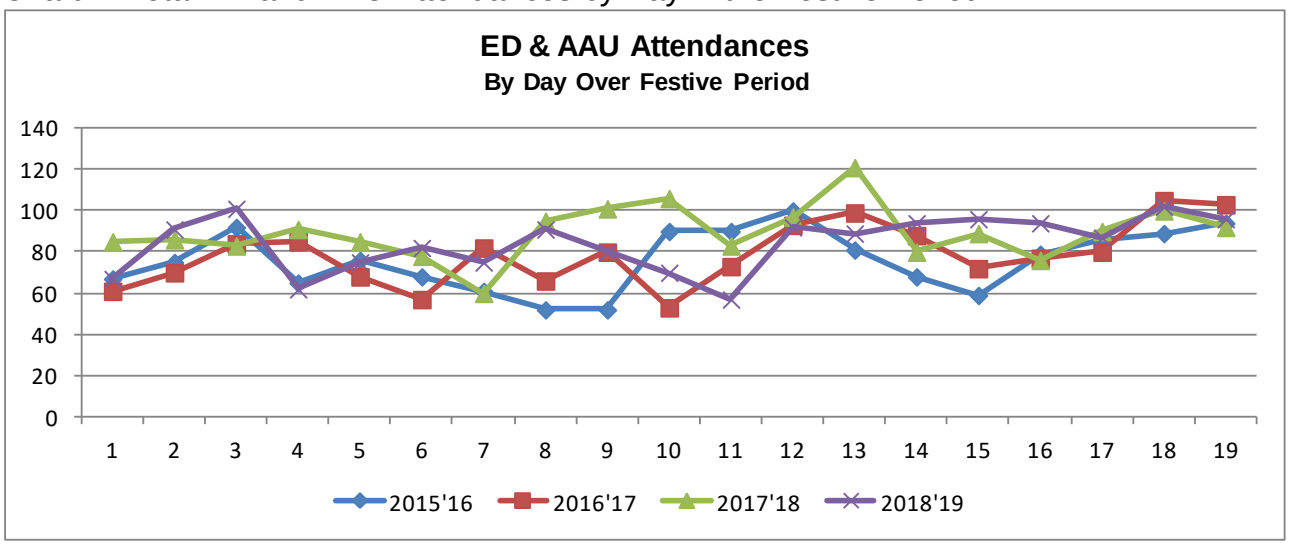


Table 2: ED, AAU and SAU Split of Total Attendances

Area	Total Attendance	Total Breaches	Weekend Attendance	Weekend Breaches	Public Holiday Attendance	Public Holiday Breaches
ED	1457	67	499	17	326	6
AAU	144	18	20	2	21	1
SAU	87	-	19	-	8	-
Total	**1688**	**85**	**538**	**19**	**355**	**7**

Total 4-hour performance, weekend performance and public holiday was significantly higher than last winter. Total performance was 4.8% higher, weekend performance 7.6% higher and public holiday increased by 11.7%. There was one day in-between the weekend and public holiday days this year which will have been a factor in the improved performance.

Table 3: EAS Performance (ED and AAU)

Year	Total EAS Performance	Weekend EAS Performance[1]	Public Holiday EAS Performance
2012/13	94.3%	97.8%	97.2%
2013/14	98.8%	98.6%	99.9%
2014/15	88.1%	88.6%	92.9%
2015/16	97.1%	97.4%	97.7%
2016/17	96.3%	96.5%	94.4%
2017/18	89.9%	88.7%	83.3%
2018/19	94.7%	96.3%	98.0%

[1]Please note: Weekend figures have been adjusted for all years to include 3 full weekends (6 days) to enable an accurate year on year comparison.

There will be a full whole-system review of the winter period at the end of March inviting stakeholders from across all of Health and Social Care. This forum will provide the basis of feedback on the 2018/19 winter period and explore what more can be done to prepare for winter 2019/20.

BGH Activity Summary

There were 10 fewer admissions this period compared to previous and 6 more admissions. There was no change in weekend discharges and Public Holiday discharges increased by 7.1% (5 more).

Table 4: BGH Adult Emergency Admissions & Discharges

Year	Total Admissions		Total Discharges		Weekend Admissions[1]		Weekend Discharges[1]		Public Holiday Admissions		Public Holiday Discharges	
2015/16	657		529		203		120		124		80	
2016/17	605	(-52) -7.9%	574	(+45) 8.5%	168	(-35) -17.2%	118	(-2) -1.7%	138	(+14) 11.3%	111	(+31) 38.8%
2017/18	561	(-44) -7.3%	529	(-45) -7.8%	151	(-17) -10.1%	145	(+27) 22.9%	119	(-19) -13.8%	70	(-41) -36.9%
2018/19	551	(-10) -1.8%	535	(+6) 1.1%	151	(0) 0%	123	(-22) -15.2%	117	(-2) -1.7%	75	(+5) 7.1%

* Figures in grey show the variance from previous year [1]Please note: Weekend figures have been adjusted for all years to include 3 full weekends (6 days) to enable an accurate year on year comparison.

Chart 2: Discharges Comparison by day, 2015/16, 2016/17, 2017/18 and 2018/19

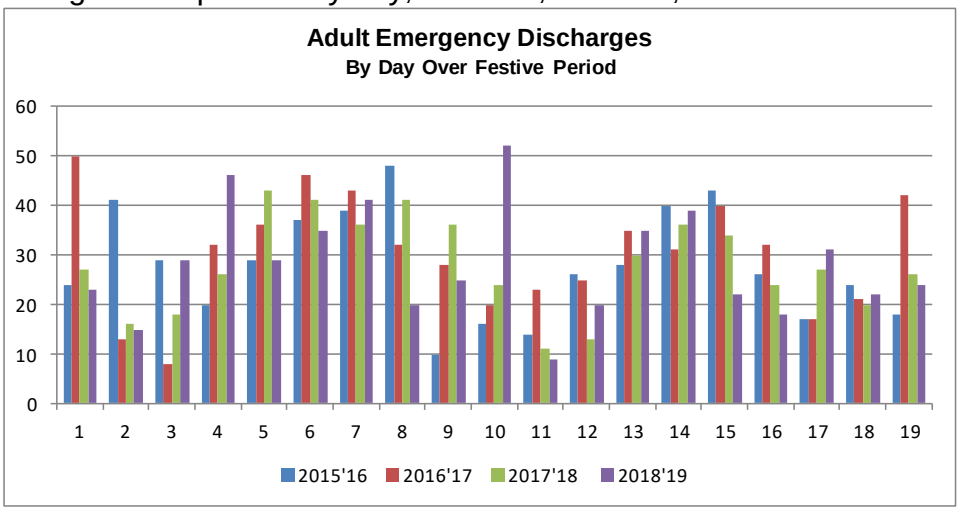
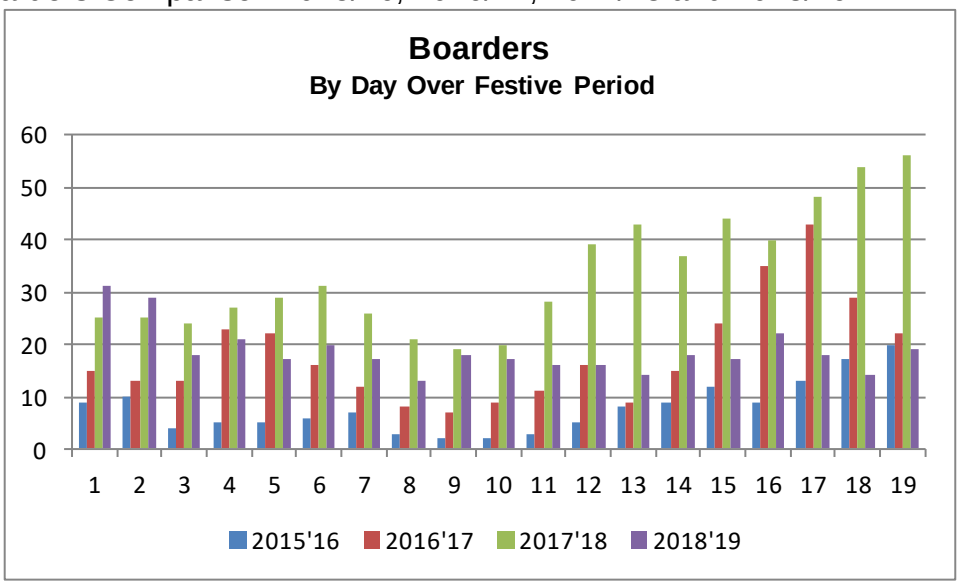


Chart 3: Boarders Comparison 2015/16, 2016/17, 2017/18 and 2018/19



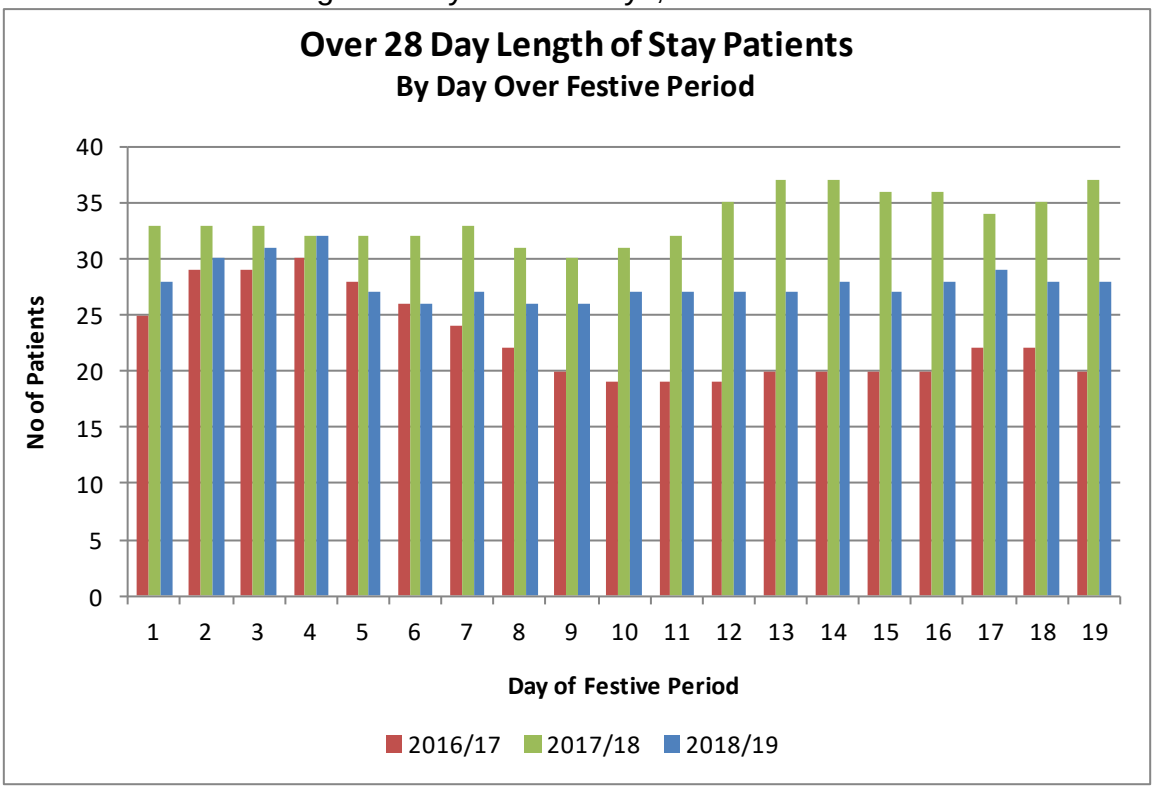
Delayed Discharges

There were 152 fewer delayed discharges compared to the previous festive period which was 20% less than last year. This reflects the development of Hospital to Home and process work undertaken across both the BGH and Community Hospitals to reduce delays. The increase from 2016/17 to 2017/18 is in part due to a change in recording delays.

Table 5: Delayed Discharge Occupied Bed Days – Comparison between festive periods 2016/17, 2017/18 and 2018/19

Delayed Discharge Occupied Bed Days	Festive Period 2016/17			Festive Period 2017/18			Festive Period 2018/19		
	Standard	Complex	Total	Standard	Complex	Total	Standard	Complex	Total
BGH	93	0	93	210	70	280	154	36	190
Community Hospitals	307	54	361	348	68	416	250	18	268
Mental Health	81	38	119	17	34	51	101	36	137
Total	**481**	**92**	**573**	**575**	**172**	**747**	**505**	**90**	**595**

Chart 4: Patients with a length of stay over 28 days, 2016/17 to 2018/19



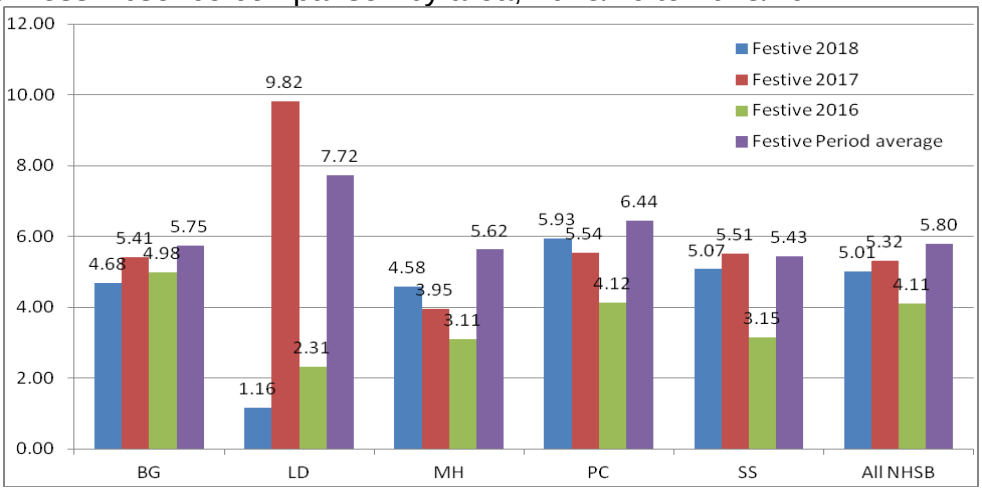
Infection Control

During the festive period (15th December 2018 – 2nd January 2019), there were closures over 6 days for infection control reasons. Ward 4 had 1 bay (6 beds) closed due to confirmed Norovirus for 4 days; and Ward 12 had 1 bay (6 beds) closed for 2 days due to the same reason.

Staff Sickness Absence

The sickness absence rate over the festive period for 2018/19 was 5.01%. This rate saw a decrease of 0.31% on the sickness absence rate from the festive period of the previous year (2017/18) where the rate was 5.32%. On average over the festive period the absence rate sits at approximately 5.80%.

Chart 5 Sickness Absence comparison by area, 2015/16 to 2018/19



This Festive period saw an increase in rate of absence for only two directorates, MH & P&C compared to last year's festive period where all of the directorates had an increase. All directorates reported a lower rate of sickness absence during this period compared to their average rate of sickness absence during the Festive Period.

Div SA %	Festive 2018	Festive 2017	Festive 2016	Festive Period average
BG	4.68	5.41	4.98	5.75
LD	1.16	9.82	2.31	7.72
MH	4.58	3.95	3.11	5.62
PC	5.93	5.54	4.12	6.44
SS	5.07	5.51	3.15	5.43
All NHSB	5.01	5.32	4.11	5.80

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Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 8 May 2019

Report By	Rob McCulloch-Graham, Chief Officer Health & Social Care
Contact	Louise Ramage, PA
Telephone:	01896 825571 / 01835 826685

STRATEGIC PLANNING GROUP REPORT

Purpose of Report:	To update the Integration Joint Board on the work of the Strategic Planning Group.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Note** this report

Personnel:	N/A

Carers:	N/A

Equalities:	N/A

Financial:	N/A

Legal:	N/A

Risk Implications:	N/A

Purpose

The purpose of this report is to update the Integration Joint Board (IJB) on any key actions and issues arising from the Strategic Planning Group (SPG) meeting held Wednesday 20 March 2019.

SPG Key Actions & Issues

Transforming Care After Treatment – TCAT
An end of project report was presented on the key points, outcomes, challenges and recommendations of the TCAT service; a national partnership between Scottish Government, Macmillan Cancer Support, NHS Scotland and local authorities to support the redesign of care following active treatment of cancer. The project was almost 3 years in total, due to a successful bid for extended funds after 2 years to roll out the project into a business as usual model. This has now been dovetailed with the NHS Phase 1 (which was a clinical project) at the referral stage, and with the What Matters hubs in terms of local community access.

Carers: Living Well in Scottish Borders
The background and key ambitions of the proposed carers plan for 2019-22 were presented for approval. Once published and implemented, this will be monitored at the Carers Action Board.

Queries were raised regarding the capacity for respite carers and carer training.

The Carers: Living Well in Scottish Borders strategy was approved.

Technology Enabled Care (TEC) Strategy
An introduction to the TEC Strategy was given and sought approval of the strategy. The aims of TEC strategy were presented, along with the following main components:

- Attend Anywhere - virtual appointments with clinicians online
- Florence – mobile health monitoring
- Strata – Facilitates patient centred care – co-ordinated across Health & Social Care Pathways.
- ARMED – personal monitor to detect and prevent falls

The above components must:

- Be robust
- Be used ‘in house’
- Be able to identify demand in care homes

It was agreed that further GP engagement would be sought in developing and implementing the TEC strategy.

Other Matters Arising
Clarification was provided on NHS Borders stage 4 status on the ladder of escalation and the financial impact, if any, on the IJB.