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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, 16th December, 2020** at **10.00 am** in Via Microsoft Teams

AGENDA

Time	No		Lead	Paper
	1	**ANNOUNCEMENTS AND APOLOGIES**		
	2	**DECLARATIONS OF INTEREST**		
	3	**MINUTES OF PREVIOUS MEETING - 21 OCTOBER 2020**		(Pages 3 - 6)
	4	**MATTERS ARISING / ACTION TRACKER**		(Pages 7 - 8)
	5	**FOR DECISION**		
	5.1	IJB Business Plan and Meeting Cycle 2021		(Pages 9 - 14)
	5.2	Representation on the IJB		(Pages 15 - 18)
	5.3	Scottish Borders Health & Social Care Partnership Commissioning and Strategy Function		(Pages 19 - 24)
	6	**FOR NOTING**		
	6.1	Proposed Evaluation Process - Presentation		

6.2	Scene Setting - IJB Financial Plan Approach & Timetable, progress from last year - presentation	
6.3	Monitoring & Forecast of Health & Social Care Partnership Budget 2020/21 at 30 September 2020	(Pages 25 - 34)
6.4	Quarterly Performance Report November 2020	(Pages 35 - 56)
6.5	Borders Primary Care Improvement Plan Update Report and Next Steps	(Pages 57 - 124)
6.6	Alcohol and Drugs Partnership Report	(Pages 125 - 146)

7 ANY OTHER BUSINESS

8 DATE AND TIME OF NEXT MEETING

- Wednesday 17 February 2021, 10 am – 12 noon via Microsoft Teams

Scottish Borders
Health and Social Care
PARTNERSHIP

Minutes of an **Extra Ordinary** meeting of the **Scottish Borders Health & Social Care Integration Joint Board held** on **Wednesday 21 October 2020** at **10am** via Microsoft Teams

Present:

(v) Cllr D Parker (Chair)
(v) Cllr S Haslam
(v) Cllr T Weatherston
(v) Cllr E Thornton-Nicol
(v) Mr M Dickson, Non Executive
(v) Mrs K Hamilton, Non Executive
(v) Mr J McLaren, Non Executive
(v) Mr T Taylor, Non Executive
Mr R McCulloch-Graham, Chief Officer
Dr K Buchan, GP
Mrs L Gallacher, Borders Carers
Ms V MacPherson, Partnership Representative NHS
Mr S Easingwood, Chief Social Work & Public Protection Officer
Mrs J Smith, Borders Care Voice
Dr Lynn McCallum, Medical Director
Dr Tim Patterson, Director of Public Health
Mr N Istephan, Chief Executive, Eildon Housing

In Attendance:

Miss I Bishop, Board Secretary
Mr R Roberts, Chief Executive NHS
Mr D Robertson, Chief Financial Officer SBC
Mrs J Stacey, Internal Auditor
Ms J Holland, Chief Operating Officer SBCares
Ms L Lang, Communications Officer, NHS
Mr P McMenamin, Finance Business Partner, NHS
Mr C McClelland, Audit Scotland
Mr A Haseeb, Audit Scotland

1. APOLOGIES AND ANNOUNCEMENTS

Apologies had been received from Cllr John Greenwell, Mrs Sonya Lam, Non Executive, Mr Andrew Bone, Director of Finance NHS Borders and Mr David Bell, Staff Officer, SBC.

The Chair welcomed Mr Paul McMenamin who was deputising for Mr Andrew Bone.

The Chair welcomed Mr Asif Haseeb and Mr Chris McClellland from Audit Scotland.

The Chair confirmed the meeting was quorate

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 THE PREVIOUS MEETING

The minutes of the previous meeting of the Health & Social Care Integration Joint Board held on 23 September 2020 were approved.

4. MATTERS ARISING

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

5. ANNUAL ACCOUNTS 2019/20

Mr Paul McMenamin provided an overview of the Annual Accounts 2019/20. He confirmed that on 2 August Mr Mike Porteous, had concluded his secondment to the post of Chief Financial Officer (CFO) for the partnership. The position remained vacant with a requirement to appoint a proper Section 95 Officer. Mr David Robertson, Section 95 Officer for Scottish Borders Council had taken on the position of Interim CFO for the Integration Joint Board (IJB) in order to ensure the accounts process could be properly concluded.

He reported that the unaudited accounts were to be published by 30 June each year with audited accounts published by 30 September each year. Given the impact of the COVID-19 Pandemic across public bodies, flexibility was granted to be able to delay the production of unaudited accounts. Mr McMenamin advised that Mr Malcolm Dickson had emailed through some narrative amendments which he was content to include.

Mr McMenamin highlighted the key messages within the accounts: underspend of £3.1m against delegated budgets; large hospital budget retained by NHS Borders; set aside budget position; delegated budget underspend was in regard to ring fenced NHS funding received by the partnership; additional contributions received from both NHS Borders and Scottish Borders Council; application of reserves policy; risk associated with carry forward funding especially in regard to the Older Peoples Change Fund; potential risk of Scottish Government clawing back ring fenced funding from NHS Borders given its on-going requirement for brokerage.

Mr McMenamin reiterated that the partnership budget would remain under pressure for the current and future years.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the report and the 2019/20 Annual Accounts.

Mr Asif Haseeb presented the Audit Scotland report and management letter. He highlighted that the audit had been completed and a clear audit opinion was provided. The independent audit certificate would be incorporated within the Annual Accounts and Mr David Robertson as Acting Chief Financial Officer of the IJB, would sign the standard management representation letter.

Mr Haseeb provided an overview of the content of the Annual Audit Report which covered the audit opinion and the wider aspects of public audit including: performance; governance and

value for money. He advised of the key messages set out in the report and highlighted the ongoing financial pressures and action plan at the end of the report. He recognised that progress had been slow on a number of elements and was assured that action would be taken to address those points with a response and revised timeline received from management.

He further advised that the accounts would be formally signed off by electronic means given the pandemic situation.

The Chair assured the Integration Joint Board that the Annual Accounts documentation had been fully discussed by the Audit Committee earlier that morning who had committed to focus on the action plan.

Mr Malcolm Dickson sought clarification on page 17/29 where it referred to brokerage funding being subject to repayment unless a balanced position was not achieved in the 3 year period. He suggested it sounded like, if a balanced position was not achieved in 3 years, (that section really only being relevant to the NHS) then brokerage would be written off, however he was not sure that was the actual case. Mr Haseeb confirmed that his understanding was the part of the brokerage was based on achieving a balanced position within 3 years.

Mr Dickson accepted that brokerage was subject to a balanced position being achieved in 3 years however he suggested the sentence alluded that brokerage would be subject to repayment if balance was not achieved and would not be repaid if balance was achieved. Mr Haseeb suggested he review the nuance of the sentence.

Mr Ralph Roberts commented that NHS Borders would be expected to repay the brokerage at some point. There was a 3 year plan in place to achieve a balanced position.

Mr Paul McMenamin echoed Mr Roberts comments and clarified that the 3 year plan to achieve balance included a requirement for brokerage and at the end of the period if balance was achieved then negotiations would begin on how the brokerage would be repaid.

The Chair thanked NHS Borders, Scottish Borders Council and Audit Scotland colleagues for their work to getting the Annual Accounts for 2019/20 to a position of sign off.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** accepted the Audit Scotland Report and Management Letter.

6. ANY OTHER BUSINESS

No further items of business were raised.

7. DATE AND TIME OF NEXT MEETING

The Chair confirmed that the next meeting of the Scottish Borders Health & Social Care Integration Joint Board would be held on Wednesday 18 November 2020, from 10am to 12noon, via Microsoft Teams.

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Scottish Borders 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	Future development session to 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 was suggested that this session is delayed until safe to do so. **23.09.20 Update:** Mr Rob McCulloch-Graham commented that with the use of MS Teams he was hopeful that plans to address the action would be secured in the next 8-10 weeks.	R

Meeting held 19 August 2020

Agenda Item: Primary Care Improvement Plan: Update

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
2	7	Evaluation report of new Primary Care Mental Health Service, funded through PCIP.	Rob McCulloch-Graham Kevin Buchan	August 2021		G

Agenda Item: Strategic Implementation Plan & Priorities

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
3	11	Undertake a review of the Scheme of Integration.	Rob McCulloch-Graham Iris Bishop	March 2021	**23.09.20 Update:** Mrs Karen Hamilton enquired if the timescale for Action 3 was for the review to have been completed by the end of March 20201. Mr McCulloch-Graham confirmed that it was. **09.10.20: Update:** An initial review of the scheme is currently being taken forward and a timeline for completion is being worked up.	

KEY:	
	Overdue / timescale TBA
	<2 weeks to timescale
	>2 weeks to timescale

HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD BUSINESS PLAN 2021/22

Item	Recurrence	Owner	IJB 17.02.2021	IJB Audit Committee 08.03.2021	IJB Development Session 24.03.2021	IJB 21.04.2021	IJB Audit Committee 14.06.2021	IJB 23.06.2021	IJB Audit Committee 13.09.2021	IJB 22.09.2021	IJB Development Session 20.10.2021	IJB Audit Committee 06.12.2021	IJB 15.12.2021	IJB February 2022
Minutes	Each Meeting	Business Lead	Approve	Approve		Approve	Approve	Approve	Approve	Approve		Approve	Approve	Approve
Action Tracker	Each Meeting	Business Lead	Approve	Approve		Approve	Approve	Approve	Approve	Approve		Approve	Approve	Approve
Internal Audit Update Report	Each Meeting	Chief Internal Auditor		Note			Note		Note			Note	Approve	
Monitoring of the Health & Social Care Partnership Budget	Each Meeting	Chief Financial Officer	Note			Note		Note		Note			Note	Note
Performance Report	Quarterly	Graeme McMurdo	Quarterly - Note			Quarterly - Note							Quarterly - Note	
Inspections Update	Each Meeting	Chief Social Work Officer												
SPG Report for IJB	Quarterly	Chief Officer	Note			Note				Note			Note	
2021/22 IJB Joint Financial Plan	Annually - late feb	Chief Financial Officer	Draft Budget			Approve Budget								Draft Budget 2022/23
Issue Directions (point approval of Joint Financial Plan)	Annually - March onwards	Chief Financial Officer				Approve Directions		Approve Directions						
Dicharge Programme Update	Annually	Chief Officer												
Scheme of Integration	Annually	Board Secretary												
Register of Interests	Annually	Board Secretary												
Winter Plan	Annually	Chief Officer / Director of Nursing												
Code of Corporate Governance Refresh	Annually	Board Secretary					Review Local CoCG							
Clinical & Care Governance Annual Report	Annually	Chief Officer, Director of Nursing, Medical Director											Note	
H&SC IJB Annual Performance Report	Annually	Chief Officer				Review Draft		Approve						
Chief Social Work Officer Annual Report	Annually	Chief Social Work Officer											Note	
IJB Annual Accounts	Annually	Chief Financial Officer					Unaudited		Audited	Approve				
Board Committee Memberships	Bi Annual	Board Secretary												
Board Meeting Dates & Business Cycle	Annually	Board Secretary								Approve				
Alcohol and Drug Partnership Annual Report	Annually	Director of Public Health											Note	
Strategic Commissioning & Implementation Plan Review (2018-2021)	2021	Chief Officer	H&SC SC&I Plan Review 5 year Look Forward							Formal Approval			Note Update	
External Audit Annual Plan	Annually	External Auditor												
IJB Audit Committee Annual Report	Annually	Chief Internal Auditor						Note						
External Audit Annual Audit Report	Annually	External Auditor								Approve				
IJB Self Evaluation	Annually	Chief Officer / Chief Internal Auditor		Undertake self assessment			Approve self assessment						IJB self assessment	
Strategic Risk Register Update	Bi-Annual IJB Annual Audit Committee	Chief Officer						Note					Note	
Risk Management Policy & Strategy	Annually	Chief Internal Auditor												
Review of IJB Terms of Reference	2021	Board Secretary												
Shifting the Balance of Care	Annually	Chief Officer												
Public Sector Equality Duty	Bi Annual Progress Report Full Refresh 2021	Simone Doyle and Jane Robertson												
Shared Lives	Annually	General Manager MH & LD												
Charging Policy	Annually	Chief Officer												
Financial Outlook Update	Quarterly	SBC & NHSB Directors of Finance												
Locality Working Groups / Community Engagement	Annually	Chief Officer												
Look Forward/Look Back	Annually	Chief Officer												
Public Protection Service	Annually	Chief Social Work Officer												
MSG Review of Progress with Integration of Health & Social Care	Annually	Chief Officer												
PCIP - Primary Care Improvement Plan	Annually	Chief Officer / General Manager P&CS												
PCIP - Primary Care Mental Health Service Evaluation Report	2021	Chief Officer / GP Sub Chair												
Transforming Specialist Hospital Dementia Care & CHAT Team Review	2021	Chief Officer / General Manager MH & LD												
Physical Disability Strategy	Annually	Michael Curran												

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Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 16 December 2020

Report By:	Iris Bishop, Board Secretary
Contact:	Iris Bishop, Board Secretary
Telephone:	01896 825525
IJB BUSINESS PLAN AND MEETING CYCLE 2021	
Purpose of Report:	To provide the Health & Social Care Integration Joint Board with a focused and structured approach to the business that will be required to be conducted over the coming year.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Approve** the business plan and meeting cycle for 2021.
Personnel:	Resource/staffing implications will be addressed in the management of any actions/decisions resulting from the business presented to the Health & Social Care Integration Joint Board.
Carers:	Any carers implications will be addressed in the management of any actions/decisions resulting from the business presented to the Health & Social Care Integration Joint Board.
Equalities:	Not necessary.
Financial:	Resource/staffing implications will be addressed in the management of any actions/decisions resulting from the business presented to the Health & Social Care Integration Joint Board.
Legal:	Policy/strategy implications will be addressed in the management of any actions/decisions resulting from the business presented to the Health & Social Care Integration Joint Board.
Risk Implications:	Risk assessment will be addressed in the management of any actions/decisions resulting from the business presented to the Health & Social Care Integration Joint Board.

Background

1.1 To deliver against targets and objectives, the Health & Social Care Integration Joint Board must be kept aware of progress on a number of key issues on a regular basis. This is provided through scrutiny of the Quarterly Performance Report.

1.2 Health & Social Care Integration Joint Board meeting agendas are mainly focused on strategic, clinical and care governance and financial issues. These are the fundamental pillars of business items for the IJB to focus its attention on.

1.3 Standing items are submitted to the Health & Social Care Integration Joint Board in full format with verbal by exception reporting at the meeting. This enables time to be set aside at the meeting for robust scrutiny and debate of substantial business items.

1.4 Attached is the proposed Business Cycle for 2021 for the Health & Social Care Integration Joint Board. The business cycle will remain a live document and subject to amendment to accommodate any appropriate changes to timelines, legislative requirements, etc.

Summary

2.1 As a consequence of the impact of the COVID-19 Pandemic on the meeting schedule and business plan for the IJB, the Board Secretary in conjunction with the Chief Officer undertook a short review of the business plan.

2.2. In conclusion, there were 4 out of 9 formal business meetings cancelled in 2020 with the business of those meetings either suspended or postponed. It was noted that none of the business from those cancelled meetings required attention outwith the meeting cycle. This therefore brought into question the frequency of meetings as well as the validity of items being submitted to the IJB for decision and debate. It was noted that frequently items were submitted to the IJB as updates for noting. It was also noted that items required to be titled correctly (ie updates were not evaluations).

2.3 In order to ensure the IJB receives tangible business of a high quality standard the number of meetings for 2021 are proposed to be reduced to 6 per year which would afford officers time to ensure the delivery of quality reports worthy of robust scrutiny.

2.4 The IJB will continue to retain the ability to call Extra Ordinary meetings outwith the normal business cycle should that be necessary.

2.5 It is proposed that the Health & Social Care Integration Joint Board now meet formally on no less than 6 occasions throughout 2021.

2.6 It is proposed that the Health & Social Care Integration Joint Board undertake 2 Development sessions throughout 2021.

2.7 It is proposed the Audit Committee of the Integration Joint Board meet formally on no less than 4 occasions throughout 2021.

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

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

2.10 All Health & Social Care Integration Joint Board meetings, Development sessions and Audit Committee meetings will take place via MS Teams.

2.11 In order to maximise the availability of Health & Social Care Integration Joint Board (H&SC IJB) members all IJB meetings and development sessions have been arranged for Wednesdays with IJB Audit Committee meetings scheduled to take place on Mondays. All are as per the schedule listed below:-

Date/Event	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
IJB Meeting 10am to 12noon		17		21		23		18		20		15
IJB Development Session 10am to 12noon			24						22			
IJB Audit Committee 2pm to 4pm			8			14			13			6

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Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 16 December 2020

Report By:	Rob McCulloch-Graham, Chief Officer Health & Social Care
Contact:	Rob McCulloch-Graham, Chief Officer Health & Social Care
Telephone:	01896 82
REPRESENTATION ON THE IJB	
Purpose of Report:	To seek the support of the IJB to expand the representation on the IJB with regards to Lesbian, Bisexual, Gay and Transgender citizens within the Borders.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **approve** the appointment of Linda Jackson as a non-voting member of the Integration Joint Board of Scottish Borders.
Personnel:	N/A
Carers:	N/A
Equalities:	In line with the Equalities Act 2010 (Scotland) which introduced a broader public sector equality duty, replacing existing equality duties for race, gender and disability. There is a general public sector equality duty in the Act itself and provision for further specific duties to be made through Regulations. The general duty came into force on 5 April 2011 and requires public authorities to consider the needs of protected groups, for example, when delivering services and in employment practices.
Financial:	N/A
Legal:	In line with the Equalities Act 2010 (Scotland).
Risk Implications:	N/A

Aim

1.1 The Integration Joint Board seeks to ensure in its operation that decisions and policy that are agreed, are both well informed and representative of all groups within the population of the Scottish Borders.

1.2 Members of the Board have sought on a number of occasions that further amendments are made to the membership that would further support this aim.

1.3 This paper seeks to further these requests, and in particular, with regards to the lesbian, bisexual, gay and transgender citizens within the Borders.

Background

2.1 The local LGBT Equality Group, have been established for 15 years within the Borders. The organisation's purposes are to promote, preserve and protect the mental and physical health and social welfare of the Lesbian, Gay, Bisexual and Transgender (LGBT) community in the Scottish Borders by:

- Promoting equality and recognition as equal members of the community;
- Promoting access and social inclusion;
- Improving emotional and physical well-being;
- Actively working to reduce discrimination;
- Increasing awareness and visibility

2.2 The group has undertaken many activities, for example:

- Work within the Borders Book Festival
- Support for the Borders College "Freshers" Week
- Support for the Dumfries Pride event
- LEAP Sports seminar co-organiser of Diversity week
- Main organiser of Queer Borders Film Festival
- Launch of the "See Me" event in Peebles
- Support for the Jedburgh 3 peaks challenge
- Co-organisers of the "Reclaim the Night" march
- Operation of the Cafe Polari - (a cafe like space offering for people identifying as LGBT and friends)
- Organising the LGBT history month, running various events
- Hosting the LGBT Cross Party Parliamentary Group - raising rural issues
- Organising the LGBT Fostering and Adoption event
- Supporting the International Day Against Homophobia

Summary

3.1 Linda Jackson is a senior member and founding member of the LGBT Equality Group. She has promoted the objects and aims of the group in many arenas, including Health and Social Care and has attended a number of IJB sessions.

3.2 Linda is also actively involved in supporting the unpaid carer community of the Borders, and has been supportive of the work of the Health and Social Care Partnership throughout its inception to today.

3.3 This paper is seeking to broaden the membership of the IJB to include representation from the LGBT community. To do so, the executive of the Board would recommend the appointment of Linda Jackson to the Board.

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Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 16 December 2020

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

SCOTTISH BORDERS HEALTH AND SOCIAL CARE PARTNERSHIP
COMMISSIONING AND STRATEGY FUNCTION

Purpose of Report:	This paper recommends changes in reporting lines within the senior management team, to support the strengthening of the "Strategic Commissioning" function of the Integration Joint Board.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **support** the changes in reporting lines within the senior management team, outlined within this paper, to strengthen the "Strategic Commissioning" function of the Integration Joint Board.
Personnel:	Are contained within the body of the report
Carers:	N/A
Equalities:	The changes proposed will support the ability of the senior management team to ensure strategies and policies of the Board meet these requirements.
Financial:	Are contained within the body of the report
Legal:	N/A
Risk Implications:	The changes proposed will mitigate the risk and impact of a lack of capacity in both operation control and commissioning functions of the health and social care partnership.

Scottish Borders Health and Social Care Partnership
Commissioning and Strategy Function

1. Aim

1.1 The capacity of the leadership structure of the Health and Social Care Partnership needs to be strengthened to better support the integrated strategic commissioning and the operation of services.

1.2 This paper recommends changes in reporting lines within the senior management team, to support the strengthening of the "Strategic Commissioning" function of the Integration Joint Board.

2. Issues

- Strategies within NHSB and SBC should be better combined in relation to the Health and Social Care Partnership agenda
- The Joint Board commissions over £201m across Health and Social Care. There is currently insufficient strategic and commissioning capacity across the partnership, with insufficient planning ability and on-going policy oversight.
- There is a lack of joined up communications to and from staff and stakeholders with regards to the vision for the partnership and alignment to the partnership goals.
- There is a need for greater strategic drive to translate into operational plans to ensure the efficiency and quality of services
- The lack of operational leadership leads to inefficiency, with a resultant lack of control to ensure compliance and adoption and implementation of policy agreed at Board level.

3. Strategic Priorities

3.1 There has been both a local and a national review of the experiences of the work and impact, of the first 5 months of the Covid 19 pandemic. This review was discussed at both the Strategic Planning Group and the Integration Joint Board. The following areas of work were agreed as the priorities that the Health and Social Care Partnership should adopt for the next two years.

1.	Localities	6.	Primary Care Improvement
2.	Older Peoples Pathway	7.	Carers Support
3.	Commissioning	8.	Health Care Technology
4.	Mental Health Strategy	9.	Workforce
5.	Learning Disability Strategy	10.	Capital Strategy

3.2 A number of these work streams commenced over a year ago as part of FF2024 and NHS transformation, but some with single input from NHSB or SBC, where a joint strategy and plan is required. There is a current lack of programme capacity for joint programmes and more joint input will be required. Individual objectives for NHSB and for SBC can still be achieved through these joint programmes, and duplication of effort removed.

4. Structural change

4.1 Many processes have already been created within the “Fit for 24”, and the NHSB “Turnaround/Recovery Programmes”, which should continue to serve the combined work streams within the partnership. There is however a need to revise the resource available to ensure there is sufficient capacity to deliver and to provide a coherent governance and managerial/project oversight.

4.2 There are four functions which drive the partnership;

1. Resource Management & Control
2. Operational Management & Direction
3. Strategy & Commissioning
4. Professional & Clinical Governance

4.3 To address the current shortfall in capacity to deliver these four functions, this paper proposes amendments to current roles and the introduction of some new appointments.

The intentions of these changes are two fold;

1. To support the IJB to fulfil its function as a strategic commissioning body.
2. To provide greater managerial capacity to secure both quality and compliance with policy.

4.4 The diagram attached, illustrates a proposed new alignment of managerial spans to ensure each of these four functions are supported through clear lines of delegation and authority. Included are some functions which are not IJB delegated functions, but are outlined here to provide a clearer understanding of reporting lines within Social Services. (*Coloured pink within the chart.) (Appendix 1)*

4.5 The next three years will require significant change in the provision of services. This change can only be implemented through the reallocation and redirection of resource. The Board will be expected to make decisions on the opening of new services and the closure of existing services. Over the next three years, these decisions will be in the magnitude of several millions of pounds, and impact on more than 1000 staff members across the totality of the Health and Social Care Partnership.

4.6 To support these decisions, the Board will require much clearer insight to the population’s needs, a clear understanding of current performance, proposals which are well researched, well informed, and coherently presented to support the decisions required.

4.7 The Health and Social Care Partnership, operates services with a resource in excess of £200m. The current arrangements for managerial control which are combined with the strategic functions of the Board, are over stretched, and cannot provide the capacity to undertake both functions. This paper proposes that these roles are now split. That the Council and the NHS Borders, support and resource the *Operational Management* of the delegated services within their responsibilities. The *Strategic Commissioning* role of the partnership through the Board, should be better supported and the capacity of the staff team increased to better support this function of the IJB as a whole.

4.8 The Chief Officer will oversee the Strategic Commissioning function of the IJB and the Health and Social Care Partnership. Two new positions are proposed to deliver on the "Directions" of the IJB through leading the "Operational Functions" of the Health and Social Care Partnership for the delegated services within NHS Borders and Scottish Borders Council. It could be argued that this proposal is a retrograde step, in moving back to "silos" and disaggregating the partnership. This would be a misconception. Both the IJB and the Health and Social Care Partnership have matured over the last few years, relationships between services and between executives have evolved, becoming much closer, especially through the formation of joint leadership to address the pandemic. There is no likelihood of a return to previous modes of operation, Council and Health Services are now linked locally, and Executive Teams have lead collectively now for nine and a half months. What is required now is a pragmatic delegation of responsibility and accountability for the leadership of service provision, coupled with a very real increase in the ability of the partnership to commission.

4.9 We know, in comparison with the rest of Scotland we fund too many hospital beds; we also know we have too few residential care beds. Our task is to rebalance this inequity. This will require a substantial re-commissioning exercise, for which the IJB which currently is ill equipped to undertake.

4.10 The recommendation of this paper seeks to address the capacity required, and allow the Board to move firmly into its role as the Commissioning Board for Health and Social Care for the Scottish Borders.

5. Proposed role changes and additional roles.

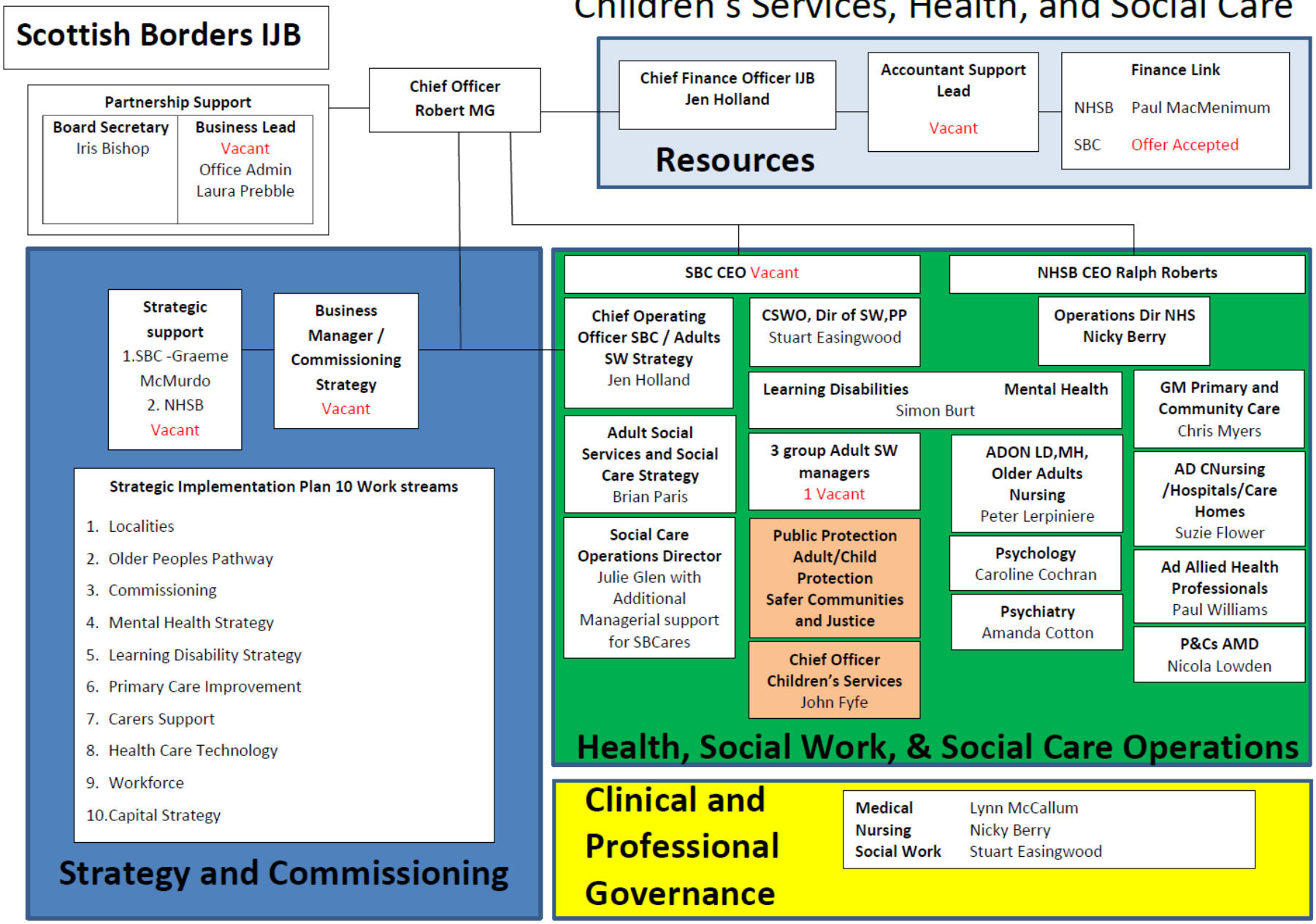
Post	Additional support / resource
Chief Operating Officer SBC / Adults SW Strategy / Chief Finance Officer IJB	Full time director post with responsibility for the Strategic function of Adult Social Work Service with overall responsibility for the Social Care provision. Chief Finance Officer responsibility for the joint IJB Budget reporting to the IJB.
Director of Delegated Health Care Operations	Full time director post within NHSB, leading Acute, Primary and Community Care, and Mental Health operations; an interim role to be reviewed after 6 months.
Chief Social Work Officer, / Overall Director of Social Work and Public Protection	This new role will be comprehensive in leading all aspects of both Adult and Children's Social Services. Learning Disabilities should now also report to this position to give a single line of accountability for all Social Services. This is in addition to Adult and Child Protection functions, as well as, all services for Safer Communities and Public Protection. This enhanced role will bring significant clarity to the leadership of these services. This wider function will allow for a greater coherence to social work operations and the functions required for protection and provision of safer communities.

Business Manager / Commissioning Lead	A new senior position to lead the commissioning function with the Chief Officer. This will be supported by 2 Programme Support to provide work stream oversight. One post is already funded through SBC; further matching support will be provided through NHSB. Modelling support is already available within SBC/NHSB and from Government. Further Contract monitoring from within SBC Contract Team, Primary Care Strategic resource is now already sourced. The 10 new work streams will be supported by existing managers within the partnership's delegated services.
IJB Finance Lead	The CFO role will form part of the Chief Operating Officer SBC / Adults SW Strategy position. This is already a demanding responsibility and for its success, it will require a further qualified and experienced accountant to provide the financial support required. The 2 existing finance business managers in NHSB and SBC will continue to support the IJB joint budget.

6. Resourcing

6.1 There are a number of additional new posts and an expansion of responsibilities for other posts which will therefore be subject to a re-grading due to the additional duties and accountabilities. These additional costs will be met within the overall resources of the IJB.

Children's Services, Health, and Social Care



Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: *16 December 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
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MONITORING AND FORECAST OF THE HEALTH AND SOCIAL CARE PARTNERSHIP BUDGET 2020/21 AT 30 SEPTEMBER 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 30 September 2020.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Note** the forecast adverse variance of (£5.525m) for the Partnership for the year to 31 March 2021 based on available information b) **Note** the forecast position now includes Scottish Government funding allocations representing the IJB's share of a £50m tranche of funding to support immediate challenges in the Social Care sector and the first tranche of funding allocated to Health Boards from the national resource envelope of £1.1bn. Further funding allocations from the Scottish Government have been assumed in respect of the additional costs incurred responding to the Covid-19 situation for the remainder of the year, noting potential shortfalls of £1.720m in delegated functions and £0.29m in large hospital functions retained. No funding has been assumed currently however to mitigate the impact on the Partnership's ability to deliver agreed Financial Plan savings c) **Note** that the position includes additional funding vired to the Health and Social Care Partnership during the first quarter by Scottish Borders Council of £3.164m to meet previously reported pressures across social care functions from managed forecast efficiency savings within other non-delegated local authority services. It also includes other miscellaneous budget adjustments across delegated and set-aside functions. d) **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.

Background

2.1 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").

2.2 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 30th September 2020. Further reports will be brought to the IJB as the financial year progresses on a regular and frequent basis. As this happens, further analysis and refinement of the impact of the Covid-19 pandemic on activity levels, mobilisation costs, remobilisation plans and associated costs, lost income and unachievable savings will take place and greater clarity with regard to remaining funding allocations will emerge.

Overview of Monitoring and Forecast Position at 30 September 2020

3.1 The paper presents the consolidated financial performance for the period to end of September 2020 (6 months). Although this position includes a forecast of the year

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end outturn, members should note that forecasts will continue to be reviewed on an ongoing basis.

3.2 At the end of month 6, functions delegated to the partnership are forecasting an adverse projected pressure of £4.544m and the large hospital budget retained and set-aside is forecasting a similarly adverse pressure of £0.981m. Within delegated functions, following the delegation of additional budget to social care functions by Scottish Borders Council, an overall breakeven position is currently projected and the total £5.525m adverse pressure on delegated and set-aside functions therefore sits entirely across healthcare functions.

3.3 Overall therefore, this represents a favourable movement from the position reported at month 3 and primarily is attributable to the receipt of first tranche of Covid19 funding allocation from the Scottish Government. There are other minor movements relating to the identification of and accounting for savings within core operational budgets as a result in the reduction in activity caused by Covid-19 during the first 6 months of the financial year. A number of actions and opportunities exist to further move to financial balance over the remainder of the financial year which are outlined later in this report.

Covid 19

3.4 Costs incurred in the first 6 months are in line with the expenditure reported to Scottish Government through the Health & Social Care Local Mobilisation Plan financial model. In turn this has informed the Scottish Government's allocation of the first tranche of core revenue funding to meet Covid-19 costs April to October including funding in respect of GP practices and social care provider sustainability as outlined in previous reports. No funding has yet been allocated in respect of other component elements such as Family Health Services, Influenza, Winter and Unscheduled Care. 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, neither of which have, to date, had any specific funding allocation made in respect of them.

3.5 At the 30 September 2020 therefore, the Scottish Borders Health and Social Care Partnership actual and forecast expenditure pertaining to Covid-19 initial mobilisation subsequent remobilisation is:

	Actual to 30 Sept 20 £m	Projected to 31 March 20 £m
Healthcare Functions	3.572	6.384
Social Care Functions	2.584	4.253
	6.156	10.637

The figures above include the projected costs of current plans for remobilisation, which are near completion but not yet fully formalised. The figures in the table above also include actual and forecast opportunity cost of planned savings that have been assessed as being undeliverable in 2020/21 as a result of Covid-19 and lost income opportunities.

Efficiency Savings

3.6 Forecasts include the estimated impact of non-delivery of savings plans. This position remains under review and the reported position reflects assumptions across Scottish Borders Council's Fit for 2024 and NHS Borders' Financial Turnaround Programmes.

	Targeted Savings per Financial Plan £m	Projected Savings to be Delivered £m	Shortfall £m
Healthcare Functions	(4.740)	(0.695)	4.045
Set-Aside Functions	(1.090)	(0.109)	981
Social Care Functions	(2.482)	*(2.482)	0
	(8.312)	(3.286)	(5.026)

*£1.814m of savings have been met by alternative means on a non-recurring basis. SBC Social Care Functions are currently forecasting to deliver the remaining £0.668m by the end of the financial year.

Year End Forecast

Healthcare functions

3.7 Beyond the additional costs of Covid-19, including the non-delivery of planned savings on which the financial plan is predicated, operational functions are reporting a reduction in core activity over the first half of the financial year that net of the additional costs of Covid-19, result in a favourable position at the end of month 6 of £1.221m. This is primarily attributable to a delay in recruitment to vacancies during the first 6 months due to Covid-19 and reduction in core activity over April to September and includes net reductions in spend across Primary and Community Services (Community Nursing, Dental and Allied Health Professionals) and Mental Health (staffing).

3.8 These partially offset Forecast Undelivered Efficiency Savings of £4.045m. NHS Borders has also projected that based on allocations confirmed to date, inclusive of amounts retained by Scottish Government pending confirmation of actual expenditure, there is an expected shortfall of £1.720m in relation to delegated functions. This estimate is based on comparison with the expenditure forecast presented in the partnership's joint Covid-19 local mobilisation plan (LMP). Scottish Government has indicated that this position will be reviewed in January and it is anticipated that this position will improve as greater certainty over in year expenditure and resources is achieved.

It should be noted that NHS Borders identified a requirement for £7.9m brokerage within its financial plan for 2020/21. It is expected that a share of this brokerage will be available to the IJB in order to mitigate the forecast deficit. This figure, and any further NHS resources available to the IJB, will be confirmed following agreement with the Scottish Government of assumptions within the Health Board's mid-year review that was submitted at the end of November.

Social Care functions

3.9 At 30 September, Scottish Borders actual spend to date on social care functions, as stated in Appendix 1, was £19.303m. The Council position includes Scottish Government allocation of £1.078m to meet specific Social Care pressures. Further anticipated Covid-19 pressures are built into the 2020-21 outturn projection of £54.658m and are funded through the Council's Covid-19 reserve, pending further Scottish Government funding. Operational pressures have arisen in some service areas, however it is anticipated that the service will meet these from existing budgets during the remainder of the year.

3.10 The Scottish Borders Council forecast at month 6 is based on detailed monthly monitoring during the first 6 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 LMP and has, similar to healthcare functions, been mitigated by off-setting cost reductions due to non-delivery of services as a result of Covid-19.

General

3.11 Forecasts therefore include indicative allocations for Covid-19 including assumed levels of funding not yet confirmed, with a residual shortfall. Assuming this, the shortfall, coupled to the opportunity cost of undeliverable financial plan savings continues to outweigh 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 potential funding allocation in respect of undeliverable savings from the Scottish Government emerges.

3.12 Further reports will be brought to the Integration Joint Board as greater clarity develops and an action plan to progress towards overall financial balance is undertaken. The route to achieving this will include:

1. Once agreed with the Scottish Government, application of the outcomes from NHS Borders' mid-year review and core performance of healthcare services over the first 6 months of the year in order to identify and implement further remedial solutions

2. Further review, challenge and remodelling of planned efficiency savings programmes and seeking out of further opportunities for efficiency savings in the current financial year

3. A review of all IJB reserves brought forward from 2019/20 and their application against expenditure included within the forecast.

4. Ongoing discussions with the Scottish Government over the level of further Covid-19 funding allocations

5. Review of brokerage requirement. The current level of assumed brokerage requirement is indicative based on assessment of the Board's requested flexibility as at the start of the financial year. This will be reviewed going forward.

3.13 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. This includes 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, engagement with other partnerships, health boards, local authorities and, in particular, the Scottish Government over likely funding scenarios and review of all costs, expenditure profiles, future commitments and refinement of assumptions for projected expenditure to the end of the year

MONTHLY REVENUE MANAGEMENT REPORT

Summary	2020/21	At end of Month:	September

	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	9,924	20,582	20,582	0	
Joint Mental Health Service	18,144	9,353	18,979	18,837	142	
Joint Alcohol and Drugs Service	390	196	392	392	0	
Older People Service	9,025	(722)	9,135	9,135	0	
SB Cares	16,170	8,102	16,826	16,826	0	
Efficiency savings	(4,740)	0	(4,740)	(695)	(4,045)	
Physical Disability Service	2,458	1,433	2,648	2,648	0	
Prescribing	23,130	11,216	23,132	22,782	350	
Generic Services	74,558	41,670	84,849	85,840	(991)	
Large Hospital Functions Set-Aside	23,630	12,338	24,021	25,002	(981)	
Total	182,904	93,510	195,824	201,349	(5,525)	

MONTHLY REVENUE MANAGEMENT REPORT

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

	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	7,859	17,138	17,138	0	Net pressure associated with Covid-19 response amounts to £0.271m including dalays in delivery of savings. This pressure largely lies within the Joint Learning Disability and Mental Health services and addressed through the Council's Covid-19 reserve, pending further Scottish Government funding allocations. The remaining funding allocation reserve is accounted for within the net Actual to Date balance under Older People Service. In addition to Covid-19 pressures identified in the Joint Learning Disability service, operational pressures of £0.392m have arisen which the service aims to manage from existing budgets during the remainder of the year.
Joint Mental Health Service	2,164	936	2,342	2,342	0	
Older People Service	9,025	(722)	9,135	9,135	0	
SB Cares	16,170	8,102	16,826	16,826	0	
Physical Disability Service	2,458	1,433	2,648	2,648	0	
Generic Services	5,278	1,695	6,569	6,569	0	
Total	51,494	19,303	54,658	54,658	0	

MONTHLY REVENUE MANAGEMENT REPORT

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

	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	2,065	3,444	3,444	0	At the end of Month 6, direct Covid-19 costs incurred to date across delegated functions amounted to £1.185m, with £6.384m forecast for the financial year as a whole. Costs incurred to date have been offset by the first allocation of local mobilisation plan funding from the Scottish Government. Work has now recommenced to review all planned savings in order to ascertain what will be delivered against the level of savings proposed within the Partnership's Financial Plan across delegated healthcare functions. To date, £0.695m has been identified although further work is ongoing. The opportunity costs of non-delivery of savings as a result of Covid-19 has been partially offset by savings across core operational budgets during the first half of the year as a result of a reduction in activity. Forecasts assume that delegated functions may have a shortfall in funding of all Covid-19 direct costs incurred until the end of the financial year, including additional Winter and Influenza programme costs (£1.720m).
Joint Mental Health Service	15,980	8,417	16,637	16,495	142	
Joint Alcohol and Drugs Service	390	196	392	392	0	
Prescribing	23,130	11,216	23,132	22,782	350	
Efficiency savings	(4,740)	0	(4,740)	(695)	(4,045)	
Allocated Non Recurring Savings Projects					0	
Allocated Brokerage					0	
Generic Services						
Independent Contractors	29,530	17,102	32,630	32,630	0	
Community Hospitals	5,780	2,675	5,580	5,480	100	
Allied Health Professionals	6,320	2,968	6,478	6,278	200	
District Nursing	3,580	1,907	3,729	3,600	129	
PCIP	0	437	836	836	0	
Generic Other	24,070	13,701	28,408	28,108	300	
Covid Net Costs	0	1,185	619	2,339	(1,720)	
Total	107,780	61,869	117,145	121,689	(4,544)	

MONTHLY REVENUE MANAGEMENT REPORT

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

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Summary Financial Commentary
Accident & Emergency	2,830	1,631	3,030	3,262	(232)	The set aside budget is again projecting an adverse variance attributable to the non-delivery of savings (£0.981m). This is offset by a reduction in General Medicine and DME during the first six months of the financial year as a result of the pandemic whilst A&E has seen higher than budgeted costs in respect of unscheduled activity.
Medicine & Long-Term Conditions	15,660	7,842	15,836	15,684	152	
Medicine of the Elderly	6,230	2,865	6,245	5,867	378	
Efficiency savings	(1,090)	0	(1,090)	(109)	(981)	
Allocated Non Recurring Savings Projects					0	Work continues to review planned savings and further reports will be brought forward during the financial year as a clearer picture over deliverability emerges.
Allocated Brokerage					0	
Covid Net Costs	0	0	0	298	(298)	
						Forecasts assume that delegated functions may have a shortfall in funding of all Covid-19 direct costs incurred until the end of the financial year, including additional Winter programme costs (£0.298m).
Total	23,630	12,338	24,021	25,002	(981)	

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 16 December 2020

Report By:	Robert McCulloch-Graham, Chief Officer Health & Social Care
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QUARTERLY PERFORMANCE REPORT, NOVEMBER 2020
(latest available data at mid-October 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) Note the key challenges highlighted. c) 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. *Note – an updated Integrated Impact Assessment will be undertaken by March 2021.*
Financial:	N/A
Legal:	N/A
Risk Implications:	N/A

1. Background

1.1 The Integration Performance Group (IPG) has 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, 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 additional Social Care indicators discussed at August 2020 IJB have been incorporated into the quarterly reporting.

1.4 The IPG endeavours to present the latest available data. However, for some measures there is a significant lag whilst local data is validated and released publicly. This does increase robustness of the data and allows for national comparison, but is not ideal.

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 Two appendices are provided with this report:

Appendix 1 provides a high level, “at a glance” summary for EMT, IJB and the public.

Appendix 2 provides further details for each of the measures including more information on performance trends and analysis.

2. Summary of Performance

2.1 The data for **emergency hospital admissions (all ages)** is up to the end March 2020 so will include the beginning of the impact of Covid-19. The specific **(age 75+)** local data is up to June 2020 and shows a much larger Covid-impact (*67.1 admissions per 1,000 populations this quarter, compared to 86.4 last quarter*). Both indicators show that the latest performance is better than our pre-Covid target (as may be expected), but that ‘performance improvement’ Nationally for the **(all ages)** indicator (*25.1 per 1,000 population*) outstrips the Borders performance (*25.5 per 1,000 population*).

2.2 The data for **A&E attendances** is up to June 2020. Historically in the Borders, we have averaged between 7,000–8,000 A&E attendances per quarter (equivalent to 60-70 per 1,000 population per quarter). The June 2020 result of *48 attendances per 1,000* population indicates a significant Covid-related reduction in A&E attendances, but once again the National result (*44 per 1,000 population*) is better

than our local result. Despite the volume of A&E attendance decreasing significantly the latest **A&E Waiting Times** data for people seen within 4hrs (*88.5% as of June 2020*) remains well below our 95% target and below the Scotland average (*95.4%*).

2.3 In relation to the **percentage of the budget spent on emergency hospital stays,** the quarterly data to June 2020 shows a huge reduction (from 18.5% last quarter to 11.8% this quarter). This should indicate that next quarter's figures for emergency hospital admissions (all ages) will also show a significant reduction.

2.4 The latest data (Oct 2020) for the **percentage of Older people receiving a package of homecare of less than 10 hours** is 67%**,** which is below our locally set target of 80%. The indicator measuring the **percentage of older people whose long-term care needs have decreased**, (again, as of Oct 2020) shows that 30% of those cases looked at can demonstrate a reduction. These are two of the new indicators agreed at August IJB and it will be interesting to look at the trend over time as this data builds up.

2.5 The latest data for **emergency admission occupied bed days (age 75+)** shows a huge reduction on the previous quarter (*513 bed days per 1,000 population to end June 2020, compared to 833 last quarter*). This is to be expected based on the reduced volume of emergency admissions for this age group shown in 2.1 above.

2.6 Delayed discharge rates vary in regard to **'snapshot'** data, but performance has declined over the last 4 periods (from 16 DDs recorded in June 2020 to 22 as of Sept 2020). The figure for the same period last year (Sept 2019) was 20. One conclusion could be that delayed discharge performance has changed very little, despite the significant DD reductions seen in the early months of the Covid-pandemic. Another conclusion could be that snapshot data is so variable (on a monthly basis) that perhaps a different more stable DD indicatgior should be used for quarterly reporting. The rate of **Bed Days Associated with Delayed Discharge** has reduced significantly (*from 200 last quarter to 118 as of June 2020*). This may see a reversal once the immediate Covid-impact is removed.

2.7 The **% of patients satisfied** with care, staff & information in BGH and Community hospitals remains high, with the combined satisfaction rate of 95.5%. The data is taken from questions asked in the "*2 minutes of your time*" survey done at BGH and community hospitals. *Please note the Patient Survey is currently suspended due to Covid-restrictions.*

2.8 The **percentage of acute patients discharged to a permanent residential care bed without any opportunity for short-term recovery** is one of the new indicators added. The latest result (October 2020) shows that for that 50% of the people discharged to permanent residential care did not have any opportunity for short-term recovery (reablement, rehabilitation….). As with the other new indicators added, it will be interesting to look at the trend over time as this data builds up.

2.9 Our performance for the **Quarterly rate of emergency readmissions within 28 days of discharge** for Scottish Borders residents has been declining with performance now showing a 11.5% readmission rate (**however this figure is as of December 2019 so is quite out of date**). This is worse than the latest Scotland average (10.4%) and worse than our local target (10.5%). Updated comparator data has been requested from Public Health Scotland.

2.10 Performance in relation to **end of life care** has improved significantly. As of June 2020, 89.8% of people have been able to spend the last 6 months of their life at home or in a community setting, compared to 87.2% last quarter.

2.11 The **% of Carer Support Plans completed** performance remains positive and remains well above our current 40% target.

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

2.13 The **% of people who require long-term care after a period of short-term reablement/rehabilitation** latest result (October 2020) is 25% which is right on target. **The proportion of older people who receive a period of domiciliary care before entering residential care** shows that as of October 2020, 75% of people are receiving homecare before entering residential car (against our local target of >80%). As above, it will be interesting to look at the trend over time as this data builds up.

1. 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: NOVEMBER 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 mid October 2020**. Annual performance is included in our latest Annual Performance Report (2019/20)

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	The % of older people who receive a package of less than 10 hours of domiciliary care	The % of older people receiving long-term care whose care needs have decreased (from their initial assessment/latest review).
25.5 admissions per 1,000 population (Q4 – 2019/20)	**67.1** admissions per 1,000 population Age 75+ (Q1 – 2020/21)	**48.0** attendances per 1,000 population (Q1 – 2020/21)	**11.8%** of total health and care resource, for those Age 18+ was spent on emergency hospital stays (Q1 – 2020/21)	**67%** (Oct 2020)	**30%** (Oct 2020)
+ve trend over 4 periods Worse than Scotland (25.1 – Q4 2019/20) Better than target (27.5)	+ve trend over 4 periods Better than Scotland (87.5– Q4 2019/20) Better than target (90.0)	+ve trend over 4 periods Worse than Scotland (44.0 – Q1 2020/21) Better than target (70.0)	+ve trend over 4 periods Better than Scotland (23.4% - 2019/20) Better than target (21.5%)	+ve trend over 4 periods Worse than target (80%)	+ve trend over 4 periods Better than target (>20%)

Summary:

The data for emergency admissions (all ages) is up to the end of March 2020 and will include the very beginning of the impact of Covid-19. The (age 75+) local data is up to June 2020 and shows a much larger Covid-impact. Both indicators show that latest performance is better than our pre-Covid target (as may be expected), but that the 'performance improvement'

Nationally for the all ages outstrips the Borders improvement. The data for A&E attendances is to end June 2020; historically in the Borders, we have averaged between 7,000-8,000 A&E attendances per quarter (which is equivalent to approx. 60-70 per 1,000 population per quarter) – the June 2020 result of 48.0 shows a large Covid-impact on A&E attendances, but once again National 'performance' has outstripped this local result. In relation to the percentage of the budget spent on emergency hospital stays, the quarterly data to June 2020 (11.8%) shows a huge reduction (last quarter's figure was 18.5%). The inference being that next quarter's figures for emergency admissions will reflect this and be much lower than those shown above. The latest data (Oct 2020) for the percentage of Older people receiving a package of homecare of less than 10 hours is 67%, which is below our locally set target of 80%. The indicator measuring the percentage of older people whose long-term care needs have decreased (Oct 2020) shows that 25% of those cases looked at can demonstrate a reduction. These are two of the new indicators agreed at August 2020 IJB. Once this monthly data builds up the trend information will be shown in more detail.

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.

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	The proportion of acute patients discharged to a permanent residential care bed without any opportunity for short-term recovery.
88.5% of people seen within 4 hours (Jun 2020)	**513** bed days per 1,000 population Age 75+ (Q1 – 2020/21)	**22** over 72 hours (Sept 2020)	**118** bed days per 1,000 pop aged 75+ (Q1 – 2020/21)	**95.5%** Overall satisfaction rate (Q4 - 2019/20)	**50.0%** **(Oct 2020)**
+ve trend over 4 periods Worse than Scotland (95.4% - Jun 2020) Worse than target (95%)	+ve trend over 4 periods Better than Scotland (1,185 – Q4 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 Better than Scotland (198 – 19/20 average) Better than target (180)	-ve trend over 4 periods Better than target (95%)	-ve trend over 4 periods Worse than target (0%)

*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.

Summary:

Despite the volume of A&E attendance decreasing significantly as a result of Covid, the latest A&E Waiting Time performance (June 2020) remains well below our 95% target and well below the Scotland average (95.4%). The data for emergency admission occupied bed days (age 75+) shows a huge reduction on the previous quarter (513 bed days compared to 833 last quarter). The National data is lagging behind (only up to Q4 2019/20), however generally our performance is always better than the Scotland average (*although see note above**). Delayed discharge rates vary in regard to 'snapshot' data, but performance has declined over the last 4 periods (from 16 in June 2020 to 22 as of Sept 2020). The figure for the same period last year (Sept 2019) was 20, therefore one conclusion could be that delayed discharge performance changed very little, despite the significant DD reductions seen in the early months of the pandemic. The rate of Bed Days Associated with Delayed Discharge has reduced significantly (to 118 Q1 June 2020, from a figure the previous Quarter of 200). However, based on the 'snapshot' data this positive result *may* well see a reversal once Q2 2020/21 data is available. The percentage of patients satisfied with care, staff & information in BGH and Community Hospitals remains high and also remains above our local target. But please note that the Patient Survey remains suspended due to Covid-restrictions.

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:	The proportion of people who require long-term care after a period of short-term reablement/rehabilitation	The proportion of older people who receive a period of domiciliary care before entering residential care.
11.5 per 100 discharges from hospital were re-admitted within 28 days (Q3 – 2019/20)	**89.8%** of people's last 6 months was spent at home or in a community setting (Q1 – 2020/21)	**66%** of carer support plans offered that have been taken up and completed in the last quarter (Q2 – 2020/21)	Health and well-being Managing the caring role Feeling valued Planning for the future Finance & benefits (Q2 – 2020/21)	**25%** (Oct 2020)	**75%** (Oct 2020)
-ve trend over 4 Qtrs Worse than Scotland (10.4 – Q3 2019/20) Worse than target (10.5)	+ve trend over 4 Qtrs Better than Scotland (88.7% - 2019/20) Better than target (87.5%)	-ve trend over 4 Qtrs Better than target (40%)	+ve impact No Scotland comparison No local target	+ve trend over 4 periods On target (25%)	Flat trend over 4 periods Worse than target (>80%)

Summary:

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. However, this data is now very out of date and updated comparator information has been requested from Public Health Scotland. Borders data in relation to end of life care has improved significantly this quarter (89.8% compared to 87.2% last quarter). The latest available data for Carers continues to demonstrate generally positive outcomes as a result of completed Carer Support Plans. The indicators covering reablement/rehabilitation and homecare are two of the new indicators agreed by IJB at the August 2020 meeting.

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 November 2020

SUMMARY OF PERFORMANCE: LATEST AVAILABLE DATA AT MID OCTOBER 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

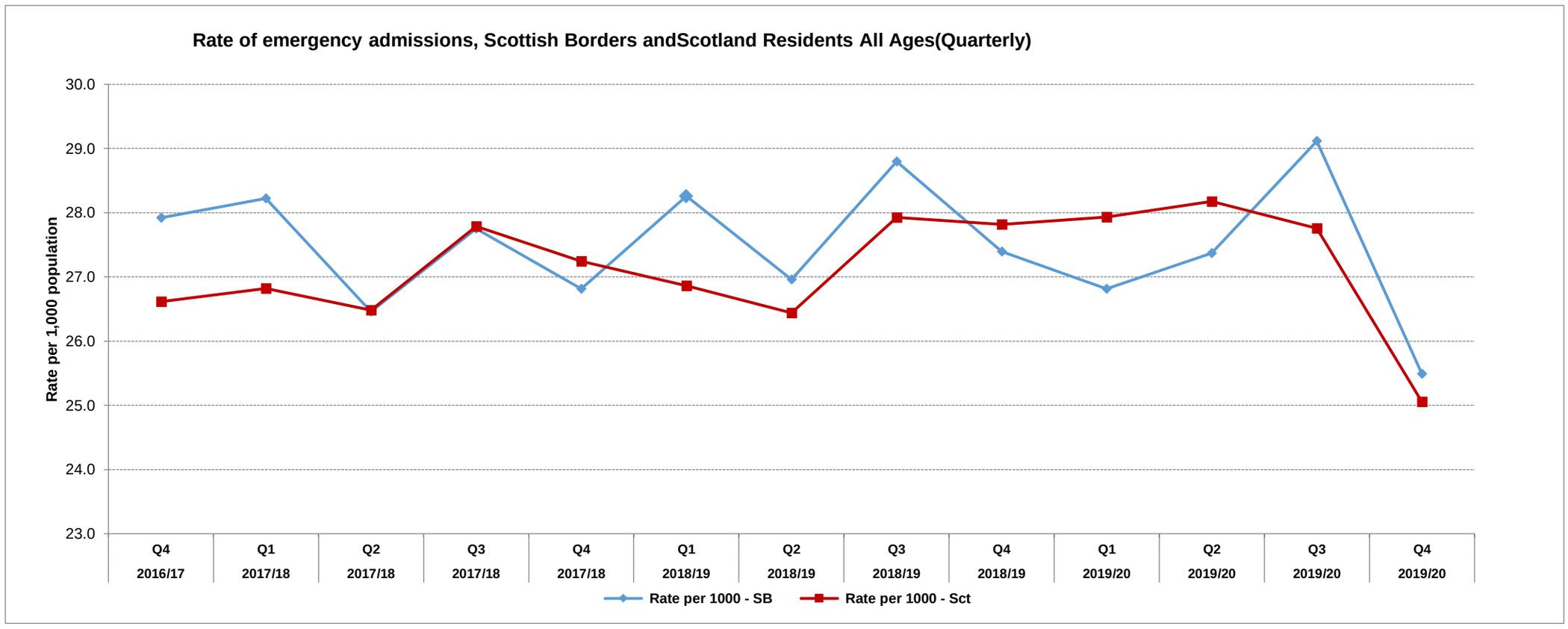
Objective 3: We will improve the capacity within the community for people who have been in receipt of health and social care services to manage their own conditions and support those who care for them

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)

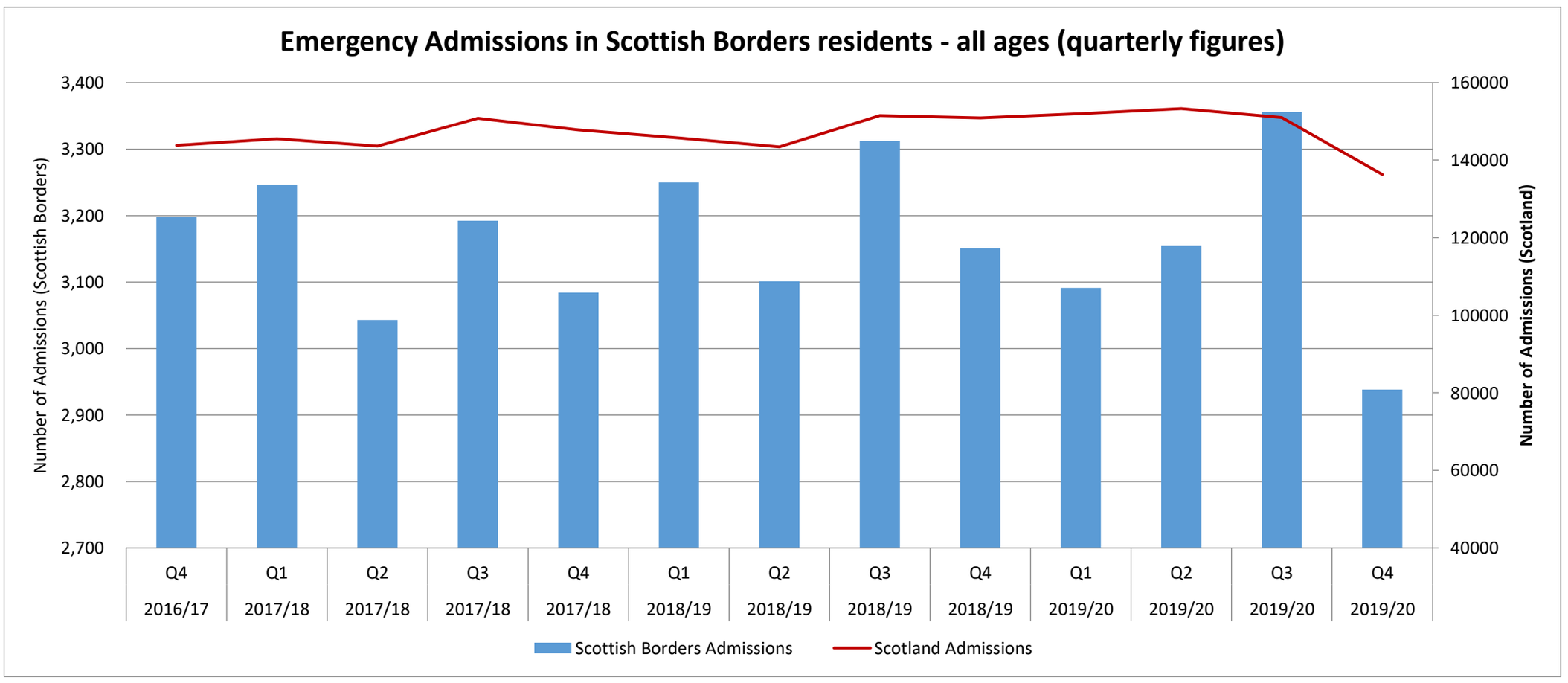
	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20
Rate of Emergency Admissions per 1,000 population All Ages	27.9	28.2	26.5	27.8	26.8	28.3	27.0	28.8	27.4	26.8	27.4	29.1	25.5
Scotland - Rate of Emergency Admissions per 1,000 population All Ages	26.6	26.8	26.5	27.8	27.2	26.9	26.4	27.9	27.8	27.0	26.8	27.6	25.1



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

Source: MSG Integration Performance Indicators workbook (SMR01 data)

	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 Scottish Borders Emergency Admissions - All Ages	3,198	3,246	3,043	3,192	3,084	3,250	3,101	3,312	3,151	3,091	3,155	3,356	2,938
Number Scotland Emergency Admissions - All Ages	143,831	145,495	143,649	150,739	147,780	145,738	143,422	151,497	150,915	151,954	153,278	150,989	136,287



How are we performing?

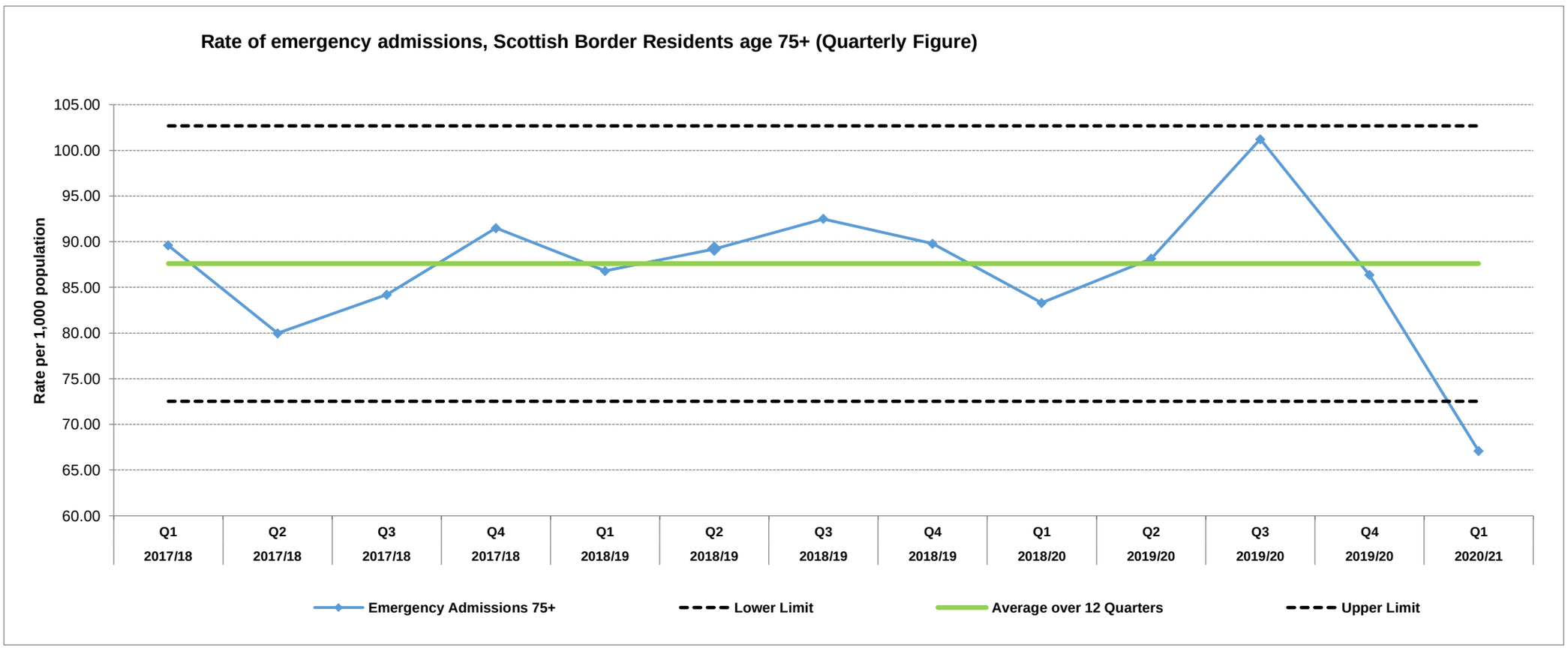
The quarterly number of Emergency Admissions for Scottish Borders residents (all ages) has continued to fluctuate since the start of the 2016/17 financial year; however, shows an overall positive decreasing trend. There was a significant spike in Emergency Admissions in Q3 2019/20 with a rate of 29.1. This is the highest Borders rate in the last 3 years and also surpasses the highest reported scottish rate of 27.9 (Q3 2018/19) for the same period.

Q4 2019/20 begins to demonstrate the impact of the Corona Virus pandemic. This is shown in the clear reduction of Emergency Admissions.

Emergency Admissions, Scottish Borders residents age 75+

Source: NSS Discovery

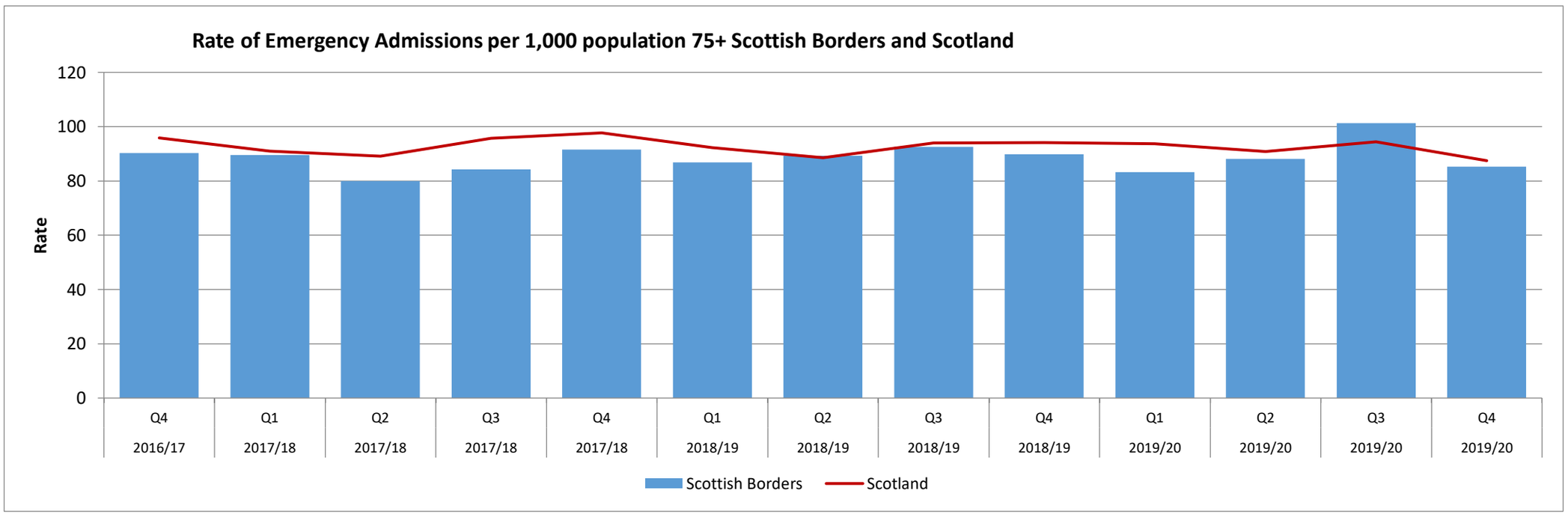
	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21
Number of Emergency Admissions, 75+	1,074	959	1,009	1,096	1,040	1,069	1,108	1,076	1,020	1,079	1,239	1,057	846
Rate of Emergency Admissions per 1,000 population 75+	89.6	80.0	84.2	91.5	86.8	89.2	92.5	89.8	83.3	88.2	101.2	86.4	67.1



Emergency Admissions comparison, Scottish Borders and Scotland 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
Rate of Emergency Admissions Scottish Borders	90.3	89.6	80.0	84.2	91.5	86.8	89.2	92.5	89.8	83.3	88.1	101.2	85.3
Rate of Emergency Admissions 75+ Scotland	95.8	90.9	89.1	95.8	97.7	92.2	88.5	94.0	94.2	93.7	90.8	94.4	87.5



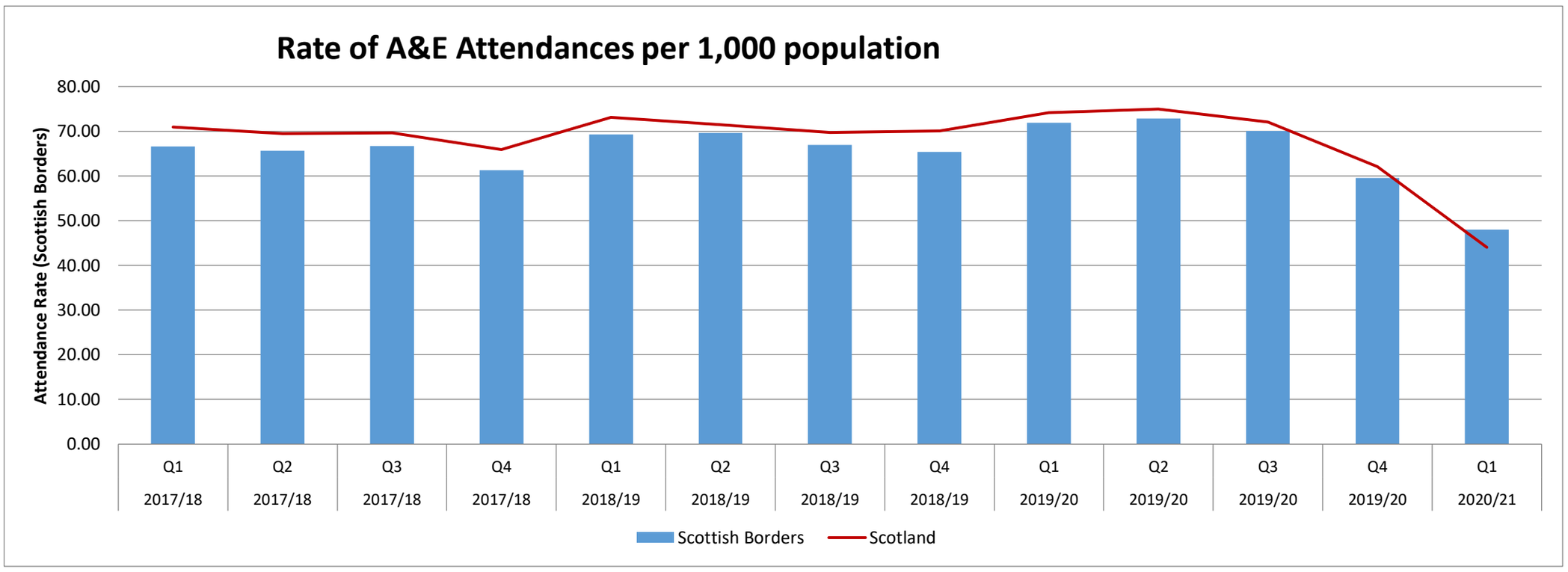
How are we performing?

The 3 year trend for the rate of 75+ emergency admissions was showing an increasing trend until Q4 2019/20. The graph shows Emergency Admission rates, for the 75+ age group, have dramatically decreased in Q4 2019/20 and Q1 2020/21. Similar to Emergency Admissions for all ages, this change comes following the highest reported rate of admissions for this age group in the last 3 years - pushing the Borders rate ahead of the Scottish average. Again the onset of the Corona Virus pandemic during Q4 2019/20 and it's ongoing effects would explain the sudden decrease in Emergency Admissions over the last 2 quarters.

Rate of A&E Attendances per 1,000 population

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

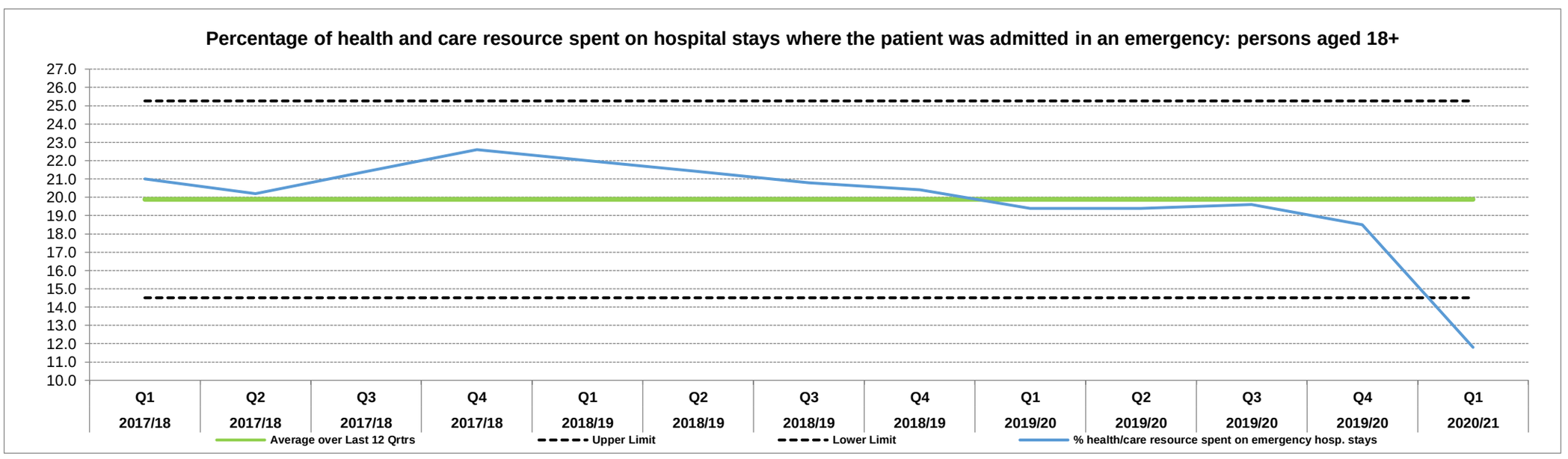
	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21
Rate of Attendances, Scottish Borders	66.6	65.6	66.7	61.3	69.2	69.6	67.0	65.4	71.9	72.8	70.1	59.6	48.0
Rate of Attendances, Scotland	71.0	69.4	69.6	65.9	73.1	71.5	69.7	70.0	74.1	74.9	72.1	62.0	44.0

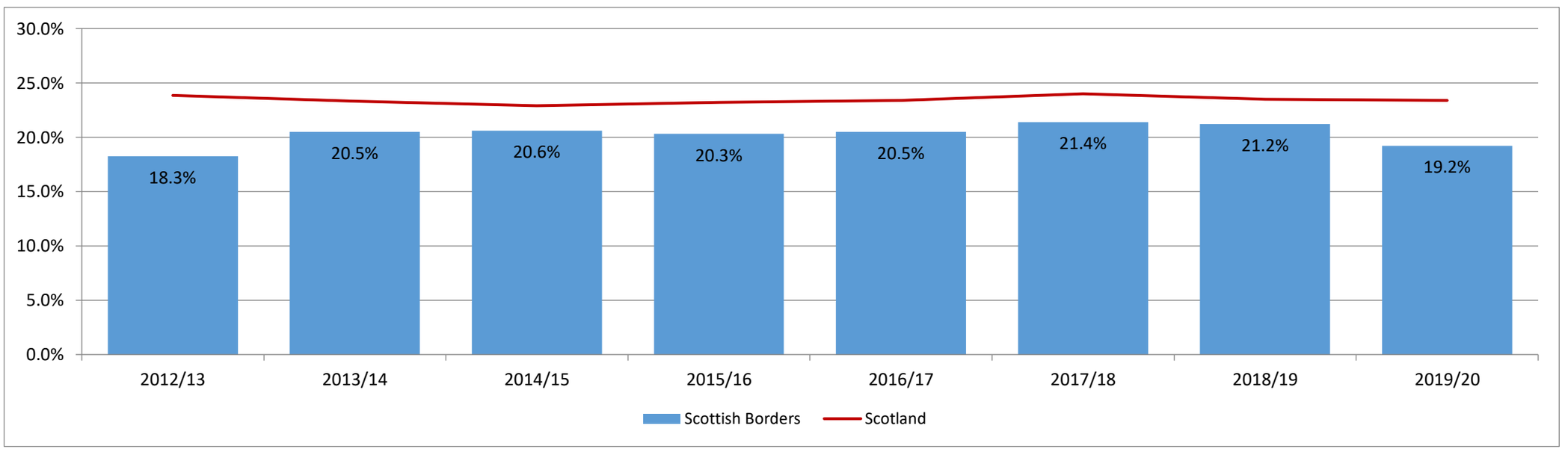


Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency: persons aged 18+

Source: Core Suite Indicator workbooks

	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 2018/19	Q4 2019/20	Q1 2020/21
% of health and care resource spent on emergency hospital stays (Scottish Borders)	21.0	20.2	21.4	22.6	22.0	21.4	20.8	20.4	19.4	19.4	19.6	18.5	11.8





How are we performing?

In contrast to Emergency Admissions, attendances at A&E shows a decrease in Q3 2019/20. With this showing further decline in Q4 and Q1 of 2020/21. However, in Q1 2020/21 the Borders rate (48.0) is above the Scottish Average (44.0).

The percentage of health and social care resource spent on unscheduled hospital stays has seen an overall slight decrease over the past 3 years. The significant reduction in spend reported in Q1 2020/21 echoes the reduced emergency admissions rate.

Both these indicators are impacted by the effects of the Corona Virus pandemic.

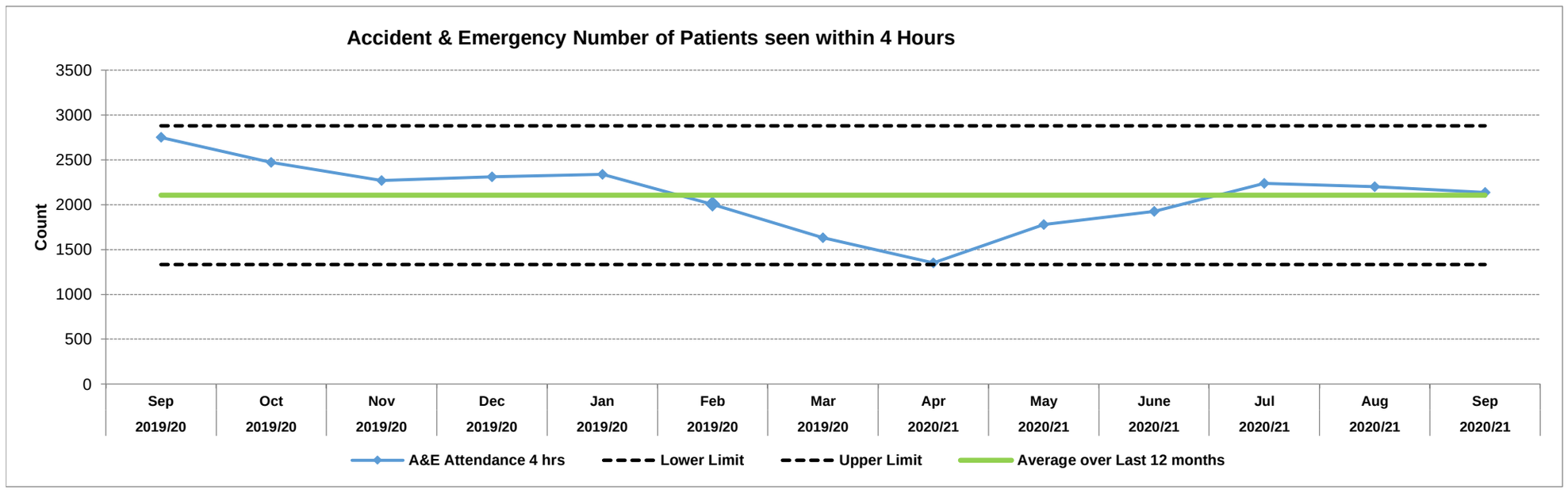
NB: December 2019, the denominator for this indicator now includes dental and ophthalmic costs. As a result, the % of spend has slightly decreased. The Table and Charts above have been updated to reflect the altered % as a result of this change.

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

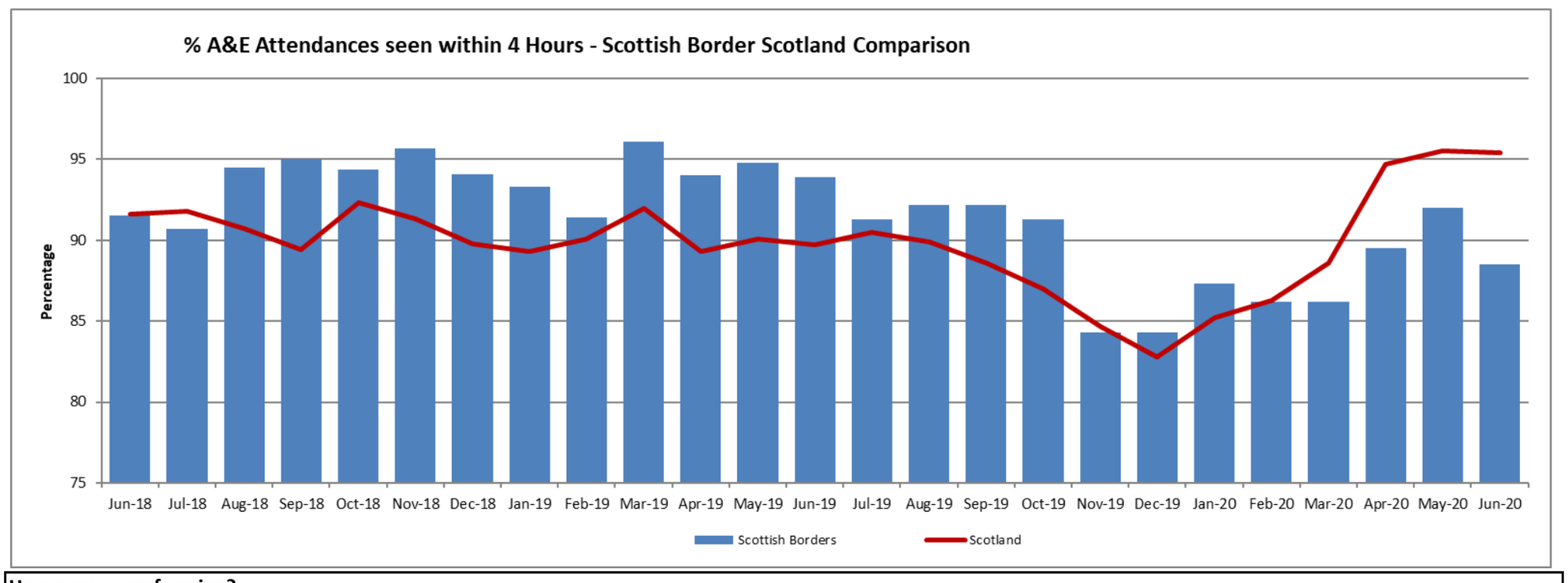
	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
Number of A&E Attendances seen within 4 hours	2749	2473	2271	2312	2338	2004	1631	1351	1779	1923	2237	2201	2136



% 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

	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
% A&E Attendances seen within 4 hour Scottish Borders	93.9	91.3	92.2	92.2	91.3	84.3	84.3	87.3	86.2	86.2	89.5	92.0	88.5
% A&E Attendances seen within 4 hour Scotland	89.7	90.5	89.9	88.6	87.0	84.7	82.8	85.2	86.3	88.6	94.7	95.5	95.4



How are we performing?

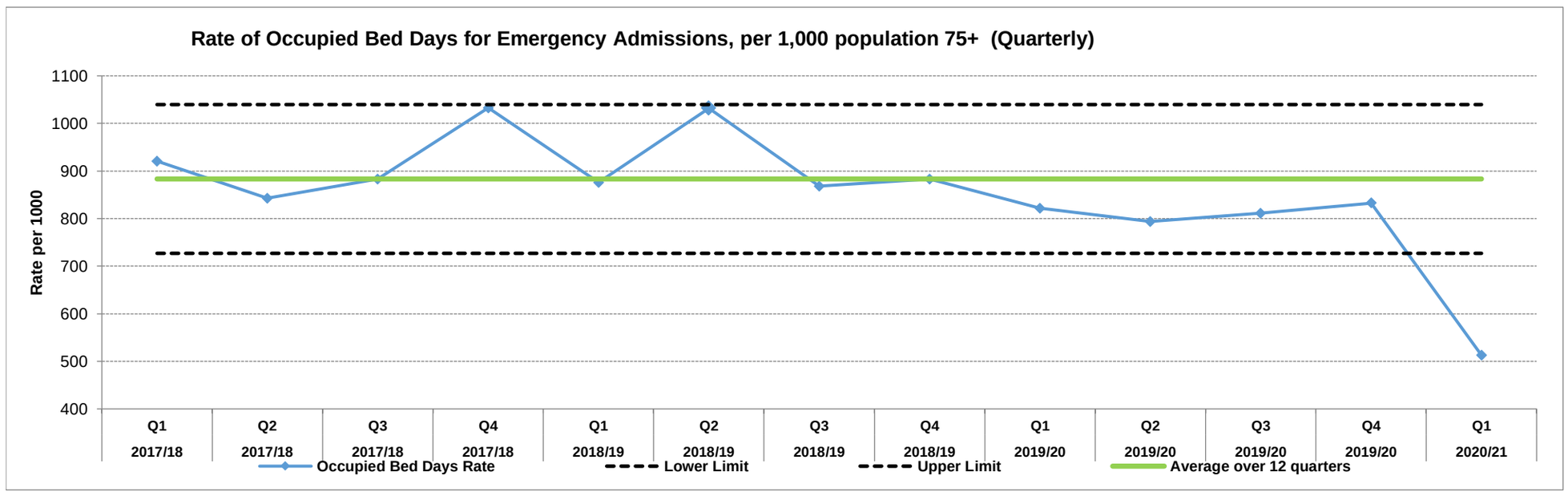
Historically, NHS Borders consistently performed better than the Scottish comparator for A&E waiting times; however, Borders has fallen below the Scottish Average on 7 occasions in the last year, with the gap widening significantly since the onset of the Corona Virus pandemic in March 2020.

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 15 months. March - May 2020 did show an improvement in performance - mostly likely as a result of fewer people attending A&E; however, this again decreased in June, which could coincide with the easing of lock-down restrictions. 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

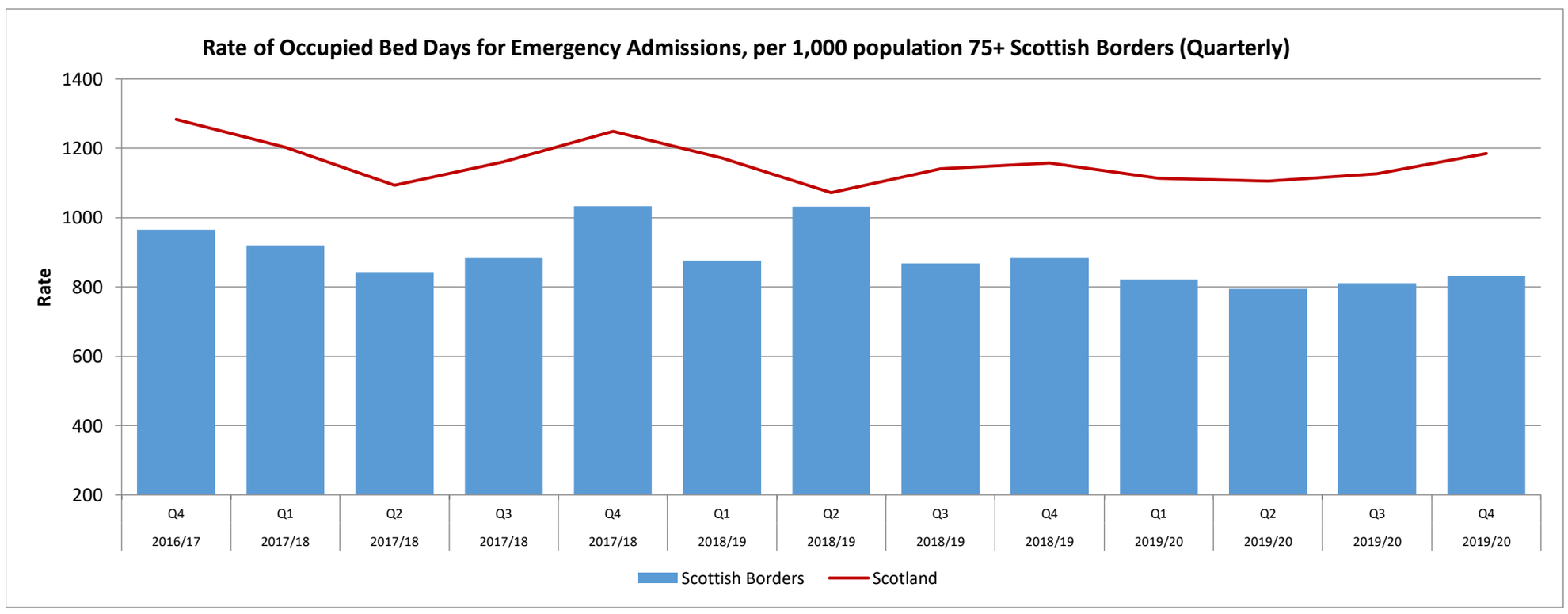
	Q1 2017/18	Q2 2017/18	Q3 2017/17	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21
Number of Occupied Bed Days for emergency Admissions, 75+	11035	10103	10582	12377	10523	12356	10407	10587	10056	9719	9933	10505	6471
Rate of Occupied Bed Days for Emergency Admissions, per 1,000 population 75+	921	843	883	1033	876	1032	868	883	822	794	812	833	513



Occupied Bed Days for emergency admissions, Scottish Borders and Scotland 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
Rate of Occupied Bed Days for Emergency Admissions, per 1,000 population 75+ Scottish Borders	966	921	843	883	1033	876	1032	868	883	822	794	812	833
Rate of Occupied Bed Days for Emergency Admissions, per 1,000 population 75+ Scotland	1284	1203	1094	1161	1250	1172	1072	1141	1157	1114	1105	1127	1185



How are we performing?

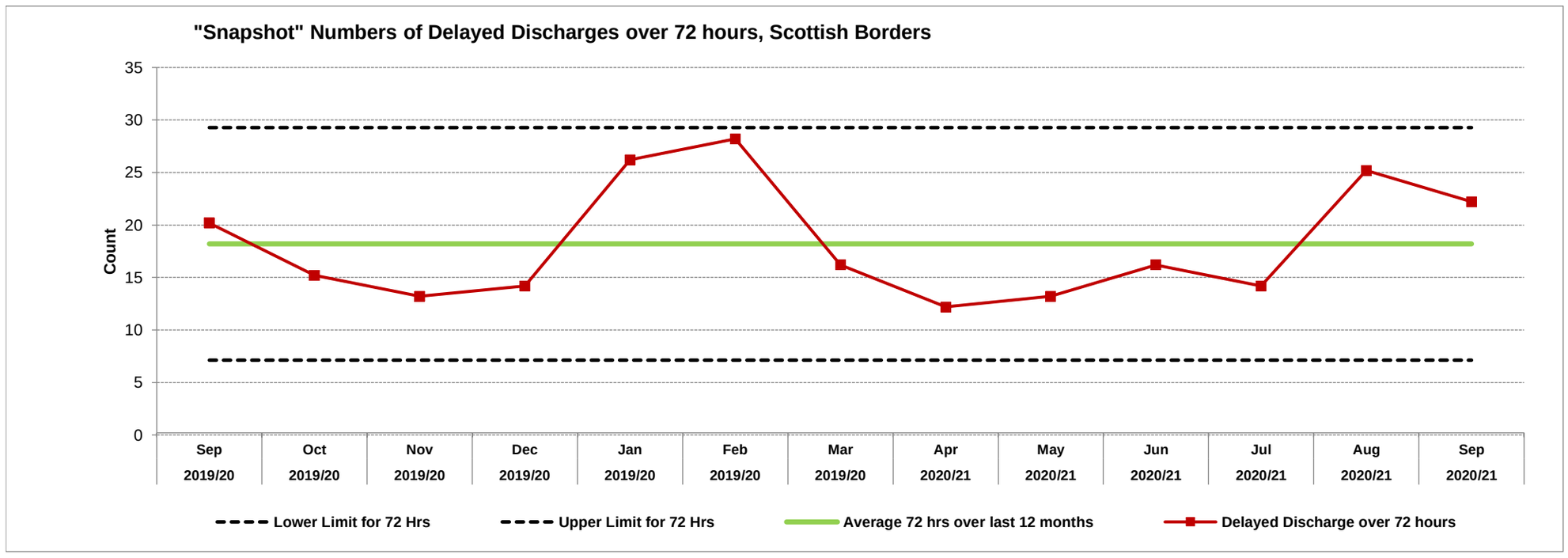
The quarterly occupied bed day rates for emergency admissions in Scottish Borders residents aged 75 and over has fluctuated over time but has remained lower than the Scottish Average (it should be noted this nationally derived indicator does not take in to account the 4 Borders' Community Hospitals).

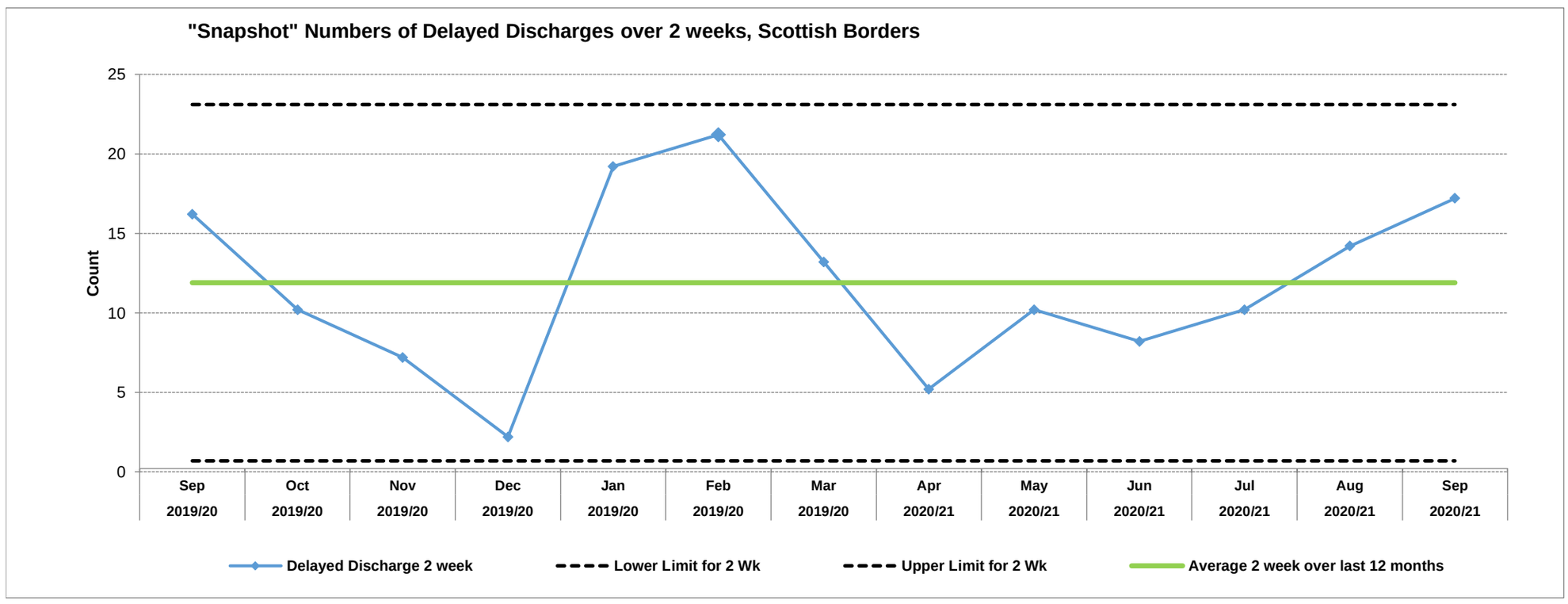
There is a notable reduction in occupied bed days for Emergency admissions since Q2 of 2018/19, drawing the Border's figure further from the Scotland average. The graph shows a positive trend over the last 3 years with an overall reduction in occupied bed days; although this has began to increase in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

Delayed Discharges (DDs)

Source: EDISON/NHS Borders Trakcare system

	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
Number of DDs over 2 weeks	16	10	7	2	19	21	13	5	10	8	10	14	17
Number of DDs over 72 hours	20	15	13	14	26	28	16	12	13	16	14	25	22





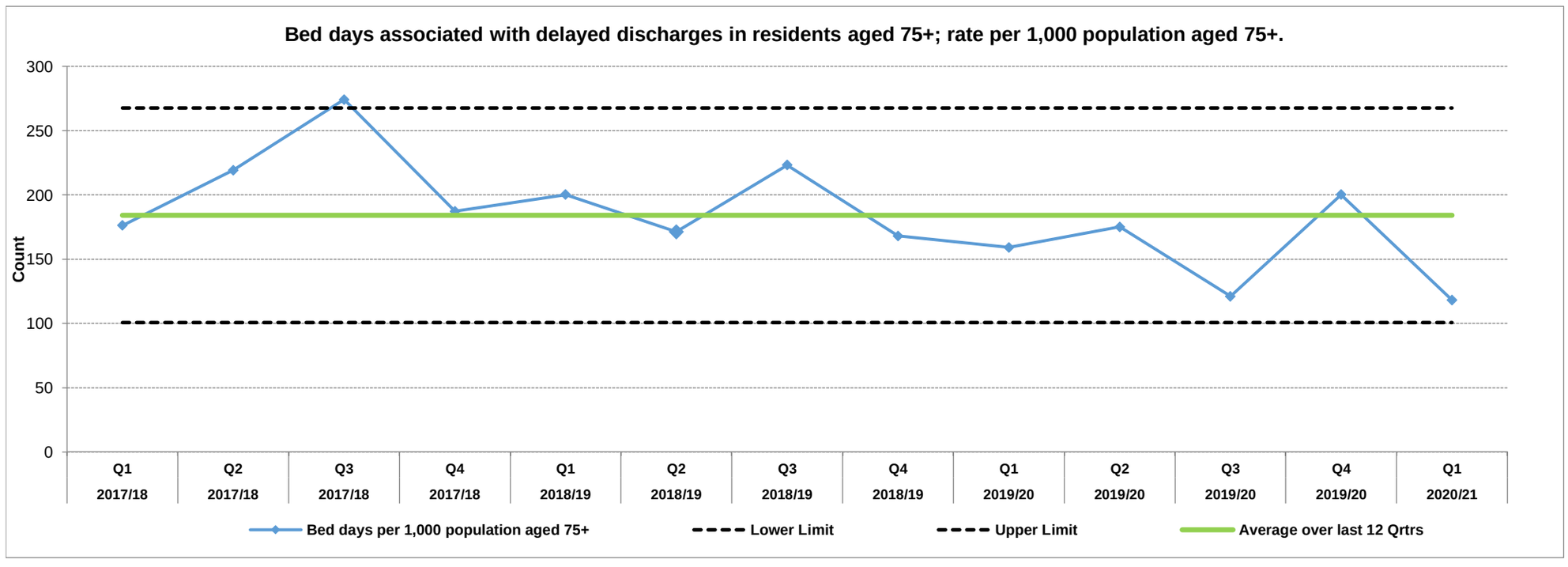
Please note the Delayed Discharge over 72 hours measurement has been implemented from April 2016.

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

	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	Q1 2020/21
Bed days per 1,000 population aged 75+	176	219	274	187	200	171	223	168	159	175	121	200	118



How are we performing?

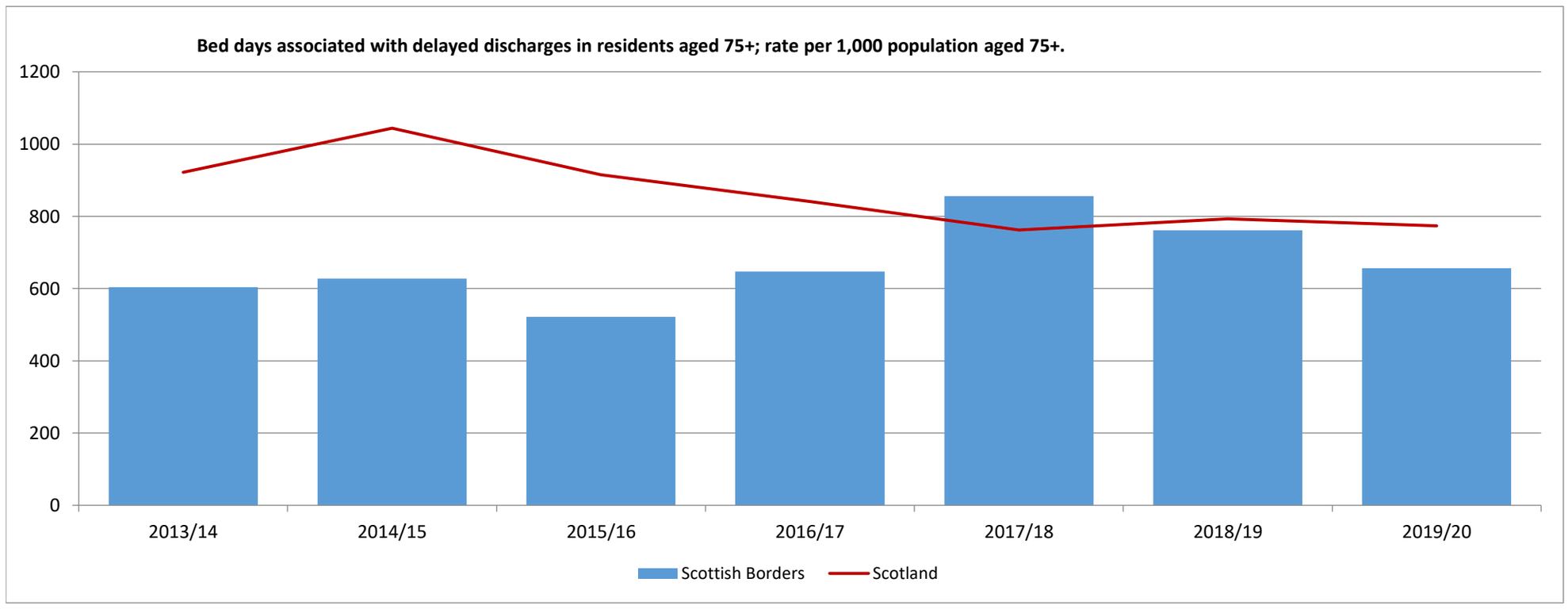
The rate of bed days associated with delayed discharges (75+) for quarter 3 of 2017/18 was higher than any previous quarter, increasing to over 250 per 1,000 residents for the first time. Quarter 3 for 18/19 had a similar spike to the same period the previous year, seeing the 2nd highest rate over the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

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 200 days, which is above the average and well above the 180 day target. Although, at the onset of the Corona Virus pandemic there was a reduction in the number of delayed discharges, this was short-lived and these have again been on an increasing trend since May 20.

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	656
Scotland	922	1044	915	841	762	793	774



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.

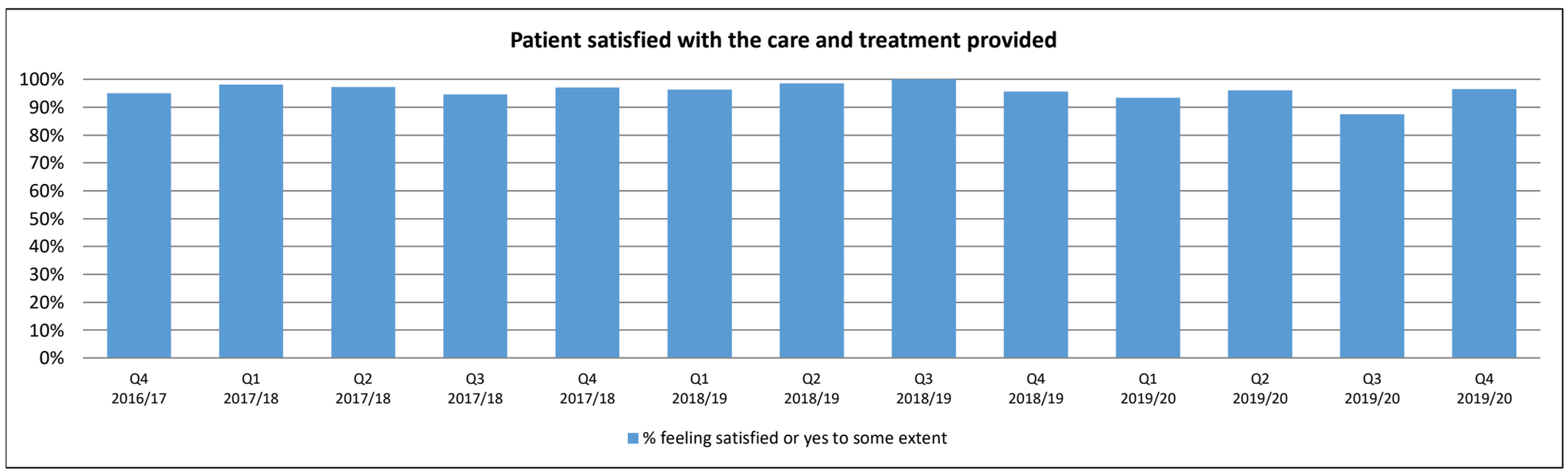
*Please note definitional changes were made to the recording of delayed discharge information from 1 July 2016 onwards. Delays for healthcare reasons and those in non hospital locations (e.g. care homes) are no longer recorded as delayed discharges. In this indicator, no adjustment has been made to account 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

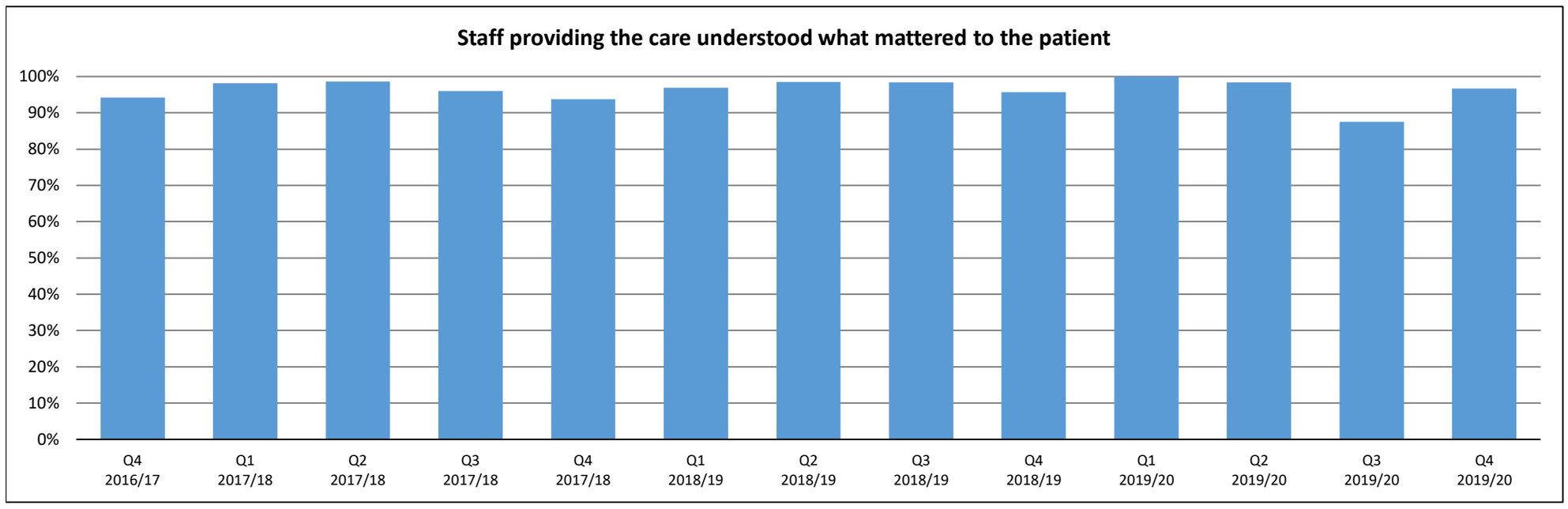
Q1 Was the patient satisfied with the care and treatment provided?

	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%



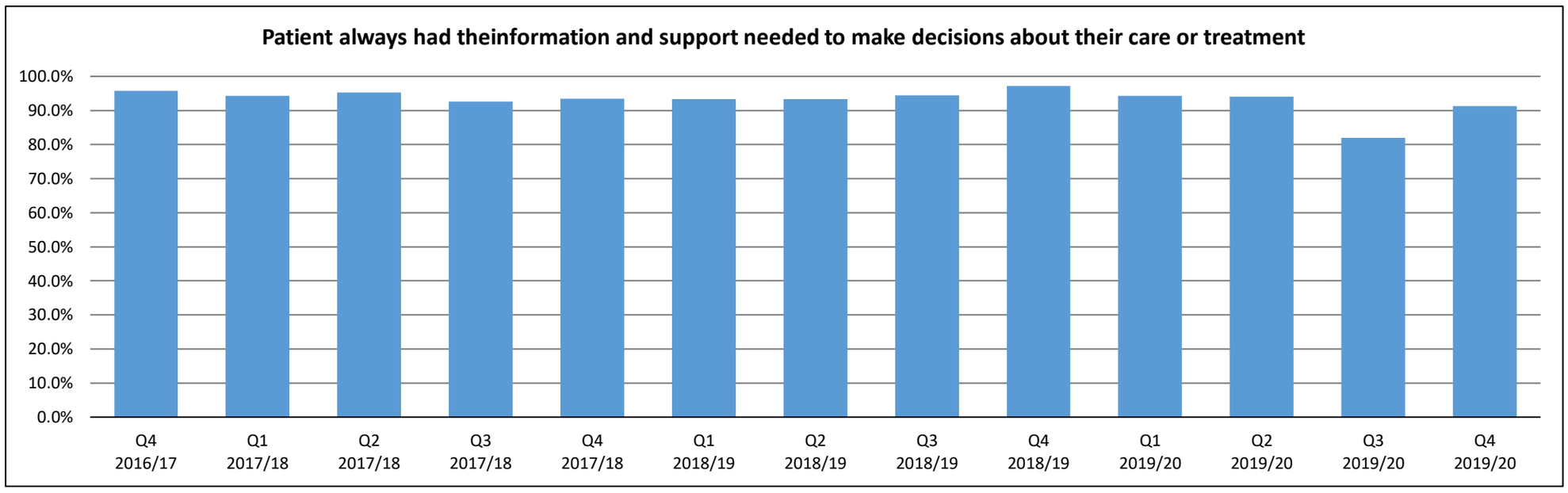
Q2 Did the staff providing the care understand what mattered to the patient?

	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.

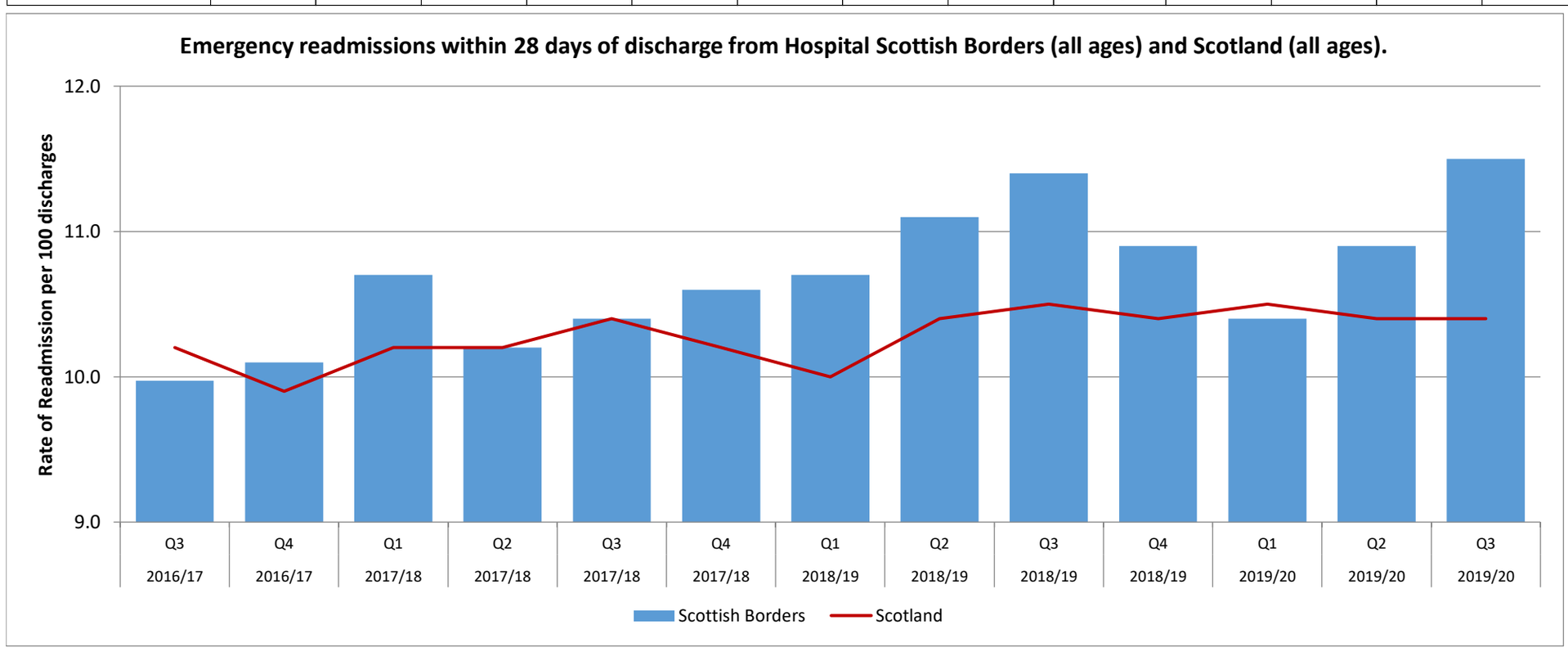
Overall, Borders scores well with an average 95.5% satisfaction rate. Patient satisfaction shows a positive trend over time and the latest overall average achieves the 95% target.

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?

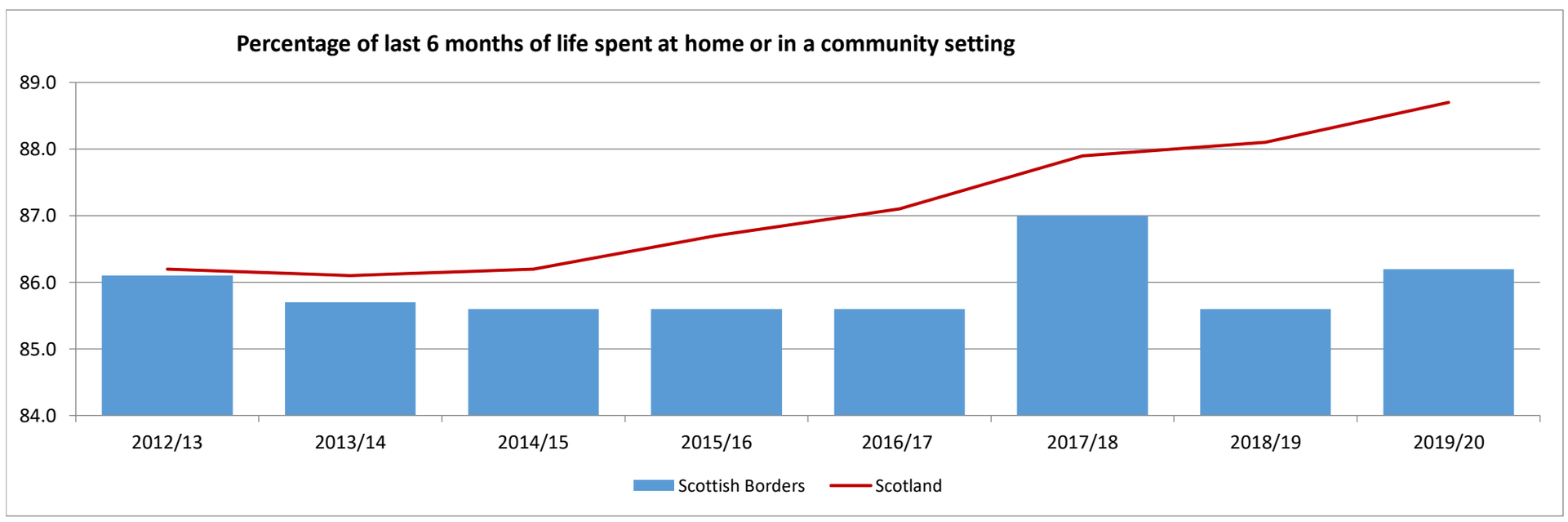
The quarterly rate of emergency readmissions within 28 days of discharge for Scottish Borders residents has fluctuated since the start of the 2016/17 financial year. There has been a notable increase in readmissions within 28 days of discharge since quarter three of 2016/17.

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. There is a significant lag in this data due to completeness issues.

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

Source: Core Suite Indicator workbooks

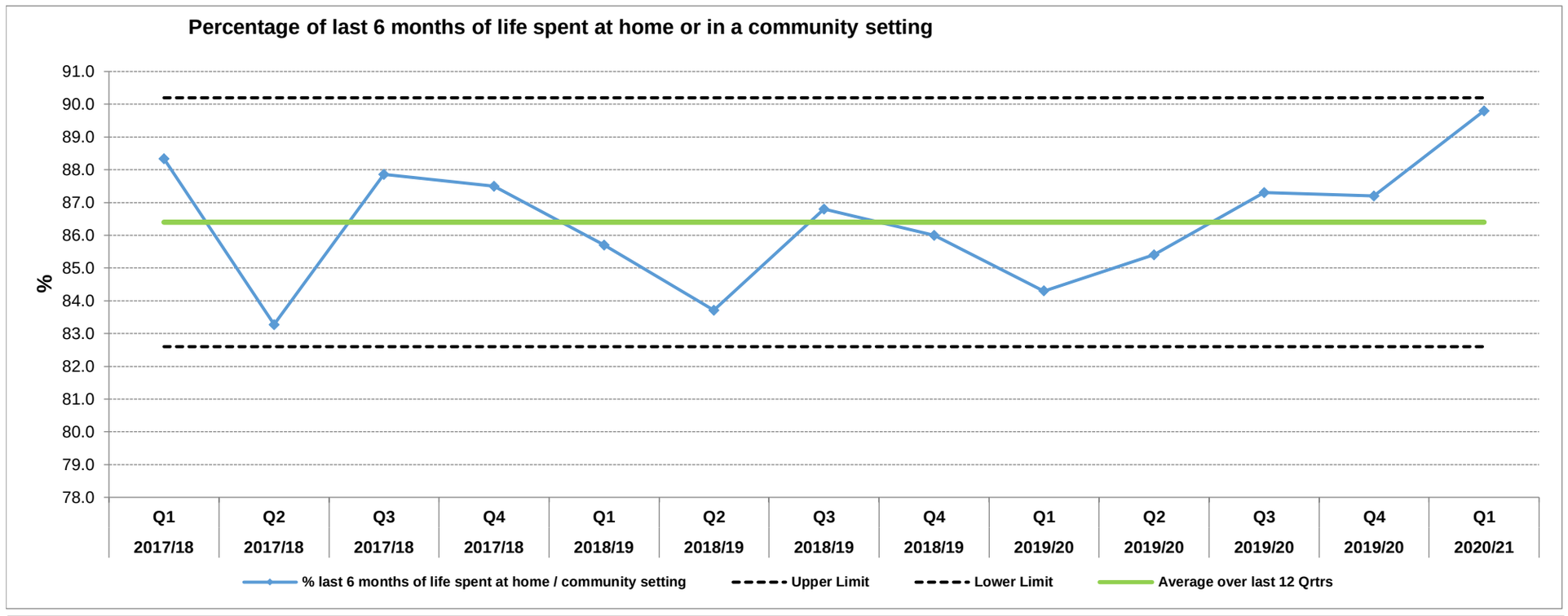
	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Scottish Borders	86.1	85.7	85.6	85.6	85.6	87.0	85.6	86.2
Scotland	86.2	86.1	86.2	86.7	87.1	87.9	88.1	88.7



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

Source: Core Suite Indicator workbooks

	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	Q1 2020/21
% last 6 months of life spent at home or in a community setting Scottish Borders	88.3	83.3	87.9	87.5	85.7	83.7	86.8	86.0	84.3	85.4	87.3	87.2	89.8



How are we performing?

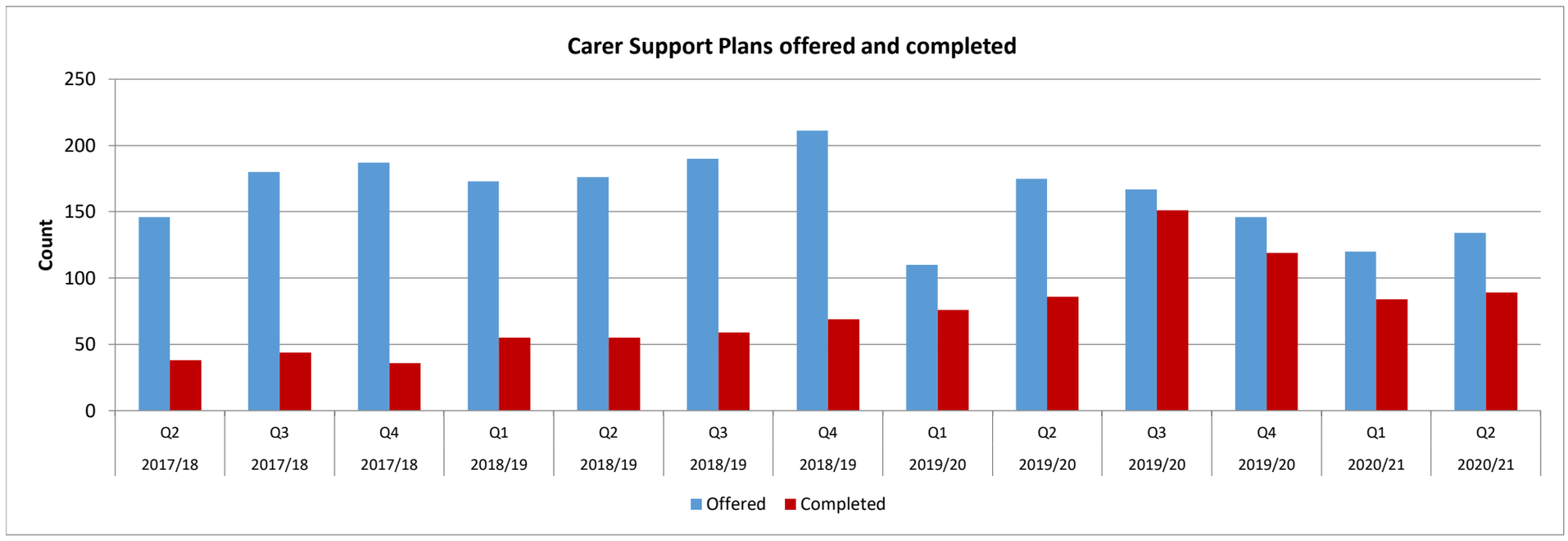
The percentage of last 6 months of life spent at home or in a community setting has appeared fairly consistent in the Borders from year to year since 2013/14 but in each case remains a little below the Scottish average which, in contrast, is gradually increasing.

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). Over the years 2017/18 and 2018/19 there was a declining negative trend for this measure; however, over 2019/20 this has improved and in Q1 2020/21 demonstrates the highest % of people, over the last 3 years, that have spent the last 6 months of life at home or in a community setting.

Carers offered and completed Carer Support Plans

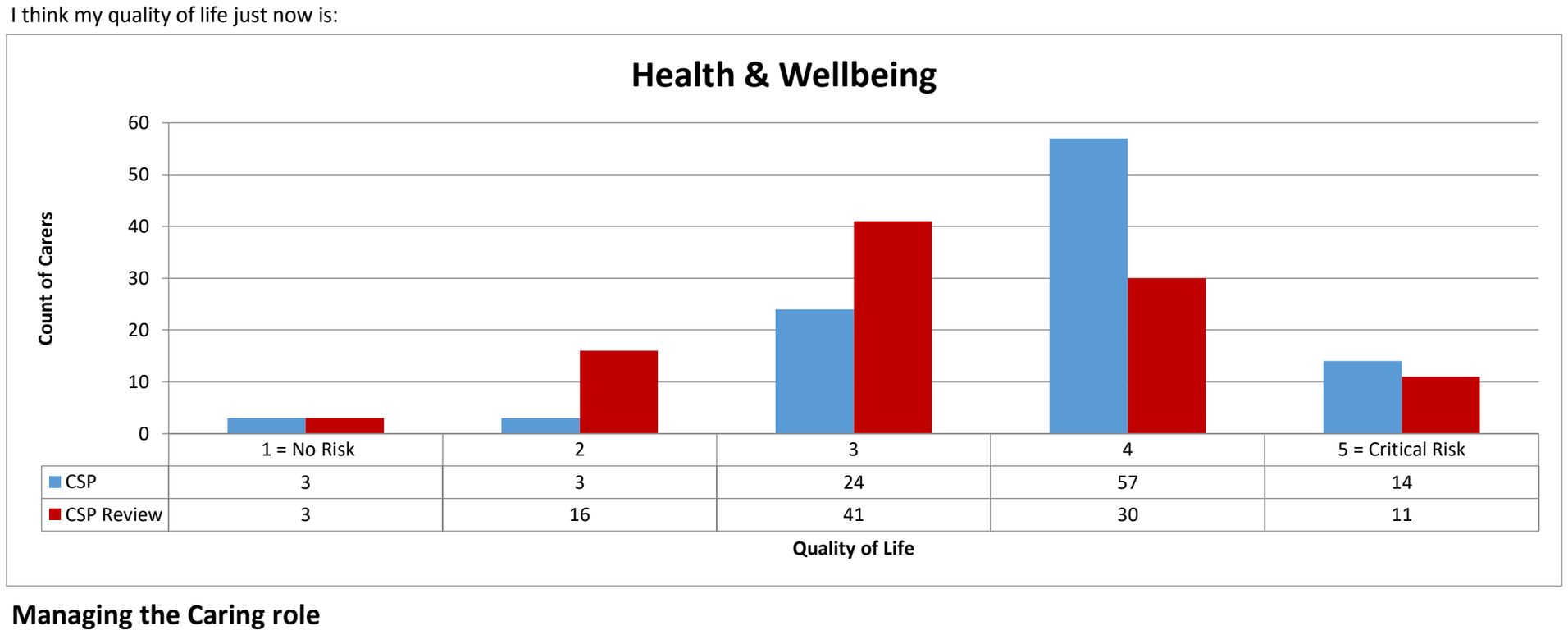
Source: Carers Centre

	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	Q1 2020/21	Q2 2020/21
Carer Support Plans Offered	146	180	187	173	176	190	211	110	175	167	146	120	134
Carer Support Plans Completed	38	44	36	55	55	59	69	76	86	151	119	84	89



Health and Wellbeing (Q2 2020/21)

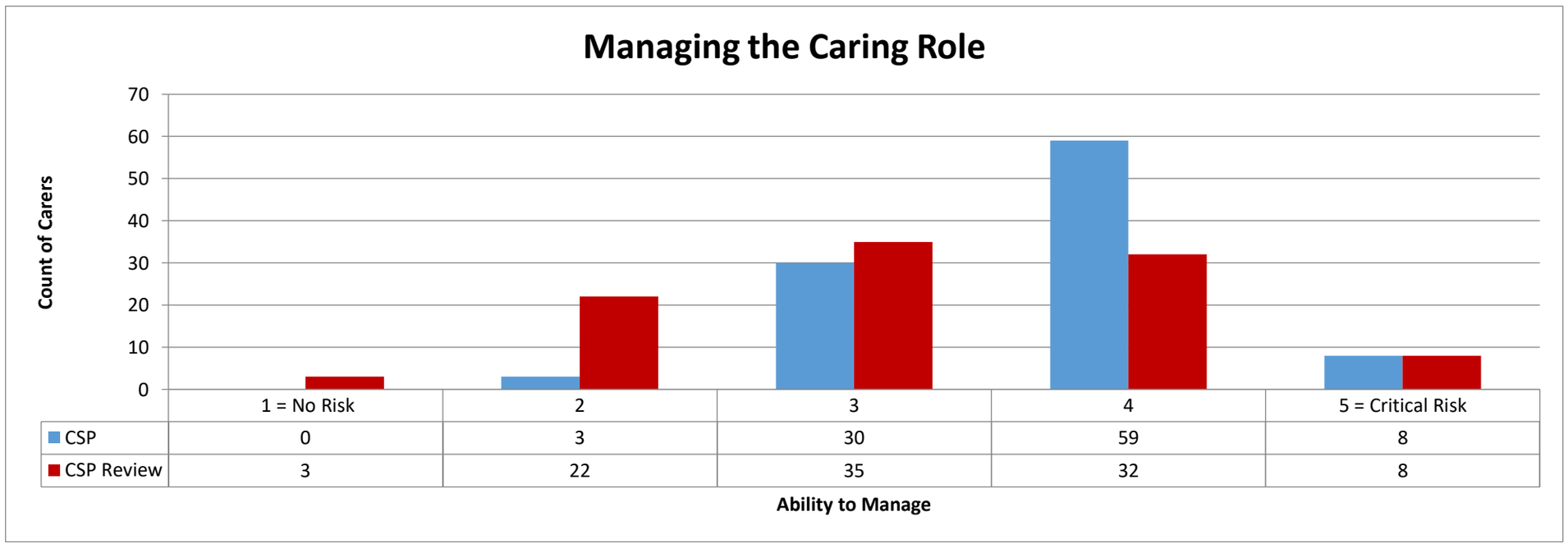
I think my quality of life just now is:



	1 = No Risk	2	3	4	5 = Critical Risk
CSP	3	3	24	57	14
CSP Review	3	16	41	30	11

Managing the Caring role

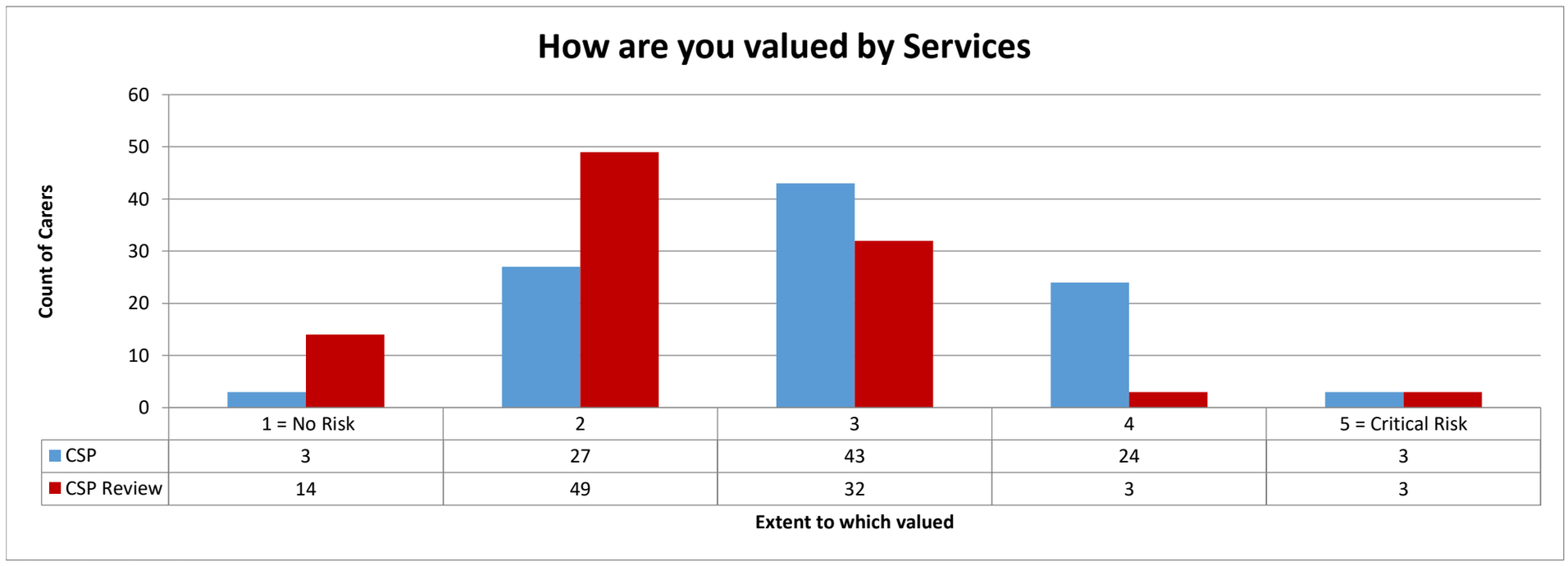
I think my ability to manage my caring role just now is:



	1 = No Risk	2	3	4	5 = Critical Risk
CSP	0	3	30	59	8
CSP Review	3	22	35	32	8

How are you valued by Services

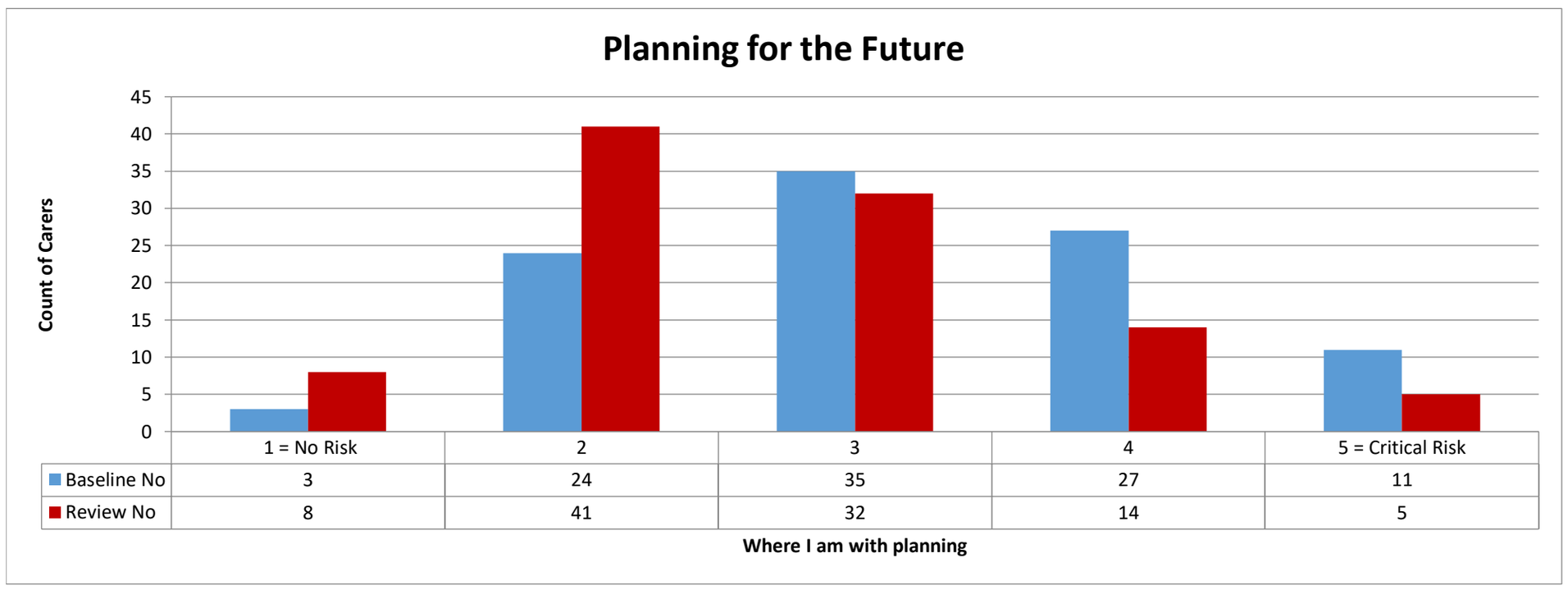
I think the extent to which I am valued by services just now is:



	1 = No Risk	2	3	4	5 = Critical Risk
CSP	3	27	43	24	3
CSP Review	14	49	32	3	3

Planning for the Future

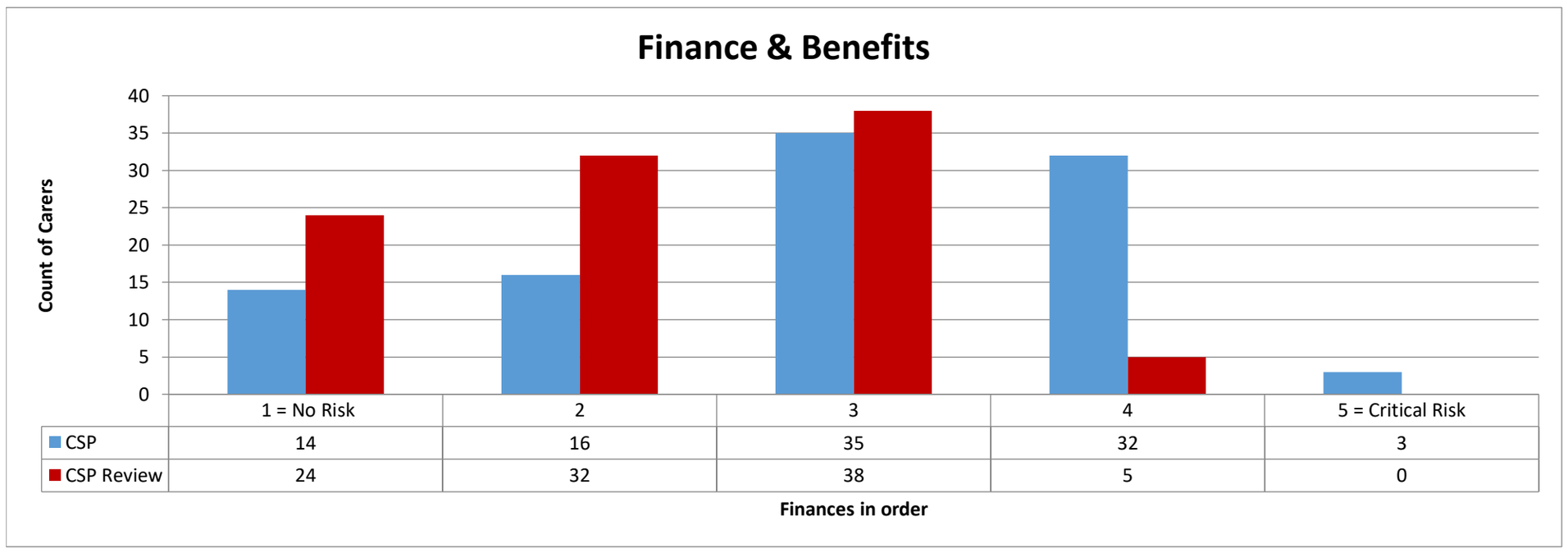
I think where I am at with planning for the future is:



	1 = No Risk	2	3	4	5 = Critical Risk
Baseline No	3	24	35	27	11
Review No	8	41	32	14	5

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	14	16	35	32	3
CSP Review	24	32	38	5	0

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. Q4 2019/20 and Q1 & 2 of 2020/21 will be affected by the impact of the Corona Virus pandemic.

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Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 16 December 2020

Report By:	Dr Kevin Buchan; Chair, PCIP Executive and GP Sub Committee; Sandra Pratt, Strategic Lead, PCIP
Contact:	Sandra Pratt
Telephone:	07880332614
BORDERS PRIMARY CARE IMPROVEMENT PLAN UPDATE REPORT AND NEXT STEPS	
Purpose of Report:	The purpose of this report is to update the Integrated Joint Board on the Borders Primary Care Improvement Plan (PCIP) and propose an ongoing governance model.
Recommendations:	The Health & Social Care Integration Joint Board is asked to **note** the progress of PCIP to date and **support** the proposal to establish ongoing governance once services are mainstreamed.
Personnel:	Circa 70 wte new posts will be established across a number of clinical and support services. All posts are resourced at a 52 week level in order to provide year-round services
Carers:	The timely access to support from the most appropriate service to meet the clinical needs of the individual will directly benefit the patient and therefore indirectly support their carers.
Equalities:	An HIIA has been carried out
Financial:	A ringfenced resource allocation has been made of £3.2m over the 3 years of PCIP programme from Scottish Govt with the direct instruction from them that this cannot be used for saving targets or for any other purpose than the delivery of PCIP
Legal:	The delivery of PCIP is part of the national GP Contract (2018) through a Memorandum of Understanding between BMA and Scottish Government (Health and Integrated Authorities)
Risk Implications:	Recruitment IT Infrastructure Accommodation Non-delivery of GP Contract

Executive Summary:

Background

- PCIP is part of the GP Contract introduced in 2018. It is defined through an agreed national Memorandum of Understanding (MoU) which mandates the delivery of specific priorities aimed at supporting people to access more easily the most appropriate healthcare to meet their needs which will release GP clinical time and will allow GPs to focus on their role as Expert Medical Generalists.
- The national MoU for PCIP was agreed by Scottish Government (Health and Integrated Authorities) and the BMA. This tripartite partnership is mirrored at a local level by the GP Sub Committee, NHS Borders and IJB who are jointly responsible for PCIP delivery.
- The PCIP Executive Committee is the body which oversees and directs the development and implementation of the PCIP programme in Borders. Its membership is at senior level and represents the three partner organisations.
- PCIP forms part of the terms and conditions of employment for all GPs and as such is not optional.

Summary

- Though slowing down in March / April work on PCIP has continued throughout the Covid pandemic and the PCIP Executive Committee have continued to meet.
- Through robust review of progress in all workstreams, the PCIP Executive Committee revised priorities and commitments in the PCIP financial plan and identified resource that could be diverted to contribute to a joint funding arrangement with Mental Health Services in order to establish a new and innovative Primary Care Mental Health service (described in the attached PCIP document). This decision was supported by GP Sub Committee, IJB and the Board Executive Team.
- It has proven difficult to recruit fully qualified Advanced Nurse Practitioners (ANPs); therefore the decision was taken to appoint trainee ANPs and to support them through their training with appropriate mentorship in place so that we can develop a local ANP workforce.
- Recruitment in general has improved over the last quarter which has allowed marked progress across the workstreams.
- The Community Treatment and Care Service workstream has been revisited and a model is currently being developed in partnership with secondary care.
- Scottish Government requested information templates to be submitted in October and November. These are attached separately alongside the updated Borders PCIP document which is a dynamic working document.
- In November 2019 Scottish Government asked all areas what the resource shortfall would be to deliver the full PCIP programme. Scottish Borders submitted an estimate of £1.9m (as reported to the Board previously). No further communication about this funding has been received from Scottish Government.
- The deadline for the delivery of the GP Contract was identified within the MoU as 31st March 2021. However, a Joint Statement from the Scottish Government and the BMA was released on 2nd December which indicates that the deadline and requirements of the contract delivery are to be extended a further 12 – 18 months with some specific requirements of Health Boards and Health & Social Care Partnerships. The implications of this require to be worked through in detail and once this work has been completed it would be the intention to bring a subsequent

update to a future meeting of the IJB.

- Following completion of the PCIP programme, when the workstreams become embedded in mainstream operational services, it will be important to maintain ongoing oversight and monitoring to ensure that they continue to deliver the contractual agreement. A model for this governance has been proposed and is appended.

Documents appended:

- Current updated version PCIP Document (submitted to Scottish Government Nov 2020).
- Covid PCIP3 Scottish Government Return (Oct 2020).
- Financial Template Scottish Government Return (Nov2020).
- Proposed model for the Ongoing Monitoring and Oversight of PCIP.
- HIIA.

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PCIP Borders
Primary Care Improvement Plan

Scottish Borders Primary Care Improvement Plan

(Revised)

2018-21

Working v5.0 Amended 12th November 2020

Scottish Borders Health and Social Care PARTNERSHIP

NHS Borders

VERSION CONTROL

VERSION REVISED TO:	DATE CHANGED	CHANGES MADE
Final Version 22nd Oct 2019		
Working v2.0	15 / 11/19	Following approval of financial report at GP Executive 14/11/19, Workforce and Finance tables updated; page numbers amended.
Working v 3.0	13 / 12 / 19	Workforce and Finance tables updated. Sentence changed Page 7 to record approval from Scottish Govt for VTP proposal
Working v 4.0	9 / 1 / 2020	Workforce and Finance tables updated
Working v5.0	12/11/2020	General update to all sections

CONTENTS

1. INTRODUCTION

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

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

In December 2019, Scottish Government asked to be informed of projected shortfalls in resource needed to fully deliver PCIP i.e. resource required in addition to the original committed allocation (which was £3.2m for Borders). Accordingly Scottish Borders identified £1.9m to be the local shortfall which largely consisted of the resource required to deliver CTAC and VTP (£1.5m). No additional resource has been received to date.

2. BACKGROUND

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

3. GOVERNANCE

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

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

Change of title

During Covid 19, the four members of GP Sub Committee known as the GP Executive of the GP Sub Committee worked closely with NHS Borders and continue to do so as recovery and remobilisation progress. In July 2020, to avoid confusion over titles, it was agreed to rename the GP Executive Committee as the PCIP Executive Committee; as such this title is used from this point forward in this document.

The PCIP Executive Committee meets monthly and provides regular reports to GP Sub Committee and IJB as well as to NHS Borders Executive Team and NHS Borders Board as appropriate. A governance diagram is at **Annex A** and membership list at **Annex B**

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

- The PCIP Executive Committee receives standardised highlight reports from each of the workstreams monthly. Scrutiny of progress takes place in line with the overarching programme plan and specifications laid down within the national contract. Any proposed changes to the workplans and workforce plans must be agreed by the PCIP Executive.
- The PCIP Executive Committee includes a designated Business Finance Partner who on a routine basis comprehensively reviews the budget and commitments in the plan and presents a confirmed financial outlook; this is formally agreed by the PCIP Executive Committee and allows robust forward planning. Finance reports are taken at each meeting where all proposed financial commitments must be approved.
- Post files have been established and specific financial coding has been attached to the PCIP posts so that the resources can be tracked and monitored.
- A delivery map has been developed; this is a dynamic working document which plots where the new posts are being sited and services are being delivered across practices as an aid to ensuring equitable provision across Borders.
- NHS Borders agreed that all PCIP vacancies will be processed in an expeditious manner as they are resourced through ring-fenced PCIP funding which is not subject to any general savings requirements and must not be used to address any wider funding pressures. All PCIP vacancies are logged within NHS Borders processes so that they are noted as part of workforce records.

Clinical Governance

A consistent approach to the delivery of service and development of an appropriately skilled workforce is essential to ensure safe and appropriate patient care. Provision has been made within the PCIP for Band 8a roles in each workstream to manage this and to provide a clinical professional line for the individual disciplines. Each workstream also has a named GP Lead from the PCIP Executive Committee who works in liaison with the Band 8a postholder. In addition, resource has been allocated to allow time for GPs to mentor

and support the new staff appointed through PCIP, most particularly the Advanced Nurse Practitioners and Pharmacists.

An Health Inequalities Impact Assessment has been undertaken across the PCIP.

Operational Governance

Working in GP practices may be a very different experience for the new PCIP post holders; having these new staff and services sited in general practice will also be a new experience for the service managers and practice staff. In order to enable consistency of approach and understanding for all of the new posts and services being established through PCIP, three "Handbooks" have been developed; one for the new postholder, one for the GP practice and one for the service manager and /or workstream lead. The Handbooks set out what to expect of each other, what to do on the first day on site, general staff governance and what to do in different circumstances e.g. when a staff member needs to take sickness absence or a complaint is received etc.

To ensure equity of service provision across practices, equity of access to services for patients and equity of workload for staff members, the PCIP Executive Committee has put in place agreed specifications, definitions of role and workplans for all PCIP services. Using the principles of the clinical productivity programme supported by NHS Borders, clear expectations of clinical vs non-clinical activity proportions within workplans have been agreed for all posts

Ongoing Monitoring and Oversight of PCIP

The PCIP Executive Committee was established to oversee the PCIP Programme until its conclusion on 31st March 2021. However with reference to the points set out in this paper it is apparent that ongoing oversight and monitoring will be essential as the new posts and services move into mainstream delivery in order to protect the major investment in primary care delivered through PCIP and to safeguard the core aims and principles set out in the MoU as part of the national GP contract.

The risks of not establishing a robust oversight, governance and monitoring structure post 2020/21 have been summarised as:

- As vacancies arise and service managers change the understanding of what the posts were established to deliver may be lost and the posts (and associated resources) could then be used in other areas of service provision not linked to primary care or PCIP.
- Equity of provision across GP practices is a core element of the MoU and as services and organisational priorities change over time this focus may be lost which would be detrimental to patients and to GP practices.
- The Vaccination Transformation Programme will not develop.
- The Community Treatment and Care Service will only partially develop and lose focus.
- New career structures in clinical services and potential for professional growth will be limited.
- The progress in shifting the balance of care will be curtailed.
- The core values and principles of PCIP will be eroded.

These risks would lead to the default in delivery of the GP Contract in Borders.

It has therefore been recommended to GP Sub Committee, NHS Borders and IJB that consideration is given to the establishment of an ongoing oversight and monitoring function to support the PCIP services after the end of the PCIP Programme in March 2021.

It will be important that any such function is made up of senior-level representation from GP Practice, NHS Borders and H&SCP with delegated decision-making authority to ensure the continuation of the PCIP programme and framework.

4. KEY PRIORITIES (PCIP WORKSTREAMS)

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

The Vaccination Transformation Programme (VTP)

The Vaccination Transformation Programme (VTP) was announced at national level in March 2017 prior to the introduction of the PCIP to review and transform vaccine delivery in light of the increasing complexity of vaccination programmes in recent years, and to reflect the changing roles of those, principally GPs, historically tasked with delivering vaccinations. This was to be incorporated within the PCIP and in Borders the plan was developed as outlined below.

However, at the outset of Covid 19, Scottish Government paused VTP for 12 months therefore the revised local model has not progressed. In line with the requirement to deliver flu vaccinations in 2020, the GP Executive has worked with NHS Borders to put in place local arrangements this year.

	Previously Completed	**Year 1**	**Year 2**	**Year 3**
Plan /Outcomes	School programme (including flu vaccines)	Pertussis/ whooping cough vaccine seasonal flu vaccination being provided by NHSB midwifery team	Continuation of 0-5 years programme work - pre-school childhood population Travel	Shingles (start) Seasonal Flu Adults 65 years and over Pneumococcal vaccines adults aged 65 years Flu Vaccines ('At risk adults' aged 18-64 years)
Progress		Reduction in healthcare appointments for pregnant women as all vaccinations are	Pre-school childhood programme Data gathering completed, this details the % vaccination uptake across all GP	Data gather completed, this details the % vaccination uptake across all GP Practices and Clusters for the 65 years and over population and the 'At risk'

		now part of midwifery led care. Practice Nurse appointment time therefore freed up.	Practices and Clusters for the Scheduled routine vaccinations (Primary and Booster vaccinations) and Seasonal flu vaccinations for 2,3 and 4 year olds Draft Protocol developed to support local delivery model Model initially identified has raised some challenges and an alternative model has been proposed to Scottish Government (detailed separately below*) <u>Travel Health & Advice</u> - liaison with GP practices ongoing; likely to become Year 3 Outcome.	adults aged 18-64 Proposed alternative delivery model has been identified (see separate detail*). Approved Dec 2019. VTP paused by Scottish Government until 2021/22

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

The VTP workstream initially identified a model of delivery for all under 5 non-flu vaccinations to be taken over by NHS Borders with plans to subsequently incorporate child flu and adult flu vaccination programmes. This model has raised some challenges in terms of the high cost attached to both the additional NHS Borders workforce required and the change to the current IT and data sharing infrastructure necessary to enable non-practice staff to provide the service. A further significant issue is the lack of suitable and accessible accommodation from which to provide the service equitably across the area. Within the original model consideration had been given to the vaccination service being provided from a central point in each locality or cluster given that it has proved impossible to find space in every health centre. However this has also proved extremely difficult; even if it were possible, the public transport infrastructure is limited and there is a concern that the more vulnerable or poorer members of the community would either choose not / be unable to travel out of their home setting for their vaccinations or would not be able to afford to do so.

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

The current scheduled routine programme of vaccinations for under 5yrs, for under 5yrs flu and adult vaccinations has been delivered successfully by GP practices for many years and from accommodation within practice premises. The alternative and preferred approach put forward would see NHS Borders taking over the

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

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

The proposal received approval from Scottish Government on 12th December 2019.

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 **21.5 wte** additional and permanent posts to be established to date in order to deliver the new pharmacotherapy model of service. 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.

In July 2020 the PCIP Executive Committee undertook a review 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, described later in this section. This was supported by GP Sub Committee, IJB and NHS Borders.

This means that the committed investment of £896,538 to support recruitment to the level of 21.5 wte 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.

	Year 1	Year 2	Year 3
Plan /Outcomes	Develop a unified repeat prescribing system Ensure a sustainable process for hospital discharge letters Establish a process for medicines reconciliation	Embed the repeat prescribing system Create a process for Level 2 pharmacotherapy services	Fulfil outstanding Level 1 elements. Roll out the medication review & high risk medicines process Develop support for Level 2 pharmacotherapy services
Progress	The Unified Prescribing Policy (UPP) has been circulated and agreed as a working document with the GP Sub Committee. Process for Discharge Letters and Medicines Reconciliation has been progressed; one practice is still to be included in the roll out.	UPP awareness raising across practices. Pharmacotherapy reviews have been introduced in a number of practices and will be rolled out to all as the workforce plan progresses. Recruitment and development of additional technicians to allow roll out of support for IDLs.	Recruitment of 3 pharmacy technicians complete; training plan in place. Covid 19 has impacted the availability of accommodation in practices. Many staff have worked remotely during Covid and a Remote Working Procedure has been developed. Delivery plan reviewed in order to ensure equitable access to service across practices in light of recruitment and skill mix changes.

Community Treatment & Care Services

It has been acknowledged that there will be insufficient resource within PCIP allocation to fully deliver the workstream, however work is progressing to develop an appropriate model.

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

Progress	Model and SOP identified	Model implemented in 4 NHS Borders Treatment Rooms as first phase and evaluation ongoing. Roll out to remaining 6 NHS Borders Treatment Rooms will be complete by end of third quarter.	Review undertaken and new model for service delivery drafted; agreement for Phlebotomy to be first phase. The potential to support improved pathways across primary and secondary care has been identified and joint work is underway to develop the model accordingly. A series of three workshops has been arranged beginning 30th Oct to confirm the model to be progressed.

Urgent Care

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

	Year 1	Year 2	Year 3
Plan/ Outcomes	SAS pilot in South Cluster NHS Borders ANP strategy developed Begin recruitment of nurses to ANP roles	Develop local training pathway Demonstrate ANP roles working in two cluster areas (West & South)	Recruit remaining practitioners for coverage of all areas. Review of paramedic practitioner role. Outcome to inform wider development of service.
Progress	4 ANPs recruited for deployment into South and West Clusters. Governance and Communication protocols complete. Paramedic Practitioners Pilot in South Cluster established.	ANPs established in South and West Clusters Activity data collection processes for South & West clusters - review and confirm. Further 11 posts approved for recruitment by end of 2019/20. Local training pathway under development.	Recruitment has been very successful since June/July with however there have been limited fully trained applicants and therefore PCIP Executive agreed to appoint trainees and to establish a supported training process. It is anticipated that all posts will be filled by March 2021.

Additional Professional Roles

First Contact Physiotherapists

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

	Year 1	Year 2	Year 3
Plan /Outcomes	Initial phase of FCP service established in East and part of Central cluster	Roll out of model	Final phase roll out to remaining practices
Progress	3.4 wte (5 staff) FCPs appointed to all of east and part of central (Gala HC & Melrose/Newtown St Boswells) clusters. Framework for service developed.	Second phase of recruitment approved for a further 4 posts in 2019/20 Evaluation of service to take place before final recruitment phase is approved	Recruitment has improved significantly and it is anticipated that all posts will be filled by March 2021. In considering the economies of scale within this service as well as lessons learned from ways of working adopted through Covid 19, a review of the original delivery model has been undertaken and a revised approach agreed, which will see a virtual hub providing a single point of referral receipt and allocation.

Community Mental Health Workers

A “test of change” took place at one GP 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 such a mental health model could assist GPs as well as offering an effective and efficient intervention to patients.

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.

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.

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. The preferred option was 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.

Following financial appraisal this model was identified as the overall preferred Borders-wide model at a cost of £845k per annum. Taking into account the already committed PCIP resource of £354k, this leaves a shortfall in funding of £491k. A joint funding solution between Mental Health and PCIP has been identified to resource this shortfall:

- Mental Health have committed to the repurposing of 3.7 WTE Action 15 Earmarked Funding into the new service, equating to £206k
- Following a robust review of PCIP priorities and resource commitments the PCIP Executive has identified a further £285k from within the existing financial plan to support the agreed model. This is made up of £184k from Pharmacotherapy as described previously and £101k across a number of other budget headings.

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.

It has been agreed to name the new service "Renew".

	Year 1	**Year 2**	**Year 3**
Plan /Outcomes	Identify a service delivery model	First Implementer site to be established at one GP practice. Referral pathway confirmed. Evaluation of first implementer site and confirmation of plan. Recruitment to further posts identified and roll out to remainder of Cluster	Roll out of model to all practices
Progress	Model developed	First Implementer site identified in South Cluster. PCMHT consisting of Psychologists, CAAPs (Clinical Associate in Applied Psychology) now based in the first implementer practice; CPN recruitment underway. Referral pathway will be	Model reviewed and new approach agreed, joint funded with Mental Health services and PCIP. The model is based around Psychological Therapies. Began 5th October 2020 in two Clusters and will be Borderswide in Jan 2021.

		signed off Nov 2019. Recruitment underway for next phase of posts required.	

Community Link Workers

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

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

5. CHALLENGES AND RISKS

Across all of the workstreams a number of common challenges have been identified and described previously (below). Covid 19 has brought most of these challenges into sharper relief, in particular the difficulties in accessing accommodation and the call on appropriate IT infrastructure.

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

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

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

6. ENABLERS AND INFRASTRUCTURE

Premises

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

"The National Code of Practice for GP Premises sets out how the Scottish Government will support a shift, over 25 years, to a new model for GP premises in which GPs will no longer be expected to provide their own premises. The measures outlined in the Code represent a significant transfer in the risk of owning premises away from individual GPs to the Scottish Government.

Premises and location of the workforce will be a key consideration in delivering the multi-disciplinary arrangements envisaged in the HSCP Primary Care Improvement Plan".

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

The issues around access to appropriate accommodation at health centre sites for the new services being introduced through PCIP has been highlighted in Section 5. While some staff have been found accommodation

at a number of locations, it is currently not possible in some buildings and is causing great disruption at others. The problem will only increase as more services are established.

A Primary Care Premises Group was established some years ago within Primary & Community Services and while it has a wider role around Primary Care Premises Modernisation for that Clinical Board, it has been agreed to re-vitalise the group to include the two PCIP areas of work identified above as part of its remit. The GP Executive will oversee and monitor this element of the Group's workplan and the Group's membership will be widened to include GP Executive representation. A whole-system review of primary care estate is to be undertaken which will feed into NHS Borders' Capital Management process which will include the requirements for PCIP.

IT Infrastructure and Data Collection

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

The Head of IM&T is working to establish a designated primary care function within the IT service. This new team will work alongside the workstream leads and GP Executive to address these points. Covid 19 has impacted on progress with this.

NHS 24

Colleagues from NHS 24 were previously in discussion with the PCIP Executive regarding a proposal to trial, evaluate and establish a Triage Programme in Scottish Borders whereby NH24 would manage the triage of calls and signpost / redirect certain referrals received through GP practices to more appropriate services in order to free up GP clinical time for more complex cases. However, in recent weeks NHS24 has informed P&CS and PCIP Executive that they will no longer be pursuing this initiative and have diverted their resources toward the national programme for the Redesign of Unscheduled Care

7. WORKFORCE

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

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

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

Whole Time Equivalents

Financial Year	Service 2: Pharmacotherapy		Services 1 and 3: Vaccinations / Community Treatment and Care Services			Service 4: Urgent Care (advanced practitioners)			Service 5: Additional professional roles			Service 6: Community link workers
	Pharmacist	Pharmacy Technician	Nursing	Healthcare Assistants	Other [a]	ANPs	Advanced Paramedics	Other [a]	Mental Health workers	MSK Physios	Other [a]	
TOTAL staff WTE in post as at 31 March 2018	2.3	1.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
INCREASE in staff WTE (1 April 2018 - 31 March 2019)	3.0	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
PLANNED INCREASE in staff WTE (1 April 2019 - 31 March 2020) [b]	3.4	4.2	0.0	0.0	0.0	7.8	0.0	0.0	0.0	3.4	0.0	4.5
PLANNED INCREASE in staff WTE (1 April 2020 - 31 March 2021) [b]	1.0	6.0	2.3	0.0	0.0	5.2	0.0	0.0	14.3	5.8	0.0	0.0
PLANNED INCREASE staff WTE (1 April 2021 - 31 March 2022) [b]	n/a	n/a	0.0	0.0	0.0	3.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL staff WTE in post by 31 March 2022	9.7	11.8	2.3	0.0	0.0	16.0	0.0	0.0	14.3	9.2	0.0	4.5

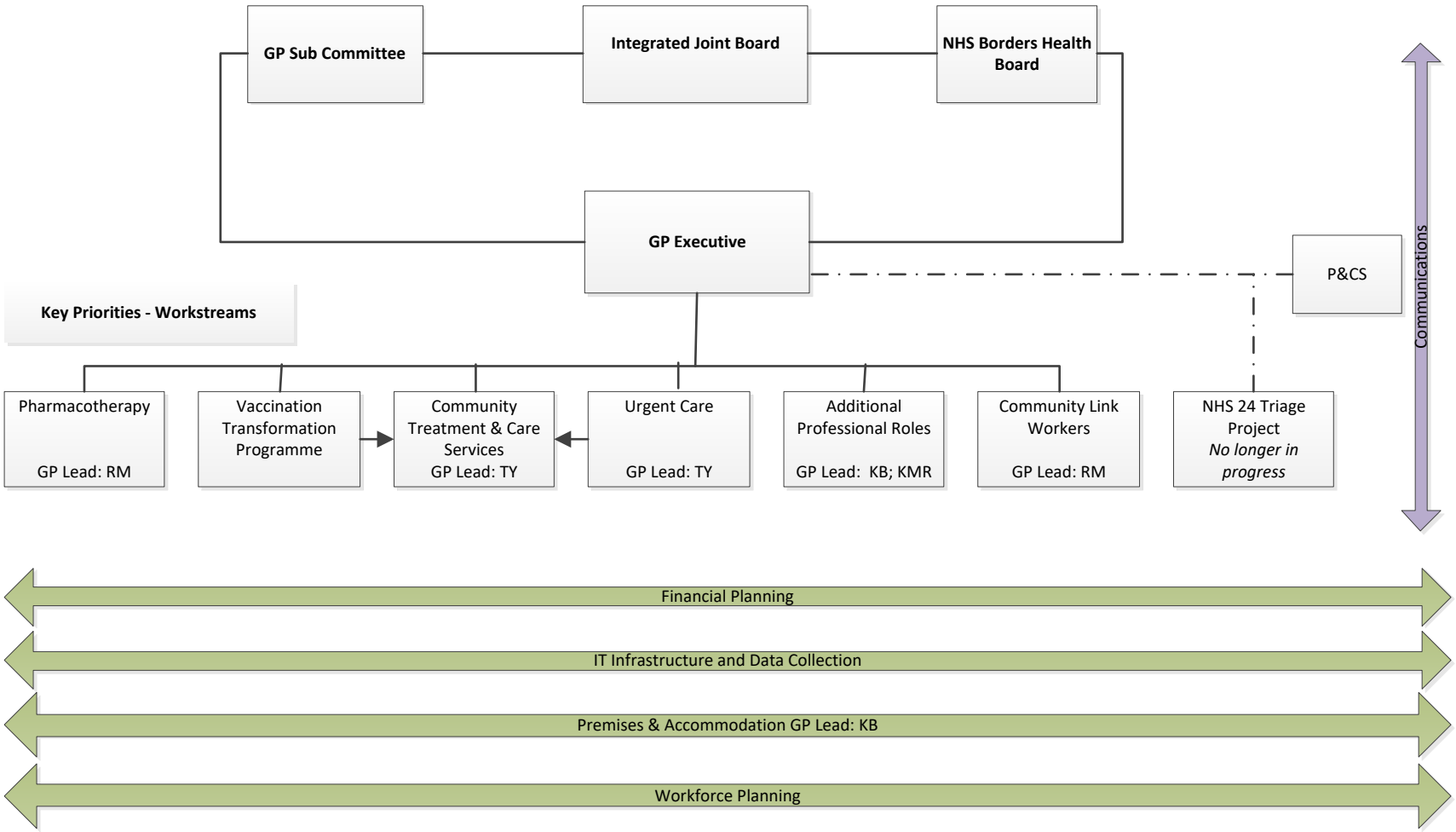
8. FINANCIAL PLANNING

Within the new governance framework, the PCIP Executive's Business Partner has undertaken a comprehensive review of the budget and commitments to date and has presented a confirmed financial outlook; this has been formally agreed by the PCIP Executive and allows robust forward planning. The information from this will inform the regular submissions made to Scottish Government in line with the required Local Implementation Tracker. The financial tables from the October 2020 submission is attached at **Annex C** and gives actual spend together with estimated planned costs for the years 2018 – 2022. As described previously, Scottish Government has been informed of the £1.9m projected shortfall in resource needed to fully deliver PCIP in Borders, of which £1.5m relates to CTAC and VTP.

9. SUMMARY

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

Annex A **Governance Structure**



Annex B PCIP Executive Membership

Dr Kevin Buchan, Chair GP Sub Committee

Rob McCullochGraham, Chief Officer, Health & Social Care Partnership

Dr Kirsty Robinson, GP Sub Committee

Dr Tim Young, GP Sub Committee

Dr Rachel Mollart, GP Sub Committee

Vivienne Buchan, PCIP Business Partner

Sandra Pratt, Associate Director, Strategic Change, NHS Borders

Chris Myers GM, Primary & Community Services

Nicola Lowdon, Associate Medical Director, Primary & Community Services

Simon Burt, GM, Mental Health Services, NHS Borders

Suzie Flower, ADoN, Primary Care NHS Borders

Paul Williams, Associate Director AHPs NHS Borders

Mags Baird, Project Manager, PCIP

ANNEX C Table 1: Spending Profile 2018 – 2022 (£s)

Financial Year	Service 1: Vaccinations Transfer Programme (£s)		Service 2: Pharmacotherapy (£s)		Service 3: Community Treatment and Care Services (£s)		Service 4: Urgent care (£s)		Service 5: Additional Professional roles (£s)		Service 6: Community link workers (£s)	
	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)
2018-19 actual spend	0	0	339167		0	0	0	0	0	0	0	0
2019-20 actual spend	0	0	308576		0	0	354560	12500	177072	0	45089	4000
2020-21 planned spend	0	0	206541	54000	105000	12000	131095	27000	383843	27000	97350	4000
2021-22 planned spend	0	0	0	0	0	0	339826	29500	565295	37100	0	0
Total planned spend	0	0	854284	54000	105000	12000	825481	69000	1126210	64100	142439	8000

Table 2: Source of funding 2018-2022

Financial Year	Total Planned Expenditure (from Table 1)	Of which, funded from:		
		Unutilised PCIF held in IA reserves	Current year PCIF budget	Unutilised tranche funding held by SG
2018-19	339167		962647	
2019-20	901797		55980	139130
2020-21	1047829		994749	163008
2021-22	971721		945000	
Total	3260514	0	2958376	302138

ANNEX D **Proposed Ongoing Monitoring and Oversight of PCIP**

PCIP Ongoing Monitoring Oversight

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Covid PCIP 3

Health Board Area: Scottish Borders

Health & Social Care Partnership: Borders Health & Social Care Partnership

Number of practices: 23

MOU PRIORITIES

n place / on target

partially in place / some concerns

lace / not on target

2.1 Pharmacotherapy	Practices with no access by 31/8/20	Practices with partial access by 31/8/20	Practices with full access by 31/8/20	Practices with no access by 31/3/21	Practices with partial access by 31/3/21	Practices with full access by 31/3/21
Practices with PSP service in place						
Practices with PSP level 1 service in place	0	23	0	0	23	0
Practices with PSP level 2 service in place	0	13	0	0	23	0
Practices with PSP level 3 service in place	2	21	0	0	23	0

Comment / supporting information

We would value Scottish Government's definition of "partial access" so that we can be sure to measure and record figures accordingly. This will inform local discussions that are underway currently to define what percentage completion constitutes "partial access" and therefore the figures submitted above may be amended in the next return .

Please detail the impact of Covid on implementation and where you are in this process, including the impact of the Covid response on previous projected delivery

Covid has seen some pharmacy staff repurposed to support wider Covid requirements. Across the service, during the Covid period the majority of pharmacists have been working remotely and face to face interventions have ceased. This has caused some issues for some staff because of dfficulties with IT infrastructure, however this is being addressed and wherever appropriate, pharmacotherapy staff are being enabled to work on site. Based on the evaluation of outcomes delivceered to date, it was agreed to fix investment in this workstream at 21.5wte new posts and to transfer some funding from the balance previously committed in the plan to allow the Additional Roles (Primary Care Mental Health Service element) workstream to be fully delivered. This is reflected in the Workforce Profile section.

2.2 Community Treatment and Care Services	Practices with no access by 31/8/20	Practices with partial access by 31/8/20	Practices with full access by 31/8/20	Practices with no access by 31/3/21	Practices with partial access by 31/3/21	Practices with full access by 31/3/21
Practices with access to phlebotomy service						
Practices with access to management of minor injuries and dressings service						
Practices with access to ear syringing service						
Practices with access to suture removal service						
Practices with access to chronic disease monitoring and related data collection						
Practices with access to other services						

Comment / supporting information This workstream has not yet started therefore there are no PCIP services listed above. However all GP Practices will currently have access to all or most of the above list of clinical interventions either through their own practice team or through NHS Borders existing treatment room services.

Please detail the impact of Covid on implementation and where you are in this process, including the impact of the Covid response on previous projected delivery submission

CTAC is the workstream least developed in Borders (see PCIP document) It has been highlighted that resources to enable full CTAC development form part of the identified respource gap previously submitted to Scottish Government. During Covid months work has been undertaken to explore the delivery of phlebotomy as a first deliverable. The PCIP Executive has developed a potential overarching CTAC model which the workstream group will develop collaboratively with Seconday Care. A practice survey is currently underway to determine which CTAC services are being delivered by existing services; results are expected by mid- October and will inform workshop discussion to develop an agreed service model.

2.3 Vaccine Transformation Program	Practices with no access by 31/8/20	Practices with partial access by 31/8/20	Practices with full access by 31/8/20	Practices with no access by 31/3/21	Practices with partial access by 31/3/21	Practices with full access by 31/3/21
Pre School - Practices covered by service			23			23
School age - Practices covered by service			23			23
Out of Schedule - Practices covered by service			0			0
Adult imms - Practices covered by service						
Adult flu - Practices covered by service						
Pregnancy - Practices covered by service			23			23
Travel - Practices covered by service	0	0	0			0

Comment / supporting information VTP deferred by Scottish Govt for 12 months. It remains the intention locally to merge VTP with CTAC. Work has continued during the Covid period to develop contractual arrangements linked to the local proposal agreed with Scottish Govt.

Please detail the impact of Covid on implementation and where you are in this process, including the impact of the Covid response on previous projected delivery NHS Borders has committed to supporting all practices by delivering Adult flu vaccinations in 2020/21 as part of an overall flu programme using a centralised team. This is to support delivery impacted by covid restrictions within GP premises and processes as well as GP capacity. Pre school and adults <65yrs at risk flu vacs are being delivered by GP practices.

2.4 Urgent Care Services	Practices with no access by 31/8/20	Practices with partial access by 31/8/20	Practices with full access by 31/8/20	Practices with no access by 31/3/21	Practices with partial access by 31/3/21	Practices with full access by 31/3/21
Practices supported with Urgent Care Service	18 practices with no access to ANP	5 Practices (in two clusters - West & South) with access to Trainees or a Trained ANP			23	

Comment / supporting information
Recruitment is underway for further ANP posts. There have been no fully trained applicants but 12 trainees were shortlisted for interview early September; 6 successfully appointed and will be supported through the training programme. An open recruitment programme is in place and the expectation is to fill all 15wte (ie a further 4wte) by March 2021
Please detail the impact of Covid on implementation and where you are in this process, including the impact of the Covid response on previous projected delivery

There was a brief delay to recruitment at the start of Covid mostly due to HR capacity, however recruitment was fully resumed late June / early July 2020.
Covid has impacted availability of appropriate accomodation for ANP staff. Some infrastructure issues have impeded progress with remote working; these issues are being addressed and accommodation is now priritised for PCIP ANPs.

Additional professional services

2.5 Physiotherapy / FCP	Practices with no access by 31/8/20	Practices with partial access by 31/8/20	Practices with full access by 31/8/20	Practices with no access by 31/3/21	Practices with partial access by 31/3/21	Practices with full access by 31/3/21
Practices accessing APP	15 practices with no access to FCP		8 practices (Central & East clusters)			23

Comment / supporting information
6.6wte x Band 7 anticipated in post by end of 2020/21. Band 8a now in post. Recruitment continues in order to achieve full complement by March 2021. The PCIP Executive has noted the impact of Covid on service delivery and learned lessons from this; consequently a revised centralised model is being developed to address the accommodation issues and the equity challenges due to ecomonomy of scale.
Please detail the impact of Covid on implementation and where you are in this process, including the impact of the Covid response on previous projected delivery

There was a brief delay to recruitment at the start of Covid, mostly due to HR capacity, however recruitment was fully resumed late June / early July 2020.
Covid has impacted the availability of appropriate accomodation for FCP staff. Some infrastructure issues impeded remote working; these issues are being addressed.

2.6 Mental health workers (ref to Action 15 where appropriate)	Practices with no access by 31/8/20	Practices with partial access by 31/8/20	Practices with full access by 31/8/20	Practices with no access by 31/3/21	Practices with partial access by 31/3/21	Practices with full access by 31/3/21
Practices accessing MH workers / support		0	0			23

Comment / supporting information
Testing of a 'see & treat' psychological therapies model in Borders was completed Dec 2019. Following consultation and an option appraisal, decisions were taken about the level of PCIP funding (which required some movement of funds between workstreams) and the transfer of Action 15 staff to support an agreed 'see & treat' centralised psychological therapies model . This model will be delived by the Mental Health Service across the Scottish Borders and started w/c 05/10, with 50% staff recruited as at 1st Oct. Expectation is to recruit fully by January 2021.
Please detail the impact of Covid on implementation and where you are in this process, including the impact of the Covid response on previous projected delivery servcie

Covid restrictionsh will bring challenges in delivering group therapies and access to accommodation for clinical intervention. However by working as a centralised service wider options can be explored which will help to mitigate some of the challenges Covid brings.

2.7 Community Links Workers	Practices with no access by 31/8/20	Practices with partial access by 31/8/20	Practices with full access by 31/8/20	Practices with no access by 31/3/21	Practices with partial access by 31/3/21	Practices with full access by 31/3/21
Practices accessing Link workers		23				23

Comment / supporting information
Please detail the impact of Covid on implementation and where you are in this process, including the impact of the Covid response on previous projected delivery
Covid has impacted the ability for the team to undertake their work in community settings. The range of services and activities available in the community has been drastically reduced and the impact on clients wellbeing has been notable. The service is working through a process to maintain wellbeing and build individuals confidence in re-engaging with activities as they become available

2.8 Other locally agreed services (insert details)	Practices with no access by 31/8/20	Practices with partial access by 31/8/20	Practices with full access by 31/8/20	Practices with no access by 31/3/21	Practices with partial access by 31/3/21	Practices with full access by 31/3/21
Practices accessing service						

Comment / supporting information
As reported in previous submissions NHS24 had been in discussion with NHS Borders and the PCIP Executive and had offered to deliver a triage service across all practices.
However in September 2020 NHS24 informed NHSBorders that this was no longer something they could pursue due to the national focus on the Redesign of Unscheduled Care.
Please detail the impact of Covid on implementation and where you are in this process, including the impact of the Covid response on previous projected delivery

2.9 Overall assessment of progress against PCIP

Specific Risks

Availability of accommodation for both clinical intervention and administrative work within Practice premises;
IT / Wi-fi connectivity;
Recruitment;
Pace of recovery to the new reality post COVID;
FLU/COVID Vaccs delivery pressure;

A risk to the delivery of the total PCIP is the shortfall in the level of funding - a shortfall of £1.9m was identified to Scottish Government in Nov/Dec 2019

Barriers to Progress

Please detail any barriers to progress and what could be done to overcome those barriers.

Funding - a shortfall in funding of £1.9m was identified to Scottish Government at their request in Nov / Dec 2019. This figure included resources to enable development of CTAC and VTP. No further communication about this has been received therefore progression of these workstreams continues to be an issue.
Within the response to Scottish Government re shorfall as request was made for Health Boards to receive additional ring-fenced capital allocation for Primary Care to assist in addressing the numerous premises and accommodation issues.

Recruitment - we have not intentionally delayed recruitment or work on PCIP because of Covid though recruitment has remained a consistent pressure across all workstreams throughout the programme. Over the last two months however, we have seen increased interest in advertised posts which has enabled workstreams to progress,

Accommodation - availability of suitable clinical space for PCIP posts has been an ongoing issue which has been compounded by the need to accommodate Covid restrictions.

Issues FAO National Oversight Group

Funding - a shortfall in funding of £1.9m was identified to Scottish Government at their request in Nov / Dec 2019. This figure included resources to enable development of CTAC and VTP. No further communication about this has been received therefore progression of these workstreams continues to be an issue and the delivery of the PCIP as a complete plan is at risk. It would be helpful if the National Oversight Group could update about this and secure the additional funding. Feedback about the request for specific Primary Care capital allocation would be welcome.

The PCIP Executive routinely scrutinises and monitors all workstreams and as circumstances change eg recruitment issues, failing to meet outcomes etc, makes decisions about and amendments to the plan in order to maintain overall progress and achieve the right results for patients and GPs. This has included the need to make some changes to resources previously allocated in the PCIP to individual workstreams which has seen some funding transferred from one workstream to another; these decisions are evidence-based but have also been impacted by the shortfall in PCIP funding as descrbed above. The most recent changes are reflected in the workforce profile and future financial profiles spreadsheets.

Ongoing Governance: The PCIP Executive Committe has identified that ongoing governance will be essential after completion of the national PCIP development and implementation programme at the end of March 2021as the new posts and services move into mainstream delivery. Therefore a proposal has been drafted to recommend the local establishment of a PCIP Ongoing Monitoring and Oversight Committee after March 2021 in order to protect the major investment in primary care delivered through PCIP and to safeguard the core aims and principles set out in the MoU as part of the national GP contract. This committee will have a membership reflective of the tripartite nature of the MoU.

Health Inequalities

Covid has highlighted existing health inequalities and without mitigation the response to Covid is likely to increase health inequalities. Ministers are keen to see all sectors renewing their efforts on this and will be encouraging all sectors to work together. HSCPs and GPs are already taking significant actions to close the gap. HSCPs are using their position to bring sectors together to help take a whole-system approach to big issues. GPs are playing their part - whether through referrals to services for weight management or smoking cessation, or through outreach to the communities which are hardest to reach and where most inequality is experienced.
Please provide any comments on the impact of Covid on health inequalities and any measures taken to mitigate this impact.
HIIA completed and signedd off by the PCIP Executive Committee

Further Reflections
Please add any other reflections on the impact of the pandemic, for example: New developments (e.g. IT, services) which were brought in during Covid which support contract delivery and aims. COVID has encouraged GPs and ckinical colleagues to make use of technology where appropriate and where IT infrastructure allows eg 'NearMe' to manage care of patients during and recovery from the first wave of the pandemic. Any other services / developments which are locally agreed. N/a Any other general comments. The ability and support locally to continue work on PCIP throughout the Covid period has been positive and appreciated by all involved. Recent improvement in recruitment has greatly contributed to progress across the workstreams. Oversight by the PCIP Executive Committee has been been a crucial element in enabling PCIP to develop at an improved pace and also in sustaining work on PCIP development throughout the Covid period. The PCIP Executive is particularly pleased about the pychological therapies model developed to deliver a primary care mental health service (Under Additional Roles) and whichbegan early October. This has been developed collaboratively and with joint funding PCIP / Action 15 monies.

Workforce profile

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

Table 1: Workforce profile 2018 - 2022 (headcount)

Financial Year	Service 2: Pharmacotherapy		Services 1 and 3: Vaccinations / Community Treatment and Care Services			Service 4: Urgent Care (advanced practitioners)			Service 5: Additional professional roles			Service 6: Community link workers
	Pharmacist	Pharmacy Technician	Nursing	Healthcare Assistants	Other [a]	ANPs	Advanced Paramedics	Other [a]	Mental Health workers	FCP Physios	Other [a]	
TOTAL headcount staff in post as at 31 March 2018	3	2				0	0	0	0	0	0	0
INCREASE in staff headcount (1 April 2018 - 31 March 2019)	3	1				0	0	0	0	0	0	0
INCREASE in staff headcount (1 April 2019 - 31 March 2020)	5	5				8	0	0	0	5	0	5
PLANNED INCREASE in staff headcount (1 April 2020 - 31 March 2021) [b]	1	6				5	0	0	15	4	0	0
PLANNED INCREASE staff headcount (1 April 2021 - 31 March 2022) [b]	0	0				3	0	0	0	0	0	0
TOTAL headcount staff in post by 31 March 2022	12	14	0	0	0	16	0	0	15	9	0	5

[a] please specify workforce types in the comment field

[b] If planned increase is zero, add 0. If planned increase cannot be estimated, add n/a

Table 2: Workforce profile 2018 - 2022 (WTE)

Financial Year	Service 2: Pharmacotherapy		Services 1 and 3: Vaccinations / Community Treatment and Care Services			Service 4: Urgent Care (advanced practitioners)			Service 5: Additional professional roles			Service 6: Community link workers
	Pharmacist	Pharmacy Technician	Nursing	Healthcare Assistants	Other [a]	ANPs	Advanced Paramedics	Other [a]	Mental Health workers	FCP Physios	Other [a]	
TOTAL staff WTE in post as at 31 March 2018	2.3	1.4				0.0	0.0	0.0	0.0	0.0	0.0	0.0
INCREASE in staff WTE (1 April 2018 - 31 March 2019)	3.0	0.2				0.0	0.0	0.0	0.0	0.0	0.0	0.0
INCREASE in staff WTE (1 April 2019 - 31 March 2020)	3.4	4.2				7.8	0.0	0.0	0.0	3.4	0.0	4.5
PLANNED INCREASE in staff WTE (1 April 2020 - 31 March 2021) [b]	1.0	6.0				5.2	0.0	0.0	14.3	5.8	0.0	0.0
PLANNED INCREASE staff WTE (1 April 2021 - 31 March 2022) [b]						3.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL staff WTE in post by 31 March 2022	9.7	11.8	0.0	0.0	0.0	16.0	0.0	0.0	14.3	9.2	0.0	4.5

[a] please specify workforce types in the comment field

[b] If planned increase is zero, add 0. If planned increase cannot be estimated, add n/a

Comment:

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Key:	IAs need to input to all orange shaded cells
	Grey cells are calculated cells - no input required

	Choose from Drop Down List:
Integration Authority:	Scottish Borders
NHS Board Area:	Borders
Total Available ADP 2020-21 (£k):	£358

ADP Funding - Expenditure Forecast 2020-21

All figures in £000s

		Actual YTD Spend £000s			Forecast Spend to the year-end £000s			2020-21 £000s
		Aug-20			Sept 20 to March 21 Spend			Full Year
Expenditure Category (choose from drop down list):	**Brief Description of Funded Activities:**	**Actual YTD Staff Costs**	**Actual YTD Non Staff Costs**	**Actual YTD Total Costs**	**Forecast Staff Costs**	**Forecast Non-Staff Costs**	**Total Forecast Costs**	**Total Costs 2020-21**
Reducing waiting times for treatment & support services	Assertive Engagement Service	30		30	42		42	72
Improved retention in treatment	Assertive Engagement Service	30		30	42		42	72
Improved access to treatment services	Assertive Engagement Service	41		41	57		57	98
Whole family approaches	Children and Families Link Worker Family Support	25		25	36		36	61
Development of advocacy services	Contribution to Children and adult advocacy	0		0	15		15	15
Continued development of recovery communities	Support Development of recovery community	8		8	12	1	13	21
Increased involvement of those with lived experience of ad	Support Development of infrastructure for involvemen	7		7	12		12	19
				0			0	0
				0			0	0
				0			0	0
				0			0	0
Total Expenditure		141	0	141	216	1	217	358

ADP Funding - Allocations 2020-21

All figures in £000s

	Expenditure	Funding held at IA		IA Adjustment	Funding Gap	Funding held at SG	Request for Tranche 2	
	2020-21 Forecast Expenditure	**2020-21 ADP interim allocation**	**Earmarked ADP Reserves**	**Other Funding contributed by IA for ADP (1)**	**Additional Funding Need 20-21 (2)**	**Deducted reserves**	**Additional 20-21 Allocation Request**	**Surplus ADP Funding held at SG (3)**
ADP Summary 2020-21	358	358	0		0	0	0	0

Guidance Notes

1 Enter positive number here only if the IA has other sources of own funding it can use towards the cost of ADP in 20-21.

2 Additional funding need is calculated as 20-21 Expenditure forecast minus ADP interim allocation minus Earmarked Reserves minus Other funding contributed by IA .

3 Surplus ADP 15 funding from 2020-21 or earlier to be held by SG.

2. Confirmation the ADP additional allocation requested is required in financial year 2020-21 [1]

No, I do not anticipate an additional ADP allocation will be required in financial year 2020-21.

Print Name

Robert McCulloch-Graham

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[1] Confirmation from IA Chief Officer or Chief Financial Officer that the additional ADP allocation requested for 2020-21 (yellow cell i32) is required and can be spent in full.

Key:	IAs need to input to all orange shaded cells
	Grey cells are calculated cells - no input required
	Choose from Drop Down List:
Integration Authority:	Scottish Borders
NHS Board Area:	Borders
Total Available Action 15 2020-21 (£k):	£506
Action 15 2019-20 Tranche 2 not drawn down (£k)	£152

Action 15 Mental Health Workforce Funding - Expenditure Forecast 2020-21

All figures in £000s

		Actual YTD Spend £000s			Forecast Spend to the year-end £000s			2020-21 £000s
		Aug-20			Sept 20 to March 21 Spend			Full Year
Expenditure Category (choose from drop down list):	**Brief Description of Funded Activities:**	**Actual YTD Staff Costs**	**Actual YTD Non Staff Costs**	**Actual YTD Total Costs**	**Forecast Staff Costs**	**Forecast Non-Staff Costs**	**Total Forecast Costs**	**Total Costs 2020-21**
Staff Costs (new workforce)	Primary Care Psychology B7 CAAP	51	0	51	47	0	47	98
Staff Costs (new workforce)	Primary Care Psychology B8a	27	0	27	44	0	44	71
Staff Costs (new workforce)	Primary Care Psuchology B4 assistant	11	0	11	19	0	19	30
Staff Costs (new workforce)	Well Being Service Manager B6	6	0	6	13	0	13	19
Staff Costs (new workforce)	Well Being Service Manager B5	29	0	29	59	0	59	88
Staff Costs (new workforce)	SBC Line Worker Manager	0	0	0	18	0	18	18
Staff Costs (new workforce)	SBC Peer Practitioner	0	0	0	15	0	15	15
Staff Costs (new workforce)	SBC Autism Co Ordinator	8	0	8	15	0	15	23
	Primary Care Consultant	0	0	0	26	0	26	26
	Primary Care Psychology 8a Mat Cover	0	0	0	42	0	42	42
				0			0	0
				0			0	0
Total Expenditure		132	0	132	298	0	298	430

Action 15 Mental Health Workforce Funding - Allocations 2020-21

All figures in £000s

	Expenditure	**Funding held at IA**		**IA Adjustment**	**Funding Gap**		**Funding held at SG**		**Request for Tranche 2**	
	2020-21 Forecast Expenditure	**2020-21 Action 15 interim allocation**	**Earmarked Action 15 Reserves**	**Other Funding contributed by IA for Action 15 (1)**	**Additional Funding Need 20-21 (2)**	**30% Tranche Two available for draw down (3)**	**Unutilised 18-19 and 2019-20 Action 15 Funding not drawn down (4)**	**Deducted reserves**	**Additional 20-21 Allocation Request**	**Surplus Action 15 Funding held at SG (5)**
Action 15 Summary 2020-21	430	354	0		76	152	306	0	76	382

Guidance Notes

1 Enter positive number here only if the IA has other sources of own funding it can use towards the cost of Action 15 in 20-21.

2 Additional funding need is calculated as 20-21 Expenditure forecast minus Action 15 interim allocation minus Earmarked Reserves minus Other funding contributed by IA .

3 IA NRAC share of 30% of £17m.

4 2018-19 and 2019-20 Action 15 Tranche 2 funding not drawn down by IA.

5 Surplus Action 15 funding from 2020-21 or earlier to be held by SG.

2. Confirmation the Action 15 additional allocation requested is required in financial year 2020-21

Yes, I confirm the additional Action 15 allocation is required in financial year 2020-21 and can be spent in full.

Robert McCulloch-Graham

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[1] Confirmation from IA Chief Officer or Chief Financial Officer that the additional Action 15 allocation requested for 2020-21 (yellow cell K32) is required and can be spent in full.

Key: IAs need to input to all orange shaded cells
Grey cells are calculated cells - no input required

	Choose from Drop Down List:
Integration Authority:	Scottish Borders
NHS Board Area:	Borders
Total Available 2020-21 PCIF (£k):	£2,318
PCIF 20-21 Tranche 2 not drawn down (£k)	£1,159

1. Primary Care Improvement Fund - Expenditure Forecast 2020-21

All figures in £000s

		Actual YTD Spend £000s			Forecast Spend to the year-end £000s			Total Spend 2020-21 £000s
YTD Spend provided for the Period Ended:		Aug-20			Sept 20 to March 21 Spend			Full Year
Service Area (choose from drop down list of six priorities in the PCIF letter):	Brief Description of Funded Activities:	Actual YTD Staff Costs	Actual YTD Non Staff Costs	Actual YTD Total Costs	Forecast Staff Costs	Forecast Non Staff Costs	Total Forecast Costs	Total Costs 2020-21
Pharmacotherapy services	Develop Repeat Prescribing	341		341	555		555	896
Community Treatment and Care Services	Develop Service Plan	0		0	105		105	105
Urgent care services	Recruitment to ANP team	154		154	288		288	442
Additional Professional Roles (including MSK physi	Expand service FCP and MH Comm Team	68		68	425		425	493
Community Link Workers	Additional staff	63		63	88		88	151
	Project Support	35		35	40		40	75
				0			0	0
				0			0	0
				0			0	0
				0			0	0
				0			0	0
				0			0	0
Total Expenditure		661	0	661	1,501	0	1,501	2,162

Primary Care Improvement Fund - Funding Sources 20-21

All figures in £000s

	Expenditure	Funding held at IA				IA Adjustment		Funding Gap	Funding held at SG			Tranche 2
	2020-21 Forecast Expenditure	2020-21 PCIF interim allocation	Earmarked PCIF Reserves	Earmarked Other Primary Care Reserves	Baselined Pharmacy Funding	Other Funding contributed by IA for PCIF (1)	Earmarked Other PC Reserves used for non-PCIF (2)	Additional Funding Need 20-21 (3)	Tranche Two available for draw down (4)	Unutilised 18-19 and 19-20 PCIF Funding not drawn down (5)	Deducted reserves	Additional 20-21 Allocation Request
PCIF Summary 2020-21	2,162	995	0	0	164			1,003	1,159	1,234	0	1,003

Guidance Notes

1 Enter positive number here only if the IA has other sources of funding it can use towards the cost of PCIF in 20-21.

2 Enter positive number here only if the IA Earmarked Other Primary Care Reserves (e.g. PCTF) are being utilised in 20-21 for non-PCIF activity and hence are not available to fund PCIF activity. Full details of non-PCIF expenditure funded from these reserves must be provided in the 'Other PC Input Sheet'. Earmarked Other Primary Care Reserves should be utilised for PCIF wherever possible. Where these reserves are ring-fenced for local non-PCIF activity, this expenditure can be profiled over a longer time period. In this case, we would look to IAs to use reserves flexibly over PCTF/PCIF over time, as required to meet the resource need.

3 Additional funding need is calculated as 20-21 Expenditure forecast minus PCIF interim allocation minus Earmarked Reserves minus Baselined pharmacy funding minus Other funding contributed by IA plus Reserves utilised in-year for non-PCIF activity.

4 IA NRAC share of 50% of £110m minus Earmarked Reserves not already deducted from the interim allocation.

5 2018-19 and 2019-20 PCIF Tranche 2 funding not drawn down by IA.

6 Surplus PCIF funding from 2020-21 or earlier to be held by SG for future use.

2. Confirmation the PCIF additional allocation requested is required in financial year 2020-21

Yes, I confirm the additional PCIF allocation is required in financial year 2020-21 and can be spent in full.

Print Name

Robert McCulloch-Graham

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[1] Confirmation from IA Chief Officer or Chief Financial Officer that the additional PCIF allocation requested for 2020-21 (yellow cell N32) is required and can be spent in full.

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PCIP Borders
Primary Care Improvement Plan

ONGOING MONITORING & OVERSIGHT AFTER 31st MARCH 2021

AIM

This paper highlights the need for ongoing monitoring and oversight of the new posts and services introduced through the new GP Contract as the delivery of the Primary Care Improvement Plan (PCIP) programme concludes and these services become mainstreamed. It also proposes a potential draft model for this purpose.

BACKGROUND

National context

In 2018 the new GMS Contract was developed and agreed between the British Medical Association (BMA) and Scottish Government. As part of the new contract a Memorandum of Understanding ("MoU") was established between The Scottish Government, the Scottish General Practitioners Committee of the British Medical Association, Integration Authorities and NHS Boards to deliver the Primary Care Improvement Plan (PCIP). As the responsibilities of the Integration Authorities will typically be delivered through the Health and Social Care Partnerships (HSCPs), for the purposes of the MoU, HSCPs are referred to as being responsible for the planning and commissioning of primary care services.

At a local level this translates into a tripartite agreement between HCSPs, Health Boards and GP Sub Committees to deliver the PCIP in collaboration with other relevant stakeholders.

Scottish Government have allocated recurring resources to support the delivery of PCIP; for Borders this equates to £3.2m at the time of writing and this is being allocated over the three years of the programme. In all Scottish Government allocation letters from the Primary Care Directorate, it has been stated explicitly that "PCIF (ie PCIP) funding (including the baselined GP pharmacy funding being treated as PCIF) is *not subject to any general savings requirements and must not be used to address any wider funding pressures."*

Local Context

While some progress was made initially across the PCIP workstreams within the plan, at the end of 2018/ 19 it was acknowledged that this had not been at the pace we would have wished and it was agreed to re-invigorate the process and subsequently to revisit and update the PCIP.

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

Change of title

During Covid 19, the four members of GP Sub Committee known as the GP Executive of the GP Sub Committee worked closely with NHS Borders and continue to do so as recovery and remobilisation progress. In July 2020, to avoid confusion over titles, it was agreed to rename the GP Executive Committee as the PCIP Executive Committee; as such this title is used from this point forward in this paper.

The PCIP Executive Committee meets monthly and provides regular reports to GP Sub Committee and IJB as well as to NHS Borders Executive Team and NHS Borders Board as appropriate. A governance diagram is at **Annex A** and membership list at **Annex B**

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

- The PCIP Executive Committee receives standardised highlight reports from each of the workstreams monthly. Scrutiny of progress takes place in line with the overarching programme plan and specifications laid down within the national contract. Any proposed changes to the workplans and workforce plans must be agreed by the PCIP Executive.
- The PCIP Executive Committee includes a designated Business Finance Partner who on a routine basis comprehensively reviews the budget and commitments in the plan and presents a confirmed financial outlook; this is formally agreed by the PCIP Executive Committee and allows robust forward planning. Finance reports are taken at each meeting where all proposed financial commitments must be approved.
- Post files have been established and specific financial coding has been attached to the PCIP posts so that the resources can be tracked and monitored.
- A delivery map has been developed; this is a dynamic working document which plots where the new posts are being sited and services are being delivered across practices as an aid to ensuring equitable provision across Borders.

- NHS Borders agreed that all PCIP vacancies will be processed in an expeditious manner as they are resourced through ring-fenced PCIP funding which is not subject to any general savings requirements and must not be used to address any wider funding pressures. All PCIP vacancies are logged within NHS Borders processes so that they are noted as part of workforce records.

Clinical Governance

A consistent approach to the delivery of service and development of an appropriately skilled workforce is essential to ensure safe and appropriate patient care.Provision has been made within the PCIP funding plan for Band 8a roles in each workstream to manage this and to provide a clinical professional linefor the individual disciplines.Each workstream also has a named GP Lead from the PCIP Executive Committee who works in liaison with the Band 8a postholder.

In addition, resource has been allocated to allow time for GPs across practices to mentor and support the new staff appointed through PCIP, most particularly the Advanced Nurse Practitioners and Pharmacists.

Operational Governance

Working in GP practices may be a very different experience for the new PCIP staff members; having these new staff and services sited in general practice will also be a new experience for the service managers and practice staff. In order to enable consistency of approach and understanding for all of the new posts and services being established through PCIP, three "Handbooks" have been developed; one for the new postholder, one for the GP practice and one for the service manager and /or workstream lead. The Handbooks set out what to expect of each other, what to do on the first day on site, general staff governance and what to do in different circumstances e.g. when a staff member needs to take sickness absence or a complaint is received etc.

To ensure equity of service provision across practices, equity of access to services for patients and equity of workload for staff members, the PCIP Executive Committee has put in place agreed specifications, definitions of role and workplans for all PCIP services. Using the principles of the clinical productivity programme supported by NHS Borders,clear expectations of clinical vs non-clinical activity proportions within workplans for all posts have been agreed and require to be monitored.

In total,approximately 70wte new, permanent posts will be established across Borders through PCIP. These postholders will deliver a range of new or reconfigured primary care services which will allow patients to be seen by the most appropriate health or social care professional to meet their needs and in a timely manner. This will allow GPs to free up clinical time to focus on more complex patient care in their role as Expert Medical Generalists.

ASSESSMENT

The development of the new services and the governance framework described previously has required stringent oversight and monitoring by the PCIP Executive Committee in order to maintain a fair and

equitable approach across all GP practice areas, to ensure the appropriate use of the allocated resource in line with the specifications laid down within the MoU and to ensure that the principles and requirements of the MoU have not been eroded.

Recruitment to posts has not always been easy across the workstreams and where workforce plans have faltered because posts could not be filled, decisions have been required to agree a different approach / skill mix, how best to manage vacancies etc in order to ensure delivery of the new service.

There has been some general misunderstanding about what PCIP actually is and what it means for GPs, for patients and for existing health and social care services. During the course of the programme PCIP has often been seen as "something additional to do" rather than as a huge opportunity (with attached resource) not only to broaden primary care services but also tooffer new career pathways which will in turn support recruitment potential and professional growth. The PCIP Executive Committee has had a crucial role in managing these misperceptions, in improving knowledge and awareness about PCIP, its workstreams and as a true enabler for shifting the balance of care which is in line with local and national strategic direction.

It is evident therefore that the PCIP Executive Committee has been vital in steering the development and progress of PCIP in Borders within a robust governance framework and through appropriate scrutiny and monitoring.

The PCIP programme as a project is due to conclude on 31st March 2021, at which point the new posts and services will be mainstreamed and will then fall under the operational management of the relevant Heads of Service within Scottish Borders Council (for Community Link Workers) and NHS Borders.

It must be recognised that in May 2020 Scottish Government deferred the work on the Vaccination Transformation Programme for 12 months across Scotland which means that that workstream will require development and oversight post March 2021.

<u>After 31st March 2021</u>

The PCIP Executive Committee was established to oversee the PCIP Programme until its conclusion on 31st March 2021. However with reference to the points set out in this paper it is apparent that ongoing oversight and monitoring will be essential as the new posts and services move into mainstream delivery in order to protect the major investment in primary care delivered through PCIP and to safeguard the core aims and principles set out in the MoU as part of the national GP contract.

The risks of not establishing a robust oversight, governance and monitoring structure post 2020/21 have been summarised as:

- As vacancies arise and service managers change the understanding of what the posts were established to deliver may be lost and the posts (and associated resources) could then be used in other areas of service provision not linked to primary care or PCIP.
- Equity of provision across GP practices is a core element of the MoU and as services and organisational priorities change over time this focus may be lost which would be detrimental to patients and to GP practices.
- The Vaccination Transformation Programme will not develop.
- The Community Treatment and Care Service will only partially develop and lose focus.
- New career structures in clinical services and potential for professional growth will be limited.
- The progress in shifting the balance of care will be curtailed.
- The core values and principles of PCIP will be eroded.

These risks would lead to the default in delivery of the GP Contract in Borders.

It is therefore proposed that consideration is given to the establishment of an ongoing oversight and monitoring function to support the PCIP services after the end of the PCIP Programme in March 2021.

It will be important that any such function is made up of senior-level representation from GP Practice, NHS Borders and H&SCP withdelegated decision-making authority to ensure the continuation of the PCIP programme and framework.

RECOMMENDATION

It is recommended that a PCIP Monitoring & Oversight Committee is established once the PCIP Executive Committee has completed the PCIP development and implementation programme.

This new Committee would consist of senior level representation from GP Practice, NHS Borders and H&SCP to mirror the tripartite nature of the original MoU and in recognition that the posts and services introduced through PCIP, while mainstreamed, remain an integral part of the GP contract and require to be maintained as such.

Members would have the delegated authority to make decisions within the triumvirate agreed PCIP plan about any proposed changes to the established PCIP services, agree the management of vacancies and ongoing use of invested resources to ensure that the terms of the GP contract continue to be met and patients continue to benefit.

The vacancy management arrangements within NHS Borders as previously described would continue for all PCIP funded posts.

While the operational management and professional oversight of the posts would sit with the service managers in liaison with the practices, regular update and performance reports would be taken by the Heads of Service to the PCIP Monitoring & Oversight Committee who would provide a scrutiny and monitoring function as well as agreeing any proposed changes to the posts or services.

The Committee would also receive regular financial reports linked to the PCIP investment. These reports would use the post files and financial coding processes in order to track and monitor the specific resources committed through PCIP.

The Committee would provide regular updates and an annual report on PCIP services and the delivery of the agreed outcomes to GP Sub Committee, NHS Borders (via P&CS Clinical Board and BET) and the IJB . The proposed governance structure for the PCIP Monitoring & Oversight Committee is shown at **Annex C**

The Committee core membership would be:

- Chair of GP Sub Committee (Chair of Committee)
- 3 x GP Executive members
- General Manager, P&CS
- General Manager, Mental Health
- Chief Officer, H&SCP
- Business Finance Partner, H&SCP
- Associate Director of Nursing, P&CS
- Associate Director of AHPs
- Associate Medical Director, P&CS
- Contracts Manager

The PCIP Project Manager would continue to be a member of the Committee whilst in post (until August 2021) to provide co-ordination and continuity during the transition to mainstreaming of the programme and to support the Committee as currently.

It is acknowledged that the PCIP Monitoring & Oversight Committee will require to engage with public representatives and Partnership colleagues as PCIP services progress and develop. Where specific engagement is needed this will be put in place accordingly. The governance structure for the Committee will ensure overarching public and Partnership engagement.

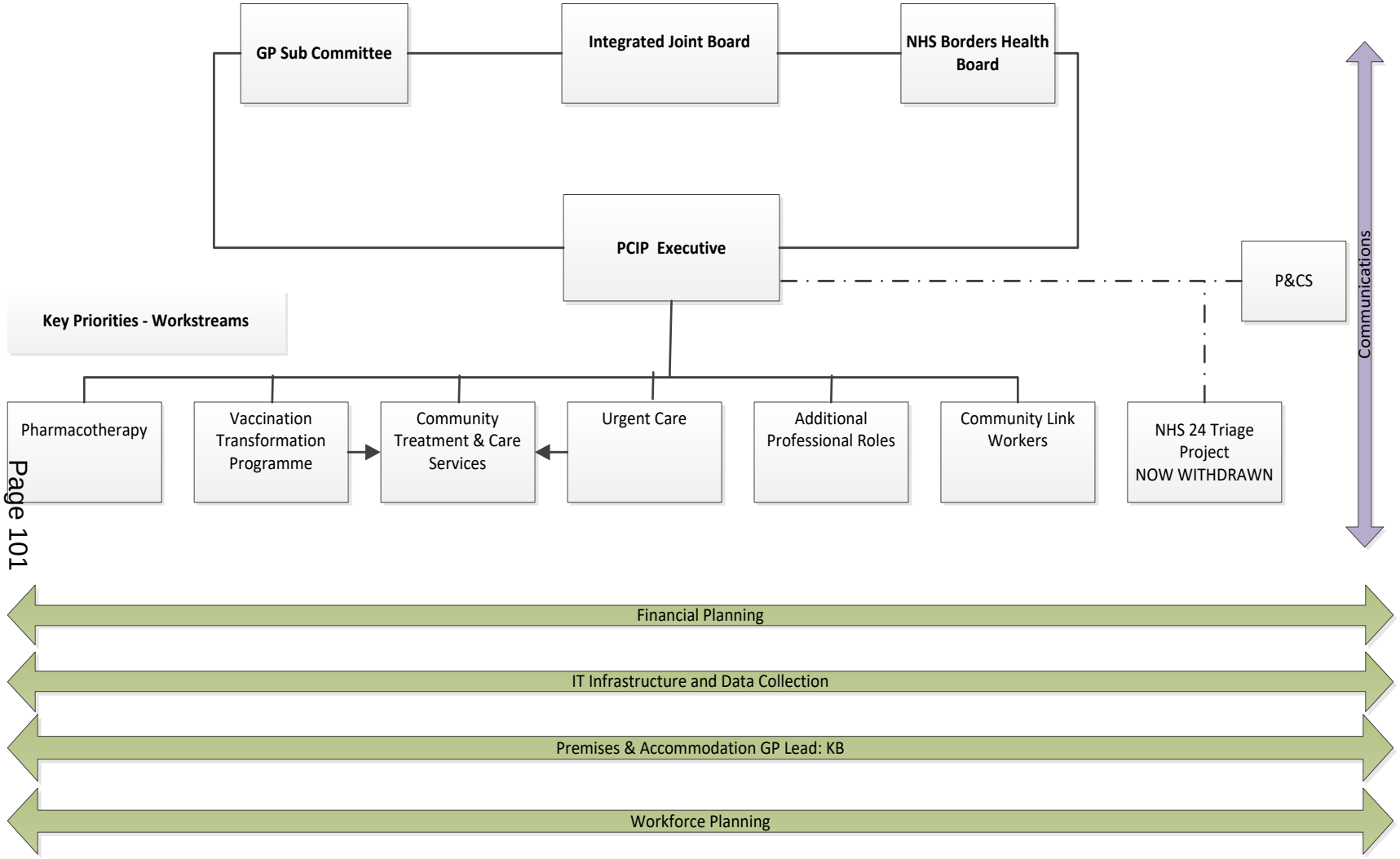
Sandra Pratt

Executive Lead for PCIP. NHS Borders

8th October2020

Final Version 8th October 2020

Annex A Current PCIP Executive Committee Governance Structure

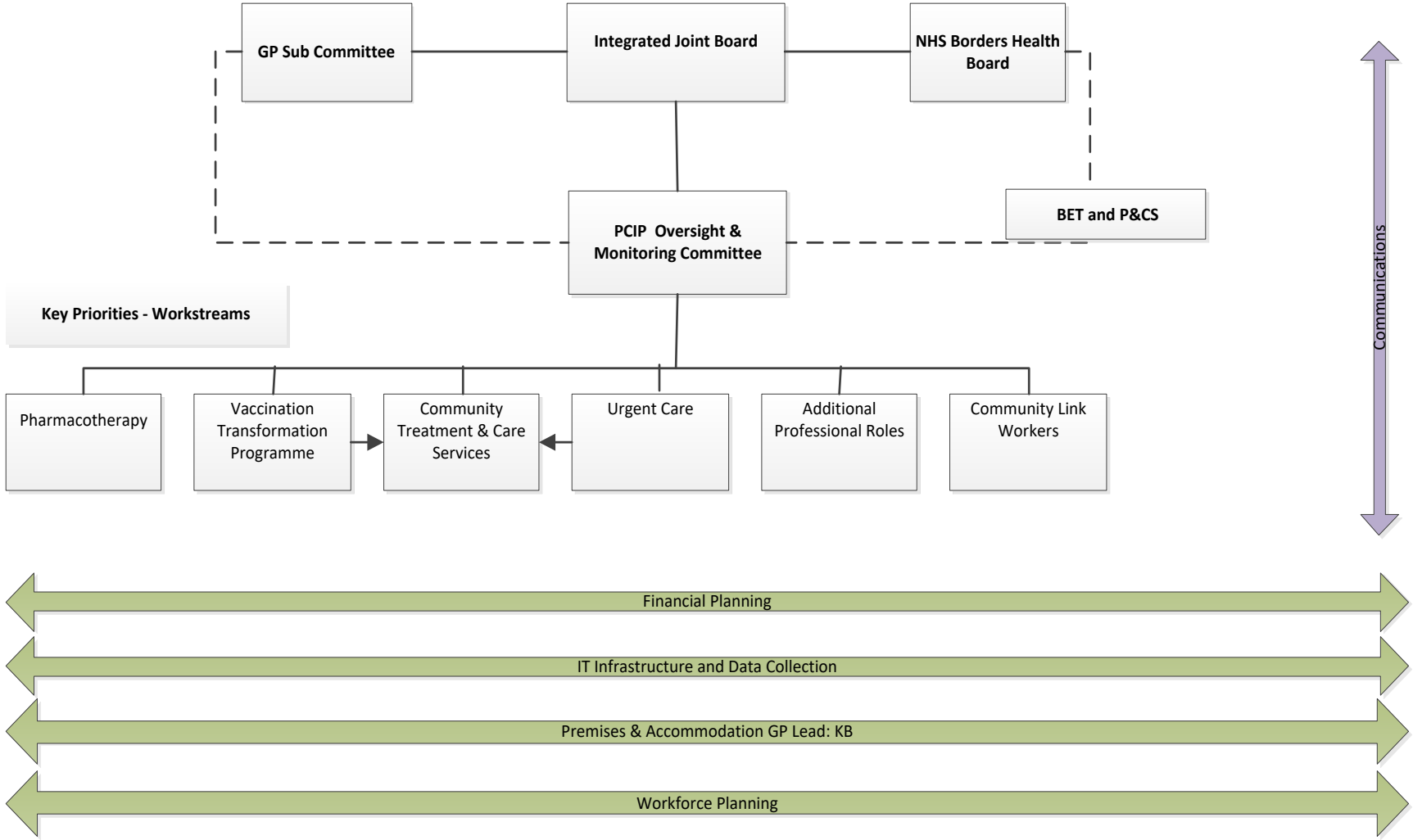


Annex B

PCIP Executive Committee: current membership

- Chair GP Sub Committee (Chair)
- 3 GP Executive members
- Chief Officer, H&SCP
- Executive Lead, NHS Borders
- General Manager, P&CS
- General Manager, Mental Health
- Associate Director of Nursing, P&CS
- Associate Director of AHPs
- Associate Medical Director, P&CS
- PCIP Business Finance Partner
- Project Manager

Annex C **Proposed PCIP Oversight & Monitoring Committee Governance Structure**



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Health inequalities impact assessment: Workbook for workshop participants

Introduction

Carrying out a Health Inequalities Impact Assessment (HIIA) will help you to consider the impact of your policy* on people. Using this workbook, alongside the HIIA: Answers to frequently asked questions guide, will help you to work through the process and strengthen your policy's contribution towards health equity.

The workshop is a core element of the HIIA and, together with a group of key stakeholders, you will work through six questions to identify any impacts your policy will have on: different population groups; health inequalities; and people's human rights. Policies do not impact on people in the same way – impact assessment is a way to consider how people will be affected differently. It will also help you to meet the requirements of the Public Sector Equality Duty by considering those groups who are protected under the Duty (information about the Duty is available at www.scotland.gov.uk/Topics/People/Equality/PublicEqualityDuties. During the workshop, the facilitator or lead for the impact assessment will take you through the process and outline the next steps.

The six questions in the workshop are:

1 Who will be affected by this policy?

2 How will the policy impact on people?

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

4 How will the policy impact on people's human rights?

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

6 What sources of evidence have informed your impact assessment?

* The word 'policy' represents any option, procedure, practice, strategy or proposal being assessed.

You should identify impacts as positive or negative, remembering that some policies may have no impacts for a population group.

Positive impact: would demonstrate the benefit the policy could have for a population group: how it advances equality, fosters good relations, contributes to tackling health inequalities or upholds human rights.

Negative impact: would mean that a population group is at risk of being disadvantaged by the policy, there is a risk of breaching the human rights of people or the requirements of the Equality Duty, or that there is a risk of widening health inequalities.

No impact: If you find that the policy will have no impacts for some groups, you do not need to record this information.

Further information on Health Inequalities is available from NHS Health Scotland Website

http://www.healthscotland.scot/health-inequalities

Question 1: Who will be affected by this policy/programme?

Example: Keep this brief, such as ‘Children aged 5–12 years’.

There is no need to explore subgroups yet, just provide an indication of how well-defined the target group is at this stage.

Borders population, registered with a GP Practice

Question 2: How will the policy/programme impact on people?

When thinking about how the policy/programme might impact on people, think about it in terms of the right for **everyone** to achieve the highest possible standard of health. The Right to Health includes both the right to healthcare and the right to a range of factors that can help us lead a healthy life (the determinants of health). Equality and non-discrimination are fundamental to this right.

The Right to Health has four related concepts: goods, facilities and services should be available, accessible, acceptable and of good quality.

When thinking about how the policy/programme might impact on people, their human rights and the factors that help people to lead healthy lives, consider and discuss:

- Is the policy/programme **available** to different population groups?
- Is the policy/programme **accessible**, (e.g. in terms of physical access, communication needs, transport needs, health literacy, childcare needs, knowledge and confidence)?
- Is the policy/programme **acceptable** to different population groups (e.g. is it sensitive to age, culture and sex)?
- Is the policy/programme of good **quality**, enabling it to have its desired effects and support the above?

Apply these questions to each population group in the following table. Try to identify any factors which can contribute to poorer experiences of health and any potential positive or negative impacts of the policy. Think about people, not characteristics, such as how the policy/programme impact on the right to health of a disabled older man with low literacy who lives in a deprived area.

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.	Service changes within the programme will have minimal impact on Borders population; services will still be delivered within the GP Practice, at the local Health Centre. However the appointment may be with another highly qualified health care professional.	Receptionists within each practice will undergo specific training as 'care navigators' Appointment with a GP is still available A robust communication plan will be in place to ensure engagement / involvement with Patients/Families, Public & Carers when necessary
Disability: physical impairments; learning disability; sensory impairment; mental health conditions; long-term medical conditions.	Service changes within the programme will have minimal impact on Borders population; services will still be delivered within the GP Practice, at the local Health Centre. However the appointment may be with another highly qualified health care professional.	Receptionists within each practice will undergo specific training as 'care navigators' Appointment with a GP is still available A robust communication plan will be in place to ensure engagement / involvement with Patients/Families, Public & Carers when necessary
Gender Reassignment: people undergoing gender reassignment	Service changes within the programme will have minimal impact on Borders population; services will still be delivered within the GP Practice, at the local Health Centre. However the appointment may be with another highly qualified health care professional.	Receptionists within each practice will undergo specific training as 'care navigators' Appointment with a GP is still available A robust communication plan will be in place to ensure engagement / involvement with Patients/Families, Public & Carers when necessary
Marriage & Civil Partnership: people who are married, unmarried or in a civil partnership.	Service changes within the programme will have minimal impact on Borders population; services will still be delivered within the GP Practice, at the local Health Centre. However the appointment may be with another highly qualified health care professional.	Receptionists within each practice will undergo specific training as 'care navigators' Appointment with a GP is still available A robust communication plan will be in place to ensure engagement /

		involvement with Patients/Families, Public & Carers when necessary
Pregnancy and Maternity: women before and after childbirth; breastfeeding.	Service changes within the programme will have minimal impact on Borders population; services will still be delivered within the GP Practice, at the local Health Centre. However the appointment may be with another highly qualified health care professional.	Receptionists within each practice will undergo specific training as 'care navigators' Appointment with a GP is still available A robust communication plan will be in place to ensure engagement / involvement with Patients/Families, Public & Carers when necessary
Race and ethnicity: minority ethnic people; non-English speakers; gypsies/travellers; migrant workers.	Service changes within the programme will have minimal impact on Borders population; services will still be delivered within the GP Practice, at the local Health Centre. However the appointment may be with another highly qualified health care professional.	Receptionists within each practice will undergo specific training as 'care navigators' Appointment with a GP is still available A robust communication plan will be in place to ensure engagement / involvement with Patients/Families, Public & Carers when necessary
Religion and belief: people with different religions or beliefs, or none.	Service changes within the programme will have minimal impact on Borders population; services will still be delivered within the GP Practice, at the local Health Centre. However the appointment may be with another highly qualified health care professional.	Receptionists within each practice will undergo specific training as 'care navigators' Appointment with a GP is still available A robust communication plan will be in place to ensure engagement / involvement with Patients/Families, Public & Carers when necessary
Sex: men; women; experience of gender-based violence.	Service changes within the programme will have minimal impact on Borders population; services will still be delivered within the GP Practice, at the local Health Centre. However the appointment may be with another highly qualified health care professional.	Receptionists within each practice will undergo specific training as 'care navigators' Appointment with a GP is still available A robust communication plan will be in place to ensure engagement /

		involvement with Patients/Families, Public & Carers when necessary
Sexual orientation: lesbian; gay; bisexual; heterosexual.	Service changes within the programme will have minimal impact on Borders population; services will still be delivered within the GP Practice, at the local Health Centre. However the appointment may be with another highly qualified health care professional.	Receptionists within each practice will undergo specific training as 'care navigators' Appointment with a GP is still available A robust communication plan will be in place to ensure engagement / involvement with Patients/Families, Public & Carers when necessary
Looked after (incl. accommodated) children and young people	Service changes within the programme will have minimal impact on Borders population; services will still be delivered within the GP Practice, at the local Health Centre. However the appointment may be with another highly qualified health care professional.	Receptionists within each practice will undergo specific training as 'care navigators' Appointment with a GP is still available A robust communication plan will be in place to ensure engagement / involvement with Patients/Families, Public & Carers when necessary
Carers: paid/unpaid, family members.	Service changes within the programme will have minimal impact on Borders population; services will still be delivered within the GP Practice, at the local Health Centre. However the appointment may be with another highly qualified health care professional.	Receptionists within each practice will undergo specific training as 'care navigators' Appointment with a GP is still available A robust communication plan will be in place to ensure engagement / involvement with Patients/Families, Public & Carers when necessary
Homelessness: people on the street; staying temporarily with friends/family; in hostels, B&Bs.	Service changes within the programme will have minimal impact on Borders population; services will still be delivered within the GP Practice, at the local Health Centre. However the appointment may be with another highly qualified health care professional.	Receptionists within each practice will undergo specific training as 'care navigators' Appointment with a GP is still available A robust communication plan will be in place to ensure engagement /

		involvement with Patients/Families, Public & Carers when necessary
Involvement in the criminal justice system: offenders in prison/on probation, ex-offenders.	Service changes within the programme will have minimal impact on Borders population; services will still be delivered within the GP Practice, at the local Health Centre. However the appointment may be with another highly qualified health care professional.	Receptionists within each practice will undergo specific training as 'care navigators' Appointment with a GP is still available A robust communication plan will be in place to ensure engagement / involvement with Patients/Families, Public & Carers when necessary
Addictions and substance misuse	Service changes within the programme will have minimal impact on Borders population; services will still be delivered within the GP Practice, at the local Health Centre. However the appointment may be with another highly qualified health care professional.	Receptionists within each practice will undergo specific training as 'care navigators' Appointment with a GP is still available A robust communication plan will be in place to ensure engagement / involvement with Patients/Families, Public & Carers when necessary
Staff: full/part time; voluntary; delivering/accessing services.	Certain staff currently employed by the GP Practice may change to NHSB, for certain hours of their contract, for example Nurses who work within the treatment room. There are currently no planned changes for any other member of the Primary Care Teams, Volunteers or those delivering/accessing services.	A workplace oversight group will be in place that includes HR, Partnership / Unions, Practice Manager, GP, Workforce rep.
Low income	Service changes within the programme will have minimal impact on Borders population; services will still be delivered within the GP Practice, at the local Health Centre. However the appointment may be with another highly qualified health care professional.	Receptionists within GP practices across Borders will undergo specific training as 'care navigators' Appointment with a GP is still available A robust communication plan will be in place to ensure engagement /

		involvement with Patients/Families, Public & Carers when necessary
Low literacy / Health Literacy includes poor understanding of health and health services (health literacy) as well as poor written language skills.	Service changes within the programme will have minimal impact on Borders population; services will still be delivered within the GP Practice, at the local Health Centre. However the appointment may be with another highly qualified health care professional.	Receptionists within each practice will undergo specific training as 'care navigators' Appointment with a GP is still available A robust communication plan will be in place to ensure engagement / involvement with Patients/Families, Public & Carers when necessary
Living in deprived areas	Service changes within the programme will have minimal impact on Borders population; services will still be delivered within the GP Practice, at the local Health Centre. However the appointment may be with another highly qualified health care professional.	Receptionists within each practice will undergo specific training as 'care navigators' Appointment with a GP is still available A robust communication plan will be in place to ensure engagement / involvement with Patients/Families, Public & Carers when necessary
Living in remote, rural and island locations	Service changes within the programme will have minimal impact on Borders population; services will still be delivered within the GP Practice, at the local Health Centre. However the appointment may be with another highly qualified health care professional.	Receptionists within each practice will undergo specific training as 'care navigators' Appointment with a GP is still available A robust communication plan will be in place to ensure engagement / involvement with Patients/Families, Public & Carers when necessary
Discrimination/stigma	Service changes within the programme will have minimal impact on Borders population; services will still be delivered within the GP Practice, at the local Health Centre. However the appointment may be with another highly qualified health care professional.	Receptionists within each practice will undergo specific training as 'care navigators' Appointment with a GP is still available A robust communication plan will be in place to ensure engagement /

		involvement with Patients/Families, Public & Carers when necessary
Refugees and asylum seekers	Service changes within the programme will have minimal impact on Borders population; services will still be delivered within the GP Practice, at the local Health Centre. However the appointment may be with another highly qualified health care professional.	Receptionists within each practice will undergo specific training as 'care navigators' Appointment with a GP is still available A robust communication plan will be in place to ensure engagement / involvement with Patients/Families, Public & Carers when necessary
Any other groups and risk factors relevant to this policy/programme	N/A	N/A

To comply with the general equality duty of the Equality Act 2010 when conducting impact assessment, you must demonstrate 'due regard' for the need to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Act;
- advance equality of opportunity between people who share a relevant protected characteristic and those who do not share it;
- foster good relations between people who share a relevant protected characteristic and those who do not share it.

This means that you must identify, record and eliminate (through appropriate policy changes) any impacts that could amount to unlawful discrimination under the act. Wherever possible you should also try to identify, record and enhance any impacts that enable the policy to advance equality of opportunity or foster good relations.

Question 3: How will the policy/programme impact on the causes of health inequalities?

The wider environmental and social conditions in which we are born, grow, live, work and age are shaped by the distribution of power, money and resources. These conditions can lead to health inequalities. While considering how your policy will impact on people and their right to health, it is also important to think about how it may impact on the causes of health inequalities (see the table below). Further information on the causes of health inequalities can be found in NHS Health Scotland's Health Inequalities Policy Review.

Not all policies/programmes will be able to act or impact on these causes, but it will be useful to reflect on whether yours will. Think about any opportunity this policy/programme might offer to reduce inequalities and also try to identify any ways in which it might inadvertently increase inequalities (you may find the prompts in Appendix 1 helpful).

You may have discussed some of these issues when considering question 2.

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. • Tax and benefits structures. • Cost/price controls: housing, fuel, energy, food, clothes, alcohol, tobacco. • Working conditions.	N/A	
The physical environment and local opportunities • Availability and accessibility of housing, transport, healthy food, leisure activities, green spaces. • Air quality and housing/living conditions, exposure to pollutants. • Safety of neighbourhoods, exposure to crime. • Transmission of infection.	N/A	

• Tobacco, alcohol and substance use.		
Education and learning • Availability and accessibility to quality education, affordability of further education. • Early years development, readiness for school, literacy and numeracy levels, qualifications.	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.	N/A	
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.	N/A	

Question 4: How will the policy/programme impact on people's human rights?

Human rights are the basic rights and freedoms which everyone is entitled to in order to live with dignity. They can be classified as **absolute**, **limited** or **qualified**. Absolute rights must not be restricted in any way. Other rights can be limited or restricted in certain circumstances where there is a need to take into account the rights of other individuals or wider society.

Not all policies/programmes will be able to demonstrate an impact against human rights but it will be useful to consider if yours will. Think about the potential impacts you have identified and consider whether these could help fulfil or breach legal obligations under the Human Rights Act. Can you think of any actions that might promote positive impacts or mitigate negative impacts? The following table includes rights that may be particularly relevant to health and social care policies/programmes.

Articles	Potential areas for consideration	Potential impacts and any particular groups affected	Recommendations to reduce or enhance such impacts
The right to life (absolute right)	• Access to basic necessities such as adequate nutrition, clean and safe drinking water. • Suicide. • Risk to life of/from others. • Duties to protect life from risks by self/others. • End of life questions. • Duties of prevention, protection and remedy, including investigation of unexpected death.	N/A	
The right not to be tortured or treated in an inhuman or degrading way (absolute right)	• Should not cause: fear; humiliation; intense physical or mental suffering; or anguish. • Prevention of ill-treatment, protection and rehabilitation of survivors of ill-treatment.	N/A	

	• Duties of prevention, protection and remedy, including investigation of reasonably substantiated allegations of serious ill-treatment. • Dignified living conditions.		
The right to liberty (limited right)	• Right not to be deprived of liberty in an arbitrary fashion. • Detention under mental health law. • Review of continued justification of detention. • Informing reasons for detention.	N/A	
The right to a fair trial (limited right)	• When a person's civil rights, obligations or a criminal charge against a person comes to be decided upon. • Staff disciplinary proceedings. • Malpractice. • Right to be heard. • Procedural fairness. • Effective participation in proceedings that determine rights such as employment, damages/ compensation.	N/A	
The right to respect for private and family life, home and correspondence	• Family life, including outwith blood and formalised relationships. • Privacy. • Personal choices, relationships. • Physical and moral integrity (e.g. freedom from non-consensual	N/A	

(qualified right)	treatment, harassment or abuse). • Participation in community life. • Participation in decision-making. • Access to personal information. • Respect for someone's home. • Clean and healthy environment. • Legal capacity in decision-making. • Accessible information and communication e.g. phone calls, letters, faxes, emails.		
The right to freedom of thought, belief and religion (qualified right)	• Conduct central to beliefs (such as worship, appropriate diet, dress).	N/A	
The right to freedom of expression (qualified right)	• To hold opinions. • To express opinions, receive/impart information and ideas without interference by a public authority.	N/A	
The right not to be discriminated against	• All of the rights and freedoms contained in the Human Rights Act must be protected and applied without discrimination. • Discrimination takes place when someone is treated in a different way compared with someone else in a similar situation. • Indirect discrimination happens when someone is treated in the	N/A	

	same way as others that does not take into account that person's different situation. • An action or decision will only be considered discriminatory if the distinction in treatment cannot be reasonably and objectively justified.		
Any other rights relevant to this policy e.g.	• Convention on the Rights of the Child • Convention on the Elimination of All Forms of Discrimination against Women • Convention on the Rights of Persons with Disabilities	N/A	

Question 5: Will there be any cumulative impacts as a result of the relationship between this policy/programme and others?

Consider the potential for a build-up of negative impacts on population groups as a result of this policy/programme being combined with other policies/programmes, e.g. relocation of services at the same time as changes to public transport networks.

PMO / Transformational change programme PASC programme P&Cs

Question 6: What sources of evidence have informed your impact assessment?

Formal sources of evidence to consider include population data and statistics, consultation findings and other research. However, your professional or personal experience and knowledge of individuals and communities (and the potential impact of a policy on them) is equally as valuable. Further information can be found in the planning a workshop section. http://www.healthscotland.scot/publications/planning-resources-hiia-scoping-workshop

What evidence have you used to support your impact assessment thinking? Have you identified any areas where more evidence is needed or where there are gaps in your current knowledge to inform the assessment?

Evidence type	Evidence available	Gaps in evidence
Population data e.g. demographic profile, service uptake.	Practice list data VTP: uptake data FCP: activity data ANP: activity data Demographic data – SBC	
Consultation and involvement findings e.g. any engagement with service users, local community, particular groups.	GP Executive Committee Engagement with key care providers: ANPs, FCPs, P&Cs management team Work-stream steering groups	Service users, Families, Carers CLW
Research e.g. good practice guidelines, service evaluations, literature reviews.	Clinical / Professional guidelines PCIP 2019 The 2018 GMS contract in Scotland, BMA Primary Care ihub network Realistic Medicine Public Protection guidance & Legislation	
Participant knowledge e.g. experiences of working with different population groups, experiences of different policies/projects/programmes.	Professional knowledge & experience of various healthcare professionals	

Summary of discussion

The facilitator or lead for the impact assessment will bring the workshop to a close and will recap on how your group has:

- identified what the potential impacts of the policy are on people and their right to health
- identified what potential impacts the policy may have on the causes of health inequalities
- identified what potential impacts the policy may have on people's human rights as set out in the Human Rights Act.
- considered how the policy impacts on the specific requirements in the Public Sector Equality Duty
- identified any actions to tackle these impacts, promote equality and the right to health
- identified any potential effects as a result of the relationship between this policy and others
- identified evidence sources to draw on and where there are gaps in your evidence.

Next steps

A report of this discussion will be written to identify the next steps. You will be asked to comment on this report to ensure that it provides an accurate record of this workshop. Next steps will be coordinated by the project lead and may involve prioritising the impacts, identifying and gathering further sources of evidence (including any consultation) in order to make recommendations from the impact assessment, followed by undertaking and monitoring any actions identified.

Thank you for participating in this workshop.

Appendix 1: Messages from the Health Inequalities Policy Review

Structural		Behavioural
Fundamental causes	**Wider environmental influences**	**Individual experiences**
Global economic forces Macro socio-political environment Political priorities and decisions Societal values to equity and fairness Unequal distribution of power, money and resources Poverty, marginalisation and discrimination	**Economic and work** • Availability of jobs. • Price of basic commodities (e.g. rent, fuel).	**Economic and work** • Employment status. • Working conditions. • Job security and control. • Family or individual income. • Wealth. • Receipt of financial and other benefits.
	Physical • Air and housing quality. • Safety of neighbourhoods. • Availability of affordable transport. • Availability of affordable food. • Availability of affordable leisure opportunities.	**Physical** • Neighbourhood conditions. • Housing tenure and conditions. • Exposure to pollutants, noise, damp or mould. • Access to transport, fuel poverty. • Diet. • Exercise and physical activity. • Tobacco, alcohol and substance use.
	Learning • Availability and quality of schools. • Availability and affordability of further education and lifelong learning.	**Learning** • Early cognitive development. • Readiness for school. • Literacy and numeracy. • Qualifications.
	Services • Accessibility, availability and quality of public, third sector and private services; activity of commercial sector.	**Services** • Quality of service received. • Ability to access and navigate. • Affordability.

	Social and cultural • Community social capital, community engagement. • Social norms and attitudes. • Democratisation. • Democratic engagement and representation.	**Social and cultural** • Connectedness, support and community involvement. • Resilience and coping mechanisms. • Exposure to crime and violence.
Key components of a health inequalities strategy		
Fundamental causes	**Wider environmental influences**	**Individual experiences**
• Policies that redistribute power, money and resources • Social equity and social justice prioritised	• Legislation, regulation, standards and fiscal policy. • Structural changes to the physical environment. • Reducing price barriers. • Ensuring good work is available for all. • Equitable provision of high quality and accessible education and public services.	• Equitable experience of socio-economic and wider environmental influences. • Equitable experience of public services. • Targeting high risk individuals. • Intensive tailored individual support. • Focus on young children and the early years.
Examples of effective interventions		
Fundamental causes	**Wider environmental influences**	**Individual experiences**
• Minimum income for health (healthy living wage) • Progressive taxation (individual and corporate). • Active labour market policies	• Housing: Extend Scottish Housing Quality Standard; Neighbourhood Quality Standard. • Air/water: Air pollution controls; water fluoridation. • Food/alcohol: restrict advertising; regulate retail outlets; regulate trans-fats and salt content. • Transport: drink-driving regulations, lower speed limits, area-wide traffic calming schemes. • Price controls: Raise price of harmful commodities through taxation; reduce price barrier for healthy products and essential services.	• Training – culturally/inequalities sensitive practice. • Linked public services for vulnerable/high risk individuals. • Specialist outreach and targeted services.

Interventions requiring people to opt-in are less likely to reduce health inequalities. Consider the balance of actions at structural and individual levels.

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 16 December 2020

Report By:	Dr Tim Patterson, Director of Public Health
Contact:	Fiona Doig
Telephone:	07825523603

ALCOHOL AND DRUGS PARTNERSHIP ANNUAL REPORT

Purpose of Report:	The purpose of this report is to: • Update the IJB on the content of ADP Annual Report 2019-20 • Provide a brief update on current service activity
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Note** the Annual Report and Update
Personnel:	Staffing is provided within the agreed resource.
Carers:	A previous needs assessment for affected family members was carried out in 2019.
Equalities:	A Health Inequalities Impact Assessment was completed on the current ADP Strategy.
Financial:	ADP funding from Scottish Government is contingent on delivery of Ministerial Priorities.
Legal:	N/A
Risk Implications:	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 Background

Borders Alcohol and Drugs Partnerships (ADP) submitted its Annual Report 2019-20 to Scottish Government as required using the template provided. Completion of the template was supported by the ADP, commissioned alcohol and drugs services and a representative from Borders Recovery Community (Appendix 1).

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.

The template format has changed this year and reflects the monitoring framework in place to support the evaluation of Rights, Respect and Recovery, Scotland's alcohol and drugs strategy.[1] The guidance notes for the template confirm that it is not expected that ADP will have all options in place.

2 Assessment

The Annual Report shows positive progress in many of the reporting areas and highlights are presented below. There are some areas which the ADP will seek to improve in future work. There is a two year delivery plan in place which is monitored by the ADP Board.

The Annual Report also presents a Financial Framework (p21) outlining income and expenditure.

2.1 Highlighted areas

b) Substance Use Education (p6; section 2.3) – A new substance use education resource (SUE) was launched in November 2019 in partnership with Education, Joint Health Improvement Team, Crew and Police Scotland. Staff briefings were provided across all clusters and high schools. Training for Early Years providers was delayed due to COVID but is now in progress.

c) Reducing barriers to treatment: Assertive Engagement Service (ES Team) (p8; sections 3.2; 3.4)/prescribing – The ES Team was commissioned from April 2019 and supports both retention and active engagement in services for some of our most vulnerable clients. The staff team is employed by Borders Addiction Service and We Are With You. Pre Covid-19 the team supported the drop-in clinics and Eyemouth Hub. The service has received very positive feedback from clients and wider stakeholders.
   Borders Addiction Service has also worked towards same day prescribing of Opioid Substitution Therapy (OST) e.g. methadone and is currently increasing the availability of new methods of OST delivery.

d) Support for children impacted by parental substance use (CAPSM) (p16; section 4.5) – A new CAPSM link worker service was commissioned from April 2019 and works closely with Children and Families Social Work to provide support to CAPSM children, parents, expectant mothers and carers. The service has received very positive feedback from clients and wider stakeholders.

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

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2.2 Areas for improvement

- Involvement of lived experience (p10: section 3.9) – The 2020-2023 ADP Strategy Refresh highlighted the need to improve the involvement of people with lived experience. Pre Covid-19 positive meetings were held with people with lived experience and we are now restarting this work and the group reconvened on 1 December 2020.
- Joint protocols for people with concurrent alcohol and drugs and mental health problems (p12: section 3.14) - The 2020-2023 ADP Strategy Refresh highlighted the need to improve the involvement of people with lived experience and this is a piece of work to be progressed in partnership with the ES Team and wider Mental Health Services
- Alcohol Related Deaths (p14; section 3.20) – at the moment there are no arrangements in place to routinely review all alcohol related deaths. Alcohol Focus Scotland has produced a toolkit for ADPs to consider for this process. AFS will be invited to an ADP Board meeting in early 2020 to support local considerations.

3 Update on service activity during COVID

The IJB will wish to note that all commissioned services (Borders Addiction Service, We Are With You, Action for Children Chimes Service) continued to accept referrals and, where required, provide face-to-face appointments for individuals including same day prescribing of Opioid Substitution Therapy (OST).

Recovery activities (e.g. Mutual Aid Partnership Groups; Creative Writing Group) continue to be delivered online.

Referrals dropped during ‘lockdown’ but have been increasing over recent months although they are not yet at pre Covid-19 levels.

4 Preventing drug related deaths

Prevention of drug related deaths remains a priority for all ADP partners. The National Records of Scotland (NRS), January – December 2019 Drugs Deaths Report will be issued in December 2020. A Borders report will be duly submitted to CSOG thereafter.

Appendix 1 ALCOHOL AND DRUG PARTNERSHIP ANNUAL REVIEW 2019/20 (Borders)

I. Delivery progress
II. Financial framework

This form is designed to capture your **progress during the financial year 2019/20** against the Rights, Respect and Recovery strategy including the Drug Deaths Task Force emergency response paper and the Alcohol Framework 2018 We recognise that each ADP is on a journey of improvement and it is likely that further progress has been made since 2019/20. Please note that we have opted for a tick box approach for this annual review but want to emphasise that the options provided are for ease of completion and it is not expected that every ADP will have all options in place. We have also included open text questions where you can share details of progress in more detail. Please also ensure all sections in yellow are fully completed.

The data provided in this form will allow us to provide updates and assurance to Scottish Ministers around ADP delivery. The data will also be shared with Public Health Scotland (PHS) evaluation team to inform the monitoring and evaluation of rights, respect and recovery (MERRR). This data is due to be published in 2021.

We do not intend to publish the completed forms on our website but encourage ADPs to publish their own submissions as a part of their annual reports, in line with good governance and transparency. All data will be shared with PHS to inform the MERRR and excerpts and/or summary data from the submission will be used in published MERRR reports. It should also be noted that, the data provided will be available on request under freedom of information regulations.

In submitting this completed Annual Review you are confirming that this partnership response has been signed off by your ADP, the ADP Chair and Integrated Authority Chief Officer.

The Scottish Government copy should be sent by **Wednesday 14th October 2020** to: alcoholanddrugdelivery@gov.scot

NAME OF ADP: **Borders**

Key contact:
Name: **Susan Elliot**
Job title: **ADP Co-ordinator**
Contact email: **susan.elliot1@borders.scot.nhs.uk**

I. DELIVERY PROGRESS REPORT

1. Representation

1.1 Was there representation form the following local strategic partnerships on the ADP?

Community Justice Partnership	Y
Children's Partnership	Y
Integration Authority	Y

1.2 What organisations are represented on the ADP and who was the chair during 2019/20?

Chair*:* Dr Tim Patterson, Joint Director of Public Health, NHS Borders and Scottish Borders Council

Representation

The public sector:	
Police Scotland	Y
Public Health Scotland	N
Alcohol and drug services	Y
NHS Board strategic planning	Y
Integration Authority	Y
Scottish Prison Service (where there is a prison within the geographical area)	N/A
Children's services	Y
Children and families social work	Y
Housing	Y
Employability	N
Community justice	Y
Mental health services	Y
Elected members	Y
Other	Local Authority Commissioning and Procurement NHS Finance Manager Joint Health Improvement Team
The third sector: we commission SDF to provide independent third sector representation	
Commissioned alcohol and drug services	Y
Third sector representative organisation	Y
Other third sector organisations	N
People with lived/ living experience	N
Other community representatives	N
Other	N

1.3 Are the following details about the ADP publicly available (e.g. on a website)?

Membership	N
Papers and minutes of meetings	N

Annual reports/reviews	Y
Strategic plan	Y

http://www.nhsborders.scot.nhs.uk/badp

1.4 How many times did the ADP executive/ oversight group meet during 2019/20?
The ADP Board met 4 times (one joint meeting with Executive Group). The Executive Group met an additional 4 times.

2. Education and Prevention

2.1 In what format was information provided to the general public on local treatment and support services available within the ADP?
Please tick those that apply (please note that this question is in reference to the ADP and not individual services)

Leaflets/ take home information	Y
Posters	N
Website/ social media	Y
http://www.nhsborders.scot.nhs.uk/badp	
Accessible formats (e.g. in different languages) Please provide details…….	Available on demand
Other Please provide details…….	☐

2.2 Please provide details of any specific communications campaigns or activities carried out during 19/20 *(E.g. Count 14 / specific communication with people who alcohol / drugs and/or at risk)* (max 300 words).

Count 14 campaign: activities carried out included table top displays set up in both Borders General Hospital and Scottish Borders Council Headquarters. Plasma screens provided information in general public areas of hospital and also staff dining area. Promoted via twitter, facebook and a media release issued.

Additional press releases in relation to FASD and Dry January.

2.3 Please provide details on education and prevention measures/ services/ projects provided during the year 19/20 specifically around drugs and alcohol (max 300 words).

A new online package of resources was launched on 7th November 2019 for teachers across Scottish Borders School (Primary and Secondary) on drugs, alcohol and tobacco education and prevention. This partnership work was led by Education, Joint Health Improvement Team and ADP Support Team.

Alongside programme leads, a short life working group was established with partners from Primary and Secondary Schools, Crew and Police Scotland. The aim of the working group was to review current resources, develop and implement a robust evidenced based programme which will be delivered in a timely approach across all Scottish Borders schools.
Staff briefings were held across all clusters and high schools to introduce the new SUE (Substance Use Education) resource.

Oh Lila training was commissioned. The intention was to deliver this to staff from all early years providers. The schedule commenced in February, however, March sessions were not delivered due to COVID.

In addition the following workforce development opportunities were delivered: Drug Trends (Crew); CAPSM briefing (ADP partners); Introduction to Drugs and Alcohol Services (ADP commissioned services); ABI (Borders Addiction Service)

2.4 Was the ADP represented at the Alcohol Licensing Forum?

Yes X
No ☐

Please provide details (max 300 words)

The ADP Co-ordinator represents Public Health on the Local Licensing Forum. The Forum hosted a visit from AFS to review production of Licensing Boards' Annual Functions Reports, new policy statements, update on Licensing Act Guidance and review of LLF's. Our LLF noted that a national review of forums was required.

2.5 Do Public Health review and advise the Board on license applications?
All -
Most -
Some X
None -

Please provide details (max 300 words)
Borders ADP Support Team review all new licence and variations on behalf of Public Health.
Occasional licences which have a child/family element are brought to the attention of ADP Support Team by Licensing Standards Officer.

3. RRR Treatment and Recovery - Eight point plan

People access treatment and support – particularly those at most risk (where appropriate please refer to the Drug Deaths Taskforce publication Evidence-Based Strategies for Preventing Drug-Related Deaths in Scotland: priority 2, 3 and 4 when answering questions 3.1, 3.2, 3.3 and 3.4)

3.1 During 2019/20 was there an Immediate Response Pathway for Non-fatal Overdose in place?

Yes	-
No	-
In development	X

Please give details of developments (max 300 words)
A local protocol between SAS, NHS Borders Addiction Service and Accident and Emergency was put in place in 2019. However, this has not successfully resulted in sharing of details by SAS and further work is required to fully implement the pathway.
We have raised our local frustration at the lack of a national approach to this issue via the Drug Death Task Force and the ongoing delay to local implementation.

3.2 Please provide details on the process for rapid re-engagement in alcohol and/or drug services following a period of absence, particularly for those at risk 19/20 (max 300 words).
The ES Team will accept referrals from the core team in both BAS and Addaction(now We Are With You) (A/WAWY) for people who have missed appointment, pharmacy pick-ups or have not engaged since original referral. These referrals also will come from the Substance Liaison Service in the acute hospital. The ES Team will make additional attempts to engage with individuals via phone or face-to-face visits. The drop-in clinics have shown to be a helpful route to sustaining engagement.

3.3 What treatment or screening options were in place to address drug harms? *(mark all that apply)*

Same day prescribing of OST	Y
Methadone	Y
Buprenorphine and naloxone combined (Suboxone)	Y
Buprenorphine sublingual	Y
Buprenorphine depot	Y
Diamorphine	N
Other non-opioid based treatment options	N

Other:
Espranor buprenorphine oral; a small number people are on existing dihydrocodeine prescriptions on admission to service

3.4 What measures were introduced to improve access to alcohol and/or drug treatment and support services during the year, particularly for those at risk 19/20 (max 300 words).

A new Assertive Engagement Team (ES Team) was commissioned by the ADP with staff from both NHS and Third Sector to both improve access to service and support those in service. This is for both alcohol and drug clients.

The ES Team has worked alongside the Core Teams in both services to identify people who have dropped out or are at risk of dropping out of service and have also supported joint 'drop-in' clinics and the Eyemouth Hub to enable low threshold access to treatment services.

Drop-in attendance is available without appointments and, as well as treatment, people can access harm reduction advice, social space and food (donated by local businesses).

Borders Addiction Service (BAS) has developed same day access to medical staff and nurse prescribers on site at their premises and has successfully implemented same day prescribing where safe including for people accessing the drop-ins.

A/WAWY and BAS deliver a First Steps harm reduction group to support people currently unable to access structured treatment.

ES Team provide additional support (e.g. transport) for clients who are facing additional barriers to attendance as well as more holistic support such as access to welfare benefits advice, liaison with other services.

The Eyemouth Hub is funded through Scottish Government Challenge Funding.

3.5 What treatment or screening options were in place to address alcohol harms? *(mark all that apply)*	
Fibro scanning	N
Alcohol related cognitive screening (e.g. for ARBD)	Y
Community alcohol detox	Y
Inpatient alcohol detox	Y
Alcohol hospital liaison	Y
Access to alcohol medication (Antabuse, Acamprase etc.)	Y
Arrangements for the delivery of alcohol brief interventions in all priority settings	Y
Arrangements of the delivery of ABIs in non-priority settings	Y
Other	☐ Please provide details…….

People engage in effective high quality treatment and recovery services

3.6 Were Quality Assurance arrangements in place for the following services (examples could include review performance against targets/success indicators, clinical governance reviews, case file audits, review against delivery of the quality principles):

	Adult Services	*Children and Family Services*
Third sector	Y	Y
Public sector	Y	n/a
Other	n/a	n/a

3.6 Please give details on how services were Quality Assured including any external validation e.g. though care inspectorate or other organisations? (max 300 words)

- Third Sector Adult – ADP quarterly monitoring meetings are in place based on Service Specification. Service registered with Care Inspectorate – last inspection was in June 2018
- Third Sector Children and families – ADP quarterly monitoring meetings are in place based on Service Specification. Internal safeguarding audits on case-files are carried out quarterly by senior managers. This service is jointly commissioned with the local Children's Planning Partnership and performance is reviewed by the Commissioning Sub-Group which includes meeting with young people using the service.
- Public Sector Adult – ADP quarterly monitoring meetings are in place based on Service Specification.

Local and senior managers from all commissioned services attend quarterly Quality Principles meeting. During 2019-20 examples of work progressed by the group included staff training audit based on LPASS report and subsequent training plan.

Data and feedback from monitoring meetings is included in the quarterly ADP Performance Report which is presented to our ADP Board.

3.7 Were there pathways for people to access residential rehabilitation in your area in 2019/20?

Yes X

No

Please give details below (including referral and assessment process) (max 300 words)

BAS accept self referrals and referrals from colleagues such as GP's and Social Workers.
Medical assessment is undertaken by the Addictions Psychiatrist in BAS. Assessment is undertaken by a BAS Support Worker.

3.8 How many people started a residential rehab placement during 2019/20? (if possible, please provide a gender breakdown)
Two females.

People with lived and living experience will be involved in service design, development and delivery

3.9 Please indicate which of the following approaches services used to involve lived / living experience *(mark all that apply).*

For people with lived experience :

Feedback/ complaints process	Y
Questionnaires/ surveys	Y
Focus groups	Y
Lived/living experience group/ forum	N
Board Representation within services	N
Board Representation at ADP	N
Other	Staff recruitment

Please provide additional information (optional)
A/WAWY staff member, in partnership with Borders Recovery Community, supported a Recovery Planning group to plan logistics, fundraising and attendance at the Inverness Recovery Walk in 2019.

During 2019-20 the ADP convened two meetings to discuss how to develop lived experience (including family members) involvement in ADP planning. These meetings were positive but the most recent one was in February 2020 and this work has been paused since and only now does the timing feel right to recommence.

In addition focus groups were held with people with lived experience at service premises and Recovery Café to support development of the ADP Strategic Plan.

For family members:

Feedback/ complaints process	Y
Questionnaires/ surveys	Y
Focus groups	None specific
Lived/living experience group/ forum	N
Board Representation within services	N
Board Representation at ADP	N
Other	

Please provide additional information (optional)
Family members were included in all meetings outlined above.

3.10 Had the involvement of people with lived/ living experience, including that of family members, changed over the course of the 2019/20 financial year?

Improved	-
Stayed the same	X
Scaled back	-
No longer in place	-

Please give details of any changes (max 300 words)
While we have involved and listened to people in, for example, developing our strategy, feedback on services there is currently no formal structure for involvement of lived/living experience within the strategic planning processes for Borders ADP and this is a key priority for us to develop.
We are grateful for the contributions that people have made to date, for example, via focus groups and initial discussion meetings and their generosity of time, for example, presenting the Inverness Recovery Walk video to the ADP.

Within A/WAWY there has been greater involvement in feedback and planning.

3.11 Did services offer specific volunteering and employment opportunities for people with lived/ living experience in the delivery of alcohol and drug services?
Yes X
No -

Please give details below (max 300 words)
Volunteering opportunities are in place in A/WAWY including co-facilitation of groups.
All services take a positive approach to employing people with lived/living experience although there are no posts which are specified in this way.

People access interventions to reduce drug related harm

3.12 Which of these settings offered the following to the public during 2019/20? *(mark all that apply)*

Setting:	*Supply Naloxone*	*Hep C Testing*	*IEP Provision*	*Wound care*
Drug services Council	n/a	n/a	n/a	n/a
Drug Services NHS	Y	Y	Y	Y
Drug services 3rd Sector	Y	Y	Y	Y
Homelessness services	N	N	N	N
Peer-led initiatives	n/a	n/a	n/a	n/a
Community pharmacies	Y	N	Y	N
GPs	N	N	N	Y
A&E Departments	Y	N	N	Y
Women's support services	N	N	N	N
Family support services	N	N	N	N
Mental health services	N	N	N	N
Justice services	N	N	N	N
Mobile / outreach services	Y	Y	Y	Y
Other … *(please detail)*	☐	☐	☐	☐

We note that prior to Lord Advocate's letter it would not be possible to supply naloxone in many of these settings during 2019-20

A person-centred approach is developed

3.13 To what extent were Recovery Oriented Systems of Care (ROSC) embedded across services within the ADP area? ROSC is centred around recognising the needs of an individual's unique path to recovery. This places the focus on autonomy, choice and responsibility when considering treatment.

Fully embedded	-
Partially embedded	X
Not embedded	-

Please provide details (max 300 words)
Commissioned services in Borders take a proactive and innovative approach to delivering ROSC and have developed new initiatives and ways of working (e.g. Eyemouth Hub, drop-in clinics, Harm Reduction support and third sector referral into APTT).

Programme for Government funding allowed commissioning of services to address gaps identified by stakeholders: family support, recovery, assertive engagement. During consultation to develop the 2020-23 ADP Strategy Refresh people with lived experience fed back their experience of more joined up work between our services negating the need to 'tell our stories over and over again'.

Good relationships are in place and supported via the Children and Young People's Leadership Group, Community Justice Board and individual services supported by ADP members.

However, we have identified in our 2020-23 Strategy Refresh an ongoing need to ensure the wider system (e.g. wider services, stigma) supports our ROSC and we also need to improve our representation of lived experience.

3.14 Are there protocols in place between alcohol and drug services and mental health services to provide joined up support for people who experience these concurrent problems (dual diagnosis)?

Yes	-
No	X

Please provide details (max 300 words)
While there are no formal protocols in place it is the case that the Borders Addiction Service is housed within NHS Borders Mental Health directorate so there is ready opportunity for liaison. This liaison is enhanced by the fact that the Consultant in Addictions Psychiatry in BAS is also a member of the Community Mental Health Team. Likewise the BAS Operation Manager also has responsibility for the Mental Health Rehabilitation Service.

BAS hosts a small Addictions Psychology Therapies Team. Third sector alcohol and drugs services are able to directly refer into this team.

The recovery community achieves its potential

3.15 Were there active recovery communities in your area during the year 2019/20?

Yes	Y

3.16 Did the ADP undertake any activities to support the development, growth or expansion of a recovery community in your area?

Yes	Y

3.17 Please provide a short description of the recovery communities in your area during the year 2019/20 and how they have been supported (max 300 words)

SCRN and the Borders Recovery Community have delivered a fortnightly recovery café evenings in 2019-20 as well as being contactable for individuals via social media and telephones. The Committee have ambitious plans to extend their offer and have been successful in obtaining funding from a variety of sources.

The ADP Strategic Lead meets with the SRCN Lead/Chair to discuss plans and support, for example, printing or logistics costs.

SCRN hosted a series of conversation cafes in relation to the Hard Edges Report and co-hosted a very well attended Christmas Party in partnership with A/WAWY.

During 2019-20 a Recovery Engagement Worker Service was developed in A/WAWY which aimed to support development of both recovery opportunities and be an asset for the recovery community. A joint meeting between SRC, the Engagement Worker and SRCN Lead/Chair helped build agreement about how to work effectively in partnership – where appropriate – while recognising the potential tensions that could arise between the community and services.

A trauma-informed approach is developed

3.18 During 2019/20 have services adopted a trauma-informed approach?

All services	-
The majority of services	Y
Some services	-
No services	-

Please provide a summary of progress (max 300 words)
For some time now the Addiction Psychological Therapies Team (APTT) in BAS has accepted self-referrals from third sector agencies (A/WAWY and CHIMES) as well as from within BAS. This therapeutic work often addresses underlying trauma issues or the present-day impact of past trauma.

In addition to this direct trauma-based work, this was built on in 2019-20 where services undertook an audit based on the LPASS report which outlined training needs with regard to psychosocial interventions which promote engagement (Motivational Interview), build resilience and psychosocial strategies (Core Skills in CBT for Relapse Prevention) and which build trauma awareness. APTT supported development of a training plan to meet these needs to include trauma informed work, some of which is maintained through regular Core Skills coaching sessions provided by APTT. APTT also delivered a talk regarding trauma and addiction to the Freedom to Change event in October 2019 for family members affected by substances as well as the wider recovery community.
Whiles the examples above, as well as the establishment of the ES Team and locality hubs all help to embody trauma-informed principles such as choice, empowerment and collaboration we will be scoping more detailed work to fully assess how trauma informed our services currently are and to then design and deliver a plan which can enable services to systematically and consistently embed a trauma informed approach.

An intelligence-led approach future-proofs delivery

3.19 Which groups or structures were in place to inform surveillance and monitoring of alcohol and drug harms or deaths? *(mark all that apply)*

Alcohol harms group	N
Drug death review group	Y
Drug trend monitoring group	Y
Other	n/a

3.20 Please provide a summary of arrangements which were in place to carry out reviews on alcohol related deaths and how lessons learned are built into practice (max 300 words)

There are no formal arrangements to undertake alcohol related deaths specifically. However, any death in service (e.g. NHS or third sector) is subject to a significant death review and lessons learned applied to that service.

3.21 Please provide a summary of arrangements which were in place to carry out reviews on drug related deaths and how lessons learned are built into practice (max 300 words)

Borders Drug Death Review Group (DDRG) is in place to improve liaison between agencies in efforts to introduce interventions aimed at reducing drug-related deaths at local level.

The DDRG is a small closed group chaired by the Chief Social Work Officer that meets on a regular basis to share and analyse relevant information on all drug related deaths including those people not in treatment services.

The aim of the group is to reduce Drug Related Deaths (DRDs) by exploring the circumstances of a death once confirmed by pathology as a DRD in the Scottish Borders; to identify learning from the reviews and promote best practice; contribute to the National Drug-related Deaths Database (NDRDD) and; implement national and local drug strategies to reduce problem drug use.

Any implications for policy or practice are then taken back through members to their organisations for progression facilitated by an Outcomes Reporting template for each review. Where an individual has been a patient of NHS Borders at time of death or within 12 months of death the Outcomes Reporting template is sent to the Healthcare Governance Lead of the appropriate Clinical Board.

Separate Significant Adverse Event Reviews are also carried out by Borders Addictions Service where a client is in service at time of death with actions identified where appropriate. Membership of the DDRG group includes NHS, Police, Scottish Borders Council, Drug Services and ADP Support Team. An annual report is provided to Critical Services Oversight Group (Chief Officers from Police, NHS and Local Authority) to allow scrutiny of the process.

4. Getting it Right for Children, Young People and Families

4.1 Did you have specific treatment and support services for children and young people (under the age of 25) with alcohol and/or drugs problems?

Yes -
No X

Please give details (E.g. type of support offered and target age groups)
Children and young people, depending on their presentation and needs are supported through the Wellbeing for Resilience service (11-18) and A/WAWY and BAS accept referrals from aged 16.

4.2 Did you have specific treatment and support services for children and young people (under the age of 25) affected by alcohol and/or drug problems of a parent / carer or other adult?

Yes X
No -

Please give details (E.g. type of support offered and target age groups)
Chimes service offers support to children and young people(up to 18 years) impacted by another's alcohol and/or drug use. An initial home visit is undertaken as part of the assessment process. Children will work with a key worker for 1:1 support, however, the nature of the work often involves additional family members and work can therefore take place in small familial groups where appropriate.
As well as emotional support for resilience, children can also access group work including first aid and lifeskills.
The service will work with parents (or the substance using family member) to help understanding and mitigation of the impacts on the child including emotional and behavioural development. This can also include some work to support wider treatment goals e.g. relapse preventions.
The service also works with kinship carers to provide support and understanding.

4.3 Does the ADP feed into/ contribute toward the integrated children's service plan?

Yes X
No -

Please provide details on how priorities are reflected in children's service planning e.g. collaborating with the children's partnership or the child protection committee? (max 300 words)
The ADP Strategic Lead is a member of the local Children and Young People's Leadership Group and member of the Commissioning Sub-group.
The current Children and Young People's Integrated Services Plan has five key priorities and these are relevant to children and young people impacted by their own or others' substance use:
1. Keeping children and young people safe
2. Promoting the health and well-being of all children and young people and reducing health inequalities
3. Improving the well-being and life chances for our most vulnerable children and young people
4. Raising attainment and achievement for all learners
5. Increasing participation and engagement.

4.4 Did services for children and young people, with alcohol and/or drugs problems, change in the 2019/20 financial year?

Improved -
Stayed the same X
Scaled back -
No longer in place -

Please provide additional information (max 300 words)

The Wellbeing for Resilience has been in place for two years and continues to provide support to children and young people.

4.5 Did services for children and young people, affected by alcohol and/or drug problems of a parent / carer or other adult, change in the 2019/20 financial year?

Improved	X
Stayed the same	-
Scaled back	-
No longer in place	-

Please provide additional information (max 300 words)
Programme for Government funding allowed for commissioning of additional CAPSM Link Workers to work closely resource to work more closely with families with higher levels of need. The Link Workers provide a service to CAPSM children (up to age 18), parents, expectant mothers and (usually kinship) carers as well as raising awareness of the impact of alcohol and drug use on children and develop understanding of resilience and the protective factors that may help the children and the family with practitioners.
The Link Workers work closely with Children and Families Social Work Duty Team and Long Term service and takes a whole family approach. The caseload reflects more in-depth and complex issues around public protection (e.g. child protection, vulnerable young people, domestic violence, custody and housing issues).

4.6 Did the ADP have specific support services for adult family members?

Yes	-
No	X

Please provide details (max 300 words)
A/WAWY provides one to one and group support for impacted adult family members based on the Craft programme. The service also provides accommodation for a peer support group.

4.7 Did services for adult family members change in the 2019/20 financial year?

Improved	-
Stayed the same	X
Scaled back	-
No longer in place	-

Please provide additional information (max 300 words)
In 2019-20 the findings of a Families Needs Assessment were presented by SFAD to the ADP and then followed up by a Stakeholder Event to test the findings. The Stakeholder Event was positively received, improved networking and was enhanced by the contribution of people with lived experience.

Arising from one of the recommendations a 'Freedom to change' event was hosted by Galashiels Learning Community in partnership with SFAD, A/WAWY and Borders Recovery Community. This community event allowed people to come together to discuss the findings and how to generate a community based support and allowed people to make positive connections.

Following completion of the assessment additional learning opportunities were scheduled and will also be within the ADP Workforce Development calendar for 2020-21.

Although there was not an additional service commissioned in response to the needs assessment it was helpful in informing the ADP and services of the needs of families and addressing some areas where practice or knowledge might be improved.

4.8 Did the ADP area provide any of the following adult services to support family-inclusive practice? *(mark all that apply)*

Services:	*Family member in treatment*	*Family member not in treatment*
Advice	x	x
Mutual aid	x	x
Mentoring	☐	☐
Social Activities	☐	☐
Personal Development	☐	☐
Advocacy	☐	☐
Support for victims of gender based violence	☐	☐
Other *(Please detail below)*	☐	☐

Please provide additional information (max 300 words)
The Domestic Abuse Advocacy Service in Borders is provided by Scottish Borders Council.

5. A Public Health Approach to Justice

5.1 If you have a prison in your area, were arrangements in place and executed to ensure prisoners who are identified as at risk left prison with naloxone?

No prison in ADP area X

5.2 Has the ADP worked with community justice partners in the following ways? *(mark all that apply)*

Information sharing	X
Providing advice/ guidance	X
Coordinating activates	-
Joint funding of activities	-
Other	n/a

Please provide details (max 300 words)

The Justice Social Work Service supports the delivery of ABI. The service delivers ABI as part of the Induction process for individuals subject to unpaid work, in addition to screening when undertaking Criminal Justice Court Report interviews.

The Justice Social Work Service commissions a Drug Treatment and Testing Order service, delivered in partnership with BAS. Use of DTTO by the Court is relatively low and requires to be reviewed.

The services Group Manager sits on and contributes to the Drug Death Review Group.

The Manager participated in the Staying Alive in Scotland – Strategies event aimed at preventing drug related deaths on the borders in February 2020.

The Reconnect Women's programme is open to women across the borders. The CBT based work undertaken can be accessed on either a voluntary or court mandated bases. Drug and Alcohol support services have over the year, played a part in the sharing of keep safe and other support information to women as part of the programme delivery.

While the use of Diversion by the Procurator Fiscal Service is relatively low, opportunities to refer individuals to drug and alcohol support services are in place. This is a useful opportunity to engage and deliver Early Effective Intervention across Youth and Adult Justice, with an aim to address problematic substance use that is impacting negatively on decision making and behaviours avoiding remittance to the Court.

5.3 Has the ADP contributed toward community justice strategic plans (E.g. diversion from justice) in the following ways? *(mark all that apply)*

Information sharing	X
Providing advice/ guidance	X
Coordinating activates	X
Joint funding of activities	-
Other	N/A

Please provide details (max 300 words)

ADP Support Team is represented on the Community Justice Board. The Community Justice Manager is a member of the ADP. Information sharing includes supporting the production of the Justice Board's strategic assessment and associated plan.

ADP and Community Safety Manager contribute to the meetings of the East Arrest Referral Faculty. This is important for us as there is only one Custody Suite in Borders and people are often moved to other parts of the country with differing arrest referral providers operating in custody areas.

5.4 What pathways, protocols and arrangements were in place for individuals with alcohol and drug treatment needs at the following points in the criminal justice pathway? Please also include any support for families. (max 600 words)

a) Upon arrest
An Arrest Referral scheme has been developed over the Lothian and Borders area. ABI's are performed in the one Custody Suite in Borders.

b) Upon release from prison

Voluntary Throughcare

Pathways are in place between Justice Social Work Services and BAS and other third sector services including A/WAWY. The arrangements seek to ensure signposting and referrals are made timeously for those being released from custody following a short term custodial sentence. BAS are in a position to enable ready access to prescriptions including same day prescribing where appropriate.

Development work is ongoing and seeks to strengthen the links between, drug and alcohol services, Justice Social Work and Scottish Prisons, with an aim to increase the take up of services by those returning to the community.

Statutory Throughcare and Community Court disposals are well supported by alcohol and drug services, including BAS and A/WAWY. Referral pathways are well established. Engagement with services is often a court or parole mandated requirement for those presenting with drug and alcohol issues. Support services regularly feed into the statutory review process and inform case management plans.

6. Equalities

Please give details of any specific services or interventions which were undertaken during 2019/20 to support the following equalities groups:
6.1 Older people *(please note that C&YP is asked separately in section 4 above)* No specific intervention
6.2 People with physical disabilities No specific intervention
6.3 People with sensory impairments No specific intervention
6.4 People with learning difficulties / cognitive impairments No specific intervention
6.5 LGBTQ+ communities No specific intervention
6.6 Minority ethnic communities No specific intervention
6.7 Religious communities No specific intervention
6.8 Women and girls (including pregnancy and maternity) ABI's are delivered by midwives in antenatal settings and by health visitors. CHIMES can provide support to pregnant women. Two Foetal Alcohol Syndrome training sessions were delivered with 40 participants attending.

II. FINANCIAL FRAMEWORK 2019/20

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

A) Total Income from all sources

Funding Source (If a breakdown is not possible please show as a total)	£
Scottish Government funding via NHS Board baseline allocation to Integration Authority	1,049,582
2019/20 Programme for Government Funding	58,400
Additional funding from Integration Authority	0
Funding from Local Authority	205,833
Funding from NHS Board	658,184
Total funding from other sources not detailed above	31,000
Carry forwards	341,000
Other	0
Total	2,343,999

B) Total Expenditure from sources

	£
Prevention including educational inputs, licensing objectives, Alcohol Brief Interventions	40,875
Community based treatment and recovery services for adults	1,749,128
Inpatient detox services	Note[1]
Residential rehabilitation services	20,507
Recovery community initiatives	1,000
Advocacy Services	5,000
Services for families affected by alcohol and drug use	Note[2]
Alcohol and drug services specifically for children and young people – Chimes	251,341
Community treatment and support services specifically for people in the justice system	48,636
Other	177,050
Total	2,293,537

[1]It is not possible to disaggregate the spend on inpatient detox from overall mental health spend
[2] Our children and families service works with adult family members e.g. kinship carers, WAWY provides 1:1 and facilitated group support to family members. It is not possible to disaggregate this from the wider overall contract.

Plans for carry forward:

- Fixed term additional psychology hours
- Upgrade prescribing database
- Workforce development – training from SDF, Crew
- Logistics support to Recovery Community
- ABI LES

7.1 Are all investments against the following streams agreed in partnership through ADPs with approval from IJBs? *(please refer to your funding letter dated 29th May 2020)*

- Scottish Government funding via NHS Board baseline allocation to Integration Authority
- 2019/20 Programme for Government Funding

Yes X
No -
Please provide details (max 300 words)
The IJB delegates authority for spend to the ADP for the baseline allocation.
2019-20 Programme for Government Funding was agreed by IJB in February 2019.

7.2 Are all investments in alcohol and drug services (as summarised in Table A) invested in partnership through ADPs with approval from IJBs/ Children's Partnership / Community Justice Partnerships as required?

Yes X
No -

Please provide details (max 300 words)
Children's Service is a joint commission with our local Partnership (Children and Young People's Leadership Group).
Development of the current suite of adult services was undertaken following an Investment Review process which was approved by ADP and NHS Borders,