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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, 21st September, 2022** at **10.00 am** in Via Microsoft Teams

AGENDA

Time	No		Lead	Paper
10.00	**1**	**ANNOUNCEMENTS & APOLOGIES**	Chair	*Verbal*
10.02	**2**	**DECLARATIONS OF INTEREST** *Members should declare any financial and non financial interests they have in the items of business for consideration, identifying the relevant agenda item and the nature of their interest.*	Chair	*Verbal*
10.05	**3**	**MINUTES OF PREVIOUS MEETING** 17.08.22 Extraordinary	Chair	*Attached*
10.10	**4**	**MATTERS ARISING** Action Tracker.	Chair	*Attached*
10.15	**5**	**APPROVED BY STRATEGIC PLANNING GROUP: FOR IJB DECISION**		
	5.1	Direction: Developing a Hospital at Home Service	General Manager P&CS	*Appendix-2022-23*
	5.2	Direction: Scottish Borders Homecare Reablement Approach	Head of Operations, Sb Cares and Associate Director of AHPs	*Appendix-2022-24*
	5.3	Direction: Review of Palliative Care Services across the Scottish Borders	Chief Nurse, HSCP	*Appendix-2022-25*

	5.4	Direction Update: Care Village Development - Hawick Outline Business Case Initial Assessment	Director of Strategic Commissioning and Partnerships	*Appendix-2022-26*
11.00	**6**	**FOR IJB DECISION**		
	6.1	Direction: Primary Care Improvement Plan	Chief Financial Officer	*Appendix-2022-27*
	6.2	Alcohol and Drugs Partnership (ADP) Self-Assessment	Head of Health Improvement & Strategic Lead	*Appendix-2022-28*
	6.3	Appointment of Selection Committee for External Member IJB Audit Committee	Chief Internal Auditor	*Appendix-2022-28*
	6.4	IJB Meeting Dates and Business Cycle 2023	Board Secretary	*Appendix-2022-30*
11.40	**7**	**FOR NOTING**		
	7.1	Monitoring of the Health & Social Care Partnership Budget	Chief Financial Officer	*Appendix 2022-31*
	7.2	Quarterly Performance Report	Chief Officer	*Appendix-2022-32*
	7.3	Strategic Planning Group Minutes: 04.05.22	Board Secretary	*Appendix-2022-33*
11.55	**8**	**ANY OTHER BUSINESS**	Chair	
12.00	**9**	**DATE AND TIME OF NEXT MEETING** IJB Development session: Wednesday 26 October 2022 10am to 12noon In person IJB: Wednesday 16 November 2022 10am to 12noon In person	Chair	*Verbal*

Minutes of an extraordinary meeting of the **Scottish Borders Health & Social Care Integration Joint Board held** on **Wednesday 17 August 2022** at 9**am** via Microsoft Teams

Present:

(v) Cllr D Parker (Chair)
(v) Cllr T Weatherston
(v) Cllr E Thornton-Nicol
(v) Cllr J Cox
(v) Mrs L O'Leary, Non Executive
(v) Mrs K Hamilton, Non Executive
(v) Mr T Taylor, Non Executive
(v) Mr J McLaren, Non Executive
Mr C Myers, Chief Officer
Dr K Buchan GP
Ms L Gallacher, Borders Carers Centre
Ms G Russell, Partnership Representative NHS
Mr D Bell, Staff Side SBC
Mr N Istephan, Chief Executive Eildon Housing
Mrs S Horan, Director of Nursing, Midwifery & AHPs
Ms L Jackson, LGBTQ+

In Attendance:

Miss I Bishop, Board Secretary
Mrs J Stacey, Internal Auditor
Mr D Robertson, Acting Chief Executive, SBC
Mr R Roberts, Chief Executive, NHS Borders
Mrs H Robertson, Chief Financial Officer
Mrs C Oliver, Head of Communications & Engagement, NHS Borders
Ms S Flower, Chief Nurse Health & Social Care Partnership
Mrs C Wilson, General Manager P&CS
Dr C Cochrane, Director of Psychological Services and Head of Psychology Speciality
Mr S Burt, General Manager, Mental Health & Learning Disability Services
Ms M Struthers, GP Practice Pharmacist, NHS Borders
Mrs N MacDonald, Vaccination Programme Manager, NHS Borders
Ms K Slater, Scottish Borders Council
Ms C Veitch, Scottish Borders Council
Mrs J Holland, Director of Stategic Commissioning & Partnerships
Mrs L Jones, Director of Quality & Improvement, NHS Borders
Ms H Jacks, Planning & Performance Officer, NHS Borders
Mr A Medley, Scottish Borders Council
Mrs K Steward, Clinical Lead CTAC, NHS Borders

1. APOLOGIES AND ANNOUNCEMENTS

1.1 Apologies had been received from Cllr Robin Tatler, Mrs Harriet Campbell, Non Executive, Ms Juliana Amaral, BAVs, Dr Lynn McCallum, Medical Director, Mr Andrew Bone, Director of Finance, NHS Borders and Mrs Jenny Smith, Borders Care Voice

1.2 The Chair welcomed Mrs Hazel Robertson to her first meeting of the Integration Joint Board (IJB) in her official capacity as Chief Financial Officer of the IJB.

1.3 The Chair to welcomed a range of attendees to the meeting.

1.4 The Chair confirmed the meeting was quorate.

2. DECLARATIONS OF INTEREST

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

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted there were no declarations.

3. MINUTES OF THE PREVIOUS MEETING

3.1 The minutes of the previous meeting of the Health & Social Care Integration Joint Board held on 15 June 2022 were approved.

4. MATTERS ARISING

4.1 **Action 2021-6:** Mr Myers confirmed that the action remained on-going.

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

5. RESOURCING OF PRIMARY CARE IMPROVEMENT PLAN AND OF THE PRIMARY CARE MENTAL HEALTH AND WELLBEING FUND FROM 2023/24 ONWARDS

5.1 Mrs Cathy Wilson provided an overview of the content of the paper and highlighted several key elements including: work on skill mix; scrutiny of workforce to validate the workforce required; £200k savings achieved; future funding envelope insufficient for the development of Memorandum of Understanding (MoU) 2; and recurring funding required to TUPE staff from GP Practices.

5.2 Mr Hazel Robertson elaborated on the content of the allocation letter and its implications for the IJB. She advised that the IJB would be required to ensure it fully spent any carry forward balances within its reserves. Then 70% of the allocation would be released to the IJB with the remaining 30% held in abeyance. She further advised that the funding envelope did not give certainty for the next year, but gave some indication of an overall direction of travel.

5.3 Dr Kevin Buchan commented that the organisation was in a reasonably good position as it had continued to work on elements of the PCIP through the COVID-19 Pandemic. He advised that the consequences of not delivering the contract were huge and suggested that there would be significant difficulties with GP Practices in the Borders being unable to provide their normal high level of care.

Page 2 of 5

5.4 Mrs Kathy Steward commented that as the clinical lead for CTAC, explained that there were lots of dependences in the project and in terms of timescales they were already part way through the organisational change process with current staff, vacancies would require to be recruited to as well as the TUPE of staff. There would be pressures to deliver CTAC by the end of March, however she suggested the IJB should consider the risks of non delivery.

5.5 Discussion focused on: what was the level resource predicted on a recurrent basis from April 2023; what was the acceptable level of risk given a lack of available funding; supported the direction of travel; Scottish Government had responsibility for financially resourcing the PCIP; escalation of the overall position to the Scottish Government to make them aware of the implications of non delivery of MoU 2; assurance to NHS Borders that the IJB will commission what it has funds to commission to ensure it does not operate an overspend position; sustainability payments; position of ring fenced reserves; any direction should clearly set out the risks and assumptions made by the IJB; and pursue a more robust approach with the Scottish Government on future funding.

5.6 Cllr David Parker commented that non recurrent resources should not be used to TUPE staff and clarification of the financial situation was required.

5.7 Mr John McLaren enquired about the level of engagement that had taken place with the Scottish Government.

5.8 Mr Tris Taylor expressed concern that the IJB did not have clarity on the financial risk and that the operational risks required to be summarised.

5.9 In terms of the financial risk, Mr Chris Myers advised that he had written to the Director of Primary Care at the Scottish Government and outlined the situation and advised that there was a risk that the MoU 2 would not be delivered. He had emphasised that the contract was clear that the financial responsibility for resourcing the contract sat with the Scottish Government.

5.10 Mr Myers suggest the Chief Financial Officer work with the NHS Borders Director of Finance and the PCIP to draw up a reserves plan and to issue a direction to NHS Borders whilst being clear that the direction would not ask NHS Borders to go beyond the funding made available for delivery.

5.11 Dr Buchan commented that he had raised the matter with the BMA and the Scottish Government Practitioners Committee. He spoke of the Action 15 monies that had always been directed to primary care and the disparity of treating GPs differently to other services in health care.

5.12 The Chair suggested that as a result of the conversation the IJB required Mr Myers and colleagues to develop a paper to clarify what needed to happen over the following 4 weeks to be able to meet the 16 September 2022 deadline and to understand the deployment of reserves and other funding streams in the short term as well as finance, workforce and other risks in moving forward. She further clarified that the paper should look at how to deliver what was currently planned to be done as safely and prudently

as possible. She suggested that the paper could be circulated virtually for the IJB to consider.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the progress made since the last Integration Joint Board.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the risks to non-delivery of the GMS Contract, GP sustainability, workforce, and mental health and wellbeing services.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that the local financial position had been escalated to the Scottish Government Primary Care Directorate, and that the Scottish Government had subsequently issued a national allocation letter and the process to be followed.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that the funding for the Mental Health and Wellbeing in Primary Care Services plan reviewed at the Integration Joint Board in June 2022 had not been released and the plan had not been signed off by Scottish Government.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that discussions would occur with the Scottish Government about the use of the Mental Health and Wellbeing in Primary Care fund to inform a future paper for the Integration Joint Board.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed that a further paper be worked up and shared with the IJB for consideration.

6. National Care Service consultation response

6.1 Mr Chris Myers provided background information to the item and the engagement process that had been followed in order to develop the response. He spoke of the content of the response and suggested that for co-terminous areas and remote and rural areas it could have a significant impact on the delivery of services that were currently operating. The response noted that that Feeley Review had put people at the centre of their care, however the Bill was focused on structures and did not elude to what it could do for people.

6.2 The Chair noted that there were 3 separate responses formulated which would be discussed and submitted from the IJB, Scottish Borders Council and NHS Borders. She suggested the option of a pathfinder would be the opportunity to formulate something that would fit with the uniqueness of the Scottish Borders rather than having something imposed that may not meet the needs of the Scottish Borders.

6.3 Mr John McLaren commented that he was concerned that being a pathfinder would add further pressure and stress onto an already fragile workforce.

Page 4 of 5

6.4 Mr David Bell echoed Mr McLaren's comments and reminded the Board that the organisations all struggled to retain staff and further pressure on staff could potentially exacerbate that position further.

Further discussion focused on the pros and cons of being a pathfinder.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** considered the response developed.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** did not provide any further comments.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the response for submission to the Scottish Parliament's 'Call for Views' and 'Your Priorities' consultations.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed (by a majority at the meeting) to the principle of progressing discussions with the Scottish Borders Council, NHS Borders and Scottish Government to explore the potential for a local pathfinder to support the development of the Bill.

7. DATE AND TIME OF NEXT MEETING

7.1 The Chair confirmed that the next meeting of the Scottish Borders Health & Social Care Integration Joint Board would be held on Wednesday 21 September 2022, from 10am to 12noon, via Microsoft Teams.

Signature: ……
Chair

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SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD

ACTION TRACKER

Scottish Borders Health and Social Care PARTNERSHIP

Meeting held 15 December 2021

Agenda Item: Day Services Petition and Future Provision

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
2021 - 6	10	The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** sought a timeline for the work to be taken forward.	Stuart Easingwood	April 2022	**In Progress:** Work to define the Carers Needs Assessment has commenced with the IJB Carers Workstream. The needs assessment and planning will be incorporated into the updated IJB Strategic Commissioning Plan, however an update on day services will be provided in advance of the conclusion to the development of the full Strategic Commissioning Plan. **Update 15.06.22:** Needs assessment questionnaire went out to unpaid carers on 06.06.22	G

Meeting held 17 August 2022

Agenda Item: Resourcing of Primary Care Improvement Plan and of the Primary Care Mental Health and Wellbeing Fund from 2023/24 onwards

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
2022 - 3	5	The **SCOTTISH BORDERS HEALTH & SOCIAL CARE**	Chris Myers			

		INTEGRATION JOINT BOARD agreed that a further paper be worked up and shared with the IJB for consideration.				

KEY:	
Grayscale = complete:	
R	Overdue / timescale TBA
A	Over 2 weeks to timescale
G	Within 2 weeks to timescale

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 21 September 2022

Report By:	Dr Patricia Cantley – Consultant Geriatrician Cathy Wilson – General Manager (P&CS) Susannah Flower – Chief Nurse HSCP Dr Tim Young – Associate Medical Director (P&CS) Bhav Joshi – General Manager (Unscheduled Care)
Contact:	Cathy Wilson, General Manager, Primary and Community Services
Telephone:	MS Teams cathy.wilson@borders.scot.nhs.uk
DEVELOPING A HOSPITAL AT HOME SERVICE	
Purpose of Report:	The Scottish Borders Health and Social Care Integration Joint Board is asked to: • Consider the requirement to scope and develop a business case for a Hospital at Home service • Direct NHS Borders to scope and develop a business case on the development of a Hospital at Home (H@H) model in Scottish Borders as a transformation initiative in line with the 2022/23 IJB Commissioning Plan; and • Note that a bid for non-recurrent funding has been made to the Scottish Government
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) Agree that the Scottish Borders should explore the option of developing a Hospital at Home service locally; b) Approve the further exploration of this model which includes working with Healthcare Improvement Scotland – recognising their extensive experience in this field in both urban and rural areas; and, c) Direct NHS Borders to scope and develop a business case on the development of a Hospital at Home (H@H) model in Scottish Borders as a transformation initiative in line with the 2022/23 IJB Commissioning Plan; and
Personnel:	There are significant workforce implications in the development of this service. The main staff group affected is likely to be nursing. A proposal to develop a Hospital at Home service is likely to appeal to a wide range of staff, leaving a risk that other areas across both Primary and Secondary Care would be left short staffed at a time when they are already struggling. In addition, due to recruitment difficulties in this sector, any offer of employment even for a small test of change would likely require permanent funding. Fixed-term contracts resulting from non-recurring funding would significantly increase the risk of non-delivery.

	Proven research with Hospital at Home models demonstrate that successful models include an integrated approach with health and social care teams. As such, Hospital at Home should not be developed in isolation within a singular service but requires the interface with multi-agencies. On a more positive note, a new service would offer substantial opportunities for career development and enhance retention of staff within the region.
Carers:	At least in the first instance, there would be no significant impact on carers, as the potential patients would usually have their care needs already met by existing arrangements. As the service expanded in future, the availability of short term care would enhance the service but would not be required in the first wave of development. Nevertheless, as with any service proposal, engagement with the IJB Carers Workstream will be undertaken, to ensure that the views of unpaid carers are adequately considered as part of the development of a Hospital at Home model.
Equalities:	Hospital at Home is a service which empowers patients and assists in reversing the power imbalance often seen in healthcare settings as the patient is in their own home and has greater autonomy in their care. An IIA would form part of the initial scoping exercise and would be presented to the IJB with a completed Business Case.
Financial:	The Scottish Government is offering financial resource to “pump prime” developing services, but longer term, the service would require recurring funding. Purchase of equipment and set up costs would be covered. There is uncertainty on long-term financial funding which would require the organisation to have long-term strategies and operational budgets to ensure that service could be sustained after initial funding had come to an end.
Legal:	There are no specific legal implications at this stage, however the “virtual ward” would run on a similar legal basis to the “real” hospital wards.
Risk Implications:	• An unclear governance structure could lead to a lack responsibility and accountability for the development of the Hospital at Home service • Workforce risks are described above. • Financial risks are also described above. • NHS Borders may not be able to enable the IT infrastructure to support Hospital at Home • Insufficient public buy-in leading to poor understanding, uptake and participation into the service.

	• Insufficient project support compromising timely delivery of Hospital at Home • Reputational damage - there are risks associated with not pursuing what is now becoming viewed as a standard way of delivering care
Direction required:	Yes

Situation:

The IJB 2021/22 annual report commissioning plan for 2022/23 considered our performance against the National Health and Wellbeing Outcomes.

The report noted that in the context of our benchmarked latest performance against the National Health and Wellbeing Outcomes, that consideration should be put to the development of a Hospital at Home service. This was specifically due to our performance in these areas:

- Fewer adults who were supported at home agreed that they are supported to live as independently as possible
- Fewer adults supported at home than the national average agreed that their services and support had an impact on improving or maintaining their quality of life
- Fewer adults supported at home agreed they felt safe
- A lower proportion of people in their last 6 months of life spent this at home or in a community setting in the Scottish Borders, compared to the national average
- There were a lower rate of adults with intensive care needs in the Scottish Borders receiving care at home, compared to the national average

In addition, the Scottish Government invited bids for resource from Health and Social Care Partnerships (HSCP) wishing to develop a Hospital at Home service, with a tight timescale of 1st September.

Background:

In recent years, HSCPs have been considering new ways to respond to the acute care needs of older people with frailty and other long-term conditions. Urgent care is needed but hospitals bring risks for older people as well as benefits, and community-based alternatives are increasingly being explored. This has resulted in a shift in focus within national healthcare and internationally towards providing hospital-level care in a person's home environment.

This service is generally referred to as "Hospital at Home" and is a short term intervention providing acute care of a level comparable with that provided in a conventional hospital. It is not the same as case management of chronic conditions but can work with this type of service to assist in the management of exacerbations of those conditions.

Across Scotland, HSCPs have developed this service to provide care in this form. The care is recognised to be safe and cost effective, and popular with patients and staff. It can provide an alternative to admission for selected patients and (once scaled up) can reduce some pressure on acute services, though only in some areas has it been shown to facilitate closure of inpatient beds.

The Scottish Government are very supportive of this form of care delivery and are providing some non-recurrent financial resource to assist HSCPs in developing their services in this direction.

The Integration Joint Board's 2021/22 Annual report and Commissioning plan for 2022/23 notes that the scoping of the Hospital at Home model should be undertaken. In line with this, the HSCP's Primary and Community Services team contacted the IJB Chief Officer to ask for advice on whether to submit a bid as an IJB would not be held in advance of the deadline date. The Chief Officer noted his support, on the conditions that it was made clear in the case that the decision on whether to scope the service had not yet been provided by the Integration Joint Board, and that further scoping was required in order to assist the development of a robust case to assist the IJB in taking a decision on whether to commit funds to the service. The Chief Officer asked that the case be taken via the usual route of the Strategic Planning Group for consideration in the first instance, and then to the Integration Joint Board to support the commissioning of scoping process for a business case.

Assessment:

Scottish Borders is one of the few remaining HSCP without a Hospital at Home service. Dumfries and Galloway, Highland, Angus and Shetland are the other areas without a service, though the team at Healthcare Improvement Scotland are working with these teams to help them develop modified versions of the classic model to fit with their more rural environments.

In-patient services within the Scottish Borders are under great pressure and it is becoming imperative to look at alternative models of care rather than the classic inpatient experience. Hospital at Home is widely perceived to result in less deconditioning of patients than conventional care, and in time would be hoped to mitigate the rising care needs of a frail population.

The Scottish Borders is divided into five localities, and a great deal of work is going on to develop new options for the deteriorating older person in their own home, or close to their home. Multidisciplinary teams are being developed in the localities, and the option of a Hospital at Home service would be a welcome addition to those services.

Although ripe for development in some ways, there are barriers to providing this form of care in the Borders. e.g. staffing issues, and the relationship between Primary and Secondary Care.

Where Hospital at Home has been established, patients are treated as though they were in the "real" hospital, having hospital level priority for inpatient investigations and using secondary care protocols and treatments. At the end of their admission, a discharge letter (SMR01) is generated in the same manner as in a physical hospital.

The current IT systems in the Borders are not well set up for this, and there is not currently widespread use of the Electronic Patient Record which would be a key component of a Hospital at Home service.

From a patient safety perspective, the same Clinical and Care Governance arrangements should apply for patients receiving care as they would receive in a conventional ward.

Developing a full Hospital at Home service would likely take a long time (2-5 years), but every journey must start with the first step. The IJB is invited to consider whether they are ready to take those first steps towards developing such a service.

From a feasibility perspective, it is expected that the service should start small and expand piloted initially in a locality. The locality chosen is Eildon, as this area covers the highest density population, and does not have a community hospital. If starting small, covering a wide area from the start would be impracticable.

In addition to the wider considerations listed in the summary, IJB Strategic Planning Group members were invited to also consider the following:

1. Whether, in principle, members wish to develop a Hospital at Home service in some form.

2. Whether members support the approach that full exploration of this kind of model care is required prior to committing to the new model. There are well established models already in place across Scotland, but the detail of how this would apply to the Borders would require significant project management to scope out what was possible and then execute the relevant changes.

The Strategic Planning Group supported both of these considerations.

Recommendations:

The Scottish Borders Health and Social Care Integration Joint Board is asked to:

- Direct NHS Borders to scope and develop a business case on the development of a Hospital at Home (H@H) model in Scottish Borders as a transformation initiative in line with the 2022/23 IJB Commissioning Plan; and
- Note that a bid for non-recurrent funding has been made to the Scottish Government

DIRECTION FROM THE SCOTTISH BORDERS INTEGRATION JOINT BOARD Direction issued under S26-28 of the Public Bodies (Joint Working) (Scotland) Act 2014	
Reference number	SBIJB-21-09-22-01
Direction title	To develop a business case based on the scoping of a Hospital at Home for Frailty and General Medicine patients
Direction to	NHS Borders
IJB Approval date	TBC – IJB to meet on 21 September 2022
Does this Direction supersede, revise or revoke a previous Direction?	No
Services/functions covered by this Direction	General Medicine, Medicine of the Elderly Services, Community Health services
Full text of the Direction	The IJB directs NHS Borders to scope the development of a Hospital at Home service for Frailty and General Medicine patients as a transformation programme. This model should be based on our local need and context but broadly follow the national approaches evidenced by iHub and the British Geriatrics Society. This process will involve: • Bidding for funding from the Scottish Government • Scoping a service model that meets needs, is safe, person-centred and sustainable, is clear on its scope, has potential for further development and is scalable. In addition, it is expected that this service will provide seamless care to patients across different health and social care services • It is expected that the use of Technology Enabled Care will be considered as part of this model • Developing a case to come back to the IJB, based upon £300,000 non-recurrent funding (from funding that the Scottish Government has allocated to invest into MDTs which clearly evidence increased 'hospital unscheduled care flow') • This case must be clear on the benefits and outcomes sought (patient and service outcomes, National Health and Wellbeing Outcomes), staffing models and the level of potential for financial savings • Equalities, Human Rights, and Fairer Scotland duties must be complied with • There must be appropriate consultation with communities (including service users, staff, partners and unpaid carers) • This process will be discussed at GP Subcommittee, the Area Medical Committee, the IJB Unpaid Carers workstream, the IJB Equality and Human Rights Reference Group and the IJB Strategic Planning Group
Timeframes	To conclude by: Consideration of a case should return to the IJB in March, having first been considered by all relevant stakeholder groups including the SPG
Links to relevant SBIJB report(s)	21 September 2022 Health and Social Care Integration Joint Board: Hospital at Home

Budget / finances allocated to carry out the detail	There is £319k recurrently remaining from Scottish Government Multi-Disciplinary Team funds that we are required to invest into initiatives that are evidenced to support improved patient flow out of the hospitals. From this, a *non-recurrent* budget of £300k per annum has been earmarked by the IJB for the development of the service. If needed, some of this funding may be used on a non-recurrent basis for planning, project management or staff backfill costs to develop the case and implement the plan, pending agreement with the IJB Chief Financial Officer. Allocation of the broader envelope of funding will only occur should the business case be approved. It is expected that this will be a service and financial transformation programme, leading to improved outcomes, and reduced financial and staffing resource across the partnership.
Outcomes / Performance Measures	Opportunity cost information on the staffing and financial model compared to the status quo is expected from the business case. In addition, the IIA, staffing model, use of technology enabled care, transformation project plan, proposed service specification and expected capacity should be included. The following improvements in the National Health and Wellbeing outcomes are sought from the business case: • The percentage of adults with intensive care needs at home • Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated • Percentage of adults supported at home who agreed that they are supported to live as independently as possible; • Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life; • Percentage of adults supported at home who agreed they felt safe; and • The percentage of carers supported to continue in their caring role At a later stage, should the business case be supported then capture of the following minimum performance dataset is required: • Service user surveys against the National Health and Wellbeing outcomes listed above • Number of patients referred per month • Proportion admitted of total referrals • Number of patients managed at home • Length of stay • Anticipated hospital bed days saved • Mortality during admission • 30 day outcomes (death, readmissions) • Onward referrals to other statutory and partner health and social care services (broken down and grouped by service)
Date Direction will be reviewed	As the business case will be reviewed at the next Integration Joint Board, formal compliance with this Direction will not be reviewed by the IJB Audit Committee but in the next Strategic Planning Group prior to the next IJB.

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Scottish Borders Health & Social Care Strategic Planning Group

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 21 September 2022

Report By:	Julie Glen/Paul Williams
Contact:	Julie Glen
Telephone:	07899309537
SCOTTISH BORDERS HOMECARE REABLEMENT APPROACH	
Purpose of Report:	To provide an update on the use of the Reablement Approach by the Scottish Borders H&SCP.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: • Note the Reablement work by NHS Borders and SBCares that is already underway and the benefits of this approach • Agree that a further business case will be submitted for discussion following the completion of the Reablement Pathfinder, its subsequent evaluation and discussions on a future Borders wide operating model. • Agree to the progression of the scoping of one integrated SB Cares / Home First service • Agree to a future proposal being submitted later in the year with an outline approach for an Integrated Reablement Service with SB Cares and Home First.
Personnel:	A future Integrated Reablement Service would impact the staff within the Current Home First Team, the OT's within H&SC teams and SB Cares Home Care Support Workers. Careful consideration will require to be given to the proposed integrated structure and will require to involve HR teams from both NHSB and SBC. In addition, this will be considered at the Joint Staff Forum.
Carers:	Unpaid Carers can play a key role in the Reablement approach so will be included in any future service development discussions. The IJB carers workstream will be engaged.
Equalities:	An Equalities Impact Assessment has been completed for the Reablement South pathfinder project, but a further EIA will be required for a potential future Integrated Reablement approach. Integrated Impact Assessment Form - Re
Financial:	SBCares and Home First have financial efficiencies which will need to be considered when developing a future Reablement approach.

Legal:	Any future integrated service provision will require to fit with relevant legislative commitments across the HSCP.
Risk Implications:	There is the risk of delays to an integrated service due to grading differences in staff roles in NHSB and SB Cares. This may also result in staff unease. A full risk assessment will be provided as the Integrated Service discussions progress.

1. Situation

1.1 The Integration Joint Board's Strategic Implementation Plan committed to to fully embedding transitional care / home based intermediate care as a model, and to develop a re-ablement approach for care at home service users.

1.2 Home First currently provide an Allied Health Professional (AHP) led Reablement service. When this service was originally commissioned by the Integration Joint Board, it was noted and expected that this would provide an integrated hospital at home and reablement Discharge to Assess service. Due to recruitment issues at the time in social care, this did not progress and so a Hospital to Home reablement service was developed that did not provide Discharge to Assess as standard for all patients.

1.3 SBCares have commenced an 8 week Reablement Pathfinder in the Teviot area. The evaluation of which will be available at the end of October 2022.

1.4 Both services seek to deliver on the aims from the IJB Strategic Implementation Plan (2018-22) as well as the National Health and Wellbeing Outcomes.

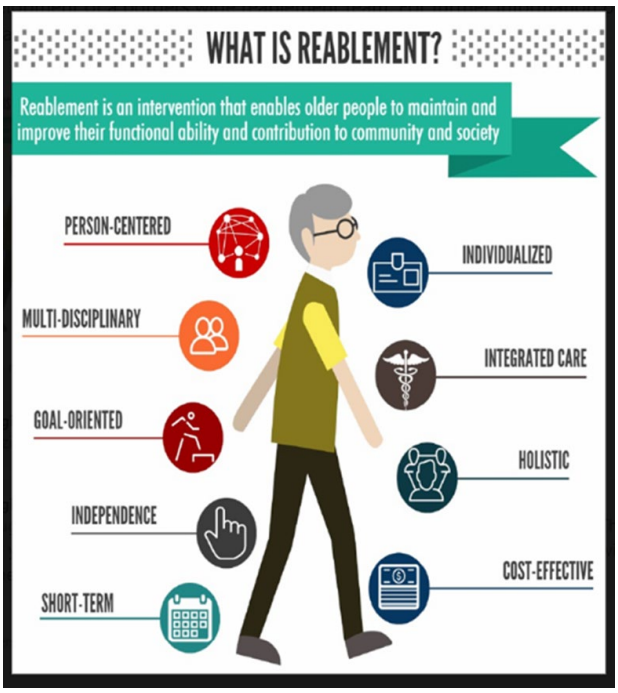
1.5 There is a desire to look at the potential for an Integrated Reablement team following the review of the Reablement Pathfinder evaluation. A future Integrated Team would provide Reablement services across the Borders, 7 days a week. The focus would not only be on hospital discharge patients, but would also focus on those in the community that may need a small package of care or some support to prevent admission.

1.6 Both Home First and SBCares have financial efficiencies that need to be met, so any future model will delivered in a financial sustainable way.

2 Background

2.1. Reablement is short term or time limited support that helps a person to adapt to changed circumstances, such as functional loss after an illness or accident, or to regain confidence and capacity to return to their previous level of activity, enabling them to do things for themselves, rather than having things done for them. It involves a process of identifying a person's own strengths and abilities by focusing on what they can safely do instead of what they cannot do anymore.

2.2. Reablement aims to assist people to maximise their independence



2.3. Research on Reablement by De Monteford University on the benefits of homecare Reablement and reported the following results at first review:

Package required at first review	Reablement service	Control Group (i.e. with no Reablement)
Discontinued	58%	5%
Reduced	17%	13%
Unchanged	17%	71%
Increased	8%	11%
	100%	100%

2.4. This approach fits with the 9 National Health and Wellbeing Outcomes.

Outcome	Comment
1. People are able to look after and improve their own health and wellbeing and live in good health for longer.	Reablement promotes independence and allows people to remain in their own homes.
2. People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.	As above.
3. People who use health and social care services have positive experiences of those services, and have their dignity respected.	The Reablement approach promotes independence giving people more choice and control over their support.

4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	A reabling approach enabling physical and social independence are inextricably linked to perceived quality of life. Quality of life will be measured at each stage of the Reablement South Pathfinder.
5. Health and social care services contribute to reducing health inequalities.	The Reablement service will be available to all that are deemed to be able to participate.
6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.	Providing education and support to unpaid carers is a fundamental component of the Reablement approach.
7. People who use health and social care services are safe from harm.	Service user safety remains paramount throughout the Pathfinder project. Daily meetings will ensure any concerns are raised and dealt with.
8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	Reablement training has been provided and support throughout the project will be provided by the OT leads. Staff motivation and job satisfaction will be measured before and after the Pathfinder and reported in the evaluation. Evidence from other areas suggests that staff motivation and satisfaction will improve as a result of working using a Reablement approach.
9. Resources are used effectively and efficiently in the provision of health and social care services	The short term investment in Reablement should reduce ongoing care costs and release staff capacity to deal with growing demand.

3. Assessment

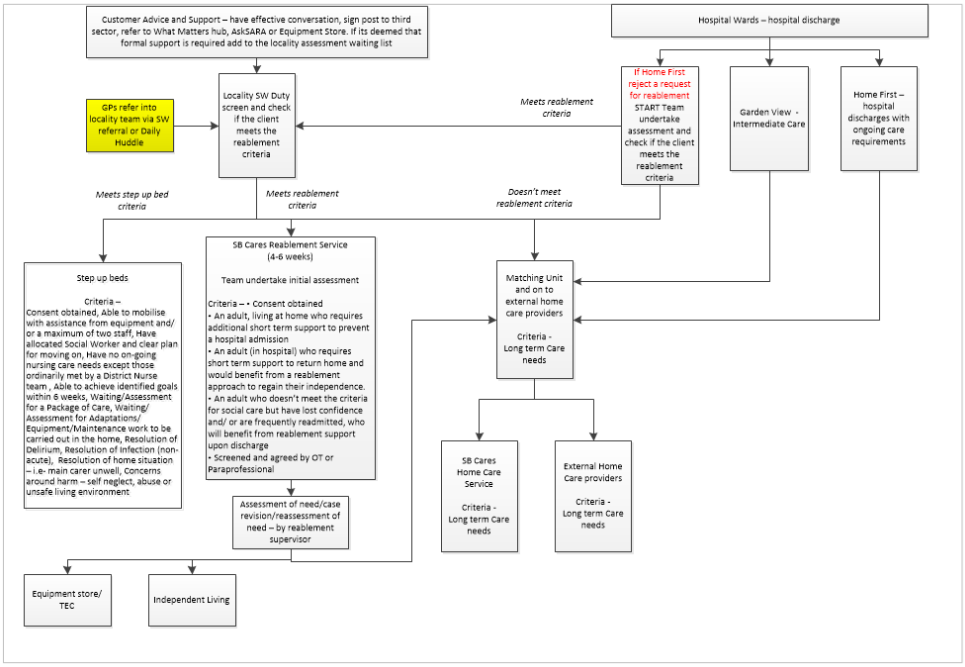
3.1 The Reablement approach has been used by the NHS Home First Team since 2019. The Home First team has evidenced that this approach over a 12 month period reduced the potential demand on long term care needs by approximately 1051.6 visits and equating to 318 hours of ongoing care. This saving would have been greater if not for the national recruitment challenges within home care. The IJB and IJB Audit Committee were updated on the Home First position earlier in the year.

3.2 In line with the IJB Strategic Commissioning Plan, SB Cares have been keen to understand how the Reablement approach can benefit their service users, their service and deliver significant efficiencies by way of reductions in care packages. Any reduction in care packages would release capacity into the care at home system as well as help manage the future demand created by demographic growth.

3.3 As a result a Reablement Pathfinder Project has been established in the South Home Care area (Hawick). The Pathfinder is running for an 8 week period from 15th September giving service users the opportunity for a 4-6 week period of Reablement. During the Reablement period, service users will be reassessed weekly to establish any change in functional ability and quality of life. When the period of Reablement is complete, the

service user will be assessed for any longer term care needs, equipment or TEC (Technology Enabled Care) which may be required. The hope being that any long term care needs will be minimal. The pathfinder is working with service users from the social care community waiting list, those discharged from hospital and those currently in Upper Deanfield Care Home.

3.4 The Reablement Pathfinder process can be seen below.



3.5 The Reablement team comprises of the Teviot Health &Social Care Team Leader, an Occupational Therapist, a Paraprofessional, a Reablement Supervisor and 9 Reablement Home Care Support Workers. Support for the project is also being provided by Senior Managers within SBCares.

3.6 The pathfinder aims to realise the following benefits for service users –

- Improving quality of life
- Keeping and regaining skills, especially those people who have potential to live independently
- Regaining or increasing confidence
- Improving health and well-being
- Increasing people's choice and autonomy
- Person centered practice
- Enabling people to be able to continue living at home
- Reducing the need for ongoing care and support

3.7 The benefits for staff

- Greater job satisfaction
- Doing something worthwhile
- Learning and developing new skills
- Motivating

3.8 Other Benefits

- Improvements in National Health and Wellbeing Outcomes (noted above)
- Prevention of admissions
- Improved whole system flow
- Reduced waiting lists
- Reduced or no ongoing care package (Glasgow outcomes 45% no care and 18% reduction on average in people who continued to need care Glasgow's Reablement Service - YouTube)
- Reduction in homecare hours will help manage future demographic pressure - research suggests an average reduction of 28% in required homecare hours Research into the Longer Term Effects/Impacts of Re-ablement Services (core.ac.uk)

3.9 The pathfinder is running for 8 weeks from 15th September 2022, with the evaluation being available by the end of October 2022.

3.10 The evaluation will cover –

- Percentage of people that have received Reablement that need no follow on support
- Assessment of package required prior to Reablement vs the package required after Reablement (Care hours and costs)
- Increase in functional ability pre and post Reablement (Recorded in Mosaic)
- % of those that have been through the Reablement approach that no longer require a service up to 6 months post-Reablement (and follow up on a sample after 12 months – satisfaction and update on current situation, provider 6 month review info)
- Perceived quality of life score pre and post Reablement (recorded in Mosaic)
- Double handed care reductions to single handed care
- Increase of use of Technology Enabled Care
- Reduced locality waiting list
- Reduced demand on START and Locality team assessments
- Staff motivation and job satisfaction

Feedback from staff and clients will also be recorded.

4. Next Steps

4.1 Should the Pathfinder evaluation be positive, it is proposed that discussions will take place with Home First around integrating the two approaches to create one Integrated Reablement team which will operate across the Borders.

4.2 A Business Case will be submitted to the SPG/IJB when a proposed future integrated operating model has been scoped.

5. Recommendations

- Note the Reablement work by NHS Borders and SBCares that is already underway and the benefits of this approach.
- Agree that a further business case will be submitted for discussion following the completion of the Reablement Pathfinder, its subsequent evaluation and discussions on a future Borders wide operating model.
- Agree to the progression of the scoping of one integrated SB Cares / Home First service
- Agree to a future proposal being submitted later in the year with an outline approach for an Integrated Reablement Service with SB Cares and Home First.

DIRECTION FROM THE SCOTTISH BORDERS INTEGRATION JOINT BOARD Direction issued under S26-28 of the Public Bodies (Joint Working) (Scotland) Act 2014	
Reference number	SBIJB-210922-2
Direction title	Development of a business case for an integrated re-ablement approach across the Scottish Borders, provided by an integrated Home First and SB Cares service
Direction to	Scottish Borders Council and NHS Borders
IJB Approval date	TBC – the paper will be considered at the IJB on 21 September 2022
Does this Direction supersede, revise or revoke a previous Direction?	Yes (Reference number: SBIJB-08-11-17-1 Discharge to Assess) Supersedes: X; Revises: X; Revokes:
Services/functions covered by this Direction	Social Care (Scottish Borders Council Care at Home), Hospital to Home (Home First)
Full text of the Direction	To evaluate the re-ablement pathfinder, and report to the December IJB with a business case for an integrated SB Cares and Home First service. As part of the development of this business case, it is expected that: • There will be full engagement with staff, with service users, unpaid carers and partners (including but not exclusively review at the IJB Joint Staff Forum, Unpaid Carers Workstream and Independent Care Sector Advisory Group) • the benefits listed including the National Health and Wellbeing Outcomes will be captured, in addition to service user feedback • the scope of the service, and referral pathways are clearly outlined • the service facilitates step up from the community • the service provides a Discharge to Recover then Assess function, so that no home care is prescribed from the Hospital system, but that instead this is determined after a period of recovery and reablement in the service user's home
Timeframes	To start by: With immediate effect To conclude by: 31 March 2022
Links to relevant SBIJB report(s)	8 November 2017 IJB: Discharge to Assess 17 February 2021 IJB: Formative Evaluation of the Discharge Programme 21 September 2022 IJB: Development of a business case for a reablement approach across the Scottish Borders
Budget / finances allocated to carry out the detail	• It is expected that the costs of the Home First service will reduce in line with the budget currently available. • In line with the integration of the service, it is expected that the budgets for Home First and SB Cares will be pooled. • As a transformation initiative, it is expected that the overall costs to deliver internal and commissioned home care services will reduce. As part of the business case, the expected financial costs and benefits must be outlined.
Outcomes / Performance Measures	All 9 National Health and Wellbeing Outcomes apply, and it is expected that these will be measured as part of service user feedback. In addition, the following performance measures will be captured:

	• Percentage of people that have received Reablement that need no follow on support • Assessment of package required prior to Reablement vs the package required after Reablement (Care hours and costs) • Increase in functional ability pre and post Reablement (Recorded in Mosaic) • % of those that have been through the Reablement approach that no longer require a service up to 6 months post-Reablement (and follow up on a sample after 12 months – satisfaction and update on current situation, provider 6 month review info) • Perceived quality of life score pre and post Reablement (recorded in Mosaic) • Double handed care reductions to single handed care • Increase of use of Technology Enabled Care • Reduced locality waiting list • Reduced demand on START and Locality team assessments • Staff motivation and job satisfaction
Date Direction will be reviewed	As the business case will be reviewed at the December IJB, the Direction will be formally reviewed by the Strategic Planning Group in advance of the IJB. The IJB Audit Committee will not review this direction.

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Integrated Impact Assessment (IIA)

Part 1 Scoping

1 Details of the Proposal

Title of Proposal: Reablement South Pilot	
What is it?	**A new** Policy/Strategy/**Practice** ☐ A revised Policy/Strategy/Practice ☐
Description of the proposal: (Set out a clear understanding of the purpose of the proposal being developed or reviewed (what are the aims, objectives and intended outcomes, including the context within which it will operate).	Reablement is the active process of an individual regaining the skills, confidence and independence to enable them to do things for themselves, rather than having things done for them. It helps people learn or re-learn the skills necessary for daily living, also known as Activities of Daily Living (ADL). These skills may have been lost through deterioration in health and / or through a change in circumstances. Research on reablement by De Monteford University on the benefits of homecare Reablement and reported the following results at first review:

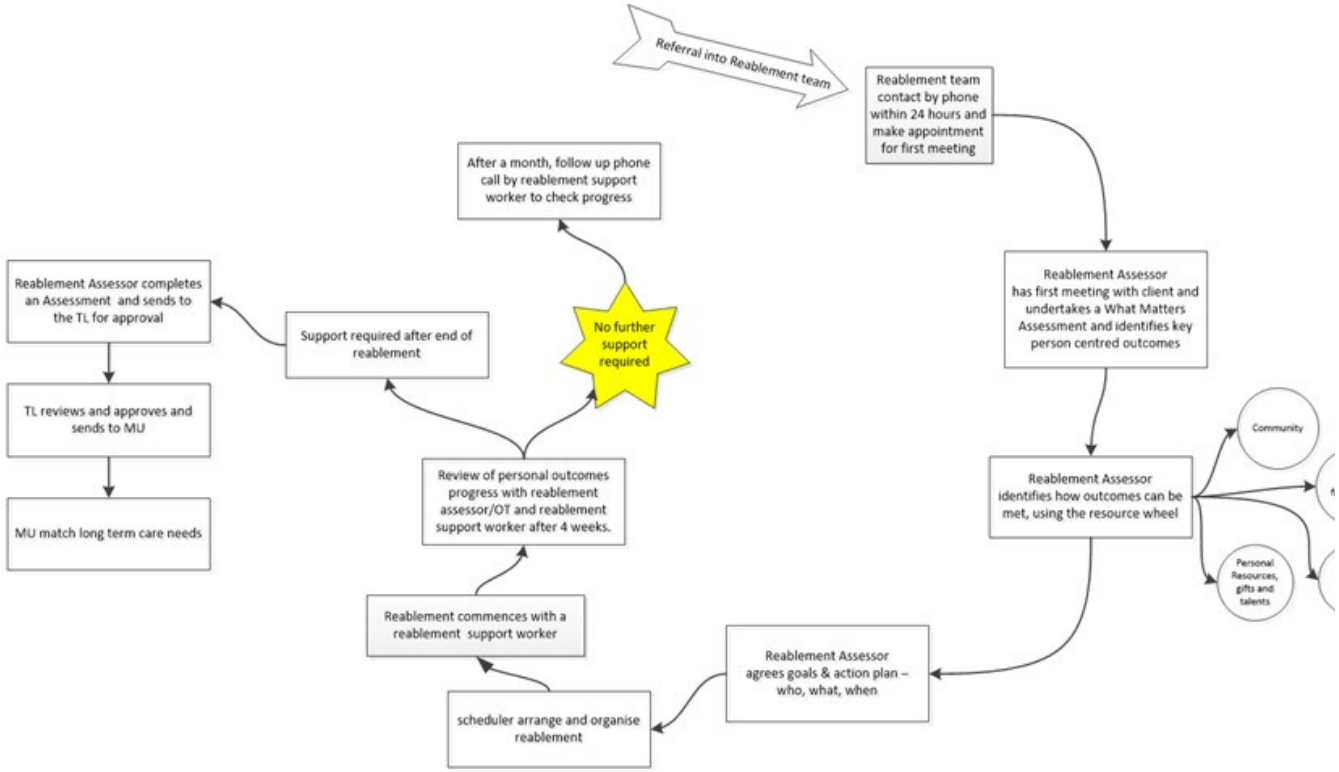
Package required at first review	Reablement service	Control Group (i.e. with no Reablement)
Discontinued	58%	5%
Reduced	17%	13%

Unchanged	17%	71%	
Increased	8%	11%	
	100%	100%	

The aim of the project will be to create a small reablement team within the South homecare team. This will use existing care staff that are currently deployed in Deanfield Care Home and we aim for the OT provision within the team to be provided by Social Work OT's and OTA's.

The team will focus on hospital discharges that Home First are unable to take on, as well as new clients to social care.

The reablement process can be seen below –



The project will monitor the following for the duration of the 8 week pilot –

- Percentage of people that have received reablement that need no follow on support
- Assessment of package required prior to reablement vs the package required after reablement (Care hours and costs)
- Increase in functional ability pre and post reablement (AUStoms or IoRN measure)
- % of those that have been through the reablement approach that no longer require a service up to 6 months post-reablement (and follow up on a sample after 12 months – satisfaction and update on current situation, provider 6 month review info)
- Perceived quality of life score pre and post reablement

	• Double handed care reductions to single handed care • Increases in the use of TEC Reablement was identified as an area of service transformation and savings in 2020 and discussions have been ongoing with the NHS Home First Service around creating a joint reablement service. These discussions have concluded with the decision that SB Cares will move to use a reablement approach for its 8 week pilot in the South homecare area, once established and outcomes monitored, we will see how this can combine/compliment the NHS Home First Service before expanding across the Borders. In order to make the required savings that are currently labelled as reablement, the night service will be decommissioned and the care provided in Newcastleton will be recommissioned to an external provider. The recommissioning/decommissioning will sit as separate projects and will be out of scope of the reablement project. **Proposed Option** 8 week pilot in the South Home Care team Use of 1 x Teviot locality OT Use of 3 x FTE home care staff from Deanfield Monitor outcomes and care package reductions Evaluate at 8 weeks and decide on future model and possible integration with Home First
Service Area: **Department:**	SBCares & Social Work
Lead Officer: (Name and job title)	Julie Glen – Operations Director
Other Officers/Partners involved: (List names, job titles and organisations)	Julie Glen (Operations Director SBCares) Daniel Smyth (Service Manager SBCares) Susan Davidson (Operations Manager SBCares) Nicki Reid (Team Leader START) Jillian Higgins (Group Manager SW) John Yallop (Business Partner Finance)

	Mark Williamson (Business Partner HR) Angela Webster (CCRT) Clare Richards (Programme Manager) Suzanne Hislop (Project Support Officer)
Date(s) IIA completed:	11.05.22

2 Will there be any cumulative impacts as a result of the relationship between this proposal and other policies?

Yes / No *(please delete as applicable)*
If yes, - please state here:

3 Legislative Requirements

3.1 Relevance to the Equality Duty: No

Do you believe your proposal has any relevance under the Equality Act 2010?
(If you believe that your proposal may have some relevance – however small please indicate yes. If there is no effect, please enter "No" and go to Section 3.2.)

Equality Duty	**Reasoning:**
Elimination of discrimination (both direct & indirect), victimisation and harassment. *(Will the proposal discriminate? Or help eliminate discrimination?)*	All SW and SBCares staff will be given an introduction to reablement session and Staff will have the opportunity to participate in the new team if they are keen to be involved. If we have more staff that required we can work staff on rotation.

	Services will not be removed from service users, support will just be provided in different ways. The new provision will be more dignified and respectful, promote independence and enable people to remain in their own homes.
Promotion of equality of opportunity? *(Will your proposal help or hinder the Council with this)*	All SW and SBCares staff will be given an introduction to reablement session and Staff will have the opportunity to participate in the new team if they are keen to be involved. If we have more staff that required we can work staff on rotation. Services will not be removed from service users, support will just be provided in different ways. The new provision will be more dignified and respectful, promote independence and enable people to remain in their own homes.
Foster good relations? *(Will your proposal help or hinder the council s relationships with those who have equality characteristics?)*	Good communication, consultation and engagement will support good relations.

3.2 Which groups of people do you think will be or potentially could be, impacted by the implementation of this proposal? (You should consider employees, clients, customers / service users, and any other relevant groups)

Please tick below as appropriate, outlining any potential impacts on the undernoted equality groups this proposal may have and how you know this.

	Impact			Please explain the potential impacts and how you know this
	No Impact	**Positive Impact**	**Negative Impact**	
Age Older or younger people or a specific age grouping		**Y**		**The reablement approach will have a positive impact, promoting independence, improving confidence and wellbeing and allowing older people to remain in the own homes.**
Disability e.g. Effects on people with mental, physical, sensory impairment, learning disability,		**Y**		**The reablement approach will have a positive impact, promoting independence, improving confidence and wellbeing and allowing people to**

visible/invisible, progressive or recurring				**remain in the own homes.**
Gender Reassignment Trans/Transgender Identity anybody whose gender identity or gender expression is different to the sex assigned to them at birth	**Y**			
Marriage or Civil Partnership people who are married or in a civil partnership	**Y**			
Pregnancy and Maternity (refers to the period after the birth, and is linked to **maternity** leave in the employment context. In the non-work context, **protection** against **maternity** discrimination is for 26 weeks after giving birth),	**Y**			
Race Groups: including colour, nationality, ethnic origins, including minorities (e.g. gypsy travellers, refugees, migrants and asylum seekers)	**Y**			
Religion or Belief: different beliefs, customs (including atheists and those with no aligned belief)	**Y**			
Sex women and men (girls and boys)	**Y**			
Sexual Orientation, e.g. Lesbian, Gay, Bisexual, Heterosexual	**Y**			

3.3 Fairer Scotland Duty

This duty places a legal responsibility on Scottish Borders Council (SBC) to actively consider (give due regard) to how we can reduce inequalities of outcome caused by socioeconomic disadvantage when making strategic decisions.

The duty is set at a strategic level - these are the key, high level decisions that SBC will take. This would normally include strategy documents, decisions about setting priorities, allocating resources and commissioning services.

Strategic decision to make financial savings based on the 22/23 budget.				
Is the proposal strategic? Yes / No ***(please delete as applicable)*** **If No go to Section 4**				
If yes, please indicate any potential impact on the undernoted groups this proposal may have and how you know this:				
	Impact			**State here how you know this**
	No Impact	**Positive Impact**	**Negative Impact**	
Low and/or No Wealth – enough money to meet basic living costs and pay bills but have no savings to deal with any unexpected spends and no provision for the future.	**Y**			**SW financial assessment in place.**
Material Deprivation – being unable to access basic goods and services i.e. financial products like life insurance, repair/replace broken electrical goods, warm home, leisure and hobbies	**Y**			**SW financial assessment in place.**
Area Deprivation – where you live (e.g. rural areas), where you work (e.g. accessibility of transport)	**Y**			
Socio-economic Background – social class i.e. parents' education, employment and income	**Y**			
Looked after and accommodated children and	**Y**			

young people				
Carers paid and unpaid including family members	**Y**			
Homelessness	**N/A**			
Addictions and substance use	**Y**			
Those involved within the criminal justice system	**Y**			

4 Full Integrated Impact Assessment Required

Select No if you have answered "No" to all of Sections 3.1 – 3.3.

Yes / <u>No</u> *(please delete as applicable)*

If a full impact assessment is not required briefly explain why there are no effects and provide justification for the decision.

Any impact identified is positive for staff and service users. Therefore there is no need to complete a full assessment

Signed by Lead Officer:	**Julie Glen**
Designation:	**Operations Director**
Date:	**11.05.22**
Counter Signature Service Director	**Jen Holland**
Date:	**11.05.22**

Part 2 Full Integrated Impact Assessment

5 Data and Information

What evidence has been used to inform this proposal?
(Information can include, for example, surveys, databases, focus groups, in-depth interviews, pilot projects, reviews of complaints made, user feedback, academic publications and consultants' reports).

Please state your answer here

Describe any gaps in the available evidence, then record this within the improvement plan together with all of the actions you are taking in relation to this (e.g. new research, further analysis, and when this is planned)

Please state your answer here

6 Consultation and Involvement

Which groups are involved in this process and describe their involvement

Please state your answer here

Describe any planned involvement saying when this will take place and who is responsible for managing the process

Please state your answer here

Describe the results of any involvement and how you have taken this into account.

Please state your answer here

What have you learned from the evidence you have and the involvement undertaken? Does the initial assessment remain valid? What new (if any) impacts have become evident?
(Describe the conclusion(s) you have reached from the evidence, and state where the information can be found.)

Please state your answer here

7 Mitigating Actions and Recommendations

Consider whether:

Could you modify the proposal to eliminate discrimination or reduce any identified negative impacts?
(If necessary, consider other ways in which you could meet the aims and objectives of the proposal.)

Could you modify the proposal to increase equality and, if relevant, reduce poverty and socioeconomic disadvantage?

Describe any modifications which you can make without further delay (e.g. easy, few resource implications)

Mitigation
Please summarise all mitigations for approval by the decision makers who will approve your proposal

Equality Characteristic/Socio economic factor	Mitigation	Resource Implications (financial, people, health, property etc)	Approved Yes/No

8 Recommendation and Reasoning *(select which applies)*

- Implement proposal with no amendments
- Implement proposal taking account of mitigating actions (as outlined above)
- Reject proposal due to disproportionate impact on equality, poverty, health and Socio -economic disadvantage

Reason for recommendation:

Signed by Lead Officer:	
Designation:	
Date:	
Counter Signature (Service Director):	
Date:	

Office Use Only (not for publication)

This assessment should be presented to those making a decision about the progression of your proposal.

If it is agreed that your proposal will progress, you must send an electronic copy to corporate communications to publish on the webpage within 3 weeks of the decision.

Complete the below two sections. For your records, please keep a copy of this Integrated Impact Assessment form.

Action Plan (complete if required)

Actioner Name:	**Action Date:**
What is the issue?	
What action will be taken?	
Progress against the action:	
Action completed:	**Date completed:**

Monitoring and Review

State how the implementation and impact of the proposal will be monitored, including implementation of any amendments? For example what type of monitoring will there be? How frequent?

Please state your answer here

What are the practical arrangements for monitoring? For example who will put this in place? When will it start?

Please state your answer here

When is the proposal due for review?

Please state your answer here

Who is responsible for ensuring that this happens?

Please state your answer here

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 21 September 2022

Report By:	Susie Flower, Chief Nurse Health & Social Care Partnership
Contact:	Carly Lyall, Planning & Performance Officer, NHS Borders
Telephone:	carly.lyall@borders.scot.nhs.uk – MS Team (wfh)
REVIEW OF PALLIATIVE CARE SERVICES ACROSS THE SCOTTISH BORDERS	
Purpose of Report:	To commission an external review of Palliative Care Services across the Scottish Borders.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: *a)* Approve and commission an external review.
Personnel:	The review will require engagement with the service and stakeholders.
Carers:	As part of the review, the IJB Carers workstream will be consulted to consider the needs of unpaid carers caring for their loved ones who receive palliative care in the community.
Equalities:	As the review has not commenced, the Integrated Impact Assessment has not yet been undertaken, but will be as part of the implementation and will be reported back to the IJB.
Financial:	Non-recurrent funding will need to be identified to commission an external provider. It is expected that this will provide the opportunity for service transformation to both improve outcomes.
Legal:	Procurement requirements and rules will be followed accordingly.
Risk Implications:	There is a risk of no identified funding to commission the review, which will impact on our performance against the National Health and Wellbeing Outcomes, and national integration indicators on the following: • Proportion of people spending their last 6 months at home, or in a homely setting • Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated • Percentage of adults supported at home who agreed that they are supported to live as independently as possible; • Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life; • Percentage of adults supported at home who agreed they felt safe; • the percentage of carers supported to continue in their caring role, and;

	• the percentage of adults with intensive care needs at home.
Direction required:	Yes

Situation

There is a need for the Integrated Joint Board (IJB) to commission an external review of Palliative Care Services across the Scottish Borders.

Palliative care as defined by the World Health Organisation is:

> *"an approach that improves the quality of life of patients (adults and children) and their families who are facing problems associated with life-threatening illness. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual".* (WHO Definition of Palliative Care - Public Health)

Marie Curie defines Palliative Care as:

> *"…treatment, care and support for people with a life-limiting illness, and their family and friends".*

They describe a life-limiting illness as:

> *"…an illness that can't be cured and that you're likely to die from. You might hear this type of illness called 'life-threatening' or 'terminal'. People might also use the terms 'progressive' (gets worse over time) or 'advanced' (is at a serious stage) to describe these illnesses. Examples of life-limiting illnesses include advanced cancer, motor neuron disease (MND) and dementia". You can receive palliative care at any stage in your illness. Having palliative care doesn't necessarily mean that you're likely to die soon – some people receive palliative care for years. You can also have palliative care alongside treatments, therapies and medicines aimed at controlling your illness, such as chemotherapy or radiotherapy. However, palliative care does include caring for people who are nearing the end of life – this is sometimes called end of life care".* What is palliative care? (mariecurie.org.uk)

Background

The majority of palliative care services within the Scottish Borders are provided in the community, both across General Practice, District Nursing, Home Care providers, Care Homes, Community Hospitals and Third Sector partners. In addition, there are number of unpaid carers who provide palliative care.

The specialist tier of care, the Margaret Kerr Unit (MKU) is a specialist palliative care unit which was built in response to the fact that the Borders was the only mainland Health Board region not to have a specialist palliative care unit. The build was funded on the back of a generous initial donation, other fundraising partners and a public appeal raising the final million of the £4.22million cost. The ongoing recurring running costs are NHS funded. It provides specialist care and some general care, though the latter should be able to be provided anywhere within the Scottish Borders i.e. other wards in the BGH, community hospitals and care homes and of course the community.

The specialist palliative care team are based in and provide the inpatient care in the MKU along with ward staff. The specialist team, also provide in-reach support to acute inpatients and provide complex symptom support for patients, families and staff in all settings across the Scottish Borders.

After the success of the MKU and recognising the high standard of care within it, NHS Borders arranged for Marie Curie to perform a needs assessment in 2015 (Appendix 1) to identify next steps in wider provision of palliative care across the system. The recommendations focussed on earlier identification of palliative care needs, assessment, care planning and review, holistic care and support, support after death and health promoting palliative care all with a focus on continual quality improvement.

The placement of the parts of palliative care services across various line management structure and associated with areas (such as health promoting palliative care which may seem less relevant in comparison to other demands e.g. on acute services) led to delays in progression of these recommendations. With the recent COVID-19 pandemic and the failure to implement the previous recommendations there is a need to do a full review of Palliative Care services.

There is an endowment fund where people who have appreciated the services of the specialist palliative care team and MKU have made donations for specialist palliative care. This endowment fund holds a high balance of funds.

The COVID-19 pandemic added to the challenges; however, it has also reinforced areas of potential. One of the key projects that was stalled is the hospice at home service – described in realistic medicine reports elsewhere in Scotland and in some areas implemented during the pandemic to great effect. A project Charter was drawn up (Appendix 2) which outlined the original bid for a broader care at home model for palliative care. MacMillan agreed funding however funding ceased due to various reasons but overall, it was rejected by the Board.

During the COVID-19 pandemic there was an additional Macmillan bid (Appendix 3). This was an abridged version of hospice at home to test a 7-day specialist advice/support service. The funding was agree by Macmillan however rejected by Board Executive Team (BET) given the additional requirement for registers nurses and the potential to destabilise already precarious acute services.

In mid-2020, Marie Curie wrote to all territorial NHS authorities across the UK in relation to Marie Curie's initial response to COVID-19. Further contact was then made with NHS Borders requesting an opportunity to discuss a future operating model for the organisation that would ensure its long-term input to specialist palliative care services in the Scottish Borders. The split of charitable funds and NHS funded changed due to a significant shortfall of donation income and the previously applied reduced service rates for Health Board changed. Although faced with the unforeseen costing pressure, Primary and Community Services recognised an opportunity to review current delivery models in an attempt to validate value for money and explore alternative models of working. A significant piece of work (Appendix 4) was undertaken by the Primary & Community Services (P&CS) Management Team to look at the Marie Curie contract and the service provided. Good engagement with Marie Curie and other key stakeholders followed over the course of several workshops to discuss a future operating model for the organisation that would ensure its long-term input to specialist palliative care services in the Scottish Borders. A briefing paper is included in Appendix 5. The workstream was the paused to align with this overall service review.

Assessment

The Scottish Borders Health and Social Care Partnership covers the sixth largest geographical Health and Social Care Partnership area in Scotland. The population served is approximately 119,000. The geography is largely rural, and the population is elderly and ageing when compared with the national average population across Scotland. The service has also experienced significant constraints on its capacity to meet demand during the pandemic and provide consistent care at home for patients

In order to address current challenges we are seeking an external full review of Palliative Care Services across the Scottish Borders to ensure an integrated approach that is seamless for service users and their families / carers, as well as staff. Further details are included within the section below.

Scope

An engagement workshop was help on 28th July 2022 to inform the scope of the review. The workshop included various stakeholders including acute, community, specialist, general practice and patient representatives and worked through the following 3 questions.

1 – What works well?
2 – Gaps and opportunities for improvements?
3 – What should be in / out of scope?

A summary of the outputs is included in Appendix 6.

It was clear from the group that this review should be whole system with nothing being out of scope and the following areas (list not exhaustive) to be included in the review of Palliative Care services:

1. Acute
   - BGH – acute hospital
   - Emergency Department
   - Specialist Palliative Care
   - Margaret Kerr Unit

2. Primary & Community Services
   - Community Hospitals
   - Community Nursing, e.g. District Nursing
   - Specialist Palliative Care
   - Out of Hours
   - General Practice
   - Care Homes
   - Community Pharmacy

3. Third Sector & Voluntary Organisations
   - Review Marie Curie contract
   - PATCH
   - Macmillan

4. Finances
   - Overview of all finances and funding streams related to Palliative Care
   - Full financial appraisal
   - Use of Endowment Fund and rules associated with it
   - Maire Curie Contract

5. Governance
   - Clear governance structure
   - Scrutiny of previous recommendations, where we got to and whether they are still relevant

Outcomes

Opportunities will include identification of improvement opportunities which should be categorised as either

a) structural
b) performance
c) transformational

Structural issues will encompass evidence that suggests the design of services is sub-optimal and can be improved leading to a future benefit.
Performance issues are where there is evidence of variation from agreed standards or expected levels of efficiency.
Transformational opportunities to ensure an integrated approach that is seamless for service users and their families / carers, as well as staff.

Intended Outcomes	
1	**Structures & Governance** • Overview of the structure; roles, goals, processes, responsibilities • Define working model required for Borders – this will then define the finances • Develop a framework that realigns to the principles of realistic medicine • Clear service delivery model • Clear Governance
2	**Processes** • Consistent processes across all localities • GP gold standard meetings • Clear pathways for staff and patients • Anticipatory Care planning • Clear, joined up, standardised documentation across acute, primary care & community services clearly stating patients end of life preferences, accessible to all services. • Share updates and consistent communications to save duplication • Communications
5	**National Guidelines and Strategies** The review should be conducted with the following national and local drivers: • Every Story's Ending - the Scottish Partnership for Palliative Care proposal for the national framework which is still pending.

	https://www.palliativecarescotland.org.uk/content/publications/1631014004_FINAL-ESE-summary.pdf (Appendix 7 - the full document). • National Health and Wellbeing Outcome indicators, developing community palliative care services, with the potential for service transformation - noted as part of the IJB's Commissioning Plan for 2022/23 (Appendix 8). • The "proportion of last 6 months of life spent at home or in a community setting" and the "percentage of adults with intensive care needs receiving care at home" in the Scottish Borders was lower than the national average in the 2021/22 Annual Performance Report & 2022/23 Commissioning Plan (Appendix 8).
7	**Networks** • Scope and develop a network of Palliative Care advice, services and resources • 3rd sector interfaces, and the use of charitable organisations
8	**Education & Training** • Dedicated Palliative Care education and training for staff across the whole pathway • Dedicated clinical supervision structure • Occupational Heather and well-being for staff
9	**Information Technology** • Review of all IT systems to reduce duplication and share communications
10	**Data** • Develop a data dashboard
11	**Engagement** • Engagement with staff, services and stakeholders • Engagement with those who have lived in experience

Recommendation

This review should identify variation across the localities and inform standard processes and pathways. It will consider areas where there is opportunity to improve efficiency or productivity and identify opportunities to transform services to build on their safety, patient centredness and sustainability. The review will define the service required and then the best model to provide it.

The IJB are asked to:

- **Commit** to carry out and follow through on an external review and the implementation of the recommendations
- **Agree** the scope of the review
- **Commission** an external body to carry out the review
- **Identify** non-recurring funding to commission an external provider

Appendices

Appendix 1: Scottish Borders Palliative Care Needs assessment

Scottish Borders palliative care needs

Appendix 2: Project Charter – original bid for a broader care at home model for palliative care

Project Charter V12 submitted to endow

Appendix 3: Macmillan final bid – abridged version within Covid to offer a 7-day Specialist advice/support service to test

Macmillan final bid approved for MKH S

Appendix 4: Marie Curie Workshop Summary Document

Marie Curie Workshop - Summar

Appendix 5: Marie Curie summary – position paper

Marie Curie Update Paper for RPG 01.02.

Appendix 6: Workshop Summary

Palliative Care Write Up 28.08.22.docx

Appendix 7: Every Story's Ending Full Report

Every Story's Ending.pdf

Appendix 8: IJB 2021/22 Annual Performance Report & 2022/23 Commissioning Plan

SBIJB Annual Report 2021-22 FINA

DIRECTION FROM THE SCOTTISH BORDERS INTEGRATION JOINT BOARD Direction issued under S26-28 of the Public Bodies (Joint Working) (Scotland) Act 2014	
Reference number	SBIJB-210922-3
Direction title	To commission an external palliative care review
Direction to	NHS Borders and Scottish Borders Council, with NHS Borders commissioning the review
IJB Approval date	TBC – the paper will be considered at the IJB on 21 September 2022
Does this Direction supersede, revise or revoke a previous Direction?	No
Services/functions covered by this Direction	Palliative Care services across: • Community Hospitals, Community Nursing, Out of Hours, General Practice, Care Homes, Home Care • Third sector and voluntary organisations • Acute hospital, Emergency Department, Specialist Palliative Care, Margaret Kerr Unit This also impacts upon Social Care service users (Scottish Borders Council and external providers)
Full text of the Direction	NHS Borders is directed to commission an external palliative care review in line with the scope and intended outcomes listed in the IJB paper. The Scottish Borders Council is directed to support this review process by ensuring appropriate stakeholder engagement. Both organisations are requested to work together on this piece of work. As part of this: • There will be full engagement with staff, with service users, unpaid carers and partners (including but not exclusively engagement and review at the IJB Joint Staff Forum, Unpaid Carers Workstream, GP Subcommittee and Independent Care Sector Advisory Group) • Improvements will be sought including the National Health and Wellbeing Outcomes benefits and other benefits listed • An integrated approach is adopted that promotes and improves the seamless and joined up delivery of care to service users • The scope of the future configuration of service, and referral pathways are clearly outlined • The review should focus on opportunities to focus on transformation opportunities for palliative care services, and as part of this aim to improve outcomes and reduce overall costs for palliative care as part of a 'Programme Budgeting' approach. The IJB Chief Financial Advisor will work with the NHS Borders and Scottish Borders Council finance teams to support this assessment.
Timeframes	To start by: With immediate effect To conclude by: 31 March 2023
Links to relevant SBIJB report(s)	21 September 2022 IJB: Palliative care review
Budget / finances allocated to carry out the detail	This is within the delegated budgetary authority of the IJB Chief Financial Officer, who will liaise with NHS Borders to ensure that appropriate funds are available.
Outcomes / Performance	The review is expected to deliver the intended service outcomes noted in the report. In addition, the review should pay cognisance to the

Measures	following National Health and Wellbeing outcomes: • Proportion of people spending their last 6 months at home, or in a homely setting • The percentage of adults with intensive care needs at home • Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated • Percentage of adults supported at home who agreed that they are supported to live as independently as possible; • Percentage of adults supported at home who agree that their services and support had an impact on improving ormaintaining their quality of life; • Percentage of adults supported at home who agreed they felt safe, and; • The percentage of carers supported to continue in their caring role As noted above, it is expected that the total costs of delivery of the service may be able to reduce as part of service transformation, and so cost is also a key outcome measure.
Date Direction will be reviewed	As this pertains to a business case that will be reviewed at the April IJB, the Direction will be formally reviewed by the Strategic Planning Group in advance of the IJB. The IJB Audit Committee will not review this direction.

Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 21st September 2022

Report By:	Jen Holland, Director of Strategic Commissioning and Partnerships, Scottish Borders Health & Social Care Partnership
Contact:	Andrew Medley – Programme Manager (SBC)
Telephone:	MS Teams. amedley@scotborders.gov.uk
CARE VILLAGE DEVELOPMENT – HAWICK OUTLINE BUSINESS CASE INITIAL ASSESSMENT	
Purpose of Report:	To present the Outline Business Case (OBC) Initial Assessment to the IJB for Hawick Care Village provision
Recommendations:	The Health & Social Integration Joint Board is asked to: a) Endorse the Outline Business Case (OBC) Initial Assessment set out in Appendix 1 b) Note the current options set out in the OBC Initial Assessment that will be taken forward and appraised within the development of the final OBC for Hawick Care Village provision c) Note that the final OBC will be submitted to the Integration Joint Board in early 2023 d) Note the findings of the NDTi engagement activity on future care provision in Hawick, as set out in the report at Appendix 2
Personnel:	None identified at this time
Carers:	Engagement/consultation/inclusion of carers is a part of the Care Village programme, and the IJB carers workstream are also being engaged.
Equalities:	Stages 1 (Proportionality and Relevance) and 2 (Empowering People) of the Equality Human Rights and Fairer Scotland Duty Impact Assessment have commenced and are in the process of being completed for Hawick Care Village. All stages including stage 3 (Findings and Recommendations) will be completed as part of the final OBC and FBC.
Financial:	It is anticipated that revenue funding for service provision in the new residential care facility in Hawick will transfer from the existing Deanfield care home which is being re-provisioned. At this stage, no further revenue implications have been identified. Capital Funding of £22.679m has been agreed in SBC's capital plan for two new residential care facilities, one for Hawick and another for Tweedbank
Legal:	Legal and legislative requirements will be met as required as the project for Hawick provision progresses.
Risk Implications:	The key risk identified at this stage is that the capital funding could be insufficient to meet expectations.
Direction required:	No – a Direction has already been issued by the Integration Joint Board and accepted by the Scottish Borders Council. The programme continues to work in line with this Direction.

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SCOTTISH BORDERS COUNCIL

Hawick Care Village

Appendix 1 - Outline Business Case

Initial Assessment

DRAFT

7th September 2022

DOCUMENT CONTROL

Version Control

Version	Amendments	Issued by	Issued to	Date
v1	Initial Draft	AM/LM		
v2	Draft for circulation and comment/feedback	AM	Chris Myers, Jen Holland, Stephanie Errington	23.08.22
v3	Incorporating feedback from Jen Holland and Chris Myers	AM	Jen Holland, Chris Myers	02.09.22
v3.1	Incorporating further feedback from Chris Myers, draft for SLT, Programme Board	AM	SLT, Programme Board	05.09.22
v3.2	Feedback from SLT and draft for APWG and IJB	AM	APWG, Programme Board	07.09.22

Table of Contents

1. CASE FOR CHANGE

1.1 Introduction

The Scottish Borders Health & Social Care Partnership propose an innovative new model of residential care, designed specifically to better support the changing needs of older people alongside providing high-quality care and support through proactive early intervention and preventative action aimed at those with complex needs, frailty and dementia.

The concept of the care village model supports unique needs, lifestyles and personal preferences for living, care and well-being for people living mainly with dementia and frailty. The focus is on possibility rather than disability and will be supported by 24-hour care, delivered by trained professionals.

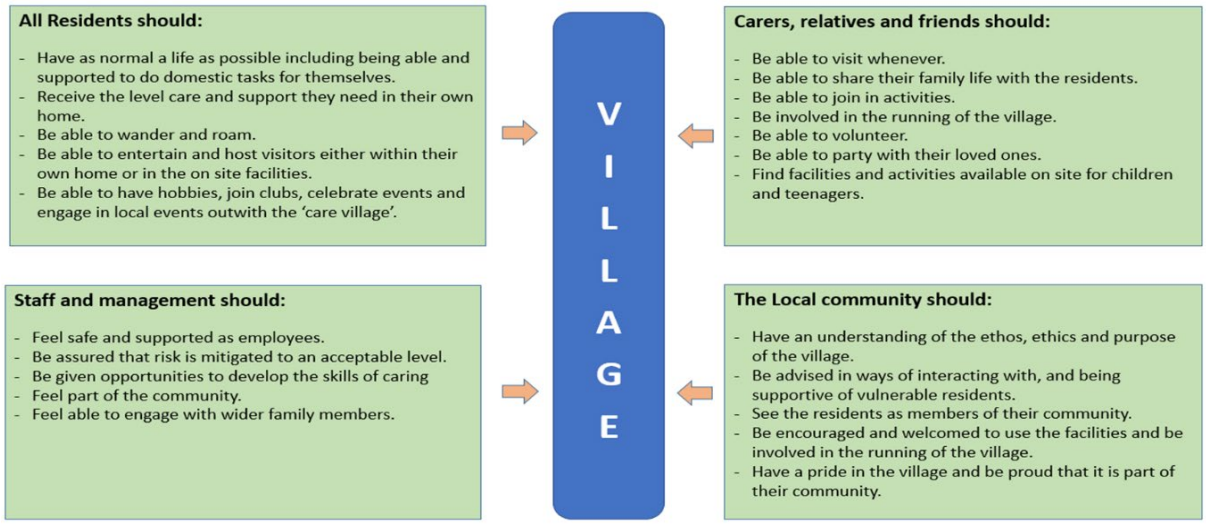
Following work already underway in enabling a Care Village setting in Tweedbank, this proposal is looking at the provision of a similar facility in Hawick. This new facility will be a re-provisioning of the existing Deanfield Care Home.

This case for change describes the proposals for delivering change and the potential options for further development and appraisal. Future work will be undertaken to demonstrate value for money; sustainability; affordability; feasibility; acceptability. The procurement strategy for the successful delivery of the project has been outlined at section 6.

1.2 The Strategic Case

In 2020 following a request by Elected Members and Senior Officers, investigative assessment was undertaken to identify innovative care and health thematic solutions for older people. This assessment involved researching eco systems, models and building solutions world-wide and a visit to the award winning Hogeweyk development in the Netherlands.

The vision, set out below, has been agreed and outline of the model of care, operational delivery and staffing model are under development:



The detail of this will be further jointly finalised between care and health colleagues. This will ensure effective use of a flexible bed-base, accompanied with a full range of care and intermediate care provision.

The outcomes of this proposal align closely with the identified population/demographic demand, and allows for the required revenue migration, through the transfer of existing provision from Deanfield, which will ultimately be closed, to the new development. Depending on the model of care, the supporting revenue model may require to be reviewed.

There has been extensive engagement with the communities in Hawick on the Care Village development to determine the requirement for the care facility and to seek the views of the Hawick communities regarding the type of provision they would like to see in the town.

National and Local Policy

Adult Social Care: Independent Review February 2021: The Feeley Report

The principal aim of this review was to recommend improvements to adult social care in Scotland, primarily in terms of the outcomes achieved by and with people who use services, their carers and families, and the experience of people who work in adult social care. The review takes a human-rights based approach.

The Hawick Care Village is an innovative alternative social and health care support model for the future which prioritises the principles of Feely and supports the recommendations of the Feeley Review. This will ensure that the citizens of Scottish Borders Council can maintain and develop rich social connections and to exercise as much autonomy as possible in decisions about their lives

Scottish Borders Health & Social Care Partnership Strategic Plan: Changing Health & Social Care For You 2018- 2022

The Partnership Strategic Plan provides the local strategic context for taking forward the care village development. Following a review in April 2021 by the Scottish Borders Strategic Planning Group, at the end of April 2021, the decision was taken to continue with the plan and with the three agreed existing objectives, and to build in lessons learned from COVID-19 and update existing priorities. The strategy and its priorities aim to deliver a vision where NHS Health and Council Social Care Services are joined-up and work in new partnerships together, with communities, residents and third sector providers to:

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

The Hawick Care Village development will help to deliver these objectives and ensure services and care are:

- Accessible
- Closer to home *(and offering greater support for care at home*)
- Delivered within an integrated model
- Give greater choice and control

- Optimise efficiency and effectiveness
- Reduce health inequality

Scottish Borders Council, "Council Plan 2022 – 2023" describes SBC's commitment to reshaping and improving services. The Hawick Care Village will contribute to the Council Plan Outcomes in relation to:

a) Good Health and Wellbeing – People of the Scottish Borders have the opportunities and are supported to take control of their health and wellbeing, enjoying a high quality of life.

b) Empowered, Vibrant Communities – The Scottish Borders has thriving, inclusive communities where people support each other and take responsibility for their local area

c) Clean Green Future – A modern environmentally designed and built building will contribute to tackling climate change and the surrounding grounds will enhance our local environment

1.3 Investment Objectives

The investment objectives for this scheme have been developed to specifically fit with the key outcomes identified within the Health & Social Care Partnership Strategic Plan.

Investment Objectives	
1	Deliver Services within an Integrated Care Model
2	Give users greater choice and control of local health & social care service provision

Investment Objectives	
3	Improve access to services
4	Improve care pathways, capacity, and flow management
5	Maximise flexible, responsive and preventative care - at home, with support for carers
6	Optimise efficiencies and effectiveness
7	Improve quality & effectiveness of accommodation used to support service delivery
8	Improve safety of health & social care, advice, support & accommodation

1.4 Existing Property Considerations

There have been several reports highlighting challenges with the current SBC owned residential care estate and the inability to make alterations/improvements to the estate in a way that represents value for money. In addition, the requirements necessary as a result of the impacts associated with COVID-19 and the need to respond to infection control techniques cannot be easily met within existing estate and these will require to feature in the design/layout of the new estate.

There are also further specific challenges with the current provision:

- Ageing estate, which does not meet update Care Inspectorate Standards in relation to Building Better Care Homes guidance
- Expensive to upgrade (and still won't meet the new standards)
- Stand-alone care home with no integration with other services and the community
- Increased service user expectations and model of care required by service users

- Institutional type care rather than in their “own home” and increased risk of isolation from community
- Barriers to providing a flexible and adaptable approach to care as service users’ needs change after admission
- Difficulties in improving existing environments in line with Dementia Friendly Design

Consideration will be required regarding what to do with the existing Deanfield facility when it will no longer be in use as a care home.

2. DESIRED SCOPE AND SERVICE REQUIREMENTS

2.1 Scope

The scope of the care facility will be informed by the work carried out by NDTi engagement activities carried out in the Hawick Community and with residents, families and staff. A summary of the engagement carried out is as follows:

- Engagement session 27 June Hawick Town Hall –
  - Local groups, GP’s, the Borders Carers Centre, Health and Social Care representatives were invited to attend
  - People were asked what they would like to see in terms of care village/facility in Hawick and outcomes for people
  - People were also asked specifically to consider equalities and human rights and how we cater for these in the new facility – these will be fed into IIA and Business case as it develops
- This was followed by NDTi engagement activity in Hawick throughout July, asking the same questions at:
  - 2 Drop-in sessions Heart of Hawick;
  - Staff drop-in sessions in Hawick Town Hall;
  - Deanfield families and residents sessions;
  - On-line workshops with specific groups – Community Groups, Third and Independent Sector, Health and Social Work professionals, Mental Health;

- Conversations with key specific groups in Hawick – e.g. Burnfoot Cuppa and Chat group, Men's Shed, Women's Craft groups, Dementia Café, mental health and learning disability representatives, health and social care staff including the District Nursing Team.

NDTI initial findings

- It's how the service is delivered that is key – joined up services
- A range of accommodation types are required to maintain independence – linked up
- Accommodation needs to allow couple with differing needs to stay together
- Respite provision required for carers
- More community involvement and not "shut away"
- More training for staff
- More trained volunteers to enhance service provision

The NDTi findings are in line with the agreed vision for the care villages. The full NDTi report can be found at appendix 2.

2.2 Care Home Demand Modelling and Assumptions

In May 2021 the HSCP and SBC CMT requested further evidence in relation to care home demand and modelling of the Scottish Borders older population. A Stakeholder Care Home modelling group was established with a specific ask to: Provide a 10-year forward projection of 24-hour care demand for older people and describe the expected changes in 24-hour care demand broken down by residential care, nursing care and specialist care provision with worse case and best case scenarios. If possible, the group were also asked to include potential for mid-range scenario. Several assumptions were applied to predicted future demand, these were

- Expected changes in population frailty or dependency levels will increase demand
- Expected changes in dementia prevalence and need for 24-hour care will increase demand

- Impact of changes in older peoples integrated preventative models of care may decrease demand for future 24-hour care

The outcomes of this study highlighted that the demographic projection and 30% increase in older people predicted the need for an additional 188 care home places by 2030, this represents between **8-11** additional care home places per year however :

- Scottish Borders benchmarks in lowest 4 Local Authorities for care home places
- There has been no change in Scottish Borders care home places 2009-2019 despite 20% increase in >75 Borders population
- The number of SBC-funded residents outwith Borders has been steady at 20% over the past 5 years
- Scottish Borders benchmarks in lowest 6 LAs for home care packages
- Suggestion that rurality and community/family support is maintaining more people at home
- The % of residents who remain in their own locality is directly related to the number of care home beds in a locality (0.91 correlation)
- Based on demographic change only, we can expect an increase of 188 beds by 2030. This has been broken down to a 28% increase in residential care beds and 29% nursing care beds
- This in numbers can be interpreted as an increase requirement of 14-17 beds per year by 2023-2026 and 19-23 beds per year in 2027-2029

Public Health Scotland are currently finalising a whole systems modelling and needs assessment piece of work covering the Scottish Borders. This work is focussing on identifying current and future need for homecare and residential care services and can be broken down to identify need in the Hawick and Tweedbank Areas. Once finalised it will help inform the current and future number and types of residential care units required in the new Hawick care facility. This needs information will be fed into the option development and appraisal process as part of the development of the final OBC.

2.3 Options for Consideration

The current options set out below will be fully developed and appraised within the final Outline Business Case following this initial assessment.

To aid the identification of further options, a market sounding exercise has been undertaken to determine potential interest from external sources to work in partnership in the development of a new care village in Hawick.

Current options identified, which include those from the market sounding, are as follows:

I. Refurbishment of Deanfield – This is a challenging option, as it may prove difficult to refurbish Deanfield so that it meets the new Care Inspectorate standards in relation to building better care homes guidance. It will also be expensive to upgrade and difficult to approve in line with dementia friendly design.

II. Development of a new care village facility, in partnership with Eildon Housing Association (EHA), on part of the Stirches site currently owned by EHA – Meetings have been held with EHA to explore this option. EHA are happy to work in partnership to look at this option to build a new integrated care facility on part of their Stirches site, which would be alongside their approved plans for Extra Care Housing.

III. Partnership with a National Private Residential Care provider at a site to be determined – A national residential care provider who currently operate care home facilities in the Borders, have come forward and are offering to work in partnership to build a new care village facility in Hawick. This could include them providing a 50% contribution to the capital funding of the build. They also have land available to build on in Hawick, the exact size and location is to be determined.

IV. Partnership with a national Housing Management and Care company (market sounding) – Through the market sounding exercise a national provider of housing management, care and support are offering to work in partnership to design, build and manage a new care village facility in Hawick. They have worked with other local authorities to deliver

and manage new housing and care schemes. However, they do not have a site on which to build.

Initial discussions occurred with NHS Borders to ascertain whether there was a possibility to explore a joint opportunity with NHS Borders for a residential care facility in Hawick. However as it became clear that this option would significantly delay the process, and due to the associated risks to the care village programme's delivery, this option has been discounted as it is not considered practical for the Hawick Care Village.

2.4 How the options will be appraised – criteria, weighting, scoring

The final non-financial appraisal of options will be undertaken using the same criteria, weighting and scoring that were agreed and used for the Tweedbank final OBC option appraisal. The criteria utilise the investment objectives set out in section 1.3 of this report, and have been developed to specifically fit with the key outcomes identified within the Health & Social Care Partnership Strategic Plan. The criteria, weighting and scoring are set out below:

Criteria – Investment Objectives	Weighting
Deliver Services within an Integrated Care Model	20%
Give users greater choice and control of local health & social care service provision	15%
Improve access to services	15%
Improve care pathways, capacity and flow management	10%
Maximise flexible, responsive and preventative	10%

care - at home, with support for carers	
Optimise efficiencies and effectiveness	10%
Improve quality & effectiveness of accommodation used to support service delivery	10%
Improve safety of health & social care, advice, support & accommodation	10%

The final options will be scored against each of the criteria using the options scoring scale set out below, which is the scale agreed and used in the Tweedbank final OBC options appraisal.

Options scoring scale

0	**Not at all**
1	**To some extent**
2	**Satisfactory**
3	**Good**
4	**Very good**
5	**Excellent**

A full financial appraisal of short-listed options will be also undertaken in the final outline business case.

3. EXPECTED OUTCOMES ARISING FROM A NEW MODEL OF CARE

On the basis that the proposed service model is put in place, the following identifies the key benefits likely to be attributable to achievement of each investment objective: As part of the project board deliverables a full benefits realisation of existing /status quo and business scope is required.

Investment Objective: Increase integration & communication between health & social care services and delivery to service users			
Outcome	**Relative Value**	**Relative Timescale**	**Type**
Delivery of more effective care with improved user outcomes	High	Medium & longer term	Qualitative and
Greater collaboration between partner organisations to improve effectiveness of	High	Medium & longer term	Qualitative
Improved staff engagement & communication between partner organisations	Medium	Medium & longer term	Qualitative
More service users able to return home following hospital care (based on draft intermediate care	High	Medium	Quantitative
Shared use of partner resources	Low	Medium term	Cash & resource
Improved working arrangements and facilities for staff resulting in greater job satisfaction and less turnover / sickness	Medium	Medium term	Qualitative & resource releasing

Investment Objective: Improve user experience of local health & social care service provision			
Outcome	**Relative Value**	**Relative Timescale**	**Type**
Positive experience of health and social care	High	Medium term	Qualitative
More people able to access care from their preferred location (i.e. at home)	High	Medium term	Quantitative
More people able to return home following hospital care (following rehabilitation and reablement)	High	Medium term	Quantitative & resource
Better transition through each care journey	High	Medium term	Qualitative
Positive experience of the environment in which services are provided	Medium	Medium term	Qualitative

Investment Objective: Improve access to care			
Outcome	**Relative Value**	**Relative Timescale**	**Type**
Maximised range of health and social care services available locally	High	Medium term	Qualitative
Point of access to care is less confusing	Medium	Medium term	Qualitative
More likely to receive the most appropriate care	High	Medium term	Qualitative
Ability to access care at home	High	Medium term	Quantitative
Better physical access to care facilities	Medium	Medium term	Qualitative
Flexible bed usage enables more user focused care	High	Medium term	Qualitative

Investment Objective: Improve care pathways, capacity and flow management			
Outcome	**Relative Value**	**Relative Timescale**	**Type**
More people treated on a scheduled rather than unscheduled basis	High	Medium & longer term	Quantitative
Service capacity meets service demands	High	Medium &	Quantitative
Flexible use of beds better meets service user needs	High	Medium term	Qualitative
Reduction in overall number of beds (from the baseline high of 161 in 2011)	High	Medium term	Quantitative & cash
Services users don't have to stay in hospital longer than necessary	High	Medium term	Quantitative

Investment Objective: Maximise flexible, responsive and preventative care - at home, with support for carers			
Outcome	**Relative Value**	**Relative Timescale**	**Type**
More people able to access care from their preferred location i.e. at home	High	Medium term	Quantitative

More people able to return home following hospital care	High	Medium term	Quantitative & resource
Providing care at home is more cost effective than institutional care	High	Medium term	Cash & resource releasing to
Carers feel better supported in their role	High	Medium term	Qualitative
Increase in visits and involvement from relatives and wider family, including children, to the residents and within the care village	High	Medium term	

Investment Objective: Make best use of available resources			
Outcome	**Relative Value**	**Relative Timescale**	**Type**
Affordable service delivery	High	Short, medium &	Quantitative
Service capacity meets service demands	High	Medium & longer term	Quantitative
Service model is more flexible to future changes in demand	Medium	Medium term	Qualitative
Reduction in overall number of beds (from the baseline high of 161 in 2011)	High	Medium term	Cash & resource releasing to
Reduced demand for more expensive care pathways (through shift from health to social care models of	High	Medium to longer term	Cash releasing to NHS &

Investment Objective: Improve quality & effectiveness of accommodation used to support service delivery

Outcome	Relative Value	Relative Timescale	Type
Improved user perception of quality of care	Medium	Medium term	Qualitative
Improved condition of available accommodation	Medium	Medium term	Qualitative
Accommodation meets modern service needs & enables flexibility of use	High	Medium term	Qualitative
Improved functionality of accommodation improves service effectiveness	High	Medium term	Qualitative

Investment Objective: Improve safety of health & social care, advice, support & accommodation			
Outcome	**Relative Value**	**Relative Timescale**	**Type**
Reduced risk of HAI incidents	High	Medium term	Qualitative
Reduced risk of harm from property related incidents	High	Medium term	Qualitative

Information Management and Information Communication Technology is a key enabler for the new village model, particularly to deliver:

- Integrated systems and care records – access to a shared clinical and care management system, joint information governance and data sharing arrangements; in and out of hours
- Connected infrastructure - mobile working solutions; shared domains
- Self-management and signposting – technology enabled care; health monitoring systems;
- Business Analytics for evaluation
- Access to STRATA referral pathways
- Access to Datix for reporting of adverse events and incidents
- Attend Anywhere for Virtual Consultation with GP and other services
- WIFI access for patients and families
- information, advice and guidance

Assessment and planning to deliver these component and operations are necessary and will be addressed further within the project planning and commissioning arrangements and a sub group has been set up to facilitate this work.

4. CONSTRAINTS AND DEPENDENCIES

4.1 Capital Funding Constraints

The project is proposed to be funded via the Council's Capital Plan. The current available capital is £22.679m for two new residential care facilities, one for Hawick and another for Tweedbank.

4.2 Dependencies

Revenue Funding Constraints - It is proposed that the revenue implications of the new development are met through the closure of Deanfield Care Home and revenue funding transferred to the Care Village. Depending on the size of the care village provision identified as required for Hawick through the needs assessment, there is potential for additional revenue to be required over and above that transferred from Deanfield.

Staffing - There may also be an increased workforce requirement if moving towards the provision of nursing/clinical care. As the model develops, specific workforce modelling will be required taking into consideration anticipated demands on the village and the skill mix required to support the proposed model.

To deliver the new model of care, requires key elements to be examined in more detail:

- transitioning the existing workforce to a new type of working model
- ability to recruit necessary workforce
- recognition of likely requirements within the proposed Health and Social Care Staff Bill
- Understanding dependency and the ratio of staffing to achieve personal outcomes

The Care Village concept is dependent upon the collaboration and inclusion of other partner organisations, such at the local GP practices, Allied Health Professionals, community nursing, community hospital services, local care providers, local charities and the voluntary Sector will enhance the Care Village concept.

5. CRITICAL SUCCSS FACTORS TO THE PROJECT

In addition to the Investment Objectives set out in the strategic case for change, a number of factors which, while not direct objectives of the investment, will be critical for the success of the project, and are relevant in judging the relative desirability of options.

The agreed Critical Success Factors are shown in the table below.

Key CSF's	Broad Description
Strategic fit and business objectives	Fits with the strategic intention to shift the balance of care from acute to primary care and from institutional care to home care. It is also in line with Scottish Borders Council's Single Outcome Agreement
VFM	It enhances service delivery, improves user experience, and achieves the project investment objectives from an efficient cost base, while at the same time reducing service delivery risks
Achievability	The key service providers are able to adapt to the proposed service changes and deliver an enhanced service from identified resources
Supply-side capacity and	Service providers have the resource capacity and capability to deliver the proposed service model and facilities; and the scheme will be able to attract the necessary investment.
Affordability	Available capital and/or revenue funds will be sufficient to provide the facilities and ongoing resources needed to deliver the proposed

6. PROCUREMENT

Since SBC are a government funded body they will have to comply with stringent procurement rules. This will include advertising the contract with the European Union via OJEU. This sets the

limit for a contract of £4,733,252 (net of VAT) so anything above this has to be marketed via the OJEU process. This process can be time consuming and can be very labour intensive in terms of reviewing the submitted returns. In some cases it can add between 3 – 6 months to the programme.

However, this process can begin early in the project to mitigate programme risks where possible. SBC has previously used Public Contracts Scotland to advertise projects above and below OJEU limits. It would be advisable to meet with the procurement team in the early stages of the project to establish the requirements.

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Future Care Provision in Hawick

A report of an engagement exercise in Hawick

A report to Scottish Borders Council and Health and Social Care Partnership

August 2022

National Development Team for Inclusion

Acknowledgements

Thank you to thank all the people we spoke with to produce this report. We appreciate how you gave us your time and shared your experiences with us. Our thanks also to the staff from Scottish Borders Council/ Health and Social Care Partnership for your guidance and help with organising the engagement exercise.

Executive Summary

Background

Scottish Borders Council (SBC) and the Health and Social Care Partnership (HSCP) are exploring options for future care provision including the development of a care village in Hawick and commissioned the National Development Team for Inclusion (NDTI) to engage with the community and key stakeholders in Hawick to hear their views.

NDTi carried out this engagement through talking with 113 people at stakeholder workshops, Locality Drop Ins, community groups, and online sessions with health and social care practitioners and third sector organisations. We also spoke with residents, families and staff at Deanfield Care Home. We structured our conversations around four key questions:

- What do you think are the **most important services** to be provided in Hawick and are there any current gaps?
- What are the most important features for care services **including 24-hour residential care** provision?
- What other services do you think would be important to be on a **community site**?
- How can the community **get involved**?

Findings

We heard that people **valued existing health and care services** in Hawick including from the community hospital, Deanfield care home, supported housing and community groups. They missed some of the services that had closed, and a core message was not to close any further facilities until new services were opened.

A number of **gaps in services** were highlighted, which reflected the demographics and focus of those engaging. Three of the main ones were a lack of support for independent living (through care at home and/or linked to sheltered housing), care and support for people with dementia, and carer support and respite. Other gaps included palliative care /end of life care at home, 24-hour care for younger people and having information about support when it is needed.

There were **concerns about a funding gap** between the cost of the services needed and resources available, and a view that that **services should be more joined up**.
Overall, it was clear that people want **flexible care options to meet their needs in a way that preserves their dignity and independence** at home and in residential settings through:

- better integration between housing, care and health services
- a person-centred approach where staff understands what matters to an individual
- future proofing when repurposing /designing care provision
- training and development for all care staff

In addition, **residential care** should be homely, have good sized bedrooms and ensuite bathrooms, provide access to outdoor space and the wider community, offer a range of activities and be a welcoming environment for visits from family and friends.

The engagement exercise showed that the question for most people is 'W**hat care services does Hawick need'** rather than what would a care village look like? This way of thinking moves the focus from a physical site to identifying a range of key services – housing, care, social and leisure facilities/activities – provided at sites across Hawick - that meet the needs of people requiring care. These needs reflect the SBC/HSCP principles for future care options in Hawick and can be summarised as:

- **People want to live as independently as possible** – either at home or in sheltered accommodation with 'my own front door' – remaining in their own neighbourhood and community, preserving the connections and networks they already enjoy – and with access to care services as needed.
- **Care services should be person-centred and flexible**, providing different options – home care, day services, respite care, 24-hour residential care - reflecting people's circumstances and choice. They should enable people to have **dignity and respect**.
- **Support for carers needs to be responsive** and timely to maintain people's independence and prevent emergency admissions to hospital/residential care.
- Residents, families and staff agree that **residential care should be provided in a homely setting that match people's preferences** with modern ways of supporting care through design and technology, access to stimulating activities and be able to have contact with family, friends and the local community

Wherever the care facilities are, people stressed how the **location is important** as people in Hawick have a strong sense of place and for residents in sheltered housing and residential accommodation it must be possible to have two-way contact with the town.

Care provision should also be **inclusive** and thought given to the need for 24-hour provision specifically for younger people. For any age group, care at home or in residential accommodation should be appropriate for people with learning disabilities, LGBT+ people, and people from minority ethnic and the Gypsy and Traveller communities.

Local people and other stakeholders thought that care of older people should be something that runs through Hawick as a community so there could be a move from a care village concept in Hawick toward **Hawick as a village/town that cares**.

Those expressing the above felt this would enable **practical community links** and people mentioned possible roles for volunteers including running communal activities, taking individuals and/or groups on trips, and befriending by volunteers with key interests that could provide stimulation and support. Stakeholders agreed that for the approach to be successful, volunteers must have access to training and support and enhance (not replace) care from paid staff.

Hawick as a town that cares would also require a **partnership approach between agencies for integrated, flexible housing and care. H**ousing, home care, day support, respite and residential care could then be delivered from across premises or 'hubs' across Hawick and be 'joined up' with the council, health, third and independent sectors working together.

Contents

1. Introduction

Background

Scottish Borders Council (SBC) and the Health and Social Care Partnership (HSCP) are exploring options for future care provision including the development of a care village in Hawick and has commissioned the National Development Team for Inclusion (NDTI) to engage with the community and key stakeholders in Hawick to hear their views. The findings of this engagement exercise are presented in this report which will inform an options appraisal and the development of an Outline Business Case for Scottish Borders Council / Health and Social Care Integrated Joint Board in September 2022.

Council/HSCP commitment

The Council and HSCP are committed to improving care provision both in Hawick and Tweedbank and as part of this exploring the concept of a care village. This commitment has been made in the context of recovering from the pandemic and recognising the demands of a growing older population and increasing complexity of needs. New legislation and guidance have set out revised standards for accommodation and support which also need to be considered.

Improving care provision is not without challenges, notably around staffing and the economic/financial climate. However it will also provide an opportunity to embrace new technology and redesign services to bring them up to date including Deanfield Care Home.

Purpose of engagement

The Council/HSCP is keen to develop care services which are based on both identified need and reflect the views of local communities and key stakeholders. This approach allows all interested parties to contribute to service planning and resource allocation and provides opportunities for cross-sectoral partnership working.

The focus of engagement is with all stakeholders in the Hawick community and those people who use current services. Alongside this engagement process SBC/HSCP is undertaking an epidemiological needs assessment including future population projections and health needs to inform the future plans and options could be considered most suitable for care and then appropriate service level.

Principles for future care provision in Hawick

The detailed model of care and support including a care village will be informed by the engagement and needs assessment work. However our engagement with stakeholders and local people was based on the principles of future care provision in Hawick. These are:

- Emphasises the Importance of **place** - neighbourhood and communities
- Provides **flexible,** up to date **care** and **support**
- Gives people using services greater **choice** and **control** of their **social care** and **health.**
- Improves **access** to services and the local **community**.
- Supports people to **l**ive as **independently** as possible with their families and/or carers at home or in a setting of their choice.
- Enables people to live in a setting of their choice surrounded by the **facilities** and support of a local **neighbourhood** model.
- Optimises efficiencies and effectiveness.
- Maximises **flexible, responsive** and **preventative** care – in a homely setting, with support for families and carers.
- Improves **quality** and **effectiveness** of a homely setting and environment used to support service delivery.
- Improves **safety** of health and social care **advice, support** and **accommodation**.
- Provides more **options** for care - how and when it is delivered.

2. Engagement

NDTi's role

NDTi's role in Hawick has been to:

- To **engage** with, **hear** and **capture** the **voice** of **people providing** and **requiring support**, including **carers** and the **community**
- To **capture** the **views** and **ideas** of the **community**, **stakeholders** and **people** of Hawick to inform the plans for the provision of care in Hawick
- To provide a **report** of our **engagement findings** to **inform** the next stage of the development- this report
- Undertaken **research around care villages and alternative models of support** to inform the options for future care village provision and associated services.

Who we engaged, how, where and when

We took a blended virtual/in person approach to the engagement work in Hawick to capture the voices, knowledge, views and ideas of different groups of people as follows:

Stakeholder workshops

- Initial stakeholder workshop: Hawick Town Hall 27th June
- Online workshop: Third & Independent sector 18th July
- Online workshop: Health & Social Work professionals 22nd July
- Online workshop: Community Groups 25th July
- Online workshop: Mental Health 1st August

Locality drop ins:

- Session 1 on 14th July between 10 and 2 at the Heart of Hawick Community Café
- Session 2 on 19th July between 10 and 2 at the Heart of Hawick Community Café

Deanfield Care Home

- Staff – 12th July, 13th July
- Families – 12th July, 19th July
- Residents – 13th July

Other discussions with key groups in Hawick

- Conversations with people from: Men's Shed and Women's Craft groups, Dementia Café, Cuppa and Chat (Burnfoot Community Centre), mental health and learning disability representatives, and health and social care staff including the District Nursing Team.

In total, **113 people were engaged** through the above sessions. There were slightly more women than men engaged. Staff from the Council, NHS, third and independent sectors tended to be of working age. Most of the local people at the drop-ins and community groups were older e.g. over 60. This provided a wide range of perspectives although underrepresents those from people from some specific Equalities Groups (e.g. LGBT+, Learning Disabled people), which we discuss later in this report.

Questions for our conversations

We structured our conversations around four key questions:

- What do you think are the **most important services** to be provided in Hawick and are there any current gaps?
- What are the most important features for care services including 24-hour residential care provision?
- What other services do you think would be important to be on a **community site**?
- How can the community **get involved**?

3. Our findings – What people said

What do you think are the most important services to be provided in Hawick and are there any current gaps?

We heard that people really valued the existing health and care services in Hawick including Hawick community hospital, Deanfield care home, supported housing and many community groups that exist. There was still a sense of loss for some of the services that had closed, and a core message was not to close any further facilities until new services were opened. There were also concerns about a funding gap between the cost of the services needed and resources available in the current financial climate.

The following **gaps in services** were highlighted by a number of people we spoke with.

- Lack of social care to enable people to live at home for as long as possible
- Sheltered housing for independent living – with care as needed
- Palliative care/ end of life support at home is limited
- Support for people with dementia
- Carer support and the need for more short break/ respite options including residential care and opportunities during the day
- 24-hour on-site support for younger people
- The importance of getting the right information and support at the right time

A number of people talked to us about accessing any new services from Newcastleton pointing out the lack of services there for people who had long term, complex needs. This issue was also raised in relation to people living in other rural areas of Teviot.

Independent living

Most people we spoke with said that **remaining independent** was very important to them. Ideally, they wanted to remain **at home for as long as possible** with social care coming to them as needed. But there were concerns that home care is inadequate or inflexible just now with stories of people only coming for 10 minutes and/or to help people into bed by late afternoon.

People explained that when they did not feel able to remain in their own home, they would want some form of **accommodation with flexible care support** which could be increased when they had mobility issues and/or felt unable to live alone, often after losing a partner. Features that were mentioned often include:

- “My own front door”

- Communal facilities – a café, residents' lounge
- A garden, space outside – somewhere to grow things
- Activities and trips – which the community can help organise
- Guest rooms or flat for when friends and relatives come to stay
- Location important – many preferred to be near centre of Hawick – to continue meeting friends, for shopping etc.
- Accommodation that could be easily adaptable as needs changed or new ways of delivering support and care developed

At present there seems to be a shortage of this type of flexible housing provision in Hawick currently although we did hear some good ideas from housing providers about how they worked in other areas to provide flexible support to people in need of housing and care.

Several people we met at the drop-in sessions and at local groups were concerned about the time that they had been waiting for sheltered housing and said that they did not know how long the wait was likely to be. Some people mentioned previous provision which could have been adapted to provide solutions such as 'the cottages around Deanfield' (sheltered housing which people said had been closed and been replaced by private housing).

Some home owners we talked with were interested in **mixed tenure housing** developments so they could buy accommodation that suited their needs as they required more care and retain their assets. There was also interest in shared ownership housing.

Support for people with dementia

The other significant gap highlighted by a range of people we spoke to was support for people with dementia and their carers. This included plugging current gaps through better:

- GP follow up post initial diagnosis e.g. for reassessment, review of medication
- Understanding and/or support for people with dementia to take part in previous interests and specialised, stimulating activities for people with dementia
- Appropriate home care as an alternative to residential care for people with moderate to severe dementia
- Support for carers through respite facilities

Carers of people with dementia explained about the gap between support for people for one year after a dementia diagnosis and the stage at which they required 24-hour (residential/nursing) care. During this time they wanted access to reviews by a GP on the progress of the disease and medication as well as social work reassessments. As one carer explained:

"People tend to see Alzheimer's and dementia as a single condition – but the disease changes and progresses AND is different for different people. So provision has to be flexible"

People with dementia at the Dementia Café told us how they enjoyed the sandwiches and music, especially the songs they liked and could sing along too. The café runs for one afternoon a month and several people pointed out that more was needed to provide people with dementia with stimulating activities and an opportunity to socialise.

Although some people with dementia have care workers supporting them at home, they tended to provide personal care rather than stimulating activities. Although some home carers took people with dementia on walks and talked/reminisced with them about their interests, we also heard about carers who were untrained in understanding dementia and/or of different carers coming each visit which was confusing for people with dementia.

Carer support and respite

Carers of people with dementia and with other conditions told us how they appreciated the information and emotional support they received through the Dementia Café, the Dementia Support Group and the Carers' Centre.

But they felt that this support, although important, does not cover the need for **home care/support and day activities to allow respite for carers**. Carers mentioned that the day care facilities at Deanfield and the community hospital had closed. We heard from several people that the only day centre in the area is 'Place and Space' in Kelso, which incurs a charge and, if the person needs help going to the toilet, the carer needs to be there all day.

Some carers told us how they receive a limited amount of respite care (e.g. 2 x 2 hours a week) but others said how they were trying to get some but did not qualify. (It was unclear whether this was through SBC/SDS or privately arranged and paid for).

Carers also wanted access to respite care for weekends and occasionally a week. We heard that the nearest place this is available is in Eyemouth and that facility (at the hospital) is currently full.

Carers were concerned about the **effect of the gap in respite care on their physical and mental health**. This was echoed by health professionals, one of whom explained that:

"Family carers are under huge stress. Lack of paid carers puts all the pressure of caring on the family. Often carers become ill because of the stress and/or because they are not looking after their own health as their focus is on the person they care for. Then they get admitted to hospital, but often too late. The carer passes away and the person being cared for has to go into a care home. It's short sighted not to support carers more"

Other care gaps

Carers and health and care practitioners spoke to us about some other specific care gaps which are related to those above but require specialist care provision. These included **palliative care /end of life care at home** so people are able to remain in their own homes and die with dignity and as much independence as possible.

There is also a need for **24-hour care for younger people in Hawick**. The lack of this has meant young people with physical and/or learning disabilities in transition from children's to adult services have needed to go out of the area to receive complex care support. We also heard about a couple of instances where middle -aged people with physical disabilities were staying in residential care geared to older people, often with dementia, because there were no alternatives. They could result in feelings of isolation and lack of appropriate stimulation.

A common theme that runs through people's comments on care provision and gaps is the need for **information and support at the right time**. Whether for management of long-term conditions, home care, sheltered housing or specialist services, such as for dementia, people had often spent a lot of time trying to find out what was available and how they should go about accessing the provision. This is often a problem for people with long-term conditions who are not told/don't know how to get support after the initial diagnosis / assessment when they become aware of wider support needs and/or as the condition progresses.

Partnership approach between agencies for integrated, flexible housing and care

Many people, including representatives of the independent and third sector we spoke to, commented on the need for a range of flexible housing solutions and tenures and more joined up planning. For example, housing, home care, day support and respite care needs to be 'joined up' with the council, health, third and independent sector working together to:

- Enable people to be able to continue to live independently/in sheltered housing and increase the level of home care and day care they required without moving
- Prevent people having to move into 24-hour residential accommodation due to a lack of appropriate home/day care support
- Provide retirement/extra care/sheltered accommodation for couples combined with flexible care options so partners could stay together when one person requires care but the other either doesn't or needs a different type/level of care.

We understand that Eildon Housing Association has plans for an extra care housing development in Hawick. A few people we met were aware of this in very general terms and asked questions about how this would link to future care support and a care village. This raises the need for **partners working together to plan future housing and care in an integrated way that meets needs**.

Sufficient capital and revenue finance

People welcomed the commitment that SBC had made to a care support and a care village in Hawick but questioned whether the £8 million capital funding allocated for the development would be sufficient. Specific concerns included:

- Whether £8 million would be enough for the sort of care village/future care services that would represent a significant improvement over what is currently available
- Whether there would be increased revenue funding for training and development of specialist staff at the staffing levels needed
- How the community could be resourced to get involved e.g. how co-ordination, training and support of volunteers would be funded

These concerns about funding a new care village in a very tight financial climate led to a degree of scepticism from stakeholders. This was given as a possible reason why relatively few Deanfield staff and families came to the engagement sessions. Some people at the drop-in sessions and community groups also seemed jaded about 'council promises coming to nothing' and 'a traditional council that isn't good at change'.

Conversations with third sector and independent providers showed that the independent sector has a range of resources that could be utilised in partnership when developing housing and care provision. Some stakeholders suggested that working with the private sector more generally should also be explored to tap into wider resources.

What are the most important features for care services including 24-hour residential care provision?

Flexible care appropriate to individuals' needs now and in the future

We talked with residents and their families at Deanfield (see below), people whose relatives had received care at home and in residential settings and people who thought about what they would want from care they might receive in the future. The overarching view was that **people want flexible care options to meet their needs in a way that preserves their dignity and independence at home and in residential settings**. This means:

- better integration between housing and care (as discussed above)
- a person-centred approach to care where staff understand the individual and what matters to them
- future proofing when repurposing /designing care provision
- training and development for all care staff.

One local resident described what she would want from a care facility as:

"Ground floor cottages with 24-hour carer support and communal areas for meals if wanted …. my want own front door and view. I'd want to be able to make a cup of tea. And I'd need to get out – go to church, go out for lunch. Lots of places you go into then they shut the door and that's it – it shouldn't be like that"

Future 24-hour residential care - Learning from Deanfield care home

One aspect of any future care provision/ care village will be the repurposing of Deanfield Care Home and we talked with residents, families and staff at Deanfield to find out about what works well and what needs to be improved in the future. Maintaining as much independence and links with their family and local community were highlighted as key principles for people when they moved into a care home.

The things that work well in Deanfield are:

- the staff - who residents and families think are kind and attentive
- activities - such as craft competitions, keep fit, musical bingo (for residents with capacity to participate)
- residents' rooms and communal areas – clean and comfortable

The things that need improving are:

- size of bedrooms and ensuite bathrooms – too small particularly if residents use wheelchairs and/or hoists-

- ability for residents/visitors to make themselves a hot drink (kettles in rooms or access to communal facilities)
- private spaces to see visitors – rooms with chairs and/or more private spaces within communal areas
- communication – reception area could be staffed and easier to contact via phone
- staffing levels - residents worry about them being overworked and staffing shortages mean there are often not enough staff to run activities/ take residents out
- staff skills – families feel staff need more understanding of dementia, how it can affect people differently and how to communicate with residents with dementia
- outdoor area – that is accessible and safe for all residents to sit/walk in

Well trained, specialist staff

The importance of staffing for good quality, flexible care services was raised by stakeholder sessions, community drop-in and in conversations at Deanfield.
Care staff shortages including care at home were seen to be a barrier to providing flexible, person care. As one health professional put it:

"Investment is needed in [the social care] workforce - both in pay and conditions"

People thought staff needed to know about how conditions such as Parkinson's, diabetes or dementia can affect people differently and what this means for their care. Several carers for people with dementia and families of residents at Deanfield suggested that specialist staff are needed to care for/support people with dementia in a similar way to having Macmillan nurses for people affected by cancer.

Stimulation and activities based on people's interests – indoors and outdoors

People also stressed how important it is for care staff to understand an individual's interests. This helps 'good conversations' and planning relevant activities such as gardening, watching football or tennis on television, going to church or learning how to Zoom with grandchildren.

Care and nursing staff agreed with this view but explained how they felt frustrated that the current staff shortages (made worse since/by Covid) made it difficult for them to spend quality time with individuals e.g. in activities or reminiscence sessions.

Carers and families of with dementia emphasised how they need stimulating activities, but that these require funding, organisation and staff with specialist skills.

In a residential setting, two members of staff are often needed for taking a resident to the park or into town, so these opportunities are restricted during staff shortages.

What services do you think would be important to be on a community site?

What care services does Hawick need?

As the engagement work progressed and we heard from people about their experience of care services, the gaps in provision and their priorities for improvement, it became clear

that the question to start with is 'What care services does Hawick need' rather than what would a care village look like?"

This way of thinking moves the focus from a physical site to identifying a range of key services – housing, care, social and leisure facilities/activities – that meet the needs of people requiring care and are integrated and provided flexibly through partners – public, private, community - working together.

These services could be provided at/from sites across Hawick as long as they are co-ordinated around a person-centred approach. This requires close working between partner agencies when planning and delivering these services.

Location for local links

Wherever the care facilities and services are situated, people stressed how it must be **possible to have two-way contact with the town**. Residents in all types of accommodation should have the choice to get into Hawick to go to for example, the shops/hairdressers, attend clubs/activities they enjoyed previously, meet friends and family for coffee or go to church/place of worship.

Likewise it is important that friends, families, volunteers from Hawick and beyond, who won't necessarily have access to a car, can get to the care village site(s). If the site(s) are outwith the centre of Hawick, and with limited bus services, this may mean that a minibus or volunteer car service is required for links between the care village and community.

"Families should be encouraged to visit [people in a care village]. Need a transport network, a playground for children, bird and wildlife watching, dog friendly visits, a coffee shop"
(Stakeholder workshop)

The **location and transport issues were raised frequently relation to Stirches**, which a lot of people thought was the agreed site for the care village. Buses only run from the town centre to Stirches once an hour and people with mobility issues find them difficult to use. There was a range of views about **other aspects of siting a care village at Stirches** including from some local residents being concerned about traffic, noise and lighting. Others living in the Stirches area raised the lack of local amenities there and thought a care village could bring facilities such as a shop and community café into the area and help bring the community together. Some people pointed to the potential inter-generational links that could be made with the local primary school which is next to the Stirches site.

People suggested **other sites for a care village** (or some parts of it if a diffused model is adopted) particularly Crumhaugh House (a disused care facility) in central Hawick. In any event, people felt strongly that **no more existing facilities should be closed before new care provision was opened.**

Key features of a care village

There were mixed views about a care village model and whether the care village is an £8 development on a single site or whether it is a more diffuse model of integrated care

provision across Hawick. However we found a lot of agreement that is should be **person-centred with some key features**. These are:

- A range of accommodation for people with different levels of care needs
    - Sheltered/extra care/retirement housing with 24-hour warden
    - 24-hour residential accommodation
    - Accommodation for couples
    - Guest rooms for visitors

- Care services including:
    - Home care – for people living independently and in sheltered housing
    - Day services – enabling participation in stimulating, social activities
    - Specialist care for people with dementia
    - Respite care and support for carers
    - Hub for specialist care services e.g. palliative care at home

- Communal facilities (for people in all types of accommodation and visitors):
    - Lounge/refreshment area
    - Café/restaurant/meal service
    - Outdoor space
    - Play area for children visiting
    - Trips and a range of regular activities (for residents)

Although people said access to communal facilities was important to them, having all services on site is not essential. Investing in and linking to existing businesses including cafes, shops, hairdressers and pharmacies would generate greater integration of a care village into the surrounding community, as well as bringing economic benefit to businesses and new jobs in the town

There were mixed views about **who a care village should be for**. Most people thought it was most practical to aim it at older people. There was some interest in including services to meet the needs of people with learning disabilities and/or young people in transition, including through a training flat. But there was a concern that it wouldn't work for there to be one or two young people in a care village where everyone else was a lot older. There were also comments that the budget wouldn't allow the necessary planning and facilities to include other demographic groups.

How can the community get involved?

Hawick as a town that cares

Local people and other stakeholders thought that care of older people should be something that runs through Hawick as a community so there could be a **move from a care village in Hawick to Hawick as a village/town that cares**.

There are already a good number of community groups and activities in Hawick, such as the Men's Shed and the Dementia Café, which enable people to maintain their interests,

socialise with other people, access information and give/receive peer support. The What Matters Hub, at Heart of Hawick can provide assessments for social care and occupational therapy and signpost people to a wide range of community support. We also heard of organisations providing support including counselling locally that could be developed.

Building on this existing community support could include helping shops, cafes and other businesses to be more aware of the needs of older people, disabled people and people with dementia and how their services could be more dementia friendly. This would also help reduce the stigma that carers of people with dementia spoke about.

Community groups could look at involving people with dementia and other care needs in their activities through additional support and/or customised sessions. One participant suggested that groups such as the Men's Shed might look into this.

Better links between the community and residents in a care village/care facilities could also be promoted through volunteering and intergenerational activities with, for example, local schools or as open community events e.g. tea party, karaoke entertainment.

This approach needs the active support of all stakeholders. While we engaged a wide range of all types of health and social care practitioners, and made contact with **GP surgeries**, we were unable to have a conversation with GPs directly. We would also have liked to **engage more local businesses, possibly through the Chamber of Commerce.** We suggest that SBC/HSCP involve these two groups during the further development of care plans in Hawick.

Inclusive care

Despite reaching out to a broad range of people and groups and our engagement providing a wide range of perspectives, we recognise that this report underrepresents some Equalities Groups including the direct voice of lived experience with:

- Learning Disabled people
- LGBT+ people
- Minority ethnic communities including the Gypsy Traveller community and Eastern European people (predominately Polish, Romanian and Roma) who stay in Hawick

However we did hear from other some professionals who were able to offer some thoughts but recognise this was not from people with direct experience of services.

As the plans for future care develops in Hawick, it will be important for SBC/HSCP to engage these groups. Although most people thought it was better that a specific care village was for older people, it would be useful to consult with people with a learning disability, their carers and practitioners in this field to discuss whether a care village could include care for Learning Disabled people, especially if a diffuse model of integrated care services across Hawick is pursued.

We are aware that people from ethnic minority communities can find it difficult in sheltered housing or residential accommodation as they may be in a very small minority and find that their language, dietary and cultural needs are not catered for. Like LGBT+ people, they can

be vulnerable to stigma, prejudice and discrimination. Engaging the relevant Equality Groups can help ensure that care services are inclusive of everyone's needs

Volunteering

Most people we spoke with thought that, in principle, **volunteering could be an important development to provide additional social support and involve more people from the Hawick community.** This would enable practical community links and people mentioned possible roles for volunteers including running communal activities, taking individuals and/or groups on trips, befriending and volunteers with key interests that could provide stimulation and support. Participants on online sessions made some specific suggestions:

"For befriending services, Interest Link a positive example of linking people with learning disabilities with volunteers with the right interest, skills and groups. Could a similar model be set up for older adults or around mental health buddying – or in a care village?"

However, a small number of practitioners expressed concerns about volunteering, often based on previous experience. They pointed out that as they would be working with vulnerable people, they would have to be trained appropriately and have PVG checks.

The current staff shortages also mean that recruiting volunteers can become a sensitive issue if it is thought that these may replace paid staff or fill gaps in staffing.

Overall it appeared that **volunteering is a good way to build community links with people needing care and support if it is follows good practice**, such as:

- Allocating resources to co-ordinate, train and support volunteers
- Using volunteers to enhance (not replace) care from paid staff
- Enabling volunteers to link people needing care with local community activities

4. Conclusions

The engagement with the Hawick community and other stakeholders on options for future care provision, including the development of a care village, has reinforced Scottish Borders Council/Health and Social Care Partnership's **principles of future care provision in Hawick.**

It is also clear that individuals and services recognise the need for modern care provision in the area, which gives people the best possible options and choice for how care is provided. The way in which this is viewed as being achieved is however inconsistent. The concept of a site based dedicated care village is attractive to some, but equally others stated a desire to have an approach which embraced the wider community and opportunities that Hawick offers, utilised, improved or better-connected existing assets

- **People want to live as independently as possible** – either at home or in sheltered accommodation with 'my own front door' – remaining in their own neighbourhood and community – and with access to care services as needed.
- **Care services should be person-centred and flexible**, providing different options – home care, day services, respite care, 24-hour residential care - reflecting people's circumstances and choice. They should enable people to have **dignity and respect**.
- **Support for carers needs to be responsive** and timely to maintain people's independence and prevent emergency admissions to hospital/residential care.
- Residents, families and staff agree that **residential care should be provided in a homely, up to date setting with access to stimulating activities** – inside and outdoors - and be able to have contact with family, friends and the local community

Although people valued existing health and care facilities in Hawick, they identified gaps (e.g. for independent living, support for people with dementia, and carer support and respite) and made suggestions about how these and other services could be improved in line with the principles.

They felt that no more existing facilities should be closed before any new care provision was opened. And there were doubts about whether the £8 million development of a care village on a single site would be able to offer the improvements in care services that are needed.

Local people think Hawick is a caring place where 'people look out for each other' and are keen that the community is involved in care and support of older and vulnerable people. So

another way of thinking about improving care services would be to move from a care village in Hawick to **Hawick as a village/town that cares.**

This would involve taking a **partnership approach between agencies for integrated, flexible housing and care.** Housing, home care, day support, respite and residential care could then be delivered from across premises or 'hubs' across Hawick and be 'joined up' with the council, health, third and independent sectors working together.

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DIRECTION FROM THE SCOTTISH BORDERS INTEGRATION JOINT BOARD Direction issued under S26-28 of the Public Bodies (Joint Working) (Scotland) Act 2014	
Reference number	SBIJB-020922-1
Direction title	Primary Care Improvement Fund 2022
Direction to	NHS Borders
IJB Approval date	IJB 21 September 2022
Does this Direction supersede, revise or revoke a previous Direction?	No Yes (Reference number:_____) (Insert cross as appropriate to select) Supersedes [ ] Revises [ ] Revokes [ ]
Services/functions covered by this Direction	Primary Care Improvement Fund 2022
Full text of the Direction	The IJB is directing the Health Board via the PCIP Exec Group (comprising IJB, HB and GP members)to : 1. Deliver agreed project outcomes using the reserves brought forward totalling £1,522,980 (Appendix 1 attached) 2. Review current project spend from main allocation to determine whether any spend can be met from reserves 3. Review the priorities for recurring activity with a view to targeting resources to higher priority workstreams. 4. Comply with commissioning (and decommissioning) guidance, involving and seeking approval from Strategic Planning Group and IJB as required. 5. Plan, initiate and monitor ongoing workstreams funded via the allocation from Scottish Government of 70% of annual allocation - £2,312,902 plus projected 30% balance. 6. Jointly, liaise with Scottish Government to advise that reserves are fully committed, express concern about level of funds available, no funding for pay awards and assumption that reserves can be used to cover recurrent spend. Highlight funding gap of £2.511m and implications of not being able to fully implement the GP contract. 7. Identify risks and issues associated with insufficient funding level, and develop mitigating strategy.
Timeframes	To start by: August 2022 To conclude by: 2023/24 Consider and note the deadlines by when the Direction is expected to be commence and conclude carried out at the latest
Links to relevant SBIJB report(s)	Insert hyperlinks here
Budget / finances allocated to carry out the detail	Reserves £1,522,980 PCIP allocation £2,312,902 plus 30% balance Note that PCIP allocation does not include inflation – for 2022/23 this is funded from reserves
Outcomes / Performance Measures	Implementation of the GP contract – full implementation of all workstreams is not possible within the funding provided. Project and workstream specific outcomes and performance measures
Date Direction will be reviewed	November 2022, February 2023

APPENDIX 1 Reserves commitment to non recurring spend

Non-Recurrent Funding

A summary of commitments made by the PCIP Executive Group against the non-recurring allocation is summarised in the table below:

Commitments	Resource Directed £	Actual Expenditure to 30 April 2022 £	Forecast Expenditure to 31 March 2023 £
ANP Training	82	2	82
CTCS Programme Management	54	0	54
CTCS Admin Support	15	3	15
CTCS General Allocation	545	7	545
PCIP Project Management	72	0	72
PCIP Comms / Engagement	25	0	25
VTP	200	0	200
System Acquisition & Installation	276	0	276
Provision for 22/23 pay inflation and drift	254		254
Total Commitments	**1,523**	**12**	**1,523**
Funded by:			
Additional NR Allocation	(1,097)		(1,097)
Non-Recurring Carry Fwd	(426)		(426)
Total Funding	**(1,523)**		**(1,523)**
Remaining for Direction	**0**		
Total Forecast Slippage / Uncommitted			**0**

APPENDIX 2 Recurring spend plan 2022/23

Recurrent Funding

A summary of 2022/23 funding, investment and forecast expenditure position on the Partnership's PCIP is detailed below:

Workstream	PCIP 3-Year Recurring Investment £'000	Actual Expenditure to 01 April 2022 £'000	Forecast Expenditure to 31 March 2023 £'000	Surplus / Slippage / (Deficit) at 31 March 2023 £'000
VTP	16	0	16	0
Pharmacotherapy	879	75	888	(9)
CTAC	121	0	121	0
Urgent Care	883	59	792	91
FCP	528	46	545	(17)
Mental Health	669	52	618	52
Community Link Workers	150	13	150	0
Central Costs	49	0	40	9
Total Expenditure	**3,296**	**245**	**3,170**	**126**
Funded by:				
2.13% of £155m	(3,296)			
Drawn Down Share			(3,170)	(126)
Total Funding Requirement	**(3,296)**		**(3,170)**	**(126)**

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Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 21 September 2022

Report By:	Hazel Robertson
Contact:	Hazel Robertson
Telephone:	07929 760533
PRIMARY CARE IMPROVEMENT FUND 2022	
Purpose of Report:	To update the IJB on Primary Care Improvement Plan funding and spend pattern for 2022/23 and seek approval for the PCIP Direction 2022.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) Note the tightening position regarding PCIP funding b) Approve the PCIP direction which will entail reprioritisation of spend patterns.
Personnel:	Deprioritisation of workstreams may have staff implications which will be addressed through applying existing HR policies
Carers:	No direct impact
Equalities:	EQIA will be carried out for individual workstreams as required.
Financial:	Covers the reserves spend of £1.5m and the recurring allocation of £2.3m (phase 1) and phase 2 still to be confirmed.
Legal:	Nothing at this time.
Risk Implications:	Risks around not delivering the full services as set out to meet the GMS contract, therefore not being able to relieve pressures on general practice nor realise benefits for the Borders population..
Direction required:	SBIJB-020922-1

Situation

1. At the Extraordinary IJB meeting on 17 August the IJB were advised of the change in approach to funding of the PCIF with a significant tightening of available resources. The IJB were also advised of the significant benefit from this programme for the population and for GP workload, and the significant risks associated with not delivering the GP contract including recruitment and stability.

2. As the funding changes were very recently announced it was not yet possible to be be clear about the implications for Borders

3. An additional paper was requested, setting out a clear way forward.

Background

4. The allocation letter indicated that future funding would be subject to business cases and it was felt that this may give opportunities for additional funding.

5. Each project has timelines for delivery and potential for transfer of significant levels of staff. It was also agreed that any direction of funding needed to be competent in terms of source of resources and ongoing financial sustainability. The overall projected recurrent financial gap is £2.5m. Borders Health Board is in a deficit position and it is not possible to direct them to implement the full programme without a funding source. It was suggested to take an aggressive approach to securing the necessary funding.

6. There are four parties involved in this programme: GPs, IJB, the Health Board and Scottish Government. Our view from the Memorandum of Understanding is that SG is responsible for resourcing this programme and we expect the funds to come in to honour the contract, with the IJB commissioning services via the Health Board and GPs.

7. Due to the delay in full implementation of the GP contract the SG has promised funding for two sustainability payments to GPs. The first such payment has been made and there is currently not a firm timescale for the second payment.

8. The PCIP Executive Committee met with two officials from SG on 8 September and had a frank discussion about the funding concerns and the impact on delivery of the contract. This discussion was not promising and an outcome was to escalate this further to the GMS Oversight Group.

9. In addition to escalating with Scottish Government officials we plan to escalate with the GMS Oversight Group.

Assessment

10. A direction has been prepared to manage the programme within the available resources. This will require the PCIP Executive Group to reprioritise the use of available recurrent funding. This is to be done in keeping with advice on commissioning and decommissioning.

11. The PCIP Executive Group will continue to escalate discussion at a national level regarding inadequacy of funds to deliver all aspects of the contract and the risks associated with that..

12. The direction also asks the PCIP Executive Group to identify the risks and issues associated with insufficient funding and to develop a mitigating strategy.

Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 21 September 2022

Report By	Keith Allan, Interim Director of Public Health, Interim Chair Alcohol and Drugs Partnership
Contact	Fiona Doig, Head of Health Improvement/Strategic Lead ADP
Telephone:	07825523603

ALCOHOL AND DRUGS PARTNERSHIP (ADP) SELF ASSESSMENT

Purpose of Report:	To seek approval for submission of the ADP Self-Assessment to Scottish Government.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: approve the report
Personnel:	Due to the nature of the Self Assessment there is no immediate impact on staffing.
Carers:	Due to the nature of the Self Assessment there is no immediate impact on Carers. The Self-Assessment has been ratified by the Lived Experience Forum representative to the ADP. The Lived Experience Forum is open to family members impacted by another's alcohol and/or drug use.
Equalities:	An EQIA is not required as part of the Self Assessment. A Health Inequalities Impact Assessment was undertaken for the ADP Strategy.
Financial:	Due to the nature of the Self Assessment there is no immediate impact on ADP Finances, however, it is an expectation of Scottish Government funding that ADPs deliver on Ministerial priorities.
Legal:	n/a
Risk Implications:	n/a
Direction	No Direction required

1 Situation

1.1 This paper presents the completed Self Assessment for Borders ADP (Appendix 1). The purpose of the Self Assessment is to assess progress in ADPs and partners in implementing the Scottish Government's and Convention of Local Authorities (COSLA) Partnership Delivery Framework (PDF) for ADPs[1] and the subsequent recommendations published in August 2021 (Appendix 2).

2 Background

2.1 Scrutiny of ADP performance, governance and contribution of partners has increased since the development of the National Mission to reduce drug related deaths.

2.2 The PDF recommendations published in 2021 included an expectation that ADPs undertake a Self Assessment. It is anticipated that independent validation of Self Assessments may be undertaken the Care Inspectorate or Health Improvement Scotland and we await further clarification of this process.

2.3 Supporting documentation from Scottish Government colleagues to implement the updated recommendations was expected from February 2022 onwards and expected to include a template for self-assessment. The Self Assessment template was issued on 30.6.22 for return by 19.9.22 following sign-off by a range of senior colleagues. In order that colleagues are suitably sighted on the Self Assessment it was agreed locally to submit following discussion and approval at the Integration Board meeting on 21.9.22.

3 Assessment

3.1 There are five Quality Standards against which ADPs must assess their local performance using the following definitions:

- Maintain: We are confident that we are demonstrating this standard. We have evidence to support this, including stakeholder confirmation and need to maintain this focus over time.
- Explore: We currently partly demonstrate this standard and may need further development
- Develop: We do not fully demonstrate this standard currently and need to develop / discuss this further.

3.2 Each standard (except standard 5) have multiple elements. For each Quality Standard there are criteria to support the Self-Assessment. In order to assist with reading the Self Assessment these criteria are copied in italics into the body of the document for each relevant

[1] https://www.gov.scot/publications/partnership-delivery-framework-reduce-use-harm-alcohol-drugs/documents/

item, for example, for Quality Standard 1, element 1.1. Transparency and Effectiveness the following criteria are included:

☐ *The strategic plan is agreed by the ADP etc*

ADPs are also expected to complete the following questions for each of the Quality Standards:

- How do we know this?
- What do we want to maintain, improve or change and how will you do it and by when?
- Any further comments.

3.3 The Self-Assessment has been agreed at the most recent ADP Board and the majority of elements within the Quality Standards have been assessed as 'Maintain' or 'Explore', however, there are two elements for which we will submit an assessment of 'Develop'. These areas for development are presented below.

3.4 Areas for development:

3.41 Section One – Strategic Planning

'Quality Standard 1: The ADP has a Strategic Plan for delivery of identified outcomes.'
In this standard item 1.4 – Needs Assessment is assessed as 'develop'. It is an expectation that ADPs undertake a review of alcohol deaths in the lifetime of the current strategy. This was scheduled to commence in early 2022 but was postponed when the staff member became unavailable. Attempts have been made to engage support via the national programme for Specialist Registrars in Public Health. There has not been immediate interest but we are revisiting this option.

3.42 The changes in national expectations have resulted in significant additional pressures on the ADP Support Team leading to a situation where there is no capacity to commence this work within this current reporting period.

3.43 Section Five: The relationship between the ADP and the Integration Authority

'Quality Standard 5: The work of the Integration Authority and the ADP is aligned and the Integration Authority is able to provide Directions to partners in support of the ADP Strategic Plan.'
There is only one element in this standard namely 5.1 – Alignment and Governance. Currently the ADP Annual Report is presented to the IJB following its approval by the Chief Officer and submission to Scottish Government. The Self Assessment outlines additional expectations which are not currently in place locally including regular performance reporting and an expectation that there is a written policy in place on how decisions and directions are managed for services out-with the scope of the Integration Authority (e.g. children's services, police, housing).

3.5 'how do we know' and 'what do we want to improve'

The Self Assessment also includes the opportunity to outline ‘how we know’, ‘what we want to improve’ and any further comments. There are a number of areas to which it would be helpful to draw the attention of IJB members to ensure members are appropriately sighted on ongoing work or concerns.

3.51 Section One – Strategic Planning

Quality Standard1: The ADP has a Strategic Plan for delivery of identified outcomes.

The ADP has noted, in relation to item 1.4, that there has not been a recent consultation with the wider community. A service evaluation was completed in 2021-22 involving people with living/living experience and staff in alcohol and drug services, however, this did not include family members or more general consultation.

3.52 Within this standard the ADP has identified the need to have influence in the revision of strategic planning in relation to the overarching priorities for whole family wellbeing; the Promise and integrated children’s services planning. This is being led outwith the ADP and is expected to be completed by end March 2023.

3.53 The ADP has noted that it would like to do better in terms terms of a more up to date needs assessment and an alcohol deaths audit and has noted that the requirement for ongoing reporting in relation to specific priorities (e.g. Medicine Assisted Treatment standards) are challenging to existing capacity.

3.54 The ADP has noted here and in other comments that it would welcome timely information in relation to the anticipated supporting documents for the Partnership Delivery Framework recommendations..

3.55 Section 2: Financial Governance

Quality Standard 2: The ADP can demonstrate public money is used to maximum benefit to deliver measurable outcomes for the local population in delivery of its Strategic Plan

In relation to item 2.5 - Financial planning the ADP has noted that at a local level it is challenging to increase investment over time since additional funding to ADPs (in line with other areas) is currently directed towards treatment services to the apparent exclusion of infrastructure and earlier interventions.

3.56 The ADP has also commented that while it is confident there are robust financial arrangements in place this not aligned with Scottish Government expectations within the PDF. Currently the ADP is supported via NHS Borders Finance colleagues, however, the PDF recommends this role is undertaken by the IJB Finance Officer.

3.6 Summary

Borders ADP continues to perform well. There are areas for improvement highlighted within the Self Assessment and further discussions are required with regards to governance and relationship with the IJB.

3.7 The pace and scale of demands from the National Mission are challenging in terms of ensuring timely briefing of senior colleagues and on the capacity in the ADP Support Team and services.

3.8 The ADP has agreed that it will be valuable to participate in a development session to set the vision for ADP performance and governance following appointment of a new Chair following the Director of Public Health retiring in August 2022.

4 Recommendation

It is recommended that the IJB:

- Approves the Self Assessment for submission
- Notes the areas for development

Appendix 1 Borders ADP Self-Assessment

ANNEX A

IMPROVING GOVERNANCE AND ACCOUNTABILITY ARRANGEMENTS WITHIN ALCOHOL AND DRUG PARTNERSHIPS: SELF ASSESSMENT TOOL

Alcohol and Drug Partnerships
Partnership Delivery Framework

Self Assessment Tool

30 June 2022

Introduction to the Self Assessment Tool

This Self Assessment Tool has been developed to support Alcohol and Drug Partnerships to deliver the Partnership Delivery Framework, Rights Respect and Recovery and the National Mission to Reduce Drug Deaths and Improve Lives.

The Scottish Government and COSLA coproduced the Partnership Delivery Framework for Alcohol and Drug Partnerships which was published in 2019. It sets out the expectations for the role of Alcohol and Drug Partnerships (ADPs

The purpose of the self-assessment

The purpose of the self-assessment is to give local ADPs a tool to engage and discuss opportunities and barriers to delivery.

Strategic Planning follows a cycle of

- Assessing need
- Aligning resources
- Agreeing delivery plans and priorities
- Reporting and learning from outcomes

ADPs are strategic planning partnerships that set out plans to delivery national and local priorities. To effectively deliver these priorities ADPs undertake strategic planning, formulate delivery plans and report outcomes. They do this on a partnership basis that aims to be inclusive and transparent with representation from stakeholders affected by alcohol and drug harms. Increasingly alcohol and drug harms are seen as a “whole system” issue and not just the realm of specialist drug and alcohol services.

ADPs are not Statutory Public Bodies, i.e. they are not “organisations” and therefore rely on the Integration Authority for financial governance and ratification of investment as well as performance oversight. Community Planning Partnerships hold the overall responsibility for population level outcomes set out in the National Outcomes Framework for Scotland and therefore provide ADPs with an overarching forum for reporting achievement of outcomes. Local areas will also have other strategic partnerships which are required in statute such as Children Service Boards, Community Justice Partnerships etc and it is important to ensure that there are strong links between ADPs and these partnerships.

The self-assessment is designed to help local stakeholders ensure that these key relationships are in place and that the local system is supporting the work of the ADP and vice versa. The self-assessment should be agreed and signed off with the relevant Chief Officers and stakeholders.

The Scottish Government use of the Self Assessment reports

As stated, the self-assessment tool is for local stakeholders to ensure that they are creating the right conditions and operating environments for ADPs to function effectively. The Scottish Government will have oversight of the self-assessment reports and the information will be used to help develop programmes of support for local areas when required and will help facilitate peer discussions with ADPs about best practice and achievements. Where an ADP signals it would like further discussion or support in responding to local barriers, this will initially be provided through discussion with the ADP Liaison leads within the ADP Support Team in the Scottish Government.

External Validation

ADPs are asked to assess their own ability to deliver against the Quality Standards and highlight any issues. At a future point the Scottish Government will seek to validate the self-assessment through a third-party organisation such as the Care Inspectorate or Health Improvement Scotland. On that basis, ADPs should complete the self-assessment from the perspective of “if an external person reviewed our approach would they find the same evidence we are presenting?”

How to complete the Self Assessment Tool

The self-assessment should tell a story about where the local ADP and relevant partners are in relation to the Partnership Delivery Framework:

1. Strategic planning
2. Financial arrangements
3. Quality improvement and Outcomes

4. Governance and Oversight
5. The relationship between the ADP and the Integration Authority

A representative national working group agreed the following five standards in relation to the Partnership Delivery Framework. The five quality standards are:

Quality Standard 1: The ADP has a Strategic Plan for delivery of identified outcomes which ensures adequate alignment with other aligned strategic plans

Quality Standard 2: The ADP can demonstrate public money is used to maximum benefit to deliver measurable outcomes for the local population in delivery of the Strategic Plans

Quality Standard 3: The ADP can demonstrate Quality Improvement in delivery of outcomes

Quality Standard 4: The ADP can demonstrate appropriate Governance and Oversight in delivery of the Strategic Plan

Quality Standard 5: The work of the Integration Authority and the ADP is aligned and the Integration Authority is able to provide Directions to partners in support of the ADP Strategic Plan

Structure of the Self Assessment Tool

The Self Assessment Tool should be completed in conjunction with the Self Assessment Criteria (Appendix 1 page 25-34). The criteria outline the minimum supporting evidence required to demonstrate the ADP is delivering and working in line with the Partnership Delivery Framework.

The first part of the Self Assessment asks ADPs to assess themselves against the Self Assessment Criteria and to map themselves again the Criteria using the definitions Maintain, Explore, Develop outlined in the table below.

	Definition
Maintain	

We are confident that we are demonstrating this standard. We have evidence to support this, including stakeholder confirmation and need to maintain this focus over time.	To meet this definition the ADP needs to be confident that it has policies and practice in place. ADP member's and senior stakeholders support this statement. The ADP has feedback processes in place and is confident that an external process could independently gather similar feedback locally. The ADP is confident in maintaining this standard as core practice.
Explore	
We currently partly demonstrate this standard and may need further development	The ADP feels it has some evidence to support the standard but isn't confident it is consistently maintained. The ADP and stakeholders feel there is room for improvement on some elements of the standard.
Develop	
We do not fully demonstrate this standard currently and need to develop / discuss this further.	The ADP is not confident it is achieving the standard. Further work is required to generate support for improvement or progress

The self-assessment then asks the ADP to demonstrate their assessment with narrative in line with the headings of:

1. How effective is the ADP in respect of this area?
2. How do you know this?
3. How will you do it and by when?

For each of the elements described above, please outline in no more than 250 each what you need to maintain, improve or do differently and provide a timeframe for these to be implemented.

Please be open and honest in your response and consider the self-assessment in collaboration with relevant stakeholders, including local communities, children, young people and families. This will provide opportunities to:

- review what progress has been made and what development and learning has happened
- provide assurance about the quality of delivery
- highlight areas of good practice for sharing
- highlight areas for improvement and levels of priority

Those completing the self-assessment are encouraged to use information from different sources to triangulate evidence of the quality of service delivery.

The completed Self Assessment should focus on outcomes rather than activities. This could include a description of the impact of changes or improvement activities on the delivery or information on how potential impact is being monitored.

The Self Assessment Tool

ADP area: Borders

Please use the box below to highlight relevant contextual and background information about the ADP including:

-Population data for context

-Outlining Governance and accountability arrangements (particularly in relation to ADP, Community Planning Partnership, Integration Joint Boards and Chief Officer Groups)

-Links to other local statutory plans/partnerships (and how they link to local delivery) e.g. what links / role does the ADP have in relation to delivery of outcomes against their Local Outcome Improvement Plan / Children's Services Plan

Population data
Drugs: The most recent estimation for Borders was provided from the 2015-16 estimating prevalence report and shows a likely population of opiates/benzodiazepines drug users in Borders of 0.7% of population aged 15 – 64 (510) compared with 1.62% in Scotland. Nationally males represent 68.5% of the estimated population compared to 31.5% females, this is reflected in Borders. The population rate of drug related deaths is 18 per 100,000 in Borders compared to 22.9 in Scotland.
In 2019/20, there were 81 new people who were treated in the Borders (general acute hospital or psychiatric hospital) in relation to drug use for the first time. The drug-related new patient rate increased from 55 new patients per 100,000 population in 2006/07 (55 Scotland) to 86 new patients per 100,000 population in 2019/20 (103 Scotland).

Alcohol: According to Scottish Health Survey (2016/2017/2018/2019 combined), 24% of all adults (aged 16 and over) in Borders are drinking above low risk guidelines (14 units per week) which is the same as Scotland average. In Scottish Borders, nearly 1 in 3 men (31%) and more than 1 in 6 women (18%) were drinking at hazardous/harmful levels (2016/19).[i] Since 2002 – 2006 the rate of alcohol-specific deaths for Scottish Borders males and females has been relatively constant at 15 and 7 per 100,000, respectively. These rates have continuously been well below the Scottish average for males and females.
The rate of alcohol-related hospital admissions for the Scottish Borders has consistently been below the average for Scotland since 2002/03. In 2020/21 the rate of admissions per 100,000 people was 621 for Scotland, and 378 for the Scottish Borders, 40% less than the Scotland rate.

There is no recent Borders prevalence data for alcohol and drugs use in young people via SALSUS.

Outlining Governance and accountability arrangements
The ADP has delegated authority from the IJB to set direction and deliver on national and local priorities. The Annual Report is presented to IJB, CPP and NHS Board. The Drug Deaths Annual Report from Borders Drug Deaths Review Group is presented at the Critical Services Oversight Group (CSOG) which is our local Chief Officer Group. CSOG also receives quarterly updates on the non-fatal overdose pathway and drug related deaths.

The ADP is representation on the Community Justice Board, Children and Young People's Leadership Group (our local Children's Planning Partnership) as well as the Violence Against Women Partnership, Child Protection Delivery Group and Adult Protection Delivery Group which are sub-groups of the Public Protection Committee. There are ADP deliverables and outcomes in the relevant plans of these groups.

Section 1: Strategic Planning

Quality Standard 1: The ADP has a Strategic Plan for delivery of identified outcomes

		Maintain	Explore	Develop
		We are confident that we are demonstrating this standard; we have evidence to support this, including stakeholder confirmation and need to maintain this focus overtime.	We currently partly demonstrate this standard and may need further development.	We do not fully demonstrate this standard currently and need to develop / discuss this further.
1.1	**Transparency and Effectiveness**		X	
1.2	**Inclusion**		X	
1.3	**Planning Cycle**	X		
1.4	**Needs Assessment**			X

1.5	**Whole System Approach**		X	
1.6	**Resources and Delivery**		X	
1.7	**Outcomes**	X		

Q.How effective is your approach to Quality Standard 1?

1.1 Transparency and Effectiveness

☐ *The strategic plan is agreed by the ADP*

☐ *The strategic plan is published and publicly available*

☐ *The ADP can demonstrate effective strategic linkage with other local partnership groups and local communities*

☐ *The ADP can demonstrate examples of improvement activities and positive outcomes for the local population*

☐ *The ADP can demonstrate evidence that Strategic Planning is safe, effective, compassionate and person-centred*

Our current Strategy is published on our ADP Website and was approved via ADP and IJB.

ADP represented on the following via ADP Support Team:

- Public protection: Adult Protection Delivery Group, Child Protection Delivery Group, Training and Development Group, Violence Against Women Partnership
- Children and Young People's Leadership Group and Commissioning Group (Chair)
- Community Justice Board
- Mental Health and Wellbeing Board and Mental Health Improvement and Suicide Prevention Steering Group

- MAT (Medication Assisted Treatment) Implementation Support Team Meetings
- Public Governance Meeting (NHS Borders)

ADP membership cross representation:

- Director of Public Health – NHS Board, IJB (non voting member)
- Director for Social Work Policy and Practice – PPC, IJB
- Lived Experience Forum representative - Lived Experience Forum
- Lead Officer Children and Families Social Work – CYPLG, Child Protection Delivery Group, Chair Community Justice Board, Chair Drug Death Review Group, Critical Service Oversight Group (local Chief Officers Group)
- Lead Officer Education – Children and Young People's Leadership Group
- Convenor Licensing Board – Licensing Board
- General Manager Mental Health and Learning Disability – Mental Health and Wellbeing Forum, IJB
- Police Scotland Inspector – Critical Service Oversight Group (CSOG) (local Chief Officers' Group)

Example of improvement activity: Non-fatal overdose pathway and links to CSOG; MAT 6 Corra funding application.
A representative from Borders Lived Experience Forum is a member of the ADP. The ADP Support Team attend the Forum and we have recently undertaken a service evaluation which has been shared with staff, people who have used services and the Forum.

1.2 Inclusion

☐ *The ADP can describe how they engage with local communities*

☐ *The ADP can demonstrate how any potential barriers to involvement or engagement are removed*

☐ *The ADP strategic planning is inclusive of people affected by drug and alcohol harms and their family members, those who use*

services, those who deliver services, and the local population

☐ *The ADP embeds equality impact assessment processes to understand the diverse needs of local populations and uses this information to inform pathways and provision in its strategic planning and ensure human rights are met*

☐ *The ADP Strategy effectively aligns to other statutory plans / priorities on delivery in support to families in crisis or at risk of being in crisis as a result of drug / alcohol use (e.g. Child Protection, Adult Protection)*

The ADP Website is searchable on the internet and via the NHS Borders public website. Information relating to services and local publications (including our newsletter) are included on the site. In the last 12 months we have proactively issued three press releases.

Borders Lived Experience Forum met online while Covid-19 restrictions were in place. This now meets monthly and a member of the ADP Support Team attends each meeting. People with lived and living experience including family members are welcome to attend this meeting.

Scottish Drugs Forum (SDF) facilitates a Living Experience Group co-facilitated with a member of staff from adult services. SDF representative has provided informal feedback directly to ADP Support Team and services. A local Steering/Reference Group will be convened once the group is more fully established.

A recent service evaluation was carried out by SDF and included feedback from staff and people who had used services within the previous 12 months. An action plan arising from the recommendations was developed and shared across services for staff and people who use services and presented to our Lived Experience Forum.

A Health Inequalities Impact Assessment was developed for our most recent strategic plan.

The ADP Strategy is aligned to the Children's Plan and the Community Justice Plan. ADP is represented at strategic and tactical level across Public Protection structures.

The ADP Support Team represents Public Health on the Local Licensing Forum.

We have not consulted more widely to members of the general public in recent times.

1.3 Planning Cycle

Planning Cycle

☐ *The ADP can demonstrate that it delivers in line with a strategic cycle for planning which includes: needs assessment, delivery, commissioning, review and reporting of outcomes / progress*

☐ *ADP Strategic Planning is based on population health approaches and includes primary, secondary and tertiary prevention*

The most recent strategy was developed during 2019-20 and was informed both by work undertaken by a consultant who engaged with people with lived experience, staff and wider stakeholders in assessing gaps and areas for improvement in the ADP. In addition a progress report on the previous strategy was discussed with the Community Justice Board, IJB Leadership Group, Police Fire and Safer Communities Committee, Children and Young People's Leadership Group. There was additional consultation with people with lived experience and this reflected the areas for improvement identified in the progress report.

The Strategy is in line with Ministerial Priorities.

1.4 Needs Assessment

☐ *The ADP has a local assessment of the needs of people who use alcohol / drugs led by NHS Public Health and involving partners*

This has not been done within the lifecycle of the existing Strategy, however, the IJB is undertaking a Joint Needs Assessment which includes alcohol and drugs and the ADP Support Team have contributed to this.

A needs assessment of family adult members impacted by another's alcohol and/or drug use was completed in 2019 more recently a

whole family audit was undertaken in relation to children and young people impacted by another's alcohol and/or drug use.

SDF were commissioned to undertake a service evaluation on behalf of the ADP in 2021, this involved people using services and staff.

An alcohol death review was undertaken in 2017-18. We have not had the capacity to undertake a review of alcohol deaths in the lifetime of the current strategy.

1.5 Whole System Approach

☐ *The ADP can demonstrate that their strategic planning is based on national and local priorities, is evidence based and aligns with delivery of local supports and services*

☐ *The ADP has representatives of the following :*

- ☐ *Health and Social Care Partnership: mental health, primary care, adult services - yes*
- ☐ *Specialist drug / alcohol services - yes*
- ☐ *Health (e.g. emergency department, relevant acute wards, health improvement / public health) - yes*
- ☐ *Children's services - yes*
- ☐ *Police - yes*
- ☐ *Justice services -yes*
- ☐ *Housing / accommodation / homelessness services - yes*
- ☐ *Employment services - **no***
- ☐ *Community - yes*
- ☐ *Lived experience - yes*
- ☐ *Education - yes*

☐ *Third Sector Interface* We have independent third sector representation from SDF

☐ *The ADP can demonstrate that other local planning partnerships and services incorporate and complement ADP activity to reduce alcohol and drug harms*

The ADP Strategy and Delivery Plan as well as our commissioning are based on Ministerial priorities and informed by local needs and feedback. This is evident in the content and actions arising. There are routes for people's experiences to influence the design and delivery of our services and interventions.

Examples of other partners complementing ADP activity include the work undertaken by Justice Social Work to develop a new model for DTTO delivery and education colleagues taking forward a training programme in response to the whole family approach audit.

1.6 Resources and Delivery

☐ *The ADP has an annual delivery plan agreed by member organisations that details resources aligned in support of delivery, including the following: direct resource, local financial investments and "in kind" resources. It details cross-system prioritisation and responsibilities within, for example, Health and Social Care Partnerships, Children's Services Planning Partnerships, Community Justice Partnerships and Community Planning Partnerships to be deployed to implement the Annual Delivery Plan and the outcomes to be achieved*

We have an annual delivery plan and partners are engaged in developing actions and reporting as appropriate.

As yet we have not developed the Service Level Agreements and other documentation as outlined in the Partnership Delivery Framework. We look forward to receiving these materials to support engagement at a local level.

1.7 Outcomes

☐ *The ADP uses the outcomes and priority actions set out in Rights, Respect and Recovery and the Alcohol Framework 2018: Preventing Harm and the National Mission Outcomes Framework*

☐ *The ADP outcomes are measurable and reportable*

☐ *The ADP routinely reports on progress against strategic outcomes*

Our strategy reflects the Rights, Respect and Recovery and the Alcohol Framework 2018: Preventing Harm. At time of developing the National Mission did not exist, however, we are confident the Strategy and local activities read across these outcomes.

Quarterly performance reports are presented at the ADP. There is an annual update to the Community Justice Board; NHS Board; IJB and CYPLG.

Quarterly information on NFO pathway and drug related deaths are presented to the CSOG. The Drug Death Annual Report is developed by the Drug Death Review Group and presented to ADP, CSOG and NHS Borders Clinical Governance Committee.

Q. How do you know this?

There is good cross representation from ADP membership to wider partnerships and the evidence presented above (e.g. reporting structures; examples of joint working) provide evidence of this.

Q.What do you want to maintain, improve or change, how will you do it and by when?

We want to maintain positive relationships.

We want to consider how to more effectively engage with the community and wider stakeholders in relation to stigma and produce a briefing by end of March to inform our 2023-24 Delivery Plan.

We want to have an influence in the revision of strategic planning in relation to the overarching priorities for whole family wellbeing; the Promise and integrated children's services planning. This is being led outwith the ADP and we wish to ensure our priorities are reflected. This is ongoing work to be completed by end March 2023.

We would like to do better in terms of a more up to date needs assessment and an alcohol deaths audit. At a local level the requirement for ongoing reporting in relation to specific priorities (e.g. MAT standards) will consume additional capacity. We hope to have a plan in place of how to approach this work by end March 2023.

Any further comments?

We would welcome timely information in relation to the anticipated supporting documents for the Partnership Delivery Framework recommendations.

Section 2: Financial Governance

Quality Standard 2: The ADP can demonstrate public money is used to maximum benefit to deliver measurable outcomes for the local population in delivery of its Strategic Plan

		Maintain	Explore	Develop
		We are confident that we are demonstrating this standard. We have evidence to support this, including stakeholder confirmation and need to maintain this focus over time.	We currently partly demonstrate this standard and may need further development.	We do not fully demonstrate this standard currently and need to develop / discuss this further.
2.1	**Investment**		x	
2.2	**Governance**	x		
2.3	**Accountability**	x		
2.4	**Reporting**	x		
2.5	**Financial Planning**	x		

Q.How effective is your approach to Quality Standard 2?

2.1 Investment

☐ *The ADP is able to demonstrate that investment in the delivery of outcomes comes from a range of sources, including the Local Authority, Health Board and the Integration Authority, as well as outside of the public sector*

☐ *The ADP can demonstrate investment is in line with Scottish Government priorities*

☐ *The ADP can demonstrate that investment is based on evidence of effectiveness and outcomes*

☐ *The ADP can demonstrate ability to disinvest based on evidence of effectiveness and outcomes and in line with changing priorities articulated though formal needs assessment*

Third sector commissions are jointly funded by the ADP and Local Authority. Third sector agencies have independently sought funding to enhance provision.

The NHS addictions service has a service level agreement (SLA) in place with the ADP and key performance indicators are monitored on a quarterly basis.

Dispersal of ADP funding is in line with existing Ministerial Priorities and aligned to outcomes described in ADP funding letters. These outcomes and appropriate related key performance indicators are included in all contract specifications.

All alcohol and drugs services submit quarterly reports and participate in quarterly monitoring meetings. These are summarised and reported to the ADP.

The most recent configuration of services was based on an ADP investment review which led to recommissioning against a new model of service which included disinvestment in a stand-alone drugs service to allow a development of a combines alcohol and drug treatment and recovery service.

A previous Children and Young People's Leadership Group's (CYPLG) commissioning review led to a realignment of services to support

young people impacted by their own alcohol and drug use and the development of a service to provide CAPSM and young carers support recognising the potential synergy in such provision.

We have recently reviewed and agreed at ADP an updated SLA for the NHS addictions service and are starting a procurement exercise for the third sector alcohol and drugs recovery service. A CYPLG commissioning review is underway which will inform the future commission plan for services including our young carers and CAPSM service.

2.2 Governance

- ☐ *The ADP has clear policies and procedures for aligning resources for investment with strategic planning*
- ☐ *The ADP seeks authorisation for investment from the Integration Authority and local scheme of delegation*
- ☐ *The ADP has a clear policy agreed with members and the Integration Authority on the treatment of underspends / overspends*
- ☐ *The ADP can demonstrate effective and transparent governance arrangements are in place*
- ☐ *The ADP can relate investments in third sector and public sector to performance and outcomes*

All funding decisions are taken through APD with due scrutiny applied. The ADP has delegated authority from the IJB to make funding decisions. Support to ADP finances is via NHS Borders and regular meetings are held to ensure the Director of Finance is sighted on any arising issues and concerns, including ADP reserves and approval of our Annual Report.

An SLA is in place with the NHS addictions service. All commissioned services complete a quarterly monitoring report and participate in a quarterly monitoring meeting.

2.3 Accountability

☐ *The ADP and the Integration Authority can demonstrate all funding allocated to NHS Boards for onward delegation to ADPs is available to the ADP*

☐ *The ADP has full accountability for the totality of funding allocated for drugs / alcohol from its NHS Board and Local Authority*

All funding decisions are taken through APD with due scrutiny applied. The ADP has delegated authority from the IJB to make funding decisions. Support to ADP finances is via NHS Borders and regular meetings are held to ensure the Director of Finance is sighted on any arising issues and concerns, including ADP reserves and approval of our Annual Report.

ADP finance reports are presented quarterly to the Board by our finance lead.

A quarterly performance report is submitted and reviewed at the ADP. The performance report includes data relating to referrals, DNA's and planned/unplanned discharges as well as LDP Standards, Take Home Naloxone, Injecting equipment provision. A summary a RAG (red, amber, green) status and narrative for each service and an update on ADP Support Team work is also included. Outstanding actions and queries are addressed and reported back at subsequent meetings.

All Scottish Government ring-fenced funding is made available to the ADP and is clearly presented in our quarterly finance reports to the ADP Board.

2.4 Reporting

☐ *The Health and Social Care Partnership Chief Finance Officer is a member (or formally represented) on the ADP*

☐ *There is regular routine financial reporting to the ADP on the total spend on alcohol and drug services*

☐ *The ADP and Integration Authority provide a quarterly and annual financial report to the Scottish Government*

☐ *The ADP reports to local governance structures on investments*

Support to ADP finances is via NHS Borders and regular meetings are held to ensure the Director of Finance is sighted on any arising issues

and concerns which include monitoring of ADP reserves and approval of our Annual Report. This arrangement has been in place for many years and to date the IJB has been content with this arrangement.

There is no IJB Chief Finance Officer at present in Borders.

ADP finance reports are presented quarterly to the Board by our finance lead.

The ADP complies with all SG reporting requirements – awaiting response re discrepancy between this (quarterly) and the request for bi-annual.

The ADP reports to local governance structures on investments via the annual report. During 2022-23 the ADP has provided updates to the Mental Health and Wellbeing Board on dispersal of increased funding from the National Mission. The Mental Health and Wellbeing Board includes representation from people with lived experience.

2.5 Financial Planning

☐ *The ADP strategy includes investment to increase activity over time in relation to prevention and early intervention aligned with other such preventative spend across local partners / partnerships*

We await with interest the development of the Consensus Statement on Substance Use in for young people which is in development via Public Health Scotland.

We have invested in training to support Whole Family Approaches and a wider workforce directory.

At a local level it is challenging to increase investment over time since additional funding to ADPs (in line with other areas) is currently directed towards treatment services to the exclusion of infrastructure and earlier interventions. The work being undertaken as part of the CYPLG commissioning review has prevention and early intervention in scope. This is an ongoing piece of work.

Q. How do you know this?

We know this from the detailed and transparent financial planning and reporting for the ADP which has oversight from NHS Borders Director of Finance.
Q.What do you want to maintain, improve or change, how will you do it and by when?
We are confident we have robust financial arrangements in place but will discuss further with local stakeholders including Scottish Government the expectations within the PDF. It is the case that we have raised this at all possible stages during the development of the PDF. We will progress these discussions by March 2023.
Any further comments?
n/a

Section 3: Quality Improvement

Quality Standard 3: The ADP can demonstrate Quality Improvement in delivery of outcomes

	Maintain	Explore	Develop

		We are confident that we are demonstrating this standard. We have evidence to support this, including stakeholder confirmation and need to maintain this focus over time.	We currently partly demonstrate this standard and may need further development.	We do not fully demonstrate this standard currently and need to develop / discuss this further.
3.1	**Methodology**		X	
3.2	**Reporting**	X		
3.3	**Sustainability**	X		

Q.How effective is your approach to Quality Standard 3?

3.1 Methodology

☐ *The ADP has or uses an underpinning quality improvement methodology*

☐ *ADP staff and members are supported to use improvement methodologies through training and other workforce development activities*

Improvement methodology is used or informs planning when developing or reviewing pieces or areas of work and also informs our approach to developments and consultations. For example, development of NFO pathway; review and update of the Residential Rehabilitation pathway; test of change for MAT 6 funded by Corra.

NHS Borders has supported colleagues in Mental Health and the ADP Support Team to undertake the Scottish Improvement Leaders programme through NES.

We are currently planning work which aims to improve outcomes for people attending our acute hospital for whom alcohol is a concern.

NHS Borders is recruiting a Quality Improvement facilitator for mental health which will be a potential resource for the NHS addiction services.

3.2 Reporting

☐ The ADP can demonstrate examples of where improvement methods have had a positive impact

☐ The ADP can demonstrate links with outcome reporting, needs assessment and financial investment / disinvestment

Examples:

We have had positive feedback from individuals who have been referred during the NFO pathway, from the staff involved and have supported people to access MAT who may previously may not have engaged.

The NHS addictions service increased the number of people receiving OST by implementing and monitoring the improvements in service through reducing barrier to access and increasing choice of medications. For example, the Programme for Government (2018) funding supported development of an Assertive Engagement Team which was in direct response to work undertaken by the Drug Death Review Group in assessing our local performance in relation to the Staying Alive Toolkit and our findings from individual drug death reviews. We can chart an increase in the number of individuals on OST since the development of this team. The National Mission funding has allowed us to grow this team and recently was able to confirm a Green RAG status on MAT standards 1-5.

3.3 Sustainability

☐ The ADP can demonstrate how achieved improvements are embedded and sustained

☐ The ADP benchmarks performance with other areas (e.g. other ADPs, other partnership groups)

All commissioned services complete quarterly performance reports and participate in quarterly minuted monitoring meetings. Key performance indicators are summarised and discussed at the ADP.

The Quality Principles Group meets quarterly comprising managers and senior manager from each service and the ADP Support Team and is the forum through which cross agency improvements and quality issues are discussed. For example, this group helped engagement with the recent service evaluation and, following consideration of recommendations from the commissioned report, developed a ‘you said we will’ document for sharing with staff and people using services. The next step is to review the ‘we wills’ to update and reissue via team meetings and the Lived Experience Forum.

In previous years we have developed a technical report to assess key data sets against a benchmarking family. This has not been

progressed in 2021 or 2022 due to limited capacity and also a recognition that, broadly, we benchmark positively although the numbers in some studies (e.g. Scottish Health Survey) are limited and therefore subject to large confidence intervals.

We continue to benchmark our drug related deaths against this grouping and we have sought information from similar boards where we appear to benchmark negatively.

Q. How do you know this?

We have charted improvement in engagement and feedback. The recent service evaluation with people who used services in the previous 12 months contained the most positive feedback of any such similar work.

Q.What do you want to maintain, improve or change?

We want to maintain the current commitment to improvement methodology and would want to improve the wider staff team's knowledge and application of improvement methodology.

Any further comments?

We are concerned that there is no clarity on the 2018 Programme for Government funding post March 2023. This funding is used to fund our assertive engagement team; children impacted by parental substance use service and advocacy.

Section 4: Governance and Oversight

Quality Standard 4: The ADP can demonstrate appropriate Governance and Oversight in delivery of the Strategic Plan

		Maintain	Explore	Develop
		We are confident that we are demonstrating this standard. We have evidence to support this, including stakeholder confirmation and need to maintain this focus over time.	We currently partly demonstrate this standard and may need further development.	We do not fully demonstrate this standard currently and need to develop / discuss this further.
4.1	**Oversight**		x	
4.2	**Governance**		x	
4.3	**Risk Management**		x	
4.4	**Accountability**		x	

Q.How effective is your approach to Quality Standard 4?

4.1 Oversight

☐ *ADP Members can demonstrate effective oversight arrangements are in place to deliver the local strategy*

☐ *The ADP can demonstrate processes to ensure oversight, coordination and alignment of ADP activity with other relevant local partnerships and strategies*

A quarterly performance report is submitted and reviewed at the ADP. The performance report includes data relating to referrals, DNA's and planned/unplanned discharges as well as LDP Standards, Take Home Naloxone, Injecting equipment provision. A summary a RAG (red, amber, green) status and narrative for each service and an update on ADP Support Team work is also included. Outstanding actions and queries are discussed with relevant agencies and reported back at subsequent meetings.

The children and families service is jointly commissioned with the CYPLG and performance is reviewed with its Commissioning Sub-group of which the ADP Support Team is Chair. Any issues arising are escalated to the CYPLG.

The ADP Support Team is a member of the Community Justice Board and there is a standing agenda item for reporting.

4.2 Governance

☐ *The ADP has published the roles and remit for members setting out how decisions are made, issues and disputes are resolved, conflicts of interest are managed*

☐ *There is a organogram that sets out the relationship of the ADP with the Integration Authority, with other planning boards (e.g. Children's Partnership and the Community Justice partnership), and with areas of statutory responsibility (e.g. Child Protection and Adult Protection)*

☐ *The ADP can demonstrate how they know governance structures provide appropriate assurance of safe, effective, compassionate and person-centred delivery*

☐ *There are process in place for the ADP Chair to escalate and progress discussions with local partners / responsible officers when a priority is not being delivered and a process in place to ensure ADP contribution to aligned plans is being progressed*

☐ *The ADP strategic plan forms part of the overall Community Planning Partnership (CPP) offer, is ratified via CPPs, and aligns with the priorities of other key statutory plans*

The ADP Rough Guide sets out the purpose of the ADP and its membership and is supported by our terms of reference which includes a governance paper and organogram setting out the relationship of the ADP and the IJB and CYPLG. It does not currently show a direct link to the Community Justice Board or Public Protection Committee. Local structures develop over time and the membership of the ADP ensures we are sighted on relevant developments.

Rough Guide to Borders ADP (Updatec

4.3 Risk Management

☐ *There is a clear process for identifying and managing risk in relation to delivery of national and local priorities*

☐ *There are clear controls in place to reduce impact of identified risks*

☐ *The ADP can demonstrate how failure is reported, analysed and learning facilitated*

The NHS Borders Risk Register holds ADP risks which are reviewed and updated by the ADP Support Team. There is not a regular

schedule in place to review risks at the ADP Board. There is a risk register in place specifically for the procurement process as noted in 2.1. This has been reviewed by the ADP.

The ADP quarterly performance reports highlight any concerns re delivery of services and provide ongoing updates to ADP on any actions taken to progress concerns.

4.4 Accountability

☐ *The ADP can describe clear accountability to appropriate Chief Officer(s) responsible for the delivery of relevant policy, system or targets*

☐ *The ADP can demonstrate clear articulation of the relationship with senior accountable officers, and specifically, the relationship between the ADP and Public Protection that sit with the local Chief Officers Group and can demonstrates that processes are in place to ensure learning from drug deaths and responsibility for reducing substance use mortality and harm*

The ADP Vice-Chair is the Director of Social Work and Practice and is responsible for the Public Protection work. They also chair the Drug Death Review Group. The ADP Support Team is represented on the Child Protection Delivery Group; Adult Protection Delivery Group and the Violence Against Women Partnership to ensure two way exchange of information and concerns.

Quarterly information on NFO pathway and drug related deaths are presented to the Critical Service Oversight Group (Borders local 'chief officers group'). The Drug Death Annual Report is developed by the Drug Death Review Group and presented to ADP, CSOG and NHS Borders Clinical Governance Committee.

Q. How do you know this?

Performance reporting to the ADP is robust and transparent, concerns are shared and addressed collectively.

Q.What do you want to maintain, improve or change, how will you do it and by when?

We want to maintain the current robust reporting mechanism within the ADP.

We want to improve the scheduling of Risk Register reviews by the ADP Board by October 2022.

We want to consult relevant accountable officers on their views on our current arrangements (October 2022 – January 2023) regarding a proportionate level of oversight and review the governance paper in light of ongoing local structural developments to ensure clarity on governance arrangements by end March 2023.

Any further comments?

n/a

Section 5: The relationship between the ADP and the Integration Authority

Quality Standard 5: The work of the Integration Authority and the ADP is aligned and the Integration Authority is able to provide Directions to partners in support of the ADP Strategic Plan

		Maintain	Explore	Develop
		We are confident that we are demonstrating this standard. We have evidence to support this, including stakeholder confirmation and need to maintain this focus over time.	We currently partly demonstrate this standard and may need further development.	We do not fully demonstrate this standard currently and need to develop / discuss this further.
5.1	**Alignment and Governance**			x

Q.How effective is your approach to Quality Standard 5?

5.1 Alignment and Governance

- ☐ *The ADP has a clear policy on taking investment plans and business cases to the Integration Authority Joint Board for ratification*
- ☐ *The ADP provides performance and financial reporting to enable support the development of the Integration Authority's Annual Performance Report*
- ☐ *The ADP regularly reports to the Integration Authority on performance*

- ☐ *The work of the ADP is reflected in the objectives of the Integration Authority Strategic Plan*
- ☐ *Governance and oversight arrangements for ADP business are supported by the Integration Authority*
- ☐ *Adult treatment services are delivered in line with ADP strategy*
- ☐ *The ADP and the Integration Authority have a clear policy on how decisions and directions are managed for services out-with the scope of the Integration Authority (e.g. children's services, police, housing will be issued)*
- ☐ *The Integration Authority ensures governance arrangements support the deployment of resources at pace to support the Mission*

The IJB has delegated authority to the ADP for resource allocation and ensuring oversight. This allows deployment of resources at pace to support the National Mission.

An annual report is made to the IJB which includes spending commitments. The ADP budgets are transparent and reviewed quarterly at ADP Board.

The IJB is undertaking a joint strategic needs assessment which will be informed by information on alcohol and drugs use. The IJB is developing an Equality and Human Rights Reference Group to which an ADP representative will be included.

Positive working relationships are in place between the ADP and the treatment services and there is also effective joint working between services. Services and ADP are able to articulate and address challenges and concerns in real time and also to recognise the successes of those delivering services. All alcohol and drugs commissioned services complete quarterly monitoring information and participate in monitoring meetings.

There is no written policy in place on how decisions and directions are managed for services out-with the scope of the Integration Authority (e.g. children's services, police, housing).

The current reporting and governance arrangements described above outline robust performance management, however, regular attendance to IJB is annual. To date this has been a satisfactory local arrangement as authority has been delegated to the ADP.

Q. How do you know this?
We are confident that the ADP effectively manages its budget and performance using both the formal reporting mechanisms outlined above and the positive feedback on services from people who have used them.
Q.What do you want to maintain, improve or change, how will you do it and by when?
We want to consult relevant accountable officers on their views on our current arrangements (October 2022 – January 2023) regarding an proportionate level of oversight and review the governance paper in light of ongoing local structural developments to ensure clarity on governance arrangements by end March 2023
Any further comments?
n/a

This Self-Assessment of Partnership Delivery Framework is agreed and ratified by:

Senior System Stakeholders	
ADP Lived Experience Stakeholder/s / Representative	Yes, 25.8.22
Chair of the Alcohol and Drug Partnership	Yes, 25.8.22
Chair of the Community Planning Partnership	
The Chief Executive of the Local Authority	
The Chief Executive of the NHS Board	
Director of Public Health	Yes. 25.8.22
The Chair of the Integration Joint Board	
The Chair of the Chief Officers Group	
Divisional Commander for Police Scotland	Yes, 8.9.22
Chief Executive of Third Sector Interface	
The Chief Officer of the Health and Social Care Partnership	

APPENDIX 1

Self Assessment Criteria

1	**Quality Standard 1 : The ADP has a Strategic Plan for delivery of identified outcomes which ensures adequate alignment with other aligned strategic plans**
1.1	**Transparency and Effectiveness** ☐ The strategic plan is agreed by the ADP ☐ The strategic plan is published and publicly available ☐ The ADP can demonstrate effective strategic linkage with other local partnership groups and local communities ☐ The ADP can demonstrate examples of improvement activities and positive outcomes for the local population ☐ The ADP can demonstrate evidence that Strategic Planning is safe, effective, compassionate and person-centred
1.2	**Inclusion** ☐ The ADP can describe how they engage with local communities ☐ The ADP can demonstrate how any potential barriers to involvement or engagement are removed ☐ The ADP strategic planning is inclusive of people affected by drug and alcohol harms and their family members, those who use services, those who deliver services, and the local population ☐ The ADP embeds equality impact assessment processes to understand the diverse needs of local populations and uses this

	information to inform pathways and provision in its strategic planning and ensure human rights are met ☐ The ADP Strategy effectively aligns to other statutory plans / priorities on delivery in support to families in crisis or at risk of being in crisis as a result of drug / alcohol use (e.g. Child Protection, Adult Protection)
1.3	**Planning Cycle** ☐ The ADP can demonstrate that it delivers in line with a strategic cycle for planning which includes: needs assessment, delivery, commissioning, review and reporting of outcomes / progress ☐ ADP Strategic Planning is based on population health approaches and includes primary, secondary and tertiary prevention
1.4	**Needs Assessment** ☐ The ADP has a local assessment of the needs of people who use alcohol / drugs led by NHS Public Health and involving partners
1.5	**Whole System Approach** ☐ The ADP can demonstrate that their strategic planning is based on national and local priorities, is evidence based and aligns with delivery of local supports and services ☐ The ADP has representatives of: ☐ Health and Social Care Partnership: mental health, primary care, adult services

	☐ Specialist drug / alcohol services ☐ Health (e.g. emergency department, relevant acute wards, health improvement / public health) ☐ Children's services ☐ Police ☐ Justice services ☐ Housing / accommodation / homelessness services ☐ Employment services ☐ Community ☐ Lived experience ☐ Education ☐ Third Sector Interface ☐ The ADP can demonstrate that other local planning partnerships and services incorporate and complement ADP activity to reduce alcohol and drug harms
1.6	**Resources and Delivery** ☐ The ADP has an annual delivery plan agreed by member organisations that details resources aligned in support of delivery, including the following: direct resource, local financial investments and "in kind" resources. It details cross-system prioritisation and responsibilities within, for example, Health and Social Care Partnerships, Children's Services Planning Partnerships, Community Justice Partnerships and Community Planning Partnerships to be deployed to implement the Annual Delivery Plan and the outcomes to be achieved

1.7	**Outcomes** ☐ The ADP uses the outcomes and priority actions set out in *Rights, Respect and Recovery* and the *Alcohol Framework 2018: Preventing Harm* and the *National Mission Outcomes Framework* ☐ The ADP outcomes are measureable and reportable ☐ The ADP routinely reports on progress against strategic outcomes
2	**Quality Standard 2 : The ADP can demonstrate public money is used to maximum benefit to deliver measurable outcomes for the local population in delivery of the Strategic Plans**
2.1	**Investment** ☐ The ADP is able to demonstrate that investment in the delivery of outcomes comes from a range of sources, including the Local Authority, Health Board and the Integration Authority, as well as outside of the public sector ☐ The ADP can demonstrate investment is in line with Scottish Government priorities ☐ The ADP can demonstrate that investment is based on evidence of effectiveness and outcomes ☐ The ADP can demonstrate ability to disinvest based on evidence of effectiveness and outcomes and in line with changing priorities articulated though formal needs assessment

2.2	**Governance** ☐ The ADP has clear policies and procedures for aligning resources for investment with strategic planning ☐ The ADP seeks authorisation for investment from the Integration Authority and local scheme of delegation ☐ The ADP has a clear policy agreed with members and the Integration Authority on the treatment of underspends / overspends ☐ The ADP can demonstrate effective and transparent governance arrangements are in place ☐ The ADP can relate investments in third sector and public sector to performance and outcomes
2.3	**Accountability** ☐ The ADP and the Integration Authority can demonstrate all funding allocated to NHS Boards for onward delegation to ADPs is available to the ADP ☐ The ADP has full accountability for the totality of funding allocated for drugs / alcohol from its NHS Board and Local Authority
2.4	**Reporting** ☐ The Health and Social Care Partnership Chief Finance Officer is a member (or formally represented) on the ADP ☐ There is regular routine financial reporting to the ADP on the total spend on alcohol and drug services ☐ The ADP and Integration Authority provide a quarterly and annual financial report to the Scottish Government ☐ The ADP reports to local governance structures on investments

2.5	**Financial Planning** ☐ The ADP strategy includes investment to increase activity over time in relation to prevention and early intervention aligned with other such preventative spend across local partners / partnerships
3	**Quality Standard 3 : The ADP can demonstrate quality improvement in delivery of outcomes**
3.1	**Methodology** ☐ *The ADP has or uses an underpinning quality improvement methodology* ☐ *ADP staff and members are supported to use improvement methodologies through training and other workforce development activities*
3.2	**Reporting** ☐ The ADP can demonstrate examples of where improvement methods have had a positive impact ☐ The ADP can demonstrate links with outcome reporting, needs assessment and financial investment / disinvestment

3.3	**Sustainability** ☐ The ADP can demonstrate how achieved improvements are embedded and sustained ☐ The ADP benchmarks performance with other areas (e.g. other ADPs, other partnership groups)
4	**Quality Standard 4 : The ADP can demonstrate appropriate Governance and Oversight in delivery of the Strategic Plan**
4.1	**Oversight** ☐ ADP Members can demonstrate effective oversight arrangements are in place to deliver the local strategy ☐ The ADP can demonstrate processes to ensure oversight, coordination and alignment of ADP activity with other relevant local partnerships and strategies
4.2	**Governance** ☐ The ADP has published the roles and remit for members setting out how decisions are made, issues and disputes are resolved, conflicts of interest are managed ☐ There is a organogram that sets out the relationship of the ADP with the Integration Authority, with other planning boards (e.g. Children's Partnership and the Community Justice partnership), and with areas of statutory responsibility (e.g. Child Protection and Adult Protection)

	☐ The ADP can demonstrate how they know governance structures provide appropriate assurance of safe, effective, compassionate and person-centred delivery ☐ There are process in place for the ADP Chair to escalate and progress discussions with local partners / responsible officers when a priority is not being delivered and a process in place to ensure ADP contribution to aligned plans is being progressed ☐ The ADP strategic plan forms part of the overall Community Planning Partnership (CPP) offer, is ratified via CPPs, and aligns with the priorities of other key statutory plans
4.3	**Risk Management** ☐ There is a clear process for identifying and managing risk in relation to delivery of national and local priorities ☐ There are clear controls in place to reduce impact of identified risks ☐ The ADP can demonstrate how failure is reported, analysed and learning facilitated
4.4	**Accountability** ☐ The ADP can describe clear accountability to appropriate Chief Officer(s) responsible for the delivery of relevant policy, system or targets ☐ The ADP can demonstrate clear articulation of the relationship with senior accountable officers, and specifically, the relationship between the ADP and Public Protection that sit with the local Chief Officers Group and can demonstrates that processes are in place to ensure learning from drug deaths and responsibility for reducing substance use mortality and harm

5	**Quality Standard 5 : The work of the Integration Authority and the ADP is aligned and the Integration Authority is able to provide Directions to partners in support of the ADP Strategic Plan**
	☐ The ADP has a clear policy on taking investment plans and business cases to the Integration Authority Joint Board for ratification ☐ The ADP provides performance and financial reporting to enable support the development of the Integration Authority's Annual Performance Report ☐ The ADP regularly reports to the Integration Authority on performance ☐ The work of the ADP is reflected in the objectives of the Integration Authority Strategic Plan ☐ Governance and oversight arrangements for ADP business are supported by the Integration Authority ☐ Adult treatment services are delivered in line with ADP strategy ☐ The ADP and the Integration Authority have a clear policy on how decisions and directions are managed for services out-with the scope of the Integration Authority (e.g. children's services, police, housing will be issued) ☐ The Integration Authority ensures governance arrangements support the deployment of resources at pace to support the Mission

Appendix 2 Partnership Delivery Framework for ADPs, August 2021

The Scottish Government and COSLA coproduced the Partnership Delivery Framework for Alcohol and Drug Partnerships which was published in 2019. Given the increased focus on drug deaths we need to look at options for increasing the speed of implementation of this framework.

The Scottish Government are keen to emphasise the importance of local Alcohol and Drug Partnerships and reinforce our commitment to good local strategic planning, engagement and leadership whilst increasing the pace of delivery.

The following 8 recommendations have been agreed between COSLA and the Scottish Government. A short life working group will be formed to take these forward.

ACTION 1: Implement the Partnership Delivery Framework which underpins ADP governance

MEASURABLE PERFORMANCE: Recommendation 1 – We will implement a Quality Assurance process to support ADP performance against the Partnership Delivery Framework, Rights, Respect and Recovery and local delivery of Mission priorities. The assessment process will be a combination of local self-assessment, ADP peer-to-peer assessment and external validation. An external agency will be commissioned to validate the assessment process. The assessment process will be in line with other national assessment processes, for instance as utilised by the Care Inspectorate and Health Improvement Scotland. We will replace the current ADP Annual Report format with a self-assessment framework. We will facilitate new alliances and synergies between clusters of ADPs facing similar challenges to support the sharing of good practice and innovation. We will seek assurance and ensure that there is specific Improvement Methodology Training available to ADPs locally and nationally and we will support progress towards Whole System Approaches to drug and alcohol issues.

STANDARDISE AND IMPROVE PLANNING: Recommendation 2 – We will increase the focus on forward planning and The Scottish Government will, in partnership, develop engage and supply an Annual Delivery Plan format and require local ADPs to submit an Annual Delivery Plan in December each year; the Scottish Government will establish a group that will provide the Mission Implementation Group assurance that local Annual Delivery Plans are in line with national priorities; evidenced based; meet local needs based on gaps identified in the self-assessment. Development of Recommendations 1 and 2 will take cognisance of and seek to support local reporting requirements to Integration Boards and Community Planning Partnerships.

STANDARDISE GOVERNANCE: Recommendation 3 – We will require ADP to have a Service Level Agreement (SLA) specifying local membership and partner contributions committed to delivering the Partnership Delivery Framework and Mission priorities. The SLA will detail investment of direct resource, local financial investments and “in kind” resources and detail cross-system prioritisation and responsibilities within, for example, Health and Social Care Partnerships; Children’s Services Boards, Community Justice Partnerships and Community Planning Partnerships to be deployed to implement the Annual Delivery Plan; outcomes to be achieved by providers; request senior accountable officers to submit to the Scottish Government via their ADP an audit of direct, indirect and in kind resources directed to the local delivery of the Mission; The SLA will specify the relationship between the ADP and the IJB and will specify how decisions and directions from the IJB to services outwith IJB scope e.g. children’s services, police, housing will be issued; SLA will specify how governance arrangements are supported to ensure resources are deployed, at pace, to support the Mission.

ACTION 2: Strengthen existing approaches to ADP governance including annual reports and approaches to planning

STRENGTHEN RESPONSIBILITY: Recommendation 4 – we will specify the relationship between ADPs and senior accountable officers, and specifically, the relationship between ADPs and Public Protection arrangements in local areas ensuring that there is clear responsibility for reducing substance use mortality and harm that sits with local Chief Officers Groups. We will specify that the HSCP Chief Finance Officer (CFO) is required to sit on the ADP and provide assurance regarding funding and require service underspends to be reinvested / carried forward into ADP strategy. We will require the CFO to provide routine financial reporting to ADPs meetings and provide the Scottish Government with an annual financial report as part of the Self-Assessment Process in Recommendation1. The above will be included in an Annexe to the Partnership Delivery Framework

STANDARDISE OUTCOMES: Recommendation 5 - Develop a menu of evidenced based standardised outcome measures to support and underpin the evaluation of Rights, Respect & Recovery and the National Mission; in addition to establishing standardise national outcomes we will support local areas to develop local outcome measures in a standardise format and share cross system learning. Outcomes will support local and national performance reporting requirements.

ACTION 3: Establish and test formal arrangements to enable ADPs to effectively quality assurance and improve services

ESTABLISH ACCOUNTABILITY FOR TARGETS: Recommendation 6 - with publication of Medication Assisted Treatment standards; forthcoming UK clinical guidelines for alcohol treatment; consideration being given to the establishment of a Mission Target/s, we will ensure that the appropriate Chief Officer/s responsible for the relevant system, work with ADPs and are accountable for the delivery of any targets / expectations for delivery. This will bring a whole system approach and ensure targets are appropriately reflected in higher level strategic planning, priorities and roles

STANDARDISE AND IMPROVE NEEDS ASSESSMENT: Recommendation 7 - we will ensure Public Health Scotland and local NHS Public Health Departments work together to supply ADPs with a standardised annual needs assessment in November each year to inform their Annual Delivery Plan and National Priorities. The format of the needs assessment will be standardised so national comparison is achievable; local NHS Public Health Departments will work with local Community Planning partners to also further identify unmet needs.

ACTION 4: Strengthen the relationship between ADPs and the Scottish Government

REAFFIRM COMMITMENT TO LOCAL ADPS: Recommendation 8 – seek to strengthen the relationship at national and local levels across public sector, including the Scottish Government, and demonstrate commitment to local strategic planning, local co-production and service delivery.

Promote a whole system approach at a national level to alcohol and drug issues and the key role of ADPs. Seek to ensure that frontline workers (public and 3rd sector services equally; doctors, nurses, social workers, care workers, volunteers; psychologists etc) and all staff committed to improving the harms of drug and alcohol issues are equally valued and their contribution is recognised. Support efforts to ensure to ensure that the alcohol and drug sector is a modern,

inclusive, dynamic and exciting place to work. Seek to highlight the importance of the National Mission and the need to deliver improvements at pace nationally and locally. We will engage with local areas and seek assurance that adequate resources are in place to support Alcohol and Drug Partnerships and local delivery of national priorities.

In summary

ADPs are asked to:

- Replace Annual Report with Self-Assessment
- Forward plan in Dec and submit proposed actions and outcomes
- Have in place an SLA specifying inputs and outputs from members
- Work in partnership with peer ADPs

Partner organisations are asked to:

- Specify in an SLA direct, indirect and in kind resources supporting ADP delivery plan are in place, available and deployed at pace (All ADP partners)
- Produce an annual standardised needs assessment (NHS Public Health / PHS)
- Articulate Public Protection arrangements to reduce substance use mortality (All ADP partners)
- Chief Officers Groups to take responsibility for the reduction of substance use mortality (All ADP partners)
- Chief Finance Officer HSPC – produce an annual finance report and ensure funding is carried forward to support ADP delivery plan (HSCP)

Scottish Government / COSLA are asked to:

- Develop in partnership a Self-Assessment tool for ADPs
- Commission an external agency to undertake validation of the ADP self-assessment process
- Develop in partnership a Delivery Plan tool for ADPs
- Develop in partnership a Service Level Agreement format for ADPs
- Develop standardised outcomes format
- Establish a Mission Scrutiny Group
- Facilitate peer networks of ADPs to support Self-Assessment
- Provide elements required for ADPs to develop an annual plan in Dec each year

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Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 21 September 2022

Report By:	Jill Stacey, SBIJB Chief Internal Auditor (Scottish Borders Council's Chief Officer Audit & Risk)
Contact:	Jill Stacey, SBIJB Chief Internal Auditor (Scottish Borders Council's Chief Officer Audit & Risk)
Telephone:	01835 825036

APPOINTMENT OF SELECTION COMMITTEE - EXTERNAL MEMBER OF IJB AUDIT COMMITTEE

Purpose of Report:	To seek approval to the appointment of a Selection Committee for the purpose of interviewing, selecting and appointing a person for the position of External Member of the IJB Audit Committee.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) Appoint a Selection Committee, comprising the Chair of the IJB Audit Committee and two of its Members, excluding the IJB Chair, for the purpose of interviewing, selecting and appointing a person as External Member of the IJB Audit Committee; and b) Note that the same recruitment advertising process will be utilised as that used by Scottish Borders Council for the External Members of its Audit and Scrutiny Committee.
Personnel:	The proposals in this report set out the arrangements for the interview, selection and appointment to the position of External Member of IJB Audit Committee to ensure compliance with CIPFA Audit Committees best practice guidance.
Carers:	There is no direct impact on carers arising from the contents of this report.
Equalities:	The Selection Committee when interviewing and considering their selection and appointment to the position of External Member Audit Committee will comply with appropriate legislation to ensure equality, diversity and socio-economic factors are accommodated.
Financial:	There are no direct financial implications arising from the contents of this report. The appointment to the External Member of the IJB Audit Committee is on a voluntary basis, though any related expenses will be reimbursed.
Legal:	The Scottish Borders Health and Social Care Integration Joint Board, established as a separate legal entity as required by the Public Bodies (Joint Working) (Scotland) Act 2014, is responsible for the strategic planning and commissioning of a wide range of integrated health and social care services across the Scottish Borders, based on resources which have been delegated to it by the partners, Scottish Borders Council and NHS Borders.

Risk Implications:	As stated in the paragraphs below, having an External Member on the IJB Audit Committee brings independent and objective views and expertise and enhances the robustness and independence of the IJB Audit Committee's role in the oversight and scrutiny of the IJB's internal controls, risk management and governance arrangements. This mitigates the risks associated with not following the CIPFA Audit Committees best practice guidance. There is a risk that there will be no suitable candidates in the current recruitment process and the Selection Committee will be unable to make an appointment. This risk is partially mitigated in that the publication of the advert for the External Member Audit Committee roles will be distributed widely within the Scottish Borders community and across the IJB's partner organisations through their networks for engagement.

1 BACKGROUND

1.1 Within the CIPFA Audit Committees (2018) guidance, which is deemed relevant for integration authorities, CIPFA endorses the approach of mandating the inclusion of a lay or independent member and recommends that those authorities, for whom it is not a requirement, actively explore the appointment of an independent member to the committee.

1.2 In 2018 the IJB decided that the membership of its Audit Committee should include somebody who was completely independent of the IJB to provide it with specialist knowledge that adds value to the Audit Committee and to improve its independence and objectivity in line with best practice. Since then the IJB has had one external member on its Audit Committee.

1.3 During the most recent self-assessment in 2020/21, using the CIPFA Audit Committees guidance as best practice, the IJB Audit Committee considered its Membership and acknowledged the added value provided by the External Member. The output was the IJB Audit Committee Annual Report 2020/21, which was presented to IJB on 28 July 2021.

1.4 The IJB is looking to appoint an External Member to its Audit Committee, following the resignation of the previous role holder, to enhance its performance in the review and scrutiny of the IJB's corporate governance arrangements, risk management systems and associated internal control environment, in line with best practice.

1.5 The CIPFA Audit Committees best practice guidance includes the following in respect of recruitment of independent members to audit committees:

- Independent members appointed to the committee should be recruited in an open and transparent way.
- The job description of the independent member should be drawn up and agreed before commencing recruitment. The requirement for relevant knowledge or expertise should be clearly determined.
- Vacancies should be publicly advertised.

- Appropriate enquiries will need to be made as part of the recruitment process to ensure that any applicants satisfy the requirements.
- Independent members' appointments should be for a fixed term and be formally approved by the authority's board.
- The primary considerations when considering audit committee membership should be maximising the committee's knowledge base and skills, being able to demonstrate objectivity and independence, and having a membership that will work together.

2 PROPOSAL

2.1 A Person Specification and an Advert for the External Member Audit Committee have been prepared using the Knowledge and Skills Framework in the CIPFA Audit Committees guidance to ensure there is clarity on the required skills, knowledge, experience and personal qualities for the role.

2.2 A formal recruitment process will commence soon with the publication of the Person Specification and Advert for External Member Audit Committee to be distributed widely within the Scottish Borders community and across the IJB's partner organisations through their networks for engagement. The appointments will be for a fixed period to 31 October 2025.

2.3 The proposal is that a Selection Committee be appointed for the purpose of interviewing, selecting and appointing a person as External Member of the IJB Audit Committee.

2.4 It is proposed that the Selection Committee has the following membership:

- Chair of the IJB Audit Committee
- Two other members of the IJB Audit Committee, excluding IJB Chair

2.5 The Selection Committee will consult with and be advised by the IJB Chief Internal Auditor (Scottish Borders Council's Chief Officer Audit & Risk) during the recruitment, selection and appointment process.

2.6 It is proposed in the spirit of partnership working to utilise the same recruitment advertising process for the vacant role of External Member of IJB Audit Committee as that used by Scottish Borders Council for the External Members of its Audit and Scrutiny Committee.

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Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 21 September 2022

Report By:	Iris Bishop, Board Secretary
Contact:	Iris Bishop, Board Secretary
Telephone:	01896 825525
IJB BUSINESS PLAN AND MEETING CYCLE 2023	
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 2023.
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 2023 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 In order to ensure the IJB receives tangible business of a high quality standard the number of meetings for 2023 are proposed to be set at 6 per year which would afford officers time to ensure the delivery of quality reports worthy of robust scrutiny.

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

2.3 It is proposed that the Health & Social Care Integration Joint Board now meet formally on no less than 6 occasions throughout 2023.

2.4 It is proposed that the Health & Social Care Integration Joint Board undertake 2 Development sessions throughout 2023.

2.5 It is proposed the Audit Committee of the Integration Joint Board meet formally on no less than 4 occasions throughout 2023.

2.6 It is proposed the Strategic Planning Group meet on 6 occasions throughout 2023.

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

2.8 All Health & Social Care Integration Joint Board meetings, Development sessions and Audit Committee meetings will revert back to taking place in person wherever possible.

2.9 In order to maximise the availability of Health & Social Care Integration Joint Board (H&SC IJB) members all IJB meetings, development sessions and Strategic Planning Group meetings have been arranged for Wednesdays. The IJB Audit Committee meetings are 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	18		15		17		19		20		15	
IJB Development Session 10am to 12noon				19						18		
IJB Audit Committee 2pm to 4pm			20			19			18			18
Strategic Planning Group 10am to 12noon		1		5		7		2		4		6

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HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD BUSINESS PLAN 2023

Standing Items	Recurrence	Owner	IJB 18.01.2023	SPG 01.02.2023	IJB 15.03.2023	IJB Audit Committee 20.03.2023	SPG 05.04.2023	IJB Development Session 19.04.2023	IJB 17.05.2023	SPG 07.06.2023	IJB Audit Committee 19.06.2023	IJB 19.07.2023	SPG 02.08.2023	IJB Audit Committee 18.09.2023	IJB 20.09.2023	SPG 04.10.2023	IJB Development Session 18.10.2023	IJB 15.11.2023	SPG 06.12.2023	IJB Audit Committee 18.12.2023	IJB January 2024	SPG February 2024
Minutes	Each Meeting	Board Secretary	Approve	Approve	Approve	Approve	Approve		Approve	Approve	Approve	Approve	Approve	Approve	Approve	Approve		Approve	Approve	Approve	Approve	Approve
Action Tracker	Each Meeting	Board Secretary	Note	Note	Note	Note	Note		Note	Note	Note	Note	Note	Note	Note	Note		Note	Note	Note	Note	Note
Internal Audit Update Report	Each Meeting	Chief Internal Auditor				Annual Plan					Internal Audit Annual Assurance Report											
Monitoring of the Health & Social Care Partnership Budget	Each Meeting	Chief Financial Officer	Note		Note				Note			Note			Note			Note			Note	
Performance Report	Quarterly	Planning & Performance Officer			Note													Note			Note	
Inspections Update	As and when	Chief Social Work Officer																				
SPG Minutes	When SPG mins approve	Board Secretary	Note		Note				Note			Note			Note			Note			Note	
Audit Scotland – Recent Audit Reports of interest	As and when	Chief Internal Auditor				Note					Note			Note						Note		
Monitoring of Directions issued by the IJB	As and when	Chief Officer				Note					Note			Note						Note		
Business Items																						
Financial Outlook Update	**As and when**	**Chief Financial Officer**	**Note**		**Note**										**Note**							
2022/23 IJB Joint Financial Plan	Annually	Chief Financial Officer			Draft Budget				Approve Budget												First Draft Budget 2024/25	
Recommend Directions to the IJB to issue	As and when	Chief Officer / Chief Financial Officer																				
Issue Directions	As and when	Chief Financial Officer / Chief Officer	Approve		Approve				Approve			Approve			Approve			Approve			Approve	
Discharge Programme Update	Annually	Chief Officer	Note																			
Register of Interests	Annually	Board Secretary			Note																	
Code of Corporate Governance Refresh	Annually	Chief Internal Auditor																		Approve		
Clinical & Care Governance Annual Report	Annually	Chief Social Work Officer / Head of Clinical Governance																CSWO Annual Report (SBC) / CGC Annual Report (NHS)				
H&SC IJB Annual Performance Report	Annually	Chief Officer							Review Draft			Approve										
IJB Annual Accounts	Annually	Chief Financial Officer									Unaudited			Audited	Approve							
IJB Annual Governance Statement	Annually	Chief Internal Auditor									Approve											
Board Committee Memberships	As and when	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 (2023-2026)	Every 3 years	Chief Officer		Draft	Draft		Recommend IJB approve		Approve													
External Audit Annual Plan	Annually	External Auditor				Approve																
IJB Audit Committee Annual Report	Annually	Chief Internal Auditor									Approve				Note							
External Audit Annual Audit Report	Annually	External Auditor												Recommend IJB Approve	Approve							
IJB Self Assessment	Annually	Chief Officer / Chief Internal Auditor				Undertake self assessment at session after the					included in Annual Report item				Report from self assessment and action plan for approval						IJB self assessment	
Strategic Risk Register Update	Bi-Annual IJB Annual Audit Committee	Chief Officer				Recommend IJB approve						Approve										
Risk Management Policy & Strategy	Annually	Chief Internal Auditor				Risk Management Update						Note			Approve							
Review of Terms of Reference	Every 3 years	Board Secretary / Chief Internal Auditor					SPG ToR Review				AC ToR Review				Next due 2024							
Public Sector Equality Duty	Full report every 2 years	Simone Doyle and Jane Robertson													Approve for publication							
Charging Policy	Annually	Chief Officer													Approval							
Locality Working Groups / Community Engagement	Annually	Chief Officer																				
Public Protection Service	Annually	Chief Social Work Officer																				
PCIP - Primary Care Improvement Plan	Annually	Chief Officer / General Manager P&CS										Annual Update										
Auditor General Work Programme	Annually	Chief Internal Auditor				Note																
Care Villages	As and when	Chief Officer																				

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Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 21 September 2022

Report By	Hazel Robertson, Chief Finance Officer IJB
Contact	Hazel Robertson, Chief Finance Officer IJB
Telephone:	07929 760533

MONITORING AND FORECAST OF THE HEALTH AND SOCIAL CARE PARTNERSHIP BUDGET 2022/23 AT 30 JUNE 2022

Purpose of Report:	The purpose of this report is to update the IJB on the year to date and forecast year end position of the Health and Social Care Partnership (H&SCP) for 2022/23 based on available information to 30 June 2022.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Note** the forecast adverse variance of (£2.390m) for the H&SCP for the year to 31 March 2023 based on available information b) **Note** that whilst the forecast position includes costs relating to mobilising and remobilising in respect of Covid-19, and also assumes that all such costs will again be funded by the Scottish Government. **c)** **Note** that a recovery plan is to be developed and that any expenditure in excess of delegated budgets in 2022/23 will require to be funded by additional contributions from the partners in line with the Scheme of Integration. **d)** **Note** that set aside budgets continue to be under significant pressure as a result of activity levels, flow and delayed discharges. **e)** **Note** the importance of ensuring that the strategic commissioning and planning process currently in progress is used to identify options for change which can improve the long term financial sustainability of the partnership whilst at the same time addressing need.
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 2022/23 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:	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

1.1 The report provides the year to date financial position and an initial forecast position for functions delegated to the H&SCP (the "delegated budget") and the budget relating to large-hospital functions retained and set aside for the population of the Scottish Borders (the "set-aside budget").

1.2 The forecast is based on the available information presented to Scottish Borders Council and the Board of NHS Borders. It highlights the key variances compared to budget at 30 June 2022 (month 3). NHS Borders and Scottish Borders Council, at the time of writing this report have considered the financial position at month 3.

1.3 Finance reports will be prepared quarterly and brought to the IJB for consideration. As the year progresses, further analysis and refinement will be provided, allowing the IJB to assess the likelihood of achieving target savings and the likelihood of achieving a breakeven position relative to the budget approved in June 2022.

Overview of Monitoring and Forecast Position at 30 June 2022

2.1 The paper presents the consolidated financial performance at the end of June 2022 (period 3). Members should be aware that the forecast is subject to risks and uncertainties which will be revised over the coming months.

2.2 Table 1 shows the end of June actual spend across the partnership.

Table 1 end June 2022	**Actual £000s**	**Key issues**
Healthcare delegated	37,915	Vacancies, unachieved savings, risk re drugs prices
Social Care delegated	420	Assumption that pressures and savings will be managed in year
Hospital set aside	7,510	Additional nursing and medical staffing, additional beds to deal with delays

2.3 Table 2 shows the current year end forecast.

Table 2 forecast year end	**Forecast £000s**	**Key issues**
Healthcare delegated	(272)	Unidentified savings (4,739) and further (1,100) in Mental Health, significant vacancies, which when filled will reduce underspends
Social Care delegated	0	Risks in all service areas. Forecast achievement of budget and savings.
Hospital set aside	(2,118)	Additional nursing and medical staffing, additional beds to deal with delays

2.4 Within delegated functions, the overspend of £(272)k sits entirely in the healthcare delegated functions.

2.5 Forecasts include the estimated impact of non-delivery of savings plans. The NHS forecast is subject to detailed review currently being undertaken. As such, members should recognise that the forecast is an indication of current expenditure trend and is unlikely to be a full representation of the likely outturn. An assessment of financial risk for this year will be developed through the NHS Quarter One review process and ongoing review and challenge of assumptions across Scottish Borders Council's Fit for 2024 and NHS Borders' Financial Turnaround Programmes.

Significant issues at 30 June 2022

Healthcare functions

3.1 Currently, NHS Borders' is presenting forecast savings undelivered in full. Beyond the additional costs of Covid-19, including the non-delivery of planned savings on which the financial plan is predicated, operational functions are still reporting a reduction in core activity over the first quarter that net of the additional costs of Covid-19 and undelivered savings, results in a favourable position at the end of period 3.

Social Care functions

3.2 Scottish Borders Council actual spend to date on social care functions, as stated in Appendix 1, was £420k. The unusual position of reporting net income for older peoples services instead of spend is due to the upfront transfer of social care funding and health board resource transfer from NHS Borders during the first quarter for the whole of the financial year. Other income factors are Scottish Government Covid-19 funding for social care sustainability and the offset of 2021/22 funding allocations brought forward into 2022/23.

3.3 The SBC forecast at period 3 is based on detailed monthly monitoring during the first 3 months of the financial year. In order to deliver a breakeven position, social care functions assume all Covid-19 costs included within the Local Mobilisation Plan, including undelivered efficiency savings, will be funded by the Scottish Government in full.

Large Hospital functions retained and set-aside

3.4 Accident and Emergency is experiencing significant cost pressure as a result of additional nurse staffing to meet increased activity / triage, flow issues within the BGH and a heightened level of delayed discharges. To date, as a result of capacity issues, little progress has been made in planning or delivering the set-aside share of the recurring savings target.

General

3.5 Additional costs of Covid-19 to date, together with the opportunity cost of undeliverable financial plan savings, continues to outweigh any financial benefit and reduced cost within core operational services arising from a reduction in activity during the first quarter of 2022/23. This position may be mitigated to some extent when a clearer picture of likely funding allocations from the Scottish Government emerges.

Reserves

4.1 The IJB can hold ring-fenced reserves to retain planned underspends. Within Scottish Borders IJB there are significant accumulated reserves in relation to COVID recovery, Scottish government health portfolio commitments, and legacy balances retained from historic transformation funds. The COVID recovery reserve is held on a whole system basis (including non-delegated functions) in line with Scottish Government guidance.

4.2 The majority of reserves relate to government provided ring fenced allocations. The funding position for the SG Health Portfolio is increasingly challenging due to macro--economic factors such as fuel prices, inflation generally and pay awards. As a result, the scrutiny over ring fenced allocations is increasing, with SG being more directive about how these may be used, or indeed returned if not utilised.

4.3 At end June the IJB holds reserves of £25.546m, which includes the Covid reserves of £11.048m. The balances per portfolio areas are appended to this report. As part of the mid year review process an assessment will be undertaken of each balance to ascertain what funds require to be released to support existing plans, what is likely to be returned to SG, and whether the release of any funds will contribute to an improved monitoring position.

Recovery Plan

5.1 Where there is a forecast overspend in delegated functions, the Chief Officer and the Chief Financial Officer of the IJB must agree a recovery plan to address the overspending budget. NHS Borders and Scottish Borders Council are expected to work in partnership with the Chief Financial Officer and Chief Officer to facilitate the development of this plan, and to share progress against the plan with the IJB.

5.2 Savings plans will proactively consider any impacts on:

- the National Health and Wellbeing outcomes
- the Integration Delivery Principles and
- the 'Triple Aim' (i.e. Improving Population Health, Improving Value for Money and Improving Service User Experience).

Page 174

5.3 Required savings plans for 2022/23 comprise £1.3m for SBC services and £4.7m for NHSB services. The savings target for NHSB includes accumulated non-delivery of prior year savings targets for services delegated by the IJB. The Health Board has deferred consideration of increased savings targets pending development of its medium term (three year) financial plan in summer 2022.

5.4 The CFO and other senior officers will continue to engage with other partnerships, health boards, and local authorities to identify options for consideration, and, in particular, with the Scottish Government over likely funding scenarios. However, the funding position at central government is becoming more challenging due to significant cost drivers such as pay awards and fuel prices. Scottish Government are being more proactive in reviewing spend against allocations and looking for unspent allocations to be returned. In this context we need to be mindful that that existing or hoped for allocations may be at risk going forward.

5.5 The recovery plan will include a review of the monitoring position at end September, challenge and remodelling of savings delivery and options, and utilisation of reserves.

5.6 The Scheme of Integration (SOI) makes provision for partner organisations to provide additional resources to the IJB where its recovery plan has been unsuccessful in a given year. Under the terms of the SOI amounts provided to meet this gap are repayable to the partners in future periods. To date this provision has not been used.

Conclusion and Recommendation to IJB Board

6.1 Currently the financial forecast holds significant risk: non delivery of financial savings targets in healthcare delegated services and continued pressures in the set aside budgets due to excess activity. There is also emerging risk around government funding allocations. A more detailed review of the level of financial risk is being conducted based on QTR1 results. Further work will include:

- Ongoing analysis and reporting of the H&SCP (and NHS Borders' and Scottish Borders Council's) local mobilisation plan financial models
- Further review, challenge and remodelling of planned efficiency savings programmes
- Review of all costs, expenditure profiles, future commitments and refinement of assumptions for projected expenditure to the end of the year
- Review of reserves and governmental income assumptions
- Consideration of financial position alongside activity levels.

6.2 The IJB should ensure that the strategic planning process currently underway is used effectively to identify, quantify and evaluate options for change which will ensure the partnership is able to move into a position of financial sustainability.

Appendix 1 Monthly Revenue Management Report

MONTHLY REVENUE MANAGEMENT REPORT

Summary	2022/23	At end of Month:	June

	Annual Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000
Generic Services	82,349	26,036	87,338	84,361	2,977
Older People Service	27,258	(7,935)	21,879	21,879	0
Prescribing	23,132	5,770	23,132	23,132	0
Joint Learning Disability Service	21,383	3,857	23,811	24,454	(643)
Joint Mental Health Service	20,767	4,951	23,949	21,816	2,133
SB Cares	13,675	4,697	14,672	14,672	0
Physical Disability Service	2,533	714	2,816	2,816	0
Targeted Savings	(4,739)	0	(4,739)	0	(4,739)
Large Hospital Functions Set-Aside	27,038	7,510	27,922	30,040	(2,118)
Total	213,396	45,600	220,780	223,170	(2,390)

Appendix 2 Monthly Revenue Management Report – Social Care

MONTHLY REVENUE MANAGEMENT REPORT

Delegated Budget Social Care Functions 2022/23 | At end of Month: June

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Summary Financial Commentary
Joint Learning Disability Service	17,801	2,809	20,262	20,262	0	It is assumed that £295k of pressures due to the 2022/23 impact of client specific pressures funded non-recurrently in 2021/22 will be managed within existing budgets during the financial year. There is also an assumption that £472k Financial Plan savings will be delivered in full.
Joint Mental Health Service	1,956	145	2,038	2,038	0	The service is experiencing pressures caused by increasing client numbers and associated increased expenditure. This is actively being addressed with the aim to reduce expenditure in line with budget.
Older People Service	27,258	(7,935)	21,879	21,879	0	Pressures relating to the agreed full year cost of Homecare Provider grants linked to increased hourly rates, required to ensure the sustainability of providers experiencing significant staffing absence and other unfunded Covid-19 pressures such as continued use of PPE to be claimed through the LMP. Credit value YTD relates to resource transfer.
SB Cares	13,675	4,697	14,672	14,672	0	£107k pressure relating largely to the continued increased PPE requirement in Care Homes and Home Care settings. Additionally, staffing pressures related to increased use of overtime and agency staff due to recruitment issues. Both are anticipated to be managed within the service.
Physical Disability Service	2,533	714	2,816	2,816	0	The service is reporting a marginal overspend against budget, this will be managed throughout the year.
Generic Services	6,958	(10)	8,235	8,235	0	Pressures amounting to £103k relating to locality based client care forecasts are anticipated to be managed within the service during the remainder of the financial year.
Total	70,181	420	69,902	69,902	0	

Appendix 3 Monthly Revenue Management Report – Healthcare

MONTHLY REVENUE MANAGEMENT REPORT

Delegated Budget Healthcare Functions	2022/23	At end of Month:	June

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Summary Financial Commentary
Joint Learning Disability Service	3,582	1,048	3,549	4,192	(643)	Small underspend at period 4 largely due to vacancies, which are in recruitment. Likely that outturn will be an improved position.
Joint Mental Health Service	18,385	4,838	21,485	19,352	2,133	Likely that outturn will be a worsening position due to undelivered savings of £1.1m, medical vacancies, ongoing use of locums and pressure on drugs.
Joint Alcohol and Drugs Service	426	(32)	426	426	-	No major issues to report
Prescribing	23,132	5,770	23,132	23,132	-	Likely worsening position for outturn £300k - some drugs in short supply resulting in significant increase in unit price, hopefully a short term issue.
Unidentified savings	(4,739)	-	(4,739)	-	(4,739)	Too early to give a definitive view but likely to be an area of significant and material concern.
Generic Services	75,391				-	
Independent Contractors		9,266	32,670	32,670	-	AHP service is mainly vacancies which are being recruited to. Similarly District Nursing reflects a number of vacancies within School Nursing and Community Healthcare Teams, which are being recruited to. PCIP spend level will reflect a combination of brought forward reserves and in year allocations. In year allocation is insufficient to cover all the workstreams, ongoing engagement with Scottish Government regarding level of recurring resource. Underspend in dental due to level of vacancies.
Community Hospitals		1,496	6,175	5,984	191	
Allied Health Professionals		1,907	7,791	7,628	163	
District Nursing		1,052	4,181	4,208	(27)	
PCIP		245	1,465	1,465	-	
Generic Other		12,325	28,286	25,636	2,650	
Total	116,177	37,915	124,421	124,693	(272)	

Appendix 4 Monthly Revenue Management Report – Large Hospital Set Aside

MONTHLY REVENUE MANAGEMENT REPORT

Large Hospital Functions Set-Aside	2022/23	At end of Month:	June

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Summary Financial Commentary
Accident & Emergency	3,149	1,105	3,450	4,420	(970)	Overspend due to additional nursing staff and supplies. In the main due to the number and length of time we are having to hold patients in A&E due to flow issues within the BGH. This is a direct result of delayed discharges within the acute and community hospitals (on average 60 to 70 patients). The projection assumes no change between now and the end of the year.
Medicine & Long-Term Conditions	17,229	4,813	17,786	19,252	(1,466)	Overspend of £237k without savings relates to additional junior medical staff, nursing and supplies within MAU. The medical staffing will be funded from August. The overspend in nursing In MAU relates to 7 additional beds currently open to deal with delayed discharges. As with the additional costs in ED it is anticipated that this will continue to the end of the financial year.
Medicine of the Elderly	6,660	1,592	6,686	6,368	318	There is a small underspend in the DME department at the end of mth 3 over both pays and supplies. This underspend will reduce between now and the end of the year.
Unidentified Savings	-	-	-	-	-	
Total	27,038	7,510	27,922	30,040	(2,118)	

Appendix 5 **IJB Reserves by Portfolio Area**

Portfolio	Ring Fenced Allocations (RRL) £	Additional Commitments (NHSB) £	Total Balance held in Reserves £
Alcohol & Drugs	368,740	605,782	974,522
BBV	0	97,329	97,329
Mental Health	2,287,674	0	2,287,674
PCIP	1,522,980	0	1,522,980
PC Digital	182,369	164,158	346,527
PC Premises	148,831	191,047	339,878
PC Other	531,524	37,155	568,679
Public Health	36,134	108,771	144,905
Regional Diabetes	1,342,059	150,939	1,492,998
Urgent & Unscheduled Care	871,566	0	871,566
Vaccines	0	153,687	153,687
Winter	0	427,468	427,468
Workforce & Wellbeing	687,261	0	687,261
Community Living Change Fund	377,966	0	377,966
Other	275,052	209,001	484,053
HB Support	0	3,720,613	3,720,613
COVID	11,048,000	0	11,048,000
	0	0	0
	19,680,156	**5,865,950**	**25,546,106**

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 21 September 2022

Report By:	Chris Myers, Chief Officer Health & Social Care
Contact:	Hayley Jacks, Planning & Performance Officer, NHS Borders
Telephone:	via MS Teams

QUARTERLY PERFORMANCE REPORT, SEPTEMBER 2022
(latest available data at June 2022)

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:	The 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.
Financial:	N/A
Legal:	N/A
Risk Implications:	N/A

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Scottish Borders
Health and Social Care
PARTNERSHIP

Quarterly Performance Report for the
Scottish Borders Integration Joint Board September 2022

SUMMARY OF PERFORMANCE:
Latest available Data at end July 2022

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

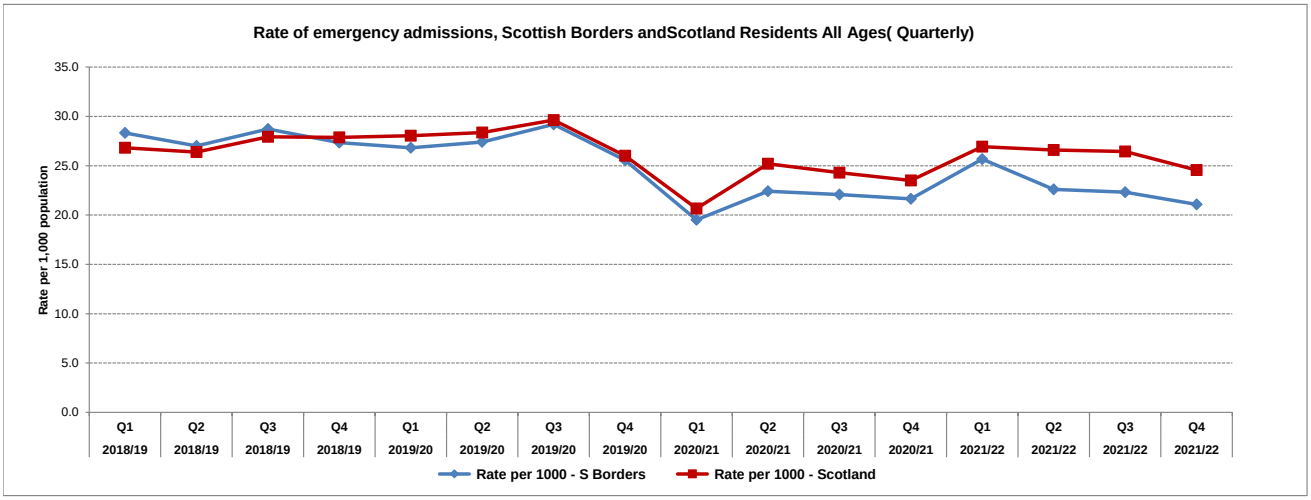
Objective 3: We will improve the capacity within the community for people who have been in receipt of health and social care services to manage their own conditions and support those who care for them

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)

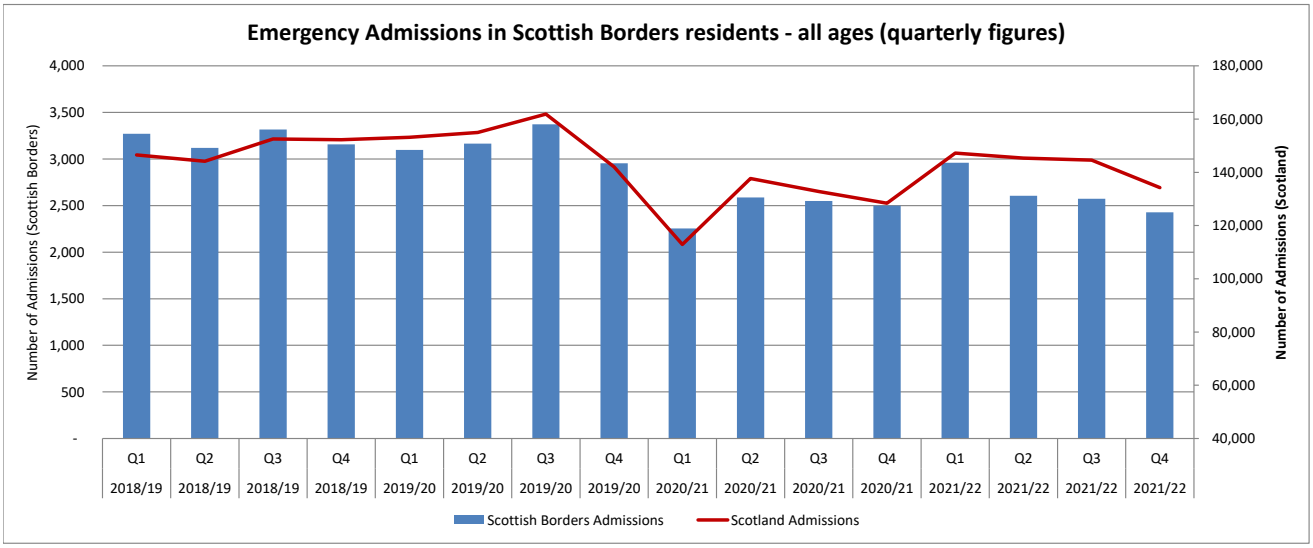
	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21	Q1 2021/22	Q2 2021/22	Q3 2021/22	Q4 2021/22
Scottish Borders - Rate of Emergency Admissions per 1,000 population All Ages	27.5	26.9	27.5	29.3	25.6	19.6	22.4	22.1	21.6	25.7	22.6	22.3	21.1
Scotland - Rate of Emergency Admissions per 1,000 population All Ages	28.1	28.2	28.5	29.8	26.1	20.6	24.6	24.3	23.5	26.9	26.6	26.4	24.6



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

Source: MSG Integration Performance Indicators workbook (SMR01 data)

	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21	Q1 2021/22	Q2 2021/22	Q3 2021/22	Q4 2021/22
Number Scottish Borders Emergency Admissions - All Ages	3,158	3,097	3,166	3,372	2,953	2,254	2,586	2,547	2,500	2,959	2,605	2,573	2,428
Number Scotland Emergency Admissions - All Ages	152,223	153,176	154,966	161,865	142,079	112,034	133,783	132,773	128,364	147,240	145,321	144,567	134,263



Please Note: where two areas are concerned it is not possible to show values as a control chart.

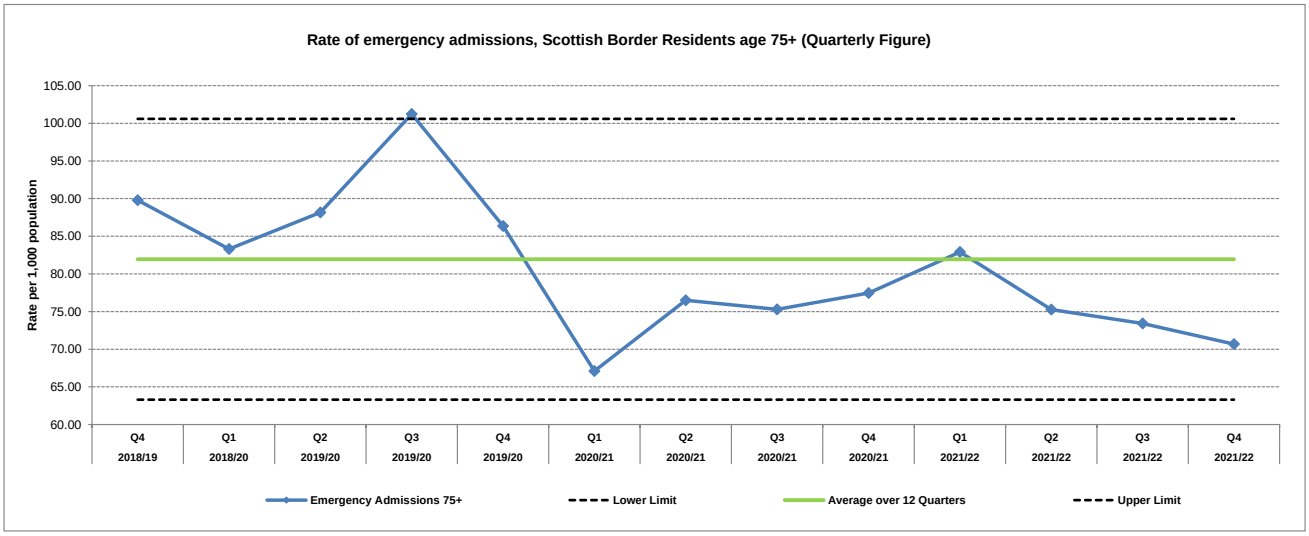
How are we performing?

The rate of emergency admissions continues to see minor fluctuations between quarters. Emergency Admission rates significantly reduced in both Q4 19/20 and Q1 20/21. This is reflective of the impact of the Covid-19 pandemic and the National measures introduced to reduce the spread of the virus. This rose again in Q2, following a similar trend to that of the rest of Scotland. There has been a dip subsequently in Q3 and Q4 2020/21 during the pandemic but emergency admissions have rose again in April - June 2021. Since that point there has been a reduction each quarter, both locally and nationally.

Emergency Admissions, Scottish Borders residents age 75+

Source: NSS Discovery

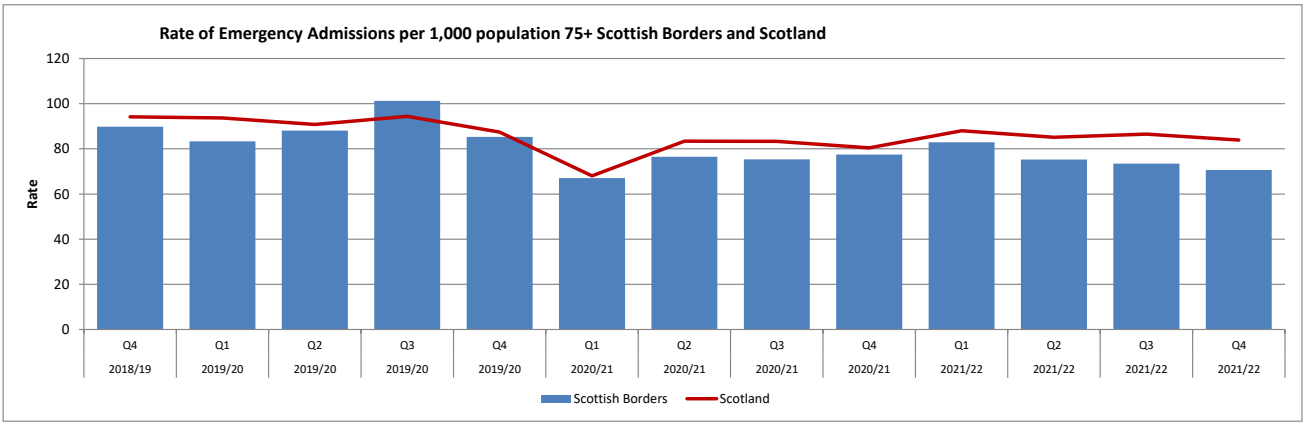
	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21	Q1 2021/22	Q2 2021/22	Q3 2021/22	Q4 2021/22
Number of Emergency Admissions, 75+	1,076	1,020	1,079	1,239	1,057	846	965	947	977	1,046	970	946	907
Rate of Emergency Admissions per 1,000 population 75+	89.8	83.3	88.2	101.2	86.4	67.1	76.5	75.3	77.5	82.9	75.3	73.4	70.7



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

Source: NSS Discovery

	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21	Q1 2021/22	Q2 2021/22	Q3 2021/22	Q4 2021/22
Rate of Emergency Admissions Scottish Borders	89.8	83.3	88.1	101.2	85.3	67.1	76.5	75.3	77.5	82.9	75.3	73.4	70.7
Rate of Emergency Admissions 75+ Scotland	94.2	93.7	90.8	94.4	87.5	68.0	83.4	83.3	80.5	88.0	85.2	86.5	83.9



Please Note: where two areas are concerned it is not possible to show values as a control chart.

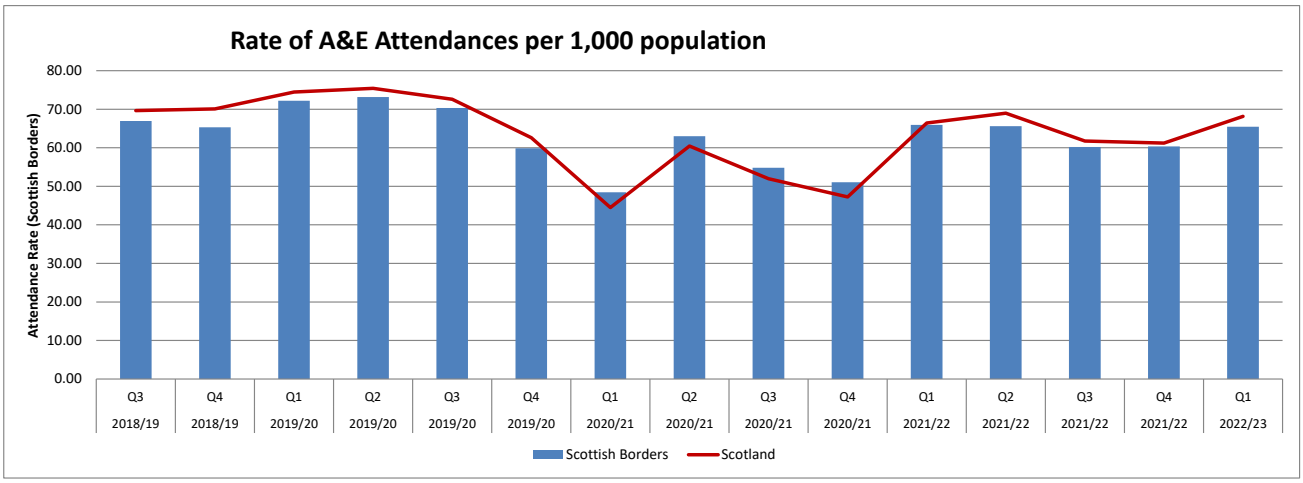
How are we performing?

The rate of 75+ emergency admissions was showing a negative trend over the last 3 years 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. 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 Covid-19 pandemic during Q4 2019/20, and its ongoing effects, would explain the sudden decrease in Emergency Admissions over the Q4 19/20 and Q1 20/21. Q2 20/21 to Q1 21/22 saw this rate increase slightly, although the next 3 quarters reduced. The Borders' rates have remained below the average over 12 quarters, of the 13 reported and the gap has widened for Q2 - Q4 2021/22.

Rate of A&E Attendances per 1,000 population

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

	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21	Q1 2021/22	Q2 2021/22	Q3 2021/22	Q4 2021/22	Q1 2022/23
Rate of Attendances, Scottish Borders	72.4	73.3	70.5	60.0	48.5	63.0	54.7	51.0	65.9	65.6	60.2	60.4	65.5
Rate of Attendances, Scotland	74.8	75.7	72.9	62.9	44.6	60.5	52.3	47.3	66.4	69.0	61.7	61.2	68.2



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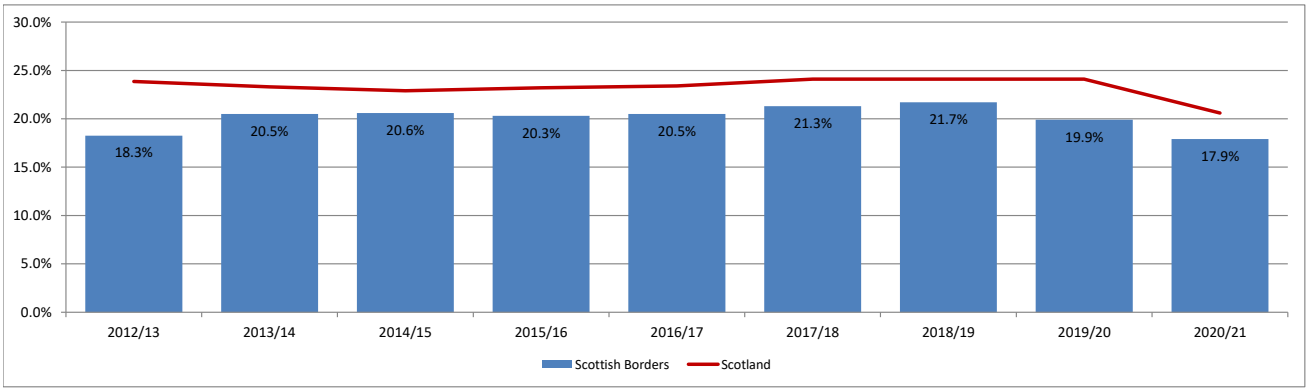
Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency: persons aged 18+

Source: Core Suite Indicator workbooks



Please Note: where two areas are concerned it is not possible to show values as a control chart.

How are we performing?

The onset of the Covid-19 pandemic (Q4 19/20 onwards) saw the rate of A&E attendances drastically reduce, with Q1 20/21 showing the lowest rate over the last 3 years. However, Q2 20/21 (Jul-Sept 20) saw this rise to almost 'normal' levels at 62.4 admissions per 1,000 of the population. After 2 quarters decreasing, rates rose again from Q1 2021/22. This behaviour mirrors that of the overall Scottish rate although it should be noted that in both Q1 of 20/21 to Q1 of 2021/22 saw the Borders rate being greater than Scotland's.

The percentage of health and social care resource spent on unscheduled hospital stays has seen an overall slight decrease over the past 3 years.

Both these indicators are impacted by the effects of the Covid-19 pandemic.

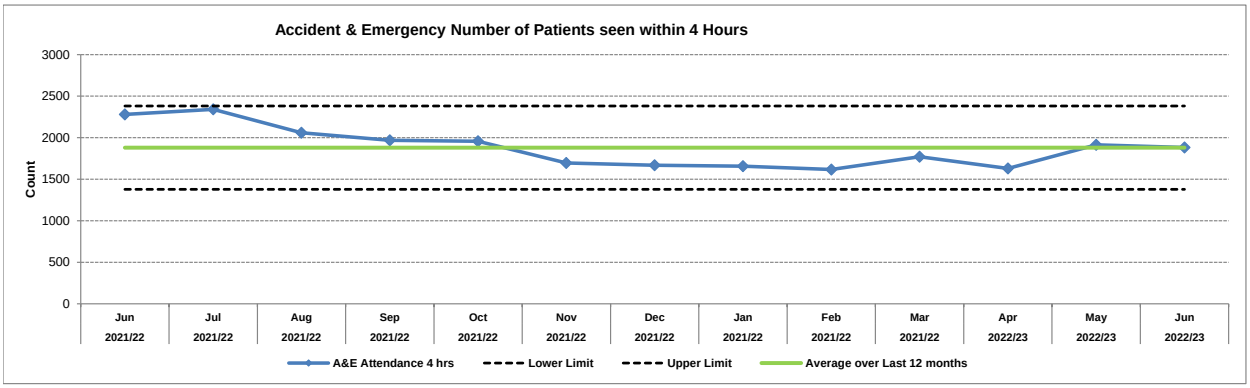
NB: December 2019, the denominator for this indicator now includes dental and ophthalmic costs. As a result, the % of spend has slightly decreased. The Table and Chart above have been updated to reflect the altered % as a result of this change.

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

Accident and Emergency attendances seen within 4 hours- Scottish Borders

Source: NHS Borders Trakcare system

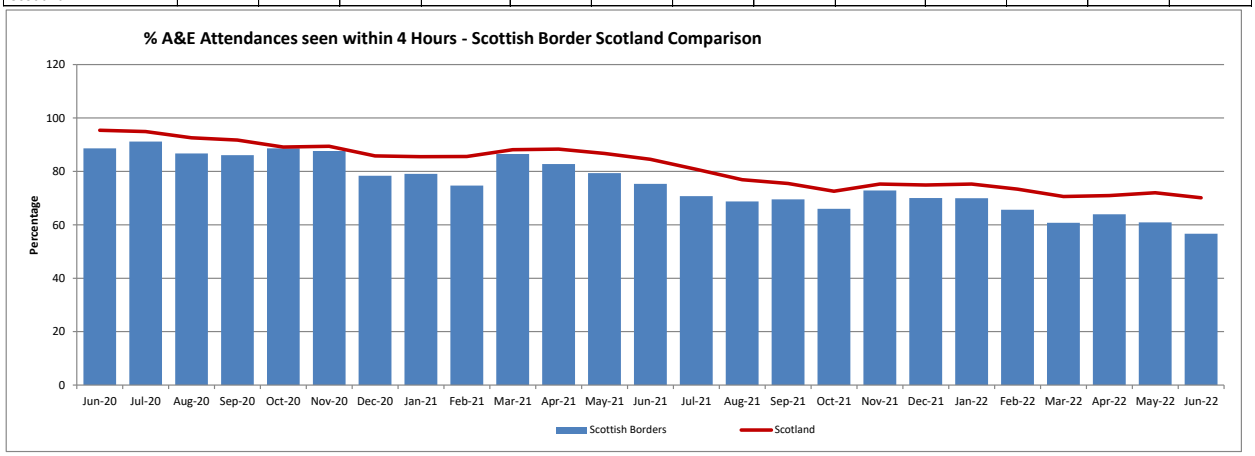
	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Number of A&E Attendances seen within 4 hours	2280	2341	2059	1969	1958	1695	1669	1657	1617	1770	1630	1914	1883



% 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-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
% A&E Attendances seen within 4 hour Scottish Borders	75.3	70.7	68.8	69.5	66.0	72.9	70.0	70.0	65.7	60.7	64.0	60.9	56.7
% A&E Attendances seen within 4 hour Scotland	84.5	80.8	76.9	75.5	72.6	75.2	74.9	75.2	73.4	70.6	71.0	72.0	70.1



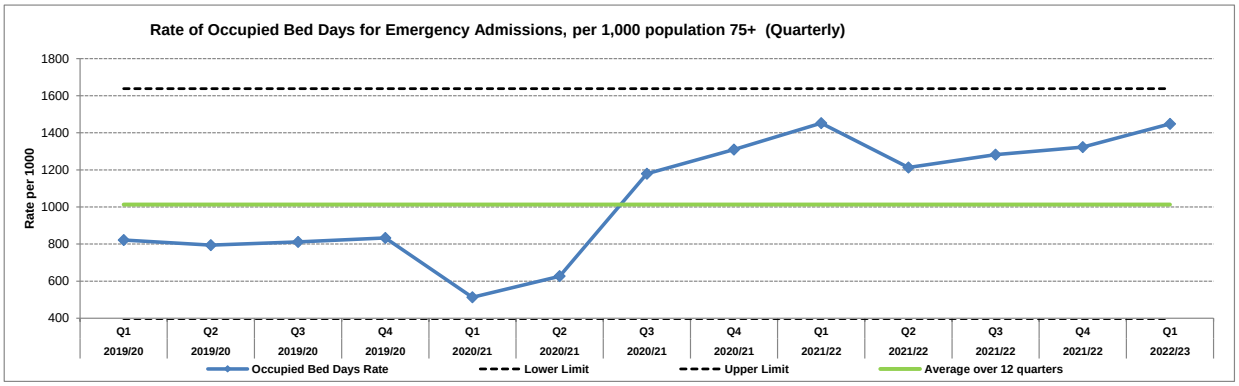
How are we performing?

Historically, NHS Borders consistently performed better than the Scottish comparator for A&E waiting times. Borders had fallen below the Scottish Average in all months reported since June 2020. The gap widened significantly since the onset of the Corona Virus pandemic in March 2020. The Scottish average is declining and the Borders position has mirrored this over the calendar year 2022.

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

Source: NSS Discovery

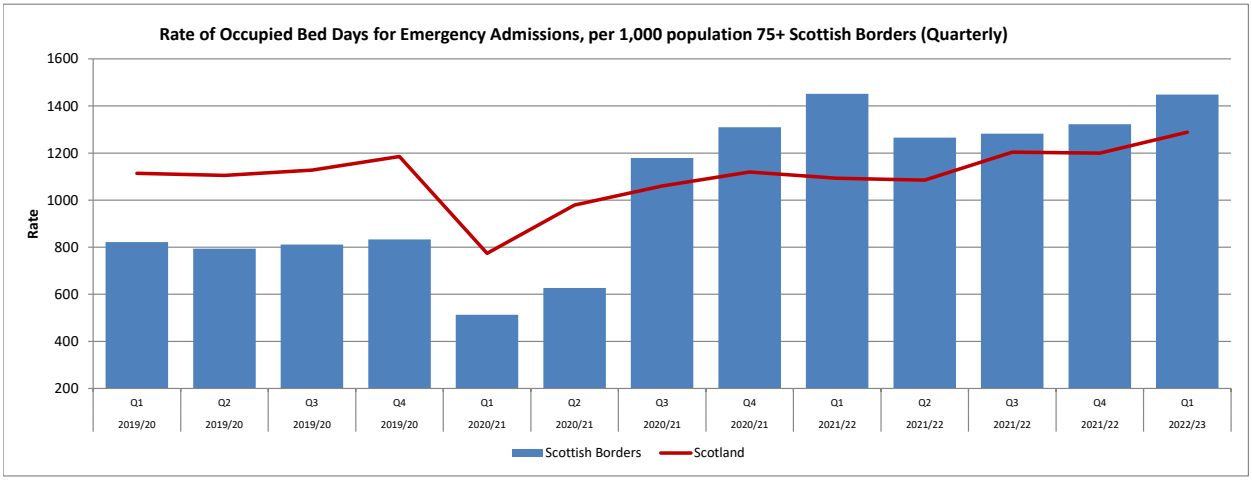
	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21	Q1 2021/22
Number of Occupied Bed Days for emergency Admissions, 75+	876	1032	868	883	822	794	812	833	513	627	1179	1310	1452
Rate of Occupied Bed Days for Emergency Admissions, per 1,000 population 75+	10523	12356	10407	10587	10056	9719	9933	10505	6471	7903	14861	16521	18378



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

Source: NSS Discovery

	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	Q3 2020/21	Q4 2020/21	Q1 2021/22
Rate of Occupied Bed Days for Emergency Admissions, per 1,000 population 75+ Scottish Borders	876	1032	868	883	822	794	812	833	513	627	1179	1310	1452
Rate of Occupied Bed Days for Emergency Admissions, per 1,000 population 75+ Scotland	1172	1072	1141	1157	1114	1105	1127	1185	774	979	1060	1119	1093



Please Note: where two areas are concerned it is not possible to show values as a control chart.

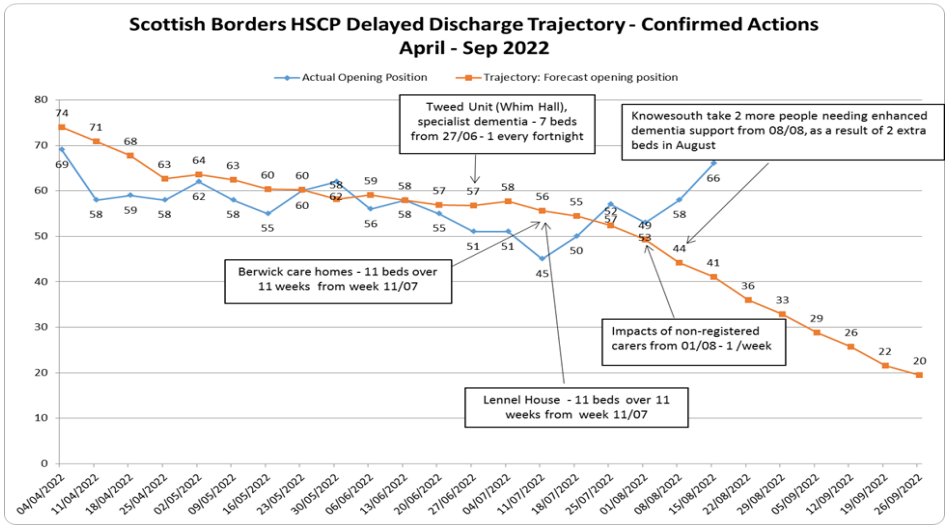
How are we performing?

NB: Data for Community Hospitals is included in both Bed Days measures from Q3 2020/21 onwards.

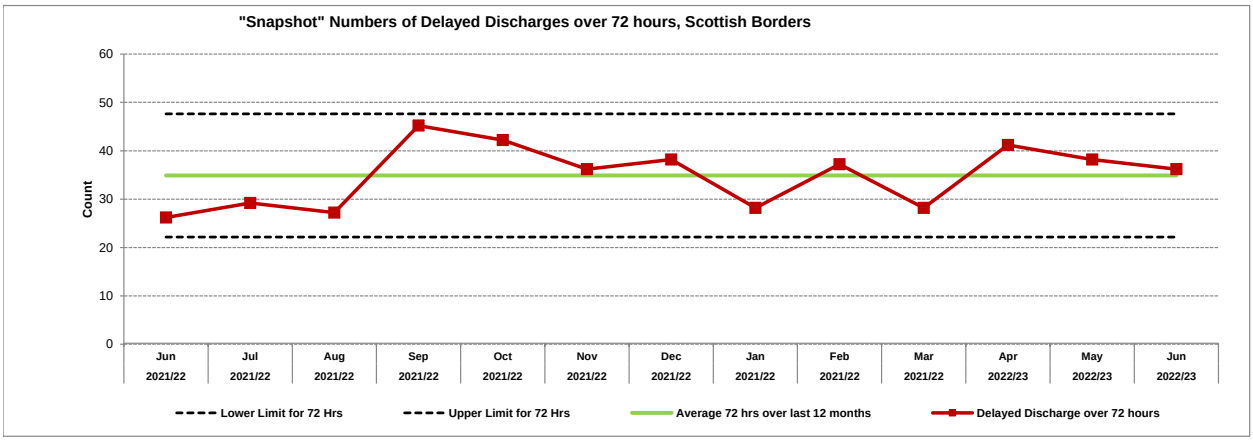
The quarterly occupied bed day rates for emergency admissions in Scottish Borders residents aged 75+ has fluctuated over time and had been lower than the Scottish Average until Q3 20/21 when Community Hospitals data are included. There was a reduction between Q1 2021/22 and Q2 2021/22 but rates have increased again from that point.

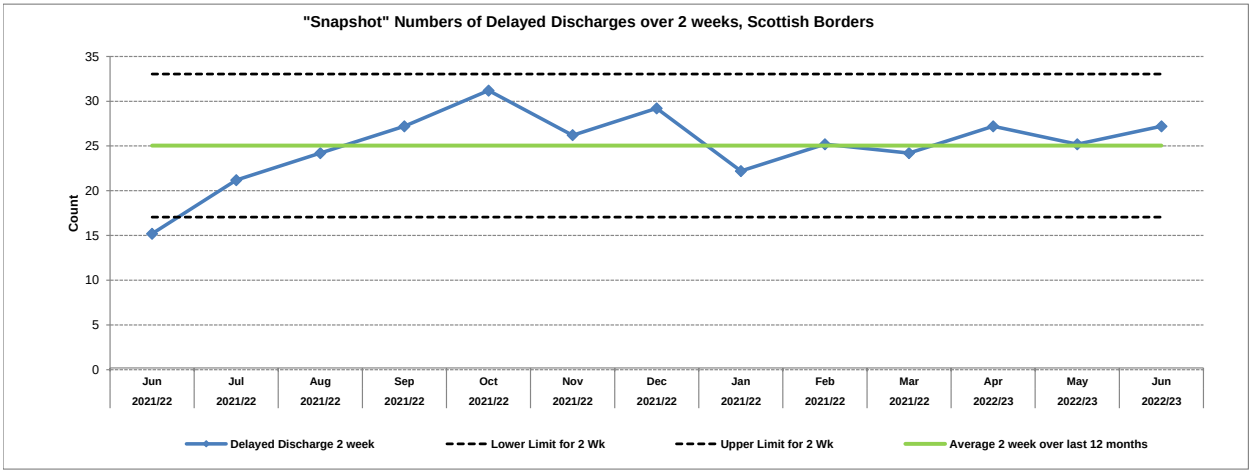
Delayed Discharges (DDs)

Source: NHS Borders Trakcare system



	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Number of DDs over 2 weeks	15	21	24	27	31	26	29	22	25	24	27	25	27
Number of DDs over 72 hours	26	29	27	45	42	36	38	28	37	28	41	38	36





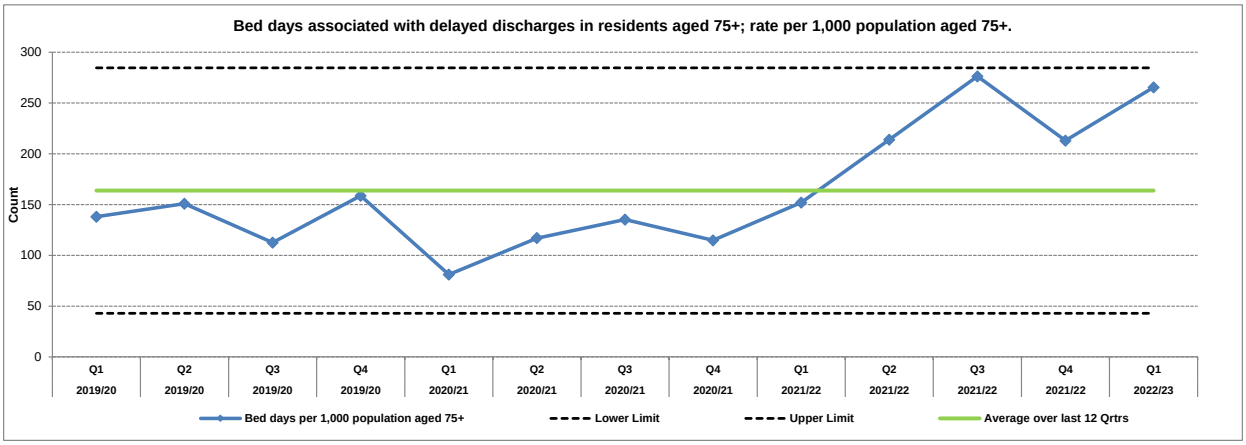
Please note the Delayed Discharge over 72 hours measurement has been implemented from April 2016.

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

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

Source: Core Suite Indicator workbooks

	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21	Q1 2021/22	Q2 2021/22	Q3 2021/22	Q4 2021/22
Bed days per 1,000 population aged 75+	137.9	150.8	112.4	158.6	80.9	116.8	135.0	114.7	151.8	213.8	276.1	212.9	265.3



How are we performing?

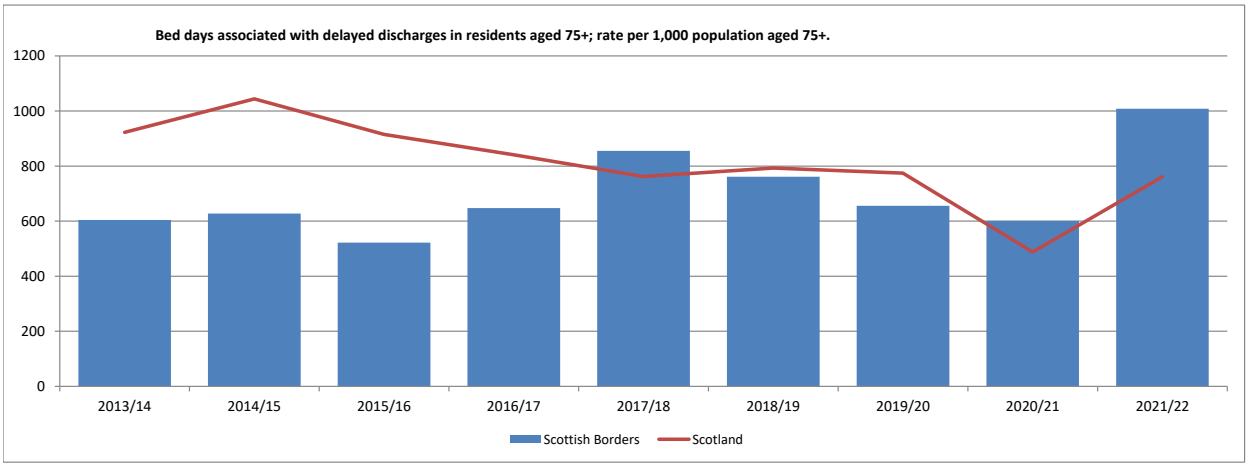
Although, at the onset of the Corona Virus pandemic there was a reduction in the number of delayed discharges, this was short-lived and these have again been on an increasing trend since May 20. December 2020 demonstrated a drop in delayed discharges; this is in-line with the previous year although the 2020 figure is higher than in 2019. In 2021 the rate of delayed discharges started to increase from February 2021 onwards. October 2021 was the first month to show a reduction in over 72 h our waits. Rates have been fluctuating from that point.

The rate of bed days associated with delayed discharges (75+) from Q1 2019/20 to Q4 2020/21 show fluctutations within control limits, there has been an increase since Q1 21/22 in the bed day rate. 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 trajectory put in place to the end of September2022 shows that currently the Partnership is above target.

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

Source: Core Suite Indicator workbooks

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Scottish Borders	522	647	855	761	656	601	1009
Scotland	915	841	762	793	774	488	761



Please Note: where two areas are concerned it is not possible to show values as a control chart.

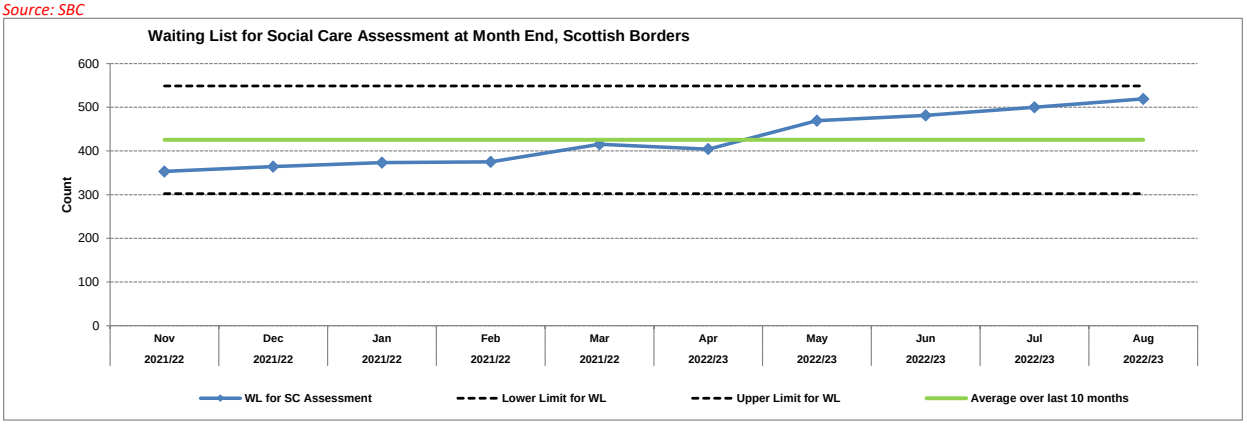
How are we performing?

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 and 2020/21. 2021/22 has seen a marked increase however.

*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+.

Social Care Assessment Waiting List

Source: SBC

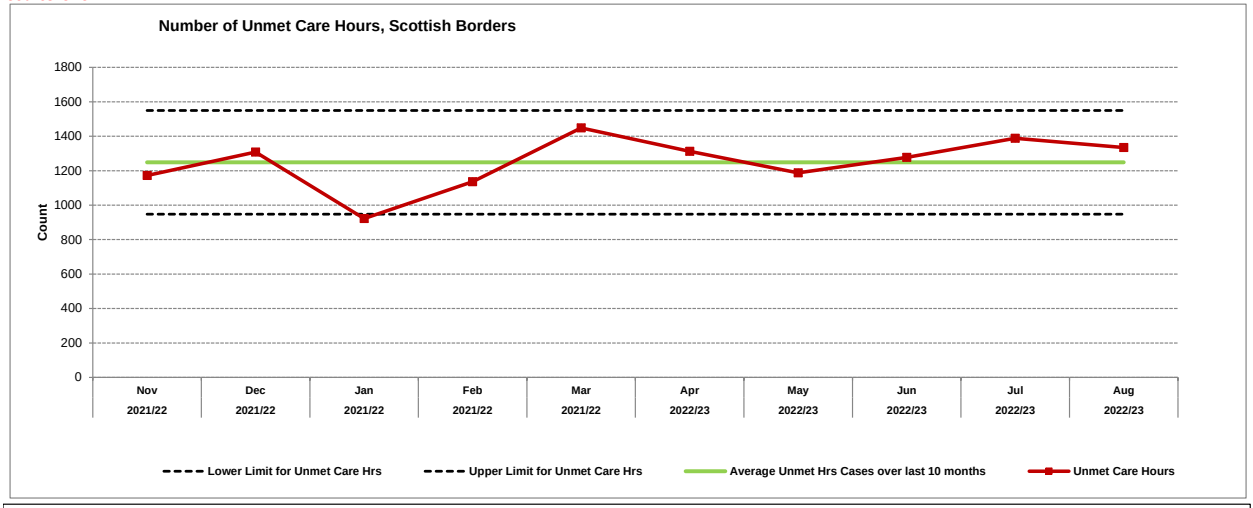


How are we performing?

Information is provided for the end of month position for the last 10 months to August 2022. This shows that patents waiting for Social Care Assessments are increasing month on month from Nov 2021 to date.

Care Hours Yet to be Provided for Those Assessed as Requiring Them

Source: SBC



How are we performing?

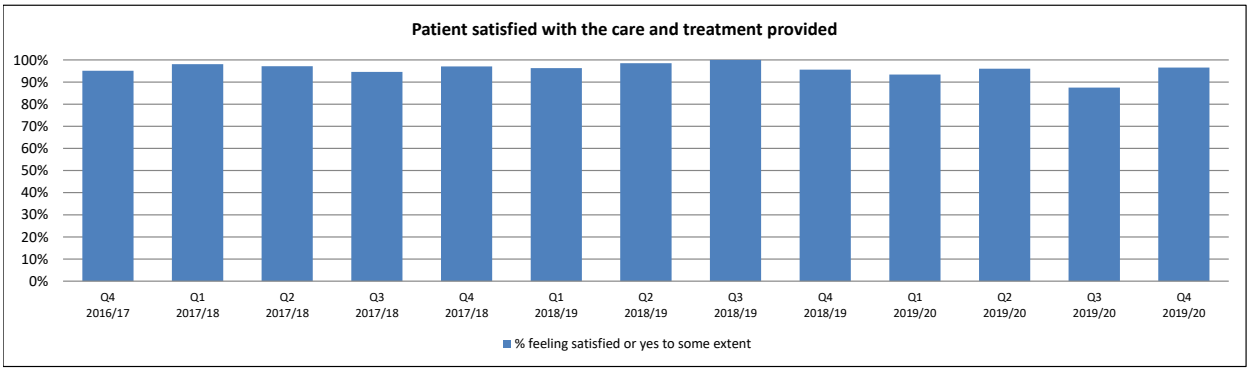
Information is provided for the end of month position for the last 10 months to August 2022. This shows that unmet care hours peaked in March 2022 and have fluctuated since then at a lower level.

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

Source: NHS Borders Please Note: data is not available at the current time for these measures as collection is paused.

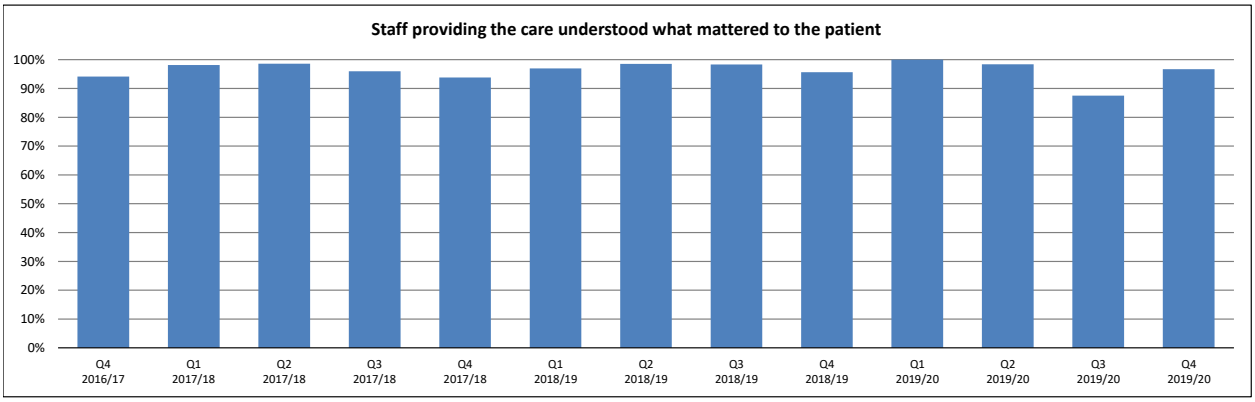
Q1 Was the patient satisfied with the care and treatment provided?

	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%



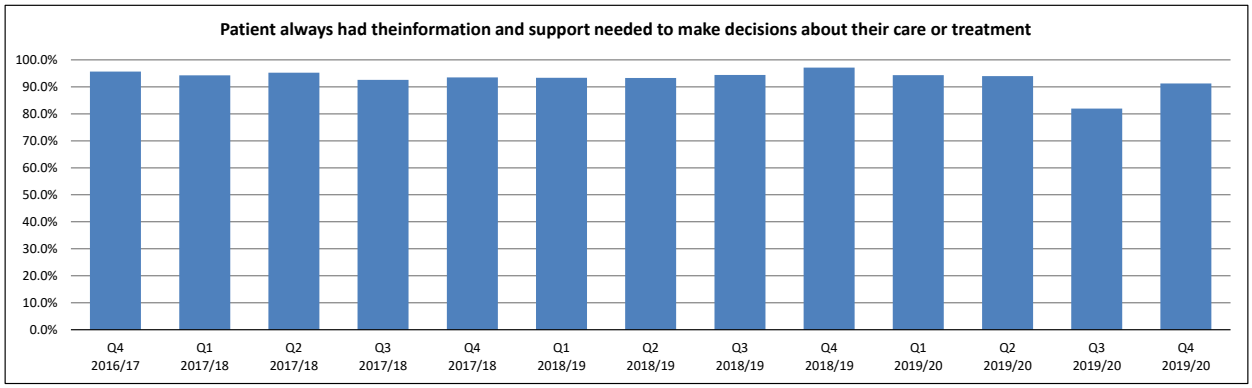
Q2 Did the staff providing the care understand what mattered to the patient?

	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.

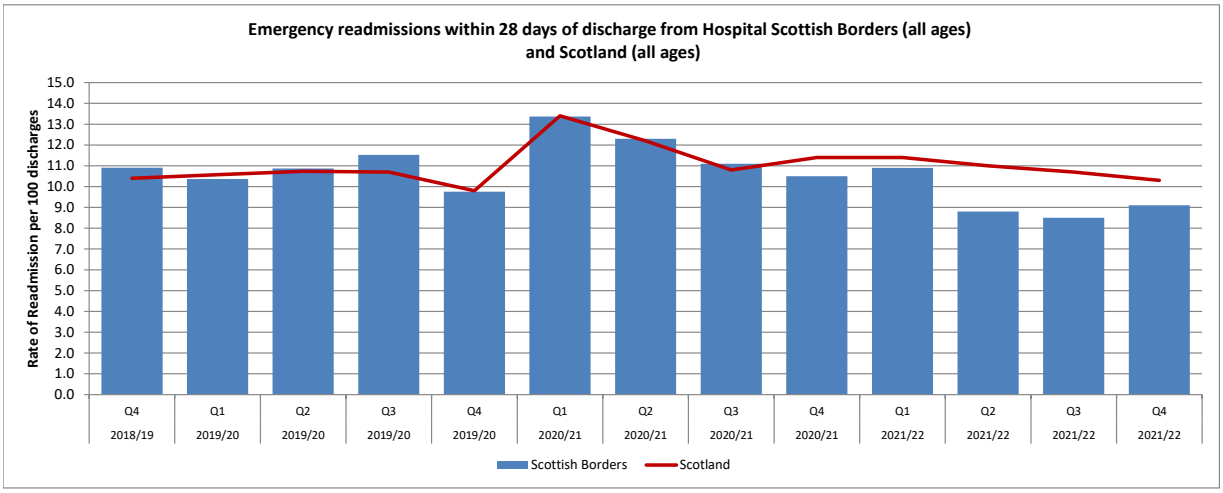
Overall, Borders scores well with an average 95.5% satisfaction rate. Patient satisfaction shows a positive trend over time and the latest overall average achieves the 95% target. *Please note the Patient Survey has been suspended from the start of the corona virus pandemic. This is due to the survey using volunteers for follow-up which is unable to happen as a result of restrictions.*

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: NSS Discovery data

	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21	Q1 2021/22	Q2 2021/22	Q3 2021/22	Q4 2021/22
Scottish Borders	10.9	10.4	10.9	11.5	9.8	13.4	12.3	11.1	10.5	10.9	8.8	8.5	9.1
Scotland	10.4	10.6	10.7	10.7	9.8	13.4	12.2	10.8	11.4	11.4	11.0	10.7	10.3



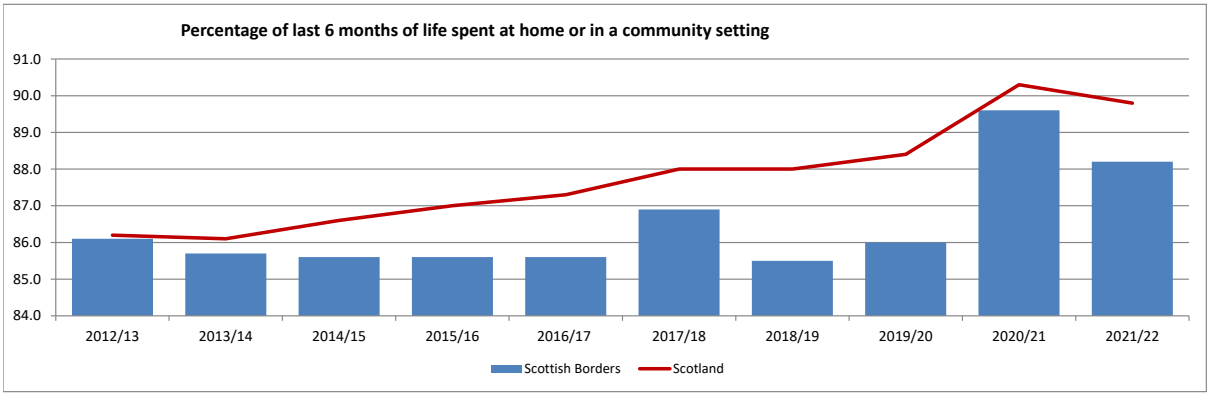
How are we performing?

The rate of emergency readmissions within 28 days of discharge shows an improving position over the last 3 quarters of 2021/22. The Borders rate which has been generally higher than the Scottish average has reduced to below the national position for the last 5 quarters to March 2022.

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

Source: Core Suite Indicator workbooks

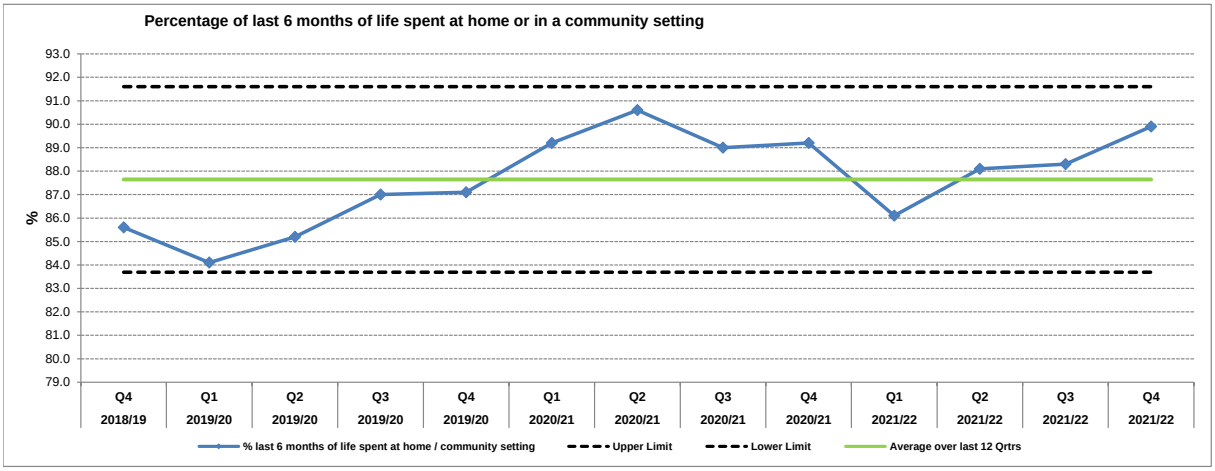
	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Scottish Borders	86.1	85.7	85.6	85.6	85.6	86.9	85.5	86.0	89.5	88.2
Scotland	86.2	86.1	86.6	87.0	87.3	88.0	88.0	88.3	90.2	89.8



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

Source: Core Suite Indicator workbooks

	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21	Q1 2021/22	Q2 2021/22	Q3 2021/22	Q4 2021/22
% last 6 months of life spent at home or in a community setting Scottish Borders	85.6	84.1	85.2	87.0	87.1	89.2	90.6	89.0	89.2	86.1	88.1	88.3	89.9



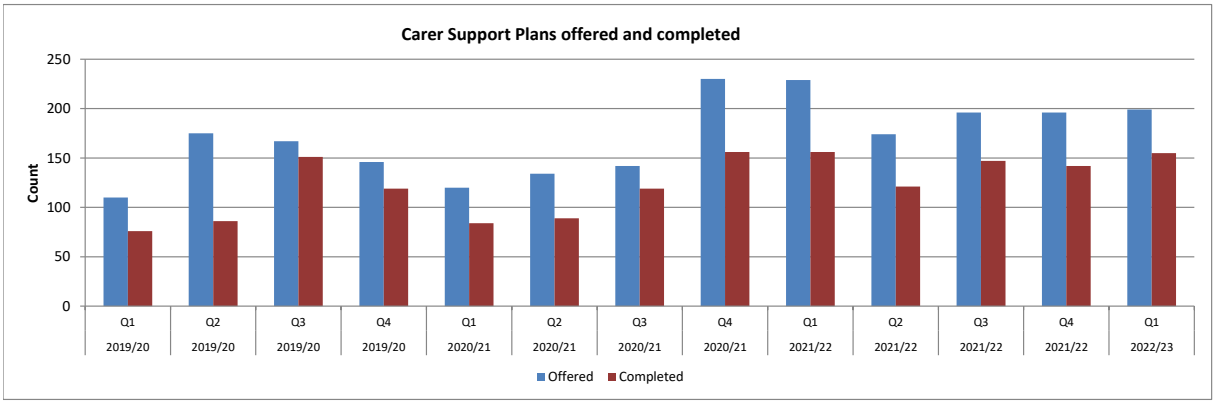
How are we performing?

The percentage of last 6 months of life spent at home or in a community setting remains below the Scottish average. Following a drop in 2018/19, 2019/20 saw performance improve for this measure. The first two quarters of 20/21 demonstrated continued improvement against this indicator. Q2 20/21 demonstrated the highest percentage (90.6%) in the last 3 years for people spending the last 6 months at home or in a Community setting. After this point there was a decrease in

Carers offered and completed Carer Support Plans

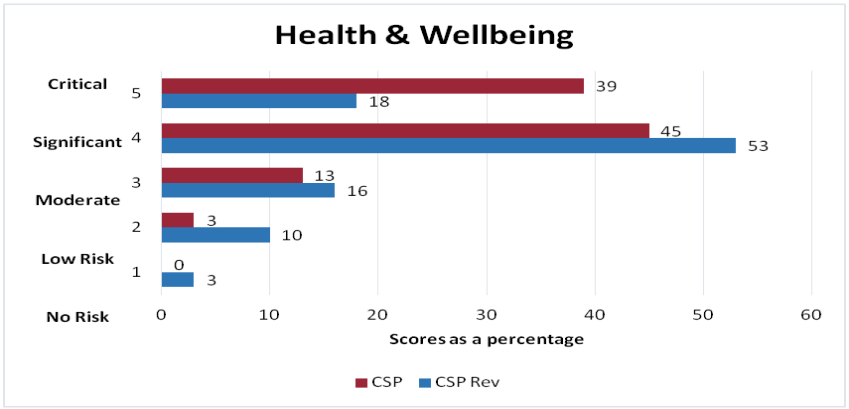
Source: Borders Carers Centre

	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21	Q1 2021/22	Q2 2021/22	Q3 2021/22	Q4 2021/22	Q1 2022/23
Carer Support Plans Offered	110	175	167	146	120	134	142	230	229	174	196	196	199
Carer Support Plans Completed	76	86	151	119	84	89	119	156	156	121	147	142	155



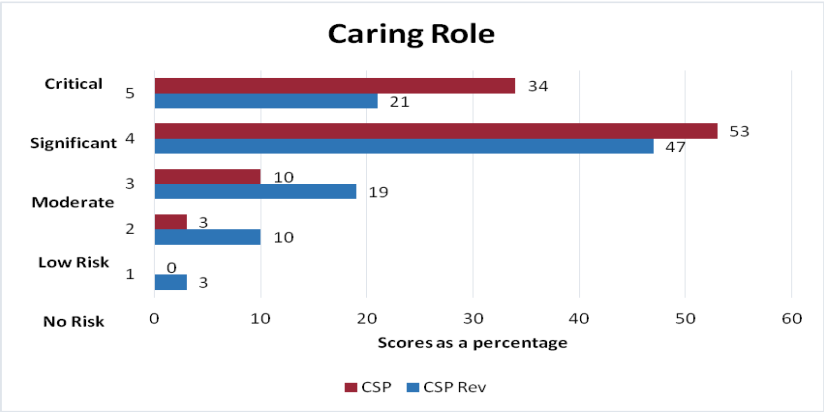
Health and Wellbeing (Q1 2022/23)

I think my quality of life just now is:



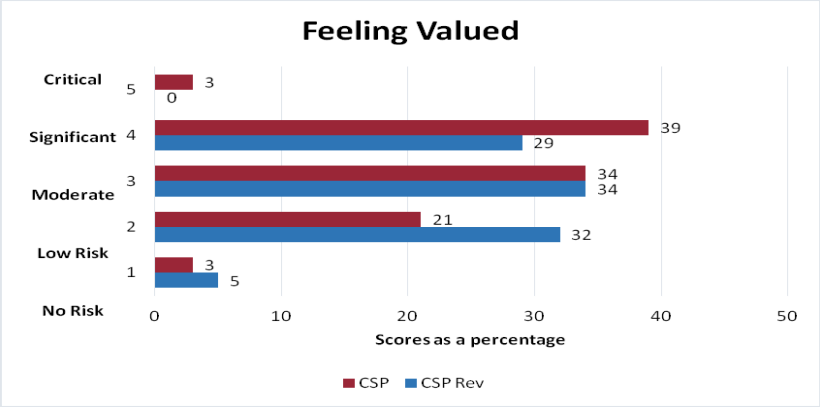
Managing the Caring role (Q2 2022/23)

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



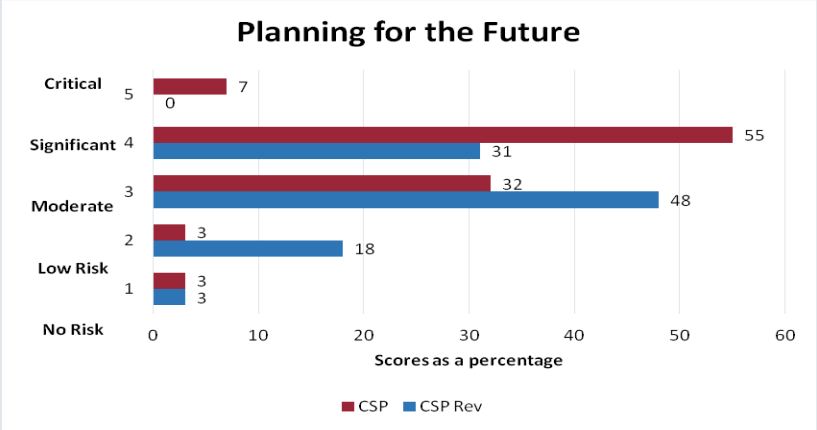
How are you valued by Services (Q2 2022/23)

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



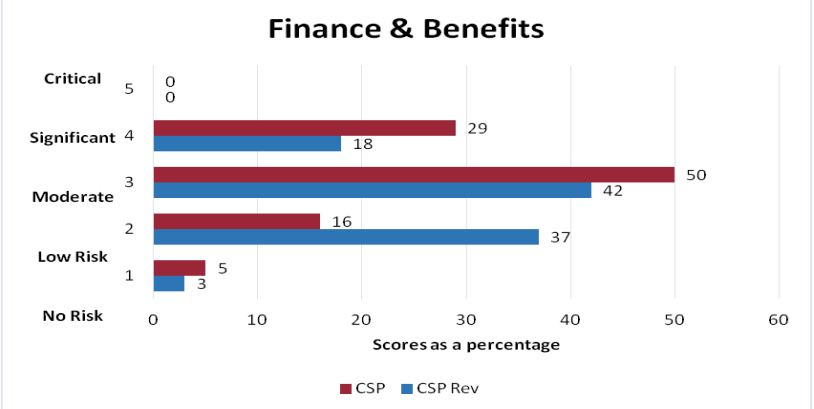
Planning for the Future (Q2 2022/23)

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



Finance & Benefits (Q2 2022/23)

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



How are we performing?
There has been a continued increase in the number of completed CSPs over the past 4 quarters. It can be implied from the movement between categories that we are managing to lift Carers out of the 'Critical Risk' category to 'Significant Risk' and from 'Significant Risk' to 'Moderate Risk' category.

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Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 21 September 2022

Report by:	Iris Bishop, Board Secretary
Contact:	Iris Bishop, Board Secretary
Telephone:	01896 825525
STRATEGIC PLANNING GROUP MINUTES	
Purpose of Report:	To provide the Integration Joint Board with the minutes of the recent Strategic Planning Group meeting, as an update on key actions and issues arising from the meeting held on 4 May 2022.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Note** the minutes.
Personnel:	As detailed within the minutes.
Carers:	As detailed within the minutes.
Equalities:	As detailed within the minutes.
Financial:	As detailed within the minutes.
Legal:	As detailed within the minutes.
Risk Implications:	As detailed within the minutes.

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Minutes of a meeting of the **Scottish Borders Health & Social Care Strategic Planning Group** held on **Wednesday 4 May 2022** at **10am** via Microsoft Teams

Present:
Lucy O'Leary, Non-Executive NHS Borders (Chair)
Chris Myers, Chief Officer
Stuart Easingwood, Chief Social Work Officer
Lynn Gallacher, Borders Carers Centre
Caroline Green, Public Member
Wendy Henderson, Independent Sector Lead
Susan Holmes, Principal Internal Audit Officer
Linda Jackson, Borders Carers Centre
John McLaren, Joint Staff Forum
Colin McGrath, Community Councillor
Amanda Miller, Eildon Housing Association
Clare Oliver, Head of Communications and Engagement, NHS
Morag Walker, Executive Officer, The Bridge

In Attendance:
Laura Prebble, Minute Taker
Keith Allan, Public Health
Elke Fabry, Project Manager
Hayley Jacks, Planning & Performance Officer
Adrian McKenzie, Lead Pharmacist

1. APOLOGIES AND ANNOUNCEMENTS

Apologies received from Gerry Begg, Graeme McMurdo and Nicola Glendinning. The Chair confirmed the meeting was quorate.

2. MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 2 February 2022 were approved.

3. MATTERS ARISING

Action Tracker: Item 7 – on-going. Item 8 – Complete.
Easy Read Versions of Documents - CO picked this up with Iris Bishop. The responsibility sits with the partnership/IJB. Any public document needs to be in different formats. CO assured the group the IJB documents will be in different formats, when required.

Colin McGrath asked what the timescale would be on the Workforce Strategy. Chris Myers noted that SBC and NHSB are working together on the Workforce Strategy which will be complete by

the end of July 2022. Amanda Miller asked that providers if care services are also involved due to the continued challenge to attract in the next generation of workforce. Colin McGrath asked what services are going to be merged and John McLaren indicated that mergers were not being considered. Wendy Henderson had a request from the workforce planning group to included social landlords, and John McLaren confirmed that Andrew Carter is looking into this. A joint workforce plan is being developed and discussions have commenced and a report will be brought to this meeting for discussion. Chris Myers noted that the direction from the SPG was comprehensive and made it clear that all stakeholders were to be included. The workforce group was commissioned by the SPG and so reporting would come back to this group. Colin McGrath added to bear in mind that staff will be concerned about their jobs and so should be informed from the start of the process.

Action: All members to consider if there are any gaps in representation and advise John McLaren to ensure all bodies are included. An updated Joint Workforce Plan to be brought to the next meeting.

Carers Workstream – Lynn Gallacher gave an update. The group is working on a questionnaire for unpaid carers to gather evidence to formulate the development plan going forward. The questionnaire will be part of the IJB Joint Needs Assessment. The group is looking at how to engage in a united way. Clare Oliver noted that there needs to be a timescale for the work and will take that back to the group at the next meeting. John McLaren noted that carers need to have been involved in the process as this is central to the process and the IJB will be seeking assurances and evidence that carers have been involved. Chris Myers confirmed the work had been co-designed and supported with unpaid carers and the Borders Carers Centre, and that Lynn had been part of this. Chris added that any new plan has to come to the SPG for scrutiny.

Members were asked to look at the ToR so that everyone is aware of their responsibilities on the Strategic Planning Group. Iris Bishop, IJB Board Secretary, is updating IJB templates to ensure processes are followed. Lynn noted the group has improved but she felt that not all papers go to this workstream for discussion so carers can be fully sighted. Chris assured Lynn that this may have been the way in the past, but that prospectively for all pieces of work, all papers that effect carers will go to the Carers Workstream for discussion. The Strategic Planning Group can turn back pieces of work which do not satisfy it from an engagement, or other perspectives.

Chris Myers gave his assurance that at an operational level there is a change in direction to a more integrated and co-productive approach. Terms of Reference have now been accepted for the H & SC Senior Management Team (SMT). There has been a lot of positive change and this will continue.

John McLaren noted that service users need be at the centre and we have to ensure they are engaged on all projects before they are brought to SPG for approval and then commissioned. Chris Myers confirmed that there is a renewed focus on engagement through the IJB, as we need to put people at the centre of everything we do.
The **STRATEGIC PLANNING GROUP** noted the Action Tracker as updated.

4. COVID VIRTUAL WARD – Catherine Kelly
Paper were circulated for information as apologies were received.

5. EQUALITY & HUMAN RIGHTS - PRESENTATION – Wendy Henderson

Wendy Henderson shared a presentation with the group. This is a key area underpinned by the legal system nationally. There is work to improve commissioning in terms of human rights. The Feeley Report is based on human rights. A process is needed to evidence compliance. Wendy asked for support from the SPG to take this forward.

Wendy noted that there are 9 protected characteristics in law which should be assessed against for new plans / proposed changes. It is important to consider what is relevant from a human rights perspective. Public Sector Equalities Duties have been an obligation since 2015 in Scotland. Wendy noted that she had been asked by Chris Myers to review and assess IJB policies and practices. Wendy advised that the 'lived experience' must be taken into consideration when consulting. As part of the Fairer Scotland Duty 2018, it was essential to consider human rights at the beginning and throughout partnership processes through an integrated impact assessment (IIA). Papers need to be supported by IIA, if considered they are needed at the start of a project. The last slide asked we move forward to meet the requirements.

Action: Wendy Henderson to circulate a copy of the presentation to group members.

John McLaren thanked Wendy Henderson for her clear presentation. It is a refresher of everyone's responsibility. He added that human rights need to be revisited across all our organisations. John confirmed that this work needs to be done at the start and not at the end of a piece of work and he is keen to get that message to all. Linda Jackson thanked Wendy for this refresher and suggested embedding the quality impact assessment in the procurement process. Linda asked how to ensure all staff fully understand the process to ensure it happens at the start as this is not the case at present. Wendy noted that she is developing a toolkit for staff to support the process and compliance with both duties, and will provide advice. Chris Myers thanked Wendy for this thought provoking presentation and asked what the IJB can do to help. How to translate the legal obligation into practice. When the IJB commission services human rights are considered at each step. The IJB need assurance that it is happening at all levels. Senior staff may be aware of the policy but this must be shared with all staff as it is everyone's responsibility, not just the IJB and Heads of Service. Senior officers also need to ensure that their staff are accountable. Wendy Henderson has worked successfully with another Health and Social Care Partnership on this. She is also considering developing a network of experts to go to when consulting and engaging.

Action: Wendy Henderson to draft a paper from the SPG on how human rights can be built into processes in the Borders.

The **STRATEGIC PLANNING GROUP** noted the presentation.

6. FUTURE STRATEGY GROUP – Elke Fabry

Elke Fabry shared the highlight report on screen. The group has met twice and an engagement piece of work has begun. A needs assessment is being carried out. The project has support from the Public Health Scotland Local Intelligence Support Team (LIST) has begun the data

collation for the needs assessment. The leads for 7 areas have been contacted to ensure questions are not duplicated. Extensive engagement with the public is also planned.

John McLaren asked what this group is for and who sits on the group. Elke Fabry offered to share the group membership and noted that the needs assessment will inform the IJB strategic plan. Lynn Gallacher noted that the Borders Carers Centre is happy to be involved in the engagement and asked who LIST is. Chris Myers confirmed it is a national organisation, part of PHS funded by the Scottish Government to support Integration Authorities. They work with local teams to capture data for analysis. Wendy Henderson offered her support with the integrated impact assessment to evidence due regard.

The Chair thanked Elke Fabry for her presentation.

The **STRATEGIC PLANNING GROUP** noted the presentation.

7. IJB DELIVERY PLAN – Chris Myers

The actions from the IJB Strategic Commissioning Plan have been reviewed by the IJB Audit Committee, and each action has been given a RAG status. Amber and Red actions are being reviewed to consider if they are achievable this year to agree which actions to focus on this financial year. Chris Myers is seeking support from the SPG to endorse this approach and resource.

An impact assessment has been carried out for each workstream. It is the IJB's legal requirement to develop a strategic plan based on the national wellbeing outcomes and to review it every 3 years. The IJB Audit Committee has reviewed the plan and are working on the new plan for April 2023 onwards. The old plan is still to be reviewed. Of the 33 areas in the current plan, 45% are Green (complete), 39% are Amber (on-going or more evidence needed) and 16% are Red (not started/started but stopped/no evidence) status. Some areas may never be green as improvement will always be sought. Some areas only need more evidence gathered. Some red areas need additional resource. If not able to be completed this year due to the scale of work then they can be included in the new plan. Prioritisation needed for this financial year.

The Chair noted that this report has been brought to this group for scrutiny, and that it is important to recognise what can be achieved this year. Wendy Henderson queried the lack of increase in dementia referrals from GPs and noted that the current dementia services may not meet the needs of everyone. Amanda Miller noted it may be too ambitious to complete all actions and that it was important to look at the gaps and needs and consider what is realistic. Ideally the use of SMART objectives should be in the next plan.

John McLaren added the importance of early diagnosis of dementia. Early support reduces the impact. Despite the significant work undertaken, GPs are a key part and are to take more responsibility. Equalities have been flagged to help the IJB understand it has been given the proper thought. It is the IJB's responsibility to consider both the financial and the risk implications.

Chris Myers noted that the report will go to the IJB after this meeting, and that the National Health and Wellbeing Outcomes would help to frame this.

The **STRATEGIC PLANNING GROUP** supported this approach to reviewing the IJB Delivery Plan.

8. ANY OTHER BUSINESS

- 3rd Sector Forum – Update. Morag Walker noted that the event was well attended and successful. There was a follow-on meeting to agree the main 3 priorities and actions. The role of the IJB is clearer and a stronger representation on the IJB is being reviewed. Chris Myers also noted it was a good session and an additional 3rd sector representative on the IJB was supported. It was a good opportunity for networking with operational HSCP groups and the 3rd sector partners. An action plan is being drafted which will come to the SPG with recommendations. Linda Jackson asked if all 3rd sector partners were included and Morag Walker noted that all commissioned services attended. Stronger engagement will be written into the new plan. Wendy Henderson added her support for the event and noted the diverse attendance. The need for a directory of local services was raised so people know what services are available in their area.

- Membership – Colin McGrath raised the issue of community council representation of the IJB. Chris Myers noted that the newly elected council members will be formally appointed to the IJB in June following the elections tomorrow re-establishing a new membership. The Alliance report suggested having a second representative from the 3rd sector on the IJB and it will be the IJB who make the decision.
  Action: Chris Myers to put together a paper for virtual comment by SPG members on their view and rational.
  Colin McGrath noted the Community Empowerment Act allows service users the right to participate and offered a community council representative to sit on this group. Locality working groups need to be included. Audit Scotland would pick up if service users were not included and the meetings not quorate. This group is 2 voting members short. The Chair recognised the points raised.

The Chair thanked everyone a noted that this is her last meeting. There will be a new vice chair for the IJB in June who will be the new Chair for this group.

9. DATE AND TIME OF NEXT MEETING

The Chair confirmed the next meeting of the Strategic Planning Group would be held on Wednesday 3 August 2022 at 10am to 12pm via Microsoft Teams.

Meeting Dates 2022: 3 August 2022, 2 November 2022.

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