Public Document Pack

Scottish Borders
Health and Social Care
PARTNERSHIP

A meeting of the **Health & Social Care Integration Joint Board** will be held on **Wednesday, 20th September, 2023** at **10.00 am** Scottish Borders Council and via Mi

AGENDA

Time	No		Lead	Paper
10:00	**1**	**ANNOUNCEMENTS AND 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** 19.07.2023	Chair	Attached
10:10	**4**	**MATTERS ARISING**	Chair	Verbal
10:15		FOR DECISION		
	5.1	Direction: Hospital at Home	Gm Primary and Community Services	Attached
	5.2	Communications and Engagement Framework	Head of Communications and Engagement	Attached
10:45		FOR NOTING		
	6.1	Financial Outlook Update	Chief Financial Officer	Presentation
	6.2	Unscheduled Care Surge Planning and Delayed Discharge Trajectory Update	Chief Officer	Attached

	6.3	Scottish Borders HSCP Learning Disability Service Coming Home Programme	GM Mental Health & Learning Disabilities	Attached
	6.4	Primary Care Improvement Plan Annual Programme Report	GM Primary and Community Services	Attached
	6.5	Alcohol and Drugs Partnership Annual Survey Return to Scottish Government 2022-23	Head of Health Improvement	
	6.6	Directions Tracker	Chief Financial Officer	Attached
	6.7	Strategic Planning Group Minutes 07.06.23 05.07.23	Board Secretary	
11:55	**7**	**ANY OTHER BUSINESS**	Chair	
12:00	**8**	**DATE AND TIME OF NEXT MEETING** Wednesday 15 November 2023 10am to 12pm Scottish Borders Council and via Microsoft Teams	Chair	Verbal

Minutes of a meeting of the **Scottish Borders Health & Social Care Integration Joint Board** held on **Wednesday 19 July 2023** at **10am** in the Council Chamber, Scottish Borders Council and via Microsoft Teams

Present:

(v) Cllr D Parker
(v) Cllr T Weatherston
(v) Cllr N Richards
(v) Cllr E Thornton-Nicol
(v) Mrs L O'Leary, Non Executive (Chair)
(v) Mrs K Hamilton, Non Executive
(v) Mr T Taylor, Non Executive
(v) Mrs F Sandford, Non Executive
(v) Mr J McLaren, Non Executive
Mr C Myers, Chief Officer
Mrs H Robertson, Chief Financial Officer
Mr N Istephan, Chief Executive Eildon Housing
Mrs S Horan, Director of Nursing, Midwifery & AHPs
Mrs J Smith, Borders Care Voice
Ms Gwyneth Lennox (for Stuart Easingwood)
Mr D Bell, Staff Side, SBC
Dr R Mollart, GP
Mrs Y Smith, Partnership, NHS Borders

In Attendance:

Mrs L Shillinglaw, Minute Taker
Mr D Robertson, Chief Executive, SBC
Mr R Roberts, Chief Executive, NHS Borders
Mrs J Stacey, Chief Internal Auditor
Mr P Grieve, Associate Director of Nursing P&CS, NHS Borders
Dr S Bhatti, Director of Public Health
Mrs L Jones, Director of Quality & Improvement, NHS Borders.
Ms W Henderson, Scottish Care
Ms S Bell, Communications, SBC
Ms C Oliver, Head of Communications & Engagement, NHS Borders
Ms J Holland, Director of Strategic Commissioning & Partnerships, SBC
Mrs C Wilson, General Manager Primary & Community Services
Ms C McElroy, Public Health Lead – for
Mrs E Dickson, Associate Nurse Director Acute
Mr Ian Ritchie, Aspiring Chair
Dr T Young, Medical Director, P&CS
Mr D Knox, BBC

1. APOLOGIES AND ANNOUNCEMENTS

1.1 Apologies had been received from Cllr R Tatler, Elected Member, Ms L Gallacher, Borders Carers Centre, Ms J Amaral, Dr L McCallum, Medical Director, Mr S Easingwood, Chief Social Work Officer, Mr A Bone, Director of Finance, NHS Borders,

Mrs J Smyth, Director of Planning & Performance, NHS Borders, Miss I Bishop, Board Secretary, NHS Borders, and Ms D Rutherford, Borders Carers Centre.

1.2 The Chair welcomed attendees and members of the public to the meeting including Mrs C Wilson, General Manager Primary & Community Services, Ms C McElroy, Public Health Lead and Mrs E Dickson, Associate Nurse Director Acute and Mr I Ritchie, Aspiring Chair (shadowing Karen Hamilton).

1.3 The Chair confirmed that the meeting was quorate.

2. DECLARATIONS OF INTEREST

2.1 The Chair sought any verbal declarations of interest pertaining to items on the agenda. Dr Rachel Mollart tendered a declaration of interest for the PCIP item (as Chair of LMC & Chief Negotiator of LNC). Dr Mollart advised that she would leave the discussion for that item.

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

3. MINUTES OF THE PREVIOUS MEETING

3.1 The minutes of the previous meeting of the Health & Social Care Integration Joint Board held on 17 May 2023 were approved.

4. MATTERS ARISING

4.1 There were no matters arising.

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

5. DIRECTION: PRIMARY CARE IMPROVEMENT PLAN BUNDLE PROPOSAL

5.1 Mrs Cathy Wilson provided an overview of the content of the proposal and highlighted: a in breach of contract and risk to the delivery of the bundle. Dr Tim Young gave an outline of the situation regarding the GP sustainability position and CTAC.

5.2 Mrs Wilson indicated that the presentation had been received at the Health Board meeting on 29 June 2023 where the proposal had been agreed in principle with certain caveats. She also intimated that a meeting regarding Polypharmacy would be taking place on 20 July 2023.

5.3 Mrs Wilson commented that further discussions would take place at the GP Executive following discussions with GPs regarding the TUPE of staff arrangements.

5.4 Mrs Wilson referred to the reserves from the IJB and noted any offset in savings would come from the Polypharmacy review. It was noted that it was a 3 year plan and an exit

strategy was required. It was noted that Mrs Hazel Robertson has also written to the Scottish Government on the issue.

5.5 In response to the caveats referred to above, Mrs Karen Hamilton stressed the need for the recommendations and caveats to be included within the paper to ensure the IJB were fully aware of the position within NHS Borders. In addition, Mrs Hamilton referred to point 5.12 of the paper and the need to ensure the date was added and also raised concern at the use of the word "lucky" at point 5.15.

5.6. In response to a query from Mrs Jenny Smith regarding any benefits and impacts for the third sector, Mrs Wilson confirmed that engagement was underway complete stages 2 and 3.

5.7 Mrs Sarah Horan commented on the purpose & scope "realistic medicine" and intimated she would like to include "values-based care". It was also noted that paediatrics had not been mentioned within the impact assessment.

5.8 Mrs Jen Holland referred to a social care proposal for pharmacotherapy and home care to reduce the amount of visits and reduce delayed discharges and highlighted the need to be coherent around priorities regarding efficiencies in health as well as health & social care.

5.9 Mrs Fiona Sandford referred to the "fragility of GP services" and noted NHS Borders had the highest vacancy rate for GPs than any other Health Board and commented that it was imperative to highlight that to the Scottish Government.

5.10 Mr Tris Taylor welcomed the approach outlined regarding the delivery of savings and the impact assessment section "improvement to health & equalities……" if there was increased capacity.

5.11 In response to a query from Mr John McLaren regarding GP payments, Mr Ralph Roberts intimated that the details of contractual parties were the responsibility of the Health Board and he was clear that it was not compensation and was paying for a contractual service around Polypharmacy. It was being funded through the funds available within the PCIP as they currently stood and the commitments of savings to fund on an ongoing basis until additional funding was received from the Scottish Government. In addition, and in response to a query regarding how other NHS Boards had delivered PCIP services, Mr Roberts intimated that they had been delivered in different ways by different Boards depending on their identified priorities.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** directed NHS Borders to implement the Bundle Proposal plan to deliver services outlined in PCIP 6 Scottish Government's direction.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** approved and endorsed the financial model supporting the PCIP Bundle Proposal, including temporary redirection of Polypharmacy efficiency savings to deliver against PCIP 6.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** agreed to escalate funding concerns and gaps for PCIP 6 delivery with the Scottish Government which include the financial risk of over and under delivery.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** agreed to review the situation at the next meeting and review the delivery in March 2024.

6. DIRECTION: SURGE PLANNING

6.1 Mr Chris Myers provided an overview of the content of the proposal and highlighted: the overspend on set aside services; the suggestion to accelerate the programme; the single assessment process; and role of the third sector.

6.2 Mrs Laura Jones highlighted the significant pressures currently within the whole system.

6.3 Mrs Jen Holland commented that “Discharge to Assess” was a fundamental whole system model.

6.4 Cllr Elaine Thornton-Nicol expressed concern regarding Single Assessment/Older People’s Pathways and the importance of communications signposting – right place, right care, right time.

6.5 Mrs Fiona Sandford highlighted the need to get the elective capacity back and the need to have the polypharmacy review undertaken before the anticipated winter surge which would assist with the overall health of the population.

6.6 Mr Ralph Roberts welcomed the paper and highlighted that it was a joint responsibility and noted there was a lot of work ongoing including improving flow and prevention. He further noted that the Scottish Borders had the worst levels of delays in Scotland and highlighted the need for collective working.

6.7 Mr David Robertson enquired what more could be done to prevent deconditioning in hospital resulting from the significant delayed discharges.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the position relating to acute hospital unscheduled care pressure outlined within the report.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the position relating to the Urgent and Unscheduled Care Programme Board.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** approved the issue of a direction to NHS Borders and the Scottish Borders Council to commence the Surge / Winter planning process, and to develop and implement the following policies: single assessment and home to assess; and to work towards strengthened engagement with the third sector, and communications which promote community supports.

7. MENTAL HEALTH IMPROVEMENT AND SUICIDE PREVENTION PLAN

7.1 Ms Clare McElroy provided an overview of the content of the IIA report and highlighted gasp with the engagement work.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** approved the IIA for Creating Hope in the Scottish Borders, prior to IJB

8. MSG SELF ASSESSMENT

8.1 Mrs Hazel Robertson provided an overview of the content of the MSG self assessment and intimated that she had re-issued the Action Plan.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** endorsed the enclosed self-assessment process.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD approved** the associated action plan for delivering on the proposed improvement actions, prior to submission to the Scottish Government.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD requested** an update to the IJB Audit Committee on progress against the delivery of the actions outlined in March 2024 from the Chief Officer.

9. ANNUAL PERFORMANCE REPORT 2022/23 AND DELIVERY PLAN 2023/24

9.1 Mr Chris Myers provided an overview of the content of the Annual Performance Report and Delivery Plan and indicated that the national level reporting cycle has changed, meaning local comparison would not take place until the national data was available in May 2024. Mr Myers indicated that he was currently working with Miss Iris Bishop in regard to the work plan and range of key themes for the coming year. He then referred to page 129 – development of a Delivery structure and indicated that the Joint Executive would have oversight in advance of the IJB, with escalation as and when required.

9.2 Mrs Fiona Sandford commented that the number of days spent in hospital when patients were ready for discharge was very concerning as it impacted patients health.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** proposed no changes to the draft APR.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** approved the APR for publication.

10. FINANCIAL REGULATIONS

10.1 Mrs Hazel Robertson provided an overview of the financial regulations and commented that they had been co-produced with colleagues in both NHS Borders and Scottish Borders Council.

10.2 Mrs Karen Hamilton acknowledged the large volume of work undertaken within the IJB and its partners.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted that the Regulations had been substantially reviewed by the IJB CFO and confirmed by SBC and NHSB. All outstanding matters had now been resolved.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted that the IJB Audit Committees approved those for implementation, replacing the current regulations.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** requested that the CFO implement those, making the required improvements in financial control, management and reporting, and communicating best practice to finance teams within the Partnership.

11. FINANCE REPORT

11.1 Mrs Hazel Robertson provided a presentation on the financial position.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the update.

12. QUARTERLY PERFORMANCE REPORT

12.1 Mr Chris Myers provided an overview of the content of the proposal.

12.2 Mrs Karen Hamilton referred to the new strategic planning objectives and asked if there was any core data available. In response Mr Myers referred to the unscheduled care element and intimated it would remain and was more around unpaid carers, social care and social work and primary care activity at a local level and the new national datasets would assist in understanding.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted and approve any changes made to performance reporting and the key challenges highlighted.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** directed actions to address the challenges and to mitigate risk.

13. DIRECTIONS TRACKER

13.1 Mrs Hazel Robertson referred to the Directions Tracker and intimated that the Audit Committee had indicated that some other factors would be relevant to consider such as materiality to the IJBs strategic direction and any legal issues or concerns. Consideration was also given as to whether to add any of the outstanding directions to the risk register.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the contents of the Directions Tracker.

14. AUDIT COMMITTEE MINUTES: 20.03.23

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

15. STRATEGIC PLANNING GROUP MINUTES: 03.05.23

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

16. ANY OTHER BUSINESS

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

17. DATE AND TIME OF NEXT MEETING

17.1 The Chair confirmed that the next meeting of the Scottish Borders Health & Social Care Integration Joint Board would be held on Wednesday 20 September 2023, from 10am to 12 noon through MS Teams and in person in the Council Chamber, Scottish Borders Council.

This page is intentionally left blank

Scottish Borders Health and Social Care Partnership
Integrated Joint Board

20 September 2023

Hospital at Home

Scottish Borders
Health and Social Care
PARTNERSHIP

Report by:
Cathy Wilson – General Manager for Primary Care and Community Services

1. PURPOSE AND SUMMARY

1.1. To seek approval to extend the current 6-month Test of Change (TOC) for the Hospital at Home (HaH) service in the Scottish Borders, so that a full Business Case can be presented at the February 2024 Integration Joint Board (IJB) meeting to decide the future continuation of the service. Existing funding from previous IJB Direction is available due to the secured Scottish Government (SG) bid fund in October 2022. An additional funding bid will be submitted to SG prior to September 2023, which may help support further development of the TOC during the extension period from 27 October 2023 to 29 March 2024.

1.2. This paper provides an update on the progress of the HaH current TOC, which has gained national recognition for its exemplary collaboration, methodology, governance, data collection and rapid implementation. The success of this project was showcased at a national conference in June 2023, leading to an invitation to mentor a neighbouring Health Board in establishing their own HaH service, and for Scottish Borders Health & Social Care Partnership (HSCP) to apply for further SG funding.

1.3. The TOC is closely governed by the HaH Programme Board whose members, such as senior management and key stakeholders across Scottish Borders Health and Social Partnership, are ultimately accountable for ensuring the TOC is delivered successfully. In tandem with the HaH Programme Board, a Reporting and Finance subgroup regularly meets to ensure accurate data is being collected as well as making sure financial controls are adhered to.

1.4. It is important to note the HaH programme has two active workstreams currently in a pilot/test of change phase - Hospital at Home and Virtual Respiratory Ward. Both workstreams focus on creating more virtual capacity with NHS Borders. The Virtual Respiratory Ward workstream commissioned their test of change in 2023 with the aim of establishing a Respiratory Hospital at Home/virtual ward service based primarily on remote patient monitoring. The virtual ward supports seven respiratory pathways, with each having pre-defined clinical physiological alarm parameters, based on an international evidence base. The virtual respiratory ward supports personalised care for patients with a range of Respiratory conditions who are stable, or improving, but require acute care and would usually require a hospital bed. This offers a safe alternative pathway to hospital admission and/or an early supported discharge pathway for patients who require ongoing monitoring.

2. RECOMMENDATIONS

2.1. **The Integration Joint Board is asked to:**

a) Note progress made between April 2023 until August 2023;
b) Extend the current TOC, scheduled to end 27 October 2023, to run until 31 March 2024; and
c) Note HaH team's intention to apply for further funding by September 2023.

3. ALIGNMENT TO STRATEGIC OBJECTIVES AND WAYS OF WORKING

3.1. It is expected that the proposal will impact on the Health and Social Care Strategic Framework Objectives and Ways of Working below:

Alignment to our strategic objectives					
Rising to the workforce challenge	Improving access	Focusing on early intervention and prevention	Supporting unpaid carers	Improving our effectiveness and thinking differently to meet need with less	Reducing poverty and inequalities
X	X	X	X	X	X

Alignment to our ways of working					
People at the heart of everything we do	Good agile teamwork and ways of working – Team Borders approach	Delivering quality, sustainable, seamless services	Dignity and respect	Care and compassion	Inclusive co-productive and fair with openness, honesty and responsibility
X	X	X	X	X	X

4. INTEGRATION JOINT BOARD DIRECTION

4.1. Direction has already been provided so it is not required at this stage.

5. BACKGROUND

5.1. In recent years, healthcare professionals 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 the NHS and internationally towards providing hospital-level care in a person's home environment.

5.2. Across Scotland, Health Boards have developed this service to provide care in this form. The care is recognised to be safe, cost effective and popular with patients and staff. It can provide an alternative to admission for selected patients, can relieve some pressure on acute services (once scaled up) and in some areas it has been shown to facilitate closure of inpatient beds. SG are supportive of this care model and NHS Borders have approached SG for funding to develop this method of care.

5.3. The HaH service has direct clinical oversight from two Community Geriatricians, with operational oversight being provided by Cathy Wilson, General Manager for Primary and Community Services. Wider leadership and governance are provided by Dr Tim Young, Primary Care and Community Services Associate Medical Director. It is however recognised by all project group members that developing a HaH service cannot be done in isolation. As such, key stakeholder engagement and cooperation is required across HSCP services.

6. TEST OF CHANGE UPDATE

Launch

6.1. Project scope and planning began in January 2023 with a target of admitting a first patient by early Spring. The commitment to rapid implementation has been pivotal to the successful launch. Through effective project management and clear and effective communication, the service was implemented within a relatively short timescale.

6.2. The HaH TOC was successfully launched in April 2023. A small project and clinical team were secured to develop and tailor nationally approved processes and procedures. They were also tasked to trial whether these could be applied as a functioning clinical model in the Borders.

6.3. It was recommended to commence the HaH TOC on a smaller scale initially, prioritising patient safety a primary concern. This approach allowed for careful monitoring and evaluation of the service's effectiveness before considering further expansion.

6.4. Until early August, the HaH service offered a five-day schedule, operating from Monday to Friday, between 8am and 6pm. This timing was chosen to align with the availability of healthcare professionals and resources, ensuring comprehensive coverage during weekdays. The decision to begin with this limited schedule was also to enable streamlined processes, assessment of outcomes, and prompt resolution of any challenges that may arise. This measured approach ensures that patient safety remains the top priority as the team continues to build a strong foundation.

6.5. Following recent staff appointments, the HaH service now offers a seven-day service which is ensuring the HaH team can look after more patients in a homely setting.

6.6. As insights are gained and data is collected, there is an intention to gradually expand the availability of the service based on patient demand, resource allocation, and clinical feasibility. A challenge encountered during the HaH TOC is limited workforce availability. Due to the nature of this innovative project, offering the necessary staff to support the service has proven to be difficult. As part of the TOC initiative, only secondments were possible to address this issue.

Challenges

6.7. While striving for a virtual capacity of up to 20 beds, it is vital to carefully consider the balance between capacity, acuity, and dependency. Factors such as patient complexity, required treatments, nurses needed per visit, travel distances, and other variables directly influence the number of patients that can be safely accommodated at any given time.

6.8. Understanding these complexities has proven challenging for external services. To address this, a Red-Amber-Green (RAG) status will be developed to reflect the variations in the service's capacity and its ability to accept to accept patients. This visual indicator will provide clear visibility of the current capacity and capability of the HaH service, considering the aforementioned factors.

6.9. Implementing the RAG status will enable better decision-making regarding patient admissions, manage whole-systems expectations, and prioritise patient safety throughout the TOC.

6.10. Continued monitoring of these factors will be essential to ensure a safe and effective HaH service. Striking a balance between meeting patient care demands and delivering it safely and efficiently, within available resources, remains a key focus for the team.

Service delivered

6.11. To date, the service has treated 60 patients (39 admissions from BGH, 21 admissions from community/outpatient settings). A service specification document is continually being updated to reflect the practices and processes of the HaH service in Borders.

6.12. The service initially targeted 'step down' patients from Borders General Hospital (BGH) but have commenced with targeting patients from community services such as Primary Care, Adult Social Care and Home First.

6.13. It is important to highlight that the HaH service is not a step-down service from acute hospital because it aims to provide acute-level care at home rather than in a hospital setting. The primary purpose of the HaH service is to deliver safe and effective hospital-level care to patients in the comfort of their own homes, bypassing the need for hospital admissions.

6.14. Unlike step-down services, which are typically used to transition patients from acute hospital care to a lower level of care (e.g. Home First), HaH actively prevents hospital admissions by providing comprehensive medical treatment, monitoring, and support in the patient's home. This can be particularly beneficial for patients with acute illnesses or exacerbations of chronic conditions who can be safely managed at home. This therefore reduces the length of stay by two days as discharge, following acute illness episode, is timely and not limited by starting or restarting community support.

6.15. The HaH TOC has received widespread recognition within the local healthcare community. The collaborative effort of a multidisciplinary team, consisting of health care professionals, administrators, and technology specialists, have been instrumental in the project's progress. The ability to effectively work together, problem solve, and harness diverse experience and expertise has set this project apart as a national exemplar.

6.16. The HaH service typically involves a multi-disciplinary team comprised of healthcare professionals who provide a range of services, including physician visits, in-home nursing care, medical management, and possible rehabilitation. HaH aims to reduce the risk of complications, improve patient outcomes, enhance patient satisfaction, and lower healthcare costs by reducing unnecessary hospital admissions and promoting a patient-centred care model.

Data Collection

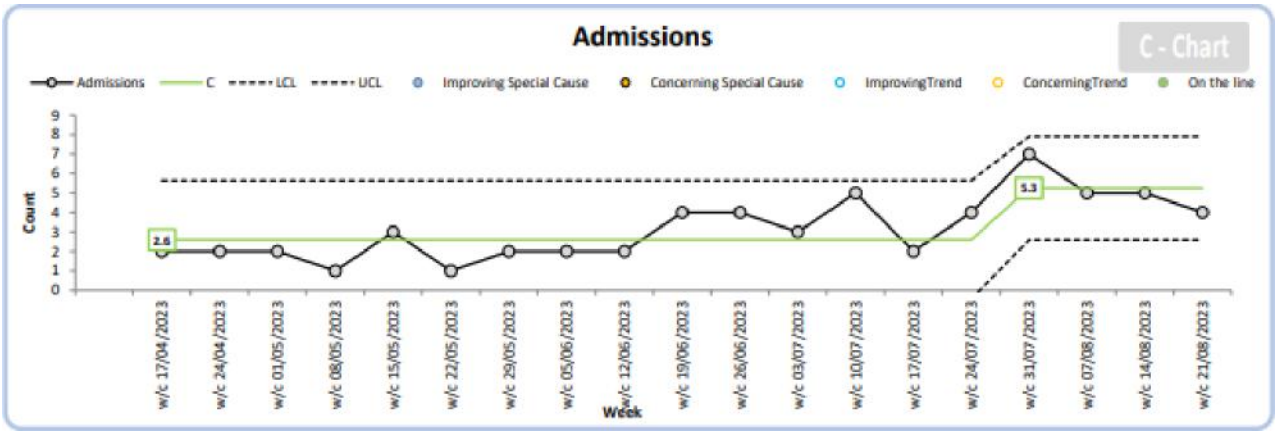
6.17. To meet the success criteria, it was agreed by Healthcare Improvement Scotland and the Borders Business Intelligence team, that NHS Borders should collect and report the following quantitative data:

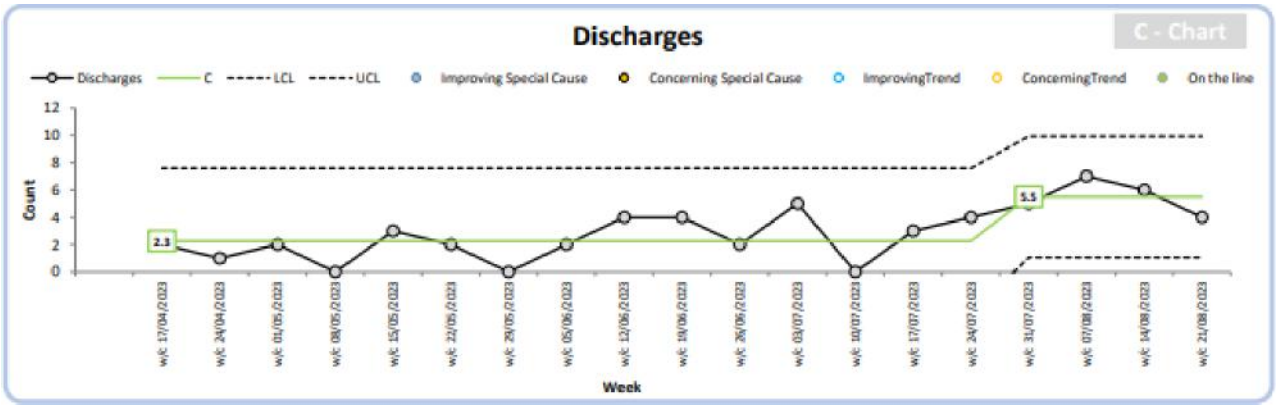
- Admissions
- Discharges
- Average Length of Stay
- Occupied bed days
- Total number of patients seen by the HaH team

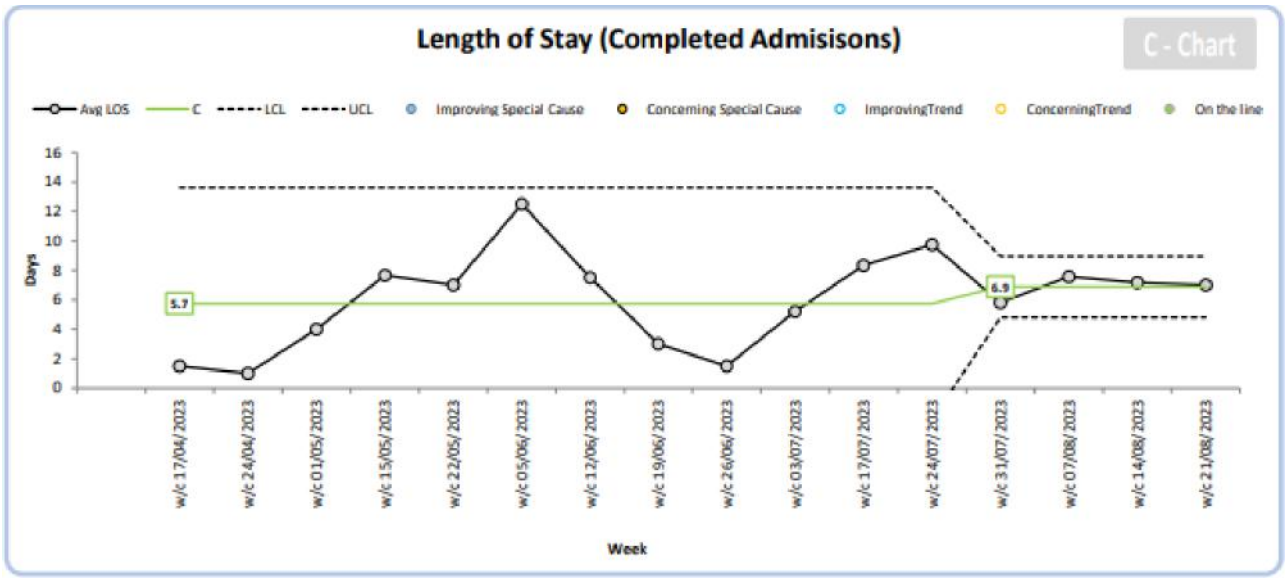
- Readmission rates

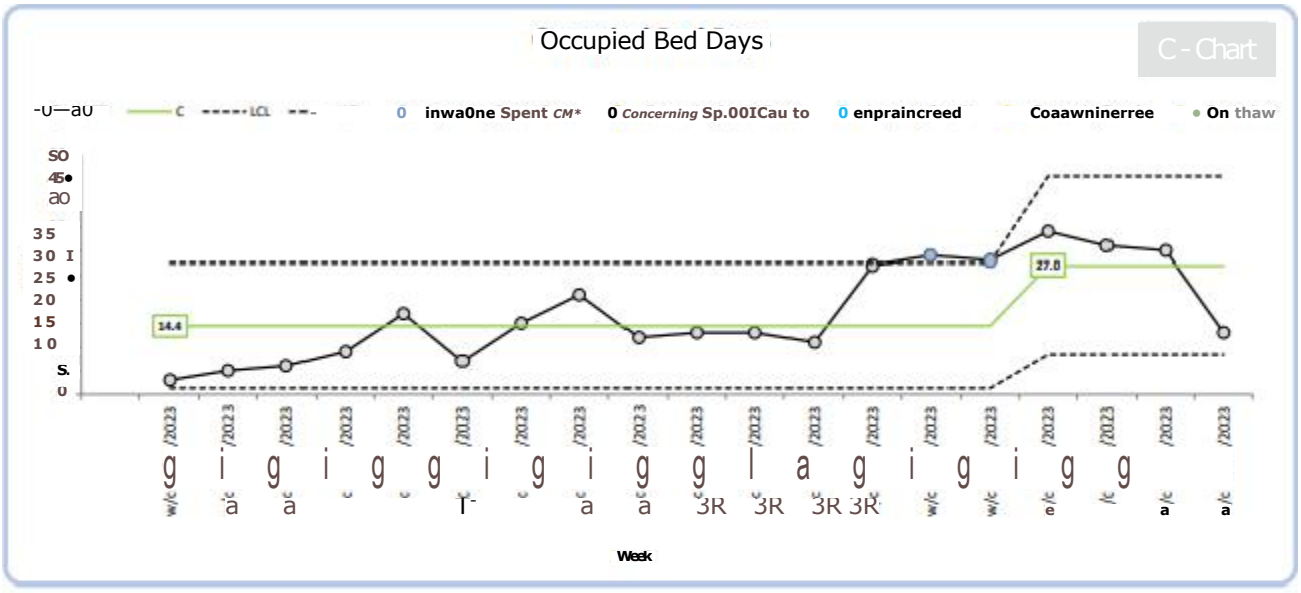
6.18. See below reported data from WC 17/04/2023 to WC 28/08/2023

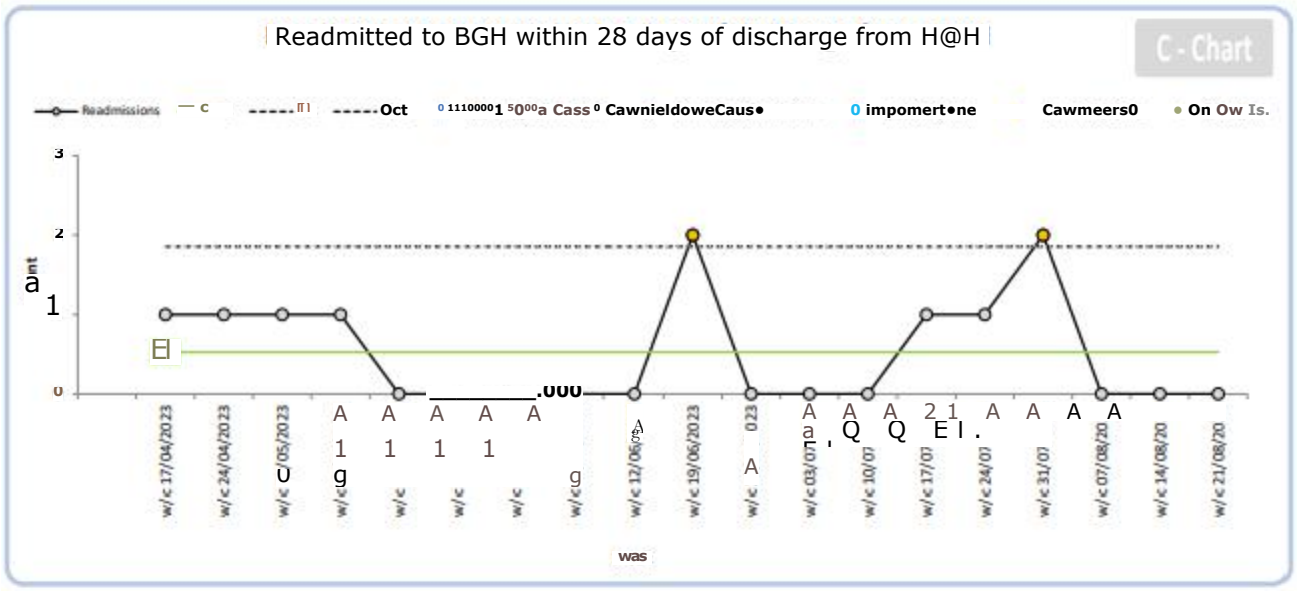
Total Admissions	60
Admissions from BGH	39
Admissions from Community/outpatient settings	21

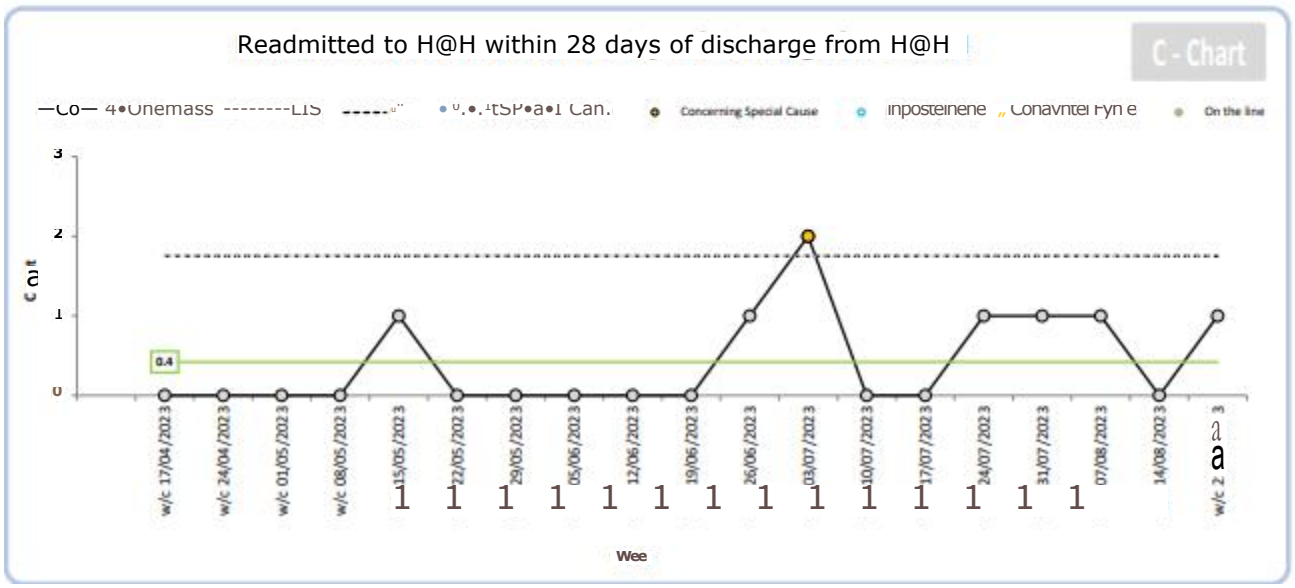







Occupied Bed Days
C - Chart
Week


Readmitted to BGH within 28 days of discharge from H@H
C - Chart
was


Readmitted to H@H within 28 days of discharge from H@H
C - Chart
Wee

Advice on other sources of information to collect was:

- **A summary of feedback from patients who have used the HaH service:**

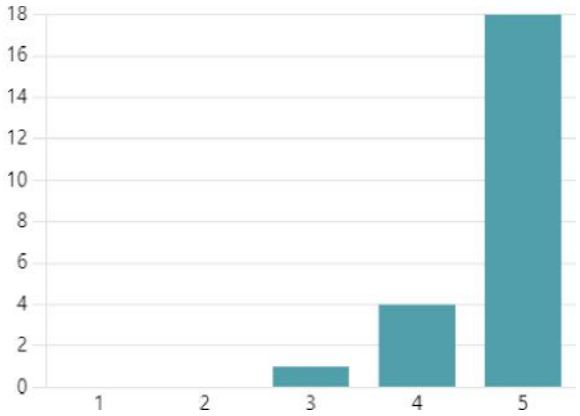
3. How much would you agree/disagree with the following statements?

More Details

4. How would you rate your care overall? (1: lowest score - 5: highest score)

More Details Insights

4.74
Average Rating



5. If you have any additional comments, please add these below:

14 Responses

ID T	Name	Responses
1	anonymous	This fantastic service meant mum could get back 'home' to Grange Hall much sooner. The hospital was very busy, noisy and made mum even more anxious which exacerbated her breathlessness. As soon as she got back to GH, she immediately relaxed. Hopefully this service will continue, as I am sure it will be much appreciated by many more families and free up much needed beds at the BGH.
2	anonymous	The nurses who came to see me were very efficient, supportive and empathetic. I could not rate them more highly.
3	anonymous	Excellent service. Most helpful and cheerful.
4	anonymous	Could have lasted longer
5	anonymous	Best service ever. Nurses and doctors were very friendly, and answered all questions honestly. Wonderful service, please keep it going. The nurses - Delia, Gail and Victoria, Dr Cantley and Dr Jenny Inglis, excellent devoted sincere people.
6	anonymous	Helped me greatly being treated at home. Thank you
7	anonymous	Once referred, the service and care was excellent. Very reassuring being able to contact the consultant and nurse on phone. Disappointed to be discharged the day after the first iron infusion but understand the short term nature of referral.
8	anonymous	Good service to keep going. Good at what treatment was needed.
9	anonymous	Service very professional and much appreciated, could not have asked for better. Home is much better than being in hospital. Long may this service continue.
10	anonymous	Tele Call First Always on Time Very Good Care
11	anonymous	5+. Outstanding care, would highly recommend this service
12	anonymous	After a decision to admit patient to BGH for further test and drove patient to ae at around 17:30 and was asked Hospital at home would pass on details to ae and they would have all info details when we arrived. This was not done ae wanted all the information from me as to why he was there. we had to wait until 9pm before he was eventually seen. ae did admit as one patient that they were aware of his admission but we would still have to wait.
13	anonymous	Written information on who is responsible for what and who to contact would be very helpful. MOT meetings would be beneficial. all staff were very friendly
14	anonymous	The nurses who attended myself were very professional and helpful. they made my hospital to home an easier transition. well done. excellent service.

- A summary of feedback from engagement sessions the HAH Team had with stakeholders is below:

Audience	Feedback	Outcome(s)
NHSB Formal Area Staffside	The idea of the HaH service was met with positivity and the only take away was to ensure the HaH service is in communication with, and involving, AHPs and the Out of Hours service.	To promote communication and involvement with AHP and OOH services, meetings with the AHP Professional Leads and the BGH Emergency Department have been organised.
NHSB Allied Health Professional Leads	The AHP Professional Leads were very welcoming of the HaH service, and only asked that similar services be considered to assist with reducing hospital admission.	AHP Lead, and member of the HaH Programme Board, is taking forward work to ensure synergies are in place with the Home First service and work done by the RAD team. AHP Lead is also considering when and where appropriate for AHPs to refer to the HaH service.
NHSB Central GP Cluster	Positive and offer of further feedback at meetings encouraged.	To keep attending future meetings to provide updates of how the service is progressing. Also, following this meeting GP Communications were drafted and approved, date for circulation TBC.
NHS Lothian (Midlothian)	Met with the Midlothian HaH team to be shown the service, the roles/responsibilities of the administrator, and the data/information that is collected.	Reassurance that NHS Borders are collecting appropriate/relevant data and information. Teams channel/network for NHS Lothian administrators being created which HaH team administrator will be invited to join.
NHSB Out of Hours Emergency Department	Met with Borders Urgent Care Service Leads, feedback was positive and future collaboration encouraged.	Meeting helped to promote positive engagement moving forward.
NHSB Scottish Ambulance Service	The SAS leads were very welcoming of the HaH service and offered their support throughout the Test of Change.	Offer of partnership working to create a referral pathway for SAS to HaH. Explained that once Test of Change is ready for this, the team will be in touch.
NHS Western Isles	Positive feedback received from NHS Western Isles Team, encouraged that a similar sized board is now on their own journey.	Sharing best practice i.e. datasets, job descriptions.
NHSB Heart Failure Spec Nurse	Provided learning on Heart Failure care and provided positive feedback on the HaH service.	Outcome was that Spec Nurse offered to provide more learning sessions if required.
NHS Highland	Positive feedback received and another HaH service in Scotland very much welcomed.	Sharing best practice i.e. datasets, job descriptions. Further meetings to be set up once ANP comes back from annual leave.
NHSB BGH – Ward 7 & Ward 9	HaH team provide overview of service and answered questions from colleagues.	HaH team have made themselves available to all staff in Ward 7 and 9 when they have questions. Referrals are now being made from there to HaH team.

NHS Dumfries & Galloway	Meeting was more about Borders HaH team educating D&G on how the services has been going as well as answering many questions D&G had.	Both agreed to share best practice when required and agreed to keep in touch to provide support and advice.
NHSB Acute Clinical Nurse Managers and Associate Nursing Director	HaH team provide overview of service and answered questions from colleagues. Positive feedback received and they will promote the services HaH can provide when looking to discharge patients.	HaH added to the acute safety brief which takes place 8.30am every day so team can provide capacity updates. HaH also added to the integrated huddle to provide capacity updates.
NHSB Junior Doctors	HaH team met with new intake of FY1's and FY2s to introduce service	Positive feedback provided and discussed referral pathways into the HAH Service
NHSB Medical Registrars	HaH team with new intake of junior doctors, to introduce service, specifically to those taking Med Reg calls from primary care	Positive feedback provided and discussed referral pathways into the HAH Service
NHSB Public Health	HaH met the team during a CPD session to discuss service and answer any questions	Meeting helped to promote positive engagement and discussions around Oral Health and Smoking Cessations pathways

Highlights

6.19. So far, the HaH service has successfully achieved the following:

- Incremental increase in treating patients since service started 17 April 2023
- HAH Team building on existing skills with funding secured to upskills 2 members to Advanced Nurse Practitioner level
- HAH Team provide capacity and service updates at the Acute Safety Brief
- HAH Team provide capacity and service updates to primary and community services
- Multiple successful engagements to gather public and professional opinion on how the HAH service is going
- Current HAH Team staffing capacity allowing the service to onboard approx. 8 patients
- HAH Team now able to pilot 7-day service
- Agreement in principle from the IJB Strategic Planning group to extend pilot to 12 months
- NHS Borders Hospital at Home Service Specification document developed
- Agreement on the HaH service workforce model
- Development of numerous referral pathways such as the Prescribing pathway, Oxygen Therapy pathway, and Primary Care referral Pathway,
- Treatment of patients with IVs
- Sourced all required equipment to provide a comprehensive HaH service
- Development and implementation of a discharge letter specific to the HaH service
- Co-ordinating care with the District Nursing team to reduce footfall in patient's homes
- Uptake of a student placement, with more students identified to participate
- Creation of sub-group tasked in identifying and assessing impacts of HaH service
- Working with business partners from both Acute and Primary & Community Services in monitoring data and financial scrutiny, supported by the IJB Chief Finance Officer.

- Collaborating with the Respiratory Virtual Ward service team to ensure best practice is aligned and that both services are providing the best care for patients being treated in the community.

7. NEXT STEPS

7.1. In terms of growth – the original Business Case had hypostasised the below model which aimed to cover a 7.5-hour day, seven-day week service, with a total virtual capacity of up to 20 beds.

	WTE
Specialist Consultant*	0.2
Consultant Geriatrician*	0.5
Nursing Band 6	3.26
Nursing Band 7/ANP	1.6
Nursing Band 8a	0.3
HCSW Band 3	3.26
Admin Band 4	1
IM&T Band 6	1

7.2. On review against Midlothian (practice population of 95,000 over a smaller geographical area), a similar sized Health Board model, the findings were:

Max. 22 patients on caseload
Seven-Day Service – 8am to 8pm

- Consultant physicians – shared cover between 2 consultants (Mon-Fri)
- Specialty doctors – 9 sessions per week
- GP Trainee 1 WTE
- Band 8 Lead pharmacist – (1 WTE shared with CH ward)
- Band 7 ANP – 1.6 WTE
- Band 7 Trainee ANP – 2.7 WTE
- Band 6 Nurse Practitioners – 4 WTE
- Band 5 Staff Nurse – 1 WTE
- Band 3 HCSW – 2.7 WTE
- Band 5 Admin – 1 WTE
- Band 2/3 Admin – 1 WTE

7.3. The Borders HaH service can currently manage 6-8[1] patients across seven days. The service requires further staffing to cover 20 open beds, working 7 days a week from 8am to 6pm. Specific staffing required would be:

	Shift pattern	WTE	Gap	Comment
Consultant		0.9	0.2	inclusive of SPA
Junior Doctor (FY2 or GP Trainee)		1	1	inclusive of SPA
Speciality Doctor		1	1	inclusive of SPA
Nursing Band 6	7 days a week 8am to 6pm	4	2	

[1] It is important to note that Hospital at Home is aiming to take patients with a higher dependency level than those people normally kept at home. Capacity is a combination of staff availability and skill plus patient dependency and acuity. Further work is being done to understand daily capacity. (see 6.8)

Nursing Band 7/ANP	7 days a week 8am to 6pm	3	1	
HCSW Band 3	5 days a week 9am to 3pm	2	2	inclusive of admin cover
Admin Band 4	5 days a week 8am to 4pm	1	0	

7.4. By recognising the workforce challenges in the NHS, there is a collaborative effort with Health Improvement Scotland[2] to explore alternative models for HaH service in the Borders – acknowledging our geographical and financial limitations. One potential option being considered is the incorporation of Advanced Nurse Practitioner (ANP) input, which would leverage their advanced clinical skills to enhance the service's capabilities.

7.5. The exploration also includes more innovative solutions, such as fostering a symbiotic relationship with District Nursing (DN) service. This approach would involve working closely with DNs to tap into their resources and expertise, ensuring a coordinated and comprehensive approach to patient care.

7.6. By considering these alternative models and embracing innovation as part of the TOC's expansion, the aim is to overcome the workforce challenges and strengthen the current HaH service. This approach acknowledges the importance of seeking novel strategies to optimise patient care and achieve sustainable healthcare delivery within the constraints of the workforce.

Scottish Government Funding

7.7. In June 2023, HaH team was invited to attend a National Hospital at Home conference in Edinburgh. The conference included workshops that focused on analysing existing data and exploring ways for current HaH teams to expand their capacity. This involved considering skills mix, reviewing functions and roles, and implementing capacity management processes.

7.8. During the conference, it was announced that a national funding of £3.6M would be made available to support Hospital at Home Services across Scotland. However, access to this fund was restricted to partly assist in establishing new services or expanding existing ones.

7.9. Despite being in the middle of a TOC, Health Improvement Scotland believed that the Borders HaH was sufficiently established to submit a bid for funding to support their expansion efforts. Up to this point, the team has been collaborating with Health Improvement Scotland in preparing a bid that aligns with the expansion criteria, with the aim to submit it by September. The bid will be reviewed by NHS Borders Executive Team prior to submission.

IJB Funding

7.10. The IJB had earmarked £319k funding for the service as part of November 2022 Direction, should the HaH business case be successful. Although it had not agreed to anything beyond project costs under the discretion of the IJB Chief Financial Officer, the project was able to conduct its test of change with SG funding. As this funding has been fully utilised, the ask is to now pull down on the £319k earmarked funds on a non-recurrent basis in order to continue the current pilot for an additional 6 months.

8. IMPACTS

Community Health and Wellbeing Outcomes

[2] In collaboration with Health Improving Scotland as part of funding bid work.

8.1. **Outcome 1 - People can look after and improve their own health and wellbeing and live in good health for longer.**

HaH provides an avenue for people to receive necessary medical care and support in the comfort and familiarity of their own homes. This environment encourages individuals to actively participate in their own care and make informed decisions about their health.

By shifting care from traditional hospital settings to home-based settings, HaH promotes self-management and personal responsibility for health. Patients are provided with tools and resources needed to effectively manage their conditions, including access to education and personalised care plans. This approach empowers individuals to understand and monitor their health status, make lifestyle modifications, and engage in preventative measures.

HaH has also shown to improve patient outcomes by reducing the risk of hospital-acquired infections and complications associated with hospital stays. Patients often experience better physical and mental wellbeing when surrounded by familiar surroundings, family support, and reduced disruptions to daily routines.

Additionally, HaH contributes to better long-term health outcomes by facilitating early intervention, ongoing monitoring and coordinated care allow HSCP health providers to identify changes in health status promptly and intervene/adjust as needed. This proactive approach can prevent the progression of diseases, reduce the need for hospital re-admissions and ultimately lead to improved overall health.

8.2. **Outcome 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.**

HaH prioritises the provision of care and support services that promote a person-centred approach, ensuring individuals can maintain their autonomy and quality of life.

HaH is designed to deliver comprehensive and coordinated care, allowing individuals to receive necessary medical treatment and support services in the comfort and familiarity of their own homes – eliminating the need for prolonged hospital stays and enable individuals to remain in their preferred environment.

For people with disabilities, long-term conditions, or frailty, HaH offers several benefits. Patients can maintain their independence by living in familiar surroundings, where they have established support networks and access to community resources. This helps to preserve their sense of identify and autonomy while receiving the necessary care and assistance tailored to their specific needs.

HaH promotes the development of personalised care plans that acknowledge the unique requirements and preferences of everyone. This ensures that the care provided aligns with their personal goals and fosters an environment that supports their wellbeing. HaH often involves multi-disciplinary teams that include healthcare professionals, AHPs, social workers, and community support workers who collaborate to address the diverse needs of individuals, including physical, emotional, and social aspects.

By enabling individuals to remain in their homes or community settings, HaH helps minimise the disruption and negative impact associated with institutional care. This can lead to improved mental wellbeing, reduced stress, and enhanced social connections, as individuals are able to maintain their social interactions and engagement within their communities.

8.3. **Outcome 3 - People who use health and social care services have positive experiences of those services, and have their dignity respected.**

HaH prioritises the delivery of person-centred care in a respectful manner. By providing care into a patient's home or community setting, HaH creates a more comfortable and familiar environment, which can contribute to a more positive overall experience. Patients are often more at ease in familiar surroundings, surrounded by their loved ones and with fewer disruptions to their daily routines.

HaH aims to provide coordinated and holistic care that considers individuals' unique needs, preferences, and values. A multi-disciplinary team approach ensures that the care provided is tailored to meet the physical, emotional, and social aspects of a patient's wellbeing.

By fostering a person-centred approach, HaH places a high emphasis on respecting a patient's dignity – involving them in the decision-making process, providing clear and timely communication about their care and actively involving them in the management of their health conditions. Patients are seen as partners in their care rather than passive recipients, promoting a sense of autonomy and maintaining their self-worth.

HaH staff are trained to have cultural competence, compassion, and sensitivity, ensuring that care is provided in a respectful and non-discriminatory manner. This helps foster trust and a positive relationship between the patient and their care providers.

8.4. **Outcome 4 - Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.**

HaH prioritises a holistic approach to care that goes beyond simply addressing medical conditions. It recognises the importance of addressing the broader social, emotional, and functional needs of individuals, in addition to their healthcare needs. By focussing on the overall wellbeing and quality of life, HaH aims to enhance the individual's overall experience and outcomes.

For patients, they receive care in the comfort and familiarity of their own homes or community settings. This promotes a sense of independence, control, and dignity, which can significantly contribute to improving their quality of life. Being able to stay in a familiar environment with support of loved ones can positively impact mental wellbeing, reduce stress, and enhance social connections.

Additionally, the HaH service involves personalised care plans that are tailored to meet the specific needs, preferences, and goals of the individuals. Using a multi-disciplinary team approach, HSCP professionals work collaboratively to develop comprehensive care plans that not only consider medical treatments, but also address social determinants of health, emotional support as needed. This comprehensive approach aims to improve the individual's overall quality of life by targeting factors that may affect their wellbeing beyond the physical aspect.

Moreover, HaH prioritises continuity of care and support. By ensuring seamless transitions between hospital and home setting or the continuation of existing package of care, patients receive consistent and coordinated care, reducing the disruptions in their daily lives, and maintaining a sense of stability. This can contribute to better management of chronic conditions, improved functional abilities, and enhanced overall quality of life.

By focussing on a patient's ability to live independently and actively engage in their communities, HaH promotes social inclusion and reduce reliance on long-term institutional care, leading to a more sustainable and person-centred health and social care system.

Peter's Story

Peter is a retired window cleaner who lives with his wife and their dog. He has had a lot of medical problems over the years, including heart failure, diabetes and a previous below knee amputation. He is usually able to manage at home with the help of his wife but has had multiple previous hospital admissions for his various problems.

The specialist Heart Failure nurse saw him at home for review and found Peter to be increasingly breathless and unwell. His leg was swollen, and his abdomen distended. She felt that he required an inpatient admission for intensive diuretic treatment, however he was very reluctant to agree to this – not least because he and his wife had a wedding anniversary coming up within the next few days.

The nurse contacted the Hospital at Home team, and we visited Peter the same afternoon. He was distressed and unwell. He told us that he felt he was drowning each night when he lay down in bed. We let his GP know that he had been admitted to our care and we commenced him on high dose diuretic treatment. Daily adjustments to his regime and regular blood monitoring were required over the next few days, but he made good progress and was able to be discharged back to the care of his GP and the heart failure nurse just over a fortnight after admission.

Peter and his wife found the service hugely reassuring and told us in our feedback that "the whole team should be given a medal". It meant a great deal to them that he had been at home for their anniversary, as they know how ill he is. On asking them whether I could share his story, his wife told me "Please do! You should be shouting it from the rooftops!"

Every new patient brings new learning for the team. In this case we also worked closely with the District Nurses so that we weren't duplicating visits, and we're currently still liaising with the GP and Pharmacy teams on how best to make changes to medication as we gear the patient up for discharge back to Primary Care. Best of all is that all the changes made to Peter's tablets were discussed at each stage with him, so we were confident that his new regime would continue after he was discharged.

8.5. **Outcome 5 - Health and social care services contribute to reducing health inequalities.**

A good example of how HaH reduces health inequalities is that because the HaH service 'takes' care to patients while in their homes, this removes the disadvantage some patients and carers may have when it comes to accessing acute care services, specifically Borders General Hospital. This is especially important to those patients who live in a geographic location that has no community hospital (e.g. Eildon) or other acute care services available.

8.6. **Outcome 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 wellbeing.**

A key area for consideration in the development of any HaH service is the recognition of unpaid carers as equal partners in the planning and delivery of care and support. It is important that members of the HaH team identify the needs of the carers also as this ultimately leads, not only to the benefit of carers, but also the people they are caring for. The HaH service provides

supporting materials, which importantly contains a contact phone number, for use by the patient and their carer.

Another benefit of having the HaH service in place allows unpaid carers to remain in their home alongside the patient rather than travelling to and from a hospital. This means the carer is far less likely to be at a financial disadvantage due to travel and helps the carer to maintain their own links in their community.

8.7. **Outcome 7 - People who use health and social care services are safe from harm.**

HaH services have shown to reduce a range of complications associated with hospital stays such as hospital-acquired infections and pressure sores as well as older people with frailty being at more risk of institutionalisation and delirium. Since the HaH service provides a more person-centred care experience for individuals in their own home, this helps the patient to avoid the need for hospital admission, therefore keeping the patient safe from the risks of unnecessary loss of independence and functionality, which can result in the requirement for care at home services or a long-term care home admission to hospital.

8.8. **Outcome 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.**

Involvement and engagement, led by the HaH team, has been key to the development of the service. By involving many other services such as Social Care, 3rd Sector, acute and community pharmacy, project management, business intelligence, and quality improvement, the HaH team have produced the following specific processes and procedures:

- Developing a Borders HaH Service Specification
- Improving the process of populating NHS Borders Immediate Discharge Letters specific to HaH
- Developing and testing several patient referral and discharge pathways
- Developing and circulating a HaH patient and carer information leaflet

The HaH team have welcomed the continued support from all the health and social care services that have been involved so far and are actively seeking further involvement to ensure a robust HaH service is available to Borders.

Gail Turner – Nurse Team Lead, Hospital at Home

"I feel I have been an active participant in all aspects of the development of HaH since I started in post. I am extremely passionate about the service and the values it represents. I feel supported by our HaH team, the wider HaH community and our health and social care colleagues, to continuously strive to develop a gold standard service, to provide the population of NHS Borders with the right care at the right time."

8.9. **Outcome 9 - Resources are used effectively and efficiently in the provision of health and social care services.**

Since the implementation of the TOC, the HaH team regularly monitors the use of resources to ensure these are being used effectively and efficiently throughout. This information is regularly recorded and will be used when evaluating the TOC, specifically looking at what impact the

resources had on the process of managing a patient at home rather than in BGH or other acute services.

8.10. In additional to the information above, it is expected that the proposal will impact on the National Health and Wellbeing Outcomes below:

N	Outcome description	How it will be measured	Increase / Decrease / No impact
1	People are able to look after and improve their own health and wellbeing and live in good health for longer.	Admissions with no onward referral to inpatient services.	Increase
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.	Admissions with no onward referral to inpatient services.	Increase
3	People who use health and social care services have positive experiences of those services, and have their dignity respected.	Through patient feedback surveys that Hospital at Home staff provide during visits.	Increase
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	Through patient feedback surveys that Hospital at Home staff provide during visits.	Increase
5	Health and social care services contribute to reducing health inequalities.	Information from Admissions to HaH service. Average length of stay – can help to reduce the amount of travel family/carers would do to hospital.	Increase
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 wellbeing.	This could be captured via a Social Care questionnaire.	Increase
7	People who use health and social care services are safe from harm.	Admissions with no onward referral to inpatient services.	Increase
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.	Through discussions at the weekly Hospital at Home Delivery Group meetings and their daily huddles.	Increase

9	Resources are used effectively and efficiently in the provision of health and social care services.	Through discussions at the weekly Hospital at Home Delivery Group meetings and their daily huddles.	Increase

Financial impacts

8.11. In order to extend the current model, the pilot will require further investment as the SG money has been utilised. Therefore, it is recommended that the IJB release the MDT allocation component that has been earmarked for HaH on a non-recurring basis.

Equality, Human Rights and Fairer Scotland Duty

8.12. Stage 1, Stage 2 and Stage 3 of Equality, Human Rights and Fairer Scotland are attached as separate documents.

Legislative considerations

8.13. Currently there are no relevant legislative considerations that impact the work on Hospital at Home.

Climate Change and Sustainability

8.14. HaH models can contribute to supporting climate change mitigation and adaption by reducing the carbon footprint associated with traditional hospital care. HaH could require less energy-intensive infrastructure compared to traditional hospitals. This includes lower energy requirements for heating, lighting, and other operational needs, resulting in reduced carbon emissions associated with energy consumption.

8.15. HaH models aim to provide care in a patient's own residence, reducing the need for resource-intensive hospital equipment/utilities. This includes the efficient use of electricity, medical supplies, and other resources such as laundry facilities.

8.16. HaH can help minimise indoor air pollution by providing care in a patient's home, where air quality can be more easily controlled and maintained compared to traditional hospital where expensively run ventilation and filtration systems.

Risk and Mitigations

8.17. **There is a risk that operational scalability may be limited due to local workforce challenges leading to partial outcome realisation and inconclusive model options.**
HaH programme is flexible and adaptable to changing circumstances. With access to the Health Improvement Scotland's Hospital at Home Portal and respective national mentors, as workforce challenges arise, the programme has been open to revising existing strategies and adjusting plans accordingly. The programme continuously evaluates the scalability of the service under a Scottish Borders context and will adjust staffing levels or allocation as needed to minimise any negative impacts to the integrity of the TOC.

9. CONSULTATION

Communities consulted

9.1. As early adopters of the Health and Social Care Partnership's Equality, Human Rights and Fairer Scotland Duty Impact Assessment process, HaH proactively identified several groups through our dedicated Impact Assessment Working Group, paying specific attention to any gaps there may be.

9.2. The group is chaired by the P&CS General Manager and members include patient representatives and NHS Borders Public Involvement Officer. They meet regularly to review any emerging service development and they can directly influence meaningful changes to safeguard or enhance people's access and interactions with the service. The group has used the HSCP Impact Assessment template to guide considerations and will actively pursue the views of those that may be impacted by the service.

9.3. There are 3 stages to the Impact Assessment with Stage 1 'Proportionality and Relevance' having been completed. Results from Stage 2 'Empowering People – Capturing their Views' are displayed in the table under section 9.4, with further consultation with identified groups planned. The last stage, Stage 3 'Analysis of Findings and Recommendations' will be discussed at the next Impact Assessment meeting in August 2023 and then all required actions will be taken forward. It is important to note that Stage 2 and Stage 3 of the Impact Assessment are ongoing stages, therefore these will not be completed until the end of the TOC. The Stage 1 and Stage 2 documents will be attached as separate documents.

9.4. Services / Teams that have been to date been contacted/ consulted:

Audience	Feedback	Outcome(s)
HaH Programme Board	Patient representatives suggested change to patient leaflet.	Suggested changes made to leaflet and updated leaflet being provided to patients treated by the HaH service.
Physical Disability Strategy Group	The Physical disability Strategy Group asked for feedback on the following 3 questions: 1. What if I need additional equipment? 2. What if a patient has complex needs? 3. What happens if I need a hoist?	All 3 questions, with answers, were added to the Information Pack's Q&A section and circulated to the group for information.
Strategic Ukrainian Settler Group	How will HaH overcome language barriers?	The HaH will follow the same procedure as in hospital – using Language Line to assist with language issues with refugees Apps such as "Say Hi" and Google Translate are tools that can also help if language barriers are unexpected.
Drug and Alcohol Partnership	Only feedback received was of a positive nature and that the HaH service is seen as an excellent addition.	Positive feedback recorded.

Poverty	Question raised re how district nurses respond to patients living in abject poverty and if the HaH service will refer patients to community larders/ foodbanks.	HaH service explained if these scenarios arise, building and continuing relationships with the patient to provide support is very important. Conversations will also take place with the GP, Adult Protection Services and Social Work if required.
Ethnic Minority Group	Only feedback received was of a positive nature and that the HaH service is seen as an excellent addition.	Positive feedback recorded.
LGBTQ+/ Gender Reassignment	Ongoing	Request sent to meet to discuss the HaH service.
Child Carers	Ongoing	Request sent to meet to discuss the HaH service.

Integration Joint Board Officers consulted

9.5. The IJB Chief Officer is a core member of the Reporting and Finance subgroup and the IJB Chief Officer is involved via the Urgent and Unscheduled Care Programme Board. Both Officers have provided feedback and contributed to the development of the project.

9.6. The IJB Equalities, Human Rights and Diversity Lead will be involved, by reviewing and by providing feedback at the Integrated Joint Board meeting taking place 20 September 2023.

9.7. In addition, consultation has occurred with our statutory operational partners at the:

- HSCP Joint Executive
- SPG Meeting – 02 August 2023
- Hospital at Home Programme Board

Approved by:

Cathy Wilson – General Manager for Primary and Community Services

Author(s)

Cathy Wilson – General Manager, Primary and Community Services
Debbie Raftery – Project Manager, Urgent and Unscheduled Care Programme, Hospital at Home

Background Papers: Stage 1, Stage 2 and Stage 3 of the Equality, Human Rights and Fairer Scotland documents will be attached as separate documents.

Previous Minute Reference: none

For more information on this report, contact us at Cathy Wilson, cathy.wilson@borders.scot.nhs.uk

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-200923-1
Direction title	Hospital at Home Pathfinder
Direction to	NHS Borders
IJB Approval date	TBC – to be considered at Health and Social Care Integration Joint Board on 20 September 2023
Does this Direction supersede, revise or revoke a previous Direction?	Yes (Reference number: SBIJB-210922-01) Supersedes X Revises Revokes
Services/functions covered by this Direction	General Medicine, Medicine of the Elderly Services, Respiratory Medicine, Community Health services
Full text of the Direction	NHS Borders is asked to undertake a 6 month test of change for the Hospital at Home service as a transformation programme, so that a full Business Case can be presented to the February 2024 Integration Joint Board meeting to decide on whether the service is sustainable using existing resource, and should be continued. As part of this test of change, the Health and Social Care Integration Joint Board would be supportive of a separate bid being made to the Scottish Government / Healthcare Improvement Scotland for further funding, should this be endorsed by the NHS Borders Board Executive Team.
Timeframes	To start by: With immediate effect To conclude by: 31 March 2024, with a paper to be considered by the IJB in February 2024.
Links to relevant SBIJB report(s)	20 September 2023 Integration Joint Board: https://scottishborders.moderngov.co.uk/ieListDocuments.aspx?CId=218&MId=6537&Ver=4 Item 4a 21 September 2022 Integration Joint Board: https://scottishborders.moderngov.co.uk/ieListDocuments.aspx?CId=218&MId=6386&Ver=4
Budget / finances allocated to carry out the detail	The Integration Joint Board has agreed to allocate £319k of the MDT funding allocation on a non-recurrent basis to the end of 2023/24 to enable the test of change. It is expected that a financially sustainable business case will be presented to the Integration Joint Board to determine the ongoing funding of this service past the timeframes outlined in this Direction.
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 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 in the February 2024 Integration Joint Board, there is not an expectation that this Direction is reviewed at the IJB Audit Committee.

Scottish Borders Health and Social Care Partnership

Equality, Human Rights and Fairer Scotland Duty Impact Assessment – Stage 1 Proportionality and Relevance

.

What Integration Joint Board (IJB) report or Partnership decision does this proportionality and relevance assessment relate to:

Development of Hospital at Home Service in the Scottish Borders

Relevant protected characteristics materially impacted, or potentially impacted, by proposals (employees, clients, customers, people using services) indicate all that apply

Age	Disability Learning Disability, Learning Difficulty, Mental Health, Physical Neurodiversity	Gender	Gender Reassignment	Marriage and Civil Partnership	Pregnancy and Maternity	Race	Religion and Belief (including non-belief)	Sexual Orientation
□	□	□	□			□	□	□

Equality and Human Rights Measurement Framework – Reference those identified in Stage 1 (remove those that do not apply)

Education	Work	Living Standards	Health	Justice and Personal Security	Participation
Higher education Lifelong learning	Employment Earnings	Poverty Housing Social Care	Social Care Health outcomes Access to health care Mental health Reproductive and sexual health*	Hate crime, homicides and sexual/domestic abuse	Access to services Social and community cohesion* Family Life*

*Supplementary indicators

Main Impacts	Are these impacts positive or negative or a combination of both	Are the impacts significant or insignificant?
People will be cared for, as far as reasonably practicable, independently in their own home.	Positive	Significant
Improved patient satisfaction and health outcomes.	Positive	Significant
Prioritises the delivery of person-centered care in a respectful and dignified manner.	Positive	Significant

Is the proposal considered strategic under the Fairer Scotland Duty?	Yes
E&HRIA to be undertaken and submitted with the report – Yes **If no – please attach this form to the report being presented for sign off**	**Proportionality & Relevance Assessment undertaken by:** **Cathy Wilson – General Manager of P&CS** **Date: 10/05/23**

Equality Human Rights and Fairer Scotland Duty Impact Assessment

Stage 2 Empowering People - Capturing their Views

Hospital at Home

The pilot will implement a Hospital at Home in NHS Border to understand how to gain the maximum benefits for the patients, how to assist with hospital pressures and how to implement the service so that it is operationally efficient- processes, procedures, sustainability.

Equality Human Rights and Fairer Scotland Impact Assessment Team

Role	Name	Job title	Date of IA Training
E&HR Service Specialist	TBD		
HSCP Joint Executive Team	Dr Lynn McCallum Chris Myers	Medical Director Chief Officer of Health and Social Care Partnership	
Responsible Officer	Cathy Wilson	General Manager – Primary and Community Services	
Main Stakeholder (NHS Borders)	Urgent and Unscheduled Programme Board		
Mains Stakeholder (SBC)	Urgent and Unscheduled Programme Board		
Third/Independent Sector Rep			
Service User	Margaret	Patient Representative	

	Carol Anderson	Patient Representative

Evidence Gathering (will also influence and support consultation/engagement/community empowerment events)

Evidence Type	Source	What does the evidence tell you about the protected characteristics affected?
What equalities information is routinely collected from people currently using the service or affected by the policy?	Not currently gathered	New service equality data to be embedded, captured and reported against as part of TOC and will include the following Patient Management data systems – TRAK, EMIS, BadgerNet
Data on populations in need	Healthcare Improvement Scotland/Cochrane Review	Older people with frailty are the single biggest users of hospital beds and the fastest growing demographic. Across the UK the population of over-85s is predicted to double between 2018 and 2043. Evidence and experience points to various drivers for developing a Hospital at Home service for older people. Safe and effective alternatives to hospital bed-based acute care are needed to manage demographic pressures and provide a better experience for individuals.
Data on relevant protected characteristic	Not currently gathered	New service equality data to be embedded, captured and reported against as part of TOC and will include the following Patient Management data systems – TRAK, EMIS, BadgerNet
Data on service uptake/access	To be gathered via Hospital at Home Dashboard	New service equality data to be embedded, captured and reported against as part of TOC. This will include: Age Sex Race
Data on socio economic disadvantage	Not currently gathered locally. Healthcare Improvement Scotland	GP referral will be recorded to identify correlation between areas of multiple deprivation and access/uptake to the service. Nationally, areas of deprivation may have higher referral rates to Hospital at Home services. COVID-19 has seen a shift towards patients requesting an alternative to hospital admission and may increase referral rates. Patients living in rural areas where it could be difficult to access medical care could see Hospital at Home as a favourable option.

Research/literature evidence	Healthcare Improvement Scotland/Cochrane Review	Evidence points to various drivers for developing a Hospital at Home service for older people as it reduces the disruption to a person's existing formal and informal care and support arrangements through the addition of acute-level care in their home. The drive to provide a more person-centred care experience for individuals, avoiding the risks of healthcare acquired infection, and/or institutionalisation.
Existing experiences of service information	Not available - new service to Scottish Borders	Not available - new service to Scottish Borders
Evidence of unmet need	NHSB delayed discharge data	Scottish Borders has the largest percentage of people going from hospital to residential care as unable to meet their needs within the community.
Good practice guidelines	Hospital at Home – Healthcare Improvement Scotland	Evidence points to various drivers for developing a Hospital at Home service for older people as it reduces the disruption to a person's existing formal and informal care and support arrangements through the addition of acute-level care in their home. The drive to provide a more person-centred care experience for individuals, avoiding the risks of healthcare acquired infection, and/or institutionalisation.
Other – please specify		
Risks Identified		Not identified yet as still to find out what the inequalities are
Additional evidence required		

Consultation/Engagement/Community Empowerment Events

Event 1: Patient Representative Discussion

Date	Venue	Number of People in attendance by category*	Protected Characteristics Represented
28/02/2023 - onward	Teams	2	Age, Poverty, Disability, Unpaid careers

***Attendance by category – including but not limited to: People using the service, people not using the service - currently, unpaid carers, paid carers, key stakeholders (organisation and job title)**

Views Expressed	Officer Response
Patient representatives asked for alternative forms of gathering patient feedback once the service has been implemented. An example given would be exploring the potential for volunteers to gather feedback from patients either online or on paper. Under Living Standards, should people living alone, with no family member close by, be included?	Patient feedback forms to be co-designed with patient representatives. Living alone does not exclude anyone from being eligible for Hospital at Home – everyone irrespective of if they live alone or with someone will be assessed against the eligibility criteria.

Event 2: Strategic Ukrainian Settler Group

Date	Venue	Number of People in attendance by category*	Protected Characteristics Represented
18/04/2023	Teams	Not documented	Age, Race, Religion/Belief, Refugees

Views Expressed	Officer Response
Language Barriers Question raised from Ukrainian Settler Group on how HAH will overcome language barriers when treating patients.	Establish at initial assessment how person would like to be communicated with. This will enable HAH team to follow the same procedure as in hospital. They will utilise services such as Language Line, Say Hi, Google Translate. Protocols around the use of language apps etc to be developed to reduce any possibility of data breach or misinformation. Patient feedback forms will look to capture satisfaction of the process.

Event 3: Physical Disability Strategy Group

Date	Venue	Number of People in attendance by category*	Protected Characteristics Represented
13/04/2023	Teams	Not documented	Disability

Views Expressed	Officer Response
What if I need additional equipment? What happens if I need a hoist? What if a patient has complex needs?	This was taken into discussion with the Physical Disability Strategy Group and resulted in the co-production of a contribution to the Hospital at Home Information Pack which addresses all of the questions asked

Event 4: Alcohol and Drug Partnership

Date	Venue	Number of People in attendance by category*	Protected Characteristics Represented
24/04/2023	Teams	Not documented	Substance/ alcohol misuse

Views Expressed	Officer Response
No view expressed at this involvement event.	Link between Hospital at Home Programme Board and the Alcohol and Drug Partnership to enable ongoing dialogue during the TOC to ensure the needs of those with the relevant lived experience are taken into account.

Event 5: NHSB Ethnic Minority Group **

Date	Venue	Number of People in attendance by category*	Protected Characteristics Represented
26/04/2023	Teams	Not Recorded	Race

Views Expressed	Officer Response
A positive development that enables individuals to meet their own cultural needs eg food preparation	

Equality, Human Rights and Fairer Scotland Duty Impact Assessment

Stage 3

Analysis of findings and recommendations

Hospital at Home

Please detail a summary of the purpose of the proposal being developed or reviewed including the aims, objectives and intended outcomes

In recent years, healthcare professionals 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 the NHS 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, Health Boards 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 relieve some pressure on acute services, though only in some areas has it been shown to facilitate closure of inpatient beds.

The pilot will implement a Hospital at Home in NHS Border to understand how to gain the maximum benefits for the patients, how to assist with hospital pressures and how to implement the service so that it is operationally efficient- processes, procedures, sustainability.

Section 1: Equality Act 2010 – Relevant Protected Characteristics as identified in Stage 1 or during Stage 2

Protected Characteristic	Equality Duty	What impact and or difference will the proposal have	Measures to evaluate/mitigating actions
Age	Eliminating discrimination, harassment, victimisation, or any other prohibited conduct	Hospital at Home is uniquely designed and planned with a person-centred approach. Hospital at Home assessments takes into account individual preferences, capabilities, and independence. Therefore ensuring that people are treated with dignity and respect.	Hospital at Home reporting dashboard monitors admission by age.
	Advancing equality of opportunity	Hospital at Home assessments criteria will ensure that the care package is designed to meet the unique requirements of each individual, enabling older people to live in their own home with their loved ones.	Hospital at Home reporting dashboard monitors admission by age. Analysis of patient feedback forms.
	Fostering good relations by reducing prejudice and promoting understanding	Hospital at Home associated communication leaflets have been designed to promote that this service is designed to meet needs and not explicitly for people over the age 65+.	Feedback mechanisms will be analysed as a way of identifying any unintended discriminatory practice. This will allow for prompt action and resolution, fostering an environment of inclusivity and eliminating any harmful practices or biases.
Disability	Eliminating discrimination, harassment, victimisation, or any other prohibited conduct	Hospital at Home is an inclusive service, that results in a more tailored service for patients because of reasonable adjustments and taking an agile/flexible approach to patient care.	Ensure our Patient Management System is up to date with knowledge about patient communication needs and capacities. It is not possible with the current data set to clearly capture and report on individuals with disabilities, however case notes and be reviewed retrospectively and daily huddles discussions include the review of

		For people with disabilities, long-term conditions, or frailty, Hospital at Home offers several benefits. Patients can maintain their independence by living in familiar surroundings, where they have established support networks and access to community resources. This helps to preserve their sense of identify and autonomy while receiving the necessary care and assistance tailored to their specific needs.	individual care – recognise each patient care and/or enhanced care needs
	Advancing equality of opportunity	Allowing individuals to be treated in the comfort of their own home environment which may be a more appropriate and familiar setting, Hospital at Home complements the person-centred approach. The Hospital at Home model of care provides the time to go over key information to help people with learning disabilities to make informed decisions.	We will engage with learning disability groups within the local community to ensure that people with learning disabilities are aware of what the Hospital at Home service is.
	Fostering good relations by reducing prejudice and promoting understanding	Hospital at Home associated communication leaflets have been designed to promote that this service is designed to meet needs including those of disabled people.	Feedback mechanisms will be analysed as a way of identifying any unintended discriminatory practice. This will allow for prompt action and resolution, fostering an environment of inclusivity and eliminating any harmful practices or biases.
Gender Reassignment	Eliminating discrimination, harassment, victimisation, or any other prohibited conduct	By supporting people at home, the service can be beneficial to those who feel any perceived risks as a result of gender	We will link with Gender Reassignment groups to understand what adjustments

		reassignment by providing the flexibility to schedule appointments or access healthcare.	may be required and we will train our staff to be aware of these. Investigating if our Patient Management System can support gender identification and use of pronouns
	Advancing equality of opportunity	Being in a familiar environment can reduce stress and contribute to a sense of safety	We will listen to our community representatives and the voices of those with lived experience to ensure our services meet the needs of people undergoing gender reassignment recognising that they may require service adjustments sensitive to these.
	Fostering good relations by reducing prejudice and promoting understanding	None identified at this time	Feedback mechanisms will be analysed as a way of identifying any unintended discriminatory practice. This will allow for prompt action and resolution, fostering an environment of inclusivity and eliminating any harmful practices or biases. Staff and caregivers will be trained on appropriate use of pronouns and questions through training.
Marriage and Civil Partnership	Eliminating discrimination, harassment, victimisation, or any other prohibited conduct	None identified at this stage	None identified at this stage

	Advancing equality of opportunity	None identified at this stage	None identified at this stage
	Fostering good relations by reducing prejudice and promoting understanding	None identified at this stage	None identified at this stage
Pregnancy and Maternity	Eliminating discrimination, harassment, victimisation, or any other prohibited conduct	None identified at this stage	None identified at this stage
	Advancing equality of opportunity	None identified at this stage	None identified at this stage
	Fostering good relations by reducing prejudice and promoting understanding	None identified at this stage	None identified at this stage
Race	Eliminating discrimination, harassment, victimisation, or any other prohibited conduct	Hospital at Home care delivery will be designed to meet the specific medication and care needs of individuals.	Ensuring communication and information is available in different languages.
	Advancing equality of opportunity		Staff will be made aware of the sensitivities relating to explaining some health issues, for example, mental health issues or sexual health issues.
	Fostering good relations by reducing prejudice and promoting understanding		We will listen to our community representatives and the voices of those with lived experience to ensure our services meet the individual needs of people recognising that some Races have a higher incidence of certain diseases.
Religion & Belief including non- belief	Eliminating discrimination, harassment, victimisation, or any other prohibited conduct	Individuals will co-produce a care plan that meets their religious requirements e.g. times of worship, religious-based dietary requirements, cultural awareness and sensitives e.g., providing hygienic shoe covers to enable entry to house	Staff awareness programme

	Advancing equality of opportunity	**Hospital at Home enables individuals to continue practice more fully their religious beliefs.**	**None identified**
	Fostering good relations by reducing prejudice and promoting understanding	**We will listen to our community representatives and the voices of those with lived experience to ensure our services meet the needs of people regardless of religion and belief.**	**Feedback mechanisms will be analysed as a way of identifying any unintended discriminatory practice.** **This will allow for prompt action and resolution, fostering an environment of inclusivity and eliminating any harmful practices or biases.** **We will link with representatives of the relevant religious and faith communities in Scottish Borders to educate and gather feedback to help inform our thinking in this respect.** **Hospital at Home staff are trained to have cultural competence, compassion, and sensitivity, ensuring that care is provided in a respectful and non-discriminatory manner. This helps foster trust and a positive relationship between the patient and their care providers.**
Gender (Sex)	**Eliminating discrimination, harassment, victimisation, or any other prohibited conduct**	**Hospital at Home enables the individual to present in their preferred gender and not to conform with hospital admission criteria.**	**Investigating if our Patient Management System can support gender identification and use of pronouns**
	Advancing equality of opportunity	**Hospital at Home enables the individual to present in their preferred gender and not to conform with hospital admission criteria.**	**Staff will be made aware of the sensitivities surrounding gender**

			Analysis of patient feedback forms.
	Fostering good relations by reducing prejudice and promoting understanding	Individuals will co-produce a care plan that recognises their gender preferences and document sensitives around care giving.	Feedback mechanisms will be analysed as a way of identifying any unintended discriminatory practice. This will allow for prompt action and resolution, fostering an environment of inclusivity and eliminating any harmful practices or biases
Sexual Orientation	Eliminating discrimination, harassment, victimisation, or any other prohibited conduct	None identified at this stage	We are still to meet with representatives of the LGBTQ-i- communities in Scottish Borders to educate and gather feedback to help inform our thinking in this respect.
	Advancing equality of opportunity	None identified at this stage	We are still to meet with representatives of the LGBTQ-i- communities in Scottish Borders to educate and gather feedback to help inform our thinking in this respect.
	Fostering good relations by reducing prejudice and promoting understanding	None identified at this stage	We are still to meet with representatives of the LGBTQ-i- communities in Scottish Borders to educate and gather feedback to help inform our thinking in this respect.

Section 2: Equality and Human Rights Measurement Framework Human– Reference those identified in Stage 1 (remove those that do not apply)

Domain	Indicator	Enhancing or Infringing	Impact and or difference will the proposal have	Measures to evaluate/mitigating actions
Education	Higher education and lifelong learning	Enhancing	The proposal will allow those to continue attendance of education without unnecessary interruption. It allows them to receive necessary medical care while still being able to attend classes or study from home. Enables individuals with disabilities or chronic illnesses to actively participate in higher education or lifelong learning. They would not be restricted to the physical limitations of hospital settings, promoting inclusion and equal opportunities for education. Patients can engage in educational activities at their own pace and convenience, preserving their dignity and autonomy throughout the treatment process. Overall, the flexibility of the service empowers patients to balance their educational commitments and medical treatment effectively.	Feedback from patients will focus on accessibility, inclusivity, autonomy, and flexibility that the service has offered.
Work	Employment Earnings	Enhancing	The proposal will allow people who work from receive necessary medical care while still being able to work. This empowers patients to balance work/life commitments and medical treatment effectively.	Feedback from patients will focus on accessibility, inclusivity, autonomy, and flexibility that the service has offered.

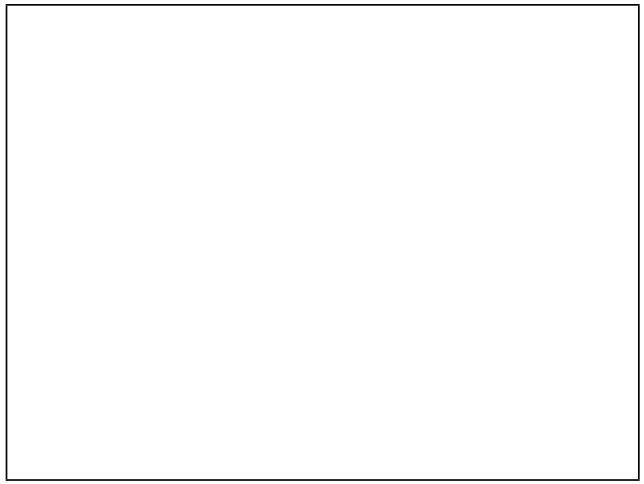
		Infringing	An unpaid carer in paid employment may be negatively affected if they are required to support the patient at home while treatment is provided.	Part of the assessment for Hospital at Home eligibility is a conversation with the individual, family and/or non-paid carer. It is important prior to admission to fully understand the impacts treatment in a home may have.
Living Standards	Poverty Housing Social Care	Enhancing	Enables people to stay at home to. The service will also be able to signpost and refer people they are caring for to community based services.	We will ensure safeguarding is in place such as researching into how food is provided to patients who need it prior to referring a patient to the Hospital at Home service. We will work with other community services such as social work to ensure patients are able to access the Hospital at Home service. We will utilise the Integrated Joint Board needs assessment to understand the needs of patient. We will tap into poverty related third sector to support patients access care in their homes. We will aim to deliver person-centred service in response to need.

				Hospital at Home is aware of possible fluid accommodation arrangements so the Hospital at Home service will develop a way of being flexible to meet the needs of potential patients, especially as patients may be in non-residential setting eg hotels
Health	Social Care Health outcomes Access to health care Mental health	Enhancing Infringing	By enabling individuals to remain in their homes or community settings, Hospital at Home helps minimise the disruption and negative impact associated with institutional care. This can lead to improved mental wellbeing, reduced stress, and enhanced social connections, as individuals are able to maintain their social interactions and engagement within their communities. The majority of unpaid carers are women and by using Hospital at Home will enable women to continue in their care-giving role Non-paid carers that may benefit from temporary respite from an acute hospital stay, may be negatively impacted by having to look after their loved ones at home.	Staff who are treating patients in their home will be able to signpost to appropriate community support services provided by third sector. Admission with no onward referral to inpatient services Through patient feedback surveys that Hospital at Home staff provide during visits.
Justice and Personal Security	Hate crime, homicides and sexual/domestic abuse	Enhancing	Hospital at Home may provide a service in a setting that has domestic abuse which may endanger the patients themselves or the non-paid carer in their home. Quality and ability of the service may also be impacted. As nurses are trained to recognize signs of domestic	We will ensure safeguards are in place for patients/ respond quickly if any gender-based violence occurs.

			abuse in the home, they will be able to raise concerns via the adult protection process.	Safer community documents are shared from community groups.
Participation	Access to services Social and community cohesion* Family Life*	Enhancing	By enabling individuals to remain in their homes or community settings, Hospital at Home helps minimise the disruption and negative impact associated with institutional care. This can lead to improved mental wellbeing, reduced stress, and enhanced social connections, as individuals are able to maintain their social interactions and engagement within their communities.	Through patient feedback surveys that Hospital at Home staff provide during visits.

Section 3: Fairer Scotland Duty

Identify changes to the strategic programme/proposal/decision to be made to reduce negative impacts on equality of outcome and or improving health inequalities	Updating Information Pack's Q&A with additional details around accessing equipment Recognising the cultural and religious sensitivity aspects of treating a patient in their home through training As the proposal is in a test to change cycle for an additional 6 months the team will be constantly reviewing and assessing changes that can be made to reduce impact and improve health inequalities.
Identify the opportunities the strategic programme/proposal/decision provides to reduce or further reduce inequalities of outcome and or improving health inequalities	Hospital at Home can enhance access to health care for patients who may face barriers such as transportation difficulties, socioeconomic challenges, or living in remote areas. By bring the necessary care directly to patients' homes, Hospital at Home can bridge the gap an ensure equitable access for all individuals, reducing inequalities in outcomes. Hospital at Home enables clinicians/ health care professionals to intervene promptly when patients' conditions require medical attention. This timely intervention can prevent exacerbation of illnesses and reduce the likelihood of complications, improving health outcomes and narrowing health inequalities caused by delayed or inadequate treatment.



Care is tailored to individual needs. This approach can address health inequalities by acknowledging and accommodating patients' specific circumstances, cultural backgrounds, and preferences. Carers don't have to travel to hospital and care packages will remain the same for patients.

Hospital at Home service facilitate better continuity of care by enhancing communication and coordination between health and social care providers, leading to more streamlined and holistic care – this is particularly important for those with complex medical conditions or multiple health care needs, reducing health inequalities.

By providing patients with information, resources, and support to manage their conditions effectively, the services can empower individuals to take control of their health, reducing health inequalities associated with knowledge gaps or limited literacy.

Section 4: Are there any negative impacts with no identified mitigating actions? If yes, please detail these below:

Not Applicable

Section 5: Equality, Human Rights & Fairer Scotland Duty Impact Assessment Recommendations

What recommendations were identified during the impact assessment process:

Recommendation	Recommendation owned by:	Date recommendation will be implemented by	Review Date
	(Name and job title)		
Analysing feedback forms to gather relevant information under Fairly Scotland Duty	Cathy Wilson, GM	31/01/2024	TBD after evaluation of TOC
Review easy read material – adapted from learning from Hospital at Home pilot	Cathy Wilson, GM	31/01/2024	TBD after evaluation of TOC
Staff training on cultural and social sensitivities	Hospital at Home Clinical Team Lead	31/01/2024	TBD after evaluation of TOC
Establish list of community services for signposting	Hospital at Home Administrator	31/01/2024	TBD after evaluation of TOC
Codesign patient leaflet	Hospital at Home Clinical Team Lead	31/01/2024	TBD after evaluation of TOC
Investigation Patient Management system for recording of additional characteristics	Hospital at Home Administrator	31/01/2024	TBD after evaluation of TOC
Continuing active engagement with representatives of LGBTQA+; religious and faith, Race and people undergoing gender reassignment	Cathy Wilson, GM	31/01/2024	TBD after evaluation of TOC

Section 6: Monitoring Impact – Internal Verification of Outcomes

How will you monitor the impact this proposal affects different groups, including people with protected characteristics?

Monthly Hospital at Home Reporting Sub-Group
Analysis of data to see if there are any variances between the protected characteristics
Through patient feedback surveys that Hospital at Home staff provide during visits
Continuous engagement with community representatives to gather feedback to help inform our thinking and develop our service

Section 7: Procured, Tendered or Commissioned Services (SSPSED)

Is any par/t of this policy/service to be carried out wholly or partly by contactors and if so, how will equality, human rights including children's rights and the Fairer Scotland duties be addressed?

N o

Section 8: Communication Plan (SSPSED)

Please provide a summary of the communication plan which details how the information about this policy/service to young people, those with a visual or hearing sensory impairment, difficulty with reading or numbers, learning difficulties or English as a second language will be communicated.

Our Public Health team has recently joined us for collaborative working to ensure that any communication plans are communicated in a way that supports young people, those with a visual or hearing sensory impairment, difficulty with reading or numbers, learning difficulties or English as a second language.

Easy read material will be provided for those who request it and communication awareness with staff to understand the challenges.

Signed Off By:

Cathy Wilson, General Manager of Primary and Community Services

Date: 13/09/23

This page is intentionally left blank

Scottish Borders Health and Social Care Partnership Integration Joint Board

20 September 2023

COMMUNICATIONS AND ENGAGEMENT FRAMEWORK

Report by Clare Oliver, Head of Communications and Engagement

Scottish Borders Health and Social Care PARTNERSHIP

1. PURPOSE AND SUMMARY

1.1. **To seek approval for the Health and Social Care Partnership Communications and Engagement Framework 2023-2026.**

1.2. The Communications and Engagement Framework is a companion document to the Health and Social Care Partnership's Strategic Framework 2023-2026.

It sets out the approach for planning and delivering effective communications and engagement activity to support the delivery of the Strategic Framework 2023-2026.

Effective communications and engagement are essential to ensure that "people are at the heart of everything we do" and support us to be inclusive, co-productive and fair in providing quality, sustainable and seamless services for the people of the Borders and achieving our ambitious aspirations for improved community outcomes.

Community engagement is a purposeful process which develops a working relationship between communities, community organisations and public and private bodies to help them to identify and act on community needs and ambitions. It involves respectful dialogue between everyone involved, aimed at improving understanding between them and taking joint action to achieve positive change. Effective community engagement and the active participation of people is essential to ensure that health and social care services are fit for purpose and lead to better outcomes for people.

2. RECOMMENDATIONS

2.1. **The Scottish Borders Health and Social Care Integration Joint Board (IJB) is asked to:-**

a) Approve the HSCP Communications and Engagement Framework 2023-2026

3. ALIGNMENT TO STRATEGIC OBJECTIVES AND WAYS OF WORKING

3.1. It is expected that the proposal will impact on the Health and Social Care Strategic Framework Objectives and Ways of Working below:

Alignment to our strategic objectives					
Rising to the workforce challenge	Improving access	Focusing on early intervention and prevention	Supporting unpaid carers	Improving our effectiveness and thinking differently to meet need with less	Reducing poverty and inequalities

X	X	X	X	X	X

Alignment to our ways of working					
People at the heart of everything we do	Good agile teamwork and ways of working – Team Borders approach	Delivering quality, sustainable, seamless services	Dignity and respect	Care and compassion	Inclusive co-productive and fair with openness, honesty and responsibility
X	X	X	X	X	X

4. INTEGRATION JOINT BOARD DIRECTION

4.1. A Direction is not required

5. BACKGROUND

5.1. The HSCP Communications and Engagement Framework is a companion document to the HSCP Strategic Framework. It has been informed by the 'We Have Listened' reports and will inform the development of individual communications and engagement plans for specific programmes of work / projects contained with the Joint Annual Delivery Plan.

5.2. The Engagement element is referred to as the 'Involving People Framework' and is informed by Scottish Government's Planning with People which is the national community engagement and participation guidance for NHS Boards, Integration Joint Boards and Local Authorities that are planning and commissioning care services in Scotland.

5.3. The 'Involving People Framework' was approved by NHS Borders Board at their meeting on 29 June 2023 as the engagement strategy for health.

6. IMPACTS

Community Health and Wellbeing Outcomes

6.1. It is expected that the proposal will impact on the National Health and Wellbeing Outcomes below:

N	Outcome description	Increase / Decrease / No impact
1	People are able to look after and improve their own health and wellbeing and live in good health for longer.	Increase
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.	No impact
3	People who use health and social care services have positive experiences of those services, and have their dignity respected.	Increase
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	Increase
5	Health and social care services contribute to reducing health inequalities.	Increase

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.	No impact
7	People who use health and social care services are safe from harm.	No impact
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.	Increase
9	Resources are used effectively and efficiently in the provision of health and social care services.	Increase

7. Financial impacts

7.1. There are no costs attached to any of the recommendations contained in this report.

8. Equality, Human Rights and Fairer Scotland Duty

The Communications and Engagement Framework is a tool to influence and inform future Communications and Engagement activity. The includes the undertaking of Equality and Human Rights Impact Assessments to inform community involvement, and is considered evidence of a mainstreaming action in relation to Equality Outcome 3: “Community engagement and empowerment across the Scottish Borders is inclusive, co-productive and fair”; 3.1 “Increased participation, influence and voice from people with protected characteristics, with lived experiences, in the Scottish Borders Locality Working Groups” and 3.2 “Adhere to the Planning with People Guidance when engaging with communities of interest”.

Legislative considerations

8.1. NHS (Scotland) Act 1978 as amended by the NHS Reform (Scotland) Act 2004
Equality Act 2010
Public Services Reform (Scotland) Act 2010
Patient Rights (Scotland) Act 2011
The Local Government (Scotland) Act 2003 gave a statutory basis to partnership working between all agencies responsible for delivering public services in an area, including health boards. This act established the role of Councils in facilitating the Community Planning process, at the heart of which is 'making sure people and communities are genuinely engaged in decisions made on public services which will affect them'.
The Community Empowerment (Scotland) Act 2015 gave new rights to community bodies and new duties to public sector authorities to help empower communities by strengthening their voices in decisions about public services.
The Public Bodies (Joint Working) (Scotland) Act 2014 put in place a requirement for NHS Boards and Local Authorities to work together to deliver integrated health and social care services through Health and Social Care Partnerships

Climate Change and Sustainability

8.2. N/A

Risk and Mitigations

8.3. Integration Joint Boards have a statutory duty to involve people in the planning and development of services, therefore the risk of not doing so could result in legal action.

9. CONSULTATION

Communities consulted

9.1. The HSCP Communications and Engagement Framework has been developed as part of the Strategic Framework 2023-2026 and has been informed by the extensive community engagement exercise commissioned by the HSCP and undertaken by the National Development team for Inclusion (NDTi).

Integration Joint Board Officers consulted

9.2. The IJB Chief Financial Officer, the IJB Chief Officer and Third Sector members of the IJB including Borders Care Voice and Borders Community Action, and Corporate Communications team members have been consulted, and all comments received have been incorporated into the final report.

9.3. The IJB Equalities, Human Rights and Diversity Lead has been consulted.

9.4. In addition, consultation has occurred with our statutory partners at

- NHS Borders Board
- IJB Future Strategy Group
- IJB Strategic Planning Group

Approved by:

Chris Myers, Chief Officer

Author(s)

Clare Oliver, Head of Communications and Engagement, NHS Borders

For more information on this report contact clare.oliver@nhs.net

Scottish Borders
Health and Social Care
PARTNERSHIP

COMMUNICATIONS AND ENGAGEMENT FRAMEWORK 2023-2026

Scottish Borders COUNCIL

NHS Borders

Table of Contents

	Page
Introduction and Purpose	3
Communications Aims	5
Communications Principles	6
Branding and Identity	7
Audiences	7
Communications Channels	8
Measurement and Evaluation	8

Introduction and Purpose

Scottish Borders Health and Social Care Partnership's Communications and Engagement Framework sets out the approach for planning and delivering effective communications and engagement activity to support the delivery of the Strategic Framework 2023-2026.

Community engagement was an integral part of the development of the Strategic Framework, and what our communities told us has been captured in the We Have Listened reports which cover two separate phases of engagement.

Effective communications and engagement activity underpins our vision, mission and the ways of working across our Health and Social Care Partnership which are set out below.

The Strategic Framework lets people know:

- What we want to achieve through the priorities identified in the 'Needs of our Communities' and 'We Have Listened' reports
- The way we plan to tackle these priorities
- What we will do, including what we will do differently to achieve our aims
- How we will use our budget and resources to do this
- How we will measure how well we are doing

To do this in the context of the challenges we face we will need:

- Everyone to play their part to take care of their health and wellbeing
- To take proactive action to manage the strategic issues
- To have a relentless focus on our objectives and ways of working
- To make difficult decisions in partnership with our communities
- To ensure continued alignment across the Health and Social Care Partnership and with our Community Planning Partners

Effective communications and engagement are essential to ensure that “people are at the heart of everything we do” and support us to be inclusive, co-productive and fair in providing quality, sustainable and seamless services for the people of the Borders.

When we engaged with them, the people of the Borders were clear about the importance of *“effective communication, between services (and them), knowing what’s happening, when and how and between different parts of the heath and social care system.”* People wanted to see an improvement in communication, with clear and up to date information about waiting times and how and where they could access services when they needed them.

This document sets out the Communications Framework which outlines how effective communications will support the HSCP and Integration Joint Board (IJB) to achieve our ambitious aspirations for improved community outcomes.

The Involving People Framework sets out the Engagement Framework for the Health and Social Care Partnership (HSCP).

Communications Aims

Based on the feedback received from our communities there is a triple aim for all communications that are issued from the HSCP and IJB.

1. Awareness and Understanding
2. Trust and Confidence
3. Encourage involvement and meaningful two-way dialogue

Awareness and Understanding
Our communities told us how important effective communication between services and service providers is. Knowing what is happening, when and how to access services is vitally important to gain awareness and achieve understanding.

Our communications will:

- build awareness amongst staff and communities about what the Health and Social Care Partnership and IJB are, what we do and why we do it
- provide information on how and where services can be accessed
- be honest about the challenges we face and the context within which we are operating
- link back to the relevant priorities and objectives in the Strategic Framework
- provide consistent, accessible information through a range of channels taking account of different needs

Trust and Confidence
Our communities told us they felt that the delivery of health and social care had worsened over the last four years.

Framed within the context of the challenges that we face our communications will:

- celebrate success and share stories about the progress we are making towards realising our vision and mission, and achieving our objectives
- be honest about what is working well and what is proving to be more challenging
- empower people to feel confident about sharing their opinions and contributing

Encourage involvement and meaningful two-way dialogue
Our communities told us that we should improve our engagement with people with lived experience, involving them at an early stage of planning and designing services.

In conjunction with effective engagement utilising the Involving People Framework we will:

- develop two-way communication channels to build continuous and meaningful dialogue so that everyone has the opportunity to influence service planning, be involved with decisions that affect them and improve outcomes
- ensure people have easy access to the information they need in a way they would choose to access it
- Utilise patient / service user feedback and data to inform service improvements
- Work across the Partnership, and in particular with our Third Sector partners to find new and creative ways to involve people with the relevant protected characteristics, lived experience and communities experiencing inequality, and the organisations who represent them.

Communications Principles

- Information contained in communications should refer back to least one of the stated objectives of the HSCP (e.g. improving access to services, rising to the workforce challenge, reducing poverty and inequalities). The relevant objective should be clearly referenced in the communication.

- All communications issued on behalf of the HSCP and IJB should be effective and timely. Consideration should be given to the sequencing of communications issued remembering that staff are a primary audience and should always be considered at the earliest stage of the issuing process.

- All communications issued on behalf of the HSCP and IJB, including those issued in relation to a delegated function / service should carry the HSCP logo and reference the HSCP and or IJB as appropriate.

- The objective of the communication should be clear and content should be relevant and easy to understand.

- Where possible communications should be issued proactively and ahead of time, however in all events we must be responsive, transparent, accountable and fair in our communications.

- The language used in the communication should be concise and jargon-free.

- Communications must be accessible and adhere to the relevant accessibility policies and guidelines.

- Where possible evidence such as data and case studies will be used in communications to bring the story to life. Consent from people named in case studies, whether staff or members of the public, must be obtained using the relevant statutory bodies consent form.

- Spokespeople can be quoted; ordinarily for NHS Borders this will be a member of the Board Executive team, for SBC this will be an Executive Member and / or Director and for the IJB this will be the Chief Officer or a relevant nominated member for example, but not limited to Chair, Chief Finance Officer or Chief Nurse.

Branding and Identity

Scottish Borders Health and Social Care Partnership has its own logo, although it may not be recognised by staff or members of the public. Brand recognition is outwith the scope of this Communications Framework.

Scottish Borders
Health and Social Care
PARTNERSHIP

The logo can be used in conjunction with the logos of NHS Borders and Scottish Borders Council.

Brand guidelines for use of the Health and Social Care Partnership logo are available here.

NHS Borders

Scottish Borders COUNCIL

When reproducing logos atention should be paid to ensuring that the logo is reproduced clearly, in high resolution, and not distorted in form by stretching the size and proportions of the original logo.

Specific questions in relation to logo use should be directed to the respective communications team in NHS Borders or Scottish Borders Council.

Audiences

For the purpose of this overarching Communications Framework our audiences can broadly be segmented into the following categories:

Staff	Working across NHS Borders and Scottish Borders Council including Joint Executive Board members
Elected members	Elected members of Scottish Borders Council 'councillors'
Non Executives	Non-Executive members of NHS Borders Board
Third Sector Interface	Members of the IJB representing Third Sector organisations
Community Groups and Representatives	Including Community Councils, Equality Groups, Area Partnerships, Locality Working Groups
Patients and Service Users	People who use our services now or will need to in the future
Carers	Unpaid Carers and advocates of people who use our services
MSPs / MPs	Members of Scottish Parliament

Not all messages need to be communicated to all audiences at all times. Identifying and understanding the needs of audiences is essential when tailoring communication messages and channels.

Individual programmes of work and projects that take place across the Partnership space will have specific audiences and require tailored communications plans to meet the needs of those audiences. Sections 1 and 2 of the Involving People Framework will help colleagues to identify and segment audiences. Audience insight is also available in the Needs of Our Communities and We Have Listened reports.

Communications Channels

Communications channels are the tools and methods used to send information to our internal and external audiences. A range of channels are available and consideration should be given to the intended audience when selecting how information is communicated. Where possible and appropriate two way channels of communication should be used to build continuous and meaningful dialogue with our audiences.

It is important to use inclusive and accessible methods to ensure no one is disadvantaged by disability, cultural or language barriers, access to the internet or difficulties with literacy, for example. Alternative formats should be offered on all communications e.g. Easy-Read, Braille or different languages. NHS Borders and Scottish Borders Council each have their own local arrangements in place for translation of communications.

Communications channels include, but are not limited to:

- Press releases
- Broadcast interviews
- Social media posts
- Online resources including SBC and NHS Borders websites and intranet sites (staff resource) and Viva Engage (SBC)
- Videos and animations
- Presentations (face to face / virtual / hybrid)
- Briefings (face to face / virtual / hybrid)

Communications can be issued using multiple channels. Communications Teams can offer advice on appropriate methods to meet the needs of different audiences to inform tailored communications plans.

Measurement and Evaluation

Communications activity can be challenging to measure and evaluate however we will monitor performance, feedback and sentiment using the following methods;

- Social media metrics (e.g. audience reach)
- Website clicks and click throughs
- Media coverage achieved
- Two way feedback received
- Engagement with activity (e.g. numbers of people atending engagement events)
- Impact on behaviour change (for specific campaigns)

INVOLVING PEOPLE FRAMEWORK (2023-2026)

A guide to effective community engagement and participation

Contents

Purpose of the Involving People Framework	Page 3
Planning	Page 5
Inclusion	Page 7
Support	Page 8
Working Together	Page 10
Methods	Page 12
Communication	Page 14
Impact	Page 15
Reference materials	Page 17

What is the purpose of the Involving People Framework?

"Community engagement is a purposeful process which develops a working relationship between communities, community organisations and public and private bodies to help them to identify and act on community needs and ambitions. It involves respectful dialogue between everyone involved, aimed at improving understanding between them and taking joint action to achieve positive change[1]."

Effective community engagement and the active participation of people is essential to ensure that health and social care services are fit for purpose and lead to better outcomes for people.

Across the Scottish Borders Health and Social Care Partnership our mission[2] is '*to help the people of the Scottish Borders live their life to the full, by delivering services that place their needs at the heart of everything we do.*'

This mission cannot be achieved by working in isolation, and we are committed to improving the ways in which people, especially those with lived experience, their families, carers and groups experiencing inequality can have their voices heard in decision making that affects them. We want current and future users of the services we provide to know that their views on what is important to them are understood and that they have influence and choice over how their health and social care needs are met.

As the resources (human and financial) we have available to us become ever tighter, it is also vital that patients, families, carers and our communities feel encouraged and supported to take an active role in their own health as well as in shaping and delivering the care we provide.

The Involving People Framework is intended to be a tool that;

- service providers can use to help plan engagement activities
- service users can refer to in order to find out what they can expect from involvement activities that take place for services provided by the Scottish Borders Health and Social Care Partnership.

The framework is based around the seven National Standards for Community Engagement

- Planning
- Inclusion
- Support
- Working together
- Methods
- Communication
- Impact

[1] The National Standards for Community Engagement, Scottish Community Development Centre
[2] Scottish Borders Health & Social Care Partnership Strategic Framework 2023-2026

Within the framework there is a section on each of the seven standards for Community Engagement, setting out the principles to be followed for Involving People in the development and delivery of the services we provide.

There is overlap across the seven standards so it is recommended that when you are using the framework to plan engagement activity, read the whole document first.

Section 1 | Planning

There is clear focus for the engagement which is based on a shared understanding of community needs and ambitions

From the outset it is essential to have a clear focus for the engagement work that is going to take place.

Establishing that clear focus is the single most important stage of planning and ensures that everyone involved has accurate expectations about what you are doing and why.

There are many reasons why you might be considering undertaking engagement including:

- Understanding public preferences and priorities
- Exploring issues and coming up with new ideas
- Increasing awareness of an issue
- Improving transparency of decision making processes / making a decision
- Deliver better, more responsive services
- Consider changes to existing services[3]
- Prompt behaviour change

Ideally the focus or 'scope' of the engagement should be agreed in conjunction with the people or 'stakeholders' who are going to be involved in the process. At times it may be immediately obvious who needs to be involved in the engagement work; but it is good practice to do a stakeholder identification exercise.

There are various tools available to help you carry out stakeholder identification but considering the following questions is a good starting point;

1. Who is going to be most affected?
   These people are your primary stakeholders and you need to work closely with them

2. Who is going to be indirectly affected?
   These people are your secondary stakeholders and you need to keep them informed, and also monitor their interest levels

3. Who else might be interested in an overview of your work?

More help on identifying stakeholders is included in Section 2 of this framework.

Once you have identified your stakeholders you should bring them together to discuss the need for your engagement work, the resources that you will require to carry it out, and the resources that are available to you.

[3] Further information at Service change | HIS Engage

Together you should then be able to agree the purpose, scope and timescale of the engagement and the actions to be taken. Remember to consider the potential costs associated with your engagement (e.g.venue hire for meetings, volunteer expenses), capture the benefits that you are looking for, and any potential risks associated with the activity.

Some general questions to help you at this stage are;

- Why are you engaging with people? (purpose)
- What do you need to know? (scope)
- Who should be involved? (stakeholders)
- When is the best time to engage? (timescale)

It is also really important to consider your success criteria at this stage of the process.
See the Impact section of this framework to help you.

Section 2 | Inclusion

We will identify and involve the people and organisations that are affected by the focus of the engagement

Providing opportunities for people to get involved with issues that affect or are important to them is a fundamental part of our mission to help the people of the Scottish Borders live their life to the full, by delivering services that place their needs at the heart of everything we do.

To ensure that your stakeholder list is inclusive you should develop a list of individuals, groups and communities that may have an interest or be affected by the focus of your engagement activity.

Your list should include:

- patients and people who may be directly affected by change, including family members and carers
- groups or organisations who support people who may be affected
- health and social care staff who deliver services being considered for change
- managers of services being considered for change
- members of the local community who may not be affected directly but have an interest in potential changes
- elected members and government officials

It is good practice to involve people in compiling your stakeholder list (including members of the public) to ensure the list is inclusive and considers everyone who may have an interest.

Undertaking an Equality and Human Rights Impact Assessment (E&HRIA) will also help you to identify your stakeholders. An E&HRIA considers the impact of a proposed change and makes sure that any potentially negative effects for stakeholders have been taken into account. It should be done as early as possible to help identify people and groups who should be involved, as well as highlight any potential barriers or imbalance of power that may need to be considered.

The Health and Social Care Partnership has adopted a three part process for Equality and Human Rights Impact Assessments.
Links to the templates are embedded below. Guidance notes are in development so if you need support to help you complete the templates please contact the Equalities Lead for the HSCP Wendy Henderson.

Stage 1: Proportionality and relevance
Stage 2: Empowering people
Stage 3: Analysis of findings

Once completed your E&HRIA should be published on the website. Please contact Public.Involvement@borders.scot.nhs.uk

Section 3 | Support[4]

We will identify and overcome any barriers to participation

Everyone has a right to share their opinions and experiences to help shape health and social care services. People who face the biggest barriers to realising their rights should be prioritised when it comes to participation and engagement.

When you are engaging with people, you need to consider the Equality Act 2010 and Human Rights Act 1998 and reach out to involve those who may not usually be involved or may find it difficult to speak up.

Nobody should be treated unfairly because of their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation or any other status. These are known as *protected characteristics*. Undertaking an EQIA can help to identify potential disadvantages and offer an opportunity to take appropriate actions to remove or minimise any adverse impact.

Other impact assessments

The Health and Social Care Standards were rolled out across Scotland in April 2018. These human rights-based standards set out what people should expect when using health, social care or social work services in Scotland. They seek to provide better outcomes for everyone; to ensure that everyone is treated with respect and dignity, and that the basic human rights we are all entitled to be upheld.

The Fairer Scotland Duty also came into force in April 2018. This Duty requires public bodies to reduce inequalities of outcome caused by socioeconomic disadvantage. To fulfil our obligations under the Duty, we must evidence how we actively consider the reduction in inequalities of outcome in any major strategic decision we make.

The significant and long-standing inequalities that exist in Scotland has resulted in disparities in health outcomes between the most and least advantaged people. These disparities are often referred to as health inequalities. Health inequalities are most commonly associated with socioeconomic inequalities but can also result from a wide range of other factors which include:

- reasons relating to a person's protected characteristics
- access to education
- access to employment
- access to adequate housing and the location in which a person lives
- individuals' circumstances and behaviours, such as their diet, alcohol consumption, drug use, smoking and exercise

Playing our part to help tackle health inequalities is key to us making care better for everyone.
Adopting a human rights-based approach is one way to help us tackle health inequalities caused by unfair and avoidable reasons.

4 Reference material at Equality and diversity | HIS Engage

Taking a human rights-based approach is about:

- improving outcomes for patients, service users and staff by taking a person-centred approach
- making people's rights integral to our work and treating them as individuals, fairly, with respect and dignity
- advancing equality and eliminating discrimination
- engaging with people and empowering them to know and claim their rights
- giving people greater opportunities to participate in shaping the decisions that impact on them
- ensuring the standards and the principles of human rights are integrated into our work
- improving our accountability to respect, protect and fulfil people's human rights

You can view a helpful video (2 mins) about barriers to participation here

For details of local groups and organisations who you may wish to speak to as part of your involvement activity please contact Public.Involvement@borders.scot.nhs.uk

Section 4 |Working Together

We will work effectively together to achieve the aims of the engagement

Now that you have a plan for your engagement activity which details the purpose, scope and timescale of the engagement, the actions to be taken, and the relevant stakeholders to involve, you need to consider how you will work effectively together.

To be clear on who is doing what, it is sensible to define the roles of the people who are involved, the responsibilities that they have, and to outline what their contribution will be. You can capture this information in 'Terms of Reference' for the engagement activity which can be shared with everyone who is involved.

A example 'Terms of Reference' template can be found here at page 23.

Good relationships

It is very likely when undertaking engagement activity that there will be differing views amongst the various stakeholder groups involved. It is important to set the ground rules for working together from the outset.

The ground rules should be based on;

Trust – be open and honest in your thoughts and actions
Respect – value each other's input and find solutions based on collective insight, wisdom and creativity
Self awareness – take responsibility for your words and actions and don't let negative emotions impact the people around you
Inclusion – welcome the opinions of others and factor their insights and perspectives into your decision making
Open communication – open and honest communication leads to better connections

Ensure that people involved know where to go if they wish to raise an issue and try to deal with any conflict as it arises.

Across the Borders there is a network of organisations and groups who can help support involvement activity to ensure that we work effectively together. For further information please email Public.Involvement@borders.scot.nhs.uk

Borders Community Action
(Third Sector Interface (TSI)

Physical Disability Strategy Group

Borders Older Peoples Pathway Project

Borders Older Persons Forum

Mental Health Forum

Learning Disability Citizens Panel

The Alliance
Borders Care Voice
Borders Carers Centre

Area Partnerships
Community Meetings
(Locality Working Groups)
Community Council Network
What Matters Hubs
Loca I Area Coordination Teams

Public Involvement Members
'Hear From You' Network

Section 5 | Methods[5]

We will use methods of engagement that are fit for purpose

Different methods of engagement offer different things to the people who are participating in the engagement.

It is important to select appropriate methods of engagement to meet the purpose, scope and timescale of your activity. It is also important to be clear with participants about the method of engagement on offer and what range of opportunities there will be for them to be involved. This helps manage expectations and allows people to make an informed choice about how and when to engage. Wherever possible you should include people and groups in discussions about how they would like to be engaged.

Inform (One way flow of information)

Purpose

- to provide balanced and objective information
- to inform those with an interest in the outcome (i.e. stakeholder groups)
- information may need to be tweaked to meet differing needs of stakeholders (i.e. accessibility requirements)

Offer to participants

- we will keep you informed
- we will provide information openly and transparently
- we will not withhold relevant information

Involve / Engage

Purpose

- to work directly with participants throughout the decision making process, ensuring that their concerns and aspirations are understood and considered
- to enable participants to directly influence the decisions or options developed (active participation)

Offer to participants

- we will keep you informed
- we will work with you to ensure that your concerns and aspirations are directly reflected in the outcomes or alternatives developed
- we will provide feedback on how your input has influenced the outcome
- we will ensure that there are a variety of engagement methods available and these will be selected appropriately to meet stakeholder needs

[5] Reference material at Participation Framework - gov.scot (www.gov.scot)

Consult (Two way process)

Purpose

- a structured process to obtain feedback on a specific issue or proposal
- to inform those developing proposals or making the decision
- the consultation process must always be applied to any potential changes that may be considered major service change

  key issues that are relevant for identifying when a proposed service change might be classed as 'major' include:
  - > the impact on patients and carers
  - > changes in the accessibility of services
  - > emergency and unscheduled care
  - > public or political concern
  - > conflict with national policy or professional recommendations
  - > changes in the method of service delivery
  - > financial implications, and
  - > consequences for other services

Offer to participants

- we will keep you informed
- we will listen to and acknowledge your concerns and aspirations
- we will give serious consideration to your contributions
- we will be open to your influence
- we will provide feedback on how your input has influenced the outcome

Once the appropriate method of engagement has been selected for your activity you will need to create a communications and engagement plan to underpin the activity.

Section 6 | Communication

We will communicate clearly and regularly with the people, organisations and communities affected by the engagement

It is a good idea to summarise all the information that you have put together in a communications plan to underpin your engagement activity. The plan can be a very simple document which summarises:

What (you are doing)
Why (you are doing it)
Who (is involved)
When (it is happening)
Where (people find out more / get involved etc)
How (the methods of communication you will use and the frequency of those communications).

It is also important to communicate the results of your engagement activity and inform stakeholders of what happens next.

You should have all the information to hand to include in your plan if you have followed the steps outlined in this framework. A basic template[6] for your communications plan can be downloaded here

[6] Reference material at Communication and engagement planning | HIS Engage

Section 7 | Impact

We will assess the impact of the engagement and use what has been learned to improve our future community engagement

In order to find out whether you have achieved what you set out to do, you need to monitor and evaluate the engagement activity to determine whether it meets its purpose.

Evaluation can help our understanding of involving people in four main ways, helping to:
- clarify the objectives of the exercise by finding practical ways to measure success
- improve project management by building in review and reflection as the work progresses
- improve accountability by reporting what is done and what has been achieved
- improve future practice by developing evidence about what works and what impact different approaches to participation can have.

Evaluating involvement activity can feel complex but thinking about it at the beginning of your involvement activity and building it in as an integral part of the project from the outset will help. By building in clear performance criteria, goals and desired outcomes you will generate learning and results from your involvement activity and improve the way you involve people in the future.

Evaluation should focus on two aspects; the way in which involvement has been undertaken (process), and the results of the involvement activity (outcomes).

Three key questions

1. **What did we do? (process)**
   What were the objectives?
   What methods were used?
   How many people did we reach and how diverse a population were they?

2. **How well did we do it? (process)**
   Were the objectives met?
   What worked well and not so well?
   Were the methods and techniques appropriate?
   What could be improved?

3. **What impact did it have? (outcomes)**
   Did it achieve intended outcomes?
   What was the impact on people or services?

Stages of Evaluation

To help keep the evaluation of your involvement activity as simple as possible there are three stages;

1. **Developing an evaluation framework and data collection tools**
   - do this at the beginning of your involvement activity linked to your aims and objectives
   - decide what your goals are and agree how you will measure them
   - think about the type of data you will collect; quantitative, qualitative or a mix of both
   - for qualitative data think about the questions you will ask to get the information you want

2. **Collecting and analysing data**
   - collect your data in line with the plan you made at stage one
   - think about how you are recording and storing the data you have collected
   - make sure that you are compliant with General Data Protection Regulation (GDPR). Information governance colleagues will be able to assist you if you have questions about data protection
   - analyse your data – what does it tell you?

3. **Reporting, sharing and responding to results**
   - decide which results need to be communicated
   - think about the best way to communicate them – you might use a variety of ways depending on your audience
   - prepare the results of your activity in the appropriate way(s)
   - share the results – again you might want to do this in a variety of ways including a summary version, written report or face to face meeting / event
   - hold a debrief session with relevant people so that learnings from your activity can be fed into future projects

Supporting materials

Supporting materials to help you select the method of evaluation that is right for your engagement activity are available in the Evaluation Toolkit.

Reference Materials

The development of the framework took account of the following duties and guidance.

- NHS Reform (Scotland) Act, Section 7: Duty to encourage public involvement - www.legislation.gov.uk/asp/2004/7/contents
- Equality Act 2010 - www.legislation.gov.uk/ukpga/2010/15/contents
- Fairer Scotland Duty (2018) - https://www.gov.scot/publications/fairer-scotland-duty-guidance-public-bodies/
- Community Empowerment (Scotland) Act 2015 - https://www.legislation.gov.uk/asp/2015/6/contents/enacted
- Human Rights Act 1998 – https://www.gov.scot/policies/human-rights
- Planning with People- Community engagement and participation guidance for NHS boards, Health and social care partnerships and Local Authorities that are planning and commissioning care services in Scotland, Scottish Government and COSLA (April 2023)
- CEL 4 (2010) Informing, Engaging Consulting People in Developing Health and Community Care Services, Scottish Government 2010 - www.sehd.scot.nhs.uk/mels/CEL2010 04.pdf
- The National Standards for Community Engagement (2016), Scottish Community Development Centre
- The Quality Framework for Community Engagement and Participation, Healthcare Improvement Scotland (May 2023)
- Participation Framework, Scottish Government (February 2023)
- Planning and delivering integrated health and social care: guidance. Scottish Government (December 2015) – Integration planning and delivery principles

Mental Health Co-production Charter https://borderscarevoice.org.uk/co-production-charter-2/

This page is intentionally left blank

Scottish Borders Health and Social Care Partnership Integration Joint Board

20 September 2023

Unscheduled Care Surge Planning and Delayed Discharge Trajectory Update

Scottish Borders Health and Social Care PARTNERSHIP

Report by Chris Myers, Chief Officer

1. PURPOSE AND SUMMARY

1.1. **To appraise the Integration Joint Board of progress following its consideration of the need for enhanced surge planning and the associated direction that was approved in its meeting on 19th July 2023.**

1.2. The Direction followed escalation by the Health and Social Care Partnership (HSCP) Joint Executive to the Integration Joint Board based on deteriorating local unscheduled care performance, and the increased associated risk.

1.3. A new surge plan and associated delayed discharge trajectory and associated surge plan is enclosed that has been approved by the Health and Social Care Partnership (HSCP) Joint Executive Team, and considered by the NHS Borders Resource and Performance Committee.

1.4. As this is a complex plan, involving actions from across the HSCP, there are a number of risks associated with this plan, but work will be undertaken by the HSCP Joint Executive Team to manage performance and risk as effectively as possible.

2. RECOMMENDATIONS

2.1. **The Scottish Borders Health and Social Care Integration Joint Board (IJB) is asked to**

a) Note the progress made by the HSCP Joint Executive Team on actions which support surge planning
b) Note the delayed discharge trajectory

3. ALIGNMENT TO STRATEGIC OBJECTIVES AND WAYS OF WORKING

3.1. It is expected that the proposal will impact on the Health and Social Care Strategic Framework Objectives and Ways of Working below:

Alignment to our strategic objectives					
Rising to the workforce challenge	Improving access	Focusing on early intervention and prevention	Supporting unpaid carers	Improving our efficiency and effectiveness	Reducing poverty and inequalities
X	X	X	X	X	X

Alignment to our ways of working					
People at the heart of everything we do, and inclusive co-productive and fair	Good agile teamwork and ways of working – Team Borders approach	Delivering quality, sustainable, seamless services	Dignity and respect	Care and compassion	Openness, honesty and responsibility
X	X	X	X	X	X

4. INTEGRATION JOINT BOARD DIRECTION

4.1. A Direction is not required

5. BACKGROUND

5.1. Further to the Integration Joint Board meeting which considered the position escalated by the HSCP Joint Executive Team, the approved direction was issued to NHS Borders and the Scottish Borders Council.

5.2. Officers within the Health and Social Care Partnership have held a surge planning workshop on 31 July 2023 to consider existing programmes of work under the HSCP Urgent and Unscheduled Care Programme Board that could potentially have a positive impact on hospital occupancy, that could be further accelerated, with minimal resource impact. Following the workshop, further work was undertaken to assess the risks and feasibility associated with these initiatives.

5.3. In addition, work has been progressed to outline the impacts of the additional £1.9m investment agreed for older adult services by the Integration Joint Board in their 2023/24 budget, and the associated Scottish Borders Council budget offer.

5.4. This paper notes the progress and outputs of this process. It must be noted that there a range of risks further outlined in the risks and mitigations sections (7.13 and 7.14).

6. OUTPUTS

6.1. The following areas of impact from an early intervention and prevention perspective have been identified:

- A focus on improving vaccination uptake for Health and Social Care staff to 75% uptake
- A focus on nutrition, hydration and anticipatory care planning in Care Homes
- Continued work to progress Hospital at Home
- Communications to promote self care, community supports, Values Based Health and Care and the Right Care, Right Place, Right Time agenda
- Commissioning of the third sector

6.2. The following areas of impact from a process and transformation perspective have been identified, with impacts on bed occupancy noted in brackets:

- Home to Assess as a core component of the integration of Home First and Adult Social Care Home Care services (impact of 18)
- Development of the Medications Administration service within Home First (impact of 15)
- Single assessment through a re-ablement assessment (reduced length of stay and improved process)

- Effective Discharge Implementation Programme (reduced length of stay and improved process)

6.3. The following areas of impact from an investment perspective have been identified, with impacts on bed occupancy noted in brackets:

- Improved carer supports, including the opening of 4 high dependency bed based respite
- Poynder Apartments (36 total units, with 9 forecast from the Hospital system)
- Upper Deanfield step down care and Waverley (9 giving forecast impact of 12 to the end March)
- Further commissioned step down beds (18 giving forecast impact of 33 to the end March)

7. IMPACTS

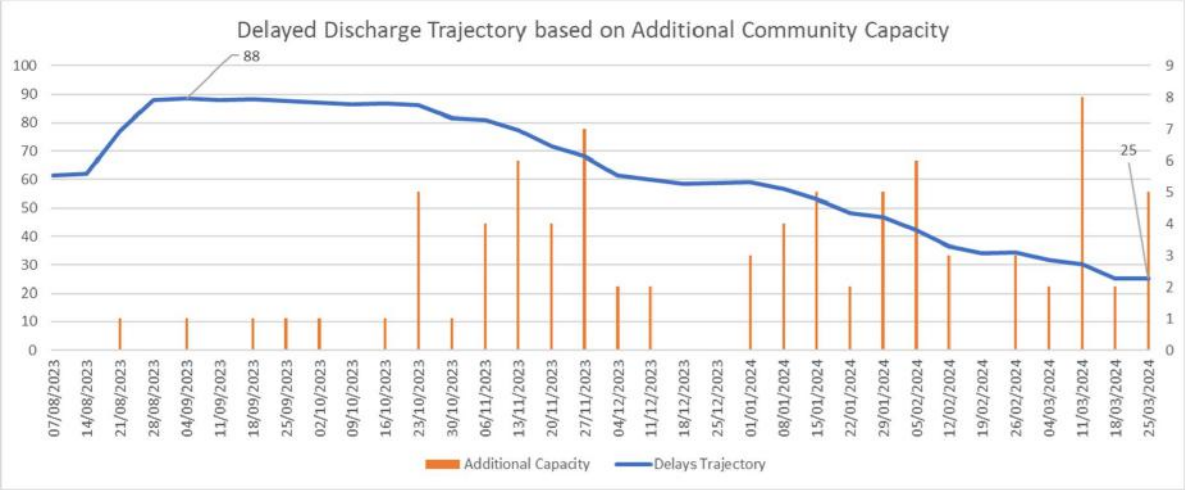
Community Health and Wellbeing Outcomes

7.1. It is expected that the proposal will impact on the National Health and Wellbeing Outcomes below:

N	Outcome description	Increase / Decrease / No impact
1	People are able to look after and improve their own health and wellbeing and live in good health for longer.	Increase
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.	Increase
3	People who use health and social care services have positive experiences of those services, and have their dignity respected.	Increase
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	Increase
5	Health and social care services contribute to reducing health inequalities.	Increase
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.	Increase
7	People who use health and social care services are safe from harm.	Increase
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.	Increase
9	Resources are used effectively and efficiently in the provision of health and social care services.	Increase

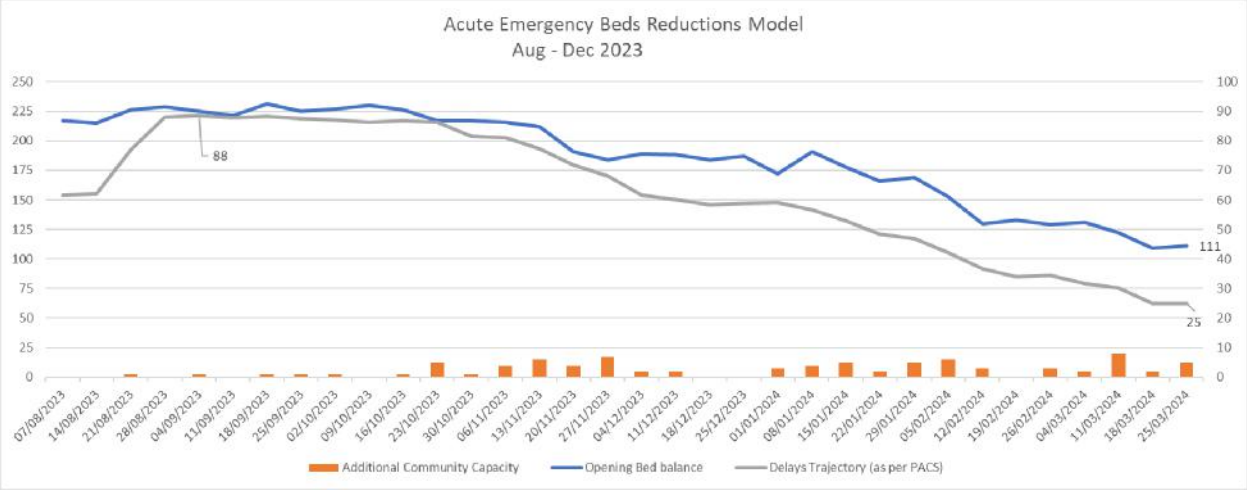
Delayed Discharge Trajectory

7.2. Based on an assumption that both core demand and activity remain as they were over the 26 week preceding period (27 February – 31 August 2023), with core demand of 12.8 / week versus core removals of 12.4 a week, and that the additional actions fully deliver, the additional actions noted above are expected to have the following impact on the number of Delayed Discharges across all hospital sites.



Surge Beds Closure in Borders General Hospital

7.3. In turn, based on bed occupancy from 22/23, the additional actions are expected to have the following impact on the number of Acute emergency beds required in the Hospital system.



Financial impacts

7.4. There is an opportunity for a reduction of large hospital set aside financial costs through the actions outlined in this paper to close surge beds. This would include the closure of Blue ED, surge in Ward 7 and Borders View surge.

7.5. The actions outlined are expected to reduce the nursing overspend from a baseline overspend of £148k/ month = £1,779k per annum, by £43k/ month. Over the remainder the financial year this would reduce the overspend by £392k to £1,387k.

7.6. Impacts are noted in the table below, but depend on the delivery of the actions described to enable closure of surge capacity, along with acute hospital occupancy aligning to the forecast.

Surge closure	Timescales and associated reduction in spend
Blue ED closed and 10 beds of the 37 in MAU ringfenced mid Nov	Mid Nov to March = **£194k**

Shutting surge in Ward 7 Mid December	Mid Dec to March = **£151k**
Shutting 8 beds in Borders View from Mid-January will reduce staffing in Borders View by 5.19wte HCSW	Mid-January to March **= £47k**
Baseline surge nursing staffing spend £148k/ month = £1,779k Spend reduced to £43k/ month with closure of surge noted Projected spend on surge beds in 23/24 with surge closure plan - £1,387k	
Total reduction in expenditure to March 24 - **£392k**	

Equality, Human Rights and Fairer Scotland Duty

7.7. Stage 1 Proportionality and Relevance has been completed. As this surge closure programme depends on the impacts of a range of other projects, associated Equality and Human Rights Impact Assessments are being undertaken, where relevant, for each of these projects.

Legislative considerations

7.8. The principles of integration set out in the Public Bodies (Joint Working) (Scotland) Act 2014 included ensuring that available facilities, people and other resources are used most effectively and efficiently, in a way that anticipates the needs (and prevents them arising) of a population with increased level of need.

7.9. Integration Authorities are responsible for strategic planning, in partnership with the hospital sector, of those hospital services most commonly associated with the emergency care pathway, alongside primary and community health care and social care. This is known as the "Set Aside" budget.

7.10. The objective is to create a coherent single cross-sector system for local joint strategic commissioning of health and social care services and a single process through which a shift in the balance of care can be achieved.

7.11. Legislation permits that where a planned change is delivered resource will be able to be transferred between the Delegated Budget and the Set Aside budget for directed hospital services, via a Direction from the Integration Authority to the delivery partners. In the case of an increase in consumption, the Integration Authority will need to consider how to fund the additional capacity through the Strategic Plan. Similarly, where resource is released, the Integration Authority will be able to consider how to use this resource through the Strategic Plan.

Climate Change and Sustainability

7.12. There are no known climate change or sustainability impacts.

Risk and Mitigations

7.13. Unscheduled care surge pressures impact on IJB Strategic Risk 002: "If we fail to ensure the effective delivery of outcomes/delegated services within the available budgets then it could lead to poorer outcomes and an inability to deliver the Strategic Commissioning Plan / Strategic Framework." The approach outlined in this paper is expected to reduce this risk.

In addition, the following risks have been identified. These will all be closely managed through the HSCP Joint Executive, and the HSCP Urgent and Unscheduled Care Programme Board.

	Risk	RAG
Capacity	There is a risk that gains made through the closure of beds (offset by community capacity) still leaves the hospital at 100% occupancy	
	There is a risk that additional community capacity does not have a targeted length of stay/adequate turnover to ensure robust flow (externally)	
	There is a risk that the additional capacity released does not match the patients currently delayed in Acute, therefore the overall beds gain Acute is reduced.	
Occupancy/Surge	There is a risk that failing to achieve 90% occupancy on the funded unscheduled bed base will impact elective requirements	
	There is a risk that Acute surge is the only feasible surge action (Community Services unable to support surge actions)	
	There is a risk to delivery of elective surgery programme	
	There is a risk that additional community capacity does not provide ongoing flow across Acute which will exacerbate congestion/overcrowding in ED	
	There is a risk that the patients delayed across the Acute setting do not match the criteria set for Borders View	
Staffing	There is a risk that increased sickness absence due to increased levels of movement across BGH (proposed bed closures will require repurposing existing resource)	
Community Capacity	There is a risk that enabling meds administration will not deliver predicted gains. There is a risk that the integrated reablement project will not be able to go through the organisational change process/ restructuring in order to impact current DDs.	
Engagement	There is risk that this plan will be perceived inaequate by system partners based on historical commitments to Winter	

8. CONSULTATION

Communities consulted

8.1. Over and above the communities consulted through the individual underpinning projects, the following groups have been consulted:

- HSCP Urgent and Unscheduled Care Programme Board

8.2. Over the coming months, as the work continues to evolve, the following groups will be consulted:

- Unpaid Carers – Carers Workstream
- Staff – Joint Staff Forum
- GP Subcommittee
- IJB Strategic Planning Group

Integration Joint Board Officers consulted

8.3. The IJB Board Secretary, the IJB Chief Financial Officer, the IJB Chief Officer and Corporate Communications have been consulted, and all comments received have been incorporated into the final report.

8.4. In addition, consultation has occurred with our statutory operational partners at the:

- HSCP Joint Executive
- NHS Borders Resources and Performance Committee

Approved by:

Chris Myers, Chief Officer

Author(s)

- Chris Myers, Chief Officer

- Philip Grieve, Chief Nurse
- Bhav Joshi, General Manager, Acute Unscheduled Care

Background Papers:
Scottish Borders Health and Social Care Integration Joint Board 19 July 2023. Surge Planning. Available from: https://scottishborders.moderngov.co.uk/ieListDocuments.aspx?CId=218&MId=6536&Ver=4

Scottish Government. Financial planning for large hospital services and hosted services: guidance. Available from: https://www.gov.scot/publications/guidance-financial-planning-largehospital-services-hosted-services/

Previous Minute Reference:
Scottish Borders Health and Social Care Integration Joint Board 19 July 2023. Meeting minutes, Surge Planning. Available from:
https://scottishborders.moderngov.co.uk/ieListDocuments.aspx?CId=218&MId=6537&Ver=4

For more information on this report, contact us at:
- Unscheduled Care Surge Planning : Bhav Joshi bhav.joshi@nhs.scot
- Delayed discharge trajectory : Philip Grieve philip.grieve@borders.scot.nhs.uk

Scottish Borders Health and Social Care Partnership

Equality, Human Rights and Fairer Scotland Duty Impact Assessment – Stage 1 Proportionality and Relevance

Completion of the template below will give senior officers the confidence that the Equality Duty, the Scottish Specific Public Sector Equality Duties, Human Rights and the Fairer Scotland Duty have been considered at the beginning of and throughout the proposal development and that action plans are in place, where applicable, which identify relevant stakeholders and the undertaking robust consultation to deliver a collaborative approach to co-producing the E&HRIA.

What Integration Joint Board (IJB) report or Partnership decision does this proportionality and relevance assessment relate to:

Urgent and Unscheduled Care Programme Board: Surge planning and delayed discharge trajectory

Relevant protected characteristics materially impacted, or potentially impacted, by proposals (employees, clients, customers, people using services) indicate all that apply

Age	Disability Learning Disability, Learning Difficulty, Mental Health, Physical Autism/Asperger's	Gender	Gender Reassignment	Marriage and Civil Partnership	Pregnancy and Maternity	Race	Religion and Belief (including non-belief)	Sexual Orientation
✓	✓	✓		✓		✓	✓	✓

Equality and Human Rights Measurement Framework – Reference those identified in Stage 1 (remove those that do not apply)

Education	Work	Living Standards	Health	Justice and Personal Security	Participation
Higher education Lifelong learning	Employment Earnings Occupational segregation Forced Labour and trafficking*	Poverty Housing Social Care	Social Care Health outcomes Access to health care Mental health Reproductive and sexual health* Palliative and end of life care*	Conditions of detention Hate crime, homicides and sexual/domestic abuse Criminal civil justice Restorative justice	Political and civic participation and representation Access to services Privacy and surveillance Social and community cohesion*

				Reintegration, resettlement and rehabilitation*	Family Life*

*Supplementary indicators

Main Impacts	Are these impacts positive or negative or a combination of both	Are the impacts significant or insignificant?
People who use health and social care services are safe from harm	Positive	Significant
People who use health and social care services have positive experiences of those services, and have their dignity respected.	Positive	Significant
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.	Positive	Significant

Is the proposal considered strategic under the Fairer Scotland Duty?	Yes

E&HRIA to be undertaken and submitted with the report – No, The Surge Plan and Delayed Discharge trajectory are expected to have a positive impact on people by ensuring that they better get access to the right care, in the right place, at the right time. The plan provides the summary of the work of a number of component projects. These projects each have a stage 1 IIA undertaken and if proportional and relevant, stages 2 and 3 are completed. The projects include:	**Proportionality & Relevance Assessment undertaken by:** **Name of Officers:** **Chris Myers** **Date:** **07/09/2023**

• Hospital at Home • Covid-19 and Flu Vaccination programmes • The integration of Home First and Adult Social Care and Home to Assess • Promotion of nutrition, hydration and anticipatory care planning in care homes **If no – please attach this form to the report being presented for sign off**	

This page is intentionally left blank

Scottish Borders Health and Social Care Partnership Integrated Joint Board

20 September 2023

Scottish Borders HSCP Learning Disability Service Coming Home Programme

Scottish Borders Health and Social Care PARTNERSHIP

Report by Simon Burt – General Manager Mental Health and Learning Disability Services

1. PURPOSE AND SUMMARY

1.1. To seek support of the Integrated Joint Board regarding the initiatives being developed in Scottish Borders towards achieving the Scottish Governments strategic aims set out in the "Coming Home: A Report on Out-of-Area Placements and Delayed Discharge for People with Learning Disabilities and Complex Needs" and the 'Coming Home Implementation: report from the Working Group on Complex Care and Delayed Discharge' (2022**).**

Summary of the main points of the report

1.2. The 2018 Scottish Government report, "Coming Home: A Report on Out-of-Area Placements and Delayed Discharge for People with Learning Disabilities and Complex Needs" concluded that all adults with learning disabilities, including those with complex needs, should experience meaningful and fulfilled lives close to home. There is an urgent need to address this and an expectation that this should be achieved by March 2024.

1.3. Scottish Government will be monitoring Health & Social Care Partnerships progress in achieving these strategic aims through the "Dynamic Support Register".

1.4. Locally we have a total of 17 people who have complex support needs who require suitable accommodation and support locally. 5 of the 17 currently live within the Borders and the remaining 12 are out of area requiring to return home. 3 of the 17 are under 18 years of age.

1.5. We have assessed 8 of the 17 individuals are likely to need alternative accommodation and support within the next 12 months, 6 within the next 24 months and the remaining 3 at some point in the future.

1.6. Our modelling indicates that there will be an average future demand of 3 new people per year.

1.7. Our modelling also indicates that on average we require 2 specialist inpatient beds for adult with learning disabilities and complex needs. We have no such beds within the Borders. We are therefore dependent upon expensive private specialist beds within England due to lack of availability throughout Scotland.

1.8. Locally, we have developed the "Coming Home Programme" which will oversee the development of services for those in scope.

1.9. We currently have 4 work streams reporting into a Coming Home Programme Board:

- Supported Living Service (previously known as Tweedbank Supported Living Service)
- Kelso Supported Housing
- Lives Through Friends
- Remaining and future demand (Individual assessment and care management led support planning)

2. RECOMMENDATIONS

2.1. **The Scottish Borders Health and Social Care Integration Joint Board (IJB), SBC H&SC Partnership Executive and the IJB Strategic Planning Group is asked to: -**

a) Support the initiatives being developed to achieve the Scottish Governments strategic aims set out in the "Coming Home: A Report on Out-of-Area Placements and Delayed Discharge for People with Learning Disabilities and Complex Needs" and 'Coming Home Implementation: report from the Working Group on Complex Care and Delayed Discharge' (2022**).**

b) Note that Scottish Government will be monitoring H&SC partnerships progress in achieving the Strategic aims set out in the reports in 2.1a via the "Dynamic Support Register".

c) Note that based upon our current forecasts, to deliver placements for all 17 people in scope creates a financial plan gap.

d) Develop a future funding model between NHS Borders, Scottish Borders Council and the IJB, which will require resources to be identified within the totality of the IJBs financial plan.

e) The Integration Joint Board remits the Chief Officer to escalate the funding risk to the Scottish Government on behalf of the Integration Joint Board and the Health and Social Care Partnership, and to seek a national risk share approach to better support the financial risk for areas with relatively smaller populations.

3. ALIGNMENT TO STRATEGIC OBJECTIVES AND WAYS OF WORKING

3.1. It is expected that the proposal will impact on the Health and Social Care Strategic Framework Objectives and Ways of Working below:

Alignment to our strategic objectives					
Rising to the workforce challenge	Improving access	Focusing on early intervention and prevention	Supporting unpaid carers	Improving our effectiveness and thinking differently to meet need with less	Reducing poverty and inequalities
x	x	x	x	x	x

Alignment to our ways of working					
People at the heart of everything we do	Good agile teamwork and ways of working – Team Borders approach	Delivering quality, sustainable, seamless services	Dignity and respect	Care and compassion	Inclusive co-productive and fair with openness, honesty and responsibility
x	x	x	x	x	x

4. INTEGRATION JOINT BOARD DIRECTION

4.1. No Direction required

5. BACKGROUND

Reasons for change – Strategic drivers

5.1. The 2018 Scottish Government report, "Coming Home: A Report on Out-of-Area Placements and Delayed Discharge for People with Learning Disabilities and Complex Needs" concluded that all adults with learning disabilities, including those with complex needs, should experience meaningful and fulfilled lives. This covers where individuals live, as well as the services that they receive. The report stressed that some people with learning disabilities and complex needs are living far from home or within NHS hospitals and that there is an urgent need to address these issues.

5.2. One of the recommendations of the recent Independent Review of Adult Social Care is for people to stay in their own communities and to exercise as much autonomy as possible in decisions about their lives.

5.3. On 16 February 2021, in a Parliamentary debate on the Independent Review, the Cabinet Secretary announced the "Community Living Change Fund" which consisted of £20 million "to deliver a redesign of services for people with complex needs, including intellectual disabilities and autism, and those who have enduring mental health problems". A letter to IJB Chief Finance Officers, NHS Directors of Finance and Local authority Directors of Finance (24th March 2021) gave further guidance as to how the Fund should be allocated and emphasised in Annex B, under the sign-off arrangements for accessing the Fund, "must bring in to play the wider resources under discussion, including large hospital budgets (the "set aside"), third sector funding and housing contributions." We do not have any large hospital budgets for LD (set aside). The fund will focus on delivering a proper sense of home for people with complex needs, including those who have encountered lengthy hospital stays or who might have been placed outside of Scotland, and who could, and should, be more appropriately supported closer to home". The full £20m was allocated to Integration Authorities, via NHS Boards, in February 2021. NHS Borders share of this fund is £377,966 (non-recurring).

5.4. On 21st February 2022 Scottish Government produced the "Coming Home Implementation: report from the Working group on Complex Care and Delayed Discharge". Its mission statement was set out as:

"By March 2024 we want and need to see real change with out-of-area residential placements and inappropriate hospital stays greatly reduced, to the point that out-of-area residential placements are only made through individual or family choices and people are only in hospital for as long as they require assessment and treatment."

It went on to recommend that a framework towards implementation is set up named the "Coming Home Implementation Framework". A National Support Panel will be created bringing together expert advice available to HSCPs.

Scottish Government and COSLA have agreed to implement the five key recommendations of the Coming Home Implementation Report which are:

1) Scottish Government and COSLA should make a policy commitment to take forward the proposed framework. There may be a financial implication for Scottish Government, e.g. to set up the Register and to support the Panel, in addition to administrative and civil service support. The

framework may also require legislative support and will sit alongside other relevant ongoing work such as the National Care Service and Mental Health Reviews.

2) The current sample Dynamic Support Register should be developed into a tool for national use. This will require digital and information management expertise and resource to produce a secure and useful electronic database that gives visibility to this hidden population on both a local and national scale.

Detailed operational guidance should be developed for the use of the Dynamic Support Register, co-produced with HSCPs.

3) A National Support Panel should be established in order to provide support and oversight of the Dynamic Support Register. The National Support Panel will bring sector expertise together to provide an open collaborative forum that can troubleshoot individual cases in partnership with local areas. Scottish Government should consult on the precise role and remit in order that the panel provides value and achieves the objectives of reducing inappropriate hospital admissions and out-of-area placements. (Scoping work is included in Appendix Two).

4) A National Peer Support Network should be established to facilitate people coming together to learn and share best practice, and to get support when planning services for individuals with particularly complex care needs. This network should offer support and advice informally to allow cases to be discussed openly and frankly, with input from clinicians, commissioners, social care providers, social workers and family members from around Scotland who have expertise and experience in developing and delivering services to people with learning disabilities and very complex support needs.

5) Recognising the lack of available evidence for people with enduring mental health conditions and the expertise of the contributors to the SLWG, further work should be undertaken to explore the issues in relation to people with enduring mental health conditions who are subject to delayed discharge from hospital. This should include sector experts in mental health and social work, as well as people with lived experience."

5.5. Scottish Government and COSLA have agreed to implement the Dynamic Support Register through a Memorandum of Understanding published on 23rd May 2023.

The Register will, in respect of relevant individuals:

- Aid monitoring, local planning and decision making for those currently in hospital or in out-of-area placements;
- Identify and address risks of breakdown of current support arrangements and admission/re-admission to hospital or out-of-area placement; and,
- Support the development of person-centred and appropriate local community placements.

6. Coming Home Programme – Scottish Borders Health & Social Care Partnership

6.1. The range of needs and potential solutions required to meet the strategic drivers set out above requires a coordinated approach. As such we have set up the "Coming Home Programme".

6.2. The Coming Home Programme's membership includes representation from Children's social work to ensure that we are collaboratively planning for future demand.

6.3. Currently there are 4 work streams sitting under the Coming Home Programme as set out below:

6.3.1 Supported Living Service (previously Tweedbank Supported Living Service)
A paper was presented to the IJB on the 14th September 2021 recommending that it supports the inclusion of the charity Cornerstone to deliver an 8-10 bed housing and support facility at Tweedbank (the Tweedbank Supported Living Service – TSLS) as part of Scottish Borders Tweedbank development plans. Unfortunately, the availability of land on this site has been delayed requiring an alternative approach to increase housing and support capacity. We published a further Prior Intentions Notification (PIN) on 23 August 2023 to set out the demand locally for this type of housing and support with the aim of attracting alternative solutions from the relevant care, support and housing sectors. The previous PIN was issued several years ago and therefore requires updating to ensure that the provider sector has a renewed opportunity to consider our current commissioning priorities for accommodation and support for adults with learning disability and complex needs.

6.3.2 ***Kelso Housing Development***
Eildon Housing Association, as part of a wider housing development in Kelso, have made available two accessible bungalows providing 4 tenancies. These properties will be subject to an agreement between Scottish Borders Council and Eildon Housing Association allowing us nomination rights to these 4 tenancies. 4 possible tenants who have critical needs for this level of support have been identified to occupy these tenancies. Work is underway to ensure that the appropriate commissioning processes are followed to procure the support required.

6.3.4 Lives Through Friends (LTFs)
LTFs are a Social Enterprise with experience of supporting Health & Social Care Partnerships across the UK to design individualised accommodation and support solutions for people with complex support needs. We have commissioned LTF's to support us in developing bespoke accommodation and support for 2 adults and 1 young person who are currently in specialist Learning Disability Hospitals where they are in a position of 'delayed discharge'. Over the next 12 months we will be working with these individuals, their support networks and other key stakeholders to design and deliver suitable accommodation and support arrangements.

6.3.5 Remaining and future demand
The Coming Home Programme Board is currently considering additional projects to meet the housing and support needs of those in scope currently without a housing and support plan in place. We envisage that learning through LTF's will allow us to develop in-house knowledge and skills across the Health & Social Care Partnership and apply this to designing support solutions with both now and in the future.

7. Demand

7. 1 Current demand
As at July 23 we have 14 people distributed across a large geographical area who are within scope as set out within the Coming Home report. There are a further 3 individuals who are 16/17 years of age with complex support needs whom we also need to plan for, as they are currently or will be placed out of area.

Of these 17 individuals:
- 3 are classed as 'delayed discharges' in specialist hospitals
- 9 are in out of area placements
- 5 are living within the Borders and are at risk of placement breakdown

We have estimated approximate likely time frames for each person in scope to find alternative accommodation and support. The table in 8.2 below sets this out. In summary we require 8 placements within 12 months, a further 6 within 24 months and 3 at some point thereafter. It should be noted that these are estimations for which changes in circumstances can significantly alter the required timescales.

7.2 Future Demand

Previous modelling indicates that on average we will require 3 new placements for adults with complex needs going forward. As such we will need to maintain this programme approach to ensure timely and robust accommodation and support plans are in place for individuals with this high level of need.

7.3 Specialist hospital placements

Our modelling also indicates that on average we require 2 specialist in-patient beds for adults with learning disabilities and complex needs. We have no such beds within Scottish Borders and nationally all NHS Scotland inpatient beds are constantly at full capacity. We are therefore dependent upon commissioning expensive specialist private inpatient beds within England.

We are awaiting the redesign of NHS Lothian's specialist Learning Disability in-patient services within which we intend to purchase 2 beds, subject to a further business case being accepted by the IJB.

Currently there is no established budget to commission these beds creating a cost pressure as and when they are required.

1. IMPACTS

Community Health and Wellbeing Outcomes

a. It is expected that the proposal will impact on the National Health and Wellbeing Outcomes below:

N	Outcome description	Increase / Decrease / No impact
1	People are able to look after and improve their own health and wellbeing and live in good health for longer.	increase
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.	Increase
3	People who use health and social care services have positive experiences of those services, and have their dignity respected.	Increase
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	Increase
5	Health and social care services contribute to reducing health inequalities.	Increase
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.	Increase
7	People who use health and social care services are safe from harm.	Increase
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.	Increase
9	Resources are used effectively and efficiently in the provision of health and social care services.	Increase

Financial impacts

8.1 The Community Living Change Fund

As set out in section 5.3 above, Scottish Government have allocated £377k to the H&SC partnership. This is intended to be spent by March 2024. Approximately £50k is currently committed to the LTF's contract.

Beyond that, we anticipate using the funding for transitional costs and capital expenditure upon adaptations as required.

8.2 Spending analysis

The table below sets out the current recurring funding and estimated forecast funding for all 17 people in scope at July 2023:

Ref LDS	Current placement:	RAG	Projects (Kelso, LTF, other supported living -OSL, SL Supported Living	NHS recurring funding £000	SBC recurring funding £000	Total combined recurring funding £000	Forecast cost £000	On-going Variance £000
1	Home In area		Kelso	0	22	22	104	-82
2	Out of area (OOA)		Kelso	0	242	242	188	54
3	Home in area (young person)		Kelso	0	0	0	78	-78
4	OOA (Until May 2024)		OSL	0	227	227	193	34
5	Hospital delayed discharge (Young person)		LTF	0	0	0	458	-458
6	Hospital delayed discharge		LTF 23/24	132	0	132	458	-326
7	Hospital delayed discharge		LTF 23/24	132	0	132	458	-326
12	Family home In area		OSL	0	208	208	264	-56
			Sub total	264	699	963	2,201	-1,238
8	OOA		OSL	75	126	201	264	-63
9	Family Home In area		SL	0	121	121	171	-50
10	Care Home OOA		OSL	0	198	198	264	-66
11	Care Home OOA		OSL	0	264	264	264	0
16	OOA		OSL	140	143	283	264	19
17	Home in area		SL/Kelso	0	20	20	86	-66
			Sub total	215	872	1087	1313	-226
13	Care Home OOA		LTF	0	170	170	196	-26
14	Care home OOA		LTF	0	69	69	196	-127

15	OOA Residential School (Young person)		OSL/LTF	0	0	0	264	-264
			Sub total	0	239	239	656	-417
	2 on-going Hospital placement, assumed to be required on a recurring			761		761	1800	-1,039
				1,240	**1,810**	**3,050**	**5,970**	**-2,920**

Estimate timescales for alternative placement

24 months plus	
12 – 24 months	
0 -12 months	

8.3 Current recurring funding
As set out in 8.2 above, the total current combined annual funding is £3,050k. While the recurring funding deficit in this project is highlighted as £3m, the expenditure on these placements is currently £5.2m (a £2.2m cost pressure). This high level of additional spend is unfunded and is partly due to the fact that we have a small number people who are in high cost hospital placements, some of whom are also delayed discharges. At this point in time there are no alternative suitable placements for these people.

It is important to note that while the coming home project will only increase the current level of expenditure by approximately £0.8m, this will mean that the level of overspend on the funded recurring budget will continue to impact detrimentally on the ability of the partnership to achieve a balanced budget.

8.3.1 The current lack of suitable community alternatives for the 3 people currently delayed in hospital placements (July 2023) needing to be discharged from hospital is currently costing £3,159k pa. which is above current available budget.

8.4 Future predicted spend
As the housing and support arrangements have yet to be finalised for any of the 17 people in scope, estimates of future predicted spend have been made.

Our estimate based upon modelling is that a total of £5,970k will be required to accommodate and support these 17 people. This includes a predicted £1,800k pa for future specialist hospital beds as described below. This is an estimated cost and is subject to change, reflecting the nature of the individual support packages and the timescale for each package being put into place.

8.5 Specialist Hospital beds
As set out in 7.2 above, the Health and Social Care Partnership requires on average 2 specialist inpatient beds pa, commissioning these from the private sector.

We estimate the typical in patient bed to cost circa £900 k pa including enhanced care, but as recent experience has shown this can increase significantly where particular complexities exist.

The partnership therefore needs to maintain £1,800k pa to fund such beds until the NHS Lothian facilities are available. Ongoing inpatient funding will be required to purchase the NHS Lothian beds for which the bed price has yet to be established.

8.7 Future funding model
The current funding model across SBC and NHSB is currently under review. A funding proposal will come back to the IJB Strategic Planning Group and IJB within this financial year. This will include consideration of approval mechanisms and delegated authority for individual packages, arrangements for jointly funded packages and risk share arrangements.

Equality, Human Rights and Fairer Scotland Duty

An assessment of proportionality and relevance to the Equality Act 2010 (Stage 1 Integrated Impact Assessment) was undertaken in July2023, reviewed in September 2023 and is attached for reference. Stage 2 Integrated Impact Assessment Empowering People – Capturing their Views has been undertaken in September 2023 and is attached for reference. This details who was consulted with, what they said and how this has been used to influence and inform the development of the programme.
Stage 3 of the Integrated Impact Assessment – Analysis and Findings is also attached for reference.

Legislative considerations

b. All housing and support solutions are underpinned by existing NHS and Community Care Act legislation. Individual circumstances may require adherence to the Adult with Incapacity (Scotland 2000) Act.

Climate Change and Sustainability

c. The Coming Home Report requires Health & Social Care Partnerships to accommodate people closer to home. Therefore, these housing and support solutions will have a reduced impact on the environment due to the reduction in travel relating to professional support and access to families.

d. Any new build housing solutions will be compliant with the relevant building and environmental standards.

Risk and Mitigations

e. Delayed discharge from hospital

Risk
We currently have 3 people in hospital delayed discharges. Not providing alternative community placements runs the risk of legal challenges and Judicial review.
The cost of private hospital placements is extremely high and a cost pressure to the H&SC Partnership

Mitigation
The 3 people in delayed discharges have been prioritised and community placements are in development to be delivered by March 2024. We estimate that these community placements will significantly reduce costs. The clinical teams at each hospital are aware of the discharge planning.

The risks of not developing alternative community placements

Risk
We are finding the availability of specialist placements for these individuals difficult if not impossible to access both within the Borders, across Scotland and the wider UK. The

placements that are available are increasing in cost, difficult to monitor (due to geographical distance from the Borders) and often don't meet the needs of individuals. This in turn increases cost and reduces their quality of life. The likelihood of placement breakdown and hospital admission, if no other resources are available will also increase. Without a programme to return people to the Borders we will not be meeting Scottish Government's strategic direction to Health and Social Care Partnerships.

Mitigation
The Coming Home Programme is managing the planned return of those in scope utilising a multi-agency approach based upon individual need.

Increase in adults with complex needs living in the Borders
Risk
Currently the majority of the 17 people live out with Scottish Borders are receiving Health services from the host Health service. When these people return to the Borders the Health service will be delivered by our Health Board increasing demand upon resources.

Mitigation
Currently we are assessing the likely impact upon local services. We will take into consideration any estimated increase in demand on services within our Coming Home Programme planning. We will liaise with Primary Care colleagues.

Finance
Risk
The current lack of suitable community alternatives for the 3 people currently delayed in hospital placements (July 2023) needing to be discharged from hospital is currently costing £3,159k pa. Without creating community alternatives, these costs will continue and increase as more people are admitted to hospital where suitable community alternatives are not available

Mitigation
The Coming Home Programme Board is overseeing the planning of more cost effective housing and support solutions for all currently in hospital.

Recruitment
Risk
An increase in the number of people living within the Borders will require a significant recruitment of additional staffing. In the current climate there is a risk that this additional recruitment may not be possible or that it draws staff from other segments of the care and support sector causing shortages elsewhere.

Mitigation
We are working collaboratively with Learning Disability providers with regards to the Coming Home Programme initiatives. Our consultants, LTF's, have experience in other areas in regards to recruitment where, with careful and collaborative workforce planning, we have been assured that recruitment is feasible. The LTFs approach seeks to maximise independence, support from local communities and informal family support evidencing a reducing demand for staffing over time. Other work streams are looking at potentials for some shared accommodation maximising the possibility for shared staffing arrangements.

Placement breakdown
Risk
There is a risk that placements may breakdown due to the complexity of individual's support needs and staff burnout.

Mitigation

The Learning Disability Service has significant experience in providing housing and support arrangements for adults with complex needs. We have excellent partnership working arrangements with our housing and support providers. We have a resilient and committed group of support providers within the Borders. That said, there are a small number of individuals with highly complex support needs whom we are attempting to place within the Borders. Working with LTFs, with expertise in successfully supporting partnerships develop, will mitigate against future placement breakdown. The contract with LTFs includes post placement support to assist with challenges that may arise.

Financial

Risk

Until actual placements are finalised, accurate costs cannot be established. There is therefore a risk that the costs are higher than estimated. Conversely they may also be lower.
Transition costs will also be required where people are moving from an existing placement.

Mitigation

For the 3 patients who are a delayed discharge, we have commissioned LTFs to support us in planning. Their experience is that this approach provides the most cost effective and resilient support arrangements and that costs reduce as people settle into their new accommodation.

The service, within its current budget, is able to accommodate some flow into and out of services. It is likely that some of the additional costs forecast may be met within this normal movement. This is currently being worked through with finance business partners.

The service will look to manage the transition of people moving back to the Borders based upon risk of placement breakdown. This will allow the estimated cost pressure to be managed over several years.

2. CONSULTATION

Communities consulted

a. Assessment and care management processes will be adhered to in relation to planning support around the individual. This takes into account the assessed needs of family and informal caring arrangements where applicable.

In addition, the following groups have been consulted:

- Care Sector – Learning Disability Providers
- Housing Providers – Registered Social Landlords

To be consulted:

- Clinical Groups – NHS Borders Clinical Reference Groups (GP Subcommittee, Area Clinical Forum, Area Dental Committee, Area Pharmacy Committee, Area Optometry Committee)
- IJB– if supported by the Strategic Planning Group
- Health & Social Care Partnership Joint Executive

Integration Joint Board Officers consulted

b. The IJB Chief Officer and the IJB CFO have been consulted. The HSCP Joint Executive have been consulted. The IJB Board Secretary, and Corporate Communications will be consulted, and all comments will be incorporated into the final report.

- IJB Equalities, Human Rights and Diversity Lead has been consulted with, to assure Equality, Human Rights and the Fairer Scotland Duty requirements have been appropriately considered.

c. In addition, consultation will occur with our statutory operational partners at the:
    - IJB Strategic Planning Group

Approved by:
Approved by Chris Myers, Chief Officer IJB.

Author(s)
Simon Burt – General Manager Mental Health and Learning Disability Services

Background Papers:

Coming Home Implementation Report
Equality and Human Rights Impact assessment: Stages 1,2,3

Scottish Borders Health and Social Care Partnership

Equality, Human Rights and Fairer Scotland Duty Impact Assessment – Stage 1 Proportionality and Relevance

Completion of the template below will give senior officers the confidence that the Equality Duty, the Scottish Specific Public Sector Equality Duties, Human Rights and the Fairer Scotland Duty have been considered at the beginning of and throughout the proposal development and that action plans are in place, where applicable, to; identify relevant stakeholders, undertake robust consultation to deliver a collaborative approach to co-producing the E&HRIA.

What Integration Joint Board (IJB) report or Partnership decision does this proportionality and relevance assessment relate to:

Scottish Borders HSCP Learning Disability Service Coming Home Programme

Relevant protected characteristics materially impacted, or potentially impacted, by proposals (clients, customers, employees, people using services) indicate all that apply

Age	Disability Learning Disability, Learning Difficulty, Mental Health, Physical Autism/Asperger's	Gender	Gender Reassignment	Marriage and Civil Partnership	Pregnancy and Maternity	Race	Religion and Belief (including non-belief)	Sexual Orientation
X	x		x			x		x

Equality and Human Rights Measurement Framework – Reference those identified in Stage 1

Education	Work	Living Standards	Health	Justice and Personal Security	Participation
Higher education Lifelong learning	Employment Earnings	Poverty Housing Social Care	Social Care Health outcomes Access to health care Mental health Palliative and end of life care*	Hate crime, homicides and sexual/domestic abuse Reintegration, resettlement and rehabilitation*	Political and civic participation and representation Access to services Social and community cohesion* Family Life*

*Supplementary indicators

Main Impacts	Are these impacts positive or negative or a combination of both	Are the impacts significant or insignificant?
People with Learning Disability who are currently placed out of Scottish Borders due to lack of availability of appropriate support and accommodation or at risk of being placed out of area will return home.	Positive for individuals and their families returning to live/remaining in the Scottish Borders.	Significant

Is the proposal considered strategic under the Fairer Scotland Duty?	Yes

E&HRIA to be undertaken and submitted with the report – Possibly for Project 1	**Proportionality & Relevance Assessment undertaken by:** Susan Henderson Planning and Development Officer 27 July 2023 Reviewed 4 Sept 2023

Equality Human Rights and Fairer Scotland Duty Impact Assessment

Stage 2 Empowering People - Capturing their Views

Scottish Borders HSCP Learning Disability Service Coming Home Programme

(People with learning disabilities will continue to live and be supported in Scottish Borders)

Equality Human Rights and Fairer Scotland Impact Assessment Team

Role	Name	Job title	Date of IA Training
E&HR Service Specialist			
HSCP Senior Mgt Team Member	Simon Burt	General Manager Learning Disability and Mental Health	
Responsible Officer	Susan Henderson	Planning and Development officer	
Main Stakeholder (NHS Borders)	Peter Old	Assistant Team Manager	
Mains Stakeholder (SBC)	Douglas Ireland	Acting Group Manager Learning Disability and Mental health	
Third/Independent Sector Rep			
Service User			

Evidence Gathering (will also influence and support consultation/engagement/community empowerment events)

Evidence Type	Source	What does the evidence tell you about the protected characteristics affected?
What equalities information is routinely collected from people currently using the service or affected by the policy?	MOSAIC and EMIS records Age, Gender, Disability (Learning)	Higher percentage of male population; spread of age from 14-55 (CHECK) Physical disabilities, neurodiversity,
Data on populations in need	National report Coming Home programme LD transitions tracker Scottish Borders Dynamic Support Register	Information on the Scottish Wide data is available here: Coming Home Implementation: report from the Working Group on Complex Care and Delayed Discharge - gov.scot (www.gov.scot)
Data on relevant protected characteristic	Not collated locally	Embedding these into the recently implemented Dynamic Support register will result in collation of this data
Data on service uptake/access	Not applicable	Currently services are in development. Subject to future reporting.
Data on socio economic disadvantage	Financial assessments	18 years plus. All in receipt of welfare benefits. Coming Home Implementation: report from the Working Group on Complex Care and Delayed Discharge - gov.scot (www.gov.scot)
Research/literature evidence	Coming Home Report Coming Home Implementation report	Health inequalities add in SCLD info reports Coming Home Implementation: report from the Working Group on Complex Care and Delayed Discharge - gov.scot (www.gov.scot)
Existing experiences of service information	Winterbourne review; service user family feedback;	Negative experience living far from families; restrictive practices; living in hospital when ready for discharge
Evidence of unmet need	Service referrals; dynamic support register; transitions tracker	People with learning disability and very complex support needs right to be accommodated and live near their families and loved ones is infringed.
Good practice guidelines	no	
Other – please specify		

Risks Identified	Coming Home Implementation: report from the Working Group on Complex Care and Delayed Discharge - gov.scot (www.gov.scot)	Breach people's human rights by detaining them in hospital longer than necessary; Legal action due to failure to comply (Check coming home report); infringing people's rights to choose support, where they live; Families increased costs due to travelling – a negative impact on the Fairer Scotland Duty (socioeconomic impacts0
Additional evidence required		

Consultation/Engagement/Community Empowerment Events

Event 1 – conversations with families impacted

Date	Venue	Number of People in attendance by category*	Protected Characteristics Represented
Various dates in 2023	Individual homes	7 families	Learning Disability; Age;

Views Expressed	Officer Response
Will improve family life by having people closer to family homes.	To gather views from families and evaluate following the move home to Scottish Borders.
Person centered support is essential	Packages of support will be tailored to each person to involve all important people in that person's life, including fostering good relationships with new neighbours and building links in their communities to enhance and sustain their community presence.
Some anxiety if the support breaks down – what then?	Learning disability service to support the support team and each individual in their new accommodation.
Some people would like to be involved in group family meetings	Meetings to be arranged from end September onwards

Event 2 – work with Live Through friends (LTF)

Date	Venue	Number of People in attendance by category*	Protected Characteristics Represented
During 2023	MS teams meetings; in person workshops	3-12	Learning Disability, Age

Views Expressed	Officer Response
LTF currently providing guidance and support to Learning Disability service, individuals, families and co-opting Studio 3 to support robust support planning. Good life planning gathers information to build robust support packages. LTF told us this approach has worked well for other people.	Member of the learning disability service will gather the learning gained from the Good Life Planning approach to share with wider learning disability team to influence and inform future approaches, planning and commissioning.

Event 3 – Conversation with AVATAR

Date	Venue	Number of People in attendance by category*	Protected Characteristics Represented
7/9/23	Conversation with AVATAR	1	Learning disability; autistic people

Views Expressed	Officer Response
Agrees that person centered approach is appropriate and would welcome further conversation when we plan the larger supported housing project.	Will include AVATAR in consultation when moving onto the larger supported housing project and in future learning disability consultations.

Equality, Human Rights and Fairer Scotland Duty Impact Assessment

Stage 3

Analysis of findings and recommendations

Report Title - Scottish Borders HSCP Learning Disability Service Coming Home Programme

Please detail a summary of the purpose of the proposal being developed or reviewed including the aims, objectives and intended outcomes

The 2018 Scottish Government report, "Coming Home: A Report on Out-of-Area Placements and Delayed Discharge for People with Learning Disabilities and Complex Needs" concluded that all adults with learning disabilities, including those with complex needs, should experience meaningful and fulfilled lives close to home. There is an urgent need to address this and an expectation that this should be achieved by March 2024. Scottish Government will be monitoring Health & Social Care Partnerships progress in achieving these strategic aims. This is called the "Dynamic Support Register". Locally, we have developed the "Coming Home Programme" which will oversee the development of services for those in scope.

A future funding model in the IJB between NHS Borders and Scottish Borders Council will require to be developed to support this going

forward. A funding gap needs to be filled to achieve these projects.

Equality Act 2010 – Relevant Protected Characteristics as identified in Stage 1 or during Stage 2 (include none identified at this stage)

Protected Characteristic	Equality Duty	What impact and or difference will the proposal have	Measures to evaluate/mitigating actions
Age	Eliminating discrimination, harassment, victimisation, or any other prohibited conduct	None identified at stage	
	Advancing equality of opportunity	Adults carers will be closer to their adult children and their ability to continue to have a relationship will be enhanced.	Evaluate the impact on family carers 1 year on.
	Fostering good relations by reducing prejudice and promoting understanding	None identified at stage	
Disability	Eliminating discrimination, harassment, victimisation, or any other prohibited conduct	People with a learning disability and complex needs will no longer be accommodated and supported in inappropriate out of area placements.	People currently accommodated outwith, or at risk of being accommodated outwith will return to/remain in Scottish Borders or and reported through the Dynamic Support register.
	Advancing equality of opportunity	People with a learning disability and complex needs will be appropriately supported in area of their choice.	Reporting on success through Dynamic Support Register.
	Fostering good relations by reducing prejudice and promoting understanding	The engagement of 'LivesThroughFriends' will enable conversations to take place in the local community as part of the new approach adopted to deliver positive and sustainable neighbourly / community relationships.	Measured through individuals being actively engaged in their local communities and evidence of natural friendships and networks outside of support arrangements.
Gender Reassignment	Eliminating discrimination, harassment, victimisation, or any other prohibited conduct	The engagement of 'LivesThroughFriends' will enable conversations to take place in the local community as part of the new approach adopted to deliver positive and sustainable neighbourly / community relationships.	Measured through individuals being actively engaged in their local communities and evidence of natural friendships and networks outside of support arrangements.

	Advancing equality of opportunity	**None identified at stage**	
	Fostering good relations by reducing prejudice and promoting understanding	**The engagement of 'LivesThroughFriends' will enable conversations to take place in the local community as part of the new approach adopted to deliver positive and sustainable neighbourly / community relationships.**	**Measured through individuals being actively engaged in their local communities and evidence of natural friendships and networks outside of support arrangements.**
Marriage and Civil Partnership	**Eliminating discrimination, harassment, victimisation, or any other prohibited conduct**	**None identified at stage**	
	Advancing equality of opportunity	**None identified at stage**	
	Fostering good relations by reducing prejudice and promoting understanding	**None identified at stage**	
Pregnancy and Maternity	**Eliminating discrimination, harassment, victimisation, or any other prohibited conduct**	**None identified at stage**	
	Advancing equality of opportunity	**None identified at stage**	
	Fostering good relations by reducing prejudice and promoting understanding	**None identified at stage**	
Race	**Eliminating discrimination, harassment, victimisation, or any other prohibited conduct**	**None identified at stage**	
	Advancing equality of opportunity	**None identified at stage**	
	Fostering good relations by reducing prejudice and promoting understanding	**None identified at stage**	

Religion & Belief including non- belief	**Eliminating discrimination, harassment, victimisation, or any other prohibited conduct**	**The engagement of 'LivesThroughFriends' will enable conversations to take place in the local community as part of the new approach adopted to deliver positive and sustainable neighbourly / community relationships.**	**Measured through individuals being actively engaged in their local communities and evidence of natural friendships and networks outside of support arrangements.**
	Advancing equality of opportunity	**None identified at stage**	
	Fostering good relations by reducing prejudice and promoting understanding	**The engagement of 'LivesThroughFriends' will enable conversations to take place in the local community as part of the new approach adopted to deliver positive and sustainable neighbourly / community relationships.**	**Measured through individuals being actively engaged in their local communities and evidence of natural friendships and networks outside of support arrangements.**
Gender (Sex)	**Eliminating discrimination, harassment, victimisation, or any other prohibited conduct**	**None identified at stage**	
	Advancing equality of opportunity	**None identified at stage**	
	Fostering good relations by reducing prejudice and promoting understanding	**None identified at stage**	
Sexual Orientation	**Eliminating discrimination, harassment, victimisation, or any other prohibited conduct**	**The engagement of 'LivesThroughFriends' will enable conversations to take place in the local community as part of the new approach adopted to deliver positive and sustainable neighbourly / community relationships.**	**Measured through individuals being actively engaged in their local communities and evidence of natural friendships and networks outside of support arrangements.**
	Advancing equality of opportunity	**None identified at stage**	
	Fostering good relations by reducing prejudice and promoting understanding	**The engagement of 'LivesThroughFriends' will enable conversations to take place in the local community as part of the new**	**Measured through individuals being actively engaged in their local communities**

		approach adopted to deliver positive and sustainable neighbourly / community relationships.	and evidence of natural friendships and networks outside of support arrangements.

Equality and Human Rights Measurement Framework Human– Reference those identified in Stage 1 (remove those that do not apply)

Article	Enhancing or Infringing	Impact and or difference will the proposal have	Measures to evaluate/mitigating actions
Education	Higher education and lifelong learning	People will be given the opportunity to learn new skills.	Support plans; participation in activities
Work	Employment Earnings	People will be given the opportunity to learn new skills, may gain access to volunteering opportunities and or supported employment where applicable.	Measure through support plans and local employment statistics.
Living Standards	Poverty Housing Social Care	Adult carers will have reduced travel costs. People will have security of tenure in housing in Scottish Borders.	Maintenance of tenancies
Health	Social Care Health outcomes Access to health care Mental health Palliative and end of life care*	Enhanced models of support will be developed to support these individuals. Close health monitoring between Learning Disability service and Primary Care will improve people's health and wellbeing.	Number of people receiving health checks
Justice and Personal Security	Hate crime	Reduce potential incidence of hate crime due to fostering good relationships in neighbourhoods and local communities.	Number of incidences reported. Invite local safer communities team to participate in families and staff meetings.
Participation	Political and civic participation and representation Access to services Social and community cohesion* Family Life*	People will live closer to families and participate in family and community life	Measured by meaningful connections being made following transition to new support arrangements.

Fairer Scotland Duty

Identify changes to the strategic programme/proposal/decision to be made to reduce negative impacts on equality of outcome and or improving health inequalities	We need to further explore the Good Life planning process with 'Lives Through Friends' to embed into future planning and commissioning approaches.
Identify the opportunities the strategic programme/proposal/decision provides to reduce or further reduce inequalities of outcome and or improving health inequalities	We are currently unable to support this cohort of individuals to return to /continue to live successfully in Scottish Borders, close to family and able to participate in community life.

Are there any negative impacts with no identified mitigating actions? If yes, please detail these below: Not applicable

Equality, Human Rights & Fairer Scotland Duty Impact Assessment Recommendations

What recommendations were identified during the impact assessment process:

Recommendation	Recommendation owned by:	Date recommendation will be implemented by	Review Date
Embed further data collection into the Dynamic Support register	Susan Henderson (Planning and development Officer)	September 2023	September 2024
Meet with AVATAR	Susan Henderson (Planning and development Officer)	March 2024	March 2025
Collate and report on measurements	Susan Henderson (Planning and development Officer)	March 2024	March 2025
Set up families meetings	Susan Henderson (Planning and development Officer)	September 2023	April 2024

Monitoring Impact – Internal Verification of Outcomes

How will you monitor the impact this proposal affects different groups, including people with protected characteristics?

Bi-monthly report to Coming Home Programme Board
Update report to Integration Joint Board
Scottish Borders Equality Outcomes and Mainstreaming Report

Procured, Tendered or Commissioned Services (SSPSED)

Is any part of this policy/service to be carried out wholly or partly by contactors and if so, how will equality, human rights including children's rights and the Fairer Scotland duties be addressed?

Not a route identified at this time

Communication Plan (SSPSED)

Please provide a summary of the communication plan which details how the information about this policy/service to young people, those with a visual or hearing sensory impairment, difficulty with reading or numbers, learning difficulties or English as a second language will be communicated.

Members and IJB briefing papers.
Easy read
Families meetings

Signed Off By

Name: Strategic Lead Simon Burt, General Manager Learning Disability and mental health

Date: 12-09-23

Scottish Borders Health and Social Care Partnership
Integration Joint Board

20 September 2023

Primary Care Improvement Plan Annual Programme Report

Report by Cathy Wilson – General Manager, Primary and Community Services

1. PURPOSE AND SUMMARY

1.1. **To update the Integration Joint Board on progress made with implementation of the Primary Care Improvement Plan (PCIP) for period April 2022 – March 2023.**

1.2. The purpose of this report is to provide a comprehensive overview of the achievements, challenges, and future goals pertaining to the delivery on the commitments outlined in the General Medical Services (GMS) 2018 contract.

2. RECOMMENDATIONS

2.1. **The Scottish Borders Health and Social Care Integration Joint Board (IJB) is asked to:-**

a) note the content of the report attached in the attached report and consider the issues raised in the report.

3. ALIGNMENT TO STRATEGIC OBJECTIVES AND WAYS OF WORKING

3.1. It is expected that the proposal will impact on the Health and Social Care Strategic Framework Objectives and Ways of Working below:

Alignment to our strategic objectives					
Rising to the workforce challenge	Improving access	Focusing on early intervention and prevention	Supporting unpaid carers	Improving our effectiveness and thinking differently to meet need with less	Reducing poverty and inequalities
x	x	x	x	x	x

Alignment to our ways of working					
People at the heart of everything we do	Good agile teamwork and ways of working – Team Borders approach	Delivering quality, sustainable, seamless services	Dignity and respect	Care and compassion	Inclusive co-productive and fair with openness, honesty and responsibility
x	x	x	x	x	x

4. INTEGRATION JOINT BOARD DIRECTION

4.1. A Direction is not required.

5. BACKGROUND

5.1. New GMS GP Contract - 2018

In 2018, a new GP contract was introduced. A new primary care model was to be rolled out to make it easier for people to access care from a wide range of healthcare professionals. The New GMS GP Contract refocused the role of GPs as Expert Medical Generalists (EMGs) working within a Multi-disciplinary Team (MDT). The aim of this is to reduce GP and GP Practice workload. New staff will be employed by Health Boards and will work with practices and clusters.

5.2. The Health Board would be required to shift GP workload and responsibilities to members of a wider primary care multi-disciplinary team when it is safe and appropriate to do so, while also demonstrating an improvement for patient care.

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

5.4. MoU2

SG issued an updated Memorandum of Understanding (MoU2) to Health Boards in July 2021. The revised MoU for the period 2021-2023 recognised what had been achieved on a national level but also reflected gaps in delivering the GP Contract Offer commitments as originally intended by April 2021.

5.5. This revised MoU2 acknowledges both the early lessons learned as well as the impact of the Covid-19 Pandemic and that the delivery of the GP Contract offer requires to be considered in the context of Scottish Government remobilisation and change plans.

5.6. SG advised that all 6 MoU service areas should remain in scope, however following the SG/SGPC letter of December 2020, they agreed that the following services should be reprioritised to the following three services:

- Vaccination Transformation Programme (VTP)
- Pharmacotherapy
- Community Treatment and Care Services (CTAC)

5.7. It is important to note that prior to the MoU2 announcement, other PCIP Borders workstreams were well underway and PCIF commitments attached.

5.8. November 2021

In recognition that nationally several HBs were struggling with the March 2022 deadline, a GP sustainability payment was offered to help cover costs- giving an additional year for implementation of both CTAC and Pharmacotherapy.

5.9. March 2022

By March 2022 the Health Board had delivered VTP in full, partially delivered Pharmacotherapy (level 1 Acute Prescriptions) and CTAC was a still to be delivered. Modelling and planning were complete and implementation was waiting for funding allocation before it could go ahead.

5.10. August 2022

Allocation from Scottish was released in August 2022 and was insufficient for fully implementing CTAC. This triggered a review of the strategic plan as a new model was required to fit within the financial envelope. This led to a reduced model, CTAC Phase 1, providing only phlebotomy services.

5.11. March 2023

As a direct result therefore and without any dialogue with the Board / Partnership regarding how the position on these reserves may have changed since they were brought forward on 01 April 2022 or any legal, contractual or strategic commitments that may have been entered into during the year, the SG has unilaterally deducted the full £1.523m from Scottish Borders 2022/23 PCIF allocation, resulting in no Tranche 2 payment being made.

6. IMPACTS

Community Health and Wellbeing Outcomes

6.1. It is expected that the proposal will impact on the National Health and Wellbeing Outcomes below:

N	Outcome description	Increase / Decrease / No impact
1	People are able to look after and improve their own health and wellbeing and live in good health for longer.	Increase
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.	Increase
3	People who use health and social care services have positive experiences of those services, and have their dignity respected.	Increase
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	Increase
5	Health and social care services contribute to reducing health inequalities.	Increase
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.	Increase
7	People who use health and social care services are safe from harm.	Increase
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.	Increase
9	Resources are used effectively and efficiently in the provision of health and social care services.	Increase

Financial impacts

6.2. As this report serves as a reflection on the previous financial year that concluded in March 2023, it is important to note that a comprehensive overview of the Primary Care Improvement Funding (PCIF) allocation and its impacts on future plans is provided in the full report.

6.3. For detailed information and analysis, please refer to page 45 in the attached report, where you will find a comprehensive breakdown of the financial allocations and their effects on our future initiatives.

Equality, Human Rights and Fairer Scotland Duty

6.4. In 2018, Health Boards were informed that national Health Inequalities Impact Assessment had been conducted, relieving them of the requirement to complete a local PCIP strategic impact assessment. However, starting from April 2023, we now recognise the importance of fulfilling our legal duty by conducting comprehensive impact assessments for PCIP.

6.5. As evidence of our commitment, the recent PCIP Bundle Proposal work and its associated impact assessments for each distinctive workstream exemplify our dedication to compliance with our responsibilities. These assessments provide robust evaluations of the potential effects of our initiatives on equality, human rights, and our fairer Scotland duty.

6.6. Moving forward, we acknowledge the need to complete impact assessments for each outstanding workstream, as emphasised in the recent PCIP 6 Letter. In our next Annual report (due in June 2024), we will seamlessly integrate our findings and patient outcomes under each service of the 2023-2024 report. This integration will ensure patient engagement, transparency, accountability, and a comprehensive understanding of the impact of our plans.

Legislative considerations

6.7. The primary legislative consideration is the delivery of the 2018 GMS contract through the PCIP contract. Implementing CTAC is a core element of this proposal. Delivery of this service will mean we will meet the stipulations in the contract by delivering the services outlined in the Primary Care Improvement Plan.

Climate Change and Sustainability

6.8. Reduced travel in provision of Pharmacotherapy and continued provision of CTAC locally in the community and making this sustainable long terms will mean reduced travel to for associated staff and patients respectively. This will have Carbon reduction impacts and will also decrease impacts of transport on air quality.

Risk and Mitigations

6.9. Failure to deliver PCIP presents a number of strategic and operation risks to the IJB and Health Board:

Risk	Description
Access to Primary Care Services	Providing a CTAC service is essential to providing a safe, equitable and accessible community-based healthcare. By failing to deliver this, it is likely that patient access to primary care will be limited by capacity and that this may vary by practice/location.
Access to Secondary Care Services	The delivery of a primary care CTAC service provides the foundation for an enhanced CTAC model (Secondary Care access to CTAC services), moving workload away from hospital services. Without primary care CTAC this is unlikely to be deliverable.
GP engagement	GP Practices may choose to implement a work to rule approach to various pharmacotherapy and CTAC services – following BMA guidance[5]. This would push activity back to secondary and acute care services increasing pressure at Hospital front door.

GP Sustainability	There is a risk that primary care provision within general practice will be unsustainable and the local population will not have access to adequate primary care services. The Health Board is responsible for the provision of GMS to its local population. Should a GP Partnership give notice on their contract it will be up to the Health Board to find a mechanism to continue service delivery. This may mean undertaking a tender exercise to find another provider or it may mean the Health Board taking on responsibility for service provision and running the practice as a 2c model. There is evidence that 2c practices are more expensive than independent GP practices.
Contract Failure/-Penalties	The Health Board is responsible for delivery of the 2018 GMS Contract. Failure to implement PCIP will result in failure to deliver the contract. Should PCIF funds not be fully utilised, additional 'transitionary' payments will be incurred. These additional payments will represent additional expenditure at no added value.
Management Capacity	The capacity of the existing P&CS management team is insufficient to undertake the potential increased activity that arises from failure to meet the contract and the consequent impact on GP sustainability within Scottish Borders.
Polypharmacy Enhanced Service	Delivery of Polypharmacy savings is predicated on GP engagement. There is a risk that GPs do not have sufficient capacity, or otherwise do not wish to engage with the delivery of the polypharmacy programme.
Polypharmacy Fees	GPs have indicated a rate of £39.60 per review is contingent upon delivery of the proposed investment in PCIP. Should this fail to be delivered the proposed rate would revert to £70.00 per review at an additional cost of up to £243k.
Polypharmacy Savings	There is a risk that the level of savings achieved through polypharmacy reviews is insufficient to support the additional investments identified. Savings are modelled on information provided within the national polypharmacy guidance which indicates a range of between £50-£200 per review (net prescribing cost reduction). Should savings delivery be at minimum levels this would result in net benefit (after GP fees) of £83k. This is insufficient to deliver the required investment and it is likely that the GP fees abatement would therefore be removed and a further liability of £243k incurred in addition to failure to deliver the proposed model. This would result in a net deficit on the polypharmacy service of £160k, although recurring savings of £400,000 would be realised after year 2.

7. CONSULTATION

Communities consulted

7.1. Impact Assessments currently exist in draft mode for outstanding CTAC and Pharmacotherapy models.

7.2. To engage with affected groups, and understand the impact of this proposal on relevant communities, a new engagement exercise will be carried out.

Integration Joint Board Officers consulted

7.3. The IJB Chief Financial Officer and the IJB Chief Officer have been consulted, and all comments received have been incorporated into the final report.

Approved by:

Chris Myers – Chief Officer, Health and Social Care Partnership and IJB

Author(s)

Cathy Wilson – General Manager, Primary and Community Services
Owain Simpson – Senior Project Manager, Primary Care Improvement Plan

For more information on this report, contact us at primary.care@borders.scot.nhs.uk

PCIP Borders
Primary Care Improvement Plan

2023

Primary Care Improvement Plan

Annual Programme Report

PCIP Executive Committee Report

“There is more to be done. As services mature, we need to look more widely at the whole system, taking into account health inequalities and GP sustainability across NHS Borders. We need to be creative in how we are able to deliver the GP Contract and strengthen Primary Care locally.”

- Dr Rachel Mollart

GP Sub-Committee Chair

PAGE OF CONTENTS

Journey 07

Vaccination 10

Pharmacotherapy 13

Community Care and Treatment 21

Community Mental Health 25

Musculoskeletal 35

Urgent Care 41

Community Links Worker Service 43

Premises 44

Finance 45

Acknowledgements 55

Foreword

Notes from the PCIP Executive Chair – Cathy Wilson

In the ever-changing landscape of healthcare, the Scottish Borders has embarked on a journey to transform primary care services through the Primary Care Improvement Plan (PCIP). Last year, faced with financial challenges, we set out on a path of innovation and progress, aiming to implement and deliver the General Medical Services (GMS) 2018 contract.

Looking back on the year ending in March 2023, this report serves as a reflection of the remarkable progress made in implementing the PCIP in the Scottish Borders. With tripartite collaboration and careful allocation of PCIP funding, we have been able to provide significant workforce resources to practices to help meet the needs of our patients. We have adopted an agile and innovative approach, responding to the evolving needs of our patients. The positive impact that this work has had on practice workload and the support it has provided to meet healthcare needs has served as a powerful motivation for all involved.

However, funding availability continues to be our greatest challenge. As we eagerly await national direction regarding future recurring funding allocation to support rapid and full implementation of the GMS contract, we remain dedicated to maximising the potential of our current resources. The PCIP Executive Committee has undertaken meticulous oversight to ensure that every opportunity for improvement is identified – even prepared to make difficult decisions to prioritise and safeguard the services that would have the greatest impact on GP sustainability.

I would like to express my deepest gratitude to our valued patients, GPs, and all the dedicated individuals and organisations that have contributed to the progress and success of the PCIP. Your commitment and unwavering support in our shared goals are deeply appreciated. United in purpose, we are transforming primary care, one milestone at a time. With a deep focus on GP sustainability, we are creating a future where exceptional healthcare is accessible to all – leaving an indelible mark on the wellbeing of our communities.

Notes from the Chair of the GP Executive – Dr Rachel Mollart

Reflecting on the last year of PCIP development in NHS Borders we need to remember a lot has been achieved, with high levels of recruitment and retention across all work streams within the financial envelope from Scottish Government. We have a highly efficient PCIP Executive Committee where decisions are made with rigorous financial scrutiny and tripartite agreement, getting the best value for every pound spent.

Despite this the GMS 2018 GP Contract remains partially delivered following delivery date 1-4-23. GP's are in desperate need of this support. Significant financial challenges for contract delivery have been faced in the last year with Scottish Government withholding a proportion of Tranche 2 money despite PCIP Executive Committee having committed NHS Borders unspent reserve. This has severely limited our ability to develop and expand PCIP work streams. With limited resource, capacity within some work streams is capped resulting in an inability to remove all the designated

workload from GP's. This workload is passed back to GP's to continue to complete when often it is no longer GP's contractual responsibility. As new services mature and become embedded in GP practices, Scottish Government need to follow with commitment to ongoing baselined recurrent funding including uplift for pay awards, work force planning and consideration given to the realistic cost of full contract delivery.

There is more to be done. PCIP Exec plan to expand data collection to allow measurement of efficiency in service provision and value for money; this will be supported with improved data collection systems. As services mature we need to look more widely at the whole system, taking into account Health Inequalities and GP Sustainability across NHS Borders. We need to be creative in how we are able to deliver the GP Contract and strengthen Primary Care locally, with increased investment through saving opportunities or unspent reserves. Expanded delivery of GP Contract and investment in Primary Care will result in improved patient care and outcomes with highly functioning multi-disciplinary teams delivering high value care in community settings; right place, right person, right time.

Notes from the Chief Officer of the Integration Joint Board – Chris Myers

Primary Care providers including General Practices work to support the needs of people across the Scottish Borders as the front door of the health service. However, in the context of increasing need and our rural GP recruitment challenges, access to General Practice was a key theme highlighted by our communities as part of the engagement for our Health and Social Care Strategic Framework.

Our Primary Care Improvement Plan is fundamental in rising to our workforce challenges to improve access. The redesign outlined in this plan, along with the recruitment and training of a significant number of skilled healthcare professionals across our community services, means that we have a more diverse workforce expertly supporting a significant and growing number of people who need access to services in Primary Care, and onward to the broader Health and Social Care Partnership.

I would like to thank everyone involved in the implementation of the Primary Care Improvement Plan for making great strides forward over the past year, so that people who need Primary Care services have improved access and get the right care, in the right place at the right time.

Cathy Wilson
PCIP Executive Chair/General Manager
Primary and Community Services

Dr. Rachel Moüart
Dr Rachel Mollart
GP Sub Chair
GP Executive

Chris Myers
Chief Officer
Integration Joint Board/Health and Social Care Partnership

“United in purpose, we are transforming primary care, one milestone at a time. With a deep focus on GP sustainability, we are creating a future where exceptional healthcare is accessible to all – leaving an indelible mark on the wellbeing of our communities. “

Cathy Wilson – Primary and Community Services General Manager

& PCIP Executive Chair

PCIP Timeline

In 2018, a new GP contract was introduced. A new primary care model was to be rolled out to make it easier for people to access care from a wide range of healthcare professionals.

Funding was to be provided for the streamlining of services and for new staff who would be employed by NHS Health Boards to help maximise the time GPs can spend for caring for those who require their expertise.

It was hoped that this transition would take place over the course of 3 years – this would be locally agreed through Primary Care Improvement Plans (PCIPs) .

2018

PCIP is part of the GP Contract. It is defined through an agreed national Memorandum of Understanding (MoU) between the Scottish Government (SG), the Scottish General Practitioners Committee of the British Medical Association (SGPC), Integration Authorities (IAs) and NHS Boards.

This MoU mandated the delivery of specific priorities aimed at supporting people to access more easily the most appropriate healthcare to meet their needs to in turn release GP Clinical time to allow GPs to focus on their role as Expert Medical Generalists.

SG funding to support the implementation of the MoU has been allocated to IAs through the Primary Care Improvement Fund (PCIF), and locally agreed PCIPs would set out in more detail how implementation of the 6 priority service areas will be achieved.

PCIP Executive April 2019

The PCIP Executive Committee (created in April 2019) is the body which overseas and directs the development and implementation of the PCIP programme in the Borders. Its membership is at senior level and represents the 3 partner organisations – a tripartite agreement between GPs, NHS Borders and the Integration Joint Board (IJB).

A revised version of the Borders PCIP Plan 2018-2021 would be published later in the year.

COVID-19 Pandemic

The PCIP Executive notes the impact of COVID on service delivery. GP Executives of the GP Sub Committee would work closely with NHS Borders to mitigate risks and focus on the recovery and remobilisation progress.

Journey

December 2021

Joint letter SG/SGPC

In December 2021, the Government issued a letter announcing an implementation change order of workstreams recognising which streams would be of more benefits to GP workloads, also the extended deadline for workstreams and also highlighting the contractual burden on Health Boards for non-delivery of these workstreams.

July 2021

MoU2

SG issued an updated Memorandum of Understanding (MoU2) to Health Boards in July 2021. The revised MoU for the period 2021-2023 recognised what had been achieved on a national level but also reflects gaps in delivering the GP Contract Offer commitments as originally intended by April 2021.

This revised MoU2 acknowledges both the early lessons learned as well as the impact of the Covid-19 Pandemic and that the delivery of the GP Contract offer requires to be considered in the context of Scottish Government remobilisation and change plans.

SG advised that all 6 MoU service areas should remain in scope, however following the SG/SGPC letter of December 2020, they agree that the following services should be reprioritized to the following three services:

- Vaccination Transformation Programme (VTP)
- Pharmacotherapy
- Community Treatment and Care Services (CTAC)

It is important to note that prior to the MoU2 announcement, other PCIP Borders workstreams were well underway and PCIF commitments attached.

November 2021

GP Sustainability Payment

In recognition that nationally several HBs were struggling with the March 2022 deadline, a GP sustainability payment was offered to help cover costs- giving an additional year for implementation of both CTAC and Pharmacotherapy.

March 2022

Position

The position at the end of March 2022, against the three priority areas from MoU2, was as follows:

- Vaccination Transformation Programme (VTP) – delivered in full (supported by non-recurrent funding)
- Pharmacotherapy (level 1 Acute Prescriptions) – partially implemented
- CTAC – not yet implemented

Modelling and planning were complete for final implementation however this was paused pending confirmation of resources to support further investment.

August

2022

Scottish Government Annual Allocation

Scottish Government confirmed the 2022/23 PCIF allocation in August 2022. In common with the position across NHS Scotland, the level of funding available to primary care within Scottish Borders was insufficient to meet the projected costs outlined within the local PCIP.

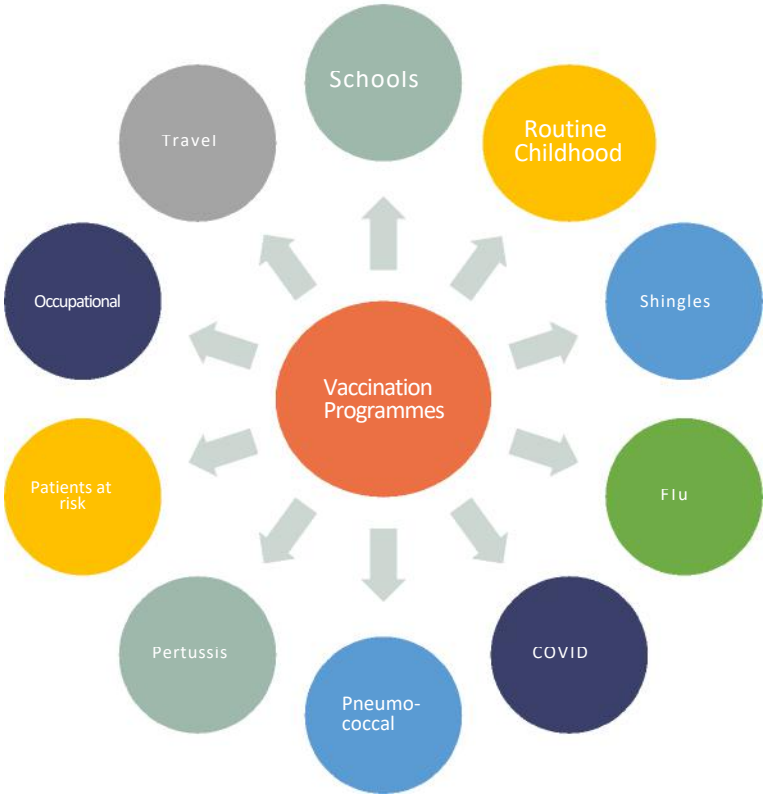
At this stage a strategic review was undertaken which identified a revised CTAC Phase I model to deliver a minimum PCIP commitment. Discussions on implementation were predicated on use of non-recurrent resources held within the IJB reserves to bridge investment pending confirmation of future Scottish Government allocations.

March

2023

Adjustment to Health Board's Funding Allocation

In March 2023 Scottish Government made adjustment to the Health Board's RRL funding allocation to offset slippage on prior year PCIF allocations against funding allocated in 2022/23. This adjustment had the effect of reducing non-recurrent IJB reserves held for PCIP by £1.523m – this triggered a review of Scottish Borders' PCIP strategic plan.



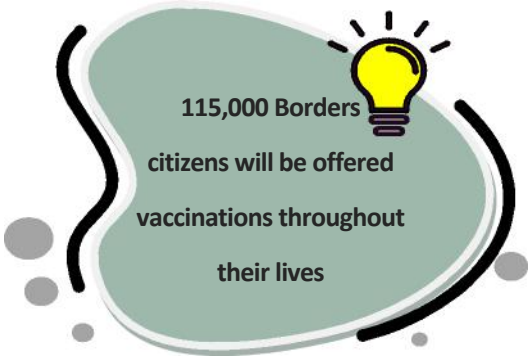
WHAT WE SET OUT TO DELIVER

As per the outcomes of the 2017 GMS contract negotiations, NHS boards and local partners are required to plan, manage and deliver vaccinations rather than the longstanding arrangement of contracting delivery through general practice.

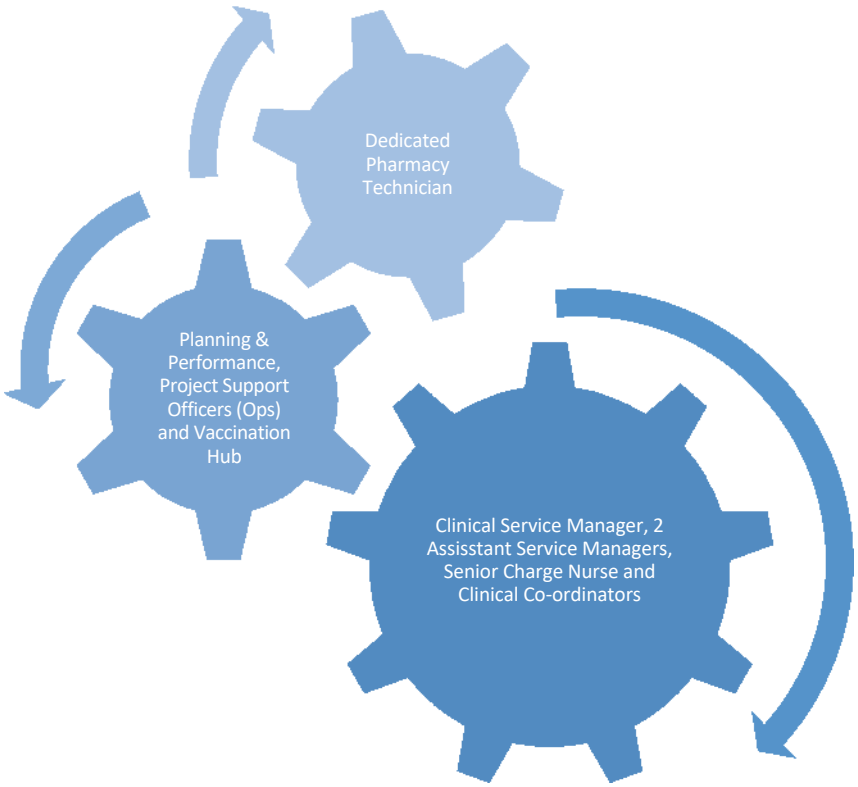
While the UK Joint Committee on Vaccination and Immunisation (JCVI) and Public Health Scotland (PHS) will continue to guide national policy and vaccination programmes, delivery must be managed and implemented by NHS health boards and their local partners to suit their local population, geography and workforce.

Between September 2021 and April 2022, NHS Borders Vaccination Transformation Programme created a dedicated Vaccination Service with responsibility for vaccinations and immunisation, and successfully transitioned all outstanding programmes from GPs to the health board by the required deadline.

NHS Borders Vaccination Service leads the delivery of programmes in partnership with public health, school immunisation, community nursing, occupational health, maternity services, child health, general practice, acute services and the wider Scottish Borders Health and Social Care Partnership.



Vaccination clinics take place on an ongoing basis in health centres, schools, hospitals and community venues across the Borders. Provision is also in place for patients who are housebound or live in residential care.



The service is led by a dedicated Clinical Service Manager, supported by two Assistant Service Managers (Planning and Operational) and the following staff:

- Senior charge nurse, Clinical Co-ordinators, vaccinators (nurses) and healthcare support workers.
- Planning and performance Co-ordinator to manage planning, uptake monitoring, change and improvement Project Support Officers manage clinic set up, logistics, kit and vaccine transport.
- Vaccination Hub for patient contacts, admin and staffing, including a coordinator, supervisors, admin officers and call handlers.
- A dedicated pharmacy technician to manage vaccine provision.

DELIVERY APPROACH

The Vaccination Transformation Programme delivered patient journeys, operating processes, policies, workforce, communications, resources, systems and reporting from scratch to support a new service.

A dedicated “Vaccination Hub” was developed following its introduction during the 2020 flu programme, evolving to provide a single centre of expertise for:

- Call handling and patient appointment booking line (inbound and outbound)
- Clinic administration (registering patients, arriving patients, liaising with clinical staff)
- Staffing support (recruitment, rostering and training support)
- Dedicated administration and operational support
- Clinical operational support (e.g. clinic kit boxes, printing documentation, ad hoc transport requests)
- Caseload and patient list management (e.g. housebound patients, care homes)
- Records management (devolved management, record amendments, issues and data quality)

Covid-19 and other non-PCIP vaccinations

The Vaccination Programme was integral in the successful delivery of Covid-19 Vaccinations. It is important to note that this vaccine along with other non-PCIP vaccines introduced after the PCIP specification was agreed are funded with a separate additional funding stream.

The Vaccination Transformation Programme capitalised on innovations and new technologies to create a streamlined, resilient, people-centred service introducing:

- A new cloud-based telephone system, increasing call capacity, improved patient routing, call queues, options for patient call back, and the capability for call handlers to answer calls remotely.
- Vaccination Management Tool, a national web-based application to support the recording of vaccinations at point of care.
- iPads to support the recording of vaccinations ‘on the move’ and in varied clinic settings.
- National Vaccination Scheduling System to support the appointing of patient en mass by cohort, and a web-based portal allowing patients to book and reschedule appointments online.
- National Clinical Data Store and COVID status app, allowing patients to view their own vaccination status online and automatically pushing data into GP systems.
- Reporting dashboards – sharing concise, visual summaries of uptake, performance and planned appointments.
- Dedicated vaccinations webpage for patients http://www.nhsborders.scot.nhs.uk/vaccinations
- Dedicate vaccinations intranet for NHS staff and partners.

CLINICAL STAFFING BREAKDOWN (31 March 2023)	Permanent		Fixed Term		As & When	
	In Post	Vacant	In Post	Vacant	In Post	Vacant
Clinical Management	2.0	0.0	0.0	0.0	0.0	0.0
VTP (Babies, Pre-School, Travel & Selective)	3.6	0.00	0.00	0.00	0.00	0.00
Adult Vaccinations (Shingles, Pneumo, Flu & CV- 19)	4.0		0.00	0.00	0.54	0.00
School Immunisations	5.06	0.00	0.53	0.00	0.00	0.00
Total:	14.66	0.00	0.53	0.00	0.54	0.00

VACCINATION ACTIVITY & UPTAKE- As of March 2023, the Vaccination Service has given over 493,000 vaccinations, including over 347,00 COVID vaccinations (since December 2020), and 146,00 vaccinations across routine childhood, pneumococcal, shingles, flu, selective and travel programme.

Programme	Vaccinations given	Uptake range
Routine childhood (baby/pre-school)	16,500	94 – 97%
Pneumococcal	7,500	67% uptake – eligible every 5 years 63% uptake 2 – 64 at risk 43% uptake over 65
Shingles	4,000	71% uptake aged 70 -79 71% overall uptake
Selective referrals	500	-
Travel	500	-
Flu	117,00	55 - 93% (all programmes)
COVID	347,00	86 – 99%

"Very efficient service. I did not have to wait to get my vaccinations and was directed straight away to a vaccinator who discussed the vaccines I was getting"

"My husband had an appointment for his jags and asked if could get mine they were very obliging and I came up ¡i today and received both of mine"

"Initially it was tricky to book online and first available appointment was 3 months away. However yesterday my sister suggested I try to reschedule and I got my appointment for today!"

"deserves a medal for being a lovely vaccinator- very kind and put me at ease"

Public Feedback:
Childhood Vaccinations

"The receptionist was so helpful and the vaccinator was child-friendly and she explained properly about the vaccine and the effects after. Very satisfied"

"Very friendly vaccinator who spoke to my child as well as me and made us both feel very comfortable for a quick pleasant visit"

What we set out to deliver

The GMS Contract (2018), subsequent Memorandum of Understandings and the draft directions released in April 2023 outlined a commitment to the development of HSCP (Health and Social Care Partnership) led pharmacotherapy services to support GP workload. Acute prescribing makes up a significant part of day-to-day workload in primary care services and this programme provides solutions to support rapid sustainable improvement.

The programme aims to deliver improvements that:

- enable staff involved in prescribing to work together effectively, and
- enable pharmacotherapy and practice staff to fully utilise their skills sets.

Service Delivery

The original service plan in 2018 for Pharmacotherapy was for 28 whole time equivalent (WTE) completing work raging from the original Level 1 – 3 as per the GMS 2018 contract. NHS Board allocated staff funded prior to PCIP were later removed early on in the plan to refocus on efficiencies, reducing the workforce to 21 WTE with further funding cuts leading to a current workforce of 16wte (Pharmacists and Technicians).

In March 2022, faced with concerns around the delivery of Levels 1, 2 and 3, a survey was sent to all GP practices to better understand which areas could make a significant difference at reducing GP workload. The results indicated that GP Practices prioritised Level 1 work. A technician led service was organised mainly focusing on supporting Level 1 prescribing, hospital discharge letters, clinic letters and repeat prescribing (increasing serial prescribing). This service has continued up until now, the release of the draft directions in April 2023 will necessitate a change in direction of service delivery.

The Pharmacotherapy service is now defined as ‘Management of all acute and repeat prescriptions, medicines reconciliation, performing polypharmacy reviews and serial prescribing (GP to only provide immediate care to prevent injury of a patient or the worsening of a patient’s clinical condition). Making available sufficient staff to ensure that an adequate service continues to be available, during annual leave, sickness absence or parental leave taken by the staff who routinely operate the service.’

Workforce

Based on our 2018 original plan we would have had 1wte member of pharmacy team per 5000 patients, with the reduction in funding available the ratio is now 1wte to 7500 patients. The team consists of staff ranging from Band 4 technicians to Band 8a pharmacists which provide a good spread of skill mix to complete the levels 1-3 pharmacotherapy work.

What has been achieved by March 2023?

Workload

Data collection has been a focus of work. The project began by creating task sheets for staff members to use as a guide in completing assigned work. These sheets include the necessary read codes that need to be referenced. A new read code template includes all the codes required to record the daily work completed by each staff member to maximize the data collected for review. This focus has also gained the support of stakeholders to utilize software now available to us (EMIS Enterprise), which will automatically pull this data from the practices, in contrast to the staff having to run manual searches.

We have learned that practice workload for Level 1 tasks is subject to wide variation (complexity of work assigned to the team, level of experience, skill mix and different practice demographics are key components of this), to minimise variation this is being addressed by standardisation of practice work using the Universal Prescribing Policy and the use of task sheets developed by the team. The suggestion of allocating staff to practices based on treated patients and not practice size would allow a pharmacy service to be provided based on equity rather than equality.

Service Delivery

A wide variance in the work that each practice would like the team to complete, that is the skill set of the team and how work is completed in practice, has led to significant challenges in delivering an equitable service. With this fact now realized, the team has turned their focus in conjunction with the pharmacy support workers to deliver increased serial prescribing as this can benefit many aspects of day-to-day GP practice work. The prompt for an annual review provides patient safety measures.

There has been an initial review to consider developing HUB working for the pharmacotherapy team, this will provide peer support and daily supervision of the team. We also expect hub working to allow sharing of work between staff members. The sharing of workload between staff members is expected to improve workflow implementation for immediate discharge and clinic letters.

Acute Requests

Acute requests are in many practices the main workload assigned to the Pharmacotherapy team. Although difficult to ascertain exact numbers, the team are beginning to take active steps to reduce the quantity by utilising other services available, for example serial prescribing and use of limited repeats. We have taken steps to collaboratively work with Health Improvement Scotland to reduce the numbers, which will increase safety of prescribing and equity in the service.

Serial Prescriptions

Managing the medicines to treat chronic disease is part of the service delivery plan and serial

prescribing is key to this. Work is continuing over 2023/24 to maximize the number of repeat medications that are managed via the serial prescribing route, currently we average at 4% over the Board.

Workforce Development

Over the past 48 months, we have been developing our service and are continually reviewing skill mix. Recognising the lack of technician workforce at a national level, we have 5 trainee pharmacy technicians in post; one who is awaiting their registration certificate, two who will qualify spring 2024, and two who will qualify in Autumn 2024. Of these trainee pharmacy technicians, we only have permanent positions for three of the five trainees due to budget demands on the service. The pharmacist team consists of nearly 70% Band 8a pharmacists, reducing the progression available for less experienced pharmacists in years to come.

GP Impact

We have Pharmacy resource split equitably across all 23 practices. The practices feel strongly that once the service has embedded and that the time freed up is fully utilised by the GPs, then it is incredibly difficult to take back that workload. The service needs to be resilient and reserve the ability to flex sufficiently to manage during sickness, vacancies and parental leave.

Community Pharmacy

The links between practice teams and community pharmacy teams are very important. Community pharmacy provides supports to general practice in a number of areas (Pharmacy First and Pharmacy First plus) as well as working alongside the team to provide Serial prescribing.

What gaps do we still have to deliver on the MOU?

Within NHS Borders the attention is focused on delivering the Level 1 tasks only and how we deliver this given the current budget constraints around staffing. This means that delivery of MoU2 is not attainable due to Level 2 and 3 not being delivered by the Pharmacy Team.

With the proposed draft directions from Scottish Government the model of pharmacotherapy in NHS Borders will need to respond to support delivery of the directions.

Key Risks:

Service resilience has been challenging, trying to maintain a service with vacancies is not possible. The definition of Pharmacotherapy previously quoted, includes covering annual, sickness and parental leave. The difficulty with this ask is that with low team numbers there is very limited flex in the allocations to move staff without leaving other noticeable gaps in practices.

Remote working from hubs is a way to improve resilience. This streamlining of staff to a central area can reduce inefficiencies in travel as well as resolve issues with space within practices. Progress with this plan has been influenced heavily by the availability of work stations and available areas to work in.

Staff training and ongoing support for staff development in line with the national direction led by NES to ensure that staff have the necessary skills and competence to carry out these new roles safely and effectively does impact on service delivery to some extent and requires negotiation with practices. Practice pharmacist specific frameworks have been developed by NES (both at foundation and advanced practice level) but the team find the workload at present does not afford them the opportunity to engage with these frameworks and future staffing models need to take this into account (staff given between 10% and 20% of their time to complete training and admin). Frustration is felt by the team that there is no time to undertake these frameworks.

Vacancy Management is an ongoing issue, not only locally but also nationally. Within the rural setting of NHS Borders, trained Pharmacy Technicians (not already employed by the Board) are becoming harder to find. Newly qualified staff (particularly pharmacists) are also moving away to the cities for a large part of their career. This is causing movement within teams and sectors rather than new employees joining the NHS.

Leadership As teams grow in size, more time is required to lead the changes required within practices and support the less experienced staff. We are currently developing new supervision models to support leadership, training and service delivery.

Travel Time All Pharmacy staff have the Borders General Hospital (BGH) as their work base and travel time is calculated from the BGH to their actual GP workplace. Due to limited staff living in the outer perimeters of the Scottish Borders, this increases the travel time and distance for others (e.g. GP practices in the East). Due to current HR policy, travel time must be inclusive of a staff working hours. This has resulted in a significant loss of clinical time for teams. (e.g. loss of 8 hours per week for a GP Practice in East historically). The recent allocations have reduced travel time by half to nearly 9 hrs for the whole team, improving efficiency of work across the Board.

What do we still need to enable this?

Understanding the workload challenges and practice systems has led to the realisation both locally and nationally that there needs to be a significant piece of quality improvement work embedded into practices to get them “pharmacotherapy ready” where the Level 1 tasks can be devolved to the pharmacy team. The required resource as well as skill mix to deliver a pharmacotherapy service is being modelled nationally based on experience to date from various boards.

Our original modelling of a total resource of 1 WTE pharmacotherapy team member per 5000

patients has been shown over the past 2 years to be inadequate and this finding is supported across Scotland. A national view is awaited regarding an optimum staffing model but this will be difficult to deliver due to current funding and workforce availability.

Delivered March 2022

Due by since April 2022

MoU 2 Priorities

PCIP Community Mental Health

PCIP Urgent Care

PCIP Musculoskeletal

Community PCIP Links Worker Service

Additional Professional Roles

PCIP Premises

PCIP Communications

Enablers

What we set out to deliver

The Primary and Community Services (P&CS) Team within NHS Borders Health Board are responsible for delivering a robust, efficient and sustainable CTAC service which will enable people to live safely and confidently in their own homes and communities, supporting them and their families and carers to effectively manage their own conditions whenever possible. The CTAC service aims to provide person-centred care through integrated models that are safe, efficient & effective – underpinned by a culture of learning, kindness and respect.

The CTAC delivery model will maximise capacity and delivery of CTAC services across NHS Borders to enable services to be run efficiently and for patients to access services in a location which is most convenient for them.

The CTAC project will also put in place the required infrastructure and workforce so that in future, an enhanced CTAC service can be offered to assist with shifting the balance of care from acute settings to the community.

NHS Borders currently operate 10 Treatment Rooms in a number of different Health Centres and Community hospitals. In 2021 a pilot of phlebotomy services in Haylodge Health centre took place. This allowed the project team to test centralised booking and consider premises and human resource issues. The learning from the pilot led to a more ambitious plan where all CTAC work would be delivered in all GP practices rather than an incremental plan. This work looked to build and improve upon the current treatment rooms in NHS Borders and to provide equity of service. With this in mind a service specification was agreed. The planned CTAC activity is summarised in the following table;

Core CTAC treatments *(as per GMS contract list)*	**Current Treatment Room Provision beyond Core CTAC** *(as currently provided in limited number of existing HB Treatment Rooms)*	**Enhanced service** *(secondary care – for further discussion/resource transfer after Core and Additional services established – likely 2023 onwards)*
Ear Care	Assisting minor surgery	Assisting for coil services
ECG	Catheterisation	Cognitive screening
INR checks (phlebotomy or near patient testing)	Continence Assessment	Diagnostic tests e.g. Short synacthen
Minor Injuries*	Complex wound Management (including leg care and Dopplers)	Eating disorder monitoring measurements
Monitoring chronic conditions (BP-including 24 hour monitoring / active stand /	Medicine Administration	Phlebotomy (secondary care)

Weight / Height / Urinalysis / Diabetic Foot Screening)		
Phlebotomy (primary care)	Phlebotomy (secondary care)	Post bariatric surgery measurements
Suture removal	Resus trolley and equipment	PSA monitoring
Wound Dressings	24 hour heart rate monitoring removal	Ring pessaries
	24 hour urine collection	Spirometry
	Glucose tolerance testing (? If not done by	Visual acuity
	MRSA Screening	

Following further review from PCIP Executive and the Integrated Joint Board a request was made for the service to focus on providing all phlebotomy in each practice in addition to exisiting treatment room provision.

A staffing model was developed, however there is no recurring funding for CTAC services and the plans have therefore been unable to move forward.

Staffing model for phlebotomy only model role out;

	Mid-point cost inc new pay award	WTE	Cost	WTE inc 21% uplift	Cost inc 21%uplift
Clinical Band 3	34,737	10.97	381,065	13.27	460,960
Clinical Band 7	65,937	1.00	65,937	1.21	79,784
Clinical Band 6	55,047	2.00	110,094	2.42	133,214
Admin Band 2	30,144	0.50	15,072	0.61	18,388
TOTAL		14.47	572,168	17.51	692,345

Engagement activity

Work has been undertaken to engage with GP practices and current treatment room staff about the planned changes to treatment room provision. This has involved one to one meetings with practices and members of NHS Borders staff. Written communication has also been provided.

For the internal organisational change process a workforce steering group has been establish which

has staff, partnership and HR representation. This group is currently paused awaiting further decision regarding the funding of CTAC services.

Appointments per cluster

Norm times for the service were established through work undertaken by Meridian and appointments range from 10 mins to 40 mins. Clinic templates are still to be fully developed.

Key Risks:

Risk	Details
Finance – delivery of CTAC	CTAC recurring expenditure is set against non-recurring, insufficient budgets which is hindering project planning and potentially setting up an unsustainable service delivery model. No funding allocation has yet been made for CTAC delivery and therefore the overall affordability of the proposal remains uncertain.
Finance – Non delivery of CTAC	There is no indication of financial risk of non-delivery however in 2022 an interim payment was made to GP practices due to non-delivery of CTAC and pharmacology work streams of PCIP. Further payments may be required by boards not able to deliver by new dates.
Recruitment	Recruitment processes can take up to 12 weeks. Delivery of CTAC service is dependent on staffing being available to run clinics and provide treatments. Temporary posts – current experience shows that recruitment to Fixed Term Posts reduces successful recruitment in RN and HCSW posts. Some types of staff e.g. Band 4 associate practitioners may not be available due to a lack of suitably trained personnel.
TUPE of staff, organisational change and wider staff engagement	For the Health Board to take on the delivery of CTAC services, a number of staff currently employed by GP Practices will need to be offered the opportunity to TUPE across to Health Board employment when the tasks they carry out are transferred. Staff will have pay and conditions protection unless consultation with individuals allows for agreement on contract variation. Also, staff can only TUPE into long-term contracts so recurrent funding would need to be available for this to happen. Delays in CTAC delivery have caused practices to employ recently hired staff on short-term contracts who will not be eligible for TUPE. Practices may also be holding vacancies for these posts currently knowing that CTAC delivery has to be imminent. A recent survey and meetings with GP practices has indicated only a small amount of staff with transfer. The transfer of staff under TUPE regulations is complex and requires a significant amount of HR legal advice and consultation. In this project, it is particularly

	complex given there are potentially 23 different employers to engage with as part of the transfer. The TUPE of staff also poses a significant financial risk to the Health Board due to the lack of recurring funding for CTAC. Under the TUPE regulations, staff will have pay protection when moving across to being Health Board employees. Initial investigations by HR colleagues has shown some GP Practice staff are currently paid higher hourly rates than NHS employed staff doing the same role. This has the potential to put an additional financial pressure on the Health Board until such times as the Agenda for Change bands progress to meet the same rates of pay. In order to be able to transfer staff to Health Board employment, all existing staff employed within the Health Board to delivery Treatment Room services need to be moved across to standardised CTAC role descriptions. This process will involve consultation with 30 staff (bands 3 – 6), with HR and Partnership support. Staff joining the organisation will need support with induction and gaining/ evidencing skills and competencies for the role.
Data assumptions	Data used to create the original CTAC staffing and financial planning model was based on 2019 activity and broad assumptions have been applied rather than a full analysis of demand/capacity across all GP practices. The assumptions will have an impact on the reliability of the model. A ratio approach has now been used and tested against existing workforce used to deliver CTAC tasks.
Project delay risk	Project timelines have slipped considerably and delivery by the new 2023 deadline will not be met. Without a clear agreement for financial funding the project team are unable to create a timeline for the rollout of these services.

Renew Annual Report 2022/23

The Renew service was established in NHS Borders in October 2020 utilising funding from PCIP, Action 15 and psychology services, with the aim of offering a "see and treat" model for mild to moderate anxiety and depression for those aged 18 and above, using evidence based psychological therapies in primary care. The aim is to reduce GP Mental Health workload as well as increase the range and access of psychological therapies.

Key Performance Indicators – Renew 2022/23

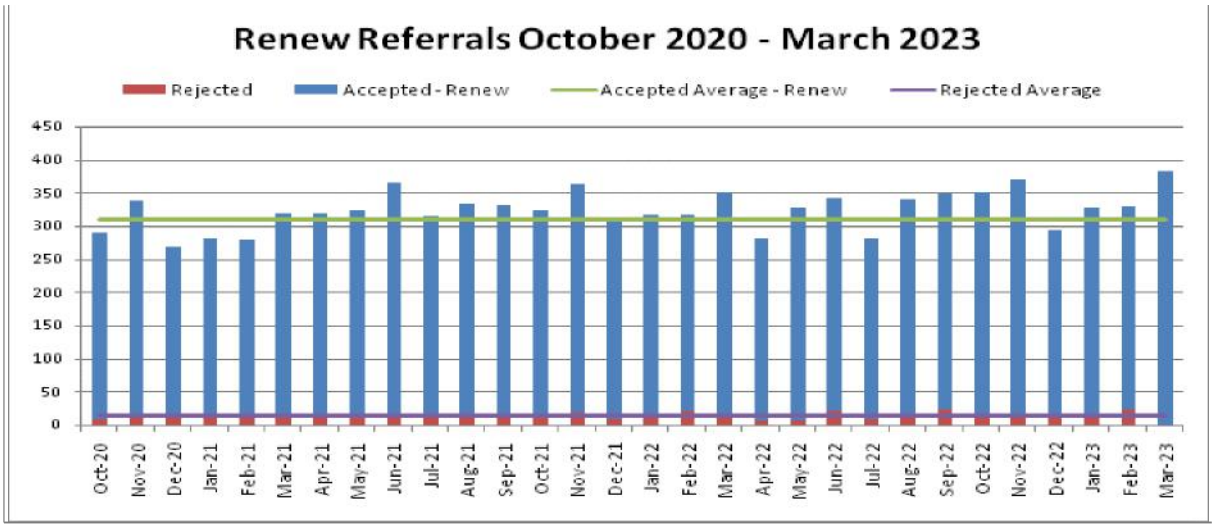
KPI 1: Demand for the service

Referrals:

All GP Practices have referred to Renew.

In the last financial year we received 3820 referrals between April 2022 and March 2023, average 318 per month. Since Renew started we have received a total of 9667 referrals of which 9307 have been accepted. This is an average of 310 referrals per month.

Figure 1: Referrals to Renew October 2020- March 2023.

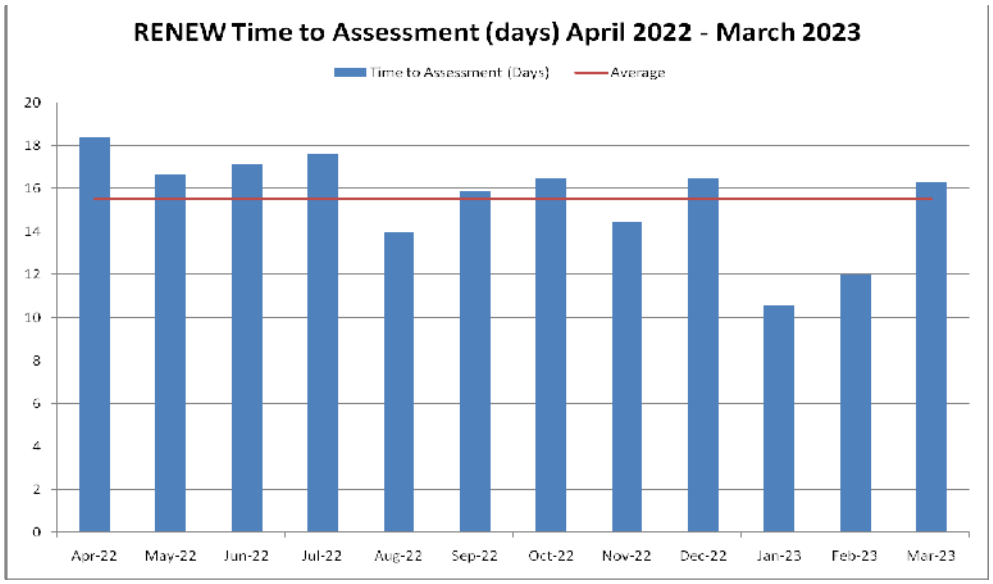


KPI 2: Speed of Access/Service Efficiency to see and treat

Assessment

In the last financial year time from referral to assessment was 15 days. This is a very slight increase to the average of time to assessment since we started to March 2023 of 13 days, but in general we continue to prioritise seeing people referred to us for an assessment appointment within a month.

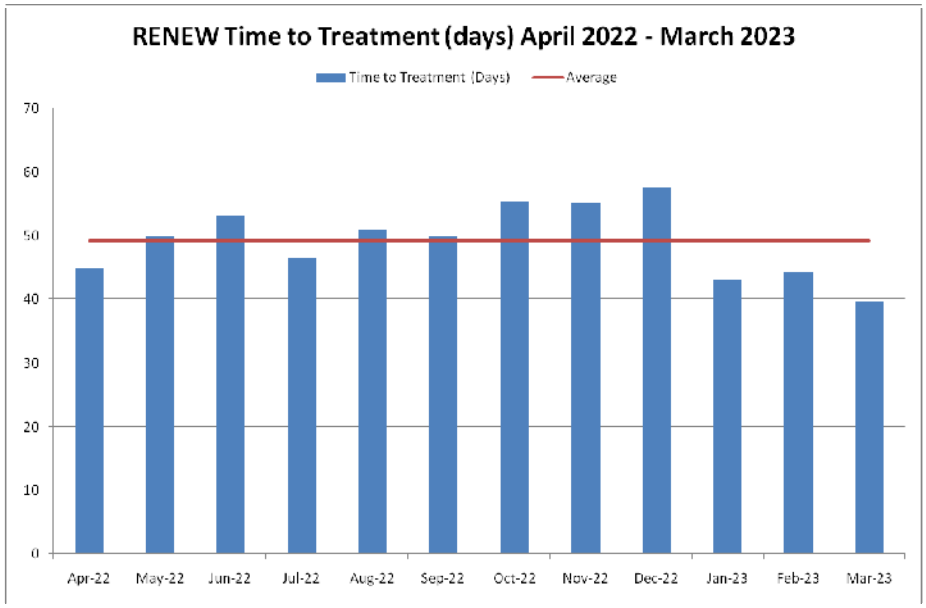
Figure 2: Renew – Time to Assessment in Days: April 2022-March 2023



Treatment

95% of treatment is delivered within 18 weeks with an average time to treatment start being 49 days. One to one individual therapy for more complex issues usually take longer in terms of treatment starts.

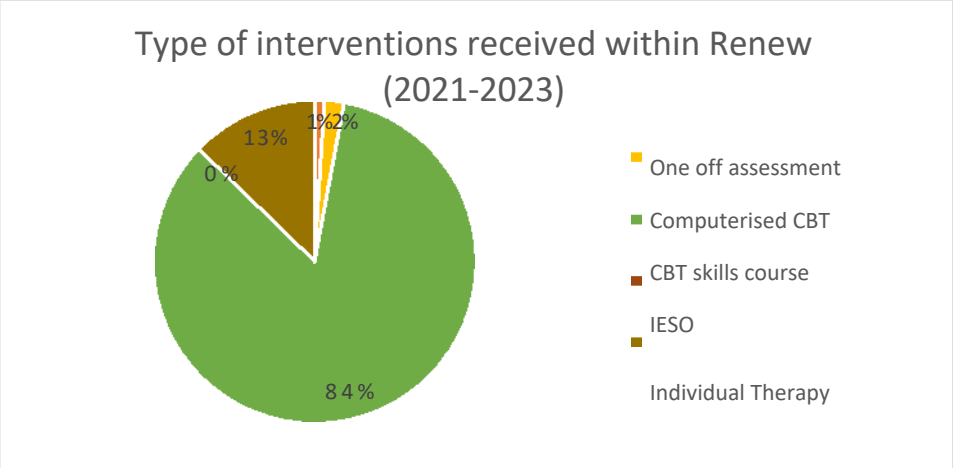
Figure 3: Renew Time to Treatment start in days: April 2022- March 2023



Treatment Interventions Offered

We continue to offer a range of interventions as the Figure 4 below indicates, all of which are evidence based:

Figure 4: Overview of types of interventions offered in Renew between 2021 and 2023.



Skills courses:

Our CBT Skills courses (low mood, anxiety and low self-esteem) continue to be the mainstay of the service and we have recently made some changes that have improved flow and accessibility. We currently offer four low mood and four anxiety courses per week (rotating on an 8 week basis). Patients attending these courses demonstrate reliable improvement in routine outcome scores (50% reliable improvement in anxiety course, and 59% reliable improvement in low self-esteem course), which is consistent with the literature.

In 2023/24 we will review these courses further to improve the course materials and online delivery. We continue to ask and monitor patient feedback on the courses to ensure they are meeting service need.

Digital Interventions:

We offer a range of effective evidence based digital therapy offerings for patients accessing Renew. Beating the Blues has now been phased out and replaced by Silvercloud which offers 14 different modules of evidence based computerized CBT (cognitive behavioral therapy). Modules offered include: depression, depression and anxiety, health anxiety, social anxiety, and generalized anxiety disorder. Silvercloud is appropriate and effective for people who have mild to moderate mental health problems. People Silvercloud are supported in its use by members of our digital mental health team, who check in at regular intervals. We are aiming to improve uptake in these interventions and develop ways of supporting full engagement with the whole treatment, which produces the best results.

IESO is a further digital intervention offered as part of the service. Offered in three tiers from guided self-help to higher intensity interventions for depression and anxiety. In this service patients make a 1:1 appointment and engage with a therapist via text, access is quick, usually within 2 weeks. People referred to this service from NHS Borders experience 67.7% reliable improvement following treatment. This effective treatment can be offered in evenings or weekends which suit people who have work or family commitments find it difficult to access appointments in working hours.

Guided self-help

The service also offers guided self-help which can suit those who need more individualized support with an intervention.

1:1 Interventions:

These are provided in the service by Enhanced Psychological Practitioners (EPPS), Clinical Associates in Applied Psychology and Clinical Psychologists. These interventions are provided by video link and in exceptional circumstances where it is clinically indicated in person.

KPI 3: Service Outcomes – service valued by GP's and patients and treatments effectiveness

1. GP Feedback:

88% GP's rate Renew excellent or very good (May 2022).

Some GP comments (May 2022):

Some of their comments about the service are:

- *Encouraging lack of hoops for us to jump through - we can leave assessment to our more expert colleagues*
- *We previously had a massive gap in MH provision in Borders and ! believe Renew has filled this gap well.*
- *Before it was very confusing to keep up with what services were still available and what were not.*
- *! found single point of referral for triage to different treatment modalities works really well.*
- *Patient feedback and ! have also noticed that they have an initial consultation quickly to discuss problems and develop a plan about most appropriate approach and ! think the patients find this discussion and choice helpful and empowering.*

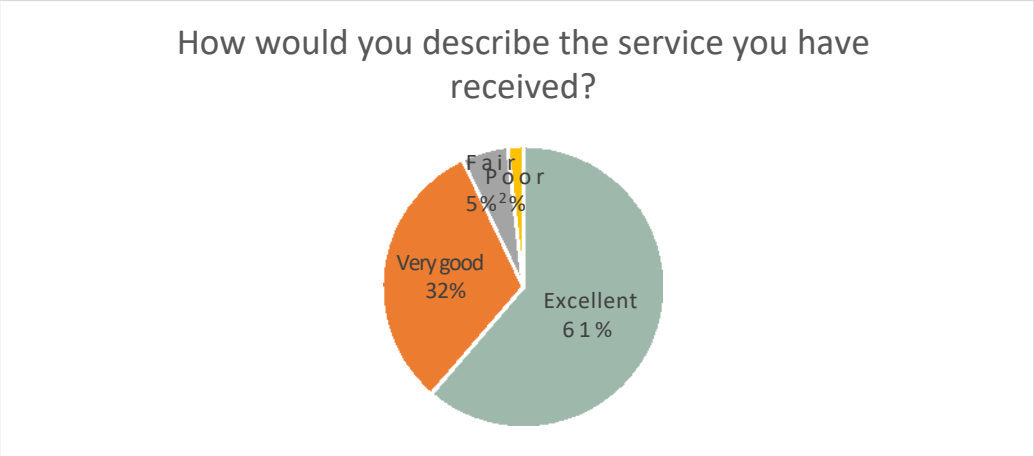
2. Service user feedback:

We gather routine service feedback using the Client Satisfaction Questionnaire (CSQ-8), a brief questionnaire which allows people using the service to rate its acceptability in a range of areas. Feedback in this section summarizes analysis of completed CSQ-8 questionnaires.

A) How would you rate the service you received?

93% of people rate the service as excellent or very good as Figure 5 indicates.

Figure 5: Overview of how our patients rated the service received in Renew (2021 – 2023)



B) How has the service helped you deal with your problems?

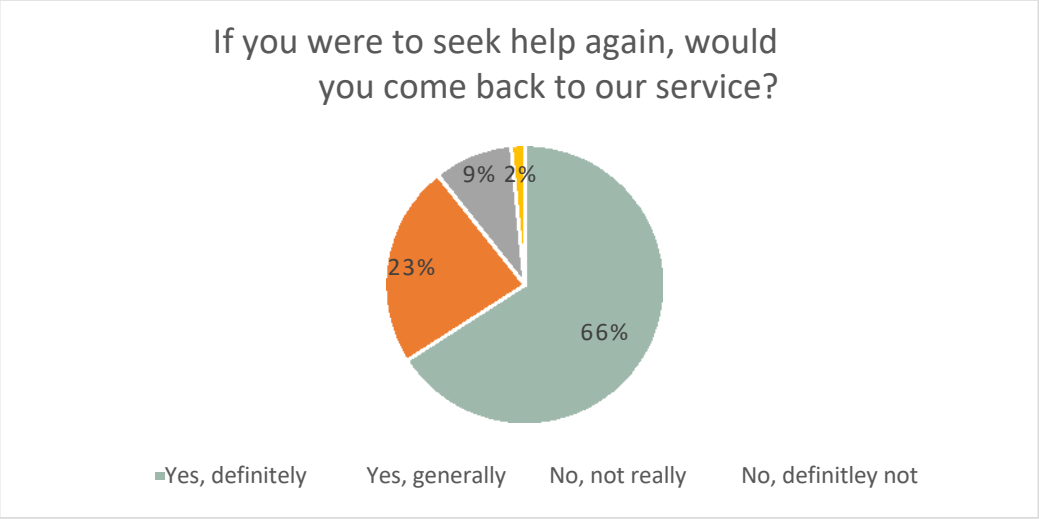
96% of people positively rated the interventions they were offered as helping them a great deal or somewhat as Figure 6 illustrates.

Figure 6: How has Renew helped people deal with their problems? (2021 -2023)

C) If you were to seek help again, would you come back to our service?

89% of people said if they were to seek help again they would come back to Renew as Figure 7 illustrates.

Figure 7: Renew: If you were to seek help again would you come back to our service? (2021 – 2023)



Here are a few comments from people using the service:

Thank you very much for the course. I was dubious about being in a group but because it was a small group I felt comfortable. I think the course was structured really well and I've learnt that even though I'll always probably be an anxious person I can move forward with all of the tools you've given me. (Skills Course)

I am happy with the service, I understand it takes more time than just the course to continue helping myself but I think the course has gave me the tools to help with my self-esteem and anxiety (Skills Course)

I really enjoyed working through the modules on this course. It was nice to get feedback from my supporter every so often as well to keep me motivated. I have learned so much and so much about myself. 100% beneficial to me and would absolutely recommend. (SilverCloud computerised cbt)

3. Treatment effectiveness

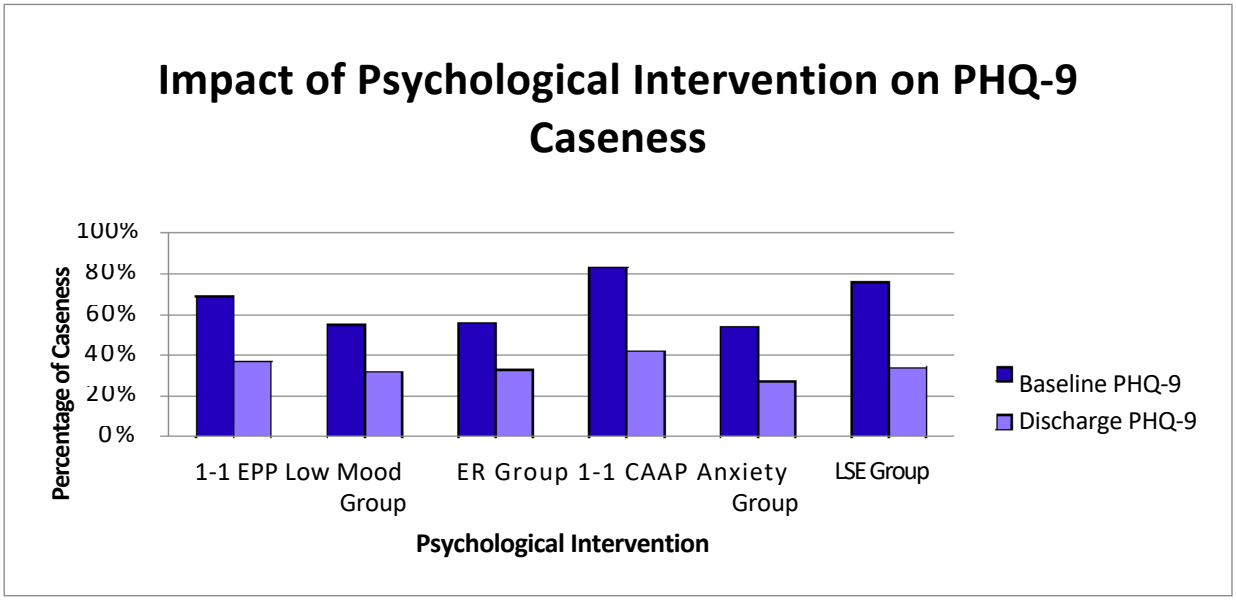
Renew aims to treat low mood/depression and anxiety that presents in a primary care setting. We measure what we call “caseness”, which is whether there is a significant enough need for an evidence based treatment to be administered. We collect routine clinical measures of depression and anxiety use nationally accepted measures called the PHQ-9 and GAD-7 which are are collected pre and post intervention in order to capture this and monitor treatment effectiveness.

Patients are routinely administered PHQ-9 (a widely accepted measure of low mood and depression) and GAD-7 (a widely accepted measure of anxiety administered with the PHQ-9) at assessment and discharge. The data in Charts 1 and 2 demonstrates the percentage of patients achieving “caseness” on each of these measures pre and post intervention.

a) PHQ-9- Low mood and Depression.

The PHQ-9 is a widely accepted measure of low mood and depression which is measured at assessment and discharge. The data in this chart below demonstrates the percentage of patients achieving "caseness" pre and post intervention. Figure 8 below shows an improvement in symptoms and caseness across all interventions offered for low mood and depression.

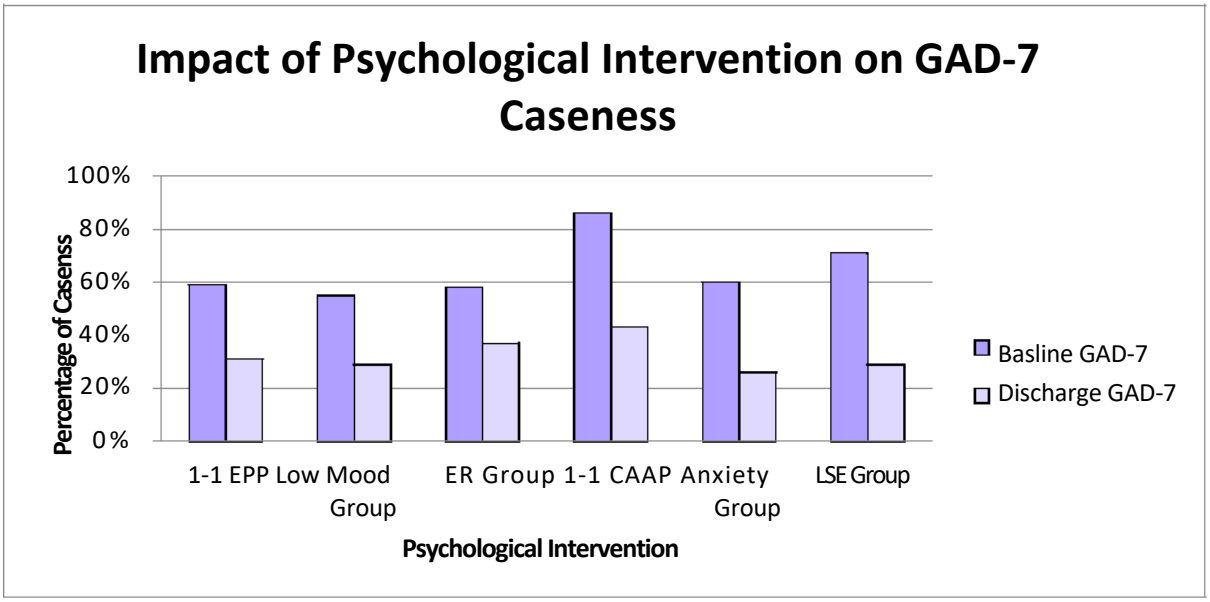
Figure 8: Impact of Psychological Intervention on depression/low mood in Renew as measured by PHQ-9



b) GAD-7 – Anxiety

The GAD-7 is a widely accepted measure of anxiety which is measured at assessment and discharge. The data in this chart below demonstrates the percentage of patients achieving "caseness" pre and post intervention. Figure 9 below shows an improvement in symptoms and caseness across all interventions offered for anxiety.

Figure 9: Impact of Psychological Intervention on Anxiety in Renew as measured by GAD-7



c) Reliable improvement

Outcome data collected by the service demonstrates reliable improvement across all interventions offered within Renew. Reliable improvement is a term in primary care psychological services that suggests efficacy and acceptability of treatment options for patients.

Summary

In general, Renew has performed well over the past financial year. Demand continues to be strong for the service from all GP practices and in the past year has remained relatively steady with a 1% increase over the financial year.

However, the type of referrals to the service seems to be changing with an increase in complexity and risk. This may be either as a result of Covid or as we emerge from Covid, the presenting problems may be changing. We are therefore starting a review of referral reasons to ensure we understand and consider how to respond to any significant changes. This is important to consider in terms of the gap between Renew and secondary care services.

The centralized model continues to work well and helps us to maximize flow and be able to see people soon and offer interventions centrally via telephone or Near Me, so we are not limited by geographical area. We now have an administrative base for the service at SBC Headquarters in Newton St Boswells.

We have established weekly meetings with secondary care adult psychology to ensure easier transitions between the services and this is making patient journeys smoother and more consistent.

We continue to work closely with the DBI (Distress Brief Intervention) Service, the clinical lead for this service is now based within Renew and patients are benefiting from this change.

Aims for 2023/24:

Our aims in the coming financial year are:

- To continue to monitor flow and reduce treatment backlogs
- Analyse referrals to ensure the model, flow and treatments fit demand.
- Consider how to meet changes in demand and gaps that have come to light between Renew and secondary care services
- Continue to improve and enhance the digital therapeutic offering (e.g. cCBT) by embedding Silvercloud, increasing uptake and establishing engagement appointments

Workforce and footprint:

First contact Physiotherapy services were implemented in the Borders in 2019 with only 2.2 WTE B7 Physiotherapists.

The service has grown to 100% of budget allocation with a staff compliment of 9.2 WTE FCP's in service from February 2022, working at a 1:20 000 population ratio. The service has carried one 0.5 WTE vacancy from February 2023. We have been successful in international recruitment with the new member of staff to join the service in September 2023.

The service is funded for 8.7 WTE Clinically and 0.5 WTE Management. FCP services are delivered in 100% of the 23 GP practices in the Borders in a hybrid model.

- Vision:
  - First contact Physiotherapy (FCP) in the Borders will provide a trusted and direct triage service, in the GP practice, for patients presenting with musculoskeletal pathologies.
- Mission:
  - To be the Gold standard of FCP in Scotland. To inspire hope and contribute to health and well-being by providing the best first contact MSK care to every patient through integrated clinical practice, education and research.
- Slogan:
  - "Together we are the difference"

Key Focus areas:

1. Multidisciplinary teams:

The team is well integrated in all 23 of the 23 GP practices within the Borders. The FCP work-stream have been using a hybrid delivery in the last year to move away from a silo working model imbedded in the GP practices. The key priorities of FCP remain to be a service of excellence in being:

- Safe
- Person centred
- Equitable
- Accessible
- Outcome focused

- Effective
- Sustainable
- Affordable
- Value for money

2. Pathways:

The team has been working continuously on developing various pathways across the MDT for better patient care, early access and “right time-right care-right practitioner”.

FCP pathways established is with

- MSK teams
- Orthopaedics
- Community link workers incl. Mental health
- OT/Speech and Language therapist
- Podiatry and orthotics
- Third party vendors e.g. Live Borders

3. Expert Generalist role

FCP continuously work towards our four pillars of practice to enhance our skill, clinical outcomes for patients and our leadership within the developing roles and delivery of care in PCIP and the Physiotherapy profession.

4. Digital innovation:
   FCP together with the MSK and podiatry work streams are working hard to establish a relationship to have a digital solution for additional triage and self management options within the Borders. We are exploring the PHIO product learning from other Boards that have embraced technology.

5. Enablers:
   1. Workforce: 8.7 Clinical WTE delivering FCP services in 23 GP practices to a 1:20 000 ratio.
      i. GP requirement is currently 223.57 hours per week (11178.5 pa – 50 weeks)
      ii. 8.7 WTE FCP = 326.25 FCP hours per week

1. 1(70% clinical time /30% time to work towards our professional four pillars of practice.
2. n228.375 clinical hours -11 418.75 pa over 50 weeks

iii. Capacity is created by virtual triage across the Borders to absorb leave/ long term illness, but still lack enough resources to deliver on a full 50 week cover.

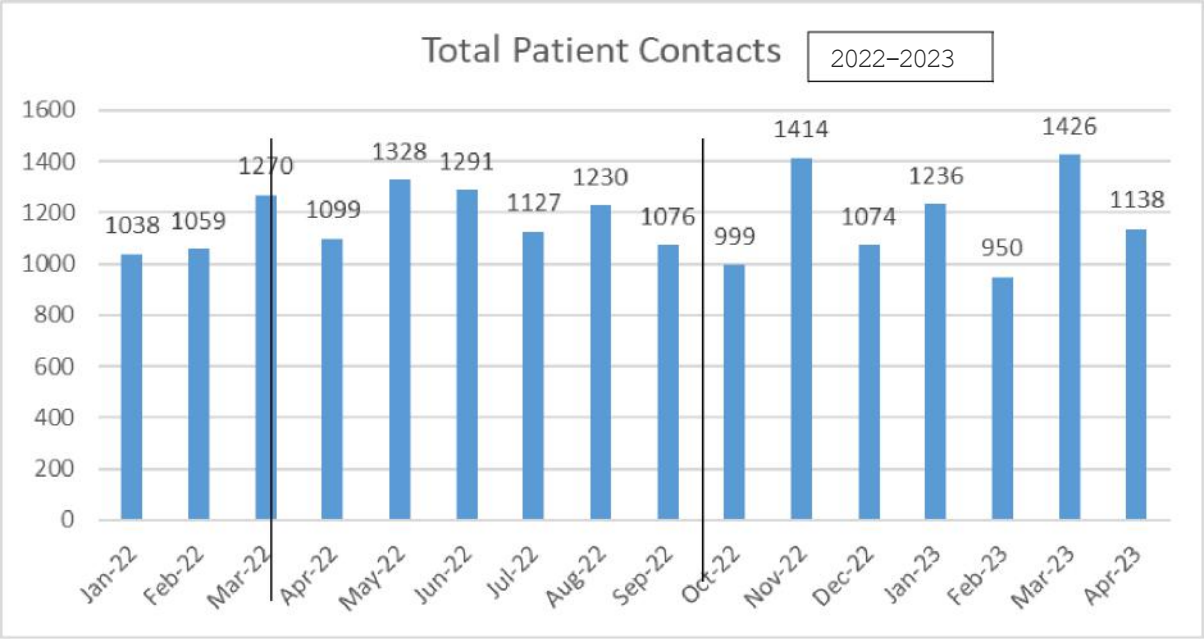
2. Education and training:
   i. 100% of the FCPs are cortisone injection therapy trained.
   ii. 100% FCP staff members are IRMER trained and refer for special investigations including MRI scans
   iii. 1 member of staff are completing their qualification in independent prescribing for non-medical prescribers with four more members of staff to follow in the next 24 months.
3. The APP lead represents The Borders at the National APP Primary Care Network.

6. Premises:
   1. Hybrid delivery model for FCP in Borders to help with accommodation in certain practices where space is a limitation.
   2. Blended working format between Face-Face / Telephone triage and Near Me consultations.

7. Digital:
   a. The change over to the hybrid IT system, to deliver the service, has been evaluated over the last year and continuous improvement are made.

What did we deliver?

1) Impact on GP workload:



3.8 WTE FCP until July 2021, increased to 5.5 WTE in July 2021. Returning members of staff from maternity leave and new recruitment increased workforce to 7.8 WTE in September 2021 and reaching 100% capacity by February 2022 with 8.7 WTE clinical FCP.

- 1282.33 (2022-2023) compared to 1016.52 (2021-2022) average consultations per month with a 73% average of self-management and no further referral/intervention required.
- 15388 (2022-2023) compared to 13216 (2021-2022)total consultations for the year
- 0.9% patients referred back to GP practice for medication or fit note prescription.

2) X-ray and MRI referrals:
- 3.7% average referral rate for x-ray views
- 2.1% average referral rate for MRI views

3) Wider system benefits:

MSK activity:
- 8% average MSK (Musculoskeletal Physiotherapy department) referral rate.

Orthopaedic activity:
- Cortisone injection therapy in primary care setting:
  - Average of 3.7% of FCP activity is administering Cortisone injection therapy
  - 455 CSI injections administered for the year
- Orthopaedic referral rate:
  - 5.6% referrals to orthopaedic secondary services.
    - Clinical pathway development was done with focus on the patient journey,
    - Education and in service training to clinically up-skill FCPs on diagnosis and referral patterns.

4) IT and technological considerations:
- Use Emis Web for more virtual cross cover- by combining all FCP diaries.
- 4- 13 hours per week virtual FCP consultation hours to address the need for cross cover.
- Creation of a platform for automated service audits and activity data.
- Creation of 1WTE administrative post for service delivery and support.
- Improved Quality of care and peer review auditing to support, mentor and educate the FCP team.

Gaps in the delivery of FCP services?

1) HR: To be in line with National service delivery of 1:12 000 population ratio over a 50 week service the Borders are in need of 372.61 additional FCP hours per week.

- FCPs to increase with 14 WTE to successfully answer to the demand.
- 2 x 0.5 WTE B3 administrative support currently employed – gaps remain:
  - Single point of contact -to ease patient queries

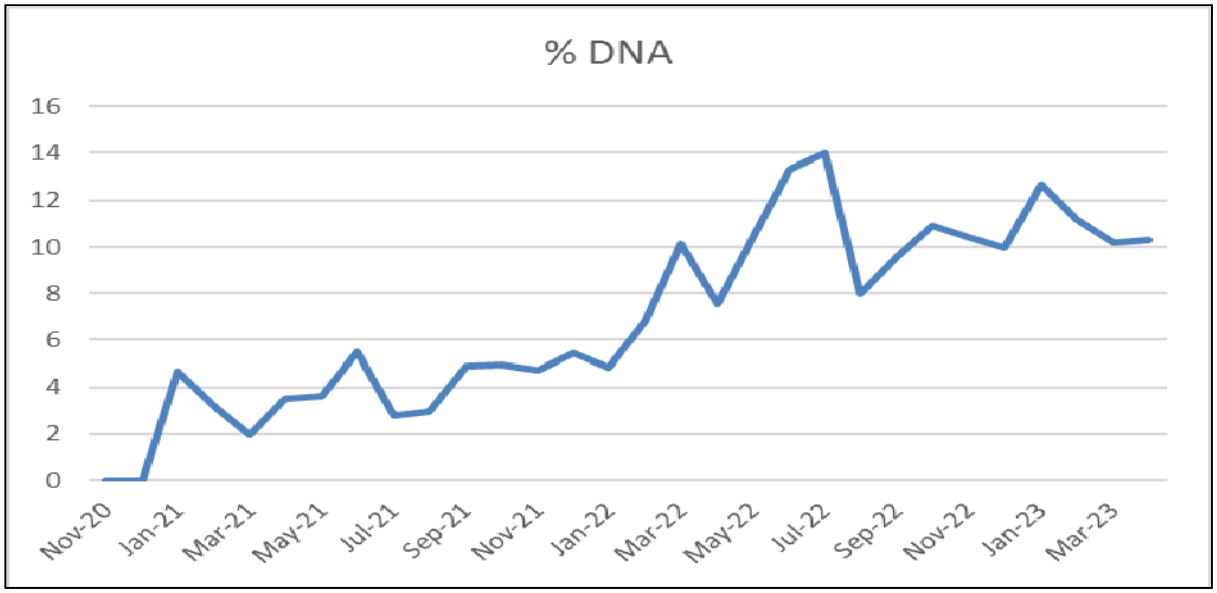
- Automated booking messaging system for appointments and reminders

2) IT systems:

a. The current IT provisioning in the Borders does not communicate successfully with IT used in GP practices. To be able to render a virtual model FCPs are using one IT system that is removed from the GP IT system and duplication of clinical notes exist.

b. Delayed times in reports for investigations due to the different IT systems and FCP need to employ a third system to search for reports.

Risk of the new hybrid system and central booking model:



The lack of a central office with central telephone line limits patients being able to contact the service and cancel or change their appointments, each GP practice has to email patient correspondence to the central hub and communications may be delayed and a rise in "Did Not Attend" (DNA) (3.4 % 2021 to 9.7% in 2022 and 11.2% in 2023) with each practice moving over to the hub system has been noticed.

To address DNAs, we are currently re-evaluating the delivery model of FCP.

The initial focus of the Scottish Borders Primary Care Improvement Plan 2018-2021 was the development and establishment of an Advanced Nurse Practitioner model. As there was a shortage of trained ANPs nationally and within the rural Borders demographic, NHS Borders undertook to recruit a cohort of untrained ANPs.

Prior to PCIP roll out there was no workforce supply of trained primary care ANPs and in 2019 a successful pilot of five trainees Advanced Nurse Practitioners (ANP) was carried out across South and West GP Clusters.

The ANP service is highly valued and supports PCIP to meet the urgent care pathway to provide a service to GP practices for `urgent care`, delivering on the day presentations: face to face consultations, telephone consultations and home visits. This releases the GP to take on a more holistic view of patient care and clinical expert role, and improving patient access to care and treatment.

The ANPs are autonomous practitioners and manage the comprehensive clinical care of their patients, including prescribing and onward referral. Independent prescribing is an integral component of advanced practice which allows easier and quicker access to medications for patients and increases patient choice in accessing medication, and there is a growing body of evidence to support the positive impact of independent prescribing by ANPs.

Service User Experience

Patients have embraced the role of advanced practitioners in primary care and they have reported high levels of satisfaction with the care they receive. They have commented on their surprise at the autonomous ability of advanced practitioners to include assessment, diagnosis and treatment. Many patients request to see the ANP again. This allows for continuity of care.

Positive feedback on the referral of patients to secondary care has also been received.

Challenges and Key Risks:

The ANP lead role has been vacant now for 6 months and it is demonstrable through iMatter results that this has had a major impact of moral and job satisfaction within the PCIP Urgent Care workstream. It is a top priority to resolve the issues surrounding the changes to the job with secondary care and recruit to the role as soon as possible.

There is a national shortage of primary care ANPs and recruitment of qualified advanced practitioners has been extremely challenging, particularly due to the rural geographical area of the Borders. This has also required a local training pathway to be developed for trainee ANP and significant support, clinical supervision time and educational input from GPs, acute medical/surgical colleagues and lead ANP, work that was not initially anticipated. We need to continue to train further ANP to address the national and local shortage.

What do we aim to achieve in the coming year?

- In the coming weeks we aim to recruit a combined clinical lead role whose time will be split between primary and secondary care. Their focus will be on the development of the proposed ANP academy
- We are hoping to develop an ANP academy - training ANPs in both secondary and primary care to develop a resilient and competent workforce capable of handling high volumes of work independently. The objective for this is that it will be much less resource intensive to train an ANP through this pathway than the previous model of a single practice taking on responsibility for the support and training of any ANPs it takes on through PCIP.

On the 8th September 2022 PCIP Executive decided to discontinue funding for the Community Link Workers (CLW) due to inadequate funding from the Scottish Government for PCIP. The workstream was prioritised for deep evaluation as it was operated under a model that was considered inadequate for its intended purpose. Additionally, the service was set during the pandemic, which presented challenges in fully integrating it with practices due to staff proximity restrictions in back offices in GP surgeries. This hindered the optimisation of information sharing and coordination, impacting the effectiveness of the service.

Despite these constraints, the dedicated team of 2.5 full-time equivalent community link workers and two full-time equivalent Local Area Coordinators continues to serve the community. Over a two-year period, while funded with through PCIF, they managed to identify and attend to 40 GP patients in need. However, the available data did not demonstrate a significant easing of GP workloads as a direct result of CLW. Despite efforts made, the overall impact on alleviating pressures and reducing the workload of GPs was limited.

Nevertheless, Local Area Coordination services continue to be available as part of the broader service offered under our Health and Social Care Partnership.

Accommodation constraints remains a central theme regarding the implementation of PCIP workstreams. Buchan and Associates were previously commissioned by Hub South East on behalf of NHS Borders to conduct a review of primary care premises, taking account of the implementation of PCIP and new housing developments with the objective of identifying investment priorities. The review was published in October 2021 and outlined significant immediate pressures faced by many practices when seeking to find space for the new workforce within primary care.

Resource constraints within NHS Borders Estates and IM&T services have also limited change and improvement works required to implement PCIP workstreams. Despite these challenges, P&CS have managed to progress work that has delivered benefits to patients, staff and services using health centres and community hospitals.

Key achievements

- Revised premises governance to accelerate decision making, increase accountability and retain a "bigger picture" view of the NHS Borders estate.
- Streamlined pathways and a dedicated digital "premises portal" for requesting space, equipment and technology required for patient treatment and administration.
- Introduction of policies to improve sustainability of service delivery, such as "shared bookable spaces", sourcing equipment from within NHS Borders estate before purchasing new equipment and the prioritisation of clinical rooms for clinical activities.
- New assistant service manager in post from August 2022 with time dedicated to leading premises delivery.
- Mapping of rooms vs services in all primary care health centres and community hospitals, enabling the expansion of services and a fairer approach to space management.
- Completion of minor estate and IM&T works across many sites to increase clinic capacity and improve fixtures and fittings.
- Investment in clinical and non-clinical equipment, furniture and IT equipment.
- Removal and disposal of a significant volume of redundant equipment to release space and improve the environment for patients and staff.
- Digital room booking platform options appraisal completed, awaiting IT resource availability to progress implementation.

Key challenges and risks

- Limited resources to progress tactical and strategic, preventing delivery of recommendations outlined in the Buchan Report.
- Limited space to support PCIP services within the finite footprints of health centres and community hospitals. Work is transferring from GP practices but not the associated accommodation.
- Competition between PCIP workstreams for the same space.

PRIMARY CARE IMPROVEMENT FUND OVERVIEW

Background

Each month, a PCIP budget monitoring report is made to the PCIP Executive. This report outlines:

- Latest known information with regard to expected / actual PCIF allocation;
- Conditions over its use;
- How the recurring PCIF allocation has been directed / allocated across PCIP workstreams by PCIP Executive;
- Expenditure against the workstream budgets created in support of this direction;
- Forecast expenditure by workstream to 31 March;
- How non-recurring slippage / allocation are expected to be utilised during the financial year;
- Proposed revisions to the PCIP and their financial impact; and
- Risks to delivery and overall affordability.

The majority of PCIP activity is funded entirely by Scottish Government Primary Care Improvement Fund allocation, with only a relatively smaller amount of resource coming from NHS Borders baseline and other funding across the CTCS (£0.840m) and MH Renew (£0.320m).

2022/23

Planned Funding Allocation

On 11 August 2022, NHS Borders and Scottish Borders Health and Social Care Partnership (the Board / Partnership) received its Annual PCIF funding letter. The national PCIP funding envelope was £170 million in 2022-23. 2022/23, NHS Borders' NRAC proportion is 2.15% of the national resource envelope equating to a PCIF allocation of **£3.648m**, an increase of **£0.352m** from 2021/22.

Within the August allocation letter, the Scottish Government stated that agreement had been made with the Cabinet Secretary for Health and Social Care that Integration Authorities should draw down existing reserves balances and that 2022/23 allocations would reflect reserves held.

The Tranche 1 allocation letter identified that (based on a forecast submitted to SG on 30 November 2021) PCIF reserves held by Scottish Borders was **£0.079m**, which would therefore be deducted from the above NRAC allocation, in addition to **£0.161m** baseline funding, the latter of which has been the case each year since the inception of PCIP.

The letter stated that there would be two allocations made during the year on a 70:30 basis, taking into account the deductions highlighted in 2.3 above. Based specifically on the annex schedule of funding allocation therefore, the PCIP Executive has, in the time since the Tranche 1 allocation letter, specifically directed the net balance outlined in the table below **(£3.569m)** across PCIP workstreams

which, at the end of January 2023, is, with the exception of slippage of **£0.032m**, expected to be spent in full.

Actual slippage at 31 March 2022 was **£0.426m**, **£0.347m** higher than forecast at 30 November 2021.

This slippage was carried forward to 2022/23 and consolidated with a balance of **£1.097m** brought forward from an additional ad-hoc non-recurring allocation made by the SG in late 2020/21 as a total of **£1.523m**. PCIP Executive has been working to direct this funding non-recurrently across a range of initiatives during 2022/23 in order to further support the delivery of the PCIP workstreams.

The Board / Partnership has never had to report back on the use of the non-recurrent allocation to the Scottish Government since it was made in late 2020/21, nor on what plans / commitments / expenditure has been made on the slippage carried forward at any point during 2022/23 and there has been no request for information, nor any discussion with Boards / Partnerships during the last year with regards to this.

Planned PCIP Funding 2022/23

	2022/23 PCIF Allocation £'000
2022/23 NRAC Allocation	**3,648**
Tranche 1	2,554
Less: Baselined Funding	(161)
PCIF Initial Allocation	2,314
Tranche 2*	1,094
2022/23 Tranche 1 and 2 Allocations	**3,408**
Add Back Baseline Funding	161
Actual Funding Allocation	**3,569**
Funding Allocation withheld by SG	**79**

Actual Funding Allocation

On 09 March 2023, the Board / Partnership received its Tranche 2 allocation letter. Tranche 2 allocations, as stated in the letter, were to be made based on 30% of the overall £170m allocated via NRAC, less additional reserves as of March 2022, stating that "*the additional reserve deductions reflect the difference between November 2021 and the final March 2022 position*".

The allocation letter states that additional funding has been made to a small number of Integration Authorities (IAs) who held legal commitments against PCIF reserves prior to Tranche 1 being issued. In the absence of any request for this information by the SG, Scottish Borders is not one of them.

What has happened is that the SG has referenced the Scottish Borders Health and Social Care Partnership Annual Accounts that the IJB approved and published late in 2022.

With hindsight, even though there has never been a request to report back on reserves brought forward this financial year from a PCIP-tracker perspective, there was always a prevalent risk that the SG would update its thinking around Tranche 2 allocations, stating that *"the approach to second tranche allocations will also be informed by updated financial data on the reserve positions as at 31 March 2022, which Scottish Government officials have separately requested from IAs."* Given however that no information had been sought by SG directly from Boards / Partnerships or any dialogue offered regarding non-recurrent reserves brought forward or any plans / commitments / expenditure against them made during the year, this risk was believed to be low and as a result, the Scottish Borders Partnership has continued to plan, direct, manage and report on additional non-recurring initiatives which require funding from this resource.

As a direct result therefore and without any dialogue with the Board / Partnership regarding how the position on these reserves may have changed since they were brought forward on 01 April 2022 or any legal, contractual or strategic commitments that may have been entered into during the year, the SG has unilaterally deducted the full **£1.523m** from Scottish Borders 2022/23 PCIF allocation, resulting in no Tranche 2 payment being made.

Impact on 2022/23 and Future Years Plans

During 2022/23, the Health and Social Care Partnership and Health Board, in order to deliver as much of the MOU as it can, then fully directed and committed the allocation as soon as it practicably could, directing all of the allocation with the exception of the anticipated £0.079m retained as notified by the SG in the Tranche 1 allocation letter.

Workstream	PCIP 3-Year Recurring Investment £'000
VTP	16
Pharmacotherapy	879
CTAC	121
Urgent Care	883
FCP	528
Mental Health	669
Community Link Workers	150
Central Costs	49
22/23 Pay Inflation and Drift (Funded Recurrent)	273
Total Expenditure	**3,569**
Funded by:	
2.15% of £170m*	(3,648)
Withheld by SG	79
Forecast Expenditure	
Total	**(3,569)**

This is in direct comparison to the Tranche 2 allocation letter which advised that no additional tranche will be made beyond Tranche 1, which was an allocation of **£2.553m**. As a result of no additional tranche, Scottish Borders has had to utilise almost **£1.100m** of its non-recurring PCIP Reserve (a non-recurring allocation made by SG at the end of 2020/21 which had been earmarked for the acquisition of Order Comms system, ANP Training and a Test of Change for CTCS. This resource is therefore no longer available and it is anticipated that the remaining reserve figure of £0.383m will again be clawed back by the SG during 2023/24 in a similar manner.

2023/24 Outlook

Presently, it is not yet known what the 2023/24 PCIF allocation will be. In relation to next year, the Scottish Government has stated that "the minimum budgeted position for PCIF in future years is £170m subject to Agenda for Change uplifts available for recruited staff. We will work with Chief Financial Officers on the exact processes for how the PCIF will be allocated next year, including exploring the possibility of baselining the fund. Baselining the fund would ensure that all funding (staff and non-staff costs) would be uplifted in line with the annual uplift applied to funding allocations to Health Boards.

On any carried over reserves from 2022-23, you should assume for the time being that you should continue to reinvest any locally held reserves in the implementation of PCIPs in 2023-24 before new funding is requested. The only exception to this is where IAs have a prior agreement with Scottish Government to hold reserves to cover legal commitments in future years. In this case, we would expect you to hold sufficient reserves to cover those legal commitments and only use reserves on PCIP implementation in 2023-24 where they are surplus to the commitments agreed with Scottish Government."

As a result of the statement underlined above, it is likely therefore that the 2023/24 allocation will be reduced by £0.383m of the remaining IJB reserves brought forward from 2022/23.

As outlined earlier also, should this happen, this will mean an inability to fund non-recurrently EMIS training, FCP Prescriber training, Order Comms, ANP training and a CTCS Test of Change.

Without a substantial increase in funding allocation (in the region of £2.4m or 67%), PCIP remains financially unaffordable, resulting in an inability to fund the costs of VTP that are now being incurred or to contribute towards the implementation of CTCS. Both of these are directly in contravention of MOU, as a result of insufficient PCIF funding.

Bridging the Gap

To be financially sustainable going forward, the affordability gap between forecast expenditure and current / forecast PCIP resource envelope must be significantly reduced. In summary, there are two main ways that this can happen:

1. Reduce the level of expenditure required by the current plan through improved cost-effectiveness, rationalisation or cessation of services currently in place or proposed;

2. **Seek to increase the level of resources available to support the delivery of the Primary Care Improvement Plan.**

In all likelihood, both approaches are required and Figure 1 below outlines some of the suggested ways that this might happen:

Figure 1: Required Affordability Objectives and Approach

Primary Care Improvement Plan	
Expenditure	**Resource Envelope**
Options to Reduce	Options to Increase
Efficiency Review of Models of Delivery Identify Alternative Models of Delivery Review Model v MOU2 Review / Challenge MOU2 Rationalise or Cease Workstreams	Seek Increased PCIF Allocation Direct Other Allocations to PCIP Partner Cost Pressures Targeted Re-Investment of Planned Efficiencies

Options to Reduce Funding Requirement

Given the current forecast recurring affordability gap, the Partnership must consider ways in which the projected forecast cost of delivering the PCIP can be mitigated. Potential options are detailed below:

Efficiency Reviews	Each workstream's model of delivery should be reviewed with a view to ensuring that the optimally economic model is in place to deliver required outcomes at the lowest possible cost.
Alternative Models	Alternative, less expensive models of delivery should be considered. It may be possible to deliver required outcomes more cost effectively.
Review against MOU2	The Memorandum of Understand should be reviewed and current targeted outcomes evaluated against it. Only specifically required outcomes should be targeted and delivery models reviewed and where required, rationalised accordingly.
Challenge MOU2	There should be ongoing dialogue with the Scottish Government as to whether previously directed PCIF resource can be moved from lower priority workstreams towards higher priority workstreams in order to reduce overall resource requirement.
Rationalisation / Cessation	Given the ongoing affordability gap, there should be an assessment of whether some workstreams now in place can be rationalised or even ceased. This will also require engagement with the Scottish Government.

Options to Increase Resource Envelope

Similarly, options for increasing the level of resource available to fund PCIP require identification and consideration. These include:

Increased Allocation	Scottish Government should continue to be lobbied for a further increase in the overall national PCIP resource envelope. It should also be highlighted that NRAC proportionately as an allocation base does not meet the resource requirement in the Borders.
Other Allocations	Some partnerships have supplemented PCIF with other SG allocations in order to increase funding of PCIPs. To date, this has not happened within the Scottish Borders although a small proportion of core baseline funding supplements MH Renew. Advice from Scottish Government also suggests that partnerships should consider how Recovery and Renewal, Action 15 investment and PCIF is combined to deliver the Mental Health model set out in the planning guidance for example.
Increased Partner Investment	It may be possible that partners can increase baseline funding to support PCIP and supplement PCIF allocations.
Planned Efficiencies	THE H&SCP IJB may wish to direct the delivery of further planned efficiencies in order to create financial capacity to reinvest any efficiency savings in a targeted manner to PCIP, although there is already a substantial challenge here.

Primary Care Infrastructure - GP Premises Improvement

In addition to the core PCIF allocation, Partnerships have received a series of small further allocation from the Scottish Government specifically to be directed towards the improvement of GP Premises. Allocations were made in each of the last 3 financial years with accompanying conditions that they be prioritised for use through a combination of improvement grants, physical property estate works or digitisation of physical records in order to create clinical or administrative space.

No confirmation of any allocation has yet been received this financial year (2023/24). Over 3 years however, the allocations received are detailed in Table 5 below:

Table 5: Premises Funding Allocations

	PCIP Premises Funding Allocation £'000
2019/20	105
2020/21	107
2021/22	106
Total	**318**
2022/23	0

In total therefore, £0.318m has been received to date. In February 2021, a report was approved by GP Executive, which following a process of evaluation of proposals, directed £0.214m towards premises improvement. This fully consumed the £0.212m of funding allocations received during 2019/20 and 2020/21.

Taking account of the subsequent £0.106m allocation received in 2021/22, no commitment has been made against the remaining balance of £0.104m to date therefore.

Actual expenditure at the end of 2021/22 is detailed in Table 6 below.

Table 6: Premises Expenditure by Workstream

	PCIP Premises Expenditure by Workstream		
	Directed by GP Executive £'000	Actual Expenditure £'000	Remaining Balance £'000
Improvement Grants	53	46	7
Premises Works to Increase Space	47	11	36
Digitisation of GP Practice Records	114	0	114
Sub-Total	**214**	**57**	**157**
2021/22 Balance Remaining Undirected	**104**	**0**	
Total	**318**	**57**	

A particular issue has arisen in respect of digitisation of practice records. In early 2021, bids were submitted by 5 practices at a total cost of £0.114m in respect of digitisation of records. At that point in time, the amount directed was based on a quoted unit cost per record of £2.28 by Microtech, the preferred supplier, in October 2020. Since then however, the supplier has revised the unit cost to £3.85 per unit, an increase of 69% which has cast the overall financial affordability and cost-effectiveness of the proposals into question, particularly given the competing premises priorities highlighted in the recent Buchan Associates review of the Primary Care Property Estate. Alternative suppliers have been approached but to date, an equally-effective and affordable solution has yet to be identified. As a result therefore, PCIP / GP Executive groups require to reconsider priorities across the estate and (a) identify how the 2021/22 allocation can be used to best address them (including any further allocation that may be received going forward) and (b) reconsider whether previously agreed proposals should continue to be progressed given competing priorities, slippage in work to date and overall affordability concerns of the previously agreed plan.

“

I would like to thank everyone involved in the implementation of the Primary Care Improvement Plan for making great strides forward over the past year, so that people who need Primary Care services have improved access and get the right care, in the right place at the right time.

”

- Chris Myers

Chief Officer of Integration Joint Board

Acknowledgements

PCIP transformation work would not be possible without the dedicated support and involvement of the various workstreams highlighted in this report. Although it is not possible to name everyone individually, PCIP Executive Committee would like to thank everyone who has contributed to the drafting, testing, implementation and refining of Scottish Borders' Primary Care Improvement Plan.

Workstream Leads

Workstream	Lead
Vaccination Transformation Programme	Nicola Macdonald – Clinical Service Manager
Community Treatment and Care Services	Kathy Steward – Clinical Nurse Manager
Pharmacotherapy	Malcolm Clubb – Lead Pharmacist Primary and Community Services
Community Mental Health "Renew"	Dr Caroline Cochrane – Director of Psychological Services and Head of Psychology Speciality
Urgent Care Services	Lisa Hume – Lead Advanced Nurse Practitioner
Musculoskeletal Services "First Contact Physio"	Wilna-Mari Van Staden – Clinical Lead Advanced Physiotherapy Practitioner
Premises	Rob Cleat – Primary and Community Services Premises Lead
Communications	Clare Oliver – Communications Manager
Finance	Paul Mcmenamin–Deputy Director of Finance / Finance Business Partner (IJB)

PCIP Executive Committee

GP Executives	Dr Rachel Mollart Dr Kevin Buchan Dr Kirsty Robinson Dr Robert Manson
NHS Borders	Cathy Wilson – General Manager Dr Tim Young – Associate Medical Director
Integration Joint Board	Chris Myers – Chief Officer Hazel Robertson – Chief Finance Officer

PCIP Project Management

Senior Project Manager	Owain Simpson

June 2023

Scottish Borders

PCIP Executive Committee

56

Scottish Borders Health and Social Care Partnership
Integration Joint Board

20 September 2023

ALCOHOL AND DRUGS PARTNERSHIP ANNUAL SURVEY RETURN TO SCOTTISH GOVERNMENT 2022-23

Scottish Borders Health and Social Care PARTNERSHIP

Report by Fiona Doig, Head of Health Improvement/Strategic Lead Alcohol and Drugs Partnership

1. PURPOSE AND SUMMARY

1.1. To brief the Integration Joint Board on the contents of the Alcohol and Drugs Partnership (ADP) on its Annual Survey Return to Scottish Government 2022-23 and seek approval for the Survey's final sign off.

1.2. The report outlines some areas of good practice, for example, involvement of people with lived and living experience and support for families impacted by another's drug use. It also provides some areas for improvement such as provision of information in different formats and support for specific groups.

1.3. A brief update is included on this cover paper on key data published since submission of the Survey.

2. RECOMMENDATIONS

2.1. **The Integration Joint Board is asked to approve final sign off of the Annual Survey.**

3. ALIGNMENT TO STRATEGIC OBJECTIVES AND WAYS OF WORKING

3.1. It is expected that the proposal will impact on the Health and Social Care Strategic Framework Objectives and Ways of Working below:

Alignment to our strategic objectives					
Rising to the workforce challenge	Improving access	Focusing on early intervention and prevention	Supporting unpaid carers	Improving our effectiveness and thinking differently to meet need with less	Reducing poverty and inequalities
	x	x			

Alignment to our ways of working					
People at the heart of everything we do	Good agile teamwork and ways of working – Team Borders approach	Delivering quality, sustainable, seamless services	Dignity and respect	Care and compassion	Inclusive co-productive and fair with openness, honesty and responsibility
x				x	x

4. INTEGRATION JOINT BOARD DIRECTION

4.1. A Direction is not required.

5. BACKGROUND

5.1. Borders ADP is a partnership of agencies and services involved with drugs and alcohol. It provides strategic direction to reduce the impact of problematic alcohol and drug use in Borders. It is chaired by the Director of Public Health and the Vice Chair is Scottish Borders Council's Director – Social Work and Practice. Membership includes officers from NHS Borders, Scottish Borders Council, Police Scotland and Third Sector. The work of Borders ADP is directed by the Scottish Government and delivery is informed by national standards and local needs.

5.2. The ADP is required to report annually to Scottish Government on performance using a prescribed format. This Annual Survey 2022-23 is intended to inform the following:

- The monitoring of the National Mission to reduce drug related deaths
- The work of a number of national groups (e.g. Whole Family Approach Group)
- The priority areas of work for national organisations which support delivery (e.g. Scottish Drugs Forum).

The survey will be analysed and findings published at an aggregate level by Scottish Government. ADPs are not expecting individualised local data.

5.3. It is not expected that the Survey will cover all of the work undertaken, for example, the ADP submits quarterly financial information to Scottish Government and quarterly progress reports on the Medication Assisted Treatment (MAT) Standards.

5.4. A link to a Highlight Annual Report Graphic is included as an Appendix.

6. KEY AREAS TO HIGHLIGHT TO THE STRATEGIC PLANNING GROUP

6.1 Areas of good practice

6.1.1 Alcohol and Drug Related Deaths Review – Questions 1-4 ask about practice in relation to reviews of alcohol and drug related deaths. Borders ADP has been recognised as following good practice in undertaken multi-agency reviews of drug related deaths which are supported by a Drug Related Death Review Group and reported to Critical Services Oversight Group (CSOG). ADPs are also expected to undertake reviews of Alcohol Specific Deaths. We have support from Public Health Scotland to take this work forward and are one of only a small number of ADPs to start this piece of work.

6.1.2 Lived and Living Experience – Questions 8-12 relate to lived and living experience. There have been improvements over time locally in how we ensure the voices of people with lived and living experience are both heard and able to influence service delivery and planning.

6.1.3 People most at risk have access to treatment and recovery – Questions 20 – 24 review support for people accessing non-fatal overdoses (NFO) and involvement with recovery communities. The local NFO pathway has been in place since May 2021 and key performance indicators are positive. Borders ADP has strong and positive links with our local recovery activists who have made a wealth of contribution to the local area.

6.1.4 Treatment and support services for particular groups – Question 31 asks about specifical support for people from particular groups (e.g. with protected characteristics). This will be

explored further during completion of an Equality and Human Rights Impact Assessment (EHRIA) which is in progress to support our new ADP Strategy.

6.1.5 Children, families and communities affected by substance use are supported – Question 36-39 ask about support for families. A dedicated Children and Families provision is provided by Action for Children Chimes Service and We Are With You provide support for adults impacted by a loved one's substance use.

6.2 Areas for improvement

6.2.1 Accessibility – Question 16 related to information available in alternative formats. This is an area of improvement to be explored during our EHRIA completion.

6.2.2 Support services for children and young people aged 16 and under – Questions 29a and 30a related to support for young people affected by their own substance use. Young people are supported by third sector colleagues in relation to risk taking behaviours and emotional wellbeing. It is anticipated that standards for children and young people's provision will be issued in Autumn by Scottish Government which will likely inform local commissioning. Local children's service commissioning is progressed by the Children and Young People's Planning Partnership.

6.3 Areas for additional noting

6.3.1 Questions 5a and 6a outline the workforce whole time equivalent within the ADP Support Team (2.9WTE) and in service delivery (currently 41.2WTE). It is important to note the relatively small scale of personnel charged with delivering on a wide agenda.

6.3.2 The majority of additional funding in recent years has led to an increase in staff to deliver on improvements in service and recovery. However, it remains the case that caseloads are high and services are under pressure. ADP Support Team staffing has increased by 0.1 WTE since 2012 during which time the reporting requirements and areas of involvement have increased.

6.4 Summary relating to the Survey

6.4.1 The ADP is sighted on the areas for improvement and, while it is the case it is not expected that all areas will have all elements of the survey in place there are particular areas for improvement noted in section 6.2 which will be explored as part of the consultation to develop a local Delivery Plan.

6.5 Update on key data published since submission of the report

6.5.1 In August and September 2023 the National Records Scotland published national drug related deaths and alcohol related deaths figures respectively.

6.5.2 Nationally there was a 21% reduction in the number of people who had a drug related death to 1051, the lowest number since 2017, however, this remains 3.7 times greater than in 2000. 13 deaths were reported for Borders compared to 17, 18 and 17 in the previous three years. A local Drug Death Review Group reviews the circumstances of all individuals and reports to the Critical Services Oversight Group.

6.5.3 Nationally there was a 2% increase in the number of people who had an alcohol related death (1276). There was a significant increase in female deaths. 21 deaths were reported for Borders compared to 21, 15 and 15 in the previous three years. The ADP is currently undertaking an

audit of all alcohol related deaths in 2021 and expect there to be some local learning arising from this.

6.5.4 Health related behaviours are reported annually for adults by the Scottish Health Survey. However, there are only 125 people sampled in the Borders. We urgently need more granular data so we can work effectively to meet locality needs and are exploring cost-effective solutions to do this.

7. IMPACTS

Community Health and Wellbeing Outcomes

7.1. This paper is an Annual Survey return on retrospective activity and while it is expected that the services described in the Survey impact positively across these outcomes the submission of the Survey will not necessarily have direct impact.

N	Outcome description	Increase / Decrease / No impact
1	People are able to look after and improve their own health and wellbeing and live in good health for longer.	**No impact**
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.	**No impact**
3	People who use health and social care services have positive experiences of those services, and have their dignity respected.	**No impact**
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	**No impact**
5	Health and social care services contribute to reducing health inequalities.	**No impact**
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.	**No impact**
7	People who use health and social care services are safe from harm.	**No impact**
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.	**No impact**
9	Resources are used effectively and efficiently in the provision of health and social care services.	**No impact**

7.2. The impact of this work on the outcome areas for the national mission are outlined in the table below. At a local level these are applied across both alcohol and drug use:

N / L	Outcome description	Increase / Decrease / No impact
1	Fewer people develop problem drug use	**No impact**
2	Risk is reduced for people who take harmful drugs	**No impact**
3	People at most risk have access to treatment and recovery	**No impact**
4	People receive high quality treatment and recovery services	**No impact**
5	Quality of life is improved for people who experience multiple disadvantage	**No impact**
6	Children, families and communities affected by substance use are supported	**No impact**

Financial impacts

7.3. There are no costs attached to any of the recommendations contained in this report.

Equality, Human Rights and Fairer Scotland Duty

7.4. This is an Annual Survey and therefore is not proposing any changes to policy or service. Gaps identified in the survey will be included in a new ADP Strategic Plan. Plans are in development for proceeding with an Impact Assessment to inform the Delivery Plan for the Strategic Plan.

Legislative considerations

7.5. There are no legislative considerations arising from the Survey return.

Climate Change and Sustainability

7.6 There are no climate change and sustainability impacts and considerations arising from the Survey return.

Risk and Mitigations

7.7 While there are no proposals associated with the Survey it is anticipated that the main risk to addressing any of the identified areas for improvement will be the relatively small size of the workforce versus the increasing expectations from Scottish Government and desire to ensure we are compliant with these.

7.8 Staff wellbeing in the face of competing pressures is noted. A Wellbeing Session is hosted weekly by the Addictions Psychological Therapies Team and is open to all alcohol and drugs services and the ADP Support Team. All staff receive monthly supervision. There is also coaching in psychological approaches to support confidence and practice.

8 CONSULTATION

Communities consulted

8.1 The expectation from Scottish Government for completing the Survey was that it should be completed by the ADP Support Team. There was no additional consultation undertaken other than clarification on workforce information from services.

Integration Joint Board Officers consulted

8.2 The Annual Survey has been presented to the HSCP Strategic Planning Group.

Approved by:

Dr Sohail Bhatti, Director of Public Heath, ADP Chair

Author(s)

Fiona Doig, Head of Health Improvement/Strategic Lead Alcohol and Drugs Partnership
Susan Elliot, Alcohol and Drugs Partnership Co-ordinator

Background Papers: n/a

Previous Minute Reference: n/a

For more information on this report, contact us at Fiona Doig, Head of Health Improvement/Strategic Lead ADP, bordersadp@borders.scot.nhs.uk , 07825523603

Alcohol and Drug Partnership (ADP) Annual Reporting Survey: 2022/23

This survey is designed to collect information from all ADPs across Scotland on a range of aspects relating to the delivery of the National Mission **during the financial year 2022/23.** This will not reflect the totality of your work but will cover those areas where you do not already report progress nationally through other means.

The survey is primarily composed of single option and multiple-choice questions, but we want to emphasise that the options provided are for ease of completion and it is not expected that every ADP will have all of these in place. We have also included open text questions where you can share more detail.

We do not expect you to go out to services in order to respond to questions relating to activities undertaken by them in your area. Where questions refer to service level activities, we are interested in the extent to which you are aware of these at an ADP level.

We are aware of some element of duplication with regards to questions relating to MAT Standards and services for children and young people. To mitigate this, we've reviewed the relevant questions in this survey and determined the ones that absolutely need to be included in order to evidence progress against the national mission in the long-term. While some of the data we are now asking for may appear to have been supplied through other means, this was not in a form that allows for consistently tracking change over time.

The data collected will be used to better understand the challenges and opportunities at the local level and the findings will be used to help inform the following:

- The monitoring of the National Mission;
- The work of a number of national groups including the Whole Family Approach Group, the Public Health Surveillance Group and the Residential Rehabilitation Working Group, amongst others; and
- The priority areas of work for national organisations which support local delivery.

The data **will** be analysed and findings will be published at an aggregate level as Official Statistics on the Scottish Government website. All data will be shared with Public Health Scotland to inform drug and alcohol policy monitoring and evaluation, and excerpts and/or summary data may be used in published reports. It should also be noted that the data provided will be available on request under freedom of information regulations and so we would encourage you to publish your return.

The deadline for returns is Tuesday 27th June 2023. Your submission should be signed off by the ADP and the IJB with confirmation of this required at the end of the questionnaire. We are aware that there is variation in the timings of 1.1B meetings so please let us know if this will be an issue.

If you require clarification on any areas of the survey or would like any more information, please do not hesitate to get in touch by email at substanceuseanalyticalteam@gov.scot.

Cross-cutting priority: Surveillance and Data Informed

01) Which Alcohol and Drug Partnership (ADP) do you represent?
[single option, drop-down menu]

Borders ADP

Q2) Which groups or structures were in place **at an ADP level** to inform surveillance and monitoring of alcohol and dreg harms or deaths? (select all that apply)
[multiple choice]

U Alcoho harms group

- ❑ Alcoho death audits (work being supported by AFS)
- Drug death review group
- Drug trend monitoring group/Early Warning System
- ❑ None
- ❑ Other (please specify):

Q3a) Do Chief Officers for Public Protection receive feedback from drug death reviews? (select only one)
[single option'
N Yes

- ❑ No
- ❑ Don't know

Q3b) If no, please provide details on why this is not the case.
(open text — maximum 255 characters)

Clila) As part of the structures in place for the monitoring and surveillance of alcohol and drugs harms or deaths, are there local processes to record lessons learnt and how these are implemented? (select only one)
[single option'
Z Yes

- ❑ No
- ❑ Don't know

Q4b) If no, please provide details.
[open text — maximum 255 characters]

This is in **place for drug related deaths. We are in the early stages of an audit of alcohol** related deaths.

Cross-cutting priority: Resilient and Skilled Workforce

Q5a) What is the whole-time equivalent staffing resource routinely dedicated to your ADP Support Team as of 31st March 2023.
[open text, decimal]

total current staff (whole-time equivalent including fixed-term and temporary staff, and those sharec with other business areas)	2.9U
Total vacancies (whole-time equivalent)	0.00

Q5b) What type of roles/support (e.g. analytical support, project management support, etc.) do you think your ADP support team might need locally? Please indicate on what basis this support would be of benefit in terms of whole-time equivalence.
[open text — maximum 255 characters]

Analyst/Project Management Support for Co-Morb dities Work/Alcohol Death Audit/Needs Assessment, co-ordination of reporting requirements, monitor trends - **1WTE**
Recovery and engagement worker - develop- family involvement 0.5W I

Q6a) Do you have access to data on **alcohol and drug services** workforce statistics in your ADP area? (select only one)
[single option]

- Yes
- ❑ No (please specify who does):
- ❑ Don't know

6b) If yes, please provide the whole-time equivalent staffing resource **for alcohol and drug services in** your ADP area.
[open text, decimal]

Total current staff (whole-time equivalent)	**41.2**
Total vacancies (whole-time equivalent)	**2.80**

Q7) Which, if any, of the following activities are you aware of having been undertaken in your ADP area to improve and support workforce wellbeing (volunteers as well as salaried staff)? (select all that apply)
[multiple choice]

- Coaching, supervision or reflective practice groups with a focus on staff wellbeing
- **Flexible** working arrangements
- Management of caseload demands

In Provision of support and well-being resources to staff

- Psychological support and wellbeing services
- ❑ **Staff recognitions schemes**
- ❑ **None**
- ❑ **Other (please specify):**

Cross cutting priorities: Lived and Living Experience

Q8a) Do you have a formal mechanism at an ADP level for gathering feedback from people with lived/living experience using services you fund? (select all that apply)
[multiple choice]
El Feedback/complaints process
El Questionnaire/survey
❑ No
El Other (please specify): Living Experience Forum (Borders Engagement Group) facilitated by SDP; Lived Experience Forum facilitated by ADP commissioned service

Q8b) How do you, as an ADP, use feedback received from people with lived/living experience and family members to improve service provision? (select all that apply)
[multiple choice]

	Lived/living experience	Family members
Feedback used to inform service design	2)	2)
Feedback used to inform service improvement	2)	21
Feedback used in assessment and appraisal processes for staff	■	■
Feedback is presented at the ADP board level	2)	2)
Feedback is integrated into strategy	2)	2)
Other (please specify)		

09a) How are **people with lived/living experience** involved within the ADP structure? (select all that apply)
[multiple choice]

	Planning (e.g. prioritisation and funding decisions)	Implementation (e.g. commissioning process, service design)	Scrutiny (e.g. monitoring and evaluation of services)	Other (please specify)
Board representation at ADP	rti	E	E	
Focus group	E4	IS	E	
Lived experience panel/forum	0	IS	E	
Questionnaire/ surveys	of-	■	E	
Other (please specify)				

Q9b) How are **family members** involved within the ADP structure? (select all that apply) [matrix, multiple choice]

	Planning (e.g. prioritisation and funding decisions)	Implementation (e.g. commissioning process, service design)	Scrutiny (e.g. monitoring and evaluation of services)	Other stage (please specify)
Board representation at ADP		•	•	
Focus group	—	Z	g	
Lived experience panel/forum	–	•	❑	
Questionnaire/ surveys	—	■	❑	
Other (please specify)				

Q9c) If any of the above are in development for either people with lived/living experience and/or family members, please provice details.
[open text — maximum 2000 characters]

The Lived Experience Forum is open to family members to attend and the Forum rep attends the Board meeting along5ide the commissioned service role of Community Engagement Worker, however, there is not specific arrangement for family members

010) What monitoring mechanisms are in place to ensure that services you fund are encouraged/supported to involve people with lived/living experience and/or family members in the different stages of service delivery (i.e. planning, implementation and scrutiny)?
[open text — maximum 2000 characters]

This is discussed during monitoring meetings although there is no formal way this is recorded/monitor

011) Which of the following support is available to people with lived/living experience and/or family members to reduce barriers to involvement? (select that apply)
[multiple choice]

El Advocacy
El Peer support
El Provision of technology/materials
El Training and development opportunities
El Travel expenses/compensation
0 Wellbeing support
❑ None
❑ Other (please specify):

Q12a) Which of the following volunteering and employment opportunities for people with lived/liv ng experience are offered by services in your area? (select all that apply)
[multiple choice]
El Community/recovery cafes
❍ lob s<ills support
• Naloxone distribution
❍ Peer support/mentoring
❑ Psychosocial counselling
❑ None
❍ Other (please specify): Addiction Worker Training Programme

Q12b) What are the main barriers to providing volunteering and employment opportunities to people with lived/living experience within your area?
[open text - maximum 2000 characters]

We are a small rural area and people with lived experience are not always comfortable to disclose this openly within their professional role.
We have had occassions where safeguarding policies in services have meant some people's Disclosure Records have prevented their employment.

C113) Which organisations or groups are you working with to develop your approaches and support your work on meaningful inclusion? (select all that apply)
[multiple choice]
❍ MAT Implementation Support Team (MIST)
❍ Scottish Drugs Forum (SDF)
❑ Scottish Families Affected by Drugs anc Alcohol (SFAD)
❍ Scottish Recovery Consortium (SRC)
❑ None
❑ Other (please specify):

Cross cutting priorities: Stigma Reduction

014) Do you consider stigma reduction for people who use substances and/or their families in any of your written strategies or policies (e.g. Service Improvement Plan)? (select only one)
[single option]
El Yes (please specify which): **ADP** Strategy/ADP Delivery **Plan**
❑ **No**
❑ Don't know

15) Please describe what work is underway to reduce stigma for people who use substance and/or their families in your ADP area.
[open text — maximum 2000 characters]

Stigma and confidentiality concerns for people accessing services can be heightened in a rural area due to smaller communities. Communications distributed about NHS Inform information on ending drug and alcohol stigma and SG 40 sec TV advert.
Specific page created on ADP website including information on recommended language.
Language matters information shared annually with all services and key stakeholders.
We have offered Stigma training via the Workforce Directory.
We directly respond to concerns raised by our Borders Engagement Group (living experience) e.g. feedback to providers on stigmatising experiences.
We share a 'you said, we did' information sheet to the Group.

Fewer people develop problem substance use

16) How is information on local treatment and support services made available to different audiences **at an ADP level** (not at a service level)? (select all that apply) [multiple choice]

	Non-native English speakers (English Second Language)	People with hearing impairments	People with learning disabilities and literacy difficulties	People with visual impairments	Other audience (please specify)
In person (e.g. at events, workshops, etc)	❑	❑	❑	❑	
Leaflets/posters	❑	❑	❑	❑	
Online (e.g. websites, social media, apps, etc.)	❑	❑	❑	❑	
Other (please specify)					

Q17) Which of the following education or prevention activities were funded or **supported by the ADP? (select all that apply)**
[multiple choice]

	0-4 (early years)	5-12 (primary)	13-15 (secondary S1-4)	16-24 (young people)	25+ (adults)	Parents	People in contact with	Other audience (please specify)
Counselling services	•	•	•	0	•	•	•	
Information services	•	•	•	0	•	•	•	?
Physical health	•	•	•	0	2)	•	•	website Rachel pilot?
Mental health	23	•			23	•		s
Naloxone	•	•	•		21	•		II
Overdose awareness and prevention	•	•	•		21	•		II
Parenting	•	•	•	0	•	•	•	
Peer-led interventions	•	•	•	•	•	•	•	
Personal and social skills	•	•	•	0	•	•	•	
Planet Youth	0	0	0	0	0	0	0	
Pre-natal/pregnancy	•	•	•	El	El	0	•	
Reducing stigma	•	•	•	0	•	•	•	
Seasonal campaigns	•	•	•	El	21	21	•	
Sexual health	•	•	•	0	•	•	•	
Teaching materials for schools	S3	-		0	•	•	•	
Wellbeing services	•	•	•	•	•	•	•	
Youth activities (e.g. sports, art)	•	•	•	0	•	•	•	
Youth worker materials/training	•	• -			•	•	•	
Other (please specify)								

Risk is reduced for people who use substances

Q18a) In which of the following settings is **naloxone** supplied in your ADP area? (select all that apply)
[multiple choice]
Ei Accident & Emergency departments
Ei Community pharmacies
- Drug services (NHS, third sector, council)
- ❑ Family support services
- ❑ General practices
- ❑ Homelessness services
- ❑ Justice services
- Mental health services
- Mobile/outreach services
- Peer-led initiatives
- ❑ Women support services
- ❑ None
- ❑ Other (please specify):

Q18b) In which of the following settings is **Hepatitis C testing** delivered in your ADP area? (select all that apply)
[multiple choice]
- ❑ Accident & Emergency departments
- ❑ Community pharmacies
- Drug services (NHS, third sector, council)
- ❑ Family support services
- General practices
- ❑ Homelessness services
- ❑ Justice services
- ❑ Mental health services
- Mobile/outreach services
- ❑ Peer-led initiatives
- ❑ Women support services
- ❑ None

Ei Other (please specify): **Sexual health Services**

018c) In which of the following settings is the provision of injecting equipment delivered in your ADP area? (select all that apply)
[multiple choice]
❑ Accident & Emergency departments
Ei Community pharmacies
El Drug services (NHS, third sector, council)
❑ Family support services
❑ General practices
❑ Homelessness services
❑ Justice services
❑ Mental health services
El Mobile/outreach services
❑ Peer-led initiatives
❑ Women support services
❑ None
❑ Other (please specify):

Q18d) In which of the following settings is **wound care** delivered in your ADP area? (select all that apply)
[multiple choice]
Accident & Emergency departments
El Community pharmacies
0 Drug services (NHS, third sector, council)
❑ Family support services
0 General practices
❑ Homelessness services
❑ Justice services
❑ Mental health services
E Mobile/outreach services
❑ Peer-led initiatives
❑ Women support services
❑ None
❑ Other (please specify):

Q19a) Are there protocols in place to ensure **all** prisoners identified as at risk are offered with naloxone upon leaving prison? (select only one)
[single option]
❑ Yes
❑ No
El No prison in ADP area

019b) If no, please provide details.
[open text — maximum 255 characters]

People most at risk have access to treatment and recovery

Q20a) Are referral pathways in place in your ADP area to ensure people who experience a near-fatal overdose (NFO) are identified and offered support? (select only one)
[single option]

- Yes
- ❑ No
- ❑ Don't know

Q20b) If yes, have people who have experienced a near-fatal overdose been successfully referred using this pathway? (select only one)
[single option]

- Yes
- ❑ No
- ❑ Don't know

Q20c) If no, when do you intend to have this in place?
[open text — maximum 255 characters]

Q21) In what ways have you worked with justice partners? (select all that apply) [multiple choice]

- Contributed towards justice strategic plans (e.g. diversion from justice)
- ❑ Coordinating activities
- Information sharing
- ❑ Joint funding of activities
- Justice partners presented on the ADP
- ❑ Prisons represented on the ADP (if applicable)
- Providing advice/guidance
- ❑ None
- ❑ Other (please specify):

Q22a) Do you have a prison in your ADP area? (select only one)
[single option]

❑ Yes
Z No

Q22b) Which of the following activities did the ADP support or fund at the different stages of engagement with the justice system? (select all that apply)
[multiple choice]

	Pre-arrest	In police custody	Court	Prison (if applicable)	Upon release	Community justice
Advocacy	D	●	●	El	•	•
Alcohol interventions	D	-4r		0		-4r
Alcohol screening	D	ir	•	0	•	ir
Buvidal provision	D	●	●	●	●	●
Detoxification	0	•	•	E	•	•
Drugs screening	D	●	●	●	E	●
Psychological screening	D	●	●	●	E	●
Harm	D	●	●	●	E	ir
Health education	D	●	●	●	E	●
"Life skills" support or training (e.g. personal/social skills, employability)	D	17	17	III	17	17
Opioid Substitution Therapy (excluding Buvidal)	D	●	●	●	●	●
Peer-to-peer naloxone	D	●	●	●	●	●
Recovery cafe	D	●	●	●	●	●
Recovery community	D	●	●	●	●	●
Recovery wing	D	●	●	●	●	●
Referrals to alcohol treatment services	0		•		•	,
Referrals to drug treatment services	D	-.	●	●	●	-..-
Staff training	D	●	●	●	●	●
Other (please specify)						

Q23a) How many recovery communities are you aware of in your ADP area? [open text, integer]

2

Q23b) How many recovery communities are you actively engaging with or providing support to?
[open text, integer]

2

Q24a) Which of the following options are you using to engage with or provide support to recovery communities in your area? (select all that apply)
[multiple choice]

- Funding
- Networking with other services
- Training

❑ None
❑ Other (please specify):

Q24b) How are recovery communities involved **within the ADP?** (select all that apply) [multiple choice]

- Advisory role
- Consultation
- Informal feedback

❑ Representation on the ADP board
❑ Recovery communities are not involved within the ADP
❑ Other (please specify):

People receive high quality treatment and recovery services

Q25) What treatment or screening options are in place to address **alcohol harms?** (select all that apply)
[multiple choice]

- ❍ Access tp alcohol medication (Antabuse, Acamprase, etc.)
- ❍ Alcohol iospital liaison
- ❍ Alcohol -elated cognitive testing (e.g. for alcohol related brain damage)
- Arrangements for the delivery of alcohol brief interventions in all priority settings
- Arrangement of the delivery of alcohol brief interventions in non-pricrity settings
- ❍ Community alcohol detox
- ❍ In-patient alcohol detox
- Fibro scanning
- Psychosocial counselling
- ❑ None
- ❑ Other (please specify):

Q26) Which, it any, of the following barriers to residential rehabilitation exist in your ADP area? (select all that apply)
[multiple choice]

- ❑ Current models are not working
- ❑ Difficulty identifying all those who will benefit
- ❑ Further workforce training required
- n Incliffirient funds
- ❑ Lack of specialist providers
- ❑ Scope to further improve/re=fine your own pathways
- ❑ None
- ❍ Other (please specify): The new pathway **and** awareness of **it is** still embedding.

Q27) Have you made
any revisions in your pathway to residential rehabilitation in the last
year? (select only one)
[single optipn]

- ❑ No revisions or updates made in 2022/23
- ❍ Revised or updated in 2022/23 and this has been published
- ❑ Revised or updated in 2022/23 but not currently published

Q28) Which, if any, of the following barriers to implementing MAT exist in your area? (select all that apply)
[multiple choice]

- ❑ Difficulty identifying all those who will benefit
- ❑ Further workforce training is needed
- ❑ Insufficient funds
- ❑ Scope to further improve/refine your own pathways
- ❑ None

Other (please specify): **MAT 7** is not implemented as locally GP colleagues do not provide shared care; ongoing development work (e.g. 6,9410) is challenging to sustain with small teams and large caeloads.

Q29a) Which of the following treatment and support services are in place specifically for children and young people **aged between 13 and 24** using **alcohol?** (select all that apply) [multiple choice]

	13 15 (secondary Si 4)	16 24 (young people)
Alcohol-related medication (e.g. acamprosate, disulfiram, naltrexone, nalmefene)	0	g
Diversionary activities	0	**0**
Employability support	0	g
Family support services	0	0
Information services	0	**0**
Justice services	**0**	**0**
Mental health services	**0**	g
Outreach/mobile	■	g
Recuveiy communities	0	0
School outreach	i'4	**0**
Support/discussion groups	**0**	**0**
Other (please specify)	Younger people requiring medication treatment can be jointly supported by our addiction service and other colleagues (e.g. CAMHS, Social Work)	

Q29b) Please describe what treatment and support is in place **specifically for children aged 0-4 (early years)** and **5-12 (primary)** affected by **alcohol.**
[open text - maximum 2000 characters]

We have children and families drug and alcohol provision via a service which also includes young carers support. Support can be provided to all age groups, sometimes people are referred as young carers but may also be impacted by alcohol.
We provide Oh Lila training and Everyone has a story training including targetted sessions for early years and education.

Q30a) Which of the following treatment and support services are in place specifically for children and young people **aged between 13 and 24** using **drugs?** (select all that apply) [multiple choice]

	13-15 (secondary S1-4)	16-24 (young people)
Diversionary activities	0	g
Employability support	0	**0**
Family support services	0	g

Information services	☐	☒
Justice services	☐	☐
Mental health services	☐	☒
Opioid Substitution Therapy	☐	☒
Outreach/mobile	☐	☒
Recovery communities	☐	☒
School outreach	☒	☐
Support/discussion groups	☐	☒
Other (please specify)		

Q30b) Please describe what treatment and support is in place **specifically for children aged 0-4 (early years)** and **5-12 (primary)** affected by **drugs**.
[open text – maximum 2000 characters]

We have children and families drug and alcohol provision via a service which also includes young carers support. Support can be provided to all age groups, sometimes people are referred as young carers but may also be impacted by alcohol.
We provide Oh Lila training and Everyone has a story training including targetted sessions for early years and education

Quality of life is improved by addressing multiple disadvantages

Q31) Do you have specifictreatment and support services in place for the following groups? (select all that apply)
[multiple choice]

	Yes	No
Non-native English speakers (English Second Language)		E
People from minority ethnic groups		E
People from religious groups		E
People who are experiencing homelessness		E
People who are LGBTQl+		g
People who are pregnant o' peri-natal		E
People who engage in transactional sex		E
People with hearing impairments		E
People with learning disabilities and literacy d fficulties		Z
People with visual impairments	D	E
Veterans	0	E
Women	0	1K
Other (please specify)		

C132a) Are there formal joint working protocols in place to support people **with co-occurring substance use and mental health diagnoses** to receive mental health care? (select only one)
[single choice]
I:1 Yes (please provide link here or attach file to email when submitting response):
El No

Q32b) If no, please provide details.
[open text — maximum 255 characters]

This is actively being developed at **the moment**

033) Are there arrangements (in any stage of development) within your **ADP** area for people who present at substance use services with mental health concerns **for which** they do not have a diagnosis?
[open text — maximum 2000 characters]

The Advanced Nurse Practitioner in NHS addictions service is embedding links across third sector alcohol and drugs services to enable discussions and interagency referrals for psychiatric assessment. All alcohol and drugs services can refer to the Addictions Psychology Therapies Team.

Q34) How are you, as an ADP, linked up with support service **not directly linked** to substance use (e.g. welfare advice, housing support, etc.)?
[open text — maximum 2000 characters]

Q35) Which of the following activities are you aware of having been undertaken in local services to implement a trauma-informed approach? (select all that apply)
[multiple choice]

☒ Engaging with people with lived/living experience
☒ Engaging with third sector/community partners
☒ Recruiting staff
☒ Training existing workforce
☒ Working group
☐ None
☐ Other (please specify):

Children, families and communities affected by substance use are supported

Q3G) Which of the following treatment and support services are in place **for children and young people** (under the age of 25) **affected by a parent's or carer's substance use?** (select all that apply)
[multiple choice]

	0-4 (early years)	5-12 (primary)	13-15 (secondary S1-4)	16-24 (you-ig people)
Carer suppert	0	2	2	E
Diversionary activities	0	2	2	E
Employability support	•	0	0	0
Family support services	0	2	0	E
Information services	0	2	0	E
Mental health services	•	0	0	0
Outreach/mobile services	•	0	0	0
Recovery communities	•	0	0	E
School outreach	•	0	0	0
Support/discussion groups	•	0	0	0
Other (please specify)				

Q37a) Do ycu contribute toward the integrated children's service plan? (select only one) [single option]

- ❍ Yes
- ❍ No
- ❍ Don't know

Q37b) If no, when do you plan to implement this?
[open text —maximum 255 characters]

Q38) Which of the following support services are in place **for adults** affected by **another person's substance use?** (select all that apply)
[multiple choice]
❑ Advocacy
El Commissioned services
❑ Counselling
El One to one support
❑ Mental health support
• Naloxone training
El Support groups
❑ Training
❑ None
El Other (please specify): **Recovery Communities**

Q39a): Do you have an agreed set of activities and priorities with local partners to implement the Holistic Whole Family Approach Framework in your ADP area? (select only one)
[single option]
El Yes
❑ No
❑ Don't know

03913) Please provide details.
[open text — maximum 255 characters]
The Whole Family Approach has funded dedicated provision in third sector alcohol and drugs services. There is also the **commissioned** Children and Families service.

039b) Please provide details.
[open text — maximum 255 characters]
The Whole Family Approach has funded dedicated provision in third sector alcohol and drugs services. There is also the commissioned Children and Families service.

C140) Which of the following services supporting Family Inclusive Practice or a Whole Family Approach **are** in place? **(select** all that apply)
[multiple choice]

	Family member in treatment	Family member not in treatment
Advice	0	S
Advocacy	0	2)
Mentoring	❑	■
Peer support	0	2
Personal development	❑	■
Social activities	81	El
Support for victims of gender based violence	❑	
Other (please specify)		

Appendix : ADP Highlight Annual Report 2022-23 (please use this hyperlink to access the information)

ANNUAL REPORT 2022-2023

action on **drugs+alcohol** BORDERS

The Alcohol and Drugs Partnership (ADP) is a partnership of agencies and services responsible for reducing the harms associated with alcohol and drug use. This is carried out in a variety of ways including:

- implementing early intervention and preventative measures
- ensuring good quality drug and alcohol treatment and support services are available
- promoting harm reduction strategies
- involving people with lived and living experience
- research and data collection to better understand the extent and nature of drug and alcohol use in Borders.

The ADP is chaired by the Director of Public Health, NHS Borders and the work of the ADP is directed by the Scottish Government.

HIGHLIGHTS

- An updated Alcohol Profile provided to Licensing Board highlighting alcohol related harm in Borders and to support decision making.
- An Addiction Worker Trainee Post was provided and supported by Scottish Drugs Forum in Borders.
- 330 people attended 25 training courses over 2022-23 and 108 people completed e-learning provided by Scottish Drugs Forum.

- 2699 people who were drinking above the low risk guidelines had a brief intervention with a trained professional.
- 524 people started treatment for their drug or alcohol use and 99.6% started within three weeks of referral.
- 124 people received a rapid emergency response following a near fatal overdose with 89% contacted by the assertive outreach team within 48 hours.
- 19% (28) of resupplies of naloxone were used in an emergency.
- An audit of alcohol specific deaths for 2021 has commenced.
- Entry routes into Residential Rehabilitation reviewed alongside increased funding which has resulted in 5 people were supported to attend.
- Implementation of medication assisted treatment standards 1 - 5 and work progressing with standards 6-10.
- Annual Drug Related Death Report 2021 completed and presented to senior officers in NHS, Scottish Borders Council and Police Scotland.

- Borders in Recovery Community has expanded over the previous year securing funding to allow recruitment of two community officers and expansion of recovery cafes across Borders.
- Recovery Coaching Scotland has provided self coaching courses with referrals open to drug and alcohol services.
- Borders Lived Experience Forum has provided formal feedback on the Residential Rehab Pathway, Injecting Equipment Provision Leaflet, ADP Strategic Plan and Scottish Government Alcohol Marketing Consultation.
- Borders Engagement Group met weekly and provided samples of drugs to WEDINOS Service for testing to generate local drug trend information. The group has also provided feedback for ADP partners on their experiences which have been shared with relevant services.

- 122 referrals to the dedicated Children and Families support service Action for Children Chimes Service.
- We Are With You provided support for 77 adults impacted by a loved one's substance use.
- Information on support for family members made more accessible highlighting both local and national support.

CHALLENGES

Stigma and confidentiality concerns can be heightened in a rural area. Services are offered stigma training, support with recommended language, and the promotion of NHS Inform drug and alcohol stigma campaign.

OUTCOME 1 3 1

Fewer people develop problem drug and alcohol use.

Risk is reduced for people who take harmful drugs and drink excessively.

People at most risk have access to treatment and recovery.

People receive high quality treatment and recovery services.

Quality of life is improved for people who experience multiple disadvantage.

Children, families and communities affected by substance use are supported.

MORE INFORMATION

This page is intentionally left blank

Scottish Borders Health and Social Care Partnership Integration Joint Board

20 September 2023

Directions Tracker

Report by Hazel Robertson, Chief Finance Officer, HSCP and IJB

1. PURPOSE AND SUMMARY

1.1. The Integration Joint Board are asked to note the overview of the implementation of approved directions.

1.2. Overall, good progress is being made in relation to the implementation of the directions issued. 4 are complete, 10 are progressing to plan, 1 is delayed, and 3 areas have been highlighted as having significant delivery challenges. Of the 3 with significant delivery challenges:

- The first relates to the overall financial position for the Health and Social Care Partnership, including the financial overspend on delegated and set aside services in health services, which is being regularly reviewed by the IJB and the IJB Audit Committee jointly with both Finance teams across the Health and Social Care Partnership.
- The second relates to managing the Primary Care Improvement Plan within the available budget, which is being regularly reviewed by the IJB and the IJB Audit Committee, in partnership with NHS Borders.
- The third relates to progress with the palliative care review direction. Whilst there has been work to test the market, it is apparent that this will have a major impact on Officer capacity, which is constrained by other service capacity pressures, including the current focus on the broader unscheduled care agenda.
    - It is proposed that this review is progressed in the 2024/25 Annual Delivery Plan.

2. RECOMMENDATIONS

2.1. **The Scottish Borders Health and Social Care Integration Joint Board (IJB) is asked to:-**

a) Note the contents of the Directions Tracker.

3. ALIGNMENT TO STRATEGIC OBJECTIVES AND WAYS OF WORKING

3.1. It is expected that the proposal will impact on the Health and Social Care Strategic Framework Objectives and Ways of Working below:

Alignment to our strategic objectives					
Rising to the workforce challenge	Improving access	Focusing on early intervention and prevention	Supporting unpaid carers	Improving our effectiveness and thinking differently to meet need with less	Reducing poverty and inequalities
x	x	x	x	x	x

Alignment to our ways of working					
People at the heart of everything we do	Good agile teamwork and ways of working – Team Borders approach	Delivering quality, sustainable, seamless services	Dignity and respect	Care and compassion	Inclusive co-productive and fair with openness, honesty and responsibility
x	x	x	x	x	x

4. INTEGRATION JOINT BOARD DIRECTION

4.1. A Direction is not required.

5. BACKGROUND

5.1. This is a monitoring report to support the effective functioning and performance oversight of the IJB, and the implementation of our strategic objectives.

6. IMPACTS

Community Health and Wellbeing Outcomes

6.1. The intention of this report is to provide a focus for improvement of health services therefore should indirectly impact on the National Health and Wellbeing Outcomes below:

N	Outcome description	Increase / Decrease / No impact
1	People are able to look after and improve their own health and wellbeing and live in good health for longer.	Increase
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.	Increase
3	People who use health and social care services have positive experiences of those services, and have their dignity respected.	Increase
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	Increase
5	Health and social care services contribute to reducing health inequalities.	Increase
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 wellbeing.	Increase
7	People who use health and social care services are safe from harm.	Increase
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.	Increase
9	Resources are used effectively and efficiently in the provision of health and social care services.	Increase

Financial impacts

6.2. There are no costs directly associated with this report. Indicative costs to implement directions are highlighted where known. The Strategic Plan and Financial Plan directions set out the overall expected costs for the IJB.

Equality, Human Rights and Fairer Scotland Duty

6.3. An assessment against these duties is not required as this is a summary report and IIAs will be conducted as required for each item.

Legislative considerations

6.4. None

Climate Change and Sustainability

6.5. None.

Risk and Mitigations

6.6. No specific risks as this is a national overview.

7. CONSULTATION

Communities consulted

7.1. Not relevant.

Integration Joint Board Officers consulted

7.2. Not relevant.

Approved by:

Hazel Robertson, Chief Finance Officer

Author(s)

Chris Myers, Chief Officer

Background Papers Not applicable

Previous Minute Reference: Not applicable

For more information on this report, contact us at
Hazel Robertson
Chief Finance Officer
07929 760333
hazel.robertson3@borders.scot.nhs.uk

Ref	Date	Service	Purpose	Direction	Value £000s	Outcomes	Sept-23
SBIJB-151221-1	02/02/22	Workforce	Development of plan	Development of a HSCP Integrated Workforce Plan, including support of immediate workforce sustainability issues			Complete
SBIJB-151221-2	02/02/22	Strategic Commissioning	Development of plan	Resource support for the development of the IJB's Strategic Commissioning Plan			Complete
SBIJB-151221-3	02/02/22	Care Village Tweedbank and Care Home Hawick	Development of FBC	Development of Full Business Cases for Care Village in Tweedbank, and the scoping of Care Home Provision in Hawick to Outline Business Case		revised direction below	n/a
SBIJB-020322-1	02/02/22	Millar House	Commissioning	Commissioning the Millar House Integrated Community Rehabilitation Service	£256k R	quality of care, LOS, costs	Complete
SBIJB-150622-2	16/06/22	Day services for adults with learning disabilities	Commissioning	To recommission a new model of Learning Disability Day Services by going to the open market	1,643,000	savings target £350,000. All nine health and well being outcomes	Complete - financial risk due to inflation during process, risk now built into LD budget
SBIJB-150622-3	16/06/22	Pharmacy support to social care users	Polypharmacy	To provide an Integrated service for all adult social care service users	NR £150k	Savings will be identified to CFO. Review of service after two cycles	Delayed due to recruitment but in progress

SBIJB-150622-4 Budget	16/06/22	All	Budgetary framework	To deliver services within the budgets and under the framework outlined in Item 5.7 of the 15 June 2022 Integration Joint Board			In progress
SBIJB-151221-3	21/09/22	Care Home Hawick	Development of FBC	Hawick Outline Business Case		present business case	In progress
SBIJB-150622-5	16/06/22	Health Board Oral Services	Development of plan	To provide support for the production of an Oral Health Plan	As per SoI	Focussed on planning principles, health improvement plan, and be financially sustainable	On Audit Committee agenda
SBIJB-21-09-22-01	21/09/22	Hospital at home	Scope the development of Hospital at home	Develop a business case to come back to IJB for approval	300	To be discussed at range of groups prior to IJB in March	Complete - paper being considered at 20 Sept IJB
SBIJB-210922-2	21/09/22	Integrated home based reablement service	Report to IJB with business case for integrated SB Cares and Home First Service	Develop a business case to come back to IJB for approval	expected that costs will reduce	To review by SPG before IJB in December	In progress, discussion occurred at Sept HSCP Joint Exec to progress

SBIJB-210922-3	21/09/22	Palliative Care review	To commission an independent palliative care review	Scope and outcomes as described in paper with full engagement and integrated approach. To improve outcomes and reduce costs through a programme budgeting approach	-	To conclude by 31 March 2023. Review by SPG before IJB	OFF TRACK DUE TO CAPACITY, REQUEST TO RESCHEDULE TO 24/25
SBIJB-020922-1	21/09/22	Primary Care Improvement Plan	Manage PCIP within existing funding	PCIP Exec to deliver outcomes from non recurrent spend, and reprioritise the use of available recurrent funding. PCIP Exec to escalate at a national level regarding inadequacy of funds and the risks associated with that.	£1.523 NR and £2.313 rec plus tranche 2 tbc	Implementation of GP contract	SIGNIFICANT FINANCIAL CHALLENGE
SBIJB-161122-1	21/12/23	Day services	Re-commissioning of the Teviot and Liddesdale Buildings Based Adult Day Service	Engage in partnership working, through an IIA, consider and evaluate options, including financial impact, outline scope of service, ensure full engagement	tbc		ON TRACK
SBIJB-010223-1	01/02/23	Care home	Scoping of the associated integrated service models of delivery	Scoping of the associated integrated service models of delivery and associated revenue costs for the Full Business Cases for the Hawick and Tweedbank Care Villages		Business case	ON TRACK

SBIJB-190423-1	19/04/23	Annual Services and Budget Direction 2023	Delivery of financial targets.	Delivery of financial targets.	Delegated budget 2023/24.	Strategic Framework objectives and ways of working, the National Health and Wellbeing Outcomes performance measures, and all other service, financial, quality and performance indicators for the cluster of services.	SIGNIFICANT CHALLENGE DUE TO OVERSPEND – BUT PROGRESS BEING DELIVERED
SBIJB-190423-2	19/04/23	Mental Health – Day services	Close GRC, reinvest in EUPD.	Not re-open / close the Gala Resource Centre. Collect baseline outcomes / performance measure information as outlined in the outcomes / performance measures section below. Earmark £70,000 of funds saved for reinvestment in the further development of service to support adults with a diagnosis of Emotionally Unstable Personality Disorder (EUPD).	Release cash savings of £166,656 (£236,656 from the closure less £70,000 for the EUPD service). Savings will support the budgetary pressure in IJB/HSCP delegated services.	Improved satisfaction for those with a diagnosed Emotionally Unstable Personality Disorder (EUPD). National Health and Wellbeing outcomes included in the paper It is expected that the baseline information is developed in advance of the new EUPD service.	ON TRACK
SBIJB-190723-1	19/07/23	PCIP Bundle	Implement the PCIP bundle with caveats, and	1. Continue to escalate funding concerns and gap for PCIP 6 delivery with the Scottish Government.	To be provided within PCIP funding	Improvements across the 9 National Health	ON TRACK

			continue to escalate funding gap to Scottish Government	2. Implement the Bundle Proposal plan to deliver services outlined in PCIP 6 Scottish Government's direction. 3. Approve and endorse the financial model supporting the PCIP Bundle Proposal, including temporary redirection of Polypharmacy efficiency savings to deliver against PCIP 6, subject to the following actions being completed as noted in the direction	including anticipated allocation, carry forward, and the temporary redirection of Polypharmacy carry out the detail efficiency	and Wellbeing Outcomes	
SBIJB-190723-2	19/07/23	Surge planning	To commence the surge planning process	To commence the surge planning process for Winter, including pre-emptive closure of surge capacity to support winter surge, and to develop and implement the following policies: - Single assessment and Home to Assess; - Strengthened engagement with the third sector in unscheduled care, and - communications which promote community supports	No costs associated to the direction, likely reduction of costs expected.	Reduced admissions to hospital, reduced length of stay and deconditioning in hospital settings, reduced need and demand for social care from the hospital system, and the number of delayed discharges.	ON TRACK, UPDATE BEING CONSIDERED AT 20 SEPTEMBER 2023 IJB

This page is intentionally left blank

Scottish Borders Health and Social Care Partnership
Integration Joint Board

20 September 2023

STRATEGIC PLANNING GROUP MINUTES

Report by Iris Bishop, Board Secretary

1. PURPOSE AND SUMMARY

1.1. To provide the Integration Joint Board with the approved minutes of the Strategic Planning Group meeting, as an update on key actions and issues arising from the meeting held on 7 June 2023 and 5 July 2023.

1.2. The meetings had focused on: Financial Recovery, Mental Health Improvement & Suicide Prevention Plan; Local Housing Strategy Consultation; PCIP and Annual Delivery Plan.

2. RECOMMENDATIONS

2.1. **The Scottish Borders Health and Social Care Integration Joint Board (IJB) is asked to:-**

a) Note the SPG minutes of 7 June 2023 and 5 July 2023.

3. ALIGNMENT TO STRATEGIC OBJECTIVES AND WAYS OF WORKING

3.1. It is expected that the proposal will impact on the Health and Social Care Strategic Framework Objectives and Ways of Working below:

3.2. All items discussed at the SPG will fall into the categories listed below.

Alignment to our strategic objectives					
Rising to the workforce challenge	Improving access	Focusing on early intervention and prevention	Supporting unpaid carers	Improving our effectiveness and thinking differently to meet need with less	Reducing poverty and inequalities
x	x	x	x	x	x

Alignment to our ways of working					
People at the heart of everything we do	Good agile teamwork and ways of working – Team Borders approach	Delivering quality, sustainable, seamless services	Dignity and respect	Care and compassion	Inclusive co-productive and fair with openness, honesty and responsibility
x	x	x	x	x	x

4. INTEGRATION JOINT BOARD DIRECTION

4.1. A Direction is not required.

5. BACKGROUND

5.1. Once approved minutes from the Strategic Planning Group and Integration Joint Board Audit Committee are submitted to the Integration Joint Board for noting.

6. IMPACTS

Community Health and Wellbeing Outcomes

6.1. It is expected that the proposal will impact on the National Health and Wellbeing Outcomes below:

N	Outcome description	Increase / Decrease / No impact
1	People are able to look after and improve their own health and wellbeing and live in good health for longer.	N
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.	N
3	People who use health and social care services have positive experiences of those services, and have their dignity respected.	N
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	N
5	Health and social care services contribute to reducing health inequalities.	N
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.	N
7	People who use health and social care services are safe from harm.	N
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.	N
9	Resources are used effectively and efficiently in the provision of health and social care services.	N

Financial impacts

6.2. There are no costs attached to any of the recommendations contained in this report.

Equality, Human Rights and Fairer Scotland Duty

6.3. An IIA is not required.

Legislative considerations

6.4. Not applicable.

Climate Change and Sustainability

6.5. Not applicable.

Risk and Mitigations

6.6. Not applicable.

7. CONSULTATION

Communities consulted

7.1. Not applicable.

Integration Joint Board Officers consulted

7.2. The IJB Board Secretary, the IJB Chief Financial Officer and the IJB Chief Officer have been consulted.

Approved by:

Chris Myers, Chief Officer Health & Social Care

Author(s)

Iris Bishop, Board Secretary

Background Papers: SPG Minutes 07.06.23, 05.07.23

Previous Minute Reference: Not applicable

For more information on this report, contact us at Iris Bishop, Board Secretary,
email: iris.bishop@borders.scot.nhs.uk

Minutes of a meeting of the **Scottish Borders Health & Social Care Strategic Planning Group** held on **Wednesday 7 June 2023** at **10am – 12pm** via Microsoft Teams

Present: Cllr Tom Weatherston (Chair)
Chris Myers, Chief Officer Health & Social Care
Keith Allan, Public Health
Dr Sohail Bhatti, Director of Public Health
Stuart Easingwood, Director of Social Work
Caroline Green, Public Member
Philip Grieve, Chief Nurse, H & SCP
Wendy Henderson, Independent Sector Lead
Jen Holland, Director of Strategic Commissioning
Susan Holmes, Principal Internal Audit Officer, IJB
Karen Lawrie, Partnership Forum
Gwyneth Lennox, Group Manager
Colin McGrath, Community Councillor
Amanda Miller, Eildon Housing Association
Hazel Robertson, IJB Chief Financial Officer
Jenny Smith, Co-ordinator, Borders Care Voice
Kathleen Travers, for Jenny Smith

In Attendance: Laura White, Minute Taker
Lindsay Renwick, Strategic Housing Development Officer, SBC
Fiona Doig, Head of Health Improvement, PHS
Claire McElroy, Wellbeing Service Lead, PHS

1. APOLOGIES AND ANNOUNCEMENTS

Apologies received from Cllr David Parker, Linda Jackson, Clare Oliver, John McLaren and Cathy Wilson.

2. MINUTES OF THE PREVIOUS MEETING

The Minute of the previous meeting held on 3 May was approved with one wording amendment.

3. MATTERS ARISING/ACTION TRACKER

All actions from the last meeting are complete.

The **STRATEGIC PLANNING GROUP** noted the Action Tracker.

4. LOCAL HOUSING STRATEGY CONSULTATION

Lindsay Renwick was welcomed to the meeting and shared a presentation on screen to raise awareness of the current formal consultation of local housing strategy for 2023-28 which is open until 21 July 2023. The local housing strategy is reviewed every 5 years in line with national strategies and the Scottish Government. An early engagement survey was carried out to gather evidence and align with strategies and policies to address the challenges in the Borders such as the aging population and current financial crisis. A vision has been developed along with 5 strategic outcomes leading to 5-7 key actions per strategic outcome. The consultation is asking do we have the vision, strategic outcomes and actions right. To set a housing supply target for 2023-28 – 353 new houses of which 141 to be affordable housing. Details of how figures were determined are in the detailed report. The survey is on Citizen Space with a drop in event on 21 June 2023. Any questions can be sent to LHS@scotborders.gov.uk.

Chris Myers thanked Lindsay for sharing the report with this group and noted that the IJB/Partnership will give their response to the consultation. Jenny Smith agreed this is a good piece of work and noted the impact assessment was in a different format to the IJB format. Jenny added that the Physical Disability Strategy was not listed or links to the IJB Strategic Framework. Jenny queried how the wheelchair housing target was calculated. Lindsay Renwick noted the target was set in 2020 from data collected for the Strategic Housing Investment Plan. This will be monitored through the plan.

Colin McGrath asked if types of building have been considered such as modular housing and building on brown field or industrial sites. Lindsay Renwick noted this is not considered at in this strategy but will be considered through the Scottish Housing Investment Plan. More operational strategy groups will be in place to deliver the strategy. Colin asked if they will consider people needing working space at home for home working and if the community councils/network had been contacted. Lindsay confirmed she had sent an email to all community councils directly but not the network. Colin noted Fiona Benton as the contact for the network and Lindsay gave her assurance to send an email to the network.

Wendy Henderson noted 2 outcomes link to equality outcomes and added she will discuss this further with Lindsay out with this meeting. The Integrated Work Plan agrees that housing supports employment. Wendy added that she will circulate the report to the Independent Sector Providers Strategic Advisory Group. Lindsay added there has been some work looking at housing for key workers but not explored in detail at this stage. There is a high demand for housing at present and so innovative solutions need to be found. There is now a permanent Empty Homes Officer looking at empty properties in the Borders.

Sohail Bhatti agreed this is a good piece of work and that homes shape our communities. Sohail asked if access to services has been considered when looking at where to build housing in relation to the impact on communities. Lindsay Renwick noted that the '20-minute neighbourhood' has been considered but the private sector is an unknown. Access to services and outside spaces are being addressed in the action plan.

Jenny Smith noted this plan would be where the locality working groups could feed in to housing and should be involved going forward to obtain a local view. Lindsay Renwick

noted there will be further engagement going forward when developing a detailed action plan and noted that these groups will be included.

Amanda Miller asked if building standards need to be met such as net carbon zero to future proof buildings for 60 years. Lindsay Renwick confirmed modular would be considered as well as home working space to future proof new housing. Place making will be part of the planning process. The RSL will formally respond. Travel for employment will also be considered as well as wheelchair accessibility. There are many strategies behind this report. Philip Grieve noted that he will circulated the report to GPs. Chris Myers noted the need to encourage working age people to the area for the general economy given the aging population in the Borders.

The **STRATEGIC PLANNING GROUP** supported the report.

5. MENTAL HEALTH IMPROVEMENT & SUICIDE PREVENTION PLAN 2023-25

Fiona Doig and Claire McElroy were welcomed to the meeting and they shared the report and action plan circulated with the Agenda. Approval for the IIA was sought covering risks, engagement, consultation and key recommendations. The proposal is to have a steering group who will review the plan annually.

Jenny Smith noted this is a thorough piece of work as asked if the Equalities & Human Rights Sub Group may have a role here. Chris Myers asked how it aligns to the Strategic Framework as it is not referenced. The need for a directory of services is in the framework and is being tasked to the Locality Working Groups. There is a need to align so both can support and implement.

Wendy Henderson noted the opportunity to link to the training and IWP Workstream as well as the IJB equalities outcomes. Wendy offered to support them on the employment initiatives. Sohail Bhatti added it would be useful to included anchor institutes, the big employers in the community, at an early stage to bring together strategies.

The **STRATEGIC PLANNING GROUP** approved the IIA and noted the report.

6. OUTTURN POSITION UPDATE/FINANCIAL RECOVERY - PROGRESS

Hazel Robertson shared a presentation on the outturn position. The additional payment to break even has reduced from £4.7M last year to £3.5M for 2022/23. The release of reserves has help cover the cost. Hazel shared a report on how delegated services performed. There was overspend in certain areas: LD services, GP prescribing and Generic Services. These will be the priorities to focus on next year in the recovery plan.

Jenny Smith asked what generic services included and Hazel noted this includes primary care and added there will be a breakdown of primary care going forward. Amanda Miller asked how much overspend was as a result of spend on agency/bank staff. Hazel Robertson showed the next slide showing the significant challenge on staffing, particularly in Acute. Staffing is a key area for the recovery plan as well as flow and avoiding admissions.

Sohail Bhatti advised that the problem has been known for more than 50 years. If you give more funding to Primary Care it will act as a diverter from Acute. The issue is how you move funding from one to the other. There is no lever to make this change and so the question is how to make this happen. Hazel Robertson noted there is no absolute clarity yet but to look at how to ensure people are in hospital for the shortest time. Colin McGrath asked for copies of the slides and Hazel Robertson agreed to share them after the meeting.

Financial recovery progress – options are being explored and common themes are emerging following engagement with the staff, the public and with partners focusing on what will have the biggest impact. Long term financial modelling is being explored.

Sohail Bhatti asked about efficiency savings. To focus on where money is being spent to get a grip on key issues. If commissioning out own services, to consider how to make an income by offering to other areas. Hazel Robertson agreed it is about spending each pound wisely and has trialled the 'best value for every pound' approach to look at where to prioritise. To look at how to get the best benefits for the least cost. Colin McGrath asked if anyone is imagining the future and Hazel Robertson agreed that future thinking is needed.

The **STRATEGIC PLANNING GROUP** noted the update.

7. ANY OTHER BUSINESS

- Extra Ordinary SPG to be arranged to approve 4 papers in July 2023.
- Colin McGrath asked if Health & Social Care employees will be integrated or remain as working for 2 separate employers. Chris Myers advised that the IJB is a strategic organisation that cannot employ staff. Staff are seconded from the two organisations. The IJB looks at how to plan across the Health & Social Care Partnership (SBC, NHSB and commissioned partners) to provide a seamless, person centred service. The IJB is about process, communication and ways of working rather than the TUPE of staff. Colin McGrath asked Laura White for the contact person for the Joint Staff Forum .
- Karen Lawie asked for any update on the National Care Service (NCS). Chris Myers noted there is work ongoing and it is progressing. Subgroups have been established and engagement and consultation is ongoing. COSLA are involved in discussions. Chris met with the new Minister and invited the former Minister to visit the Borders to see what is happening locally without the need for a NCS. Views are not as fixed as a result of feedback received. Philip Grieve noted there are Chief Nurses events in the Summer to look at what the NCS would look like. Wendy Henderson noted the partners for integration have raised the issue of the lack of inclusivity of the consultation as there are no events in Edinburgh, Fife or the Borders.
- Wendy Henderson noted the first meeting of the Equalities & Human Rights Subgroup on Thursday. A progress report will be brought to this group in August.

8. DATE AND TIME OF NEXT MEETING

The Chair confirmed the next meeting of the Strategic Planning Group would be held on Wednesday 2 August 2023 at 10am to 12pm via Microsoft Teams.
Date of Extra Ordinary meeting to be confirmed.

Minutes of a meeting of the **Scottish Borders Health & Social Care Strategic Planning Group** held on **Wednesday 5 July 2023** at **10am – 12pm** via Microsoft Teams

Present:
Cllr David Parker (Chair)
Dr Sohail Bhatti, Director of Public Health
Wendy Henderson, Independent Sector Lead
Jen Holland, Director of Strategic Commissioning
Susan Holmes, Principal Internal Audit Officer, IJB
Linda Jackson, Service User Representative
Colin McGrath, Community Councillor
Amanda Miller, Eildon Housing Association
Hazel Robertson, IJB Chief Financial Officer
Gail Russell, Partnership Collective
Jenny Smith, Co-ordinator, Borders Care Voice
Kathleen Travers, for Jenny Smith
Cathy Wilson, General Manager for P&CS
Tim Young, AMD

In Attendance: Laura White (Minute Taker), Rachel Mollart (GP).

1. APOLOGIES AND ANNOUNCEMENTS

Apologies received from Keith Allan, David Bell, Katrina Culley, Stuart Easingwood, Caroline Green, Gwyneth Lennox, Chris Myers, Clare Oliver and Debbie Rutherford.

2. MINUTES OF THE PREVIOUS MEETING

The Minute of the previous meeting held on 7 June 2023 was approved.

3. MATTERS ARISING/ACTION TRACKER

No actions from the last meeting.

The **STRATEGIC PLANNING GROUP** noted the Action Tracker.

4. PCIP UPDATE

Cathy Wilson and Tim Young shared a presentation on screen. Following PCIP 6 letter on 31st March 2023 from the Scottish Government (SG) this proposal has been drafted on how the Health Board and GPs can deliver Community Treatment and Care (CTAC) services to allow GPs to fulfil a more medical role. Funding sits with the SG and is less than anticipated making it insufficient to deliver all the legal service requirements. This is being challenged.

The proposal is for CTAC to be smaller and to focus on the top 3 services. GP practices in the Borders are struggling and primary and secondary care are working in silos rather than collaboratively. The aim is to improve patient journeys/outcomes. The proposal is to have a 3 phase approach. Phase 1 – Phlebotomy service – to TUPE staff to the Health Board. Funding needs to be recurring to be able to TUPE staff. Phase 2 - Admin Hub – to take on existing duties. Phase 3 – Rest of the services. Staff will be on a 2 year fixed contract as funding is not permanent. The plan is to have enhanced CTAC services in the future. Three streams proposed – DMARDS/Pharmacy Hub/Polypharmacy. These will release recurring funding to be able to TUPE staff on a permanent basis and increase efficiencies such as reducing clinical time spent travelling. There are over 8,000 people taking more than 5 drugs which may be causing them harm so reviewing their medication can have a better outcome for patients, reducing bed space as well as reducing resources. These 3 streams will release funding to be able to achieve CTAC 2 and 3. Costs are based on the midpoint range and so costs can be predicted with confidence.

Jenny Smith as a service user representative asked if there would be any access issues relative to this proposed change. Cathy Wilson noted this will enhance access giving equitable access to all. GPs have been anticipating these changes for the last 2 years. Tim Young added this proposal in an enabler. There will be a more standardised approach for people to understand. People will be able to attend the CTAC most suitable for them. Jenny Smith asked if there will be a smaller reach into communities and Tim Young noted they will be in all existing GP surgeries. Cathy Wilson noted they are trying to avoid there being less locations but a peripatetic service may be possible in some cases.

Wendy Henderson noted the IWP are looking at a review of medication management and Tim Young noted they are aware and are working with Malcolm Clubb on this. Tim advised they are looking to do a piece of work in Duns to look at polypharmacy and medical management to see if there are any efficiencies to be made to release capacity. Wendy Henderson offered to involve independent providers in the area to help with the test of change.

Colin McGrath noted TUPE as his speciality and asked if employee rights will be protected, both salary and terms and conditions. Cathy Wilson noted that independent legal advice has been given to staff which was helpful and aligned with the proposal. Linda Jackson asked if there would be an impact on emergency prescriptions and Tim Young said no. Rachel Mollart is a working GP and noted the presentation has been well received and will improve patient care and GP recruitment. Most GPs are supportive and the Borders will lead the way by doing this. There are some financial risks as the plan relies on savings being made at phase 1. There is significant risk if this proposal is not taken forward as 19 out of 20 practices in the Borders are reporting to be 1 step away from being sustainable. Rachel Mollart urged the IJB to support this proposal.

Jen Holland asked about the timeline as the social care proposal for polypharmacy in the community as this had been noted as a priority by the H & SC Joint Exec meeting. Cathy Wilson noted this as a separate piece of work and the 8000 people identified were people not know to social work/home care. Tim Young noted staff have just been employed for this now and offered to work alongside this project in Duns to look at both sets of people to achieve social care savings too. Jen Holland offered to provide Tim with an up to date list of people who are receiving 4 visits a day to receive medication.

Dr Sohail Bhatti noted the need to take learning back into practices and to have some formal recognition of lessons learnt to help change behaviour rather than leaving this to chance. Tim Young noted the 4 GP clusters will be collating information to identify savings although increasing drug costs will also be a factor. Rachel Mollart noted there will be organic learning and also work on value based medicine and looking at quality improvement. Secondary as well as primary care prescribe medicines and so learning should be shared in both areas of medicine.

Jenny Smith asked about equality and human rights as it's the SPG's role to scrutinise this in all proposals. Whilst happy to support the proposal, an IIA is required. Cathy Wilson noted she is working with Wendy Henderson on this and will have stage 1 complete by Friday based on the principles for circulation to this group for approval. Wendy Henderson as equality lead for the Partnership was supportive of the process as assured the group the IIA will be proportionate and relevant and sent for approval ahead of the IJB meeting.

Cathy Wilson noted that modelling work has not yet begun due to confidentiality issues. Progress will be measured against the national health and wellbeing outcomes. Risks and actions will be re-assessed after each stage. Financial modelling shows the required savings of £633K will be made to achieve CTAC 1 and 2.

The recommendation is for the SPG to recommend the Direction to the IJB to approve. The Directions will then be sent to both the Health Board and SBC (for social care).

Action: Stage 1 IIA to be completed by Cathy Wilson and Wendy Henderson. Direction to be updated by Cathy Wilson and Tim Young to reflect today's discussion. Both papers to be circulated by email to the group for approval in advance of the IJB meeting.

Action: Cathy Wilson to circulate PCIP Update slides after the meeting.

The **STRATEGIC PLANNING GROUP** supported the paper in principle today to go to IJB with the inclusion of the stage 1 IIA and updated Direction.

5. FINALISED ADP

Hazel Robertson shared a paper for endorsement before going to the IJB for approval. The annual delivery plan is in line with both SBC and NHSB. It aligns to the 6 core objectives in the strategic commissioning framework. The structure has been re-framed to align with the framework. Community Integration Groups (formerly Locality Working Groups) will be a part of the structure to take the strategic commissioning framework forward. Dr Sohail Bhatti noted the risk of having skills dispersed and groups potentially working differently. Wendy Henderson noted the opportunity to reference and embed equality outcomes into everything. Hazel Robertson asked what do we want this document to do given the time constraints. Conversations to continue out with the meeting. Wendy Henderson noted the ADP should not hold anything back but enhance progress. Hazel Robertson noted the report will inform the reporting structure. Each area of the plan has an action identified and a main owner and aligned to the strategic objectives to guide activity over this year.

.

The **STRATEGIC PLANNING GROUP** approved the ADP.

6. END OF YEAR FIGURES

Hazel Robertson shared the Borders IJB financial outturn for 2022/23. Draft accounts are prepared and on the website. The contribution to delegated services was at its lowest 22/23 due to the reserve offset. Overspend on set aside has been absorbed by the Health Board. There are significant financial issues including an overspend on set aside functions. Underspend for Covid-19 has been returned to the Scottish Government. The Borders IJB is in the top 5 for the size of financial challenges. Significant savings need to be achieved. Medium and long term modelling is needed to be sustainable.

Wendy Henderson asked if anything could be learnt from the better performing IJBs and Hazel Robertson noted there are monthly meetings but that the Borders is in a different place to other IJBs. Dr Sohail Bhatti asked what do we mean by transformation noting it would be worth having a definition to benchmark and Hazel Robertson agreed noting transition is to be the focus. Amanda Miller asked if there was any early planning for Winter at present and Hazel Robertson noted there is a lot of energy going into this at present. Jen Holland noted the Scottish Government have a programme of work underway. Teams are looking at having a discharge hub involving multiple teams to be able to speed up discharges, having a single assessment and being able to manage people in their own beds which is best for the patient. Amanda Miller asked to be involved in Winter planning as a provider of social care housing so the workforce can be prepared. Jen Holland agreed it would be good to involve external partners in Winter planning to help the flow. Colin McGrath asked how the PCIP bundle intended to make the Borders GPs attractive since they are privately owned. Hazel Robertson noted that digital capability and estates would be a part of this. Rachel Mollart noted GPs are independent practitioners and noted the issue in recruiting due to the number of GPs retiring. The PCIP Exec Group is a sub group of the GP Sub Committee set up by the Scottish Government and are looking at how to improve recruitment into the Borders.

Action: HR to share the financial outturn slides after the meeting.

The **STRATEGIC PLANNING GROUP** noted the financial outturn figures for 2022/23.

7. ANY OTHER BUSINESS

- To follow for virtual approval: Winter Planning & Common Assessment Direction.
- Jenny Smith noted the Live Borders SBC consultation that is currently open and asked if there would be a strategic response from the Partnership. **Action: Hazel Robertson to send a link to the Live Borders Consultation, receive comments and collate a response.**

8. DATE AND TIME OF NEXT MEETING

The Chair confirmed the next meeting of the Strategic Planning Group would be held on Wednesday 2 August 2023 at 10am to 12pm via Microsoft Teams.

This page is intentionally left blank