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HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD MONDAY, 1ST FEBRUARY, 2016

A MEETING of the HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD will be held in the COMMITTEE ROOM 2, COUNCIL HEADQUARTERS, NEWTOWN ST BOSWELLS on MONDAY, 1 FEBRUARY 2016 at 2.00 pm

AGENDA			
1.	**ANNOUNCEMENTS & APOLOGIES**		1 mins
2.	**DECLARATIONS OF INTEREST**		1 mins
3.	**MINUTES OF PREVIOUS MEETING** (Pages 1 - 10) Monday 14 December 2015		3 mins
4.	**MATTERS ARISING** (Pages 11 - 12) Action Tracker		5 mins
5.	**STRATEGIC**		
	5.1 **Health & Social Care Strategic Commissioning Plan**	(Pages 13 - 86)	15 mins
	5.2 **Integrated Care Fund** Progress Update – Chief Officer	(Pages 87 - 124)	15 mins
6.	**GOVERNANCE**		
	6.1 **Chief Officer's Report**	(Pages 125 - 126)	10 mins
	6.2 **Communications Update** Verbal update by Communications Officer		5 mins
	6.3 **Appointment of Chief Internal Auditor**	(Pages 127 - 130)	10 mins
	6.4 **Integration Joint Board Audit Committee Arrangements**	(Pages 131 - 134)	10 mins
7.	**FINANCE**		

	7.1 Monitoring of the Integration Joint Budget 2015/16	(Pages 135 - 148)	10 mins
	7.2 **Integrated Joint Board Governance - Draft Financial Regulations**	(Pages 149 - 164)	20 mins
8.	**FOR INFORMATION**		10 mins
	8.1 **Committee Minutes**	(Pages 165 - 170)	
	8.2 **Audit Scotland Report**	(Pages 171 - 218)	
	8.3 **Chief Financial Officer**	(Pages 219 - 230)	
9.	**ANY OTHER BUSINESS**		5 mins
	9.1 **Health & Social Care Integration Joint Board: 07.03.16**		
10.	**DATE AND TIME OF NEXT MEETING** Monday 7 March 2016 at 9.30 am in the Council Chamber, Scottish Borders Council		

Please direct any enquiries to Iris Bishop, NHS Board Secretary
Tel: 01896 825525 Email: iris.bishop@borders.scot.nhs.uk

Minutes of a meeting of the **Health & Social Care Integration Joint Board** held on Monday 14 December 2015 at 2.00pm in the Board Room, Newstead

Present:	Cllr C Bhatia (Chair)	Mrs P Alexander
	Cllr F Renton	Mr J Raine
	Cllr J Mitchell	Mr D Davidson
		Dr S Mather
		Mrs K Hamilton
In Attendance:	Miss I Bishop	Mrs S Manion
	Mrs C Gillie	Mr D Robertson
	Mrs J Davidson	Mrs J McDiarmid
	Mr J McLaren	Mr D Bell
	Mr J Lamb	Ms S Campbell
	Mrs J Smyth	Dr E Baijal
	Mrs E Rodger	Dr A McVean
	Mrs J Douglas	

1. Apologies and Announcements

Apologies had been received from Cllr Jim Torrance, Cllr David Parker, Mrs Fiona Morrison, Ms Jenny Miller, Dr Sheena MacDonald, Mrs Tracey Logan and Mrs Elaine Torrance.

The Chair confirmed the meeting was quorate.

The Chair welcomed various attendees to the meeting.

The Chair welcomed members of the public to the meeting.

2. Declarations of Interest

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

Dr Stephen Mather raised the matter of two late papers (Chief Officer Report and Financial Regulations paper) being emailed to members the previous day and tabled at the meeting. He confirmed that he and other members of the Integration Joint Board had been unable to read the papers in advance of the meeting and requested they be withdrawn and submitted to the next meeting.

The **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** agreed to receive the Chief Officer report at the meeting and to defer the Financial Regulations paper to the Development session on 20 January 2016.

3. Minutes of Previous Meeting

The minutes of the previous meeting of the Health & Social Care Integration Joint Board held on 12 October 2015 were amended at page 2, paragraph 3, line 1, replace "Torrence" with "Torrance" and at page 4, minute 8, line 5, replace "Governance" with "Government" and with those amendments the minutes were approved.

4. Matters Arising

4.1 Minute 5: Consultation on the Draft Strategic Plan for Health & Social Care: Clarification of dealing with Delayed Discharges was sought. It was noted that Delayed Discharges was a feature of the Development session to be held on 20 January 2016, where a full discussion of the topic would take place.

4.2 GP Representation: Mr John Raine advised that it was for the Health Board to determine the GP representative on the Integration Joint Board, and noted that Mrs Pat Alexander had made a sensible suggestion of seeking interest across all GP practices in being involved with the work of the Integration Joint Board. This suggestion was supported by the Health Board Medical Director.

Mrs Susan Manion confirmed that discussions had taken place with the GP Sub Committee, which was the usual engagement route for the Health Board to GP Practices in that regard. She further commented that information on the new GP contract was anticipated and had the expectation that GP leads would be identified for each GP Practice on a cluster basis in localities and the finer details of that would be discussed with colleagues across primary care.

Dr Angus McVean commented that GPs would welcome the broadening of input into the process and suggested the Health Board might consider clarification of the role and function of the GP representative to the Integration Joint Board, were they to represent the GP community across Scottish Borders or as an interested individual.

Mrs Alexander noted the parallel between the GP representative and the Third sector representatives to the Integration Joint Board. Cllr Catriona Bhatia suggested the Organisational Development plan might assist.

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

5. Update on the consultation on the Draft Strategic Plan for Health & Social Care

Dr Eric Baijal advised that the formal consultation had concluded on 11 December 2015. Cllr Catriona Bhatia noted the different methods of consultation used and looked forward to hearing the substance of the feedback. Mr David Davidson enquired how many people had

actually participated in the consultation. Dr Baijal gave a commitment to circulate that information to the Integration Joint Board.

Mr Davidson enquired if all of the opportunities to engage through social media had been used. Cllr Bhatia noted there had been over 100 people present at the interchange session and Mrs Susan Manion confirmed there had been a very good turnout at each of the engagement sessions that had been held.

Dr Baijal confirmed that there was sufficient feedback to be able to analyse it by locality.

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

The **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** agreed to receive the consultation participation numbers from Dr Eric Baijal by email.

6. Organisational Development Plan

Mrs June Smyth gave an overview of the content of the plan and advised that it remained a working document. It had been designed around the development of the Integration Joint Board, Strategic Planning Group and Health and Social Care Management Team. She further commented that she was keen to take forward something around the Joint Staff Forum at a future point.

Dr Eric Baijal welcomed the Organisational Development (OD) Plan and suggested inclusion of the Integration Joint Board establishing "Vision and Values" and inclusion of a risk commentary at the end of the plan to mitigate some of the issues, given the activity was heavily loaded towards the early months of the year. It was noted that some of the dates seemed challenging in relation to the March 2016 deadline. Mrs Smyth agreed to revise with the managers and Integration Joint Board to ensure realistic implementation.

The **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the updated Organisational Development Plan.

The **HEALTH AND SOCIAL CARE INTEGRATON JOINT BOARD** requested the Board Secretary confirm the outstanding appointments for the Integration Joint Board members with Mr George Hunter.

7. Update on Scottish Borders Dementia Strategy

Mrs Jane Douglas gave an update on the Dementia Strategy and highlighted several key elements including: commitments 10 and 11 had launched as national strategies; reconstitution of the dementia training group; funding of stress and distress training for staff; formation of enhanced dementia team; development of dementia friendly communities; and evaluating the effectiveness of the objectives moving forward.

Dr Angus McVean noted the progress made with post dementia support and enquired if more focus was now required on the diagnostic element. Mrs Douglas agreed that more focus on raising awareness was now required.

Mrs Evelyn Rodger welcomed the detailed paper and suggested a gap analysis against the strategy be produced to enable clear sight of progress and the difficulties to be mitigated.

Mr John McLaren noted the approach to train up 500 staff in distress/stress training and enquired if there would be a further roll out to staff. Mrs Douglas gave a commitment to clarify the position and advise Mr McLaren outwith the meeting.

Cllr John Mitchell enquired if the Scottish Dementia Working Group had branches UK wide and if the service required volunteers? Mrs Douglas confirmed that the group was made up of those who already had dementia, for those with dementia and there were several main groups across Scotland that linked together and into Alzheimers Scotland. She confirmed the intention to set up a branch in the Scottish Borders and advised that recruiting those with dementia to the group was currently underway.

Mr John Raine commented that he was encouraged to hear Dr McVean express a need to increase the rate of diagnosis and he sought quantification against the objectives. The extent of the effort towards achieving the dementia diagnosis target and the success to date should not be under estimated though. He further queried why the Enhanced Dementia Team had concluded given the suggestion had been that it was ahead of its time. Mrs Douglas confirmed that work was required to reframe, relaunch and implement alongside other existing teams.

Mrs Jane Davidson encouraged the Integration Joint Board to consider how the strategy would influence the strategic commissioning plan moving forward and how it would contribute to the outcomes set by the Integration Joint Board.

The **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the report and agreed to receive an update in April 2016.

8. Health & Social Care Integration Programme: End of Phase 1 Report

Mr James Lamb gave an overview of the content of the report, highlighted several key elements including: stock take; transition from phase 1 to phase 2; programme plan to phase 2; and introduce of the new programme manager. Whilst the Joint Staff Forum was not mentioned in the paper Mr Lamb recorded that credit should be afforded to them for their input to the engagement sessions and the position engagement that had taken place with both management, staff and unions.

Ms Sandra Campbell, gave an overview of the content of Appendix 2 highlighting the formation of a small focus team to oversee delivery and address any risks and difficulties. She further commented that there would be a rationalisation of the current working groups to ensure they were outcome focused with clear delivery plans and they would include the commissioning and implementation plan; locality plans; performance monitoring work; and the integrated care fund plan.

Mr John Raine raised issues of governance in regard to the Integrated Care Fund. Mrs Susan Manion suggested addressing those issues during the Integrated Care Plan Update item later on the agenda.

Cllr John Mitchell suggested there remained gaps in the plan to be addressed before "business as usual" could commence. Mrs Campbell confirmed that names, dates and plans were being clarified so that implementation could progress.

Mrs Karen Hamilton highlighted several typographical errors within the document.

Mr David Bell noted that the revised Draft Scheme of Integration stated that the Integration Joint Board "may" set up a Joint Staff Forum and he requested that the Integration Joint Board reaffirm its commitment to a Joint Staff Forum. Mrs Manion commented that the change had been made on the advice received from Scottish Government. Mrs Jane Davidson clarified that it referred to the Integration Joint Board having the ability to set up a Joint Staff Forum the same as it had the ability to set up an Audit Committee. She assured both Mr Bell and Mr McLaren of the commitment of NHS Borders to the Joint Staff Forum.

Mrs Manion recorded her thanks to Mr Lamb for developing the programme and bringing it to the point of moving into implementation.

The **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the report.

Mr David Robertson arrived.

9. Chief Officer Report

Mrs Susan Manion gave an overview of the report.

Dr Stephen Mather commented that delayed discharges were a risk to the system over the winter period and he enquired about the current position in regard to delayed discharges and social care provision.

Mrs Marion referred to the presentation and discussion at the recent NHS Board meeting which had outlined in detail the actions being taken in support of the winter plan. She advised that there were some 30 delayed discharges with pressures across both health and social care systems. Operationally a number of different options were being taken forward.

Mrs Jane Davidson suggested the Integration Joint Board needed to commit to deliver against the Delayed Discharges target. He further commented that bearing in mind there were 2 different organisations that had come together, the Integration Joint Board was the ideal body to look at the total outcome from both commissioned services. The Integration Joint Board should commit to ensuring both bits worked for the collective good and in future he wished to receive reports that tied the 2 parts of the journey together.

Mr David Robertson commented that it should also be looked at to what extent services were able to reduce admission to hospital.

Cllr Catriona Bhatia highlighted the immediate winter plan issues and the longer term strategic issues of preventing admissions in the first instance.

Dr Angus McVean suggested looking at the bigger picture of readmission rates. Mrs Davidson advised that Mrs Jane Douglas and others from health were reviewing readmissions as a specific issue and would be engaging with GPs to work out what was of concern as it appeared to be a holistic issue.

The **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the report.

10. Health & Social Care Integration Joint Board Business Cycle 2016

Miss Iris Bishop gave an overview of the business cycle and meeting dates for the 2016.

Cllr John Mitchell suggested revisiting the choice of venue for Development sessions in order to reduce any costs.

Mrs Jeanette McDiarmid enquired about the formal approval by Scottish Parliament of the Scheme of Integration in regard to impact on meetings in 2016. Mrs Susan Manion advised that once approved by the Cabinet Secretary it would be laid before Parliament for 28 days. Formal approval was therefore expected to be received by 6 February 2016 which would mean the Development session on 7 March would commence as a formal meeting for the first hour or so to formalise the Health & Social Care Integration Joint Board.

The **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** approved the meeting dates and business cycle for 2016.

11. Integrated Joint Board Governance – Draft Financial Regulations

The **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** agreed to defer the paper to the Development session on 20 January 2016.

Mrs Jane Davidson left the meeting.

12. Monitoring of the Integration Joint Budget 2015/16

Mrs Carol Gillie gave an overview of the report and highlighted the overspend on NHS drug costs and confirmed that a breakeven position would be achieved at the year end. In regard to local authority adult services she confirmed that there was a projected overspend and a number of actions were being taken forward to address the position.

Mr David Robertson commented that in relation to Scottish Borders Council there was an overspend at this point in the year as additional residential and flex beds were commissioned. The current budget was for about 50 beds however activity levels were greater and there had been additional pressure from two major care home contracts being passed back to the Council during the current financial year. Actions were being taken forward to address the pressures.

Mr David Davidson suggested the Integration Joint Board receive assurance on the stability and sustainability of some of the services that Border residents relied on especially during the winter period.

Cllr Catriona Bhatia outlined that in terms of strategic commissioning, Scottish Borders Council provided 50% of home care provision and the private/third sector provided 50%. However, that balance had now moved to 60% Scottish Borders Council, 40% private/third sector. She suggested that in future the Integration Joint Board would receive a report in relation to qualitative and quantitative elements across the range of services provided.

Mrs Jeanette McDiarmid highlighted that costs of other providers were increasing and the dilemma was the ability to meet the increase in costs or use SB Cares as an alternative.

Mrs Karen Hamilton commented that it was important the Integration Joint Board was sighted and aware of the consequences for service users and patients.

Mrs Pat Alexander enquired in regard to the GP prescribing budget if any work was underway nationally in terms of direct contact with drug companies. Mrs Gillie confirmed that the NHS Board Directors of Finance were working collectively on the matter.

The **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the reported projected position of overspend by £891k at 31st October 2015 and noted that both organisations were working to address the financial pressures and put in place actions to ensure financial targets were delivered.

The **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted that Budget Holders/Managers would continue to work to deliver planned savings and deliver a balanced budget. Where this was not possible managers would work to bring forward actions to mitigate any projected overspends.

13. Integrated Care Plan Update

Mrs Susan Manion advised that the Integrated Care Fund (ICF) plan had been agreed the previous year in line with the criteria for the funding given at that time. The ICF Plan had been developed to assist in meeting the national outcomes and had been mindful of the lessons learnt from the Change Fund programme. Rather than seeking bids, work was done to commission key pieces of work to achieve outcomes Commissioned projects were taken through the ICF Programme Board and Strategic Planning Project Board before being submitted to the Integration Joint Board. Mrs Manion recalled that Mr Raine had been concerned that the Integration Joint Board was not sighted on how the ICF monies were being used and that the governance routes were unclear. She suggested that the governance arrangements be refreshed and the plan be updated.

Mr David Davidson enquired if the ICF monies were spent without the direction of the Integration Joint Board? Mr Raine clarified that it was a similar point that he had raised earlier, seeking clarification on how the Integration Joint Board satisfied itself that it had proper governance over the £6.3m over the next 3 years, when the report before the

Integration Joint Board gave a schedule of schemes which could not determined as to what they were, how they were prioritized and what they were delivering.

Mrs Carol Gillie confirmed that earlier in the year around March the governance arrangements around the ICF had been agreed by the IJB and it had been confirmed that the Integration Joint Board delegated the authority to approve project funding to the Programme Board and had asked for six monthly update reports. She summarised that the ICF Steering Group reviewed each project against the criteria which included outcomes, sustainability and financials. The Strategic Planning Board had authority to approve individual projects up to £75k and a total spend of £500k in one year. Anything above that level was escalated to the Programme Board for a decision. It was obvious that by the time the update was submitted to the Integration Joint Board it was presented as a very high level update with the detail removed. She suggested the Integration Programme Board would find data on the outcomes delivered critical and the report should be amended accordingly.

Mr David Robertson clarified that the budget for 2015/16 for the ICF was £2.1m with a projected spend of £47k by end of March 2016. Discussions had taken place between Mr Robertson and Mrs Gillie in regard to passing the resource to Scottish Borders Council to carry forward.

Mr Davidson enquired if the Health Board had made a formal arrangement to ring fence the money when passing across to Scottish Borders Council in terms of audit. Mrs Gillie confirmed a formal arrangement had been agreed by the 2 parties and any arrangement could be subject to review by audit .

Cllr Bhatia noted that the report was light on detail in relation to the projects themselves. It was agreed that, as well as a refresh of the governance arrangements, now that the ICF had been considerably extended, more detail on the agreed pieces of work would be outlined at the next meeting.

The **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** agreed to a refresh of the ICF governance arrangements and an update of the plan.

The **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** agreed that the report be revised to include further detail.

The **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the report.

14. Committee Minutes

The **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the committee minutes.

15. Any Other Business

The Chair confirmed that the next Integration Joint Board Development session was being held on Wednesday 20 January 2016 at 9.30am, at Tweed Horizons.

Dr Stephen Mather recorded his apologies for the Development session.

16. Date and Time of Next Meeting

The Chair confirmed the next meeting of the Health & Social Care Integration Joint Board would be held on Monday 1 February 2016, at 2pm in the Council Chamber, SBC.

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Health & Social Care Integration Joint Board Action Point Tracker

Meeting held 27 April 2015

Agenda Item: Draft Strategic Plan – A conversation with you

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
	8	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to have a Development session later in the year dedicated to Commissioning (the commissioning cycle, review of the Manchester model and lessons learned).	Susan Manion/ Iris Bishop	October	**Complete:** Item included as part of the Commissioning discussion scheduled for the 20 January 2016 H&SC IJB Development Session.	G

KEY:	
R	Overdue / timescale TBA
A	<2 weeks to timescale
G	>2 weeks to timescale
Blue	Complete – Items removed from action tracker once noted as complete at each H&SC Integration Joint Board meeting

HEALTH AND SOCIAL CARE STRATEGIC COMMISSIONING PLAN

Aim

1.1 The aim of this paper is to describe the further development of the Health and Social Care Strategic Commissioning Plan, previously approved the by the Integration Joint Board (IJB) for consultation. The paper summarises the responses to the consultation and how the Strategic Commissioning Plan has been developed in the light of these to produce a final draft. It is anticipated that this will enable Board members to approve the plan.

Background

2.1 The Health and Social Care Strategic Commissioning Plan (Appendix 1) was approved for formal consultation on 12 October 2015; there was a period of consultation from 20 October 2015 to 11 December 2015. Both staff and public were targeted with engagement activities. Appendix 2 is a full report on the communications and engagement activity.

2.2 The Borders challenge of having a huge number of staff dispersed across different environments was tackled by equipping managers with "tools" to have "conversations" with their staff in an appropriate way.

2.3 The public were reached in a number of ways:

- Pop- up information sessions in the five localities with staff in attendance to engage members of the public in discussion
- Presentations at Area Forums, to the Independent and Third Sector as well as to others
- Distribution of hard copies
- Media coverage
- Social Media
- Plasma Screen messages
- Qualitative and quantitative feedback

2.4 All identified stakeholders were contacted, yielding both qualitative and quantitative data. Managers who attended the two launch sessions represented 35 different areas/departments/groups. There were up to 78,000 users of social media channels. There was feedback from 65 students and staff at Borders College. The Borders Carers Centre, which represents 700 carers, gave feedback. There were six pieces of feedback from community councils; these involve more than 50 elected members. The reach of this work benchmarks well against that of other partnerships.

Update of the Plan

2.5 The Plan has been updated as a result of:-

- Subsequent exchanges with members of the IJB, Strategic Planning Group, Strategic Planning Project Board, Strategic Planning Managers and the Localities Planning Group
- Feedback on the formal consultation that ran until 11th Dec
- Other changes identified by the core team of staff working on the Plan

2.6 Feedback from the formal consultation was collated by a small core team and initially categorised by predominant theme if possible (e.g. Carers, Mental Health, and Learning Disability) although much of the feedback was multi-topic. At a workshop on 16th December, the Strategic Planning Managers' group triaged the feedback into three categories

- Update the Plan now in response
- Hold the feedback for future consideration
- Feedback not to be acted upon (e.g. unclear, impractical)

2.7 The Strategic Planning Managers' group then provided additional content for the plan in response to the first category of feedback.

2.8 Key themes in the consultation feedback included:

- Examples of objectives linked to specific care groups should apply to others or all.
- There was mixed feedback on the targets in the plan.
- The partnership's work must recognise that local needs vary.
- Carers need more support and higher priority.
- Transport and rurality are key challenges.
- Communications around the patient or client and their carer need to be more joined up.

2.9 The most significant changes to the document as a result of the consultation are:

- An explicit acknowledgement of the Equalities Duty of the Partnership;
- A development of the section on the nine local objectives to give additional examples of work already planned or being undertaken;
- A development of the section on locality planning;
- An improvement in the visual accessibility of the document to people by increasing the font size and layout in some sections. This has resulted in an apparent increase in document length.

Next Steps

2.10 Following formal approval of the Strategic Commissioning Plan by the IJB a number of pieces of work required to be completed:

- Easy- Read Version
- Equality Outcomes
- Communication and Engagement Plan
- Commissioning/Implementation Plan
- Financial Plan
- Locality Plans

- Market Facilitation Plan
- Collaborative planning of appropriate acute services
- Performance Monitoring Framework

2.11 Formal approval of the Strategic Commissioning Plan is on the critical path for the delivery of a number of dependent pieces of work; deferring formal approval will delay these.

Summary

3.1 Following a period of extensive consultation the Health and Social Care Strategic Commissioning Plan has been revised to take account of responses. Formal approval will allow dependent pieces of work to be progressed.

Recommendation

The Health & Social Care Integration Joint Board is asked to **approve** the Health and Social Care Strategic Commissioning Plan.

Policy/Strategy Implications	This document sets the direction for the delivery of better outcomes from more integrated health and social care services and a better client/patient service experience.
Consultation	Formal consultation as described. Discussion with the Strategic Planning Group
Risk Assessment	The significant risks relate to delay in formal completion of the strategic plan which will delay the production of further work dependent on it and which are likely to result in a loss of credibility and reputational damage.
Compliance with requirements on Equality and Diversity	A three stage Equality and Diversity Impact Assessment is in progress.
Resource/Staffing Implications	None

Approved by

Name	Designation	Name	Designation
Dr Eric Baijal	Director of Strategy (Integration)		

Author(s)

Name	Designation	Name	Designation
Dr Julie Kidd	Principal Information Analyst		

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Scottish Borders *Health & Social Care partnership*

Changing Health & Social Care for You

Working together for the best possible health and wellbeing in our communities

Draft Strategic Commissioning Plan 2016 – 2019

Scottish Borders Health & Social Care Partnership
Strategic Commissioning Plan 2016-2019

NOTE: Content that has been amended or added relative to the 2nd consultation draft version is highlighted in yellow, for easy reference.

Contents

Foreword

People are living longer than ever and this trend is set to continue. This is something that we should all celebrate. It means that we need to plan ahead, both as communities and as individuals, to ensure that we, in the Borders, make the most of the benefits and positive experiences of a long healthy life. This Plan sets out why we want to integrate health and social care services, how this will be done and what we can expect to see as a result. We want to create health and social care services that are more personalised and improve outcomes for all our service users, their Carers and their families.

This is our first Strategic Commissioning Plan as a new Health and Social Care Partnership (HSCP). This builds on the progress that has already been made by NHS Borders, Scottish Borders Council and our partners to improve services for all people in the Scottish Borders.

This Plan is based on what we have learned from listening to local people; service users, carers, members of the public, staff, clinicians, professionals and partner organisations. From April to December 2015 we engaged on first and second consultation drafts of the Plan through workshops and locality events across the Borders.

We believe that through strong leadership, innovative thinking, robust planning and by putting the views of patients, service users and carers at the heart of all that we do, we can achieve our ambition of “Best Health, Best Care, Best Value” for our communities. We will make sure that strong and effective relationships continue to develop between Scottish Borders Council and NHS Borders, colleagues in the Third and Independent sectors and with other key partner organisations. The aim is that we plan, commission and deliver services in a way that puts people at the heart of decision-making.

Together, with you, we know we can make a real difference.

< Susan Manion’s Signature here >

Susan Manion
Chief Officer Health and Social Care Integration
March 2016

Executive Summary

This plan sets out what we want to achieve to improve health and well-being in the Borders through integrating health and social care services.

The case for changing the way we deliver health and social care services in the Borders is compelling. We have a growing number of people needing our services, but limited resources with which to deliver them. These services could be provided more effectively and efficiently if they are integrated. We want to achieve better outcomes for all our communities. The Borders is largely a remote and rural area. There are five Area Forum localities in the Borders, which have individual characteristics and therefore different needs. This makes delivery of services complex. About a quarter of the households in the Borders are composed entirely of people aged 65 and over. This age group has a greater need for our services. The growing number of people with dementia is a big challenge.

Deprivation is an issue in the Borders. Although it may only seem to affect a small number of communities, it is often hidden in rural areas. Research indicates that people from deprived areas are more likely to make greater use of hospital and other health and social care services. Health inequalities exist beyond deprivation and we need to take into account that some people have different health outcomes. As an example, people with mental health issues or a learning disability tend to have poorer health outcomes. This plan contains actions to address such issues. It also sets out our local objectives, which will enable us to achieve the nine national health and well-being outcomes.

This Plan sets out a high level summary of some of what we will do when working together to deliver more personalised care, making best use of advancing technology to achieve "Best Health, Best Care, Best Value". This high-level Plan will be supported by the implementation of Strategies related to specific themes (such as Dementia, Mental Health) and Locality Plans that reflect differing patterns of need across the Borders.

Case for Change: Why we need to change

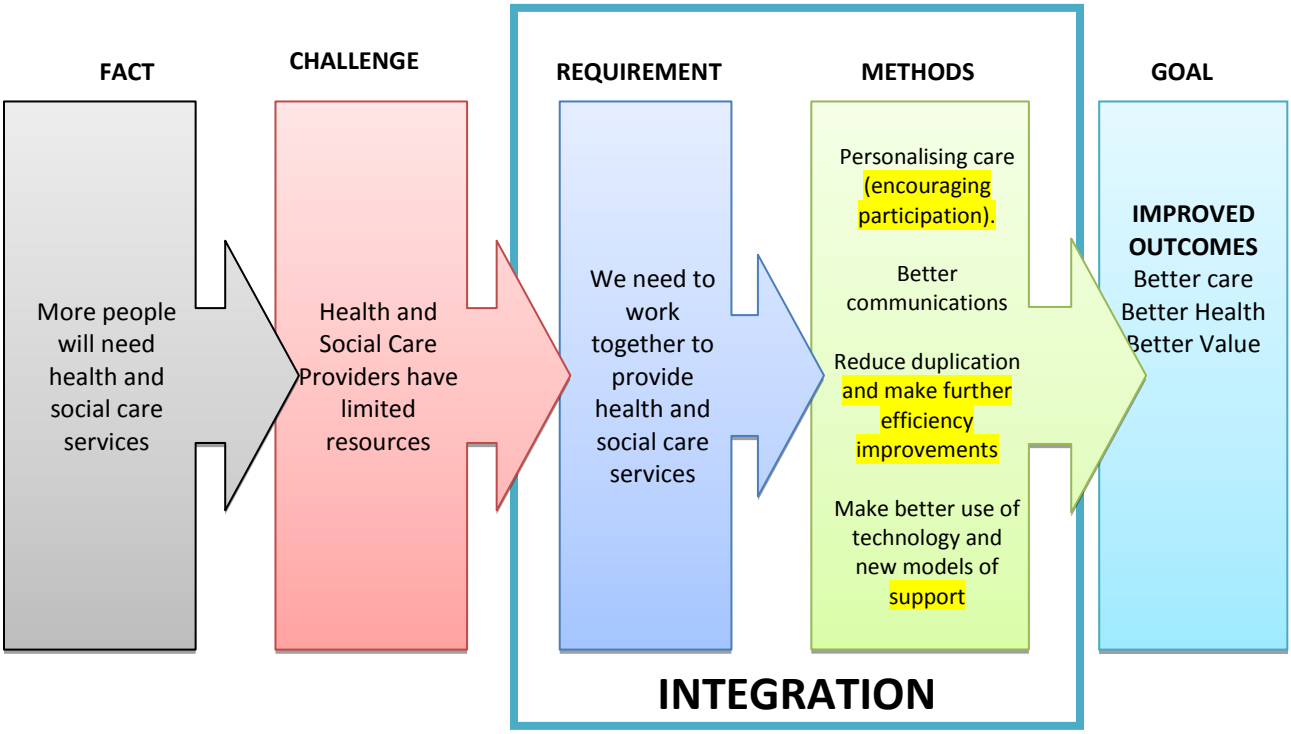
There are a number of reasons why we need to change the way health and social care services are delivered.

These are illustrated in the figure below and include:

- **Increasing Demand for Services** – with a growing ageing population, more people need our health and social care services and will continue to do so.
- **Increasing Pressure on Limited Resources** – the rise in demand puts pressure on our limited resources and this is happening at a time of constraint on public sector funding and rising costs of health and social care services.
- **Improving Services and Outcomes** – service users expect – and we want to provide – a better experience and better results.

We need to make better use of the people and resources we have by working more effectively together. If we do not change we will not be able to continue the high quality services the people of the Borders expect to meet their needs.

Figure 1 – The Case for Change



The Scottish Borders: A Summary Profile and Some of our Key Challenges

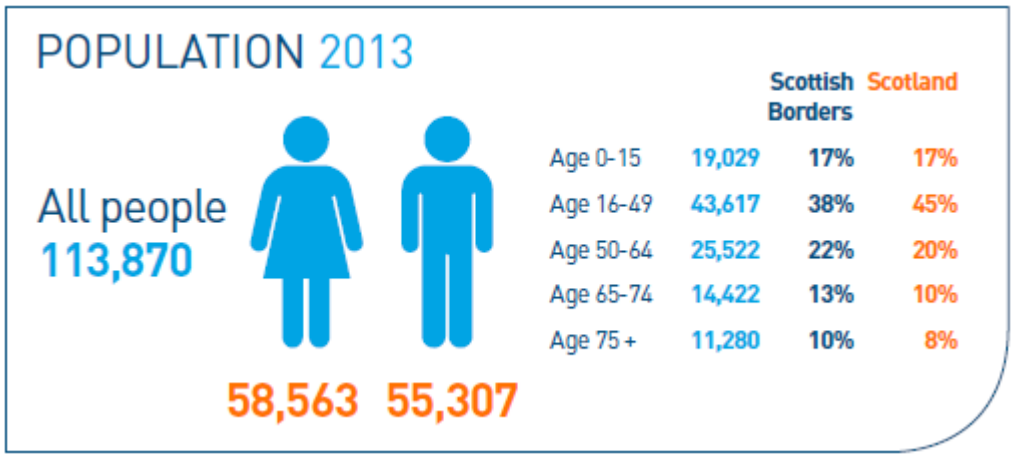
This 12 page section of the Plan gives a high level summary profile of the Scottish Borders and some of our key challenges. More detailed information is also available in two further documents published alongside this Plan – Facts and Statistics, and the Joint Strategic Needs Assessment.

Who Lives in the Borders?

Understanding the needs and issues of people and communities across the Borders is critical in the planning and provision of better health and social care services. In this section, we look at how the population structure and characteristics impact on health and social care services. This highlights some of the challenges we need to address.

As the figure below shows, we have a higher percentage of older people than the rest of Scotland.

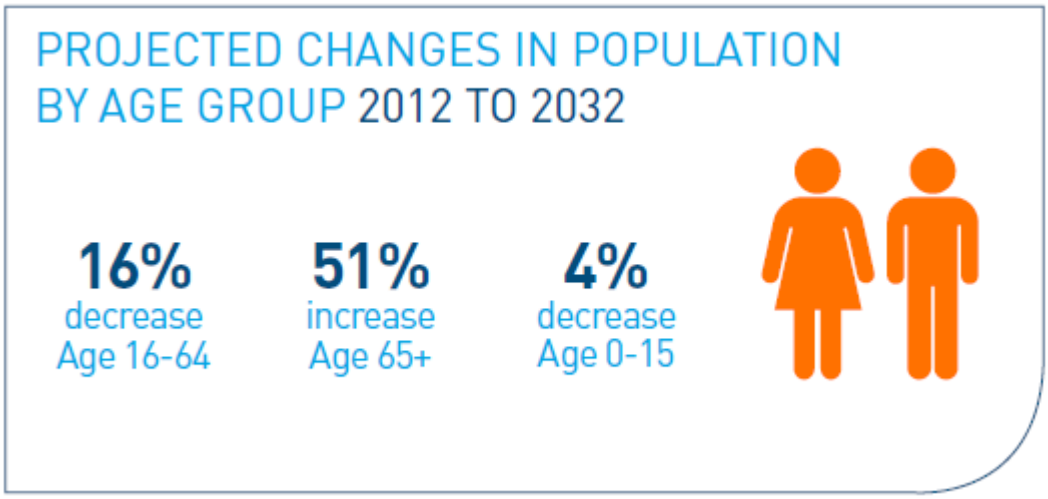
Figure 2



Source: National Records of Scotland, mid-year population estimates.

By the year 2032, the number of people aged over 65 is projected to increase by 51%, a faster rate than the 49% for Scotland overall. The number of people under 64 is also projected to decrease in the Scottish Borders. Age is strongly related to patterns of need for health and social care. These changes will influence how we deliver services in the future. Integration will enable us to work more effectively and efficiently to achieve "Best Health, Best Care, Best Value".

Figure 3



Source: National Records of Scotland 2012-based population projections.

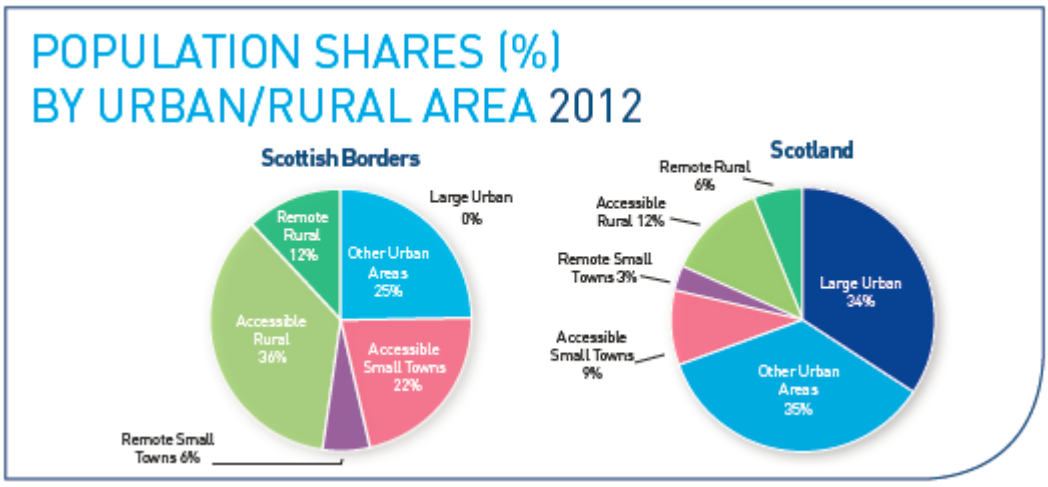
WHAT THIS MEANS…
This is a priority. We need to promote active ageing and address the range of needs of older people.

Where do people live?

The Urban/Rural profile of the Borders presents challenges in terms of both the accessibility and cost of services. The challenges are different in nature to those facing densely populated cities such as Glasgow, Edinburgh and Dundee.

In the Borders nearly half (48%) of the population live in rural areas, as shown in Figure 4. Just under one-third of people live in settlements of fewer than 500 or in remote hamlets, in contrast to 34% of the Scottish population who live in "Large Urban" areas (part of towns/cities with populations of more than 125,000). Our main towns are Hawick (population 14,209) and Galashiels (population 12,604), which come under the Scottish Government classification of "Other Urban Areas". Peebles, Kelso and Selkirk are the only other towns with a population of more than 5,000. As people in the Borders do not live close together in cities, planning services is more challenging.

Figure 4



Source: Scottish Government Urban/Rural Classification 2013/14 and National Records of Scotland

Category	Description
1 – Large Urban Areas	Settlements of 125,000 or more people.
2 – Other Urban Areas	Settlements of 10,000 to 124,999 people.
3 – Accessible Small Towns	Settlements of 3,000 to 9,999 people and within 30 minutes drive of a settlement of 10,000 or more.
4 – Remote Small Towns	Settlements of 3,000 to 9,999 people and with a drive time of over 30 minutes to a settlement of 10,000 or more.
5 – Accessible Rural	Areas with a population of less than 3,000 people, and within a 30 minute drive time of a settlement of 10,000 or more.
6 – Remote Rural	Areas with a population of less than 3,000 people, and with a drive time of over 30 minutes to a settlement of 10,000 or more.

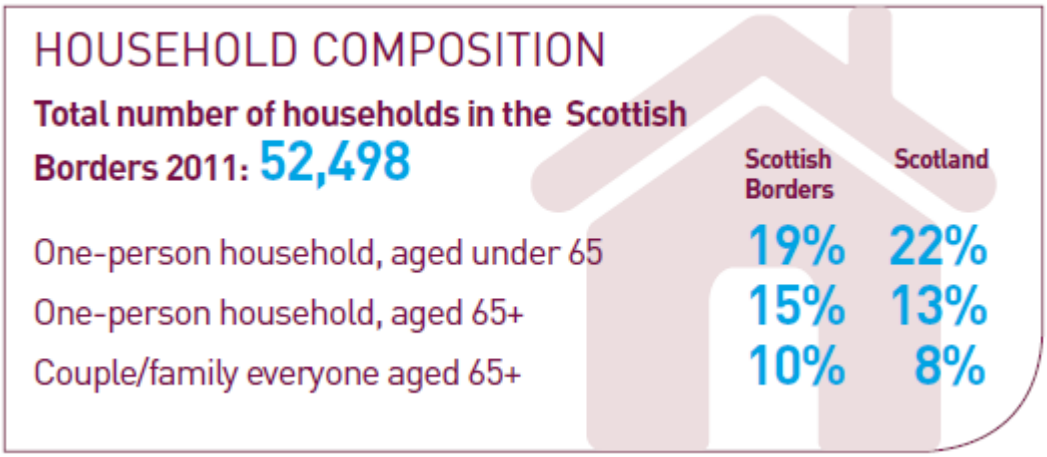
WHAT THIS MEANS…
Services therefore need to be provided locally whenever possible and accessible transport arrangements put in place.

Borders Households

With the changes predicted in the population (see Figure 3 on page 7), we expect an increase of the numbers of older people living alone with complex needs. This will have major implications for housing, health and social care.

More than one third of households in the Borders are made up of one adult. The number of households in the Borders in which one or all occupants are aged over 65 is 25%, higher than the 21% for Scotland as a whole.

Figure 5



Source: Scotland Census 2011

The number of single adult households is projected to increase by 24% between 2012 and 2037, whilst the number of larger households is projected to decline. Households headed by people aged 60-74 are projected to increase by 9% and those headed by a person aged over 75 are projected to increase by 90%.

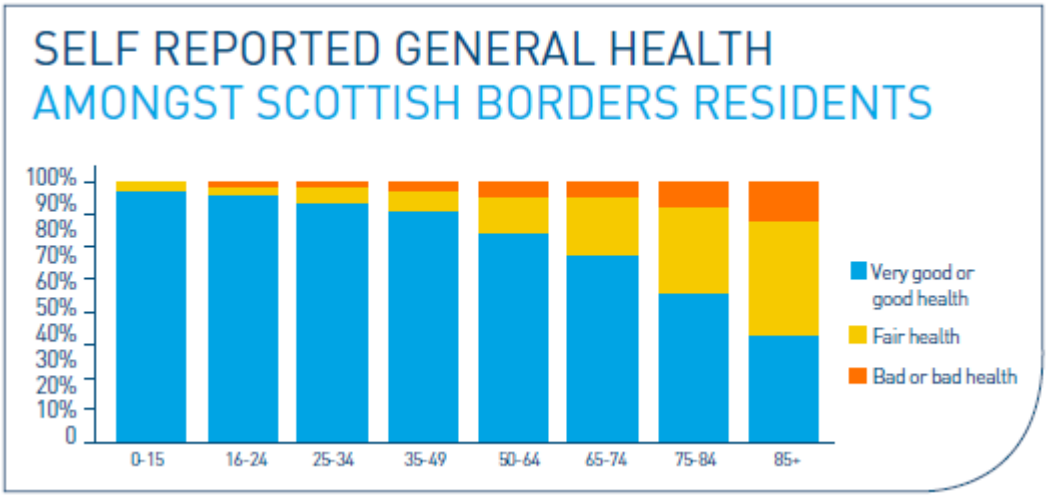
WHAT THIS MEANS…
Housing options need to be a key feature of our integrated health and social care services. Our existing Local Housing Strategy (2012-2017) and Housing Contribution Statement (2016) set out our work in relation to housing in more detail. An updated strategy will be in place in 2017.

How Do People in the Borders View Their Health?

In general, people in the Scottish Borders enjoy good health, with 84 % considering their health to be 'very good or good'; 12 % of respondents consider themselves in 'fair' health, while 4 % think their health is 'bad or very bad'.

The graph below shows that the number of people who consider their health to be 'very good or good' decreases with age. For example, more than 1 in 10 people aged over 75 reported their health as being 'bad or very bad', compared with only around 1 in 100 people aged 16-24.

Figure 6



Source: Scotland Census 2011

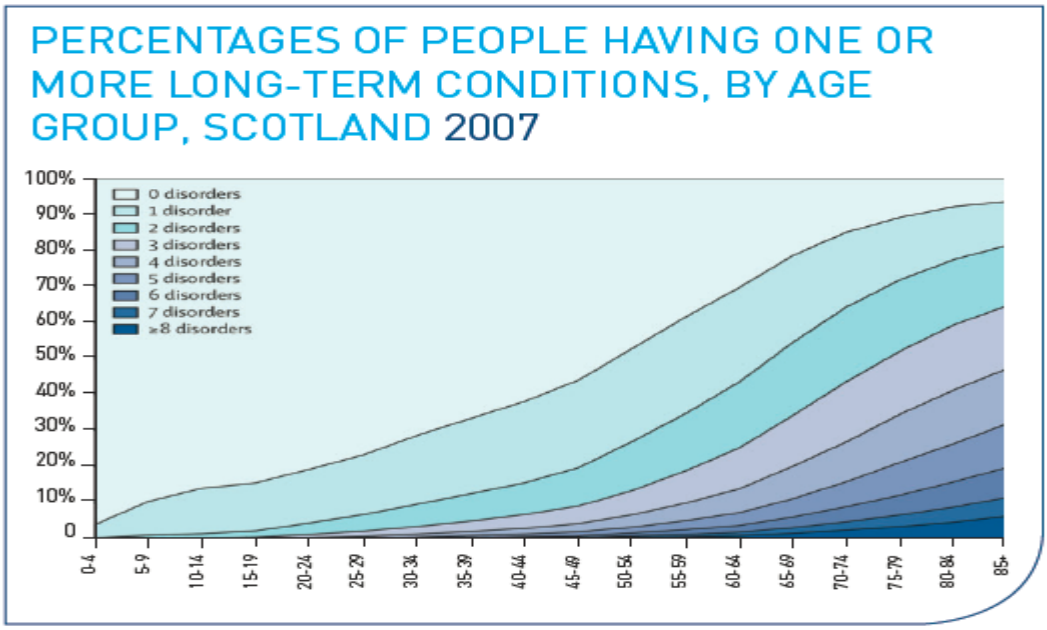
WHAT THIS MEANS…
We must enable people to keep well as long as possible through promoting healthier lifestyles, earlier detection of disease, and support to recover and manage their conditions.

People Living with Multiple Long Term Conditions

We know that many people in the Borders live with one or more long-term conditions. This may affect how they access and use services. We need to make sure that services are integrated to support individuals with complex needs to enable them to manage their conditions to lead healthy, active and independent lives as long as possible.

The number of people living with two or more long-term conditions rises with age as illustrated in figure 7. For example, nearly two thirds of patients aged 65-84 and more than 8 in 10 patients aged over 85 had multi-morbidity. This presents a significant challenge to plan and deliver health and social care services.

Figure 7



Source: Barnett et al (2012). Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)60240-2/abstract

Disability

The needs of people living with disabilities and sensory impairments are distinct from those who live with one or more health conditions. According to the 2011 Scotland Census, 6,995 people in Borders live with a physical disability. We have at least 555 people aged over 16 in our population who have a learning disability. About 2,300 people are estimated to have severe sensory impairment.

WHAT THIS MEANS…
People with a disability need flexible support arrangements to maintain and improve their quality of life.

It is estimated that around 500 people in our population are blind or have severe sight loss, while 1,800 people have severe or profound hearing loss. The National Health and Well-being Outcomes focus on people having a positive experience and their dignity respected when in contact with health and social care services, and that services are to be centred on helping maintain and improve the quality of life of people who use those services. This means that we must ensure services are accessible and easy to use by people with sensory impairment.

At the time of the 2011 Scotland Census, 612 people resident in Scottish Borders identified themselves (or were identified by a member of their household) as having a Learning Disability . 485 people in this group (81%) were aged 16 or over in 2011. Meanwhile, the total number of adults with Learning Disabilities known to Scottish Borders services is higher than the figures captured through the Census. As at March 2014, 599 people aged over 16 with Learning Disabilities were known to Scottish Borders services, of which 555 had confirmed addresses in the area.

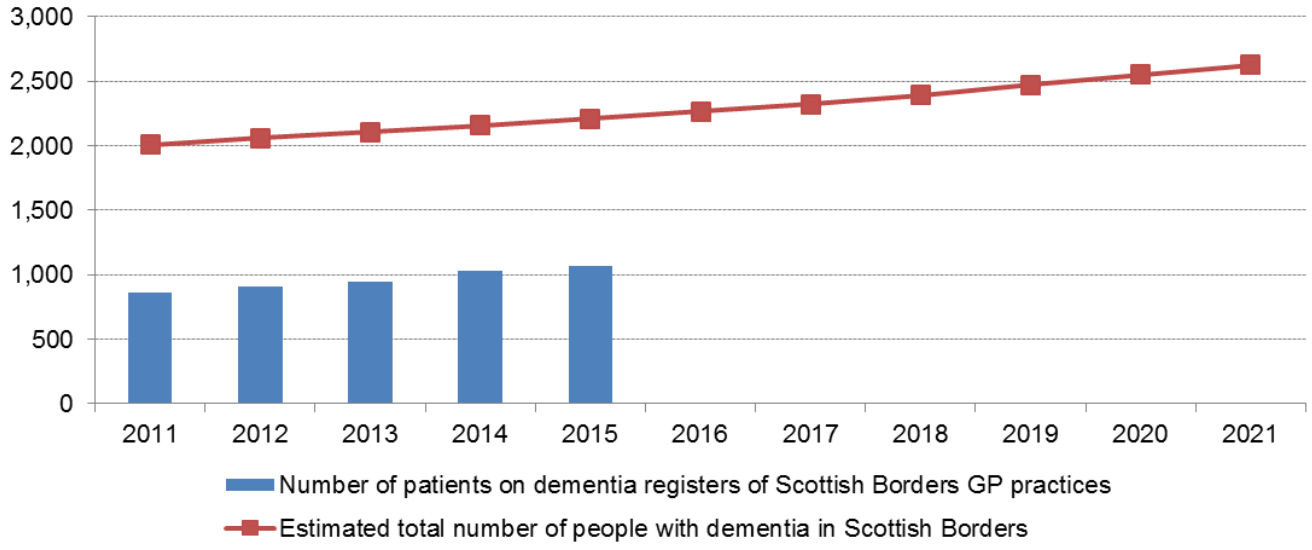
Learning Disability resources within NHS Borders and Scottish Borders Council Social Work were formally integrated in 2006. The Scottish Borders Learning Disability Service provides a range of specialist health and social care services for people with learning disabilities. The service is open to people with learning disabilities who need additional support to access other health and social care services, or whose needs are complex and require a more specialist intervention than that provided by mainstream Health and Social Care services. As part of the learning disability governance structure, people with learning disabilities and family Carers have places at the Partnership Board table to help inform decision making and strategic direction. Locality citizens' panels throughout the Borders provide opportunities for conversations between the Learning Disability Service and people directly affected by learning disabilities. A local area coordination service supports people to be more involved in their local communities.

Around one in four Scottish adults will experience at least one diagnosable mental health problem every year, and we are all likely to experience poor mental wellbeing at some point in our life. Due to the stigma related to mental illness, many will not access treatment and tend to have poorer health outcomes. Mental Health Services are in the process of developing integrated teams to provide easy access and multi-agency support to people with mental health needs. A full mental health needs assessment has been completed and this will help shape how we plan services in the future.

Dementia

Dementia is a growing issue and represents a challenge in planning and providing appropriate integrated care. The number of people living with dementia is projected to increase across Scotland, however the rate of increase in the Borders may be faster than the Scottish average as our population is older. Figure 8 below shows the number of people diagnosed with dementia in the Borders (shown in blue). For a number of reasons, including difficulties in diagnosis, the actual figures of people living with dementia are likely to be higher. The red line shows the likely number of people and how this number is predicted to increase over time as the population ages.

Figure 8: Projected potential increase in numbers of people with dementia in the Borders



Source:

1. Diagnosed cases: Quality and Outcomes Framework (QOF) www.isdscotland.org/qof

2. Estimated overall numbers of cases: Scottish Government projection, based on 'Eurocode' prevalance model used by Alzheimer's Scotland, and 2010 - based population projections.

WHAT THIS MEANS…

A range of support needs to be provided for people with dementia and their Carers, with appropriate training for all involved, to provide care across all settings.

People Living with Complex and Intense Needs

Health and Social Care resources are not utilised evenly across the population, as illustrated in the box below. As a Partnership, we need to develop a better understanding about the people who use very high levels of resource and use this knowledge to help plan our services more effectively. For example, where someone has had multiple hospital admissions and/or visits to A&E, it might have been more appropriate to deliver more of their care at home or in another community setting and reduce the risk of them having an avoidable admission to hospital. Changes in how care is provided to these people could produce better outcomes for them and allow us to treat more people more effectively.

Work to support people living with complex and intense needs will include:-

- Identifying the main factors that increase the risk of emergency admission or re-admission to hospital;
- Using this information to help strengthen our responses to patients and service users earlier on, and
- Exploring alternative models of care.

Use of Health and Social Care resources: an example

Analysis of expenditure in 2012/13 showed that:

- 2,332 people (2.5% of all Scottish Borders residents using selected major health services*) accounted for half of all expenditure on those services.
- 1,451 people aged 65 and over (7% of Scottish Borders residents aged 65+ who used any of the selected health services) accounted for half all expenditure on people aged 65 and over across those services.

*Health Services included in the analysis were: A&E attendances, Inpatient and day case hospital admissions (all specialties), new attendances at consultant-led outpatient clinics, and community prescribing.

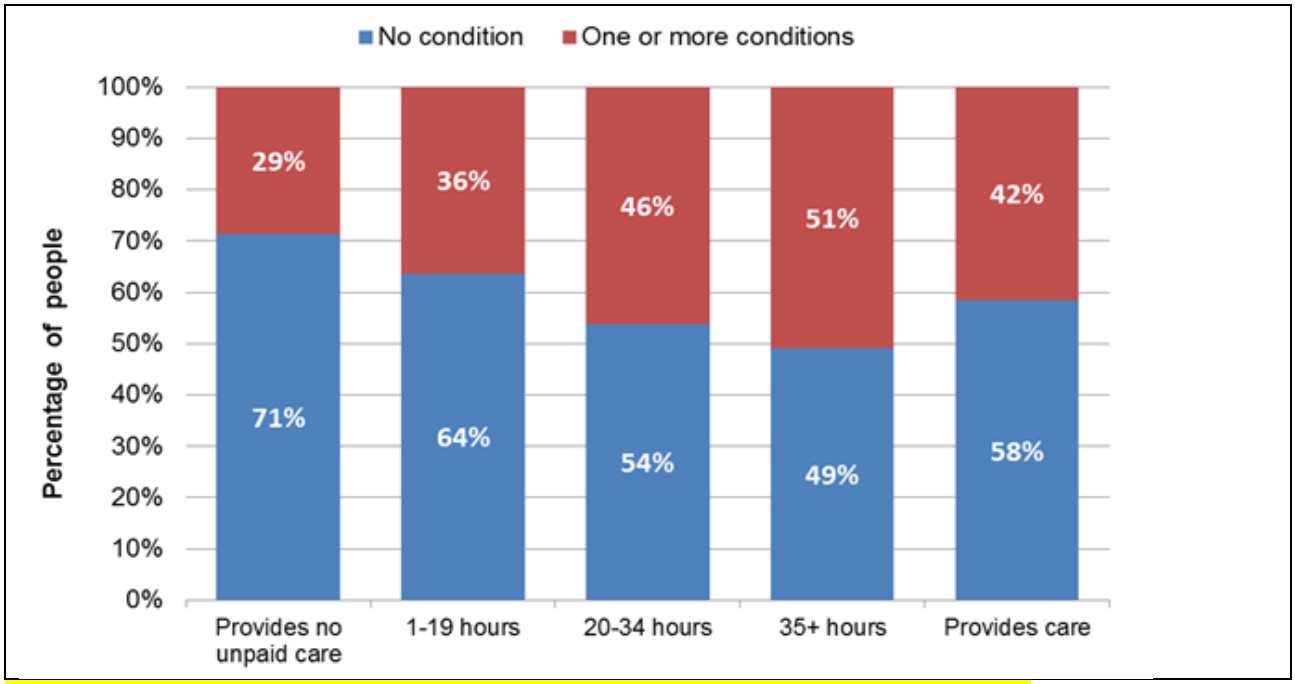
Source: Integrated Resource Framework (IRF), ISD, NHS National Services Scotland.

Carers in the Borders

Health and Social Care Services are dependent on the contribution of Carers*. In the Borders approximately 12,500 people aged 16 and over provide unpaid care, around 13% of people in this age group.

The burden of caring is greater in more deprived areas. 46% of Carers living in the most deprived areas of the Borders provide 35 or more hours of care per week, compared with 22% of Carers living in the least deprived areas. Research also indicates that providing care for someone else often affects the Carer's own health – and Carers are often themselves older people with one or more long term conditions. More Carers (42%) than non-Carers (29%) have one or more long-term conditions or health problems. Of people providing more than 50 hours of unpaid care per week 13% rated their own health as 'bad or very bad' compared with 4% of people who were not carers.

Figure 9: Percentage of Carers with one or more long-term health conditions, 2011, by weekly hours of care they provided



Source: Scotland Census 2011 / Scotland's Carers (Scottish Government, March 2015).

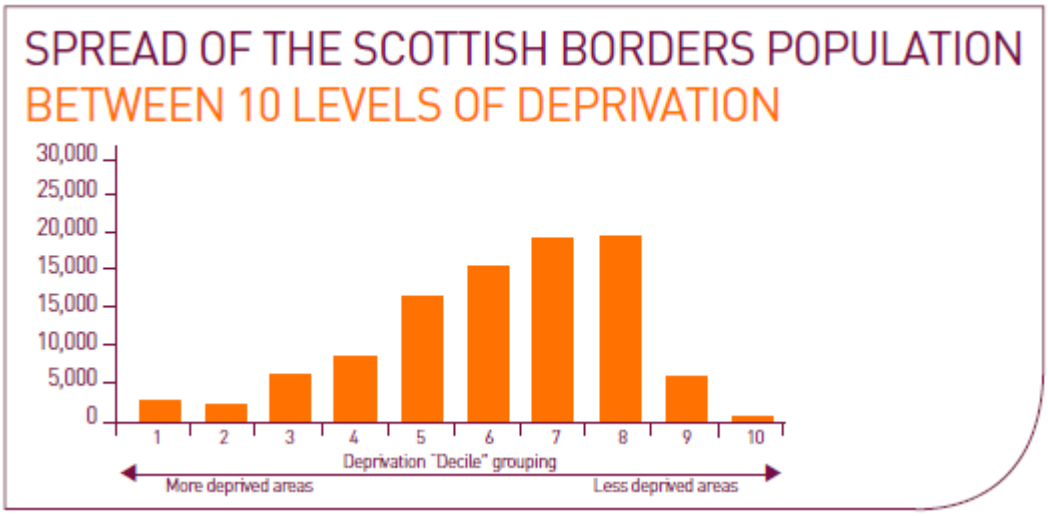
WHAT THIS MEANS…
A range of easily accessible information and available support needs to be a key priority to ensure the wellbeing of Carers.

*Carers are individuals who care for a friend, relative or neighbour without receiving paid income in addition to income received through the benefits system. (Definition source: Care 21 Report: The future of unpaid care in Scotland. www.gov.scot/Publications/2006/02/28094157/0).

Deprivation in the Scottish Borders

Deprivation has a big effect on the need for, and use of, health and social care services. Taken as a whole, levels of deprivation in the Borders' population are relatively lower in comparison to Scotland. Figure 10 below shows the spread of our population between 10 different categories of deprivation (with 1 being the most deprived and 10 being the least deprived). If our deprivation profile were the same as Scotland's, we would see about 10% of our population in each category. What we see instead is an uneven distribution, with clearly less than 10% of our population living in the most deprived areas. However, some of our more urban areas - in Burnfoot (Hawick) and Langlee (Galashiels) - continue to show as amongst the most deprived in Scotland.

Figure 10



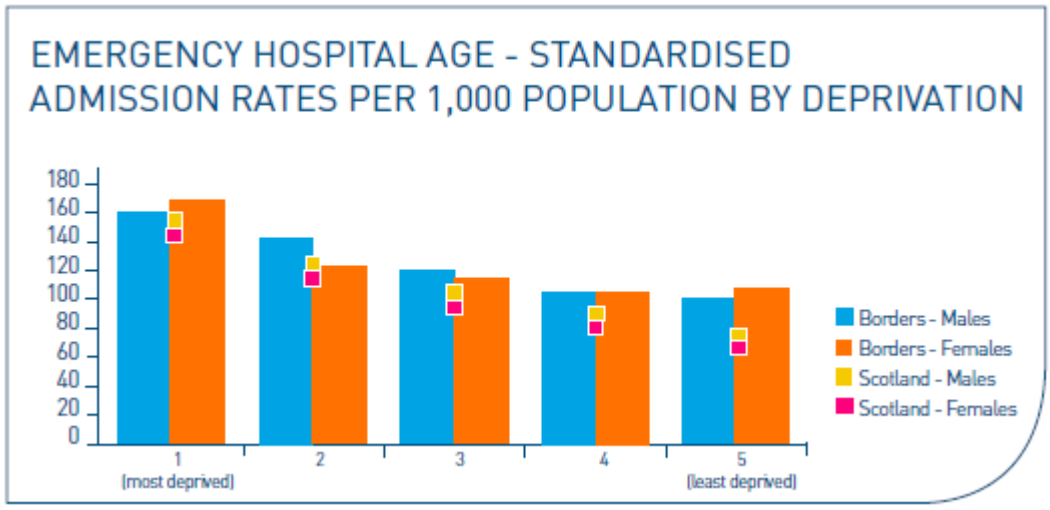
Source: Scottish Borders Strategic Assessment 2014.

We know, however, that deprivation is not confined to geographical areas. It also applies to more vulnerable groups who may live in deprived circumstances, such as homeless people, offenders, people with disabilities and/or mental health problems.

An example of how the use of health and care services varies by deprivation is shown in Figure 11 below. The Borders follows the national pattern of having higher emergency hospital admission rates for people living in areas of higher deprivation. The figure also shows that emergency admission rates in the Borders are higher than the Scottish average within any given deprivation grouping.

A report on deprivation-related hospital activity noted: "Given that people at increased risk of health inequalities make proportionately greater use of acute and community health services, hospitals offer an important opportunity for health improvement actions to reduce health inequalities". The need for health and social care services to contribute to reducing health inequalities is the focus of the Scottish Government's National Health and Wellbeing Outcome number 5 (see Appendix B).

Figure 11



Source: NHS Health Scotland (March 2015) Hospital discharges and bed days in Scotland by deprivation 2011-12.

WHAT THIS MEANS…
The Strategic Commissioning Plan and Locality Plans that we will be developing in 2016 must reflect the local needs of communities, recognising patterns of deprivation and inequality. These plans will cross-reference with work already being developed under our Reducing Inequalities Strategy.

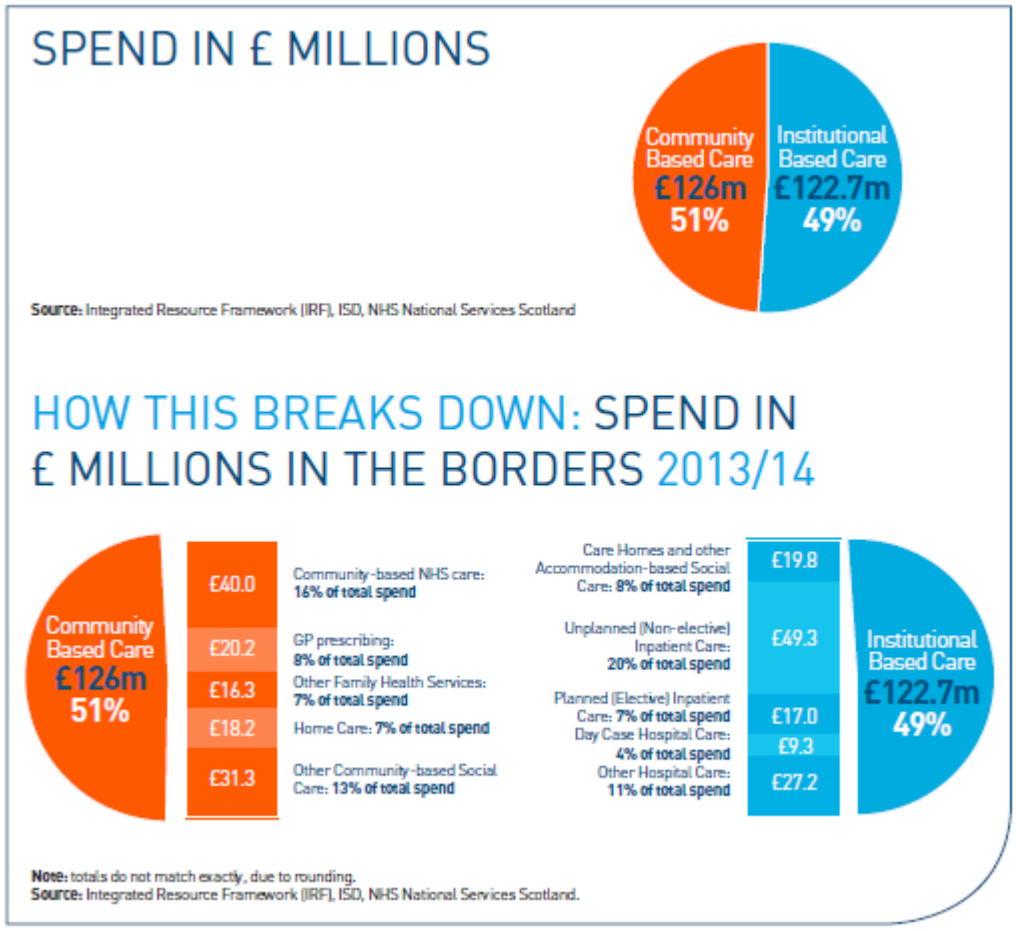
Health and Social Care Spending

The total NHS and social care spending in the Borders in 2013/14 was £248.7m. All NHS services are included in this total – including health services that are not covered by integration (such as planned outpatient and inpatient care). The overall spending was split 51% Community-Based Care versus 49% Institutional Care.

- Community-Based Care comprises all NHS community services, family health services including GP prescribing, and all social care expenditure excluding accommodation-based social care services.
- Institutional Care comprises all hospital-based care including outpatients, day case and day patients, plus accommodation-based social care services.

The Borders has already made significant progress towards the aim of providing more care in the community compared with Scotland as a whole, where the split was 44% on Community-Based Care versus 56% on Institutional care.

Figure 12 (graphics team to correct error in top pie chart – 51% and 49% are shown the wrong way round)



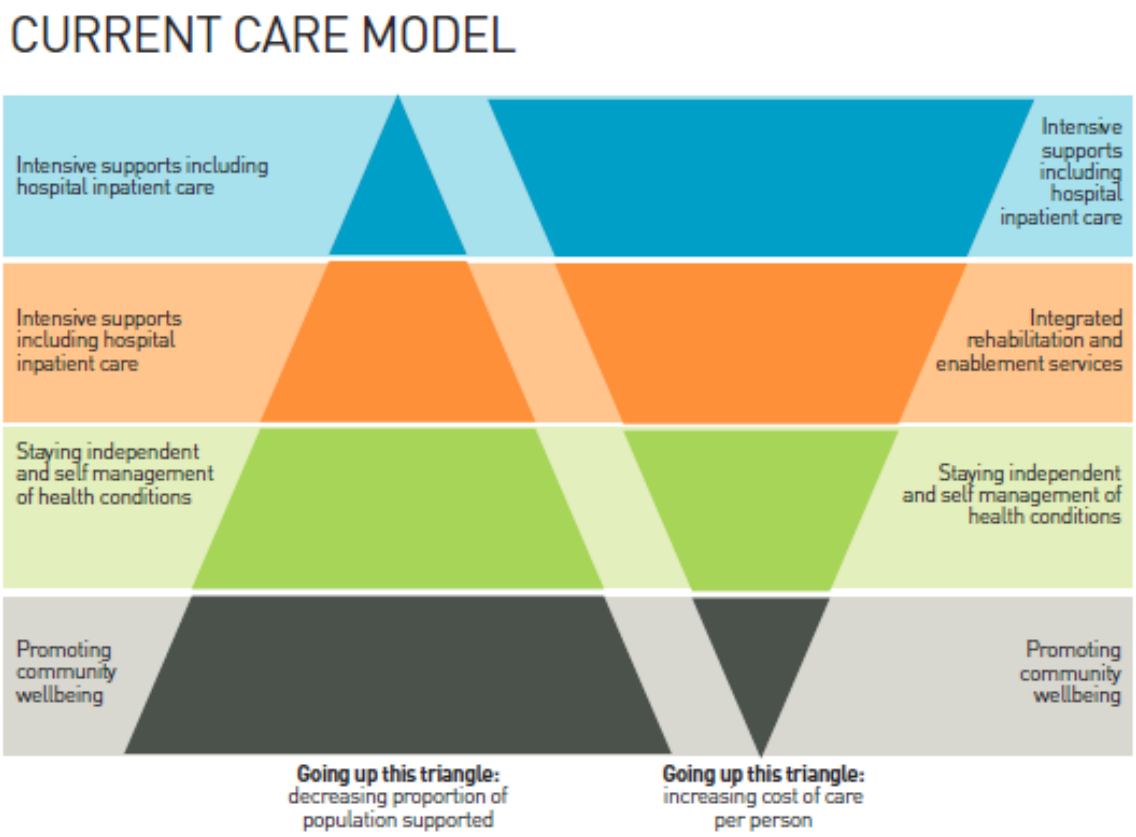
Shifting the Balance of Care Towards Prevention and Early Intervention

The aim of integrated health and social care services is to shift the balance of care towards prevention and early intervention to ensure that individuals have better health and well-being. Services need to be redesigned around the needs of the individual, to:-

- Ensure that their journey through their care and treatment is as integrated and streamlined as possible;
- Enable them to remain independent for as long as possible; and
- Support them to recover after illness and at times of crisis.

In Figure 13 below, services that promote health and well-being are shown at the bottom of each triangle, whilst intensive support services (such as acute hospital inpatient care) are shown at the top. The triangle on the left shows that a small number of people need the intensive support and care provided within hospital. However the triangle on the right shows that this small group of people use a large amount of total resource available for health and social care.

Figure 13 [graphics team to correct error– wording in left-hand orange section should read "Integrated rehabilitation and enablement services"]

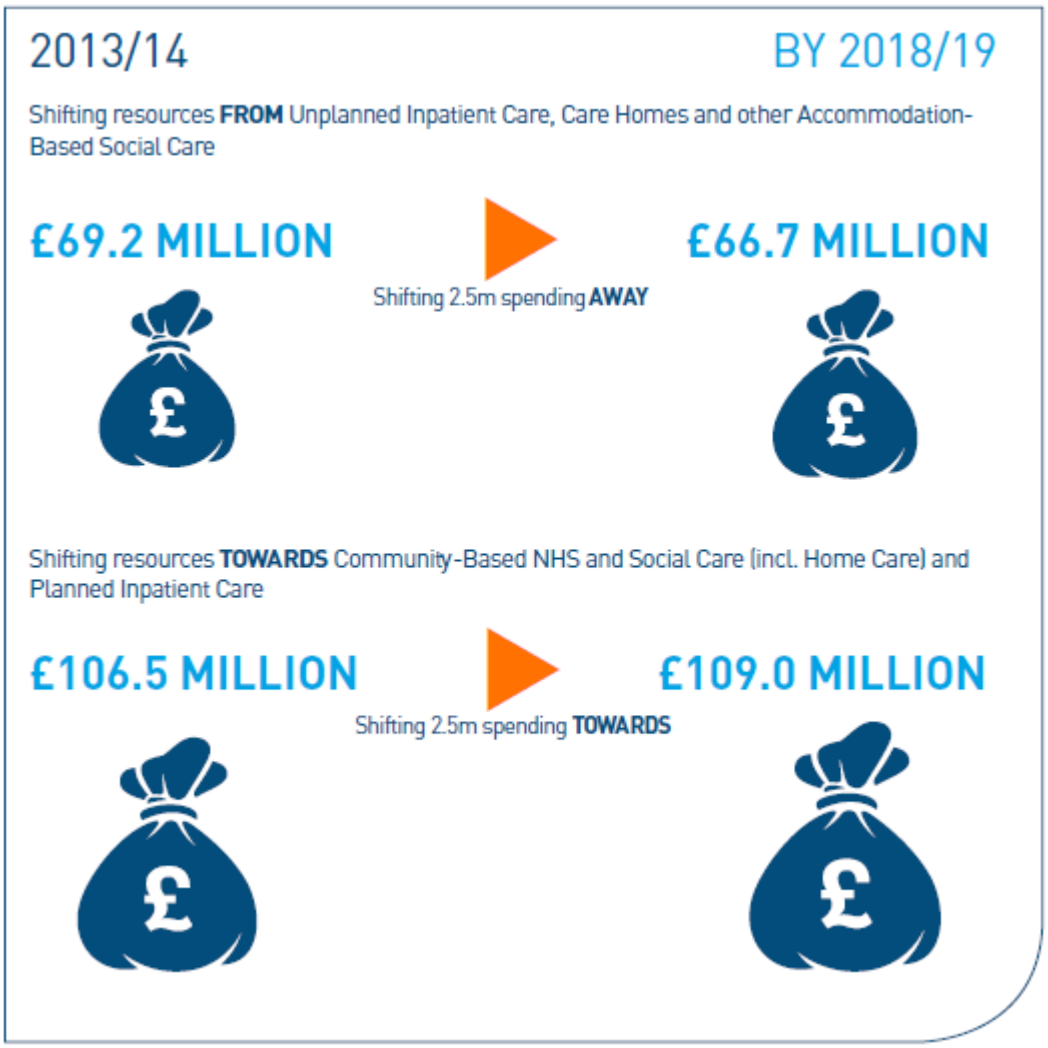


If we are able to improve health and well-being through preventive and supportive community-based care, resources can be moved and the balance of care shifted into the community as illustrated in figure 14.

What shifts do we need to make?

By shifting just 1% of our total spend of approximately £250m **FROM** Unplanned Inpatient Care and Institutional-Based Social Care **TOWARDS** Community-based NHS and Social Care and Planned Inpatient Care, we will use our resources more effectively. This will help us invest in new integrated ways of working particularly in terms of early intervention, reducing avoidable hospital admissions, reducing health inequalities, supporting unpaid carers and independent living.

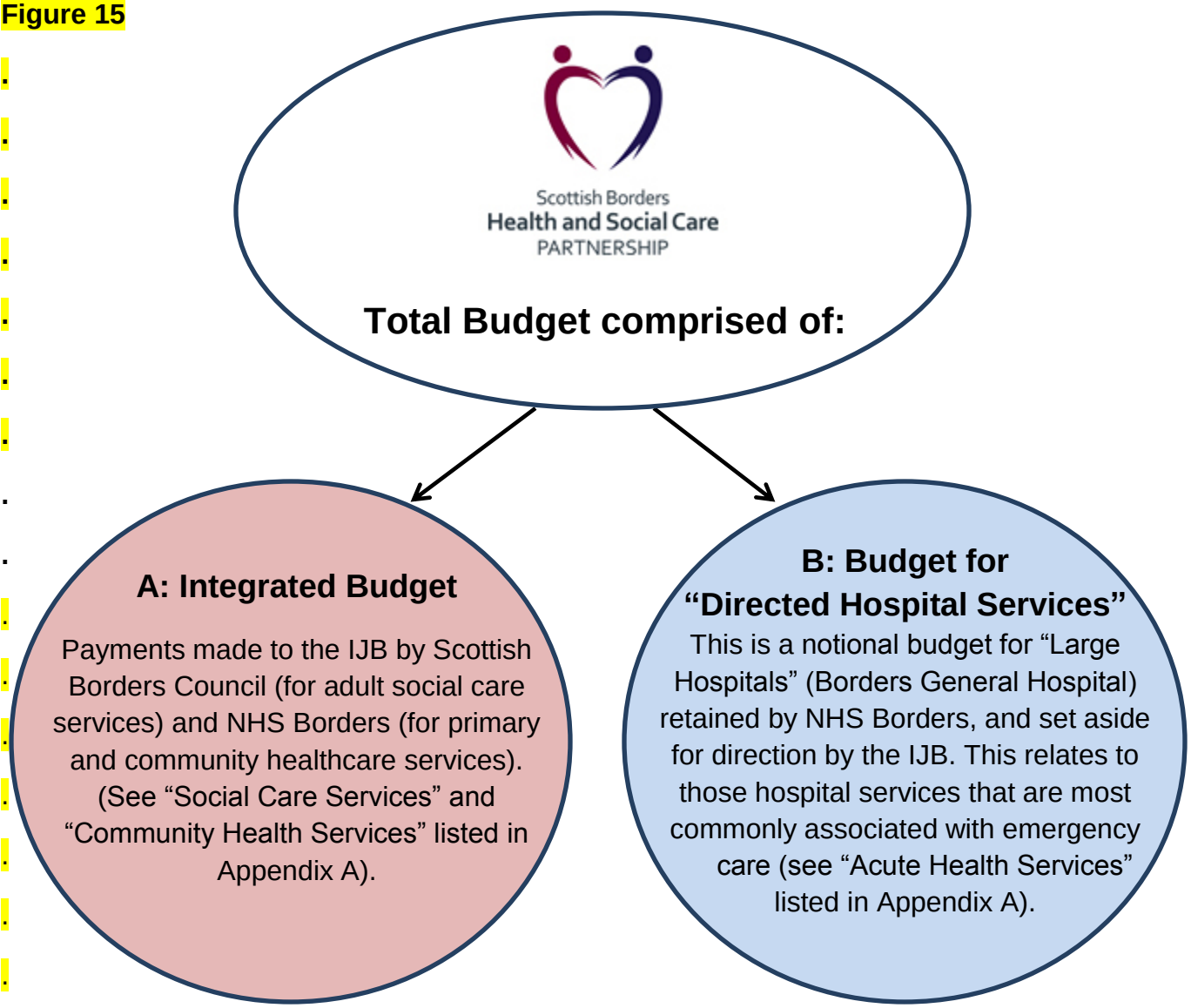
Figure 14 [graphics team to add £ symbol to 2.5m referred to under the orange triangles]



The e Health and Social Care partnership's budget

We have shown above that total NHS and social care spend in the Borders in 2013/14 was £248.7m. The budget for which the new Health and Social Care partnership will be responsible will represent a high proportion (about two thirds) of total spend on Health and Social Care. The use of this budget will be directed by the partnership's Integration Joint Board (IJB), which is a separate legal entity from either the Council or the NHS Board, and is responsible for directing and overseeing the delivery of integrated health and social care services in the Borders. Details of our final budget for 2016/17, once formally approved in March 2016, will be published in our first annual Financial Statement at www.scotborders.gov.uk/integration. The Financial Statement will support the delivery of this Strategic Commissioning Plan.

Figure 15



What You Said and What We Plan to do

This section of this document describes some of the actions we will take to start to make the shift towards more community-based NHS and social care services, the outcomes we will seek to achieve and the steps we will take to deliver our local objectives. We will describe some of the performance measures we will use to assess the progress we are making. This has been influenced by what you have told us was important to you.

Each of our 9 Strategic Objectives is set out on the following pages with:

- A reflection of some of your feedback relating to each objective.
- An outline of how we intend to deliver what is needed to achieve the objective.
- Examples of activities identified in our current service strategies which relate to the objective. Although many examples give the name of a particular service or strategy in brackets, all of the objectives relate to all of our client/patient groups and we intend that they all benefit from these approaches.
- Related projects which are already underway.
- What people can expect to see in terms of targets and outcomes against each objective over the next 3 years.

Objective 9 - We want to improve support for Carers to keep them healthy and able to continue in their caring role - was added as a Strategic Objective following the round of consultation in May and June 2015. This reflects the way in which engagement with the people who use and provide our services is central to the development of our Strategic Commissioning Plan and the activities that underpin it.

The information given on the following pages is not exhaustive. This high-level Plan will be supported by the implementation of Strategies related to specific themes (such as Dementia, Mental Health) and Locality Plans that reflect differing patterns of need across the Borders.

As a Health and Social Care Partnership, we also have a Public Sector Equality Duty under the Equality Act (2010). We have a duty to:-

- Eliminate unlawful discrimination, harassment and victimisation.
- Advance equality of opportunity between people who share a characteristic that is protected under the Act, and those who don't.
- Foster good relations between people who share a characteristic and those who don't. This involves tackling prejudice and building understanding.

The characteristics that are protected under the Act are:

Age Younger people, older people, or any specific age group	**Disability** Including physical, sensory, learning, mental health and health conditions	**Gender** Male, Female and Transgender
Marriage and Civil Partnership Including single, divorced, civil partnership, married, separated	**Pregnancy and Maternity** Including breastfeeding	**Race** People from ethnic minorities including Gypsy Travellers and Eastern European immigrants
Religion or Belief Including people who have no belief	**Sexual Orientation** Bisexual, Gay, Heterosexual and Lesbian	**Carers** Both formal and informal carers

In taking forward the work of the Health and Social Care Partnership, we will embrace these duties and ensure that all requirements are met, through the implementation of the Business and Commissioning Plans for the Service and Strategic areas that are Integrating.

OBJECTIVE 1 - We will make services more accessible and develop our communities

Strong communities are a real asset of the Borders. Community capacity building makes a big improvement to the health and independence of people.

What we heard you say is important to you:

- Ensure information is up-to-date, accessible both off- and on-line and improve how people are directed to and can access services.
- Build on existing work to increase to community capacity throughout the Borders.
- Use community-based education from an early age to encourage better lifestyles.

We want to:

- Improve access and signposting to our services and information, and assist people to help themselves.
- Develop local responses to local needs.
- Communicate in a clear and open way.

Some examples of how we intend to do this through our current services and strategies:

- Improve co-ordination for individuals and build capacity in communities to support older people at home. (Older People).
- Put people with dementia at the centre of planning and providing services and ensure they are able to live independently within their own homes and community. (Dementia).
- Improve information and advice to carers. (Carers).
- Strengthen partnership and governance structures. (Drugs and Alcohol).
- Achieve best outcomes for service users, foster recovery, social inclusion and equity. (Mental Health and Wellbeing).
- Ensure that people with sensory loss receive seamless provision of assessment, care and support. This will be provided by local partnerships, which will identify local priorities and approaches. This will include a review of the local sensory loss strategy in the light of the publication of the national "See Hear" Strategy (Sensory Services).
- Develop a multi-agency training strategy and programme, specialist development sessions and forums, disseminate knowledge, share good practice and enhance practitioner skills. (Adult Support & Protection).
- Health literacy training (delivered by Health Improvement Team) for staff to improve the accessibility of information about keeping well and services.
- Delivering affordable housing across the Scottish Borders; working with local housing associations to provide housing which is warm, in good condition and fit for purpose.

OBJECTIVE 1 - Continued

These are some of the changes that we have started to make:

- **Burnfoot Community Hub** – supporting the creation of a Community Hub facility to allow delivery of a range of community services and activities.
- **Borders Community Capacity Building** – supporting older people in Cheviot, Tweeddale and Berwickshire to establish or create new activities and support in their local communities – initiated through co-production and involving local residents.
- **Learning Disabilities** - Involve service users in the design and delivery of services. Local area co-ordinators are available to support people in accessing support and services in their local communities.
- **Locality Citizens Panels** – providing forums for people with learning disabilities and their Carers to meet and discuss local issues affecting them, and to contribute as part of the Learning Disabilities governance structure.
- **Locality Planning/Locality Management** – Taking into account the varying needs of the Borders population, we will have local plans and will devolve some services accordingly.

We will measure performance against this objective over the next three years by measures including:

- We would like to maintain 90% of adults in the Borders rating the overall care provided by their GP as "Excellent" or "Good" (higher than 87% overall for Scotland) in 2013/14. (Source: Health and Care Experience Survey 2013/14, Scottish Government.)
- We want to increase the proportion of adults who received support and care services in the Borders and rated the services as "Excellent" or "Good" in 2013/14 to 85% from 83%.
- We want to see the number of adults who agree that the support or care services they had received improved or maintained their quality of life from 83% (lower than the Scottish average of 85%) to 86%.

OBJECTIVE 2 - We will improve prevention and early intervention

Ensuring that people attempting to manage independently are quickly supported through a range of services that meet their individual needs.

What we heard you say is important to you:

- Be more proactive about providing early intervention and prevention: support people better/earlier, and promoting existing services e.g. health checks at GP surgeries.
- More Anticipatory Care Planning for people, their families or Carers.
- Work with other organisations, staff and people to develop integrated approaches to prevention and promote personal responsibility.
- More acute care and community services in local communities.
- Local wheelchair-friendly housing options.
- A good transition into adult services ensures that young adults with disabilities can live as independently as possible and can prevent/reduce reliance on services.

We want to:

- Prioritise preventative, anticipatory and early intervention approaches.
- Focus services towards the prevention of ill health, to identify problems earlier on, to anticipate the need for support, to offer care and support at an early stage, and to respond where possible to prevent crisis.
- Improve supports for people to manage their health conditions, improve access to healthcare when required, and make best use of recovery models.
- Ensure that young people with disabilities transition from children's to adult services in a seamless way.

Some examples of how we intend to do this through our current services and strategies:

- Help the growing pool of 'young old' people to stay well through prevention measures. (Older People)
- Reduce the amount of drug and alcohol use through early intervention and prevention. (Drugs and Alcohol).
- Promoting healthier lifestyles for patients, staff and visitors through our health improvement campaign 'Small changes, big difference'.
- Increasing referrals to services that support lifestyle change, such as Lifestyle Advice & Support Services (LASS) and Quit4Good (smoking cessation services) in primary care; and signposting to community resources such as 'Walk It' groups to promote physical activity.
- Strengthening falls prevention work.
- Delivering the Long Term Conditions project to support people to manage their conditions better.
- Promoting uptake of health screening opportunities and immunisation programmes.

Examples of how we intend to do this through our current services and strategies (continued):

- Raising awareness of signs and symptoms of health conditions (physical and mental health) and encouraging people to get checked early (e.g. Detecting Cancer Early campaign; Suicide prevention training).
- Providing Housing Options and Housing Support, directly and with partners, to help people remain in their own home and prevent homelessness. This includes Housing Officers visiting vulnerable households on a regular basis – identifying the needs of those people.
- Promoting social contact with local resources to reduce isolation and loneliness.
- Develop a mechanism to ensure that anticipatory care plans are used effectively.
- Focussing on implementing the recommendations in the Mental Health Needs Assessment.
- We will work with all partners to raise awareness about dementia and improve diagnosis rates.

Review the support mechanisms for transition into adult services (Physical Disability)

These are some of the changes that we have started to make:

- **Telehealthcare –** looking at how technology can be used to provide better home-based health care services.
- **Lifestyle Advice and Support Services (LASS) – strengthening pathways from** from acute care to these services
- **Bowel Screening** - Improving uptake in deprived areas
- **Long Term Conditions** - Testing out new ways of working to support the shared-management of long term conditions.
- **Targeted health improvement projects for people with learning disabilities**. For example 'A healthier me'.

We will measure performance against this objective over the next three years by measures including:

- We want to maintain and improve on the 96% of Scottish Borders GP practice patients who felt that they were able to look after their own health 'very well' or 'quite well' (a little higher than the Scottish average of 94%). (Source: Health and Care Experience Survey 2013/14, Scottish Government.)

OBJECTIVE 3 - We will reduce avoidable admissions to hospital

By appropriate support in the right place at the right time, we will ensure people are supported to remain in their own homes.

What we've heard you say is important to you:

- Ensure essential equipment is easily accessible at all times for people, staff, families and carers.
- Improve discharge planning to ensure it is clearly communicated and coordinated.
- Ensure there is an integrated response to prevent admissions.
- Increase self-referral and reduce waiting list times so that people can be supported as quickly as possible before their needs change.

We want to:

- Reduce unnecessary demand for services including hospital care. If a hospital stay is required we will minimise the time that people are delayed in hospital.

Some examples of how we intend to do this through our current services and strategies:

- Helping older people to stay well through prevention measures; improving the coordination and help them in making their way through the health and social care system.
- Building capacity in communities to support older people at home.
- Holistic assessments/personalised care planning that addresses broader health and social care issues important to individuals, such as welfare benefits/financial issues, housing issues, and social connectedness.
- Stronger links with community based support services/resources.
- Housing - Providing warmer, more comfortable homes to help prevent existing health problems from becoming worse. Also adaptations to homes, such as grab rails, to help prevent falls or other injuries, and to help keep people independent.

OBJECTIVE 3 - Continued

These are some of the changes that we have started to make:

- **Connected Care –** aims to create improved community support to prevent hospital admission and ensure timely discharge. We are working with other organisations to develop new and improved approaches to make this happen.

We will measure performance against this objective over the next three years by measures including:

- We would like to reduce overall rates of emergency hospital admissions by 10% by improving health and care services for people in other settings.
- We would like to reduce the rate of multiple emergency hospital admissions in people aged 75 and over, by 10%, by improving health and care services for people in other settings.
- We will reduce instances of patients being readmitted to hospital within 28 days of discharge by 10%
- We will reduce falls amongst people aged 65 and over by 10%.

OBJECTIVE 4 - We will provide care close to home

Accessible services which meet the needs of local communities, allows people to receive their care close to home and build stronger relationships with providers.

What we've heard you say is important to you:

- Ensure there are appropriate and accessible services in the community to support prevention.
- Ensure that the right staff are in place to support people who need to access services.
- Work more closely with our communities and organisations and make better use of local knowledge.
- Make the care profession a more attractive career.

We want to:

- Support people to live independently and healthily in local communities.
- Improve care pathways to ensure more co-ordinated, timely and person-centred care.
- Ensure the right services are in place to meet people's needs.
- Ensure staff (and carers) have the necessary knowledge, skills and equipment to provide care at/close to home.
- Move to outcome-focussed delivery of care and support.

Some examples of how we intend to do this through our current services and strategies:

- Work with other organisations so people with a physical disability can live as independently as possible; develop opportunities for people with a physical disability to fully engage in their local community; and improve access to public transport. (Physical Disability)
- Build capacity in communities to support older people at home.
- Have appropriate housing in place to keep people independent. (Older People)
- Ensure people with dementia have access to services which enable them to remain independent within their own homes and community as long as practical. (Dementia)
- Develop a joint approach to commissioning; achieve the best outcomes for service users; foster recovery, social inclusion and equity; and achieve a balanced range of services. (Mental Health and Wellbeing, Older People).
- Deliver a programme of workforce development to ensure that staff have the right skills to support people with more complex care needs.
- Use Locality Planning to inform service development based on the needs of people in each of our localities.

OBJECTIVE 4 - Continued

These are some of the changes that we have started to make:

- **Health Improvement** – To support people to live well with long term conditions – we will promote self-management to empower people and their carers to actively engage in creating individualised care.
- **Borders Ability Equipment Store –** Ensure provision meets the future demands of a growing elderly population which will require additional equipment, technology options and support.
- **Introduction of local area co-ordination services for Learning Disabilities.**
- **Change models of support** – reduce the number of people with Learning Disabilities living in a care home setting to living in a Supported Living Model of support.

We will measure performance against this objective over the next three years by measures including:

- We would like to see more people supported and cared for in their own homes or another homely setting, currently 65% in the Borders and 62% in Scotland overall.
- We would like to maintain the average proportion of the last six months of a person's life that they spent at home at 91.6%, a little higher than the Scottish average of 91.2%. (Source: Health and Care Experience Survey 2013/14, Scottish Government).

OBJECTIVE 5 - We will deliver services within an integrated care model

Through working together, we will become more efficient, effective and provide better services to people and give greater satisfaction to those who provide them.

What we've heard you say is important to you:

- More integrated and proactive local teams, sharing responsibility and enabling faster decision making.
- Recognise and clarify the roles of all organisations involved in providing health and care services and make better use of each other's skills and experience.
- Integrate IT systems between organisations to improve communications and information sharing.
- Ensure communities are considered individually when planning health and care services.

We want to:

- Ensure robust and comprehensive partnership arrangements are in place.
- Pro-actively integrate health and social care services and resources for adults.
- Integrate systems and procedures.
- Ensure that our workforce are equipped to provide good quality, effective, integrated services with the person at the centre.

Some examples of how we intend to do this through our current services and strategies:

- Improve the coordination and help for individuals making their way through the health and social care system. (Older People)
- Develop an integrated approach to commissioning, and achieve a balance of services. (Mental Health and Wellbeing, Older People)
- Improve access and develop effective and integrated quality services. (Sensory Impairment)
- The housing sector in the Borders has a range of partnership mechanisms to enhance the level of staff engagement, including the Local Housing Strategy Partnership, Borders Housing Hub, New Borders Alliance and the Strategic Housing Investment Plan Working Group.

OBJECTIVE 5 - Continued

These are some of the changes that we have started to make:

- **Mental Health Integration –** build on existing arrangements in Mental Health Service to integrate community teams.
- **Improve integration of health and social care provision**. (Learning Disability, Older People)
- **Co-production approach** – working together between professionals and patients to review redesign and deliver integrated services.

We will measure performance against this objective over the next three years by measures including:

- We would like to see the proportion of adults who agreed that their health and care services seemed to be well co-ordinated rise from 79% (the average for Scotland) to 85%. (Source: Health and Care Experience Survey 2013/14, Scottish Government.)
- We would like to reduce the number of bed-days occupied by adults due to delayed discharge across all ages, but particularly for those aged 75 and over from 84% to the Scottish average of 73%.
- We will do more to support and empower our staff and achieve a higher proportion of employees who would recommend their workplace as a good place to work. Currently 56% of NHS Borders staff would recommend their workplace as a good place to work compared to 61% for NHS Scotland as a whole. We will aim to improve our rating to a minimum of 61%, preferably higher at 70%. The same question will be included in future council staff surveys.

OBJECTIVE 6 - We will seek to enable people to have more choice and control

Ensuring people have more choice and control means that they have the health and social care support that works best for them.

What we heard you say is important to you:

- Ensure services are flexible to address short- and long-term needs and to be as close to 24/7 as possible to enable people to access the services they need when they need them.
- Provide more housing options, giving people more freedom and choice.
- Increase availability of self-referral to access services and ensure consistency across services.
- Encourage more people to self-manage their conditions.

We want to:

- Ensure the principles of choice and control, as exemplified in Self Directed Support, are extended across all health and social care services. This includes the participation and involvement of people in their care and support.

Some examples of how we intend to do this through our current services and strategies:

- Enable people with a physical disability to have choice and control over how they are supported to live independently. (Physical Disability).
- Borders Care & Repair services help disabled homeowners or private sector tenants with adaptations that will enable them to stay in their own home. Borders Care & Repair offer help and assistance and can project manage the entire adaptation process. (Housing).
- Ensure the needs of people with dementia are at the centre of all planning and provision of services specific to them. (Dementia)
- Improve the provision of information and advice to Carers, improve quality of Carer assessments/ support plans and involvement of Carers in care planning. (Carers)
- Improve access, develop effective and integrated services, ensure high quality of delivery of services. (Sensory Impairment, Older People).

OBJECTIVE 6 - Continued

These are some of the changes that we have started to make:

- **Self-Directed Support (SDS) –** is now being implemented across health and social care services. SDS is an approach across health and social care services that ensures people have choice over their support and over how it is arranged and paid for.
- **Dementia –** The Scottish Borders Dementia Strategy is being updated to align it with national strategies. One area of focus is Post Diagnostic Support for people who are recently diagnosed. New models are being explored. Another area of development is a local Dementia Working Group which, with support for Alzheimer Scotland, will ensure people with dementia have their voices heard and are involved in service development. The group will link to the Scottish Dementia Working Group and will have opportunities to be involved with strategic developments at a national level.

We will measure performance against this objective over the next three years by measures including:

- Amongst adults who received support and care services in the Borders in 2013/14, 83% agreed that they were supported to live as independently as possible (a little lower than the Scottish average of 84%). We want to increase this to 85%. (Source: Health and Care Experience Survey 2013/14, Scottish Government.)
- We want to increase the number of people who agreed that they had a say in how their support or care was provided, from 80% to 85% (the Scottish average was 83%). (Source: Health and Care Experience Survey 2013/14, Scottish Government.)
- We will ensure that everyone eligible for social care support will have choice and control through the Self-Directed Support approach.

OBJECTIVE 7 - We will further optimise efficiency and effectiveness

Strategic Commissioning requires us to constantly analyse, plan, deliver and review our services which give us flexibility to change what we do and how we do it.

What we've heard you say is important to you:

- Improve clarity of decision making process and enable decisions to be made more quickly.
- Ensure that we make the most of our staff through training and flexibility and create more opportunities to offer additional support.
- Acknowledge and address changes required for a more flexible and responsive workforce.
- Value and support our volunteers.
- Make better use of our existing resources and assets including buildings, people, and finance to ensure that they are sufficient and used as effectively and efficiently as possible.

We want to:

- Transform the way we provide and deliver services.
- Efficiently and effectively manage resources to deliver "Best Health, Best Care, Best Value".
- Support and develop our staff to be confident and reach their full potential.
- Deliver effective support and care through a mixed economy of care, utilising all key partners in the voluntary and private sector.

Some examples of how we intend to do this through our current services and strategies:

- Working to improve the energy efficiency of homes; providing adaptations to enable people to stay at home rather than move someone at higher cost.
- Make efficient use of the funding and other resources available. (Dementia, Older People).
- Deliver a programme of workforce development to ensure that staff have the right skills to support people with more complex care needs.

OBJECTIVE 7 - Continued

These are some of the changes that we have started to make:

- **Transitions** – focusing on improving the transition pathway for young people with learning disabilities as they move from children's to adults' specialist services.
- **My Home Life** – offer training to managers to help improve quality of life in care homes.
- **Focus on Outcomes Training** – deliver a new outcome-focused assessment for social care and associated training.

We will measure performance against this objective over the next three years by measures including:

- We will do more to support and empower our staff and achieve a higher proportion of employees who would recommend their workplace as a good place to work. (Currently 56% of NHS Borders staff would recommend their workplace as a good place to work compared to 61% for NHS Scotland as a whole. The same question will be included in future council staff surveys.)
- We would like a higher proportion of our budget to be spent on community-based health and social care and planned hospital care. In the Borders, 20% of all NHS and Social Care expenditure in 2013/14 was in relation to hospital stays, where the patient was admitted as an emergency. This is lower than the Scottish average of 22%. (Source: Integrated Resource Framework, www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Publications/index.asp)

OBJECTIVE 8 - We will seek to reduce health inequalities

Ensuring that people do not miss out on services due to, for example, a health condition, or lack of easy access to transport.

What we've heard you say is important to you:

- Ensure openness and consistency around access to services.
- Work with communities to address loneliness, deprivation and inequality and empower them to develop their own solutions.
- Work with local transport providers across all sectors to provide appropriate and accessible transport services.
- People with learning disabilities are more likely to have more undiagnosed health conditions, die younger than the general population and need more support to access health care.

We want to:

- Reduce inequality, in particular health inequality and support and protect those who are vulnerable in our communities.

Some examples of how we intend to do this through our current services and strategies:

- Develop a Carers Rights Charter, ensure carer representation on Health and Social Care Partnership. (Carers)
- Reduce the amount of drug and alcohol use through early intervention and prevention, reduce drug and alcohol related harm to children and young people, improve recovery outcomes for service users and reduce related deaths. (Drugs and Alcohol)
- Improve access, develop effective and integrated services, ensure high quality of delivery of services. (Sensory Impairment).
- Develop a multi-agency training strategy and programme, specialist development sessions and forums, disseminate knowledge, share good practice and enhance practitioner skills. (Adult Support & Protection).
- The four outcomes of the Local Housing Strategy (2012-2017) aim to tackle the inequalities in our society – this includes health inequalities.

OBJECTIVE 8 - Continued

These are some of the changes that we have started to make:

- **Transport Hub** – Scottish Borders Council, NHS Borders, The Bridge, Red Cross, Berwickshire Association of Voluntary Services and Royal Voluntary Service are working as partners to put in place a coordinated, sustainable approach to providing community transport.
- **Community Learning Portal** – provide free access to the Community eLearning Portal for staff in partner organisations.
- **Stress & Distress Training** – provide training in a personalised way to understanding and intervening in stress and distressed behaviours in people with dementia. This training aims to improve the experience, care, treatment and outcomes for people with dementia, their families and carers.
- **Deaf Awareness E-learning** – create an e-learning training resource focusing on the needs of older people with hearing loss. Initially the training will be available to Scottish Borders Council and NHS staff, but the intention is to ensure that partner organisations have access to it in the future.
- **Community nurses and social care staff** support people with Learning Disabilities to access mainstream healthcare.
- **Liaison nurses** are based in Borders General Hospital (Learning Disabilities, Mental Health).

We will measure performance against this objective over the next three years by measures including:

- We want to improve and increase the percentage of adults who received support and care services in the Borders who agreed that they felt safe from 81% (lower than the Scottish average of 85%) to 86%. (Source: Health and Care Experience Survey 2013/14, Scottish Government.)
- We would like to maintain the downward trend in the Borders in death rates in people aged under 75.
- We will address the recommendations within “The Keys to Life” (2013) National Strategy for people with learning disabilities, through local action plans for people with learning disabilities, to improve their health.

OBJECTIVE 9 - We want to improve support for Carers to keep them healthy and able to continue in their caring role

What we've heard you say is important to you:

- Improve support for Carers to avoid deterioration in their own health and well-being and prevent crisis.
- Encourage people to recognise their roles as Carers and ensure Carers are involved in decision making and planning.

We want to:

- Improve support for Carers so they can avoid deterioration in their own health and well-being and prevent crisis.
- Encourage people to recognise their roles as Carers and ensure Carers are involved in decision making and planning.
- Improve access to respite care.

Some examples of how we intend to do this through our current services and strategies:

- Ensure the needs of Carers are considered alongside those of the person living with dementia. (Dementia)
- Develop a Carers Rights Charter, improve communication and advice to Carers, improve quality of Carer assessments and support plans, ensure carer representation on health and social care partnership and produce a resource on issues relating to stress and caring. (Carers).
- Improve identification of Carers at an earlier stage and signpost/refer them for their own assessment.
- All staff will be provided with training around Carers and their needs.
- Carers will be consulted and included in all aspects of their relative's care needs, on planning and delivering the care need, during any hospital stays, on discharge, and in the community.
- Implement requirements set out within the new Carers legislation in 2017.

OBJECTIVE 9 - Continued

These are some of the changes that we have started to make:

- **Carers** - We have commissioned the Carers Centre to be the first point of contact for Carers' Assessments. This model has been extremely successful and reduced the length of time for Carers waiting for assessment. However not all Carers are accessing the Centre. Work is underway to consider how we can promote the service and additionally how the Carers Centre can be supported to meet increased demand.

We will measure performance against this objective over the next three years by measures including:

- We want to increase the percentage of Carers reporting that they feel supported to continue caring from 41% (lower than the Scottish average of 44%) to 50%. We will review this target with a view to improving it further if possible.
- We want to support Carers in the Borders so that fewer carers feel caring has had a negative impact on their health and well-being and reduce this figure from 30% to 20%. (Source: Health and Care Experience Survey 2013/14, Scottish Government.)

Planning for Change – Key Priorities

Below are the Partnership priorities identified so far for 2016/17. A fund of £2.13m per year has been provided to assist, support and develop the integration of Health and Social Care Services until March 2018.

- To develop integrated accessible transport.
- To integrate services at a local level.
- To roll out care coordination to provide a single point of access to local services.
- To improve communication and accessible information across groups with differing needs.
- Work with communities to develop local solutions.
- Provide additional training and support for staff and for people living with dementia.
- Further develop our understanding of housing needs for people across the Borders.
- To promote healthy living and active ageing.
- To improve the transition process for young people with disabilities moving into adult disability services.
- To improve the quality of life of people with long term conditions by promoting healthy lifestyles, access to leisure services, along with support from the Third Sector.
- To improve support for Carers within our communities.
- Promote support for independence and reablement so that all adults can live as independent lives as possible.

Locality Planning

There are five commonly recognised localities in the Borders as the maps in this section show. These are based on the five existing Area Forum localities - Berwickshire, Cheviot, Eildon, Teviot & Liddesdale, and Tweeddale. Summary profiles for each of the five localities show some of the differences between them. As part of the planning process, we will build more detailed locality profiles, including a wider range of measures relevant to health and social care. This will allow us to target need most appropriately.

Map showing our five Area Forum Localities (with all towns and villages with a population of 500 or more).

We have set up a group to oversee the development of planning in each of the five localities. We expect to appoint locality co-ordinators to act as a focus for planning in each locality. They will:

- Build relationships with established community groups, partners across the localities, such as other leads working at locality level for example in Community Learning and Development.
- Map out what is already happening, using and building upon the mapping work already in existence across relevant partnerships - established community groups, many of which are linking up through the Community Learning Partnership approach.
- Identify where existing funding is coming from, where there are gaps and where there are ideas or plans.
- Clearly define what is happening in the short, medium and longer term, how these priorities have been identified and what the consultation process has been/is going to be.
- Co-ordinate action plans, planned expenditure and how these fit with local priorities.

Planning at this level will need to take account of existing local plans such as Community Action Plans or Neighbourhood Plans as well as cross-Borders strategies such as the reducing inequalities strategy and health inequalities action plan. It will also need to address cross-border issues (between Borders localities, and between Borders and neighbouring areas of Scotland and England). Some priorities are the same across localities but others are different. Locality plans will also need to take account of projects starting at the moment. For example, we are beginning to develop care coordination, which will be undertaken by care coordinators which will be rolled out across the localities in a phased way. This will help us provide more person centred care. Another project is to provide a means for Borders Community Transport providers to work together to make best use of available transport and reduce duplication of journeys. Some projects are specific to a locality such as “the Eildon Community Ward”.

Service users, carers, families, communities and professionals – including GPs – must be actively involved in locality planning so that they can influence how resources are spent in their area – genuine co-production. Co-production is where people using services, their families and their neighbours work as equals with professionals to plan and deliver services. We are rolling out a “Borders Community Capacity Building Project” which will provide communities with support and ability to do this. We want communities to use the collective resources (assets) which they have at their disposal, to protect against poor health and improve health.

Assets are the strengths that people and communities have such as relationships, networks, enthusiasm, social cohesion and resilience as well as plans, land, buildings and funding. The people of the Scottish Borders are perhaps our single biggest asset. The networks and relationships that exist within and across communities are invaluable in themselves and they are health-improving. They provide a solid foundation for any work to improve health and wellbeing alongside the strong volunteer ethic and a natural commitment to supporting others. There is growing evidence of the combination of local people, community groups, partners and physical

assets in action across localities, examples include Borders Healthy Living Network, Langlee Residents Association, Burnfoot Community Futures, Eyemouth Community Development Trust and the relationships and activities these community based groups/organisations have been developing with agencies and local people.

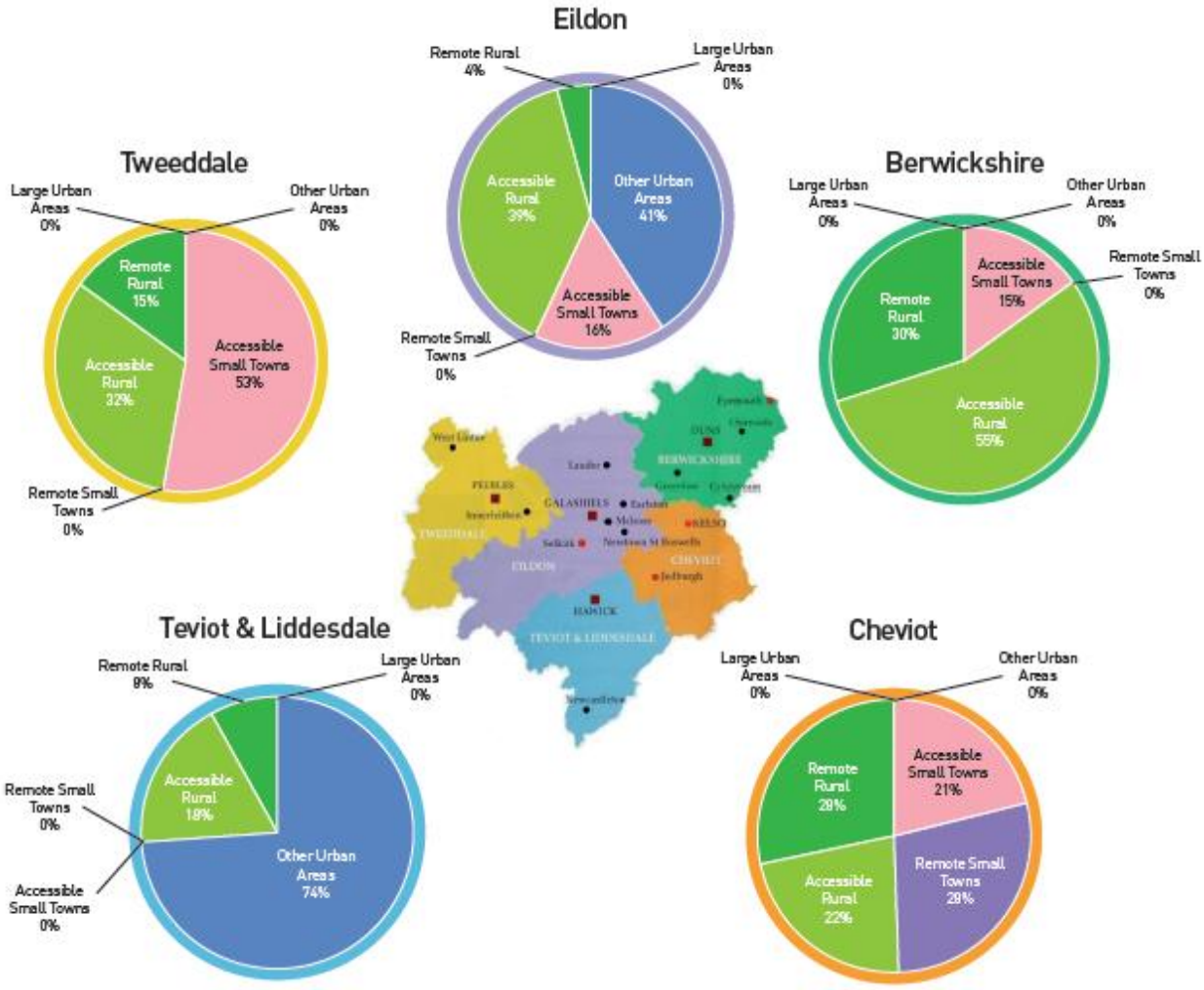
In addition to people, other assets within the Scottish Borders include land and buildings. The Scottish Borders is a stunning place to live and this applies to all localities, with some of the most breath-taking views, areas of green space and outdoor walks available right on our doorstep. The Scottish Borders is steeped in history and this could be brought to life through social projects that involve communities and people who have experience of the changes influencing health and wellbeing in the Borders. We know that older people are living longer, healthier lives and they have a wealth of knowledge, skills and experience to share with others. We should make every effort to capitalise on this and positively influence the next generation of children and young people by connecting up these assets.

The Scottish Borders is made up of 'can do' communities and this is very much seen through their actions to support others on a day to day basis as well as in times of crisis. If these assets are nurtured and harnessed in everyday life, this culture of support could be further enhanced. An assets approach at its simplest turns what we know on its head and questions what we think in a positive way for example, instead of asking about what's not going well, asking about what's going right and doing more of this. This is very much the current thinking influencing some local groups and networks. This can also be applied in practice through training and development to ensure that people are viewed in this way and seen for their strengths and the contribution they have to make. An assets approach therefore presents a significant shift in the way we engage with people and communities, from a deficit model that emphasises need and problems to an asset model that values active participation and sees people and communities as co-producers of long term sustainable solutions. Focusing particularly on health, the fundamental shift from what makes us ill to what makes us well and doing more of this is at the heart of an asset approach.

Where appropriate, we will devolve resources towards the delivery of particular local outcomes. For example, we will strengthen the work of the healthy living network in areas of disadvantage to improve the health and well-being of those communities. We will prioritise engagement with vulnerable groups, isolated residents and people who are not already accessing existing groups and local services. We will make the best use we can of community capacity and capability to do this.

Our Area Forum Localities and their Urban/Rural Population Profiles

(Map in middle of this page to be updated by graphics team to match the one shown on the following page).



Category	Description
1 – Large Urban Areas	Settlements of 125,000 or more people.
2 – Other Urban Areas	Settlements of 10,000 to 124,999 people.
3 – Accessible Small Towns	Settlements of 3,000 to 9,999 people and within 30 minutes drive of a settlement of 10,000 or more.
4 – Remote Small Towns	Settlements of 3,000 to 9,999 people and with a drive time of over 30 minutes to a settlement of 10,000 or more.
5 – Accessible Rural	Areas with a population of less than 3,000 people, and within a 30 minute drive time of a settlement of 10,000 or more.
6 – Remote Rural	Areas with a population of less than 3,000 people, and with a drive time of over 30 minutes to a settlement of 10,000 or more.

Source: Scottish Government Urban/Rural Classification 2013/14 and National Records of Scotland.
www.gov.scot/Publication/2014/11/2763/downloads

Some illustrative Facts and Stats about our Area Forum Localities

Tweeddale

- Estimated population in 2013: 19,192.
- 41% of live in its largest settlement, Peebles (population 7,908), whilst 59% live in smaller settlements or rural areas.
- The locality with the highest proportion of its population aged under 16 (18.7%). 60.1% of the population are aged 16-64 and a further 21.2% are aged 65+.
- In 2014/15 there were 16.6 attendances at Borders General Hospital A&E for every 100 population.
- In 2011-2013 the emergency hospital admission rate was 80 per 1,000 population.

Eildon

- Estimated population in 2013: 38,798. Our largest locality in population terms (over one third of Scottish Borders residents live here).
- Nearly one third of residents live in Galashiels (estimated population 12,394) and another 14% in Selkirk (estimated population 5,608).
- The locality with the highest proportion of its population aged 16-64 (62.3%) and the lowest proportion aged 65+ (20.5%). A further 17.2% of the population are aged under 16.
- In 2014/15 there were 27.3 attendances at Borders General Hospital A&E for every 100 population – this is the highest rate across our localities.
- In 2011-2013 the emergency hospital admission rate was 93 per 1,000 population; this is the highest rate across our localities.

Berwickshire

- Estimated population in 2013: 20,862.
- No large towns; most people live in small settlements or rural areas. Eyemouth (population 3,152) and Duns (population 2,444) are the largest settlements here.
- 15.8% of the population are aged under 16, 60.0% are aged 16-64, 24.2% are aged 65+.
- In 2014/15 there were 15.8 attendances at Borders General Hospital A&E for every 100 population – this is the lowest rate across our localities.
- In 2011-2013 the emergency hospital admission rate was 79 per 1,000 population.

Cheviot

- Estimated population in 2013: 16,407. Our smallest locality in population terms.
- More than 60% of residents live in Kelso and Jedburgh, which have estimated populations of 6,139 and 3,959, respectively.
- The locality with the highest proportion of its population aged 65+ (25.6%). It also has the lowest proportions of children aged under 16 (15.6%) and people aged 16-64 (58.8%).
- In 2014/15 there were 19.7 attendances at Borders General Hospital A&E for every 100 population.
- In 2011-2013 the emergency hospital admission rate was 75 per 1,000 population; this is the lowest rate across our localities.

Teviot & Liddesdale

- Estimated population in 2013: 18,611.
- Nearly three-quarters of the population live in the town of Hawick (estimated population 13,696).
- 15.7% of the population are aged under 16, 60.6% are aged 16-64, 23.7% are aged 65+.
- In 2014/15 there were 23.4 attendances at Borders General Hospital A&E for every 100 population.
- In 2011-2013 the emergency hospital admission rate was 87 per 1,000 population.

What Will Success Look Like

Services are integrated and there is less duplication

People participate in planning their own care and support

There is easier access to services through a single point of contact

The benefits of new technology improve people's health and well-being

People with multiple long term conditions are supported

There is a shift to early intervention and prevention for children and young people, families and Carers

Carers will feel better supported and have improved health and well-being

There will be a reduction in health inequalities

Make best use of staff

Spend money wisely

Planning for Integrated Services

The two case studies here illustrate how ordinary people should experience a better integrated health and social care service.

PAMELA AGE 57	I'm Pamela and I've lived in Innerleithen most of my life. I live with my husband Owen and our daughter Jane. My 83 year old Father lives in sheltered housing nearby and our eldest daughter Jillian lives 7 miles away in Peebles. I have a lot of friends who live in the area.		
	MY SITUATION	**MY THOUGHTS**	**INTEGRATION FOR ME**
CARING 	I look after my 3 year old grandson, Jack, 3 times a week. I visit my elderly father every day and I am the first responder to his Bordercare alarm. I recently had a Carer Assessment carried out.	I recently realised how much I've been looking after my Father. I love my Father and I want to care for him, but sometimes, I resent being his first responder and I feel I sacrifice things that are important to me to look after him. I feel guilty for thinking these things. Sometimes I don't understand what's happening with his care. I worry a lot about him.	• Clear information on available support and services. • Health and care co-ordinate services. • A single number to access services. • More support for me as a Carer.
HOME 	I live in a modern, rented house. My husband Owen and I don't drive so we rely on public transport.	I love where I live and I like that I can walk to shops and the bus stop. But I find organising transport to get my Father to appointments can be really difficult.	• A single number to book transport. • Easier access to more coordinated services.
FAMILY 	Owen recently retired for health reasons. My Father has dementia and is prone to falling. Jane is taking her higher exams. I love looking after Jack and seeing Jillian. Her partner Bill is nice too.	Owen is eight years older than me. He struggles with depression and I feel I need to be with him, which can result in me not being able to spend enough time with my Father or Jane. My Father falls occasionally. He has been recommended to attend gentle exercise classes but he says no.	• More opportunities to meet other people in the local community. • Supporting local communities to connect people and interests.

PAMELA AGE 57	Her situation, continued…		
	MY SITUATION	**MY THOUGHTS**	**INTEGRATION FOR ME**
WORK 	I work part-time in a shop in nearby Galashiels.	I've considered reducing my hours to spend more time with my Father and my family, but I can't for financial reasons. I often have calls to make or receive about my Father when I'm at work which is challenging as I've limited flexibility. I sometimes have to take leave to take him to appointments.	• More options to enable me to take my father to appointments. • Longer opening hours for services.
HEALTH 	I've high blood pressure, arthritis and anxiety. I'm a cancer survivor. I take many prescription drugs. I've been a heavy smoker for years.	I don't take the best care of myself because by the time I've looked after my Father, grandson, Owen, daughter, been to work and volunteered at Church I'm often too tired. I tend not to tell Owen about my worries because of his depression. Smoking helps me feel more relaxed, but I've noticed I smoke more now. I'm quite anxious so I was grateful that the Carer's Assessment lady listened to me.	• Locally available acute health and care services. • Forward (Anticipatory) care planning for my Father, Owen and me. • A named person that I can speak to.
COMMUNITY 	Owen and I have many friends here. I enjoy volunteering at my local church.	We have a good community with neighbours and friends helping out. I've school friends and friends at Church, so every once in a while, if things are ok, I meet them for lunch. My Father is isolated and he would really like visits from people as he has trouble going out.	• Supporting local communities to connect people and interests.

CHARLIE AGE 78	I'm Charlie. I've lived in Kelso since I retired here 15 years ago with my wife, Sandra, who died 5 years ago. I've been alone since. My two children live far away. They come for visits, but they have busy lives and their own families. I love Kelso, I feel safe and happy here, apart from being so far from my family.		
	MY SITUATION	**MY THOUGHTS**	**INTEGRATION FOR ME**
CARING 	I am a widower. I don't need health and care services at the moment.	I feel capable, but having recently had a fall, I had a bit of a fright and I was admitted to hospital for a short while. It was sad as I had no visitors which made me start to think about what would happen to me when I do need more help. I don't want to be a burden to my children. I always thought I would grow old with Sandra. There are home carers who can help me, but I would prefer to have someone I could rely on, not a lot of different people.	• I can choose the staff I want to support me at home. I will get support if I want to employ my own staff. • A single number to access services.
HOME 	I live in a 3 bedroom house with a large garden, on the outskirts of the town. I drive, but I'm less confident now so I don't like driving.	I know my house is too big and I cannot manage the garden alone, but I don't want to move and start over with a new house and neighbours. I'm a 10 minute walk to the bus stop and buses are regular but if I need to go to the Hospital, I have to change buses. I feel I need to drive more and more.	• Better co-ordinated local transport • Bigger range of locally based housing options
FAMILY 	My son Paul lives in England. My daughter Steph and her family moved to Florida 3 years ago.	Paul visits every couple of months. I can see he's worrying about me and I know Steph feels guilty for being so far away. I want to be able to reassure them I have a plan for any future needs and that I can support myself. Paul wants me to move near him but I don't deal with change very well.	• Forward (Anticipatory) Care Planning. • I am in control of planning for the future.

CHARLIE AGE 78	His situation, continued…		
	MY SITUATION	**MY THOUGHTS**	**INTEGRATION FOR ME**
WORK 	I'm retired. I had to step back from my voluntary work at my bowls club which I enjoyed.	I liked being Treasurer of my local bowls club. My friend introduced me to bowls and she takes me when she can, but she can't make it every week. I had to give up being Treasurer as it became too much. I don't feel as fulfilled as I did. I would love to do more voluntary work.	Appropriate volunteering opportunities for older people
HEALTH 	I'm slowing down and finding things harder. I've many medications, I'm not sure what they are and why I take them.	I like to keep active and I do drive when I need to, usually to appointments and shops. It was a scary when I fell, but I don't think I needed to go to the emergency department, but I couldn't be checked locally. I felt very overwhelmed by the number of people asking me the same questions – surely the staff can look it up on my medical notes?	• Locally based services • Better information sharing across organisations
COMMUNITY 	When Sandra was alive we did lots of things together, but it's not the same without her.	I feel lonely without my wife and not as confident to socialise with people. My neighbours are lovely, but I don't see them as often as I used to. I wish there were more activities and groups for older people like me.	• Community based groups and activities

Planning into the Future

The Strategic Commissioning Plan will only be the beginning. It will be a living working document which will
change and grow throughout its life. It will build on feedback from people living in the Borders. It will be reviewed at least every three years, based on an on-going assessment of need. In the future, we will focus particularly on how to meet the needs of people who use services in local communities.

Throughout the last 12 months we held a number of engagement events for both the public and staff. The information we received from these events has been used to inform this document. For example, the 9th local objective on support for unpaid carers was added as a direct result of your feedback. Thank you to all who gave us feedback in person or in writing throughout the process of developing this Plan. We have been able to act on some of your comments at this stage whilst others will be retained to help us in our ongoing planning and engagement work.

APPENDIX A: Services that are Integrating

Which health and social care services are we integrating?

Our partnership will be responsible for planning and commissioning integrated services and overseeing their delivery. These services are all adult social care, primary and community health care services and elements of hospital care which will offer the best opportunities for service redesign. The partnership has a key relationship with acute services in relation to unplanned hospital admissions and will continue to work in partnership with Community Planning Partners. This includes charities, voluntary and community groups so that, as well as delivering flexible, locally based services, we can also work in partnership with our communities.

ADULT SOCIAL CARE SERVICES*	ACUTE HEALTH SERVICES (PROVIDED IN A HOSPITAL)*	COMMUNITY HEALTH SERVICES*

• Social Work Services for adults and older people;
• Services and support for adults with physical disabilities and learning disabilities;
• Mental Health Services;
• Drug and Alcohol Services;
• Adult protection and domestic abuse;
• Carers support services;
• Community Care Assessment Teams;
• Care Home Services;
• Adult Placement Services;
• Health Improvement Services;
• Re-ablement Services, equipment and telecare;
• Aspects of housing support including aids and adaptations;
• Day Services;
• Local Area Co-ordination;
• Respite Provision;
• Occupational therapy services.
	• Accident and Emergency;
	• Inpatient hospital services in these specialties:
	  ○ General Medicine;
	  ○ Geriatric Medicine;
	  ○ Rehabilitation Medicine;
	  ○ Respiratory Medicine;
	  ○ Psychiatry of Learning Disability;
	• Palliative Care Services provided in a hospital;
	• Inpatient hospital services provided by GPs;
	• Services provided in a hospital in relation to an addiction or dependence on any substance;
	• Mental health services provided in a hospital, except secure forensic mental health services.
		• District Nursing;
		• Primary Medical Services (GP practices)*;
		• Out of Hours Primary Medical Services*;
		• Public Dental Services*;
		• General Dental Services*;
		• Ophthalmic Services*;
		• Community Pharmacy Services*;
		• Community Geriatric Services;
		• Community Learning Disability Services;
		• Mental Health Services;
		• Continence Services;
		• Kidney Dialysis outwith the hospital;
		• Services provided by health professionals that aim to promote public health;
		• Community Addiction Services;
		• Community Palliative Care;
		• Allied Health Professional Services

*Adult Social Care Services for adults aged 18 and over.

*Acute Health Services for all ages – adults and children.

*Community Health Services for adults aged 18 and over, excepting those marked with an asterisk (*), which also include services for children.

APPENDIX B: The National Health and Wellbeing Outcomes

The National Health and Wellbeing Outcomes are high-level statements of what health and social care partners are attempting to achieve through integration and ultimately through improving quality across health and social care.

By working with individuals and local communities, Integration Authorities will support people to achieve the following outcomes:

Nine National Outcomes	
Outcome 1	People are able to look after and improve their own health and wellbeing and live in good health for longer.
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.
Outcome 3	People who use health and social care services have positive experiences of those services, and have their dignity respected.
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.
Outcome 5	Health and social care services contribute to reducing health inequalities.
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 well-being.
Outcome 7	People using health and social care services are safe from harm.
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.
Outcome 9	Resources are used effectively and efficiently in the provision of health and social care services.

Source: Scottish Government

APPENDIX C: Our Local Objectives and the National Outcomes Cross-Referenced

Our Local Objectives are:

1. We will make services more accessible and develop our communities.
2. We will improve prevention and early intervention.
3. We will reduce avoidable admissions to hospital.
4. We will provide care close to home.
5. We will deliver services within an integrated care model.
6. We will seek to enable people to have more choice and control.
7. We will further optimise efficiency and effectiveness.
8. We will seek to reduce health inequalities.
9. We want to improve support for Carers to keep them healthy and able to continue in their caring role.

The National Outcomes cross-referenced with Our Local Objectives

National Outcomes	1	2	3	4	5	6	7	8	9
Local objective 1	☆	☆	☆	☆		☆		☆	
Local objective 2	☆	☆		☆	☆			☆	
Local objective 3	☆	☆							☆
Local objective 4	☆	☆	☆	☆	☆	☆			☆
Local objective 5				☆				☆	☆
Local objective 6	☆	☆	☆	☆	☆	☆	☆		
Local objective 7								☆	☆
Local objective 8	☆	☆	☆		☆	☆	☆		
Local objective 9	☆	☆	☆	☆	☆	☆	☆		

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January 2016

Report on Community Engagement Activities
Formal consultation on second draft of Strategic Commissioning Plan for Health and Social Care

The Second Draft of the Strategic Commissioning Plan for Health and Social Care Integration 'changing health and social care for you – a further conversation' was published on 20th October 2015. The consultation ended on 11th December 2015.

The document, along with a summary version (both shown right), was distributed as hard copies to key stakeholders. In addition, the documents along with the formal consultation questions were published online at www.scotborders.gov.uk/integration and www.scotborders.gov.uk/consultations and sent electronically to identified stakeholders (Please see Appendix 1).

All events were supported by a large amount of communication activities to promote the events including direct emailing, press releases and regular social media content.

Activities for staff and public

Engagement activities were broadly divided into two categories: staff and general public.

Staff

In terms of staff, the major challenge for communicating was the huge number of staff affected across a wide range of areas and locations. These staff also have varied roles, shift patterns, accessibility to online information and ways of communicating with each other and their line managers. Therefore, there was no identified 'one communication method that fits all' in this situation.

As a result, it was agreed that responsibility should be placed on managers who were to be given the 'tools' to have conversations with their staff in the most appropriate and effective way.

To prepare managers and other key opinion leaders for this two launch events were held in early November 2015 and a total of 50 people attended. The participants came from 35 different departments/organisations/groups (Please see Appendix 2). The main objective of these events was to update attendees on integration and the Strategic Commissioning Plan and give them the relevant materials so that they in turn could inform their own staff and networks, and report back.

All the managers were provided with one of our Health and Social Care Partnership bags (which were produced for the previous phase of consultation) these included a copy of the plan, summary document, questions, conversation prompts, briefing notes, and a feedback form. They were also emailed all the materials as well as presentation.

General public

For the general public the activities were based on the principle of taking information to people instead of asking people to attend a specific event. Members of staff met people in all five localities, having pop-up information booths at the following locations:

- Local food market - Jedburgh
- Popular café - Hawick
- Transport Interchange - Galashiels
- Library - Duns
- Supermarket - Peebles

A simplified questionnaire was developed for the pop-up events. In addition to general publicity, an A1 sign (right) was placed outside the pop-up locations to inform people of the on-going events and encourage them to come in and take part.

Presentations were also given to key stakeholders at Area Forum meetings, independent and third sector organisations and selected community groups. At these meetings copies of the document and summary document were also distributed.

Our future workforce

A presentation/workshop was held at the Borders College in Galashiels in early December for the students studying health and social care. The purpose of this was to reach those who may become our future workforce – to tell them about what Integration is about and also encourage their feedback. The programme director made the event mandatory for the students and a total of 65 students and staff attended. A joint press release between the partnership and Borders College was issued after the event and promoted on website (right) and social media to highlight the success of the event.

Hard copies distributed

Few copies remain of the 450 copies of the Strategic Commissioning Plan and the 1350 copies of the summary printed for this consultation. In addition to copies distributed at public engagement events, Area Forum meetings and to community councils, hard copies of the plan and the

Plan to support unpaid Borders carers revealed

Second draft paper adds new key objective

Improving support for unpaid carers is a new key objective in the latest draft of the Scottish Borders Health and Social Care partnership plan.

Susan Manion 'It is crucial we get the views of as many people as possible'

Susan Manion, chief officer for health and social care, said that the second draft of the plan builds on progress made in previous consultation.

summary document were sent to all libraries, library contact centres and registered GP practices in the Borders (Please see Appendix 3). The Borders Carers Centre mailed out 700 copies of the summary document to their carers.

Media overage

In connection with the publication of the Strategic Commissioning Plan on 20th October, a news release with accompanying photograph was sent out to media partners. It was picked up by local newspapers for their on-line versions and articles were also published in the paper editions of the Berwickshire News and the Southern Reporter (right). The Integration team at the Scottish Government picked up the news story that appeared in the Hawick News online edition and mentioned our events in their monthly national newsletter that went out the following week. The Scottish Government's newsletter also included a blog post written by our own dedicated Communications Officer for Integration (Carin Pettersson) about our engagement activities in the Scottish Borders.

Another news release was issued to announce the public consultation events. The announcement was picked up by Hawick News and appeared in their printed edition.

Social media

All engagement activities were supported by social media coverage on both Facebook and Twitter. A total of 14 messages were published on SBC's Facebook page (currently 10.k followers) and another 14 were published on SBC's Twitter (currently 8k followers). The campaign was kicked off by two messages on Facebook and two on Twitter during the first week of the consultation (right), followed by three on each of the two channels the following week. During the week of December 11 when the consultation ended, a total of 8 messages were published, four on each channel. A short link to the consultation on the Council's website was created and included in all posts.

Plasma screen message

The Council has plasma information screens which are regularly used to promote events, news and consultations. A screen message (below right) informing of the consultation was displayed on all screens December 9, 10 and 11. The Council has screens in the following locations:

- Coldstream Library Contact Centre
- Duns Library Contact Centre
- Eyemouth Contact Centre
- Galashiels Contact Centre
- Hawick Contact Centre
- Newtown St. Boswells HQ Reception Desk
- Innerleithen Library Contact Centre
- Jedburgh Library Contact Centre

- Kelso Library Contact Centre
- Peebles Contact Centre

Feedback received

Responses were not received from all those contacted. This may be because they felt their comments from the previous consultation on the Plan had been reflected in the final draft or they felt that the Plan was fit for purpose.

Written and/or detailed responses were received from:

- Berwickshire Association for Voluntary Services (BAVS)
- Borders College, health and social care students and staff
- Borders Equality Forum
- Encompass
- Eyemouth Town Community Council
- Gavinton, Fogo & Polwarth Community Council
- Kalewater Community Council
- Lammermuir Community Council
- Lilliesleaf, Ashkirk & Midlem Community Council
- Mental Health & Wellbeing Forum (via BVCV)
- NHS Borders Training & Professional Development
- Public Health Department
- SAMH
- Scottish Care
- Swinton & Ladykirk Community Council
- User & Carer Working Group (via BVCV)

- 24 responses from individuals
- Approximately 220 questionnaires from the pop-ups engagement events

Information quality

Feedback received is in both qualitative and quantitative formats. The questionnaires used at the pop-up information sessions were designed to give a quantifiable indication. Whether or not this will be possible depends on the quality of the data received. The data from these events has not yet been fully analysed, but it is believed that the data will be useful in the future localities planning.

The formal consultation questions and other feedback received mainly fall into the qualitative category. Whenever possible the qualitative information has been used to inform the final draft of the Strategic Commissioning Plan or retained for future use.

Please see Appendix 4 for an overview of the main themes in the consultation feedback.

Conclusion

Although all data from this consultation is not yet fully analysed, it is believed that the information received is of high quality, that it has been provided by a broad cross section of the Borders population and that it will be useful in further planning.

Community engagement is however about more than just receiving feedback or consulting by presenting information for comment, it is also about co-production, informing and involving individuals and communities.

The feedback received does not equal the number of people who have received information about the plan and had conversations about it, nor does the feedback give any indication of how many people who have reviewed the actual document, but decided, for whatever reason, not to comment.

Based on the number of copies distributed, the attendance at the engagement events, the publicity generated, social media activity carried out, and the number of presentations held, it can be assumed and acknowledged that the number of people who know at least something about health and social care integration is substantial. It is estimated that based on the activities conducted and the media coverage, including social media, the campaign has potentially reached over 10 % of the Borders population.

Appendix 1

Health & Social Care Integration Strategic Commissioning Plan

Consultation on final draft

Stakeholders consulted

Information was distributed electronically, in the first instance, to groups and individuals across the Borders. These included both service providers and service users.

The following groups were consulted with information being sent via named contacts (the assumption has been made that these contacts have distributed information as requested):

- Scottish Borders Councillors
- NHS Non-Executive Directors
- NHS Public Partnership Forum (including some individual members)
- NHS Public Participation Network
- NHS Borders Public Reference Group
- BGH Participation Group
- Community Councils
- Borders Voluntary Care Voice
- Borders Carers Centre
- Third Sector Interface
- Scottish Borders Community Planning Partnership
- Senior Managers - NHS Board Executive Team
- SBC Corporate Management Team
- Police Scotland
- Scottish Fire & Rescue Service
- Social Care staff

- Social Workers
- Mental Health Officers
- RSLs
- GPs/GP Practice Managers
- Community Dentists
- Private Dentists
- Opticians
- Social Care staff – Care Homes
- A&E Staff
- Out of Hours staff
- AHPs
- Outpatient staff
- Public Health Professional
- Nurses
- Community Hospital staff
- Pharmacists
- DME
- Hospital based pharmacists
- Friends of the BGH
- Sensory Services Team
- User/carer working group (BVCV)
- Parent/carers working group
- Citizens Panels
- Youth Voice
- Equality Forum
- Borders LGBT Equality Forum
- Borders Talking Newspaper
- NHS Public Governance Committee
- Volunteer Centre Borders
- Social Care staff – Third Sector
- Joint Staff Forum
- Medicines Resource Group
- Area Clinical Forum
- Mental Health Professional Nurses Forum
- Physical Disabilities Strategy Group
- Alzheimer Scotland – Borders Services

Individual stakeholders that attended previous consultation meetings in Duns, Galashiels, Hawick, Peebles and Kelso were also sent information.

Information was also sent to organisations working in the following fields:

- Care homes
- Drugs and alcohol
- Housing support
- Sheltered housing
- Homecare
- Older people
- Learning disability

Appendix 2

Key stakeholders were invited to two launch events held in early November. The people attending were asked to inform their own staff and networks. Participants came from the following areas:

AMD, BGH
BGH Local Partnership Forum
Business & Performance, Social Work, SBC
Children & Young People, SBC
Clinical Service, NHS
Communal mental health, NHS Borders
Communications , NHS Borders
Community Nurse, P&CS, Hawick Health Centre
Delivery Support, NHS Borders
Director of Integration
Gala Resource Centre and Mental Health Local Area
Health & Social Care Integration Programme, SBC
Housing and Care Services
Integrated Joint Forum
ISD, NHS, National Service Scotland
Learning Disability Service
Local Integration - Falkirk and Scottish Borders
Mental Health & Addictions
Mental Health Local Partnership Forum
Mental Health, NHS Borders
NHS Borders
Nursing, NHS Borders
Org & Change Business, SBC
PACS Local Partnership Forum

PH Dept, NHS borders
Planned Care and Commissioning, NHS Borders
Planning & Performance, NHS Borders
Primary & Community Services, Borders General Hospital
Procurement, Estates & Facilities, NHS
SB Cares
Social Care & Health, SBC
Social Work Services, SBC
Training & Professional Development, NHS Borders
Work & Well-Being, NHS Borders
Workforce & Planning, NHS Borders

Appendix 3

List of General practitioners within the NHS Borders

Merse Medical Practice, South Crofts	CHIRNSIDE
Coldstream Medical Practice	COLDSTREAM
Merse Medical Practice	DUNS
Duns Medical Group, The Knoll	DUNS
Earlston Medical Practice, Kidgate	EARLSTON
Eyemouth Medical Practice, Houndlaw Park	EYEMOUTH
Waverley Medical Practice Centre, Currie Road	GALASHIELS
Braeside Medical Practice, Currie Road	GALASHIELS
The Ellwyn Medical Practice, Currie Road	GALASHIELS
Glenfield Medical Practice, Currie Road	GALASHIELS
Roxburgh Street Surgery, 10 Roxburgh Street	GALASHIELS
Greenlaw Surgery, Duns Road	GREENLAW
Teviot Medical Practice, Teviot Road	HAWICK
The O'Connell St Medical Practice, O'Connell Street	HAWICK
St.Ronan's Practice	INNERLEITHEN
Jedburgh Medical Practice Queen Street	JEDBURGH
Kelso Medical Group Practice, Health Centre	KELSO
Stow & Lauder Health, The Surgery, 1 Factors Park	LAUDER
The Health Centre, St Dunstan's Park	MELROSE
Newcastleton Health Centre, Moss Road	NEWCASTLETON
The Neidpath Practice	PEEBLES
The Tweed Practice, Neidpath Road	PEEBLES
Eildon Surgery, Auction Mart	NEWTOWN ST BOSWELLS

Selkirk Medical Practice, Viewfield Lane	SELKIRK
Stow & Lauder Health, Station Road	STOW
West Linton Medical Practice, Deanfoot Road	WEST LINTON

Appendix 4

Main themes in consultation feedback

The feedback on the second consultation was detailed and varied. The table below lists the main themes that were mentioned in multiple sets of feedback. There are many more instances of individual, often very specific comments, which are not reflected here.

Theme	Action(s)
The work mentioned under the nine Local Objectives does not just relate to the care group given in brackets – it does and should relate to me/us/other users too.	Strategic Commissioning Plan updated:- 1. Objectives section extended to include additional examples of work against each objective. 2. Text added to objectives section to note that although many examples give the name of a particular service or strategy in brackets, all of the objectives relate to all of our client/patient groups and we intend that they all benefit from these approaches. 3. Text added to emphasise that the examples/detail are not exhaustive and this high-level Plan will be supported by

	the implementation of Strategies related to specific themes (such as Dementia, Mental Health) and Locality Plans that reflect differing patterns of need across the Borders.
Mixed feedback regarding the targets referred to in respect of the nine Local Objectives. Mix being:- • Targets too ambitious • Targets not ambitious enough • Not enough targets • More evidence required for targets and how they link to the objectives.	Further work to be done around Performance Monitoring. The targets outlined in the Strategic Commissioning Plan are a starting point, based on the "Core Suite" List of integration indicators prescribed by the Scottish Government. Further work will be done to develop the Performance Monitoring Framework for the Health and Social Care Partnership.
The Strategic Commissioning Plan is not detailed enough with respect to actions, partnership resources, monitoring/evaluation of the work undertaken.	The Strategic Commissioning Plan has been developed under the direction of the IJB as a high level document (and its high level nature is emphasised in the final version). It is anticipated that related strands of the work in relation to commissioning, implementation and performance monitoring (amongst others) will start to provide additional detail.
Doubts that everything set out in the Strategic Commissioning Plan is achievable. For example, how will it all be affordable? It tries to be "everything to everyone". The partnership needs to be more up-front about what it will deliver and what it can't. Some contrary views also expressed – don't cut anything, increase spending on everything!	This is work that the Partnership needs to consider further over successive months.
The Plan should make more reference to the third sector and other partners, and the partnership should build closer links with the third sector.	Discussions are in progress with third sector colleagues to improve links and communications, and work together more closely.
Communications need to be more joined up. This was particularly in respect of the various health and social care teams/disciplines communicating with each other, the recipient of care and their Carer. Suggestions included having a key worker/single main point of contact.	This is work that the Partnership needs to consider further over successive months.
Transport issues are a key factor for many patients/clients and/or their Carer. Telecomms/telecare may be useful in some instances, but in others connectivity is slow	ICF-funded transport hub project is underway. Partnership to consider further work required in respect of this often-repeated feedback.

and/or not very accessible to all in our population. Challenges around rurality are a significant concern.	
Needs vary across Borders and between towns/rural areas and you need to take account of this.	Locality Planning work that will be done in 2016 will need to recognise and address this. The Strategic Commissioning Plan commentary has been extended to outline the partnership's arrangements for Locality Planning.
Carers need to be referred to under the list of priorities, have greater recognition and support, and be supported to be more involved.	Strategic Commissioning Plan has been updated – with support for Carers referenced under the "Planning for Change – Key Priorities" section. Other references to Carers – in the Scottish Borders profile and the section on the Local Objectives - have been extended.
Awareness (e.g. by the primary care/acute care team) of who the Carers are is low, and can feel like a tick box exercise.	This is work that the Partnership needs to consider further over successive months.
Social isolation/loneliness is a concern for many. A variety of methods are likely to be required to help alleviate this.	Community Capacity Building work is in progress. Suggest that the Partnership needs to consider this theme further over successive months.

Scottish Borders Council

Scottish Borders Health and Social Care Partnership

NHS Borders

INTEGRATED CARE FUND – PROGRESS UPDATE

Aim

1.1 To update and refresh the members of the Health & Social Care Integration Joint Board with the details of the current administration and progress of the Integrated Care Fund in the Borders.

Background

2.1 The Integrated Care Fund (ICF) was introduced by the Scottish Government in 2015. In parallel with the early implementation work within the Public Bodies (Joint Working) (Scotland) Act 2014, the ICF resources are intended to be used by health and social care partnerships to support investment in integrated services for all adults and to be used to support the delivery of improved outcomes from health and social care integration, help drive the shift towards prevention and further strengthen local approaches to tackling health inequalities.

2.2 To assist with the implementation of the Fund a series of governance and associated administrative protocols were approved and put in place to ensure the robust and smooth running of the Fund. Amongst other things these include:

- ***Terms of Reference*** – incorporating the approval process, role and membership of the ICF Steering Group, approval limits and the tiered governance agreement (see Appendix 3)
- ***Initial Appraisal Process*** – based upon the expectations of the 'Strategic Plan' and the criteria of the "Scottish Borders 2015-16 ICF Plan" which incorporates Scottish Government Guidance and the National Health & Social Care Outcomes. All projects are appraised against a comprehensive range of both financial and non-financial ICT criteria.
- ***Current Monitoring Arrangements*** – There are requirements to meet quarterly, annual and end of project reporting. This includes the frequency and dates which projects need to report.

Current Portfolio of projects

3.1 Within the current group of projects planned and/or supported by the ICF are a small series of prestigious projects that have been targeted to 'make a difference' when it comes to phasing in new and significant initiatives to advance the integration of health and social care. These currently include Health & Social Care Co-ordination incorporating a locality and reablement approach and the Eildon Community Ward.

3.1.1 Eildon Community Ward

This project aims to develop community ward capacity (to be known as Eildon Community Ward) out with the BGH, that supports Central Borders patients who are unable to access local community hospital services to receive the care they need at home or within the local community setting.

This model of care will provide a clinical bridge across primary and secondary care as well as with partner agencies and will be consistent with the principles of the Scottish Borders Health & Social Care Partnership's Strategic Plan, NHS Borders Corporate Objectives and Clinical Strategy. The community ward will focus on supporting patients in their local community, preventing admission where appropriate and enabling rapid-return from acute and sub-acute care to the patient's own home or community. It will aim to improve patient experience and safety and will be person – centred.

There is an acknowledged co-dependency with the Health & Social Care (H&SC) Coordination Project and therefore it is proposed to link the two projects with patients being transferred / discharged from Eildon Community Ward when they are clinically fit into the care of the integrated community teams developed within the H&SC Coordination Project. This will also allow testing of the transfer processes to and from sub-acute care and enable appropriate best use and rationalisation of resources.

3.1.2 Health & Social Care Co-ordination including Reablement

This project aims to introduce a Health and Social Care Coordination approach through integrating teams within two localities (Cheviot and Eildon) to test the change and consider scaling up across the remaining localities.

The project will develop the role of a duty coordinator to assist with screening and referrals, similar to the Torbay model. The integrated team will provide a 7 day approach through the coordinator role and the reablement support workers.

The model of operation seeks to combine the work of the Community Health Team with the locality Social Care & Health Team – and crucially to jointly screen and assess all referrals.

Working as a multidisciplinary team, focussing upon rehabilitation the service will avoid unnecessary hospital admissions & ease hospital discharges and provide a point of contact for GP's, health & social care professionals, district nurses, support workers along with patients and carers to provide suitable packages of care to prevent crises.

3.2 Per the projects outlined in (Appendix 1), ICF funding is also deployed supporting/enhancing localities and through those priorities outlined in the draft Partnership Strategic Plan (2016-19) 'Planning for Change' – Key Priorities.

- The development of integrated accessible transport ***(Transport Hub)***
- Integration and co-ordination of services at a local level ***(Health & Care Co-ordination including reablement), Mental Health Integration, Eildon Community Ward.***

- Work with communities including carers & supported by the voluntary sector to develop local solutions ***(Community Capacity Building, Access to Information)***
- To promote healthy living & active ageing ***(Community Capacity Building, Health Improvement Management & Long Term Conditions)***
- To improve the quality of life of people with long term conditions by promoting healthy lifestyles, access to leisure services, along with support from the voluntary sector ***(Health Improvement, Self-Management and Long Term Conditions, Access to Information)***

Progress to date

4.1 There are presently ten projects receiving ICF funding and a further eight projects are in the process of being approved and/or supported to further develop Project Briefs. Financial summary attached (Appendix 2).

4.2. From an early stage each project is required to produce a sufficiently detailed project brief to enable it to be appraised and scored. This includes the application of specific financial appraisal criteria covering an analysis of the funding requested, sustainability, timeframe, ability to deliver, risks & ability to comply with financial governance. Also crucial to this process is the identification of which National Outcomes are in support of the integration of health & social care. In turn the National Outcomes are supported by a Core Suite of Performance Indicators. Each project is now required to report their progress, using national outcome & indicators on a quarterly basis.

4.3 The use of the ICF has been an opportunity to make health and social work links with Community Planning activity. Two of the three Borders Community Planning priorities have tangible links to ICF i.e. 'Reducing Inequalities' and 'Future Service Reform'. There are a range of projects addressing health inequalities e.g. Health Improvement, Self-Management and Long Term Conditions; Community Capacity Building and a further range of initiatives specifically concerned with a locality or a community focus e.g. Health & Care Co-ordination, Mental Health Integration, Eildon Community Ward.

4.4 Progress has also been made connecting ICF activity with a Strategic Commissioning approach. The ICF Plan (an early requirement by Scottish Government) has been consolidated within the Partnerships Draft Strategic Commissioning Plan (2016-19). The four previously identified themes of Health Improvement, Community Capacity Building, Access to Services and Early Intervention and Prevention have all been assimilated within the continuing development of the Strategic Commissioning Plan and incorporated within the Partnerships nine Strategic Objectives. Detailed within each of the above strategic objectives are summarised statements addressing aspects of planning for change & including:

- What we want to do
- How we intend to do this through current services of strategies
- Some of the changes we have started to make *(this includes use of ICF funding)*
- What can be expected to be seen over the next three years.

Summary

5.1 A considerable amount of work has been undertaken during the last ten months to administer and progress the use of the ICF within the Borders.

5.2 The strength of the approach taken to managing the Fund is its emphasis upon competent governance in all its aspects and robust Performance Management. However there is perhaps some scope for reducing the layers of governance to a much more accessible model.

5.3 The future progress of the fund is now linked to the ability to timeously translate further actions arising from the Strategic Commissioning Plan to support the continued implementation of the integration of health and social care.

Recommendation

The Health & Social Care Integration Joint Board is asked to **note** the progress update report.

Policy/Strategy Implications	The contents of this report are consistent with local and national policy and strategy
Consultation	The widest possible consultation is an integral part of the process of approving, appraisal and the performance management of projects
Risk Assessment	Appropriate governance will minimise financial and other risks. Risks to delivery mitigated by robust performance management
Compliance with requirements on Equality and Diversity	The use of the funding in the way outlined in this report is expected to promote inclusion and reduce health inequalities
Resource/Staffing Implications	The resource implications are detailed in Appendix 2 to this report

Approved by

Name	Designation	Name	Designation
Susan Manion	Chief Officer – Health & Social Care		

Author(s)

Name	Designation	Name	Designation
Bob Howarth	Programme/Planning Manager		

Current ICF Projects
Summary and Decisions

Appendix 1

Contents

Project 0a Programme Team

Appendix 1

Summary and Decisions

For each financial year covered by the ICF a sum of funding has been approved for the management and support of the process of planning and evaluation.

£61k per annum was approved by the Strategic Planning Project Board on 21st September 2015 to enable programme planning and management of the fund.

	Total Cost Including On-Costs		
	2015/16	2016/17	2017/18
Programme Management & Support*	**£'000**	**£'000**	**£'000**
1.0 FTE Grade 7	28	29	30
1.0 FTE Grade 9	39	40	42
	67	**69**	**72**

Project 0b Independent Sector Officer

Funding has been approved to fund the costs of representation by an Independent Sector Officer in ad advisory role to the programme.

	Total Cost Including On-Costs		
Independent Sector Officer			
0.6 FTE (01 Oct 2015 - 31 Mar 2016)	19		
0.6 FTE Full Year		37	37
	19	**37**	**37**

Project 1 Transport Hub

The project is facilitating an integrated transport solution for older people needing to access health and social care services. An aim is to utilise a single point of contact booking system which allows service users to simply call one number where staff will be able to co-ordinate transport for the user by engaging with a variety of transport providers. This project will build on existing services and feed into wider analysis to see which journeys are required and which existing services/routes are perhaps no longer required.

The Community Transport Hub has begun to and will continue to throughout the lifespan and thereafter the project: engage citizens & customers; provide a single point of contact and information; facilitate one number for all; host a single vehicle booking system; build a volunteer base; ensure health & safety and quality; report on performance; and contribute to the wider aims of the Strategic Transport Board.

Timeline of Transport Hub Project approval		
To award the following funding resource Year 1 £29k, Year 2 £70k, Year 3 £40k		
ICF Steering Group	06.07.2015	**Recommend to approve**
Strategic Planning Project Board	20.07.2015	**Recommendation endorsed**
Integration Programme Board	28.07.2015	**Recommendation approved**

Project 2 Access to Information

Summary and Decisions

This project will look to improve online and offline access to information for the public (16+) on services and support which meet in particular peoples Health and Social Care needs. Timescales to be agreed following scoping of the project and fuller proposal completed, but would expect 9-12 months from start date. Project scope is still being defined following recent stakeholder survey exercise, but likely to include adult health and social care, information for SDS users, preventative info (including arts, education), and building on Online Borders model.

Project Team aims to submit Project Brief by March, (in time for March ICF Steering Group meeting).

Project 3 Health Improvement

This proposal builds on a current project designed to improve shared management of LTCs amongst older people (Phase One). The new proposal (Phase Two) extends the basic concept to include *all* adults with Long Term Conditions (LTC's), including those with multiple conditions, so learning from experience and maximising the use of short-term funding.

The two components are as follows:

Phase One: LTC shared-management project (older people): This is an extension of 6 months to the existing LTC Shared Care project which operates in the Coldstream and Ellwyn (Galashiels) practices, focusing on older adults: The extension will ensure a longer term evaluation is developed, including the continued involvement of service users and carers, and embedding of developments within the practices to support sustainability and provide a platform for the future roll out of this approach in the Borders.

Timeline of Health Improvement (Phase One) project approval		
To award funding resource of £19k over 6 months to facilitate the requested extension.		
ICF Steering Group	02.09.2015	**Recommend to approve**
Strategic Planning Project Board	21.09.2015	**Recommendation approved**

Phase Two: LTC locality project: The will involve the development of a locality-based model that supports all adults with LTCs within a specific locality across the tiers of intervention:

-Tiers 1 (e.g. targeted work within local communities via existing networks such as Healthy Living Networks);

-Tier 2 (front-line primary and community health & social care services);

-Tiers 3 and 4 (e.g. specialist community-based/acute/residential services).

Timeline of Health Improvement (Phase Two) project approval		
Recommendation to combine Project Management and Support resources with project 07 and Project 18 for 6 months to develop a robust business case. Funding resource of £35,770 to facilitate recommendation.		
ICF Executive Steering Group	17.11.2015	**Recommend to approve**
Strategic Planning Project Board	23.11.2015	**Recommendation approved**

Project 4 Community Infrastructure

On hold temporarily.

Project 5 Transitions

Appendix 1

This project is focussing upon young people who have a diagnosed learning disability between the ages of 14 and 21 who are moving towards and are progressing through the transition from children's to adult services across Health, Social Care, Children's Services and Education. The Project Lead is in the process of recruiting a Transition Development Officer (TDO), full time for 12 months, who will have the expertise and knowledge both of services and the needs of young people with learning disabilities.

This Officer will scope the current pathways across services for this group of people in transition, including the legislative duties and responsibilities before moving on to developing improved integrated pathways and processes. This will include the development of accessible information and coordinated assessments. Young people with learning disabilities, their carers/advocates and people who have experienced the transitions process will be included in a co productive approach.

Timeline of Transitions project approval		
To award requested funding of £65.2k over 12 months (NB £5k of total resource to be used in year 3 for project evaluation)		
ICF Executive Steering Group	06.07.2015	**Recommend to approve**
Strategic Planning Project Board	20.07.2015	**Recommendation endorsed**
Integration Programme Board	28.07.2015	**Recommendation approved**

Project 7 Health & Social Care Coordination incorporating reablement

This project aims to introduce a Health and Social Care Coordination approach through integrating teams within two localities (Cheviot and Eildon) to test the change and consider scaling up across the remaining localities.

The project will develop the role of a duty coordinator to assist with screening and referrals, similar to the Torbay model. The integrated team will provide a 7 day approach through the coordinator role and the reablement support workers.

The model of operation seeks to combine the work of the Community Health Team with the locality Social Care & Health Team – and crucially to jointly screen and assess all referrals.

Working as a multidisciplinary team, focussing upon rehabilitation the service will avoid unnecessary hospital admissions & ease hospital discharges and provide a point of contact for GP's, health & social care professionals, district nurses, support workers along with patients and carers to provide suitable packages of care to prevent crises.

Timeline of the Health & Social Care Coordination project approval		
Recommendation to combine Project Management and Support resources with Project 03 and Project 18 for 6 months to develop a robust business case. Funding resource of £35,770 to facilitate recommendation. **To further consider funding 1st year (2016/17) £511,000 (Cheviot) and £420,000 (Eildon), 2nd year – 6 months (2017/18) £246,000 (Cheviot) and £246,000 (Eildon).**		
ICF Executive Steering Group	17.11.2015	**Recommend to approve shared project management & support costs of £35,770 with projects 03 & 08**
Strategic Planning Project Board	23.11.2015	**Recommendation approved**

Project 8 CM2000

Summary and Decisions

The proposed innovation project with Edinburgh Napier University and CM2000 will develop and extend the current work into Frailty, with the long term focus on encompassing not only clinical factors, but economic, environmental and social factors.

The project proposes to identify falls prevention and additional issues such as immobility and physical inactivity. It will adopt early intervention and prevention models through the analysis of the existing care at home quantitative data sets (currently captured through the use of CM2000's technologies) and the capture of qualitative related information (also achievable through the use of the same CM2000 technologies). It is further proposed that there would be an identified cohort of citizens where adopting the use of enhanced technology will predictively identify potential risks or incidents prior to them occurring. This will be particularly pertinent in cases where there are citizens identified suffering from multi morbidity conditions allowing greater self-management capabilities and allow for formal "service" management, by exception.

Further discussions around the development of this proposal are currently taking place to ensure inclusion of a responder team.

Project 9 Autism Coordinator

In response to the launch of the Scottish Strategy for Autism in 2011 and an identified need to improve the co-ordination of services for people with Autism, a multi-agency steering group in Scottish Borders developed the Scottish Borders Autism Strategy and 10 year action plan.
This project is recruiting an Autism Coordinator to commence and coordinate all of the work streams within the Delivery Plan.

The Autism Coordinator is going to directly progress pieces of development work in particular, development of a care pathway, development of online resources and information, linking networks and groups, identifying training opportunities and providers and establishing links with other strategies such as housing strategy as well as set up working groups and liaise with other agencies, departments and sectors to support the necessary decision making and service changes needed.

Timeline of the Autism Coordinator project approval		
A recommendation was made to award two year funding of £99,386.		
ICF Steering Group Executive Meeting	17.11.2015	**Recommend to approve**
Strategic Planning Project Board	23.11.2015	**Recommendation endorsed**
Executive Management Team	04.12.2015	**Recommendation approved**

Project 10 ARBD Service Development Officer

The ARBD Service Development Officer has been identified to take forward a number of key recommendations identified in the needs assessment commissioned by the Borders Alcohol & Drugs Partnership (ADP). The Development Officer is responsible for developing and supporting joint and integrated services to this service user group along with arranging the necessary skills and knowledge to implement community based provision where appropriate.

Timeline of the ARBD Service Development Officer project approval

An advisory recommendation was made to award a sum of £102,052 for 24 months to recruit and employ a Development Officer until 31st March 2018.		
ICF Steering Group	07.01.2016	Recommend to approve
Strategic Planning Board	11.01.2016	Recommendation endorsed
Executive Management Team	Will meet on the 22nd Jan 2016	

Project 11 Stress and Distress Training

Stress & Distress Training is going to provide training in an individualised, formulation driven approach to understanding and intervening in stress and distressed behaviours in people with dementia.

This training is aiming to improve the experience, care, treatment and outcomes for people with dementia, their families and carers.

This approach can improve the quality of life for individuals with dementia, their carers, families and staff. This proactive training can reduce exacerbation in situations that may result in the need for residential or hospital care.

This model has demonstrated significant results in reducing the frequency of distressed behaviour for the person with dementia and staff/carer distress (Wood-Mitchell et al, 2007).

Trained staff will be better able to identify issues that are negatively effecting peoples health and wellbeing. Training is going to be provided to staff in NHS Borders, SBC residential settings and third sector settings including residential/ nursing homes.

Timeline of the Stress and Distress Training Project approval		
To award the following funding resource Year 1 £83k, Year 2 £83k		
ICF Steering Group	06.07.2015	Recommend to approve
Strategic Planning Project Board	20.07.2015	Recommendation endorsed
Integration Programme Board	28.07.2015	Recommendation approved

Project 12 My Home Life

My Home Life (MHL) is a UK-wide charitable initiative promoting quality of life for older people living and dying in care homes and support staff who work there and those that visit there.
The programme offers a fourteen month community and practice development, leadership support and training to help improve quality of life in care homes by supporting the Care Home Managers through a collaborative approach.

The suggestion for this approach to be rolled out in the Borders follows an in depth review of 'Quality of Older People's Care Homes' in the Scottish Border, through the Officer/ Member working group to enable the managers of the care home across the Borders to improve the quality of care and leadership provided across the Care Homes in the Scottish Borders.

The programme enables managers to look at innovative ways to deliver care within a care home and work towards different models of support and care, such as intermediate or step up / step down models.

Timeline of the My Home Life project approval		
Recommendation was made to award funding resource of £71.4k for 1 year. A contractual agreement is going to be made with independent sector providers to ensure staff are released to participate in training courses. The intent is to improve the quality of care in Care Homes which is a key priority for the partnership and will do much to ensure we are working across the workforce as a whole with the same aims.		
ICF Steering Group	06.07.2015	**Recommend to approve**
Strategic Planning Project Board	20.07.2015	**Recommendation endorsed**
Integration Programme Board	28.07.2015	**Recommendation approved**

Project 13 Mental Health Integration

The Borders Joint Mental Health Service has been in place since 2007 and within this time joint governance arrangements have been developed. Building on these joint arrangements we are now integrating community teams to provide multi-disciplinary support to service users and carers.

To facilitate integration of the community teams a temporary Team Leader was recruited and the project is looking to recruit a temporary Administrator to further facilitate this.

Timeline of the Mental Health Integration project approval		
To award the requested funding resource of £37.5k for period of 6 months		
ICF Steering Group	06.07.2016	**Recommend to approve**
Strategic Planning Project Board	20.07.2015	**Recommendation endorsed**
Integration Programme Board	28.07.2015	**Recommendation approved**

Project 15 Continuation of Osteoporosis Service

If funded this project would be the Continuation of a service previously funded by the Change Fund.

This service provides bone densitometry and clinical care for patients who have suffered a fragility fracture within NHS Borders and an open access bone densitometry service for primary care practitioners within the Borders.

The main components of the service are: an assessment clinic, treatment clinic, a fracture liaison service and an open access DXA service.

The ICF Steering Group has noted the need for ongoing Falls Prevention work and would like this proposal to be inclusive of Falls Prevention. A request has been made to the Project Lead to develop a revised project brief.

Project 16 Border Community Capacity Building (BCCB)

This proposal builds upon the success of the Community Capacity Building Project for older people funded by the change fund and operational in Cheviot, Tweeddale and parts of Berwickshire. Looking at the next phase of capacity building, the project is looking to develop a series of community support projects to bring together services and to support further development and growth of local services and activities.

Appendix 1

The work funded by the Older Peoples Change Fund has been able to demonstrate the potential of the capacity building approach and highlight the benefits of co-production. Over the next period, the project is embarking upon significant change in how we develop services. Our planned outcome is that by the end of the project in 2018 we will have established a number of different services-each independently managed and funded. The success of the project will be measured by this significant change in community services available and by the improvements in integration of services.

The proposed projects are linking to preventative health initiatives, existing and planned, in localities. Many are stand-alone projects, designed to be independent of SBC but they will link with other supporting services, new and planned. The provision of low level supports will not only improve the quality of life for older people and their carers, but may also reduce the need for GP consultations, day centre provision, respite care, even emergency hospital admissions.

Timeline of the BCCB project approval		
To award the following funding resource Year 1 £80k, Year 2 £160k, Year 3 £160k		
ICF Steering Group	02.09.2015	**Recommendation advised**
Strategic Planning Project Board	21.09.2015	**Recommendation endorsed**
Executive Management Team	02.10.2015	**Recommendation approved**

Project 18 Eildon Community Ward

This project aims to develop community ward capacity (to be known as Eildon Community Ward) out with the BGH, that supports Central Borders patients who are unable to access local community hospital services to receive the care they need at home or within the local community setting.

This model of care will provide a clinical bridge across primary and secondary care as well as with partner agencies and will be consistent with the principles of the Scottish Borders Health & Social Care Partnership's Strategic Plan, NHS Borders Corporate Objectives and Clinical Strategy. The community ward will focus on supporting patients in their local community, preventing admission where appropriate and enabling rapid-return from acute and sub-acute care to the patient's own home or community. It will aim to improve patient experience and safety and will be person – centred.

There is an acknowledged co-dependency with the Health & Social Care (H&SC) Coordination Project and therefore it is proposed to link the two projects with patients being transferred / discharged from Eildon Community Ward when they are clinically fit into the care of the integrated community teams developed within the H&SC Coordination Project. This will also allow testing of the transfer processes to and from sub-acute care and enable appropriate best use and rationalisation of resources.

Timeline of the Eildon Community Ward project approval		
Recommendation to combine Project Management and Support resources with Project 03 and Project 07 for 6 months to develop a robust business case. Funding resource of £35,770 to facilitate recommendation. **To further consider funding: 1st year: £720k 2nd year: £650k (as some services realign) This total package includes funding of the provision of services in this specific locality through Project 07**		
ICF Executive Steering Group	17.11.2015	**Recommend to approve shared project management and support costs of £35,770 with projects 03**

		and 07 above
Strategic Planning Project Board	23.11.2015	Recommendation approved

INTEGRATED CARE FUND ANALYSIS - APPROVED PROJECTS

Appendix 2

Dec-15

	NHS / SBC	Cost Centre	#REF!	Budget 15-16	Funds Available 15-16	Budget 16-17	Budget 17-18	TOTAL APPROVED
Project Management Team	SBC	WB6101	57,598	61,000	3,402	61,000	61,000	183,000
Community Capacity Building	SBC	WB6102	0	80,000	80,000	160,000	160,000	400,000
Independent Sector Officer	SBC	WB6103	0	19,000	19,000	37,480	37,480	93,960
Transport Hub	SBC	WB6105	42,147	29,000	(13,147)	70,000	40,000	139,000
Mental Health Integration	SBC	WB6107	24,393	23,437	(956)	0	0	23,437
My Home Life	SBC	WB6109	0	71,340	71,340	0	0	71,340
Community Ward	SBC	WB6111	0	35,770	35,770	0	0	35,770
Health Care & Co-ordination	SBC	WB6113	0	0	0	0	0	0
Autism Co-ordinator	SBC	WB6115	0	12,423	12,423	49,693	37,270	99,386
			124,137	**331,970**	**207,833**	**378,173**	**335,750**	**1,045,893**
Health Improvement (*phase 1*)	NHS	?	0	19,000	19,000	0	0	19,000
Stress & Distress Training	NHS	BICF005	0	83,000	83,000	83,000	0	166,000
Mental Health Integration	NHS	?	0	14,097	14,097	0	0	14,097
Community Ward	NHS	?	0	0	0	0	0	0
Transitions	NHS	BICF004	0	65,200	65,200	0	0	65,200
			0	**181,297**	**181,297**	**83,000**	**0**	**264,297**
			124,137	**513,267**	**389,130**	**461,173**	**335,750**	**1,310,190**

Scottish Borders

Integrated Care Fund Steering Group Terms of Reference

Appendix 3

2015 – 2016

1. Introduction

The Scottish Government has announced an Integrated Care Fund (ICF) of £173.5m to support the integrated working for health and social care. Resources of £100m are to be made available to Health Boards in 2015-16, 2016-17 and 2017-18. Of this, £2.13m has been allocated to the Scottish Borders for 2015-16.

ICF funding will support the delivery of improved outcomes from health and social care integration, help drive the shift towards prevention and further strengthen the approach towards tackling inequalities.

This fund builds upon the earlier work of the Reshaping Care for Older People Change Fund and will be accessible to local partnerships to support investment in integrated services for all adults.

Funding will support partnerships to focus on prevention, early intervention and care and support for people with complex and multiple conditions, particularly in those areas where multi-morbidity is common in adults under 65 as well as in older people.

The ICF supports the work of the Scottish Government's ten year Reshaping Care agenda and also the Public Bodies (Joint Working) (Scotland) Act.

Locally, the plan is to invest in four key areas for 2015-16:

- Health improvement
- Community capacity building
- Access to services
- Early intervention and prevention

ICF Plan 2015-16

2. Purpose of Steering Group

- To review, recommend and oversee the investment of ICF in line with the ICF Plan 2015-16 and the emerging Joint Strategic Plan for Health and Social Care Integration and make project recommendations to the Strategic Planning Project Board.

- To performance manage the ICF programme to ensure investments are delivered and that relevant and necessary performance measures are in place to manage the performance of the ICF programme against:
  - National Health and Social Care outcomes through/and corresponding local outcomes
  - JIT Multiple Conditions Advice Note, November 2014 – Ten Actions
  - National TEC deliverables

- To ensure collaborative working and effective communications is sustained across all stakeholders with a strategic interest in ICF activities

- To plan the future use of the Integrated Care Fund and make recommendations to the Strategic Planning Project Board

- To ensure alignment to the Health and Social Care objectives, provide good financial governance, monitoring of project delivery and effective reporting

- To oversee remaining Change Fund projects as they complete ensuring good financial governance, monitoring of project delivery and effective reporting.

3. Main Roles and Responsibilities

Programme Management

- Appraise and score projects based on analysis of strategic priorities
- Provide advice and prompt decision making and risk management and support projects in issue resolution
- Ensure consistency in the development of project briefs into project initiation documents with plans, governance and resources

- Undertake regular project and programme performance monitoring
- Ensure governance arrangements are clear to investments and once in place are followed and when not followed, that there is appropriate follow up
- Report on progress to Scottish Government as required

Performance Management and financial governance

- Undertake regular project and programme performance monitoring
- Ensure robust and regular programme financial monitoring and ensuring appropriate action taken to challenge inappropriate spend

Communications and Stakeholder Engagement

- Ensure key priorities are communicated effectively to all stakeholders with an interest in ICF
- Ensure regular and concise communication with those involved in ICF investments
- Maintain and strengthen partner relationships within the ICF and with their partners
- Ensure governance arrangements are in place and followed, providing appropriate reports to Boards and Scottish Government as required
- Communicate good practice and commissioning successes locally and nationally as appropriate

4. Membership

The membership and roles for the ICF Steering Group is proposed as follows:

Name	Job Title	Role
Susan Manion	Chief Officer Health and Social Care Integration	Chair
Eric Baijal	Director of Strategy (Integration)	Deputy Chair
Susan Swan	Deputy Director of Finance and Board Fraud Liaison Officer, NHS	Financial assurance
Paul McMenamin	Finance Business Partner – Social Work, SBC	Financial assurance
Steph Errington	Head of Planning and Performance, NHS	Performance and planning assurance
Bob Howarth	Programme Manager, SBC	Performance and planning assurance
Eric Livingston	Contracts Manager, SBC	Contractual assurance
Shona Hall	Procurement, NHS	Contractual assurance
Morag Walker	Executive Officer, The Bridge	Third sector representative
Jenny Miller	Coordinator, BVCV	Third sector representative
Margaret McGowan	Independent Sector Development Officer, Scottish Care	Independent sector representative
Hamish McRitchie	Consultant Radiologist/ Associate Medical Director and Co-Chair of Primary, Community and Acute Services	NHS representative
Dr Sandy Morris	GP, Kelso Health Centre	GP representative
David Thomson	Associate Director of Nursing, NHS	NHS representative
Elaine Torrance	Chief Officer Social Work, SBC	SBC representative and Deputy Chair
Jane Douglas	Principal Assistant Social Care & Health/ Group Manager	SBC representative
Simon Burt	Joint Learning Disability Service Manager	SBC representative
PPF rep	TBC	User representative
Joint Staff rep	TBC	Staff representative
Carer Rep	TBC	Carer representative
Nursing Rep	TBC	Nursing representative
In attendance:		
PJ Harding	Project Manager, SBC	Programme team
Jillian Scott	Project Officer, SBC	Programme team

5. Quorum

The ICF Steering Group will be considered quorate provided the meeting is attended by:

- The Chair or a Deputy Chair or another group member agrees to act as Chair
- A minimum of 5 members consisting of representatives from majority of partners including NHS, SBC, Third Sector and Carers.

6. Declarations of Interest

If a Steering Group member has an interest in a project (e.g. direct involvement):

- They must declare their interest in a project prior to any discussion on the project beginning
- They can only speak on behalf of a project or answer questions – they will not be allowed to participate in any scoring or decision making for the project

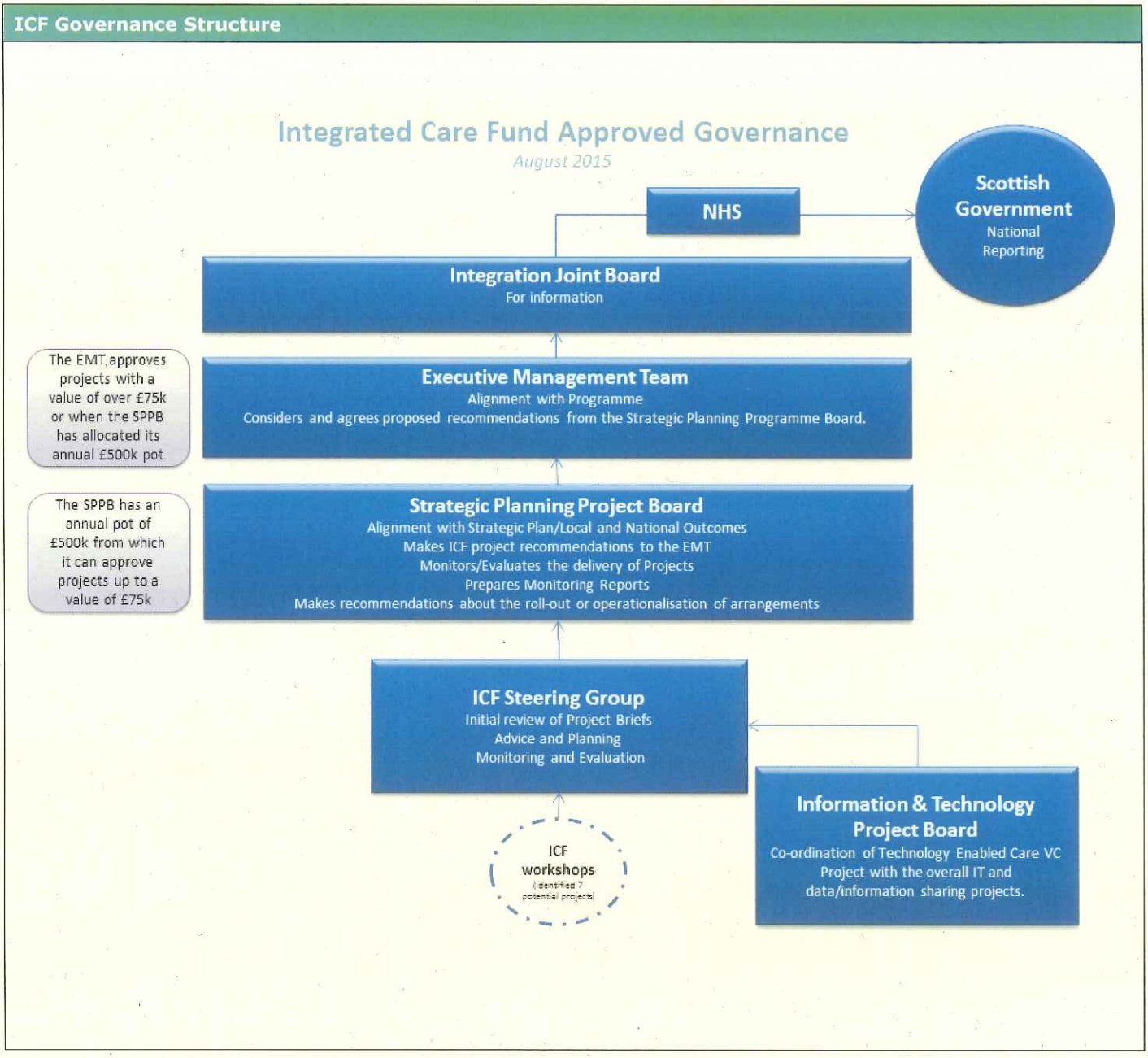
7. Governance

The ICF Steering Group will be supported by a programme team (Currently a Project Manager and Project Officer) which will support the delivery of ICF investments and the governance of the ICF programme.

It is expected that projects will report on progress to the ICF Steering Group which in turn will report to the Strategic Project Planning Board (SPPB), Programme Board, Shadow/ Integration Joint Board and Scottish Government. The Steering Group will make project recommendations to the SPPB for approval, endorsement will be given by the Shadow/ Integrated Joint Board laid out in the table below.

Appendix 3

ICF Governance Structure

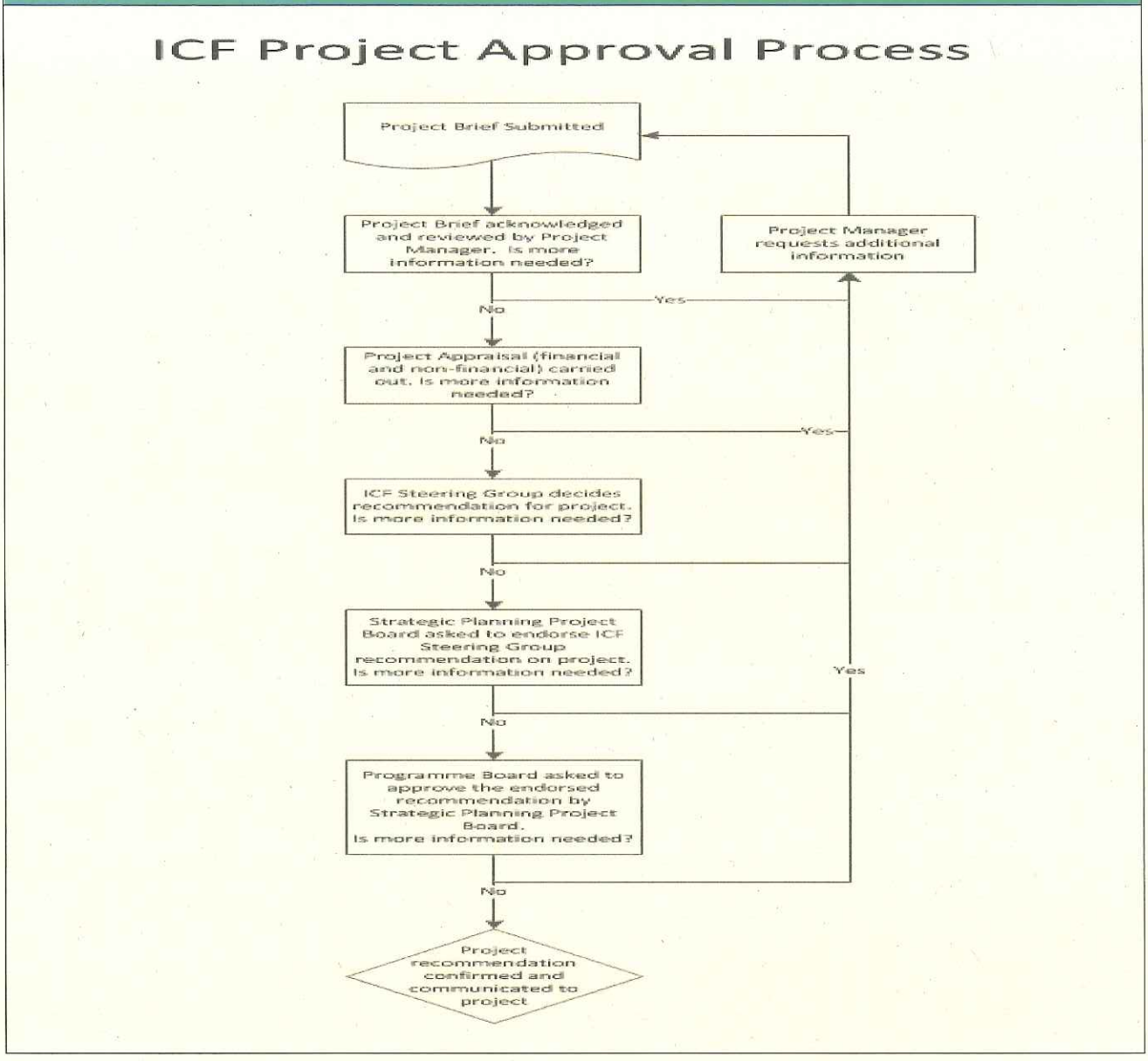


8. Project Approval Process

The ICF Steering Group will follow the approved governance route and will receive initial projects, carry out financial and non-financial appraisal and recommend any further work to be carried out before a project is taken to the ICF Steering Group for consideration.

The ICF Steering Group will propose recommendations to the Strategic Planning Project Board to endorse prior to projects being taken to the Programme Board for final agreement. The flowchart below shows the process for project approval.

ICF Approvals Flowchart



ICF Proposal Scoring v6

The financial and non-financial criteria can be found in the embedded document:

9. Process/ Method of Operation

Membership

- Proposed membership and roles of the Steering Group have been outlined in section four of this report.

Frequency and Length of Meetings

- The ICF Steering Group will meet two weeks prior to the Strategic Planning Project Board and frequency can be reviewed at meetings
- The meetings will last no more than 1.5 hours unless there are exceptional reasons why a longer meeting is required.

Format of Meetings

- Agenda and action tracker
- Items will only be considered for the agenda when an approved report template is completed and submitted by given deadlines, unless there is an exceptional circumstance.
- Key decisions and actions only will be minuted (clarified by Chair)
- Steering Group members will be expected to bring their own copies of papers (either electronic or hard copy)

Type of Agenda items

- Previous minutes
- Action tracker and matters arising
- Project Initiation Documents/ Evaluations (for approval)
- Project exception reports (i.e. stating key issues and/or key decisions)
- ICF finance and performance reports
- Project progress reports (for discussion – maximum 5 mins/ project)
- Change Fund update
- Scottish Government ICF business
- AOB

10. Terminology

- **Change Fund:** a Scottish Government fund for Older People which ran from 2011 to 2015. Local projects funded were led by SBC, NHS and voluntary, third and independent sectors to help shift the balance of care from primary health and care settings and support older people at home or in a homely setting.

- **Technology Enabled Care:** a Scottish Government programme committed to embedding technology-enabled options in the redesign of health, care and support services.

11. 2015-16 Outline ICF Steering Group Meeting Calendar

ICF SG	SPPB	PB	IJB
	6 Apr	17 Apr	27 Apr
15 April	5 May	***	
(was 18) 27 May	1 Jun	12 Jun	22 Jun
6 Jul	20 Jul	30 Jul	10 Aug
9 Sept	21 Sep	None	23 Sep
19 Oct			11 Nov
11 Nov	23 Nov	4 Dec	14 Dec
21 Dec			

*** A special meeting of the SPPB and PB may be needed to approve initial recommendations for ICF projects

ICF SG – ICF Steering Group || SPPB – Strategic Planning Project Board || PB – Programme Board || IJB – Integrated Joint Board

Scottish Borders

Integrated Care Fund Plan

2015 – 2016

1. Introduction

The Scottish Government has announced an Integrated Care Fund (ICF) of £173.5m to support the integrated working for health and social care. Resources of £100m are to be made available to Health Boards in 2015-16. Of this, £2.13m has been allocated to the Scottish Borders.

A Technology Enabled Care Programme 2014-16 will be supported by £10m from the overall ICF into which partnerships can apply. Approved applications will be expected to provide a degree of match funding and the local ICF allocation could be used towards this.

ICF funding will support the delivery of improved outcomes from health and social care integration, help drive the shift towards prevention and further strengthen the approach towards tackling inequalities.

This fund builds upon the Reshaping Care for Older People Change Fund and will be accessible to local partnerships to support investment in integrated services for all adults.

Funding will support partnerships to focus on prevention, early intervention and care and support for people with complex and multiple conditions, particularly in those areas where multi-morbidity is common in adults under 65 as well as in older people.

The ICF supports the work of the Scottish Government's ten year Reshaping Care agenda and also the Public Bodies (Joint Working) (Scotland) Act.

2. How ICF will be invested

In the context of the Integration scheme and emerging Strategic Plan, the Scottish Borders Partnership intends to take a truly integrated approach in using the ICF. It will be pragmatic in its investments in order to maximise potential and begin work quickly by:

- Using existing programme management arrangements to ensure seamless continuity
- Develop investments through a workshop programme with relevant stakeholders using the priorities identified in the Joint Commissioning Strategies and emerging Joint Strategic Plan
- Use existing resources; redirecting them to support new ways of working rather than seeking to disinvest in one service and reinvest in another.

Taking into account the Scottish Government's six principles (see section three) for investing the Integrated Care Fund and the given timescales to progress rapid implementation, the Scottish Borders Integrated Care Fund Plan will:

- Building on existing projects
- Further develop and test successful models
- Use a small scale rapid cycle test of change.

Locally, the plan is to invest in four key areas (see also table one):

1. **Health Improvement**
   - Scottish Borders has a Joint Health Improvement Team which works across NHS Borders and Scottish Borders Council and with other sectors led by the Joint Director of Public Health. The team has identified gaps in current work programmes in relation to support for adult groups with high needs and those with long term/ multiple conditions.

     With the support of the Integrated Care Fund we will:
     - Build on the success of the Walkerburn Community-focused approach to delivering health improvement in areas of deprivation by developing initiatives addressing inequalities in other areas of the Borders
     - Continue to work on the Health Improvement in Older People Project.

     This will be focused through mainstream health and social care services supported by specialist health improvement advice and expertise.

2. **Community Capacity Building**
   - Strong communities are a real asset of the Scottish Borders. Community capacity building has the potential to significantly improve the health and independence of people with health and social care needs.

     With the support of the Integrated Care Fund we will:
     - Continue to support and develop a Community Capacity programme for older people which has, over the last year, involved over 1,000 people in the project and its activities. This will support the development of Local Plans as described in section 3.3.
     - Build on models of community for people with learning disabilities and mental health issues
     - Extend and bring together these models to target other care groups, including those with multi-morbidities.

3. **Access to Services**
   - Access to services has been identified as a key area for development in all commissioning strategies. Establishing single points of access for information and signposting to services and support will be a priority for ICF.

     With the support of the Integrated Care Fund we will:
     - Develop models for supporting access to services through working on child to adult transitions being carried out within out integrated Learning Disability (LD) service
     - Build a robust online portal based on ALISS (national) and Online Borders (local) through Technology Enabled Care
     - Establish the systems to support people to access these portals to support self-management and to facilitate more effective sign posting to sources of information and support in the community
     - Develop and test models of integrated transport and improved access to public transport through the Community Planning Partnership Strategic Transport Board.
     - Improve upon the transitions of young people coming through into adult LD service by building on work to date including developing the Transitions Worker role to support this work.

4. **Early Intervention and Prevention Model**
   - Ensuring people who are struggling to manage independently can be rapidly supported through a range of services that meet their individual needs has been a focus for the development of new ways of working.
     With the support of the Integrated Care Fund we will:
     - Build on the model of Connected Care to develop a new model to support a programme of work taking a focused and data driven approach to ensuring people are cared for in the right environment, by driving new approaches to providing step down care and supporting people to return home and keeping them at home.
     - Increase the local work with the independent sector to develop new models of care home and homecare provision, such as existing supported work around the use of care home beds to provide respite and prevent long-stay specialist care for dementia patients.

Table 1: ICF investment diagram

These four areas have clear links towards addressing the ten actions outlined in the JIT's November 2014 Multiple Conditions Advice Note (see appendix one). For example:

- Action five is about introducing local volunteers and new roles in GP practices to simplify access to local sources of community support, including support for unpaid carers and work within Community Capacity could support this.
- Action six is about increasing use of technology, access to information etc. Work on this would be tied into the access to information stream as well as the planned application for funding through Technology Enabled Care theme three to promote and expand the use of a local online directory.

As well as building on existing Joint Commissioning Strategies, action plans (such as Multi-Morbidity), existing work and the Strategic Plan there are clear links between the areas of investment in reaching the ultimate goal of supporting people to self-manage.

The Borders has also applied to the Technology Enabled Care (TEC) allocation, of which there are five priority areas (highlighted in table two below). It was agreed that the partnership would only apply for funds under three of the five priorities:

- Priority two: looking to use technology to improve access to appointments, especially for hard to reach groups.

- Priority three: maximising potential for online platforms providing service information and maximising their potential through innovative ways of access and promotion.
- Priority four: developing a catalogue of services for users to choose from in order to provide a package appropriate to their needs.

The ICF plan links strongly to the proposals outlined in the Scottish Borders TEC expression of interest and ICF will work towards ensuring that technology becomes a routine part of the care pathway and will provide assistance with the change in practice.

Table 2: TEC Priority Areas	
i.	Expansion of home health monitoring
ii.	Expanding the use of video conferencing
iii.	Building on the emerging national digital platforms
iv.	Expanding the take up of Telecare
v.	Exploring the scope and benefits of switching current provision of Telecare from analogue to digital telecare

The Scottish Borders ICF plan has been developed through a series of workshops including all appropriate stakeholders. This joint approach to planning the full use of ICF allows us to ensure that people with multi-morbidities are at the heart of changing the way in which we do things. It sets an integrated approach towards commissioning adult services and creates common pathways of care.

3. Intended financial allocation of the ICF grant

ICF is an opportunity to use as leverage for change and projects may be fully or part-funded by ICF depending on their needs and plans for sustaining.

Criteria were identified against which service development projects would be assessed to ensure fit with the ICF Plan 2015-16:

- Needs based – link to requirements in Joint Commissioning Strategies and the emerging Joint Strategic Plan
- Co-production – user involvement/ possibilities for co-production
- Project outcomes in the context of the national outcomes
- Feasibility – can it be delivered
- Sustainability – is there an exit plan? Principle of funding existing services/ resources to release service to redesign/ deliver in a new way
- Spread – across adult services
- Value for money.

All projects will also need to be able to demonstrate their contribution towards:

- National Social Care and Health outcomes
- JIT Action Note on Multi-Morbidities
- ICF principles
- Scottish Government reporting requirements.

As noted in section two of this plan, the Partnership has agreed themes of investment that will help us deliver the scale of change required:

- Health improvement – estimated investment £495k
- Community capacity building – estimated investment £570k
- Access to services – estimated investment £495k
- Early intervention and prevention – estimated investment £570k

Across each theme the funding will be used to invest in the workforce in order to facilitate service redesign and will ensure investment is also supporting carers, the third sector and approved Technology Enabled Care projects.

Supporting these themes, a number of developments have been identified as priority areas; these are outlined below but may change as scopes are developed:

- Transport hub – to provide co-ordinated community transport, including all transport providers, with a single point of contact for getting people to and from hospital, health and social care services

- Access to information – to maximise local access to information through online and offline portals providing service information that people and staff can self-navigate their own way through and open up opportunities for online assessment and increasing sign-posting

- Health improvement, self-management and long term conditions – to consider expanding the Health Improvement for Older People work to other client groups, spreading key health messages and communication to client groups

- Community infrastructure/ support – to broaden existing community capacity building work and apply the preventative approach to all services across all Borders localities

- Transitions mode l– to develop and test a transition model to ease the move from children to adult services and apply principles to all transitions

- Reablement – to progress reablement opportunities primarily within Homecare (with full scope to be established shortly). The aim is to focus on delivering short-term support to individuals as a means of reducing reliance on long-term care packages to promote independent living

- Co-ordination – to define and further health and social care co-ordination including roles that might aid co-ordination, culture change and learning from existing models such as the Torbay model.

Other areas of priority which may be considered for investment include housing and falls prevention and project ideas may be developed further following decisions to proceed on the above the service developments.

4. ICF Principles

ICF investments need to be considered alongside the Principles set by the Scottish Government:

1. **Co-production**

   ICF will focus on priorities identified in Joint Commissioning Strategies for each care group. Each Strategy has been developed in co-produced with users, carers and service providers etc.

   ICF will be focused and person-centred with a three layer approach:
   1) Build on the Joint Commissioning Strategies which have all been co-produced
   2) Test using 'Mrs Scott' scenarios (see appendix two)

3) Projects invested in will be developed in co-production.

It is the intention to continue the approach of ensuring 20% of whole investment supports local carers either directly or indirectly.

2. Sustainability

The Scottish Borders Partnership sees ICF as a central driver for delivering changes to the way we provide services in the Borders to build sustainability into investment plans. ICF will be used to maintain existing services, which allows new ways of working to be tested and established and in turn it will facilitate an effective move to sustainable new services. This will ensure that ICF will support new ways of working rather than seeking to disinvest in one service and reinvest in another.

3. Locality

The Scottish Borders is already working well with communities to ascertain their needs through the strategic planning process. Health and Social Care Integrated arrangements will address health inequalities and isolation in the areas of most need through a locality planning approach.

ICF will take a locality approach working with the five localities agreed by the Shadow Board in November 2014. The themes outlined in section two for the ICF are issues that have been highlighted regularly at consultation and awareness-raising events organised across localities as part of the Integration process.

Scottish Borders Council is considering adopting the locality approach to ensure that future service delivery, investment, property decisions, projects and actions are better co-ordinated and involve local stakeholders.

There will be a focus on involving the locality in building community based services and this will include GPs in the planning approach. This is something that is already successfully being addressed by Health Improvement and Community Capacity Building Project. Existing work with communities has focused on areas which have been identified as having significant need; this will continue to underpin the use of ICF.

4. Leverage

The investment of the ICF will be focused on delivering changes to the way we deliver services that reflect the priorities in the emerging Strategic Plan.

The focus of building on existing projects and the sustainability approach described above demonstrate the commitment to using ICF to make fundamental changes to health and social care. This will demonstrate the way in which ICF delivers against Strategic Plans and will include models which will deliver] a a whole system change.

Investments (continued or started) are informed by existing Plans and deliver towards the National Outcomes.

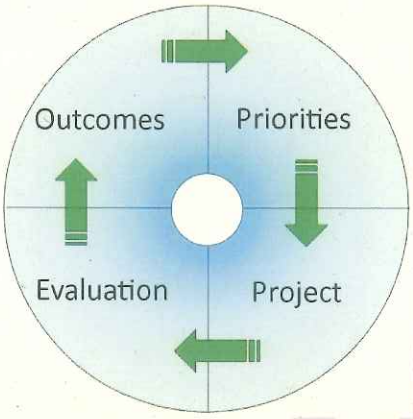
5. Involvement

The ICF intends to take a truly integrated approach to ICF ensuring there is a representative from each of the four partnership sectors (NHS, SBC, third/voluntary sector and independent sector) with decision making ability on the ICF Board. The workshop approach to the ICF has and continues to involve many stakeholders in the approach to assessing the local priorities for the ICF.

6. Outcomes

ICF investments will be measured against the Health and Social Care Integration National Outcomes (see appendix three). Through the work being carried out as part of Integration, these outcomes will be quantified at a local level allowing ICF to measure its contribution towards meeting them.

Existing outcome measures contained within the Local Delivery Plan, Single Outcome Agreement and existing Joint Commissioning Strategies will be reflected in the specific outcomes that will be looked for in investments. This is explained more fully in section five.



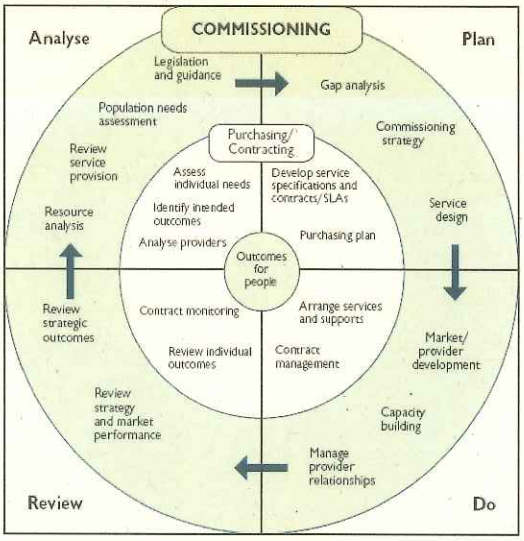


Figure 1 Joint Commissioning Model for Public Care (based on IPC model)

5. Strategic Plan

It is a statutory requirement of Public Bodies (Joint Working) (Scotland) Act 2014 to produce a Strategic (Commissioning) Plan which sets out how the planning and delivery of services will be achieved in the Borders during the next three years.

The Strategic Plan will consolidate the priorities and intentions of the existing health and social care group commissioning plans and strategies. Additionally this Plan will be subject to a comprehensive needs assessment for adult social care and an engagement exercise seeking the views of a cross-section of health and social care users, practitioners, other stakeholders including locality based representatives.

Its intended purpose is, through the strategic commission process, that the national health and well-being outcomes will be delivered and the required shift in the balance of care also be achieved.

In order to ensure the best from investments and sustainability, ICF will build on existing work, developing initiatives based on priorities in local joint commissioning strategies developed by all adult services which are being incorporated into a single Strategic Plan.

ICF will underpin and inform the emerging priorities from the Strategic Plan.

6. Outcomes and benefits

The approach to ICF will be outcome focused and projects/ initiatives will be expected to directly impact on the health and social care Integration outcomes (see appendix three).

ICF investments will also collectively support the 2020 aim that all adults with multiple conditions are supported to live well and experience seamless care from the right person when they need it and, where possible, where they want it. The Scottish Government has outlined points it is keen to monitor ICF progress against (see table three) and these will be the basis of future Scottish Government ICF progress reports.

Table 3: Scottish Government Progress Reporting Points
• Tackling health inequalities with Community Planning Partnerships in an integrated way. • Improved in-year outcomes and lay the foundations for future work to be driven through Strategic Commissioning • Relationships with localities; including how input from the Third Sector, users and carers will be achieved. Bottom up approach should maximise the contribution of local assets including volunteers and existing community networks • Long term sustainability of investments and the extent to which use of the fund will leverage resources from elsewhere • How resources will be focused on the areas of greatest need • How the principles of co-production will be embedded in the design and delivery of new ways of working • Progress in implementing priority actions for partnerships as described in the National Action Plan for Multi-Morbidity

Investments will be expected to address one or more of the four key areas identified locally for ICF investment described above and illustrated in table two. They will also need to consider their input into addressing the Multiple Conditions Action Points and be able to align their work with the Strategic Plan being developed for Integration.

The National TEC programme is to be seen in context with the National Health and Wellbeing Outcomes and is also aligned with the overall aim of the National Telehealth and Telecare Delivery Plan which is:

- To enable greater choice and control in health, care and wellbeing services for an additional 300,000 people *[from baseline March 2012]* by March 2016, enabling more of our citizens to remain at home and in their communities.

It is expected that TEC investments will work towards this aim and collectively deliver towards ten national deliverables (see appendix four) by 2016.

7. Outline ICF Programme – Key Milestones

Key Milestones	Date
Scottish Borders ICF workshop #1	10 Sept 14
Scottish Borders ICF workshop #2	14 Nov 14
Technology Enabled Care (TEC) Expression of Interest submitted to Scottish Government	28 Nov 14
ICF Plan submitted to Scottish Government	12 Dec 14
Discussions with interested partnerships re TEC Expressions of Interest	Dec 14/ Jan 15
Selection of Partnerships for TEC funding	Jan 2015

Scottish Borders ICF workshop #3	27 Jan 15
2015-16 ICF funding starts	01 Apr 15
Six monthly Scot Govt progress report #1	Sept/ Oct 15
Six monthly Scot Govt progress report #2	Mar 16
2015-16 ICF funding ends	31 Mar 16
Progress report to be locally published	Autumn 2016

8. Governance

An Integrated Care Fund Board will be established and Terms of Reference agreed. It is thought that the Board will be formed of:

- Chief Officer Health and Social Care Integration (Chair)
- Strategic Lead from each 4 partners (decision making authority)
- Representatives from services – Health Improvement/ Public Health, Mental Health, Learning Disability, Older People, Physical Disability (input only?)
- Finance Representative
- Performance Management
- IT (input only?)

The ICF Board will be supported by a programme team which will support the delivery of ICF investments and the governance of the ICF programme. It will follow NHS Borders and Scottish Borders Council Scrutiny as it will be accountable for the ICF to the Scottish Government.

It is expected that Technology Enabled Care projects will also report on progress to the ICF Board and follow the governance route illustrated in table four.

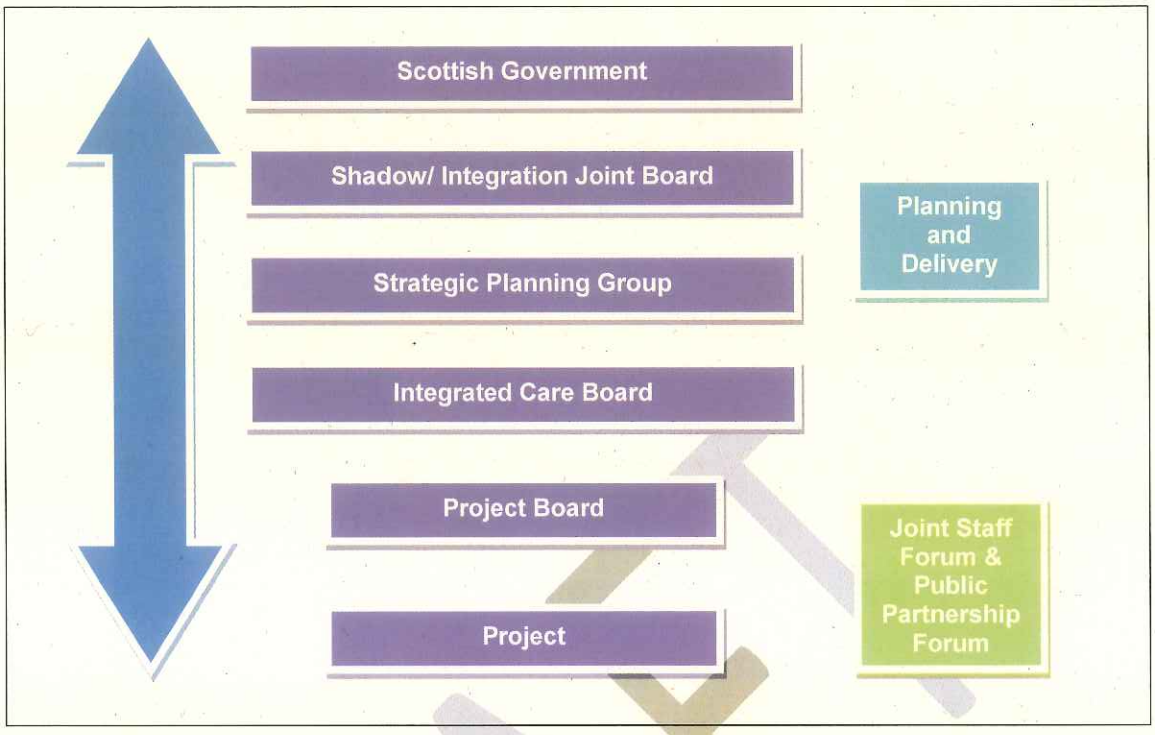
There is an existing joint IT group which is providing leadership and oversight for the Health and Social Care Integration Programme Board and Shadow Integration Joint Board. This group will oversee delivery of the technical aspects of the TEC Programme and will also report to the ICF Board to ensure that the work of TEC is aligned to the ICF and drives the outcome rather than just delivering technology.

It is expected that projects will report on progress to the ICF Board which in turn will report to the Strategic Planning Group, Shadow/ Integration Joint Board and Scottish Government. This is illustrated in table four below.

Key ICF Contacts

Role	Organisation	Contact Details
Scottish Government	JIT	Katie McWilliam
Sponsor	TBC	TBC
Manager	NHS Borders/ SBC	Susan Manion
Programme Support	SBC	PJ Harding, Jillian Scott

Table 4: Proposed ICF Governance



9. Programme Management

The ICF Board will be the programme board for the projects supported through ICF and will be responsible for:

- Ensuring good financial governance
- Monitoring of project delivery
- Programme reporting
- Programme performance

ICF will be co-ordinated by a programme team, a model which has proved to work well, bringing existing knowledge, experience and skills related to co-ordinating a similar type of programme. This will bring continuity to the ICF ensuring investments are appropriately supported from the start and the programme can be run in a seamless manner.

The programme team will be responsible for:

- Day to day management of the ICF programme
- ICF communications and stakeholder engagement
- Data gathering/ project and programme performance
- Scottish Government report e.g. ICF plan and submission, mid-year progress reports etc.
- Integrated Care Fund Board management and managing reporting requirements
- Programme financial monitoring with Finance Business Partners
- Ad-hoc programme and related tasks
- Providing generic and specific project/ programme management support as required

The programme team would expect to liaise between the ICF Board and investments around ICF reports/ paperwork required which should be completed as part of the project process, such as:

- Project Initiation Documents

- ICF Monthly/ quarterly highlight reports and detailed reports when requested
- ICF Exception reports
- ICF Mid-year progress/ evaluation reporting
- Final evaluation
- ICF Information/ data requests.

10. Appendices

Appendix 1: JIT Multiple Conditions Advice Note, November 14 – Ten Actions

- **Action 1:** Make sure health and social care staff really listen to those they provide care and support for and help people to achieve what matters to them.
- **Action 2:** Make sure that appointments provide enough time for the person to talk about what really matters to them and about their physical, psychological, emotional and spiritual wellbeing.
- **Action 3:** Increase the use of Anticipatory Care Planning, Carer support plans and Key Information Summaries. This will mean that people, and those who support and care for them, are better prepared to deal with health problems which may fluctuate or get worse over time.
- **Action 4:** Pharmacists more regularly do reviews with people who take many different medicines and support them to understand and to manage their medicines at home.
- **Action 5:** Introduce local volunteers and new roles in GP practices to simplify access to local sources of community support, including support for unpaid carers.
- **Action 6:** Increase the use of day to day technology to help people to have more information and control over their own health and care. Increase access to digital information, home monitoring and video consultations to reduce the number of appointments they need to attend.
- **Action 7:** Make every health and care contact an enabling experience and an opportunity to improve health and wellbeing.
- **Action 8:** Support staff to learn from each other so that specialist staff have better general skills, and staff in community teams develop extended roles.
- **Action 9:** Managed Clinical Networks work together to develop care and support pathways and guidelines that make sense for people who have multiple conditions. This will help individuals and staff to make the right decisions and ensure people with multiple conditions have the right care, support and rehabilitation, including support to remain in work.
- **Action 10:** Identify people with multiple conditions so that they can access the right level and type of care and support as their needs change. This should include coordinated health and care services, along with support from peers, third sector and use of technology.

Appendix 2: Mrs Scott scenario – Older People

Mrs Scott encounters daily frustration in navigating the health and social care system.

Mrs Scott is 81 years old, has diabetes and has had a stroke for which she was hospitalised and required rehabilitation in order to return home.

She has slight memory loss and her diabetes can be unstable. She has poor mobility due to her stroke and is at high risk of falling. Due to her diabetes she has a leg ulcer which is being dressed by the District Nurse. She is prone to Urinary Tract Infections (UTIs) which exacerbate her cognitive impairment. Due to the falls and UTIs she has recurrent admissions to hospital.

She has equipment in her home such as a stair lift and other aids to assist with her mobility. She receives a package of care three times a day and is care managed by the local Social Work office. She has family living nearby and they visit regularly and she still attends church. She is in receipt of the frozen meal service and has a Bordercare Alarm. There are allegations of financial abuse which have been reported to Social Work.

Appendix 3: Health and Social Care Integration National Outcomes

1) People are able to look after and improve their own health and wellbeing and live in good health for longer.
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.
3) People who use health and social care services have positive experiences of those services, and have their dignity respected.
4) Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
5) Health and social care services contribute to reducing health inequalities.
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.
7) People using health and social care services are safe from harm.
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.
9) Resources are used effectively and efficiently in the provision of health and social care services.

Appendix 4: National TEC deliverables

i. A 100% increase in the number of people receiving home health monitoring;
ii. An increase to 80,000 the number of people who are supported to self-manage via digital platforms;
iii. A marked increase in the number of people with dementia who are able to be effectively and safely supported through technology-enabled care;
iv. A marked increase in the number of people supported through the provision of telecare systems/services;
v. An integrated VC service across health & social care in at least two geographic areas – including extending the network to the third sector, independent sector and into citizens own homes;
vi. A 100% increase in the number of technology-enabled clinical & care consultations;
vii. A developing national data monitoring repository/information support system and local use of TEC data as part of routine management & planning of services;
viii. A scalable service model for home health monitoring that is efficient from both a clinical and financial perspective. This will include improved patient targeting, triaging and monitoring arrangements and the introduction of more cost effective technologies;
ix. A detailed feasibility report will be available that sets out the costs, benefits and methods of moving from analogue to digital for Telecare devices and services;
x. A sustainable funding model to support expansion of Living it Up across all of Scotland.

Integrated Care Fund

Project Financial and Non-financial Approval Criteria

July 2015

Background

The Scottish Government has announced an Integrated Care Fund (ICF) of £173.5m to support the integrated working for health and social care. Resources of £100m are to be made available to Health Boards in 2015-16. Of this, £2.13m has been allocated to the Scottish Borders.

Three workshops have been held in the Borders to review the Scottish Government guidance and develop an Integrated Care Fund Plan giving a high-level outline of how the Fund will be invested and managed locally.

Four key areas of investment have been identified as health improvement, community capacity building, access to services and early intervention and prevention which are in line with local Joint Commissioning Strategies.

At the workshop on 27 January 2015, seven service transformation projects were identified in line with the four key areas. Leads have been identified and developed project initiation documents. The seven projects are: transport hub, access to information, health improvement and self-management and long term conditions, community infrastructure, transitions model, re-ablement, co-ordination.

This paper aims to outline the process for allocating ICF funding and also the timeline for achieving this.

Process

Criteria and scoring have been developed to assess each proposal to ensure that they meet the requirements of the ICF purpose. It will also allow stakeholders to contribute and assess the strengths and weaknesses of different proposals and highlight any risks and issues.

Criteria has been developed and weighted as per the table below:

Criteria	Description	Score	Weighting
Improving and simplifying access	• Does this proposal aim to have a simplified assessment and care plan for patients?	1 - 5	15
	• Does this proposal offer improved communications for service users?		
	• Does this proposal aim for single point of access?		
	• Is there a joint approach to assessments and care planning?		
	• Is there appropriate health and care co-ordination for integrated packages of care?		
	• Does the proposal include better data sharing? For example between health and social care based on the CHI number.		
	• Does the project facilitate greater access to universal services?		
Connections across Health, Social Care and the Third Sector	• Does this proposal build and support relationships between Primary, Secondary Care and the third sector?	1 - 5	25
	• Does this proposal provide services to be created that offer an alternative to hospital stays?		
	• Does this proposal offer opportunities to harness the power of the wider community with a focus on early action and prevention?		
	• Does this proposal offer opportunities to develop different approaches that mobilise local people and are more clearly targeted at particular communities?		
	• Does the proposal provide opportunities for staff to listen to those they provide care and support for and help people to achieve what matters to them?		
Multidisciplinary Care	• Does this proposal provide opportunities to improve the management of people with long-term conditions and multi-morbidity?	1-5	25
	• Does this proposal provide opportunities to provide robust care planning?		
	• Does this proposal allow opportunities for joint working between nursing/residential homes?		

	• Does this proposal provide opportunities for regular reviews, e.g. management of medicines?		
	• Does the proposal provide opportunities for staff to listen to those they provide care and support for and help people to achieve what matters to them?		
	• Does this proposal support a learning culture so that specialist staff have better general skills, and staff in community teams develop extended roles?		
	• Does this project encourage people to have greater choice and control over their needs?		
	• Is there any agreement on the consequential impact of any changes in the acute sector?		
	• Does the application support the introduction of 7 day services in health and social care to support patients being discharged and present unnecessary admissions at weekends? •		
Workforce/resource Planning	• Does this proposal support and provide skills development for new roles/specialist skills required?	1 - 5	10
	• Does this proposal adopt shared ways of working and standardised approaches to common conditions?		
	• Does this proposal help to introduce local volunteers and new roles in GP practices to simplify access to local sources of community support, including support for unpaid carers?		
Ability to Deliver	• Can this proposal be in place within a reasonable timescale and has programme management approach been identified including spending plans?	1 - 5	25
	• Will this proposal contribute to the delivery of 3 or more of the National Outcomes?		
	• Is this proposal sustainable and does it have an exit strategy?		
	• Does this proposal offer value for money?		
	• Is it clear who the project beneficiaries are?		

	• Are there robust governance arrangements in place?		
	• Is the project innovative in its proposed and effective delivery of services?		
	• Will staff be supervised, if so by whom?		

The following scoring model has been identified in the table below:

Proposals will be scored against these criteria using a 1-5 rating:

Score	Description
1	Not compliant / consistent with criteria
2	Only limited compliance with criteria or significant limitations / compromises
3	Partial compliance with criteria, but with some limitations / compromises
4	Compliance with criteria, although with some minor limitations / compromises
5	Fully compliant with criteria

Financial criteria

1. Funding requested, analysed by each separate element.
2. Sustainability assumptions, where recurring resource will be funded to enable the project to embed.
3. Timeframe and financial requirement for delivery of project.
4. Any risks to spend, project delivery from a financial aspect, e.g. recruitment delay.
5. How successful achievement of project objectives will be measured and reported.
6. Complies with financial governance
7. Is project a test of change
8. Is there evidence that the appropriate service/ clinical board/ organisation has agreed to the project

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CHIEF OFFICER'S REPORT January 2016

Aim

1.1 To provide the Health & Social Care Integration Joint Board with an overview of activity undertaken by the Chief Officer in relation to the Integration Joint Board.

Background

2.1 The Health & Social Care Integration Joint Board will receive a report from the Chief Officer at each of its meetings.

Summary

3.1 Primary Care

Initial notification received of the GP contract with specific reference to localities and cluster models has been received from the Scottish Government. There will be discussion with local GPs as to what that means. The Integration Joint Board will be updated in terms of the links localities and information shared on the new standing arrangements.

3.2 IJB Business

The Integration Joint Board Business Plan for future formal meetings and development sessions is attached for information (Attachment 1).

3.3 Delayed Discharges

Delayed discharges for patients moving out of our hospitals continue to be a challenge. Plans are in place to meet the changing standard from no delays above two weeks to no delays above 72 hours. The General Manager for Primary and Community services and the General Manager Unscheduled Care in NHS Borders gave a presentation to the Health Board in January as an update on the winter plan. There are specific steps being taken for improving patient flow on a daily basis as well as actions to improve access to home care, discharge to assessment unit and clinical decision making. The updated winter plan will go to the Integration Joint Board to note.

3.4 Physiotherapy

Excellent progress in reducing patients' wait for MSK appointments over 9 weeks from over 1,300 at the beginning of 2015 to less than 40 as last reported to the NHS Board in January.

3.5 Further work is taking place to redesign the service to ensure improvement continues and the service is able to meet further demand in line with the Strategic Commissioning Plan.

Recommendation

The Health & Social Care Integration Joint Board is asked to **note** the report.

Policy/Strategy Implications	As detailed within the report.
Consultation	As detailed within the report.
Risk Assessment	As detailed within the report.
Compliance with requirements on Equality and Diversity	Compliant
Resource/Staffing Implications	As detailed within the report.

Approved by

Name	Designation	Name	Designation
Susan Manion	Chief Officer, Health & Social Care Integration		

Author(s)

Name	Designation	Name	Designation
Susan Manion	Chief Officer, Health & Social Care Integration		

APPOINTMENT OF CHIEF INTERNAL AUDITOR

Aim

1.1 To consider the appointment of the Chief Internal Auditor of the Health and Social Care Integration Joint Board.

Background

2.1 The Public Bodies (Joint Working) (Scotland) Act 2014 was passed by the Scottish Parliament on 25 February 2014 and establishes the framework for Integration of Health and Social Care in Scotland. The Scottish Government established the Integrated Resources Advisory Group (IRAG) to develop professional guidance. This guidance outlines that it is the responsibility of the Integration Joint Board to establish adequate and proportionate internal audit arrangements for review of the adequacy of the arrangements for risk management, governance and control of the delegated resources. This will include determining who will provide the internal audit service for the Integration Joint Board and nominating a Chief Internal Auditor.

2.2 The Integration Joint Board is required to comply with Article 7 of The Local Authority Accounts (Scotland) Regulations 2014 which states:

"7(i) A local authority must operate a professional and objective internal auditing service in accordance with recognised standards and practices in relation to internal auditing".

Proposal

3.1 In order to comply with the Regulations, it is proposed that the Internal Audit services for the Integration Joint Board will be provided by Scottish Borders Council's Internal Audit team for review of the adequacy of the arrangements for risk management, governance and control of the delegated resources. The Internal Audit service will undertake its work in compliance with the Public Sector Internal Audit Standards[1]. It is proposed that the Chief Officer Audit and Risk, Scottish Borders Council, currently Jill Stacey, is appointed to act as Integration Joint Board Chief Internal Auditor in addition to her substantive post within Scottish Borders Council.

3.2 The operational delivery of internal audit services within NHS Borders and Scottish Borders Council on behalf of the Integration Joint Board will be covered by their respective Internal Audit arrangements as at present.

3.3 On or before the start of each business year, the Integration Joint Board Chief

[1] Relevant internal audit standard setters adopted set of common internal audit standards from 1 April 2013

Internal Auditor will prepare and submit a strategic risk based audit plan to the Integration Joint Board for approval. This plan will be shared with the Audit Committee of NHS Borders and the Audit and Risk Committee of Scottish Borders Council.

3.4 The Chief Internal Auditor of the Integration Joint Board, in developing the Internal Audit plan of the Integration Joint Board, is expected to consider the risks associated with:

- The strategic plan and planning process and the adequacy of the governance arrangements;
- Financial plan underpinning the strategic plan; and
- Relevant matters raised from NHS Borders Health Board and Scottish Borders Council Chief Internal Auditors.

3.5 To ensure that the internal audit plans for the Integration Joint Board, NHS Borders and Scottish Borders Council are aligned, the Chief Internal Auditors for each of the respective bodies will share information and co-ordinate activities with each other and with other external providers of assurance to ensure proper coverage, avoid duplication of effort and determine areas of reliance.

3.6 At the conclusion of each business year the Integration Joint Board Chief Internal Auditor will submit an internal audit annual report to the Chief Officer Health and Social Care Integration and the Integration Joint Board's Audit Committee, providing the Chief Internal Auditor's opinion on the adequacy of arrangements for risk management, governance and control of delegated resources, including the extent of internal audit cover achieved and a summary of internal audit activity during the year. The internal audit annual report will also be shared with the Audit Committee of NHS Borders and the Audit and Risk Committee of Scottish Borders Council.

3.7 The Integration Joint Board Chief Internal Auditor will report on each internal audit engagement to the Chief Officer Health and Social Care Integration. The Integration Joint Board will determine any other reporting arrangements it requires from its Chief Internal Auditor.

Recommendation

The Health & Social Care Integration Joint Board is asked to:

- **appoint** Jill Stacey, Chief Officer Audit and Risk, Scottish Borders Council as Chief Internal Auditor of the Integration Joint Board; and

- **note** the content of the report.

Policy/Strategy Implications	The appointment of a Chief Internal Auditor is one of the key components of good governance. In compliance with the Public Bodies (Joint Working) (Scotland) Act 2014 and any consequential Regulations, Orders, Directions and Guidance.
Consultation	Members of the Integration Programme Board have been consulted on the report. The report has also been reviewed by and

	approved by relevant Management Teams within both partner organisations.
Risk Assessment	Approval of the appointment of the Chief Internal Auditor will ensure that the Integration Joint Board complies with professional guidance issued by the Integrated Resources Advisory Group (IRAG) in compliance with The Public Bodies (Joint Working) (Scotland) Act 2014 and complies with The Local Authority Accounts (Scotland) Regulations 2014.
Compliance with requirements on Equality and Diversity	It is anticipated that there are no adverse impact due to race, disability, gender, age, sexual orientation or religion/belief arising from the proposals in this report.
Resource/Staffing Implications	There are no additional costs associated with the recommendation to appoint Mrs Stacey as Chief Internal Auditor to the IJB in addition to her substantive role as Chief Officer Audit and Risk of Scottish Borders Council. However it should be noted that provision of internal audit services to the IJB is subject to their being adequate staff and other resources in place for 2016/17 and beyond. The Health and Social Care Integration Scheme for the Scottish Borders, which is anticipated to be approved on 8 February 2016, states that Scottish Borders Council and Borders Health Board will by the end of March 2016, have: identified the corporate resources used to deliver the delegated functions; and agreed the corporate support services required to fully discharge Integration Joint Board duties under the Act. These support services will include Internal Audit.

Approved by

Name	Designation	Name	Designation
Susan Manion	Chief Officer Health and Social Care Integration		

Author(s)

Name	Designation	Name	Designation
Jill Stacey	Chief Officer Audit and Risk		

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INTEGRATION JOINT BOARD AUDIT COMMITTEE ARRANGEMENTS

Aim

1.1 The purpose of this report is to recommend the establishment of an Audit Committee for the Scottish Borders Health and Social Care Integration Joint Board (IJB) and to agree the Terms of Reference for the IJB Audit Committee.

Background

2.1 The Public Bodies (Joint Working) (Scotland) Act 2014 was passed by the Scottish Parliament on 25 February 2014 and establishes the framework for Integration of Health and Social Care in Scotland. The Scottish Government established the Integrated Resources Advisory Group (IRAG) to develop professional guidance. This guidance outlines that it is the responsibility of the Integration Joint Board to make appropriate and proportionate arrangements for consideration of the audit provision and annual financial statements which are compliant with good practice governance standards in the public sector.

2.2 The Integration Joint Board is required to comply with The Local Authority Accounts (Scotland) Regulations 2014.

Summary

3.1 In order to comply with the Regulations, it is proposed that the Integration Joint Board establishes an Audit Committee as part of its governance arrangements.

3.2 The Health and Social Care Integration Scheme for the Scottish Borders, which is anticipated to be approved on 8 February 2016, states that the Integration Joint Board (IJB) may establish an Audit Committee to seek and secure assurance over effective governance and to focus on financial, audit and governance matters, including (where necessary) making recommendations. The Integration Joint Board will require to establish a forum where these issues are discussed and it is recommended that an Audit Committee is established which will meet at least twice per year. This will include any reports from Internal Audit and External Audit and the annual accounts.

3.3 The role of the Audit Committee will be to provide high-level oversight of the IJB's governance, risk management and control frameworks and to oversee the financial reporting and annual governance processes. It will receive reports from Internal Audit and External Audit, helping to ensure efficient and effective assurance

arrangements are in place.

3.4 It will be the responsibility of the Integration Joint Board to agree the membership having regard to the agreed remit, skills and good practice for a public sector Audit Committee[1].

3.5 IRAG in its Guidance for Integration Financial Assurance recognises that the post-integration period is a critical stage of the change process and the IJB Audit Committee has a key role in ensuring that an effective assurance process is in place to enable the IJB to fulfil its objectives through the assessment of the resources delegated to it, the financial, legal and operational risks, and post integration performance results. IRAG has recommended that the IJB Audit Committee is provided with a post integration report within the first year of the establishment of the IJB to evaluate the actual risk and financial performance against the post-integration assumptions, performance on relevant integration milestones, identify lessons learned and assess whether the IJB is on course to deliver long term benefits. The results of this review should be shared with the Scottish Government to enable wider learning.

3.6 The draft Terms of Reference for the Integration Joint Board Audit Committee is presented as Appendix 1 to this report.

Recommendation

The Health & Social Care Integration Joint Board is asked to:

- **Agree** to establish an Audit Committee as part of the governance arrangements of the Health and Social Care Integration Joint Board; and

- **Approve** the Terms of Reference of the IJB Audit Committee as detailed in Appendix 1 of this report.

Policy/Strategy Implications	The establishment of an Audit Committee is one of the key components of good governance. In compliance with the Public Bodies (Joint Working) (Scotland) Act 2014 and any consequential Regulations, Orders, Directions and Guidance.
Consultation	Members of the Integration Programme Board have been consulted on the report. The report has also been reviewed by and approved by relevant Management Teams within both partner organisations.
Risk Assessment	Approval of the establishment of the IJB Audit Committee will ensure that the Integration Joint Board complies with its Scheme of Integration and professional

[1] On Board: A Guide for Board Members on Public Bodies in Scotland, 2006 , section 4.8 Audit Committees http://www.scotland.gov.uk/Topics/Government/public-bodies/On-Board

	guidance issued by the Integrated Resources Advisory Group (IRAG) and operates in compliance with The Public Bodies (Joint Working) (Scotland) Act 2014.
Compliance with requirements on Equality and Diversity	It is anticipated that there are no adverse impact due to race, disability, gender, age, sexual orientation or religion/belief arising from the proposals in this report.
Resource/Staffing Implications	There are no direct financial implications arising from the proposals in this report. However it should be noted that provision of committee support services to the IJB and its committee(s) will be required.

Approved by

Name	Designation	Name	Designation
Susan Manion	Chief Officer Health and Social Care Integration		

Author(s)

Name	Designation	Name	Designation
Jill Stacey	Chief Officer Audit and Risk		

Appendix 1

SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD (IJB)
AUDIT COMMITTEE TERMS OF REFERENCE

Constitution
The IJB shall appoint the Committee. The Committee will consist of at least four voting members of the IJB, excluding professional advisors. The Committee should agree the professional advisors it requires on a regular and adhoc basis. The Committee is required to review its terms of reference on an annual basis.

The Committee will meet at least twice per annum. The Committee will be supported and serviced by the Chief Financial Officer. The Audit Committee should report to the IJB.

Chair
The Chair of the Committee will be a voting member nominated by the IJB, noting that the Chair of the IJB cannot also chair the Audit Committee.

Quorum
Three members of the Committee will constitute a quorum.

Functions Referred
The following functions of the IJB shall stand referred to the Audit Committee -

1. Assess the adequacy and effectiveness of the IJB's internal controls and corporate governance arrangements against the good governance framework and consider the annual governance reports and assurances to ensure that the highest standards of probity and public accountability are demonstrated;

2. Ensure existence of and compliance with an appropriate Risk Management Strategy. Review risk management arrangements and receive regular risk management updates and reports;

3. Review and approve the Internal Audit Annual Plan on behalf of the IJB, receive reports and oversee and review progress on actions taken on audit recommendations and report to the IJB on these as appropriate;

4. Consider the External Audit Annual Plan on behalf of the IJB, receive reports and consider matters arising from these and management actions identified in response before submission to the IJB;

5. Consider annual financial accounts and related matters before submission to and approval by the IJB; and

6. Promote the highest standards of conduct and professional behaviour by IJB members in line with The Ethical Standards and Public Life etc (Scotland) Act 2000.

7. The committee is responsible for ensuring best value for those delegated functions.

8. The Committee is authorised by the IJB to investigate any activity within its terms of reference, and in so doing, may seek any information it requires.

MONITORING OF THE INTEGRATED JOINT BUDGET 2015/16

Aim

1.1 To provide the Integrated Joint Board with a full report, on the Partnership's Integrated Budget based on the actual expenditure outturn as at 31st December 2015.

Background

2.1 The total revised Integrated Joint Budget stands currently at £136.97m.

2.2 The services contained within this report relate to national guidance issued following the consultation.

2.3 It was agreed that 2015/16 will be a shadow year and the integrated budget will be on an aligned basis. Therefore any cost pressures remain the responsibility of the partner organisations.

Outturn

3.1 The revenue monitoring position reported to the Board is based on the actual out turn as at the 31st December 2015. As at the end of December the Partnership's expenditure position was £1.1m overspent against budget to date and projecting a year end out turn position of £0.466m overspent against the revised annual budget. The projected year end out turn overspend mainly relates to generic services offset by an underspend on Mental Health Services. Further analysis of this position is detailed below. This is an improved position from the October report. SBC services are now projecting a break even position at the year end, predicated on an additional contribution from SB Cares of £55k (a further 11.5% on planned contribution) and additional resources of £52k from elsewhere across the People Department within Scottish Borders Council.

3.2 The projected outturn pressures within the Social Care element of the Integrated Budget have reduced consistently over recent months due to the implementation and delivery of a range of savings actions including rigorous challenge of all new clients' care and support planning, review and reduction of existing care packages, a large-scale vacancy freeze and the delayed implementation of the Dementia Care team. A reduction in the number of clients requiring residential care during December has helped considerably also, alongside a contribution from the SBC's People Department Business and Performance service. NHS Borders continues to ensure that all possible actions are taken to minimise the projected overspend but the main element of overspend continues to be GP Prescribing over which the Board has little control.

Key Issues

4.1 Joint Mental Health Service

At December the Mental Health Service are reporting an underspend of £53k This underspend (£168K) is mainly within mental health services within NHS Borders and relates to staffing vacancies. This underspend is being offset by higher costs in Social Care due to a new admission. It is anticipated the Social Care overspend will be brought back into line prior to year end.

4.2 Older Peoples Service

The Older Peoples Service in Scottish Borders Council is overspent by £0.462m at the end of December with a projected overspend of £0.137m by the end of the year. There has been a reduction in the number of clients in receipt of residential care during December which it is anticipated will continue to the end of the financial year.

4.3 Generic Services

Generic Services are £0.486m overspent at the end of December and it is predicted that the heading will be overspent by £0.586m at the year end. The main issues within generic services continue to be GP Prescribing offset by underspends in dental, smoking cessation, and sexual health services.

4.4 The GP prescribing budget is reporting an overspend of £0.673m at the end of December and a year end out turn of £1.0m overspent. This prediction is as robust as current information allows but due to the normal time lag in receiving information variation is still possible. Currently seven month's price data and eight months volume data have been received. The key issue continues to be volatility in global drug prices over which NHS Borders has limited control. The Medicines Resource Group locally continues to recommend the most cost effective drugs taking into account patient safety. Work is ongoing nationally to identify how NHS Scotland can address the price changes which are impacting on all NHS Boards.

4.5 Dental services are underspent by £0.2m at the end of December with a similar position projected at year end after offsetting any agreed efficiencies. The staffing vacancies which have created this underspend have now in the main been filled.

4.6 The smoking cessation service is currently underspent and this is expected to continue for the remainder of the year due to reduced up take of this service.

4.7 The Integrated Care fund £2.130m is included under generic services. To date potential project expenditure of £479k has been identified. Any underspend at the year end will be carried forward into next financial year through a ring fenced agreement with Scottish Borders Council.

Summary

5.1 The revenue monitoring position set out in this report is based on the actual income and expenditure to the 31st December 2015. The Partnership is reporting an out turn position of £1.1m overspent to the end of December and is projecting a year end adverse out turn of £0.466m. Both organisations will continue working to minimise this overspend. As the budgets are on an aligned basis any year end overspend will be met by the relevant responsible organisation.

Recommendation

It is recommended that the Health & Social Care Integration Joint Board **note** the budget monitoring reports at Appendix 1.

Policy/Strategy Implications	In compliance with the Public Bodies (Joint Working) (Scotland) Act 2014 and any consequential Regulations, Orders, Directions and Guidance.
Consultation	Members of the Integration Programme Board have been consulted on the report and the position reported to the Shadow Board. The report has also been reviewed by and approved by relevant Management Teams within both partner organisations.
Risk Assessment	A full risk assessment and risk monitoring process for the Integration Programme is being developed as part of the Integration Programme arrangements.
Compliance with requirements on Equality and Diversity	An equality impact assessment will be undertaken on the arrangements for Joint Integration when agreed.
Resource/Staffing Implications	It is anticipated that the Integration Shadow Board will oversee services which have a budget of over £130m, within the existing scope. The budget will change as other functions are brought within the scope of the Integration Shadow Board.

Approved by

Name	**Designation**	**Name**	**Designation**
David Robertson	Chief Financial Officer	Carol Gillie	Director of Finance

Author(s)

Name	**Designation**	**Name**	**Designation**
Paul McMenamin	Business Partner	Janice Cockburn	Deputy Director of Finance

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MONTHLY REVENUE MANAGEMENT REPORT

Joint Health and Social Care Budget -SBC | **2015/16** | **AT END OF MTH: December**

	Base Budget £'000	Profiled to Date £'000	Actual to Date £'000	To date Variance £'000	Revised Budget £'000	Actual Outturn £'000	Outturn Variance £'000	Base WTE	Summary Financial Commentary
Joint Learning Disability Service	**14,488**	**10,451**	**10,480**	**(29)**	**14,745**	**14,745**	**0**	**32**	
Residential Care	1,492	1,095	1,441	(346)	1,492	1,499	(7)	0	
SBC Carers	2,065	1,552	1,710	(158)	2,062	2,059	3	0	
Homecare	667	2,019	1,319	700	2,696	2,786	(90)	0	
Day Care	791	439	502	(63)	632	658	-26	3	
Community Based Services	8,181	4,311	4,571	(260)	6,476	6,371	105	0	
Respite	200	142	145	(3)	200	215	(15)	0	
Same as You	0			0	0		0	0	
Other	1,092	893	792	101	1,187	1,157	30	29	
Joint Mental Health Service	**1,988**	**1,336**	**1,451**	**(115)**	**1,887**	**1,887**	**0**	**25**	
Residential Care	21	0	0	0	0	0	0	0	
Homecare	227	144	148	(4)	200	201	(1)	0	
Day Care	182	135	115	20	181	175	6	5	New admission has increased
Community Based Services	835	470	592	(122)	720	694	26	0	projected costs recently but
Respite	15	11	46	(35)	15	30	(15)	0	overall forecasting a
SDS	44	79	83	(4)	107	113	(6)	0	breakeven outturn
Choose Life	69	0	0	0	0	0	0	0	
Mental Health Team	595	497	467	30	664	674	(10)	20	
Joint Alcohol and Drug Service	**197**	**116**	**151**	**-35**	**202**	**185**	**17**	**0**	
D & A Commissioned Services	177	124	49	75	177	155	22	0	
D & A Team	20	(8)	102	(110)	25	30	(5)	0	
Older People Service	**23,668**	**16,987**	**17,449**	**(462)**	**24,075**	**24,212**	**(137)**	**23**	Ongoing additional pressure
Residential Care	5,557	4,422	4,736	(314)	6,353	6,483	(130)	0	in homecare and residential
Homecare	8,107	5,797	5,715	82	7,935	8,053	(118)	0	care although there was a
Day Care	198	120	4	116	210	234	(24)	0	considerable reduction on the
Community Based Services	1,018	938	1,100	(162)	1,426	1,435	(9)	16	number of clients in receipt of
Extra Care Housing	6,792	5,455	6,659	(1204)	7,478	7,462	16	0	the latter during December
Housing with Care	283	307	280	27	439	439	0	0	resulting in an overall
Dementia Services	0			0	0	0	0	0	breakeven position on the
Delayed Discharge	267	100	208	(108)	267	267	0	0	integrated budget to be
Other	1,446	(152)	(1253)	1101	-33	(161)	128	7	projected as a whole
Change Fund									
Physical Disability Service	**3,250**	**2,429**	**2,667**	**(238)**	**3,258**	**3,258**	**0**	**0**	Physical Disability service
Residential Care	503	354	351	3	503	372	131	0	now projecting breakeven
Homecare	1,801	1,239	1,271	(32)	1,671	1,675	(4)	0	position as a result of transfer
Day Care	192	146	163	(17)	195	196	(1)	0	of uncommitted demographic
Community Based Services	682	636	822	(186)	817	943	(126)	0	increases in budget and a
Other	72	54	60	(6)	72	72	0	0	reduction in hours provided

MONTHLY REVENUE MANAGEMENT REPORT								
Joint Health and Social Care Budget -SBC		2015/16			AT END OF MTH:	December		
								within a specific care package

MONTHLY REVENUE MANAGEMENT REPORT

Joint Health and Social Care Budget -SBC | **2015/16** | **AT END OF MTH: December**

	Base Budget £'000	Profiled to Date £'000	Actual to Date £'000	To date Variance £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Base WTE	Summary Financial Commentary
Generic Services	**3,977**	**2,528**	**2,626**	**(98)**	**3,585**	**3,465**	**120**	**97**	
Community Hospitals	0	0	0	0			0	0	
GP Prescribing	0	0	0	0			0	0	
AHP Services	0	0	0	0			0	0	
General Medical Services	0	0	0	0			0	0	
Community Nursing	0	0	0	0			0	0	
Assesment and Care Management	238	180	223	(43)	300	298	2	0	
Group Managers	263	111	122	(11)	150	164	(14)	0	
Service Managers	160	2	1	1	4	1	3	0	
Planning Team	247	167	117	50	226	132	94	0	Progress ongoing across
Locality Offices	2,636	2,011	1,799	212	2,595	2,442	153	69	Generic Services to deliver
SB Carers	471	408	562	(154)	473	475	(2)		planned remedial savings
BAES		0	0	0					particularly relating to a
Duty Hub	51	0	7	(7)	0	13	(13)	0	vacancy freeze and allocation
Extra Care Housing	0	0		0			0	0	of cash savings targets across
Joint Health Improvement	56	42	1	41	56	54	2	0	localities. Almost £200k of
Respite	42	9	6	3	12	8	4	0	previously targeted savings
SDS	96	37	(72)	109	97	96	1	0	will not be delivered (Other)
OT	58	44	48	(4)	75	75	0	0	but offset by saving across
Grants to Voluntary	43	32	24	8	43	34	9	0	other service areas
Out of Hours	110	34	1	33	117	67	50	0	
Community Based Services	7	4	21	(17)	6	34	(28)		
Sexual Health				0			0	0	
Public dental Services	0			0			0	0	
Community Pharmacy Services	0			0			0	0	
Continence Services	0			0			0	0	
Smoking Cessation	0			0			0	0	
Primary & Community Management				0					
Health Promotion				0					
Ophthalmic Services				0					
Patient Transport	0			0			0	0	
Accommodation Costs	0			0			0	0	
Resource Transfer	0			0			0	0	
Other	(501)	(193)	126	(319)	(89)	106	(195)	28	Increased contribution to wider pressure in integrated budget from SB Care
SB Cares Contribution to General Fund		(360)	(360)	0	(480)	(534)	54		
Total	**47,568**	**33,847**	**34,824**	**(977)**	**47,752**	**47,752**	**0**	**177**	
Financed By:									
AEF, Council Tax and Fees & Charges									
NHS Funding from Sgovt etc									
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**		

MONTHLY REVENUE MANAGEMENT REPORT			
Joint Health and Social Care Budget -SBC	2015/16	AT END OF MTH:	December

Joint Health and Social Care Budget	NHS	2015/16			AT END OF MTH:	December					
	Base Budget £'000	Profiled to Date £'000	Actual to Date £'000	To date Variance £'000	Revised Budget £'000	Actual Outturn £'000	Outturn Variance £'000	Base WTE	YTD WTE	Current Month WTE	Summary Financial Commentary
Joint Learning Disability Service	**3,585**	**2,688**	**2,606**	**82**	**3,585**	**3,545**	**40**	**21**	**19**	**20**	
Residential Care	2,689	2,017	1,969	48	2,689	2,689	0	0	0	0	Fluctuating demand for assessment & treatment
SBC Carers											
Homecare				0			0	0	0	0	
Day Care				0			0	0	0	0	
Community Based Services				0			0	0	0	0	
Respite				0			0	0	0	0	
Same as You				0			0	0	0	0	
Other	896	671	637	34	896	856	40	21	19	20	Staffing vacancies
Joint Mental Health Service	**13,807**	**10,346**	**10,178**	**168**	**13,850**	**13,665**	**200**	**319**	**311**	**320**	
Residential Care	0	0	0	0	0	0	0	0	0	0	
Homecare	0	0	0	0	0	0	0	0	0	0	
Day Care	0	0	0	0	0	0	0	0	0	0	
Community Based Services	0	0	0	0	0	0	0	0	0	0	
Respite	0	0	0	0	0	0	0	0	0	0	
SDS	0	0	0	0	0	0	0	0	0	0	
Choose Life	0	0	0	0	0	0	0	0	0	0	
Mental Health Team	13,807	10,346	10,178	168	13,865	13,665	200	319	311	320	Staffing vacancies
Joint Alcohol and Drug Service	**879**	**638**	**638**	**0**	**879**	**879**	**0**	**3**	**3**	**3**	BAS reported under mental health
D & A Commissioned Services	768	536	536	0	768	768	0	0	0	0	
D & A Team	111	102	102	0	111	111	0	3	3	3	
Older People Service	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	
Residential Care	0	0	0	0	0	0	0	0	0	0	
Homecare	0	0	0	0	0	0	0	0	0	0	
Day Care	0	0	0	0	0	0	0	0	0	0	
Community Based Services	0	0	0	0	0	0	0	0	0	0	
Extra Care Housing	0	0	0	0	0	0	0	0	0	0	
Housing with Care											
Dementia Services	0	0	0	0	0	0	0	0	0	0	
Delayed Discharge	0	0	0	0	0	0	0	0	0	0	
Other	0	0	0	0	0	0	0	0	0	0	
Change Fund	0	0	0	0	0	0	0	0	0	0	
Physical Disability Service	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	
Residential Care	0	0	0	0	0	0	0	0	0	0	
Homecare	0	0	0	0	0	0	0	0	0	0	
Day Care	0	0	0	0	0	0	0	0	0	0	
Community Based Services	0	0	0	0	0	0	0	0	0	0	
Other	0	0	0	0	0	0	0	0	0	0	

Joint Health and Social Care Budget	NHS	2015/16	0	AT END OF MTH:	December

	Base Budget £'000	Profiled to Date £'000	Actual to Date £'000	To date Variance £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Base WTE	YTD WTE	Current Month WTE	Summary Financial Commentary
Generic Services	**70,435**	**51,820**	**52,208**	**(388)**	**70,891**	**71,597**	**(706)**	**506**	**497**	**505**	
Community Hospitals	4,593	3,474	3,491	(17)	4,651	4,672	(21)	125	128	133	
GP Prescribing	21,349	15,885	16,558	(673)	20,935	21,935	(1000)	0	0	0	Increased drug prices
AHP Services	5,445	4,145	4,142	3	5,579	5,609	(30)	146	137	144	
General Medical Services	16,132	12,696	12,659	37	16,929	16,878	51	4	4	4	
Community Nursing ex HV/SN	4,232	3,191	3,155	36	4,272	4,224	48	114	102	101	
Assesment and Care Management				0			0	0	0	0	
Group Managers	0			0			0	0	0	0	
Service Managers	0			0			0	0	0	0	
Planning Team	0			0			0	0	0	0	
Locality Offices	0			0			0	0	0	0	
SB Carers											
BAES	246	184	191	(7)	246	246	0	0	0	0	
Duty Hub				0			0	0	0	0	
Extra Care Housing	0			0			0	0	0	0	
Joint Health Improvement	0			0			0	0	0	0	
Respite	0			0			0	0	0	0	
SDS	0			0			0	0	0	0	
OT	0			0			0	0	0	0	
Grants to Voluntary	0			0			0	0	0	0	
Out of Hours	0			0			0	0	0	0	
Community Based Services	0										
Sexual Health	599	467	407	60	624	549	75	7	6	6	
Public dental Services	3,992	2,771	2,568	203	3,667	3,421	246	81	80	78	
Community Pharmacy Services	3,856	3,022	3,022	0	3,933	3,933	0	0	0	0	
Continence Services	435	334	364	(30)	441	477	(36)	3	3	3	Increased demand for service
Smoking Cessation	255	182	129	53	243	171	72	4	4	4	Reduction in patient numbers
Primary & Community Management	1,617	1,232	1,337	(105)	1,696	1,836	(140)	15	21	19	Continued use of flex beds
Health Promotion	508	365	346	19	522	498	24	8	12	12	
Opthalmic Services	1,605	1,257	1,257	0	1,591	1,591	0	0	0	0	
Patient Transport				0			0	0	0	0	
Accomodation Costs	878	658	626	32	823	823	0	0	0	0	
Resource Transfer	2,563	1,957	1,956	1	2,609	2,604	5	0	0	0	
Other	2,130	0	0	0	2,130	2,130	0	0	0	0	
Total	**88,706**	**65,492**	**65,630**	**(138)**	**89,205**	**89,686**	**(466)**	**849**	**829**	**847**	
Financed By:											
AEF, Council Tax and Fees & Charges											
NHS Funding from Sgovt etc											

Joint Health and Social Care Budget	NHS	2015/16		0	AT END OF MTH:	December					
Total	0	0	0	0	0	0	0	0	0	0	

MONTHLY REVENUE MANAGEMENT REPORT

Joint Health and Social Care Budget | **2015/16** | **AT END OF MTH: December**

	Base Budget £'000	Profiled to Date £'000	Actual to Date £'000	To date Variance £'000	Revised Budget £'000	Actual Outturn £'000	Outturn Variance £'000	Base WTE	YTD WTE	Current Month WTE	Summary Financial Commentary
Joint Learning Disability Service	**18,073**	**13,139**	**13,086**	**53**	**18,330**	**18,290**	**40**	**53**	**19**	**20**	
Residential Care	4,181	3,112	3,410	(298)	4,181	4,188	(7)	0	0	0	
SBC Carers	2,065	1,552	1,710	(158)	2,062	2,059	3	0	0	0	
Homecare	667	2,019	1,319	700	2,696	2,786	(90)	0	0	0	
Day Care	791	439	502	(63)	632	658	(26)	3	0	0	
Community Based Services	8,181	4,311	4,571	(260)	6,476	6,371	105	0	0	0	
Respite	200	142	145	(3)	200	215	(15)	0	0	0	
Same as You	0	0	0	0	0	0	0	0	0	0	
Other	1,988	1,564	1,429	135	2,083	2,013	70	50	19	20	
Joint Mental Health Service	**15,795**	**11682**	**11629**	**53**	**15752**	**15552**	**200**	**344**	**311**	**320**	
Residential Care	21	0	0	0	0	0	0	0	0	0	
Homecare	227	144	148	(4)	200	201	(1)	0	0	0	
Day Care	182	135	115	20	181	175	6	5	0	0	
Community Based Services	835	470	592	(122)	720	694	26	0	0	0	
Respite	15	11	46	(35)	15	30	(15)	0	0	0	
SDS	44	79	83	(4)	107	113	(6)	0	0	0	
Choose Life	69	0	0	0	0	0	0	0	0	0	
Mental Health Team	14,402	10843	10645	198	14529	14339	190	339	311	320	
Joint Alcohol and Drug Service	**1,076**	**754**	**789**	**(35)**	**1081**	**1064**	**17**	**3**	**3**	**3**	
D & A Commissioned Services	945	660	585	75	945	923	22	0	0	0	
D & A Team	131	94	204	(110)	136	141	(5)	3	3	3	
Older People Service	**23,668**	**16987**	**17449**	**(462)**	**24075**	**24212**	**(137)**	**23**	**0**	**0**	
Residential Care	5,557	4,422	4,736	(314)	6,353	6,483	(130)	0	0	0	
Homecare	8,107	5,797	5,715	82	7,935	8,053	(118)	0	0	0	
Day Care	198	120	4	116	210	234	(24)	0	0	0	
Community Based Services	1,018	938	1,100	(162)	1,426	1,435	(9)	16	0	0	
Extra Care Housing	6,792	5,455	6,659	(1204)	7,478	7,462	16	0	0	0	
Housing with Care	283	307	280	27	439	439	0	0	0	0	
Dementia Services	0	0	0	0	0	0	0	0	0	0	
Delayed Discharge	267	100	208	(108)	267	267	0	0	0	0	
Other	1,446	(152)	(1253)	1101	-33	(161)	128	7	0	0	
Change Fund	0	0	0	0	0	0	0	0	0	0	
Physical Disability Service	**3,250**	**2,429**	**2,667**	**(238)**	**3,258**	**3,258**	**0**	**0**	**0**	**0**	
Residential Care	503	354	351	3	503	372	131	0	0	0	
Homecare	1,801	1,239	1,271	(32)	1,671	1,675	(4)	0	0	0	
Day Care	192	146	163	(17)	195	196	(1)	0	0	0	
Community Based Services	682	636	822	(186)	817	943	(126)	0	0	0	
Other	72	54	60	(6)	72	72	0	0	0	0	

MONTHLY REVENUE MANAGEMENT REPORT

Joint Health and Social Care Budget | **2015/16** | **AT END OF MTH: December**

	Base Budget £'000	Profiled to Date £'000	Actual to Date £'000	To date Variance £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Base WTE	YTD WTE	Current Month WTE	Summary Financial Commentary
Generic Services	**74412**	**54386**	**54834**	**(486)**	**74476**	**75062**	**(586)**	**603**	**497**	**505**	
Community Hospitals	4,593	3,474	3,491	(17)	4,651	4,672	(21)	125	128	133	
GP Prescribing	21,349	15,885	16,558	(673)	20,935	21,935	(1000)	0	0	0	Risk area for the partnership due to price volitility and currently little information
AHP Services	5,445	4,145	4,142	3	5,579	5,609	(30)	146	137	144	
General Medical Services	16,132	12,696	12,659	37	16,929	16,878	51	4	4	4	
Community Nursing	4,232	3,191	3,155	36	4,272	4,224	48	114	102	101	
Assesment and Care Management	238	180	223	(43)	300	298	2	0	0	0	
Group Managers	263	111	122	(11)	150	164	(14)	0	0	0	
Service Managers	160	2	1	1	4	1	3	0	0	0	
Planning Team	247	167	117	50	226	132	94	0	0	0	
Locality Offices	2,636	2,011	1,799	212	2,595	2,442	153	69	0	0	
SB Carers	471	408	562	(154)	473	475	-2	0	0	0	
BAES	246	184	191	(7)	246	246	0	0	0	0	
Duty Hub	51	42	7	(7)	0	13	(13)	0	0	0	
Extra Care Housing	0	9	0	0	0	0	0	0	0	0	
Joint Health Improvement	56	37	1	41	56	54	2	0	0	0	
Respite	42	44	6	3	12	8	4	0	0	0	
SDS	96	32	-72	109	97	96	1	0	0	0	
OT	58	34	48	(4)	75	75	0	0	0	0	
Grants to Voluntary	43	4	24	8	43	34	9	0	0	0	
Out of Hours	110	34	1	33	117	67	50	0	0	0	
Community Based Services	7	4	21	-17	6	34	-28	0	0	0	
Sexual Health	599	467	407	60	624	549	75	7	6	6	
Public dental Services	3,992	2,771	2,568	203	3,667	3,421	246	81	80	78	
Community Pharmacy Services	3,856	3,022	3,022	0	3,933	3,933	0	0	0	0	
Continence Services	435	334	364	(30)	441	477	(36)	3	3	3	
Smoking Cessation	255	182	129	53	243	171	72	4	4	4	
Primary & Community Management	1,617	1,232	1,337	(105)	1,696	1,836	(140)	15	21	19	
Health Promotion	508	365	346	19	522	498	24	8	12	12	
Opthalmic Services	1,605	1,257	1,257	0	1,591	1,591	0	0	0	0	
Patient Transport	0	0	0	0	0	0	0	0	0	0	
Accomodation Costs	878	658	626	32	823	823	0	0	0	0	
Resource Transfer	2,563	1,957	1,956	1	2,609	2,604	5	0	0	0	
Other	1,629	(193)	126	(319)	2,041	2,236	(195)	28	0	0	
SB Cares Contribution to General Fund	0	(360)	(360)	0	(480)	(534)	54	0	0	0	
Total	**136,274**	**99,377**	**100,454**	**(1115)**	**136,972**	**137,438**	**(466)**	**1026**	**829**	**847**	
Financed By:											
AEF, Council Tax and Fees & Charges	0	0	0	0	0	0	0	0	0	0	
NHS Funding from Sgovt etc	0	0	0	0	0	0	0	0	0	0	
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	

MONTHLY REVENUE MANAGEMENT REPORT

Joint Health and Social Care Budget | **2015/16** | **AT END OF MTH: December**

	Base Budget £'000	Profiled to Date £'000	Actual to Date £'000	To date Variance £'000	Revised Budget £'000	Actual Outturn £'000	Outturn Variance £'000	Base WTE	YTD WTE	Current Month WTE	Summary Financial Commentary
Joint Learning Disability Service	**18,073**	**13,139**	**13,086**	**53**	**18,330**	**18,290**	**40**	**53**	**19**	**20**	Staff vacancies and review and management of care packages a have created underspend
Joint Mental Health Service	**15,795**	**11,682**	**11,629**	**53**	**15,752**	**15,552**	**200**	**344**	**311**	**320**	
Joint Alcohol and Drug Service	**1,076**	**754**	**789**	**(35)**	**1,081**	**1,064**	**17**	**3**	**3**	**3**	
Older People Service	**23,668**	**16,987**	**17,449**	**(462)**	**24,075**	**24,212**	**(137)**	**23**	**0**	**0**	
Physical Disability Service	**3,250**	**2,429**	**2,667**	**(238)**	**3,258**	**3,258**	**0**	**0**	**0**	**0**	
Generic Services	**74,412**	**54,386**	**54,834**	**(486)**	**74,476**	**75,062**	**(586)**	**603**	**497**	**505**	Risk continues around GP Precribing due to drug prices as volumes are as expected. Concern regarding the robustness of prediction due time lag in data.
Total	**136,274**	**99,377**	**100,454**	**(1115)**	**136,972**	**137,438**	**(466)**	**1026**	**829**	**847**	
Financed By:											
AEF, Council Tax and Fees & Charges	0	0	0	0	0	0	0				
NHS Funding from Sgovt etc	0	0	0	**0**	0	0	0				
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**				

INTEGRATED JOINT BOARD GOVERNANCE – DRAFT FINANCIAL REGULATIONS

Aim

1.1 The purpose of this report is to provide the Integration Joint Board (IJB) with draft Financial Regulations, for noting and approval prior to 1st April 2016.

Background

2.1 For the last 2 years, NHS Borders and Scottish Borders Council Finance Staff have been working closely to ensure appropriate financial arrangements are in place to support the IJB as part of the Finance Workstream. Development of a robust set of Financial Regulations consistent with those already applied within NHS Borders and Scottish Borders Council is a key objective and deliverable from this workstream.

2.2 Accordingly, Scottish Borders Council's Financial Regulations will be reviewed and revised where appropriate in order to ensure they are consistent with and complement these IJB Financial Regulations, as will the Standing Financial Instructions for NHS Borders to recognise the impact of the IJB.

Summary

3.1 This report provides the background to and current issues relating to the draft Financial Regulations relating to the Scottish Borders Integrated Joint Board. The Financial Regulations have been developed in partnership between the IJB Chief Officer, NHS Borders and Scottish Borders Council as part of the Finance Workstream and are intended to provide the financial governance framework within which the IJB will operate. A copy of the draft Financial Regulations is included as Appendix 1 to this report.

3.2 The Financial Regulations are informed professional guidance developed by the Integrated Resources Advisory Group (IRAG), a national group established to develop guidance to support the implementation of the Public Bodies Joint Working (Scotland) Act 2014, together with work to date from officer working groups comprising NHS and Local Authority finance professionals developing IRAG guidance into a set of procedures that will support the IJB in decision making in strategic and operational finance matters. Reference has also been made to other IJB's Financial Regulations already approved and/or implemented across Scotland so far.

3.3 These Draft Financial Regulations remain subject to revision in order to reflect ongoing local and national work in a number of areas including:

- Treatment of VAT

- Treatment of overheads and support services
- Reserves strategy
- Year end accounts – treatment and content

Financial Governance

4.1 A number of key financial principles underpinning the financial governance of the IJB's activities have been developed or are in development, to be completed and implemented by the end of 2015/16. These cover a wide range of areas including:

- Financial Regulations and Standing Financial Instructions
- Governance Statement and Statement of Internal Control
- Risk Management, Insurance and Business Continuity
- Managing Integrated Budgets Guiding Principles and the Treatment of Planned and Windfall Over and Underspends
- Budget Setting and Financial Planning process
- Scheme of Virement
- Capital Planning Process
- Managing Financial Performance
- Financial Governance Checklist
- Internal and External Audit Arrangements
- Reserves Strategy and the carry forward of Resources
- Annual Accounts (national issue)
- Treatment of VAT (national issue)

4.2 These policies will be customised for the Scottish Borders IJB beginning with a draft set of Financial Regulations for consideration and approval by the IJB Audit Committee, in January 2016. There are no specific issues to highlight and there is no conflict with Scottish Borders Council's Financial Regulations or NHS Borders Standing Financial Instructions.

4.3 Subsequent updates will be brought for approval, to the IJB Audit Committee, as each of the remaining outstanding issues is resolved. In addition to the issues above work remains ongoing on the treatment of overheads and running costs relating specifically to the IJB.

Operational Considerations

5.1 As previously discussed, a commencement date of 1 April 2016 for financial responsibilities of the IJB will allow a clean and transparent transfer of resources, including set aside budgets for large hospital services, for the IJB and its partners. This will align with the Strategic Plan covering the period 2016-19.

5.2 In the interim, aligned financial reporting will continue to be brought to the IJB for information, with inclusion of large hospital set aside and hosted service budgets and an integrated budget on agreed final position on the integrated scope from April 2016. This will be based on the Financial Statement which will be reported to the IJB in March 2016 and which will support the delivery of the 3-year strategic plan.

5.3 Financial reporting will broadly follow the integrated reporting previously presented to the CHCP however it will be further developed to include reporting for large hospital services and for hosted services, with a methodology currently being developed, further enabled by an single integrated reporting mechanism.

5.4 Strategic reporting will be developed to include a longer term financial strategy, annual financial performance statements and other requirements as determined in the final professional guidance.

Other Issues

6.1 Employment status of the Chief Officer and Chief Financial Officer remains subject to confirmation, along with associated VAT treatment. An update will be provided upon confirmation. The appointment of a Chief Financial Officer remains pending and an update will be provided when complete.

6.2 As the Scottish Borders partnership already has an integrated management structure there are no cost implications or savings opportunities resulting from this legislative change. However the costs of servicing the IJB will be required to be identified and funded. An update will be provided upon confirmation.

Recommendation

It is recommended that the Health & Social Care Integration Joint Board **notes** the contents of this report and **agrees** the content of the Draft Financial Regulations.

Policy/Strategy Implications	As per the content of the paper.
Consultation	N/A
Risk Assessment	As per the content of the paper.
Compliance with requirements on Equality and Diversity	Compliant
Resource/Staffing Implications	As per the content of the paper.

Approved by

Name	Designation	Name	Designation
David Robertson	Chief Financial Officer, SBC	Carol Gillie	Director of Finance, NHS Borders

Author(s)

Name	Designation	Name	Designation
Paul McMenamin	Business Partner		

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SCOTTISH BORDERS INTEGRATION JOINT BOARD
FINANCIAL REGULATIONS

1. SCOPE

2. Scottish Borders Integration Joint Board (IJB) is a legal entity in its own right created following approval of The Joint Working Public Bodies (Scotland) Act 2014 Act and, subsequent Ministerial approval of the Scheme to establish the Integration Joint Board between NHS Borders and Scottish Borders Council to integrate the planning and, commissioning of health and Social care services in the Borders.

The Integration Joint Board therefore exist out with the Corporate Governance arrangements of Scottish Borders Council and NHS Borders and requires its own set of financial regulations.

The IJB is accountable for the stewardship of public funds and is expected to operate under public sector best practice governance arrangements, proportionate to its transactions and responsibilities. Stewardship is a function of management and, therefore, a responsibility placed upon the appointed members and officers of the Integration Joint Board.

The Financial Regulations are a key component of the Partnership Board's governance arrangements. They set out the expectations on and the responsibilities of the Partnership Board and senior officers in relation to the proper administration of the Partnership Board's finances, as well as the internal and external audit arrangements that the Partnership Board will have to put inplace. These provide a framework for the Partnership Board and senior officers to ensure proper administration of the Partnership Board's finances

3. These financial regulations should be read in conjunction with the code of corporate governance of NHS Borders and the Financial Regulations of Scottish Borders Council.

4. Elected and appointed Members of the Integration Joint Board together with Officers appointed or seconded to the Board have a duty to abide by the highest standards of probity in dealing with financial issues. This is achieved by ensuring everybody is clear about the standards to which they are working and the controls in place to ensure these standards are met.

The key controls and control objectives to ensure effective financial management are

- The promotion of the highest standards of financial management by the board

- An effective monitoring system that ensures compliance with these financial regulations: and,
- Effective budget monitoring and reporting arrangements that compare the financial performance of the IJB to its financial plan. The financial performance of the IJB should be fully aligned with the reports submitted to NHS Borders Health Board and Scottish Borders Council.

FINANCIAL MANAGEMENT AND PERFORMANCE REPORTING

Responsibility of the IJB

5. The Integration Scheme sets out the detail of the arrangements for the Borders. In relation to financial management of the Integrated Health and Social Care budget it specifies

- The financial management arrangements to be followed including the treatment of budget variances
- The reporting arrangements between the IJB,NHS Borders and Scottish Borders Council
- The functions which are delegated to the IJB by NHS borders Health Board and Scottish Borders Council
- The method of determining the resources to be delegated each year by the Health Board and the Council.

6. The integration Joint Board will prepare its Strategic Plan in consultation with other stakeholders. The plan must include

- The resources delegated from Scottish Borders council to the IJB for social care services
- The resources delegated from NHS Borders to the IJB for delegated primary and community health care services The amount set aside by NHS Borders for delegated Services for the population of the IJB area.

Responsibility of IJB Chief Officer

7. The Chief Officer is the accountable officer of the Integration Joint Board. The Chief Officer will discharge their duties in respect of delegated resources by:

- ensuring that the strategic plan meets the requirement for economy, efficiency and effectiveness in the use of the Integration Joint Board resources; and
- giving directions to the NHS Borders Health Board and Scottish Borders Council that are designed to ensure resources are deployed and spent in accordance with the plan.

It is the responsibility of the Chief Officer to ensure that the provisions of such directions enable them to discharge their responsibilities in this respect within available resources.

8. In their operational role within NHS Borders and Scottish Borders Council, the Chief Officer is accountable to the Chief Executives of the Health Board and Scottish Borders Council for financial management and performance of services managed by the Chief Officer. The status of the Section 95 officer in legislation means this reporting to the Chief Executive of Scottish Borders Council associated with financial management operates via the Council's Chief Financial Officer.

Responsibility of the Integration Joint Board Chief Finance Officer

9. The Integration Joint Board will appoint an officer responsible for its financial administration.

10. In appointing the Chief Finance Officer the Integration Joint Board will comply with CIPFA guidance on the 'Role of the Chief Financial Officer in Local Government'.

11. The Integration Joint Board Chief Finance Officer and Chief Officer will discharge their duties in respect of the delegated resources by:

- Establishing financial governance systems for the proper use of the delegated resources; and

- Ensuring that the Strategic Plan meets the requirement for best value in the use of the Integration Joint Board's resources.

Responsibility of Health Board Accountable Officer; NHS Director of Finance & Council Section 95 Officer
(Chief Finance Officer)

12. The Health Board Accountable officer and the Council's Section 95 Officer discharge their responsibility - as it relates to the resources that are delegated to the Integration Joint Board - by setting out in the Integration Scheme the purpose for which resources are used and the systems and monitoring arrangements for financial performance management. It is their responsibility to ensure that the provisions of the Integration Scheme enable them to discharge their responsibilities in this respect. (See paragraph 6)

13. The Health Board Director of Finance and the Chief Finance Officer (Section 95 Officer) of Scottish Borders Council will provide specific advice and professional support to the IJB Chief Officer and IJB Chief Finance Officer to support the production of the Strategic Plan and also to ensure that adequate systems of internal control are established by the Integration Joint Board.

FINANCIAL PLANNING

14. The Integration Joint Board is responsible for the production of a Strategic Plan – setting out the services for their population over the medium term (3 years). This should include a medium term financial plan for the resources within the scope of the

strategic plan, incorporating:

- The Integrated Budget – aggregate of payments to the Integration Joint Board; plus

- The notional budget – the amount set aside by NHS Borders for large hospital services used by the Integration Joint Board population

15. NHS Borders and Scottish Borders Council will provide an annual allocation of funding, and indicative three year rolling funding allocations to the Integration Joint Board, to support the Strategic Plan and medium term financial planning process. Such indicative allocations will remain subject to annual approval by both organisations as part of their respective annual budgeting processes.

16. It is the responsibility of the Chief Officer and the Integration Joint Board Chief Finance Officer to develop an Integrated Budget for the forthcoming financial based on the Strategic Plan in conjuction with The CFO of the Council and the Director of Finance NHS Borders and to present this to the Health Board and Scottish Borders
Council for consideration and agreement as part of each organisation's annual budget setting process. The budget should reflect

- **Activity Changes**. The impact on resources in respect of increased demand (e.g. demographic pressures and increased prevalence of long term conditions) and for other planned activity changes;

- **Pay and Price inflation**. Pay and supplies cost increases;

- **Efficiencies**. All savings (including increased income opportunities and service rationalisations/cessations) should be agreed between the Integration Joint Board, Scottish Borders Council and NHS Borders as part of the annual
financial planning process.

- **Performance on outcomes**. The potential impact of efficiencies on agreed outcomes must be clearly stated and be open to scrutiny and challenge by the Scottish Borders Council and NHS Borders

- **Legal requirements**. Legislation may entail expenditure commitments that should be reflected in an adjustment to the payment;

- **Transfers to/from the notional budget for hospital services** set out in the Strategic Plan.

17. The method for the determination of contributions to the Integrated Budget is stated in the Integration Scheme.

Limits On Expenditure

28. No expenditure will be incurred by the Integration Joint Board unless it has been included within the approved Integration Budget and Strategic Plan, except:

- Where additional funding has been approved by NHS Borders and Scottish Borders Council and

- the integrated budget/strategic plan updated appropriately;

- Where a supplementary budget has been approved by the Integration Joint Board

- In an emergency situation in terms of any scheme of delegation;

Virement

19. Virement is defined by CIPFA as "the transfer of an underspend on one budget head to finance additional spending on another budget head, in accordance with the Financial Regulations". In effect virement is the permanent approved transfer of budget from one main budget heading (employee costs, supplies and services etc), to another, or a transfer of budget from one service to another. As such a virement is an ajustment to the approved budget.

20. Virements require approval and they will be permitted subject to any Scheme of Delegation of the Integration Joint Board as follows:

(i) Virement must not create additional overall budget liability. One off savings or additional income should not be used to support recurring expenditure or to create future commitments including full year effects of decisions made part way through a year.

Where the virement involves the transfer of up to £50,000 between operational budget headings, and will not affect the execution of existing Integration Joint Board policy, the transfer will be approved jointly by the Chief Finance Officer and Chief Officer and be reported to the Board at the first available opportunity.

(ii) Where the amount is over £50,000 or where the transfer of any amount would affect existing Integration Joint Board policy, the prior approval of the Integration Joint Board will be required.

Budgetary Control

21. It is the responsibility of the Chief Officer and Chief Finance Officer to report regularly and timeously on all budgetary control matters, comparing projected outturn with the approved financial plan to the Integration Joint Board and other bodies as
designated by NHS Borders Board and the Council.

22. The Director of Finance (NHS Borders) and the Chief Finance Officer of Scottish Borders Council will, along with the Integration Joint Board Chief Finance Officer, put in place a system of budgetary control which will provide the Chief Officer with management accounting information for the Integration Joint Board.

23. It is the responsibility of the Integration Joint Board Chief Finance Officer, in consultation with the Director of Finance (NHS Borders) and the Chief Finance Officer of Scottish Borders Council, to agree a consistent basis and timetable for the preparation and reporting of management accounting information to the IJB.

Budget Variances

24. The Integration Scheme specifies how in year over/under spends against approved budgets will be treated. Where it appears that any heading of income or expenditure may vary from that appearing in the Financial Plan, it will be the duty of the Chief Officer and Integration Joint Board Chief Finance Officer, in consultation with the NHS Board Director of Finance and the Council's Chief Financial Officer, to report in accordance with the appropriate method established for that purpose by the Integration Joint Board, NHS Board and Council, the details of the variance and any remedial action required.

The Director of Finance of NHS Borders and the Chief Financial officer retain the right to report independently to the IJB in the event of a material disagreement as to the financial implications of reports or proposed service development or the financial performance of the IJB budget.

Reports to Integration Joint Board

25. All reports to the Integration Joint Board must specifically identify the extent of any financial implications. These must have been discussed and agreed with the Integration Joint Board Chief Finance Officer prior to
lodging of reports. If there are any additional financial consequences arising from reports for either the Health Board or Scottish Borders Council these must be agreed with those organisations prior to approval being sought from the IJB.

LEGALITY OF EXPENDITURE

26. It will be the duty of the Chief Officer to ensure that no expenditure is incurred, or included within the Strategic Financial Plan unless it is within the power of the Integration Joint Board. In cases of doubt the Chief Officer should consult the respective
legal advisors of the NHS Board and Council before incurring expenditure. Expenditure on new service developments, initial contributions to other organisations, must be clarified as to

legality prior to being incurred. Responses to emergency situations which require expenditure will be reported to the first subsequent meeting of the IJB.

RESERVES

27. Legislation, under Section 106 of the Local Government (Scotland) Act 1973 empowers the Integration Joint Board to hold reserves, which should be accounted for in the financial accounts and records of the Integration Joint Board.

28. Any underspend will be held by the Council on behalf of the Integration Joint Board and can be drawn down with the approval of the Integration Joint Board. No interest will be credited to the Integration Joint Board for balances held.

VAT

29. HM Revenues and Customs has confirmed that there is no requirement for a separate VAT registration for the Integration Joint Board as it will not be delivering any services within the scope of VAT. This position will require to be kept under review
by the Integration Joint Board Chief Finance Officer should the operational activities of the Board change and a need to register be established. HMRC guidance will apply to Scotland which will allow a VAT neutral outcome.

COMMISSIONING OF SERVICES

30. Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014/285 provides that the Integration Joint Board may enter into a contract with any other person in relation to the provision to the integration joint board of goods and
services for the purpose of carrying out the functions conferred on it by the Act.

31. As a result of specific VAT and accounting issues that would be associated with the Integration Joint Board contracting directly for the provision of goods and services the Chief Officer is required to consult with the NHS Board Director of Finance, the Council's Chief Finance Officer prior to any direct procurement exercise being undertaken.

ACCOUNTING

Accounting Procedures and Records

32. All accounting procedures, records and systems of financial control of the Integration Joint Board will be determined by the Integration Joint Board Chief Finance Officer. These will also be subject to discussion with the Chief Finance Officer
of the NHS Board/Council.

33. Legislation provides that the Integration Joint Board is subject to the audit and accounts provision of a body under section 106 of the Local Government (Scotland) Act 1973. This requires audited annual accounts to be prepared with the reporting
requirements specified in the relevant legislation and regulations i.e. Section 12 of the Local Government in Scotland Act 2003 and regulations under section 105 of the Local Government (Scotland) Act 1973. These will be proportionate to the limited

number of transactions of the Integration Joint Board whilst complying with the requirement for transparency and true and fair reporting in the public sector. The Accounts will be prepared on an accruals basis complying with the CIPFA UK Code of practice on Local Authority Accounting in force at the balance sheet date.

34. Scottish Borders Council and NHS Borders will include additional disclosures in their statutory accounts which reflect their formal relationship with the Integration Joint Board. The Integration Joint Board Chief Finance Officer will liaise with nominated contacts within each organisation to ensure that appropriate information is exchanged within the timescales required by the statutory Audit processes of the Council and the NHS.

Financial Statements of the Integration Joint Board

35. The reporting requirements for the Integration Joint Board will be as specified in applicable legislation and regulation. Financial statements will be prepared following the Code of Practice on Local Authority Accounting in the UK. Statements
will be signed as specified in regulations made under section 105 of the Local Government (Scotland) Act 1973 or as amended by subsequent legislation.

36. The financial statements must be completed to meet the audit and publication timetable specified in regulations made under section 105 of the Local Government (Scotland) Act 1973 or as amended by subsequent regulation. It is the primary responsibility of the Integration Joint Board Chief Finance Officer to meet these requirements and of the Chief Officer to provide any relevant information to ensure that NHS Borders and Scottish Borders Council to meet their respective statutory and publication requirements for the single entity and group accounts.

37. The Integration Joint Board Chief Finance Officer will agree the financial statements timetable with the external auditors of the Integration Joint Board, NHS Borders and Scottish Borders Council.

INTERNAL AUDIT
Responsibility for Internal Audit

38. The Integration Joint Board will establish adequate and proportionate internal audit arrangements for review of the adequacy of the arrangements for risk management, governance and control of the delegated resources.

39. The role of Integration Board Chief Internal Auditor and associated Internal Audit services will be provided by the Head of Audit and Risk Scottish Borders Council. The specific nature of operational audit support to the IGB agreed with the Chief Officer.

40. The Internal Audit Service will undertake its work in compliance with the Public Sector Internal Audit Standards.

41. On or before the start of each financial year the Integration Joint Board Chief Internal Auditor will prepare and submit a strategic *risk based* audit plan to the Integration Joint Board for approval. It is recommended this is shared with the relevant

Audit committee of both NHS Borders and Scottish Borders Council.

The Chief Financial Officer will work with the internal auditors of the Health Board, Local Authority and the Partnership Board to ensure that there is clarity and consistency of appropriate scrutiny of the work of the Partnership Board and the Health & Social Care Partnership; and that the internal audit plans of the respective audit committees provide necessary assurance to all three of the bodies.

42. The Integration Joint Board Chief Internal Auditor will submit an annual audit report of the Internal Audit function to the Chief Officer and the Integration Joint Board providing, assurance regarding the adequacy of the internal control environment and providing a summary of audit activity during the year. The annual audit report and Chief Internal Auditor's opinion will also be reported to the Audit
Committees of the Council and the Health Board

Reports on each internal audit engagement will be submitted to the Chief Officer and Chief Financial Officer

Authority of Internal Audit

43. The person appointed by the Integration Joint Board to carry out the Internal Audit or their authorised representatives will have authority, on production of identification, to:

- **(i)** Enter at all reasonable times and without notice any premises or land used or operated by the Integration Joint Board Members;

- **(ii)** Have access to, and remove, all records (both paper and electronic), documents and correspondence within the possession or control of any officer, relating to any financial or other transaction of the Integration Joint Board;
- **(iii)** Be provided with a separate log-in to any computer system used by the members of the Integration Joint Board and have full access to any system, network, personal computer or other device including hardware owned by third party service providers;
- **(iv)** Require and receive such explanations as are necessary concerning any matter under examination;
- **(v)** Require any employee to produce records cash, stores or any other assets under their control .

RISK MANAGEMENT AND INSURANCE

Responsibility for Insurance and Risk
44. The Integration Joint Board will make appropriate insurance arrangements for all activities of the Integration Joint Board in accordance with the risk management strategy.

45. The Chief Officer will arrange, taking such specialist advice as may be necessary, that adequate insurance cover is obtained for all *normal insurable risks arising* from the activities of the Integration Joint Board and for which it is the general custom to insure. This will include the provision of appropriate insurance in respect of Members of the Integration Joint Board acting in a decision making capacity.

The Health Board and Council will continue to identify and manage within their own risk management arrangements any risks they have retained under the Integration Scheme. The NHS Board and Council will continue to report on the management of such risks, alongside the impacts of the integration arrangements.

46. The NHS Board Director of Finance and the Chief Finance Officer (Section 95) of the Council will ensure that the Chief Officer has access to professional support and advice in respect of risk management.

Risk Strategy

47. The Chief Officer will be responsible for establishing the Integration Joint Board's risk strategy and profile and developing the risk reporting arrangements; this will include arrangements for a risk register. The Risk Management Strategy will be approved by the Integration Joint Board.

48. The NHS Borders Board and Scottish Borders Council will continue to identify and manage within their own risk management arrangements any risks they have retained under the integration arrangements. The Health Board and Council will continue to report risk management to the existing committees, including the impact of the integration arrangements.

Notification of Insurance Claims

49. The Chief Officer and the Integration Joint Board Chief Finance Officer will put in place appropriate procedures for the notification and handling of any insurance and negligence claims made against the Integration Joint Board.

ECONOMY, EFFICIENCY AND EFFECTIVENESS (BEST VALUE)

50. The Chief Officer will ensure that arrangements are in place to maintain control and clear public accountability over the public funds delegated to the Integration Joint Board.

This will apply in respect of:

- the resources delegated to the Integration Joint Board by the partner Local Authority and Health Board; and
- the resources paid to the partner Local Authority and Health Board by the Integration Joint Board for use as directed and set out in the Strategic Plan.

51. The Integration Joint Board has a duty to put in place proper arrangements for securing Best Value in the use of resources and delivery of services. There will be a process of strategic planning which will have full Member involvement, in order to establish the systematic identification of priorities and realization of Best Value in the delivery of services. It will be the responsibility of the Chief Officer to deliver the arrangements put in place to secure Best Value and to co-ordinate policy in regard to ensuring that the Joint Board provides Best Value.

52. The Chief Officer will be responsible for ensuring implementation of the strategic planning process. Best Value should cover the areas of human resource and physical resource management, commissioning of services, financial management and policy, performance and service delivery process reviews.

PARTNERSHIPS

53. The IJB will put in place appropriate governance arrangements to record all joint working arrangements entered into by the IJB.

OBSERVANCE OF FINANCIAL REGULATIONS

Responsibility of Chief Officer and the Integration Joint Board Chief Finance Officer

54. It will be the duty of the Chief Officer assisted by the Integration Joint Board Chief Finance Officer to ensure that these Regulations are made known to the appropriate persons within the Integration Joint Board and to ensure that they are adhered to.

Breach of Regulations

55. Any breach of these regulations should be reported immediately to the Chief Finance Officer, who may then discuss the matter with the Chief Officer, NHS Board Chief Executive, Local Authority Chief Executive or another nominated or authorised person as appropriate to decide what action to take. This may in the case of material breach result in disciplinary action up to and including dismissal for gross misconduct. Material Breach of these regulations should be reported to the Integration Joint Board.

Review of Financial Regulations

56. These Regulations will be the subject of regular review by the Integration Joint Board Chief Finance Officer in consultation with the NHS Board Director of Finance and the Council's Chief Financial Officer, and where necessary, subsequent adjustments will be submitted to the Integration Joint Board for approval.

Date of Review: 5/12/15

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COMMITTEE MINUTES

Aim

To raise awareness of the Health & Social Care Integration Joint Board on the range of matters being discussed by the Strategic Planning Group.

Background

The Health & Social Care Integration Joint Board will receive various approved minutes as appropriate.

Summary

Committee minutes attached are:-

- Strategic Planning Group: 24.11.15

Recommendation

The Health & Social Care Integration Joint Board is asked to **note** the minutes.

Policy/Strategy Implications	As detailed within the individual minutes.
Consultation	Not applicable
Risk Assessment	As detailed within the individual minutes.
Compliance with requirements on Equality and Diversity	As detailed within the individual minutes.
Resource/Staffing Implications	As detailed within the individual minutes.

Approved by

Name	Designation	Name	Designation
Susan Manion	Chief Officer, Health & Social Care Integration		

Author(s)

Name	Designation	Name	Designation
Iris Bishop	Board Secretary		

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Meeting of Strategic Planning Group
24 November 2015
Committee Room 2, Scottish Borders Council Headquarters

Minute

Attendees (SPG Member): David Bell, M McGowan, Fiona Morrison, Amanda Miller, Bob Howarth

Also in attendance: Clare Malster, Carin Pettersson, Sandra Campbell (Chair in Susan Manion's absence), Julie Kidd (Minutes in Suzanne Hislop's absence)

		Action
1.	**Apologies**: Susan Manion (Chair), Eric Baijal, Suzanne Hislop, Shirley Burrell, Jane Douglas, Tim Young, Elaine Torrance, Morag Walker	
2.	**Minutes of the previous meeting** As too few SPG members were present for the meeting to be quorate, the minutes of the previous meeting (14 October 2015) were not reviewed for accuracy nor signed off – carry forward to next meeting.	
3.	**Matters Arising** There were no matters arising.	

4	**Second Draft of Strategic Plan Update** The group discussed the Strategic Plan Highlight Report. JK noted that the Plan as it stands is not representative of all Service/Strategy areas that come under the H&SC Partnership's responsibility and that she had sought input from the Strategic Planning Managers group to help rectify the imbalance. She had also attended Susan's weekly Health and Social Care Management Team meetings, the Strategic Planning Project Board (23rd November) and now this SPG, to relay the same message. She noted that Housing colleagues in Cathie Fancy's team were working to provide at least a brief contribution (which will likely cross-reference the Housing Contribution Statement that they are preparing). However, other areas are still absent from the Plan other than as part of a list of services that are integrating. Those round the table agreed that they would help source and provide material for inclusion in the Plan, and help to publicise it to others.	**All**
5	**Integrated Care Fund (ICF) update** • BH gave an update on the ICF Programme, noting that he is currently in a "caretaker" role before a new Project Manager is appointed. He tabled:- o An ICF Highlight report; o The list of 18 projects submitted (a subset of which are approved); o An outline of the current financial position. • It was noted that there is a possibility of the names given to the projects in the ICF list may differ from the way the same projects are described in the current draft strategic plan. This is because the wording in the Strategic Plan was "simplified" and this may have inadvertently resulted in projects being given varying names. Agreed that the names on the ICF list will be cross-checked against those on the Plan for consistency. BH agreed to send electronic copies of the tabled documents for circulation to all. • In relation to potential ICF projects involving voluntary/3rd sector (and indeed more widely), the group noted that there were challenges to successfully engaging with the voluntary/3rd sector and trying to improve the communication links (we currently use the same email/distribution list each time). All SPG members present took an action to this about what more could be done (and how) to develop closer communication links. • A suggestion was made about perhaps having an ICF information event regarding some of the projects already in progress. It was agreed that this would be referred to Susan Manion for a view.	BH All SC -> SM

6	**Engagement Plan** Regarding staff engagement events (feedback from which is required by the close of consultation on 11th December), it was not clear to what extent these were taking place. CP took an action to contact senior managers and see if they need any help in raising the profile of the Strategic Plan and/or seeking feedback on it. The drop-in sessions for public are in progress. Attendance at the Jedburgh Food Market on 1st November was successful and 60 questionnaires were completed. The session in Hawick on 23rd was smaller but Susan Manion felt that she received good quality feedback from the c.10-12 people she talked to. The remaining sessions are:- • Galashiels Interchange, 27th November • Duns Library, 3rd December • Tesco Peebles, 4th December. Susan and CP are also due to present at a session for Borders college, to students who are studying Health and Social Care. A third H&SC Integration Newsletter will be sent out very soon, as widely as possible. FM reported that the consultation events with carers have happened now in each locality, that they were good and came up with some good practical solutions. FM to forward feedback to CP for further discussion/action amongst SP Managers group. Housing events (in relation to the Housing Contribution Statement) are due to take place in December). It was acknowledged that colleagues of AM's in housing are working on some suggested wording for inclusion in the Strategic Plan and that this wording will be forwarded to JK once ready.	CP CP/SM CP/SM FM **Housing (Lindsey Renwick)**
7	**Future of Groups** SC introduced the document written by Eric Baijal and directed SPG members to the appendix – the lists of current and potential future membership. The observation in response to this was that the appendix is difficult to follow, there appears to be some duplication and it was asked whether the membership of any groups could be cut down. It was also felt that it would be helpful to map out related activities that are happening, e.g. community groups. It was felt that the restructure of groups should take account of the existing (cluttered!) group landscape, e.g. multi-agency groups that already exist re key strategic areas such as Learning Disability and Mental Health. It was acknowledged that to do a stocktake of this would probably be time consuming. However, SC took an action to do this in discussion with Susan and Eric in early 2016. Points to include:- 1. Stocktake of groups 2. Consider whether we have managed with all current groups. 3. Consider whether we have engaged with all groups in the right way. It was also noted that it can be difficult for group members to keep track of who else is a member of a given group as emails don't tend to explicitly include all group members in the "To" field. It would be helpful (presumably once group membership has been revised accordingly) for contact details	SC Suzanne Hislop

	for all members of the SPG group to be emailed to all others.	
8	**AOCB** • None noted.	
9	**Date and time of next meeting:** **13 January 11.00am – 12.30pm**	

AUDIT SCOTLAND REPORT – HEALTH & SOCIAL CARE INTEGRATION

Aim

1.1 To share with the Health & Social Care Integration Joint Board the Audit Scotland report issued in December 2015.

Background

2.1 The Public Bodies (Joint Working) (Scotland) Act 2014 sets out a framework for integration adult health and social care services.

2.2 The Act creates new partnerships known as Integration Authorities. The Act puts in place several national outcomes for health and social care and Integration Authorities are accountable for making improvements to those outcomes.

Summary

3.1 This is the first of three planned audits of this major reform programme. Subsequent audits will look at Integration Authorities progress after their first year of being established and their longer-term impact in shifting resources to preventative services and community based care and in improving outcomes for the people who use these services.

3.2 The content of the report will be taken into consideration as part of the evolving oversight arrangements through the organisational development plan.

Recommendation

The Health & Social Care Integration Joint Board is asked to **note** the report.

Policy/Strategy Implications	As detailed within the recommendations within the report.
Consultation	N/A.
Risk Assessment	N/A.
Compliance with requirements on Equality and Diversity	Compliant.
Resource/Staffing Implications	N/A.

Approved by

Name	Designation	Name	Designation
Susan Manion	Chief Officer, Health & Social Care Integration		

Author(s)

Name	Designation	Name	Designation
Iris Bishop	Board Secretary		

Health and social care series

Health and social care integration

ACCOUNTS COMMISSION

AUDITOR GENERAL

Prepared by Audit Scotland
December 2015

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Contents

Key facts

Over **£8 billion**

Health and social care resources will be delegated to integration authorities in 2016/17

18-29 per cent

Scottish Government estimate of the increase in the need for health and social care services between 2010 and 2030

31

Integration authorities are required to be operating by April 2016

£138-£157m

Scottish Government estimates of annual savings from integration

9

National outcomes that integration authorities are required to contribute towards

Summary

Key messages

1 The Public Bodies (Joint Working) (Scotland) Act 2014 introduces a significant programme of reform affecting most health and care services and over £8 billion of public money. The reforms aim to ensure services are well integrated and that people receive the care they need at the right time and in the right setting, with a focus on community-based and preventative care. The reforms are far reaching, creating opportunities to overcome previous barriers to change.

2 We found widespread support for the principles of integration from the individuals and organisations implementing the changes. The Scottish Government has provided support to partnerships to establish the new arrangements, including detailed guidance on key issues and access to data to help with strategic planning. Stakeholders are putting in place the required governance and management arrangements and, as a result, all 31 integration authorities (IAs) are expected to be operational by the statutory deadline of 1 April 2016.

3 Despite this progress, there are significant risks which need to be addressed if integration is to fundamentally change the delivery of health and care services. There is evidence to suggest that IAs will not be in a position to make a major impact during 2016/17. Difficulties in agreeing budgets and uncertainty about longer-term funding mean that they have not yet set out comprehensive strategic plans. There is broad agreement on the principles of integration. But many IAs have still to set out clear targets and timescales showing how they will make a difference to people who use health and social care services. These issues need to be addressed by April 2016 if IAs are to take a lead in improving local services.

4 There are other important issues which also need to be addressed. The proposed governance arrangements are complex, with some uncertainty about how they will work in practice. This will make it difficult for staff and the public to understand who is responsible for the care they receive. There are significant long-term workforce issues. IAs risk inheriting workforces that have been organised in response to budget pressures rather than strategic needs. Other issues include different terms and conditions for NHS and council staff, and difficulties in recruiting and retaining GPs and care staff.

there are significant risks which need to be addressed if integration is to fundamentally change the delivery of health and care services

Recommendations

Stakeholders have done well to get the systems in place for integration, but much work remains. If the reforms are to be successful in improving outcomes for people, there are other important issues that need to be addressed:

- Partners need to set out clearly how governance arrangements will work in practice, particularly when disagreements arise. This is because there are potentially confusing lines of accountability and potential conflicts of interests for board members and staff. There is a risk that this could hamper the ability of an IA to make decisions about the changes involved in redesigning services. People may also be unclear who is ultimately responsible for the quality of care. In addition, Integration Joint Board (IJB) members need training and development to help them fulfil their role.

- IAs must have strategic plans that do more than set out the local context for the reforms. To deliver care in different ways, that better meets people's needs and improves outcomes, IAs need to set out clearly:
  - the resources, such as funding and skills, that they need
  - what success will look like
  - how they will monitor and publicly report on the impact of their plans.
- NHS boards and councils must work with IAs to agree budgets for the new IAs. This should cover both their first year and the next few years to give them the continuity and certainty they need to develop and implement strategic plans. IAs should be clear about how they will use resources to integrate services and improve outcomes.

Integration authorities need to shift resources, including the workforce, towards a more preventative and community-based approach. Even more importantly, they must show that this is making a positive impact on service users and improving outcomes.

A more comprehensive list of recommendations is set out in (Part 4).

Background

1. The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) sets out a framework for integrating adult health and social care services. Social care services include supporting people to live their daily lives and helping them with basic personal care like washing, dressing and eating. People are living longer and the number of people with long-term conditions such as diabetes, and complex needs, such as multiple long-term conditions, is increasing. Current health and social care services are unsustainable; they must adapt to meet these changing needs. This means shifting from hospital care towards community-based services, and preventative services, such as support to help prevent older people from falling at home or to encourage people to be more active.

2. Integrating health and social care services has been a key government policy for many years. Despite this, there has been limited evidence of a shift to more community-based and preventative services. The Act sets out an ambitious programme of reform affecting most health and social care services. The scale and pace of the changes anticipated are significant, with a focus on changing how people with health and social care needs are supported.

3. The Act creates new partnerships, known as IAs, with statutory responsibilities to coordinate local health and social care services. The Act puts in place several national outcomes for health and social care and IAs are accountable for making improvements to these outcomes. The Act also aims to ensure that services are integrated, taking account of people's needs and making best use of available resources, such as staff and money. Each IA must establish at least two localities, which have a key role, working with professionals and the local community to develop services local people need.

4. IAs are currently at various stages in their development; all are required to be operational, that is taking on responsibility for budgets and services, by April 2016. The Scottish Government has estimated that IAs will oversee annual budgets totalling over £8 billion, around two-thirds of Scotland's spending on health and social work.

About this audit

5. This is the first of three planned audits of this major reform programme. Subsequent audits will look at IAs' progress after their first year of being established, and their longer-term impact in shifting resources to preventative services and community-based care and in improving outcomes for the people who use these services.

6. This first audit provides a progress report during this transitional year. We reviewed progress at this relatively early stage to provide a picture of the emerging arrangements for setting up, managing and scrutinising IAs as they become formally established. This report highlights risks that need to be addressed as a priority to ensure the reforms succeed. The audit is based on fieldwork that was carried out up to October 2015. We hope that the issues raised in the report are timely and helpful to the Scottish Government and local partners as they continue to implement the Act.

7. We gathered audit evidence by:

- reviewing documents available at the time of our work, including integration schemes, strategic plans, and local progress reports on integration arrangements[1]
- drawing on the work of local auditors, the Care Inspectorate, and Healthcare Improvement Scotland
- issuing a short questionnaire to IAs on their timetable for reaching various milestones

- interviewing stakeholders who included, board members, chief officers and finance officers from six IAs, and representatives from the Scottish Government, the British Medical Association, the voluntary sector, the Convention of Scottish Local Authorities and NHS Information Services Division.[2]

Appendix 1 provides further information on our audit approach.

8. This work builds on previous audits that have examined joint working in health and social care. For example, our *Review of Community Health Partnerships* [PDF] highlighted the organisational barriers to improving partnership working between NHS boards and councils, and the importance of strong, shared leadership across health and social care.[3] Our subsequent report *Reshaping care for older people* [PDF] found continuing slow progress in providing joined up health and social care services.[4] This lack of progress in fundamentally shifting the balance of care from hospital to community settings, coupled with the unsustainability of current services, mean that there is a pressing need for this latest reform programme to succeed.

9. The Accounts Commission and Auditor General are currently conducting two other audits which complement this work:

- *Changing models of health and social care* examines the financial, demographic and other pressures facing health and social care and the implications of implementing the Scottish Government's 2020 vision for health and social care. We will publish the report in in spring 2016.

- *Social work in Scotland* will report on the scale of the financial and demand pressures facing social work. It will consider the strategies councils and integration authorities are adopting to address these challenges, how service users and carers are being involved in designing services, and leadership and oversight by elected members. We will publish the report in summer 2016.

Part 1

Expectations for integrated services

Integration authorities will oversee more than £8 billion of NHS and care resources

10. The Public Bodies (Joint Working) (Scotland) Act 2014 sets out a significant programme of reform for the Scottish public sector. It creates a number of new public organisations, with a view to breaking down barriers to joint working between NHS boards and councils. Its overarching aim is to improve the support given to people using health and social care services.

11. These new partnerships will manage more than £8 billion of resources that NHS boards and councils previously managed separately. Initially, service users may not see any direct change. In most cases, people seeking support will continue to contact their GP or social work services. But, behind the scenes, IAs are expected to coordinate health and care services, commissioning NHS boards and councils to deliver services in line with a local strategic plan. Over time, the intention is that this will lead to a change in how services are provided. There will be a greater emphasis on preventative services and allowing people to receive care and support in their home or local community rather than being admitted to hospital.

Change is needed to help meet the needs of an ageing population and increasing demands on services

12. Around two million people in Scotland have at least one long-term condition, and one in four adults has some form of long-term illness or disability. These become more common with age (Exhibit 1, page 10). By the age of 75, almost two-thirds of people will have developed a long-term condition.[5] People in Scotland are living longer. Combined life expectancy for males and females at birth has increased from 72 to 79 years since 1980, although there are significant variations across Scotland, largely linked to levels of deprivation and inequalities.[6] The population aged over 75 years is projected to increase by a further 63 per cent over the next 20 years.[7]

13. The ageing population and increasing numbers of people with long-term conditions and complex needs have already placed significant pressure on health and social care services. The Scottish Government estimates that the need for these services will rise by between 18 and 29 per cent between 2010 and 2030.[8] In the face of these increasing demands, the current model of health and care services is unsustainable:

- The Scottish Government has estimated that in any given year just two per cent of the population (around 100,000 people) account for 50 per cent of hospital and prescribing costs, and 75 per cent of unplanned hospital bed days.

the significant changes under way will have an impact on everyone who needs to access, provide or plan health and social care services

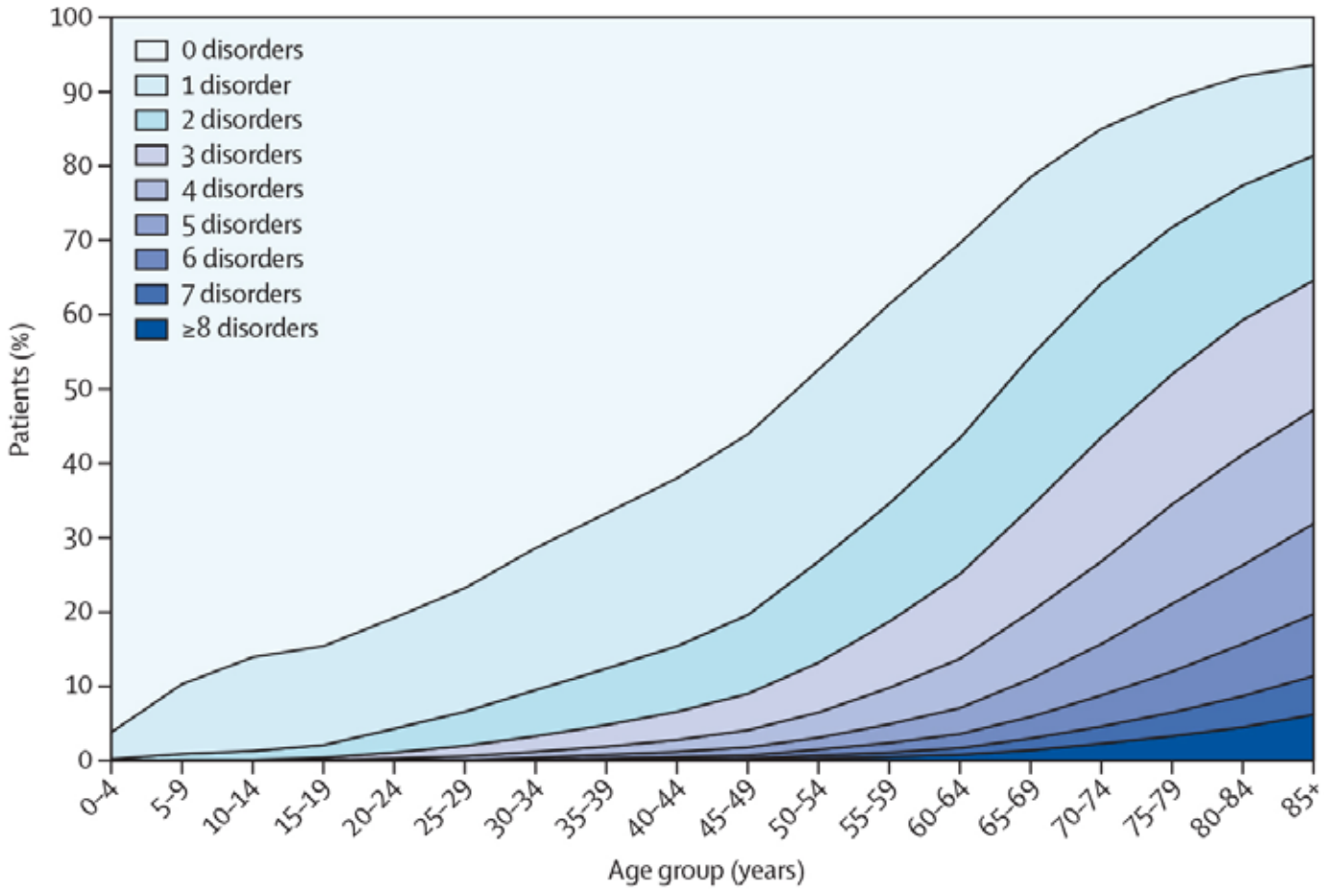
- A patient's discharge from hospital may be delayed when they are judged to be clinically ready to leave hospital but unable to leave because arrangements for care, support or accommodation have not been put in place. In 2014/15, this led to the NHS in Scotland using almost 625,000 hospital bed days for patients ready to be discharged.[9]

14. As a result of these pressures, there is widespread recognition that health and social care services need to be provided in fundamentally different ways. NHS boards, councils and the Scottish Government have focused significant efforts on initiatives to reduce unplanned hospital admissions and delayed discharges, yet pressures on hospitals remain. There needs to be a greater focus on anticipatory care, helping to reduce admissions to hospitals. There also needs to be better support to allow people to live independently in the community.

Exhibit 1

Long-term conditions by age

The number of long-term conditions that people have increases with age.



Source: Reprinted with permission from Elsevier (*The Lancet*, 2012, 380, 37-43)

15. None of this is unique to Scotland. Other parts of the UK and Europe face similar challenges. There have been various responses across the UK, but all try to deal with the changing needs of an ageing population, putting more emphasis on prevention and anticipatory care and seeking to shift resources from hospitals to community-based care.

16. A series of initiatives in Scotland over recent years has aimed to encourage a more joined-up approach to health and social care (Exhibit 2). Perhaps the most significant of these was creating Local Health Care Cooperatives (LHCCs) in 1999 and replacing them with Community Health Partnerships (CHPs) in 2004. While these reforms led to some local initiatives, LHCCs and CHPs lacked the authority to redesign services fundamentally. As a result, they had limited impact in shifting the balance of care, or in reducing admissions to hospital or delayed discharges.[10]

Exhibit 2

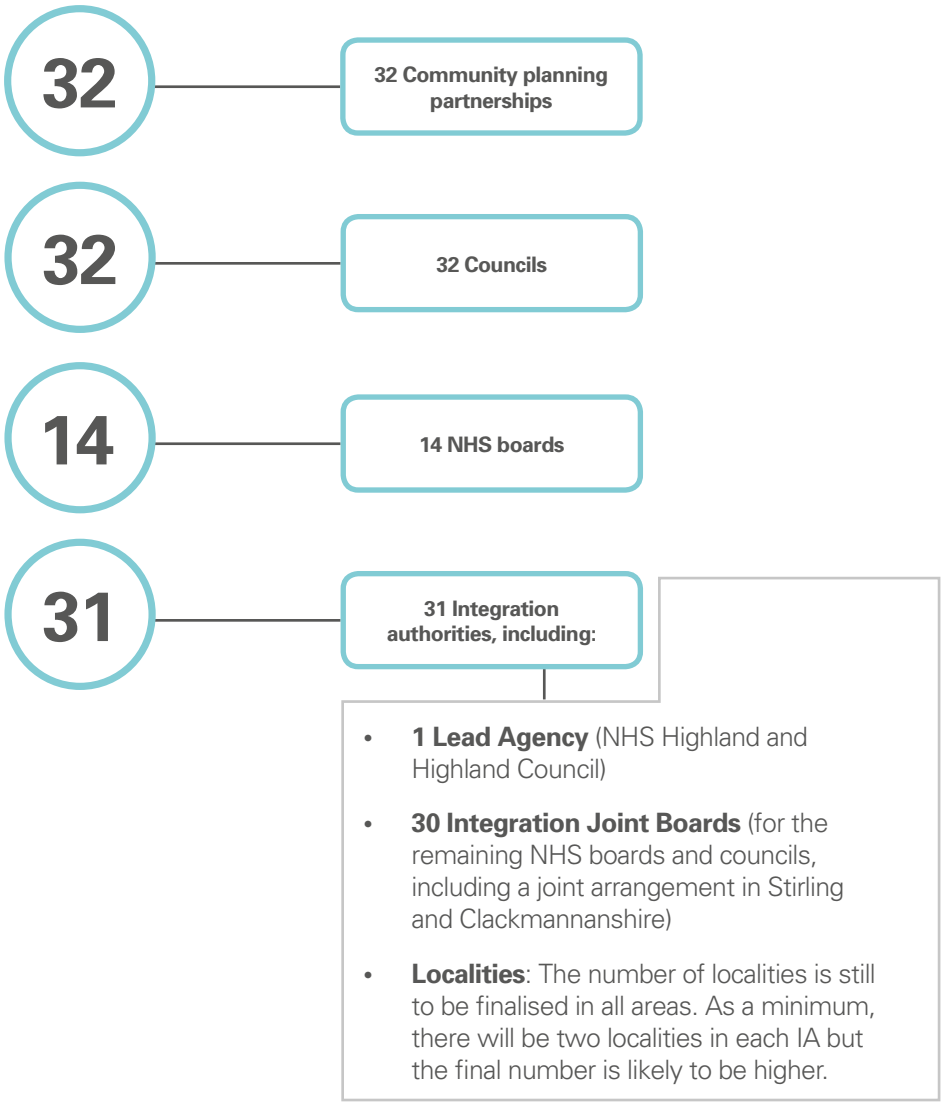
A brief history of integration in Scotland

1999	Seventy-nine **Local Health Care Cooperatives (LHCCs)** established, bringing together GPs and other primary healthcare professionals in an effort to increase partnership working between the NHS, social work and the voluntary sector.
2002	**Community Care and Health (Scotland) Act** introduced powers, but not duties, for NHS boards and councils to work together more effectively.
2004	**NHS Reform (Scotland) Act**, required health boards to establish CHPs, replacing LHCCs. This was a further attempt to bridge gaps between community-based care, such as GPs, and secondary healthcare, such as hospital services, and between health and social care.
2005	**Building a Health Service Fit for the Future: National Framework for Service Change**. This set out a new approach for the NHS that focused on more preventative healthcare, with a key role for CHPs in shifting the balance of care from acute hospitals to community settings.
2007	**Better Health, Better Care** set out the Scottish Government's five-year action plan, giving the NHS lead responsibility for working with partners to move care out of hospitals and into the community.
2010	**Reshaping Care for Older People Programme** launched by the Scottish Government. It introduced the Change Fund to encourage closer collaboration between NHS boards, councils and the voluntary sector.
2014	**Public Bodies (Joint Working) (Scotland) Act** introduced a statutory duty for NHS boards and councils to integrate the planning and delivery of health and social care services.
2016	All integration arrangements set out in the 2014 Act must be in place by 1 April 2016.

Source: Audit Scotland

17. The relative lack of progress of earlier attempts at integration led to the Public Bodies (Joint Working) (Scotland) Act 2014. This is the first attempt in the UK to place a statutory duty on the NHS and councils to integrate health and social care services. The Act abolished CHPs, replacing them with a series of IAs (Exhibit 3, page 12). These bodies will manage budgets for providing all integrated services. Most will not initially employ staff, but instead direct NHS boards and councils to deliver services in line with a strategic plan.

Exhibit 3
The public sector bodies overseeing health and social care services



Note: See Exhibit 4 for details of Integration Joint Board and lead agency approaches.
Source: Audit Scotland

The Scottish Government has set out a broad framework that allows for local flexibility

18. The Public Bodies (Joint Working) (Scotland) Act 2014 sets out a broad framework for creating IAs. The Act and the supporting regulations and guidance give councils and NHS boards a great deal of flexibility, allowing them to develop integrated services that are best suited to local circumstances. The main aspects of this flexible framework follow below.

Timing for establishing the new integration authorities

19. Scottish ministers must formally approve integration schemes for IAs: these set out the scope of services that are to be integrated and broad management and governance arrangements, including the structures and processes for

decision-making and accountability, controls and behaviour. Within this overall framework, IAs can choose when they become operational but all IAs must be established and operational, with delegated responsibility for budgets and services, by 1 April 2016.[11] Subject to the approval of their integration scheme, they can take on delegated responsibility for budgets and services at any time between April 2015 and 1 April 2016.

Scope of services to be integrated

20. Councils and NHS boards are required to integrate the governance, planning and resourcing of adult social care services, adult primary care and community health services and some hospital services. The hospital services included in integration are the inpatient medical specialties that have the largest proportion of emergency admissions to hospital. These include:

- accident and emergency services
- general medicine
- geriatric medicine
- rehabilitation medicine
- respiratory medicine
- psychiatry of learning disability
- palliative care
- addiction and substance dependence service
- mental health services and services provided by GPs in hospital.

Other, non-integrated, hospital services continue to be overseen directly by NHS boards. The Act also allows NHS boards and councils to integrate other areas of activity, such as children's health and social care services and criminal justice social work.

How IAs are structured

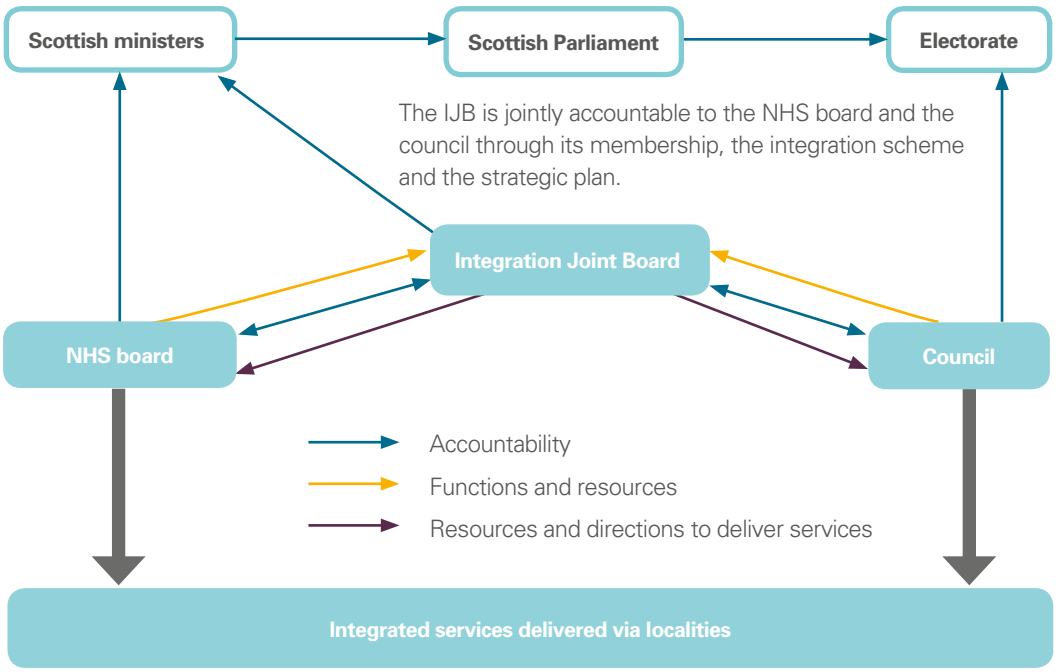
21. IAs will be responsible for overseeing certain functions that are delegated from the local NHS board and council(s). IAs can follow one of two main structural models (Exhibit 4, page 14).

22. All areas, apart from Highland, are planning to follow the body corporate model, creating an Integration Joint Board to plan and commission integrated health and social care services in their areas. IJBs are local government bodies, as defined by Section 106 of the Local Government (Scotland) Act 1973. Partners will need to understand the implications of differences between how councils and NHS boards carry out their business, so they are able to fulfil their duties. For example:

- IJBs must appoint a finance officer. The finance officer, under the terms of Section 95 of the Local Government (Scotland) Act 1973, has formal responsibilities for the financial affairs of the IJB.

Exhibit 4
Integration authorities will follow one of two main models

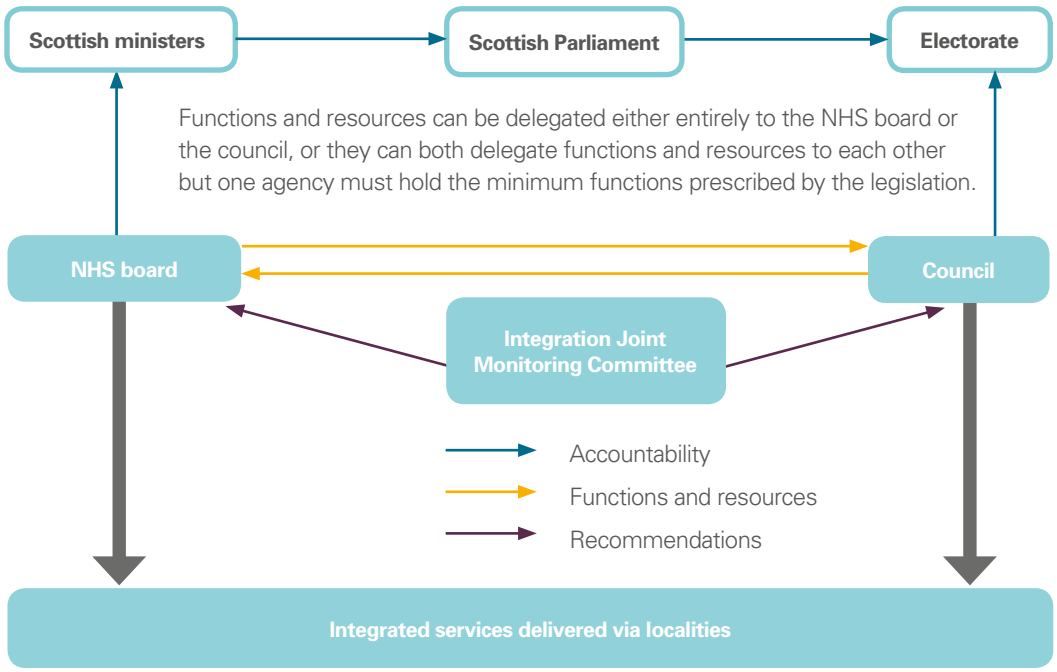
Body corporate or Integration Joint Board model



Body corporate

- NHS boards and councils delegate health and social care functions to an Integration Joint Board (IJB)
- The Act allows for partners to work jointly, for example, for two councils to work with their local NHS board to create a single IJB

Lead agency model



Lead agency

- NHS boards and councils delegate some of their functions to each other
- Carrying out of functions is overseen and scrutinised by an Integration Joint Monitoring Committee

Source: Audit Scotland

- The way local government bodies make decisions differs to NHS boards. Local government bodies in Scotland must take corporate decisions. There is no legal provision for policies being made by individual councillors.

- A statutory duty of Best Value applies to IJBs.

23. NHS boards and councils delegate budgets to the IJB. The IJB decides how to use these resources to achieve the objectives of the strategic plan. The IJB then directs the NHS board and council to deliver services in line with this plan. Only Highland has chosen the lead agency model, continuing arrangements established in earlier years for integrated services.[12] Under powers first set out in the Community Care (Scotland) Act 2002, NHS Highland is the lead for adult health and care services, with Highland Council the lead for children's community health and social care services. This provides continuity with lead agency arrangements in place in Highland since 2012. The council and the NHS board cannot veto decisions taken by the lead agency. Instead, as required by the legislation, they have established an integration joint monitoring committee (IJMC). The IJMC cannot overturn a decision made by the council or NHS board, but it can monitor progress in integrating services and make recommendations.

24. Whichever model is chosen, the underlying objective remains the same. The IA is expected to use resources to commission coordinated services that provide care for individuals in their community or in a homely setting and avoid unnecessary admissions to hospital.

Membership of Integration Joint Boards (IJBs)

25. For the IAs that follow the body corporate model, board members of IJBs are a mix of voting and non-voting members. Councils and NHS boards are each required to nominate at least three voting members. The NHS board and council can nominate more members, but both partners need to agree to this and the number from each body needs to be equal. The NHS board nominates non-executive directors to the IJB, and the council nominates councillors. Where the NHS board is unable to fill their places with non-executive directors, it is able to nominate other members of the NHS board. At least two of the NHS members should be non-executive directors. The IJB should also include non-voting members, including a service user and a representative from the voluntary sector (Exhibit 5, page 16).[13]

26. Initially, IJBs are not expected to directly employ staff, operating only as strategic commissioning bodies.[14] This may change over time as the Act allows IJBs to employ staff, but this needs to be approved by Scottish ministers, rather than decided locally. A chief officer and finance officer provide support for the IJB, but they are employed by either the council or NHS board and seconded to the IJB. The finance officer, under the terms of Section 95 of the Local Government (Scotland) Act 1973, has formal responsibilities for the financial affairs of the IJB.

Scrutinising integrated health and social care

27. Various scrutiny bodies have an interest in the integration of health and social care:

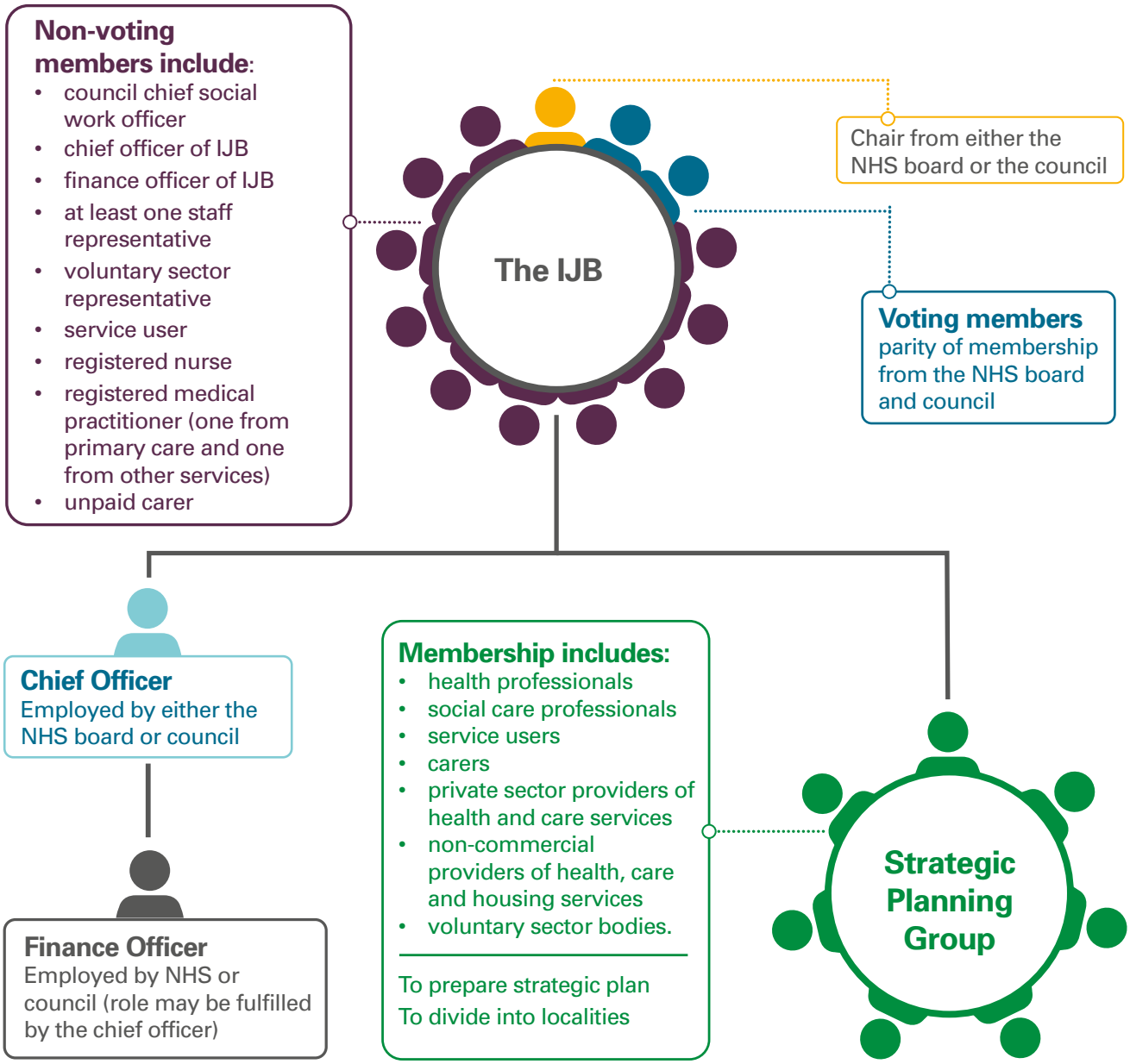
- The Accounts Commission is responsible for appointing auditors to IJBs and so has an interest in financial management and governance arrangements. As local government bodies, IJBs are also covered by the duty of Best Value as set out in the Local Government in Scotland Act 2003. The Accounts Commission has the power to audit the extent to which local government bodies are discharging their Best Value duty.

- Health and social integration is a significant national policy development. Therefore, the Auditor General for Scotland (alongside the Accounts Commission) has an audit interest in the extent to which it is being implemented at a national and local level, and in its impact on NHSScotland.

- The Care Inspectorate and Healthcare Improvement Scotland are responsible for scrutinising and supporting improvement in health and care services. Both organisations inspect individual services and work together to perform joint inspections of health and care services. These organisations will inspect the planning, organisation or coordination of

Exhibit 5

Organisation chart for a typical IJB



Source: Audit Scotland

integrated health and social care services. From April 2017, the Care Inspectorate and Healthcare Improvement Scotland are required by legislation to assess progress in establishing joint strategic commissioning and the early impact of integration.

Implications for the public, voluntary and private sectors

28. The significant changes under way will have an impact on everyone who needs to access, provide or plan health and social care services. Integration is part of the Scottish Government's focus on developing person-centred care. This is aimed at improving services, ensuring people using health and social care services can expect to be listened to, to be involved in deciding upon the care they receive and to be an active participant in how it is delivered. The aim is that this will result in improved outcomes for people, enabling them to enjoy better health and wellbeing within their homes and communities.

29. Health and social care integration is complex and it is important that IAs engage with the public on an ongoing basis so that they understand the purpose of integration and are able to influence the way services change. People may not see a significant difference in the services they receive immediately, but the reforms are focused on making better use of all health and social care services. Therefore there are implications for how people use services, for example GP, A&E and community-based services. If the reforms are to be successful, IJBs, NHS boards and councils need to involve people in decisions about the implications for local services. To help with this, there is a requirement that a service user and unpaid carer are members of the IJB and that IJBs consult and engage with local people as they develop their strategic and locality plans. It is also important that IAs are clear about how they link into the wider community planning process.

30. It is not only statutory services that need to change, other providers need to be involved. Voluntary and private sector providers employ two-thirds of the social services workforce and provide many social care services across Scotland. They are significant partners in developing integrated services, with the voluntary sector represented on the IJB as a non-voting member. Our previous report *Self-directed support* [PDF] highlighted some of the ways that councils have started to change how they work with the voluntary and private sectors.[15] There are lessons here for IJBs.

Localities

31. The Act requires IAs to divide their area into at least two localities, but they can choose to create more. Localities have an important role in reforming how to deliver services. They bring together local GPs and other health and care professionals, along with service users, to help plan and decide how to make changes to local services. A representative from each locality is expected to be part of the IA's strategic planning group, helping to ensure that specific local needs are taken into account. Localities also have a consultative role. When an IA is planning a change that is likely to affect service provision in a locality significantly, it must involve representatives of the local population in that decision.

32. As part of their role in planning services, localities are expected to plan expenditure on integrated health and social care services in their area, based on local priorities and to help shift resources towards preventative and community-based health and care services.

Outcomes and performance measures

33. IAs are required to contribute towards nine national health and wellbeing outcomes (Exhibit 6). These high-level outcomes seek to measure the quality of health and social care services and their impact in, for example, allowing people to live independently and in good health, and reducing health inequalities. This is the first time that outcomes have been set out in legislation, signalling an important shift from measuring internal processes to assessing the impact on people using health and social care services. IAs are required to produce an annual performance report, publicly reporting on the progress they have made towards improving outcomes.

The Scottish Government is providing resources to help support integration

34. The integration of health and social care is a complex reform and the Scottish Government is providing support to help organisations as they establish the new arrangements. The Scottish Government will provide more than £500 million over the three years from 2015/16 to 2017/18 to help partnerships establish new ways of working that focus on prevention and early intervention in a bid to reduce

Exhibit 6

National health and wellbeing outcomes

IAs are required to contribute to achieving nine national outcomes.

1	People are able to look after and improve their own health and wellbeing and live in good health for longer.
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.
3	People who use health and social care services have positive experiences of those services, and have their dignity respected.
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
5	Health and social care services contribute to reducing health inequalities.
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.
7	People who use health and social care services are safe from harm.
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.
9	Resources are used effectively and efficiently in the provision of health and social care services.

Source: National Health and Wellbeing Outcomes, Scottish Government

long-term costs. This money is not directly to support integration, but to continue initiatives that were already under way to improve services. The money is made up as follows:

- £300 million is an integrated care fund to help partnerships achieve the national health and wellbeing outcomes and move towards preventative services
- £100 million to reduce delayed discharges
- £30 million for telehealth
- £60 million to support improvements in primary care
- £51.5 million for a social care fund.

35. The Scottish Government has provided guidance to partnerships, covering issues such as strategic commissioning of health and care services, clinical and care governance, and the role of housing services and the voluntary sector. The timescales to implement the Act are tight. For some partnerships, guidance came too late. For example, the Scottish Government issued its guidance on localities in July 2015, yet localities play an important part in strategic plans and many partnerships had already begun the strategic planning process by then. The Scottish Government plans to issue further guidance on performance reporting late in 2015. However, for some areas this is coming too late – the three Ayrshire IJBs will present their first performance reports on or before 2 April 2016 and are developing these in advance of the guidance being issued.

36. The Scottish Government is supplementing this formal guidance with a series of support networks for IJB chairs and finance officers, such as regular learning events, and through the work of the Joint Improvement Team (JIT), including support for IJBs in developing their strategic plans.[16] Healthcare Improvement Scotland and the Care Inspectorate are currently developing a support programme for IAs, tailoring training and development events to fit local needs.

37. IAs are also being supported by the Information Services Division (ISD) of NHS National Services Scotland. ISD is creating a single source of data on health, social care and demographics. It is making this information available to NHS boards, councils and IAs to help them to gain a better understanding of:

- the needs of their local population
- current patterns of care
- how resources are being used.

38. This is the first time this detailed information on activity and costs will be routinely available to partnerships to help them with strategic planning. It will also help inform decisions on how to better use resources to improve outcomes for service users and carers. ISD is also providing data and analytical support through a Local Intelligence Support Team initiative, where partnerships can have an information specialist from ISD working with them in their local area.

Part 2

Current progress

Integration authorities are being established during 2015/16

39. Thirty-one IAs are being established, with one for each council area and a shared one between Clackmannanshire and Stirling. All partners submitted their draft integration schemes to Scottish ministers by the April 2015 deadline. Some, such as East Dunbartonshire, already plan to extend the scope of services being integrated and will resubmit their integration scheme for approval. By October 2015, 25 integration schemes had been formally approved, with the remainder expected to be agreed by the end of 2015.

40. By October 2015, six IAs had been established and taken on operational responsibility for budgets and services (Exhibit 7, page 21). The remaining IAs plan to be operational just before the statutory deadline, in March and April 2016.

Most integration authorities will oversee more than the statutory minimum services, and their responsibilities vary widely

41. The Act requires councils and NHS boards to integrate adult health and social care services. But it also allows them to integrate other services, such as children's health and social care services and criminal justice social work services.

42. The scope of the services being integrated varies widely across Scotland. Almost all the IAs will oversee more than the minimum requirement for health services, mainly by including some aspects of children's health services. But there is a wide range in responsibilities for other areas, such as children's social work services, criminal justice social work services, and planned acute health services (Exhibit 8, page 22). These differences in the scope of services included create a risk of fragmented services in some areas. Good clinical and care governance arrangements will be important to ensure that vulnerable people using integrated and non-integrated services experience high standards of care.

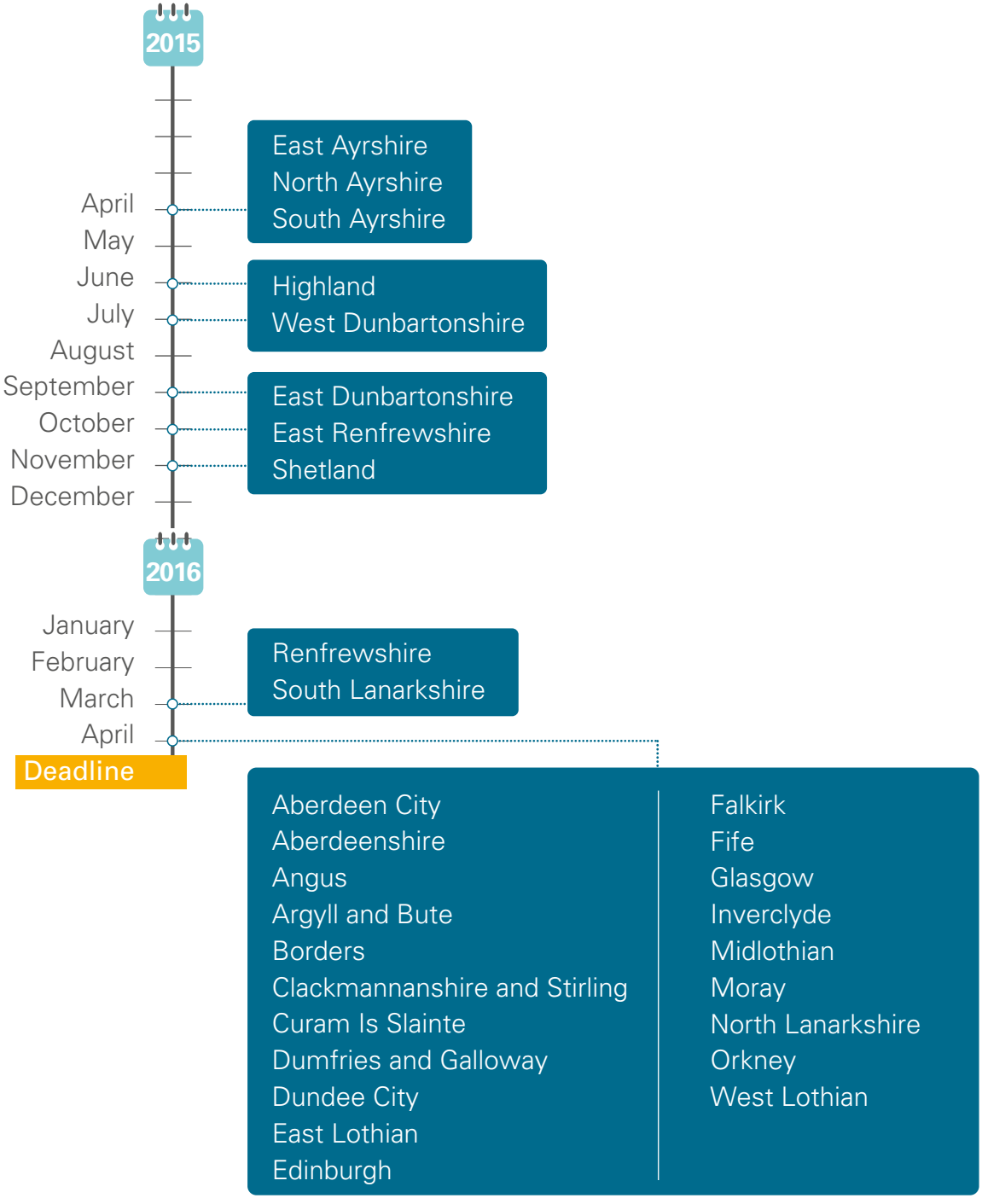
the scope of the services being integrated varies widely across Scotland

43. Among the variations the most notable are in Argyll and Bute IJB and Dumfries and Galloway IJB. These IJBs will oversee all NHS acute services, including planned and unplanned hospital services. In theory, this should allow these IJBs to better coordinate all health and care services in their area.

44. Various 'hosting' arrangements are also being implemented across the country. Where the area covered by an NHS board has more than one IJB it is often not practical or cost-effective to set up separate arrangements to deliver services for individual IJBs. This is particularly the case for specialist services, such as certain inpatient mental health services with small numbers of patients or staff. For example, North Ayrshire IJB hosts the following services on behalf of East Ayrshire and South Ayrshire IJBs:

Exhibit 7

Services will be delegated to IAs throughout 2015/16 with most delegating in April 2016



Notes:
1. The date of becoming operational is still to be agreed in Perth and Kinross.
2. Curam Is Slainte is the name for the partnership between NHS Western Isles and Comhairle nan Eilean Siar.

Source: Audit Scotland

Exhibit 8

Additional integrated services

Partnerships are integrating a wider range of services in addition to the statutory minimum.

Argyll and Bute	✓	✓	✓	✓
East Ayrshire	✓	✓	✓	–
East Renfrewshire	✓	✓	✓	–
Glasgow	✓	✓	✓	–
Inverclyde	✓	✓	✓	–
North Ayrshire	✓	✓	✓	–
Orkney	✓	✓	✓	–
South Ayrshire	✓	✓	✓	–
West Dunbartonshire	✓	✓	✓	–
Aberdeen City	–	✓	✓	–
Aberdeenshire	–	✓	✓	–
Curam Is Slainte	–	✓	✓	–
East Lothian	–	✓	✓	–
Midlothian	–	✓	✓	–
Moray	–	✓	✓	–
Shetland	–	✓	✓	–
Highland	✓	–	✓	–
Dumfries and Galloway	–	–	✓	✓
Angus	–	–	✓	–
Borders	–	–	✓	–
Clackmannanshire and Stirling	–	–	✓	–
Dundee	–	–	✓	–
East Dunbartonshire	–	–	✓	–
Edinburgh	–	–	✓	–
Falkirk	–	–	✓	–
Fife	–	–	✓	–
North Lanarkshire	–	–	✓	–
Perth and Kinross	–	–	✓	–
Renfrewshire	–	–	✓	–
South Lanarkshire	–	–	✓	–
West Lothian	–	–	✓	–

Key

- Children's social work services
- Criminal justice social work services
- Children's health services
- Planned acute health services

Notes:
1. Criminal justice social work services can include services such as providing reports to courts to assist with decisions on sentencing. Planned acute health services can include services such as outpatient hospital services.
2. The range of children's health services delegated varies by IA. They may include universal services (such as GPs) for people aged under 18, or more specialised children's health services such as school nursing or health visiting, or both universal and specialised services.
3. IAs may also be responsible for additional integrated services not listed here.
4. East Dunbartonshire plan to amend their integration scheme to include children's primary and community health services before 1 April 2016.
5. Where integration schemes have not yet been approved by ministers, the final integration scheme may vary from the information included here.

Source: Scottish Government, 2015 and Audit Scotland, 2015

- inpatient mental health services
- learning disability services
- child and adolescent mental health services
- psychology services
- community infant feeding service
- family nurse partnership
- child health administration team
- immunisation team.

IJBs are appointing voting board members and most have chief officers in post

45. Most IJBs are currently appointing board members. Our review of the 17 IJB integration schemes that Scottish ministers had approved at the time of our audit shows the following:

- Thirteen IJB boards will initially be chaired by a councillor, with the remaining four chaired by a non-executive from the local NHS board.
- Only three areas have chosen to nominate the minimum of three voting members each from the council and NHS board.[17] In 13 schemes, councils and NHS boards have each nominated four voting members. In Edinburgh, the council and NHS board each have five voting members.
- There are also local variations in the number of additional non-voting members. For example, East Renfrewshire has appointed an additional GP member to help provide knowledge on local service needs. In most cases, these variations do not add significantly to the number of IJB board members. But some IJBs have very large boards. For example, Edinburgh has 13 non-voting members, in addition to its ten voting members. The IJB board for Clackmannanshire and Stirling is expected to be even larger, reflecting the joint arrangements between the two council areas, with 12 voting members and around 23 non-voting members.

46. Almost all IJBs have now appointed a chief officer.[18] Edinburgh and Falkirk expect to have their chief officers in post by the end of 2015.[19] Chief officers are employed by either the NHS board or the council and then seconded to the IJB. Terms and conditions of employment vary between councils and NHS boards, so successful candidates choose their preferred employer, based on the packages offered.

Chief officer accountability

47. Accountability arrangements for the IJB chief officer are complex and while there may be tensions in how these arrangements will work in practice, we have attempted to set out the technical arrangements as clearly as possible. The chief officer has a dual role. They are accountable to the IJB for the

responsibilities placed on the IJB under the Act and the integration scheme. They are accountable to the NHS board and council for any operational responsibility for integrated services, as set out in the integration scheme.

Accountability to the IJB

- The chief officer is directly accountable to the IJB for all of its responsibilities. These include: strategic planning, establishing the strategic planning group, the annual performance report, the IJB's responsibilities under other pieces of legislation (for example, the Equalities Act and the Public Records Act), ensuring that its directions are being carried out, recommending changes and reviewing the strategic plan.

- Integration schemes can pass responsibility for overseeing the operation of specific services from the NHS board or council to the IJB. In these circumstances, the chief officer is accountable to the IJB for establishing the arrangements to allow it to do this. This includes setting up performance monitoring, reporting structures, highlighting critical failures, reporting back based on internal and external audit and inspection. If the council or NHS board passes responsibility for meeting specific targets to the IJB, the IJB must take this into account during its strategic planning, and the chief officer is accountable for making sure it does so.

Accountability to the NHS board and council

- All integration schemes should set out whether the chief officer also has operational management responsibilities. Where the chief officer has these responsibilities, they are also accountable to the NHS board and the council.

- Where the chief officer has operational management responsibilities, the integration scheme makes the chief officer the responsible operational director in the council and NHS board for ensuring that integrated services are delivered. The chief officer is therefore responsible to the NHS board and council for the delivery of integrated services, how the strategic plan becomes operational and how it is delivered. They are also responsible for ensuring it is done in line with the relevant policies and procedures of the organisation (for example staff terms and conditions).

- Although this is untested, the accountable officers for delivery should still be the chief executives of the NHS board and the council. But they must discharge this accountability through the chief officer as set out in their integration scheme. The chief executives of the NHS board and council are responsible for line managing the chief officer to ensure that their accountability for the delivery of services is properly discharged.

48. Although employed by one organisation only, most chief officers are line managed by the chief executives of both the council and the NHS board. This means that in some NHS board areas the chief executive is line managing several IJB chief officers. South Lanarkshire has adopted a more streamlined approach, where the chief officer reports to both the council and NHS board chief executive, but the organisation that employs the chief officer performs day-to-day line management.

Part 3

Current issues

There is widespread support for the opportunities offered by health and social care integration

49. Integrated health and social care offers significant opportunities. These include improving the services that communities receive, the impact these services have on people, improving outcomes and using resources, such as money and skills, more effectively across the health and care system. The Scottish Government expects integrated services to emphasise preventative care and reduce both the level of hospital admissions and the time that some patients spend in hospital. A measure of success will be the extent to which integration has helped to move to a more sustainable health and social care service, with less reliance on emergency care.

50. Because integrated services with a focus on improving outcomes should result in more effective use of resources across the health and social care system, the Scottish Government expects integration to generate estimated annual savings of £138 - £157 million. The savings are as follows:

- Annual savings of £22 million if IAs can meet the current target to limit the delay in discharging patients to no more than two weeks and £41 million if they can reduce this further, to no more than 72 hours.
- Annual savings of £12 million by using anticipatory care plans for people with conditions that put them at risk of an unplanned admission to hospital. These plans provide alternative forms of care to try to avoid people being admitted to hospital.
- Annual savings of £104 million from reducing the variation between different IAs in the same NHS board area. The Scottish Government expects that IAs will identify the inefficiencies that cause costs to vary and, over time, reduce them.[20]

51. The Scottish Government estimated the initial cost of making these reforms to adult services to be £34.2 million over the five years up to 2016/17, and £6.3 million after this. It has not estimated the additional costs, or savings, from integrating other services such as children's health and social care or some criminal justice services.[21] It is unclear whether these anticipated savings will release money that IJBs can invest in more community-based and preventative care or how the Scottish Government will monitor and report progress towards these savings.

widespread support for the policy of health and social care integration, but concerns about how this will work in practice

52. There have been previous attempts at integration, as listed in Exhibit 2 (page 11). Our *Review of Community Health Partnerships* [PDF] highlighted that CHPs had a challenging remit, but lacked the authority needed to implement the significant changes required.[22] We also found limited progress with joint budgets across health and care services. This latest reform programme contains important new elements to help partnerships improve care. The Act:

- provides a statutory requirement for councils and NHS boards to integrate services and budgets, in contrast to previous legislation that encouraged joint working with resources largely remaining separate
- provides, for the first time, a statutory requirement to focus on outcome measures, rather than activity measures
- introduces a requirement for co-production as part of strategic planning. Co-production is when professionals and people who need support combine their knowledge and expertise to make joint decisions
- has clear links to other significant legislation, including The Children and Young People (Scotland) Act 2014 and the Community Empowerment (Scotland) Act 2015, where similar principles of co-production, engagement and empowerment apply.

53. Throughout our audit, we found there is widespread support for the policy of health and social care integration, but concerns about how this will work in practice. In this part of our report, we summarise the most important risks and issues we have identified through our audit. These are significant and need to be addressed as a priority nationally and locally to integrate health and care services successfully.

NHS boards, councils and IJBs need to be clear about how local arrangements will work in practice

Sound governance arrangements need to be quickly established

54. Good governance is vital to ensure that public bodies perform effectively. This can be a particular challenge in partnerships, with board members drawn from a wide range of backgrounds. Previous audit reports on community planning partnerships (CPPs) and CHPs have highlighted the importance of issues such as:

- a shared leadership, which takes account of different organisational cultures
- a clear vision of what the partnership wants to achieve, with a focus on outcomes for service users
- a shared understanding of roles and responsibilities, with a focus on decision-making
- an effective system for scrutinising performance and holding partners to account.

Members of IJBs need to understand and respect differences in organisational cultures and backgrounds

55. IJBs include representatives from councils, NHS boards, GPs, the voluntary sector, and service users. Everyone involved in establishing the new arrangements needs to understand, respect and take account of differences in organisational cultures so these do not become a barrier to progress. Members of the IJB need quickly to establish a shared understanding of their new role, how they will work together and measure success.

56. Voting members are drawn exclusively from councils and NHS boards and it is particularly important that they have a shared vision and purpose. There are important differences in how councils and NHS boards operate. Councils, for example, are accountable to their local electorate, while NHS boards report to Scottish ministers. There are also differences in how councils and the NHS work with the private sector. Councils have had many years of contracting services out to the voluntary and private sectors; for example, around 25 per cent of home care staff are employed in the private sector.

57. IJBs are aware of the need to establish a common understanding of the roles and responsibilities of board members. We found that many are planning opportunities for board development by providing training and support to board members. Other IJBs are also reinforcing this by developing codes of conduct to ensure that their board members follow the same standards of behaviour.

58. IJBs include representatives from a wide range of organisations and backgrounds. This inclusive approach has benefits, including a more open and inclusive approach to decision making for health and care services, but there is a risk that boards are too large. For example, the Edinburgh IJB will have 23 members and the Clackmannanshire & Stirling IJB will have around 35. As we have highlighted in previous audits of partnerships across Scotland, there is a risk that large boards will find it difficult to reach agreement, make decisions and ensure services improve.

IJB members will have to manage conflicts of interest

59. The design of IJBs brings the potential for real or perceived conflicts of interest for board members. The NHS board and council nominate all voting members of the IJB. Their role is to represent the IJB's interests. Voting members will also continue in their role as an NHS board member or councillor. As a result, there is a risk that they may have a conflict of interest, particularly where there is a disagreement as part of IJB business.[23]

60. There is a similar potential for a conflict of interest for senior managers. IJB finance officers, for example, are required to support the needs of the IJB, but may also have responsibilities to support their employer – either the local NHS board or council. Similarly, legal advisers to the IJB will be employed by the council or the NHS board and, at a time of disagreement, may have a conflict of interest.

61. There is also a particular issue for NHS board members. Some NHS boards have to deal with several IJBs, and this places significant demands on their limited number of non-executive members. As a result, the Act and its associated regulations allow for NHS executive members to be appointed as voting members of the IJB. This means that there is the possibility of individuals acting as IJB board members who commission a service, and as NHS board members, responsible for providing that service. IJBs need to resolve this tension as part of their local governance arrangements.

62. IJBs are taking action to manage these tensions. For example, they are providing training to alert board members to the need to act in the IJB's interests when taking part in IJB meetings, and declaring conflicts of interest when they arise. But underlying conflicts of interest are likely to remain a risk, particularly at times of disagreement between local partners.

Although IJBs will lead the planning of integrated services, they are not independent of councils and NHS boards

63. IJBs set out how they will deliver services in their strategic plans, which they develop through strategic planning groups. The legislation allows NHS boards and councils jointly to ask IJBs to change their strategic plans only if they think it hinders their work in achieving the national health and wellbeing outcomes. As such, NHS boards and councils cannot individually veto an IJB decision. However IJBs are not fully independent of NHS boards and councils which can influence them through the following:

- **Membership of IJBs**: Chairs, vice chairs and voting members are all nominated by NHS boards and councils.
- **The approval process to agree future budgets:** Guidance issued by the Scottish Government's Integrated Resources Advisory Group (IRAG) suggests that, for future years, each IJB develops a business case and budget request and submits this to the NHS board and council to consider.
- **Control of integration schemes:** NHS boards and councils can decide to resubmit their integration schemes, changing the terms under which the IJB operates, or replacing it with a lead agency approach.

64. IJBs may overcome the challenges of working with a large board, with different organisational cultures and tensions, but once difficult decisions have been made there are still complex relationships back to the NHS board and council to negotiate. As a result, it is not clear if IJBs will be able to exert the necessary independence and authority to change fundamentally the way local services are provided.

Only a few IJBs will oversee the operation of acute services in their area, potentially limiting their impact

65. Regulations allow NHS boards and councils to choose what role IJBs will have in relation to operational management of services, in addition to commissioning and planning services. This flexibility allows, for example, NHS boards to remain solely responsible overseeing the operation of large hospital sites. The alternative is a more complex arrangement where responsibility for overseeing the operation of an A&E department is shared across several IJBs. Where the IJB has no operational management of hospital services, the IJB will receive regular performance reports from the NHS board on hospital services, so the IJB can assess whether the NHS board is delivering services in line with the IJB strategic plan. From the 17 schemes we reviewed that establish IJBs, we found the following:

- All 17 IJBs oversee the operation of non-acute integrated services, such as district nursing.
- To date, only Argyll and Bute, and Dumfries and Galloway IJBs will oversee the operation of the acute hospital integrated services in their areas, and

the chief officer will operationally manage these services. In Argyll and Bute, this continues an arrangement that existed previously and arises because the NHS board contracts most acute services from NHS Greater Glasgow and Clyde. Argyll and Bute CHP received information from the NHS board as part of the contract monitoring process. The IJB and NHS Greater Glasgow and Clyde are in the process of agreeing the information the chief officer and IJB board members will receive on the operational performance and delivery of these services.

- In Dumfries and Galloway, the IJB will oversee the operation of all integrated services, including all acute hospital services. The chief officer will be responsible for managing the operation of these integrated services, receiving regular information from the council Chief Social Work Officer and the NHS board acute services management team. The geographical circumstances in Dumfries and Galloway help to make this arrangement possible, as there is only one IA in the NHS board area, with only one acute hospital.

There needs to be a clear understanding of who is accountable for service delivery

66. There is a risk that the complex interrelationship between IJBs and councils and NHS boards will get in the way of clear lines of accountability. Their respective roles appear to be clear: IJBs are responsible for planning and commissioning services; councils and NHS boards are responsible for delivering those services.

67. But this understanding of accountabilities could be tested when there is a service failure, either in the care of an individual or in meeting outcome targets. The consensus amongst those we spoke with during our audit is that responsibility would lie with the council or NHS board delivering the service. But it could also be argued that ultimate responsibility might lie with IJBs, which plan and direct councils and NHS boards in how services are to be delivered. All parties need to recognise this risk and set out clearly an agreed understanding of each other's roles and responsibilities. It is essential that the chief officer is clear about how this joint accountability will work in practice from the start.

68. Clear procedures also need to be in place for clinical and care governance. These are procedures for maintaining and improving the quality of services and safeguarding high standards of care. NHS boards use long-established clinical governance approaches within the NHS. Similarly, councils follow well-established approaches for social care. IJBs have a great deal of flexibility over this issue and are required only to consider what role they will have in supporting the councils' and NHS boards' clinical and care governance work and how integration might change some aspects of this.

69. The Act introduced a requirement that IJBs set out in their integration scheme how they will work with NHS boards and councils to develop an integrated approach to clinical and care governance. We found that, at present, most IJBs plan to retain existing arrangements, with NHS boards directly overseeing clinical governance and councils overseeing care governance. However, IJBs will need to have a role in monitoring clinical and care standards without duplicating existing arrangements. Perth and Kinross IJB has developed a new clinical and care governance framework that other IJBs are now considering. In addition, the Royal College of Nursing has developed an approach that helps IJBs, councils and NHS

boards review their clinical and care governance arrangements. The aim is to ensure consistent approaches within each integrated service, and that these are aligned to existing clinical and care governance arrangements in the NHS and councils.[24]

IAs need to establish effective scrutiny arrangements to help them manage performance

70. IAs need to establish effective arrangements for scrutinising performance, monitoring progress towards their strategic objectives, and holding partners to account. Using the nine statutory outcome measures, listed at Exhibit 6, will help IAs to focus on the impact of health and care services. But as well as simply monitoring performance, IJB members will need to use these to help redesign services and ensure services become more effective.

71. There is also a need for regular reporting to partner organisations. This is particularly important where most members of the local council or NHS board are not directly involved in the IJB's work. Aberdeenshire Council, for example, has 68 councillors, with only five sitting on the IJB. Those not directly involved need to be kept informed on how the budgets provided to the IJB have been used and their effectiveness in improving outcomes for local people.

Councils and NHS boards are finding it difficult to agree budgets for the new integration authorities

72. At this stage, IAs are establishing financial procedures that look to be sound. While there is a range of approaches to financial monitoring and dealing with overspends and underspends, the processes outlined in the integration schemes are reasonable.

73. There are, however, significant concerns about funding. Councils and NHS boards are having great difficulty in agreeing budgets for the new IAs. At October 2015, six months before they were required to be established and commissioning health and care services, the Scottish Government had only been informed of the agreed budgets for six IAs. This uncertainty about budgets is likely to continue until early 2016. The results of the UK spending review were not announced until November 2015, and the Scottish Government will only publish its financial plans on 16 December 2015.

74. NHS boards and councils have faced several years of financial constraints and this is expected to continue in the coming years. There is a risk that, if NHS boards and councils seek to protect services that remain fully under their control, IAs may face a disproportionate reduction in their funding, despite the focus on outcomes that all partners should have. We have reported previously on increasing pressures on health and care budgets. This risk of budget overspends is a significant risk for IJBs. Other specific factors add to these difficulties in agreeing budgets:

- **Set-aside budgets:** These relate to the budgets retained by NHS boards for larger hospital sites that provide both integrated and non-integrated services. There are difficulties in agreeing these set-aside budgets, despite the Scottish Government issuing specific guidance. The current difficulties relate to how to determine the integrated and non-integrated costs for these hospitals and how to allocate a fair share to each IJB within the NHS board area. More fundamentally, however, there is a risk that NHS

boards may regard this funding as continuing to be under their control, making it difficult for IAs to use the money to shift from acute hospital care to community-based and preventative services. As a result of these uncertainties, not all of the strategic plans published so far consider the set-aside budgets or plan for the level of acute services that will be needed in future years.

- **Different planning cycles:** NHS boards and councils agree budgets at different times. In North Ayrshire, for example, the council agreed its 2015/16 budget in December 2014, while the NHS agreed its budget in March 2015. NHS budgets and allocations can change during the financial year. This could bring further challenges for IJBs. Similar budget-setting cycles exist across Scotland. If councils and NHS boards continue with these cycles, then IJBs will be involved in protracted negotiations for budgets and ultimately cannot expect partners to approve their plans until just before the start of each financial year. In response, NHS Forth Valley has adapted its budgeting process to allow it to provide an earlier indication of the integrated health budget to its local IAs. In addition, as part of the community planning process, there is an expectation that community planning partners will share information on resource planning and budgets at an early stage, before formal agreement.[25] This should help IAs' financial planning.

Integration authorities need to make urgent progress in setting out clear strategic plans

Most IAs are still developing their overall strategic plans, but those that are in place tend to be aspirational and lack important detail

75. Strategic planning is central to the role that IAs will have in commissioning and helping redesign local health and care services. Scottish Government guidance emphasises the importance of localities in this process, and of strategic plans to reflect the different priorities and needs of local areas.

76. At the time of our audit, only six IAs had published their strategic plans. Some, such as Aberdeen City, Aberdeenshire and Moray, have developed draft plans in advance of the formal approval of the integration schemes. Difficulties with reaching agreement on budgets are an important factor hindering IAs from developing comprehensive strategic plans. This raises concerns about the readiness of IAs to make an immediate impact in reshaping local services. Our audit involved speaking to people involved with strategic planning, including IJB board members. Many of them felt it would be at least another year before most IAs have established plans that are genuinely strategic and can redesign future service delivery rather than simply reflect existing arrangements.

77. Even where strategic plans are in place, there tend to be weaknesses in their scope and quality. They often set out the broad direction of how to provide integrated health and social care services in their areas over the next three or so years, identifying local priorities for their area and for localities. But they can be unclear about what money and staff are available, particularly over the longer term, or how to match these to priorities. They lack detail on what level of acute services is needed in an area and how they will shift resources towards preventative and community-based care. They generally lack performance measures that directly relate to the national outcomes.

78. Strategic planning is even less developed at the locality level. There is a risk that strategic planning is not joined up with locality planning. Some IAs have completed strategic needs assessments, helping to identify the different needs and priorities of individual localities. They are using these to develop local priorities and budgets. There are also significant challenges in involving a wide range of service users, voluntary organisations, GPs and other clinicians and other professional staff in the planning process. These groups are represented at IJB board level, as non-voting members. But involving these groups more widely and actively at locality level is crucial to providing community-based and preventative health and social care services.

Most IAs have still to produce supporting strategies

79. In addition to their overall strategic plans, IAs need to establish supporting strategies for important areas such as workforce, risk management, data sharing, and how they will work with people who use health and social care services. They are required to set out a broad timetable for producing these in their integration schemes.

80. We analysed the timetables in the approved integration schemes available at the time of our audit. This reveals some significant variations (Exhibit 9, page 33). Some risk management and workforce strategies have been developed and are scheduled to be agreed well in advance of the IA becoming operational. In others, however, it will be up to 12 months after the IA becomes operational before these strategies are due to be agreed and can start to contribute to progress with integrating services.

81. This raises questions about the effectiveness of some IAs, at least in the first year of their operation. It is important that IA strategies are well thought through, built on an analysis of local needs and resources and meaningful consultation, clearly setting out how the IA will deliver against the aspirations of the Act. We did not look in detail at the strategies produced at this early stage. But there is a risk that strategies produced quickly lack the detail needed to show how IAs will take practical steps that:

- improve outcomes
- integrate services
- make best use of the funds, skills and other resources available to them.

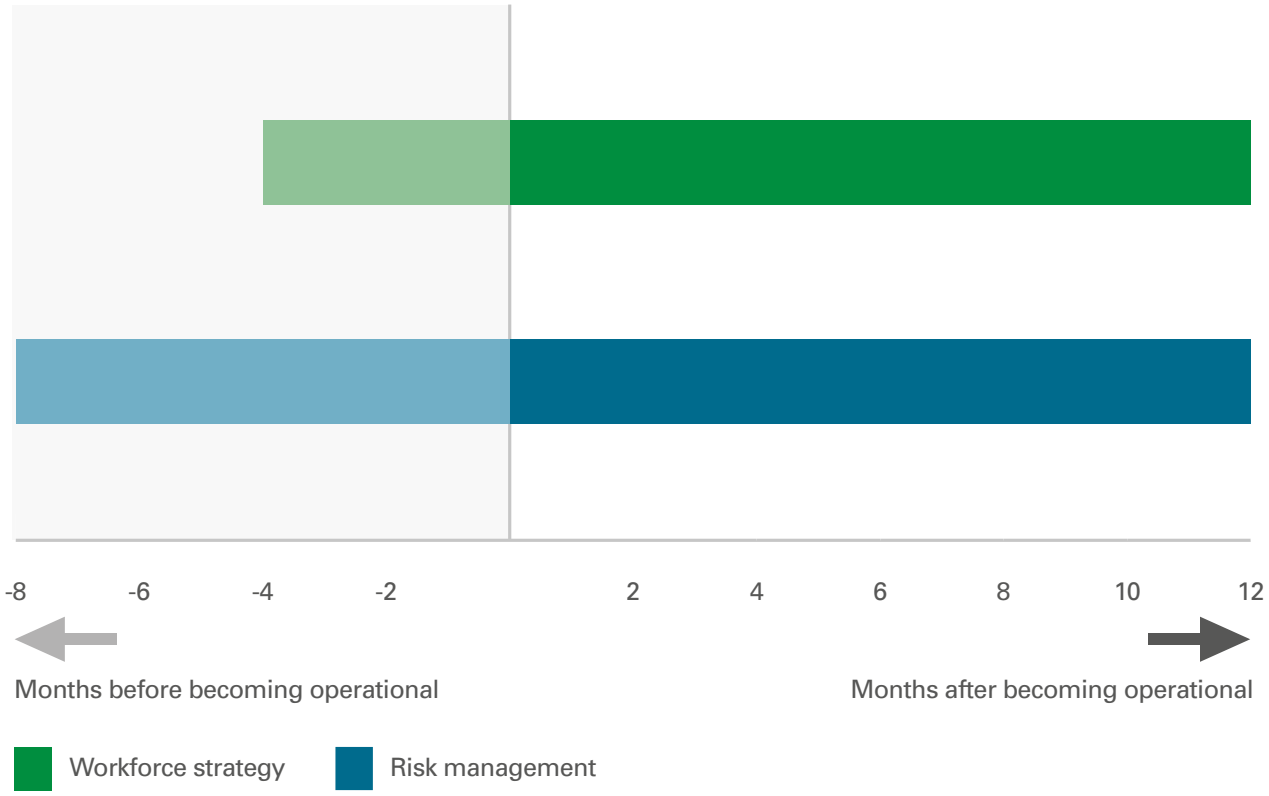
Equally, there are risks where the IA will not have plans in place until they have been operational for many months. It is important that IAs have clear strategic priorities and use these in developing:

- a workforce strategy, showing how they will redesign health and care services
- a risk management strategy to demonstrate that they are properly prioritising their work and their resources.

Exhibit 9

Range of timescales for supporting strategies

It will be up to a year before some IJBs have established workforce and risk management strategies.



Source: Audit Scotland analysis of available integration schemes

There is a pressing need for workforce planning to show how an integrated workforce will be developed

82. The health and social care workforce is critical to the success of integration. Health and social care services are personal services; it is important that staff have the skills and resources they need to carry out their roles, including providing emotional and physical support and clinical care.

83. At present, few IAs have developed a long-term workforce strategy. Developing a suitably skilled workforce is crucial to the success of integrated health and social care services. This is particularly challenging, given the wide range of people involved and the size of the workforce. NHS Scotland employs around 160,000 staff.[26] Social services employ almost 200,000, both directly employed council staff and others from the private and voluntary sector.[27] Furthermore, an estimated 759,000 people in Scotland are carers for family members, friends or neighbours.[28] IJBs need to work closely with professional and regulatory bodies in developing their workforce plans.

84. IJBs do not directly employ staff, but they are responsible for coordinating services from this varied mix of staff and carers. There will be implications for the skills and experience that staff will need to deliver more community-based support as services change. Developing and implementing workforce strategies to meet these needs will be challenging.

85. The following will add to these difficulties:

- **Financial pressures on the NHS and councils.** NHS boards and councils continue to face pressures from tightening budgets and rising demand for services. Most councils have responded to these pressures in part by reducing staff numbers and outsourcing some services to the private and voluntary sectors. These changes are less evident in the health sector. As a result, there are concerns that any future changes to the workforce will not affect health and care staff equally.

- **Difficulties in recruiting and retaining social care staff.** Over many years, councils have had difficulties recruiting and retaining care home and home care staff. Organisations in areas such as Edinburgh and Aberdeen, with high living costs, have had particular difficulties. There is a need to develop a valued, stable, skilled and motivated workforce. We found examples of organisations developing new approaches to making careers in caring more attractive. For example in Dumfries and Galloway and Aberdeen City they are considering creating caring roles that are part of a defined career path, to encourage more people into these roles.

- **The role of the voluntary and private sectors.** Voluntary and private organisations play an important role in providing care and support, but there are particular challenges in how IJBs can involve these diverse organisations as part of a coordinated workforce plan. The introduction of the national living wage will have a significant impact on the voluntary sector and their ability to provide the same level of support for health and care services. We will comment on this further in our audit of Social Work in Scotland.

86. GPs have a particularly important role but there are concerns over GPs having time available to contribute actively towards the success of integrated services. Most GPs are independent contractors, not employed by the NHS. GPs have a crucial role in patient referrals and in liaising with other health and care services. Ultimately, if there are concerns about the quality or availability of community-based services, there is a risk that GPs will refer patients to hospital to ensure they receive the care they need.

87. Throughout Scotland, there are difficulties in recruiting and retaining GPs. As a result, GPs are facing increasing pressures, at a time when a planned shift to community care and support can be expected to increase their workload. The Scottish Government has recognised this issue and has announced £2.5 million to fund a three-year programme to improve recruitment and retention of GPs and improve the number of people training to be GPs. It also has plans to revise GP contracts, to allow GPs to delegate some services to other healthcare professionals, freeing up GPs' time. However, it will be many years before these measures will have a significant impact.

The proposed performance measurement systems will not provide information on some important areas or help identify good practice

88. There is wide support for the Scottish Government's focus on health and wellbeing outcomes (set out earlier at Exhibit 6). In addition to the nine national outcomes, the Scottish Government developed core integration indicators to measure progress in delivering the national health and wellbeing outcomes and to allow national comparison between partnerships. These 23 measures, listed in Appendix 2, cover a mixture of outcome indicators – based on people's perception of the service they received – and indicators based on system or organisational information, such as people admitted to hospital in an emergency or adults with intensive care needs receiving care at home.

89. The Scottish Government has provided further support through the Information Services Division (ISD) of NHS National Services Scotland. It provided access to local data and technical support to help partnerships understand and plan for their areas' health and social care needs. The ISD data brings together health, social care and demographic information for the first time and is a significant step forward in providing partnerships with the information they need to plan locally and to measure the impact of their activity. Much of the data is already available for partnerships to use, and ISD plans to develop the data further including analysing the cost of end-of-life care.

90. Some IAs have been unable to make use of this resource as data-sharing agreements are not yet in place. ISD has access to health data but requires permission from councils to access the social work data they hold for their areas. Before councils can grant access they need to ensure they are not breaching data protection legislation and are doing this by agreeing data-sharing procedures. Most councils and NHS boards are making progress with this, but where information sharing has not been agreed IAs are having to plan without it.

91. National care standards were created in 2002 to help people understand what to expect from care services and to help services understand the standard of care they should deliver. Given the way that services have changed since then, in June 2014, the Scottish Government issued a consultation on new national care standards. The consultation proposed developing overarching standards, based on human rights, setting out the core elements of quality that should apply across all health and social care services.

92. The standards are an important part of integrating and scrutinising health and care services and it is important that they are in place quickly and publicised widely. However, overarching principles will not be finalised until April 2016; this will be followed by a consultation on specific and generic standards, with a view to them being implemented from April 2017.

93. While all these developments are clearly a step in the right direction, all partners need to consider the following issues:

- **The core integration indicators do not fully take account of all the expected benefits of the reform programme.** Overall, the Scottish Government's reform programme is expected to shift the balance of care to community-based or preventative services. However, demographic pressure will create increased demand for both hospital and community-

based services. It is not clear how the proposed indicators will measure progress in transferring from hospital to community care. There may be central data that the Scottish Government can use to track some of these changes but these should be set out clearly as part of measures to publicly monitor and report on progress. It is also unclear how the Scottish Government will track expected savings. An example is the expected annual savings of £104 million from reducing some of the variation evident in the cost of providing health and social care services across different parts of Scotland.[29] The core set of integration indicators does not attempt to give a national measure of reductions in cost variation or the savings that arise from this. Anticipatory care plans are projected to yield savings of £12 million a year, but there are no proposed indicators to assess if IAs are using them, or what impact they have on releasing resources such as skills and equipment.[30] This means the Scottish Government will not know if integration has freed up resources for other uses, in line with its expectations, or if it has achieved a shift from institutional to community-based care.

- **The process of linking measures and outcomes is incomplete and it may be difficult to measure success.** This means that the Scottish Government will be unable to see what progress is being made nationally, or to compare the different approaches adopted by IAs to identify which are most effective. For example, one of the measures seen as indicating success is 'reducing the rate of emergency admission to hospitals for adults'. (A reduction in this is seen as evidence of a positive impact on outcomes 1, 2, 4, 5 and 7, as listed at Exhibit 6.) But hospital emergency admission rates can reduce for many reasons. At present, it is up to individual partnerships to decide which additional local measures they will adopt to explore why hospital emergency admission rates are changing.

  Councils and NHS boards are required to set out in their strategic plans which local measures they will use. We compared plans for North Lanarkshire and North Ayrshire IAs, both relatively advanced in their performance management arrangements at the time of our audit. We found the following:

  – They will use different measures from each other. This has the benefit of allowing IAs to focus on their local priorities. However, it will make it difficult for the Scottish Government to compare performance across IAs to identify what approaches are working best (Exhibit 10, page 37).

  – In various places, both IAs have associated a different mix of indicators to an outcome from that set out in Scottish Government guidance. This occurs more frequently in North Ayrshire which developed its plans before the Scottish Government published its approach. But North Lanarkshire also has taken a different view on which indicators it will use to measure progress on some of the national outcomes, making it difficult for the Scottish Government to measure progress at a national level.

  – We have provided a more detailed comparison of the approaches used by North Lanarkshire and North Ayrshire IAs in a supplement to assist other IJBs when developing their plans (Exhibit 10, page 37).

Exhibit 10

Integration authorities can use different information to measure progress towards national outcomes

National Outcome	Core integration indicator			Number of additional local indicators mapped to national outcome	
	Mapped to national outcome by both	Not mapped to national outcome by both		North Ayrshire	North Lanarkshire
People are able to look after and improve their own health and wellbeing and live in good health for longer	Percentage of people who say they are able to look after their health very well or quite well	• Premature mortality rate	NL	5	19
		• Emergency admission rate	AL		
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	None	• Percentage of staff who say they would recommend their workplace as a good place to work	NA	8	8
Resources are used effectively and efficiently in the provision of health and social care services	None	• Percentage of adults supported at home who agree that their health and care services seemed to be well coordinated	NL	10	31
		• Readmission to hospital within 28 days	NL		
		• Proportion of last six months spent at home or in community setting	NL		
		• Falls rate per 1,000 population aged 65+	NL		
		• Number of days people spend in hospital when clinically ready to be discharged per 1,000 population	NL		

NL = North Lanarkshire map this to outcome

NA = North Ayrshire map this to outcome

AL = Neither map this to outcome

Source: Audit Scotland analysis of performance frameworks

- **It is important that there is a balance between targeted local measures and national reporting on impact.** This has the benefit of providing flexibility so that local partnerships can focus their efforts on priority areas. It is important that local partnerships set ambitious targets. The reforms bring the opportunity to have local outcome measures that local people recognise as responding to specific issues in their community. However, the Scottish Government and IAs need to resolve tensions between introducing better local measures and the need for clarity at national level about the impact that IAs are having. An increasing focus on local measures means it is timely to review whether existing national measures are fit for purpose.

The role of localities still needs to be fully developed

94. Localities are intended to be the key drivers of change, bringing together service users, carers, and health and care professionals to help redesign services. The Act requires IAs to establish at least two localities within their area. Scottish Government guidance, issued in July 2015, suggests that localities should be formed around natural clusters of GP practices. Naturally, the number and size of localities vary. Edinburgh, for example, has established four localities, with an average population of around 120,000. By contrast, Shetland has seven localities, each with an average population of around 4,000. Under the Act, localities need to be involved in both planning services and play a consultative role about service change in their local area. This raises an issue about the scale and size of localities – the optimal scale for locally planning services may not be the same as that for consulting on service change.

95. With IAs still focusing on their overall budgets and governance arrangements, the arrangements for localities are relatively underdeveloped. Some have now agreed priorities and budgets for individual localities, but in most cases, work at locality level has initially focused on networking with stakeholders and on needs assessments. Localities are key to the success of integration, therefore IJBs must focus on how localities will lead the integration of health and care.

96. We found that GPs are becoming involved in locality planning. But, in many areas, there are concerns about their ability to remain fully involved in locality planning. Some GPs are also sceptical, given earlier experiences with LHCCs and CHPs, which failed to provide a fundamental shift towards preventative and community-based services. In response, the Scottish Government is piloting a new approach in ten health centres across the country. These centres will form 'community care teams' and test different ways of delivering healthcare. It is important that there is a clear link between the work of these teams and locality planning arrangements to avoid confusion.

There will be a continuing need to share good practice and to assess the impact of integration

97. The 31 IAs are putting different arrangements in place to deliver integrated health and social care services. This high level of variation is permitted by the Act and, in allowing IAs to respond to their local context and priorities, has many advantages. However, at some point, the Scottish Government and individual IAs will need to review their initial arrangements and consider how these might evolve to reflect good practice in other parts of Scotland. We hope that this report, and our subsequent audits, will contribute towards this wider review.

Part 4

Recommendations

We have made recommendations to help organisations address potential risks to the success of health and social care integration. We will monitor progress as part of our future work on integration.

The Scottish Government should:

- work with IAs to help them develop performance monitoring to ensure that they can clearly demonstrate the impact they make as they develop integrated services. As part of this:
  - work with IAs to resolve tensions between the need for national and local reporting on outcomes so that it is clear what impact the new integration arrangements are having on outcomes and on the wider health and social care system
- monitor and publicly report on national progress on the impact of integration. This includes:
  - measuring progress in moving care from institutional to community settings, reducing local variation in costs and using anticipatory care plans
  - reporting on how resources are being used to improve outcomes and how this has changed over time
  - reporting on expected costs and savings resulting from integration
- continue to provide support to IAs as they become fully operational, including leadership development and sharing good practice, including sharing the lessons learned from the pilots of GP clusters.

Integration authorities should:

- provide clear and strategic leadership to take forward the integration agenda; this includes:
  - developing and communicating the purpose and vision of the IJB and its intended impact on local people
  - having high standards of conduct and effective governance, and establishing a culture of openness, support and respect
- set out clearly how governance arrangements will work in practice, particularly when disagreements arise, to minimise the risk of confusing lines of accountability, potential conflicts of interests and any lack of clarity about who is ultimately responsible for the quality of care and scrutiny.

This includes:

- setting out a clear statement of the respective roles and responsibilities of the IJB (including individual members), NHS board and council, and the IJB's approach towards putting this into practice
- ensuring that IJB members receive training and development to prepare them for their role, including managing conflicts of interest, understanding the organisational cultures of the NHS and councils and the roles of non-voting members of the IJB

- ensure that a constructive working relationship exists between IJB members and the chief officer and finance officer and the public. This includes:
  - setting out a schedule of matters reserved for collective decision-making by the IJB, taking account of relevant legislation and ensuring that this is monitored and updated when required.
  - ensuring relationships between the IJB, its partners and the public are clear so each knows what to expect of the other

- be rigorous and transparent about how decisions are taken and listening and acting on the outcome of constructive scrutiny, including:
  - developing and maintaining open and effective mechanisms for documenting evidence for decisions
  - putting in place arrangements to safeguard members and employees against conflict of interest and put in place processes to ensure that they continue to operate in practice
  - developing and maintaining an effective audit committee
  - ensuring that effective, transparent and accessible arrangements are in place for dealing with complaints
  - ensuring that an effective risk management system in in place

- develop strategic plans that do more than set out the local context for the reforms; this includes:
  - how the IJB will contribute to delivering high-quality care in different ways that better meet people's needs and improves outcomes
  - setting out clearly what resources are required, what impact the IJB wants to achieve, and how the IA will monitor and publicly report their progress
  - developing strategies covering the workforce, risk management, engagement with service users and data sharing, based on overall strategic priorities to allow the IA to operate successfully in line with the principles set out in the Act and ensure these strategies fit with those in the NHS and councils
  - making clear links between the work of the IA and the Community Empowerment (Scotland) Act and Children and Young People (Scotland) Act

- develop financial plans that clearly show how IAs will use resources such as money and staff to provide more community-based and preventative services. This includes:
  - developing financial plans for each locality, showing how resources will be matched to local priorities
  - ensuring that the IJB makes the best use of resources, agreeing how Best Value will be measured and making sure that the IJB has the information needed to review value for money and performance effectively
- shift resources, including the workforce, towards a more preventative and community-based approach; it is important that the IA also has plans that set out how, in practical terms, they will achieve this shift over time.

Integration authorities should work with councils and NHS boards to:

- recognise and address the practical risks associated with the complex accountability arrangements by developing protocols to ensure that the chair of the IJB, the chief officer and the chief executives of the NHS board and council negotiate their roles in relation to the IJB early on in the relationship and that a shared understanding of the roles and objectives is maintained
- review clinical and care governance arrangements to ensure a consistent approach for each integrated service and that they are aligned to existing clinical and care governance arrangements in the NHS and councils
- urgently agree budgets for the IA; this is important both for their first year and for the next few years to provide IAs with the continuity and certainty they need to develop strategic plans; this includes aligning budget-setting arrangements between partners
- establish effective scrutiny arrangements to ensure that councillors and NHS non-executives, who are not members of the IJB board, are kept fully informed of the impact of integration for people who use local health and care services
- put in place data-sharing agreements to allow them to access the new data provided by ISD Scotland.

Endnotes

1 This included reviewing 18 approved integration schemes, 17 of which were for integration joint boards following the body corporate model and one of which was for Highland's lead agency model.

2 Clackmannanshire and Stirling, Dumfries and Galloway, East Renfrewshire, Edinburgh City, North Ayrshire and North Lanarkshire.

3 *Review of Community Health Partnerships* [PDF], Audit Scotland, June 2011.

4 *Reshaping care for older people* [PDF], Audit Scotland, February 2014.

5 *Maximising Recovery, Promoting Independence: An Intermediate Care Framework for Scotland,* Scottish Government, 2012.

6 *Scotland Performs*, Scottish Government, 2015.

7 *Projected Population of Scotland (2014-based),* National Records Scotland, 2015.

8 *Finance Committee. 2nd Report, 2013 (Session 4): Demographic change and an ageing population.* Scottish Parliament, 11 February 2013.

9 *Bed days occupied by delayed discharge patients*, ISD Scotland, May 2015.

10 *Review of Community Health Partnerships* [PDF], Audit Scotland, 2011.

11 After approval of its integration scheme, an IJB is established by parliamentary order. An IJB is operational when it has delegated responsibility from the NHS board and council for integrated budgets and services.

12 The lead agency is between Highland Council and NHS Highland. NHS Highland also has an IJB with Argyll and Bute Council.

13 Where the IJB spans across more than one council area, the minimum number of voting members is different. For IJBs of two council areas, at least two councillors from each council are required. For IJBs of more than two areas at least one councillor from each council is required. In both cases, the NHS board must nominate board members equal to the total number of councillors.

14 As IJBs have no plans to directly employ staff in this early stage of development, we are not commenting on related potential risks and issues. We are likely to return to this issue in more detail in future reports on integration.

15 *Self-directed support* [PDF], Audit Scotland, June 2014

16 The Joint Improvement Team is a partnership between the Scottish Government, NHSScotland, COSLA (Convention of Scottish Local Authorities) and the voluntary, independent and housing sectors.

17 East Dunbartonshire, Shetland and West Dunbartonshire.

18 Some areas, have a chief officer designate. This happens where, although recruitment for a chief officer is complete, until the IJB is established it cannot formally appoint the chief officer.

19 Falkirk currently has an interim chief officer in post and expects to make a permanent appointment to this role by the end of the year.

20 Public Bodies (Joint Working) (Scotland) Bill, Financial Memorandum, 2013.

21 Ibid.

22 *Review of Community Health Partnerships* [PDF], Audit Scotland, June 2011.

23 We explore these tensions more fully in our report *Arm's-length external organisations (ALEOs): are you getting it right?* [PDF], Audit Scotland, June 2011.

24 *RCN briefing 2: Clinical and care governance in an integrated world,* May 2015, Royal College of Nursing.

25 *Agreement on joint working on community planning and resourcing*, Scottish Government and COSLA, September 2013.

26 *NHS Scotland Workforce Information Quarterly update of Staff in Post, Vacancies and Turnover at 30 June 2015*, ISD Scotland, 2015. This figure refers to all staff in NHS Scotland, not just those working in integrated services.

27 *Scottish Social Service Sector: Report on 2014 Workforce Data*, Scottish Social Services Council, 2015.

28 *Scotland's Carers,* Scottish Government, March 2015.

29 Public Bodies (Joint Working) (Scotland) Bill, Financial Memorandum, 2013.

30 Ibid.

Appendix 1

Audit methodology

We reviewed a range of documents during our audit. Where available, this included:

- the Act and national guidance and regulations on implementing the Act
- 18 approved integration schemes[1]
- strategic and related financial plans
- minutes, papers and agendas for IJB meetings
- internal audit reports and local reports on integration arrangements
- financial audit information
- joint inspection reports from the Care Inspectorate and Healthcare Improvement Scotland.

We interviewed stakeholders in the following IA areas:

- Clackmannanshire and Stirling
- Dumfries and Galloway
- East Renfrewshire
- Edinburgh City
- North Ayrshire
- North Lanarkshire.

We drew on the work already carried out by:

- the Care Inspectorate
- Healthcare Improvement Scotland
- local auditors.

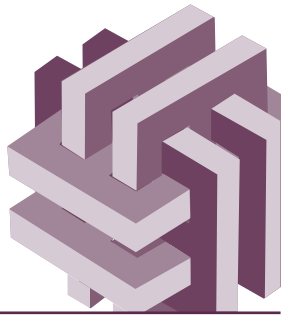
We also interviewed staff from:

- the Scottish Government
- the Joint Improvement Team
- the British Medical Association
- the Convention of Scottish Local Authorities
- NHS Information Services Division
- the Care Inspectorate
- Healthcare Improvement Scotland
- the voluntary sector.

Note: 1. We reviewed 17 integrations schemes establishing IJBs for Argyll & Bute, East Ayrshire, East Dunbartonshire, East Lothian, East Renfrewshire, City of Edinburgh, Eilean Siar, Inverclyde, Midlothian, North Ayrshire, North Lanarkshire, Renfrewshire, Shetland Isles, South Ayrshire, South Lanarkshire, West Dunbartonshire and West Lothian, and Highland's integration scheme setting out its lead agency approach.

Appendix 2

Scottish Government core integration indicators



Outcome indicators, based on survey feedback, available every two years, include:

- Percentage of adults able to look after their health very well or quite well.
- Percentage of adults supported at home who agree that they are supported to live as independently as possible.
- Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.
- Percentage of adults supported at home who agree that their health and care services seemed to be well coordinated.
- Percentage of adults receiving any care or support who rate it as excellent or good.
- Percentage of people with positive experience of care at their GP practice.
- Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.
- Percentage of carers who feel supported to continue in their caring role.
- Percentage of adults supported at home who agree they felt safe.
- Percentage of staff who say they would recommend their workplace as a good place to work.*

Outcome indicators derived from organisational/system data, primarily collected for other reasons, available annually or more often, include:

- Premature mortality rate.
- Rate of emergency admissions for adults.*
- Rate of emergency bed days for adults.*
- Readmissions to hospital within 28 days of discharge.*
- Proportion of last six months of life spent at home or in community setting.
- Falls rate per 1,000 population in over 65s.*
- Proportion of care services graded 'good' or better in Care Inspectorate Inspections.
- Percentage of adults with intensive needs receiving care at home.
- Number of days people spend in hospital when they are ready to be discharged.
- Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency.
- Percentage of people admitted from home to hospital during the year, who are discharged to a care home.*
- Percentage of people who are discharged from hospital within 72 hours of being ready.*
- Expenditure on end-of-life care.*

* Indicates indicator is under development.

Health and social care integration

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CHIEF FINANCIAL OFFICER

Aim

1.1 To advise the Integration Joint Board of the content of the job description for the Chief Financial Officer and the timeline for recruitment.

Background

2.1 The Health & Social Care Integration Joint Board is required to appoint a Section 95 Officer who will be the responsible officer for the financial arrangements of the Integration Joint Board.

Summary

3.1 The Chief Officer will set out the timeline for recruitment to this post.

Recommendation

The Health & Social Care Integration Joint Board is asked to **note** the report.

Policy/Strategy Implications	As per the requirements of the Public Bodies (Joint Working) (Scotland) Act.
Consultation	SBC and NHS Borders Chief Financial Officer and Director of Finance.
Risk Assessment	To ensure compliance with the requirements of the Public Bodies (Joint Working) (Scotland) Act.
Compliance with requirements on Equality and Diversity	Compliant
Resource/Staffing Implications	As per the job description

Approved by

Name	Designation	Name	Designation
Susan Manion	Chief Officer, Health & Social Care Integration		

Author(s)

Name	Designation	Name	Designation
Iris Bishop	Board Secretary		

INTEGRATION JOINT BOARD (IJB) – CHIEF FINANCIAL OFFICER ROLE

1. JOB IDENTIFICATION
Job Title: **Chief Financial Officer – Integration Joint Board (IJB)** Reporting to: Chief Officer – Integration Joint Board Accountable to : Integration Joint Board Professionally Accountable to: Chief Financial Officer (SBC) and Director of Finance (NHS)

2. JOB PURPOSE
• Is a key member of the leadership team, accountable to the Integration Joint Board for the planning, development and delivery of the IJB's three year financial strategy linked to the achievement of the Strategic Plan; • Is responsible for the provision of strategic financial advice and support to the Integration Joint Board and Chief Officer and for the financial administration and financial governance of the IJB; • The post holder is the senior professional financial advisor to the Integrated Joint Board and is the Accountable Officer for financial management and administration of the IJB. The Chief Officer has all other accountable officer responsibilities. The Chief Financial Officer's responsibility includes assuring probity and sound corporate governance and responsibility for achieving Best Value.

3. DIMENSIONS
The Chief Financial Officer : • will work with the Chief Officer to establish, plan, develop and implement a business and financial strategies to resource and deliver the IJB's strategic objectives sustainably and in the public interest; • will in collaboration with the Chief Officer put in place arrangements to finance the agreed strategic outcomes of the IJB • is responsible for developing the financial strategy and financial governance arrangements of the IJB; • must be actively involved in, and able to bring influence to bear on, all material business decisions to ensure immediate and longer term financial implications, opportunities and risks are fully considered, and alignment with the IJB's financial strategy; and • must lead the promotion and delivery by the IJB of good financial management so that public money is safeguarded at all times and used appropriately, economically, efficiently and effectively. • is responsible for creating, in conjunction with related Local Authority (LA) and Health Board (HB) Directors of Finance, a collaborative arrangement with Business partners and associated Chief Financial Officers within the related Board Area(s).

The Budget under direct financial management is £136m, and the funding under control of the strategic plan is £156M.

4. KEY RESULT AREAS

Developing and implementing Organisational Strategy

- Ensure the delegated resources specified within the Strategic plan are deployed to deliver the outcomes agreed
- Provide a strategic financial focus and advice to the IJB
- Ensure that the directions to the Health Board and Local Authority require that the financial resources are spent in accordance with the Strategic Plan.
- Establish a process of regular monitoring of the financial performance of the IJB budget in conjunction with the Health Board and Local Authority Directors of Finance to provide the Chief Officer with management accounts for both arms of the operational budget and for the Integration Joint Board as a whole
- Ensure regular comprehensive budget monitoring reports are prepared for the IJB
- Develop business cases for changes to delegated resource budget in line with the strategic plan to improve outcomes for patients carers and service users in conjunction with the Chief Officer
- Work collaboratively with the Partnership Senior Management Team to achieve the objectives of the IJB.
- Assist the Chief Officer and Senior Managers to deliver change and improvement through service redesign.
- Identify priority areas for action and contribute to policy development to address these in the short, medium and long-term in a way which draws on a sound theoretical base and personal experience and knowledge of financial management.
- Supporting the Chief Officer to ensure efforts within the Partnership are co-ordinated to improve health, reduce inequalities, improve health and social care services, and increase social inclusion based on the user's journey.

Responsibility for Financial Strategy

- Take a lead role in the compilation of the IJBs financial strategic plan and annual revenue budget
- Prepare strategic scenario planning to allow the IJB to be able to approve a balanced financial plan/budget
- Provide expert advice on policy, legislative and accountancy developments
- Production and management of the IJB's Financial Plans in terms of processes and outcomes ensuring compliance with relevant regulations and local and national requirements and timescales.
- Liaise and provide finance advice and guidance on all aspects of planning and performance out with the partnership including statutory agencies, community planning partnerships and other Health and Social Care partnerships.
- Develop and implement Financial Planning for all areas of the IJB

Influencing Decision Making

- Responsible for ensuring effective liaison and working relationships with all financial functions within the Health Board, Council and other partnerships.
- Contribute to relevant wider NHS, Council and Community Planning Partnership Strategy.
- Contribute to the delivery of a comprehensive and coherent performance management system, facilitating real performance improvement across the Partnership, reducing duplication and delivering excellence in governance.

Financial Information for Decision Makers

- Deliver professional, consistent and appropriate financial management advice across the Partnership, in line with statutory accounting guidance and regulations

Value for Money

- Responsibility for value for money assessment contributing to the IJB's Strategic Plan, playing a key role in the production and development of the plan.
- Monitor and advise on the strategic financial implications/considerations of Best Value.

Safeguarding Public Money

- Manage all aspects and take a lead role in the development of financial governance, control and compliance, management of risk, and deliver a comprehensive financial management system for the IJB.

Assurance and Scrutiny

- Plan, monitor, co-ordinate and ensure completion of the annual closure of the Partnership's accounts and the production of the annual financial statements, ensuring compliance with statutory reporting requirements required by Local Authority/ NHS group accounts .
- Establish procedures in conjunction with the Health Board accountable officer and Local Authority Section 95 Officer to allow the best practice principles set out in the Code of Guidance on Funding External Bodies and Following the Public Pound to be followed.;
- Act as point of contact with the External Auditor in respect of the audit of the IJB's financial statements and liaising with them during this process.
- Receive assurance from Health Board and LA Directors of Finance re anti-fraud measures within their organisations and to develop and necessary local procedures to monitor anti-fraud measures designed to reduce risk.
- Ensure that Financial Risk Management is properly addressed within the Integration Joint Board.

4. KNOWLEDGE, TRAINING AND EXPERIENCE REQUIRED TO DO THE JOB

- Educated to degree level or equivalent with significant financial experience at senior management level within a large complex organisation, preferably within the NHS or Local Authority.

- CCAB, CIMA or overseas equivalent Qualified Accountant
- Strong negotiating and communication skills
- Practical experience of applying relevant strategic business and financial support tools.
- Demonstrate a track record in collaborative working that produces results.
- Demonstrate leadership and influencing skills and have a proven track record in developing structures and/or systems to support the attainment of organisational goals.
- Demonstrate integrity and effective management skills necessary to enable the successful delivery of redesign programmes to improve services.
- Ability to develop and maintain effective, positive relationships with key partner organisations at a national as well as local level providing a positive role model for partnership, relationship and conflict management.

PERSON SPECIFICATION

Factor	**Essential**
Qualifications and/or experience	• Degree in a relevant subject or equivalent qualification. • Membership of a CCAB professional body, CIMA or overseas equivalent. • Evidence of continuing, relevant, professional and personal development. • Extensive experience in a senior role within a complex or multi-agency / disciplinary financial management environment, with practical experience of applying strategic planning and performance tools. • Leadership and influencing skills. • Proven track record in collaborative working that produces results within dynamic, and participative decision making environments. • Proven track record in developing structures and systems to support the attainment of organisational goals.
	Desirable
Qualifications and/or experience	• Experience of overseeing the production of annual accounts for a large/complex organisationExperience of working at a senior level in a political environment within health service and/or local authority.
	Essential
Knowledge	• Detailed knowledge of relevant policy change in Scotland, particularly in relation to the business support element of health and social care. • Detailed knowledge of development agenda facing Health and Social Care Partnerships. • Comprehensive knowledge of tools and techniques for strategic financial support and development. • Critical appraisal skills. • Highly effective numeracy/ data interpretation, analysis and presentation skills.
Attributes	• Demonstrable and facilitative leadership skills. • Excellent communication and inter-personal skills, including sensitivity,

	tact and political astuteness. • Honesty, integrity and with high professional standards • Self-starter. • Values driven. • Team player. • Ability to work on own initiative.
Training	• Record of continuous professional development (CPD).

ROLE OF THE CHIEF FINANCIAL OFFICER FOR AN INTEGRATION JOINT BOARD

INTRODUCTION

This paper outlines the background to the **role** of the Chief Financial Officer for an Integration Joint Board and describes the proposed role that the Chief Financial Officer must fulfil to meet their professional obligations. Each Integration Joint Board will be responsible for the appointment of its Chief Financial Officer.

This paper has been prepared from two main sources:

1. CIPFA Statement on the Role of the Chief Financial Officer in Local Government. There have been amendments to this following discussion with IRAG to ensure that they are focussed on the requirements of the Integration Joint Board.

2. Professional Guidance, Advice and Recommendations for Shadow Integration Arrangements – as approved by IRAG. IRAG paper of May 20, 2014 outlined these core financial duties which have been included in the role of the Chief Financial Officer.

Following the discussion of this role at the May IRAG meeting, areas which required policy clarification based on IRAG views were identified. IRAG recommendations on the following were:

- Chief Financial Officer should be professionally qualified.
- It would be inappropriate for Chief Executives to fulfil the role.
- In most cases the role of Chief Financial Officer should not be filled by either the Director of Finance of the Health Board or the S.95 officer of the Local Authority. However, there may be local circumstances that would allow this to happen. Any potential issues of conflict would need to be carefully considered in this instance.
- It is possible for one person to be the Chief Financial officer for more than one IJB.

From the work outlined above a Role Outline/Job Description for a Chief Financial Officer has been prepared. This has been reviewed by the Head of Health & Social Care Workforce Integration and the NHS Head of Pay & Conditions.

The impact that these roles will have on existing Directors of Finance in both Health and Local Authority has been considered. The scale of funds that will flow through the Health Board and Local Authority will be unchanged because of integration. The close working relationship that Directors of Finance will have to have with the Chief Financial Officer(s) in their area cannot be understated.

These are based on the Roles and responsibilities of the IJB on Day 1 and would need to be amended if the IJB became a trading/employment organisation.

I

CIPFA STATEMENT ON THE ROLE OF THE CHIEF FINANCIAL OFFICER IN LOCAL GOVERNMENT

The Chief Financial Officer in a public service organisation:

- is a key member of the Leadership Team, helping it to develop and implement strategy and to resource and deliver the authority's strategic objectives sustainably and in the public interest;
- must be actively involved in, and able to bring influence to bear on, all material business decisions to ensure immediate and longer term implications, opportunities and risks are fully considered, and alignment with the authority's financial strategy; and
- must lead the promotion and delivery by the whole authority of good financial management so that public money is safeguarded at all times and used appropriately, economically, efficiently and effectively.

To deliver these responsibilities the Chief Financial Officer:

- must have access to appropriate financial information and analysis.

Core CFO responsibilities:

Developing and implementing organisational strategy

- Contributing to the effective leadership of the authority, maintaining focus on its purpose and vision through rigorous analysis and challenge.
- Contributing to the effective corporate management of the authority, including strategy implementation, cross organisational issues, integrated business and resource planning, risk management and performance management.
- Supporting the effective governance of the authority through development of corporate governance arrangements, risk management and reporting framework; and
- Leading development of a medium term financial strategy and the annual budgeting process for the Integration Joint Board to ensure financial balance and a monitoring process to ensure its delivery.

Responsibility for financial strategy

- Agreeing the financial framework with sponsoring organisations and planning delivery against the defined strategic and operational criteria.
- Maintaining a long term financial strategy to underpin the authority's financial viability within the agreed performance framework.
- Implementing financial management policies to underpin sustainable long-term financial health and reviewing performance against them.
- Co-ordinating the planning and budgeting processes.

Influencing decision making

- Ensuring that opportunities and risks are fully considered, decisions are aligned with the overall financial strategy. and appropriate briefings are provided to the Integration Joint Board.
- Providing professional advice and objective financial analysis enabling decision makers to take timely and informed business decisions. (This will require a strong working relationship with Directors of Finance and related Chief Financial Officers).
- Ensuring that clear, timely, accurate advice is provided to the Chief Officer/Integration Joint Board in setting the funding plan/budget.
- Ensuring that advice is provided to the scrutiny function in considering the funding plan/budget.

Financial information for decision makers

- Monitoring and reporting on financial performance that is linked to related performance information and strategic objectives that identifies any necessary corrective decisions.
- Responsibility for the consolidation of appropriate management accounts information received from Health Board and Local Authority.
- Ensuring the reporting envelope reflects partnerships and other arrangements to give an overall picture.

Value for money

- Challenging and supporting decision makers, especially on affordability and Best Value, by ensuring policy and operational proposals with financial implications are signed off by the finance function.
- Reporting to the IJB on the efficiency programmes being delivered within the Operational Units
- Co-ordinating appropriate Benchmarking Exercises.

Safeguarding public money

- Implementing effective systems of internal control that include standing financial instructions.
- Ensuring that the authority has put in place effective arrangements for internal audit of the control environment and systems of internal control as required by professional standards and in line with CIPFA's Code of Practice.
- Ensuring that delegated financial authorities are respected.
- Promoting arrangements to identify and manage key business risks, risk mitigation and insurance.
- Implementing appropriate measures to prevent and detect fraud and corruption.
- Ensuring that any partnership arrangements are underpinned by clear and well documented internal controls.

Assurance and scrutiny

- Reporting performance of both the authority and its partnerships to the board and other parties as required.
- Ensuring that financial and performance information presented to members of the public, the community and the media covering resources, financial strategy, service plans, targets and performance is accurate, clear, relevant, robust and objective.
- Supporting and advising the Audit Committee and relevant scrutiny groups. This now needs to include a review of the Statement of Internal Controls.
- Ensuring that clear, timely, accurate advice is provided to the Chief Officer/ Integration Joint Board and the scrutiny functions on what considerations can legitimately influence decisions on the allocation of resources, and what cannot.
- Ensuring that the financial statements are prepared on a timely basis, meet the requirements of the law, financial reporting standards and professional standards as reflected in the Code of Practice on Local Authority Accounting in the United Kingdom developed by the CIPFA/LASAAC Joint Committee.
- Certifying the annual statement of accounts.
- Ensuring that arrangements are in place so that other accounts and grant claims (including those where the authority is the accountable body for community led projects) meet the requirements of the law and of other partner organisations and meet the relevant terms and conditions of schemes
- Liaising with the external auditor.

Leading and Directing the Finance Function - arrangements *will depend on local agreement*

- To receive assurance from Directors of Finance that efficient and effective professional services from the finance staff in both Health and Local Authorities is being delivered.
- Identifying and equipping managers and the Leadership Team with the financial competencies and expertise needed to manage the business both currently and in the future.

PROFESSIONAL GUIDANCE, ADVICE AND RECOMMENDATIONS FOR SHADOW INTEGRATION ARRANGEMENTS

IRAG paper - Role of the Integration Joint Board Chief Financial Officer

The integrated Joint Board financial officer will have to fulfil the following tasks. However local consideration may add other duties to the post.

Tasks that the **Integration Joint Board financial officer** will have to undertake:

- Be Responsible for the financial administration of the IJB;
- Establish financial governance systems for the proper use of the delegated resources;
- Ensure that the Strategic Plan meets the requirement for best value in the use of the Integration Joint Board’s financial resources;

- Ensure that the directions to the Health Board and Local Authority require that the financial resources are spent according to the allocations in the Strategic Plan;

- Establish a process of regular in-year reporting and forecasting in conjunction with the Health Board and Local Authority Directors of Finance to provide the Chief Officer with management accounts for both arms of the operational budget and for the Integration Joint Board as a whole;

- Develop a business case for the resources of the Integrated Joint Board in line with the method set out in the Integration Scheme in conjunction with the Chief Officer;

- Develop financial regulations which incorporate a minimum set of controls. It is recommended that the financial regulations are approved by the Integration Joint Board;

- Establish procedures in conjunction with the Health Board accountable officer and Local Authority Section 95 Officer to allow the best practice principles as set out in the Code of Guidance on Funding External Bodies and Following the Public Pound to be followed.;

- Authorise the relevant financial statements for the IJB;

- Determine the appropriate accounting policies for the Integration Joint Board

- In conjunction with the Chief Officer develop a case for the Integrated Budget based on the Strategic Plan and present it to the Local Authority and Health Board for consideration and agreement as part of the annual budget setting process.

Lynne Hollis

Scottish Government Health Finance

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