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Scottish Borders Health and Social Care PARTNERSHIP

HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD MONDAY, 18TH APRIL, 2016

A MEETING of the SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD will be held in COMMITTEE ROOM 2, COUNCIL HEADQUARTERS, NEWTOWN ST BOSWELLS on MONDAY, 18 APRIL 2016 at 2.00 pm

AGENDA			
1.	**ANNOUNCEMENTS & APOLOGIES**		1 mins
2.	**DECLARATIONS OF INTEREST**		1 mins
3.	**MINUTES OF PREVIOUS MEETINGS** (Pages 1 - 12) Monday 7 March 2016 Wednesday 30 March 2016		3 mins
4.	**MATTERS ARISING** (Pages 13 - 14) Action Tracker		5 mins
5.	**STRATEGIC**		20 mins
	(a) **Housing Contribution Statement**	(Pages 15 - 36)	
	(b) **Integrated Care Fund - Progress Update**	(Pages 37 - 68)	
	(c) **NHS Borders Local Delivery Plan 2016/17**	(Pages 69 - 136)	
6.	**GOVERNANCE**		30 mins
	(a) **Issue of Directions from Integration Joint Board 2016 - 17**	(Pages 137 - 146)	
	(b) **Health & Social Care Integration - Commissioning and Implementation Plan**	(Pages 147 - 168)	
	(c) **Draft Performance Management Framework**	(Pages 169 - 180)	
7.	**FINANCE**		30 mins
	(a) **Monitoring of the Shadow Integrated Budget 2015/16**	(Pages 181 - 186)	
	(b) **Financial Statement 2016/17 - Overview of Due Diligence Process**	(Pages 187 - 200)	
	(c) **Update: Financial Governance and Management**	(Pages 201 -	

	Arrangements	224)	
8.	**FOR INFORMATION**		15 mins
	(a) **Chief Officer's Report**	(Pages 225 - 242)	
	(b) **Committee Minutes**	(Pages 243 - 252)	
9.	**ANY OTHER BUSINESS**		15 mins
	(a) **Health and Social Care Integration Joint Board Development Session: 23 May 2016**		
10.	**DATE AND TIME OF NEXT MEETING** Monday 20 June 2016 at 2.00 pm in the Council Chamber, Scottish Borders Council		

AT THE CONCLUSION OF THE PUBLIC MEETING THE BOARD WILL RECONVENE FOR ANY MATTERS OF RESERVED BUSINESS

Minutes of a meeting of the **Health & Social Care Integration Joint Board** held on Monday 7 March 2016 at 9.30am in the Council Chamber, Scottish Borders Council

Present:	(v) Cllr Catriona Bhatia (Chair)	(v) Mrs Pat Alexander
	(v) Cllr Frances Renton	(v) Mr John Raine
	(v) Cllr John Mitchell	(v) Dr Stephen Mather
	(v) Cllr Iain Gillespie	(v) Mr David Davidson
	Mrs Susan Manion	(v) Mrs Karen Hamilton
	Mr Paul McMenamin	Dr Cliff Sharp
	Mr John McLaren	Mrs Evelyn Rodger
	Mr David Bell	Dr Angus McVean
	Mrs Linda Jackson	Mrs Angela Trueman
	Mrs Elaine Torrance	

In Attendance:	Miss Iris Bishop	Mrs Jane Davidson
	Mrs Jill Stacey	Dr Eric Baijal
	Ms Sandra Campbell	Mrs Carol Gillie
	Mr David Robertson	Mrs Carin Petterson
	Mrs Clare Smith	Mrs Karen McNicoll
	Ms Julie Watson	Mrs Tracey Logan

1. Apologies and Announcements

Apologies had been received from Cllr Jim Torrance, Mrs Jeanette McDiarmid, Mrs June Smyth, Mrs Clare Hepburn, Mrs Jenny Miller and Mrs Fiona Morrison.

The Chair confirmed the meeting was quorate.

The Chair welcomed Mrs Clare Smith and Ms Julie Watson to the meeting who were speaking to the Workforce Planning Framework item on the agenda.

The Chair welcomed and announced that Cllr Iain Gillespie had been formally appointed by Scottish Borders Council to the Health & Social Care Integration Joint Board in place of Cllr David Parker.

The Chair confirmed that the items 3 (Formal Appointment of Chief Officer) and 4 (Appointment of Interim Chief Financial Officer) on the agenda would be taken at the end of the meeting in a private session of the Health & Social Care Integration Joint Board.

2. Formal Establishment of the Scottish Borders Health & Social Care Integration Joint Board

Mrs Susan Manion confirmed that the Health & Social Care Integration Joint Board was now legally established.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the legal establishment of the Scottish Borders Health & Social Care Integration Joint Board.

3. Declarations of Interest

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

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted none were declared.

4. Minutes of Previous Meeting

The minutes of the previous meeting of the Health & Social Care Integration Joint Board held on 1 February 2016 were approved.

5. Matters Arising

5.1 Minute 5: Health & Social Care Strategic Commissioning Plan: Dr Eric Baijal confirmed that the population figures for Hawick and Galashiels had been checked and were accurate.

5.2 Action Tracker: Mrs Susan Manion advised that the Development session timetable and subject matter for the Health & Social Care Integration Joint Board would be reviewed.

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

6. Health & Social Care Integration Joint Board – Code of Corporate Governance

Mrs Susan Manion gave an overview of the suite of documents that made up the Code of Corporate Governance for the Health & Social Care Integration Joint Board. Each document was then discussed in turn.

In regard to the Local Code of Corporate Governance, Mrs Jill Stacey confirmed that the cover paper set out how the Board would measure itself and meet the key principles that would apply.

Mr David Davidson suggested reviewing the wording in terms of labels and titles as page 50 referred to the “Leader” and that was an incorrect terminology for the Health & Social Care Integration Joint Board.

Mr John McLaren sought clarification of a staff governance element to the code. Mrs Manion advised that there were two outstanding items, one of which was staff governance and the

other was patient public involvement, both of which were referred to in the Scheme of Integration. Both elements would be included in the Code in future once the detail had been fully worked up and agreed.

Mrs Stacey suggested Principle 5 was the key element around staff governance and she reminded members that the document remained live and would change as the Health & Social Care Integration Joint Board evolved.

Mrs Manion advised that the Standing Orders element had been in place during the shadow period and were now submitted for formal approval.

Mrs Pat Alexander suggested revising the wording at Point 24 to include members of sub committees.

Mrs Manion suggested the Audit Committee Terms of Reference and formal appointment of members to that Committee would be brought to the next meeting of the Health & Social Care Integration Joint Board.

A discussion took place in regard to the Clinical and Care Governance Assurance Framework and several issues were raised including: the Health & Social Care Integration Joint Board receive a copy of the Health Board Clinical Governance reports and the equivalent Local Authority reports; the NHS Clinical Governance Committee expand its membership to include a member of the Health & Social Care Integration Joint Board; NHS Clinical Governance Committee minutes be shared with the Health & Social Care Integration Joint Board; linking assurance to performance information/reports;

Mr John Raine cautioned against over complicating matters and was clear that there were governance processes in all organisations around the table and there was no need to duplicate those. The requirement of the Health & Social Care Integration Joint Board was to be assured that good governance was in place in the organisations from which it commissioned services.

Mrs Manion agreed with the suggestions raised and advised that the next step was to work out a common approach and understanding in terms of providing an assurance for all the services within the delegated functions.

Mrs Evelyn Rodger advised that she would work with Mrs Manion and Mrs Karen McNicoll on the wording of the document as the Healthcare Governance Steering Group referred to had been disbanded.

Mrs Pat Alexander enquired how Scottish Borders Council received assurance in regard to the Arms Length Organisation, SB Cares. Cllr Frances Renton advised that SB Cares had a Strategic Board and the minutes of that Board were submitted to Scottish Borders Council full Council meetings. Mrs Elaine Torrance confirmed that quality assurance issues were also addressed through that Board.

Mr John McLaren recalled that it had been muted previously that a member of the Health & Social Care Integration Joint Board should sit on the SB Cares Board. Mrs Torrance

confirmed that a request would be made to the Health & Social Care Integration Joint Board to identify a member for the SB Cares Board.

In relation to the Risk Management Strategy, Mrs Manion advised that the principles were simple and straight forward and recognised the different systems and processes that were in place in partner organisations.

Mrs Evelyn Rodger suggested including clinical risk as types of risks to be reported at section 2.3.

Mr David Davidson commented that in the health service there was a drive for Audit Committees to become both audit and risk owners for those risks above those covered by the Clinical Governance Committee. He suggested Mrs Manion speak with colleagues in the Scottish Government to seek their advice and suggestions.

Mrs Manion recorded her thanks to the workstreams for their significant effort in producing the suite of documents.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the current suite of documents which form the Code of Corporate Governance for the Health & Social Care Integration Joint Board.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved an annual review of the Code of Corporate Governance.

7. Health and Social Care Strategic Plan

Mrs Susan Manion gave an overview of the content of the document and the next steps to be taken. Dr Eric Baijal reminded members that they had seen and commented on the document previously.

Mr John Raine confirmed that he was happy to support the approval of the strategic plan.

The Chair thanked Dr Baijal and his team for developing the strategic plan and confirmed that the document was in essence what the Health & Social Care Integration Joint Board was all about and would in effect hold everyone to account for making improvements to the health and care of the people of the Scottish Borders.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** homologated the decision to approve the Health & Social Care Strategic Plan.

8. Workforce Planning Framework

Mrs Clare Smith gave an overview of the workforce planning framework and Mrs Julie Watson spoke of the people planning process within Scottish Borders Council and how both were taken into account and used to formulate a single plan for the Health & Social Care Integration Joint Board. It was noted that both processes were very similar and the next step was to align the processes in terms of timescales. It had been agreed to ensure both NHS

Borders and Scottish Borders Council workforce plans would be in place by 30 June each year.

A discussion ensued which focused on several elements including: linking to third sector partners; a challenge for staff in integrated services where terms and conditions vary; recognition of potential difficulties in regard to professional guidance for staff in integrated services; creative solutions for localities in regard to GP recruitment and locum cover; a strategic approach to recruitment; impact of living wage on low paid staffing groups; and workforce age profiling; sharing values based recruitment processes.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the Workforce Planning Framework report and the planned actions for 2016/17.

9. Monitoring of the Shadow Integrated Budget 2015/16.

Mr Paul McMenamin detailed the content of the monitoring report of the shadow integrated budget advising of a projected pressure position of £403k overspent at the end of January 2016. He detailed the pressure areas and mitigating actions that had been taken. He confirmed that any year end overspends would be addressed by the responsible organisations.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the reported projected position of £403k net pressures at 31st January 2016 and noted that both partner organisations were working to minimise any adverse variance at year-end but should that not be possible the responsible organisation would ensure that resources were available to ensure a break even out turn.

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

10. Health and Social Care Integration Integrated Resources Advisory Group

Mr Paul McMenamin gave a detailed overview of progress made to establish the financial governance arrangements for the partnership as well as the proposed way forward.

Mr John Raine commented that the compliance assessment to date report, was a report approved by the Interim Chief Financial Officer and the Financial Statement for 2016/17 was complete and to be approved by the Health & Social Care Integration Joint Board in March and accompanied by a due diligence report. He enquired if the due diligence report as contained within the appendices and if it was contradicted by the Chief Officer's report that suggested the Interim Chief Financial Officer and the Chief Officer could not recommend acceptance of the draft budget until such time as the efficiency gap for the Health Board had been resolved.

Mr McMenamin confirmed that there was an anomaly as the report had been written with the full expectation that a fully funded report would be presented for approval. It became

apparent late on in the process that a fully funded report would not be received. Work continued to develop a finally agreed position in terms of forecasts and the due diligence of the sufficiency of resources.

Mr Raine enquired if the due diligence report was available. Mr McMenamin advised that the report was drafted and the assurance report reflected the due diligence process. The final due diligence report would be submitted to the Health & Social Care Integration Joint Board for their consideration.

Mr Raine enquired of the status of other Health & Social Care Integration Joint Boards across Scotland in regard to determining and accepting their budgets. Mrs Manion advised that a number of other Health & Social Care Integration Joint Boards were meeting in March to agree their budgets.

Mrs Susan Manion advised that on reflection the recommendation had been amended in order to provide the Health & Social Care Integration Joint Board with an update in relation to the financial arrangements and the expectation that the budget required resolution by end of March.

Cllr John Mitchell commented that he was delighted the Health & Social Care Integration Joint Board was deemed VAT neutral.

The Chair sought clarification that the compliance check document would be resubmitted to the Health & Social Care Integration Joint Board as completed. Mr McMenamin confirmed that that would.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the progress made to date in the development and implementation of the key financial arrangements following recommended best practice and compliance with legislation which required to be in place prior to 1 April 2016 and beyond and agreed the plan of actions for the remaining work requiring completion and approval.

11. Health and Social Care Partnership Draft Financial Statement 2016/17 and Assurance over the Sufficiency of Resources

Mrs Susan Manion gave an overview of the content of the report. She highlighted several key elements including: draft budgets to be delegated and summary of delegated functions; highlighting the set aside budget; financial risks of resources available to it and the mitigation that had taken place; due diligence; base line; understanding of existing and evidenced emerging pressures; and planned efficiencies. Mrs Manion was keen to stress she was absolutely clear of the intent to complete the planned efficiencies work across the systems to ensure there were plans in place through the NHS in order to be able to provide assurance to the Health & Social Care Integration Joint Board on the sufficiency of resources.

Mrs Manion further highlighted that Scottish Borders Council had agreed its efficiencies and the NHS given their later national timeframe had been unable to confirm their efficiencies to date. She suggested further work would be undertaken on the financial statement and the accompanying due diligence report and both would be submitted to the next meeting.

A discussion ensued that focus on several matters including: caveats in place until a settled financial position for the NHS is reached; £5m for development and refinement of Health & Social Care Integration Joint Board services; further guidance on the £5m to be issued by Scottish Government; double counting of £5.2 sitting in baseline budget for both Scottish Borders Council and NHS Borders; and the Health & Social Care Integration Joint Board would direct Scottish Borders Council through written directions how to use the £5.2m.

Mr David Robertson quoted from the John Swinney letter to all Council Leaders and advised that he would share the letter with Health & Social Care Integration Joint Board members.

Cllr John Mitchell enquired how the financial figure was arrived at for the NHS. Mr McMenamin confirmed that it was a calculated share of NHS Borders financial budget for 2016/17 as at present and a determination of set aside. Mrs Carol Gillie expanded on the explanation and advised that legislation and guidance defined which services were set aside. She advised she would happy to provide Cllr Mitchell with more detail outwith the meeting.

In regard to efficiency savings Mr John Raine recognised that the Health & Social Care Integration Joint Board needed to be assured on the affordability of the functions delegated to it. He advised that the NHS dealt with efficiency savings each year by tasking senior staff and others including Board members to find efficiency savings during the course of the financial year. He advised that NHS Borders was required to make £11m savings in 2016/17 and was not at present in a position to identify in detail how those savings would be achieved.

Mrs Manion highlighted the differences between the two organizations processes in dealing with financial gaps and savings targets. She clarified that there were ongoing discussions within the NHS about the level of efficiencies and where they could be achieved and where the headline figures were. She reiterated that the NHS was complex in terms of different budgets sitting within it and efficiency plans across the whole system were being considered and the determination of an efficiency level for the Health & Social Care Integration Joint Board was determined by a proposition of the totality of the NHS Budget.

Mrs Elaine Torrance sought assurance on the potential impact on joint services and delivery of the strategic plan.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the current position in relation to the production and agreement of a fully evidenced and funded joint delegated and notional budget for 2016/17 for the Scottish Borders Health and Social Care Partnership

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed that further work should be undertaken to bring forward efficiency proposals within NHS Borders 2016/17 financial plan (delegated or non-delegated) or alternatively, identify other sources of potential funding in order to fully fund the proposed level of budget to be delegated to the Partnership on the 1st April 2016.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed that a final financial statement accompanied by a full assurance report be presented to the Board prior to the 1st

April 2016 for approval, requiring the convention of an extra-ordinary meeting in late March 2016

12. Chief Officer's Report

Mr David Davidson suggested the report should contain more detail and timelines. The Chair echoed Mr Davidson's request.

The Chair advised that the next Development session for the Health & Social Care Integration Joint Board was identified as 23 May and she proposed that it be a full day taking the Board out into the region. She asked Board members to alter their diaries accordingly.

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

13. Committee Minutes

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

14. Any Other Business

14.1 SB Cares: Mrs Elaine Torrance sought a member of the Health & Social Care Integration Joint Board to become a member of the SB Cares Governance Committee. Mrs Torrance was asked to circulate the Terms of Reference for the Committee. It was noted that Cllrs Renton and Mitchell were already members of the Group and a member from the NHS membership of the Health & Social Care Integration Joint Board would be welcomed.

14.2 Extraordinary Meeting: It was agreed that an Extraordinary meeting of the Health & Social Care Integration Joint be called before the end of March to focus solely on the Financial Sufficiency of Resources. The Board Secretary was tasked with identifying a suitable date.

15. Date and Time of next meeting

The Chair confirmed that the next meeting of the Health & Social Care Integration Joint Board would take place on Monday 18 April 2016 at 2.00pm in Committee Room 2, Scottish Borders Council.

The meeting concluded at 11.30am.

Minutes of an **Extra Ordinary** meeting of the **Health & Social Care Integration Joint Board** held on Wednesday 30 March 2016 at 10.30am in the Council Chamber, Scottish Borders Council.

Present:	(v) Cllr Iain Gillespie	(v) Mrs Pat Alexander (Chair)
	(v) Cllr John Mitchell	(v) Mr John Raine
	(v) Cllr Frances Renton	(v) Mrs Karen Hamilton
	Mr David Bell	(v) Dr Stephen Mather
	Mrs Jenny Miller	(v) Mr David Davidson
	Mrs Angela Trueman	Dr Andrew Murray
	Mrs Susan Manion	
In Attendance:	Miss Iris Bishop	Mr Paul McMenamin
	Mrs Jane Davidson	Mrs Jeanette McDiarmid
	Mrs Jill Stacey	Mr Kirk Lakie
	Mr David Robertson	Dr Eric Baijal

1. Apologies and Announcements

Apologies had been received from Cllr Catriona Bhatia, Cllr Jim Torrance, Mrs Evelyn Rodger, Mrs Elaine Torrance, Mr John McLaren, Mrs Fiona Morrison, Dr Angus McVean, Mrs June Smyth, Mrs Tracey Logan and Ms Sandra Campbell.

The Chair confirmed the meeting was quorate.

The Chair welcomed newly appointed Andrew Murray, Medical Director, NHS Borders 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 the single item on the agenda.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted there were none.

3. Health & Social Care Partnership Financial Statement 2016/17 and assurance over the sufficiency of resources

Mr Paul McMenamin gave an overview of the content of the paper highlighting: historical funding; temporary measures; savings targets; determination of 16/17, 17/18 and 18/19 budgets; mitigation of risks; horizon scanning; and the governance arrangements in place for the partnership.

Mrs Jane Davidson advised that the budget from NHS Borders was indicative as was the efficiency plan and that it would be confirmed as the year progressed as the Health Board had

yet to approve the budget. She reiterated that it was a fair and reasonable assessment of NHS Borders' expectation from Scottish Government.

The Chair questioned if the amount of outstanding efficiency was reducing. Mrs Davidson advised that the main areas were the Alcohol and Drug Partnership and Dental Services. She advised that plans were being worked up to redesign to deliver similar outcomes and other opportunities were also expected to be identified.

Mr John Raine thanked Mr McMenamin for a comprehensive and detailed report. He noted that the £5.26m made available by Scottish Government in respect of health and social care was to be split, with 50% of the sum used for releasing cost pressures in social work taking into account the living wage and cost of reducing charging thresholds. Mr Raine enquired how the other 50% would be used, if it was intended to be additional monies and represented additionality, and if it was for the Health & Social Care Integration Joint Board to determine the use of that funding?

Mr McMenamin confirmed that the uncommitted amount in theory was for the Health & Social Care Integration Joint Board to direct as additionality and he cautioned that the full implications of the cost of the living wage on the full financial year were not yet known as well as other unknown factors. Mr Raine sought confirmation that Mr McMenamin was suggesting the full £5.26m could be swallowed up in meeting the cost of the living wage and unknown factors as anticipated at present and Mr McMenamin confirmed that this may in fact be the case given the current estimates represented only a part year impact.

Mr Raine commented that he understood there was a clear steer from the Cabinet Secretary that part of the £5.26m (50%) would represent additional money to support integration for the Health & Social Care Integration Joint Board to develop integration in the way that it wished to see it developed. Mr McMenamin commented that he aspired to that being the case and advised the letter from Mr Swinney was quite clear on the intended use of the £5.26m.

Mr David Robertson advised that the funding from the Scottish Government around the living wage was predicated on care home providers themselves providing 25% of the cost of the uplift and he suggested in reality that cost would flow back to the Health & Social Care Integration Joint Board in terms of care home providers. He supported the aspiration of resources to be open to the Health & Social Care Integration Joint Board for integration and urged caution around specific sums.

Mr David Davidson sought clarity that the £5.26m would remain in the notional budget for the Health & Social Care Integration Joint Board until such time as the Health & Social Care Integration Joint Board issued directions as to its use. Mr McMenamin advised that both he and Mrs Susan Manion were committed to that approach and he committed to bring back a report once the full implications of the living wage, etc were known so that the report could assist the Health & Social Care Integration Joint Board in its deliberations on where to direct the use of the full £5.26m funding.

Cllr John Mitchell enquired with regard to the set aside budget rising, if it had altered as the percentage had altered. Mrs Manion advised that the set aside budget was set on the basis of what were considered to be services for acute care in hospital most related to the Strategic

Plan for the Health & Social Care Integration Joint Board and that it was essentially around unscheduled care provision.

Cllr Mitchell enquired if the cost of running wards were included. Mr McMenamin explained that they were included and NHS Borders set aside budget as defined by the Scheme of Integration included the relevant wards/bed functions. The set aside budgets were solely owned and managed by NHS Borders and simply supported the overall aims and objectives of the partnership.

Mr Raine commented that the Integrated Care Fund monies equated to £6.4m over the 3 year life of the Strategic Plan and were there to make a difference to integrating services. He was pleased to see the fund referred to in the report as a key enabler of integration and he welcomed the review of the governance arrangements and requested a timescale for that review. He further emphasised to colleagues that the Health & Social Care Integration Joint Board had to be the controlling influence over the fund. Mrs Manion advised the Integrated Care Fund report would be submitted to the next meeting and would outline the timescales of, the work agreed, outcomes and proposed planned expenditure, as well as the review of the governance arrangements.

Mr Davidson sought clarification on the role of the Audit Committee and if it was to be an Audit and Risk Committee. Mrs Jill Stacey clarified that the Terms of Reference agreed for the Audit Committee included the oversight of scrutiny of risk management arrangements and internal control and would fulfill the scrutiny role of governance in the widest sense.

The Chair summed up the conversation commenting that it had been a useful discussion and raised a range of issues to be worked through as the Health & Social Care Integration Joint Board entered its first year of business.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted and approved the estimated Health and Social Care partnership budget for 2016/17, including both the element delegated by NHS Borders/Scottish Borders Council and that retained by NHS Borders and set-aside, specifically:

	2016/17	**2017/18 indicative**	**2018/19 Indicative**
	£'000	**£'000**	**£'000**
Budgets Delegated:			
Scottish Borders Council Funding Delegated	46,531	46,583	47,083
NHS Borders Funding Delegated :			
- Primary & Community Services	87,352	87,272	87,685
- Large Hospital Budget	18,128	18,160	18,325
- Social Care Fund	5,267	5,267	5,267
Total Delegated Funding	**157,278**	**157,282**	**158,360**

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the key areas of financial risk in 16/17 and the proposed actions for mitigation.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** instructed the Chief Officer to identify, in partnership with NHS Borders and Scottish Borders Council, further proposals / directions for ensuring that the total budget delegated is fully funded by agreed levels of activity/efficiency savings across both delegated and notional areas of the integrated budget.

Mrs Karen Hamilton advised she was supportive of the proposal provided it did not link to the plans to deliver £793k efficiency savings so that there was flexibility for that to be delivered. Mrs Davidson advised it would difficult given that directions had yet to be issued and the annual financial statement required the inclusion of sums attached to spend and activity to be applied.

Mr McMenamin clarified that the financial plan remained a work in progress and was evolutionary and he would continue to work with colleagues across the partnership and he assured the Health & Social Care Integration Joint Board that it would remain business as usual on 1 April 2016. Mrs Manion confirmed that directions were required to be agreed by all parties to enable the creation of change to deliver the strategic plan in the future.

Mr Davidson commented that as there was no confirmation of the national funding settlement for Health Boards, it was difficult to make an informed decision. Mrs Davidson advised that she would be submitting a paper to the Health Board in early April which would recommend the level of resource to be provided to the Health & Social Care Integration Joint Board, and reiterated that the funding proposed at this stage was indicative.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the risks which may emerge in future years and consider them and any others which may arise as part of the wider 2017/18 financial planning process.

4. Any Other Business

There was none.

5. Date and Time of next meeting

The Chair confirmed that the next meeting of Health & Social Care Integration Joint Board would take place on Monday 18 April 2016 at 2.00pm in Committee Room 2, Scottish Borders Council.

The meeting concluded at 11.20am.

Scottish Borders
Health and Social Care
PARTNERSHIP

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
1	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	**In Progress:** Item included as part of the Commissioning discussion scheduled for the 20 January 2016 H&SC IJB Development Session. **Update:** The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed that the session that had taken place on 20 January 2016 had not fully accommodated the commissioning suggestion and the action would therefore return to amber.	A

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

HOUSING CONTRIBUTION STATEMENT

Aim

1.1 To note the contents of the Housing Contribution Statement for Scottish Borders area and endorse its submission with the Strategic Plan.

Background

2.1 In 2015 Scottish Government has published Statutory Guidance which requires that a Housing Contribution Statement be developed for each Integrated Joint Board area. This is referred to as `The Housing Advice Note (HAN)' which is the statutory guidance to Integration Authorities, Health Boards and Local Authorities under the Public Bodies (Joint Working) (Scotland) Act 2014. It applies especially to the preparation of Integration Authorities' Strategic Commissioning Plans, which must include a Housing Contribution Statement (HCS). The HCS is essentially a joint process and responsibility and the Guidance is clear that the Integration Authority must put in place a Housing contribution Statement as part of its Strategic Plan.

2.2 This Guidance sets out the contents for the required Housing Contribution Statement. A Housing Contribution Statement (Appendix 1) has been prepared in line with the Statutory Guidance and The Scottish Borders Housing Contribution Statement sets out how the Statutory Housing Authority and Registered Social Landlord sectors will work to support the Scottish Government's strategic objectives with particular regard to the integration of Health and Social Care.

2.3 The Integration Joint Board is required to comply with Section 5 of the Housing Advice Note which states "it should be treated under the Governance arrangements for the Integrated Joint Board.

Summary

3.1 In order to comply with the Housing Advice Note it is proposed that the attached Housing Contribution Statement which has been prepared in partnership and as a joint process between the Statutory Housing Authority, local Social Landlords and Health & Social Care is endorsed by the Integrated Joint Board and submitted to Scottish Government as part of the Strategic Plan.

3.2 The Housing Contribution is vital to the effective delivery of the Strategic Plan as it is recognised that the architecture and urban design of our neighbourhood environment effects health and well-being both from a physical and mental perspective. It also plays a key contribution as a sufficient supply of good quality, energy efficient spacious accommodation supports independent living which is not only important for good physical and psychological health but is required to meet the needs of our growing older population.

Recommendation

The Health & Social Care Integration Joint Board is asked to **note** the contents of the Scottish Borders Housing Contribution Statement and **endorse** its submission with the Strategic Plan.

Policy/Strategy Implications	The Housing Contribution Statement has been developed in order to meet the requirements of the recently published Statutory Guidance by Scottish Government.
Consultation	The development of the document has been led by the Council's Housing Strategy Team through a participative approach involving Registered Social Landlords which was facilitated and supported by consultancy from the Joint Improvement Team, who have also reviewed the document to ensure that it complies with the Guidance.
Risk Assessment	The document draws upon the contents of the Scottish Borders Councils current Local Housing Strategy 2012/17, and Strategic Housing Investment Plan 2015/20. Both of which have been subject to their respective risk assessments, and Equality Impact Assessments.
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 content of this document.
Resource/Staffing Implications	There are no additional costs associated with the document.

Approved by

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

Author(s)

Name	**Designation**	**Name**	**Designation**
Cathie Fancy	SBC Group Manager Housing Strategy and Services		

Housing Contribution Statement 2015

Draft

Scottish Borders COUNCIL

CONTENTS

1. INTRODUCTION

The Integration of Health and Social Care Agenda and the Public Bodies (Joint Working) Act (2014) is the most substantial reform to the National Health Service and social care services in decades. Health Boards and local authorities must integrate services to provide a more joined-up and person-centred approach to health and social care, enabling independent living where appropriate. National health and wellbeing outcomes and associated joint strategic commissioning plans / housing contribution statements, provide a practical framework and set an ambitious agenda to improve the health and wellbeing of people across Scotland, within a challenging context of an ageing population, public sector budget constraints, technological change and increasing expectations.

Poor or inappropriate housing can contribute to a wide range of physical and mental health problems. Actions relating to housing have the potential to produce significant benefits in the health and well-being of individuals and the wider community, and generate savings in public and private expenditure on health, housing and social services.

The Housing Contributions Statement sets out the role of the housing sector in achieving the Health and Social Care Integration outcomes in the Scottish Borders.

This statement continues on from the first Housing Contributions Statement that was produced in September 2014, which looked at identifying the Borders housing sector services contribution and the role housing has to play within the Health and Social Care Partnership.

2. LOCAL HOUSING STRATEGY

The Housing (Scotland) Act 2001 places a statutory requirement on local authorities to produce a Local Housing Strategy (LHS) which sets out its strategy, priorities and plans for the delivery of housing and related services. The Act also states that the LHS must be supported by an assessment of housing provision and related services, that it must be submitted to Scottish Ministers, and that local authorities must keep their LHS under review.

LHS Vision

every person in the Scottish Borders has a home which is secure, affordable, in good condition, energy efficient, where they can live independently and be part of a vibrant community

The LHS has a key role to play in contributing to the effective integration of health and social care. It should set out clearly the contribution that housing can make in

support of this agenda, through the design and delivery of housing and housing related services, that are capable of responding to the needs of individuals as and where they arise.

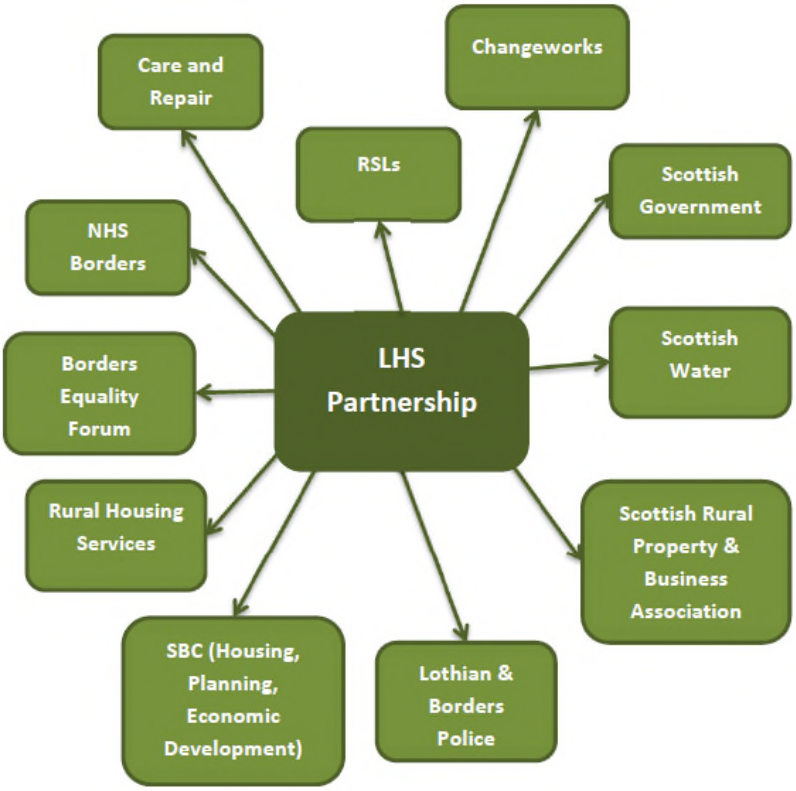
The LHS should be clear on what the integration of health and social care means in terms of providing suitable accommodation and the care and support required to fully support this agenda, whilst enabling people to live independently within their own home for as long as possible. Having the right amount of care and/or support in place can help prevent unplanned hospital admissions and allows people to leave hospital more quickly, benefitting both the individual and the hospital system.

Local Housing Strategy Partnership

The Scottish Borders Local Housing Strategy (LHS) Partnership is the housing market partnership for Scottish Borders. Figure 1 on page 5 highlights all of the representatives on the partnership. Issues from commissioning to completion of both the Scottish Borders Housing Need and Demand Assessment (HNDA) Update and the South East Scotland Plan (SESPlan) HNDA have been reported and discussed at meetings of the Scottish Borders LHS Partnership. The Scottish Borders LHS Partnership, the Council and other partners participate in the South East Scotland Housing Market Partnership in developing the SESPlan HNDA, contributing the development of the Main Issues Report and the Strategic Development Plan.

Over and above the Housing Market Partnerships, the Council is hugely reliant on a range of partners to ensure that the ambitions of the LHS are realised and the range of partnership groups responsible for development and delivery of LHS objectives is set out in figure 1:

Figure 1: LHS Partnership



Work is currently underway to develop the next LHS and this will be in place in 2017. The LHS will reflect the priorities identified within the Housing Contribution Statement as well as identifying new priorities and outcomes relating to the health and social care agenda.

3. HOUSING NEED AND DEMAND ASSESSMENT

Revised guidance for housing need and demand assessment (HNDA) was provided by the Scottish Government in 2014, emphasising the need for housing practitioners to engage with health and social care planners to share evidence, identify needs and plan for solutions across health, social care and housing. One of the key aspects of the HNDA is to provide evidence to inform policies related to the provision of specialist housing and housing-related services.

The second SESplan (Scottish Borders, Edinburgh, East Lothian, West Lothian, Midlothian and part of Fife) Housing Need and Demand Assessment received robust and credible status in March 2015. One of the purposes of this assessment is to provide evidence to inform policies related to the provision of specialist housing and housing-related services.

Housing is at the heart of independent living with the term 'social care' associated with certain housing functions which can improve the lives of vulnerable and older people and significantly reduce health and care costs. Typically, such housing functions can be categorised as follows:

- Provision of 'fit for purpose' housing – this includes provision of sheltered; very sheltered and extra care housing and repairs and adaptations
- Provision of information and advice – on housing options; welfare advice; training and employment support; advocacy support; befriending services and assistance in finding alternative housing
- Provision of low level support and preventative services – this includes housing support; community alarms; tele-care and tele-health; care and repair services; small repair services; handyperson services and garden maintenance.
- Community capacity building – with housing organisations promoting tenant participation in local activities and development of community led social enterprises

Based on the demographic and health profiles, the current level of health and social care provision is unlikely to keep up with the levels that will be required in future, particularly for an ageing population. Not only are people living longer, but a significant number of these people are projected to live beyond 85 years. Despite relatively good health and life expectancy, this will mean increased frailty and complex health needs, with increased housing, health and social care services required, particularly in areas where there are a high proportion of older people living alone.

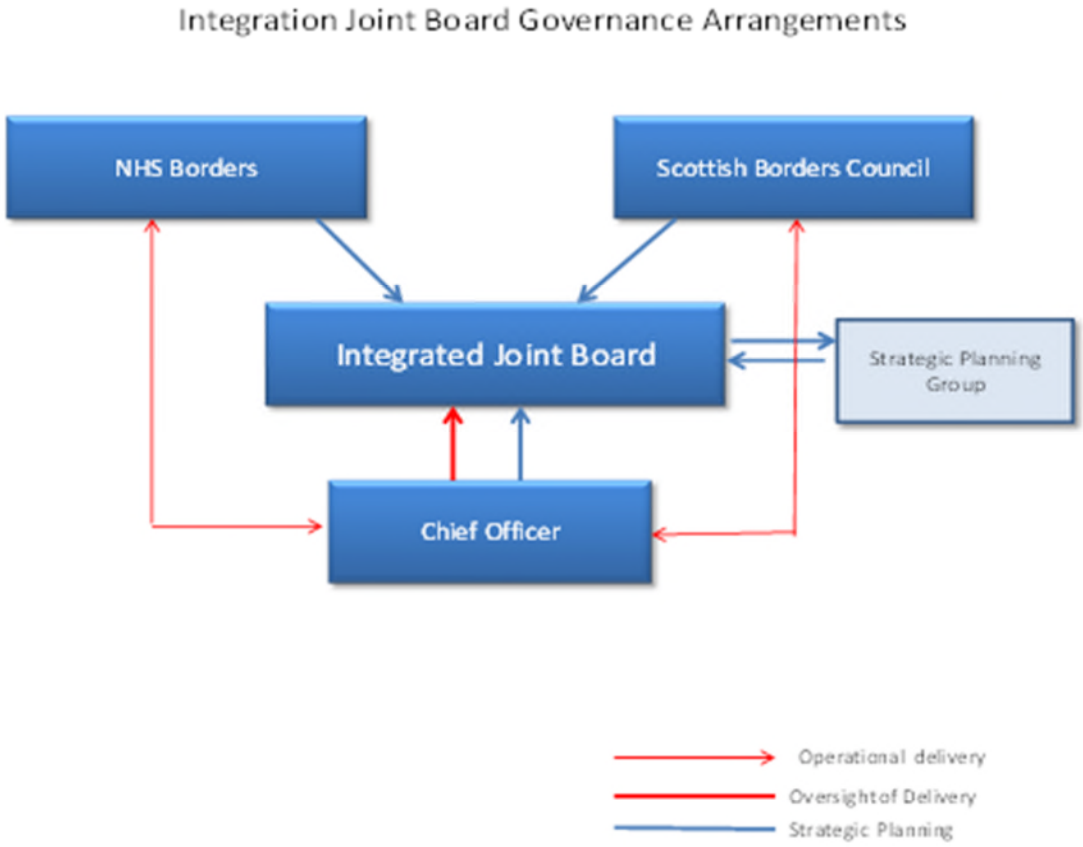
The SESplan HNDA estimated 6,423 households in the Scottish Borders were in housing need. (31st March 2013) comprising a requirement for adaptations (47%); households living in poor quality housing (25%); overcrowding households (17%); special forms of housing (5%); concealed households (4%) and homeless households (3%). Most of this can be resolved in-situ or by the market (5,204) leaving 1,219 households remaining in need. The housing needs of these households cannot be met in-situ using existing social housing and they cannot afford a market solution. Instead they will require additional (including new) social housing.

4. GOVERNANCE

The legislation supporting Health and Social Care Integration, through the Integration Joint Board, offers the opportunity for Councillors, Health Board Non-Executive Directors, the Third Sector and Independent Sector to work together to plan for a future health and care service able to meet the demands of the future. The Integration Joint Board will plan and commission services to ensure that the national and local outcomes are all based on providing a more person centred approach with a focus on supporting

individuals, families and communities. Figure 2 below shows the structure of the Integration Joint Board process.

Figure 2: Integration Joint Board Governance Arrangements



The main purpose of integration is to improve the wellbeing of people who use health and social care services, particularly those whose needs are complex and involve support from health and social care at the same time. The Integration Joint Board will set out within the Strategic Plan how it will deliver the national Health and Wellbeing Outcomes as prescribed by Scottish Ministers.

5. HEALTH AND SOCIAL CARE PARTNERSHIP

The Scottish Borders Health and Social Care Partnership was launched in April 2015 and has the responsibility for proving a Strategic Plan by April 2016.

Scottish Borders
Health and Social Care
PARTNERSHIP

The 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 total resource

within the partnership is £135.2 million. 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, and we can also work in partnership with our communities.

The new legislation requires the Partnership to set up a Strategic Planning Group (SPG) to support the development of the new integrated arrangements. The Borders SPG was established in May 2015.

Reflecting the range and diversity of health and social care stakeholders in the Borders, the group is made up of representatives from a range of organisations including representatives from both the Statutory and social housing sector as shown in figure 3 below.

Figure 3: Strategic Planning Group

The Strategic Plan

The Scottish Borders Health and Social Care partnership published the first draft of the strategic plan in early 2015, '*Draft Strategic Plan 2015 -18; A Conversation with You'*

The second draft, called '*changing health & social care for you - a further conversation*', is based on what the partnership learned during consultation in May/June 2015 from listening to: local people, service users, carers, members of the public, staff, third sector and independent organisations.

The local strategic 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. Resources are used effectively and efficiently in the provision of health and social care services

6. NATIONAL OUTCOMES

The National Health and Wellbeing Outcomes are shown in table 1 below. Scottish Borders Council and it partners can make a contribution to the achievement of many of the National Health and Wellbeing Outcomes. For example, Outcome 2 is of particular important in when considering the housing contribution.

Table 1: National Health and Wellbeing 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

Housing can make a contribution to national outcomes for health and wellbeing at a local level by:

- undertaking effective strategic housing planning
- providing information and advice on housing options
- identifying, facilitating and delivering suitable housing that gives people choice and an appropriate home environment
- providing low level, preventative services which can prevent the need for more expensive interventions at a later stage
- building capacity in local communities

7. LOCALITY PLANNING

There are five commonly recognised localities in the Borders as figure 4 shows. There are based on the five existing Area Forum localities – Berwickshire, Cheviot, Eildon, Teviot and Liddesdale and Tweeddale.

Figure 4: Area Forum Localities

Planning groups will be established in each locality to identify local priorities and help shapes plans to address them. Service users, carers, communities and health and social care professionals will be actively involved in locality planning so that they can influence how resources are spent in their area.

Housing Associations have an important role in localities planning. The approach currently being developed in the Scottish Borders is to appoint two Localities Co-coordinators who will take forward and develop Localities Plans.

8. HOUSING PROFILE

Figure 5 below highlights some of the key information in regards in housing in the Scottish Borders. This information is also captured in the Scottish Borders Health & Social Care Partnership Joint Strategic Needs Assessment document to support the development of the Strategic Commissioning Plan 2015 – 2018. This document provides a wide range of evidence which will be continually built on to inform decision making in the future.

Figure 5: Housing Profile

Population
- 114,030 total population, 34,418 aged 60 and over – 30% of the population

Households
- 53,157 total households (2.6% increase from 2009-2014)

Household Composition
- 34% one person, 8% Lone parent, 18% Couple with children, 26% Couple no children

Tenure
- 64% owner occupied, 22% social rent and 12% private rent (2014

Dwellings
- 57,274 total dwellings – 2.9% increase from 2009-2014

Rurality
- 48% of the population live in rural areas (2012) – 36% Accessible Rural, 12% Remote Rural

House Building
- 2013/14 – 72 affordable housing, 288 total market completions

Empty Homes
- 975 long term empty homes, 1,076 second homes in the Scottish Borders

Adaptations
- 2014/15 – 88 major adaptations carried out. Over five years – 493 major adaptations been carried out

Temporary Accommodation
- 104 temporary accommodation units, 58 Private Sector Leasing units

Specialist Provision
- 22 Care Homes, 975 Medium Dependency/ Amenity, 614 Sheltered, 56 Very Sheltered/ Extra Care housing, 131 Wheelchair housing and 64 housing with care clients across 4 venues

9. DELEGATED AND NON-DELAGATED FUNCTIONS

By the 31st March 2016, the Integration Joint Board will have approved the Strategic Plan, and Scottish Borders Council and NHS Borders will have delegated functions to the new Scottish Borders Health and Social Care Partnership. The Act sets out a range of health and social care functions, including functions under housing legislation, which 'must' or 'may' be delegated to an integration authority.

The housing functions that are being delegated by Scottish Borders Council to the Health and Social Care Partnership are:

- Adaptations – an adaptation is defined in housing legislation as an alteration or addition to the home to support the accommodation, welfare or employment of a disabled person or older person, and their independent living.
- Housing Support – housing support is defined in housing legislation as any service which provides support, assistance, advice and counselling to an individual with particular needs to help that person live as independently as possible in their own home or other residential accommodation such as sheltered housing.

There are some housing functions which are not delegated functions but which provide a resource to support health and Social Care Integration and the outcome it is seeking to achieve:

- RSL adaptations – providing adaptations to their tenants to enable them to live independently, for example providing , a handrail or ramp at the entrance, or a shower in place of a bath
- Care and Repair – providing independent advice and assistance to older and disabled homeowners or private tenants with services that enable them to continue to live independently in their own homes. The service provides adaptations, home improvements and a handy person service
- Housing support services for homeless people – providing housing and tenancy support to vulnerable homeless people
- New supply housing – the Strategic Housing Investment Plan (SHIP) has identified 410 new affordable homes for anticipated completion from 2015-20

10. THE ROLE OF HOUSING IN THE INTEGRATION OF HEALTH AND SOCIAL CARE

The Local Housing Strategy (LHS) provides the strategic direction to tackle housing need and demand and to inform the future investment in housing and related services across the Scottish Borders area.

The LHS brings together the Local Authority's responses to the whole housing system including: requirements for market and affordable housing; prevention and alleviation of homelessness; meeting housing support needs; addressing housing conditions across tenures including fuel poverty and linkages with the Climate Change (Scotland) Act 2009.

It is important that the LHS links with Health and Social Care Strategic Plan and table 2 on page 13 highlights the links between the Strategic Local Objectives and the LHS Outcomes.

Table 2: Links between Strategic Local Objectives and LHS Outcomes

	LHS Outcome's			
Strategic Plan Local Objectives	1. The supply of housing meets the needs of Borders Communities	2. People have better access to good quality, energy efficient homes	3. People are less likely to become homeless and those affected by homelessness have improved access to settled accommodation	4. More people with particular needs and/or requiring support are able to live independently in their own homes.
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 unpaid carers to keep them healthy and able to continue their caring role				

Table 3 provides a further breakdown of how housing links into the Strategic Plan's local objectives and how housing can contribute to each of the objectives.

Table 3: Housings Contribution towards Strategic Plan Objectives

Strategic Plan local Objectives	Housing Contribution
1. We will make services more accessible and develop our communities	• Access to affordable housing – delivering affordable housing across the area • Delivering warm housing in good condition • Working with local housing associations and private sector landlords to provide housing which is fit for purpose • Deliver more accessible, barrier free housing
2. We will improve prevention and early intervention	• Preventing homelessness through the Housing Options approach • Adaptations • Expand on and develop new initiative housing with support models for particular needs groups such as transitional housing for those leaving care or institutions • Provision of welfare benefits advice and financial inclusion services • Unified, partnership working framework for assessing health and housing needs (Unified Health Assessment) • Housing Officers visiting vulnerable households on a regular basis – identifying the needs of that person
3. We will reduce avoidable admissions to hospital	• Providing housing support, directly and with partners to help people remain in their own home and prevent homelessness. Reduces stress, anxiety – keeping people in their homes • Providing warmer more comfortable homes can reduce existing health problems – heart attacks, strokes, hypothermia, raised blood pressure, asthma, mental health problems, respiratory disease • Adaptations – grab rails etc – reduces falls
4. We will provide care close to home	• Housing Support Services • Borders Care & Repair provide a handyman service which will carry out handyperson jobs or advise on home upgrading & grant funding
5. We will deliver services within an integrated care model	The housing sector in the Borders has a range of partnership mechanisms to enhance the level of staff engagement: • LHS Partnership • Borders Housing Hub • Strategic Housing Investment Plan Working Group • New Borders Alliance • Private Landlord Forum • Community Planning Partnership
6. We will seek to enable people to have more choice and control	• Enabling people to live independently in their own homes • Flexible Housing Support • Modernisation, remodelling and reprovisioning of existing sheltered housing schemes • Training and employment skills development and opportunities for employment • Aids and Adaptations • 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 • Safe Housing Options and co-ordinated services for Domestic Abuse Victims and their families
7. We will further optimise efficiency and effectiveness	• Energy efficiency of homes – better use of building; sourcing cheaper energy options • Adaptations – prevention work, provide adaptation and ensure future best use on re-let of the property • RSLs – EESSH targets
8. We will seek to reduce health inequalities	• The four outcomes of the LHS aim to tackle the inequalities in our society – this includes health inequalities • Building safer and thriving communities is a key priority to focus local community planning activities to assist Borders's most disadvantaged communities and improve employment and health inequalities

11. PRIORITIES

A number of workshops have been held between SBC, housing providers and colleagues from health and social care to have a focused overview on the housing dimension of integration, explore the existing provision and linkages in the Borders and to identify the key priorities and challenges for the Housing Contribution Statement.

Challenges

- Improving the joint analysis of housing, health and social care needs – ensuring that we all work jointly to identify the needs of the local community – building on work in the Local Housing Strategy and Housing Need and Demand Assessment
- Improving strategic and operational planning structures - effective working between different agencies, in particular housing, health and social service authorities with respect to strategic planning, service commissioning and service provision
- Identifying and implementing initiatives to get a better understanding of the housing sectors role and improve outcomes - Housing, health and adult social care services will develop closer working relationships in the commissioning arrangements of supported housing and housing support services in order that we maximise their impact for both individuals and the wider health and social care system
- Providing support to all staff across the housing sector – ensuring staff are kept up to date and supported through these changes.
- Providing housing options advice – continuing to provide housing options advice and widening this service to assist people as they get older - helping people stay at home for longer

Priorities

Housing Support and Homelessness

- More integrated accessible housing options and advice for all customers with a focus on health and well-being and prevention
- Develop new models and expand on existing specialist housing models for older people and vulnerable client groups, such as transitional housing for young people leaving care and people with learning disabilities,

Access to housing

- Provide a range of housing allocation protocols for vulnerable adults

- Greater early involvement of housing partners in the planning of hospital discharges to co-ordinate and ensure that safe, suitable housing is available upon discharge to prevent delays in discharge once clinical needs are met and reduce risk of re-admissions

Affordable warm and fuel poverty

- Providing warm, energy efficiency homes and home energy advice
- Linking fuel poverty work and health and well-being

Adaptations

- Increasing demand and need for focus on preventative aspects with associated resource
  Increase use of technology and safety measures such as telehealth and community alarms to support independent living

Housing supply

- Increasing the supply of specialist housing such as wheelchair accessible, extra care, housing with support, and intermediate housing designed with and for people with particular needs, as well as emphasising the wider contribution of warm, safe, affordable housing supply

Private sector

- Improve the condition and management in private rented housing

Sustainable places

- Examining housing standards and link to health and well-being – condition, energy efficient and specialised aspects such as dementia-friendly
- Better joint planning on examining opportunities to re-model or find alternative uses for existing housing stock
- Encourage and support community cohesion and resilience such as facilitating cross-generational community based activities and events
- Promote visiting support services such as befriending and carers support services particularly in rural villages to prevent social isolation and increase/maintain social networks of vulnerable people and their carers
- Support local initiatives to increase training and employment opportunities

12. RESOURCES

There are a number of specific local authority housing functions which the legislation specifies must be delegated to the Integration Authority, these are; adaptations and housing support aspects of social care services. The Scottish Borders Council budget identified as making a direct contribution to health and social care through delivery of the delegated functions is £375k.

The Council currently budgets £375k from its Capital Budget to provide means tested grants to assist major adaptations in private sector properties. This is currently sufficient to meet the needs of cases prioritised through Occupational Therapist assessment as being "critical" or "substantial".

Scottish Borders Council is a post transfer Council, and one consequence is that the former Supporting People budget has been disaggregated and operational management spread across Social Work managers. There has been considerable work done by the Council's Social Work Department to successfully develop a range of Housing with Care services in existing RSL owned sheltered housing developments. But it is no longer easily possible to identify Housing Support funding other than that which is managed by the Council's Housing Services to commission a voluntary sector provider.

The extent of the resources that could be influenced by the health and social care agenda is less clear. Some examples of housing activities that can be influenced by health and social care (and vice versa) include new build housing, housing improvement across all tenures, actions to address poverty and disadvantage.

<u>New-build housing</u>

Strategic oversight of delivery of the new supply of affordable housing is led by the Council working in partnership with locally active Registered Social Landlords (RSLs) to develop the Strategic Housing Investment Plan (SHIP) submission to Scottish Ministers. This is now submitted every two years and provides a rolling five year planning horizon to set out proposed and prioritised affordable housing projects. This is framed within Resource Planning Assumptions. RSL project proposals are considered in context of deliverability, housing need, strategic fit, and impact, which enables projects which contribute to the health and social care agenda to score highly in the prioritisation process. Examples of this include new supported housing solutions to assist the Joint Learning Disability Service and Extra Care Housing.

Scottish Government are the main provider of grant to assist delivery of affordable housing by responding to SHIP submissions through the development of 3 year Strategic Local Programme (SLP) Agreements to direct grant towards securing delivery of individual RSL projects. In 2015/16 Scottish Government is

allocating £4.634m to assist Scottish Borders projects through the SLP. Grant Allocation decisions are framed by benchmark grant rates set, and periodically reviewed and revised by Scottish Government. Notwithstanding grant allocations, the largest source of funding of affordable housing is raised by the RSLs themselves via their own capacity to borrow from the private sector money markets.

Scottish Borders Council can also assist delivery of affordable housing through use of its Second Homes/Council Tax budget which assumes that £715k income will be received annually for this purpose, and which is prioritised to assist delivery of projects identified through the SHIP process.

The Council can also contribute to delivery of affordable housing through use of developer contributions which are secured through the operation of its Affordable Housing Policy, with this assistance again prioritised to support delivery of projects identified through the SHIP process. However in reality, the current low level of private sector housing building within Scottish Borders is not generating significant amounts of such contributions.

RSL affordable housing is built to Housing for Varying Need standards which are slightly larger than comparably sized housing built for market sale, which are built to comply only with Scottish Building Regulation standards. RSLs also build homes which meet the needs of people with particular needs which the private sector housing building sector typically does not address, e.g. wheelchair standard housing or Extra Care Housing, or "core and cluster" groupings to facilitate delivery of cost effect housing support or care services, provided or commissioned by the Council or NHS Borders.

<u>Housing improvement across all tenures</u>

RSLs are able to access 100% funding of costs of major adaptations in their housing stock from "Stage 3" funding from Scottish Government, which is allocated from a Scottish national budget annually to individual RSLs. In 2015/16 the following allocations were made to Borders based RSLS –

- Berwickshire Housing Association £41k
- Eildon Housing Association £68k
- Scottish Borders Housing Association £109k
- Waverley Housing £41k[1]

[1] In addition there are a number of other RSLs based out with SBC with small amounts of housing stock within the area. They also receive Stage 3 allocations, but we have no information available as to how much, if any, is spent within Scottish Borders.

Scottish Borders has a nationally recognised Care and Repair service which won the Scottish Public Sector award in December 2015. This is commissioned by the Council and is funded from the Council's Housing Services revenue budget. The Care and Repair Services delivers major adaptations in private sector housing, and in those homes owned by the above mentioned 4 Borders based RSLs, thereby streamlining delivery and providing efficiencies and quality control across this activity, in addition to a range of other housing support services to enable people to live at home in the community. Currently 1 FTE Occupational Therapist is funded by the same Council budget, which is based within the Care and Repair service.

The Home Energy Efficiency Programme Scotland (HEEPS) is Scottish Government funded to offer grant funding to private households to install a range of energy efficiency measures including external wall insulation (EWI). Scottish Borders Council successfully secured £1,623,023 of funding from the Scottish Government's HEEPS:ABS 2014/15 allocation and has been awarded £1.87m for 2015/16.

The success of HEEPS: ABS relies on strong partnerships with RSLs mainly because EWI projects require coordination of social and private upgrades (such as mixed tenure blocks of flats).

Housing Support Services

There a range of non-delegated housing support services provided, which include housing and tenancy support for young people and to vulnerable homeless people. Housing support services help people to live independently in the community, regardless of their tenure. Providing a range of services to homeless people, including advice on budgeting and debt management; assistance with benefit claims; maintaining the security of the dwelling and general counselling and advice. RSLs also provide similar services, giving advice to those facing difficulties with their housing.


Scottish
Borders
COUNCIL

INTEGRATED CARE FUND - UPDATE

Aim

1.1 The attached reports update the Board on the use of the Integrated Care Fund (ICF) to date. They provide the background to the work planned to develop and manage a strategic financial plan for the use of the Integrated Care Fund (ICF) and improved coherent governance arrangements.

Background

2.1 The suite of papers provided (Appendices 1- 3) give an update on the progress of the Integrated Care Fund, in particular the progress of the Eildon Community Ward project, and proposals for revised interim governance arrangements for the ICF, pending the development of more appropriate ones.

2.2 A rigorous review of all projects has commenced, scrutinising, amongst other things, alignment to the local objectives of the Strategic Plan. More robust performance monitoring is being put in place. Projects that are not focussed on the delivery of the local objectives, as described in the Strategic Plan, and/or not performing properly will be considered for decommissioning. It is anticipated that there will be a reduction in the number of projects going forward. In very recent discussion, the Executive Management Team has agreed that a strategic spending plan for the ICF of a small number of high value funding streams will be developed. These will target the delivery of key strategic priorities. It is expected that the Integration Joint Board will be asked to endorse this financial plan.

2.3 Given this work and the poor experience of existing governance arrangements, further work will be done to develop simpler governance arrangements that will facilitate speedier decision-making.

Assessment

3.1 Current use of the ICF has been hampered by cumbersome governance arrangements and it has become apparent that some initiatives may not be as focused on delivery of local objectives as they might be; others may well be more appropriate for working at locality level.

3.2 A process of action learning has highlighted the need to put new governance arrangements in place and enhance the performance monitoring that has been in place to ensure more effective use of the fund.

3.3 As we move forward we will focus on mainstreaming the ICF projects and we will monitor how these are impacting and delivering the shift in overall resources in line with the Strategic Plan.

Recommendation

The Health & Social Care Integration Joint Board is asked to **note** this update.

Policy/Strategy Implications	There is a need for a more strategic approach to the use of the ICF and simpler governance arrangements.
Consultation	
Risk Assessment	Simpler governance arrangements will increase the speed of decision-making in relation to the use of the ICF. Improved performance monitoring is necessary to make more effective use of the fund.
Compliance with requirements on Equality and Diversity	The use of funding in this way will promote inclusion.
Resource/Staffing Implications	The ICF is £6.39M over the three years 15/16, 16/17, 17/18.

Approved by

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

Author(s)

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

APPENDIX 1

INTEGRATED CARE FUND – PROGRESS REPORT

Aim

1.1 This report provides an update on progress of the Integrated Care Fund.

Background

2.1 In 2014 The Scottish Government announced an Integrated Care Fund 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.

2.2 On 13th March 2015 it was announced by the Health Secretary that additional funding of £200 million will be allocated over two years to extend the Integrated Care Fund into 2016-17 and 2017-18.

2.3 Four key areas of investment have been identified in line with the expectations of the Strategic plan framework:-

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

Summary

3.1 Thirteen projects have been approved and are in progress. This includes three projects that have been combined to make up the Eildon Community Ward.

3.2 One project, for a Transitional Care Facility, is in progress.

3.3 Not all approved projects have progressed at the same pace since approval. A review is underway of these projects, along with their documentation to assess their potential to deliver against the strategic aims.

Recommendation

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

Policy/Strategy Implications	The implementation described in the report will ensure local delivery of national policy and strategy.
Consultation	
Risk Assessment	The time taken for projects to be approved and feedback from the different levels of governance. Governance structure to be reviewed.
Compliance with requirements on Equality and Diversity	The use of funding in way described will promote inclusion.

Resource/Staffing Implications	

Approved by

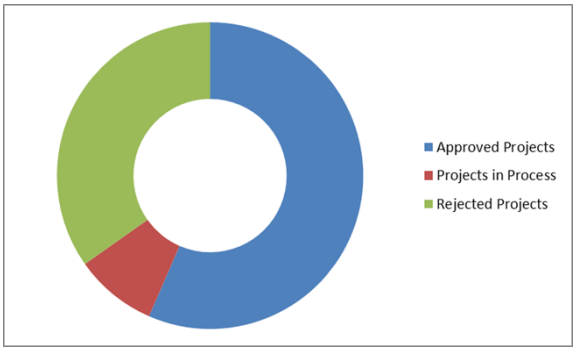
Name	Designation	Name	Designation
Susan Manion	Chief Officer – Health and Social Care Integration		

Author(s)

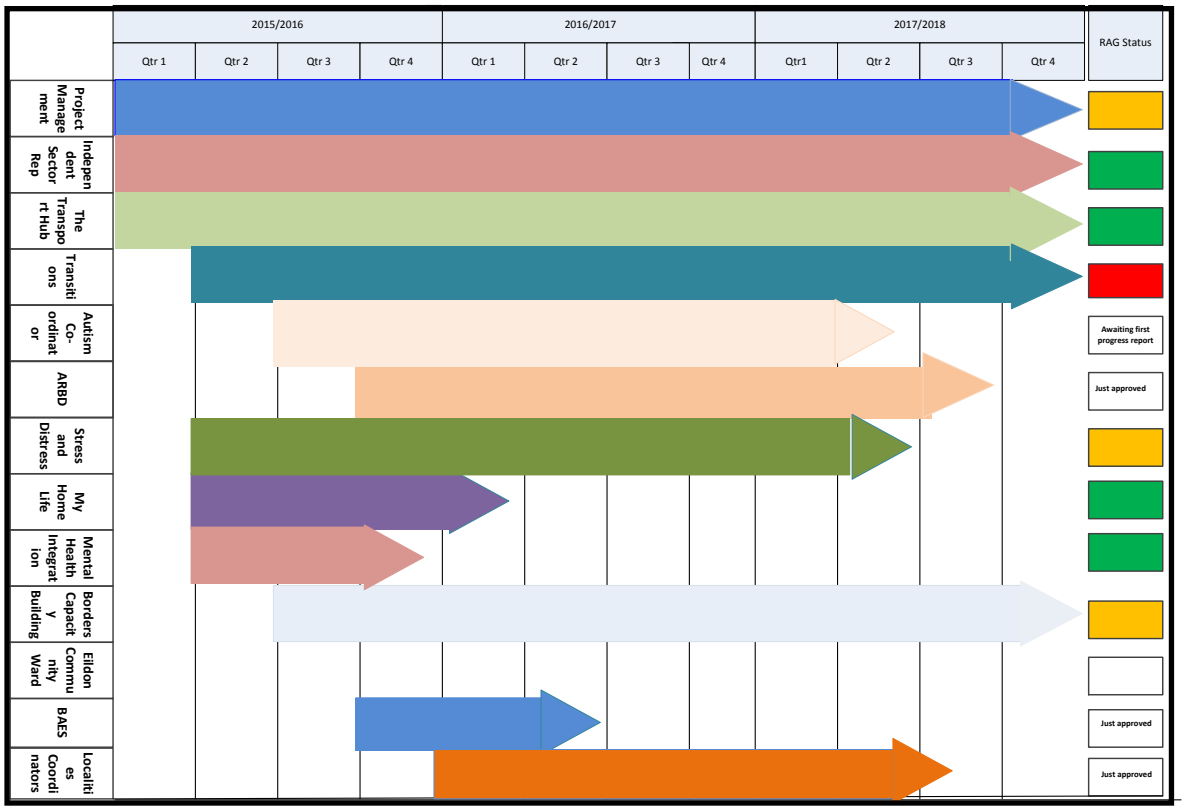
Name	Designation	Name	Designation
Clare Richards	Project Manager		

1. Progress at a glance

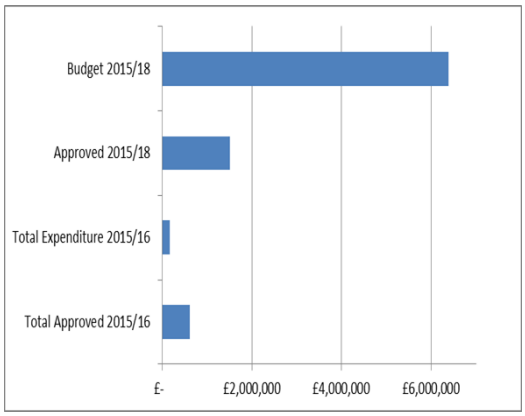
Number of projects



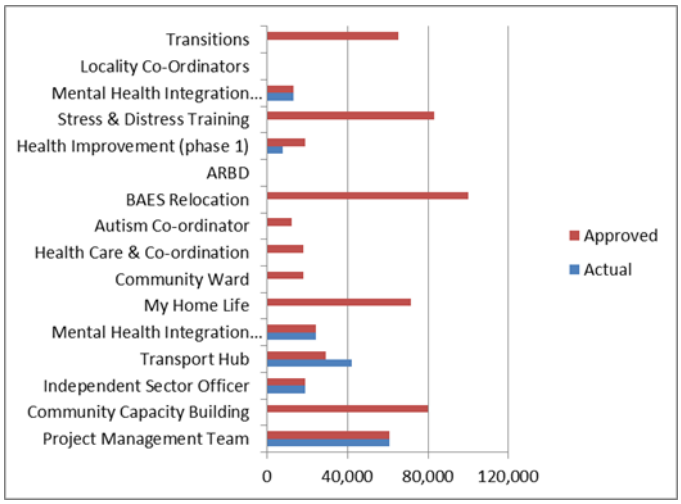
Timeline and RAG status of current projects



ICF Budget



Project Expenditure to date



5. The Approved Projects

5.1 Projects that fit with this strategic framework have been submitted have been appraised against a comprehensive range of both financial and non-financial ICF criteria. To date thirteen projects have been approved for ICF funding by ICF Steering Group/SPB/ EMT:

1. Programme Team
2. Independent sector Representative
3. Eildon Community Ward, Health and Social Care Integration and Health Improvement LTC's (PM and PSO posts – 6 months)
4. Transport Hub
5. Transitions
6. Stress and Distress Training
7. My Home Life
8. Mental Health Integration
9. Autism Coordinator
10. ARBD Service Development Officer
11. Borders Capacity Building

12. BAES Relocation
13. Locality Coordinators

5.1 Following an ICF workshop in January 2016 it was agreed that there was a great deal of connectivity between the Eildon Community Ward, Health and Social Care Integration (including reablement) and the Health Improvement Project.

5.2 A recommendation was approved by the Strategic Planning Board on the 23rd November 2015 to fund a Project Manager and Project Support Officer to develop a business case and project brief for these interconnected projects.

5.3 Further information on the combined project can be seen in the Eildon Community Ward paper.

6. Review of progress

Project	Scope	Outcomes	Approved Cost	End date
Programme Team	To allocate the Integrated Care Fund in line with the ICF Plan 2015-18	Projects to be aimed at health improvement, community capacity building, early intervention and prevention and access to services	Year 1 £61k Year 2 61k Year 3 61K	March 2018
Independent Sector Development Officer	To fund the costs of representation by an Independent Sector Officer in an advisory role to the programme		Year 1 £19k Year 2 £37k Year 3 £37k	March 2018
Transport Hub	Scottish Borders Council, NHS Borders, The Bridge, The Red Cross, Berwickshire Association of Voluntary Services and the RVS are partners in this project with the overall aim of putting in place a co-ordinated, sustainable approach to community transport provision.	Reduction in user stress & improved health & wellbeing Reduction in user cost due to shared journeys Reduction in duplicate journeys – more than one user could be transported in one vehicle More effective and efficient utilisation of community transport assets in the Borders. Users attending appointments and social activities that they would not attend if no transport was available Respite for carers	Year 1 29k Year 2 £70k Year 3 £40k	July 2018

Project	Scope	Outcomes	Approved Cost	End date
		Greater level of support for users – door to door, befriending service Facilitates discharge to hospital Facilitates partnership working		
Access to Information	Project on hold. Project Management Support may be available from June to develop a business case and brief – agreed at ICF SG 16th March.			
Health Improvement, Self-Management			Phase 1- 6 months £19k	
Community Infrastructure Support	The project brief is no longer fit for purpose. Recommendation by ICF SG on 16th March to remove this project.			
Transitions	This project will focus 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.	Reduce likelihood of emergency support Reduce admissions to care Improve the likelihood of a positive transitional experience Improve quality of life for young person, family and carers Improved continuous health care provision Reduced anxiety of carers Professional development of staff Better use of finance and staff resources	Year 1 £65.5k (NB £5k of total resource to be used in year 3 for evaluation	July 2016
Reablement	In development – to be included under remit of P07			
Health & Social Care Coordination incorporating a locality and reablement approach			6 months PM & PSO costs = £35,770	December 2018

Project	Scope	Outcomes	Approved Cost	End date
CM2000	A recommendation was made by the ICF SG on 16th March not to award requested funding as the project does not meet ICF Criteria.			
Autism Coordinator	An autism coordinator to commence and coordinate all of the work streams within the Borders Autism Strategy.	Professional development of staff Integrated care pathway for Autism Increase employability opportunities Increase in social opportunities Improved access to housing opportunities Empower people with autism and their families	24 months = £99,386	December 2018
ARBD	A development officer post to deliver the actions identified in the 2013 ADP needs assessment.	Improved access to diagnosis and assessment Right level of treatment Increased and improved awareness Better coordination of care and support Improved data and use of resources Increased ability for people with ARBD to live at home Access to a dedicated ARBD unit	24 months = £102,052	February 2018
Stress and Distress Training	Stress & Distress Training provides training in an individualised, formulation driven approach 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	Reduction stereotypes and discrimination of people with dementia Improvement of collective experience for people who use/live in service/establishment Keeping people in the community Reduction in social isolation, stigma for user and carer, loss of dignity and social embarrassment Playing active part in community Accessing community facilities Achieves outcomes that are truly person centred Reducing unmet need Improving the ability of professional to understand and meet needs Prevention of admission to residential NHS wards	Year 1 £83k Year 2 £83k	August 2017

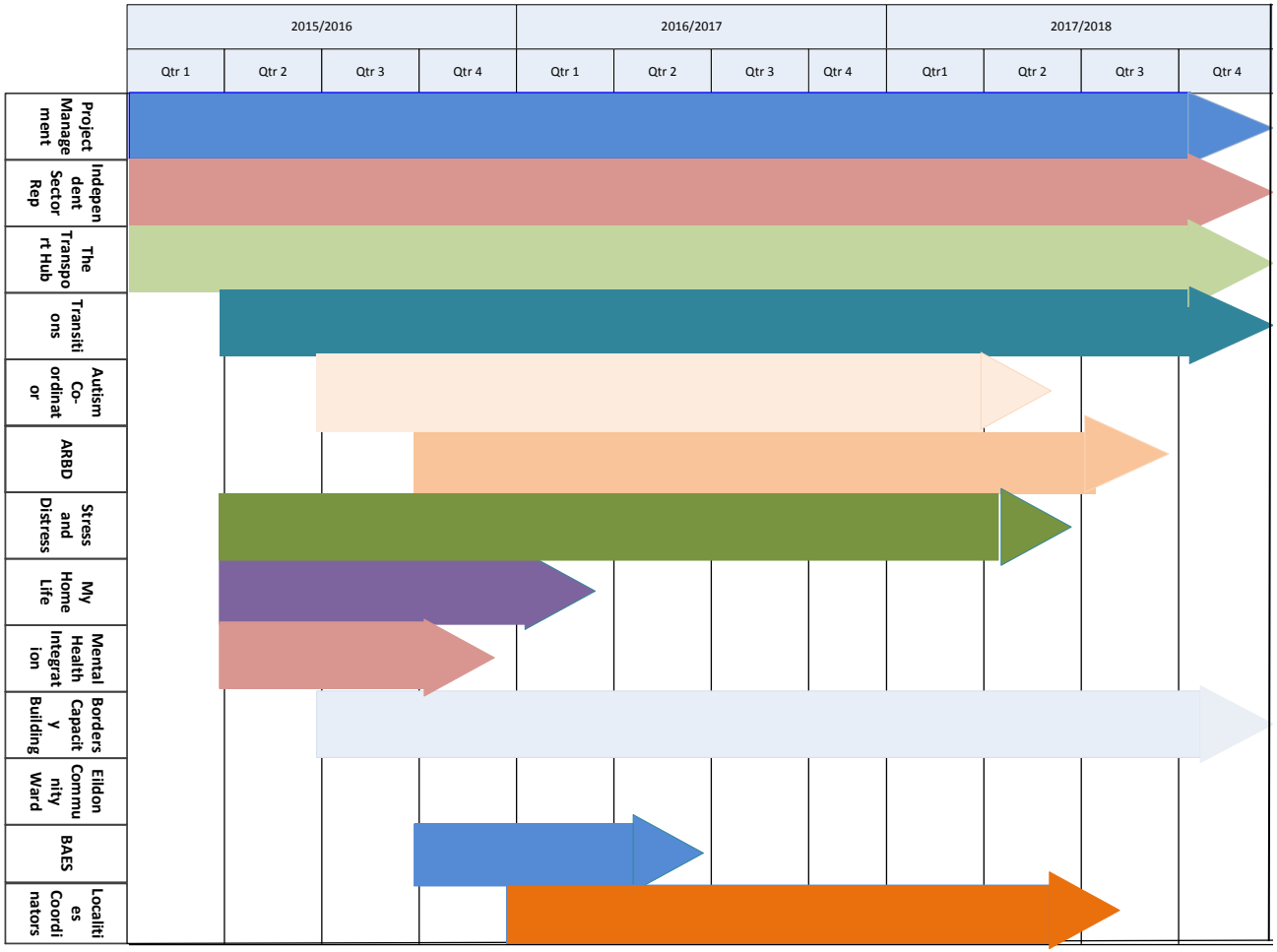
Project	Scope	Outcomes	Approved Cost	End date
		Reducing in bed days Reduce prescribing of anti-psychotic medication resulting in reduced prescribing costs, reduction in falls and reduction of risks of strokes Reduction in the use of prescribed by registered nurse medication (PRN) Reducing staff sickness stress (due to staff feeling more skilled and competent) Psychosocial model is less costly than medical model (saving costs of medication, admissions and medic costs) Reduce of risk restraint Reducing use of specialist, high cost, out of area facilities such as St Andrews Reduction in compulsory detentions under mental health act because it support social model as alternatives		
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 home 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	Reduction in hospital admissions from care homes All discharges to care homes will be achieved within the 72 hours target 90% of care homes in the Borders will achieve grades of 4 or higher within a 12 month period Reduction in staff turnover in care homes and increased staff retention Increase in recruitment	Year 1 £71.4k	Jan 2017

Project	Scope	Outcomes	Approved Cost	End date
	Home Managers through a collaborative approach			
Mental Health Integration	The temporary Team Leader role and temporary administration role which will support the transition from a dedicated social work team to having social work functions such as care management and assessment and use of IT software such as Frameworki embedded within the integrated teams.	Removal of bureaucratic barriers between organisations that unnecessarily stop the service user getting the service they need, when they need it, Reduced duplication of information gathering and recording across health and social care Quicker access to services for service users and their families, Better use of buildings and staff that results in more face to face care and higher quality services, Better allocation of work across different professional groups that makes the best use of the unique skills/perspectives that each profession brings, Performance and Quality Outcomes More efficient use of resources that allows money to be spent where it will have maximum effect on the mental health and well-being of the service user group Easier access for staff in terms of involving appropriate colleagues across organisational boundaries, in the care of their service users.	6 months = £37.5k	March 2016
Continuation of Osteoporosis and Bone Health Service	A recommendation was made by the ICF SG on 16th March not to award requested funding as the project has not had any contact with the Project Team since August 2015.			
Borders Community Capacity Building	To develop a series of community support projects to	An increase in the number and variety of activities co-produced with older people	Year 1 £80k	October 2018

Project	Scope	Outcomes	Approved Cost	End date
	bring together services and to support further development and growth of local services and activities.	An increase in the numbers of people across the borders who are using these activities An improvement in the delivery and co-production of services More effective use of resources by adopting a multi-agency approach involving older people A reduction in the future demand for all NHS and related social care and voluntary services	Year 2 £160k Year 3 £160k	
Pharmaceutical Care	A recommendation was made not to award requested funding as the project does not meet ICF Criteria. Recommendation approved by the SPPB on 23 Nov 15			
Eildon Community Ward	To develop a model of care, initially in central Borders, which will provide a clinical bridge across primary and secondary care as well as with Social Work and other partner agencies. It will focus on supporting patients in their local community, preventing admission where appropriate and enabling rapid-return from acute care to the patient's own home or community	Reduced admissions; Reduced readmissions; Reduced number of GP home visits; Reduced Length of Stay; Reduced number of out of locality placements; Reduced number of delayed discharges. Wider: Reduced LOS in other community hospitals; Improved patient satisfaction; Improved staff satisfaction.	6 months PM & PSO costs = £35,770	
Borders Ability Equipment Store (BAES) Relocation	Relocation of the Borders Ability Equipment store to a purpose built location.	Reduced risk of infection Increased staff productivity Increased equipment recycling rates Increase in processes store able to carry out improved delivery turnaround	One off capital payment of £100k	
Locality Coordinators	To improve communications and coordination of services.	TBC	TBC	October 2017

Project	Scope	Outcomes	Approved Cost	End date
	Improve access to services. Link to GP services, the third and Ind sector. Develop locality plans. Redesign services to meet needs. Make Recommendations to the localities group.			

7 Project delivery



8 Investment and approach

8.1 Projects that fit with this strategic framework have been submitted and appraised against a comprehensive range of both financial and non-financial ICF criteria. To date thirteen projects have been approved for ICF funding by ICF Steering Group/SPB/ EMT. In the future we expect that the Strategic Planning Board will be instrumental in determining the Integrated Care Fund projects in line with the Strategic Plan.

	15/16	**16/17**	**17/18**	**18/19**	**Total**
Resources Available	£2,130,000	£2,130,000	£2,130,000		£6,390,000
Committed Projects					
Approved budget	£613,267	£512,199	£386,776		£1,512,242
Actual expenditure of Projects (Feb)	£174,842				
Difference	**£438,425**				
Uncommitted Funds	**£1,516,733**	**£1,617,801**	**£1,743,224**		**£4,877,758**
Planned projects not yet committed (proposed costs)					
Eildon Community Ward		£1,090,186	£1,228,186	£173,000	£2,491,372
Transitional Care Facility		£700,000	£500,000	£500,000	£1,700,000
Increased access to home care		TBC	TBC	TBC	
Total		**£1,790,186**	**£1,728,186**	**£673,000**	**£4,191,372**
Expenditure if planned projects are approved	**£613,267**	**£2,302,385**	**£2,114,962**	**£673,000**	**£5,703,614**

8.2 Any unsolicited bids received by the ICF Programme Team are being informed that applications are not currently being accepted.

APPENDIX 2

INTEGRATED CARE FUND – EILDON COMMUNITY WARD PROGRESS REPORT

Aim

1.1 This report aims be give a clear understanding of the Projects that make up the Eildon Community Ward.

Background

2.1 The Scottish Borders has four community hospitals. There is no such facility within the Eildon area as Ward 14 in the BGH used to provide this function but this was decommissioned in 2008. In order to flex capacity and increase patient flow, patients can be placed out of area in a community hospital where they have a transitional care need which prevents them from being discharged home. There is a complex model of medical support within the Community Hospitals through the local GP practices. The GPs feel that the service is inequitable, not patient centred nor is this sustainable.

2.2 Consideration was given to test a community ward model in the Eildon area to assess whether this would improve the care given to the community within the borders. It was agreed to seek ICF funding to support this model.

2.3 It was noted by the Strategic Planning Board on 23rd November 2015 that there were links between three ICF project proposals; the Eildon Community Ward, Health Improvement LTC's and Health and Social Care Coordination.

2.4 The Strategic Planning Board approved the recruitment of a Project Manager and Project Support Officer to develop a joined up business case and project brief for these projects under one banner of "The Eildon Community ward".

Summary

3.1 The Eildon Community Ward is a key project within the portfolio of Integrated Care Fund projects. It is one of three key projects that contribute to a new model of care, initially in central Borders, which will provide a bridge across primary and secondary care as well as with Social Work and other partner agencies, as is aligned to the principles of the House Of Care approach.

3.2 Progress to date has been limited. The recruitment of the Project Manager on a 6 month basis was unsuccessful; agreement has been given to re-advertise on the basis that this post will be 18 months in duration. The recruitment of the Project Support Officer was successful.

Recommendation

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

Policy/Strategy Implications	The implementation described in the report will ensure local delivery of national policy and strategy.

Consultation	
Risk Assessment	The time taken for projects to be approved and feedback from the different levels of governance. Governance structure to be reviewed.
Compliance with requirements on Equality and Diversity	The use of funding in way described will promote inclusion.
Resource/Staffing Implications	See section

Approved by

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

Author(s)

Name	Designation	Name	Designation
Clare Richards	ICF Project Manager	Alasdair Pattinson	General Manager - Primary & Community Services
Sandra Pratt	Associate Director, Delivery Support (Medical Directorate)	Jane Douglas	Principal Assistant Social Care & Health/ Group Manager

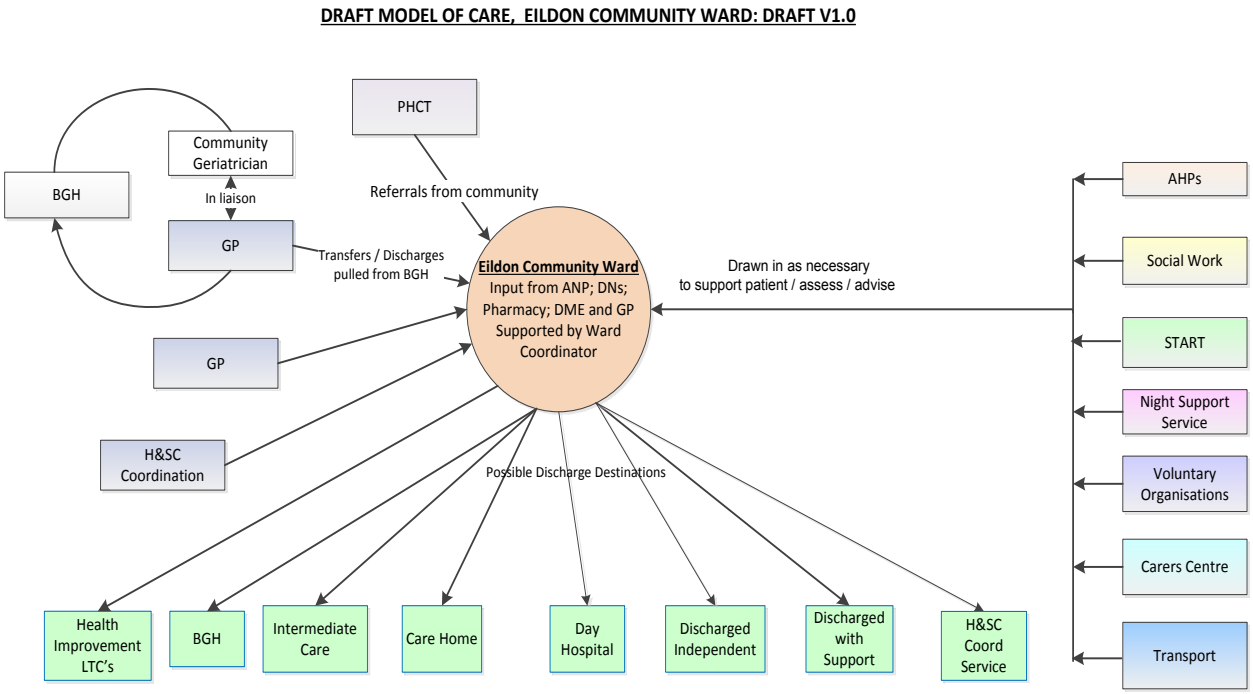
4. Eildon Community Ward Model

4.1 The transfer of patients to facilities away from their own community can impact adversely on patient experience, is not person-centred and potentially compromises patient safety - elderly patients can become very disoriented and confused when they are moved to somewhere unfamiliar.

4.2 It is proposed to develop a model of care, initially in central Borders, which will provide a clinical bridge across primary and secondary care as well as with Social Work and other partner agencies. It will focus on supporting patients in their local community, preventing admission where appropriate and enabling rapid-return from acute care to the patient's own home or community. It will aim to improve patient experience and safety and will be person-centred, utilising anticipatory care planning and care continuity.

4.3 It was agreed to focus on those patients requiring community hospital level care i.e. sub-acute care but the co-dependency with the Health & Social Care Coordination Project and the Health Improvement Project was recognised. Accordingly, it has been agreed that these projects will be brought together under one banner, which would allow testing of the transfer processes to and from sub-acute care and enable appropriate rationalisation of resources.

4.4 The diagram below shows how these projects would link together.



5. Overarching Objective

5.1 To develop a model of care, initially in central Borders, which will provide clinical consistency across primary and secondary care as well as with Social Work and other partner agencies. It will focus on supporting patients in their local community, preventing admission where appropriate and enabling rapid-return from acute care to the patient's own home or community. It will aim to improve patient experience and safety and will be person-centred, utilising personalised care planning, anticipatory care planning and care continuity delivered by a multidisciplinary team approach.

6. Combination of Projects

6.1 Three projects will work together to produce this model of care.

6.2 Eildon Community Ward -The objective of the Eildon Community Ward is to develop community ward capacity outwith 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.

6.3 Specifically contracted GP input (i.e. separate from existing GP practices) will be responsible for the clinical management of patients identified as no longer requiring acute services but who still require a level of care equivalent to that normally provided in a community hospital. The GPs will work as part of a multi-disciplinary and multi-agency team. While delivering care in patient's own homes or in the local community setting, the team will also provide an in-reach service to help "pull" patients from BGH. In doing so, they will work in close consultation with acute clinicians as well as with social work and voluntary organisations to ensure the right outcomes for individual patients.

6.4 Eildon Community Ward will be patient-focussed and will be flexible enough to provide care and support wherever is most appropriate for the patient.

6.5 The model will provide:

- A step-down/step-up 7 day service which links with BGH specialties and works closely with ED and BECS as well as Social Work.
- Appropriate eligibility/admission criteria.
- Resilient anticipatory care planning processes and care escalation policies.
- In-reach to BGH to "pull" patients from acute care – with the potential to consider direct care by the Eildon Community Ward GPs/AHPs.
- Multi-disciplinary assessment within 48 hours of admission to the Ward.
- The capability to manage IV therapy in the Ward.
- A level of flexible training and education potential through rotations/placements to support the development of a pool of staff with consistent skill sets across the system.

6.6 Health and Social Care Coordination including Reablement - This project aims to introduce a Health and Social Care Co-ordination approach through integrating teams within one locality in the Borders. We will test the model of reablement in regard to the utilisation of Reablement Support Workers.

6.7 Phase 1 of the integrated team approach will be to introduce the Health and Social Care Co-ordinator (Duty Coordinator) role, based on the Torbay model, to create a single point of access, will be created to facilitate liaison between the team and main point of contact for GPs, patients and carers. The role will be able support screening provision to enable small packages of care to prevent crisis.

6.8 Phase 2 of the integration would result in the delivery of the following functions:

- Rapid assessment and prevention of admission
- Crisis response
- Discharge management
- Rehabilitation and reablement (please note this will link with the reablement project)

6.9 The Reablement Programme of activities within Social Care is now in Phase 2. It now needs to deliver the following objectives:-

- Develop the Reablement Support Worker role across locality teams that can follow the person across traditional organisational boundaries to deliver reablement plans *
- Develop a matching unit that identifies and manages external home care provision across the localities to ensure flexible and responsive use of resources, and frees up practitioner time in trying to resource provision
- Enable self-assessment through technology to support people to self-manage their conditions thus preventing inappropriate referrals to social work, and enable rapid response to other solutions e.g. Smartcare solution; tablet technology at point of access in hospital. This is being managed through another project
- Implementation of sustainable reablement training programme

** the role of Generic Support Worker, comparable to the role of the Reablement Health Care Support Worker, was developed under the reablement programme 2009. This did not come to fruition at that time due to NHS Health & Safety policies. The purpose of this role was to work across traditional boundaries following the person not the service. It is anticipated that by establishing this role now within community services that this will morph with the pending integration of community locality teams. This role has been the key role in delivering the reablement plans within the traditional IC beds since 2007.*

6.10 Health Improvement LTCs - Health Improvement LTC's focuses on strengthening the capacity to support shared management of LTCs which is critical in addressing the changing health needs of the Borders population, and in developing integrated care models. This project builds on a current project designed to improve shared management of LTCs amongst older people. This new project extends the basic concept to include all adults with LTCs, including those with multiple conditions, so learning from experience and maximising the use of short-term funding.

6.11 There are two key components to this project:

- LTC shared-management project (older people): An extension of 12 months to the existing LTC Shared Care project operating in the Coldstream and Ellwyn

(Galashiels) practices and focusing on older adults. This would be to ensure a longer term evaluation, 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

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

  - Tier 1 - 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.

6.12 This is an extension of a Change Fund project. Initially 6 months funding was granted for component 1 of this project. Years 2 and 3 would involve developing, testing, then scaling up and implementing new ways of working that support health improvement across the care system with a wider application that can be sustained.

6.13 As with the existing LTC project, this project is based on the House of Care approach (Kings Fund 2013). House of Care is designed to empower patients and carers to be actively involved in their own care, and focuses on having 'good conversations' with professionals to create individualised care and support plans.

6.14 Four key components of the House of Care model are:

- Service users and carers are engaged, informed and supported: Service user outcomes include more meaningful involvement in own care, improved compliance with treatment plans, healthier lifestyle choices, greater stability of symptoms, improved management of LTCs, improved health and well-being.

- Services have systems, tools, structures and processes in place that support shared-management: Service level outcomes include having a consistent, equitable, evidence-based quality service that addresses service users' needs, and a reduced demand in inappropriate contact resulting from improved access to information, advice and tailored support.

- Professionals (health, social care and third sector) are committed to partnership working. Service provider/professional outcomes include improved knowledge, understanding and competencies around supporting shared-management and the application of these competencies in practice.

- Planning and funding partnerships ensure the responsive allocation of resources: Partnership outcomes would include synergy across and between funded projects that collectively contribute to achievement of agreed goals; continued service improvement that demonstrates impact of investment in resources; local commissioning informed by evidence of what is needed and what works within a locality context.

6.15 The LTC Locality Project would apply the House of Care model at various tiers across community settings, social care, primary and secondary specialist care, and acute/residential settings/intermediate care unit beds. The project would work

across the NHS, social care, and third sector and with housing providers, actively engaging local communities.

6.16 The LTC Locality Project includes a partnership with the Borders Sport & Leisure Trust to develop accessible health programmes which aim to get more people with LTCs physically active.

7. Outcomes

7.1 The combined project will deliver against all four of the Scottish Government's priority areas and ICF principles and have identified the following key outcomes -

Project	Locality	Outcomes	National Outcome
ECW (including Health Improvement LTC's and H&SC Coordination)	Eildon	Reduced admissions	2,
		Reduced readmissions	7, 9
		Reduced number of GP home visits	2,
		Reduced Length of Stay	
		Reduced number of out of locality placements	
		Reduced number of delayed discharges	2
		Improved wellbeing	1
		Reduced dependency on services	1
	Wider Community	Reduced LOS in other community hospitals	
		Improved patient satisfaction	3
		Improved staff satisfaction	
	Coldstream and Ellwyn – Year 2 locality to be confirmed	Improved self-management of LTCs	1,2
		Improved knowledge and understanding of LTC	1
		Healthier lifestyles	1
		Improved ability for carers to look after their own health	6
		Greater capacity for, and use of, peer support	6
		Greater stability of symptoms	1
	Wider Outcomes	Service delivery outcomes	3
		Professional Outcomes	8
		Organisational Outcomes	8,9

8. Review of Progress

8.1 To date, each project has produced a project brief. The Eildon Community Ward and the Health and Care Coordination project have worked together to produce a combined project brief.

8.2 The Strategic Planning Board has approved ICF funding to recruit a Project Manager and a Project Support Officer to develop the combined Eildon Community Ward business case and associated project Documentation. The Project Support Officer post has been filled; the Project Manager post has been re-advertised and is expected to be in post by May 2016.

9. Implications

9.1 Financial – Indicative costs are detailed below -

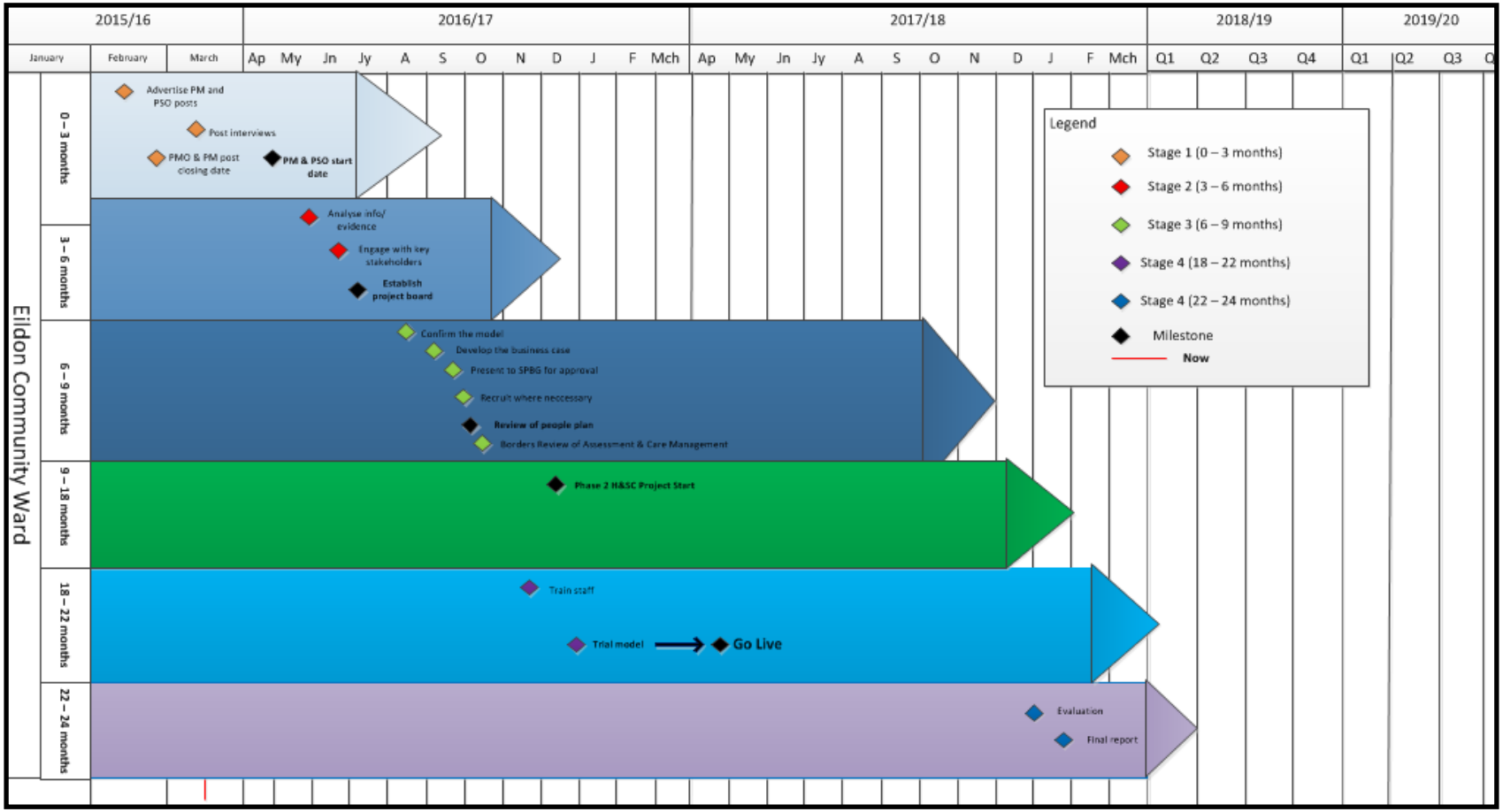
Project	Year 1	Year 2	Year 3	Total
ECW	£1,090,186	£1,228,186	£173,000	£2,491,372

9.2 Please note that these costing's will be refined by the ECW Project Manager when the business case for the ECW is developed. Year 3 costs are just for the Health Improvement LTC's project.

9.3 Risks - The following risks have been identified –

Risks	Control measure	Owner
Model may not work.	Ongoing Monitoring and Evaluation to measure performance.	Project Manager and Sponsors
Overlap with the Transitional Care Facility.	Ensure that the projects work together to form the business case and brief.	Project Manager and Sponsors
There is a potential need for more specialist home care	This will be monitored throughout the project.	Project Manager and Sponsors

10. Implementation Plan



APPENDIX 3

REVISED GOVERNANCE ARRANGEMENTS - INTEGRATED CARE FUND

Aim

1.1 This report highlights the challenges of the current system for the use of the Integrated Care Fund (ICF) and proposes actions to address these. These will improve the speed of decision-making and performance monitoring; they will also ensure more coherent governance. Moreover, these arrangements will ensure that the focus of the ICF projects will be driven by strategic priorities in line with the Commissioning and Implementation Plan.

Background

2.1 The existing arrangements for the governance of the ICF have proved to be poorly understood, cumbersome, slow and so delaying implementation of new models of service delivery. The current process had its inception in a workshop in September 2014 to look at various initiatives which might be funded by the ICF in line with a spending plan agreed in March 2015 with the Scottish Government. This spending plan was superseded by the development of the Strategic Plan for Health and Social Care Integration. The workshop helped assess how proposals would align with the key themes and outcomes developed in the strategic planning process. As a result of this it was agreed to fund various proposals. The process has been to take these to the ICF Steering Group. At this group proposals are assessed for fit to the strategic approach and where appropriate there is work with the project lead to develop a satisfactory formal project application. These are then scored by a small executive group (ICF chair, vice-chair, finance representative and others). Scored applications are then considered by the ICF Steering Group. Those that have a low score are dismissed and those that are high-scoring are recommended for approval to the Strategic Planning Board (SPB). The SPB has delegated authority to approve projects up to £75K to maximum cumulative total of £500K in the financial year. Projects exceeding these financial limits are put to the Executive Management Team (EMT) for approval. Because of the difficulty in arranging meetings process has proved slow and virtual approval has been required. The experience of the current ICF process has demonstrated that it is not fit for purpose.

2.2 For the Integration Joint Board to have assurance that these challenges are being dealt with, it requires a more in-depth appreciation of the issues and the planned remedial action.

Assessment

Current Challenges

3.1 The current approval process is too slow because of

- The number of inappropriate proposals being put forward for consideration
- Protracted, inconclusive discussion between the ICF Steering Group and applicants for funding.
- The number of groups involved in the chain of decision-making.

3.2 Performance monitoring has been slow to highlight initiatives that have not been progressing satisfactorily. Not all projects have progressed since approval.

3.3 Information flow to executive and board level could be greater and give board members more satisfactory assurance.

Proposed Revised Process

4.1 A more overt, strategic commissioning approach would ensure far fewer inappropriate proposals put forward. The Health and Social Care Partnership should proactively plan the use of the ICF from 2016/17 onwards to commission large-scale projects. These should deliver sustainable, transformational change in models of service delivery which improve outcomes for individuals and communities. The aims are expressed in the local objectives of the Strategic Plan. The IJB needs to be sufficiently informed to provide governance to the work. To do so, in terms of existing structure it needs to be supported by the SPB via the EMT and the advice of the Strategic Planning Group. The SPB needs to ensure that collaboratively commissioned changes are significant, evidence-based and fit with the Strategic Plan and locality planning. They should be reflected in the Commissioning and Implementation Plan. There should be strategic support to this from the Executive Management Team.

4.2 Return on investment, including "reach" amongst the target population, could be more robustly assessed for each proposal. It is proposed that the ICF Programme Manager would coordinate applications for funding and arrange for a small panel similar to that of the Executive Group of the ICF to score proposals more robustly before they are considered at the SPB. Initiatives would have to reach an agreed threshold score before being presented to the SPB for consideration. This would enable rapid decision making and prevent protracted, inconclusive discussion. The consequence is that the current ICF Steering Group would not be required. There is considerable cross-membership and duplication of function between that and the SPB. Stakeholders currently involved in that group have the opportunity to advise through the SPG.

4.3 A more robust performance monitoring framework should be put in place to give the IJB assurance that the fund is being invested to good effect. More rigorous performance monitoring should be used to identify projects that are not delivering with a view to driving improvement or decommissioning. Should services be decommissioned, the funding would be allocated to more appropriate initiatives

4.4 The flow of decision-making would be as follows:

4.4.1 The IJB would agree strategic direction and priorities for ICF investment as part of a financial plan, reflected in or drawn from the Strategic Plan and locality planning.

4.4.2 The EMT, supported by the SPB, would give strategic direction for commissioning using the ICF and decide on funding projects with an annual budget in excess of £500K.

4.4.3 The SPB would only consider high-scoring, fully worked up bids and make quick decisions within delegated level of an annual budget of £75K.

Exceptional requests for extension of funding or requests for additional funding requests would only be considered from highly performing projects.

4.4.4 The membership of the SPB would need to be checked to ensure it is appropriate for the purpose. The role of the EMT would become one of giving strategic direction to the use of the ICF and identifying major initiatives that should be funded from this source. In addition, EMT would be informed about all proposals approved by the SPB; the SPB would make recommendations on those exceeding delegated limits for approval to the EMT, asked it to decide whether to progress these. All decisions in relation to the use of the ICF would be reported to the IJB.

4.4.5 Appendix A illustrates the proposed interim process.

Summary

5.1 The current arrangements for managing the use of the ICF are not fit for purpose. This paper proposes a streamlined process which should prove more efficient and effective. It involves abolishing one of the three groups currently involved in the process. The revised process will entail more rigorous assessment of proposals for funding and performance monitoring with clarity around what decisions each group makes. This will ensure more effective use of the ICF and speedier decision-making in relation to proposals for funding by the ICF. It will deliver more coherent governance to the use of the ICF.

Recommendation

The Health & Social Care Integration Joint Board is asked to **note** the proposals in this report to improve the process for the use of the Integrated Care Fund.

Policy/Strategy Implications	The implementation of the revised process described in the report will ensure more effective use of the ICF.
Consultation	
Risk Assessment	The revised process will increase the speed of decision-making in relation to proposals for funding by the ICF. It will deliver more coherent governance to the use of the ICF and improved performance monitoring.
Compliance with requirements on Equality and Diversity	The use of funding in this way will promote inclusion.
Resource/Staffing Implications	The ICF is £6.39M over the three years 15/16, 16/17, 17/18.

Approved by

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

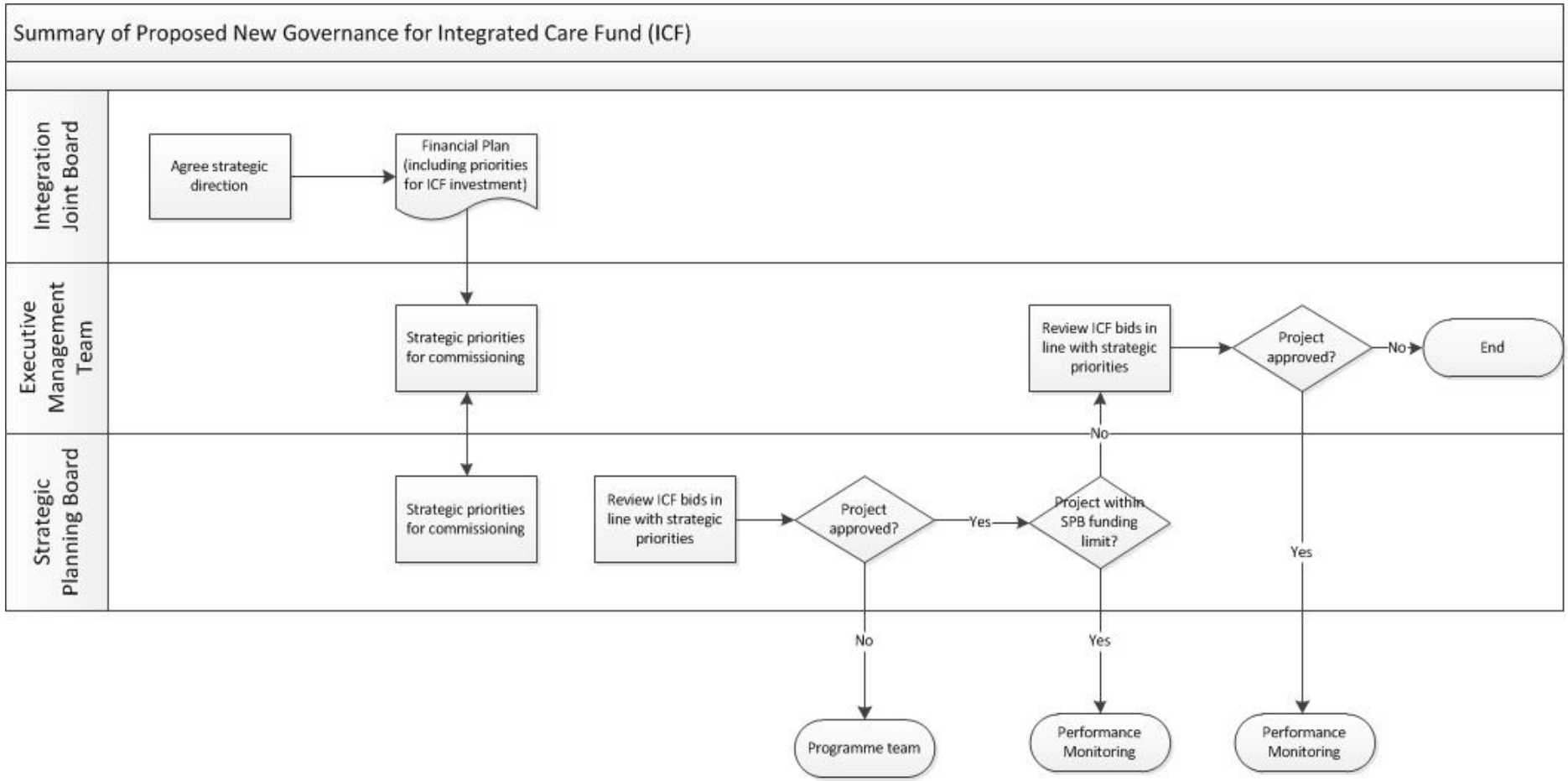
	Integration		

Author(s)

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

Appendix A

Summary of Proposed Interim Governance for Integrated Care Fund



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LOCAL DELIVERY PLAN 2016/17

Aim

1.1 This paper is to update members of the Integrated Joint Board on NHS Borders' formal draft 2016/17 Local Delivery Plan (LDP) and invite comments and feedback on this draft. The LDP was submitted to the Scottish Government Health Department as a draft on 25th March 2016, with the final copy to be submitted on 31st May 2016, subject to Health Board approval on 23rd June 2016.

Background

2.1 LDPs were introduced during 2006/07 and have been required for the last 8 years. The LDP acts as a corporate contract between NHS Boards and the Scottish Government, outlining priority outcomes and deliverables. NHS Borders' performance against LDPs will be discussed at the Annual Review.

Significant policy developments underway include the national clinical strategy, integration of Health & Social care, national conversation and a range of service reviews. The scale of the challenges that NHS Scotland faces means that we need to deliver fundamental reform and change to the way that the NHS delivers care.

2.2 As with the previous years, NHS Borders is required to produce and submit a LDP which forms a performance and delivery agreement between NHS Borders and the Scottish Government Health Department. 2015/16 was labelled a 'transitional year' for the LDP by the Scottish Government which reflected the change in emphasis in the Government guidance for the plan, and which continues into 2016/17.

2.3 Health Boards and their partners in local government must take account of the effect of their plans on the outcomes for health and wellbeing set out in legislation as part of integration of health and social care, and on the indicators that underpin them – including delayed discharge. There is a legal duty for Health and Social Care Partnerships to produce a Strategic Plan (which must be reviewed and revised every three years) and a duty for the delegating parties to be fully involved throughout that process. It is important that the Health and Social Care Partnership is involved in the preparation of LDP with a relationship based on collaboration and alignment.

2.4 In the past the LDP has focused largely on the delivery of the HEAT (Health Improvement, Efficiency, Access to services and Treatment) targets set by the Scottish Government. From 2015/16 these targets have been known as LDP Standards. These Standards will continue to be closely monitored to maintain performance, however this year, as last, the LDP guidance focuses on what actions Boards are taking towards achieving the 2020 Vision for health and social care in Scotland and how we are working with our partners and members of the public to achieve this. It also relates to the work that is being undertaken by the Integration Joint Board that is represented in the Strategic Plan.

2.5 NHS Boards and Local Authorities delegate appropriate national and local standards to their Health and Social Care partnerships, along with the relevant functions and budgets. Whichever functions and standards / targets are integrated, it will be important that robust planning operates to reflect interdependencies so that, for instance, where non-elective care is integrated and elective is not, then these two must operate in a mutually supportive way.

The LDP should set out a summary of how the delivery of national and local standards / targets will be aligned between the local planning and operational structures.

2.6 The following sections are included in the 2016/17 LDP:

1. Improvement Plan
    a. Health Inequalities and Prevention
    b. Ante-Natal and Early Years
    c. Person-Centred Care
    d. Safe Care
    e. Primary Care
    f. Integrated Care
    g. Unscheduled Care
    h. Scheduled Care
    i. Mental Health

2. Workforce section
3. NHS Contribution to the Community Planning Partnership
4. LDP Standards
5. Financial Plans (submitted separately)

2.7 Following the inclusion of an Improvement and Co-Production Plan (ICP) in last year's LDP focussing on 6 key areas, the Scottish Government this year has asked Boards to focus on 9 key priority areas that we are being asked to make measurable progress towards to achieve the 2020 Vision. The 2020 Vision was set out by the Cabinet Secretary in 2011 to achieve sustainable quality in the delivery of healthcare services across Scotland, improve efficiency and achieve financial sustainability. Service leads have produced a short narrative containing the work undertaken and planned for each area, including links to relevant plans or strategies, local and national.

2.8 This is the fourth year that we have included a section on the NHS Contribution to the Community Planning Partnership. This section has been updated since last year and focuses on the key tangible contributions NHS Borders will make towards improved outcomes in: health inequalities and physical activity; and early years and early intervention.

2.9 The LDP incorporates the key standards, plans, and levels of performance that NHS Borders will have to achieve during 2016/17. This in turn will inform discussions about performance at the Annual Review.

2.10 The draft has been created by narrative received from service leads and managers across the organisation. The Planning and Performance team will be liaising with

national leads to receive feedback from them and to finalise thereafter each section during April 2016.

Summary

3.1 There has been engagement across the service as the draft Local Delivery Plan has been developed. Feedback has been sought on this draft plan from the Clinical Executive Operational Group, members of the Board Executive Team, the Area Partnership Forum, Area Clinical Forum, Public Reference Group and wider stakeholders, which will include staff who work in services fall under the partnership.

3.2 NHSB is keen that members of the IJB have an opportunity to review and comment on the LDP.

3.3 The final version will be submitted to Scottish Government on 31st May 2016 subject to NHS Borders Board approval on the 23rd June 2016.

Recommendation

The Health & Social Care Integration Joint Board is asked to **note** the work in progress and **provide any feedback / comments** on the attached draft Local Delivery Plan 2016/17 to June Smyth by 25th April.

Policy/Strategy Implications	The LDP will be the primary mechanism for monitoring the performance of NHS Boards by the Scottish Government.
Consultation	The LDP 2016/17 has been developed in conjunction with the service, the Clinical Executive, Board Executive Team and service leads.
Risk Assessment	See Above
Compliance with requirements on Equality and Diversity	The risks for delivery of LDP actions have been factored into the plan. Performance will be monitored proactively throughout 2016/17 through reporting to allow remedial actions to be taken.
Resource/Staffing Implications	The LDP has been developed to be fully compliant with NHS Borders' Equality and Diversity requirements.

Approved by

Name	Designation	Name	Designation
June Smyth	Director of Workforce and Planning, NHS Borders		

Author(s)

Name	Designation	Name	Designation
Meriel Smith	Planning and Performance Officer, NHS Borders	Karen Shakespeare	Planning and Performance Manager, NHS Borders

NHS Borders

Local Delivery Plan 2016/17

Planning & Performance

Contents

Glossary

ADP	Alcohol and Drugs Partnership
AHP	Allied Health Professional
BECS	Borders Emergency Care Service
BHIH	Borders Health in Hand
BI	Brief Intervention
BIST	Borders Improvement Support Team
BME	Black and Minority Ethnic Communities
BSL	British Sign Language
CAMHS	Child and Adolescent Mental Health Service
CDI	Clostridium Difficile Infection
CEL	Chief Executive Letter
CHCP	Community Health and Care Partnership
CHW	Child Healthy Weight
CPC	Child Protection Committee
CPP	Community Planning Partnership
DCE	Detect Cancer Early
DMARDs	Disease-modifying antiheumatic drugs
DNA	Did Not Attend
ED	Emergency Department
eMART	environment Monitoring and Reporting Tool
ENP	Emergency Nurse Practitioner
EY	Early Years
GCCAM	Good Corporate Citizenship Assessment Model
GIRFEC	Getting it right for every child
GRFW	Get Ready for Work
HAI	Healthcare Acquired Infection
HEAT Targets	Health Improvement, Efficiency, Access and Treatment Targets

HLN	Healthy Living Network
HSMR	Hospital Standardised Mortality Rate
IRIO	Integrated Research and Innovation Office
ISD	Information and Statistics Division of National Services Scotland
IUCD	Intrauterine Contraceptive Device
JIT	Joint Improvement Team
KSF	Knowledge and Skills Framework
LASS	Lifestyle Advisor Support Service
LD	Learning Disability
LES	Local Enhanced Service
LTC	Long Term Conditions
LUCAP	Local Unscheduled Care Action Plan
MAU	Medical Admissions Unit
MCN	Managed Care Network
MIU	Minor Injury Unit
NES	NHS Education Scotland
P&CS	Primary and Community Services
QPQOF	Quality and Productivity Quality and Outcomes Framework
SAB	Staphylococcus aureus bacteraemia
SAS	Scottish Ambulance Service
SBC	Scottish Borders Council
SEAT	Regional Planning Area for South East Scotland
SGHD	Scottish Government Health Department
SIGN	Scottish Intercollegiate Guidelines Network
SIMD	Scottish Index of Multiple Deprivation
SME	Substance Misuse Education
SOA	Single Outcome Agreement
SPSI	Scottish Patient Safety Indicator

SWHMR	Scottish Women Hand Held Medical Record
TNA	Training Needs Analysis
VAP Bundle	Ventilation-Associated Pneumonia Bundle
VAW	Violence Against Women
VSM	Value Stream Mapping

Section 1: Improvement Plan

This is the third year of the Improvement Plan which is intended to be a 5 year transformational plan setting out how we will deliver on the 2020 Vision for NHS Scotland. This year follows last in focussing around priority areas of the 2020 Route Map. This plan is structured around 6 key areas of work undertaken and planned that will help us achieve our 2020 Vision for NHS Borders, but it should be noted that this Plan is not inclusive of all the improvement work that is ongoing.

NHS Borders is committed to maintaining financial balance through integrated and focused working as well as seeking out efficiencies. This is becoming increasingly challenging given the economic environment and the high level of efficiencies to be achieved whilst sustaining the range of services currently provided, ensuring accessible healthcare across remote and rural areas; managing increased demand generated through population growth and public expectations and delivering HEAT trajectories.

Over time the LDP will be closely aligned to the Commissioning Plan developed by the Integration Joint Board for Health and Social Care that will set out how services will be planned and delivered for the Scottish Borders.

A 2020 Vision for NHS Borders reiterates and emphasises the commitment to patient safety, and sets out how we want to make things even safer to drive up the quality of our local services and improve the experience of patients, families, carers and our staff.

The **executive leads** for each priority area in the plan are as follows:

	Priority Area	**Executive Lead**
1	Health Inequalities and Prevention	Tim Patterson
2	Ante-Natal and Early Years	Tim Patterson
3	Person-Centred Care	Evelyn Rodger
4	Safe Care	Cliff Sharp (Interim)
5	Primary Care	Susan Manion
6	Integration	Susan Manion
7	Scheduled Care	Evelyn Rodger
8	Unscheduled Care	Evelyn Rodger
9	Mental Health	Susan Manion

Health Inequalities Executive Lead: Tim Patterson	
Targeting resources to the most deprived – community & assets-based approaches	The Healthy Living Network (HLN) takes an assets based approach in its work with local communities and with partners. Volunteering development features strongly for example through peer support. HLN also supports community members to undertake the Health Issues in the Community programme and to support those who complete the programme to use their skills and confidence. The HLN continues to work in close partnership with key community groups and partners including Registered Social Landlords in areas of high deprivation (Burnfoot, Langlee and Eyemouth) to improve health and enhance access to health and social care. HLN is an active partner in the Community Learning and Development Strategy and supports implementation in localities. In addition HLN is making an active contribution to the locality planning processes for health and social care, as these evolve. Targeted programmes for protected characteristics groups continue. We have used initial consultation and engagement work with migrants to improve access and uptake and will continue to deliver a range of programmes and initiatives to respond to identified community needs. In relation to welfare benefit reforms, Public Health continues to raise awareness among staff of the impacts of welfare reform as this impacts on the local population. The project on Financial Help in Early Years, funded through the Scottish Government Health and Welfare Fund, has provided opportunity to build capacity among maternity and child health staff of resources and pathways for families affected. The project has been working closely with the Early Years Centres to raise awareness of sources of help and advice and as the project comes to conclusion, the learning and resources developed will be integrated into mainstream services and pathways. Improvement work has been undertaken, supported by Health Improvement, to increase uptake of Healthy Start entitlements. Maternity services are working increasingly closely with Welfare Benefits services and it is intended to widen this to paediatric services. The recent mental health needs assessment and the emerging strategy recognises the need to promote the health and wellbeing of mental health service users. This will be the focus for concerted work in 2016, with support from smoking cessation, health psychology and the LASS service. Feasibility work is underway within one local community to develop community referral in order to support those at risk of poor mental health and suicidal behaviour. Men of working age are a focus for this project, delivered in partnership with the third sector.

Targeting resources to the most deprived – service approaches	The local Keep Well service continues to deliver health checks targeted at our more deprived communities to reduce inequalities in health, focusing on CVD risk factors and wider determinants of health such as literacy/numeracy, income and benefits advice, and mental health & well-being. Planning for the withdrawal of central funding by 2017 is well advanced and the service will continue but focus on those at greatest need and become fully integrated with the Lifestyle Adviser Support Service (see Prevention section). Other services that are targeting the more deprived communities and localities to reduce inequalities in health include: • Detecting Cancer Early campaign – there is great potential for screening programmes to exacerbate inequalities in health because uptake tends to be lower in more deprived populations. To prevent this the local programme is being proactive in promoting screening in such local populations with some success. • Smoking cessation – the LDP HEAT Standard focuses on those from more deprived areas and the local Quit4Good service is currently on target to reach out and encourage uptake in these areas where smoking prevalence is highest and support quits • Long Term Conditions (LTC) project – a pilot project working with two general practices is using the House of Care model and implementing a range of changes to improve the shared management of LTCs, which are more prevalent in more deprived populations. This work shows promising positive outcomes for service users in terms of health, well-being and reduced inequalities, and reduced demand on primary care services
Tackling inequalities faced by people with a learning disability	The Learning Disability Service continues to work closely with Public Health to promote awareness and develop skills and knowledge among people with learning disabilities, carers and service providers. There are many interventions planned over 2016-17 which address recommendations within 'The keys to life' 2013 and are captured within a local action plan, structured around 4 priority areas. Some of the following are examples of this: The Keep Safe scheme in Scottish Borders in partnership with Safer Communities. This is established in 2 main towns and will be rolled out across the Borders in 2016. This Health Improvement lead responsible for this initiative also coordinates the 'A Healthier Me' action plan with a key leads network of service providers. This network will mainstream the Healthier Me approach to a healthy lifestyle throughout learning disability services in the Borders. An adapted programme of safe relationships and sexual health awareness is being offered to young people with learning disabilities.

	The 5 Locality Citizens Panels continue to meet 5 times a year as part of the Learning Disability Governance Structure and following their evaluation in 2015 have an action plan in place to continue to improve and grow. A celebration event is planned for February 2016 to enable panels to showcase some of their achievements to date and enable people to come together to inform plans for the future. The learning disability nursing team have drawn up a work plan with a number of targeted health intervention plans for people with learning disabilities in 2016. These include among others health groups, screening and health checks. A learning disability liaison service to the Borders General Hospital supports people with learning disability in planned and unplanned admissions. We are progressing the introduction of a flag within Trakcare in the hospital for people with learning disability. The Community Learning Disability Nursing Team implemented the Health Equalities Framework (HEF) in May 2014, completing the HEF tool for all new referrals. All existing referrals had a HEF completed by end Nov 2015. Through identifying levels of exposure to health determinants nurses are able to target interventions and evidence outcomes to improve the health and reduce the impact of health determinants on people with learning disabilities. A small pilot is currently being run across the wider learning disability team to evaluate the use of the tool as a service wide outcomes tool. This is highlighting the need for agreed processes to ensure accurate use of the tool where multi-disciplinary approaches are employed. We continue to carry out proactive screening with all people with Downs Syndrome for dementia from the age of 30 onwards as well as having a reactive pathway for all referrals for dementia screening and a post diagnostic pathway. In 2016, Project SEARCH will be launched as a partnership arrangement between Scottish Borders Council, NHS Borders and Borders College. This initiative aims to bring people with learning disabilities into competitive employment through on-site internship experiences over 1 year. It is for young people with learning disabilities and/or autism, aged between 17-24, who are nearing the end of their time in education and who are committed and ready to progress into paid employment after the course. There will be 8 places in this first group. Integrated Care Fund money has been granted to develop and improve the Transitions Pathway for young people moving into adult learning disability services with a clear project plan overseen by the multiagency Transitions Steering Group.
Health inequalities	Inequalities in Mental Health are a priority for the health inequalities

and Mental Health	action plan in development. This includes: • Promoting the wellbeing of people with mental health problems to reduce barriers to healthy life styles and to support behaviour change • Awareness raising and capacity building to enable more people to access support for mental health and wellbeing from a wider range of sources (including non medical support) • Reviewing how support for people in distress can be improved • Supporting carers including those affected by suicide
Health Inequalities and Physical Activity	NHS Borders through Public Health work with partners to develop physical activity programmes for those who are inactive or with low levels of activity. Programmes continue to be targeted in areas of deprivation and disadvantaged groups. We are working with partners Border Sport and Leisure Trust to signpost NHS patients to community based activity programmes. Work is also underway to develop a physical activity programme for people with diabetes and will be targeted to areas of higher deprivation in 2016.
Reducing Inequalities Strategy	The CPP has produced a Reducing Inequalities strategy in 2015 and this is leading into more focused action planning on health inequalities, led by Public Health. The action planning process is actively engaging with health and social care partners, the third sector, children and young people's planning structures and wider community planning partners.
Health impact of Rurality	Many health issues and impacts in rural areas are similar to those in urban or suburban locations. There are, however, a number of key issues that particularly affect health in rural communities. Many of these interact. So, for example, the problem of lower wages in rural areas compounds the extra costs associated with reliance on motor vehicles and higher food and fuel costs. Other factors include: • Population – youth out-migration and ageing of the population • Economy – lack of major employers and reliable work; lack of diversity • Employment – 'portfolio' careers (seasonal working and seasonal/ transient workforce), lower wages; lack of jobs for young people in some locations; recruitment and retention of high skill workers • Access to Services – need to travel long distances to access services and amenities • Physical Environment – different patterns of land use, physical terrain, water and land use • Infrastructure – vulnerability of supply and distribution chains; higher costs • Cost of living – fuel costs; food costs

	• Resilience of people in rural communities - Many of these issues relate to the physical environment and long distances in rural areas. These pose challenges for the provision of infrastructure and services. The Directorate of Public Health and Scottish Borders Council Planning Department have worked together to give local developers tools and support to undertake Health Impact Assessments in the Borders to ensure that infrastructure and services are supportive of public health and the reduction of health inequalities.
Measures that will be used to assess improvements made	The health inequalities action plan (in development) and the Public Health Scorecard will be used to monitor progress.

Prevention	**Executive Lead: Tim Patterson**
Anticipatory care	The local Lifestyle Advisor Support Service (LASS) provides an integrated service to support health behaviour change and has three strands: • Mainstream LASS, operating in primary care and communities, supports lifestyle change to reduce risk of ill health associated with CVD, diabetes and stroke. The distribution of those targeted and attending LASS favours the more deprived and disadvantaged and therefore it contributes to local effort to reduce inequalities in health. • Keep Well Borders targets hard to reach/more deprived groups and those at higher risk of ill health(see Health Inequalities section) • Tier 2 weight management offering a bespoke approach to reduce weight looking at food behaviours, diet and weight management
Gender Based Violence	NHS Borders continues to support the Pathways project that provides a co-ordinated interagency response to domestic abuse. NHS Borders facilitates and supports the partnership work on prevention within the VAW Partnership. This includes awareness raising and training within NHS Borders to improve early identification of domestic and other abuse and appropriate signposting to support for those affected. Connections between GBV work and early years health improvement are integrated into the early years action plan.
Health Promoting Health Service	Over 2015 we continued to build on the successes of the local social marketing campaign, 'Small changes, big difference', targeting staff, patients and visitors with health improvement messages and

	opportunities (training & development; personal pledges; access to resources to support health improvement conversations). Improvements are continuing in pathways from secondary care to lifestyle support services, including support for those accessing mental health services. 2016 sees a strengthening of the health inequalities focus with the introduction of specific measures around financial inclusion, mental health, homelessness and Managed Clinical Network pathways. Plans are progressing to roll out the marketing campaign to SBC, and to focus on improving staff health and well-being in NHS Borders and the Council (their own health and as providers of health and social care services).
Alcohol whole population approach	Alcohol Brief Intervention delivery continues: In priority settings and also in LASS and Keep Well. Supporting delivery in wider settings including social work, police custody suites, Anti-Social Behaviour Unit, Learning Disabilities Service and Penumbra Youth Project. Working with Education to develop a Borders approach to substance misuse education as part of an integrated approach to health and wellbeing in schools. Support will continue to be given to the Local Licensing Forum and to the development of an annual Alcohol Profile to inform licensing decisions. This will include presentations to Area Forums relating to findings from a local Alcohol Project and information about the Licensing Process to enable communities to become more involved
Promoting healthy weight	Public Health continues to leads on implementation of multi agency approaches to reduce barriers to healthy eating and physical activity in a range of settings across the life span. Priorities are: promoting access to and availability of sustainable food within local communities; and the development of knowledge and confidence in the workforce. This links closely to the physical activity work described above.
Sexual health	The joint sexual health strategy for Scottish Borders is being updated in 2016 and continues to focus strongly on inequalities. Through the expertise within the Joint Health Improvement, sexual health services and school nursing, we continue to support capacity in partner organisations to work with young people and other target groups to promote healthy relationships and prevent STIs, HIV and unwanted pregnancy and to tackle stigma and discrimination. Education, third sector youth work services and LGBT networks are actively involved in this. Education is leading working on relationships education as part of the development of wider integrated approach to health and wellbeing and learning.

Detecting Cancer Early	A DCE awareness raising programme was delivered amongst networks working with deprived communities and staff working with vulnerable groups (mental health & learning disabilities services). Key aims were to promote uptake of cancer screening opportunities, increase awareness of warning signs and symptoms, and encourage those with concerns to make early contact with health services. This awareness is now being embedded into core business via these networks within a broader health improvement and inequalities framework.
Tobacco	A Tobacco Control Plan has been developed involving key partners and has a cross cutting theme to reduce health inequalities. In addition the Joint Health Improvement Team are leading on work to enable NHS Borders and Scottish Borders Council to sign up to Scotland's Charter for a tobacco-free generation. The Charter is aimed at organisations whose work impacts on young people and families and will result in supporting prevention actions to protect children from the harmful effects of tobacco. We will continue with the current tobacco prevention programme with young people in partnership with Community Learning & Development to support the objectives of the Children and Young Peoples services plan. Tobacco prevention programmes are targeted at areas of higher deprivation and vulnerable groups of young people. The promotion of Smoke Free Homes will be focused through our Early Years work and other community facing programmes.
Long term conditions management	This 2 year project has been extended to end June 2016 to allow comprehensive evaluation. The project is testing out improvements in the shared-management of long term conditions (LTCs) amongst older people, in the context of two GP practices. Early evaluation results show positive outcomes for patients and practices resulting from holistic assessment and tailored support by the Red Cross, particularly for those with multiple morbidities who are struggling to cope. Overall aims include: • improved access to assessment, information, advice and support (practical and emotional) for individuals and their carers; • improved health and well-being and reduced health inequalities; and • reduced inappropriate demand on Practices; Evaluation findings will help to inform future developments as part of the broader integration agenda.
Measures that will be used to assess improvements made	The health inequalities action plan (in development) and the Public Health scorecard will be used to monitor progress.

Antenatal and Early Years Executive Lead: Tim Patterson	
Improvement aims agreed locally	The Scottish Borders Children & Young People's Health Strategy identifies the aims and outcomes with measures agreed as part of the Improvement Framework.
Development of integrated locality model of service delivery	NHS is an active partner in the Early Years Centres in four areas of high deprivation across Borders. Two were established in 2014 -15 and a further two came on stream in 2015 -16; work continue to provide a 'hub and spoke' model of support in the areas that do not have an Early Years Centre. NHS maternity and child health services are being delivered as part of a multi-agency approach, underpinned by the GIRFEC methodology, to support families in these areas with a focus on those who are hard to reach. The locality Early Years Networks are supported to incorporate improvement methods as a means to further local service development and to take forward the priorities identified by the multiagency Early Years Group. We are already making use of the data from 27 month Child Health Reviews to improve attainment of developmental milestones in particular in relation to child weight / nutrition and to speech and language development. The introduction of the new universal health visitor pathway will bring additional opportunity for health improvement work with families through increased health visiting contacts.
Parenting support	The Psychology of Parenting programme will continue in 2015 and health staff are actively involved in this. The Family Nurse Partnership was introduced from July 2015 as a hybrid model in partnership with NHS Lothian, the monitoring/review of this model will continue throughout 2016/17. Transitions work is an important focus with the improvement work of the Early Years Collaborative. The implementation of the GIRFEC practice model will continues to support smooth transitions into and between services. Improvement work on attachment focused practice is informing how we will implement the universal Health Visiting Pathway.
Maternity care and maternal and infant nutrition	We will continue to implement the renewed antenatal education programme, with a focus on promoting early access and consistency of messages for families across different services. In addition targeted work in selected communities will test out the feasibility of strengthening antenatal contact and support. We will implement pathways to enhance maternal health outcomes and reduce health inequalities in relation to tobacco, alcohol, healthy weight and mental health. Further work will be undertaken to maintain Baby Friendly Initiative

	standards, following the attainment of Stage 3 accreditation for community and maternity services in 2014. This includes an NHS led initiative to promote 'baby welcome' environments using a whole systems approach. Child Healthy Weight programme implementation in early years settings will continue to support the early years workforce in relation to nutrition and will also deliver targeted work with vulnerable families.
Community capacity building	Continued delivery of collaborative programmes through Healthy Living Network and Community Learning and Development and the third sector to develop skills, confidence and opportunities, including volunteering development where appropriate.
Early Years Collaborative	NHS Borders supported three members of staff to complete the Improvement Advisor Programme with a key future aim to build capacity and capability in using quality improvement tools and resources. NHS Borders are key members of the multiagency Early Years Group, a subgroup of the Leadership Group. The priorities for Early Years have been identified that focus on the key themes from the Early Years Collaborative and using data for improvement. We anticipate being able to support an agreed set of tests of change so that these can be followed through and learning used for scale up as appropriate.
Early Years and early intervention	This is a Community Planning Partnership (CPP) priority area and more information and actions planned and undertaken can be found in the NHS Borders Contribution to the Community Planning Partnership section.
Children and young Peoples Act (Scotland) 2014	NHS Borders continues to be actively involved in the implementation of 'Getting it right for every child' (GIRFEC) both locally across the CPP and also regionally through the Lothian and Borders GIRFEC Group. There is a Scottish Borders Multiagency GIRFEC plan which sets out the implementation tasks and timelines. In support of this the Health Board has a NHS Borders GIRFEC plan which addresses the specific systems and processes that we have to have in place to support children till they are school age. We have named person training and all midwives and health visitors received named person training in 2014; with additional training being delivered/planned for 2016. We rolled out an eGIRFEC learning module as part of our Learnpro resource which all staff across adult and children's services have to complete before progressing to the child protection update eLearning

	module. We developed and have rolled out the Scottish Borders Information Sharing Guidance this is being supported by a training programme to support the document. We have a single plan which is used for all children who meet the criteria for a multiagency child's plan. We are working nationally through the CEL 13 group to establish the numbers of Health Visitors that we will require to carry out both the duties of the Act and the new universal health visiting pathway. We currently have two health visitors in training.
Performance Measurement – measures that will be used to assess improvements made	Our Children and Young People's Health Strategy was developed in 2013 and includes an Improvement Framework with updated progress in 2014 and 2015. The Improvement Framework highlights the sustained effort by staff in improving services and support for children and young people across the Scottish Borders. Additionally an Early Years Improvement Scorecard with aims and measures has been established to support monitoring of progress and to focus activity for improvement work.
Key Documents	<u>Joint Early Years Priorities</u> Includes review of achievements from Early Years Strategy 2012-15; Early Years Improvement Scorecard provides data to support work re Early Years Collaborative.  Y:\early years\Early Years Strategy.pdf  Early Years Strategy_priorities 20  EYC Scorecard January 16.pdf <u>NHS Borders Child Health Strategy</u> Desired outcomes and measures of improvement included in strategy appendix and updates for 2014 and 2015 included.  CHILDYP STRATEGY FINAL.pdf  child health strategy update Sept2014 FIN  Childhealthstrategyimprovementupdate C <u>NHS Borders GIRFEC Plan</u> <u>Partnership GIRFEC Plan</u>

	 NHS Borders GIRFEC Plan.doc  Multi Agency GIRFEC Action Plan V10 Aug1 <u>Maternity Care Action Plan</u> This was reviewed and updated in 2015. The current working draft is attached  Maternity Care Action Plan 2014-201

Person-Centred Care Executive Lead: Evelyn Rodger	
Patients and Carers	We are continuing to look at ways in which we can further involve the public in developing channels of communication with our patients, families, carers and communities. We are aiming to embed a culture of listening within the organisation ensuring that people have a strong voice when it comes to the design and delivery of services as well as their own care. Our objectives are in this priority area are: • Through the introduction of the Supervisory Senior Charge Nurse (SCN) programme in inpatient areas we will focus on collecting real time feedback from patients. Supervisory SCNs will have daily conversations with patients and their families and, where issues arise, work with staff, using a coaching and mentoring approach, to implement immediate changes • Gathering patient, carer and family member feedback on their experience of care and treatment. Using volunteers to help us gather this feedback and extending the use of hand held devices cutting down on administration and speeding up the feedback process to frontline areas to drive improvements • Continue to provide an open and transparent process for formal complaints and feedback, encouraging supported dialogue between patients, carers, families and staff • Testing a new approach to complaints handling which encourages active listening, dialogue and reflective practice with patients, families and staff • Developing our approach to the use of Patient Opinion to provide independent patient led virtual feedback • Continue to commission independent advocacy services and refresh our joint Independent Advocacy Plan with our partners including Scottish Borders Council and the Third Sector identifying any gaps in provision and articulating plans to address these gaps • Work with Scottish Borders Council and the third sector to refresh our Carers strategy identifying any gaps in provision and articulating plans to address these gaps

Public Involvement and Community Engagement	We have a solid foundation of public involvement activities to date, over the next 3 years we are aiming to build on this by involving the public to much greater degree in the day to day activities of the organisation. Our objectives in this priority area are: • To continue to actively embed public involvement as a core element of any policy and strategy development and clearly evidence the impact of the input from the public • To develop and refresh the role of the Public Partnership Forum ensuring that the group is well positioned particularly to support the integration of health and social care; and that the work of the group is valued by the organisation and positive outcomes are communicated both back to the group and to NHS Borders. Membership is to be expanded during the year to include wider and more diverse representation. • To extend and include as a matter of routine public members in decision making in a wider variety of working groups within the organisation • To build on the success of the Learning Disability Citizens Panel and the BGH Participation Group, and actively seek to foster and support participation groups around specific services or service developments • To improve our engagement and communication with communities covering a wide range of ages and locations with a particular focus on hard to reach or seldom heard groups. Our Health in Your Hands: What Matters to You? programme of public engagement will test and explore innovative ways of involving the public and capturing the views of seldom heard groups and individuals • Test approaches and improve how we provide feedback to communities • As our involvement infrastructure expands we will explore a model of locality based coverage ensuring that local needs are met and that we align ourselves with the shift towards planning at a locality level

Volunteering	Volunteering plays an important role within NHS Borders, our current volunteer roles work to enhance patient experience and help us to gather feedback. We are committed to continuing to expand the number and type of volunteering roles available offering more people from our communities the opportunity to become involved with the work of NHS Borders and to gain skills and satisfaction from their volunteering role. Our objectives are in this priority area are: • Evaluate the impact of volunteering on patient experience and outcomes • Continue to grow our cohort of volunteers to enhance patient experience by working with departments to explore new volunteering opportunities, support growth in existing volunteer roles and maintain levels when volunteers move on • To continue to ensure that volunteers feel well supported and valued in their roles and have a positive experience while volunteering by building the infrastructure to support and guide volunteers. Also to strengthen and optimise the support to and from volunteers during the year. • Explore and test the use of service user volunteers in the recruitment process, giving the public a strong voice and ensuring openness and transparency • Explore working with the local High Schools to develop a schools programme and engage senior pupils in volunteering giving pupils the opportunity to enhance and develop their knowledge of NHS Borders and the healthcare sector
Staff	Our staff are our most valuable assets, they deliver our services on the front line and behind the scenes and are the first point of contact for people using our services. By recognising our staff to be assets we also recognise NHS Borders responsibility to listen and learn from their experience as well as develop and support them to embed the values of public involvement and community engagement in day to day service delivery. Our objectives are in this priority area are: • Develop and implement values- based recruitment: recruitment process and induction programme designed around our core organisational values • Review how we engage and communicate with staff currently

	and look to develop innovative ways of communicating and listening to staff • Ensure we retain our Carers Positive Award which assesses how we support carers in the workplace • Continue to roll out the iMatter staff experience tool to measure and improve staff experience and well-being • Continue to encourage and support staff to complete the annual Staff Survey and work with partnership to formulate an action plan based on the results • Continue to promote an open and collective leadership culture at all levels of the organisation
Frailty pathway for older people	Within the Health Foundation funded Measurement and Monitoring of Safety programme, a workstream was established to test the Framework on a pathway for frail patients within secondary care. To date objectives have been: • Establish a reliable care pathway, which is now in final the stages of development • A frailty screening tool, adapted from the national screening tool has been developed, tested, embedded into the new rapid risk assessment document and implemented within all admitting areas; it is currently being tested with Acute Assessment unit (AAU)and the Emergency department (ED) of Borders General Hospital. • Augmenting, then testing, a local version of the national 'getting to know me' booklet to reflect needs of frail patients For 2016/ 17, the aim is to establish a multi-disciplinary frailty team to manage the care and flow of frail patients.
Palliative Care	Palliative Care has seen national and local developments which will inform our Delivery Plan. The Scottish Government Inquiry into Palliative and End of Life Care and the Strategic Framework for Action which was published in November 2015 along with the Scottish Borders Palliative Care Needs Assessment which concluded in April (and helped inform the SG Inquiry) have identified the priorities. The development of a Palliative Care Network will now be responsible for formulating the action plan.

	Outside of this, and with the support of Macmillan, we have an end of life care facilitator who will be implementing out new unitary patient record for end of life care, as well as co-ordinating the approach to an end of life care strategy. Within our palliative care team, we are developing skills to help patients and families manage symptoms, develop outcome measures and create resilience. We are also leading on improving communication skills within the wider NHS Borders staff group including clinical and non-clinical staff.

Safe Care	**Interim Executive Lead: Cliff Sharp**
Improvement aims	The provision of safe care has many elements to it but by far the most comprehensive programme of work is the Scottish Patient Safety Programme. SPSP is one of a family of national improvement programmes developed over recent years in relation to the national Healthcare Quality Strategy. These programmes draw on improvement methodology advocated by the Institute for Healthcare Improvement. SPSP now contains four distinctly identified workstreams as follows: • Acute Adult • Primary Care • Mental Health • MCQIC (incorporating Paediatrics, Maternal Care & Neonatest)
Scottish Patient Safety Programme	The Scottish patient Safety Programme (SPSP), led and coordinated by Healthcare Improvement Scotland, is a unique national programme that aims to improve the safety of healthcare and reduce the level of harm experienced by people using healthcare services. SPSP aims support outcome 7 of the National health and Wellbeing Outcomes *"People using health and social care services are free from harm".* With the current aims of two core programmes within SPSP, Adult Acute and Primary Care, ending in March 2016, a 90 day consultation exercise has been underway. The draft report recommends that the coming year is used to: • Embed and spread existing work • Prototype new areas and • Transition programme delivery in line with recommendations
Adult Acute SPSP	**ADULT ACUTE** Please see below a synopsis of the measures and a recommendation moving forward:

	Leadership Walkrounds: The walkrounds and inspections will continue as per the current format with named executive leadership for each clinical area across NHS Borders. These will continue to be prioritised locally with Non-Executive Director attendance included, although we may not be required to report to Health Improvement Scotland. Critical Care: Process measures are showing reliability and outcome measures will continue to be monitored. Theatre Measures: Local safety priorities have identified that an improvement programme on the quality of the safety briefs and pauses will be the focus for 2016/17. General Ward Measures: Four of the ten essential measures of safety apply to the general ward workstream. These are: • Hand hygiene • General Ward Safety Brief • Peripheral Vascular Cannula Maintenance Bundle, and • Early Warning Scores These measures will continue to be collected in 2016/17 to ensure the processes are reliably embedded in clinical teams. Deteriorating Patient Workstream: The outcome measure for deteriorating patient is a 50% reduction in cardiac arrests (or 300 days between events). This is achieved through a collection of measures such as identification, escalation and treatment of the deteriorating patient, with one of the main causes of deterioration being sepsis. Communication: It is recommneded that a focus of safety improvement work for 2016/17 focuses on ensuring SBAR communication is implemented reliably, with particular emphasis on handovers. It is recommended that as part of the deteriorating patient workstream, debriefs on cardiac arrests are incorporated in to the daily hospital huddle, with an emphasis on sharing the learning across sites. This will facilitate improved understanding of cardiac arrest incidence and esclation of deteriorating patient. Structured Review and Response: It is recommended that in line with the Connected Care programme,

	some testing work for these measures is undertaken. A pilot ward will required to be identified by the Deteriorating Patient Workstream Team. Sepsis: Sepsis forms a key component of the deteriorating patient workstream It is recommended that 'Sepsis Six' bundle is rolled out across all inpatient areas. Medicines: Nationally, a medicines workstream has been created spanning all specialities. NHS Borders plan to reflect that model locally in 2016/17 with an improvement focus on medicines reconciliation on admission and discharge. Red Allergy Bands: As a result of the ongoing medicines reconciliation audit and a significant adverse event, the introduction of red wrist bands to indicate if the patient has an allergy is being tested. This is a common practice in other hospitals across the country. Whilst not a component of SPSP, the testing work was undertaken in ward 7 and has proved to be both popular and effective with staff and patients alike. It is recommended that this practice is rolled out across NHS Borders in 2016/17. Venous thromboembolism (VTE): VTE will not be a core measure for the revised SPSP measurement plan; instead it will be an optional supplementary measure. NHS Borders have been successful in securing national funding for one year for an Improvement Advisor to focus on VTE in NHS Borders. This post will be nationally recognised and lead the way in diagnosing, testing and implementing a suite of measures for VTE. Falls: The second phase of the Scottish Patient Safety Programme (SPSP) aims to achieve a 25% reduction in all falls and 20% reduction in falls with harm by the end of 2015, while promoting recovery, independence and rehabilitation. Falls measures form an integral part of the revised measurement plan and the local delivery plan for 2016/17. As one of the four priority areas for the Nursing Directorate and of the Older People In Acute Hospitals (OPAH) workstream, the Clinical Improvement Facilitators will continue to undertake tests of change and quality improvement in the areas with the highest numbers of falls, whilst triangulating the outcome data with process data and reported events. Pressure Ulcers: As one of the four priority areas for the Nursing Directorate, the clinical improvement facilitators will continue to undertake quality improvement in this area, whilst triangulating the outcome data with process data and reported events.

	Catheter Acquired Urinary Tract Infection (CAUTI): Testing and innovation work will continue on the patient catheter passport, containing the insertion and maintenance bundles have been rolled out in BGH and Primary Care. <u>2016/17</u> For the adult acute workstream, it is recommended that improvement support is prioritised in to distinct areas: • Frailty • Communications (transitions of care, handovers, multi disciplinary team working) • Deteriorating patient • Medicines
Mental Health	Outcome data continues to be collected on a monthly basis via the reporting template from the Brigs and Huntlyburn. The national team are currently scoping the future of the Programme. Current focus' for improvement is medicines management and risk assessment processes.
Maternity, Paediatrics and Neonates (McQIC)	The national team are currently scoping the future of the Programme and the expected focus in to embed process measures in the deteriorating patient and infection control workstreams in 2016/17.
Primary Care	The national team are currently scoping the future of the Programme.
Adverse Event Management	NHS Borders continue to develop the process of reviewing adverse events in a timely manner, with a focus on identifying learning and driving improvements in practice. A focus of this work in 2016/17 will be on working with front line clinical teams to ensure a learning system is developed and that a robust system of support can be offered to patients and staff.
Innovating for Improvement – Health Foundation Award	An application for funding was made to the Health Foundation Innovating for Improvement Programme to build a model of recognition of deterioration in the community building on the success of the model already well embedded in acute services. The application was successful and funding of around £75,000 was provided to accelerate and test this work over 15 months until September 2016. The aim of the Project is to ensure 100% of patients in the two test sites, receive reliable and timely early warning scores as their clinical condition dictates, to ensure that nursing staff respond appropriately and in a timely manner, and are able to follow a reliable escalation procedure, by July 2016. Test sites will include one community hospital and the out of hour's service covering one geographic area in the Borders. The out of hour's service will work

	with a care home, Community hospital and out of hours nursing team within a defined test area. A project manager and project team are in place and are currently testing changes in process.
Safety Measurement and Monitoring – Health Foundation Award	In April 2014 the Health Foundation published a Safety Measurement and Monitoring Framework prepared by Charles Vincent. Healthcare Improvement Scotland (HIS) was specifically invited to submit a proposal with two delivery partners. NHS Borders was approached to be one of the delivery partners in recognition of the progress the Board has made in the use of data to drive quality, safety and improvement, along with NHS Tayside and the combined proposal from the three organisations was successful. NHS Borders has begun testing the Framework at Board level and across a frailty pathway for older people. This has offered the opportunity to accelerate our local improvement work in patient safety and the care of older people by establishing a pathway, using a multi disciplinary approach and by liaising with national partners. Several test of change have been undertaken to establish a reliable pathway for the frail population of NHS Borders. From a Board perspective, the Framework is being tested at the Joint Executive meeting, such as at the hospital wide safety huddle. Qualitative feedback has been positive, and descriptions about the way safety is discussed and anticipated is evolving.

Primary Care Executive Lead: Susan Manion	
Improvement aims	This section includes work underway and planned within Primary Care that will support increased capacity through increased physical capacity in terms of development of premises and facilities; clinical capacity through service redesign and efficiency initiatives and also through improvements in infrastructure and support networks.
Leadership and Workforce	The joint senior clinical and management arrangements and working practices have continued to support a whole system approach across primary and secondary care. The proposed new management structure for NHS Borders is has now been concluded and is now building on the success of the existing joint leadership and management roles. The integration agenda across health and social care will support the continuation and development of shared leadership and working practices across a range of services in both the day time and out of hours periods. NHS Borders has recently launched its review of all clinical services and work across a range of service areas is underway. For Primary Care the outcomes from this review will continue to inform and shape the ongoing discussions and decisions regarding redesign of community based services, for example treatment rooms and minor injury services as well as supporting the local implications of the national review of community nursing services. The options appraisal work undertaken in 2015/16 to develop a suitable model for medical cover across community hospitals was concluded and steps will be taken during 2016/17 to implement the preferred option. This will, however need take account of the proposed outcomes of a significant redesign project supported by the Integrated Care Fund to develop a Community Ward model of care in one locality. Through this project we aim to agree the future role of the Community Hospital in an integrated Health and Social Care system and design an appropriate clinical and non-clinical workforce to support its delivery. The two clinical sessions established in 2015/16 to support closer working with our LMC specifically on improving key interface issues and in development of enhanced services is now embedded. This role will also support the understanding of the Transitional Quality Arrangements set out in the new GMS contract for 2016/17 which will link directly with the recently established Locality Planning arrangements across the partnership. Further to the workforce survey carried out along with the GP stress survey the findings were presented to the Board. Key issues included a shift of workload at the interface between primary and secondary care, remote access to IM&T to facilitate an ability to do admin from home and

	the ongoing provision of protected learning time. We identified a range of actions to address these issues in the 2015/16 LDP and work on this will continue in 2016/17. We have recently appointed a new Associate Medical Director for Primary and Community Services and have agreed that the appointment provides an opportunity for us to review and refresh our engagement and communication processes with GPs. We have established a Primary Care Feedback inbox as well as a Secondary Care Feedback box which aims to capture issues from individual GPs or practices and provide a response and source a solution. This will also be reciprocal for secondary care colleagues to enable issues relating to the interface to be highlighted and addressed constructively. This can include sharing the points raised with the relevant service, taking issues for discussion to the appropriate forum, completing Datix incident recording and feeding back to the GP or practice who had submitted the issue to support ongoing improvement, learning and relationship management. We have now collated the information from the GP Stress and Workforce surveys and together with the recurring themes from the Primary Care Feedback inbox this will help inform our more regular dialogue and ongoing planning processes with GP colleagues. There will be collaboration in planning the better, appropriate use of skill within Primary Care to free GPs up to focus on more complex clinical issues and provide leadership to integration. Lessons from the Inverclyde pilot of practice cluster will be taken forward in planning as well as other innovative projects. Various options are being appraised to enhance recruitment and retention of primary care staff, in particular GPs. The OOHs service (BECS – Borders Emergency Care Service) is also looking at innovative ways to recruit and retain staff and at service provision, enhancing the high quality person centred care they provide to complex patients including palliative care patients. In line with the clinical strategy for Scotland, we will be looking at providing more care in the community learning from projects elsewhere and areas of success within our own region. We will also be looking for sources of funding to support this. This will be further supported through the establishment of 3 Locality Coordination roles designed to support engagement and planning within the anticipated cluster arrangements for GP practices as well as the development of locality needs assessments and plans. Actions nationally which would support Practices are referenced below as per previous LDP submission: • Development of a national training programme for Physician Assistants (primary care). • A move to 24 hour unscheduled care provision supported by skill mix (for example paramedics/specialist nurse grades). • Removing the central allocation of GP trainees. The removal of

	GPs being able to recruit their own trainees has led to difficulty in maintaining trainees within Borders after full qualification. In the past GPs tended to recruit registrars who had a desire to live and stay in their area. Many of these went on to become partners. We now find that many trainees who have been allocated form a central scheme prefer to return to the central belt after training is complete. This has significantly reduced the benefit to Practices of training. A review of training is recommended to make this more beneficial and attractive for Practices to participate. • Likewise a review of both the rural fellowship and retainer schemes is recommended to make these more attractive to Boards and Practices alike. A review of the potential unintended consequences of pension changes may be beneficial.
Service Planning and Interfaces	<u>Urgent Care/Out of Hours Care</u> A local implementation plan will be developed by the Integrated Joint Board during 2016/17 which will support the delivery of the recommendations highlighted in Sir Lewis Ritchie's review of out of hours primary care services. This was detailed in our IJB response letter earlier this year. The large geographical area and lengthy journeys between home visits will remain a challenge for our Borders Emergency Care Service (BECS). Planning is currently underway to update and renew our 3 vehicles during the course of the next 12 months, taking into account winter resilience and mileage tolerance. We are considering plans to improve our IT infrastructure and connectivity to ensure ongoing safety and high quality clinical care. An Unscheduled Care Project was established to progress a range of key work streams. The Project concluded in December 2015 at which point the work had progressed to a sufficient degree to mainstream within local services. The work now sits with the operational services and a brief description of progress is listed below; • <u>Community Response</u> – this is being taken forward as the Hawick Paramedic Practitioner Pilot. Two GP Practices are working directly with SAS to test a different model of in-hours response to emergency calls to GPs. • <u>Patient re-education</u> - the "Meet ED" pocket guides have been developed (using the NHS D&G template) and printed. They offer the public information and guidance about where to find the support they need e.g. when to go to the pharmacist, when to contact a GP, self help guidance, when to go to the Emergency Department. The guides have now been distributed through a

	range of venues and organisations across the region. • Emergency Department Redesign - including a review of the medical model. This redesign programme will move forward during 2016/17 now that ED Consultants have been appointed Overnight Governance in the Emergency Department.- arrangements have now been established within the specialties to address this • Ambulatory Care and Acute Assessment - A new Ambulatory Assessment Unit has been established and the model is being evaluated in line with agreed improvement methodologies. • Review Mental Health Crisis Team input to the Emergency Department – discussions are underway to identify the most appropriate location for the team to ensure timely access and support for patients attending in crisis. • Accommodation – BECS and ED – an initial scoping exercise has been done in the light of potential changes in approach, in particular issues arising from the requirement to ensure joint working with Social Care and the third sector. These requirements have been placed on the Board capital register and will be reviewed within the standard local capital planning processes. BECS will continue to offer direct out of hours access to palliative care patients, without the need to telephone 111 NHS24. The BECS hub number is given directly to palliative care patients by local District Nursing Teams and GPs. We will also look at how to improve access to community based care facilities for palliative care patients who are not coping at home in line with the review of Community Hospital functionality as described above. Ongoing collaboration with local GPs and District Nurses to ensure that Anticipatory Care Plans (eKIS) are updated remains an essential focus and will feed in to the Transitional Quality Arrangements for 2016/17 in the revised GMS contract. Focus within the plan will also improve arrangements for key groups of people, for example those presenting with mental health crises, Frail elderly, children, and those with special access requirements. We will also develop strategies that consider raising public awareness of the out of hours arrangements and appropriate self-management strategies through a number of mechanisms including social media, the NHS Borders website, local press articles, engagement with local volunteers and community groups. We will be looking to review our sustainable plan for the out of hours clinical workforce in line with our Strategic Plan.

	In line with the Transitional Quality Arrangements in the revised GMS contract each GP practice will nominate Practice Quality Leads and each cluster of GP practices will have a Cluster Quality Lead appointed by the practices and overarching services which will have a developing key role in leading clinical or professional groups and the community in planning high quality integrated services at locality level. This will have to take account of existing resources such as minor Injury Units and Community Hospitals and looking at how best these services/facilities can best serve the people of the Scottish Borders which may not be their current format. Enhanced Services will continue to be discussed and agreed in liaison with the Local Negotiating Committee, GP Sub Committee and local GP practices. <u>Public Dental Services (PDS)</u> Work has progressed and in the next year the intention is to: • Enhanced services to Special needs/ additional needs with core tooth brushing in all schools with special needs units • Expansion of core tooth brushing to all pre-school and school age children in primary schools • The Elderly- all care homes to have named Caring for Smiles champions to ensure improved oral health within all care establishments • Through more effective communication and interagency work increase the emphasis on ensuring improved access for patients identified as having mental health challenges, drug and alcohol dependencies, homeless and ex-offender. • Review use of the remaining two mobile dental units (MDU) and establish a forward plan in relation to capital spend. • Implement the new model of working identified through improvement methodology and roll this out across PDS to ensure a reduction in the numbers of children who persistently do not attend appointments • Train additional clinicians to ensure anxiety management services are fully supported within the community and in secondary care. • Seek approval for Provision of bariatric dental facility or shared bariatric OPD facility within PDS. <u>LASS - Supporting your Lifestyle change</u> With reduction in core budgets and central funding ceasing for KW from April 2017 a sustainable model for the future delivery of LASS will be adopted this year retaining the most effective elements of the existing service and maximise cost effectiveness. • Reconfigure LASS services to continue to support those in the most vulnerable groups. • Disinvest in Counterweight, further develop and implement a new adult weight programme Weigh 2 Go Borders that combines a number of evidenced based approaches offering wider options to

	the clients. Sexual Health • Consistent >90% recording of alcohol and GBV in all attendees • SLA established with Lothian to ensure sustainability and succession planning within Sexual Health services • HIV and Hepatitis testing over 5 years to be fed back to individual GP practices in to encourage consideration of appropriate testing and early diagnosis. • Adoption of Lothian draft HIV treatment protocol to include first line use of generic antiretrovirals to address costs • All school nurses participate in the condom distribution scheme, C-card, in partnership where possible and appropriate, with locally trained youth workers. • Enhanced presence in secondary schools and Borders College to better support young people's access to Sexual Health services. Links continue with optometry services delivered in the community to ensure care is in line with local initiatives as they are developed. Diabetic retinal screening continues to be delivered by local opticians. Primary Care Premises Modernisation Programme Some significant progress has been made during 2015/16 in our primary care premises developments. Four health centre sites were identified as the highest priority (Band 1) for major reconfiguration / development and through a robust prioritisation process, the order of build was agreed as: 1. Selkirk 2. Eyemouth 3. = Melrose and Knoll Two schemes were also identified at West Linton and Earlston (Band 1a) where substantial development work would be required as the next phase of the overall programme. Capital resource was released through NHS Borders Capital Plan to take forward to completion the Selkirk scheme and Phase One of the Eyemouth scheme within the financial year 2015/16. The tender process for the Selkirk scheme identified a cost increase from the feasibility stage estimates. Following verification of the costs by external independent cost advisors, approval was given to proceed. The work at Selkirk commenced in November 2015 and is due to be completed by 18th March 2016. The tender process for Eyemouth concluded in November 2015; the lowest submitted tenders were a significant cost increase from the feasibility stage estimates. External independent cost advisors reviewed

	the cost differences and confirmed that the submitted tenders were fair, reasonable, competent and competitive. The work planned in 2015/16 on the first phase at Eyemouth was therefore paused until adequate resource levels could be sourced. In view of the increased costs for the schemes at Selkirk and Eyemouth, the external cost advisors were asked to review and revise the original feasibility costs for the two remaining Band 1 sites at Melrose and The Knoll and the two Tier 1a sites at Earlston and West Linton. The costs for all four sites have increased. The cost increases described take the total programme cost out with NHS Borders' annual capital allocation levels and following discussion with Scottish Government, an Outline Business Case has been submitted in request of additional capital allocation of £3m to support the entire programme of Band 1 schemes and Band 1a schemes (at West Linton and Earlston NHS Borders has followed to date traditional procurement routes for this development programme. In line with Scottish Government requirements due to current indicative levels for the projects and to further evidence the delivery of best value for this overall programme, discussions are underway with colleagues from the hub South East Region Territory Partnering Board. Completion of the work required at the identified priority sites would bring to a conclusion the requirement for major capital investment in NHS Borders primary care health centre estate for the foreseeable future. The governance and decision-making framework established to enable primary care premises issues to be considered and progressed will remain in place and future minor schemes will be managed within NHS Borders' standard capital allocation and capital planning processes. <u>Roxburgh Street, Galashiels</u> The development of the new health centre for the Roxburgh Street Medical Practice and community services has been progressed separately as the proposal pre-dated the Primary Care Premises Modernisation Programme described above. Procurement has been secured through Hubco. The site is currently being cleared and work is due to begin in May 2016 with an anticipated completion date of February 2017.
Technology and Data	The provision of technology and use of data is variable across different settings in primary care. Clearly General Practice are quite well served while Community based nursing teams are less so. We have made some progress in using technology with Digital Pens now in place in two localities. The benefits of this are being reviewed prior to a wider implementation. Work is underway to introduce the use of National Early Warning Scoring

	in a community setting supported by telehealth technology to help clinical decision making in community hospital and care home settings. We are running a project to re-provision IT systems for Community teams and will develop a business case for investment. We are keen that any new system must deliver functionality that supports staff in their work, facilitates better information sharing across sectors including General Practice and Social work and provides access to information both about individual patients but also for performance and planning purposes. Access to high quality information to manage and plan services will be part of our focus in 2016/17 and we are exploring what additional support can be provided in terms of data reporting and real time information. All of our GP Practices now offer on line repeat prescription ordering and some offer appointments. We plan to work to increase uptake of these services during the course of the coming year. We have now deployed remote access to our GP community – giving them more choice and freedom to access information and do work from outside the practice. We have also undertaken a major upgrade to our GP IT servers as a significant step forward in the provision of a modern IT infrastructure. The issues identified within the Primary Care Strategic Assessment and included in the LDP submission 2014/15 remain and are repeated below. A huge barrier is the inability for IT systems to communicate with each other effectively. Sharing of information across services and agencies is essential if the 2020 Vision of a coordinated, integrated approach to health and social care is to be achieved. IT systems **must** interface appropriately between primary and secondary care and also, crucially, between healthcare services and social work services in order to allow staff to work together more productively and provide a better service for patients. The ever–increasing reliance on electronic systems brings with it increasing maintenance, installation and educational issues which impact on the capacity of IM&T support services.
Contracts & Resources	The imminent review of clinical services, the integration agenda, efficiency programme and any subsequent realignment of budgets will influence the shape of future primary care services. A range of redesign initiatives are being progressed and are resourced by the Integrated Care Fund in line with the local Health and Social Care Strategic Plan. These will focus on community based models of care to help support our most vulnerable people to be cared for as close to home as possible, reducing avoidable emergency admissions and dependence on secondary care services. We will be adopting a ‘House of Care’

	approach to coordinating care and resources around GP practices supported by our Locality Planning development infrastructure, Voluntary and Independent sector colleagues. Primary Care GPs are well represented on both the IJB and Strategic Planning Group and are involved in decision making in relation to the spend against the ICF allocation. We are working with GP colleagues to determine very specifically how we wish to see the ongoing joint working with GPs at a practice, locality and strategic level. The Integration Joint Board has already identified five localities and these will be used as the baseline for locality planning. We recognise that GPs will be critical in that process and will be working closely with local GP groups to manage the Transitional Quality Arrangements in the revised GMS Contract.

Integrated Care	**Executive Lead: Susan Manion**
Overview	The Integrated Joint Board (IJB) has agreed the content of the Strategic Plan for 2016-2019 and will have the accompanying Financial Statement in place by the end of March 2016. The Strategic Plan sets out the nine Strategic Objectives for the Health and Social Care Partnership, an outline of how we intend to deliver what is needed to achieve each objective, and examples of activities identified in our current service strategies which relate to each objective. The Plan also shows how each of the Strategic Objectives maps to one or more of the nine National Health and Wellbeing Outcomes. The Plan is high level and will be supported by the implementation of Strategies related to specific themes (such as Dementia, Mental Health), a more detailed implementation/action plan that will provide additional detail underpinning the high level objectives, and Locality Plans that reflect differing patterns of need across the Borders. To facilitate delivery the IJB will engage as a partner along with the NHS in the community planning process.
National and local standards/targets	The Strategic Plan references specific targets and outcomes against each of the Strategic Objectives. Many of these measures are drawn from the Core Suite of Integration Indicators published at http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Outcomes/Indicators/Indicators. The targets and outcomes referenced in our Strategic Plan are just a starting point. In 2016/17 we will be further developing our draft Performance Management Framework for Integration. From an NHS perspective, the IJB will be keen to assess progress on delivery in relation to key themes such as the national health and wellbeing outcomes. Over the three years of the Strategic Plan, these will be measured by progress in relation to all of the indicators included in our developing Performance Management Framework, where services provided by NHS Borders relate directly or in part to the improvement against that indicator. In year 1 of the Plan (i.e. 2016/17) we are focusing on key target areas – supporting people at home and the wellbeing of our staff. Therefore, we will be prioritising work that will contribute to improving performance against the following indicators:- • Percentage of people who are discharged from hospital within 72 hours of being ready (Health &Wellbeing Outcomes2, 3 and 9) • Number of bed days people spend in hospital when they are ready to be discharged (H&W Outcomes2, 3, 4 and 9) • Overall rates of emergency hospital admissions (H&W Outcomes1, 2, 4, 5 and 7)

	• Readmissions to hospital within 28 days of discharge (H&W Outcome 2,3 , 7 and 9) • Admissions to hospital in the over 65s as a result of falls (H&W Outcome 2, 4, 7 and 9) • Percentage of adults with intensive care needs receiving care at home (H&W Outcome 6) • Proportion of employees who would recommend their workplace as a good place to work (H&W Outcome 8).
Locality planning	Our Locality Planning will take place across our five existing Area Forum localities - Berwickshire, Cheviot, Eildon, Teviot & Liddesdale, and Tweeddale. The Strategic Plan includes summary profiles for each of the five localities, to 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. Within Borders Health and Social Care Partnership, we have set up a group to oversee the development of planning in each of the five localities during 2016/17 and beyond. We expect to appoint locality co-ordinators in Spring 2016 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 Housing, Community Learning and Development, Voluntary and Third Sector, carers, clients and patient representatives. • 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. The Integration Authority expects to make a significant contribution to tackling

	inequalities at locality level. 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". 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 and an asset-based approach to do this. The IJB will want to see local joined up delivery teams, primarily the integrated management of health and social care staff across NHS Borders and Scottish Borders Council.

Scheduled Care **Executive Lead: Evelyn Rodger**	
Local improvement aims	To consistently achieve a 12 week wait for outpatient services To consistently achieve a 12 week wait for inpatient services To consistently achieve a 6 week wait for diagnostic services To reduce the use of non-recurrent capacity for waiting times. Although significant investment has been made the delivery of waiting times and A&E targets remains a challenge for NHS Borders. The achievement of TTG remains challenging for NHS Borders for a number of specialities.
Summary of local work to be carried out under the National Scheduled Care Programme (sustainability) in 2016/17	• Review activity requirements to ensure best possible performance • Ensure optimal design and configuration long-term – Capacity and design optimisation – recurrent and non-recurrent shortfalls – Relate planning and unscheduled care services – manage variation and variability – Establish planning cycles – Project and plan capacity locally, regionally and nationally
Measures which will be used to assess improvements made	12 week wait for outpatient services 12 week wait for inpatient services 6 week wait for diagnostic services The use of non-recurrent capacity for waiting times.

Unscheduled Care Executive Lead: Evelyn Rodger	
NHS Borders Clinical Strategy and Unscheduled Care	The Scottish Government introduced the 6 Essential Actions programme for unscheduled care in June 2015 which included a focus on optimising the admission and discharge balance in hospitals each day and appropriately avoiding admission wherever possible. NHSB have priority actions against each of these Essential Actions and monthly summary sheets of a specific action are submitted to Scottish Government to demonstrate what is being achieved with outcomes and evidence provided as part of this submission. The activity around each of the 6 Essential Actions is as follows: <u>EA1 Clinically Focussed and Empowered Hospital Management</u> **Improvement Aim** – To ensure that patient flow is supported at all levels of hospital management with clear and consistent roles. Other actions include • To further develop the Hospital Safety Brief and extend this to mental health and other services to provide a comprehensive whole systems daily review • The establishment of 7-day senior manager leadership of patient flow through the establishment of a Duty Manager role • Daily Patient Flow Plan providing regular and visible data on expected admissions and required discharges by ward and allocated senior manager support for each ward to assist in delivering these • Establishment of a training programme and competency framework for Hospital bleepholders to ensure that the front-line management of patient flow and the hospital is carried out consistently and that staff are well-supported. • Effective and comprehensive Winter Plan for 2016/17 that minimises requirement for surge beds **Measures for Assessment & Actions** • Achieving the 4 hour 95% Emergency Access Standard and NHS Borders stretch target of 98% • Reduction in the number of patients boarding out of speciality to a stretch aim of zero medical boarders • Reduction in number of patients being boarded overnight to zero • Daily ward Board Rounds with consistent attendances by advocates to focus on forward planning for safe and timely patient discharge **<u>EA2 Hospital Capacity & Patient Flow Realignment</u>** **Improvement Aim** – Hospital Capacity and Patient Flow Realignment To ensure that hospital footprint enables the safe, timely and appropriate accommodation of all patients at all times. • Provision of an Acute Assessment & Ambulatory Care Unit to ensure

	that assessment of acutely unwell patients occurs timeously based on clinical condition, with senior clinical decision makers involved as early as possible. The purpose of this process is to assess to discharge rather than admit to assess. • Remodel medical unit footprint to provide additional acute elderly care capacity, with intention of earlier rehabilitation, improved care for patients and reduced length of stay • Reduce or eradicate medical boarders through a series of measures including rapid identification of patients needs and early transfer of patients to appropriate area for care • Remodel urgent and planned surgical inpatient flows to separate and protect elective work **Measures for Assessment & Actions** • Increase in numbers of patients being discharged on same day through Acute Assessment Unit (AAU) to 35% of all presentations • Reduction in admissions to Medical Assessment Unit by 5 per day • Reduction in length of stay in General Medicine and overall BGH length of stay • Establishment of separate emergency and elective surgical flows **<u>EA3 Patient rather than Bed Management – Operational Performance</u>** Improvement Aim – To provide effective patient flow through BGH by creating early capacity in inpatient areas. Thus ensuring all emergency admissions arriving via Emergency Department or AAU are assessed and, if necessary, admitted within the 4 hour Emergency Access Standard (EAS) or discharged if clinically appropriate. • More effective use of discharge lounge and discharge team to enable more patients to be transferred to the discharge lounge. This includes use of day hospitals as discharge lounges in community hospitals • Discharge team to coordinate next day and same day discharge arrangements – coordination of discharge tasks, transfer to lounge and transport arrangements • Collaborative working with Scottish Ambulance Service providing timed transfers from BGH to Community Hospitals (trial beginning in February 2016) **Measures for Assessment & Actions** • Reduced pressure in ED by creating capacity for patients who require to be admitted throughout the 24 hour period – *Reduction in EAS breaches due to lack of beds* • Reduction in number of patients boarding out of speciality. • Reduction in number of patients transferred overnight • Zero GP referrals admitted via ED for all specialties, unless clinically indicated

	• Increase in number of patients being discharged before midday with a stretch aim of achieving 40% discharges by 12 midday and 30% by 11:00am. **<u>EA4 Medical & Surgical Clinical Processes arranged to Pull Patients from ED</u>** **Improvement Aim** – Improve systems for pulling patients from ED in a timely fashion • Streamlined pathways to orthopaedic and surgical admissions. New protocols for allowing rapid transfer to appropriate surgical ward will be in place. Urgent short-notice review appointments will be established to avoid patients attending ED for review **Measures for Assessment & Actions** • Reduction in Flow 4 ED breaches of EAS standard (patients admitted through ED to surgical beds) **<u>EA5 7 day services – to smooth variation across 'out of hours' and weekend working</u>** **Improvement Aim:** to maintain discharge numbers at consistent level throughout the week. To ensure elective operating is not impacted by emergency patient flow To provide standard levels of unscheduled care across 24 hours and 7 days a week • Participation in QuEST/IHO proof of concept testing to remodel elective and emergency surgical patient flow • The coordination of the various weekend services to support discharge planning and to ensure that patient care within the hospital progresses across 7 days. • Detailed work to choreograph discharges to increase morning discharge rates, including community hospital transfer • Reconciliation of planned next-day discharge profile against actual discharge profile to identify causes for failure to discharge • Re-establishment and roll-out of criteria-led discharge to become norm for discharge planning **Measures for Assessment & Actions** • Reduction in operating cancellations • Patients requiring urgent surgery treated within agreed timescales • No reduction in discharge rate at weekend compared to weekdays

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Increase in number of patients being discharged before midday with a stretch aim of achieving 40% discharges by 12 midday and 30% by 11:00am.

<u>EA6 Ensuring Patients are cared for in their own homes</u>
Improvement Aim – To ensure no patients in hospital who can be cared for in their own home

We will undertake active work to reduce emergency admissions for common conditions, focusing on developing pathways for patients with common respiratory and cardiac conditions to be reviewed and managed within their own homes
Development of a community ward model (Eildon Ward) to provide hospital at home
Extension of Day Of Care Audit (DoCA) to Community Hospitals and Mental Health and active use of DoCA data to manage discharge planning

Measures for Assessment & Actions

Reduction in acute admissions, especially in target conditions
Increase in patients cared for at home
Reduction in Community Hospital length of stay to 18 days average

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<tr><td>Compliance with 4hr HEAT target</td><td>
NHS Borders has consistently met the 95% access target since May 2015 and aims to continue to do so during 2016/17. We will strive to achieve the 98% target during 2016/17. NHS Borders' current performance can be seen below:
<table>
<tr><th>4 Hour Compliance</th><th>Oct-15</th><th>Nov-15</th><th>Dec-15</th><th>Jan-16</th></tr>
<tr><td>Borders</td><td>95.96%</td><td>97.24%</td><td>96.88%</td><td>96.77%</td></tr>
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While the current national target for the access standard is 95%, NHS Borders has committed to maintaining performance at or above 98%. During 2015/16 NHS Borders will continue to plan for service delivery at 98%.
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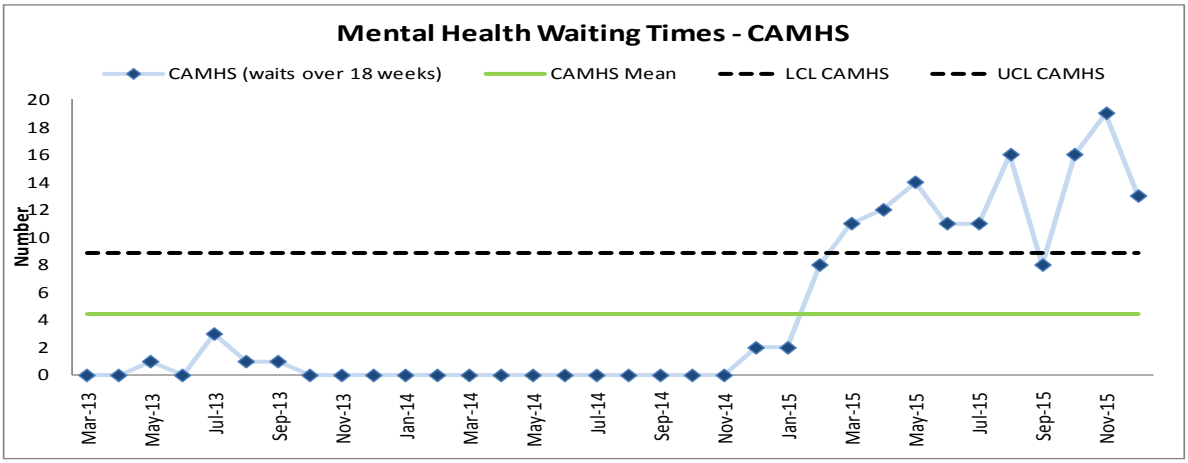
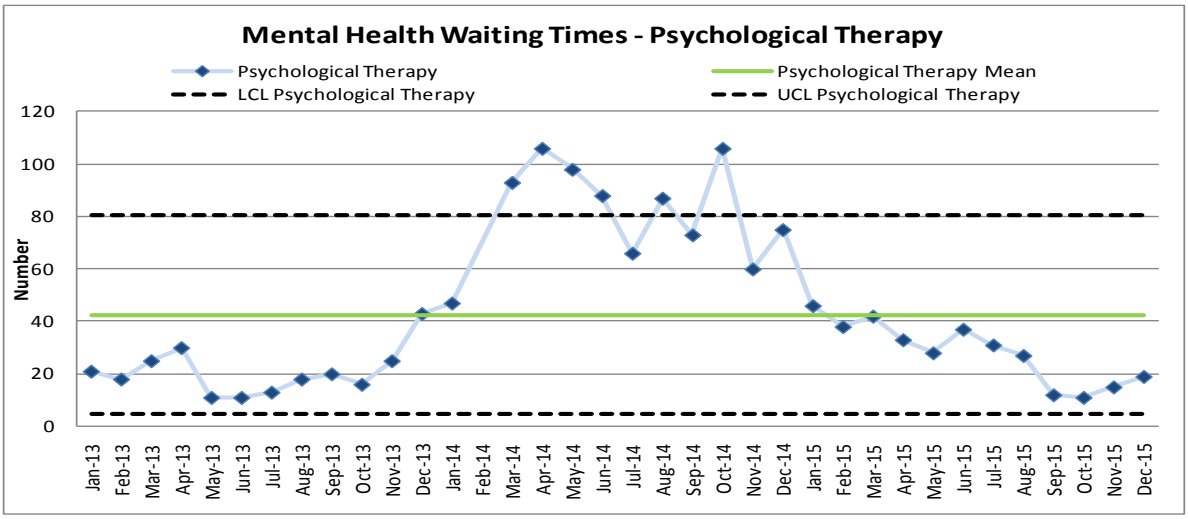
Mental Health

Executive Lead: Susan Manion

The Child and Adolescent Access Target (Referral to Treatment Target reduced from 26 weeks to 18 weeks by December 2014) and the Psychological Therapies Mental Health Access Target (Referral to Treatment within 18 weeks) Scottish Borders Mental Health Service has been unable to meet during the last year. The Child and Adolescent Access Target should be delivered for at least 90% of patients. In Quarter 2, performance for NHS Borders was 78% of patients seen within 18 weeks. In Quarter 3, this decreased slightly to 76.7%. Performance for January 2016 has increased to 83% due to additional resource being allocated to the CAMHS team and we expect to meet the target in February 2016.

Similarly the Psychological Therapies (PT) Access Target should be delivered to 90% of people referred for PT. In Quarter 2, performance for NHS Borders was 71.7% of patients seen within 18 weeks. In Quarter 3, this increased to 74.3%, but was still below the Scottish Average of 83.5% for the same time period.





Local improvement aims	**Child and Adolescent Access Target:** Local analysis of the dip in performance has been undertaken using the DCAQ (Demand, Capacity, Activity, Queue) analysis. The Mental Health Service has also enlisted the support of an external management company to assist us in introducing an improvement programme aimed specifically at supporting staff and managers to: utilise to the maximum face to face time with service users; improve quality and to identify where the demands are within the service allowing us to make strategic workforce planning decisions about allocation of resources. Our aim is to meet the Access target of 90% (Referral to treatment) by the end of February 2016. **Psychological Therapies in Mental Health:** We have now improved our data collection systems and are now able to identify who is delivering what psychological therapies to whom, and where. Our data shows that we are consistently not meeting the Access to Psychological Therapies Target (our percentage waiting 18 weeks or less sits at around 66.2% (Quarter 2 2015) against the target of 90% and a Scottish average of 80.1% for the same period. Moreover we are only referring a small proportion of our local population for psychological therapies (referrals per 1,000 is 2% for NHS Borders; the highest which clearly identifies this is Dumfries and Galloway at 6.7%). There is no national data clearly identifying levels of need for psychological therapies (or even a map of how this might be derived), thus demand is most commonly used as a proxy for need. We do have prevalence data, which suggests around 1 in 4 people will experience a mental health illness (the most common of which are depression and anxiety, and we know that psychological therapies can be very helpful for these conditions.). These three strands of information show that our demand is currently exceeding our delivery by some way. We have a training and development plan for psychological therapies, which identifies priorities and risks based on current evidence-based best practice. Beyond this, we need a workforce plan to improve our capacity within a defined budgetary resource and in a very small service where staff moves and vacancies hit our capacity very strongly. When we look at who is delivering psychological therapies locally, we see that the people who deliver the most are CAAPs (Clinical

	Associates in Applied Psychology). We have invested in multi-professional delivery, and we note that other health boards have successfully employed nursing staff as psychological therapists. We also need to clarify further the local enablers and restrictors on access, and create an action plan to tackle these. We are currently clarifying our improvement aims and action plan through our Psychological Therapies Steering Group which has representation from service users as well as service staff. These are likely to focus on: 1. Meeting the HEAT target by December 2016 2. Increasing the proportion of our local population accessing psychological therapies by a further 1% by December 2016.
Improvement Actions	**Child and Adolescent Access Target:** The Improvement programme includes the introduction of management tools to monitor activity, allocate work more effectively and deliver training for managers. The programme is due to be fully implemented and operational by the end of February 2016 and will then be embedded into management and staffing routines. There is recognition that staffing resources within Child and Adolescent Mental Health Service (CAMHS) are stretched and this has been reinforced through the management data now being routinely collected. The CAMHS workforce capacity is therefore under review. The latest management information indicates that the CAMHS Access Target is now at 85% for December 2015 and we are confident that our trajectory is moving towards meeting the 90% Access to Treatment target by the end of February 2016 **Psychological Therapies in Mental Health:** 1. To clearly understand our current capacity –work here is in hand via the Improvement Programme described earlier. 2. To ensure that people trained in a psychological therapy have clearly specified time allocated in their job plans for the delivery and to ensure this time is utilised;

	3. To refocus job plans where appropriate to enable a greater focus on delivery of psychological therapies using the Improvement Programme data to inform the prioritisation of staffing resource to areas of greatest need; 4. To create a psychological therapies workforce plan focussed on identifying opportunities to recruit more staff who will have job plans clearly focussed on delivery of psychological therapies (such as CAAPS and Nurse Psychological Therapists) whilst maintaining good practices in work pacing, support for staff, supervision and Continual Professional Development; 5. To identify additional local enablers and restrictors on access to psychological therapies and devise further actions depending on what we find.
Measures to assess the improvements made	**Child and Adolescent Access Target and Psychological Therapies in Mental Health:** As described above, the Improvement Programme now allows managers to identify available staffing capacity and allocate work accordingly in a more consistent and efficient manner than before. Management reports are now available on a weekly basis to the teams, managers and senior managers to ensure that staffing resources are targeted at the areas of highest demand. Internal performance data is routinely collated and reported to the Mental Health Clinical Board and Performance meeting which closely track the Child and Adolescent Access to Treatment Target and the Psychological Therapies Access Target. Using both these measures we will be able to assess and monitor our trajectory towards meeting these targets.

Section 2: Workforce

As a Health Board we are faced by the familiar challenges of constrained resources and greater demand for our services. As such we recognise that in order to provide a sustainable model of service delivery we must promote innovation and encourage different, more efficient ways of working.

In addition we will continue to focus on our staff, our most valuable asset, who are central to the delivery of person centred, safe and sustainable healthcare. Included below is the approach we are taking to implementing *Everyone Matters: 2020 Workforce Vision* and how we plan to engage with staff and partners.

We work to a common set of corporate objectives and values which guide the work we do, the decisions we take and the way we treat each other. By promoting excellence in organisational behaviour we believe we can improve patient experience and the quality of care we provide.

Workforce	**Executive Lead: June Smyth**
Plan for the 5 priority areas for action as set out in Everyone Matters: 2020 Workforce Vision Implementation Framework	**1. <u>Healthy Organisational Culture</u>** NHS Borders has recently updated our corporate induction to ensure it promotes the values and behaviours expected of NHS staff. The key threads throughout induction are Care and Compassion and Dignity and Respect. The introduction of Values Based Recruitment has ensured that we are recruiting people who share and are able to demonstrate our values, and we are supporting our managers to attend Values into Action Training as they have a responsibility to embed this approach across their teams. The mandatory induction standards allow measurement of compliance and success of this approach. Current staff have a responsibility to be aware of our corporate objectives and demonstrate the values and behaviours expected. Our Staff Governance Action Plan links directly to the Corporate Objectives promoting a collective approach to ensuring full buy in and involvement across the organisation Mechanisms for implementation include the embedding of good people management; through joint development review process, KSF PDPs and reviewing patient/staff feedback. The key theme of our Workforce Conference on the 11th March 2016 is "Living our Values – working in partnership with staff to support positive values in NHS Borders." The conference is aimed at frontline staff and outcomes will feed into our 3 year Local Workforce Plan for 2016-19. The staff experience employee engagement tool, **iMatter**, is being developed throughout NHS Borders in a 2-year programme, as we recognise that positive staff experience will lead to better patient care. The roll out commenced in February 2015 and this is currently being rolled out throughout NHS Borders, with many areas now about to embark on Phase 2. We see the big message of 2020 Workforce Vision compared to previous workforce plans; is to emphasise and embed our

shared values in NHS Borders, these are:

• care and compassion

• dignity and respect

• openness, honesty and responsibility

• quality and teamwork.

The link between staff health & well-being and improved clinical outcomes is well recognised and reflected in the Workforce 20:20 Vision. In support of this NHS Borders has developed a person centred work and well-being framework which sets out how we will support staff to keep them motivated, healthy and engaged. One of our Staff Side reps chairs the Healthy Working Life group which works to ensure we maintain the gold award.

All staff have the primary responsibility for their own health. However, as the employer, NHS Borders has a clear obligation to support staff health and well-being in the workplace. Success will require co-operative effort at all levels, with managers and staff working together and taking collective ownership and responsibility for improvement. This framework identifies the long term ambition NHS Borders has to foster improvement in staff well-being and makes specific commitments to a number of key priority areas.

2. <u>Sustainable Workforce</u>

NHS Borders continues to facilitate a more joined up approach to Workforce Planning ensuring all relevant stakeholders (internally and externally are involved). NHS Borders and Scottish Borders Council are working together to produce a framework document for the IJB to consider by the end of March 2016 which outlines how we currently develop workforce / people plans, how we look to integrate where possible and how we might develop these in a more integrated fashion, where relevant, moving forward.

Our NHS Borders Local Workforce Plans will support our Clinical Strategy and outline how we can work differently because of these changes. One example is our Paediatric Hospital at Night service. For this innovative service we have introduced new advanced roles and skill mix between the different professions, to ensure we can sustain our local acute children's health services effectively and safely. Our Clinical Strategy recognises that NHS Borders benefits from a dedicated workforce which is committed to providing the highest quality services for our patients. However our workforce itself is becoming older and we are planning now how we will address this demographic challenge by the year 2020.

There are 3 key points to be made about our local workforce plan:

1. It describes a range of scenarios tested by using accepted methodologies for workforce planning and workload measurement. We utilise six step workforce planning methodology for line managers and staff involved in a service redesign so a

consistent framework applies for the development of the future workforce.

2. Created in partnership with staff and their representatives with discussion at Area Partnership Forum.
3. Workforce projections are based on intelligence gathered from our locally developed workforce tool, which highlights potential workforce changes due to turnover, end of fixed term contracts, potential retirements (crucially based on our age profile), and the out- come of service redesign processes. All service redesign has been subject to a workforce assessment, including risk assessment, as part of the project initiation process.

Our Workforce Plans incorporate education and training needs assessment and are closely linked with education governance/learning and development strategies.

Workforce Risks will be monitored using our existing Workforce Risk Assessment Template as part of all redesign proposals. Workforce risks from ongoing service redesigns are collated onto our corporate Service Redesign Inventory ensuring management of workforce risks across all services.

The ability to recruit and retain staff, especially in some specialties and specialist services, remains a significant service as well as financial risk for NHS Borders. The cost of supplementary staff is often significantly higher than substantive staff but is critical to service provision.

A significant workforce planning activity in the forthcoming year is the continuing implementation of the new national electronic Employee Support System (eESS).

eESS is being rolled out across all NHS Boards to provide a single national HR system. The system is planned to provide:

- manager and staff self service (e.g. a benefit is that existing employees will access their own personal details and enable direct electronic updating of changes of address, next of kin etc, reducing paperwork and bureaucracy),
- e-payroll interface (reducing the need for paper based payroll instructions),
- a national training administration system

Our staff data has already been migrated from our previous HR system to eESS and the system is “live” in the HR Department. All managers attended an initial training course in preparation for full roll out of eESS, with update sessions planned over the coming year. The system will be an important tool for effective people management (e.g. absence and leave management) once the SSTS and Payroll interfaces have been fully implemented.

3. Capable Workforce

We see the capable workforce as ensuring that everyone has the skills to deliver safe, effective patient centred care.

In October 2015 an Internal Audit Report on "Mandatory Staff Training" identified recommendations with an overall rating of high risk. These were subsequently added to by the Audit Committee when they discussed the report in December 2015. An action plan to address these has been put in place. An update is to be available to the Audit Committee in March 2016.

The Statutory and Mandatory training subgroup of the Area Partnership Forum continues to meet on a regular basis to review monitor and to identify methods to be more responsive to service requirements.

NHS Borders has for several years achieved the HEAT Standards for Knowledge and Skills Framework (KSF) personal development review and KSF Personal Development Plans. Managers are supported to do this by service champions who support them to develop realistic trajectories and provide technical support where required. We are focussing on quality to ensure that our people have a meaningful face to face conversation with their line manager about performance, development needs and career aspirations. Following a commitment in our 2014 – 2015 Staff Governance Action Plan, a Quality Audit was undertaken of personal development reviews under KSF utilising recognised tools to measure the impact of appraisals and PDPs. The review identified areas for improvement resulting in a new action in the 2015-2016 Staff Governance Action Plan to "Implement revised process to Support Personal Development Review as an outcome of the previous quality audit" by April 2017.

The Senior Charge Nurse Review is an example of where we are building capacity and capability to improve the quality of what we do. NHS Borders are currently piloting having this role as supernumerary and the development of dashboards etc is giving managers information required to improve quality. Through the introduction of the Supervisory Senior Charge Nurse (SCN) programme in inpatient areas we will focus on collecting real time feedback from patients. Supervisory SCNs will have daily conversations with patients and their families and, where issues arise, work with staff, using a coaching and mentoring approach, to implement immediate changes.

The Patient Safety Programme and Executive Walkrounds further support our aim to ensure a capable workforce and the Executive Team use this opportunity to promote corporate objectives, Knowledge and Skills Framework etc.

4. Integrated Workforce

NHS Borders is introducing revised managerial structures and processes, with a view to providing synergy of services across acute, primary and community services, and a firmer working approach to support patient safety and quality of care for patients. An integrated approach will support

	discharge planning and patient flow across the system, including with partners from across health and social care, therefore improving the quality of care for our patients. **Specific examples of developing a more integrated workforce include:** • 11 O'Clock Team – Daily patient flow meeting in the BGH. • Community Day Hospitals reference group. • Integrated Workforce Planning and Development Meeting with SBC and NHS Borders • Joint Early Years Network • Joint Learning Disabilities Group • Joint integrated staff forum • Early years assessment team including Surestart midwives • Staff and Public Engagement sessions to develop Integration Strategic Plan. **5. <u>Effective Leadership and Management</u>** NHS Borders recognises the importance of management and leadership capacity and capability in ensuring the delivery of safe, effective and high quality services for the people of the Scottish Borders and to support the 2020 vision. Promoting excellence in organisational leadership is embedded into the Staff Governance Action Plan. Using the Engaging Leadership Framework (Beverley Alimo-Metcalfe) NHS Borders is committed to promoting and engaging leadership through: • Supporting a developmental culture • Showing genuine concern • Enabling • Inspiring others By building this into local programmes as well as appraisal processes we will ensure that managers and leaders are clear about their role and responsibilities and enable performance to be managed appropriately. In addition the link between engaging leadership and employee engagement will be strengthened through the support of iMatter. Development of further work streams will support the six priority actions identified in the 2020 2015-16 implementation plan, in particular the adoption of value driven approaches, addressing the challenges around middle management and the development of more robust succession and talent management plans. We will continue to support those leading the transition into Health and Social Care Integration. This is likely to involve both individual personal

	development in leading change in a complex and ambiguous environment, as well as, shared local, regional and national development ensuring collaborative working across health, social care and other agencies. We will continue locally to support our taught programmes with coaching, mentoring, leadership exchanges, 360, action learning and opportunities for embedding skills and knowledge 'on the job' furthering our implementation of a 702010 approach.
Application of nursing and midwifery workload and workforce planning tools	NHS Borders are currently rolling out of the nursing and midwifery workload and workforce planning tools - all services review their workload and establishments on an annual basis, and are supported to produce a summary report of findings for the attention of the Director of Nursing. An annual report on outcomes is submitted to the full NHS Board to ensure board members are apprised of nursing & midwifery workforce matters. We view use of the planning tools as being an important foundation to balance demands on staff with the supply of staff, to ensure that numbers and skill mix of appropriately trained nursing and midwifery staff are available, in the right place and at the right time to match service needs. The workforce data obtained helps us understand our workforce and make appropriate decisions about supporting sustainable patient services across the health sector including the redesign of services, available resources, affordability and our clinical strategy. We have implemented new specialty workload and workforce planning tools as they have become available nationally such as the neonatal nursing tool and the community nursing workload tool. Other specialty tools are well established and where there is no available national measurement tool, work has progressed on local workload and workforce planning tools incorporating accepted Time Task Analysis methodology. The Director of Nursing and Midwifery continues this year as a key member of the National Steering Group, ensuring NHS Borders is at the forefront of developments. Where we have found the national tools in need of further development for example, for a Dementia setting, we feedback to national forums for wider sharing and consideration.
Recruitment Issues, Vacancy Rates or Concerns	NHS Borders have developed a Vacancy Monitoring Process where detailed reports are provided to the Exec Team on a weekly basis to monitor the number of current vacancies going through the process and the length of time taken from interview to start date (with a target of less than 8 weeks). We have a commitment to pre-emptive employment within Nursing & Midwifery where we are recruiting staff for a Fixed Term post (e.g. Winter Surge, hard to fill community posts) permanently, with the intention to slot them into future gaps. The APF have been fully engaged with this process which helps to ensure a safe environment for our patients and staff. Despite running regular Nursing and Midwifery

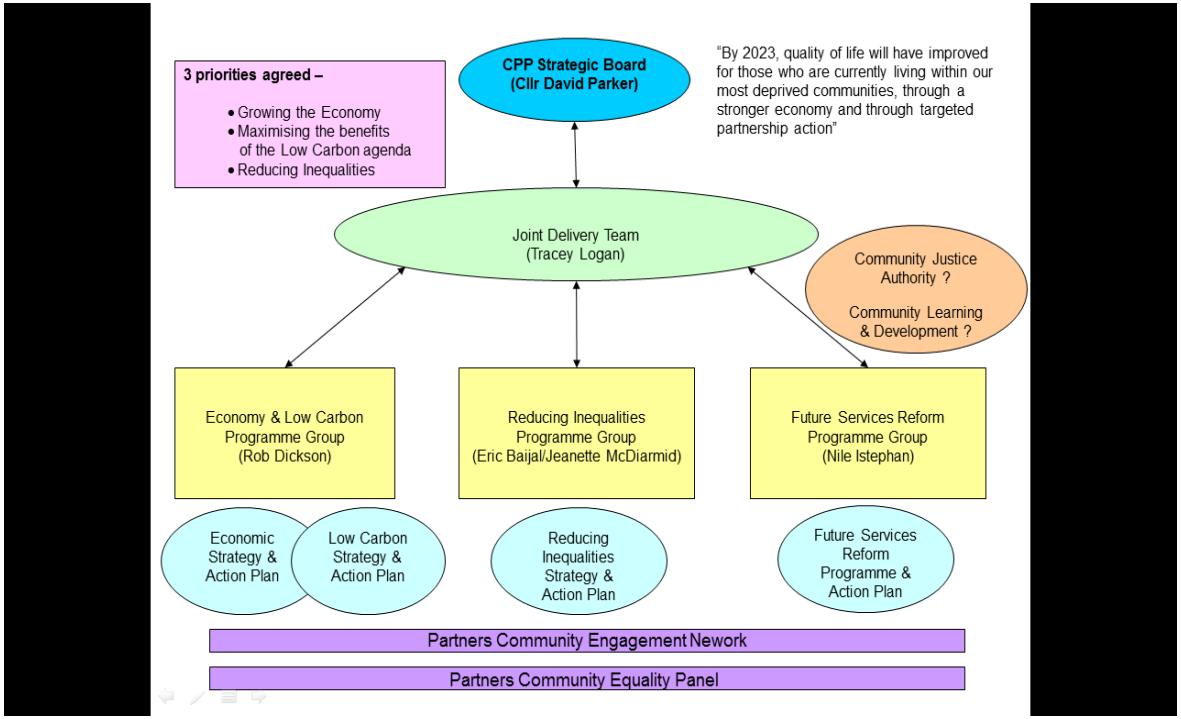
	recruitment events over the past few months we have experienced a shortage of registered nursing applicants and have reviewed our advertising strategy to encourage applicants from further a field. The introduction of a radio advert has been successful and targeting universities (particularly with the introduction of the train line making our main hospital more accessible). Vacancy rates for consultants are approximately the national average (6%) – we have had some success in the latter part of 2015 in recruiting new consultants to four shortage specialties (including Acute Medicine and Rheumatology). Our most significant recruitment challenge in the acute sector has been to Consultant Anaesthetist vacancies in recent years. We have taken some measures to address recruitment difficulties; including revamped job descriptions featuring NHS values, highlighting the new Borders railway as an attraction and a consultant development programme and mentoring. Our recruitment and selection process for Consultant Anaesthetists is currently underway.
Areas in which services are being developed which may have specific implications for the NHS Workforce, or for individual professions as appropriate and steps to manage these locally.	During 2016 NHS Borders will publish a further 3-year Local Workforce Plan in line with the guidance for submission and timetable for workforce planning and workforce projections issued by the Scottish Government Health and Social Care Department. Some of the specific areas where we are developing services, which may have specific implications, are moving to 7 day working within Theatres, and recruiting to Health Visiting.
Demographic Information – i.e. age of workforce impacting on service delivery, local pressures, staff numbers, other workforce factors influencing the sustainability or otherwise of services	Age Profiles/Succession Planning work is ongoing within Mental Health Services where a high proportion of experienced registered staff are eligible to retire in the next few years. We are currently working to identify the number of staff with Mental Health Officer status to ask staff to let us know their plans for retirement (if they are happy to do so).
How workforce Factors are	A good example in SEAT where mutual aid has been delivered on Emergency Medicine is when our single handed ED consultant resigned

being dealt with as part of action being taken to address services which are under stress e.g. A&E Oncology, Radiology	in November 2015, we agreed visiting consultant cover with NHS Lothian on most weekdays Tuesdays to Fridays. The consultant cover included some hands-on clinical work but also more importantly, clinical leadership of the department, clinical governance, complaints advice, training and support for medical and nursing staff. NHS Lothian also now provide overnight remote clinical support on a telephone contact basis to the ED Doctor overnight, which is an essential feature of safe practice overnight – 24/7 services have been maintained by this development. This is a front line vulnerable service – unacceptable disruption has been avoided by a cooperative approach of mutual aid. It is in the interests of both NHS Boards for the BGH ED to remain operational – avoiding the prospect of 22,000 new attendances going to Edinburgh Royal Infirmary.

Section 3: NHS Borders Contribution to the Community Planning Partnership

Scottish Borders Community Planning Partnership

Scottish Borders' Community Planning Partnership structure can be mapped as shown in the diagram below. NHS Borders' Chair and Vice Chair sit on the CPP Strategic Board with the Chief Executive Officer. Members of NHS Borders' Executive Team sit on the Joint Delivery Team with oversight of the 3 programmes of work: Economy and Low Carbon; Reducing Inequalities and Future Services Reform.



The NHS and Scottish Borders Council have integrated services for Public Health with the Health Improvement Team a joint service. Mental Health and Learning Disability Directorates are hosted jointly. The Director of Public Health and Associate Director for AHPs are a joint posts between both

organisations. This section summarises key tangible contributions that NHS Borders plans to make during 2015/16 towards improved outcomes. Each strand below has its own monitoring structures in place to check on progress throughout the year.

Priority	NHS Board Contribution in 2016/17	Current and Planned Performance Levels
Health Inequalities strategic action planning	NHS Borders Public Health Department leads the development and coordinates implementation of action plans to address health inequalities in support of the Community Planning Partnership's Reducing Inequalities strategy 2015 -20. Reducing Health Inequalities is a key theme for the Integrated Joint Board (IJB). Public Health provides advice and support to the CPP and IJB partners in relation to health inequalities to assess need and ensure effective targeting of evidence-informed interventions through policies, service delivery, and models of practice.	Health inequalities needs assessments are being undertaken using a full range of data across the CPP to understand the particular nature and distribution of health inequalities across Borders. This analysis will be used to inform locality planning and service planning for different life stages, population groups within the CPP and IJB. The health inequalities action plan will enable partners to focus interventions on agreed priorities (to be determined) to ensure that the CPP creates added value.
Early Years	NHS Borders leadership to early years work comes through membership of the CYP Leadership group and chairing of two sub groups including the Early Years Group. NHS Borders leaders are actively engaged in promoting skills and knowledge in improvement methods across early years services and partners locally. NHS Early Years Change Fund monies and additional resources attracted are used to support partnership working.	Early Years priorities led by NHS Borders for the CYP Leadership group include sponsoring improvement in key service and process to improve parenting support, family engagement with services, income maximization and nutrition. The Health Improvement team provides regular support and advice on nutrition and other lifestyle issues to Early Years providers across the CPP. NHS Borders core services such as midwifery and health visiting work closely with local Early Years Centres to deliver integrated support for families. Following the establishment of the 4 Early Years Centres in 2015 -16, NHS Borders will work closely

Priority	NHS Board Contribution in 2016/17	Current and Planned Performance Levels
		with other partners to extend the Early Years locality model to all areas. Smoking cessation, ABI, adult weight management and mental health pathways are adapted to respond to needs in pregnancy and post-natally, with the support of partner services to promote engagement.
Children and young people	NHS Borders is committed to the vision and priorities of the Integrated Children and Young Persons Plan 2016 – 18. The NHS Borders Child Health Strategy aligns with the Integrated Plan NHS provides leadership to key agendas for the Leadership group e.g. mental health and supports core processes such as performance reporting, service improvement and workforce development.	In partnership with youth services and Scottish Borders Council (SBC), NHS Borders is working with partners towards endorsement of the Tobacco Free Generation Charter and is supporting young people to make informed choices about relationships and sexual health.
Working age	NHS Borders is committed to promoting healthy lifestyles within the Health Promoting Health Service programme.	Public Health is now extending aspects of this Health Promoting Organisation approach to the Scottish Borders Council workplace, in conjunction with Healthy Working Lives.
Communities and vulnerable groups	A range of primary care based services offer frontline support to lifestyle change across Borders. Integration of health and social care and locality planning provide fresh opportunities to target on high needs and to strengthen early intervention and prevention. The development of long term conditions prevention and	Improvements are planned to provide more integrated approaches to support lifestyle change for health improvement and to maximize engagement and impact with disadvantaged groups. This will include capacity building with workforce to use motivational interviewing, health behaviour change and health literacy skills and techniques. Our Healthy Living Network will continue to use assets

Priority	NHS Board Contribution in 2016/17	Current and Planned Performance Levels
	self management approaches, led by Public Health, supports the objectives of the Strategic Plan in reducing health inequalities. The third sector is a key partner in this work. Core NHS screening programmes are actively promoted through partnerships and networks to raise awareness with target groups and encourage uptake. NHS Borders is involved in collaborative programmes targeted towards groups that experience multiple barriers in accessing services for example women offenders and Health Improvement make an active contribution through advice and training. Borders Alcohol and Drugs Partnership maintains a whole population approach and plans and supports the delivery of effective interventions to prevent harm across age range.	based approaches and co-production methods to address priorities affecting local communities. Health Improvement specialists focus support to priority groups to build capacity in services for health improvement. This includes the development of a health and wellbeing programme with mental health services to address recognized inequalities. In relation to people with learning disabilities, a collaborative programme on nutrition and healthy eating was developed as a partnership project (A Healthier Me) involving LD services, Public Health and service providers, families and carers. This is now being mainstreamed to sustain the gains and the learning. Additional project work on health relationships, respect and safety has been supported through Public Health with LD, Safer Communities, Education and other partners.

Section 4: LDP Standards

NHS Borders aims to maintain the performance against the LDP standards as set out below. Performance will be monitored on an ongoing basis. 18 indicators showing performance towards the 9 outcomes for Health and Social Care Partnerships continue to be developed. Once these are in place they will become part of the performance management cycle for NHS Borders and the partnership.

Identifier	Standard
Cancer	People diagnosed and treated in 1st stage of breast, colorectal and lung cancer (25% increase)
CWT	Cancer Waiting Times: 31 days from decision to treat (95%) 62 days from urgent referral with suspicion of cancer (95%)
Dementia	People newly diagnosed with dementia will have a minimum of 1 year's post-diagnostic support
TTG	12 weeks Treatment Time Guarantee (TTG 100%)
18WKRTT	18 weeks Referral to Treatment (RTT 90%)
12Week	12 weeks for first outpatient appointment (95% with stretch 100%)
Antenatal Services	At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation
IVF	Eligible patients commence IVF treatment within 12 months (90%)
CAMHS	18 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (90%)
PsyTher	18 weeks referral to treatment for Psychological Therapies (90%)
CDI	Clostridium difficile infections per 1000 occupied bed days (0.32)
SAB2	SAB infections per 1000 acute occupied bed days (0.24)
Drug&Alc	Clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery (90%)
Alcohol	Sustain and embed alcohol brief interventions in 3 priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings
Smoking	Sustain and embed successful smoking quits, at 12 weeks post quit, in the 40% SIMD areas
GPAccess	48 hour access or advance booking to an appropriate member of the GP team (90%)
Sickness	Sickness absence (4%)
4HourA&E	4 hours from arrival to admission, discharge or transfer for A&E treatment (95% with stretch 98%)
Breakeven	Operate within agreed revenue resource limit; capital resource limit; and meet cash requirement

Although significant investment has been made the delivery of waiting times and A&E targets remains a challenge for NHS Borders. The achievement of TTG remains challenging for NHS Borders for a number of specialities.

LDP standard performance will be monitored bi-monthly through the LDP Standard Performance Scorecard presented to each Borders Health Board public meeting. These will be available after the meetings on the NHS Borders website as part of the public board meeting papers.

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ISSUE OF DIRECTIONS FROM INTEGRATION JOINT BOARD 2016-17

Aim

1.1 To issue formal directions to Scottish Borders Council and NHS Borders Health Board in relation to the delivery of health and social care services in 2016-17, to support the delivery of the first year of the Strategic Plan.

Background

2.1 The legislation laid out in the Public Bodies (Joint Working) (Scotland) Act 2014, requires the Integration Joint Board (IJB) to formally issue Directions to the two public bodies within the partnership. For year one, the focus is on continued delivery of current services in line with the Commissioning and Implementation Plan.

2.3 As the Partnership develops this plan, the IJB will determine future priorities for service delivery and these will inform the Directions to be issued in year two and subsequent years. The Directions need to be formed in conjunction with the NHS and the Council to ensure a collectively agreed approach in translating these into action.

Summary

3.1 It is proposed that the Directions are issued as follows:

"Scottish Borders Council and Borders Health Board are directed to continue to deliver services pursuant to the functions delegated to the Integration Joint Board in line with the Integration Joint Board's Strategic Plan and notional budgets for 2016-17 as advised by the Chief Officer, pending any further directions from the Integration Joint Board, it's committees or the Chief Officer on its behalf acting under delegated authority"

3.2 The attached paper provides the detailed document to be issued, which provides details of the functions that are included and the associated financial resources for each.

Recommendation

The Health & Social Care Integration Joint Board is asked to **approve** the Directions and instruct the Chief Officer to issue these on the IJB's behalf.

Policy/Strategy Implications	Compliance with the Public Bodies (Joint Working) Act 2014
Consultation	Scottish Borders Council and Borders Health Board Directors of Finance, Chief Executives and the Chief Officer.

Risk Assessment	As detailed within the Scheme of Integration.
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
Sandra Campbell	Programme Manager	Paul McMenamin	Interim Chief Financial Officer - IJB

ISSUE OF DIRECTIONS FROM INTEGRATION JOINT BOARD 2016-17

1 Functions Delegated to the Integration Joint Board

1.1 The functions that are delegated by Borders Health Board to the Integration Joint Board are set out in Appendix 2 of the Health and Social Care Integration Scheme for the Scottish Borders. The services to which these functions relate , which are currently provided by Borders Health Board and which are to be integrated, are set out in Part 2 of Appendix 2.

1.2 The functions that are delegated by Scottish Borders Council to the Integration Joint Board are set out in Part 1 of Appendix 3. The services to which these functions relate, which are currently provided by Scottish Borders Council and which are to be integrated, are set out in Part 2 of Appendix 3.

1.3 The Integration Joint Board has oversight of the functions delegated to it and of the performance of the services related to those functions and will have provided to it, the necessary resources to undertake the functions delegated with the appendices to the Scheme.

Borders Health Board

1.4 The functions **delegated by Borders Health Board to the Integration Joint Board**, as set out in the Scheme of Integration Appendix 2, are shown below:

	Service
1.	Accident and Emergency services provided in a hospital.
2.	Inpatient hospital services relating to the following branches of medicine—
3.	(a) general medicine;
	(b) geriatric medicine;
	(c) rehabilitation medicine;
	(d) respiratory medicine; and
	(e) psychiatry of learning disability.
4.	Palliative care services provided in a hospital.
5.	Inpatient hospital services provided by General Medical Practitioners.
6.	Services provided in a hospital in relation to an addiction or dependence on any substance.
7.	Mental health services provided in a hospital, except secure forensic mental health services.
8.	District nursing services.
9.	Services provided out with a hospital in relation to an addiction or dependence on any substance.
10.	Services provided by allied health professionals in an outpatient department, clinic, or out with a hospital.
11.	The public dental service.*

12.	Primary medical services provided under a general medical services contract, and arrangements for the provision of services made under section 17C of the National Health Service (Scotland) Act 1978, or an arrangement made in pursuance of section 2C(2) of the National Health Service (Scotland) Act 1978.*
13.	General dental services provided under arrangements made in pursuance of section 25 of the National Health (Scotland) Act 1978.*
14.	Ophthalmic services provided under arrangements made in pursuance of section 17AA or section 26 of the National Health Service (Scotland) Act 1978.*
15.	Pharmaceutical services and additional pharmaceutical services provided under arrangements made in pursuance of sections 27 and 27A of the National Health Service (Scotland) Act 1978.*
16.	Services providing primary medical services to patients during the out-of-hours period.
17.	Services provided out with a hospital in relation to geriatric medicine.
18.	Palliative care services provided out with a hospital.
19.	Community learning disability services.
20.	Mental health services provided out with a hospital.
21.	Continence services provided out with a hospital.
22.	Kidney dialysis services provided out with a hospital.
23.	Services provided by health professionals that aim to promote public health.

**Functions exercisable in relation to the health care services set out in paragraphs 11-15 above are delegated in relation to persons of any age and for the purposes of this Integration Scheme therefore include reference to "universal children's health services".*

1.5 The total resources delegated by Borders Health Board to the Integration Joint Board, in respect of the above functions, for 2016/17 is:

	£m
Total funding delegated by Borders Health Board	**92.619**

Scottish Borders Council

1.6 The functions **delegated by Scottish Borders Council to the Integration Joint Board**, as set out in the Scheme of Integration Appendix 3, are shown below:

Functions Delegated by Scottish Borders Council to the IJB	
	Service
1.	Social work services for adults and older people
2.	Services and support for adults with physical disabilities and learning disabilities

3.	Mental health services
4.	Drug and alcohol services
5.	Adult protection and domestic abuse
6.	Carers support services
7.	Community care assessment teams
8.	Support services
9.	Care home services
10.	Adult placement services
11.	Health improvement services
12.	Aspects of housing support, including aids and adaptions
13.	Day services
14.	Local area co-ordination
15.	Respite provision
16.	Occupational therapy services
17.	Re-ablement services, equipment and telecare

1.7 The total resources delegated by Scottish Borders Council to the Integration Joint Board, in respect of the above functions, for 2016/17 is:

	£m
Total funding delegated by Scottish Borders Council	**46.531**

1.8 The total resources delegated to the Integration Joint Board in respect of functions delegated for 2016/17 therefore amounts to £139.15m. This is supplemented by £18.128m notional resources retained by Borders Health Board and set-aside for large hospital services. This total resource envelope was agreed by the Integration Joint Board on the 30th March 2016.

1.9 Neither Borders Health Board nor Scottish Borders Council may reduce the payment in-year to the Integration Joint Board to meet exceptional unplanned costs within the constituent authorities, without the express consent of the Integration Joint Board and constituent authorities for any such change.

1.10 Where appropriate supplementary resources are identified or received by Borders Health Board or Scottish Borders Council e.g. as a result of RSG redetermination, these will be passed on to the Integration Joint Board through increasing the level of budgets delegated to it.

1.11 As per section 4.6.4 of the Integration Scheme, the Integration Joint Board will receive regular reports for the delegated functions from Borders Health Board and Scottish Borders Council on the delivery of integrated services and issue directions in response to those reports to ensure improved performance as required.

2 Directions

2.1 Within section 4 of the Health and Social Care Integration Scheme for the Scottish Borders, the local arrangements through which operational delivery of the services related to the functions delegated to the Integration Joint Board are defined. Section 4.1 of the Scheme states that "as per Section 26 of the Act, the Integration Joint Board will give direction to Borders Health Board and Scottish Borders Council to carry out each function delegated to it."

2.2 The Integration Joint Board Directions to Scottish Borders Council and Borders Health Board are set out below in relation to the delivery of health and social care services in 2016-17, to support the delivery of the first year of the Strategic Plan.

2.3 Scottish Borders Council and Borders Health Board are directed to continue to deliver services pursuant to the functions delegated to the Integration Joint Board in line with the Integration Joint Board's Strategic Plan and notional budgets for 2016-17 as advised by the Chief Officer, pending any further directions from the Integration Joint Board, its committees or the Chief Officer on its behalf acting under delegated authority.

NHS Borders

2.4 At 1st April 2016, the services relating to the functions that will be delivered by Borders Health Board, together with the resources available to support this delivery will be:

	2016/17 £'000
NHS Borders	
Learning Disability	3,599
Mental Health	14,015
GP Prescribing	22,437
General Medical Services	16,933
Non-Cash Limited Service	5,524
Other Generic Primary & Community Services	24,845
	87,353

2.5 At 1st April 2016, the services relating to the functions that will be delivered by Scottish Borders Council, together with the resources available to support this delivery will be:

	£'000
Scottish Borders Council	
Adults with Learning Disabilities	14,674
Older People	28,116
Generic Services	3,659
People with Mental Health Needs	2,168

People with Physical Disabilities	3,180
	51,797

2.6 It should be noted that within the above resource envelope, £5.267m pertains to an allocation of social care funding from Borders Health Board to fund health and social care expenditure in 2016/17. The direction of this funding is the responsibility of the Integration Joint Board (IJB) and both Borders Health Board and Scottish Borders Council should be aware that further direction over the use of this funding will be made during early 2016/17 and accordingly, should remain uncommitted by Scottish Borders Council. The funding will be utilised by the IJB in line with the John Swinney letter of 27th January 2016. The funding may require to be transferred between SBC and other organisations/parties depending on any decisions by the IJB on how the currently uncommitted balance would be utilised.

Efficiency and Other Savings

2.7 The level of resources delegated by both Borders Health Board and Scottish Borders Council is predicated on the delivery of efficiency and other savings plans during 2016/17. Within the revenue financial plans of both organisations specifically, the following savings require delivery in 2016/17:

Borders Health Board Savings	**2016/17 £'000 recurring**	**2016/17 £'000 n/recurring**	**2016/17 £'000 total**
Nursing Skill Mix Review	(93)	0	(93)
Non Support Service Admin	(118)	0	(118)
Supplies Uplift 2016/17	(235)	0	(235)
Travel Costs	0	(95)	(95)
Suspend Clinical Excellence Fund 2016/17	0	(186)	(186)
Clinical Productivity	(750)	0	(750)
Borders Wide Day Hospitals Review	(200)	0	(200)
Drugs & Prescribing	(600)	0	(600)
Review Step Down Facilities	(200)	(350)	(550)
Improving Pathway of Care	(640)	0	(640)
MH & LD Management Costs	(100)	0	(100)
AHP Models of Care	(100)	0	(100)
Review Public Health	0	(150)	(150)
Other Schemes	(100)	0	(100)
Total Savings Proposed	**(3,136)**	**(781)**	**(3,917)**
Target Savings	3,261	979	4,239
Net (deficit)/surplus	**(125)**	**(198)**	**(322)**
Ring-fenced Allocations	(471)	0	(471)
Total savings (deficit)/surplus on delegated budget	**(596)**	**(198)**	**(793)**

Scottish Borders Council Savings

	2016/17 £'000 recurring	2016/17 £'000 n/recurring	2016/17 £'000 total
Supporting Independence when providing Care at Home	(316)	0	(316)
Further contribution of surplus from SB Cares	(547)	0	(547)
Reduction in the costs of Commissioning	(378)	0	(378)
Residential and Home Care Efficiencies and Income	(235)	0	(235)
Assessment and Care Management	(100)	0	(100)
Staffing	(300)	0	(300)
Adults with Learning Disabilities Efficiencies	(549)	0	(549)
Older People Efficiencies	(234)	0	(234)
Other	(4)	0	(4)
	(2,663)	**0**	**(2,663)**

2.8 £793k of savings require further identification and the IJB will work in conjunction with both organisations to identify and deliver further plans to address the current gap. This may result in the requirement to issue of further directions during the financial year.

2.9 Both organisations will deliver the above savings plans during 2016/17. Should plans be undelivered the Scheme of Integration states:-

8.6.2 The Chief Officer of the Integration Joint Board will deliver the agreed outcomes within the total agreed delegated resources. Where there is a forecast outturn overspend against an element of the operational budget the Chief Officer and the Chief Financial Officer of the Integration Joint Board must agree a recovery plan to balance the overspending budget with the relevant finance officer of the constituent authority. The recovery plan will need to be approved by the Integration Joint Board.

8.6.3 Should the recovery plan be unsuccessful the Integration Joint Board may request that the payment from Borders Health Board and Scottish Borders Council be adjusted, to take account of any revised assumptions. It will be the responsibility of the authority who originally delegated the budget to make the additional payment to cover the shortfall.

2.6 These Directions are in line with the guidance that has been issued by the Scottish Government in relation to the Act. Further Directions may be issued, if required by the IJB during each year, which will supersede any previously issued Directions.

2.7 The IJB is asked to approve these Directions to enable them to be issued to the appropriate bodies.

APPENDIX

Breakdown of Costs for Other Generic Primary & Community Services

	2016/17 £'000
Joint Alcohol and Drug Service	
D & A Commissioned Services	621
D & A Team	128
Generic Services	
Community Hospitals	4,802
AHP Services	5,658
Community Nursing ex HV/SN	4,387
BAES	250
GP Out of Hours	2,131
Sexual Health	558
Continence Services	441
Smoking Cessation	209
Primary & Community Management	1,684
Health Promotion	438
Public dental services	3,479
Resource Transfer	2,609
Integrated Care	2162
Social Care Fund	
Total	**29,555**
Savings Requirement 2016/17	
- Reductions to Ring Fenced Allocations	**(316)**
- Public Dental Services	(155)
- Proportional Share Efficiency Target (11.451m)	(4,239)
Other Generic Primary & Community Services	**24,845**

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HEALTH & SOCIAL CARE INTEGRATION - COMMISSIONING & IMPLEMENTATION PLAN

Aim

1.1 To provide an update to the Integration Joint Board (IJB) on the development of the Commissioning and Implementation (C&I) Plan, including the details of the activities for the Partnership for 2016-17 to ensure that we deliver on our key target areas.

1.2 This is in line with the proposed Directions from the IJB to NHS Borders and Scottish Borders Council, which also outline the respective financial budgets for the services involved.

Background

2.1 The Strategic Plan for the Scottish Borders Health & Social Care Partnership will be published on 19th April 2016. This articulates nine local objectives to address the continuing improvement in the delivery of our services to ensure improved outcomes for the people of the Borders. These were determined through a range of consultation and engagement activities, focused on ensuring that our delivery focus reflects the needs of our communities, as well as developing our approach on a co-production basis.

2.2 This resulted in the development of nine local objectives, which drive the planning and delivery of our services, both at the individual service level, and as a partnership as a whole.

2.3 The C&I Plan sets out how this will be achieved. This will continue to develop and evolve as we move through the first year of the official implementation of the Integration Authority, under the governance of the Integration Joint Board (IJB).

2.4 This is also being developed with, and is closely linked to, the Performance Monitoring Framework (PMF). Similarly, this plan contributes to, and is reflected within, both the NHS Borders local delivery plan and the Scottish Borders

Summary

3.1 For year one, the focus will be on ensuring that business as usual can continue, whilst key strategic change processes are delivered, to enable us to move efficiently to a fully integrated service in the second and subsequent years. Through both the Integrated Care Fund (ICF) and the Social Care Fund (SCF) we will deliver services which will reflect the key priorities of integration, including the introduction of new models of care which will be tested to inform strategic decisions on further investment.

3.2 Through 2016-17, the first year of the Integrated Authority, in line with the NHS Borders Local Delivery Plan and the Scottish Borders Council Corporate Plan, we have identified two target areas for us to focus our activities in meeting the local objectives - supporting people at home and the wellbeing of our staff

3.4 We have developed a detailed view of the actions that we will take in the first year of the Integrated Authority and this is shown at the Appendix to this document. This is a work in progress, demonstrating the range of activities that will be carried out to ensure that we carry on with critical business-as-usual service delivery, whilst implementing key aspects that are required to effect transformational change (including those that will be delivered through the ICF and Social Care fund).

3.5 The C&I plan outlines which of these actions will be treated as priority for 2016-17

Recommendation

The Health & Social Care Integration Joint Board is asked to **note** the work that has been undertaken to develop the C&I plan and to approve the approach to its continued development. The IJB is also asked to **confirm** that the priorities, and actions to address them, are in line with expectations and the overall strategic direction.

Policy/Strategy Implications	Compliance with the Public Bodies (Joint Working) Act 2014
Consultation	This plan will be subject to consultation with communities and staff
Risk Assessment	As detailed within the Scheme of Integration.
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**
Members of Health & Social Care Management Team		Sandra Campbell	Programme Manager

HEALTH & SOCIAL CARE INTEGRATION - COMMISSIONING & IMPLEMENTATION PLAN

Introduction

1.1 The Strategic Plan for the Scottish Borders Health & Social Care Partnership will be published on 19th April 2016. This articulates nine local objectives to address the continuing improvement in the delivery of our services to ensure improved outcomes for the people of the Borders. These were determined through a range of consultation and engagement activities, focused on ensuring that our delivery focus reflects the needs of our communities, as well as developing our approach on a co-production basis.

1.2 The key challenges that were identified in the process of developing the Strategic Plan include the following aspects:

- People living with multiple long term conditions
- Disability
- Dementia
- People living with complex and intense needs
- Deprivation in the Borders
- Carers in the Borders.

1.3 This resulted in the development of nine local objectives, which drive the planning and delivery of our services, both at the individual service level, and as a partnership as a whole.

1.4 The Commissioning & Implementation (C&I) Plan sets out how this will be achieved. This will continue to develop and evolve as we move through the first year of the official implementation of the Integration Authority, under the governance of the Integration Joint Board (IJB).

1.5 This is also being developed with, and is closely linked to, the Performance Monitoring Framework (PMF). Similarly, this plan contributes to, and is reflected within, both the NHS Borders local delivery plan and the Scottish Borders Council corporate plan for 2016/17.

1.6 For year one, the focus will be on ensuring that business as usual can continue, whilst key strategic change processes are delivered, to enable us to move efficiently to a fully integrated service in the second and subsequent years. Through both the Integrated Care Fund (ICF) and the Social Care Fund (SCF) we will deliver services which will reflect the key priorities of integration, including the introduction of new models of care which will be tested to inform strategic decisions on further investment.

1.7 To that end, formal Directions to the two public bodies for 2016/17 from the IJB will effectively be a statement to continue delivery as planned by the existing services and associated planning activity. As we progress through year one, moving our strategic focus and our service development activities to the locality approach and testing of new models of care, these Directions will become more specific and will be reflected in the emerging C&I plan at that time. This may mean reprioritisation of

certain services, disinvestment in others whilst clearly identifying areas for further investment which demonstrate a direct impact on achieving our outcomes.

1.8 This approach will continue to build our commissioning approach, enabling us to deliver transformational change in the way that the people of the Borders experience health and social care services.

Aims of Commissioning & Implementation Plan

2.1 The document aims to ensure that commissioning arrangements link to each partner's mainstream activities and budget processes. It has been produced on the basis of existing plans and processes within both NHS Borders and Scottish Borders Council, as well as the work that is underway via the ICF. In term of timescales for delivery, this will be our focus for year one and we will continue to develop the plan for subsequent years.

2.2 In line with our focus on co-production and community involvement, we will carry out a programme of consultation and engagement in the further development of the C&I plan. This is currently being worked on in the development of the overall Communications and Engagement plan, which will be brought to the IJB in due course.

2.3 Additionally, this will be a key part of our locality planning activity so that we reflect the needs of each locality in delivering our services. In the future, locality planning will play a much more significant role in driving commissioning.

Development of Commissioning & Implementation Plan

3.1 We have developed the plan with reference to the nine local objectives, which form the basis of our Strategic Plan. These 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

3.2 These in turn, have been mapped to the nine National Health and Wellbeing Outcomes and our planning approach ensures that the delivery of our services is focused on these, taking into account local priority needs.

3.3 For year one, in line with the NHS Borders Local Delivery Plan and the Scottish Borders Council Corporate Plan, we have identified two target areas for us to focus our activities in meeting the local objectives - **supporting people at home and the wellbeing of our staff.**

3.4 Therefore, we will be prioritising work that will contribute to improving performance against the following indicators:

- Percentage of people who are discharged from hospital within 72 hours of being ready (Health & Wellbeing Outcomes 2, 3 and 9)
- Number of bed days people spend in hospital when they are ready to be discharged (Health & Wellbeing Outcomes 2, 3, 4 and 9)
- Overall rates of emergency hospital admissions (Health &Wellbeing Outcomes 1, 2, 4, 5 and 7)
- Readmissions to hospital within 28 days of discharge (Health &Wellbeing Outcomes 2,3 , 7 and 9)
- Admissions to hospital in the over 65s as a result of falls (Health & Wellbeing Outcomes 2, 4, 7 and 9)
- Percentage of adults with intensive care needs receiving care at home (Health & Wellbeing Outcome 6)
- Proportion of employees who would recommend their workplace as a good place to work (Health &Wellbeing Outcome 8).

3.5 These are our priorities and we will develop these as we progress in line with our commissioning arrangements and the development of directions for future years, refining these as we continue to monitor performance against these indicators and taking into account the results of our consultation and engagement activity.

3.6 As we move forward we will focus on mainstreaming the ICF projects and we will monitor how these are impacting and delivering the shift in overall resources in line with the Strategic Plan.

Action Plan for Service Delivery 2016-17

4.1 We have developed a detailed view of the actions that we will take in the first year of the Integrated Authority and this is shown at the Appendix to this document. This is a work in progress, demonstrating the range of activities that will be carried out to ensure that we carry on with critical business as usual service delivery, whilst implementing key aspects that are required to effect transformational change (including those that will be delivered through the ICF and Social Care fund).

4.2 In line with our focus on supporting people at home, the priority activities against each objective have been identified and are as follows:

1. *We will make services more accessible and develop our communities through:*

    - Review Primary Care Premises Modernisation programme to review and increase capacity for services available to local communities and assess opportunities for co-location
    - Development of Community Capacity Building delivered through the Eildon work and Locality planning and implementation.
    - Improve access to social care and health from local communities and GP practices (test first point of contact model)

- Review Day Hospitals providing day services delivered within a locality model and providing a local resource to the wider communities for health and social care

2. *We will improve prevention and early intervention through:*

   - Ensuring that Anticipatory Care Plans (eKIS) are updated remains an essential focus and will feed in to the Transitional Quality Arrangements for 2016/17 in the revised GMS contract
   - Personalised care planning and self-management as part of the Long Term Condition management improvement work (supported by ICF)
   - Promoting healthier lifestyles for patients, staff and visitors through our health improvement campaign 'small changes, big difference'

3. *We will reduce avoidable admissions to hospital through:*

   - Development of the Eildon Community Ward and links with the Health & Social Care coordination project to provide a proactive case management approach for people with multiple complex co-morbidities most at risk of hospital admission and readmission. (supported by ICF)
   - GP Enhanced Services to support the management of patients in the community or at home, such as near patient testing, warfarin and services to people in care homes.
   - GPs working with BGH consultants via direct access by phone to discuss any cases for early ward or clinic review by a Specialist team
   - Reviewing Mental Health Crisis Team input to the Emergency Department

4. *We will provide care close to home through:*

   - Working with care providers to develop different models of care that will support people to stay at home for as long as possible.
   - Development of Technology Enabled Care models to maintain independence and care closer to home
   - Commissioning of 24 Specialist Dementia care beds to support people with high level dementia care needs and provide specialist in-reach nursing services to support providers

5. *We will deliver services within an integrated care model through:*

   - Quality agenda within the Transitional Year GP Contract to develop processes with the full involvement of Practices
   - Linking to GP practices to ensure communication and speedier access
   - Linking to the third and independent sector locally to improve access to services and coordinate between the services

6. *We will seek to enable people to have more choice and control through:*

- Embedding co-production within the care management and assessment approach and deliver at a locality level
- Completion of the review of the Physical Disability Strategy
- Increasing overall uptake of Self Directed Support

7. *We will further optimise efficiency and effectiveness through:*

    - Continuing to employ service improvement methodology across a range of services to enable staff to spend increasing time with service users and patients improving the quality of service provision

8. *We will seek to reduce health inequalities through:*

    - Development of locality plans to identify how to include those who are hard to reach within our communities and implement change
    - Revision of the Mental Health Commissioning Strategy

9. *We want to improve support for Carers to keep them healthy and able to continue in their caring role through:*

    - Ongoing identification of Carers within GP Practices and signposting to Carer support such as the local Carer Centre
    - Ongoing information and education for Carers across the range of health and social care services
    - School Nursing Services continuing to support young carers and their physical and mental wellbeing

4.3 The full set of activities is shown in the Appendix, with the above priorities highlighted in bold text.

4.4 In line with our focus on the wellbeing of our staff, we are developing a plan to address this key target area. We have established a Workforce Project team who will be taking this forward. Among the activities that will be included in the delivery plan are:

- Engagement in a series of communication activities with staff across NHS Borders and Scottish Borders Council to build awareness and identify key training and development needs
- Working with individual teams to develop appropriate support requirements to help them operate in a seamless way with colleagues across organisational boundaries
- Implementing solutions to improve access to, and sharing of, key patient and client information to support staff in delivering together within joint teams.

Responsibility and Accountability for Commissioning

5.1 As the statutory body responsible for ensuring the successful delivery of health and social care for the people of the Borders, the IJB is accountable for the commissioning activity. Aligning our planning to the local objectives will provide a

basis for measurement of our performance in relation to these. In addition, each of these objectives contributes to, and has been mapped to, the nine National Health and Wellbeing outcomes.

5.2 This approach has been adopted in the development of the Performance Management Framework which is intended to support and enhance the commissioning activity. This will provide assurance to the IJB and the reporting against the framework will enable the IJB to take strategic decisions as we move through the commissioning cycle.

Risk

6.1 Implementation of the C&I plan will be considered and assessed in relation to corporate risks in the context of the IJB.

Conclusion and Next Steps

7.1 In line with the formal Directions from the IJB, we will engage and consult with key stakeholder groups to implement the C&I plan within the financial budgets set out and the agreed strategy. We will develop a communication plan to support this.

7.2 We are working on developing a locality framework for delivery of the strategic plans for each locality. This will include developments such as the Eildon Community Ward and the Transitional Care Facility. We will bring a report on our progress towards our locality plans to the IJB meeting in June 2016.

7.3 This document, and the Appendix, is draft at this time and we will continue to develop this through our communication and engagement activities, the plan for which will be submitted to the IJB in due course.

7.4 The IJB is asked to note the work that has been undertaken to develop the C&I plan and to approve the approach to its continued development. The IJB is also asked to confirm that the priorities and actions to address them are in line with expectations and the overall strategic direction.

7.5 Using the key performance indicators we will baseline activity and measure change, improvement and progress towards the outcomes

APPENDIX

HEALTH & SOCIAL CARE INTEGRATION - COMMISSIONING & IMPLEMENTATION PLAN

SERVICE DELIVERY ACTIONS FOR YEAR ONE TO ACHIEVE LOCAL OBJECTIVES

Local 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.

How delivery of our services will help us to meet this Objective.

- **Review Primary Care Premises Modernisation programme to review and increase capacity for services available to local communities and assess opportunities for co location**
- **Development of Community Capacity Building delivered through the Eildon work and Locality planning and implementation.**
- Development of Locality Plans by Locality Co-ordinator posts
- Home Care Tender to ensure we meet requirements at a locality level.
- Further develop Local Citizen's Panels
- **Improve access to social care and health from local communities and GP practices (test first point of contact model)**
- Development of Veterans Mental Health Services
- **Review Day Hospitals providing day services delivered within a locality model and providing a local resource to the wider communities for health and social care**
- Development of Child and Adolescent Mental Health intensive support
- Improvement work to increase capacity to deliver Psychological Therapies
- Redesign services and develop processes under the Transitional Quality arrangements of the GP Contract for 2016/17, to suit a locality approach.
- Further development of Local Area Co-ordination to increase independence, resilience and local resources.
- Provision of Emergency Dental Services 7 days per week
- Work with partners to remove barriers to access dental services within the community
- Review Day Services and preventative services to ensure they meet needs within each Locality
- Provide Health Literacy Training for staff to improve accessibility of information

Local 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.

How delivery of our services will help us to meet this Objective.

- Ongoing creation and review of existing Anticipatory Care Plans.
- **Ensure that Anticipatory Care Plans (eKIS) are updated remains an essential focus and will feed in to the Transitional Quality Arrangements for 2016/17 in the revised GMS contract.**
- **Personalised care planning and self management as part of the Long Term Condition management improvement work (supported by ICF)**
- Develop preventative services that involve the third and independent sector
- Promote good physical and mental health through well-being advisors.
- Develop an Integrated health and social care transitions pathway for young people moving from children's to adult services.
- Reduce the amount of drug and alcohol use through early intervention and prevention approaches
- **Promote healthier lifestyles for patients, staff and visitors through our health improvement campaign 'small changes, big difference'.**
- Increase referrals to Lifestyle Advisory Services, Quit4Good, as well as signposting to community resources such as 'Walk It' groups.
- Deliver the Long Term Conditions project to support people to self manage their conditions better, promoting social contact and reducing isolation.
- Promote the uptake of health screening opportunities and immunisation programmes
- Raise awareness of the signs and symptoms of health conditions and encourage people to get checked e.g. Detecting Cancer Early, Suicide Prevention Training.

Local 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.

How delivery of our services will help us to meet this Objective.

Opportunities to reduce emergency admissions will include development and review of Anticipatory Care Planning, District Nursing Services, Social Care Services, GP clusters and new GP contract, Out of Hours Services, models of Intermediate Care, and the use of Technology Enabled Care, all of which will support people through all stages of the care pathway.

- **Development of the Eildon Community Ward and links with the Health & Social Care coordination project to provide a proactive case management approach for people with multiple complex co-morbidities most at risk of hospital admission and readmission. (supported by ICF)**
- **GP Enhanced Services to support the management of patients in the community or at home, such as near patient testing, warfarin and services to people in care homes.**
- Health and Social Care coordination projects Services will support the 'Reducing Inappropriate Emergency Admissions Working Group' to achieve its objectives.
- Hawick Paramedic Practitioner Pilot. Two GP Practices are working directly with SAS to test a different model of in-hours response to emergency calls to GPs. (Unscheduled Care Project)
- **GPs working with BGH consultants via direct access by phone to discuss any cases for early ward or clinic review by a Specialist team**.
- The 2015/16 Unscheduled Care Project work streams will be mainstreamed within local services and will include a range of initiatives to support this objective;
- Ambulatory Care and Acute Assessment - A new Ambulatory Assessment Unit has been established and the model is being evaluated in line with agreed improvement methodologies.
- **Review Mental Health Crisis Team input to the Emergency Department – discussions are underway to identify the most appropriate location for the team to ensure timely access and support for patients attending in crisis**.
- Ongoing collaboration with local GPs and District Nurses to ensure that Anticipatory Care Plans (eKIS) are updated remains an essential focus and will feed in to the Transitional Quality Arrangements for 2016/17 in the revised GMS contract.
- Effective Psychiatric Liaison Services operating within hospital settings
- Effective Community Mental Health Rehabilitation Services
- Increasing uptake of Self-Directed Support to increase effective individualised community support arrangements.

Local 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.

How delivery of our services will help us to meet this Objective.

- District Nursing and Treatment Room services will continue to provide care delivered in a locality model that; ensures people achieve the best possible health outcomes – promotes self-management and independence – uses skilled assessment working with a person and their family to develop their care plan – focuses on prevention and anticipatory care – avoids unnecessary hospital admission/supports early discharge – offers a care management function and improves coordination of services – ensures collaboration and interface with third and independent sector – uses knowledge of local community resources and networks
- **We will work with care providers to develop different models of care that will support people to stay at home for as long as possible.**
- Specialist Outreach clinics and screening services will be delivered in localities
- **Development of Technology Enabled Care models to maintain independence and care closer to home**.
- Long Term Care will be reviewed to ensure care homes are providing high quality care across the localities
- **We will commission 24 Specialist Dementia care beds to support people with high level dementia care needs and provide specialist in-reach nursing services to support providers**.
- We will commission effective community support and supported accessible housing options with our communities
- NHS Dental Services will be available across the region with domiciliary care to those cared for at home or in long term care facilities.

Local 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.

How delivery of our services will help us to meet this Objective.

- **Quality agenda within the Transitional Year GP Contract to develop processes with the full involvement of Practices**.
- Creation of Quality Clusters in Localities.
- Review assessment and care management to ensure teams across the partnership are able to work efficiently and enable further integrated working.
- Ongoing HB engagement with GP representative bodies regarding development work and best use of Primary Care funding.
- Ongoing use of the Primary Care Feedback facility to identify interface issues affecting everyday working, e.g. with Secondary Care.
- START staff based in Community Hospitals and working the hospital and community MDTs
- Deliver projects supported by the Integrated Care Fund to maximise integrated working for Health and Social Care.
- Discharge Hub Developments (supported by Connected Care)
- Complete integration of Community Mental Health teams and continue to deliver services within an integrated governance structure incorporating service providers, users, professionals and other stakeholders.
- Joined up Adult Protection services and response.
- **Linking to GP practices to ensure communication and speedier access**
- **Linking to the third and independent sector locally to improve access to services and coordinate between the services**
- Facilitating the development of locality plans based on local needs and co produced in the context of local partnership arrangement.
- Working with services across the NHS and Council to redesign services locally to meet the needs of the local population, local communities and in line with improved outcomes, using localities group
- In consultation with partners, make recommendations to the Localities group on future arrangements to support locality planning and integrated organisational arrangements on an ongoing basis.

Local 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.

How delivery of our services will help us to meet this Objective.

- Further the development of personalisation and outcomes approaches to assessment
- **Embed co-production within the care management and assessment approach and deliver at a locality level**
- **Complete the review of the Physical Disability Strategy**
- **Increase overall uptake of Self Directed Support**
-
- Public involvement and representation in teams working on the redesign and development of services.
- Multidisciplinary presence in projects developing new services.
- Increase the use of patient/service user feedback processes.
- Lifestyle advisory services will work with communities offering support with a specific emphasis to vulnerable groups.

Local 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.*

How delivery of our services will help us to meet this Objective.

- **Continue to employ service improvement methodology across a range of services to enable staff to spend increasing time with service users and patients improving the quality of service provision**.
- Creation of Quality Clusters with clear set of outcomes and their improvement through repeating cycles of work and evidence bases approach to their improvement.
- Review of current management arrangements towards a more integrated model that delivers efficiency and effective use of resources
- Joint approach to Efficiency Planning by partners
- Commission a review of assessment and care management teams to ensure they are able to meet future demand and deliver services efficiently and effectively.
- Commission care at home through a tender process.
- Ensure intelligence is available from locality planning processes to inform any commissioning cycles.

Local 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.

How delivery of our services will help us to meet this Objective.

- **Through the development of locality plans we will identify how to include those who are hard to reach within our communities**
- We will ensure that we carry out Equality Impact Assessments across all strategic developments
- Representation at the Health Equalities steering group.
- We will ensure Rural Proofing is carried out
- GP Keep Well Enhanced Service, targeting populations in the most deprived areas.
- Ensure intelligence is pulled from locality planning activity and considered in any future service reviews.
- **Revision of the Mental Health Commissioning Strategy**

Local Objective 9

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

How delivery of our services will help us to meet this Objective.

- Acknowledge the significant role carers have in meeting health and social care needs of our population.
- Review of Carers Strategy to identify the key areas of development over the next 3 years
- **Ongoing identification of carers within GP Practices and signposting to carer support such as the local Carer Centre**.
- Carer's assessments carried out by the main stream services.
- Engagement with carers on Strategic Planning Group and emerging Locality Planning groups.
- **Ongoing information and education for carers across the range of health and social care services**
- **School Nursing Services will continue to support young carers and their physical and mental wellbeing**.

The Nine 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

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	☆	☆	☆	☆	☆	☆	☆		

Priority Indicators for focus in 2016/17

Core Suite Indicator Number	Indicator description
10	Percentage of staff who say they would recommend their workplace as a good place to work.*
12	Rate of emergency admission for adults.
14	Readmissions to hospital within 28 days of discharge.*
16	Falls rate per 1,000 population in over 65s.*
18	Percentage of adults with intensive needs receiving care at home.
19	Number of days people spend in hospital when they are ready to be discharged.
22	Percentage of people who are discharged from hospital within 72 hours of being ready.

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DRAFT PERFORMANCE MANAGEMENT FRAMEWORK

Aim

1.1 To provide an update to the Integration Joint Board on the development of the Performance Management Framework that will be used for monitoring and reporting as we progress delivery of the integrated services.

Background

2.1 The integration of health and social care has two key objectives which are mutually reinforcing - securing better outcomes and experiences for individuals and communities and obtaining better use of resources across health, care and support systems at national and local levels.

2.2 The National Health and Wellbeing Outcomes provide a strategic framework for the planning and delivery of health and social care services. They are high-level statements of what health and social care partners are attempting to achieve through integration and ultimately through the pursuit of quality improvement across health and social care.

2.3 The IJB will be responsible for planning and ensuring the delivery of a wide range of health and social care services, and will be accountable for delivering the National Health and Wellbeing Outcomes. The IJB are also required to publish an annual performance report, which will set out (amongst other evidence) how we are improving the National Health and Wellbeing Outcomes. These reports will include information about the core suite of integration indicators as set by the Scottish Government, supported by local measures and contextualising data to provide a broader picture of local performance.

Summary

3.1 NHS Borders and Scottish Borders Council both have organisational performance frameworks already in place and therefore it is important that we join these up as appropriate to avoid duplication. A “Core Suite” set of 23 Integration Indicators has been set by the Scottish Government, developed from national data sources so that the measurement approach is consistent across all Health and Social Care Partnership areas. This set of core indicators underpin the 9 National Health and Wellbeing Outcomes.

3.2 It is proposed that the initial performance framework is based on current and existing measures including the National Health and Wellbeing Outcomes. A framework consisting of 3 reporting levels is proposed and this is detailed in the paper.

3.3 Given the many elements of integrated care and the wide range of services delegated to Health and Social Care Partnerships it will be important to ensure our performance framework addresses as many of the key local dimensions as possible, including specific sub-sets of indicators for particular groups of service users and also information at a locality level. This wider dataset needs developed as commissioning matures through the IJB.

3.4 It is therefore proposed that performance reports to the IJB, for the first 12 months, include only level 1 and level 2 measures as per appendix 1.

3.5 It should be noted that the framework will need to remain flexible over the first 12 months as it will be subject to amendment as discussions progress regarding the Local Delivery Plan performance standards that may fall under the Partnership moving forward.

Recommendation

The Health & Social Care Integration Joint Board is asked to **approve** the draft Performance Management Framework to enable this to be progressed further.

Policy/Strategy Implications	Compliance with the Public Bodies (Joint Working) Act 2014
Consultation	Scottish Borders Council and Borders Health Board Directors of Finance, Chief Executives and the Chief Officer.
Risk Assessment	As detailed within the Scheme of Integration.
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
Stephanie Errington	Head of Planning and Performance, NHS Borders	Julie Kidd	Principal Information Analyst, NHS National Services Scotland
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SCOTTISH BORDERS HEALTH & SOCIAL CARE PARTNERSHIP PROPOSED INTEGRATED PERFORMANCE MANAGEMENT FRAMEWORK DRAFT AT 7TH APRIL 2016

Purpose

1.1 The integration of health and social care has two key objectives which are mutually reinforcing - securing better outcomes and experiences for individuals and communities and obtaining better use of resources across health, care and support systems at national and local levels.

1.2 The National Health and Wellbeing Outcomes provide a strategic framework for the planning and delivery of health and social care services. They are high-level statements of what health and social care partners are attempting to achieve through integration and ultimately through the pursuit of quality improvement across health and social care.

1.3 The IJB will be responsible for planning and ensuring the delivery of a wide range of health and social care services, and will be accountable for delivering the National Health and Wellbeing Outcomes. The IJB are also required to publish an annual performance report which will set out how we are improving the National Health and Wellbeing Outcomes. These reports will include information about the core suite of integration indicators as set by the Scottish Government, supported by local measures and contextualising data to provide a broader picture of local performance.

1.4 An integrated Performance Management Framework therefore needs to be developed and agreed.

1.5 This paper therefore sets out a draft proposed framework and outlines the work which is required in order to develop this further.

Background

2.1 NHS Borders and Scottish Borders Council both have organisational performance frameworks already in place and therefore it is important that we join these up as appropriate to avoid duplication. A “Core Suite” set of 23 Integration Indicators has been set by the Scottish Government, developed from national data sources so that the measurement approach is consistent across all Health and Social Care Partnership areas. This set of core indicators underpin the 9 National Health and Wellbeing Outcomes.

2.2 It is proposed that the initial performance framework is based on current and existing measures including the National Health and Wellbeing Outcomes. A framework consisting of 3 reporting levels therefore may be a sensible way forward as outlined in the diagram below.

Level 1 **National Health & Wellbeing (H&W) Outcomes**

Healthier Living	Independent living	Positive experiences of service users	Quality of life of service users	Reducing health inequalities

Carers are supported	Safety of service users	Supported and engaged workforce	Resources are used effectively

The nine national Health and Wellbeing Outcomes are high-level statements of what the Health and Social Care Partnership is attempting to achieve through integration. These outcomes and indicators will rely on nationally gathered data to ensure consistency of definition and collection methodology.

Level 2 **Publicly Accountable Indicators and Targets**

23 Health and Social Care "Core Suite" Indicators have been set by the Scottish Government, against which every Health and Social Care Partnership is required to publicly report on. These measures need to be monitored to allow performance management and improvement to take place within the partnership. These Indicators each map to one or more of the 9 National Health and Wellbeing Outcomes. ***Appendix 1*** incorporates the 23 Core indicators in the draft performance matrix. Existing targets/standards (such as HEAT) as set by Scottish Government for NHS / Local Authorities also need to be reviewed and if applicable, to Integrated Services, to be added to the matrix.

Level 3 **Local Management Information**

Locally agreed Partnership specific measures	Locally agreed locality specific measures	Care group specific measures	Workforce specific measures	Financial performance	Corporate Performance

Level 3 will require further discussion and development to determine local measures, as whilst the Core Suite of Integration Indicators set by the Scottish Government will provide an indication of progress, they will not provide the full picture. As a Partnership we will need to collect and understand a wide range of data and feedback that helps understand the system at locality level, and manage and improve services.

Key Issues

3.1 The overall performance framework for the IJB therefore needs to reflect objectives and help to monitor:

- Progress on the delivery of national outcomes and indicators
- How the strategic planning arrangements have contributed to delivering services which reflect the integration principles
- Transformation of individual outcomes and experience
- Transformation of local health, care and support systems
- Change in local process including:
    - Effective engagement of housing and other services including the third sector and independent sector
    - in care models
    - in whole systems planning and investment
    - evidence based models of care.

3.2 Given the many elements of integrated care and the wide range of services delegated to Health and Social Care Partnerships it will be important to ensure our performance framework addresses as many of the key local dimensions as possible, including specific sub-sets of indicators for particular groups of service users and also information at a locality level. This wider dataset needs developed as commissioning matures through the IJB.

Recommendation

4.1 It is therefore proposed performance for the first 12 months to the IJB includes only level 1 and level 2 measures as per appendix 1.

Priority measures for 2016/17

5.1 Over the three years of the Strategic Plan, performance will be measured by progress in relation to all of the indicators included in our developing Performance Management Framework. In year 1 of the Plan (i.e. 2016/17) we are focusing on key target areas – supporting people at home and the wellbeing of our staff. Therefore, we will be prioritising work that will contribute to improving performance against the following seven indicators:-

- Percentage of people who are discharged from hospital within 72 hours of being ready (Health &Wellbeing Outcomes 2, 3 and 9);
- Number of bed days people spend in hospital when they are ready to be discharged (H&W Outcomes 2, 3, 4 and 9);
- Overall Rates of emergency hospital admissions in adults (H&W Outcomes 1, 2, 4, 5 and 7);
- Readmissions to hospital within 28 days of discharge (H&W Outcomes 2,3 , 7 and 9);
- Admissions to hospital in the over 65s as a result of falls (H&W Outcomes 2, 4, 7 and 9);
- Percentage of adults with intensive care needs receiving care at home (H&W Outcomes 2 and 6);
- Proportion of employees who would recommend their workplace as a good place to work (H&W Outcome 8).

How this will be managed

5.2 The corporate services functions in both NHS Borders and Scottish Borders councils will together collate data on the indicators included in the Performance Monitoring Framework. These will be regularly reviewed by the Chief Officer for the Health and Social Care Partnership and the Health and Social Care Management Team. In turn, reports will be provided to the IJB at intervals to be mutually agreed.

Appendix 1 Draft Performance Management measures against National Outcomes

Notes:

1. Individual performance measures often map to more than one of the National Health and Wellbeing Outcomes, therefore some indicators appear more than once in the matrix below. In some cases, indicators map to a greater number of Outcomes than shown here, but the full one-to-many relationship is not always shown here (typically in the case of indicators that map to more than two of the National Outcomes).
2. More information on the Core Suite of Integration Indicators for Health and Social Care Partnerships is published at http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Outcomes/Indicators.

The goal or vision	Primary Drivers	Indicators for Assessing Performance (LOCAL PRIORITY INDICATORS FOR 2016/17 ARE SHADED IN YELLOW)
National H&W Outcome 1		
People are able to look after and improve their own health and well being and live in good health for longer	Accessible and appropriate information and support on lifestyle factors	Percentage of adults able to look after their own health very well or quite well
	Build capacity in communities	Premature mortality rates
	Improve prevention and early intervention	Rate of emergency admissions for adults.
		Local indicators to be determined

The goal or vision **National H&W Outcome 2**	Primary Drivers	Indicators for Assessing Performance (LOCAL PRIORITY INDICATORS FOR 2016/17 ARE SHADED IN YELLOW)
People, including those with disabilities, long term conditions, or who are frail are able to live, as far as reasonably practicable independently at home or in a homely setting in their community	Accessible and appropriate information on self care and services available	% of adults supported at home who agree that they are supported to live as independently as possible
	Increase the use of technology enabled care	Rate of emergency admissions for adults.
	Provision of appropriate housing/adaptations/equipment	% of adults with intensive needs receiving care at home
	Planning and delivery of service to ensure they are accessible e.g. transport links	Proportion of last 6 months of life spent at home or in community setting
	Build Community Capacity	No of days people spend in hospital when they are ready to be discharged.
		% of people admitted from home to hospital during the year, who are discharged to a care home
		% of people who are discharged from hospital within 72 hours of being ready
		Local indicators to be determined

The goal or vision **National H&W Outcome 3**	Primary Drivers	Indicators for Assessing Performance (LOCAL PRIORITY INDICATORS FOR 2016/17 ARE SHADED IN YELLOW)
People who use Health and Social Care Services have positive experiences and have their dignity respected	Appropriate opportunities to gather information from service user before, during and after health and care services has been delivered	% of adults supported at home who agree that their health and care services seemed to be well co-ordinated.
		% of adults receiving any care or support who rate it as excellent or good
		% of adults supported at home who agree that they had a say in how their help, care or support was provided.
	Appropriate, accessible and consistent information	% of people with positive experience of care at their GP practice
		Proportion of last 6 months of life spent at home or in community setting
		Proportion of care services graded 'good' or better in Care Inspectorate inspections
	Coordinated Care across health and social services	% of people who are discharged from hospital within 72 hours of being ready
		Local indicators to be determined

The goal or vision	Primary Drivers	Indicators for Assessing Performance (LOCAL PRIORITY INDICATORS FOR 2016/17 ARE SHADED IN YELLOW)
National H&W Outcome 4		
Health and Social Care Services are centred on helping to maintain or improve the quality of life of service users	Build Community Capacity	% of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life
		Rate of emergency admissions for adults
	Prevention and early intervention/anticipatory care	Rate of emergency bed days per 100,000 population for adults.
		No of days people spend in hospital when they are ready to be discharged
	Accessible information	Local indicators to be determined

The goal or vision	Primary Drivers	Indicators for Assessing Performance (LOCAL PRIORITY INDICATORS FOR 2016/17 ARE SHADED IN YELLOW)
National H&W Outcome 5		
Health and Social Care Services contribute to reducing health inequalities	Build Community Capacity	Premature mortality rate
	Prevention and early intervention/anticipatory care	
	Accessible information	Rate of emergency admissions for adults
	Targeted support for vulnerable groups	
	Targeted interventions	Local indicators to be determined

The goal or vision	Primary Drivers	Indicators for Assessing Performance (LOCAL PRIORITY INDICATORS FOR 2016/17 ARE SHADED IN YELLOW)
National H&W Outcome 6		
People who provide unpaid care are supported to reduce the potential impact of their caring role on their own health and wellbeing	Accessible information for carers on where and who they can go to for support	% of Carers who feel supported to continue in their caring role
	Ensuring the partnership organisations identify and provide appropriate practical support to carers	% of adults with intensive care needs receiving care at home
	Ensuring the partnership has a clear mechanism for carers to relay feedback on their experiences	Local indicators to be determined. *Number of people receiving respite care has been noted as a potential measure.*

The goal or vision	Primary Drivers	Indicators for Assessing Performance (LOCAL PRIORITY INDICATORS FOR 2016/17 ARE SHADED IN YELLOW)
National H&W Outcome 7		
People who use Health and Social Care Services are safe from harm	Build Community Capacity	% of adults supported at home who agree they felt safe
	Appropriate care packages including equipment/adaptations on discharge	Readmissions to hospital within 28 days of discharge
		Rate of admissions to hospital in the over 65s as a result of falls.
	Appropriate Staff and Clinical Governance	Local indicators to be determined

The goal or vision	Primary Drivers	Indicators for Assessing Performance (LOCAL PRIORITY INDICATORS FOR 2016/17 ARE SHADED IN YELLOW)
National H&W Outcome 8		
People who work in Health and Social Care Services are supported to continuously improve the information, support, care and treatment they provide, and feel engaged with the work they do	Engaged workforce	% of staff who say they would recommend their workplace as a good place to work
	Appropriate training, support and development	
	Appropriate workload and prioritisation	Local indicators to be determined

The goal or vision	Primary Drivers	Indicators for Assessing Performance (LOCAL PRIORITY INDICATORS FOR 2016/17 ARE SHADED IN YELLOW)
National H&W Outcome 9		
Resources are used effectively and efficiently in the provision of Health and Social Care Services without waste	Robust discharge planning	Readmissions to hospital within 28 days of discharge
		No of days people spend in hospital when they are ready to be discharged
	Prevention and early Intervention	% of total health and care spend on hospital stays where the patient was admitted in an emergency
		Proportion of last 6 months of life spent at home or in community setting
	Shared Services/processes	Expenditure on end of life care.
		Local indicators to be determined

MONITORING OF THE SHADOW INTEGRATED BUDGET 2015/16

Aim

1.1 To provide the Shadow Board with a report, by exception, of any significant pressures within the Partnership's Integrated Budget based on the projected outturn as at 29th February 2016.

Background

2.1 The total Shadow Revised Integrated Budget stands currently at £137.807m.

2.2 The services contained within this report related to those prescribed functions for delegation within the Public Bodies (Joint Working)(Scotland) Act 2014 which form the basis of the budget delegated to the IJB on 1st April 2016 for 2016/17.

2.3 2015/16 has operated as a shadow year with the shadow delegated budget being managed on an aligned basis only. Accordingly, any cost pressures reported in 2015/16 remain the responsibility of the partner organisation responsible who, during the year to date, have put in place remedial action plans which include actions across service areas and budgets from both delegated and non-delegated functions.

Key Issues

3.1 At 29th February 2016, the partnership's shadow delegated budget is reporting an overall position of projected year end pressures of £0.678m. This position is net of considerable pressures which have required permanent or temporary investment into key areas of budget during the year. Further remedial actions to address the projected overspend have been agreed including the delivery of savings from elsewhere across organisational budgets, within functions both delegated and non-delegated.

3.2 Total projected spend on the shadow budget at the 29th February 2016 is £138.485m

3.3 Relating to the overall projected position reported above, there are a number of areas where cost and demand factors are driving increased total spend above budget. These include:

3.4 *Joint Mental Health Service* - Mental Health Services are reporting a year end out turn underspend of £174k related primarily to services within NHS Borders due to staffing vacancies. Year to date while overall mental health services are underspent there is an overspend in SBC mental health service due to a number of new care packages, however it is anticipated the Social Care element of the current overspend will be brought back into line prior to year end.

3.5 *Older People's Service* – The level of both residential care beds and care at home hours commissioned externally during 2015/16 continues to exceed the level of budget available, with the drop in overall numbers in both areas over December and January having been offset by a subsequent rise during February (net

increase of 8 beds and 280 hours per week respectively). The financial position this year has further been exacerbated by other exceptional factors including the transfer of homecare contracts to SB Cares, the Council's provider of last resort, and new night support sleep-in wage costs as a result of employment legislation changes. These pressures have been met temporarily in 2015/16 by a range of actions including vacancy freeze, targeted locality team savings and the postponement in the establishment of the new dementia care team. In order to ensure the Older People's budget is affordable going forward, further investment in the 2016/17 financial plan has been aimed at permanently addressing these additional cost drivers and other new emerging pressures.

3.6 *Generic Services* – The highest area of risk and greatest financial pressure across the shadow delegated budget continues to be within GP Prescribing. The projected out turn position for this services has increased by £0.1m to £1.1m for the financial year due to the volatility in the global supply of drugs and the impact this is having on the price of drugs. This position is driven by the unprecedented cost pressure within the GP Prescribing budget over which influence and control are limited. The Medicines Resource Group continues to monitor the situation and to take actions where possible. This pressure has been partly offset by savings across other generic services including Dental Services and Sexual Health (£348k total). Vacant posts in dental at the start of the financial year are largely responsible for this underspend. The delivery of additional remedial savings targets across locality offices (£151k) and targeted management of staff turnover has contributed towards delivering savings to offset the social care pressures within Older People. A combination of other savings including vacancy control within planning and service management (£243k), out of hours (£122k), general medical services (£50k) and smoking cessation (£40k) has enabled an overall projected pressure of £775k to be reported.

Summary

4.1 The revenue monitoring position set out in this report is based on the actual income and expenditure to the 29th February 2016. The Partnership is reporting a projected out turn position of £0.678m. 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.

4.2 NHS Borders will manage its element of the overspend by implementing agreed actions and will continue to use a number of financial control measures to minimise the overspend. In anticipation of any unforeseen pressures, NHS Borders set aside a small contingency in its financial plan to deal with any issues.

4.3 Discussions have already taken place within Scottish Borders Council's corporate management team and an agreed plan for funding the social care pressures within the shadow delegated budget from elsewhere across the Council and in particular, the People Department (non-delegated services) is in place should the requirement arise at outturn, although the current breakeven position provides a degree of assurance that this may not be required.

4.4 The Board will be informed should any further pressures arise and of any management action being taken to mitigate the pressure and a draft outturn

position will be available at the IJB meeting in June 2016.

Recommendation

It is recommended that the Board:

Notes the above reported projected position of £0.678m net pressures within the shadow delegated budget at 29th February 2016 and notes that both partner organisations are working to minimise any adverse variance at year-end but should this not be possible the responsible organisation will ensure that resources are available to ensure a break even out turn.

Notes that Budget Holders/Managers will continue to work to deliver planned savings and deliver a balanced budget. Where this is not possible managers will work to bring forward actions to mitigate any projected overspends.

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 IJB. 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	The IJB will oversee services which has a delegated budget of over £130m, within the existing scope. The budget may 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	Interim Chief Financial Officer - IJB	Janice Cockburn	Deputy Director of Finance

MONTHLY REVENUE MANAGEMENT REPORT

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

	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
Joint Learning Disability Service	18,073	16,258	16,466	(208)	18,324	18,284	40	53	19	20	
Joint Mental Health Service	15,795	14,353	14,207	146	15,747	15,573	174	344	311	313	
Joint Alcohol and Drug Service	1,076	838	754	84	1,082	1,062	20	3	3	3	
Older People Service	24,148	21,408	20,242	1,166	24,429	24,588	(159)	23	0	0	
Physical Disability Service	3,250	3,079	3,239	(160)	3,277	3,246	31	0	0	0	
Generic Services	74,412	66,981	67,406	(425)	75,428	76,203	(775)	599	498	501	
SB Cares Contribution	(480)	0	0	0	(480)	(471)	(9)	0	0	0	
Total	136,274	122,917	122,314	603	137,807	138,485	(678)	1,022	831	837	
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				

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FINANCIAL STATEMENT 2016/17 - OVERVIEW OF DUE DILIGENCE PROCESS

Aim

1.1 To provide Integration Board (IJB) members with further information on the process of due diligence over the historic budgets supporting the functions delegated to the partnership from the 1st April 2016 and progress against the development of a Schedule of Payments to the IJB, for 2016/17, from partner organisations.

Background

2.1 The Scottish Borders Health and Social Care Partnership approved its 2016/17 Financial Statement at its meeting of 30th March 2016. In order to do this, IJB members were required to form a view over the sufficiency of resources delegated for 2016/17. In order to enable a holistic view to be formed, a number of factors required to be considered by members, emanating from various individual pieces of work undertaken as part of the assurance process including:

- Evaluation of progress made by the Scottish Borders Partnership against the recommendations made by the Integrated Resources Advisory Group (IRAG) relating to the provision of financial management and governance arrangements. Reports have been previously made to the IJB in respect of compliance against the recommendations.. Similarly, in relation to the financial arrangements put in place, the IJB has, within reports on both 7th and 30th March 2016, been provided with assurance over their compliance with the partnership's Scheme of Integration
- Ensuring compliance with the partnership's Scheme of Integration – in particular, sections 8.1 to 8.6, which specifically lay out the key arrangements for financial planning and management operations of the IJB during the first year following its establishment and in subsequent years
- Definition of the wider governance mechanisms in place for the partnership and across NHS Borders and Scottish Borders Council
- In February 2016, PwC, NHS Borders Internal Auditor, published their findings from a review of the NHS governance arrangements pertaining to the integration of health and social care within the Scottish Borders. Within this report, it was noted that a number of documents referred to within the final Scheme of Integration have not yet been completed or signed off

2.2 A number of further work packages are now progressing in relation to wider governance arrangements such as internal audit and risk management and further reports will be made to the partnership in due course. Financial planning and management arrangements will be further supported by monthly monitoring reports to the IJB during 2016/17 and enhanced by the ongoing development of strategic financial planning and a more integrated approach to budget-setting prior to 2017/18.

2.3 The IJB agreed the 2016/17 Financial Statement on the basis of assurance over the sufficiency of resources provided within the supporting report. A key feature of this assurance was based on the outcomes from due diligence undertaken over the historical spend / base budget levels of delegated functions during the period 2012/13 to 2015/16.

Due Diligence

3.1 The partnership's Scheme of Integration states that "in determining payment to the IJB in the first year (2016/17) for delegated functions, delegated baseline budgets will be subject to due diligence and comparison to recurring actual expenditure in the previous three years adjusted for any planned changes to ensure they are realistic" and that "there will be an opportunity in the second year of operation to adjust baseline budgets to correct any inaccuracies".

3.2 Accordingly, detailed analysis was undertaken on all budget monitoring reports made to the IJB and its Executive Management Team / Programme Board during the shadow year 2015/16 and on budget monitoring reports to NHS Borders Board and Scottish Borders Council Executive during financial years 2012/13 to 2014/15.

3.3 Accompanying this analysis were further considerations around the nature (e.g. one-off or recurring) of any reported pressures arising during this period, how they were addressed (e.g. temporarily or permanent / remedied in-year or as part of the annual budget setting process / etc) and with specific emphasis on any potential residual impact on 2016/17, whether the 2016/17 financial planning process and in particular, the partnership's Financial Statement provides financially for the recurring impact of any historical financial pressure. Examples of these considerations are those reported in the regular monitoring reports to the IJB, some examples including:

- The temporary drawdown of reserves by Scottish Borders Council to meet the 2015/16 costs of transferring homecare contracts to SBC Cares or the outcome from an Employment Tribunal on Night Support Sleep-ins / Living Wage
- The use of underspends in Dental Services and Mental Health Services to offset the increased costs of some GP prescribed drugs which are in short supply.
- The allocation of cash savings targets to locality teams
- Managed staff turnover to deliver savings to offset wider pressures

3.4 A summary of 3-year outturn positions for delegated services is detailed in **Appendix A** to this report.

	2012/13 Actual	2013/14 Actual	2014/15 Actual	2015/16 Outturn Projected*
	£000	£000	£000	£000
Total Spend 2012/13-2015/16	**131,523**	**137,460**	**138,484**	**139,051**

*at 31st January 2016

3.5 As can be seen from the above summary, there has been a considerable increase in spend between 2012/13 and 2015/16 due to sustained net investment by way of uplift and growth/pressures across delegated functions within NHS Borders and Scottish Borders Council. This is a continuing trend and as a result of ongoing pressures above base budget, the delegated budget for 2016/17 proposed for the IJB is £139.150m as approved by the IJB on 30th March, based on the following component elements:

	£m
Total funding delegated by Borders Health Board	**92.619**
Total funding delegated by Scottish Borders Council	**46.531**

3.6 A breakdown of the basis of the above delegated budgets is detailed in Appendix A.

3.7 A key reason for this ongoing net increase in budget is attributable to the actions aimed at ensuring the ongoing affordability of delegated services from 1st April. A number of key areas of financial pressure from previous financial years, which have recurred in 2015/16, have been identified in-year (as part of the ongoing monthly monitoring process) with appropriate remedial action put in place (within both delegated and non-delegated functions). All such significant pressures have been factored into the 2016/17 financial planning process as either recurring efficiency targets or new savings proposals, or as identification of an ongoing pressure and in respect of the latter, by a range of uplift and targeted investment into these budgets.

3.8 A summary of these significant recurring pressures experienced and reported during 2015/16, together with how they have been addressed as part of the 2016/17 financial planning process is detailed below:

GP Prescribing	Projected 2015/16 pressure of £1.0m attributable to the cost of drugs in short supply / price volatility has been addressed by targeted uplift of £1.5m in 2016/17
Older People Residential Care	Additional demand for bed numbers above budgeted level £178k has been addressed by demographic pressure investment of the same amount in 2016/17
Older People Homecare	Additional pressure of £579k attributable to additional provider costs and demand levels has been addressed by demographic and other targeted investment in full in 2016/17
Learning Disability Night Support	Additional sleep-in costs due to living wage implications in 2015/16 has been addressed in full by targeted investment in 2016/17 £200k
Phys. Disability Comm. Services	Demand pressures have not yet been addressed in full through the 2016/17 financial planning process and require further permanent resolution during the financial year £50k

3.9 Overall, during 2015/16, the level of the shadow delegated budget has increased from £136.3m to £137.8m, an increase of £1.5m in-year. This is in direct contrast to total projected spend of £138.5m, projected overspend of £700k.

3.10 For 2016/17, the planned base budget for delegated resources is £139.150m. This represents an increase in base budget of £2.85m, a significant proportion of which is attributable to the additional investment made to address historic and current pressures. Additionally, the increase is net of considerable savings targets allocated to delegated services in 2016/17, amounting in total to £7.373m, for which delivery plans have been, or are currently being, developed.

3.11 There are a considerable number of other areas of the delegated budget where variances have occurred over the period 2012/13 to 2015/16. These are both favourable and unfavourable and like all budgets across wider partner organisations, require ongoing management to ensure a balanced and breakeven outturn is delivered.

3.12 In addition to the above, a number of other emerging pressures not experienced during 2012/13 – 2015/16 but likely to occur in 2016/17 have also been addressed as part of the financial plan. Examples include expected cost increases due to the retendering of large Care at Home contracts due to take effect from 1st May 2016, or changes in legislation which have driven up the costs which require to be met by clients in receipt of Direct Payments which will require factoring into the DP rates structure from 2016/17.

3.13 Whilst these other ad-hoc pressures in these and other areas of the delegated budget may arise in future, with the levels of investment into these budget areas in 2016/17 outlined above, then following the process of due diligence undertaken, the budget is believed to be sufficiently affordable to meet current levels of activity / cost and was approved accordingly by the IJB on 30th March.

Schedule of Payments

4.1 Within the legislation, a schedule of notional payments requires to be provided to Integration Joint Board following approval of the Strategic Plan and the Financial Statement. Section 8.6.8 of the Integration Scheme specifically states that the IJB will "*Provide a schedule of payments to the Integration Joint Board following approval of the Strategic Commissioning Plan and its related financial plan. It is intended that this will be a one-off payment made during April/May of each financial year. This payment may be subject to in-year adjustments*."

4.2 The schedule of payments to be made in settlement of the payment due to the IJB will include the financial effects of:

- Resource Transfer
- Virement between partner organisations during the course of 2016/17 (if any)
- The net difference between payments delegated to the IJB and resources paid by the IJB in respect of its commissioning arrangements with partners (taking account of all intra-adjustments)

Resource Transfer

4.3 In terms of Resource Transfer, the following historical amounts have been paid to Scottish Borders Council by NHS Borders over the financial years 2012/13 – 2015/16 excluding Children's respite care (non-delegated):

	2012/13	**2013/14**	**2014/15**	**2015/16**
	£000	**£000**	**£000**	**£000**
St Aidans - Gattonside	735	749	764	764
St Aidans - Liverpool	16	17	17	17
Ark Housing				
Hawick Residential	31	31	32	32
Tweedbank Residential	25	25	26	26
Kelso Residential	23	24	24	24
Kelso Respite	41	42	42	42
Gala Day Services	29	30	30	30
Infrastructure Costs	38	39	40	40
People with Mental Health Needs	72	73	75	75
Older People				
Crawwood	506	517	527	527
Saltgreens	174	177	181	181
Phase 1	245	250	255	255
Phase 2 and 3	396	404	412	412
	2,331	**2,378**	**2,425**	**2,425**

4.4 Historically, resource transfer provided a means of funding to establish services in the community at a time of considerable change and shift in the balance of care. It represents the cost of funding service provision, not specific to individuals, nor even specific models of care which over the years since, may have changed from how the baseline position was calculated. The impact of this change needs to be clarified for both NHS Borders and Scottish Borders Council.

Net Payment: Social Care Funding

4.5 In addition to Resource Transfer, following agreement and direction over the use of the Social Care funding element of the delegated budget (£5.267m), the relevant level of resources will transfer from NHS Borders to Scottish Borders Council in respect of the costs of funding social care services during 2016/17 (e.g. living wage, demand pressures, etc).

4.6 Presently within Scottish Borders Council's Financial Plan, the following provisions have been made:

Social Care Funding Earmarked	**2016/17**
	£'000
Homecare demand shortfall	300
Older People demographic increases	234
Increased young adults with learning / physical disabilities	549
Living Wage (from 1st October 2016)	1,474
Health & Social Care Partnership Uncommitted	2,717

***5,274**

*rounded assumption

4.7 It will be for the IJB however to direct the full use of the social care funding, taking account of prevalent factors such as financial settlement conditions, forecast cost/demand pressures and partnership priority requirements for 2016/17, in line with the Strategic Plan outcomes. Once the full impact of the proposal to implement a living wage of £8.25 for all social care staff from 1st October 2016 is known, a further report on the direction in the use of all social care funding by the IJB will be made in June 2016.

4.8 Once finalised, a full report summarising the Schedule of Payments will be reported to the IJB for noting prior to the conclusion of the financial year and the production of 2016/17 annual statutory accounts. It is not anticipated however, that beyond those areas outlined above, there will be any further difference between the payments delegated to the IJB and resources paid by the IJB to NHS Borders and Scottish Borders Council during 2016/17.

Timetable for Financial Reporting

5.1 Section 8.6.8 of the Integration Scheme also states that "in advance of each financial year a timetable of financial reporting will be submitted to the Integration Joint Board for approval".

5.2 A detailed operational timetable for the production of reports is currently being developed. This timetable will ensure the reporting of full, frequent and regular budgetary control reports to each formal meeting of the Integration Joint Board during 2016/17. An exception report on the delegated budget will be made to each meeting of the Executive Management Team on a monthly basis.

Recommendation

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

- **Note** the due diligence process undertaken to provide assurance over the 2016/17 delegated budge
- **Note** the concluded position that based on all known factors at the time of setting budgets for the areas delegated, that there are no identified recurring pressures of a significant nature that have not been addressed as part of the 2016/17 or prior financial planning processes
- **Note** that a report on the options for direction of £5.267m social care funding by the partnership will be made to the IJB in June 2016
- **Note** that a full Schedule of Payments between the IJB and its partners will be reported on conclusion of all financial activity prior to the production of annual statutory accounts at the end of 2016/17
- **Note** the proposed budgetary control reporting basis for 2016/17

Policy/Strategy Implications	
Consultation	
Risk Assessment	

Compliance with requirements on Equality and Diversity	
Resource/Staffing Implications	

Approved by

Name	Designation	Name	Designation
Susan Manion	Chief Officer, Health & Social Care Integration	David Robertson	Chief Financial Officer - SBC

Author(s)

Name	Designation	Name	Designation
Paul McMenamin	Interim Chief Financial Officer - IJB		

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APPENDIX A

Health and Social Care Partnership Due Dilligence Summary

	2012/13 Actual £000	2013/14 Actual £000	2014/15 Actual £000	2015/16 Outturn Projected £000	2016/17 Baseline Budget £000
Joint Learning Disability Service	**18,306**	**17,690**	**17,227**	**18,291**	**18,273**
Residential Care	4,665	3,923	4,167	4,260	4,181
Homecare	2,894	2,690	2,465	2,717	2,582
Day Care	373	454	789	656	656
Community Based Services	8,185	8,344	7,720	6,370	6,477
Respite	172	249	254	215	201
Other	2,017	2,030	1,832	2,013	2,075
SB Cares	0	0	0	2,060	2,101
Joint Mental Health Service	**15,653**	**15,857**	**15,751**	**15,549**	**16,051**
Residential Care	31	56	0	0	0
Homecare	274	214	200	200	190
Day Care	174	173	179	175	192
Community Based Services	763	810	770	692	720
Respite	28	25	35	30	15
SDS	12	44	116	113	102
Choose Life	651	59	66	0	68
Mental Health Team	13,720	14,476	14,385	14,339	14,764
Joint Alcohol and Drug Service	**213**	**181**	**162**	**1,065**	**881**
D & A Commissioned Services	184	160	125	923	753
D & A Team	29	21	37	142	128
Older People Service	**23,759**	**24,058**	**24,156**	**24,465**	**28,116**
Residential Care	11,622	11,086	11,150	6,541	11,428
Homecare	9,435	9,439	8,684	7,825	7,658
Day Care	1,012	941	1,015	234	1,000
Community Based Services	821	968	1,344	1,365	999
Extra Care Housing/SB Cares	73	638	575	7,462	5,989
Housing with Care	0	23	328	439	409
Dementia Services	0	147	(46)	0	37
Delayed Discharge	259	257	279	262	259
Other	537	559	334	337	337
Change Fund	0	0	493	0	0
Physical Disability Service	**3,249**	**3,419**	**3,173**	**3,255**	**3,180**
Residential Care	414	444	440	362	566
Homecare	1,939	1,991	1,789	1,669	1,747
Day Care	160	151	142	196	201
Extra Care Housing/SB Cares	299	232	0	0	353
Community Based Services	364	529	730	956	241
Other	73	72	72	72	72
Generic Services	**48,877**	**54,712**	**56,004**	**54,024**	**54,902**
Assessment & Care Management	295	333	281	296	271
Group Managers	221	171	239	164	172
Service Managers	152	156	161	1	5
Planning Team	117	151	225	132	255
Locality Offices	2,354	2,338	2,443	2,444	2,733
BAES	569	607	682	709	731
Duty Hub	161	150	27	13	0
Extra Care Housing	0	0	258	0	0
Joint Health Improvement	46	52	53	55	55
Respite	27	15	16	7	12
SDS	(24)	(110)	35	97	51
OT	58	56	56	76	61

APPENDIX A

Health and Social Care Partnership Due Dilligence Summary

	2012/13 Actual £000	2013/14 Actual £000	2014/15 Actual £000	2015/16 Outturn Projected £000	2016/17 Baseline Budget £000
Grants to Voluntary	34	34	34	34	43
Out of Hours	24	42	0	67	112
Other	348	260	297	248	(592)
SB Cares Contribution to Gen Fund	0	0	0	(475)	0
Community Hospitals	4,508	4,489	4,507	4,672	4,802
GP Prescribing	19,657	20,095	21,260	21,935	22,436
AHP Services	5,594	5,641	5,266	5,609	5,658
Community Nursing ex HV/SN	5,671	5,982	5,898	4,224	4,387
GP Out of Hours	2,196	2,229	2,084	2,030	2,131
Sexual Health	553	592	553	549	558
Continence Services	418	463	507	477	441
Smoking Cessation	203	222	219	171	208
Primary & Community Management	1,756	1,756	1,937	1,836	1,684
Health Promotion	440	508	594	498	438
Public dental services	994	3,952	3,522	3,421	3,479
Resource Transfer	2,505	2,554	2,720	2,604	2,609
Intergrated Care	0	1,974	2,130	2,130	2,162
Non-Cash Limited	**21,466**	**21,543**	**22,011**	**22,402**	**22,457**
Community Pharmacy Services	3,806	3,690	3,790	3,933	3,933
Opthalmic Services	1,532	1,576	1,579	1,591	1,591
General Medical Services	16,128	16,277	16,642	16,878	16,933
Savings to be allocated	**0**	**0**	**0**	**0**	**(4,710)**
Total Per Summary	**131,523**	**137,460**	**138,484**	**139,051**	**139,150**

APPENDIX A

NHSB Due Dilligence Summary

	2012/13 Actual £000	2013/14 Actual £000	2014/15 Actual £000	2015/16 Outturn Projected £000	2016/17 Baseline Budget £000
Joint Learning Disability Service	**3,596**	**3,345**	**3,507**	**3,545**	**3,599**
Residential Care	2,707	2,403	2,646	2,689	2,689
Other	889	942	861	856	910
Joint Mental Health Service	**13,720**	**13,828**	**13,812**	**13,665**	**14,015**
Mental Health Team	13,720	13,828	13,812	13,665	14,015
Joint Alcohol and Drug Service	**0**	**0**	**0**	**879**	**749**
D & A Commissioned Services	0	0	0	768	621
D & A Team	0	0	0	111	128
Generic Services	**44,749**	**50,724**	**51,472**	**50,402**	**51,242**
Community Hospitals	4,508	4,489	4,507	4,672	4,802
GP Prescribing	19,657	20,095	21,260	21,935	22,436
AHP Services	5,594	5,641	5,266	5,609	5,658
Community Nursing ex HV/SN	5,671	5,982	5,898	4,224	4,387
BAES	254	267	275	246	249
GP Out of Hours	2,196	2,229	2,084	2,030	2,131
Sexual Health	553	592	553	549	558
Continence Services	418	463	507	477	441
Smoking Cessation	203	222	219	171	208
Primary & Community Management	1,756	1,756	1,937	1,836	1,684
Health Promotion	440	508	594	498	438
Public dental services	994	3,952	3,522	3,421	3,479
Resource Transfer	2,505	2,554	2,720	2,604	2,609
Integrated Care	0	1,974	2,130	2,130	2,162
Non Cash Limitied	**21,466**	**21,543**	**22,011**	**22,402**	**22,457**
Community Pharmacy Services	3,806	3,690	3,790	3,933	3,933
Opthalmic Services	1,532	1,576	1,579	1,591	1,591
General Medical Services	16,128	16,277	16,642	16,878	16,933
Total	**83,531**	**89,440**	**90,802**	**90,893**	**92,062**
Savings to be allocated:					
- Reductions to Ring Fenced Allocations					(316)
- Public Dental Services					(155)
- Proptional Share Efficiency Target (11.451m)					(4,239)
Social Care Funding Delegated by NHSB					5,267
Total Planned Expenditure	**83,531**	**89,440**	**90,802**	**90,893**	**92,619**

APPENDIX A

SBC Due Dilligence Summary

	2012/13 Actual £000	2013/14 Actual £000	2014/15 Actual £000	2015/16 Outturn Projected £000	2016/17 Baseline Budget £000
Joint Learning Disability Service	**14,710**	**14,345**	**13,720**	**14,746**	**14,674**
Residential Care	1,958	1,520	1,521	1,571	1,492
Homecare	2,894	2,690	2,465	2,717	2,582
Day Care	373	454	789	656	656
Community Based Services	8,185	8,344	7,720	6,370	6,477
Respite	172	249	254	215	201
Other	1,128	1,088	971	1,157	1,165
SB Cares				2,060	2,101
Joint Mental Health Service	**1,933**	**2,001**	**1,939**	**1,884**	**2,036**
Residential Care	31	28	0	0	0
Homecare	274	214	200	200	190
Day Care	174	173	179	175	192
Community Based Services	763	810	770	692	720
Respite	28	25	35	30	15
SDS	12	44	116	113	102
Choose Life	651	59	66	0	68
Mental Health Team	0	648	573	674	749
Joint Alcohol and Drug Service	**213**	**181**	**162**	**186**	**132**
D & A Commissioned Services	184	160	125	155	132
D & A Team	29	21	37	31	0
Older People Service	**23,759**	**24,058**	**24,156**	**24,465**	**28,116**
Residential Care	11,622	11,086	11,150	6,541	11,428
Homecare	9,435	9,439	8,684	7,825	7,658
Day Care	1,012	941	1,015	234	1,000
Community Based Services	821	968	1,344	1,365	999
Extra Care Housing/SB Cares	73	638	575	7,462	5,989
Housing with Care	0	23	328	439	409
Dementia Services	0	147	(46)	0	37
Delayed Discharge	259	257	279	262	259
Other	537	559	334	337	337
Change Fund	0	0	493	0	
Physical Disability Service	**3,249**	**3,419**	**3,173**	**3,255**	**3,180**
Residential Care	414	444	440	362	566
Homecare	1,939	1,991	1,789	1,669	1,747
Day Care	160	151	142	196	201
Extra Care Housing/SB Cares	299	232	0	0	353
Community Based Services	364	529	730	956	241
Other	73	72	72	72	72
Generic Services	**4,128**	**3,988**	**4,532**	**3,622**	**3,660**
Assessment & Care Management	295	333	281	296	271
Group Managers	221	171	239	164	172
Service Managers	152	156	161	1	5
Planning Team	117	151	225	132	255
Locality Offices	2,354	2,338	2,443	2,444	2,733
BAES	315	340	407	463	482
Duty Hub	161	150	27	13	0
Extra Care Housing	0	0	258	0	0
Joint Health Improvement	46	52	53	55	55
Respite	27	15	16	7	12
SDS	(24)	(110)	35	97	51
OT	58	56	56	76	61

APPENDIX A

SBC Due Dilligence Summary

	2012/13 Actual £000	2013/14 Actual £000	2014/15 Actual £000	2015/16 Outturn Projected £000	2016/17 Baseline Budget £000
Grants to Voluntary	34	34	34	34	43
Out of Hours	24	42	0	67	112
Other	348	260	297	248	(592)
SB Cares Contribution to Gen Fund	0			(475)	
Total Planned Expenditure	47,992	47,992	47,682	48,158	51,798
Social Care Funding not delegated by SBC	0	0	0	0	(5,267)
	47,992	**47,992**	**47,682**	**48,158**	**46,531**

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UPDATE: FINANCIAL GOVERNANCE AND MANAGEMENT ARRANGEMENTS

PROGRESS TO DATE AND COMPLIANCE ASSESSMENT WITH LEGISLATION / RECOMMENDED BEST PRACTICE

Aim

1.1 The aim of this report is to provide an update of the progress made within the Scottish Borders Health and Social Care Integration (H&SCI) programme in advance of 1st April 2016. The report summarised the latest position against compliance with the legislative provisions within The Public Bodies (Joint Working) Scotland Act 2014 and the subsequent recommended best practice guidance issued by the Scottish Government / Integrated Resources Advisory Group (IRAG), in terms of the establishment of the arrangements for Financial Governance and Management within NHS Borders, Scottish Borders Council and the Scottish Borders Health and Social Care partnership, specific to the establishment of the Integrated Joint Board (IJB).

Background

2.1 Specific to the establishment of an integration model for the Scottish Borders – delegation to a (body corporate) Integration Joint Board – there are 69 key provisions / recommendations within the IRAG guidance that require addressing, from a financial arrangements perspective and against which, progress has been evaluated. An updated summary of progress by the Scottish Borders partnership, with the recommended requirements, is detailed in Appendix 1 to this report.

2.2 Progress made to date has been identified in order to ensure that all required provisions in relation to the financial arrangements required by the Act or desired locally are in place. These arrangements will ensure all partners consider:

- The robustness of governance over the operations of the IJB now that it is established
- The overall affordability of its Strategic Plan and any financial risks inherent
- The adequacy of levels of delegated resources and controls over how these resources are managed
- Any impact on NHS Borders and Scottish Borders Council that may have arisen as a result.

2.3 The Integration Programme Finance workstream Action Plan has been subsequently updated in respect of the initial review and progress update and it is anticipated at the time of writing this report that all required arrangements which require to be put in place prior to 1st April will be approved and established by the IJB.

2.4 These arrangements will supplemented by an ongoing programme of development during the first year of operation of the IJB.

2.5 This report updates the previous report to the IJB on 7th March 2016.

Summary

3.1 Within the previous report to the IJB, Appendix 1 detailed 69 key IRAG provisions, against which overall progress to date was evaluated. These provisions covered a range of areas of financial governance and management:

- Governance Structure
- Assurance and Governance
- Financial Reporting
- Financial Planning and Financial Management
- VAT
- Capital and Asset Management
- Accounting Standards

3.2 Evaluation of progress was made based on the work undertaken to date and supporting evidence and a "RAG" rating (Red, Yellow, Amber, Green, Grey) applied against each provision. These were:

Actions Complete
Actions Complete, Minor Remaining Actions Profiled
Actions On Track, Actions Planned
Requires Further Action to be Instigated
Does Not Currently Apply – No Actions Currently Required

3.3 In early March, of the 69 provisions within the guidance, the following assessment was made:

- 30 provisions were assessed as Green
- 7 provisions were assessed as Yellow
- 18 provisions were assessed as Amber
- 6 provisions were assessed as Red
- 8 provisions were assessed as not requiring any action currently but may require addressing in the future

3.4 31 provisions therefore required one or more further actions in order to ensure that sufficiently robust arrangements are in place. These obviously varied in terms of their overall materiality and required timing however and during March 2016, focus has been specifically placed on ensuring that all required arrangements which require to be put in place prior to the 1st April, are. A summary of the progress made against these areas is outlined in Appendix 1, together with the current RAG rating, timing required and any outstanding issues.

3.5 Of the provisions stated within the guidance, 24 are believed to still require action (rated Yellow, Amber or Red). In terms of materiality however, only a small number require action prior to the first of April. All outstanding action points are summarised below in chronological importance. Each have one or more driving IRAG principle behind them and these are detailed, along with their current RAG rating – this will allow IJB members to cross-refer to the actual IRAG provision detailed in Appendix A.

Prior to 01 April 2016

3.6 Two immediate actions required undertaking prior to 01 April 2016. These were:

01 April 2016	The development, publication and approval by the IJB of a Financial Statement (1 year + 2 indicative years) outlining the resources delegated to support the Strategic Plan	Report to IJB 30 March 2016	*Provision Refs:* 34 45

01 April 2016	Assurance to the IJB over the 'sufficiency of resources' included within the Financial Statement and any inherent risks and mitigating arrangements put in place	Report to IJB 30 March 2016	*Provision Refs:* 40 67

3.7 The report to the IJB on 30th March 2016 detailed a medium-term Financial Statement for the partnership and proposed delegated and notional budgets for 2016/17. Accompanying the Financial Statement was a comprehensive statement of assurance over the sufficiency of resources detailed within these budget areas including an analysis of risks inherent, such as whether historic pressures have been addressed sufficiently within financial plans, the requirement to identify further savings proposals or risks to the delivery of efficiency/savings measures. By agreeing this report, the IJB ensured that IRAG provisions 34, 45, 40 and 67 are in place at the point when the IJB becomes operational following its establishment and that all recommended best practice / legal requirements are now in place, in advance of the 01 April 2016.

2016/17 – Strategic Developments

30-Jun-16	The allocation of resources within the outcomes of the Strategic Plan requires to be developed further		*Provision Refs:* 55

3.8 The 2016/17 delegated budget is based on previous years' budget levels, adjusted incrementally to reflect:

- Partners' absolute level of funding by the Scottish Government
- Past performance and known areas of financial pressure arising due to cost, demand, legislative and other factors
- Efficiencies and other required savings delivery to ensure overall affordability
- New priorities as expressed within partners' plans and the Integration Joint Board's Strategic Plan
- Other emerging areas of financial impact

3.9 For the first year of the IJB therefore, the budget is formed by the product of both partner organisations' respective financial planning processes. Building on this, with

reference to the approved Strategic Plan, it is important that resource analysis within the Financial Statement is developed further, linking finances to the outcomes and objectives of the Strategic Plan and on a more detailed level, to the work of locality planning currently underway. This will further inform the development of an integrated financial planning process for 2017/18 onwards.

30 June 2016	The publication of written Directions from the IJB to NHS Borders and Scottish Borders Council detailing the duties of the IJB and partners and amount of delegated budget/set-aside and how it will be used, a description of services together with any supplementary provisions		*Provision Refs:* 6 37 46 47

3.10 Each Integration Authority is required to produce a Strategic Plan that sets out how services will be planned and delivered over the medium-term using the integrated budgets under its control. To action these, a mechanism is required by partnerships, as laid out in the Act, taking the form of binding directions from the IJB to one or both partners. A direction must be given in respect of every function that has been delegated to the IJB, setting out how each function is to be exercised and the budget associated with that. In relation to area b) above, the partnership should use Directions to NHS Borders and Scottish Borders Council in order to ensure actions are undertaken in order to make its overall 2016/17 financial plan fully funded and affordable. During early 2016/17, work will commence on developing initial medium-term directions by the IJB in order to deliver the Strategic Plan within its available resources framework, although directions can be given, retracted or superseded at any time.

31 August 2016	Refinement of and quality assurance over large hospitals budget set-aside remains ongoing following and will be incorporated into any revised financial statement		*Provision Refs:* 62 64

3.11 Work will also continue during the first half of 2016/17 to review the methodology for calculating the large-hospitals budget set-aside. Currently, direct costs-only has been used but going forward, the use of the Integrated Resource Framework (IRF) will be a key enabler of the calculation of the amount of these resources. The current approach is felt to be appropriate at the current time given that:

- IRF has currently not been fully updated in respect of 2014/15 expenditure and income and there have been considerable changes in spending patterns since 2013/14
- Further work is required to interrogate and interpret the Scottish Government summary tables of historic IRF information in order to determine overall relevance and usefulness in establishing the amount set-aside
- In terms of influence and therefore relevance to the IJB, direct-only costs are more likely to be, if required, increased or decreased in line with the requirements of the partnership's Strategic Plan over the medium-term of its life

- A key benefit of IRF will be to measure over time, the financial impact of changing policy decisions, delivery of strategic objectives and the degree to which resources have been realigned in their respect. At this embryonic stage however, it is believed that the direct spend supporting large hospital services under the Strategic Plan provides a more transparent measure of the resources controllable by NHS Borders which are consumed in specifically supporting the plan directly

3.12 As part of the work to further develop the financial planning process however, in advance of the commencement of planning for 2017/18 in late summer 2016, a new approach will be developed, developing not only the notional budget in line with the Scheme of Integration, but how the Strategic Plan and other key drivers such as partners' absolute level of funding by the Scottish Government, past performance and known areas of financial pressure arising due to cost, demand, legislative and other factors, the requirement for efficiencies and other required savings delivery to ensure overall affordability influence the level of resources across all integrated functions:

31 August 2016	An integrated Financial Planning process, involving the IJB, within each organisation, which takes account of priorities and results in a negotiated contribution from each partner must further be developed for 2017/18		*Provision Refs:* 42 43

30 September 2016	A Financial Strategy will be developed which will cover a number of key areas including forecast funding levels for the Integrated Budget, priority areas for investment and disinvestment and identification of financial risks and an approach to a strategy for building and managing IJB reserve levels		*Provision Refs:* 57

3.13 This approach will also be developed concurrently with a Financial Strategy for the Integrated Joint Board and will include the requirements for both Revenue and Capital Planning within both partner organisations.

30 September 2016	The Integration Joint Board will identify the asset requirements to support the Strategic Plan to enable the Chief Officer to identify capital investment projects, or business cases to submit for consideration as part of each organisation's capital financial planning processes		*Provision Refs:* 68

Other Operational Developments

3.14 In addition to the above summary actions, underpinned by the guiding principles referenced, there are a number of other operational financial planning, management and reporting tasks which require undertaking or agreement reached during 2016/17. These are:

During 2016/17	At an operational financial management level, a policy on the application of monthly accrual accounting requires further discussion and agreement		Provision Refs: 54
During 2016/17	Further work is also required in relation to clear identification of the nature, value, source and services supported by current Health Board Resource Transfer which will then require to be accounted for in the method of calculating the Integrated Budget of the IJB. Similarly, further work is also required in relation to hosted services.		Provision Refs: 48 49 50
During 2016/17	The IJB's Internal Audit Plan for 2016/17 still requires developing and approval by the IJB		Provision Refs: 24 25
During 2016/17	A proposed strategy for Insurance over the activities of the IJB still requires agreement and approval		Provision Refs: 23
During 2016/17	Completion of the risk analysis process (for both the IJB and NHSB/SBC – updated risk registers for both the latter organisations) is required and a Risk Register and Risk Management Strategy both require completion		Provision Refs: 19 20 22
During 2016/17	NHS Borders and Scottish Borders Council are in the process of reviewing their respective organisation's own Financial Regulations to ensure they are consistent with and complement the new proposed Financial Regulations of the IJB		Provision Refs: 18 59
During 2016/17	The Health Board and Local Authority may make use of non-current assets, owned or otherwise, to deliver the services in scope of the Strategic Plan. Arrangements for Capital Financial Planning require to be developed post April 2016		Provision Refs: 13

3.15 In addition to the above provisions, there are a number of financial reporting undertakings that require to be actioned at the end of each financial year, in order the IJB meet its statutory reporting requirements. It is unclear at this stage if there will be any requirement to report on 2015/16 and discussions continue with External Audit.

Recommendation

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

- **Note** the progress made to date in the development and implementation of the key financial arrangements following recommended best practice and compliance with legislation which require to be in place prior to the 1st April 2016

- **Note** the plan of actions for the remaining work requiring completion and approval before and beyond 1st April 2016

Policy/Strategy Implications	
Consultation	
Risk Assessment	
Compliance with requirements on Equality and Diversity	
Resource/Staffing Implications	

Approved by

Name	Designation	Name	Designation
Paul McMenamin	Interim Chief Financial Officer - IJB		

Author(s)

Name	Designation	Name	Designation
Paul McMenamin	Interim Chief Financial Officer - IJB		

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Complete
Complete, Minor Remaining Actions Profiled
OnTrack, Actions Planned
Requires Further Action
Does not currently apply

Scottish Borders Health and Social Care PARTNERSHIP

NHS Borders | Scottish Borders COUNCIL

APPENDIX A

SCOTTISH BORDERS INTEGRATED JOINT BOARD
COMPLIANCE CHECK WITH INTEGRATED RESOURCES ADVISORY GROUP GUIDANCE

ACTION POINT	IRAG REFERENCE	IRAG PROVISION	PROGRESS	ACTIONS REQUIRED	COMMENTS / STATUS>	
1. DELEGATION TO AN IJB						
1.1 INTEGRATION SCHEME AND STRATEGIC PLAN						
1	22/1.1.1	The Integration Scheme sets out the detail of the integration arrangement, as agreed by the Local Authority and Health Board and submitted to Scottish Ministers for approval	Detailed in Final Scheme 151215	None	Received ministerial approval mid-2015 s2-6 set out governance and delivery arrangements, functions delegated and accountability / etc	
2	22/1.1.1	The SOI will cover a number of matters provided for by the legislation and Regulations and for finance related matters these will include: • Functions which are to be delegated to the Integration Joint Board by the Health Board and Local Authority; • The method for the determination of the resources to be made available by the Local Authority and Health Board to the Integration Joint Board for the delegated functions; • Reporting arrangements between the Integration Joint Board, Health Board and Local Authority; and • Financial management arrangements.	SOI appendix 2 and 3 outlines functions delegated Method for determining resource allocationand treatment of variations is detailed in SOI s8.	None	Also covers arrangeements in relation to large hospital budgets set-aside	
3	22/1.1.3	Integration Scheme should also define those services which are not delegated to the Integration Joint Board but are managed by the Chief Officer on behalf on the partner Local Authority and Health Board.	There are no services of this nature managed by the Chief Officer	None	This does not preclude such an arrangement taking place in the future	
1.2 CHIEF OFFICER						

Complete
Complete, Minor Remaining Actions Profiled
OnTrack, Actions Planned
Requires Further Action
Does not currently apply

Scottish Borders Health and Social Care PARTNERSHIP

NHS Borders | Scottish Borders Council

APPENDIX A

SCOTTISH BORDERS INTEGRATED JOINT BOARD
COMPLIANCE CHECK WITH INTEGRATED RESOURCES ADVISORY GROUP GUIDANCE

ACTION POINT	IRAG REFERENCE	IRAG PROVISION	PROGRESS	ACTIONS REQUIRED	COMMENTS / STATUS>	
4	22/1.2.1	The Integration Joint Board must make arrangements for the proper administration of its financial affairs and appoint an officer with this responsibility, (the Integration Joint Board financial officer)	IJB Chief Financial Officer appointed on an interim basis from 1st March 2016	Permanent appointment will be made during 2016	The Chief Financial Officer will be responsible for developing a number of further governance and operational planning, management and reporting arrangements going forward	
1.3 FINANCIAL MODEL						
5	23/1.3.0.1	The Health Board and Local Authority will delegate functions and make payments to the Integration Joint Board in respect of the delegated functions and the Health Board will also set aside amounts in respect of large hospitals for use by the Integration Joint Board.	This is set out in section 8 of the SOI. Specifically, 8.3/8.4 set out the provisions for making payments to the IJB whilst 8.5 sets out the method for determining the amount set aside for large hospital services.	None	Amount delegated / Set-aside is subject to due dilligence process and assessment of sufficiency of resources when compared to current spend levels and current and future risks	
6	23/1.3.0.1	The Integration Joint Board will produce the Strategic Plan for the use of these resources and give direction and make payment where relevant to the Health Board and Local Authority for delivery of the services in line with the Strategic Plan.	Strategic Plan approved 7th March 2016 Formal directions yet to be developed	Directions from IJB to partners require to be developed and issued		
7	23/1.3.1.1	Resources within the scope will comprise: • The payment made to the Integration Joint Board by the Local Authority for delegated adult social care services (A); • The payment made to the Integration Joint Board by the Health Board for delegated primary and community healthcare services and for those delegated hospital services which will be managed by the Chief Officer (B); and • The amount set aside by the Health Board for delegated services provided in large hospitals for the population of the Integration Joint Board (C).	This is explicitly stated within the SOI 3.3 and sections 8.3-8.5 clearly reflect that this will be the case. Figure 1 P24 graphically reflects this - also detailed within Appendices 2 and 3.	It is intended that a financial statement and assurance report will be approved by the IJB at its extraordinary meeting of 30 March 2016, detailing the amout of resources following within the scope across each of the 3 elements	3 areas of resource (A+B+C) constitute all available resources supporting the delivery of the Strategic Plan, whilst only A+B form part of the delegated budget Rated green in anticipation of IJB approval on 30th March	

Scottish Borders Health and Social Care PARTNERSHIP

Complete
Complete, Minor Remaining Actions Profiled
OnTrack, Actions Planned
Requires Further Action
Does not currently apply

NHS Borders | Scottish Borders COUNCIL

APPENDIX A

SCOTTISH BORDERS INTEGRATED JOINT BOARD
COMPLIANCE CHECK WITH INTEGRATED RESOURCES ADVISORY GROUP GUIDANCE

ACTION POINT	IRAG REFERENCE	IRAG PROVISION	PROGRESS	ACTIONS REQUIRED	COMMENTS / STATUS>	
8	24/1.3.1.2	The Integrated Budget comprises of parts (A) and (B).	This is explicitly stated within the SOI 3.3 and sections 8.3-8.5 clearly reflect that this will be the case. Figure 1 P24 graphically reflects this - also detailed within Appendices 2 and 3.	In the report to IJB on 30 March which will propose the resources delegated and due dilligence over them, this should be stated	These are the budget heads over which CO has direct management responsibility	
9	24/1.3.2.1	In addition to the services within scope of the Strategic Plan and managed by the Chief Officer, the Local Authority and Health Board may request that the Chief Officer manage services that are outside of the scope of the Strategic Plan.	Presently, this is not the case within the Scottish Borders. The Chief Officer is only responsible for functions delegated to the IJB. There is scope for this however, within the SOI 1.3.2.1.	None	Is not precluded from future arrangements	
1.4 FINANCIAL GOVERNANCE						
10	25/1.4.1.1	The Integration Joint Board will be required to produce its own statutory accounts as a body under Section 106 of the Local Government (Scotland) Act 1973.	This is not referred to within the SOI, but will apply following the closure of each Financial Year.	None	Awaiting agreement on whether 2015/16 accounts will be required	
11	25/1.4.1.2	The Local Authority and Health Board will be required to include additional disclosures and group accounts as part of their financial statements which reflect their relationship with the Integration Joint Board.	This is not referred to within the SOI, but will apply following the closure of each Financial Year.	None	15/16 may require to be restated for comparative purposes / or produced for period from IJB establishment date	
12	25/1.4.2.1	The Integration Joint Board must appoint an officer to be responsible for the administration of its financial affairs, referred to in this guidance as the Integration Joint Board financial officer.	4.4b of SOI Scheme P9 explicitly refers to the IJB requiring to appoint a CFO.	None	Interim IJB CFO appointed from 1 March 2016	
13	25/1.4.2.3	The Health Board and Local Authority may make use of non-current assets, owned or otherwise, to deliver the services in scope of the Strategic Plan. Ownership of the assets and the associated liabilities will be unchanged and remain with the partner Local Authority and Health Board.	This will be the case for the Scottish Borders partnership, explicitly defined in 8.7.1.	None	Arrangements for Capital Financial Planning require to be developed post April 2016 and applied during the medium-term planning from 17/18	
14	26/1.4.3.1	The Integration Joint Board should establish a system of risk management arrangements for the functions delegated to it.	This is explicitly defined in section 13 of the SOI.	None		
2. ASSURANCE AND GOVERNANCE						
2.1 FINANCIAL ASSURANCE						

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	Complete, Minor Remaining Actions Profiled
	OnTrack, Actions Planned
	Requires Further Action
	Does not currently apply

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15	27/2.1.1	The Health Board accountable officer and the Local Authority 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.	Provision within the SOI for the processes through which performance and resources will be managed.	None	Performance Management and Reporting group established in order to deliver rounded financial and performance information and processes to inform integrated decision making from 16/17	
16	27/2.1.3	The Chief Officer is: • Accountable to the Chief Executive of the Health Board for financial management of the operational budget, and is advised by the Health Board Director of Finance; • Accountable to the Section 95 Officer of the Local Authority for financial management of the operational budget; and • Accountable to the Chief Executive of the Local Authority and Chief Executive of the Health Board for the operational performance of the services managed by the Chief Officer.	This is the arrangement proposed for the Scottish Borders partnership, supplemented by the CO's accountability to the IJB for all matters on services and budgets integrated and for which she is responsible. SOI 6.4 explicitly defines accountability to Chief Executives. There is less explicit reference to the COs accountability for matters financial.	None		
17	27/2.1.4	The financial regulations should be developed by its financial officer and incorporate a minimum set of controls. It is recommended that the financial regulations are approved by the Integration Joint Board.	Developed, agreed and reported to the IJB for approval on 01/02/16 following IJB members development session 20/01/16.	None		
18	27/2.1.5	The financial regulations of the Health Board and Local Authority should be revised, if necessary, to incorporate changes resulting from the financial integration arrangements including the arrangements for virement associated with the Integrated Budget.	Still to be completed.	A review of both NHSB and SBC Financial Regulations is required to ensure complementary and consistent governance policy and application.		
2.2 RISK MANAGEMENT						
19	28/2.2.1	The Chief Officer will be responsible for establishing the Integration Joint Board's risk strategy and profile and developing the risk reporting arrangements.	This is explicitly defined in 13.1 of the SOI	None	Development of a risk management strategy and risk register remains ongoing	

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Complete, Minor Remaining Actions Profiled	
OnTrack, Actions Planned	
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20	28/2.2.2	The participating authorities should identify and manage within their own risk management arrangements any risks they consider to have retained under the integration arrangements.	Requires to be further reviewed within both NHSB and SBC following establishment of the IJB.	Requires to be further reviewed within both NHSB and SBC following establishment of the IJB.	Risk registers within SBC and NHSB require updating and reporting in respect of new and retained risks	
21	27/2.2.3	The Integration Scheme should consider provisions to address the key risks inherent in integration and include: • Governance, management and strategy; • Financial management; • Asset management; • Information management; • Performance management; and • Customer management.	Arrangements/provisions for control and governance across each of these areas is provided for within the Scheme of Integration, including complaints handling, etc, primarily within sections 10 to 13	None		
22	27/2.2.4	It is also recommended that the provisions for risk management in the Integration Scheme include: • Leadership/lines of accountability; • Arrangements for recording, updating, monitoring and reporting of risk management information; and • Arrangements for accessing professional risk management support.	None of this is explicitly defined in detail within the Scheme of Integration.	A report to the IJB on the Code of Governance including Risk Management arrangements and strategy was made to the IJB on 07 March 2016 with further organic development planned during 2016		
2.3 INSURANCE						
23	29/2.3.1	Integration Joint Boards should make appropriate provision for insurance according to the risk management strategy.	Risk Management strategy is still in development and remains unapproved.	Requires inclusion and finalisation.	Interim insurance options are currently being considered	
24	29/2.4.1	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.	IJB has approved the appointment of CIA to the IJB. Audit committee will be established. Internal Audit plan to be developed Etc.	Work ongoing.	There are a number of items requiring reporting to both the IJB and NHSB/SBC audit committees with regard to audit arrangements for the IJB	

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25	30/2.4.6	There should be a risk based internal audit plan developed by the Chief Internal Auditor of the Integration Joint Board and approved by the Integration Joint Board or other committee.	Not complete.	To be completed.		
26	30/2.4.7	Internal audit service should be provided by one of the internal audit teams from the Health Board or Local Authority and the Chief Internal Auditor from either of the partner Health Board or Local Authority fulfil this role in the Integration Joint Board.	IJB has approved the appointment of CIA to the IJB. Audit committee will be established. .Audit committee has been approved and established.	Approved February 2016	This requires formal approval by the IJB - 01 Feb 2016	
27	30/2.4.9	The Integration Joint Board Chief Internal Auditor should report to the Chief Officer and the Integration Joint Board on the annual audit plan, delivery of the plan and recommendations and should provide an annual internal audit report including the audit opinion.	From 2016/17	None		
28	31/2.5.2	The Accounts Commission will appoint the auditors to the Integration Joint Board.	KPMG, Scottish Borders Council's external auditors, have been appointed as auditors to the IJB	None		
29	31/2.6.1	The Integration Joint Board should 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.	From 2016/17	None		
3. FINANCIAL REPORTING						
3.1 STATUTORY ACCOUNTS						
30	33/3.1.0.1	Audited annual accounts to be prepared with the reporting requirements specified in the relevant legislation and regulations	With effect from 2016/17	None	15/16 may require to be restated for comparative purposes	
31	33/3.1.0.2	The Local Authority and Health Board should include additional disclosures in their statutory accounts which reflect their formal relationship with the Integration Joint Board. .	With effect from 2016/17	None	15/16 may require to be restated for comparative purposes	
32	34/3.1.1.4	The Integration Joint Board financial statements must be completed to meet the audit and publication timetable specified in regulations	With effect from 2016/18	None	15/16 may require to be restated for comparative purposes	

Further work will be undertaken during 2016/17 to ensure full compliance with IRAG in relation to Financial Reporting

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4. FINANCIAL MANAGEMENT						
4.1 RESOURCES WITHIN THE SCOPE OF THE STRATEGIC PLAN						
33	38/4.1.1	The legislation requires that the Integration Joint Board produce a Strategic Plan, which sets out the services for their population over the medium term (3 years)	Updated Strategic Plan published and launched in November 2015.	Currently being refined		
34	38/4.1.2	The Strategic Plan should incorporate a medium term financial plan (3 years) for the resources within scope of the Strategic Plan which will comprise: • the Integrated Budget, i.e. the sum of the payments to the Integration Joint Board (see 4.2); plus • the notional budget, ie the amount set aside by the Health Board, for large hospital services used by the Integration Joint Board population (see 4.4).	This is not explicitly within the Strategic Plan although the services to be integrated are defined in Appendix A. These resources within scope will be formally defined within the 2016/17 Financial Statement which will be approved by the IJB in March 2016 and which will support the delivery of the Strategic Plan. This will also include large hospital set-aside notional budget. Formal Written Directions, including the value of specific integrated budget, will also be issued by the IJB to its partners	Report to IJB 30 March will detail financial statement for approval. Review of notional budget / IRF scheduled for 2016.		
35	38/4.1.4	The relative proportions of partners' contributions to the resources within scope of the plan will not influence the proportion of services that will be directed by The Integration Joint Board through the Strategic Plan, although it is likely that in the first years they will be similar.	This is not specifically referred to within either the SOI or the Strategic Plan but has been a working principle of the financial planning work to date as proposed at a member development session in 2015.	Development of budget relative to financial plan is scheduled for early 2016/17.	2016/17 initial delegated budget is the sum of the outcomes from 2 component financial planning processes within SBC/NHSB	
4.2 THE INTEGRATED BUDGET						
36	39/4.2.1	The legislation requires that Health Boards and Local Authorities make payments to the integration joint board for the delegated functions and that the method for determining the value of the payments is included in the Integration Scheme	8.3.1 of the SOI states that "the baseline payment will be established by reviewing recent past performance and existing plans for NHSB and SBC for the functions delegated adjusted for material items" and 8.1-8.2 provides for the mechanism of value determination.	None		
37	39/4.2.2	The legislation also requires that where the Integration Joint Board gives direction for the partner Local Authority and Health Board for the operational delivery of services, that the value of the payment or the method of agreeing the value of the payment be included in the direction	Directions not yet developed within the Scottish Borders.		See background document - "Note: minimum contents of Directions" / Scottish Government guidance	

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38	39/4.2.3	Integration authorities should undertake a shadow period in 2014-15. The allocations in the shadow period should be based on the existing financial plans of the Local Authority and Health Board including the planned efficiencies and consideration of recent financial outturn and trends in expenditure; this process must be transparent and the assumptions underlying the budgets must be available to all partners.	Shadow period commenced 1st April 2016 - aligned budgets reflected approved 2015/16 Financial Plans for both NHSB and SBC, including planned efficiencies, savings/income proposals and service pressures/growth. Financial Plans between both partners shared and published.	None		
39	39/4.2.4	The financial performance of the Integrated Budget is monitored during the shadow period with full transparency so that all partners have a clear understanding of the cause and type (recurrent/non-recurrent) of variances and the remedial actions taken by the Local Authority and Health Board. They should have a clear understanding of the adequacy of the budgets in the financial plan for the following year and the assumptions on which they are based.	Monthly aligned financial monitoring reports by exception to Programme Implementation Board / Executive Management Team, with a full quarterly report to IJB detailing current and projected position to date and key areas of pressure/savings variances with detailed explanation where required, including proposed remedial action across integrated and non-integrated budget heads. Financial Plan process paper to be developed for IJB.	Financial Statement to IJB 07 March 2016	Financial Planning paper to IJB in addition to Financial Statement Due dilligence paper over sufficiency of resources to deliver Strategic Plan	
40	39/4.2.5	The initial payments to the Integration Joint Board should be based on analysis of the shadow period in 2014-15 to provide the Local Authority, Health Board and Integration Joint Board with reassurance that the delegated resources are sufficient to deliver the delegated functions. It should also consider the respective financial plans of the Local Authority and Health Board including full transparency on the budget assumptions and planned efficiency savings. These allocations should be tested against the actual performance in the shadow period and adjusted if necessary. Although not included in the payment, the analysis in the shadow period should include the notional budget for hospital services.	This is the approach and takes account of both organisations existing financial plans. Assurance over the sufficiency of resources has been undertaken and key risks identified. Both organisations are experiencing significant pressures presently on functions which will be delegated - full assurance / risk assessment has been undertaken allowing a view over the resources and demands on them to be formed.	Assurance over the sufficiency of resources is a key work package - report to IJB 30 March 2016		

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41	40/4.2.7	The method for determining the allocations to the Integrated Budget in subsequent years will be contingent on the respective financial planning and budget setting processes of the Local Authority and Health Board. They should aim to be able to give indicative three year allocations to the integration joint board, subject to annual approval through the respective budget setting processes.	Section 8.4 of the SOI clearly lays out the detailed method through which payment in subsequent years to the IJB for delegated functions will be made. Reference is also made to the IJB agreeing and delivering the Strategic Plan/Financial Plan but through a process of joint discussion and planning with partners.	None presently	Integrated Financial Planning process to be developed for 17/18 onwards	
42	40/4.2.8	The Chief Officer, and the Integration Joint Board financial officer where such is appointed separately, should 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.	This hasn't been the case for 2016/17 budget directly. Will require to be the case for 2017/18 however. In the interim, the CO also acts as manager of services within both organisations and is therefore part of the management team and financial planning process within each respective partner's organisation.	None prior to April 2016	2017/18 Financial Planning process	
43	40/4.2.9	Local Authority and Health Board will evaluate the case for the Integrated Budget against their other priorities and are expected to negotiate their respective contributions accordingly. The allocations will be a negotiated process based on priority and need and it should not be assumed that they will be the same as the historic or national allocations to the Health Board and Local Authority.	Whilst little reference has been made to specifically 'integrated' services as part of NHSB's/SBC's financial planning process for 2016/17, budgets, pressures and requirement for proposed savings have been recognised as part of a prioritisation process. This has the impact of increasing/decreasing certain budgets supporting integrated services.	None prior to April 2016	A clearer approach to prioritisation of integrated services' budgets as part of a wider approach to financial planning in partner organisations will require development for 2017/18.	
44	40/4.2.9	The method for determining the contributions is required to be included in the Integration Scheme.	SOI 8.3-8.5	None		
45	41/4.2.10	The allocations made from the Integration Joint Board to the Local Authority and Health Board for operational delivery of services will be approved by the Integration Joint Board. The value of the payments will be those set out in the Strategic Plan approved by the Integration Joint Board	Report to IJB in March 2016, accompanied by Financial Statement.			

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46	41/4.2.11	The legislation will require that a direction should be in writing and must include information on (Section 26): • The integrated function/(s) that are being directed and how they are to be delivered; and • The amount of and method of determining the payment to carry out the delegated functions.	Formal Written Directions, including the value of specific integrated budget, will also be issued by the IJB to its partners in early 2016/17	Pending		
47	41/4.2.12	It anticipated that a direction from the Integration Joint Board will take the form of a letter from the Chief Officer to the Health Board or Local Authority referring to the arrangements for delivery set out in the Strategic Plan and/or other documentation. Once issued they can be amended or varied by a subsequent direction	Formal Written Directions, including the value of specific integrated budget, will also be issued by the IJB to its partners in early 2016/17	Pending	Clarity of understanding of Directions is required and form/content requires agreeing.	
48	41/4.2.14	Some social work expenditure budgets will be funded by resource transfer payments. It is recommended that partners identify these and adopt a transparent and consistent approach to their inclusion in the payment to the Integration Joint Board. The options for this are: • For the Health Board to stop paying resource transfer to the Local Authority and instead to include it in its payment to the Integration Joint Board. The Local Authority would need to make a corresponding reduction in its payment to the Integration Joint Board to cover the loss of resource transfer income from the Health Board; or • For the Health Board to continue paying resource transfer to the Local Authority and to exclude it from its payment to the Integration Joint Board. The Local Authority would include in its payment to the Integration Joint Board the social work services funded by the resource	Work is ongoing in this area analysing out the level of resource transfer, its basis and its current application.	Ongoing		
49	41/4.2.15	It is recommended that the local decision on treatment of resource transfer be set out in the Integration Scheme.	Resource transfer is not referred to within the SOI. This will therefore require local agreement and may require reporting to IJB.	Further work and agreement required		

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50	42/4.2.17	Resources used by the population of an Integration Joint Board for delegated services that are provided on a hosted arrangement, should be included in the respective Integrated Budget	Further work required	Further work required		
4.3 MANAGING FINANCIAL PERFORMANCE						
51	42/4.3.0.1	The partners should include in the Integration Scheme provisions for managing in-year financial performance of the Integrated Budget. This will require that the Chief Officer receive financial performance information for both her/his operational role in the Health Board and Local Authority and strategic role in the Integration Joint Board.	SOI 8.6 outlines how any in-year variations will be addressed. Within the Shadow Year, the CO receives financial performance information for both her operational role in the Health Board and Local Authority and strategic role in the Integration Joint Board.	None	Single entity reporting still in development	
52	42/4.3.0.2	It is recommended that the Health Board and Local Authority Directors of Finance and the Integration Joint Board financial officer establish a process of regular in-year reporting and forecasting to provide the Chief Officer with management accounts for both arms of the operational budget and for the Integration Joint Board as a whole.	A monthly management report is presented to the CO for discussion and approval covering all functions delegated. This is also reported to her management team on a monthly basis where detailed discussion and (if required) remedial actions are planned and approved.	None	Single entity reporting still in development	
53	42/4.3.0.2	It is also recommended that a joint appointment from the senior finance teams of the Health Board and Local Authority provide the Chief Officer with financial advice for the respective operational budgets. This would allow for the same person carry out both this role and the role of financial officer for the joint board, but this is a matter for local determination.	Interim CFO appointment from 1 March 2016			
54	42/4.3.0.3	It is recommended that the Health Board and Local Authority agree a consistent basis for the preparation of management accounts, i.e. accruals vs. cash basis; this is a matter for local decision.	This is a matter for further discussion. Whilst an accruals basis is consistently applied for statutory reporting, there is inconsistency between the partners in terms of monthly accrual accounting for management reporting purposes.	Ongoing work package		

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55	43/4.3.0.4	Integration Joint Board will allocate the resources it receives from the partner Health Board and Local Authority in line with the Strategic Plan; in doing this it will be able to use its power to hold reserves	This will be undertaken as part of the work developing the approach to Strategic and Operational Financial Planning during 2016/17	Costed Strategic Plan		
56	43/4.3.0.5	In her/his operational role, the Chief Officer will manage the respective operational budgets so as to deliver the agreed outcomes within the operational budget viewed as a whole. The Chief Officer will be responsible for the management of in-year pressures and will be expected to take remedial action to mitigate any net variances and deliver the planned outturn	This is currently happening to a degree. The CO takes full responsibility for the management of in-year pressures during 2015/16. Whilst in shadow year and budgets only as aligned presently, the operational budget is not viewed as a whole for the purposes of such remedial action however.	None	Shift from aligned to fully integrated budgets, supported by Financial Regulations / Virement rules from 1st April 2016	
57	43/4.3.0.7	It is recommended that the Integration Joint Board has a reserves policy and reserves strategy, which include the level of reserves required and their purpose. This should be agreed as part of annual budget setting and reflected in the Strategic Plan agreed by the Integration Joint Board.	This has yet to be developed and be approved during 2016/17 in preparation for 2017/18 financial planning process.	CFO will develop and seek agreement from CO/IJB and respective partners	Will form part of IJB Financial Strategy	
58	43/4.3.0.9	The Chief Officer will not be able to vire between the operational Integrated Budget and those budgets that are managed by the Chief Officer, but are outside of the scope of the Strategic Plan, unless agreed by the partner Local Authority and Health Board.	The arrangements for this are defined in s8.6 of the SOI	None	Specifically stated in 8.6.4 - 8.6.6 of SOI	
59	43/4.3.0.9	The arrangements for the virement of budgets should be specified in the scheme of delegation within the partner authorities.	Outstanding - partners' Financial Regulations require review and if appropriate, updating	Schemes of administration in NHSB and SBC require review and update accordingly.		
60	44/4.3.1.1	The Integration Scheme should include provisions for the treatment of in-year under and overspends.	s8.6 of SOI clearly defines these provisions	None		

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61	44/4.3.1.5	In-year underspends on either arm of the operational integrated budget should be returned from the Local Authority and Health Board to the Integration Joint Board and carried forward through the general fund.	8.6.8 of the SOI states "Any unplanned underspend will be returned to Borders Health Board or Scottish Borders Council by the Integration Joint Board either in the proportion that individual pressures have been funded or based on which service the savings are related to. " 8.6.7 states "Where there is a planned underspend in operational budgets arising from specific action by the Integration Joint Board it will be retained by the Integration Joint Board. This underspend may be used to fund additional capacity in-year or, with agreement with the partner organisations, carried forward to fund capacity in subsequent years. . The carry forward will be held in an ear-marked balance within Scottish Borders Council's general reserve."	None	Treatment of planned overspends defined in SOI 8.6.7, unplanned overspends in 8.6.8	
4.4 NOTIONAL BUDGET FOR DIRECTED HOSPITAL SERVICES						
62	46/4.4.0.3	Legislation requires that the method for determining the amount to be set aside by the Health Board should be included in the Integration Scheme	This is defined in s8.5 of the SOI, specifically referencing IRF. Currently, further work to develop IRF by partner organisations is required before this can inform fully the calculation - resources have been identified on a 'direct-only' basis in the interim	A calculated notional budget is presented within the financial statement to the IJB 30 March 2016		
63	.	Where material; the notional budget should include the resources for the in scope hospital services used by the partnership population in all Health Boards.	Not relevant within Scottish Borders			
64	46/4.4.1.4	It is recommended that partners should establish a process for the Chief Officer and the hospital sector to jointly monitor in year actual demand against plan and provide for virements, if required, based on practical thresholds.	t.b.a.	t.b.a.		
5. VAT						
5.1 REVENUE						
5.2 CAPITAL						

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65	50/5.2.1	In the short term the Integration Joint Board will not be empowered to own capital assets and the VAT regimes of the Local Authority and Health Board will apply to capital assets used to provide the delegated services.	8.7.1 of SOI states "The Integration Joint Board will not own any capital assets but will have use of such assets which will continue to be owned by Borders Health Board and Scottish Borders Council who will have access to sources of funding for capital expenditure". The SOI does not refer to VAT regimes, however, following national recommended practice (HSCI Finance Leads recommendations, existing partners' VAT regimes will apply.	None	VAT approach should be simple and pragmatic - watching brief presently to ensure all decisions proposed and implemented are VAT neutral	
6. CAPITAL AND ASSET MANAGEMENT						
6.1 ASSET MANAGEMENT						
66	51/6.1.1	The Integration Joint Board should identify the asset requirements to support the Strategic Plan. This will enable the Chief Officer to identify capital investment projects, or business cases to submit to the Health Board and Local Authority for consideration as part of the capital planning processes, recognising that partnership discussion would be required at an early stage if a project was jointly funded.	SOI 8.7.2 states "The Chief Officer will consult with Borders Health Board and Scottish Borders Council to identify need for asset improvement owned by either party and where investment is identified, will submit a business case to the appropriate party which will be considered as part of each party's existing capital planning and asset management arrangements." Following the IRAG guidance therefore, a formal process will be in place to consider IJB capital requirements as part of both organisations' wider capital planning process".	None		
67	51/6.1.3	The Integration Joint Board, Health Board and Local Authority are recommended to undertake due diligence to identify all non-current assets which will be used in the delivery of the Strategic Plan.	This is not stipulated in SOI, nor has any work been undertaken to identify fixed assets specifically.	An audit of all fixed assets supporting the functions delegated will be require undertaking and a report to the IJB, linking them to the delivery of the Strategic Plan will be made during 2016/17	2016/17	
6.2 CAPITAL FUNDING						

Scottish Borders Health and Social Care PARTNERSHIP	Complete
	Complete, Minor Remaining Actions Profiled
	OnTrack, Actions Planned
	Requires Further Action
	Does not currently apply

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ACTION POINT	IRAG REFERENCE	IRAG PROVISION	PROGRESS	ACTIONS REQUIRED	COMMENTS / STATUS>
68	52/6.2.1	The Integration Joint Board will not receive any capital allocations, grants or have the power to borrow to invest in capital expenditure. The Health Board and Local Authority will continue to own any property and assets used by the Integration Joint Board and have access to sources of funding for capital expenditure.	SOI s8.7.1 states that "In line with guidance, the Integration Joint Board will not receive any capital allocations, grants or have the power to borrow to invest in capital expenditure." Asset ownership will be retained by each partner and a formal process for accessing sources of capital funding from either organisation will be develoepd".	Capital Planning process	
6.3 R&M					
69	53/6.3.1	The Integrated Budget may include payments from the Local Authority and Health Board to cover the revenue costs of assets e.g. rents, repairs and maintenance, rates, cleaning, property insurance etc.	Locally, we have decided not to include property repairs, maintenance and servicing within the Integrated Budget and both partners' will retain the responsibility for this function.	None	

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CHIEF OFFICER'S REPORT

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 Health and Social Care Integration.

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 February: Attended the Cheviot Area Forum as a representative of NHS Borders and discussed issues with regard to access to community hospital services for the population of Jedburgh.

19 February: Attended the Chief Officers National Network meeting to discuss financial planning, the NHS National Clinical Strategy and an update on the Development and Learning Programme for Chief Officers. This was attended by approximately 20 of the 32 Chief Officers across Scotland.

March saw the start dates of the 3 locality coordinators funded through the Integrated Care Fund to support front line staff, make connections across agencies and services, and to help deliver local improvements and facilitate the implementation of local plans.

3 March: Attended the Berwickshire Area Forum as a representative of NHS Borders and discussed issues with regard to the NHS Clinical Strategy and performance of the Board over the winter period and progress on integration.

1 April: The communications team successfully ensured engagement from local press on the launch of the Health and Social Care partnership arrangements. There were positive media messages displayed in a number of local newspapers.

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

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		

Complete	
Complete, Minor Remaining Actions Profiled	
OnTrack, Actions Planned	
Requires Further Action	
Does not currently apply	

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1. DELEGATION TO AN IJB						
1.1 INTEGRATION SCHEME AND STRATEGIC PLAN						
1	22/1.1.1	The Integration Scheme sets out the detail of the integration arrangement, as agreed by the Local Authority and Health Board and submitted to Scottish Ministers for approval	Detailed in Final Scheme 151215	None	Received ministerial approval mid-2015 s2-6 set out governance and delivery arrangements, functions delegated and accountability / etc	
2	22/1.1.1	The SOI will cover a number of matters provided for by the legislation and Regulations and for finance related matters these will include: • Functions which are to be delegated to the Integration Joint Board by the Health Board and Local Authority; • The method for the determination of the resources to be made available by the Local Authority and Health Board to the Integration Joint Board for the delegated functions; • Reporting arrangements between the Integration Joint Board, Health Board and Local Authority; and • Financial management arrangements.	SOI appendix 2 and 3 outlines functions delegated Method for determining resource allocationand treatment of variations is detailed in SOI s8.	None	Also covers arrangeements in relation to large hospital budgets set-aside	
3	22/1.1.3	Integration Scheme should also define those services which are not delegated to the Integration Joint Board but are managed by the Chief Officer on behalf on the partner Local Authority and Health Board.	There are no services of this nature managed by the Chief Officer	None	This does not preclude such an arrangement taking place in the future	
1.2 CHIEF OFFICER						

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4	22/1.2.1	The Integration Joint Board must make arrangements for the proper administration of its financial affairs and appoint an officer with this responsibility, (the Integration Joint Board financial officer)	IJB Chief Financial Officer appointed on an interim basis from 1st March 2016	Permanent appointment will be made during 2016	The Chief Financial Officer will be responsible for developing a number of further governance and operational planning, management and reporting arrangements going forward	
1.3 FINANCIAL MODEL						
5	23/1.3.0.1	The Health Board and Local Authority will delegate functions and make payments to the Integration Joint Board in respect of the delegated functions and the Health Board will also set aside amounts in respect of large hospitals for use by the Integration Joint Board.	This is set out in section 8 of the SOI. Specifically, 8.3/8.4 set out the provisions for making payments to the IJB whilst 8.5 sets out the method for determining the amount set aside for large hospital services.	None	Amount delegated / Set-aside is subject to due dilligence process and assessment of sufficiency of resources when compared to current spend levels and current and future risks	
6	23/1.3.0.1	The Integration Joint Board will produce the Strategic Plan for the use of these resources and give direction and make payment where relevant to the Health Board and Local Authority for delivery of the services in line with the Strategic Plan.	Strategic Plan approved 7th March 2016 Formal directions yet to be developed	Directions from IJB to partners require to be developed and issued		
7	23/1.3.1.1	Resources within the scope will comprise: • The payment made to the Integration Joint Board by the Local Authority for delegated adult social care services (A); • The payment made to the Integration Joint Board by the Health Board for delegated primary and community healthcare services and for those delegated hospital services which will be managed by the Chief Officer (B); and • The amount set aside by the Health Board for delegated services provided in large hospitals for the population of the Integration Joint Board (C).	This is explicitly stated within the SOI 3.3 and sections 8.3-8.5 clearly reflect that this will be the case. Figure 1 P24 graphically reflects this - also detailed within Appendices 2 and 3.	It is intended that a financial statement and assurance report will be approved by the IJB at its extraordinary meeting of 30 March 2016, detailing the amout of resources following within the scope across each of the 3 elements	3 areas of resource (A+B+C) constitute all available resources supporting the delivery of the Strategic Plan, whilst only A+B form part of the delegated budget Rated green in anticipation of IJB approval on 30th March	

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8	24/1.3.1.2	The Integrated Budget comprises of parts (A) and (B).	This is explicitly stated within the SOI 3.3 and sections 8.3-8.5 clearly reflect that this will be the case. Figure 1 P24 graphically reflects this - also detailed within Appendices 2 and 3.	In the report to IJB on 30 March which will propose the resources delegated and due dilligence over them, this should be stated	These are the budget heads over which CO has direct management responsibility	
9	24/1.3.2.1	In addition to the services within scope of the Strategic Plan and managed by the Chief Officer, the Local Authority and Health Board may request that the Chief Officer manage services that are outside of the scope of the Strategic Plan.	Presently, this is not the case within the Scottish Borders. The Chief Officer is only responsible for functions delegated to the IJB. There is scope for this however, within the SOI 1.3.2.1.	None	Is not precluded from future arrangements	
1.4 FINANCIAL GOVERNANCE						
10	25/1.4.1.1	The Integration Joint Board will be required to produce its own statutory accounts as a body under Section 106 of the Local Government (Scotland) Act 1973.	This is not referred to within the SOI, but will apply following the closure of each Financial Year.	None	Awaiting agreement on whether 2015/16 accounts will be required	
11	25/1.4.1.2	The Local Authority and Health Board will be required to include additional disclosures and group accounts as part of their financial statements which reflect their relationship with the Integration Joint Board.	This is not referred to within the SOI, but will apply following the closure of each Financial Year.	None	15/16 may require to be restated for comparative purposes / or produced for period from IJB establishment date	
12	25/1.4.2.1	The Integration Joint Board must appoint an officer to be responsible for the administration of its financial affairs, referred to in this guidance as the Integration Joint Board financial officer.	4.4b of SOI Scheme P9 explicitly refers to the IJB requiring to appoint a CFO.	None	Interim IJB CFO appointed from 1 March 2016	
13	25/1.4.2.3	The Health Board and Local Authority may make use of non-current assets, owned or otherwise, to deliver the services in scope of the Strategic Plan. Ownership of the assets and the associated liabilities will be unchanged and remain with the partner Local Authority and Health Board.	This will be the case for the Scottish Borders partnership, explicitly defined in 8.7.1.	None	Arrangements for Capital Financial Planning require to be developed post April 2016 and applied during the medium-term planning from 17/18	
14	26/1.4.3.1	The Integration Joint Board should establish a system of risk management arrangements for the functions delegated to it.	This is explicitly defined in section 13 of the SOI.	None		
2. ASSURANCE AND GOVERNANCE						
2.1 FINANCIAL ASSURANCE						

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	Complete, Minor Remaining Actions Profiled
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	Requires Further Action
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15	27/2.1.1	The Health Board accountable officer and the Local Authority 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.	Provision within the SOI for the processes through which performance and resources will be managed.	None	Performance Management and Reporting group established in order to deliver rounded financial and performance information and processes to inform integrated decision making from 16/17	
16	27/2.1.3	The Chief Officer is: • Accountable to the Chief Executive of the Health Board for financial management of the operational budget, and is advised by the Health Board Director of Finance; • Accountable to the Section 95 Officer of the Local Authority for financial management of the operational budget; and • Accountable to the Chief Executive of the Local Authority and Chief Executive of the Health Board for the operational performance of the services managed by the Chief Officer.	This is the arrangement proposed for the Scottish Borders partnership, supplemented by the CO's accountability to the IJB for all matters on services and budgets integrated and for which she is responsible. SOI 6.4 explicitly defines accountability to Chief Executives. There is less explicit reference to the COs accountability for matters financial.	None		
17	27/2.1.4	The financial regulations should be developed by its financial officer and incorporate a minimum set of controls. It is recommended that the financial regulations are approved by the Integration Joint Board.	Developed, agreed and reported to the IJB for approval on 01/02/16 following IJB members development session 20/01/16.	None		
18	27/2.1.5	The financial regulations of the Health Board and Local Authority should be revised, if necessary, to incorporate changes resulting from the financial integration arrangements including the arrangements for virement associated with the Integrated Budget.	Still to be completed.	A review of both NHSB and SBC Financial Regulations is required to ensure complementary and consistent governance policy and application.		
2.2 RISK MANAGEMENT						
19	28/2.2.1	The Chief Officer will be responsible for establishing the Integration Joint Board's risk strategy and profile and developing the risk reporting arrangements.	This is explicitly defined in 13.1 of the SOI	None	Development of a risk management strategy and risk register remains ongoing	

Complete	
Complete, Minor Remaining Actions Profiled	
OnTrack, Actions Planned	
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20	28/2.2.2	The participating authorities should identify and manage within their own risk management arrangements any risks they consider to have retained under the integration arrangements.	Requires to be further reviewed within both NHSB and SBC following establishment of the IJB.	Requires to be further reviewed within both NHSB and SBC following establishment of the IJB.	Risk registers within SBC and NHSB require updating and reporting in respect of new and retained risks	
21	27/2.2.3	The Integration Scheme should consider provisions to address the key risks inherent in integration and include: • Governance, management and strategy; • Financial management; • Asset management; • Information management; • Performance management; and • Customer management.	Arrangements/provisions for control and governance across each of these areas is provided for within the Scheme of Integration, including complaints handling, etc, primarily within sections 10 to 13	None		
22	27/2.2.4	It is also recommended that the provisions for risk management in the Integration Scheme include: • Leadership/lines of accountability; • Arrangements for recording, updating, monitoring and reporting of risk management information; and • Arrangements for accessing professional risk management support.	None of this is explicitly defined in detail within the Scheme of Integration.	A report to the IJB on the Code of Governance including Risk Management arrangements and strategy was made to the IJB on 07 March 2016 with further organic development planned during 2016		
2.3 INSURANCE						
23	29/2.3.1	Integration Joint Boards should make appropriate provision for insurance according to the risk management strategy.	Risk Management strategy is still in development and remains unapproved.	Requires inclusion and finalisation.	Interim insurance options are currently being considered	
24	29/2.4.1	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.	IJB has approved the appointment of CIA to the IJB. Audit committee will be established. Internal Audit plan to be developed Etc.	Work ongoing.	There are a number of items requiring reporting to both the IJB and NHSB/SBC audit committees with regard to audit arrangements for the IJB	

Complete	
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25	30/2.4.6	There should be a risk based internal audit plan developed by the Chief Internal Auditor of the Integration Joint Board and approved by the Integration Joint Board or other committee.	Not complete.	To be completed.		
26	30/2.4.7	Internal audit service should be provided by one of the internal audit teams from the Health Board or Local Authority and the Chief Internal Auditor from either of the partner Health Board or Local Authority fulfil this role in the Integration Joint Board.	IJB has approved the appointment of CIA to the IJB. Audit committee will be established. .Audit committee has been approved and established.	Approved February 2016	This requires formal approval by the IJB - 01 Feb 2016	
27	30/2.4.9	The Integration Joint Board Chief Internal Auditor should report to the Chief Officer and the Integration Joint Board on the annual audit plan, delivery of the plan and recommendations and should provide an annual internal audit report including the audit opinion.	From 2016/17	None		
28	31/2.5.2	The Accounts Commission will appoint the auditors to the Integration Joint Board.	KPMG, Scottish Borders Council's external auditors, have been appointed as auditors to the IJB	None		
29	31/2.6.1	The Integration Joint Board should 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.	From 2016/17	None		
3. FINANCIAL REPORTING						
3.1 STATUTORY ACCOUNTS						
30	33/3.1.0.1	Audited annual accounts to be prepared with the reporting requirements specified in the relevant legislation and regulations	With effect from 2016/17	None	15/16 may require to be restated for comparative purposes	
31	33/3.1.0.2	The Local Authority and Health Board should include additional disclosures in their statutory accounts which reflect their formal relationship with the Integration Joint Board. .	With effect from 2016/17	None	15/16 may require to be restated for comparative purposes	
32	34/3.1.1.4	The Integration Joint Board financial statements must be completed to meet the audit and publication timetable specified in regulations	With effect from 2016/18	None	15/16 may require to be restated for comparative purposes	

Further work will be undertaken during 2016/17 to ensure full compliance with IRAG in relation to Financial Reporting

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	Complete, Minor Remaining Actions Profiled
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ACTION POINT	IRAG REFERENCE	IRAG PROVISION	PROGRESS	ACTIONS REQUIRED	COMMENTS / STATUS>	
4. FINANCIAL MANAGEMENT						
4.1 RESOURCES WITHIN THE SCOPE OF THE STRATEGIC PLAN						
33	38/4.1.1	The legislation requires that the Integration Joint Board produce a Strategic Plan, which sets out the services for their population over the medium term (3 years)	Updated Strategic Plan published and launched in November 2015.	Currently being refined		
34	38/4.1.2	The Strategic Plan should incorporate a medium term financial plan (3 years) for the resources within scope of the Strategic Plan which will comprise: • the Integrated Budget, i.e. the sum of the payments to the Integration Joint Board (see 4.2); plus • the notional budget, ie the amount set aside by the Health Board, for large hospital services used by the Integration Joint Board population (see 4.4).	This is not explicitly within the Strategic Plan although the services to be integrated are defined in Appendix A. These resources within scope will be formally defined within the 2016/17 Financial Statement which will be approved by the IJB in March 2016 and which will support the delivery of the Strategic Plan. This will also include large hospital set-aside notional budget. Formal Written Directions, including the value of specific integrated budget, will also be issued by the IJB to its partners	Report to IJB 30 March will detail financial statement for approval. Review of notional budget / IRF scheduled for 2016.		
35	38/4.1.4	The relative proportions of partners' contributions to the resources within scope of the plan will not influence the proportion of services that will be directed by The Integration Joint Board through the Strategic Plan, although it is likely that in the first years they will be similar.	This is not specifically referred to within either the SOI or the Strategic Plan but has been a working principle of the financial planning work to date as proposed at a member development session in 2015.	Development of budget relative to financial plan is scheduled for early 2016/17.	2016/17 initial delegated budget is the sum of the outcomes from 2 component financial planning processes within SBC/NHSB	
4.2 THE INTEGRATED BUDGET						
36	39/4.2.1	The legislation requires that Health Boards and Local Authorities make payments to the integration joint board for the delegated functions and that the method for determining the value of the payments is included in the Integration Scheme	8.3.1 of the SOI states that "the baseline payment will be established by reviewing recent past performance and existing plans for NHSB and SBC for the functions delegated adjusted for material items" and 8.1-8.2 provides for the mechanism of value determination.	None		
37	39/4.2.2	The legislation also requires that where the Integration Joint Board gives direction for the partner Local Authority and Health Board for the operational delivery of services, that the value of the payment or the method of agreeing the value of the payment be included in the direction	Directions not yet developed within the Scottish Borders.		See background document - "Note: minimum contents of Directions" / Scottish Government guidance	

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38	39/4.2.3	Integration authorities should undertake a shadow period in 2014-15. The allocations in the shadow period should be based on the existing financial plans of the Local Authority and Health Board including the planned efficiencies and consideration of recent financial outturn and trends in expenditure; this process must be transparent and the assumptions underlying the budgets must be available to all partners.	Shadow period commenced 1st April 2016 - aligned budgets reflected approved 2015/16 Financial Plans for both NHSB and SBC, including planned efficiencies, savings/income proposals and service pressures/growth. Financial Plans between both partners shared and published.	None		
39	39/4.2.4	The financial performance of the Integrated Budget is monitored during the shadow period with full transparency so that all partners have a clear understanding of the cause and type (recurrent/non-recurrent) of variances and the remedial actions taken by the Local Authority and Health Board. They should have a clear understanding of the adequacy of the budgets in the financial plan for the following year and the assumptions on which they are based.	Monthly aligned financial monitoring reports by exception to Programme Implementation Board / Executive Management Team, with a full quarterly report to IJB detailing current and projected position to date and key areas of pressure/savings variances with detailed explanation where required, including proposed remedial action across integrated and non-integrated budget heads. Financial Plan process paper to be developed for IJB.	Financial Statement to IJB 07 March 2016	Financial Planning paper to IJB in addition to Financial Statement Due dilligence paper over sufficiency of resources to deliver Strategic Plan	
40	39/4.2.5	The initial payments to the Integration Joint Board should be based on analysis of the shadow period in 2014-15 to provide the Local Authority, Health Board and Integration Joint Board with reassurance that the delegated resources are sufficient to deliver the delegated functions. It should also consider the respective financial plans of the Local Authority and Health Board including full transparency on the budget assumptions and planned efficiency savings. These allocations should be tested against the actual performance in the shadow period and adjusted if necessary. Although not included in the payment, the analysis in the shadow period should include the notional budget for hospital services.	This is the approach and takes account of both organisations existing financial plans. Assurance over the sufficiency of resources has been undertaken and key risks identified. Both organisations are experiencing significant pressures presently on functions which will be delegated - full assurance / risk assessment has been undertaken allowing a view over the resources and demands on them to be formed.	Assurance over the sufficiency of resources is a key work package - report to IJB 30 March 2016		

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41	40/4.2.7	The method for determining the allocations to the Integrated Budget in subsequent years will be contingent on the respective financial planning and budget setting processes of the Local Authority and Health Board. They should aim to be able to give indicative three year allocations to the integration joint board, subject to annual approval through the respective budget setting processes.	Section 8.4 of the SOI clearly lays out the detailed method through which payment in subsequent years to the IJB for delegated functions will be made. Reference is also made to the IJB agreeing and delivering the Strategic Plan/Financial Plan but through a process of joint discussion and planning with partners.	None presently	Integrated Financial Planning process to be developed for 17/18 onwards	
42	40/4.2.8	The Chief Officer, and the Integration Joint Board financial officer where such is appointed separately, should 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.	This hasn't been the case for 2016/17 budget directly. Will require to be the case for 2017/18 however. In the interim, the CO also acts as manager of services within both organisations and is therefore part of the management team and financial planning process within each respective partner's organisation.	None prior to April 2016	2017/18 Financial Planning process	
43	40/4.2.9	Local Authority and Health Board will evaluate the case for the Integrated Budget against their other priorities and are expected to negotiate their respective contributions accordingly. The allocations will be a negotiated process based on priority and need and it should not be assumed that they will be the same as the historic or national allocations to the Health Board and Local Authority.	Whilst little reference has been made to specifically 'integrated' services as part of NHSB's/SBC's financial planning process for 2016/17, budgets, pressures and requirement for proposed savings have been recognised as part of a prioritisation process. This has the impact of increasing/decreasing certain budgets supporting integrated services.	None prior to April 2016	A clearer approach to prioritisation of integrated services' budgets as part of a wider approach to financial planning in partner organisations will require development for 2017/18.	
44	40/4.2.9	The method for determining the contributions is required to be included in the Integration Scheme.	SOI 8.3-8.5	None		
45	41/4.2.10	The allocations made from the Integration Joint Board to the Local Authority and Health Board for operational delivery of services will be approved by the Integration Joint Board. The value of the payments will be those set out in the Strategic Plan approved by the Integration Joint Board	Report to IJB in March 2016, accompanied by Financial Statement.			

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46	41/4.2.11	The legislation will require that a direction should be in writing and must include information on (Section 26): • The integrated function/(s) that are being directed and how they are to be delivered; and • The amount of and method of determining the payment to carry out the delegated functions.	Formal Written Directions, including the value of specific integrated budget, will also be issued by the IJB to its partners in early 2016/17	Pending	
47	41/4.2.12	It anticipated that a direction from the Integration Joint Board will take the form of a letter from the Chief Officer to the Health Board or Local Authority referring to the arrangements for delivery set out in the Strategic Plan and/or other documentation. Once issued they can be amended or varied by a subsequent direction	Formal Written Directions, including the value of specific integrated budget, will also be issued by the IJB to its partners in early 2016/17	Pending	Clarity of understanding of Directions is required and form/content requires agreeing.
48	41/4.2.14	Some social work expenditure budgets will be funded by resource transfer payments. It is recommended that partners identify these and adopt a transparent and consistent approach to their inclusion in the payment to the Integration Joint Board. The options for this are: • For the Health Board to stop paying resource transfer to the Local Authority and instead to include it in its payment to the Integration Joint Board. The Local Authority would need to make a corresponding reduction in its payment to the Integration Joint Board to cover the loss of resource transfer income from the Health Board; or • For the Health Board to continue paying resource transfer to the Local Authority and to exclude it from its payment to the Integration Joint Board. The Local Authority would include in its payment to the Integration Joint Board the social work services funded by the resource	Work is ongoing in this area analysing out the level of resource transfer, its basis and its current application.	Ongoing	
49	41/4.2.15	It is recommended that the local decision on treatment of resource transfer be set out in the Integration Scheme.	Resource transfer is not referred to within the SOI. This will therefore require local agreement and may require reporting to IJB.	Further work and agreement required	

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SCOTTISH BORDERS INTEGRATED JOINT BOARD
COMPLIANCE CHECK WITH INTEGRATED RESOURCES ADVISORY GROUP GUIDANCE

ACTION POINT	IRAG REFERENCE	IRAG PROVISION	PROGRESS	ACTIONS REQUIRED	COMMENTS /	STATUS>
50	42/4.2.17	Resources used by the population of an Integration Joint Board for delegated services that are provided on a hosted arrangement, should be included in the respective Integrated Budget	Further work required	Further work required		
4.3 MANAGING FINANCIAL PERFORMANCE						
51	42/4.3.0.1	The partners should include in the Integration Scheme provisions for managing in-year financial performance of the Integrated Budget. This will require that the Chief Officer receive financial performance information for both her/his operational role in the Health Board and Local Authority and strategic role in the Integration Joint Board.	SOI 8.6 outlines how any in-year variations will be addressed. Within the Shadow Year, the CO receives financial performance information for both her operational role in the Health Board and Local Authority and strategic role in the Integration Joint Board.	None	Single entity reporting still in development	
52	42/4.3.0.2	It is recommended that the Health Board and Local Authority Directors of Finance and the Integration Joint Board financial officer establish a process of regular in-year reporting and forecasting to provide the Chief Officer with management accounts for both arms of the operational budget and for the Integration Joint Board as a whole.	A monthly management report is presented to the CO for discussion and approval covering all functions delegated. This is also reported to her management team on a monthly basis where detailed discussion and (if required) remedial actions are planned and approved.	None	Single entity reporting still in development	
53	42/4.3.0.2	It is also recommended that a joint appointment from the senior finance teams of the Health Board and Local Authority provide the Chief Officer with financial advice for the respective operational budgets. This would allow for the same person carry out both this role and the role of financial officer for the joint board, but this is a matter for local determination.	Interim CFO appointment from 1 March 2016			
54	42/4.3.0.3	It is recommended that the Health Board and Local Authority agree a consistent basis for the preparation of management accounts, i.e. accruals vs. cash basis; this is a matter for local decision.	This is a matter for further discussion. Whilst an accruals basis is consistently applied for statutory reporting, there is inconsistency between the partners in terms of monthly accrual accounting for management reporting purposes.	Ongoing work package		

Complete
Complete, Minor Remaining Actions Profiled
OnTrack, Actions Planned
Requires Further Action
Does not currently apply

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ACTION POINT	IRAG REFERENCE	IRAG PROVISION	PROGRESS	ACTIONS REQUIRED	COMMENTS / STATUS>	
55	43/4.3.0.4	Integration Joint Board will allocate the resources it receives from the partner Health Board and Local Authority in line with the Strategic Plan; in doing this it will be able to use its power to hold reserves	This will be undertaken as part of the work developing the approach to Strategic and Operational Financial Planning during 2016/17	Costed Strategic Plan		
56	43/4.3.0.5	In her/his operational role, the Chief Officer will manage the respective operational budgets so as to deliver the agreed outcomes within the operational budget viewed as a whole. The Chief Officer will be responsible for the management of in-year pressures and will be expected to take remedial action to mitigate any net variances and deliver the planned outturn	This is currently happening to a degree. The CO takes full responsibility for the management of in-year pressures during 2015/16. Whilst in shadow year and budgets only as aligned presently, the operational budget is not viewed as a whole for the purposes of such remedial action however.	None	Shift from aligned to fully integrated budgets, supported by Financial Regulations / Virement rules from 1st April 2016	
57	43/4.3.0.7	It is recommended that the Integration Joint Board has a reserves policy and reserves strategy, which include the level of reserves required and their purpose. This should be agreed as part of annual budget setting and reflected in the Strategic Plan agreed by the Integration Joint Board.	This has yet to be developed and be approved during 2016/17 in preparation for 2017/18 financial planning process.	CFO will develop and seek agreement from CO/IJB and respective partners	Will form part of IJB Financial Strategy	
58	43/4.3.0.9	The Chief Officer will not be able to vire between the operational Integrated Budget and those budgets that are managed by the Chief Officer, but are outside of the scope of the Strategic Plan, unless agreed by the partner Local Authority and Health Board.	The arrangements for this are defined in s8.6 of the SOI	None	Specifically stated in 8.6.4 - 8.6.6 of SOI	
59	43/4.3.0.9	The arrangements for the virement of budgets should be specified in the scheme of delegation within the partner authorities.	Outstanding - partners' Financial Regulations require review and if appropriate, updating	Schemes of administration in NHSB and SBC require review and update accordingly.		
60	44/4.3.1.1	The Integration Scheme should include provisions for the treatment of in-year under and overspends.	s8.6 of SOI clearly defines these provisions	None		

Complete
Complete, Minor Remaining Actions Profiled
OnTrack, Actions Planned
Requires Further Action
Does not currently apply

Scottish Borders Health and Social Care PARTNERSHIP

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SCOTTISH BORDERS INTEGRATED JOINT BOARD
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ACTION POINT	IRAG REFERENCE	IRAG PROVISION	PROGRESS	ACTIONS REQUIRED	COMMENTS / STATUS>	
61	44/4.3.1.5	In-year underspends on either arm of the operational integrated budget should be returned from the Local Authority and Health Board to the Integration Joint Board and carried forward through the general fund.	8.6.8 of the SOI states "Any unplanned underspend will be returned to Borders Health Board or Scottish Borders Council by the Integration Joint Board either in the proportion that individual pressures have been funded or based on which service the savings are related to. " 8.6.7 states "Where there is a planned underspend in operational budgets arising from specific action by the Integration Joint Board it will be retained by the Integration Joint Board. This underspend may be used to fund additional capacity in-year or, with agreement with the partner organisations, carried forward to fund capacity in subsequent years. . The carry forward will be held in an ear-marked balance within Scottish Borders Council's general reserve."	None	Treatment of planned overspends defined in SOI 8.6.7, unplanned overspends in 8.6.8	
4.4 NOTIONAL BUDGET FOR DIRECTED HOSPITAL SERVICES						
62	46/4.4.0.3	Legislation requires that the method for determining the amount to be set aside by the Health Board should be included in the Integration Scheme	This is defined in s8.5 of the SOI, specifically referencing IRF. Currently, further work to develop IRF by partner organisations is required before this can inform fully the calculation - resources have been identified on a 'direct-only' basis in the interim	A calculated notional budget is presented within the financial statement to the IJB 30 March 2016		
63	.	Where material; the notional budget should include the resources for the in scope hospital services used by the partnership population in all Health Boards.	Not relevant within Scottish Borders			
64	46/4.4.1.4	It is recommended that partners should establish a process for the Chief Officer and the hospital sector to jointly monitor in year actual demand against plan and provide for virements, if required, based on practical thresholds.	t.b.a.	t.b.a.		
5. VAT						
5.1 REVENUE						
5.2 CAPITAL						

Scottish Borders Health and Social Care PARTNERSHIP

Complete
Complete, Minor Remaining Actions Profiled
OnTrack, Actions Planned
Requires Further Action
Does not currently apply

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ACTION POINT	IRAG REFERENCE	IRAG PROVISION	PROGRESS	ACTIONS REQUIRED	COMMENTS / STATUS>	
65	50/5.2.1	In the short term the Integration Joint Board will not be empowered to own capital assets and the VAT regimes of the Local Authority and Health Board will apply to capital assets used to provide the delegated services.	8.7.1 of SOI states "The Integration Joint Board will not own any capital assets but will have use of such assets which will continue to be owned by Borders Health Board and Scottish Borders Council who will have access to sources of funding for capital expenditure". The SOI does not refer to VAT regimes, however, following national recommended practice (HSCI Finance Leads recommendations, existing partners' VAT regimes will apply.	None	VAT approach should be simple and pragmatic - watching brief presently to ensure all decisions proposed and implemented are VAT neutral	
6. CAPITAL AND ASSET MANAGEMENT						
6.1 ASSET MANAGEMENT						
66	51/6.1.1	The Integration Joint Board should identify the asset requirements to support the Strategic Plan. This will enable the Chief Officer to identify capital investment projects, or business cases to submit to the Health Board and Local Authority for consideration as part of the capital planning processes, recognising that partnership discussion would be required at an early stage if a project was jointly funded.	SOI 8.7.2 states "The Chief Officer will consult with Borders Health Board and Scottish Borders Council to identify need for asset improvement owned by either party and where investment is identified, will submit a business case to the appropriate party which will be considered as part of each party's existing capital planning and asset management arrangements." Following the IRAG guidance therefore, a formal process will be in place to consider IJB capital requirements as part of both organisations' wider capital planning process".	None		
67	51/6.1.3	The Integration Joint Board, Health Board and Local Authority are recommended to undertake due diligence to identify all non-current assets which will be used in the delivery of the Strategic Plan.	This is not stipulated in SOI, nor has any work been undertaken to identify fixed assets specifically.	An audit of all fixed assets supporting the functions delegated will be require undertaking and a report to the IJB, linking them to the delivery of the Strategic Plan will be made during 2016/17	2016/17	
6.2 CAPITAL FUNDING						

Scottish Borders Health and Social Care PARTNERSHIP	Complete
	Complete, Minor Remaining Actions Profiled
	OnTrack, Actions Planned
	Requires Further Action
	Does not currently apply

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SCOTTISH BORDERS INTEGRATED JOINT BOARD
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ACTION POINT	IRAG REFERENCE	IRAG PROVISION	PROGRESS	ACTIONS REQUIRED	COMMENTS / STATUS>
68	52/6.2.1	The Integration Joint Board will not receive any capital allocations, grants or have the power to borrow to invest in capital expenditure. The Health Board and Local Authority will continue to own any property and assets used by the Integration Joint Board and have access to sources of funding for capital expenditure.	SOI s8.7.1 states that "In line with guidance, the Integration Joint Board will not receive any capital allocations, grants or have the power to borrow to invest in capital expenditure." Asset ownership will be retained by each partner and a formal process for accessing sources of capital funding from either organisation will be develoepd".	Capital Planning process	
6.3 R&M					
69	53/6.3.1	The Integrated Budget may include payments from the Local Authority and Health Board to cover the revenue costs of assets e.g. rents, repairs and maintenance, rates, cleaning, property insurance etc.	Locally, we have decided not to include property repairs, maintenance and servicing within the Integrated Budget and both partners' will retain the responsibility for this function.	None	

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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: 09.02.16
- Strategic Planning Group: 08.03.16

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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Scottish Borders Health and Social Care PARTNERSHIP

Meeting of the Strategic Planning Group
2.00pm to 3.30pm on 9 February 2016
Ruberslaw Room, Tweed Horizons

Minute

Attendees: Susan Manion (Chair), Eric Baijal, Carin Pettersson, Tim Patterson, Tim Young, David Bell, Clare Malster, Jenny Miller, Dr Peter Symms, Sandra Campbell, Linda Jackson, Karen McNicoll, Clare Richards, Bob Howarth, Amanda Miller, Jenny Miller, Suzanne Hislop (Minutes)

1.	**Welcome** • The Chair welcomed members and emphasised the need to clarify proposals on how the group both link into and raise awareness among the wider community. The way in which the group gives messages to the IJB needs to also be given thought and a more formal process considered to allow the group to fulfil its original intention. The Chair proposed a development session for this group with a separate session for the IJB where the Commissioning and Implementation Plan, Integrated Care Fund and performance monitoring/draft performance framework can also be discussed.	**Action SC/SH**
2.	**Apologies**: Margaret McGowan, Jane Douglas, Steph Errington, Fiona Morrison, Elaine Torrance, Alasdair Pattinson, Morag Walker	
3.	**Minutes of the previous meeting** • The minutes of the previous meeting of 13 January were accepted as a true record. SPG Minutes 13 January 2016.doc • The group went through the actions arising from the last minute and updated the action tracker. Action MASTER Action Tracker SPG.dc	
4.	**Matters Arising** • It was agreed that clear differentiation between people who are in attendance and those who are present was required. This is to be	**ACTION EB/SH**

	clarified and reflected in the minutes of the next meeting of the group. • There was discussion around how the Strategic Planning Group interacts with the Integrated Joint Board and the wider projects that exist and link into the key themes of the IJB. Governance arrangements were also discussed. LJ suggested that a diagram clarifying the governance arrangements would be useful. SC is currently working on this and it will be available soon. It was agreed that the development session would be an appropriate forum to explore these issues more fully. <u>SPG term of Reference:</u> • EB gave a brief overview of the draft Terms of Reference including the role of the SPG in terms of stakeholder engagement. • EB explained that he was looking to the group to endorse the Term of Reference paper subject to the membership being clarified as discussed and the aforementioned development session being arranged. • KM highlighted that AHP's were not included on the list of services being brought together. The Chair suggested that the list was not helpful and it was agreed to instead refer to the Scheme of Integration. The Terms of Reference are to be adjusted as discussed and will now cross reference other documents rather than trying to list separate services.	**ACTION EB**
5.	**Feedback from Integrated Joint Board Meeting 1 February 2016** • Integrated Joint Board members were pleased with the Strategic Plan which is to go to the meeting being held on 7 March for final signed off. • The Chair highlighted the clarity of the documents journey, with the IJB having had sight of the extensive engagement work undertaken. This has been thorough, imaginative and well attended and the Chair acknowledge thanks to those involved including CP, CM and JK. • It has been acknowledged that we need to have a Commissioning Plan for the coming year with the role of the IJB to issue instructions on how services will be delivered in the future. We acknowledge all of the services that are part of the Strategic Plan, however there are the things that we want to be focusing on in the coming year. The Commissioning and Implementation Plan will go to the IJB in April along with draft performance monitoring proposals. • The Commissioning and Implementation Plan will take into consideration the money coming down to the Integrated Care Fund. • The new social care fund of 5.7 million for Scottish Borders (£250million for Scotland as a whole) was discussed. The Chair explained that the expectation was that a significant amount would be used to alleviate pressures in social care. We have to identify how we want to shape it but are conscious that there are expectations around the use of this fund. • TP asked if the SPG could influence the IJB decision making process and ask for the allocation of some of these funds for practise development around the elderly. • TY suggested that it was not ideally about giving more money to practises but what services can be provided for practices.	

	• EB highlighted that the work of planning has to be done elsewhere as this is an advisory group. We have to invest in where we are going to get the maximum input for our services • The Chair supported the comments made by EB and highlighted that the SPG are making recommendations to the IJB about use of total resource in the terms of the Strategic Plan, with reducing admissions one of the elements where we can work with GP colleagues. • TY asked how ideas could be put forward and the Chair explained that we are aiming for a big shift with some major pieces of work and ideas can potentially be taken there and fed into what is already happening. JM pointed out the difficulty in moving forward until the commissioning plan is finalised. • EB stated that TY had summarised 3 big issues that are fundamental to the commissioning plan: o Anticipatory Care. o Avoidable Emergency hospital admissions. o Delayed discharge. • EB added a fourth issue of health and wellbeing to the aforementioned list and emphasised the importance of tackling health inequalities outwith the care system. • LJ suggested that the Carers Centre would be in an ideal position to help to address these issues and the Chair explained that there was recognition that this is not just about the work of the council and the health board. • LJ explained that Carers are coming up against difficulties including confidentiality which can become a barrier to effective communication. • TY suggested that putting a huge amount of resources into small minority of those with greatest need was not going to be most effective use of resources, as this was not going to prevent hospital admissions. • It was suggested that we look at the uniqueness of the Scottish Borders and at local people doing different things which are not just evidence based and explore ideas at community level for some quick wins. The Chair agreed that we all want quick wins but we have to be mindful that this is 3 year plan and is a long game. • There was further discussion around the priorities of the IJB and the Chair explained that it is for the IJB to decide on their priorities and for this group to advise. • It was agreed that at the planned development session the group will look at/ ratify the Commissioning Plan before it goes to the IJB in April. DB highlighted that the group has to be mindful of the submission dates for the IJB. SC to speak with those currently working on this and seek their agreement that the document will be ready to be brought to development session. • EB highlighted the concerns of the Chair of the IJB about attendance at SPG meetings. TY suggested that this comes back to members having clarity on their role within the group and this was another reason why a development session would be useful. <u>ICF Update Paper:</u> • BH provided an overview of the ICF update paper presented to the IJB and highlighted appendix three as of particular interest to the group as it shows the existing arrangements from approval.	**ACTION SC**

	• The intention of the report was to note the progress to date and highlight the existing layers of governance. • KM asked if there had been any emerging themes around projects that haven't been funded and any learning from things that haven't progressed through the several layers of governance. BH agreed that there were lessons to be learned with the governance. Time had however been spent looking at the interconnectivity of projects. Several bids had been around the houses and were coming to the ICF as a last resort which is not acceptable. Also issue of people submitting project ideas and then failing to develop or progress these further. • JM asked if there was a position statement regarding no more unsolicited applications and if so that must be communicated to the Third Sector. • The Chair explained that it is about how we have those conversations and take forward those discussions before we get to that point. • DB noted that posts had been taken for approval and highlighted previous IJB concerns that this gives you a quick win but long term sustainability becomes an issue. The Chair explained that the reality is that we haven't had the people to put the proposal together and develop these. The Autism Co-ordinator for example is about how we progress the autism strategy. The Chair explained that the processes around ICF governance arrangements will be looked at in light of the recent Audit Scotland Report.	
6.	**AOB** • CP requested that a winner of the competition that ran during the consultation/engagement period be selected. CP asked for a random number between 1 and 219 to be chosen so that a winner of the iPad prize may be identified. Entry number 177 was selected.	
7.	**Date and time of next meeting:** **The date of the next meeting was given as 8 March from 2.00pm to 3.30pm in Committee Room 2**	

Scottish Borders Health and Social Care PARTNERSHIP

Meeting of the Strategic Planning Group
2.00pm to 3.30pm on 8 March 2016
Committee Room 2, Scottish Borders Council Headquarters

Minute

Present: Margaret McGowan, David Bell, Dr Peter Symms, Linda Jackson, Tim Young, Jenny Miller

In Attendance: Eric Baijal (Chair), Carin Pettersson, Sandra Campbell, Clare Malster, Paul McMenamin, Gerry Begg, Trish Wintrup, Tim Patterson, Tamara Mulherin, Suzanne Hislop (Minutes)

1.	**Welcome** • EB confirmed that the meeting was quorate and welcomed Tamara Mulherin who was attending to observe.	
2.	**Apologies**: Susan Manion, Elaine Torrance, Karen McNicoll, Shirley Burrell, Alasdair Pattinson, Steph Errington, Julie Kidd, Clare Richards, Amanda Miller, Jane Douglas, Morag Walker	
3.	**Minutes of the previous meeting** • The minutes of the previous meeting of 9 February were accepted as a true record. SPG Minutes 9 February 2016.doc • The group went through the actions arising from the last minute and updated the action tracker. Action Tracker SPG 8 March.doc	
4.	**Matters Arising** • SC tabled a diagram showing the structure of the various Health & Social Care Integration Governance, Project and Operational groups. • Decisions are to be made about the Business Operating Model that will influence the content of the Operational Service Delivery grouping. • Further detail around the flow of information and interactions was suggested and this detail is to be developed following further discussions within the groups. Discussions are currently ongoing to clarify the role of the Executive Management Team (EMT) and the way in which groups interact with EMT.	

	• It was agreed that it was important that the work of the Community Planning Partnership (CPP) is connected with the Programme and Shona Smith (Communities & Partnership Manager) sits on the Localities Planning Sub-Group to ensure that H&SCI plans that are developed link in with the Plans being produced by the CPP. • The diagram is to be amended in light of comments received at today's meeting and a further developed version is to be brought to the next meeting. In view of this the draft diagram is not for wider circulation. • The importance of providing people with context when the diagram is circulated was discussed, as was the benefit of showing the diagram to a small informed group for comments in advance of circulating.	**ACTION SC**

5.	**Membership of the Strategic Planning Group**
	• The revised draft paper addresses the two issues that came out of the last meeting:
	  o Clarification of the membership and those in attendance.
	  o List of services being brought together revised in line with the Scheme of Integration.
	• When the Strategic Planning Group (SPG) was originally initiated a small group was decided upon. There was concern that the group was becoming officer heavy and that is why the group has been separated into members and those in attendance.
	• It was agreed that DB and SB as staff representatives are to be full members with the membership amended to reflect this change.
	• Development work is planned with the possibility that a voting member of the Integration Joint Board (IJB) may become Chair of the SPG.
	• Julie Watson (Organisational Design & Change Business Partner) has been identified as an Organisational Development representative for this group. EB to speak with June Smyth (Director of Workforce and Planning, NHS Borders) and Clair Hepburn (Chief Officer Human Resources, Scottish Borders Council) regarding this, as it was agreed that it would be helpful to have Julie Watson in attendance.
	• GB proposed that the membership of the SPG be revised to include representation from Housing Strategy as well as Registered Social Landlords (RSL), as there is a difference between the RSL Sector and the work undertake by the Council. EB agreed that this warranted further discussion outwith the meeting.
	• There was discussion around the different roles of the SPG and the Strategic Planning Board (SPB) and the way in which both groups interact with the IJB. It was agreed that the planned development session would be an appropriate forum to further discuss these issue.
	• Guidance on the strategic planning process that covers the SPG to be recirculated.
	• The Terms of Reference are to be circulated and signed off electronically following amendments and discussion between EB and GB about the extent of housing representation.
	• Revised membership to be attached to email composed by EB reminding members of the importance of attending or sending a deputy.
		ACTION EB
		ACTION EB
		ACTION EB/GB
		ACTION SH
		ACTION ALL
		ACTION EB

6.	**Update from Integration Joint Board Meeting 7 March 2016** • Formalisation of the Chief Officer and Chief Financial Officer to the legal entity of the IJB. • The Workforce Planning Framework was discussed. • PM gave an overview of the financial issues considered at the meeting and the 3 key papers discussed which were: o Monthly Monitoring Report on services that will be delegated on 1 April. o Position Statement - where we are in establishing the IJB financial governance. o Position Statement on the work done so far. • Financial statement for 1 April still to be signed off and published. This will be a three year financial plan. • One of the main issues is agreeing what the integrated budget will be, but it is clear what functions will be delegated and the budgets that have been allocated to these currently. Work ongoing to produce a robust budget for approval to the IJB. • The Financial Statement requires an Equality Impact Assessment (EIA) which is in progress. The Strategic Plan also requires an EIA and a concerted effort had been made to obtain feedback from protected groups in order to inform this process. • There was some discussion around plans for any underspend and PM gave a brief overview of this issue.	
7.	**Strategic Plan Update** • The Strategic Plan was formally approved at the IJB meeting held 7 March. Work on the Commissioning & Implementation Plan, Performance Management Framework and Localities Plans is ongoing. • The launch of the Strategic Plan was discussed. This focus for this is not on the document but on how this will impact on service users. The Strategic Plan and associated documents will be made available and circulated to stakeholders. There will be a press release but no official launch. • The Communications Team is looking at ways of collecting information on how this is impacting on people receiving the services and collecting individual stories. The Community Council's circulation list and that of the Carers Centre were suggested as additional means of circulating the outcome of this work.	
8.	**Update on Financial Statement** • Discussed under Item No. 6.	
9.	**Local Delivery Plan** • Meriel Smith (Planning & Performance Officer, NHS Borders) gave a brief overview of the Local Deliver Plan (LDP) which is to be submitted to the Scottish Government by 31 May. • The LDP was introduced in 2007/08 and is a contract between NHS Boards and the Scottish Government. The NHS is required to engage with the IJB in developing the LDP, which is to be considered beside the Health & Social Care Integration Strategic Plan. The LDP has been discussed at the Strategic Planning Board and is going to the IJB for discussion on 18 April. New sections on Scheduled Care, Unscheduled Care and Mental Health have been	

	added this year. • SC gave a brief overview of the Integration section of the plan. • It was agreed that the group would submit feedback to SH by Friday 18 March, with particular focus on the Inequalities, Primary Care, Integration and Locality Planning Sections.	**ACTION ALL**
10.	**Localities Update** • The Chair welcomed Trish Wintrup to the meeting and to her new role as Locality Co-ordinator. Two further Locality Co-ordinators will start in the coming weeks.	
11.	**AOB** • EB asked members to submit any comments on issues discussed that they wished passed on to the IJB at the extraordinary meeting scheduled for the end of March. Comments for the IJB on issues such as financial assurance etc. to be forwarded to S Hislop within next 7 days.	**ACTION ALL**
12.	**Date and time of next meeting:** **The date of the next meeting was given as 19 April from 10.00pm to 11.30am in Committee Room 2.**	