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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, 19th August, 2020** at **10.00 am** in Via Microsoft Teams

AGENDA

Time	No		Paper
	1	**ANNOUNCEMENTS AND APOLOGIES**	
	2	**DECLARATIONS OF INTEREST**	
	3	**MINUTES OF PREVIOUS MEETING**	(Pages 3 - 6)
	4	**MATTERS ARISING**	(Pages 7 - 8)
	5	**FOR DECISION**	
	5.1	Risk Management Policy & Strategy	(Pages 9 - 22)
	5.2	Alcohol & Drugs Partnership : Strategy Refresh	(Pages 23 - 90)
	5.3	Primary Care Improvement Plan : Update	(Pages 91 - 96)
	6	**FOR NOTING**	
	6.1	Performance Report	(Pages 97 - 120)
	6.2	NHS Borders Recovery Update	(Pages 121

		- 128)
6.3	Finance Update	(Pages 129 - 136)
6.4	Strategic Implementation Plan & Priorities	(Pages 137 - 144)
6.5	Strategic Risk Register Update	(Pages 145 - 154)
6.6	IJB Audit Committee Annual Report 2019/20	(Pages 155 - 158)

7 ANY OTHER BUSINESS

8 DATE AND TIME OF NEXT MEETING

Wednesday 23 September 2020
10 am – 12 noon
Either Via Microsoft Teams or
Council Chambers, SBC

Scottish Borders
Health and Social Care
PARTNERSHIP

Minutes of a meeting of the **Health & Social Care Integration Joint Board** held virtually be teleconferencing facilities on Tuesday 24 March 2020 at 10am

Present:	(v) Dr S Mather (Chair)	(v) Cllr D Parker
	(v) Cllr J Greenwell	(v) Mr M Dickson
	(v) Cllr S Haslam	(v) Mrs K Hamilton
	(v) Cllr T Weatherston	(v) Mr J McLaren
	(v) Cllr E Thornton-Nicol	
	Mr M Porteous	Mr R McCulloch-Graham
In Attendance:	Miss L Ramage	Mr R Roberts

1. APOLOGIES AND ANNOUNCEMENTS

Apologies had been received from Mr Tris Taylor.

The Chair confirmed the meeting was quorate.

The Chair reminded members that only voting members and select officers were asked to join the virtual meeting due to the current Covid19 pandemic constraints and priorities.

The Chair advised that feedback had been collated virtually and a summary was circulated the previous day.

2. DECLARATIONS OF INTEREST

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

The **Health & Social Care Integration Joint Board** noted there were none.

3. MINUTES OF PREVIOUS MEETING

The minutes of the previous meeting of the Health & Social Care Integration Joint Board held on 19 February 2020 were approved.

4. MATTERS ARISING

The **Health & Social Care Integration Joint Board** noted the action tracker.

Due to the virtual nature of the meeting the Chair advised that, after the introduction of each report, officers would address the circulated feedback and expand where necessary. Members could then verbally request further clarity timeously and where appropriate.

The Chair and members gave verbal thanks to all key workers who continue to support the local community during this difficult time.

5. DISCHARGE PROGRAMME FUNDING MODEL

Mr Rob McCulloch-Graham provided an overview of the report which gave an evaluation of the Discharge Programme presented to the last Integration Joint Board. It proposed a whole system approach to fund the continued operation of the services within the Discharge Programme: Home First, Waverly Transitional Care Facility, Garden View, the Matching Unit and Strata.

No further comments were made on the circulated feedback document.

Mr Ralph Roberts welcomed the direction of travel detailed in the report in principle to support the ongoing redesign / development of Older Peoples services, however placed emphasis on the level of risk in relation to two issues to be aware of when the IJB were supporting the recommendations.

Firstly, members must recognise that there would be an impact on implementation timescales and therefore costs as a result of Covid-19. A level of risk would be carried alongside the agreement of the report, as the assumptions used within the report were based on a non Covid-19 baseline.

Secondly, an aspect of the funding source for the Discharge Programme was reliance on the closure of a Department for Medicine of the Elderly (DME) Ward in Summer 2020 and the re-investment of a proportion of the savings from this into the Discharge programme and a proportion towards the Health Boards underlying deficit. It was therefore important to recognise that agreement to the report recommendations indicated that the IJB and partners were accepting this was the appropriate use of re-investment from any ward closure

The Chair commented that issues related to the Covid-19 pandemic would be unavoidable. A discussion ensued on the impact of postponing a decision due to Covid-19, encase of potential implementation disruptions. Mrs Karen Hamilton advised that a similar discussion had taken place between NHS Scotland Chairs who took the view to proceed with decision making processes as far as possible, with a clear caveat on services and financial risk.

Mr Rob McCulloch-Graham advised members that the local extent of Covid-19 was unknown and may well present severe demand challenges; the proposed Discharge Programme would be critical in the provision of essential capacity to support the acute team. In addition, the actions detailed in the report would have been proposed regardless of current Covid-19 issues.

Members agreed to add an additional recommendation to the report as a caveat of Covid-19 ramifications.

The **Health & Social Care Integration Joint Board** approved the funding allocations from the Transformation Fund 2020-2021, detailed in Table 2, paragraph 8.4.

The **Health & Social Care Integration Joint Board** approved that the "Step Down" facilities of Waverley Care Home be merged with the operations of Garden View, as soon it is practical and safe to do so.

The **Health & Social Care Integration Joint Board** approved that the IJB receives a further paper outlining a detailed "Direction" on the reduction of hospital beds.

The **Health & Social Care Integration Joint Board** noted that, should the effects of the Covid-19 pandemic become overwhelming, there would be an increased level of risk associated with timeline of model implementation, additional demand on service capacity and the associated unknown expense.

6. INTEGRATION JOINT BOARD 2020/21 – 2022/23 FINANCIAL PLAN

Mr Mike Porteous provided an overview of the report which presented members with the proposed Joint Financial Plan from 2020 to 2023 for formal approval. Members were asked to note that the cost of the Discharge Programme was set in the context of the overall Financial Plan.

As part of the reflection on the circulated feedback, Mr Ralph Roberts asked that an additional paragraph is added to the report to further emphasize that NHS Borders currently predicted a balanced Financial Plan for 2020/21, subject to the identified assumptions / savings plans and receipt of agreed brokerage from Scottish Government.

Members agreed to amend the recommendations to change "approve" to "accept" the provision of resource in 2020/21and to reference forthcoming IJB directions following the partner body contributions.

The **Health & Social Care Integration Joint Board** accepted the Provision of Resources from NHS Borders (£135.417m) and Scottish Borders Council (£51.477m) for 2020/21.

The **Health & Social Care Integration Joint Board** noted that in line with the scheme of integration any expenditure in excess of these delegated budgets in 2020/21 will require to be funded by additional contributions from Partners provided all appropriate steps have been taken to deliver a balanced position.

The **Health & Social Care Integration Joint Board** noted that direction detailing the allocation of resource would be issued to partner bodies after IJB ratification in due course.

The **Health & Social Care Integration Joint Board** noted that Partner bodies expect a financial impact from the work to address Covid-19. This paper assumes these costs will be separately identified and will not impact on the delegated function budgets.

7. ANY OTHER BUSINESS

Mr Rob McCulloch-Graham thanked Dr Stephen Mather for his time as the IJB Chair and wished him all the best in his retirement.

The Chair thanked colleagues for their support and participation over the years, and wished Cllr David Parker and Mr Malcolm Dickson all the best as the new IJB Chair and IJB Vice Chair.

The Chair advised an IJB Development Session was due to be held on 22 April 2020, however the continuation of the session would be informed by local response to Covid-19. **This session was subsequently cancelled**

8. 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 20 May 2020 at 10am in the Council Chamber, Scottish Borders Council.

The meeting concluded at 10.40am.

Signature: ……
Chair

Health & Social Care Integration Joint Board
Action Tracker

Scottish Borders Health and Social Care PARTNERSHIP

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	TBA	***In light of Covid-19, it is suggested that this session is delayed until safe to do so.***	R

Meeting held 19 February 2020
Agenda Item: Quarterly Performance Report

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
1	7	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed the action to expand the quarterly performance report to include social care data.	Rob McCulloch-Graham Graeme McMurdo	August 2020	***Underway.***	A

Agenda Item: Delayed Discharges

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
2	8	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed the action of asking the Executive Management Team to develop a whole system reporting framework to inform and provide context on the delayed patients across the health and social care estate.	Executive Management Team	May 2020	***Complete***	

KEY:	
R	Overdue / timescale TBA
A	<2 weeks to timescale
G	>2 weeks to timescale

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 19 August 2020

Report By:	Rob McCulloch-Graham, Chief Officer Health & Social Care
Contact:	Jill Stacey, IJB Chief Internal Auditor & SBC Chief Officer Audit & Risk
Telephone:	01835 825036

RISK MANAGEMENT POLICY & STRATEGY

Purpose of Report:	To provide for approval the new Risk Management Policy and refreshed Risk Management Strategy for the Scottish Borders Health & Social Care Integration Joint Board (SB IJB) following their endorsement by the IJB Audit Committee. Robust Risk Management within its governance arrangements will assist the IJB making informed business decisions and provide options to deal with potential problems.

Recommendations:	The Scottish Borders Health & Social Care Integration Joint Board is asked to: a) *Approve* the new IJB Risk Management Policy (Appendix 1) b) *Approve* the refreshed IJB Risk Management Strategy (Appendix 2)

Personnel:	In line with the role and responsibilities set out in the Risk Management Policy: • IJB Chief Officer leads on the identification, evaluation, control and review of the IJB strategic risks, supported by Scottish Borders Council (SBC) Corporate Risk Officer • SBC Chief Officer Audit & Risk leads on the development and review of the IJB's Risk Management Policy and Strategy.

Carers:	There is no direct impact on carers arising from the contents of this report.

Equalities:	There are no direct equalities and diversities implications arising from the contents of this report.

Financial:	There are no direct financial implications arising from the contents of this report.

Legal:	The SB IJB, established as a separate legal entity as required by the Public Bodies (Joint Working) (Scotland) Act 2014, is responsible for the strategic planning and commissioning of a wide range of integrated health and social care services across the Scottish Borders partnership area, based on resources which have been delegated to it by the partners, SBC and NHS Borders.

	The SB IJB is therefore expected to operate under public sector good practice governance arrangements which are proportionate to its transactions and responsibilities to ensure the achievement of the objectives of Integration. The establishment of robust Risk Management is one of the key components of good governance and will be critical to the capacity of the SB IJB to function effectively.

Risk Implications:	Risk Management arrangements will assist the IJB making informed business decisions and provide options to deal with potential problems in line with its agreed Risk Management Strategy within its governance arrangements. In addition to its own governance arrangements, the SBIJB places reliance on the governance arrangements adopted by NHS Borders and SBC, the partners. Where appropriate, existing mechanisms embedded within both NHS Borders and SBC will be used to provide assurance to the SB IJB on managing those risks associated with the operational delivery of services that have been commissioned by the IJB.

1 BACKGROUND

1.1 Effective Risk Management is one of the foundations of effective Corporate Governance. Compliance with the principles of sound corporate governance requires the integration authority to adopt a coherent approach to the management of the risks in a way that both addresses significant challenges and enables positive outcomes. Better and more assured risk management will bring many benefits to the health and social care partnership and the people it serves.

1.2 In order to demonstrate that robust risk management procedures are in place for health and social care integration and to comply with its Scheme of Integration and with best practice, the SB IJB approved its own Risk Management Strategy on 7 March 2016.

1.3 A review and evaluation of the efficiency and effectiveness of the IJB's risk management arrangements has recently been carried out. This has concluded that a new Risk Management Policy and a refreshed Risk Management Strategy would enhance risk management arrangements in place to ensure they are fully embedded in strategic planning, performance monitoring and reporting practices.

1.4 Part of the IJB Audit Committee's role is to scrutinise the adequacy and effectiveness of the IJB's risk management arrangements. The IJB Audit Committee considered the new Risk Management Policy and refreshed Risk Management Strategy for the SB IJB at its meeting on 9 March 2020, and recommended them for approval by the IJB.

2 RISK MANAGEMENT POLICY

2.1 The Risk Management Policy (developed in February 2020 for approval – Appendix 1) sets out the intent for managing the strategic risks of the IJB, and the roles and responsibilities of various stakeholders.

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2.2 The Policy states that it shall be reviewed annually.

3 RISK MANAGEMENT STRATEGY

3.1 The Risk Management Strategy (approved by IJB in March 2016; revised in February 2020 for approval – Appendix 2) sets out the arrangements for applying the risk management policy in practice, building on the foundation of existing risk management arrangements, and adding value by aligning risk management to the strategic planning and performance monitoring and reporting processes.

3.2 The primary objectives of the Risk Management Strategy are to:

- Ensure that the risk management framework is applied consistently and with appropriate oversight.
- Establish standards and principles for the efficient and effective management of risks affecting the delivery of the Scottish Borders Health and Social Care Strategic Plan, including regular monitoring, reporting and review.
- Identify how and what risk information will be reported to the IJB

3.3 The Risk Management Strategy includes the: governance structure; types of risks to be reported; risk management framework and process; roles and responsibilities; monitoring risk management activity and performance; and reporting of risks to the IJB. Reliance is placed on the risk management arrangements within the partner organisations in respect of the operational delivery of commissioned services.

3.4 The Strategy states that it shall be reviewed annually.

4 SUMMARY

4.1 It is important that the IJB has its own robust risk management arrangements in place because if objectives are defined without taking the risks into consideration, the chances are that direction will be lost should any of these risks materialise. The identification, evaluation, control and review of the IJB strategic risks is a Management responsibility. However, knowledge of the strategic risks faced by the IJB and associated mitigations will enable the Board members to be more informed when making business decisions.

4.2 An evaluation of the efficiency and effectiveness of the IJB's risk management arrangements will be carried out as part of the annual assurance process on the IJB's corporate governance arrangements. The output in the Annual Governance Statement within the Statement of Accounts will be considered by the IJB Audit Committee prior its approval by the IJB.

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Attachment 1

RISK MANAGEMENT POLICY STATEMENT

Introduction

The Integration Joint Board (IJB), like all organisations, faces a wide range of risks at all levels of the organisation. The aim of this policy is to communicate why risk management should be undertaken, provide a common risk management language and a description of the approach that will be adopted by the IJB to manage its strategic risks. This policy is supported by the Risk Management Strategy, which is underpinned by the Management of Risk (M_o_R) Guide and its associated framework, principles, approach and processes.

The IJB understands that effective Risk Management is one of the foundations of effective Corporate Governance which has been adopted in its Local Code of Corporate Governance. Compliance with the principles of sound corporate governance requires the IJB to adopt a coherent approach to the identification and effective management of the risks with the outcome that better and more assured risk management will bring many benefits to the IJB and the people it serves.

The IJB recognise that risk management should be aligned with strategic objectives and will therefore be considered within the strategic planning process. This ensures that the risks to achieving these objectives are identified and prioritised.

The IJB will continue to systematically identify, analyse, evaluate, control and monitor those risks that potentially endanger or have a detrimental effect upon its people, property, reputation and financial stability whether through core service delivery or through a programme of change.

Risk appetite, capacity and tolerance

Risk appetite is how much risk the IJB is willing to seek, accept or tolerate. A consistent approach to identifying and analysing risk will be followed, which will be compatible with the IJB's capacity to bear and manage risk. This will be supported by the Risk Management Strategy to ensure that the IJB, nor its stakeholders, are exposed to an unknown, unmanaged or unacceptable degree of risk. Risk tolerance will be determined by using a combination of Impact and Likelihood within the Risk Matrix followed by the IJB.

Roles and responsibilities

Integration Joint Board

The IJB Members will need to assure themselves that they have adequate information including risks and mitigations to ensure they are fully informed during decision-making and that strategic risks are being managed effectively.

Chief Officer Health & Social Care Integration

The Chief Officer Health & Social Care Integration will ensure all major decisions are subject to a risk assessment, fostering a supportive culture where all members of staff are openly able to discuss and escalate risks appropriately, and will regularly review the most significant risks threatening strategic objectives and support internal and external audits.

Scottish Borders Council Chief Officer Audit & Risk

The Chief Officer Audit & Risk (SBC) will develop and maintain IJB risk management policy and strategy, ensure these are communicated effectively, and ensure processes are in place to embed these in the IJB's culture and working practices.

Scottish Borders Council Corporate Risk Officer

The Corporate Risk Officer (SBC) will support the management of risk in the IJB by: ensuring that the processes and procedures are followed; ensuring that a strategic risk register is in place and reviewed; preparing management reports; offering training and support; and facilitating risk workshops.

IJB Audit Committee

The Audit Committee will scrutinise the adequacy and effectiveness of the IJB's risk management arrangements.

Risk management process

Risk management is not a one-off exercise. It is a continuous process because the decision-making processes it underpins are continuous. Risk management must become an integrated part of good management within the IJB, but not be over bureaucratic and a process for its own justification. To these ends it will be aligned with the strategic planning process and the performance monitoring and reporting schedule.

Risk management will be applied to every activity relating to the IJB, including programmes and projects. It will be part of the decision-making process when developing and reviewing strategic plans.

Reporting

Reporting, to support fulfilment of roles and responsibilities set within the Policy, will include:

- Bi-annual strategic risk register update reports to the IJB.
- Annual report to the IJB Audit Committee on risk management arrangements.

Quality Assurance

This policy will be subject to document control, version control, be reviewed at least annually, and be revised to reflect changes in legislation, risk management best practice, and significant changes in corporate governance.

Attachment 2

Scottish Borders
Health and Social Care
PARTNERSHIP

Scottish Borders Integration Joint Board

Risk Management Strategy

CONTENTS

1. Introduction to Strategic Approach

1.1 The Scottish Borders Integration Joint Board (IJB) is committed to a culture where the workforce is encouraged to develop new initiatives, improve performance and achieve goals safely, effectively and efficiently by appropriate application of good risk management practice.

1.2 In doing so the IJB aims to provide safe and effective care and treatment for service users, and a safe environment for everyone working within and others who interact with the services delivered under the direction of the IJB.

1.3 The IJB believes that appropriate application of good risk management will prevent or mitigate the effects of loss or harm and will increase success in the delivery of better clinical and financial outcomes, the achievement of objectives and targets, and fewer unexpected problems.

Key benefits of effective risk management:

- appropriate, defensible, timeous and best value decisions are made;
- risk 'aware' not risk 'averse' decisions are based on a balanced appraisal of risk and enable acceptance of certain risks in order to achieve a particular goal or reward;
- high achievement of objectives and targets;
- high levels of morale and productivity;
- better use and prioritisation of resources;
- high levels of user experience/satisfaction with a consequent reduction in adverse incidents, claims and/or litigation; and
- a positive reputation established for the Integration Joint Board.

1.4 The IJB purposefully seeks to promote an environment that is risk 'aware' and strives to place risk management information at the heart of key decisions. This means that the IJB can take an effective approach to managing risk in a way that both addresses significant challenges and enables positive outcomes.

1.5 The IJB promotes the pursuit of opportunities that will benefit the delivery of the Strategic Plan. Opportunity-related risk must be carefully evaluated in the context of the anticipated benefits for service users, the IJB and other stakeholders.

1.6 The IJB will receive assurance reports (internal and external) not only on the adequacy but also the effectiveness of its risk management arrangements. These assurance reports will be submitted by the partner organisations Scottish Borders Council and NHS Borders and will pertain to the relevant work streams under the strategic control of the IJB.

2. Risk Management Strategy - Implementing Health and Social Care Integration for the Scottish Borders

2.1 Objectives

The primary objectives of this strategy are to:

- Ensure that the risk management framework is applied consistently and with appropriate oversight.
- Establish standards and principles for the efficient and effective management of risks affecting the delivery of the Scottish Borders Health and Social Care Strategic Plan, including regular monitoring, reporting and review.
- Identify how and what risk information will be reported to the Integration Joint Board (IJB).

2.2 Governance structure

The Integration Joint Board (IJB) is responsible for the strategic planning of the functions delegated to it and the risks arising from that undertaking.

The IJB will identify any high level strategic risks.

The partner organisations Scottish Borders Council and NHS Borders will report any relevant risks via the reporting structures by having oversight of delivery and/or governance routes:

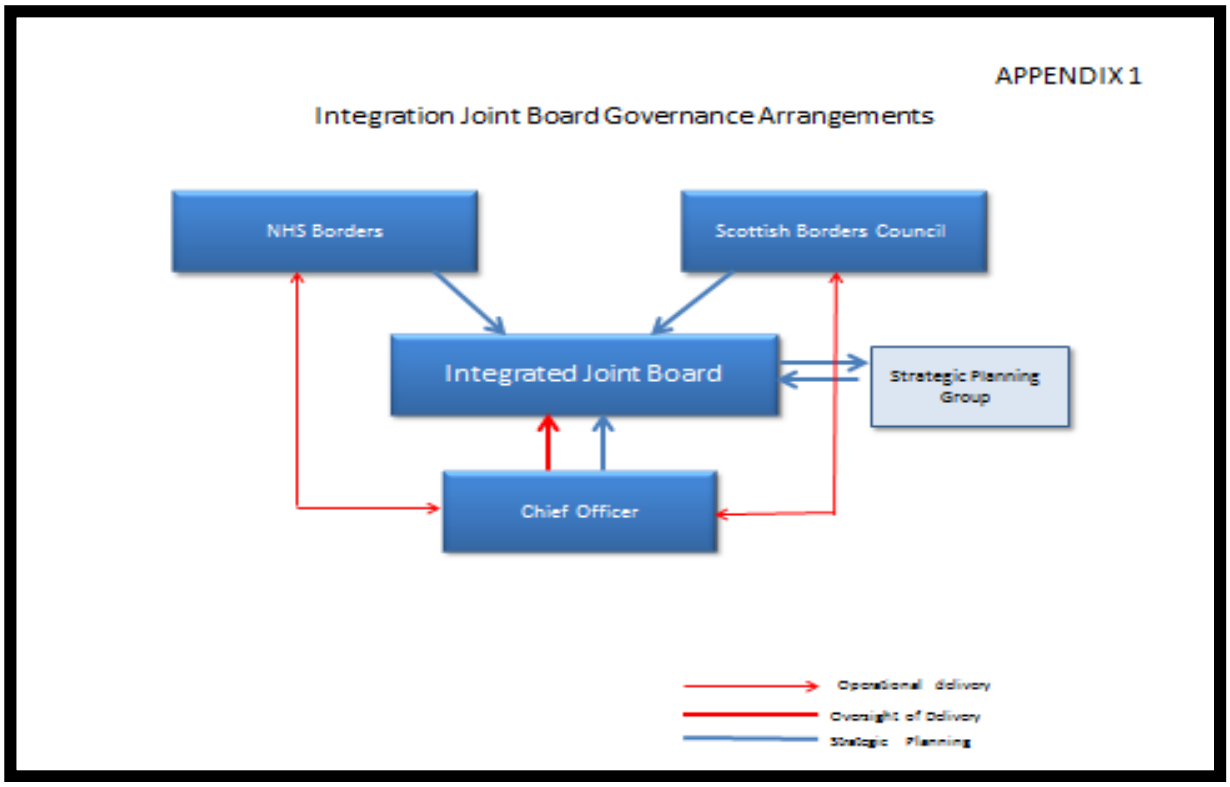

Diagram 1: Integration Joint Board Governance Arrangements Source: Scheme of Integration

2.3 Types of risk to be reported

This strategy takes a positive and holistic approach to risk management. The scope applies to all risks, whether relating to the clinical and care environment, employee safety and wellbeing, business objectives, opportunities or threats.

2.3.1 Strategic risks represent the potential for the Integration Joint Board (IJB) to achieve (opportunity) or fail to meet (threat) its desired outcomes and objectives as set out within the Strategic Plan, and typically these risks require strategic leadership in the development of activities and application of controls to manage the risks.

2.3.2 Operational risks represent the potential for impact (opportunity or threat) within or arising from the activites of an individual service area or team operating within the scope of the IJB's activities which are more 'front-line' in nature. The development of actions and controls to respond to these risks will be led by local managers and team leaders which will be overseen by the Chief Officer. Where a number of operational risks impact across multiple service areas or, because of interdependencies, require more strategic leadership or significantly impact on the delivery of the strategic plan, then these will be proposed for escalation to 'strategic risk' status for the IJB.

2.3.3 Business continuity and resilience risks will be the responsibility of the partner organisations to identify and manage. Each partner organisation must have business continuity/resilience plans in place which are developed and tested in accordance with respective Scottish Borders Council and NHS Borders internal corporate policies and arrangements.

2.4 Risk management framework and process

This document represents the risk management framework to be implemented across the services delivered under the direction of the Integration Joint Board (IJB) and will contribute to the IJB's wider corporate governance arrangements.

Risk Management is about the culture, processes and structures that are directed towards realising potential opportunities whilst managing adverse effects. It is proactive in understanding risk and uncertainty; it learns and builds upon existing good practice and is a continually evolving process that has an important role in ensuring that defensible and beneficial decisions are made.

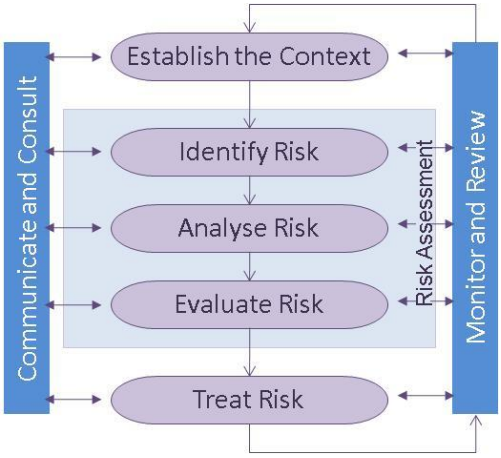

Diagram 2: Standard risk management process

For consistency the IJB will **adopt the standard risk management process** shown in the diagram on the right. This reflects the processes currently used in both partner organisations.

Risk management tools for the purpose of identification and **risk scoring will be as used by each partner organisation**.

The strategic risk register will be held by the IJB with risk information from partner organisations being utilised to help identify the relevant risks to the strategic objectives of the IJB.

Effective communication of risk management information across the services delivered under the direction of the Integration Joint Board is essential in developing a consistent and effective approach to risk management.

2.5 Roles and responsibilities

2.5.1 Integration Joint Board (IJB)

Members of the Integration Joint Board are responsible for:

- Ensuring awareness of any risks and mitigations linked to recommendations from the Chief Officer concerning new priorities, policies and decisions.
- Having oversight of its risk management arrangements and strategic or escalated risks to ensure risks are being adequately managed.
- Receiving and reviewing of risk reports on strategic risks and any key operational risks that require to be brought to its attention.

2.5.2 Chief Officer

The Chief Officer has overall accountability for the IJB's risk management framework, ensuring that suitable and effective arrangements are in place to manage the risks relating to the services delivered under the direction of the IJB. The Chief Officer will be responsible for drawing to the attention of the IJB any new or escalating risks and associated mitigations to ensure appropriate oversight and action.

The Chief Officer will keep the IJB and the Chief Executives of the partner organisations informed of any significant existing or emerging risks that could seriously impact the IJB's ability to deliver the outcomes and objectives of the Strategic Plan or the reputation of the IJB or the partner organisations.

2.5.3 Chief Financial Officer

The Chief Financial Officer will be responsible for promoting arrangements to identify, analyse, evaluate and manage key financial risks, risk mitigation and insurance for the IJB.

The Chief Financial Officer will be responsible for ensuring financial implications and risks are considered within decision making in alignment with the financial strategy of the IJB.

2.5.4 Partner Organisations

It is the responsibility of the partner organisations to provide risk information as required by the IJB as part of monitoring arrangements and/or highlight any significant single risk arising that requires immediate notification to the IJB. This risk information will be communicated via the reporting structures and when necessary by the Chief Officer.

2.6 Monitoring risk management activity and performance

Measuring, managing and monitoring risk management performance is key to the effective delivery of the objectives within the Strategic Plan.

The Integration Joint Board (IJB) operates in a dynamic and challenging environment. A suitable system is required to ensure risks are monitored for change in context and scoring so that appropriate response is made.

Monitoring will includereview of the risk profile, as defined by the content of the IJB strategic risk register, on a quarterly basis. Any new or emerging risks will be identified and escalated as appropriate to the IJB at any time.

It is expected that partner organisations will use the IJB strategic risk register to keep their own organisations updated on the management of the risks, highlighting any IJB risks that might impact on the partner organisation.

Reviewing the IJB's risk management arrangements and delivery of this Risk Management Strategy will be done onn annual basis.

Scottish Borders Council Internal Audit will review the efficacy of Risk Management arrangements and associated internal controls put in place by Management and provide independent assurance on the effectiveness of the Risk Management Strategy and activities as part of its assurance on the IJB's Corporate Governance arrangements.

2.7 Reporting of Risks to the Integration Joint Board

The IJB Strategic Risk Register will be reviewed on a quarterly basis by the Chief Officer and Chief Financial Officer. This will be done with the input from Senior Managers as necessary.

The Chief Officer will deliver bi-annual strategic risk register updates to the Board, ensuring they have adequate oversight to fulfil their role and responsibility with regard to the management of risk.

An evaluation of the efficiency and effectiveness of the IJB's risk management arrangements will be carried out as part of the annual assurance process on the IJB's corporate governance arrangements. The output will be considered by the IJB Audit Committee within the annual governance statement.

The Strategy (version 2) was approved by the Integration Joint Board at its meeting of……

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Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 19 August 2020

Report By	Tim Patterson, Director of Public Health
Contact	Fiona Doig, Head of Health Improvement/Strategic Lead - ADP
Telephone:	07825523603

ALCOHOL AND DRUGS PARTNERSHIP STRATEGIC PLAN REFRESH

Purpose of Report:	The purpose of this report is to: • seek approval for the ADP Strategic Plan Refresh for 2020 onwards • provide an update on ADP Funding 2020-21
Recommendations:	The Health & Social Care Integration Joint Board is asked to: *a)* *Approve* the Strategic Plan Refresh *b)* *Note* the Funding Update
Personnel:	Staffing is provided within the agreed resource.
Carers:	A previous needs assessment for affected family members was carried out in 2019 and this informs the draft Strategic Plan Refresh.
Equalities:	A Health Inequalities Impact Assessment will be available on 10.8.20.
Financial:	ADP funding from Scottish Government is contingent on delivery of Ministerial Priorities. There is no additional financial commitment assumed within the draft Strategic Plan Refresh. Although not funded by ADP budgets the NHS Borders Pharmacy budget for supervising dispensing of Opiod Substitution Therapy (OST) is overspent due to increasing numbers of people on the Borders Addiction Service caseload. This issue is unresolved and will be presented as a future agenda item for IJB.
Legal:	N/A
Risk Implications:	There are no immediate risks to delivery of actions, however, the timescales for year one of the refreshed plan have been revisited in light of COVID. Engagement with this particular client group can be challenging and many social and economic influences outside the control of the ADP will impact on the success of the initiatives. If statutory agencies fail to prioritise this area of work outcomes may not be achieved.

1. ADP Strategic Plan Refresh

1.1 Purpose

Alcohol and Drugs Partnerships (ADP) are required to provide an updated strategic plan from April 2020. The draft plan is attached for information and approval from IJB (Appendix 1). The associated Health Inequality Impact Assessment is included for information (Appendix 4).

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. Membership includes officers from NHS Borders, Scottish Borders Council, Police Scotland and Third Sector.

Scottish Government has requested that Alcohol and Drugs Partnerships develop 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. This should be based on 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.

It is expected that people with experience of alcohol/drug use and those affected are involved in the planning, development and delivery of services. This is in parallel with adopting a human rights approach.

ADP's are required to ensure a quality improvement approach to service planning and delivery is in place and 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.

This locally agreed Strategic Plan and associated Delivery Plan should be in place by September 2020.

The current ADP Strategy 2015-20 expired at the end of March 2020 and the ADP refreshed its strategic plan in line with the framework required above.

ADP approved this strategic plan in March 2020 and is required to seek approval from NHS/SBC Interface group prior to IJB thereafter.

1.2 Key Issues

During the term of the strategy there was a significant unanticipated workload associated firstly with the 22% reduction in ADP funding in 2016-17 and then the award of an additional £357,000 in 2018-2019. In order to implement the 22% reduction in funding, the ADP commissioned a consultant to engage with people with lived experience, staff and wider stakeholders in assessing gaps and areas for improvement in the ADP.

In response to the December 2018 announcement of additional funding for 2018-19, the ADP used the findings from the above work to support engagement with stakeholders, staff and people using services in how to allocate the funding in response to Ministerial Priorities and funding requirements. The proposals developed from this engagement process were approved by IJB in February 2019.

1.3 Assessment

There has been clear progress made in delivering the actions committed to in the 2015-20 strategy, however, there is significant concern about the number of drug related deaths. There is increased work at a national level to review alcohol related deaths and this is reflected in the Strategic Plan Refresh. The ADP is aware of the change to Public Protection procedures locally and the commitment to ensure oversight of drug related deaths is at a significantly senior level and that alcohol and drug services are appropriately engaged.

Local actions to understanding and responding to individuals with co-morbid experience of alcohol and/or drug use and mental health concerns are considered within the mental health transformation work, however, it will be an expectation for the ADP to consider their support/input to this work.

There is work to do to improve the voice of lived experience in planning and delivery of services and conversations are currently taking place on how to do this effectively. People with lived experience continue to experience stigma and the APD awaits with interest support from Scottish Government on adopting a rights approach and how best to deliver anti-stigma messages. There is currently a draft Stigma Strategy developed by the national Drug Death Task Force which will inform local actions.

The Partnership Delivery Framework is clear in its expectation of statutory partners as key players in this arena. These are namely: Children's Planning Partnership (Children and Young People's Leadership Group); Community Justice Board and Integrated Joint Board. The ADP must ensure that these statutory partners continue to develop and share actions and responsibilities relating to alcohol and drug use; this is not the job of the ADP Support Team and Commissioned Services alone. This is likely to include a commitment to workforce development.

Summary of gaps/areas for improvement:

- Involvement of lived experience
- Further development of recovery communities
- Alcohol pathways
- Co-morbidity with mental health and long-term conditions
- Stigma
- Strategic partnerships

1.4 Recommendation

This paper recommends that Health & Social Care Integration Joint Board approve the ADP Strategic Plan Refresh for 2020 onwards.

2.0 Summary note for IJB: Funding allocation 2020-21

2.1 Introduction

The update provides information relating to ADP Funding 2020-21 including spend for 2019-20. Due to reporting delays finalised spend for 2019-20 and projections for 2020-21 will be confirmed at the ADP meeting in August.

2.2 Funding

The Scottish Government's (SG) funding letter for 2020-21 outlines three different SG streams (Appendix 2). The table below summaries funding streams outlined in the funding letter.

Funding route	Amount	Description
1. Baselined in NHS Boards for delegation to IJB	£1,049,582	Recurring
2. Increased investment of 5% from NHS Boards	£52,479	Recurring
3. Programme for Government	£358,278	Non-recurring (ends March 2021, future not confirmed)
4. Drugs Death Task Force funding	£26,688	Non-recurring (from April 2020-March 2022). Subject to SG approval of proposals.

2.3 Baselined in NHS Boards for delegation to IJB - £1,049,582

This is unchanged since 2016-17.

This funding is fully allocated for 2020-21.

2.4 Increased investment of 5% from NHS Boards

The funding letter notes that NHS Boards are expected to increase investment for ADP projects by 5% over this recurrent budget. This would equate to an additional £52,479.

NHS Directors of Finance have raised a concern in relation to the 5% increase. At time of writing it is not confirmed if this money will be available to Borders ADP in 2020-21.

This funding was only notified in the funding letter. Due to the uncertainty relating to this budget stream no spend has been committed against this funding.

2.5 Programme for Government funding - £358,278

This is unchanged since 2018-19. Funding is released based on local spend. Allocation of this funding was agreed at IJB in February 2020.

2.6 Drug Death Task Force funding - £26,688

This is new funding and will only be released on the basis of an approved proposal to address gaps based on six national priorities.

The ADP submitted a proposal to SG on 26th June 2020 (Appendix 3) and requested funding in relation to two priorities as shown in the table below.

Priority	Proposal	Total £ requested
Priority 3: Optimising medication-assisted treatment (MAT);	Support anticipated increase in prescribing costs associated with compliance with MAT standards	£15,000
Priority 4: Targeting people most at risk	Improve harm reduction response including wound care training, additional injecting equipment provision, extension of harm reduction group.	£11,650
	Overall total	**£26,650**

Feedback was received from Scottish Government on 25 July 2020 as follows:
Priority 3: Declined
Priority 4: Agreed to fund additional IEP - amount funded not yet confirmed.

The ADP Support Team is currently seeking a meeting to discuss the feedback with Scottish Government colleagues.

2.7 Summary ADP Financial Statement

RECURRING INCOME	
Alcohol Prevention, Treatment and Support	£1,049,582
BBV MCN	£25,000
Total available	**£1,074,582**
Expenditure planned 2020-21	
Commissioned Services	
Borders Addiction Service (NHS Borders)	£508,209
Low- Moderate Needs & Integration Service (We Are With You)	£205,556
Chimes (Action for Children)	£133,000
Primary Care - Locally Enhanced Service for ABI	£25,000
Prescribing and pharmacist support (NHS Borders)	£10,480
Advocacy - BIAS	£5,000
Third Sector Representation - Scottish Drugs Forum	£3,000
Total commissioned services	**£890,245**
Support functions	
ADP Support Team - Pays & Supplies	£128,088
NHS Borders Corporate Support	£44,504
Development Fund (administered via ADP Support Team)	£3,000
Service User Involvement (via ADP Support Team)	£2,000
Star Outcomes (outcome recording tool)	£1,386
Responsible Drinking (via ADP Support Team)	£500
Neo data recording (injecting equipment provision recording)	£4,000
Total support functions	£183,478
TOTAL PLANNED SPEND 2020-21	**£1,073,723**
NON RECURRING INCOME	
Programme for Government Funding	**£357,000**
Recovery Service (We Are With You)	£39,000
Engagement Service (We Are With You, BAS, NHS Borders Pharmacy)	£242,000
Family Engagement (via ADP Support Team)	£3,000
Advocacy (tbc)	£15,000
Children Affected by Parental Substance Use Link Worker (Action for Children)	£58,000
Total PfG spend	**£357,000**
Drug Death Taskforce Funding	**TBC**
Awaiting funding decision	

APPENDIX ONE
ADP Strategic Plan Refresh 2020

Table of Contents

Foreword

The ADP aims to improve the health and quality of life for all of us by working to ensure that that individuals, families and communities live in an area where fewer people are using alcohol and drugs and, for those that do, recovery is a realistic option.

Since the publication of our 2015-2020 strategy[1] significant changes have taken place in terms of legislation and guidance and these are outlined in Section 3. Significant progress has been made locally in developing our services to provide earlier access to treatment and also we are proud of our growing recovery community led by Serendipity. However, this progress is overshadowed by the continuing and shocking rise in drug related deaths. The number of drug related deaths in Scotland reached its highest ever in 2018 and it is expected that 2019 will be even higher. Borders is no different; in the first four years of our strategy (2015-2018) we lost 47 people to drug deaths (2019 data not available).

Responding to the Public Health emergency of drug related deaths requires a whole system approach, we are confident that our alcohol and drugs services in Borders are performing well and changing practice in respond to need. I would also ask key partners to become more involved in addressing the needs of some of our most vulnerable individuals and families.

We were pleased to see the inclusion of a rights based approach to the recent alcohol and drugs strategy[2] and a reminder that people have the right to health and life – free from the harms of alcohol and drugs.

This strategy provides context and a high level overview of where our identified gaps and areas for improvement are in Borders. We have also agreed a two year delivery plan which outlines the new actions we will take. This strategy was developed in consultation with colleagues and people with lived and living experience of alcohol and drug use. I extend my thanks to them for their commitment, insight and wisdom.

Update: This document was finalised by Borders Alcohol and Drugs Partnership (ADP) in March 2020 subject to approval via local governance arrangements. At that time we were starting to deliver a response to COVID-19 which, of necessity, put final approval on hold and which has interrupted delivery of some of the actions described in section 7. Timescales for these will be updated in the ADP Delivery Plan 2020-22.

Tim Patterson
ADP Chair
Joint Director of Public Health

[1] Borders Alcohol and Drugs Partnership Strategy http://www.nhsborders.scot.nhs.uk/patients-and-visitors/our-services/general-services/alcohol-and-drugs-partnership-(adp)-support-team/key-documents/local-adp-strategies/

[2] Rights, respect and recovery: Scotland's strategy to improve health by preventing and reducing alcohol and drug use, harm and related deaths https://www.gov.scot/publications/rights-respect-recovery/

1 Introduction

The Scottish Borders Alcohol & Drugs Partnership (ADP) is tasked with delivering a reduction in the level of drug and alcohol related problems amongst young people and adults in the Borders, and reducing the harmful impact on families and communities. We are committed to working with the Scottish Government, colleagues, people with lived experience and local communities to tackle the problems arising from substance use.

This refreshed Strategic Plan builds on the work directed by the previous ADP Strategy and reflects current local context, new Ministerial Priorities and updated national strategies[3] as outlined in Section 4 below and is a response to the national Partnership Delivery Framework for ADPs[4].

In line with the national strategies our refreshed Strategic Plan is aligned to the chapter headings in Rights, Respect and Recovery as follows:

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

2 ADP membership

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

- NHS Borders (Public Health, Mental Health, NHS Borders Addiction Service)
- Scottish Borders Council (Elected Members, Social Work, Safer Communities Team)
- Police Scotland
- Drug & Alcohol Third Sector organisations

The ADP is currently chaired by the Joint Director of Public Health for NHS Borders and Scottish Borders Council (SBC). The Vice Chair is the Chief Social Work Officer for SBC.

3 Context

Our 2015-2020 Strategy was underpinned by previous strategic documents related specifically to alcohol and drugs as well as the introduction of the Children's and Young People (Scotland) Act 2014[5]. At the time of writing that strategy the process of Health and Social Care Integration was taking place which has led to a different local landscape including the way in which ADP funding is reported.

[3] Alcohol Framework, 2018, next steps on changing our relationship with alcohol https://www.gov.scot/publications/rights-respect-recovery/

[4] Alcohol and Drugs Partnership Delivery Framework available at: https://www.gov.scot/publications/partnership-delivery-framework-reduce-use-harm-alcohol-drugs/

[5] The Quality Principles: Standard Expectations of Care and Support in Drug and Alcohol Services available at: https://www.gov.scot/publications/quality-principles-standard-expectations-care-support-drug-alcohol-services/

During the timeline of the 2015-20 Strategy a series of significant national developments took place which impacted on ADPs:

- December 2015: ADP's were informed of 22.4% reduction to ring-fenced funding from 2016-17.
- January 2016: introduction of new Chief Medical Officer alcohol guidelines
- January- July 2016: the Care Inspectorate undertook a 'validated self-assessment' of ADPs in line with the Quality Principles.[6]
- April 2017: introduction of new Health and Social Care Standards
- Programme for government 2018: ADP's were informed of additional funding for 2018-19 which was confirmed in August 2019
- November 2018: publication of Rights, Respect and Recovery (RR&R) (ii) and the Alcohol Framework (ii)
- July 2019: publication of Partnership Delivery Framework for ADPs
- November 2019: publication of RR&R Action Plan
- January 2020: draft monitoring framework for RR&R issued[7]

Various legislative changes have also taken place:

- May 2015: Introduction of Air Weapons and Licensing (Scotland) Act 2015 (consideration of licensing objectives and over provision)
- May 2016: Introduction of Psychoactive Substance Act 2016
- May 2019: Introduction of Alcohol (Minimum Pricing) (Scotland) Act 2012
- October 2019: New drug driving offence

In addition to 'business as usual' the ADP and its Support Team was required to respond to each of these developments and/or changes, at a time when all partners continue to work in a landscape where public sector services are required to make year on year efficiency savings within increasingly constrained budgets.

4 Context – Rights, Respect and Recovery

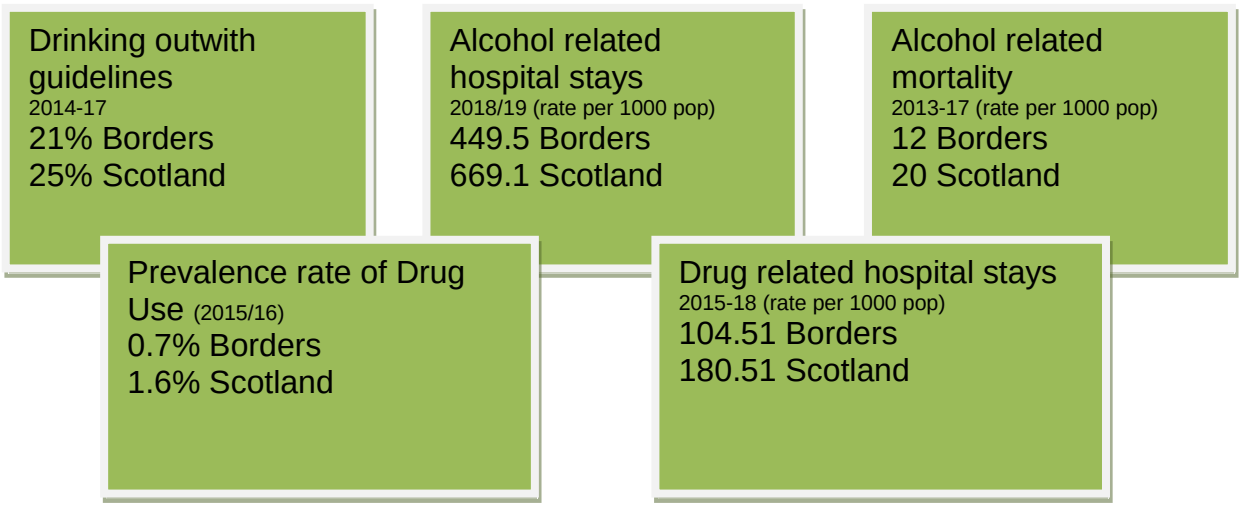
The following infographic from Rights, Respect and Recovery (reproduced with permission from Scottish Government) clearly illustrates the national context in which ADPs and partners are working.

[6] The Health and Social Care Standards available at: http://www.newcarestandards.scot/

[7] RR&R Monitoring Framework available at: TBC


High-risk alcohol and problematic drug use remains high
Drug related deaths and hospital admissions are increasing and remain too high for alcohol
Problematic alcohol and drug use disproportionately impacts deprived communities
Complex needs of an ageing population
More needs to be done to protect those most at risk of harm and death
Dynamic and changing drugs market and challenges
Stigma remains a significant barrier
Services need to be person-centred, trauma-informed and better integrated
The whole family needs support
Respect, diversity and ensure equity
Fewer people (including young people) are using drugs and drinking alcohol
Recovery communities are flourishing
Information and evidence is vital
The Justice System has a role to play
Need to build on Partnership working

5 Local Data (May 2020)



For more information on data relating to Borders please see ADP Technical Report available here

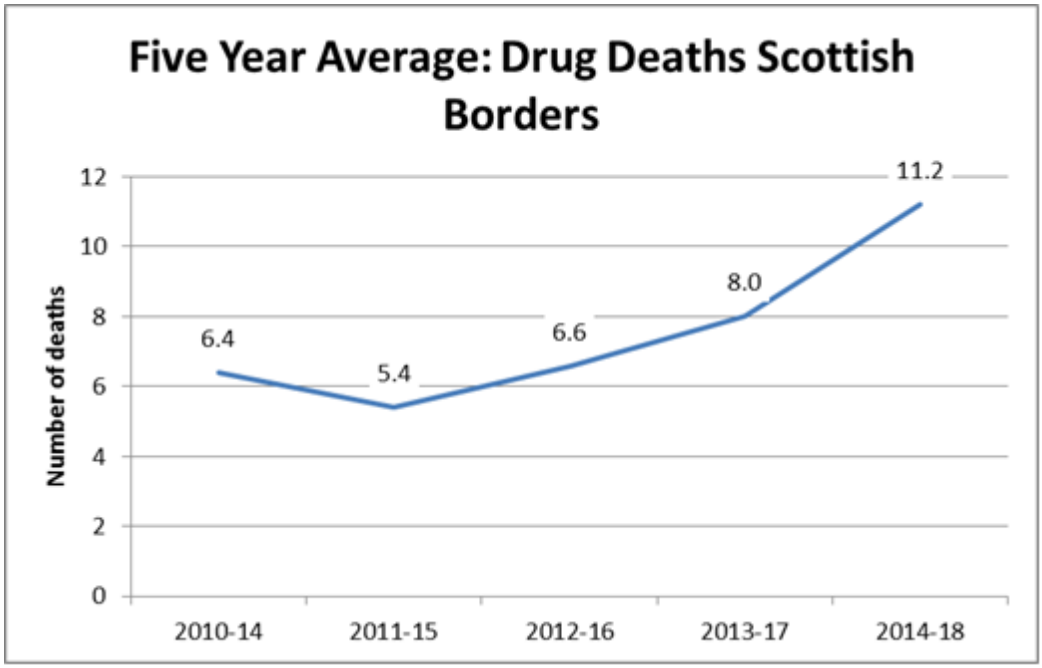
6 Drugs Deaths – a Public Health Emergency

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 one death was out with the remit of the DDRG.

The following table sets out how Borders death rates based on estimated prevalence of drug users compare with seven similar local authority areas.

Area	Estimated number of problem drug users (2015/16)	Number of drug deaths according to NRS (2018)	Drug deaths as a percentage of the population at risk
Scottish Borders	510	22	4.3%
Moray	270	17	6.3%
Highland	1400	36	2.6%
East Lothian	920	18	2.0%
Argyll & Bute	560	9	1.6%
Stirling	1000	19	1.9%
Midlothian	760	14	1.8%
Angus	800	13	1.6%

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.



At the time of writing, the data for 2019 was not available. This is due to a delay in national toxicology processes which are outwith local control. However, based on local intelligence we expect another year where we sadly lose another significant number of people.

In our last strategy we highlighted the actions we would take to reduce drug related deaths. We have taken the following actions forward since the last strategy:

- The local Naloxone Co-ordinator provides overdose prevention training within the ADP Workforce Directory and also offers a bespoke service.
- Participants in all ADP training and events are provided with a drugs deaths briefing which outlines risk factors and circumstances for drug deaths.
- Provision of Take Home Naloxone has extended to Addaction*, pharmacies providing injecting equipment and Accident and Emergency. Funding has been agreed for ensuring all community pharmacies have access to naloxone for use in an emergency situation.
- Alcohol and drug service make proactive contact with families who have been bereaved by drugs deaths.

- Scottish Families Affected by Alcohol and Drugs provide 'Bereaved by substance use' training as part of the ADP Workforce Development Directory All first appointment letters contain information about (SFAD) helplines.

*NB Addaction rebranded to 'We are with you' as of 26 February 2020. Actions relating to the service previous to the rebranding will be noted as Addaction. Future actions will be recorded as 'We are with you'.

In 2018, in response to the concerning higher numbers of deaths, 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.

In January 2020 a briefing was issued by Scottish Government of evidence based emergency responses to drug related deaths; the table below provides a high level assessment of Borders progress at May 2020.

Evidence based strategy	Borders Assessment
Targeted distribution of naloxone	Since March 2011 first supplies of naloxone have been provided to 75% of out estimated targeted population. Going forward we will look to expand naloxone supply into Mental Health Settings.
Implement immediate response pathway for non-fatal overdoses and target people most at risk	A local protocol is in place between Scottish Ambulance Service and Borders Addiction Service, however, referrals are low. Borders Addiction Service and Addaction deliver an Assertive Engagement Service which aims to make rapid contact with individuals who are not or have ceased engaging with services. Going forward this team will lead on developing improved alcohol and drug pathways for patients attending acute hospital.
Optimise use of medication-assisted treatment (MAT) – this involves low barrier access to treatment (e.g. methadone); appropriate dose levels	Borders Addiction Service and Addaction are trialling 'drop-in' clinics for those at highest risk and successfully initiating the majority of prescriptions within 7 days (48%* same day). *Quarter 3 2019-20 Going forward we will work towards implementing MAT Standards once

	published.
Ensure equivalence of support for people in the Criminal Justice System	There is no prison in Borders and the majority of Borders citizens tend to be released from HMP Edinburgh. Positive relationships are in place between local services and the Justice Service.

Our emergency response: Drug Death Task Force January 2020

On 26 February 2020 a Drugs Death Workshop was held in Borders. This was facilitated by SDF and linked to the Staying Alive Toolkit. Immediate actions arising from this workshop are being followed up. A report was received from SDF in May and it was agreed at the DDRG that an action plan would be developed and progressed by the ADP Quality Principles sub-group which next meets in September 2020.

Scottish Government has convened a Drugs Death Task Force which has as its primary role to co-ordinate and drive action to improve the health outcomes for people who use drugs, reducing the risk of harm and death. The ADP Support Team is represented on the Task Force.

The ADP believes it is taking a robust approach to reducing drug deaths and this will continue in 2020 and beyond.

7 Areas for Improvement

While the high level outcome areas and aims are set through RR&R, we have identified gaps/areas for improvement which the ADP is required to address within this high level Strategic Plan. Over the period of the last strategy significant work was done to assess current performance and gaps/needs in our system particularly in response to the removal of ADP funding and the investment of new monies released in 2018-19.

In preparation for refreshing this Strategic Plan a progress report was developed which updated on work related to objectives in the previous strategy. This was presented to the ADP Executive group. The ADP Executive Group agreed an approach to refreshing the Strategic Plan through consultation on gaps/areas for improvement with key partners including people with lived experience. This inclusive approach acknowledged the significant previous engagement work. An updated progress report[8] was shared with and discussed with people with lived experience

and wide stakeholders to help develop this refreshed Strategic Plan. This report was updated throughout the process in response to findings.

A list of groups involved in the refresh is included in Appendix one.

Based on this consultation work the following areas for improvement have been identified and shared by partners.

7.1 Prevention and early intervention:

Stigma continues to be a concern for people affected by alcohol and drugs. Stigma can lead to prejudice and discrimination and prevent people with problems, and their families, from seeking help. It can also impact on the help provided.

In addition, stereotypical reporting of drug and alcohol use in printed and social media can perpetuate stigma while there is little reporting on positive recovery.

The incidence of childhood adverse experiences and experience of trauma in people using alcohol and drugs is well evidenced, however, the portrayal of some our most vulnerable people via printed and social media can compound the difficulties experienced.

Reducing stigma will be of benefit to individuals, families and communities experiencing impact of alcohol and drug use.

7.2 Developing Recovery Orientated Systems of Care (ROSC)

7.21 Co-morbidity

In the foreword to this Strategic Plan Refresh the ADP Chair noted the developments and improvements in service delivery and options for people with alcohol and drugs problems. An improvement approach, however, requires us to consider where services can be further developed. Locally we have identified a need to improve responses for people with co-occurring alcohol and/or drug use and mental health problems and also clarity of pathways for responding to alcohol care, particularly post hospital discharge.

We have also identified that people with alcohol and/or drug use are more likely to experience physical ill-health and co-occurring long term conditions.

Public Health England[9] note that alcohol and drug problems are common among people with mental health problems and cite evidence that people with co-occurring conditions are often unable to access the care they need from both mental health and addiction services. Locally staff and people with lived experience have reported that it is not always possible to readily access correct support for people who have concurrent alcohol and/or drug problems and mental health concerns. Some initial scoping work has been undertaken to try to confirm the extent to which individuals within our relevant services self-report (or are diagnosed) with co-occurring problems. Mental health services in Borders are undergoing significant transformation and understanding and addressing the needs of this cohort are part of that work with which the ADP will want to be involved.

7.22 Alcohol Pathways

During our consultation staff and people with lived experience described missed opportunities for intervention relating to people's alcohol consumption, in particular relating to people who may have emergency hospital admissions for a variety of conditions but where there is an underlying contributory factor from their alcohol use.

It is also the case that initial work on an Alcohol Related Brain Damage (ARBD) pathway including awareness raising and training is still to be fully implemented and it is anticipated that this work will continue during the lifetime of this strategy.

A stakeholder workshop to review alcohol pathways and identify areas for improvement was planned for May 2020. This was postponed due to COVID and will take place in Autumn 2020. Actions arising from this work will be included in the ADP Delivery Plan 2020-2022.

7.23 Recovery opportunities

As well accessing high quality services for treatment and support to reduce harm from alcohol and drug use, a ROSC requires opportunities for people to both address wider aspects of their

[9] [9] Better care for people with co-occurring mental health and alcohol/drug use conditions available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf

lives and also take steps towards recovery which is away from the harm experienced towards a healthier and more fulfilling life. While recovery remains a contested term and will mean different things for individuals there is recognition that recovery activities and communities can reduce social isolation, provide peer and mutual support, allow safe spaces to connect with others and help reduce stigma as people see visible recovery.

Activists in rural areas such as Borders face particular challenges. A challenge for many services in Borders is transport, however local activists potentially experience increased stigma as people are less 'anonymous' than in cities. Also, there is a smaller population from which to develop activists. In Borders, however, Borders Recovery Community has sustained the Serendipity Cafe in Galashiels and are ambitious to spread their success. In December 2019 Serendipity and Addaction hosted their first joint Christmas party.

The ADP has funded a whole time post in We Are With You to support development of recovery opportunities in partnership with the local recovery community.

There is a role for ADP partners to support this work through providing training and capacity building opportunities for activists and ensuring that they remain up to date with the work of the community.

7.24 Involvement of lived and living experience in planning of services

Over time Borders ADP has tried different approaches to involving people with lived experience in developing and planning services and while services have made improvements in their recruitment and client feedback, we have not found a consistent, regular and meaningful way of finding a way to have the voices of people with lived experience influencing the work of the ADP.

At a meeting of the ADP Executive Group in December 2019 people with lived experience discussed an approach which will be further explored in early 2020.

This is a workstream requiring to be prioritised in this strategic plan.

7.3 Getting it right for children, young people and families

At the time of writing the governance and structure for the Children and Young People's Leadership Group (local Children's Planning Partnership) is under review. The CYPLG is a statutory consultee in developing this Strategic Plan.
The expected arrangements for the CYPLG will include oversight of alcohol, drugs and tobacco work and the needs of impacted children.

Local protection arrangements have also recently been reviewed in order to deliver Public Protection Services (PPS) where co-located children and adult protection; domestic abuse and community safety staff will adopt a 'think family' approach to their work. ADP Support Team is represented on the Delivery Groups for the PPS and the Assertive Engagement Team is a confirmed link to operational work.

The ADP considers a key role to continue to raise awareness of the needs of children impacted by another's alcohol and/or drug use. During Spring-Summer 2020 training in Oh Lila (learning for children age 3 to 5 years which aims to build resilience and protective factors in young children, helping them to develop social skills and encouraging them to communicate) was commissioned for all local authority early years staff. This is a significant investment but will provide assurance that the needs and responses to this group are highlighted in this session. The delivery of these sessions is incomplete due to COVID. The training provided is exploring how best to deliver the remaining sessions.

The ADP is supportive of Alcohol Focus Scotland's work to support children's right to an alcohol free childhood and will continue to support the local Licensing Board to support its Licensing Objectives including protecting and improving public health and protecting children and young people from harm.

A new package of resources held on Glow (School Intranet) was launched in November 2019 for teachers across Scottish Borders Schools (Primary and Secondary) on drugs, alcohol and tobacco education and prevention. These resources are age and stage appropriate and linked to Curriculum for Excellence, experiences and outcomes and benchmarks held on GLOW. At time of writing this strategy there has been 12,800 visits to the site.

The next stage of this work will be to consider education-based approaches that are delivered in line with evidence-based practice to reach our children and young people not present in traditional settings, such as Youth Groups and Community Learning and Development. This work will align with any national recommendations from Scottish Government.

7.4 A Public Health Approach in Justice

A partnership between Borders Community Justice, Statutory Justice Social Work Services and NHS Borders Public Health is developing a Wellbeing Worker post. The focus of the post will be to assist people who find themselves within the Justice System, many of whom present as socially and financially disadvantaged, to overcome barriers with regard to the attainment of healthier life styles. Advice, signposting and 1:1 or group learning opportunities will be offered to all those who are made subject to a Community Payback Order or other community disposal. Outcomes will be focused on the improvement of dental hygiene, physical and mental wellbeing and drug and alcohol related issues.

7.5 Crosscutting work

Strategic Partnerships
Throughout the discussions in developing this Strategic Plan the significant progress and innovation from the alcohol and drugs services was acknowledged. ADP members and partners continue to have a role to ensure the needs and rights of our client groups are addressed and to ensure appropriate priority is given to the needs of people with alcohol and/or drug related problems particularly during this challenging time in public services.

7.6 Summary of gaps/areas for improvement:

- Involvement of lived experience
- Further development of recovery communities
- Alcohol pathways
- Co-morbidity with mental health and long term conditions
- Strategic partnerships

8 Monitoring progress

Supporting this strategy is an ADP Delivery Plan 2020-22 (and subsequent two-year plans) which sets out key activities, indicators and timescales against each of the Core Outcomes listed to address our strategic aims.

Progress will be monitored via the following mechanisms:

- Monthly reporting on alcohol and drugs service waiting times target

- Monthly reporting on ABI target
- Quarterly performance report to ADP and ADP Executive Group
- Quarterly financial report to the ADP and ADP Executive Group
- A minimum of six monthly contract monitoring meetings with commissioned services
- Bi-annual Alcohol Profile updates will collate local information relating to alcohol related harm
- Annual Reports based on the Strategy and Delivery Plan will be submitted to the IJB, CPP and Scottish Government.
- Regular feedback and engagement with people with lived experience based on agreed future ways of working

In future we will be expected to report on the MERRR framework. At time of writing the process for this is not confirmed.

9 Conclusions

Locally there has been significant progress from our previous strategy, however, there are identified gaps areas for improvement requiring attention of ADP partners as outlined above. The strategic approach outlined above informs our 2020-2022 Delivery Plan.

Appendix Groups Consulted

Discussions to inform this strategy were held with the following groups:

- Children and Young People's Leadership Group
- Community Justice Board
- Integrated Joint Board Leadership Group
- People with lived experience – We Are With You (previously Addaction)
- Serendipity Recovery Cafe members
- Staff from alcohol and drugs services

Appendix 2

Population Health Directorate
Health Improvement Division
E: alcoholanddrugsupport@gov.scot

Scottish Government
Riaghaltas na h-Alba
gov.scot

ADP Chair
Integration Authority Chief Officer

Copies to:
NHS Board Chief Executive
Local Authority Chief Executive
NHS Director of Finance
Integration Chief Finance Officer
ADP Co-ordinators

29th May 2020

Dear ADP Chair and Integration Authority Chief Officer

SUPPORTING THE DELIVERY OF ALCOHOL AND DRUG SERVICES: 2020-21 FUNDING ALLOCATION, PROGRAMME FOR GOVERNMENT FUNDING AND MINISTERIAL PRIORITIES

1. I write to provide detail about the funding arrangements, Ministerial priorities and planning and reporting arrangements for Alcohol and Drug Partnership (ADP) work for 2020-21. These arrangements will support the delivery of Rights, Respect and Recovery *Scotland's strategy, to improve health by preventing and reducing alcohol and drug use, harm and related deaths*, and the Alcohol Framework 2018: Preventing Harm – *next steps in changing our relationship with alcohol.*

Funding Allocations

Baselined funding

2. The Scottish Governments direct funding to support ADP projects in 2020-21 has been transferred to NHS Board via their baseline allocations for onward delegation to Integration Authorities (**IAs**) for ADP projects. .

3. NHS Boards are expected to increase investment for ADP projects by 5% over the recurring 2020-21 budget. This increase is detailed in **Appendix 1**.

Programme for Government

4. An additional £20 million was announced as part of the 2017-18 Programme for Government to support improvement and innovation in the way alcohol and drug services are developed and delivered as part of the Rights, Respect and Recovery strategy and the Alcohol Framework 2018 Preventing Harm. In the previous financial year (2019-20), £17 million was allocated directly to ADPs through the Local Improvement Fund. The same amount is available for 2020-21 as set out in **Appendix 2**. We are aware that several IAs are holding earmarked ADP reserves. As agreed through the Chief Finance Officers network, we ask that IAs utilise earmarked ADP reserves in 2020-21 before accessing new funding.

Drugs Death Taskforce Funding

5. The primary role of the Drug Deaths Taskforce is to co-ordinate and drive action to improve the health and wellbeing outcomes for people who use drugs, reducing the risk of harm and death. A total of £3 million has been identified by the Taskforce for spend by ADPs and a breakdown of allocated by Integrated Authority is provided in **Appendix 3**; allocations are based on the prevalence of drug problems. To receive this funding ADPs are required to submit a proposal, clearly setting out how they will use this funding to address gaps in delivering the Taskforce's six evidence-based strategies to help reduce drug-related deaths[1]. These include:

- Targeted distribution of naloxone;
- Having an immediate-response pathway for non-fatal overdose;
- Optimising medication-assisted treatment (MAT);
- Targeting people most at risk;
- Optimising public health surveillance; and
- Ensuring equivalence of support for people in the criminal justice system.

6. The application form, timeframes and other further information are also set out in Appendix 3. Please note that all bids must be submitted by **5pm Friday 26th June 2020** to **alcoholanddrugsupport@gov.scot** otherwise they will not be considered for funding.

7. The Taskforce has also established a £1 million research fund with further information available *here* and a further fund of £5 million to support innovative tests of change to address drug harms and deaths initiated by the Taskforce subgroups.

8. Ministers are clear that we still face a public health emergency in relation to drug deaths and that services should be protected during the Covid-19. The minister and the Chief Medical Officer have been clear that alcohol and drug services are essential services and that pre-COVID-19 service levels be maintained for this at-risk group.

9. The Minister is also clear that the full funding allocation for all the funding streams covered in this letter should be expended on the provision of projects and services which deliver locally agreed outcomes in relation to reducing the use of, and harm from, alcohol and drugs. Projects should be agreed in partnership through ADPs. The allocations described in this letter represent the minimum amounts that should be expended on these services in 2020-21. We fully expect that additional resources, including funding, will continue to be invested in reducing alcohol and drug harms and deaths. Further, all of these resources should be invested transparently in partnership, and be informed by the evidence base to deliver priorities within local strategic plans and be based on an appropriate and current needs assessment.

Context for Delivery

10. Scottish Ministers have established five priorities which underpin the delivery of national strategies: Rights Respect and Recovery and the Alcohol Framework in 2020-21. The priorities are consistent with the previous year and cover both alcohol and drugs, with the exception of priority 5 which refers to alcohol only:

i. A recovery orientated approach which reduces harms and prevents deaths
ii. A whole family approach
iii. A public health approach to justice
iv. Prevention, education and early intervention
v. A reduction in the affordability, availability and attractiveness of alcohol

[1] https://www.gov.scot/publications/drug-deaths-taskforce-emergency-response-january-2020/

11. These priorities will inform our national plans to deliver these strategies, as well as our requirements in relation to local ADP annual reports. **Appendix 5** sets out more detail on the Ministerial priorities. **Appendix 6** provides some links which may be helpful in delivering Ministerial Priorities. **Appendix 7** provides the detail for the Local Delivery Plan Standards: Alcohol and Drug Waiting Times and Alcohol Brief Interventions.

COVID-19

12. Scottish Ministers recognise that the response to COVID-19 is the overarching priority for ADPs during the pandemic. Your ongoing work, contingency planning and efforts to support the alcohol and drug community is recognised and is much appreciated by Ministers and the Scottish Government Teams. Focus should continue on the continued delivery of alcohol and drug services in line with the joint letter from the Minister and the Chief Medical Officer dated 16th April and available *here*.

Planning and reporting arrangements

13. The Scottish Government and COSLA have worked with a range of stakeholders to develop a *Partnership Delivery Framework*, which published in July 2019 to support local planning arrangements to address alcohol and drug harms. This sets out joint expectations about the role and function of ADPs in in delivering Rights, Respect and Recovery and the Alcohol Framework.

14. The deadline for the completion of ADP strategic plans has been extended to 21 September 2020, in recognition of ADP ongoing challenges locally in response to COVID-19.

15. A new template of the annual report will follow later in the year. This will cover the reporting year 2019-20.

16. If you have any queries on the content of this letter, please contact Ruth Winkler or Geraldine Smith at: alcoholanddrugsupport@gov.scot.

Yours sincerely

Elizabeth Sadler
Deputy Director, Health Improvement Division
Population Health Directorate

APPENDIX 1 – SUPPORTING THE DELIVERY OF DRUG AND ALCOHOL SERVICES: 2020-21 SCOTTISH GOVERNMENT DIRECT FUNDING ALLOCATIONS INCLUDED IN NHS BOARD BASELINE AND THE EXPECTED ALCOHOL AND DRUG UPLIFT

NHS Board	2019-20 Allocation (£)	2020-21 Allocation including the 5% uplift (£)
Ayrshire & Arran	3,538,392	3,715,311
Borders	1,049,582	1,102,061
Dumfries & Galloway	1,531,827	1,608,418
Fife	3,297,788	3,462,677
Forth Valley	2,653,555	2,786,232
Grampian	4,511,429	4,737,000
Greater Glasgow & Clyde	14,479,282	15,203,246
Highland	2,847,456	2,989,828
Lanarkshire	5,424,984	5,696,233
Lothian	8,887,134	9,331,490
Tayside	4,158,654	4,366,586
Orkney	427,044	448,396
Shetland	462,201	485,311
Western Isles	530,673	557,206
Total Scotland		
	53,800,001	**56,490,001**

* 2020-21 funding allocation includes 5% uplift to NHS Board baselines for onward delegation to Integration Authorities (IAs) for ADP projects

APPENDIX 2 – PROGRAMME FOR GOVERNMENT: LOCAL IMPROVEMENT FUND INVESTMENT IN SERVICES TO REDUCE PROBLEM ALCOHOL AND DRUG USE

ALLOCATION TO INTEGRATION AUTHORITIES

Integration Authority	Allocation (£)
Aberdeen City	662,695
Aberdeenshire	721,450
Angus	363,927
Argyll and Bute	314,290
Clackmannanshire and Stirling	434,122
Dumfries and Galloway	504,745
Dundee City	498,274
East Ayrshire	411,380
East Dunbartonshire	308,929
East Lothian	314,738
East Renfrewshire	265,923
Edinburgh	1,425,019
Falkirk	489,003
Fife	1,159,099
Glasgow City	2,046,396
Highland	781,756
Inverclyde	278,798
Midlothian	271,129
Moray	293,936
North Ayrshire	460,605
North Lanarkshire	1,085,055
Orkney Islands	82,380
Perth and Kinross	463,688
Renfrewshire	577,343
Scottish Borders	358,278
Shetland Islands	82,745
South Ayrshire	382,468
South Lanarkshire	1,008,328
West Dunbartonshire	310,244
West Lothian	532,777
Western Isles	110,481
	17,000,000

Appendix 3: Drug Deaths Taskforce Funding

This appendix sets out:

- Section 1: allocations made to each ADP
- Section 2: The application form
- Section 3: Guidance to release this funding

Section 1: Allocations made to each ADP

Integration Authority	Allocation (£)
Aberdeen City	125,589
Aberdeenshire	62,794
Angus	41,863
Argyll and Bute	29,304
Clackmannanshire and Stirling	85,249
Dumfries and Galloway	57,561
Dundee City	120,356
East Ayrshire	83,726
East Dunbartonshire	37,153
East Lothian	48,142
East Renfrewshire	41,863
Edinburgh	313,972
Falkirk	62,794
Fife	146,520
Glasgow City	622,711
Highland	73,260
Inverclyde	78,493
Midlothian	39,770
Moray	14,129
North Ayrshire	83,726
North Lanarkshire	188,383
Orkney Islands	1,570
Perth and Kinross	78,493
Renfrewshire	141,287
Scottish Borders	26,688
Shetland Islands	8,896
South Ayrshire	49,189
South Lanarkshire	209,314
West Dunbartonshire	57,561
West Lothian	68,027
Western Isles	2,616
	3,000,000

Section 2: Guidance to releasing Drug Deaths Taskforce Funding

Background

The Drug Deaths Taskforce has established six evidence based Strategies to reduce drug deaths and drug harms. These are set out *here*. Section 1 sets out the further funding available to support Integration Authorities to provide these services where they are not already in place for all those at risk in the local area. All bids must be developed in partnership through ADPs to ensure they are aligned to existing approaches across the local alcohol and drug strategy.

Applying for additional funding

ADPs must complete the application form in Section 3 of this Appendix and should be submitted by email to alcoholanddrugsupport@gov.scot by **Friday 26th June 2020.**

All applications must be signed off by the IA Chief Officer as well as the ADP Chair.

Applications can only be made for the allocation set out in Section 1 of this Appendix. For example Aberdeenshire can submit an application for a maximum of £125,589.

Applications should only cover the evidence based Strategies where the IA/ADP has identified that there are gaps in delivery and further funding is required.

Applications will be reviewed by a panel made up of representatives from the Drug Deaths Taskforce including people with lived experience. The criteria used to assess the bids will be as follows:

- Clear understanding of the gaps in service delivery
- Relevance of the proposal to the evidence based Strategy
- Relevance of the proposal to meet the gaps identified in service delivery
- Innovative and person centred approach

Decisions will be communicated to ADP Chairs / IA Chief Officers by **Friday 24th July 2020.**

Section 3: The application form

Priority 1: Targeted Distribution of Naloxone
Please set out your current progress in delivering priority 1, including the current gaps in delivery
Max 300 words
Please set out your proposals to address these gaps/enhance existing delivery, with costings
Max 500 words
Please set out your baseline and expected improvement against national or local indicators, including timeframes. E.g. • On 31 By 31 March 2021 (number) of Naloxone kits will have been distributed from community settings • By 31 March 2021 (number) of Naloxone kits will have been distributed from prison settings.

Priority 2: Implement Immediate Response Pathway for Non-fatal Overdose
Please set out your current progress in delivering priority 1, including the current gaps in delivery.
Max 300 words
Please set out your proposals to address these gaps / enhance existing delivery, with costings
Max 500 words
Please set out your baseline and expected improvement against national or local indicators, including timeframes. E.g. By 31 March 2021 an increase of (number) of people will have receiving immediate and proactive offer of treatment and support following a non-fatal overdose.

Priority 3: Optimise the use of Medication-Assisted Treatment
Please set out your current progress in delivering priority 3, including the current gaps in delivery.
Max 300 words
Please set out your proposals to address these gaps / enhance existing delivery, with costings
Max 500 words
Please set out your baseline and expected improvement against national or local indicators, including timeframes. E.g. By 31 March 2021 same day prescribing will be available at a further 8 treatment service access points for all those assessed as requiring OST.

Priority 4: Target the People at Most Risk
Please set out your current progress in delivering priority 4, including the current gaps in delivery.
Max 300 words
Please set out your proposals to address these gaps / enhance existing delivery, with costings
Max 500 words
Please set out your baseline and expected improvement against the national indicators set out below, as well as any local indicators

Priority 5: Optimise Public Health Surveillance
Please set out your current progress in delivering priority 5, including the current gaps in delivery.
Max 300 words
Please set out your proposals to address these gaps / enhance existing delivery, with costings
Max 500 words

Priority 6: Ensure Equivalence of Support for People in the Criminal Justice System
Please set out your current progress in delivering priority 6, including the current gaps in delivery.
Max 300 words
Please set out your proposals to address these gaps / enhance existing delivery, with costings
Max 500 words
Please set out your baseline and expected improvement against national or local indicators, including timeframes. E.g. By March 2021 an increase of (number) of people will have started treatment following intervention prior to arrest.

Summary of funding required

Priority	Total £ required
Priority 1	
Priority 2	
Priority 3	
Priority 4	
Priority 5	
Priority 6	
Overall total	

Please indicate any proposed or actual reductions in funding for alcohol and drug services in 2020/21.

Area of service delivery	Funding reduction £	Proposed / actual	Impact

Signed ADP Chair: **Signed IA Chief Officer:**

Date: **Date**

APPENDIX 4– NATIONAL CONTEXT FOR ADP FUNDING

Measuring Success

Rights, Respect and Recovery[2] and *The Alcohol Framework 2018*[3] and the *Partnership Delivery Framework to Reduce the Use of and Harm from Alcohol and Drugs*[4] collectively provide the national framework for delivering alcohol and drug prevention, treatment and support in Scotland.

The Monitoring and evaluation framework for Rights, Respect and Recovery (MERRR)[5] was published on 9 March 2020 by Public Health Scotland. This will sit alongside the MESAS (Monitoring and Evaluating Scotland's Alcohol Strategy) programme, as the evaluation plan for the Alcohol Framework 2018. Together these plans will set out outcome indicators, performance measures and evaluation studies to enable an assessment of progress against the delivery of these strategies at a national level.

The monitoring and evaluation plans will also lead to the development of a series of national benchmarks which will be used to identify progress against the implementation of the strategies at a local and national level.

In the meantime, National Services Scotland, Information Services Division, continue to update the ScotPHO profiles. The profiles can be accessed here: http://www.scotpho.org.uk/comparative-health/profiles/online-profiles-tool.

National Support

The SG National Support Team takes forward key projects to deliver national strategic priorities; it is also available to support capacity building, sharing of learning and good practice amongst ADPs in order to promote the delivery of our national strategic priorities. Examples of the support available include:

- Establishing effective governance arrangements and strategic plans
- Benchmarking local governance, service systems and delivery approaches
- Support with the use of data to understand need and evidence progress
- Implementing quality improvement approaches
- Liaising with nationally commissioned organisations (Scottish Drugs Forum, Scottish Recovery Consortium, Scottish Families Affected by Alcohol and Drugs, Crew, Scottish Health Action on Alcohol Problems and Alcohol Focus Scotland) to provide support on:
    - Developing recovery-oriented systems of care through system redesign including community, prison and prison through care services
    - Putting in place a whole population approach to reducing alcohol use and preventing alcohol harm
    - Workforce development
    - Supporting family members
    - Developing recovery communities
    - Involving people with lived and living experience of addiction, recovery and participating in services in the delivery, design and planning of services.
    - Developing plans to reduce drug and alcohol deaths and harm.

[2] https://www.gov.scot/publications/rights-respect-recovery/
[3] https://www.gov.scot/publications/alcohol-framework-2018-preventing-harm-next-steps-changing-relationship-alcohol/
[4] https://www.gov.scot/publications/partnership-delivery-framework-reduce-use-harm-alcohol-drugs/
[5] http://www.healthscotland.scot/publications/monitoring-and-evaluation-framework-for-rights-respect-and-recovery

We strongly encourage ADPs to use the national support available to them. Please contact Ruth Winkler at alcoholanddrugsupport@gov.scot if you wish to discuss opportunities for support.

Public Health Reform

Public health reform is a partnership between the Scottish Government and COSLA. It is a programme of work which aims to challenge our current ways of working, put more decisions directly in the hands of citizens and provide support to local communities to develop their own approaches and solutions to local population health challenges

To deliver the vision for public health reform, Scottish Government and COSLA:

- Have agreed public health priorities for Scotland that are important public health concerns and that we can do something about
- Will establish a new national public health body for Scotland bringing together expertise from Public Health Scotland, Health Protection Scotland and Information Services Division
- Will support different ways of working to develop a whole system approach to improve health and reduce health inequalities.

There are six public health priorities for Scotland:

1. A Scotland where we live in vibrant, healthy and safe places and communities.
2. A Scotland where we flourish in our early years.
3. A Scotland where we have good mental wellbeing.
4. A Scotland where we reduce the use of and harm from alcohol, tobacco and other drugs.
5. A Scotland where we have a sustainable, inclusive economy with equality of outcomes for all.
6. A Scotland where we eat well, have a healthy weight and are physically active.

Further information on public health reform is available at https://publichealthreform.scot/

Health and Social Care Integration

The Public Bodies (Joint Working) (Scotland) Act 2014 provides a statutory framework for the integration of health and social care delivery in Scotland. The legislation provides that both in-patient and community based addictions functions are delegated to Integration Authorities (IAs). It is important that ADPs continue to make effective connections into local decision-making and raise awareness of alcohol and drug issues to inform local priorities, ensuring Strategic and Delivery plans for alcohol and drug outcomes are embedded within local Health and Social Care arrangements.

ADPs should enable joint decision making, across local strategic partnerships such as, Community Justice Partnerships, alongside IAs to address alcohol and drug harms.

Drug Deaths Taskforce

The Drugs Deaths Taskforce was established in July 2019 by the Minister for Public Health and Sport, supported by the Cabinet Secretary for Justice, to tackle the rising number of drug deaths in Scotland.

The 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 taskforce has published a number of documents to support the work to reduce drug deaths across Scotland, including:

- Preventing drug related deaths in Scotland: emergency response strategies - January 2020
- Drug Deaths Taskforce: COVID-19 Recommendations– 16 April 2020
- Drug Deaths Taskforce: COVID-19 and opiate replacement therapy

Further information about the Taskforce is available *here*.

APPENDIX 5 – MINISTERIAL PRIORITIES AND NATIONAL DELIVERABLES FOR 2020-21

The Minister has set out the following five priorities and a series of improvement goals for 2020-21. ADPs will be asked to report progress against these improvement goals in their annual reports

Ministerial Priorities	National deliverables 2020/21 against which local areas will report against in their annual reports
1. A recovery orientated approach which reduces harms and prevents alcohol and drugs deaths	• Update and implement plans to reduce deaths from alcohol and other drugs, making use of best practice outlined in Staying Alive in Scotland, Dying for a Drink and the forthcoming Alcohol Deaths Review Guidance from Alcohol Focus Scotland, in collaboration with local partners. • Implementation of the Drug Death Task Forces six evidence based strategies to reduce drug- related deaths. • Continue to improve access to naloxone in the community and on release from custodial and hospital settings • 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 • 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. (https://www.gov.scot/publications/quality-principles-standard-expectations-care-support-drug-alcohol-services/) • Ensure mechanisms are in place for people with lived and living experience of addiction/recovery and of participating in services to be involved in delivering, planning and developing services • Continued delivery against the Local Delivery Plan Standards Waiting Times Standard. (See appendix 7) • Implementation of DAISy before the end of 2020 in line with national DAISy implementation plans (https://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Drug-Alcohol-Information-System/)
2. A whole family approach on alcohol and drugs	• 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 • 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. A public health approach to justice for alcohol and drugs	• 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 through care • Develop improvement plans as needed
4. Education, prevention and early intervention on alcohol and drugs	• 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. • Meet the Local Delivery Plan – the Alcohol Brief Interventions (ABIs) Standard to ensure delivery of the target overall for your area with 80% of ABIs delivered in priority settings. (See appendix 7) • Support the delivery of the SG's Count 14 campaign to raise awareness of the UK Chief Medical Officers' lower-risk maximum weekly drinking guidelines. Amplify the campaign at a local level utilising partnerships, media and online resources.
5. A reduction in the attractiveness, affordability and availability of alcohol	• 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.
Cross Cutting work	• Implement the Partnership Delivery Framework to Reduce the Use of and Harm from Alcohol and Drugs • Contingency Planning in relation to COVID-19

As a part of local strategic planning ADPs should set their own actions, improvement goals, measures and tests of change, alongside the national deliverables, to drive quality improvement at a local level.

Local improvement measures for delivering Ministerial priorities should be described in the 2020-21 ADP Reports due for completion in autumn 2021. Further information will be forthcoming on these reports.

Appendix 6 – USEFUL LINKS

The following links may be helpful in delivering the Ministerial Priorities:

Scottish Neighbourhood Statistics (SNS) website – enter the range of ADP Postcodes (top left of the home page), or use an Area Profile for ADP area (lower right of the home page) statistics.gov.scot

National Records of Scotland information on alcohol deaths:
https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths/alcohol-deaths

ISD alcohol and drug misuse publications: http://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/

National Records of Scotland information on drug-related deaths data -
https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths/drug-related-deaths-in-scotland

Scotpho alcohol and health and wellbeing profiles:
https://www.scotpho.org.uk/

Staying Alive in Scotland – Strategies to Combat Drug Related Deaths;
http://www.sdf.org.uk/wp-content/uploads/2019/08/Staying-Alive-in-Scotland-Aug-2019-Digital.pdf

Dying for a Drink - Circumstances of, and contributory factors to, alcohol deaths in Scotland: results of a rapid literature review and qualitative research study
http://www.shaap.org.uk/images/dying-for-a-drink-text_for_web.pdf

Older People with a Drug Problem in Scotland: Addressing the Needs of an Ageing Population. http://www.sdf.org.uk/wp-content/uploads/2017/06/Working-group-report-OPDPs-in-2017.pdf

The world drug perception problem: countering prejudices about people who use drugs
http://www.globalcommissionondrugs.org/wp-content/uploads/2018/01/GCDP-Report-2017_Perceptions-ENGLISH.pdf

Guidance on contingency planning for people who use drugs and COVID-19
http://www.sdf.org.uk/covid-19-guidance/

Guidance on Coronavirus (COVID-19) and People with Alcohol-related Problems: Recommendations for Services
https://www.shaap.org.uk/downloads/238-new-guidance-for-covid-19-and-people-with-alcohol-related-problems/viewdocument/238.html

APPENDIX 7 – LDP STANDARDS

DRUG AND ALCOHOL TREATMENT WAITING TIMES

The Local Delivery Plan (LDP) standard supports sustained performance in fast access to services and requires that 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery.

- Nobody will wait longer than 6 weeks to receive appropriate treatment
- 100% compliance is expected from services delivering tier 3 and 4 drug and alcohol treatment in Scotland

Performance against the Standard will continue to be measured via the Drug and Alcohol Treatment Waiting Times Database (DATWTD) with national reports being published on a quarterly basis via the ISD website: http://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/

This will continue until the new national integrated Drug and Alcohol Information System (DAISy) is operational, when waiting times will be reported through DAISy.

4. It is expected that access to treatment is equitable across all areas and settings in Scotland and across drug *and* alcohol treatment interventions. We expect that ADPs and services undertake routine reviews of subsequent treatments to ensure that people are not waiting lengthy periods of time between interventions. We also expect that nobody will wait longer than 6 weeks to receive treatment and as such expect that any on-going waits are dealt with swiftly. **ADPs should review data on secondary waits for treatment, particularly where there is local intelligence that people are waiting longer than 3 weeks for interventions such as opiate replacement therapy.**

ALCOHOL BRIEF INTERVENTIONS

The LDP Standard supports sustained performance against the delivery ABIs and the embedding of these interventions into existing practice.

The LDP Standards for ABI delivery is as follows:

ABI LDP Standard 2020-21	Target delivery
Ayrshire & Arran	4,275
Borders	1,312
Dumfries & Galloway	1,743
Fife	4,187
Forth Valley	3,410
Grampian	6,658
Greater Glasgow & Clyde	13,085
Highland	3,688
Lanarkshire	7,381
Lothian	9,757
Orkney	249
Shetland	261
Tayside	4,758
Western Isles	317
Total	**61,081**

The split between delivery in priority and wider setting delivery remains the same in 2020-21 as 2019-20: 80% delivery in priority settings; 20% in wider settings. Priority settings include:

- Primary care
- Accident and Emergency
- Antenatal

We recognise this was set out before the current coronavirus situation. The impact on delivery is being considered and further information will follow this letter. In the meantime, NHS Boards and their partners within the ADP are asked to continue to consider ways to increase coverage of harder to reach groups, supporting the focus in communities where deprivation is greatest. All delivery should be planned, implemented and evaluated in line with the ABI LDP standard national guidance[6]. Data should continue to be reported through ISD.

We welcome a continued dialogue with local colleagues around any risks or issues which could impact on the delivery and sustainability of the LDP Standards. Please contact Geraldine Smith (alcoholanddrugsupport@gov.scot).

[6] http://www.show.scot.nhs.uk/alcohol-brief-interventions/

Appendix 3 Borders ADP Funding Proposal for Drug Death Task Force Funding

Priority 1: Targeted Distribution of Naloxone
Please set out your current progress in delivering priority 1, including the current gaps in delivery.
Our local naloxone co-ordinator works in NHS Borders Addiction Service (BAS) and attends national meetings. Naloxone provision is governed through our multi-agency ADP Harm Reduction Group and, since withdrawal of national funding, has been supported by Public Health budget. Naloxone is currently available from: • adult drug services via scheduled appointments and drop-ins • IEP's (fixed site and pharmacy) • Emergency Department (ED) for people who attend to A/E following NFO • Prisons Following the Lord Advocate's letter we are pursuing supply of kits via: • Mental Health Rehab • Justice Social Work - kits can then be issued to those in crisis and or on DTTO's, when presenting at supervision appointments • Local CAPSM service. We also engaged early with SAS re supplying naloxone kits following NFO. This work is now absorbed within the Drug Death Task Force tests of change and we will participate in the extension of the DDTF pilot from Springburn. In our 2015-18 Delivery Plan we set an ambitious target to achieve cumulative supply of first kits to 50% of our estimated prevalence of problem drug users by March 2018. Since the programme started in 2011 at 31 March 2020 we had provided 390 first supplies of take home Naloxone (76% of our estimated population of drug users) and 1400 total supplies. We have sustained the target number of first time kits for this year (28). Gaps: At the moment there is no programme of peer supply of naloxone Max 300 words (245)
Please set out your proposals to address these gaps / enhance existing delivery, with costings.
Peer supply: We have previously trained a number of peers to supply naloxone but individuals' changing circumstances and the relatively small cohort of people ready and able to undertake this role at a point in time has not been sustainable and there have been limited opportunities for peer engagement (e.g. clinic based services, small numbers of attendances per day per IEP).

In April 2019 the ADP commissioned an assertive engagement service (ESTeam). The specification for this service includes exploring feasibility for peer supply in year two of the contract. At the moment the opportunity to do this is curtailed due to social distancing but it remains within the workplan. Our work to develop drop-in support and a Hub in Eyemouth is paused, however, have the potential to be venues for peer supply.
ESTeam provides a service to people who have problematic alcohol and/or drug use and who are currently experiencing barriers to accessing service or at risk of dropping out of service and/or people who have been identified at increased risk of drug related death (. This includes, actively seeking out and engaging with people who have not attended service including support to attend and working with colleagues in the wider system to support people who may not be ready to engage or prepare for structured treatment

There are minimal associated costs with peer supply and are anticipated to be met within existing budgets.

If appropriate reassurance is given by the Lord Advocate we propose to continue supply via the new areas mentioned above. Funding has been identified for 2020-21 therefore is required in 2021-22 only.
Estimated number of kits: 30
Costs: 40 x 18 = £18+VA = £864

Max 500 words (279)

Please set out your baseline and expected improvement against national or local indicators, including timeframes.

E.g.
By 31 By 31 March 2021 (number) of Naloxone kits will have been distributed from community settings

By 31 March 2021 naloxone kits will be available from Justice Social Work, Mental Health Rehab and our CAPSM services.
The total number of kits issued by 'new' providers will total 40 in year 2021-22.

Priority 2: Implement Immediate Response Pathway for Non-fatal Overdose

Please set out your current progress in delivering priority 1, including the current gaps in delivery.

The most recent local Non-Fatal Overdose Protocol was updated in 2018 and was developed in partnership with SAS, BAS, ADP Support Team and ED. The protocol includes pathways between SAS, A/E and in-patient wards in the acute hospital as well as information about alcohol and drugs services and naloxone.

Our NHS Addictions team employs a substance liaison nurse who is able to facilitate engagement into service. The ESTeam is able to initiate low barrier

access to OST if required.

Gaps – this issue was discussed during a local Staying Alive in Scotland session delivered by SDF in Borders. Areas noted for improvement were:

- Staff knowledge and awareness of the protocol and access to drugs services
- Receiving information from SAS following NFO
- Receiving information from Police Scotland about people at risk when SAS not in attendance (this is not restricted to NFO, Police Scotland not part of the existing protocol). This has previously been flagged locally but we have been unsuccessful in having agreement to share this information. Following the DDTF in Dundee a discussion with Police Scotland to request a similar model of information sharing between police and services to that described by Dundee colleagues be implemented in Borders. Advice is currently that we must await findings from the Dundee trial.
- Referrals not routine from ED to drugs service
- Information sharing with Public Health e.g. suspected 'clusters' of overdose not routine

Max 300 words (236)

Please set out your proposals to address these gaps / enhance existing delivery, with costings

We await progress re Police Scotland information sharing arrangements to allow for a 'once for Scotland' approach.
We are in discussion with SAS to implement an improved system for Borders.
Following the discussion above we have developed better links with ED and are planning to:

- refresh naloxone training and communications about drugs services
- explore substance liaison nurse supplying naloxone and IEP to in-patients at point of discharge
- raise the profile and understanding of the protocol (including monitoring of referrals)

We have linked closely with our microbiologist to form part of the pathway re wound and other infections and are actively pursuing SAS colleagues.

This work will be taken forward by a small working group.

Any additional costs are minimal and will be absorbed in the existing budgets.

Max 500 words (130)

Please set out your baseline and expected improvement against national or local indicators, including timeframes.

E.g. By 31 March 2021 an increase of (number) of people will have receiving immediate and proactive offer of treatment and support following a non-fatal overdose.

During 2019-20 there were no referrals from SAS to BAS.

By 31 March 2021 an increased number people will have received a timely and proactive offer of treatment and support following a non-fatal overdose. Based on 2020-2021 performance we will update a specific target for 2021-22.

Priority 3: Optimise the use of Medication-Assisted Treatment

Please set out your current progress in delivering priority 3, including the current gaps in delivery.

Good progress is being made in Borders in relation to MAT standards 1-5 and BAS is participating in the MAT Sub-Group test of change. The numbers of people starting same day prescribing has increased. Patient choice has expanded to include Espranor and Buvidal.

ESTeam and the service's investment in non-medical prescribers (5) enables support to two weekly drop-in clinics and the Eyemouth Hub. At the drop-in and Hubs people can access prescribing, harm reduction advice, naloxone supply, IEP and dry blood spot testing for BBV'.

Over time the number of individuals receiving OST has increased:

Year number	People receiving OST
2017-18	356
2018-19	358
2019-20	386

In 2019-20 69 people had their first prescription within that reporting year. We attribute much of that increase to the work of ESTeam and the reduction in barrier although wish to explore this further.(Priority 5).

Gaps – the approach by BAS and WAWY to active engagement and retention in service has increased the overall caseload and onward costs to pharmacy. The pharmacy supervision budget is now over subscribed and likely to increase.

Max 300 words (284)

Please set out your proposals to address these gaps / enhance existing delivery, with costings

We are evaluating the ESTeam and drop-ins in terms of process indicators and also patients' views. We know anecdotally that this approach is welcomed by the people accessing it. The evaluation will be presented to the next ADP Board in September and will allow us to identify further improvement. The Hub is funded by Challenge Funding and has successfully been awarded additional funding to roll out that model to more areas of Borders. This work has been impacted by Covid at the moment and will continue in line with easing of restrictions.

Given the significant progress which has been supported by the Programme for Government funding, we are proposing to allocate £15,000 to the increased supervision costs for people on OST/MAT associated with low

threshold access and retention in treatment. An estimated cost of daily supervision for one individual is £1000 per year. This would fund an additional 15 individuals.

Pharmacy colleagues have reviewed models of funding and prescribing colleagues have reviewed supervision needs in terms of patient safety and patient acceptability and we are confident the governance of the budget is sound, however, the challenge of delivering our services in line with Rights, Respect and Recovery require us to consider the impact on other parts of the system.

Max 500 words (208)

Please set out your baseline and expected improvement against national or local indicators, including timeframes.

E.g. By 31 March 2021 same day prescribing will be available at a further 8 treatment service access points for all those assessed as requiring OST.

From Jan-March 2020:

- 63% (20) – people commenced OST the same day as initial assessment
- 31% (10) – people commenced OST between 1-7 days after initial assessment
- 6% (2) – commenced OST 8 or more days after initial assessment

At 15.6.2020 6 patients had started Buvidal treatment we expect this to gradually increase.

It is not considered prudent to estimate a specific increase within this time period as this is dependent on patient choice and risk assessment. Our ambition therefore is that by 31 March 2021 the percentage of people accessing same day prescribing and numbers starting Buvidal treatment will have increased.

Priority 4: Target the People at Most Risk

Please set out your current progress in delivering priority 4, including the current gaps in delivery.

The work of the ESTeam is key to success in this area as was reflected in the covid response where we were able to make contact with people who, prior to this innovation, were not engaged with services. A ‘no unplanned’ discharge approach prevents frequent entrance and exit from treatments.

Future work of the team includes a requirement to progress improved pathways for people experiencing co-morbid mental health concerns. This will be aided by the fact that the Consultant Psychiatrist in BAS is also a member of the Community Mental Health Team.

First Steps harm reduction groups take place in Galashiels and Hawick supported by peers and staff from WAWY and BAS and its programme

includes support for safer injecting, understanding poly drug use.

WAWY have implemented the AIR (Assessing Injecting Risk) in their IEP, however, people accessing the service are often reluctant to stay longer than required for their transaction.

Gaps – service users in First Steps and the Staying Alive Development day highlighted a gap in staff knowledge and service user support in terms of wound care and access to IEP in one area of Borders.
There is no specific intervention for people over 35.
Max 300 words (196)

Please set out your proposals to address these gaps / enhance existing delivery, with costings

We propose to extend IEP provision to Selkirk. There are 30 people currently receiving OST and feedback from staff and people with lived experience is that the lack of provison is leading to unsafe practices, particularly while travel is reduced. The IEP will also provide naloxone kits.

To support wound care we have engaged with our Consultant Microbiologist to work with us and ED to support a care pathway for people with wound site infections.

We propose to expand the nurse role within the First Steps groups to support physical health considerations (including woundcare) and we propose to train our non-medical prescribers to undertake a qualification in advanced clinical practice to enable them to assess and prescribe treatment.

This will allow people to access this support within clinics and at WAWY, over time this will also provide additional support to pharmacies.

This will also support us to address the health needs of our cohort of older drug users (of current BAS drug clients 72% are aged 35 or over (68% of female cohort; 78% of male cohort; 33% are aged over 45).

We have agreement to deploy a new Specialist Registrar in Public Health to undertake a health needs assessment of our drug using population. This will commence late in fiscal year 2020-21.

Our aim is to increase the reach of the First Steps groups by offering in additional Borders area. It is proposed to support this through funding 5 hours staff time; peer travel costs and logistics.

Year one	**Cost**	**Year two**	**Cost**
IEP set-up costs	£1000	-	-
IEP Fee	£1500	IEP Fee	£1500
Staff training inc travel (x3)	£3600	Staff training inc travel (x2)	£2400*
First Steps group – staff hours	£5800	First Steps group – staff hours	£5800
First Steps group – peer	£600	First Steps group – peer	£800**

travel and logistics		travel and logistics	
Total	£11,650	Total	£11,650

*estimated costs , fees may change
** expect additional attendees

Max 500 words (317)

Please set out your baseline and expected improvement against the national indicators set out below, as well as any local indicators

We expect an increase:

- Notifications of injecting site infections to BAS from ED/acute site
- Attendance and engagement with First Steps (Harm Reduction) groups

Priority 5: Optimise Public Health Surveillance

Please set out your current progress in delivering priority 5, including the current gaps in delivery.

Borders ADP leads a multi-agency Drug Death Review Group chaired by our Chief Social Work Officer/Vice Chair AD Annual report produced and presented at the Critical Services Oversight Group (CSOG). An annual report is prepared for the Critical Services Oversight Group.

Our local Drug Trend Monitoring Group continues to meet to to share intelligence regarding emerging trends of drugs/alcohol use and related harm. The mailing list is used to disseminate briefings/alerts to members.

Gaps: we have completed an overview of numbers of people receiving OST and noted some interesting features: e.g. 11 people received prescriptions in 2017-18 and 2019-20 but not in 2018-19. We are keen to use the prescribing data to understand more about the characteristics of our cohort.

Max 300 words (120)

Please set out your proposals to address these gaps / enhance existing delivery, with costings

A small project group will be convened in September to review the existing prescribing data to explore areas likely to include:

- Demographic characteristics of the cohort
- Relationship between demographics and service uptake (e.g. age groups and retention in service)
- Characteristics of those who have returned to service
- Characteristics of those who are new to service

The group will develop a project plan which will include the areas of exploration.
This work aims to improve understanding the characteristics of our cohort to inform future service planning and improvements.

There are no additional costs associated with this piece of work.

Max 500 words (102)

Priority 6: Ensure Equivalence of Support for People in the Criminal Justice System

Please set out your current progress in delivering priority 6, including the current gaps in delivery.

There are positive strategic relationships locally between the ADP and Criminal Justice system. The Safer Communities & Community Justice Manager is a member of the ADP and the ADP Strategic Lead sits on the local Community Justice Board. ADP related items are regularly scheduled there for discussion.

The majority of any Borders residents given a custodial sentence will be housed in HMP Edinburgh the Governor of which also sits on the Justice Board.

There is a full drug service available in prison from the health board geographically connected to the prison. Medication is issued on release and handover made to home health board. Pharmacy costs are met by health board of holding prison.

We are aware of the potential of prison to provide a respite space for long term drug users to consider a change. Recovery services available in some prisons as well as established addiction support via NHS and third sector and are positive about the recent introduction of Buvidal for people with six months or more remaining on their service.

The Justice Service has previously supported a piece of work to explore concerns around access to service for people at risk of drug deaths and is currently progressing engagement in supply of naloxone. There is an arrangement in place for DTTO delivery is alongside BAS.

The Borders Community Justice Board has agreed to nominate Borders as an area to be included in the DDTF Justice Sub-Group in relation to diversions from prosecutions.

Gaps –
Potential for people to continue on Buvidal following liberation from prison
Potential for increased information sharing between Justice Social Work and drugs services to identify people at increased risk.

Max 300 words (273)

Please set out your proposals to address these gaps / enhance existing delivery, with costings

Prisons
During this year we are keen to explore a baseline and improvements and to implement a pathway for continuing of Buvidal prescribing at liberation.
To facilitate that we are bringing together a group of interested parties on 29.6.20 to discuss that issue and broader concerns regarding support for Borders residents.

Justice Social Work Alongside the Community Justice Board we will explore current referral and engagement rates with ESTeam and how best to improve information sharing/risk escalation between the respective services. There is no additional costs associated with this proposal Max 500 words (90)
Please set out your baseline and expected improvement against national or local indicators, including timeframes. E.g. By March 2021 an increase of (number) of people will have started treatment following intervention prior to arrest.
By March 2021 the following will be in place: • A pathway for continuation of prescribing from HMP Edinburgh to BAS • Increase in number of referrals from Justice to BAS. Baseline = 3 in 2019-20

Summary of funding required

Priority	Total £ required
Priority 1	**0**
Priority 2	**0**
Priority 3	**£15,000**
Priority 4	**£11,650**
Priority 5	**0**
Priority 6	**0**
Overall total	**£26,650**

Please indicate any proposed or actual reductions in funding for alcohol and drug services in 2020/21.

Area of service delivery	Funding reduction £	Proposed / actual	Impact
There are no proposed reductions in alcohol and drugs services in 2020-21.	n/a	n/a	n/a

Signed ADP Chair:

Dr Tim Patterson
Date: 26.6.2020

Signed IA Chief Officer:

Rob McCulloch-Graham
Date: 26.6.2020

Appendix 4: Health Inequality Impact Assessment

ADP Strategy Refresh – Health Inequality Impact Assessment

Scoping workshop report

Policy/service title: Alcohol and Drugs Partnership (ADP) Strategy Refresh
Date of workshop: 7 August 2020
Location: via MSTeams
Policy lead: Fiona Doig
Equality and diversity lead: Nic White
Report Author: Fiona Doig
Date of Report:10 August 2020

This is a report of the findings from a workshop held to identify potential impacts of this policy, including differential impacts on different population groups. The workshop was the first stage of a Health Inequalities Impact Assessment of the policy. Findings are based on the knowledge and experience of those present at the workshop.

This report is not a definitive statement or assessment of impacts but presents possible impacts that may require further consideration. The report also identifies some questions to be addressed to understand the impacts further. The purpose of further work following this scoping stage is to inform recommendations to improve impacts on health and enhance actions to reduce health inequalities, avoid discrimination and take action to improve equality and enhance human rights.

People present: Lorna Peddie, Nic White, Fiona Doig

Rationale and aims of policy:
The Scottish Borders Alcohol & Drugs Partnership (ADP) is tasked with delivering a reduction in the level of drug and alcohol related problems amongst young people and adults in the Borders, and reducing the harmful impact on families and communities. It is responsible for working with the Scottish Government, colleagues, people with lived experience and local communities to tackle the problems arising from substance use.

The ADP is made up of representatives from NHS Borders, Scottish Borders Council, Police Scotland and alcohol and drugs Third Sector organisations.

The refreshed Strategic Plan builds on the work directed by the previous ADP Strategy and reflects current local context, new Ministerial Priorities and updated national strategies.

The Strategy is formed to align with chapter headings in the national alcohol and drugs treatment strategy Rights, Respect and Recovery as follows:

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

1. Who will be affected by this policy?

People with alcohol and drugs concerns and/or problems
Family members impacted by another's alcohol and drug use including children
Staff in alcohol and drugs services
Children and Young People in young people's settings e.g. education, youth sector
Members of the public

2. How will the policy impact on people?

The group sought to identify potential differential impacts of the policy on different population groups. These impacts are noted below.

Population groups and factors contributing to poorer health	Potential Impacts and explanation why	Recommendations to reduce or enhance such impacts
Age: older people; middle years; early years; children and young people.	The Strategy covers all age groups. There will be a positive impact on children and young people. Chimes service provides support to children and young people impacted by parental substance use, support to parent in understanding and mitigating the impact of their substance use and support to kinship parents of impacted children. Quarriers Resilience for Wellbeing Service provides support for children and young people in relation to alcohol and drugs and emotional wellbeing. Quarriers and Chimes work closely together We Are With You (WAWY) has an identified young person's worker who leads on developing young people appropriate engagement and service provision and works with Quarriers and Borders Addiction Service (BAS) to ensure support for	Continue to monitor outcomes of commissioned alcohol and drugs and Children and Young People's Leadership Group services to ensure fitting local need.

	children and young people experiencing problems from their use of alcohol and/or drugs. ADP delivers a workforce development programme including introduction to alcohol and drugs and Children affected by Parental Substance Misuse (CAPSM)briefing. Substance use education for schools has been developed. In addition to specific SUE resources, Relationships, Sexual Health and Parenthood resource also includes sections relating to impact of drug and alcohol use on quality of young people's relationships; Peaches and Aubergine resource also supports this work and these are supported by education and wider youth sector; What's the Harm training is relevant in this context. These resources develop skills and knowledge for children and young people. Alcohol Brief interventions are delivered to people over the age of 16 in the NHS priority settings based on clinical presentation and opportunistic screening and in wider settings. This will include identification of older adults who are harmful or hazardous drinkers.	Explore new methods of delivery in response to impact of COVID on face to face learning Evaluation of SUE planned for 2020-21 school year. Seek opportunities to enable access to youth sector. Adult services are briefed on the specific needs of older adults and although there is not a specific service interventions are delivered to respond to need e.g. home visits.
Disability: physical, sensory and learning impairment; mental health conditions; long-term medical conditions.	Overall this plan is positive for people with disability since it directly impacts on those individuals with substance misuse issues. It is challenging to find any UK data relating to	Healthier Me delivery offers an opportunity to

	prevalence of substance misuse in people with physical and/or learning disabilities. There is a suggestion the people with learning disabilities are likely to present similar rates of alcohol use to those of the general population and ADP Strategic Lead attends Mental Health and Wellbeing Board. Strategy is positive for people with experiencing mental ill-health. These are often intertwined with substance use issues. WAWY staff attend the Mental Health Forum to promote positive relationship ensure good communications, access to services and feedback from people with lived experience. Strategy impact is positive for people with alcohol and drugs concerns who may attend ED with unrelated or related ussed. Alcohol and Drugs Liaison Nurse works within acute hospital to support individuals and pathways. Alcohol and drugs service have a role to play in supporting emotional and physical wellbeing e.g. healthy lifestyles. Use of Star Outcomes tool allows people in service to identify health goals.	explore any support required by third sector learning disability providers to support concerns relating to alcohol and drug use. Take forward local work to examine 'co-morbidity' needs and responses in relation to substance use and mental ill-health. Review Alcohol and Non-fatal Overdose pathways to ensure access to specialist services for those attending the acute hospital or seen by Scottish Ambulance Service Recommendation to scope additional resources for services staff re healthy eating, physical activity.
Gender Reassignment: people undergoing gender reassignment	Stigma is experienced by people using alcohol and drugs, however, the additional stigma experienced by trans people can further compound people's avoidance of services. Although there is no dedicated service in Borders for LGBT alcohol and	Ensure services are sighted on emerging data. Recommendation to scope training needs in relation to LGBT, stigma, unconscious bias within alcohol and drugs services

	drugs issues, all services are available confidentially and all commissioned alcohol and drugs services are required to have an Equality and Diversity policy.	
Marriage & Civil Partnership: people who are married, unmarried or in a civil partnership.	No specific impacts in relation to this characteristic.	
Pregnancy and Maternity: women before and after childbirth; breastfeeding.	The impact on this group is positive: Alcohol Brief Interventions (ABI's) are delivered by midwives in antenatal settings and Health Visitors. CHIMES supports pregnant women to understand impact of alcohol and drug use	Continue to review ABI performance, awareness raising of Foetal Alcohol Spectrum Disorder, commissioned services outcome monitoring. Continue positive relationships between alcohol and drugs services and social work; Health Visitors and Early Years Centres.
Race and ethnicity: minority ethnic people; non-English speakers; gypsies/travellers; migrant workers.	There are no specific interventions within the plan relating to minority ethnic people, non-English speakers, gypsies/travellers; migrant worker. While the impact of the strategy is positive in that services are open to all it is recognised that barriers may be experienced for people in this group. Currently there is no local evidence of unmet or unrecognised needs in relation to alcohol and drugs. Any anecdotal suggestion of such will be acted upon within current planning structures including ADP Board Meetings.	Commissioned services are required to give due consideration to engaging with and supporting people for whom English is not a first language. Translation services are available in Borders. Recommendation that alcohol and drugs service review existing materials and scope potential for offering in other languages.
Religion and belief: people with different religions or beliefs, or none.	Stigma is experienced by people using alcohol and drugs, however, the additional stigma experienced by people with some religious beliefs may further compound people's avoidance of services.	Commissioned services are required to give due consideration to engaging with and supporting people with different beliefs or customs and to reduce barriers for access.

		Service providers will ensure that clients' wishes to have appointments with a staff member of a specific gender will be fulfilled.
Sex: men; women; experience of gender-based violence.	This strategy will have a positive impact on all groups by providing services and interventions for people seeking support for alcohol and drugs concerns and also prevention and early intervention activity (e.g. ABIs, education). Men are more likely to experience problems associated with alcohol and drug use and this is shown in service uptake data as well as the demographics of those experiencing drug related deaths. Staff have been trained in gender-based violence awareness and adult services have implemented routine enquiry for domestic abuse. ADP Support Team represented in Violence Against Women Partnership structures. WAWY facilitates a Women's Group. Services participate in MARAC meetings processes.	Continue to review staff training needs in relation to gender based concerns including briefing for Drug Death Review Group.
Sexual orientation: lesbian; gay; bisexual; heterosexual.	Stigma is experienced by people using alcohol and drugs, however, the additional stigma experienced by lesbian, gay, bisexual can further compound people's avoidance of services. LGBT people have higher prevalence of alcohol and drug use than the population as a whole.	Ensure services are sighted on emerging data. Services are required to have an Equality and Diversity policy. Recommendation to scope training needs in relation to LGBT, stigma, unconscious bias within alcohol and drugs services. Ensure the current project with LGBT Forum

	Daily drinking in those aged 65 and over is significantly higher than the population as a whole.	and Joint Health Improvement Team supporting health and wellbeing includes consideration of impact and support for people with alcohol and/or drug use concerns.
Looked after (incl. accommodated) children and young people	This strategy will have a positive impact on all groups by providing services for children and young people impacted by parental substance use which can be a factor contributing to the person being looked after or accommodated. Chimes service provides support to children and young people impacted by parental substance use, support to parent in understanding and mitigating the impact of their substance use and support to kinship parents of impacted children. Joint working with BAS and WAWY ensures appropriate level of treatment for young people with higher substance use needs. Alcohol and drugs services are sighted on and involved with the revised Public Protection Services developments.	Continue to maintain positive relationships exist between the Transitions Team and commissioned services. WAWY deliver bespoke sessions with transitions clients. ESTeam to continue to build networks and capacity with key services.
Carers: paid/unpaid, family members.	This strategy will have a positive impact on this group by providing access to support for adults impacted by another's substance use via the Concerned Other Group and access to structured support on an individual basis using evidence based approach (CRAFT). Often people in this group do not see themselves as carers and may seek support initially from alcohol and drugs services rather than carer specific services. Serendipity Recovery Café is open to and	Continue to provide support for concerned others and maintain links with carers services. Continue to promote SFAD information via appointment letters and other service literature. WAWY have established links with local Kinship Carers Support Group and will raise any concerns arising from the group with relevant colleagues are sighted on this.

	accessed by family members. CHIMES service provides support for young carers. This group is often reluctant to disclose family substance use, the joint nature of this service ensures staff are able to provide support for this issue.	
Homelessness: people on the street; staying temporarily with friends/family; in hostels, B&Bs.	This strategy will have a positive impact on this group. Borders Addiction Services Support Workers are employed with Social Work services. Use of Star Outcomes tool allows people in service to identify accommodation issues and to chart progress.	Commissioned services continue to maintain positive relationships with homelessness services. ESTeam to continue to build networks and capacity with key services.
Involvement in the criminal justice system: offenders in prison/on probation, ex-offenders.	This strategy will have a positive impact on this group. Use of Star Outcomes tool allows people in service to identify accommodation issues and to chart progress. Justice Social Work commission Borders Addiction Service to provide Drug Testing and Treatment Order service (DTTO). Cross representation between Community Justice Board and ADP Board.	Continue to maintain positive relationships with Justice Services. Borders Addiction Service to continue to explore support for people during and at liberation from HMP Edinburgh.
Addictions and substance misuse	This strategy will have a positive impact on people experiencing, impacted by or at risk of developing addictions and substances use concerns. The strategy is based on consultation with key stakeholders including people with lived experience; it is evidence based and follows the strategic aims and objectives of the national alcohol and drugs strategies.	ADP to continue to monitor quarterly performance reports. ADP Support Team to ensure involvement in national (e.g. ADP Leads Meeting; Drug Death Co-ordinators) and local opportunities to ensure our local plans fit needs. ADP to continue to pursue a mechanism for lived experience involvement.

Staff: full/part time; voluntary; delivering/accessing services.	Staff in services were involved in informing development of this policy so impact is positive as it reflects system needs and staff experience. ADP delivers a workforce development programme to support staff to feel equipped to work with this client group. This includes locally developed and commissioned sessions as well as external specialists providers (e.g. Scottish Drugs Forum, Alcohol Focus Scotland, Crews) and on-line opportunities. The requirement to wear PPE for face-to-face work may not align with specific religious practices.	Ensure staff are aware of finalised strategy and associated Delivery Plan and are able to identify any development needs. Explore new methods of delivery in response to impact of COVID on face to face learning Services to follow national guidance.
Low income	This strategy will have a positive impact on this group. People experiencing problems associated with alcohol and drug use are more likely to be experiencing health inequalities and low income. Alcohol and drug problems can lead to people being less likely to be in employment than the general population. During COVID-19 services responded by offering digital/remote opportunities for accessing support. This requirement is likely to remain in place for some time. While this can be seen potentially as a positive development e.g. reduction in need to travel, for some people less able to access digital responses e.g due to lack of connectivity or hardware this may be problematic. Commissioned services have accessed small grants during this	Ensure service provision reduces barriers to access particularly in relation to COVID-19 response and move towards digital/remote appointments by ensuring there are alternative options available for those less able to use digital solutions.

	time to enable provision of e.g. telephones and data credit.	
Low literacy / Health Literacy: includes poor understanding of health and health services as well as poor written language skills.	**There are no specific impacts in relation to this characteristic although it is recognised that impact could be negative if services are not able to support both access to and treatment for people with low literacy/health literacy.** **All services will accept self-referral and also referrals from health professionals. Information about services is available on line.**	**Ensure services are able to support people in this group through considering e.g. service materials, appointment lengths and communication methods. People are able to attend an appointment with another if they wish.**
Living in deprived areas	This strategy will have a positive impact on people living in deprived areas People experiencing problems associate with alcohol and drug use are more likely to be experiencing health inequalities and live in deprived areas. Services are available in each Borders locality e.g. via GP clinics and/or drop-ins. CHIMES services are available based on Learning Community clusters. During COVID-19 services responded by offering digital/remote opportunities for accessing support. This requirement is likely to remain in place for some time. While this can be seen potentially as a positive development e.g. reduction in need to travel, for some people less able to access digital	Ensure service provision reduces barriers to access particularly in relation to COVID-19 response and move towards digital/remote appointments by ensuring there are alternative options available for those less able to use digital solutions. .

	responses e.g due to lack of connectivity or hardware this may be problematic. Commissioned services have accessed small grants during this time to enable provision of e.g. telephones and data credit	
Living in remote, rural and island locations	This strategy will have a positive impact on people living in remote and rural locations. Service are available in each Borders locality e.g via GP clinics and/or drop-ins. CHIMES services are available based on Learning Community clusters. During COVID-19 services responded by offering digital/remote opportunities for accessing support. This requirement is likely to remain in place for some time. While this can be seen potentially as a positive development e.g. reduction in need to travel, for some people less able to access digital responses e.g. due to lack of connectivity or hardware this may be problematic. Commissioned services have accessed small grants during this time to enable provision of e.g. telephones and data credit	Ensure service provision reduces barriers to access particularly in relation to COVID-19 response and move towards digital/remote appointments by ensuring there are alternative options available for those less able to use digital solutions. Continue to monitor referral route and sources of commissioned alcohol and drugs and Children and Young People's Leadership Group services to ensure fitting local need.
Discrimination/stigma	This strategy aims to reduce people experiencing discrimination/stigma in relation to their own or another's alcohol and/or drug use. Evidence of stigma experienced by people using alcohol and drugs impacts on likelihood of accessing services, by making this a key priority	ADP to continue to pursue a mechanism for meaningful lived experience in the work of the ADP.

	for the term of the strategy there is likely to be positive impact.	
Refugees and asylum seekers	No specific impacts in relation to this characteristic.	ADP members to ensure that any evidence or concerns for people in this group are brought to the attention of the ADP Board and services to ensure an appropriate response.

3. How will the policy impact on the causes of health inequalities?

The group identified the following potential impacts of the policy on the causes of health inequalities

Will the policy impact on?	Potential impacts and any particular groups affected	Recommendations to reduce or enhance such impacts
Income, employment and work • Availability and accessibility of work, paid**/ unpaid employment, wage levels**, job security.	This strategy will have a positive impact on this cause of health inequality. WAWY Re-integration Service employs an Employability Worker who helps support adults who have experience of alcohol and drugs problems to access support with e.g. CV writing, applications for college and jobs. Volunteering opportunities including peer workers are available.	ADP to continue to pursue a mechanism for meaningful lived experience in the work of the ADP.
The physical environment and local opportunities • Tobacco, alcohol and substance use.	ADP membership includes the convenor of the Licensing Board. The ADP produces a bi-annual Alcohol Profile which aims to support the Licensing Board by providing evidence to support decision making and inform development of future Licensing Policy Statement and supporting the Licensing	Continue to monitor alcohol license applications. Support engagement in communities via the Local Licensing Forum. Engage in any future consultations relating to licensing reform.

	Objectives: - Preventing crime and disorder - Securing public safety - Preventing public nuisance - Protecting children and young people from harm - Protecting and improving public health	
Education and learning	**n/a**	
Access to services • Availability of health and social care services, transport, housing, education, cultural and leisure services. • Ability to afford, access and navigate these services. • Quality of services provided and received.	This strategy will have a positive impact on this cause of health inequality. The development of the Assertive Engagement Service and locality drop-ins/Hubs remove barriers to alcohol and drugs services and allow potential for access to wider services e.g. sexual health, via these structures.	Continue to develop and evaluation the drop-in/Hub model.
Social, cultural and interpersonal • Social status. • Social norms and attitudes. • Tackling discrimination. • Community environment. • Fostering good relations. • Democratic engagement and representation. • Resilience and coping mechanisms.	This strategy will have a positive impact on this cause of health inequality by taking forward action to address stigma for people with alcohol and drugs problems.	ADP members and their constituent organisations to respond to national stigma strategy when published. Continue to produce ADP Bulletins, Annual Report and proactive media campaigns e.g. Festive Safety

4. Potential impacts on human rights

The group identified the following potential human rights impacts.

Articles	Potential impacts and any particular groups affected	Recommendations to reduce or enhance such impacts
The right to life (absolute right)	Yes. Evidence supporting alcohol and drug treatment as a protection factor in preventing drug related deaths. Provision of Take Home Naloxone (THN), implementing non-fatal overdose policy and harm reduction are evidence based in interventions to reduce drugs deaths.	Ensure implementation of Delivery Plan and examine and implement as appropriate and recommended interventions from emerging evidence.
The right not to be tortured or treated in an inhuman or degrading way (absolute right)	Yes. Evidence of stigma experienced by people using alcohol and drugs impacts on likelihood of accessing services, by making this a key priority for the term of the strategy there is likely to be positive impact.	ADP members and their constituent organisations to respond to national stigma strategy when published.
The right to liberty (limited right)	n/a	
The right to a fair trial (limited right)	n/a	
The right to respect for private and family life, home and correspondence (qualified right)	n/a	
The right to freedom of thought, belief and religion (qualified right)	n/a	
The right to freedom of expression (qualified right)	n/a	
The right not to be discriminated against	Yes. Evidence of stigma experienced by people using alcohol and drugs impacts on likelihood of accessing services, by making this a key priority for the term of the strategy there is likely to be positive impact.	Respond to national stigma strategy when published.
Any other rights relevant to this policy.	n/a	

5. Will there be any cumulative impacts as a result of the relationship between this policy and others?

The impact of this Strategy will be enhanced by implementation of: Community Justice Board Action Plan, Mental Health Strategy, Child Poverty Action Plan, CPP Strategic Plan, HSCP Strategic Plan and Integrated Children's Services Plan.

6. What sources of evidence have informed your impact assessment?

Evidence type	Evidence available	Gaps in evidence
Population data e.g. demographic profile, service uptake.	National Alcohol and Drug Profile http://www.scotpho.org.uk/ (site collates a variety of sources including– demographics, hospital admissions and mortality; prevalence, access to treatment). This data is used to produce an annual Technical Report to complement the ADP Annual Report. Borders Alcohol Profile https://www.scotborders.gov.uk/downloads/file/2739/alcohol_profile A quarterly report is presented to the ADP which includes service uptake; outcomes and key performance indicators.	Due to the demographics of Borders it is not possible to present data relating to each of the protected characteristics. The most recent publication of Borders specific SALSUS data in relation to alcohol and drug use in children and young people was last published in 2013. An updated publication is delayed by COVID-19.
Consultation and involvement findings e.g. any engagement with service users, local community, particular groups.	Prior to the development of this Strategy consultation work had previously taken place in relation to reduction in ADP Funding, additional funding was received in 2018-19 and additional	

	consultation was performed with people using services and with lived experience to inform decisions relating to the new funding. This strategy builds on the finding of above. Prior to developing the strategy we consulted with people with lived experience with the help of We Are With You and also via attendance with Serendipity Recovery Cafe members.	
Research e.g. good practice guidelines, service evaluations, literature reviews.	Rights Respect and Recovery – Scotland Alcohol and Drugs Treatment Strategy[10], Clinical care and prescribing is guided by the UK Department of Health's Drug misuse and dependence: UK guidelines on clinical management[11], LGBT in Britain – Health Report, Stonewall[12] , https://www.stonewall.org.uk/system/files/lgbt_in_britain_-_health_report_final.pdf LGBT in Britain – Trans Report[13] https://www.stonewall.org.uk/system/files/lgbt_in_britain_-_trans_report_final.pdf	
Participant knowledge e.g. experiences of working with different population groups, experiences of different policies.	Staff represented in the workshop include the Service Manager of We Are With You alcohol and drugs treatment and re-integration service; Health Improvement Equality Lead and Sexual Health Improvement Specialist; Head of Health Improvement and Strategic Lead ADP. This group therefore comprises expertise on alcohol and drugs service delivery; equality and diversity; young people; strategic policy development and implementation.	

[10] https://www.gov.scot/publications/rights-respect-recovery/

[11] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf

[12] https://www.stonewall.org.uk/system/files/lgbt_in_britain_health.pdf

[13] https://www.stonewall.org.uk/system/files/lgbt_in_britain_-_trans_report_final.pdf

7. Summary of key impacts, research questions and evidence sources

The following is a summary of the key areas of impact identified at the workshop, some possible questions to address in order to understand these, and suggested evidence sources to answer these research questions.

This is not a definitive or necessarily complete list of research questions and some may turn out on further assessment not to be relevant. The list is put forward as a starter to inform the next stage of the impact assessment, and is likely to be amended by the steering group.

The work done to explore these questions should be proportionate to the expected benefits and potential to make changes as a result.

Evidence-informed recommendations are central to a robust impact assessment; however, 'evidence' to support the development of recommendations can be thought of more widely than just formal research. Furthermore, a lack of available robust evidence should not lead to the impact assessment process being delayed or stopping altogether. Often there is poor or insufficient evidence about the links between a proposal and health; there may, however, be plausible theoretical grounds to expect an impact.

Area of impact	Research questions	Possible evidence sources
n/a		

8. Who else needs to be consulted?

The group agreed that no additional stakeholders need be involved or consulted in the process.

9. Suggested initial recommendations

During the workshop participants identified some initial suggestions to improve the policy. Most of these will be informed by the suggested work to address the questions identified above. The suggestions are noted below but will need discussion and refinement by the steering group.

- Review any training needs of commissioned services as in relation to protected characteristics and inequalities
- Continue to monitor outcome and impacts of commissioned services
- Ensure services consider impact of any changing practice relating to COVID-10 response

10. Conclusions

During the HIIA Scoping Workshop the participants considered the potential impacts arising from implementing this policy. These potential impacts have been summarised above. As a result of this workshop we conclude (select the most appropriate conclusion).

- ❖ No major changes required to the policy

Fiona Doig, Head of Health Improvement/Strategic Lead ADP, NHS Borders

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: Wednesday 19 August 2020

Report By:	Dr Kevin Buchan; Sandra Pratt
Contact:	Sandra Pratt, Associate Director, Strategic Change
Telephone:	01896 825584

PRIMARY CARE IMPROVEMENT PLAN: UPDATE

Purpose of Report:	To seek IJB agreement for the proposal and resource allocation recommended by the PCIP Executive in the development of a new Primary Care Mental Health Service

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) *Agree* the transfer of resource between PCIP workstreams but within the total resource allocation for the programme in order to develop a Borderswide Primary Care Mental Health Service.

Personnel:	The proposed Mental Health model will see the establishment of permanent new posts in Psychological and Mental Health Services :

Carers:	N/A

Equalities:	An EQIA will be carried out.

Financial:	A joint funding package of £845k has been identified for the new Mental Health model comprising Mental Health resource, Action 15 monies and PCIP resource. The PCIP contribution will be £639k in total which includes the initial funding commitment of £354k and an additional £285k identified through review of the PCIP financial plan.

Legal:	There is a requirement for PCIP to be implemented in order to deliver the new GP Contract.

Risk Implications:	Non-delivery of the GP Contract may attract penalties from Scottish Government.

BORDERS PRIMARY CARE IMPROVEMENT PLAN:

THE DEVELOPMENT OF A NEW PRIMARY CARE MENTAL HEALTH SERVICE

1 AIM

1.1 The aim of this paper is to update the IJB about specific aspects of Borders Primary Care Improvement Plan (PCIP) related to the development of a new Primary Care Mental Health Service and to seek agreement for the proposal from the PCIP Executive Group to re-allocate resources within the PCIP resource to introduce this new service.

2 BACKGROUND

2.1 One of the PCIP workstreams prescribed within the GP Contract is titled "Additional Professional Roles" which includes the introduction of First Contact Physiotherapists and also the development of Community Mental Health Worker roles. Within the work to develop the latter, a "test of change" took place at O Connell Street Medical Practice in October 2019 to test out a "see and treat" Mental Health model where patients with mild to moderate anxiety and depression were seen by a mental health practitioner and offered evidence based psychological therapy depending on their needs. The aim of this was to understand how the development of a mental health strand as part of the GP Contract could assist GPs as well as offering an effective and efficient intervention to patients.

2.2 On the basis of a proposal following the success of this test of change, PCIP funding of £354k was allocated to scale the model up in one area as a first phase but due to a number of factors, this did not go ahead and further work was delayed because of the Covid 19 outbreak.

2.3 Once the immediate acute Covid crisis had abated it was decided to reconvene a group of key stakeholders from primary care, GP Practice and Mental Health in order to review the proposed approach and agree a primary care mental health model that could be developed across Borders. There has never been a primary care mental health service previously and GPs report that such a service would massively improve their workload whilst enabling our patients to access the right professionals at the right time to meet their needs.

2.4 A Primary Care Mental Health workshop took place in late May where shared goals and principles were discussed and agreed and subsequently a small sub group was remitted to consider possible models. On the 11th June 6 options were presented to the full group who undertook a non-financial options appraisal and a preferred option was identified. It is known currently as "The Centralised Model" and is based on a "see and treat" model that utilises a skill mix/ Multi-Disciplinary Team approach. Assessment and treatment will take place in a variety of settings/formats and be as patient led as possible. Strong links will be made with secondary care, and complementary/commissioned services to ensure that patients are able to get the most appropriate help with as few barriers as possible.

2.5 While it is impossible to know the exact level of referrals the service might receive, planning assumptions for the model of circa 104 referrals per week have been made based on the original Test of Change figures projected across the Borders population figures.

2.6 Centralised Model staffing requirement:

2 x	B8a	Clinical Psychologist
12 x	B7	Clinical Associate in Applied Psychology (CAAP)
2 x	B6	Mental Health Practitioners
2 x	B4	Assistant Psychologists
2.0	B3	Administration

2.7 Following financial appraisal this model was identified as the overall preferred model but was projected to cost £945k per annum. Further review identified that the cost of the preferred option could be reduced to £845k per annum without significantly impacting the quality of the service by reducing the number of Clinical Associates in Applied Psychology (CAAPs) from 12 to 10.

2.8 Taking into account the already committed PCIP resource of £354k, this leaves a shortfall in funding of £491k. The following joint funding solution has been identified to resource this shortfall:

- 3.7 WTE (2.7 WTE CAAPs Band 7 and 1.0 WTE Psychology Band 8a) of existing permanent staff will be transferred to support the new model within their existing roles thus ameliorating the requirement for additional investment / recruitment. These posts are currently funded from NHS Borders' Action 15 Mental Health allocation and equate to £206k.

- Following a robust review of PCIP priorities and resource commitments £285k will be transferred to support the Primary Care Mental Health Service model as proposed funded. The detail is set out in a subsequent section of this paper.

Resources to deliver Primary Care Mental Health Service Model as a Centralised Service ("See and Treat" Model)		
	£'000	**£'000**
Projected Annual Cost of Model:		
Option 4 Coasted	945	
Reduction in Option (reduce CAAPs from 12.0 to 10.0 WTE)	(100)	
		845
Recurring Resource Availability:		
Initial PCIP allocation to Mental Health	(354)	
Transfer of additional resource allocation from Primary Care Improvement Plan	(285)	
Repurposing of 3.7 WTE Action 15 Earmarked Funding	(206)	
		(845)
Funding Shortfall		**0**

3 IDENTIFICATION OF PCIP RESOURCES

3.1 The resource envelope of £3.2m for the delivery of the whole PCIP programme is finite and the PCIP Executive Committee (formerly known as the GP Executive Committee) review progress across all workstreams on a routine basis in order to ensure that each strand remains in line with the agreed specifications, service provision is equitable across Borders and delivers best value to patients and practices alike. Progress has inevitably varied across workstreams for a number of reasons and at certain points the PCIP Executive has had to revise priorities in order to remain within the overall budget but achieve the best outcomes possible. The reviews involve robust monitoring and scrutiny across all workstreams and are considered alongside the PCIP financial plan.

3.2 Following agreement about the new Primary Care Mental Health model as described above, the PCIP Executive reviewed the PCIP and Financial Plan at their meeting in July and based on that review have agreed to divert funds not yet spent on (though previously earmarked for) particular service areas in the current plan and also some non-recurring commitments made against the recurring budget which will release resource on a permanent basis to contribute to the funding of the identified shortfall . The section below gives detail of which areas of PCIP budget this affects

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3.2.1 Pharmacotherapy

Since the introduction of the new GP Contract in 2018 the PCIP Executive Committee has invested **£896,538** (incorporating the previous PCIF resource £163,000) in pharmacy services which has enabled **21.1 wte** additional and permanent posts to be established to date in order to deliver the new pharmacotherapy model of service outlined within the Primary Care Improvement Plan. The total earmarked resource for Pharmacotherapy in the original financial plan over the three year implementation programme was identified as **£1.1m**.

The Pharmacotherapy workstream has been complex and has had to contend with many variables e.g. recruitment issues, the need to change post bandings and skill mix which has then required the introduction of training programmes, access to accommodation etc. While it is appreciated that it hasn't been an easy landscape to manage operationally, from a PCIP Executive Committee there remains a lack of assurance that equitable access, value and consistent progress is being achieved.

As previously stated, at the July meeting of the PCIP Executive Committee a review was undertaken of all investments and priority areas across the whole programme. Taking all of the above points into consideration, the Executive came to the difficult decision to halt the level of investment in the Pharmacotherapy workstream at the current position and to divert **£184k** (of the remaining earmarked funding of £203,462 in the financial plan) to contribute to the support required for the development of the Primary Care Mental Health Service workstream.

This means that the committed investment of £896,538 to support recruitment to the level of 21.1wte as approved to date will be honoured but there will be no further investment made into the pharmacotherapy service within the PCIP programme.

This decision has not been taken lightly however the investment in pharmacy services through PCIP at the level stated above has been significant; indeed it is a major proportion of the total funding allocation and has enabled the service to substantially grow and develop.

3.2.2 Non -recurring commitments

The transfer of £184k to the Primary care Mental Health Services workstream leaves a balance of £101k required to achieve the £285k additional PCIP contribution to the identified funding shortfall for the new model.

The PCIP Executive have made a number of non-recurring commitments in the financial plan across different headings during the programme but within the overall recurring budget. As these non-recurring commitments conclude or are not used at the anticipated level then this funding is identified through the review process and can be made available

for re-investment within the workstreams on a permanent basis. It has therefore been identified that the balance of £101k can be met in this way through revised levels of costs over the programme for:

- Travel.
- Equipment.
- Mentorship.
- Slippage in recruitment of fixed term support.
- Fixed term posts associated with the duration of the project.

4 SUMMARY

4.1 Through collaborative and integrated joint working an innovative Primary Care Mental Health Service model has been developed which will allow primary care patients to receive timely and appropriate support by the most appropriate professionals whilst enabling GPs to be freed up to focus on the role of Expert Medical Generalist. This is a completely new service to Borders and will be accessible across all practices.

4.2 The funding of this new model will be a joint arrangement between Mental Health and PCIP. Through robust review, the PCIP Executive has revised priorities and commitments in the current financial plan and has identified resource that can be diverted to contribute to the joint funding arrangement in order to establish this service. The PCIP Executive are confident that this is the most appropriate way forward and that the overall Plan will not exceed the £3.2 allocated resource envelope.

4.3 The PCIP Executive Committee has representation from all three partners in the Memorandum of Understanding linked to the new GP Contract: 4 x GPs (i.e. the GP Sub Committee Executive); IJB Chief Officer; Executive Lead for PCIP for NHS Borders; PCIP Business Partner; P&CS General Manager, Associate Medical Director, Associate Director of Nursing and Associate Director for AHPs; Mental Health Service General Manager.

5 RECOMMENDATION

5.1 The IJB is asked to agree the proposal of the PCIP Executive Committee to transfer funds between workstreams and budget headings as described.

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 19 August 2020

Report By	Robert McCulloch-Graham, Chief Officer for Integration
Contact	Graeme McMurdo, Programme Manager, Scottish Borders Council
Telephone:	01835 824000 ext. 5501

PERFORMANCE REPORT
AUGUST 2020 (LATEST AVAILABLE DATA AT END JUNE 2020)

Purpose of Report:	To provide a high-level summary of quarterly performance for Integration Joint Board (IJB) members, using latest available data. The report focuses on demonstrating progress towards the Health and Social Care Partnership's Strategic Objectives

Recommendations:	Health & Social Care Integration Joint Board is asked to: a) *Note* and approve any changes made to performance reporting. b) *Discuss* any proposed additional performance measures c) *Note* the key challenges highlighted. d) *Direct* actions to address the challenges and to mitigate risk

Personnel:	*n/a*

Carers:	*n/a*

Equalities:	A comprehensive Equality Impact Assessment was completed as part of the strategic planning process. Performance information supports the strategic plan.

Financial:	*n/a*

Legal:	*n/a*

Risk Implications:	*n/a*

1. BACKGROUND

1.1 The Integration Performance Group (IPG) established a set of high-level key performance indicators (KPI) for quarterly reporting to Integration Joint Board (IJB). The KPIs are aligned under the three Health and Social Care Strategic Plan 2018-2021 strategic objectives, broadly summarised below as:

- *Objective 1*: keeping people healthy and out of hospital
- *Objective 2*: ensuring people only stay in hospital for as long as required
- *Objective 3*: building capacity within Scottish Borders communities

1.2 The IPG continues to review, refine and develop the indicators to better balance the mix of hospital-focussed and social care KPIs. Wherever possible, the indicators are selected from robust, reliable data sources that can be compared to the Scottish average. The IPG will ensure that any new indicators for reporting are similarly robust and that proposed changes are discussed at IJB.

1.3 The February 2020 IJB raised concerns about the balance of indicators and requested that the report be expanded to include additional social care measures. The proposed additional social care measures have been discussed by IPG (*July 2020 meeting*) and have been shown in Section 3 of this covering paper for IJB discussion.

1.4 The IPG endeavours to present the latest available data. For some measures there is a significant lag whilst local data is validated and released publicly. This does increase robustness and allows for national comparison, but it is not ideal. Normally this is an inconvenience, but given the Covid-pandemic it is a bigger issue (i.e.) this quarterly performance report generally indicates performance pre-Covid, whereas most people are understandably more interested in our pandemic-related performance. To try and balance this, some more up to date data has been shown in Section 4 of this report showing the National impact of Covid on delayed discharge, A&E attendances and hospital admissions. This data comes from a 'lessons-learned' report that the Cabinet Secretary and COSLA requested in July 2020.

1.5 The IJB Strategic Risk Register focuses on risk and controls. The focus of the Quarterly Performance Report is to highlight performance trend, but the indicators also show where performance is off target and where mitigating action to address this needs to be taken. Performance and risk are very closely linked.

1.6 As normal, the quarterly performance report has three parts to it:

Covering report:	Providing background and summarising performance against a standard set of KPIs
Appendix 1:	Provides a high level, "at a glance" summary of the KPIs for publication. *Note: this summary does not yet include the additional Social Care measures discussed in 1.3 above. If will be amended upon approval of the new measures by IJB*
Appendix 2	Provides further details for each of the measures including more information on performance trends and analysis.

2. SUMMARY OF PERFORMANCE: (NOTE: BULK OF DATA REPORTED IS PRE-COVID)

2.1 The rate of **emergency hospital admissions (all ages) [*data to December 2019*]** performance trend has worsened over the last four reporting quarters, with the latest figure now 29.1 admissions per 1,000 population. This is worse than the Scottish average (27.6) and worse than our locally set target (27.5). The decline for Borders up to December 2019 quarter (from 27.4 to 29.1) is greater than the decline for Scotland (from 26.8 to 27.6). This becomes even more apparent when looking specifically at the **over 75 years [*data to December 2019*]** age group. Performance here is now 101.2 per 1,000 population (again to December 2019. The previous quarter was 88.1). The Scottish average also shows performance decline, but at a lesser rate (current is 94.4, previous quarter was 90.8). Winter pressure is likely to be one factor impacting the figures.

2.2 **A&E waiting times [*data to March 2020*]** appears to be relatively static and shows that 86.2% of people attending A&E were seen within 4 hours. This is below the Scottish average of 88.6% and worse than our locally set target (95%). Conversely, the data for **A&E attendances [*data to March 2020*]** shows that the number of attendances at A&E has fallen significantly. Borders A&E attendances were 70.1 per 1,000 population in Q3 2019/20, but have fallen to 59.6 per 1,000 population in Q4. The rate for Scotland also dropped over the same period and by a similar amount (from 72.1 to 62.0). it is likely that the early impact of Covid-19 during March 2020 will have played a part in the reduction in A&E attendances

2.3 The **balance of spend on emergency hospital stays [*data to September 2019*]** remains very positive - with 19.1% of health and care resource spent on hospital stays where the patient was admitted as an emergency (persons aged 18+). However this data is as of Q2 2019/20 so is close to 12 months out of date and does not reflect any Covid-impact.

2.4 The **quarterly occupied bed day rates for emergency admissions [*data to March 2020*]** in Scottish Borders residents *age 75+* is demonstrating a relatively flat performance trend over the last 4 quarters (824 to 826 per 1,000 population as of March 2020). Performance remains better than the Scotland average (1,108) and better than our local target (997), which is based on remaining at least 10% better than the national average. The Covid-19 impact will not be reflected in these figures.

2.5 With regard to delayed discharge, the **'snapshot' data performance [*taken on one day in May 2020*]** is positive, with 13 delayed discharges recorded. This demonstrates a positive performance trend over the last 4 months (28 to 13) and is better than our target of 23. The quarterly **rate of bed days associated with delayed discharges (75+) [*data to March 2020*]** performance however has worsened this quarter (to 206 beds per 1,000 population aged 75+ as of March 2020). This is worse than the Scotland average (for 2019) and worse than our locally set target (180). However, this once again, pre-dates any Covid impact.

2.6 The **% of patients satisfied** with care, staff & information in BGH and Community hospitals remains very good and the combined satisfaction rate remains high at 95.5%. The data is taken from questions asked in the "*2 minutes of your time*" survey done at BGH and community hospitals.

2.7 Our performance for the **Quarterly rate of emergency readmissions within 28 days of discharge [*data to December 2019*]** for Scottish Borders residents has declined with performance now showing a 11.5% readmission rate. This is worse than the latest Scotland average (10.4%) and worse than our local target (10.5%). Performance against this indicator has been discussed on a number of occasions at SPG and IJB.

2.8 Performance in relation to **end of life care [*data to December 2019*]** is improving, with 87.6%% of people able to spend the last 6 months of their life at home or in a community setting. This is slightly above target (87.5%) and close to the Scotland average (88.1%).

2.9 The % of **Carer Support Plans completed** performance is very positive, with 82% of the plans offered, having been completed, well above our 40% target.

2.10 Similarly, the **outcomes for carers** indicators remain positive. This suite of indicators looks at the positive outcome change between baseline assessment and subsequent review.

3 ADDITIONAL SOCIAL CARE PERFORMANCE INDICATORS

3.1 A Social Work performance group has been established within SBC. This group is developing a suite of measures covering services for older people, mental health and LD. Below is a selection of these measures that are suggested for inclusion in the quarterly reporting. Reasons for suggesting these include:

- The data being used by the SW Performance Group should be robust and gathered on a regular basis – therefore will also be available for SPG/IJB meetings
- The proposed measures align to a number of Strategic Implementation Plan (SIP) workstreams.

3.2

No'	Measure Description	Target	Measure Purpose
1	The proportion of acute patients who are discharged to a permanent residential care bed without any opportunity for short-term recovery.	tbc	Want people to have the opportunity to receive intermediate care – where appropriate – post Hospital discharge and pre-admission to residential care
2	The proportion of older people (with or without a diagnosis of dementia) who enter residential care after receiving domiciliary care.	tbc	Ideally want people to be supported to live as independently as possible for as long as possible, only entering 24hr residential care where absolutely necessary.
3	The proportion of older people who receive less than 10 hours of domiciliary care (as a proportion of all older people receiving domiciliary care).	tbc	This will show our package of care split (e.g.) <4hrs, <10hrs, >10hrs, to examine trend over time and to generate discussion on the value of small and large packages of care.
4	The proportion of older people receiving longer term care whose original care needs have decreased (from their initial assessment to latest review).	tbc	Do not want to maintain anyone on a package of care that is no longer appropriate. Will also indicate the value/impact of regular review and reablement
5	The proportion of people who require long-term care after a period of short-term reablement / rehabilitation	tbc	Ideally would like the people selected to receive reablement as having no little to no requirement for long-term care.

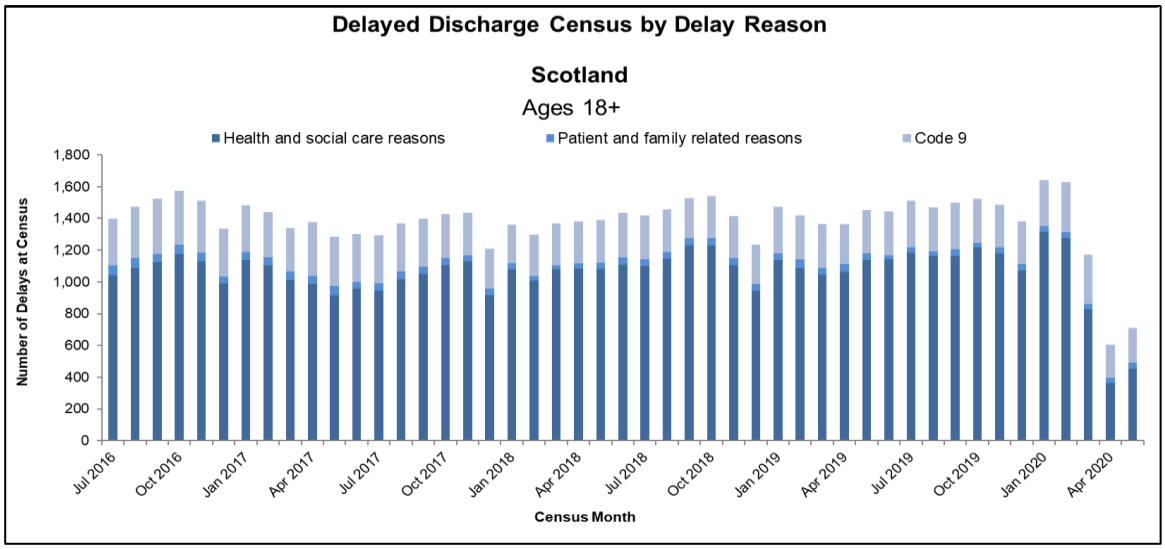
4 ADDITIONAL CONTEXT FOR DELAYED DISCHARGES, A&E ATTENDANCES AND HOSPITAL ADMISSIONS

4.1 The Cabinet Secretary and COSLA agreed to undertake a piece of work with all Health & Social Care Partnerships to look at how delayed discharges, A&E attendances and hospital admissions all reduced significantly during March and April as the COVID-19 outbreak hit. The paper looked to establish what had worked well, what hadn't and what could be done differently. Conclusions and results from the report are shown below:

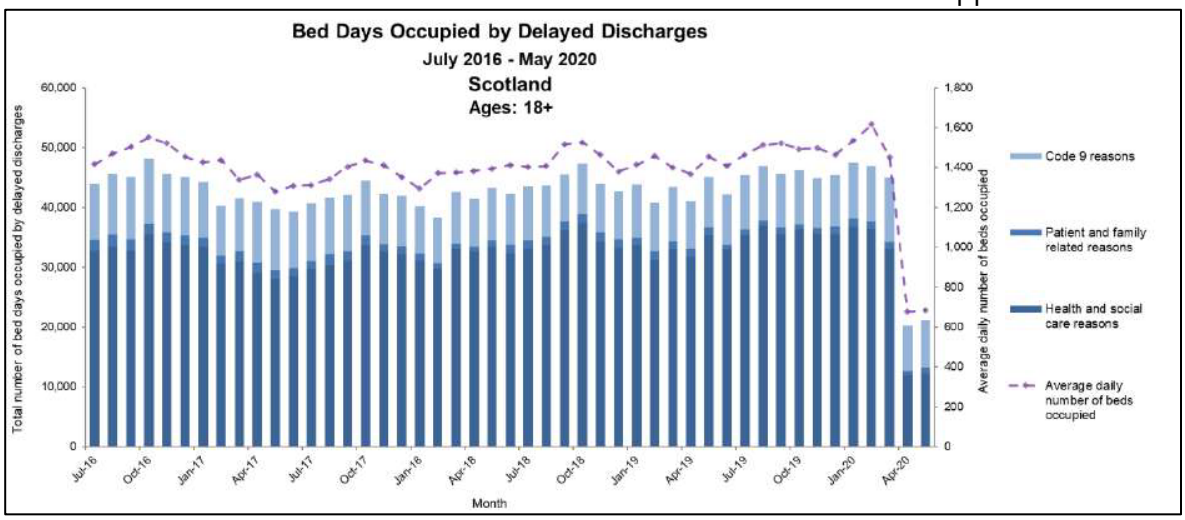
4.2 The report concluded that historical problems with **Delayed Discharges** have:

- Been compounded by deep-rooted behavioural issues, different organisational and professional cultures leading to a lack of trust in which the default position has become staying in hospital. [**Lack of Trust**]
- With hospitals being increasingly busy, staff tended, by necessity, to move on to the next crisis and the delayed patient could be forgotten, with all the known harmful consequences of deterioration and deconditioning. [**Lack of focus on outcome**]
- Leading to a blame culture where people don't trust each other there is a tendency to blame each other when things go wrong. [**Blame Culture/Pass the Problem**]
- As the delayed discharge numbers kept getting higher and higher, there was an acceptance of failure, fed by a perception of futility. Bad became the norm and nothing changed because everyone reverted to how things had always been done. **[Acceptance of poor performance**]

4.3 With the onset of the COVID-19 outbreak, it was clear that delayed discharges needed to reduce, both in order to free up hospital capacity and to create better outcomes for individuals at risk of acquiring infection in hospital. The result was that Nationally, delayed discharges reduced from 1,627 (February 2020) to 604 (end April 2020).



4.4 The report found that COVID-19 has undoubtedly proved to be the stimulus needed to make significant delayed discharge and subsequent **Bed Days Occupied by Delayed Discharge** reductions. The response to the outbreak removed some of the historic barriers as well as providing the enablers and the incentive for progress. It has in a perverse way created the necessary conditions to make the sort of significant progress that had long proved difficult to achieve. This progress has come at a speed that has never before been possible.

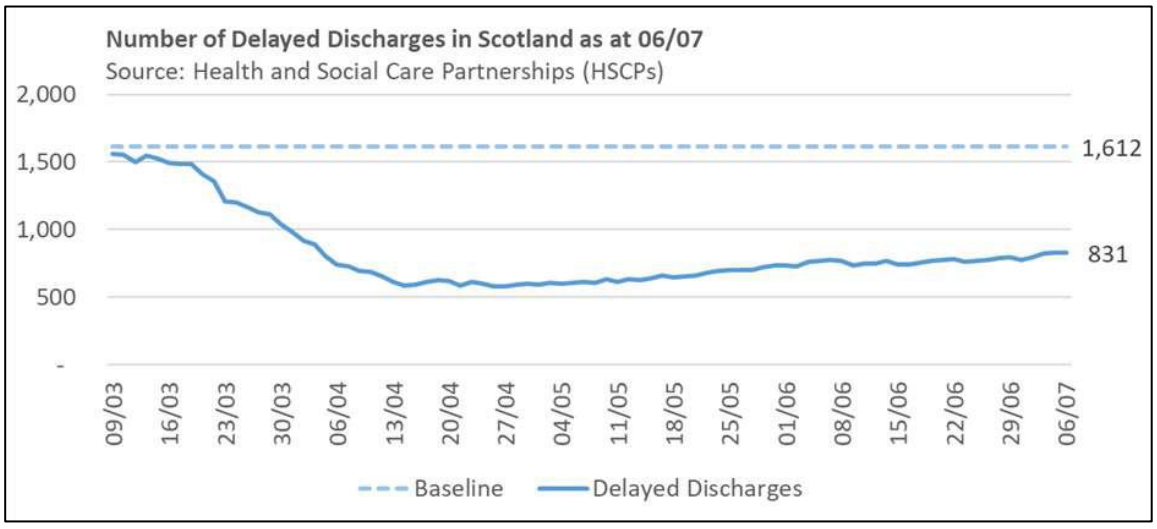


4.5 Bed days associated with delayed discharge reduced from 45,061 in May 2019 to 21,225 in April 2020.

5 POST COVID-19

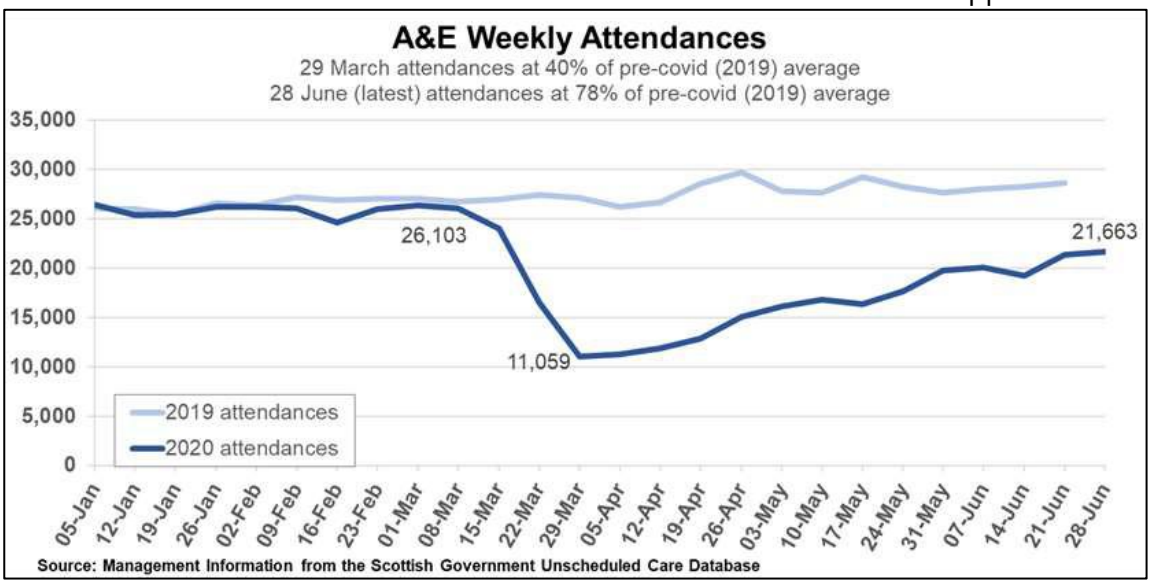
5.1 Delayed Discharge

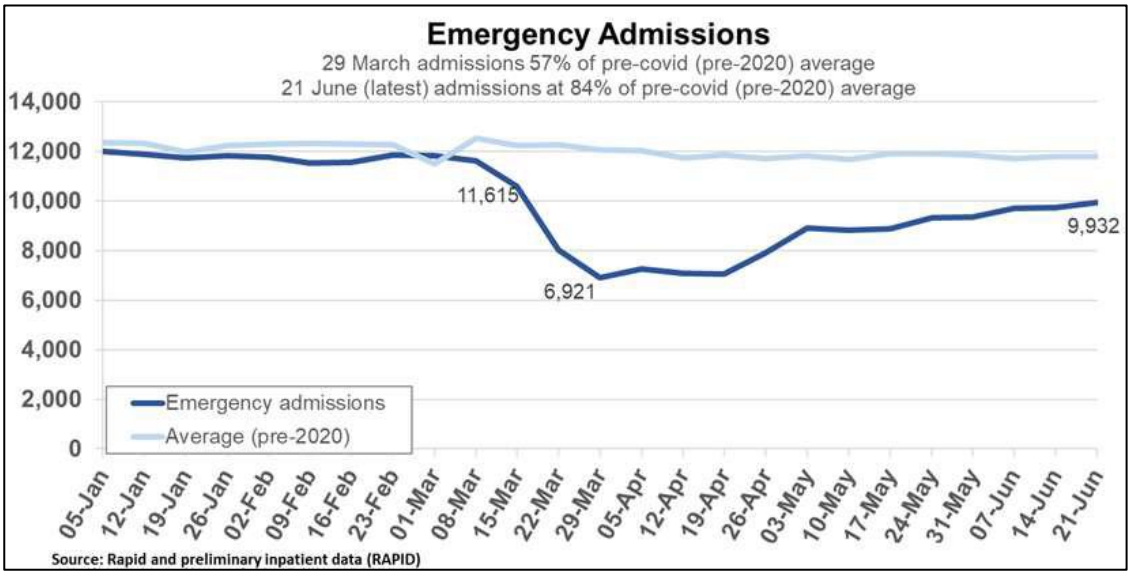
Everyone agrees that delayed discharge is a bad thing. Everyone agrees that being in hospital when you do not need to be there is a bad thing. There is no 'upside' to this problem. It uses up valuable NHS resources, denies a bed to others that need it and it is a very poor outcome for the individual concerned. However, delays have begun to creep up once more.



5.2 A&E Attendances and Emergency Admissions

Similarly, A&E attendance dropped significantly because of Covid and Emergency admissions dropped likewise. Both are now returning to previous levels – with both now back to approx. 80% of the level they were pre-Covid.


A&E Weekly Attendances
29 March attendances at 40% of pre-covid (2019) average
28 June (latest) attendances at 78% of pre-covid (2019) average
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
26,103
11,059
21,663
2019 attendances
2020 attendances
05-Jan
12-Jan
19-Jan
26-Jan
02-Feb
09-Feb
16-Feb
23-Feb
01-Mar
08-Mar
15-Mar
22-Mar
29-Mar
05-Apr
12-Apr
19-Apr
26-Apr
03-May
10-May
17-May
24-May
31-May
07-Jun
14-Jun
21-Jun
28-Jun
Source: Management Information from the Scottish Government Unscheduled Care Database


Emergency Admissions
29 March admissions 57% of pre-covid (pre-2020) average
21 June (latest) admissions at 84% of pre-covid (pre-2020) average
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
11,615
6,921
9,932
Emergency admissions
Average (pre-2020)
05-Jan
12-Jan
19-Jan
26-Jan
02-Feb
09-Feb
16-Feb
23-Feb
01-Mar
08-Mar
15-Mar
22-Mar
29-Mar
05-Apr
12-Apr
19-Apr
26-Apr
03-May
10-May
17-May
24-May
31-May
07-Jun
14-Jun
21-Jun
Source: Rapid and preliminary inpatient data (RAPID)

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CHANGING HEALTH & SOCIAL CARE FOR YOU

Working with communities in the Scottish Borders for the best possible health and wellbeing

SUMMARY OF PERFORMANCE FOR INTEGRATION JOINT BOARD **AUGUST 2020**

This report provides an overview of quarterly performance under the 3 Strategic Objectives within the Health & Social Care Partnership Strategic Plan, with **latest available data at the end of June 2020**. Annual performance is included in our latest **Annual Performance Report 2018/19**

KEY

- +ve trend over 4 reporting periods
- compares well to Scotland average
- compares well against local target

- trend over 4 reporting periods
- comparison to Scotland average
- comparison against local target

- -ve trend over 4 reporting periods
- compares poorly to Scotland average
- compares poorly to local target

HOW ARE WE DOING?

OBJECTIVE 1

We will improve health of the population and reduce the number of hospital admissions.

EMERGENCY HOSPITAL ADMISSIONS (BORDERS RESIDENTS, ALL AGES)	EMERGENCY HOSPITAL ADMISSIONS (BORDERS RESIDENTS AGE 75+)	ATTENDANCES AT A&E (ALL AGES)	£ ON EMERGENCY HOSPITAL STAYS
29.1 **admissions** per 1,000 population (Q3 - 2019/20)	**101.2** **admissions** per 1,000 population Age 75+ (Q4 – 2019/20)	**59.6** **attendances** per 1,000 population (Q4 – 2019/20)	**19.1%** of **total health and care resource**, for those **Age 18+ was spent** on **emergency hospital stays** (Q2 – 2019/20)
-ve trend over 4 periods Worse than Scotland (27.6 – Q3 2019/20) Worse than target (27.5)	**-ve trend over 4 periods Worse than Scotland (94.4 – Q3 2019/20) Worse than target (90.0)**	**+ve trend over 4 periods Better than Scotland (62.0 – Q4 2019/20) Better than target (70.0)**	**+ve trend over 4 periods Better than Scotland (23.5% - 2018/19) Better than target (21.5%)**

Main Challenges

The rate of emergency admissions over the long-term (3 year period) remains relatively positive. Quarterly performance does fluctuate; and Covid-19 will have an impact – although not reflected in the figures to date. Historically, the number of A&E attendances has fluctuated between 7,000-8,000 attendances per quarter (which is equivalent to approx. 60-70 per 1,000 population per quarter), generally better than the Scotland average and better than our local target. Again, Covid-19 will impact A&E attendances and may well impact the peoples use of A&E for a long time to come. In relation to the percentage of the budget spent on emergency hospital stays, Borders has consistently performed better than Scotland and can demonstrate a positive trend over time. The most recent figure of 19.1% is the lowest % of spend in the last 3 years but the data is once again pre-Covid. *(note: as of December 2019, the denominator for this measure was updated to include Dental and Ophthalmic costs and, as a result, the % of Health Care spend has slightly reduced).* As with all Health and Social Care Partnerships, there is an expectation to minimise the proportion of spend attributed to unscheduled stays in hospital.

Objective 1: Our plans for 2020/21

Our Strategic Implementation Plan (SIP) includes the development of our Localities (e.g.) building on 'What Matters' and Community Assistance Hubs to improve and facilitate early intervention, shared client cohorts, agile responses, close coordination of effort, all reducing admissions and avoiding or slowing progression to higher levels of care and health needs

Work continues to be progressed to improve patient flow, including; Frailty Front Door (admission avoidance), quicker discharge processes, trusted assessor models, new Intermediate Care and Reablement Services.

#yourpart

Scottish Borders Health and Social Care PARTNERSHIP

OBJECTIVE 2

We will improve the flow of patients into, through and out of hospital.

A&E WAITING TIMES (TARGET = 95%)	RATE OF OCCUPIED BED DAYS* FOR EMERGENCY ADMISSIONS (AGES 75+)	NUMBER OF DELAYED DISCHARGES ("SNAPSHOT" TAKEN 1 DAY EACH MONTH)	RATE OF BED DAYS ASSOCIATED WITH DELAYED DISCHARGE	"TWO MINUTES OF YOUR TIME" SURVEY – CONDUCTED AT BGH AND COMMUNITY HOSPITALS
86.2% of **people seen within 4 hours** (Mar 2020)	**826** **bed days** per 1000 population Age 75+ (Q4 – 2019/20)	**13** **over 72 hours** (May 2020)	**206** **bed days** per 1000 population Age 75+ (Q4 – 2019/20)	**95.5%** **overall satisfaction rate** (Q4 - 2019/20)
-ve trend over 4 periods Worse than Scotland (88.6% - Mar 2020) Worse than target (95%)	-ve trend over 4 periods Better than Scotland (1,108 - Q3 2019/20) Better than target (min 10% better than Scottish average)	+ve trend over 4 periods Better than target (23)	-ve trend over 4 periods Worse than Scotland (198 - 19/20 average) Worse than target (180)	-ve trend over 4 periods Better than target (95%)

*Occupied Bed Days in general/acute hospital beds such as Borders General Hospital. This does not include bed days in the four Borders' community hospitals.

Main Challenges

The latest A&E Waiting Time (Mar 2020) figure is under our 95% target and also below the Scotland average. This data pre-dates the Covid pandemic and it is likely that our next reporting will show waiting time performance improvement as a result of fewer people attending A&E. Occupied bed day rates for emergency admissions (age 75+) has seasonal fluctuations and again in future reporting will be impacted by Covid. Delayed discharge rates vary in regard to 'snapshot' data, but performance is positive and a target to reduce delayed discharges by 30% in 2019/20 has been achieved by the Health & Social Care Partnership if comparing snapshot data for May 2019 (26) with May 2020 (13). The percentage of patients satisfied with care, staff & information in BGH and Community Hospitals remains positive. The rate of Bed Days Associated with Delayed Discharge has an overall positive trend over the long term (3 years) but Q4 2019/20 shows a significant increase to 206 days, which is above the average and above our 180 day local target. Covid will impact on a number of measures, including delayed discharge, A&E attendances/waiting times, and emergency admissions.

Objective 2: Our plans for 2019/20

As part of our Strategic Implementation Plan (SIP), we will continue to work across the HSC Partnership and Public Health to initiate a number of events, campaigns and communications promoting personal responsibility and encouraging Borderers to remain safe and to be healthy in areas including diet, exercise and mental health. We will further develop community capacity and we will examine the bed-base mix across the care estate including the usage, role & function of Community Hospital beds. We will review our contracted and commissioned services and support our workforce to ensure that we have flexible staff with the skills, training and equipment required to deal with the impacts of Covid and any future pandemics.

OBJECTIVE 3

We will improve the capacity within the community for people who have been in receipt of health and social care services to manage their own conditions and support those who care for them.

EMERGENCY READMISSIONS WITHIN 28 DAYS (ALL AGES)	END OF LIFE CARE	CARERS SUPPORT PLANS COMPLETED	SUPPORT FOR CARERS: change between baseline assessment and review. Improvements in self- assessment
11.5 per **100 discharges from hospital** were re-admitted within 28 days (Q3 – 2019/20)	**87.6%** of **people's last 6 months** was spent at home or in a community setting (Q3 – 2019/20)	**82%** of **carer support plans offered** that have been **taken up and completed in the last quarter** (Q4 – 2019/20)	Health and well-being Managing the caring role Feeling valued Planning for the future Finance & benefits (Q4 – 2019/20)
-ve trend over 4 Qtrs Worse than Scotland (10.4 – Q3 2019/20) Worse than target (10.5)	+ve trend over 4 Qtrs Worse than Scotland (88.1% - 2018/19) Worse than target (87.5%)	+ve trend over 4 Qtrs Better than target (40%)	+ve impact No Scotland comparison No local target

Main Challenges

The quarterly rate of emergency readmissions within 28 days of discharge (all ages) peaked at 11.5% in Q3 2019/20 – the highest readmission rate in the last 3 years and increasing from a low of 10.0% in 2016/17. Borders data in relation to end of life care shows has improved but is still less than the Scotland average. The latest available data for Carers demonstrates positive outcomes as a result of completed Carer Support Plans.

Objective 3: Our plans for 2019/20

As part of our Strategic Implementation Plan (SIP), we will continue to support Carer services – the partnership has always recognised the essential work of carers, and even more so through the Pandemic. It is a precarious resource that requires support. We will continue trialling and implementing technology to improve health and care provision, workforce enablement, administration and processes. We will implement Joint Capital Development and Planning, including a Primary Care Capital Strategy, new Intermediate Care provision and an overarching Joint Capital Plan for the Border's Public Sector.

Scottish Borders
Health and Social Care
PARTNERSHIP

Quarterly Performance Report for the Scottish Borders Integration Joint Board August 2020

SUMMARY OF PERFORMANCE: LATEST AVAILABLE DATA AT END JUNE 2020

Structured Around the 3 Objectives in the Strategic Plan

Objective 1: We will improve health of the population and reduce the number of hospital admissions

Objective 2: We will improve patient flow within and outwith hospital

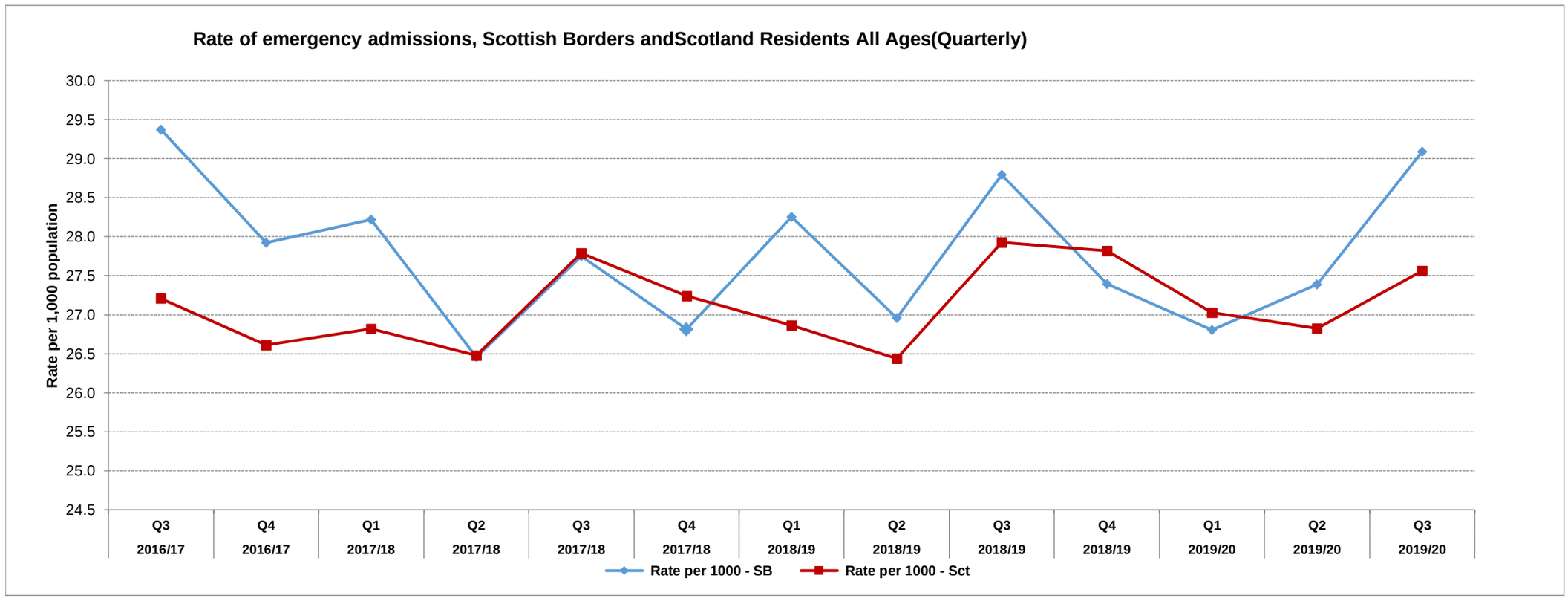
Objective 3: We will improve the capacity within the community for people who have been in receipt of health and social care services to manage their own conditions and support those who care for them

Objective 1: We will improve health of the population and reduce the number of hospital admissions

Emergency Admissions, Scottish Borders residents All Ages

Source: MSG Integration Performance Indicators workbook (SMR01 data)

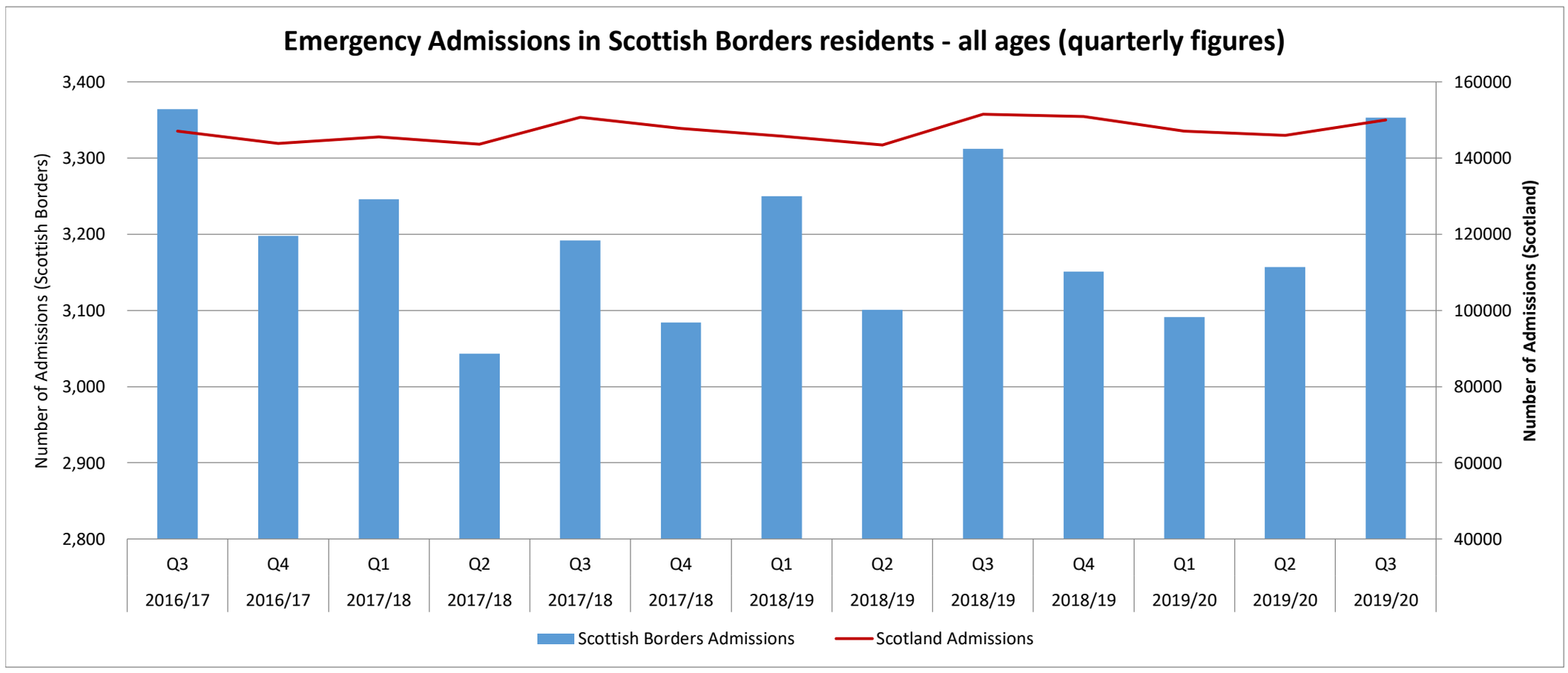
	Q3 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20
Scottish Borders - Rate of Emergency Admissions per 1,000 population	29.4	27.9	28.2	26.5	27.8	26.8	28.3	27.0	28.8	27.4	26.8	27.4	29.1
Scotland - Rate of Emergency Admissions per 1,000 population All Ages	27.2	26.6	26.8	26.5	27.8	27.2	26.9	26.4	27.9	27.8	27.0	26.8	27.6



Number of Emergency Admissions in Scottish Borders residents - all ages (quarterly figures)

Source: MSG Integration Performance Indicators workbook (SMR01 data)

	Q3 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20
Number Scottish Borders Emergency Admissions - All Ages	3,364	3,198	3,246	3,043	3,192	3,084	3,250	3,101	3,312	3,151	3,091	3,157	3,353
Number Scotland Emergency Admissions - All Ages	147,051	143,831	145,495	143,649	150,739	147,780	145,738	143,422	151,497	150,915	147,024	145,919	149,947



How are we performing?

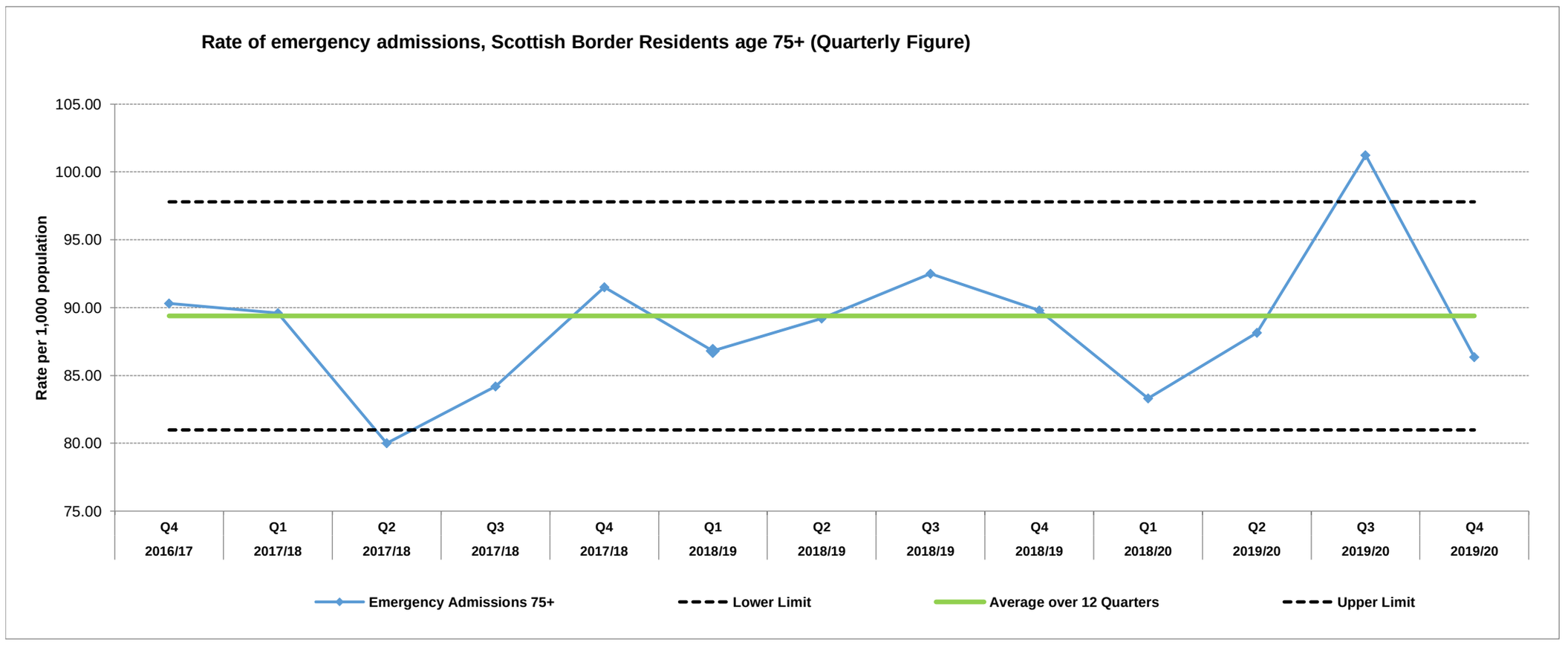
The quarterly number of Emergency Admissions for Scottish Borders residents (all ages) has continued to fluctuate since the start of the 2016/17 financial year; however, shows an overall positive decreasing trend. Q1 of 2019/20 saw an initial reduction in the rate of Emergency Admissions; however, this increased in Q2 and again in Q3; almost bringing the most recent reported rate in line with the Emergency Admission rate of Q3 2016/17.

Borders has had a higher rate of Emergency Admissions for the past 2 consecutive quarters when compared to the Scottish Average.

Emergency Admissions, Scottish Borders residents age 75+

Source: NSS Discovery

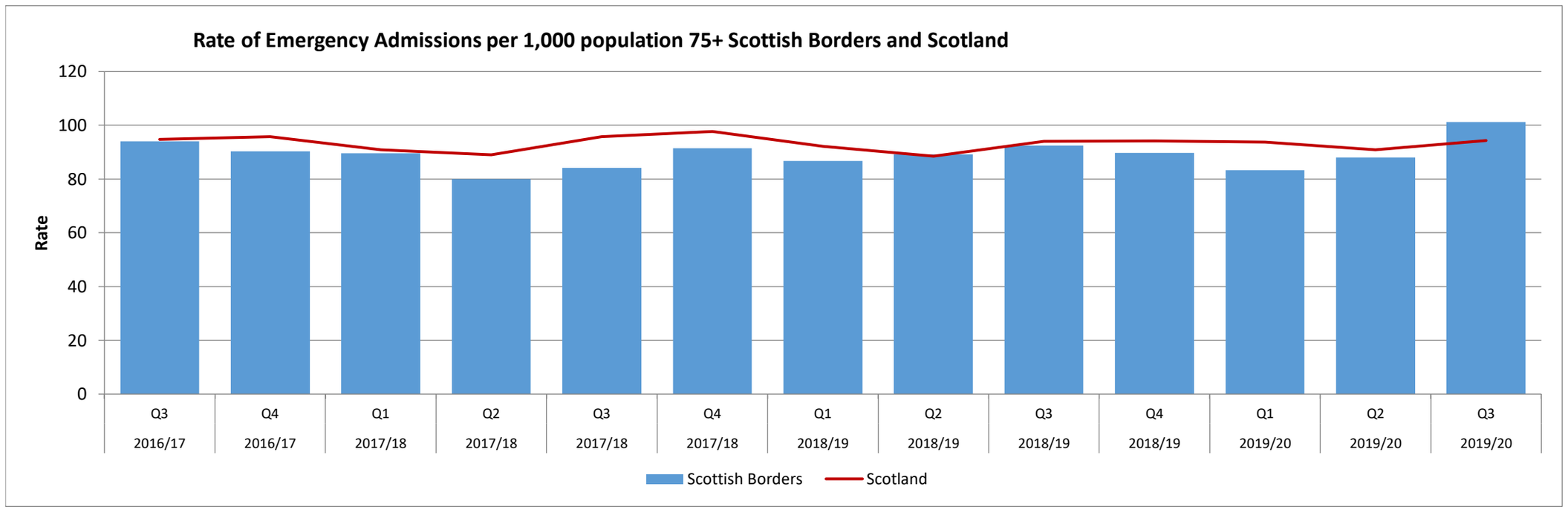
	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20
Number of Emergency Admissions, 75+	1,065	1,074	959	1,009	1,096	1,040	1,069	1,108	1,076	1,020	1,079	1,239	1,057
Rate of Emergency Admissions per 1,000 population 75+	90.3	89.6	80.0	84.2	91.5	86.8	89.2	92.5	89.8	83.3	88.2	101.2	86.4



Emergency Admissions comparison, Scottish Borders and Scotland residents age 75+

Source: NSS Discovery

	Q3 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20
Rate of Emergency Admissions Scottish Borders	94.0	90.3	89.6	80.0	84.2	91.5	86.8	89.2	92.5	89.8	83.3	88.1	101.2
Rate of Emergency Admissions 75+ Scotland	94.7	95.8	90.9	89.1	95.8	97.7	92.2	88.5	94.0	94.2	93.7	90.8	94.4



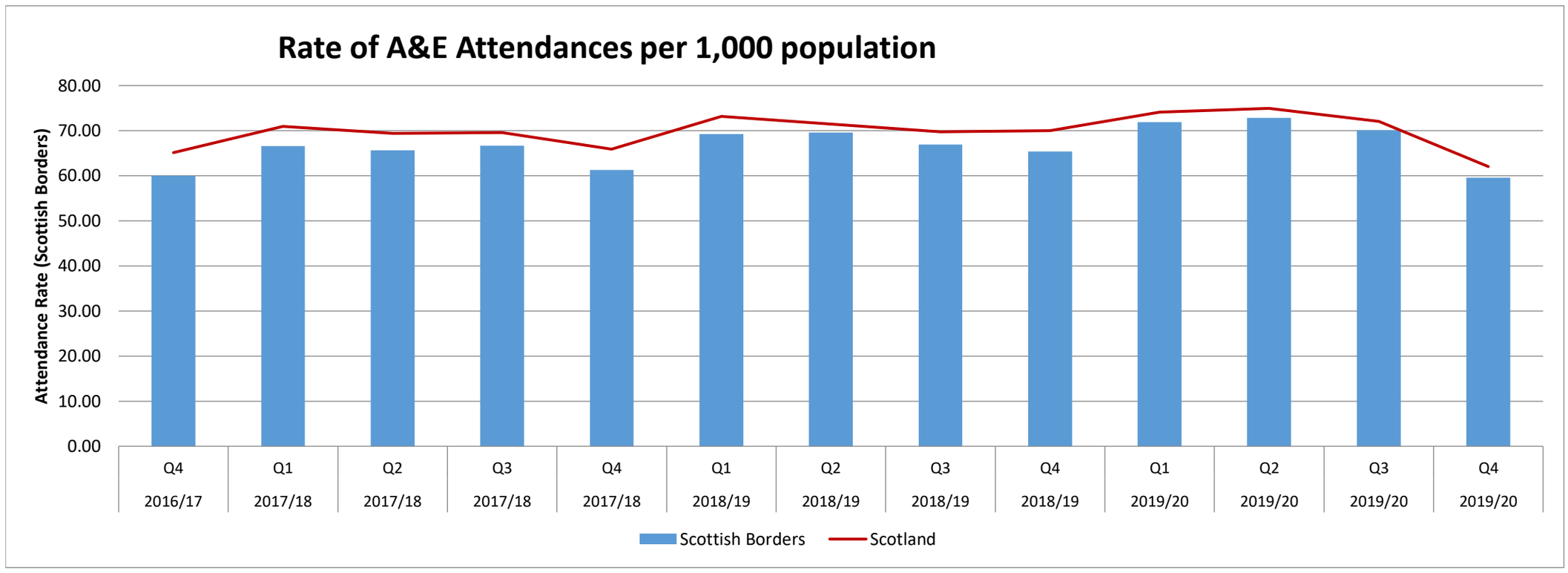
How are we performing?

The rate of emergency admissions per 1,000 population fell slightly in quarters 2 & 3 of 2017/18 but crept back up in Q4 2017/18. The 3 year trend for this indicator has seen a slight increase in the rate of 75+ emergency admissions. The Emergency Admission rate has been increasing over the last 2 quarters with Q3 2019/20 reporting the highest rate in the last 3 years.

Rate of A&E Attendances per 1,000 population

Source: MSG Integration Performance Indicators workbook (data from NHS Borders Trakcare system)

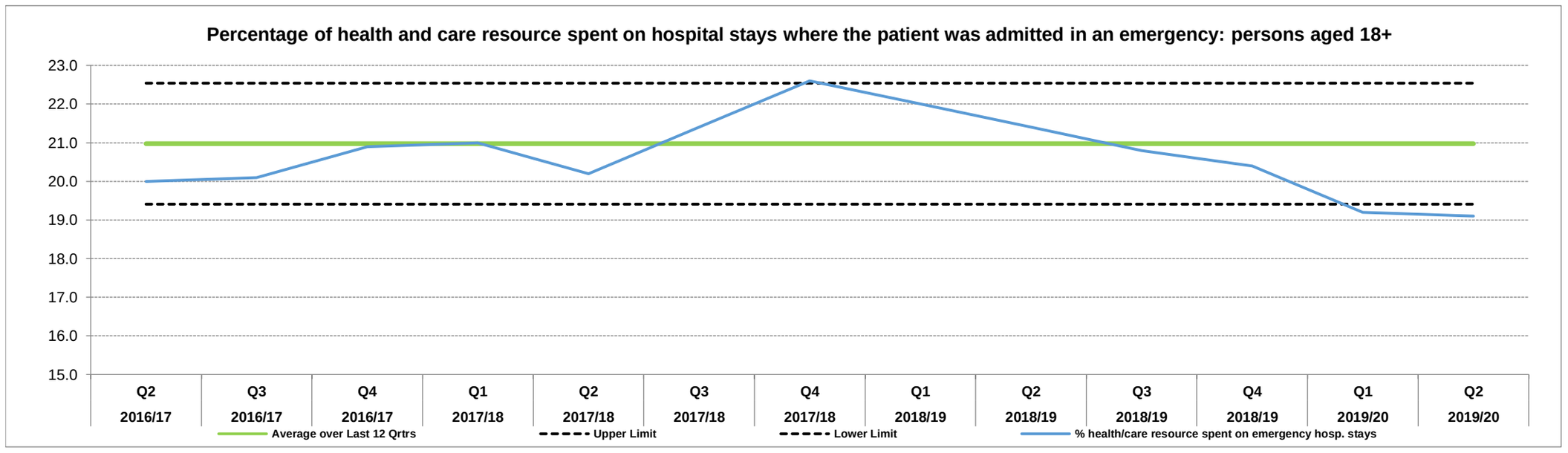
	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20
Rate of Attendances, Scottish Borders	60.0	66.6	65.6	66.7	61.3	69.2	69.6	67.0	65.4	71.9	72.8	70.1	59.6
Rate of Attendances, Scotland	65.2	71.0	69.4	69.6	65.9	73.1	71.5	69.7	70.0	74.1	74.9	72.1	62.0

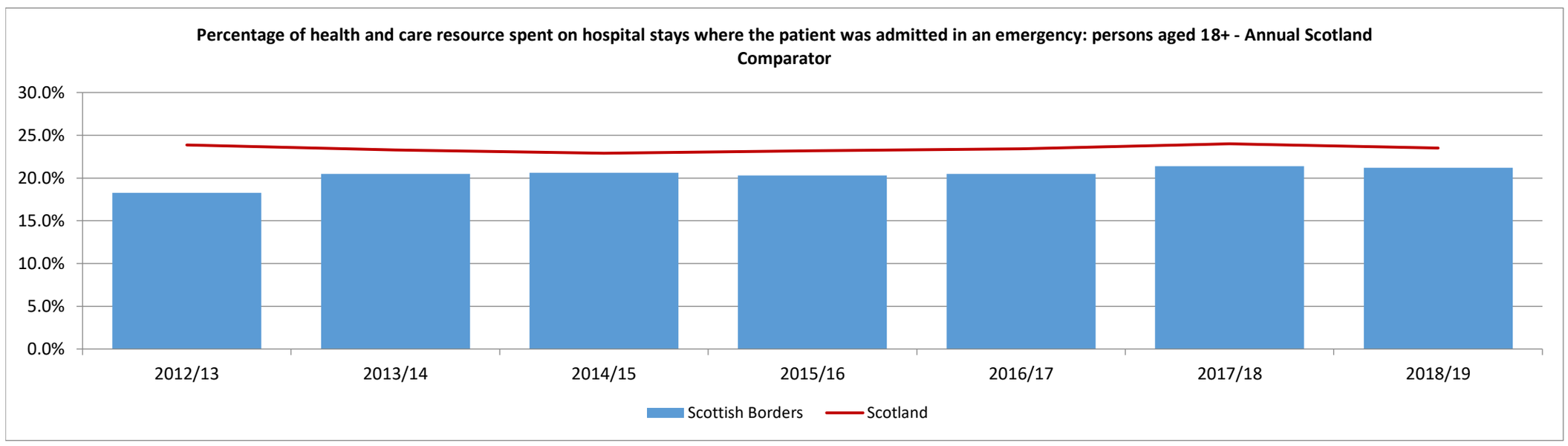


Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency: persons aged 18+

Source: Core Suite Indicator workbooks

	Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20
% of health and care resource spent on emergency hospital stays (Scottish Borders)	20.0	20.1	20.9	21.0	20.2	21.4	22.6	22.0	21.4	20.8	20.4	19.2	19.1





How are we performing?

The percentage of health and social care resource spent on unscheduled hospital stays has seen an overall slight decrease since the first quarter of 2016/17. This peaked at 22.6% in Q4 2017/18 and has subsequently been reducing each quarter since. This indicator displays a change in behaviour for HC Spend and the reported Q3 figure of 19.1% is the lowest percentage of spend attributed to emergency hospital stays in the last 3 years. Figures for Q3 & Q4 of 2019/20 are affected by completeness (Q4 - 71% complete) and will be refreshed in future reports.

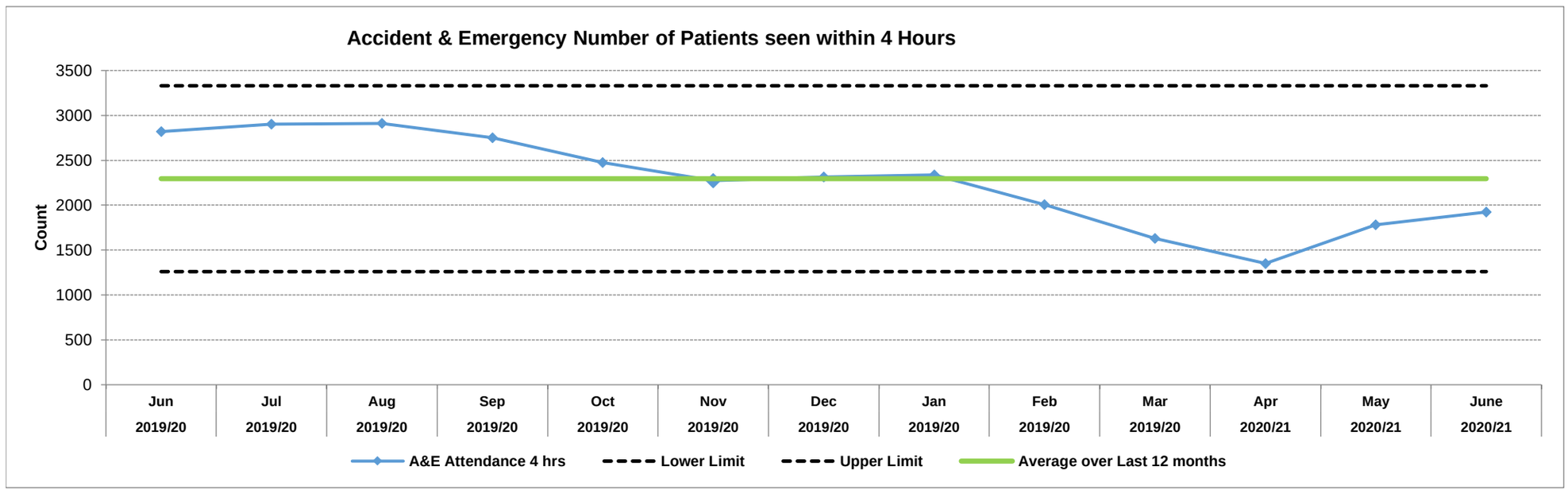
NB: December 2019, the denominator for this indicator now includes dental and ophthalmic costs. As a result, the % of spend has slightly decreased. The Table and Charts above have been updated to reflect the altered % as a result of this change.

Objective 2: We will improve patient flow within and out with hospital

Accident and Emergency attendances seen within 4 hours- Scottish Borders

Source: NHS Borders Trakcare system

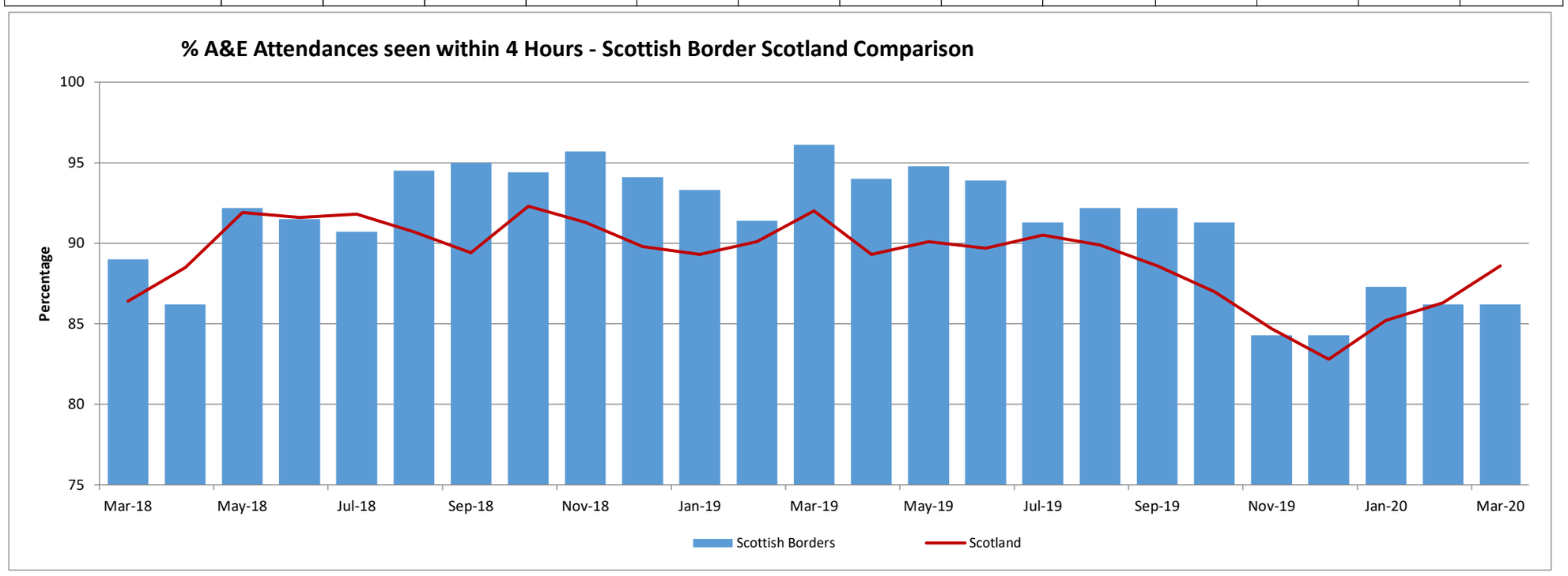
	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Number of A&E Attendances seen within 4 hours	2821	2900	2910	2749	2473	2271	2312	2338	2004	1631	1351	1779	1923



% A&E Attendances seen within 4 Hours - Scottish Borders and Scotland Comparison

Source: MSG Integration Performance Indicators workbook (A&E2 data) / ISD Scotland ED Activity and Waiting Times publication

	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
% A&E Attendances seen within 4 hour Scottish Borders	96.1	94.0	94.8	93.9	91.3	92.2	92.2	91.3	84.3	84.3	87.3	86.2	86.2
% A&E Attendances seen within 4 hour Scotland	92.0	89.3	90.1	89.7	90.5	89.9	88.6	87.0	84.7	82.8	85.2	86.3	88.6



How are we performing?

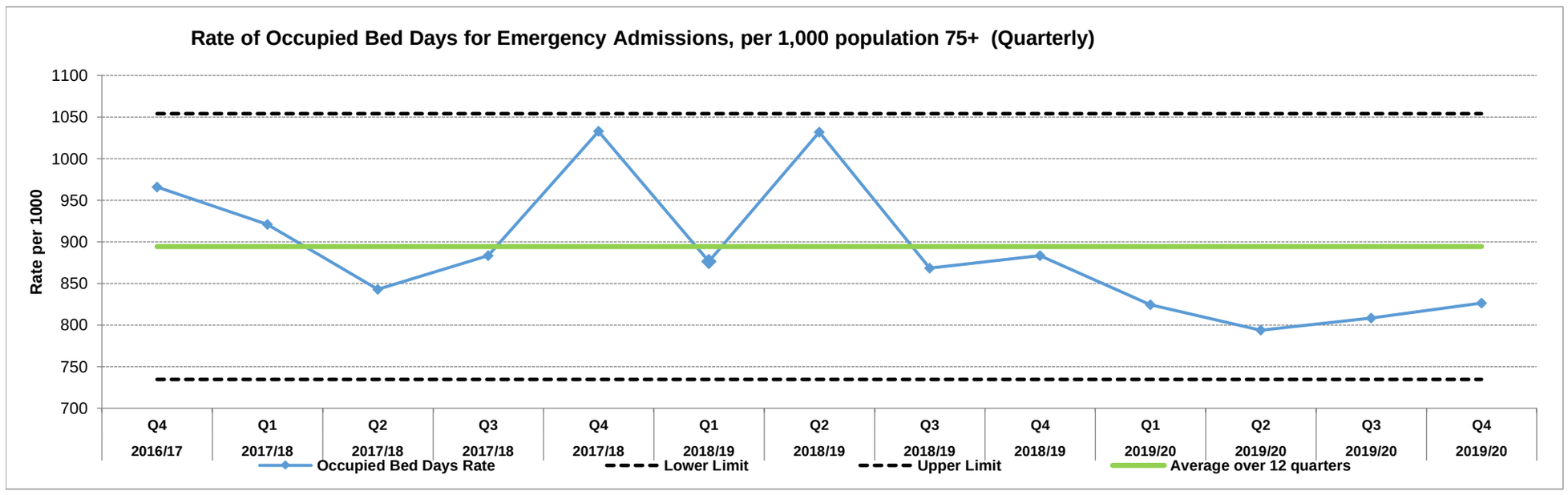
NHS Borders consistently performs better than the Scottish comparator for A&E waiting times; however, Borders has fallen below the Scottish Average on 3 occasions in the last year - Nov 19, Feb and Mar 20.

Performance against this measure showed a positive trend over the year 2018/19, peaking in March 2019 at 96.1%. In contrast to this the chart shows a negative trend in 2019/20. The 95% target has not been met in the last 12 months. NHS Borders are working towards consistently achieving an ambitious local 98% standard; therefore action is required to improve A&E waiting times.

Occupied Bed Days for emergency admissions, Scottish Borders Residents age 75+

Source: NSS Discovery

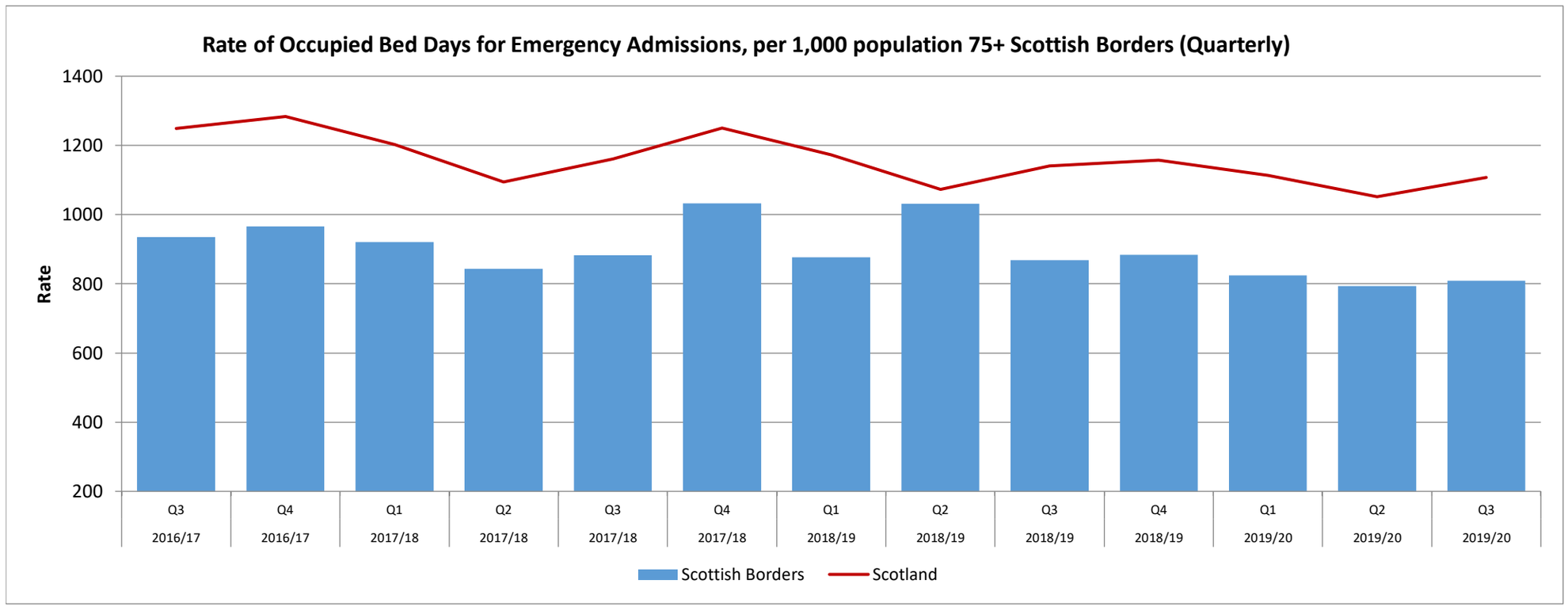
	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/17	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20
Number of Occupied Bed Days for emergency Admissions, 75+	11387	11035	10103	10582	12377	10523	12356	10407	10587	10089	9715	9893	10116
Rate of Occupied Bed Days for Emergency Admissions, per 1,000 population 75+	966	921	843	883	1033	876	1032	868	883	824	794	808	826



Occupied Bed Days for emergency admissions, Scottish Borders and Scotland Residents age 75+

Source: NSS Discovery

	Q3 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/17	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20
Rate of Occupied Bed Days for Emergency Admissions, per 1,000 population 75+ Scottish Borders	935	966	921	843	883	1033	876	1032	868	883	824	794	808
Rate of Occupied Bed Days for Emergency Admissions, per 1,000 population 75+ Scotland	1248	1284	1203	1094	1161	1250	1172	1072	1141	1157	1113	1052	1108



How are we performing?

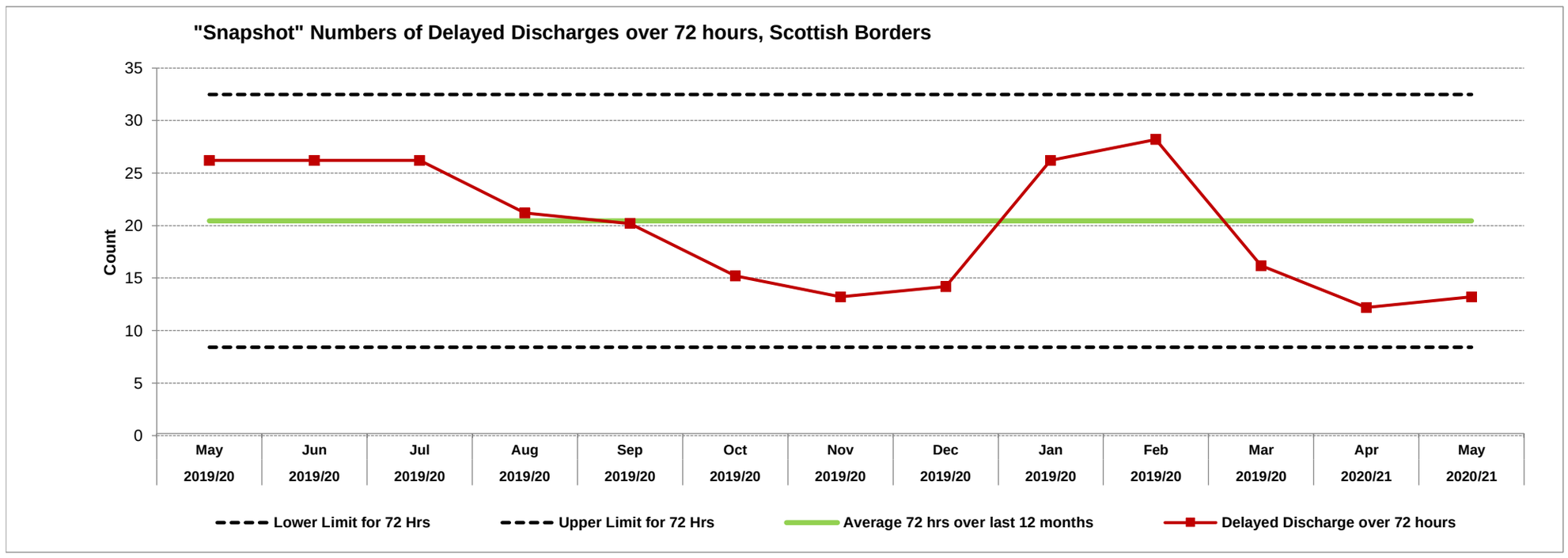
The quarterly occupied bed day rates for emergency admissions in Scottish Borders residents aged 75 and over has fluctuated over time but has remained lower than the Scottish Average (it should be noted this nationally derived indicator does not take in to account the 4 Borders' Community Hospitals).

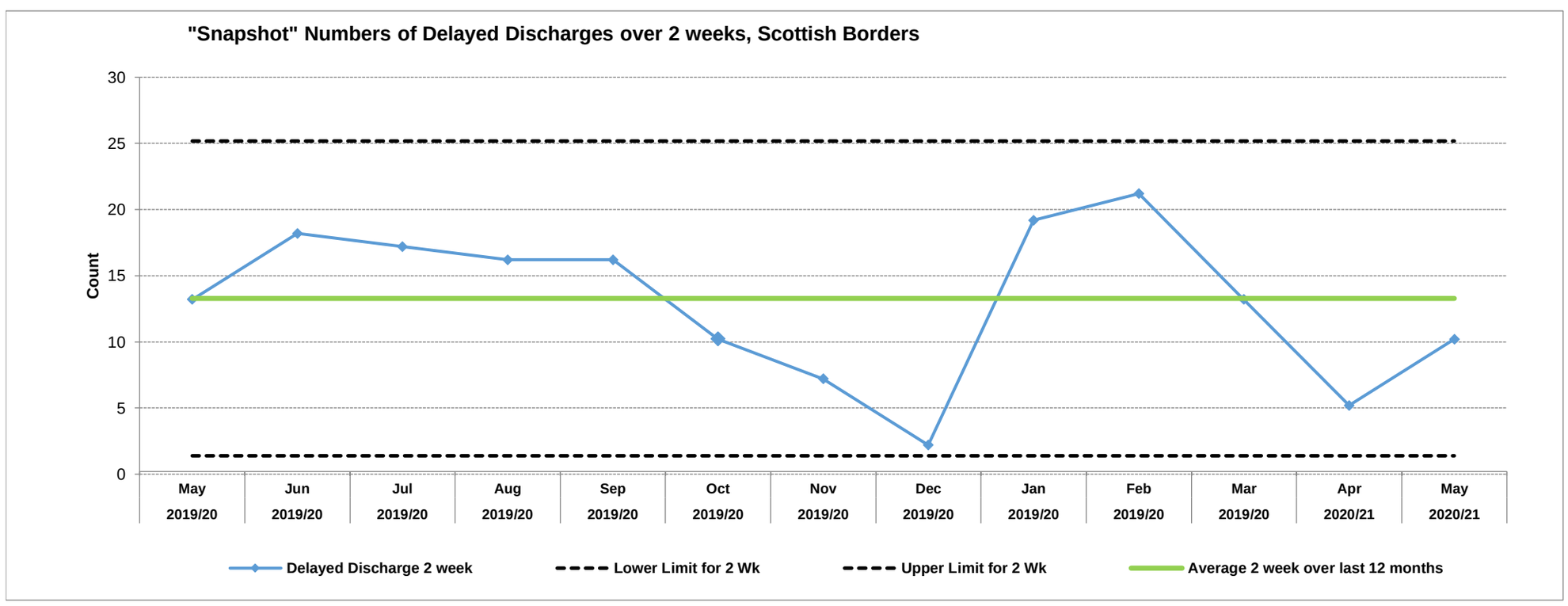
There is a notable reduction in occupied bed days for Emergency admissions since Q2 of 2018/19, drawing the Border's figure further from the Scotland average. The graph shows a positive trend over the last 3 years with an overall reduction in occupied bed days; although this has began to increase in Q3 & Q4 of 2019/20.

Delayed Discharges (DDs)

Source: EDISON/NHS Borders Trakcare system

	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20
Number of DDs over 2 weeks	13	18	17	16	16	10	7	2	19	21	13	5	10
Number of DDs over 72 hours	26	26	26	21	20	15	13	14	26	28	16	12	13





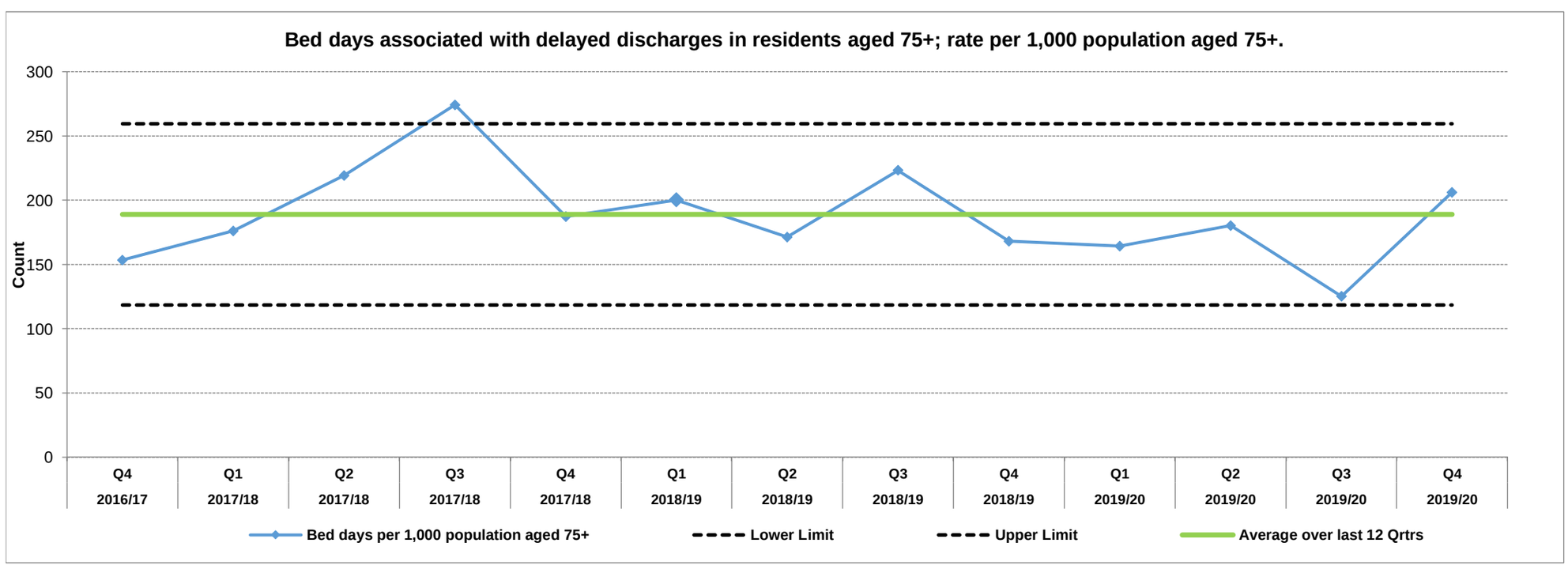
Please note the Delayed Discharge over 72 hours measurement has been implemented from April 2016.

The DD over 2 weeks measurement has several years of data and has been plotted on a statistical run chart (with upper, lower limits and an average) to provide additional statistical information to complement the more recent 72 hour measurement.

Bed days associated with delayed discharges in residents aged 75+; rate per 1,000 population aged 75+

Source: Core Suite Indicator workbooks

	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20
Bed days per 1,000 population aged 75+	153	176	219	274	187	200	171	223	168	164	180	125	206



How are we performing?

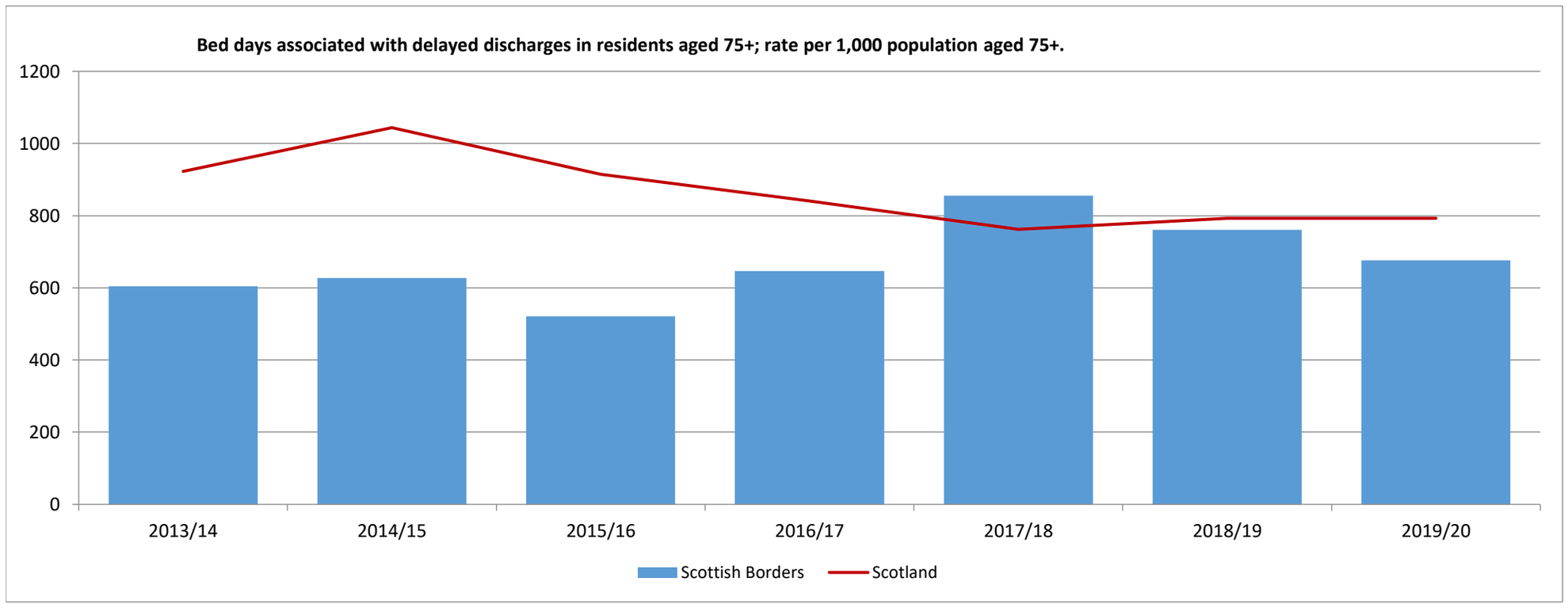
The rate of bed days associated with delayed discharges (75+) for quarter 3 of 2017/18 was higher than any previous quarter, increasing to over 250 per 1,000 residents for the first time. Quarter 3 for 18/19 had a similar spike to the same period the previous year, seeing the 2nd highest rate over the past 2 years.

NHS Borders is facing significant challenges with **Delayed Discharges**, which continues to impact on patient flow within the Borders General Hospital and our four Community Hospitals. The measure has an overall positive trend over the last 3 years, although, Q4 2019/20 shows a significant increase to 206 days, which is above the average and well above the 180 day target.

Scotland / Scottish Borders comparison of bed days associated with delayed discharges in residents aged 75+

Source: Core Suite Indicator workbooks

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Scottish Borders	604	628	522	647	855	761	676
Scotland	922	1044	915	841	762	793	793



How are we performing?

Up to 2016/17, rates for the Scottish Borders were lower (better) than the Scottish average. However, in 2017/18 the Borders' rate was higher than Scotland's. This reduced in 2018/19 - when the Scottish average increased - and further reduced in 2019/20.

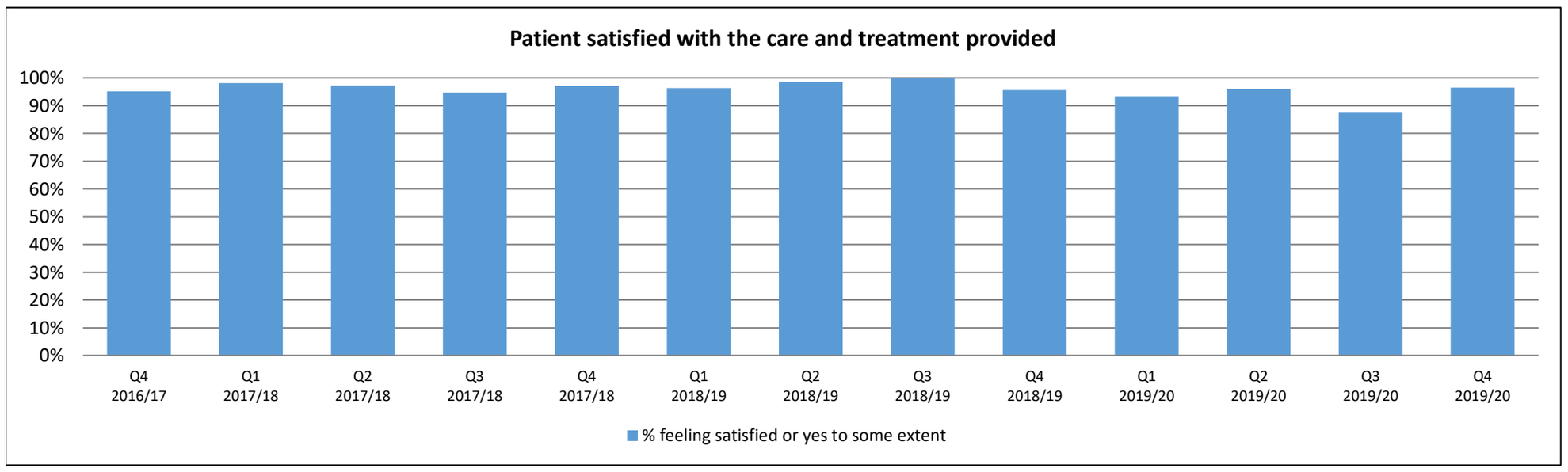
*Please note definitional changes were made to the recording of delayed discharge information from 1 July 2016 onwards. Delays for healthcare reasons and those in non hospital locations (e.g. care homes) are no longer recorded as delayed discharges. In this indicator, no adjustment has been made to account for the definitional changes during the year 2016/17. The changes affected reporting of figures in some areas more than others therefore comparisons before and after July 2016 may not be possible at partnership level. It is estimated that, at Scotland level, the definitional changes account for a reduction of around 4% of bed days across previous months up to June 2016, and a decrease of approximately 1% in the 2016/17 bed day rate for people aged 75+.

BGH and Community Hospital Patient/Carer/Relative '2 Minutes of Your Time' Survey

Source: NHS Borders

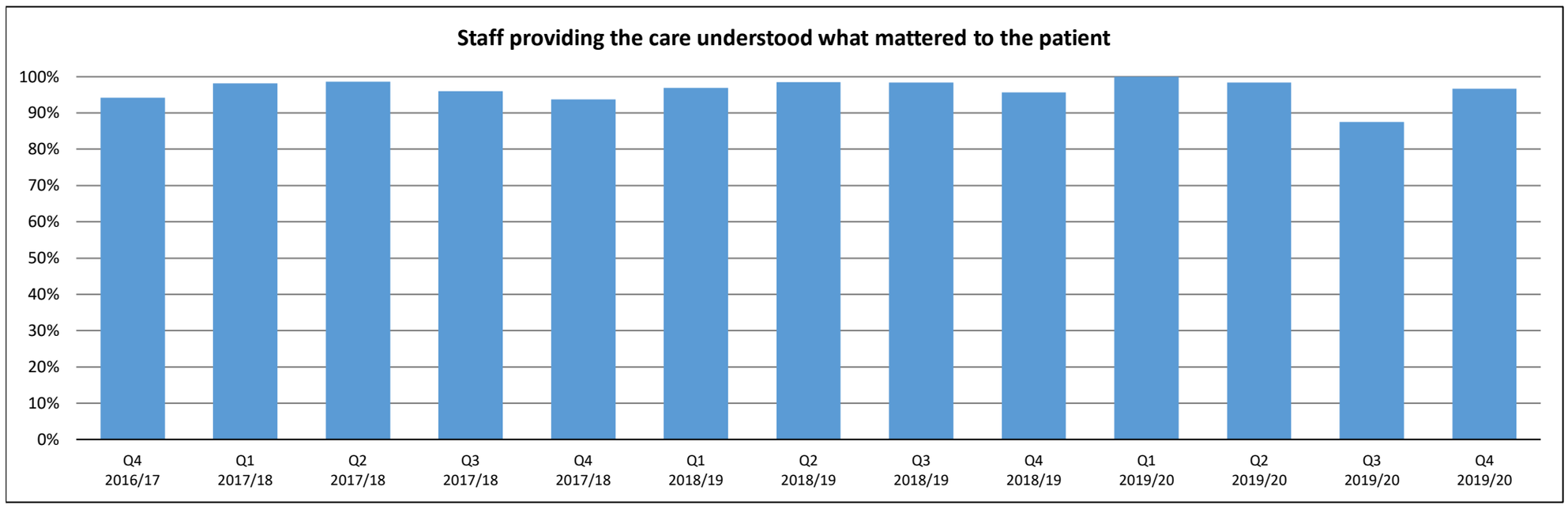
Q1 Was the patient satisfied with the care and treatment provided?

	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20
Patients feeling satisfied or yes to some extent	116	105	206	141	135	156	135	117	108	99	121	63	56
% feeling satisfied or yes to some extent	95.1%	98.1%	97.2%	94.6%	97.1%	96.3%	98.5%	100.0%	95.7%	93.4%	96.0%	87.5%	96.6%



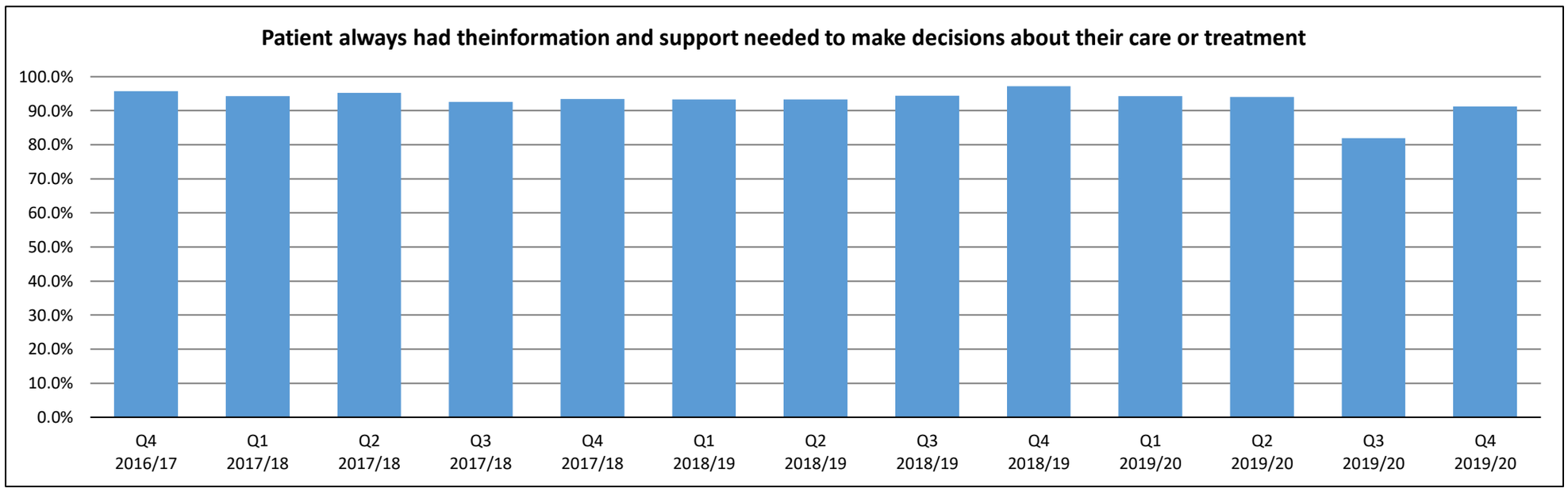
Q2 Did the staff providing the care understand what mattered to the patient?

	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20
Staff providing the care understood what mattered to the patient, or yes to some extent	113	105	213	144	135	158	136	119	110	106	125	63	59
% understood what mattered or yes to some extent	94.2%	98.1%	98.6%	96.0%	93.8%	96.9%	98.6%	98.3%	95.7%	100.0%	98.4%	87.5%	96.7%



Q3 Did the patient always have the information and support needed to make decisions about their care or treatment?

	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20
Patients always had the information and support needed to make decisions about their care or treatment, or yes to some extent	111	99	200	137	129	141	125	101	102	100	110	59	52
% always had information or support, or yes to some extent	95.7%	94.3%	95.2%	92.6%	93.5%	93.4%	93.3%	94.4%	97.1%	94.3%	94.0%	81.9%	91.2%



How are we performing?

The 2 Minutes of Your Time Survey is carried out across the Borders General Hospital and Community Hospitals and comprises of 3 quick questions asked of patients, relatives or carers by volunteers. There are also boxes posted in wards for responses. The results given here are the responses where the answer given was in the affirmative or 'yes to some extent'. Percentages given are of the total number of responses.

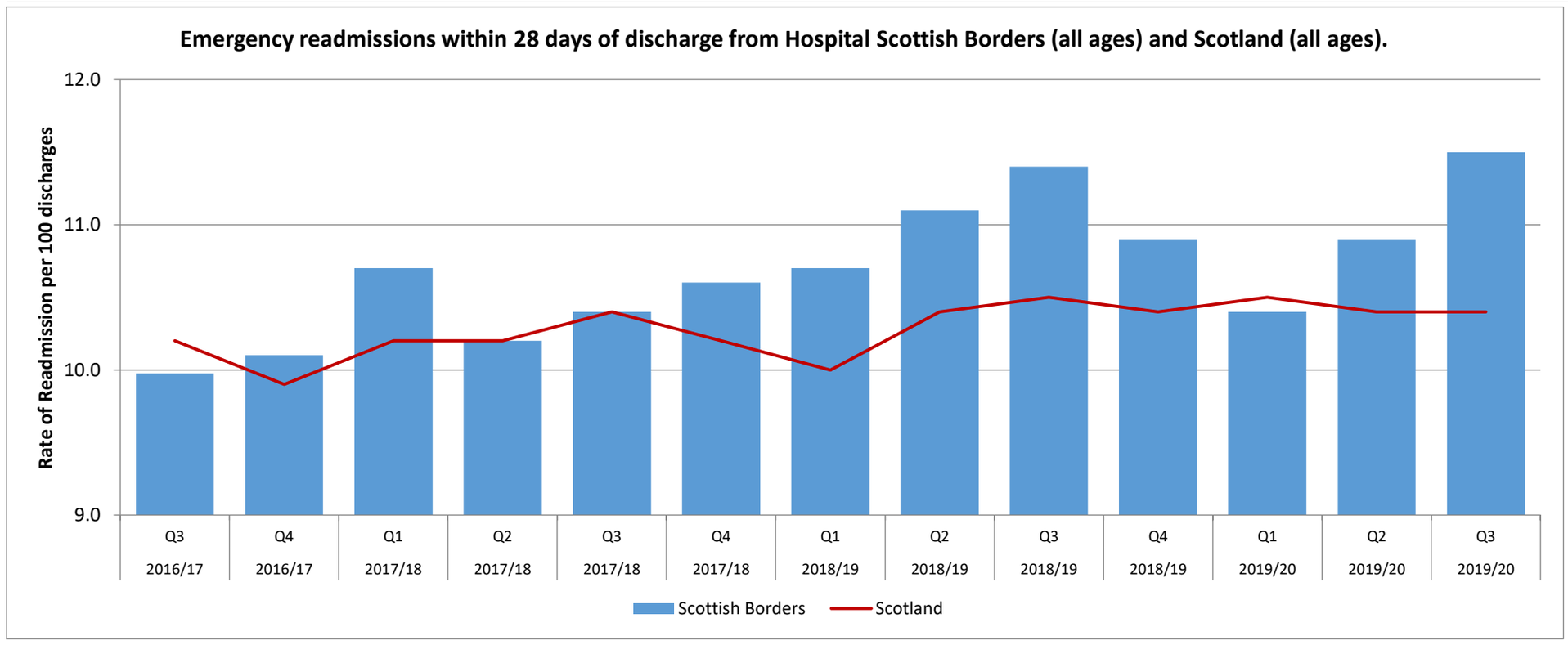
Overall, Borders scores well with an average 95.5% satisfaction rate. Patient satisfaction shows a positive trend over time and the latest overall average achieves the 95% target.

Objective 3: We will improve the capacity within the community for people who have been in receipt of health and social care services to manage their own conditions and support those who care for them

Emergency readmissions within 28 days of discharge from hospital, Scottish Borders residents (all ages)

Source: ISD LIST bespoke analysis of SMR01 and SMR01-E data (based on "NSS Discovery" indicator but here also adding in Borders Community Hospital beds).

	Q3 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20
Scottish Borders	10.0	10.1	10.7	10.2	10.4	10.6	10.7	11.1	11.4	10.9	10.4	10.9	11.5
Scotland	10.2	9.9	10.2	10.2	10.4	10.2	10.0	10.4	10.5	10.4	10.5	10.4	10.4



How are we performing?

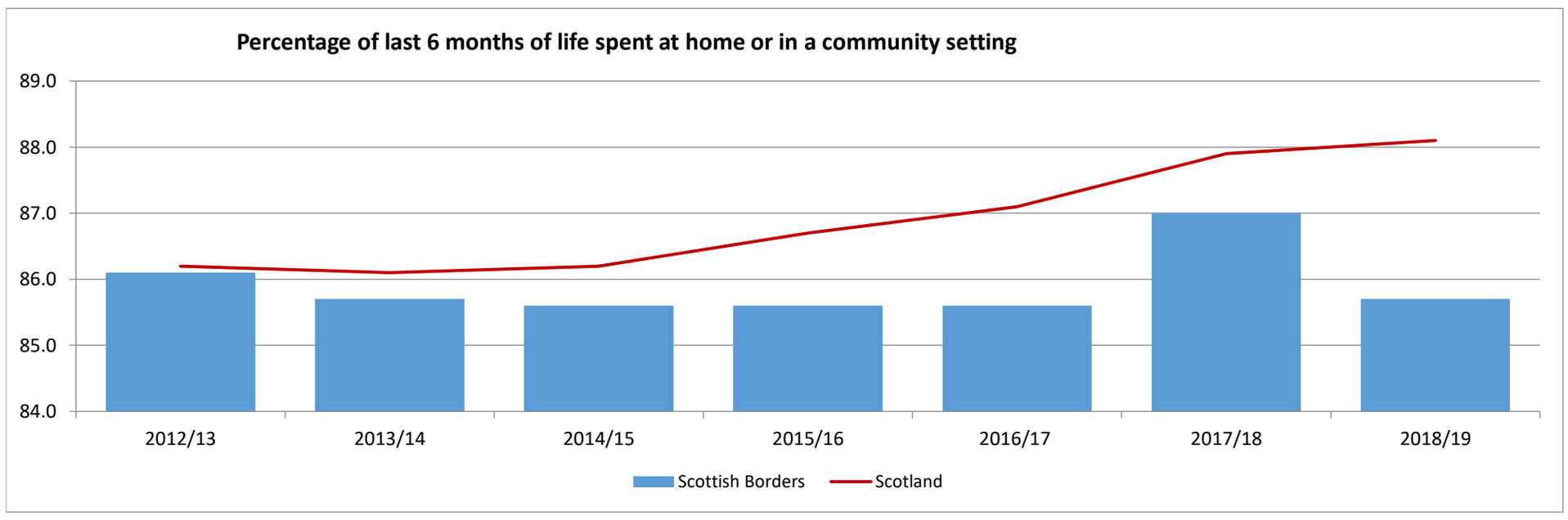
The quarterly rate of emergency readmissions within 28 days of discharge for Scottish Borders residents has fluctuated since the start of the 2016/17 financial year. There has been a notable increase in readmissions within 28 days of discharge since quarter three of 2016/17.

The Borders rate has usually been higher than the Scottish average and this trend continues. 2019/20 has seen a negative trend with an increasing pattern emerging across quarters 2 and 3. This followed a positive period where there was a reduction in readmission rates across the second half of 2018/19 and into Q1 of 2019/20. Q3 2019/20 has recorded the highest rate or readmissions in the last 3 years.

Percentage of last 6 months of life spent at home or in a community setting

Source: Core Suite Indicator workbooks

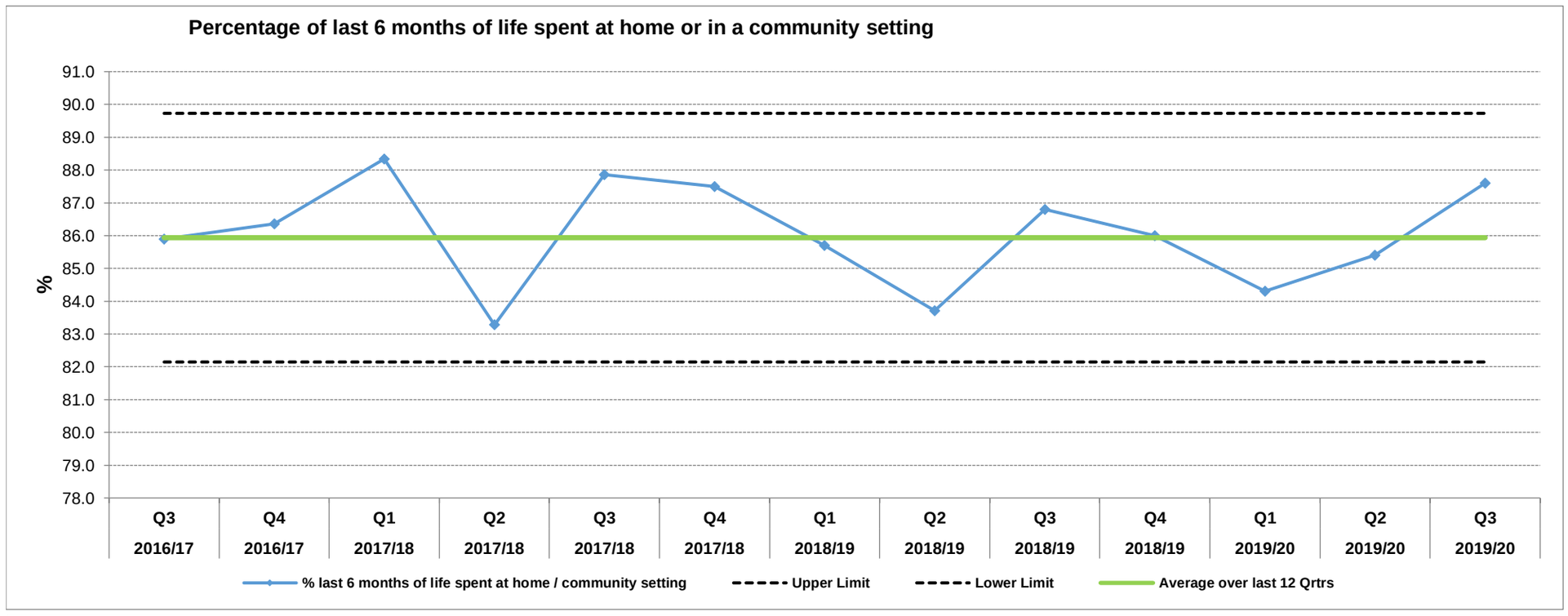
	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Scottish Borders	86.1	85.7	85.6	85.6	85.6	87.0	85.7
Scotland	86.2	86.1	86.2	86.7	87.1	87.9	88.1



Percentage of last 6 months of life spent at home or in a community setting

Source: Core Suite Indicator workbooks

	Q3 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20
% last 6 months of life spent at home or in a community setting Scottish Borders	85.9	86.4	88.3	83.3	87.9	87.5	85.7	83.7	86.8	86.0	84.3	85.4	87.6



How are we performing?

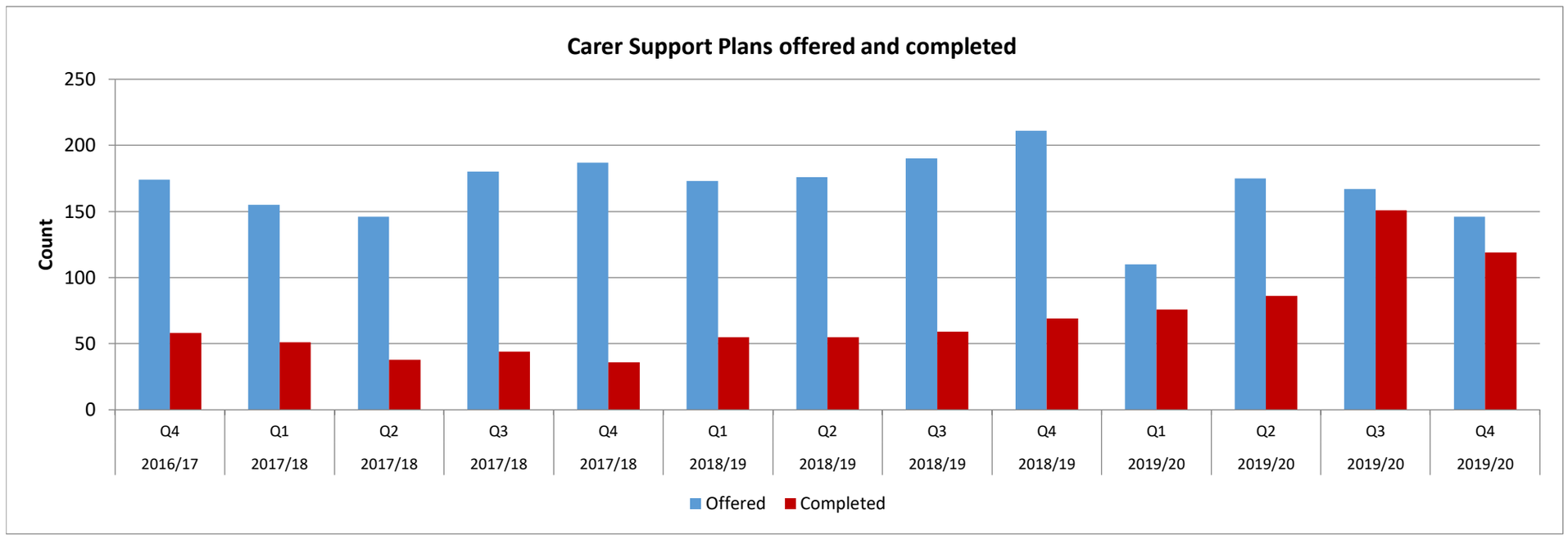
The percentage of last 6 months of life spent at home or in a community setting has appeared fairly consistent in the Borders from year to year since 2013/14 but in each case remains a little below the Scottish average which, in contrast, is gradually increasing.

In addition to the annual measure around end of life care, local quarterly data has been provided in relation to last 6 months of life (for Scottish Borders only). In the most part, the % of people who spend the last 6 months at home or in a community setting is >=86%. However, the measure displays a negative trend over the last 3 years.

Carers offered and completed Carer Support Plans

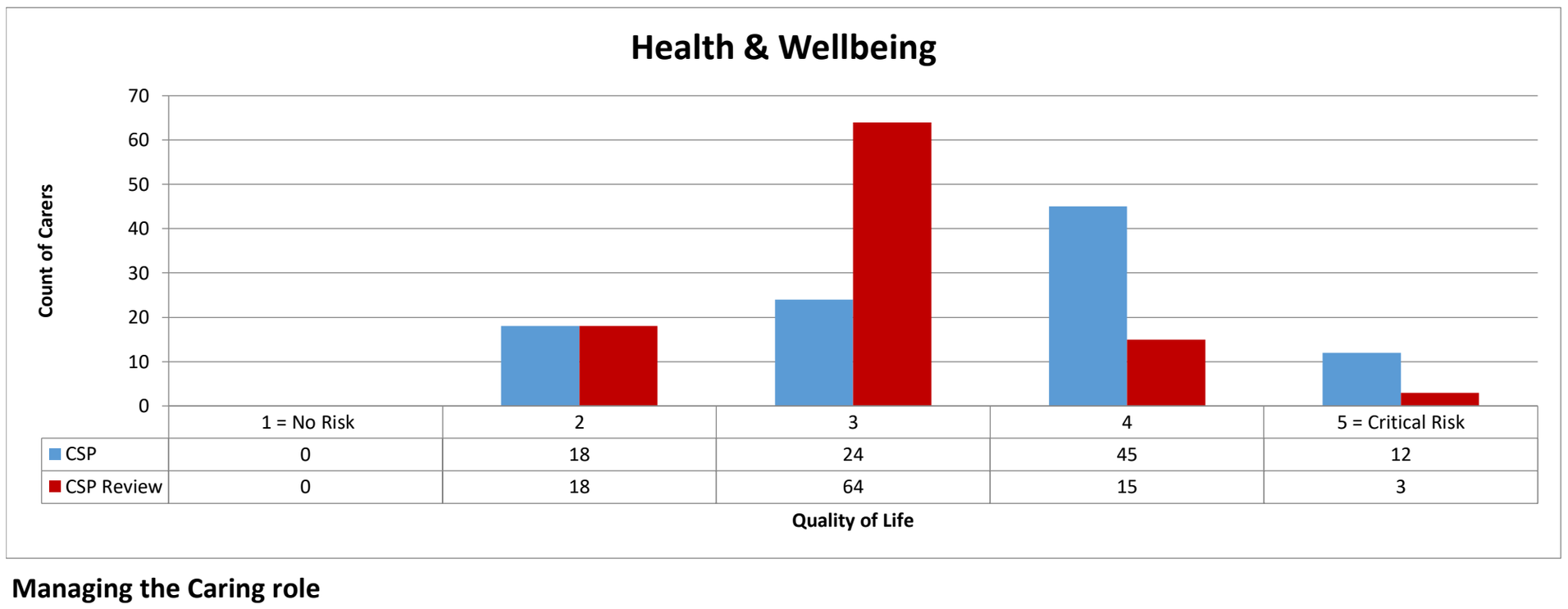
Source: Carers Centre

	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20
Carer Support Plans Offered	174	155	146	180	187	173	176	190	211	110	175	167	146
Carer Support Plans Completed	58	51	38	44	36	55	55	59	69	76	86	151	119



Health and Wellbeing (Q4 2019/20)

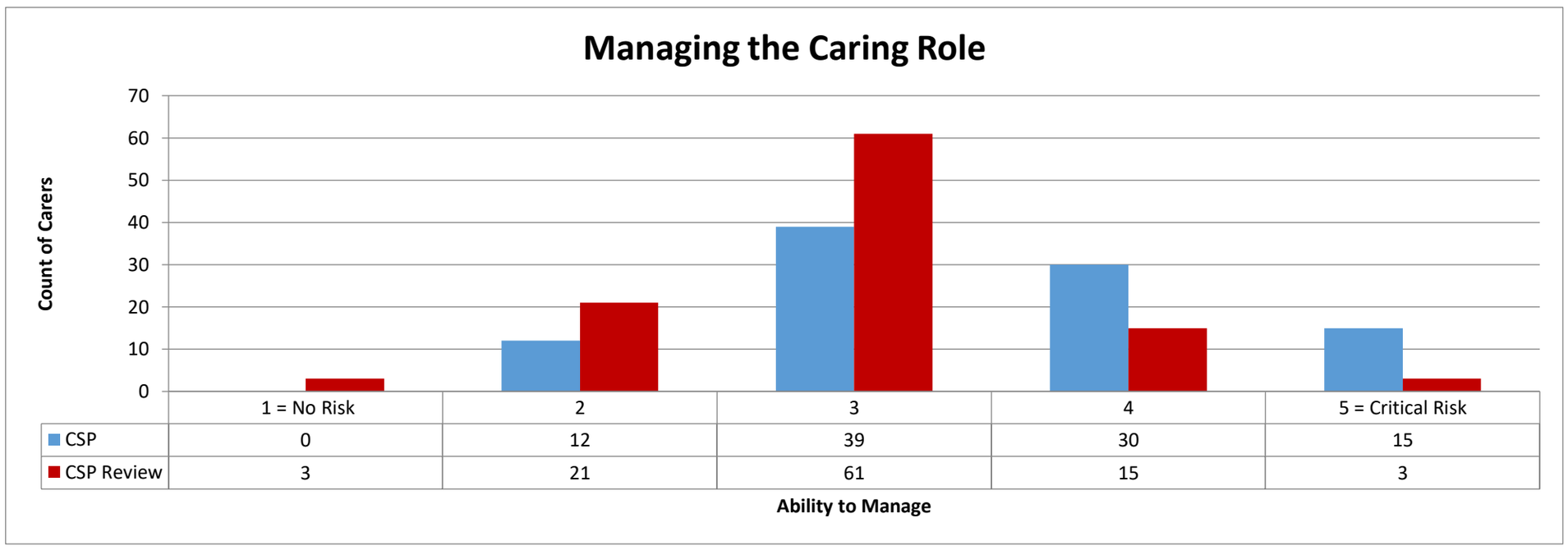
I think my quality of life just now is:



	1 = No Risk	2	3	4	5 = Critical Risk
CSP	0	18	24	45	12
CSP Review	0	18	64	15	3

Managing the Caring role

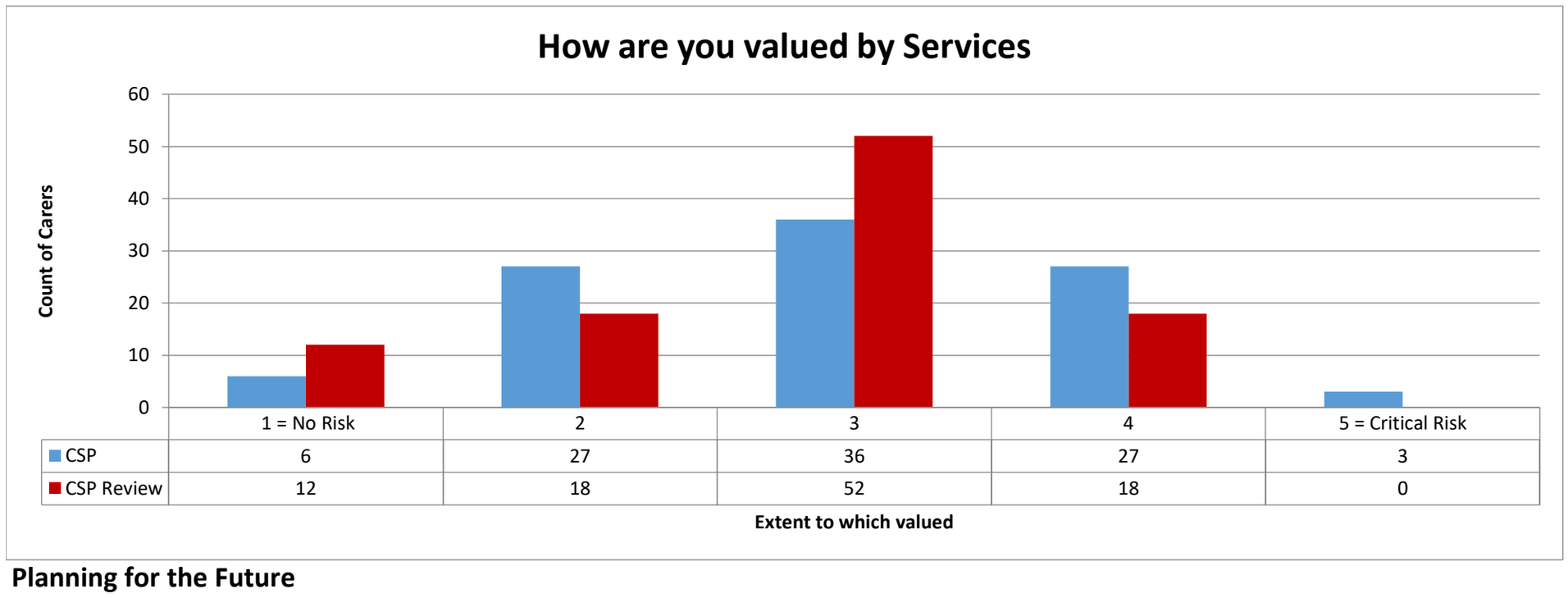
I think my ability to manage my caring role just now is:



	1 = No Risk	2	3	4	5 = Critical Risk
CSP	0	12	39	30	15
CSP Review	3	21	61	15	3

How are you valued by Services

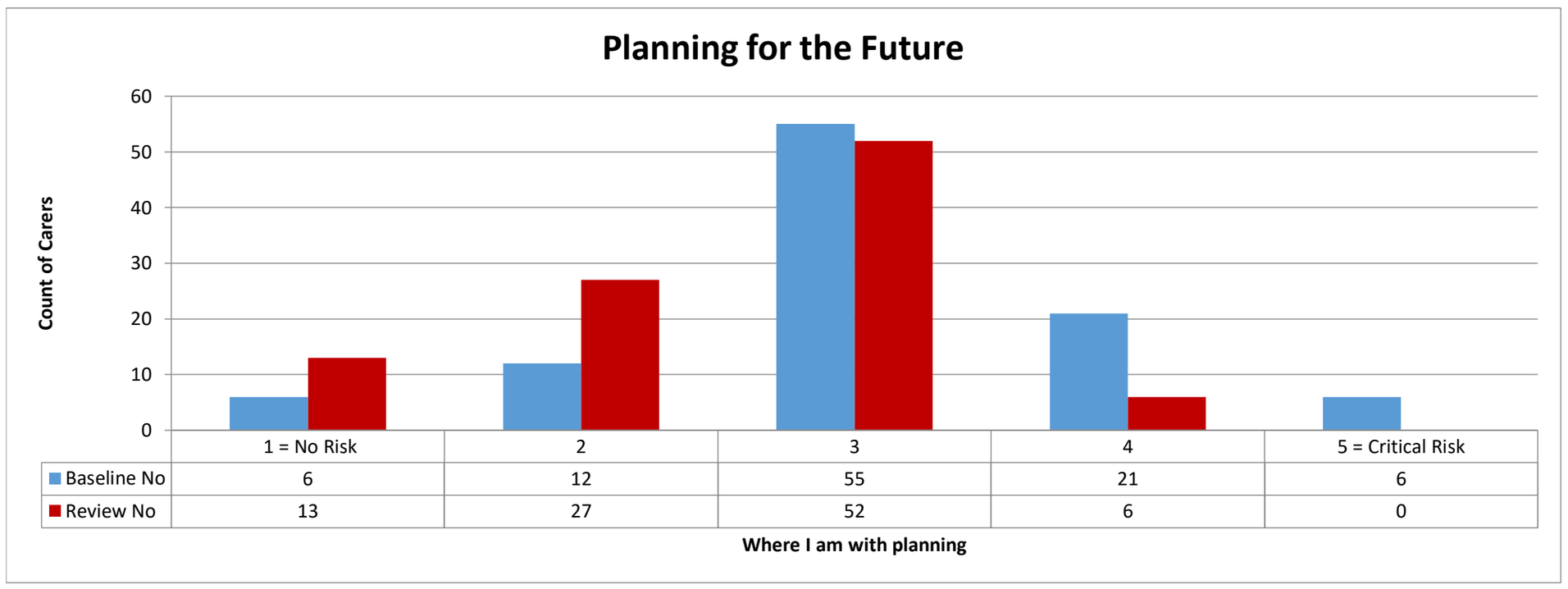
I think the extent to which I am valued by services just now is:



	1 = No Risk	2	3	4	5 = Critical Risk
CSP	6	27	36	27	3
CSP Review	12	18	52	18	0

Planning for the Future

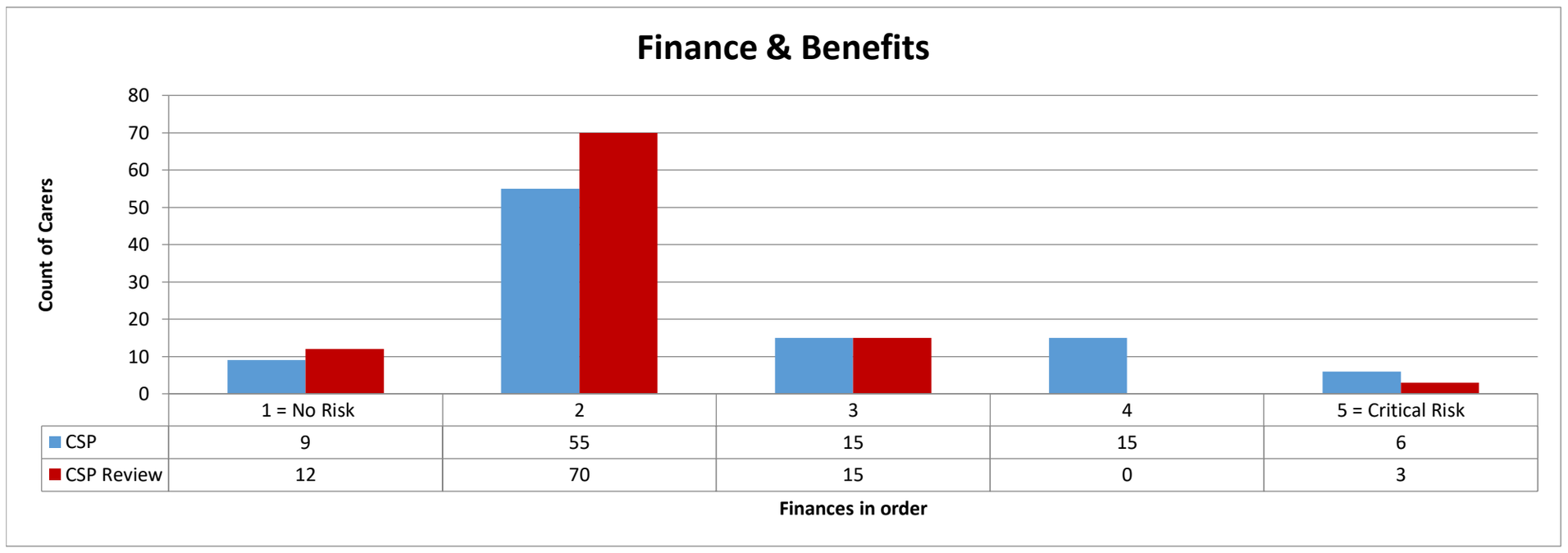
I think where I am at with planning for the future is:



	1 = No Risk	2	3	4	5 = Critical Risk
Baseline No	6	12	55	21	6
Review No	13	27	52	6	0

Finance & Benefits

I think where I am at with action on finances and benefits is:



	1 = No Risk	2	3	4	5 = Critical Risk
CSP	9	55	15	15	6
CSP Review	12	70	15	0	3

How are we performing?

It is evident from the data above that there was a reduction in the number of Carer Support Plans (CSP) being offered in 2019/20 compared to the previous 2 years. However, the number of CSPs being completed has significantly increased and closes the gap that has been present between the number being offered and the number that were being completed. This would indicate a positive trend for 2019/20 and an assurance that Carers are receiving the support that is required. The number of completed CSPs has shown a gradual increase over the last 2 years.

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Appendix-2020-11

NHS Borders

COVID-19
Future Modelling and Impact on Health Services

26 August 2020

Appendix-2020-11

COVID-19 in Borders: current status

COVID-19 cases in the Borders

- First COVID-19 case in Borders on 9th March
- Peak week – week commencing 30th March – 72 positive tests
- 3 positive COVID-19 tests since 8th June (most recent 6th August)

Current status of COVID-19: As of 13th August,

- R number for Scotland is reported to be rising due to recent clusters (note - there is no R number for Borders specifically)
- Estimated current daily infection rate - 0.425 per 100,000 population. For Borders this means:
  - 3-4 new cases per week, of which 25% are known (through positive test)
  - 7 people in Borders who are currently infectious (assumes 14 day infectious period)

COVID-19 in hospital

- There are currently no COVID-19 positive inpatients in hospital in the Borders.
- The last COVID-19 positive admission was on 8th June
- There are a number of patients with negative COVID-19 test but with suspected COVID-19 symptoms

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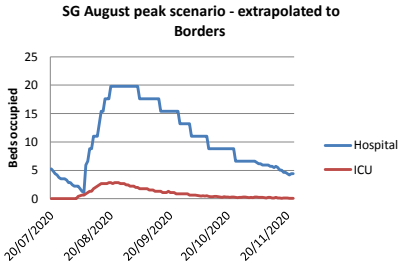
What might happen in future - peaks

Scottish Government has issued 3 possible **'reasonable worst case'** scenarios:

1. Early resurgence in August and peaking in September

2. Winter Peak from current low prevalence (similar to first peak)

3. Winter Peak following small second peak in September (3x first peak)



Peak Bed usage – Hospital 33
Peak Bed usage – ICU 4.84

Peak Bed usage - Hospital 110
Peak Bed usage – ICU 15.4
NB: no indication of dates in scenarios 2 & 3

The local Borders COVID-19 daily model is being revised to take account of national scenarios. This will provide prediction of likely Borders demand by day.

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What might happen in future - Settings

- Most infection spread by a small number of people (80% of infections spread by 10% of infected people) (Endo et al; https://wellcomeopenresearch.org/articles/5-67)
- Infection outbreaks are clustered in certain high-risk settings or locations (Leclerc et al: https://wellcomeopenresearch.org/articles/5-83)
- Therefore, future COVID-19 outbreaks will impact different groups depending on setting and have different effects
- We need to consider who will be affected in each of these locations and plan for the likely impact on our services

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What might happen in future - Settings

- Within the Borders, likely high-risk areas include:
  - Care Homes
  - Schools/Higher Education
  - Localities, especially areas of deprivation
  - Other Health and social care facilities
  - Workplaces – food packing
  - Workplaces – Call Centre
  - Workplaces - Healthcare Staff
    - Patient-facing staff
    - Office staff
  - Leisure and Tourism
  - Entertainment

Appendix-2020-11

Impact on health services – priorities to ensure safe services

- Managing COVID-19
  - COVID-19 prevention – Infection control and PPE, testing and tracing, communications plan for staff and public
  - Services to support people with COVID-19
  - Supporting high-risk groups – services for conditions affected by COVID-19 addressing causes of ill-health
  - Managing services to reduce COVID-19 risk – separating COVID-19 and non COVID-19 pathways, social distancing, cleaning regimes, use of protective equipment
- Preparing for Winter
  - Flu prevention, including significant vaccination programme
  - Winter planning – planning for increases in demand in A&E, BECS and primary care, plus additional inpatient surge beds

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Planning Assumptions

- Planning for careful, gradual and phased resumption of services
- Linked to the Scottish Government's overall strategy to resume a more normal life across Scotland, whilst remaining vigilant with regard to the ongoing possibility of coronavirus infections.
- Decisions are based on clinical need with the overall objective of ensuring the safety of our patients and staff.
- Due to a number of factors - including the need for Personal Protective Equipment (PPE), infection control measures and physical distancing - we will not be able to treat the same number of patients as we would normally. As a result, managing the backlog of patients, both from before the pandemic and also as a result of delays over the last four months will be challenging.
- Need retain some hospital capacity so that we can treat people with COVID-19 and if necessary manage any increase or outbreak of cases in the community as the lockdown continues to be eased.

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Central NHSB services

SG Directed Services:

• COVID-19 Testing Service- operates out of a drive through testing centre within the BGH campus with outreach into care home settings
• Track and Trace- Provides a local contact tracing service, required as part of the national Test and Protect strategy
• COVID-19 Hub- currently operates within the acute hospital, direction is that this will need to be continued to be delivered, links into "scheduling unscheduled care" direction

Examples Locally Implemented Services:

• Staff Deployment Hub- central deployment allowed flexible, agile approach to allocation of staff whilst maintaining a safe environment
• Here4U-Staff Welling Service- developed to ensure that staff had timely access to the right support whilst working in very challenging circumstances
• Transport Hub- creation of a central transport service

We have also rapidly deployed digital tools and alternative contacts : Near Me / Telephone – depending on patient choice

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Primary & Community Services

- **GP practices still at Level 2** – and assessing what level of service can be provided given constraints
- **Dentists and Optometrists** – now re-opened on a reduced basis in line with the Scottish Government Routemap
- **Primary Care enhanced access to diagnostic interventions** – to support urgent cancer referral decisions
- **Health Centres** – works have been scoped to support infection control / maximise capacity available in the context of covid-19
- **COVID-19 Assessment Hub and Centre** – work to develop hub in line with Scot Gov Reshaping Urgent Care agenda
- **Treatment Rooms** – supporting GPs, District Nurses and Secondary care (elective and Reshaping Urgent Care) to schedule treatments, tests and investigations in community

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Mental Health Services

- **MH inpatient admissions (including out of hours)** - new admission process to avoid risk of infection
- **'Near Me' -** continues to be first & preferred option for initial assessment/routine appointments within all MH community teams
- **Community Assessment Hub -** Implementing community assessment/near me hubs to support patients classed as technology deprived - to increase engagement with health services
- **Mental Health Primary Care Service -** this is now being developed in conjunction with P&Cs

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Delegated Services

- **Creation and Availability of-** Clear intermediate care pathway utilising AHP's, hospital to home service "Home First" & bed based intermediate care in 24 hour care settings
- **Integrated working / increased social care capacity** – reduced delayed discharges
- **Locality Hubs-** Creation of multi-disciplinary, multi-agency locality hubs involving health, social care and third sector
- **Care Inspectorate Registered Nursing Care Home-** to support patient flow from the acute setting

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Acute Services

- **Emergency Department –** in response to COVID-19 department size was doubled, staffing increased staffing by 6.78,WTE, activity now at 90% of pre COVID-19
- **Operating Theatres –** commencing 50% of pre COVID-19 activity from 31st August, patients asked to self-isolate for 14 days prior to op
- **Outpatients –** 50% being delivered virtually. Face-to-face outpatients now operating at 40% of pre COVID-19 levels
- **Intensive Care** – existing ITU has only has capacity for1 COVID-19 Positive patient, if more than 1 COVID-19 positive patient needs ITU care we have to open a second ITU in operating theatre with the cancellation of elective operating

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Next Steps

- Awaiting feedback from SG on last submission
- Continually refine local modelling so as to be alerted early of any increase in cases to assist swift and local response
- Continue to finalise Remobilisation plan (which must incorporate plans for responding to winter pressures)
- Sense check the plan against latest infection control guidance released by SG
- Continue to engage and inform partners
- Finalise Remobilisation plan by end of September

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Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 19 August 2020

Report By:	David Robertson, Chief Finance Officer SBC Andrew Bone, Chief Financial Officer, NHS Borders
Contact:	David Robertson, Chief Finance Officer SBC Andrew Bone, Chief Financial Officer, NHS Borders
Telephone:	01835 825012 / 01896 825555

MONITORING AND FORECAST OF THE HEALTH AND SOCIAL CARE PARTNERSHIP BUDGET 2020/21 AT 31 MAY 2020

Purpose of Report:	The purpose of this report is to update the IJB on the forecast year end position of the Health and Social Care Partnership (H&SCP) for 2020/21 based on available information to the 31st May 2020.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) *Note* the forecast overspend of (£11.938m) for the Partnership for the year to 31 March 2021 based on available information b) *Note* the forecast position only includes £1.078m Scottish Government funding representing the IJB's share of an initial £50m tranche of funding to support immediate challenges in the Social Care sector. No further funding allocations from the Scottish Government have been assumed in respect of the additional costs incurred responding to the Covid-19 situation, including the impact on the Partnership's ability to deliver agreed Financial Plan savings c) *Note* that any expenditure in excess of the delegated budgets in 2020/21 will require to be funded by additional contributions from the partners in line with the approved scheme of integration

Personnel:	There are no resourcing implications beyond the financial resources identified within the report. Any significant resource impact beyond those identified in the report that may arise during 2020/21 will be reported to the Integration Joint Board.

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. The report draws on information provided in finance reports presented to NHS Borders and Scottish Borders Council. Both partner organisations' Finance functions have contributed to its development and will work closely with IJB officers in delivering its outcomes.

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

1 BACKGROUND

1.1 The report relates to the initial forecast position on both the budget supporting all functions delegated to the partnership (the "delegated budget") and the budget relating to large-hospital functions retained and set aside for the population of the Scottish Borders (the "set-aside budget").

1.2 The forecast position is based on the available information presented to Scottish Borders Council and the Board of NHS Borders. It highlights the key areas of financial pressure at 31 May 2020. It should be noted that this is an initial report. The reported expenditure to date and projected expenditure, particularly in relation to Healthcare functions requires significant further analysis and refinement as a result of the impact of the Covid-19 pandemic on activity levels, mobilisation costs, remobilisation plans and associated costs, lost income and unachievable savings.

2 OVERVIEW OF MONITORING AND FORECAST POSITION AT 31 MAY 2020

2.1 The paper presents the consolidated financial performance for the period to end of May 2020 (2 months). Although this position includes a forecast of the year end outturn members should be aware that this forecast remains subject to a number of risks and uncertainties which are likely to result in substantial revision as greater certainty is attained over the next few months.

2.2 Covid 19

2.2.1 Costs incurred in the first two months are in line with the expenditure reported to Scottish Government through the Health & Social Care Local Mobilisation Plan tracker. Although there has been initial allocation of £1.078m (the IJB share of an initial £50m tranche of funding) to support immediate challenges in the Social Care sector, all other costs remain unfunded at this time. It is anticipated that funding will be made available following conclusion of the COSLA peer review process and at conclusion of the NHS Scotland Quarter One (Q1) Review in September 2020. At this time we expect that all costs will be fully funded, although no assumption has been made within the financial projections currently. In addition to direct costs attributable to Covid 19, mobilisation plans also include other attributable costs such as lost income and the opportunity cost of delivery of planned efficiency savings.

2.3 Efficiency Savings

2.3.1 Forecasts include the estimated impact of non-delivery of savings plans. This position remains under review and will be updated following the conclusion of forecasting work at Month 3 and through the NHS Quarter One review process.

2.4 Year End Forecast

2.4.1 The Scottish Borders Council forecast at month 2 is based on detailed monthly monitoring during the first 2 months of the financial year to assess the financial implications of the Covid 19 pandemic on the IJB including increased costs, loss of income and the impact of delays in delivery of financial plan savings. This impact has been reported through the Health & Social Care Local Mobilisation Plan tracker and is estimated at a gross impact of almost £3.8m which has been netted down by the Scottish Government funding of £1.078m to a net pressure of £2.688m.

2.4.2 The NHS forecast has been prepared on a pro-rata basis in advance of detailed review currently being prepared through the Q1 review process. At this stage costs related to the expected remobilisation of clinical services are not included within the forecast. As such, members should recognise that the forecast is presented as an indication of current expenditure trend and is unlikely to be a full representation of the likely outturn position.

2.4.3 What is clear however is that overall, the additional costs of Covid 19, together with the opportunity cost of unachievable savings greatly outweighs any financial benefit and reduced cost within core operational services attributable to a reduction in activity during the initial months of the pandemic. This position may be mitigated considerably when a clearer picture of likely funding allocations from the Scottish Government emerges.

2.4.4 Further reports will be brought to the Integration Joint Board as greater clarity develops. To enable this, further work will be undertaken across a number of key areas in order to refine the forecast impact on the IJB in 2020/21 including:

- Ongoing analysis and reporting of the Health and Social Care Partnership's (and wider NHS Borders' and Scottish Borders Council's) local mobilisation plan financial models
- Further review, challenge and remodelling of planned efficiency savings programmes
- Ongoing engagement with other partnerships, health boards, local authorities and, in particular, the Scottish Government over likely funding scenarios
- Review of all costs, expenditure profiles, future commitments and refinement of assumptions for projected expenditure to the end of the year

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MONTHLY REVENUE MANAGEMENT REPORT

Summary	2020/21	At end of Month:	May

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Summary Financial Commentary
Joint Learning Disability Service	20,139	2,386	19,895	21,184	(1,289)	
Joint Mental Health Service	18,236	2,905	18,380	18,517	(137)	
Older People Service	8,127	2,731	8,287	9,691	(1,404)	
SB Cares	17,067	2,745	16,474	16,524	(50)	
Unidentified savings	(4,740)	0	(4,740)	0	(4,740)	
Physical Disability Service	2,458	483	2,452	2,613	(161)	
Prescribing	23,130	3,855	23,132	23,432	(300)	
Generic Services	74,558	9,250	77,517	79,881	(2,364)	
Large Hospital Functions Set-Aside	23,630	4,218	23,765	25,308	(1,543)	
Total	165,538	25,828	168,688	180,626	(11,938)	

MONTHLY REVENUE MANAGEMENT REPORT

Delegated Budget Social Care Functions	2020/21	At end of Month:	May

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Summary Financial Commentary
Joint Learning Disability Service	16,399	1,678	16,529	17,008	(479)	Almost £3.6m of projected pressure in 2020/21 associated to responding to the Covid-19 pandemic. This is partly offset by funding which has been received from the Scottish Government £1.1m, together with additional in-year projected savings of almost £0.5m. Other wider service pressures of over £0.5m however, are also forecast. The additional costs of Covid-19 above and therefore the forecast outturn variance is also inclusive of the impact of the Partnership's inability to deliver the level of planned savings targeted within the 2020/21 Financial Plan. Overall, this amounts to almost £1.4m, as a direct result of the redesignation of resource capacity to meet the requirements of Covid-19 response at the opportunity cost of the planning and delivery of planned savings.
Joint Mental Health Service	2,256	234	2,164	2,227	(63)	
Older People Service	8,127	2,731	8,287	9,691	(1,404)	
SB Cares	17,067	2,745	16,474	16,524	(50)	
Physical Disability Service	2,458	483	2,452	2,613	(161)	
Generic Services	5,278	(2,274)	5,538	6,069	(531)	
Total	51,585	5,597	51,444	54,132	(2,688)	

MONTHLY REVENUE MANAGEMENT REPORT

Large Hospital Functions Set-Aside	2020/21	At end of Month:	May

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Summary Financial Commentary
Accident & Emergency	2,830	532	2,830	3,192	(362)	The set aside budget is again projecting an adverse variance attributable to additional costs of Covid-19 mobilisation and the non-delivery of savings (£1.1m). This is offset by a reduction in unscheduled care activity during the first two months of the financial year as a result of the pandemic. Work continues to review planned savings and further reports will be brought forward during the financial year as a clearer picture over deliverability emerges.
Medicine & Long-Term Conditions	6,230	1,002	6,245	6,012	233	
Medicine of the Elderly	15,660	2,684	15,780	16,104	(324)	
Turnaround Savings Target	(1,090)	0	(1,090)	0	(1,090)	
Allocated Non Recurring Savings Projects					0	
Allocated Brokerage					0	
Total	23,630	4,218	23,765	25,308	(1,543)	

Appendix-2020-12
Attachment 1

MONTHLY REVENUE MANAGEMENT REPORT

Delegated Budget Healthcare Functions **2020/21** **At end of Month:** **May**

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Summary Financial Commentary
Joint Learning Disability Service	**3,740**	**708**	**3,366**	**4,176**	**(810)**	There is considerable pressure across delegated healthcare functions arising as a result of additional costs of Covid-19 mobilisation to date of £2.7m, together with forecast non-delvery of planned savings of £4.7m. This is partly offset by savings within core operational services as a result of a reduction in activity during the initial months of the Covid-19 pandemic.
Joint Mental Health Service	**15,980**	**2,671**	**16,216**	**16,290**	**(74)**	
Joint Alcohol and Drugs Service	390	**61**	**392**	**393**	**(1)**	
Prescribing	**23,130**	**3,855**	**23,132**	**23,432**	**(300)**	
Unidentified savings	**(4,740)**	**0**	**(4,740)**	**0**	**(4,740)**	Likely funding allocations from the Scottish Government remain unknown at the current time.
Allocated Non Recurring Savings Projects					**0**	
Allocated Brokerage					**0**	Work has now recommenced to review all planned savings in order to ascertain what level, if any, of the level of savings proposed within the Partnership's Financial Plan across delegated healthcare functions.
Generic Services						
Independent Contractors	**29,530**	**6,695**	**31,515**	**31,515**	**0**	
Community Hospitals	**5,780**	**889**	**5,536**	**5,306**	**230**	
Allied Health Professionals	**6,320**	**979**	**6,379**	**5,704**	**675**	
District Nursing	**3,580**	**630**	**3,606**	**3,784**	**(178)**	
Generic Other	**24,070**	**2,331**	**24,943**	**27,503**	**(2,560)**	
Total	**107,780**	**18,819**	**110,345**	**118,103**	**(7,758)**	

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: Wednesday 19 August 2020

Report By:	Rob McCulloch-Graham, Chief Officer Health & Social Care
Contact:	Graeme McMurdo, Programme Manager
Telephone:	01835 824000 ext. 5501

STRATEGIC IMPLEMENTATION PLAN & PRIORITIES

Purpose of Report:	To formally progress the IJB Strategic Implementation Plan, in light of lessons learned from the service response to the Covid-19 Pandemic

Recommendations:	The Health & Social Care Integration Joint Board are asked to: a) *Agree* the revised priorities for the IJB in light of lessons learned from experiences within services in their response to the pandemic. b) *Note* the changes to the decision making and governance structures within the Health and Social Care Partnership.

Personnel:	There are no specific staffing implications within the agreements sought within this paper.

Carers:	The response to and support of carers within the Borders will be strengthened within the changes to the implementation of the IJB Strategy, which the Board is asked to note.

Equalities:	An EQIA is not required for these changes however as the implementation of the plan progresses there will most likely be such a requirement for various aspects within the work streams outlined within the paper.

Financial:	There are no additional financial details requiring agreement within this paper, however as the implementation of the plan progresses further financial decisions will be required, and appropriate papers will be brought to the Board.

Legal:	There are no additional legal details requiring agreement within this paper, however as the implementation of the plan progresses further legal issues will need to be considered, and appropriate papers will be brought to the Board.

Risk Implications:	None of the issues discussed within this paper alter the existing risk register for the IJB.

1 Introduction

1.1 The purpose of the Integration Joint Board (IJB) Development Session held on Wednesday 24 June 2020 was to:

1. Look back at a number of the key decisions made by IJB over the last 12 months.
2. Reflect on the operational impact that Covid-19 has had on the Partnership.
3. Use the lessons learned from the Covid-19 response to inform our priorities going forward.

1.2 In regard to looking back (1), topics covered at the development session were:

- The Strategic Implementation Plan (SIP) 2019-2024, including the governance arrangements and the areas of work to be undertaken.
- Demand modelling work, demographic change and our whole-system bed requirement.
- The Discharge Programme funding model covering the funding requirements for Home First, Waverley, Garden View, Matching Unit and Strata.

1.3 In regard to (2), the operational impact of Covid-19, topics covered included:

- Impact of social distancing measures on waiting areas, bed capacity, care home operations.
- Impact of PPE and shielding requirements.
- Impact of testing and screening.
- Impact of a number of staff working from home.
- Impact on financial plans including the ability to deliver planned financial savings / service transformation (both positively & negatively).

1.4 In regard to (3), lessons-learned, discussion highlighted that during Covid-19 we had collectively:

- Worked in an agile way, reviewing service change quickly and adapting this quickly to meet demand and to deliver improved outcomes.
- Utilised staff, volunteers and technology in a flexible, joined up way.
- Been able accelerate the implementation of some planned service transformation

1.5 Discussion turned to how the lessons-learned could be used to inform our on-going execution of the Strategic Implementation Plan. The discussion sought to ensure that the priorities and timescales in the plan reflect the post Covid-19 landscape that that the control and governance arrangements for the SIP are effective.

1.6 The remainder of this paper uses the output from the development session to propose changes to our SIP priorities and SIP governance.

2 SIP Priorities

2.1 The SIP is a vehicle to deliver the three objectives within the IJB Strategic Plan. The objectives are:

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.

2.2 The drivers that influenced the creation of the strategic objectives and the subsequent SIP still remain, but the SIP needs updating as a result of the Covid-19 pandemic, prioritising work to meet both short and longer term requirements. Discussion at the development session suggests that the focus should be on work to deliver the following priority areas:

a) Reduction in unnecessary admissions and the length of stay within all hospitals; and a reduction in the number of delayed hospital discharges.
b) Re-commissioning of hospital beds, residential care places and home care provision. (*To achieve better outcomes and improve service sustainability, both workforce and financial, for SIP delivery and to achieve a reduction in hospital beds to meet care demand.*
c) Further development of Locality operations, incorporating services from across health and social care, in conjunction with other public sector, and third sector services and organisations.
d) Redesign of our Primary Care provision by creating Multi-disciplinary Teams (MDTs) that operate within our localities and respond to our Primary Care Improvement Plan (PCIP).
e) Ensuring that our workforce is prepared for both the immediate and longer term future, in terms of training, skill-base and flexible deployment.
f) Further development and expansion of Intermediate Care (Step Up / Step Down care, Respite and Reablement provision)
g) Expanded use of technology in the delivery of care and health services, in the support of communication with communities and within internal communications, administrative support, and the sharing of data.
h) Further development of our work with carer services and support agencies to enable them to access assistance and resources that support them in their crucial role within the partnership.
i) Increase our focus on addressing improvements in population health and reducing health inequalities, particularly in light of the impact of Covid-19.

3 SIP Governance

3.1 The SIP published in September 2019, outlined a comprehensive governance and decision making arrangement which included all stakeholders, and explained the required routes for decision making. The structure served its purpose at that time within the partnership, which required shared ownership throughout, providing full transparency across all parties.

3.2 The Covid-19 pandemic has changed these governance requirements. Our Covid-19 response highlights that the pandemic required a rapid and shared response, and necessarily the governance was replaced by new joint groups and new staff teams operating across different employers, in different venues with many new clients with new needs. Decision making groups were disbanded, new ones formed, disbanded and reformed again. Authority was delegated, and new local operations rapidly put in place. Communities themselves were mobilised, new provision and services created overnight in some cases, and a new relationship with the citizens of the Borders began to be realised.

3.3 Although we have yet to exit the pandemic, the above has served us well to date, and avoided fears of overflowing hospitals, and an inability to provide care and support for those affected. Pandemic aside, the lessons-leaned from the Covid-19 response need to be applied to how we plan and deliver services, how we build relationships, and how we utilise the collective resource we have. This will become increasingly important when coupled with even more health and social care financial and economic pressures.

3.4 Our SIP therefore needs more agile governance, built on trust between agencies, in a shared endeavour between us all, with a willingness to accept risk, learn from mistakes, and continually adapt together. With this in mind the proposed new governance is significantly stripped down, and has a greater reliance on the delegation of responsibility.

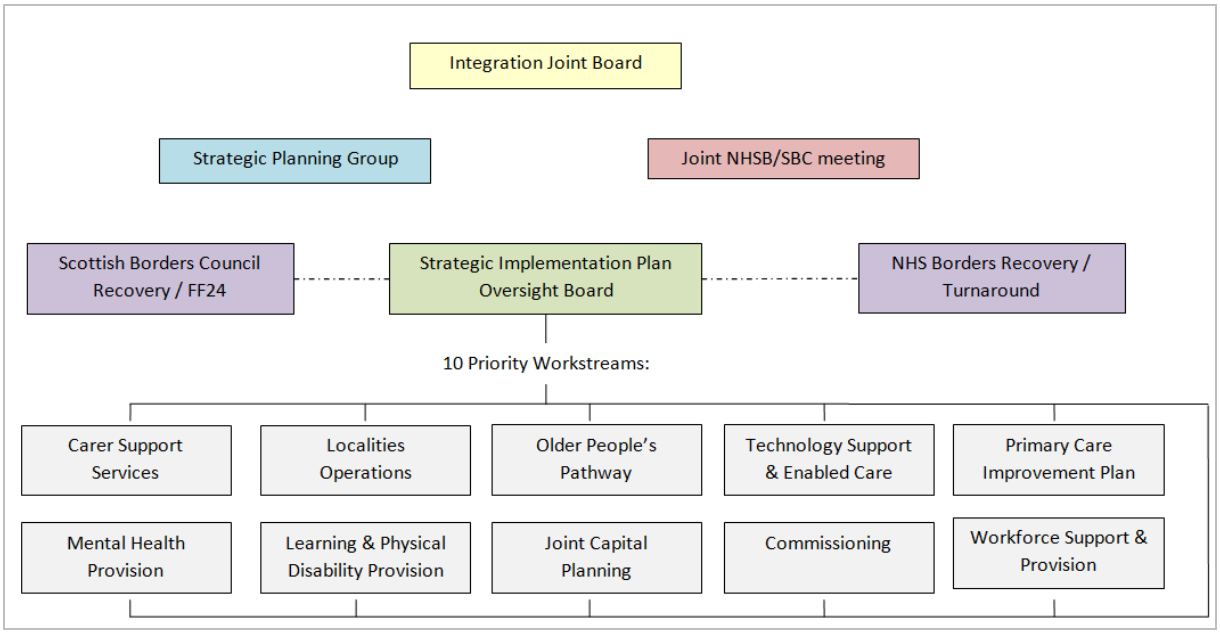
3.5 The intention for the SIP Oversight Board is to debate and agree proposals jointly; ensuring IJB, NHSB and SBC concerns are fully addressed and considered before proposals ultimately progress to the IJB where they require Board approval. Where appropriate, agreements and proposals from the SIP Overview Board will be discussed within the joint NHSB/SBC leadership group which has been meeting since the beginning of the Covid 19 Pandemic, and with the Strategic Planning Group of the IJB, ahead of the IJB itself.

3.6 In so doing this new governance structure will facilitate joint decision making with all parties present and represented.

3.7 The new culture developed through the experience of the Pandemic, should now support truly joint decision making.

4 SIP Governance Structure Proposal

4.1



4.2 The Strategic Implementation Plan Oversight Board is a multi-disciplinary team comprised of professional key leaders across Scottish Borders Council (SBC) and NHS Borders (NHSB) formed to support the delivery of the SIP of the Integration Joint Board. In doing so it will also ensure the delivery of NHS Borders objectives in relation to service transformation and financial turnaround as well as relevant elements of Scottish Borders Council's Fit for 2024 programme.

4.3 The role of the SIP Oversight Board is to lead on the delivery of the SIP, to oversee and co-ordinate the agreed work identified within the SIP and to hold the individual work streams accountable for the delivery of their agreed objectives. This will require work across the whole of the Health and Social Care Partnership. In line with the lessons on agile decision making and culture learnt during the COVID-19 response it should also necessarily be dynamic and responsive and we should expect this to change and adapt as required over the lifetime of the work.

4.4 As the membership and content of the work streams change over time these will be agreed by the SIP Oversight Board, in line with partnership governance.

5 SIP Oversight Board Membership

5.1 The initial membership of the SIP Oversight Board is proposed as follows:-

Rob McCulloch-Graham (Chair)	Chief Officer Health & Social Care
June Smyth	Director of Strategic Change & Performance
Clair Hepburn	Service Director HR & Communications
Nicky Berry	Director of Nursing, Midwifery & Acute Services
Lynn McCallum	Consultant Acute Medicine / Medical Director
Jen Holland	Chief Operating Officer- Adult Social Work & Social Care
Stuart Easingwood	Chief Social Work & Public Protection Officer
Chris Myers	General Manager Primary and Community Services
Simon Burt	General Manager Mental Health & Learning Disability Services
Gareth Clinkscale	Associate Director of Acute Services
Keith Allan	Associate Director of Public Health
In attendance:	
Graeme McMurdo	Programme Manager, Business Change & Improvement
Sonia Borthwick	Project Change Manager

5.2 Each member's support and assurance will come from both their own management and governance teams as well as additional sources, both internal and external to agencies.

5.3 A number of workstreams / project groups and reference groups are already in operation. The proposal is that they will reform within the above governance structure, taking on the role of one of the workstreams. It is expected that leads for each work stream may also sit on the oversight board. Where this is the case it is recognised that they will be held accountable by the oversight board for the delivery of their work stream objectives, while also participating in the decisions and discussions of the overall programme.

5.4 Specialist input, from colleagues who are not standing members, will be required within the SIP Oversight Board and within each of the priority workstreams. It is proposed that specialist input is added as and when required in order to support the decision making process.

5.5 To keep the momentum of change, it may be necessary for members to identify deputies or substitutes to act on their behalf when they are unable to attend. Should this be the case, members should empower those acting on their behalf to hold their delegated decision making authority.

5.6 It will be the responsibility of the SIP Delivery Board, based on the work of its associated workstreams, to provide the detail for individual "Directions" that may be required to be developed and recommended to the Strategic Planning Group of the IJB and ultimately to the

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IJB itself, for implementation across the partnership.

6 Workstreams

6.1 The number and range of priority workstreams will develop as we progress and as the drivers for change adapt to influences such as the Covid-19 pandemic and demographics. At present the workstreams have been identified from the priorities outlined under Item 2:

6.2

Priority workstream	Description
Carer Support Services	The partnership has always recognised the essential work of carers, and even more so through the Covid-19 pandemic. It is a precarious resource that requires support.
Locality Operations	Early intervention, prevention, shared client cohorts, agile responses, close coordination of effort, all reducing admissions and avoiding or slowing progression to higher levels of care and health needs. *(Prof. John Bolton Older People's Pathway 0)*
Older People's Pathway	Patient flow, including; Older Persons Assessment Area (admission avoidance), quicker discharge processes, Trusted Assessor models, new intermediate care and reablement services *(Prof. John Bolton Older People's Pathway 1,2 and 3)*
Technology	Technology support across health and care provision, workforce enablement, administration, processes and the sharing of information across the partnership.
Primary Care Improvement Plan	Supporting the introduction of the new GMS contract, and the development of community health services.
Mental Health Provision	For adults and children, including the Dementia Care Strategy and Autism Strategy
Learning & Physical Disability Provision	To support the recovery from the pandemic and "re-imagine" the service provision for both Learning Disability and Mental Health Cohorts
Joint Capital Planning	Including Primary Care capital strategy, new intermediate care and care provision and overarching joint Capital Plan for the Borders Public Sector.
Commissioning of Services	Reviewing, planning and contracting
Workforce support and provision	New skills, new operations, new equipment and processes

6.3 The work of the SIP Oversight Board, will necessarily be dynamic, and constantly change and adapt. The number, nature and content of the work streams will also change as the priorities evolve. For the present however, these terms of reference outlined here are deemed appropriate for the Oversight Board at this time.

6.4 The terms of reference and membership for some work streams are already in place, and others require development. These along with the agreed project objectives and outcomes will be agreed by the Oversight Board in line with partnership governance.

6.5 The delivery of this work will require effective partnership across a multitude of staff teams and services within a range of different employers. Close working arrangements will continue within the Joint Staff Forum and representative staff bodies within both Borders Council and NHS Borders will be appropriately involved with individual work streams in line with the standards for

staff engagement and involvement set out by the NHS and SBC.

6.6 The successful delivery of this work will also require appropriate public, patient and client engagement and this will be incorporated in line with the relevant Public engagement standards for both the NHS and SBC.

7 Next Steps

7.1 The SIP Oversight Board will now commence work as a matter of urgency. The immediate next steps will include:

Action	Timescale
Finalisation of SIP Oversight board TOR	End Aug 2020
Development and agreement of individual workstreams TOR	Sept 2020
Development of workstream PIDs / Key Deliverables	Oct 2020
Overall SIP work plan to end of March 2021 (including key decision points)	Oct 2020
Updating of high level financial framework to support SIP delivery	Nov 2020

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Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 19 August 2020

Report By:	Rob McCulloch-Graham, Chief Officer Health & Social Care
Contact:	Jill Stacey, SBIJB Chief Internal Auditor (SBC Chief Officer Audit & Risk)
Telephone:	01835 825036

STRATEGIC RISK REGISTER UPDATE

Purpose of Report:	The purpose of this report is to provide Members of the Board with an update of the most recent review of the IJB Strategic Risk Register as it is important that the Board is kept informed of the IJB's key risks and the actions undertaken to manage these risks.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) *Consider* the IJB Strategic Risk Register to ensure it covers the key risks of the IJB; b) *Note* the actions in progress to manage the risks; and c) *Note* that a further risk update will be provided in December 2020.

Personnel:	In line with the role and responsibilities, the IJB's Chief Officer has carried out the current review of the IJB Strategic Risk Register on 31 July 2020, supported by SBC's Risk Team.

Carers:	There are no direct carers' impacts arising from the report.

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

Financial:	There are no direct financial implications arising from the proposals in this report.

Legal:	Good governance will enable the IJB to pursue its vision effectively as well as underpinning that vision with mechanisms for control and management of risk.

Risk Implications:	Risk Management arrangements will assist the IJB making informed business decisions and provide options to deal with potential problems in line with its agreed Risk Management Strategy within its governance arrangements.

1 Background

1.1 The IJB, as strategic commissioner of health and social care services, gives directions to NHS Borders and Scottish Borders Council for delivery of the services in line with the Strategic Plan. The Scheme of Integration sets out how the managerial arrangements across the integrated arrangements flow back to the IJB and the Chief Officer. These arrangements are further supported by the IJB's Local Code of Corporate Governance.

1.2 Compliance with the principles of good governance requires the IJB to adopt a coherent approach to the management of risks that it faces in the achievement of its strategic objectives. A new Risk Management Policy and refreshed Risk Management Strategy is presented for approval by the IJB on 19 August 2020.

1.3 In accordance with Risk Management Policy and Strategy, the IJB Chief Officer carries out a review of the risk register on a quarterly basis and the IJB considers the Strategic Risk Register on a six monthly basis i.e. June and December each year.

1.4 The previous six-monthly risk review report, representing the overview by the Chief Officer Health and Social Care of the IJB's strategic risks and mitigations as at 4 December 2019, was presented to and discussed at the IJB full Board on 17 December 2019.

2 Summary

2.1 It is important that the IJB has its own robust risk management arrangements in place because if objectives are defined without taking the risks into consideration, the chances are that direction will be lost should any of these risks materialise. The identification, evaluation, control and review of the IJB strategic risks is a Management responsibility. However, knowledge of the strategic risks faced by the IJB and associated mitigations will enable the Board members to be more informed when making business decisions.

2.2 The IJB Chief Officer carried out a quarterly review of the risk register on 28 February 2020. The most recent management review of the IJB Strategic Risk Register has taken place on 31 July 2020, taking into consideration the impact of Covid-19 and, to a certain extent, Brexit on governance, commissioning and service delivery arrangements. The review was undertaken by the IJB's Chief Officer in line with his role and responsibilities and was supported by SBC's Risk Team.

2.3 A high level summary of the IJB's Strategic Risk Register, which sets out the strategic risks associated with the achievement of objectives and priorities within the IJB's Strategic Plan, is shown in Appendix 1. There are currently 10 risks on the IJB Strategic Risk Register; one Red and nine Amber rated risks.

2.4 Changes on specific risks for the IJB to note since the previous six-monthly report to the IJB Board on 17 December 2019 include:

- IJB001, while remaining Amber, has reduced from 12 to 8 due as the likelihood was reassessed from 3 (Possible) to 2 (Unlikely) due to improvements in joint working between the two partner organisations and lessons learned from Covid-19.
- IJB003 has reduced from Red to Amber, arising from progress with actions and internal controls to reduce the likelihood of the risk materialising.
- IJB005 has reduced from a score to 20 to 16 as the IJB directed the two partner organisations to produce a joint budget – an action that is now complete. However, the full financial implications of Covid-19 will become apparent over the coming months and will need to be considered at future reviews.
- IJB006, while remaining Amber, has reduced from 9 to 6 as the agility of the workforce has become clear in response to Covid-19, work with Borders College in relation to the training of Health and Support staff is underway, and recruitment has improved.
- IJB008 has reduced from 12 to 8 as new internal controls and actions have been added to this risk; the management approach has been changed from Tolerate to Treat as new ways have been devised to proactively mitigate this risk, for example through increased scrutiny of external providers.
- IJB009 has reduced in score from 12 to 6 in light of the new structure for support for the Strategic Implementation Plan that is being presented for approval at the IJB Board on 19 August 2020.

2.5 Further detail on the remaining Red-rated risk is shown in Appendix 2 to outline the current internal controls and further mitigation actions required to reduce the likelihood and/or the impact of the risk materialising.

2.6 This report and the IJB Strategic Risk Register are intended to provide the Board with assurance that the strategic risks associated with the achievement of objectives and priorities within the IJB's Strategic Plan are being effectively managed and monitored.

2.7 Reliance is placed on the risk management arrangements within the partner organisations in respect of the operational delivery of commissioned services. As stated in the IJB Risk Management Strategy, any of these risks that significantly impact on the delivery of the IJB Strategic Plan will be escalated to the Chief Officer for consideration.

2.8 The IJB Strategic Risk Register will continue to be reviewed alongside the implementation of the Strategic Plan by the IJB's Chief Officer on a quarterly basis with support from SBC's Risk Team. A further update will be presented to the Board in December 2020 i.e. on a six monthly basis in line with the IJB's Risk Management Policy and Strategy.

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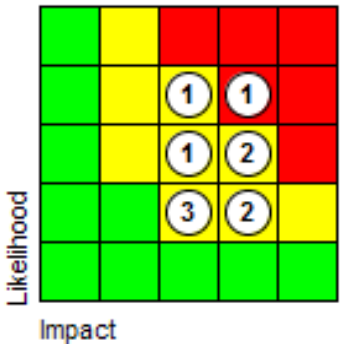
Scottish Borders
Health and Social Care
PARTNERSHIP

IJB Risk Register Summary

Generated on: 07 August 2020



Risk Code	Risk Title	Risk Description	Risk Score	Status	Trend	Last Review Date	Risk Approach	Update
IJB001	Cultural change	If the required change in culture is not achieved then the delivery of the Partnership's strategic objectives may be delayed or may not be fully met	8 Major - Unlikely			27-Jul-2020	Treat	The advent of the Pandemic has demanded closer working of the senior Executive teams of the Council and NHS. Communications have improved and there is a greater understanding of objectives. Lessons have been learned from our response to COVID-19, discussed at the last IJB development session and a revised structure for the Strategic Implementation Plan (SIP) is being brought to the IJB in August 2020. Internal Control - "Appointment of temporary IJB Director of Finance" changed from Fully Effective to Partially Effective because staff member is leaving. Likelihood changed from 3 to 2 so improvement in overall score from 12 Amber to 8 Amber. Target for the risk changed from 3 likelihood/3 impact to 1 likelihood/4 impact = 4 Green.
IJB002	Resources	If we do not ensure that resource directed by the	12 Moderate			27-Jul-	Treat	No Change to current score Likelihood/Impact and no

Risk Code	Risk Title	Risk Description	Risk Score	Status	Trend	Last Review Date	Risk Approach	Update
		IJB is used efficiently and effectively then we may not achieve best value	- Likely			2020		change to target score. Internal Control "Long Term Interim Chief Financial Officer in Post" changed from Fully Effective to Partially Effective as staff member is leaving and while this is being looked into it does not affect score. Linked Action "IJB has directed NHS Borders, SBC and IJB CEOs and CFOs to produce a joint budget for 2021 and the following 2 years" has been completed so marked as 100%.
IJB003	Future market for care	If the future market for care is insufficient to meet increasing demand then there may be gaps in service provision and poor outcomes/choices	12 Major - Possible			27-Jul-2020	Treat	Introduction of Housing with Extra Care expected Autumn 2020 and 2021 Covid-19 has developed more sufficiency within the community to care for those in lesser need, therefore we have been able to increase capacity. However, the impact of another cluster outbreak within one or more care homes would significantly reduce our ability to staff at the required level. Also we have yet to have a clear picture of the impact of Brexit. No Change to current score. New Internal Control "Regular meetings with Residential Care Providers" added and marked Fully Effective. Brexit added to Risk Factors/Causes due to potential impact on workforce. Linked Action "Market Facilitation Plan" due date extended to 31 March 2021 as Covid-19 has delayed the progression of this. Target risk changed from 3 Likelihood/ 4 Impact to 2 Likelihood/ 4 Impact = 8 Amber. Target date is 31 October 2020.
IJB004	Stakeholder engagement	If we do not ensure that we have a partnership approach when communicating and engaging with stakeholders then we may fail to get them to play their part in delivering the partnership's strategic objectives	9 Moderate - Possible			27-Jul-2020	Treat	No Changes to this risk in terms of internal controls, target risk or overall risk rating; however risk is being re-thought.
IJB005	Delegated Budget	If both Partners do not sufficiently and rigorously plan and manage their Efficiency and Savings	16 Major - Likely			27-Jul-2020	Treat	Progress has been made locally; however the uncertainty of future funding within Covid-19 is unclear,

Risk Code	Risk Title	Risk Description	Risk Score	Status	Trend	Last Review Date	Risk Approach	Update
		Programmes then the delegated budget may continue to overspend leading to inability to commission sufficient services to deliver the strategic objectives						therefore no change to overall Likelihood/Impact. No change to internal controls or target score. Linked action "Ongoing conversations with Scottish Govt re NHS funding" marked as 50% complete but as currently on hold as a result of Covid-19 due date changed to 31 January 2021. Linked action "IJB has directed NHS Borders, SBC and IJB CO and CFO to produce a joint budget for 2021 and following 2 years" marked as 100% complete.
IJB006	Workforce	If we do not have a workforce fit for purpose now and in the future then the Partnership may fail to deliver on the strategic objectives leading to poor outcomes	6 Moderate - Unlikely			27-Jul-2020	Treat	The response to Covid-19 has brought a greater flexibility to the deployment of staff teams and experience of NHS staff working within SBC and vice versa. This has improved relations and brought staff representatives closer to management teams. Likelihood 3 / Impact 3 changed to Likelihood 2 / Impact 3 = 6 Amber. No changes to internal controls. Brexit added to Risk Causes/Factors. Target Likelihood 2/Impact 3 changed to Likelihood 1/ Impact 3 and target date changed to 31 October 2021. Linked Action "Work underway with Borders College for training for Care and Health support staff" has been marked as 66% complete as we have managed to achieve 2 out of 3 cohorts. Work paused at present but should start again once colleges and schools reopen. Due date changed to 31 July 2021 to account for this.
IJB007	Supplier failure	If a significant supplier was unexpectedly unable to fulfil their contract then there may be a serious gap in service provision leading to risk of harm and reputational damage	12 Major - Possible			27-Jul-2020	Treat	Further challenge to the financial stability of external care providers has increased the likelihood of failure. Measures brought in by government have however mitigated this, We are still unclear as to the impact of Brexit on available workforce, as we reported last time. The likelihood and impact therefore remain the same so no change to overall score. Also no changes to internal controls or target risk. Brexit added to risk factors/causes.
IJB008	Harm to service users	If someone under the care of the IJB comes to harm because of a failure attributed to the	8 Major - Unlikely			27-Jul-2020	Treat	Further scrutiny of external care providers in Covid-19 response, thus risk score is reduced from Likelihood

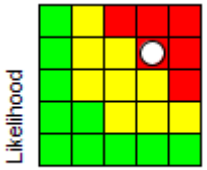
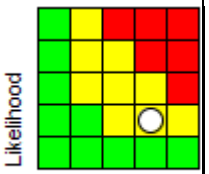
Risk Code	Risk Title	Risk Description	Risk Score	Status	Trend	Last Review Date	Risk Approach	Update
		Partners then this may result is significant reputational damage						3/Impact 4 to Likelihood 2/Impact 4 = 8 Amber Target Risk changed from Likelihood 3 / Impact 4 to Likelihood 1 / Impact 4 = 4 Green. Covid-19 added to risk factors/causes. New internal control "weekly meetings with External Providers to increase oversight and monitoring" added and assessed as partially effective. New linked action "Initiation of Strategic and Operational Oversight groups to provide monitoring and support of all care providers" added and target date set for 31 December 2020 but currently 0% complete. Given the addition of the internal control which is assessed as partially effective and the linked action which is not yet complete the risk approach has been changed from Tolerate to Treat as we are, again, actively putting in place new mitigations.
IJB009	Programmes / projects management	If we fail to manage and appropriately resource major programmes/projects undertaken simultaneously then we may be unable to achieve objectives	6 Moderate - Unlikely			27-Jul-2020	Treat	SBC have provided programme support resource but NHS Borders are still to agree to provide support. A new structure for support for the SIP is being negotiated and is for decision at the IJB on 19 August. Score changed from Likelihood 3 / Impact 3 to Likelihood 2 / Impact 3 = 6 Amber. Target score changed from Likelihood 2 / Impact 3 to Likelihood 1 / Impact 3 = 3 Green. Target date changed to 31 October 2020. Linked action "Will renegotiate project management support from NHS Borders" has been marked as 50% complete and due date amended to 31 October 2020.
IJB010	Data Breach	If the Partners lose sensitive data or use data inappropriately then we may be in breach of data protection legislation resulting in fines and reputational damage	6 Moderate - Unlikely			27-Jul-2020	Tolerate	The risk of data breaches lies within the two partners. The IJB may have reputational damage, as a result of any failure within the organisations. The Leadership Team of the IJB working within the partners, abide by internal controls to mitigate this risk. There is no change in this position, scores, targets, internal controls or management approach to risk.

IJB Risk Register

Generated on: 07 August 2020

Scottish Borders
Health and Social Care
PARTNERSHIP

Risk Register	Risk Code	Risk Title	Risk Description	Risk Owner	Risk Approach	RAG Status
IJB	IJB005	Delegated Budget	If both Partners do not sufficiently and rigorously plan and manage their Efficiency and Savings Programmes then the delegated budget may continue to overspend leading to inability to commission sufficient services to deliver the strategic objectives	Robert McCulloch-Graham	Treat	

Latest Note	Current Risk	Current Risk Score	Date Reviewed	Target Risk	Target Date	Risk Trend
Progress has been made locally, however the uncertainty of future funding within Covid-19 is unclear, therefore no change to overall Likelihood/Impact. No change to internal controls or target score. Linked action "Ongoing conversations with Scottish Govt re NHS funding" marked as 50% complete but as currently on hold as a result of Covid-19 due date changed to 31 January 2021. Linked action "IJB has directed NHS Borders, SBC and IJB CO and CFO to produce a joint budget for 2021 and following 2 years" marked as 100% complete.		16 Major - Likely	31-Jul-2020		31-Mar-2021	

Risk Factors/Causes	Effects/Consequences	Internal Controls	Internal Controls Score
Inability of the partners to resource the IJB to the levels required Lack of shared responsibility and accountability across the partnership for the prioritisation of resource to meet the strategic objectives of the IJB.	Overspend position, unless subsequent direction made to reduce spend across delegated functions or partners identify alternative temporary or permanent investment or savings proposals; Responsibility of the partner who originally delegated the budget to cover the shortfall; Inability to commission sufficient services to deliver the strategic objectives; Increased waiting times; Delayed discharge; Poor outcomes.	Transformation / Efficiency programme governance within NHSB and SBC;	Partially Effective
		It will be the responsibility of the authority who originally delegated the budget to cover the shortfall;	Fully Effective
		Regular financial reporting and monitoring at the Board	Partially Effective
		Performance Group	Fully Effective
		Joint Finance Group	Partially Effective
		IJB has directed NHS Borders, SBC and IJB CO and CFO to produce a joint budget for 2021 and following 2 years	Partially Effective

Linked Action Code	Linked Action	Assigned To	Action Due Date	Action Progress
IJB Action 003	Ongoing conversations with Scottish Govt re NHS funding;	Robert McCulloch-Graham	31-Jan-2021	50%

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 19 August 2020

Report By:	Cllr Tom Weatherston, Chair of IJB Audit Committee
Contact:	Jill Stacey, IJB Chief Internal Auditor (SBC Chief Officer Audit & Risk)
Telephone:	01835 825036

NTEGRATION JOINT BOARD AUDIT COMMITTEE ANNUAL REPORT 2019/20

Purpose of Report:	To provide Members with the IJB Audit Committee Annual Report 2019/20 that sets out how the IJB Audit Committee has fulfilled its remit and provides assurances to the Board.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) *Consider* the IJB Audit Committee Annual Report 2019/20 (Appendix 1) on the performance in relation to its Terms of Reference and the effectiveness of the Committee in meeting its purpose and the assurances therein b) *Note* the change in Membership of the IJB Audit Committee in recent months as stated in paragraph 2.4.

Personnel:	This report relates to Members of the IJB Audit Committee.

Carers:	There is no direct impact on carers arising from the contents of this report.

Equalities:	There are no direct equalities and diversities implications arising from the contents of this report.

Financial:	There are no direct financial implications arising from the contents of this report.

Legal:	The IJB is expected to operate under public sector good practice governance arrangements which are proportionate to its transactions and responsibilities. The IJB Audit Committee fulfilling its terms of reference is one of the key components of good governance which will enable the IJB to pursue its vision effectively with mechanisms for control and management of risk in the achievement of the objectives of Integration.

Risk Implications:	There is a risk that the IJB Audit Committee does not fully comply with best practice guidance thus limiting its effectiveness as a scrutiny body as a foundation for sound corporate governance. The completion of the annual self-assessment and identification and implementation of improvement actions as evidenced through this Annual Report will mitigate this risk.

1 BACKGROUND

1.1 It is important that the IJB's Audit Committee fully complies with best practice guidance on Audit Committees to ensure it can demonstrate its effectiveness as a scrutiny body as a foundation for sound corporate governance for the Scottish Borders Health and Social Care Integration Joint Board.

1.2 The Chartered Institute of Public Finance and Accountancy (CIPFA) issued an updated guidance note Audit Committees Practical Guidance for Local Authorities and Police 2018 Edition (hereinafter referred to as CIPFA Audit Committees Guidance) which is deemed appropriate for the IJB under the legislative framework for integration authorities. The CIPFA Audit Committees Guidance sets out CIPFA's view of the role and functions of an Audit Committee (Position Statement), includes a self-assessment checklist and an effectiveness toolkit, and recommends as best practice the production of an annual report on the performance of the Audit Committee against its remit for submission to the full Board.

2 SUMMARY

2.1 The IJB Audit Committee carried out self-assessments of Compliance with the Good Practice Principles Checklist and Evaluation of Effectiveness Toolkit from the CIPFA Audit Committees Guidance during an Informal Session held on 9 March 2020 facilitated by the IJB's Chief Internal Auditor. The Annual Report 2019/20, along with the self-assessments, was considered by the Members of the IJB Audit Committee and agreed at its meeting on 8 June 2020.

2.2 The outcome of the self-assessments was a high degree of performance against the good practice principles and a medium, but improving, degree of effectiveness. Further improvement has been identified by the Committee.

2.3 The IJB Audit Committee Annual Report 2019/20 (Appendix 1) is designed both to provide assurance to the IJB's full Board on the effectiveness of the Committee in meeting its purpose and to provide some actions for the Committee to improve its effectiveness.

2.4 Changes in Membership of the IJB Audit Committee were made since then in accordance with the IJB Standing Orders para 25.1 Urgent Decisions by the IJB Chief Officer in consultation with the Chair and Vice Chair of IJB. Mrs K Hamilton has been appointed as Chair of the IJB Audit Committee, in accordance with the rotation arrangements as stated within its Terms of Reference; and Mrs S Lam has been appointed as a Member of IJB Audit Committee in place of Mr M Dickson.

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SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD
IJB AUDIT COMMITTEE
ANNUAL REPORT FROM THE CHAIR – 2019/20

This annual report has been prepared to inform the Scottish Borders Health and Social Care Integration Joint Board of the work carried out by its Audit Committee during the financial year. The content and presentation of this report meets the requirements of the CIPFA 'Audit Committees' Guidance to report to the full Board on a regular basis on the Committee's performance in relation to its Terms of Reference and the effectiveness of the Committee in meeting its purpose.

Meetings

The IJB Audit Committee has met 4 times during the financial year on 5 June, 12 August and 9 December 2019, and 9 March 2020 to consider reports pertinent to the audit cycle.

The remit of the IJB Audit Committee is to have high level oversight of the IJB's framework of internal financial control, corporate governance, risk management systems and associated internal control environment. To fulfil this remit, it sought assurance on the adequacy and effectiveness of IJB's systems of corporate governance and internal control for efficient operations and for the highest standards of probity and public accountability. It did this through material it received from Internal Audit (provided by SBC's Internal Audit team), External Audit (delivered by Audit Scotland), other external scrutiny and inspection agencies, and assurances from Management.

The Committee scrutinised the IJB's Statement of Accounts at appropriate times in accordance with its Terms of Reference, which also includes promotion of the highest standards of conduct and professional behaviour.

The Minutes of IJB Audit Committee meetings were presented for approval by the IJB, and the Committee referred any exceptional items to the IJB in accordance with its remit.

Membership

The Membership of the IJB Audit Committee is set out within its Terms of Reference, namely "at least four voting members of the IJB". This structure, which is based on legislative requirements, does not meet with independence principles of good practice within CIPFA 'Audit Committees' Guidance. In addition, an Independent Member has been appointed from an external source as a non-voting member to enhance independence of the IJB Audit Committee's role in the scrutiny process.

The Committee membership during the year was Councillor T Weatherston (Chair), Councillor J Greenwell, Mr M Dickson, Mrs K Hamilton, Mr A Clark (Independent Member October 2018 to October 2019) and Mr J Wilson (Independent Member from February 2020).

The attendance by each member at the Committee meetings throughout the year was as follows:

Member	Meeting of 5 June 2019	Meeting of 12 August 2019	Meeting of 9 December 2019	Meeting of 9 March 2020
Cllr T Weatherston (Chair)	Present	Present	Present	Present
Cllr J Greenwell	Present	Present	Present	Present
Mr M Dickson	Present	Present	Present	Present
Mrs K Hamilton	Apologies	Present	Apologies	Present
Mr A Clark	Present	Apologies		
Mr J Wilson				Present

Every meeting of the IJB Audit Committee in 2019/20 was quorate (i.e. at least three Members present).

All other individuals who attended the meetings are recognised as being "in attendance" only. The Chief Officer, Chief Financial Officer, Chief Internal Auditor, external auditors, and the Secretary (provided by NHS Borders) attend all Committee meetings to support the Committee.

Skills and Knowledge

Given the wider corporate governance remit of IJB Audit Committees and the topics covered by the external and internal audit functions, it is noteworthy that there is a range of skills, knowledge and experience that IJB Audit Committee members bring to the committee, not limited to financial and business management. This enhances the quality of scrutiny and discussion of reports at the meetings. No one committee member would be expected to be expert in all areas.

Self-Assessment of the Committee

The annual self-assessment was carried out by members of the IJB Audit Committee on 9 March 2020 during an Informal Session facilitated by the IJB Chief Internal Auditor using the 'Good Practice Principles Checklist' and 'Evaluation of Effectiveness Toolkit' from the CIPFA 'Audit Committees' Guidance. This was useful for Members to ensure the Committee can demonstrate its effectiveness as a scrutiny body as a foundation for sound corporate governance for the IJB.

The outcome of the self-assessments for the Committee was a high degree of performance against the good practice principles and a medium, but improving, degree of effectiveness. The following improvement has been identified: utilise the Knowledge and Skills Framework to inform future learning and development needs of IJB Audit Committee members.

Assurance Statement to the Council

The IJB Audit Committee provides the following assurance to the Integration Joint Board:

- The IJB has received the Minutes of the IJB Audit Committee meetings throughout the year.
- The IJB Audit Committee has operated in accordance with its agreed terms of reference, and accordingly with the audit committee principles in CIPFA Position Statement.
- It did this through material it received from Internal Audit, External Audit, other audit and inspection bodies, and assurance from Management. It focussed entirely on matters of risk management, internal control and governance.
- For all audit reports, the IJB Audit Committee considered whether it was satisfied that an adequate Management response was in place to ensure action would be taken to manage risk and address concerns on internal controls and governance arrangements.
- The IJB Audit Committee has reflected on its performance during the year in respect of its Audit functions, and has identified areas for improvements.

Recommendations of the Terms of Reference for the IJB Audit Committee for the coming year

None.

Councillor Tom Weatherston
Chair of IJB Audit Committee
May 2020