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Scottish Borders
Health and Social Care
PARTNERSHIP

A meeting of the **Health & Social Care Integration Joint Board** will be held on **Wednesday, 30th October, 2019** at **10.00 am** in Council Chamber, SBC

AGENDA

Time	No		Lead	Paper
10:00	**1**	**ANNOUNCEMENTS AND APOLOGIES**	**Chair**	Verbal
10:01	**2**	**DECLARATIONS OF INTEREST** Members should declare any financial and non financial interests they have in the items of business for consideration, identifying the relevant agenda item and the nature of their interest.	**Chair**	Verbal
10:03	**3**	**MINUTES OF PREVIOUS MEETING**	**Chair**	(Pages 3 - 10)
10:05	**4**	**MATTERS ARISING** Action Tracker	**Chair**	(Pages 11 - 16)
10:10	**5**	**FOR DECISION**		
	5.1	Winter Plan 2019/20	**Hospital Manager**	(Pages 17 - 24)
	5.2	Physical Disability Strategy	**Chief officer Older Peoples Services & Transformation**	(Pages 25 - 60)
	5.3	Board Meeting Dates and Business Cycle	**Business Lead Health & Social Care**	(Pages 61 - 64)
10:45	**6**	**FOR NOTING**		

	6.1	Primary Care Improvement Plan Update	**Associate Director of Strategic Change & GP Sub Chair**	(Pages 65 - 140)
	6.2	Financial Outlook Update • NHS Borders • Scottish Borders Council • IJB	**Directors of Finance**	Verbal
	6.3	Joint Financial Plan - Assumptions 2020/21	**Chief Finance Officer**	(Pages 141 - 144)
	6.4	Inspections Update	**Chief Officer Adult Services**	Verbal
	6.5	Alcohol and Drugs Partnership Update	**Director of Public Health**	(Pages 145 - 196)
11.55	**7**	**ANY OTHER BUSINESS**	**Chair**	
	7.1	Health & Social Care Integration Joint Board Development Session: 20 November 2019	**Chief Officer**	Verbal
	8	**DATE AND TIME OF NEXT MEETING** Wednesday 17 December 2019 at 10.00am in the Council Chamber, Scottish Borders Council	**Chair**	Verbal

Minutes of a meeting of the Health & Social Care **Integration Joint Board** held on Wednesday 25 September 2019 at 10.00am in the Council Chamber, Scottish Borders Council.

Present:	(v) Dr S Mather (Chair)	(v) Cllr D Parker
	(v) Cllr J Greenwell	(v) Mr M Dickson
	(v) Cllr T Weatherston	(v) Mrs K Hamilton
	(v) Cllr E Thornton-Nicol	Mr R McCulloch-Graham
	Dr C Sharp	Mr M Porteous
	Miss V Macpherson	Mrs J Smith
	Mrs S Horan	Ms Linda Jackson
In Attendance:	Mr R Roberts	Mrs T Logan
	Mrs C Gillie	Ms S Douglas
	Mr G McMurdo	Miss L Ramage
	Mrs J Stacey	Ms I Bishop
	Mr G Clinkscale	Mrs J Stephen
	Mr J Lamb	Mr Brian Paris
	Dr L McCallum	Dr R Mollart
	Dr K Buchan	

1. Apologies and Announcements

Apologies had been received from Mr John McLaren, Mr Tris Taylor, Cllr Shona Haslam, Mrs Nicky Berry, Mr Stuart Easingwood, Mr David Bell, Dr Angus McVean, Mr David Robertson and Ms Lynn Gallacher.

The Chair confirmed the meeting was quorate.

The Chair welcomed members of the public to the meeting.

2. Declarations of Interests

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

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted there were none.

3. Minutes of Previous Meeting

The minutes of the previous meeting of the Health & Social Care Integration Joint Board (IJB) held on 14 August 2019 were approved.

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4. Matters Arising

4.1 Action 11: Mr Rob McCulloch-Graham advised that resource was yet to be identified to carry out the work required for a monthly newsletter and hopefully the first newsletter would be available in October 2019. Mrs Karen Hamilton provided reassurance that any potential shortage of capacity could be raised through NHS Borders executives to ensure support is provided.

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

5. Strategic Implementation Plan

Mr Rob McCulloch-Graham set the context of the revised Strategic Plan and provided an overview of the intended Strategic Implementation Plan (SIP) to direct programmes to achieve the strategic objectives. The SIP promoted the development of a locality based approach to health and social care provision in the Scottish Borders; consistent with commissioned evaluations undertaken over the years.

The next phase delivering the SIP would be to set timings and elect leads; with formal IJB directions to follow. Mr Mike Porteous added that a financial strategy will be developed to underpin the SIP.

Members were assured that strong steps have been made increase digital compatibility between organisations, which would be an integral to the successful delivery of workstreams.

Mr Ralph Roberts urged members to look at Health & Social Care as a single system where the positive impact of the SIP system wide.

Mr Malcolm Dickson was fully supportive of the direction of travel and asked for assurance that strong programme and performance management would be in place to gain robust data from the implementation of the several workstreams.

Mrs Karen Hamilton advised of her support and asked for a clear direction on a public engagement strategy going forward.

Cllr Elaine Thornton-Nicol requested the removal of the word ‘suffers’ on page 12 of the document, under the Mental Health/Dementia section.

Mrs Tracey Logan advised that a commitment had been made with the joint management teams to implement a further shift into community services; however the challenges should not be underestimated in the ambitious plan.

Ms Jenny Smith asked if third sector contribution opportunities could be explored further and added into the SIP.

Mr Ralph Roberts advised that a joint resource plan needed to be developed as a priority, to understand the requirements and prioritisation required to deliver against the SIP.

Ms Linda Jackson asked for carers and services users to have a greater level of engagement in the delivery of the SIP and offered assistance with communicating to the necessary groups.

Mr Rob McCulloch-Graham thanked Mr Graeme McMurdo for his support in the development of the SIP.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the strategic implementation plan for 2019 to 2024 and the areas of work to be undertaken within that time period.

6. Transformation Fund Review

Mr Rob McCulloch-Graham provided an overview of the report and advised the Integrated Care Fund (ICF) was henceforth referred to as the Transformation Fund as part of core budget.

The present annual commitments to the Transformation Fund were presented along with the proposal of extensions and expansions, to further address delayed discharges within the acute and community hospitals. Mr Mike Porteous then gave an overview of the supporting finance detail.

Ms Linda Jackson was advised that the IJB would be looking to mainstream the Community Capacity Building which was funded through the Transformation Fund at present.

Mrs Karen Hamilton advised that there had been no significant impact on reducing delayed discharges and asked for a tangible trajectory of the planned reduction. Mr Ralph Roberts added that patients would not receive what was best for their needs as a delayed discharge; this should be the primary focus. Mr Rob McCulloch-Graham advised that weekly meetings would be in place to ensure whole system utilisation to reduce the delays and he would bring an update on a trajectory to a future meeting.

Dr Cliff Sharp advised that the view of front line clinicians and managers were the preferred area of investment would be Hospital to Home, rather than extending the use of Garden View. Mrs Sarah Horan added that Garden View continued to operate with empty beds on a regular basis, had a 12% readmission rate back into the Borders General Hospital and, from the external evaluations, appeared to run at a financial deficit. Mr Mike Porteous reminded members it is not possible to compare costs like for like, in terms of acute hospital beds.

Mr Rob McCulloch-Graham advised that whilst he appreciated the clinical opinions, Garden View had been relied on heavily during the winter months and the average occupancy of the facility was 11 of out 15 beds used. The report therefore suggests continuing to operate Garden View to mitigate any risk of the Hospital to Home expansion and ensure efficient patient flow in the system.

Mrs Tracey Logan reminded members that Garden View was opened in response to a crisis of patient flow within the acute setting, but was yet to be utilised to full potential. Discussions ensued regarding the possibility of reviewing the criteria for admission, with the possibility of including Allied Health Professionals (AHPs) in a reablement model. Mrs Tracey Logan added that she had doubts over the accuracy of the £136 cost per bed day.

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The Chair asked Dr Lynn McCallum for a clinical perspective. Dr Lynn McCallum acknowledged the real risk of removing the facility, however retaining investment in the bed base would be against the vision of the agreed SIP by the continued institutionalisation of patients which may not be the best suited to their needs. Dr Lynn McCallum reiterated that Garden View was an expensive model of care for patients, that clinicians were struggling to identify as appropriate admissions anyway, and therefore an investment in the community would be preferred.

Cllr David Parker advised he did not believe the report justified the increased investment and was very concerned that clinicians appeared to question the direction of travel, with obvious tension. Cllr Parker added that members had no option but to accept the recommendations in the report at present.

Mr Ralph Roberts advised that the IJB should look to make permanent decisions on the programmes with current Transformation funding and reflect it in the budget setting process.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the current position of Transformation Fund.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the project extensions set out in section 4 of the report.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the changes in funding commitments highlighted in section 6 of the report.

7. Annual Review of IJB Terms of Reference

Mr Rob McCulloch-Graham provided an overview of the proposed changes to the Terms of Reference and summarised the additions to the non-voting membership.

Miss Vikki Macpherson asked for the NHS Borders Staff Side position to be stated as rotational representation.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD c**onsidered and agreed the proposed additions to the non-voting membership of the IJB (2 Service User Representatives; GP Sub Committee Chair; Public Health Representative and 2 Housing Sector Representatives).

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the revised IJB Terms of Reference.

8. Strata Evaluation

Mr Rob McCulloch-Graham provided the context of the six month break clause detailed in the Strata evaluation report, which was agreed due to the uncertainty of the project deliverables.

Mrs Jackie Stephen, Mr James Lamb and Mr Brian Paris gave a presentation on the value of Strata for patients and service users, as well as the benefits of enabling integrated system for staff use. Members were advised that timely and accurate data input would be required for

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the system to work efficiently. Dr Lynn McCallum advised that, from a clinical perspective, Strata would be an enabler to take forward patient care in a community focused approach.

Dr Kevin Buchan advised that the joint system was exactly what GPs need to enable full use of referral strands and improve patient care.

Mr Malcolm Dickson asked for the future business case to include more robust financial information, timelines and targets and therefore outline the contribution to enable savings. Mr David Robertson added that it would be useful to illustrate the data gathered from those who use the system and the optics on how widely it was used.

Mrs Tracey Logan asked for assurance that alterative tiers of referral would be available if there should be no available capacity in the immediate area of demand.

Mrs Carol Gillie advised that, for NHS Borders, a cashable saving would only be gained as a result of bed closures. Mrs Tracey Logan advised there may be cashable savings as a result of efficiencies within Scottish Borders Council (SBC).

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the attached Project Evaluation Report for the Strata project.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the continuation of the Strata Project until the end of the financial year.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that a further project evaluation will be produced for IJB in spring 2020.

9. Bi-Annual Review of Risk Register

Mr Rob McCulloch-Graham provided and overview of the most recent review of the IJB Strategic Risk Register.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD c**onsidered the IJB Strategic Risk Register to ensure it covers the key risks of the IJB.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the progress in managing one of the risks to reduce its rating from Red to Amber.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that a further risk update will be provided in December 2019.

10. Monitoring of the Integration Joint Budget 2019/20

Mr Mike Porteous gave a brief overview of the content of the report and advised that the IJB is reporting a forecast overspend of £1.464m at the end of the financial year, with £1.3m falling within services commissioned from NHS Borders.

Mrs Carol Gillie advised of an improved position in NHS Borders financial recovery. The Chair asked for financial outlook updates to be presented at the 30 October 2019 IJB meeting from NHS Borders, SBC and the IJB.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** acknowledged the forecast financial position for the Partnership of an overspend of (£1.464m) for the year to 31 March 2019/20 based on available information.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** acknowledged the underlying pressures, the actions being taken to manage these pressures, and the risks highlighted in relation to delivering a break even year end position.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** requested the H&SCP work to identify further actions which will inform the next Monitoring Report to bring the forecast spend back in line with budget by year end.

11. Inspections Update

Mr Rob McCulloch-Graham advised that the Care Inspectorate would be returning for a review of the 2017 report on the 'Joint Inspection of Adult Health and Social Care Services' and the subsequent recommendations. The inspectors are to be on site week commencing 25 November 2019 and had advised of their intended attendance at the 20 November IJB Development Session.

An update is scheduled to be presented at the October IJB meeting.

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

12. Draft Winter Plan 2019/20

Mr Gareth Clinkscale presented an overview of the draft Winter Plan for 2019/20 and advised members of the approach based on the previous year's success. Scottish Government allocated £100k and NHS Borders allocated an additional £800k, as a budget pressure, to enable the delivery of the Winter Plan. Mr Ralph Roberts advised that NHS Borders would need to consider the annual requirement of additional winter funding, due to the organisation's financial turnaround.

Mr Ralph Roberts thanked colleagues for the contribution to the draft and asked that the 2020/21 plan be truly joined as Health and Social Care, rather than more of an acute focus.

Dr Kevin Buchan raised concern over the lack of GP involvement and engagement and asked for GP colleagues to be approached regarding what value they could input into the Winter Plan. Mr Gareth Clinkscale advised Practice Managers were being contacted above GP input and suggested a GP representative on the Winter Planning Board would be a valuable contribution.

Mrs Tracey Logan raised concern over the lack of Social Care reference in the plan.

Mr Rob McCulloch-Graham advised that both of the above points would be explored and incorporated into the final plan.

The Chair asked for the 2020/21 Winter Plan to be comprehensively integrated, whilst being process and resource focused.

The final Winter Plan would be presented to the IJB on 30 October for sign off.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the draft Joint Winter Plan 2019/20.

13. Quarterly Performance Report

Mr Graeme McMurdo provided an overview of the content of the report.

Members were advised that work was underway to revise the measures relating to Carer's Support performance to ensure a true reflection of current experience is reported.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD n**oted and approved any changes made to performance reporting.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the key challenges highlighted.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** directed actions to address challenges and to mitigate risk.

14. Strategic Planning Group Report

Mr Rob McCulloch-Graham provided an overview of the issues which were raised and discussed at the Strategic Planning Group meeting held on 4 September 2019.

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

15. Any Other Business

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that there was none.

16. Date and Time of next meeting

The Chair confirmed that the next meeting of Health & Social Care Integration Joint Board would take place on Wednesday 30 October 2019 at 10am in Council Chamber, Scottish Borders Council.

The meeting concluded at 12.12pm.

Signature: ……
Chair

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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~~ November 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** 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.	~~Claire Pearce,~~ Nicky Berry, Angus McVean	~~December 2018~~ ~~April 2019~~ December 2019	**In Progress:** Item scheduled for 17 December 2018. **Update:** Item rescheduled to April 2019 meeting. **Update:** Item rescheduled to June 2019 meeting due to reconfiguration of IJB meeting dates. **Update 08.05.19:** Agreed that Clinical Governance Annual Report will be submitted to the IJB annually to provide assurance on this item. Awaiting final report from Clinical Governance Committee.	G

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~~ November 2019	**In Progress:** Item scheduled for 19 November 2018. **Update:** Session cancelled.	G

					Item rescheduled to 25 November 2019 Development session.	

Meeting held 8 May 2019

Agenda Item: Primary Care Improvement Plan (April 2019-March 2020)

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
8	7	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed that a future Development session be led by service users and primary care leads in regard to long term conditions.	Rob McCulloch-Graham, ~~Kenny Mitchell~~ Erica Reid	November 2019	**In Progress**: Item added to November Development session schedule.	G

Meeting held 19 June 2019

Agenda Item: Chief Officer's Report

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
11	5	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to remove the Chief Officer's Report as a standing item on the agenda and instead to receive a newsletter format report on a monthly basis to also include what was happening around the partnerships across Scotland.	Louise Ramage	~~August~~ October 2019	Communications colleagues across NHS Borders and SBC to support newsletter. **Update:** capacity in NHS Borders is still challenged due to priorities of turnaround. We will look to provide a newsletter every two months	A

Agenda Item: Integration Joint Board 2019/20 Financial Plan

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
13	8	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** directed the IJB Officers to continue to work with NHS Borders and SBC to develop a Joint Turnaround Programme and a Joint Financial Recovery Plan to address the financial gap and mitigate the risks relating to Health and Social Care services.	Mike Porteous	~~September~~ November 2019	Planning is underway and dates for joint planning will be discussed at the upcoming EMT. As a financial gap remains, further work and agreements are required. Update: Financial implications of the strategic plan will be discussed at the November development session. Additional Joint Finance Sessions to be arranged over the next few months to inform partners of necessary updates during the budget setting process.	G

Meeting held 25 September 2019

Agenda Item: Transformation Fund Review

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
14	6	Mr Rob McCulloch-Graham to provide an update on a delayed discharge trajectory.	Rob McCulloch-Graham	December 2019		G

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

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Winter Plan 2019/20

Authors: Gareth Clinkscale, Hospital Manager, BGH

Sam Whiting, Deputy Hospital Manager and Infection Control Manager

Katy Simpson, Project Support Manager, Unscheduled Care

Sponsors: Robert McCulloch-Graham, Chief Officer, Scottish Borders Health and Social Care Partnership

Nicky Berry, Director of Nursing, Midwifery & Acute Services

Introduction

This document forms the Scottish Borders Health and Social Care Partnership overarching Winter Plan. The overall aim of the planning process is to ensure that the partnership prepares effectively for winter pressures so as to continue to deliver high quality care, as well as national and local targets.

A winter debrief event was held on 30th April 2019. The learning from last winter has been invaluable in shaping the Winter Plan for 2019/20 as well as its early planning and execution.

The delivery of the Winter Plan in the Scottish Borders is overseen by an Integrated Winter Planning Board, co-chaired by the Chief Officer for Health and Social Care and the Director of Nursing, Midwifery & Acute Services. The Board reports to both the Health Board and the Council, with regular updates to the Integrated Joint Board.

As with the plan for the Winter 2019/20, this year's plan is very much a joint plan across the Council, NHS and the IJB. With all services directed to reduce admissions, speed up hospital processes, reduce any delay in discharge and support care in the community to prevent a re-admission to acute.

Review of 2018/19

Analysis of data from previous years, along with the application of predictors, supported the development of a whole system bed model to meet the winter demand. Trajectories along with daily and weekly monitoring processes allowed the system to make early informed decisions. This had significant impact on our system and enabled us to protect the Medical Assessment and Surgical/Gynaecology Assessment areas on the whole. On the few occasions they were used, they were recovered quickly.

The review of last winter confirmed the effectiveness in last year's winter plan. NHS Borders achieved significantly better compliance with the 4 Hour Emergency Access Standard compared with the winter of 2017/18. There was a statistically significant reduction in the number of patients with a length of stay of over 28 days this winter compared with last winter.

The step-down facilities at Garden View, and Waverley Care home coupled with the introduction of Hospital to Home services further supported patient flow and reduced delayed discharges.

Development of improved patient pathways increased whole system capacity and capability though winter which has continued all year round to meet the needs of the local population.

The 2018/19 winter plan incorporated the decision to cancel non urgent and non cancer related elective surgery for the month of January 2019, creating additional capacity for orthopaedic trauma patients. This will form part of this year's winter plan.

The BGH General Medicine winter ward model will be created again this year to ensure sufficient inpatient acute hospital capacity is in place. Process changes developed last year to protect GP assessment areas will also form part of this year's plan.

The BGH Escalation policy was reviewed and updated prior to last winter. This supported improved patient flow and safety across the site. This policy is currently under review ahead of this winter to incorporate learning from last winter.

Summary of Winter Plan for 2019/20

Clinical engagement and integrated working has been at the heart of this year's winter planning process. The 2019/20 Winter Plan aims to achieve the following objectives:

- Weekend discharges will be increased to smooth flow across the seven days
- Capacity will be increased across Health & Social Care to meet increased demand
- Patient flow will be improved throughout the system
- Care will be enhanced in the community and fewer patients will be delayed
- Services will be safer
- Staff wellbeing will improve

The delivery of safe and effective care for people requiring the health and social care will be measured through delivery of:

- Emergency Access Standard
- Local and National Waiting Times Targets
    - Treatment Time Guarantee
    - 18 Weeks Referral to Treatment
    - Stage of Treatment
    - Cancer Waiting Times
    - Stroke Standards
- Number of delayed discharges
- Bed occupancy compared to target of 85%
- Maintained boarding levels

The plan seeks to ensure capacity is allocated appropriately to meet demand. Access to alternative care settings when acute care criteria is no longer met is a key focus for this year's plan. The planned extension of intermediate care in the community and development of community Health & Social Care Multi-Disciplinary Teams are critical components of the '19/20 Winter Plan. The new BGH Frailty model and seven day Margaret Kerr Hub both planned to open in January are innovative new developments within this year's plan that should help ensure more patients receive care in the right environment.

There is an ambition to protect the elective programme and this will be balanced against expected periods of high demand, only reducing elective admissions from the end of

December 2019 until end January 2020. A full day case elective programme will run throughout the winter season.

Appendix 1 provides the high-level activities that will contribute to creating the capacity within the whole system to meet local need during winter.

Financial Plan

Committed to delivering safe effective patient flow during 2019/20 winter, the total winter allocation has been enhanced locally by £0.8m from NHS Borders with a further 0.1m from the Scottish Government. The Council, through the IJB, continues to support the resource required for Garden View and Waverley step down facilities, collectively approximately £500k over the winter period. In addition the Social Work team based within the hospital has increased capacity aimed at reducing delays.

Below are the high level details of areas of additional capacity:

Borders Emergency Care Service – increased staffing at weekends
Increase ED staffing (medical and nursing)
Staffing for surge capacity
Weekend medical cover
AHP staffing – extend
Weekend pharmacy cover
Weekend domestic and portering
Contingency plan – additional surge

The Integration Joint Board has also approved funding of £1.4m for the continuation and expansion of the following Discharge Programme services until March 2020. These services will support the delivery of the Winter Plan by preventing admissions, reducing the length of people's stay in hospital and ensuring people are cared for in the most appropriate setting:

Garden View - providing 15 step down beds
Waverley Care Home - providing 16 step down and rehabilitation beds
Hospital to Home - expanding rehabilitation and support in patient's homes to all localities.
Matching Unit - ensuring care packages are matched with patient need in a timely manner

Weekend and Earlier in the Day Discharge

In addition to enhanced resource being allocated to weekends, there is also focussed improvement support to achieve earlier in the day discharge and an increase in weekend discharge. The well-established BGH Site and Capacity Team will work beside the weekend hospital social work team for the first time this year to ensure a joined up

approach to maintained flow into the community out of hours. Trajectories for weekend discharge rates, earlier discharge and average length of stay are in place and will be monitored weekly.

Reducing Delays

Waverley will continue to provide step down rehabilitation capacity with 16 beds open through the winter period. Garden View will operate 15 beds throughout winter to reduce patients delayed in the BGH and Community Hospitals. The START team and Matching Unit will continue to facilitate care in the community and timely discharge. A Discharge Hub model will be tested in partnership between NHS Borders and the START team through winter aiming to reduce the length of stay for patients discharge out of hospital to care. A new AWI policy will be released in early January that aims to improve flow for this patient group.

Admission Avoidance

Hospital to Home service now covers the whole of the Scottish Borders and will continue to provide a prevention of admission service and support discharge from the acute hospital. The increase in Allied Healthcare Professionals across all of the Scottish Borders will enable a Discharge to Assess model that is expected to be a critical component of this year's plan.

A Pulmonary Rehabilitation Programme is in the final stages of implementation with the aim to have the programme fully implemented by January 2020.

Scottish Borders Council and NHS Borders are working to develop an anticipatory care planning pack which will include the ReSPECT document (the emergency care and treatment summary) for Care Homes.

We aim to provide all patients discharged from the Acute hospital to 24 hour care (Community Hospitals, Care Homes and some sheltered accommodation) with a completed ReSPECT form.

We also provide familiarisation training and support to undertake the ReSPECT process with current residents. Of the 24 Care Homes in the Scottish Borders, around 17 are using the forms. In some of the Care Homes, the process is GP led and in others, it is MDT led including the Care Home staff.

Primary Care

The new GP Contract introduced in 2018 and agreed by Scottish Government and the BMA has at its core the requirement for the development and implementation of a Primary Care Improvement Plan (PCIP) the aim of which is to empower GPs to function as an expert medical generalists and to enable them to focus on undifferentiated presentations, complex care, quality and leadership as well as supporting them to engage more easily in strategic and planning processes. This refocusing of the GP role will require some tasks currently

carried out by GPs to be carried out by members of a wider primary care multi-disciplinary team – where it is safe, appropriate, and improves patient care.

The development of the PCIP is being taken forward through partnership working across the GP Sub Committee, the Health & Social Care Partnership and NHS Borders. The PCIP has 6 key priority areas which over a three year period will see the development of new roles and posts which will support the GPs to refocus as described above and will help to broaden the capacity of primary care. The six priorities in the PCIP are:

- Vaccination Services;
- Pharmacotherapy Services;
- Community Treatment and Care Services;
- Urgent Care Services;
- Additional Professional Roles (First Contact Physiotherapy Services, Community Mental Health Services);
- Community Link Worker Services.

Measurement and Monitoring

A project management approach is being applied to ensure full implementation of the winter plan to ensure risks are highlighted allowing mitigation plans to be put in place. The Whole System activity datasets developed last year will be used again this year to assess any fluctuations in how the system is managing so that timely action can be taken when patient flows slow.

Progress against the overall programme will be monitored through the Winter Planning Board, chaired by the Chief Officer on a bi-weekly basis.

Resilience

Business Continuity Plans are in place and a testing schedule developed.

Norovirus & Seasonal Flu

NHS Borders now conducts on-site Norovirus testing which reduces the turnaround time for test results. This supports improved infection control decision making which reduces risk of cross transmission and reduces unnecessary bed closures. Test results are entered into the Laboratory Information System and ICNet Infection Control software.

NHS Borders Laboratories have capability to conduct on-site flu testing in small numbers to support decision making and patient flow at peak times when there is excessive demand for single rooms.

Appendix 1

High Level Winter Plan 2019/20	September					October				November				December			
	W/C 2nd	W/C 9th	W/C 16th	w/C 23rd	w/C 30th	W/C 7th	W/C 14th	W/C 21st	w/C 28th	W/C 4th	W/C 11th	w/C 18th	w/C 25th	W/C 2nd	W/C 9th	W/C 16th	W/C 23rd
Admission Avoidance																	
Creation of Frailty Model at Front Door																	
Hospital to Home Prevention of Admission Pilot in Central Borders																	
Emergency Department																	
Allocate capacity (medical and nurse staffing) to meet demand																	
Increase Rapid Assessment and Discharge to 7 day service																	
Reduce delays																	
Expand Garden View criteria to reduce delays																	
Maintain Garden View at 15 beds																	
Maintain Waverley at 16 beds																	
Release new AWI policy																	
Test Discharge Hub model																	
Enhance Hospital to Home																	
Implement Robust Discharge to Assess Service																	
Reduced Length of Stay - Acute																	
Increased medical cover at weekends and for surge capacity																	
Ensure Pharmacy and Physio access at the right time at weekends																	
Social Work access at weekends																	
Maintain "Hospital at Weekend"																	
Enhance DDD with the inclusion of criteria led discharge																	
Establish SCN Delayed Discharge meetings																	
Develop process for transfer of patients to Community Hospital at Weekends																	
Develop seven day Margaret Kerr Hub																	
Strengthen Health & Social Care locality working																	
Enhance multi-disciplinary decision-making and coordination																	
Patient Flow Management																	
Review Escalation Policy, implementing triggers																	
Develop Discharge Hub and implement STRATA																	
Review Boarding Policy																	
Better links between Site & Capacity Team with START Team at Weekend																	
Increase utilisation of Discharge Lounge																	
Safer Services																	
Protect Acute Assessment Unit																	
Protect Surgical Assessment Unit																	
Infection Control Plan																	
Severe Weather Plan																	
Staff Wellbeing																	
Wellness Wednesdays																	
Flu vaccination plan																	

Work Commenced	
Work Completed	

Appendix 2

Winter Plan 2019/20 – KPIs

Objectives	Activities	Key Performance Indicators
Increase weekend discharge	➢ 7 day RAD service ➢ Increased weekend medical cover ➢ Enhanced weekend pharmacy service ➢ Increased weekend social work access ➢ Continue Hospital @ Weekend ➢ Increase discharge to community services	% weekend discharges
Increase capacity to meet demand	➢ Winter surge ward ➢ Elective cessation plan ➢ ED twilight shifts ➢ Enhanced BECS during public holidays ➢ Increase AHP capacity	Length of stay (LOS) ED first assessment breaches Cancelled Electives
Improve patient flow	➢ Daily Dynamic Discharge re-launch in DME and BSU ➢ Unscheduled care improvement forum ➢ Escalation policy review ➢ Establish rapid assessment and transfer/discharge	4 hour EAS breaches Pre 12pm discharges Delayed Discharges (DDs)
Reduce delays	➢ Enhancing Hospital to Home service ➢ Garden View and Waverley capacity ➢ Develop locality model ➢ Community hospital capacity ➢ Weekly Delayed Discharge (DD) meeting ➢ Test Discharge Hub	Delayed Discharges (DDs) Community hospital DD Less than 28 days LOS
Safer Services	➢ Review BGH Boarding policy ➢ Protect Acute Assessment Unit (AAU) ➢ Protect Surgical Assessment Unit (SAU)	Boarders AAU bedded / functioning SAU bedded / functioning
Staff Wellbeing	➢ Winter Wellness	Reduced sickness absence

Scottish Borders Health & Social Care
Integration Joint Board

Meeting Date: 30 October 2019

Report By	Robert McCulloch-Graham, Chief Officer Health & Social Care
Contact	Michael Curran, Programme Manager
Telephone:	01835 824000 ext 5939

PHYSICAL DISABILITY STRATEGY

Purpose of Report:	To inform IJB on the outcome of the physical disability strategy consultation To outline key changes to the strategy as a result of the consultation. To present and seek approval for a delivery approach and detailed plan.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: *a) Approve the Strategy and delivery plan*

Personnel:	*There are no personnel directly impacted by this strategy*

Carers:	*This Strategy develops a focus on a number of priority areas and improvement which important for people with a physical disability and their carers.*

Equalities:	*An equality impact assessment has been carried. The proposal will directly support the elimination of both physical and social barriers in the Scottish Borders as it promotes equality of access and confirms the right of people with PD and LTC to speak for themselves on issues and plans that impact them.*

Financial:	*There is no additional financial implications any delivery costs will identified within relevant adult resources*

Legal:	*There are no legal issues identified*

Risk Implications:	*There are no major risks associated with this strategy*

Physical Disability Strategy 2019-22 implementation Plan

1. Aim

1.1. To inform IJB on the outcome of the physical disability strategy consultation

1.2. To outline key changes to the strategy as a result of the consultation.

1.3. To present and seek approval for a delivery approach and detailed plan.

2. Background

2.1. The Scottish Borders Physical Disability Strategy*, a fairer Scottish Borders for people with a physical disability or long-term condition and their carers*, outlines the way in which SBC, NHS Borders and the third sector partners aim to provide support for people with a physical disability or long-term condition to contribute, live and thrive in the Scottish Borders. It has been developed following a review of national and local strategies for people with a physical disability or long-term condition.

2.2. A consultation on the draft strategy was carried out making full use of all standard SBC and NHS Borders communication channels to deliver key messages and encourage engagement. The outcome of the consultation, amendments and proposed approach was presented and approved by the SPG on the 4th September.

3. Consultation feedback

3.1. There are identifiable themes emerging from the Physical Disability Strategy consultation summarised in appendix 1. The top two themes make up 26% of the feedback with over 99 comments. These comments, when compiled, outline a clear request from people with a Physical Disability; they wish to be fully involved and consulted with in planning and wish to keep organisations accountable for actions and undertakings.

3.2. Due to the strength of this message council officers approached Ability Borders to further engage with users and explore how they might wish to do this. A reference group was formed and co-produced the appended action plan (appendix 2).

4. Implementation approach

4.1. The underpinning approach, based on peoples' wish to be consulted and involved, is to empower the physical disability community to engage in areas of public services and communities that impact on their life, they intend to:

4.1.1. Firstly advise and support services and communities to be more physically disability aware and better placed to respond positively to people who have a physical disability.

4.1.2. Secondly, engage in relevant planning and development groups to advise planners and strategists on what would make a positive impact on people with physical disabilities.

4.1.3. Thirdly, identify those issues that will not be changed without national involvement or structural change and investment and work with appropriate agencies to seek resolution to these issues.

5. Detailed action plan

5.1. A detailed delivery plan has been produced from the content and suggestion given by the reference group (appendix 2). The plan is set out to reflect the 7 ambitions stated in the strategy.

5.2. The reference group believe that through involving the correct managers in delivering the Physical Disability Strategy and by holding organisations and managers accountable for improvements, they will be able to deliver change meaningful to people with a physical disability.

6. Implementation resources

6.1. Notwithstanding the need to develop the correct delivery and governance structure that fully involves the correct organisations and managers, the reference group believe that they require a level of support and resource to be engaged effectively. This will be best delivered through their own organisation, Ability Borders. An additional support worker will be funded to support people with a physical disability to engage effectively, the funding for which will be identified within relevant adult resources.

7. Recommendations & Next Steps

7.1. Approve the strategy based on the 7 ambitions developed in consultation with stakeholders.

7.2. Approve the delivery approach and agree to involve people with a physical disability in areas that are important to them.

7.3. Approve the delivery plan and request appropriate manager to make themselves available to be part of the delivery team.

Approved by

Name	Designation	Name	Designation
Robert McCulloch-Graham	Chief Officer for Integration	Michael Murphy	Interim Chief Officer Adult Social Care

Author(s)

Name	Designation	Name	Designation
Michael Curran	Programme Manager		

Appendix 1 - identifiable themes emerging from the Physical Disability Strategy consultation

Theme	Total	%
Consultation/Involvement/Feedback	54	14%
Accountability/Plans	45	12%
Transport	37	10%
Unpaid Carers	33	9%
General Comment	27	7%
Accessible Spaces/Meetings	20	5%
Accessible Housing	18	5%
Ability Borders	17	4%
Employment/Education	17	4%
Isolation/Socialisation/Activities	16	4%
Aids Adaptations/Equipment/Grants	15	4%
Transition	12	3%
Early Intervention/Prevention/Assessment	11	3%
Paid Carers/Direct Payments/Flexible Resources	11	3%
Proposed changes to Terminology/Language/ Queries/ Easy Read	11	3%
Welfare Advice/Empowerment/Advocacy	11	3%
Training	8	2%
Rehabilitation/Long Term Conditions	6	2%
Cradle to Grave/Age	5	1%
Partnership	4	1%

Appendix 2 Physical Disability strategy implementation plan

Ambition 1	Turning ambitions into Actions	Action/Product	Responsible for delivering
Support services are designed and delivered to support all people with a physical disability to live the life they choose, have control, make informed choices and have support to communicate this when needed at every stage of their lives	We will promote Ability Borders to be the 'go-to' group so that people with physical disabilities have a forum to comment on the choice, quality and effectiveness of services.	Develop an accessible service (Ability Borders) through multiple mediums using existing resources (develop a marketing strategy to engage with the Public)	Ability Borders
		Develop marketing approach that will reach professionals and users	Ability Borders
		Develop a partnership with relevant stakeholders to deliver a user led model of engagement to empower people with PD e.g. partner with BVCV to deliver training to become effective advocates	PD Strategic lead
		Create/Apply resources to test out Transport	Ability Borders
		Get access panels to test out services including transport	Chairs of Access Panels
		Identify resources required to support people with a physical disability to be involved	Chief officer adult services
	We will ensure that prevention and early intervention activities that aim to maintain health and wellbeing are inclusive of people with a physical disability.	Person with PD to be part of the early intervention and prevention board	PD strategic lead to negotiate place on Board
		Health promotions Board assess if they have a broad section of disabilities represented	Early intervention and prevention Board
		People with PD Test out a series of early intervention and prevention activity programmes	Access Panels
		Ensure customer services direct /aware of Ability Border and childrens' equivalent	PD strategic lead

Ambition 2	Turning ambitions into Actions	Action	Who Responsible for delivering this
People with a physical disability are able to participate fully in education and paid employment, enabling their talent and abilities to enrich the Borders. People with a physical disability are supported through transitions in their lives e.g. from school to work.	As public bodies, we will ensure that we are monitoring and reporting on our compliance with the Equality Act duties to raise awareness and promote the rights of people with a physical disability.	Equality impact assessment are carried out in partnership with people with a disability	Key strategic managers
		Engage with all strategic managers and communicate the opportunity to use Ability Borders and Access panels as a partners in carrying out equality impact assessments	Ability Borders & Access panels Chairs
	We will actively engage with major employers and institutions in the Scottish Borders and explore what proactive steps they can take to improve employment for people with physical disabilities.	In partnership with the chambers of commerce develop an approach to Promote the disability aware employer approach	Chamber of commerce
		College to describe good practice and getting ready for work and monitor the take up of courses by people with PD	Borders College
		Transitions – adopt the LD Transitions pack for PD as a resource for children with PD coming through the system	Education lead
		Ways to work service to review if they have the correct skills, knowledge and specialists to provide help with CV's, interview skills, emotional and physical support to gain employment.	Ways to work service
		Use commissioning powers to employ people with PD	Procurement & Contract team
		Consider and explore expanding project search for people with PD	PD strategic Lead
		Review people and workforce plans to ensure that people with PD are offered the every opportunity to work	Workforce plan leads

Ambition 3	Turning ambitions into Actions	Action	Who Responsible for delivering this
People with a physical disability can live life to the full in their homes and communities with housing designed and adapted to meet their needs	Engage with Registered Social Landlords and ensure that the needs of people with Physical Disability are fully considered.	Scope the volume of housing being built within the borders that would constitute accessible housing for people with PD	Housing strategic lead
		Review if the volume and technical specifications actually constitute accessible in real terms for people with PD	Housing strategic lead
		Review and amend SHIP with findings of Scoping and review process	Housing strategic lead
		Develop mechanism for planning housing for current people coming through	PD strategic lead
		Ensures that Technical and practical conversation for aids and adaptations help people with PD purchase equipment that works	SBCares

Ambition 4	Turning ambitions into Actions	Action	Who Responsible for delivering this
People with a physical disability can live life to the full in their communities with transport designed and adapted to enable people with a physical disability to participate as full and equal citizens.	Review barriers to transport for people with disabilities and with advice from key community planning partners, develop suitable actions to address these concerns.	Develop/identify a national presence/ conduit to feedback on transport issue that require a National response/action	Passenger transport Manager
		Develop/identify a presence for people with PD in local transport groups	Ability Border & Strategic Lead for transport
		Within Planning ensure that the needs of people with PD are considered from first principles at the Start of the process	Roads and infrastructure Strategic Lead
		Test Door to Door Transport systems in line with the three approaches set out in the three year plan	Ability Borders
		Ensure that accessible transport is advertised and known about to people with PD Knowledge about what's out there – access to and criteria	Third Sector interface leads
		Ensure that Changing places are considered in all new buildings & key interchanges in communities are considered for capital investment	Roads and infrastructure Strategic Lead

Ambition 5	Turning ambitions into Actions	Action	Who Responsible for delivering this
People with a physical disability are confident that their rights will be protected and they will receive fair treatment at all times.	Actively promote the rights of people with physical disabilities	Ensure effective Training for staff who will be engaged with people with PD to ensure that all people can engage, respect and understanding Disability	PD strategic lead in partnership with training department
		Re issue the *How to Chair* guide to ensure all people have an opportunity to engage effectively in meetings	BVCV
		Increase the volume of people with PD involved in the planning, designing of services	SBC & NHS planning sections
	Take steps to tackle discrimination and reduce stigma associated with physical disability and promote physical disability awareness among service providers.	Seek opportunities to publicise positive contributions by people with PD (defined by contribution not condition)	PD strategic lead/ability borders in partnership with NHS & SBC communication team
		Ability Borders support people to understand their rights	Ability Borders in partnership with CAB
		Dispel & Challenge assumptions whenever they are identified	PD Strategic Group
		Insist on a written statement of what organisations will do if they are 'called out' on an issue impacting people with A PD	PD strategic Group
	Public bodies will carry out Equality Impact Assessments on policies and service plans to ensure that universal and targeted services are accessible to people with a physical disability.	Opportunities for children are considered to ensure that full integration of people with PD is designed in form an early age	Education strategic lead
		Equality impact assessment carried out under the guidance of person with PD	SBC and NHS equalities officer

Ambition 6	Turning ambitions into Actions	Action	Who Responsible for delivering this
People with a physical disability participate as active citizens in all aspects of daily and public life in Scotland. Physical disabilities are involved in shaping their lives and the decisions that impact upon them.	Each decision-making process should have a person with a physical disability or representative as part of the process.	Identify all planning groups that people with PD would like to be involved in and request a presence	PD Strategic lead
		Develop information and support for people with PD to get involved	Ability Borders In partnership with BVCV
		Support personal development for people with PD to feel empowered and skilled and knowledgeable about getting involved	Ability Borders In partnership with BVCV
		Ability borders continue developing a Network of support for people to communicate and support each other	Ability Borders
		Audit current activity that will fit with engagement and empowerment – mapping exercise	PD strategic in partnership with equalities officers
		Establish a Project Board to manage the 3 year project and structure that fits	PD strategic lead
	Assess if the wider physical and cultural environment designed and adapted to enable people with a physical disability to participate as full and equal citizens.	Services meaningful to People with Physical Disabilities are identified and encouraged to carry out 360 degree service review	PD strategic group
		Access Panel are supported to carry out tests on physical environment and services identified by people with PD	Access Panels
		Review current function of access panels – analyse where is it working well and replicate this in all areas of the Borders	Access panel Chairs
		Engage with Scottish Disability Equality Forum	Ability Borders
		Request Training for building control and planners to encourage technical to practical conversion around PD	Training department
		Audit Training provided for access panels to carry out their work effectively	Ability Borders & Access panel chairs
		Identify and collate structural issues that create Barriers for people with a Physical disability discussion to develop a Capital Fund to address structural changes identified in year one and two of the plan.	Ability Borders
		Engage with relevant managers to seek resolution to structural issue collated by Ability Borders	PD Strategic lead

Ambition 7	Turning ambitions into Actions	Action	Who Responsible for delivering this and when
Unpaid carers of people with physical disabilities and long term conditions are acknowledged and supported to recognise their rights as a carer.	We will review physical disability services to ensure that carers are actively identified.	Contingency plans if carer is no longer able to care (especially those not linked to Social Work)	Carers Centre
		Helping others to understand they are classed as a carer	Carers Centre
		Support continued referrals to carers centre	PD Strategic group
	We will involve and consult with carers in relation to strategic developments in physical disability services.	Borders Carers centre scope strategies that should have a carer's component and identify if it's missing?	Carers centre
		Carers centre to be fully engaged in PD strategic group	PD Strategic lead

Scottish Borders **Health & Social Care** Partnership

Scottish Borders
Health and Social Care
PARTNERSHIP

physical disability strategy

a fairer Scottish Borders for people with a physical disability or long-term condition and their carers

NOVEMBER 2019

CONTENTS

SCOTTISH BORDERS
PHYSICAL DISABILITY STRATEGY

FOREWORD

This strategy outlines the way in which the Integrated Joint Board (IJB), Scottish Borders Council (SBC), NHS Borders and the third sector aim to provide support for people with a physical disability or long-term condition to contribute, live and thrive in the Scottish Borders. It has been developed following a review of national and local strategies for people with a physical disability or long-term condition, and their carers.

Our aim is to work in partnership to provide a positive environment that supports not just people's health and wellbeing, but allows them to participate in and contribute to the communities they live in. We are committed to ensuring that all our services and supports are accessible for people with a physical disability and offer choice, increase confidence and independence, widen opportunities, and respect their rights.

The purpose of this document is to outline the ambitions we have for people living with a physical disability or long-term condition in the Borders.

It draws inspiration from the five ambitions set out by the Scottish Government's document, 'A Fairer Scotland for Disabled People', and focuses on a number of areas to improve services and opportunities. We have included an additional two ambitions to reflect the critical role carers play and the importance of suitable housing. Both ambitions were identified in the engagement and consultation stages of the strategy's development.

The high-level actions come from local knowledge about how to move forward with these ambitions. They also reflect the feedback from the review process and from conversations with stakeholders, including people with a physical disability or long-term condition and their carers.

We believe that direct involvement with people with a physical disability or long-term condition will ensure that services meet people's needs.

The opportunities to participate in the social, cultural and economic life of the Borders will ensure that people will achieve positive outcomes for themselves and the communities they live in.

Throughout the document, the term "people with a physical disability" will also relate to people with a broad range of disabilities and long-term conditions.

Rob McCulloch-Graham
Chief Officer Health and Social Care

INTRODUCTION

This document outlines the way in which services will be developed for people with a physical disability and their carers who are living in the Scottish Borders, now and in the future. While the principles it contains are not age specific, it does not include services for children and young people (0-16 years), which are covered in other strategies.

It outlines our seven ambitions, and considers a number of priority areas and improvements identified by focus groups and feedback from representative groups involved in the evaluation of our previous strategy. The actions are intended to improve opportunities and are important to people with a physical disability and their carers.

This strategy sits in the context of the Integrated Joint Board's strategic plan (Health & Social Care Strategic Plan 2018-21) which has a commitment to develop opportunities for people with a physical disability to fully engage in their local community, to have choice and control over how they are supported to live independently.

OUR SEVEN AMBITIONS:

Ambition 1

Support services in the Scottish Borders are designed and delivered to support all people with a physical disability to live the life they choose, to have control, to make informed choices and to have support to communicate this when needed at every stage of their lives.

Ambition 2

People with a physical disability are able to participate fully in education and paid employment, enabling their talent and abilities to enrich the Scottish Borders. People with a physical disability are supported through transitions in their lives e.g. from school to work.

Ambition 3

People with a physical disability can live life to the full in their homes and communities with housing designed and adapted to meet their needs.

Ambition 4

People with a physical disability can live life to the full in their communities with transport designed and adapted to enable people with a physical disability to participate as full and equal citizens.

Ambition 5

People with a physical disability are confident that their rights will be protected and they will receive fair treatment at all times.

Ambition 6

People with a physical disability participate as active citizens in all aspects of daily and public life in Scotland. People with a physical disability are involved in shaping their lives and the decisions that impact upon them.

Ambition 7

Informal carers of people with physical disabilities and long term conditions are acknowledged and supported to recognise their rights as a carer.

These ambitions sit alongside, and should be considered with other strategic documents that explain plans to develop and improve a range of services across SBC, NHS Borders and the Third Sector.

BACKGROUND

The definition of 'disability' under the Equality Act 2010 is:

"having a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on your ability to do normal daily activities".

Public bodies have duties under this legislation to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited under this Act
- advance equality of opportunity between persons who share a relevant characteristic (e.g. physical disability) and persons who do not
- foster good relations between people who share a protected characteristic (e.g. physical disability) and those who do not.

This document relates to people who have one or more physical impairments, which may be present from birth, acquired at any age, be temporary or longer term, stable or fluctuating.

Not all physical disabilities are visible or registered.

A physical disability is unique for each individual in the way it affects their life. It is not unusual for people to be affected by more than one health condition or physical disability, or for someone with a physical disability to experience mental health problems.

Services therefore need to be person-centred, with a clear understanding of an individual's rights to independence, self-determination, dignity and respect.

Services need to take a holistic approach considering not only the individual, but also the needs of informal carers and their family.

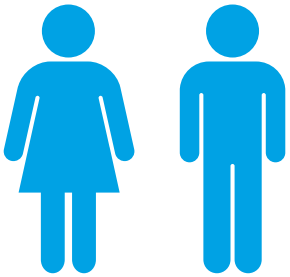

Borders Independent Advocacy Service
BIAS
Self Dire
Support S
A free and confident
open to anyone in th

LOCAL PROFILE OF PEOPLE WITH A PHYSICAL DISABILITY OR LONG-TERM CONDITION

The 2011 census revealed that the current population in the Scottish Borders is **113,870**.

POPULATION 2011

113,870
Total population of the Borders



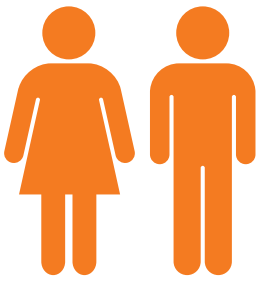
58,563 **55,307**

34,000 approx
People with one or more long term conditions (30%)

PROJECTED INCREASE IN POPULATION IS SMALL

113,870
2011

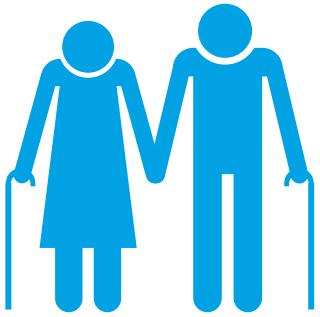
114,881
2032



OLDER POPULATION TO INCREASE SIGNIFICANTLY BY 2032

32%
increase
Age 65-74

75%
increase
Age 75+



LONG TERM CONDITIONS

60%
of people aged 65+ will have developed a long term condition.
(3 in 5 people)

75%
of people aged 75+ will have two or more long term conditions.
(3 in 4 people)

People with multiple and complex physical disabilities are living longer. Projections indicate significant increases in incidents of diabetes, cancer, arthritis, sensory loss, dementia and obesity by 2032. These conditions affect the health and wellbeing of people, and their life chances, in different ways.

There are characteristics and circumstances which can further affect the health and wellbeing of those with a physical disability. These include age, gender, sexual orientation, being a parent or a carer, a migrant, having a problem with alcohol, or living in an area of higher deprivation. Each individual therefore needs to be viewed in a holistic way.

People with a physical disability are more likely to be living in poverty and living in the social rented sector than those who do not have a physical disability. Fewer people with a physical disability are in employment and education, compared to those who do not have a physical disability.

SOCIAL WORK SPEND

Social Work spend **over 1 million pounds** on Homecare for people with a Physical Disability

£1,028,038
total spend

52,778
homecare hours per annum

LIVING WITH A PHYSICAL DISABILITY

According to the 2011 census

6,995
people in the Borders live with a physical disability

16%
of respondents to Scottish Borders household survey identified themselves as having some type of physical disability

OUR COMMITMENT

The Integrated Joint Board, Scottish Borders Council and NHS Borders are committed to working in partnership with the third sector to meet the seven ambitions and support the health, wellbeing and inclusion of people with a physical disability and their carers.

By enabling and supporting people with a physical disability to be active in all aspects of life in the Borders, including decision making and co-production of services, we will make the Scottish Borders a fairer place to live.

Through our Community Planning Partnership, we are committed to reducing inequalities that can affect the health and social outcomes for people with a physical disability. This includes working on access to opportunities for work or learning, a reasonable income, and participation in wider social and cultural activities. It is consistent with national and local strategic outcomes for more accessible services and communities.

We are committed to developing and improving services based on the priority areas identified by people with a physical disability and their carers.

The sections below outline how we plan to turn these ambitions into a reality by articulating what we want and describing how we will do it. The actions reflect the priorities identified by people with a physical disability during the evaluation of the previous strategy. There is also a description of what success looks like. The Joint Physical Disability Strategy group will oversee the development and delivery of this plan and send annual updates to the Integrated Joint Board on its progress.

Ambition 1

Support services in the Scottish Borders are designed and delivered to support all people with a physical disability to live the life they choose, to have control, to make informed choices and to have support to communicate this when needed at every stage of their lives.

In the Borders, we want:

- Support and resources for healthy living to be accessible and appropriate for people with a physical disability, including smoking cessation support, resources for mental health and wellbeing, healthy eating, community health and wellbeing programmes
- People with a physical disability and people with a long term condition to have access to the right information support at the point of diagnosis
- People with a physical disability to be able to participate as active citizens in all aspects of daily and public life
- Support for independent living for people of all ages with a physical disability, and increased say over how that support will be managed and provided
- The provision of high quality health and social care services, with all organisations working together to remove the barriers faced by people of all ages with a physical disability
- Design and delivery of services will require input and sign off by representatives for those with physical disabilities.

Turning ambitions into action:

- We will promote Ability Borders to be the 'go-to' group so that people with physical disabilities have a forum to comment on the choice, quality and effectiveness of services.
- We will ensure that prevention and early intervention activities that aim to maintain health and wellbeing are inclusive of people with a physical disability.

What will success look like:

- We will know when we are successful when organisations routinely request input and commentary and can be measured by an increase of people contacting Ability Borders.

Ambition 2

People with a physical disability are able to participate fully in education and paid employment, enabling their talent and abilities to enrich the Scottish Borders. People with a physical disability are supported through transitions in their lives e.g. from school to work.

In the Borders, we want:

- People with a physical disability to be visible and participating within communities, learning, education, volunteering and employment
- Equal opportunities for people with a physical disability in education and employment
- Greater understanding and a positive attitude amongst employers and educators to people with a physical disability
- Improved awareness and understanding of discrimination, prejudice and barriers faced by people with a physical disability including the physical environment, stigma and negative attitudes.

Turning ambitions into action:

- As public bodies, we will ensure that we are monitoring and reporting on our compliance with the Equality Act duties to raise awareness and promote the rights of people with a physical disability.
- We will actively engage with major employers and institutions in the Scottish Borders and explore what proactive steps they can take to improve employment for people with physical disabilities.

What will success look like:

- We will know when we are successful when employment, volunteering and education rates for people with physical disabilities increase.

Ambition 3

People with a physical disability can live life to the full in their homes and communities with housing designed and adapted to meet their needs.

In the Borders, we want:

- Greater and more meaningful involvement by people with a physical disability in designing policies and services.
- People with a physical disability to benefit from increased availability of affordable and accessible housing to support them to continue to live independent lives.
- Increased awareness of the additional barriers that living in rural or remote areas can bring for people with a physical disability.

Turning ambitions into action:

- Engage with Registered Social Landlords and ensure that the needs of people with Physical Disability are fully considered.

What will success look like:

- We will know when we are successful when more houses for people with Particular Needs are available for people with a physical disability.
- The supply of housing meets the needs of our communities.

Ambition 4

People with a physical disability can live life to the full in their communities with transport designed and adapted to enable people with a physical disability to participate as full and equal citizens.

In the Borders, we want:

- Greater and more meaningful involvement by people with a physical disability in designing policies and services.
- Increased availability of accessible and inclusive transport and services.
- Increased awareness of the additional barriers that living in rural or remote areas can bring for people with a physical disability.

Turning ambitions into action:

- Review barriers to transport for people with disabilities and with advice from key community planning partners, develop suitable actions to address these concerns.

What will success look like:

- We will know when we are successful when transport as a reported barrier to participation reduces.

Ambition 5

People with a physical disability are confident that their rights will be protected and they will receive fair treatment at all times.

In the Borders, we want:

- People with a physical disability to be treated as equal citizens within all elements of society, with full access to the physical environment, advocacy and support, information and advice.

Turning ambitions into action:

- Actively promote the rights of people with physical disabilities
- Take steps to tackle discrimination and reduce stigma associated with physical disability and promote physical disability awareness among service providers.
- Public bodies will carry out Equality Impact Assessments on policies and service plans to ensure that universal and targeted services are accessible to people with a physical disability.

What will success look like:

- We will know we are successful when people with disabilities report positive outcomes in all areas of life.

Ambition 6

People with a physical disability participate as active citizens in all aspects of daily and public life in Scotland. People with a physical disability are involved in shaping their lives and the decisions that impact upon them.

In the Borders, we want:

- People with a physical disability to be empowered through peer support and learning and development opportunities to participate fully as active citizens.
- Increased understanding of the needs of people with a physical disability.
- Communication to be accessible to, and inclusive of, all.
- The barriers facing people with a physical disability to be known, understood and addressed.
- People with a physical disability have access to the networks that support them to make connections, build resilience and cope with challenges.

Turning ambitions into action:

- Each decision-making process should have a person with a physical disability or representative as part of the process.
- Assess if the wider physical and cultural environment is designed and adapted to enable people with a physical disability to participate as full and equal citizens.

What will success look like:

- We will know we are successful when all major strategic developments have been considered and commented on by a person with a physical disability.

Ambition 7

Informal carers of people with physical disabilities and long term conditions are acknowledged and supported to recognise their rights as a carer.

In the Borders, we want:

- To support carers' health and wellbeing and help make caring more sustainable
- Carers to have access to assessment and support in their own right.

Turning ambitions into action:

- We will review physical disability services to ensure that carers are actively identified.
- We will involve and consult with carers in relation to strategic developments in physical disability services.

What will success look like:

- We will know we are successful when there is an increase in the number of carers, caring for someone with a physical disability or long term condition receiving, a carers support plan.

SUMMARY

This document outlines the way in which NHS Borders, Scottish Borders Council, the Integrated Joint Board and the Third Sector will improve and develop opportunities for people with a physical disability.

Our approach is based on national ambitions and our actions reflect the feedback and priorities discussed by people with a physical disability and their carers living in the Scottish Borders.

An implementation plan for this strategy is being developed. This will be monitored and reviewed by the Joint Physical Disability Working Group, who will report progress to the Integrated Joint Board which is accountable for the planning and commissioning of services for people with a physical disability in the Scottish Borders.

This strategy is one of a number of documents that outline plans to develop and improve a broad range of services across SBC, NHS Borders and the Third Sector and should be read in conjunction with those mentioned as well as those having an impact on people with a physical disability.

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Scottish Borders COUNCIL

NHS Borders

Scottish Borders Health and Social Care PARTNERSHIP

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Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 30 October 2019

Report By	Robert McCulloch-Graham, Chief Officer Health & Social Care
Contact	Louise Ramage, Business Lead for Health & Social Care
Telephone:	01896 828290 / 01835 826685

HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD BUSINESS CYCLE 2020

Purpose of Report:	To provide the Health & Social Care Integration Joint Board with a focused and structured approach to the business that will be required to be conducted over the coming year.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) ***Approve*** the proposed meeting dates and business cycle for 2020.

Personnel:	Resource/staffing implications will be addressed in the management of any actions/decisions resulting from the business presented to the Health & Social Care Integration Joint Board.

Carers:	Any carers implications will be addressed in the management of any actions/decisions resulting from the business presented to the Health & Social Care Integration Joint Board.

Equalities:	Compliant.

Financial:	Resource/staffing implications will be addressed in the management of any actions/decisions resulting from the business presented to the Health & Social Care Integration Joint Board.

Legal:	Policy/strategy implications will be addressed in the management of any actions/decisions resulting from the business presented to the Health & Social Care Integration Joint Board.

Risk Implications:	Risk assessment will be addressed in the management of any actions/decisions resulting from the business presented to the Health & Social Care Integration Joint Board.

Background

1.1 To deliver against targets and objectives, the Health & Social Care Integration Joint Board must be kept aware of progress on a regular basis.

1.2 Health & Social Care Integration Joint Board meeting agendas will be mainly focused on strategic, clinical and care governance and financial issues in order to facilitate strong debate of items.

1.3 Standing items will be submitted to the Health & Social Care Integration Joint Board in full format with verbal by exception reporting at the meeting.

1.4 Attached is the proposed Business Cycle for 2020 for the Health & Social Care Integration Joint Board and Development sessions. The business cycle will remain a live document and subject to amendment to accommodate any appropriate changes to timelines, legislative requirements, etc.

Summary

2.1 It is proposed that the Health & Social Care Integration Joint Board meet on no less than 9 occasions throughout 2020 with 2 Development sessions scheduled.

2.2 It is proposed the Audit Committee of the Integration Joint Board meet on no less than 4 occasions throughout 2020 in March, June, September and December, a change from 2019 to better align with the audit reporting cycle.

2.3 It is proposed that all meetings of the Health & Social Care Integration Joint Board are scheduled for 10am to 12pm.

2.4 It is proposed that all meetings of the Audit Committee of the Integration Joint Board are scheduled for 2pm to 4pm, quarterly throughout the year.

2.5 It is proposed that there are no meetings held in July.

2.6 Both the Scottish Borders Council and the Borders Health Board schedules of meetings have been taken into account in order to maximise attendance.

2.7 All Health & Social Care Integration Joint Board meetings, development sessions and Audit Committee meetings will take place at Scottish Borders Council.

Date/Event	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
IJB Meeting	22	19	18		20	24		19	23		18	16
IJB Development Session				22						21		
IJB Audit Committee			9			15			14			7

HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD BUSINESS PLAN 2020/21 (H&SC IJB)

Appendix-2019-51

Item	Recurrence	Owner	IJB 22.01.2020	IJB 19.02.2020	IJB Audit Committee 09.03.2020	IJB 18.03.2020	IJB Development Session 22.04.2020	IJB 20.05.2020	IJB Audit Committee 15.06.2020	IJB 24.06.2020	IJB 19.08.2020	IJB Audit Committee 14.09.2020	IJB 23.09.2020	IJB Development Session 21.10.2020	IJB 18.11.2020	IJB Audit Committee 07.12.2020	IJB 16.12.2020	IJB January 2021
Minutes	Each Meeting	Business Lead	Approve	Approve	Approve	Approve		Approve	Approve	Approve	Approve	Approve	Approve		Approve	Approve	Approve	Approve
Action Tracker	Each Meeting	Business Lead	Approve	Approve	Approve	Approve		Approve	Approve	Approve	Approve	Approve	Approve		Approve	Approve	Approve	Approve
Internal Audit Update Report	Each Meeting	Chief Internal Auditor			Note				Note			Note				Note		
Monitoring of the Health & Social Care Partnership Budget	Each Meeting	Chief Financial Officer	Note	Note		Note		Note		Note	Note		Note		Note		Note	Note
Performance Report	Quarterly	Graeme McMurdo		Quarterly - Note				Quarterly - Note			Quarterly - Note				Quarterly - Note			
Integration Care Fund Update (ICF)	Each Meeting	Chief Financial Officer	Note Update			Note Update		Note Update		Note Update	Note Update		Note		Note		Note	Note
Inspections Update	Each Meeting	Chief Social Work Officer																
SPG Report for IJB	Quarterly	Chief Officer	Note					Note					Note				Note	
2020/21 IJB Financial Plan Budget - Delegated Functions (late Feb each year)	yearly - late Feb	Chief Financial Officer		Draft 2019/20		Approve 2019/20 Budget		Approve 2019/20		David Robertson and Carol Gillie to attend							Draft Budget 2020/21	
Issue Directions (March each year as soon as Financial Plan is agreed)	yearly - March	Chief Financial Officer				Approve Directions 19/20		Approve Directions 2019/20										
Financial Planning	/	Chief Financial Officer																ppt
Scheme of Integration	/	Board Secretary																
Register of Interests	yearly	Board Secretary																
Festive Period Report (Review of winter plan)	yearly	Chief Officer, Hospital Manager						Final										
Winter Plan	yearly	Chief Officer, Hospital Manager									DRAFT to note		Final Approval					
Code of Corporate Governance Refresh	yearly	Board Secretary							review Local Code of Corporate Gov		Approve							
Clinical & Care Governance Annual Report		Chief Officer, Director of Nursing, Medical Director								Clinical Governance Annual Report					Note			
H&SC IJB Annual Performance Report								Review Draft		Approve								
Chief Social Work Officer Annual Report	yearly	Chief Social Work Officer													Note			
IJB Annual Accounts	yearly	Chief Financial Officer							unaudited		Approve	audited	Approve					
Board Committee Memberships	yearly	Board Secretary													Approve			
Board Meeting Dates & Business Cycle	yearly	Business Lead													Approve			
Alcohol and Drug Partnership Annual Report	yearly	Director of Public Health													Note			
Health & Social Care Strategic Commissioning & Implementation Plan Review (2018-2021)	3 yearly	Chief Officer											Formal Approval		Note Update		Note Update	
Health & Social Care Delivery Plan Update - Regional	/	Chief Officer																
Internal Audit Annual Plan	yearly	Chief Internal Auditor															Receive Internal Audit Report & Improvement Plan	
External Audit Annual Plan	yearly	External Auditor																
External Audit Annual Audit Report	yearly	External Auditor											Approve					
IJB Self Evaluation	yearly	Chief Internal Auditor			undertake self-assessment				approve self-assessment		approve Audit Committee self assessment				undertake IJB self-assessment		approve IJB self-assessment	
H&SC IJB Model Publication Scheme	yearly	Chief Officer																
Review of Risk Register	Bi-Annual IJB; Annual Audit Committee	Chief Officer																
Annual Review of IJB Terms of Reference	2 yearly (next 2021)	Board Secretary, Business Lead																
Guardianship		Adult Social Work Officer																
Elderly Geriatric Medicine from Acute to Community	/	Chief Officer																
Public Sector Equality Duty	Progress Report every 2 years. Full Refresh every 4 years	Simone Doyle and Jane Robertson						4 year refresh report due 2020										
Shared Lives		General Manager MH & LD																
Charging Policy		Chief Officer																
Strata Evaluation		Chief Officer				Business Case												
Financial Outlook Update	Quarterly	Directors of Finance																
Crumhaugh House		Chief Officer																
Locality Working Groups		Chief Officer																
Eildon Medical Practice		Chief Officer																
Look Forward/Look Back		Chief Officer																
Public Protection Service		Chief Social Work Officer																
MSG Review of Progress with Integration of Health & Social Care		Chief Officer																
PCIP - Primary Care Improvement Plan (April 2019-March 2020)	**Yearly**	Chief Officer												LTC service users lead				
Transforming Specialist Hospital Dementia Care		Chief Officer																
Outcomes from April Development Session		Chief Officer																
Ministerial Strategic Group for Health & Community Care - Integration Review		Chief Officer														assess progress IJB Action Plan		
Physical Disability Strategy		Michael Curran													Approve			
Long Term Conditions Update (COPD) (mins 080519 refer)		Chief Officer																
Accounts Commission Report November 2018: Health and Social Care Integration Update on Progress		Chief Internal Auditor													Note			

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Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 30 October 2019

Report By	Kevin Buchan**,** Chair GP Sub Committee and GP Executive Sandra Pratt, Assoc. Director, Strategic Change, NHS Borders (Executive Lead for PCIP)
Contact	Sandra Pratt, Assoc. Director, Strategic Change, NHS Borders (Executive Lead for PCIP)
Telephone:	01896 825584

PRIMARY CARE IMPROVEMENT PLAN UPDATE

Purpose of Report:	To inform the Integrated Joint Board of the progress to date, current status and designated priorities of the local Primary Care Improvement Plan (PCIP) linked to the GMS Contract introduced in 2018 and to share the Implementation Tracker and updated PCIP document required by Scottish Government.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Note and support** the information and progress to date of the Primary Care Improvement Plan as outlined above and contained within the revised PCIP document. b) **Support** the submission of the revised PCIP document to Scottish Government.

Personnel:	New posts within the programme – identified within Workforce Plan

Carers:	n/a

Equalities:	HIIA to be undertaken

Financial:	Financial tables within document

Legal:	PCIP is a core element of the new GMS Contract 2018 agreed with Scottish Govt and BMA

Risk Implications:	Lack of accommodation for new posts Inadequate access to IT systems at every location Recruitment challenges Wider engagement of GPs

1. BACKGROUND

While some progress was made initially across the PCIP workstreams, at the end of 2018/ 19 it was acknowledged that this had not been at the pace we would have wished. Scottish Government had also indicated that this was also their view. To address this issue and in liaison with the GP Sub Committee it was agreed to re-invigorate the process.

A GP Executive was therefore established in April 2019 with membership from GP Sub Committee, NHS Borders and the Health & Social Care Partnership with the remit to oversee and steer the development and implementation of the Primary Care Improvement Plan (PCIP).

2. ASSESSMENT

Alongside the introduction of the GP Executive, NHS Borders identified an Executive Lead external to Primary & Community Services (P&CS) to help drive forward progress; this post began in June 2019. A Project Manager for the programme was subsequently appointed and started at the end of August.

Governance and planning

Since its inception, the GP Executive has introduced a number of steps to ensure more robust planning, reporting and governance arrangements:

- The GP Executive receives standardised highlight reports from each of the workstreams each month. Scrutiny of progress in each workstream takes place in line with the overarching programme plan. Any proposed changes to the workplans and workforce plans must be agreed by the GP Executive.
- The GP Executive includes a designated Business Partner who has comprehensively reviewed the budget and commitments to date and has presented a confirmed financial outlook; this has been formally agreed by the GP Executive and allows robust forward planning. Finance reports are taken at each meeting where all proposed financial commitments must be approved.
- A delivery map has been developed; this is a dynamic working document which plots where the new posts are being sited and services are being delivered across practices as an aid to ensuring equitable provision across Borders.
- A Communications Plan is in development and will incorporate processes to raise the profile and awareness of the PCIP locally.
- The GP Executive has previously reported at the Primary Care Strategy Group, however this Group is under review and may not continue in its current format. The GP Executive will continue to provide regular update reports to GP Sub Committee and IJB as well as to BET / NHS Borders Board as appropriate.

Submissions to Scottish Government

Regular Scottish Government returns are required via an implementation tracker. Dates and parameters around the reporting timetable have been changed over the course of

recent weeks, however it was agreed locally to submit an interim tracker on 30th September as previously required in order to provide some reassurance to Scottish Government that pace and progress has improved over recent months. Following this submission Scottish Government have confirmed the release of Scottish Borders' funding allocation, which they had previously held in reserve until they could be assured of progress and that more robust plans had been put in place.

The revised formal submission date to Scottish Government of the Implementation Tracker and an updated PCIP document has been set at no later than 30th October. The tracker has been updated since the interim September submission and a revised draft of the PCIP document has been produced. Both the October Implementation Tracker and revised PCIP document are attached separately.

Scottish Government representatives from the Primary Care Division are planning to visit Borders on 12th December to discuss our PCIP. No programme for or details of the visit have yet been received.

Update on Workstreams

The revised PCIP document and Implementation Tracker describes the detail about the workstreams established and the associated new posts approved and planned in line with the Memorandum of Understanding for the 2018 GMS Contract. Some key points are:

- Vaccination Transformation Programme (VTP): the process for delivery of school age vaccinations and vaccinations for pregnant women has been agreed and is in place. Work is still underway to address a model for travel vaccinations and out of hours is still to progress. A lot of work had been done previously on a potential model for <5 yrs and <5 yrs flu and adult vaccinations and adult flu vaccinations. However, following assessment of this by GP Executive a new proposal has been put forward and is currently under consideration by Scottish Government. Initial feedback has been cautiously optimistic but with support for the proposed model to be worked up in more detail. This is now in hand.

- Urgent Care: Advanced Nurse Practitioners (ANPs) are the first phase of this; recruitment is underway with approval for 10 posts by December 2019 (4 posts appointed to date) and a further 5 by end of the financial year.

- Pharmacotherapy: the furthest ahead in terms of progress against agreed outcomes and recruitment to posts. There have been some problems with recruitment of Technicians but a training programme has been developed and skill mix arrangements are supporting the programme to move on.

- Additional Roles:

    - First Contact Physios: Approval to recruit 8 by Dec 2019; 3.4wte (5 staff) recruited to date. There have been some issues with the availability of accommodation for FCPs in health centres. The service will be evaluated

after recruitment to this level before approval for further appointments and roll out.

- Mental Health workers – a delivery model has been developed and is being trialled and evaluated in one First Implementer site (O'Connell Street GP practice) Recruitment is underway to further Band 6 CPN posts.

- Community Link Workers: recruitment is underway. All practices have access to this service currently, however referral pathways will be firmed up and more flexible access will be developed as the additional staff are appointed.

- Community Treatment & Care Services: The development of a service model for NHS Borders treatment rooms (informed by the Clinical Productivity programme) will be established and evaluated in the first phase, with plans to be developed for the next phase of roll out across GP practice treatment rooms. It is envisaged that VTP services will eventually be delivered through the Community Treatment & Care services and that there will be an interface with the development of ANP roles.

N.B. The GP Executive have agreed that all new posts will be funded at 52 weeks to ensure full year service provision.

A proposal by NHS 24 around a Triage and redirection service was shared with the GP Executive. If this is agreed for implementation locally, then the GP Executive's view is that it would be developed alongside the PCIP and would be an enabler for the wider MDT development.

Issue / Challenges

- Accommodation. Space within local health centres is at a premium and the introduction of additional posts through PCIP will impact further. Discussions are underway with colleagues in capital planning and the P&CS Primary Care Premises Group to address the issues.

- IT / Data Collection. Similarly, new posts and new services will place additional demand on IT systems and information sharing processes. The Head of IM&T has proposed the development of a designated primary care team within the IT service to provide a more consistent and co-ordinated approach and will work with GP Executive to support progress.

- Recruitment. While there may be approval and funding for the new posts described, there may not be the personnel available in the wider recruitment market. This may cause delays in the establishment of new services and / or delays in accessing services equitably across the area.

- GP Involvement in delivery. Involvement in the development and delivery of the PCIP to date has fallen mainly to a small cohort of GPs. It has proved challenging to attract additional GPs willing to undertake a more formal role in delivering the contract with the associated risk to ensuring wider engagement and ownership as implementation progresses.

Next steps

The GP Executive will agree future phases of priorities within the PCIP based on the confirmed financial plan and will update the document, workforce plan and programme plans accordingly. Further reports will be brought to IJB on a regular basis and similarly to GP Sub Committee, with update reports to the NHS Borders Board and Board Executive Team as appropriate.

3. SUMMARY

While there is ongoing work to do, progress across the PCIP has been made over recent months and pace has improved. The revised PCIP document and tracker reflects the improved position planned future commitments.

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Scottish Borders Primary Care Improvement Plan

(Revised)

2018-21

Final Version 22nd Oct 2019

CONTENTS

1. INTRODUCTION

The Scottish Borders Primary Care Improvement Plan (PCIP) was originally developed in 2018 in line with the National Memorandum of Understanding between the Scottish Government, BMA, Integration Authorities and NHS Boards linked to the introduction of the 2018 GMS Contract in Scotland.

While some progress was made initially across the PCIP workstreams within the plan, at the end of 2018/ 19 it was acknowledged that this had not been at the pace we would have wished and it was agreed to re-invigorate the process and subsequently to revisit and update the PCIP. This document reflects that and should be considered in conjunction with the original plan (attached separately as **Appendix 1**) which describes the local and wider context in detail.

2. BACKGROUND

Scottish Borders covers a rural area of 1831 square miles with a practice population of circa 118,484 and a population density of 25 persons per square kilometre, compared to 65 persons per square kilometre for Scotland. There is no one large centre of population, rather a number of small towns ranging in size from 2,000 to approximately 16,000 and many smaller villages and hamlets in rural settings. NHS Borders is co-terminous with one Local Authority and there is one Health & Social Care Partnership. There are 23 GP practices in Borders with 4 GP clusters.

3. GOVERNANCE

As part of the PCIP revitalisation process, it was evident that a more robust governance framework was required; a GP Executive was therefore introduced in April 2019 with membership from GP Sub Committee, NHS Borders and Borders Health & Social Care Partnership at senior level. The GP Executive is chaired by the Chair of GP Sub Committee and has the remit to oversee and steer the development and implementation of the PCIP. In doing so, the GP Executive ensures that the six priority areas for change within the PCIP are progressed and monitored in a meaningful way, according to an agreed timetable and with a level of scrutiny; thereby safeguarding the principles of the GP Contract and making sure that there will be equitable access to the new models of care across Scottish Borders.

In addition, NHS Borders identified an Executive Lead to help drive forward progress; this post began in June 2019. A Project Manager for the overall programme was also appointed and started at the end of August. Both are members of the GP Executive.

The GP Executive meets monthly and has previously reported at the Primary Care Strategy Group, however that group is under review and may not continue in its current format. The GP Executive provides regular reports to GP Sub Committee and IJB as well as to NHS Borders Executive Team and NHS Borders Board as appropriate. A governance diagram is at **Annex A** and membership list at **Annex B**

Since its inception, the GP Executive has introduced a number of steps to ensure more robust planning, reporting and governance arrangements:

- The GP Executive receives standardised highlight reports from each of the workstreams each month. Scrutiny of progress takes place in line with the overarching programme plan. Any proposed changes to the workplans and workforce plans must be agreed by the GP Executive.
- The GP Executive includes a designated Business Partner who has comprehensively reviewed the budget and commitments to date and has presented a confirmed financial outlook; this has been formally agreed by the GP Executive and allows robust forward planning. Finance reports are taken at each meeting where all proposed financial commitments must be approved.
- A delivery map has been developed; this is a dynamic working document which plots where the new posts are being sited and services are being delivered across practices as an aid to ensuring equitable provision across Borders.
- A Communications Plan is in development and will incorporate processes to raise the profile and awareness of the PCIP locally.

Clinical Governance

A consistent approach to the delivery of service and development of an appropriately skilled workforce is essential to ensure safe and appropriate patient care. Provision has been made within the PCIP for Band 8a roles in each workstream to manage this and to provide a clinical professional line for the individual disciplines. In addition, resource has been allocated to allow time for GPs to mentor and support the new staff appointed through PCIP, most particularly the Advanced Nurse Practitioners and Pharmacists.

Health Inequalities Impact Assessment(s) will be undertaken across the PCIP.

4. KEY PRIORITIES (PCIP WORKSTREAMS)

The key priorities have been developed in line with the MoU and are managed through individual workstreams. The additional posts appointed and planned within each workstream are detailed in **Section 7**.

The Vaccination Transformation Programme (VTP)

The Vaccination Transformation Programme (VTP) was announced at national level in March 2017 prior to the introduction of the PCIP 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. This was to be incorporated within the PCIP and in Borders the plan was developed as overleaf:

	Previously Completed	Year 1	Year 2	Year 3
Plan /Outcomes	School programme (including flu vaccines)	Pertussis/ whooping cough vaccine seasonal flu vaccination being provided by NHSB midwifery team	Continuation of 0-5 years programme work - pre-school childhood population Travel	Shingles (start) Seasonal Flu Adults 65 years and over Pneumococcal vaccines adults aged 65 years Flu Vaccines ('At risk adults' aged 18-64 years)
Progress		**HPS Data** **Pertussis –** **Quarter 1 2018** NHSB deliveries =138 with vaccination rate of 64.49% **Quarter 1 2019** NHSB deliveries =136 With vaccination rate of 67.65% **increase in % vaccination rate by +3%** Reduction in healthcare appointments for pregnant women as all vaccinations are now part of midwifery led care. Practice Nurse appointment time therefore freed up.	<u>Pre-school childhood programme</u> Data gathering completed, this details the % vaccination uptake across all GP Practices and Clusters for the Scheduled routine vaccinations (Primary and Booster vaccinations) and Seasonal flu vaccinations for 2,3 and 4 year olds Draft Protocol developed to support local delivery model Model initially identified has raised some challenges and an alternative model has been proposed to Scottish Government (detailed separately below*) <u>Travel Health & Advice</u> - liaison with GP practices ongoing; likely to become Year 3 Outcome.	Data gather completed, this details the % vaccination uptake across all GP Practices and Clusters for the 65 years and over population and the 'At risk' adults aged 18-64 Proposed alternative delivery model has been identified (see separate detail)

*<u>Alternative model for under 5 non-flu and flu vaccinations, adult vaccinations and adult flu vaccinations</u>

The VTP workstream initially identified a model of delivery for all under 5 non-flu vaccinations to be taken over by NHS Borders with plans to subsequently incorporate child flu and adult flu vaccination programmes. This model has raised some challenges in terms of the high cost attached to both the additional NHS Borders

workforce required and the change to the current IT and data sharing infrastructure necessary to enable non-practice staff to provide the service. A further significant issue is the lack of suitable and accessible accommodation from which to provide the service equitably across the area. Within the original model consideration had been given to the vaccination service being provided from a central point in each locality or cluster given that it has proved impossible to find space in every health centre. However this has also proved extremely difficult; even if it were possible, the public transport infrastructure is limited and there is a concern that the more vulnerable or poorer members of the community would either choose not / be unable to travel out of their home setting for their vaccinations or would not be able to afford to do so.

The potential need to use centrally located accommodation in geographical areas rather than within each health centre or community also presents the risk of a reduced vaccination uptake and an associated increased risk to "herd immunity" with potential widening of health inequalities.

The current scheduled routine programme of vaccinations for under 5yrs, for under 5yrs flu and adult vaccinations has been delivered successfully by GP practices for many years and from accommodation within practice premises. The alternative and preferred approach put forward would see NHS Borders taking over the element of practice nurse time required to deliver this vaccination programme, thereby becoming health board salaried hours. This would allow the practices to divert the element of their budget currently attached to these hours to support additional capacity within the practice e.g. by developing further professional roles / advanced practitioners etc. The use of existing accommodation and IT infrastructure would continue thereby removing the problem highlighted previously around changes to IT, sourcing space elsewhere and the need for patients to travel for vaccinations. This would maximise the potential to sustain our current good vaccination rates and minimise the risk of a reduction in them and to herd immunity. The approach proposed has been tested successfully in one GP practice.

The VTP workstream had identified a modus operandi and governance structure for the original proposed delivery model which would be transferrable to this new proposal and would ensure a standardised approach to the vaccination programme across the area.

This proposal is being developed in more detail and will be considered further by Scottish Government. The PCIP will be amended based on the response received.

Pharmacotherapy

	Year 1	Year 2	Year 3
Plan /Outcomes	Develop a unified repeat prescribing system Ensure a sustainable process for hospital discharge letters Establish a process for medicines reconciliation	Embed the repeat prescribing system Create a process for Level 2 pharmacotherapy services	Roll out the medication review & high risk medicines process Develop support for Level 2 pharmacotherapy services
Progress	The Unified Prescribing Policy (UPP) has been circulated and agreed as a working document with the GP Sub Committee. Process for Discharge Letters and Medicines Reconciliation has been progressed; full service provision across all practices will be possible once more technicians are in post	UPP awareness raising across practices. Pharmacotherapy reviews are being rolled out across all practices as recruitment progresses. Reporting information on activity and outcome will be available by November 2019. Recruitment and development of additional technicians to allow roll out of support for IDLs.	Recruitment and development of additional technicians

Recruitment to Technician posts has proven difficult, however a new 2 year training cycle has been developed with three students currently enrolled. The first three students will be in Primary Care training posts from 2020/21.

Community Treatment & Care Services

	Year 1	Year 2	Year 3
Plan /Outcomes	Data gathering and development of a model of service delivery for Treatment Rooms	Application and testing of model with first phase NHS Borders treatment rooms. Roll out to remaining NHS Borders Treatment Rooms. Develop plan for roll out to GP Treatment Rooms. Identify and plan interface with Urgent Care Workstream and	Confirmation and of Treatment Room model and plan for roll out to GP Treatment Rooms. Implementation of the roll out plan for Treatment Rooms. Confirm plan for transfer of VTP services to treatment rooms in Year 4 Identify interface with wider MDT development and new

		establishment of ANP cohort.	community services model – plan to be in place Year 4
Progress	Model and SOP identified	Model implemented in 4 NHS Borders Treatment Rooms as first phase and evaluation ongoing. Roll out to remaining 6 NHS Borders Treatment Rooms will be complete by end of third quarter.	

Urgent Care

The main focus will be on the development and establishment of an Advanced Nurse Practitioner model.

	Year 1	Year 2	Year 3
Plan/ Outcomes	SAS pilot in South Cluster NHS Borders ANP strategy developed 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. Review of paramedic practitioner role. Outcome to inform wider development of service.
Progress	4 ANPs recruited for deployment into South and West Clusters. Governance and Communication protocols complete. Paramedic Practitioners Pilot in South Cluster established.	ANPs established in South and West Clusters Activity data collection processes for South & West clusters - review and confirm. Further 11 posts approved for recruitment by end of 2019/20. Local training pathway under development.	

Additional Professional Roles

First Contact Physiotherapists

Patients with musculoskeletal problems can be directed to First Contact Physiotherapists (FCP) rather than a GP within a practice. FCPs can autonomously assess, diagnose and address the immediate clinical needs of this patient cohort; initiating further investigations and making onward referrals where clinically appropriate.

	Year 1	Year 2	Year 3
Plan /Outcomes	Initial phase of FCP service established in East and part of Central cluster	Roll out of model	Final phase roll out to remaining practices
Progress	3.4 wte (5 staff) FCPs appointed to all of east and part of central (Gala HC & Melrose/Newtown St Boswells) clusters. Framework for service developed.	Second phase of recruitment approved for a further 4 posts in 2019/20 Evaluation of service to take place before final recruitment phase is approved	

Community Mental Health Workers

Community Mental Health Professionals will provide a “see and treat” mental health model for individuals experiencing conditions such as low mood, anxiety, and depression. The new team will offer triage, assessment and a range of different types of psychological therapies, using telephone, face-to-face and remote access.

	Year 1	Year 2	Year 3
Plan /Outcomes	Identify a service delivery model	First Implementer site to be established at one GP practice. Referral pathway confirmed. Evaluation of first implementer site and confirmation of plan. Recruitment to further posts identified and roll out to remainder of Cluster	Roll out of model to all practices
Progress	Model developed	First Implementer site identified in South Cluster.	

		PCMHT (3 staff) consisting of Psychologists, CAAPs(Clinical Associate in Applied Psychology) now based in the first implementer practice; CPN recruitment underway. Referral pathway will be signed off Nov 2019. Recruitment underway for next phase of posts required.	

Community Link Workers

The Community Link Workers (CLWs) will work closely with the Local Area Coordinators to enable the most appropriate support to be provided for individual clients. CLW support will be provided for as long as necessary to enable the individual to achieve the outcomes they have identified, it is not time limited. Where the initial assessment determines that the service is not appropriate, signposting to other relevant services will be undertaken and information supplied to the referring agency.

	Year 1	**Year 2**	**Year 3**
Plan /Outcomes	Development of the service model	Recruitment to additional posts Development of referral pathway for GP practices. Roll out of model across all GP practices	Evaluation and further development of service model
Progress	Building on the existing service delivery model with the Local Area Coordinators and CLW hours, the new model of service has been identified and will incorporate additional posts. Staffing model identified.	First phase of recruitment complete. Recruitment to second phase underway.	

5. CHALLENGES AND RISKS

Across all of the workstreams a number of common challenges have been identified:

I. Accommodation: space within existing health centre premises is already at a premium and making available appropriate clinical space for use by the additional staff appointed through the PCIP is proving difficult. This has the potential to inhibit or even prevent the establishment of the new services in some areas and carries the risk of inequitable access across Borders. This issue is being addressed through the work on Premises (see Section 6)

II. IM&T: access to the relevant IT systems is not available at every health centre site for the new services being introduced and the different needs of the new services for appropriate recording and collection of data has added to the complexity of issues highlighted to date. This brings the risk of not being able to appropriately and safely deliver and record clinical activity. Work is underway with IM&T to address these issues (see Section 6)

III. Recruitment: A range of new posts are being created across various disciplines and at various levels within the workstreams. Recruitment at senior levels of skill and therefore at higher Bandings can prove difficult as there are not necessarily the numbers of suitably qualified professionals available nationally; this has particularly applied to ANPs and to FCPs, though not solely. Conversely, Pharmacotherapy have had difficulty with the lack of available Technicians. While service leads have tried to review skill mix and develop training programmes to develop staff into roles where recruitment has been problematic, this takes time. Core senior level posts are crucial in terms of clinical leadership, professional supervision clinical governance and also in delivery of specific clinical practice. Inability to recruit to posts will cause delays in delivering the proposed new PCIP services.

IV. GP Involvement in delivery: involvement in the development and delivery of the PCIP to date has fallen mainly to a small cohort of GPs. It has proved challenging to attract additional GPs willing to undertake a more formal role in delivering the contract with the associated risk to ensuring wider engagement and ownership as implementation progresses.

6. ENABLERS AND INFRASTRUCTURE

Premises

The Memorandum of Understanding has identified the requirement for two main priorities linked to premises to be progressed as part of the PCIP:

"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".

NHS Borders has historically owned the majority of local health centre premises and in the recent past has taken over two sites previously practice-owned through reprovisioning via new builds. There remains only 1 practice (O'Connell Street in Hawick) who own their main premises, another 2 own branch surgery premises and 1 leases branch surgery premises from a third party landlord.

The issues around access to appropriate accommodation at health centre sites for the new services being introduced through PCIP has been highlighted in Section 5. While some staff have been found accommodation at a number of locations, it is currently not possible in some buildings and is causing great disruption at others. The problem will only increase as more services are established.

A Primary Care Premises Group was established some years ago within Primary & Community Services and while it has a wider role around Primary Care Premises Modernisation for that Clinical Board, it has been agreed to re-vitalise the group in order to progress the two PCIP areas of work identified above as part of its remit. The GP Executive will oversee and monitor this element of the Group's workplan and the Group's membership will be widened to include GP Executive representation. Discussions are now also underway with colleagues from the Capital Management Team to ensure links with their space utilisation programme in order to address and plan accommodation requirements for new PCIP services – this will sit within the Primary Care Premises Group workplan.

IT Infrastructure and Data Collection

As highlighted in the previous Section, the requirement to access specific IT systems is crucial in the development and delivery of the new services identified across all of the workstreams. IT colleagues have been involved in a number of workstream discussions to date but there requires a more co-ordinated approach to the issue to allow them to manage their responses appropriately and to develop workable solutions – some solutions may be applicable over a number of services whilst others may need to be tailored to individual service need. Similarly, appropriate data sharing and collection processes need to be developed and managed across the new services and in liaison with GP colleagues.

The Head of IM&T is now working to establish a designated primary care function within the IT service. This new team will work alongside the workstream leads and GP Executive to address these points.

NHS 24

Colleagues from NHS 24 have been in discussion with the GP Executive regarding a proposal to trial, evaluate and establish a Triage Programme in Scottish Borders whereby NH24 will manage the triage of calls and signpost / redirect certain referrals received through GP practices to more appropriate services in order to

free up GP clinical time for more complex cases. Importantly it will also enable patients to be seen without delay and to receive the right care from the right person at the right time. Work is now taking place to develop this proposal in more detail.

7. WORKFORCE

The revitalisation of the PCIP governance process and consequent review and confirmation of the overall programme has allowed the development of a more robust workforce plan. All of the workstreams have identified workforce requirements in line with their workplans. These workplans and any changes proposed as implementation progresses must be approved by GP Executive.

All staff within the workforce plan are employed either by NHS Borders or by Scottish Borders Council. GP Executive have confirmed their commitment to establish all new posts at 52 week level to ensure continuity of service provision to our patients; accordingly the associated costs have been built into the financial plan. Line managers of the relevant services will be operationally responsible for ensuring that this level of service is delivered equitably across practices.

The tables overleaf shows the current workforce plan in terms of headcount and whole time equivalents (wte). It must be noted however that this is a fluid picture and can change as service models are evaluated and progressed and as highlighted previously, recruitment difficulties may impact on the skill mix and timetable.

Headcount

Financial Year	Service 2: Pharmacotherapy		Services 1 and 3: Vaccinations / Community Treatment and Care Services			Service 4: Urgent Care (advanced practitioners)			Service 5: Additional professional roles			Service 6: Community link workers
	Pharmacist	Pharmacy Technician	Nursing	Healthcare Assistants	Other [a]	ANPs	Advanced Paramedics	Other [a]	Mental Health workers	MSK Physios	Other [a]	
TOTAL headcount staff in post as at 31 March 2018	10	7	0	0	0	0	0	0	0	0	0	0
INCREASE in staff headcount (1 April 2018 - 31 March 2019)	5	2	0	0	0	0	1	0	0	5	0	0
PLANNED INCREASE in staff headcount (1 April 2019 - 31 March 2020) [b]	9	8	3	0	1	15	0	1	8	5	1	3
PLANNED INCREASE in staff headcount (1 April 2020 - 31 March 2021) [b]	1	3	23	n/a	0	8	n/a	0	0	n/a	0	0
PLANNED INCREASE staff headcount (1 April 2021 - 31 March 2022) [b]	n/a	n/a	n/a	n/a	n/a	n/a	n/a	0	0	n/a	0	0
TOTAL headcount staff in post by 31 March 2022	25	20	26	0	1	23	1	1	8	10	1	3

Whole Time Equivalents

Financial Year	Service 2: Pharmacotherapy		Services 1 and 3: Vaccinations / Community Treatment and Care Services			Service 4: Urgent Care (advanced practitioners)			Service 5: Additional professional roles			Service 6: Community link workers
	Pharmacist	Pharmacy Technician	Nursing	Healthcare Assistants	Other [a]	ANPs	Advanced Paramedics	Other [a]	Mental Health workers	MSK Physios	Other [a]	
TOTAL staff WTE in post as at 31 March 2018	5.2	3.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
INCREASE in staff WTE (1 April 2018 - 31 March 2019)	5.3	1.6	0.0	0.0	0.0	0.0	1.0	0.0	0.0	3.8	0.5	
PLANNED INCREASE in staff WTE (1 April 2019 - 31 March 2020) [b]	7.8	7.0	1.5	0.0	1.0	15.0	0.0	0.5	8.0	4.2	0.0	2.5
PLANNED INCREASE in staff WTE (1 April 2020 - 31 March 2021) [b]	1.0	3.0	2.3	n/a	n/a	8.0	n/a	0.0	0.0	n/a	0.0	0.0
PLANNED INCREASE staff WTE (1 April 2021 - 31 March 2022) [b]	n/a	n/a	n/a	n/a	n/a	n/a	n/a	0.0	0.0	n/a	0.0	0.0
TOTAL staff WTE in post by 31 March 2022	19.3	15.4	3.8	0.0	1.0	23.0	1.0	0.5	8.0	8.0	0.5	2.5

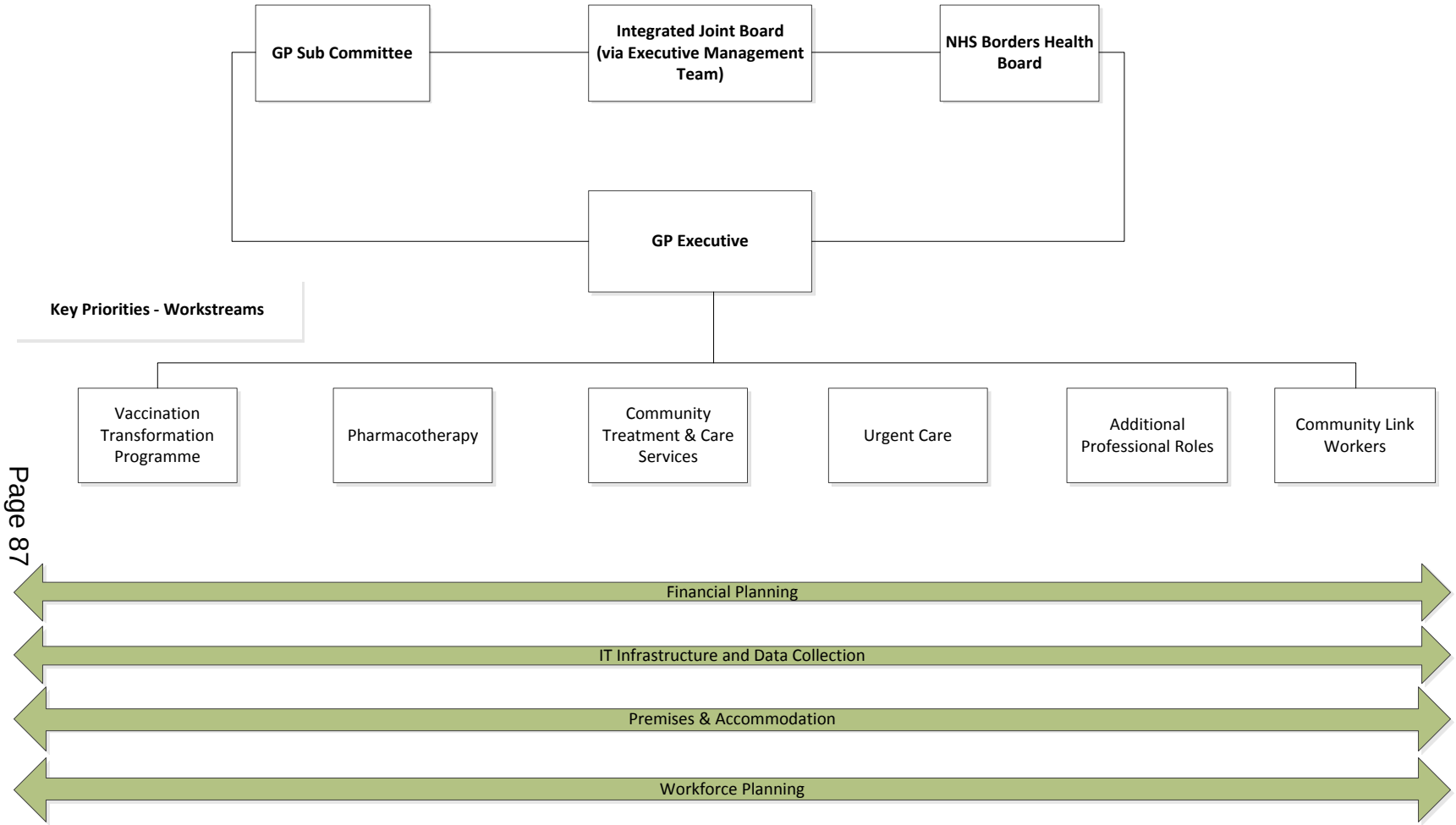
8. FINANCIAL PLANNING

Within the new governance framework, the GP Executive's Business Partner has undertaken a comprehensive review of the budget and commitments to date and has presented a confirmed financial outlook; this has been formally agreed by the GP Executive and allows robust forward planning. The information from this will inform the regular submissions made to Scottish Government in line with the required Local Implementation Tracker. The financial tables from the October 2019 submission is attached at **Annex C** and gives actual spend together with estimated planned costs for the years 2018 – 2022.

9. SUMMARY

This revised Primary Care Improvement Plan is set in the context of the recognised need to increase pace and progress across the programme and the consequent introduction of a revitalised local governance framework. The document reflects not only the good progress made over the last six months but also the more robust planning now in place for the remainder of year two and into years three and four. It is a dynamic working document and will be updated as the new services are progressed and implemented.

Annex A **Governance Structure**



Annex B GP Executive Membership

Dr Kevin Buchan, Chair GP Sub Committee

Rob McCullochGraham, Chief Officer, Health & Social Care Partnership

Dr Kirsty Robinson, GP Sub Committee

Dr Tim Young, GP Sub Committee

Dr Rachel Mollart, GP Sub Committee

Vivienne Buchan, Business Partner, IJB

Sandra Pratt, Associate Director, Strategic Change, NHS Borders

Erica Reid, Acting GM, Primary & Community Services

Nicola Lowdon, Associate Medical Director, Primary & Community Services

Zena Trendell, Contracts Manager, Primary & Community Services

Mags Baird, Project Manager, PCIP

ANNEX C

Table 1: Spending profile 2018 - 2022 (£s)

Financial Year	Service 1: Vaccinations Transfer Programme (£s)		Service 2: Pharmacotherapy (£s)		Service 3: Community Treatment and Care Services (£s)		Service 4: Urgent care (£s)		Service 5: Additional Professional roles (£s)		Service 6: Community link workers (£s)	
	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)
2018-19 actual spend	0	0	340489	0	0	0	11044	0	0	0	0	0
2019-20 planned spend	124980	29750	959075	0	15533	29750	250000	37250	644706	33750	45089	8000
2020-21 planned spend	95490	0	974910	0	0	29750	1162766	33750	778855	33750	142439	8000
2021-22 planned spend	95490	0	1004157	0	0	29750	1197649	29750	802219	29750	147401	8000
Total planned spend	315960	29750	3278631	0	15533	89250	2621459	100750	2225780	97250	334929	24000

Table 2: Source of funding 2018 - 2022 (£s)

Financial Year	Total Planned Expenditure (from Table 1)	Of which, funded from:		
		Unutilised PCIF held in IA reserves	Current year PCIF budget	Unutilised tranche 2 funding held by SG
2018-19	351533		962647	
2019-20	2177883	440867	1157757	240404
2020-21	3259710		2314561	
2021-22	3344166		3261426	
Total	9133292	440867	7696391	240404

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

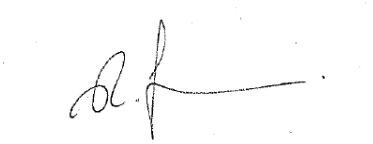
I would like to introduce Scottish Borders' updated Primary Care Improvement Plan as part of the Scottish Governments transformation of Primary Care essentially improving services for all.

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:

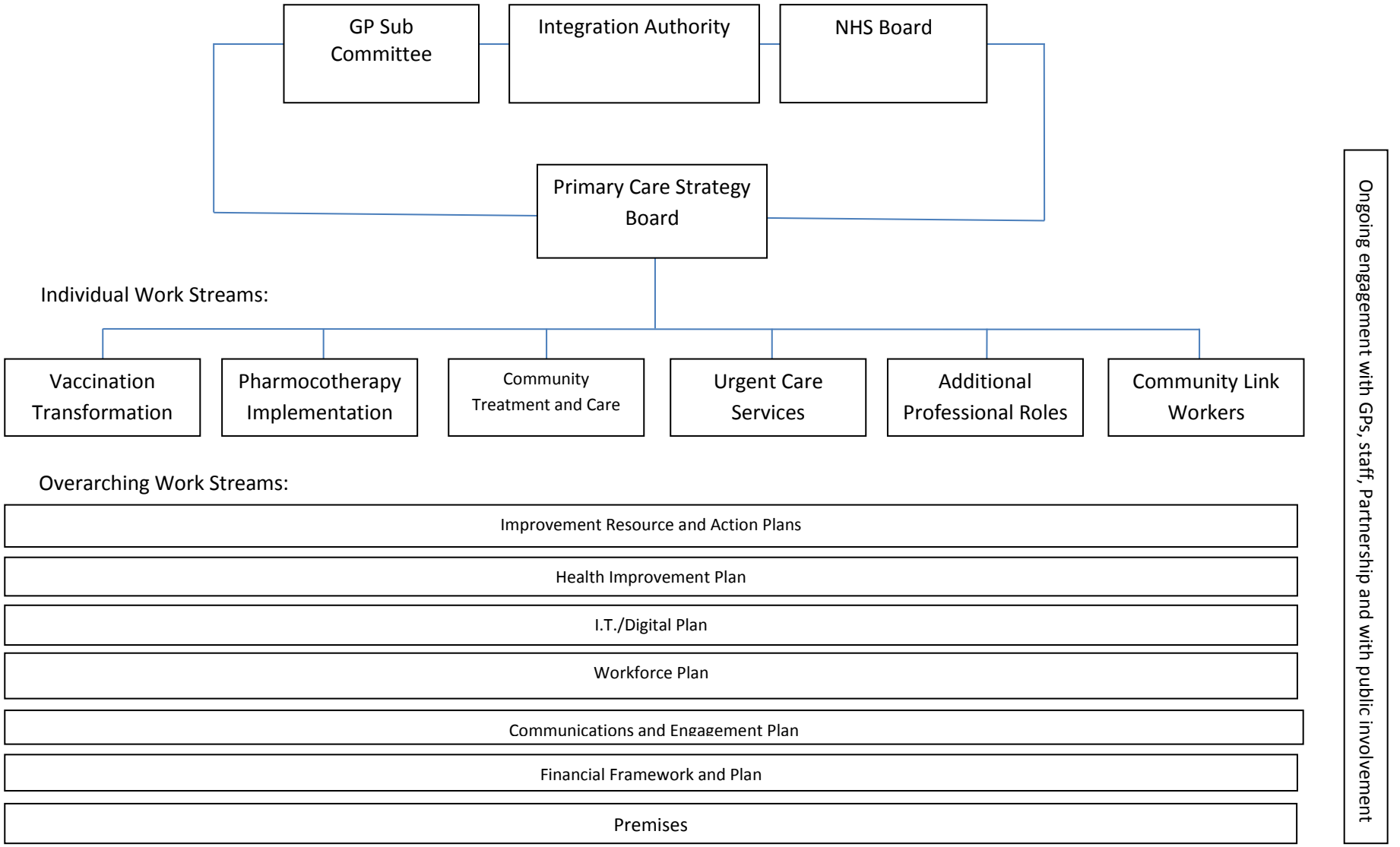
- Vaccinations Transformation Group;
- Pharmacy Services (via the Primary Care Prescribing Group & Pharmacotherapy Oversight Group);
- Community Care & Treatment Group;
- Urgent Care Group;
- Physiotherapy First Point of Contact Group;
- Primary Care Mental Health Group (to include Community Mental Health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

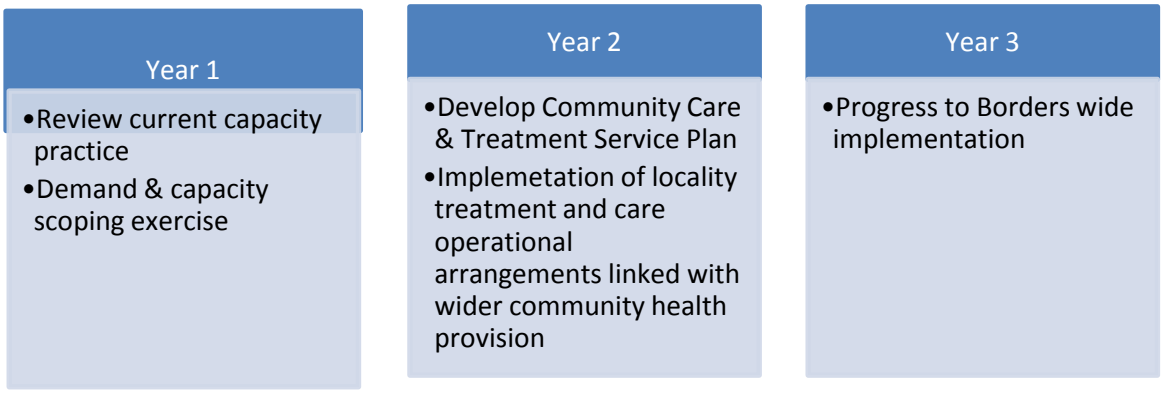
Key to these changes is the evolving role of the nursing profession and their training requirements. The national transforming roles programme is currently in phase 1 which is focussing on a consistent approach to Advanced Nurse Practitioners (ANP's) and developing an integrated community nursing team (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:

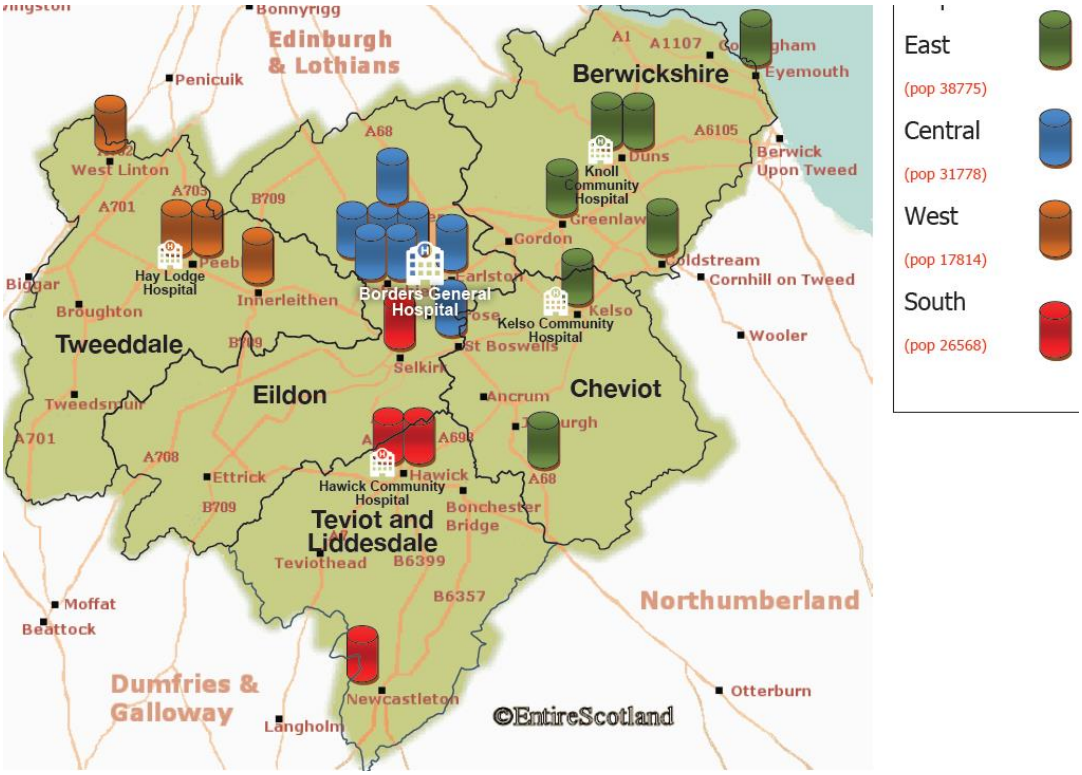
- Data;
- Health Intelligence Analysis;
- Facilitation (leadership provided through the clusters);
- Improvement Advice (national collaboration);
- Leadership (training for cluster leads).

'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

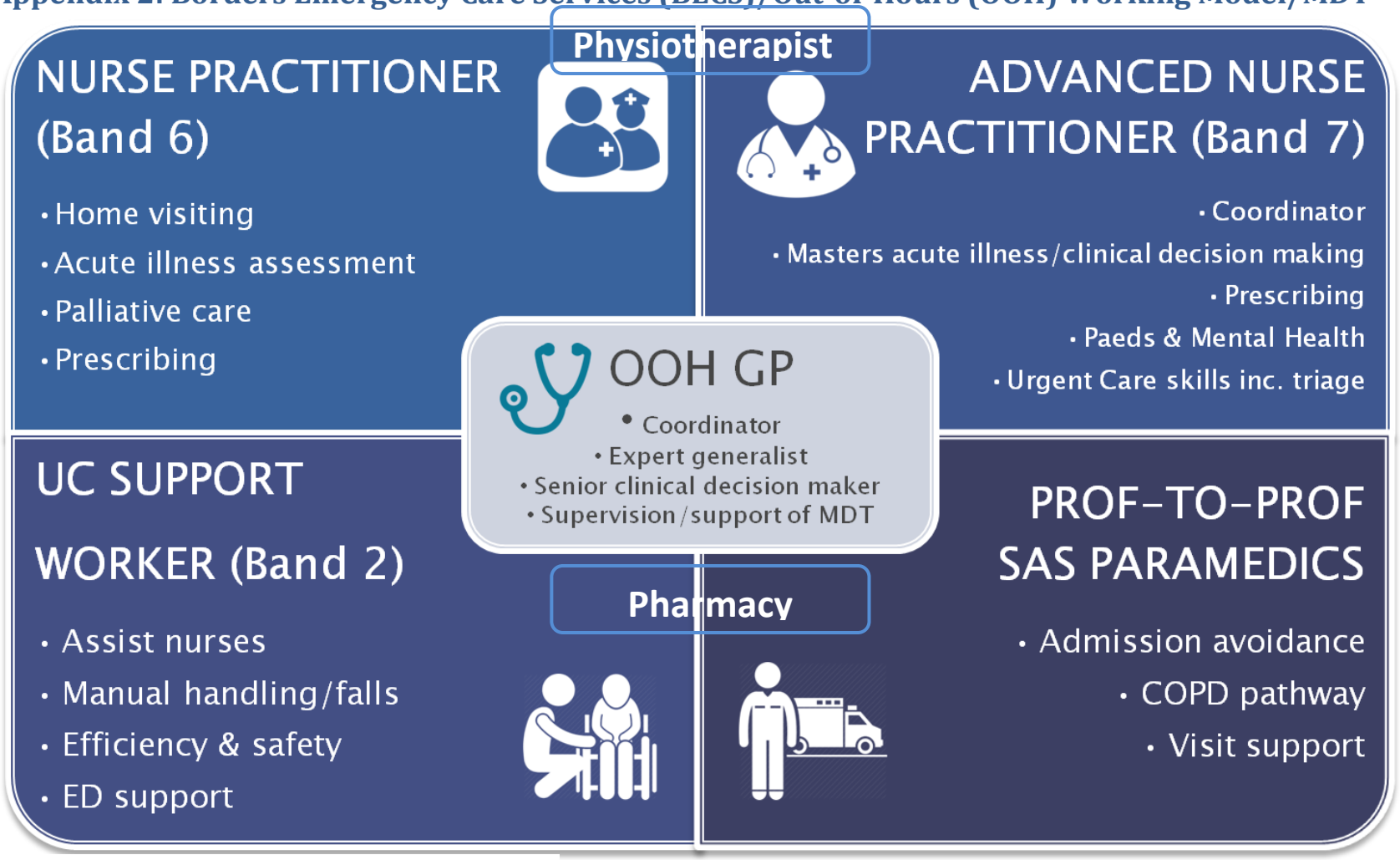
Name: Alan McDevitt, Chair, Scottish GP Committee of the British Medical Association
Date: 10 November 2017

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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Local Implementation Tracker Guidance

The following tracker should be used by Integration Authorities in collaboration with Health Boards and to monitor progress of primary care reform across their localities, and in line with service transfer as set Memorandum of Understanding.

The **MoU Progress tabs** should be used through local discussions between Integration Authorities and G agree on progress against the six MoU priority services as well as enablers required to deliver these. Th completed using a RAG system, and comments boxes have been provided to supply further information

If you are funding staff through different funding streams, for example, mental health workers through please include this information in the relevant section so we are aware that you are taking steps to recr

The **Workforce and Funding Profiles tab** replaces the Template C returns that were provided to Scottish 2018/19. These tables should allow Integration Authorities to consider financial and workforce planning primary care improvement, and reassure GP sub-committee of progress. These tables will also support Authorities in requesting the second tranche of the Primary Care Improvement Fund allocation in Octob

If you are funding staff through different funding streams, for example, recruiting mental health worker record these in Tables 1 and 2. However, they should be included in Tables 3 and 4 to inform workforce

We would also ask that this local implementation tracker be updated and shared with Scottish Governm **September 2019.**

GP sub-committees
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GP sub-committee to
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Action 15 funding,
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Integration
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ıent by **30th**

Primary Care Improvement Plans: Implementation Tracker Autumn 2019

Health Board Area: NHS Borders	**Completed by Sandra Pratt**
Health & Social Care Partnership: Scottish Borders	**For HSCP/Board:**
Number of practices: 23	**For GP Sub Committee:**
	Date: 17th October 2019
Implementation period	
From: 1st April 2019	
To : 30th October 2019	

1.1 Overview (HSCP)	**Progress to date**
MOU – Triumvirate enabled - GP Sub Engaged with Board / HSCPs	fully in place / on target
A GP Executive has been established since April 2019 through the GP Sub Committee with membership from GP Sub Committee, NHS Borders and HSCP. with the remit to oversee and steer the development and implementation of the Primary Care Improvement Plan (PCIP). As part of this remit, the GP Executive ensures that the six priority areas for change within the PCIP are progressed and monitored in a meaningful way, according to an agreed timetable and with a level of scrutiny; safeguarding the principles of the GP Contract and making sure that there will be equitable access across Scottish Borders to the new models of care.	
PCIP Agreed with GP Subcommittee	fully in place / on target
Date of latest agreement	April 2019 but will be updated for Oct 2019 return
Transparency of PCIF commitments, spend and associated funding	fully in place / on target
The GP Executive has a designated Business Partrner as a member of the group who has thoroughly reviewed the budget and commitments to date and has presented a robust and confirmed financial outlook; this was discussed and agreed by GP Executive on 26th Sept. This allows robust forward planning to be progressed by the GP Executive.	

1.2 Enablers / contract commitments	**Progress to date**
BOARD	
GP Owned Premises: Sustainability loans supported -	fully in place / on target
Number of applications	2
Number of loans approved	2
Comment / supporting information	
GP Leased Premises: Register and process in place	fully in place / on target
Number of applications	0
Number of leases transferred	0
One lease will transfer at the expiry date (this has been agreed with the practice)	
Stability agreement adhered to	partially in place / some concerns
GP Contract National Code of Practice being followed.	
GP Subcommittee input funded	fully in place / on target
Funding agreed and ongoing	
Data Sharing Agreement in Place	fully in place / on target
On track.	
HSCP	
Programme and project management support in place	partially in place / some concerns

Significant progress made with the confirmation of an Executive Lead from NHS Borders and the appointment of an overall Project Manager. Work is underway to formalise and confirm workstream project support.	
Support to practices for MDT development and leadership	partially in place / some concerns
Work in other projects in NHS Borders and HSCP around MDT is progressing concurrently with PCIP. As the wider primary care teams are being developed through the PCIP workstreams work will progress to ensure delivery of both agenda.	
GPs established as leaders of extended MDT	fully in place / on target
The GP Executive is now in place and taking a lead role in the progression of this from a PCIP perspective. The GP workstream leads are in place and functioning.	
Workforce Plan reflects PCIPs	fully in place / on target
Workforce plan has been updated.	
Accommodation identified for new MDT	partially in place / some concerns
A proportion of the accommodation required has been identified but further work is required to confirm details for planned new posts and to link with NHS Borders capital development programme.	
GP Clusters supported in Quality Improvement role	partially in place / some concerns
Discussions currently underway to enable full participation of GP Clusters.	
EHealth and system support for new MDT working	fully in place / on target
Working with eHealth Leads to develop and deliver the national Primary Care Digital Strategy. Links with local IM&T services around PCIP delivery are being strengthened and as part of this IM&T are working to to establish a designated primary care team within the service.	

Primary Care Improvement Plans: Implementation Tracker Autumn 2019

Health Board Area: NHS Borders
Health & Social Care Partnership: Scottish Borders
Number of practices: 23

MOU PRIORITIES

2.1 Pharmacotherapy	**Progress to date**
PCIP pharmacotherapy plans meet contract commitment	fully in place / on target
Pharmacotherapy implementation on track vs PCIP commitment	partially in place / some concerns
Number of practices with PSP service in place	23
Number of practices with PSP level 1 service in place	All practices have some elements of level 1
Number of practices with PSP level 2 service in place	21 (partial)
Number of practices with PSP level 3 service in place	20 (partial)
Total WTE staff/1,000 patients	0.12
Pharmacist Independent Prescribers (as % of total)	85%

On track to deliver contractual obligations pending final recruitment phase. Technician recruitment has proven difficult. Work is in progress to address this. Working with IM&T to address remote access needs. All new posts provide 52 week service.

2.2 Community Treatment and Care Services	**Progress to date**
PCIP CTS plans meet contract commitment	partially in place / some concerns
Development of CTS on schedule vs PCIP	not in place / not on target
Number of practices with access to phlebotomy service	23
Number of practices with access to management of minor injuries and dressings service	23
Number of practices with access to ear syringing service	23
Number of practices with access to suture removal service	23
Number of practices with access to chronic disease monitoring and related data collection	information not currently available
Number of practices with access to other services	information being sourced
Total WTE staff/1,000 patients	information to be confirmed

Work progressed slowly on the introduction of a standardised model for treatment room services which forms the first phase of this key priority. The GP Executive are in the process of revitalising the workstream to ensure pace and delivery and a more robust workplan plan has been developed.

	Progress to date
PCIP VTP plans meet contract commitment	partially in place / some concerns
VTP on schedule vs PCIP	not in place / not on target
Pre-school: model agreed	partially in place / some concerns
Number of practices covered by service	
School age: model agreed	fully in place / on target
Number of practices covered by service	23
Out of schedule: model agreed	not in place / not on target
Number of practices covered by service	
Adult imms: model agreed	partially in place / some concerns
Number of practices covered by service	
Adult Flu : model agreed	partially in place / some concerns
Number of practices covered by service	
Pregnancy: model agreed	fully in place / on target
Number of practices covered by service	23
Travel: model agreed	not in place / not on target
Number of practices covered by service	
Total WTE staff/1,000 patients	

Model agreed for NHS Borders to deliver school age and pregnant women vaccinations. Alternative model agreed locally and proposed to Scottish Govt for <5 yrs and < under 5 yrs flu , adult and adult flu vaccinations - this proposal is currently under consideration by Scottish Government and therefore remains amber until response from Scottish Govt is received. Out of schedule - work still to progress.

2.4 Urgent Care Services	Progress to date
Development of Urgent Care Services on schedule vs PCIP	partially in place / some concerns
Number of practices supported with Urgent Care Service	5
Total WTE staff/1,000 patients	Not available as not yet area wide
5 posts apointed. Recruitment underway for further 6 posts by Dec 2019 with plans for further recruitment last quarter and 20/21 as roll out progresses. All new posts will provide 52 week cover. Work will be undertaken to review Advanced Paramedic Practitioner roles and requirements.	
Additional professional services	
2.5 Physiotherapy / MSK	**Progress to date**
Development of APP roles on track vs PCIP	partially in place / some concerns
Number of Practices accessing APP	14
Total WTE staff/1,000 patients	Not available as not yet area wide
3.4 wte (5 staff) FCPs introduced to all of east and part central clusters in Borders. Recruitment to 4 further posts underway to be place by Dec 2019. All new posts will provide 52 week cover. Has proven difficult to find accommodation in all areas and there have been some IT issues. However, joint working is underway to resolve issues and achieve most efficient system to support practice requirements. Current focus on embedding existing FCPs and evaluation will inform further expansion. Recruitment may be difficult given the lack of trained FCPs nationally.	
2.6 Mental health workers (ref to Action 15 where appropriate)	**Progress to date**
On track vs PCIP	fully in place / on target
Number of Practices accessing MH workers / support	Being implemented in 1 site initially to test the model
Total WTE staff/1,000 patients	
First Implementer site identified in South Cluster; team now based on site. Referral pathway for roll out to other practices will be finalised Nov 2019. Recruitment is underway for next phase of posts required.	
2.7 Community Links Workers	**Progress to date**
On track vs PCIP	fully in place / on target
Number of Practices accessing Link workers	23
Total WTE staff/1,000 patients	not currently available
Additional posts in place. CLWs will work with Local Area Coordinators (LACs)to establish effective operational model across the area.	
2.8 Other locally agreed services (insert details)	**Progress to date**
Service	NHS24 Triage service
On track vs PCIP	select one from….
Number of Practices accessing service	
Total WTE staff/1,000 patients	
NHS24 are working with NHS Borders to explore the development of a Triage service that will include all practices. This is at an initial stage.	

2.9 Overall assessment of progress against PCIP	partially in place / some concerns
Note: Include interdependencies, and indicate if local or national	
Specific Risks	
Progress with recruitment of approved posts has not been at the speed we would have wished. However the recently formed GP Executive has injected significant pace and scrutiny and we are confident that the measures put in place will see this improve. Accommodation for the additional posts planned is proving difficult in some places; work continues with capital managenmnt colleagues to address this.	
Barriers to Progress	
Capacity in general across local services is at a premium and has impacted on the ability to move at the pace required to date. However, the GP Executive is working with partners to address this. Project support has been limited to date and discussions are underway to address this.	
Issues FAO National Oversight Group	

While the RAG status has remained at Amber overall, we feel that the establishment of the GP Executive has brought a new impetus and oversight to the delivery of the PCIP and feel that real progress has been made over the last 6 months, including improved engagement across all partners. We feel therefore that overall we are on target and see the RAG status moving more quickly to Green than the current status is able to reflect. The PCIP document has been revised to reflect the progress made over the last 6 months.

Funding and Workforce profile

Health Board Area: NHS Borders
Health & Social Care Partnership: Scottish Borders

Table 1: Spending profile 2018 - 2022 (£s)
Please include how much you spent in-year from both PCIF and any unutilised funding held in reserve

Financial Year	Service 1: Vaccinations Transfer Programme (£s)		Service 2: Pharmacotherapy (£s)		Service 3: Community Treatment and Care Services (£s)		Service 4: Urgent care (£s)		Service 5: Additional Professional roles (£s)		Service 6: Community link workers (£s)	
	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)
2018-19 actual spend	0	0	340489	0	0	0	11044	0	0	0	0	0
2019-20 planned spend	124980	29750	959075	0	15533	29750	250000	37250	644706	33750	45089	8000
2020-21 planned spend	95490	0	974910	0	0	29750	1162766	33750	778855	33750	142439	8000
2021-22 planned spend	95490	0	1004157	0	0	29750	1197649	29750	802219	29750	147401	8000
Total planned spend	315960	29750	3278631	0	15533	89250	2621459	100750	2225780	97250	334929	24000

Table 2: Source of funding 2018 - 2022 (£s)

Financial Year	Total Planned Expenditure (from Table 1)	Of which, funded from:		
		Unutilised PCIF held in IA reserves	Current year PCIF budget	Unutilised tranche 2 funding held by SG
2018-19	351533		962647	
2019-20	2127883	440867	1157757	240404
2020-21	3259710		2314561	
2021-22	3344166		3261426	
Total	9133292	440867	7696391	240404

Comment:

Table 3: Workforce profile 2018 - 2022 (headcount)

Financial Year	Service 2: Pharmacotherapy		Services 1 and 3: Vaccinations / Community Treatment and Care Services			Service 4: Urgent Care (advanced practitioners)			Service 5: Additional professional roles			Service 6: Community link workers
	Pharmacist	Pharmacy Technician	Nursing	Healthcare Assistants	Other [a]	ANPs	Advanced Paramedics	Other [a]	Mental Health workers	MSK Physios	Other [a]	
TOTAL headcount staff in post as at 31 March 2018	10	7	0	0	0	0	0	0	0	0	0	0
INCREASE in staff headcount (1 April 2018 - 31 March 2019)	5	2	0	0	0	0	1	0	0	5	0	0
PLANNED INCREASE in staff headcount (1 April 2019 - 31 March 2020) [b]	9	8	3	0	1	15	0	1	8	5	1	3
PLANNED INCREASE in staff headcount (1 April 2020 - 31 March 2021) [b]	1	3	23	n/a	0	8	n/a	0	0	n/a	0	0
PLANNED INCREASE staff headcount (1 April 2021 - 31 March 2022) [b]	n/a	n/a	n/a	n/a	n/a	n/a	n/a	0	0	n/a	0	0
TOTAL headcount staff in post by 31 March 2022	25	20	26	0	1	23	1	1	8	10	1	3

[a] please specify workforce types in the comment field
[b] If planned increase is zero, add 0. If planned increase cannot be estimated, add n/a

Table 4: Workforce profile 2018 - 2022 (WTE)

Financial Year	Service 2: Pharmacotherapy		Services 1 and 3: Vaccinations / Community Treatment and Care Services			Service 4: Urgent Care (advanced practitioners)			Service 5: Additional professional roles			Service 6: Community link workers
	Pharmacist	Pharmacy Technician	Nursing	Healthcare Assistants	Other [a]	ANPs	Advanced Paramedics	Other [a]	Mental Health workers	MSK Physios	Other [a]	
TOTAL staff WTE in post as at 31 March 2018	5.2	3.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
INCREASE in staff WTE (1 April 2018 - 31 March 2019)	5.3	1.6	0.0	0.0	0.0	0.0	1.0	0.0	0.0	3.8	0.5	
PLANNED INCREASE in staff WTE (1 April 2019 - 31 March 2020) [b]	7.8	7.0	1.5	0.0	1.0	15.0	0.0	0.5	8.0	4.2	0.0	2.5
PLANNED INCREASE in staff WTE (1 April 2020 - 31 March 2021) [b]	1.0	3.0	2.3	n/a	n/a	8.0	n/a	0.0	0.0	n/a	0.0	0.0
PLANNED INCREASE staff WTE (1 April 2021 - 31 March 2022) [b]	n/a	n/a	n/a	n/a	n/a	n/a	n/a	0.0	0.0	n/a	0.0	0.0
TOTAL staff WTE in post by 31 March 2022	19.3	15.4	3.8	0.0	1.0	23.0	1.0	0.5	8.0	8.0	0.5	2.5

[a] please specify workforce types in the comment field
[b] If planned increase is zero, add 0. If planned increase cannot be estimated, add n/a

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 30 October 2019

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

JOINT FINANCIAL PLAN – BUDGET PLANNING ASSUMPTIONS 2020/21

Purpose of Report:	This paper provides the IJB with an initial high level assessment of the budget planning assumptions underpinning the 2020/21 Joint Financial Planning process.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Note** the budget planning assumptions being made for the 2020/21 Financial Planning process

Personnel:	There are no resourcing implications beyond those identified within the report.

Carers:	N/A

Equalities:	There are no equalities impacts arising from the report.

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

Legal:	Supports the delivery of the Strategic Plan and is in compliance with the Public Bodies (Joint Working) (Scotland) Act 2014 and any consequential Regulations, Orders, Directions and Guidance.

Risk Implications:	The key risks are highlighted within the report

1 Context

1.1 The paper sets out these assumptions and an initial insight into their potential implications for the Revenue Resource allocations the IJB will receive from the Council and NHS Borders in 2020/21. The intention is to bring the draft Joint Financial Outlook for 2020/21 to the IJB in January and a final Joint Financial Plan for approval in March. These timescales are dependent on confirmation of budget allocations from the Scottish Government (SG) in December 2019.

1.2 Whilst this paper focuses on the Joint Financial Plan (FP) for 2020/21 the intention is to present a medium term (3 year) Joint FP in future papers. However, currently NHS Borders is in the process of developing a 3 year FP and the Council is preparing its 5 year FP so further work is required to produce a Joint FP covering the next 3 years.

2 Background

2.1 The UK Government's Spending Review in September announced a range of funding proposals for public services. Scotland's share of these proposals has not been confirmed at this stage, nor is the breakdown of any increase over the different public sectors. The assumptions presented in this paper therefore reflect the most recent guidance from SG for Health and Local Government and the high level internal estimations by each Partner organisation.

3 Assumptions

3.1 NHS Borders

3.1.1 The Health Board is assuming an overall uplift of 2.6% on its base funding for 2020/21. This would equate to £5.2m. This increase is allocated by the SG to fund nationally agreed pay awards and initiatives as well as to cover inflationary increases such as contractual uplifts. The Health Board's (HB) planning process has identified a number of areas of spend highlighted below which will be commitments against the uplift received in the coming year.

- Pay – 2020/21 will be the third year of the 3 year reform of the AFC pay scales relating to non medical staff pay and its not clear if the uplift will cover the final year increase. Detailed modelling will be undertaken to identify the expected cost for the coming year.

- Supplies uplift has been assumed at 2% however this may not be sufficient to fund contractual increases from external providers. This is especially relevant for Learning disabilities and Mental Health services where some patients are placed outwith the Borders.

- Drugs – the HB is forecasting an increase of 6.3% on its drugs budget, driven by the impact of new drugs, the implementation of new protocols, and the expected increase in Prescribing spend.

- National and Regional investments – some of which are driven by legislation. Further work is required to confirm the HBs commitments to National and Regional developments.

- General demographic and activity growth

- Non recurring commitments linked to Financial Turnaround and the Winter programme.

3.1.2 As part of its FP process NHS Borders is working to produce robust estimates of these elements of spend. Any adverse outcomes arising from a comparison of the levels of income and expenditure assumed will increase the financial gap forecast for 2020/21.

3.1.3 The HB is working on a 3 year financial recovery plan which will propose ways in which it can deliver a balanced financial position at the end of 2022/23. Any increase in the overall financial gap arising from the 2020/21 planning process will have an adverse impact on that 3 year plan.

3.2 Scottish Borders Council

3.2.1 The Scottish Borders Council (SBC) is again developing a 5 year revenue and 10 year capital financial plan from 202/21. The broad planning assumptions reflected in the existing plan have been reviewed and updated to provide detailed planning assumptions for the coming financial year and indicative plans for the following 4 years.

3.2.2 The overall assumptions underpinning the Council's 2020/21 FP are set out below, including any specific implications for the IJB delegated function within the Health & Social Care Partnership. The assumptions presented reflect the latest guidance and information from COSLA where appropriate. The Council's main sources of funding are:

- Local Government Financial Settlement – overall SBC are assuming a flat cash settlement in core grant funding for next year. Whilst this is an improvement on the 1% reduction previously assumed, it still presents financial challenges, not least in addressing the impacts of inflation.

- Council Tax – the 2020/21 FP assumes an increase of 3% in line with the rate approved in 2019/20.

3.2.3 The implications of these income assumptions have been assessed in relation to the main areas of expenditure, including specific assumptions relating to the IJB delegated services:

- Pay – Council staff are moving into the 3rd year of a 3 year pay agreement which will award all staff and increase of 3%. It has been assumed that the SG will continue to fund any differential increase for teaching staff as part of their separate agreement.

- Non Pay – based on recent trends the council has assumed RPI will be 2.8% and CPI will be 2%. These indices form the basis of contractual uplifts imposed by providers in the coming year.

3.2.4 H&SC Services

- As a result of budget work confirmed by COSLA the Council has assumed that the £2.496m allocated directly to Integrated Services in 2019/20 will be baselined in 2020/21. The plan assumes that the budget increases funded from that uplift will also be recurring.

- The SBC FP assumes that the Social Care Fund balance of £7.397m will continue to flow from Health to Social Care.

- The Council FP recognises that ongoing pressures, particularly relating to demographic growth and Scottish Living Wage increases may not be funded directly by the SG and has therefore assumed that any planned increases in these areas will be funded by the Council. Work is underway to produce robust estimates of growth that will inform the plan.

4 Delivering a Balanced FP

4.1 Both organisations' FPs assume the need for a level of savings to be delivered in 2020/21 to address existing gaps in funding. NHSB, through their Turnaround savings process acknowledges there is a requirement for significant additional year on year savings to bring the organisation back into financial balance.

4.2 Similarly, the Council has a medium term savings scheme Fitfor2024 which is expected to deliver substantial savings over the coming years.

4.3 Both organisations recognise that any unfunded pressures identified in 2020/21 which cannot be mitigated against will result in the need to deliver additional savings.

4.4 The impact of all of the above for the IJB will be reflected in the initial resource allocations proposed by the partner organisations in December.

5 Risks

5.1 Apart from an element of uncertainty inherent in considering information based on assumptions there are further risks external to the FP process which may impact on its outcomes.

5.2 There is a risk that Brexit may result in significant disruption and availability of resources (goods and staff) for a sustained period of time. The impact of this is likely to be adverse for both partner organisations.

5.3 A further risk may arise in relation to national events linked to Brexit.

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 30 October 2019

Report By	Tim Patterson, Joint Director of Public Health
Contact	Susan Elliot, ADP Co-ordinator; Fiona Doig, Strategic Lead – ADP and Health Improvement
Telephone:	01835 825900

ALCOHOL AND DRUGS PARTNERSHIP UPDATE

Purpose of Report:	The purpose of this report is to update the Board on: 1) Drug Related Deaths 2) Progress of new commissions 3) Alcohol and Drugs Partnership (ADP) Annual Report 2018-19 4) ADP Action Plan 2019-20 5) Governance arrangements – Partnership Delivery Framework

Recommendations:	The Health & Social Care Integration Joint Board is asked to: • Note this update report

Personnel:	Staffing is provided within the agreed resource

Carers:	The SFAD Needs Assessment (see page 2) was informed by family members lived experience (including carers) and service developments will impact positively on this group.

Equalities:	*An EQIA will be carried out on the Strategic Plan required by April 2020.*

Financial:	ADP funding from Scottish Government is contingent on delivery of Ministerial Priorities. The ADP is presenting a balanced budget.

Legal:	n/a

Risk Implications:	There are no immediate risks to delivery of actions.

1 Situation

Borders ADP is a partnership of agencies and services involved with drugs and alcohol. It provides strategic direction to reduce the impact of problematic alcohol and drug use. It is chaired by the Director of Public Health and the Vice Chair is the Chief Social Work & Public Protection Officer /Interim Service Director Children and Young People and membership includes officers from NHS Borders, Scottish Borders Council, Police Scotland and Third Sector.

1.1 Drug deaths

Significant concern has been raised locally and nationally about the increase in drug related deaths and the ADP is keen to report on local work to reduce deaths. Scotland's drug related deaths have continued to increase and reached 1,187 in 2018, the highest number ever recorded and a 27% increase on 2017 figures. In Scottish Borders the trend overtime is increasing and reflects the national picture. Every death is a tragedy and impacts on families and friends. National Records of Scotland reported 22 drug deaths for Scottish Borders. Scottish Borders Drug Death Review Group (DDRG) examined 21 drug deaths for 2018. The remaining 1 death was outwith the remit of the DDRG.

The annual average number of deaths investigated by DDRG for the five year period 2014 – 2018 was 11.2, an increase on the 2010 – 2014 average of 6.4 deaths.

1.2 Progress of new commissions

ADP's were informed in August 2018 of additional funding for years 2018 – 2021. Locally this was an increase of £357,000 over our ring-fenced allocation of £1,049,582. The additional funding came with recommended priorities for investment. Through consultation a range of proposals were developed, agreed and commissioned following agreement by the IJB in February 2019. The IJB requested an update on commissions in due course.

The cost of these commissions is included in Table 1 below. A summary of the agreed commissions is included in Appendix 1 (p10).

Table 1: Budget for new commissions

Commission	Annual Costs
Assertive Engagement Service	242,000
Children Affected by Parental Substance Use (CAPSM) Service	58,000
Advocacy	15,000
Recovery	39,000
Families Needs Assessment*	3,000
Total	357,000

*Committed funding of £3000 is included for 2019-20 onwards. An initial cost in 2018-19 was incurred of £13,000 which provided a commission with Scottish Families Affected by Alcohol and Drugs (SFAD) to deliver a Families Needs Assessment in relation to adult family members of people with alcohol and drugs problems.

In addition the ADP had sought support to co-locate alcohol and drugs services in one building, however, a suitable building has not been identified. Thanks are given to SBC Estates and NHS Borders Capital Planning for their support in this.

1.3 Annual Report 2018-2019

The ADP is required to produce an Annual Report each year. The report has been endorsed by the ADP Board and the Chief Officer. Format of the Annual Report is based on a template issued Scottish Government and includes information relating to the financial framework and Ministerial Priorities. The full report is included as Appendix 2 (p13) and was submitted to Scottish Government on 30 September 2019.

1.4 Action Plan

The ADP has produced an Action Plan for 2019-20 based on the new alcohol and drugs strategy and the new alcohol framework[1] published in November 2018. It is also informed by updated Ministerial Priorities which were issued in August 2019. This was developed in consultation with services and approved by the ADP and is included as Appendix 3 (p23).

1.5 Partnership Delivery Framework

In July 2019 a Partnership Delivery Framework outlining governance expectations was issued by Scottish Government and COSLA to IJB Chief Officers, NHS Chief Executives, Chairs of Community Planning Partnerships and ADPs. This document reflects the changing environment in which ADP's operate since the previous memorandum of understanding. The Framework includes expectations of ADP membership and requirement to produce a local strategic plan by April 2020. The Framework document is included as Appendix 4 (p34).

2 Background

2.1 Drug Related Deaths

In early 2018 a specific group was set up in response to the increase in deaths in Borders to allow a closer look at service responses.

Actions arising from the group were as follows: review of Risk Assessments, review of potential barriers to accessing services and an audit of adult concern forms. No apparent 'missed opportunities' or areas of concern were noted at that point.

Actions to reduce drug related deaths are included within the 2019-2020 Action Plan (Appendix 3). The ADP and the DDRG have reviewed evidence for reducing drug deaths and Table 2 outlines the Borders approach to working in line with the evidence.

[1] https://www.gov.scot/publications/rights-respect-recovery/ ; https://www.gov.scot/publications/alcohol-framework-2018-preventing-harm-next-steps-changing-relationship-alcohol/

Table 2: Evidence to reduce drug deaths and related harm.

Evidence based approaches	**Borders ADP Response**
Low threshold access to opioid substitute therapies (OST) e.g. methadone	A new Assertive Engagement Service has been commissioned from April 2019 which aims to remove barriers to accessing drug and alcohol services and reduce the harms
Provision of opioid substitution treatment (OST) of optimal quality, dosage and duration	Work with Borders Addictions Service (BAS) to consider evidence on suboptimal OST prescribing and current activity
Optimise retention in treatment	Maintain engagement in adult services of 60% of population of estimated problem drug users (currently 306 individuals (60% estimated drug users) active inBorders Addiction Service
Develop protocols for active follow-up after non-fatal overdoses	A non-fatal overdose protocol is in place between BAS, SAS and BGH.
Increase overdose awareness and availability of take home naloxone to people who use opioids and their families and friends	38 first time kits were supplied in 2018-19 and 107 resupplies made. Since 2011-12, 70% of people with problem drug use have been supplied. A further target of 28 first supplies has been set for 2019-20. Two Training For Trainers events took place in 2018-19 for provision of naloxone with 7 staff attending and four festive client drop-ins offered to ensure people most at risk had access to naloxone. A Drug Related Deaths briefing sheet was given to delegates attending all ADP training events in 2018-19 (186 delegates). 7 specific overdose awareness sessions were provided to 36 staff from various agencies including Criminal Justice Social Work Team, Health Visitors, Mental Health and Young People's Service.
Tackling poverty and addressing childhood adversity	New children affected by parental substance misuse (CAPSM) link worker service commissioned from April 2019. Deliver one early years CAPSM training (Oh Lila) and evaluate impact 3 months post training Drug and alcohol services to develop trauma informed approaches by implementing actions identified from LPASS (Lead Psychologist in Addiction Services Scotland) report
Positive opportunities in education and employment	New recovery worker recruited to expand recovery opportunities across Scottish Borders. Review of alcohol, drug and tobacco education and prevention within schools and within less traditional settings (e.g. youth groups, community learning and development) and resource pack, CPD for teachers

	and parent information to be launched November 2019.
Improve access for HIV / hepatitis B / hepatitis C prevention and treatment	Drug services support delivery of the recommendations within the Hepatitis C Virus Case Finding and Access to Care report.
Data	Information continues to be collated to identify learning from the case reviews and contribute to the National Drug-related Deaths Database (NDRDD).

The ADP is awaiting updated guidance from Scottish Drugs Forum about actions to be taken to reduce Drug Related Deaths. A workshop for key stakeholders will be convened to identify any further actions that can be progressed locally.

Scottish Government has convened a Drugs Death Task Force which has as its primary role of the taskforce is to co-ordinate and drive action to improve the health outcomes for people who use drugs, reducing the risk of harm and death. The Strategic Lead – ADP and Health Improvement is representing ADP's on the Task Force.

The ADP believes it is taking a robust approach to reducing drug deaths.

2.2 Progress of new commissions

A short overview of progress is presented below. Appendix 5 (p42) provides additional information relating to the Assertive Engagement Service, CAPSM Service and Recovery Work.

2.21 Assertive Engagement Service – staffing is now in place and new approaches to accessing services are being trialled by the services including drop-in clinics where clients can attend to seek initiation of prescription or access to wider support. This has enabled rapid initiation on to opioid prescribing for those in need. An example of success is a client with a history of 'did not attends' and non fatal overdoses who managed to attend drop-in on the same day he made contact with service and start on prescription the next day.

The service has also made links with other agencies including the anti-social behaviour unit where they now participate in Core Group meetings to offer ready support and diversion from offending as required. Discussions are ongoing with Police Scotland regarding information sharing for vulnerable clients.

The ADP Support Team is providing assistance to ensure correct capture of activity and outcomes.

2.22 CAPSM Service – staffing is now in place and linked closely to Children and Families Social Work staff. The additional staffing has allowed more in depth work to be undertaken in partnership.

The service is clear on outcomes to be collected.

2.23 Advocacy - Work to update the adult independent advocacy commission is being taken forward by a working group and a new award is anticipated in 2020.

The Children and Young People's Leadership Group (CYPLG) has a small sub-group actively scoping potential role and needs of a commissioned advocacy service for children and young people. This work is due to be presented to the CYPLG in November 2019.

2.24 Recovery - Staffing is now in place and work has been undertaken with the existing recovery community and wider partners to map what is available for people in recovery. A group was convened to co-produce a plan to attend the annual Recovery Walk in Inverness. 23 people with lived experience attended. Representatives from the community will attend the ADP on 21st November 2019 to discuss how best to include people with lived experience in planning.

2.25 Families Needs Assessment – a draft report was presented to stakeholders on 1 October to test the recommendations and help operationalise arising actions. This worked included a community survey, focus groups and 1:1s with family members and services staff and a draft report was approved at the ADP in June 2019. Actions are continuing in to 2019-20 are training and development; a stakeholder event to review recommendations took place on 1 October and a community event planned in partnership with Gala Learning Community Partnership took place on 8 October. These engagement events will inform additional actions for the 2019-20 Action Plan.

2.26 Summary

The newly commissioned services are progressing within the expected timelines.

There is a plan in place to progress advocacy led by SBC (adults) and CYPLG (children and young people) respectively.

2.3 Annual Report 2018-19

The Annual Report shows the following:

- Financial framework – the report shows a balanced budget (p15)
- Ministerial priorities – the report shows positive progress across the majority of priorities, highlights are noted below:

Priority: Tackling drug and alcohol related deaths (DRD & ARD)/risks in your local ADP area. Which includes increasing the reach and coverage of the national naloxone programme for people at risk of opiate overdose, including those on release from prison and continued development of a whole population approach which targets harder to reach groups and focuses on communities where deprivation is greatest:

- Information continues to be collated to identify learning from the case reviews and contribute to the National Drug-related Deaths Database (NDRDD). Provision of Take Home Naloxone continues to be a priority for Borders ADP. 70% of estimated prevalence of people with problem drug use have received a first supply. Assertive Engagement Service commissioned from April 2019 to remove barriers to accessing drug and alcohol services and reduce the harms associated with problem alcohol and drug use.

- 96% of individuals started treatment within three weeks of referral (n=523/546) against a target of 90% nationally (p16).

- Borders ADP has supported a review of current drug, alcohol and tobacco education and prevention within primary and secondary schools with new resources based on evidence available from November 2019.

Priority: Continued implementation of improvement activity at a local level, based on the individualised recommendations within the Care Inspectorate Report, which examined local implementation of the *Quality Principles.*

- Borders ADP provided 11 free training opportunities with 186 attendees (p5).

Exceptions – Alcohol brief interventions (ABIs) (p7) were not met in 2018-19. Reinstatement of Local Enhanced Service in Primary care has been agreed and is expected to be in place imminently.

2.4 ADP Action Plan 2019-20 (Appendix 3, p23)

The Action Plan is framed around the high level outcomes areas in Rights, Respect and Recovery[1] and represents a significant amount of new work to reduce alcohol and drug related harm in Borders.

To date the ADP is progressing the plan in accordance with original timescales. In addition to the work described above the ADP would like to highlight the good practice in the plan relating to work undertaken by the Quality Principles Group to respond to the LPASS (Lead Psychologist in Addiction Services Scotland) report which included a training matrix. An audit was performed in commissioned services against the matrix and additional training developed to ensure compliance. The psychology service in BAS supports provision of coaching and practice supervision to staff in all three services for their motivational interviewing practice which is a model of good practice.

2.5 Partnership Delivery Framework (Appendix 4, p34)

The Framework sets out the partnership arrangements needed to reduce the use of and harms from alcohol and drugs and aims to ensure that all bodies involved are clear about the accountability arrangements and their responsibilities in working together.

It is expected ADP's will continue to lead on this work via a whole system approach through development of a local Partnership Delivery Framework (local framework) components of which are outlined in the Framework document.

The ADP has reviewed the Framework document and is satisfied that governance arrangements reflect requirements outlined (Appendix 6 (p46). There is a robust planning structure and the ADP has a positive relationship with the IJB.

The ADP will take forward work in order to publish a Strategic Plan to reduce use of and harms from alcohol and drugs as outlined in the Framework.

Assessment

The ADP believes it is taking a robust approach to reducing drug deaths, however, it is clear that actions to reduce preventable deaths do not sit with alcohol and drugs services alone. There is a responsibility across the wider system to ensure that people at risk or with alcohol and drug problems are identified early and supported to access help. A key component of the Assertive Engagement Service's role is to build capacity within wider

services (e.g. Police, Social Work, Housing) to ensure an appropriate response to our clients who are some of the most vulnerable in society and be aware of what the alcohol and drugs services offer.

There is a requirement to reduce stigma relating to people with alcohol and drugs problems. Recently the ADP Support Team issued information to a variety of partners including all staff in NHS Borders, key colleagues in SBC and strategic partnerships[2] about appropriate person centred language which was recommended by the Dundee Drugs Commission and includes suggestions such as using the term 'substance use' rather than 'abuse or misuse' and 'person with a dependence on....' rather than 'addict' or 'alcoholic'[3]. This mailing also included information on what services are available.

The ADP hopes that everyone involved in governance or professional roles within the partnership use language carefully.

The ADP is satisfied that commissioned services are making good progress. Significant change has happened in Borders Addiction Service and Addaction in terms of offering joint drop-ins which would not have been feasible without additional capacity, particularly when considering the significant funding reduction in BAS's core contract funding in 2017-18 (£120,000).

Social work has engaged well with the CAPSM Service, however, the intensity of the work means that is staff are currently working with young people over several months which can has resulted in a waiting list. Action for Children are actively managing their caseload alongside social work staff.

The Recovery service is building on the success of attendance at the Inverness Recovery Walk and there are high expectations that this will support further growth in our recovery community.

The Board can see that there is a significant Action Plan for this year which is led by the ADP Support Team (2.65 WTE). The Action Plan does not reflect all of the 'business as usual' work undertaken by the team. The ADP believes the Support Team performs to a high standard which is reflected in the inclusion of local staff both in the national Drug Death Task Force and also in requests to support colleagues in other areas in relation, in particular, to Licensing work.

The Partnership Delivery Framework recognises the wider role of local systems in responding to and reducing drug related harm. The ADP is considering how best to develop a strategic plan and also welcomes support from other partnerships to ensure that outcomes are shared across the system.

[2] Education weekly newsletter; Social Work; Safer Communities Team including DAAS, Homelessness Team, Violence Against Women Partnership; Community Planning Partnership

[3] www.nada.org.au/wp-content/uploads/2018/03/language_matters_-_online_-_final.pdf

Recommendations

The Health & Social Care Integration Joint Board is asked to:

- note this update report

Appendix 1: Summary of agreed commissions

Commissioning Proposal	Purpose	Outcomes	Key Performance Indicators
1. Assertive Engagement Service	To identify and support 'harder to reach' vulnerable people who are not engaged with drug and alcohol services as well as support development of alcohol pathways from hospital to community.	Improved identification of those with alcohol and drug problems Improved access and quicker engagement in drug and alcohol services. Reduced DNA rates. Improved retention in services. Reduced drug related deaths.	Quantitative • Reduced unplanned discharges • Reduced DNA rates • Increased re-engagement rates for unplanned discharges • Reduced drugs deaths Qualitative • Revised alcohol pathway • Improved engagement following in-patient stay • Service user feedback • Feedback from wider stakeholders (e.g. MARAC, ASBU Core Unit, Public Protection)
2. Children impacted by parental substance use work	To work alongside social work, adult drug and alcohol services and other relevant services to identify families earlier to reduce the risk of harm related to parental substance use.	Early identification of children and families affected by problematic alcohol and drug use. Families affected by problem drug and alcohol use receive holistic integrated support. Improved integrated approaches between adult drug and alcohol and children	Quantitative • Increased number of CAPSM and parents referred • Increased number of parenting capacity assessments completed • Reduced number of children placed on register due to

Commissioning Proposal	Purpose	Outcomes	Key Performance Indicators
		& families services. Approaches are in line with GIRFEC. Better parenting, better attachment.	parental substance use Qualitative • Service user feedback • Feedback from wider stakeholders
3. Family Support and Recovery Needs Assessment: Adult family members impacted by another's drug / alcohol use.	Carry out a needs assessment to understand support needs and strengths including how to identify, reach and engage families. Assess workforce confidence and skills around family inclusive practice. A small amount has been identified for investment in year 2 in anticipation of additional training/workforce development delivery.	Families affected by problem drug and alcohol use receive holistic integrated support. Stigma reduced for families. Increased advocacy for families.	Year 1 – completed needs assessment Years 2&3: • Increased number of family members accessing commissioned services and SFAD helplines • Increased number of family members accessing Carers Centre • Increased number of family members accessing recovery community
4. Community engagement worker	Increase availability of recovery communities across Borders and develop model to involve people with lived experience in co-production and planning of services.	Increased recovery opportunities in wider Borders. Reduced stigma due to wider visibility of recovery. Improved service design due to involvement of people with lived experience. Increased individual and community resilience. Improved social	Quantitative • Number of recovery opportunities • Number of individuals attending opportunities Qualitative • Feedback from individuals attending recovery events • Feedback from

Commissioning Proposal	Purpose	Outcomes	Key Performance Indicators
		connectedness.	ADP and contributors to planning/design of services
5. Development of advocacy services	Increase ADP contribution to reviewed contract to allow for identified hours for our services. Provide contribution to any future children and young people's provision.	Increased advocacy for people who use alcohol and drugs. Increased advocacy for families affected by another's drug and/or alcohol use. Children and young people have access to independent advocacy.	Adults: Quantitative • Number of individuals accessing independent advocacy Qualitative • Feedback from service users and providers Children: This provision will be part of a wider commission which relies on partner agencies additionally contributing. Anticipated outcomes likely to be numbers accessing and wellbeing outcomes for children.

Appendix 2 ADP Annual Report, 2018-19

ADP ANNUAL REPORT 2018-19 (SCOTTISH BORDERS)

Document Details:

ADP Reporting Requirements 2018-19

1. Financial framework

2. Ministerial priorities

3. Formal arrangements for working with local partners

Appendix 1 Feedback on this reporting template.

In submitting this completed Annual Report we are confirming that this has been signed off by both the ADP Chair and Integrated Authority Chief Officer.

The Scottish Government copy should be sent by **30 September 2019** for the attention of Amanda Adams to: alcoholanddrugdelivery@gov.scot copied to Amanda.adams@gov.scot

1. FINANCIAL FRAMEWORK - 2018-19

Your report should identify all sources of income (excluding Programme for Government funding) that the ADP has received, alongside the funding that you have spent to deliver the priorities set out in your local plan. It would be helpful to distinguish appropriately between your own core income and contributions from other ADP Partners. It is helpful to see the expenditure on alcohol and drug prevention, treatment & recovery support services as well as dealing with the consequences of problem alcohol and drug use in your locality. You should also highlight any underspend and proposals on future use of any such monies.

A) Total Income from all sources

Funding Source (If a breakdown is not possible please show as a total)	preventing and reducing alcohol and drug use, harm and related deaths
Scottish Government funding via NHS Board baseline allocation to Integration Authority	£1,049,582 allocation
Additional funding from Integration Authority (excludes Programme for Government Funding)	£0
Funding from Local Authority	£164,945
Funding from NHS (excluding NHS Board baseline allocation from Scottish Government)	£124,459
Total Funding from other sources not detailed above	£25,000
Carry forwards	£52,000
Total (A)	**£1,415,986**

B) Total Expenditure from sources

	preventing and reducing alcohol and drug use, harm and related deaths
Prevention (include community focussed, early years, educational inputs/media, young people, licensing objectives, ABIs)	£108,924
Treatment & Recovery Support Services (include interventions focussed around treatment for alcohol and drug dependence)	£1,064,783
Dealing with consequences of problem alcohol and drug use in ADP locality	£180,962
Total (B)	**£1,363,162**

C) 2018-19 Total Underspend from all sources: (A-B)

Income (A)	Expenditure (B)	Under/Overspend
£1,415,986	**£1,363,162**	**£52,824**

D) 2018-19 End Year Balance from Scottish Government earmarked allocations (through NHS Board Baseline)

	* Income £	Expenditure £	End Year Balance £
2018-19 investment for preventing and reducing alcohol and drug use, harm and related deaths	£1,074,582	£1,021,758	£52,824
Carry-forward of Scottish Government investment from previous year (s)	£52,000	£52,000	

Note: * The income figure for Scottish Government should match the figure given in table (a), unless there is a carry forward element of Scottish Government investment from the previous year.

2. MINISTERIAL PRIORITIES

Please describe in bullet point format your local Improvement goals and measures for delivery in the following areas during 2018-19:

PRIORITY	*IMPROVEMENT GOAL 2018-19 This should include your percentage target for each priority area where applicable.	PROGRESS UPDATE Maximum of 300 words for each priority. This should include percentage of delivery against target	ADDITIONAL INFORMATION Maximum of 150 words
1. Preparing Local Systems to Comply with the new Drug & Alcohol Information System (DAISy)	All identified staff trained in DAISy and implementation plan delivered by April 2019 – not achievable due to slippage in national timescales.	Borders ADP has continued to work with services in anticipation of DAISy Continued to attend the national DAISy implementation group and regular updates have been provided to all services involved which is overseen by the local Data & Performance Group. Anonymous records have been reduced to 0%. Services continue to improve on compliance with SDMD. The number of initial assessments completed on SDMD equated to 95% of new people starting treatment recorded on Waiting Times database. This will never be exactly 100% due to separate systems and timing.	
2. Tackling drug and alcohol related deaths (DRD & ARD)/risks in your local ADP area. Which includes - Increasing the reach and coverage of the national naloxone programme for people at risk of opiate overdose, including those on release from prison and continued development of a whole population approach which targets harder to reach groups	To supply 27 first time naloxone kits for 2018/19. Short life working group to review service responses to increase in DRD incl: - review of Risk assessments - review of potential barriers to accessing serviced	38 first time naloxone kits (141%) and 107 resupplies were issued in 2018-19 2 Training for Trainers events on provision of naloxone with 7 attendeess. Four festive naloxone drop-ins provided. DRD: Annual report produced and presented at the Critical Services Oversight Group (CSOG) Short life working group carried out specific review to increased drug deaths. No apparent 'missed opportunities' or areas of concern	Take Home Naloxone has been provided to 70% of people with problem drug use. A further target of 28 first supplies to be provided within 2019-20 has been set which would

PRIORITY	*IMPROVEMENT GOAL 2018-19 This should include your percentage target for each priority area where applicable.	PROGRESS UPDATE Maximum of 300 words for each priority. This should include percentage of delivery against target	ADDITIONAL INFORMATION Maximum of 150 words
and focuses on communities where deprivation is greatest.	- audit of adult concern forms. Contribute to the review of Substance Misuse Policy in Schools. Continue to support licensing objectives by participating in the Local Licensing Forum (LLF)	were noted. Information collated to identify learning from the case reviews and contribute to the National Drug-related Deaths Database. DRD briefing sheet provided to 186 delegates attending all ADP training events 7 overdose awareness sessions provided to 36 multi-agency staff Supported Scottish Borders Council in production of consultation materials for Alcohol in Public Places Consultation Review of current drug, alcohol and tobacco prevention programme completed. Work commenced on new resource pack with support from Crew - due November 2019. Policy being updated Presentation delivered to Galashiels Learning Community to support involvement with Licensing. Training planned in September 2019 based on AFS community toolkit. Participated in research being carried out by University of Stirling on examining the impact of alcohol licensing in Scotland and England. Borders ADP continue to represent Public Health on the Local Licensing Forum and monitor any new licence applications/variations to ensure compliance with Licensing Objectives.	equate to 75% of our estimated prevalence. **Local Drug Trend Monitoring Group:** This group continues to meet to share intelligence regarding emerging trends of drugs/alcohol use and related harm. Briefings on Alprazolam and Botulism and information on reclassification of Gabapentin and Botulism have been circulated through the Drug Trend Monitoring Group.

PRIORITY	*IMPROVEMENT GOAL 2018-19 This should include your percentage target for each priority area where applicable.	PROGRESS UPDATE Maximum of 300 words for each priority. This should include percentage of delivery against target	ADDITIONAL INFORMATION Maximum of 150 words
		Press releases/Social media in relation to FASD, 'Dry January', Responsible drinking and Count 14 issued. Display stands to promote Count 14 held in hospital and council reception.	
	90% of individuals start treatment within three week of referral No one waits longer than 6 weeks to start treatment	95% of individuals started treatment within three week of referral (n=496/472). 1 client waited 6 weeks to start treatment in 2018-19.	
	100% Compliance from all services completing Drug & Alcohol Waiting Times	100% Compliance from all services completing Drug & Alcohol Waiting Times	
	1312 Alcohol Brief Interventions to be delivered with 80% in priority settings	579 individuals (44% of target) received an alcohol brief intervention with 29% delivered in priority settings and 71% in wider settings.	**ABI:** New areas of development included Health Visitors and Adult Social

PRIORITY	*IMPROVEMENT GOAL 2018-19 This should include your percentage target for each priority area where applicable.	PROGRESS UPDATE Maximum of 300 words for each priority. This should include percentage of delivery against target	ADDITIONAL INFORMATION Maximum of 150 words
			Work Teams. Reinstatement of Local Enhanced Service in Primary care currently being explored (reinstated Autumn 2019).
3. Ensuring a proactive and planned approach to responding to the needs of prisoners affected by problem drug and alcohol use and their associated through care arrangements, including women	Provide direct alcohol and drug support and guidance to women within the justice system or vulnerable and or at risk of entering the system.	Justice Service undertook enquiry with services users regarding barriers to accessing services Service users report to being aware of the availability of local services in Scottish Borders however identify that referrals are not of assistance, when they are " not ready to engage ". ADP Support Team is a member of the local Community Justice Board. Justice Service manager is a member of the Drug Death Review Group. ADP Training calendar continues to be circulated for Criminal Justice inclusion. Colleagues from Addaction engage in the Re - Connect Woman's group though inclusion on a partner workshop rota. Voluntary and Statutory Supervision delivers within an established pathway linking, prison and community based throughcare officers with alcohol and drug support services to ensure support opportunities are available to all service users	

PRIORITY	*IMPROVEMENT GOAL 2018-19 This should include your percentage target for each priority area where applicable.	PROGRESS UPDATE Maximum of 300 words for each priority. This should include percentage of delivery against target	ADDITIONAL INFORMATION Maximum of 150 words
4. Continued implementation of improvement activity at a local level, based on the individualised recommendations within the Care Inspectorate Report, which examined local implementation of the *Quality Principles.*	Continue to implement areas for improvement based on feedback from Care Inspectorate. Review of psychological interventions (LPASS report) and audit of staff in alcohol and drugs services training to be completed.	Quality assurance of decision making within case files considered as part of NHS Patient Centred Coaching Tool and reviewed in supervision. Similar approach in place in third sector. ADP are working with NHS and SBC colleagues to review current adult advocacy provision. A review of Children Affected by Parental Substance (Mis)use (CAPSM) guidelines took place and new parental screening tool circulated. New Community Engagement Service commissioned which includes Service User involvement in ADP. Families Needs Assessment commissioned – findings events in October 2019. Review of psychological interventions report and audit of staff in alcohol and drug services training in psychological therapies completed. An additional nurse in Borders Addiction Service was trained to deliver Core Skills Coaching (for CBT-based relapse prevention) and is co-facilitating a year-long run of practice development group with Addaction, for both NHS and third sector addictions staff. Clinical Psychologist providing formal consultancy slots at third sector partner agency An in-house trauma education workshop was delivered for NHS & Third sector partners in Autumn 2018. A trauma informed practice training day for wider partners was delivered	

PRIORITY	*IMPROVEMENT GOAL 2018-19 This should include your percentage target for each priority area where applicable.	PROGRESS UPDATE Maximum of 300 words for each priority. This should include percentage of delivery against target	ADDITIONAL INFORMATION Maximum of 150 words
		by Scottish Drugs Forum as part of the ADP Workforce Development Programme. The Addictions Psychological Therapies Team provide a consultancy role within development of ARBD pathway; conducting neuropsychology assessments for suspected ARBD cases. Workforce Development: 11 free training opportunities provided to the workforce between April 2018 and end March 2019. During this time there were 186 attendees (131 individuals). In addition 62 people were trained in Alcohol Brief Intervention by Borders Addiction Service staff over several sessions within NHS, Scottish Borders Council and Police Scotland.	

* SMART *(Specific, Measurable, Ambitious, Relevant, Time Bound)* measures where appropriate

3. FORMAL ARRANGEMENT FOR WORKING WITH LOCAL PARTNERS

What is the formal arrangement within your ADP for working with local partners including Integrated Authorities to report on the delivery of local outcomes?	Quarterly Performance Reports are reviewed by the ADP Board and Executive. Annual Reports and Delivery Plans and other associated documents are formally reported via the Community Planning Committee, Integrated Joint Board, NHS Board Executive Team. The Drug Related Death Annual Report is presented to the Critical Services Oversight Group (CSOG).

In submitting this completed Investment Plan, we are confirming that this has been signed off by both the ADP Chair and Integrated Authority Chief Officer.

Appendix 3 ADP Action Plan, 2019-20

Action Plan including Ministerial Priorities 2019-20: Version (10.9.19)

1 Introduction

This plan has been produced following discussions at ADP Executive Group and ADP Board. Contributions have also been sought from the Children and Young People's Leadership Group and Community Justice Board. This action plan was originally developed in the absence of Scottish Government requesting a Delivery Plan, however, in September 2019 the Scottish Government's ADP Funding Letter outlined new ADP Ministerial Priorities and National Deliverables for 2019-20. This plan has therefore been updated to allow read across to the priorities and deliverables.

2 Structure of plan

The plan presents each of the four high level outcome areas in Rights, Respect and Recovery[4] (RR&R). Associated local actions relating to the Alcohol Framework[5] are included within the four outcome areas. There is a fifth table relating to the cross cutting work Ministerial Priority.

It should be noted that the Action Plan presents priority or new actions and does not include all ADP activity.

The four high level outcome areas are:

- Prevention and early intervention
- Developing Recovery Orientated Systems of Care
- Getting it right for children, young people and families
- Public Health Approach in Justice

In September 2019 the Scottish Government's ADP Funding Letter outlined new ADP Ministerial Priorities and National Deliverables for 2019-20 as follows:

1. A recovery orientated approach which reduces harms and prevents alcohol and drugs deaths

2. A whole family approach on alcohol and drugs

3. A public health approach to justice for alcohol and drugs

4. Education, prevention and early intervention on alcohol and drugs

5. A reduction in the attractiveness, affordability and availability of alcohol

6. Cross Cutting work

[4] https://www.gov.scot/publications/rights-respect-recovery/
[5] https://www.gov.scot/publications/alcohol-framework-2018-preventing-harm-next-steps-changing-relationship-alcohol/

It can be seen from the above list that these priority areas broadly match across the outcome areas in RR&R and so there has not been a major revision to the original plan. However, the table now includes the Ministerial Priorities and Deliverables.

Each outcome area is presented in a table containing:

- Outcomes described in RR&R
- Linked Ministerial Priority(ies)
- Targets based on ADP Core Outcome Areas (data baseline and source are included in Appendix 1 of this action plan (p33)
- National deliverables and linked actions
- Local actions for 2019-20 and associated milestone and lead agency(ies)

There is a shorter section at the end relating to the cross cutting work.

There are a small number of local actions which were included in the original plan but which do not directly correspond to the national deliverables, however, they are agreed actions appropriate in response to RR&R and therefore continue to be included.

Outcome Area 1: Prevention and early intervention

Ministerial Priority: Education, prevention and early intervention on alcohol and drugs

Ministerial Priority: A reduction in the attractiveness, affordability and availability of alcohol

1.1 Outcomes
1.11 Fewer people develop problem alcohol and drug use 1.12 Increased knowledge and awareness of drugs and alcohol issues including harmful effects 1.13 Increased skills to make positive choices around healthy lifestyles 1.14 Prevent and reduce the harm caused in pregnancy
1.2 Targets
1.21 Deliver 1312 alcohol brief interventions across Scottish Borders (80% priority settings, 20% wider settings) 1.22 Reduce prevalence of individuals over 16 yrs exceeding low risk guidelines by 5% by end 2020-21 to 19% 1.23 Reduce the percentage of 15 yr olds drinking on a regular basis by 10% by end 2020-21 to 12.6% 1.24 Reduce rate of 3 years aggregated alcohol related hospital stays per 100,000, aged 11-25 years by 10% by end 2020-21 to 275 1.25 Reduce rate of 3 years aggregated drug related hospital stays per 100,000, aged 11-25 years by 10% by end 2020-21 to 109

1.3 National Deliverables	**Related Actions/comment**
1.31 Develop plans to address stigma surrounding alcohol and drugs, including: Ensure the appropriate use of language to address stigma; Identify and improve capacity for advocacy; Ensure those in leadership roles and integral to the ADP strategy engage within people with lived living experience of using services.	1.41, 1.42, 1.43,
1.32 Engage with Licensing Forums, local partners and Licensing Boards to address overprovision and control the availability of alcohol, in line with the licensing objectives, including the public health objective.	1.44, 1.45, 1.46

1.4 Actions		
Action	**Milestone 2019-20**	**Lead**
1.41 Develop engagement plan with Area Partnerships around reduction in stigma, alcohol and drugs, and links to wider Health Improvement	Tbc	ADPST/JHIT
1.42 Develop anti-stigma work and support human rights messages	Review actions in	ADPST

- deliver one SDF Stigma course (6.9.19) - ensure all communications via Area Partnership include mention of stigma and human rights - respond to actions arising from the SFAD needs assessment	November 2019	
1.43 Complete and support re-commission of independent advocacy contract. Confirm updated contract will include dedicated time for alcohol and drug clients	New commission in place September 2020	SBC
1.44 Support to Local Licensing Forum and production of alcohol profile for 2017-18	Profile produced by October 2019	ADP Support Team (ADPST)
1.45 Increase community involvement in licensing: Contribute to SBC Alcohol and Public Places Consultation via Area Partnerships and raising at relevant multi-agency groups	Recommendation to Council by Dec 2019	ADPST
1.46 Increase community involvement in licensing: Support Galashiels Learning Community Partnership (Gala LCP) action plan relating to alcohol including SFAD community event	Event planned October 2019	ADPST/Gala LCP)
1.47 Review alcohol, drug and tobacco education and prevention within schools and within less traditional settings (e.g. youth groups, community learning and development) and produce a resource pack, CPD for teachers and parent information	Pilot pack from August 2019 and launch Nov 2019	Education
1.48 Increase awareness of the risks, increased awareness of, and improved diagnosis and support for Foetal Alcohol Spectrum Disorder based on SIGN guidance - CAMHS FASD working in partnership to develop diagnostic pathway - deliver two FASD training sessions (21 & 22.8.19) - deliver ABI and FASD refresher session for community midwives (16.6.19)	Diagnostic pathway in place by March 2020	CAMHS ADPST
1.49 Provide an accessible programme of workforce development/training to meet identified needs in partnership with Action for Children/Addaction/Borders Addiction Service/Child Protection	Programme available by May 2019 (achieved)	ADPST
1.50 Explore reinstating ABI LES within Primary Care, support increase in ABI delivery within adult health and social care teams and continue to deliver within other priority and wider settings	Attend LNC in June 2019	ADPST/PACS

Outcome area 2 Developing Recovery Orientated Systems of Care
Ministerial Priority: A recovery orientated approach which reduces harms and prevents alcohol and drugs deaths

2.1 Outcomes
2.11 People in need will have good access to treatment and recovery services, particularly those at most risk 2.12 Improved retention in effective high quality treatment and recovery services 2.13 Improve access to key interventions which will reduce harm, specifically focussing on those who inject drugs 2.14 Reduction in drug-related deaths 2.15 Reduction in drug-related general hospital admissions 2.16 Reduction in drug-related psychiatric hospital admissions
2.2 Targets
2.21 95% of clients wait no longer than 3 weeks for treatment (ongoing) 2.22 Ensure no one waits longer than 6 weeks for treatment (ongoing) 2.23 Reduce rate of alcohol related hospital stays per 100,000 by 10% by end 2020-2021 to 406 2.24 Reduce rate of 3 years aggregated drug related hospital stays per 100,000 by 10% by end 2020-21 to 68 2.25 Reduce the rate of 5 year aggregated alcohol-related mortality by 10% by end 2020-21 to 11 2.26 Reduce the 5 year rolling average of drug related deaths investigated by Borders Drug Death Review Group by 20% by end 2020-21 to 9 2.27 Maintain engagement in adult services to 60% of population of estimated problem drug users: 306 (60% of 510)

2.3 National Deliverables	**Related Actions/comment**
2.31 Update and implement plans to reduce alcohol and drug deaths local and national public health surveillance and evidence of best practice including the Staying Alive in Scotland and the Dying for a Drink reports	2.41, 2.42, 2.43, 2.44, 2.45, 2.46, 2.47
2.32 Continue to improve access to naloxone in the community and on release from custodial and hospital settings	2.48
2.33 Establish protocols between mental health and alcohol and drug services to support access and outcomes for people who experience mental health and alcohol and drug problems	2.49, 2.50
2.34 Services are delivered in line with the Quality Principles: Standard Expectations of Care and Support in Drug and Alcohol Services, including clear plans to respond to the individualised recommendations within the Care Inspectorate Reports, which examined the local implementation of these Principles	Ongoing - led by Quality Principles Group
2.35 Ensure mechanisms are in place for people with lived and living experience of addiction/recovery and of	2.51

participating in services to be involved in delivering, planning and developing services		
2.36 Continued delivery against the HEAT Waiting Times Standard.		Ongoing
2.37 Implementation of DAISy before the end of 2019 in line with national DAISy implementation plans		Ongoing
2.4 Actions		
Action	**Milestone 2019-20**	**Lead**
2.41 Complete recruitment to Assertive Engagement Service including relevant communications with partners and stakeholders and identify key performance indicators.	Service implemented by July 2019, KPI's available from September	Addaction/Borders Addiction Service (BAS)
2.42 Complete recruitment to Recovery Worker post and develop new opportunities for recovery in areas other than Galashiels	Service implemented by July 2019, KPI's available from September	Addaction
2.43 Drug services support delivery of the recommendations within the Hepatitis C virus Case Finding and Access to Care report	Action plan in place by August 2019	BBV MCN
2.44 Implement 'Assessment of Injecting Risk' tool in Addaction	September 2019	Addaction
2.45 Continue provision of Injecting Equipment Provision with annual monitoring and review visit	Review visits for 2019 completed by June (complete)	ADPST/Pharmacy/ Addaction
2.46 Work with BAS to consider evidence on suboptimal OST prescribing and current activity	Timescale tbc	ADPST/BAS/ Pharmacy
2.47 Complete assessment of strengths and weakness in delivering key harm reduction initiatives to those most at risk ***need more info from Scottish Government on how this is envisioned***	**Tbc**	SG/ADPST
2.48 Continue provision of Take Home Naloxone Programme	Issue 27 first time kits in 2019-20	BAS/Addaction/ Pharmacy/ ED
2.49 Work with mental health, assertive engagement team to deliver on improved pathways for people with co-morbidity	Initial scoping paper to Mental Health Governance October 2019	Mental health services/Assertive Engagement Team
2.50 Drug and alcohol services develop trauma informed approaches by implementing actions from LPASS (Lead Psychologist in Addiction Services Scotland) report	Action plan in place by August 2019	Quality Principles Group*

2.51 Develop process for people with lived and living experience to be involved in service design, development and delivery	Process in place by March 2020	Addaction/ADPST

*Quality Principles Group membership: ADPST, Addaction, BAS, Action for Children, Scottish Drugs Forum

Outcome Area 3 Getting it right for children, young people and families

3.1 Outcome		
3.11 Children and families affected by alcohol and drug use will be safe, healthy, included and supported in their own right and where appropriate will be included in their loved ones treatment and support		
3.2 Targets		
tbc		
3.3 National Deliverables		**Related Actions/comment**
3.31 Improve understanding of the experience of family members whose loved one is in treatment / uses alcohol and/ or drugs problematically in preparation for national work on defining the principles of family inclusive practice		3.41, 3.43
3.32 Map existing investment in and scope of family support services used by people with alcohol and drug problems in preparation for the development of a whole families approach		3.41, 3.43
3.4 Actions	**Milestone 2019-20**	**Lead**
3.41 Complete Families Needs Assessment (SFAD) and develop an action plan in response to findings which includes: • Online survey and interviews (April 2019) • Community event through Gala – LCP (July 2019) • Staff and partner training (May –June 2019)	Complete needs assessment and deliver training by June 2019 Develop action plan by November 2019	SFAD ADPST
3.42 Involve children, parents and other family members in the planning, development and delivery of services	TBC following discussion at CYPLG	TBC
3.43 Complete recruitment and implement Link Worker service including relevant communications with partners and stakeholders	Service implemented by July 2019, KPI's available from September.	Action for Children
3.44 Deliver one early years training (Oh Lila) and evaluate impact 3 months post training	August 2019	SBC Early Years/ADPST

Outcome Area 4 Public Health Approach in Justice
Ministerial Priority a Public Health approach to justice

4.1 Outcome		
4.1 Vulnerable people are diverted from the justice system wherever possible and those within justice settings are fully supported		
4.2 Targets		
TBC via Community Justice Board		
4.3 National Deliverables		**Related Actions/comment**
4.31 Identify the investment, outcomes and outputs delivered by alcohol and drug services which act as a diversion measure from justice including those services which work with people: - as a condition of sentence - in prison - leaving prison / voluntary throughcare		4.31, 4.32, 4.33
4.32 Develop improvement plans as needed		As required
4.4 Actions	**Milestone 2019-20**	**Lead**
4.41 Support development of health improvement post in Justice setting	*Under discussion*	Justice Services/JHIT
4.42 Assist women whose behaviour is affected by drugs and or alcohol to remain outwith the Court system through partnership delivery of the new Arrest Referral Service. The service is aimed at engaging with women on a voluntary basis, who come into contact with community police services at the earliest opportunity.	Performance Indicators and quality assurance measures to be developed and implemented. KPI returns to be available from July 2019 onward.	Justice Service
4.43 Develop robust health and wellbeing diversion opportunities that will be offered to the Procurator Fiscal for consideration.	Criminal Justice Officer to be recruited, June 2019 to support development, including strengthening links with drug and alcohol support services. Increased KPI returns to be available from Autumn 2019.	Justice Service

5 Ministerial Priority Cross cutting work

5.1 National Deliverables		**Related Actions/comment**
5.11 Implement the Partnership Delivery Framework to Reduce the Use of and Harm from Alcohol and Drugs		5.21, 5.22
5.2 Actions	**Milestone 2019-20**	**Lead**
5.21 Discuss governance with Integrated Joint Board	October IJB meeting	ADP Chair
5.22 Confirm timetable and implement development of Strategic Plan	Plan in place by April 2020	ADP Exec Group

Appendix to ADP Action Plan - Data Baseline and Sources

Target	Baseline (most recent data)
Outcome Area 1	
1.21 Deliver 1312 alcohol brief interventions across Scottish Borders (90% priority settings/10% wider settings) *(Source: ADP Performance Report)*	579 (2017-18)
1.22 Reduce prevalence of individuals over 16 exceeding low risk guidelines by 5% by end 2020-21 to 19 *(Source: Scottish Health Survey)*	21%
1.23 Reduce the percentage of 15 yr olds drinking on a regular basis by 10% by end 2020-21 to 12.6% *(Source: SALSUS 2019 data expected Winter 2019)*	14% (2013)
1.24 Reduce rate of 3 years aggregated alcohol related hospital stays per 100,000, aged 11-25 years by 10% by end 2020-21 to 275 *(Source: ScotPHO profiles)*[6]	306
1.25 Reduce rate of 3 years aggregated drug related hospital stays per 100,000, aged 11-25 years by 10% by end 2020-21 to 109 *(Source: ScotPHO profiles)*	121 (2014-17)
Outcome Area 2	
2.21 95% of clients wait no longer than 3 weeks for treatment (ongoing) *(Source: ISD – Drug and Alcohol Waiting Times Database)*	96% (2018-19) (470 of 492 referals)
2.22 Ensure no one waits longer than 6 weeks for treatment (ongoing) *(Source: ISD – Drug and Alcohol Waiting Times Database)*	0 (2018-19)
2.23 Reduce rate of alcohol related hospital stays per 100,000 by 10% by end 2020-2021 to 406 *(Source: ScotPHO profiles)*	412 (2016-17)
2.24 Reduce rate of 3 years aggregated drug related hospital stays per 100,000 by 10% by end 2020-21 to 68 *(Source: ScotPHO profiles)*	75 (2013/2014-2016-17)
2.25 Reduce the rate of 5 year aggregated alcohol-related mortality by 10% by end 2020-21 to 11 *(Source: ScotPHO profiles)*	12 (2013-2017)
2.26 Reduce the 5 year rolling average of drug related deaths investigated by Borders Drug Death Review Group by 20% by end 2020-21to 9 *(Source: Borders Drug Related Deaths Review Group)*	11.2 (2014-18)
2.27 Maintain engagement in adult service at 60% of population of estimated problem drug users[7] to 306 (60% of 510) *(Source: ISD – Drug and Alcohol Waiting Times Database – BAS clients only therefore assume some underreporting)*	31/3/2019 BAS Active Drug Clients = 307

[6] ScotPHO profiles available at: https://scotland.shinyapps.io/ScotPHO_profiles_tool/

[7] * Problem drug use is defined as the problematic use of opioids (including illicit and prescribed methadone use) and/or the illicit use of benzodiazepines, and implies routine and prolonged use as opposed to recreational and occasional drug use.

Appendix 4 Partnership Delivery Framework

PARTNERSHIP DELIVERY FRAMEWORK TO REDUCE THE USE OF AND HARM FROM ALCOHOL AND DRUGS

Introduction

1. This document sets out the partnership arrangements needed to reduce the use of and harms from alcohol and drugs. It aims to ensure that all bodies involved are clear about the accountability arrangements and their responsibilities when working together in the identification, pursuit and achievement of agreed, shared outcomes.

2. The new framework is designed to be consistent with, and to build directly upon:
   - The Scottish Government's Purpose and National Performance Framework[8];
   - The high-level commitment between Ministers and CoSLA to work together in partnership;
   - The established performance management arrangements between the Scottish Government and NHS Boards;
   - Statutory duties for community planning, built around a purpose that local public services work together and with community bodies to improve outcomes and tackle inequalities;
   - The Public Health Reform Programme, jointly led by Scottish Government and CoSLA, which aims to reduce health inequalities and improve life expectancy across the Scottish population. This includes the Public Health Priority: Reduce the use of and harm from alcohol and drugs;

   and
   - Scotland's alcohol and drug strategy, Rights Respect Recovery and the Alcohol Framework 2018;

3. This Partnership Delivery Framework replaces three previously agreed memoranda of understanding (MoU) between the Scottish Government and CoSLA:
   - A New Framework for Local Partnerships for Alcohol and Drugs (2009)
   - Supporting the Development of Scotland's Alcohol and Drug Workforce (2010)
   - Updated Guidance for Alcohol and Drug Partnerships on Planning and Reporting Arrangements 2015-18 (2014)

4. The Scottish Government and CoSLA undertake, and invite community planning partners, to operate within the terms of this framework.

Context

[8] https://nationalperformance.gov.scot/

5. Much has been achieved to prevent and reduce the harms experienced by individuals, families and communities and support people in their recovery. However Scotland continues to experience significantly higher levels of harm and health inequalities than other parts of the UK and Europe. This is recognised in the Public Health Reform Programme which identified 'Priority 4: A Scotland where we reduce the use of and harm from alcohol, tobacco and other drugs', as one of the key Public Health Priorities for the country over the next decade[9]. Public Health Reform recognises that this will require a focus on prevention and reducing inequalities and is best delivered by adopting a whole system approach[10].

6. In 2018 the Scottish Government published two strategic documents to address alcohol and drug harms:
   - Rights, Respect and Recovery[11]; and
   - The Alcohol Framework 2018[12]

   These documents set out a series of outcomes and priority actions for Scotland, supporting the delivery of the Public Health Priorities. This is summarised in the table below:

Vision Scotland is a country where "we live long, healthy and active lives regardless of where we come from" and where individuals, families and communities: • have the right to health and life - free from the harms of alcohol and drugs; • are treated with dignity and respect; and • are fully supported within communities to find their own type of recovery.				
Prevention and Early Intervention	**Developing Recovery Oriented Systems of Care**	**Getting it Right for Children, Young People, and Families**	**Public Health Approach in Justice**	**Alcohol Framework 2018**
Fewer people develop problem drug use	People access and benefit from effective, integrated Person centred support to achieve their recovery	Children and families affected by alcohol and drug use will be safe, healthy, included and supported	Vulnerable people are diverted from the justice system wherever possible, and those in the system are fully supported	A Scotland where less harm is caused by alcohol

   Rights, Respect and Recovery sets out the context for a Human Rights based approach. This requires 'rights bearers' and 'duty holders' work together to ensure that people's human rights are recognised and met. In the context of this strategy this means that people with experience of problem alcohol and drug use as well as those who are affected need to work with those involved in the planning, development and delivery of services to deliver shared outcomes.

7. The Audit Scotland Report, Alcohol and Drug Services – An update[13] identifies six areas where progress will help the successful implementation of the strategy:

[9] https://www2.gov.scot/Resource/0053/00536757.pdf
[10] https://publichealthreform.scot/media/1520/phob-enabling-the-whole-system-to-deliver-the-public-health-priorities-paper-22.pdf
[11] https://www.gov.scot/publications/rights-respect-recovery/
[12] https://www.gov.scot/publications/alcohol-framework-2018-preventing-harm-next-steps-changing-relationship-alcohol/
[13] https://www.audit-scotland.gov.uk/uploads/docs/report/2019/briefing_190521_drugs_alcohol.pdf

- Effective performance monitoring
- Clear actions and timescales
- Clear costings
- Spending and outcomes linked
- Public performance reporting
- Evaluating harm reduction programmes

The Partnership Delivery Framework

8. Alcohol and Drug Partnerships (ADPs) will continue to lead the development and delivery of a local comprehensive and evidence based strategy to deliver local outcomes. This should be achieved through applying a whole system approach to deliver sustainable change for the health and wellbeing of local populations.

9. Since 2009 the local delivery landscape has changed significantly. This includes the introduction of Community Justice Partnerships to replace Community Justice Authorities, and Integration Authorities have been created as a new public body to oversee the integration of health and social care services, including adult alcohol and drug services. The statutory requirements of key local partnerships and organisations in relation to strategic planning and annual reporting are summarised in Appendix 1.

Key features

10. The partnership delivery framework should include the following key features:

- A clear and collective understanding of the local system in particular its impact, how it is experienced by local communities, and how effectively it ensures human rights are met.
- Informed by the above, a locally agreed strategic plan, which sets out the long term measureable outcomes and priority actions for the local area, focussing on preventing and reducing the use of and harm from alcohol and drug use and the associated health inequalities.
- People with experience of problem alcohol/drug use and those affected are involved in the planning, development and delivery of services. This will require a shared understanding of the roles of duty holders and duty bearers in the context of a human rights based approach.
- A quality improvement approach to service planning and delivery is in place.
- Clear governance and oversight arrangements are in place which enable timely and effective decision making about service planning and delivery; and enable accountability to local communities.
- A recognition of the role played by the third sector and arrangements which ensure their involvement in the planning, development and delivery of services alongside their public sector partners.

Strategic planning

11. Each ADP should publish agreed, measureable outcomes and priority actions to reduce the use of and harms from alcohol and drugs within a strategic plan. ADPs should use the outcomes and priority actions set out in Rights, Respect and Recovery and the Alcohol Framework 2018, as well as the associated monitoring and evaluation plans, to support the development of their local strategy.

12. Through the development and delivery of the local strategy the ADP should identify where there are shared outcomes and priorities with other local strategic partnerships. In these cases they should develop shared arrangements to support delivery. As a result minimum agreement to the strategic plan and arrangements for delivering should to come from:

    - Community Justice Partnership
    - Children's Partnership
    - Integration Authority;

    The relevant statutory requirements for the local strategic plans and reporting arrangements are set out in Appendix 1.

13. Community planning requires local public sector bodies to work together with community bodies, to improve outcomes on themes they determine are local priorities for collective action. Where reducing the use of and harms from alcohol and drugs feature in these priorities, local Community Planning partners should consider how co-operation with Alcohol and Drug Partnerships can support delivery.

14. The identification of priorities and delivery of strategic plans should be underpinned by needs assessment and action plans.

<u>Financial arrangements</u>

15. Public money must be used to maximum benefit to deliver outcomes for the local population. Investment in the delivery of outcomes will come from a range of sources, including the Local Authority, Health Board and the Integration Authority, as well as outside of the public sector. Effective and transparent governance arrangements must be in place to invest in partnership to deliver the shared outcomes and priority actions in the strategy. Financial arrangements should enable the ADP to:
    - Establish a shared understanding of the total investment of resources in prevention of harm and reducing inequalities from alcohol and drugs across the local system.
    - Make effective decisions to invest in the delivery of these outcomes.
    - Ensure there is scrutiny over investments in third sector and public sector to deliver outcomes.
    - Report to local governance structures on investment
    - Report to the Scottish Government on specific alcohol and drug funding allocated to Health Boards for onward delegation to Integration authorities; and in line with financial reporting arrangements agreed with Integration Authorities.

Quality improvement

16. The Scottish Government will work with local areas to develop an approach to quality improvement based on self-assessment and peer review. This approach will cover the breadth of Rights, Respect and Recovery, the Alcohol Framework 2018; it will apply to governance, investment plans, strategic planning and service delivery. These improvement arrangements need to complement the existing inspection frameworks applied to local areas.

17. The monitoring and evaluation plans for Rights, Respect and Recovery and the Alcohol Framework 2018 will enable the Scottish Government to identify progress in delivering the strategy as well as impact. The plans will identify national performance benchmarks which will identify progress at both the national and local level. This will be published on a regular basis and will inform the focus for quality improvement work.

Governance and oversight

18. Governance and oversight arrangements for the delivery of the strategic plan and the investment of resources needs to be consistent with local governance arrangements to meet other relevant local outcomes. In practice this means that the following members of the ADP will need to ensure that effective oversight arrangements are in place to deliver the local strategy:
    - The Local Authority
    - Police Scotland
    - NHS Board
    - Integration Authority
    - Scottish Prison Service (where there is a prison within the geographical area)
    - The third sector
    - Community members

The relationship between the ADP and the Integration Authority

19. Alcohol and drug services are included within the Integration Authority scheme of delegation, alongside other adult health and social care services. Governance and oversight arrangements are needed which ensure that the directions issued by the Integration Authority to the NHS and Local Authority support the delivery of outcomes identified in the local strategic plan. Commissioning and Planning Guidance for Integration Authorities[14] sets out the required membership of the Strategic Planning Groups in this context.

20. ADPs will need to provide relevant performance and financial reporting to enable support the development of the Integration Authority's Annual Performance Report.

[14] https://www.gov.scot/publications/strategic-commissioning-plans-guidance/pages/9/

21. Healthcare services for people in prison are also included within Integration Authority scheme of delegation. Local strategic plans will need to include plans to improve outcomes for people in prisons sited within the local area; this includes considerations about the means by which people entering and leaving prison are able to access the right support.

Statutory requirements in relation to strategic planning and annual reporting

The table below summaries the statutory requirements in relation to local partnership strategic plans:

Strategic planning document	Responsible body	Legislative framework
Health and Social Care Strategic Plan	Integration Authority	Public Bodies (Joint Working) (Scotland) Act 2014
Health and Social Care Annual Performance Report	Integration Authority	Public Bodies (Joint Working) (Scotland) Act 2014
Children's Services Plan	Local Authority and Health Board	Children and Young People (Scotland) Act 2014
Community Justice Outcomes Improvement Plan	Community Justice Partners[15]	The Community Justice (Scotland) Act 2016
Locality Plan	Community Planning Partners[16]	Community Empowerment (Scotland) Act 2015 [Note: Duties apply to locally identified priorities. Only applies to alcohol or drugs where the CPP agrees that these or related issues are one of the priorities for the locality]
Local Outcome Improvement Plan	Community Planning Partners[17]	Community Empowerment (Scotland) Act 2015 [Note: Duties apply to locally identified priorities. Only applies to alcohol or drugs where the CPP agrees that these or related issues are one of the priorities for its area]
Police Scotland Local Policing Plans	Divisional Commanders	Police and Fire Reform (Scotland) Act 2012

Licensing Boards

Licensing Boards are made up of locally elected councillors and are distinct from local authorities, they have responsibilities in relation to the local administration of alcohol (and gambling) and are obliged to publish a licensing policy statement and annual report under the Licensing (Scotland) Act 2005 and Gambling Act 2005, as amended.

[15] http://www.legislation.gov.uk/asp/2016/10/section/13/enacted
[16] http://www.legislation.gov.uk/asp/2015/6/schedule/1/enacted
[17] http://www.legislation.gov.uk/asp/2015/6/schedule/1/enacted

Appendix 5 Progress report relating to new commissions

5.1 Assertive Engagement Service – Borders Addictions Service and Addaction

Key achievements to date (mid September 2019)

Recruitment

- X1 Band 6 nurse now in post (2 weeks)
- X1 Band 6 nurse in post (core BAS to support with Capacity)
- X2 Addaction worker in post

There is a weekly meeting with manager of BAS and Addaction with assertive engagement staff to commence planning for future service delivery. This includes systems, processes and referral pathway. Early preparation is ongoing of a review of all open cases to the service to identify key individuals who would be deemed "harder to reach" in order to initially take a targeted approach.

This has led to the transition of caseloads regarding x1 band 6 nurse in BAS and 1 worker in Addaction to take these patients in preparation for assertive engagement work. In Addaction conversations are in progress across the team to identify those with multiple treatment episodes, identifying barriers to accessing treatment, highlighting 'high end' clients not in structured treatment.

With the x1 band 6 core nurse this has allowed capacity to pilot a weekly drop in service within Hume Galashiels, offering access to a support worker, Addaction, BAS worker, Medical staff. If proves successful will also expand and have access to sexual health service and psychology.

It has allowed an additional drop in session with the Addaction service specifically targeting opiate dependant users to enable quicker access to prescribing and also targeting patients who use their injection equipment provision, This commenced in September 2019.

Drop-ins across both Addaction and BAS have been implemented to offer harm reduction, access to prescribing, naloxone, BBV testing and IEP supply with Assertive Engagement Team becoming involved in targeting those identified as 'hard to reach' to support follow up.

Performance against KPI's and outcomes

- No update as too early in process of service provision, however, meetings held with ADP Support Team to develop Evaluation Plan

Any barriers to progress

- No update or identified barriers at present other than delay to recruitment of second Addaction worker

Plans for next quarter

- Confirm referral document and systems for recording and progressing evaluation plan
- Increased focus on KPIs and outcomes
- All the identified "hard to reach" patients within the assertive engagement team's caseload

- Focussed target on the 40% of patients who don't opt in or DNA on their first appointment
- Closer working with police and Scottish ambulance service to support and enhance surveillance on the high risk non fatal drug overdoses and create robust referral pathways
- Review the role of substance use nurse and the links required for the assertive engagement team – Role - non fatal overdoses, follow up when discharged from acute hospital
- Establishing links to other services coming into contact with client group

5.2 Community Engagement Service – Addaction

Key achievements to date

Recruitment

- X1 Engagement Worker in post since April

i) Recovery work:

Recovery walk, Inverness September 2019:
The recovery walk is an event that has the potential to galvanise the recovery community and kick-start other recovery activities. The trip to Inverness is co produced by people in recovery, Serendipity, services and planners, supported by Scottish Recovery Consortium. A planning group was convened and also met with Serendipity Recovery Cafe and the MAP (Mutual Aid Partnership) group in Hawick. The group meets weekly and has planned transport, accommodation, catering and raised external funds.
Following the walk a 'reflection' event will take place which will help develop future work.
Hawick: Initial meeting held to develop a community asset map. Partnership with BAS and volunteers
Eyemouth: initial meeting held to bring together people with lived experience to develop recovery opportunities. Working in partnership with BAS who are developing a Recovery Hub pilot in Eyemouth.
Gala: planning to support Scottish Families Affected by Alcohol and Drugs community event in October with the Learning Community Partnership (LCP).
Links made with other key stakeholders including LCP's in Hawick and Eyemouth and the Wellbeing College.

ii) Lived experience involvement

Discussions taking place with Scottish Recovery Consortium and Scottish Drugs Forum about a potential model of involvement. Some individuals identified to participate. This work will be prioritised following the Reflective session.

Performance against KPI's and outcomes

- New opportunities for recovery are being developed. Over 20 individuals engaged with Recovery Walk Planning

Any barriers to progress

- The role aims to work closely with Serendipity Recovery Cafe. Serendipity is recovery community led and has been operating independently for several years. The community engagement role must therefore ensure a mutually supportive relationship with Serendipity without undermining the significant achievements. The co-production of the Recovery Walk will support this

Plans for next quarter

- Reflection event
- Support SFAD event in Gala
- Develop action plans for Hawick and Eyemouth
- Develop plans for Lived Experience involvement

5.3 Scottish Borders CHIMES Service, Action for Children

Key achievements

- 2 P/T staff working 25 hours each in post from 1st April 2019
- Staff have visited and updated; Social Work teams, Early Years Centres and attending occasional drop-ins at the Early years centres and bring along resources (alcohol and substance information) for themes such as 'keeping well in the winter'.
- Good interagency working with SW; joint visits have taken place to families not agreeable to SW involvement. Staff also being asked by SW to visit parents and get an update when new concerns re substance use have arisen.
- High levels of engagement with parents and children - 90% received a home visit, initial assessment and 6 sessions.
- The service has contributed to 3 parental capacity assessments.
- Whole family approach – staff feel work is more focused and more transparent due to involving all family members. Family members say that due to feeling supported (in their own right) they feel validated and this is encouraging them to keep going.
- Whole family approach – staff are being involved in family conflict resolution work. There is an acknowledgement that working with the whole family can be very difficult and can result in the opening up of years of strongly held feelings about things that have been hidden and not talked about for a long time.
- Staff are clear about the need to stick to their remit as they are often asked to complete work out with their remit, e.g. parenting work

Performance against KPIs and Outcomes

- Staff have worked with 21 parents, 32 CAPSM and 3 concerned others from 1st April to 31st Aug 2019.
- Outcomes have been achieved /met for 60% cases
- Level of risk in regard to child neglect has reduced for 60% of families.
- Level of risk of taking substances has reduced for 60% of parents.
- 80% of parents moving on from the service are engaging with APTT or employability worker at Addaction.
- Through our work one CAPSM young person placed on VYP register due to risk taking behaviour.

Barriers to progress

- Influx of referrals for months June and July and time taken to prioritise and assess need.
- High number of Child Protection cases causing cases to be held longer term work as they are labour intensive and time consuming due to number of meetings scheduled and the expectation that staff attend all meetings. Staff will always submit a report if not available to attend meetings.
- We have had to start a 'Waiting List' due to number of referrals and work not yet completed with current cases.

Plans for Next Quarter

- Reduce waiting list.

- Close cases where no/little contact.
- If capacity allows, continue with visits to pastoral staff in High Schools who have requested an update.

Appendix 6 ADP Governance Arrangements

Borders Alcohol & Drugs Partnership (ADP)

Governance Paper

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1. Situation:

There has been a need to clarify local governance and financial decision-making arrangements for the Borders Alcohol and Drugs Partnership to align with the new Health and Social Care Partnership arrangements.

2. Background:

A review in 2009 resulted in the formation of dedicated Alcohol and Drugs Partnerships in each local authority area. These new partnerships, firmly embedded within wider arrangements for community planning, were to have a much broader span of interest than the narrower remit of the previous Alcohol and Drug Action Teams. recognising that alcohol and drug issues cut across not only the conventionally defined “Health” stream of community planning but also those relating to the economy and community safety

The governance and accountability arrangements for these partnerships were to be consistent with existing accountability arrangements between the Scottish Government and local partners - chiefly, SOAs between Government and Community Planning Partnerships (CPP); and the NHS performance management arrangements.

A previous version of this paper was agreed at the CHCP in 2012.

The emerging structures supporting the Health and Social Care Partnership requires the ADP to update its governance arrangements. The Scheme of Integration includes the ADP budget therefore there will be a line of reporting to the Integrated Joint Board. This will include performance and finance reporting.

The Scottish Government funding allocation is explicit that the ADP is accountable to the CPP. The ADP submits annual reports to the CPP however there is potential to increase the visibility of the ADP and develop a greater understanding of its role and contribution.

3 Draft Governance Structure

Figure 1 (overleaf) outlines a high level draft governance structure. The ADP covers a wide range of work including prevention and intervention, treatment and support across all age-groups and a range of settings. It is not possible to discretely break down the entirety of the breadth of work across the different governance bodies as there will be cross-cutting interest and relevance across all, however, it is possible to present the key priority areas directly related to each body. These priority areas are presented in Table 1 (overleaf).

Appendix1 (p43) and 2 (p46) of this report present the ADP Constitution and Financial Framework.

Figure 1: Draft Reporting Arrangements for ADP

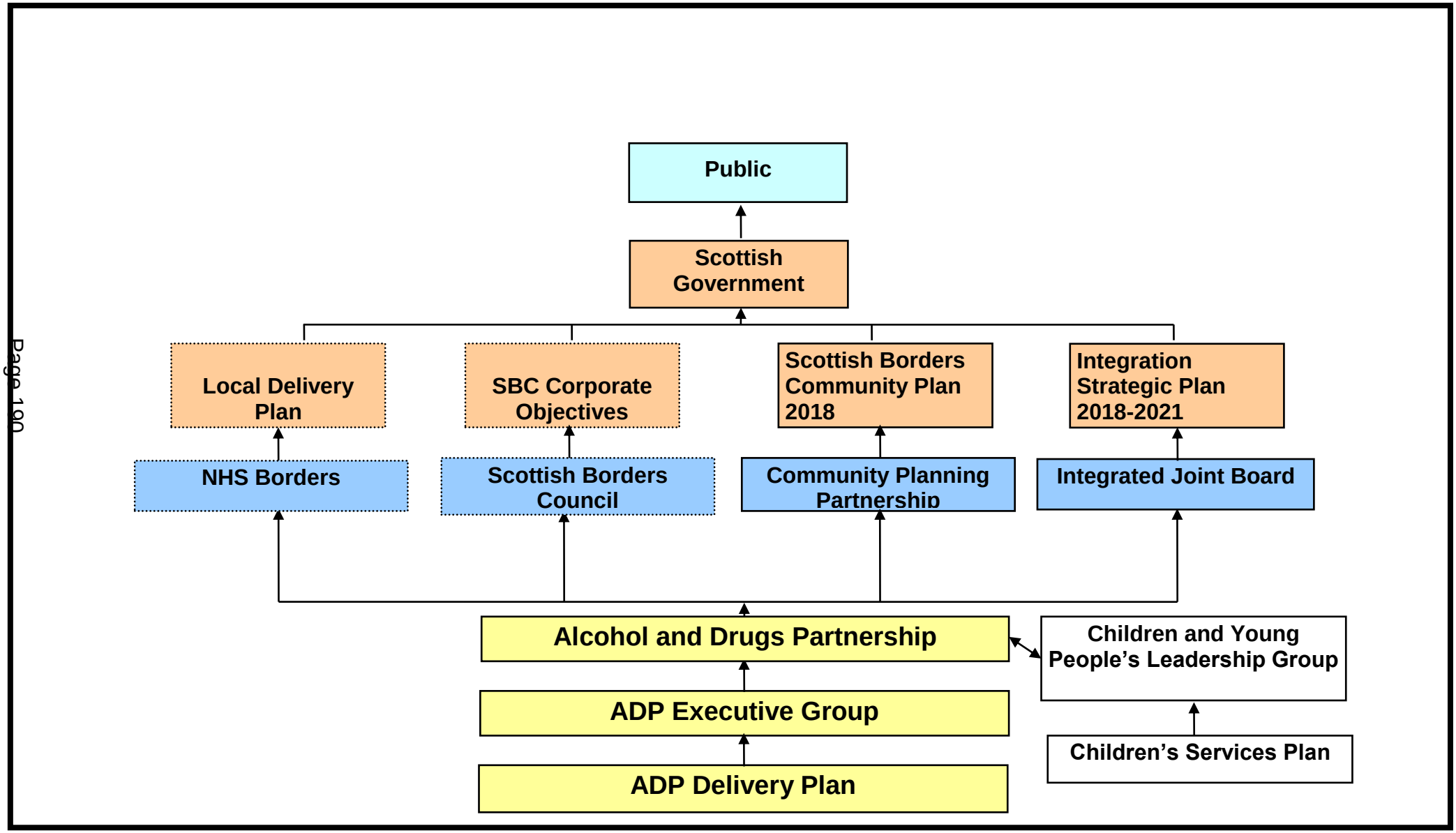

Table 1: Priority Governance Areas

Governance body	Priority Areas
1. NHS Borders	Local Delivery Plan Standards: • Alcohol Brief Interventions • Drug and Alcohol Waiting Times
2. Scottish Borders Council	Licensing Safer Communities joint work
3. Community Planning Partnership	Overview of all ADP work via Annual Report • Whole Population Approach to alcohol and drugs: Licensing, Alcohol Brief Interventions (performance), Responsible Drinking, • Recovery oriented systems of care including commissioned services • Workforce development • Ministerial priorities
Children and Young People's Leadership Group	• Children and young people's commissioned services • Children affected by parental substance misuse • Prevention and early intervention
4. Integrated Joint Board	Delegated alcohol and drugs budget: • Treatment and support services (statutory and third sector) • Alcohol Brief Interventions

4 Proposed Reporting schedule

Group	Frequency[1]	Content
ADP	Quarterly	Performance scorecard
CPP	Twice Yearly	Consultation on Annual report/ mid-year update on delivery plan
CYPLG	Twice Yearly	Consultation on Annual report/midyear update on delivery plan relating to children and young people. Performance data on commissioned service 6 monthly via commissioning group
CYPLG Commissioning Sub-group	Twice Yearly	Monitoring visits with commissioned service
Children and Young People Planning Group	Quarterly	Matters arising from Action Plan
IJB[2]	Twice Yearly	Consultation on Annual report/ mid-year update on delivery plan
Full Council	Annual	Annual Report for noting
NHS Borders Board	Annual	" "

[1] Exception reporting may occur more frequently
[2] Reporting structures to the IJB are emerging

5 Conclusion

The ADP's Annual Report provides an update on the range of work required by Scottish Government and is presented to the CPP, NHS Borders and Full Council. NHS Borders receives monthly reporting on LDP standards. It is recognised that governance arrangements are emerging in particular for the IJB.

Appendix 1 – of ADP Governance Report: Borders Alcohol And Drugs Partnership (ADP): Constitution

1. Purpose
The purpose of Borders ADP is to reduce the impact of problematic drug and alcohol use on individuals, families, communities, and frontline services by co-ordinating the work of the Statutory and Voluntary Agencies and by developing and implementing strategies for tackling drug and alcohol problems at a local level.

2. Membership
The ADP is made up of representatives from the following organisations:

- NHS Borders (Public Health, Mental Health, NHS Borders Addiction Services, Borders General Hospital)
- Scottish Borders Council (Elected Members, People Department, Community Safety Partnership)
- Police Scotland
- Lothian & Borders Community Justice Authority
- Drug & Alcohol Voluntary Organisations

Members of the ADP must be sufficiently senior representatives of their organisation to ensure that the partnership has the ability to make strategic decisions which will be carried out across the partnership. In addition to the above anyone appointed as Chairperson of any subgroup established by the ADP will be a full member of the Partnership for the duration of the appointment.

3. Ex – officio members
In addition up to 2 members of any other relevant Board or Committee within the Community Planning Partnership framework will attend. These members will be decided by the Chair or Vice Chair in regards to promoting the ADP strategic outcomes. The ADP may invite representatives of public or other groups or any individual to attend any, or all meetings, or any part of a meeting of the ADP, where the full members of the ADP consider that this will enable them to conduct the business efficiently and effectively.

All persons attending under the arrangements in this paragraph may speak to any business on the agenda, but they may not vote and may not be counted towards the required number for the ADP to form a quorum.

4. Chairperson

Appointment to the ADP will be by a nomination by other members of the partnership. If in the case there is more than one nomination this will go to a postal vote by members to agree the Chair person. The tenure of the Chairperson will be on a three yearly basis, though the ADP reserves the right to appoint a new Chairperson at any time should this be deemed necessary by the ADP members.

5. Vice chairperson
Nominations for the position of Vice Chairperson will be sought at the ADP. If there is more than one nominee a vote will be taken to decide (as per the Chair procedure). This appointment will normally be for a period of three years. At this point a new Vice Chair will be appointed this will allow continuity of business in ensuring the strategy is meeting its outcomes.

6. Conduct of meetings

- The ADP shall normally meet at intervals of not more than three months
- Meetings will be quorate when at least six full members are present.
- Meetings will be chaired by the Chairperson or Vice Chairperson. In the absence of both of these individuals, the members present will elect a Chairperson for that meeting from among their number.
- Meetings will be conducted in accordance with the current governance.
- Deputes may be sent by members by negotiation with Chair/ Vice Chair; these deputes must have clear authority from their agency to make decisions on their behalf.
- Where necessary, decisions at meetings will be made by a majority vote of members present (or deputes). Each member or depute will have one vote. In the event of a tie the chairperson will have a second casting vote.

7. Administration
Notice of meetings, including the agenda, the minutes of the previous meeting and relevant reports shall normally be circulated at least seven days in advance.

8. Sub groups
Implementation of the ADP strategy will be supported by an agreed subgroup structure. In addition, it may approve the setting up of short-life working groups to pursue specific remits, which would be chaired by a member of the ADP or another member nominated by the ADP and will report to the main group.

9. Authority
The ADP is held accountable by the Scottish Government and the Community Planning Partnership to co-ordinate and implement the national alcohol and drug strategies locally. The ADP will report to the Community Planning Partnership and the Integrated Joint Board. This accountability will relate to locally agreed outcomes which will be monitored by the Scottish Government, financial and other performance measures.

10. Support services for the ADP
The ADP and all of its sub groups will be provided with appropriate support by ADP Support Team to allow those committees/sub groups to effectively and efficiently conduct their business. Such support shall include:
- ADP Support Team (strategic co-ordination and developmental work)
- Administrative support
- Accommodation for meetings
- Such other support as may, from time to time, be required

11. Use of confidential and private information
In the course of their duties, members of the ADP will necessarily acquire certain information which may be of a private, confidential, or sensitive nature. Confidentiality is a corporate responsibility of the ADP and where indicated, issues under discussion should not form part of a wider public forum, subject to statutory legislation. Members should declare if they have a specific interest or may benefit from specific decisions e.g. funding for service providers.

12. Alterations to the constitution
Any proposed alteration to this constitution should normally be tabled at a quorate meeting of the ADP. The text of any alteration will be circulated to all members of the Committee, with the Minute of the meeting, and the proposal shall be voted upon at the next quorate meeting of the Committee. Any such proposed change shall be adopted, if approved, by a two-thirds majority of the voting members who vote at this second quorate meeting.

Appendix 2 of ADP Governance Report
Borders Alcohol & Drug Partnership (ADP) Financial Framework

1. Purpose of the Framework

The purpose of this Framework is to set out key points of understanding between NHS Borders and Scottish Borders Council on a range of material financial planning, management and control issues on behalf of the Scottish Borders Alcohol & Drug Partnership (ADP).

The scope of this framework covers arrangements for strategic financial planning; risk assessment and management; operational budget setting of earmarked drug and alcohol allocations, control and management; agreement on treatment of over/underspends and dispute resolution.

2. Parties contributions

The contributions of the parties will be amalgamated into a discreet fund hereinafter referred to as “the ADP budget”.

All monies from this budget will be used only for the provision of alcohol and drug-related services unless authorised by the ADP.

At the start calendar year of each partner must inform the host agency of the budget allocation for the following financial year. The Executive Group will then consolidate this information and present the annual allocation to the ADP.

Any reduction in funding from the previous years allocation must be notified to the ADP and explanations given.

3. Management arrangements

Once allocation levels have been established the ADP Executive Group must bring forward to the ADP annual plans on how these allocations will be spent. The Executive Group will formulate these plans using the Commissioning Strategy as the basis, which will inform the prioritisation of the local distribution of funding.

However, should any partners have particular projects they wish to have funded these must be come to the Executive Group where they will be prioritised and affordability assesses.

The Executive Group will then present a consolidated annual budget plan to the ADP containing all partners’ financial budgets and expenditure for approval. Each quarter the ADP will receive a consolidated report detailing annual budget, budget to date, expenditure to date, and year end forecast.

Where the year end forecast is significantly different from the annual budget partners will be expected to detail reason for the difference.

If the forecast under/overspend is deemed to be real the ADP will be required to take a decision on how to deal with the situation.

This may involve instructing the partners agency to bring the budget back into line or agreeing the bids for additional funds can be sources from partners, or the host agency may be asked to consider a carry forward of funds.

4. Monitoring

Executive Group will bring a draft budget plan for each financial year to the ADP in Quarter 4 of the financial year for the following year for approval. The Executive Group will receive quarterly monitoring report for discussion and approval. These monitoring reports will form the basis of a quarterly monitoring report to the ADP.

5. Governance and accountability

Both parties shall retain clinical and professional accountability within their respective corporate governance frameworks, for their personnel within the ADP budget agreement.

This responsibility may transfer to the Integrated Joint Board in the future.

No major change generated externally to the ADP services will be accepted without prior agreement from the ADP (e.g. budget reduction / savings required at an organisational level).

6. Financial management

Under the Scheme of Integration the ADP ring-fenced budget will be delegated to the Integration Joint Board.

NHS Borders will prepare and maintain financial accounts in respect of the ADP funding and Scottish Borders Council is required to provide the necessary information.

Both parties will work together to prepare:

(i) quarterly reports on payments into and out of the fund with an explanation of any variances and a forecast to the end of the financial year from the half-year position;

(ii) an annual return

(iii such other information as is reasonably required by each contributor to enable that contributor to monitor the effectiveness of this Agreement.

7. Asset management

Ownership of any capital purchases made during ring-fenced budget agreement shall remain with the purchasing organisation.

8. Dissolution of agreement

In the event of the ADP budget agreement terminating, the ADP will be responsible for preparing a jointly agreed exit strategy ensuring the needs of both service users and staff are safeguarded.