Aberdeen City Health & Social Care Partnership
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INTEGRATION JOINT BOARD

Date of Meeting	4 Feb 2025
Report Title	Marywell Practice Options Appraisal
Report Number	HSCP.25.001
Lead Officer	Emma King, Primary Care Lead ACHSCP
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Consultation Checklist Completed	Yes
Directions Required	No
Exempt	No
Appendices	A: Options Appraisal B. Health Screening Initiative Summary Report C: Integrated Impact Assessment D: EQIA E: Consultation & Engagement Summary
Terms of Reference	1c - Any other matter that the Chief Officer determines appropriate to report to the IJB.

1. Purpose of the Report

1.1. This report provides an update to the Integration Joint Board (IJB) on the Marywell Practice redesign, its consideration of options and recommendations on the service's future direction.

2. Recommendations

ABERDEEN CITY COUNCIL NHS Grampian

2.1. It is recommended that the Integration Joint Board (IJB):

a) Notes the benefits of the continued collaboration between the Marywell Practice and the Integrated Drug Service;

b) Notes the Options Appraisal (Appendix A) and multi-agency and service user consultations (Appendix E);

c) Agrees to implement Option 2, namely for Marywell General Practice to continue to operate as a 2c General Medical Service (Specialist Service); and

d) Agrees that the recurring alignment of Alcohol & Drugs Partnership (ADP) funding of £100,000 to Marywell Practice should proceed to implement Option 2 referred to above.

3. Strategic Plan Context

3.1. The findings and proposals presented in this report are aligned with the strategic objectives in the Aberdeen City Health and Social Care Partnership (ACHSCP) Strategic Plan 2022–2025. These objectives encompass Preventing Ill Health, Caring Together, Keeping the Population Safe at Home and Achieve Healthy Fulfilling Lives.

3.2. The findings and proposals, will directly enhance the realisation of the strategic objectives outlined by ACHSP, as follows:

Figure 1: Alignment to ACHSCP Strategic Priorities

ACHSCP Strategic Aims	ACHSCP Strategic Priorities (relevant to the work)	Linked Key Aims/Deliverables
Caring Together	✓ Undertake whole pathway reviews ensuring services are more accessible and coordinated ✓ Empower our communities to be involved in planning and leading services locally ✓ Create capacity for General Practice improving patient experience	✓ Increase resilience and collaboration of cross system services and teams ✓ Equitable and increased access for GMS (General Medical Services) for most vulnerable

Keeping People Safe At Home	✓ Reduce the impact of unscheduled care on the hospital	✓ Supporting people in their acute phase of need with support to transition to mainstream services
Preventing Ill Health	✓ Tackle the top preventable risk factors for poor mental and physical health including: - obesity, smoking, and use of alcohol and drugs ✓ Enable people to look after their own health in a way which is manageable for them	✓ Improved access for patients to healthcare and drug treatment in line with MAT (Medication Assisted Treatment) standards; ✓ Effectively support & empower patients/service users to engage
Achieve Healthy Fulfilling lives.	✓ Help people access support to overcome the impact of the wider determinants of health ✓ Ensure services do not stigmatise people ✓ Improve public mental health and wellbeing ✓ Improve opportunities for those requiring complex care ✓ Remobilise services and develop plans to work towards addressing the consequences of deferred care	✓ Developing a Primary Care Health Inequalities Plan and network ✓ Reduce stigma and increase wider understanding in primary care. ✓ To recognise current resource constraints in terms of staffing, funding, Infrastructure and the need to ensure services are integrated;

4. Summary of Key Information

Background

4.1. The Marywell Practice was established in 2001 to support people who were homeless and who faced barriers to registering with a mainstream GP practice when they didn't have an address or were sleeping rough.

4.2. The practice is a 2c General Medical Services (GMS) Health Board contract held by NHS Grampian. The Aberdeen City Health and Social Care Partnership (ACHSCP) Primary Care Team have operational responsibility for the service. A '2c' practice is a health board run practice. This means that the practice is not operated by an independent contractor model like other practices in the city, as per the General Medical Services Contract (2018). In 2020, the IJB issued a Direction to NHSG to provide General Medical Services to a number of 2c practices in existence at that time, of which Marywell was one. Following the 2c redesign of primary care during

2020/2021, the Marywell Practice had no expressions of interest during the retender process and remains as the only 2c GMS operating throughout Aberdeen City. As such the direction in respect of the Marywell Practice is still current.

4.3. There have been various attempts over the years to review and redesign services provided by the Marywell Practice due to the changing demographic of homelessness and sustainability concerns of the practice in its current format. Ongoing challenges include limited clinical GP coverage (temporary and seconded posts), limited budget, and a low practice population. Patients who present are some of the most vulnerable in Aberdeen, with increasing multiple complex needs.

4.4. The most recent review being the Marywell and Timmermarket Integrated Service Review which commenced in May 2022 and aligned £480,000 of ADP funding to support the implementation of Medication Assisted Treatment Standards (MAT) and also contributed funding to a collaborative service redesign, in partnership with primary care as a direct response to drug related deaths. Local reviews of drug deaths show that a high number of people had undiagnosed, underlying and untreated health conditions.

4.5. An update on this work was presented to the IJB on the 29th of November 2022 **HSCP22.102_Marywell.pdf (aberdeencity.gov.uk)** and again on the 7th of May 2024 **HSCP.24.027 Marywell and Timmermarket Integrated Service Review.pdf (aberdeencity.gov.uk)**

4.6. During the past 2 years the focus of the Marywell and Timmermarket Integrated Service Review programme of work outlined specific goals to:

- Reduce health inequality;
- Improve life expectancy;
- Improve access to primary health care for the most vulnerable populations across the city;
- Advance critical priorities; and
- Pilot initiatives during the approved 2-year duration of supplementary ADP funding with some funding continuing beyond this period, into February 2025.

4.7. An essential part of the redesign has involved enhancing collaboration among Marywell Practice, Integrated Drug Service (IDS), Aberdeen City Alcohol and Drug Partnership (ADP), and the Community Nursing Outreach Team (CNOT). This aims to prioritise person-centred care, allowing services

to work more seamlessly together to meet the needs of the most vulnerable and address local health inequality. This has primarily focussed on the co-location of Marywell Practice and the CNOT at the Timmermarket Clinic to support the implementation of Medication Assisted Treatment (MAT) Standards to improve health care for people seeking drug treatment whilst also developing opportunities for community outreach.

4.8. On the 7th of May 2024 the Integration Joint Board (IJB) received a report to update on the progress of the Marywell and Timmermarket Integrated Service Review. This report included several recommendations, one which was to proceed with an options appraisal and report back to the meeting of the IJB scheduled for the 4 February 2025, outlining the future trajectory of the Marywell Practice. This report concludes the work undertaken and makes recommendations as outlined above.

4.9. The Timmermarket Clinic is the 'frontdoor' service for the Integrated Drug Service (IDS) located at 1 East North Street Aberdeen. The Marywell Practice also operates from the Timmermarket Clinic since December 2019. The IDS is an Aberdeen City Health and Social Care Partnership specialist drug treatment service led by the (ADP). The multi-disciplinary teams comprise of approximately 25 staff including nurses, medics, psychology, social work, 3rd sector and administrative staff. The service receives approximately 60 referrals per month and are currently working with approximately 300 service users. Overall there are approximately 1,700 service users in drug treatment across the city.

4.10. Medication Assisted Treatment (MAT) Standards, set by the Scottish Government, set out ten treatment and support standards that are to be delivered in Integration Authority areas. They cover a range of drug treatment standards that include same day access, choice of medication, support for the most vulnerable, consistent harm reduction and to be retained in treatment for as long as they require. The standards also incorporate trauma and psychologically informed practice in service areas. The work between the drug service and Marywell incorporates several of the MAT standards such as harm reduction, direct access and retention in treatment. MAT standards improvement work is directly funded by the Scottish Government as part of its National Mission to Reduce Drug Deaths.

4.11. In addition to the MAT Standards the Scottish Government have published the National Charter of Rights for People Affected by Substance Use. It contains key human rights – drawn from national and international law - belonging to people affected by substance use, most importantly the right to

the highest attainable standard of physical and mental health, along with the right to an adequate standard of living and the right to a healthy environment.

Alignment to Community Planning Aberdeen Local Outcome Improvement Plan & Homewards Aberdeen Coalition

4.12. The vision set out in the Community Planning Aberdeen Local Outcome Improvement Plan (LOIP) highlights that Aberdeen will be "a place where all people can prosper" by 2026. In order to achieve this 16 stretch outcomes have been developed which cover four themes of Economy, People, Place and Community Empowerment with 97 improvement projects in progress.

4.13. The Aberdeen Alcohol & Drug Partnership is an Outcome Improvement Group (OIG) of Community Planning Aberdeen with an aligned stretch outcome to reduce the rate of both alcohol related deaths and drug related deaths by 10% by 2026. In addition there is an improvement aim to ensure that the most vulnerable substance users are supported proactively.

4.14. Aberdeen City has been chosen as 1 of 6 flagship locations across the UK for the Homewards programme which is part of the Royal Foundation of the Prince and Princess of Wales. This is a transformative 5 year locally led programme that will aim to demonstrate that together it is possible to end homelessness, making it rare, brief and unrepeated.

4.15. A Homewards Aberdeen Coalition has been set up which includes a range of committed people, organisations and businesses who will work together to create and deliver a tailored plan to prevent and end homelessness in Aberdeen based on local needs and expertise. Up to £500,000 of seed funding will be available to each location across the lifecycle of the five year programme.

4.16. In November 2023 it was agreed that governance of the Homewards programme would be routed through Community planning Aberdeen structures and the LOIP. A Homewards Aberdeen Steering Group / Outcome Improvement Group has been established since January 2024 with an aligned stretch outcome to reduce homelessness by 10% and youth homelessness by 6% by 2026. To ensure it is rare, brief and non-recurring with a longer term ambition to end homelessness in Aberdeen City.

Alignment to NHS Grampian Primary Care Premises Plan

4.17. The NHS Grampian Primary Care Premises Plan sets out the key overall priorities as assessed by the NHSG Primary Care Premises Group. The provision of appropriately located and designed premises, which promotes integration of service delivery, optimal use of space and effective IT infrastructure is critical to the development and delivery of accessible high quality primary care within our communities.

4.18. The Marywell Practice previously operated from purpose built premises at the Marywell Healthcare Centre on College Street. This was a multi-storey mixed use premises owned by Grampian Housing Association. On the 13th of December 2019 there was a flood in the upper floor of the building, which caused severe damage to the ground floor unit occupied by the practice at that time. The practice was relocated to the Timmermarket Clinic in December 2019 initially on a temporary basis, however subsequent redesign of services during the covid pandemic resulted in the College Street premises being repurposed as a Community Treatment and Care Services (CTAC) hub.

Alignment to General Practice Vision

4.19. The agreed General Practice Vision is "A sustainable General Practice across Grampian which enables people in their communities to stay well through the prevention and treatment of ill health". Practices throughout Grampian will be aligned to the 10 joint objectives to increase sustainability of services and improve patient and staff satisfaction, patients will be empowered to stay well; when required they will have access to tailored services through clear pathways and integrated systems.

4.20. The GP Vision Programme has progressed to the implementation phase with a focus on the following key priority areas (Data, Premises, Models of Contract, PCIP review and Digital). The implementation of option 2 following the development of the options appraisal for the Marywell 2c Practice within Grampian aligns and contributes to this vision for general practice. With the progress of key priorities and initiatives such as the health screening initiative, including a flexible and responsive hub and spoke model co designed in partnership with those who use services which focus on reducing health inequality, improve life expectancy and improve access to primary health care for the most vulnerable within communities.

Alignment to NHS Grampian Health Equity Plan 2024 – 2029

4.21. NHS Grampian's Plan for the Future 2022 – 2028 sets out a vision to re-imagine the organisational purpose to reach beyond responding to poor health to one which equally invests in preventing harm. NHS Grampian's 5-year Health Equity Plan 2024 – 2029 has a long-term ambition to reduce the gap in healthy life expectancy between the most and least vulnerable groups in society. The development of the options appraisal and implementation of option 2 fully aligns and compliments the vision and ambition including the outlined priorities and enabling actions.

Alignment to ACHSCP Market Position Statement 2024 - 2024

4.22. The Aberdeen City Health and Social Care Partnership Market Position Statement 2024 – 2034 outlines the vision, commitment and expectations for accommodation across the city for people with specialist requirements, which included a thorough evaluation of the needs of those with substance use and homelessness. The recommendations of this report will directly support the Market Position Statement for those who require specialist input due to their substance use or homelessness. The continued collaboration between the Marywell Practice, Timmermarket and the Community Nursing Outreach Team (CNOT) in conjunction with key partners including Aberdeen City Council and the Homewards Programme will ensure that specialist support is available and continues to develop.

Achievements during period of ADP Funding (Nov 2022 - Nov 2024)

Key priorities and initiatives which have been progressed during the two year ADP funding are outlined below:

- Implementation of a **Health Screening Initiative** to address any underlying health conditions for those entering drug treatment, given the high number of drug related deaths linked to undiagnosed health conditions
- An **expanded patient criteria** to include those who are homeless, sleeping rough, sofa surfing, residing in temporary accommodation, substance use, complex needs, unable to sustain relationships with mainstream general practice
- Integrating teams to support the delivery of **Medication Assisted Treatment (MAT)** Standards and Direct Access Clinics
- To progress an **integrated front door** access at Timmermarket (for the Integrated Drug Services (IDS) and Marywell patients) to improve patient experience and staff resilience

- To ensure that the service prioritises those most in need during periods of instability the implementation of the **co-ordination and transfer of patient's protocol** to support patients to transition to mainstream general practice
- A flexible and responsive **Hub & Spoke Model**, to maximise outreach opportunities for people who are affected by severe and multiple disadvantage, in collaboration with the Community Nursing Outreach Team (CNOT) and Homewards Programme
- Implementation of a **Training & Development** Clinical Lead with a focus to enhance links across primary care

Reducing Under-diagnosed / Under Treated Health Conditions in Vulnerable Groups - Prevention Health Initiative

4.23. Significant clinical impact has been progressed on preventing and improving health outcomes due to joint working with Marywell and the Timmermarket drug service.

4.24. Multiple research studies demonstrate that due to the impact of substance use, multiple complex other needs and stigma that there is significant under diagnosis and treatment in the drug using population and is significant factor on the morbidity and mortality. Reviews of drug deaths in Aberdeen revealed that 342 deaths, 76% had an associated physical health condition.

4.25. One hundred and forty-two drug users undertook preventative health screening at Marywell / Timmermarket. The health screening initiative identified considerable levels of physical health abnormalities particularly in areas of nutrition, cardiac and respiratory health. There were also high levels of acute conditions requiring medication and treatment. Leaving these conditions untreated would increase demand on secondary care services and or contribute to shorter life expectancy. Poor respiratory health is a significant factor in drug use deaths.

4.26. Results from Health Assessments (some people had more than one condition)

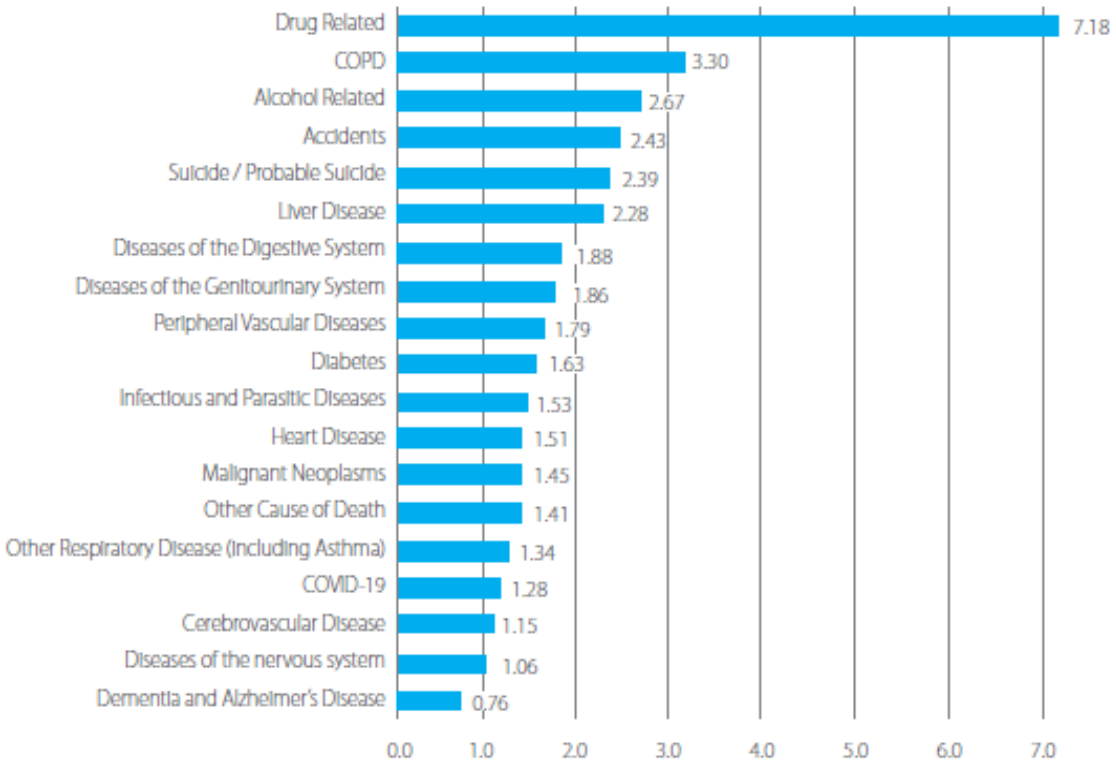
- General blood screening in 81 clients showed that 24% of readings were lower than the normal range for iron and 10% had abnormal platelet readings.
- Cholesterol (bad) was raised in 31% of 81 clients.
- Vitamin D was insufficient in 38% and deficient in 42% of 76 clients.
- Body mass index (BMI) was in the healthy range for 51% of 113 clients, with 9% being underweight, 22% overweight and 18% obese.

- Blood pressure was raised in 21% of 119 clients.
- Oxygen saturation was lower than normal in 10% of clients.
- Electrocardiogram (ECG) was abnormal in 56% of 61 clients.
- Peak flow was abnormal in 42% of 61 clients.
- Chronic Obstructive Pulmonary Disease (COPD) screening indicated 42% were abnormal from 61 clients.
- Kidney function was normal in all but 1 case and liver function had indicators of various raised enzymes in 10-22% of 81 clients.
- Of all 142 clients 86 (61%) required same day prescriptions for acute ailments. This was largely for skin and respiratory complaints. In total 171 prescriptions were issued.
- A small number required urgent emergency medical admissions (for pulmonary embolism, kidney stones and appendicitis).

4.27. The preventative health initiative has demonstrated significant clinical benefit to the individual patients as well as significant impact reduction to the health and social care system.

4.28. The NHS Grampian Director of Public Health Annual Report (2023) shows the clear link with deprivation, reduced life expectancy and the need for preventative inclusion health for the most vulnerable. The report notes, in Grampian heart disease and cancer are the leading cause of death. The mortality rates for these causes are about 1.5 time higher in the poorest compared to the wealthiest areas. Some of the largest differences in mortality rates are observed for Chronic Pulmonary Disease (the most deprived areas have a rate 3.3 times higher than the least deprived areas), alcohol-related (2.7 times), accidents (2.4 times), suicide (2.4 times) and liver disease (2.3 times). A much greater inequality than all of these is seen for drug-related deaths, where rates are 7.2 times higher in the most deprived areas. See below graph from the report;

Figure 2. Ratio of mortality rate in most deprived quintile to least deprived by cause (2013-2022)



4.29. This work and data shows is the extreme vulnerability of the population group we are trying to engage and support. Compounded issues such as deprivation, substance use and other physical health conditions significantly increase the risk of premature death. Having holistic and integrated health and social care at points where vulnerable people engage, such as drug treatment services, creates a unique opportunity to help support people. The service being developed is unique in Scotland and is already demonstrating improved health outcomes.

Options Appraisal Development

4.30. A Marywell Practice Options Appraisal Short Life Working Group (SLWG) was established to co-ordinate the necessary work, the first meeting took place on the 27 August 2024 which included key representation from the ACHSCP Medical Lead, Primary Care Lead, GP Clinical Leads and the aligned Primary Care Development Manager.

4.31. In conjunction with this the Primary Care Development Manager liaised with the Strategic Lead for Alcohol and Drugs following the Marywell and Timmermarket Integrated Service Review to discuss ongoing collaboration opportunities, which could be incorporated into the options appraisal.

4.32. A list of objectives for the options appraisal were finalised at the SLWG meeting held on the 15 October 2024 and are outlined as follows:

Figure 3: Marywell Practice Options Appraisal Objectives

Objectives
To progress a sustainable future delivery route taking cognisance of current resource constraints (financial, budget, staffing etc.)
To facilitate equitable and increased access to primary healthcare for those most at risk, multiple complex needs, affected by severe and multiple disadvantage
To maximise collaboration opportunities with key partners including Integrated Drug Service (IDS), Alcohol & Drug Partnership (ADP), Community Nursing Outreach Team (CNOT) and Homewards to improve patient/service user outcomes
To support and empower patients/service users to engage with wider health and social care services (prevention & early intervention)
To align and enhance the realisation of the ACHSCP strategic aims, priorities and key aims
To assess and review options in line with relevant legislation (Equality Act 2010, Human Rights, Health Inequalities/Fairer Scotland Duty, Children's Rights and Welfare, Environment, Financial, Island or Rural Communities) and limit any adverse effects / negative impact identified.

4.33. At the meeting of the SLWG on the 15th of October 2024, the following list of options were also agreed and finalised. This provided the necessary information to commence the options appraisal and the development of key documentation which included an action plan and a communications, stakeholder and engagement plan.

Figure 4: Marywell Practice Options Appraisal List of Options

Option	Description
1	Continue as a 2c GMS (specialist service) with no further ADP funding aligned
2	Continue as a 2c GMS (specialist service) alignment of recurring ADP funding of 100k
3a	Transition to a 2c GMS (mainstream service only) expand and grow services to the general public only
3b	Retender Marywell 2c GMS Practice (specialist service) to independent contractor
4	Close the Marywell Practice and disperse current patients
5	Cease Marywell Practice GMS status and provide service differently

4.34. The options appraisal (see appendix A) includes a summary of the business need and specific information on the Marywell Practice including staffing, patient population, core budgets, year-end positions and GMS income. Each of the options 1-5 are outlined in detail with the associated costs and advantages/ disadvantages, scoring of options against the objectives and subsequent recommendation.

4.35. In addition for each of the options 1-5 a Stage 1 Integrated Impact Assessment (see appendix C) has been completed and incorporated into the options appraisal template, to support consideration of equality and diversity issues, human rights (including children and young people's rights), socio-economic disadvantage and climate change and sustainability in the design, development and delivery of policies and services. In addition for the recommended option a full EQIA has been completed. Further detail on this can be found within section 5.

Stakeholder Communications and Engagement

4.36. NHS Boards and Integration Joint Boards must work with people when they are considering changes to health and care services. The Scottish Government and COSLA have produced national guidance, *Planning with People* guidance which sets out the process which should be followed when involving people in decisions about local services.

4.37. Therefore, contact was made with colleagues at Health Improvement Scotland (HIS) who provided the necessary advice and support in line with the Planning with People guidance. HIS also undertake assurance of all changes, this is set out in the following flowchart Overview of the engagement and quality assurance process for service change | HIS Engage. HIS provided an assurance letter to the ACHSCP dated 8th January 2025 that confirms the Planning with People guidance and process was followed.

4.38. A detailed stakeholder, communication and engagement plan was developed in conjunction with advice and guidance from Health Improvement Scotland. Additional resource was aligned to support the necessary engagement activities from the ACHSCP Development Officer – Consultation and Engagement.

4.39. A phased approach was taken to the engagement activities planned pre and post the independent scoring panel. A range of engagement materials were developed which included briefing documents, posters and surveys for both

patients/service users and professionals, HIS provided advice, support and guidance during the development of these.

4.40. Stage 1 of the consultation and engagement activities took place from the 22 October and ran until the 18 November 2024. This included a survey which was developed for professionals and a survey for patients / service users. A range of stakeholder events were held at the Timmermarket, Toastie Club and at Aberdeen in Recovery on Union Street, where staff, service users and patients were given an opportunity to discuss the options and ask any questions with support provided to help complete the surveys if required. Surveys could be completed either online using a link to a Microsoft Form or on paper which was later transferred to the online system.

4.41. Stage 2 of the consultation and engagement activities took place from the 22 November 2024 until 13 January 2025. This included a survey which was developed for professionals and a survey for patients / service users. A further follow up series of engagement events were held at the Timmermarket, Toastie Club and at Aberdeen in Recovery, where staff, service users and patients were given feedback on the outcome of the process and to inform them of the preferred option. In addition, an opportunity was given to people or groups who may wish to take part in co-designing future initiatives e.g. expansion of outreach clinic's, implementation of health assessments and mobile bus.

4.42. Further details of the full engagement and consultation activities undertaken since the project inception can be found within appendix E. In summary, an extensive consultation and engagement process has been underway since 2022 to date with a vast array of staff, relevant services, patients / service users, third sector services and those with lived experience to ensure we have thoroughly captured and considered the current and future needs of the service. This includes how we can future proof, improve, flex and expand to meet the needs of the most complex and vulnerable individuals in Aberdeen City. Future co-design of the service is vital by seeking to work collaboratively and in partnership with people with lived experience.

Independent Scoring Panel

4.43. An independent scoring panel took place on Wednesday 20 November 2024 to score the list of options against the objectives. Representation included key professional GP and Clinical Lead colleagues from both Aberdeen city and Aberdeenshire ensuring no conflict of interests. In addition, representation also included Aberdeen City Council Housing Access and Support as well as a representative from the independent and third sector

Aberdeen in Recovery charity, to represent views of those with lived experience.

4.44. Panel members were provided with key information including:

- Presentation (need for change/successful initiatives/opportunities)
- Survey Results from Patients/Service Users & Professionals
- Marywell Practice/ACHSCP Information
- Health Screening Initiative Report
- Stage 1 Integrated Impact Assessment (IIA) for each option
- Options 1 – 5 (costs, risks, advantages)

The outcome of the independent scoring panel is outlined below:

Figure 5: Collective Scores of the Independent Scoring Panel Meeting 20th Nov 2024

NHS Grampian

Aberdeen City Health & Social Care Partnership
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Marywell Practice Options Appraisal Scoring Panel
Wednesday 20th November 2024

Option Numbers	1	2	3a	3b	4	5
Options	Do Nothing / Do Minimum - Continue as a 2c GMS (specialist service) with no supplementary ADP funding	Continue as a 2c GMS (specialist service) alignment of recurring ADP funding	Transition to a 2c GMS (mainstream service only) expand & grow	Retender Marywell GMS Practice (specialist service) to Independent Contractor	Close Marywell Practice & disperse patient population	Cease Marywell Practice GMS status and provide service differently
Objectives						
1. To progress a sustainable future delivery route taking cognisance of current resource constraints (financial, budget, staffing etc.)	4	11	-2	7	-5	5
2. To facilitate equitable and increased access to primary healthcare for those most at risk, multiple complex needs, affected by severe and multiple disadvantage	3	9	-4	2	-5	-1
3. To maximise collaboration opportunities with key partners including Integrated Drug Service (IDS), Alcohol & Drug Partnership (ADP), Community Nursing Outreach Team (CNOT) and Homewards to improve patient/service user outcomes	5	12	-2	0	-5	6
4. To support and empower patients/service users to engage with wider health and social care services (prevention & early intervention)	4	10	-4	2	-5	3
5. To align and enhance the realisation of the ACHSCP strategic aims, priorities and key aims	3	9	2	-1	-3	5
6. To assess and review options in line with relevant legislation (Equality Act 2010, Human Rights, Health Inequalities/Fairer Scotland Duty, Children's Rights and Welfare, Environment, Financial, Island or Rural Communities) and limit any adverse effects / negative impact identified.	4	10	-4	-2	-5	3
Totals	**23**	**61**	**-14**	**8**	**-28**	**21**

Scoring
Fully Delivers = 3
Mostly Delivers = 2
Delivers to a limited extent = 1
Does not deliver = 0
Will have a negative impact = -1

Ranking in order of preference:
1. Option 2 – Most preferred
2. Option 1
3. Option 5
4. Option 3b
5. Option 3a
6. Option 4 – Least preferred

4.45. The collective scores of the Independent Scoring Panel clearly shows option 2 scoring the highest with a score of 61, this is followed by option 1 with a score of 23, option 5 with a score of 21, option 3b with a score of 8, option 3a with a score of minus 14 and option 4 scoring minus 28.

Option Appraisal Recommendation

4.46. Following assessment of the information contained within the options appraisal and supplementary information provided in relation to the health screening initiative, the Integrated Impact Assessment of options 1-5 and the consultation and engagement feedback, we can conclude following the Independent Scoring Panel and scoring of options against the objectives that Option 2 has scored the highest.

4.47. The alignment of recurring ring-fenced ADP funding enables the practice to continue the successful collaboration and joint working with the IDS/Timmermarket and CNOT during the last 2 and a half years. Services would continue with the opportunity to enhance these further with improved access, and expansion of outreach areas, further embedding of health assessments and continue to support the implementation of MAT standards/direct access, including the opportunity to maximise opportunities with the Homewards Programme and the development of an outreach mobile bus. The recurring ADP funding would provide an opportunity to make permanent arrangements for clinical GP staff and create a sustainable model and staffing structure to meet the needs of this vulnerable patient group. ADP funding is contingent on Marywell funding continuing at current or increased level in the future.

4.48. Ensuring the service prioritises those most in need during periods of instability, ongoing coordination and transfer of patients to mainstream general practice is crucial. The previously known 'Moving on Policy' has been streamlined into the Co-ordination and Transfer of Patients Protocol, facilitating a seamless transition for patients with clinical input from GPs and aligned CNOT team members. Patients are then supported to transition to mainstream general practice, maintaining ongoing primary care input and continuity of care.

5. Implications for IJB

5.1. Equalities, Fairer Scotland and Health Inequality

To ensure compliance and due regard is given to the Equality Act 2010, the Fairer Scotland Duty and Health Inequality the SLWG have been working with NHS Grampian's Equality and Diversity Manager during the development of the options appraisal.

A Stage 1 Integrated Impact Assessment (IIA) has been completed for all of the identified options 1-5 contained within the options appraisal (see appendix C).

In summary the IIA identified Option 2 – Continue as a 2c GMS (specialist service) alignment of recurring ADP funding as the preferred option as it outlined numerous positive impacts and potential for improvement.

Following the outcome of the independent scoring panel a full Equalities Impact Assessment (EQIA) has been completed on the recommended Option 2, which can be found within appendix D.

The EQIA has been completed to ensure that any decisions made are compliant with the aims of the Public Sector Equality Duty and that any adverse impact for any protected characteristics are identified and resolved.

The completed EQIA highlights that following assessment option 2 which is being recommended has outlined numerous positive impacts and potential to improve and enhance services.

5.2. Financial

A paper was presented to the Alcohol & Drug Partnership (ADP) meeting on 20th December 2024. At this meeting the ADP approved the commitment of £100,000 ringfenced ADP funding from the Scottish Government to the Marywell Practice Core Budget on a recurring basis to support the ongoing collaboration between the Marywell Practice and the Integrated Drug Service.

5.3. Workforce

The progress of the Marywell Practice options appraisal links to the Aberdeen City Health and Social Care Partnership Workforce Plan 2022 – 2025 key priorities:

- Recruitment and Retention
- Staff Mental Health and Wellbeing
- Growth and Development Opportunities

5.4. Legal

There are no direct legal implications arising from the recommendations of this report.

5.5. Unpaid Carers

There are no direct implications relating to unpaid carers arising from the recommendations of this report.

5.6. Information Governance

There are no direct information governance implications arising from the recommendations of this report. Colleagues will continue to liaise with the Information Governance team on any relevant matters as necessary considering the General Data Protection Regulations (GDPR), Data Protection Impact Assessments (DPIA) and Information Sharing Agreements (ISA)

5.7. Environmental Impacts

There are no direct environmental implications arising from the recommendations of this report.

5.8. Sustainability

There are no direct sustainability implications arising from the recommendations of this report.

5.9. Other

There are no direct sustainability implications arising from the recommendations of this report.

Management of Risk

Colleagues have reviewed the IJB Risk Appetite Statement and will monitor progress towards mitigating the areas of risk closely in line with the recommendations of this report.

5.10. Identified risks(s)

Risk	Likelihood	Impact	Mitigation/Actions
Potential demand too high	Low	Medium	Controls of new patient criteria has been introduced along with a communication plan to engage with general practice.
Lack of clinical capacity	Low	High	Recommended option 2 of ringfenced funding has allowed for a permanent solution to support additional capacity for clinical time
Recruitment to specialist area of work	Medium	High	Practice has been modernised and increased collaboration to allow for increased resilience and reduced isolation. More attractive place to work.
Potential risk of recurring Scottish Government ADP funding reducing or stopping	Medium	High	Implementation of critical services only and possible reduction to planned expansion of outreach services/outreach bus Reduction in clinical hours

5.11. Link to risks on strategic or operational risk register and how might the content of this report impact or mitigate the known risks:

The Strategic Risk Register of the IJB has been reviewed in line with the development of this report with the following risks highlighted including specific mitigation.

Risk 1: The commissioning of services from third sector and independent providers (e.g. General Practice and other primary care services) requires all stakeholders to work collaboratively to meet the needs of local people.

Mitigation: The proposal within this report aims to mitigate this risk by developing a sustainable and integrated service.

Risk 5: Demographic and financial pressures requiring IJB to deliver transformational change which helps to meet its strategic priorities.

Mitigation: The proposals within this report outline a sustainable model with recurring financial stability for the Marywell Practice and the recommendations align with the strategic priorities of the IJB.

Risk 6: Need to involve lived experience in service delivery and design as per integration principles.

Mitigation: The proposals within this report include Planning with People national guidance as outlined by the Scottish Government and COSLA.

Risk 7: The ongoing recruitment and retention of staff

Mitigation: The proposals within this report will create permanent sustainable arrangements for clinical staff, which have previously been a range of temporary and fixed term secondment arrangements.